Pragmatic Help Seeking: How Sexual and Gender Minority Groups Access Mental Health Care in a Rural State

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Objective: **This qualitative study examined how lesbian, gay, bisexual, and transgender (LGBT) people in rural areas of the poor and multiethnic state of New Mexico access secular (professional and lay) and sacred (indigenous and Christian) mental health care resources.** ***Methods:*** **In-depth, semistructured interviews were used to document the help-seeking processes of 38 rural LGBT people.** ***Results:*** **Obtaining assistance was complicated by the ideal of self-reliance and the view of mental illness as a sign of weakness. Financial considerations and a lack of and community-based LGBT social networks also exerted substantial influence on help seeking. Many LGBT people would strategically remain silent about their sexuality or gender status and rely on their family ties to access the range of secular and sacred resources that are most commonly available in medically underserved rural communities.** ***Conclusions:*** **Although persons from sexual and gender minority groups often experience positive outcomes as a result of help seeking, some LGBT people remain vulnerable to anti-LGBT sentiments that persist within secular and sacred sectors of rural health care systems. (*Psychiatric Services* 57:871–874, 2006)**

Few people with mental health problems seek and receive professional care (1). Rural residents, especially persons from ethnic minority groups, face substantial economic barriers that, when coupled with the stigma of mental disorders and insufficient service availability, hinder use of such care (2). Homophobia and transphobia in extant treatment settings make rural residents who are lesbian, gay, bisexual, or transgender (LGBT) particularly wary of professional services (3). Literature concerning mental health care for rural LGBT people is scant (3–7) and typically neglects the experiences of ethnic minority groups (8). However, this literature points to the lack of LGBT social networks and resources in rural areas, provider limitations in caring for sexual and gender minority groups, and the pivotal role that social supports—that is, family and close peers—play in informal help seeking and help giving (3–7). As a contribution to this literature we draw on qualitative data to illustrate how an ethnically diverse group of rural LGBT people in New Mexico use secular (professional and lay) and sacred (indigenous and Christian) mental health resources to alleviate psychological distress, addiction, or both.

Methods

As part of a larger ethnographic study of help-seeking behavior among sexual and gender minority groups in New Mexico, we conducted semistructured interviews between February 2004 and July 2005 with 38 LGBT rural residents. The majority lived in two counties that were vast in size (5,449 and 5,858 square miles); rates of poverty exceeded the national average in each county (20.5 percent and 36.1 percent).

The adults in our purposive sample recently sought help for mental health problems, such as depression, anxiety, relationship issues, or substance abuse. Almost all had low incomes and were uninsured. Recruitment involved snowball and advertising sampling methods, in which candidates contacted our researchers regarding their possible participation. We also initiated ethnographic observations in community forums on LGBT issues, which afforded opportunities to invite candidates into the study. The final sample reflected the ethnic diversity of New Mexico; 16 (42 percent) participants self-identified as Hispanic, 13 (34 percent) as American Indian, eight (21 percent) as white or Anglo, and one (3 percent) as other. Twenty (53 percent) were male, 15 (39 percent) were female, two (5 percent) were transgender female, and one (3 percent) was transgender male.

We were interested in the help-seeking processes of participants and the social contexts in which these processes unfolded. Derived from the network-episode model (NEM), our theoretical framework held that such processes were neither discrete

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nor episodic phenomena, but instead were socially dynamic—a series of commonsense decisions influenced by local perspectives on mental illness, social networks, treatment system factors, and other contextual features of rural communities (1,9). In an initial in-person interview, we used open-ended questions extrapolated from the NEM to elicit in-depth discussion about personal experiences with different types of mental health care. The interview guide consisted of 43 questions and typically took between 90 and 120 minutes or longer to administer. Fourteen individuals (37 percent) took part in two follow-up interviews that focused on changes in help-seeking activities and how social networks function in the management of ongoing mental health problems. The first follow-up was undertaken approximately six months after the initial interview; the second was conducted approximately six months later. The follow-up interview guides were comprised of 24 and 27 questions, respectively; each guide was administered over the course of 60 to 90 minutes. Participants were compensated $25 per interview event.

Interview transcripts were analyzed through a systematic line-by-line coding process. 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 (10). We also engaged in a continuous process of joint reflection in which we challenged our interpretation of the results, explored areas of disagreement, and revised interpretations.

Results

Help-seeking processes were influenced by the lack of affirmative LGBT social networks and services, fear of anti-LGBT bias, and lay understandings of mental illness. Participants employed adaptive strategies involving family connections, nonprofessional healing options, and negotiation of identity disclosure to mitigate the effects of these barriers to care. However, such strategies did not necessarily result in positive outcomes, particularly for participants who did not conform to gender norms. Financial constraints greatly affected use of secular and sacred healing resources.

Although other studies suggest that involvement in a cohesive LGBT social network is a protective factor for LGBT people facing the effects of discrimination, stigma, and violence (11), our participants often lacked such networks. They described their LGBT communities as loosely organized, "underground," and "hidden." Consequently, participants relied on alternative support networks in which family predominated.

