No Need to Hide: Out of the Closet and Mentally Ill

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Research suggests that the mental health needs of the lesbian, gay, bisexual, and transgendered (LGBT) population differ from those of heterosexual seriously mentally ill individuals. Unfortunately, the unique treatment needs of the LGBT population who suffer from serious mental illness are often overlooked, even though self-acceptance and support have been shown to go a long way in ameliorating the stresses and risks faced by LGBT persons. Despite these findings, mainstream clinics and hospitals seldom make a commitment to provide LGBT consumers with culturally competent and affirming treatment. This paper will present an overview of the dynamics of the dual stigma of being an LGBT person living with a major mental illness. The paper will discuss the history and development of a psychosocial and support agency, the Rainbow Heights Club, which was developed to address the unique social needs of this population and help them to participate maximally in the community.

Key words: *bisexual; consumer input; gay; lesbian; mental illness; transgender; stigma*

Introduction

Research suggests that the mental health needs of the lesbian, gay, bisexual, transgendered (LGBT) population differ from those of heterosexual seriously mentally ill individuals and that mainstream mental health care systems may not fully address their concerns. Cochran and Mays (2000) studied suicide symptoms of men with same sex partners and found a higher prevalence of suicide symptoms over their lifetime than men reporting female partners only.

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Although the empirical research on the prevalence of psychiatric disorders among LGBT individuals, as well as studies evaluating the effectiveness of various interventions, is only in its early stages, a number of studies indicate that gay men and lesbians show elevated risk for psychiatric morbidity when compared with heterosexuals. Fergusson, Horwood, and Beautrais (1999) found that by age 21, LGBT individuals were at increased risk for major depression, conduct disorders, substance abuse and/or dependence, suicidal ideation, and suicide attempts. The pattern holds at midlife as well. Cochran, Sullivan, and Mays (2001) found evidence that lesbian, gay, and bisexual respondents to the National Survey of Midlife Development in the United States showed increased risk for psychiatric disorders as compared with heterosexual women and men. Elevated risk for suicide attempts has been found in lesbian, gay, and bisexual-identified youth (Fergusson et al., 1999; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Remafedi et al., 1998), homosexually experienced youth (Faulkner & Cranston, 1998, Russell & Joyner, 2001), and homosexually active adults (Cochran & Mays, 2000; Gilman et al., 2001) as compared with heterosexually classified counterparts. Several studies also demonstrate that lesbians and gay men show a greater risk for comorbidity of alcohol and substance abuse (Cochran, Sullivan, & Mays, 2001; Fergusson et al., 1999; Sandfort, de Graaf, Bijl, & Schnabel, 2001).

Unfortunately, the unique treatment needs of LGBT individuals who suffer from serious mental illness are often overlooked, even though self-acceptance and support have been shown to go a long way in ameliorating the stresses and risks faced by LGBT persons. Hershberger and D'Augelli (1995) found in a study of the effects of victimization on the mental health and suicidality of LGB youth that self-acceptance was a strong predictor of mental health. A study of the relationship between social support, AIDS-related symptoms, and depression among gay men found that level of satisfaction with emotional, practical, and informational support was inversely correlated with depression, and that men who were more satisfied with their level of social support were less likely to show increased depression one year later (Hays, Turner, & Coates, 1992).

It can be concluded, therefore, that LGBT people often show a higher incidence of certain psychiatric disorders, suicidality, and comorbidity and that acceptance and support appear to provide significant amelioration of such difficulties. However, despite these findings, mainstream clinics and hospitals seldom make a commitment to provide LGBT consumers with culturally competent and affirming treatment.

This paper will present an overview of the dynamics of the dual stigma of being an LGBT person living with a major mental illness. The paper will discuss the history and development of a psychosocial and support agency, the Rainbow Heights Club that was developed to address the unique social needs of this population and help them to participate maximally in the community.

