ABSTRACT

Title of Dissertation:	MENTAL HEALTH AMONG BLACK LESBIAN, GAY, AND BISEXUAL PEOPLE: EXAMINING PATTERNS OF RISK, TREATMENT UTILIZATION, AND MENTAL HEALTH MANAGEMENT STRATEGIES
	Natasha Diamond Williams, Doctor of Philosophy, 2023
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Empirically, a Black-White "double paradox" exists whereby 1) despite living in a society plagued by anti-Black racism, Black individuals in the United States are no more likely to experience depression than their White counterparts and 2) Black individuals are *more* likely to report severe psychological distress, a construct that is correlated with depression. Further, intersectional theory suggests that Black lesbian, gay, and bisexual, transgender, and queer (LGBTQ+) young adults may experience elevated risk for mental health issues due to overlapping systems of oppression (i.e., racism, heterosexism). Lastly, Black LGBTQ+ persons' utilization of professional mental health services (PMHS; e.g. therapy, medication) may be impacted by these same forces, but quantitative research has yet to explore utilization disparities at this intersection. Therefore, Studies 1 & 2 of this investigation documented disparities in major depressive episodes (MDE) and severe psychological distress (SPD), as well as differences in the utilization of outpatient PMHS. Study 3 involved semi-structured interviews

with Black LGBTQ+ young adults that explored participants' (i) experiences of intersectional minority stress; (ii) perceptions of the relationship between these experiences and their mental health; and (iii) strategies for managing their mental health.

In Study 1 covariate-adjusted models, compared to White heterosexual individuals, Black LGB males and females evidenced similar or reduced odds of an MDE; there were no statistical differences between these groups for SPD. Compared to their White LGB peers, Black LGB males and females were less likely to report an MDE or SPD. However, compared to their Black heterosexual counterparts, Black LGB males and females had higher odds of an MDE and SPD. Bisexual identity (as opposed to lesbian/gay identity), age, and education were associated with MDE or SPD among the subsample of Black LGB adults.

In Study 2 unadjusted models, compared to White heterosexual females, Black LGB females were less likely to use PMHS. This relationship was not significant in models adjusted for covariates. In models that accounted for mental health need, Black LGB females were less likely to use PMHS than White heterosexual females in unadjusted and adjusted models. The association for Black LGB males, relative to White heterosexual males, was not significant in unadjusted or adjusted models, regardless of mental health need. Still, predicted probabilities illustrated disparities among Black LGB adults, with and without accounting for mental health need, in PMHS utilization relative to White LGB adults and Black heterosexual adults. Age, income, and education were also associated with PMHS utilization among Black LGB individuals.

Participants in Study 3 generally did not describe their identities or attribute their bias experiences in intersectional terms. Rather, most described themselves as "Black first" and discussed instances of anti-Black or, separately, anti-queer discrimination. Almost all shared

periods of poor mental health and discussed myriad strategies for managing their mental health, including seeking PMHS, as well as social supports and self-care strategies.

Together, these studies illustrate differences in risk for depression and psychological distress, disparities in utilization of PMHS, and mental health experiences of Black [LGB]TQ+ young people. Based on all three studies, it appears that the experience of being a sexual minority in Black contexts may have different, and potentially more deleterious, mental health consequences than being Black in queer contexts. In aggregate, this investigation's findings have implications for health policy and mental health practice related to bias/discrimination, barriers to care, and PMHS quality. Directions for future research are also discussed.

MENTAL HEALTH AMONG BLACK LESBIAN, GAY, AND BISEXUAL PEOPLE: EXAMINING PATTERNS OF RISK, TREATMENT UTILIZATION, AND MENTAL HEALTH MANAGEMENT STRATEGIES

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Dedication

This dissertation is dedicated to my younger self. She knew for a long time that a PhD would come. Little did she know just how fully, authentically, and joyfully we'd be living life when it happened.

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I may be the student, but this dissertation, as with all of my doctoral accomplishments, was a team effort. First, to Jessica – my mentor, advisor, and friend. Your confidence in me, from encouraging me to apply to Maryland through to the completion of this project, kept me going. You've laughed with me, pushed me to think deeply, passed me the tissues when things got overwhelming, and have been a steadying force for me these last 5 years. To know you and learn from you has been one of the great joys of my life. Thank you. I also owe a debt of gratitude to Kevin Roy. You have taught me to see not just my work, but the world, in new ways. You've given me space to embrace the nuances and messiness of all things. Because of your kindness, guidance, and encouragement, I am a better researcher, teacher, and colleague. To the rest of my committee, Drs. Craig Fryer, Richard Shin, Mia Smith-Bynum, and Rodman Turpin, you have each helped me think critically and push myself in ways I didn't think I could. You have also served as examples of what it means to succeed in the academy as people of color. I *see* each of you. Thank you for all that you do within these systems and for showing others who look like us what is possible. I also want to thank the interview participants who trusted me with their stories. Each of you left a mark with your vulnerability, honesty, and courage, not just while speaking with me but as you move through the world. You made my favorite part of this project possible and for that, I am forever grateful.

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were instrumental in our department's excellence. You helped me problem-solve and provided incredible supports for me. I thank you for your guidance. To the FMSC faculty, whether I was your student, TA, RA, or just said "hi" in passing, thank you for being a part of the fabric that helped get me here. And to the other students who have met this milestone before me and will do so after me – there is nothing like being in a PhD program. Thank you for understanding how much work this is, listening to me complain, and providing instrumental support throughout the process.

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List of Abbreviations

ACASI – audio computer-assisted self-interviewing

AMI – any mental illness

aOR – adjusted odds ratio

CES-D – Center for Epidemiological Studies Depression Scale

CSA – combined statistical area

DSM – Diagnostic and Statistical Manual of Mental Disorders

K6 – Kessler 6

LGB – lesbian, gay, and bisexual; used interchangeably with *sexual minority* and *LGBQ*

LGBQ – lesbian, gay, bisexual, and queer; used interchangeably with *sexual minority* and *LGB*

LGBT – lesbian, gay, bisexual, and transgender

LGBTQ – lesbian, gay, bisexual, transgender, queer

MDE – major depressive episode

MIDUS – National Survey of Midlife Development in the United States

MSA – metropolitan statistical area

NCS – National Comorbidity Survey

NCS-R – National Comorbidity Survey Replication

NESARC – National Epidemiologic Survey on Alcohol and Related Conditions

NHIS – National Health Interview Survey

NSDUH – National Survey of Drug Use and Health

PHQ-9 – Patient Health Questionnaire

PMHS – professional mental health services

POC – people of color

RUCA – rural-urban commuting area

SAMHSA – Substance Abuse and Mental Health Services Administration

SMI – serious mental illness

US – United States

Introduction

1.1. Background and Significance

Depression is a leading cause of disability in the United States (US; Centers for Disease Control and Prevention, 2020) and worldwide (Pan American Health Organization, 2021). However, depression and other mental health issues are not experienced uniformly across the populace. Longstanding inequities exist across racial/ethnic groups[1] (Center for Behavioral Health Statistics and Quality, 2019) and dimensions of sexual identity (Plöderl & Tremblay, 2015). Black lesbian, gay, and bisexual (LGB) young adults may experience unique risk for mental health issues. To start, depression in the US is most common among those aged 18-29 with 2019 National Health Interview Survey (NHIS) data indicating that over 20% of young adults had experienced any symptoms of depression (Villarroel, 2020). Further, extant theories and empirical evidence point to complex and impactful experiences of stigma and discrimination for those who are both racial and sexual minorities (Meyer, 2003; D. R. Williams & Williams-Morris, 2000). This includes racism within lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities (Ghabrial, 2017), homophobia in Black communities (Chae et al., 2010), and unique stressors that emerge at the intersection of these identities (Fattoracci et al., 2021). These factors have deleterious effects on mental health (Bostwick et al., 2014; Vargas, et al., 2020). However, research about these effects is nascent and often conflicting.

[1] Throughout this document, the term *race/ethnicity* is used for brevity; race and ethnicity are, however, distinct constructs. When *race* or *ethnicity* is discussed independently, the language used reflects the construct(s) of interest in the cited literature.

Research literature demonstrates that Black people experience discrimination and bias that harms their mental health (Pieterse et al., 2012). However, health disparities researchers have identified a "double paradox" (Barnes & Bates, 2017). First, despite experiences with racial bias, Black people consistently have lower rates of depression compared to their White counterparts (Center for Behavioral Health Statistics and Quality, 2019). Second, although measures of general psychological distress are based on the clinical symptoms of depression, Black-White disparities in psychological distress typically function distinctly from measures of depression. That is, Black individuals show higher levels of psychological distress than White people, despite having consistently lower rates of depression. There are many hypotheses about why this double paradox exists, but researchers have yet to reach a consensus on an explanation.

LGB persons also experience harmful bias and discrimination in the United States (McLaughlin et al., 2010; Nadal et al., 2011). Similar to the effects of racism, these sexual minority stressors erode the mental health of LGB people, increasing the risk for mental health issues such as depression (Rodriguez-Seijas et al., 2019). The limited research on disparities in depression and psychological distress for Black LGB people is equivocal. Some studies find that Black LGB persons have higher prevalence rates of depression and psychological distress compared to their Black heterosexual counterparts (Hayes et al., 2011; Platt & Scheitle, 2018), whereas others find no differences (Mustanski et al., 2010) or lower prevalence rates (Meyer et al., 2008). When interpreting and comparing the results of these studies, it is essential to

consider the reference group as it appears that sexual identity-based disparities are more consistent within Black samples than are race-based disparities in LGB samples.

For those who require or desire traditional mental health supports (e.g., outpatient mental health services, talk therapy, medication), there are no clear treatment utilization patterns at the intersection of sexual identity and race/ethnicity. Studies have found that Black LGB adults are no different in their utilization of mental health services (Dunbar et al., 2017; Jeong et al., 2016) or less likely to seek care (Meyer et al., 2015; N. D. Williams et al., 2023) than their White LGB counterparts. There are, however, documented barriers for, separately, Black and LGB people who want to access traditional mental health services, including cost, availability of providers, and fear of discrimination (Alang, 2019; Rees et al., 2020; N. D. Williams & Fish, 2020; N. D. Williams et al., 2021). There is also evidence that, separately, Black and LGB people may be managing their mental health outside of traditional treatment settings. For example, Black adults may prefer to seek help from spiritual or religious leaders or try to manage their mental health on their own (Hines et al., 2017; Mowbray et al., 2017), and LGB individuals may prefer lesbian, gay, bisexual, transgender (LGBT) community-based resources over traditional mental health services (Martos et al., 2019).

Given the state of the science, this multi-method study sought to elucidate the mental health needs, treatment utilization, and management strategies of Black LGBTQ+ young adults (aged 18-26). Extant research on the Black-White mental health double paradox has not yet taken sexual identity into account. This study examined how these two paradoxes take shape in the context of this additional social

identity. It also fills a gap in the literature by examining traditional mental health service utilization patterns at the intersection of sex, sexual identity, and race/ethnicity, providing insights that may inform future epidemiologic surveillance, mental health intervention, and mental health workforce development efforts. Finally, given the evidence that, separately, Black and LGB adults may prefer to manage their mental health outside of traditional systems of care, this study includes a qualitative examination of mental health management among Black LGBTQ+ young adults in major metropolitan areas of the US.

1.2. Specific Aims and Hypotheses

Recognizing the complexity of mental health experiences of Black LGB persons, it is important to document depression and psychological distress inequities to explore the double paradox, identify patterns in treatment utilization, and understand how Black LGB young adults manage their mental health. Therefore, this dissertation addressed the following research questions across three papers. Given the lack of clear empirical and theoretical direction for anticipated findings, several research questions were exploratory.

Study 1: Accounting for Sexual Identity in an Exploration of the Black-White Depression Double Paradox

RQ1: To what extent do indicators of mental health (e.g., MDE and SPD) vary on the basis of sex, sexual identity, and race/ethnicity?

Hypothesis: Black LGB individuals will report higher rates of MDE and SPD than other subgroups, regardless of sex.

RQ2: Among LGB people, do Black and White adults differ in the prevalence of MDE and SPD?

Hypothesis: The prevalence of MDE and SPD will be higher for Black LGB people relative to White LGB persons.

RQ3: Among Black people, do heterosexual and LGB adults differ in the prevalence of MDE and SPD?