Distance and economic insecurity prevented many participants from using LGBT-affirmative mental health care, largely available in urban areas. For example, Jennifer, an uninsured Hispanic bisexual woman, was unable to obtain services: "I'm broke. . . . By the time I pay my bills I have $70 to last the month." (Names have been changed throughout the report to protect participants' identities.) Even in situations where such factors exerted little influence, finding LGBT-affirmative care remained challenging because knowledge of services was usually communicated through word of mouth in social networks, as we found in the broader study of urban LGBT people (data not shown). Because rural participants in this study lacked such networks, many were not privy to such referrals.

Participants distrusted the few professional options available locally. Living in small towns, participants usually possessed personal knowledge about mental health providers and feared that the providers would respond negatively to LGBT people. Although some participants tolerated heterosexist bias when turning to assistance in the religious sector, the prospect of such bias infusing clinical interactions contributed to the avoidance of professional care. For those who had sought professional help, provider prejudice and inadequate knowledge about LGBT people often led to inappropriate care and the discontinuation of services (3). After her therapist disparaged her "lifestyle," Karen, an Anglo lesbian, shunned local services. She remarked, "Considering [my] experience was with the director of that place, I can't imagine that subsequent experiences would be much more positive."

A generalized aversion to professional services also dissuaded some rural LGBT people from seeking assistance in local treatment settings. In fact, few participants regularly turned to professional services to address health concerns. Jett, a Hispanic lesbian, said, "We have our ways. We're from a ranch. . . . We don't use medical. We fix ourselves here." This attitude applied to mental health problems as well, which were frequently portrayed as problems that one could "will away" through "self-reliance" and "hard work." The notion of mental illness as a character defect or marker of laziness was also common. Labeling oneself as "depressed" was considered a "cop-out" by Esteban, an HIV-positive Hispanic gay man, who believed that a solid work ethic prevents mental illness, a view shaped by his grandmother and other close kin.

Although many participants from minority groups viewed the resolution of mental health and substance abuse problems as a matter of personal responsibility, they clearly benefited from supportive relationships predicated on social ties shaped by family, ethnicity, and geography (4). We were particularly struck by the recurrent example of returning "home" among people of color who sought emotional support from their rural families for recovery purposes after taking part in urban LGBT subcultures, where substance abuse was prevalent. Instead of coping with issues on their own, they were doing so with their families.

Family regional history often shaped how one was treated within rural communities. Angela, a Hispanic lesbian, said, "If it's me, I'm one of their own. It's fine. But if [a woman] was to come here and just be a lesbo, God forbid! She'd be the topic of gossip." Angela also challenged the notion that rural LGBT people were invariably "isolated" because of their sexualities (7). Like other minority participants, she maintained that "confidence," inspired by a strong sense of place and kinship, promot-

ed community acceptance and overall mental health. She added, "If you're insecure about your sexuality, then others here are gonna sense it and . . . they're gonna go after you." Indeed, many Anglo urban-to-rural immigrants who lacked Angela's "confidence" and sense of belonging expressed concerns about community gossip and went to great lengths to hide their sexual identities. Unlike Angela, these individuals experienced fear of disclosure as a major stressor and felt isolated in rural communities in which few had family ties.

For Hispanic and American Indian participants specifically, family influenced their decisions to turn to services based in nonbiomedical belief systems. Grief stricken over losing his aunt, Leroy, an American Indian gay man, fell into a depression first recognized by his mother. At her urging, Leroy sought services from an indigenous healer. He explained, "My sister had gone to a Medicine Man and had a ceremony done for that same problem. Since it helped her, [my mother] thought I could go to this Medicine Man. After I had the ceremony done, it seemed like it helped."

Although Leroy hoped for a second ceremony, his family could not afford this option. Instead, they consulted with several other practitioners, both secular and sacred, in a pragmatic process consisting of a series of prudent, economically sensible strategies based on diverse, often contradictory opinions about what Leroy was experiencing and what he needed to overcome his grief.

Following an episode of what Leroy described as "weird" behavior, his family took him to an American Indian charismatic healer, who identified "devil possession" as the problem. The healer and his wife prayed to expel the demon. Afterward, the wife told Leroy that "homosexuality is wrong" and then asked him to complete a diagnostic survey. Leroy recalled, "I was to bring back the form and set up a time for an exorcism. The questions asked if I masturbated and if I thought of having sex with animals or children." Distressed by the questions and the unanticipated assault on his sexuality, Leroy did not submit the form or return for the exorcism. Although Leroy used the advice of family to help him cope with mental health problems, his subsequent choices regarding treatment were sometimes contested. Leroy's rejection of the exorcism upset his family members, which only intensified his distress.

