

## **Black and Minority Ethnic Lesbian and Bisexual Women**

### **Useful web sites**

[www.bluk.org.uk](http://www.bluk.org.uk)

Black Lesbians in the United Kingdom

### **Black lesbians**

"Attitudes toward sexuality differ within the diverse ethnic and racial communities that exist in the UK. and the cultural values and beliefs surrounding sexuality play a major role in determining how we behave within our sociological context. The family unit is the domain where such values and beliefs are nurtured and developed. Our value system is shaped and reinforced within the family context which usually reflects the broader community norms. Disclosure of a lesbian sexual preference and lifestyle by a family member presents challenges to African and Caribbean families who tend not to discuss sexuality issues and presume a heterosexual orientation."

"For the UK black lesbian the 'coming out' process present challenges in our identity formation processes and in our loyalties to one community over another. UK black lesbians need to live within three rigidly defined and strongly independent communities: the LGBT community, the black community, and the society at large. It requires a constant effort to maintain oneself in three different worlds, each of which fails to support significant aspects of our lives. The complications that arise inhibit our ability to adapt and to maximize personal potentials." Black Lesbians in the UK

<http://www.mind.org.uk/Information/Factsheets>

Black lesbians and gay men face double oppression because of their race and their sexuality. Some feel they have been forced to choose between the gay and the Black and minority ethnic cultures. Black communities can be homophobic, in the same ways white ones can be.

Anne Hayfield points out that when homophobia occurs within Black communities this can mean that an individual is cut off from support networks of family and friends, which are important to enable a person to develop a positive Black identity and to counter the racism faced on a daily basis. Black lesbians and gay men therefore have to consider the importance of 'coming out', weighing the possible loss of family and community support against the gains.

Black lesbians, gay men and bisexual women and men also face discrimination from organisations that exist to support them. It seems that Black issues are often ignored within political/campaigning groups and in social/support groups, as well as out on the 'scene'. Anne Hayfield claims that Black lesbians have often been refused admission to lesbian spaces and have been subjected to racism from white lesbians.

Quibilah Montsho, a Black lesbian poet and survivor who was wrongly diagnosed as mentally ill and forced into hospital against her will, believes that as many as 60 per cent of Black lesbians in this country have had, or will have, some experience of the mental health system. She says that it is impossible for a Black lesbian to complain of sexism, racism and/or homophobia in a psychiatric setting because complaining may be interpreted as an aspect of paranoid psychosis. This psychosis is seen to be suppressible, either by increasing the dosage of medication or prescribing additional drugs. In these circumstances it is unlikely that a Black person will feel safe to 'come out' within the mental health services. Montsho also makes the point that because of language and cultural differences the service user/survivor can be misunderstood and further labelled as defensive or uncommunicative.

MIND

Extract from **Metaminorities and Mental Health: A model of vulnerability for Black and Minority Ethnic Queer Folk** - *Roshan das Nair*

Five per cent of Britain's population is believed to be gay or lesbian, and Black and Minority Ethnic (BME) individuals constitute 7.9 per cent (4.6 million) of the total population of the United Kingdom. BME-Queer (BME-Q) individuals are minorities of sexuality and colour, *metaminorities* (minorities within a minority population) living in a predominantly White and heterosexual region.

While Britain has come a long way in trying to improve the wellbeing of her ethnic minorities, there is a lacuna in terms of care for her BME- Q people. In this context, "care" is a rather large umbrella term that includes factors such as needs-analysis, service provision, protection from race-related and homophobic crime, social support and recognition, etc. The visibility of BME people in the community has led to their recognition as valuable contributors to society, and has also led to the development of services that address their specific needs, along racial, ethnic and religious lines. While BME-Q people may be visible on the basis of their ethnicity, such visibility based on sexuality is rather low.

There are numerous factors that may have led to, or sustain and perpetuate this condition. Some of these factors can be subsumed under the banner of *homophobia and heterosexism* (from the society in general, and the BME society in particular), and *racism* (from the society in general, and the majority-LGBT community in particular). Perhaps it is this paucity in visibility that has led to the dearth in literature relating to BME-Q issues. This lacuna is particularly glaring when it comes to issues relating to mental health (MH). Paucity of such research

has also left us uncertain about the effects of multiple levels of discrimination, and whether they have synergistic or additive effects.

