QUEER LIVES IN IDAHO AND THE SURROUNDING REGION: IMPACTS OF ANTI-DISCRIMINATION LAWS, HIGH SCHOOL ENVIRONMENT AND THE COVID-19 PANDEMIC ON MENTAL HEALTH.

by

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The following individuals read and discussed the thesis submitted by student Ollie Shannon, and they evaluated the student's presentation and response to questions during the final oral examination. They found that the student passed the final oral examination.

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DEDICATION

"Tell me, what is it that you plan to do with your one wild and precious life?"

-Mary Oliver

This thesis is dedicated to those who inspire me to achieve difficult things, Cole, Julie,Carol, Kelsey, Anna, and Nikki, without your support and patience I would be lost.

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ABSTRACT

The experiences of Queer people in the Intermountain-West are under- documented by the scientific community. Suicide is the 10th leading cause of death in theUnited States. It was responsible for more than 47,500 deaths in 2019. Members of the Queer community have higher rates of suicidal ideation and attempts than the general population. Theoretically, we may predict that people experience negative mental health outcomes under situations of reduced social contact and support or during periods of exclusion by conspecifics. My research explores mental health in the Queer community utilizing data collected in an online survey during the COVID-19 pandemic. With a sample size of 147 participants from the intermountain west, this study examines whetherrates of suicidal ideation and behavior are influenced by a person's high school experience. Specifically, I investigate effects of experienced positive curriculum related to Queer identities, supportive teachers, status of protection under the law, and the impactof COVID-19, particularly related to a lack of pride festivals. Statistical analysis found that mental health declined during the pandemic, and when sexual and gender identity areincluded in anti-discrimination laws Queer people's mental health improves. These findings are supported in the high school environment as well. People who heard anti- Queer had five times the odds of engaging in suicidal behaviors. Access to a supportive community improves mental health and suggests that the adaptive use of technology to create social connections in novel ways may be key to thriving during times of cultural change and unpredictability.

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A NOTE ON TERMINOLOGY

The community of people covered in this thesis is diverse, including a wide range of sexualities, genders, and biological sexes. I use a variety of terms throughout this thesis and here I explain the process of how I decided which terms to use. Sexuality, gender, and biological sex are separate categories constructed by society and science. Thebody of scientific literature uses a wide range of terminology when writing about people who are not cisgender and heterosexual. Over time and across disciplines, scientists use acomplex and fluid set of terms. The studies use many terms for different reasons, early studies may use the term "homosexual" to refer to gay men, lesbians, bisexual people, or any person who is not solely heterosexual. This term is seen by many as dated in reference to sexual orientation. It has negative connotations for some. The term is also imprecise and relies on an outdated idea of binary gender.

LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual and others) and variants are used to refer to the diverse community in some research and are often used by organizations and communities to refer to themselves. The acronym has elongated with time to include as many identities as possible. While this elongation has been somewhat successful at improving inclusion, there are still some who are left out of the acronym. Within the community terminology is evolving, splitting, and merging as our understanding of gender and sexuality shift.

There are people that only use the word Queer to identify themselves and their communities. The word Queer is inclusive of all genders and sexualities, including all

people who are not both cisgender and heterosexual. I engage in a discussion of Queer theory and self-identify as Queer which can relate to both sexuality and gender. The word Queer has been reclaimed by some people and is in pervasive use in some places and in some communities; however other people would never use the word Queer to self- identify due to the violence that is connected to that word for them.

One of the ways that research has adapted to the shifting landscape of terminology in this avenue is to name the group of people who are not cisgender and heterosexual the "Sexual and Gender Minority (SGM)". I will use this term most often inthis thesis. I have some reservations about SGM because I am not convinced that there isgood science to support the use of the word 'minority' in this phrase, as cisgender and heterosexual people may not represent a majority of the population. However, SGM is the most inclusive and precise term to refer to the participants of this research and therefore will be used most frequently.

LIST OF ABBREVIATIONS

LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, IntersexAsexual. Plus
SGM	Sexual and Gender Minority
COVID-19	Coronavirus Disease of 2019
NESARC	National Epidemiologic Survey on Alcohol and RelatedConditions
LGB	Lesbian, Gay, and Bisexual
USTS	United States Transgender Survey
BIPOC	Black, Indigenous and People of Color
AIDS	Acquired Immunodeficiency Syndrome
BDSM	Bondage and Discipline (BD), Dominance and Submission (DS),Sadism and Masochism (SM)
GLSEN	Gay, Lesbian and Straight Education Network
HRT	Hormone Replacement Therapy
PHQ-9	Patient Health Questionnaire 9

CHAPTER ONE: INTRODUCTION AND THEORY

Introduction

"I believe that telling our stories, first to ourselves and then to one another and the world, is a revolutionary act" Janet Mock

My research seeks to explore how the COVID-19 pandemic impacts LGBTQ communities across the Intermountain-West of the United States. There is little that has been left untouched by the pandemic, through stay-at-home orders, social distancing, and isolation. The LGBTQ community does not stand alone in the cancellation of cultural events, but because members of the sexual and gender minorities are already at higher risk for suicidal ideation and actions, I seek to understand how current social conditions may be impacting the mental health of this community.

Depression and Suicide in Gender and Sexual Minority Communities

Suicide is the 10th leading cause of death in the United States. It was responsible for more than 47,500 deaths in 2019, which is about one death every 11 minutes Suicide rates increased 33% between 1999 and 2019 Idaho, Washington, Wyoming, and Oregon rank in the top ten of states in suicide mortality rates per capita (Centers for Disease Control and Prevention National Center for Health Statistics, 2020). Rural suicide rates increased 48% from 2000 (13.1 per 100,000) to 2018 (19.4 per 100,000). Urban suicide rates increased 34% from 2000 (10.0 per 100,000) to 2018 (13.4 per 100,000) (Pettrone & Curtin, 2020).Young people who are lesbian, gay, or bisexual have a higher rate of suicidal ideation and behavior compared to their peers who identify as

straight(Ivey- Stephenson et al., 2020). In one study of gay and bisexual men, 21% had made a suicide plan and 12% had attempted suicide (Paul et al., 2002). The 2015 U.S. Transgender

Survey (USTS), which is the largest survey of transgender people in the U.S. to date, found that 81.7% of respondents reported seriously thinking about suicide in their lifetimes, while 48.3% had done so in the past year. With regard to suicide attempts, 40.4% reported attempting suicide at some point in their lifetimes, and 7.3% reported attempting suicide in the past year (Herman et al., 2019). It is important to note that there are no statistics in the United States that measure the rate of death due to completed suicide in the Sexual and Gender Minority (SGM) community as sexual orientation and gender identity are not collected by state or federal governments at the time of death.

What can be measured is suicidal ideation (thoughts of suicide), and attempts. Membersof the SGM community have higher rates of suicidal ideation and attempts than the general population. Studies have shown that experiencing school-based harassment, bullying or violence because of sexual orientation, mental health disorders, and individual and institutionalized discrimination are risk factors for suicidal behaviors (Herman et al., 2019). Lesbian, gay, and bisexual (LGB) adults also have higher rates of mood and anxiety disorders and are at a higher risk for suicidal behavior than heterosexual adults. Depression in lesbian, gay, and bisexual adults is usually rooted in discrimination and victimization from childhood and adolescence. Research on transgender people is still lacking (Herman et al., 2019). Most studies have shown an association between mental disorders and suicide attempts in LGB respondents who report suicidal behavior. Mental disorders, however, do not appear to entirely explain

elevated rates of suicide attempts in these individuals. An unpublished analysis of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) data found that after adjusting for mental disorders, suicide attempt rates in LGB respondents overall remained two-to-three times higher than among heterosexual respondents (McCabe et al., 2009). One aim of that research is to examine how supportive school environments (or lack thereof) impact suicidal ideation and behaviors during high school among sexual minority youth.

With the onset of the COVID-19 pandemic, all types of people have felt the impacts of isolation, fear of the unknown, and fear for their safety and the safety for their family, friends, and neighbors. Symptoms of anxiety disorder and depressive disorder increased considerably in the United States during April–June of 2020, compared with the same period in 2019 (Czeisler et al., 2020). As rates of depression and anxiety rise in the general population and as the pandemic continues it is key to understand how the pandemic is impacting communities of people differently. A second aim of this research is to examine how the COVID-19 pandemic has impacted suicidal ideation and behaviors among members of the SGM community.

COVID-19 in Marginalized communities

"We are all not in the same boat. We are all in the same storm. Some are onsuper-yachts. Some have just the one oar." Damian Barr

The COVID-19 pandemic has impacted every part of life worldwide, but communities that already experience marginalization are impacted more severely by the virus. Research conducted in the United States suggests that people with low socioeconomic status are more likely to have to go to work in the community at high

exposure jobs, to face barriers in access to healthcare, and if they have access to health care are more likely to experience discrimination in their care that leads to higher rates of death (Barber, 2020; Center for Health Statistics, 2015; Gould & Wilson, 2020). These issues, which were evident in the US pre-pandemic, continue to impact Black, Indigenous, and people of color (BIPOC) during the pandemic (Gauthier et al., 2021; Gibb et al., 2020). In times of human turmoil, those in power tend to broadcast a unifying message that we are all in this together, which in some ways is true, we are all facing a deadly global pandemic. Barr's quote above did not refer to the impacts of marginalization during a global pandemic, but I think it is an apt metaphor. The boat that each of us experiences, is impacted by many factors. Those who have access to appropriate healthcare, do not experience the daily stress of marginalization, and can work from home or take time off work are in a boat that is much more seaworthy. Those whose lives are impacted by systematic marginalization, must work in high-exposure environments, need work to put food on the table and pay rent, fear discrimination from the healthcare system, and have less access to resources to keep themselves safe and healthy are more likely to sink.

