Deciding Who to See: Lesbians Discuss Their Preferences in Health and Mental Health Care Providers

Christine Flynn Saulnier

Few researchers have studied how lesbians choose health and mental health care providers. Using a series of studies, the Lesbian Health Care Project of Western New York gathered region-specific information concerning lesbians' preferences and decision making. This article reports on community focus groups in which 33 working class, middle class, African American, young, and older lesbians, as well as lesbians who frequent bars, reported that decision making was based on their past experiences and their hopes for high quality care. They encountered a continuum of provider reactions that helped shape their decisions. The continuum and consisted of five categories: homophobia, heterosexism, tolerance, lesbian sensitivity, and lesbian affirmation. Each category is discussed and examples are provided.

Key words: *choice; focus groups; health; lesbians; mental health; providers*

Lesbians' access to high-quality physical and mental health care is hampered by long-standing provider biases (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Lucas, 1992; Saghir & Robins, 1973; Stevens, 1992; Stevens & Hall, 1988). These negative attitudes on the part of physical and mental health care providers continue to interfere with services provision despite the progress that has been made in increasing lesbian visibility and decreasing overall stigma against lesbians and gay men (Appleby & Anastas, 1998).

Like most people, lesbians seek acceptance, respect, and a welcoming attitude in health care providers (Stevens & Hall, 1988). Few researchers have asked lesbians to elaborate on what else they want in a health care provider or on the factors that enter into their decision making when they choose a provider. Most of the information we have documents lesbians' preferences concerning the gender, sexual orientation, or race of their providers. Preferences regarding a clinician's sexual orientation vary. Modrcin and Wyers' (1990) nonprobability study of 128 lesbians and gay men found that only 40 percent of the respondents said they preferred to see someone of their own sexual orientation for counseling. In a national nonprobability survey of 1,925 lesbians, Bradford, Ryan, and Rothblum (1994) found that 66 percent said they wanted to see a lesbian or gay male counselor. Lucas (1992) found that 92 percent of a convenience sample of 178 southwestern lesbians preferred a lesbian health care provider.

Preference for a female health care provider is consistently high: 89 percent of lesbian respondents to the Bradford et al. (1994) survey stated a preference for women counselors, as did 68 percent of those in the study by Modrcin and Wyers (1990) and most of the 25 lesbians in the Midwestern snowball sample by Stevens and Hall (1988). Bradford and colleagues found that 73 percent of lesbian respondents had no preference

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for the race or ethnicity of their counselors. When asked by Lucas (1992) to respond to the practice of recording sexual preference in clients' charts, reactions varied considerably, although many disagreed (16 percent) or strongly disagreed (41 percent) with the practice.

Little additional information exists on how lesbian and bisexual women assess providers or what provider-specific information they believe is important to know when making choices about physical and mental health care. Although some information on differences between lesbians and bisexual women's perception of health risks (Price, Easton, Telljohann, & Wallace, 1996) is available, researchers have yet to examine whether the two groups have different preferences in physical and mental health care providers.

This article describes a research project conducted by the Lesbian Health Care Project of Western New York (LHCP), a coalition of lesbians involved in physical health, mental health, and alcohol and drug care delivery and analysis. The coalition includes physician assistants, nurse practitioners, social workers, health care administrators, psychologists, educators, and academics dedicated to improving lesbians' access to high-quality services. LHCP gathered region-specific information about lesbians' experiences, perceptions, and decision making. LHCP had four stages: (1) community survey, (2) five community focus groups, (3) survey of physical and mental health services providers, and (4) development and distribution of a community resource book/directory of services. Because a full report on the project is beyond the scope of this article, only the focus groups are discussed. The reader is referred to additional articles—one detailing the social action thrust of the project (Saulnier & Wheeler, 2000) and another describing the analysis of community survey data (Saulnier, 1999)—as well as to the resource book/directory of services produced by LHCP (Lesbian Health Care Project, 1997).

