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Lesbian, Gay, and Bisexual People with Severe Mental Illness

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Very little has been written about lesbians, gay men, and bisexual people (LGBs) with severe mental illness (SMI). In general, LGBs with SMI have the same mental health needs as their heterosexual counterparts. However, there is a need for some basic understanding and confronting potential bias among health practitioners. Although specialized services for lesbian, gay, bisexual, and transgender (LGBT) people with severe mental illness exist in some large metropolitan centers, efforts need to be made to expand access to services that are safe and welcoming to LGBT people, whether those services are specialized or not. Practitioners can help their LGB patients with severe mental illness by taking a thorough sexual history, being aware of gay-affirmative mental health services in their area, and advocating for services where none exist.

KEYWORDS  lesbians, gay men, severe mental illness, psychiatric services

INTRODUCTION

Consider the following vignettes:

Martha is a 70-year-old black woman living in a trailer in a rural area and supporting herself with Social Security and her teacher's pension. She never had mental health problems until five years ago, when her female partner of 30 years passed away. Martha and her partner had no connections to the lesbian community, had never been open about their relationship at work or with family, and had no close friends who knew them as a couple. In the five years since her partner's death, Martha...
has had a paralyzing depression and continues to find daily activities a struggle. She gets therapy and medications from the local community mental health center, where she is open about her sexuality to her individual therapist and psychiatrist but not to her women’s therapy group. She is also not out to her primary care physician. Martha has been diagnosed with Major Depressive Disorder and Complicated Bereavement.

Abby is a 43-year-old Latina lesbian, a survivor of childhood sexual abuse and the foster care system. She has had contact with the mental health system since she was a child and for many years went in and out of psychiatric hospitals due to cutting herself, alcohol intoxication, and suicide attempts. She has been in recovery from her alcohol use for four years and is attending therapy and psychiatry visits just once a month at the local university hospital clinic, as well as AA once a week. Abby lives with her partner, who is also in recovery from alcoholism, and both women support themselves with Supplemental Security Income (SSI). Abby is volunteering as a peer advocate in the university hospital psychiatric ER and is considering transitioning to part-time paid work as a step toward getting off of SSI. Over the years, Abby has been diagnosed with Borderline Personality Disorder, Post-Traumatic Stress Disorder, Bipolar Disorder, and Alcohol Dependence.

Larry is a 34 year old black man with a bipolar diagnosis and a reading learning disability. His reading problems and disruptive behavior made school difficult for him as a child; by his late teens he had been hospitalized for the first of many manic episodes. He is doing much better now, and is in his first apparently serious relationship with Johnny, who is ten years older than Larry. Johnny accompanies Larry to his appointments at the mental health center. When Larry’s therapist and psychiatrist attempt to discuss his relationship with a man, or connect him to resources at the local gay and lesbian community center, Larry giggles nervously and dismisses the relationship as “all about sex,” or “he’s just giving me a place to stay.”

Roger is a 25-year-old white man who has struggled with intense mood swings, hallucinations, and paranoia since his teens. At about the same time, he began using crack cocaine, and it is not clear whether his psychotic symptoms followed or preceded his drug use. What is clear now is that Roger often hallucinates when not using crack. He mostly has male sexual partners but also has girlfriends and considers himself “queer.” He attends a mental illness and chemical abuse (MICA) day program run by the state hospital but frequently misses appointments; he also uses local ERs when his symptoms are bothering him. Roger has not followed through with disability or social security applications and mostly lives off the support of friends and family. He has been diagnosed with Schizoaffective Disorder and Cocaine Dependence.
People with severe mental illness (SMI) also have been referred to as having severe and persistent mental illness (SPMI) or chronic mental illness. While operational definitions of these terms differ (Parabiaghi et al., 2006; Ruggeri et al., 2000; Schinnar et al., 1990), they generally refer to a person with a diagnosed psychiatric disorder (American Psychiatric Association, 1994) which causes serious difficulties with functioning in one or more areas (work, relationships, etc.) over a period of time (not just acutely or one episode of illness). It has been estimated that about 6% of the population can be considered to have SMI (Kessler et al., 2005).

Definitions of SMI are not diagnosis-specific but rather reflect more difficulties with functioning or more serious illness across diagnostic categories. Thus, a person diagnosed with major depression who is unable to work and has had several recent hospitalizations would be categorized as having SMI, while a person with schizophrenia who is partnered, working, and has minimal symptoms on her medication would not. While generally a diagnosis such as schizophrenia includes more people with SMI than those diagnosed with personality disorders or major depression, there is a wide range of illness severity and level of functioning across most psychiatric diagnoses.

