

# RAISING ISSUES: LESBIAN, GAY, BISEXUAL, & TRANSGENDER PEOPLE RECEIVING SERVICES IN THE PUBLIC MENTAL HEALTH SYSTEM

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In memory of Cookie Gant

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# INTRODUCTION

Mental health services are part of the fabric of U.S. society. Therefore, they embody the assumptions, values, and conflicts present in society at large including homophobia, mental illness stigma, and other biases. As a result, people who are lesbian, gay, bisexual, and/or transgender (LGBT) and recipients of mental health services face stresses connected to both, from inside and outside the mental health system. Ill informed, abusive, or disrespectful treatment impairs the health of people who come to (or are brought to) mental health service providers for assistance, and so is antithetical to the fundamental purposes of mental health care.

Moreover, there is a developing movement to better recognize the full human complexity of people receiving mental health service -- including their cultural, personal, and social identities. Professional efforts are scattered and trail behind the work of some self-help, advocacy, and alternative voices, but they are growing. While changes in the health industry push for standardizing care (Koch, Lewis & McCall, 1998; Glueckaul & Frank, 1996), there is a competing awareness that the most effective “treatments” are those that address the unique situation, wishes, and nature of each individual client (for example: Erskine, 1998; Gwirtsman, Blehar, McCullough & Kocsis, 1997). Knowledge about and appreciation of sexuality, sexual orientation, and gender identity are a lagging but vital part of this broader developing consciousness.

Psychiatry, psychology, and other helping professions have long histories of pathologizing sexual and gender identities that don't conform to traditional heterosexual standards (see Masters, Johnson & Kolodny, 1988; Campbell, Hinkle, Sandlin & Mollic, 1983 for examples), and poorly, even inhumanely, treating people who are lesbian, gay, bisexual, and/or transgender (see McConaghy, 1970; Bancroft, 1969; White & Dull, 1998; Forenstein, 1993). Indicators that LGBT consumers have been historically and likely still are at high risk for inferior, insensitive, and even abusive treatment and experience obstacles seeking needed care are discussed in this report and the sources it references (see Maccio & Doueck, 2002 and Brotman, Ryan, Cormier, 2003 for a human services overview).

In 2002 (most recent data available) the U.S. Department of Health and Human Services concluded that some 27.3 million adults received some form of mental health services in the 12 months prior to data collection (Manderscheid et al, 2002). If one accepts the common estimations that LGBT people make up 2-10% of the U.S. population, and then assumes that LGBT people receive proportionate mental health services, then how well mental health services address the needs of LGBT people may be directly relevant to between 546,000 and 2.7 million Americans per year.

Furthermore, non-LGBT clients are also impacted by how LGBT affirming (or not) mental health services are, often through the narrow ideas about gender that accompany anti-LGBT biases. For example, female clients who do not fit heterosexual stereotypes of “femininity” are sometimes “accused” of being lesbian regardless of their self-identification. Similarly, heterosexual men may be presumed bisexual or gay if they don’t adhere to “masculine” expectations. Both (heterosexual) groups therefore sometimes encounter anti-gay discrimination.

For all these reasons, and others as well, people who are both LGBT and mental health care recipients are adamantly trying to make their voices heard and have their experiences recognized. While some consumers, providers, program staff, and self-help leaders are working energetically to improve the situation, most often LGBT consumer / survivor issues are ignored by professional research and practice, and even by the mental health consumer/survivor rights and LGBT liberation movements. LGBT clients’ experiences, both good and bad, have mostly been left out of mental health services literature and the growing consumer/psychiatric survivor autobiographical, self-help, and advocacy literatures, even though they have many insights to share.

This report will try to assist their efforts to be heard. By bringing together academic and popular literature, grass roots and unpublished materials, and the first-person reflections of key people who live and/or work with these issues I hope to make the experiences, opinions, complaints, and suggestions of LGBT consumers more accessible, to reflect on the current state of mental health services *vis a vis* these groups, and to suggest research, program and policy work that will document and improve the status quo.

## **Scope & Purpose**

The scope of this report as requested by the federal agency (CMHS) that originally commissioned it, is to “identify and describe needs, issues, and experiences of people who have serious mental illnesses and are lesbian/gay/bisexual/transgender (LGBT) adults. It will also include perspectives from the lesbian / gay / bisexual / transgender community regarding practical ideas for improving mental health service delivery to this particular population.

To effectively address these areas, this report differs in three ways from what is written above: (1) In addition to drawing information from people who consider themselves to have a mental illness, I also have included

the experiences and ideas of people who do not, but who have had extensive contact with the mental health system as clients/patients/consumers. (2) Although the bulk of this report addresses services provided to adults there is a section on teen/youth issues because they are neglected, revealing, and crucial to later adult development. (3) Important topics outside the professional mental health system, such as self-help and advocacy groups and communities (LGBT, Consumer, and both) have also been included to give a holistic picture.

Overall, the purpose of this report is to gather and integrate information currently available from published and unpublished sources so that the knowledge that does currently exist is more accessible to interested parties. It must be noted that many related topics are omitted or only briefly mentioned, usually because so little information is available; it is hoped that criticism of this report and the inevitable gaps in it will motivate others to address additional areas and issues. In later sections, the report highlights resources and exemplary programs and practices - to assist those working to improve mental health care and community for LGBT people and to bring them in better touch with each other. Throughout, it also presents the words and experiences of LGBT consumers verbatim so that readers might better understand the issues and people involved.

## **Notes on Language**

Preferences vary from person to person in describing one's mental health system involvement and one's social identities. For example, a 1996 survey of 302 people receiving mental health services in 20 settings across 5 states (Mueser, Glynn, Corrigan, & Baber, 1996) reported that 44.7% preferred the term "client," 19.9% preferred "patient," and "8.3% preferred "consumer" to describe their mental health services involvement. Twenty percent expressed no preference, and 6.6% preferred yet a different term (but no two people preferred the same term!).

Since there is no universally preferred term among mental health services recipients, this will use several terms, especially as related to specific settings or situations (e.g., patient for inpatient units, residents for housing programs). As the author/, I may tend toward using "consumer" due to its common usage in my locale and because of its connotation that the person so named deserves respect and good service, and has power to enact her/his own preferences in the system. This word has been criticized for being misleading or "sugar-coated" in that many recipients of mental health services have little say in the type, provider, or quality of services available to

them, or even in whether they participate or not. This makes “consumer” more of an aspiration than a current reality.

The term “serious mental illness” (SMI) means a mental illness that substantially disables a person’s daily functioning over a long period of time (years), in contrast to a brief if intense crisis or troubling but not disabling distress. Therefore, the term “psychiatric disability” is also sometimes used interchangeably. These terms are often associated with diagnoses such as schizophrenia, bi-polar disorder, and recurrent serious depression, but may also pertain to others. Different researchers and policy makers have operationalized “substantial,” “impairment,” “functioning,” and “long” in a great variety of ways in different contexts (see Schinnar et al, 1990).

Terms labeling sexual orientations are similarly complex. It has long been accepted in some LGBT and academic circles that sexual orientation is made of multiple facets (e.g. inner identity, feelings, behavior, fantasy content, social role; Friedman, Green, & Spitzer, 1976; Kinsey 1948 & 1952), and that people fall along continua rather than in discrete categories. Nonetheless, the labels of gay, lesbian, bisexual, heterosexual persist as socially constructed categories of considerable import and so will be used here, with acknowledgement that people are always more complex than any label suggests. In most places friendly to LGBT people, the term “homosexual” is rarely used due to its pathological connotation, clinical origins, and solely sexual focus. It has been replaced by “gay man” and “lesbian” in most cases, as terms chosen by (rather than imposed upon) the respective communities as positive and more holistic. “Gay woman” is also commonly used in some communities, but disliked in others. An alternative for “bisexual” has not come into common usage despite problems that parallel “homosexual.” “Bi-amorous” and “bi-affectional” are used in some settings but not widely; the abbreviation “bi” is more common.

Regarding gender identities (which are distinct from sexual orientations), “transgender” and “transsexual” also elicit strong opinions and debate. Often “transgender” is used as an umbrella term for people who cross and redefine gender categories in various ways, while “transsexual” is reserved to refer to people who would like to or have undergone sexual reassignment surgery, hormone therapy, or other somatic treatments. Under this way of thinking, transgender is a broader term that includes transsexual as well as many other identities. This report will follow these conventions.

The term “queer” is gradually changing from solely a street epithet to also being used as an umbrella term (for LGBT all together) within LGBT communities. However, because of its history and that it is still commonly used by hate-mongers, its newer usage is rejected by many LGBT people. Readers might also notice that some



direct quotations use “gay” as a short-hand term for “lesbian, gay, bisexual, transgender” because it is so much shorter to say. Although not unusual, this too has been criticized because it leaves out the often-different realities of lesbians, bisexual people, and transgender people. Therefore, this report will use “LGBT” as an umbrella term in the text (also written GLBT or BGLT by some), while quotations will stand as spoken. In the text “heterosexism” refers to attitudes that heterosexuality is “better” (healthier, more moral, preferable) to bisexual or gay/lesbian orientations, or that heterosexuality is the only orientation (e.g. assuming all clients are “straight”). “Homophobia” is used to connote fearful or hostile reactions to LGBT issues and/or people, and “transphobia” the same type of response to transgender issues or people.

It is important to recognize that some people prefer names for their sexual / gender identities and mental health care involvement other than those used in this report. Because personal experiences and preferences are so varied, the common courtesy of asking people their preferences is wisest in personal interactions (Xavier, 1997).

Finally, the communities and lives of lesbian/gay/bisexual/transgender people are very diverse, as are the lives and experiences of people who receive mental health services, and the services themselves. An individual’s personal experience and situation depends on regional geographical and political factors, the people and organizations involved, socially important demographics such as race, gender, class and disability, surrounding cultural and societal contexts, and history—so that one person’s experience is often very different from another. Therefore this report will tend to discuss mental health “systems” and LGBT “communities” in the plural.

## **Methodology**

The information in this report comes from various sources. The small, sparse professional/research and popular literatures that address the experiences and issues of LGBT consumers in public mental health services have been thoroughly reviewed. Sources from related areas of the academic and popular press were also considered (e.g., the mental health system’s addressing adult sexuality among heterosexual clients/consumers, queer studies, etc), as was academic work on LGBT clients and psychotherapy (see Appendix). Many of the topics emphasized by other

sources (below) are not covered in professional social-sciences literature, or only rarely. Thus “old” references may appear because they are the only published literature on a given topic, as well as for historical context.

Most information about the lives of LGBT consumers can only be found in “fugitive literature” sources – local newsletters and periodicals, unpublished reports and essays, in-house materials, meeting proceedings, personal correspondence and reflection, and more recently, web sites and email discussion groups. Therefore, in addition to exploring libraries and bookstores, computer-assisted literature searches, and publisher’s catalogues small and large, I also contacted many individuals and organizations: people in LGBT communities and organizations, self-help advocacy and support organizations of people who consider themselves to have mental illnesses or psychiatric disabilities, groups of people who have had extensive contact with the mental health system but do not identify as having a disability, activists and dissidents, mental health service programs and providers, professional organizations, related non-profits, and government agencies. All in all, I contacted more than 500 people and organizations, many of whom shared materials, information, and further contacts. Reference citations follow conventions of the American Psychological Association stylebook, although improvisation was occasionally required. A bibliography of materials and a list of resources are appended to the end of this report.

Nonetheless, much of the knowledge germane to this report was not in written form at all, but rather was recorded in the lives and memories of people living and working it. Therefore, informal interviews were conducted (1997-1998) with more than 30 Key Informants who have extensive experiences with LGBT consumers’ issues and mental health services. Their perspectives include personal experiences as LGBT consumers, activists, community workers, and/or providers of services serving LGBT people with serious mental illnesses.

Each Key Informant was recommended by others as having particular relevant knowledge. S/he was sent a letter explaining the report and asking for assistance, which was followed by a phone call. Most were very willing to share their views, usually by phone. I took notes (summary, with verbatim quotes) during our conversation(s) and mailed them to the person for review. Once they returned comments and corrections (if any), the revised notes became my “text” to draw from. In this report, key informants are cited similarly to “personal communication” references and identified with “KI”: (KI Name, Date). However, because of the stigma currently attached both to having a psychiatric services history and to being LGBT (or to being presumed either), the “name” in these citations may take several forms, depending on each person’s preference: full name, first name only, pseudonym, or Anonymous. People who sent letters without contact information or who otherwise could not be reached to ask their

preference are cited as “anonymous” to protect their privacy and safety. That this is necessary should be taken as one indication of the importance of addressing the issues of LGBT psychiatric consumers.

The issues and experiences drawn from these published, unpublished, and first person sources make up the body of this report. It must be emphasized that there is as yet no body of organized research documenting LGBT consumers’/ survivors’ experiences in the public mental health system or with self-help and advocacy organizations. While the material here is carefully considered and the themes are robust, the available information is sparse and incomplete, so they must be considered “anecdotal.” This highlights the report’s main purpose: to raise questions, highlight issues, and spark various types of deliberate, organized inquiry and action.

**PART I: MENTAL HEALTH SERVICES**

## **Mental Health Services and Sexuality**

People who identify as lesbian, gay, bisexual and/or transgender and who also have a serious mental illness face numerous challenges in receiving quality mental health care that meets their needs, and in finding a sense of community. In the public mental health system, where most people with serious mental illnesses receive at least some of their services, they face the same problems as all clients: variable quality and availability of services, a paucity of resources, lack of decent affordable housing, societal stigma against people who are mentally ill, ignorance, disrespect. At the same time, they also face the same hostility and heterosexism faced by LGBT people in all walks of life: stereotypes, discrimination, hostility, ignorance, disrespect. That is, many of the difficulties LGBT consumers encounter are manifestations of more general shortcomings that run through the entire mental health system and/or are common in society at large. One ready example is that of sexuality.

This is a Catch-22 in many settings: sexuality is abstractly considered part of “normal” adult functioning, yet any client/patient who expresses any sexual desires or sexual relationships is considered “acting out” or the behavior is seen as a psychiatric symptom. This happens to people with physical and psychiatric disabilities (Cook, 2000; Mossman, Perlin & Dorfman, 1997; KI Cookie Gant, August 1998; KI Bert Coffman, May 1998), and is often heightened if the person is LGBT (Akhtar, et al., 1977; Trudel & Desjardins, 1992).

Only recently have mainstream providers started to acknowledge affectional and sexual life as part of healthy adult development among “psychiatric patients” (Mossman, Perlin & Dorfman, 1997; Trudel & Desjardins, 1992; Markowitz, 1991). While outward trappings of conventional sexual attractiveness and heterosexuality are commonly encouraged (e.g., women clients seen as “doing better” if they apply makeup), true appreciation for positive sexuality as an important part of clients’ lives is only beginning. Furthermore, even among those few programs that do address client sexuality positively, there is a strong assumption that all service recipients are (or should be) heterosexual (for example: Akhtar, et al., 1977; McEvoy, 1986; Modestin, 1981; Raboch, 1984; Strakosch, 1934). Several key informants explained that disregard for sexuality underlies important types of disrespect experienced by all consumers in the public system, including LGBT people:

[Providers] think sexual orientation is not important... because they don't cover sexuality with their straight clients either – so why should they for GLB clients? This is even a mistake for their heterosexual clients, and more so for GLB clients because of what they have to deal with regarding society and their sexual orientation. (KI Anonymous L., March 1998)



At an outpatient clinic, especially community based, [staff] have perhaps less problem realizing that patients have lives outside the clinic, including sexuality. The state system tends to be more patriarchal, treat patients like children, make them dependents rather than learning to do things to help themselves – and so therefore see patients as less adult, and therefore, less appropriate to have any sexuality. 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 has a rule that residents cannot have sex in the house, [but] they don't 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. (KI Mary Barber, March 1998)



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 – they are always very calm. 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... Part of the reason sexuality (all sexuality) tends to be pathologized among SMI people is the systems tendency to over-generalize, over-pathologize such clients. That is, once someone is seen as ill, everything about them is interpreted as part of their illness, sexuality included. (KI Orren Perlman, June 1998.)

## **Lingering Pathologization of LGBT Identities**

Psychiatry sets lesbians and gay men up for abuse by claiming that heterosexuality is the only healthy, natural way for human beings to be....Lesbianism/homosexuality are seen as deviations from normal development, immature phases and mental illness. (Hughes, 1985)

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. (KI Anonymous W., May 1998)

Sexuality that does not fit conventional heterosexual and gender roles has been frankly pathologized for much of psychology and psychiatry's history (Esterberg, 1990; Fassinger, 1991; Friedman, 1986; Ogborn, 1993; Scasta, 1997). As is well known, “homosexuality” alone deemed one mentally ill according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders until 1973, when the Association voted to amend its taxonomy so that “only” “ego-dystonic homosexuality” was considered a psychiatric illness (Friedman, Green, & Spitzer, 1976; Lief & Kaplan, 1986; Stoller, 1973; Smith, 1980; Stone, 1980). This second

diagnostic label was removed in 1987 (Berkman, 1997; Chaimowitz, 1991; O'Hare, Williams, & Ezoviski, 1996). Homosexuality per se was considered a psychiatric illness in the International Statistical Classification of Diseases, Ninth Edition (ICD-9) but not the more recent ICD-10.

There are many people alive today who experienced decades of "treatment" for homosexuality under these earlier designations. Their past often agonizing experiences (e.g., Duberman, 1992; Green, Peraza, McFadden, & Compton, 1998; Nardi, Sanders, & Marmor, 1994) continue to influence their lives today. As one example, a psychiatrist at an LGBT-affirmative inpatient unit said:

▼ 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' 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 an attractions to members of their own sex. (KI Orren Perlman, July, 1998.)

In parallel, many currently-working mental health professionals were trained prior to 1973, or by people who were (Deacon, Rea, & Largey, 1991). Certainly many of these have changed with the times or never did consider gay, lesbian, or bisexual identities pathological. However, others do and have not changed. Moreover, some more recently trained therapists, program staff, and doctors still consider homosexuality a mental illness or an inferior "level" of psychological development, and act on this assumption in their work (Brody, 1982; Rubinstein, 1995; Smith, 1988). For example:

▼ I told my shrink I didn't want to be cured of being a lesbian. He said that just proved how sick I was. He said I needed shock treatment....19 shock treatments and I still wasn't cured of being a lesbian. (Blackbridge and Gilhooly, 1985)

There is also a long professional history of theories that homosexuality causes mental illness or vice versa (Falk, 1989), especially regarding schizophrenia, mania, borderline personality, and general "insanity". From Evelyn Hooker (1957) through more recent history (Friedman & Downey, 1995; Gonsiorek, 1982, 1991; Herdt & Boxer, 1993; Nurius, 1983; Reis, Safer & Yotiv, 1974; Remafedi, Farrow, & Deisher, 1991) scientific research disproves them. However, prejudices often persist even in the face of contravening evidence (Brody, 1982; Freedman, 1975; Turner, 1981).

Transgender identity is still deemed pathological per se, evidenced by Gender Identity Disorder (GID) in the DSM-IV (American Psychiatric Association, 1994; Bradley, Blanchard, Costes, & Green, 1991). Indeed, being professionally diagnosed with GID is usually a prerequisite to gaining access to somatic treatments (sexual reassignment surgery, hormones). Israel, Tarver (1997, 2002) and others make the point that “depathologization” of transgender identities is gradually making progress in psychiatry and other mental health disciplines, but that it has a long way to go (see also Jones & Hill, 2002). This lingering tendency is also reflected in the professional literature’s apparent preoccupation with publishing co-occurrences of transgender identity and DSM Axis I psychiatric diagnoses, implying cause although single-case studies can be found (Caldwell & Keshavan, 1991; Commander & Dean, 1990; Hyde & Kenna, 1977; Lothstein & Roback, 1984). Methodologically sound studies with larger samples (e.g., Cole, O’Boyle, Emory, & Meyer, 1997) do not find any causal connections.

The lingering assumption of LGBT identities as pathological and as tied to other pathologies still color the legacy and zeitgeist of U.S. mental health systems (Ogborn, 1993). Homophobia and misinformation linger in many strata of American society, and mental health workers and consumers are members of that society. Clinically, LGBT mental health consumers still find that some mental health professionals consider their sexual orientation and/or gender identity a delusion or symptom that will “go away” when their illness is resolved (Lucksted, 1996). Some consumers have found that this translates into their not being considered healthy enough to leave a hospital or program until they express (or feign) movement toward heterosexual orientation (Blackbridge & Gilhooly, 1985). Others have found that providers claim that having same gender relationships causes or exacerbates their illness (Green, Peraza, McFadden, & Compton, 1998). Pathologization is still debated in prominent professional journals (e.g., Igbokwe, 2004; Boynton, 2004).

## **Equating Health with Conventional Heterosexual Presentation**

One modern manifestation of pathologization is to equate heterosexuality with health, thereby deeming non-heterosexual identities unhealthy by comparison. In some mental health systems, perhaps particularly some inpatient and residential facilities, narrow gender-related expectations seem to combine with a tendency to pathologize non-heterosexual identities. That is, staff at some inpatient programs have been observed to equate conventional gender roles with mental health, especially for women (Lucksted, 1996; Plumb, 1993). Thus patients on such units tell of having been pressured to dress and act in more stereotypically “feminine” (for women) or



“masculine” (for men) ways, and having their mental health judged by how readily and well they conform. For example:

▼ When I was at \_\_\_\_\_ 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. (KI Anonymous P., September 1998)

The extent of this phenomena is undocumented, but anecdotes suggest that people find such experiences insulting and annoying at least, and often harmful, disorganizing, and frightening, with long-term effects. Thus almost 30 years after the experience, in an interview about her work as an “anti-psychiatry activist who spent most of her adolescence in the psychiatric system,” Lilith Finkler (1994) easily recalled:

▼ The second time I was admitted to a psychiatric institution, in 1976, two women doctors took me to their office and asked me if I was a lesbian. I nodded. They inquired as to whether I had ever been sexual with a woman. I refused to answer. The two psychiatrists screamed at me for thirty minutes. They told me I had sexual identity problems; I should wear skirts instead of pants, put on a bra and wear make-up. It was clear to me that I had to get out of there because they wanted to remake me in their own image. (p. 231)

This sexism and homophobia often extend to transgender people who want access to medical protocols for hormone or surgical treatment. As presented by a number of key informants and other sources, they have had to learn what the doctors want to see/hear and then edit their self-presentation to fit these gender expectations in order to gain access to services and avoid harsh judgment or rejection (Denny, 1992b).

## **Biased Diagnostics**

There are also indications that clinicians (and other mental health workers) may inaccurately diagnose or label LGBT clients if they are unfamiliar or uncomfortable with LGBT communities and cultures. One advocate (KI Anonymous P., September 1998) said “an area that I think could use some serious research [is] how accurate are the mental health diagnoses given to gay people and how many of them are simply the result of subtle forms of discrimination and/or a total lack of understanding of the gay experience?”

Examples from several LGBT-affirmative mental health providers support her point. Key informant Steve Hartman (May 1998), a psychologist with PRIDE Institute, finds that urban gay men are sometimes inappropriately diagnosed as having Bipolar Disorder, or a Personality Disorder, due to clinician misunderstanding of urban gay male cultural patterns. For example, the “acting like a queen” style of self expression adopted by some gay men is

seen by LGBT people as a way of coping with stress, expressing frustration, or being humorous. Dr. Hartman (KI, May 1998) finds that it is sometimes pathologized as “histrionic” and a symptom of Borderline Personality Disorder by clinicians unfamiliar with it. He has also observed that gay and bi men who have had many sexual partners are sometimes labeled “Bipolar” because they are seen as “hypersexual” (taken to be a sign of mania). While a given person’s number of sexual partners over time many or may not reflect a healthy life choice, culturally uninformed mental health providers may jump to conclusions based on stereotypes instead of sound clinical judgment.

