Intercom Trust

Lesbian, gay, bisexual & trans people in the South West

Registered charity 1072772

Briefing note: Internalised Phobia

Internalised homophobia, biphobia and transphobia: client support profiles in the South West

Michael Halls
Executive Director

Tina Hill-Art, RegMBACP
Community Support Advocate

February 2015

PO Box 285 Exeter EX4 3ZT 01392 201015 office@intercomtrust.org.uk

1. Contents

1. Summary of key points

The mental health condition known as Internalised Phobia ("IP") is experienced by a significant proportion of LGB and Trans people.

It must be emphasised that IP is an externally-generated conflict experienced by some LGB people and some Trans people: it is not some kind of negative aspect of being LGB or Trans, *per se*. IP has its source in people's experience of negative environmental social attitudes towards homosexuality or gender dysphoria.

> **As so often happens...**
>
> ... the way people are externally treated by others may become the way they internally treat themselves.

It is extremely difficult to survey LGBT people on this issue, since many who live with the condition do not perceive it as such. However, a finding from Intercom's *Big LGBT Community Survey* (2014) can be read as suggesting a prevalence in the adult LGBT population of around 20%.

The Intercom Trust's analysis of our recent support and advocacy cases shows that 57% of those who contacted the service for help on any topic were living with IP, usually as part of a wide complex of issues in their lives. This analysis also shows that there are very strong evidence-based correlations between IP and at least seven other critical social issues:

a. suicidal and parasuicidal behaviours and ideations
b. self-harming behaviours
c. depression
d. drug and alcohol problems
e. domestic violence or abuse other than between same-sex partners
f. negative or risky sexual behaviours
g. social isolation.[1]

> **Support and Treatment**
>
> In many cases, even severe ones, IP can be successfully addressed, reduced, or managed by individuals who are supported by mental health practitioners who understand the issues and have the right skills and cultural competencies.

1 All these correlations are statistically significant: that is, there is less than a 5% probability that they could have arisen by chance.

2. Overview

i. What is internalised phobia?

The three terms "internalised homophobia", "internalised transphobia" and "internalised biphobia" are used widely in the UK and internationally. They indicate that someone is affected by a conflict between their actual sexual orientation or gender identity and the self-image that they feel it is safe or acceptable to present to themselves and to others.

> **The IP spectrum**
>
> Cases can present on a wide spectrum ranging from low-level but pervasive problems with self-esteem to strong feelings of self-hatred. Such strong feelings can be externalised to the point where someone can pose a significant potential or actual danger to others or to themselves. Major internal conflict ican be expressed through emotional or physical violence against other people who are (or are perceived to be) LGB or Trans, or against oneself. (See "The IP spectrum" on page 3 below.)

Internalised phobia has been a recognised mental health condition since 1977 or earlier, and is found in the World Health Organisation standard handbook (WHO, ICD-10, 1992 code F66-1).[2]

ii. Terminology

For the sake of equality and brevity, at Intercom we use the term "internalised phobia", or "IP", to indicate any position on the IP spectrum in respect of internalised homophobia, internalised biphobia, or internalised transphobia. (People who are living with both sexual orientation conflict and gender identity conflict can of course be vulnerable to more than one of these.)

3. Where does IP come from?

When someone grows up LGB or Trans, or lives or works, in a strongly negative environment, especially one where narrow and stereotyped gender-roles and gender-behaviours are strongly promoted and reinforced, they may find themselves significantly influenced by the surrounding hostile perceptions of LGBT people, or by negative attitudes towards themselves as an individual. They may accordingly find they have learned to identify themselves as being "deficient", "inadequate", "bad", "not OK", "diseased", "wicked", or "socially unacceptable", solely on account of their perception of their sexual orientation or gender identity.[3]

---

2 See "10. Annex: Clinical history" on page 15. Other terms in use include "internalised shame" and "internalised guilt". The WHO term is "egodystonic sexual orientation" (but see page 16 below).

3 The words in quotation-marks are some of the terms that we hear service-users who are living with IP using of themselves.

Negative self-image

People's internal image of themselves can become focused on social shame and/or personal guilt.

This inevitably impacts, sometimes dramatically, even destructively, on their self-esteem, their capacity for intimacy, and their personal identity and self-image. Common coping mechanisms for shame and guilt include rage, internal withdrawal, blame, contempt, striving for power and control, perfectionism, and comparison making. All of these strategies serve the function of temporarily alleviating the painful feelings of inadequacy, inferiority and unlovability that people are struggling with, but none of them, of course, addresses the root cause. In cases where such feelings become externalised the resulting behaviours can be physically or emotionally violent.

4. Self-recognition and diagnosis

Many people, even those most severely affected at the higher end of the IP spectrum, are not consciously aware (or do not admit to themselves) that this is a condition by which they themselves are affected. For many people, living with IP is simply a part of being LGB or Trans: they take it for granted that all other LGB or Trans people inevitably share these negative feelings, and that there is no possibility of living as an LGBT person without IP. Others resist identifying, or altogether refuse to identify, as LGBT.

This being the case, many people affected by IP are unable to understand their own negative feelings until they are with a support-worker who discusses IP with them as part of a discussion of (for instance) low self-esteem, domestic abuse, or self-harming. At this point many of our service-users have said something along the lines of "it's like a light-bulb going on".

5. The IP spectrum

Internalised phobia underpins or generates a very wide spectrum of affects and behaviours. Many of these, at all levels, can include, or lead to, chosen or self-imposed social isolation.

The following sample profiles are based on the Intercom team's long experience of encountering and addressing such issues.

They are ordered below roughly in ascending order of actual harm and risk of harm.