Hypothesis: The prevalence of MDE and SPD will be higher for Black LGB people than Black heterosexual persons.

RQ4: Within Black LGB populations, what sociodemographic indicators independently associated with MDE and SPD?

Hypothesis: Among Black LGB individuals, sociodemographic indicators will predict MDE and SPD but the direction of these associations are exploratory.

Study 2: Patterns of Outpatient Mental Health Service Utilization at the Intersection of Sex, Sexual Identity, and Race/Ethnicity

RQ1: To what extent does traditional mental health treatment utilization vary on the basis of sex, sexual identity, and race/ethnicity? This research question is exploratory.

RQ2: Within Black LGB populations, what sociodemographic indicators are independently associated with traditional mental health treatment utilization? This research question is exploratory.

Study 3: A Template Analysis of Mental Health Management among Black LGB Young Adults

1. RQ1: How do Black LGBTQ+ young adults navigate the world, and their understanding of themselves, in the context of being both racial and sexual minorities.
2. RQ2: What meaning do Black LGBTQ+ young adults ascribe to experiences of [intersectional] minority stress?
3. RQ3: How do Black LGBTQ+ young adults manage their mental health?

1.3. Research Implications

The results of this investigation have broad implications in a variety of domains. For instance, the information gleaned from this study can inform the ways epidemiologic surveillance and prevention efforts conceptualize Black LGB mental health [management]. It challenges the predominant mental health measures and questions their use with this population. Further, it challenges assumptions that measuring formal treatment utilization is the best way to capture mental health management. Findings also inform targeted interventions aimed at supporting the mental health of Black LGB persons, including interventions outside traditional mental health care systems. Finally, mental health professional disciplines are still working to cultivate a competent workforce that meets the needs of racial and sexual minority individuals. The findings from this study can also inform workforce development and training efforts about the mental health needs and management strategies of Black LGB persons, including those that may be different from heterosexual Black persons and/or White LGB individuals.

Literature Review

2.1. Mental Health in Black Communities

Black individuals report high levels of racial discrimination in several domains, including housing and employment, in addition to "everyday" discrimination, which consists of "routine and more chronic experiences of being treated with less courtesy or respect in everyday interactions" (Chae et al., 2017 p. 2). Generally, anti-Black racism in the U.S. has morphed over time to be less overt (i.e., "racism as prejudice") and more covert and structural (i.e., "racism as ideology"; Banks et al., 2006; Bonilla-Silva, 2015; D. R. Williams et al., 2012). These more subtle experiences with bias also have deleterious effects on the mental health of Black people; the mental effects of race-related stressors are well-documented in the literature. In one meta-analysis of studies assessing the association between perceived discrimination and mental health among Black Americans, participants who reported greater exposure to racist events and appraised them as more stressful were more likely to report mental distress (Pieterse et al., 2012). This aligns with other studies of Black persons that connect more frequent self-reported racial discrimination experiences with poorer mental health outcomes, including greater risk for depression and global psychological distress (Banks et al., 2006; Chae et al., 2011; Pittman, 2011; David R. Williams & Williams-Morris, 2000)

Researchers have identified myriad mechanisms linking racial discrimination and compromised mental health in Black communities. Early hypotheses about Black individuals possessing limited ability to effectively manage and cope with daily

hassles (Pearlin et al., 1981; Thoits, 1995) have been supplanted by more recent work focused on internalized negative racial group attitudes and their impact on developing a positive self-concept (Rowley et al., 1998; Sellers et al., 2003). Still, other frameworks suggest that individuals integrate both cognitive and unconscious processes when perceiving racial discrimination. Thus, associations between self-reported racial discrimination and health outcomes may be based on dimensions of racial identity and implicit ideas about race (Chae et al., 2011; Fuller-Rowell et al., 2012; Sellers et al., 2003). One 2010 analysis of National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III) data found that among 1,500 Black adults who experienced past-year discrimination, those who accepted the discrimination as a fact of life and did not disclose the experience had 2.5 times higher odds of major depression than those who did not accept the discrimination and disclosed it to others (McLaughlin et al., 2010). Another vein of work posits that residential segregation may be a mechanism linking racial discrimination and compromised mental health. Residential segregation disproportionately funnels Black persons into socioeconomically disadvantaged neighborhoods with fewer employment opportunities and lower-quality education (Darity, 2003; David R. Williams, 1999; David R. Williams & Collins, 2001). Certainly, the presence of crime and poverty have been linked to psychological sequelae like depression and anxiety (Cromley et al., 2012; Curry et al., 2008; Galea et al., 2007; Gapen et al., 2011).

Based on theoretical frameworks and empirical information, hypotheses about Black-White mental health disparities, specifically regarding mood disorders and

psychological distress, appear straightforward. However, the research findings are not consistent. Recently, researchers have begun to examine the so-called "Black-White depression double paradox" (Barnes & Bates, 2017). The first paradox states that because of elevated experiences of identity-based bias and discrimination, and the deleterious effects of these experiences on mental health, rates of mood disorders should be higher among Black populations relative to their White counterparts. However, the analyses of multiple population-based data sources (e.g., NHIS, National Survey on Drug use and Health [NSDUH], National Comorbidity Survey [NCS], National Comorbidity Survey Replication [NCSR]) consistently find rates of depression in Black populations that are equivalent to (Villarroel, 2020) or lower than (Breslau et al., 2006; Center for Behavioral Health Statistics and Quality, 2019) those of White individuals. In a systematic review of the literature on the double paradox, Barnes and Bates (2017) found that Black individuals had a significantly lower prevalence of depression than their White counterparts in six of the nine comparisons they conducted. This review also considered the impact of diagnostic reference periods (i.e., the timing of retrospective recall respondents are asked to consider when reflecting on their mental health experiences). In doing so, they found that Black individuals had a significantly lower prevalence of depression than their White peers in all four lifetime comparisons, and in two of the three past-year comparisons.

The second component of the "Black-White depression double paradox" involves measures of general or non-specific psychological distress. Because measures of general psychological distress like the Kessler-6 (K6) are based, at least in part, on the diagnostic criteria for mood disorders, patterns of psychological

distress should mirror those of mood disorders. In fact, empirical evidence documents strong positive associations between depression and general psychological distress as measured by instruments like the K6, the Center for Epidemiological Studies Depression Scale (CES-D), and the Patient Health Questionnaire (PHQ-9; Andrews & Slade, 2001; Fechner-Bates et al., 1994; Kroenke et al., 2001). In their review of research on the double paradox, Barnes and Bates (2017) found that in 15 of 34 comparisons, Black persons were significantly more likely to score over the clinical cut points (as determined by the scoring for the psychological distress tool specific to each study) than their White counterparts. Of the remaining studies, three found non-significant differences, 13 indeterminate differences due to limited sample size, and three studies in which White people scored higher on distress, two of which were statistical differences. Thus, where we would expect to see similarities in Black-White differences in depression, we observe an inverted pattern when studies assess psychological distress.

Notwithstanding inconsistent findings across studies, when Black people experience compromised mental health, their symptoms are often more persistent than those of their White counterparts. Breslau et al. (2005) analyzed the NCS to document the lifetime risk and persistence of psychiatric disorders across ethnic groups in the US. Compared to non-Hispanic White persons, non-Hispanic Black individuals had significantly lower 12-month prevalence of any disorder, lower lifetime prevalence across all four categories of psychiatric symptomology (mood disorders, anxiety disorders, substance use, and any disorder), yet higher odds of persistence of mood, anxiety, and any disorder. The authors concluded that, for Black

persons and other people of color (POC), the timing of factors known to influence mental health may make a difference. Factors occurring before the onset of disorders (e.g., parents' socioeconomic status) appear to reduce the risk of psychiatric disorders. However, factors concurrent with, or subsequent to, the onset of disorders (e.g., timing or quality of care) increase the risk of persistence among those who become ill. Persistence of symptoms may also explain why the Black–White depression paradox in the past 12 months is less pronounced than the lifetime prevalence that Barnes and Bates (2017) found. Because prevalence accounts for both incidence and duration, groups with more persistent symptoms are more likely to be captured in shorter reference periods (e.g., last 30 days) than those with symptoms that are quickly treated.

These differences in symptom severity and persistence have been explained in several ways. First, they may speak to a cultural conceptualization of what constitutes mental distress. In a 12-month ethnography of mental health in a predominantly Black, economically depressed urban neighborhood, Alang (2016) found that members of this community often considered depression a sign of weakness; typical depressive symptoms (e.g., sadness, hopelessness) were viewed as inconsistent with prevailing notions of strength. Further, depression was not typically considered a health problem warranting professional help. Thus, differences in symptom severity and persistence may also result from cultural stigma around seeking formal care or a mental health care system that often provides lower quality or less effective care to Black clients. For example, greater persistence in symptoms among Black individuals may be attributed to poorer access to high-quality screening, diagnosis, and treatment

relative to their White counterparts (Department of Health and Human Services, 2001; Wang, Berglund, et al., 2005; Wang, Lane, et al., 2005).

2.1.1. Within-Group Differences in Mental Health

There is variation in patterns of mental health by sex within Black communities. Greer et al. (2009) used a sample of Black college students in the Southeastern US to examine sex-based differences in the relationship between race-related stress and mental health. Overall, they found that Black women experienced poorer mental health relative to Black men, including in symptoms of depression. Further, general stressful life events have been found to have differential effects on mental health between Black men and women. Assari and Lankarani (2016) found that the deleterious effects of stressful life events on mental health are stronger for White men than Black men; however, the link between stressful life events and depression does not differ between Black and White women. From the perspective of Black women in focus groups, there is a recognition that Black men's depression is a cultured and gendered phenomenon that is qualitatively different from that of Black women (Watkins et al., 2013). The Black women in the study pointed to the differential effects of slavery on Black men and their influence on contemporary gendered norms and definitions of masculinity, whereby "Black men must be strong, macho, and work twice as hard as men from other racial and ethnic groups in order to do well by society's standards" (Watkins et al, 2013, p. 51S).

Socioeconomic factors also influence patterns of mental health in Black communities. For example, Mouzon et al. (2016) analyzed data from the 2001-2003 National Survey of American Life and found that psychological distress (as measured

by the K6) was lower for Black adults with higher levels of income and more years of education. The relationship between socioeconomic variables and depression may be more nuanced for Black men in particular. Assari (2017) found that, although each additional year of schooling reduces Black men's risk of depression (education as a gradient), graduating from high school (education as a threshold) imparted additional risk of depressive symptoms over time. None of the other subgroups in this longitudinal analysis (i.e., Black women, White men, White women) evidenced this pattern. Similarly, although higher income is generally protective against depression, this protective effect is attenuated for Black adults relative to their White peers (Assari, 2018). In fact, high-income Black men may be more likely to experience a major depressive episode (MDE) in the past year relative to their lower-income counterparts (Assari, Lankarani, et al., 2018). Assari (2017; 2018) explains the differential effects of education and income on Black mental health by pointing to increased opportunity and expectations for success that accompany higher education and income that are thwarted by structural and institutionalized barriers to meeting those expectations.

Although there do not seem to be geographic regional differences in mental health among Black people (Mouzon et al., 2016), other place-based factors differentially impact mental health in Black communities. For example, low- and middle-income (but not high-income) Black adults perceived neighborhood social disorder as associated with past-year MDE (Hastings & Snowden, 2019). Further, neighborhood composition may impact the mental health of Black adults, with one study finding that the percentage of White individuals in a neighborhood is associated

with higher levels of racial discrimination which, in turn, is associated with higher levels of depressive symptoms (English et al., 2014). In their study of nearly 900 Black children ages 10-12 who were followed for up to 18 years, Assari, Gibbons, et al. (2018) also found that living in a predominately White neighborhood predicted higher average depressive symptoms over time; this association was fully explained by higher perceived racial discrimination. Additionally, higher income was associated with more depressive symptoms but only in predominately White compared to predominately Black neighborhood contexts.