Similarly, key informant Orren Perlman (June, 1998), former unit chief and assistant clinical professor at Univ. of California San Francisco, has observed that some mental health professionals mistakenly consider people who identify as bisexual as having a Personality Disorder. He noted that a bisexual person’s attraction to men and women is misperceived by these providers as de facto indicating poor personal boundaries (and therefore a symptom of personality disorder), when in reality it does not. In yet another example, the fundamental reorganization of one’s self-concept and life that comes with gender transitioning often creates a tumult of anxiety, exaltation, and relief for a transsexual person. This has been mislabeled as “mania” in some instances (Denny, 1998a, 1998b; KI Melanie Spritz, June 1998).

Deeper into the issue of mislabeling pathology, Anonymous T. (KI, June 1998) observed that when a person’s symptoms fit certain diagnostic criteria, too often professionals stop there – with “the person has X” – rather than inquiring into the stresses that may have created their distress in the first place. She said:

▼ Throughout my tenure with the mental health system, I was diagnosed with clinical depression. This seemed accurate at the time, but now I wonder how much of what I experienced during all those years was really simply the “blues” caused by trying to live openly in the subtly hostile world. How many other gays become depressed for the same reason, or because of the many conflicts inherent in trying to stay in the closet? I was seeing highly respected mental health professionals in a fairly liberal urban college town, and yet none of these was ever willing to admit that maybe my depression was at least partially situational and not necessarily a sign of serious mental illness. How much worse it must be for those gay people trying to survive in more conservative environments?”

She continues --

▼ By now I even question the accuracy of the major mental health diagnosis I was given – that of Multiple Personality Disorder. There is a lot of evidence that I do have, or at least had, multiple personalities... This was later “verified” by several experts in the field. But because I am doing so well now contrary to the dire predictions of those “experts,” I do wonder [if] many of my supposed multiples were really simply the result of the different ways I feel/think/ behave, etc. as a gay person in a heterosexual world.... I certainly know I had to develop a variety of different personas to deal with the hazards of being openly gay...as well as a gay activist.... How many gay people, then, are diagnosed as dissociative when in reality they are simply displaying practical differences that are essential for their survival?

Situations commonly faced by transgender and transsexual people further highlight her point. Medical and mental health professions wrestle with their own, usually “medical model” conceptualizations of “transgender,” often quite far removed from individuals’ actual experiences (for examples see Bradley & Zucker, 1997; Bradley & Zucker, 1999, Loeb, 1999 and subsequent letters in response). Some professionals continue to consider it a psychosis. Speaking about male-to-female (MtF) transsexualism, key informant Dr. Melanie Spitz (June 1998) said, “Professionals often see transsexual people as delusional – ‘think they’re a woman when they’re not’ -- which just isn’t true. It’s not really [thinking you’re] ‘trapped in a man’s body’ but rather a very strong affinity, feeling.” More frequently, health workers view and diagnose distraught transgender individuals -- who have been shut out of social support systems, ridiculed, and discriminated against -- as having personality disorders, especially “borderline,” without contextualizing the behaviors with an appreciation for what the person is going through. After describing the upheaval, isolation, conflict, and wrenching difficulties that often come with transgender identities, Melanie Spitz (KI, June 1998) commented:

▼ All this can very much make you think “what’s wrong with me?” and feel, and act, borderline-ish. So yes, personality disorder-type behaviors are [there], but they are mal-adaptations to very difficult situations -- more socially constructed behavior patterns than personality based. People need to consider how they are constructing the meaning of such behaviors regarding their clients. Most, almost all, staff have absolutely NO knowledge of current literature or thinking regarding transgender/transsexuality.

## The Continuum from Ignorance to Discrimination

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....[Once] I and another staff-person did an inservice on GLB issues. People asked very basic questions and did not know of even the most common community resources we listed. (KI Mary Barber, March 1998)

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, and why you are there. (KI Melanie Spritz, June 1998)

Fundamental to being a recipient of mental health services is interacting with mental health staff. These interactions greatly shape one’s experiences with any program or treatment plan. And, in at least one study (APA ,

1990) a full 95% of general psychotherapists had seen at least one gay, lesbian, or bisexual client during their careers. Nonetheless, mental health providers, across disciplines, are often uneducated regarding issues and concerns important to LGBT clients (Key Informants: Lynne D’Orsay, Feb 1998; Anonymous L., March 1998; Mary Barber, March 1998; Angel Olmeda, July 1998; Melanie Spritz, June 1998; Anonymous M., July 1998; Also see Iasenza, 1989; Buhrke, 1989). This usually extends to ignorance of community and mental health resources that could benefit LGBT consumers as well. Some observers have noted that there can also be willful ignorance that shades into prejudice around these topics, such as deciding that LGBT resources are “not worth knowing about.” Key informant Mary Barber (1998) commented, “Many staff people have...the attitude that ‘I think being gay is fine, what else could I need to know?’ ...not knowing of or appreciating the issues that are important and their consequences.”

Cabaj (1988) and others have emphasized that such unfamiliarity both comes from and feeds internalized and externalized anti-LGBT prejudices among mental health service providers. Clients are omni-present but seldom discussed. One staff person lamented, “People still make these assumptions that a male homosexual is AIDS infected, or that a gay client sexually wants [the therapist] or all other men” (KI Anonymous W., May 1998). Other common misconceptions include the pathologization discussed in the previous section, assumptions that all LGBT people are sexually voracious and aggressive, that lesbians hate men and children, and that people of color are never “really” LGBT but rather have been coerced or co-opted by white LGBT people.

Not knowing otherwise and therefore accepting such stereotypes can lead otherwise competent staff to make serious mistakes. First, it can cause them to ignore important topics in clients’ lives that do not fit with the staffperson’s assumptions; to only address those that fit their stereotypes (KI Bert Coffman, May 1998). Second, it can lead staff to overlook the considerable psychological and emotional impact of certain events and situations, including the impact of their own actions.

- ▼ At the clinic, my last six months were a constant battle because of the support group my therapist wanted me in. I tried it for more than the recommended trial and still decided it was definitely not for me. But I was never able to make my therapist see how totally unhelpful that all-straight group was, especially given the open hostility of one straight female member who blamed me (and all gays) for the fact that she had AIDS. My therapist never got it and just kept harping on me for not being good at making friends. (KI Anonymous T, June 1998)
- ▼ 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 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. (KI Lynne D’Orsay, February 1998)

Third, failing to appreciate the complexity of LGBT identities and the power of prejudice can bias staff (psychiatrists, psychologists, social workers included) toward attributing problems to individuals – ignoring societal pressures and environmental influences –while paradoxically assuming all LGBT’s are “like that.” In talking about staff in general, and then about a specific person he saw for counseling, key informant Angel Olmeda (July 1998) explained this clearly:

- ▼ Some of them see something bad in the gay community and (1) they 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, affect people -- how these bad things they see (promiscuity, drinking) come about.... (KI Angel Olmeda, July 1998)
- ▼ So, she had stereotyped assumptions and would jump to conclusions that often ended up blaming the gay community for the negative aspects of its existence, without any analysis of how these things come to be, and [without awareness] that many are because of problems with society, not inherent in gay people. And I was surprised to find out how unknowledgeable she was about homosexuality. So, among other things, I really felt like I couldn’t talk about negative issues around being gay or the community because she’d pick up on it so much. (KI Angel Olmeda, July 1998)

Therefore, even naive ignorance of LGBT issues and resources can lead to inadequate treatment and unprofessional interactions. Individual staff people have a professional responsibility to educate themselves about the people and problems with which they work, while programs and service systems also must address consumers’ needs and develop staff competencies.

### **Invisibility & Ignoring**

While ignorance is passive, ignoring is an active practice of omission or neglect. Observers have noted that most mental health programs completely ignore the existence of LGBT clients, even to the point of erroneously asserting that all clients (and all staff) are heterosexual (Johnson, 1994). This fallacy allows programs and mental health systems to avoid addressing the needs of LGBT clients by simply denying they exist. Since “It is important for those who provide treatment to recognize all of a person’s life, not just selected parts of it” (Roberts, 1996), such denial leads to neglect and outright abuses. As a long-time mental health worker and peer advocate, Audrey Grifel (KI, March 1998) stressed that,

- ▼ Even most progressive CMH programs, at least here, don’t take into consideration that you may be a sexual minority. Especially day treatment programs and Housing programs. A number of clients have experienced it, in day programs, outpatient clinics, inpatient units, community residences, boarding

homes, sexual orientation is just *never taken into account*.... I've worked with clients who felt there was no awareness and acknowledgement by staff that sexual orientation is an important part of their [clients'] lives, and would/should be an integral part of their recovery and treatment. (KI Audrey Grifel, March 1998)

▼ Around mental health providers there are many things about people that aren't acknowledged. For a long time your ethnicity was not at all. So sexual orientation is one of many parts that just don't exist [in the system]. There is no visibility in the mental health system of people who are LGBT, and so no affirmation – at a time when people...are in the system because they need affirmation. (KI Audrey Grifel, March 1998)

Drawing on her career as a mental health professional, key informant Anonymous L. (March 1998) concluded, “[LGBT consumers] are approached clinically from a heterosexual mode, mis-treated by the public mental health system.... They get treatment for their mental illness, but not as a whole person. It's really very damaging...and creates a profound sense of isolation for LGBT people who are clients.”

Concrete manifestations of ignoring can be seen in administrative policies. Lynne D'Orsay from the Seacoast Consumer Alliance of Portsmouth New Hampshire (KI, February 1998) noted that housing program intake forms usually ask if one is married or single – leaving no room for LGBT people in important same-gender relationships which are not currently recognized by law (nor for bi or heterosexual people who are not married to their significant other). She added that LGBT clients are often annoyed by this omission and wonder what it signals about the inclusion of LGBT subjects and people in the rest of the program (KI Lynne D'Orsay, February 1998). Similarly, Mary Barber (KI March 1998) has seen “administrative staff, or in charts, not accept same-sex significant others as ‘family members.’”

As another example, some programs may disregard the fact that prejudice and discrimination lead many LGBT people to closely guard their privacy. Several key informants described programs with unofficial but active policies of denying homophobia while requiring all LGBT clients to be “out” to all staff and clients (KI Zappalorti Society Meeting, August 1998). Forced disclosure takes power away from the individual as to who should or should not know personal information, whether for simple privacy or blatant safety concerns. It also deprives LGBT people of services they seek – either if they refuse or if the response is hostile to their disclosure. In fact, some perceive it as a way of discouraging LGBT people from attending programs (KI Zappalorti Society Meeting, August 1998).

Some of the ignoring that LGBT consumers experience in mental health facilities are LGBT-specific examples of much larger problems in mental health systems, including a tendency dehumanize patients/clients and the insensitive care that results. Mental health services tend to neglect the intense distress that can be caused by oppression and discrimination whether it occurs before, during, or after psychiatric therapy (Holochuck, 1993). To

the degree that people working in these systems are part of the problem, ignoring and denying oppression conveniently lets them avoid seeing their own actions for what they are. For example, key informant Anonymous N. (August, 1998) argued that confidentiality is sometimes misused to avoid talking about LGBT topics openly:

▼ This center is unlike some places where people just don't talk about sexual orientation except to their therapist in private.... Partly this may be because of confidentiality but also I think it's because the staff don't want to deal with it, hear about it. Confidentiality can be misused as a way of sanctioning making sexual orientation a "dark secret" versus a real need to keep confidentiality...so the person will feel safe.

## **Discrimination & Harassment**

To make appropriate decisions and plans about their treatment and their lives, it is crucial that LGBT consumers, and the staff they work with, have access to good information about LGBT issues and resources in the community. Staff also need to be able to assist clients in obtaining and thinking about this information just as they do regarding other topics (e.g., educational choices or religious participation). Instead, all too this information and collaboration are scarce, and programs – from residential, to vocational rehabilitation, day programs, community mental health centers, and inpatient facilities -- embody neglect and biases that translate into discriminatory practices and/or a hostile environment (National Empowerment Center, 1995). For example, the erroneous but persistent myth that LGBT people are pedophiles may lead an employment program to steer away or bar LGBT consumers from a day-care provider training program. Certainly there are many exemplary people and programs serving clients who are LGBT. However, although documentation is sparse, the studies and anecdotes that do exist suggest that disrespect, frank hostility, and even abusive treatment are all too common.

Consumers tell of being isolated on an inpatient unit with no roommate because staff assumed they would sexually abuse any person sharing the room (for one published example, see Duff, 1993). In some places, staff have been reported to let anti-LGBT verbal abuse (name-calling, provocation) continue indefinitely, and sometimes to even join in. Homophobic jokes and remarks creep into common conversation as well as clinical discussions (O'Hare, 1996; Brady, 1998). Nancy Nystrom's 1997 survey of gay men and lesbians who had been therapy clients found that 46% reported receiving care they experienced as homophobic. Similarly, in a 1995/96 survey of 116 LGB consumers aged 18-75, across 36 states (snowball sample) the following experiences were reported (Lucksted, 1996):

▼ Therapist or psychiatrist tried to change or convert you to be straight..... 23%

- ▼ Ever been verbally harassed for being lesbian, gay, or bi, by a mental health worker or professional ..... 29%
- ▼ Ever been physically hurt because you are lesbian, gay, or bi, by a mental health worker or professional..... 10%
- ▼ Ever experienced discrimination or poor treatment in the mental health system because you are lesbian, gay, or bi.....64%

Surveying a New York city sample of LGBT people receiving inpatient or outpatient mental health care, Avery, Hellman, & Sudderth (2001) found that, compared to a previously collected sample of non-LGBT people, significantly more LGBT respondents (18% v 8%) were dissatisfied with the care they received. Examples from other first person accounts and key informant interviews elaborate on these statistics:

- ▼ Q: What was it like being out of the closet as a lesbian at the hospital?  
A: A lot of staff were after me, grabbing my butt and kissing me. I thought they were gross. A lot of them tried to hook me up with men (Lafferty, 1999).
- ▼ Key Informant Anonymous V. (1998) described being denied services at a sexual abuse program because of her sexuality and gender identity. Staff said they thought her presence would upset other clients and disrupt their group-based program.
- ▼ [During my transition from living as a man to living as a woman,], one psychiatrist asked me to dress as a man to meet with him and then said I wasn't really transsexual because I hadn't had any suicide attempts. When I said I had indeed tried to commit suicide, he asked if I'd ended up in the hospital for any of them. I said I hadn't, and he said that then they couldn't have been very 'serious!' (KI Melanie Spritz, June 1998)
- ▼ Key Informant Anonymous K. (July 1998) described a 1997 hospital commitment where he believed he was restrained unnecessarily and pushed to the ground especially roughly because he is gay, based on comments made by the involved staff-members. He complained to doctors, but felt dismissed because they declined to even talk with the staff. When he continued to press the matter, he was abruptly transferred to another hospital, in his view to "get rid of the problem."
- ▼ Key Informant Anonymous K. (July 1998) also related another incident in which 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. Anonymous K. recalls that a doctor said to him, "scum like you should be locked up," and was not interested in hearing his version of what happened.

Again, there are no good figures regarding how rare or widespread such mistreatment is. However, many LGBT consumers consider harassment and mistreatment likely when they attend a new mental health program and prepare for it (see Coffman & LittleMoon, 1997; Duff, 1993; Hellman, 1996; McClure, 1994; Smith, 1993), constituting an additional stress from the very places and people they are going to for help.



## Causes & Effects

In the abstract, the causes of insensitivity and ignorance regarding LGBT mental health consumers are the same as the causes of homophobia in general society – among them, lack of familiarity, historical prejudice and vilification, acceptance of misinformation and stereotypes, cognitive errors, fear of people different from oneself, personal identity issues (Yarhouse, 1999; Conley, Calhoun, Evett, & Devine, 2002) And, they have the same effects for those on the receiving end: anxiety, ambivalence, fear, stress (Herek, 1998) Consumers are aware of these dynamics:

Often straight therapists are afraid of LGBT clients – afraid that anything they do (being nice) will cause the client to be attracted to them. This sets up tension in any therapeutic relationship...Many therapists are also afraid of people with SMI diagnoses – stigma – afraid that any disclosure of personal information on the part of the therapist will end up with the client stalking them or something. (KI Bill Adams, July 1998)



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. (KI Anonymous M., July 1998)



First I saw a psychiatrist, just for meds. He'd ask something, but then would quickly go on to other topics if I brought up anything that made him uncomfortable – anything gay. For example, he'd ask how my family was, but when I'd say something about my difficulties with my mom being so homophobic, he'd just be like "So! When should we have our next appointment?" (KI Angel Olmeda, July 1998)



LGBT-affirmative professionals also notice the discomfort and ambivalence of some of their co-workers. For example, one clinician noted that new colleagues mentioned her supposed expertise with "trauma patients." This was not her specialty. When she said so, they were embarrassed but gave no explanation. In the end she found out they were using "trauma patients" as an (inaccurate) substitute term for "lesbians" because they wanted to broach the topic but couldn't openly ask! Similarly, when she asked that a local free LGBT periodical be delivered to the clinic as a source of information about community resources, some staff objected that it would "trigger paranoid patients." Although the clinician could not get them to explain further, she inferred that they were afraid

some clients might conclude that some staff members were LGBT, which these staff members further assumed the clients would find threatening.

Nonetheless, there is a consensus that mental health systems are, on the whole, less hostile to LGBT clients than in decades past. More workers are knowledgeable and supportive of LGBT clients. Many more programs, institutions, and individual professionals know that being openly intolerant is no longer permissible in many settings. Still, increased tolerance does not necessarily mean enlightened views or addressing issues. In fact, some key informants had observed mental health providers who constructed a veneer of sensitivity, or became entranced with in certain aspects of clients' lives that piqued their interest or anxiety – regardless of the client's priorities or needs. They called this “PC but shallow” or “pseudo-sensitive.” For example:

Mental health workers often put on how advanced, knowledgeable, OK they are with LGBT 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. (KI Bill Adams, July 1998)



My social worker years ago in Philly was very interested, would comment on, my gendered appearance all the time while I was much more interested in my inner life. This was while I was transitioning and my whole social milieu, friends, etc were changing. And she was caught up in my appearance! (KI Melanie Spitz, June 1998)



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. (KI Angel Olmeda, July 1998)

Whether subtle or blatant, clients describe homophobic experiences in the mental health system as invalidating, annoying, and as impeding the development of therapeutic relationships (Nystrom, 1997). They can also impede recovery and exacerbate existing problems by increasing stress and conflict in settings where clients expect support. For some people with tenuous self-concepts or conflict about their identities, such experiences can constrain personal exploration and increase/induce self-hatred (KI Anonymous L., March, 1998). “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).

In Nancy Nystrom’s work (1997) gay and lesbian therapy clients experienced therapists who did not or could not affirm their clients’ identities as less engaged, less validating, and subtly condemning. In this current project, one consumer (KI Angel Olmeda, July 1998) noted that “if a counselor is bad to talk to on one thing, doesn’t want to hear you out or talk about what’s going on -- then you don’t want to talk to them on other things. It affects trust, and can make it hard just to get yourself to go.” Many mental health providers argue that to work with someone effectively you must honor all facets of his/her life (Roberts, 1996). Yet, one key informant explained, “Many clients have never told any [providers] that they are gay. You can’t be treating the whole person then! If a Muslim African-American man comes to me, is he going to be able to work well with a [non-Muslim] Caucasian woman?...maybe, maybe not. But at least its out there, we can talk about it (KI Anonymous L., March 1998). Similarly, “according to Diane Johnson, president of Lamda 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, quoted in Chassman, 1996, p. 2).

## **Table 2: Common Lapses in Staff Behavior**

### **It is not uncommon for mental health staff in various roles to...**

- τ ...Absorb and apply societal stereotypes and prejudices in conducting their professional duties / roles.
- τ ...Ignore that LGBT people are diverse regarding gender, race, culture, class, disabilities and other facets of life, and that all of these interact with sexual orientation and gender identities.
- τ ...Assume/believe that a consumer's LGBT identity is a symptom of mental illness and not a "real" part of the person) or pathologize LGBT identities as mental illness per se and/or as indicators of sub-par development.
- τ ...Confuse sexual orientation and gender identity.
- τ ...Assume that sexual orientation/gender identity is the "real" core issue among LGBT people, whatever their "presenting problem," but never presume so for heterosexuals.
- τ ...Believe that being gay, lesbian, or bi is "no big deal," and that a client who wants to talk about sexual orientation must be using it to shy away from "real" issues they "should" be talking about.
- τ ...insist that a client's identity or orientation is "merely a phase," and therefore pressure client to adopt heterosexually identified behavior such as dressing in certain ways, asking other-gender people out, etc.
- τ ...Constrain a client's exploration and self-discovery by the staff person jumping to their own conclusions about what the client's sexual orientation "really is" or "should be" and impressing this view on the client.
- τ ...Accept prejudices and misinformation leading them to advocate interventions designed to change the client's LGBT identity (Conversion / Reparative attempts). These have been discredited by major professional organizations but do persist in a few faith-based counseling systems and secular models.
- τ ...Hold narrow, rigid ideas of how one "should be" LGBT – and overtly or covertly pressure clients to conform, while in reality there are many "ways" of being LGBT.
- τ ...Be unprepared and unable to discuss gender, sexuality, or sexual orientation issues beyond the superficial.
- τ ...Use heterosexual patterns as their standards for healthy personal and relationship functioning, thereby perceiving LGBT people and relationships as de facto less healthy where they differ.
- τ ...Make unwarranted assumptions about a person's values or lifestyle based on common myths and stereotypes about LGBT people (e.g., assuming all LGBT clients are non-religious).
- τ ...Positively stereotype LGBT people out of fear of being called homophobic or romanticized views; perhaps pressuring clients to hide distress or pathology, and leading the therapist to shy away from client problems.
- τ ...inquire about clients' sexual lives and history voyeuristically, as an exotic or erotic subject of education or titillation for themselves, rather than as it is relevant to the client's issues

(Sources include: Greene, 1997; Hartman, 1997; Markowitz, 1991; Sherebrin, 1996; and Key Informants)



## Peer Intolerance

Lesbian, gay, bi, and transgender consumers often experience intolerance from other clients. Especially in residential, day, and inpatient programs, one spends considerable time with other consumers – often more than with staff. Numerous LGBT consumers (including Holochuck, 1993; National Empowerment Center, 1993) report that to be “out” as lesbian, gay, bisexual, or transgender among most consumers/clients in these facilities is to risk rejection, ridicule, and harassment. Melanie Spitz (KI, June 1998) noted that “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.”

Many of the problems involved are the same as when dealing with anyone who is disrespectful – ignorance, fear, ignoring, hostility, discrimination. So are the causes – internalization of common stereotypes, lack of information, fear of unfamiliar “different” people. The relationships are considerably different, however. Whereas staff-client relations are hierarchical and subject to professional expectations, client-client relationships are more informal. Nonetheless, although consumer peers do not have the formal power in one’s life that staff often do, they are a main source of social support, concrete assistance, and friendship, and so are often a major factor in one’s daily quality of life. Key informant Anonymous D. (August, 1998) described the atmosphere in a nominally tolerant therapy group she attends:

- ▼ At the other clinic it’s 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.

She went on to explain that she feels other group members do not really want to hear about her life because she is a lesbian, much less engage in conversation. Similarly, Anonymous W. (KI, May 1998) said “In any kind of group situation it [being LGBT] is still somewhat of an anathema – there are still repercussions of being forthright, especially since the HIV health crisis.” Stereotypes about HIV status were a strong theme among key informants, and Anonymous W. (KI, May 1998) continued, “That’s one assumption made about people in a psyc hospital – that everyone is HIV positive. And therefore patients will go out of the way to avoid being associated with anyone...any identity that is associated with HIV – like gay men.”