Biologists who study humans have shown that adverse health conditions are felt along the lines of marginalization (Gibb et al., 2020). Transgender and non-binary individuals faced discrimination in healthcare prior to the pandemic. Exacerbating this already difficult situation, the Trump administration reversed the Obama-era rule that protected transgender people from medical discrimination. Evidence suggests that experiencing discrimination can result in negative psychological and physiological

suffering (Haas et al., 2011). This will be further discussed in the section on Minority Stress Theory.

Theory

There is a suite of theoretical perspectives that fit together to build a foundation to explore the lives of SGM people in the Intermountain-West. Queer Theory sheds light on how society and culture frame SGM people's experiences. It also explores how people navigate institutionalized heterosexism within constructed social systems day as they go about their lives. Identity Theory informs how people build identities both individual and communal and how they communicate their identities to navigate the cultural landscape. Minority Stress Theory enumerates the ways that social systems, and identity interact and impact mental and physical health outcomes in stigmatized groups of people.

Identity Theory

Approaching identity through an anthropological lens one sees that identity is constructed by the individual, with the tools given to them by the society in which they live. Identity can only be constructed at the individual and group level when there is more than one group with which one can identify. The ability to recognize who is in your group and who is not is at the most basic identity formation. While it may seem like this distinction would make identity categories rigid and inflexible it is quite the opposite (Eriksen, 1994). Identity is fluid, and people move in and out of groups. Group identities shift and morph as they move through different social contexts and as social norms and ideas change. Humans at our core are adaptable creatures We migrated from our evolutionary home of the Great Rift Valley to thrive on every continent and in nearly every environment. Our physical adaptations as well as our ability to flexibly construct

identity, helps us adapt to the specific requirements of the physical and social environment in which we live. Flexibility and the ability to adapt are deeply coded in our evolutionary history.

When applying what we know about identity construction to the SGM community it is important to remember that individuals have engaged in same-sex sexual behavior since time immemorial Throughout human history, homoerotic behavior has been regarded in a multiplicity of fashions, ranging from an outlook of disgust and vitriol to a one of respect and reverence. SGM people negotiate their sexual and gender identities in relation to cultural messages they receive about gender and sexuality. A largemajority of Queer people do not come from Queer families, therefore much of their internal negotiation of identity is done either alone or, if they have access, within the Queer community. Cass (1984) proposes a model of identity formation in lesbian and gay individuals. Her theoretical model proposes there are six steps that an individual progresses along in a linear fashion. While this model fails to consider the fluidity of identity and that people engage in identity management, there are important aspects that this model addresses. First, the precondition is that the individual assumes that they are heterosexual. Eriksen's identity theory as he relates it to ethnicity states that the first condition of identity development is a distinction between "us" and "them". Cass's model identifies this as an important step as well. The first step is beginning to question "who am I?" and "who am I not" (Cass, 1984). Within Cass's model individuals first begin to question if they are heterosexual and if they are not heterosexual, then who are they?

Internal acceptance of identity is an important progression in Cass's model. The secondstage of identity formation is feeling that you are different and seeking out other

peoplewith the identity that you are beginning to associate with yourself. In this phase an individual is becoming attuned to the cultural communications presented by somebody who is in their group. Learning how to identify others in your group is a key step to becoming part of that group. Stereotyping is one of the ways societies develop groups and negotiate relations between those groups. Eriksen writes that stereotypes are used in several ways. First, they make dividing the world into kinds of people possible. With broad categories and sweeping generalizations, it becomes easier to quickly define who is in a group and who is not. Secondly, stereotypes can be used to allocate resources and negotiate power dynamics. Thirdly stereotypes make identifying yourself as part of a group easier. While stereotyping has positive uses it also can have negative impacts, especially when power is not equally allocated in a society (Eriksen, 1994). While in Cass's model identity development is linear, Eriksen's identity theory is based in the fluidity of identity, the ability of identity to shift on a social level as well as a personal level. While there are broad stereotypes in the US, stereotypes are also impacted by other cultural categories and environments. Ethnicity, age, local community, socioeconomic status, religion, and gender all impact which social stereotypes of non-heterosexual people exist. The next stage of Cass's model describes a person, who is relatively certain that they are Queer, but is uncertain of their desire to communicate this to other people. In this phase of identity development people may overtly communicate a heterosexual identity. while covertly communicating a non-heterosexual identity to others in the SGM community. Communication of identity is also fluid and falls on a spectrum. There are a myriad of ways to communicate and signal membership to an identity group, and this communication shifts depending on with whom you are communicating. Eriksen writes

about under- and over-communication as the ability to read cultural signals and then decide what is the appropriate way to communicate identity. The ability to read cultural signals and respond in an appropriate way is sometimes key to survival. This may be especially true in an environment where violence against SGM minority people is rampant or culturally acceptable. One of the ways that SGM people manage the communication of their identities is through the decision to come out, and openly share with members of their communities that they are part of the SGM community. Coming out is not a single event, it is a fluid and shifting experience that exemplifies the social skills and navigation that someone who is SGM has gained throughout their life to protect their well-being. Coming out is not a universal experience. While some members of the community have the privilege to decide when to come out and to whom, others do not.

The ramifications of coming out are disproportionate and influenced by other identities that individuals hold; Socioeconomic status, age, and gender impact how they navigate their identities. Coming out is a form of identity management. One study that looked at the experiences of homeless or college enrolled youth found that both groups engage in strategic identity management, although they differ in the reasoning behind the management College enrolled students tend to manage their identities to avoid social stigma and rejection, while homeless youth tend to manage their identities to protect themselves from physical, sometimes lethal bodily harm. Masking identity or identity concealment is distressing in both groups, but the outcomes of failed concealment differ (Schmitz & Tyler 2019). This study neglects that there are college enrolled students who are homeless, however, I would expect that these students would still be at higher risk for bodily harm than non-homeless students. One identity that is often overlooked is the

rural-urban split. I would expect that rural LGBTQIA+ people also use identity management more often to protect themselves from discrimination. Cities tend to be more diverse and anonymous, while rural areas more homogenous (Eriksen, 1994). This split is most likely mediated by layered identities. People in rural areas often lack connections to others like them, and rural communities tend to be more conservative in the US today.

Queer Theory

Queer theory was officially labeled and published in the 1990s in academic circles. However, like any theory, it has diverse and deep roots - in this case, feminist writings and the thoughts of women of color, the "gay rights" movement, the AIDS epidemic, and activism in the 1980s, as well as decolonization theory and the BDSM (Bondage/Discipline, Dominance/ Submission, and Sadism/Masochism) community, had great impact on Queer theory. Queer theory stresses that identities are fluid and shifting and therefore rejects any binary categories and identities. Queer Theory challenges ideas of normalcy and deviance. Heterosexism and homophobia work hand in hand to create the conditions that marginalize people whose sexuality or gender identity is seen as deviant. Heterosexism is a belief in an inherent superiority of heterosexual orientations. Heterosexism is predicated on the gender binary and reinforces it through the structural idea that heterosexual relationships are the only natural and normal relationships, with all other sexualities falling into the category of deviance (Lorde, 1979). Heterosexism and homophobia create systems and societies where people who are not cisgender and heterosexual are marginalized and oppressed. Minority stress theory shows that navigating a heterosexist system and experiencing homophobia in their communities

creates negative psychological and physiological health outcomes in LGBTQIA+ people (Brim & Ghaziani, 2016). Queer theory is a tool to understand and deconstruct the systems that people navigate and live within. Heterosexism and homophobia reinforce the social systems that marginalize and oppress people who are sexual and gender minorities. Minority Stress Theory explores the impacts of these systems on the lives ofthose who are impacted by oppressive social systems.

Minority Stress Theory

It is through the lens of Queer Theory that Minority Stress Theory can be best understood when thinking about Sexual and Gender Minority communities. Minority Stress Theory was first studied in racial and ethnic minority communities and has since been applied to the experiences of the Sexual and Gender Minority community. Minority Stress Theory defines how a person in a stigmatized group experiences extra stress that is related to being a member of that group. Minority Stress Theory defines minority stress as stress that is: 1) unique to a stigmatized minority population or individual; 2) experienced in addition to non-minority-specific stress; and 3) is chronic or long-term (Hatzenbuehler et al, 2014; Meyer, 2003). The cause of the stress that is experienced is not being a member of the minority group itself, but rather the life experiences of stigma and discrimination perpetuated by the majority culture (Meyer, 2003). Minority stressors can be described as external (navigating heterosexist social systems, institutionalized homophobia, and transphobia, legal inequities, housing inequity, employment inequity and negative interpersonal experiences) and internal (internalized homophobia and transphobia, anxiety related to sexual and gender identity concealment). Both types contribute to health disparities. Institutionalized minority stressors, such as experienced

interpersonal stigma, heterosexist social norms, and limited access to healthcare, jobs, housing, and legal rights may facilitate reactions that predispose for outcomes such as depression (Kaniuka et al., 2019; Lefevor et al., 2019; Polihronakis et al., 2020; Wong et al., 2014). Members of sexual and gender minority groups have higher rates of mental health disorders, including depression and anxiety (Wong et al., 2014). Within the sexual and gender minority there are many other identities that impact in what ways and how often a person experiences stress related to being a part of a stigmatized group. Rural SGM people have more barriers to accessing housing, healthcare, public accommodations, schooling, and parental rights. Lack of access comes from a variety of sources, some of which all people in rural places must contend with, but others are specific to the SGM community. If SGM people are refused housing or healthcare due to their sexual orientation and/or gender identity one study found that there were few other options to choose from in the community. This means that SGM people may need to conceal their identity when seeking services and housing, or risk being denied necessities for human survival. ("Where We Call Home: LGBT People in Rural America", 2019).

