

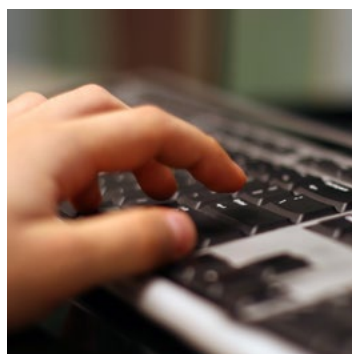
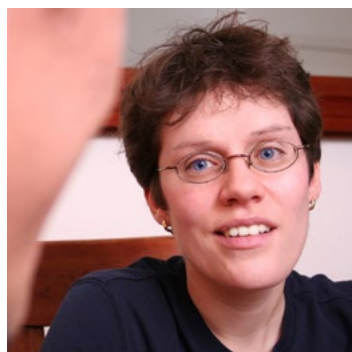
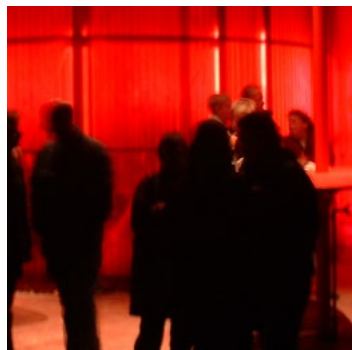
LGB&T People & Mental Health: Guidance for Services and Practitioners

Written for the National LGB&T Partnership by
Meg John Barker, Ruth Overton, Patricia Durr, Lucy Rolfe,
Heather Williams, Caroline Walters & Christina Richards



Contents

Introduction	2
Gender and sexual diversity	3
Lesbian, Gay and Bisexual people	6
LGB people and mental health	6
LGB people and mental health support	7
What you need to know about LGB people	7
Good practice in services	8
Good practice for practitioners	8
Trans people	9
Trans people and mental health	9
Trans people and mental health support	9
What you need to know about trans people	10
Good practice in services	11
Good practice for practitioners	11
Conversion therapy	12
Further resources link	12



Introduction

International and national research consistently finds that lesbian, gay, bisexual and trans (LGB&T) people experience higher rates of mental health problems than other groups. Additionally, LGB&T people often do not feel able to be open about their gender and/or sexual identities with health professionals, and some still sadly experience discrimination from services or practitioners.

This booklet aims to give you the basic information that you need about gender identity and sexuality, and the needs of LGB&T people in relation to mental health. We are aware that this is an area which many people remain confused about. We hope that you will find it an accessible overview which will help you in your work with LGB&T people.

Throughout the booklet we provide clear lists of good practice when working with LGB&T people, which can be implemented in services and by practitioners. At the end of the booklet there is also a link to a website of further resources which provided a large part of our evidence base. These are good places to go to if you want to find out more. It also includes community resources which will be useful to refer clients or patients on to.

Thank you for reading.

Gender and Sexual Diversity

This booklet focuses on LGBT people because these groups have been found to be particularly at risk of mental health difficulties. However, it is important to remember that everybody has a gender and sexual identity, which may or may not be relevant to any distress or mental health issues that they experience. In this section of the booklet, we give a brief overview of key aspects of gender and sexual diversity that it is worth being aware of when working with all clients or patients. First, here are a few definitions.



Sex

This term refers to physical characteristics generally regarded in binary terms as either male or female. This binary biological distinction is problematic, as there is diversity at all levels of biological sex including chromosomes, hormones, brain and body. Therefore, it's not inclusive of the diversity of sex development which exists.

Gender

Gender refers to the roles, behaviours, activities, and attributes that a given society considers appropriate for males and females. This can cause difficulties for many as they can feel constrained by assumptions about gender.

Trans (transgender) people don't identify as and/or present as the gender commonly associated with the gender they were assigned at birth, some or all of the time. Cisgender (cis) people do. Non-binary people don't experience themselves as either male or female. It isn't necessary to specify whether somebody is trans or cis, binary or non-binary, unless directly relevant (e.g. to a medical procedure) or they identify themselves in this way.