Efforts to improve mental health care for LGBT consumers must include client/milieu interventions as well as staff training. Some examples could include group discussion addressing sexuality and LGBT issues directly with skilled facilitation so everyone can have a voice (KI Kletter, 1999), can understand program policies and expectations, and can have a role in resolving problems. Including LGBT concerns in program policies and procedures, such as those against discrimination or hate speech, programming, and program materials (brochures, literature offered to clients, posters and notices, etc) would be positive steps in creating affirming settings. Policies mandating that staff not condone or tolerate peer harassment along LGBT lines – or race, gender, disability, or others – would also improve atmosphere and trust if actually practiced consistently.

## **The Power of Fear and the Drain of Managing Identity**

“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)

Its difficult and frightening to come out in various services settings – people are always afraid of the reactions they’ll get, put downs, and the possibility of discrimination. It has gradually gotten better to be out as gay in society, but still not easy. (KI Kwame Asante, July 1998)

Small, “everyday” experiences of disrespect and anti-LGBT discrimination create considerable tension and stress. Overt hostility, threats, and violence are much less common and more acutely traumatizing. Both leave lasting impressions. Just as one burglary makes all the neighbors cautious, fears of humiliation, rejection, or bodily harm are powerful forces in the lives of LGBT mental health consumers. Realistic fears are sparked when one senses insensitivity or repugnance in a person or group, whether professional or peer, and they are reinforced by actual experiences, other’s and one’s own. For example, in one national poll (NGLTF, 1998, 1999) 7% of LGB respondents reported having been physically assaulted in the past year. In another, 19% reported being physically assaulted at least once in life due to their sexual orientation, and 94% reported experiencing some form of anti-LGB harassment at some time (see also Herek & Berrill, 1992). Particular to mental health services, one person interviewed (KI Bert Coffman, May 1998) said, “people are afraid of getting terribly harassed if they are out or

outed – because they hear about it happening regularly, and they experience it.” More pointedly, Deacon, Rea, and Largey (1991) discussed the effects of knowing that harassment and even physical aggression may well be part of one’s hospital stay if one is “out,” and that staff and patients alike may be hostile. They noted that it is very hard to face hospitalization with these likelihoods in mind, and that it adds to the already considerable stresses. Many others echoed these themes (Key Informants: Anonymous D., August 1998; Anonymous K., July 1998; Anonymous M., July 1998; Kwame Asante, July 1998; Lynne D’Orsay, February 1998; Zappalorti Society Meeting, August 1998).

One of the direct results of these fears and awareness is the energy and pressure LGBT consumers have to invest in “managing identity.” Lynne D’Orsay (KI, February 1998) said, “The gay world does not open it’s arms to mental illness.... And the straight world has very little knowledge of LBGT issues that affect mental illness. We have felt that in either world, we have had to make choices about which aspects of ourselves we have to keep 'secret' in order to be welcome.”

LGBT identities, and psychiatric histories, can sometimes be hidden, and many individuals work hard to do so as self-protection. However, with hiding come needs to constantly assess the relative safety of one’s surroundings, to monitor one’s behavior, and to cope with perpetual fears of discovery and its consequences (KI Cookie Gant, August 1998; Herek & Berrill, 1992; Vanderbosch, 1994). Needing to assess safety and managing one’s self-presentation are so commonly necessary for LGBT people as to become automatic even unconscious, for many. Some also seek counseling to help develop strategies for adaptive coping and managing fear that results from the possibility and experience of hostility and discrimination – including managing identity disclosure (Browning, Reynolds, & Dworkin, 1991).

In addition to taking energy, being closeted carries other prices relevant to mental health: It often involves being vague about large portions of one’s life, editing stories and opinions or remaining silent, changing pronouns and other details when talking about current or past relationships or friends, and monitoring one’s behavior and mannerisms lest they happen to meet an LGBT stereotype (KI Kwame Asante, July 1998; KI Anonymous M., July 1998). Anonymous L. (KI, March 1998) asserted that these pressures interfere with recovery from mental illnesses because, “if they [LGBT consumers] have to hide who they are as a whole person, they can’t bring their self to recovery.



Key informant Cookie Gant (August 1998) also noted that hiding facets of one's self means one can never tell who are allies – who would be supportive, who shares similar identities and experiences. Key informant Audrey Grifel (March, 1998) reflected, "...really the fear of the discrimination and harassment is very powerful and constraining. The only way a person can find out if the harassment, etc. will happen is to be out, to try it. But then it's too late [to choose being closeted if reaction is negative]." Therefore, many LGBT consumers err on the side of extreme caution, especially within the mental health system.

This may include avoiding supportive others, including other LGBT consumers and affirmative providers, for fear of being identified with them (KI Bert Coffman, May 1998). For example, Anonymous L. (KI, March 1998) organizes programs on LGBT mental health issues as part of her clinical practice, but finds that many "GLB folks are... frightened to be seen at [the] events. So, some only come for individual counseling, and won't be seen at lectures, groups, etc." Key informant Ron Hellman (June 1998) has also observed that a fair number of LGBT consumers cannot put their finger on why they are slow to "connect" with even LGBT-affirmative therapists. Later they realize that they are so used to having to "edit" their issues and self presentation to mental health workers for fear of homophobic reactions (and in response to a "heterosexist context that does not catalyze discussion of these issues") that they don't even notice they are being reserved and self-protective even in safer situations.

In these myriad ways, bias against LGBT consumers impedes forming strong bonds with peers and helpful professionals, finding one's place in the larger community, and strengthening one's self (see also Table 2). The vigilance necessary to monitor and manage one's identity and others' reactions can be stressful and draining even when skillful or automatic – for all members of groups who are discriminated against, mental health consumers or not. This energy is then not available for other priorities, such as gaining skills, coping with mental illness, or working toward goals and recovery.

## **Exemplary Practices**

The converse of inadequate or discriminatory services is exemplary practices and attitudes. Some core points to providing exemplary mental health services to LGBT clients across diverse settings and staff roles are

discussed below, drawing from published and unpublished literature, and key informant interviews. Examples of some LGBT-affirmative providers of public mental health services are detailed in a later section.

While staff-consumer relationships take many forms, only individual psychotherapy has so far received any academic attention -- therapy between LGBT clients and heterosexual therapists for the most part. This is a sizeable and growing literature (see APA, 2000; Cabaj & Stein, 1996; D'Augelli & Patterson, 1995; Davis, Cole & Rothblum, 1996; Davies & Neal, 1996; Dworkin & Gutierrez, 1992; Fassinger, 1991; Glassgold & Iasenza, 1995; Markowitz, 1991; Weasel, 1996; and others in the reading list located in the Appendices). While not everything is relevant to staff-consumer interactions outside psychotherapy, many elements are very useful.

As a whole, the therapy research tends to focus on coming out issues (Welch, 1996), the stresses of living in a heterosexist world, and on a generic "general" population of LGBT clients. More recently, couples and family counseling with lesbian, gay and bi (LGB) clients, and therapy with LGB people of color, have also received some attention (Brown, 1995; Deacon, Reinke, & Viers, 1996; Greene & Boyd-Franklin, 1996; Laird & Green, 1996; Okun, 1996; Pearlman, 1996; Scrivner, 1997). However, these otherwise excellent resources usually neglect to even mention the many ways that mental health care is delivered (e.g., inpatient, day treatment), medication, or serious mental illnesses (Browning, Reynolds, Dworkin, 1991; Fassinger, 1991). Also, the published research regarding therapy with bisexual and transgender clients is much thinner and focuses almost exclusively on identity development -- neglecting other facets of the clients' life and health (Klein, 1978; Leland, 1995; Clare & Tully, 1989; Bradley, et al., 1991). Dallas Denny's work (1992a, 1992b, 1998a, 1998b) is a notable exception. Additionally, some writers and researchers question whether individual psychotherapy is even appropriate for LGBT individuals struggling with identity or stigma/prejudice conflicts (Kitzinger, 1996, Perkins, 1996), and favor community development and self-help instead.

Steven Ball (1994) is one of only two that addresses group therapy with LGBT people with serious mental illnesses (SMI) (the other: Helfand, 1993). With experience, Ball observed that the group worked best when it departed from "usual" support or counseling groups in certain ways that responded to client-member needs, and suggested:

- ▼ Introduce and process issues in a more structured and gradual manner than is commonly done in community-based groups, with the facilitators taking a more active role and often slowing down discussion and confrontation. He suggested that members' psychiatric disabilities and already high stress level made the usual unstructured open discussion format too confrontational and stressful.

- ▼ Expect a wide range of problematic personal and interpersonal styles, including more passivity, helplessness, and interpersonal skill deficits, since these are common parts of many mental illnesses and are often part of the reason the person is under psychiatric treatment.
- ▼ Develop safety and trust in the group, including acceptance of doubt around gay and lesbian identities
- ▼ Focus on individuation and differentiation rather than common identity and group cohesion. Ball found that group members often had a weak sense of self and low self-confidence, which made usual group strategies of creating cohesion through emphasis on commonalities impossible and unhelpful. Group members in his group were particularly uncomfortable identifying with each other's gay, lesbian, or bisexual experiences or ideas, reflecting their own development and difficulties in identity.
- ▼ Bring in outside materials for members to discuss, both as a way of talking about gay and lesbian issues without confronting personal issues directly and as an educational enrichment.

Helfand (1993) concurred that group therapy for LGBT people with SMI has many things in common with other therapy groups, but also that mixing people of differing identities sometimes made group cohesion difficult and recommended creating more structure than a generic "support group" model might assume.

Thus there is only piecemeal research regarding therapeutic approaches to assist LGBT people with serious mental illnesses. Additionally, the literature that does exist is often under-utilized by both training programs and individual providers. Available surveys document that, for the most part, therapists and other mental health workers are given little training in serving LGBT clients competently, although this is improving slightly (Amico & Neisen, 1997; Graham, Rawlings, Harris, & Hermes, 1984; Helfand, 1993; Johnson, 1994; Kocarek & Pelling, 2003; Nystrom, 1997). Only a few are motivated to seek further information on their own (Markowitz, 1991).

To work affirmatively with LGBT clients, mental health workers need to know their own sexuality well and to have thought through their personally internalized values and messages about other identities. Being self aware allows insight into how one's own "issues" influence professional behavior, to manage them, and to discuss relevant issues with clients, peers, or supervisors -- essential qualities of good practice. Similarly, organizations must reflect on their organization's history and current attitudes toward LGBT people, and the unspoken issues and societal views embodied in their usual practices in order to serve LGBT clients well.

Secondly, both individuals and organizations must be knowledgeable about LGBT communities: identity, culture, politics, strengths, problems, challenges, resources, and achievements. This is essential for seeing and appreciating the complexities of LGBT communities and the differences and commonalities among people who identify as each, as well as for knowing of relevant community resources.

Thus for a mental health program to create positive therapeutic relationships with LGBT consumers requires training and supervision for students and staff, and the organization must examine its policies and procedures. Explicitly expecting LGBT-affirmative work from everyone, supporting it, and censuring LGBT-insensitive practices are also essential. These efforts must be ongoing -- not thought to be “taken care of” in a 2 hour in-service or one university class. At the same time, individuals must take personal responsibility for also seeking resources and growth opportunities to build their competence. Iasenza (1989) provides several concrete suggestions for doing so:

- ▼ Educate yourself: read, attend community events, follow issues, take action to be an ally
- ▼ Explore sexual orientation and gender identity issues in your own therapy and peer groups
- ▼ Consult formally with members of the groups you are trying to learn about
- ▼ See clients with substantial supervision
- ▼ Speak up when you see discrimination, insensitivity, gaps in knowledge and action
- ▼ Look for and create opportunities for self, colleagues, and students to gain information and experience
- ▼ Address atmosphere issues in your workplace
- ▼ Examine your own language use and social behavior for heterosexual assumptions.
- ▼ Reflect on your reactions and feelings as you attempt and do these things.
- ▼ Others are included in Table 1

## **Table 1: Some Basic Steps Toward LGBT-affirmative Practice**

### **To develop LGBT-affirmative therapeutic relationships, mental health staff & programs need to know...**

- τ ...That culturally competent practice (including LGBT-affirmative) is an ongoing process, not something static to be achieved and finished.
- τ ...About common prejudices, many of which come from historical, invalid assumptions within mental health professions and U.S. society at large.
- τ ...That LGBT-affirmative staff and programs must be non-homophobic and informed about the professional literature, communities, and cultures relevant to clients' lives, but need not be LGBT themselves.
- τ ...That even well-informed mental health consumers and providers live in heterosexist environments. Therefore, like other prejudices, awareness and active affirmation does not preclude homophobia cropping up in one's views and behavior.
- τ ...Of the complexities of human sexuality and social identities that are inherent in LGBT and heterosexual clients' lives, so that they may honor and work with consumers as unique individuals.
- τ ...That even among staff and clients of similar identities, there may be misunderstandings and friction about LGBT and other issues. Programs and staff should state this forthrightly while beginning therapeutic relationships and to remain active and open to discussing it.
- τ ...That LGBT-affirmative mental health workers may nonetheless not meet a consumer's needs in other ways. Consumer preferences should be respected as much as possible in all areas, not just LGBT issues.
- τ ...That mental health providers who themselves are LGBT may be able to draw from this commonality in working with LGBT clients, but they may also face challenges such as higher expectations, conflicting views or identities, assumed agreement and common prejudices in some LGBT communities about each other.
- τ ...That due to the small size of many LGBT communities, an LGBT staff-person and an LGBT client may find themselves in the same (social, political, cultural) circles, may encounter each other in community settings, and may be acquainted with more of each other's associates than a therapy dyad of differing sexual orientations/identities or one in which both are heterosexual.
- τ ...Of the tendency of some health-care providers (and some consumers) to view LGBT identities as beleaguered or tragic because of the challenges of living as LGBT in current society – thereby ignoring or discounting many of the very positive aspects of these identities.

(Sources include: APA, 1990; Amico & Neisen, 1997; Markowitz, 1991)

## Every Aspect of Mental Health Care is Affected

In the public system you have to take whatever provider is given to you, even if they are prejudiced against your very being. (Deacon, Rea, & Largey, 1991).

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 depends on the available professionals and the politics in the surrounding area. Politics and health care certainly intermix. (KI Anonymous P., September 1998)

### Outpatient Settings

Mental health services are delivered within systems of facilities, professionals, and programs. A fair number of LGBT-focused health clinics and private practices have developed in urban centers across the U.S. over the past 3 decades – in response to the generally insensitive nature of many “mainstream” health services. Most of the clinics offer some mental health services, and a handful offer quality service to people with serious mental illness diagnoses. However, anecdotal reports suggest that many have to turn away such clients due to limitations of staff expertise, funding, not accepting medical public assistance payments, and other shortfalls (Ball, 1985; Hellman, 1996). Additionally, in recent years a few managed care companies have opened “specialty practices” aimed at lesbian and gay male therapy clients (rarely bisexual or transgender) (KI Anonymous L., March 19998; KI Audrey Grifel, March 1998). However, most do not serve LGBT people with serious mental illnesses, and their actual commitment to high quality LGBT-affirmative services (vs. more shallow niche marketing) is unclear in some cases.

Therefore, almost all LGBT people receiving mental health services do so from the mainstream system. Outpatient services are most frequently accessed, and their giving short shrift to sexual orientation and gender identity as important facets of clients' lives was especially prominent when key informants discussed them. Peer advocate Audrey Grifel (KI, March 1998) said,

▼ Standard, even most progressive, community mental health programs, at least here, don't take into consideration that you may be a sexual minority. Especially day treatment programs and housing programs. A number of clients have experienced it – in day programs, outpatient clinics, inpatient units, community residences, etc– sexual orientation is just never taken into account.

Others relayed stories of outpatient programs where LGBT people were forced to be out to all staff and program attendees, such as at a community meeting. Most found this intrusive, inappropriate, and frightening; a blatant disregard for concerns about privacy and safety. They also felt that it was a particular betrayal in a mental health setting, where one had gone for help and sanctuary (KI Zappalorti Society Meeting, August 1998). A few even argued that it is done strategically – “I think that mental health providers get rid of LGBT consumers by stating there is a forced outing policy” (KI Zappalorti Society Meeting, August 1998).

Specific outpatient services each may have their own issues. For example, regarding vocational rehabilitation, Lynne D'Orsay (KI, February 1998) said, “My experience at the agency is that ... vocational [issues] and benefits are the only ones where gay members feel more uneasy than straights. Fear of a job being homophobic, or whether to come out at a job, and issues around a partner's coverage for any benefits -- which is pretty non-existent.” Many LGBT clients reported they had been advised to “keep quiet” about their identities when looking for jobs or when employed, or to only pursue types of jobs thought to be more accepting. Given that as of August, 2003 36 U. S. states have no laws prohibiting the firing of people simply because of their sexual orientation (NGLTF, 2003), such advice sometimes felt supportive and appropriate. However, at other times it was received as indicating staff refusal to really discuss the issues with a client – how to assess and weigh potential costs and benefits, likelihood of discrimination, and possible coping or response strategies. For example key informant Steve Holochuck (July, 1998) recalled,

▼ Later I was in another vocational program, also very affirming. People advised me to be discreet about my sexual orientation, but it felt like in an appropriate way, not oppressive. [But] on the other hand ... I got NO help in thinking about how to manage being out or not vis a vis vocational issues, even though it was a very important issue in some of the places I've been – where there's possible fallout of being thought of or known of as gay. To have done that would be more actively helping us to think through issues regarding sexual orientation.

Others experience a more actively LGBT-positive atmosphere. Ron Hellman (KI, June 1998), a psychiatrist in New York, said that in addition to the positive things they already do, his staff “also hopes to network with a vocational counselor to get some volunteer / work positions in organizations in the LGBT community locally.” Many advocate groups suggest that consumers ask potential service providers about their views and experience with LGBT clients before committing to seeing (or paying) them (Gottfried, 1990; McClure & Vespry, 1994, and many others).

Although helpful, it is often nerve-wracking and difficult for clients to do, and may not be relevant for those who have little say in who provides their services, such as because of public assistance or HMO provider panels.

## Inpatient Settings

Inpatient psychiatric services have changed a great deal in recent years (McLeod-Bryant, et al., 1997). Given the closing or shrinkage of many state psychiatric hospitals and the reduced lengths of stay (Bezold, Macdowell, & Kunkel, 1996), in many cases the entire purpose of hospitalization has moved from “therapeutic” to “crisis stabilization.” Also, particular to this report, tolerant and positive messages about LGBT people and issues have become more widespread, although certainly not universal. Therefore the experiences of individuals who are hospitalized now varies in important ways from experiences of only 5 or 10 years ago, much less 20 or 30. At the same time, it is important to remember that past inpatient experiences have lasting effects on the present attitudes and lives of both patients and staff. Summing up his recent experiences, Anonymous W. (KI, May 1998) ruefully concluded,

- ▼ Having been in a few myself, I think [psychiatric hospitals] are fear-based by virtue of the fact that they are the place for patients, and patients are people that are ill. I don't think it's a place of support. I don't think there's the utmost sensitivity to issues by staff...gay and lesbian issues, or any other personal issues too. It tends to be a crisis place, and people talk about the crisis... incessantly.

Alongside recent changes, inpatient settings are still highly structured and hierarchical – geared toward times when a person needs help to structure their decisions and actions. They still remove the person from daily life and environments – even if for briefer periods of time. They still take away a great deal of personal autonomy after someone's assessment that the person cannot, at least for the moment, handle it him/herself. And, being hospitalized is still greatly stigmatized. Perhaps related to these realities, published first-person accounts over the past decade and key informants (e.g., Brady, 1998; Deacon, Rea, Largey, 1991; Teleconference, 5/23/95) alike repeatedly mentioned inpatient facilities as the most homophobic and poorly informed settings regarding LGBT issues and sexuality. Close living conditions seem to bring out fears and assumptions. For example, Deacon, Rea, and Largey (1991) concluded,

- ▼ Psychiatric institutions do not acknowledge LGBT as “valid” identities. At the same time they have a great deal of control over your life and future while you are there -- Who you can interact with, what information you have access to, what services you receive, your physical liberty.



And one therapist said that when one of her clients needs or wants hospitalization,

- ▼ ...the first thing I do is hope and pray that they make it through. Then I try to get them into an inpatient facility that is more OK. It's very hard to find, almost impossible. There are no hospitals in this area that treat LGBT mentally ill people well. (KI Anonymous L., March 1998)

Similarly, a consumer concluded, "I also think there is considerable inaccuracy, prejudice, and even serious damage done to gay people by the inappropriate treatment they often receive inpatient" (KI Anonymous P., September 1998). Another commented both about a specific hospitalization and inpatient facilities in general, "I'm happy that I didn't come out in the place I was in. I overheard my doctor talking in the common area and he was making very homophobic comments. You don't always have to fear how the other patients will react, you also have to fear the doctors" (KI Zappalorti Society Meeting, August 1998). Steve Hartman (KI, May 1998) explained further,

- ▼ Often on mainstream inpatient units, patients' actual needs are eclipsed by "gay" issues – often the staff's attitudes and issues about the client being gay. The client has to worry about coming out, or not, being found out, about justifying the OK-ness of relationships and identity, about repercussions, being stereotyped, etc. All competing with whatever they are there for help with.

And, Daphne Scholinski echoed this point while reflecting on her personal experience in her 1995 book:

- ▼ [as it turned out,] I would spend my entire 'treatment' never really dealing with my depression or the symptoms resulting from the abuses from parents, teachers, peers, or previous psychiatric interactions. Instead I was immediately targeted for my 'sexual identity' as the problem and the only 'thing' that needed resolution. Each and every day was reinforcement that I WAS THE PROBLEM. (Scholinski, 1995, p. 20)

Nonetheless, inpatient psychiatric programs vary tremendously, with several in the U.S. expressly developing LOBT-affirming expertise (Burling, 2002; Wilson, 2003). Therefore, others told of more positive experiences.

One person recalled,

- ▼ In 1991 I was inpatient and had a ... primary counselor, who was a lesbian. She was very helpful. She wasn't out in general but she was out to me. I got the sense that she didn't tell her supervisor, etc. that she was out to me – that it was "our secret." This made me wonder about the atmosphere of the place, since she didn't think it'd be wise. Although I found it very positive that she'd be out to me. (KI Steve Holochuck, July 1998)

Similarly, a worker on an LGBT-affirmative inpatient unit (KI Anonymous P., September 1998) reported that,

- ▼ When people are GLB-identified and do come to an affirmative unit, they report that it does make a difference. Not that they wouldn't get as good clinical care somewhere else necessarily, but rather it's their comfort level. Trust. They can settle down and work.

We currently do not know to what extent these positive experiences, or negative ones, predominate people's experiences. This is one of many question needing urgent documentation and investigation.

This urgency is heightened by individual reports from a number of consumers with extensive experience in the public system that threats, severe harassment, and actual violent assault are very possible risks for any patient on a psychiatric unit who is "out" as LGBT, especially in the public system (Deacon, Rea, Largey 1991). LGBT consumer leaders attending a 1995 teleconference on issues of importance to LGBT mental health care recipients discussed these risks as a given (Teleconference, 5/23/95). In a more recent example, one consumer said, "[A major concern is] being incarcerated in a psychiatric facility in which you are in fear for your physical safety if you reveal that you are gay to possibly violent homophobic individuals" (KI Lynne D'Orsay, February 1998). Additionally, several specific ways that intolerance and risk manifest on inpatient units were highlighted across various sources as needing documentation and scrutiny. These are briefly discussed below.