Stigma

LGBT individuals with serious mental illness are subject to dual stigma which stems from societal discrimination toward same sex preference and bias against

mental illness. In addition, the LGBT seriously mentally ill may be shunned by homosexual peers who are not themselves living with mental illness, or believe themselves not to be. In the classic perspective elaborated by Goffman (1963), stigma is conceptualized as an "attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted, discounted one" (p.3). Persons who are stigmatized possess characteristics which position them outside of the expectations established by socially accepted norms. Stigma represents a relational attribute, a mark, associated with a person that links him/her to undesirable stereotypical characteristics (Link & Phelan, 2001). Stigma is not merely a label, but rather directs social attention to something in the person which inherently makes the person tainted. As such, the victims of stigma are blamed for being socially unacceptable. Whereas individuals diagnosed with cancer are referred to as having cancer, individuals diagnosed with schizophrenia are seen as being schizophrenic. Research shows that stigma is a central process that has serious consequences in shaping the pursuit of activities related to life chances: occupation, education, health, and general well-being. In the case of LGBT persons with severe mental illness, this becomes compounded by the duality of the stigmatization process and the spillover into all areas of social and subjective experience.

The process of stigmatization unfolds when five critical components converge: 1) Labeling; 2) stereotyping; 3) separating "us" from "them"; 4) status loss and discrimination; and 5) an imbalance of power (Link & Phelan, 2001).

1) Every junior high school student knows that the worst thing you can call someone is "faggot" or "dyke." For LBGT persons, sexual preferences are socially identified as normatively different and as such, they are labeled as distinct from heterosexuals. Similarly, the seriously mentally ill are viewed as different from the norm, due to what some consider bizarre behaviors and/or appearance. In both cases, the seriously mentally ill and LGBT individuals are seen as significantly different and deviating from social standards. Labeling differences is an important first step along the road to stigmatization.

2) Once LBGT persons who are seriously mentally ill have been socially labeled as different, the second step in the stigmatization process is to assign these differences a negative attribute. As such, gays and lesbians are perceived to be different in negative ways, as amoral, inadequate, insufficiently developed, or deviant. In addition, their mental illness leads to further social exclusion due to societal attitudes toward mentally ill persons including the belief that the mentally ill are dangerous and bizarre, and therefore, should be socially shunned.

3) LGBT persons are denied access to basics such as housing and employment. The mentally ill experience a similar situation when confronted with the NIMBY (not in my backyard) phenomenon when residential programs seek to develop housing or there is a rehabilitation program featuring supported employment. There is a denial of access and in extreme cases, when a stigmatized group becomes dehumanized, they can become victims of fatal violence.

4) Once the process of stigma construction evolves to the point where negative associations are group specific, members of such groups experience downward mobility and status loss, and due to their negative stereotype, become the subject of discrimination. Low social status engenders low self-esteem. For those who are chronically mentally ill, a process of self-designation evolves where clients refer to themselves as having become a schizophrenic, rather than having schizophrenia (Estroff, 1981). Their illness defines who they are and evolves into a loss of social roles and identity. Identification with the LGBT sexual minority population further complicates this loss of social acceptance. The comparatively higher incidence of substance abuse and suicide among LGBT adolescents attests to the deleterious effects of stigma (Fergusson, Horwood, & Beautrais, 1999).

5) The ability to construct a complex system such as stigma is dependent on an imbalance of power: those who actively participate in stigmatizing others must have the power to proceed unchecked, and victims of stigma must lack sufficient power and resources to counter and oppose status loss, marginalization, and a reduction in life chances. In effect, the process of social stigmatization rests on social, economic, and political power over the populations designated for stigma. Despite the demographic incidence of homosexuality (estimated at 15% to 20% of the population), LGBT individuals remain a socially marginalized population whose members do not readily identify themselves, particularly those in positions of power, such as elected officials, corporate executives, and professionals. Similarly, the mentally ill are equally underrepresented in positions of social and political power. Whereas they are overwhelmingly dependent on social programs for their subsistence, they have not become a political voting block capable of influencing the political process.

Thus, in the field of mental health, stigma constitutes a psychosocial stressor that warrants the attention of mental health practitioners and planners as a public health matter. In this light, the development and implementation of the Rainbow Heights Club responded to the public health needs of the targeted population. The challenge was to create a program that would confront the manifold stresses created by stigma and provide an affirmative atmosphere for psychological, social, emotional, and physical well-being. The staff developed and, through grant funding, implemented their idea to create The Rainbow Heights Club, a supportive, sensitive place to affirm one's identity as an LGBT consumer of mental health services.