"I have been continually bullied at work through a variety of jobs because of my sexuality. I believe that this has had a detrimental effect on my mental health."

Sexual orientation

Some people are attracted to people of one gender - heterosexual, lesbian or gay - whereas others are attracted to more than one gender, or do not find gender to be important in determining their attraction - bisexual, pansexual or queer.

Sex and sexuality

Sexuality is how an individual defines and expresses their sexual self. People often assume that 'sex' means penis-in-vagina intercourse leading to orgasm. However, there are a wide variety of sexual practices that people engage in, many of which do not necessarily involve genitals or orgasms. They can be done alone, with another person, or with more than one person. These can be as, or more, important to somebody's sexual identity than the gender of their partners, and may involve various sensations, roles, or dynamics. People should not be pathologised for the consensual sexual practices they share with another adult or adults, as there is no relationship between specific sexual practices and mental health difficulties.

Level of sexual desire

Levels of desire also vary, between people and across their lifetimes. Asexual people, who don't experience sexual attraction, should not be pathologised as there is no relationship between stable periods of high, low or no sexual desire and mental health difficulties. A change in levels of desire can be related to some mental and physical health conditions.

Relationships

There are various models of sexual - and non-sexual - relationships including versions of being single, monogamous, and non-monogamous. Again, none should be pathologised.

"I haven't had informed reactions in the past and would like to be confident that whoever I was coming out to wouldn't make assumptions about me."

Gender and sexual diversity

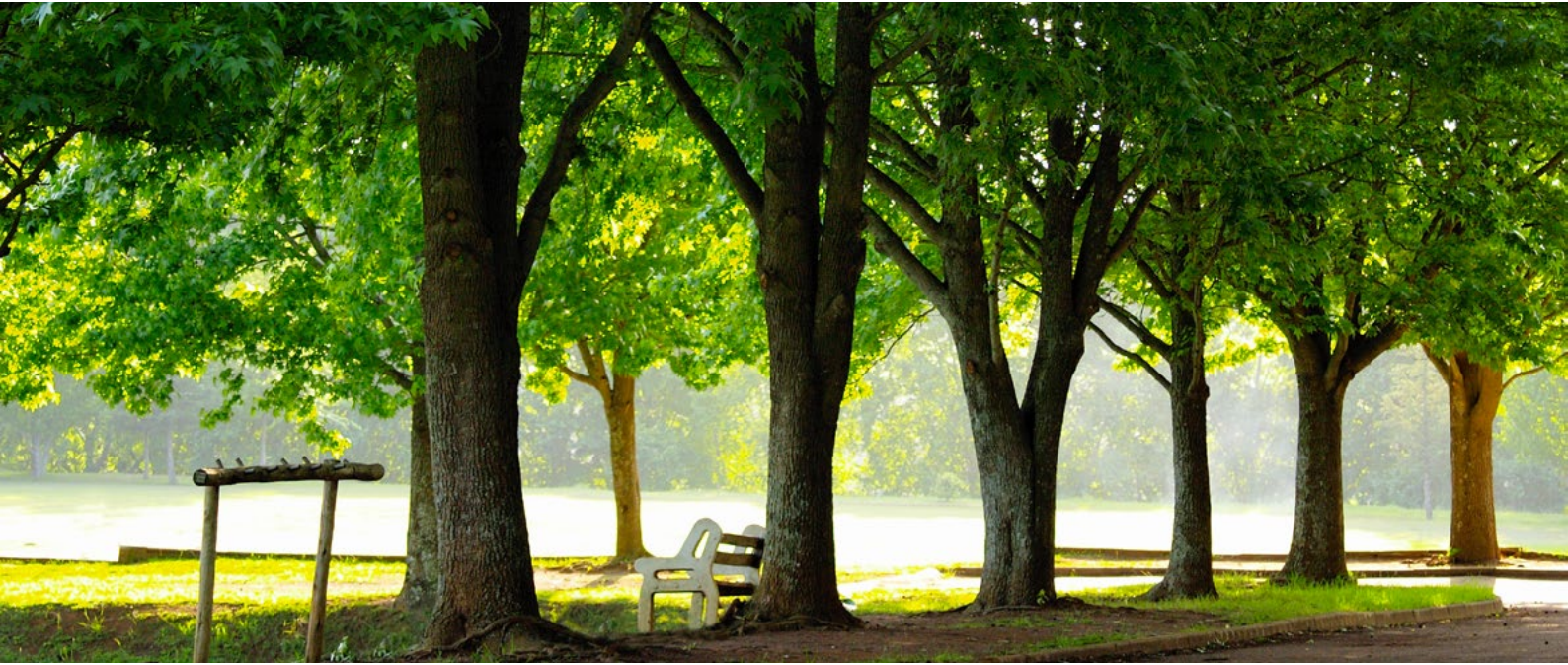
Some genders and sexual identities are seen as more 'normal' and acceptable than others, and some have historically been viewed as criminal or as mental 'disorders'. People who fit into the perceived norm are less likely to face certain issues to those outside the norm. This is due to prejudice and discrimination from others - often called minority stress.