## **Assumptions of Sexual Predation**

Several stories surfaced of inpatient staff assuming that anyone they knew or thought to be gay, lesbian, or bisexual was likely to sexually molest or coerce other patients. This is likely due to the historical misconception that GLB people, especially men, are indiscriminately hypersexual. It is unclear whether this assumption of predation includes transgender people. Therefore, staff watched these patients very carefully, often invaded their privacy, and jumped to conclusions about their behavior and friendships. Deacon, Rea, and Largey (1991) noted that staff sometimes leave GLB patients alone in a double room, refusing to place a roommate with them because they thought the GLB patient would try to seduce or force anyone there to have sex. As well as drawing negative attention to the GLB patient in question, this practice also added to consumers' isolation on inpatient units. In their 1985 book, Blackbridge and Gilhooly tell a similar story:

▼ So she was sitting on her bed crying. And I had my arm around her, comforting her. She was my friend. But then the nurse came in and saw us and started yelling about how she was afraid that this was where our friendship would lead, and did Rose Ann know I was a lesbian and how could I take advantage of her.... [Rose Ann] couldn't be friends with me after that without being in bad trouble with the staff.

These two specific examples were echoed in other key informant interviews and source materials. We cannot, of course, conclude how rare or common these problems are from such anecdotes. However, their reiteration across multiple sources suggests it is a potential problem that merits further inquiry.

## **Not Considered Family**

Many LGBT people draw primary support from a chosen family of close friends and a spouse or life partner. While this is common enough among adults of all identities, it is even more pronounced among LGBT people due to higher rates of conflict with or rejection by one's family of origin (Abinati, 1994; Hartman, 1997; Herdt & Boxer, 1993). Unaccustomed to this cultural pattern and often uncomfortable with LGBT patients' differences, health professionals may not treat these central relationships as legitimate and important (e.g., Teleconference, 5/23/95). While present in many settings, this problem seems particularly common on inpatient units. One key informant included it among the most important issues she wanted to convey: "Having your partner not treated as a straight person's spouse is treated. Having her excluded, or not consulted with treatment options" (KI Lynne D'Orsay, February 1998).

For heterosexual married couples, if one is thought or declared "incompetent" the other is consulted about care and decisions. However, a same gender couple may find their relationship unrecognized by psychiatric (and legal) systems or personnel. When an incapacitated adult doesn't have a spouse, parents or siblings are usually consulted. If the patient's relatives are uncomfortable with or hostile to the patient's same sex relationship, the partner may find her/himself completely excluded from her/his loved one's care and visitation (McClure & Vespry, 1994). More subtly, "sometimes [the] family of origin is listened to more than the partner, especially if there is conflict between the partner and family of origin" (KI Jim Huggins, September 1998).

This same inequity (not being considered "family") is also used in some inpatient and residential institutions to bar same gender partners from visiting or to subject their contact and relationships to extraordinary scrutiny (McClure & Vespry, 1994; National Empowerment Center, 1995). Such practices reveal staff stereotypes of same gender relationships as unhealthy or not real, and put undue pressure on the individuals and relationship at a time when the comfort and support of significant others is most important. Randall (1985) summarized one story:

▼ In 1984, Sumi was hospitalized for bipolar symptoms and [then] caught kissing her girlfriend Les in the bathroom during visiting hours. Sumi was put in seclusion and involuntarily medicated when she got angry that Les was forcibly removed from the ward. Les was then barred from visiting although she was Sumi's main support person. Potential access to visits was used to get Sumi to comply with staff directives.

Again, we do not know how often such things occurred in the 80's nor how often they happen now, because the inquiry and documentation simply have not existed. In contrast, LGBT-affirmative clinicians advocate for including

significant others and close “chosen family” friends in all aspects of care and offering them support as one would any family (Smith, 1992).

## **Fundamental Conflicts Around Transgender Patients**

In a related coupling of societal biases and inpatient treatment, many psychiatric units are wholly unprepared to adequately serve transgender clients, especially given the pervasive gender segregation of most inpatient programs regarding living quarters, bathing, bathrooms, and some activities (e.g., “men’s group”).

It’s very difficult for trans people in hospital settings. People (staff, clients) are not respectful of their gender identity, and go on genitals only. So [trans people are] treated as their wrong gender, placed in a wrong gender room. Very stressful, not helpful. (KI Jim Huggins, September 1998)

As a transgender person, you are either placed into an uncomfortable showering situation with other women or other men, or you are placed into a 3rd shower group altogether. The whole process of stripping naked and showering as a group is very traumatizing for a trans. (KI Zappalorti Society Meeting, August 1998)

Even one of the few LGBT-affirmative inpatient units in the country wrestles with serving transgender people well:

▼ Physically [our unit] has 2 wings...The history for the last 20 years has been to have men in one hall and women in the other, which we still do. It is always interesting to see where trans folks end up, room-wise. Part of it, of course is just practicality – where is there an empty room? When possible we try to give trans patients their own room – additional privacy, especially since they have a longer...process to get ready for public self presentation in the am. This is very important to them, and we like to give them this space as part of creating a comfortable therapeutic environment for them...[But,] often giving a solo room isn’t possible. Oddly, without consciously meaning to, we (staff) find that transgender clients often end up in between the two halls – even at the junction in the common area joining the two sides when there is a room crunch. Transgender issues are an area we constantly need to raise our consciousness about around on the unit. (K I Orren Perlman, June 1998.)

However, what sets such services apart is their awareness of the issues, their shortcomings, and the impact on patients -- and a willingness to continue efforts to address problems and educate themselves. Many others, it seems, see the transgender patient as the problem rather than the unit structure as needing adjustment or the staff as needing information.

## **Discharge Planning**

“According to Diane Johnson, president of Lamda 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, quoted in Chassman, 1996, p. 2). Given all the changes in health care and inpatient mental health services, discharge planning now begins as soon as a patient is admitted. Since the

goal of discharge planning is to link clients with services and resources that will support their recovery and community living, good plans must reflect clients' goals and life realities.

Therefore, inpatient discharge planning for LGBT patients embodies facets of each of the previously discussed issues. Staff who do not know about a patient's life context and are not open to listening respectfully cannot be helpful to the patient in laying out their next steps. If they do not recognize LGBT consumers' strengths or important relationships, they cannot adequately discuss recovery plans or social support. Workers who do not know whether a given board and care home will be safe for an LGBT resident may be sending patients into a dangerous situation. Discharge planners who do not know where one might find an outpatient therapist or a support group that is knowledgeable and welcoming to LGBT members cannot create an adequate discharge plan. However, even those who do consider such issues often find that there simply are no local resources for LGBT people with psychiatric disabilities.

## Housing

I've been looking for a residential situation where I can deal with issues of mental health and to find something that will also allow me to be gay. I live with 11 ex-cons right now and "faggot" is the word of the day. Although it tremendously bothers me, I have to live there and I don't want to be isolated – so I've had to make choices... You know, do I come out and say "hey" and then risk being hassled, rejected, or maybe hurt. (Anonymous, 1998)

Discrimination, including in public accommodations and housing, due to one's sexual orientation or gender identity is legal in most U.S. jurisdictions (NGLTF, 2003). In addition, housing options for people with psychiatric disabilities are notoriously poor across the country. Not surprisingly, then, it seems that LGBT mental health consumers may have few affirming options for housing programs. In part, this may stem from mental health residential programs often not addressing adult sexuality well in general, but there also may be particular negativity toward LGBT issues (KI Zappalorti Society Meeting, August 1998). Anonymous W. (KI, May 1998) said: "Housing and residential, it's a big issue. One cannot express, have, same-sex relationships in a supported housing situation. It's just not tolerated. Even more than heterosexual expression is quashed, it is." Key informant Audrey Grifel (March 1998) pointed out how the disregard of LGBT residents starts at the first step:

- ▼ On every application for housing programs I can ever recall seeing, you never see any questions that respectfully, meaningfully address these issues. It's a non-issue, ignored, invisible, and so induces fear of bad reactions.... At a training for clients who want to be providers we had county agency staff

going through their procedures. I was paired up with a trainee because there were an odd number of them. We were taking turns interviewing each other, and [we] couldn't even get past the first page! The county shelter system forms have tons of personal questions but **none** of the "marital status" options applied to me. Just didn't fit. I brought it up and the speaker/presenter just didn't get it at all.

Mental health housing programs also have a reputation for being actively hostile environments for LGBT consumers, although how warranted this is in reality has not been evaluated. Residents report that someone who is known or even thought to be LGBT is often blamed when s/he is badgered or assaulted by intolerant residents or staff (McClure & Vespry, 1994). Many of the stereotypes and hostilities found in inpatient settings occur in housing as well: Both staff and other residents express narrow gender role expectations, extreme reactions about sleeping and bathing quarters, irrational AIDS concerns, inability to house transgender people respectfully due to rigid ways gender is segregated, moral and psychiatric condemnation. LGBT residents are presumed to be sexually predatory toward other residents, especially same-gender roommates – even given no hint of such behavior. Often, appealing to staff for support and help is moot – staff are sometimes among the perpetrators or tacitly condone the harassment through inactivity (McClure & Vespry, 1994). The stories below were cited by key informants as examples of common events:

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. (KI Bert Coffman, May 1998)



One specific client was living in the local YWCA (a common local housing option). She was casually out, or was presumed to be a lesbian by staff and other residents, and she was harassed and discriminated against, made to feel very uncomfortable. (KI Audrey Grifel, March 1998)



Shelters cannot deal with men who are at all effeminate – they get beaten up. (KI Bill Adams, July 1998)



LGBT or questioning Youth in juvenile justice settings or residential are often faced with "macho" staff who are very stuck on that gender role and can be brutal toward boys who don't fit a macho image. (KI Jim Huggins, September 1998)



Going to the staff when clients/residents are harassing you is no good. Often the staff condone it, or say "what can I do!?" like they did to her. (KI Bert Coffman, May 1998)



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. (KI Melanie Spirtz, June 1998)

Consumers hear these stories, or experience them personally, and logically react with fear. For self protection many stay closeted and keep to themselves. Individuals may feel scrutinized and endangered by the knowledge that their being accepted is fragile and depends on hiding parts of themselves. For example,

▼ In terms of housing, several lesbian clients have been really frustrated with having to be in the closet or it just not being acknowledged at all. No one considering how a roommate might react if the client is outed; just don't even think about prejudices that might impact clients. And this happened at times when the person was already feeling alienated and fragile, and needed... affirmation. To then have these pieces of one's self that are not affirmed, are invisible or disliked, is a big problem. (KI Audrey Grifel, March 1998)

Due to the lack of housing alternatives, at least some LGBT mental health consumers are forced to live in actively hostile settings (KI Zappalorti Society Meeting, August 1998) perhaps compromising their own health and recovery.

For example:

▼ There was one client who came to the [LGBT consumer support] group for about 6 months, seemed to be getting a lot out of it, and then stopped showing up. We checked in with him and found that another person at his residence was coming [here] for individual therapy. He had seen her here and was very afraid that she would see him and tell others that he attended the gay group, and that this would create big problems at the residence. We know this is realistic, so we have now modified our way of doing things to lessen this. Before the group members would wait for the group to start in the general waiting room. Now we have them come directly into the group room when they arrive. It's more private. We also leave some literature etc out so that they can read it if they want while waiting for the group to start. It creates a peer atmosphere that has been good – sometimes people arrive 15 or 30 minutes before we do for the group. And, once we did this that client started attending the group again. (KI Ron Hellman, June 1998)

▼ I know of a gay youth who is living in a straight residential home where he can't be out and is very depressed. He can't be out at his home because his parents are homophobic. He can't afford to get away from the residential home to travel into the city where there are more opportunities to commune with other gay men. (KI Zappalorti Society Meeting, August 1998)

The other side of the paradox is that some housing programs apparently force LGBT people to reveal personal information to staff and residents as a condition of residence that they do not require of heterosexual residents, as was mentioned with inpatient units. While most LGBT consumers are not ashamed of their identities, the disempowerment and intrusion of being required to reveal such information to potentially antagonistic strangers

is often perceived as abusive (KI Zappalorti Society Meeting, August 1998). Suspicions arise that such programs do this as a way of discouraging (or even getting rid of) LGBT residents, thereby alleviating any need for the program to substantially address the issue.

In several cities (at least New York and San Francisco) there are efforts to create overtly LGBT-affirmative housing programs/units for consumers (Ron Hellman, personal communication, Nov 1998.) Funding for one such program was promised and then rescinded by the New York city government in 1998 (Personal communication, Bert Coffman, October 1998), but another does exist in San Francisco ( KI Orren Perlman, June 1998).

## **Medication Side-effects and Sexuality**

I remember one client at a halfway house I rotated through in Boston who could not put a condom on the demonstration dildo [during a safer sex workshop] because of his pronounced tardive dyskinesia. I remember people cheered for him and really cheered when he finally did it. (KI Orren Perlman, June 1998)

Many common psychiatric medications have been documented as have adverse sexual side effects (Demyttenaere, DeFruy & Sienaert, 1998; Finger, Lund, & Slagle, 1997; Hummer, 1999; Rosenberg et al, 2003). Recent studies exploring this area (most involving only men) have shown variable findings and a wide range of effects, depending on the medication studied and other factors (Gitlin, 1994, 1995; Segraves & Balon, 2003; Teusch, et al., 1995). These include increased and decreased libido, and decreased sexual response (Gitlin,1994; Rosen, Lane & Menza, 1999;Teusch et al., 1995; Wirshing et al., 2002), and only recently has professional literature given serious attention to treatment strategies (see Zajecka, 2001 and Wirshing, et al., 2003). Key Informant, and Director of the Office of Consumer and Ex-Patient Relations for the Massachusetts Department of Mental Health, Steve Holochuck (July 1998) commented:

It doesn't get much visibility or mention, but its very important: The impact of meds on people's sexual functioning. Many people experience this, with many different meds, to different degrees. Sexual dysfunction is an awful thing for most anyone... and isn't given the attention it merits. It's also part of a larger issue of people not dealing well with sexuality, period, for anyone with a mental illness label.

Sexual side effects are also found to affect medication-taking compliance (Rosenberg, et al, 2003), yet most mental health programs do not address any sexuality implications of psychiatric medications (KI Steve Holochuck, July 1998; Kaplan, et al., 1996) even though they are of considerable importance to people using or considering



psychiatric medications (KI Angel Olmeda, July 1998; KI Bert Coffman, May 1998). Key informants also emphasized that their concerns have usually not been listened to even when they initiated the conversation. Steve Holochuck (KI, July 1998) continued,

▼ Providers don't seem to take it seriously. They don't really want to talk about the sexual side effects of meds, nor how important sexuality is for some people. I've heard basically, 'Would you rather be crazy? That's the price you have to pay.' They don't take sexuality as important, especially if you're a 'mental patient.' ....So, we really need professionals who are willing to reach out and are willing to help people manage and cope with this. Who are willing to try different things, to help or compensate. AND, we need these folks in the public mental health system too!

There is perhaps even less chance that LGBT consumers will be offered information or assistance in managing sexual side effects if providers are uncomfortable talking about non-heterosexual sexuality. There also may be particular social and emotional weight to this issue for some men (gay, bi, and heterosexual) given the emphasis on sexual performance in male socialization. At the same time, there is a particular lack of attention paid to women's sexuality in most facets of health care, and this area is no exception.

Consumers want and "need to talk about [sexual side effects] and how to handle it, how to talk with clinicians about it. Some men end up saying they feel like they have to choose between 'sanity or a sex life' (KI Bert Coffman, May 1998.) This is usually a false bind. If there is open communication, provider and client can consider issues of dosage and dose scheduling, medication choice, and enhancing of facets of the client's sex life. In doing so, many sexual side effects can be eliminated, compensated for, or accommodated (Finger, Lund & Slagle, 1997, Wirshing et al, 2002).

## **Specific Sub-Group Issues & Identities**

Transgender, bisexual, gay and lesbian mental health consumers are people with cultural, ethnic, religious, and political identities, of various genders, ages, social and economic situations, values, priorities, and interests. Every facet is essential to one's whole self. While there are many issues that face LGBT consumers as a whole, some impact people with certain identities in unique ways. Previous sections have already included some mention

of certain experiences particular to lesbians, gay/bi men, bisexual people, or to transgender people. These and others from this study's data are compiled in summary form below, followed by sections addressing issues of particular relevance to people of color. In addition, please see Appendix C for a supplementary section on youth. In keeping with the overall report, these sections should be viewed as raising questions and issues that invite further inquiry rather than as exhaustive, complete, or offering definitive answers.

## **Bisexual People**

- ▼ Bisexual identity is still sometimes pathologized in the mental health system, mistakenly equated with borderline personality disorder or seen as self fragmentation that needs to be cured.
- ▼ Bisexual people sometimes experience pressure to “give up” same-gender attraction or relationships and “become normal” by heterosexist peers and providers.
- ▼ Some gay, lesbian, transgender people have internalized stereotypes about bisexuality that prevent them from being allies, or leave them with ambivalent feelings about people who identify as bi.
- ▼ Bi people may encounter discomfort or hostility repeatedly if they have romantic partners of different genders over time – from those who want to see them as “straight” when they have an other-gender partner or “gay” when they have a same-gender partner.
- ▼ Therefore, bi people find themselves sometimes unwelcome in both “gay” and “straight” circles – whether in the general communities, among mental health consumers, or somewhere else.
- ▼ In many locales, bi people do not have a bisexual-identified community to provide mutual support.
- ▼ Bisexuality is stereotypically linked with HIV in many people's minds; bi men may find themselves especially vilified.

## **Transgender People**

- ▼ Many providers and peers (of all orientations) feel uncomfortable or threatened by the very presence of transgender people because they transgress gender categories and are unfamiliar.
- ▼ Transgender people make up a small proportion of clients in many places, which some providers and administrators use as a rationale for not developing staff competencies.
- ▼ Most mental health workers, like the general public, are ignorant of transgender issues and some confuse gender identity with sexual orientation, when in reality a transgender person may have any of the various sexual orientations.
- ▼ There are some current mental health professionals who still perceive transgender identity as delusional or psychotic. This issues can be complicated even more if the person actually is or has been delusional or psychotic as part of a mental illness.

- ▼ Transgender clients sometimes feel they are eroticized or exoticized by mental health professionals – even to the point that some may feel they are accepted into treatment more as objects of titillation rather than for their own well-being.
- ▼ There are contentious and complex issues surrounding the psychiatric (DSM-IV) diagnosis of Gender Identity Disorder, in that a diagnosis is often necessary to obtain somatic treatments, but is it also stigmatizing (equating gender identity with mental illness) and does not accurately capture many transgender people’s experiences.
- ▼ Transgender people often encounter pressures to match the images that mental health and medical providers hold of what it means to be “a man” or “a woman.” Sometimes this involves their feeling forced to present themselves as “hyper-feminine” (for MtF) or “hyper-masculine” (for FtM) -- to “prove” they really are transgender/transsexual to healthcare providers.
- ▼ The interactions between psychotropic medications and the hormones and other medications used by some transgender people are mostly unknown.
- ▼ The dichotomous gender segregation of medical and mental health systems can make respectful accommodations for transgender people very difficult. For example, in which of the (sex-segregated) wards, sleeping rooms, shelter, bathrooms, showers, men’s/women’s group does the person “belong”?
- ▼ A monolithic view of transgender identities is common, but ignores the tremendous variety within transgender and transsexual identities.
- ▼ Being forced to assume name, dress, and roles of birth sex while getting mental health services, regardless of self identity, preference, or somatic therapy or surgical sex reassignment is a common and traumatic experience for many transgender people.
- ▼ Transgender people experiences a high level of prejudice and ignorance from GLB community members.
- ▼ The stress and mental health implications of the disruption that transitioning creates in one’s life are considerable:

When we come out we deal with hostility from our family that is far worse than for GLB people coming out. Your daughter becomes a son. Your sister becomes a brother. You yourself change, and your relationships with family members change – I am now my father’s daughter rather than son, and we interact differently because of it. I’m still not allowed near my nieces and certain other relatives. The whole way people deal with me, the dynamics of our interaction, changed. (KI Melanie Spritz, June 1998)

## **Lesbians (Some probably also hold for Bi women)**

- ▼ Psychiatric labeling still seems to be sometimes used to pathologize lesbian identity.
- ▼ Sexism still operates in many health facilities, making women’s concerns and voices often invisible or ignored.

- ▼ Lesbians are sometimes subject to ridicule, sexual harassment, threats and even sexual assault from certain heterosexual male clients and staff who perceive “lesbianism” as a rejection of men in general and of themselves personally. This is especially dangerous in the closed environment of inpatient/residential facilities and/or when the women being harassed are already in distress.
- ▼ In some places there is a strong gender pressure on lesbian clients to fit providers’ ideals of how women “should” look and act. This sometimes includes linking a lesbian consumer’s psychiatric problems with supposed “rejection of femininity”
- ▼ There is a persistent misconception that lesbian women are sexually predatory, and will harass or molest same-gender roommates or consumers.
- ▼ It is not known whether the sexual side effects of psychiatric medications differ for lesbian and/or bisexual women than heterosexual women, and research even regarding heterosexual women is sparse.
- ▼ Some lesbian communities may be quite accepting of members having psychiatric histories while others may exhibit considerable stigma regarding mental illness.

### **Gay Men (Some probably also hold for Bi men)**

- ▼ Pathologization of gay identity and of culturally normative behavior still happens.
- ▼ Gay men often experience harassment and condemnation in mental health programs (and other places) if they are seen as “effeminate” or not conforming to male gender expectations.
- ▼ Stereotypes about promiscuity, pedophilia, and AIDS are directed toward gay men in particularly virulent forms that affect the care they receive.
- ▼ Medication side effects, especially those that effect sexual response, are not taken seriously by many providers.
- ▼ Conversely, many mental health services and providers do not deal well with HIV/AIDS issues or the grief gay male consumers may be experiencing over the AIDS pandemic and loved ones’ deaths.

### **Table 3: LGBT Identity and Societal Issues that Individuals may bring to their Interactions with Mental Health System & Workers**

#### **LGBT consumers may...**

- τ ...Bring the effects of having experienced insensitivity from previous health providers. Such experiences have been tied to experiencing greater emotional distress after such services.
- τ ...Seem “hyper vigilant” to homophobia or discomfort in others, due to finely tuned self-protective abilities to read subtle signs of other’s reactions -- developed in order to avoid or prepare for potential and actual embarrassing and dangerous homophobia-related incidents.
- τ ...Be wary or reserved with others until they feel assured the person is both LGBT-affirmative and able to work with them in other areas as well (focal problems, culture, class, etc).
- τ ...Not let a mental health worker know they are LGBT in order to avoid possible rejection or intolerant reactions, even if they are comfortable with their identity.
- τ ...Be distressed about discord their identity creates with family members who are not LGBT-affirmative, especially if they rely on family support, come from cultural or personal background that emphasize family harmony, honor, and/or filial loyalty, and/or already experience family conflict around their mental illness.
- τ ...Be isolated or lonely due to not having a community of similar others for belonging and validation, particularly if they are bisexual or transgender, are people of color, have other stigmatized “differences,” or don’t live near a large metropolitan area.
- τ ...Be conflicted or distressed about their sexual orientation, due to misinformation, cultural or religious values, and/or internalized negative messages about LGBT identities.
- τ ...Have to work actively to develop a positive identity. Heterosexuals usually do not have to engage so deliberately in their identity development, because they seldom encounter challenges to it.
- τ ...Be concerned about stressors related to anti-LGBT prejudice, such as losing one’s job or custody of one’s children.
- τ ...Need to address substance abuse or addiction that may or may not be tied to social isolation, stress, or personal conflict related to being LGBT.
- τ ...Be facing pressures (and joys) unique to same-gender relationships in addition to those experienced in all relationships. Pressures: a lack of the social sanction automatically afforded mixed-gender relationships, pathologization of relationship patterns that do not follow heterosexual templates, lack of relationship models, overt discrimination. Strengths: deep degrees of friendship and of flexibility, egalitarian roles, creative relationship models unconstrained by heterosexual templates, high levels of intimate and sexual communication

(Sources include: Brown, 1989; Browning, Reynolds, & Dworkin, 1991; Fassinger, 1991; Firestein, 1996; Gottfried, 1990; Markowitz, 1991; National Gay Health Workers, 1978; Neison, 1990; Nystrom, 1997; Key Informants)



## **Racism, Homophobia, and Multiple Identities**

There really is no body of published literature regarding people who are LGBT, people of color, and have a serious mental illness (but see Hidalgo, 1995 and Harris & Licata, 2000 for two exceptions). In fact, work on LGBT issues often excludes minority identities and people, and vice versa (Friedman & Downey, 1994). However, the thoughtful literature regarding the lives of people of color who are LGBT issues makes a number of points that apply to LGBT people of color receiving psychiatric services. This section summarizes some of this literature, in combination with key informant comments.

