Original Research

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Insidious Trauma, Heteronormative Steeping, and Help-seeking: Exploring the Non-Heterosexual Experience in Rural Northern Michigan

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Abstract

Non-heterosexual (NH) individuals are often exposed to stressors based on their non-heterosexual status and, therefore, may have unique needs related to help-seeking for mental health, especially in rural areas where residents are more likely to identify as religious or conservative, groups that have historically been opposed to NH individuals. This study was completed to explore the lives of 10 non-heterosexual individuals in rural northern Michigan related to their daily encounters with minority stress and their experiences with help-seeking for mental health symptomology. In-depth semistructured interviews were conducted, and transcriptions were analyzed to identify the occurrence of traumatic experiences at a systemic/interpersonal level, subsequent internalization of those experiences, how that prompted the need for counseling, and the individual experiences within those therapeutic encounters. Thematic analysis identified three themes: (a) experiences of distal stressors and proximal stress reactions related to environmental and interpersonal interactions, (b) heteronormativity and heterosexism within the help-seeking process, and (c) suggestions for improving the help-seeking process. The results of this study include increasing awareness of, and focus on, the NH population in rural northern Michigan, which may have increased negative experiences based on minimal community acceptance, few affirming and diversity-educated mental health provider options, and negative provider reactions. The knowledge generated from this study could lead to increased awareness of the insidious environmental trauma experienced by NH individuals in rural conservative areas and reduce the disparities for this population by improving provider awareness and services.

Introduction

Literature has suggested that individuals who are not heterosexual, or the non-heterosexual (NH) population at large, have an increased risk for mental health and substance abuse issues (Kano et al., 2016) and, NH

individuals in rural areas, have an even greater risk of increased mental health issues due to factors of sexual minority stigmas and experiences, especially in rural areas (Marsack & Stephenson, 2017). The research also indicates that not all rural experiences or rural areas are the same in relation to the provision of services for NH individuals (Barefoot et al., 2014; Marsack & Stephenson), and therefore the previous research or data cannot be generalized to any specific bounded system or location.

Some studies have found similar occurrence and prevalence of clinically diagnosable mental health issues between general rural and urban populations (Rost et al., 2007; Tirupati et al., 2010); however, other studies have found that, because rural areas often lack the supportive infrastructure to adequately identify and deliver mental health services, rural residents with these issues continue to be dramatically under identified and underserved (Horvath et al., 2014; Probst, 2014).

Recent data has shown that there is a significant set of factors for NH individuals in rural areas specifically related to their NH status, factors that heterosexual individuals do not have. Compliance and initial help-seeking can be especially difficult for members of the NH community, as stigma is already a social issue that is at the forefront in the rural community due to the minority status (Swank et al., 2013). Adding the intersectionality of NH identity and mental health needs, continues to compound minority status and minority stress. The impact of this in relation to limited provider options in rural northern Michigan can have an increased compounded effect relating to willingness and ability to seek affirming services (Swank et al, 2013). However, because mental health clinicians are responsible for providing services to this rural population, it is increasingly important to have a better understanding of this population's experiences of previous help-seeking in this area in an effort to increase clinician awareness of the needs of NH individuals.

Within a distinctively rural community in northern Michigan, with historically limited resources for the NH population (CDC, 2018), it was previously unknown how individuals within that rural group experienced day-to-day life in that socio-political climate and how that contributed to mental health symptoms as well as their experience with the acquisition and use of clinical mental health services. By exploring these experiences, area clinicians are better able to understand this population's needs coming into care, their comfort in accessing services, as well as the perception of clinician preparedness and sensitivity. The findings of this study can be used to educate service providers on a perceived need to alter service provision, create and provide training related to acceptance and diversity, and promote understanding of the intersectionality of non-heterosexual individuals in a rural setting.

Background

NH Identity and Mental Health Need in Rural Areas

Identifying as a member of the lesbian, gay, or bisexual population and experiences associated with that identification can vary based on geography (Swank et al., 2013). Individuals residing in rural areas are more likely to experience homophobic statements (Roberts et al., 2017; Swank et al., 2013), property damage, employment discrimination (Tilcsik, 2011), housing discrimination, and physical assaults (Poon & Saewyc, 2009; Swank et al., 2012), than those individuals in urban areas. Spatial factors or location-based factors related to the personal and individualized experiences of these events have varied between studies, but primarily indicate an increased incidence in rural and small-town areas (Paceley et al., 2017; Feinstein et al., 2012). Community (and the composition of that community) has been indicated to play a role in the predicted increase in these experiences as well, where densely populated areas may contain more individuals that possess traits connected to liberalism, including increased levels of education and less religious fundamentalism, which are linked to decreased levels of discriminatory or prejudicial actions and experiences (Paceley et al.; Swank et al., 2013; Perkins et al., 2013). Specifically, NH individuals in rural areas have indicated that this increased religiosity and the conservative community climate have influenced their

complete public identification related to "out" sexual orientation or at least influenced their comfort in doing so (De Pedro et al., 2018; Van Eeden-Moorefield & Alvarez, 2015). Moreover, research indicates that sexuality-based stigma, including anticipated, enacted, or internalized, is associated with increases in depression (De Pedro et al.; Marsack & Stephenson, 2017; Van Eeden-Moorefield & Alvarez). This is in line with Meyer's theory of minority stress and components of microaggressions related to rural living, as well as a 20% greater risk of attempting suicide than NH individuals living in affirming community climates (Hatzenbuehler et al., 2012). Ongoing public or media-based exposure to large-scale hate crimes, assault, hatred, and identity-based discrimination have been found to contribute to ongoing levels of fear and hypervigilance (Stults et al., 2017).

Community climate can include familial relationships, as many rural communities are comprised of multigenerational family systems that contribute to the overall community population. Rural communities can improve resilience and offer protective factors for some individuals (McKibbon et al., 2016); however, for NH individuals, smaller communities provide fewer resources specific to that population (Handley et al., 2014), more conservative views, and multigenerational rejections (Ryan et al., 2010), which can drastically reduce protective factors and decrease resilience. This can subsequently affect mental and physical health related to insidious trauma exposure secondary to residence in the non-affirming environment (Keating & Muller, 2017; Roberts et al., 2010), wherein insidious trauma is defined as the gradual and cumulative effect of lower-level, but constant traumatic experiences. Therefore, the systemic composition of community, subsystems, family systems, and nuclear family contributes to the ecological systems lens used to interpret the data collected in this study.