2.2. Mental Health in LGB Communities

Although views of LGBTQ persons as a group in the US have improved over the last few decades (Gallup, 2019), LGB people continue to face bias, stigma, and discrimination due to their sexual identity. Similar to scholarship on how racism has changed over time, researchers have identified various forms of pervasive, subtle discrimination that LGB persons experience (Cowan et al., 2005; Nadal et al., 2010, 2011; Silverschanz et al., 2008) that have become more common than the overt homophobia that characterized past eras. Researchers have documented the prevalence of identity-based discrimination among LGB individuals. In one analysis of data from The National Survey of Midlife Development in the United States (MIDUS), Mays and Cochran (2001) found an adjusted prevalence of lifetime discrimination among LGB persons of over 75%, including things like being fired from a job and being hassled by police. Although not universal among the sample, sexual orientation was commonly the perceived reason for this discrimination. In another study of LGB persons from the NESARC-II (2004-2005), one in five

respondents had experienced some form of discrimination in the past year, including being called an offensive name or being pushed, shoved, or threatened (McLaughlin et al., 2010). These incidents occurred in various contexts, including in public settings, while obtaining health care, and at work.

The deleterious effects of these experiences on the mental health of LGB people are well documented. In an analysis of the NESARC-III, Rodriguez-Seijas et al., (2019) identified mental health disparities in most psychiatric disorders, including past-year diagnosed major depressive episode, between LGB people and their heterosexual counterparts. These disparities were attenuated after controlling for sexual orientation-based discrimination experiences. Using data from the MIDUS, Mays and Cochran (2001) observed a similar phenomenon. After finding robust associations between experiences of discrimination and indicators of psychiatric morbidity, controlling for discrimination experiences attenuated the association between sexual orientation and psychiatric disorders.

These findings reflect the major proposition of minority stress theory: that LGB individuals are subject to bias and stigma based on their identity and that these stressful experiences compromise their health (V. Brooks, 1981; Meyer, 2003). Minority stress theory posits the existence of proximal and distal impacts of minority stressors on the health of LGB people. For example, the psychological mediation framework enumerates how minority stress "gets under the skin." According to this framework (Hatzenbuehler, 2009), stigma-related stress disrupts adaptive emotion regulation processes, negatively affects interpersonal relations, and encourages cognitive processes associated with psychopathology (e.g., rumination). One

systematic review examined mediators of the disparities in depression between LGB and heterosexual individuals across 40 studies and identified a breadth of mediators, including discrimination, victimization, violence, stress, social support, and other interpersonal factors, as well as intrapersonal psychological processes (Argyriou et al., 2021).

Mental health disparities research consistently indicates compromised mental health for LGB persons relative to their heterosexual counterparts (Plöderl & Tremblay, 2015). The Substance Abuse and Mental Health Services Administration (SAMHSA) published a report on sexual orientation differences in the 2015 NSDUH stating that LGB adults were more likely than their heterosexual counterparts to have any past-year mental illness (AMI), serious mental illness (SMI), and AMI excluding SMI in the past year. LGB adults were also more likely than their heterosexual peers to have a past-year MDE (18.2 vs. 6.2 percent) or to have had a MDE with severe impairment in the past year (13.1 vs. 3.9 percent; Medley et al., 2016). Further, in their analysis of 2013-2014 NHIS data, Cochran et al., (2017) found that LGB individuals, regardless of sex, were significantly more likely than heterosexual persons to evidence high levels of psychological distress (i.e., K6 score $\geq$ 13) and more likely to report that psychological distress interfered with their life. LGB men and women were also more likely than their heterosexual counterparts to report experiencing monthly high-intensity depression (Cochran et al., 2017). Using NESARC-III data, Kerridge et al., (2017) found that, compared to heterosexual individuals, the odds of 12-month prevalence of major depressive disorder were 1.8 times higher for gay and lesbian participants and 1.9 times higher for bisexual

participants. When depression was assessed over participants' lifetime, the odds of depression for gay and lesbian individuals were even higher at 2.6 times the odds of heterosexual persons.

2.2.1. Within-Group Differences in Mental Health

There are substantial within-group differences in LGB mental health, which include sex differences in the association between minority stress and mental health. For example, in an analysis of NESARC-II data (2004-2005), Bostwick et al. (2010) found that among men, any sexual minority status (defined by identity, attraction, or behavior) was associated with a higher prevalence of lifetime mood disorders. Among women, however, only sexual minority identity was associated with higher rates of lifetime disorders; exclusive same-sex attraction and behavior, independent of identity, was associated with lower rates of almost all lifetime mood disorders. Kerridge et al (2017) found similar differences in 12-month prevalence of major depression; gay and bisexual-identifying men (separately) had higher odds of depression relative to heterosexual men but gay/lesbian-identifying women did not have statistically different odds from the heterosexual women in the sample. Notably, bisexual-identifying women did report higher odds of major depression in the past-year relative to heterosexual women. SAMHSA's report on 2015 NSDUH data (Medley et al., 2016) also reported sex-based differences in past-year MDE. Compared to heterosexual/straight males (4.3%), LGB males (14.8%) were more likely to have experienced a past-year MDE. Among females, compared to heterosexual/straight females (8.0%), LGB females (20.4%) were more likely to have

experienced a past-year MDE. Notably, this report did not separate bisexual and gay/lesbian women in these comparisons.

These sex/gender-related[2] differences may be connected to qualitative differences in experiences with minority stressors. In Nadal et al.'s (2016) review of the literature on LGBTQ microaggressions, the authors note that heteronormative cultural norms may dictate differences in the content and context of microaggressions that LGB women and men experience. For example, lesbian and bisexual women were more likely to confirm experiences of exoticization by heterosexual men and describe being inappropriately sexually propositioned, a microaggression not reported by gay male participants (Nadal et al., 2011). They also note that although men may be encouraged to conform to gender in many other ways, women tend to be targeted more for their dress or appearance. In the LGB sample from Mays and Cochran's (2001) study, lesbian and bisexual women were more likely than gay and bisexual men to report not being hired for a job, not being given a promotion, being discouraged from continuing education, and being denied or given inferior services (e.g., by a plumber, mechanic).

The microaggressions experienced by gay men are qualitatively different from those experienced by gay/lesbian women. Bostwick et al., (2010) contextualize the findings above by noting that heteronormative scripts are more strictly enforced among and by men than they are for women. In Nadal et al's (2016) review, the use of heterosexist language (e.g. "that's so gay," calling someone a "f*g") as a social

[2] Throughout this document, the term *sex/gender* is used for brevity; sex and gender are, however, distinct constructs. When *sex* or *gender* is used independently, the language reflects the use of construct in the cited literature.

sanction was one of the most common types of microaggression experienced by gay men and boys. Nadal et al. (2011) reported that gay males described the casual use of this language to degrade other males perceived as violating gender norms. The use of this language was closely related to another common microaggression for gay men identified in the review: the policing of masculinity. This may include the belief that gay men cannot play stereotypically hypermasculine sports (e.g., football) or that their career choices are necessarily restricted to traditionally "feminine fields" (e.g., interior decorating, cosmetology). In the LGB sample from Mays and Cochran's (2001) study, gay and bisexual men were more likely than lesbian and bisexual women to report being prevented from renting or buying a home, being forced out of their neighborhood by neighbors, and being hassled by the police.

Within LGB populations, there is also evidence that being in a partnered relationship serves a protective function against the mental health effects of minority stressors. For example, M. E. Williams and Fredriksen-Goldsen (2014) analyzed surveys from 2,150 LGBT older adults (50+ years of age) and found that participants who indicated that they were in a same-sex partnership (i.e., married or partnered) reported fewer depressive symptoms compared to those who were not currently in a relationship (i.e. single, divorced, widowed, or separated). Similarly, using data from the California Health Interview Survey, Wight, et al. (2013) found that LGB persons married to a person of the same sex scored significantly lower on the K6 than LGB persons not in a legally recognized relationship. This data was from 2009, after marriage equality was passed in California but prior to nationwide marriage equality.

Thus, although being in a relationship may be protective, it is also possible that having that relationship recognized by the state was a factor in this study.

2.3. Black LGB Mental Health

Generally, LGB POC experience simultaneous race- and sexuality-based bias and discrimination (Balsam et al., 2015; Fattoracci et al., 2021) in addition to unique forms of oppression like racism within LGBT communities (Balsam et al., 2011; Chae et al., 2010; Han, 2007; J. Ward, 2008). Importantly, research on the discrimination experiences of LGB POC has typically split intersectional minoritized identities into pieces and focused on racism in queer spaces or homophobia in non-White spaces; it should be noted that LGB POC experience racism and homophobia everywhere and not just in minoritized spaces. For example, 76% of respondents to the Black LGBTQ Community Survey (2021), indicated at least one form of discrimination (e.g., racial, sexual orientation, gender, gender identity, age) in the past three years. Discrimination during consumer interactions and workplace discrimination were the most common contexts for these experiences. Similarly, a 2021 Williams Institute report using data from 2016-2017 found that the proportion of Black LGBT individuals reporting at least one instance of everyday discrimination in the past year (82%) was not statistically different from the proportion of Black non-LGBT adults (79%). Data from the 2019 Black Census (Black Futures Lab, 2019) indicate that Black LGB+ persons are more likely (52-63% depending on specific identity) than their Black heterosexual counterparts (45%) to report having been treated with less courtesy (e.g., being treated as dishonest, less intelligent, or dangerous) than other people at least a few times in a given month. The Black Census

does not ask respondents to attribute this treatment to a given identity; thus, this mistreatment may be due to sexual orientation, race, gender, or any combination of factors. The same survey found that, compared to Black heterosexual individuals (52%), Black LGB+ respondents were more likely to report having felt threatened or harassed at least a few times a year (62-71% depending on specific identity). These differences were not tested for statistical significance.

Importantly, it is easy to focus on homophobia in Black communities as if it is unique to Black culture, as if Black communities are inherently homophobic, or as if Black communities are devoid of affirming individuals and structures. Certainly, homophobia can be found in any group of people defined by race, including white communities, and many Black-identified individuals are outspoken supporters of LGBTQ+ people and communities. Christian faith is often used to explain homophobia when it comes from Black individuals and communities. Although this is an empirically supported explanation for anti-LGBTQ+ beliefs, it is also possible that Black individuals' experiences of racism inform their reaction, for example, to a child disclosing an LGBTQ+ identity. When people have firsthand knowledge of the effects of anti-Black racism, they may be reluctant to affirm another marginalized identity that could expose their loved one to additional axis of oppression.

Although overt forms of racism are not uncommon, LGB POC have reported experiencing additional forms of discrimination, including microaggressions (Balsam et al., 2011; Crichlow, 2004; Nadal, 2011; Sue et al., 2007; E. G. Ward, 2005). These "new" forms of discrimination are more subtle and include "commonplace statements or behaviors that are derogatory, hostile, and insulting, yet often done without the

intent to harm" (Ghabrial, 2017 p. 43). Racism in LGBT communities can also be systemic, reflected in things like community structure and one's environment. For example, non-White LGB people have reported feeling alienated by LGBT organizations and bars because they do not offer culturally specific services and events (Kudler, 2007; J. Ward, 2008). Relative to other non-White sexual minorities, Black LGB persons may be most affected by racism in LGBT communities. In one study of 589 sexual minority men, Black participants reported significantly higher race-based stigma in LGBT spaces than Asian and Latino/a/x participants (McConnell et al., 2018). Thus, community contexts that are generally thought to promote resilience may in fact perpetuate racism and race-based stigma.

LGB POC also experience heterosexism within communities of color (Balsam et al., 2011; Bridges, Selvidge, & Matthews, 2003; Chae et al., 2010). In Black communities specifically, historically Black institutions (e.g., the family, the church, Black social groups) have been crucial supports for Black people. However, these same institutions have not typically supported LGB people and others who face gender- and sexuality-based oppression (Mosley, et al., 2016). Generally, LGB identities remain largely stigmatized in families, faith communities, and the larger Black community (Balaji, et al., 2012). Much of the research about homophobia and heterosexism in Black communities has focused on messages from the church. Studies consistently find that, although there are some exceptions, Black churches overwhelmingly espouse homophobic and heterosexist beliefs and attitudes (Balaji, et al., 2012; Harris, 2009; Walsh, 2016; Ward, 2005). A handful of studies have explored the impact of this marginalization specifically for Black gay, bisexual, and

men who have sex with men; these men must contend with the rigid norms of Black masculinity in addition to homophobia (Balaji, et al., 2012; Bowleg, 2013; Ward, 2005).