Program Description

The Rainbow Heights Club is a psychosocial and advocacy program that serves LGBT people ages 18 and older who have a past or present Axis I diagnosis. The emphasis is on creating a safe space within which people can disclose both their sexual and psychiatric issues, find social support and acceptance, feel like a welcome member of a community, find that they can offer support and acceptance to

others, and be heard and validated. The Rainbow Heights Club opened its doors in September 2002, with a membership of 15 and a daily census of four or five people. The daily program was unstructured, with one formal group planned daily, no support groups, and relied on the milieu provision of support to members. By June 2004, the Club total membership was 188. The breakdown was male: 118 (63%); female: 70 (37%); transgender: 20 (11%); Native American: 3 (2%); Asian/Pacific Islander: 5 (3%); black, non-Latino: 40 (21%); Latino: 36 (19%); white, non-Latino: 102 (54%); other: 2 (1%); persons ages 0 to 17: 0; ages 18 to 34: 51 (27%); ages 35 to 64: 131 (70%); and ages 65 and over: 6 (3%). It is thought that Club growth was facilitated through a plan of increased member input and outreach.

In designing the program, the Rainbow Heights Club was inspired by traditional psycho-social clubs which allow for a great deal of member choice and participation in program development. Ongoing consumer input is an indispensable part of the work at the Rainbow Heights Club. To solicit consumer input and, even more importantly, to promptly act on it, is paramount in empowering consumers and in valuing what they have to say. Staff vividly recall the first day that a club member suggested the addition of a particular discussion group to the schedule. The director said, "That's a great idea," and immediately wrote the group into the schedule posted in the members' club room. Everyone in the room looked shocked by the possibility that their thoughts and ideas would be taken seriously. Members requested that the club have a computer room, and currently there is a place for members to access the Internet, use literacy software, use typing-skills and word processing programs, all of which are avidly used by club members.

At the club, all staff and members respect the right of each member to express their sexual and gender identity. This is a particularly important point for transgender club members, because many of them would not be able to pass a psychiatric evaluation and be approved for gender reassignment surgery; others would not choose to do so; and most would find it very difficult to afford a full physical transition. For both personal and external reasons, therefore, the range of choices people at Rainbow Heights Club make about how they will enact their sexual or gender identity is very broad. Some transgender club members have had gender reassignment surgery; some have used hormones; some have changed the way they dress, speak or carry themselves; and for some, their gender identity is a matter of personal inner experience and conviction.

The Rainbow Heights Club, unlike traditional clubhouse models, does not incorporate a work-ordered day; wherein work is viewed as the central regenerative activity and clubhouse members, consequently, are engaged in a variety of work experiences (Jackson, 2001). Clubhouses began as a way to provide a place for social support as an adjunct to outpatient clinic and day treatment programs for discharged mental health consumers. However, mindful that the unique treatment needs of LGBT consumers, for whom stigma has heretofore precluded a supportive and affirming community, the Rainbow Heights Club was designed to emphasize social support and interaction. Consumer response confirms that this

was the appropriate emphasis for our programming. Most Rainbow Heights Club members currently report that they do not feel ready to make use of a work-ordered day and that currently acceptance and social support are the key aspects of their lives that are missing. The club does offer a weekly career club group that addresses the needs of those consumers who are interested in assistance with job seeking, resume building, and interviewing skills.

Community Education

Rainbow Heights Club staff give educational presentations to mental health care providers and/or consumers, discussing the barriers to effective treatment of LGBT people with mental illness and how to address those barriers on an ongoing basis. Key points of the presentation include the fact that care providers are often not aware of the prevalence of the LGBT experience among their client population, and therefore do not inquire about it or take steps to provide a supportive atmosphere for such disclosures. Some care providers understand so little of the history of the psychiatric establishment in pathologizing same-sex desire and divergent gender identity, that LGBT consumers have good reason to believe that they will receive poor or inappropriate treatment if they disclose such issues. It is therefore incumbent upon care providers to demonstrate that they are supportive and open to hearing about such concerns. Both providers and consumers have come to realize, through these educational presentations, that a thorough understanding of the challenges and dilemmas facing consumers is indispensable in providing effective and culturally sensitive treatment.