After Leroy experienced another episode of "weird" behavior, a different pastor from a mainline Protestant denomination intervened at the family's request and instructed Leroy to consult with a professional provider. Leroy was dissuaded from doing so earlier by relatives who distrusted conventional mental health care. He stated, "I have an uncle who went to a psychiatrist. He was prescribed all these medications. . . . The medications messed up his mind more." Overcoming his skepticism, Leroy saw a provider at the Indian Health Service, where he received free care. Although the provider nervously "laughed" when Leroy revealed that he was gay, he was not swayed from returning for counseling (3). Leroy valued the provider's status as an American Indian Christian elder, even if he could not discuss his sexual identity with the provider. Leroy stated, "The older people don't like to talk about homosexuals or anything to do with something they see as wrong." Leroy argued that discussion of his sexual identity would only divert attention from his grief, and despite his negative experience with the charismatic healer, he appreciated that this provider encouraged him to attend church services.

Several participants turned to religious institutions for support because of financial considerations. Benita, a Hispanic bisexual woman, turned to a Christian church when she could no longer afford professional mental health and substance abuse treatment. Ability to pay was not an issue at the church, where she was "prayed over." Benita used "silence" about her sexuality as a strategy to access mental health assistance. She had no qualms about keeping her sexual identity secret and attributed her past three years of sobriety to the church's influence. Other participants also emphasized that they were not compromising their integrity by remaining "silent" about their sexuality during encounters with sacred or secular providers, although most shared the desire for therapeutic spaces where "silence" was not a precondition for care.

Although some LGBT people successfully negotiated heterosexism in rural health care systems, others encountered significant challenges. Pilar, a Hispanic transgender woman, raped a decade ago in Albuquerque, landed in a psychiatric hospital following serious depression and heavy drinking. She was constantly humiliated by hospital staff and providers because she was transgender. Feeling unsafe in Albuquerque, she returned to the rural area where she grew up. Pilar continued to relive the trauma of the rape and was repeatedly hospitalized for various mental health problems. Over the next ten years, Pilar could not locate an LGBT-affirming provider. Although she moved "home" for emotional and financial support, her family refused to accept her transgender status. Feeling out of place in her native Catholic environment, Pilar turned to a Pentecostal community, where members prayed for her "depression," "anxiety," and "life." One day, members confronted Pilar about her gender identity: "I was dressed [female]. . . . This man called a bunch of guys over. . . . They said that I was going to change from being a homosexual and [that they would] change me to a man." Pilar became suicidal after this incident. Her help-seeking narrative illustrated that religious resources, although readily obtainable, might necessitate gender reparation—an option that ultimately proved harmful to Pilar's mental health.

Discussion

Our participants utilized all available community-based resources, including those tainted by homophobia and transphobia, in attempts to meet basic mental health needs. Moreover, participants frequently combined multiple and sometimes contradictory approaches to mental health. Although Pilar and others would benefit from professional

care, their economic insecurity, distance, and perceptions of provider bias decreased help-seeking in this sector, a process already complicated by ideals of self-reliance and the view of mental illness as a personal shortcoming. These factors compel us to ponder the pragmatics of actual help-seeking processes. Such pragmatics, which can vary from outright refusals to seek care to decisions to stay silent about one's LGBT status in treatment contexts, can be seen as adaptive responses to the sometimes harsh realties of rural health care systems that reinforce traditional gender norms. Given these realities, most participants turned to non-LGBT social networks to ensure that mental health needs were satisfied. Vital support systems consisting of religion, family, and community provide the safety net that rural residents in economically depressed areas require to cope with their problems.

We suspect that many of the findings reported here are not unique to LGBT people but are applicable to medically underserved rural New Mexicans in general. First, non-LGBT social networks, which are based on family and ethnic ties, are central to informal help seeking and help giving (4). In urban areas of New Mexico, where we have conducted parallel research as part of our larger study, participants tend to rely primarily on professional services and their LGBT social networks in the course of help seeking (12). Second, rural LGBT residents, in contrast to their urban counterparts, are far more likely to turn toward spiritual spaces and religious institutions for therapeutic purposes. This difference may suggest that the sacred sector offers needed social support for rural LGBT residents and acceptable pathways into care in communities where mental illness is highly stigmatized.

Conclusions

The help-seeking processes of rural LGBT people are shaped by local ideas about mental illness and treatment, financial constraints, and non-LGBT social networks. Many LGBT New Mexicans are pragmatic health care consumers, strategically remaining silent about their sexuality and relying on family ties to access secular and sacred resources in rural areas.

The cases presented above point to the potential of nonprofessional resources as sites for mental health intervention. These sites need not constitute the only viable option for certain individuals. Although we might naïvely suggest that practitioners in all rural health care sectors—secular and sacred—play proactive roles in ensuring that LGBT mental health needs do not remain unmet, the conditions under which silence has evolved into a viable help-seeking strategy might not permit such sweeping social reform. Thus we call for further examination of the apparent schism between community support systems and the advocation of LGBT-affirmative care in rural New Mexico.

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