

**Lesbian/Gay/Bisexual/Transgender
(LGBT)-Supportive Mental Health Services
in San Luis Obispo County:
HOW ARE WE DOING?**

A Focus Group Project commissioned by the

Growing Together Initiative
of the

SAN LUIS OBISPO COUNTY
 **COMMUNITY
FOUNDATION**

Report on Findings
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I. INTRODUCTION

The Growing Together Initiative (GTI) was established in 2001 by the San Luis Obispo County Community Foundation, with a mission to address the needs of the region's lesbian, gay, bisexual and transgender (LGBT) community. Initial funding for the GTI was provided through the National Lesbian and Gay Community Funding Partnership, with additional support from the California Endowment to address LGBT-related health concerns. A growing number of individual donors have contributed to this endowed grant program, which in June 2003 completes its second cycle of giving to local organizations. An advisory committee to the GTI provides guidance and support in reaching its goals to address needs in the LGBT community by 1) providing grants, 2) raising community awareness, and 3) promoting philanthropy.

Community needs assessment is a key responsibility of the GTI, and is used as a way to further all three of its stated goals. In November 2001, the Foundation distributed the results of a broad-based Community Individual Survey, completed by over 500 local community members. This study, conducted and administered by Thomas Keifer Consulting, was designed to identify issues important to and services needed by the local LGBT community.¹

Findings of the Community Individual Survey included a list of LGBT service needs, ranked by respondents in terms of "level of concern." In reviewing these data, the GTI Advisory Committee determined that deeper analysis was required on one of the top five service needs that respondents had ranked as "serious" or "very serious": *LGBT Supportive Mental Health*. A focus group model was chosen as an effective research tool to better understand the issues that have created a barrier to LGBT supportive mental health and related services, and to explore strategies for positive change. Consultant Wendy Wendt was commissioned to design and administer the project.

II. METHODOLOGY AND IMPLEMENTATION

A focus group is defined as a one-time, confidential discussion among participants with characteristics in common that relate to a particular topic. Focus groups are used to gain a deeper understanding of how people think or feel about the issue. Focus group studies use a set questioning route to conduct multiple discussions with different groups. Analysis involves the search for recurring themes or ideas across groups, as well as nuances within groups.²

The GTI Focus Group Project was designed to involve one-time discussions by five distinct groups: Mental Health Providers: Youth (Gay/Lesbian/Bisexual/Questioning/Straight); Transgender/Transsexual ("TG/TS")³; Women (Lesbian/Bisexual); and Men (Gay/Bisexual). Each group would contribute insights towards a deeper understanding of perceptions regarding the status of mental health services in relation to the local LGBT community, as well as suggestions for positive change.

The Focus Group Project was divided into four phases of implementation: participant recruitment, questioning protocol design, focus group sessions, and analysis.

¹ A copy of the full report including detailed findings can be downloaded from the San Luis Obispo County Community Foundation (www.slocf.org/growing_together.html) or by calling Janice Fong Wolf at 805-543-2323.

² Krueger and Casey, *Focus Groups: A Practical Guide for Applied Research*, p. 4.

³ It bears noting here that the terms "transgender" and "transsexual" are variously defined in both lay and professional contexts. Though there is still no universal agreement, "transgender" is increasingly used as an umbrella term referring to a range of groups, from cross-dressers to people who have had hormone treatments and/or surgery. "Transsexual" refers more narrowly to a person who is in some stage of full "transition" from one gender to the other. This report will make use of the inclusive acronym TG/TS, keeping in mind that focus group participants were all "transsexuals" according to the above definition.

Recruitment involved a combination of outreach methods, including press releases in regional newspapers, mailings through local LGBT organizations and e-mail list-serves, flyer distribution at establishments throughout SLO County, and personal contact with guidance counselors and Gay Straight Alliance (GSA) advisors at county high schools.

The questioning protocol (see Exhibit B) included two areas of inquiry: 1) perceptions about the current state of mental health services relative to the LGBT community in SLO County and 2) ideas for positive change. Draft questions were pilot tested and revised by members of the GTI Advisory Committee.

A total of 40 people participated in five focus group sessions conducted between January and March 2003. As described above, the group categories were: Mental Health Providers, Youth, Transgender, Men, and Women. Participants ranged in age from 15 to 75, and represented a broad range of geographic communities in San Luis Obispo County. Approximately 90% of participants were white (the remaining 10% were of Hispanic, Asian, African American, and mixed ethnic heritage). The provider group included representatives from a variety of professional sectors, including psychotherapy, mental health agency administration, school personnel, and religious leadership (See Exhibit C for a detailed Participant Profile of each group). All group sessions proceeded along the lines of a common questioning route, and were facilitated by the same moderator. Each session was observed, documented, and summarized by a co-moderator who was her/himself a member of the same constituent group. Sessions were taped and transcribed for the purposes of subsequent analysis.

Analysis of focus group deliberations used transcript-coding to identify repetitive “themes” occurring across discussions. Transcribed co-moderator summaries at the end of each session provided additional interpretive information regarding nuances within groups. Analysis was somewhat compromised by two logistical challenges that developed during the focus group sessions. First, a line-by-line transcript was not available for the Transgender session due to a breakdown of recording equipment. In lieu of these data, a copy of the co-moderator’s detailed session notes was clarified and annotated by both the moderator and co-moderator following the session. Second, the women’s focus group session experienced smaller-than-expected attendance (Seven had planned to be part of the group – three came). The session itself was nonetheless very informative. In addition, the moderator succeeded in contacting and interviewing three of the women who had missed the meeting. These interviews included the same questioning protocol that had been used during the group discussion, as well as several clarifying questions related to the actual content of the session.

III. FINDINGS

Participant perceptions regarding mental health services in relation to the local LGBT community fell into five broad categories: 1) Descriptions of a supportive mental health provider; 2) LGBT community roles in accessing and promoting mental health; 3) Key barriers to supportive service; 4) “Intersections” between the LGBT community and the mental health sector; and 5) Suggestions for positive change to bring about a more responsive system of mental health related services for LGBT community members.

