Experiences of Queer Women and Nonbinary Individuals with Mental Health Care Services During the COVID-19 Pandemic

Elizabeth Claire Simpson

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EXPERIENCES OF QUEER WOMEN AND NONBINARY INDIVIDUALS WITH MENTAL HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC

A Dissertation

Presented to the Faculty of
Antioch University New England

In partial fulfillment for the degree of
DOCTOR OF PSYCHOLOGY

by

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EXPERIENCES OF QUEER WOMEN AND NONBINARY INDIVIDUALS WITH MENTAL HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC

This dissertation, by Elizabeth Claire Simpson, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University New England in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

EXPERIENCES OF QUEER WOMEN AND NONBINARY INDIVIDUALS WITH MENTAL HEALTH CARE SERVICES DURING THE COVID-19 PANDEMIC

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Background: The COVID-19 pandemic has had a negative effect on mental health. Queer women and nonbinary individuals disproportionately experience mental health issues when compared to heterosexuals, often facing challenges in receiving care from providers who are sensitive to their concerns and competent in their care. Objective: To report experience of queer women and nonbinary individuals in the United States with mental health care services before and during the pandemic. Methods: Data were gathered via a 43-item survey about experiences with mental health care services before and during the pandemic that was posted on four social media sites, and flyers hung in university student centers and businesses friendly to LGBTQ individuals. Queer women and nonbinary individuals between the ages of 18 and 75 were invited to participate. Descriptive statistics and Spearman’s correlations were used for data analysis.

Results: There were 175 participants who met inclusion criteria and were included in the analysis. During the pandemic, more survey participants received mental health services compared with before the pandemic. How they received care significantly changed from before the pandemic (mostly in-person) to during the pandemic (mostly remote). Participants reported being seen significantly more frequently for mental health care during the pandemic compared to before. A higher percentage of participants received both psychotherapy and medication during the pandemic compared with before. They were generally satisfied with their mental health care; however, satisfaction was significantly higher during the pandemic. Conclusion: During the
pandemic, compared with before, significantly more participants received mental health care and there were significantly more virtual mental health visits, more frequent mental health visits, more intensive therapies, and higher patient satisfaction. Telehealth care was perceived to be beneficial by most participants. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

*Keywords*: queer women, nonbinary individuals, mental health services, telepsychology, sexual minorities, COVID-19, health care disparities, social justice
Dedication

To my friends and family,

without whom this tremendous endeavor would not have been possible,

to my grandmother, Dorothy June Heinze Rice,

who always believed in me and the liberating power of education,

and to my parents, Kathleen Rice Simpson and Daniel Thomas Simpson,

their love and support mean the world to me.
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CHAPTER I: INTRODUCTION

Experiences of Mental Health for Sexual and Gender Minorities

Members of sexual and gender minority groups, such as gay, lesbian, and nonbinary individuals, have unique health care needs (American Psychological Association [APA], 2021; Martos et al., 2019; National Academies of Sciences, Engineering, and Medicine [NASEM], 2020). Social isolation, substance use, eating disorders, anxiety, shame, guilt, depression, suicide, suicidal ideation, and lack of acceptance, social support, and community are disproportionately experienced by many who identify as a member of a sexual or gender minority group when compared to heterosexuals (APA, 2021; de Vries, 2014; Frost et al., 2019; NASEM, 2020; Pachankis, Cochran, et al., 2015; Zelle & Arms, 2015). Sexual and gender minorities often face barriers in accessing mental health services with providers who are sensitive to their concerns and competent in their care (APA, 2021; Baptiste-Roberts et al., 2017; NASEM, 2020; Plöderl et al., 2017; U.S. Department of State, 2022).

There are limited data on the numbers of sexual and gender minorities in the United States. The most recent health surveys conducted by the U.S. Department of Health and Human Services (USDHHS) in 2013 and 2016 reported approximately 3.2% to 3.5% of adults in the United States identify as gay or lesbian (Copen et al., 2016; Cunningham et al., 2018). However, the most recent Gallup poll conducted in 2022 notes that this number has been increasing, now at 7.1%, predominantly among millennials (10.5%) and generation Z (21.1%) and is twice the percentage that was reported when this topic was initially polled by Gallup in 2012 (Jones, 2022). These include the approximately 4.0% of adults in the United States who identify as bisexual, 1.5% as gay, 1% as lesbian, 1.7% as nonbinary, and 0.7% as transgender (Jones, 2022; U.S. Census Bureau, 2021). These data are consistent a report from the Pew Research Center
(Brown, 2022) indicating that 1.6% of U.S. adults are transgender or nonbinary. The proportion of adults who identify as a member of a sexual and/or gender minority group varies by state and area of the country and ranges from less than 3.7% in more rural and southern states to more than 4.5% in western and eastern states (Williams Institute, 2019; Wilson & Meyer, 2021). Sexual and gender minority individuals represent a significant portion of the U.S. population (Wilson & Meyer, 2021). Meeting their mental health care needs is an important aspect of the psychological health of the country (NASEM, 2020).

Access to health care and specifically mental health care during the COVID-19 pandemic has been negatively affected (Alonzi et al., 2020; Czeisler et al., 2020; Dawson, McGough, et al., 2021; Fish et al., 2021). During the current COVID-19 pandemic, members of sexual and gender minority groups are at more risk for mental health disorders than their sexual and gender majority counterparts due to existing psychological barriers to care before the pandemic, such as discrimination, prejudice, rejection, or violence when seeking health services, including therapy (Casey et al., 2019; Dawson, McGough, et al., 2021; Fish et al., 2021; Meyer, 2003; NASEM, 2020; Plöderl et al., 2017; Tebbe & Budge, 2022; Williams et al., 2019). The pandemic has potentially put members of sexual and gender minority groups at greater risk of mental health related distress than members of majority groups (Banerjee & Nair, 2020; Dawson, McGough, et al., 2021; Fish et al., 2021; Kamal et al., 2021; Kidd et al., 2021; Mitchell et al., 2022; World Health Organization [WHO], 2020a). Although the pandemic affects all people, not all people have the same resources and supports available to them to weather the pandemic (Banjeree & Nair, 2020; Dawson, Kirzinger, et al., 2021; Fish et al., 2021; Kidd et al., 2021; Koma et al., 2020; Pillay & Barnes, 2020). The purpose of this study is to address the impact of the pandemic on queer women and nonbinary individuals, as groups under the larger sexual and gender
minority umbrella, who are likely to struggle to receive adequate mental healthcare during the pandemic.

**Statement of Purpose: Evaluating the Experiences of Queer Women and Nonbinary Individuals with Mental Health Care Services During the COVID-19 Pandemic**

The purpose of this study was to assess the experiences of mental health care services for queer women and nonbinary individuals during the COVID-19 pandemic. This study explored the experiences of mental health care for queer women and nonbinary individuals before the United States stay-at-home order in March 2020 and how their experiences with mental health care have changed during the pandemic. The study reviewed what their mental health service delivery experiences looked like, whether video call, audio-only calls, or in-person care, how often they received care, and type of care received, their satisfaction with mental health services, and aspects of mental health care they would like changed. Evaluation of experiences with mental health services was reviewed through the Minority Stress model, which has been used in several studies focused on sexual minority groups (Meyer, 2003) and expanded to include the LGBTQ+ population (NASEM, 2020).

**Key Constructs and Concepts**

**Population**

Sexual minorities are individuals “whose sexual and affectual orientation, romantic attraction, or sexual characteristics differ from that of heterosexuals. Sexual minority persons are inclusive of lesbian, gay, bi+, and asexual identified individuals” (American Psychological Association [APA], 2021, p. 57). Bi+ is a term used to cover a broad category that includes “multiple sexual orientations that involve having an attraction to more than one sex or gender. Bi+ persons include those who identify as bisexual, pansexual, demisexual, or queer. Another
term for this is plurisexual” (APA, 2021, p. 56). Gender minorities are people “whose gender identity or gender expression differs from the social norms that are associate with their sex assigned at birth. This is separate and distinct from sexual minority, as gender identity differs from sexual orientation” (APA, 2021, p. 56). The acronym most commonly used to represent sexual and gender minorities refer to lesbian, gay, bisexual, and transgender (LGBT) individuals; however, this term is often used imprecisely. This study focused on individuals who identify as gay, bisexual, pansexual, queer, lesbian, and nonbinary individuals. There are minimal published data specifically about other subgroups of sexual and gender minorities. Although people may share identities and minority status, they are not monolithic, rather they have individual and unique experiences (APA, 2021; Coleman et al., 2022; Greaves & Ritz, 2022; Martos et al., 2017; NASEM, 2020). The experience of queer women (specifically those who identify as bisexual, gay, pan, queer, and lesbian) and nonbinary individuals are the focus of this study.

**Queer Women.** As opposed to queer women, the experiences of queer men have been excluded from this study as men (specifically cisgender men) have been the focus of a disproportionately large amount of funded and published research when compared to queer women and more research needs to be done on non-male individuals to promote greater awareness of the struggles this population experiences (Coulter et al., 2014; Kates et al., 2018; Mirin, 2021; NASEM, 2020; Pharr et al., 2019; Worthen, 2013). In one study, a review of National Institutes of Health funding from 1989 to 2011, revealed of studies of the LGBT population, over 86% of funding was for studies of sexual minority men while only 13.5% was for studies of sexual minority women, even when excluding studies of HIV/AIDS (Coulter et al., 2014). Women are more likely than men to report needing mental health services and have higher prevalence of depression, anxiety, and trauma-related and stress-related disorders (Kuehner,
Women are more likely to be dissatisfied with mental health services when compared to men, in part because they perceive discrimination, gender bias, and stigma from health care providers (Hagen et al., 2018; Mizock & Brubaker, 2021; Sommer et al., 2020; Stamboglis & Jacobs, 2020). There are approximately 16.5 million individuals in the United States who identify as lesbian or queer women (Statistica Research Department, 2022). Long COVID appears to affect women more than men (Di Toro et al., 2021; Msherghi et al., 2021; Pelà et al., 2022; Perlis et al., 2022). This includes a subgroup of nonbinary individuals since many nonbinary individuals were assigned female at birth (Wilson & Meyer, 2022). The science on Long COVID is evolving as time from initial infection (and in some cases, reinfection) to recurrence of symptoms and for some, recovery, continues to be studied, thus more data is needed to support these preliminary findings.

**Nonbinary Individuals.** Nonbinary individuals experience similar, if not more, challenges with their mental health, both in receiving and seeking it, as compared to their binary (non-heterosexual cisgender women and trans women) counterparts (Hagen et al., 2018; Matsuno, 2019; Rider et al., 2019; Streed et al., 2018; Tebbe & Budge, 2022). According to the U.S. Census Bureau data, more than one percent (1.7%) of United States adults identify themselves as “none of these [options]” when presented with the options of “[cis] female,” “[cis] male,” “trans female,” and “trans male” (U.S. Census Bureau, 2021). Of this 1.7% of the United States adult population of “none of these [options] for gender,” 11.2% are bisexual, 7.1% are gay or lesbian, 33.1% are straight, 24.1% are “something else,” and 24.5% “don’t know” their sexual orientation (U.S. Census Bureau, 2021). The 2022 Gallup poll recorded 4.3% of LGBT adults said they were “other” when asked about their gender (this is about 0.3% of all United States adults overall; Jones, 2022). According to data from the TransPop Study conducted in 2018,
there are approximately 1.2 million nonbinary adults in the United States (Wilson & Meyer, 2021). Nonbinary adults are reported to have poorer health outcomes (both physical and mental) as compared to their binary counterparts (APA, 2021; Kattari et al., 2020; Rider et al., 2019; Streed et al., 2018; Warren et al., 2016). It is reported nonbinary adults have more unmet healthcare needs and worse access to care as compared to their binary counterparts (Koma et al., 2020; Steele et al., 2017; Tebbe & Budge, 2022). Nonbinary adults and their specific challenges are not as commonly studied as their binary counterparts (Fiani & Han, 2019; Gates, 2017; NASAM, 2020; Safer, 2021; Ulrich et al., 2022; Wilson & Meyer, 2021). Although they have unique challenges and needs, they are considered under the same gender minority umbrella as trans and cisgender women and they experience difficulties receiving satisfactory care (Bauerband et al., 2019; Feinstein et al., 2020; Goldberg et al., 2019; Lefevor et al., 2019; Matsuno, 2019; Steele et al., 2017; Streed et al., 2018).