Within the SGM community experiences of discrimination and harassment that lead to higher stress levels are not felt equally throughout the community. Within the gender minority community harassment is not evenly experienced, one study found that people who are genderqueer, or non-binary experience harassment at higher levels and have more stress and anxiety associated with harassment than their binary peers (Lefevor et al., 2019). Another study found that gay and bisexual men's stress is uniquely experienced as well. In this group the focus on sex and physicality, along with the higher risk of HIV/AIDS leads to differing stressors alongside the ones that the larger SGM

community experiences (Pachankis et al., 2020). Minority stress impacts psychological and physical health outcomes in these communities and can be a factor in higher rates of mood disorders and other mental health disorders, as well as poorer cardiovascular health (Kann et al., 2017).Sexual minority adults are more likely to report asthma, neck and back pain, chronic health conditions and lowered immune systems (Fredriksen-Goldsen et al., 2017; Hoy- Ellis & Fredriksen-Goldsen, 2016). While the stress itself has impacts on health, the ways that people cope with higher amounts of stress also impacts their health. Sexual andgender minority adults tend to have higher rates of alcohol and drug use and risky sexual behavior, and sexual and gender minority youth tend to have higher rates of self-harm and suicidal behaviors (Chapman & Dixon-Gordon, 2007; Czeisler et al., 2020; Kaniuka et al., 2019; Williams et al., 2021).

Study Purpose and Hypotheses

My research seeks to answer questions about the lives of SGM people in the Intermountain West. The political, cultural, and geographical environments interact to make the experiences of people in these places unique. Applying identity theory to understand how individuals construct their sexual and gender identities in these communities then how group identity interacts with personal leads to the ability to ask better questions about how individual and group identityimpacts the lives of sexual and gender minority people in the Intermountain West.Queer theory lends a depth and specificity to Identity Theory. Identity Theory andQueer Theory contradict each other in that identity theory seeks to explain how identity is formed and this formation depends on belonging to a group, and QueerTheory seeks to explicitly name and deconstruct power systems connected to sexual and gender identity centering social power with individuals

instead of concentrated with group identities. This research combines Identity Theory and Queer Theory address the formation of complex and fluid identities of SGM individuals and systems that cause inequity and stress in their lives. Minority Stress Theory quantifies the physical and psychological impacts that come along with being a member of a stigmatized group. These three theories work together tounderstand the formation of identity, the systems within social structure that interact with identity, and the impacts that being a member of a sexual and gender minority have on health. The purpose of the current study is to answer the following questions: (1) Does knowledge of laws that protect and individual from discrimination impact PHQ-9 depression scores? (2) Does high school environment predict suicidal ideation and behaviors? (3) What are the experiencesof SGM people during the COVID-19 pandemic?

Each of the three broad research questions are made up of several narrower questions. The first broad question is: Does an individual's knowledge of laws thatprotect them from discrimination impact PHQ-9 depression scores? Within this question, a narrower question is: does the number of laws that an individual knowsprotect them matter? Studies in the past have looked at state level laws and found that anti-discrimination laws do positively impact sexual and gender minority people's mental health (Riggle et al., 2010). My research looks at the number of laws that protect people, and if they know that they are protected by those laws.

Not all anti-discrimination laws are created equal, some laws protect the sexual minority and distinctly not gender minority people. My research specifically asksif people are protected from discrimination for both their gender and sexual identity. When a city or town passes a law that protects SGM people from discrimination, the laws are being

passed by people that live in their community. This may be indicative of an environment where SGM people experience less minority stress. I hypothesize that as the number of protective laws an individual identifies protects them from discrimination their depression scores tend to decrease.

The second question is: does high school environment predict suicidal ideation and action? Prior research indicates the LGB youth are more likely to experience suicidal thoughts and attempts than their heterosexual peers. One study found that LGBT youth were 20% more likely to attempt suicide if they lived in an unsupportive environment based on social indicators of acceptance (Hatzenbuehler et al., 2014). My study seeks to understand what may be drivers of suicidal action and behavior in the high school environment. My study asks questions that are usedto quantify the level of social support for LGBTQIA+ students, then asks about suicidal ideation and attempts during their time spent in high school. Many of the questions in my study are based on the 2019 GLSEN School Climate Survey, this isthe largest survey of SGM youth in the US. The GLSEN survey does not collect data on suicidal ideation and attempts, and instead focuses on feelings of safety at school, harassment, and discrimination. The second largest survey that includes collets data on sexual orientation and gender identity is The Youth Risk Behavior Survey (YRBS) conducted by the CDC. This survey is focused on high school students, and examines behaviors associated with health risks. In 2019 this survey included a chapter on sexual minority youth and persistent depressive symptoms, thoughts of suicide, making a plan to die by suicide, and attempting to die by suicide. In all accounts LGB youth were more likely than their heterosexual peersto have thoughts, plans and actions related to suicide (Kann et al., 2017).

My research sits at the intersection of these two surveys, connecting school climate to suicidal thoughts and attempts. I hypothesize if participants answer thatthey had more support at school they will be less likely to report suicidal ideation and attempts. As a student has support and social acceptance at their place of education, then their probability of suicidal thoughts and attempts will decrease.

The COVID-19 pandemic changed much of how people across the world lived daily, academia reflects this shift as well. As a first-year graduate student when the pandemic began, having finally decided on a topic and a plan for data collection, many things had to shift as meeting with people in person was not possible and pride festivals all over the world had been cancelled. While shifting my thesis topic and research was frustrating at times, it also presented an opportunity to collect data on SGM people during an unprecedented pandemic. Mysurvey collects data on subjects related to how people are coping with the pandemic, what their worries are, if they can continue to work, and how the pandemic has impacted their ability to connect with others in the SGM community.It is from this chaotic and unpredictable place that my third research question is born. The third question investigates SGM people's experiences during the COVID-19 pandemic. This research compares depression scores pre-pandemic to post-pandemic. I hypothesize that depression scores will tend to be higher during the pandemic when compared to pre-pandemic scores. The pandemic has necessitated isolation and cancellation of in person events, specifically pride festivals worldwide. I am interested in how the pandemic may be intensifying already existing inequities in access to health care and intensifying the amount and severity of minority stress SGM people experience. This survey collects qualitative data asking participants if they have any concerns about how

the pandemic may impact them differently because of their sexual and/or gender identity. I hypothesize that gender minority people will be concerned about seeking medical care if they become ill due to their fear of medical discrimination. Respondents mayalso be concerned about their familial rights if someone in their family becomes ill especially if they are not legally married or if all adults who fulfill parental rolls arenot legal guardians.

CHAPTER TWO: METHODS

Cultural & Historical Context

Pride Festivals during the COVID-19 Pandemic (2020 and 2021)

Stay at home orders and limitations on the size of gatherings have halted many of the normally accessible events that many SGM people attend each year. In 2020, Pride Celebrations were canceled across the US, and many Queer organizations in rural places are facing financial struggles due to the inability to fundraise at the festivals. Almost all pride festivals were cancelled outright in the Intermountain West. The future of Pride festivals in the Intermountain West is in flux now, with the three largest Pride festivals taking differing approaches to resuming festivities. Boise, Idaho Pride Festival, the largest in the state is scheduled to tentatively resume in person festivities in September of 2021. Seattle, Washington Pride is scheduled to be an online festival in 2021, and Portland, Oregon Pride is still in the process of deciding how to move forward with their festival. The Festival in Boise is a change of timing as Pride festival has usually occurred during June or close to the anniversary of the 1969 Stonewall riots that took place at the Stonewall Inn located in New York City.

Historic Origins of Pride Festivals

The 1969 Stonewall riots are often cited as the beginning of the gay liberation movement but is not the first instance of Queer resistance in the United States. In 1966 the Compton Cafeteria Riots occurred in San Francisco when a drag queen, tired of being harassed by the police resisted arrest and the community rallied around her. What

followed was organized resistance to the police brutality and oppression put upon the Queer community there. It is important to note that both early instances of Queer resistance were organized by BIPOC members of the community and those who would most likely be members of the modern Trans community today. The history of Pride festivals and Queer resistance is intrinsically connected to Pride celebrations and may be the only opportunity for some rural SGM people to physically occupy the same space as others in their community.

Legal protections (or lack thereof) for LGBTQ people in Idaho

In Idaho, it is legal to fire, evict, and deny service based on real or perceived sexual orientation or gender identity, this includes providing medical service (cite?). The state of Idaho lost several legal battles in 2020 regarding transgender people's rights within the state. The first is a law that would require girls or women to undergo a genital examination or a genetic test at the request of anybody who thought she did not belong in women's sports. A second law would have made it illegal for people to change the gender marker on their birth certificate. Both laws did not stand up to legal scrutiny. However, the political climate in Idaho is conservative and while legal decisions offer some support, they do little to change discrimination that people experience -especially, in rural areas where there are few laws that protect them.

Idaho does not have any state level laws that protect SGM people from discrimination, however there are 15 municipalities that have laws that protect members of the SGM community. Of the 15 municipalities, 14 protect public accommodations, employment, and housing discrimination for both sexual and gender minorities. Moscow does not include public accommodations for either group (Lgbtmap.org, 2020). In June of

2020, The Supreme Court ruled in *Bostock v. Clayton County, Georgia* that both sexual orientation and gender identity are protected identities covered by sex discrimination.

