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Understanding the Needs of Lesbian, Gay, Bisexual, and Transgender People Living With Mental Illness

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Introduction

People who are lesbian, gay, bisexual, and transgender (LGBT) face particular obstacles, barriers, and challenges that frequently make it difficult for them to find and receive competent and affirming healthcare. Because of this, they may experience a higher degree of distress and symptoms than their non-LGBT counterparts. These issues also make it difficult for LGBT people to receive optimal mental healthcare. This article describes some of these issues and challenges and provides guidelines for affirmative treatment.

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Prevalence of Psychiatric Disorders Among LGBT Populations

Empirical research on the prevalence of psychiatric disorders among gay and lesbian populations is in its infancy. Similar research on bisexual and transgender populations is virtually nonexistent,[1] despite repeated calls for research that focuses on the treatment issues of these populations.[2-4] A few important existing resources are Cabaj and Stein's *Textbook of Homosexuality and Mental Health*[5]; Perez, DeBord, and Bieschke's *Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients*[6]; and the *Handbook of LGBT Issues in Community Mental Health* (Hellman and Drescher, eds.).[7]

Several studies indicate that gay men and lesbians are at greater risk for psychiatric morbidity than heterosexuals. Ramafedi and colleagues[8] found a higher risk for suicide attempts in lesbian, gay, and bisexual-identified youth, with 28.1% of young bisexual/homosexual boys, 20.5% of young bisexual/homosexual women, 14.5% of young heterosexual women, and 4.2% of young heterosexual men reporting suicide attempts. Russell and Joyner[9] reported similar results in a study of same-sex sexually oriented (SSSO) youth, with 15.4% of SSSO and 9.7% of non-SSSO participants reporting suicidal thoughts in the previous 12 months; and 5% of SSSO and 2% of non-SSSO participants reporting suicide attempts in the previous 12 months.

The same pattern has been found among adults. Using data from the National Comorbidity Survey, Gilman and his associates[10] found that people reporting same-sex sexual partners have consistently greater odds of experiencing psychiatric and suicidal symptoms compared with their heterosexual counterparts. Among men reporting same-sex sexual partners, the odds of experiencing an anxiety disorder were 1.3 times higher, the odds of experiencing a mood disorder were 1.7 times higher, and the odds of experiencing a substance abuse disorder were 1.5 times

higher than odds for their heterosexual counterparts. Among women reporting same-sex sexual partners, the odds of experiencing an anxiety disorder were 1.8 times higher, the odds of experiencing a mood disorder were 2.0 times higher, and the odds of experiencing a substance abuse disorder were 2.4 times higher than odds for their heterosexual counterparts. Participants also had higher odds of reporting suicide symptoms. Among men reporting same-sex sexual partners, the odds of having thought about suicide in their lifetimes were 2.2 times higher, the odds of having made a plan for committing suicide were 1.6 times higher, and the odds of having attempted suicide were 2.4 times higher than odds for their heterosexual counterparts. Among women reporting same-sex sexual partners, the odds of having thought about suicide in their lifetimes were 2.0 times higher; the odds of having made a plan for committing suicide were 2.6 times higher; and the odds of having attempted suicide were 1.5 times higher than odds for their heterosexual counterparts.

Cochran and Mays[11] studied men with same-sex partners, using data from the National Health and Nutrition Examination Survey, and found a markedly higher prevalence of suicide symptoms during their lifetimes than men reporting only female partners. Among men reporting any male sex partners during their lifetimes, 18.5% reported having experienced a desire to die, compared with 7.6% of those with female partners only and 1.9% of those reporting no sexual intercourse. Suicidal ideation was described by 41.2% of men reporting any male partners during the course of their lifetimes, compared with 17.2% of those with female partners only and 13.0% of those reporting no sexual intercourse. Suicide attempts were reported by 19.3% of men reporting any male partners over the course of their lifetimes, compared with 3.6% of those with female partners only and 0.5% of those reporting no sexual intercourse.