Theoretically, there are a number of hypotheses about how this kind of victimization and discrimination might be related to Black LGB mental health (Mallory & Russell, 2021). For example, minority stress theory posits that Black LGB persons would experience "double jeopardy" whereby experiences of bias and discrimination based on both sexual identity and race would compound, resulting in compromised mental health above and beyond that experienced by people who occupy one of these identities alone (Meyer, 2010). Intersectional theory, however, posits that the experiences of Black LGB people are not additive; it problematizes this additive hypothesis and suggests that the experiences of Black LGB people should be understood as more than just Black + LGB (Bowleg, 2008; Crenshaw, 1991). Bostwick et al's (2014) analysis of an LGB-identifying subsample from NESARC-II data (2004-2005) illustrates the complexity of the association between multiple types of marginalization and mental health. They found that, compared to LGB persons who reported no experiences of discrimination, sexual orientation or racial discrimination alone were not associated with higher odds of a past-year mental health disorder (defined as past year major depression, dysthymia, mania, hypomania, panic with and without agoraphobia, social phobia, specific phobia, or generalized anxiety disorder). However, those who experienced sexual orientation discrimination and racial discrimination had 2.25 higher odds of a past-year mental health disorder compared to those who reported experiencing no discrimination. Adding the

dimension of gender further complicated matters. Gender discrimination alone predicted higher risk for a mental health disorder but was not a significant predictor when paired with sexual orientation discrimination. Those who reported experiencing gender and race discrimination had the highest odds of a mental health disorder (aOR=4.30), higher than those who reported experiencing all three types of discrimination. Further, in a critical review of literature about multiple types of discrimination and mental health, Vargas et al., (2020) found that participants who reported experiencing more than one type of discrimination – regardless of the combination of identities attributed to these experiences – were 60-263% more likely to experiences depression symptoms or meet criteria for major depression than those who endorsed one type of discrimination.

Internally, LGB POC may feel a tension between their communities and/or the interactions between their identities (Ghabrial, 2017). For some, their identities may be in direct conflict with each other, compounding stressors and creating obstacles to mental wellness (Balsam et al., 2011; Bowleg, 2008). Findings from Jackson et al (2020) provide evidence for the role of identity conflict in the mental health of Black LGB individuals. They adapted minority stress theory and the psychological mediation framework to examine the relationship between intersectional experiences and negative affect (as a measure of psychological distress). They found that identity conflict mediated the association between negative daily intersectional experiences and negative affect. The same study also identified negative rumination as a mediator of the relationship between negative intersectional experiences and negative affect. Ajayi and Syed's (2021) phenomenological examination of what they call “dual

minority stress" identified three manifestations of internalized oppression: psychological maladjustment, acting out (i.e., risky behaviors), and identity disintegration (i.e., struggling to integrate Black and LGB identities). The interview data from this study also suggest three mechanisms by which oppression becomes internalized: notions of prototypicality (i.e., narrow ideals of Blackness and queerness), socio-political invisibility, and the absence of counterspaces (e.g., contexts and spaces for Black LGB individuals to be in community and challenge deficit-based notions of their existence). These studies provide insight into how minority stressors might "get under" Black LGB skin.

There exists limited research on the mental health of LGB POC, and even less on Black LGB persons. Although it did not include a direct measure of mental health or a comparison group, the 2020-2021 Black LGBTQ Community Survey (2021) asked respondents to indicate, from a list of 18 options, the health issues that are of the greatest concern to them. Among those age 18-34, "depression/anxiety/PTSD or other mental health concern" was the most common concern for both cisgender gay and bisexual men (64%) and cisgender lesbian and bisexual women (75%). Understanding Black LGB mental health is further complicated depending on which comparison group is used in a given study; comparisons between Black LGB and Black heterosexual individuals appear to generate different conclusions from comparisons to White LGB persons. For example, Hayes et al (2011) found support for the double jeopardy hypothesis, but only for LGB students of color relative to heterosexual students of color; among racial/ethnic minority students, LGB students of color experienced greater distress than heterosexual students of color. However,

racial/ethnic minority LGB students and European American LGB students reported similar amounts of distress. These findings are similar to Platt and Scheitle (2018), who used data from the 2013-2015 NHIS to investigate differences in psychological distress (as measured by the K6) between heterosexual, gay, lesbian, and bisexual individuals across gender and racial categories. They found that psychological distress was higher among Black LGB men and women than their Black heterosexual counterparts. In a comparison of rates of diagnosed depression, a 2021 Williams Institute report found that Black LGBT adults were significantly more likely to report a depression diagnosis compared to Black non-LGBT adults (26% to 14.8%, respectively). This pattern was also present in subgroup analyses based on gender; Black LGBT men and women were more likely to have been diagnosed with depression than Black non-LGBT men and women. Ramchand, et al. (2021) found that Black LGB men and women had higher past-year odds of suicide thoughts, plans, and attempts relative to their heterosexual Black counterparts.

Other studies find conflicting evidence about racial/ethnic differences in LGB samples. In a study of 246 LGBT youth ages 16-20, Mustanski et al., (2010) found no differences in the rate of depression between racial/ethnic minority participants and their White counterparts. Contrary to the findings in Hayes et al (2011), Platt and Scheitle (2018) observed that distress was higher for gay Black men than for gay White men; these differences were not present among women. Thus, there is some indication that racial differences in psychological distress within LGB samples may be sex/gender dependent. In their analysis of 388 LGB adults in New York City, Meyer et al., (2008) found that Black LGB participants had half the odds of having a

mood disorder relative to their White counterparts. This lack of clarity about racial/ethnic disparities within LGB communities may be compounded by measurement differences; each of the studies outlined above uses different mental health outcomes (i.e., depression, psychological distress, any mood disorder).

Some studies explore both comparison groups. Rodriguez-Seijas et al (2019) analyzed the NESARC-III and once again found that relative to Black heterosexual individuals, Black sexual minority individuals had over twice the odds of past-year diagnosed major depressive episode. Compared to non-Hispanic White sexual minority individuals, there was no significant difference in past-year MDE diagnosis. In the same study, additional analysis that focused on transdiagnostic factors – the underlying core constructs of psychopathology (e.g. internalizing and externalizing factors) – found that relative to White sexual minority individuals, Black persons showed reduced rates of internalizing disorders (which includes mood disorders like depression). Calabrese et al. (2015) explored the experiences of Black sexual minority women relative to two comparison groups: White sexual minority women and Black sexual minority men. Black sexual minority women experienced greater discrimination frequency, scope (total number of different types of discrimination experienced), and number of bases (race, gender, sexual orientation) compared to White sexual minority women. Black sexual minority women also reported poorer psychological well-being relative to Black sexual minority men, Black sexual minority women experienced discrimination on more bases and reported a higher level of depressive symptoms.

2.4. Mental health management in Black communities

Mental health management is a broad term for how individuals maintain or improve their mental health. This includes everything from relying on and activating social support networks and utilizing individual coping skills (e.g. journaling, mindfulness practice, exercising) to mitigating symptoms through reliance on substances, attending talk therapy, or taking psychotropic medication. In national datasets, the key measures of mental health management typically capture professional mental health service (PMHS) utilization. Based on this type of measurement, the 2019 NSDUH found that Black individuals were 40% less likely than their White counterparts to have received any outpatient mental health treatment in the past 12 months; when inpatient care and medication are factored into treatment utilization, Black people were half as likely to have received treatment in the past-year (Substance Abuse and Mental Health Data Archive, 2020). In an analysis of the 2013-2015 NHIS, Platt et al., (2018) found that, after controlling for covariates including 30-day psychological distress (as measured by the K6) and daily activity limitations due to mental health, Black adults had lower odds of past-year mental health service utilization compared to White adults in the sample. The disparities do not appear to be narrowing over time. For example, Cook et al. (2017) analyzed 2004-2012 Medical Expenditure Panel Survey data and found that disparities between Black and White people's utilization of any mental health care and any psychotropic medication use widened over time. Further, despite national efforts to reduce racial disparities in mental health care, these disparities have remained wider than most

other areas of health care services (Agency for Healthcare Research and Quality, 2013).

Within Black communities, engagement patterns with formal mental health services may vary by sex. Alang's (2019) analysis of the 2011-2015 NSDUH revealed that, among Black individuals reporting unmet mental health needs, women were more likely than men to endorse minimization (i.e. believe they could handle the problem without treatment or not feel the need for treatment at the time). This seemingly conflicts with qualitative findings from Thompson et al., (2004), which indicated that men were more likely to endorse ideas about the need for Black people to demonstrate strength and that mental illness is a sign of weakness. In their systematic review of the literature on depression and Black men, Ward and Mengesha (2013) concluded that although Black men may not hold explicitly negative attitudes toward seeking PMHS, they do hold attitudes that indirectly appear to erode their willingness to seek care.

Beyond sex differences, Alang (2019) also reported that higher levels of education were associated with higher odds of minimization. Further, people who reported some college or having a college degree were more likely to report unmet need because of low perceived effectiveness of treatment compared to those who did not attend college. Alang (2019) also identified place-based differences. Relative to people who lived in large metropolitan areas, those living in non-metropolitan areas had greater odds of foregoing care because they thought treatment or counseling would not help and had higher odds of reporting accessibility barriers (i.e., no

transportation, location was inconvenient, did not know where to go for services, or did not have time) than those in large metro areas.

It is important to contextualize these findings. First, there are historical, shared trauma experiences that individuals from racial/ethnic minority groups shoulder (M. T. Williams et al., 2013). The resulting institutional mistrust may dissuade Black adults from engaging with traditional services because they, for example, may feel that they are being experimented on (Alang, 2019). These historical influences blend with ongoing, contemporary biases in U.S. society; interconnected systems of oppression leave Black individuals skeptical of how they will be treated in mental health settings. For example, Black adults may be reluctant to engage with traditional systems of care, fearing that those systems will be weaponized against them, jeopardizing their jobs or custody of their children (Alang, 2019). As one focus group participant in Alang's (2019) study stated, "They treat us bad in school, at work and on the streets. If I'm not dying, I'm not going to the hospital. They'll treat us bad there too. You want them to give you medications for mental health? That stuff can mess with you real good" (p. 349). These fears are not unfounded. Black individuals are often subject to microaggressions and poor treatment (Gómez, 2015; N. D. Williams, et al., 2023) when they do engage with mental health care systems that some characterize as "a White system" (Nicolaidis et al., 2010).

Secondly, mental health stigma influences the use of traditional services. In Alang's (2019) study, Black adults expressed a fear of being discriminated against based on their race and mental illness. Although mental health stigma is pervasive throughout the US, there may be cultural facets of Black communities that perpetuate

this stigma. For example, Wallace and Constantine (2005) found that higher levels of Afrocentrism were associated with higher levels of perceived stigma about PMHS. Further, some researchers have noted that Black individuals may be more likely to endorse beliefs about the etiology of mental illness that challenge the biological basis of things like depression and lean more toward spiritual explanations for distress. Black individuals are also more likely than their White counterparts to doubt the effectiveness of mental health interventions, including talk therapy and medication (Gonzalez et al., 2011). Recognizing the power of stigma in Black communities, numerous researchers have pointed to the need to reduce/eliminate stigma to connect more Black individuals to PMHS (E. Ward & Mengesha, 2013).

These experiences contribute to decisions to continue treatment or re-engage with formal systems of care in the future (Alang, 2019). In fact, one study found that Black adults were more likely than their White counterparts to quit mental health care sooner than the provider-recommended duration (Mowbray et al., 2017). Black adults were more likely than White participants to quit when their provider was a medical doctor, counselor, or non-MD health professional. Notably, there were no significant difference in the percentage of Black and White participants who quit services with their spiritual advisor or healer (Mowbray et al., 2017). Similarly, Hines et al. (2017) found that the sector in which people received their mental health care (e.g. psychiatrist, human services, spiritual, etc.) moderated racial/ethnic disparities in utilization. Relative to their White counterparts, Black individuals were less likely to have had at least four, eight, or 12 visits to human services providers. At the *at least one visit* level, Black individuals were less likely to have visited a medical provider

for their mental health. The authors noted no differences between Black and White individuals utilizing spiritual sector services. They concluded, then, that race-based disparities in mental health care utilization point to a preference by Black individuals for the use of non-mental health and non-medical settings (Hines et al., 2017).

Finally, Black communities disproportionately experience barriers to accessing traditional services, often measured in health services research. In one representative sample of Black U.S. adults, cost and insurance coverage were the most oft-cited reasons for foregoing PMHS, with half of the respondents endorsing this reason (Alang, 2019). However, in a sample of well-insured college students who had relatively easy access to free-to-reduced cost PMHS, Black students were substantially less likely to utilize services, indicating that additional barriers may influence utilization (Hunt et al., 2015).