- Low-level permanent self-esteem problems, possibly enhancing or generating depression;
- Higher-level self-esteem problems that can lead to lack of self-care, or self-medication with alcohol or drugs, or to obsessive, random or risky sexual behaviours;
- Higher-level self-esteem problems that can stand in the way of choosing positive life-changing opportunities (e.g. promotion, a new relationship, engagement with family or friends);
- Self-hatred, expressed by blaming oneself for any of a wide range of possible issues; for instance, perceiving oneself as having "deserved" to be the victim of (e.g.) neighbour harassment, discrimination, family rejection, or a phobic attack;
- Self-hatred that leads directly to destructive behaviours (e.g. driving partners away, self-harming);
- Self-hatred that perceives one's own hated self in other LGB or Trans people (or in people who are perceived to be such) and is expressed in angry or violent ideations, and possibly local abuse or violence directed at an acquaintance, a partner or another family member;
- Self-hatred that is actively externalised, and is directed towards causing physical harm to other people who are perceived as being LGB or Trans;
- Self-hatred that perceives deliberately causing the death of other LGBT individuals as being in a sense a revenge, or reparation, for being LGB or Trans oneself.

These profiles are indicative and desctiptive. Many people living with IP will show a cross-profile set of these affects and behaviours, responding to their own life and environment.

It will be seen that in certain of these profiles there are significant risks not only to the individual but to others, and it is important that anyone providing support for someone who is living with IP (whether or not they themselves perceive or admit this) should keep an eye on risk factors both in respect of the client and in respect of other people.

It is particularly important to be aware that with some people the externalisation of IP into direct and serious violence can be triggered by, a sexual encounter.

6. Treatment and support

i. Effective assessment and treatment

Not all cases of (say) low self-esteem, or DVA, or drug and alcohol misuse, among LGB and Trans people are IP-related. Here as always, community-competent skilled assessment is critical.

Addressing IP needs to be part of a 360° approach, enabling cognitive change that will help the client to envisage the possibility of living a life that is not diminished by IP, to identify and address the origins of the internal phobia, and to move on. In practice, the first sessions will often focus on identifying positive steps towards improving self-esteem.

Such client care is effective when it can be perceived by the client as both

- securely based within an empathic positive and non-judgemental LGBT community background, and
- demonstrating deep community-based understanding of these issues.

The issues of IP can be extremely sensitive, and with some clients there can be a real risk of violence. Such cases must be carefully risk-assessed on an ongoing basis as the case develops.

Case story: "Sam"

"Sam" spent many years as a recipient of NHS mental health care, trying to manage living with severe social phobia, a destructively negative self-image, and obsessive self-harming and other negative behaviours. In their thirties Sam met the first NHS mental health worker with whom Sam felt safe enough to mention having problems living with the fact that they identified as LGBT. Signposted by this worker in confidence, Sam rang the Intercom Trust's helpline. After an extended grilling of the helpline listener about how the Trust operated, Sam agreed to meet one of our support workers, once. It became clear during the call that severe and potentially violent IP was involved, and that an internal risk-assessment needed to be undertaken before our support-worker met Sam.

The meeting turned out to be the first of many.

Twelve months later: risk-assessments were no longer called for; the negative behaviours and the affects behind them were history; Sam was living an ordinary life, holding a job down for the first time ever, looking for volunteering opportunities, and engaging with their own LGBT community.

At this point Sam volunteered the remark, "One year with you lot at Intercom has done me more good than 17 years with the NHS."

ii. Hidden IP underlying other issues

IP that may underlie depression, social phobia, stress and anxiety, or self-harming, or DVA, physical assaults, or harassment , but we find few people who are aware they are affected by IP will be prepared to be open to a counsellor, or police or probation officer, about the underlying issue.

IP as unnoticed background lighting

Many people with IP do not recognise or understand the condition, let alone have a label for it.

With awareness training, mental health workers and CJS officers can be alert for these possibilities. If they have reason to suspect that a service-user may be living with IP, they would do well to consult a specialist agency about the case, if only on a no-names basis. For one thing, there can be a serious element of public risk involved in such cases, and Intercom has observed that it may be difficult for non-specialists to assess this particular kind of risk accurately.

iii. Risky "conversion-therapy"

So-called "reparative" or "conversion" therapy, aiming to assist people to change their sexual orientation or their gender identity, has been widely discredited by professionals over the last few years for being ineffective and potentially harmful.

It is evident that such an approach is particularly risky when dealing with people who are affected by IP, since by endorsing the client's negative attitudes towards their sexual orientation or gender identity it is highly likely to have the effect of intensifying the conflict, and increasing destructive or dangerous affects and behaviours.

Intercom welcomes the very important national *Memorandum of Understanding on Conversion Therapy in the UK*, signed in January 2015 by fourteen key organisations including NHS England, the BACP, Relate, the Association of Christian Counsellors, Pink Therapy, PACE and the Royal College of General Practitioners. As part of this MoU the NHS has undertaken to make it known to all CCGs that "NHS England does not endorse or support conversion therapy".[4]

In another interesting recent development, a Superior Court judge in New Jersey has ruled that, on the evidence submitted by proponents of conversion therapy, the claims made by those who promote conversion therapy are unlawful under the state's Consumer Fraud Act.[5]

7. Conflicts and barriers around coming Out

With some clients, addressing IP will involve exploring possibilities of coming Out. This must include working with the client to assess the very real risks that this might involve, particularly where the root of the IP lies not only in the past but in current family and cultural environments.

Where the strong negative influence is that of the family or cultural environment in which someone has found themselves growing up LGB or Trans, it is unlikely that they will ever consider coming Out within the family or cultural community and risking hostility or exclusion.

Where someone feels painfully that they can only earn or retain such critical links by living a lie, this can of course inflict further emotional and psychological damage. However, it cannot be safely

4 www.psychotherapy.org.uk/UKCP_Documents/policy/MoU-conversiontherapy.pdf. Paragraph 8 points to the evidence for the ineffectiveness, and the potential to cause harm, of such approaches.

5 Ruling made on Tuesday 10 February 2015: http://www.cbsnews.com/news/judge-gay-conversion-therapy-claims-are-fraud/.

assumed that the way forward would involve the client simply coming Out. A realistic 360° approach must involve working with the client to find cognitive approaches, as well as considering socialisation changes to their daily lives. Coming out is, after all, by its nature, irreversible.