Descriptions of a Supportive Provider

Focus group participants began their discussions by sharing thoughts on key factors that contribute to ensuring a supportive mental health encounter for members of the LGBT community. Their ideas fell into four overarching areas: 1) provider attitudes about the LGBT community, 2) an atmosphere of individualized care, 3) provider training and/or experience with LGBT issues, and 4) a supportive environment in which care is delivered.

Participants across groups repeatedly emphasized that supportive providers demonstrate a clear **attitude of support for a client’s LGBT identity**. People mentioned that when entering into a therapeutic relationship, they look for indicators of acceptance. “Respectful,” “non-judgmental,” “open-minded,” “comfortable/not threatened,” “compassionate” were among the most common descriptors. While these provider characteristics

seem self-evident in any therapeutic environment, they are particularly important – and not easy to find – in the context of mental health care for LGBT individuals. In the face of persistent societal divisions regarding the LGBT community, *trust* remains a key issue for gays, lesbians, bisexuals, and transgender/transsexual individuals. “Can I trust this person?” is a question that participants say they ask at the beginning of any encounter, and especially when entering into a therapeutic relationship with a mental health provider. As discussed below in a section on barriers to service, all-too-many LGBT members have found themselves in therapy with a provider who treats their identity as a problem that needs to be fixed. For many, trust indicators often become evident right away in therapy – “you can tell early on,” commented one participant. Several focus group participants also emphasized the important presence of sensitive support staff (e.g. nurses, administrative assistants, etc.).

Another key indicator commonly described is the feeling of “**being treated like an individual.**” Related comments included “not feeling rushed”, “not feeling pigeon-holed, as if I’m just another questioning youth”, “not being seen as a test-rat”, “seeing me as a person, not a disease or a condition.” Participants repeatedly emphasized that supportive providers see and relate to their clients’ sexual orientation and/or gender identity in the context of their larger individual life experiences. One woman commented that she avoids telling her therapists about her sexual orientation out of concern that the therapist will latch onto that aspect of her life at the expense of working with her in a holistic way. A TG/TS participant described how the “curiosity factor” around her gender identity clouds therapists’ vision against seeing and working with her as an individual.

Various preferences related to provider **training and/or experience with LGBT issues** were articulated in all groups. Most participants felt that a mental health provider with at least some previous experience and/or training in working with LGBT clients increased the likelihood for supportive care. Several people remarked that “open-mindedness” and “willingness to learn” would suffice in lieu of experience, while others felt that they would only be comfortable working with an experienced provider. People in the latter group described a frustration around the feeling that they were repeatedly put in the position of “educating” their therapist. Several people mentioned the importance of having a mental health provider who is actively aware of resources and support networks available to the LGBT community.

There was a lack of consensus on preference regarding providers’ own sexual orientation. Some gay and lesbian participants felt that they would feel most supported with a therapist who shares the same sexual orientation, while others indicated that other aspects of a provider’s background are equally or more important (e.g. a shared life philosophy such as Buddhism or expertise in other mental health areas such as bipolar disorder). Some people mentioned that they would prefer not to be seen by a provider with the same sexual orientation (“I wouldn’t see a lesbian therapist. It’s too small a community – I’m afraid of confidentiality issues”; “I’m a gay man, and...it’s really easy for me to connect with a woman therapist.”). In a follow-up interview, one woman drew a distinction between the two options, depending on the nature of her need for care. She felt that if she needed help working on issues related directly to her sexual orientation – intimacy, societal pressures related to being lesbian/bisexual, etc., -- she would want a lesbian therapist. However, if her mental health primarily involved other aspects of her life, she would hope to find a provider who is a ‘lesbian ally,’ though not necessarily a member of the community. Another interviewee commented that she looked for providers who “had done their own work and felt comfortable with their own sexuality,” as a critical factor in their capacity to offer competent, supportive service.

A number of comments described indicators of a **safe, accessible environment** for mental health care. Being in a space that feels confidential was discussed in particular detail by youth participants, many of whom felt that they could *not* find this sort of private zone in the context of their schools’ existing guidance departments. One high school student described needing a place to go where you could talk privately to someone, but felt that his school culture does not respect confidentiality, even among adults. Paradoxically, another environmental criterion articulated across groups was the need for easy proximity to supportive care. For many youth, this would imply school-based services.

LGBT Community Roles in Accessing and Promoting Improved Mental Health.

“A lot depends on us.” This thought offered by a gay male participant highlights a recurring sentiment in most groups that LGBT community members themselves play a crucial role in increasing the likelihood that they will receive competent mental health related services. Participant descriptions of this “consumer” role clustered around two topics: 1) common strategies used to access care, and 2) self-help opportunities to work on mental health issues in lieu of (or in addition to) professional care.

In addressing the question of **access strategies** currently used by the LGBT community, focus group participants were quick to differentiate between approaches used by people who openly self-identify within the community versus those who do not (either because they are closeted or have not come to terms with their sexual orientation or gender identity). For those who are active in the LGBT community, “word of mouth” was identified most frequently across groups as the strategy of choice in finding a supportive mental health provider. Friends, family, classmates, and co-workers (LGBT and not) were mentioned as providing the most trustworthy referrals to appropriate care. Participants commented that people frequently access referral information through one or more informal social and on-line networks in the LGBT community, as well as popular establishments (most often cited was the Volumes of Pleasure Bookstore in Los Osos) and formal organizations (e.g. Central Coast Gay and Lesbian Alliance -- GALA, Parents and Friends of Lesbians and Gays -- PFLAG, the AIDS Support Network -- ASN, and Cal Poly’s Gays Lesbians and Bisexuals United -- GLBU). Meanwhile, “crisis” was a word used by participants in several groups to describe access to care by people who have not previously identified as LGBT. One provider elaborated that many people in this situation – often youth – first access services “by hurting themselves. Not very many people are going to say, ‘this is my issue.’ They’re going to do something, and the parents are going to get scared and bring them to therapy....It’s so different than a 35-year old looking for therapy.”