**Stigma**

Stigma, in psychology and social sciences, refers to negative associations attributed to people due to deviations from expected social, cultural, physical, psychological norms (Goffman, 1963). For example, sexual and gender minorities are seen as deviants by some in society because their sexual and gender identities do not follow norms of the predominately heterosexual American culture (APA, 2021; Baptiste-Roberts et al., 2017; Begeny & Huo, 2017; Glotfelter et al., 2017; Gomez et al., 2021; NASEM, 2020; Taylor et al., 2020; Tebbe & Budge, 2022). The stigma can have a negative impact on their ability to seek mental health services, find therapists trained in their backgrounds, or access appropriate care across the lifespan (APA, 2021; Casey et al., 2019; Kates et al., 2018; Martos et al., 2017; NASEM, 2020; Taylor et al., 2020; Valente et al., 2022).
**Disparity**

A significant concept is lack of access to care for sexual and gender minorities is health disparities. For example, a number of mental and physical health issues are known to be experienced disproportionately by sexual and gender minorities when compared to heterosexuals, including anxiety, depression, suicide, suicidal ideation, eating disorders, obesity, substance use, HIV, and other sexually transmitted infections, breast, anal, and cervical cancer, and cardiovascular disease (Gonzalez et al., 2016; Kattari et al., 2020; Martos et al., 2017; Matsuno, 2019; NASEM, 2020; Tebbe & Budge, 2022; USDHHS, 2019). According to APA (2019a), health disparities are “preventable, adverse differences in health experienced by socially disadvantaged populations in comparison to more advantaged populations” (p. 1). This definition is consistent with literature describing the state of access to equitable care and overall health of sexual and gender minorities in the United States (Frimpong et al., 2020; Koma et al., 2020; NASEM, 2020; Potter & Patterson, 2019; USDHHS, 2019).

**Access to Care**

The existence of services does not guarantee access. Factors associated with lack of access include stigma, provider expertise, discrimination, hostility towards their identity, fear of rejection, shame, hypervigilance, geographic restrictions, lack of social support, and other minority stressors (Casey et al, 2019; Hatzenbuehler, 2010; Martos et al., 2018). Access requires necessary health services to be in place, readily available, affordable, relevant to patient needs, and effective (Gulliford et al., 2002). Patients with access can receive high-quality, reasonably priced care in a timely manner that is located in a geographically feasible distance (Levesque et al., 2013). Care must be relevant to the patient population. In the context of access to care for sexual and gender minorities, providers should be knowledgeable about gay, lesbian, and
nonbinary people and how to address patients’ other potentially intersecting identities such as a minority ethnicity, race, or religion (APA, 2021; Coleman et al., 2022; Gulliford et al., 2002; Matsuno, 2019; NASEM, 2020; Rider et al., 2019).

**Patient Satisfaction**

According to the Agency for Healthcare Research and Quality (2016), patient satisfaction is a measure of whether the patient’s expectations for care were met. Results can vary based on how and when patients are surveyed after their interaction with the health care system (Heath, 2022). Patient satisfaction has been defined in the literature as a measure of how content the patient is with the care they received (Manzoor et al., 2019). Patient satisfaction is associated with the quality of care received (Priebe & Miglietta, 2019), timeliness and efficiency of care provided (Prakash, 2010), better clinical outcomes, meeting patient’s goals, and therapeutic rapport (Crosier et al., 2012). There are various methods to measure patient satisfaction and several government and national agencies that help health care systems evaluate patient satisfaction.

Some experts are concerned that focusing on patient satisfaction could lead to health care professionals catering to the patient’s wants instead of the patient’s needs as dictated by best practice and standards of care (Badu et al., 2019; Junewicz & Youngner, 2015; Manzoor et al., 2019; Prakash, 2010; Priebe & Miglietta, 2019). However, others have argued that measuring patient satisfaction allows health care systems, health care providers, and researchers to gauge the care provider’s level of empathy and the therapeutic relationship (Crosier et al., 2012), encourage focus on the equity of care provided for patients, and evaluate both objective and subjective clinical outcomes of care (Badu et al., 2019).
In the United States, the Centers for Medicare and Medicaid Services (CMS) require hospitals to measure their patients’ perceptions of their hospital experience using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (CMS, 2022). The survey has 29 items and is administered to a random sample of patients via email, telephone, or interactive voice recognition after hospital discharge (CMS, 2022). Results are reported quarterly on the government website Care Compare so the public can have information to make an informed decision about where to seek care (CMS, 2022). While the HCAHPS survey measures patient experience rather than patient satisfaction, hospitals and health care systems use these data to consider how satisfied patients were with their care (Heath, 2022).

In 2007, the Human Rights Campaign Foundation established the Health Equality Index to promote LGBTQ+ friendly practices in the health care setting (Human Rights Campaign Foundation, 2022). Ten recommendations for hospitals were made in four aspects of services that included policies for LGBTQ+ inclusive patient non-discrimination, inclusive visitation, inclusive employment non-discrimination, and staff training in LGBTQ+ patient-centered care (Human Rights Campaign Foundation, 2022). Hospitals that achieve top scores on the Health Equality Index are awarded the LGBTQ+ Healthcare Equality Leader designation. As of March 2022, 906 of the approximately 6000 acute care hospitals in the United States (American Hospital Association, 2022a) have participated in the program with 496 earning the leader designation (Human Rights Campaign Foundation, 2022). This designation has been associated with higher patient satisfaction and experience scores (DiLeo et al., 2020; DiLeo et al., 2022) and better quality of nursing care (Blackwell, 2020) when compared to hospitals that have not earned this designation. Thus, hospitals that actively work to provide LGBTQ+ inclusive and
appropriate care have been found to be effectively improving the experiences of the LGBTQ+ population.

The Joint Commission (TJC) is the accreditation body for the majority of acute care hospitals and behavioral health care and human services in the United States (TJC, 2022). When investigating the unique healthcare needs of the LGBTQ+ population in their field guide of *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community*, TJC reported care providers should confidentially survey patients about their satisfaction with their care (TJC, 2011). The survey questions TJC recommended in the patient satisfaction surveys included questions about a patient’s sexual identity, gender identity, LGBT inclusive care, questions assessing the effectiveness of health care provided, if the patient’s needs were met, and how their services were used (TJC, 2011). They are developing new guidelines for the LGBTQ+ community, scheduled to be published in 2023. Patient satisfaction and the care needs of the LGBTQ+ community continue to be a focus of research for TJC (Cordero & Tschurtz, 2022). LGBTQ+ patients’ experience of care providers and non-care provider personnel in the inpatient setting affects their satisfaction with care received (Klotzbaugh & Spencer, 2020). LGBTQ+ patients report less satisfaction with their care when they perceive their care was negatively influenced by their LGBTQ+ identity (Casey et al., 2019; Klotzbaugh & Spencer, 2020). In a recent study, 16% of LGBTQ patients reported discrimination during health care encounters (Casey et al., 2019), a finding that is not uncommon in research about the LGBTQ+ community (Kates et al., 2018).

Patient satisfaction with mental health care in the community outpatient setting is generally more favorable than the inpatient setting (Fortin et al., 2018; Priebe & Miglietta, 2019;
Stamboglis & Jacobs, 2020). Other factors positively influencing patient satisfaction with mental health services include continuity of care, older age, being employed, and perceived patient involvement in their care (Sohn et al., 2014; Stamboglis & Jacobs, 2020; Tambuyzer & Van Audenhove, 2013). Negative satisfaction with mental health patient services is associated with being female, having a severe mental illness, and previous admission to the hospital for mental illness (Stamboglis & Jacobs, 2020).

**Mental Health Services**

Mental health services are also referred to as mental health care. These services include inpatient and outpatient therapy (both individual and group therapies) and psychiatric interventions to address mental, behavioral, and emotional concerns (ex. depression, anxiety, grief, loss, etc.; National Institutes of Health, 2021). The services can be provided in-person, on the phone, or virtually for patients receiving care. During the COVID-19 pandemic, adaptations have been made to address safety concerns of spreading the pandemic including moving mental health services to more distanced options like virtual visits or phone calls (CMS, 2020; Pfender, 2020).

**Telepsychology**

A concept explored in this study was telehealth. In the literature, telepsychology is also referred to as tele-mental health (APA, 2014). Many other terms are used in the literature, for example virtual care, remote visits, and telemedicine. For this dissertation, the terms used by the researchers are used in reporting their findings. The APA defines telepsychology as “the provision of psychological services using telecommunication technologies” and “it is not limited to telephone, mobile devices, interactive videoconferencing, email, chat, text, internet” (APA, 2013a). The APA published guidelines to address the use of telepsychology in 2013, outlining
recommendations and suggestions for psychological services using telecommunication (APA, 2013a). Generally, the guidelines recommend psychologists are familiar with the technology they are using to conduct treatment, that the treatment meets the standards of care (compared to in-person treatment), special informed consent addressing telepsychology is obtained, take reasonable lengths to ensure confidentiality and secure using telepsychology, and be familiar with laws and regulations of telepsychology for their location and the location of their patient (APA, 2013a). Due to the COVID-19 pandemic, the APA has made efforts to increase access to care by lobbying the United States government to temporarily allow for more flexible regulations for telepsychology (Owings-Fonner, 2020). Some mental health care professionals as well as the general public use the term virtual to describe telepsychology (Mishkind et al., 2021; Robbins, 2020).

The U.S. Department of Health and Human Services describes telemedicine as a method for health care providers to use computers or telephones to offer patients clinical health remotely without an in-person office visit (Lucas & Villarroel, 2022). Benefits include improved access to care and convenience (Hays & Skootsky, 2022). According to data from the National Health Interview Survey conducted in 2021, approximately 37% of US adults reported using telemedicine in the past 12 months when they were surveyed (Lucas & Villarroel, 2022). Users were more likely to be women (42%) versus men (31.7%) and usage was reported to be higher as age and level of education increased (Lucas & Villarroel, 2022).

COVID-19

COVID-19, or the novel coronavirus “COVID-19” was defined by the World Health Organization as “the infectious disease caused by the coronavirus, SARS-CoV-2, which is a respiratory pathogen. WHO first learned of this new virus from cases in Wuhan, People’s
Republic of China on December 31, 2019” (WHO, 2020b). According to Johns Hopkins University and Medicine (2022), the COVID-19 virus has killed over 1,076,801 Americans as of November 18, 2022, and there are 98.2 million confirmed cases of the virus in the United States. The Centers for Disease Control and Prevention (2022a) reports a steady increase in COVID-19 cases and deaths in the United States from the beginning of the pandemic in 2020 to November 2022.

**Theoretical Framework**

The theoretical framework used for this study is the minority stress model initially developed by Brooks (1981) about lesbian women that was expanded by Meyer (2003) to include gay men and bisexuals, and then further extended by NASEM (2020) to include the entire sexual and gender diverse population. According to Meyer (2003), minority stress represents the “excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position” (p. 675). Meyer’s (2003) model of minority stress refers specifically to sexual minorities and their intersecting identities (e.g., race, ethnicity, religion, age, etc.). It covers “stress processes, including experiences of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and ameliorative coping processes” (Meyer, 2003, p. 675). Extending the application of the minority stress theory to all sexual and gender minorities, NASEM (2020) includes evidence that being a sexual and/or gender minority increases the risk for social and psychological challenges and distress when compared to heterosexuals and can have a negative impact on social and psychological functioning, leading to poorer mental health outcomes, similar to Meyer (2003). Minority stress is chronic due to societal norms and biases and socially based because it is related to “social processes, institutions, and structures beyond the individual” (Meyer, 2003, p. 676). Stressors...
can be internal or external, initiated by stressful events and conditions, concern about stressful events occurring, and by internalizing societal stigma (Meyer, 2003).
CHAPTER II: REVIEW OF THE LITERATURE

Queer women and nonbinary individuals are a significant and increasing percentage of the United States population (Jones, 2022; U.S. Census Bureau, 2021). They are more likely to endorse symptoms of mental illness compared to heterosexuals (Frost et al., 2019; Kates et al., 2018; Pachankis, Cochran, et al., 2015). The psychological distress and mental illness they experience due to societal stigma and prejudice can be studied via psychological research and treated in psychotherapy (Rosenthal, 2016; Valdiserri et al., 2019). Understanding the intersectionality and unique experience of gay men, queer women, and nonbinary individuals is consistent with APA’s Principle D, justice and Principle E, respect for people’s rights and dignity (APA, 2017a, p. 4). Principle D refers to offering all people equal quality and competent care (APA, 2017a, p. 4). Principle E refers to a psychologist’s duty to be aware of their patient’s background and consider that background in their practice (APA, 2017a, p. 4). Increased availability of competent and informed care providers would lessen barriers to care for queer women and nonbinary individuals (APA, 2021; Coleman et al., 2022; Martos et al., 2019).