We learned from community survey respondents that, of the many things that lesbians took into account when choosing a provider, the factor they considered most important was competence. Respondents also were concerned about insurance coverage, particularly for physical health care. Positive attitudes, knowledge, and sensitivity toward the lesbian community were high priorities in choosing a mental health care provider. About one-third said they preferred a lesbian provider. Issues such as ageism, disabilities, and attitudes toward size, weight, and food were important, especially in a mental health care provider. Practitioners' hospital affiliation and knowledge of lesbian sexuality issues were important, particularly for physical health care providers (Saulnier, 1999).

Despite this new information, answers to some questions remained ambiguous. The community focus groups helped clarify how lesbian and bisexual women assess providers and what provider-specific information participants believe is important to know when making a choice about physical and mental health care. The significance of this research is that lesbian and bisexual women themselves have now been given the opportunity to elaborate on how they assess providers and the criteria they consider important—in addition to gender and sexual orientation—in choosing a physical or mental health practitioner.

Method

This was an exploratory study that used purposive techniques to select subpopulations, then convenience and snowball sampling to identify volunteers for five focus groups. A total of 33 lesbian and bisexual women participated in the focus groups, ranging from four to 15 women in each group.

Respondents

Before recruitment strategies were selected, LHCP identified which lesbians would be targeted. Information was obtained from both working class and middle-class women, and included African American women, young lesbians, and older lesbians. Each of these populations was targeted. Although there is disagreement about the proportion of lesbians who visit bars (Bloomfield, 1993; Ziebold & Mongeon, 1982), bars seem to play an important role in the coming out process and ongoing socializing for some lesbians (Kennedy & Davis, 1996). Because bars may provide access to lesbians who are heavier consumers of alcohol (Bloomfield, 1993), input from these women was sought to obtain information about alcohol and drug services, as well as other physical and mental health care.

Lesbian and bisexual women were identified through convenience and snowball sampling. Grouping lesbians together with bisexual women is not unusual (Saulnier & Miller, 1997). Lesbian

and bisexual women have been grouped together for comparison with heterosexual women in alcohol studies both for practical reasons, such as sample size (Bloomfield, 1993), and theoretical reasons, such as an effort by bisexual women to be included in lesbian communities (Kelly, 1991).

First and Second Community Focus Groups. For the middle-class and working-class groups, LHCP members attended a lesbian community function and solicited volunteers to attend one of two already scheduled community focus groups. Volunteers signed up for the group of their choosing and were encouraged to invite other lesbian and bisexual women to accompany them. They were asked for suggestions and contact information for additional women. The focus groups were held in convenient locations, known to community members and accessible by public transportation.

Youth Focus Group. For the youths, we asked a local gay and lesbian youth services agency for assistance in identifying potential participants. LHCP members were invited to use a Friday evening drop-in session at the agency to conduct the focus group.

Older Women and African American Focus Group. One member of LHCP was also a member of two lesbian organizations: one for older aduts and one for African American lesbian and bisexual women. Because both organizations are relatively small, and the facilitator anticipated limited participation, she invited members of both organizations to attend a single focus group, which was held at the usual meeting place of one of the organizations.

Bar Focus Group. A local bar owner, a longtime activist in the lesbian community, offered to conduct outreach. She successfully encouraged a wide range of her patrons, including local athletes, extremely poor women with chronic illnesses, wealthy professionals and executives, students, laborers, and rural, suburban and urban lesbians representing a significant range of experience with physical health, mental health, and alcohol and drug services organizations to attend the focus group, making it the best attended (15 participants), longest running (two hours), and most widely representative of all the focus groups.

Unlike anonymous surveys, participants in focus group research meet face-to-face with researchers. Given the sensitive nature of studying lesbians and the likelihood that some participants may have been wary of disclosing potentially identifying information, LHCP made a decision that reassurances of confidentiality might be insufficient to put focus group participants at ease. Participants were not asked to answer any written questions; therefore, demographic information was not gathered systematically. All that is known is what can reasonably be assumed, given the auspices under which the focus groups were conducted and the information participants disclosed during the group sessions.