Mental Health Services With NH Individuals in Rural United States

In addition to community composition, the availability of clinical resources in rural areas is much less than in an urban area (Handley et al., 2014). This resource absence could be due to limited finances for community programs paired with the identified conservative nature of rural areas, possibly putting less of a priority on alternative or controversial resource development (Eleveld, 2015). In addition, resources are typically geographically scattered even when available (Eleveld). Several community resource needs assessments have been completed in rural areas to indicate that, while there may be resources available, they may be an excessive distance away, and, while perhaps centrally located to a geographical area, they may be difficult to access (Perkins et al., 2013; Handley et al; Li et al., 2014). This is especially difficult in rural areas that may not have public transportation systems, leaving individuals without the means to access services even if they are available (Jansuwan et al., 2013).

In rural areas, services for NH individuals are less prominent. This could be due to a variety of reasons, including: lack of resources in general, lack of funding due to religiously/conservatively based social climate, and/or lack of sexual-orientation disclosure, leading to lack of need awareness (Rhodebeck, 2015; Whitehead, et al., 2016). Use of services is a separate issue, as several reasons may explain why an NH identified individual might limit access or be less inclined to seek services, including less privacy in a smaller community, fear of lack of knowledge/awareness/training of the therapist, fear that the therapist will attribute all presenting concerns to the individual's sexual orientation, and experiences of sexual orientation microaggressions even within the therapeutic environment (Liddle, 1999; Provence et al., 2014; Shelton & Delgado-Romero, 2011).

Best practices found in the literature for treatment of NH individuals include trauma-informed treatment systems, lesbian, gay, bisexual, transgender-responsive agencies, welcoming and inclusive climate for agencies, and linkages with sexual minority community resources and social networks (Drabble & Eliason, 2010). However, in rural communities with limited referral resources, these best practices may be more difficult to utilize.

It is common for rural-based clinicians to practice from a more generalist or neutral set of therapeutic techniques, as specialization is not always financially feasible or desired (Ruud et al., 2016). In addition, there is not always the client base to mandate provider specialization. As a result, treatment for specific populations can go unaddressed and certain populations may be unserved or underserved (Ruud et al.). Secondly, many clinics are religiously based, and providers may or may not subscribe individually to the religious pretense (Minnex, 2018). However, non-affirming help-seeking experiences with religious providers or agencies with religious platforms adversely affect the rate of suicides among NH individuals (Meyer et al., 2015). Further research indicates that NH individuals who have social and professional support from other NH individuals, therapists, parents, or respected/trusted supports exhibit far less depression, fewer feelings of isolation, lower suicide rates, and less substance abuse (Wright & Perry, 2006); however, in rural areas where the overall NH population is relatively small or "closeted" for one of several reasons discussed, the ability for NH individuals to find and acquire positive relationships with other supportive NH individuals is difficult (Oswald & Culton, 2003). It is unknown if the rates of suicide and symptom exacerbation in this identified rural area are due to the environment or community climate, the provider, or the agency; however, the internalized homophobia and proximal stress reactions to these non-affirming factors are discussed and processed below.

Help-seeking

In the seminal article on the topic, D'Augelli (1987) identified that rural NH individuals have a distinctly less than adequate representation within rural health care and mental health treatment. An ongoing disparity continues between the number of individuals that report having a mental health need, as compared to the number of individuals who seek help for those symptoms (Marsack & Stephenson, 2017). Help-seeking for mental health needs within the general population can be affected by several different internal factors, including age, gender, and cultural beliefs (Boerema et al., 2016). These numbers can also be affected by the additional factors of proximity, community availability and accessibility, and use of faith-based services over specialized clinical services, which is common to rural areas, with estimates of only 28–60% of individuals in the general population seeking help for depression and other identified mental health disorders (Boerema et al.). For NH individuals, these additional factors can be related to lack of acquisition of service or fear of acquisition based on fear of judgment or stigma (Feinstein et al., 2012), previous negative experiences (Choudhury et al., 2009), or concern related to finding services tailored to their specific needs (Smalley et al., 2015).

Provider Per Person and Mental Health Utilization Rates

Within the public mental health system, or Community Mental Health (CMH) systems in Michigan, the most recent data collected is from 2014 and reports a state-wide mental health service utilization amount of 120,836 in the entire state of Michigan, with 3,539 adults (over the age of 18) receiving some form of public mental health services in the identified eight-county area for the purpose of this study (Fingertip Report, 2015). While community mental health agencies in the identified rural area provide one office location per county, a county can span up to 2,573 square miles in this eight-county area (MDCH, 2017). In addition, each of these offices employs only 2–4 therapists at each location. This indicates that all of these 3,539 adults are served by no more than 24 non-profit therapists. It is unknown how many of those served are part of the non-heterosexual population. However, most recent census reports that these eight counties have 132,219 individuals over the age of 18 and current data reports between 3–5% of the national rural population are a member of the NH population (US Census, 2010). This can be interpreted as meaning that, if generalizable to this area, the NH population may be close to 4,000 individuals. The national average of mental health issues is approximated to be 20–25% of the population (NAMI, 2019), with NH individuals being 2–3 times more likely to suffer from a mental illness than heterosexual individuals (Chakraborty et al., 2011). Using these statistics and generalizing them to this area indicates that 40–50%, or 1,600–2,000 individuals of the 4,000 potential NH individuals in the area may have a diagnosable mental illness. Comparing the number of

potential NH individuals with a mental illness against the number of individuals receiving services in this area, reveals a great disparity. This lack of acquisition can be interpreted in a number of ways.

As already identified, some barriers to rural mental health care acquisition relate to transportation and lack of accessibility related to location. Although limited data exists related to the available smaller private practices accessible to this rural locale, many private practices in this area do not offer services to individuals with publicly funded health insurance programs (Medicaid and Medicare) and are therefore not available to individuals who exist below a certain socioeconomic threshold (Willging et al., 2008).