Scanning electronic health and mental health databases, using citation indexing, and examining cross-references from articles and book chapters, a few observations can be made about BME-Q MH research. Even though there are specific journals devoted to homosexuality, sexual health, ethnic minority issues, and issues relating to LGBT health, BME-Q issues are still underrepresented. Interestingly, when BME-Q issues are addressed, most of these pertain to HIV/AIDS. While this is a crucial issue within the BME and the LGBT communities; other aspects, such as Mental Health (and positive mental health) cannot be ignored. This being the state of affairs, this paper aims to focus on a few pertinent issues that affect BME-Q individuals, and pools findings from BME (largely heterosexual) and LGBT (largely White) research to develop a model of vulnerability to developing Mental Health problems. While this kind of aggregating of information from two sources (communities) is not methodologically sound, it generates some hypotheses that can be put to the test by more rigorous scientific studies.

### **Coming out issues**

*Coming out* is a contentious issue, particularly for the BME population. The following questions attempt to address the three large issues here:

- (i) Is coming out necessary in the first place?
- (ii) If yes, who does the BME-Q individual come out to, and
- (iii) Where does he/she come out (in)to?

The first question is related to the sexual identities that the BME-Q individual acknowledges. If he/she acknowledges a (same-sex) sexual desire/act without subscribing to a minority sexual identity (e.g., LGB or T), the whole issue of coming out may not arise. In certain cultures where terms such as “gay” and “lesbian” may be considered “Western” concepts/identities, individuals belonging to these cultures may not apply such identities to themselves (for instance, Khan provides an overview of how men who have sex with men in India construct their identities).

However, mainstream (dominant) LGBT identities may be adopted by BME non-heterosexual people, wholly or in part, as an attempt to fit in with the majority LGBT culture. Secondly, as difficult as the coming out process may be, the BME-Q person also has to contend with poor comprehension of alternative sexualities and lifestyles in many BME and/or traditional communities. Some communities regard such non-heterosexual sexualities as “social deviance”, or a “Western disease”. Strong familial, cultural, and religious backgrounds, which tend to be heterosexist, may make the process of coming out more arduous. Because sex and sexuality are generally considered suitable to reside in the private domain, open discourse pertaining to these topics has been limited. Furthermore, most traditional societies also look upon marriage and procreation as a familial and social obligation. This fosters a sense of duty, failing to fulfil which may be fraught with feelings of guilt and shame. Associated to this communal obligation, there may be a sense of fear of rejection from the family, and being ostracised

from the larger community also. This is especially pertinent for the BME individual for whom their own ethnic communities form an extended support system in the face of racial and other adversities. However, with the process of acculturation, some BME people may come to identify themselves as being LGBT. To this extent, coming out may be beneficial, as studies have reported lower social and trait anxiety, and depression in people who are “out”. However, BME-Q literature on coming out has found inconsistencies with regard to timing of coming out, identity formation, and identity integration. It is at this point that the third question arises. Considering that the mainstream LGBT social venues are not immune to racism, the sources of socialisation with (coming out into) the majority LGBT community are limited. Racism may be explicit (racist comments from patrons, being ignored by bar staff, etc.); or covert, for example, not being represented in gay media, or being “undesirable” because of one’s colour. These forms of racism in majority LGBT social venues may further foster a sense of isolation for the BME-Q person. Some of this hostility towards BME people is related to the *otherness* that they represent for White communities. While this *otherness* can be a source of celebration of diversity, it can also be a source of distrust and disgust because of the difference that *they* signify, which stems from factors such as ignorance and stereotyping. Some BME-Q people attempt to mitigate this difference by merging into the *in* crowd, at the expense of their own individuality. Such attempts to assimilate may be at the cost of losing connections with their ethnic culture, a loss that can have significant consequences. But some authors argue that lesbians and gay men need to learn the customs of the dominant LGBT communities to fit in these communities. This argument is sound if the objective is one of assimilation, but for BME-Q people who possess multiple identities of race/ethnicity and sexuality, *integration* (incorporating aspects the dominant culture within the matrix of one’s own personal and cultural histories) is also important. In fact, integration is perhaps most important for a healthy psychological functioning for the BME individual.