Participants described the value of being proactive in their search for supportive professionals by acting as discriminating, informed consumers. Several recounted engaging potential therapists in interviews to determine up front their attitudes and approach with respect to LGBT clients. Other participants pointed out the obvious irony to this point. People seeking mental health care often are not emotionally prepared or self-actualized within the LGBT community to take on this level of self-advocacy in accessing supportive care. A related area of client responsibility in promoting quality care was that of “educating the provider.” Members of the TG/TS group in particular described feeling like they often found themselves in the role of a “teacher” during therapy. While they admitted that this could be frustrating, many appeared accepting of the responsibility, as long as they felt the provider was committed to learning from them and doing their own outside research regarding TG/TS issues.

In addition to describing elements of competent care as managed by a professional provider, focus group participants articulated a number of **other supportive contexts** that assist LGBT individuals in their work towards improved mental health. Peer support groups were championed in most discussions as a safe-feeling, affordable environment for emotional growth. Examples included groups coordinated through GALA, women’s groups sponsored through the San Luis Obispo Women’s Resource Center and Women’s Shelter Program of San Luis Obispo, informal social networks (e.g. Amelia’s Friends -- a group of older lesbians), campus-based organizations such as Cal Poly’s GLBU, Trans Central Coast (a support group open to TG/TS individuals and partners), and high school student groups such as San Luis Obispo High School’s Student Assisted Program⁴ or Gay Straight Alliance⁵ groups in several high schools throughout the county (Arroyo Grande High School, Morro Bay High School, San Luis Obispo High School). Youth participants also identified other school-based programs that have provided them with safe havens for emotional support and sharing with peers and teachers. Cited examples included a course on leadership and a dance class. Finally, participants in all groups stressed the

⁴ Youth participants from SLO High School described the “SAP” program as a menu of confidential support group options (e.g. “Loss”, “Drugs and Alcohol”, “Misc.”) open to any student. Each group meets weekly and is facilitated by a school counselor.

⁵ Some of the participants in the youth focus group felt that their needs were not being met by the Gay Straight Alliance at their school. People either felt unsafe identifying with the group, or were concerned that straight members might outnumber GLBT members and compromise the ability of the group to act as a true *peer* support environment. See *Barriers* below for a more thorough discussion.

ultimate importance of having a network of supportive friends, families, partners and mentors in maintaining emotional and mental balance.

Barriers to Supportive Services

After considering definitions of competent care and the roles that LGBT community members currently use to increase their chances of finding quality mental health services, focus group participants turned their attention to the flip side of the issue. A detailed list of barriers was identified, all of which contribute to keeping members of the local LGBT community from receiving supportive mental health care. Comments fell into five broad categories: 1) Client fear of and/or experience with inappropriate care; 2) Insufficient number of trained providers in key areas of care; 3) Societal pressures that put up barriers to care; 4) Inadequate system of access and referral to appropriate care; and 5) Prohibitive costs of care.

“**Fear**” was a word used repeatedly by focus group members to describe one of the greatest barriers to care experienced by members of the LGBT community. Underlying this common descriptor are a host of factors related to people’s real and perceived concerns that they might have negative encounters during an experience with mental health care. People described feeling that accessing services felt like a “hit or miss” endeavor. They never knew when they might encounter providers who are inexperienced, insensitive, or openly judgmental regarding the LGBT community. Examples⁶ based on personal experience included providers who:

- ...refuse to respect the client’s sexual orientation and/or gender identity (e.g. attempt to “de-gay” the client, deny treatment to TG/TS clients seeking hormone therapy⁷)
- ...state they are “gay-friendly” but betray judgmental attitudes
- ...act patronizing (e.g. towards clients with HIV, towards TG/TS clients in transition, towards youth)
- ...repeatedly use inappropriate terms, indicating a lack of experience and/or sensitivity (e.g. misusing gender pronouns with TG/TS clients, such as calling a person transitioning from female-to-male “she”).
- ...appear overly interested in the client’s LGBT identity over all other aspects of their lives
- ...trace every issue or problem in the client’s life to her/his sexuality

Many participants emphasized that even one bad experience with a provider can be devastating and drive people away from much-needed care. One TG/TS group member explained that repeated negative encounters with providers have led her to avoid all health care – “I probably won’t go back again unless I’m dying.”

Another commonly mentioned set of fears involved internal anxieties held by LGBT individuals, regardless of perceived provider qualities. Several described a worry among people who are not yet self-actualized as LGBT that therapy will “force me to deal with it.” Others, especially in the youth group, described a sense of embarrassment over the idea of seeking mental health services. When envisioning approaching a school counselor for help, one young man commented, “I wouldn’t want to be seen going through the door. People would ask, ‘why?’” Similarly, several young men in the youth group pointed out that they were afraid to associate with their school’s Gay Straight Alliance because of what people might think.

Insufficient services in several key areas of mental health service accounted for another set of barriers identified in multiple groups. First, there is a concern about the lack of local providers who possess training and/or experience working with TG/TS clients.⁸ Participants in both the TG/TS and the provider group emphasized this problem. Many TG/TS individuals feel forced to leave the county for both physical and mental health care, particularly when related to their transition experience. Participants identified several large urban

⁶ Additional provider-related fears along these lines that are also frequently echoed by mental health clients outside of the LGBT community included 1) feeling rushed – youth in particular described this sensation in trying to get help from guidance counselors, 2) worrying about possible breach of confidentiality, 3) being treated like a “product”

⁷ See “Intersections” below for a more thorough discussion of the relationship between TG/TS individuals’ transition experience and the mental health sector.

⁸ See “Intersections” below for a more thorough discussion of TG/TS transition issues as related to the mental health sector.

areas where they have found providers with established reputations for providing supportive care (e.g. San Francisco, Houston, Philadelphia). Others, frustrated by repeated, unsuccessful attempts to find competent providers to guide them through the transition process have resorted to more drastic measures. These include accessing hormones over the Internet without any consultation with a doctor or mental health professional, and traveling overseas (Thailand is a common destination) to have surgery. For their part, participants in the providers' focus group described the lack of locally available training opportunities in the area of TG/TS issues. As one therapist put it, "I have to say that most impossible thing I have found is trying to get training on transgender...It's not that easy to find a workshop about working with transgender clients that is within 400 miles of here that is legitimately sanctioned..."