The club's values and priorities are embodied in each of its groups, whether run by the director, assistant director, peer specialists, or students. The purpose of the group and the club's guidelines, which include safety, confidentiality, and each person getting a fair share of time, are recited before each group begins. Once a week, separate men's, women's, and transgender support groups are offered; in all other groups, club members come together, regardless of race, class, or gender. Members differ on their level of interaction, capacity, and symptomatolgy, but an ambiance of congeniality and acceptance is prevalent.

The following are suggested guidelines toward effective and culturally competent treatment with LGBT mental health consumers.

Use inclusive language. 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 as a signal that the care provider is unwilling to hear about relationships that fall outside a heterosexual paradigm, and some of them will be silenced. Using more inclusive language, such as Are you in a relationship right now? What kind of people do you tend to have relationships with? is a simple change that may have far-reaching results.

Be aware of subtle signals you may be sending. Nearly all LGBT people at some point in their lives have lost or disrupted relationships with friends,

family members, or religious communities over disclosure of their sexual or gender identity. As a result, many of them are hypervigilant toward possible clues as to whether a given person may or may not be accepting and supportive of them. The use of routine language such as that in the previous example can unintentionally telegraph a heterosexist point of view. Conversely, hanging even a small pro-LGBT flyer in your waiting room, or posting information about LGBT resources in your community, may make LGBT consumers feel that their disclosures are welcome.

Welcome and normalize consumer disclosures. 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 kind of question 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 a LGBT consumer that you are willing to put yourself in his or her shoes can have a tremendous effect on the working alliance and undo some of the estrangement from the mental health establishment that many LGBT consumers experience.

Utilize knowledge about consumer sexuality in discharge planning. At Rainbow Heights Club, a number of consumers have a long history of decompensations and hospitalizations whereas others have long standing, supportive, monogamous relationships. If you are working with consumers, the person's romantic partner, as well as their friends, are all part of your treatment team. You need to be hearing about them, and if possible you should be talking with them. Partners, loved ones, friends, and family can provide crucial information, invaluable support for treatment compliance, and ongoing monitoring of the consumer's mental status.

Avoid pathologizing. Many care providers pathologize any aspect of a consumer's expression of his or her sexual or gender identity, interpreting it as further evidence of the person's illness. However, LGBT consumers' efforts to express their sexuality and find connections with others are often the locus of a great deal of creativity, resilience, courage, and even playfulness. Conversely, it is not helpful to assume that any expression of a consumer's sexuality or gender identity is to be celebrated. Any such activity should be pragmatically evaluated in terms of its effect on the consumer's physical and emotional health, self-esteem, and relationships.

Support and acceptance are indispensable to mental and emotional health. The way Julie arrived at the club on her first day typifies this. She marched straight toward a staff member, extended her hand, smiled and said, "Hi! I'm a lesbian and I have a major mental illness!" The staff member smiled back at her and said, "Great! Come on in." This moment may seem inconsequential unless you stop to consider how rare it would be for someone like Julie to feel comfortable saying what she said, with a proud smile on her face—and to receive the reception she got. Julie quickly blossomed in the club; on her next visit she brought her girlfriend

of four years, and she soon offered club members classes in entrepreneurial skills, karate, and self-defense.

Clinical Application of the Stigma Framework

In working with the LGBT population, it is useful to utilize the stigma conceptual framework outlined earlier to inform and guide interactions with Rainbow Heights Club members. Specifically, staff are mindful of:

Labeling: Make careful choices about what we call the people that seek mental health services since labeling can create severe obstacles to the recovery process (Knight, 1997). Once labeled there is often a vicious cycle of social isolation and discrimination that follows.

Stereotyping: At intake, ask about someone's partner or if they have had a sexual relationship. Do not ask about their husband, girlfriend, etc. Leave the door open for the consumer to disclose their sexuality. Let the consumer define what is and is not the problem; don't try to solve a problem such as ego syntonic same-sex sexual attraction if the consumer does not consider this to be a problem.

Separating us from them: It is key to realize that LGBT consumer's feelings of love, desire, infatuation, rejection, loss, and disappointment feel just like anybody else's. It is enormously helpful to a working alliance if care providers empathize with LGBT consumers' feelings. When care providers take this simple, important step, the impact on the treatment alliance is often enormous.

Status loss and discrimination: Acknowledge the dual stigma that exists for those that are identified as LGBT, and that this causes more of a societal prejudice and discrimination in housing, employment, education, and in other areas of need.