In their multicultural guidelines, the APA (2017b) encourages psychologists to recognize and understand their patients' backgrounds, the context in which the patient exists, power dynamics in society as well as the therapy room, and patient barriers to care. Understanding the experience of queer women and nonbinary individuals allows for better quality of care (APA, 2021; Casey et al., 2019; Coleman et al., 2022; Martos et al., 2018). The more important the LGBTQ+ identity is to sexual and gender minority individuals, the more they perceive prejudice against their identity and the greater the negative effects (Begeny & Huo, 2017; Kidd et al., 2021; Valente et al., 2020). Membership in other minority groups (e.g., those characterized by
race, ethnicity, or religion) adds to their intersecting identities and should be integrated into their care (APA, 2021; Bowleg, 2017; Chung & Bemak, 2012; NASEM, 2020).

Since queer women and nonbinary individuals are distinct and unique minority populations, and not all disclose their identity when seeking health care, some psychologists may be unfamiliar with their specific experiences that inform their mental health care needs (Gomez et al., 2021; NASEM, 2020; Pachankis, 2018; Valente et al., 2020). In 2012, APA (2012) offered guidelines on best practices for psychologists working with gay, lesbian, and bisexual patients and in 2015, APA (2015) issued guidelines for practice with transgender and gender nonconforming individuals (includes nonbinary individuals). The guidelines encourage psychologists to recognize gender is not binary, and sexuality and gender are different concepts (APA, 2015). The APA (2012) guidelines were revised and updated in 2021 (APA, 2021). Each guideline includes a rationale and application to clinical psychology. The APA guidelines recommend psychologists actively seek resources to be up-to-date and well-versed on gay men, lesbian women, bisexuals, and trans and nonbinary individuals including continuing education, supervision, and consultation (APA, 2015, 2021). Psychologists should educate themselves about the distinct experience and challenges faced by the LGBTQ+ population’s the lifespan (APA, 2015, 2021). The guidelines encourage psychologists to consider the intersectionality of their LGBTQ+ patients in research and clinical practice (APA, 2015, 2021). Psychologists should be aware of discrimination and barriers to care faced by this population, and psychologists should engage in advocacy, collaborate with other health care providers to support optimal outcomes, and participate in continuing education to keep abreast of the most current evidence about the LGBTQ+ populations (APA, 2015, 2021; Evans, 2019). The APA proposes that psychologists work with other professional organizations like the National Institutes of Health, the Centers for
Disease Control and Prevention, and the IOM (now known as the National Academies of Sciences, Engineering, and Medicine) to further the research of health disparities of LBGTQ+ individuals (APA, 2013b). In 2022, the World Professional Association for Transgender Health published an eighth edition of their standards of care for the health of transgender and gender diverse people, a comprehensive guideline to meet the mental and physical needs of this population (Coleman et al., 2022).

Implications of Treatment or Intervention

The APA recognizes that health disparities of lesbian women and nonbinary individuals are a major issue across the lifespan (APA, 2013b, 2015). They propose that psychologists become more involved in learning about lesbian women and nonbinary individuals to inform their practice, including mental and general health risks, substance use, homelessness, harassment and victimization, and suicidal ideation of this population (APA, 2013b, 2015). In subsequent guidelines, APA includes the recommendations for caring for queer women and nonbinary individuals in the context of their greater risk for developing mental illnesses (APA, 2015, 2021). These include mood, eating, and substance use disorders, and anxiety, depression, attempting suicide, and completed suicide (Kates et al., 2018; Kidd et al., 2021; Matsuno, 2019; NASEM, 2020; Plöderl & Tremblay, 2015), in part from the stress of ongoing societal stigma, discrimination, and bias against them due to their sexual and/or gender minority status (Gomez et al., 2021; Kattari et al., 2020; Meyer, 2003; NASEM, 2020; Pachankis, 2018; Williams et al., 2019). The difficulties in accessing mental health care that they often experience have negative implications for obtaining appropriate and timely psychological treatment (Martos et al., 2019; Tebbe & Budge, 2022). Beyond locating psychological services that are affordable and open to taking them as a patient, queer women and nonbinary individuals need care providers who are
cognizant of and sensitive to their unique concerns to enhance the likelihood of symptom reduction (Cohn et al., 2018; Coleman et al., 2022; Ulrich et al., 2022). The APA encourages affirmative and competent psychological practice for caring for queer women and nonbinary individuals (APA, 2015, 2021).

**Satisfaction with Mental Health Care**

Data on the satisfaction of gay men, lesbian women, and nonbinary individuals with mental health services are mixed. Generally, queer individuals would prefer if their providers were queer-friendly, but the fear of disclosing and facing discrimination when they finally have access to care is significant (Begeny & Huo, 2017; Gomez et al., 2021; Greaves & Ritz, 2022; Herek et al., 2015; Martos et al., 2018; Pachankis, 2018). Research suggests that when queer individuals find care which is culturally and sexual and gender minority-affirmative, they are happy with their care (APA, 2021; Cohn et al., 2018; Coleman et al., 2022; Gomez et al., 2021); however, that care is difficult to find, especially in less urban settings (Budge et al., 2021; Kattari et al., 2020; Martos et al., 2018; NASEM, 2020). In some areas of the country where there are more dense populations of sexual and gender minorities, such as the east and west coasts, community LGBT health services clinics have been established (Martos et al., 2017; Tebbe & Budge, 2022). Many were started in response to the HIV crisis; however, as treatment for HIV has dramatically improved and related mortality has decreased, the health centers have focused on the general health of LGBT individuals (McClain et al., 2016). There are approximately 200 of these types of community health clinics in the United States, offering a variety of care, including mental health services (Martos et al., 2017). There are three avenues for LGBTQ+ minorities to seek mental health care; (a) within the mainstream health system during which they may or may not disclose their LGBTQ+ identity, (b) at a health service specifically dedicated to
LGBTQ+ care, and (c) at a subspecialty service for LGBTQ+ care embedded in a general hospital or health care system (Martos et al., 2017; Martos et al., 2018; McClain et al., 2016).

Queer women and nonbinary individuals prefer to receive care in environments that are LGBTQ-friendly and from nonjudgmental LGBT-competent providers (Coleman et al., 2022; McClain et al., 2016; NASEM, 2020; Samrock et al., 2021). This type of care environment includes confidentiality, all those who interact with patients being knowledgeable about how to communicate with sexual and gender minorities, use of gender-neutral pronouns, asking patients what pronouns they use, health information and posters that are inclusive of sexual minorities, and an open and warm attitude that is not premised on their sexual and/or gender identity being an abnormality (Kattari et al., 2020; McClain et al., 2016; Rossi & Lopez, 2017; Safer, 2021). Incorporating these aspects of care sends a message that sexual and gender minorities are welcome and will receive LGBT-competent care. Queer women and nonbinary individuals sometimes screen potential providers to gauge cultural competence and acceptance of their population before scheduling appointments (Cohn et al., 2018; Coleman et al., 2022; Gomez et al., 2021; Tebbe & Budge, 2022). Researchers found LGBT+ individuals screen providers by looking up the provider online (searching for evidence of pro-LGBT opinions or the provider's workplace being openly pro-LGBT) and asking for provider referral recommendations from other LGBT+ friends (Martos et al., 2018). The APA (2015, 2021) encourages providers to examine their biases, if any, toward queer individuals to promote more culturally-affirmative care. Recognition of potential biases, reconciliation of personal beliefs with their professional role, communication skills related to appropriate and inclusive language for gay, lesbian, and nonbinary patients, and a nonjudgmental approach is requisite for a therapeutic provider-patient relationship (Coleman et al., 2022; Rossi & Lopez, 2017). These requisite skills are consistent
with factors that promote patient satisfaction with mental health services including continuity of care, establishing a relationship, integration of care, perception of needs being met, and being supported (Coleman et al., 2022; Fortin et al., 2018; NASEM, 2020; Skar-Fröding et al., 2021; Stamboglis & Jacobs, 2020).

**Obstacles to Satisfaction with Mental Health Care Services for Queer Women and Nonbinary Individuals**

While it is known that the minority stress model (Meyer, 2003) can explain some of the mental health conditions of queer individuals due to their chronic exposure to the stress of discrimination and stigma, there are limited data on types of interventions for mental health care specific to this population beyond sexual and gender minority-affirming care by competent providers in an LGBT-friendly environment (APA, 2021; Coleman et al., 2022). In a randomized controlled trial, using cognitive-behavioral therapy in the context of the minority stress model, culturally-affirmative care was found to be more effective in improving anxiety and depression when compared to standard treatment for sexual minority men (Pachankis, Hatzenbuehler, et al., 2015). However, more research is needed to assess the efficacy of sexual and gender minority-affirming mental health care while integrating the minority stress model into practice for this population (NASEM, 2020; Pachankis, 2018; Safer, 2021; St. Pierre, 2018; Tebbe & Budge, 2022). Greater acceptance by providers, increased knowledge, and the practice of sexual and gender minority-affirming care could result in more mental health professionals that members of the LGBTQ+ population are comfortable seeing for treatment (APA, 2015, 2021; Cohn et al., 2018; Kattari et al., 2020; Pachankis, 2018). Offering mental health care to queer individuals using the minority stress model to understand their needs and plan appropriate therapeutic
interventions that are sexual and gender minority-affirming can be beneficial in enhancing symptom reduction (NASEM, 2020).

Societal norms and a culture that discriminates against those who do not conform to these norms perpetuate the prejudice and stigma that queer women and nonbinary individuals face (Casey et al., 2019; Hatzenbuehler, 2010; NASEM, 2020). It is important to recognize that it is not their sexual or gender identity that is associated with challenges in access to care and poor mental health outcomes, rather their exposure to these negative societal factors (Begeny & Huo, 2017; Herek et al., 2015; Martos et al., 2018; Pachankis, 2018). If the societal stigma and discrimination could be eliminated or minimized, the mental health of sexual and gender minorities would be improved (NASEM, 2020; Valdiserri et al., 2019; Williams et al., 2019).

Queer women and nonbinary individuals live all over the country in suburban, urban, and rural settings (Austin, 2013; Martos et al., 2019; NASEM, 2020; U.S. Census Bureau, 2021). They are all ages, levels of fitness, religious or atheist (Martos et al., 2019; NASEM, 2020). They serve in the military (Glotfelter et al., 2017). They are of every race and ethnicity (USDHHS, 2019). They are diverse. Access to mental health care for queer women can reflect access to care for other minority groups (Tan et al., 2017). Queer women and nonbinary individuals who are members of other minority groups are more vulnerable to issues accessing mental health care than non-minority counterparts (Jarrett et al., 2021; Kates et al., 2018; Kidd et al., 2021; Tan et al., 2017). Mental health providers must address the inequalities of access to mental health care for queer individuals (APA, 2019b; NASEM, 2020). The stigma and prejudice queer women and nonbinary individuals face who are members of other minority groups are greater because of societal and cultural biases (APA, 2021; Budge et al., 2021; Casey et al., 2019; Coleman et al., 2022; Frost et al., 2020; Meyer, 2003; Tan et al., 2017).
Because of the various intersecting diversity factors among queer women and nonbinary individuals, there is no universal characterization of this population (Greaves & Ritz, 2022; Martell & Williams, 2019). In clinical practice and in research, it is important to acknowledge nuances within this population (APA, 2015, 2021; Greaves & Ritz, 2022; Martell & Williams, 2019). In the minority stress model, Meyer (2003) acknowledges the context in which a sexual minority individual exists informs their experience of being a sexual minority, including their race, ethnicity, gender, and other individual differences. The same experiences are found among nonbinary individuals (NASEM, 2020). More research is needed to explore the unique experiences of queer women and nonbinary individuals within other minority populations (APA, 2021; Martell & Williams, 2019; Meyer, 2003; NASEM, 2020).