Conceptual Framework

The conceptual framework for this study was a combination of Meyer's (2004) minority stress perspective (MST) and Brofenbenner's (1994) ecological systems perspective. The ecological systems theory is a way of seeing case phenomena (the person and the environment) in their interconnected and multilayered reality, to order and comprehend complexity, and to avoid oversimplification and reductionism related to heavy emphasis on either the person or the environment (Lea et al., 2014). This perspective was used to examine the NH research participants as a member of a larger system that is interconnected and multilayered. Within the parameters of a rural community and the multiple players that encompass that system, there are several contributing factors and roles that each component plays in the transactional relationship, including family, friends, healthcare, religious supports, and mental health services. Examining the system as a whole, the perceived impact of the rural community, the social supports of the individual, and the available resources for that individual allowed for a closer look at the individual experiences of acceptance or rejection within that system and provided the opportunity for a rich and thorough description of those experiences.

Applying Meyer's minority stress theory (MST) shows that individuals who identify as a member of the NH population can be at an increased level of vulnerability solely in response to the unique issues related to their NH status (Shilo & Mor, 2014). This can be observed in both distal objective stressors and proximal subjective stressors, where distal stressors are defined as external stressors such as minority-related prejudicial acts (words, actions, discrimination) and proximal stressors, which are the internal reactions to those distal stressors, including internalized homophobia and concealment of sexual orientation (Alessi, 2014). As found in the literature, the MST provides evidence of the relationship between perceptions of minority stress and increased mental health symptomology (Muehlenkamp et al., 2015) and minority stress being elevated in rural areas (Swank et al., 2012). The influence of that stress on the mental health of NH individuals in this study will be explored through this lens to examine the lived experiences of this population (related to the exacerbation of pre-existing mental health symptomology or the generation of new symptoms secondary to traumatic stress) secondary to both living in this rural area as well as the perceived experiences they had receiving mental health services in this area.

The integration of both the MST and the ecological systems theory allowed for a richer examination of the participants in this study. By focusing on the multilayered systems and the various roles encompassed in this community through the lens of the ecological systems theory, there was an increased ability to examine individual's traumatic experiences, perceptions of supports, and community atmosphere as a whole. This use of the systems theory was also combined with minority stress and how those stressors can be perceived to influence community systems and mental health supports. This allowed for a unique, novel examination of traumatic experiences and the subsequent help-seeking of NH individuals.

Methodology

This research used a qualitative, single-subject study design, where the subject being examined was the bounded system of the geographical location, focusing on generating meaning and understanding of

experiences of LGB individuals in rural northern Michigan. Because there is a lack of literature on LGB individuals in rural areas, a qualitative approach was taken to explore the population and gather a rich description of their experiences (Seigle, 2019). Therefore, attempting to understand and describe the essence or nature of human experience was imperative in the exploration of help-seeking LGB experiences. It was essential to capture the experience of perceived minority stress to allow the participants to discuss their experiences with help-seeking with respect to their location, their minority status, and their mental health. After approval from the IRB committee, the study was comprised of in-depth semistructured interviews with LGB individuals who had sought out clinical intervention for self-identified or professionally identified mental health or substance abuse issues. These data were then analyzed and interpreted to provide a rich, valid, and comprehensive understanding of the experiences of LGB individuals with rural mental health services.

Role of Researchers

I acknowledge the possibility of bias in empirical research and acknowledge my role as a practicing mental health clinician, a researcher, and a student in the selected research area. To control for these potential biases, member checking, peer debriefing, and research journaling were used (Lincoln & Guba, 1986; Patton, 2015). Data emerged independently and themes were not pre-formed. I also used thick descriptions to analyze commonalities in data, while also taking into consideration assumptions and bias. In addition, I received IRB approval prior to the initiation of this study (Approval Number 10-30-17-0546152).

Defining the Location and Community

The identified area was the eight counties that fall above the east-west Michigan state road M-72. This area was chosen due to its rural designation, as defined by the Census Bureau where any area not classified as an urbanized or urban cluster area is by default classified as rural (Ratcliffe et al., 2016). These eight counties are: Emmet, Charlevoix, Presque Isle, Cheboygan, Antrim, Alpena, Montmorency, and Otsego. The total population for this area is estimated at 185,278 based on the most recent census (U.S. Census Bureau, 2010). This area also has a total of 9,116 square miles, 4,749 of which are comprised completely of water and inland lakes (US Census Bureau, 2010). This provides an average population of 46 people per square mile. The community consists of 94% White individuals, compared to the Michigan average of 75% (US Census Bureau, 2010). In addition, all eight counties have over 70% registered voters as reporting Republican party affiliation (Michigan Secretary of State, 2020), and 54% of all residents report being of a practicing religious affiliation—higher than the state rates of 42% of Michigan residents (US Religious Census, 2010).

Participants

Data saturation was reached at 10 participants, which is an assumed representative sample based on the population in this rural area and estimates of NH population ratios, which included a state-wide estimate of 3.8% of the population identifying as NH (Gates, 2017). Participants were recruited using both criterion and snowball sampling. This was done by way of social media boards, public unrestricted message boards, and fliers distributed in primary care and mental health offices. Criteria for inclusion included: the participant being over the age of 18, an identification of non-heterosexuality, and the participant must have received professional treatment for substance abuse or mental health concerns within the last five years in this rural locale. All individuals were White, as is 93.9% of the total population in those eight counties measured (US Census, 2010). Socioeconomic status varied as well, with annual income ranging from $12,000–$80,000 individually (information related to married or joint income was not obtained). Specifically, participants included three cis-gender men and seven cis-gender women, aged 18–63, with an average age of 37. All were at different stages of the "coming out" process. This group included individuals who had lived in this area between two years to 43 years, with an average of 16.5 years. Finally, participants ranged in number of instances seeking therapy and amount of time spent in therapy. All individuals had seen at least one therapist within the last five years (per inclusion criteria), with four individuals seeing more than four therapists in that

time frame. During their time in therapy, all individuals spent at least 2 months with each therapist. A more detailed description of each of these participants can be found below in Table 1. These demographics are based on self-report.

