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LGB Help-Seeking for Mental Health and Substance Abuse Services in Rural Northern Michigan

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Abstract

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Abstract

Lesbian, gay, and bisexual (LGB) individuals are often exposed to stressors based on their nonheterosexual status; they may have unique needs related to help-seeking for mental health in a rural area where more people identify as religious or as politically conservative. To date, there have been no studies on the mental health help-seeking experiences of LGB individuals in rural Northern Michigan. This qualitative, single case study was completed to explore the help-seeking experiences of 10 LGB individuals who were recruited through criterion and snowball sampling. In-depth, semi structured interviews were conducted. Transcribed interview data were entered into Nvivo software for coding and then examined through two perspectives: Meyer's minority stress theory and Bronfenbrenner's ecological systems theory. Thematic analysis identified three themes: (a) reasons for seeking treatment, which included experiences of distal stressors and proximal stress reactions, (b) experiences with the help-seeking process, and (c) suggestions for improving the help-seeking process. Findings of the study were that distal stressors increased feelings of isolation and "otherness." 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. The results of this study draw attention to LGB population in rural Northern Michigan, who may be inadequately treated based on little community acceptance, few provider options, and negative provider reactions. The knowledge generated from this study could lead to improved services and reduce the aforementioned disparities for this population.

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Chapter 1: Introduction

Introduction

Literature on help-seeking behaviors among lesbian, gay, and bisexual (LGB) individuals has focused on the patterns of help-seeking behaviors, and on their preferences or needs in a clinician and their needs for clinical resources in rural areas. Much of the literature includes research on increased incidence of mental health concerns among the LGB population (Barnes, Hatzenbuehler, Hamilton, & Keyes, 2014), the differences between urban and rural resources (Perkins et al, 2013), and the experiences of LGB individuals who have sought clinical help and their experiences with clinicians who have limited training on LGB-specific issues (Smalley, Warren & Barefoot, 2015; Liddle, 1999). While research has explored the differences between rural and urban help-seeking behaviors in the LGB population, no research has been done in rural Northern Michigan to explore the help-seeking experiences, including the perceived adequacy of those services. It is known from the literature that there are differences among rural areas in relation to services and perceived adequacy, and therefore not all information related to the LGB population in rural areas is transferrable or generalizable to all areas. There is no information for rural Northern Michigan, and therefore it is not known how services have been perceived in relation to their adequacy or how easily they can to be accessed. This study was needed to address this gap in the literature and to gather information could be used to help area clinicians, as well as the community at large, increase awareness of LGB experiences and needs. This chapter covers the background information, problem

statement, the purpose of the study, and the research questions which will describe the specific questions that I explored.

Background

Literature has suggested that there is an increased risk for mental health and substance abuse issues in the LGB population at large (Kano, Silva-Anuuelos, Strum, & Willging, 2016) and an even greater risk of increased mental health issues for LGB individuals in rural areas due to the added factors of sexual minority stigmas and experiences (Marsack & Stephenson, 2017). The research also indicated that not all rural experiences or rural areas are the same in relation to the provision of services for LGB individuals, and therefore the previous research or data cannot be generalized to this chosen bounded system or location (Barefoot, Rickard, Smalley, & Warren, 2014; Marsack & Stephenson, 2017). So even though there is literature on the topics of mental health and substance abuse help-seeking among LGB individuals, and even literature related to rural areas, no research has been found specific to rural Northern Michigan. Furthermore, the studies that have been completed are primarily case studies in a variety of rural areas, where the demographics including socio-economic status, racial and ethnic composition, and religious and political preponderance may be vastly different than the potential participant pool in rural Northern Michigan, and therefore is it unclear if those study's findings can be generalized to this area. Thus, this was a unique examination of the population and their experiences and it allowed me to test whether the previous literature, such as in other rural areas, applied to this specific case. Gaining insight into

these experiences helped improve awareness for area clinicians, but also for the community at large. This study also provided an opportunity for individuals who have sought services in this area to describe their experiences. As a result, clinicians and the community should have a greater understanding of the needs of this population, how adequately those needs were perceived as getting met, and suggestions for future training, funding, or focus.

Problem Statement

Within a distinctively rural community, with historically limited resources for the LGB population, it is unknown how individuals within that rural group experienced the use of clinical mental health services and interpreted their experiences with acquiring clinical mental health services. Therefore, it was essential to explore this population's experiences with available services to learn how they feel local service providers are prepared to deliver services.

Some studies have found similar occurrence and prevalence of clinically diagnosable mental health issues between general rural and urban populations (Tirupati, Conrad, Frost & Johnston, 2010; Rost & Adams, 2007); 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 underidentified and underserved (Probst, 2014; Horvath, Iantaffi, Swinburne-Romine & Bockting, 2014). For example, the incidence of depression in rural populations may actually be quite higher than reported– with estimates that at least 50%

of rural individuals with depression or depression symptomology are grossly untreated or undertreated (Rost et al., 2012).

Literature suggests that the acceptance of treatment for mental health issues by rural residents is often hindered by stigma, cultural beliefs, and the tendency for rural residents to value self-reliance or a reliance on faith-based services versus clinical social work or counseling services (Zellmer & Anderson-Meger, 2011; Cooper-Patrick & Powell, 1997). Huttlinger, Schaller-Ayers, and Lawson (2004) found that at least one-third of their respondents reported managing their mental health symptoms at home and not seeking treatment at all. Adherence to medication regimens have also been identified as a barrier to continued mental health stability– with estimates between 33–50% of adults not taking the psychotropic medications prescribed by their primary care doctors with continued regularity (Whitehead, Shaver, & Stephenson, 2016; Bulloch & Patten, 2010; Goff, Hill & Freudenreich, 2010). Compliance and initial help-seeking can be especially difficult for members of the LGB community, as stigma is already a social issue that is on the forefront within the rural community due to the minority status (Swank, Fahs, & Frost, 2013). Adding the additional minority stress of a mental health need may even more adversely affect individuals. Because social workers are responsible for providing services to this population, it is increasingly important to have a better understanding of this population's experiences of previous help-seeking, especially within rural Northern Michigan area, which has yet to be studied. This study explored

these help-seeking experiences in this geographical area to better understand the perceived adequacy of services and the clinical skills for the LGB population.

Purpose

The purpose of this research was to understand the experience of LGB individuals with the mental health system in rural Northern Michigan. This was accomplished by exploring the help-seeking experiences of individuals with either self-identified or professionally identified mental health or clinical needs. For the purpose of this study, LGB represented any form of minority related to sexual orientation, including, but not limited to LGB or pansexual. The aim was to examine the experiences of self-identified LGB members with a history of clinical mental health interventions, who live in the identified Northern Michigan rural area. Further understanding of this population's mental health needs and experiences could support the need for increased clinical competency training or resource development among providers.

This study reflects a constructivist paradigm, wherein all individuals have individual experiences and create meaning in the world and in themselves through their interpretation of that experience (Hanson, 2004; Lauckner, Paterson & Krupa, 2012). Essentially, constructivists postulate that the concept of reality is constructed within the mind of a singular person, instead of the reality being an externally singular unit (Hansen, 2004, Lauckner, Paterson & Krupa, 2012). This paradigm further postulates that reality is subjective and that each reality is experienced differently, but all are equally valid (Schwandt, 2000). Furthermore, the constructivist position embraces a hermeneutical

approach, which maintains that meaning and reality are hidden and must be brought to the surface through deep reflection (Schwandt, 2000; Sciarra, 1999).

Research Questions

The main research question was as follows: What were the experiences of LGB individuals who sought clinical intervention for mental health or substance abuse needs in rural Northern Michigan?

- Subquestion 1: What factors are related to the positive or negative experience of help-seeking?
- Subquestion 2: How did those experiences influence future help-seeking?
- Subquestion 3: What are the challenges/barriers to seeking help for this population?

Conceptual Framework

The conceptual framework for this study was a combination of a minority stress perspective and the ecological systems perspective. Both informed and enriched the study to help fully capture the lived experience of this group.

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, Wit, & Reynolds, 2014). It is a way of placing conceptual boundaries around cases to limit and define the parameters

of practice with individuals, families, groups, and communities. I used this perspective to examine the 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. 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 within that system and provided the opportunity for a rich and thorough description of those experiences. Given the rural community and its typically conservative nature, the environment could influence the LGB individual, impact their desire to obtain help for their identified issues, or even make the help-seeking experiences difficult overall.

Minority Stress Theory

Meyer's minority stress theory (MST) suggests that individuals who identify as a member of the LGB population can be at an increased level of vulnerability solely in response to the unique issues related to their LGB 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). The influence of that stress on the mental health of those LGB

individuals will be explored through this lens to examine the lived experiences of this population related to help-seeking. As found in the literature, the MST provides evidence of the relationship between perceptions of minority stress and self-destructive behaviors (Muehlenkamp, Hilt, Ehlinger, & McMillan, 2015), as well as perceptions of minority stress being elevated in rural areas (Swank, Frost, & Fahs, 2012).

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, I was able to examine individual's perceptions of supports and community atmosphere. This use of the systems theory was also combined with minority stress and how those stressors can be perceived to influence those systems and roles. In so doing, there was a unique, novel examination of help-seeking experiences of LGB individuals.

Nature of the Study

Methodology

This research used a qualitative, single-case study design, where the case 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 (Merriam, 2009). 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. The study was comprised of in-depth semi structured 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. Using qualitative data collection and analysis enabled me, as the researcher, to gain a richer and deeper understanding of the participants (Creswell, 2013).

Participants and Site

The method of the study was a single, case-study design. Recruiting participants was done by way of social media boards, information boards, and fliers. Candidates were self-identified members of the LGB population with history of seeking clinical interventions related to either self-identified or clinically identified mental health issues. Recruitment attempted to select a diverse group of LGB participants with respect to age, race/ethnicity, and stage in the "coming out" process. I administered a semi structured, face-to-face interview to gain information of clinical help-seeking experiences related to their past mental health or substance abuse issues. Thematic analysis was used to interpret the results of both individual and collective themes as they related to the conceptual framework (Kvale, 2014). Analyzing the results of this study through the lens

of the ecological systems theory allowed me to examine the themes related to system-wide issues. With the person-in-environment component of the ecological systems model, there was a more linear examination related to specific environmental issues that affect the participant. Because of its inherent flexibility, this approach allowed me to gather in-depth information about personal LGB experiences in rural areas.

Definitions

For the purpose of this study individuals who fall into a minority related to sexual orientation were referred to as LGB. This acronym encompassed, but was not limited to lesbian, gay, queer, bisexual, or pansexual.

This area met classifications as a rural community as defined by the US Office of Management and Budget (US OMB) (Michigan Rural Health Profile, 2010), as the chosen counties have a population less than 20,000 people and a population density of 45 people per square mile, with 6.2% of residents below the poverty line (Michigan Rural Health Profile, 2010).

Help-seeking behavior: was defined as individuals who have sought professional or clinical counseling or intervention for the purpose of treating a mental health concern or substance abuse issue within the last 5 years (Zellmer & Anderson-Meger, 2011). This consists of Licensed Professional Counselors, Limited Licensed Professional Counselors, Licensed Masters of Social Work, Limited Licensed Masters of Social Work, individuals holding a Masters of Counseling degree, PhDs in relevant fields of study, or individuals who are “grandfathered” into licensure.

Clinical intervention: was defined as in-person attendance of a counseling session or group session (Bassey & Melluish, 2013). This did not include on-line chat groups or on-line self-help materials. This did not include any self-guided courses. This must have included personal interaction with a professional in an office or other professional setting.

Sexual minority or *sexual orientation minority*: were defined as any person not identifying as heterosexual – but for the purposes of this study, will include, lesbian, gay, queer, bisexual, or pansexual (Manning, 2015).

Assumptions

For the purpose of this study, I assumed that the rural area being studied would provide an adequate representation of a rural Midwestern area, in terms of typical availability of rural resources, sparse population, and common ratios related to community composition (the average socioeconomic status, resource availability, racial/ethnic ratios, as well as number of LGB individuals in the area).

I also assumed that participants would identify with a specific sexual orientation that was not exclusively heterosexual at the time of the study. However, I did not assume that either their sexual identity or sexual orientation was permanently fixed. I acknowledge that while they may identify at one point as a singular identity related to sexual orientation, that identity or piece of their identity may likely change within their lifetime. I was, therefore, gathering a snapshot of information at a specific time related to their current sexual identity and history of mental health help-seeking experiences.

For the purposes of recruitment, I disclosed my sexual orientation on the recruitment flyer and assumed that my disclosure would allow candidates to see me as an affiliate or ally and that they would be more likely to volunteer to participate. While I did not assume that all LGB individuals identify as part of the "community," where there is a group of "insiders" or "outsiders," I was hoping that disclosing my orientation on recruitment materials would break down some barriers or hesitancy. Nor did I make assumptions based on the aforementioned "community" or assume that all members would have had the same experience, knowledge, or terminology. Thus, I clarified talking points, vocabulary, or experiences as needed to ensure that information collected was accurate.

In addition, it was assumed that LGB individuals have a more difficult time accessing services that they perceive to be adequate for their needs, in some capacity. This could be in terms of client perceptions, therapist knowledge and comfort with their orientation, or perception of available resources in the area that are specific to the LGB population. I also assumed that participants would have an interest in participating and that interest may be motivated by a desire to share an experience that was potentially very positive or very negative. I needed to discuss the possibility that this might affect how the participating sample impacts the transferability of the findings, specifically if participants had significantly poor experiences and the need to express that then motivated participation. I discuss this further in Chapter 3 and 5.

Scope and Delimitations

Scope and delimitations refer to who is included and excluded in the participation pool. The study took place in rural Northern Michigan; the eight-county location identified in the Methods section was the bounded system. Individuals who participated were over the age of 18 and identified as LGB (which for the purposes of this study included gay, bisexual, lesbian, pansexual, queer, and any sexual orientation minority). Transgender individuals were not excluded from the study, but the focus of the study was on sexual minority. Therefore, transgender individuals might have been included in the study if they were also a member of a sexual orientation minority, as gender expression is a separate issue from sexual orientation (Manning, 2015). The transgender population may face different and unique stressors that could have convoluted the results of the study. Therefore, analysis for this study focused specifically on sexual orientation, not gender identity, and I am not attempting to transfer findings to diverse gender identities. (There is need for future research that focuses specifically on gender identity.) Participants also needed to have received clinical services within the last 5 years (2012-2017) in order to participate. Much can change in 5 years, including area clinicians, resources, and the community dynamic. Therefore, it was important to get a clear picture of the most current help-seeking experiences, especially if the findings were to be used to indicate current perceived needs and resource availability.

Limitations

This study was subject to limitations related to sample size, the potential for polarization of participants based on motivations to volunteer, and a singular data source. Case studies typically rely on triangulation of data sources, therefore utilizing a singular data set is a limitation for this study. In order to control for this, I planned to triangulate data collected between the first and second interviews, to assist with confirmability. In addition, I compared the findings of the data to those reported in previous literature and analyzed the data 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 my ability to gather a full picture of the population. Therefore, there was a potential for bias or skewed data collection. To control for that, I actively tried to recruit a diverse set of individuals with different perspectives. Once I had a pool of volunteers, I identified and interviewed individuals who came from varying backgrounds, who have had a diverse set of experiences. The sample I selected was a diverse group of individuals who represented different sexual orientation minorities and represented differences in age, gender, and socioeconomic status. I addressed this potential limitation by ensuring that my analysis was grounded in the data, that it provided a thick description; in addition, I made sure that I did not generalize beyond the scope of the participants' responses. Generalization to the larger population was not possible because, as found in the

literature, many rural areas with similar demographics vary in their data on both mental health services and LGB experiences. However, thick description of sample characteristics of this bounded system allowed readers to determine whether they could transfer any themes based on similarities in their areas.

Significance and Social Significance

This study was significant because it allowed the further exploration of the LGB population and identified their clinical needs. The results of this research provide much needed insight into the experiences of this population within the bounded system, thus allowing for the development LGB-sensitive clinical resources, trainings, and overall clinical program improvement. The data were analyzed through an ecological systems framework and the minority stress theory. In providing this expanded exploration of this population in this bounded system, there could be benefit to the enhancement of treatment programs specific to this population and their identified needs or deficits as presented in the study. In addition, there was further identification of a potentially underserved population with respect to treatment and support. The literature established a link between geographic location and sexual orientation regarding to mental health symptomology, and this research study provided important knowledge to improve this population's help-seeking and service provision (Swank, Fahs, & Frost, 2013). Further identification of multifaceted intersectionality of this very specific group could further knowledge and treatment with respect to the mental health of rural LGB residents.

