the Clearinghouse

The Key ASSISTANCE REPORT

Focus on LGBTQI MENTAL HEALTH CONSUMERS

National Mental Health Consumers' Self-Help Clearinghouse

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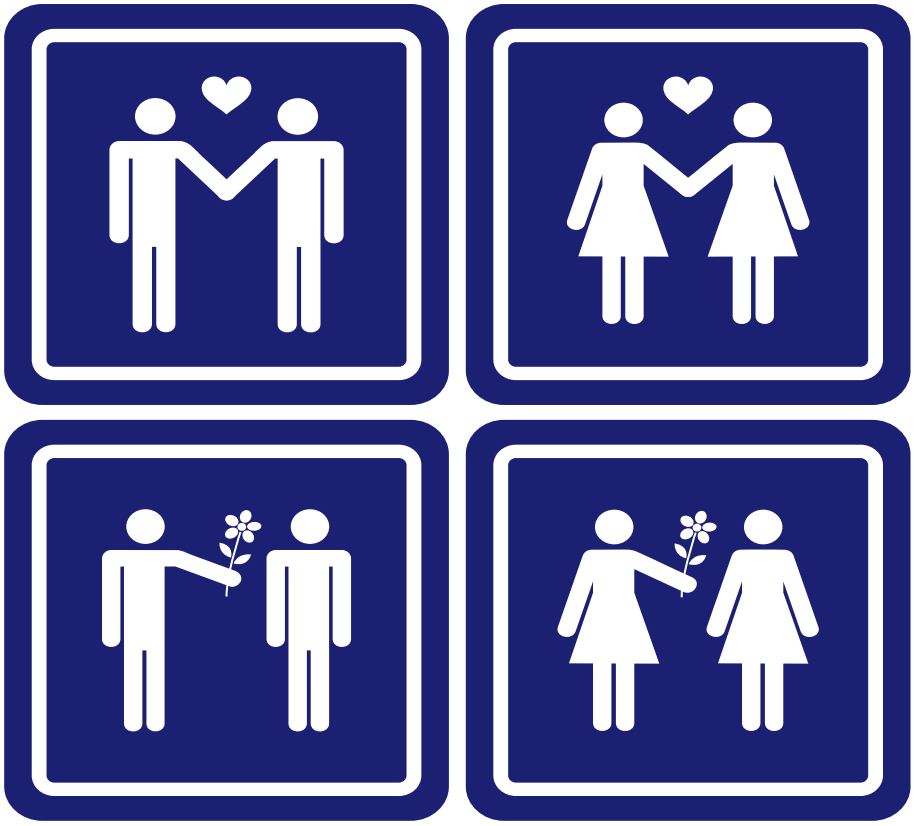

Listening to members of the LGBTQI (Lesbian Gay Bisexual Transgender Questioning Intersex) community speak of their experiences in the public mental health system can break your heart. A. Dionne Stallworth, a Philadelphia activist for transgender rights, described the ordeal of going into a psychiatric hospital to be treated for depression in the 1990s. First, she recalled, the professionals acted as if both her depression and her gender identity were problems. Then, some of the patients drew lots to decide who would have to be her roommate.

Stallworth's story is emblematic of the treatment that individuals who are lumped together in the LGBTQI alphabet soup have experienced in the mental health system. Now, however, effective advocacy by LGBTQI activists and other concerned citizens is resulting in changes, albeit incremental, in both mental health policy and practice.

THREE BROAD CATEGORIES

The LGBTQI community is divided into three broad categories. Sexual minorities are people who define themselves as attracted to members of the same gender or to both genders. Gender variant individuals are those who self-identify as not conforming to the conventions of male and female behavior. Within the gender variant community are transgender persons who live at least some of their lives as members of the opposite gender; those who seek gender reassignment surgery form a subgroup. A third broad category – intersex – comprises individuals who are endowed with physical, genetic, or biochemical features of both genders. According to Alicia Lucksted, Ph.D., a professor at the Center for Mental Health Services Research at the University of Maryland in Baltimore, drawing a circle around all of these communities is a way of pointing out the common issue of marginalization.

Members of LGBTQI communities continue to face barriers to accessible and appropriate mental health treatment. The biggest obstacle is the fact that, until 1973, homosexuality was defined as a mental illness in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. In reaction, many gay people rejected anything that suggested that they might experience mental illness, according to Mark A. Davis, a longtime activist for LGBTQI individuals with mental health conditions and the founding president of the Pennsylvania Mental Health Consumers'

HOW CONSUMER GROUPS CAN HELP:

IDENTIFY local LGBTQI leaders who can offer trainings on how to be LGBTQI-affirming.

COOPERATE with the LGBTQI community on issues of mutual concern.

START an LGBTQI support group.

PARTICIPATE in a gay pride march.