It is well known but poorly addressed, that people of color experience disregard and discrimination in many mental health service settings (Edwards, 1996; Hidalgo, 1995; Sashidharan, 2001; Wade, 1993). Individuals and groups face stereotyping, cultural ignorance, denial of the problem, ignoring of cultural context, discriminatory staff and peer behavior, prejudicial program and systems-level policies and practices, and more. Diagnostic and treatment biases are well-documented and all too common (Jones & Hill, 1996; Laszloffy & Hardy, 2000; Whaley, 1998), making seeking help from outside one's own ethnic community feel hazardous to many. Therefore, people may not value or readily seek professional mental health care but instead turn primarily to other resources within their communities (Greene, 1997), and those who do seek "outside" services may be wary.

Racism is a persistent problem among psychiatric survivor/consumer organizations and LGBT communities as well (KI Bert Coffman, May 1998; Garnets & Kimmel, 1993), further narrowing the places that LGBT consumers of color can assume they will be welcomed and comfortable. While there is still too little societal attention paid to the impact of racism on the mental health of racial/ethnic minorities and of whites (De La Cancela & Sotomayor, 1993; Thompson & Neville, 1999), there is abundant research evidence that racism and other forms of oppression do have strong negative effects (Counseling Psychologist, 1999; Greene, 2000; Glauser, 1999; Lee & Zane, 1998; Hendryx & Ahern, 1997).

## **Cultural Defining of Sexual Orientation and Identity**

A culture organizes and defines sexuality and sexual orientation for its members in many ways – what identities are recognized as existing, what valence each holds (Gonzalez & Espin, 1996. p. 584; Tafoya, 1996; Ryan

& Futterman, 1993), and the “membership criteria” for being considered one rather than another. Regarding LGBT identities, “criteria” usually consist of behaviors, the situations under which behaviors take place, and the meanings attributed to each combination (Manalansan, 1997; Monteiro & Fuqua, 1994; Nakajima, Chan, & Lee, 1996). For instance, Gonzalez & Espin, (1996) observe that very close relationships between women are considered perfectly normal and appropriate in many cultures (Latin America and India are mentioned in particular) and are not questioned, sometimes even if they may include discrete intimate or sexual contact. Similarly, men who have sex with men are not necessarily considered “homosexual” in some Latino and Asian cultures. Furthermore, several authors discuss African American families as often sincerely warm and accepting of a family member’s same-sex partner as long as the identities and sexuality involved are not overtly spoken (Jones & Hull, 1996; Greene, 1997). Nakajima, Chan, & Lee (1996), in particular, point out that individualistic identity categories may simply not be as salient or codified for some groups, leading to more fluid self-conceptions and a focus on community harmony & roles separate from one’s personal identities and behavior (see also Lipat, Ordon, Steward, & Ubaldo, 1997).

In a related meeting of culture and identity, one’s roles in the community and family, including having children (Gonzalez & Espin, 1996; Greene, 1997; Nakajima, Chan, & Lee, 1996), are of immense import in any culture. For ethnic/racial minority groups they are often seen as elemental to continuing the group into the future (Greene, 1997). Tied closely to these are gender role and sexuality expectations (Monteiro & Fuqua, 1994; Sohng & Icard, 1997). Not meeting these expectations often carries a high price, and LGBT identities usually cannot fit within the rewarded parameters (Monteiro & Fuqua, 1994). Having a serious mental illness often disrupts them as well. Therefore, people attracted to others of the same-gender may choose to fulfill family and cultural responsibilities by marrying and parenting with an other-gender spouse while not giving up their same-gender identity or behavior.

Thus staff and clients, or peers within a group, from different ethnic/racial backgrounds may have very different ideas about the meaning of certain relationships or behaviors, and about what it means to be LGBT, or to be an adult. For example, ethnic minority individuals may feel pressure from predominantly white LGBT peers or allies to “come out” publicly – pressure that may be ill informed about the cultural meanings and repercussions involved. Or, conversely, a group may assume that none of its members could possibly be LGBT (because it is not openly acknowledged) when this is clearly not the case – adding to the isolation of a portion of its members.



## Multiple Identities

As is implied in the sections above, the nexus of culture, gender and sexuality is complex, especially for ethnic minority persons interacting with the dominant culture (Monteiro & Fuqua, 1994). People report feeling pressure to choose alliances: Which identity to foreground? Which community to call home, since active participation in one often makes participation in the other difficult or impossible? Never feeling whole or wholly accepted in either, afraid of losing both (Jones & Hill, 1996; Sohng & Icard, 1996), and consciously feeling out which facets of one's self can feel at home in which settings (KI Anonymous J., July 1998).

Indeed, it often takes a draining, delicate balance to avoid being marginalized/outcast from two important communities, even for people without the challenge of psychiatric disabilities. For people of color, to risk losing one's family/ethnic community by embracing an LGBT community may be additionally dangerous due to racism in the LGBT communities, and, for LGBT mental health consumers of color, due to the stigma associated with mental illness (KI Anonymous J., July 1998; Greene & Boyd-Franklin, 1996; Jones & Hill, 1996). Most locales do not have specific ethnic-minority LGBT communities big enough to sustain people (Sohng & Icard, 1997). And even if one does exist, members only know they have two points in common, and likely have many more not in common, so they still don't know if they will find community or be accepted. For example, one key informant said:

▼ There is a strong Black Lesbian community in Detroit....It's really good. Worth the trip to Detroit. BUT, still, you can't be sure if they'll be ok around other differences (including disabilities), even though we all share race. ....You don't have a support system (around race, or other things), and then when you do find one you are not sure how much of yourself – your other parts or identities – to divulge. You can't be sure if they'll continue to be supportive of you. (KI Cookie Gant, August 1998)

Thus, negotiating the development of one's multiple identities, especially stigmatized ones -- sometimes simultaneously (especially for younger generations; Ryan & Futterman, 1993), other times ethnic identity first (older generations) -- can be very stressful. Whether or not this impinges on a person's mental health depends on many factors – not the least of which is his/her mental health status before or outside this stress. Anxiety about coming out, community-oriented risks, and torn “loyalties” can look like a psychiatric disorder to someone who does not understand the situation, and can exacerbate existing mental health problems (Solarz, 1999). Therefore, it is not surprising that the multiple identities, and concomitant experiences, of LGBT mentally ill men and women of color are sorely under-acknowledged (Harris & Licata, 2000).

## **Conclusion**

Providing consumers with an option to work and associate with staff and peers like themselves is often desirable – whether in a self-help organization or a psychosocial rehabilitation program. However, doing so is not an answer to the issues raised above as they pertain to mental health services: “matching” simply on skin color or country of origin can be tokenism, and working with someone like one’s self can have its own complexities. Moreover, in many places there are simply not enough providers of color, and most consumer spend ample time interacting with members of dominant groups, whether in obtaining services or other parts of their lives.

Therefore, the currently developing concept of “cultural competence” (Dana, 1998; Huff & Kline (1999); Sue, 1998), applies as well to the needs of LGBT mental health consumers of color – whether in a consumer-run program or an inpatient facility. To work well with people of color different from oneself who are also LGBT and mental health consumers, one needs:

- ▼ Cultural literacy; awareness of multicultural issues (including LGBT and ethnic cultures)
- ▼ Awareness of one’s own ideas and feelings regarding various racial/ethnic minority groups, and LGBT people of color – and the ability to handle one’s own issues and countertransference (Greene, 1997, p. 229)
- ▼ An appreciation for the societal situation and the stresses of dealing with multiple sources of oppression.
- ▼ An appreciation that multiple identities also bring with them multiple strengths, creativity, adaptation skills, and multiple communities from which to draw energy and support.
- ▼ Programmatically, one needs to examine how being “different” in any of a myriad of ways is received and treated in the program or group.

## **HIV Status**

Because HIV and AIDS are still linked to being gay in the public’s mind and, lesbian, gay, bisexual and transgender people receiving services in public and community mental health systems often face stereotypes. This report will not address consumer experiences with HIV/AIDS services, nor exemplary practices (see the following: Perry et al., 1997; Kaplan, et al., 1996; Hamilton, et al., 2002; Otto-Salaj et al, 1998). However, within mental

health programs and systems, Key Informants commented that staff often assume that all LGBT people are HIV positive. For example,

▼ When I was hospitalized once, the first question that they asked me was what my sexual preference was and I said I don't know if I really want to answer that. They said well you have to answer that because we have to do an AIDS test if you're gay. (KI Anonymous W., May 1998)

A particular concern from several consumers was that they were pushed to consent to testing when they were not cognitively or psychologically able to consider the implications of having HIV information recorded in their medical charts, given the persistent stigma attached to being HIV+ , or in some places to even having been tested, and the growing access to personal records by employers and the like (KI Anonymous W., May 1998; KI Lynne D'Orsay, February 1998). For those who are HIV positive, receiving good referrals and services within the mental health system can be difficult because of such prejudices (Perry, et al., 1997).

At the same time, the AIDS crisis has also led to some accelerated consciousness-raising about LGBT issues, particularly those of gay men, among health care staff in general (Cabaj & Stein, 1996; see Chap. 42). And, it has brought more of the general public into contact with LGBT issues, even if just through mass media, than may have happened otherwise. But, even these small "silver lining" benefits have had mixed effects. For example, as more health care money was earmarked for AIDS mental health services, less was available for the mental health needs of HIV negative LGBT people due to the stereotyped equation that HIV=LGBT (KI anonymous D., March 1998; See also Chapter 42 of Cabaj & Stein, 1996).

## **Substance Abuse**

Although a full review of substance abuse issues vis a vis LGBT people and/or people with SMI (serious mental illnesses) is beyond the scope of this report, several themes recurred among key informants' remarks vis a vis substance abuse and mental health. These are summarized below. For further information regarding addictions and LGBT people see CSAT, 2001; Hughes & Eliason (2002); Kus (1995); and Philleao & Brisbane (1997); regarding substance abuse and SMI see Buckley (1998), and Drake et al. (1998).

Alcohol and street drugs have long been used to "self medicate" troubling emotions and to temporarily escape stress and despair by many disenfranchised populations. Given this, it is no surprise that up to 50% of people with serious mental illnesses abuse controlled substances (Fowler et al, 1998; Kosten & Ziedonis, 1997; Mueser et al., 1990), even apart from recent theories that schizophrenia and addictions may share common biological

vulnerabilities (Mueser, Drake, & Wallach, 1998; Kosten & Ziedonis, 1997). As one Key Informant (Cookie Gant, August 1998) commented,

▼ A lot of people with [psychiatric and physical] disabilities turn to substances out of loneliness. It's cheaper and easier to get a pint of something than it is to deal with public transportation only to get [to an event] and find that it's not wheelchair accessible – that I have to be lifted into the place once I get there!

For similar reasons of isolation and societal bias, it is not surprising that some LGBT people have addiction problems, nor that the prevalence is sometimes higher than in the general population (Cabaj, 1995; Cochran, Sullivan, & Mays, 2003; Hughes & Eliason, 2002). It is also known that people with serious mental illnesses have high rates of addiction (Gilman et al., 2001). Therefore, although there is no research at this specific crossroads, it is logical to assume that some LGBT mental health consumers also have substance abuse problems, and to speculate that rates may be higher than either heterosexually-identified consumers or LGBT people not receiving psychiatric services.

Nonetheless, addiction programs may share many of the shortcomings of mental health facilities when it comes to serving LGBT clients – lack of staff training, stereotypical assumptions about clients, insensitive policies, tolerance for homophobic comments and behavior, etc. (K I Orren Perlman, June 1998). Many are similarly ill equipped to meet the needs of clients with serious mental illnesses (Kirchner et al, 1998). Talking about a friend's experiences, consumer and advocate Audrey Grifel (KI, March 1998) illustrated the results:

▼ He started using alcohol to help self-medicate when he experienced hallucinations, and got hooked. He said that when he'd been in alcohol treatment programs, he'd try the detox program for part of the 26 days, but no matter how nice the people were, there was **never** any acknowledgement of sexual orientation as important, or of gay issues. And he felt so isolated and alienated that he couldn't stick with it. The atmosphere in these programs became a real clinical issue and made his other disabilities even more of a challenge.

Amico and Neisen (1997) report that in addiction groups LGBT people are often told to hide their identities under the pretext that it is not the focal problem and so shouldn't need mentioning, or because group members will be condemning. Both rationales encourage shame and ask a person to enter the group with less than their whole selves, which are detrimental to recovery work (Ball, 1994 ; Marrow, 1996). In other instances, clients are pressured or forced to disclose their being LGBT to group members (or are outed by the therapist) when they don't wish to. If this results in their being snubbed or harassed by group members, often the same therapist may offer little support or assistance. In both cases therapists may be acting out their own discomfort with a client's identity or with having to deal (in their role as therapist) with group-members' negative responses to disclosure.

Such experiences can increase the pressure, isolation, and conflicts in the LGBT group member's life -- which are detrimental to recovery (Cabaj, 1995).

Currently, treatment models are shifting to integrating mental health and addictions services for people with both substance abuse problems and SMI (Kosten & Ziedonis, 1997; Mueser, Drake, & Miles, 1997). In the past two decades, gay and lesbian-specific addictions services have also been created to address the communities' specific concerns (Amico & Neisen, 1997; Cabaj, 1995; Hellman, 1992; Hicks, 2000; Paul et al., 1996), although with less attention to bisexual and transgender persons' needs. However, few programs have combined these two.

**PART II: LOOKING FOR & CREATING**  
**COMMUNITY**

These two identities – mental patient and homosexual – evoke the worse stereotypes in the public mind – axe murderer and child molester. What do you think it is like to deal with the fall-out of this??.... To have in one's person two such charged identities is incredible to deal with, very complex and challenging, because of what they mean in this society currently. It is often even more challenging to deal with when you also have the challenges of a diagnosis of mental illness – which often includes problems managing one's self and one's life. (KI Steve Holochuck, July 1998)

Seeking community with similar others is a common and effective way of coping with adversity and strengthening one's self image. The mental health consumer / psychiatric survivor movement has a long history of building mutual support and advocacy efforts across many states and countries (Chamberlin, 1990; Davidson et al., 1999; Everett. 1994). Similarly, lesbian, gay, bisexual, and transgender people have also created vibrant communities around their commonalities, with similar functions. However, “although the psychiatric survivor community is oppressed and the lesbian/gay community is oppressed, as communities we are not immune from prejudice towards our own internal minorities” (Holochuck, 1993, p. 17).

▼ LGBT consumers are members of 2 oppressed identities. Each community and movement is a microcosm of the larger society. So LGBT people encounter homophobia in the mental health system and the consumer movement. And, consumers/survivors/ex-patients encounter mentalism or stigma in the LGBT community and its organizations. (KI Steve Holochuck, July 1998)

Numerous LGBT consumers (Holochuck, 1993; National Empowerment Center, 1993; KI Cookie Gant, August 1998; KI Lynne D'Orsay, February 1998; KI Anonymous W., May 1998; KI Kwame Asante, July 1998; ZSM; KI Orren Perlman, June 1998) describe that to be out as gay, lesbian, bisexual or transgender in many mental health consumer / psychiatric survivor groups or as a patient/client/consumer in most LGBT groups is to risk rejection, exclusion, and harassment. As a result, neither feels welcoming. “We have felt that in either world,” said key informant Lynne D'Orsay (February 1998) “we have had to make choices about which aspects of ourselves we have to keep 'secret' in order to be welcome.” Key Informant Anonymous W. (May 1998) reflects, “By virtue of the experiences of both, both communities should be about tolerance and acceptance...Instead there's fear. Just mutual fear.” There are few places where both are embraced, and even fewer if one also belongs to other marginalized groups (Coffman & LittleMoon, 1997). For example, key informant Kwame Asante (July 1998) said that being part of four stigmatized groups (African-American, HIV+, gay, mental health consumer), he frequently feels like people push parts of him – parts they don't want to deal with.

Therefore, the need for community that welcomes “both” (LGBT people involved in the mental health system) was repeated over and over by various information sources. In the discussion below, experiences of LGBT consumers involvement with their families of origin, and then with the larger LGBT community are explored. Then parallel experiences in the mental health consumer/survivor community are summarized. Last, the recent history of community organizing efforts among people who are both LGBT and mental health care consumers is discussed. Examples of the few organizations of LGBT consumers that exist in the U.S., and other exemplary groups, are then profiled at the end of this chapter.

## Family & Stress

The important role of families and other caregivers in the lives of adults with serious mental illnesses has long been well documented (Adamec, 1996; Caton, 1984; Jubb & Shanley, 2002). Persons with schizophrenia and other diagnoses frequently live with their families of origin (Adamec, 1996; Caton, 1984; Marsh, 1992) and regardless of residence usually have regular family contact (Dixon & Lehman, 1995). Many people with psychiatric disabilities rely on relatives for emotional support, instrumental and financial assistance, housing, and advocacy (Leff, 1994; Heru, 2000), either primarily or as a last-resort back-up.

For many lesbian, gay, bisexual, and transgender people with serious mental illnesses, however, these supports are not available – or come at a great price. A social worker (KI Anonymous C, March 1998) said, “Because many of the people we see don’t have family support available – especially due to family conflict regarding homophobia, they have less social support than other people with SMI do... fewer “last resort” supports they can count on if they need to.” Others do live with or have substantial contact with family members. If these relatives are intolerant, LGBT consumers must be very closeted and/or navigate the chronic stress of recurring arguments, threats, and ill feelings. Examples from two individuals help make clear the impact of this stress:

▼ When I got depressed and all the rest, I lost my job. I’m living with my mother now, who’s very homophobic, very unaccepting. It’s been really hard – a tremendous stress on me to live there. But where else? It’s very unhealthy. I’m planning to move out and thinking about just having less contact with them when I do, because it will make things so much easier. If they’d just give me something to work with, that’s one thing, but they don’t and I’m really tired of it. (KI Angel Olmeda, July 1998)



- ▼ 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]. (Haller, 1996, p. 1)

For some LGBT consumers, family relations are even more conflicted. In 1997 Anonymous K. (KI, June 1998) was involuntarily committed by his mother after longstanding friction between them over his sexual orientation, in his view because she was upset at his manic behavior and hoped that the hospital could “deprogram” him from being gay. Hotchkiss (1990) recalls that her family was more comfortable with thinking of her as “schizophrenic” than “gay” and so aggressively pushed psychiatric treatment. In a straightforward, sensitive article, Sciana (1990) recounts that while his partner/lover was hospitalized, family members moved him to a distant hospital and away from familiar surroundings so that Sciana could not visit, because they disapproved of the relationship.

These published accounts are echoed in more recent interviews and other sources: One of the coordinators of a consumer-run organization (KI Lynne D’Orsay, February 1998) said “Family issues, family support. This is a big issue. This state is very conservative for the most part, and I have to say that to my knowledge every single member of the Alliance who is LGBT has little or no family contact or support.” She went on to sum up her own experience:

- ▼ 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.

Another person related:

- ▼ A transsexual person needs lots of support of various kinds – the major expenses of surgery, and hormones, and therapy, and transition. Often the family will not support the person if they are attacked or discriminated against, are not available for any support regarding their mental illness issues, or any parts of the person’s life, even those unrelated to being transsexual. Often we’re not even allowed at home, or at family events. (KI Melanie Spritz, June 1998)

Often LGBT people of all backgrounds create a “family of choice” among close friends to compensate for the absence of family-of-origin support if it is denied. However, due to stigmas against those with mental illnesses, this alternative is sometimes not available to LGBT consumers. As key informant Lynne D’Orsay (February 1998) said,

“Well, we all know how much family support means to a person suffering mental illness. If you don’t have the support of your family, then you would naturally hope that you could turn to the gay and lesbian community. But when the gay and lesbian community has ‘internalized mental illness phobia’ then it is hard to turn to that community either.”

## Experiences in LGBT Communities

Many gay, lesbian, bisexual and transgender people who receive mental health services want to participate in LGBT organizations and communities. While sometimes welcomed, more often they find that LGBT communities believe and act on the same stereotypes about mental illness that permeate other sectors of society (Deacon, Rea, and Largey 1991; KI Anonymous S., 1998). As a result, people feel distinctly unwelcome:

- ▼ Stigma in the gay community is when people find out you're a mental health consumer, they assume that you cannot be trusted, won't be reliable. And so, then you're not someone they could have any kind of friendship or relationship with. (KI Bill Adams, July 1998)
- ▼ The stigma of being a psyc. survivor often ends relationships before they begin, which hurts. But [like coming out as LGBT] its also a good screen, if they can't handle it what kind of friend will they be? (Deacon, Rea, and Largey, 1991)

Anticipating and experiencing rejection and hostility from the very community one seeks can be disheartening. Some advocate coming out as a mental health consumer regardless of reception, as a way of breaking down stereotypes and educating the broader LGBT communities (Deacon, Rea, & Largey, 1991). Many others participate in the community tentatively while hiding their psychiatric history and/or current involvement in mental health services (KI Mary Barber, May 1998; KI Zappalorti Society Meeting, August 1998). For example,

- ▼ ...We would never have known, at GLB events and organizations, that some people there were consumers, except that we knew each other [beforehand]. It just was NOT ok to mention in those organizations and events; there was a lot of fear about what would happen if you did." (KI Audrey Grifel, March 1998)

Those who do take part in the general LGBT communities report being challenged by jarring experiences:

- ▼ Gay groups (if I can get to them [transportation]) do not like having gay "mentals" around. When they get to know my problems, gay men go bananas – it seems I frighten them too much – and then the hostility starts rolling! (Anonymous, 1998, personal communication to Bert Coffman)
- ▼ If someone has been in the hospital and wants it to be very secret—wants to encapsulate and hide that part of their life – then seeing other "patients" or providers out in the gay community could be very scary, given the chance they could be outed as having been hospitalized. Like – "so, how do you know each other?" While this sort of disclosure can be a problem for anyone, it's more common among LGBT people because the communities in question are quite small in many places. (KI Steve Holochuck, July 1998)

Some LGBT groups may also have a particularly hard time welcoming mental health consumers for historical reasons. The long history of homosexuality itself being formally pathologized by psychiatry and psychology may have left a legacy of fearing any associations with people who carry pathologized labels, for fear of rekindling this past. Lynne D'Orsay (KI, February 1998) muses,

▼ I think...gayness had been perceived as a form of mental illness for so long... that no one in the gay rights arena wants to even talk about gay people with mental illnesses and their special needs. I think that there is probably a real fear that to even say out loud that there might be a higher percentage than average of GBLT people with mental illnesses scares the beejesus out of gay leaders -- because then the straights can say, 'yeah, they're all crazy anyway,' and discount us. Of course, no one wants to talk about the stresses, trauma, and repression that growing up gay in this country [involves] -- which could possibly be a factor in mental illnesses.

In addition to these attitudinal barriers, there are also concrete obstacles that gay men, lesbian, bi and transgender consumers confront in participating fully in LGBT communities. Some people may feel self conscious about patterns of their own behavior or symptoms they know to be unusual or discomforting to others. Some also find that illness symptoms, medication side effects, cognitive, or emotional difficulties may literally interfere with their taking part in meetings, events, or organizations unaccustomed to accommodating them (Ball, 1985; KI Audrey Grifel, March 1998; AG, KI Mary Barber, May 1998).