Procedure

Group sessions generally took from 60 to 90 minutes. The purpose of LHCP and the focus groups was explained, and participants were encouraged to offer their perspectives and contribute any information they thought was important. A semistructured, open-ended focus group guide was designed to elicit information that had not been asked on the community survey, for example, the information participants would need to decide whether to use a particular provider: "If you could interview potential providers, what information would you need from them to help you decide whether to use their services?" We asked questions intended to clarify ambiguous responses to the community survey, such as, "What constitutes a lesbian-sensitive provider? What are the characteristics?" In some cases, we asked participants to be quite specific. For example, after asking the general question, "Where should lesbian/bisexual/questioning/women-who-love-women look for help with their concerns about emotional, relationship, or mental health issues?" we asked them to specify, "What should they be looking for?" We also encouraged participants to prioritize their concerns by asking, near the end of the session, "Of all the things we've discussed, what do you think are the most important for you in choosing a health care provider?"

As the sessions drew to a close, we summarized what the facilitators had heard, reviewing the handwritten notes taken during the sessions, and asked the groups whether our summaries were adequate representations of what had been said. The focus group sessions were tape-recorded and transcribed verbatim by a research assistant.

Data Analysis

A minimum of four people read each transcript. Two qualitative researchers read all transcripts, as

did a research assistant who was unfamiliar with the community but trained to extract answers to the research questions. At least one additional LHCP member, who had not been present at the focus group sessions, also read each transcript. Readers were given the following instructions on how to respond to the transcripts: "Our data analysis will be done, in part, by each of us reading and making notes on the transcripts and, in part, by our group discussion of our findings. Please read the transcripts and react to them. Write comments in the margins—your responses, thoughts, and so forth. Please make notes about whatever you see—themes, explanations, questions, and so forth. Your notes, called 'memos,' will classify ideas, tie ideas together, and raise questions for discussion. When we meet, we'll talk about what you saw."

Guided by the semistructured questionnaire used in the focus groups, LHCP members met to compare the initial analysis and answer research questions. Decisions regarding meaning were reached through discussion and group consensus. Perhaps because LCHP members were all lesbians; all involved in administration, education, or provision of services; and all had worked collectively for such a long time, consensus was not difficult to reach.

We reread relevant portions of the transcripts when any discrepancies were identified. For example, one reader's perception was that participants viewed charting of sexual orientation as a problem. Another reader thought there was a range of opinion about whether sexual orientation should be noted in a client's chart. It was a relatively simple process to scan the transcripts to determine which perception most accurately reflected the data.

For a more detailed reanalysis that followed this collective process, the transcripts were entered into HyperRESEARCH (Hesse-Biber, Dupuis, & Kinder, 1991), a qualitative program that allows the researcher to analyze transcript content through a system of coding, organization, storage, and retrieval. Analysis is assisted by manipulation of portions of researcher-coded source material. HyperRESEARCH records the location of selected text, along with the specified code name assigned by the researcher. Coding facilitates analysis by allowing the researcher to cluster all data on a particular topic under one heading, thus making the study of source material more manageable (Franklin & Bloor, 1999). For example, when a participant in one focus group described receptive, respectful treatment by a receptionist, it was coded as "respect."

Comments made by a participant in another focus group about a physician who suggested journal articles that might help the patient make up her mind concerning a proposed medical procedure was given the same code.

Segments of the transcript were assigned multiple, nonexclusive codes, because, at this stage, it was premature to rule out any of the analytic topics to which a segment relates. Final interpretation came later when the material was compared with similarly coded segments. For example, the following excerpt was coded both as "discrimination" and as "insurance": "They told me with my medical coverage, I've got to complain at least a million times within a year to really get any services." The coding process was cyclical. As new codes were used in transcripts of subsequent focus groups, the researcher returned to earlier transcripts to determine where the new code should be applied.

When all the transcripts were coded, a full report was generated that contained all coded source material labeled by code name and case name. The full code report contained the sequence and name of the focus group; the code that was assigned; and the source material or excerpt from the transcript. A typical example follows:

> Bar Focus Group; Sexism
>
> *Source Material:* "He doesn't recognize women at all I think. And me saying openly that I was a lesbian, you could really see the expression on the man's face. He was appalled."

