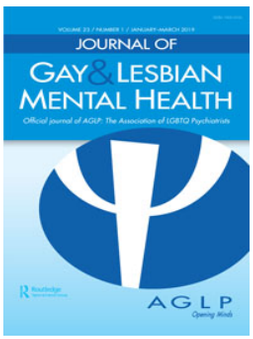

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"There's a stopgap in the conversation": LGBTQ + mental health care and community connection in a semi-rural county

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ABSTRACT

Introduction: LGBTQ + people face barriers accessing affirming mental health care in semi-rural communities. Little research has addressed the unique barriers, needs, and experiences of LGBTQ + communities, including the intersection of factors including community connectedness that may buffer distress.

Method: This qualitative study comprised focus groups of LGBTQ + youth and adults living in a semi-rural county.

Result: Thematic analysis identified six themes and sixteen subthemes focused on experiences in the local community and with mental health providers.

Conclusion: Living in a semi-rural community may impose additional barriers to receiving affirming care and building necessary supportive community networks for LGBTQ + people.

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Research repeatedly finds higher rates of psychological distress and mental health disorders in lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) communities (Cochran et al., 2003; Meyer, 2003; Mustanski et al., 2010). Sexuality diverse people are at greater risk for lifetime suicide attempts (King et al., 2008), panic disorders (Cochran et al., 2003), depression, anxiety, alcohol use, and substance use (Cochran et al., 2003; King et al., 2008). Psychological distress is additionally elevated among transgender communities (Mustanski et al., 2010; McNair & Bush, 2016). The mental health disparities between LGBTQ + communities and cisgender, heterosexual populations are commonly understood in the context of minority stress theory (Meyer, 2003), a framework that attributes disparities in psychological health outcomes to societal stressors (e.g., stereotyping,

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prejudice, and discrimination) and internal stressors (e.g., internalized stigma, identity concealment, self-isolation).

Living in rural areas may compound the mental health concerns that LGBTQ + people face (Holt et al., 2020; Horvath et al., 2014; Koch & Knutson, 2016). For example, rural LGBTQ + people report higher usage of tobacco, alcohol, and other drugs, and higher rates of depression, suicidal ideation, and suicidal attempts when compared to their urban counterparts (Rosenkrantz et al., 2017). Furthermore, LGBTQ + people living in rural areas may face unique barriers to seeking and accessing affirming mental health services, preventing these communities from receiving necessary treatment (Barefoot et al., 2015; Currin et al., 2018). Barriers to seeking and receiving support services include prior negative experiences with mental health providers, fear of treatment, stigma, and being refused care (Moore, 2002; Rosenkrantz et al., 2017; Whitehead et al., 2016). Additional barriers faced in small towns and rural communities may include insufficient transportation, high cost of services, lack of affirming providers, and inadequate LGBTQ + social networks (Horvath et al., 2014). Exacerbating these disparities, rural LGBTQ + people may experience increased exposure to proximal and distal minority stressors such as increased discrimination and victimization and less comfort disclosing sexual or gender identities, perceived social support, and identification and involvement with LGBTQ + communities than their non-rural counterparts (Rickard & Yancey, 2018).

However, there is risk in the singular narrative that rural towns and communities are always dangerous for LGBTQ + people (Oswald & Culton, 2003) and deleterious to their mental health. Positive perceptions about being LGBTQ + in rural communities have included more close relationships, high quality of life, and stronger LGBTQ + social networks (Oswald & Culton, 2003). As prior research has identified community connectedness as a protective factor for mental wellness among LGBTQ + communities (Craney et al., 2018; Jackson, 2017), supportive community may be a key mechanism by which LGBTQ + people and communities cope with discrimination and structural barriers to receiving needed care. It is imperative that research investigates the manifestations of supportive communities among LGBTQ + people living in small towns to better understand the roles of these communities in buffering against minority stressors. More nuanced explorations are needed about specific communities' experiences with mental health care, barriers to accessing care, and community connectedness.

The present study consisted of a focus groups as part of a behavioral health department-funded community-based participatory research (CBPR; Hacker, 2013; Northridge et al., 2007) needs assessment exploring mental

health experiences, barriers to care, and service needs of LGBTQ + people in a semi-rural coastal California county. This region is characterized by the presence of several liberal-leaning small cities and towns surrounded by conservative-leaning communities. Agriculture, tourism, and a large state university drive much of the local economy. Residents primarily include college students, older adults, and retirees, that primarily identify as White, non-Hispanic, or Latinx. Although specific identity groups within the broader LGBTQ + community may face unique barriers to care (Whitehead et al., 2016), the present study was inclusive of all LGBTQ + community members because LGBTQ + people also often confront common stressors and barriers to help-seeking (e.g., hesitation to come out to providers, non-affirming resources; Hackman et al., 2020). We utilized thematic analysis to explore three main research questions: (1) What are the barriers, experiences, and services needs influencing LGBTQ + mental health in a semi-rural area? (2) What are the social and community-level factors influencing mental health and wellness? and (3) What changes are needed to better support LGBTQ + mental health and wellness in a small town and semi-rural setting?

Method

Participants

Participants included 34 LGBTQ + youth and adults living in a semi-rural county in California. Participants ranged in age from 14 to 72 years old ($M = 35.5$; see Table 1 for demographics). Participants selected all identity labels that applied to them in each category from a list of gender identities, sexual orientations (e.g., bisexual and pansexual), and racial/ethnic identities. Nearly half identified as transgender or non-binary (48%; $n = 18$) and more than half of the participants identified as women (56%; $n = 19$). Approximately one-third identified as lesbian (29%; $n = 10$), queer (29%; $n = 10$), gay (26%; $n = 9$), or pansexual (24%; $n = 8$). The majority of participants (70%; $n = 24$) identified as White.

Procedure

Methodology

Using a community-based participatory research approach (CBPR; Hacker, 2013; Northridge et al., 2007), several LGBTQ + community members and consumers of mental health services served as collaborators and stakeholders throughout the development of the project, including participant recruitment, data collection, data analysis, and the dissemination of results. LGBTQ + activists and consumers of mental health services identified a

Table 1. Participant demographics.