### **LGBT folk and mental health**

Historically, LGBT people have had a fraught relationship with mental health professions (MHPs), given that alternative sexualities were pathologised by the MH fraternity till recently. However, even today acceptance is limited. A study by the National Association of Mental Health (MIND) reported that a third of gay men, 40% of lesbians, and over 60% of bisexual females in their sample (in England and Wales) received a negative or mixed reaction from their MHP when being open about their sexuality. Furthermore, 33% of bisexual males and 20% of gay men and lesbians reported that their MHP made a causal link between their sexuality and their MH problem. Despite this, more lesbian and gay men reported having had a consultation with a MHP than heterosexual people. The reasons for this finding are myriad. Most research has focused on one (or more) of the following areas: substance misuse, mood and anxiety spectrum disorders, deliberate self-harm, and suicide. Elevated incidence rates have been consistently reported on all these conditions in LGBT populations, compared to heterosexual counterparts

## **BME folk and mental health**

Like the many areas of vulnerability faced by the LGBT people, BME people also have specific Mental Health concerns. The Irish in England, for instance, have higher incidence rates of depression and anxiety, alcohol misuse, and suicide compared to the rest of the population. Similarly, South Asians (particularly young women) have higher rates depression and suicide, partly attributed to the stressful situations they experience living as a minority. Amongst the Black Caribbean population, high rates of schizophrenia have been reported. However, such findings need to be treated with caution, as there is some evidence to suggest that there is over-diagnosis of schizophrenia and under-diagnosis of anxiety and depression in this population. South Asian, African and African-Caribbean people are at increased risk of General Practitioners (GPs) not recognising MH problems or wrongly attributing their presenting problem to mental illness. This could be because some GPs fail to recognise the cultural variations in the manifestation of some of these conditions. Depression, for example, can sometimes be masked as somatisation. These factors raise an important caveat, in that while it is important to know who is being diagnosed, it is equally pertinent to know who is making the diagnosis. One systematic review of ethnic variations in pathways to specialist MH services in the UK, found variations in trajectories to specialist MH care, with Black people negotiating more complex pathways and with more crisis routes of entry into care. Treatment issues have also been problematic as reflected in research suggesting that Black patients are more likely than their White counterparts to be given *physical* treatments (such as pharmacotherapy, or electroconvulsive therapy), and are less likely to be offered counselling. Research also suggests that such treatments may not be successful because GPs tend to prescribe antidepressants in lower doses and for shorter courses than are recommended to South Asian patients. While there appears to be a general interest in examining Mental Health concerns of the BME individual, there is limited information with regard to the BME-Q individual's experience of using Mental Health services.

## **BME-Q folk and mental health: pathways to vulnerability**

Diaz and colleagues examined the impact of homophobia, poverty, and racism on the MH of gay and bisexual Latino men in the United States and found that there was a high prevalence of suicidal ideation, anxiety, and depression in their sample. More than 70% reported that as a child they had heard negative things about non-heterosexual people, and more than 30% reported having been “treated rudely or unfairly” because of their racial minority status. It is interesting to note however that 62% reported that they felt “objectified sexually”. The valence of such a statement is difficult to discern and it is beyond the scope of this paper to deconstruct the meaning of such objectification. However, stereotypes based on race and ethnicity may have played a significant role. The theoretical model espoused by these authors identifies two psychosocial factors (social isolation and low self-esteem) caused by social discrimination and low resiliency, that contribute to poor MH. This is a pertinent finding in that it highlights the importance of focusing on resilience when developing health initiatives for BME-Q people, considering that there is dissatisfaction among this population with MH services.

Models that focus on the psychosocial aspects of vulnerability to developing MH problems in BME-Q people, need to consider three aspects: (i) the internal (individual and *intrapsychic*) vulnerabilities, (ii) the psychological manifestation of this vulnerability, and (iii) the external (social) contributors to such vulnerabilities (fig 1).

### **1. Internal vulnerabilities**

A. Coming-out issues: Some authors have criticised the unbridled importance given to coming out in developing a queer identity, and extending it to BME-Q people also. This term has been criticised for being culturally insensitive, and researchers have not understood the use of the *closet* as a powerful tool to negotiate multiple identities. However, the *effects* of coming out in the BME context have been equivocal. Chan found that Asian lesbians reported a sense of loss, both psychologically and socially, as a result of coming out, while Wooden, Kawasaki, and Mayeda found that Japanese gay men who had disclosed their sexual orientation to family members were more likely to express more positive attitudes concerning gay political involvement, and social activity (deemed to be beneficial in identity acceptance). These discrepancies acknowledge the heterogeneity of BME populations and the diversity of their experiences.

B. Identity issues: For *metaminorities*, identities can co-exist by being in the background or foreground in any given circumstance and/or time. However, some authors have suggested that establishing an identity, especially when belonging to a minority group, is psychologically beneficial, and the development of racial and sexual identities are considered pertinent in coping with multiple identities. But LGBT labels are Anglo-centric, and are therefore restrictive as BME people need not always associate themselves with these terms. Additionally, some BME individuals who identify as being LGBT are urged by their immediate family not to reveal this identity to others (especially to their own ethnic community) for fear of stigmatisation and retribution. Having a multiple, sometimes fragmented and compartmentalised existence, can have significant psychological effects on the individual.