Family and cultural identities

People may well feel bitterness and deep unhappiness about secretly having to feel they are in conflict with, and at risk of being rejected by, a family or community environment in which they have a place and an emotional stake.

Where there are cultural as well as family issues involved, this conflict can lead to an even more distressing or damaging sense of secret alienation from a wider religious or ethnic community, within which they naturally feel a very strong need to maintain their personal sense of cultural identity.

8. Negative impacts on society

There have been occasional high-profile cases of IP, where it has reached the public domain that IP was a motivating factor in a murder. However, the most frequent examples of IP-related social harm are largely invisible, except within the community and to practitioners. Familiar examples are where someone's IP-related low self-esteem blocks them from aiming for the employment level they would like or from looking for a long-term relationship, or causes them to self-exclude from contact with their own birth-family, or from LGB or Trans community spaces or acquaintances. IP can sometimes be seen to underlie drug and alcohol abuse and self-harming, and domestic violence and abuse where one partner is externalising against their partner their negative attitudes to themselves. Practitioners are also familiar with cases where men who use public sex areas suddenly turn physically violent against other men who are using the same space.

9. Annex: data from Intercom's casework

i. Introduction

The following data is drawn from the Intercom Trust's most recent 741 client-support cases, those that were active in the period March 2010 to October 2014.

The IP-related analysis given below is new, and was made from the original data in January 2015 specifically for this briefing-note. The results that this new analysis came up with were of great and unanticipated interest to us at Intercom, and will we think be found valuable by our professional colleagues in other agencies across the South West.

We disaggregated the data from these 741 cases by whether the client had issues that were somewhere on the IP spectrum. There were 420 cases with an IP element (57%) and 321 without (43%).

ii. First contact

The overwhelming majority of these service-users first approached our Helpline on issues other than IP. A random sample of 50 recent Intercom clients who evidenced that they were living with IP shows that only 3 of them (6%) approached our helpline service with a request for help around their self-esteem as an LGB or Trans person, or some other issue that showed they were to some extent aware that they wre living with IP.

The other 47 had made first contact looking for help with any of 23 other issues, including:

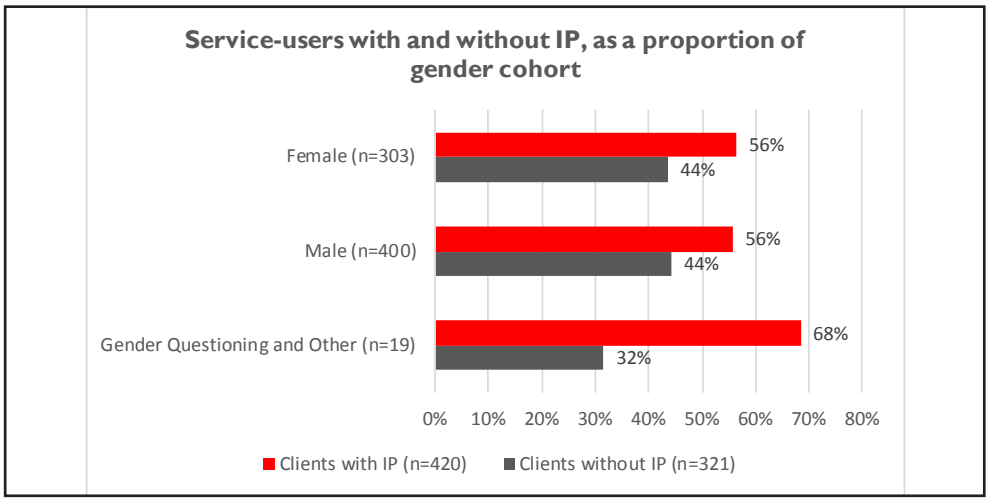
- social isolation and loneliness (34%)
- family and relationship problems (18%)
- crime and anti-social behaviour (16%)
- coming Out problems (16%)
  domestic violence and abuse (10%)
- confusion or uncertainty around sexual orientation or gender identity (8%)

As usual with our casework, most of these first-time callers wanted to ask for help with more than one issue.

The important fact is that all 50 were found to be living with IP, but 47 of the 50 did not first approach us on that issue.

iii. Gender and gender-identity

Analysis shows that amongst these 741 service-users, IP affected exactly equal proportions of males and of females.

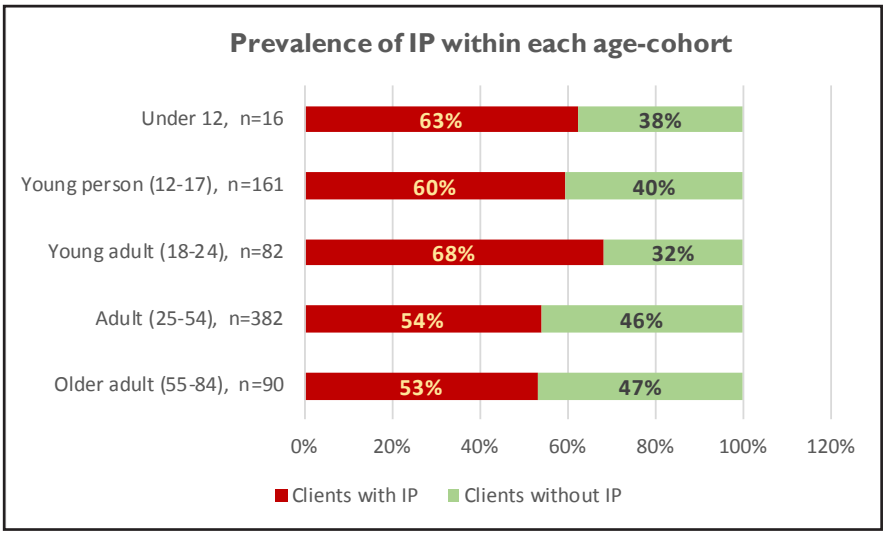


Trans people and Gender Identity Questioning people showed a somewhat higher proportion with IP than people who were not Trans. (See the following chart.) However, this difference is not