According to the APA, mental health professionals must provide care competently and ethically (APA, 2017a, 2017b). They must be multiculturally-conscious (APA, 2017a). If a provider is uninformed, they should seek resources such as continued education, supervision, review of the available research, and consultation (APA, 2015, 2017a, 2021). Although the multicultural guidelines are aspirational, the APA recommends that providers use them in practice along with the ethical principles (APA, 2017b, p. 13).

Patients should not be pathologized based on being gay, lesbian, or nonbinary (APA, 2015, 2021; Davison, 2001). The LGBTQ+ identity is not pathological; it is how those identities are perceived in society that increases the risk for mental health issues (APA, 2021; Begeny & Huo, 2017; Davison, 2001). Although societal views of the queer population are important considerations in care, they are not necessarily the sources of distress (APA, 2015, 2021; Davison, 2001; Matsuno, 2019). Providers must address problem patterns of behavior, thoughts, and emotions, and whatever the source of distress may be (Coleman et al., 2022; Davison, 2001;
Matsuno, 2019). Care should be in the context of the minority stress model, with the recognition that some mental health disorders exist independently of the stress of their minority status. Queer women and nonbinary individuals seek psychological treatment for reasons unrelated to their sexual and gender identity (APA, 2015, 2021; Davison, 2001; Matsuno, 2019; Meyer, 2003).

Providers following ethical principles (APA, 2017a), multicultural guidelines (APA, 2017b), and guidelines created for sexual and gender minorities (APA, 2015, 2021) are prepared to serve these populations (Martell & Williams, 2019). Providers using sexual and gender minority-affirmative practice within the minority stress model are equipped to give high-quality care (APA, 2021; Coleman et al., 2022; Davison, 2001; Martell & Williams, 2019; Meyer, 2003). By offering equitable and high-quality care, challenges in access to mental health care for queer women and nonbinary individuals may lessen over time (Pachankis, 2018). More research is needed to confirm or refute this theory; however, available research suggests providers practicing as such will reduce access barriers to mental health care for queer women and nonbinary individuals (Martos et al., 2018; Pachankis, 2018).

Queer women and nonbinary individuals have been oppressed groups in the United States, often defined by heterosexual and cis normative societal members as pathologically different and needing treatment to be cured (Glotfelter et al., 2017; Kattari et al., 2020; Martell & Williams, 2019; NASEM, 2020; Pachankis, 2018; Valente et al., 2020). While perceptions and acceptance by society have evolved over recent years, societal stigma and bias remain significant factors having a negative impact on sexual and gender minorities (Casey et al., 2019; Herek et al., 2015; Lefevor et al., 2019; Martell & Williams, 2019; Pachankis, 2018; Rider et al., 2019). Social psychology science involves the study of the ways people think and act based on real or perceived behaviors of other individuals and within the complete social situation (Aronson et al.,
2018). The science of social psychology is integral to understanding the effects of perceived, implied, or actual experiences of the prejudice of sexual and gender minorities (Begeny & Huo, 2017; Frost, 2011; Hatzenbuehler, 2010; Hegarty et al., 2018). Queer women and nonbinary individuals experience prejudice (perceived, implied, or actual) in their everyday lives, and specifically when seeking mental health treatment (Lefevor et al., 2019; Martos et al., 2018; Matsuno, 2019; NASEM, 2020). When sexual and gender minorities face discrimination, rejection, and stigma when attempting to get mental health care or they encounter these issues during therapy, the challenges in access to equitable mental health care are perpetuated (Frost, 2011; Matsuno, 2019), and existing mental health issues for this population are worsened (Kattari et al., 2020; Martell & Williams, 2019; Martos et al., 2018; NASEM, 2020; Valente et al., 2020). In examining the issue from a social psychology perspective, where positive interactions and relationships affect outcomes (Aronson et al., 2018), LGBT-affirming and LGBT-competent providers within an LGBT-friendly therapeutic environment promote mental health treatment with the most likelihood of symptom reduction (APA, 2015, 2021; Cohn et al., 2018; Coleman et al., 2022; Kattari et al., 2020; Levesque et al., 2013; Martos et al., 2017; McClain et al., 2016).

There is evidence that societal norms and culture are shifting to become more accepting and tolerant of queer women and nonbinary individuals in recent years (Coleman et al., 2022; Human Rights Campaign Foundation, 2022; Oyamot et al., 2017). Even among more conservative groups in the United States, tolerance of queer individuals has increased (Oyamot et al., 2017). Researchers suggested the more conservative groups may feel pressure from the larger society to shift from intolerance to tolerance (Oyamot et al., 2017). Although there has been a movement in societal attitude towards greater acceptance of sexual and gender minorities,
inequalities and biases still exist (Casey et al., 2019; Coleman et al., 2022; Frost et al., 2019). However, the growing tolerance of queer women and nonbinary individuals may increase the availability of culturally-affirmative mental health care and thus promote better mental health for sexual and gender minorities (Austin, 2013; Human Rights Campaign Foundation, 2022; Martell & Williams, 2019; Martos et al., 2018; Pachankis, 2018).

Obstacles to queer women and nonbinary satisfaction with mental health care include societal stigma and discrimination, not always feeling safe to disclose their identity, lack of inclusive policies in the health care facility, lack of LGBTQ+ competent therapists, and lack of queer therapists (Human Rights Campaign Foundation, 2022; NASEM, 2020; Tebbe & Budge, 2022; Ulrich et al., 2022; Williams et al., 2019; Valdiserri et al., 2019). However, there is evidence to suggest efforts are underway to improve health care experiences for queer women and other sexual and gender minorities. There have been recent changes in how hospitals, health care systems, and health care providers and their professional organizations view LGB and gender diverse populations. They now recognize that all patients deserve respectful care tailored to their specific needs and actions need to be taken to make sure that happens for all sexual and gender minority patients in all interactions with the health care system (American College of Obstetricians and Gynecologists, 2021; American Hospital Association, 2022b; Association of Women’s Health, Obstetric, and Neonatal Nurses, 2022; Human Rights Campaign Foundation, 2022; Society for Maternal-Fetal Medicine et al., 2022).

The COVID-19 Pandemic and Mental Health

The United States Government Accountability Office (US GAO, 2021) reported that the prevalence and severity of mental health conditions have increased significantly during the pandemic. For example, before the pandemic 11% of adults reported experiencing symptoms of
anxiety or depression, but during the first year of the pandemic from April 2020 through February 2021, approximately 40% of adults reported these symptoms (US GAO, 2021). According to NCHS (2022a), over 39% of adults continued to report experiencing symptoms of anxiety or depression in the last 4 weeks during the period between April and May 2022. The percentage of adults reporting symptoms of anxiety or depression within the last 4 weeks did not differ by age, but was different by sex (female, 28.8%; male, 17.1%; (NCHS, 2022a). More members of the LGBT population (gay or lesbian, 34.3%; bisexual, 38.6%; transgender, 40%) reported these symptoms than straight (21.6%) or cisgender (22%) individuals (NCHS, 2022a). These data prompted concern from the United States Senate Committee on Finance (2022) that issued a report on the case for federal action on mental health care in the United States including expanding coverage for mental health care through Medicaid and Medicare and increasing the mental health work force to promote more timely access to care when needed. These recommendations cannot be quickly and universally implemented since individual states have control over how Medicaid coverage is offered and increasing the mental health work force will take many years due to rigorous requirements for education and credentialing.

The COVID-19 Pandemic and Queer Women and Nonbinary Individuals

Sexual and gender minorities, including queer women and nonbinary individuals, have been identified as particularly vulnerable communities during COVID-19, along with the rest of the sexual and gender minority population (Dawson, Frederiksen, et al., 2021; Fish et al., 2021; Kidd et al., 2021; Ralston et al., 2020; Salerno et al., 2020). The discrimination and stigma queer individuals experience combined with the pandemic has created a disproportionate impact on this population. The necessary safety restrictions of COVID-19, like social distancing and quarantine, have removed a source of coping and social support and intimacy that normally would be
available outside of a pandemic (Wallach et al., 2020). The isolation from social distancing and the quarantine can contribute to increased symptom presentation of pre-existing mental illness, which the LGBT population is more at risk for having than the non-LGBT population (Banerje & Nair, 2020; Kidd et al., 2021; Perlis et al., 2022; Salerno et al., 2020; Stefana et al., 2020). Due to the COVID-19 virus, many people have lost their jobs and ability to support themselves; this is also true for queer women and nonbinary individuals, who are discriminated against due to their sexual orientation outside of the pandemic, adding another stressor (Jarrett et al., 2021; Kidd et al., 2021; Salerno et al., 2020; Wallach et al., 2020). The job loss can affect the ability of queer women and nonbinary individuals who relied on their job for health insurance to seek mental health care, telepsychology or not, due to being outside of the open enrollment period for the Affordable Care Act based health plans (Dawson, McGough, et al., 2021; Salerno et al., 2020).

The historical parallel to the HIV/AIDS epidemic of the 1980s and 1990s and the COVID-19 virus also resonates with the sexual and gender minority community, acting as a reminder of another time of mass death and fear (APA, 2021; Dawson, Kirzinger, et al., 2021; Wallach et al., 2020). The pandemic disproportionately affected both queer women and nonbinary individuals as these populations are more likely to not have access to health care and greater rates of mental illness as compared to binary non-queer individuals (Banerje & Nair, 2020).

Sexual and/or gender minorities, such as queer women and nonbinary individuals, are more vulnerable to having mental health issues, substance misuse, heart issues, and financial difficulties due to societal oppression (Mereish & Poteat, 2015; Meyer, 2003; NASEM, 2020). The COVID-19 virus has added another stressor to a population that already experiences disparities in mental health care (Alonzi et al., 2020; Dawson, McGough, et al., 2021; Fish et al., 2021; Pillay & Barnes, 2020). In a survey conducted by the U.S. Census Bureau in the summer
of 2021 with over 266,000 households responding, significant disparities in mental health were found when comparing LGBT respondents and non-LGBT respondents (U.S. Census Bureau, 2021). For example, 47.9% of LGBT respondents compared to 23.5% of non-LGBT respondents reported experiencing anxiety for more than half of the days in a week and 38.2% of LGBT respondents compared with 16.1% of non-LGBT respondents experienced depression for more than half of the days in a week (U.S. Census Bureau, 2021). Discrimination and violence against sexual and gender minority groups, including queer women and nonbinary individuals, has only increased with the COVID-19 virus-related social separation and societal stressors (Kamal et al., 2021; Pillary & Barnes, 2020). The isolation and barriers to care have only increased with the appearance of COVID-19 for older sexual and gender minorities, including queer women and nonbinary individuals, due to discrimination and its pervasive effects on their lives (Jarrett et al., 2021; Kidd et al., 2021; Lee & Miller, 2020; Meyer, 2003; Salerno et al., 2020).

It is important to recognize information and research concerning the COVID-19 virus itself along with comorbid psychiatric issues are ongoing, and new findings were emerging as this dissertation was conducted. The incidence and implications of long-COVID and vaccine-resistant viral strains are being studied (Mehandru & Merad, 2022). Based on preliminary data, Long COVID appears to affect women more than men (Di Toro et al., 2021; Msherghi et al., 2021; Pelà et al., 2022; Perlis et al., 2022), thus there can be significant implications for the gay, queer, and lesbian women population and nonbinary individuals who were assigned female at birth. There is little known about the long-term effects of Long COVID on mental health. More research and time are needed for science to evolve on the topic. There is evidence to suggest Long COVID is associated with increased rates of anxiety, sleep disorders, difficulties with concentration, memory loss, and chronic fatigue (Bai et al., 2021; Ballering et
Data suggests COVID-19 survivors may experience socially based challenges including isolation, grief, loss of routine, loss of employment, and more (Palmer, 2021).