INCLUDE a clause in your group's non-discrimination policy stating that your organization does not discriminate against sexual or gender minorities. If your group does not have such a policy, develop one.

DISAVOW "conversion" therapies that seek to change individuals' sexual or gender identities.

USE inclusive language, such as the word "partner" instead of "husband" or "wife."

REMEMBER that LGBTQI communities are cultures akin to cultures of race, ethnicity, and religion.

DO NOT ASSUME that every LGBTQI individual has the same concerns; they come from all segments of society.

HIRE LGBTQI consumer staff members who are diverse in terms of age, race and gender.

DISPLAY LGBTQI literature (posters, magazines, newspapers and flyers) to create a welcoming atmosphere.

INVITE the local gay press to cover your events, and advertise in gay periodicals.

TRACK your group's progress in becoming more inclusive of LGBTQI consumers.

Association. While the gay community neglected individuals among them with such disorders, in the mental health system old prejudices against the gay community continued to hold sway.

The identification of homosexuality as a mental illness in the *DSM* "was our Tuskegee," said Davis, referring to the infamous medical experiment on non-consenting African-American men that resulted in an overarching suspicion of the health care system within the African-American community. "Gay liberation and the mental health consumer/survivor movement ran a thousand miles away from each other," said Davis, who facilitates the Pink & Blues, a Philadelphia peer support group for LGBTQI individuals in recovery from psychiatric disabilities. "I couldn't be safely out as a gay man in the mental health community or accepted as a person living with bipolar disorder in the gay community."

Even now, people in gender variant communities face the same dilemma that gay people encountered until 1973, in that "gender identity disorder" is still considered a psychiatric condition. (At this writing, in the draft *DSM-V*, the proposal is to rename gender identity disorder "gender incongruence.") However, transgender individuals challenge the very idea of gender distinctions. Dividing people into two mutually exclusive genders "is not the natural state," Stallworth said. "Gender is on a continuum."

Transgender individuals have a tougher time than the LGB community, she continued. "LGB people can choose not to come out, [but] a trans person is [immediately] visible," Stallworth said. "From the most basic thing, everything is problematic." The core difficulty that the dominant (i.e., heterosexual) culture has with transgender people is more fundamental than the *DSM* definition, Stallworth added. "People are bashed, not because of their sexual orientation," but because they don't conform to conventional gender roles, which scares many people, she said.

OPPRESSIVE PRACTICES

These issues color all interactions that LGBTQI persons with psychiatric disabilities have with their environment, and translate into oppressive practices in the public mental health system. Mental health line staff disapprove of sexual interaction among consumers in general, said Lucksted, and often cannot address LGBTQI-specific issues. Staff can be superficially affirming but subtly homophobic and trans-phobic. For example, when providers segregate residential units, shelters, shower rooms and bathrooms according to gender, they assume that they are preventing sexual expression and overlook the possibility that LGBTQI consumers may be present. If sexual or gender minority individuals do make themselves known, others may see them as predators toward same-gender clients and staff.

In addition, individuals who may not feel welcome in these settings may feel unable to speak openly even when encouraged to do so, as in group therapy. Peer intolerance can make consumer-run groups seem unwelcoming, and can place LGBTQI consumers living in inpatient or residential facilities at grave risk of harassment and even assault. Further, therapists and staff may view conforming to a heterosexual norm as indicating recovery, while misinterpreting as pathology dressing and acting in ways consistent with LGBTQI cultures.

Staff may also misinterpret as psychiatric issues the social problems that gay or gender variant consumers face. Like members of LGBTQI communities in general, who are fearful of the reactions of others if they reveal too much, LGBTQI individuals who are living with psychiatric disabilities have to expend a great deal of energy managing the way they present themselves.

Compounding their difficulties, LGBTQI mental health consumers often cannot count on emotional or financial support from their own families or social networks, and the AIDS epidemic has deprived many of peers. Instead of understanding that such individuals face a twofold problem of discrimination and lack of social support, staff may attribute their emotional distress about these social problems to their sexual or gender identities.

LAYERS OF BIAS

Individuals with psychiatric disabilities from LGBTQI communities who are also racial and ethnic minorities report increased barriers to recovery with each additional layer of minority identity. Because of these cumulative layers of bias, many LGBTQI consumers from racial or ethnic minorities are not working, are homeless, or may not access help, said Renae Sewell, an African-American lesbian and executive director of Hearts and Ears, a peer-run center in Baltimore for LGBTQI people with mental illnesses. All too frequently, there may be no single "home base" where individuals of multiple minority backgrounds can feel fully accepted.