Services for LGBT youth is a second area that participants described as insufficiently developed in SLO County. This concern reflected services both in and out of school. Students from several high schools around the county felt that their guidance counselors were either too busy or too focused on academic counseling to provide any useful support around emotional or mental issues (the notable exception was San Luis Obispo High School, where students described feeling well-supported through a variety of guidance-initiated programs). Furthermore, some of these same schools do not currently have a functioning Gay Straight Alliance group that could act as an alternative support mechanism for LGBT or questioning youth. A provider group participant who is an employee in the public schools commented that confounding political, budgetary, and time-related pressures leave schools with few options in offering any more services than are currently available. -- "Schools can't do it alone." Meanwhile, participants in multiple groups bemoaned the lack of community-based providers who are known as experienced in working with LGBT and questioning youth. One agency representative pointed out that parents frequently call looking for referrals to therapists who specialize in working with LGBT youth. "We really use about one referral on that and it would be great to know if there were more..."

A third area of care in the category of "insufficient services" is a lack of LGBT-specific support groups for individuals who have a mental illness (an exception is Alcoholics Anonymous, which does hold meetings in SLO County for LGBT individuals). One woman who has bipolar disorder commented that in the past she had participated in a support group for people with mood disorders, but dropped out because she felt uncomfortable sharing aspects of her life connected with her identity as a lesbian.

A host of **societal pressures** were brought up that keep people from receiving competent mental health services. These pressures in part contribute to some of the concerns raised above regarding client fears and quality of service. There is a concern, for example, that pressures from parents and school board members who are hostile to the LGBT community have contributed to the dearth of in-school support for youth. Youth participants further went on to describe anti-LGBT peer pressures – not to mention peer pressure against accessing adults for any kind of support – as playing an enormous role in dissuading LGBT or questioning adolescents from seeking out needed professional help, sometimes during moments of extreme emotional crisis. Judgment imposed by religious communities and leaders was repeatedly mentioned as traumatic and confusing for spiritually devout LGBT individuals who seek guidance and counseling from the clergy. TG/TS participants described societal norms as playing a significant role in a well-known phenomenon of preferential treatment by providers towards "female-to-male" clients over "male-to-female clients." One female-to-male participant offered an anecdotal explanation – "Society can handle women wearing levis better than men in dresses. It's the same issue..." (quote paraphrased by the focus group moderators). Finally, men's group participants pointed to the pervasive societal pressures against men – gay or straight -- talking about their feelings as an enormous barrier against accessing needed care. As one participant mused, "We're raised to believe, 'You don't need therapy; suck it up'..."

Providers described ways that societal pressures stymie their ability to provide open and supportive care to LGBT clients. One therapist offered an example in relation to cultural norms in the Latino community. "[Relatives] claim that we are promoting promiscuous lifestyles...If we are suddenly perceived as being [LBGT] producers, then the chances of [family members] coming in to get the supportive services they need

[are unlikely].” Other providers described school policies that block their ability to talk about LGBT issues during school presentations or workshops.

Many participants pointed out that they believe a sufficient supply of competent, LGBT-supportive providers exists in San Luis Obispo County, but that *finding* them is a daunting prospect with **limited or no systems for access and referral**. Participants across groups described the exhausting process of searching for an appropriate therapist that all-too-often results in individuals giving up on getting the care that they need. One provider described the “double wammy” for people who are already in a fragile emotional place in their lives and who are then faced with the task of seeking out a supportive provider. During a follow-up interview, a lesbian woman echoed this problem, pointing out that people in mental and emotional distress are often not able to call up the energy necessary to research caregivers. Youth participants described being worried about other adolescents they know who are isolated from peer support networks and/or adult role models.⁹

Many participants recognized referral efforts by local LGBT organizations (e.g. GALA’s on-line listing of LGBT-friendly counselors/therapists¹⁰), but were concerned that these services cannot begin to fully address the need for broad-based access to information. For example, people who do not actively associate in the LGBT community (e.g. youth, closeted adults, TG/TS individuals who are straight) would not necessarily feel comfortable – or even know about – these options. Others felt that GALA is not currently staffed in such a way that it could support a consistent, broad-based referral system over time. Finally, a worry emerged that LGBT organizations and issues are not currently part of other local planning efforts and outreach around mental health.

The most frequent barrier to access that people described encountering is that of **cost**. While this problem certainly exists across the board for people seeking mental health care, there are particular nuances within the context of LGBT-supportive mental health that warrant special consideration. First, the well-known scenario of insurance companies offering limited mental health coverage for care by a list of preferred providers presents an additional challenge to LGBT clients searching for an even smaller subset of LGBT-supportive therapists. TG/TS clients are presented with a greater bind, considering the preponderance of insurance companies who do not cover any physical or mental health services related to “Gender Identity Disorder” (an official term used in the *Diagnostic and Statistical Manual IV – DSM IV*). Paradoxically, the mental and physical health care requirements for transition, as defined in the Harry Benjamin Gender Dysphoria Association’s (HBIAGDA) Standards of Care for Gender Identity Disorders, are extensive and highly costly.¹¹ Meanwhile, under- or un-insured clients are forced to rely on public services through County Mental Health, where they have almost no opportunity to choose a caregiver based on sensitivity to LGBT issues, and where providers are unlikely to have received special training in this area.

A recurring concern was voiced regarding the economic disenfranchisement of some groups within the LGBT community. Lesbian women are viewed to be poorer as a group than gay men, or than the community overall. As one provider pointed out, “I do think that particularly in the lesbian community, we have a reality that women tend to make less than men, and so if you have two women who are together, then do the math...” Several participants described the cost barrier faced by youth. Even if they recognize that they need care and want to access it privately, most are forced to rely on their parents to pay for it, whether through an insurance carrier or out of pocket. As a result, many young people may opt to avoid the care over admitting to their parents that they need professional help.