More researchers are investigating the COVID-19 virus and its effect on the world, and on more specific populations, like LGBTQ+ individuals (Dawson, Kirzinger, et al., 2021; Dawson, McGough, et al., 2021; Kidd et al., 2021; Perlis et al., 2022). Researchers can provide the needed information to adapt and overcome the obstacles of the COVID-19 virus and how to attend to the mental health needs of the population (Stefana et al., 2020). One method is the use of virtual mental health care sessions or telepsychology; the restrictions on this method of mental health care have been temporarily lifted in the United States to increase access to care and ease the way for providers to give therapy (Taylor et al., 2020). With telepsychology, there is a potential of increasing the ability of marginalized groups, like queer women and nonbinary individuals, to receive psychological services when it would otherwise not be possible due to geographic limitations or societal stigma (Ralston et al., 2020). Telepsychology limits the need for transportation to a session, the cost of transportation, and potentially can be more convenient for patients to access from where they live, work, or wherever they are (Hunt & Hooten, 2020). Removal of these barriers by offering telepsychology can improve access, convenience, and satisfaction with mental health care during the pandemic as there is a large body of evidence that supports the feasibility, efficacy, and patient support of telehealth services before the pandemic (Bashshur et al., 2016; Irvine et al., 2020; Jenkins-Guarnieri et al., 2015; Orlando et al., 2019; Shigekawa et al., 2018) and during the pandemic (Chen et al., 2022; Fear et al., 2022; Gliske et al., 2022; Iturralde et al., 2022; Sugarman et al., 2021; Thomas et al., 2021; Waite et al., 2022). The COVID-19 pandemic caused a major and rapid change in how health care is delivered in the
United States and around the world, from the traditional in-person clinical setting to telehealth methods such as video conferencing and telephone or smart phone use between patients and their health care providers (Bees, 2022; CMS, 2020; Fear et al., 2022; Kisicki et al., 2022; Lucas & Villarroel, 2022; USDHHS, 2021; Ward et al., 2022; Xu et al., 2021; Zangani et al., 2022).

In 2021, approximately 37% of US adults reported having used telehealth in the past 12 months (Lucas & Villarroel, 2022). This change was not limited to younger patients; usage was higher as patient age increased (Lucas & Villarroel, 2022; NCHS, 2022b). USDHHS (2021) reported that telehealth Medicare visits increased 63-fold, from 840,000 visits in 2019 to 52.7 million visits in 2020. Mental health care played a prominent role in this dramatic increase of telehealth among Medicare recipients. Telehealth visits with behavioral health care providers comprised one-third of visits, which was the highest rate when compared to other health care providers in 2020 (USDHHS, 2021). NCHS (2022b) reports most recent data from the Pulse Household Survey conducted in May and June 2021 that approximately 23% of US adults stated they had a telemedicine visit within the last 4 weeks. The percentage of respondents indicating this recent telemedicine use increased by age, ranging from 19% to those aged 18 to 19 to 31% for those over 80 years of age. More women (26.2%) than men (19.2%) reported a telemedicine visit within the last 4 weeks (NCHS, 2022b). The LGBT population (gay or lesbian, 27%; bisexual, 31%; transgender, 41%) used telemedicine more than straight (22%) or cisgender (22%) individuals (NCHS, 2022b).

However, the availability of virtual mental health care does not necessarily mean it can be accessed. To access telepsychology, a patient needs the technology to hold a session, a reliable internet or cellular signal, a phone, tablet, or computer, a safe, private, and secure place to hold a session, comfortability with technology, along with a number of other concerns, which is not
guaranteed for the patient to have access to or have at all (Lucas & Villarroel, 2022; Ralston et al., 2020; Taylor et al., 2020). Some of these limitations go beyond needing the physical technology; if the infrastructure is not in place for telepsychology (high-speed internet, cell signal), patients may be left without an avenue to receive the treatment previously available in person (Kisicki et al., 2022; NCHS, 2022b; Ralston et al., 2020; Zangani et al., 2022). A patient must also have the mental energy to attend the telepsychology sessions to gain any benefit of therapy (Stefana et al., 2020). If the symptom presentation is too severe, patients may be unable to engage in treatment when session attendance requires more technological navigation (Ralston et al., 2020). As more evidence about ease of accessibility and patient satisfaction with virtual mental health services emerges, it is important to recognize that these trends may leave some patients behind. Therefore, more study is needed to seek solutions to increase virtual accessibility to mental health care for as many patients as possible with opportunities to have virtual care sessions, including those without smartphones. Patient satisfaction with mental health sessions via telephone is similar to that of videoconferencing (Bashshur et al., 2016; Chen et al., 2022; Hays & Skootsky, 2022). Some mental healthcare providers have expressed concerns about potential provider barriers to telehealth delivery including access to technology to have remote sessions as well as restrictions on licensure and lack of reciprocity among states (Thomas et al., 2021). The Psychology Interjurisdictional Compact (PSYPACT) is one organization working to decrease the barriers of state bound licensure by increasing member states to allow for licensure reciprocity between states and broaden mental healthcare providers’ reach (there are 33 states that are members of PSYPACT; PSYPACT, n.d.-a, n.d.-b). Expanded mental health services that include telepsychology as a routine option for many psychological disorders may become standard care, however as more patients use this service during the pandemic, it is worth
continuing to study its utility in promoting optimal outcomes and allowing more patients who need mental health services to be able to receive them. These data may inform the future of mental health care treatment.

Summary

Even with flexible regulations, increased availability of mental health care through telepsychology, and the potential convenience of telepsychology, pre-existing health disparities and societal barriers to care may be too much to overcome for queer women and nonbinary individuals seeking telepsychology during a time it is more available (Meyer, 2003; Pfender, 2020, Salerno et al., 2020; Smith et al., 2020). Continued mental health care disparities for queer women and nonbinary individuals during the COVID-19 pandemic are likely to continue to result in deceased satisfaction with mental health care services (Banerjee & Nair, 2020; Dawson, Kirzinger et al., 2021; NASEM, 2020; Zelle & Arms, 2015). More research needs to be done to assess the access to mental health care of queer women and nonbinary individuals during the COVID-19 pandemic by surveying queer women and nonbinary individuals between the ages of 18 and older who are receiving telepsychology in the United States, regarding their satisfaction with care.

This dissertation provides the foundation for further exploration and understanding of the mental health care disparities even when telepsychology is reported to be more available during the COVID-19 pandemic than previously. Specific research questions included the following: (a) Are there differences in the percentage of survey respondents who received mental health care before the pandemic and during the pandemic? (b) Are there differences in how survey participants received care before the pandemic and during the pandemic (in-person, remote, or a combination of the two)? (c) Are there differences in the number and type of mental health
services survey respondents received before and during the pandemic? and (d) Are there differences in satisfaction with mental health care reported by survey respondents before and during the COVID-19 pandemic?
CHAPTER III: METHODS

This study was a quantitative descriptive research design using survey methods. Data provides a sample of a larger cross-section of the population of queer women and nonbinary individuals in the United States who were receiving mental health services. The study was conducted through distribution of a survey posted on four social media websites and flyers hung in university student centers and queer-friendly businesses to recruit queer women and nonbinary individuals in the United States currently in mental health care.

Sample

Inclusion criteria were queer women and nonbinary individuals ages of 18 and older living in the United States during COVID-19 who have had mental health services some time before or since the pandemic shutdown in March 2020. The survey was formatted so that if participants did not meet inclusion criteria (age $\geq$ 18, female or nonbinary, lesbian, gay, bisexual, pansexual, or other, and within the United States or their territories), they could not proceed. They were invited to participate via a link to a 43-item online survey posted on four social media sites and flyers hung in university student centers and queer-friendly businesses in the Kansas City and Saint Louis areas. It was estimated the survey would take 10 to 15 minutes to complete. No compensation for participation was offered or provided to respondents; however, at the end of the survey they were invited to enroll in a drawing for one of four $25 Amazon gift cards by entering their email address via a separate survey link to maintain participant confidentiality.

Recruitment

Recruitment occurred on four social media websites (Facebook, Twitter, Reddit, and Tumblr) and by flyers hung in university student centers and queer-friendly businesses in the Kansas City and Saint Louis areas to allow for a representative sample, considering how specific
and small the overall population of queer women and nonbinary individuals is in the United States (Bull et al., 2013; Corey et al., 2018; Darmawan et al., 2020). The social media sites Facebook and Twitter have been successfully used to recruit members of various types of targeted groups to participate in research surveys without paid advertisement (Barnes et al., 2020; Guillory et al., 2016; Hendricks et al., 2016; Keaver et al., 2019; Srivastav et al., 2021; Yuan et al., 2014). Examples of groups on Facebook were LGBTQ+ groups in various U.S. cities.

Accounts on Twitter with large followings such as The National Coalition for LGBT Health and National Center for Lesbian Rights were followed to boost survey dissemination. This information is not available for Reddit and Tumblr; therefore, on these platforms, relevant groups were identified by search of each site using the terms lesbians, lesbian women, queer women, queer, LGBT, LGBTQ, and LGBTQ+. On Facebook, most groups allow posting of invitations to participate in surveys, including both marketing surveys and surveys involving research, after getting permission from the administrator of the group via email. Examples of groups on Facebook were LGBTQ+ groups in various U.S. cities. Each group administrator was contacted to request permission to post a flyer with an invitation to participate and a link to the survey (Figure 3.1). The request asked that the administrator post the survey once per week for four weeks. On Twitter, groups allow posting of surveys involving research after joining the group, so the survey flyer was posted every week during participant recruitment. The survey was live for six weeks in September and October 2022 until at least 150 usable surveys were collected.

SurveyMonkey analytics tracks the number of users that access the link (i.e., the “traffic rate”) along with how many respondents complete the survey (i.e., the “conversion rate”). The
survey was promoted with the flyer (Figure 3.1) including a short introduction of the research and a link to the SurveyMonkey site and the informed consent form (Appendix). The informed consent form detailed the purpose of the study, how their participation in the survey was voluntary, possible risks and benefits of participating, and who they could contact for further information about the study. SurveyMonkey was formatted so that the respondent could not proceed with the survey unless they complete the informed consent process and meet study inclusion criteria.

Figure 3.1

*Flyer for Survey Promotion on Social Media*

This recruitment method allowed for more diversity across racial, ethnic, cultural, regional, socio-economical, and other boundaries compared to other survey methods. Sampling was convenience-based, using a snowball technique, as members of Facebook, Twitter, and Tumblr groups could post the information about the study and link to the survey to their individual account feeds.
**Instrumentation**

A survey assessing mental health care experiences and barriers to care for people with Parkinson’s Disease (Dobkin et al., 2013) was adapted to assess the experiences of queer women and nonbinary individuals using mental health services before and during the COVID-19 pandemic. The authors of the survey granted permission for their survey to be used for research upon the publication of their study (Dobkin et al., 2013). The survey prompted respondents to report their demographic information in addition to their information about their experience with mental health services before and during COVID-19 (exploring satisfaction with care at both times). Survey items include multiple-choice questions and yes or no questions. Items from the original survey were adapted for mental health services and satisfaction and barriers to care before and during COVID-19, rather than before and after treatment for Parkinson’s Disease. The original researchers did not have psychometric data available for their instrument (Dobkin et al., 2013). The adapted survey has face validity, however other psychometric analyses have not been done. The survey was formatted on SurveyMonkey, a secured and encrypted website, and the access link was included as part of the recruitment flyer (SurveyMonkey, 2021).

**Informed Consent**

Informed consent was given by respondents before the survey began (see Appendix). The survey was formatted such that respondents were not able to proceed without completing the informed consent process. The respondents were informed of the purpose of the research, potential risks and benefits of participating, that participation was voluntary, and who to contact for more information. I provided my contact information as well as contact information of the Provost of Antioch University New England and the Chair of Institutional Review Board for the reference of the respondents.
Data Analysis

The data allowed for a greater understanding of the experiences and satisfaction of queer women and nonbinary individuals with mental health care before and during the COVID-19 pandemic based on survey responses. Data analysis was conducted via SPSS IBM v.28. Each item’s responses were numerically coded to allow for statistical analysis. Characteristics of the sample were analyzed based on responses to demographic items. Demographic data such as age, race, gender, ethnicity, relationship status, level of education, work status, health insurance, and overall health status were analyzed and reported using descriptive statistics. Charts and tables were used to report findings for select items. States where respondents report living were coded based on four geographical regions as per the Centers for Disease Control and Prevention (2022b). Nominal and ordinal data were analyzed using Spearman’s correlation to evaluate potential correlations between the variables in the survey responses to answer the research questions.