However, research on this population and the prevalence of psychiatric conditions is in its early phases, and some studies have found similar rates of psychiatric hospitalizations, and even somewhat lower rates of psychotic disorders among LGBT people compared with the general population.[12] Some LGBT people may have greater resilience because of the stresses and challenges that they experience. Although these possibilities are certainly worthy of further study, pursuing them is beyond the scope of this article.

Mental Health Concerns of LGBT Consumers

A study by Lucksted,[1] commissioned by the Center for Mental Health Services, found that a number of issues and problems were frequently cited by hundreds of LGBT mental health consumers across the country. In mainstream mental health settings, they often feel compelled to hide their sexual orientation or gender identity; conversely, in the LGBT community, mention of their mental health status is often unwelcome. In addition, most programs and practitioners seem to assume that LGBT people do not exist, and that all their clients are heterosexual. LGBT patients say they are often made to feel that their care providers neither understand nor like them, and that any exploration or expression of their sexual or gender identity is further evidence that they are mentally ill. Moreover, especially in inpatient units and day programs, other consumers are frequently derogatory or even threatening toward LGBT patients. The mental health staff is often slow to discourage this behavior. These instances of homophobia and heterocentrism within the mental health system needlessly impede the recovery process and the effectiveness of the treatment and services being provided.[13]

Unfortunately, mental health professionals have helped to create this unacceptable situation. Until 1973, the American Psychiatric Association (APA) defined homosexuality as a mental illness. LGBT people with mental illness are acutely aware of their dependency on their care providers, and often hesitate to do anything that might cause providers to withdraw their care and support. Many LGBT people have experienced the loss of friendships, family relationships, and the support of religious communities as a result of disclosing their sexual or gender identity. This often leaves LGBT individuals with a sense of hypervigilance toward cues that a particular individual may or may not be supportive and affirming. Given the healthcare profession's history of stigmatizing and pathologizing patients' sexuality, care providers are, unfortunately, in a position of "guilty until proven innocent" in the eyes of many LGBT patients. Unless they do something to demonstrate the potential to accept and affirm patients' choices regarding the expression of their sexual or gender identity, patients are likely to assume that their providers will reject and stigmatize them.

Even in a large, sophisticated metropolitan center such as New York City, I have heard numerous LGBT mental health consumers say that they are not comfortable disclosing their sexual or gender identity to their therapists or psychiatrists. One woman continued to see a therapist she knew was homophobic, and avoided disclosing her sexual identity or relationships to him because, as she put it, "I needed him. There's a lot of things I need to get off my chest." Another patient pointed out that according to the APA, homosexuality is no longer a mental illness and was told by his psychiatrist, "Yes, but in your case it is a mental illness." Both consumers stated that their ability to freely discuss their sexuality in these treatment relationships was nonexistent (personal communications with author

by members of Rainbow Heights Club, 2004).

Inclusive Approaches to Serving LGBT Patients

Rainbow Heights Club, where I have served as Director for the past 3 years, is an agency that provides advocacy and psychosocial support to LGBT adults living with Axis I psychiatric diagnoses. The agency, which is funded largely by New York City's Department of Health and Mental Hygiene, was founded largely to address the fact that this population is vulnerable and underserved.

The following guidelines, excerpted from Rosenberg and colleagues,[14] constitute relatively simple and concrete steps that can lower the barriers to effective treatment, build working alliances, support disclosure and dialogue, and improve treatment compliance.

- Use inclusive language. This simple shift is perhaps the most important first step a clinician can take in building working relationships with consumers. In many clinics and inpatient units, male patients are routinely asked, "Are you married, or do you have a girlfriend?" Many LGBT consumers will interpret this question as a signal that the person asking it is unwilling to hear about other kinds of relationships. Language like this implies that care providers and institutions would prefer that LGBT consumers remain silent and invisible. Inclusive language, such as "Are you in a relationship right now?" or "What kinds of people do you tend to have relationships with?," is simple to use and may encourage a much broader range of disclosures;

- Be aware of subtle signals you may be sending. As noted, nearly all LGBT people at some point in their lives have lost or disrupted relationships with friends, family members, or religious communities by disclosing their sexual or gender identity. As a result, many of them are extremely aware of possible cues indicating whether a given person may or may not be accepting and supportive of them. For this reason, hanging a small pro-LGBT flyer in your waiting room, or posting information about LGBT resources on a bulletin board in your office or community, may help LGBT consumers feel that their disclosures are welcome;