Table 1: *Participant Descriptions*

	Age	Gender Identity	Sexual Orientation	Relation-ship Status	Length of Residency	Religious Affiliation	Political Leanings	"Out-ness"	Number of Therapists
1	61	Cis-Female	Lesbian	M-SS*	15 years	Jewish	Liberal	All areas	2
2	27	Cis-Female	Bisexual	M-SS*	27 years	Non-Religious	Liberal	Friends and Family	2
3	24	Cis-Male	Gay	Single	24 years	Non-Religious	Liberal	All areas	1
4	48	Cis-Female	Lesbian	M-SS	8 years	Christian	Moderate	All areas	3
5	22	Cis-Female	Lesbian	Single	2 years	Baptist	Moderate	All areas	1
6	18	Cis-Male	Bisexual	D-DS**	18 years	Non-Religious	Non-political	Minimal	2
7	42	Cis-Female	Lesbian	E-SS***	3 years	Methodist	Liberal	All areas	3
8	43	Cis-Female	Bisexual	E-SS***	43 years	Christian	Liberal	All areas	5
9	50	Cis-Male	Gay	E-SS***	20 years	Lutheran	Liberal	All areas	2
10	32	Cis-Female	Bisexual	M-DS	5 years	Non-religious	Liberal	Friends only	2

Notes:
* M-SS: Married to someone of the same sex
** D-DS: Dating someone of different sex
*** E-SS: Engaged to someone of same-sex

Data Collection

Data were collected through semistructured interviews which sought to obtain descriptions of the world of the interviewee with respect to interpreting that meaning into themes (Brinkmann & Kvale, 2014). Some questions were asked directly to all participants, but in a semistructured format, which allowed for changes of format or structure in order to follow up to specific answers given (Rubin & Rubin, 2012). An interview script had the initial questions and follow-up questions, which were formed through the interviewer's active listening skills, specifically clarifying and summarizing, as suggested by Brinkmann & Kvale, to prompt interviewees to share more information or to explore the selected topic in more depth. Interviews were audio recorded and transcribed. These questions align with the conceptual framework related to minority stress and systems theory, as the questions sought to explore individual experiences, but also how those experiences were affected by the greater geographical system at large. An example of questions and prompts used in the

interview are: "How has living in this community affected your mental health (either positively or negatively)?" and "tell me about your experience seeking professional support for mental health or substance abuse issues." A full list of questions can be found in the Appendix.

Procedure

Participants were recruited from social media boards, information boards and fliers in the community, as well as word of mouth with area clinical service providers. Participants were screened by answering qualifying questions confirming residency in the selected geographical area, their sexual identity, and that they had received services within that area as well within the last 5 years. Participation was voluntary, with informed consent verifying that participants were aware that they may decide not to participate at any time. Participants' identity was kept confidential. Participants were assigned a pseudonym that was used as an identifier for the purpose of data collection and analysis. Each participant was asked to participate in one 1–1.5 hour-long initial voice-recorded interview conducted in person, over the phone, or via video conference. That interview was transcribed within one month and a second additional recorded and transcribed 30–45 minute interview was scheduled either in person or via telephone to ensure member checking as well as complete any additional questions or clarifications from the initial interview. Member checking consisted of the interviewer providing a summary of the interview to confirm the participant's transcript was interpreted correctly and to present initial themes that are emerging (Brinkmann & Kvale, 2014). This process allowed participants to add to or clarify any missing or additional information.

Data Analysis

In-depth semistructured interview data were analyzed to provide rich, valid, and comprehensive data to understand the experiences of NH individuals who have utilized rural mental health services. The interviews were transcribed, read through, and coded using NVivo software. This coding process allowed for recoding and combining codes or common words/themes found in the interviews. Coding involved attaching one or more keywords to a text segment in order to allow the researcher to later identify that statement and combine common statements into categories and themes (Brinkmann & Kvale, 2014). Data saturation occurred at this point, when no further insights or interpretations emerged from the interviews (Brinkmann & Kvale).

Categorization of information was not pre-formed; codes and themes emerged from the data, thus allowing the participant's answers, combined with researcher analysis, to formulate the primary categories of data analysis. After the initial interviews, categories emerged from the interview data through coding. Following the initial interview transcription, further follow-up interviews were completed within 30 days to clarify information and determine if it deviated from a specific category or primary theme.

Negative case analysis was addressed in terms of identifying any outlying data or participant's data that did not appear to be in conjunction with the majority of reported information. Instead of ignoring this information, it was addressed by stating that the majority of participants reported certain themes but leaving room for acknowledgement of alternative experiences that may not have been captured by this participant pool (Morse, 2015).

Strategies for Trustworthiness

It is imperative for researchers to establish a set of criteria for trustworthiness in qualitative research studies such as this (Creswell & Creswell, 2018). In order to ensure trustworthiness, I included several techniques to manage any bias I may have held, including member checking, prolonged engagement, and peer debriefing

(Linclon & Guba, 1986; Patton, 2015). Member-checking ensured the credibility and confirmability of the information and the emerging themes (Rubin & Rubin, 2012).

Results

The findings of this study indicate a multi-systemic influence on the participants in a variety of settings that both increase need for clinical intervention but also hinder willingness to seek help, primarily due to the preponderance of environmental microaggressions and heteronormative clinical interventions. Participants identified systemic and interpersonal experiences that provided hostile living environments, steeping residents in heteronormative or heterosexual influences. Participants indicated that because of living in this area and experiencing this immersion, they experienced an increase in mental health symptomology or exacerbation of pre-existing symptomology, which lead them to initially seek mental health services. However, heteronormative experiences and assumptions from providers influenced clients' perception of the therapeutic experiences and often hindered willingness to return. Three primary themes emerged from the interview data. These themes were: experiences of distal and proximal stressors, heterosexism or heteronormativity during help-seeking, and participants' suggestions for improvement of the help-seeking process for NH residents.

Theme 1: Environmental and Systemic Heteronormativity and Interpersonal Heterosexism

This theme was the first theme to present itself within the data analysis, as all individuals had a basic reason for seeking help. It encompasses the stressors and experiences of the participants leading up to help-seeking as well as how help-seeking was obtained and utilized.