Ethical Considerations

Because the respondents of this study are members of a group that has suffered systemic and societal stigma and discrimination, it is important to recognize the vulnerability of this population. These survey items have potential to be distressing for those who have had invalidating experiencing receiving mental health care. However, it was unlikely that harm came to the respondents of the survey because it is a low-risk activity. The internet survey venue provides anonymity to the respondents, which could lessen the potential risk of being outing for their sexual or gender orientation. Respondents do not gain any tangible reward or benefit from completing this survey, aside from contributing to the literature available on this minority population. Four respondents were recipients of one of the four $25. Amazon gift cards offered.
as part of a random drawing for those who chose to enter after completing the survey.

Contributing to the larger body of LGBTQA+ research is a potential benefit considering it is a small but growing area of study. Research about COVID-19, mental health services, and telepsychology is currently growing, and contributions to this body of knowledge may draw more attention to mental health care disparities in the United States.
CHAPTER IV: RESULTS

Demographic data were analyzed using descriptive statistics including frequencies and percentages. Research questions were analyzed using Spearman’s correlations.

Demographic Data

Based on SurveyMonkey analytics, 216 respondents clicked on the link and 175 respondents completed the survey, for a conversion rate of 81%. Of the 216 survey respondents, 32 were excluded due to not having met the inclusion criteria (n = 1, did not consent to participate; n = 6, male; n = 20, straight; n = 2, under 18 years old; n = 3, not residents of the United States) and n = 9 did not answer any questions beyond the demographic items, leaving n = 175 that were included in the analysis. Most of the 175 total participants were recruited from Facebook (n = 149) and flyers hung in university student centers and businesses friendly to queer women (n = 20). Only six accessed the link from Twitter and there were no participants that accessed the links posted on Reddit and Tumblr. Average time to complete the survey was 4 minutes, with a range of 3 to 7 minutes.

The majority of participants were White (78.86%, n = 138), non-Hispanic (88.57%, n = 155), women living in urban (44%; n = 77) or suburban (46.29%, n = 81) areas. All but six were between the ages of 18 to 24 (52%, n = 91) and 25 to 44 (45.57%; n = 78); none were over age 64. See Table 4.1 for full demographic data details. Participants reported being from 45 of the 50 states, the District of Columbia, and Puerto Rico. Using the CDC (2022b) regions of the country categories, 20% (n = 35) were from the Northeast, 29.14% (n = 51) from the Midwest, 28.57% (n = 50) from the South, and 22.28% (n = 39) from the West. Most had at least some college education (92%, n = 161). Slightly more than one-half of participants (55.42%, n = 97) were college graduates or had attended graduate school. Most were working full or part time (80%,
and had private health insurance coverage (80%, n = 140). Average (68.57%, n = 120) or excellent (18.85%, n = 33) health status was most commonly reported.

Participants’ gender included the majority (79.43%; n = 139) female, with 19.43% (n = 34) nonbinary and 1.14% (n = 2) other. Sexual orientation was predominantly Lesbian (70.29%, n = 129). Other sexual orientation included gay (1.71%, n = 3), bisexual (13.71%, n = 24), pansexual (9.71%, n = 17), and other (4.57%, n = 8). Slightly more than half of participants (53.71% n = 94) reported not currently being in a relationship. Other relationship status included married (8%, n = 14), living with a partner (17.71%, n = 31), and in a relationship but not living together (20.57%, n = 36).

Almost all participants reported they believed that mental health services were beneficial (25.71%; n = 45) or very beneficial (69.14%, n = 121) for helping individuals cope with depression, anxiety, and/or the stress of living with mental illness. Yet only 24.57% (n = 43) were very aware of mental health services in their local community; 67.43% (n = 118) reported they were aware to some degree and 8% (n = 14) were not aware at all. Of those who did not receive mental health services before the pandemic (n = 55), 96.36% (n = 53) felt they needed help managing concerns such as depression, anxiety, stress, or other mental health disorders during the pandemic. Almost half (46.63%, n = 76) of participants reported that someone close to them had become serious ill with the COVID-19 virus during the pandemic and 15.37% (n = 25) of participants reported that someone close to them had died of COVID-19.
Table 4.1

Demographic Characteristics of Participants

<table>
<thead>
<tr>
<th>Demographic Categories</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>139</td>
<td>79.43%</td>
</tr>
<tr>
<td>Non-Binary</td>
<td>34</td>
<td>19.43%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.14%</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesbian</td>
<td>123</td>
<td>70.29%</td>
</tr>
<tr>
<td>Gay</td>
<td>3</td>
<td>1.71%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>24</td>
<td>13.71%</td>
</tr>
<tr>
<td>Pansexual</td>
<td>17</td>
<td>9.17%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>4.57%</td>
</tr>
<tr>
<td>Age Range</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>91</td>
<td>52%</td>
</tr>
<tr>
<td>25-44</td>
<td>78</td>
<td>44.57%</td>
</tr>
<tr>
<td>45-64</td>
<td>6</td>
<td>3.43%</td>
</tr>
<tr>
<td>CDC Geographic Regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>35</td>
<td>20%</td>
</tr>
<tr>
<td>Midwest</td>
<td>51</td>
<td>29.1%</td>
</tr>
<tr>
<td>South</td>
<td>50</td>
<td>28.6%</td>
</tr>
<tr>
<td>West</td>
<td>39</td>
<td>22.3%</td>
</tr>
<tr>
<td>Urban/Suburban/Rural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>77</td>
<td>44%</td>
</tr>
<tr>
<td>Suburban</td>
<td>81</td>
<td>46.29%</td>
</tr>
<tr>
<td>Rural</td>
<td>17</td>
<td>9.71%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>138</td>
<td>78.86%</td>
</tr>
<tr>
<td>Black/ African American</td>
<td>10</td>
<td>5.71%</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
<td>1.14%</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>1.14%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>1</td>
<td>0.57%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>17</td>
<td>9.71%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>2.86%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>20</td>
<td>11.43%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>155</td>
<td>88.57%</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>14</td>
<td>8%</td>
</tr>
<tr>
<td>Living with a Partner</td>
<td>31</td>
<td>17.71%</td>
</tr>
<tr>
<td>In a Relationship, But Not Living Together</td>
<td>36</td>
<td>20.57%</td>
</tr>
<tr>
<td>Demographic Categories</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>------------------------</td>
<td>----</td>
<td>------</td>
</tr>
<tr>
<td>Not Currently in a Relationship</td>
<td>94</td>
<td>53.71%</td>
</tr>
<tr>
<td>Highest Educational Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School Graduate</td>
<td>14</td>
<td>8%</td>
</tr>
<tr>
<td>Some College</td>
<td>64</td>
<td>36.57%</td>
</tr>
<tr>
<td>College Degree</td>
<td>53</td>
<td>30.29%</td>
</tr>
<tr>
<td>Some Graduate School</td>
<td>21</td>
<td>12%</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>23</td>
<td>13.14%</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed, Working Full-Time</td>
<td>87</td>
<td>49.71%</td>
</tr>
<tr>
<td>Employed, Working Part-Time</td>
<td>53</td>
<td>30.29%</td>
</tr>
<tr>
<td>Not Employed</td>
<td>35</td>
<td>20%</td>
</tr>
<tr>
<td>Health Insurance Source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private or Commercial</td>
<td>140</td>
<td>80%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>16</td>
<td>9.14%</td>
</tr>
<tr>
<td>Medicare</td>
<td>8</td>
<td>4.57%</td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>6.29%</td>
</tr>
<tr>
<td>Overall Health Rating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>22</td>
<td>12.57%</td>
</tr>
<tr>
<td>Average</td>
<td>120</td>
<td>68.57%</td>
</tr>
<tr>
<td>Excellent</td>
<td>33</td>
<td>18.86%</td>
</tr>
</tbody>
</table>

Note. N = 175

Testing the Research Questions

Are there differences in the percentage of survey respondents who received mental health care before the pandemic and during the pandemic? Before the COVID-19 pandemic, 68.57% (n = 120) of 175 survey participants received mental health care services, compared with 86.31% (n = 145) during the pandemic (p = .002). Therefore, there was a significant increase in the percentage of survey respondents who reported they received mental health care before the COVID-19 pandemic when compared to those who reported they received mental health care during the pandemic. See Table 4.2 for correlations data.

Are there differences in how survey participants received care before the pandemic and during the pandemic (in-person, remote, or a combination of the two)? Of the 120 survey participants who received care before the pandemic, n = 114 answered the question on
how they received care. In-person care was most reported before the pandemic (82.46%, \(n = 94\)), followed by a combination of remote care (which included videoconferencing and telephone consultation) and in-person care (10.53%, \(n = 12\)), and remote care (7.02%, \(n = 8\)). Of the 168 survey participants who received care during the pandemic, \(n = 142\) answered how they received care. Remote care was most reported (65.48%, \(n = 93\)), followed by a combination of remote and in-person care (26.76%, \(n = 38\)), and in-person care (7.75%, \(n = 11\)). Therefore, compared to before the pandemic, significantly more survey participants reported receiving remote care during the pandemic (\(p = .026\)). See Table 4.2 for correlations data.

**Are there differences in the number and type of mental health services survey respondents received before and during the pandemic?** Before the pandemic, 26.32% \((n = 30)\) of participants received care weekly, 42.11% \((n = 48)\) every 2 weeks, 16.67% \((n = 19)\) monthly, and 7.02% \((n = 8)\) every 2 months, compared with frequency of care during the pandemic, 37.32% \((n = 53)\) weekly, 26.76% \((n = 38)\) every 2 weeks, 23.24% \((n = 33)\) monthly, and 6.34% \((n = 9)\) every 2 months. See Table 4.2 for correlations data. There was a significant difference in type of care received such as psychotherapy and/or medication (\(p < .001\)). A higher percentage of participants (64.79%, \(n = 92\)) received both psychotherapy and medication during the pandemic compared with before the pandemic (52.63%, \(n = 43\)). Therefore, there was a significant increase in how often participants were seen during the pandemic when compared to before the pandemic (\(p = <.001\)).

**Are there differences in satisfaction reported by survey respondents with mental health care before and during the pandemic?** Satisfaction was measured by asking survey participants three questions: (a) How satisfied they were with their mental health care before and during the pandemic, (b) How helpful they perceived the mental health care they received before
and during the pandemic, and (c) If they were able to be seen as frequently as they felt they needed before and during the pandemic. Participants were generally satisfied with the mental health care they received before and during the pandemic, however satisfaction during the pandemic was significantly higher; 75.35% (n = 107) of participants reported they were satisfied or very satisfied with their mental health care during the pandemic as compared 70.18% (n = 80) before the pandemic (p < .001). Most found the care helpful or very helpful (Figure 4.1), although the percentage of participants that found the mental health care helpful or very helpful was reported higher during the pandemic compared to before the pandemic (p = .004). There was no significant difference in participants reports’ of being able to be seen as frequently as they needed before and during the pandemic (p = .86). See Table 4.2 for correlations data.