As we seek to understand how Black people manage their mental health, it is necessary to expand utilization measures and consider using less formal mental health management strategies (e.g., faith leaders, social and community supports, etc.). Black individuals may rely on these mental health management strategies more often than formal, professional treatment and, in doing so, can take care of their mental health while circumventing mistrust, stigma, and access barrier issues (Hines et al., 2017; Jones et al., 2020; Snowden, 2001; Taylor et al., 2003; E. Ward et al., 2013). For example, some researchers have suggested that a reluctance to seek formal treatment is related to cultural norms of self-sufficiency and a belief in the ability to overcome stressors through personal effort (Breland-Noble et al., 2006; Snowden, 2001). This mentality translates to high-effort coping (i.e., "John Henryism"; S. A.

James et al., 1983) as Black individuals – especially those of higher socioeconomic status – are "faced with the daunting task of creating for themselves, an American identity, [one which is] a coherent expression of core American values such as hard work, self-reliance, and freedom." (S. James, 2002). The idea of the "strong Black Woman" and its relationship to hesitation to engage with treatment is evidence of this as well (Nicolaidis et al., 2010). Relying on religious, familial, and social supports likely does not violate this norm of self-sufficiency in the way that engaging with professional mental health providers does (Snowden, 2001).

2.5. Mental health management in LGB communities

Generally, LGB persons use traditional services more than their heterosexual peers (Dunbar et al., 2017; Filice & Meyer, 2018). In one analysis of the 2013-2015 NHIS, Platt et al. (2018) found that gay and lesbian adults were 2.6 times more likely than their heterosexual counterparts to have seen or talked to a mental health professional in the past 12 months; bisexual participants were 3.6 times more likely. In regression models that accounted for measures of mental health and sociodemographic factors, gay/lesbian and bisexual adults both had over twice the odds of past-year mental health care utilization compared to heterosexual adults. Data from the 2015 NSDUH indicated that LGB people with any mental illness (AMI) in the past year were more likely than heterosexual adults with AMI to receive mental health services during the past 12 months (Medley et al., 2016).

Even still, LGB communities experience unique barriers and challenges when seeking PMHS. For example, mental health services that attend to the unique needs of LGB people (e.g., those that create space to address experiences of LGB identity-

based bias, do not pathologize LGB identities, etc.) appear to be of limited availability. In one analysis of data from national SAMHSA surveys of state-approved mental health and substance abuse facilities, N. D. Williams and Fish (2020) found that 12.6% of mental health facilities reported LGBT-specific programs. A previous analysis of this same mental health facility dataset suggests that this number is likely overestimated, as some facilities may inaccurately report offering these programs (B. N. Cochran et al., 2007). Notably, LGB and heterosexual adults have comparable insurance coverage rates since the enactment of the Affordable Care Act, yet studies suggest that LGB individuals may be underinsured (i.e. high cost-sharing plans; Dawson et al., 2018; Fish et al., 2021).

LGB communities may also face some institutional mistrust issues, based on how same-sex/gender attraction and behavior has been regarded by the mental health field historically. It was only in 1973 that the Diagnostic and Statistical Manual of Mental Disorders (DSM) depathologized homosexuality. Still, systems of care and individual providers subject LGB clients to harmful practices like sexual orientation change efforts (i.e., conversion therapy). As of July 2023, 23 states had not enacted laws banning these practices (Movement Advancement Project, 2023). Although most LGB individuals will not be subject to sexual orientation change efforts, it is important to note that these harmful and unethical practices are related to increased risk for mental health issues, including depression and suicide (Blosnich et al., 2020; Fish & Russell, 2020; Green et al., 2020) and perpetuate perceptions of the mental health care field's inability to meet the needs of LGB persons.

Studies of LGBTQ client experiences in therapy have been largely qualitative and illustrate the difficulties these clients face. Rees et al. (2020) conducted an integrative review of qualitative studies about LGB and transgender (LGBT) experiences of mental health services. In 12 of the 14 studies analyzed, LGBT clients experienced stigma and discrimination when accessing PMHS, including heteronormative language, monosexism (i.e., regarding strictly other- or same-sex/gender attraction as superior or more normative than bisexuality and both sex/gender attraction), and stereotypical expectations of appearance and behavior. Seven of the studies in this analysis found that participants engaged with health professionals who did not understand the needs of LGBT communities, including feeling pathologized for their sexual orientation.

Similarly, in a phenomenological exploration of 16 lesbian, gay, bisexual, and queer (LGBQ) adults' experiences in counseling, Shelton and Delgado-Romero (2011) identified seven ways that microaggressions occurred: assuming that sexual orientation is the cause of all presenting issues, avoidance and minimizing of sexual orientation, attempts to overidentify with LGBQ clients, making stereotypical assumptions about LGBQ clients, expressions of heteronormative bias, assumption that LGBQ individuals need psychotherapeutic treatment, and warnings about the dangers of identifying as LGBQ. Participants reported that these sexual orientation microaggressions in the therapeutic environment negatively impacted the therapeutic process and reported affective reactions like frustration, discomfort, confusion, and powerlessness (Shelton & Delgado-Romero, 2011). LGBQ clients' experiences with microaggressions may also affect the ways and degree to which they actively

participate in treatment. Many participants noted that they began withholding information and felt the need to be deceptive to meet their needs. Ultimately, some participants postponed or discontinued services altogether (Shelton & Delgado-Romero, 2011). This aligns with research that outlines a number of factors that predict LGB clients' premature termination of services (Filice & Meyer, 2018). It is therefore unsurprising that LGB individuals are more likely to report unmet mental health needs relative to heterosexual persons (Dunbar et al., 2017; Filice & Meyer, 2018).

It should be noted that, although there is substantial research documenting unhelpful or even harmful mental health service experiences, Filice and Meyer's (2018) scoping review found that 70-92% of LGB individuals reported that their mental health services and providers were useful or satisfactory. Although McNamara and Wilson's (2020) systematic review identified many of the same negative experiences outlined above, they also found positive themes like therapists who demonstrated good therapy skills, such as validation, openness, compassion, and respect or office setting with visual markers of affirming providers (e.g., posters in the waiting room). These positive experiences are also reflected in Israel et al.'s (2008) analysis of 42 interviews with LGBT clients. The participants in their study noted that basic counseling skills and the therapeutic relationship were the key factors in the perceived quality of care.

To circumvent some of the aforementioned barriers to traditional care, some LGB persons may elect to use LGBTQ-specific community-based resources (as "non-traditional" methods) to meet their mental health management needs. LGBQ clients

generally want providers who understand that their sexual identity is one part of their overall identity and not pathological (Quiñones et al., 2017). In the absence of therapists and counselors demonstrating this ability, non-traditional methods may be perceived as better able to meet their needs. These non-traditional methods include the use of LGBTQ community-based organization services (e.g., support groups, community engagement) as well as a reliance on social support from family, kin and chosen. For example, LGB individuals in one study tended to associate mental health providers who hold an LGB identity with higher quality care (Martos et al., 2018). Further, LGB adults with greater psychological distress are more likely than LGB individuals with lower levels of distress to express an interest in LGBT-specific clinics and providers (Martos et al., 2019).

2.6. Mental health management among Black LGB folks

Research about traditional mental health service utilization by Black LGB persons is nascent and yields mixed findings. In one study of over 33,000 college students, Non-Hispanic Black LGB individuals in need of mental health treatment were no different in their utilization of mental health services or on-campus mental health services compared to White LGB counterparts (Dunbar et al., 2017). Results from Jeong et al. (2016) indicate that among a sample of lesbian and bisexual women, Black and White women were no different in their lifetime use of mental health treatment. However, in a community sample of LGB adults in New York City, Meyer et al. (2015) found that Black LGB participants were less likely than White LGB adults to seek mental health or medical treatment prior to a suicide attempt. Notably, these studies compare Black LGB individuals to White LGB individuals; to my

knowledge, no studies of PMHS utilization compare Black LGB individuals to heterosexual Black persons.

Given research about racial disparities in mental health treatment quality (Gómez, 2015; N. D. Williams, et al., 2023) and how poorly equipped the mental health workforce is to work with LGB populations (Graham et al., 2012; Nowaskie, 2020; Rock et al., 2010; Shi & Doud, 2017), satisfaction with services (or lack thereof) may be an important factor in understanding mental health management options for Black LGB persons. Among a sample of adults receiving inpatient or outpatient psychiatric services in New York City, Black LGBT participants were less likely to be satisfied with their care than Black cisgender, heterosexual participants (Avery et al., 2001). Further, Moore et al.'s (2020) qualitative investigation of mental health service engagement among Black and Hispanic LGB young adults provides insights into the treatment-seeking behaviors of this population. Themes included 1) reluctance to engage with services, or prematurely terminating services, due to personal factors (e.g., belief that treatment would not help, handling problems on their own, shame about symptoms and LGB identity); 2) the impact of the social environment (e.g., reliance on LGB peers to find affirming services/providers, family members discouraging the use of traditional mental health services); 3) accessibility factors (e.g., lack of knowledge about how to navigate the health care system, trouble affording care); and 4) provider characteristics (e.g. continued engagement when providers are "nonjudgmental" and knowledgeable about the LGBT community, withholding information from providers who do not share their racial/ethnic or LGBT identity). Many of these factors appeared in N. D. Williams et al.'s (2023) analysis of

an online sample of 476 LGB adults. Regression analysis indicated that Black LGB individuals were more likely to postpone or avoid mental health care compared to their White LGB counterparts. Further, when asked why, Black LGB persons were more likely to state that they believed they should work their problems out on their own or with family/friends and reported that a provider had refused to treat them.

These factors may underlie a preference for "non-traditional" services among Black LGB persons. These include community-based resources and faith-based resources. In a study of utilization of LGBT-specific clinics and providers (not necessarily for mental health but in general), Martos et al. (2019) found that Black LGB individuals had nearly three times the odds of White LGB persons in expressing an interest in future utilization of LGBT healthcare; however, their past 5-year use of LGBT-specific clinics did not differ from White participants. This disconnect between higher interest and similar utilization levels suggests that Black LGB individuals may continue to experience barriers in accessing care (Martos et al., 2019). Research also indicates that Black LGB adults are more likely than White LGB adults to seek mental health treatment from religious or spiritual advisors (Meyer, et al., 2015).

2.7. Conceptual Frameworks

The methods in this dissertation are guided by minority stress theory and principles of intersectionality. Minority stress theory posits that members of marginalized identity groups are subject to identity-based stigma in addition to general life stressors. These stigma experiences interact with characteristics of the individual's minority identity as well as their coping and social supports to influence

mental health outcomes (Meyer, 2003). Intersectionality is a natural extension of these processes; individuals hold multiple (stigmatized and marginalized) identities which locate them at the nexus of multiple forms of stigma related to these identities and their overlap (e.g., sexism, racism, gendered racism; Crenshaw, 1991; Lewis, et al., 2016). Further, these experiences of stigma are mutually constituted, not additive. That is, although one or more identities may hold primacy or be more salient, intersectional identities reinforce each other; they cannot be parsed into distinct parts (Collins, 2014). Intersecting systems of oppression (i.e., racism, [hetero]sexism) shape how sexual, gender, and racial/ethnic identities are expressed and experienced (Crenshaw, 1991). Thus, it is theorized that Black LGB people – above and beyond everyday racism and heterosexism – experience racism in LGBTQ communities, heterosexism within their racial/ethnic community, and "varying forms of oppression that interact in different contexts" (Ghabrial, 2017 p. 42).

There is clear and consistent evidence for these systems of oppression conferring differential risk for mental health issues; less is known about how mental health management may be impacted, especially for Black LGB individuals. Certainly, coping and social support – constructs explicitly included in the minority stress model at the community and individual levels – are mental health management strategies. However, given the knowledge of how racism and [hetero]sexism impact access to treatment, this dissertation explores and extends these constructs of coping and support to include the utilization of formal treatment and other mental health management strategies with a specific focus on a multiply marginalized population. Thus, minority stress and intersectionality provide the lenses through which I

examine patterns of depression and psychological distress, patterns of treatment utilization, and mental health management experiences of Black LGB young adults.