Specifically, all participants reported issues of rejection, discrimination, or safety concerns, as well as subsequent trauma reactions, anxiety, and depression. These reasonings also included: increased stress related to community exclusion or ostracism, difficulty with family relationships secondary to NH orientation, negative cognitions and increase in mental health symptomology, and difficulty with family or relationship status in this rural area. The theme was then separated into two sub-themes: distal stressors and proximal stressors. The distal stressors are representative of external events, minority stressors, and discrimination. Proximal stressors include internalization of those events, changes in cognition about themselves, and presenting mental health symptomology secondary to those stressors.

Subtheme 1: Distal stressors
Systemic and environmental. These distal stressors are comprised of systemic and environmental factors that contributed to participants' feelings of rejection based simply on the area they reside in and their NH status. For example, Participant 4 stated:

> We all know it's a very conservative, white, and religious area, but I never imagined that I would get treated this way. The culture in this area is that of one way of thinking. There are actually signs that are against LGBT rights like "pray the gay away," or "nothing is impossible with the love of Jesus" with the rainbow flag with an X drawn through it. I don't feel like I could count on anyone that you would normally go to for protection. I can't go to churches because you never know who will judge. I can't go to the police, because they are part of the problem. I can't go to friends or family, because they have rejected me. I'm alone and living here makes me feel even more alone. I'm safer in the closet.

In addition to the environmental stressors, participants also discussed sociopolitical stressors that contributed to feelings of disconnection, fear, and rejection and feeling surrounded in heteronormativity and heterosexist attitudes. Participant 8 stated:

> The views of LGBT people in this area reflect some of the most frustrating and demeaning views of our country. You hear people talking about Caitlin Jenner in the most horrific ways. You hear gay jokes and threats everywhere. Schools have bomb threats that target the gay-straight alliances. Ever since the most recent election it's like people have had permission to be terrible to each other, and they are taking full advantage. The entire area is steeped in a cloud of hate and rejection.

Interpersonal distal stressors

In addition to the systemic experiences, participants experienced interpersonal heterosexism with friends, family, and specific members of the community. Participant 4: "I've been threatened, yelled at, and my car has been keyed with 'faggot' scraped into the hood. That was after I told only one person. What does that say about small town gossip?"

Participant 2 discussed further how living in this area has contributed to her "closeted" approach to her job:

> I work in the school system and was actually told by my supervisor that I needed to keep my sexual orientation a secret. She said that parents would not allow me to work with their children if they knew I was in a relationship with a woman, and if I lost clients, I would lose my job. She meant well, she was looking out for me and my job, but the fact that I have to do that made me feel like I should be ashamed and like I should hide my relationship and my family.

Participant 2 also indicated that her family and friends rejected her when she came out, which is a similar experience shared by Participant 7, Participant 3, Participant 5, and Participant 9. Each shared an experience of rejection, hatred, "shunning," shaming, or refusal to accept their NH identity. Specifically, they stated the following.

Participant 7:

> My mom pretty much disowned me and my father doesn't acknowledge it at all. I was really close to my sisters, but they have cut me off as well. My grandmother states that I just haven't found the right man yet.

Participant 3 contributed, saying:

> I was dating a girl and her father got so enraged, he actually shot at my house. He made verbal threats, tried to physically remove her from my house, shot at the house, and finally cut her off financially and she had to move away.

Participant 5 described how her family tried to get her to change, stating:

> My family sent me all sorts of bible verses, religious articles, and bullshit stories about how being gay is a choice. They tried to tell me that I was going to go to hell if I didn't "choose" a different path. They didn't realize that I didn't necessarily want to be gay, that I'd prayed everyday when I first realized I was attracted to other women. I knew it was going to be so hard, but it wasn't a choice. It was just me.

Finally, Participant 2 goes on to explain the complexity of her family dynamic:

> My father and step-mother no longer speak to me. When I first told them, they were intentionally negative and demeaning. My father told me that he could not be around me without sharing his

opinions and disgust. I am invited to fewer family events, and when I do go, I almost feel like they are proud of themselves for still talking to me, like they deserve thanks or an award for putting up with it.

Subtheme 2: Proximal stress reactions

Participants have experienced a significant amount of proximal stress reaction as a result of the perception of acceptance or rejection and fear of retaliation. They experienced these proximal stress reactions as a result of the aforementioned distal stressors, such as discrimination, rejection, traumatic experiences, and feelings of not being validated. Through these anecdotes, participants then drew the connection to internal processes of depression, anxiety, traumatic reactions (hypervigilance, nightmares, feeling unsafe), and also changed their behaviors (minimizing public displays of affection toward partners, not disclosing sexual orientation or relationship status, and "being semi-closeted" depending on the environment). For example, participants indicated that their proximal stress processes and mental health symptoms were due to ongoing distal stressors. Participant 3:

> As soon as I came out, I was rejected by my family. I have been made to feel ashamed of my love for my wife. I have never been happier in my romantic relationship before, but at the same time have lost all my friends and family. I lost my job. We have been yelled at on the street or in the store. We've heard the nasty comments people say when we walk by. We've been spit at. Our children have been rejected by friends at school. We've had death threats left at our house or on our cars. The police say that there is nothing they can do. I have nightmares about getting hurt, or my wife or children getting hurt. I have panic attacks in public or even at just the thought of going out in public, which makes us all stay home and isolate. I am afraid. I am in love. And I don't know how to reconcile the two. I cry everyday because I don't know how to keep my family safe, keep myself happy, and not be hurt for who I love. I never had any of these symptoms before.

These proximal stress reactions secondary to the distal stress experiences of interpersonal rejection and systemic sociopolitical views of the region continue to exacerbate some participants' pre-existing mental health symptoms (Participants 2 and 7) in addition to the presentation of new symptoms as seen above. As Participant 1 indicates:

> My mental health isn't because I'm gay, I'm gay and I have mental health problems. Are my mental health symptoms increased because I live in an area that doesn't accept me? Because I have to constantly worry about what I'm doing or saying? Because I'm always worried that I'm going to get yelled at, or discriminated against, or not accepted? Has all of this made me hate myself and question whether I should even be alive? Absolutely.