This decision makes employment discrimination based on these identities illegal federally. While this case does protect SGM people from employment discrimination it does not address, public accommodations, and housing ("U.S. Supreme Court Rules That Federal Anti-Discrimination Law Protects Gay and Transgender Workers | Liskow & Lewis - JDSupra" n.d.).

Survey Data Collection

This study uses data collected from an online survey written and administered through Qualtrics. Participants for this survey are SGM individuals, who live in or spent most of their childhood in the Intermountain-West encompassing Idaho, Washington, Oregon, Montana, and Wyoming. This geographic boundary was chosen because there is variety in anti-discrimination laws between states, all states include urban and rural areas, and belong to the cultural area of the West. Participants were recruited through social media and through snowball sampling. Participants shared the survey with others they knew. While this type of sampling is not ideal, it was one of the only plausible ways to connect with and collect data during the COVID-19 pandemic lock-down. The sample consists of those who had access to the internet and an electronic device, and those who are already connected to the SGM community either through interpersonal connections or connections on social media. The survey was active October 2020 through January 2021. A total of 140 people completed the survey. The survey collected information on what state respondents currently live in, spent most of their childhood, and if the area is considered urban, rural, or suburban. They survey also collected information on, whether

the respondent usually attends a Pride festival, how far they travel to attend a Pride festival, how they typically connect with the LGBTQ community, concerns about how the COVID-19 pandemic may influence respondents differently because of their sexual

or gender identity, mental health questions, prior experiences of assault, and social support. The full survey can be found in the Appendix. This survey was approved by theIRB (Internal Review Board) at Boise State University IRB #041-SB20-157, all participants are over the age of 18, all requirements for consent were met and approved before collection of data could begin.

Question One

Do legal protections (independent variable) predict depression scores (dependent variable)? To test this question the survey collected data on depressive symptoms asked participants about their knowledge of anti-discrimination laws that protect them from discrimination in employment, housing, and public accommodations. Participants were asked to think back to the two weeks before the pandemic and stay at home orders began and answer the questions about depressive symptoms based on their experiences at that time. To measure depression, I use the Patient Health Questionnaire-9 (PHQ-9), a tool used by healthcare professionals to diagnose depressive disorder. The PHQ-9 is documented to be reliable and valid across diverse populations (Monahan et al. 2009; Kroenke, Spitzer, & Williams 2001; Indu et al. 2018). The goal of this study is not diagnostic; however, the PHQ-9 is a valid way to score the level of depressive symptoms across a population. In the PHQ-9 a score of 9 and above is generally seen as warranting further investigation by the healthcare professional to investigate if a depressive disorder diagnosis is appropriate. The PHQ-9 consists of 9 questions that ask participants to think

about a two-week period and rate the frequency of symptoms, their answers are scored on a scale of not at all (0), several days (1), more than half the days (2), and nearly every day (3). Here are a few examples of questions in the PHQ-9: “How often have you felt bad about yourself -that you are a failure or have let yourself or your family down?”, “How often have you had little interest or pleasure in doing things?” and “How often have you felt down, depressed, or hopeless?”. My survey included a 10th question that is usually a modifier for the PHQ-9. “If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?” This question was scored in the same way as the others. To calculate the depression score I added together the score for each of the 10 questions, my depression score ranges between 0 and 30 due to the addition of the 10th question which would change to depression threshold to a score of 10 or above.

Protective laws are those which protect people from discrimination based on a group to which they belong. In this instance I was interested in laws that protect SGM people from discrimination in housing, employment, and public accommodations. Within the SGM community there are two distinct groups that can be protected classes- sexual orientation, and gender identity. There are also levels of government that can pass protective laws including Federal, State, County and City or Municipality. To have a full understanding of what classes are covered and at what levels the survey asked participants to identify what levels of laws they knew of that protected them and what classes of people those laws protect. I calculated a “law” score, where I gave each level of law a point, then also gave a point if all the laws covered both sexual orientation and gender identity. The law score’s range from no protective laws (0) to four levels of

protective laws that cover both sexual orientation and gender identity (5). This score is based on self-reported knowledge and/or belief that there are, or are not, protective laws in place. I used a similar method to calculate an assault score for each respondent. The survey asked “Have you ever been assaulted because of your sexual orientation or gender identity? Choose all that apply”. Each respondent indicated if they had experienced each kind of assault the choices were (1) Yes, Verbally, (2) Yes, Physically, (3) Yes, Sexually, and (4) No. To calculate the assault score I added 1 for each type of assault that people reported they experienced, the assault score ranges from (0)- No reported assault, (1)- 1 type of assault, (2) 2 types of assault, (3)- 3 types of assault.

To test the hypothesis that people who reported a greater number of protective laws tend to have a lower depression score I first verified that the depression scores were normally distributed by creating a histogram. I then ran a stepwise regression including the independent variables of age, general demographic category (urban, rural, or suburban), law score, and assault score predicting the dependent variable of depression scores.

Question Two

My second research question is:” Does a person’s high school environment predict suicidal ideation and suicidal action during high school?” My dependent variables are suicidal thoughts and suicidal actions, my independent variables are “supportive faculty”, “faculty advocate”, “how often homophobic or transphobic slurswere heard in the high school environment?” and “inclusive curriculum”. This study does not include individuals under the age of 18 due to IRB restrictions, therefore the questions about high school environment asked participants to recall their high schoolexperiences. This study

seeks to replicate data that have been collected and published with active high school students.

I collected data on suicidal ideation and suicidal action during high school. Participants were asked “While you were in high school did you ever experience suicidal thoughts?” (1) Yes, (2) No, and (3) I don’t remember. Secondly a question about self-harm and suicidal actions “While you were in high school did you ever try to hurt or kill yourself?” with the answers (1) Yes, once, (2) Yes, more than once, (3) No, and (4) I don’t remember.

The independent variables were measured through the survey questions: ‘While you were in high school did you have a supportive faculty or staff member you could talk to?’,” While you were in high school did you have a faculty or staff member that advocated for you?”, “While you were in high school did you hear transphobic or homophobic slurs?” and “Did your primary, secondary or high school include curriculum that showed members of the LGBT community in a positive way? (Select all that apply)”. The questions concerning supportive faculty or staff are simple yes/no/can’t remember answers, while the questions about hearing slurs and inclusive curriculum are more complex. The answers available for the question of slurs are (1) Yes, once, (2) Yes, often,

(3) Yes, almost every day, (0) No and (4) I don’t remember. The questions about faculty/staff and slurs were left as they were for analysis. In the question about curriculum, subjects chose all the answers that applied (1) Yes, in primary school, (2) Yes, in secondary school, (3) Yes, in high school, (4) No, and (5) No, they were shown in a negative way. To calculate the curriculum, score any person that answered positively that there was inclusive curriculum in their schooling at any level was coded as “yes”,

and any person who answered that there was no curriculum was coded as a no. A secondary variable was coded using data from the last possible answer. Respondents who answered that their school had curriculum that showed SGM people in a negative way were coded (1) Yes and all others were coded (2) No for the Negative curriculum variable. This category was coded this way because there were very low numbers of people who selected that they had inclusive curriculum in school at any level and separating the levels out left very low numbers in each of the categories. I then ran a logistical regression for each of the dependent variables of suicidal action and suicidal ideation- Independent variables included "inclusive curriculum" "faculty/staff advocate", "faculty/staff support", and "homophobic and transphobic slurs".

Question Three

In what ways are the social lives, mental and physical health of SGM people in the Intermountain-West being impacted by the pandemic? My survey collects data on many subjects related to how people were coping with the pandemic, what their worries were, if they can still work, and how the pandemic has impacted their ability to connect with others in the SGM community. To understand how depressive symptoms may have changed during the pandemic I asked participants to answer the questions of the PHQ-9 for the last two weeks. All the data for this thesis was collected after the onset of the pandemic. The calculation of current depression scores followed the same calculation as the pre-pandemic depression scores and is scored on the same scale. I was interested in how much depression scores may have changed between pre-pandemic and the time of survey. To calculate this variable, I subtracted an individual's current pandemic depression score from their pre-pandemic score. If their current score was higher than

pre-pandemic their change score is a negative number, if it did not change their score is a 0 and if their current score was lower than their pre pandemic score their change score is a positive number. To determine if there is a significant increase in depression scores, I ran a paired t-test.

Qualitative Data and Grounded Theory

I used qualitative data to add depth to the quantitative data I collected on the pandemic. To understand if SGM people were worried about how the pandemic might impact them differently because of their sexual or gender identity I asked participants "Do you have any concerns about how COVID-19 might impact you differently because of your sexual orientation or gender identity?" If they answered yes, they were given the opportunity to elaborate on their concerns in a free answer question. To analyze these data I used grounded theory. I read through the answers, I looked for themes and created codes for each of the themes I observed. In the end I had 9 codes, they are as follows (1) Medical discrimination, (2) On Hormone replacement therapy and don't know how COVID-19 might impact, (3) No, (4) Isolation, (5) Higher rates of economic vulnerability, (6) Higher stress levels may lead to higher risk of infection, (7) Discrimination in housing, jobs, and available resources, (8) Loss or lack of insurance, and (9) Other. Once I had assigned the codes to each response, I re-read over all the responses to double check that I had not missed any themes and had categorized each of the responses correctly. The second set of data that I used grounded theory to code asked participants to talk about how their connection to community had changed during the pandemic, many gave examples of how they adapted to this change. The question "Has your ability to connect to the LGBTQ community changed since the COVID-19

pandemic? If so, how have you dealt with this change?". I used the same approach to code these data as I used with the health data. My final categories for this question are:

(1) No, or no answer, (2) Use social media or use social media more, (3) Isolation, (4)Moved to online in person media e.g., zoom, facetime, (5) Yes, no explanation, (6) Minimize in person group size, (7) Missing in person Queer space, and (8) Other.