Additionally, gender and sexual identity are commonly viewed as fixed and so something people have for life. It is important to understand that some people experience their gender and sexual identity in this way, whereas others find that their experiences of gender and/or sexual identity change over the course of their lives. Assuming that a client or patient has always, or will always, identify in the same way can be unhelpful - particularly when supporting someone who has come out about their sexual or gender identity at a later stage in life.

It is commonly assumed either that people have chosen their gender or sexual identity, or that they are biologically 'born that way', but gender and sexual identity are the result of a complex combination of biological makeup, individual psychology, and social context, which varies from person to person. The important thing is that gender and sexual identity are respected, and that there is fair and equal treatment.

Finally, a person's gender and sexual identity intersects with other aspects of identity, meaning that people's experience of their gender and sexual identity may differ depending on their age, class, race, ethnicity, geographical location, generation, and many other factors. It is important to keep this in mind when finding out what terms people prefer and how they understand their own gender and sexual identity.

Improving mental health and wellbeing



Research has found that people have better mental health and wellbeing if:

- ▶ They feel able to express their gender and sexual identity as they experience it.
- ▶ They can be open about their gender and sexual identity with people around them.
- ▶ People around them use their preferred terms.
- ▶ Their wider culture is aware and accepting of gender and sexual diversity.
- ▶ They have a sense of community and support.

“Self-harming provided me with comfort. My whole life I was a reject from society. I didn’t take it out on others. I took it out on myself.”

People do worse if:

- ▶ Their gender or sexual identity is stigmatized or marginalized.
- ▶ Their gender or sexual identity is invisible.
- ▶ Others assume their gender or sexual identity is the reason for their distress.
- ▶ They can’t be open about their gender or sexual identity, or somebody else discloses it without their consent.
- ▶ They feel that they have to educate people about their gender or sexual identity.
- ▶ They are asked inappropriate questions about their gender or sexual identity (which wouldn’t be asked of people of other genders or sexual identities).

Lesbian, Gay, and Bisexual (LGB) people

LGB people and mental health

International and national research has consistently found that LGB people have worse mental health than heterosexual people. LGB people are far more likely to have attempted to take their own lives, and rates of depression, anxiety and self-harm are also much higher. Bisexual people have particularly high rates of mental health problems.



The key reason for these higher rates of mental health problems is the impact of discrimination, stigma, bullying and abuse on LGB people. We live in a society where being heterosexual is the 'norm'; this is called heteronormativity. People who are not heterosexual report significant negative impacts on their day-to-day lives, because of the attitudes they experience from others. Early acceptance, emotional support and having someone to talk to are the key resilience factors that enable us to manage key milestones and life stages. For many LGB people, these factors have been absent, particularly as young people. Keeping one's sexual identity hidden from others and living with the fear of having it disclosed can create additional stress. We know that at least a third of older LGB people report hiding their sexual identity throughout their lives.