These frameworks also inform the methods chosen for each study. Studies 1 and 2 begin with analyses that arguably violate a principal tenet of intersectionality; main effects modeling, and even the use of interaction terms, have been problematized for their power limitations (most samples cannot accommodate more than a two-way interaction) and the need for a reference group (Bowleg, 2008; del Río-González et al., 2021). However, these approaches are important in nascent fields of inquiry; they highlight the need to focus on disparities and inform efforts to ameliorate them. To bring main effects models into better alignment with the principles of intersectionality, Studies 1 and 2 include follow-up within-group analyses of Black LGB persons. Although these regressions still require a reference group, the selection of said group will be based on characteristics of the population of interest (e.g. choosing a referent income level) and not a majority racial group. Second, these studies address the problem of selecting a referent group through the use of predicted probabilities, allowing for a full review of all groups rather than a comparison to any one group. In response to their critique of regression analyses, intersectionality scholars urge us also to acknowledge the value of qualitative examinations of lived experience (Bowleg, 2008). Thus, Study 3 examines Black LGBTQ+ mental health management by centering the voices of Black LGBTQ+ young adults. There is no comparison group of Black heterosexual persons or White LGB individuals. The experiences of Black LGBTQ+ persons will stand on their own.

Methods

3.1. Studies 1 and 2

3.1.1. Data Source and Population

Data for Studies 1 and 2 came from the National Survey of Drug Use and Health (NSDUH), an annual population-based surveillance survey managed by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is designed to "provide accurate data on the level and patterns of alcohol, tobacco and illegal substance use and misuse; track trends in the use of alcohol, tobacco and various types of drugs; assess the consequences of substance use and misuse; and identify those groups at high risk for substance use and misuse" among members of the U.S. civilian, noninstitutionalized population aged 12 years old or older (Substance Abuse and Mental Health Services Administration, 2021b). The NSDUH has provided national estimates on tobacco, alcohol, and drug use, mental health, and other health-related issues in the United States since 1971 and is conducted annually in all 50 states and the District of Columbia (Substance Abuse and Mental Health Services Administration, 2021a).

NSDUH data are collected using computer assisted interview methods. The target sample size for each of the years included in this analysis is 67,507 (actual sample sizes: 2016 = 67,942; 2017 = 68,032; 2018 = 67,791; 2019 = 67,625; Substance Abuse and Mental Health Data Archive, 2016, 2017, 2018, 2019). SAMHSA employs a multistage area probability design; large geographic areas are broken down into increasingly smaller areas before contacting households about survey participation (Center for Behavioral Health Statistics and Quality, 2015). The

sampling design also caps the number of responses from specific states to increase the proportion of the sample from smaller states which aids in improving state-level estimates (Substance Abuse and Mental Health Data Archive, 2019). Further, sample weights are computed for each respondent so that analyses accurately represent the target population and to account for disproportionate sampling by age group (Center for Behavioral Health Statistics and Quality, 2019). Each year of the NSDUH in this analysis used 2010 census-based population estimates in the poststratification adjustment.

Table 3.1 NSDUH state-level response caps

States	Number of survey interviews
California	4,560
Florida, New York, Texas	3,300 each
Illinois, Michigan, Ohio, & Pennsylvania	2,400 each
Georgia, New Jersey, North Carolina, & Virginia	1,500 each
Hawaii	967
Remaining 37 states & DC	960 each

A coordinated sample design is utilized such that there is a 50% overlap in the area segments (i.e. portions of census blocks) sampled between each two successive years (Substance Abuse and Mental Health Data Archive, 2019). Further, the target national sample size is broken down across five age groups: 25% for youths aged 12-17, 25% for young adults aged 18-25, 15% for adults aged 26-34, 20% for adults aged 35-49, and 15% for adults aged 50+. The survey's large sample size eliminates the need to oversample specially targeted demographics, as was required prior to 1999 (Center for Behavioral Health Statistics and Quality, 2019).

3.1.2. Analytic Sample

To bolster power to detect differences at the intersection of sex, sexual identity, and race/ethnicity, this study used pooled data from years 2016-2019 of the NSDUH. The 2019 NSDUH was the most recent publicly available data year at the time of this project's proposal. The NSDUH implemented a new study design in 2016, precluding data from 2015 and earlier from being included in pooled analyses (Substance Abuse and Mental Health Services Administration, 2019). Further, given the passage of national marriage equality in 2015 (Obergefell v. Hodges, 2015) and the known positive impact of marriage equality legislation on the mental health and wellbeing of LGB people in the U.S. (Drabble, et al., 2021; Ogolsky, et al., 2019a; Ogolsky, et al., 2019b), the pooled sample is limited to 2016-2019.

NSDUH does not administer the sexual identity question or mental health module to respondents aged 12-17. Thus, the analytic sample for Studies 1 and 2 includes respondents age 18+ who provided a valid response to questions about sexual orientation, self-reported depression diagnosis, psychological distress, and use of outpatient mental health services (N=167,771). NSDUH provides imputed variables for the covariates in these analyses; thus, data for these variables are complete. Further, missingness on outcome variables (i.e. observations excluded from analysis), and sexual identity did not exceed 3% of observations in a given survey year. Thus, analyses used complete cases and did not utilize imputation; the missingness in the dataset is negligible and is limited to variables that are not covariates.

Table 3.2. NSDUH variable missingness by survey year (n, %)

		2016	2017	2018	2019	Total
Respondents 18+ years old		42,625	42,554	43,026	42,739	170,944
Sexual identity	sexident	766 (1.80%)	752 (1.77%)	929 (2.16%)	907 (2.12%)	
Race/ethnicity	NEWRACE2	--	--	--	--	
Past-year depressive episode	amdeyr	491 (1.2%)	488 (1.1%)	549 (1.3%)	557 (1.3%)	
Past-year psychological distress (worst month)	K6SCMAX	--	--	--	--	
Past-year MH service utilization	AMHOUTP3	259 (0.6%)	258 (0.6%)	291 (0.7%)	289 (0.7%)	
Age	AGE2	--	--	--	--	
Sex	irsex	--	--	--	--	
Income	income	--	--	--	--	
Education	IREDUHIGHST2	--	--	--	--	
Relationship status	irmarit	--	--	--	--	
Insurance coverage	IRINSUR4	--	--	--	--	
Total eligible from sample		**41,441 (97.22%)**	**41,934 (98.54%)**	**42,357 (98.45%)**	**42,039 (98.36%)**	**167,771 (98.14%)**

Given the fixed sample size, post-hoc power analyses were conducted in G*Power to determine the level of power for the proposed analyses. These power analyses were based on the smallest subgroup used amongregression models (e.g. within-group analyses of Black LGB individuals; n=1,650) For logistic regressions, I have 100% power to detect even small effects (e.g. odds ratios under 2.00). For linear regressions, I have 100% power to detect small effects (e.g. Cohen's *d*=0.2).

Table 3.3. NSDUH sample sizes by year and subgroup

	2016	2017	2018	2019	Total
LGB	2,653	2,940	3,148	3,618	12,359
Black	7,318	7,047	7,198	7,256	28,819
Black * LGB	352	399	438	461	1,650

Due to sample size, analyses are likely overpowered relative to expected effect sizes. This leads to the risk of statistically significant findings that lack practical or meaningful differences. The use of postestimation comparison methods help address this issue. In addition to reporting statistical differences, these methods aid in identifying, for example, predicted K6 scores that fall above or below the clinical cutoff of 13. Together, these methods provide meaningful and practical context for findings beyond statistical significance.

3.1.3. Variables and Measures

Independent variables: sexual identity, race, and ethnicity. Sexual identity is measured in all four years of the NSDUH with the following question: *Which one of the following do you consider yourself to be?* Respondents select from the following choices: heterosexual, that is, straight; lesbian or gay; bisexual. These three categories are analyzed as-is. Race is measured in all four years of the NSDUH with the following question: *Which of these groups describes you?* Respondents are provided the following answer choices: White; Black or African American; American Indian or Alaska Native (American Indian includes North American, Central American, and South American Indians); Native Hawaiian; Guamanian or Chamorro; Samoan; Other Pacific Islander; Asian (Including: Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese); Other (specify). Ethnicity is measured by asking participants to respond with a yes or no to "*Are you of Hispanic, Latino, or Spanish origin or*

descent?" The publicly available NSDUH data files offer a recoded race variable that collapses some racial groups and combines responses to race and ethnicity questions. This seven-level variable includes Non-Hispanic White; Non-Hispanic Black or African American; Non-Hispanic Native American or Alaska Native; Non-Hispanic Native Hawaiian or Other Pacific Islander; Non-Hispanic Asian; Non-Hispanic more than one race; Hispanic. Analysis for Studies 1 and 2 are limited to non-Hispanic White and non-Hispanic Black respondents.

Dependent variables (Study 1): major depressive episode and psychological distress. For Study 1, the outcomes of interest are past-year major depressive episode and past-year psychological distress. To determine if respondents had a major depressive episode in the past year, they were first asked three introductory questions: 1) "Have you ever in your life had a period of time lasting several days or longer when most of the day you felt sad, empty or depressed?" 2) "Have you ever had a period of time lasting several days or longer when most of the day you were very discouraged about how things were going in your life?" and 3) "Have you ever had a period of time lasting several days or longer when you lost interest in most things you usually enjoy like work, hobbies, and personal relationships?" Those participants who answered no to all three questions moved to the next module. Those who answered yes to any of these three introductory questions were then asked a series of questions related to nine attributes (i.e., symptoms) of MDE based on DSM-IV diagnostic criteria. Despite the update to the DSM, NSDUH documentation ensures that this variable is comparable across data years (Substance Abuse and Mental Health Services Administration, 2019). The MDE questions included multiple items adapted

from the depression section of the National Comorbidity Survey Replication (NCS-R; Center for Behavioral Health Statistics and Quality, 2017) about each of the following symptoms: depressed mood most of the day; markedly diminished interest or pleasure in all or almost all activities most of the day; appetite and weight; insomnia or hypersomnia, psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness; diminished ability to think or concentrate or indecisiveness; and recurrent thoughts of death or recurrent suicide ideation (κ=0.52; SE=0.07; Substance Abuse and Mental Health Services Administration, 2010). For each symptom-specific group of questions, participant responses were marked as having the symptom if they answered in the affirmative to at least one item in the group. See Table 3.4 for MDE items, symptom groups, and how participant responses were scored. Respondents were classified with lifetime MDE if they were scored as having at least five of the nine symptoms. Past-year MDE is provided as a binary constructed variable in the NSDUH. Participants are assigned a value of 1 if they were classified with lifetime MDE and answered yes to the following question "In the past 12 months, did you have a period of time when you felt [affirmative symptom] for two weeks or longer while also having some of the other problems we asked about?" All other respondents were assigned a value of 2; these responses were recoded to 0 for analysis. Notably, no distinction is made for MDE caused by medical illness, bereavement, or substance use disorders, thus MDEs captured in this survey may be related to these factors.

Table 3.4. MDE items, symptom groups, and scoring

During that [worst/most recent] period of time…	
1. Depressed mood most of the day	
a. did you feel sad, empty, or depressed most of the day nearly every day?	Y/N
b. did you feel discouraged about how things were going in your life *most of the day nearly every day?*	Y/N
A respondent was assigned a positive response to this symptom if he or she answered yes to either of the above questions.	
2. Markedly diminished interest or pleasure in all or almost all activities most of the day	
a. did you lose interest in almost all things like work and hobbies and things you like to do for fun?	Y/N
b. did you lose the ability to take pleasure in having good things happen to you, like winning something or being praised or complimented?	Y/N
A respondent was assigned a positive response to this symptom if he or she answered yes to either of the above questions.	
3. Appetite and weight	
a. Did you have a much smaller appetite than usual nearly every day during that time?	Y/N
b. Did you have a much larger appetite than usual nearly every day?	Y/N
c. Did you gain weight without trying to during that period of time?	Y/N
i. because you were growing?	Y/N
ii. because you were pregnant?	Y/N
d. How many pounds did you gain?	RANGE 0-200
e. Did you lose weight without trying to?	Y/N
i. because you were sick or on a diet?	Y/N
f. How many pounds did you lose?	RANGE 0-200
A respondent was assigned a positive response to this symptom if he or she answered yes to questions 'a' or 'b' above, or the answer to either question 'd' or 'f' was greater than or equal to 10. (Note that 'd' was only asked if 'ci' and 'cii' were not 'yes,' and 'f' was only asked if 'ei' was not 'yes.')	
4. Insomnia or hypersomnia	
a. Did you have a lot more trouble than usual falling asleep, staying asleep, or waking too early nearly every night during that [worst/most recent] period of time?	Y/N
b. During that [worst/most recent] period of time, did you sleep a lot more than usual nearly every night?	Y/N
A respondent was assigned a positive response to this symptom if he or she answered yes to either of the above questions.	