The World Health Organization (WHO) estimates that 38,000 Americans commit suicide each year, and 90% of them suffered from a reported mental illness (WHO, 2016). The same study estimated a range of lost productivity and output between $2.5 and $8 trillion due to mental health or substance abuse issues (WHO, 2016). Additionally, while depression and anxiety issues have risen by over 50% in the last 50 years, most governments worldwide spend an average of 1-3% of their budget on mental health care for their citizens (WHO, 2016). As further developed in Chapter 2, most of those resources are allocated to urban areas, leaving a significant amount of rural residents without access to care geographically or financially (Eleveld, 2015). Adding in the factor of identifying as LGB and searching for services specific to that population, there may be a significant gap in resource allocation and availability, leaving this population at risk for further issues, such as further social ostracization and increased mental health symptoms. The findings of this study shed further light on the perception of resource availability and adequacy from LGB residents and assist area social workers and counselors by identifying gaps in training and preparedness as identified by the same LGB population in relation to their past help-seeking experiences. This small-scale study could lead to a greater impact in this community, but it could also be used as reference for future rural studies and focus on this population's needs in greater depth or with a larger sample. In addition, higher awareness of mental health issues in this group could impact mental health services, and thus the costs of untreated or inadequately treated mental health concerns.

Summary

There is a lack of research on LGB individual's experiences with help-seeking in rural areas – specifically rural Northern Michigan. This study focused on gathering information about help-seeking from voluntary LGB participants who had received help for mental health or substance abuse within that identified area and within the previous 5 years. With this data, it was expected that the results could further identify needs, perceived gaps in training or knowledge among existing practitioners in the area, and the participant's perceptions of resource availability and accessibility.

In Chapter 2, I will examine the existing literature and identify key concepts that are pertinent to the study at hand. The conceptual framework, which incorporates Bronfenbrenner's ecological system's model and Meyer's minority stress theory will also be discussed. In Chapter 3, there will be an extensive discussion of the methods used and ethics involved in the study. Chapters 4 and 5 I will present and analyze the findings of the study.

Chapter 2: Literature Review

Introduction

There are several studies on rural LGB experiences, but to date none have focused on rural Northern Michigan. Rural areas tend to offer fewer mental health and substance abuse services overall (Kano, Silva-Banuelos, Strum, & Willging, 2016), but there tend to be fewer LGB individuals in these areas (Willging, Salvador, & Kano, 2006). Thus, there is minimal information about their experiences, including (a) whether individuals who used these services viewed them as adequate, (b) the individuals' views about the clinicians, (c) the other factors that went into seeking help and (d) their experiences overall.

Current literature indicates that LGB individuals at times feel underserved due to the treating clinician's lack of LGB-specific knowledge or training (Smalley, Warren, & Barefoot, 2015). In addition, there is a noted lack of resources overall for rural areas (Willgingm Salvado, & Kano, 2006). Therefore, this study sought to address the gaps in the literature by exploring the help-seeking experiences of LGB individuals in rural Northern Michigan.

In this chapter, I discuss the literature search strategy and offer a comprehensive review of the literature. I also discuss the conceptual framework and indicate how the framework and the literature inform the study. The primary topics discussed in this chapter include mental illness and substance abuse services in the United States,

including rural services; sexuality and identity development models; and LGB research in rural communities.

Literature Search Strategy

To identify prospective, peer-reviewed articles and books, the following databases were searched for the years 2007-2017, except for resources that contained seminal research: LGBT Life with Full Text, PsycINFO, PsycARTICLES, Academic Search Complete, ERIC – Educational Resource Information Center, PubMed, Google Scholar, and SocINDEX with Full Text.

The following keywords were used: *LGB, rural area, help-seeking, sexual orientation, sexual identity, sexual development models, minority stress, rural families, rural services, rural LGB, help-seeking, LGB help-seeking, LGB counseling, LGB substance abuse, LGB health, LGB mental health, rural mental health, case study, minority stress theory,* and *ecological systems theory.* I used the Boolean operators, *and* and *or* to optimize the results.

The terms listed above were searched throughout the literature in several different combinations to complete an exhaustive review of the literature. Terms such as *LGB, help-seeking, and rural areas* yielded few results when combined, so other combinations using only two of the words, such as LGB and rural communities, were used to ensure that all terms were combined in such a way that produced more results. Each of the terms were combined with one of the other key terms to ensure that the topics were connected appropriately and that the results provided by the search were applicable to the current

study. In addition, this technique was done to assist in the exhaustive review of the existing literature.

The database searches yielded several results in specific areas; for example, a keyword search of LGB identity would yield thousands of articles, but when combined with a term such as rural help-seeking there would be no results. This led to an expansion of the search terms such as *LGB, gay, gay men, lesbian,* and *bisexual*. Using broader terms revealed literature that collectively identified the aforementioned LGB persons in the larger LGBTQ category under keywords such as rural.

During the search, several studies were found wherein LGBT mental illness was the primary topic (Barnes, Hatzenbuehler, Hamilton, & Keyes, 2014; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). Other studies included LGBT in the United States (Dunlap, 2014), mental illness in rural areas (Handley et al, 2014; Perkins et al, 2013), sexual orientation development (Hepler & Perrone-McGovern, 2016), help-seeking (Boerema, Hatzenbuehler, Hamilton, & Keyes, 2014; Zellmer & Anderson-Meger, 2011), and LGBT in rural areas (Marsack & Stephenson, 2017), and LGB mental health in rural areas (Willging, Salvador, & Kano, 2006). No literature was found where LGB help-seeking experiences in rural Northern Michigan were the primary topic of the study.

Conceptual Framework

The use of theory in qualitative research allows me, as the researcher, to both structure the study and interpret the findings in a particular way (Maxwell, 2005). Utilizing theory can assist in the development of the study design by way of the literature

review and justification of the structure and development of the research questions (Creswell, 2013). In so doing, the researcher can justify the framework and concepts related to the study and then structure the study accordingly. Without the use of theory or conceptual frameworks, there can be a misalignment of the study wherein the information presented, data collected, and conclusions drawn may not be linear in theoretical interpretation or analysis (Patton, 2015). Likewise, theory can assist in the interpretations of the study's data collection and interpretation of that data (Patton, 2015). The conceptual framework for this study will be a combination of a minority stress perspective and the ecological systems perspective.

Ecological Systems Perspective

The ecological systems perspective, established by Bronfenbrenner (1994), is a way of seeing case phenomena (the person and the environment) in their interconnected and multilayered reality, to order and comprehend complexity, and avoid oversimplification and reductionism related to heavy emphasis on either the person or the environment (Lea, Wit, & Reynolds, 2014). This perspective, postulates the way of placing conceptual boundaries around cases to provide limits and define the parameters of practice with individuals, families, groups, and communities (Bronfenbrenner, 1994). The use of this perspective will allow me to examine the participants as a member of a larger system, interconnected and multilayered. Within the parameters of a rural community and the multiple players that encompass that system, including: school systems, religious systems, local governments and businesses, there are several

contributing factors and roles that each component plays in the transactional relationship. Examining the system as a whole, the perceived impact of the rural community and all that that encompasses, the social supports of the individual, the available resources for that individual, and other systematic components, will allow for a closer look at the potential for a rich description of individual experiences within that system. Within the rural community and the typically conservative nature therein, there could be a potential impact of the environment on the LGBT individual, impacting their desire to obtain help for their identified issues, or potentially having difficult help-seeking experiences overall (Scala, Johnson, & Rogers, 2015).

Minority Stress Theory

The Minority Stress Theory (MST), originally proposed by Meyer (2003), suggests that individuals who identify as a member of the LGB population can be at an increased level of vulnerability solely in response to the unique issues related to their LGB status (Shilo & Mor, 2014). Meyer (2003) hypothesized that higher prevalence of psychiatric disorders among LGB people is a consequence of minority stress. His minority stress theory is based on the notion that, similar to other minority groups, LGB persons face chronic stress due to homophobic and heterosexist social conditions. Meyer's hypothesis was supported by a meta-analysis that revealed LGB individuals were about 2.5 times more likely than heterosexual individuals to have a mood, anxiety, or substance abuse disorder at some point in their lifetime and twice as likely to have a current disorder (Kuyper & Fokkema, 2011).

The minority stress theory postulates that this stress can be observed in both distal objective stressors and proximal subjective stressors, where an experience of a distal (external) stressor is then accompanied by a proximal (internal) stressor (Alessi, 2014). In this instance, the distal stressors would be minority-related prejudice and discrimination, whereas proximal subjective stressors would include the fear of rejection, internalized homophobia, or concealment of sexual orientation related to their LGB status (Alessi, 2014). Researchers have used the MST as a means of exploring and interpreting connections between experiences of minority stress and reports of impact on mental health (Muehlenkamp, Hilt, Ehlinger, & McMillan, 2015). In addition, several studies indicated perceptions of minority stress being elevated in rural areas, with a higher occurrence of micro-aggressions. These micro-aggressions refer to small acts that are discriminatory in nature and may be purposeful and intentional, or acts that are not necessarily meant to be malicious, but are able to be interpreted that way by the receiving party (Swank, Frost, & Fahs, 2012). There has yet to be a study that integrates both help-seeking experiences and rurality as examined through the lens of the minority stress theory specific to rural Northern Michigan. The influence of that stress on help-seeking behaviors of LGB individuals will be explored through this lens.

Theoretical Application

Applying these theoretical principles, the ecological systems theory and the minority stress theory, to the current study will assist in examining current issues related to LGB individuals in the identified rural area. Utilizing the rural area as a singular case

study, in which the rural locale constitutes the singular unit of measure, I as a researcher am better able to identify the case study dynamics and experiences, as postulated by Yin (2005) who gives guidelines specific to case study composition and analysis. Within this singular system, there are several contributing facets – social, political, economic, and individual, as defined by Brofenbrenner (1994). An example of a political influence can be seen by examining this question of help-seeking experiences for this population of LGB 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 LGB 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. 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. This could play a role related to the systems perspective, affecting comfort of help-seeking in rural areas, which are already primarily conservative (Rhodebeck, 2016). Rostosky, Riggle, Horne, Denton, and Huellemeier (2010) state that political majority issues can have adverse effect 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. This can include comments, gestures and actions by

others to incite a feeling of inferiority towards the individuals within the minority. It can also be internal struggles with views of self, views of societal acceptability, and internal schemas.

With the post 2016 political climate, specifically referring to the shift from a democratic and socially liberal administration to conservative electoral outcome of 2016, there may be factors that contribute to recent help-seeking behavior as well. Speaking from an ecological systems perspective, a political shift could mean that there will be more fiscal focus in other areas aside from those under a different political system, a shift in social structures related to support for LGB issues and rights. This could translate to a greater preponderance of conservative viewpoints that may not be as affirming of LGB individuals, which in turn my 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 turn, 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, LGB individuals may be more hesitant to "out" themselves, even to professionals in the area.

However, help-seeking behaviors within the last 5 years (2012-2017) were examined, so the most recent political climate is not a primary factor, but should be considered within the ecological systems perspective when examining minority stress in this rural locale as it relates to the system and the individuals therein. This is an example

of how one aspect of a broader system may influence the target population– both feelings of need for seeking help, as well as the experiences of clinical intervention once sought.

Major Concepts

LGB Identity in the United States

The National Health Interview Survey (NHIS) reported in July 2014 that 1.6% of Americans identify as gay or lesbian, and 0.7% identify as bisexual (Gallup, 2014). In a Williams Institute review based on a June–September 2012 Gallup poll, approximately 3.4% of American adults identify themselves as being LGBT (lesbian, gay, bisexual, or transgender) (Williams, 2013). The 2013 Williams Institute report also states that 8.2% of Americans reported that they had engaged in same-sex sexual behavior, and 11% reported some same-sex attraction (Williams, 2013). Within this population, whose number have maintained a steady increase since they first began being studied (Gates, 2013; Steinmetz, 2016), it is important to identify what their experiences are in the general U.S. population so we can compare them to the bounded system explored in my study. This snapshot study does not necessarily capture the entirety of this population, as individuals may have a particular orientation in which they experience same-sex attraction, but may not specifically identify as LGB or engage in same-sex acts or behaviors (Semlyen, King, Varney, & Hagger-Johnson, 2016).

Differences in LGB and General Population Experiences

There are a number of studies that indicate that the experience of an individual who identifies as LGB is significantly different than an individual that does not fall into

that minority group (Alessi, Martain, Gyamerah, & Meyer, 2013; Feinstein, Goldfried, & Davila, 2012; Watson, Wheldon, & Russell, 2015). Namely, individuals who are openly identified as a member of the LGB population have a higher preponderance of stress, discrimination, and stigmatization (Gates & Kelly, 2013). In addition, these individuals experience these factors across a variety of arenas, including the workplace, school, and the community (Gates & Mitchell, 2013). While I will be examining self-identified LGB individuals, not just individuals who are open to the public, this is not to say that openly identifying oneself as LGB is the only way to experience stress. Hiding one's identity completely, or not disclosing it in various aspects (for example: identifying to family, but not at work) can create similar stressors of a proximal nature (Bostwick & Hequembourg, 2014).

What defines identity? Sexual and LGB identity is multifaceted and individualized for each person. The development of identity is not a simplistic experience or one that is static. It is an ever evolving process that encompasses several stages and a multitude of arenas (Cass, 1979). One of the earliest theories (and perhaps most well-known) of what was then referred to as homosexual identity development and synthesis was developed by Vivian Cass (1979). In this developmental model, an individual who identifies as homosexual (or who would today identify as "gay") is believed to have gone through six stages that begin with identity confusion and result in identity synthesis, which Cass (1979) defined as the relinquishing an "us versus them" mentality toward heterosexually identified people and brings about an integrated internal and external

identity (Cass,1979). Although the six stages that Cass (1979) identifies appear to be linear or deterministic in progression, Cass indicated that it is more a process of ongoing interconnected engagements related to the individuals and their environments. Therefore, it is not necessarily a linear interaction, but a reciprocal and intertwined interaction of multiple variables (Cass, 1979). This concept is congruent with basic identity development, but can be expanded on further.

While Cass' theory of identity development assists in explaining general development, this study is assuming that psychosexual development and the expression of sexual orientation is a fluid concept, and will not assume a static identity. This aligns with Lisa Diamond's work related to sexual fluidity, and the assumption that sexual orientation and expression are constantly changing facets of one's identity, influenced by a variety of environmental factors (Hammond & Diamond, 2015). It is both this environmental influence and internal/external stressors that align with the chosen theoretical framework of this study.

There are a wide number of individuals who may have thoughts, attractions, fantasies, or behaviors with or about members of the same sex, but not identify as LGB. This can be for a variety of reasons and can make a census count on actual number of LGB individuals difficult. In looking through the MST, there are several stressors that can be attached to the LGB identification alone. For example, an individual may be LGB, but be fearful of disclosing that identity publicly for fear of discrimination and prejudice. This lack of public identification or public validation can bring about subsequent internal

struggles with identity and self-esteem. Likewise, an individual who does openly identify as LGB may face prejudices, stigma, and stress related to LGB identification (Platt & Lenzen, 2013). This entire multifaceted and individualized identification process and reality can bring about feelings of stigma, acts and experiences of discrimination, and other previously discussed distal and proximal stressors (Alessi, Martain, Gyamerah, & Meyer, 2013).

"Coming-Out" Process. Coming out can be defined as a personal attestation of alternative sexual orientation, by means of making that orientation known to others (Wagaman, 2013). The process of identification and "coming out" is one that has been reported by LGB individuals as being met with mixed reactions from family, friends, their community, and themselves-based on narrative of those individuals in previous studies (Feinstein, Wadsworth, Davila, & Goldfried, 2014; Manning, 2015). Specifically, self-identified LGB individuals have described several factors that are involved in the process of coming out and the themes related to the struggles and rewards of that process. These factors consisted of family support, having an active partner, and community climate (Dunlap, 2014). It is found that feeling a certain level of support from family or community made the coming out process easier in relation to distal stressors (McCabe, Gragowski, & Rubinson, 2013). Whereas, having an active partner made the initiation of the coming out process a more common occurrence and eased the transition of identifying openly as a LGB individual (Baptist & Allen, 2008).

Major themes related to coming-out struggles relate to community, social, political climate, belief systems of social and familial relationships, and dysregulation with cultural and personal expectations of oneself (Dunlap, 2014). Individuals identified that they have experienced losses of family and friends, jobs, community relationships, and have struggled with mental health repercussions due to the identification and subsequent coming out process (Wagaman, 2013). The minority stress, or at least that individual's immediate experience with those proximal and distal stressors, at this point of the identification or coming out process can be significantly different and more prominent in current experience and current everyday life in comparison with an individual who has had years of being out (Dunlap, 2014). This is not to say that individuals who have been out for long periods do not experience minority stress or prejudicial actions. There is evidence to indicate a continued experience with minority stress as there is an ever present amount of distal stressors related to LGB individuals in the United States (Nadal et al, 2011; McCabe, Dragowski & Rubinson, 2013).