This reanalysis using qualitative research software was not a collaborative enterprise; I, a member of LHCP, completed it. Before coding the transcripts, I reviewed notes from the group discussions and handwritten comments on the transcripts. To maintain the integrity of the collaborative analysis, these notes supplied the preliminary keywords used for the reanalysis.

Results

Because of the data-gathering procedures, it was not possible to identify an individual speaker. If participants mentioned individuals, we changed the names.

How Participants Assessed Physical and Mental Health Care Providers

There was considerable disagreement over whether a provider's habit of charting sexual orientation was a positive or negative response. Some women saw benefits to including the information on their charts, for example, to ensure recognition of a partner's role or to avoid having to answer irrelevant questions, such as birth control practices. Other women argued against charting out of concern for potential breaches in confidentiality or, in some cases, because they thought the providers or their staff could not be trusted to use the information properly. There was consensus, however, that the client herself, rather than the provider, should decide whether sexual orientation was noted on the chart. For a detailed discussion, see Saulnier and Wheeler (2000).

Family issues were important. Focus group participants wanted to know whether practitioners would include their partners in their care and they wanted to know about accommodations for children; for example, whether there were books and toys available for children in a practitioner's waiting room. To make an informed decision about whether to use a provider's services, participants wanted to know whether providers were aware of the number of lesbian and bisexual clients they served, a provider's likely response to a disclosure of lesbian orientation by someone under 18 years of age, and how a provider handled information about a lesbian's emergency contact. Participants also wanted to know whether there were any out lesbian, gay, or bisexual people on the provider's staff and how well providers prepared themselves and their staff to serve lesbians.

Provider-Specific Information Participants Believed Important

An interest in alternatives to Western medicine has been identified in earlier literature on lesbians (Trippet & Bain, cited in Peterson & Bricker-Jenkins, 1996). Participants in this study expressed a similar interest. They also said they considered whether walk-in and emergency services were available and what specialty training a provider had. Practical considerations included insurance, sliding fee scales, and clinic and agency affiliations. For most participants, a provider's sexual orientation was less important than training, experience, and level of understanding of lesbians.

On reanalysis, an overall theme became clear: Lesbians anticipated and experienced a continuum of responses to their sexual orientation from providers. The continuum ranged from irrational fear to celebration of lesbians and consisted of five categories: (1) homophobia, (2) heterosexism, (3) tolerance, (4) lesbian sensitivity, and (5) lesbian affirmation, with the middle range—tolerance—spoken of in terms of desire rather than lived experience. These expectations and experiences influenced future choices.

To clarify terms, homophobia is a mental illness designation that signifies a clinically phobic reaction to nonheterosexual people (Neisen, 1990). Heterosexism signifies reinforcement of the marginalized sociopolitical position of lesbians and other nonheterosexual people. Like other "isms" such as classism or sexism, the term points out a cultural devaluation of people based on a group characteristic, in this case lesbian sexual orientation, and combines it with the power ascribed to the dominant group, that is, heterosexuals, to sanction lesbian, gay, and other nonheterosexual people (Lorde, 1984; Neisen, 1990). In sum, homophobia is a psychological construct whereas heterosexism is a sociological one (Spaulding, 1993).

Actual encounters with providers tended to be described in positive or negative rather than neutral terms. Comments were grouped according to how well they fit a theoretical category, not according to the intensity of the behavior described. That is, a participant might have mentioned a spirited response on the part of a health care provider, but the provider's behavior, despite the fervor and potential for damage, fit best under the category heterosexism rather than homophobia. An example follows:

> What I went through I hope no girl has to go through when she's in her twenties. Because I went for a PAP smear, and the doctor said, "Well, you're awful tight for your age. You should try men. They're not that bad." . . . I wouldn't go back for a PAP smear for about three years after that . . . I was so embarrassed I didn't know what to say or what to do. I hope the girls don't have to go through that today. [Bar Focus Group]

Although the provider's response had a serious, negative effect on the woman's decision to avoid health care, the action did not indicate an

irrational fear or extreme loathing of lesbians. It did suggest a serious disparagement of lesbians and a presumption that heterosexual activity is superior to other forms of sexual expression. The comment was considered heterosexist.