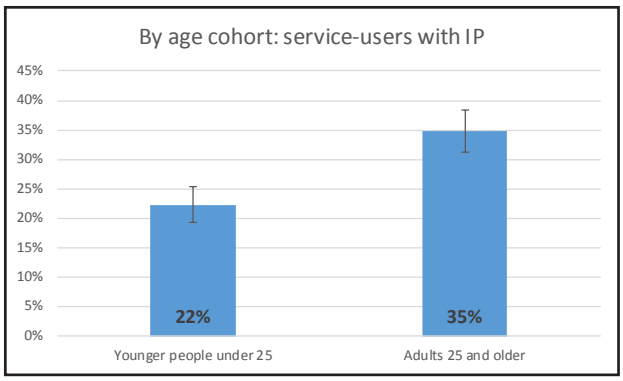
statistically significant at the 95% confidence level.

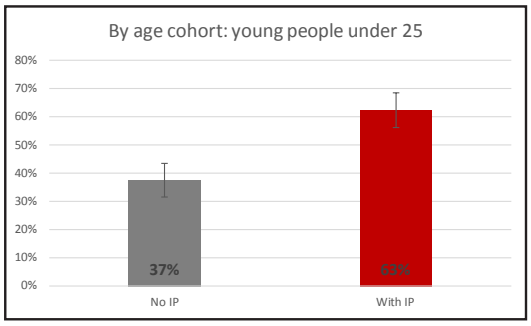
iv. Age-ranges

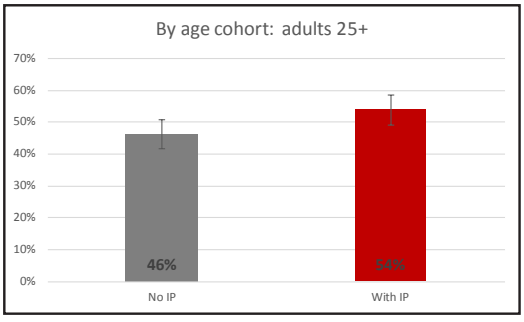
We observed that there is a higher prevalence of IP among our service-users in the age-ranges under 25 than amongst adults aged 25+. We can think of various possible explanations, touching on different areas of social concern, but these remain hypothetical.



Whatever the cause might be, this difference is found to be statistically significant as between age-cohorts, and also for the young people's cohort.