CHAPTER THREE: RESULTS

Sample demographics are shown in Tables 1.1 – 1.5. To date there has not been a demographic collection of data on SGM communities in Idaho and this survey provides a snapshot of the participants' lives. The geographic locations of the participants are broken down by state (Table 1.2), the population density of the place they live (Table 1.3), the place they spent the most time during their childhoods (Table 1.3), and their age (Table 1.1).

Table 1.1 Descriptive Statistics of Age

	N	Minimum	Maximum	Mean
What is your age?	119	18	75	39.7

Table 1.2 Descriptive Statistics: Number of Anti-Discrimination laws and State.

Number of Anti-Discrimination Laws		*What state do you live in?*	
	Frequency		Frequency
No laws	33(27.5%)	Idaho	102(72%)
1 type	8(6.7%)	Oregon	4(3%)
2 types	40(33.3%)	Wyoming	1(<1%)
3 types	24(20%)	Washington	9(6%)
4 types	6(5%)	Other	25(18%)
All laws cover SOand GI	9(7.5%)		

Table 1.3 Descriptive Statistics for Demographic Area: Current and Childhood.

Do you currently live in an area best described as?		*Did you spend most of your childhood in an area best described as?*
	Frequency	Frequency
Rural	14(10%)	48(31%)
Urban	94(67%)	51(33%)
Suburban	32(23%)	42(27%)

The mean age of participants is approximately 40 years old, while the real mean age of SGM community is most likely lower than this. However, because of IRB restrictions people under the age of 18 could not be participants. One hundred and two (72%) of theparticipants live in Idaho. Of the demographic information collected one can see that SGM people report growing up in rural areas at a higher rate than currently live-in ruralareas, suggesting a migration away from rural areas and into urban and suburban areas.

Moving away from demographic information we can investigate the experiences of SGM people in the study. This study collected information on assault (Table 1.4), discrimination (Table 1.4) and LGBTQ organizations (Table 1.6).

Table 1.4 Descriptive Statistics for Discrimination and Assault.

Have you ever been fired, evicted, or deniedservice because of your real or assumed sexual orientation or gender identity?		*Have you ever been assaulted because of your real or assumed sexual orientation or gender identity?*	
	Frequency		Frequency
Yes	30(23.4%)	No assault	48(40%)
Not sure	19(14.8%)	1 type	2(1.7%)
No	79(61.7%)	2 types	65(54.2%)
		3 types	5(4.25)

Table 1.5 Descriptive Statistics for LGBTQ Organization in community.

	Frequency
Yes	112(84.8%)
No	9(6.8%)
I don't know	11(8.3%)

More than half of SGM people have experienced two kinds of assault the greatest occurrence of assault was verbal 62 (40.5%), followed by physical assault 11 (7.2%),

sexual assault 7 (4.6%), and no assault 52 (34%). Of those assaulted 70 (95.9%) did notreport the assault, 2 (2.7%) did report the assault, and 1 (<1%) did not remember if they reported the assault. 30 (23.4%) of SGM people experienced discrimination in housing, employment, and public accommodations and 19 (14.8%) were not sure if they had beendiscriminated against because of their sexual orientation and gender identity. A large majority 112 (84.8%) of SGM people have a LGBTQ organization where they live.

Question One

Table 1.6 displays the results of the regression model predicting pre-pandemic depression scores. The number of protective laws, age, and number of categories of assault experienced. There were no significant group differences in the number of categories of assault experienced ($p = .821$). There are significant group differences in age ($p = .03$) and number of protective laws ($p < .001$).

Table 1.6 Multiple regression analysis showing Depression Score (pre-pandemic) by Number of Protective Laws and Assault and Controlling for Age.

Parameter	**B**	**Std. Error**	**Sig.**
Intercept	12.47	1.37	0
Number of Protective Laws	-0.72	0.3	<0.001
Kinds of Assault Experienced	0.09	0.43	0.821
Age	-0.08	0.03	0.003

Question Two

Tables below (2.1-2.3) show the frequencies of the dependent variables in question 2. Eleven (9%) participants reported not hearing slurs during their time in high school, 113(91%) reported hearing them at some time during high school. Fifty-seven (46%) report hearing them often and 20(16%) hearing them every day. Forty-two (34%) reported that they had someone on the faculty or staff that advocated for them, and 58(47%) reported having someone supportive on faculty or staff with whom they could talk. Eighty-three (67%) reported having suicidal thoughts while in high school and 50(41%) reported hurting themselves at least one time during high school.

Table 2.1 Descriptive Statistics for Faculty Advocate and Supportive Faculty

While you were in high school did you have a faculty or staff memberthat advocated for you?		*While you were in high school did you have a supportive faculty or staff member you could talk to?*	
	Frequency		
Yes	42(34%)		58(47%)
No	67(54%)		56(45%)
I do not remember	15(12%)		10(8%)

Table 2.2 Descriptive Statistics for Suicidal Ideation and Suicidal Behaviors.

While you were in high school did you ever experience suicidal thoughts?		*While you were in high school did you ever try to hurt or kill yourself?*	
	Frequency		**Frequency**
Yes	83(67%)	Yes	18(15%)
No	39(32%)	Yes, more than once	32(26%)
I do not remember	2(1%)	No	73(59%)
		I do not remember	1(<1%)

Table 2.3 Descriptive Statistics for Slurs.

While you were in high school did you hear transphobic or homophobic slurs?	**Frequency**
No	11(9%)
Yes, a few times	36(29%)
Yes, often	57(46%)
Yes, everyday	20(16%)

Table 2.5 displays the results from the logistic regression model predicting suicidal actions. There are significant results in "hearing slurs almost every day" variable. A person who "heard slurs almost every day" has 5.149 greater odds of having engaged in suicidal actions than someone who never heard slurs Exp(B)=5.149, p=.044.

Table 2.4 Logistical Regression Analysis Results for Suicidal Behaviors.

	B	S.E.	Wald	d f	Sig.	Exp(B)	95% C.I.for EXP(B)	
							Lower	Upper
Curriculum did not show LGBTQ people	-0.626	0.736	0.723	1	0.39	0.535	0.126	2.264
LGBTQ people shown negatively	-1.001	0.834	1.439	1	0.23	0.368	0.072	1.885
Supportive Faculty	1.085	0.74	2.152	1	0.14	2.96	0.695	12.614
While you were in high school did you hear transphobic or homophobic slurs?			5.5	3	0.13			
Yes, a few times	0.095	0.477	0.04	1	0.84	1.1	0.432	2.8
Yes, often	-0.438	0.687	0.407	1	0.52	0.645	0.168	2.478
Yes, almost everyday	1.639	0.815	4.046	1	0.04	5.149	1.043	25.423
Constant	-0.772	0.371	4.326	1	0.03	0.462		

Table 2.5 Logistical Regression Analysis Results for Suicidal Thoughts.

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B)	
							Lower	Upper
Curriculum did not show LGBTQ people	-0.864	0.60	2.042	1	0.15	0.422	0.129	1.378
LGBTQ people shown negatively	0.163	0.63	0.065	1	0.79	1.177	0.336	4.12
Supportive Faculty	1.03	0.84	1.501	1	0.22	2.801	0.539	14.546
While you were in high school did you hear transphobic or homophobic slurs?			5.597	3	0.13			
Yes, a few times	-0.567	0.46	1.478	1	0.22	0.567	0.228	1.415
Yes, often	-1.284	0.608	4.459	1	0.03	0.277	0.084	0.912
Yes, almost everyday	0.255	0.81	0.097	1	0.75	1.29	0.26	6.392
Constant	0.902	0.37	5.826	1	<0.01	2.466		

Table 2.4 displays the results of the logistic regression model predicting suicidal thoughts. There are significant results in “hearing slurs often” variable. Counter to predictions, a person who “heard slurs often” has lower odds of having had suicidal thoughts than someone who never heard slurs Exp(B)=.227, p=.035.

Question Three

42(31.8%) of SGM people surveyed had concerns about how they might be impacted differently by the pandemic because of their sexual orientation and/or gender identity. Of these concerns 17(47.2%) are worried about medical discrimination. One participant said “I fear because I'm trans and if I get COVID-19 I fear how doctors may treat me since I'm on Testosterone, but my gender marker hasn’t been changed. I have pretty bad asthma so that concern is constantly in my mind.”. A second participant said “I am concerned about how inequalities compound with COVID-19. Although how

COVID-19 has affected me and my sexuality in minuscule ways, I am concerned for myQueer friends who struggle financially and do not have consistent family support.”. Five(13.9%) reported that isolation impacted them differently “I feel more isolated than my cis-het friends seem to be. They can rely more on family during this time and relying onfamily is complicated for my spouse and me. We feel very lonely.”.

Mean depression scores increased during the pandemic compared to depression scores pre-pandemic. Table 3.1 shows the scores pre-pandemic, during the pandemic and the change in depression scores. The mean depression score pre-pandemic falls under the threshold of 9 that professionals use to signal a depressive disorder may be present in an individual. During the pandemic, the mean score rose to 12.11 which is above the

threshold. Table 3.2 shows the results of a paired t test showingthe difference in means is significant ($p \leq .001$).