LGB Identity in Rural vs Urban Populations

Identifying as a member of the Lesbian, Gay or Bisexual population and experiences associated with that identification can vary based on geography (Swank, Fahs, & Frost, 2013). Studies have indicated that individuals that have resided in rural areas are more likely to have experienced homophobic statements (Swank et al., 2013), property damage, employment discrimination (Tilcsik, 2011), housing discrimination, and physical assaults (Poon & Saewyc, 2009; Swank, Frost, & Fahs, 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 (Feinstein, Goldfried, & Davila, 2012). Community and the composition of that community have been indicated to play a role in the predicted increase in these experiences as well, where larger populated areas may contain more individuals that possess traits connected to liberalism, including increased levels of education and less religious fundamentalism which has been linked to decreased levels of discriminatory or prejudicial actions and experiences (Swank, Fahs, & Frost, 2013; Perkins et al., 2013). Specifically, LGB individuals in rural areas have indicated that this increased religiosity and conservative community climate have influenced their complete public identification related to "out" sexual orientation, or at least influenced their comfort of doing so (Van Eeden-Moorefield & Alvarez, 2015). Moreover, research indicates that sexuality-based stigma, including anticipated, enacted, or internalized, is associated with increases in depression – in line with Meyer's theory of minority stress and components of microaggressions related to rural living (Marsack & Stephenson, 2017).

This community climate can include familial relationships, as many rural communities are comprised of multigenerational family systems that contribute to the overall community population. Literature shows us that some rural communities can improve resilience and provide protective factors for some individuals (McKibbon et al., 2016), however, for LGB individuals, smaller communities provide less resources

specific to that population (Handley et al., 2014), more conservative views, and multigenerational rejections (Ryan et al.., 2010) can drastically reduce protective factors and decrease resilience, which can in turn affect mental and physical health.

Other influences include places of employment, school systems, and small community government (Feinstein, Goldfried, & Davila, 2012). This systemic composition of community, subsystems, family systems, and nuclear family contributes to the ecological systems lens that will be used to interpret the data collected in this study.

Resources in Rural Areas

In addition to community composition, the availability of clinical resources in rural areas is much less than that 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, 2015). 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., 2014; 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, Christensen, & Chen, 2013).

Mental Health in the United States

Before I can discuss the specifics of LGB experiences with rural mental health, it will be necessary to examine mental health from a broader base to examine the differences in mental health access and resources between urban areas and rural settings. This will be discussed in this section. Then there will be a discussion related to mental health and the differences for LGB individuals related to accessibility, stigma, and utilization.

Most recent statistics from the National Association for Mental Illness report that approximately 1 in 5 adults in the U.S.—43.8 million, or 18.5%—experiences mental illness in a given year (NAMI, 2015). In fact, 1 in 25 adults in the U.S. which equates to 10 million, or 4.2% of the population, experience a serious mental illness in a given year that substantially interferes with or limits one or more major life activities (NAMI, 2015). These numbers, based on a national representative sample, are estimates based only on individuals who were self-identified or professionally identified and may not be truly indicative of the real number of individuals with and mental health need. Individuals who do not seek clinical help or who do not self-identify as having a mental illness were not captured by this statistical analysis.

Several factors are related to help-seeking behaviors among individuals who experience psychological distress or mental illness. These factors can contribute to

willingness to seek help and include: lack of awareness of resources, fear of stigma, and poor referral processes from general practitioners (Perkins et al., 2013). Help-seeking in rural areas has been found to be less common per capita, and including the aforementioned help-seeking deterrents (Willging, Salvador, & Kano, 2006). Reasoning behind this includes: poor public transportation, increase focus on faith-based interventions, increased fear of stigma in a smaller community (including bullying), and an increase of general practitioner treatment as opposed to specialized clinical treatment (Zellmer & Anderson-Meger, 2011; Rughani, Deane, &Wilson, 2011; Li et al., 2014). In addition, there is a significant disparity related to general population percentages of individuals with mental health needs, and the number of LGB individuals with mental health needs. In one study, Semlyen, King, Varney, and Hagger-Johnson (2016) found that LGB individuals are at an increased risk of exhibiting mental health symptoms – specifically anxiety and depression as compared to the general population.

Rural Mental Health Services

The reported access of mental health or clinical services in rural United States varies by location and study, however, studies have found common themes related to the likelihood of individuals seeking help for mental health or clinical needs. These themes include issues of availability of services related to geographic location (Barefoot, Smalley, & Warren, 2015), overall belief systems of the area in relation to religious-based services being more prominent or use of rural primary care doctors to treat mental health issues (Li et al, 2014; Zellmer & Anderson-Meger, 2011), or more conservative

belief systems resulting in distal and proximal minority stress or microaggressions (Handley et al., 2014).

Several studies have indicated that both the intention to seek help and the actual experience with help-seeking and acquisition are dependent on multiple factors related to the knowledge of the therapist, the gay-affirming attitudes of the therapist, and other types of affirmation and disclosure of the therapist – many of which can be related to cultural competence or frequent use of certain knowledge and skills based on common treatment or exposure to certain populations (Grove, 2006; Israel et al., 2008; Jabson, Mitchell, & Doty, 2016)

As previously discussed, rural areas have a higher usage of primary care physicians in place of specialized clinical services such as licensed professional counselors or clinical social workers. This could be explained by the general lack of existence or lack of easy access to specialized services as it relates to geographical location (Perkins et al., 2013). However, not all primary care physicians are as trained or well-versed in clinical interventions and evidence based practices needed by individuals seeking mental health help, and therefore some of those individuals may be under-treated (Perkins et al., 2013).

In addition to a higher preponderance of general practitioner treatment, there is a higher degree of faith-based treatment in rural areas (Rughani, Deane, & Wilson, 2011). There is a tendency for an increased level of organized religious proclivity in the rural social climate as it stands, and this overall social climate may therefore affect the separate

acquisition of services that are specialized to mental health or clinically based (Rughani, Deane, & Wilson, 2011). In addition to the procurement of faith- based factors in help-seeking, there are also more proximal characteristics of less confidence in outside clinical resources and more focus on individual ideologies related to faith-centered healing principles (Zellmer & Anderson-Meger, 2011). This could have an adverse effect on the cultural competence of rural practitioners – in that less exposure or need for continued training and awareness based on limited population diversity, could affect the continued education or simply lack of continued exposure to certain topics specifically related to LGB individuals that then subsequently reduce the overall competence of the practitioner (McCann & Sharek, 2014; Walinsky & Whitcomb, 2010;).

Mental Health with LGB Individuals in the United States

Studies have shown an increase in reported mental health symptoms and psychological distress among identified LGB individual in comparison to the general population (Shilo & Mor, 2014; Muehlenkamp, Hilt, Ehlinger, & Mcmillan, 2015). Factors related to this increase span from both distal and proximal stressors and include an escalation in bullying in school or workplace (Pizer, Sears, Mallory, & Hunter, 2012), parental rejection and/or peer rejection (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010), unstable sense of self, self-loathing, or a rejection of one's feelings of same-sex attraction (Feinstein, Goldfried,& Davila, 2012), and social and/or political climate. In addition, geographical factors can play a role in these feelings of isolation and rejection (Shilo & Mor, 2014). There have been reports of a higher incidence of suicidality, self-harm and

substance abuse among LGB individuals due to community and family acceptance as well (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Research indicates that family acceptance or rejection can influence protective factors, the absence of which correlate with heightened levels of depression and anxiety and manifest into higher levels of substance use/abuse and suicidality (Ryan et al., 2010). These heightened levels of rejection and fear are also aligned with Meyer's theory of microaggressions and stressors that affect the individuals overall feelings of self-actualization and belonging – essential pieces to mental health (Semlyen, King, Varney, & Hagger-Johnson, 2016). From a systems perspective, the systematic rejection and multi-arena stress or discrimination could manifest into further ostracism and feelings of multi-level invalidation and rejection, thus creating further possibilities for increased mental distress and mental health symptomology (Kuyper & Fokkema, 2011).

Service utilization and help-seeking experiences have been captured in several studies, which indicate that while LGB individuals seek-out clinical services, there are a variety of factors that lead to reports of "successful" therapy experiences. These factors include the knowledgebase of the therapist as it relates to the individual needs of the LGB identified client (Liddle, 1999), the comfort of the therapist related to the sexual orientation of the client (Isreal, Gorcheva, Burnes, & Walther, 2008), and the validation received by the client related to their sexual –orientation (Shelton & Delgado-Romero, 2013). Clients also indicated that both LGB specific groups and mixed sexual orientation groups were helpful, reportedly due to the fact that while their sexuality was important to

their identity, it was not always the primary focus (McCann & Sharek, 2014). In addition, developing an increased comfort with that identity in a safe space or controlled group environment increased their confidence to freely express that identity in other realms (Provence, Rochlen, Chester, & Smith, 2014).

Mental Health with LGB Individuals in Rural United States

In rural areas, services for LGB 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, lack of sexual-orientation disclosure – leading to lack of need awareness (Rhodebeck, 2015; Whitehead, Shaver, & Stephenson, 2016). Utilization of services is a separate issue, as there are several reasons why an LGB 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, Rochlen, Chester, & Smith, 2014; Shelton & Delgado-Romero, 2011).

Literature has been completed that reports a higher incidence of mental health issues in the LGB population as a whole (Semlyen, King, Varney, & Hagger-Johnson, 2016). LGB help-seeking in rural areas can bring factors that are unique do to the spatial components of a small community. This can include the increased possibility of clinicians having to manage dual relationships with clients in the community, or the

possibility of managing several roles as a clinician, based on the needs of the client – including assistance with additional resources (transportation, food assistance, etc.) (Schank, Helbok, Haldeman, & Gallardo, 2010). This type of multiple roles relationship could affect the fidelity of any evidence-based practice that would otherwise be used in a clinical setting (Schank et al., 2010). There are some best practices found in the literature for treatment of LGB individuals include: trauma-informed treatment systems: lesbian, gay, bisexual, transgender–responsive agencies; welcoming and inclusive climate; and linkages with sexual minority community resources and social networks (Drabble & Eliason, 2010). However, in rural communities where there are limited referral resources, this best practice may be more difficult to utilize.

Studies have made recommendations to increase therapist knowledge bases and awareness, and several political and social movements have occurred within the timeframe of the examined data, with results being the same as it relates to continued apprehension of seeking services in rural areas for most LGB individuals (Barnes, Hatzenbuehler, Hamilton, & Keyes, 2014; Israel, Gorcheva, Burnes, & Walther, 2008). 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 such specialization. In so doing, however, treatment related to specific populations can go unaddressed and that population may go unserved or underserved (Ruud et al., 2016).

Help-Seeking

In the seminal article on the topic, D'Augelli (1987) identified that rural LGB individuals have a distinctly less than adequate representation within rural health care and mental health treatment. There continues to be an ongoing disparity 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 be also affected by the additional factors of proximity, community availability and accessibility, and use of faith-based services over specialized clinical services 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., 2016). Help-seeking in LGB individuals can have even more factors compounded on the previously mentioned stressors. These additional factors can be related to lack of acquisition of service or fear of acquisition based on fear of judgement or stigma (Feinstein, Goldfried, & Davila, 2012), previous negative experiences (Choudhury et al., 2009), or concern related to finding services tailored to their specific needs (Smalley, Warren, & Barefoot, 2015).

Mental Health Rates and Available Services

Services Available

Within this study I will be examining an eight county area. However, it is advantageous to compare that to the entire State of Michigan, so that I will be more aware of the services available in the entire state as compared to the study area. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Michigan's annual average of mental health treatment/counseling among adults aged 18 or older with any mental illness was similar to the annual average for the nation (42.7%) from 2010 to 2014 (SAMSHA, 2015). Within the public mental health system, or Community Mental Health (CMH) systems, the most recent data collected is from 2014, and reports a state-wide utilization amount of 120, 836 in the entire state of Michigan, with 3539 adults (over the age of 18) receiving some form of public mental health services in the identified 8 county area for the purpose of this study (Fingertip Report, 2015). According to SAMHSA, these individuals are adults that have met a certain criteria and served by this entity due to that criteria, which includes insurance (CMH is the primary Medicaid provider), socioeconomic status, and level of need of care (serious and persistent mental illness diagnosis only) (2015). These numbers do not capture individuals who have private insurance or the ability to pay privately, individuals who have milder to moderate symptoms, or individuals who are typically served by private clinicians or primary care physicians (Fingertip Report, 2015). There is no current data related to utilization reports of this population in this area, so it is difficult to

ascertain the need and/or actual numbers of individuals served. While these CMH agencies may provide counseling or even small group-therapy options, there are strict eligibility requirements to receive services based on those aforementioned factors of diagnosis severity, insurance, and socioeconomic status (Fingertip Report, 2015). Therefore, the mild to moderate individuals with private insurance or the ability to privately pay for services who might access community private practitioners are underrepresented in the data found. This lends further evidence to the need for this study and the examination of how the existing systems either assist or impede the ability to access care for individuals who identify as LGB.

Defining the Location

The identified area is 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, Burd, Holder, & Fields, 2016). These eight counties are: Emmet, Charlevoix, Presque Isle, Cheboygan, Antrim, Alpena, Montmorency, and Otsego County. 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.

Provider per Person Rates

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. We also know that, as already identified, some barriers to rural mental health care acquisition are issues related to transportation and lack of accessibility related to location. This extreme rural locale – especially in an area with an average annual snowfall of 104 inches per winter (National Weather Services, 2016) - could lead to even less acquisition and utilization of mental health services. There is limited data related to the available smaller private practices that are accessible to this rural locale.

Reports of Help-Seeking Experiences

As help-seeking is a primary topic in this study, it is important to know how services are rated and the reports of those experiences. Among publicly accessed and funded mental health services such as Community Mental Health, consumer satisfaction has decreased over the last year as satisfaction survey data indicates that consumers have reported long wait times for psychiatric services or even routine appointments, lack of support groups for specific issues, and frequently cancelled routine therapy appointments (Northern Michigan Regional Entity, 2015). This information indicates the lack of services in this area and its impact on the satisfaction of clients in this area, regardless of LGB status.

Services Available to LGB Individuals

Rural Northern Michigan will be defined for the purpose of this study as the geographical area above M-72 (which is the Michigan state road that runs east-west in the upper forth of the lower peninsula of the state of Michigan). There is an average population per square mile of 46 individuals, with a total estimated population of 185, 278 in this 9,116 square mile area (Michigan Department of Community Health, 2017). In this identified region, as searched by me through internet search, clinical resource databases, social media, and newspapers - no official LGB face-to-face support groups are available. A wide spread internet search which included general search engines, as well as sites specific to clinical services found no evidence of community centers or locations that are identified safe spaces. There are gay-straight alliances in several schools at a high school level, with sponsorship by a teacher volunteer. There are no identified LGB-specific counselors and in fact these type of mental health or clinical services are grouped amongst a list of possible areas of generalist treatment on private practice websites or only found in areas of interest among private practitioners. In the public mental health system, there are no LGB specific resources, support groups, or LGB-specific/specialized clinicians, as this system is structured in a generalist form as well.

We do not have adequate records of the number of LGB individuals who utilized Mental Health services in northern Michigan over the course of any period of time, as identifiable health information is protected and not public. This applies to any positive or

negative experiences of individuals as well. It is because of this missing data and lack of information, that this study is so important in capturing the help-seeking experiences of LGB individuals in rural northern Michigan.

Summary

There is a great deal of research that indicates varying experiences of LGB individuals throughout the United States. Minority stress and discrimination can play an especially large role in experiences of individuals in rural areas, and can influence help-seeking experiences. No research has been done in rural Northern Michigan to examine the help-seeking experiences of LGB individuals to determine if this area has similar experiences to previous studies found in the literature review. Minimal LGB-specific services are available in this area, and little is known related to how LGB individuals have interpreted the clinical services that have been sought out, and what factors influenced their willingness to both seek help and continue to utilize services once established. This study furthered knowledge of these topics, thereby expanding on the preexisting literature.

In Chapter 3, I discuss in detail the methods of the study. This detail will encompass recruitment, data collection and storage, as well as details related to informed consent and trustworthiness.

Chapter 3: Methods

Introduction

The purpose of this study is to examine the help-seeking experiences of LGB individuals in rural Northern Michigan. The purpose of this chapter is to address the research methodology used to complete this research study. It includes the methodology that was used to recruit participants and how data were gathered. In addition, within this chapter I review the role of the researcher (including any researcher bias), the methodology of the study (including a description of the details of data collection and analysis), and trustworthiness (including the techniques I used to ensure that the study met criteria for credibility and ethical safeguards).

Research Design and Rationale

The purpose of this research design was to understand the experience of LGB individuals with the mental health system in a Northern Michigan rural area. The chosen research design was picked due to the inherent exploratory nature of a case study, in which in-depth understanding is sought by capturing a snapshot of the selected participant pool. This was accomplished by exploring the help-seeking behavior for individuals with either self-identified or professionally identified mental health or clinical needs within the LGB population. The aim was to examine the experiences of self-identified LGB members with a history of clinical mental health intervention within the last 5 years, who live in an identified Northern Michigan rural area. This study explored this research gap to further understand this population's mental health needs and

experiences, which could lend evidence to the need for increased clinical competency training or resource development.