Theme 2: Help-Seeking Experiences: Heteronormativity and Heterosexism

Seeking help in this rural area can come with additional complications of stigma or vulnerability based on seeking mental health help, even before the additional factor of NH status. At times that small-town stigma for mental health or mental health treatment can cause a hesitancy to seek-help. Participants also indicated that even if they needed help, being NH made it even more difficult to seek help based on fear of rejection, and that, overall, there was a general negative experience related to interactions with clinical service providers in this rural area.

Of the 10 participants, all had had negative experiences with help-seeking at some point in the 5-year timeframe. Often participants were met with minimal affirming viewpoints or reassurance. In all cases, participants were not asked about their sexual orientation. This required clients to volunteer that information without prompt or correct the therapist if there was a heteronormative assumption. In some of those cases, clients were met with avoidance and passivity, where therapists would not probe beyond the initial information related to sexual orientation or relationship status. In other cases, clients were met with rejection

or judgment related to the nonheterosexual orientation or relationship. Themes related to positive and negative experiences these NH individuals have encountered when seeking help are related to attitudes of the therapist, knowledge base related to NH issues, willingness to discuss NH issues, and ability to identify NH affirming agencies. The participants unanimously agreed that when seeking help for mental health concerns in this rural area, it is difficult to identify who or where is a "safe" place to seek help. Often individuals "go in blind" to an agency or counselor without knowing beforehand the views of the therapist or how they will be treated based on their nonheterosexual orientation. Rural northern Michigan has limited options for treatment (based on insurance, proximity issues, and preponderance for religiously affiliated agencies), and therefore nine of the 10 participants had no previous knowledge of their therapist prior to attending their first session.

Participants' perceptions of the therapist was based primarily on therapists' attitudes and willingness to discuss major concerns related to sexual orientation or the proximal stress processes for which counseling was sought. Therapists who responded in either a neutral or affirming manner when the disclosure of sexual orientation was made were understandably viewed more favorably than those therapists who avoided talking about the topic further or gave the perception of passing judgment. Therapists overall appeared to have little training or exposure to working with NH individuals; however, clinicians who were "willing to ask questions and learn more about it" gave some participants a sense of an improved and workable therapeutic relationship. Therapists who avoided discussing it or passed over the topic quickly before moving on provided other participants "with a sense of my relationship or identity not being important,… which tells me that I'm not important." There were several reports of therapists who would blatantly disregard the individual's partner, "making me feel like I should be ashamed of something,… like I was doing something wrong," said another participant. This dismissal further contributed to the feelings and experiences of minority stress and receiving microaggressive or homo-negative experiences in a therapeutic environment and significantly reduced perceptions of therapeutic effectiveness.

Subtheme: Avoidance, passivity, and rejection

Heteronormative assumption was a pervasive theme within the responses to questions related to help-seeking experiences within the general community distal stressors, but also within the help-seeking experiences with community therapists. Participants admitted that not one therapist asked about sexual orientation or used neutral pronouns when asking about spouses or relationships. None of the intake forms or assessment forms left spaces for other sex options or sexual orientation. Ultimately this left the disclosure of sexual orientation completely up to the client. Participant 1:

> You go to a counselor and they don't ask the questions, or you're so used to looking at life through filters, that you're not as open—or don't volunteer the information. So if you're not volunteering it and they aren't asking about it, all you do is tiptoe around the superficial issues and never actually process fully. It's a minority or stressor that is not typically visible from the outside, so without the right questions, not only do I have to acknowledge it, I have to have courage to bring it up, and have the faith that the reaction I get will not send me back into the closet or into a bad headspace.

Subtheme: Limited affirming provider options

Finding an affirming provider in the rural area proved to be difficult as well. Some of these NH individuals were treated by primary care providers or relied on faith-based providers for mental health care due to the lack of options in this area. This limitation of service options can make finding an affirming or supportive mental health provider difficult in an area where the number of mental health providers in general is sparse. Nine out of the 10 participants said that they did not know the clinician's beliefs related to NH individuals prior to entering services. One participant stated that she knew her provider prior to seeking services from her, and therefore knew her stance on NH issues and non-heterosexual relationships. Due to this stance, she felt more comfortable attending the initial session, as well as subsequent sessions. However, another

participant, who has had three therapists in 2 years, stated that it is often difficult to find an affirming therapist. This is in part due to the preponderance of faith-based or church-affiliated options in this area, which can be a deterrent for NH individuals who fear judgment or lack of affirmation based on the assumed religious undertones of the agency and therefore assume the therapist shares these views. Participant 7:

> For fear of judgment, I would not seek out a Christian counseling agency in this area. But it's such a large part of the services we have here, so it eliminates a lot of the options. Going to a Christian counselor would be difficult because I would feel inherently judged, as if my depression or symptoms was my way of "paying penance for this great sin of homosexuality" in their mind. I'd rather just not go to therapy and deal with my issues on my own.

This led to the issues of therapeutic effectiveness with nonaffirming clinicians. While the participants indicated that they were less likely to be open with nonaffirming therapists, they also indicated that they were less likely to "buy-in" to therapeutic treatments and suggestions of a nonaffirming therapist. Subsequently, participants were reluctant to return to previously sought therapy options and some choose not to seek therapy at all in the future.

In addition to managing the rural acceptance of mental health issues, accessing services can also be a hindrance. As with most professional services, the client's insurance commonly dictates possibilities for care. However, once those options are narrowed due to insurance, clients have even fewer opportunities for access based on the special issues related to the rural area. Within this rural area, there is a singular agency that serves individuals with Medicaid coverage. This agency has one office in each county. However, because of the rurality, counties can span several miles and accessing those offices can be problematic for individuals with limited income options or transportation issues. Participant 4:

> I can only see individuals in my one agency in my county, unless I want to pay out-of-pocket for a therapist in private practice. I can't afford that, so my options are limited. If I can't make it to that one office, or if I don't connect with the therapist they assign to me, I don't have any other options.

