Unequal Treatment: Mental Health Care for Sexual and Gender Minority Groups in a Rural State

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Objective: **This qualitative study examined the social dynamics of communities and clinic settings that impede the delivery of culturally relevant services to lesbian, gay, bisexual, and transgender (LGBT) people living in rural areas.** ***Methods:*** **Ethnographic interviews were conducted with 20 providers in rural areas to document their perceptions of LGBT mental health care.** ***Results:*** **A majority of rural providers claimed that there is no difference between working with LGBT clients and non-LGBT clients. This neutral therapeutic posture may be insufficient when working with rural LGBT clients. Despite providers' claims of acceptance, lack of education about LGBT mental health issues, and homophobia influenced services for rural LGBT people. LGBT clients had been denied services, discouraged from broaching sexuality and gender issues by providers, and secluded within residential treatment settings.** ***Conclusions:*** **The challenges of ensuring access to quality care for this population are magnified by provider discourses of "therapeutic neutrality." (*Psychiatric Services* 57:867–870, 2006)**

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Mental health disparities among lesbian, gay, bisexual, and transgender (LGBT) people are of growing national concern (1,2). The risk of mental illness is greater for LGBT people because of their repeated exposure to psychosocial stressors associated with anti-LGBT attitudes and behaviors, including discrimination, stigmatization, and violence (1–4). The consequences of such exposure may be exacerbated in rural areas, where mental health care resources are often insufficient for the general population and virtually nonexistent for LGBT people. Geographical isolation, lack of insurance, and confidentiality concerns are common barriers to care for rural residents (5,6). Rural LGBT people may encounter additional barriers within heterosexually oriented treatment systems (7–9). Recent policy documents concerning culturally relevant services cast critical attention on the relationship between health care environments and disparities among racial and ethnic minority populations (10–12), entreating us to examine how this relationship also affects rural LGBT people.

For this brief report, we have drawn from exploratory ethnographic research concerning LGBT mental health care in the predominantly poor and rural state of New Mexico. At-risk rural LGBT people find few affordable mental health services designed to address their specific needs (9). Despite the lack of LGBT-supportive care, the prevailing attitude within the provider community is that everyone deserves and can receive the "same" quality of services. This attitude diverts attention from the distinctive problems that rural LGBT people face when accessing care and the difficulties that providers encounter when delivering services. We challenge the stance of "treating everyone the same," which assumes that LGBT clients "are no different from the rest." This well-intentioned sentiment glosses over the social dynamics impeding the delivery of culturally relevant services to LGBT people.

Methods

We conducted ethnographic interviews with 20 providers of mental health–related care, most of whom primarily served two rural New Mexico communities. We first interviewed providers locally known for caring for LGBT people and then were referred to other area providers. We sampled until the point of data saturation. Our purposive sample included providers in psychology and social work, as well as substance abuse counselors and HIV-AIDS outreach workers. One participant (5 percent) self-identified as Hispanic, six (30 percent) self-identified as American Indian, and 13 (65 percent) self-identified as white or Anglo. Eight participants (40 percent) were male, 11 (55 percent) were female, and one (5 percent) was transgender female. We estimated that nine participants (45 percent) openly identified as gay or lesbian. We estimated that nine participants (45 percent)

were "known" for their willingness to work with LGBT individuals. Data derived from the provider sample were triangulated with narrative information collected from 38 rural LGBT individuals who had recently sought help for mental health problems, such as depression, anxiety, relationship problems, and substance abuse. The characteristics of this second ethnically diverse sample are discussed in a separate article in this issue of *Psychiatric Services* (9).

From September 2003 to August 2004, we used a semistructured interview guide to ask providers 25 open-ended questions about their general views of and personal experiences with mental health services for rural LGBT people. More specifically, the guide was designed to assess the following domains: individual and community attitudes toward sexual and gender minority groups, available services and barriers to care encountered by these groups, training and workplace policies that bear upon treatment of LGBT people, and perceived best practices when working with this population.

The audiotaped interviews were transcribed into an electronic database and analyzed through a series of iterative readings. A systematic line-by-line categorization of data into codes allowed us to determine prominent issues in the data. Data were first analyzed by open coding to discover themes and issues. Through focused coding, we then determined which themes and issues were repeated and warranted further attention (13). Finally, the findings from the provider sample were reviewed in relation to data obtained from the interviews with LGBT community members (9).

Results

Providers commonly reported the presence of both individual and institutional forms of anti-LGBT bias in outpatient mental health clinics, residential treatment centers, and inpatient hospitals serving rural LGBT people. They suggested that this bias is derived from inadequate knowledge of LGBT mental health care. Only one provider that we interviewed was formally trained to work with LGBT clients; the others were broadly trained in culturally relevant care. A heterosexual male provider asserted, "I got educated on the street" and a gay provider said, "My life," when asked what prepared them to work with LGBT clients.