"I really had a sense that she respected us and that she had respect for our experiences. I think there were times when we were both thinking 'oh my God this isn't going to work out' and it seemed like she was the one that was kind of carrying the torch for our relationship."

Experience of mental health problems mean that LGB people can also experience isolation and poorer physical health, and may not reach their full potential in areas of life such as work and education. They have a greater risk of other experiences such as domestic abuse, drug use, poverty and homelessness, and greater risk of harmful behaviours such as alcohol dependency and smoking.

Lesbians and gay men face many similar experiences of discrimination to one another. However, lesbians may also face discrimination specific to the fact that they are gay and female – this mix of homophobia and sexism is sometimes called 'lesbophobia'. Gay men particularly, may encounter

socialisation and expectations about what it means to be a man, which assume heterosexuality, and often limit their self-expression and behaviour.

In addition to homophobia, bisexual people face biphobia due to the fact that wider culture often regards sexual orientation as binary: either a person is gay or they are straight. This is why bisexuality is often dismissed as 'a phase', 'confusion', or 'greediness'. Such bisexual erasure explains the lack of openly bisexual people in the media, as well as the common experience of discrimination from both heterosexual and lesbian/gay communities.

"Loneliness is a problem for older gays, especially when living in rural and remote areas, which can lead to mental health issues."

LGB people and mental health support

Despite a high prevalence of mental health problems, LGB people are less likely than heterosexual people to access support. This is not surprising considering that half of LGB people have had negative experiences with healthcare professionals, with many reporting professionals attempting to link their sexual orientation to their mental health issues, or even attempting to change their sexual orientation (see later section on conversion therapy). Of those who have come out to mental health professionals, only just over half reported that the practitioner reacted positively to their sexual identity.

It wasn't until 1992 that homosexuality was removed from the international classification of diseases mental disorders list, and some older LGB people may have received 'treatment' from mental health professionals for their sexual identity. This could make older LGB people less likely to be open to healthcare professionals, or even act as a barrier to them accessing services at all.

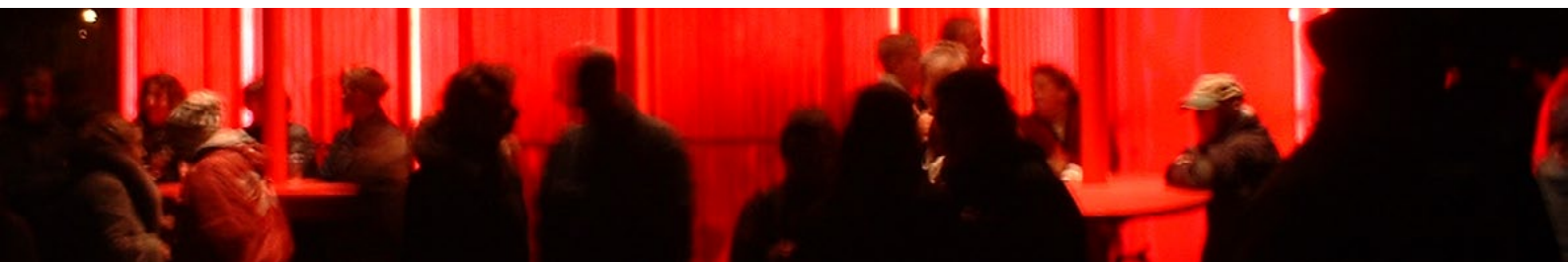
What you need to know about lesbian, gay and bisexual people

Lesbians are women who are attracted physically, emotionally or romantically to other women. Gay men are men who are attracted physically, emotionally or romantically to other men. Bisexual people are attracted to more than one gender, or to people irrespective of their gender.