Research Questions and Subquestions

What were the experiences of LGB individuals who sought clinical intervention for mental health or substance abuse needs in rural Northern Michigan?

- Subquestion: What factors are related to the positive or negative experience of help-seeking?
- Subquestion: How did those experiences influence future help-seeking?
- Subquestion: What are the challenges/barriers to seeking help for this population?

Paradigm

This study reflected a constructivist paradigm, where all individuals have individual experiences and, through their interpretation of that experience, create meaning in the world and themselves (Ertmer & Newby, 1993). The paradigm further postulates that reality is subjective, and that each reality is experienced differently, but each is equally valid. Thus, there is not one universal truth, but several billion individual truths as each individual's truth in experience is different, yet legitimate (Ertmer & Newby, 1993). Essentially, constructivists postulate that the concept of reality is constructed within the mind of a singular person, instead of reality being an externally singular unit (Hansen, 2004). Furthermore, the constructivist position embraces a hermeneutical approach, which maintains that meaning and reality are hidden and must

be brought to the surface through deep reflection (Schwandt, 2000; Sciarra, 1999). As with this study, this reflection can be inspired through the interactive dialogue between the researcher and participant within the semi structured interviews. Thus, a significant distinguishing factor within constructivism is the significance of the interaction between the investigator and the object of investigation, or participant (Ponterotto, 2005). As there is no universal reality, but multiple versions of equally important realities and experiences, a case study design allowed each individual to discuss her or his experiences related to help-seeking in this area. As a result, I gained a deeper understanding of their case and experiences. The bounded system as the single-case study allowed for a group of individuals to be studied. However, thematic analysis was done on the group as a whole. In this way, I examined this set of individuals within the separate realities, but pulled out themes related to their shared location.

Research Design and Rationale

The chosen research design was a qualitative single-case study design, wherein the case examined was the bounded system of the geographical location, specifically focusing on generating meaning and understanding of experiences of help-seeking among LGB individuals within that bounded geographical location in rural Northern Michigan as well as the bounded time frame of services between 2012-2017. The selected model was chosen because qualitative research focuses on generating meaning and understanding through rich description (Yin, 2014; Merriam, 2009). By using a case study design, I was able to capture a snapshot of the chosen sample related to LGB help-

seeking experiences in this geographical area at this specific time. This qualitative case study examined the participants as a member of a larger system, interconnected and multilayered. In so doing, each participant's reality was equally valid and important, as there is not one true reality. Utilizing the bounded system as the single-case study, allowed for a group of individuals to be studied and thematic analysis to be done on the group as a whole, thereby examining this set of individuals within the separate realities, and pulling out themes related to their shared location.

Role of the Researcher

I, as primary researcher, was responsible for recruiting participants, conducting interviews, and analyzing the data. I collected data through in-depth qualitative semi structured interviews. Pertaining to the interview, the questions were open-ended in format to elicit comprehensive responses. There was minimal sharing or disclosure of information pertaining to myself or my interest in the topic throughout the interview. This was only discussed if directly asked by a participant, and even at that time it was only discussed at the end of the interview after all questions have been asked. This was done in this manner as not to unintentionally influence the answers given by the participants in any way. The initial open-ended questions were predetermined and approved by the committee members prior to implementation or use.

Research suggests that some LGB individuals might be at a heightened risk for major mental illness, substance abuse, or self-harming behaviors. If a participant disclosed that they were having difficulty with those issues currently, I had planned to

provide information regarding local resources. In addition, it would be ascertained whether individuals were in direct and acute risk of harm to themselves, at which point I would have deescalated the situation and safety would have been addressed. This safety could have been managed by means of information regarding local therapy resources, or a safety plan that included immediate presentation to a local emergency room. It was not a requirement of the study for the participant to be actively in treatment, only that they have received treatment within the last 5 years, so current mental health symptomology could be an issue that presents. However, the availability of community resources was explained at the beginning of the interview process and if the interview reached a point where the interviewee wished to stop the interview, that option was available at any time. This was always offered, but no participants requested to stop the interview.

I have over 15 years of experience working in the mental health field. During this time, I have had several clients that identify as lesbian, gay, or bisexual. Many of these individuals had previous experiences with mental health providers in the same geographical area or other surrounding areas. There were reports of both positive and negative experiences, with a variety of reasoning behind these reports. Through this study, I explored further the experiences of this particular group of individuals in this particular geographic area. Results are presented in a way that was confidential, meaning that they cannot be able to be tied back to one provider or participant exclusively. This confidentiality will be exceptionally important given the small rural area and the limited number of providers present. In addition, none of the participants were chosen from past,

current, or future clients that I have served directly. Any participants that were recruited via contacts or colleagues within the community were provided with confidentiality, and no identifying information of any kind was returned to the referral source.

In order to reduce my own bias as a researcher, a member of the clinical community, and as a woman who identifies as bisexual, there were several steps taken to ensure an unbiased approach. I am a member of all of these and recognize the power differential inherently present within my roles and how that could have influenced my role as a researcher. This study was conducted in a way that views the participants as the experts of their own experiences, thereby minimizing that power dynamic. I recognize that my individual story related to my experiences while living in a rural area as an "out" bisexual woman may not be the same as the individuals participating in this study. I also honor the reality that while I am able to identify seemingly small minority stressors, both distal and proximal that I have experienced while living and working in this area, the other individuals that participate in the study or live in this area may not feel oppressed, identify or feel those minority stressors, and may have a very different experience than I have had. Likewise, some individuals may have had a harsher or more profoundly negative experience, and that should be similarly recognized and valued as a part of their personal experience. It was important for me to continue to practice reflexivity by means of laying open pre-conceptions, bias, and experiences, and becoming aware of situational dynamics as they arise (Creswell, 2013). This was continuously processed through a research journal as well.

In addition, as it is a small community, some individuals may already have known my name or have individuals or colleagues in common. This was controlled by establishing clear boundaries of research and while acknowledging the possibilities of a dual relationship, managing the expectations of my separate roles. I continued to work on processing this through my research journal as a part of this journey. Continued reflection related to my roles, my ever evolving identity, and the study in general was imperative as a part of this process.

Methodology

Participant Selection

Participants consisted of recruited individuals of varying age (over 18), socioeconomic status, and coming out stages. While individuals may self-identify as a specific sexual orientation, there were several stages of "being out." Some participants may only identify to family or friends, or a specific set of individuals (Dunlap, 2014; Manning, 2015). Participants needed to self-identify at this point as a sexual minority, which may include but is not exclusive of gay, lesbian, queer, pansexual, or bisexual at the time of the interview, and needed to have had mental health treatment in the Northern Michigan within the last 5 years, and within the region designated.

Transgender individuals could have been included in this study if they also identified as a minority related to sexual orientation, as this study is specifically focused on minority related to sexual orientation, not gender-expression or gender specific minority. Therefore, if an individual is both a transgender individual as well as

nonheterosexual, they were eligible to be included in the study. It should be noted that if individuals that participated had met these criteria, they may have faced different kinds of minority stressors and may have had different experiences related to their specific gender expression versus sexual-orientation. This would have been identified throughout the interview process and then be discussed further in the discussion section. However, no participants met this criterion.

As there is not a priori test to select sample size for qualitative case study, the number of participants was slightly plastic until a level of data saturation and redundancy was reached (Yin, 2014). Data saturation refers to the point at which no new information is being presented by the participants. More specifically, data saturation is reached when there is enough information to replicate the study (O'Reilly & Parker, 2012; Walker, 2012), when the ability to obtain additional new information has been attained (Guest et al., 2006), and when further coding is no longer feasible due to no emergence of new themes (Guest et al., 2006; Fusch & Ness, 2015). Redundancy refers to a similar concept, in which the researcher is hearing the same common themes throughout the course of each interview (Creswell, 2011), at which point the stopping criterion is reached. As I needed to reach data saturation, I started with recruiting participants, and anticipated reaching data saturation with 9-12 participants. Once I began to hear redundancy of information, I performed an additional one or two interviews to ensure that no new themes emerged. At that point, I assumed data saturation. Yin (2014) postulates that there is no recommended sampling size with case-study design as the case study is not to be

viewed as a “sample” of a broader generalizable population. Instead, the case study is to get a snapshot view of the individual or individuals being studied (Yin, 2014). Therefore, the final number of participants was ten.

The previously mentioned 9-12 participants was an estimate based on the population in this rural area and estimates of LGB population ratios, which included a state-wide estimate of 3.8% of the population as identifying as LGB (Gates, 2017). However, the general population estimates and the estimates of the LGB population differ, as sexual orientation is not a question identified on the national census. Therefore, estimates of LGB population may be incorrect. In addition, there tend to be a higher preponderance of LGB individuals located in urban areas, even after controlling for population ratios as a whole. Therefore, the urban and rural ratios may be even more different than reported (Lee & Quam, 2012).

Recruiting of participants used both criterion and snowball sampling to gather individuals in this geographic area. Criterion sampling is defined as the specific recruitment of individuals based on specific predetermined criteria of importance (Patton, 2001). Snowball sampling occurs when one individual passes the information on to others who meet eligibility criteria, who then pass it to additional individuals (Patton, 2001). This was done by way of social media boards, public, unrestricted information boards, and fliers distributed to area clinicians and primary care offices. Individuals were instructed to contact me by way of phone or email. I then confirmed that they met the inclusion criteria and scheduled a time for the interview. These individuals were self-

identified members of the LGB population with a self-reported history of seeking clinical intervention related to either self-identified or clinically identified mental health issues. Recruitment attempted to sample a diverse group of LGB participants as it pertained to age, race/ethnicity, and stage of the coming out process. However, a diverse population in terms of race and ethnicity was not as likely in this geographical area. This is a limitation that will be discussed more in the limitations section.

Instrumentation

Kvale (2015) suggests a seven step process for completing qualitative interviews. This consists of three primary steps prior to and during the conduction of the interviews (Thematizing, Designing, and Interviewing), and an additional four steps through the data analysis and presentation of findings (Transcribing, Analyzing, Verifying, and Reporting). The initial identified theme to be investigated was already identified as the exploration of help-seeking experiences of LGB individuals in rural Northern Michigan. The design of the study, in congruence with what data is to be collected, was chosen as a single case study design, wherein the geographical region is the bounded system representing the single case study. The interviewing process, as suggested by Kvale (2015), was based on specific interview protocol, with a reflexive approach that considers the interpersonal relation of the interview.

Interviews

Data were collected through semi structured interviews. Semi structured interviews sought to obtain descriptions of the world of the interviewee with respect to

interpreting that meaning into themes (Kvale, 2015). In other words, I gathered a snapshot experience of the bounded system as the single-case study, which allowed for a group of individuals to be studied but thematic analysis to be done on the group as a whole, thereby examining this set of individuals within the separate realities but pulling out themes related to their shared location.

There was some sequence of theme specific questions, but with openness to changes of format or structure in order to follow up to specific answers given (Rubin & Rubin, 2012). There was an interview script that has the basic initial questions, but then leaves openness and room for that deviation from the script to capture the unique interviewee experience. Follow-up questions were formed through the interviewer's active listening skills, specifically clarifying and summarizing, as suggested by Kvale (2013), to prompt interviewees to share more information or to explore a topic in more depth. Interviews were audio recorded and transcribed. Informed consents were signed, which include acknowledgement of the use of the interview and data collected.

The purpose of the interview was discussed at the onset of the interview, but prior to the initiation of the actual questioning. There was a discussion related to what I was studying and information I was attempting to gather. For example, that I aimed to understand help-seeking experiences of LGB individuals in rural Northern Michigan. Minimal discussion was had related to my personal interests in the study topic, unless directly asked by the interviewee. At the closing of the interview, there was some discussion about my role as a bisexual individual who is a practicing therapist in the area,

but that was as needed and was not part of the onset of the interview so as not to sway or skew any data collection or openness of the interviewee.

With the specific questions within the semi structured interview, my goal was to explore the help-seeking experiences of the LGB population within the rural Northern Michigan area. This information was gathered through specific questions that focus on experiences of participants related to help-acquisition, their specific experiences related to positive and negative aspects of the therapist specifically, and their feelings and experiences related to help-seeking in their area of residence specifically. The focus on the interviews was not presenting symptomology or questions related to specifics of mental health or substance abuse. These questions align with the conceptual framework related to minority stress and systems theory, as it sought to explore individual experiences, but also how those experiences were affected by the greater geographical system at large.

Research Journal

I kept a research journal to process my research, better understand and conceptualize my role, and as a means of continuing to manage any ongoing issues that arose. I continued using this tool throughout the interview process as a means of recording my thoughts and learning during the process. This assisted in my own understanding of my part in the journey through reflection and experiences. It also continued to assist in the data analysis and verification stages as a means of how my understanding of the data changed and altered throughout the research process.

Researcher Developed Instruments

To date there is little literature on the experiences of LGB individuals who seek clinical help in rural areas. This data were gathered through the use of semi structured interviews, as aforementioned. The semi structured interview consisted of questions focused on the personal experiences of the subjects that are recruited from the identified rural region and was developed through the ongoing feedback of my committee and informed by the theoretical framework of the study.

Even though the screening process included questions related to residency, there were additional demographic questions within the interview. The purpose of this was to determine if there are commonalities and themes related those separate factors (age, gender, when they received services, etc). Questions related to when the individuals received services was used to focus on discussion of political or societal shifts in the area, and as it related to the LGB population. Initial questions related to the experiences of help-seeking were open-ended questions, with additional questions or prompts to clarify and further explore the participant's responses (Kvale, 2013). An example of these questions are: "Tell me about your experience seeking professional support for mental health or substance abuse issues." These initial questions promoted general discussion related to help-seeking experiences, with follow-up questions related to both positive and negative experiences and opinions of the clinician. There was also questions related to the participants overall experiences in the community at large. This sparked discussion

related to the issues of community-wide experiences with minority stress and how that related to the seeking of help and the interpretation of those help-seeking experiences.

The initial interview guide was developed and questions were presented to the dissertation chair for revision and clarification. After revisions were made, I ran mock interviews using the guide with two colleagues that are not part of the participant pool to ensure that I was asking the questions in a way that would incite responses congruent and in alignment with my overall research question and selected methodology. Further revisions were made to wording and presentation prior to the final version of the interview guide.

Procedures for Recruitment, Participation and Data Collection

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. A recruitment announcement is attached in the Appendix. These social media boards consisted of Facebook, public information boards were PFLAG and other Michigan-based online boards. Fliers were distributed to local coffee shops and college campus public boards. Fliers were also distributed to area clinicians and physicians – who were asked to share with either current or former clients who might have been interested or fit the criteria. Participants contacted me directly and no information went back to providers.

Participants were screened to ensure that they resided within 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. Participant's identity was kept confidential, and no form of identifying information was used in the finished publication. Participants were assigned a pseudonym that was used as an identifier for the purpose of data collection and analysis. Interviews were conducted in a location that was convenient for the participant and ensured confidentiality and neutrality. Each participant was asked to participate in one 1–1.5 hour-long initial voice-recorded interview that was conducted in person, over the phone, or via video conference. That interview was transcribed within one month and an 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. Member checking consisted of the interviewer providing a summary of the interview to confirm the participant's story was interpreted correctly and to present initial themes that are emerging (Kvale, 2014). This process allowed participants to add to or clarify any missing or additional information. The inductive data analysis plans and further clarification are presented below.

Data Analysis Plan

The study is comprised of in-depth semi structured interviews with LGB individuals who have sought out clinical intervention for self or professionally identified mental health or substance abuse issues. This data were then analyzed to provide rich, valid, and comprehensive data to understand the experiences of LGB individuals who have utilized rural mental health services. Using qualitative data collection and analysis

enabled me as the researcher to gain understanding related to the types of experiences these individuals have had in seeking help for mental health and substance abuse, within this bounded system (Creswell, 2013).

Interviews took place in a neutral area that was mutually agreed upon by both researcher and interviewee. There was a general statement of purpose and signing of informed consent prior to initiation of the interview. In addition, the interviewee was made aware that they can stop the interview at any point in time, should they have felt uncomfortable for any reason.

The interviews were transcribed, read through, and coded by myself 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 for the researcher to later identify that statement and combine common statements into categories and themes (Kvale, 2015). It is at this point where the aforementioned data saturation occurred – when no further insights or interpretations emerged from the interviews (Kvale, 2015).

Categorization of information was not pre-formed, codes and themes emerged from the data – thus allowing the participant's answers, combined with my 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). It could prompt further study at a later date, as well as provide a rich and full description of the existing data pool. Including this information allowed me to challenge my assumptions and continue to address bias (Barusch, Gringeri, & George, 2011).

Trustworthiness

Trustworthiness refers to the research study's ability to demonstrate credibility (or the ability for the research results to mirror the participant's responses), transferability (applies to the ability of information and findings to transfer beyond the scope of the study), dependability (which is akin to quantitative reliability, through which the researchers conduct the study in such a way that it could possibly be replicated), and confirmability (of the ability for others to confirm the information) (Creswell, 2013). These terms are the qualitative equivalent to validity, reliability, and objectivity found in quantitative research, which provides proof of authenticity and accuracy of the research data and process (Creswell, 2013).