The special issues that confront members of LGBTQI communities who are mental health consumers are not well documented, said Davis, because researchers have neglected doing focused research on their welfare in such areas as inpatient treatment, outpatient social service provision, and vocational rehabilitation. For example, in 1999, *Mental Health: A Report of the Surgeon General*, published by the U.S. Department of Health and Human Services, contained no substantive discussion of LGBTQI issues; and the report's supplement on culture, race, and ethnicity made no mention of LGBTQI communities as a culture.

One issue that has received attention from both the LGBTQI and mental health communities is youth suicide prevention. According to Davis, "There is a bias toward [creating programs for] people becoming suicidal over coming-out issues." Such programs may not address mental health and addiction concerns, "nor are there significant suicide prevention initiatives for adults and older adults" from the LGBTQI community, Davis said. The higher rate of suicide in the transgender community is also not being addressed, added Stallworth.

Despite the barriers that LGBTQI individuals with psychiatric disabilities face, remedies can be simple, said Lucksted. She challenges organizations to ask themselves how to become more welcoming: "Think about the little things." *(See sidebar on Page 2.)*

SOME PROGRESS

There has been progress. A 2005 study published in *Psychotherapy: Theory/Research/Practice/Training* indicated that in 1991 only 5 percent of mental health professionals maintained an LGBTQI-affirming perspective in therapy; in 2005, 58 percent were affirming. In Pennsylvania in 2009, an LGBT workgroup developed a series of recommendations for the state's Office of Mental Health and Substance Abuse Services (OMHSAS) to improve behavioral health services to the LGBTQI community; the recommendations were embraced by OMHSAS officials. In Maryland, the statewide consumer-run organization, On Our Own, has held a statewide conference on LGBTQI issues, and includes a workshop on the subject at each of its annual conferences. An On Our Own affiliate, the Office of Consumer Advocates in Hagerstown, has begun an LGBTQI support group. Another, Lower Shore Friends, includes LGBTQI news in every issue of its newsletter. Still another, the aforementioned Hearts and Ears of Baltimore, works specifically with that city's LGBTQI consumer population.

In several other cities, leaders have established organizations specifically for LGBTQI consumers. The Zappalorti Society in New York City and the Pink and Blues in Philadelphia are examples. On a national basis, Parents and Friends of Lesbians and Gays (PFLAG) has developed a program for transgender youth; and the Trevor Project, a suicide prevention program for LGBTQ youth, operates an around-the-clock crisis and suicide prevention helpline.

Numerous guides and toolkits are available on the Internet for assistance in developing policies of inclusion and welcome. *(See sidebar on Page 3.)*

In ever-increasing numbers, LGBTQI consumers are demanding to be treated with dignity and respect. "Being denied your identity is the ultimate non-recovery," said Stallworth. "We are not really very exotic," concluded Lucksted. "We just need to feel welcome and respected, and that we can speak about our lives."

GLBTQI Mental Health: Recommendations for Policies and Services
http://www.upennrrtc.org/var/tool/file/222-GLBTQI_MH_Recommendations_for_Policies_and_Services-1.pdf

Enhancing Cultural Competence: Welcoming Lesbian, Gay, Bisexual, and Transgender Clients in Mental Health Services
http://medschool.umaryland.edu/facultyresearchprofile/uploads/59eabd4ebe674d01ae00ebfad157c442.pdf

Issues of Access to and Inclusion in Behavorial Health Services for Lesbian, Gay, Bisexual, Trangender, Questioning and Intersex Consumers
http://www.parecovery.org/services_lgbtqi.shtml

A Mental Health Recovery and Community Integration Guide for GLBTQI Individuals: What You Need to Know
http://www.nami.org/Content/ContentGroups/Multicultural_Support1/Fact_Sheets1/GLBTQI_Recovery_Community_Integration_booklet.pdf

GLBT Mental Health Resources
http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Resources/GLBT_Resources.htm

Disparities in Mental Health Treatment Among GLBT Populations
http://www.nami.org/TextTemplate.cfm?Section=Fact_Sheets1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=48109

Psychologists' attitudes and therapeutic approaches to gay, lesbian, and bisexual issues continue to improve: An update
http://linkinghub.elsevier.com/retrieve/pii/S0033320405601581

Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients
http://www.apa.org/pi/lgbt/resources/guidelines.pdf

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The Clearinghouse welcomes all programs in which consumers play a significant role in leadership and operation to apply for inclusion in its Directory of Consumer-Driven Services. The directory, accessible at www.cdsdirectory.org, is searchable by location, type of organization, and targeted clientele, and serves as a free resource for consumers, program administrators and researchers.

Apply online at www.cdsdirectory.org/contact, via fax at 215-636-6312, or by phone at 800-553-4KEY (4539). To receive an application by mail, write to info@cdsdirectory.org or NMHCSH Clearinghouse, 1211 Chestnut Street, Suite 1100, Philadelphia, PA 19107.

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