Table 3.1 Descriptive Statistics: Depression Scores

	N	Minimum	Maximum	Mean
Depression scores pre-pandemic	118	0	27	8
Depression scores last two weeks	118	0	30	12.1
Change in depression score	118	-20	11	-4.1

Table 3.2 Analysis Results of a Paired Samples Test: Pre-Depression--Current-Depression

			95% ConfidenceInterval of the Difference				
Mean	Mean	Std. Error Mean	Lower	Upper	t	df	Sig. (2-tailed)
-4.067	5.554	0.51131	-5.08	-3.05	-7.956	117	0

Isolation and access to community events and other people who are members of the SGM community shifted during the pandemic. Ninety-five (68.3%) people said that they usually attend a pride festival and of those 95 people 84(92.3%) of people reported that the pride festival that they usually attend did not happen this year. In the appendix isa that table shows the rates that participants take CDC recommended steps to protect themselves and their community from virus spread.

CHAPTER FOUR: DISCUSSION AND FUTURE STUDIES

Discussion

This study collected data on discrimination and assault rates in SGM people. One of the most astounding statistics collected is the percentage of participants that report being assaulted because of their sexual orientation or gender identity. 62 (40.5%) reported being verbally assaulted, 11 (7.2%) report being physically assaulted, and 7 (4.6%) report being sexually assaulted. Of those who reported being assaulted, only 2 (2.7%) said that they reported the assault. This leads to the conclusion that assault is happening at high levels and that these assaults are vastly underreported. This leads to the question: why is assault underreported at this rate? Thirty (23.4%) of people in the study report that they have been fired, evicted, or denied service based on their sexual orientation and/or gender identity, and an additional 19(14.8%) reported that they were not sure if they have been discriminated against. In Idaho there are not statewide protections for SGM people; - therefore even if a person is discriminated against there is no way to report it to the state. This may influence the percentage of people who were not sure if they had been discriminated against, because not all discrimination is overt and without the ability to report the discrimination people may never know if they were discriminated against due to their sexual orientation and/or gender identity. Reporting assault or discrimination in conservative or rural areas may lead to further discrimination or assault from the people who are supposed to be protecting the community. The percentage of people who report being assaulted and/or discriminated against supports

that SGM people in Idaho are experiencing stress that is related to their SGM status. This provides evidence that SGM people are experiencing stress based on their sexual and/or gender identity. This is the stress that Minority Stress Theory theorizes impacts health in stigmatized populations. We would expect to be able to capture this stress in future studies that look at physical and mental health in this population.

Results of the first question show that the number of governmental levels that have laws protecting SGM people predicts depression scores, where the more laws that a person knows protects them the lower their depression score is predicted to be. This research differs from previous studies in several ways. First, this study asks participants to identify the governmental laws that protect them throughout the governmental hierarchy from city to federal laws. Many prior studies look only at the laws that cover people across the entire state (Riggle, Rostosky, & Horne 2010). This approach ignores the city and county anti-discrimination laws. In the rural West, the passage of these laws indicate that these places are more accepting to SGM people and this may lower the amount of stress that a person experiences based on their sexual or gender identity. While statewide protections are ideal, my data suggests that cities and counties that pass inclusive anti-discrimination laws do have an impact on the mental health of SGM people in those cities and counties. The study differs from previous research by asking people what laws protect them, for people to answer this question they must know about the laws that protect them. Knowledge of laws is not perfect, and there may be people in this study who do not know that there are laws that protect them, as well as people who believe that there are laws when there are not. This begs the question, is knowledge of protective laws influencing depression scores through internal means, or do protective laws impact the

social environment, which in turn shifts the environment a person lives in influencing depression scores? While this study is not able to tease these two influences apart, I hypothesize that both internal and external factors impact depression scores in people living in a community. Future research might attempt to tease these influences apart by trying to gauge internal and external causes of minority stress. Looking to the intersections of Queer Theory, Identity Theory and Minority Stress Theory we know that people internalize cultural messages. This internalization connects the external environment to the internal environment therefore it would be difficult to fully separate these kinds of stress. Out migration of SGM people from rural to urban areas may reflect a desire to move to a more accepting environment shifting external messages about identity and overtime this may shift internalized identity as well. Identity Theory in combination with Queer Theory may explain this phenomenon. Identity theory explains that people may feel more comfortable in places where they are able to belong to a community that matches their identities. Urban places with higher population tend to be more diverse, in turn diversity may provide people with a community that matches more of their identities. In rural places due to the low number of SGM people all SGM people may be lumped into the same community, when there may be vast differences between the identities of members. Moving to a more populated area gives people the opportunity to begin to break down their broad identities from living in rural areas the breaking down of identity systems is supported by Queer Theory. This illustrates how the identification with a community may shift based on population and diversity. Identity theory shows that people will seek out others with their similar identity, and Queer theory shows that as

population and diversity increase it is easier to breakdown broad identities into more specific identities.

The results of the second research question show some expected, as well as some unexpected, results. This suggests that further research on high school environment and suicidal ideation and behavior is warranted. The result that peoples who heard slurs often are less likely to have suicidal thoughts is at first perplexing. Why might this be the case? Perhaps people in this instance become desensitized to hearing slurs if they hear them often, but if they hear them every day. Secondly the data collected only asks about high school environment, not home environment. A person may have an accepting and supportive environment in their high school but may have an unsupportive environment at home or elsewhere. Or they may have a better home environment than they do at school. Experiences of people in elementary and junior high school also may differ from the environment that a person experiences in their high school years. These experiences may be more impactful than their high school experience. Minority Stress Theory includes a wholistic snapshot of the stress a person experiences across all environments in their lives due to this, future studie might capture a more holistic snapshot of the environments that a person navigates to see how this stress impacts suicidal thoughts and behaviors. Keeping this in mind the finding that students who hear slurs every day are more likely to self-harm and/or engage in suicidal behaviors warrants replication and attention. Working with schools to address homophobic and transphobic language is key to helping SGM students feel comfortable in their school environments. Suicide data also only can capture the experiences of the survivors, with SGM suicide rates being high unfortunately, there is missing data from those who died by suicide.

COVID-19 is impacting mental health across the world (Ahmed et al. 2020; González-Sanguino et al. 2020; Pappa et al. 2020; Qiu et al. 2020). These studies use a variety of scales to measure depressive symptoms, which makes comparison across studies difficult. My research provides additional evidence that COVID-19 has mental health implications, particularly among SGM populations. Respondents in the survey expressed concern about facing medical discrimination due to their sexual or gender identity. In rural areas there can be little choice in medical care, and if the available healthcare providers discriminate against SGM people there may be nowhere else to access healthcare. Talking to transgender people about their experiences while seeking medical care, it is easy to understand why gender minority people have anxiety and fear about seeking medical care from unsupportive healthcare professionals. People report refusal of care, inadequate care, and disparaging remarks from staff. Even if the healthcare professionals are not overtly discriminatory, there is a general lack of understanding of treating transgender patients, especially those who are on hormone replacement therapy (HRT). Employing the tenets of Queer Theory to break down the ideas of what is "normal" and what is "deviant" when training future medical staff may be one way to combat medical discrimination towards SGM people. Medical research on gender minority patients is lacking. Purposefully including SGM people in medical studies in the future along with baseline studies of impacts of HRT on the body and mind would provide more data and exposure for future medical students as well. Studies show that the attitude of the medical professional towards transgender people predicts how positive the interaction is rated by the patient;(Hobster &McLuskey. 2020) and that transgender individuals are likely to delay treatment due to their fear of discrimination

(Seelman et al., 2017). Considering these trends during the time of the COVID-19 pandemic we might expect to see a higher mortality rate in transgender people who do not have access to inclusive healthcare. Future research with gender minority people might look at these statistics and investigate what variables impact transgender patients' decision making about whether to seek medical care, and how providers can educate themselves on the needs of transgender patients.

There are limitations in this study regarding how widely applicable the finding of this study is to the wider population. The sample size is small, and a majority of the people in the study live in Idaho. While this did not meet the goals of geographic diversity sought in this study it can inform the experience of SGM people living in Idaho. There are no studies that solely focus on SGM people in Idaho, so this thesis can provide some insights into this population. The sample is lacking in ethnic diversity with 111 (72.5%) of the respondents being white. However, the population captured in this survey is more diverse than the state of Idaho which has a 93% white population according to the US Census Bureau ("U.S. Census Bureau QuickFacts: Idaho", n.d.).

My research takes a snapshot of the experiences of SGM people in Idaho during the COVID-19 pandemic. The sample size in this study is small, so a larger study may confirm that the experiences of the people in this study are occurring more widely. The pandemic is ongoing and unpredictable. A longitudinal study that explores how the loss of pride festivals may be impacting the lives of SGM people and communities across the world would better track change over time than a cross-sectional survey. Researchers should examine the strategies being employed by community organizers to keep their communities connected during a time when gathering of large groups in person is

inadvisable. As communities are adapting to a new way of life, how is the pride festival changing? Are there any positives that have come out of the pandemic? Has shifting pride festivals to online events made the festivals more accessible? As people are shifting much of their social interaction online, how might this impact the makeup of a person's community as online communities are not defined by geography? One last future study may look at how fictive kin networks are being used by SGM people during the pandemic, does a person's social network size and makeup predict mental and physiological health outcomes in SGM people? With the pandemic forcing people into isolation, research on the impact of loneliness in SGM populations is important and relevant. One recent found that access to a multigenerational community and the opportunity to mentor young SGM people can mediate the negative impacts of loneliness on mental and physical health in these populations (Perone et al.,2019. The aging population of SGM people is vulnerable to the impacts of loneliness due to several factors: severed relationships with biological family due to rejection, living in unwelcoming assisted living facilities, and the impact reduced mobility has on the ability to get into the community and meet and connect with others (Hughes & King, 2018).