Additionally, economics can be a major obstacle for mental health consumer participation in any cultural community. Event tickets prices, transportation, and other keys to access are often out of reach (KI Zappalorti Society meeting, August 1998). Therefore, "...there is an added isolation, in addition to the gay and mental illness, which is that of class status. So, within the gay community, one may also be ostracized by the fact that they are... poor because they are forced to rely on Disability due to their mental illness" (KI Zappalorti Society meeting, August 1998). Cookie Gant (KI, August 1998) adds,

▼ You have to pay a hell of a price, literally, for your ability to socialize and come out....The visible gay community for the most part does not include people without money – they don't even think about the gay people who have none, and how we can't participate in most of the events that assume disposable income. And then it's even more expensive when you have to go a distance – or when things aren't accessible, even for a wheelchair.

At the same time, some consumers have found LGBT circles that are safe, welcoming places linking human rights among mental health consumers to women's liberation, LGBT, and social justice issues (Vanderbosch, 1994). Irene Shimrat (1990) wrote that she found "salvation" from abuse in the psychiatric system among radical lesbian

communities. Irene Rea (1991) also found lesbian and feminist communities to be more open and inclusive, more likely to see psychiatric activists as doing needed political work for consumer rights and respect, more open to taking the issues seriously and wanting to learn more. She said, “Lesbian community has experience breaking out of molds, and so can do this [questioning psychiatry] too. Lesbians have begun examining what society’s messages are, what conformity is (Rea, 1991).

## **Being Part of Consumer/Survivor Communities**

Unfortunately, LGBT consumers also report often feeling unwelcome in mental health consumer self-help or advocacy groups (National Empowerment Center, 1993; National Empowerment Center, 1995; see also Razzano, Matthews, Hughes, 2002). As one dramatic example, a 1995 teleconference audio-taped by the National Empowerment Center includes participants recalling LGBT individuals being physically and verbally assaulted, and their rooms arsoned, at an early Alternatives (consumer movement) conference! They also discussed ongoing struggles to have LGBT issues heard at subsequent conferences, despite mixed reception, and in consumer/survivor/ex-patient (C/S/X) groups in their home communities. One teleconference participant told of being asked to leave the Board of Directors of a statewide consumer organization simply because she is gay.

One hopes that such experiences are “ancient history” but more recent anecdotes unfortunately suggest otherwise. LGBT and allied consumers involved in consumer self-help organizations are often dismayed at the negative reactions and resistance when they raise LGBT issues. However, with repetition their surprise may turn to cynicism. Indeed, two consumer activists who have worked together for years to improve the atmosphere in various parts of the C/S/X movement had harsh things to say about their experiences:

- ▼ Disability communities – including mental illness – are not open to LGBT people at all. You get shunned, they don’t invite you to participate, or be part of what’s going on... It’s really hard here. Very isolated. (KI Cookie Gant, August 1998)
- ▼ The mainstream consumers’ movement is full of rampant homophobia, racism, and misogyny. I just turn my back on them. Some of the few out homosexuals in the consumer movement, as long as they get a minute to put in their gay politics schtick they’ll ignore all the other bad things going on...But then, in most places the consumer movement wouldn’t tolerate anything more. (KI Bert Coffman, May 1998)

Others have had more positive experiences, finding varying degrees of openness in their local consumer/survivor community (National Empowerment Center, 1995; KI Lynne D’Orsay, February 1998; Audrey Grifel, March 1998). They emphasized the strength they draw from gathering with other LGBT mental health service users to support and assist each other, and from finding allies in various organizations. Two advocates reflected,

▼ The legacy of gay leaders in the [consumer] groups locally had a great positive impact. Not in terms of sweeping initiatives, but rather more subtle – that the atmosphere of these places was affirming, safe, comfortable. Although they now have straight leaders, the legacy seems to continue. (KI Audrey Grifel, March 1998)

▼ I was so ashamed of how crazy I had been, and I knew I wouldn’t be well received in the community, that I just stayed in my house – for 3 years. Finding the consumer alliance and being welcomed as a lesbian and as a consumer very literally changed and saved my life. In a nutshell, the traditional psych. community totally tore me apart, and the consumer movement helped me put my life back together, in a stronger and more healthy way. (KI Lynne D’Orsay, February 1998)

Activist LGBT consumers debate how much energy to expend seeking alliances among LGBT groups and consumer/survivor groups, as well as among other anti-oppression movements (Holochuck, 1993; National Empowerment Center, 1993; National Empowerment Center, 1995). They find the common issues compelling, but the constant need to educate one group about the other and the experiences and risk of hostility exhausting. Additionally, within LGBT organizing and self-help (as within mental health services, LGBT communities and Consumer organizing in general), transgender and bisexual people often feel further marginalized, as do people of color (National Empowerment Center, 1993).

## Creating Welcoming Communities

LGBT consumers are emphatic about the need for communities that welcome all parts of their lives (KI Steve Holochuck, July 1998; KI Cookie Gant, August 1998; KI Bert Coffman, May 1998). Consumer and advocate Bert Coffman (KI, May 1998) stressed,

- ▼ Another absolutely crucial issue is increasing the opportunities for [support] groups and for social opportunities with other LGBT consumers. People feel so alone, have to be so secretive.... Even if a person doesn't come to a gathering or a group. Just seeing the publicity that it exists makes people feel less alone and more supported. And, potentially they'll come later.
- ▼ "There is a lot of stigma to being gay and mentally ill in this...So...I wouldn't tell anyone in the gay community that I was mentally ill because I didn't want the stigma. [I'm] trying to break through that now...When I hear someone bashing people who are mentally ill, I stand up for them. I see things are changing, but there is a lot more changing to do."

A few small groups across the country have been and are working to create groups and networks that welcome people who are or have been clients in the mental health system and who identify as lesbian, gay, bi, or transgender. Because historical and current information are sparse, it is likely that important efforts in various locales are not widely known, and therefore that the summary below is incomplete. Nonetheless, conveying what is known makes clear that the gradual progress of building networks, highlighting unmet needs, publicizing relevant efforts, becoming visible, and encouraging others to take part is part of an overall movement (Rogers, 2002).

Undoubtedly there have been LGBT people involved in the mental health system since these cultural/identity categories and the mental health system both first developed. Certainly, before "homosexuality" was removed from the DSM in 1973 one could be considered in need of psychiatric treatment simply because of LGBT identity per se. According to one person with long-time involvement, some of the earliest groups of the "mental patients liberation movement" in the 1960's and 70's directly addressed LGBT topics for this reason (KI Steve Holochuck, July 1998).

The original annual International Conference on Human Rights and Psychiatric Oppression (ICHRPO), is reported to have sometimes had an LGBT caucus. Steve Holochuck (KI, July 1998) also reported that as the ICHRPO conference was replaced by the federally-funded Alternatives conferences, it too had a gay and lesbian

caucus, which eventually broadened into an LGBT caucus around 1985. Nonetheless, caucus members were often made to feel unwelcome by other attendees and event organizers (National Empowerment Center, 1995), and even harassed. Organizers of these caucuses found that although some members were interested in advocacy and activism, most felt a primary need for camaraderie, sharing stories, and mutual support (KI Steve Holochuck, July 1998).

“The ongoing caucuses led to the formation of a loose informal network [between conferences], which led to a more deliberate call for LGBT involvement in presentations and the planning of Alternatives” (KI Steve Holochuck, July 1998). The caucuses and local organizing efforts also led to the founding of LGBT mutual support organizations in several U.S. cities. The tongue-in-cheek named “Fruit and Nut Bar” was founded in 1991 at the Alternatives conference held in Berkeley, CA “because some of us felt it was time for LGBT people to have a more organized presence in the consumer movement, including Alternatives as the major gathering of the movement in this country each year” (KI Anonymous R., April 1998). Twenty to thirty people formed the group and held a protest to insist that LGBT organizing be included at all Alternatives (KI Anonymous R., April 1998). At the 1992 Alternatives in Philadelphia the group adopted a mission statement (see below), was successful in getting several LGBT-themed presentations on the program, and has held a caucus meeting every year since.

### **Fruit and Nut Bar Mission, 1992**

- ▼ The Fruit and Nut Bar is an organization of gay males, lesbians, bisexuals, and transgenderists who have a psychiatric history.
- ▼ Our focus is to build mutual support among people who have this identity and make the mental health system more responsive to our needs and preferences.
- ▼ We desire to build an acceptance and affirmation of people with psychiatric labels in the sexual minority community and, likewise, of sexual minority people in the mental health consumer/survivor community.

The Fruit and Nut Bar also made the presence of LGBT consumer/survivors visible at conferences held by the National Association for Rights Protection and Advocacy (NARPA), the International Association of Psychosocial Rehabilitation Services (IAPSRS) and others. In 1993 the Fruit and Nut Bar organized a gathering for LGBT consumers in conjunction with the March on Washington for Lesbian, Gay, Bisexual and Transgender Rights and Liberation in Washington DC. Later, a small group of member/supporters walked with the disabilities contingent in the 1995 “Stonewall-25 International March to the UN for LGBT Rights and Liberation.” While the

group is still active, it exists as a network of individuals rather than an organization. At the February, 1998 Alternatives conference LGBT caucus members discussed the need to regroup and refocus their energies to sustain a more visible presence (Green, Peraza, McFadden, & Compton, 1998; KI Steve Holochuck, July 1998).

Similar names have since been used by several other groups, including “Fruits and Nuts!” founded in 1992 in California, profiled in the following section. GLEBIT’s APPLE [Gay males, Lesbians, Bisexuals, Transgender people and other Sexual minorities in Action as People with Psychiatric Labels], was founded around the same time in Boston as a support and advocacy group, but functioned for only about a year (KI Steve Holochuck, July 1998).

In 1994 members of the Alternatives LGBT caucus decided to pursue funding a newsletter for LGBT consumers. By 1996 Janet Chassman, Mark Davis, and Gilberto Alvarez had secured \$2000 from the New York State Office of Mental Health to publish 4 issues. Unfortunately, funding was not extended and the newsletter ceased after the fourth issue. (Copies are available from the author.)

The development of other groups was separate from the ICHRPO or Alternatives conferences, but came out of the same 1960’s and 70’s social movements, and some of the founders did know each other. Anonymous S. (KI, 1998) recalled that in the “early-mid 80’s [she] was involved with a “Mad Dykes” group in Manhattan, [that has] disbanded since.” She said, “we got together just as women who identified as mad dykes, not psyc oriented regarding diagnosis, not political.” Bert Coffman founded the Zappalorti Society in 1992, a self-help and empowerment group named after a gay man who was a Viet Nam war veteran and mental health consumer and who was murdered by gay-bashers (also profiled below). Other groups have developed within larger consumer organizations that included LGBT people from the beginning, such as the Seacoast Consumer Alliance in New Hampshire, or as support groups in a few community mental health clinics, rehabilitation programs, or mental health associations.

One of the strongest examples of the latter is Hearts & Ears, Inc. in Baltimore, founded in 1998 within a psychosocial rehabilitation program as a support group for LGBT-identified clients of the program. It is now an independent, multi-faceted self help and advocacy organization with its own office and a paid staff position (see organization profiles section for details). In October of 2000, after 14 months of mostly volunteer organizing, Hearts & Ears hosted a full day regional conference on the needs and views of LGBT people with mental illnesses, entitled “Mission Possible.” It attracted more than 130 people from various states, including long-time activists central in the history summarized above. Attendees deemed the conference a “historic first.”



As the LGBT and consumer movements have had positive effects on society, LGBT consumers have found it marginally easier to organize and find each other, at least in some locations. Still, the most frequently heard laments are of isolation and continued disrespect in LGBT and mental health circles. Furthermore, LGBT consumer support groups exist in only a very few towns and cities in the U.S. Unanimously, people trying to organize groups of LGBT consumers speak of persistent challenges: Their constant struggle to convince other consumers, providers, and the public to listen to their issues respectfully; their lack of money and material resources since most members are unemployed and/or on disability; their frequent disappointment when being left out of programs, policies, and funding; their fatigue from constantly having to educate one about the other; their thankfulness for having found allies and peers who “get it,” and their worry over the welfare of LGBT consumers who do not have even this support.

**PART III: EXAMPLES OF LGBT-AFFIRMATIVE**  
**SELF-HELP & MENTAL HEALTH PROGRAMS**

The brief profiles below are included to provide examples of LGBT affirmative mental health programs and self-help organizations assisting people with SMI, and to facilitate networking. They are not endorsements, and this list is not exhaustive. It is also probably out of date as soon as it appears. Apologies to all who were inadvertently omitted – please be in touch!

## **Self-help, Advocacy, and Social Groups for LGBT Mental Health Consumers**

Although most U.S. communities do not have groups created by and for LGBT mental health consumers, the four below are exceptions, nurtured with creativity and persistence. Information for each profile was drawn from the organization’s literature, observation where possible, and Key Informant conversations and is current as of early 2004.

**Zappalorti Society**  
**14 E 28<sup>th</sup> Street, #1014,**  
**New York, NY 10016-7464**  
**Contact: Bert Coffman 917 / 286-0616**  
**bertcoffmanzsmh@hotmail.com**

Founded in 1992 by Bert Coffman, the Zappalorti Society was named after Jimmy Zappalorti, a disabled Vietnam-era U. S. Navy veteran and psychiatric survivor who was murdered by gay-bashers on Staten Island in January of 1990 (“Up Against”, 1997; “Fifth Anniversary,” Feb. 1995; Duga, 1990). Shortly after, Bert asked the New York City LGBT Services Center if he could use their space for a “mental patients’ support group.” The Center’s director, Barbara Warren, agreed, and the group has been on-going ever since (Bert Coffman, personal communication, 1998). Although they occasionally schedule events and speakers, it is primarily a self-help support group, and runs on no outside funding, although the Center provides some in-kind support. The group’s flyers give its mission statement:

We are a group of gays, lesbians, bisexuals, and transgender persons who have been labeled as mentally ill or depressed by the mental health system. We are committed to mutual support, advocacy and

empowerment. Our primary goal is to obtain relevant and quality services to meet the needs of our community. Our voices will be heard! Join us to bring about:

1. Empowerment, advocacy and political action
2. An organization of support and caring
3. Self-help
4. Cultural, social and recreational events

In a local periodical article (“Up Against,” 1997), Bert Coffman said,

The gay community stigmatizes us for being mentally ill, and the mental health community stigmatizes us for being gay...Gay mentally disabled people simply don't fit into anyone's funding priorities, leaving most of us to wonder 'why not?' when we look at the huge health and social service programs operated separately in New York City by both the gay community and the mental health community.

The Zappalorti Society sees itself as complementary to clinical services. Members assist each other in coping with experiences of homophobic services, and discovering LGBT-affirmative and supportive mental health and social services. They also seek to create and extend dialogue about LGBT issues with relevant providers.

**Pink & Black Triangle Society**

c/o Project Return: The Next Step  
1336 Wilshire Blvd. 2<sup>nd</sup> Floor,  
Los Angeles CA, 90017-1705  
Contact: 213 / 413-1130 ext 121  
Prtns@aol.com

The Pink & Black Triangle Society (formerly called Fruits and Nuts!) groups are “a different kind of social club, for gays and lesbians with psychiatric disability” (from the group's brochure). Founded around 1992 after the Philadelphia Alternatives conference (KI Anonymous R., April 1998), it is now several groups meeting in different locations in southern California, including Long Beach and Hollywood -- all as “specialty clubs” of Project Return: The Next Step, a consumer-run social and support network. When first starting they found little support from the gay community, which seemed reluctant to have “something that was connected with MI at their gay centers” (Bill Compton, in Green, Peraza, McFadden, & Compton, 1998). Their brochure describes,

We all know the double whammy of stigma. Our gay friends don't understand our psychiatric disability and keep us at arms' length. Our friends who have a psychiatric disability don't understand our being homosexual, and they shun us, too. As much as we want the freedom to be “out” about both our illness and our sexual orientation, discrimination keeps us, not in just one closet, but in two! ...That's why we all need

one another. That's why *you* need Fruits and Nuts!...At meetings...we can be ourselves. We meet people with common experiences. We meet for light chats or heavy conversations about things that only someone else in our shoes can understand. And after our meetings we may go out to dinner and talk about what everyone else in town is talking about...politics, music, life in LA....

**Hearts & Ears, Inc.**  
**3501 St. Paul Street**  
**Baltimore, MD 21218**  
**Contact: Paula Lafferty**  
**410 / 837-7778**  
**[office@heartsandears.org](mailto:office@heartsandears.org)**

Hearts & Ears started as a support and discussion group, within a Baltimore psychosocial rehabilitation program called Transitions, Inc. in 1998. With the support of Transitions staff, a core group formed and soon began expanding activities and publicizing outside of Transitions. Eventually Hearts & Ears grew into an independent organization, first sharing space with the educational programs of a local church, and then moving into their own office and activity space when they applied for and were awarded a modest operating budget from the local mental health system.

Throughout this growth, Hearts & Ears' activities have broadened but its vision has remained constant: "we warmly welcome all sexual and gender minorities with mental illness as people who are dually stigmatized for being GLBT and having a mental illness...H&E aims to be the one community where GLBT persons with mental illness can feel safe, supported, and welcomed" (recent brochure). Currently, Hearts & Ears hosts two weekly support groups, drop-in hours, educational and recreational programs, and special projects, such as the October 2002 conference in Baltimore described in the previous section. Support group meetings discuss topics such as members' past week, illness, goals, empowerment, prejudice, and daily challenges. Hearts & Ears also publishes a newsletter, offers a speakers bureau to educate mental health agencies and other community groups, and features the Family Friends peer friendship program that matches group members with community volunteers for socializing.

**Pink & Blues: LGBT Mental Health and Recovery****Philadelphia, PA****Contact: Mark A. Davis****[Mark.davis@phila.gov](mailto:Mark.davis@phila.gov)****215/546-0300 x 3301 or 215 / 627-0424**

The Pinks and Blues was established in January of 2003 as a peer-run discussion and support group for bisexual, gay, lesbian, transgender and questioning individuals dealing with mental illness. Founded and led by Mark A. Davis, a long-time advocate within the mental health consumer/survivor, HIV/AIDS, and sexual and gender minority movements, the group meets weekly.

“We are about creating a safe space for LGBTQ folks to explore recovery from mental illness and we share resources that promote wellness.” (Mark Davis, personal communication June 2004). The group is an affiliate of the Delaware Valley Depression and Bipolar Support Alliance ([www.dbsalliance.org](http://www.dbsalliance.org)).

**LGBT-Affirmative Mental Health Programs**

There is a slowly growing number of LGBT-affirmative programs for various inpatient and outpatient mental health services, especially in or near major metropolitan areas. While there is a sizeable published literature on clinicians seeing LGBT people in counseling and therapy (see recommended reading list in the appendix), there is little regarding residential, rehabilitation, hospitalization, vocational, day hospital or other similar services for LGBT mental health care consumers. Therefore, the profiles below are included as descriptive examples, and not as recommendations. Like the profiles of LGBT consumer self help and advocacy groups, the groups below are only those with which I had contact during this project. There may be others that were missed (– apologies if so!). The information included in each summary was drawn from conversations with key informants (clients, staff, etc), the program’s self-description literature, observation (when possible), and publicly available information (website, brochures, etc.).

**Columbia Center for Lesbian, Gay,  
and Bisexual Mental Health**

16 E. 60<sup>th</sup> Street  
New York, NY 10022  
Director: Benjamin McCommen, MD  
(212) 326-8441 or 212 / 874-2702

At the impetus of a small group of psychiatry residents (especially key informant Justin Richardson) and other professionals, the Columbia Center opened July 1, 1995 in Manhattan, under the Department of Psychiatry at Columbia Presbyterian Medical Center and sharing space with other outpatient clinics. The center offers individual, couples, and group services, including therapy as well as psychiatric consultation and evaluations, and is staffed by LGB-identified psychiatrists and therapists. Its stated mission and goal is to provide high quality academically-based psychiatric treatment in an LGBT-affirmative environment. Their rationale is that people in New York City who are LGBT are often reluctant to go for services to a big medical center because they fear they will face bias, which is not unrealistic. However, at the same time, smaller community-based services may not be able to offer a full range of psychiatric services, and/or may not be knowledgeable about serious mental illnesses.

Providers at the Columbia Center for Lesbian, Gay, and Bisexual Mental Health see people with a wide range of situations and problems, including people with serious mental illnesses and disabilities, people with medical problems (such as AIDS), Columbia University students, and professionals in the community. Fees tend to be between those of public systems and private practice. (Profile based on the website and conversations with Justin Richardson)

**Persad Center, Inc.**

5150 Pennsylvania Ave, Pittsburgh PA  
15224-1627  
Contact: Jim Huggins, PhD, BCD  
Or Betty Hill, Executive Director  
(412) 441-9786  
[www.persadcenter.org](http://www.persadcenter.org)

The Persad Center was founded in 1972 by two gay professionals responding to community need. From the beginning, its stated mission has been to provide comprehensive mental health services to all sexual minorities (LGBT and questioning people). Currently, Persad provides services to the community in four areas: (1) Clinical services include general mental health care and specialized services in HIV, adolescent services, family services, and transgender evaluation and treatment (including referrals for hormones and/or surgery). All clinical services serve individuals, groups, couples, and families. (2) Education services provide training opportunities for mental health professionals, staff, students, and others, including some public education. (3) the Research division carries out grant activities, which currently focus primarily on HIV. (4) Community Organization services provide assistance to the LGBT community, helping community organizations get started and continue, with the underlying goal of improving the health of community members.

Persad has particular commitments to people with serious mental illnesses, to people in poverty (who make up more than half of the Center's clientele), and to community mental health efforts that strengthen the community. It is a fully state licensed outpatient psychiatric clinic, and in 1996-97 over 70% of people seeking Persad's services were public mental health system clients (Annual Report, p.3). They report seeing a broad range of clients, and have cultivated good relationships with other mental health providers. For example, Dr. Huggins (KI, September 1998) mentioned the trainings around LGBT client issues that Persad staff have conducted for psychiatric hospitals and other providers. Due to its longevity, Persad also has many former/current staff and allies in the surrounding professional community and thorough knowledge about the care and LGBT sensitivity at various facilities and clinics in the area.

Nonetheless, like many health care organizations, Persad has encountered some financial difficulties due to the changing healthcare and payment mechanisms over past several years, and has had to cut back on some of the non-clinical services to remain financially solid. In the past, Persad has also had difficulties with politically conservative county officials blocking public funding in the past, which was restored to them in 1997 after 22 years. Unlike many LGBT-affirmative "counseling centers" they have accepted Medicaid payment from their beginning. Nonetheless, as a non-profit, Persad still relies greatly on donations and their annual Art for AIDS gala has become a big art event in the surrounding community. (Profile based on Persad annual report, flyers, and Jim Huggins)



**Team II, Monterey Clinic**

298 Monterey Blvd.,  
San Francisco, CA 94131  
Contact: Stan Lipsitz, PhD  
(415) 337-4795

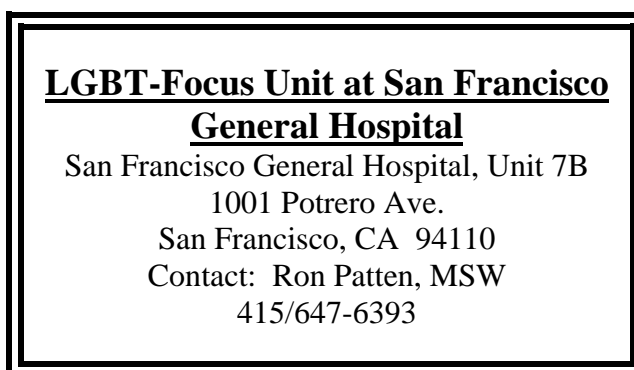
Team II is a city and county community mental health center opened in the mid-1970's. Unlike other programs which formed expressly to provide LGBT-affirmative services, the LGBT-affirmative focus at Team II evolved over time due to its proximity to the LGBT communities in San Francisco. According to a key informant who works in mental health, (KI Anonymous D., March 1998), as of 1993 the community mental health centers were finding that larger proportions of their clientele were people with severe mental illnesses -- due to reorganization within the city mental health administration. Therefore, in recent years Team II has combined these two emphases, although the clinic still serves a range of people and is experiencing additional changes due to further reorganization within the public health system. Until recently all services were funded by the city, but that too is changing.