When characterizing the social dynamics of rural clinic settings, providers offered examples of colleagues who allow problematic assumptions about sexuality and gender to influence their interactions with LGBT clients. These examples also reflected the experiences of the LGBT community members who took part in this study. In particular, some providers took for granted that clients were heterosexual. Such assumptions could provoke uncomfortable situations, as underscored by one client whose heterosexual male provider "laughed" in disbelief when this LGBT community member disclosed his gay status. In a related example, a transgender HIV-AIDS outreach worker would not refer LGBT clients to the local mental health clinic because its counselors "make you feel dirty." Finally, another LGBT client recounted how a heterosexual provider blamed her for "deciding" to be in an interracial relationship with a woman while living in a rural area. It was simply "too much" to ask other community members "to swallow" her "lifestyle choice." This woman remained socially isolated, depressed, and reluctant to seek care locally, but she could not afford to travel elsewhere for services.

Position statements and guidelines from the major mental health disciplines that discourage anti-LGBT bias and reparative approaches to treatment were ineffectual in countering anti-LGBT therapeutic practices (14,15). Indeed, one gay provider observed his colleagues pressuring LGBT clients to change their orientations: "They'd communicate [to clients] that they didn't think it was okay that [the clients] were gay. [They would say,] 'If they'd get over that, things would fall into place.'"

In group therapy, providers also discouraged LGBT clients from broaching sexuality and gender issues. Providers could not be relied on to quell the negative reactions of non-LGBT clients when facilitating such groups, thus allowing hostile attitudes to thrive. One gay provider stated, "In those groups it was open for everyone to talk about their sexual feelings. When [one gay youth] started to talk about his sexual feelings, he was voted as acting out [by other clients]." A lesbian provider witnessed a similar occurrence. She said, "A lesbian [came] out in a group at [the residential treatment center]. Everybody went haywire. The women were afraid to undress in front of her and were complaining about not being able to sleep because they didn't know if she was going to get in bed with them." Participants recognized that such occurrences led LGBT clients to avoid self-disclosure during group therapy, because of assumptions that providers would not stop harassment from fellow clients (8).

Providers highlighted a lack of LGBT-supportive policies in treatment facilities. They also blamed high-ranking clinical personnel for creating informal policies that compromise access to and quality of care for LGBT clients. One gay provider described a clinical director at a residential treatment center who believed that he was "open minded" and "protecting" LGBT youth in his refusal to admit them to preempt their exposure to on-site discrimination. Similarly, this provider recalled an LGBT youth who was "sheltered" or separated from non-LGBT clients: "My client was devastated. . . . The center put in him isolation. . . . [Staff members] did this, thinking this was not discriminatory. . . . They thought by protecting him from the other kids that were ridiculing him, that that was good for him."

Provider reports of "isolating" LGBT clients for varied reasons were widespread. "This isn't happening in like the 60s," stated one lesbian provider, whose young client had to sleep and eat in the timeout room because her colleagues "were so convinced that [the client] was going to 'convert' the other children."

Even providers who did not view homosexuality or alternative genders as pathological were not free of bias. For example, a gay client who was interviewed terminated treatment be-

cause he perceived his therapist as unable to break free from her morally imbued model of relationships. He said, "She disapproved of the fact that I was given permission to have recreational sex in the relationship. . . . She was judging me and it wasn't her thing to judge. . . . I did not want to keep seeing her as a therapist."

A lesbian client also expressed frustration with her heterosexual provider, whose bias manifested itself in the inability to address issues of homosexuality: "[My counselor] tries to be sensitive to my issues, [but] my issues have to do with my sexuality. I've brought it up several times. . . . She'll focus on something else."

Homophobia and transphobia within clinic settings reflected anti-LGBT sentiments circulating within the greater community. Some rural providers found that the lack of access to community-based LGBT resources heightened feelings of social isolation among LGBT clients. However, fears of societal condemnation prevented rural providers and clients from developing LGBT resources locally. The only practicing lesbian therapist in one town declined to participate in the formation of an LGBT advocacy organization, because she did not want to bring attention to herself and her partner. She explained, "We do not get involved. We don't speak publicly about it [being gay] ever. Most of the time [we are] in hiding."

Rural providers described compensating for anti-LGBT sentiments by treating LGBT clients "the same" as all clients. Despite tales of negative practices engaged in by colleagues, rural providers generally did not perceive themselves as manifesting anti-LGBT bias, asserting that they must be "nonjudgmental" and "respectful" with clients, regardless of race, culture, gender, or sexuality.

As described by providers, therapeutic neutrality is rooted in the notion that "they," meaning LGBT clients, are "no different from the rest" and that "they" should not be pathologized because of their sexual orientations or gender identities. Ironically, however, "therapeutic neutrality" insinuates another layer of bias into treatment contexts. Sustained by the multicultural ideal of caring for all clients in, as one lesbian provider stated, a "colorblind" way, this concept encourages providers to apprehend the common humanity within all psychologically distressed individuals seeking care. Yet the assumption that "everyone is the same" makes it possible for providers to maintain an outward appearance of acceptance, without compelling them to challenge their own cultural prejudices and lack of knowledge of LGBT mental health issues (16).