⁹ Independent study was mentioned by youth participants as an option taken by many LGBT and questioning high school students. Members of the focus group felt that this opportunity was availed by some as a way to protect themselves against harassment and other pressures related to their sexual orientation and/or gender identity. There was concern that this use of independent study may in fact further isolate many teens who need support.

¹⁰ For more information, go to www.ccgala.org

¹¹ The Harry Benjamin Association is a professional group whose mission is to develop better understandings and treatment of gender identity disorders. The Standards of Care were established in 1979 and revised in 1998. They are widely accepted and used in the provider community as a way of providing TG/TS clients with consistent care during gender transition. Refer to “Intersections” for a more thorough discussion of the Standards and their impact on TG/TS individuals’ experience with mental health services.

Intersections between the LGBT Community and Mental Health Sector

Throughout the focus group discussions, a set of issues emerged that are unique to the LGBT community, and that represent potential points of intersection with the mental health sector. These include 1) coping with a range of societal pressures and stereotypes, 2) stresses associated with coming out, 3) LGBT couples issues, 4) family dynamics, and 5) challenges related to gender transition.

Despite enormous progress over the past two decades, members of the LGBT community continue to experience the **strains of prejudice**, negative stereotypes, harassment, and abuse because of their sexual orientation and/or gender identity. Living in an environment of constant uncertainty about “whom to trust” takes its toll on the strongest of wills, and can have devastating effects during times of mental or emotional strain. One lesbian woman explained that her first attempt to find a therapist was motivated by a persistently hostile work environment and an abusive boss. A male participant pointed out that societal pressures often create internalized homophobia – “The [providers] better be well-versed enough to know that there is enough homophobia out there that we are going in with a perceived fear and we are going to mirror it back on them at times.” Many participants commented on the destructive effects of the “guilt factor” imposed by some religious communities and leaders on their LGBT members. Youth struggle with peer pressure in what one young man described as a “sexually charged, intensely hetero environment.” A provider participant who works with youth added to this point that “‘gay’ is the worst thing you can call a boy.” Others echoed this disproportionate level of societal antagonism against males in the LGBT community (including male-to-female TG/TS individuals).

Focus group participants offered numerous accounts – both positive and negative – related to the **challenges of coming out** in the context of therapy. Several people indicated that their first therapeutic experience ultimately included coming out, though most added that it “took awhile” before they were either ready to trust their provider, or were fully aware of what they were going through. It was also emphasized that people often end up in therapy because of self-destructive behavior that is in part masking underlying struggles with sexual orientation or gender identity. Frequently cited examples included suicide attempts (especially among youth), substance abuse, and depression.

Couples issues emerged as an area in which experiences and challenges exist in LGBT relationships that may be unique from or manifest themselves differently than in couples outside of the LGBT community. Examples include domestic violence in same-sex couples,¹² decision-making around starting and raising a family, and topics related to sexual intimacy.

In addition to couples issues, participants articulated a host of other **family dynamics** related to LGBT identities that either do or might play out in a therapeutic context. Many parents, children, and partners of LGBT individuals face their own challenges in coming to terms with a loved one’s sexual orientation and/or gender identity. At the same time, LGBT individuals all-too-often struggle with judgment and rejection from family members, sometimes throughout their lifetimes. Examples of these types of dynamics that were shared by group members include the emotional issues faced by partners of people going through a transsexual transition, the experiences of children whose parents identify as LGBT, and parental relationships with teens who are questioning their sexual orientation or gender identity. One provider pointed out that extreme cases of this latter example have contributed towards creating a disenfranchised population of homeless LGBT youth who face a particularly daunting set of emotional challenges. One youth participant described his personal experience being forced to leave his parents’ home when they found out that he is gay.

Members of the TG/TS community cross paths with the mental health sector in significant ways during the course of **gender transition**. In terms of physical requirements, this process involves an ongoing regimen of

¹² The issue of domestic violence within lesbian relationships is currently being addressed through a project at the SLO Women’s Shelter Program of San Luis Obispo County, with support from the Growing Together Fund. For further information, contact Sarah Galetti at 805-781-2550.

hormone therapy leading ultimately to surgery. All TG/TS individuals “in transition” lie somewhere along this continuum. As mentioned above, the Harry Benjamin Gender Dysphoria Association is a professional group that maintains Standards of Care for Gender Identity Disorders, a set of guidelines for consistent treatment during transition.¹³ Included in the Standards of Care are psychological assessments by a mental health professional as a prerequisite to both hormone therapy and surgery. In some cases, a regimen of psychotherapy is also recommended or required. TG/TS focus group participants talked at length about their transition experiences in relation to the Standards of Care. While there was general agreement that psychological assessment (as well as psychotherapy in some cases) is in principle an important component of a challenging physical and emotional process, all participants felt that the reality of this requirement can play out in extremely negative ways that are demeaning, demoralizing, and potentially destructive. People described an intensely uncomfortable power dynamic that can develop between the individual and the mental health professional responsible for assessing and “signing off” on hormone therapy or surgery. Anecdotes were shared of people who have been denied a signature because the mental health professional believed that the individual would not be able to “pass” as the new gender. In general, participants pointed out that without sufficient training or background in gender identity issues, mental health providers are not in a position to make informed recommendations. These inexperienced professionals run the risk of refusing access to treatment for otherwise stable, informed clients. The result of this sort of recurring experience and the accompanying reputation of the mental health sector at large is that increasing numbers of people seeking gender transition are resorting to black market channels for hormones without the support of mental health or physical health professionals.

Suggestions for Positive Change

In shifting from “what is” to “what could be,” focus group participants came up with a comprehensive list of ideas for positive change in the area of LGBT-supportive mental health. Consistent themes that emerged across groups included a need for 1) more provider education, 2) a system of peer advocacy and support related to mental health, 3) improved referral and advertising methods, 4) an increase in provider “supply” in key areas of the sector, 5) greater community outreach and education on LGBT issues, and 6) ongoing strategic dialogue between mental health providers and LGBT communities.