Although the group of people with SMI is diagnostically heterogeneous, people with SMI do share some common characteristics. Many people with SMI are supported by long-term government assistance programs such as Social Security Disability (SSD) or SSI. People on SSD have accrued sufficient federal work credits before becoming disabled and are insured by Medicare. People on SSI, who did not have substantial work histories before becoming disabled, are covered under Medicaid. Both groups, as well as the other large number of uninsured and working-poor people with SMI, usually receive services through the patchwork of state, local government, and nonprofit voluntary mental health agencies known as the public mental health system. The public mental health system, so-called because its member agencies and hospitals receive some or all funding from state and federal governments, includes hospital and outpatient clinic treatment, intensive day programs, and partial hospital programs, as well as housing, case management, and vocational services for people with mental illness. Much has been written about the shortcomings, challenges, and limited resources of this system (President’s New Freedom Commission on Mental Health, 2003).

**Epidemiology**

Early studies on psychiatric disorders in LGBs were limited by a lack of representative samples. More recent studies have used large representative sample survey data. In these more scientifically rigorous studies, women
and men who report same-sex sexual partners show increased incidences of depression, anxiety disorders, post-traumatic stress disorder, substance use disorders, and suicidal thoughts and behavior (Cochran et al., 2007; de Graaf, Sandfort, & ten Have, 2006; Gilman et al., 2001; Sandfort et al., 2001). However, these studies are themselves limited in that women and men who have same-sex partners may identify as lesbian/gay, bisexual, or heterosexual. The studies either did not ask about sexual identity or combined subjects who identified as LGB with those who reported same-sex partners (Cochran et al., 2007).

One study using a national representative sample that did ask subjects about sexual identity found higher rates of generalized anxiety in lesbians and bisexual women compared to heterosexual women, and a greater prevalence of depression and panic disorder among gay and bisexual men compared to heterosexual men (Cochran, Mays, & Sullivan, 2003). Interestingly, this study found no significant differences in alcohol and substance dependence between LGB and heterosexual subjects. There is some support for the generally-held belief that any higher incidence rates found are attributable to the stress of being a sexual minority and discrimination faced by LGBT people (Mays & Cochran, 2001).

Research done on the incidence of psychiatric illnesses in LGB populations has either not included diagnoses such as bipolar disorder and schizophrenia or has not found those diagnoses in large enough numbers to be able to draw any conclusions. In general, we do not know if LGB people have a higher or lower incidence of severe mental illness than heterosexuals, but we may assume that the incidence is the same.

By some estimates, as many as two-thirds of people with SMI have a co-occurring substance disorder, either abuse or dependence. Since substance abuse rates have been found to be higher among LGBT populations (Sandfort et al., 2001; Gilman et al., 2001), we can infer that the percentage of LGBs with SMI who have a co-occurring substance disorder may be even higher.

SPECIAL CONSIDERATIONS FOR LGBS WITH SMI

The fact that little has been written about the sexual lives/sexual activities of LGB people with SMI reflects a larger reality that little has been written about the sexual lives of people with SMI in general. People with SMI, reflecting a practice dating back to the times of institutionalization, have often been regarded as children. As such, a person with severe mental illness has often been assumed to be asexual. Moreover, illnesses such as bipolar disorder and schizophrenia commonly have their onset in adolescence or early adulthood, the very time when people define their sexual identities and begin having an active sexual life. For many people with SMI, whether LGB or heterosexual, the process of becoming a sexual person, dating, and
finding a life partner has been derailed by severe illness and hospitalizations in their early adulthood.

Larry had his first hospitalization for mania at age 17. He missed his high school prom. As his friends either went on to college or jobs, Larry continued to have relapses of his bipolar illness and repeated hospitalizations. He eventually lost touch with his high school peers.

While people with mental illness rarely have their total care take place in inpatient institutions any more, they are still often treated within a system that “does for” them rather than approaching them as thinking adults. This system was put into place as a beneficent alternative to previous approaches to mentally ill people, and it is understandable that mental health clinicians and institutions traditionally took a directive and care-giving role with people who were severely ill. Increasingly, mental health consumers, as well as some providers, have begun to question such practices, and are pushing to make the system more recovery-focused and person-centered (Adams & Grieder, 2005; Davidson, Harding, & Spaniol, 2005). This shift has followed other advocacy efforts in medicine, notably in obstetrics and oncology, which have led to increased patient involvement and shared decision making in treatment (Edwards & Elwyn, 2001). In psychiatry, an important component of this shift in thinking is to better consider the whole person with SMI in terms of work, daily life, and relationships, which obviously includes sexuality.

Martha’s primary care physician tried unsuccessfully to treat Martha’s depression for several months, using an SRI antidepressant and regular visits with the social worker in his office, before referring her to the mental health clinic. The primary care physician and social worker never asked Martha explicitly about relationships with women, and Martha never revealed the precipitant of her distress.

The clinician working with a person with SMI should not assume that the person is heterosexual, or that he or she is not sexually active. A sexual history needs to be taken with people with SMI as with any other patient, and sexuality needs to be considered as an important part of the person’s life regardless of whether she is currently in a relationship.