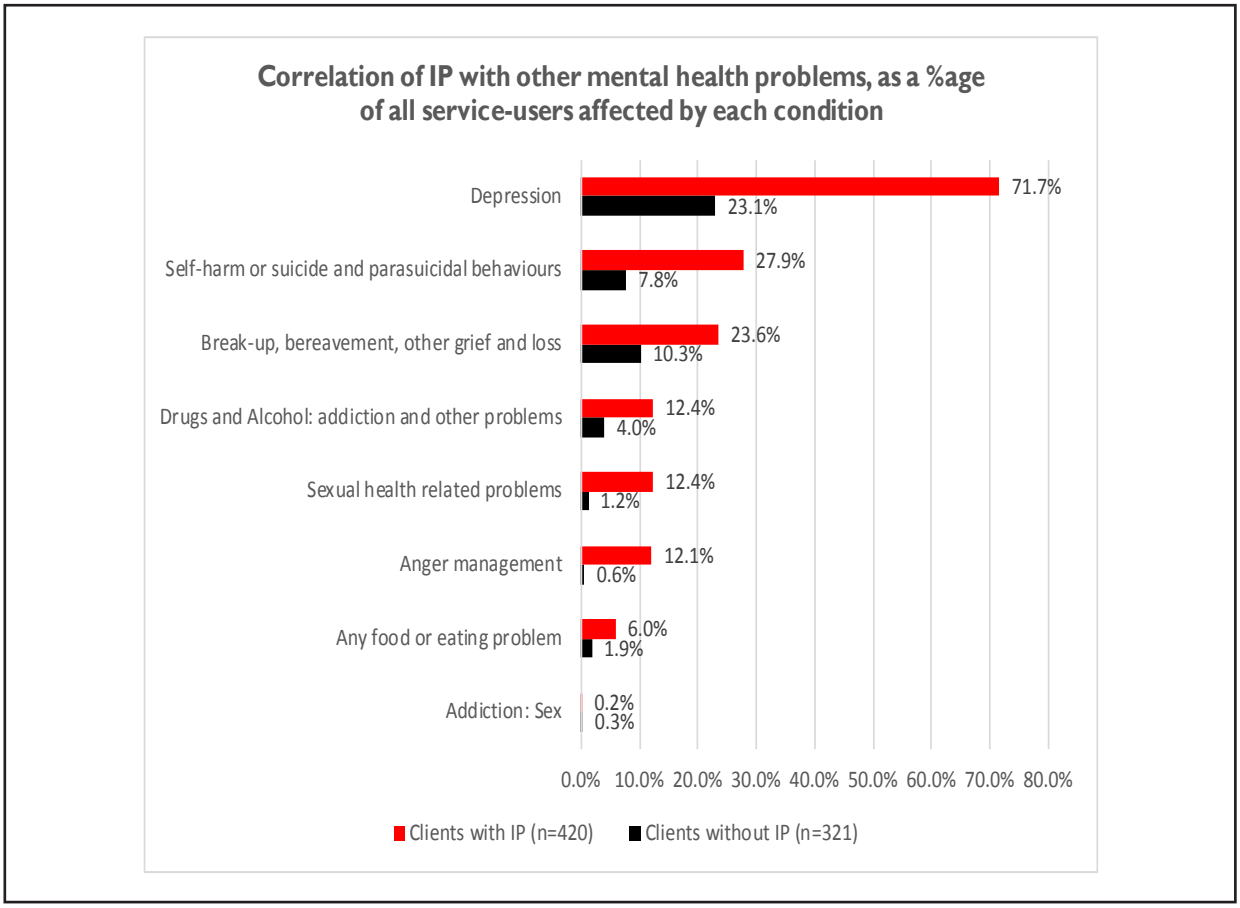






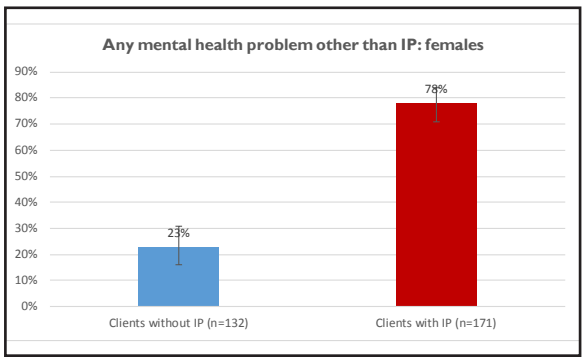
v. Correlation with other mental health and social issues

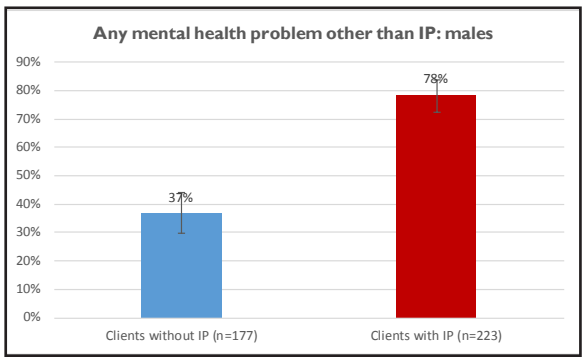
We found that other mental health and social issues were very much more prevalent amongst the clients who were living with IP than amongst those who were not.

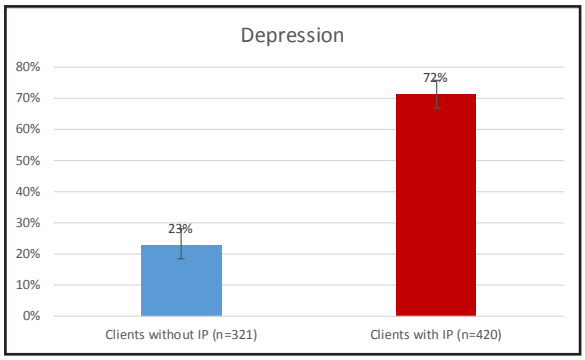


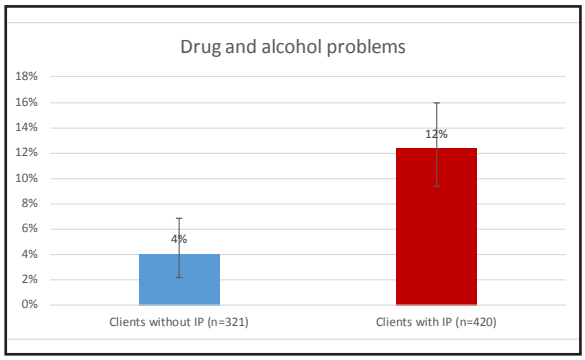
We then disaggregated the mental health issues by gender, and also drilled down in more detail into some individual mental health conditions and negative behaviours. We discovered that there was in every case a higher incidence of these conditions and behaviours amongst those who are living with IP than amongst those who are not living with IP.

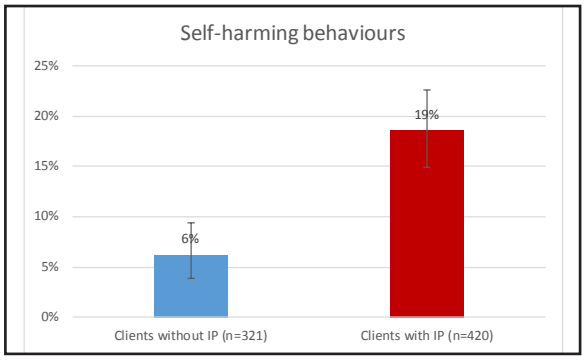
As will be seen from the error-bars in the following charts, all the results we found are significant to the 95% probability level, or higher.

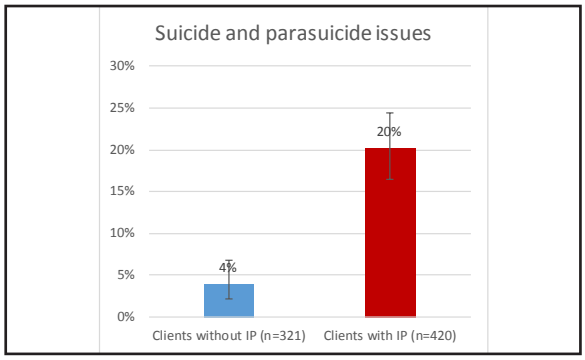

Any mental health problem other than IP: females
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
23%
78%
Clients without IP (n=132)
Clients with IP (n=171)

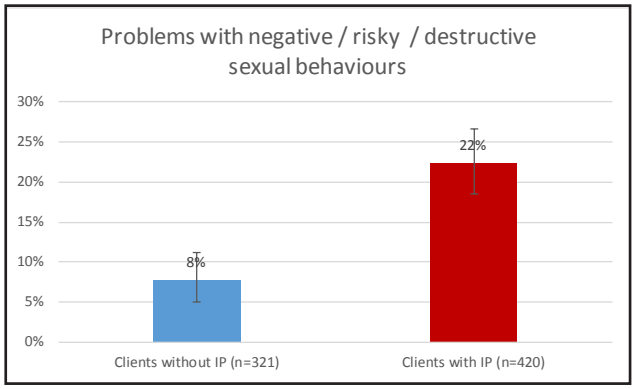

Any mental health problem other than IP: males
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
37%
78%
Clients without IP (n=177)
Clients with IP (n=223)