As sexual identity is not routinely monitored, there are no accurate figures about how many people in the UK identify as LGB. It is estimated that between 1-7% of people identify as gay or lesbian, whilst around 2-4% of the population identify as bisexual. However, between a quarter and a third of people have some degree of same-gender attraction, either exclusively or in addition to other-gender attraction.

Some people use the words lesbian, gay and bisexual for their sexual identities, while others use different words (such as pansexual or queer) or prefer not to label their sexual identity. This may be due to fear of discrimination and/or cultural and generational diversity in language use. It is important to affirm that it is for every person to decide how they want to describe themselves and that this may change over time.

Some groups of LGB people experience further marginalisation due to intersecting identities and experiences which put them at greater risk of stigma, invisibility and mental health problems. These groups include, but are not limited to, younger and older LGB people, black and minority ethnic LGB people, disabled LGB people, trans LGB people, and LGB people with religious faith or spiritual beliefs.



Good practice in services

- ▶ Be clear that UK equality legislation does not allow discrimination on the basis of sexual orientation and that attempting to change sexual orientation is not accepted by any of the UK medical, counselling or therapy bodies. Ensure that this is reflected across the service.
- ▶ Ensure that all staff are trained in, and have a good understanding of, matters of gender and sexual diversity including LGB identities.
- ▶ Ensure visibility of LGB people. For example, using images and inclusive language, peppered throughout websites, posters, magazines and other resources.
- ▶ Challenge homophobia and biphobia. Raise awareness of and challenge negative stereotypes about LGB people; encourage regular, open conversation. Ensure homophobia and biphobia are included in documents relating to bullying and discrimination and that these are enforced and are not tokenistic.
- ▶ Encourage a culture in which staff can be openly LGB through supportive networks and affirmative policies and practices.
- ▶ Ensure monitoring includes sexual identity. Be clear with clients how this information will be used and that it is confidential; and ensure that staff and volunteers feel confident when gathering this information.
- ▶ Involve LGB people in developing services.

Good practice for practitioners

- ▶ Ensure that you have received sufficient training in matters of gender and sexual diversity including LGB identities.
- ▶ Know and understand that UK equality legislation does not allow discrimination on the basis of sexual orientation and that attempting to change sexual orientation is not accepted by any of the medical, counselling or therapy bodies.
- ▶ Never attempt to change an LGB person's sexual identity, or pathologise their sexuality in any way.
- ▶ Don't expect your clients to educate you. Please use the resources at the end of this briefing.
- ▶ Be aware of cultural stereotypes that you, or other members of staff, may hold. Be careful not to assume a person's sexual identity on the basis of information such as a person's physical appearance, whether they are a parent, or the gender of their current or previous partner(s). Be careful to use whatever labels clients themselves use.
- ▶ Give consideration to the social context of distress (i.e. that it likely stems from experiences of prejudice and marginalization), and familiarise yourself with community support, particularly from others in the LGB communities.
- ▶ As always, it's important to be positive and affirming of LGB identities and experiences by accepting the client's description of their sexual identity and valuing the courage required to come out.

"A psychiatric nurse asked me what I'd done at the weekend and I mentioned I'd been at a bisexual event, and as a result came out as bisexual. He seemed fine at the time but when it came to see my counsellor, I found out that my referral letter said that I had unresolved issues with my sexuality. I hadn't said anything like that! I felt so betrayed, knowing that he'd secretly been judging me like that."

Trans people

Trans people and mental health

Trans people are people whose gender identity does not match the gender they were assigned at birth. International and national research has found that trans people who do not receive adequate support can experience higher rates of mental health problems than cisgender (non-trans) people.

The Royal College of Psychiatrists, the British Psychological Society and the American Psychiatric Association have released position statements which recognise that, while having gender dysphoria can be intensely distressing, it is not, in and of itself, evidence of psychopathology or mental illness. Indeed, research shows that trans people do not have higher rates of psychopathology than cisgender people, if they're well supported in their transition.