	%	Number of Participants
Gender Identity		
Man	26%	9
Woman	56%	19
Transgender man	12%	4
Transgender woman	12%	4
Genderqueer/Non-binary/Gender nonconforming	24%	8
Sexual Orientation		
Heterosexual	3%	1
Gay	26%	9
Lesbian	30%	10
Bisexual	15%	5
Pansexual	24%	8
Queer	9%	3
Questioning or unsure	3%	1
Some other sexual orientation	12%	4
Racial/Ethnic Identity		
Asian/Asian American	9%	3
Latinx/Hispanic	9%	3
Native American	3%	1
White/European American	70%	24
Biracial/multiracial	9%	3
Education		
Less than high school/secondary school	6%	2
Some high school, no diploma or GED	9%	3
Some college, no degree	26%	9
Associate/occupational/vocational degree	15%	5
Bachelor's degree	12%	4
Some graduate work, no graduate degree	3%	1
Master's degree	26%	9
Professional degree	3%	1

Note. Participants were given the option to select all gender identities, sexual orientations, and racial identities that applied to them, and thus the sum of the participants across gender identities and sexual orientations is greater than the sum of participants ($N = 34$) in the study.

need for better LGBTQ + mental health care in their semi-rural community and asked the first author to support their goals. Repeated conversations led to the present study, a community-driven assessment of the local mental health needs, barriers to care, and support services for LGBTQ + community members. The researchers and stakeholders developed collaborations with behavioral health organizations, community organizations, and other LGBTQ + community leaders. Biweekly or monthly meetings throughout the course of the project helped to clarify the research goals and questions, outreach to participants, and plans to disseminate the results to the community for action planning.

Data collection

The study was approved by a university institutional review board (IRB). Participants were recruited through purposive and snowball sampling methods online and in-person. Eligible participants (i.e., those who identified as LGBTQ+, were at least 14 years of age, and lived in the locality) were recruited through social media and research team outreach at

community events and support groups hosted by local LGBTQ + organizations, mental health agencies, and public schools (e.g., gay-straight alliance meetings). Further, the stakeholders and research team promoted the study by posting flyers at businesses and public locations throughout the county. Additionally, all who participated in a co-occurring online survey as part of a county-wide LGBTQ + needs assessment had the opportunity to sign-up for a focus group via an online form.

Eligible participants who completed the focus group interest form were contacted to schedule their participation in one of six focus groups. The focus groups included a gay men's group, a lesbian women's group, a transgender people's group, a bisexual/pansexual/asexual/queer people's group, and two mixed identity groups (one for adults and one for youth aged 14-17 years old). This configuration facilitated group members' discussions of topics, issues, and concerns that were relevant to their identities and experiences. For example, a transgender participant might have felt most comfortable discussing cissexism with other transgender people. As LGBTQ + people may hold multiple marginalized identities, adult participants were encouraged to choose the focus group in which they most wanted to participate. To protect the safety and comfort of youth participants, and at the request of the IRB, all youth participants took part in the youth-specific focus group. Youth participants were not required to obtain parental informed consent as LGBTQ + youth may not be out to their parents or guardians and requiring parental consent may put youth at risk (Fisher & Mustanski, 2014). Youth were included in the study because of the minimal risk to participating and potential direct benefits to participants through the amelioration of the very health care services they may receive in the future (Rew et al., 2000).

Given the small town, semi-rural nature of this community, we anticipated that some members of the research team may have known some of the participants. To minimize participant discomfort, participants were aware of the lead researcher's involvement in each of the focus groups and research assistants excused themselves from note-taking in the focus groups in which they knew a participant.

The six focus group interviews took place at three locations across the county that were selected to maximize privacy, comfort, and accessibility. These locations included a local mental nonprofit organization with offices in two towns and a local LGBTQ + organization with a private conference room. The first author, a licensed counseling psychologist, facilitated the focus groups and followed a semi-structured interview script loosely adapted from previous qualitative LGBTQ + research (Hackman et al., 2020). The questions used were developed specifically for this study and in consultation with stakeholders. The interview script included questions

about experiences within the local community (e.g., "What are your general perceptions of being a member of the LGBTQ + community in [the county]?"), positive and negative experiences with mental health professionals (MHP; "What are some of the negative experiences you have had with mental health providers in [the county]?"), barriers to care (e.g., "What might be the barriers to seeking or receiving mental health care in [the county] for the LGBTQ community?"), and the mental health support services needed across the county ("What can [the county] do to better support the mental health and wellness of the LGBTQ community?"; see Appendix A). At the beginning and end of each focus group, participants were asked to keep the content of the discussion confidential to protect each other's privacy. At the conclusion of each focus group, participants were given a debriefing form and a list of local and national mental health and LGBTQ + resources and were compensated a $25 gift card.

Data analysis

The research team transcribed, de-identified, and coded the focus group data using thematic analysis (Braun & Clarke, 2006) and the qualitative software program Dedoose. The thematic analysis was conducted using a deductive approach to explore themes related to the research questions and a semantic approach to analyze the explicit meanings of the data (Braun & Clarke, 2006). Audio recordings were transcribed by research team members and audited by a different team member to ensure accuracy. After research team members developed familiarity with the data corpus, they compiled notes on the aggregate data as an initial step in identifying themes. The research team then met to merge brainstormed ideas into the first draft of the codebook. Research team members coded the transcripts using the draft codebook in Dedoose. A different research assistant then audited each initial transcript coding, with the auditing pairs staggered such that no two transcripts were coded and audited by the same pair of research team members. Throughout the coding and auditing stages, research team members suggested changes to the draft codebook that were discussed to consensus.

Upon initial development of the main themes and subthemes within the draft codebook, the research team reviewed the codebook a second time for clarity. In this process, the team revisited the data, renamed, added, or split subthemes to more accurately capture the nuances in the data. These preliminary results were shared with stakeholders and community members to explore their thoughts about the coding structure. When all authors reached consensus for all themes and subthemes, the final coding structure was considered complete. Once the codes were finalized, the results were written into a report and presented online and via social media.

Table 2. Mental health care perceptions and experiences themes and subthemes.