Depression
80%
70%
60%
50%
40%
30%
20%
10%
0%
23%
72%
Clients without IP (n=321)
Clients with IP (n=420)


Drug and alcohol problems
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
4%
12%
Clients without IP (n=321)
Clients with IP (n=420)


Self-harming behaviours
25%
20%
15%
10%
5%
0%
6%
19%
Clients without IP (n=321)
Clients with IP (n=420)

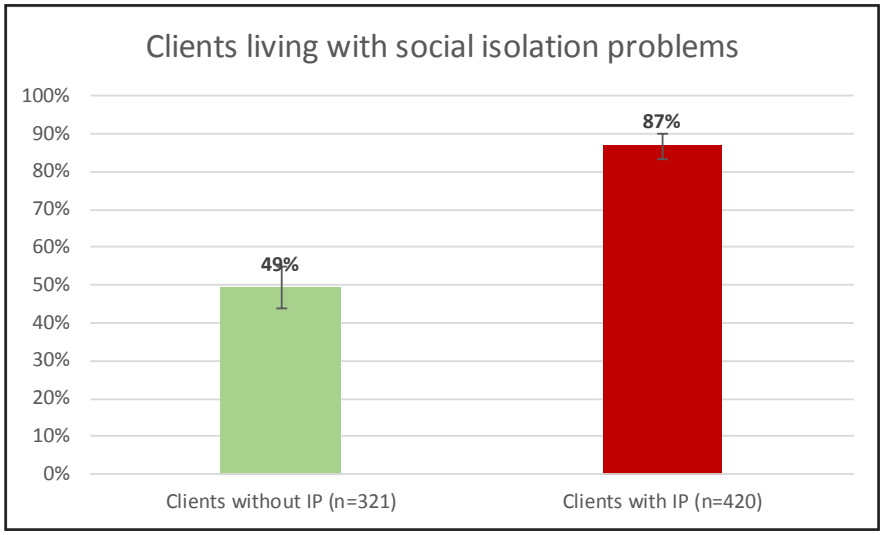

Suicide and parasuicide issues
30%
25%
20%
15%
10%
5%
0%
4%
20%
Clients without IP (n=321)
Clients with IP (n=420)


Problems with negative / risky / destructive sexual behaviours
30%
25%
20%
15%
10%
5%
0%
8%
22%
Clients without IP (n=321)
Clients with IP (n=420)

vi. Social Isolation

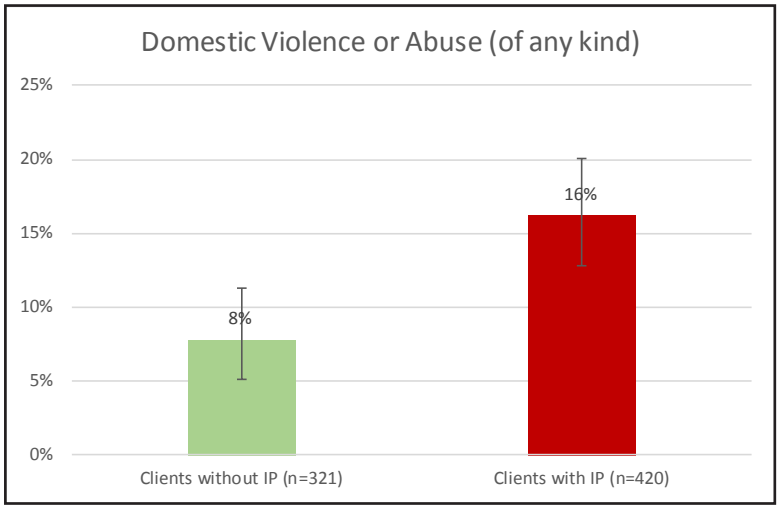
There is a clear (and, again, statistically significant) difference between the two cohorts in respect of their having problems with social isolation. This is particularly interesting since we already know that there is a correlation between social isolation and issues of health and wellbeing. [6]

On the basis of the Intercom team's casework experience, we would expect that more detailed research would show that there is a strong causal relation between the more severe experiences of IP and the more severe forms of social isolation (e.g. agoraphobia and social phobia).



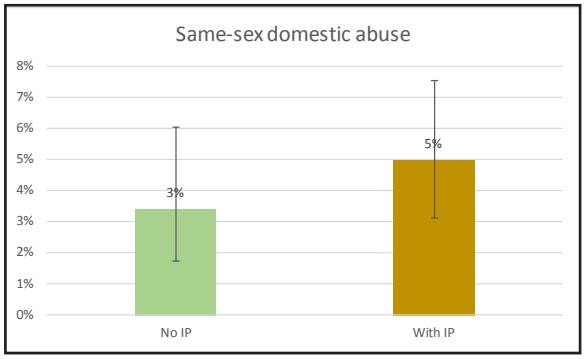
vii. Domestic violence and abuse

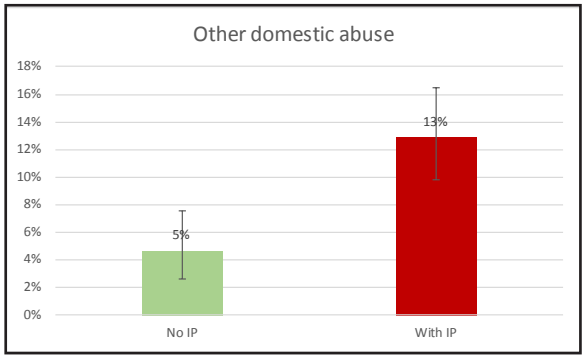
There is a clear overall correlation between IP and our consolidated measure of DVA.



6 See, for example, Devon LGBT Health Needs Assessment (Public Health Devon / Devon CCGs, 2014), passim: http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/09/Devon-LGBT-Health-Needs-Assessment-2014.pdf.

Looked at more closely, it is useful to differentiate between two types of DVA. The difference in respect of DVA between same-sex partners is not statistically significant: on the other hand, that relating to other, more common, forms of DVA (e.g. from parents / grandparents, siblings or in-laws, and sometimes from spouses, offspring or opposite-sex partners) is significant.