The enactment of therapeutic neutrality also allowed some providers to discount the possibility that sexuality and gender issues could be implicated in the mental health or substance abuse problems of clients. One heterosexual provider who was interviewed illustrated the limitations of his version of therapeutic neutrality when his client asked him, "You don't give a shit if I am gay, do you?" To which he replied, "No. What does that have to do with your drug problem?" Likewise, an unsuccessful attempt to develop a support group for LGBT clients was interpreted by another heterosexual provider whom we consulted as evidence of disinterest in LGBT programming. Rather than address the barriers to participation inherent in rural communities, he asserted that LGBT clients did not want to be treated differently from other clients and that they preferred to integrate into the heterosexually oriented groups. In his view, the clinic was delivering culturally relevant care precisely because the staff members were adequately considering the preferences of the LGBT clients. However, this type of integration may mean suppressing discussion of the sexuality and gender issues of LGBT clients.

Other rural providers pointed to potential conflicts between treating clients the "same" and social reality. For example, one heterosexual provider asserted that employment discrimination was a major life stressor for her "obviously very gay" clients. Despite her aspirations to treat them like "regular people," she advised them to present as "heterosexual" to reduce their exposure to bigotry and to improve their mental health status. A lesbian provider also struggled with treating "those people just like they're regular people." She stated, "If they're dealing with discrimination in this town, I try to help them uphold their dignity and integrity and be who they are—but quietly, so they don't get hurt." Both strategies exemplify the dilemma faced by rural providers where no one course of action is optimal and illustrate the impracticality of treating clients "neutrally" in a nonneutral world. Living "quietly" may be the best option for a particular time and place, even if in the long run it reinforces negative messages about being LGBT. The alternative strategy of living more openly as an LGBT person could adversely affect rural clients in the short run, particularly if such openness elicits antagonistic and potentially violent community reaction.

Discussion

We did learn of positive clinic settings where provider misconceptions about LGBT clients and ensuing actions such as isolation were not condoned. However, the conspicuous lack of explicit policy, deficient training related to LGBT issues, and embedded heterosexually oriented value systems meant that personnel at all levels of the clinical hierarchy were often not prepared to work effectively with LGBT clients. Although providers typically stated that all clients should be treated "respectfully" and "equally," rural LGBT people remained subject to negative attitudes circulating within various treatment venues. Discourses of neutrality reinforced the belief that these clients did not require special approaches to care, allowing some providers and their fellow staff members to disregard the varied social adversities and lived experiences that affected this at-risk, underserved group.

One implication of "viewing people in terms of universal sameness" is the tendency not to take into account social or political categories that remain meaningful and influence how specific groups of individuals are perceived and treated by others (16). Within rural communities of New Mexico, the assignment of sexual or gender minority status can compromise the em-

ployment, housing, and health care opportunities of LGBT people, consequently increasing their risk of mental distress. The discrimination that these individuals face in everyday social settings, such as the workplace, is due to their LGBT status, which makes their mental health issues deserving of special attention. Much like the members of other stigmatized minority groups, these individuals require providers who are knowledgeable of their social environments and the problems that can arise from being marginalized (8). However, the unreflective pursuit of therapeutic neutrality deters attention from the power imbalances that allow anti-LGBT sentiments to flourish and ultimately undermine the delivery of quality care.

Given the paucity of basic resources for rural LGBT people and their heightened risk for mental illness, it is imperative that providers contemplate creative strategies for engaging this vulnerable population. Providers must recognize how their own biases and community dynamics have an impact on the provision of quality care to sexual and gender minority groups. It is also incumbent on providers to challenge heterosexism, whether it is manifest among colleagues, in institutions, or in the community at large (8,15). Nevertheless, it may be naïve to presume that providers who live and work in rural settings are professionally or even personally equipped to tackle the substantial challenges of delivering LGBT-supportive services on their own. Efforts must be made to reform treatment systems by empowering providers through ongoing training and the enforcement of institutional and public policies prohibiting LGBT discrimination.

State governments can take the lead in nurturing institutional reform, particularly in rural settings where lack of insurance is commonplace and providers are thus dependent on public insurance programs for their revenue and continued financial survival. State governments can contractually oblige providers participating in public insurance programs to deliver culturally relevant services to LGBT people. Similar mandates exist for racial and ethnic minorities. Such services can be based on existing professional guidelines that entreat providers to obtain accurate information about LGBT mental health care; to understand the social, political, and economic challenges that LGBT people face; to avoid a priori assumptions that clients are heterosexual; and to simply recognize how their own attitudes and behaviors affect caregiving processes (15).

Conclusions

The challenges of caring for rural LGBT people are complicated. Institutional reforms that heighten provider sensitivities of LGBT mental health issues will enhance the capacity of rural caregivers to effectively serve LGBT clients (7). The cultivation of rural treatment systems supportive of "LGBT-friendly" providers will offer collegial environments in which the practicable dilemmas of clinical work can be addressed. Although the neutral posture espoused by providers is intended to "depathologize" LGBT people, it may divert attention from the issues of discrimination, stigmatization, and violence, which affect the mental health of sexual and gender minorities in rural settings.

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