Transferability and dependability are difficult at times within a qualitative study, especially when new areas of study are represented and there is limited data for certain

areas, or within a small case study where the results might vary depending on the mixture of participants that self-select to participate. I attempted to recruit participants who were a diverse sample of individuals relative to this area, and not have a sample that is too laden in one demographic. I also analyzed the data in a way to address the individuality of each participant and discuss possible variations within the sample, as well as collected the common themes related to the sample as a whole. In addition, I kept a research journal as a means of continuously checking my findings and managing bias. This can also be used for auditing purposes and as a means of replicating the study as near as possible to the original (Morse, 2015). I triangulated the data by way of comparing my findings to the chosen theory to determine if the findings are congruent with the theoretical framework. I also compared my data to that found in the literature review to determine if the results of this study are similar to results from other areas.

In order to ensure trustworthiness, I included several techniques to manage any bias I may hold, including member checking and peer debriefing (Linclon & Guba, 1986; Patton, 2015). I also provided a rich description of the individuals and their experiences through the in-depth interviews, member checking, and continued immersion and engagement within the community as a clinician and as a member of the LGB community.

Member checking includes the review of initial theme development and conclusions of the researcher by the participants themselves to ensure that there are not themes missing or misunderstandings of information (Brinkman & Kvale, 2015). This

was done through the follow-up interviews. Member-checking ensured the credibility and confirmability of the information and the emerging themes (Rubin & Rubin, 2012).

Prolonged engagement was done within the community, but not within the specific participant group (Houghton et al, 2013). I continued to participate in my clinical work while completing the study, and also continued to immerse myself in the culture and community by participating in local LGBT nights at area restaurants, continuing to participate in social media forums, and attending meetings with local schools related to the Gay-Straight alliance found in two of the area school systems. I also attended a state-wide LGB conference with focus on resource development and health/mental health needs. I continued to research LGB and mental health literature and research throughout the course of the study. Creswell (2013) maintains that the purpose of this is to continue to build the trust of the participants and to continue learning the culture and checking for distortions or misinformation that can occur due to bias or lack of cultural awareness.

Peer debriefing was completed by getting ongoing feedback related to my process and methods (Houghton et al., 2013). I continued to debrief through weekly phone sessions with another PhD candidate and clinician who provided suggestions or challenged procedures related to the study, which allowed for continued validation and trustworthiness. I also kept an ongoing dialogue with my dissertation chair through email as well as phone call meetings 3 times per quarter. This allowed me to reflect on the process, as well as provided support to me throughout the process.

I provided a thick description of the participants, themes, or case description, through which readers can determine transferability. This refers to whether or not the study or the results can be transferred or applied to other settings because of shared characteristics (Creswell, 2013). As there is a relatively small group pf participants, it was imperative to provide as much description as possible to gather a true picture of the experiences of these individuals within this bounded geographical case study.

Ethical Procedures

I received IRB approval prior to the initiation of this study (Approval Number 10-30-17-0546152). Then, participants were recruited via message boards and public social media sites, as well as recruited by distribution of fliers to area clinicians. After they agreed to participate in the study, they were assigned a pseudonym to ensure that their identity is protected in the study documentation or any subsequent publications. In addition, the recruitment through area clinicians was done through distribution of the recruitment announcement. Clinicians were instructed to only provide the information to potential participants, and to reassure participants that no information will be shared with the clinician, and that their treatment was in no way influenced by their participation or lack of participation. While there were pseudonyms for the use of data collection, analysis, and documentation, and I kept a master list of names and contact information on an encrypted and password-protected program on my personal computer. I was the only person who had access to this data.

The nature of the interviews could have produced sensitive information related to experiences and ongoing mental health concerns. There were no questions that explicitly asked about illegal activities, such as some types of substance abuse. All questions pertained to past experiences with help-seeking behavior, and no questions related to current treatment were asked. An informed consent was given to the participants prior to any initiation of the interview. This document explained the procedures, the possibility of sensitive material being discussed, and participants signed and agreed to participation prior to participation.

It was the role of this researcher to only collect the data required to complete the interview. Even though I am a member of the community and a licensed provider of clinical counseling services, there was a clear separation between my role as a researcher and my role in the community. I acknowledged that this inherently creates a power differential. I attempted to contain this by assuring the participants that even though I am a member of the clinical social work community, my role in this study is as a researcher only. In addition, I used my research journal and peer debriefing to ensure that the conclusions that are drawn from the data are those reported by the participants, and not skewed by my own perceptions.

Due to my training and experience as a clinician, I would have been able to de-escalate any potential emotional concerns that are emergent in nature and refer to outside supports as needed. Specifically, participants were provided with information on accessing area resources for additional support, should they have identified need at any

point during or after the interview process. While there are not a variety of resources available specifically to LGB individuals, as previously identified, there are general mental health resources. This information was provided on the informed consent. However, no de-escalation was needed and no emergent referrals were requested or identified as needed.

I made participants aware that I am a mandated reporter and bound by the NASW code of ethics (NASW, 2015). This incorporated the stipulations of confidentiality and should issues have come up in the interview where I was concerned about safety, individuals knew that other action may have had to be taken wherein confidentiality would be broken to ensure their safety. This would have only happened if I believed that there was a credible and concerning threat of real harm. Real harm refers to imminent danger of suicide or homicide, not other potentially self-harming behaviors such as cutting – which would not require a breach of confidentiality, but would prompt distribution of contact information for local area clinical supports). Other concerns of a more moderate or mild nature would have been addressed by providing information related to local area resources for additional follow-up or support. At any time, the participants would have been able to discontinue the interview. Any participants that became distressed at any time throughout the interview would have been offered to take a break or to discontinue to interview or withdraw from the study. This did not occur, as no individuals were in acute distress or requested to discontinue or pause the interview at

any time. No credible threats were made to safety, and therefore no breaches of confidentiality were needed to ensure safety.

Storing of Information

All data, including audio interviews, transcript data, signed consents, and the pseudonym list were stored on my personal computer and are password protected and encrypted. Paper copies of the signed consents were kept in a locked file drawer of a desk in my home. Only I have access to these records. They will be stored for 5 years and then destroyed.

Summary

Participants were recruited via message boards and snowball sampling. Participants varied in age, ethnicity, and "coming out" stages. Participants contacted me via phone or email and I ensured that they meet the inclusion criteria. Once this was determined, the initial interview was scheduled. The initial interview took between 60-90 minutes and was transcribed within one month. After that time the participant was contacted for a follow-up interview to ensure member checking and correct data were collected. Data were analyzed using a thematic analysis with codes and themes that emerged from the data.

In Chapter 4 I will present the findings of the study, including details of the data collection and thematic analysis.

Chapter 4: Results

Introduction

The purpose of this qualitative case study was to examine the help-seeking experiences of LGB individuals in rural Northern Michigan. Data for this study was collected through semi structured interviews with 10 participants who met predetermined inclusion criteria. The interviews were then coded and analyzed using thematic analysis. Three primary themes emerged from the data: motivations for help-seeking, common experiences, and suggestions for improvement. In this chapter I discuss the data collection process and data analysis, including the setting, demographics, data collection and analysis, and evidence of trustworthiness. In Chapter 5, I will further analyze how the data can be interpreted through the use of previous literature and within the context of the contextual framework.

The research questions for this study were as follows:

RQ1: What were the experiences of LGB individuals who sought clinical intervention for mental health or substance abuse needs in rural Northern Michigan?

- Subquestion: What factors are related to the positive or negative experience of help-seeking?
- Subquestion: How did those experiences influence future help-seeking?
- Subquestion: What are the challenges/barriers to seeking help for this population?

Setting

I gathered data through semi structured interviews that were completed with 10 participants who were recruited via fliers posted on public message boards, in area doctor's offices, libraries, and on online public forums. Participants came from all eight counties where recruitment took place. A choice of a face-to-face or Skype format for the interview was offered, but all chose to meet face-to-face. Each interview was conducted at a location that was determined by the participant. Locations included offices, coffee shops, a park, and a library. Each interview lasted 45-90 minutes and was recorded using a hand-held digital recorder.

As participants were voluntary and had to initiate contact, my Walden e-mail address and a cell phone that was purchased for the purpose of this study were the primary methods of initial and ongoing contact. Once a candidate contacted me, I would discuss the nature of the study as outlined on the participant recruitment announcement (Appendix A) and send them (through e-mail) a copy of the Consent Form (Appendix C). They were asked to read over the consent form and I then would contact them after 48 hours to discuss any questions and to set up a face-to face interview if they agreed to participate. They were notified that they were free to contact me at any time to with further questions or clarifications pertaining to the informed consent, the interview process, to schedule an interview, or to indicate that they were no longer interested in participation. Nine of the original 12 individuals were recruited by locating the flier directly on posted message boards or online forums. The other three participants were

recruited through snowball sampling, either through individuals who already participated in the interview, or who were referred to the study by another individual who knew they met the inclusion criteria.

Initially 14 individuals volunteered to participate, however two volunteers were excluded from participation because they did not meet all the inclusion criteria, one individual left for college and would not be available for a face-to face interview (and preferred not to participate over Skype), and the other individual returned correspondence sporadically before indicating that they were not longer interested in participation. Therefore, 10 total participants were interviewed. They all signed the informed consent (Appendix C), without modification.

All participants chose the location, time, and day of their interview. Each had different schedules based on work or childcare schedules, and therefore interviews took place during daytime, evening, and weekend hours. No compensation was given as an incentive to volunteer or participate. All participants were given copies of the recruitment flier to give to other individuals who may meet criteria for participation.

Demographics

Criteria for inclusion included: the participant being over the age of 18, an identification of lesbian, gay, or bisexual (as discussed and defined in Chapter 3), and the participant must have received professional treatment for substance abuse or mental health concerns within the last five years in this rural locale. The participants in this study ranged in age from 18-63, included both cis-male and cis-female individuals, included

participants at all stages of the "coming out" process, and individuals who have lived in this region for both very short (less than six months) to very long periods of time (45 years). LGB individuals who reside in the eight-county identified area, who have received professional mental health or substance abuse counseling in this area within the last five years, were the targeted participants for this study. Participants were recruited using purposive and snowball sampling. The participant recruitment announcement (Appendix A) was used as a tool to recruit and inform potential participants of the inclusion criteria. For the ten participants who met the inclusion criteria, all participated in face-to-face initial interviews, as well as follow-up interviews. Each of the participants identified seeking help from a professional clinician, for either mental illness or substance abuse services. All ten participants had sought services for mental health concerns, and two had received additional or concurrent substance abuse counseling as well. Significantly personal demographic information was excluded from this study to ensure confidentiality and to protect the identities of all participants. However, the demographic information that was collected, per the interview guide (Appendix B), included age, gender identity, relationship status, race/ethnicity. Information that was collected naturally throughout the course of the semi structured interview included length of relationship (if partnered), length of time living in this area, information related to number of counselors or sessions received, as well as some of the symptomology presented at the time of help-seeking. No transgender individuals or individuals with non-cis gender identity were included in the sample, as none volunteered. They would have

been included, as long as they identified as nonheterosexual as well. Some of this information is included in this write-up, as it pertains to the analysis of the information of the data. This includes, relationship status, age, length of time living in area, length of time in therapy/number of therapists seen, and how "out" each individual identifies. This information assisted in the theoretical analysis of the data and how it relates to the conceptual framework.

Descriptions of the participants are found below; pseudonyms replace their actual names:

- Janet is a 61-year-old white cis-female who is married to a woman. She identifies as lesbian and has lived in rural Northern Michigan for 15 years. She has been seen by two area therapists for more than one year, but less than five years. She identifies that she is "out" in all areas of her life.
- Meredith is a 27 year old white cis-female who is married to a woman. She identifies as bisexual and has lived in Northern Michigan for 27 years. She has had 2 therapists for between 1-2 years. She identifies that she is "out, with restrictions", specifically her work environment and some family connections.
- Kenny is a 24 year old white cis-male who is single. He identifies as gay and has lived in Northern Michigan for 24 years. He has seen one therapist for less than a year. He reports that he is "out" in all areas of his life.

- Sarah is a 48 year old white female who is married to a woman. She identifies as lesbian and moved back to this area eight years ago. She originally lived in this area prior to moving away for several years. She has had 3 therapists over several years, but none longer than two years at a time. She reports that she is “out” in all areas of her life.
- Annie is a 22 year old white cis-female who is single. She identifies as lesbian. She moved to this area two years ago. She has had one therapist in this area for less than a year. She reports that she is “out” in all areas of her life.
- Oscar is an 18 year old white cis-male who has a girlfriend. He identifies as bisexual. He has lived in this area for 18 years. He has interacted with two therapists within the last year. He reports that he is only “out” to a few people.
- Katie is a 42 year old white cis-female who is engaged to a woman. She identifies as lesbian. She moved back to the area three years ago, although originated from rural Northern Michigan. She has interacted with three area therapists for less than a year each. She is “out” in all areas of her life.
- Rachel is a 43 year old white cis-female who is engaged to a woman. She identifies as bisexual. She has lived in rural Northern Michigan for 43 years. She has had several area therapists for three months-three years each. She is “out” in all areas of her life.

- Alex is a 50 year old white cis-male who is engaged to a man. He identifies as gay and has lived in Northern Michigan for over 20 years. He has had two therapists for less than two years each. He is “out” in all areas of his life.
- Christina is a 32 year old white cis-female. She identifies as bisexual and is married to a man. She has lived here five years and has seen two therapists for less than six months each. She reports that she is “semi-closeted” and only close friends know that she is nonheterosexual.

Data Collection

For this study, I used purposive and snowball sampling to recruit participants to participate in a semi structured interview. I developed open-ended questions and included them in an interview guide (Appendix B) to ensure that the main research questions were addressed and no pertinent information was omitted. Interviews were between 45-90 minutes long and were digitally recorded, with the total time being 673 minutes. Time was allotted at the beginning of each interview to go over the informed consent and sign the consent, as well as answer any preliminary questions related to the interview process. Participants were reminded that they could stop the interview at any time. No de-escalation was required throughout any of the interviews and individuals who identified any current symptomology also indicated participation in current treatment and were in no acute distress related to the interview. Interviews took place in various locations at the selection of the individual participant. Locations included coffee shops, offices, the

library, and the park. Interviews took place between November 21, 2017 and December 20, 2017 with follow-up interviews taking place December 12, 2017 through January 20, 2018.

As aforementioned, ten participants were interviewed out of an initial 14 who responded to the recruitment efforts. The ten individuals that participated met the inclusion criteria discussed in Chapter 3 and sat for a digitally recorded interview that lasted 45–90 minutes. After completing the 4th interview, there was repetition of ideas and phrases related to what would later be determined to be the primary themes. I continued to conduct the interviews, as I had originally anticipated data saturation between nine and 12 participants. Similar information continued to present itself throughout each interview. After the completion of the eighth interview, no new information was offered by the participants. I conducted two final interviews to ensure that I had reached data saturation, and the continued redundancy in terms confirmed that data saturation had been reached.

Once interviews were completed, the audio files were transferred to my password protected computer and assigned an alphanumeric pseudonym. The original recording on the handheld digital recording device was deleted prior to recording the next participant's interview. Once the location was selected by the participant, we met at the agreed upon location and the informed consent was reviewed and signed. A copy of the consent was provided to the participant, as it contained the numbers to local resources for mental health assistance, should they determine that was needed. The recording device was

situated close enough to both the participant and I, so that questions and responses could be heard clearly. The interview guide was used to initiate the interview, using reflective listening and responsive interviewing techniques to elicit a rich description of the participant's personal experiences. Follow-up questions were used when additional clarification was needed.

Throughout the interview I kept a running research memo, denoting key terms, common or repeated phrases and emerging themes. Throughout the interview process, no unusual or unexpected issues arose that required any variations from my research plan presented in Chapter 3. No participants presented any emergent issues that required emergency intervention for safety or de-escalation. No participants required or requested additional support or treatment referral, as this was a covered topic in the informed consent. After each interview I shared my own story if it pertained to theirs in a way that could have provided comfort or joining. For example, with Kenny, I shared an instance where I too lost a job due to my sexual orientation.

The audio recordings of the interviews were transferred to my password protected computer and transcribed. This transcription took between 1-3 hours per interview, depending on the length of the initial interview and the quality of the recording. At times, the recording needed to be played back several times to ensure accurate transcription, especially when the interview took place in a location that had excess background noise. There was no use or professional transcription software or individuals, as personal transcription allowed me to be more immersed in the data collection and analysis process.

The interviews were all reviewed in their entirety once fully transcribed by myself, in comparison to the recorded interview to ensure completeness and accuracy. Follow-up interviews were scheduled within 30 days of the initial interview with that participant.