- Welcome and normalize disclosures of sexuality or gender identity. A tentative disclosure of LGBT identity or experience can be welcomed with a simple "I'm glad you told me that." This can be followed with the same kinds of questions that would follow upon any consumer's mentioning of a relationship or experience, such as "What's he like?" or "Where did you meet her?" Showing an LGBT consumer that you are willing to put yourself in his or her shoes (eg, "That must have really hurt," or "That's great, I'm happy for you!") can have a tremendous effect on the working alliance and undo some of the estrangement from the mental health establishment that LGBT consumers have experienced. Many LGBT consumers report being stunned and deeply moved upon learning that their care providers empathize with them, support them, and wish them happiness;

- Use knowledge about a consumer's sexuality in discharge planning. At Rainbow Heights Club, a number of members have an extensive history of decompensations and hospitalizations and yet have managed to maintain long-standing, supportive, intimate relationships. When considering discharge-related and treatment compliance issues, the patient's romantic partner, extended family, and network of friends are all potential members of your treatment team and should be welcomed into family meetings. Partners, loved ones, friends, and family can provide crucial information, support with treatment compliance, and ongoing monitoring of the consumer's mental status. Welcoming these collateral contacts and taking them seriously can amplify the effectiveness of your work, demonstrate the fact that you value and support these relationships, and generate better outcomes. Conversely, if you never hear about these relationships in the first place, your ability to effectively support your patient's recovery is diminished;

- Avoid both over- and under-pathologizing. Echoing the mental health field's past tendency to pathologize same-sex desires and gender-discordant identities, some care providers interpret any expression or exploration of sexual or gender identity by a patient as further evidence of the person's mental illness. However, our patients' efforts to explore, understand, and express their sexuality, and to find connections with others, are often the locus of a great deal of creativity, resilience, courage, and even playfulness. These qualities deserve our support and admiration. By contrast, it is not helpful to assume that every possible expression of a consumer's sexuality or gender identity is to be celebrated. Sexual behavior has the potential to be destructive to both self and others in people with and without mental illness. Any such activity can and should be pragmatically evaluated in terms of its effects on the consumer's physical and emotional

health, self-esteem, and relationships;

- Be comfortable with your own sexuality. Issues of sexuality and gender identity raise anxiety and discomfort for many people. However, it is unfair and unethical to allow one's patients to suffer the fallout of this. As care providers, we must resolve our issues and conflicts concerning our sexuality and gender identity so that we can work effectively to help our patients build lives, identities, and relationships of their own choosing.

Shielding or Supporting?

As mental health professionals, we often hope to shield our patients from risk and harm. But this may not be what some of our patients need most. I have worked with a number of patients who choose to publicly display a highly gender-discordant self-presentation even though this frequently makes them targets of verbal and even physical abuse. These individuals insist that they much prefer to be true to themselves and accept the consequences, rather than hide the person they understand themselves to be. As care providers, our protective instincts might lead us to encourage patients to make their appearances more normative so that they can "blend in" and avoid becoming targets for further abuse. Ultimately, however, this choice is not for us to make.

We can certainly express concern for our patients' safety, inquire about social support, raise issues of self-protection and self-defense, and help them build affirming, accepting friendships and relationships. Ultimately, our patients will find the balance between safety and careful self-expression that works best for them. Realizing that they have the freedom to choose how they express themselves in different situations and contexts can be an important step in the therapeutic process. Failing to respect our patients' choices can needlessly disrupt the treatment alliance, or even cause a patient to leave treatment altogether. Conversely, by honoring our patients' choices, we may find ourselves deeply impressed by their creativity, courage, and conviction.

LGBT people living with mental illness are a vulnerable, underserved, and sometimes invisible population. Sexuality and gender identity are issues that provoke anxiety and uncertainty in nearly all of us. Awareness of the particular challenges they face can markedly improve the effectiveness of treatment.

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