All participants indicated that their initial impressions of their therapist were integral in their attendance of subsequent sessions. If clients felt that their sexual orientation was adequately acknowledged and accepted, even if the therapist had minimal experience working with non-heterosexual individuals, the participants still maintained attendance and "felt heard and workable." If the individuals were met with avoidance or passivity "it incited a level of distrust and sneakiness that didn't sit well." At times this rejection would increase mental health symptomology, as identified by another participant, "a bad experience with a mental health professional, someone who is supposed to be unbiased and culturally competent, led to increasing my anxiety and shame. I didn't return to therapy for 2 years after."

Theme 3: Participant Suggestions for Improvement

All participants identified ways in which previous professional counselors could have been better at affirming and making the counseling experience more effective and welcoming. Participants expressed that the addition of these factors could promote change related to an affirming office setting, positive counselor experiences, and reduction of proximal stressors related to help-seeking within rural areas. Suggestions for improvement were as follows:

- Adding demographic information on intake forms to include non-heterosexual orientation.

- Adding options for gender identity on intake forms.

- Eliminating "mother" and "father" names on intake forms and replacing with "parent."

- Asking basic questions throughout the intake assessment that have to do with sexual orientation, the coming out process, and perceptions of community acceptance and social support.

- Asking questions related to how their experience has been living in the area (with the understanding that the area may not be affirming and may be rejecting).

- Educating themselves about environmental trauma and avoiding heteronormative assumptions.

- Asking basic questions related to preferred pronouns on intake forms and at the onset of therapy.

- Identifying the agency as affirming or "friendly" by displaying a rainbow flag symbol or equality symbol on the website, door, or marketing materials.

- Creating a network of affirming counselors in the area that is accessible to the general public by means of social media outlets.

Participants discussed how interactions with well-meaning therapists might improve dialogue and feelings of affirmation and safety, allowing therapists to better address issues of coming out and minority stress. Increasing counselor education related to individuals who are non-heterosexual can also improve the counselor-client relationship from the onset if the counselor is able to use the correct language and ask questions pertinent to the client's identity. Without this initial step by the counselors, the burden of "outing" oneself to the counselor was left solely up to the client, which, at times, prompted more anxiety and fear of rejection related to the presumption of heteronormativity within the therapeutic setting.

Discussion and Further Research

This study brought awareness to NH clients' perception of acceptance in their community and how that impacted mental health, as well as the impact practitioners have on the affirmation or retraumatization of these NH individuals. The findings can be used to educate service providers on a perceived need to alter service provision, create and provide training related to acceptance and diversity, and promote understanding of the intersectionality of NH individuals in a rural setting. Factors that influenced past help-seeking sparked individuals to identify positive improvements that would influence their willingness to seek help in the future. These suggestions for counselor and counseling offices could provide a safer environment from the onset of therapy, thus prompting a more affirming and positive experience. Findings of the study were that distal stressors increased feelings of isolation and "otherness." Several individuals reported significant incidents of hatred, rejection, and heterosexism/homophobia. These incidents increased mental health symptomology concurrent with post-traumatic stress These symptoms included nightmares, flashbacks, hypervigilance when in public, self-hatred and shame related to sexual orientation, feelings of isolation, and increased depression and anxiety. These symptoms were then compounded when individuals sought clinical intervention from non-affirming clinicians. Furthermore, when individuals sought help, they encountered barriers related to lack of resource options, lack of acceptance, or feelings of passivity. This created a sense of distrust with providers, thus affecting future help-seeking. This significantly differed from urban areas, where provider options are more diverse and accessible (Handley et al., 2014), where the sociopolitical atmosphere is diversified (Stults et al., 2017), and where more LGBT resources or communities are available (Perkins et al., 2013; Li et al., 2014). In addition, viewing the environment and atmosphere of a community as the basis of insidious trauma exposure could promote an increased need awareness for further education related to rural area practitioners where non-heterosexual individuals feel increasingly traumatized and isolated.

Distal and Proximal Stressors Prompting Help-Seeking

The first theme discovered through this research was the reasoning behind seeking treatment for this population. Due to the emergent themes, this was not initially the focus of this research study, but quickly presented itself as such. The results indicate that further focus on this topic specifically could warrant important information for both NH individuals and area practitioners. Specifically, it could shed light on stressors that prompted initial help seeking, as well as community and family experiences that may influence willingness or hesitancy to seek help. Increasing clinical knowledge related to the effects of simply residing in a rural area as a non-heterosexual could provide a shift in treatment provision and incorporate types of trauma treatment related to insidious exposure to minority stressors, hypervigilance, and rejection, as described by the participants. The underlying weight of residing in a highly conservative and religious area, coupled with lived experiences of discrimination, increased reports of traumatic responses, including nightmares, flashbacks, hypervigilance, fear, guilt, and shame related to sexual orientation, and increase in depression and anxiety, can contribute to a greater need for mental health services but less confidence in seeking those services. Changing the lens through which mental health practitioners view and treat NH individuals and identifying the systemic and systematic discrimination that they face due solely to their NH status could provide NH individuals more specific, effective, and appropriate mental health treatment.

Political Climate and Increase Minority Stress

Within this singular system, there are several contributing facets: social, political, economic, and individual, as defined by Brofenbrenner (1994). An example of political influence can be seen by examining this question of help-seeking experiences for this population of NH individuals. The political climate post-2016 election has changed significantly. The United States has shifted from a presidential period of Democratic majority, which had a more liberal political focus and included several social and political movements to support and legitimize the NH population, including marriage equality. However, post-2016 election, there is a seemingly significant shift in priorities with the current Republican administration, which embraces more conservative values (Prusaczyc & Hodson, 2019; Price, 2018). This could cause feelings of delegitimizing the previous social progress and could affect the willingness of individuals to seek help, or cause more distress related to social and political stressors, resulting in the need to seek additional help (Prusaczyk & Hodson, 2019; Stone, 2016). This could play a role related to the systems perspective, affecting the comfort of help-seeking in rural areas, which are already primarily conservative (Rhodebeck, 2016) with high levels of religiosity (Piumatti (2017).