Participants had the option of holding interviews in person or via Skype (or video-based communication equivalent). All 10 participants agree to meet in person at a location of their choosing. These locations consisted of coffee shops, offices, and the local library. Interviews were held with the purpose of ensuring that I had understood the initial interview by reviewing major ideas and experiences with that participant. This was done using a paraphrasing of major themes, as well as direct quotes related to the research questions and emerging themes. No corrections were made by the participants related to the initial interview analysis and my understanding. None of the participants required alteration to the interpretation of their individual interview. Follow-up interviews were held to confirm with participants that I had interpreted their interview accurately and give opportunity for any clarification I needed to accurately and adequately interpret the emerging data and themes. These interviews were recorded, transcribed, and coded as well, however, no new emerging themes or information emerged. Instead, the follow-up interviews reiterated emerging themes and confirmed previously collected data from initial interviews.

Data Analysis

The purpose of this study was to examine the help-seeking experiences of LGB individuals in rural Northern Michigan. In order for me to accurately do this, I needed to

immerse myself in the data collection and analysis related to this study. This included the arduous process of data transcription as well as the coding and analysis of said data, totaling 124 pages. Initially, I printed out all the transcriptions of the interviews and began underlining and highlighting on a very broad basis, any key words or concepts. This data were also examined through the theoretical lens of the minority stress theory and the ecological systems perspective, where I looked for ideas and concepts related to system relationships, distal and proximal stressors, or ideas related to traumatic experiences. Again, these were all used to help answer the research questions related to help-seeking experiences. This included phrases such as “living in this area is hard” and “I can’t be myself.” This type of initial or first cycle coding can allow a researcher to categorize and begin to interpret the data into analyzable pieces (Saldana, 2016). This initial coding process took over 12 hours and produced 127 separate terms and phrases.

The second stage of coding involved a deeper analysis of the code meaning and grouping the words and phrases into larger categories that were specific in application to the research questions (“I had a falling out with my father”, “my mother stopped talking to me”, and “my parents rejected me”) were grouped into “Family Reactions to Coming Out.” At this point in the data analysis, I was able to input all the transcribed interviews into Nvivo 11 data analysis software. This allowed me to digitally code the first cycle words and phrases, but then shift and maneuver those codes into parent and child nodes, allowing me to examine the data relationships and connections. These parent and child nodes are synonymous with “terms” and “categories” wherein the initial data included

127 terms (child nodes), which were then grouped into 16 categories (parent nodes). This software was chosen due to my familiarity with it, having used it in previous courses. The software can run word analysis and other grouping functions, but it is the researcher's responsibility to assign meaning to the words and phrases and group them together in ways that bring meaning to the data. Words that were flagged most frequently were words just as "um", "yeah", and other simple phrases that had no bearing on the data. Once those were eliminated from the coding, the most frequently used words were "depression", "gay", and "therapist." These word counts were not surprising, as those were the primary target topics related to the research question. However, once secondary data analysis cycle started, I was able to see more global themes emerging related to areas of mental health, LGB population, and help-seeking, fitting into conceptual groupings. After regrouping the initial codes into more specific and meaningful groups, I was able to reduce the number of codes to create distinct categories of data that pertained specifically to my research question, reducing the 127 codes to 16 categories.

From those categories, I was able to continue through the third stage of coding to examine the direct category relationships and analytic storytelling (Saldana, 2016) relating what happened to the clients and their perceptions of why it happened and what can improve. These appeared throughout the data as a both a linear process, with the participant attributing one event as directly influencing and anecdotally causing another, and multi-systemic process of events, where multiple events or influences from multiple systems affected the participant. This prompted those 16 major categories to converge

into the three main themes that emerged. These themes are listed below. Themes will be discussed in full in the results section further on in this chapter.

Theme 1: Why LGB individuals sought help for mental health or substance abuse

- Subtheme: distal stressors and micro-aggression
- Subtheme: Proximal stressors and increased symptomology

- Theme 2: Experience of Help-Seeking
  - Subtheme: Avoidance and passivity
  - Subtheme: Lack of validation and rejection
- Theme 3: Suggestions for improvement of service provision

Discrepant Cases

Any information that did not fit with the consensus was discussed as a discrepant case within the individual sections on themes. Throughout the interview process, the majority of individuals reported negative interactions with therapists, as well as the community at large. Three individuals reported current therapist relationships that had some positive qualities. This information, of variance within the reports of therapeutic relationships and experiences, was not ignored. It was analyzed in a way to determine how and why each report was different. It was then categorized within the theme of suggestions for improvement with relation to positive attributes of therapists or therapeutic experiences.

Evidence of Trustworthiness

Trustworthiness refers to the research's ability to demonstrate credibility, transferability, dependability, and conformity (Creswell, 2013). Credibility is the ability for the research results to mirror the participant's responses. Within this study, credibility was ensured through the transcription process and the second interview which confirmed the main ideas and interpretations that I gathered from the participant's interview. This process also allowed the participants to correct any misinterpretation, however none of the participants requested any corrections to my understanding of their initial interview.

Transferability is the ability of information and findings to transfer beyond the scope of the study. Due to the limitations of this study in relation to sample size, and specific demographic area, as well as the study design (qualitative case study), the findings cannot be generalized to a greater population. However, the findings could be applied to similar areas with similar demographics within the scope of other studies. To aid in this transferability, use of a thick description of the participants and the findings will allow future researchers to determine the appropriateness of transferring these findings to their own demographic.

Dependability is akin to quantitative reliability, through which the researchers conduct the study in such a way that it could possibly be replicated. This study was completed and presented in a way that could be replicated, by way of criterion sampling and snowball recruitment, semi structured interviews, transcription and coding, as well as data analysis. It should be said, however, that this qualitative case study was designed to

be a snapshot of this group of individuals at this particular point in time. Several internal or proximal changes can occur, as identity is not static and is ever changing. In addition, ongoing political and social changes are constant. As discussed through the conceptual framework of the ecological systems theory and the minority stress theory, these changes can therefore affect each person individually. This should be taken into consideration should this study be replicated.

Confirmability relates to the ability for others to confirm the information. While the interviews were confidential, and no outside data analysis was done by outside researchers, I did keep a lengthy research journal and memos to continue to check for researcher bias or any personal bias that I might have integrated either into the questions, the interviews, the analysis, or the data interpretation. I also used my peer-debriefing sessions for this purpose as well, to ensure that my bias was not unduly manipulating any data collection or analysis as a way to assist in confirmability. These terms are the qualitative equivalent to validity, reliability, and objectivity found in quantitative research, which provides proof of authenticity and accuracy of the research data and process (Creswell, 2013).

Transferability and dependability are difficult at times within a qualitative study, especially when new areas of study are represented and there is limited data for certain areas, or within a small case study where the results might vary depending on the mixture of participants that self-select to participate. While I was able to recruit a variety of individuals for this study, it was only a variety based on the available population and

demographic of this area, which is predominately Caucasian, Christian individuals with middle to lower-socioeconomic status. Therefore, any discussion of diversity should be interpreted within the context of the available sample and refers more to variability. There was no deviation or diversity related to racial or ethnic backgrounds. All individuals were Caucasian, as is the majority of the population in this area. There was I was able to recruit participants who were of varying age and varying relationship status. Three individuals identified as Christian, while the remaining seven identified as agnostic or atheist. Socioeconomic status varied as well, with annual income ranging from 12,000 – 80,000 individually (married income was not asked about). Two individuals were on disability and did not work, with the remaining eight working full-time jobs. Specifically, there were three men, and seven women, age ranged from 18-61, with an average age of 37. This group included individuals who had lived in this area between two years to 43 years, with an average of 16.5 years. The participants also ranged in current relationship status, including: single, married (to member of other sex), married (to member of the same sex), dating same sex, dating other sex, and engaged to member of the same sex. 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 4 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 they saw. This variability in group composition could assist other researchers in similar areas to be able to transfer findings and apply ideas to similar demographic areas.

I analyzed the data in a way to address the individuality of each participant and discuss possible variations within the sample, as well as collected the common themes related to the sample as a whole. This was done by first completing the individual interviews and coding the individual data. Then, data were combined and coded as a whole with the interviews of all the participants being coded for similarities and commonalities. Any information that did not fit with the consensus was discussed as a discrepant case within the individual sections on themes. I kept a research journal as a means of continuously checking my findings and managing bias. My research journal was a notebook that I wrote in during and after interviews. I would make notes about the interview, key points, ideas, and quotes, as well as my interpretation of those. I also would include any thoughts, feelings, or struggles that I was having during or after the interview. My notes after the interview were to ensure that I justified lines of questioning beyond the semi structured preset questions. This was done to ensure that I did not ask specific questions in a way to elicit specific material or manipulate the answers to draw out biased information. After each interview, I would also contact my peer to debrief and review the interview questioning process to ensure no manipulation of data occurred, that I was staying within my role as a researcher, and that I was allowing the data to emerge from the interview instead of drawing it out with bias or agenda in mind beyond answering the research questions in a natural way.

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). Member checking was done through the follow-up interviews. These follow-up interviews took place within 30 days of the initial interview. The purpose of the follow-up interview was to ensure that I had understood the initial interview and that my interpretation of the interview and interview questions was correct. No participants corrected my understanding of their initial interviews.

I immersed myself in the topic and the culture to be as informed as possible related to the topic of LGB individuals in this area. I continued to participate in my clinical work while completing the study and continued to immerse myself in the culture and community, by participating in two local LGBT nights at area restaurants, continued to participate in social media forums, and attended two meetings with local schools related to the Gay-Straight alliance found in two of the area school systems. I also continued to research LGB and mental health literature and research throughout the course of the study. Creswell (2013) maintains that the purpose of this is to continue to build the trust of the participants and to continue learning the culture and checking for distortions or misinformation that can occur due to bias or lack of cultural awareness. While I was not immersing myself with the participants themselves, I wanted to make sure that I was as knowledgeable about the population and community as possible.

Peer debriefing was completed by continuing to participate in phone calls with another PhD candidate 2x/week. During these calls, I was able to get ongoing feedback

related to my process and methods (Houghton et al, 2013). As the other student was also involved in the dissertation process as well and provide suggestions or challenge procedures related to the study, allowed for continued validation and trustworthiness. After interviews were completed, I would call this peer and discuss the interview process and any methods questions or concerns I had related to my role in the interview or my process and interpretation. Specifically, there were times where it would have been natural for me to transition into my more comfortable role of therapist or counselor and assist the participant in processing his or her stories related to mental health concerns or past experiences of invalidation. However, this was not my role for this project. Therefore, I refrained from doing this and processed the difficulty of maintaining roles with my peer. In addition, I continued to participate in dialogue and discussion with my dissertation chair. This allowed me to reflect on the process, as well as provided support to me throughout the process.

No major adjustments or alterations were made to any of the areas discussed in Chapter 3 related to trustworthiness and credibility. Steps that were planned, were followed to maintain consistency.

Results

This research study aimed to examine the help-seeking experiences of LGB individuals in rural Northern Michigan in an effort to better understand the systemic influence of rural location on this population, as well as determine how adequately this population is served in this area. The findings of this study indicate that there is 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. In addition, these experiences influence perceptions of clinical intervention once help is sought and during or after services were provided. Three primary themes emerged from the interview data. These themes were: participant's perceptions of why clinical intervention was needed, what participants experienced during help-seeking, and participant's suggestions for improvement for therapists or clinics.

Theme 1: Perceptions of Why Clinical Intervention Was Needed

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. The initial interview questions related to experiences with sexual orientation or help-seeking and support that participant had received from family. This was meant to be a transition into discussion of help-seeking specific to the LGB population. However, I did not expect the participants to put so much emphasis on their LGB components contributed to their seeking of mental health services. 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 LGB 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. This theme answers the research question (Help-seeking experiences of rural LGB individuals) by examining why these individuals sought help, which in turn could affect both their willingness to seek help in general and their experiences once help was acquired.

Subtheme 1: Distal stressors. As aforementioned, participants presented a variety of experiences that prompted or contributed to their desire to seek mental health counseling. These distal stressors were identified by participants as key components to the initiation of symptoms such as fear or the exacerbation of pre-existing mental health concerns such as anxiety or depression, which then promoted the need for seeking help and treatment. Participants offered examples of distal stressors, including community rejection related to conservative or religious views of the area, largely rejecting LGB individuals. Janet is a 61 year old lesbian who has lived in this area for over 15 years. She is married to a woman, but is unable to express herself completely, even though she is "out" in all areas of her life.

Janet:

> There is a huge lack of diversity up here for our community. It's conservative, and we know that it's not really affirming and it can feel like you're half back in the closet. I always have to think…who is safe to be to be myself around, where I can hold hands, and where I can sit close at the movie theater.

Meredith is a 28 year old female who is married to a woman. She has to be closeted in some areas of her life due to fear of job loss or societal ramifications. She has lived in this area her entire life and is well known in the community.

> Meredith: I feel reluctant to be myself or speak up when I am out in the community. Based on appearance I am often assumed to fit the accepted community profile of white, straight, modest, conservative and sometimes it's hard to correct people when they make these assumptions. I find it easier to speak up about my religious or political views, even though they are not in line with the community norm either, but it still seems to be easier than disclosing my sexual orientation.

Katie is engaged to a woman, and has lived in this area "off and on" her entire life. She is "out" in all areas of her life, but has encountered a significant "backlash" with regards to her relationship with her fiancé in this area. These types of distal or outward stressors were identified by participants as key factors in seeking help.

> Katie: I come from a very conservative Christian background and I went to a Christian school in a very conservative Christian area, and I have a few people that have sort of shunned my girlfriend and I.

Rachel continued to discuss the religious aspect and experiences related to rejection or condemnation within the quote below. She is engaged to a woman and has lived in this area her entire life. Her girlfriend's parents are prominent members of the community by her opinion, and therefore, she felt that her relationship was not able to be as "closeted." While she identifies that her girlfriend's parents are somewhat supportive, she did receive a great deal of negative response by other individuals in the community. She reports that this response contributed to feelings of shame and anxiety.

> Rachel: I had lived back here for maybe six months and my girlfriend's parents received a letter from an anonymous person, that we later found out was someone we used to go to church with. It basically said that it was too late for me, but that my girlfriend was able to saved, if she repented. It said that she's going down the wrong path and will end up in hell, but that there was a way that she could still go to heaven. I mean basically and it was this five page typed letter that included Bible verses and quotes was sent to her parents to help them try to convince them, to convince her to 'give up the gay lifestyle'.

Additional community-wide rejection and systematic concerns were bought up related to medical help-seeking and experiences with other professional areas. These system issues, in line with the conceptual framework of systematic stressors and systematic lack of support, contributed to Katie's feelings of community rejection. This rejection then "spun into a depression", connecting those distal stressors with proximal stress reactions.

> Katie: I saw my primary care doctor before I started dating my girlfriend ….then some time went by…and the next appointment I had my girlfriend come in because she was concerned and wanted to be supportive. And you could tell the doctor just got weird after knowing we were together. She just got a little uncomfortable and she wouldn't make eye contact with my girlfriend. When my girlfriend would speak she just kind of shook her head and not really listen to her. And, previously she had always been very personable and really would want to sit with you and talk to you. So, I know she has a really good bedside manner, but when it came to my girlfriend and I, it was "I don't want to acknowledge you" and it was very uncomfortable.

Assumed heterosexuality is another distal stressor that individuals have identified within this area, as being LGB is not the norm. This takes place when others in the community assume the LGB individual is heterosexual, as opposed to accounting for the other possibilities. This assumed heterosexuality can create stressful or awkward interactions between members of the community and the participants. This leads to an increase in feelings of community rejection or ongoing feelings of needing to hide pieces of one's identity, which can lead to an increase in mental health symptomology. Meredith continues to add information related to system responses to her relationship, specifically her primary care doctor's office. She also discusses how the assumed heterosexuality can affect her confidence and relationship with her primary care office

and staff when there is a negative or dismissive reaction to the disclosure of her sexual orientation or relationship status.

> Meredith: My primary care doctor and the nurses at his office assumed that I was straight and with a man. When I told them I got married they asked what my husband's name was, even after I had been to the office a few times with my wife…. Nurses there continue to assume that she is my sister, friend, and some have even called her my mother. When I correct them it typically ends the conversation. When I was with a man, they would continue to ask his name, what he does, and so on. Now, once I say that my husband is a wife, they shut down and stop asking questions. It makes me uncomfortable. There are times when you have to share personal embarrassing things with your doctor and if they give you a negative reaction about something as simple as who I am married to, then it does not give me confidence to divulge more. And if my doctor and his staff cannot remember that my wife is my wife, how do I trust them with my medical care?

Along with reactions and experiences of participants in the community, several individuals report having negative experiences with family and friends. This can include rejection of the sexual orientation, rejection of a relationship, or "disowning" the family member. Feelings of being rejected and "damaged or not good enough" can lead to shame and increased mental health issues, for which participants would then seek

> Meredith: As far as my sexual orientation, with family, my father and step mother no longer speak to me. When I first told them, their response was negative and intentionally demeaning. My father basically said that he could not be around me without sharing his opinions and disgust, so he has not been around.