An imbalance of power: All of the empowerment efforts made at Rainbow Heights Club including the incorporation of as much consumers input as possible can be seen as an attempt to address this imbalance of power. We find that joining in a partnership with the consumer, rather than using status as a provider in a power position, is most effective toward promoting consumer well being (Deegan, 1988).

The following vignettes vividly illustrate the many and varied ways that the Rainbow Club members have benefited from this program:

Larry

Larry is a 63-year-old African American man with a psychiatric history spanning over 40 years. He has abused substances and alcohol, and was frequently hospitalized for extended periods of time during much of his adult life. He was considered so high-risk to himself and the community that he was discharged from an

inpatient setting on mandated outpatient treatment. His appearance is striking: he is fastidious about painting his long fingernails an opalescent pink, and he combs his reddish hair straight out from his head. Larry's transition to outpatient life and daily attendance at the club was facilitated by assisted visits to the club while he was still an inpatient. While in inpatient care he was ostracized for his flamboyant appearance and obvious homosexual orientation. Nine months later, Larry is attending the club daily with no decompensations. Most remarkable is that during this time his lover of 39 years passed away, as did three of his beloved pet dogs yet he did not abuse alcohol or stop taking his prescribed medication. Of note is that Larry is a well-connected and respected member of the Rainbow Heights community: other younger members seek out his warmth, wisdom, and guidance. Larry is a good example of how a consumer who might well have been labeled a misfit or outcast in a more mainstream setting can be recognized as a role model and mentor in a more culturally appropriate and supportive setting.

Jill

Because of psychiatry's long history of homophobic pathologizing of LGBT people, this population is often uncomfortable disclosing their sexual identity even when it is of paramount importance to their receiving effective treatment. Jill's story demonstrates this. Jill was hospitalized because she was suicidal and distraught, precipitated because Jill's female lover of 10 years had recently relapsed on heroin. Because of the multiple layers of stigma, Jill did not feel comfortable disclosing any of these issues to her treatment team. Consequently, her treatment team was unable to address her real needs or provide effective treatment for her depression.

Nathaniel

Nathaniel was educated at Harvard and Oxford and has been a poet and playwright for many years. Since his twenties he has suffered from paranoid schizophrenia and has experienced numerous hospitalizations. He is very articulate in stating that he feels no treatment he received actually helped him until he received LGBT affirmative treatment from a gay identified psychiatrist and received social support at Rainbow Heights Club. Since becoming a member of the club he has published his first book of poetry, and he currently leads a popular weekly writing workshop, the fruits of which often appear in the club's quarterly journal of members' art and writings.

Program Evaluation

In April 2004, a mail-in satisfaction survey was conducted of the approximately 150 people who belonged to Rainbow Heights Club at that time. The survey comprised 47 questions, most of them multiple choice. No compensation was offered for participation in the survey. However, stamped, self-addressed envelopes were provided. Thirty-five club members (23.3%) responded to the survey. An

analysis of responses to nine of the survey questions follows. In response to the question, Do you feel your mental health has improved because of participating in Rainbow Heights Club? 26 respondents (74.3%) answered yes, 3 respondents (8.6%) said no, and 6 (17.1%) were unsure. Twenty-four respondents (68.6%) stated they had been able to be more open about their sexual or gender identity because of participation in Rainbow Heights Club; 4 (11.4%) said they had not; and 7 (20%) were unsure. When asked to compare the services available at Rainbow Heights Club with services respondents received elsewhere, 57.1% felt the services at Rainbow Heights Club were much better; 25.7% felt they were somewhat better; 11.4% felt they were equally good; and 2.9% felt they were not as good at all. In other words, 77.8% of respondents preferred Rainbow Heights Club over other services they had received.

When asked about how long they have been coming to Rainbow Heights Club, 57.1% had been attending the club more than nine months; 11.4%, six to nine months; 14.3% had been coming three to six months; 5.7%, one to two months; and 8.6% of respondents had joined the club within the month prior to the survey. As for frequency of attendance at the club, 48.6% stated they attend the club two or more days a week; 25.7% attend about once a week; 11.4% attend about once a month; 5.7%, about once every three to six months; and 8.6% attend almost never.