5. Psychomotor agitation or retardation	
a. Did you talk or move more slowly than is normal for you nearly every day?	Y/N
i. Did anyone else notice that you were talking or moving slowly?	Y/N
b. Were you so restless or jittery nearly every day that you paced up and down or couldn't sit still?	Y/N
i. Did anyone else notice that you were restless?	Y/N
A respondent was assigned a positive response to this symptom if he or she answered yes to either of the above 'ai' or 'bi' questions. (Note that 'ai' was only asked if 'a' was 'yes' and 'bi' was only asked if 'b' was 'yes.')	
6. Fatigue or loss of energy	
a. During that [worst/most recent] period of time, did you feel tired or low in energy nearly every day, even when you had not been working very hard?	Y/N
A respondent was assigned a positive response to this symptom if he or she answered yes to the above question.	
7. Feelings of worthlessness	
a. Did you feel that you were not as good as other people nearly every day?	Y/N
i. Did you feel totally worthless nearly every day?	Y/N
A respondent was assigned a positive response to this symptom if he or she answered yes to question 'ai.' (Note that 'ai' was only asked if 'a' was 'yes.')	
8. Diminished ability to think or concentrate or indecisiveness	
a. During that [worst/most recent] period of time, did your thoughts come much more slowly than usual or seem confused nearly every day?	Y/N
b. Did you have a lot more trouble concentrating than usual nearly every day?	Y/N
c. Were you unable to make decisions about things you ordinarily have no trouble deciding about?	Y/N
A respondent was assigned a positive response to this symptom if he or she answered yes to any of the above questions.	
9. Recurrent thoughts of death or recurrent suicide ideation	
a. Did you often think about death, either your own, someone else's, or death in general?	Y/N
b. During that period, did you ever think it would be better if you were dead?	Y/N
c. Did you think about committing suicide?	Y/N
i. Did you make a suicide plan?	Y/N
ii. Did you make a suicide attempt?	Y/N
A respondent was assigned a positive response to this symptom if he or she answered yes to any of the above questions.	

Psychological distress was measured with the six-item Kessler-6 (K6; Kessler, et al., 2002), a widely used measure of general psychological distress. The K6 has been validated on racially diverse samples in the U.S. and around the world (Ferro, 2019; Prochaska et al., 2012; Stolk et al., 2014) but not explicitly on Black- or African American-identifying persons in the U.S. The K6 asks participants how frequently they experienced symptoms of psychological distress in the past 30 days. These questions include feeling nervous, hopeless, restless or fidgety, so sad or depressed that nothing could cheer you up, that everything was an effort, and down on yourself, no good, or worthless. For each of the six items listed above, responses ranged on a Likert scale from "none of the time" (0) to "all of the time" (4). Respondents were then asked if there was a month in the past year when they felt more depressed, anxious, or emotionally stressed than they felt in the past 30 days ("worst month in the past year"). If they replied yes, they were then asked to complete the K6 again, thinking of the "month in the past 12 months when [they] were the most depressed, anxious, or emotionally stressed." Items were summed to create a composite score of psychological distress ranging from 0-24 defined to be the higher K6 score between the past-month K6 total score variable, and the K6 total score in the worst month of the past year if the worst month was not the past 30 days variable.

Dependent variable (Study 2): mental health service utilization. For Study 2, the primary outcome is mental health service utilization. The NSDUH asks questions about the utilization of a variety of mental health services. Given that the mental health variables explored in Study 1 do not necessarily indicate severe mental illness

requiring a higher level of care (inpatient, residential, psychological hospitalization, etc.), Study 2 focuses on the use of outpatient mental health services in the past year. The survey question is presented to respondents as follows:

> "*The list below includes some of the places where people can get outpatient treatment or counseling for problems with their emotions, nerves, or mental health. During the past 12 months, did you receive any outpatient treatment or counseling for any problem you were having with your emotions, nerves, or mental health at any of the places listed below? Please do not include treatment for alcohol or drug use."*

The question is followed by the following response options: An outpatient mental health clinic or center; the office of a private therapist, psychologist, psychiatrist, social worker, or counselor that was not part of a clinic; a doctor's office that was not part of a clinic; an outpatient medical clinic; a partial day hospital or day treatment program; some other place. Respondents indicated yes or no.

Covariates: For Study 1, adjusted models include age, sex, income, education, relationship status, and survey year as covariates. Age, sex, income, education, and relationship status are all empirically related to depression and/or psychological distress in Black, LGB, or Black LGB populations (see literature review). Controlling for survey year reduces the impact of time, given that the analyses utilize multiple years of a cross-sectional survey. In the NSDUH, after a respondent has entered their birthdate in the first part of the questionnaire, they have multiple opportunities to change their age in response to consistency checks throughout the questionnaire. The

final age variable used in this analysis considers responses to each of these checks and compares the raw birthdate and the final interview date. Each age from 12-21 is coded individually; the remaining age categories are 22 or 23 years old; 24 or 25 years old; 26-29; 30-34; 35-49; 50-64; and 65+. Age was recoded to collapse ages 18-25 into a single category. Sex is collected with response options male or female. Participants were prompted to consider "the total family income from all sources during [the survey year] before taxed and other deductions." This data is then organized by SAMHSA into four categories: "less than $20,000," "$20,000 - $49,999," "$50,000 - $74,999," and "$75,000 or more." For those missing on income (n=1,721 in 2016; n=1,501 in 2017; n=1,544 in 2018; n=1,595 in 2019), values are imputed by the NSDUH administrators prior to public release. Participants self-report education by responding to the following question: "What is the highest grade or year of school you have completed?" Each grade from 5^{th} to 12^{th} (no diploma) is coded separately. These were collapsed into a "less than high school" group. The other education categories include high school diploma/GED; some college credit, but no degree; Associate degree; and college graduate or higher. For those missing on education (n=50 in 2016; n=35 in 2017; n=41 in 2018; n=36 in 2019), values were imputed by the NSDUH administrators prior to public release. Relationship status was similarly imputed for missing values (n=10 in 2016 and 2017; n=15 in 2018; n=13 in 2019). Response options are married, widowed, divorced or separated, and never been married. Given that the analyses for Studies 1 and 2 utilized data pooled over 4 years, adjusted models also control for survey year.

In addition to the covariates above, adjusted models in Study 2 also control for insurance coverage. This imputed binary variable marks respondents as having health insurance if they indicated that they are covered by any one of the following: private insurance; Medicare; Medicaid or CHIP; Champus, ChampVA, VA, or military; or other health insurance.

3.1.4. Analytic Approach

All analyses for Studies 1 and 2 were conducted using the Stata 16 survey data analysis command to account for the complex sampling design and apply the NSDUH sampling weights for U.S. representativeness.

First, a series of bivariate tests were conducted to assess sex differences for all three dependent variables to determine whether sex-stratified models should be fit. Based on these tests, previous analyses, and research on sex-based differences in depression and psychological distress (Bostwick et al., 2010; Fish & N. D. Williams, 2019; Greer et al., 2009; Kerridge et al., 2017), as well as mental health service utilization (Alang, 2019), all analyses warranted sex stratification. For both studies, unadjusted and adjusted models were used to draw conclusions and generate future hypotheses about how covariates impact the associations of interest.

Study 1. To address RQ1, descriptive statistics were used to examine the distribution of major depressive episodes and psychological distress as well as the distribution of each covariate in the analytic sample. Next, sex-stratified Rao-Scott chi-square tests (Scott, 2007) were used to estimate sexual orientation and racial/ethnic differences in MDE and ANOVAs were used to identify differences in psychological distress. Then four adjusted, sex-stratified regression models were fit to

estimate 1) odds of past-year MDE by sexual orientation, race/ethnicity, and the interactions therein using logistic regression and 2) associations with past-year psychological distress by sexual orientation, race/ethnicity, and the interactions therein using linear regression. Post-estimation methods were then used to calculate predicted probabilities and 95% confidence intervals of past-year MDE and average predicted K6 scores across groups defined by sexual identity, race/ethnicity, and groups defined by the interaction between these two identities.

To address RQ2, using the adjusted predicted probabilities and average predicted K6 scores computed for RQ1, postestimation pairwise comparisons identified statistical differences in the prevalence of MDE and prevalence of severe psychological distress for Black LGB people compared to White LGB people. These pairwise comparisons employed Šidák's adjustment to correct for family-wise comparison error. This adjustment is more conservative with large numbers of comparisons than the Bonferroni adjustment.

To address RQ3, descriptive statistics were calculated to examine the distribution of MDE and psychological distress, as well as the distribution of each covariate in the analytic subsample of Black LGB persons. Then Rao-Scott chi-square tests and ANOVA were used to examine differences in MDE and psychological distress, respectively, by sex, income, and education. Then four adjusted, sex-stratified models were fit to estimate 1) odds of past-year MDE by sex, income, and education using logistic regression and 2) associations with past-year psychological distress by sex, income, and education using linear regression. Post-estimation methods were then used to calculate predicted probabilities and 95% confidence

intervals of past-year major depressive episode and average predicted K6 scores across groups of Black LGB persons defined by sex, income, and education. Finally, postestimation pairwise comparisons were used to identify differences in MDE and psychological distress across groups of Black LGB persons. These pairwise comparisons employed Šidák's adjustment to correct for family-wise comparison error.

Study 2. To address RQ1, descriptive statistics examined the distribution of service utilization and each covariate. Then sex-stratified Rao-Scott chi-square tests were used to estimate sexual orientation and racial/ethnic differences in utilization of outpatient mental health services. Next, sex-stratified adjusted logistic regression models were fit to compare service utilization by sexual orientation, race/ethnicity, and the interaction therein. Post-estimation methods were then used to calculate the predicted probability of service utilization across groups defined by sexual identity, race/ethnicity, and groups characterized by the interaction between these two identities. Pairwise comparisons of these predicted probabilities were used to determine differences in service utilization. These pairwise comparisons employed Šidák's adjustment to correct for family-wise comparison error.

To address RQ2, first descriptive statistics were calculated to examine the distribution of service utilization as well as the distribution of each covariate in the subsample of Black LGB persons. Rao-Scott chi-square tests were used to estimate age, sex, income, education, and insurance coverage differences in service utilization among Black LGB respondents. Then adjusted logistic regression models were used to compare service utilization by age, sex, income, insurance coverage, and

education. Post-estimation methods were used to calculate the predicted probability of service utilization across groups of Black LGB persons defined by age, sex, income, insurance coverage, and education. Pairwise comparisons of these predicted probabilities were used to determine within-group differences in service utilization. These pairwise comparisons employed Šidák's adjustment to correct for family-wise comparison error.

3.2. Study 3

To examine the mental health management strategies of Black LGB young adults, Study 3 initially consisted of a grounded theory study, the result of which was to be a substantive theory of mental health management among Black LGB young adults. Changes to recruitment methods, as well as the content of the data themselves, resulted in a template analysis instead of a grounded theory approach. Still, the study employs a contextual constructionist epistemological stance, one which can appropriately be taken with template analysis (Madill, 2000). In qualitative inquiry, I do not believe that the researcher can be separated from that which is researched. Thus, rather than objectivist approaches that "render the researcher somewhat invisible" (Daly, 2007, p. 107), this study involved the co-construction of data between the study participants and myself. This means, relative to objectivist grounded theory approaches, I placed a greater emphasis on "theoretical sensitivity to prior experiences, concepts, ideas, and theories" (Daly, 2007, p. 107). I come to this work with clinical experience in working with the population of interest, familiarity with research literature and extant theories, and personal lived experience with the constructs of interest. It is impossible for me to compartmentalize these factors and

pretend that they did not inform the data collection and analysis processes. Rather, these sensitizing concepts served as the impetus for the inquiry in the first place and suggested "directions along which to look" during the data collection process (Blumer, 1986, p. 148). In fact, it could be argued that these sensitizing concepts informed the assumptions that ultimately warranted the shift in approach away from grounded theory – I made assumptions about discrimination experiences based on extant theory that were not borne out in the interviews.