Conditional Feelings of Safety	1. Conditional feelings of safety based on identity and presentation
	2. Conditional feelings of safety based on location
Supportive LGBTQ + Space and Community	1. Importance of supportive formal meetings and spaces
	2. Importance of supportive informal hangout spaces
	3. Importance of social support
	4. Lack of cohesion in LGBTQ + community
Barriers to Accessing Mental Health Care	1. Financial issues
	2. Mental health stigma
	3. Not knowing how to find or access mental health care
	4. Lack of LGBTQ + affirming providers
Negative Experiences with Mental Health Providers and Systems	1. Mental health providers lack LGBTQ + competence
	2. Structural issues with mental health organizations
Positive Experiences with Mental Health Providers	1. Providers are knowledgeable and affirming of LGBTQ + people
	2. Providers show humility, openness, and interest in learning
Experiences and Perceptions Specific to Transgender Community Members	1. Experiences within the community
	2. Providers lack knowledge about issues relevent to transgender clients

Infographics from this data were created and used as part of a resource distribution effort for mental health providers and local LGBTQ + community members. The results and recommendations for action were also presented to LGBTQ + townhalls, during listening sessions, for LGBTQ + community organizations, county government, and mental health providers and organizations. A #Out4MentalHealth taskforce worked alongside this project to develop a strategic plan to improve LGBTQ + mental health in the local community and utilized the data, community voices, and a stakeholder approach to continue moving the results into action.

In terms of positionality for this project (Bourke, 2014), one author is a professor at a state university in a semi-rural small town, two are graduates of the state university, and one is a current student at the same university. One author identifies as a non-binary transmasculine person and three identify as cisgender women. Two authors identify as queer, one identifies as pansexual, and one as heterosexual. Two identify as biracial (Latinx or Hispanic and White) and two identify as White.

The researchers took various steps to ensure the trustworthiness of the findings (Morrow, 2005). To enhance credibility, the researchers took field notes during the focus groups and peer researchers consulted with each other regularly to improve coding. Dependability was addressed by maintaining an audit trail via records of meeting notes, emerging themes, and coding decisions, as well as data collection, analysis, and interpretation.

Results

Thematic analysis resulted in six major themes and sixteen subthemes. We did not approach thematic analysis with the intention of identifying differences across focus groups, and instead we observed commonalities (i.e., themes). Table 2 shows the organization of these themes and associated subthemes. The themes included (a) Conditional Feelings of Safety, (b) Supportive LGBTQ + Space and Community, (c) Barriers to Accessing Mental Health Care (d) Negative Experiences with Mental Health Providers and Systems, (e) Positive Experiences with Mental Health Providers, and (f) Experiences and Perceptions Specific to Transgender Community Members. Quotes from participants were edited lightly for clarity, including removal of filler words or phrases (e.g., "like" and "um").

Theme: Conditional feelings of safety

Participants were open in sharing their personal experiences within the county. While some reported feeling safe in certain spaces, others expressed significant concern about safety. Participants reported conditional feelings of safety both *based on identity and presentation* and *based on location.*

Subtheme: Conditional feelings of safety based on identity and presentation

Some participants expressed that they did not always feel safe in public spaces throughout the county, depending on their identities and their physical presentation of gender identity and sexual orientation. Specifically, several participants who identified as transgender or presented as gender nonconforming conveyed fear in expressing their gender identities. One participant stated, "Sometimes I'm a little anxious about wearing my skirt somewhere where it seems very cis-expressive … that's a little nerve-wracking." Other participants reported that they did not feel comfortable and safe expressing their sexual orientation, such as holding hands with a same-gender partner or even disclosing their identity to coworkers and acquaintances. On the other hand, a few participants reported feeling safe to express their identities, with one stating, "I feel safe; that is, I feel physically safe with regard to my sexual orientation." Participants also noted a distinction between physical "safety" and "comfort." As one noted, "Not in every circumstance would I feel comfortable … making a loud declaration of bisexuality."

Subtheme: Conditional feelings of safety based on location

Although some participants reported feeling safe to express their identities, participants emphasized that perceived safety was strongly tied to location

within the county. Many shared the belief that the semi-rural nature of the county lent to feeling unsafe expressing their identities in their home communities. For example, some stated that they felt less "freedom" in their identity expression within the county compared to urban settings. Another expressed that the county is not as open-minded as some may perceive it to be, stating, "if you're comparing this area to the Bible Belt or something, amazing … But anywhere else it's kind of like we're still in the boonies." Participants in several groups shared that their work environments were not safe spaces to be out about their sexual orientation or gender identity. One participant stated,

> I think it has a lot to do with your workplace. I mean, that's where you encounter so much of the pressure to disclose or not disclose, or talk about these things, or [wonder], am I going to respond to that weird comment or just let it go?

Although participants felt unsafe expressing their identities in more rural and politically conservative areas of the county, many also felt wary in the more populous towns. One participant expressed, "You still get crawly creatures up your back when you see some people—you worry about even walking downtown … after dark, especially at bar closings."

Theme: Supportive LGBTQ + space and community

In each focus group, participants emphasized the centrality of supportive LGBTQ + spaces and community to their well-being or expressed a longing for more LGBTQ + supportive spaces and opportunities to build LGBTQ + community within their localities. In all groups, participants spoke about the *importance of supportive formal meetings and spaces,* the *importance of informal hangout spaces,* stressed the *importance of social support,* and described a *lack of cohesion in the LGBTQ + community.*

Subtheme: Importance of supportive formal meetings and spaces

Participants continually stated a need for structured supportive meetings tailored to LGBTQ + people. Proposed formal meetings took a variety of forms, including support groups for women who are in the process of coming out, identity specific mixers, and wrap groups. One participant said that he wanted to see the creation of more support groups, to have a place to go and have somebody reflect back to him, "That's okay that you feel that way," or, "Yeah, I've had that feeling, too. Here's how I've dealt with it." Participants in the LGBTQ + youth focus group stressed that for them, social support often came from supportive teachers, a safe space for a gay-straight alliance, and access to other youth specific LGBTQ + groups and spaces. Some reported benefiting from existing meetings but stressed that

these support groups congregate too infrequently to meet the community's needs. For example, one participant in the youth focus group stated that she feels "cut off" from sources of community support in between the youth LGBTQ + support group meetings. Overall, participants agreed that their communities would benefit from having more supportive formal meetings and spaces.