The multidisciplinary staff at Team II provide the usual range of mental health services (assessment, therapy, medication, case management, urgent care). They also offer a gay men's serious mental illnesses support/therapy group, and a women's (lesbian, bi, straight together) group with a similar focus. Both of these are designed to help attendees recover and cope with the difficulties caused by their mental illness, in a way that integrates their social identities as well so their recovery is holistic: "Most people are comfortable and feel safe when they are here. They quickly get the message that we're gay-friendly, although we take that so much for granted around here [San Francisco], I don't even know that we always say it out loud" (KI Anonymous D., March 1998).

In large part this is because all staff are LGBT-sensitive and informed, and many are LGBT-identified. Also, many staff hold a city-level specialty credential of "LGBT health specialist," which entails extensive supervised clinical and course work in the specialty area, in addition to their professional training credentials. Like other LGBT-affirmative services, Team II also ends up assisting clients in dealing with the effects of past insensitive mental health services. For example, Stan Lipsitz (KI, March 1998) noted,

People in treatment who have not had a gay-identified therapist often have therefore had therapists who just don't address coming out issues, family issues around sexual orientation, the person's having lived for years with the knowledge of being gay before coming out, struggling alone, relationship issues particular to being gay. Many mainstream therapists seem only to touch on HIV and safe sex with gay clients, leaving out all of these other things that are very important developmental issues for a gay person [especially who has a serious mental illness.

(Profile based on interviews with Stan Lipsitz, May 1998, and recent administrative program description)



Beginning in the early 1980's, San Francisco General Hospital began developing "focus units" in its inpatient psychiatric service, in which staff would have particular cultural sensitivity, training, services, and resources with which to address the unique needs of large sub-groups of the San Francisco population. The first such unit formed focused on serving Asian clients. African-Americans' and Women's focus units developed next. However, such units do not serve solely members of their focal group -- any person can be a client on any unit. In 1985, "half" a unit (services for 11 patients) was dedicated as an HIV/AIDS focus unit. Key informant Orren Perlman (June 1998) said, "Informally, this also became a place where LGBT clients and staff gravitated, although it was not advertised or officially talked about as LGBT-affirmative."

When Dr. Perlman came to the hospital in the early 1990s, he joined with nursing staff to promote the idea of formally making the entire unit an LGBT-affirmative focus unit. This became official in 1994. He described the unit (7B) as manifesting its LGBT and HIV affirmative focus in many ways: LGBT information integrated into all clinical services, referral and community resources boards regarding LGBT community organizations and events, openly LGBT staff members and heterosexual staff members who are openly supportive, LGBT-affirmative support groups and family meetings, LGBT and HIV library materials, open discussion of LGBT issues among staff and with clients, validating décor and atmosphere. He also noted that the focus is always openly stated in the unit's internal and public literature and at community meetings. Another staff person (KI Anonymous P., September

1998) added that 7B staff have extensive knowledge of community resources and that San Francisco is fortunate to have LGBT-affirmative outpatient and human service programs – to which 7B clients can be referred if they wish. He also noted that hospital and city administration have been supportive in creating the expectation that providers who work with LGBT people have the city specialty credential (see the profile for Team II), and that the teaching hospital at UCSF includes professionals who are very dedicated to training people in diversity – which leads to the resources and a pool of people to fill the positions. (Profile based on interviews with Orren Perlman, Staff, and program description in the newsletter of the Association of Gay and Lesbian Psychiatrists, August, 1995, vol. 11 (3), p. 13.)

**The LesBiGay and Transgender  
Affirmative Program for Individuals  
with Chronic Mental Illness**

Heights-Hill Mental Health Service, South  
Beach Psychiatric Center  
25 Flatbush Ave, Brooklyn NY 11217  
Contact: Ron Hellman, MD  
(718) 875-1420

The LesBiGay and Transgender Program (LBGT Program) of South Beach Psychiatric Center opened in February of 1996. A Center-wide review of multicultural program needs at the time led to the realization that no psychosocial services were being provided for LGBT individuals at Heights-Hill or in the area. The start of the program was well received by the local LGBT community. From the program's promotional brochure:

The LesBiGay and Transgender Affirmative Program is a component of Height-Hill's multicultural services. It is designed for lesbian, gay, bisexual, and transgendered individuals with chronic mental illness. Treatment is directed by a team of licensed professionals sensitive to the concerns of this varied clientele. Interventions are geared to help address the stigma associated with homosexuality, transgender issues, and mental health, and to foster a deeper sense of heritage and community.....Heights-Hill believes that effective treatment must go beyond traditional psychotherapy approaches by providing services that are relevant to a culturally diverse population. The LesBiGay and Transgender Program is a unique and essential service that can help lesbian, gay, bisexual, and transgender individuals with chronic mental illness bridge the social and cultural gap that they commonly experience in the traditional mental health care setting.

The first expressly affirmative service started was an LGBT support group that continues today. Dr. Ron Hellman (KI, June 1998) said that it has been steadily popular because many of South Beach's LGBT clients have difficulty socializing in "mainstream" settings as well as LGBT settings, due to their psychiatric symptoms and the effects of dual stigma (against mental illness and against homosexuality). The group includes psychotherapeutic interactions and mutual assistance. Common themes include coping with stigma and psychotic symptoms, family attitudes and rejection around LGBT-identity and having a mental illness, religion, medications and the impact of side-effects on sexuality, disclosure (of sexual identity and psychiatric history), the social stigma of being unemployed, and loneliness.

The presence of the support group also gradually opened discussion and sensitized the staff in the larger surrounding clinic to LGBT issues. Staff-members began to talk about LGBT issues more openly throughout the clinic and to see LGBT clients more as part of the overall group of people served. This in turn integrated the LGBT Program components into the overall clinic workings more closely.

In the years since its inception, the LGBT Program at South Beach has continued to grow. In addition to serving clients, the Program has become well known among providers and the LGBT communities in the area. It is the only LGBT-affirmative program in the region for people with major psychiatric illnesses, and it accepts Medicaid. Clients tell Program staff that they value it as a place to bring their whole selves.

Program components currently include the weekly support group, a weekly Cultural Awareness group, a monthly coffee house, a reading room, a "sexual minorities consumer advisory committee," staff enrichment, student training, a research project, community networking, cultural events, a consumer self-help group, and other activities. However, none of these activities are as large as those involved would wish, due to limited resources. (Profile based on Interviews with Ron Hellman, several group members, and the program's informational brochure)

**The Community Living Room, a  
program of CO-MHAR, Inc.**

207 N. Broad Street, Philadelphia, PA 19107

Contact: Jeff Hoeltzel

(215) 569-8414

[www.comhar.org/HIVAIDS.html](http://www.comhar.org/HIVAIDS.html)

The Community Living Room (CLR) is a “community based psycho-social day program for people with both a Mental Health (MH) and HIV/AIDS diagnosis. In addition, many people may be striving to overcome substance addiction. The doors are open to consumers of all races, religions, ethnic groups, genders and sexual orientations. CLR’s mission is, quite simply, to be an environment where people can enter to learn and grow and then go forth to serve and thrive” (Program Description, 28 April, 1998). While it is not a program restricted to LGBT-identified consumers, it is an LGBT-affirmative program, and a majority of its members are gay and bisexual men of color.

The CLR strives to meet its goals through three conceptual “pillars supporting all the program activities and services: (1) being a place where members can create strong social and support networks, (2) holding fast to a philosophy that focuses on successes, and on small successes as stepping stones to larger ones,” (3) creating a “nourishing milieu for members’ empowerment” by sharing knowledge, building skills, and encouraging / supporting people in using their skills and knowledge to the fullest. Both through these principles and by virtue of a large LGBT membership, CLR integrates LGBT-affirmative ideas and action so often into their program fabric that it is sometimes taken for granted.

The program combines a structured schedule of therapeutic groups and skill-focused workshops with periodic individual counseling sessions (either to discuss matters one-on-one when they prefer that to the group format, or to give – regularly scheduled – feedback about the CLR’s functioning), and excursions that are sometimes recreational and sometimes political advocacy (rallies, demonstrations, talks re mental health issues and services). Members shape their own involvement, and programs include ample opportunities for creative self-expression and for discussion of relationships, sexuality, and LGBT issues. Also, it is designed and run less hierarchically than most psychosocial programs. like a treatment type program. Members all take part in running it, and play a large role in making it what it is, and relaxing the roles between staff and members.

The commonalties of dealing with HIV and mental illnesses unite CLR members across sexual orientation, ethnic, and other identity lines. According to counselor Jeff Hotzel (KI, July 1998),

They [members] know that they don’t have to make any great announcement – its known that everyone is HIV+ And I think this carries over to discussions in groups. People talk about gay and straight relationships, both easily. In more mainstream places that I’ve worked people are much more closeted and have to worry about disclosure and what they discuss much more.

(Profile based in Interviews with Jeff Hotzel, program members, website program description / brochure)

## **Characteristics of LGBT-affirmative Mental Health Programs and Systems**

As illustrated in the profiles above, variation in local contexts, history, individual people, and needs make it impossible to list a universal set of specifics that all LGBT-affirmative mental health and self-help programs share, or a single set of steps that will “make” all mental health and self-help programs LGBT-affirming and knowledgeable. Nonetheless, there are some themes and signposts common across such programs that may be useful to consider. In general, LGBT-affirming organizations create a non-discriminatory, positive atmosphere in all areas of operations, from employee policies to their waiting area.

First, LGBT-affirmative programs employ staff and volunteers who are knowledgeable and at ease with LGBT issues and people and skillful at integrating this knowledge into service delivery. While acknowledging realistic limitations and not overstating their collective competencies in addressing LGBT client needs, they provide staff with ongoing pertinent training and information, and uphold expectations that staff at every level will conduct their work in non-discriminatory and LGBT-affirmative ways. For instance:

Much of the services we provide aren't very different than general clinics or those with particular ethnic focuses, of course. The main difference is that all the staff here is gay-sensitive. Many have the waiver for gay health specialist (city-level specialty credential) which means they met certain criteria of training and experience. (KI Stan Lipsitz., March 1998)

...There needs to be a way to make sure we have clinicians who can provide the services that are needed, including gay-affirmative mental health 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. (KI Anonymous P., September 1998)

Second, these expectations are backed up with policies and formal practices. That is, such organizations have administrative systems that work to ensure that program operations, administration, and the surrounding infrastructure are non-discriminatory and LGBT-positive, not just one-to-one interactions among staff and clients. as well. Some specific administrative issues might include:

- Confidentiality concerns that both respect LGBT people and respect that sometimes homophobia requires them to need to keep their sexual orientation or gender identity private, such as how records are kept, how a program bills for its services, or answers its phone.
- Assuring that policies regarding visitors, overnight guests, roommates etc. are not discriminatory towards LGBT people or same-gender relationships.
- Creating grievance and harassment policies and procedures that back up non-discrimination statements and which are LGBT-affirmative and informed by common problems LGBT clients and staff encounter
- Facilitating discharge planning that is informed by current knowledge about LGBT-community resources and the atmosphere within local mental health services regarding LGBT people and issues – such as by revising standard planning forms.

Such efforts could also include periodic administrative reviews of the functioning and outcomes of such policies and practices, and strategic goal setting. They may also involve creating mechanisms for gathering feedback from LGBT (and other) clients and staff, and ways the agency can benefit from LGBT individuals' requests and suggestions.

Fourth, LGBT-affirmative programs and services create an organizational culture that values the discussion of sexuality and LGBT issues in various aspects of its services. That is, which fosters respectful, open communication and information-gathering regarding LGBT issues, adult sexuality in general (including heterosexuality), and relationships, in various ways that are professionally and therapeutically appropriate. These could include making sure that staff know about LGBT-affirming community resources, having periodic speakers and discussions for staff and/or clients, and/or setting an overall expectation that it is acceptable and even encouraged to talk about sexuality in ways that relate to the services provided and people served. For example:

τ 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. [Healthy sexuality is part of the program] (KI Steve Hartman, May 1998).

Fostering a LGBT-affirming atmosphere can also involve including LGBT community images and information as a natural matter of course, such as in leaflets, décor, reading material. KI Ron Hellman (June, 1998) remarked, "Posting information, posters, books, brochures on LGBT issues and organizations is part of creating an affirmative environment." It also includes interacting (as an agency) with LGBT communities as the agency does with other cultural communities, and supporting openly LGBT staff and volunteers in being so professionally, and non-LGBT staff in being active allies in LGBT issues. For example:

τ The leader is open as a gay psychiatrist, and so clients and staff see that (and it counteracts many LGBT stereotypes, and the assumption of everyone being closeted) Also, a colleague who

is not gay co-leads the support group and also directs the day hospital. So clients and other staff see both of them in multiple roles and positively so. [A. Lucksted, field notes re interview with KI Ron Hellman]

Finally, LGBT-affirming organizations watch for stereotypes about LGBT people and communities that may creep into these efforts, simply because they are operating in a social/cultural context where such misconceptions are still common. Thus, they deliberately view all clients, staff, and others, as multidimensional people with complex interacting identities (eg., class, gender, race, culture, disabilities, politics, religious beliefs). Often this also necessitates recognizing the economic, legal, and societal ways in which many of these (including LGBT identities) are disadvantaged in the larger society.



**PART IV: CONCLUSIONS &**  
**RECOMMENDATIONS**

“We need to be at the table where any decisions are made about policy, services, evaluation, planning, and development. We need to speak for ourselves and no longer allow anyone to speak for us” (Davis, 1996).

As discussed throughout this report, there are troubling indications that lesbian, gay, bisexual, and transgender people receiving mental health services in public/community systems may not be well-served by current programs and practices. Yet research documenting these problems is almost non-existent. The most basic conclusion of this report is that such research and documentation are sorely needed. At the same time, it is also clear that mental health providers, programs, and systems must become more knowledgeable about assisting LGBT individuals, and must put that knowledge into practice.

While formal program-model evaluations have not yet been conducted, key informants consistently report that LGBT clients experience LGBT-affirmative programs as safer, more comfortable, more conducive to developing trust, and more effective (than places they have experienced as less hospitable; KI Steve Holochuck, July 1998; KI Anonymous D., March 1998; KI Angel Olmeda, July 1998; KI Anonymous P., September 1998). Currently, the few openly LGBT-affirmative programs and individual staff within larger programs often find themselves in demand far beyond their availability (KI Ron Hellman, June 1998; KI Anonymous G., August 1998). Therefore, key informants called for increased financial and moral support for LGBT-affirmative consumer-run groups and professional services in all parts of the mental health system (KI Bert Coffman, May 1998; LD, KI Ron Hellman, June 1998; KI Orren Perlman, June 1998; D, KI Ron Hellman, June 1998) as well as for formal program evaluation.

These issues are embedded in the overall U.S. mental health system, including a multitude of local systems. In the long run, LGBT-affirming changes in knowledge and practices by individual service providers is important, but will be more sustainable and effective if corroborated by supportive administrative, political and financial infrastructures. Moreover, LGBT mental health care consumers would greatly benefit from more aggressive action by mental health systems to address problems that all consumers face such as insufficient resources and services, stigma, sub-standard care, a lack of a true voice in services (Anonymous, 1992; Green, 1997). One key informant (Anonymous P., September 1998) said,

Our system, like most mental health systems, lacks enough services period. Of any kind. Especially housing and drug treatment. Not just [lgbt-]affirmative ones, but any services. Resources. There's just not enough. So in that sense LGBT consumers face the same problems as other clients – just not enough services, and not enough good ones.

The specific recommendations below are drawn directly from the range of sources cited in this report, including key informant interviews. They have been categorized for clarity and reference, although many relate to each other across categories. At each level, creating change requires several elements:

- ▼ Willingness, commitment, motivation to envision and enact change
- ▼ Organizational and financial support, including advocacy and funding that does not further divide already too-small multicultural and “special populations” pies into yet smaller pieces.
- ▼ Expertise – working with knowledgeable, skilled, LGBT-identified and LGBT-affirmative consumers, researchers, trainers, and providers to make the best use of existing knowledge
- ▼ Anticipation of and planning for resistance to change.

## **Recommendations for Researchers & Funders**

### **Funders**

- ▼ Fund and otherwise support a range of documentary and evaluative research and knowledge application activities regarding LGBT consumer experiences, staff and program knowledge and prejudices, and LGBT-affirming mental health programming.
- ▼ Foster knowledge exchange between LGBT-affirming services and consumer organizations and those wishing to develop their competencies.
- ▼ Organize / Facilitate a national conference of LGBT mental health consumers to discuss experiences and develop strategies for addressing problems.
- ▼ Support the development and evaluation of consumer run programs and self-help / advocacy groups that serve the needs of LGBT consumers.
- ▼ Require appropriate attention to LGBT issues and anti-discrimination within broader CMHS-sponsored initiatives, contracts, and projects.

### **Researchers**

- ▼ Explore and document the nature of LGBT people’s experiences receiving public-sector mental health services with well-constructed samples in various locales, addressing diverse services and settings.
- ▼ Consider including sexual orientation and gender identity as variables in general population and other mental health and serious mental illness surveys and studies.

- ▼ Evaluate whether differences in program policy, atmosphere, and/or staff training make real differences in services received and benefit gleaned by LGBT clients. For example, do LGBT-affirmative services indeed foster better therapeutic relationships? More consistent attendance? More substantial progress or faster course of improvement?
- ▼ Investigate the most effective ways to increase staff and other parties' skills and knowledge re LGBT consumers' issues, and to foster their application to improving services.
- ▼ Involve LGBT-identified consumers substantially in designing and carrying out research efforts .
- ▼ Build information dissemination and utilization plans into research and other initiatives, planning for the likely resistance it will encounter in some places.

### **Recommendations For Individual Mental Health Workers**

- ▼ Examine one's own information, attitudes, and beliefs about LGBT issues and LGBT consumers.
- ▼ Seek out self-education opportunities and resources: reading, workshops, supervision, etc. and incorporate LGBT-affirming practices into professional work.
- ▼ Allow one's self to fully engage in trainings, discussions, and other such opportunities.
- ▼ Advocate for quality care and systems change regarding LGBT issues and consumers; offer assistance in creating change.
- ▼ Consult with professional mental health organizations that have committees on LGBT issues, and with LGBT community organizations, especially those with mental health components.

### **Recommendations For Mental Health Programs, Services, Agencies**

- ▼ Assess and improve program/agency operations, climate, and quality of care regarding LGBT consumers
- ▼ Facilitate the development of staff and organizational competence, such as through trainings, supervision, feedback, and expectations.
- ▼ Create positive programmatic expectations for respect, professionalism, and intolerance of discrimination within the program/agency, backed up with policies and practices that address both successes and complaints seriously.

- ▼ Assess and address the problems and unmet needs of LGBT consumers.
- ▼ Advocate for relevant funding and larger-systems' improvement
- ▼ Periodically evaluate progress and standard operations for LGBT-affirmative inclusion.
- ▼ Some specific, concrete services recommendations from key informant interviews are included below:

### **Concrete Service Recommendations**

- ▼ Assume that staff, clients, and other people associating with the program are of diverse sexual orientations and gender identities.
- ▼ Reflect the diversity of people and lives in the program's physical space, including artwork, literature, flyers.
- ▼ Examine records, protocols, and common practices for places where LGBT clients might have reasonable concern about the ramifications of sexual orientation / gender identity information being disclosed to insurers, employers, and others.
- ▼ Examine and correct policies and practices to eliminate discriminatory, double-standard, or insensitive language, practices, and gaps regarding LGBT consumers.
- ▼ Do not tolerate LGBT clients being harassed or belittled by other program clients, nor staff.
- ▼ Consider knowledge, skills, and experience with LGBT persons an asset in all employees, and as one of the criteria for employee hiring and evaluation
- ▼ Include the community and cultural needs of LGBT clients in treatment, care, and discharge planning.
- ▼ Know which local mental health and human service resources are LGBT-affirmative and which are not.
- ▼ Consider ways to make LGBT-affirmative services more financially and physically accessible to clients who have low-incomes and/or have serious mental illnesses
- ▼ Plan for training and other initiatives to be ongoing over time (not one-shot workshops) and to need outside resources and trainers at times.
- ▼ Include all staff in training and information, not only front line staff or clinicians, but also administrators, receptionists, aids, etc.
- ▼ Address health promotion and the positive sides of healthy adult sexuality as well as negative topics such as sexual assault, abuse, and STDs.

## **Recommendations for Local, State, & Federal Mental Health Administrative & Public Policy Systems**

- ▼ Facilitate the development of program/staff competence through sponsoring education and experience re LGBT issues in various parts of the public mental health system, including training programs, conferences, continuing education, training/supervision opportunities at all levels.
- ▼ Make LGBT-competence a criterion in program evaluation and/or certification / licensure / renewal, along with other multicultural competencies. Consider creating a specialty certification in working with LGBT populations
- ▼ Attach positive value in hiring and promotions to employees' having such certification or otherwise demonstrating their competencies in working with LGBT consumers and issues.
- ▼ Fund the development of LGBT-affirmative mental health and human services that can assist people with serious mental illnesses..
- ▼ Invite and assist LGBT consumers (and all mental health consumers) to have a substantial voice in service system decisions.
- ▼ Address anti-LGBT attitudes and practices across all human services, not only mental health.
- ▼ Require managed care or other administrating bodies to address LGBT sensitivity in their administration and policies, and to allow their providers to list LGBT-issues as a specialty if qualified.
- ▼ Include LGBT issues in cultural competency training initiatives, evaluation criteria, and expectations.

## **Recommendations To Consumer / Survivor Self-Help And Advocacy Organizations**

- ▼ Examine one's own practices, priorities, and activities for insensitivity towards or neglect of LGBT consumer issues.
- ▼ Create ways to make one's activities and atmosphere feel safer and more welcoming to LGBT consumers.
- ▼ Start or sponsor local discussion or support meetings for LGBT consumers if none exist near you.
- ▼ Facilitate LGBT consumers' opportunities to talk with each other locally and across distances: newsletters, gatherings, email lists, LGBT caucuses at state and national consumer conferences and organizations, networks to share local information with newcomers, phone support trees.
- ▼ Incorporate more information and resources about LGBT issues/communities and LGBT-consumers into mental health consumer technical assistance and self-help clearinghouses.

- ▼ Facilitate LGBT consumers finding role models – people who are “out” as both LGBT and mental health service recipients and active in their communities.
- ▼ Reach out to the LGBT consumer/survivor groups listed in this report (and others) to exchange ideas, join forces, and support each other. Seek out and support the few existing LGBT consumer groups for their valuable contributions and knowledge.
- ▼ Make available self-help and advocacy skills (effective communication, problem-solving, etc) to assist LGBT-identified/affirmative consumers in confronting homophobia, deciding when and how to advocate for LGBT consumers’ rights, gauging others’ reactions and the safety of situations, etc.