Homophobia

Many participants described experiences they hoped would never be repeated. Most of the examples of mistreatment were classified under heterosexism. However, some descriptions of fear or irrational responses can be described as phobias. An example suggestive of this extreme end of the spectrum—homophobia—follows:

> Well, that's how she looked. She looked like she was [scared]. I think I was probably her first lesbian. I mean she's like 30 . . . really young. . . . She wasn't hysterical or anything. . . . But she seemed uncomfortable and she was sweating. [Second Community Group]

Such experiences were not as common as instances of heterosexism, which seemed to permeate physical and mental health care.

Heterosexism

One of the most common complaints of heterosexism had to do with lesbian invisibility. Participants often complained about health information and intake forms in this regard:

> Heterosexism is the assumption that everybody's heterosexual unless you say you aren't; it's really debilitating. And I think that so much of it occurs in the way demographics are collected in the health care system, the way questions are framed. . . . when you fill out a form, and you get that "single, married, divorced, widowed" status, I always ask myself, "Is this a real good form that I'm filling out?" [It should have] inclusive language so you [can] write in that you're a lesbian, so it'll fit in the form and not [be] scribbled on the side. That's the kind of oppression that I think is the worst—invisibility—that we get. And when you're sick, you're vulnerable. [First Community Group]

Besides failing to notice lesbians, practitioners failed to observe and honor their family forms. Providers and biological family members sometimes seemed unable or unwilling to cope with a family constellation that differed from the prescribed social norm:

> It was real important to me that Shannon, my partner, was the person that the doctor recognized as my primary relationship and gave her the information. . . . We just recently had a friend, an older woman, who went through a terrible loss of her long-time partner. And the doctor and this woman's biological family had left our friend, Annette, sitting in the waiting room. They were waiting for Betty to come out of surgery. And Annette was left sitting in the waiting room when the doctor talked to the biological family and then they went home. [Bar Focus Group]

One can only imagine the profound pain and frustration of being dismissed at a time like this—when a partner is most needed. Reports of lesbian invisibility and lack of attention to lesbians' families were supplemented by descriptions of providers who were ignorant of lesbian issues and needs. Several women said that they trained their providers. When asked what they meant by training, participants said:

> Well, first of all, that lesbians exist, and that lesbians exist in their practice. And that there are lesbians that do feel comfortable with acknowledging their homosexuality and their relationships. [Second Community Group]

There is nothing wrong with educating your health care provider:

> This is what you should talk about. I have a cold sore on my lip and it comes up all the time in the same place and it's herpes. You should be advising me about sexual contact using my mouth.[Older Women and Women of Color Focus Group]

Another form of heterosexism consists of negative stereotyping. A common stereotype, the association of lesbians with illness, is described in the following statements. In the first instance, a woman reported that years earlier, she had been presumed to have a sexually transmitted disease because she is lesbian. In the second, more recent instance, the provider associated lesbianism with mental illness:

> I can remember years ago when I went to the doctor and he found out I was a lesbian. . . .

He wanted me tested to see whether or not I had syphilis. And I said, "Wait a minute. . . . I just told you I was a lesbian . . . it just so happens that I've been in the same relationship for about four years and that it's a monogamous relationship." [Older Women and Women of Color Focus Group]

* * *

I went to him maybe a year or two ago for some severe strains at work and at home. I said I was really depressed and I was having a problem. So, he says to me, "So do you have a girlfriend?" This was not my problem! So [I think] he looked at the chart and said, "Well, she came here because she has a problem with homosexuality. Let's see if she's seeing somebody and that's why she's depressed," as opposed to "Hello." My mother's sick . . . but that's the only way he sees me. I'm very comfortable about being a lesbian. That was not my stress at all. [First Community Focus Group]

In this case, a provider's stereotyping caused him to miss the problem for which the woman sought help, seriously limiting the provider's capacity to give adequate care. Some participants reported explicit disparagement because of their sexual orientation. One woman described her experience of being infantilized when she came out to her doctor:

My doctor didn't even talk to me because I openly said that I was gay. He didn't want to talk to my partner at all. . . . He talked to my mother! I am 28 years old. I am responsible for myself, and my partner should be involved. [Bar Focus Group]

Although many focus group participants reported trying to avoid the negative encounters with health providers described in these statements, other women talked about what they wished they would experience. Expectations tended to be low. Few hoped for enthusiasm; most wanted only to be treated with the same dignity accorded more socially accepted care recipients.