Subtheme: Importance of supportive informal hangout spaces

Participants also repeatedly referenced a strong want or need for casual spaces where LGBTQ + people could meet new LGBTQ + friends, congregate informally, and enjoy the company of others who share their identities. Participants proposed several ideas, including gay bars and LGBTQ + coffee shops; however, members of some focus groups felt more comfortable than others with the idea of a gay bar. While participants in the gay men's focus group believed that a gay bar would benefit the LGBTQ + community, members of the bisexual/pansexual/asexual/queer group stated that they would feel unsafe in such a setting and preferred to see new LGBTQ + meeting spaces where alcohol is not consumed. For example, one participant in the lesbian woman focus group wanted

> … one place in the town that was, I don't know even if it was just a coffee shop or like a clubhouse or some sort of LGBT central area where you could just go at any time and just to hang out and meet people.

Another suggested "a brick-and-mortar place … where you could go and belong and not fear for your safety." Others stated that supportive informal community gatherings might be community-organized rather than taking place at an established LGBTQ + business, with one saying, "I also really appreciate things like [local community-organized LGBTQ + activist group], which are just bringing together, 'Are you queer anything? If so, show up. We'll take you." Participants shared a desire for increased opportunities to foster informal LGBTQ + support systems.

Subtheme: Importance of social support

Participants' desires for increases in the number of formal and informal supportive spaces for LGBTQ + people seemed to be driven by a common belief that social support is vital to the mental health, well-being, and overall quality of life for LGBTQ + people living within the county. As one participant stated succinctly, "I rely on my friend network quite a bit." Another noted that her involvement within LGBTQ + communities locally has been an important aspect of her sense of community, stating, "I'm very involved in the local community … and I've felt very supported here." Another referenced his place of work as a key source of support, saying, "I

also really lucked out with my job being super open-minded. As soon as I came out to them … they all rallied around me." While participants drew support from a variety of sources, participants were vocal about the centrality of identity-affirming support and community with other LGBTQ + people for their mental health.

Subtheme: Lack of cohesion in LGBTQ + community

Although many participants cited examples of positive and welcoming social support, some participants referenced instances in which local LGBTQ + communities felt incohesive and unsupportive. One participant noted, "And it's not cohesive. There are little tiny groups here and there and you can find cool people and make friends and stuff but it's really pretty one-on-one." One participant echoed this sentiment when they described the local queer community as "fragmented." Further, a participant who had recently come out as a lesbian woman said of a time when she attended a local lesbian women's event,

> I really felt like I was walking into a reality show. I really was looking for love and support and acceptance when I came out, and then I really wish I would have not gotten involved because … I just feel like it's such a small community that when you have a newcomer it throws off the group dynamics … I just had to stop communicating and just hope that I made it on my own …

In this way, her attempt at reaching out for support instead led to rejection, leaving her cut off from her newfound community and with greater feelings of isolation. Another participant concurred that the community can feel

> … a little bit judgmental, too, in a way. I guess, again, having expectations of the LGBTQ community being very welcoming and accepting of, like, no matter where you're from or no matter what your beliefs or anything, and it seems almost like if you don't fit in the certain boxes that … you're kinda left out.

Overall, participants described circumstances in which the local LGBTQ + community fell short of their hopes for connectedness, solidarity, and support.

Theme: Barriers to accessing mental health care

Participants identified several barriers to accessing mental health care, some of which were specific to identifying as LGBTQ + or exacerbated by living in a semi-rural community. One participant stated of providers,

> Nobody's taking new clients, or the one person that is, is not the right fit, and the one person that's gonna have an opening is in [a different town] and I don't have a car, so it's like I'm stuck. And … I couldn't get into any of the free places, so I literally have no idea how I'm gonna get a therapist.

Participants explained that *financial issues, mental health stigma, not knowing how to find or access mental health care,* and the *lack of LGBTQ + affirming providers* were among the most common barriers to accessing mental health care.

Subtheme: Financial issues

Participants cited the high cost of services, challenges with finding providers who accept insurance, and being limited in provider choice by insurance as common financial barriers to accessing mental health care. They noted that it was particularly challenging finding a therapist that accepted their insurance and was also a good fit. One participant noted that LGBTQ + affirming providers, "never take insurance and they're … never sliding scale … they think that they're this specialized therapist … so they can charge more." This struggle was further compounded by the limited group of LGBTQ + mental health providers in the area. Moreover, some participants expressed that when they found a provider that fit their needs, high cost inhibited their ability to receive care. As one participant stated, "sometimes … you'll find a provider that is exactly what you want and then you can't go there because you can't afford it." In sum, participants were frustrated by a lack of LGBTQ + affirming and low-cost providers who take insurance which made services "really inaccessible."

Subtheme: Mental health stigma

Participants commonly expressed the belief that perceived stigma around mental health was "one of the biggest barriers" to receiving care. Additionally, participants discussed experiences of mental health stigma layered on top of other identity-based stigmas. To highlight this compounding effect, one participant said,

> There's stigma about mental health and then there's the whole stigma around LGBTQ + Issues. It's like a double whammy there. I feel like in that there's extra that creates an even larger barrier to accessing care.

Participants described mental health stigma at familial, workplace, healthcare, and societal levels—among other levels. For example, youth participants discussed familial struggles with stigma, with one stating, "I've never had a[n] outside of school therapist because my mom doesn't believe in that." Participants explained that these issues sometimes carry into adulthood, with one individual saying, "And I think it's just from growing up, so for the last fifteen years of my life, it's been very stigmatized." Further, the barrier of mental health stigma trickled into other areas of participants' lives, such as work, with one participant saying, "There is a huge stigma

attached with mental health … It's one of those things where I just, I don't talk about it at work."

Subtheme: Not knowing how to find or access mental health care

Participants varied in their knowledge about how to find or access mental health care, but overall expressed the belief that "stuff is just hard to find." Participants who had specific service needs also expressed disappointment. For example, one participant stated, "Part of the problem that I've had is … finding doctors and therapists who have experience in medical pharmacology because there aren't any psychiatrists in this area." When describing experiences of homelessness, another participant stated,

> The big problem that I had when I was homeless was there was nobody there like me. I was the only gay guy in the entire program, and it was very isolating. And when I was given to my counselor for homeless services, she freely admitted, "I don't know what I can offer you." And it crushed me because it was just like, okay. Now I have to go out and do all this leg work myself.