While this prior research was not conducted during a pandemic many of the same factorsare present during this time of isolation.

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APPENDIX

Survey

You are invited to participate in a research study. This consent form will provide you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what will be expected of you as a participant, as well asany known risks, inconveniences, or discomforts that you may have while participating. There are questions in this survey ask about self-harm and suicide.

PURPOSE AND BACKGROUND

The purpose of this research is to examine the impact that the COVID-19 pandemic has had on the LGBTQ community, as well as examining the impact government laws and regulations haveon mental health of members of the LGBTQ community. You are being asked to participate because you are a member of the LGBTQ community who is over the age of 18.

PROCEDURES

If you agree to be in this study, you will participate in the following: One 12-minute survey about you experiences during the COVID-19 pandemic and your experiences being a member ofthe LGBTQ community.

RISKS

The survey will include a section requesting demographic information. Due to the make-up of the target population, the combined answers to these questions may make an individual person identifiable. We will make every effort to maintain confidentiality. However, if you are uncomfortable answering any of these questions, you may leave them blank. Some of the survey and interview questions might make you feel

uncomfortable or upset. This survey asks about self-harm and suicide. You are always free to decline any question, take a break, or to stop your participation at any time. If after taking the survey you feel like hurting yourself or need someoneto talk to, contact your own health care provider or call the Trevor Lifeline at 1-866-488-7386.

The Trevor lifeline is staffed by LGBTQ informed and supportive staff.

BENEFITS

There will be no direct benefit to you from participating in this study. However, the informationthat you provide may help provide information on how pandemics and governmental laws and regulations may impact the members of the LGBTQ community.

EXTENT OF CONFIDENTIALITY

Reasonable efforts will be made to keep the personal information in our research records private and confidential. Any identifiable information obtained in connection with this study will remainconfidential and will be disclosed only with your permission or as required by law. The membersof the research team, the and the Boise State University Office of Research Compliance (ORC) may access the data. The ORC monitors research studies to protect the rights and welfare of research participants. Data will be kept for at least 3 years (per federal regulations) after the studyis complete and then destroyed.

PAYMENT/COMPENSATION

You will not be paid or compensated for your participation in this research study.

PARTICIPATION IS VOLUNTARY

Your decision to participate in this research study is entirely voluntary. You may withdraw fromthis research study at any time.

QUESTIONS

If you have any questions or concerns about your participation in this study, you may contact the Principal Investigator, Ollie Shannon at ollieshannon@boisestate.edu or Dr. Kristin Snopkowski at kristinsnopkowski@boisestate.edu. This study has been reviewed and approved by the Boise State University IRB (IRB). If you have questions about your rights as a research participant, youmay contact the IRB, which is concerned with the protection of volunteers in research projects. You may reach the board through the Office of Research Compliance by calling (208)426-5401 or emailing humansubjects@boisestate.edu.

I am 18 years old or older and am not educationally or intellectually vulnerable and am capable ofgiving consent. I understand the risks of participation in this survey and consent to continue.

- ○ Yes (1)

Q8 What State do you live in?

- ○ Idaho (1)
- ○ Oregon (2)
- ○ Montana (4)
- ○ Wyoming (5)
- ○ Washington (6)
- ○ Other (7) ____

Q9 In which city or town did you spend the largest part of your childhood?

_____

Q63 In which state did you spend the largest part of your childhood?

_____

Q32 Did you spend most of your childhood in an area that is best described as :

- Rural (places with less than 2,500 people or less than 1,000 people per square mile) (1)
- Urban (Places with more than 50,000 people) (2)
- Suburban (Closely situated near an urban area) (3)

Q52 Do you currently live in an area best described as:

- Rural (places with less than 2,500 people or less than 1,000 people per square mile) (1)
- Urban (Places with more than 50,000 people) (2)
- Suburban (Closely situated near an urban area) (3)

Q31 Do you usually attend a Pride Festival?

- Yes (1)
- No (2)

Skip To: Q20 If Do you usually attend a Pride Festival? = No

Q10 How many times have you attended a Pride Festival in your lifetime?

_____

Q11 How many miles do you usually travel to attend a Pride Festival?

- I have never attended a pride festival (1)
- I do not have to travel more than 45 miles to attend a Pride Festival (2)
- I usually travel between 46 and 120 miles to attend a Pride festival (3)
- I usually travel between 121 and 240 miles to attend a Pride Festival (4)
- I usually travel more than 240 miles to attend a Pride Festival. (5)

Q12 How old were you when you attended your first Pride Festival?

_____

Q13 Did the Pride festival that you usually attend happen this year?

- I do not attend Pride. (1)
- No, because of the Covid-19 pandemic (2)
- No, because of another reason (3)
- Yes (6)

Q20 Is there an LGBTQ organization in your community?

- Yes (1)
- No (2)
- I don't know (3)

Q14 How did you most often connect with the LGBTQ community before the COVID-19 pandemic? (Choose all that apply)

- I do not connect with the LGBTQ community (1)
- I connected through social media (2)
- I connected in person (3)
- I connected through the Pride Festival. (4)
- I connected in another way (5)

Q15 Has your ability to connect to the LGBTQ community changed since the COVID-19 pandemic? If so how have you dealt with this change?

_____

Q66 What steps do you regularly take to protect yourself and others from contracting COVID-19? (Check all that apply)

- ○ Wear a facial covering that covers my nose and mouth when in public places. (1)
- ○ Practice social distancing of 6 feet with people outside my close social circle, andwhen in public. (2)
- ○ Sanitize hands often. (3)
- ○ Sanitize high touch surfaces more often than before. (4)
- ○ Stay home when not feeling well. (5)
- ○ Stay home as often as possible. (6)

Q67 Are you able to work from home?

- ○ Yes, I work remotely all the time. (1)
- ○ Yes, I work remotely some of the time. (2)
- ○ No, my job does not offer remote working. (3)
- ○ No, my job cannot be done remotely. (4)

Q16 Are there any organizations that are providing resources to members of the LGBTQ community where you live?

- Yes (4)
- No (5)
- I don't know (6)

Q17 Do you have any concerns about how COVID-19 might impact you differently because ofyour sexual orientation or gender identity?

- Yes (1)
- No (2)

Skip To: Q28 If Do you have any concerns about how COVID-19 might impact you differently because of

Q18 What are your concerns about how COVID-19 might impact you differently from the rest ofthe population?

_____

Q28 What laws protect you from discrimination as a member of the LGBT community? (Chooseall that apply)

- ○ There are state laws that protect me (1)
- ○ There are city laws that protect me (2)
- ○ There are county laws that protect me (3)
- ○ There are federal laws that protect me (6)
- ○ There are no laws that protect any members of the LGBT community where Ilive (4)
- ○ There are laws that protect sexual orientation but not gender identity. (5)
- ○ Don't know. (7)

Q36 Are you "out"? (Choose all that apply)

- Yes, to friends (1)
- Yes, to family (2)
- Yes, at work (3)
- Yes, to everybody (6)
- I am out only to those with whom I feel safe. (5)
- No, I am not. (4)

Q68 Have you ever been fired, evicted, or denied service because of your real or assumed sexualorientation or gender identity?

- Yes (1)
- Not sure (2)
- No (3)

Q69 Have you ever been assaulted because of your real or assumed sexual orientation or genderidentity?

- Yes, Physically (1)
- Yes, Verbally (2)
- Yes, Sexually (3)
- No (4)
- I don't know (7)

Skip To: Q29 If Have you ever been assaulted because of your real or assumed sexual orientation or gender identity? = No

Q70 Did you report it to local authorities?

- Yes (1)
- No (2)
- I don't remember (3)

Q29 Do you remember when Matthew Shepard was murdered in Laramie, Wyoming?

- Yes (4)
- No (5)

Skip To: Q30 If Do you remember when Matthew Shepard was murdered in Laramie, Wyoming?

Q64 What do you remember? How did it impact your life?

_____

Q30 Do you remember when Ellen DeGeneres came out on her TV show?

- No (4)
- Yes (5)

Skip To: Q33 If Do you remember when Ellen DeGeneres came out on her TV show? = No

Q65 What do you remember? How did it impact your life?

_____

Q33 How old were you when you knowingly first met a person who was part of the LGBT community? (Answer with a number that is a whole number. Example if you were 5 years oldyou would put 5.)

_____

Q34 How was the person's sexual orientation or gender identity introduced to you?

- Positively (1)
- Indifferently (2)
- Negatively (3)
- I don't remember (4)

Q35 Did your primary, secondary or high school include curriculum that showed members of theLGBT community in a positive way? (Select all that apply)

- Yes, Primary (1)
- Yes, Secondary (6)
- Yes, High school. (7)
- No, we did not learn about LGBT people in any of my classes. (2)
- No, they were shown in a negative way. (4)

Q78 What type of school did you attend in high school? (select all that apply)

- Public (1)
- Private (2)
- Home school (3)
- Parochial (4)
- Didn't attend high school (5)

Skip To: End of Block If What type of school did you attend in high school? (select all that apply) = Didn't

---

Q73 While you were in high school did you have a supportive faculty or staff member you couldtalk to?