Tolerance

Often participants seemed so relieved by the thought of an absence of hostility that they sought toleration in a provider. Respondents said:

I look for somebody who's going to treat me like I'm a person who needs medical care . . . not psychiatric care. [Older Women and Women of Color Focus Group]

Perhaps most minimal was the hope of "just not getting hassled" [Second Community Group].

It is not surprising, given social approbation commonly encountered in daily life, that lesbian and bisexual women's hopes for care were often so minimal. However, some focus group participants experienced more than tolerance. They described providers who were cognizant of lesbians' needs and who realized lesbians' needs sometimes differed from those of heterosexuals. Such providers became the standard by which others were often judged.

Lesbian Sensitive

When asked to define "lesbian sensitive," one woman described a matter-of-fact reaction from a practitioner that acknowledged the possibility of a patient's nonheterosexual orientation:

I said, "Well I don't use birth control." And she said, "Are you celibate or are you gay?" [Older Women and Women of Color Focus Group]

Lesbian sensitivity includes working with partners, as needed:

My surgeon . . . he was very open with my partner . . . like if I had to go for a test you could take somebody with you. He spoke freely to her and allowed her to be with him in his office. He coached her to come in. He spoke with her as if he was speaking to anybody's partner, and he included her in everything. . . . I was too sick to have anybody around me that was not open to lesbian[s]. [Older Women and Women of Color Focus Group]

Like several other women, this participant suggested that her level of tolerance for heterosexism decreases when she is ill. Participants talked about comfort, receptivity, and lesbianism as normative, when they discussed lesbian-sensitive practitioners. A provider should be a "comfortable person [who] makes lesbians comfortable and feels comfortable around me." [Older Women and Women of Color Focus Group]. Participants said they wanted "a friendly atmosphere where you don't feel like you're under a microscope" and "someone

who won't get freaked out and . . . who's kind of like open-minded. A comfortable kind of atmosphere" [Youth Group]. Gaining basic knowledge is necessary but not sufficient. A lesbian-sensitive provider would need to keep up on new knowledge concerning lesbian and bisexual women: "I guess I'd want to know . . . if they were up to date on STDs, how—if—they were transmitted woman to woman . . . if they were up to date on the readings and the research." [Youth Group]

Others hoped to see some symbol of openness to lesbians in the provider's office, including pictures of lesbian families, for example. Symbols that were sought were not necessarily of lesbianism. One woman suggested that lesbians also looked for indications of a provider's political views on social issues:

> We look to see if there's information around the waiting room that indicates a more liberal outlook, a progressive outlook. . . . I doubt there's anybody who would be pro-life, who would be a good health care provider for gay and lesbian people. [First Community Group]

Being lesbian sensitive also meant that providers were able to place a lesbian's concerns or problems in their sociopolitical context:

> I think you need a savvy counselor to look at the multiple oppressions that [we] have. So I'm dealing with alcohol. . . . But I'm also dealing with society and bigotry and antigay situation[s] too, and whatever that does to my psyche. [Second Community Group]

Lesbian sensitivity was described as almost a mirror opposite of heterosexism: Lesbians are visible; their partners are included in care. Instead of ignorance, practitioners have up-to-date knowledge. Positive images replace negative stereotypes. Disparagement gives way to a comfortable, friendly, professional atmosphere and practitioners who are sensitive to the sociopolitical position of lesbians in our culture. Many seek an antidiscrimination policy that explicitly mentions sexual orientation. Such sensitivity was more than many of the participants expected. Remarkably, a few women reported a level of care that went beyond lesbian sensitivity.