Table 4.2

Responses to Questions about Mental Health Care Before and During the COVID-19 Pandemic* Spearman’s Correlations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Before (n)</th>
<th>During (n)</th>
<th>Correlation</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received Mental Health Care</td>
<td>120</td>
<td>145</td>
<td>.223</td>
<td>.002</td>
</tr>
<tr>
<td>How Care Was Received (In-Person, Remote or a Combination)</td>
<td>100</td>
<td>142</td>
<td>.224</td>
<td>.025</td>
</tr>
<tr>
<td>Frequency of Mental Health Care Received</td>
<td>101</td>
<td>142</td>
<td>.423</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Satisfaction with Mental Health Care Received</td>
<td>101</td>
<td>139</td>
<td>.401</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>How Helpful was Mental Health Care Received</td>
<td>101</td>
<td>142</td>
<td>.288</td>
<td>.004</td>
</tr>
<tr>
<td>Received Mental Health Care as Frequently as Needed</td>
<td>101</td>
<td>142</td>
<td>.086</td>
<td>.402</td>
</tr>
</tbody>
</table>

*Not all participants answered each item
Figure 4.1

Helpfulness of Mental Health Care Received

Follow-Up Question

Participants were asked about what aspects of mental health care they would like to change. Options included gender affirming care, queer-specific care and expertise in queer identity, explicit signs of queer support, more queer care providers, and other. The most common responses were more queer-specific care and expertise in queer identity, followed by more queer care providers.
CHAPTER V: DISCUSSION

The aim of this study was to investigate the experience of queer women and nonbinary individuals with mental health care before and during the COVID-19 pandemic. The survey was administered to 175 queer women and nonbinary individuals recruited by social media posts and flyers hung in university student centers and queer-friendly business in the Kansas City and Saint Louis areas. Survey items asked participants about demographic information as well as questions about their mental health care experiences before and during the pandemic including the following: (a) Are there differences in the percentage of survey respondents who received mental health care before the pandemic and during the pandemic? (b) Are there differences in how survey participants received care before the pandemic and during the pandemic (in-person, remote, or a combination of the two)? (c) Are there differences in the number and type of mental health services survey respondents received before and during the pandemic? (d) Are there differences in satisfaction with mental health care reported by survey respondents before and during the COVID-19 pandemic?

The most noteworthy findings of this study were that, during the pandemic, compared with before the pandemic, significantly more survey participants received mental health care, and they reported significantly more virtual mental health visits, more frequent mental health visits, more intensive therapies, and higher patient satisfaction. Telehealth was perceived to be beneficial by most participants.

Representative Sample

The sample was geographically diverse, representing all areas of the country. Demographic data about survey respondents are remarkably similar to data about the population of queer women and nonbinary individuals in the United States most recently collected from the
U.S. Census Bureau (2021), thus findings of this study may contribute to what is known about the experiences of queer women and nonbinary individuals in the United States receiving mental health care before and during the COVID-19 pandemic. The sample was comprised of predominately non-Hispanic White, college educated, employed, private insurance covered participants between the ages of 18 and 44 in average to good health living in urban or suburban metropolitan areas. The U.S. Census Bureau’s Household Pulse Survey started collecting data about the LGBT population in July 2021. The Household Pulse Survey found the majority of LGBT adults were predominately non-Hispanic White, college educated, between the ages of 18 and 49, and had health insurance (U.S. Census Bureau, 2021), very similar to participants in this study. LBGT adults in same sex households are more likely to be employed (65%) than non-LBGT adult opposite sex couples (51%) per the U.S. Census Bureau (2021). There are approximately 20 million members of the LGBTQ+ population living in the United States (Human Rights Campaign Foundation, 2021) and approximately 3 to 5 million of those (~20%) live in rural areas (Movement Advancement Project, 2019). Thus, employment status (80%) and urban/suburban residence (90%) of this sample also are generally representative of the US LGBTQ+ population demographics.

After demographic information was analyzed, the research questions were tested, specifically evaluating the (a) differences in number of participants receiving mental health care (b) differences in how mental health care was received (c) differences in frequency and type of mental health care and (d) differences in satisfaction with mental health care.

**Differences in Number of Participants Receiving Mental Health Care**

Findings of this study showed that the majority of queer women and nonbinary individuals who participated in the survey reported receiving mental health care both before and
during the pandemic, however use of mental health services was significantly increased when comparing before and during the pandemic. These findings are consistent with the literature that has been published to date on mental health services before and during the COVID-19 pandemic (Bashshur et al., 2016; Bees, 2022; Fear et al., 2022; Irvine et al., 2020; Iturralde et al., 2022; Jenkins-Guarnieri et al., 2015; NCHS, 2022a, 2022b; Orlando et al., 2019; Shigekawa et al., 2018). This trend has continued from the early months of the pandemic in May 2020 until at least October 2022 based on results of this study.

Nearly all of those who did not receive mental health services before the pandemic felt they needed help managing concerns such as depression, anxiety, stress, or other mental health disorders during the pandemic. These findings are consistent with the data from the NCHS (2022a) that more members of the LGBT population (gay or lesbian, 34.3%; bisexual, 38.6%; transgender, 40%) reported symptoms of anxiety or depression within the last 4 weeks than straight (21.6%) or cisgender (22%) individuals. More women (26.2%) than men (19.2%) reported a telemedicine visit within the last 4 weeks and the LGBT population (gay or lesbian, 27%; bisexual, 31%; transgender, 41%) used telemedicine more than straight (22%) or cisgender (22%) individuals (NCHS, 2022b).

**Differences in How Mental Health Care was Received**

Before the pandemic, a high percentage of queer women and nonbinary individuals who participated in the survey reported receiving mental health care in person, with a less than 10% combination of virtual and in-person sessions, and even fewer receiving virtual only. During the pandemic, there was a significant change in how they received care, with almost completely opposite results. Less than 10% reported receiving mental health care in person, and the rest reported virtual only or a combination of virtual and in-person. These study results are consistent
with reported trends in health care in the United States during the COVID-19 pandemic and reflect the dramatic shift from in-person sessions to remote sessions to decrease risk of viral exposure (Fear et al., 2022; Jarrett et al., 2021; Kidd et al., 2021; Kisicki et al., 2022; Lucas & Villarroel, 2022; NCHS, 2022a, 2022b; USDHHS, 2021; Ward et al., 2022; Xu et al., 2021; Zangani et al., 2022). At the beginning of the COVID-19 pandemic, in the face of stay-at-home orders, patients avoiding health care visits due to concerns about being infected with the virus, and lack of vaccines, hospitals, health care systems, and health care providers, were faced with a rapidly developing, unavoidable, and enormously consequential choice: not seeing patients at all or seeing patients virtually (Fear et al., 2022). Health care outcomes of their patients and financial viability were at stake. Results of this study are in line with the choices that were made to rapidly accommodate patient care needs using various types of telehealth (NCHS, 2022a).

**Differences in Frequency and Type of Mental Health Care**

Compared with before the pandemic, queer women and nonbinary individuals who participated in the survey reported being seen more frequently during the pandemic. These data may reflect a great need for mental health care during the pandemic, thus more frequent mental health care sessions were received. Likewise, reflecting an increased need, a significantly higher percentage of queer women and nonbinary individuals who participated in the survey reported receiving both psychotherapy and medication during the pandemic compared with before the pandemic. These study results on increased frequency and intensity of therapy are similar to recent national data. For example, before the pandemic, 11% of adults reported experiencing symptoms of anxiety or depression, but during the first year of the pandemic from April 2020 through February 2021, approximately 40% of adults reported these symptoms (US GAO, 2021). According to NCHS (2022a), over 39% of adults continued to report experiencing symptoms of
anxiety or depression in the last 4 weeks during the period between April and May 2022. The percentage of adults reporting symptoms of anxiety or depression within the last 4 weeks did not differ by age, but was different by sex (female, 28.8%; male, 17.1%; NCHS, 2022a). More members of the LGBT population (gay or lesbian, 34.3%; bisexual, 38.6%; transgender, 40%) reported these symptoms than straight (21.6%) or cisgender (22%) individuals (NCHS, 2022a).

**Differences in Satisfaction with Mental Health Care**

Queer women and nonbinary individuals who participated in the survey were generally satisfied with their mental health care before and during the pandemic and reported that they found the mental health care services helpful. Interestingly, satisfaction with mental health care was significantly higher during the pandemic than before the pandemic. Potential reasons for the findings of higher satisfaction during the pandemic may be due to patients feeling their increased need for more frequent and intense mental health services were adequately met. Participants reported that they were able to be seen as frequently as they felt they needed both before and during the pandemic. These findings are consistent with the literature that has been published to satisfaction with remote mental health care during the pandemic (Bees, 2022; Chen et al., 2022; Gliske et al., 2022; Kruse et al., 2017; Orlando et al., 2019; Sugarman et al., 2021; Thomas et al., 2021; Waite et al., 2022).

Before the pandemic, telemedicine including for mental health care, had been gaining more widespread use and appeal as well as supportive evidence based on several systematic reviews (Bashshur et al., 2016; Irvine et al., 2020; Jenkins-Guarnieri et al., 2015; Kruse et al., 2017; Orlando et al., 2019; Shigekawa et al., 2018). Bashshur et al. (2016) found strong evidence for the feasibility and efficacy of telehealth for mental health care including improvements in medication adherence, depressive symptoms, and quality of life. Shigekawa et al. (2018) found
that telehealth for mental health care was largely equivalent to in-person care in interventions and outcomes for multiple conditions, including post-traumatic stress disorder, attention deficit hyperactivity disorder, major depressive disorder, and autism. Although telephone and video visits may be shorter than in-person sessions, there were no differences reported in therapeutic relationships between mental health care providers and patients based on type of session (Irvine et al., 2020). Patients and health care providers reported satisfaction with telehealth in the domains of patient and provider rapport, emotional support, quality of care, professionalism and cultural competence in a systematic review conducted before the pandemic, although not all studies measured patient satisfaction or defined patient satisfaction when evaluating patient and health care providers’ perceptions (Kruse et al., 2017; Orlando et al., 2019). Patients appreciated the convenience of the ability to access care without having to travel (Kruse et al., 2017; Orlando et al., 2019).

The change to virtual mental health visits to video and telephone sessions has been generally well accepted by patients and mental health care providers. Patient satisfactions and outcomes continue to be similar between virtual and in-person care, and patients value being able to get care without having to be potentially exposed to the COVID-19 virus (Bees, 2002; Fear et al., 2022; Gliske et al., 2022; Sugarman et al., 2021; Thomas et al., 2021). Convenience and lack of a required commute were similarly cited by behavioral health care workers as positive aspects of virtual mental health in a survey of clinicians in US behavioral health programs, however some acknowledged that technology access for patients was a challenge (Kisicki et al., 2022).

In a survey of patients and clinicians in a large Midwest health care system about behavioral health care, patients rated virtual treatment high and reported they preferred it over
in-person visits (Waite et al., 2022). Over time as the COVID-19 pandemic continued, patient and clinician preference for virtual visits increased and clinicians felt both types of care to be equally effective (Waite et al., 2022). Quality data from the health care system indicated higher completion rates, attendance rates, and number of treatment visits supporting evidence that virtual mental health care had similar or better outcomes than traditional in-person sessions (Waite et al., 2022). In the systematic review by Thomas et al. (2021), results of all randomized controlled trials included in the review found no difference in outcomes or measures of satisfaction when comparing virtual mental health care and traditional in-person treatment. Either telephone or videoconferencing appear to be efficacious and well accepted by patient and mental health care providers (Chen et al., 2022).

Findings from these studies and systematic reviews are consistent with the results of this study in which patient satisfaction was high during the pandemic where virtual mental health care was the predominate method of receiving care. It is important to note that process and outcomes of the change to virtual mental health care during the COVID-19 pandemic were not the same across the world. In some countries, technology limitations were challenges for patients to access virtual care when compared to high-income developed countries such as the United States and those in Europe (Zangani et al., 2022).

**Suggestions for Changes in Mental Health Care**

In response to the follow-up questions, participants offered suggestions for aspects of mental health care they would like to see changed, including more queer providers. Consistent with the existing literature, survey participants offered suggestions for aspects of mental health care they would like to see changed including more queer providers, more providers with
queer-specific expertise, gender affirming care, and more explicit signs that the clinic or health services office was a supportive and safe for queer women and men.

Members of the LGBTQ+ prefer gay- and lesbian-friendly care providers and queer providers (Begeny & Huo, 2017; Herek et al., 2015; Kirubarajan et al., 2021; Martos et al., 2018; Pachankis, 2018; Tebbe & Budge, 2022). Queer women and nonbinary individuals prefer to receive care in environments that are LGBT-friendly and from nonjudgmental LGBT-competent providers (Cohn et al., 2018; Coleman et al., 2022; Gomez et al., 2021; Kirubarajan et al., 2021; McClain et al., 2016; Rossi & Lopez, 2017). Creating an environment of care where there are explicit signs that it is a safe place for LGBTQ+ patients sends a message that sexual and gender minorities are welcome and will receive LGBT-competent care (Coleman et al., 2022; Kirubarajan et al., 2021; NASEM, 2022). For example, gay pride flags or posters and care providers with pride pins show support for the LGBTQ+ population’s health care needs and encourage patients to feel comfortable in seeking health care (Tebbe & Budge, 2022).