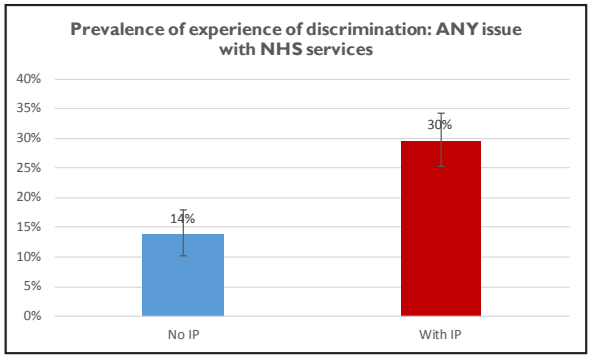


viii. Lack of skills in public services: police

At 8%, the proportion of our service-users who had issues relating to discrimination and lack of skills consolidated across the police, CPS and the rest of the criminal justice system was very low, considering the history around these issues. This figure was the same for those clients who were living with IP as for those who were not. It is well known that over the last fifteen years the police and other CJS agencies have made serious efforts to mainstream equality into service-delivery, to ensure they have raised officers' skills level around LGBT issues, and where necessary to take disciplinary action against lack of skills and negative attitudes.

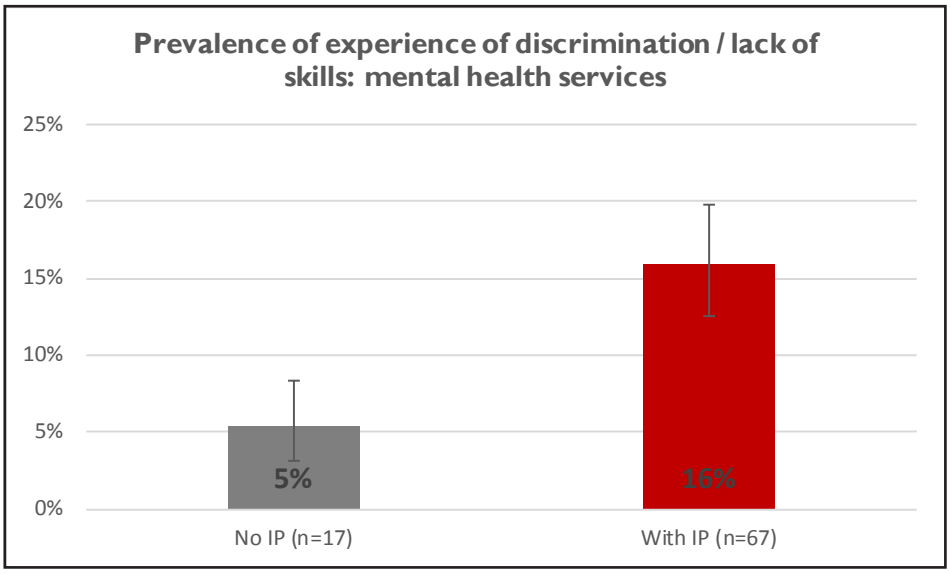
ix. Lack of skills in public services: NHS in general

By contrast, 23% of these 741 clients had issues relating to discrimination and lack of skills consolidated across the NHS a a whole, and clients living with IP were ecountering these problems significantly more frequently than those without IP.



x. Lack of skills in public services: mental health care

Since IP is a mental health condition, we analysed the difference specifically for those clients who reported that they had encountered discrimination or lack of skills in the mental health care system. Again, there is a statistically significant difference.