Kenny provides a unique perspective. While his family rejected him, his primary care physician was supportive and was able to acknowledge his mental health concerns. His primary care physician referred him to his current therapist, whom he has developed a good working relationship with. These positive experiences with therapists will be discussed in the second theme, however, it is important to note that there was an incidence of a positive interaction with one member of the medical system in this community with the surveyed participants.

> Kenny: After I came out my dad didn't look me in the eye for six months my mom cried for four days. They kept asking themselves what they did wrong. But after my last suicide attempt, I knew I had to get help. My doctor referred me for counseling again.

In addition to strained family relationships with “coming out”, some individuals continued to hide their sexual orientation in an effort to maintain the family relationship. In accordance with the minority stress theory, these types of proximal stress beliefs (having to hide one’s orientation or relationship status) anecdotally created feelings of disconnect and strain.

Sarah: I had made the decision that as long as my parents were alive, especially my dad, I was not going to pursue any one of the same sex because of the conflict and the anger that it would create between he and I.

In addition to rejection, issues of safety in the community were presented by several participants. These ongoing distal stressors contributed to trauma-related reactions of hypervigilance, nightmares and fear of future incidents of discrimination and safety.

Annie: I was dating this girl and got shot at by her dad. He actually shot at the house while I was sitting on the porch. Another time someone pulled a gun on me in the grocery store. I was standing in line and he started to pull a gun out of his pocket and his wife stopped him and they ran out of the store. I've never gone back. I'm always looking over my shoulder.

Oscar is an 18 year old male who recently "came out" to his mother. He has not come out to any other family or friends. He continues to fear retaliation and both emotional and physical safety.

Oscar: I was scared of losing all my friends, getting made fun of, and one of the "out" kids is on the football team, and I was scared that they were going to turn it up a notch on me and actually try to physically hurt me and things like that.

Christina (who is a bisexual woman, married to a man) discussed how even though she is married to a man, she would not openly be bisexual in this area, based on her witnessing the interactions that others have had:

> I would never be out in certain areas up here. I know too many people who have been screamed at or assaulted, even in front of their kids, just because one of the women has short hair or just because a couple's body language indicates that they are a couple.

Along with community rejection, family relationship strain, safety concerns, and rejection on religious principles, participants reported additional workplace concerns. Some feared for their employment or even lost employment due to their sexual orientation or relationship status. Meredith explained:

> I work in the school system, two of them, both located in conservative towns. I have been advised not to share my sexual orientation or put pictures of my wife and I around my office because I would likely lose many current and potential clients if they were to find out. I depend on parents and teachers to keep my caseload full and if they are no longer willing to refer to me, I could lose my job.
>
> Oscar: If my coworkers found out, it would be a really bad thing. They would tease me and treat me differently. It would really affect my mental health. I wouldn't be happy about going to work and wouldn't want to work there anymore. I would probably try to find a different job.

Sarah reports on a time that she did lose a professional job that she had worked at for several years:

> In my mind and heart, and in my wife's mind and her heart, we both knew it was because we were together. However, there is no protection in the job place in

Michigan for any retribution or wrongful termination because of same-sex or sexual orientation.

Lastly, distal stressors and microaggressions were reported surrounding the level of relationship status or expression in the community. Several individuals reported that they had to hide true and complete expression in the community and often referred to themselves as “having to be semi-closeted” to avoid community disapproval.

Alex: It makes it difficult for us to hold hands walking down the street, or sit or stand too close, simple things that you take for granted in heterosexual relationships. Avoiding those things can make it seem like you are ashamed of your relationship or your spouse when that isn’t the case at all.

Kenny: I'll go on a date or whatever, and there've been times that I felt like the server judged me or judged us from the time we got there until the time we left. We feel stared at.

Rachel: The first time we went on a date, there is a family where the woman was purposely talking loudly to the husband and were making really nasty comments, then her and the kids would turn on stare at us. And I'm thinking... I don't want to live here and I don't want to go through this.

In order to understand the experience with mental health help-seeking, it is important to understand the cultural context in why help is being sought. These quotes suggest an ongoing and pervasive experience of community rejection from a variety of sources. Several individuals indicated that they have experienced stressors in all, if not

most, of the aforementioned key areas of: community rejection and response, family rejection and response, safety, workplace concerns, and difficulty with relationship expression. All participants sought help for mental health symptoms, as per the inclusion criteria. However, conclusions about a singular and direct link between the environment and the presentation of initial symptoms cannot be drawn. Participants did indicate that they sought counseling for symptoms (depression and anxiety) secondary to rejection of family related to sexual orientation, workplace discrimination, or other various distal stressors. We do not know whether those distal stressors were the sole catalysts to proximal stress reactions and subsequent mental health symptomology, or if those distal stressors simply exacerbated preexisting mental health issues. However, all participants did indicate that these distal stressors were key components for perceptions of why clinical services and help were needed – either as sole motivators or as a contributing factor to preexisting conditions.

Subtheme 2: Proximal Stress Processes. Proximal stress processes are internal, and are often the byproduct of distal stressors. They typically include stress and shame related to concealment of one's minority identity, vigilance and anxiety about prejudice, and negative feelings about one's own minority group. These proximal stress processes are known to increase mental health symptoms such as anxiety and depression, as indicated by the participants in this study. Participants indicated that often the preponderance of distal stressors, such as family rejection and concealment of sexual orientation, increased their depression, anxiety, or perception of rejection. In some cases,

individuals identified that pre-existing mental health concerns were exacerbated, while other individuals indicated that those distal stressors caused so much emotional stress and proximal stress processes (such as poor self-esteem), that new mental health concerns emerged. This further answers the research question of help-seeking experiences related to why there was a need to seek help initially. Janet and Christina both indicate that their proximal stress processes and mental health symptoms were exacerbated due to ongoing distal stressors:

> Janet: 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? Absolutely.
>
> Christina: So, that, kind of, perpetual lack of validation and having to continually say, this is me this, this is who I am, and fight, fight, fight. I completely feel that that type of environment contributed to my increased depression, anxiety, stress, frustration.

Katie, who is Christian and engaged to a woman, discusses how external rejection can contribute to internal feelings of hatred toward one's body or orientation, leading to ongoing identity issues that are socially perpetuated:

> You need to understand that I woke up every day thinking I was going to hell and I would pray all night God let me wake up and be attracted to boys or let me have

a penis (like one of those things fix us) because I don't want to go to hell, because that's how I was raised and that's what society told me was right and wrong.

Annie: Living here... its rough. it makes my anxiety bad and depression bad. Always having to watch what I say or do... it makes me so paranoid. I am constantly jumping and looking over my shoulder. I've had nightmares about getting hurt or killed because of my sexual orientation. Everyday I limit a little more of myself so that I can feel safer.

Rachel: It's absolutely that stress or worrying that added stress of having to like check yourself all the time. there is that. You know, it's become the norm, I usually feel pretty strong about it, but when you actually stop and think about it, you do subconsciously have all these fears and worries and filters running in the back of your head all the time. And it totally plays into your anxiety.

And Sarah: So, during this time of taking care of my sick mom, and rolling around in my own depression dealing with my sexual orientation... wondering why I can't be normal - per society- worrying if I am always going to be alone if I live up here... thinking that there's always got to be more to life and if not, why am I here? It was hard. So, in 2011 I started to a deep cycle of depression. I wasn't sleeping very much and not eating very much and isolated myself in my room upstairs and tried to hide it. I'd worry about how people would judge me and who would find out if I came out. About November it was full-blown, I didn't want to live anymore.

Based on these quotes from the participants, there is a significant amount of proximal stress reaction that is experienced, as a result of the perception of acceptance or rejection, and fear of retaliation. These proximal stress reactions were experienced by the participants as a result of the distal stressors aforementioned, 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). In addition, participants also expressed concern for being "out" in this area with community providers, such as physicians. This further answers the research question of what are the barriers to seeking help for this population as well as the experiences leading up to the initiation of services.

Theme 2: Help-Seeking Experiences

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 LGB status. At times that small-town stigma for mental health or mental health treatment can cause a hesitancy to seek-help.

> Meredith: It's a small community where everybody knows everybody, so, if you have mental health issues, like anxiety or depression, and seek help for it, then it will be known amongst the community, which then could affect employment

> opportunities and things like that. In this community, mental health is not viewed as nearly as important as physical health. If you seek treatment for cancer, then you are a fighter and viewed as strong, whereas, if you admit to having depression, you are weak and potentially incompetent.

Participants also indicate that even if they needed help, being LGB made it even more difficult to seek help based on fear of rejection, indicated that overall there was a general negative experience related to interactions with clinical service providers in this rural area. This directly relates to the research question of help-seeking experiences, but also the subquestion related to barriers for seeking help.

Of the ten participants, all had had negative experiences. Three participants did indicate that they had had some neutral or positive interactions with a therapist at some point in their lives. 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 offer that information without prompt or correct the therapist if there was a hetero-normative 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 judgement related to the nonheterosexual orientation or relationship. Themes related to positive and negative experiences these LGB individuals have encountered when seeking help are related to attitudes of the therapist, knowledge base related to LGB issues, willingness to discuss LGB issues, and ability to identify LGB 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 ten participants had no previous knowledge of their therapist prior to attending their first session.

This was based primarily on therapist's 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 judgement. Therapists overall appeared to have little training or exposure to working with LGB individuals, however clinicians who were "willing to ask questions and learn more about it" gave Janet a sense of an improved and workable therapeutic relationship. Therapists who avoided discussing it or passed over the topic quickly before moving on provided Alex "with a sense of it 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 Meredith. This dismissal further

contributed to the feelings and experiences of minority stress, and receiving micro-aggressive or homo-negative in a therapeutic environment, significantly reduced perceptions of therapeutic effectiveness.

Subtheme: Avoidance, Passivity, and Rejection. Hetero-normative 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.

> Rachel: 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 it tiptoe around the superficial issues and never actually process fully. It's a minority or stressor that is not visible from the outside usually, so without the right questions, not only do I have to acknowledge it, I have to have to 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.

In other circumstances, participants described avoidance or rejection once the topic of sexual orientation was brought up in session. Individuals reported that this

caused an additional level of concern in disclosing difficult topics to therapists, especially if the therapist was actively avoiding a topic that was integral to the stress, anxiety, or depression that was bringing the client in for therapy in the first place. This caused additional barriers for acquisition of care, as well as acquisition of affirming care.

> Kenny: The topic of my sexual orientation wouldn't be addressed. It will be general avoidance. I would talk about my (now) ex and how he used to strangle me in my sleep or beat the crap out of me, the therapist wouldn't validate or talk about it. They would completely avoid it, and instead ask me about my family life or my job. They completely negated anything having to do with past, or the relationship, or abuse it was occurring solely because I was dating someone of the same sex.
>
> Alex: My therapist before, whenever I would talk about my ex and or my abusive relationship and how that affected my mental illness, he would avert questions around that or avoid. They were just older therapists that were set in their ways that you could tell they really didn't agree with the LGBT lifestyle.

Subtheme: Limited Affirming Provider Options. Finding an affirming provider in the rural area proved to be difficult as well. Some of these LGB 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 are sparse. Nine out of the 10 participants said that

they did not know the stance of their clinical providers prior to entering into services. Meredith states that she knew her provider prior to seeking services from her, and therefore knew her stance on LGB issues and nonheterosexual relationships. Due to this stance, she felt more comfortable attending the initial session, as well as subsequent sessions. However, Sarah, who has had 3 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 LGB individuals who fear judgement or lack of affirmation based on the assumed religious undertones of the agency, and therefore the therapist.

> Sarah: I have steered clear of getting help so many times because of what my insurance dictates what's in the area, a lot of times has been Catholic human services or Lutheran social services, or something church based behind it were you already know that there is going to be in nonacceptance of what your major area or main issues are. So you're in there once or twice and you already know you're not gonna get a connection with them because you can't really get at the heart of what's there… So the door is already half closed, so why be vulnerable? It is 100% trust issue and handing over your ability to control your own life to someone else, to let someone else in your mind and your deepest darkest secrets and feelings and hoping that they understand and respect it and allow you to talk. But if they do not accept you for who you are, then how can anything be effective?

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. Additionally, participants were reluctant to return to previously sought therapy options and some choose not to seek therapy at all in the future.

> Sarah: I would not seek out a Christian counseling place in this area. And that's too bad really, because you can obviously be gay and Christian, but this area is so close minded. For fear of judgment, I would not seek that out. But it's such a large part of the services we have a here, so it eliminates a lot of the options. So 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.

In addition to managing the rural acceptance of mental health issues, accessing services can also be a hindrance. As with most professional services, insurance of the client commonly dictates possibilities for care. However, once those options are narrowed due to insurance, clients have even less 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.

> Christina: 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 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, answering subquestion 3 related to factors leading affecting future help-seeking. If clients felt that their sexual orientation was adequately acknowledged and accepted, even if the therapist had minimal experience working with nonheterosexual 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", as explained by Christina. At times this rejection would increase mental health symptomology, as identified by Rachel, "sending me half-way back into the closet or into a really negative headspace."

Discrepancy within this theme. While the theme related to negative therapeutic experiences was discussed above, with all participants indicating that they had negative experiences with therapy or therapeutic interaction, there were individuals who were in current therapeutic relationships that they identified as positive. These experiences were different primarily due to the interaction and investment of the therapist.

> Annie: Recently I started counseling at a new place and it's been a lot of help just with anxiety and depression. Like I can actually talk. I feel like it's more open because she's actually talking to me. She responds with actual conversation, like she's invested. Her being invested puts me at ease. it's nice to know that someone cares enough to remember details of my life.

This indicates that while her previous experiences have been significantly negative, there are still positive relationships that can occur, and ways in which an individual can receive what they perceive to be a supportive connection.

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. This theme relates to my research question with relation to help-seeking experiences overall, but specifically expands on the subquestion 2: What are the factors related to positive and negative experiences of help-seeking? Within this subquestion, individuals identified a myriad of negative experiences, but followed those reports with ways that the therapeutic experiences could have been more effective or how they could have felt more validated. In addition, subquestion 3: Factors that influenced future help-seeking, sparked individuals to identify positive improvements that would influence their willingness to continue to seek help. Suggestions for improvement were as follows:

- Adding additional demographic information on intake forms to include nonheterosexual orientation

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

Addressing these issues would make a difference in participant’s comfort level when seeking help at an agency in rural Northern Michigan, Rachel states:

> I feel like it's necessary if counselors in the beginning could advertise or have that flag or the equality symbol, so it's just an automatic sigh of relief. And then it really would make a hell of a difference and it would just take away so many anxieties and just open people up and then they could be more comfortable. I think it would just be really cool if even if the counselors you know collectively in northern Michigan came up with their own symbol, or their own way to communicate a safe space.

Annie discusses 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:

Annie: Stop acting afraid to talk about it. Find ways to break the ice and bring it up in a way that we don't assume it's an issue… but at least provide the safe space to acknowledge it and discuss it if it is.

Summary

In this chapter, I provided a summary and report of the findings from the collected survey data of 10 volunteers recruited to participate in this study. Each individual met specific criteria for participation and completed both a 45-90 minute initial interview as well as a follow-up 30 minute interview. Interviews were transcribed and coded using thematic analysis to group multiple nodes and phrases into key themes. Three primary themes emerged from the data: Reasons for seeking mental health help, experiences of help-seeking, and suggestions for improvement. It was revealed through this process that individuals seeking treatment, were doing so due to a substantial amount of pervasive minority stress and both distal stressors and proximal stress processes. Once clinical services were sought, these individuals experienced multiple instances of rejection, avoidance, and passivity related to their nonheterosexual orientation. Often participants described a lack of validation and affirmation. Participants also provided suggestions for how clinicians in this area can improve service provision and ways that agencies as a whole can be more "friendly" to this demographic.

In the following chapter, I will discuss how these findings can be interpreted through the lens of the conceptual framework, and how the findings connect to the

existing literature. In addition, I will discuss the limitations of the study and recommendations for implementation of the findings and future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative, single case study was to explore help-seeking of LGB individuals in rural Northern Michigan. I used a qualitative, single case-study design, where the case being examined was the bounded system of the geographical location. Specifically, I focused on generating meaning, understanding of motivations, and experiences of help-seeking for 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 bring a rich description of the population and the needs, specifically because qualitative research focuses on generating meaning and understanding through rich description (Merriam, 2009). It was essential to capture the participants' perceptions of minority stress and to allow them to discuss their experiences with help- seeking with respect to their location, their minority status, and their mental health. The study was comprised of in-depth, semi structured interviews with 10 LGB individuals who sought out clinical intervention for self-identified or professionally identified mental health or substance abuse issues. Interview data were then coded and analyzed using thematic analysis to identify common issues and themes within the group. The comprehensive data were analyzed and interpreted to provide rich and valid, understand of the experiences of LGB individuals with rural mental health services. Using qualitative data collection and analysis I was able to gain a richer and deeper understanding of the participants (Creswell, 2013).