Some participants reported not knowing the available resources and participants were apt to brainstorm potential solutions to the issues, such as,

> If someone could throw some dollars to have a person just call everyone in the county who's listed in *Psychology Today* as a therapist and put them on a list as either personally LGBTQ-identified or specifically LGBTQ-trained, I feel like that would be a really helpful thing.

Subtheme: Lack of LGBTQ + affirming providers

Participants reported a variety of issues around identity affirmation when finding or working with providers, including providers lacking knowledge. One participant said, "I've basically gone through all of the counselors in [a college health center] … they can help with almost everything except for anything that has to do with gender. And I feel like that's a big problem here." Another participant stated,

> I feel like there's this stopgap in the conversation where they're waiting for me to explain something and I'm, like … "I know I told you I'm gay. Why are we focusing on it?" And I feel like that is maybe indicative of a lack of knowledge … why do we have to be in the educating role all the time with everyone?

Some participants reported that therapists even directly discriminated against them by turning them away because of their LGBTQ + identities. As one participant recalled,

> It was really hard … calling around and realizing that you had to ask that question, that if I was hetero, I would have never had to bring this up, but having to … asking that person, "Are you okay with that?" And there's always that seven-year-old self in you that you always want to hear everybody be like, "Oh, that's fine, that's

> completely fine." You know, [that] you're loved, you belong. And, [then] people say to you, "No, actually I'm not really comfortable with that, but thanks for calling."

Additionally, participants described the struggles of finding LGBTQ + affirming providers. As one participant stated, "I've had a couple different therapists in the past who have straight up told me, 'Well, I don't really know how to help you with your gender thing because I don't understand it." Others reported that providers who self-described as LGBTQ + affirming were not always affirming in practice or understanding of other identities under the LGBTQ + umbrella.

Theme: Negative experiences with mental health providers and systems

Participants were clear and vocal about the various negative experiences they had with mental health providers and mental health care systems. Many of the statements suggested that *mental health providers lack LGBTQ + competence.* Participants also spoke about the various *structural issues with mental health organizations* that made their experiences accessing and receiving care negative.

Subtheme: Mental health providers lack LGBTQ + competence

Participants explained that some therapists do not have the knowledge about LGBTQ + identities or skills to be helpful. Participants suggested that some therapists do not understand queer and trans relationships, terminology, norms, or subcultures within LGBTQ + communities. This lack of competence was especially problematic when therapists did not understand the intersections of identities. As one participant explained that therapists often do not "understand how I can be both gay and Christian." Given that some therapists seemed to lack knowledge about LGBTQ + communities, participants spoke about the additional burden of having to educate their therapists. As one participant stated, "It's frustrating sometimes because I don't want to be the one to educate you."

Participants also noted that therapists often make normative assumptions about LGBTQ + people's identities and relationship structures. One person explained, "their questions are very mononormative and heteronormative." Another stated,

> I think there's a lot of people trying to pretend they're colorblind, don't see race. I think people treat sexual orientation the same way. That they like to pretend it doesn't matter to them when in fact like they do have stereotypes that they won't acknowledge.

Therapists' lack of knowledge and understanding about LGBTQ + communities seemed to be linked to how connected, or

disconnected, participants felt to their therapist. One participant explained, "I couldn't really get deep into any topics with people because they just weren't getting the basic stuff." Some reported feeling cautious with therapists, and many noted concerns about trusting their therapists with LGBTQ + related topics because they were uncertain about how the therapists might react.

Participants also noticed instances with therapists seeming uncomfortable talking about LGBTQ + topics, including therapists redirecting the conversation away from LGBTQ + concerns and verbal and non-verbal cues that participants noted when speaking with some providers. For example, one participant stated, "I've asked counselors, 'What do you do if somebody walks in and reveals themselves to be of a different sexual orientation than the norm?' … They always have this slightly panicked look on their face."

Subtheme: Structural issues with mental health organizations

Participants noted their frustration, anger, and disappointment with structural and organizational issues when attempting to access mental health care. These experiences were often not about the providers themselves, but rather the systems in which they work and the broader context for accessing mental health services. One participant spoke about struggling with insurance providers around gender care, explaining,

> [The insurance company is] like, "Oh, well, we don't want to approve that." Like, "Why do you need to see a therapist because of your gender?" And it's like, "Because my mental health is suffering." And it almost feels like they'd rather stick you in a corner and be like, "Oh, you'll expire on your own eventually," than be helpful.

Participants also noted experiences with clinics and agencies that included long wait times, poor services, lack of follow-up or wrap around services, and other roadblocks that made their experiences accessing mental health services worse.

Theme: Positive experiences with mental health providers

In contrast to the negative experiences participants reported having with mental health providers, participants also highlighted their positive experiences. Participants described positive experiences in which *providers are knowledgeable and affirming of LGBTQ + people* and *providers show humility, openness, and interest in learning.*

Subtheme: Providers are knowledgeable and affirming of LGBTQ + people

Participants cited experiences with therapists that displayed knowledge of LGBTQ + identities and topics. Some participants talked about having

therapists who identified as members of the LGBTQ + community themselves, which made them feel more comfortable disclosing their identities and discussing them in therapy. One participant said, "I had one [therapist] recently who was gay, and who got it, and I felt like we had a shared language there." Another noted, "I super lucked out when I came out in this community by connecting with a lesbian therapist." Participants also cited experiences in which their therapists displayed affirmation and support of their identities. One participant stated,

> I feel like everyone I saw in a professional capacity who I told I was bi was overwhelmingly positive in their reception. There was never a moment's hesitation with whether or not that was an okay way to be a human.

Finally, participants spoke to their therapists understanding the intersections of their identities. In one participant's experience, "it was really neat getting to work with [provider] because she totally understood the intersection of faith and spirituality and sexuality." Participants noted how lucky they felt when a therapist accepted and embraced all of their identities, noting that it made them feel more comfortable opening up in deeper and more meaningful ways.