Regarding level of satisfaction with the work Rainbow Heights Club staff are doing, 54.3% were very satisfied; 28.6% were satisfied; 11.4% felt neutral; 5.7% felt somewhat dissatisfied; and no respondents felt very dissatisfied. In other words, 82.9% of Rainbow Heights Club members feel satisfied or very satisfied with the work that staff is doing. When asked how they would rate the overall improvement they have made since coming to Rainbow Heights Club, 37.1% of respondents stated it was excellent; 37.1%, stated it was good; 11.4% felt it was fair; and 5.7% felt it was poor. In other words, 74.2% felt their level of improvement was good or excellent.

When asked if they felt their quality of life had improved since coming to Rainbow Heights Club, 60% responded definitely; 22.9% responded somewhat; 14.3% replied not really; and 2.9% said no. In other words, 82.9% of respondents felt their quality of life had shown at least some improvement since coming to Rainbow Heights Club. When asked if coming to Rainbow Heights Club helps them to stay out of the hospital, 60% of respondents responded definitely; 8.6% responded somewhat; and 14.3% replied not really. 17.1% of respondents did not feel this question applied to them. Overall, 68.6% of the total respondents to the survey, or 82.7% of the people who felt this question applied to them, found Rainbow Heights Club helpful in remaining out of the hospital. In fact, only one of Rainbow Heights Club's 200 members has been hospitalized in the nearly two years that the club has been open.

Bivariate correlations were run to assess possible relationships between responses to the above questions. A number of two-tailed correlations were significant at the .01 level or above. A significant degree of correlation was seen

between length of membership and frequency of attendance ($r = .501$; $p = .003$; $N = 34$). In other words, people who attend the club for longer periods of time tend to come to the club more and more frequently.

A significant degree of correlation was seen between level of satisfaction with services at Rainbow Heights Club as compared with services elsewhere, and level of satisfaction with the work that Rainbow Heights Club staff are doing ($r = .678$, $p < .0005$, $N = 34$).

A very significant degree of correlation was seen between frequency of attendance at the club and degree of perceived overall improvement ($r = .685$, $p < .0005$, $N = 32$). In other words, people who attend the club more often see more improvement in themselves. It is also possible that people who perceive that the club is helping them come to the club more frequently.

A significant degree of correlation was seen between satisfaction with the work Rainbow Heights Club staff are doing and degree of perceived overall improvement ($r = .466$, $p = .007$, $N = 32$). In other words, people who feel that they are improving also feel staff are doing a good job. It may be the case that if people perceive themselves to getting better, they then conclude that it is because staff are doing good work.

A significant degree of correlation was seen between level of satisfaction with services received at Rainbow Heights Club and perceived improvement in quality of life ($r = .485$; $p = .004$; $N = 34$).

A significant degree of correlation was seen between frequency of attendance at the club and perceived improvement in quality of life ($r = .487$, $p = .003$, $N = 35$). In other words, people who come to the club more often feel that their quality of life has improved.

A significant degree of correlation was seen between level of satisfaction with the work Rainbow Heights Club staff is doing and perceived improvement in quality of life ($r = .447$, $p = .007$, $N = 35$).

A very significant degree of correlation was seen between perceived degree of overall improvement and perceived improvement in quality of life ($r = .774$, $p < .0005$, $N = 32$). Together with other data collected here regarding improvement in overall mental health, improvement in quality of life, remaining free of hospitalizations, and participation in Rainbow Heights Club, it appears that for many consumers, more participation in Rainbow Heights Club means better quality of life, which means better mental health and staying out of the hospital and staying in the community.

A significant degree of correlation was seen between degree of satisfaction with services at Rainbow Heights Club as compared with services elsewhere, and remaining free of hospitalizations ($r = .560$, $p = .002$, $N = 28$). A significant degree of correlation was seen between satisfaction with the work Rainbow Heights Club staff are doing, and remaining free of hospitalizations ($r = .492$, $p = .007$, $N = 29$). Again, people who are satisfied with the work Rainbow Heights Club staff are doing are likely to credit this with their ability to remain in the community. This data from the Rainbow Heights Club consumer satisfaction survey

suggests that culturally specific and appropriate support prevents relapse and inpatient treatment.