Rostosky et al. (2010) stated that political majority issues can have adverse effects on this population, and residence in an area with a conservative majority can have an increase of minority stress incidence and reports of negative experiences, both outward experiences and internal subjective emotional experiences. Elevated safety concerns of identity-related attacks, threats, and world-wide hate crimes additionally add to pervasive trauma and hypervigilance (Stults et al., 2017). When coupled with first-person experiences of this discrimination or identity-based hatred in one's own community, individuals can experience pervasive and ongoing insidious trauma (Alessi et al., 2013; Keating & Muller, 2019). Based on the findings of this study, being immersed in this heterosexual environment, with few supports for NH individuals, and a socio-politically charged and nationally polarized atmosphere, can create trauma reactions related to individuals' experiences in sexually violent or harassing situations (Roberts et al., 2010; Keating & Muller, 2020). This can include comments, gestures, and actions by others to incite a feeling of inferiority towards the individuals within the minority. It can also include a perceived threat of immediate physical or emotional harm, feelings of fear related to ongoing safety (Roberts et al., 2010), and internal struggles with views of self, views of societal acceptability, and internal schemas, often increasing levels of depression, suicidality, anxiety, and other common symptoms of complex post-traumatic stress disorder (Alessi et al., 2013; Keating & Muller, 2020).

With the post-2016 political climate, specifically referring to the shift from a Democratic and socially liberal administration to the conservative electoral outcome of 2016, other factors may contribute to recent help-seeking behavior as well (Prusaczyk and Hodson, 2019; Stone, 2016). From an ecological systems perspective, a political shift could mean more fiscal focus in other areas aside from those under a different political system, therefore limiting or restructuring funds that had been focused on the expansion of NH programs and specialization. This in turn could lead to a shift in social structures related to support for NH issues and rights. This could then translate to a greater preponderance of conservative viewpoints that may not be as affirming of NH individuals, which in turn can increase minority stress and incidents of discrimination. This potential increase in minority stress may create more need for help-seeking, in turn resulting in an increase in those help-seeking behaviors. In addition, there may also be a concern for seeking help in a conservative environment, with the decrease in political and social support shifting away from protections previously felt under a more liberal political climate. Thus, NH individuals may be more hesitant to "out" themselves, even to professionals in the area. Recently introduced legislation related to the "consciousness clause" that allows individuals to withhold goods, services, and provisions to individuals on the basis of religious beliefs (Dept. of Health and Human Services, 2019)—thereby further legalizing the discrimination of non-heterosexual individuals—may make NH individuals even more reluctant to seek out services, and less supported if they do. A further research suggestion includes a closer examination of political climate on perceptions and incidents of minority stress in rural areas.

Limitations

This study was subject to limitations related to homogeneity of race, sample size, and the potential for polarization of participants based on motivations to volunteer. Case studies typically rely on triangulation of data sources; therefore, utilizing a small data set is a limitation for this study. In order to control for this, data was triangulated between the first and second interviews to assist with confirmability. In addition, findings of the data were compared to those reported in previous literature and analyzed through the theories selected. Due to a small sample size, transferability was limited. Volunteers may have been those who were polarized, that is, having had either very good experiences or very bad experiences, and may be motivated to participate based on those extreme experiences. This polarization may have impeded ability to gather a full picture of the population. Therefore, there was a potential for bias or skewed data collection. However, the data set consisted of a diverse set of individuals with different perspectives—which represented different sexual orientation minorities and represented differences in age, gender, and socioeconomic status. This potential limitation was also addressed by ensuring that analysis was grounded in the data and that it provided a thick description; in addition, no generalizations were made beyond the scope of the participants' responses.

Conclusion

Within a deeply politically conservative rural area of northern Michigan, participants of this study reported ongoing experiences with distal stressors and microaggressions, both within the community, as well as within experiences seeking professional help for mental health needs. These distal stressors led to an increase in feelings of community-wide rejection, ranging from concerns for physical safety to increased feelings of needing to "remain in the closet" related to their non-heterosexual identity. Secondary to this community-wide rejection was the increase in mental health symptomology, either the exacerbation of pre-existing symptoms or the creation of new symptomology. These symptoms and insidious trauma experiences mirrored symptomology found in individuals who have post-traumatic stress symptoms from large-scale traumatic occurrence (Robinson & Rubin, 2016). These participants then sought out treatment from clinical mental health professionals in their community, to address this symptomology. However, throughout the help-seeking process and treatment, participants reported feelings of continued rejection, a lack of validation, and

avoidance or dismissal of their non-heterosexual status, expressing retraumatization related to rejection, attempts at conversion, and/or assumed heterosexuality. Participants provided suggestions for improvement of therapeutic relationship building, promotion of safe therapeutic environments, and techniques for affirmation for helping professionals. Therapists in this area, as well as agencies and the community as a whole, can improve the services provided to these NH individuals by increasing awareness, increasing education related to affirmation of the experiences of NH individuals, and providing a safe and welcoming community of acceptance for NH individuals in rural northern Michigan. In addition, the validation of NH individuals' experiences of heteronormative steeping as a potentially traumatic environmental rejection and insidious traumatization and providing subsequent trauma treatment as such, will not only substantiate their experiences, but also provide an increase of available affirming and welcoming clinicians in this underrepresented and underserved community.

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Appendix

Interview Guide

Demographics:

- Pseudonym
- DOB
- Sexual Identity
- Gender
- Relationship Status
- Race/Ethnicity

Semi-structured Survey Questions:

A. Mental Health and Substance Abuse

1. How has living in this community affected your mental health (either positively or negatively)?
2. Tell me about support you have related to your mental health or substance abuse issues within:
    a. Family
    b. Friends
    c. Community (non-professional).
3. Do you feel that your sexual orientation has affected the support you received from family, friends, and community, and if so, how?

B. Help-Seeking

1. Tell me about your experience seeking professional support for mental health or substance abuse issues.
    a. Describe any positive experiences or details
    b. Describe any negative experiences or details
    c. How did the clinician influence those experiences—if they did?
    d. How did those experiences influence future help-seeking?
    e. How do you feel your sexual orientation influenced your willingness to seek help or affected the help you received?
    f. How did it influence your willingness to continue going once you started?
2. How has your sexual orientation influenced the type of treatment you received in northern Michigan?
    a. Explain how/if it has been a factor.
    b. If it was a factor, how did you address that?
3. Is there anything else I should know or ask?