## **Recommendations To LGBT Communities and Organizations**

- ▼ Examine one’s own (individual and collective) views and practices regarding mental illnesses and people with psychiatric disabilities, from informal language to programming priorities, and address shortcomings and work to eliminate stigma.
- ▼ Welcome and actively include mental health consumers and groups in all LGBT community initiatives and events.
- ▼ Sponsor / support a mental health consumers’ discussion or advocacy group.
- ▼ Encourage LGBT press and media outlets to cover LGBT consumer/survivor issues and organizations.
- ▼ Address the economic inaccessibility of some LGBT community groups and events; examine class issues.
- ▼ Foster LGBT mental health providers’ access to training/experience with serious mental illnesses, to broaden their organizations’ capacity to serve this sector of the LGBT community
- ▼ Help dismantle stigma and ignorance regarding mental illness within LGBT communities, including issues left from the legacy of LGBT identities per se being pathologized.
- ▼ Support LGBT mental health consumer groups and their allies.

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**APPENDICES**

**A. RESOURCES**

**B. ADDITIONAL READING LIST**

**C. YOUTH ISSUES**



## Appendix A: Resources

This appendix contains a list of resources helpful in the preparation of this report, but which don't appear in the References. Please note that while all information was current as of December, 2003 contact information can change quickly.

### Confronting Homophobia and Heterosexism in Health Care

Giving the Best Care Possible: Unlearning Homophobia in the Health and Social Service Setting, (1996). Office of Gay and Lesbian Health Concerns, New York City Department of Health and Community Health. 125 Worth Street, New York, NY 10013. Phone: 212-788-4310.

Peterson, K. J. (1996). Health Care for Lesbians and Gay Men: Confronting Homophobia and Heterosexism. New York: Haworth Press.

### People and Organizations

**\*\* See also the LGBT-affirmative mental health programs listed in Profiles section of the text \*\***

Fruit & Nut Bar – a loose national network of LGBT people with a psychiatric history to build mutual support and make the mental health system more responsive. It gathers annually at the Alternatives conference, forming its LGBT caucus, and in various local forms.

Contact: Mark Davis, 107 Arch Street, Apt 5A, Philadelphia PA 19106 215 / 685-5662

Steve Holochuck Director, Massachusetts Office of Consumer & Ex-Pt. Relations. Presentations, Consultation, Training, Technical Assistance. 25 Staniford Street, Boston, MA 02114. Phone: (617) 626-8063, Email: steve.holochuck@state.ma.us

Identity House From their brochure: “A peer counseling organization of caring volunteers, ready to speak with you, listen to you and share the struggles – and joys – of being gay, lesbian or bisexual....We offer a wide range of services, including peer counseling, rap groups, events, referrals, conferences, speakers bureau.”

Contact: Mailing address: Identity House, P.O. Box 572, Old Chelsea Station, New York, NY 10011  
Meeting address: 39 West 14<sup>th</sup> Street, Suite 205, Manhattan NYC 212 / 243-8181

Light House Community Support Program, Sexual Minorities Support Group. From their brochure: A group for LGBT mental health consumer “to provide support and education in order to decrease isolation and help members to participate in gay, lesbian, bisexual and transgender community activities as well as help to access services in the mental health system.”

Contact: Light House CSP, 1825 Chicago Ave., Minneapolis MN, 55404 or 612 / 879-5474; Theresa Flynn (612/879-5491) or Randy Nelson (612/871-1449)

MC Video Productions, Inc. carries several videos and audiotapes (for rent or purchase) about LGBT Consumer issues. Write or call for a list and prices: PO Box 3012, Madison, WI 53704-0012. Phone: 608/244-2793  
E-mail: MCvideoPro@aol.com

## Reports and Meeting Proceedings

Access and Use of Health Services by Lesbians and Gay Men in the Boston Area: An Exploratory Study (June, 1997). Report by Mark Griswold, MSc and the JSI Project Team. Copies available from Gary Fallas of JSI at 617/482-9485.

American Psychological Association, Committee on Lesbian and Gay Concerns. (1990). Bias in Psychotherapy with Lesbians and Gay Men. Washington, DC: American Psychological Association, 750 First St., N.E., Washington, DC 20002-4242. Phone: (202) 336-5500

Cultural Diversity Series: Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons, (August, 1999). Prepared by Susan r. McCarn, MA, for the National Technical Assistance Center of State Mental Health Planning, 66 Canal Center Plaze, Suite 302, Alexandria VA 22314  
Contact: 703 / 739-9333, or ntac@nasmhpd.org, or go to: www.masmhpd.ntac

Health Concerns of the Gay, Lesbian, Bisexual, and Transgender Community, 2<sup>nd</sup> Ed. (June, 1997). Produced by the Medical Foundation for the Massachusetts Dept. of Public Health, 250 Washington Street, Boston MA 02108-4619 or 617/624-6000

Investigation into Discrimination Against Transgendered People, (Sept., 1994). A Report to the Human Rights Commission of the city and county of San Francisco, by Jamison Green & Larry Brinkin.  
Contact: San Francisco HRC, 25 Van Ness Ave., Suite 800 San Francisco, CA 94102-6033.  
Phone: 415 / 252-2500

New Approaches to Research on Sexual Orientation, Mental Health, and Substance Abuse. Sponsored by the National Institutes of Health and the American Psychological Association. Held September 27-28, 1999 at the Neurosciences Center of the NIMH campus, 6001 Executive Blvd., Rockville MD.  
Contacts: Howard S. Kurtzman, PhD, Behavioral Sciences Research Branch, NIMH: 301/443-9400 or kurtzman@nih.gov  
Clinton W. Anderson, MA, Officer, Lesbian, Gay, & Bisexual concerns, American Psychological Association: 202/336-6037 or canderson@apa.org

Removing Barriers to Health Care for Lesbian, Gay, Bisexual and Transgendered Clients: A Model Provider Education Program, (March, 1997). Trainer Handbook and Participant Resource Guide, as well as other materials developed by the National Lesbian & Gay Health Association and the Mautner Project for Lesbians with Cancer.  
Contact: NLGHA, 1407 S Street NW, Washington DC, 20009 Phone: 202-939-7880  
Fax: 202-234-1467

Report from a Meeting on Services for Lesbians, Gay Men, Bisexuals, and Transgendered Persons with Psychiatric Disabilities. (October, 1998). Copies may be obtained from Janet Chassman, New York State Office of Mental Health, Training Bureau, 44 Holland Ave, Albany NY, 12229 .  
Phone: 518/474-2578 or 800-597-8481

## Websites & On-line Resources

FTM International: [www.ftm-intl.org](http://www.ftm-intl.org)

Website of the FtM International organization includes information, support, local meetings, newsletter, announcements, etc for a wide variety of female-to-male identified people.

Contact Info.: FTM International, 1360 Mission St., Suite 200 San Francisco, CA 94103  
415 / 553-5987 or TSTGMen@aol.com

LesbiansWDepression: [www.onelist.com/subscribe/LesbiansWDepression](http://www.onelist.com/subscribe/LesbiansWDepression)

From the list description: “Created as a forum for Lesbians who are suffering from, or recovering from depression. Topics can include, but are not limited to: medications, therapies, social support and alternative treatment methods. Lesbians only please. All information regarding subscribers will be kept confidential. “

Contact: [LesbiansWDepression-owner@onelist.com](mailto:LesbiansWDepression-owner@onelist.com)

QWORLD (LGBT people with Mood Disorders): [www.onelist.com/subscribe/QWORLD](http://www.onelist.com/subscribe/QWORLD)

From the site description: “Support E list for Queers, Gay men, Fags, Lesbians, Dykes, Lesbians, Womyn, Bisexuals, Drag Queens, F/F, F/M, M/M, people affected with HIV/AIDS – and the politics of it all – who are living with Mental and Mood Disorders such as Bipolar Illness, Clinical Depression, Borderline Personality , Schizoaffective Disorder, etc. QWORLD is a members-only list.”

Contact: Co-Moderators: Jace ([jacevela@mcia.com](mailto:jacevela@mcia.com)) and Jen ([jpadron@toto.csustan.edu](mailto:jpadron@toto.csustan.edu))

Transgender Forum: [www.tgfmall.com](http://www.tgfmall.com)

Large sites connecting many transgender resources, on and off the web. Includes a national listing of transgender sites at <http://www.tgfmall.com/tgfc.html>

## **Appendix B: Additional Readings on LGBT-Affirmative**

### **Therapy**

This appendix contains a list of books and articles focusing on therapy with LGBT clients. It is not the references list for the report itself, but rather a separate resource, included because there is such an extensive literature developing in the area of therapy, and because much of the material is useful for other roles and helping relationships as well.

### **General / Mixed Group**

- Alexander, C. J. (1996). Gay and lesbian mental health: A sourcebook for practitioners. New York: Harrington Park Press/Haworth Press.
- Amico, J. M., & Neisen, J. (1997, May/June). Sharing the secret: The need for gay-specific treatment. The Counselor, 12-15.
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- Drescher, J., e'Ercole, A., Schoenberg, E (Eds.) (2003). Psychotherapy with gay men and lesbians: Contemporary dynamic approaches. Binghamton NY: the Harrington Park Press / The Haworth Press.
- Fassinger, R. E. (1991). The hidden minority: Issues and challenges in working with lesbian women and gay men. The Counseling Psychologist, 19(2), 151-176.
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## **Appendix C: Youth Issues**

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Although the American Psychiatric Association removed homosexuality from its official list of mental disorders in 1973, the U.S. mental health system remains an extremely hostile environment for lesbian, gay, and bisexual youth, who are still routinely viewed by child and adolescent psychiatrists as “emotionally disturbed” and in need of aggressive psychiatric treatment to ‘prevent adult homosexuality’. (Scholinski, 1995, p. 18)

While this report focuses on the experiences and needs of adults who are LGBT and have a serious mental illness, every adult used to be a child and what happened to one then may color one’s adult experiences in the present. Adolescence can be emotionally, physically, and psychologically challenging. Lesbian, gay, bisexual, and transgender adolescents face not only the daily tribulations of their heterosexual peers, but also hurdles created by a society prejudiced against them. D’Augelli (1996) reported that “a recent study of harassment in American high schools found that the type of harassment considered most upsetting [by the general student body] was to be called gay” (p. 268). Actually being LGBT in high school means coping with fear of the harassment and violence behind such “insults” (Abinati, 1994). For example, D’Augelli’s 1991 study reviewed the most prominent fears of gay male college students (average age 21 years) and found fear of being rejected by their parents as first, closely followed by fear of physical and/or verbal abuse regarding their sexual orientation.

Unfortunately, the incidence of violence against LGBT youth justify such fears. In 1990, Hunter surveyed 500 youth seeking services at the Hetrick-Martin Institute, a community based agency for gay and lesbian adolescents in New York: 41% reported suffering violent assaults from family, peers, or strangers. Similar surveys echo these results (D’Augelli, 1992; Du Rant, Krowchuk, & Sinal, 1998; Savin-Williams, 1994). The pervasiveness of these crimes, the passivity surrounding their prosecution, and the controversy that ensues whenever media portray positive gay and lesbian characters all echo negative societal attitudes heard loud and clear by LGBT youth.

### **Life Stress**



Coming out has been recognized as “a developmental process through which gay people recognize their sexual orientation and choose to integrate this knowledge into their personal and social lives” (Mallon, 1992, p. 54). Unfortunately, this is rarely a smooth process for LGBT youth. For most adolescents, neither sexual orientation nor mental health concerns are broached by parents or guardians, much less discussed in depth (Brown, 1981). Verbally coming out to a parent as LGBT may represent a young person’s taking initiative in communicating with family adults about their emotional well-being or need for support in coping with social and/or peer negativity. Unfortunately, D’Augelli and Hershberger (1993) found that “only 11% of a sample of lesbian, gay, and bisexual youth received a positive response from parents upon disclosure. Of parents aware of their child’s gay, lesbian, or bi orientation, 20% of mothers and 28% of fathers were either intolerant or rejecting” (p. 275, D’Augelli, 1996).

D’Augelli further concluded that “...accumulated evidence supports the idea that stresses that jeopardize mental health are common in lesbian, gay, and bisexual youth and young adults. Such an idea is consistent with the unusual life stresses these young people face in addition to the stresses related to adolescent development and young adulthood in general” (1996, pp. 278-279). Martin & Hetrick (1988) reported that students experienced:

- ▼ Pervasive loss of pleasure, feelings of sadness, change of appetite, sleep disturbances, slowing of thought, lowered self-esteem with increased self-criticism and self-blame, and strongly expressed feelings of guilt and failure....They repeatedly report that they feel they are alone in the world, that no one else is like them, and they have no one with whom they can confide (as quoted in Savin-Williams, 1998, p. 267) .

Similarly, in 1991, Rotheram-Borus, Rosario, and Koopman interviewed 2,000 LGBT New York City adolescents between the ages of 12 and 21. Nearly 95% indicated that “they frequently felt separated and emotionally isolated from their peers because of feelings of differentness” (p. 263). D’Augelli (1996, p. 273) notes that,

- ▼ A cyclical pattern emerges; because youths feel different (and are often not able to understand the feelings), they may withdraw from others, may distort their life, or may try to act straight with varying degrees of success. This widens the gap between core identity and public identity...As a result, anxiety and depression may increase, especially if the individual understands the nature of his or her difference.

Depression, isolation, and fear in the lives of LGBT youth were brought to the forefront in 1989 with the publication of the Report of the Secretary’s Task Force on Youth Suicide (Gibson, 1989). The statistics that LGBT youth were two to three times more likely to inflict potentially lethal harm upon themselves compared to their heterosexual peers have since been used as catalysts for research and investigation into the causes (For example, Blumenthal, 1990; Brent & Kolko, 1990; D’Augelli, 1996; Farrow, 1995; Gould, Wallenstein, & Davidson, 1989;

Hoberman & Garfinkel, 1988; Kosky et al., 1990; Lewinsohn et al., 1993; Marttunen et al., 1992; Remafedi, French, Story, Resnick, & Blum, 1998; Rich et al., 1988). Collectively, the factors predicting increased suicide risk include substance abuse, social isolation, conflicts in romantic relationships, conflicting sense of self acceptance/ internalized homophobia, recent loss of a loved one, family history of suicide attempts or completions, accumulated life stressors, antisocial or impulsive behaviors, being rejected following coming out to family and/or friends, history of self-destructive behaviors, persistent victimization, and any history of physical and/or sexual abuse.

Critics since have emphasized that the risk factor is not “sexual orientation” per se, but rather the stressors that sometimes accompany it (Muehrer, 1995). Several researchers (Herek, 1990; Remafedi et al., 1991; Muehrer, 1995; Remafedi et al., 1998) have recently sought to clarify this information. Reassessment of both the adolescent population and past research has found that “because of sampling limitations, data from these [early] studies do not permit projections of suicidal behavior among gay and lesbian youth in general” (Muehrer, 1995, p. 17). Remafedi et al. (1991) concurred that “bisexuality and homosexuality per se was not associated with self-destructive acts” (p. 873). Depression that can lead to suicide could be the psychopathology Herek (1990) refers to in his conclusion that “gay people are claimed to be more suspect to psychopathology, not because of their sexual orientation, but because of society’s negative reaction to them” (p. 1036). Gibson (1989) cited, “One young gay male involved in prostitution attempted suicide after receiving a ‘hate’ letter from his parents. In it his mother said she was sorry she had not gotten an abortion before he was born and his father said that he only had half a son. The young man completed suicide two years later” (p. 3-122). In sum, while not linked causally with sexual orientation, stressors and the potential for any adolescent to consider hurting himself or herself should always be considered carefully by clinicians and mental health care providers. Prominent researchers are now calling for a shift in research – from assessing risks to considering the strengths and resiliency of LGBT and questioning youth, and to addressing intolerance (Wright, 1999).

## **Mental Health System Involvement of Youth**

In 1988, minors in the United States were admitted to psychiatric institutions by juvenile courts, parents, and public school districts at a rate of 48,000 annually (Minter, 1994). The road traveled by most of these youth into the mental health system is rocky and not always helpful. Most heterosexual parenting couples strongly want and encourage their children to be heterosexual as well. Too often they interpret any deviation from this expectation as

failed parenting, often leading them to seek out “help” for their “damaged” child (Boxer, Cook, & Herdt, 1991).

Also, while many parents and professionals question whether an adolescent can have an accurate understanding of him/herself as gay, lesbian, bisexual or transgender, they do not question that a heterosexual youth can be confident in his or her sexual orientation. Lisa R., a 17 year-old lesbian states, “When my parents found out I was gay last year they sent me to a therapist. The therapist had my parents admit me to a hospital...I was told over and over again that I was gay because of sexual confusion. I was not confused” (Mallon, 1998). Mallon (1997) provides another example of a young person’s route into the mental health system,

▼ The grandmother was very upset that her grandson was insisting that he was gay. She asked if we [a residential therapy team] could help. When the worker asked how could we be of help, she replied: “Is it possible for you to change him?” When she was told that changing Joe was not possible, she replied: “Then you can have him.” (p. 599).

Once in, whether referred appropriately or inappropriately, mental health services provided to LGBT youth vary widely. LGBT youth seeking support from professionals such as school counselors, teachers, parents, clergy or mental health providers often face individuals and institutions that are poorly informed, uniformly negative, and actively unsupportive of LGBT youth (Gibson, 1989). The normal personal exploration of adolescence becomes the possible focus of treatment (Terry, 1985). The person’s presenting mental health issues are too often assumed to result from her/his sexual orientation while the actual issues and causes of distress are ignored. Regarding her own time in the mental health system as a teenager, Daphne Scholinski (1995, p. 20) commented,

▼ I would spend my entire “treatment” never really dealing with my depression or the symptoms resulting from the abuses from parents, teachers, peers, or previous psychiatric interactions. Instead I was immediately targeted for my “sexual identity” as the problem and the only “thing” that needed resolution. Each and every day was reinforcement that I WAS THE PROBLEM.

As is indicated in Brunstetter’s (1998) research on adolescents in psychiatric hospitals, the overriding assumption in many settings is that all youth are heterosexual. This says to LGBT youth that their feelings and self-concepts are invalid and unimportant. Similarly, Price and Telljohann (1991) surveyed 289 high school counselors regarding their perceptions of the LGBT youth in their academic environments. Sixteen percent (approximately 36) of the counselors believed their student populations to be completely heterosexual and twenty percent (one in five) indicated that they did not feel competent to counsel an LGBT student (cited in Messina, 1992). One staff member spoke frankly, “We’ve always had gay adolescents ‘though they were often invisible. They said nothing about it

and neither did we. Then kids started openly stating they were gay, and suddenly we didn't know how to respond" (p.48, Mallon, 1992).

## **Misuse of Psychiatric Diagnoses with Youth**

Misuse and misinterpretation of diagnoses are further concerns in many instances. There are a number of psychiatric disorders usually diagnosed first during the early teen through young adult years (American Psychiatric Assoc., 1994). Accurate and appropriate diagnosis can be challenging with adolescents. Though assessment guidelines have been established, reviewed, and refined, "the type of behavior and the degree of deviation necessary for a given diagnosis remain vague and depend on 'clinical judgment'" (Sue et al., 1997, p. 475). When that subjective judgment is made by a professional who is unaware of LGBT developmental issues, or when professional opinion is clouded by bias, the result can be inaccurate and detrimental. Gender Identity Disorder is a prominent example (American Psychiatric Association, 1994, p. 532). Even though most adolescents explore various identities and express the desire to change some aspect of their physical appearance (Van Ornum & Mordock, 1996), this diagnosis focuses in part on narrow gender "appropriate" behaviors and appearance. While the formal diagnostic criteria caution clinicians to distinguish between GID and "simple non-conformity to stereotypical sex role behavior" (p. 536), overall it gives an impression that deviations from this "norm" are diagnostically maladaptive and in need of correction (Pela, 1997).

▼ In particular, lesbian youth are vulnerable to being labeled with so-called 'Gender Identity Disorder,' a psychiatric diagnosis that pathologizes girls and young women who 'display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire,' who 'prefer boy's clothing and short hair,' who 'prefer boys as playmates, with whom 'they share an interest in contact sports, rough-and-tumble play, and traditional boyhood games,' and who 'show little interest in dolls or any form of feminine dress up or role-play activity.' (p. 217, Minter, 1996, quoting the DSM-IV, p. 533)

Similarly, "oppositional" behavior or Oppositional Defiant Disorder may be diagnosed when a young person's identity conflicts with parental expectations and values and family conflict ensues. Or, LGBT youth may find themselves diagnosed with Borderline Personality Disorder based on a therapist's interpretation that their same sex attraction is merely a symptom of "confusion" over sexual orientation and identity (Minter, 1994). The treatment plans that result from such practices are ineffective in the least, and quite possibly detrimental. Terry (1985) summarized the concept that often prevails:

- ▼ ...progress in treatment may be measured by the individual's ability to modify same-gender preference to the more "acceptable" opposite-gender attraction. Families will be happier and staff certainly will take credit for exceptional role modeling and expert intervention during this critical "identity crisis." ...The observed changes are more likely to be a result of stress reduction through accommodation rather than a "cure" through changing gender attraction (p. 107).

Paradoxically, when one is not at variance with gender role expectations, one's real distress around identity may be ignored:

- ▼ Mr. C [17 years old, questioning his sexual orientation] was recognized by the treatment staff to be depressed; however, because his behavior was perceived to be gender appropriate, most of the staff felt he was not gay and should be encouraged to develop his heterosexual interests and dating skills. His concerns about being homosexual were minimized and not explored further during his hospitalization (Hartstein, 1996, p. 830).

Furthermore, in addition to detrimental labeling and poor treatment, ignoring the existence of LGBT youth and their needs in a facility allows harassment and abuse to occur unchallenged. Brown (1981) quotes one such case, "Some of my friends said that one of the seniors in the cottage was 'queer.' One night six of the guys forced him to perform fellatio on them" (p. 172).

## **Exemplary Services to Youth**

There do exist some exemplary programs that effectively identify and address the needs of LGBT youth seeking mental health and emotional support. These are programs, such as Green Chimneys in New York and The Horizons Program in Chicago, that take "leadership in developing opportunities, through training and education, to provide both staff and residents with accurate, relevant, and nonjudgmental information about homosexuality" (p. 49, Mallon, 1992). These programs take a proactive stance to decrease distress, depression, and anxiety by creating an environment for healing and growth through acceptance and support (Herdt & Andrew, 1993; Farrow, 1995).

Existing literature and opinion offer numerous suggestions for programs seeking to follow in these footsteps:

- ▼ Mental health staff members are encouraged to educate themselves on adolescent sexual identity development while consciously evaluating any homophobic and/or heterosexist biases they may have (Morrow, 1993).
- ▼ As a therapist, open up the topic of sex and sexuality in a safe, open, and understanding manner (Gibson, 1989).
- ▼ Validate adolescents' attempts to understand their sexuality and the feelings associated with those efforts (Gibson, 1989).

- ▼ Clearly display acknowledgment and support of gay, lesbian, bisexual, and transgender identities in therapeutic demeanor, physical surroundings, and information available (Hartstein, 1996).
- ▼ Therapy should endeavor to provide a safe place for all family members to express feelings (Scharff & Scharff, 1987) while empowering the youth and their parents to live positively in a homonegative society (Savin-Williams, 1998)
- ▼ Therapy should combat negative stereotypes of gay men, lesbians, bisexual men and women, and transgender individuals (Saltzburg, 1996)
- ▼ Mental health administrators should review facility policies and procedures to ensure that both formal policy and real practice are not discriminatory, such as allowing heterosexual relationships between patients while pathologizing or forbidding same-sex attraction (Brunstetter, 1998), or deeming gay-bashing rape victimization an “unfortunate consequence of institutional life” (Forrest & Higgins, 1981).

Mallon (1992) reminds professionals that “gay and lesbian youth are in treatment in every Residential Treatment Center in this country. Serving their needs by training staff, board members, and other residents, to work more effectively with the gay and lesbian adolescents is an issue of equality, not an issue of sexuality or morality” (p. 59).