Mental health care providers and leaders of health care facilities can use these data to guide their efforts to promote a safe, friendly, and therapeutic clinical setting for LBGTQ+ patients. In the virtual care environment, using a virtual background with LGBTQ+ friendly posters, flags, or symbols can be effective in welcoming LGBTQ+ patients and letting them know the therapist is competent in the care of the LGBTQ+ population. Therapists can wear a pride pin or safe zone pin that is visible to the patient. Therapists can insert their pronouns after their name in their virtual sign on signatures that are displayed for the patient to see during a virtual session.
Limitations

Convenience and snowball sampling using social media may have produced a biased sample. Some recruitment occurred with flyers posted in university student centers which may have introduced an age bias to include more younger participants as compared to older adults. Demographic items did not include financial data or if participants were cisgender or transgender. There is a perception among some people in the United States, especially younger people who may not believe they are at high risk of an adverse outcome if they are infected with the COVID-19 virus, that the pandemic is essentially over (McNamara, 2022). While this perception is not accurate based on the ongoing case and mortality rates (Johns Hopkins University and Medicine, 2022), it may have influenced their responses to survey questions.

The survey used for this study was adapted from the study by Dobkin et al. (2013) in which no psychometric analysis of the survey was conducted. Satisfaction was measured by asking survey participants three questions: (a) How satisfied they were with their mental health care before and during the pandemic, (b) How helpful they perceived the mental health care they received before and during the pandemic, and (c) If they were able to be seen as frequently as they felt they needed before and during the pandemic. While these questions may have covered survey participants’ perceptions of satisfaction with the mental health care they received, they are not part of a valid and reliable patient satisfaction survey, thus may not have fully captured the concept of patient satisfaction. The concept, definition, and study of patient satisfaction should be more well-defined and specific in the health sciences. Creation of a standard definition with greater consensus would allow for more focused research on the topic. A reliable and valid tool to measure patient satisfaction that could be applicable to most settings would be a major contribution. Better measures could be created to explore patient satisfaction of care to determine
what specific aspects of care are being assessed (e.g., appointment scheduling ease, appearance on video calls, wait time for responses by care providers, parking, seating in the office, reduction of symptoms, strength of the therapeutic alliance, rapport, respectful care, empathy, partnership between patient and care provider, treatment planning, etc.) to allow for more focused research and ultimately an improved healthcare experience for patients. Greater specificity in what part of patient satisfaction is being addressed will allow for more specialized interventions and changes in practice. Timing of measuring patient satisfaction is an important issue as patients who asked about their case while they are still receiving care may not disclose their experiences if they are negative for fear of further poor care. Timing is a factor in asking about patient experiences if the patient is not yet feeling up to responding but waiting too long to ask can introduce recall bias.

Implications of the Findings for Future Research

The findings of this study support the need for more research about patient satisfaction with mental health care and access to care. Although the sample of participants in this dissertation were representative of the queer and non-binary population of the United States, greater investigation in the experience of subgroups of queer women, including transwomen, would be a benefit to the field. In the literature, transwomen have reported difficulties with finding and receiving identity affirming care as compared to their cisgender counterparts (American College of Obstetricians and Gynecologists, 2021; Cicero et al., 2019; Coleman et al., 2022; Society for Maternal-Fetal Medicine et al., 2022). More focus on the unique experiences of other minority populations (e.g., racial and ethnic minorities) within the larger population of queer women and nonbinary individuals would potentially increase awareness and understanding of the challenges they have seeking and receiving mental health care services as compared to the majority populations (White, college educated, employed, etc.). The intersectionality of different
identities needs to be explored further, as having more minority statuses increases the challenges faced by an individual in the world (Brooks, 1981; Meyer, 2003; NASEM, 2020). The satisfaction with mental health services reported here by the queer women and nonbinary individuals who participated in the survey ideally should be the experience of all subgroups of queer women and nonbinary individuals, however, not all women and nonbinary individuals are fortunate to receive care they perceive as beneficial and timely.

As this study was a quantitative analysis of the experience of queer women and nonbinary individuals, it is recommended future researchers incorporate qualitative data in their assessment of patient satisfaction of mental health care, as qualitative data could provide richer detail and narrative of the patients’ experience in their own voices. Qualitative research could be done on this topic, using the hermeneutic phenomenological research. Hermeneutic phenomenological research is research used to “understand the lived experience of persons about a phenomenon” (Creswell et al., 2007, p. 241). The research methodology could include individual interviews and/or focus groups and thematic analysis of the transcribed interviews, focus groups and field notes (Braun & Clarke, 2006; Braun & Clarke, 2022; Creswell et al., 2007). Qualitative data could also be collected by incorporating open ended questions into an online survey and using thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2022; Creswell et al., 2007). Individual interviews and focus groups would allow for greater exploration of patient satisfaction with mental health care, mental health care providers, and accessing mental health care. Participants would be able to express their experience in more detail to researchers for greater depth of understanding of their experiences. The voices of the patients can contribute greatly to treatment providers’ insights into how their care is perceived and allow treatment providers to make changes as necessary.
Clinical Implications for Practice

This study provides greater awareness of the experience of queer women and nonbinary individuals and their satisfaction with mental health service during the COVID-19 pandemic. Patient satisfaction with virtual mental health care was high as reported by participants in the survey, suggesting remote access to care was beneficial to patients. Most participants found virtual mental health care to be helpful. These findings are consistent with a large body of evidence supportive of remote or virtual health care. Virtual health care has increased access and feasibility of care for populations that may have had challenges accessing care otherwise (e.g., transportation, financial, anonymity in the waiting room, etc.). It would be beneficial if access to virtual care persisted after the pandemic to allow patients to have ease of access to care and support mental health providers in addressing the growing need for mental health care.

Expansion of virtual care across state lines through telehealth regulatory flexibilities, and the payment parity for in-person, video, and audio-only telehealth that was made possible by the president declaring a public health emergency due to the COVID-19 pandemic (CMS, 2020) should be continued indefinitely and eventually made permanent. Laws in most states and the District of Columbia require commercial insurance companies to pay for telehealth visits, but payment to providers and health care facilities for these telehealth visits is often significantly less when compared to in-person care (Ellimoottil, 2021). During the public health emergency, payment parity was enacted on a temporary basis (CMS, 2020), however once the emergency expires, there is concern that telehealth will return to previous unfavorable reimbursement levels.

COVID-19 related emergency allowances for across state practice should be codified into law and payment parity for telehealth should continue to better address the on-going mental health crisis in the United States. There is a movement among health care systems, organizations
representing hospitals, health care providers, and American businesses to strongly encourage the U.S. Department of Health and Human Services to extend the telehealth regulatory flexibilities that enabled widespread use of remote health care tools (Vaidya, 2022). As of November 2022, the public health emergency is set to end on January 11, 2023, and the telehealth regulatory flexibilities will expire 151 days after, thus this is an urgent time-sensitive issue.

Telehealth, telemedicine, virtual sessions, and other types of remote mental health care have been found to be feasible, high-quality, improve access, and have at least as equivalent outcomes as traditional in-person care. Both patients and care providers appreciate the convenience. Introducing and operationalizing national licensure or interstate licensure reciprocity rather than state-by-state licensing would also increase access to mental health care and decrease health care disparities. Mental health care providers could work remotely to cover areas lacking in providers. In May 2022, an analysis of mental health care in the United States using data from CMS found that approximately 570 counties across the country, mostly in the South and Midwest, have no psychologists, psychiatrists, or counselors, thus they are considered mental health deserts (Livingston & Green, 2022). The Center for Healthcare Quality and Payment Reform (2022) estimates that almost one-third of rural hospitals in the United States, located mostly in Southern states, are at risk of closing due to poor reimbursement for patient care services from all payers and lack of financial reserves. These closures will further exacerbate the access to care issues facing patients who live in rural areas. Remote mental health services in these areas have helped close the gap between needed care and available care but there are major challenges in accessing mental health care in many states (Livingston & Green, 2022).
Although satisfaction was high for the represented sample population of queer women and nonbinary individuals (which was largely White, college educated, and employed), more can be done to ensure satisfaction of mental health care for all LGBTQ+ groups who are not represented by the majority. More advocacy and legislation can be born from research like this study to increase access to virtual mental health care for all. Mental health care providers would benefit from increasing their knowledge and skill in working with queer patients and provide greater access to care via remote sessions (telepsychology).

Based on the data gathered in this dissertation, it is recommended mental health care providers become more familiar with queer identities and identity affirming care to increase patient satisfaction with their care (APA, 2015, 2021; Coleman et al., 2022; Ruben et al., 2017). It is also recommended mental health care providers engage with their patients in a collaborative manner and understand the unique context and experience of their patient (Semlyen & Rohleder, 2022). Care providers should speak with their patients in clear terms and understand the unique context in which their patients exist (Hauenstein et al., 2018). Mental health care providers can work towards greater patient satisfaction of care by engaging in continuing education, in outreach and psychoeducation about the queer population, exploring intersecting identities with patients, and being aware of local and national resources available to their patients (APA, 2015, 2021; Canvin et al., 2022; Coleman et al., 2022; Semlyen & Rohleder, 2022).

The suggestions for changes in practice offered by survey participants should be incorporated into clinic practice. Recruiting and supporting more queer mental health care providers is much needed but not an immediate solution as the path to graduate education and licensing is challenging and lengthy, however more providers with queer-specific expertise, and more explicit signs that the clinical environment is safe and supportive of the LGBTQ+ patient
population can be accomplished to promote better care. Virtual mental health services create a more likely ability to allow a match between the mental health provider of choice or type because proximity or location of services is no longer a prohibiting issue. For example, there may be more mental health care providers in some areas of the country who are competent in LGBTQ+ mental health care and virtual access would allow patients in areas of the country without these types of providers to be able to receive LGBTQ+ competent mental health care.

Closing Thoughts

This research adds to the growing body of literature about the experience of queer women and nonbinary individuals during the ongoing pandemic. There is limited research on the queer population and their experiences with mental health care during the pandemic, thus these findings fill a gap in the literature. Virtual mental health care is perceived as beneficial and seems to be well accepted by survey participants. Expansion of virtual mental health care options and allowing mental health providers to care for patients in any area of the country without the barriers of state-by-state licensure would promote greater access to mental health care for all who need it.
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APPENDIX: INFORMED CONSENT FORM

Informed Consent Form.
Dear Survey Participant,

This is a survey about access to mental health services during COVID-19 for lesbian women in the United States of America. One type of care provided during pandemic has been telepsychology is the provision of psychological services using telecommunication technologies" and "it is not limited to telephone, mobile devices, interactive videoconferencing, email, chat, text, internet" (APA, 2013). This survey will give you an opportunity to share your access to and experience of receiving mental health services during COVID-19 and how it compares to your access to and experience of mental health services before the March 2020 shutdown due to COVID-19.

Your responses will be used to assess the access to and experience of mental health services before and since COVID-19.

There are minimal, if any, risks from participating. Your identity will be anonymous. You will not be asked for your name and all demographic data being collected will be reported as aggregated information. No personally identifiable information will be associated with your responses to any reports of these data. The survey will take approximately 10-15 minutes to complete.

This survey is part of my dissertation research at Antioch University in the fulfillment for the Degree of Doctor of Clinical Psychology (PsyD) in the Department of Clinical Psychology. The information may be used for future research without additional consent.

Your participation is voluntary and you may elect to discontinue your participation at any time.

If you have any questions about the survey or the research study, please contact me at: xxxxxxx@antioch.edu.

This project has been approved by the Institutional Review Board at Antioch University. If you have any questions about your rights as a research participant, please contact Kevin Lyness, PhD., Chair of the Antioch University New England Institutional Review Board or Shawn M. Fitzgerald, PhD., Provost and CEO of Antioch University New England.

I have read and understood the above information. By clicking "Next" below, I am indicating that I have read and understood this consent form and agree to participate in this research study.

Please print a copy of this page for your records.

Thank you for your participation!