The literature indicated that LGB individuals commonly have an increase in mental health symptomology overall (Peltzer & Pengpid, 2016); they also have a more difficult time accessing affirming mental health care in rural areas (Calton, Cattaneo, & Gebhard, 2016). The results of this study reflected this literature, indicating a perception of increased stress and symptomology due to pervasive minority stress and microaggression. In addition, the increase in symptomology, where one would assume an increased desire for seeking mental health help, was hindered by concern about appropriate and affirming options for clinical care.

Interpretation of the Findings

The findings of this research study confirm the knowledge that has been found in the previous research on LGB experiences in rural areas, especially related to mental health. However, the findings also extend beyond previous research to incorporate the struggle between the rural location increasing the perception of need for mental health intervention, but also including the inherent hesitancy to get help due to the rural demographic. The main research question will be discussed below, woven together with the published literature. The subquestions and themes discovered are interconnected, with one theme being identified as contributing to or correlating to another theme, which is consistent with Bronfenbrenner's theory of systems and connection (Brofenbrenner & Ceci, 1994). Therefore, the themes will be discussed separately, but then discussed as a larger system, providing a thick description of the findings and discussion of implications.

Experiences Seeking Services

The main research question for this study is: What are the experiences of LGB individuals who sought clinical intervention for mental health or substance abuse services in rural Northern Michigan? Little research has been found pertaining to LGB individuals in Michigan, and no research has been found that directly pertains to this particular demographic area with this specific population. In this rural area, clinical mental health and substance abuse services are limited based on several factors not specifically pertaining to LGB individuals. Literature suggests that the acceptance of treatment for mental health issues by rural residents is often hindered by stigma, cultural beliefs, and the tendency for rural residents to value self-reliance or a reliance on faith-based services versus clinical social work or counseling services (Zellmer & Anderson-Meger, 2011; Cooper-Patrick & Powell, 1997). Huttlinger, Schaller-Ayers, and Lawson (2004) found that at least one-third of their respondents reported managing their mental health symptoms at home and not seeking treatment at all.

Initial help-seeking can be especially difficult for members of the LGB community, as stigma is already a social issue that is on the forefront within the rural community due to the minority status (Swank, Fahs, & Frost, 2013). Therefore, adding the additional minority stress of a mental health need, individuals may be even more adversely affected. In addition to a limited pool of resources in this area, the overall political and religious nature common to rural midwestern areas (Whitehead, Shaver, & Stephenson, 2016) is reportedly present and can affect individual's experiences within the

community at large. Perceptions of social ostracism and minority stress were reported by every participant. Most participants even stated that minority stress, social rejection, and overt systematic prejudice were experienced regularly. Participants reported that this daily stress significantly impacted their mental health, with reports of nightmares, hypervigilance, flashbacks to previous negative interactions, and affected their personal relationships with others. In relation with Meyer's minority stress theory (MST), pervasive distal stressors, such as micro-aggression and social rejection and prejudice, leads to internal processing of those negative messages – resulting in proximal stress processes (Meyer, 2013). These proximal stressors could include an increase in negative cognitions related to self-esteem and exacerbate pre-existing mental health symptomology, creating an environment that is inherently traumatic to live in (Robinson & Rubin, 2016). This was reported repeatedly within the interviews, with some participants expanding on this idea and transitioning into anecdotal expressions of trauma. This trauma, as defined by the participant, was expressed as a direct result of living in this rural area with daily minority stress, micro-aggression, and prejudicial behaviors. Annie reports how living in this area has affected her mental health, as related to minority stress:

> Living here... its rough. It makes my anxiety and depression bad. Always having to watch what I say or do... it makes me so paranoid. I am constantly jumping and looking over my shoulder. I've had nightmares about getting hurt or killed because of my sexual orientation. Every day I limit a little more of myself so that

> I can feel safer. I've had to go on medication because the panic attacks I have now are so bad, I can hardly function at work. Its traumatic just to exist here.

In addition to feeling unsafe in the community, systematic rejection does not promote confidence in help-seeking for LGB individuals. Participants expressed concern related to seeking a therapist after many bad experiences with other community professionals, including schools, employers, and the medical field. The ecological systems perspective, established by Bronfenbrenner (1994), is a way of seeing case phenomena (the person and the environment) in their interconnected and multilayered reality, to order and comprehend complexity, and avoid oversimplification and reductionism related to heavy emphasis on either the person or the environment (Lea, Wit, & Reynolds, 2014). This perspective, postulates the way of placing conceptual boundaries around cases to provide limits and define the parameters of practice with individuals, families, groups, and communities (Bronfenbrenner, 1994). The use of this perspective allowed me to examine the participants as a member of a larger system, interconnected and multilayered. Within the parameters of a rural community and the multiple players that encompass that system, including: school systems, religious systems, local governments and businesses, there are several contributing factors and roles that each component plays in the transactional relationship. By examining the system as a whole, the perceived impact of the rural community and all that that encompasses, the social supports of the individual, the available resources for that individual, and other systematic components, allowed me to better understand the

ongoing systematic rejection that these individuals face daily. In addition, within the rural community and the typically conservative nature therein, there was a major impact of the environment on the LGB individual, impacting their desire to obtain help for their identified issues, or potentially having difficult help-seeking experiences overall (Scala, Johnson, & Rogers, 2015).

Once help was sought by participants, there was a consensus of avoidance, passivity, or rejection related to sexual orientation, as discussed in Chapter 4. Most participants were met with therapists who did not inquire as to sexual orientation or relationship status at all. However, if they were asked about relationship status, it was assumed that they were involved in a heterosexual relationship. This assumption put a strain on the initial intake process, at times creating hesitancy to disclose information to therapists, for fear of judgement or fear that systematic rural-based hetero-normative belief systems would be infused in this therapeutic relationship as it had been in previous community-based services. Participants who had had previously negative experiences reported more hesitancy to seek services again, even if stressors or symptoms had increased.

Identifying as a member of the Lesbian, Gay or Bisexual population and experiences associated with that identification can vary based on geography (Swank, Fahs, & Frost, 2013). Studies have indicated that individuals that have resided in rural areas are more likely to have experienced homophobic statements (Swank et al., 2013), property damage, employment discrimination (Tilcsik, 2011), housing discrimination,

and physical assaults (Poon & Saewyc, 2009; Swank, Frost, and Fahs, 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 (Feinstein, Goldfried, & Davila, 2012). These stressors then increase individual's identified need for mental health help. However, due to the inerrant nature of the community dynamic, several barriers to services can be identified. Identification if practitioners who are affirming and "gay-friendly" has been reportedly difficult in this area. There are no networks of affirming or "gay-friendly" businesses or websites that indicate vetted organizations. Typically, word-of-mouth related to other's experiences is the most commonly used way for others who need help to locate a practitioner or other professional who will be a good fit. Even if another individual is able to provide a good reference, the expansive rural location is difficult to traverse if there is concern for financial means or transportation issues. In addition, as mentioned above, insurance coverage also dictates who patients can see for clinical intervention.

This rural location also houses many agencies that are religiously based, meaning that there is a concern for initial judgement or fear of an ill-fitting therapeutic relationship before the initial intake even takes place. Sarah refers to this, stating:

> I have steered clear of getting help so many times because of what my insurance dictates the options of what's in the area. A lot of times the only options are Catholic human services or Lutheran social services, or something church based.

> So, you already know that there is going to be in nonacceptance of what your major areas or issues are. So you're in there once or twice and you already know you're not going to get a connection with them because you can't really get at the heart of what's there… So the door is already half closed.

These major themes related to the research questions are consistent with the merging of Meyer's minority stress theory and Bronfenbrenner's systems theory. The combination of systematic rejection as a form of minority stress reportedly contributed to the incidence of pervasive and anecdotally problematic proximal stress processes. Participants identified that these proximal stress processes both contributed to existing mental health issues or created mental health symptomology and traumatic reactions. The traumatic reactions were primarily described as being based on rural location and hetero-normative immersion. This contributed to participant's initial reasoning for help-seeking, but also influenced individual's willingness to seek help and proved to be a major barrier in help-acquisition. Furthermore, once help was acquired, participants were met with avoidance or passivity related their sexual orientation and a general lack of validation or affirmation was reported. In some cases this lack of validation promoted a reluctance for future help-seeking.

Conceptual Framework

This research study used Meyer's minority stress theory and Bronfenbrenner's ecological systems theory. While analyzing the data and findings through the theoretical lens of those theories, I was able to see commonalities related to the systematic issues

(Bronfenbrenner) and stressors (Meyer) that residence in this rural location can perpetuate reports of negative experiences and negative cognitions. These cognitions and experiences can anecdotally produce an unstable sense of safety and belonging, which participants have reported then contributed to increased mental health symptoms and a lack of faith in the neutrality of mental health practitioners. This hesitancy to obtain help, led to an increase in untreated symptoms, which has been found in earlier literature (Calton, Cattaneo, & Gebhard, 2016). Once help was sought, participants reported additional accounts of stress, rejection, and lack of affirmation overall. This lead to reports of ineffective therapeutic alliances and a perpetuation of presenting symptoms, as well as hesitancy seeking help in the future. Noting this systemic rejection and multisystem minority stress or microaggression, individuals reported several ways that their therapeutic experiences could have been improved. These suggestions varied in system level, some suggestions being more global (increased social acceptance), mezzo-level suggestions (increased agency-wide training, LGB affirming policy development, and visible symbols on recruitment or advertising materials), and micro-level changes to clinician attitudes, clinician questioning process, and inclusivity training.

Limitations of the Study

Limitations of the study include a small sample size and vested interest of participation by the use of recruited volunteers. I was able to recruit a variety of participants, based on age, sexual orientation, relationship status, length of time living in this area, and amount of time spent in therapy or number of therapists seen. Most

individuals had at least one very negative therapeutic experience, which could indicate that those participants may have had a motivation of participation that involved expressing their negative experiences. However, three of the participants also had some elements of positive experiences that they shared with me, allowing me to further expand on their reports of positive therapeutic qualities. This discrepant case data were discussed in Chapter 4, but the presentation of this data could suggest that there is not a singular way in which to interpret the data. Meaning, that one could focus singularly on the positive experiences within the experiences, and further studies could be done to extrapolate only those positive traits and qualities. This will be discussed more in the recommendations section below.

Given the small sample size, the eight-county area, and the diversity of the sample, the findings are transferable only to similar areas with like population composition. The sampled area is comprised of a population that is predominantly Caucasian, lower-mid socioeconomic status, politically conservative, and has a strong faith-base. Therefore, information from this study may be compared to similar areas or areas that have a similar demographic composition. However, these results may not necessarily be transferable to areas that are predominantly urban, politically liberal, or areas with a more diverse racial/ethnic composition, as stressors, acceptance, and available supports may be inherently different.

As case studies typically use multiple data sources for purposes of triangulation, and only a single data source was used, triangulation occurred by comparing the first

interview of the participant with the second interview, thereby confirming I had both accurate information and understanding. In addition, the findings and analysis were compared to previous literature to determine if the themes were in agreement with previous literature. Finally, the data were interpreted using the conceptual framework selected. This multidimensional triangulation approach allowed for cross-validation of data as well as looking at the singular data set from multiple dimensions.

Lastly, while I had initially intended to interview individuals who has received professional treatment for either/or/both mental health and substance abuse treatment, no participants volunteered that were exclusively treated for substance abuse. While some interviewed participants indicated the use of substances, they attributed the use to maladaptive coping with larger issues related to mental health concerns. Therefore, as there were no participants who were exclusively treated for substance abuse services, the findings of this study may not be able to be as transferable or applicable to other areas with similar demographics related to substance abuse help-seeking.

Recommendations

This study's initial focus did not intend to include reasonings behind seeking therapeutic intervention, however, this theme presented itself in an emergent way. Additional research recommendations would include: studies related to help-seeing rationale, as motivations for seeking help in rural locations is a topic of research that is minimally studied in this specific area. In asking questions related to help-seeking, individuals presented a significant exposure to distal stressors. This appearance and long-

term effects of distal stressors is an area of research that has not been explored in this rural location, and exploration of how these distal stressors effect individuals in general could assist in furthering awareness of needs of service provision, as well as needs of community supports. Also, implications that consistent minority stress, micro aggressions, and rural locale contribute to increased mental health symptomology, including symptoms of trauma-exposure, and viewing residence in a rural location as a potentially "traumatic" experience as reported by the participants would be a further recommendation.

In addition to further examination of the LGB population, a further study that includes focus groups of providers to gain more insight into perceptions of care, perceptions of awareness or preparedness for working with the LGB population could provide increased knowledge related to this topic as well.

Implications for Positive Social Change

The results of this study can provide several implications for positive social change. Specifically, increased awareness of the distal stressors experienced by the participants can allow individual therapists in the area to translate that awareness to improvement of their therapeutic techniques. These techniques include, asking questions specific to the distal stressors experienced, asking questions related to how those stressors have been internalized of affected the client specifically, and how those stressors contribute to mental health symptomology.

Therapeutic relationship building is imperative to a quality experience with help-seeking (Rizvi, 2016). The participants of this study indicated that not feeling welcomed or affirmed related to their sexual orientation was a major factor in their experiences with help-seeking and the ability for them to build a trusting relationship with their therapist. In addition, it affected their willingness to continue attending therapy or seeking therapy in the future if they had a negative experience with a previous therapist. This study could increase knowledge and awareness for therapists in this area, by understanding that their interactions with LGB clients related to affirming and welcoming responses to disclosure of sexual orientation can directly influence the effectiveness of the therapeutic experience.

From an organizational standpoint, the results of this study could lend awareness to local agencies and companies related to the need for further education and training related to acceptance, affirmation, and support for LGB individuals. The participants of this study indicated that there were at times agency-wide rejection or "set-up for lack of acceptance" when forms did not specifically allow for options related to nonheterosexual relationship status. Also, participants indicated that at times they were not clear as to the agency standpoint on nonheterosexual relationships, and not knowing that created an initial feeling of uneasiness or fear of rejection prior to initial appointments. They indicated that making a statement on the agency's website or advertising materials which indicates acceptance of all clients would assuage those fears. Participants also indicated that at times they were deterred from accessing services due to the names of clinics or the

religious affiliation of agencies. While agencies may have religious affiliation, which may or may not include specific policies or stances on nonheterosexual relationships, the individual therapists employed within those agencies still have the ability to be sensitive and affirming to LGB clients.

From a political or societal standpoint, the potential impact of positive social change comes in community-wide awareness of how these LGB individuals perceive being treated, the experiences they have had, and the effects that those experiences have on their individual lives. Some individuals report that simply living in this area of political conservativism and hetero-normativity brings an increased sense of inherent rejection. These chronic feelings of rejection, combined with the reports of minority stress and microaggressions manifest into insidious trauma exposure which can perpetuate pre-existing mental health symptomology and proximal stress reactions, as well as promote new mental health symptomology. As a community, increased awareness and the ability for community inclusion, support, and affirmation can assist these individuals in feeling more connected, supported, and decrease feelings of rejection. Providing these LGB individuals with a safe and affirming community, whether it be a community center, a series of support groups, or changing the dynamic of acceptance throughout the community, can decrease those reported feelings of alienation and thereby combating those experiences of microaggressions or proximal stress reactions.

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 and substance abuse 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 nonheterosexual relationships. 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 participants then sought out treatment from clinical mental health professionals in their community. Throughout the help-seeking and treatment, participants reported feelings of continued rejection, a lack of validation, and avoidance or dismissal of their nonheterosexual status. 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 LGB individuals by increasing awareness, increasing education related to affirmation of the experiences LGB individuals, and providing a safe and welcoming community of acceptance for LGB individuals in rural northern Michigan.

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Appendix A

PARTICIPANT RECRUITMENT ANNOUNCEMENT

Seeking volunteers to participate in a study that examines the help-seeking experiences of LGB individuals in Northern Michigan. Criteria for participation:

- Participant is over the age of 18,
- Who are or have been seen for mental health or substance abuse counseling in Northern Michigan, and
- Who self-identify as a sexual minority, which may include but is not limited to: gay, lesbian, queer, pansexual, or bisexual at the time of the interview. This identification can include thoughts, feelings, attractions, behaviors, affections, and/or relationships.

The goal of this study is to understand and describe help-seeking experiences for mental health and substance abuse among the LGB population in rural Northern Michigan.

Participants will be asked to:

- Take part in an initial 1-1.5 hour audio-recorded interview about your experiences with help-seeking and counseling. Interviews can be in-person, by phone or video-conference (i.e., Skype).
- Participate in ½-hour follow-up phone interview within 30 days of the initial interview.

Participation is completely voluntarily and participants may withdraw from the study at any time.

The researcher is a PhD candidate at Walden University's College of Social Work and Human Services and is conducting this research for her dissertation. Research may also be used for future publications. The researcher is currently a therapist in Northern Michigan and identifies as bisexual. She is seeking to better understand the experiences of this population and the services they have received.

Appendix B: 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 (nonprofessional).

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?