C. Isolation: Research examining the influence of ethnicity on the relationships between multicultural Queer youth and their families, has concluded that BME-Q youth felt a part of their ethnic and Queer culture, but without feeling a complete sense of belonging in either. This lack of acceptance from either community can lead to feelings of isolation and estrangement, with resulting adverse psychological consequences.

D. Low self-esteem: Negative attitudes from the larger communities can be internalised in BME-Q individuals, which can lead to lower self-esteem and psychological distress. This in turn, has been linked to eating disorders, and with risky sexual behaviours that place such individuals at risk for HIV. Conversely, high levels of self-esteem and social supports may act as a buffer to “gay-identified stressors”.

E. Internalised racism: Internalised racism has been regarded as a “determinant of homophobia”, especially if concomitantly held with internalised racist stereotypes of sexuality. This feeling of vulnerability may be intensified by the “embarrassment” caused by non-heterosexual BME visibility. Some attempts at assimilating with the majority LGBT population may be associated with internal racism.

F. Internalised homophobia: Internalised homophobia has been defined as “the gay person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard”. A significant relationship has been observed between internalized homophobia and depression, substance misuse, guilt, sex difficulties, suicide, HIV-related traumatic stress response, and low self-esteem. Most people identify with and are socialised in their own ethnic, racial, and cultural groups, before acknowledging a sexual identity. This identification can position the BME individual at odds with anything that is construed as belonging to the *other*, even non-heterosexual identities. Such distancing may be positively reinforced by the individual's own community, thereby enhancing the bonds he/she has within this community.

## **2. Physical and Psychological manifestation**

A. Poor physical health: Minorities have poorer general health, when compared to the rest of the population. The relationship between health inequity and a minority status (whether ethnic or sexuality-related) is complex. Factors such as limited access to services, institutional homophobia and racism, language barriers, and religious and cultural insensitivity of services, are some of the social factors that restrict BME-Q people from accessing health services at the appropriate time.

B. Depression and anxiety: A preponderance of depression and anxiety is found in non-heterosexual populations. The *bio-psycho-social* factors contributing to the development of these disorders are multiple. Within the social framework of such a matrix, several authors have implicated social inequality, discrimination, and even *perceived* discrimination as contributing to the aetiology of these disorders. This has been documented in LGBT research, and BME research.

C. Sexual dysfunction: Sexual dysfunctions have a negative impact on the quality of life of the person who has the problem and his/her partner(s). The aetiology of sexual dysfunctions is multidimensional, and there is a strong correlation, and a bidirectional relationship, between sexual dysfunctions and depression, anxiety, and substance misuse. This scenario is further

complicated by the side effects (which include sexual dysfunctions) of certain antidepressant and anti-anxiolytic medications, even the “newer” ones.

D. Stress: Being a *metaminority* predisposes individuals from experiencing more number of negative life events, leading to poor psychological wellbeing. High rates of such (chronic) stress have been associated with MH problems, such as substance misuse, sexual dysfunctions, depression and other affective and anxiety spectrum disorders. Some of these conditions can lead to suicidal ideations and suicide.

E. Substance misuse: Although substance misuse amongst the LGB population has declined over the last two decades, heavy use is still prevalent, mostly in LGBT pubs and nightclubs (*the scene*). A relationship between frequency of being on *the scene* and multiple sex partners with heavy alcohol, and polydrug use has been reported, placing such individuals in circumstances that can lead to high-risk sexual behaviours.

F. Eating disorders: LGBT orientations and eating disorders appear to be correlated. Sociocultural aspects of the aetiology of such disorders have suggested an exaggerated emphasis placed on attractiveness, equated with slimness as being the “ideal” (to obtain partner/s) as a contributory factor.

G. Self harm and suicide: In the UK, lesbian and gay people were found to have more frequently considered or actually self-harmed than bisexual or heterosexual people. One US study also reported that suicide was the leading cause of death among LGBT youth.

### **3. External vulnerabilities**

A. Homophobia: Homophobia and victimisation due to non-heterosexual sexual orientation can have a negative impact on mental health from childhood. Such victimisation is associated with high health risk behaviours, including substance use, and sexual risks and bipolar psychiatric disorders and depression.

B. Racism: BME-Q people experience racism from society at large, the organisations that exist to support them, and LGBT spaces. The negative effects of racism on Mental Health have been documented.