Lesbian Affirmative

Some providers actively affirm lesbians by doing outreach to lesbian and bisexual women or taking special care to make lesbians feel like an important part of their practice. In some instances, the practice includes lesbian-specific services not normally available elsewhere. Few of these were available in Western New York, although participants mentioned services in larger cities, such as alternative insemination in Boston and San Francisco or alcohol and drug services in Minneapolis. In an unusual story of outreach to the lesbian community, a bar owner told of an ongoing arrangement she has with a lesbian-affirmative physician:

> "Dr. C" I said, "You know, there's a lot of women [who can't get care] and I know sometimes you don't take [new patients]." And she said, "You want anyone to come in, you call me and they're here, they're in." . . . For instance . . . there was this woman that comes in the bar and she was in here one night and she looked like hell. . . . She was talking to one of my bartenders . . . and she was saying that she had felt terrible over a urine and PAP, but the doctor just says, "Oh, it's pretty much all in your head." So, I kind of listened in and . . . I said, "Well you don't need him anymore. You need to go to a woman doctor." So I wrote down [the information] and said, "Do not forget to mention my name." . . . I didn't see her for a couple of months. And what happened, she come back in saying there was a precancerous condition . . . and . . . she's going for some surgery, but it didn't go left unattended. [Bar Focus Group]

In addition to life-saving outreach, Dr. C provided lesbian-specific services, described here by one enthusiastic recipient of care:

> Dr. C is excellent. . . . She has a whole women's department health clinic and it's all women on staff, which is really great. She . . . talks about that a lot of the women that she gets want to have children [through alternative insemination] and [she tells them] how you go about it and what the best way is. [Bar Focus Group]

Summary and Implications for Practice

Lesbians, reporting on their experiences with and preferences for physical and mental health care, described care that ranged from homophobic to lesbian affirmative. This study supports Neisen's

(1997) theory of a continuum of level of sensitivity toward lesbian and gay people on the part of mental health providers and is similar to what Stevens (1996) found among physicians. Participants in LHCP focus groups reported that they continued to experience insensitivity and that this negative treatment by practitioners helped them decide which practitioners to use and which ones to avoid. Even well-meaning providers need to be more aware of lesbians' fears of negative repercussions that could result from coming out. Practitioners should consider the number of lesbians they serve and be ready to answer questions about their services for lesbians and discuss how they have prepared themselves and their staff to sensitively incorporate lesbians into their practice.

The decision to include sexual orientation in a chart or client record was important to participants in this study. Lucas (1992) identified reluctance by many lesbians to having their sexual orientation charted; Peterson and Bricker-Jenkins (1996) suggested that lesbian and bisexual women prefer to make that choice themselves. Because our data confirm this, social workers should examine their charting practices closely and encourage other providers to do the same. Social workers need to consider how providers and recipients of care might best be encouraged to discuss charting issues and come to an agreement about whether sexual orientation is noted, thus supporting client self-determination.

Focus group participants said they sought practitioners who include lesbians' partners and other family members in physical and mental health care. To support this, agency policies that exclude lesbian families from their definition of family must be changed, with definitions expanded to include same-sex families (Tully, 1994). Provisions must also be made for lesbians' children.

According to participants in this study, the much sought after lesbian-sensitive provider is open to the likelihood that lesbians are part of the practice and, as appropriate, include a lesbian's family members in physical or mental health care. Lesbian sensitivity means that providers demonstrate comfort with and receptivity to lesbians in their practice and see lesbianism as normative. They find ways to make it known that lesbians are welcome to receive care in that setting. They understand that lesbians often face challenges that are not faced by heterosexuals; for example, maintaining a sense of dignity in a heterosexist social climate. A lesbian-sensitive practitioner prepares agency staff for working with lesbian and gay clients; this includes having a clear, specific, and enforced nondiscrimination policy and using inclusive intake and other health care forms.

Not all of our findings indicate a need for change, however. Many participants reported success in locating sensitive treatment, practice that included their families, and well-trained staff and professionals. Lesbians reported that providers are beginning to recognize the significance of documenting a woman's sexual orientation.

Although the results of this study are important, there were significant limitations. This research involved a small sample and was intentionally limited geographically. Because probability sampling was not used, it is not generalizable, even to the geographic region in which it was conducted. It is reasonable to assume that selection biases influenced the findings throughout. Nevertheless, this information contributes to our understanding of how some lesbians choose physical and mental health providers.