Opportunities for **provider education** in LGBT issues were identified by most participants as an important method for improving quality of care. A variety of possible venues were explored, as well as topics and target provider groups. Suggestions included:

- LGBT speakers bureaus available for presentation at provider meetings/workshops
- Curriculum reform initiatives in higher education counseling programs to include more training/information on LGBT issues
- Inclusion of LGBT-specific topics and speakers at local/regional professional workshops/conferences (e.g. Hospice Conference, Wellness Fair)
- LGBT sensitivity training for religious leaders
- Training in LGBT issues targeted to: county mental health workers, support staff in mental health organizations.
- Increased reliance by the mental health sector on GALA and other local LGBT organizations as sources of feedback, ideas, and provider education.

Participants emphasized a need for improved **peer support and advocacy** related to mental health issues in the LGBT community. “A lot depends on us,” as quoted above, sums up a collective sentiment that there are improvements to be made within the LGBT community that will lead to improved experiences with mental health care. Following is a list of ideas in this category:

¹³ The Standards of Care for Gender Identity Disorders are available on-line at the website of the Harry Benjamin International Gender Dysphoria Association: www.hbigda.org

- Offer “consumer training” workshops and/or materials that provide LGBT community members with strategies for seeking an appropriate provider, including a list of questions to ask when interviewing a potential therapist.
- Provide more peer support groups sponsored by GALA, local colleges or schools, or PFLAG. Cited examples included a mood disorders group and more groups for family members of LGBT individuals (e.g. parents, children).
- Create a “peer advocate” resource – a group of trained volunteers or hired professionals to help LGBT individuals navigate the system in seeking supportive mental health care.
- Build and make more publicly visible a base of peer networking groups in the local LGBT community (e.g. Trans Central Coast, Amelia’s Friends). Disseminate information about these resources in key locations, such as doctor’s offices, school counseling centers, and mental health agencies.

Participants related their strategic ideas on **referral and advertising** directly to the barrier of access, as described above. People felt that measures can be taken to better link with and take advantage of qualified providers who are already doing good work with the LGBT community. It should be noted that participants recognized that many providers likely do not want to become exclusively identified as serving only LGBT clients. The message is, as one provider participant articulated, that “we are prepared and comfortable serving *all* clients, not just ‘straight people.’” Concrete suggestions for improved referral and advertising included:

- Creation of a system for screening and listing of local mental health providers who meet a set of “standards of supportive, competent care.” Providers interested in earning this distinction would receive some sort of initial assessment according to established standards, and would have ongoing, locally-available opportunities for professional development on LGBT issues in mental health. Focus group participants emphasized that ongoing dialogue between the provider- and LGBT communities would need to take place to collaboratively craft and implement such a system.
- More prominently available lists of LGBT-supportive providers, organizations and support groups at mental health clinics, school and university counseling offices, and in published student handbooks.
- Compilation/dissemination of LGBT-supportive clergy and pastoral counselors.
- Compilation/dissemination of providers who have experience/specialize in work with LGBT or questioning youth.
- A “message-only” hotline option at GALA or other LGBT organization that allows individuals who may be intimidated by the prospect of a live conversation, but want to be sent referral information.
- Improvement of GALA’s website, including expanded information on mental health providers and more links through search engines.
- Targeted outreach on mental health provider information to elder LGBT population (who may not access other above-mentioned channels for referral).
- Encouragement of providers who do identify as “LGBT-friendly” to advertise as such, possibly using graphic tags such as lavender borders or rainbow decals, or inclusive language on company brochures. The motivation behind this suggestion in part stems from a concern that therapists sometimes avoid advertising themselves as LGBT-friendly out of fear that they will be pigeon-holed into serving only LGBT clients (or openly associated – accurately or inaccurately -- as being members of the LGBT community themselves).

Various suggestions related to a need for **increased supply** of existing services, as well as the creation of new service options:

- Increase in-school and after-school counseling opportunities for youth. Encourage high school guidance offices to maintain a strong, confidential focus on personal issues counseling as well as academic counseling. Involve after-school programs in efforts to increase care options for youth.
- Increase the supply of trained mental health providers specializing in TG/TS issues, including transition-related assessment and psychotherapy.

- Offer on-site counseling at GALA for LGBT clients.
- Create more services/support groups for children of LGBT individuals.

The connection between a need for ongoing **community education/outreach** and improved LGBT-supportive mental health was best stated by a member of the provider focus group: “I always think that we don’t have to do anything special with the homosexual community, but we need to do something with the straight community. Because this guilt that [we’ve] been talking about does not come from the gay and lesbian community in my opinion – it comes from the straight community.” A youth participant made a similar point that “being gay [needs to be] 100% ok...It needs to be one of those things that nobody cares about. I think that’s the only thing that will ever really make it any different.” All focus groups devoted significant time to discussing ways to better educate the broader community as a mechanism towards improved tolerance, understanding and support, and ultimately as a way to promote improved emotional and mental well-being for members of the LGBT community. Particular emphasis was placed on the following areas:

- More open/integrated education related to LGBT topics made available in schools and other programs for youth.
- Outreach on LGBT topics (especially TG/TS) for spiritual groups.
- Increased number of public outlets for creative and social expression by the LGBT community (several participants felt that local Pride Day as the only major public event portrays a limited picture of the entire community).
- Broader LGBT presence among community leaders. A participant in the youth group added to this point by suggesting that a scholarship fund be set up so that “kids who are gay and out [can go] into the world to college and become educated. That would be a really valuable asset to your community, because when they come back they’ll be heads of clubs, boards or whatever. They’ll bring it back to you.”
- Use of documentary film as a tool for community education and training.

Finally, the focus groups overwhelmingly agreed that they would like to see **continuing dialogue** between local LGBT and health provider communities toward improved mutual understanding, information sharing, and collaborative efforts to bring about positive, systemic change. As described in other categories above, two concrete ideas for possible partnership include:

- Creation/dissemination of provider education opportunities
- Development of a referral system for “preferred providers”

It is important to note that amidst the many concerns and hopes for improvement in SLO County’s mental health sector, LGBT participants across groups also offered a collective sentiment that things are better than they used to be in many ways. Several people articulated a sense that the younger generation seems more empowered as a group than those who went through their adolescence even ten years ago. Others felt that despite San Luis Obispo’s profile as a largely homogenous town, it is steadily building a greater tolerance for diversity and feels “safer” than other small-town areas of the state where participants had lived in the past.