Another important pitfall to avoid is that of confusing a patient’s sexuality with his or her psychiatric illness. For example, a physician seeing a lesbian or gay man with PTSD who has a history of childhood sexual abuse may erroneously attribute the sexual identity to her or his abuse history. While there is some data from nonrepresentative samples that suggest higher rates of childhood sexual abuse in lesbians than in heterosexual women (Balsam, Rothblum, & Beauchaine, 2005; Hughes, Johnson, & Wilsnack, 2001), it
would be erroneous to conclude that the abuse might be a causal factor in a woman’s lesbian identity (and this applies to men as well). There is a suggestion that causality might flow in the opposite direction, however. The Balsam et al. study (2005) showed higher rates of abuse in lesbians than in their heterosexual siblings. It is possible that the lesbian siblings were at higher risk for abuse because of their lesbian identity or because of gender atypical behaviors or appearance as children. Another study showing elevated rates of sexual and physical assault among lesbian, gay, and bisexual youth in general, but finding even higher rates among the subset of youth with gender atypical behavior (D’Augelli, Grossman, & Starks, 2006) supports this same conclusion.

One of Abby’s counselors remarked that “maybe [she] would have been able to have a ‘normal’ life with a man” if she hadn’t had such bad experiences with men in her childhood.

For people with SMI and co-occurring substance disorders, past clinical teaching called for the clinician to identify which disorder was “primary” and led to delays in treatment of people’s psychiatric disorders, as well as stern warnings by the psychiatrist to not mix drugs and medications. These guidelines led to some people stopping their psychiatric medications and dropping out of treatment. Current thinking is that it is important to treat both disorders simultaneously, preferably within the same treatment program (Muesner et al., 2003). We also know that starting medication for a psychiatric disorder early, even if it is not clear whether the disorder is substance-induced, can lead to better retention in treatment and a better chance of the person stopping their substance use. These guidelines are equally valid for LGB people with co-occurring disorders.

Roger’s day program has counselors trained in both mental health and substance abuse treatment. They are beginning to engage him using motivational interviewing, working with his family who attend treatment regularly, and by offering him small tokens for attendance at a “Should I get sober?” group.

Recent research has pointed to a potential 25-year reduced life expectancy for adults with SMI (Parks et al., 2006), due to chronic health factors such as smoking, obesity, physical inactivity, and reduced access to health care. Presumably LGBs with SMI would carry this same illness burden. This suggests that mental health clinicians have a role to play in attending to the basic health needs of their LGB patients with SMI, such as helping them to quit smoking and lose weight, and linking them with primary and specialty medical care.
SERVICES

There is a growing body of literature on lesbian and gay-affirmative psychotherapy and lesbian and gay-affirmative mental health services (Group for Advancement of Psychiatry, 2007; Drescher, 1998; Magee & Miller, 1997; Cabaj & Stein, 1996; Domenici & Lesser, 1995; Isay, 1987). The major principles of such therapies include a starting point of viewing LGB identities as normative, being willing to examine antigay feelings in both patient and therapist, and some knowledge about issues specific to lesbians and gay men, such as coming out. While this literature is almost entirely written from the vantage point of treatment with patients without severe mental illness, it may be applicable to people with SMI as well. Yet this body of knowledge is not always well-known to practitioners in the public mental health system. LGBT people receiving mental health services in public settings continue to report discrimination and insensitive care (Willging, Salvador, & Kano, 2006) and have been shown in at least one study to have lower rates of satisfaction with their care than a general sample of patients (Avery, Hellman, & Sudderth, 2001).

In frustration, Larry’s therapist asks him, “Why can’t you just accept that you’re gay?” Larry misses the next several appointments. The therapist finds and attends a professional conference in a nearby city on treating LGBT people, and learns more about the coming out process.

Most large urban centers, and many smaller ones, have LGBT Community Centers with support and social services for LGBT people, yet these too are mostly targeted at the general LGBT community and not specifically for those with SMI. Thus, LGB people with severe mental illness may not feel welcome in these centers, or may feel alienated from the other center participants by their illness (Hellman, 1996; Hellman & Drescher, 2004). Although some local Alcoholics Anonymous and Narcotics Anonymous chapters have established special groups for LGBT people in recovery, LGB people with SMI may feel more comfortable in Double Trouble Recovery (DTR) groups, that is, recovery groups for people with co-occurring mental health and substance abuse problems that acknowledge their mental illness and accept their use of psychiatric medication.

A few specialized services for LGBT people with SMI do exist which overcome these barriers. These include peer-run psychosocial clubs, services within larger mental health programs, and services within specialized health centers for LGBT people (Hellman & Drescher, 2004; Huygen, 2006; see also Resources). Such specialized programs can provide a place where LGB’s with SMI can feel able to be open about and address all aspects of their identity.
Many areas of the United States still have no services available for LGB people with SMI. Clinicians who want to provide the best care for these patients will need to play an advocacy role. They can call the local mental health center and ask if the center provides gay-affirmative treatment. They can similarly inquire of the local LGBT community center, if one exists, about whether services are welcoming to individuals with SMI. They can consult with LGBT mental health specialized services in other geographic areas, or get specialized training in order to better treat their patients. Finally, clinicians can advocate with state and local governments and community leaders for the creation of more sensitive and welcoming services for this population.

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