Conclusion

The history and development of Rainbow Heights Club and the impact it has had on consumers and care providers demonstrates the importance of providing culturally sensitive and specific psychosocial support and advocacy services within a peer based environment. We feel strongly that mental health consumers who are members of a number of marginalized, oppressed communities can benefit from the establishment of similar agencies addressing their particular needs. Stigma among some cultures is a significant barrier to seeking mental health treatment and services (Howard, et al. 1996). Reduction of stigma through culturally competent treatment will increase service use, and ultimately improve outcomes. With the implementation of managed care in mental health treatment service provision, there are more and more financial barriers to long term treatment. Connecting people to social support networks and self-help groups will reduce use of mental health services and it will help utilize scarce resources more efficiently. The Rainbow Heights program is practical in providing support in a self help atmosphere for a patient cohort that are high users of services. Kent and Yellowlees (1994) found that addressing social concerns would reduce readmission to hospitals and suggest targeting resources to avoid social crises. Programs have to be developed with an eye toward feasibility and social consequences. Several studies have indicated that consumers that actively participate in their treatment have longer community tenure. Knight (1997) stated that participation in a meaningful activity and the development of social supports is important for coping with mental illness, and that consumers are more satisfied with their treatment when they have input and can openly express their wishes about programming. Therefore, it is crucial that the Rainbow Heights Club supports members' right to define what the problem is, and what is not. At Rainbow Heights, the consumer's view of the problem is accepted. This attitude of respect and affirmation for the consumer's point of view is critical to maintaining a seriously and persistently mentally ill person in the community.

References

Cochran, S. D., & Mays, V. M. (2000). Lifetime prevalence of suicidal symptoms and affective disorders among men reporting same-sex sexual partners: Results from the NHANES III. *American Journal of Public Health, 90*, 573–578.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2001). Prevalence of psychiatric disorders, psychological distress, and treatment utilization among lesbian, gay, and bisexual individuals in a sample of the U.S. population. Unpublished manuscript, University of California, Los Angeles.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11,* 11–19.

Estroff, S. (1981). *Making it crazy: An ethnography of psychiatric clients in an American Community*. Berkeley, CA: University of California Press.

Faulkner, A. H., & Cranston, K. (1998). Correlates of same-sex sexual behavior in a random sample of Massachusetts high school students. *American Journal of Public Health, 88,* 262–266.

Fergusson, D. M., Horwood, L. J., & Beautrais, A. L. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry, 56*, 876–880.

Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide Attempts among a representative sample of youth. *Archives of Pediatrics and Adolescent Medicine, 153*, 487–493.

Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Prevalence of DSM-III-R disorders among individuals reporting same-gender sexual partners in the National Comorbidity Survey. *American Journal of Public Health, 91*, 933–939.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

Hays, R. B., Turner, H., & Coates, T. J. (1992). Social support, AIDS-related symptoms, and depression among gay men. *Journal of Consulting and Clinical Psychology, 60,* 463–469.

Hershberger, S. L., & D'Augelli, A. R. (1995). The impact of victimization on the mental health and suicidality of lesbian, gay, and bisexual youths. *Developmental Psychology, 31,* 65–74.

Haaster, E., Lesage, A. D. Cyr, M., & Toupin, J. (1994). Problem a needs of care of patients suffering from severe mental illness. *Social Psychiatry and Psychiatric Epidemiology, 29,* 141–148.

Howard, K. I., Carnill, T. A., Lyons, J. S., Vessey, J. T., Lueger, R. J., & Saunders, S. M. (1996). Patterns of mental health service utilization. *Archives of General Psychiatry, 5*, 696–703.

Kent, S., & Yellowlees, P. (1994). Psychiatric and social reasons for frequent hospitalization. *Hospital and Community Psychiatry, 45,* 347–350.

Knight, E. (1997, October) What's in a name? *Empowerment*.

Jackson, R. L. (2001). *The clubhouse model: Empowering applications of theory to generalist practice*. Belmont, CA: Wadsworth.

Link, B., & Phelan, J. (2001). *On stigma and its public health applications*. Paper presented at Stigma and Global Health: An International Conference, Bethesda, Maryland.

Remafedi, G., French, S., Story, M., Resnick, M. D., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health, 88*, 57–60.

Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, 91,* 1276–1281.

Sandfort, T, G. M., de Graaf, R., Bijl, R. V., & Schnabel, P. (2001). Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands mental health survey and incidence study (NEMESIS). *Archives of General Psychiatry, 58,* 85–91.