IV. CONCLUSIONS

This focus group project was launched with two goals in mind – 1) to gain a deeper community-wide understanding of concerns about the state of LGBT supportive mental health services in SLO County, and 2) to help inform future directions towards fostering improved approaches to serving local LGBT mental health needs. To this end, the Growing Together Initiative (GTI) of the San Luis Obispo County Community Foundation plans to use the findings compiled herein in two ways. First, the report will be disseminated broadly throughout both the LGBT and provider communities, along with an invitation to engage in an ongoing “town meeting” across constituency groups. Second, the report will help shape the development of GTI’s funding guidelines in order to encourage and support local innovations focused on addressing this issue.

During a parting comment at the conclusion of the youth focus group, one young man exclaimed, “You know, the reason I came tonight -- Martin Luther King stood up for something he believed in, so I’m here standing up for something that I believe in...” In the spirit of his sentiment, the San Luis Obispo County Community Foundation would like to express its deep gratitude to every one of the forty-three participants in this focus group project who were willing to share deeply personal experiences and insights in the interest of improving capacity to meet needs in the LGBT community.

EXHIBITS

A. Executive Summary

B. Sample Questioning Protocol (Youth)

C. Participant Profiles

EXHIBIT A**EXECUTIVE SUMMARY****Lesbian/Gay/Bisexual/Transgender
(LGBT)-Supportive Mental Health Services in San Luis Obispo County:
HOW ARE WE DOING?****A Focus Group Project commissioned by the Growing Together Initiative of the
San Luis Obispo County Community Foundation**

PROJECT OVERVIEW

The Growing Together Initiative (GTI) was established in 2001 by the San Luis Obispo County Community Foundation, with a mission to address the needs of the region's lesbian, gay, bisexual and transgender (LGBT) community. An advisory committee to the GTI provides guidance and support in reaching its goals to address needs in the LGBT community by 1) providing grants, 2) raising community awareness, and 3) promoting philanthropy. In furthering all three of these goals, the GTI commissioned this Focus Group Project to gain a deeper community-wide understanding about a human service area that is of both local and national concern: LGBT-supportive mental health care.

The GTI Focus Group Project was designed to involve one-time discussions by five distinct groups: Mental Health Providers; Youth (Gay/Lesbian/Bisexual/Questioning/Straight); Transgender/Transsexual ("TG/TS"); Women (Lesbian/Bisexual); and Men (Gay/Bisexual). Each group followed a similar questioning route facilitated by a moderator. Analysis of recurring themes across discussions uncovered participants' collective insights regarding the status of mental health services in relation to the local LGBT community, as well as their suggestions for positive change. The study was divided into four phases of implementation: participant recruitment, questioning protocol design, focus group sessions, and analysis. A total of 40 people participated in five focus group sessions conducted between January and March 2003 (three additional people took part in individual interviews). Participants ranged in age from 15 to 75, and represented a broad range of geographic communities in San Luis Obispo County. Approximately 90% of participants were white (the remaining 10% were of Hispanic, Asian, African American, and mixed ethnic heritage). The provider group included representatives from a variety of professional sectors, including psychotherapy, mental health agency administration, school personnel, and religious leadership.

SUMMARY FINDINGS

Participant perceptions regarding mental health services in relation to the local LGBT community fell into five broad categories: 1) Descriptions of supportive care; 2) LGBT community roles in accessing and promoting mental health; 3) Key barriers to LGBT-supportive services; 4) "Intersections" between the LGBT community and the mental health sector; and 5) Suggestions for positive change to bring about a more responsive system of mental health related services for LGBT community members.

Descriptions of Supportive Care.

I think it's very important to be seen as an individual and not just like, in this particular case, not as just another questioning youth who's treated in a routine way, but to be seen with your own particular instincts and your own particular emotions and situations.

–youth participant

...someone who doesn't care that you are a lesbian but is also sensitive to the specific issues that you face as an individual or as a couple. In other words, they're looking at your spirit and your personality and not your lesbianism as some kind of twisted and dark thing.

-woman participant

...someone who is willing to do the research to understand my circumstances.

-female-to-male transgender participant

Focus group participants began their discussions by sharing thoughts on key factors that contribute to ensuring a supportive mental health encounter for members of the LGBT community. Their ideas fell into four overarching areas: 1) provider indicators of support for LGBT identity, 2) a holistic, individualized approach to mental health treatment, 3) provider training and/or experience with LGBT issues, and 4) a safe, confidential environment.

LGBT Community Roles in Accessing and Promoting Improved Mental Health.

A lot depends on us and how open we are with [providers]...

-gay male participant

I think the first thing that many people do who have any sense of identification as LGBT would be to check out the GALA newsletter...

-provider participant

I would go to my friends [for support.] I'm very lucky that I have friends who care about me.

-youth participant

A recurring sentiment was articulated in most focus group sessions that LGBT community members themselves play a crucial role in increasing the likelihood that they will receive competent mental health related services. Participant descriptions of this “consumer responsibility” clustered around two topics. The first involved common strategies that LGBT individuals use to access care. Most indicated word-of-mouth and reliance on both informal and formal LGBT networks as the mode of choice for people who are active in the LGBT community. Participants across groups were concerned about the potential isolation of those who do not openly identify as LGBT, one consequence being the lack of access to valuable information regarding supportive mental health providers. The second type of community-level responsibility focused on the use of self-help strategies by LGBT members to work on mental health issues in lieu of (or in addition to) professional care.

Barriers to Supportive Services.

It's very, very difficult to get through the door. Because most of us don't put a sign outside saying “gay and lesbian people are welcome here.” ...You have to get over that hurdle of, “Is it going to be ok here?” and so, for many people, actually even getting to the door, is a huge step.

-provider participant

Finding a mental health professional who is qualified in [transgender issues] is NOT trivial.

-male-to-female transgender participant

If you connect with the wrong person, it can be horrible and you may never go back and if that person is judgmental...