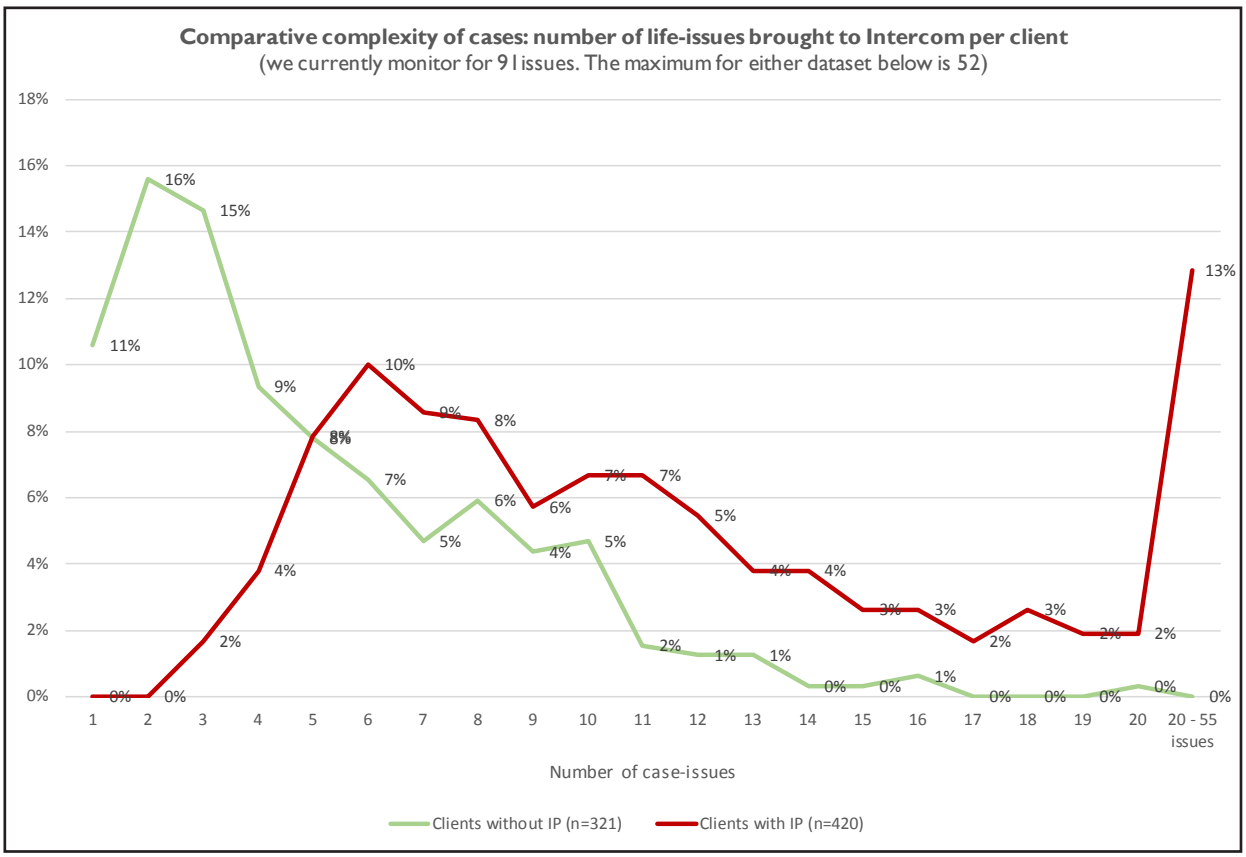
xi. Complexity of cases

As stated above, we currently monitor all calls and meetings on a possible 91 issues, ranging from various mental health problems and access to GP services to neighbour harassment, domestic abuse and rape, and from social isolation to bereavement, family problems, and relationship breakdown.

Simply monitoring the number of issues monitored for each individual is a useful and revealing broad indicator of the complexity of our casework. Disaggregating this complexity measure by IP we find a clear and revealing pattern: as the chart on the following page shows, cases with an IP element are, by this measure, very likely to be a great deal more complex than the cases which have no IP element.

It will be seen that the non-IP cases cluster towards the lower end of the complexity-spectrum. None of these has more than 20 separate issues. By contrast, the IP-related cases cluster towards the opposite end of the spectrum: 21% of these cases have more than 20 issues. 54 cases (13% of all IP-related cases) have between 21 and 52 separate issues. The least complex cases, with between 1 and 4 issues, make up 50% of all non-IP cases, but only 5% of IP cases.

A separate measure of complexity is the number of direct contact-hours between the service and each client. Overall, casework with clients living with IP takes up 3.6 times as many hours as casework with clients who are not living with IP.



We believe this chart is a clear indicator of the far-reaching and complex damage that IP can do to the health and social wellbeing of vulnerable individuals, and thus of wider social and health-related harm within wider South West society.

10. Annex: Clinical history

i. Earliest usage

The term "internalised homophobia" has been in common use for many decades amongst LGB people, providers of mental health care, clinical researchers, and others.

It was originally most frequently used, within the communities, in the specific context of crime. There was a sense amongst LGB people from the 1960s onwards (and probably earlier) that there was a pattern whereby many men who had homophobically attacked gay men were found to be gay men who were "in denial".

As far as Intercom is aware, the earliest discussion of this phenomenon by a psychiatrist was indeed in a forensic context. Donald J. West (now Emeritus Professor of Clinical Criminology, University of Cambridge), discussed what he described as "latent homosexuality" in his study *Homosexuality Re-examined* (Minneapolis: University of Minnesota Press, 1977). West said that some

people living with this conflict, "when placed in a situation that threatens to excite their own unwanted homosexual thoughts, […] overreact with panic or anger." [7]

ii. Current professional usage

The terms "internalised homophobia", "internalised biphobia" and "internalised trans-phobia" correspond to the less user-friendly term "egodystonic sexual orientation", used by the World Health Organisation in the *International Statistical Classification of Diseases and Related Health Problems* (current edition, ICD-10, 1992).[8]

The ICD conflates gender identity conflict and sexual orientation conflict under the same heading "sexual orientation", and the same code. It would have been good practice not to extend the term "sexual orientation" so violently, but to employ an inclusive term such as "egodystonic gender / orientation conflict". Many Trans people are not, after all, same-gender oriented, so they may understandably regard "sexual orientation" in this context as a term that is irrelevant to, and not inclusive of, any conflict they may be living with.

For the purposes of general discussion Intercom recommends the neutral and inclusive term "internalised phobia" as a better alternative to "egodystonic sexual orientation". However, in dealing with individuals it is important to be led by the client in the appropriate use of either "Internalised homophobia / biphobia" or "Internalised transphobia".

iii. First academic research (University of Georgia)

By the 1990s these issues were familiar elements in psychiatric training and discourse, and the concept was standardised and made official in ICD-10.[9] Professor Henry Adams and his team (Department of Psychology, University of Georgia) began an important new research project in the 1990s. This team's first paper, "Is Homophobia Associated With Homosexual Arousal?", was published in the *Journal of Abnormal Psychology*, 1996, Vol. 105.3, pp. 440 – 445.[10] It reported ground-breaking research conducted with 64 males aged between 18 and 31, of whom 35 were rated as homophobic on the Hudson and Ricketts 1980 Index of Homophobia, and 29 as non-homophobic. The conclusion was clear: "Homophobia is apparently associated with homosexual arousal that the homophobic individual is either unaware of or denies."

This paper, and its successors, [11] immediately gained widespread international attention amongst-mental health professionals, criminologists, LGB community workers and in the media. Research suggests that there is now mainstream awareness of the concept of internalised phobia, or "egodystonic sexual orientation", amongst mental health professionals in Europe and internationally.

---

7 West 1977, p. 202.

8 ICD-10 1992, code F66-1: http://apps.who.int/classifications/icd10/browse/2015/en#/F66.1.

9 E.g., in 1996, "Psychoanalysts use the concept of repressed or latent homosexuality to explain the emotional malaise and irrational attitudes displayed by some individuals who feel guilty about their erotic interests and struggle to deny and repress homosexual impulses." Adams et al. 1996, p. 441.

10 Currently (2015) available at https://my.psychologytoday.com/files/u47/Henry_et_al.pdf.

11 Subsequent papers are all available through the PubMed on-line journal store.