As would be expected, at the very least participants preferred tolerance, but many hoped for lesbian sensitivity. Participants wanted up-to-date information about how to locate lesbian-sensitive providers. Projects such as this one help to meet that demand. In subsequent stages of this project, LHCP gathered provider data and provided a summary in the form of a resource book distributed free to the community (Lesbian Health Care Project, 1997). In addition, the National Lesbian and Gay Health Association has recently begun collecting data for a national resource guide to lesbian, gay, bisexual, and transgender health organizations. Updated resources can often be found online; for example, "The Pink Pages" (www.pinkweb.com) is a guide to regional information for lesbian and gay people. Responses to the community survey (Saulnier, 1999) and the focus groups suggest that such resource guides are sought after by lesbians. Practitioners should be aware of and support the development of community guides that help lesbians locate sensitive physical and mental health care in their geographical area.

This research explored how lesbians chose physical and mental health care providers and found that decision making is based on a continuum of experiences with providers and hopes

for high quality care. Social workers who encourage elimination of the negative experiences described here and the practice of the more positive examples of care can help make physical and mental health services more responsive to lesbian clients. It is not enough for a provider to have good intentions and a good understanding of what lesbians might want. According to participants in this study, providers still behave in ways that are experienced as homophobic and heterosexist.

Disappointingly, common sense knowledge about how to serve lesbians in an affirming manner does not seem to have sufficiently influenced the physical and mental health providers with whom these participants interacted. We need to do more. For a start, we need a better understanding of the nature of providers' attitudes toward and experiences with lesbian and bisexual women. This must go beyond simple dichotomous questions about a respondent's like or dislike of people with various sexual orientations. Detailed information, if obtained on a range of professional groups, could be used to identify the specific training needs of providers who serve lesbians. Such research could contribute to an increase in high-quality training that could, in turn, significantly improve services to lesbian and bisexual women. Although it might seem self-evident, it is important to state that each new cohort of providers needs to be trained in how to deliver lesbian-sensitive services, and practitioners already in the field need to be apprised of new knowledge in this area.

Social workers in schools of social work can ensure that information on lesbian, gay, and bisexual people is covered in cultural sensitivity courses and that students are provided with clear recommendations for practice. Both academics and social work practitioners can band together with other professionals through mechanisms such as orthopsychiatry, Academy for Health Care Quality (www.jcaho.org/academy.htm), National Assembly of National Voluntary Health and Social Welfare Organizations (www.nassembly.org), and National Association of State Alcohol and Drug Abuse Directors (www.nassembly.org) to encourage ongoing training on the needs of lesbian and bisexual women.

In Massachusetts the Department of Public Health helped fund the Gay, Lesbian, Bisexual and Transgender Health Access Project (GLBT; www.glbthealth.org). The project developed a document called "Community Standards of Practice for the Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgender Clients" that was distributed across the state. It addresses five areas: personnel, client's rights, intake and assessment, services planning and delivery, and confidentiality. Each area has recommendations for standards and indicators of whether the standards are met. For example, Standard 1 encourages an inclusive, nondiscriminatory workplace. One of six indicators is the "discussion of policies with job applicants during interviewing process" (GLBT Health Access Project, 1999, p. 2).

Social workers can contact their state departments of public health to see whether similar standards have been developed. If so, social workers can help make their own organizations aware of the standards and encourage their implementation. If no such standards are available, social workers can work with state departments of public health to develop standards of care, incorporating the research findings discussed here and other recent research on lesbians' physical and mental health needs. The Massachusetts standards can serve as a model for other states. ■

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Christine Flynn Saulnier, PhD, ACSW, *is academic planner, Office of Academic and Student Affairs, System Administration, University of Wisconsin, 1638 Van Hise Hall, 1220 Linden Drive, Madison, WI 53706. An earlier version of this article was presented at the annual meeting of the American Orthopsychiatric Association, April 1998, Washington, DC.*

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Correction: In the editorial, "Using Knowledge about Knowledge Utilization" (April 2002), on page 102 the Internet address for the Web site NYU Frequently Asked Questions was incorrect. It should have read http://forums.nyu.edu/faq/

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