- Yes (1)
- No (2)
- I don't remember (4)

Q74 While you were in high school did you have a faculty or staff member that advocated foryou?

- Yes (1)
- No (2)
- I don't remember (3)

Q75 While you were in high school did you ever experience suicidal thoughts?

- Yes (1)
- No (2)
- I don't remember (3)

Q76 While you were in high school did you ever try to hurt or kill yourself?

- ○ Yes, once (1)
- ○ Yes, more than once (2)
- ○ No (3)
- ○ I don't remember (4)

Q77 While you were in high school did you hear transphobic or homophobic slurs?

- ○ Yes, a few times (1)
- ○ Yes, often (2)
- ○ Yes, almost every day (3)
- ○ No (4)
- ○ I don't remember (5)

End of Block: Main body of questions

Start of Block: Mental health Block

Q71 The next block of questions will ask you to think about two time periods; the last two weeksas well as two weeks before the COVID-19 pandemic happened.

Q42 How often have you had little to no interest in doing things?

	Not at all (1)	One or a few days (2)	More than halfthe days (3)	Nearly everyday (4)
Pre-pandemic(Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q53 How often over the last two weeks have you felt down depressed or hopeless?

	Not at all (1)	One or a few days (2)	More than halfthe days (3)	Nearly everyday (4)
Pre-pandemic(Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q54 How often over the last two weeks have you had trouble falling asleep, staying asleep orsleeping too much?

	Not at all (1)	One or a few days (2)	More than halfthe days (3)	Nearly everyday (4)
Pre-pandemic(Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q55 How often over the last two weeks have you felt tired or had little energy?

	Not at all (1)	One or a few days (2)	More than halfthe days (3)	Nearly everyday (4)
Pre-pandemic(Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q56 How often over the last two weeks have you had poor appetite or experienced overeating?

	Not at all (1)	ne or a few days (2)	lore than half the days (3)	arly everyday (4)
Pre-pandemic (Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q58 How often over the last two weeks have you felt bad about yourself - that you are a failure orhave let yourself or your family down?

	Not at all (1)	One or a few days (2)	More than half the days (3)	Nearly every day (4)
Pre-pandemic(Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q59 How often over the last two weeks have you had trouble concentrating on things, such asreading or watching television?

	Not at all (1)	One or a few days (2)	More than halfthe days (3)	Nearly everyday (4)
Pre-pandemic(Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q60 How often over the last two weeks have you been moving or speaking so slowly that otherpeople could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?

	Not at all (1)	One or a few days (2)	More than halfthe days (3)	Nearly everyday (4)
Pre-pandemic(Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q61 How often over the last two weeks have you had thoughts that you would be better off dead,or of hurting yourself?

	Not at all (1)	One or a few days (2)	More than halfthe days (3)	Nearly everyday (4)
Pre-pandemic(Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

Q62 If you have experienced any of the previous problems listed so far, how difficult have theseproblems made it for you at work, home, or with other people?

	Not at all difficult (1)	Somewhat difficult (2)	Very difficult(3)	Extremely difficult (5)
Pre-pandemic (Feb 2020) (1)	○	○	○	○
Current (Last Two Weeks) (8)	○	○	○	○

End of Block: Mental health Block

Start of Block: Demographics

Q21 What is your age?

_____

Q25 Do you have any dependents?

- ○ 1 (1)
- ○ 2 (2)
- ○ 3 (3)
- ○ 4 (4)
- ○ 5 + (5)
- ○ 0 (6)

Q24 What is your political affiliation?

- ○ Republican (1)
- ○ Democrat (2)
- ○ Independent (3)
- ○ Other (4) ____

Q37 How politically active are you?

- ○ Very (1)
- ○ Somewhat (2)
- ○ Not at all (3)

Q38 Did you vote in the last presidential election?

- ○ Yes (1)
- ○ No (2)
- ○ I was not eligible to vote (4)

Q39 Did you vote in the last presidential primary election? (Spring 2020)

- ○ Yes (1)
- ○ No (2)
- ○ I was not eligible to vote (4)
- ○ I don't remember (6)

Q40 Do you plan to vote in the next presidential election?

- ○ Yes (1)
- ○ No (2)
- ○ I'm not eligible to vote (4)
- ○ Not sure (8)

Q26 What is your Ethnicity (check all that apply)

- ○ Black or African American (1)
- ○ Asian/ Pacific Islander (6)
- ○ White (2)
- ○ Hispanic or Latino (3)
- ○ Indigenous American (4)
- ○ Other (5) _

Q27 What is your highest level of education?

- ○ Elementary School (1)
- ○ Middle School (2)
- ○ High School Diploma (3)
- ○ GED (4)
- ○ Bachelor's Degree (5)
- ○ Master's Degree (7)
- ○ Doctorate Degree (8)

Q22 What is your gender?

- ○ Man (1)
- ○ Transman (2)
- ○ Woman (3)
- ○ Transwoman (4)
- ○ Genderqueer (5)
- ○ Agender (6)
- ○ Other (7) _____

Q23 What is your sexual orientation?

- ○ Gay (2)
- ○ Heterosexual (3)
- ○ Bisexual (4)
- ○ Lesbian (5)
- ○ Asexual (6)
- ○ Queer (7)
- ○ Other (8) _____

Q41 What sex were you assigned at birth?

- ○ Intersex (1)
- ○ Male (2)
- ○ Female (3)

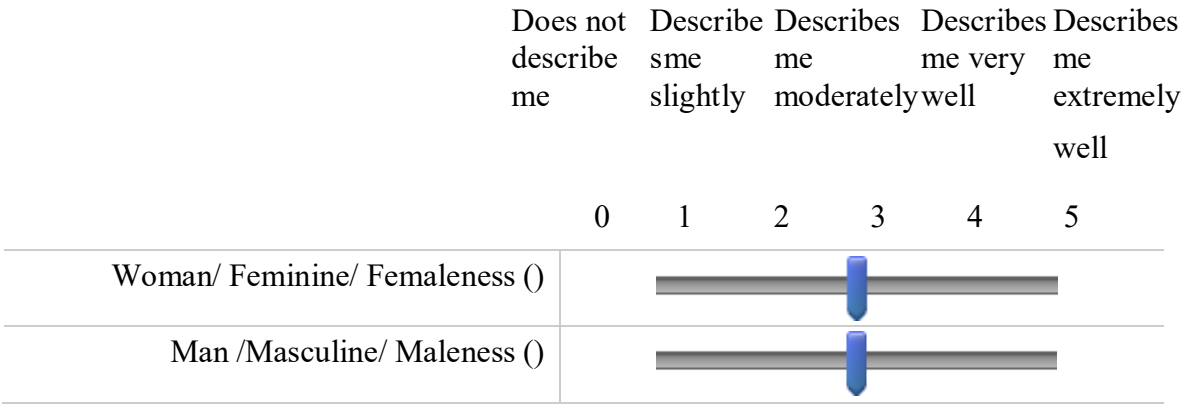
Q5 Move the bars to match your Gender Expression. " I prefer to present myself as..."

	Does not describe me	Describes me slightly	Describes me moderately	Describes me very well	Describes me extremely well
	0	1	2	3	4	5
Masculine ()						
Feminine ()						

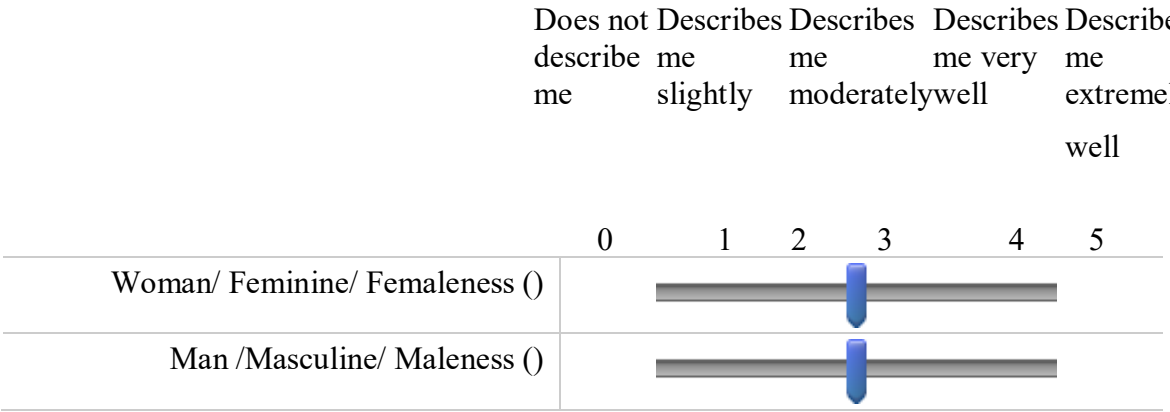
Q2 Move the bars to match your Gender Identity." I feel in myself..."

	Does not describe me	Describes me slightly	Describes me moderately	Describes me very well	Describes me extremely well
	0	1	2	3	4	5
Woman-ness ()						
Man-ness ()						

Q3 Move the bars to match your sexual attraction to others. "I am sexually attracted to..."



Q4 Move the bars to match your romantic attraction to others. "I am romantically attracted to..."



COVID-19 Prevention Measures

Table 4.1 Showing Descriptive Statistics of Measures Taken to Prevent Covid-19

	Frequency	**Percent**
Wear a facial covering that covers my nose and mouth when in public places.	128	83.7
Practice social distancing of 6 feet with people outside my close social circle, and when in public.	124	81
Sanitize hands often	111	72.5
Sanitize high touch surfaces more often than before	74	48.4
Stay home as often as possible	108	70.6