Subtheme: Providers show humility, openness, and interest in learning

Even when therapists were not especially knowledgeable of the LGBTQ + community, participants relayed experiences in which their therapist displayed openness to discussing participants' identities and wanted to learn more. One participant stated,

> I have a great relationship with my therapist. He's very nice. Definitely [does not have] a whole lot of understanding about specific … LGBTQ concerns or issues, but he's great and we have a good relationship and he's helped me a lot.

Another participant stated, "I haven't had any negative experiences with [a local agency], either. Everybody's been really open to whenever I wanted to share, anything about my sexual orientation, so that was pretty refreshing." Participants also discussed a shift in recent years in which therapists have been more open to working with LGBTQ + clients. One stated, "I think the biggest positive for me in recent years is just seeing that more minds are opening, and more people are willing to educate themselves." Another noted that "more and more people are willing to take that step and to open their doors and their arms and their hearts."

Theme: Experiences and perceptions specific to transgender community members

Experiences and perceptions specific to transgender community members constituted a common thread throughout and across focus groups.

Cissexism, cisnormativity, and lived experiences shared among transgender men, transgender women, and non-binary people were influential in shaping participants' thoughts about community connectedness and experiences with mental health providers. Specifically, participants described transgender community members' *experiences within the community* and asserted that many *providers lack knowledge about issues relevant to transgender clients.*

Subtheme: Experiences within the community

Transgender participants repeatedly described interactions within local LGBTQ + communities and the county at large that exemplified the continual experiences of cissexist prejudice and discrimination. As one participant stated, "I've only been out as transgender for less than two years, and … I just ended up being badly discriminated against." Some participants discussed issues with inappropriate treatment or a lack of access to non-gendered bathrooms at their places of employment. One participant stated,

> I identify as genderqueer and that feels very, very invisible to me, especially at work. We have gendered bathrooms … if I really wanted to, I could say, "Hey, you all need gender inclusive bathrooms," and they couldn't tell me "no," but I also haven't because I feel like that would put a target on me.

Another detailed a culture of "White conservatism" in her place of work where there were "incidences in the past of not hiring people just because they weren't religious, or they weren't on the gender binary." Several youth participants experienced misgendering by regular or substitute teachers at school. Some participants also reported not feeling accepted by some cisgender sexuality diverse community members. One participant noted,

> I have tried to kind of find a way to participate in what we call the LGBTQ community … ever since I've been out and trying to participate in gay culture, I really have had almost no ability to assimilate. I feel like, in general, the cis gay males, at least, are all about a heteronormativity and I just don't fit into that description. So, I'm just kind of this outsider.

While many transgender participants reported negative and, at times, hostile interpersonal interactions from within the community, some described moments and relationships marked by support and affirmation, often from other transgender community members. One youth participant recalled an anecdote during which one of his teachers, who was also transgender, supported his right to be called the correct name in the classroom.

> One of my teachers told [my transgender teacher] to not call me the correct name … I was sitting outside between classes or lunch or something and my teacher came out and sat down next to me and was like, "Do you know your rights as a student in California?" … He was like, "This teacher is refusing to call you your

> correct name and is telling me to not call you your correct name." … And he read me my rights and shit.

A participant who was attending college said that she had built a substantial network of LGBTQ + friends. She recounted that she

> … was at one point trying to practice using my head voice instead of my chest voice and I asked one of my friends to remind me to use my head voice, and they actually told me that they didn't feel comfortable doing that because that would be essentially helping me pass. They just requested that if that's important to me then I can do it myself, and that actually made me think about it and from that I really decided that it wasn't really for me. I've been really helped by wonderful friends.

Subtheme: Providers lack knowledge about issues relevant to transgender clients

While participants discussed instances of mental health providers demonstrating inadequate knowledge, awareness, and skills pertaining to sexual orientation, several participants described practitioners as particularly uncomfortable with and inexperienced in exploring topics of gender identity and expression. The perception that providers in the county were less knowledgeable, comfortable, and helpful in addressing gender identity relative to sexual orientation in sessions with transgender clients was reflected by cisgender and transgender participants alike. A participant who identified as a gay transgender man said,

> Sexuality-wise, I've had a lot more luck with people being open-minded and really understanding, but, unfortunately, at least in my case when it comes to gender stuff, it's just been really hard to find anyone to talk to about it.

A youth participant also noted that some providers seemed to understand and affirm some identities more than others, saying,

> I think another thing that I would like from providers is not to treat some identities more important than others. Kind of like having like this weird ranking that I feel like a lot of people have, where they put like gay men at the top, and then lesbians, and then like, trans people, this weird system where they're like, "Oh, if you're far down here, then you're less gay than everyone else and your issues are less important."

One participant attributed her experiences of being dismissed by a marriage counselor as an issue of inadequate training. "How many times are you going to say, 'I'm a lesbian in a man's body?' You can't. You just don't have those opportunities … [the agency] was just not geared for it. They basically were not trained for it." Some described bearing the burden of educating providers on gender identity. As another participant stated,

> When it comes to bringing up gender issues, there has definitely been a disconnect even with therapists that I've had successful sessions with in terms of dealing with

> the other issues. Once the gender part comes up, it becomes a little bit … it's not antagonistic at all. Mostly it's just ignorant, or a lack of knowledge on their part, and thus a lack of understanding, too. And it feels unhelpful to be spending my time educating my therapist on why I feel a certain way or how I identify and what that means instead of being able to talk about it.

Other participants had seen providers who were overtly disaffirming of their gender identities and described how the providers' non-affirming position tarnished the experience, with one saying,

> I would definitely say that having people straight-up tell you to your face that they're not willing to respect your pronouns, to me, immediately makes the whole rest of the encounter, no matter how positive it might attempt to be, it just sours it. Being kind of either tucked into a corner, 'Oh, well, you should seek this somewhere else,' and then you go to the other place and they send you to somebody else and it's just, ugh.

In sum, participants observed stark gaps in provider knowledge about gender and inadequate skills vital to providing affirming care for transgender clients. Participants stressed the necessity of increased access to gender affirming treatment in the locality for the mental health of transgender community members.