-male participant

If you wanted to go see a therapist, you'd have to tell your parents because you couldn't pay for it on your own. And then they'd want to know why...

-youth participant

After considering definitions of competent care and the roles that LGBT community members currently use to shape the quality of mental health services, focus group participants turned their attention to the flip side of the issue. A detailed list of barriers was identified, all of which contribute to keeping LGBT individuals from receiving supportive mental health care. Comments fell into five broad categories: 1) Client fear of and/or experience with inappropriate care; 2) Insufficient number of trained providers in key areas of care, including identified specialists on LGBT/questioning youth or the transgender transition experience); 3) Societal pressures that put up barriers to care; 4) An inadequate system of access and referral to appropriate care; and 5) Prohibitive costs, especially for youth, lesbians and transgender members of the community.

Intersections between the LGBT Community and Mental Health Sector.

As far as psych services, some people need active ongoing counseling [during and after gender transition], some don't. But all need a letter of support. This is held like a carrot in front of people. It costs a lot of money and people in transition can be held hostage [by non-supportive mental health-care professionals].
-female-to-male transgender participant

I drank it down for 13 years; I was terrified....Alcohol is prevalent – we need groups to focus on alcoholism in lesbians.
-2 lesbian participants

I was kind of forced to go see [my therapist] before I even really realized....It was really hard for me to come out, I mean, I had go around behind the couch to talk about it...It was that hard for me, my mouth would not even form the words and I had been seeing this person for about a year at that point....
-youth participant

What a difference a supportive family makes...I know gay people who have been disowned by their parents, which I was really fearful of at one time...
-male participant

Throughout the focus group discussions, a set of issues emerged that are unique to the LGBT community, and that represent potential points of intersection with the mental health sector. These include 1) coping with a range of ant-LGBT societal pressures and stereotypes, 2) stresses associated with coming out, 3) LGBT couples issues, 4) family dynamics associated with LGBT identification, and 5) challenges related to gender transition.

Suggestions for Positive Change.

I think training for me is a huge issue...I agree that mental health and human service agencies in our community are very open to this, but as far as direct training on LGBT issues, I don't get it, I've never seen it.
-2 provider participants

We need to build a peer-based advocacy model [for accessing supportive mental health care.] This is not intact in our community.
-gay male participant

Being gay needs to be 100% OK. It needs to be one of those things that nobody cares about. I think that's the only thing that will ever really make it any different.
-youth participant

In shifting from “what is” to “what could be,” focus group participants came up with a comprehensive list of ideas for positive change in the area of LGBT-supportive mental health. Consistent themes that emerged across groups included a need for 1) more provider education, 2) a system of peer advocacy and support related to mental health, 3) improved referral and advertising methods, 4) an increase in provider “supply” in key areas of the sector, 5) greater community outreach and education on LGBT issues, and 6) ongoing strategic dialogue between mental health providers and LGBT communities.

EXHIBIT B

SAMPLE QUESTIONING PROTOCOL: YOUTH GROUP

1. Let's start by taking just a minute to remember a recent time you visited a health care professional (of any kind). (*Pause*) Do you have a memory in mind? Ok, let's briefly go around the room. Tell us your first name, and one word or phrase to describe how you felt about that experience.
2. As you know, this study is looking at the topic of counseling and support for lesbian/gay/bisexual/transgender and/questioning (LGBTQ) youth. First off, what kinds of services do you think of when you hear the phrase "counseling and support?"

(Remind people that all definitions are valid in the context of this discussion)

3. How would you define a "LGBTQ-supportive" counseling experience? (*encourage comments in multiple mental health contexts as listed in Q2*)
4. How about a "LGBTQ-non-supportive" counseling experience?"
5. If you thought you needed to talk to someone professional about your feelings, where would you go to find help?
(PROBE: Do you think LGBTQ youth have different approaches when it comes to seeking and getting help? If so, how?)
6. What do you think might keep a young person who is LGBTQ from getting professional counseling help?
(PROBE: Are these barriers different than for straight youth? If so, how?)
7. What positive or negative personal experiences have you or your circle of family/friends had that influence your opinion about counseling for LGBTQ youth in SLO County?
8. How has your sexual orientation or gender identity played a role in your experience with professional counseling or support?
9. What services or programs do you think would help you or your friends in your experience with sexual orientation and/or gender identity?
10. What improvements would you like to see in SLO County's array of counseling and support services for LGBTQ youth?
11. If you could sum it up, what is the one biggest problem with the current counseling and support system for LGBT or questioning youth who need professional help?
12. If you could make only one improvement, what would it be?

(co-moderator summary)

13. Have we missed anything? Is there a question that you wish was asked that you didn't hear?

EXHIBIT C

PARTICIPANT PROFILES

Providers

- 11 participants
- professions represented:
 - licenced therapist
 - campus minister
 - mental health agency administrators
 - school nurse
 - school-based mental health professional
 - teacher (retired)
 - psycho-drama therapist: juvenile hall and prison
- regions represented:
 - county-wide services
 - San Luis Obispo
 - Los Osos
 - Arroyo Grande
 - Santa Barbara

Youth

- 12 participants +1 (a youth provider joined the group)
- Average age: 16 (youngest – high school sophomore; oldest – '00 high school graduate)
- 5 young men; 7 young women
- mix of gay, lesbian, bi, straight, questioning
- regions/schools represented:
 - SLO High School
 - Atascadero High School
 - Paso Robles High School
 - Coast Union High School (Cambria)

Transgender

- 6-7 participants (1 partner joined end of focus group discussion)
- Even mix of female-to-male/male-to-female
- Age range: early 20's – mid 50's (Wendy's estimate)
- Regions represented:
 - San Luis Obispo
 - Santa Maria
 - Nipomo
 - Atascadero

Women

- 3 participants (+ 3 post-session individual interviews)
- Ages: 40's, 50's, 70's
- Regions represented:
 - San Luis Obispo
 - Morro Bay
 - Los Osos

Men

- 7 participants
- Age range: mid 20's –mid/late 50's (Wendy's estimate)
- Regions represented:
 - San Luis Obispo
 - Atascadero
 - Los Osos
 - Shell Beach