One of the key factors which can cause distress for trans people is discrimination. By no means all trans people experience this, but sadly some do and it can, understandably, affect mental health. Mental distress can also occur when a trans person is unable to access appropriate care in a timely manner, which may include such things as hormonal and surgical assistance and emotional support.

Mental distress from such experiences can result in self-harm and suicide and sadly, there is evidence that the rates of suicide and suicide attempts in some trans populations are disproportionately high. However many trans people are, of course, mentally healthy and psychologically robust. A thoughtful approach therefore, which neither views trans people as inevitable victims, nor as being in an entirely non-stressful position, is warranted.

"When I tried to kill myself and was taken to a suicide center, I was made fun of by staff and treated roughly."

Trans people and mental health support

Historically some trans people have had problems with mental health services. Trans identities have been pathologised and this still persists in some settings, which may leave some trans people mistrusting clinicians. This is changing, especially with the increasing numbers of clinicians who are trans themselves, but it's useful to recognise that clinicians may need to build rapport from a position of deficit, and may therefore not be at a neutral starting point. This is important as trans people can, of course, suffer from any of the forms of mental distress that anyone else can and should be treated appropriately. As part of this, it's important to note that the NHS gender clinics have made it quite clear that if a trans person has a managed mental health issue such as schizophrenia, bipolar disorder etc., then that shouldn't prevent them from accessing trans-related services.

What you need to know about trans people

Trans or transgender (sometimes also written with an asterisk - trans*) is an umbrella term which includes a number of different ways in which people express their gender identity. Some trans people transition on a permanent basis from their birth assigned gender to the gender they identify as. So a trans woman will have been assigned male at birth and will transition to be a woman, possibly with hormonal or surgical assistance. Conversely a trans man will have been assigned female at birth and will transition to be a man, again possibly with hormonal or surgical assistance. After transition they will, of course, simply be a woman or a man respectively.

"I have several health issues and have been refused care by one doctor who 'suggested' that I go someplace else because she could not treat me since she 'did not know anything about transgender people.'"

Other trans people, sometimes called cross-dressers or 'transvestites', (although 'transvestite' is not a safe term and should not be used unless the client/patient uses it to refer to themselves), spend some time in a gender role other than the one assigned at birth and some time in the gender they were assigned at birth. This too is an entirely acceptable way of being. A further group of trans people, often referred to as non-binary people, fall between, or outside, the man/woman binary, and may adopt self-descriptions such as: genderqueer, agender, bigender, pangender or gender neutral (see further resources on page 12 for descriptions of these terms).

All these groups of trans people will respond to mental health interventions in much the same way as anyone else. However, as with all clients, (but perhaps more so with trans people), rapport can be irretrievably damaged if the person is not treated with appropriate respect, both in general and in relation to their gender.

It can be useful to remember that some groups of trans people experience further marginalisation due to intersecting identities and experiences which put them at greater risk of stigma, invisibility and mental health problems. These groups include, but are not limited to, younger and older, black and minority ethnic, disabled, and LGB trans people, and those with religious faith or spiritual beliefs.



Good practice in services

- ▶ Be clear that UK equality legislation does not allow discrimination on the basis of gender identity or gender reassignment.
- ▶ Ensure that all staff are trained in and have a good understanding of matters of gender diversity and a working knowledge about trans people.
- ▶ Challenge transphobia; raise awareness of and challenge negative stereotypes about trans people; encourage regular, open conversations; ensure transphobia is included in documents relating to bullying and discrimination.
- ▶ Ensure that staff recognise that it is not acceptable for any personal beliefs about trans people to adversely affect their professional practice.
- ▶ A person's gender of presentation should generally be respected in terms of name, address, accommodation, facilities, toilets etc.
- ▶ Remember that endeavoring to convert someone from being trans is not a recognised or appropriate clinical practice (see section on conversion therapy).
- ▶ It is useful to encourage a culture in which trans staff are supported and can be open through supportive networks and trans-affirmative policies and practices.
- ▶ It is particularly important for trans people that their privacy and confidentiality is assured at all times. Data collection should include gender identity questions, but any data collected must have a clear purpose, and must indicate how sensitive information about gender histories is to be protected. Breaches of the Data Protection Act 1998, may have serious consequences for trans people, and where they have a Gender Recognition Certificate, such a breach could amount to a criminal offence for the clinician, even if it is standard policy.