Discussion

The present qualitative study provides a rich description and analysis of the experiences and perceptions of LGBTQ + semi-rural community members with regard to mental health care, barriers to accessing affirming treatment, and community connection. The results of this study echo previous research that found that LGBTQ + people in rural areas can face various barriers to accessing mental health services, including prior negative experiences with mental health providers (Moore, 2002; Rosenkrantz et al., 2017; Whitehead et al., 2016), high cost of services, and a lack of affirming providers and social networks (Horvath et al., 2014). Some participants also reported less perceived social support, difficulty connecting or being involved with the local LGBTQ + community, and discomfort disclosing sexual orientation or gender identities in certain settings, similar to findings in previous research (Rickard & Yancey, 2018). As prior research with rural LGBTQ + communities has found (e.g., Oswald & Culton, 2003; Oswald & Masciadrelli, 2008), participants also reported positive experiences within the LGBTQ + community, including feeling supported, developing close relationships, and involvement in local LGBTQ + organizations and advocacy work. Participants additionally described positive interactions with therapists, including therapists who were knowledgeable, affirming, and genuinely open to learning more about the LGBTQ + community (Israel et al., 2008).

This nuanced analysis of both positive and negative aspects of LGBTQ + community connection, access and barriers to mental health care, and therapist cultural competence provide a lens through which we may understand a range of experiences, rather than focusing solely on negative perceptions, as is common in the literature (Oswald & Culton, 2003). LGBTQ + participants in this particular semi-rural coastal community face unique challenges accessing peer and professional support; however, they also noted various ways that this small town also provides support, connection, and affirming care.

Implications for mental health care in semi-rural communities

Participants cited numerous challenges to accessing affirming mental health treatment, including not knowing how to find or access mental health care, financial issues, lack of LGBTQ + affirming providers, as well as stigma surrounding struggles with receiving healthcare treatment (Rosenkrantz et al., 2017; Shipherd et al., 2010; Whitehead et al., 2016). These findings highlight several cultural, practical, and structural areas for change that might increase LGBTQ + semi-rural residents' mental health care utilization.

It is important that mental health systems and insurance providers ensure transparency to facilitate help-seeking among those looking for affirming, accessible providers. Individual semi-rural communities and providers should identify solutions to bridge gaps in care for low-income and underinsured communities and those with limited transportation. Further, campaigns to increase mental health awareness and reduce mental health stigma may be needed to attenuate the effects of this cultural taboo (Collins et al., 2019). Mental health peer advocates may work hand-in-hand with these structural and cultural reforms to help LGBTQ + people navigate mental health systems (Willging et al., 2016).

Drawing from participants' positive as well as negative experiences with mental health providers, providers should seek relevant and up-to-date self-education on gender and sexual orientation to prepare for providing affirming care to LGBTQ + clients starting at intake. In line with prior research, our findings indicate a strong need for LGBTQ + cultural competency training for rural providers (Rorie, 2019). The results of this study suggest that LGBTQ + people are best served when providers are knowledgeable and affirming of their identities and experiences; however, many benefit from therapeutic relationships with supportive providers who demonstrate humility in the limits of their knowledge, openness to discussing topics that may be unfamiliar, and interest in learning more to provide culturally competent care to their clients. We posit that providers who are knowledgeable about working with LGBTQ + clients may also benefit from

displaying humility, openness, and curiosity about the intersections of identities as no two clients with shared identity labels necessarily have similar internal or external experiences with their identities.

Research has consistently demonstrated the protective role of LGBTQ + community connectedness for mental health (Craney et al., 2018; Jackson, 2017). As communities seek to foster connectedness, community leaders may need to recognize that creating welcoming spaces for LGBTQ + people may look different for semi-rural regions relative to metropolitan areas with large LGBTQ + populations and vibrant subcultures. Community leaders in semi-rural areas may need to be intentional in establishing formal support groups for attendees to provide and receive emotional support and solidarity. Identity-specific support groups may offer numerous benefits to attendees; however, some semi-rural communities may not have the resources or large enough representation of some segments of the LGBTQ + community to provide tailored support groups for particular sexual or gender identities. Therefore, support groups in semi-rural regions may need to target LGBTQ + people broadly to be accessible to more community members, and to avoid alienating community members whose identities are not well represented in identity-specific support groups.

Future directions for research

More research is needed to further explore the needs and multitude of experiences LGBTQ + people have in rural and semi-rural communities. Specifically, a better understanding of the interplay between feelings of community connection and mental health care in rural LGBTQ + communities is needed (Horvath et al., 2014). This study amplifies the call for researchers to utilize CBPR to further elucidate and center the needs and goals of LGBTQ + community members in the exploration and development of public health initiatives (Hulko & Hovanes, 2018). Longitudinal and experimental research may be particularly helpful in identifying the most effective structural changes and tailored interventions for improving the delivery of mental health care in semi-rural communities. Further, research is needed to explore ways in which LGBTQ + trainings might help increase cultural competence for rural providers or peer advocates (Willging et al., 2018). Additionally, quantitative research should explore the mechanisms by which mental health distress relates to experiences with providers and within the community for LGBTQ + people.

Further qualitative research is also needed to document the needs and experiences of LGBTQ + people whose identities and environments may make them targets for further interpersonal and structural discrimination

or pose additional constraints on access to care. For example, transgender and non-binary people face particular challenges with mental health care, as noted in our results, and more research is needed to explore the specific experiences of transgender people in rural areas. Additionally, this study included a focus group of youth ages 14-17 to capture the experiences of LGBTQ + adolescents; however, the primary purpose was neither to identify the unique concerns of this population, nor to offer comparisons relative to adults. Future research should explore the particular needs of LGBTQ + youth with mental health care, support, and community connection.

Researchers should also prioritize the needs of other historically and presently underserved communities. It is important for LGBTQ + mental health research to engage communities marginalized by racial and ethnic prejudice actively, responsibly, and with humility when designing any study. Research is needed to shed light on the cultural and structural systems of racism, xenophobia, ableism, sexism, heterosexism, and cissexism that drive mental health and treatment disparities within LGBTQ + communities as well as cisheterosexist structures that manufacture disparities.