C. Sanism / Mentalism: This is discrimination on Mental Health grounds. In many BME communities, Mental Health is sometimes not adequately understood, with failure to grasp the nature of diagnoses and the rationale for treatment. This has implications with regard to early detection of psychological problems, and accessing appropriate services.

D. Poor visibility: Because of the inherent difficulties in *coming out*, BME-Q people essentially form an invisible mass. As a result of this lack of visibility, agencies are reticent in developing services that address specific needs of this population. This lack of visibility may be a function of the homophobia and racism they experience.

E. Poor / lack of services: In addition to the lack in specialised services, some general services are not BME-Q affirmative, and King and McKeown observed that some clients’ experiences with MHPs ranged from overt homophobia to perceived lack of empathy around issues related to sexuality.

F. Poor / lack of social support: Social support buffers the psychological effects of stressful life events, and actual or perceived lack of social support has been linked to problems such as depression. However, social support can also be a double-edged sword, in that some researchers posit that there can

be psychological costs in terms of indebtedness and obligations. This is particularly pertinent for BME-Q individuals who have to negotiate identities between two or more (sometimes distinct) social networks, which can be problematic.

### **Addressing vulnerability**

To address the vulnerabilities posed by this model, there needs to be an integrated effort to impart psychoeducation and therapeutic interventions at different levels. These different levels should address issues related to an individual's (i) BME affiliation, (ii) LGBT association, and (iii) Mental Health and psychological wellbeing. These three issues need to be holistically addressed within the context of (i) individual work, (ii) work with his/her families and friends, and (iii) work with the wider society. To aid BME-Q individuals develop a positive and fulfilling life, society at large, and Mental Health services in particular, need to be not only reactive or remedial (to address morbidity) but also proactive or affirmative, protective, and growth orientated (to foster positive Mental Health).

### **Intervention issues**

In view of the difficulties *metaminorities* (such as BME-Q people) face, new specific services are needed to address some of the aforementioned challenges. However, it is also pertinent that mainstream services adapt to the diversity reflected in the community.

Training that addresses BME and LGBT issues need to be comprehensive and not tokenistic. For dedicated LGBT (affirmative) services already in existence, their BME profile needs to be enhanced, by improving BME visibility in such spaces. Culturally sensitive publicity of such services needs to be considered, to create awareness of the service for patrons, and to bring about LGBT visibility within BME communities. To this extent, services need to liaise with cultural, religious, and/or community leaders and agencies, at all levels. As GPs and the police are most often the first port of contact for BME individuals who have psychological problems, they need to be sensitised to the cultural variation in the manifestation of Mental Health conditions. Furthermore, GPs need to sensitively address sexuality when dealing with psychological problems (and not assume that all BME people are heterosexual). Additionally, GPs and Mental Health Professionals need to develop and adopt culturally appropriate, holistic approaches when addressing Mental Health issues in the BME context.

### **Preventative measures**

Health is not just the absence of infirmity, just as wellness is more than the absence of distress. *Eudiamonic* wellbeing, which includes engaging in purposeful and meaningful activities providing opportunities for personal growth, positive relations, feelings of mastery, and positive self-regard, are pertinent to growth. Formation of BME-Q support groups may aid in combating isolation, fostering a sense of belonging, and providing information. Such support needs to be extended to others, such as a spouse, parents, family members, etc. of BME-Q people. While some practitioners today (particularly in the UK) are Queer affirmative, and *Pink therapists* are available, there still is a need for Mental Health Professionals to focus on positive mental health and psychological wellbeing, and move away from a model of pathology, when dealing with BME-Q individuals. Research addressing BME-Q MH issues is still rare, and such research is vital in

assessing the needs, vulnerabilities, and resilience of such communities, and the manner in which services can be developed and improved to help them grow.

### **Conclusions**

It is evident that *metaminorities*, such as BME-Q individuals, face multiple levels of discrimination, which can adversely affect their health, particularly their MH and their subjective wellbeing. There is currently a dearth in literature examining issues of vulnerabilities, health-costs, and protective factors and resiliency in this population, which has resulted in nonexistent or inadequate service provision. The pathways of vulnerability appear to be multi-pronged and complex, with the interactions between internal (*intrapsychic*) factors and external (social) factors. The model proposed here is by no means comprehensive, in that there are other variables likely to contribute to this vulnerability, and future studies will need to validate it, and examine the valence of these associations using a modeling technique (e.g., structural equation modeling). Service provision needs to be imparted at the individual, family, and community levels, addressing not only ill-health but also psychological wellbeing and growth.

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