"It was such a relief to see somebody who had a clue. There was no sense of me having to educate him. He knew plenty about trans, and also never assumed that it was anything to do with my depression."

Good practice for practitioners

- ▶ It is essential to build rapport, for instance, by using appropriate names, titles and pronouns. Always respect how the person identifies and if you are unsure, ask politely, how the person wishes to be addressed.
- ▶ Trans people will see clinical practitioners for the same range of reasons a cisgender (non-trans) person will. Consequently, it is important that the fact that the person is trans does not inappropriately influence the clinician's practice. Just as certain attributes a person has – their ethnicity, sexual orientation, religion, age etc., may be relevant to the presenting situation, it also may not be.
- ▶ If a trans person approaches you in your clinical practice it is important not to assume that they are there to educate you. Good practice is to have a basic level of knowledge about trans experience and then adapt that understanding to fit your client's unique experience. One of the most common complaints made by people from minority backgrounds is that of being required to educate clinicians with basic information. This can make the client lose confidence in you and feel marginalized and uncomfortable.
- ▶ If you wish to gain further information, then the resources at the end of this factsheet are a good place to start and many groups offer training on these topics.
- ▶ It is acceptable however, to ask about things you are unsure of in a kind and matter-of-fact way.

Conversion therapy

Sometimes called reparative therapy, conversion therapy is an umbrella term to describe a range of treatments that aim to change sexual orientation or gender identity. Historically, conversion therapy has included various types of interventions, such as aversion therapy and electric shock therapy as well as talking therapies.

“When I told my therapist that I was bisexual and that I was having trouble finding a place in society where I fit in, he assumed I wanted help to become straight. He referred me for CBT to ‘cure’ me”

Can conversion therapy change a person’s sexual or gender identity?

There is no evidence to show that conversion therapy can change a person’s sexual or gender identity, and there is research which shows that it can be harmful. The Government and UK therapeutic governing bodies strongly condemn conversion therapy and the harm it can cause.

Is conversion therapy only carried out by religious fundamentalists operating outside professional channels?

No. A 2009 survey of more than 1,300 UK mental health professionals showed that 17% had ‘... assisted at least one client/ patient to reduce or change his or her homosexual or lesbian feelings.’ It also showed that of those clients treated, 40% of those clients received the therapy in an NHS practice. While much of this was historical, additional research has found that some practitioners still attempt to change bisexual people’s sexual orientation (either to gay or to heterosexual), and/or endeavor to prevent trans people from expressing their gender identity. Of course most compassionate clinicians wouldn’t dream of doing such a thing, but it is important to assist and educate colleagues who may consider such interventions believing that they are acting in the best interests of the client/patient.

“I think just a bit of respect and a willingness to listen/talk about it is all that’s needed. I don’t think my sexuality means I have special considerations; I just expect it to be treated as something that’s a part of my identity and is acceptable.”

Do people who seek conversion therapy do so freely?

LGB&T people can experience discrimination and lack of acceptance from their families, communities and wider society. Evidence has shown that LGB&T people who have conversion therapy frequently feel pressurised or coerced to do so and commonly report experiences of depression, lack of self-worth, anxiety and suicide attempts as a result. There are some LGB&T people who struggle to accept their own identity, which is often called ‘internalised homophobia/biphobia/transphobia’. This should not be interpreted as a wish to engage in conversion therapy or to change identity, but rather as a signal that an individual needs to explore the issues that concern them, in a supportive and accepting space.

Further Resources

In order to keep up-to-date, we’ve provided links to further resources on our website. Here you will find links to the research underpinning this booklet; to further resources for services and practitioners; and to community resources where clients can be directed.

www.nationallgbtpartnership.org