Limitations

Whereas some of the perceptions and experiences of the participants may be common among rural LGBTQ + individuals and communities, the needs of other semi-rural communities may vary by state, proximity to larger metropolitan areas, predominant political affiliation, socioeconomics, race and ethnicity, and other demographic variables. The lack of racial and ethnic diversity is an important limitation of the present study. While about one third of our participants identified as Asian, Latinx or Hispanic, Native American, or biracial/multiracial, common perceptions and experiences of LGBTQ + people of color in the community sampled may not have been expressed during the focus groups and captured in thematic analysis due to underrepresentation. The sample demographics largely mirrored the racial and ethnic makeup of the county sampled, but oversampling of traditionally underrepresented groups may have enabled a deeper understanding of how intersections of identities (e.g., gender, sexual orientation, racial identity, ethnic identity, age, mental health history) may, in turn, intersect with circumstances (e.g., living in a small town in a semi-rural county, limited access to public transportation) when it comes to receiving LGBTQ + affirming treatment.

Additionally, the logistics of organizing and holding the focus groups may have discouraged or hindered participation among some eligible and

otherwise interested potential participants. In particular, lack of transportation, mental health stigma or anti-LGBTQ + stigma, and accessibility concerns may have posed a barrier to participation. Further, it is possible that people who have faced especially challenging barriers to care, negative or non-affirming experiences with providers, or severe prejudice and discrimination for their LGBTQ + identities or mental health histories may have self-selected out of participation. The absence of anonymity in focus group settings, and the inability of the researchers to guarantee that participants would uphold each other's confidentiality after the focus groups, may have led to an overrepresentation or oversharing of participants who are out and secure in their sexual and gender identities and comfortable disclosing histories of mental health distress and treatment, particularly in a semi-rural county.

Conclusion

This study is notable in its provision of several important contributions to literature on mental health care and community connection in semi-rural LGBTQ + communities. In receiving and implementing input of local LGBTQ + community organizers and longtime residents who constituted members of the research team and critical community partners in every step of designing and administering the focus groups, the present study followed a CBPR approach (Hacker, 2013; Northridge et al., 2007). As such, we responded to and repeat Hulko and Hovanes (2018) call for CBPR qualitative approaches to explore the needs and experiences of LGBTQ + people in alliance with local community organizations. We used rigorous thematic analysis to synthesize the feelings, beliefs, and experiences of our participants within the contexts of their communities and mental health care systems. The mental health needs and experiences of small town and semi-rural LGBTQ + youth and adults have been understudied, and the present study offers important insights that may provide the bases for future studies highlighting non-urban communities with intersecting identities and mental health experiences.

The engagement our participants demonstrated by taking part in an effort to improve their community through sharing their perceptions and experiences for the purposes of the present study is a signal to rural and semi-rural community leaders that LGBTQ + people know what they need and want from their communities and mental health providers. Qualitative needs assessments can be informative for outlining steps communities and providers can take to enhance mental health connectedness among LGBTQ + communities, and future studies should further elucidate the ways in which LGBTQ + people are underserved, dismissed, and

unaffirmed in mental health environments as well as the ways that therapists affirm and provide support for LGBTQ + communities.

While LGBTQ + people continue to experience challenges stemming from interpersonal and institutional cisheteronormativity, they display personal and collective resilience. Despite barriers to accessing psychological support services, the participants in the present study persevered in seeking affordable and affirming providers. In describing the changes that they wanted to see within the community and mental health systems, participants expressed a desire for both people who identify as LGBTQ + and those who do not to be proactive in cultivating more welcoming and supportive spaces. Specifically, participants wanted to give and receive support from other LGBTQ + people in supportive environments, and they wanted mental health providers to bridge the gaps in their knowledge that hinder their capacity to adequately serve LGBTQ + clients. Overall, participants' experiences and perceptions highlighted important structural and interpersonal sources of social and mental health support as well as areas for increasing support for LGBTQ + people residing in the semi-rural community.

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Appendix

Interview Questions and Prompts

1. What are your general perceptions of being a member of the LGBTQ + community in [the county]?
   a. Is there a sense of community among LGBTQ people living in [the county]?
   b. Do LGBTQ people in [the county] feel supported?
   c. Do LGBTQ people feel safe in [the county]?
   d. Is there anything you'd like to add before we move to the next question?
2. Drawing from your perceptions or your experiences, how knowledgeable are mental health providers in [the county] about the needs of LGBTQ people?
   a. Do mental health providers understand the needs and experiences of the LGBTQ community?
   b. Do they understand the identities of people in the LGBTQ community?
   c. Are they more knowledgeable about certain segments of the LGBTQ community than others? (i.e., gay men but not lesbian women; cisgender but not transgender people, etc.)
   d. What do you want providers to know about working with LGBTQ + clients?
   e. Is there anything you'd like to add before we move to the next question?
3. How skilled are the mental health providers in [the county] in serving LGBTQ clients?
   a. Do they have the skills needed to provide affirming services to the LGBTQ community?
   b. Do they do a good job with LGBTQ clients?
   c. Do they have enough experience working with LGBTQ people to give useful, good advice and recommendations on mental health?
   d. Is there anything you'd like to add before we move to the next question?
4. Where do LGBTQ community members in [the county] seek mental health services and support?
   a. Do they seek mental health services from mental health agencies and organizations? LGBTQ organizations? Friends and community? Online?
   b. What [local county] resources are used to support mental health and wellness?
   c. Is there anything you'd like to add before we move to the next question?
5. What are some of the negative experiences you have had with mental health providers in [the county]?
   a. Have you felt disrespected, devalued, or misunderstood by mental health providers?
   b. What made the experience or experiences negative?
   c. What would have made the experience better?
   d. Is there anything you'd like to add before we move to the next question?
6. What are some of the positive experiences you have had with mental health providers in [the county]?
   a. How have you felt respected, valued, or understood by mental health providers?
   b. What made the experience or experiences positive?

   c. What could have made the experience better?
   d. Is there anything you'd like to add before we move to the next question?
7. What might be the barriers to seeking or receiving mental health care in [the county] for the LGBTQ community?
   a. What might prevent LGBTQ people from seeking mental health services?
   b. What might prevent LGBTQ people from accessing mental health services?
   c. What would make it easier for LGBTQ people to reach out for support?
   d. Is there anything you'd like to add before we move to the next question?
8. What can [the county] do to better support the mental health and wellness of the LGBTQ community?
   a. What types of new programs or services would you like to see in your community?
   b. How might existing programs and services better serve the needs of LGBTQ community members?
   c. What needs to change in [the county] to better support mental health and wellness in the LGBTQ community?