3.2.1. Sample and Recruitment

In-depth interviews (n=24) were conducted to explore the meaning Black LGBTQ+ young adults ascribe to experiences of intersectional minority stress, how those experiences are perceived to impact their mental health, and how they manage their mental health. To attend to the differences in lived experience, including a different/additional axis of oppression, this study was originally limited to cisgender LGB young adults. However, difficulties in recruitment and feedback regarding the prevalence of gender diverse identities among the youth receiving services from community partners who aided in recruitment, led to a change in eligibility criteria. Thus, everyone who was interviewed held a sexual minority identity (i.e. lesbian, gay, bisexual, queer, or pansexual) but nine participants also identified as transgender, nonbinary, and/or genderqueer. During interviews, participants were reminded that the study was focused on sexual minority identities but that their gender diversity was not being intentionally ignored. Additionally, as the interviewer I acknowledged that their experiences as non-cisgender people are likely an important part of their story

and that they did not need to omit these experiences when responding to interview questions.

To explicate possible geographic differences in experiences, participants were initially set to be recruited from the Chicago-Naperville-Elgin metropolitan statistical area (MSA) and the Washington-Arlington-Alexandria MSA. The Office of Management and Budget creates MSA designations by grouping one or more adjacent counties that have at least one urban core of at least 50,000 people with adjacent jurisdictions that have a high degree of social and economic ties as measured by commuting patterns (U.S. Census Bureau, 2020). These were chosen instead of combined statistical areas (CSA) because 1) MSAs evidence a higher degree of social and economic connection than CSAs and 2) MSAs are used in the National Center for Health Statistics Urban-Rural Classification Scheme for Counties (National Center for Health Statistics, 2019) which will allow for consistency in subsequent analyses. These two locations were selected because of my personal familiarity with each of them, my community relationships to support recruitment, their different histories of Black-White residential segregation, and anecdotal knowledge about how LGBTQ community resources are geographically distributed given the current racial segregation in each locale. Again, due to recruitment difficulties, this geographic parameter was dropped and the eligibility criterion was changed to those who live in a major metropolitan city in the U.S. based on the rural-urban commuting area (RUCA) code assigned to their zip code. The requirement that participants reside in a metropolitan area was important for ensuring a reasonable level of homogeneity of experience given the relatively small sample; LGBTQ+ people and Black people have

different experiences of bias and discrimination, as well as access to mental health services, in rural contexts than their urban counterparts (Barefoot et al., 2015; Jenkins et al., 2022; Ji & Cochran, 2022). Additionally, traditional mental health services are generally more accessible in urban areas as compared to rural contexts. Everyone included in the study listed a zip code that corresponded with a RUCA code of one, indicating residence in a metropolitan area (United States Department of Agriculture, 2019).

Originally, the sample was to be recruited using both purposive and theoretical sampling (Morse, 2007); purposive sampling was intended to guide decisions about with whom to speak and theoretical sampling was going to guide where to go to fill gaps in information (Daly, 2007). Recruitment difficulties and the timeline restrictions of a dissertation project made both sampling procedures infeasible. Purposive quota sampling was intended to include two a priori categories: utilization of traditional outpatient mental health services since age 16 and gender. In Illinois, Maryland, Washington DC, and Virginia, there are legal statutes that vary in language but that all allow minors to seek some kind of mental health services without parental consent for a time (District of Columbia, n.d.; Illinois Foundation for Quality Health Care, n.d.; Maryland General Assembly, 2021; State of Virginia, n.d.). Thus, age 16 allows for some increased independence in access to care (e.g. ability to drive oneself to therapy) and provides a temporal buffer for interview participants on the younger end of the eligibility age range. The goal was to interview young adults to better understand the minority stress experiences and mental health management strategies of Black LGB young adults. Given the possibility that mental health

management involves seeking supports outside of traditional mental health services, it was also important to interview participants who have not engaged with traditional mental health services to understand how they have chosen to manage their mental health instead. Due to difficulties with recruitment, purposive sampling was not as prominent as intended; only 25% of participants had never been to therapy since the age of 16. For those who sought traditional mental health services, it was important to understand how they decided to utilize these services and their search criteria, among other factors. Additionally, given differences in gender-based norms in disclosure of mental health issues and help-seeking behavior, it was important for the interview sample to include men and women. If recruitment had not been so difficult, I would have liked to engage in theoretical sampling that targeted recruitment to young adults who could have provided additional or different data pertaining to emerging themes in the data or bolstered representation of certain sexual identities or other dimensions of lived experience.

Table 3.5. Proposed interview recruitment demographics

	Traditional services	No traditional services	
Chicago MSA	3 men	3 men	6 men from Chicago
	3 women	3 women	6 women from Chicago
Washington, DC MSA	3 men	3 men	6 men from DMV
	3 women	3 women	6 women from DMV
Total	12 therapy	12 no therapy	24 total participants

I interviewed 24 self-identified Black LGB young adults (age 18-26) for 2-hour interviews. This age group was specified for a few reasons. First, there is evidence of this time being developmentally significant for the onset of mental disorders, including depression (Beronio et al., 2014). Additionally, this is a critical period for identity development where young Black LGB persons are making sense of

their racial and sexual identities, as well as the intersectional complexities therein (Bishop et al., 2020; Martos et al., 2015; Umaña-Taylor et al., 2014). Relative to younger persons, young adults in this age range also have more autonomy and independent control over whether to engage in services. Parents of minor children may prohibit youth involvement in mental health treatment, or mandate that their child(ren) utilize unwanted services. Further, young adults between 18-26 may be less likely to contend with being uninsured, given the ACA's protection for adults up to 26 staying on their parents' insurance (Kozloff & Sommers, 2017). This impacts the accessibility of traditional mental health services (Ali et al., 2016). Finally, this cohort (born approximately between 1995 and 2003) has come of age in a distinct sociopolitical environment. They were in their adolescence and early adulthood during the debate about and eventual passage of national marriage equality in 2015, while LGBT representation in popular media was expanding, and during a resurgence of calls for Black liberation with the birth of the Black Lives Matter movement in 2013.

Participants were recruited through announcements and flyers disseminated at LGBTQ community centers and events in Washington, DC and Chicago, as well as online (Facebook, Twitter, Instagram, Tumblr, Craigslist). Given the economic/resource differences among college samples relative to the general population (U.S. Department of Education, 2017), college campuses were regarded as a final recruitment option. Towards the end of recruitment, word-of-mouth from members of the listserv for Division 44 of the American Psychological Association resulted in a groundswell of participants. This included Division 44 members sharing

recruitment materials with their university colleagues and campus-based LGBTQ+ student groups/organizations. Thus, the sample in this study is more likely to hold a college or graduate degree than the general population in the U.S. Additionally, to bolster recruitment efforts, I began to offer referral incentives to participants; for every completed interview with a person who listed them as the reason they heard about the study, participants could receive an additional $10, up to $50 total.

Table 3.6. Interviewee Demographic Characteristics (n=24)

	n	%
Sexual Identity		
Bisexual	7	29%
Gay	4	17%
Lesbian	3	13%
Pansexual	5	21%
Queer	5	21%
Gender		
Man	5	21%
Nonbinary/Genderqueer	5	21%
Woman	14	58%
Sexual Behavior		
Never had sex	6	25%
Only men	7	29%
Mostly men, some women	4	17%
Equally men and women	3	13%
Mostly women, some men	2	8%
Only women	2	8%
Sexual Attraction		
Only attracted to men	4	17%
Mostly attracted to men	2	8%
Equally attracted to men and women	11	46%
Mostly attracted to women	6	25%
Only attracted to women	1	4%
Education		
High school diploma/GED	2	8%
Some college	6	25%
College degree (Associate's or Bachelor's)	12	50%
Master's degree	3	13%
Professional or doctorate degree	1	4%

Relationship Status		
Single	12	50%
In a committed relationship	10	42%
Married	2	8%
Income		
Less than $20,000	4	17%
$20,000 - $49,999	7	29%
$50,000 - $74,999	5	21%
$75,000 - $99,999	5	21%
$100,000 or more	3	13%
Health Insurance		
Yes	23	96%
No	1	4%
Coverage Gap (Past-Year)		
Yes	2	8%
No	21	88%
Not sure	1	4%
Mental Health Coverage		
Yes	15	63%
No	1	4%
Not sure	8	33%
Mental Health Service Use		
Yes	18	75%
No	6	25%
Severe Psychological Distress		
Yes	5	21%
No	19	79%
	Mean	SD
Age	22.6 years	2.57 years
Feminine Gender Expression (0-100)	61.1	23.4
Masculine Gender Expression (0-100)	42.8	26.1
Psychological Distress (K6)	8.8	4.4

3.2.2. Procedures

Recruitment began in April 2022 and closed in March 2023. All recruitment materials included a link to a screener form. Those who did not meet all of the basic eligibility requirements were thanked for their interest and the survey ended. Due to

recruitment difficulties, some criteria were revised in July 2022 (e.g., allowing gender diverse participants). The screener made it clear that not everyone who was eligible would be selected for interviews. The screener form that all interested persons completed included the following constructs to determine eligibility and inform selection for inclusion (originally with purposive sampling in mind).

Table 3.7. Screener Constructs

Construct	Question	Answer Choices	Eligible if
Age	What is your age?	Drop down menu 18-30+	Response is 18-26
Race/ethnicity	*Which of the following best describes your race/ethnicity? (Choose one)*	• Asian • Black or African American • Hispanic or Latino/a/x • Native American or Alaska Native • Native Hawaiian or Other Pacific Islander • White • My race/ethnicity is not listed (please specify)	Black or African American is selected
Gender	*Which of the following best describes your gender? (Choose one)*	• Woman • Man • Nonbinary • My gender is not listed here (please specify)	Original: Woman or man is selected Revised: any gender accepted
Gender identity	*Do you identify as transgender, nonbinary, or gender nonconforming?*	• No • Yes (please specify)	Original: No is selected Revised: either answer accepted
Sexual identity	*Which of the following best describes your sexual identity?*	• Lesbian • Gay • Bisexual • My sexual identity is not listed here (please specify)	Original: Lesbian, gay, or bisexual selected

			Revised: any non-heterosexual identity accepted
Attention/validity check	*Attention check: what is your favorite color?*	Open-ended text box	n/a
Mental health service utilization	*In the time since your 16th birthday, have you gotten professional help for your mental health? This may include a therapist, counselor, pastor, or medical doctor*	• No • Yes	*Not used to determine eligibility; used for purposive sampling*
	If yes: *How often and for how long did you consistently receive professional help? For example, maybe you went to therapy every other week for 6 months.*	Open-ended text box	*Not used to determine eligibility; used for purposive sampling*
Zip code	*What is the zip code of the place you sleep most often?*	Open-ended text box	Original: Zip code falls within Washington DC or Chicago MSA Revised: Zip code corresponds to an area in the U.S. with a RUCA score of 1 (major metro)
Technological access	*Which of the following do you have access to? (Choose all that apply)*	• quiet place to talk alone for up to 90 minutes • laptop computer with reliable internet connection	Quiet place to talk + one of the other options selected

		• desktop computer with reliable internet connection	
Attention/validity check	*The responses I have given on this survey are true and accurate*	• No • Yes	Must answer yes
Contact information	*Please enter your email and/or phone number below. This information will be used for scheduling and compensation purposes, as well as contact for follow-up*	Open-ended text boxes	*Not used to determine eligibility*
Referrals	*How did you hear about this study? If a previous participant referred you, please include their name.*	Open-ended text box	*Not used to determine eligibility*

By the end of the study, 141 people had completed the screener. Early in recruitment, it became apparent that many of those who completed the screener had misrepresented themselves, likely in an effort to receive the participant payment, or were bots. Thus, attention check items were added to the screener and the demographic survey (described below) to weed out bots and to allow me to compare responses to the same item at two points in time as a validity check. This effort to reduce the number of illegitimate screener responses was successful.

Those who were selected for interviews were emailed the link to an online consent form. If they consented to the study (including being recorded), the screen advanced to a demographic form which collected the following information:

Table 3.8: Demographic Information

Construct	Question	Answer Choices
Gender expression	*Using the sliders below, how would you describe your gender expression? Gender expression is the way you carry yourself, the way you dress, etc.*	First slider with low feminine on the left, high feminine on the right Second slider with low masculine on the left, high masculine on the right
Pronouns	*Which pronouns do you use?*	• She/her/hers • He/him/his • They/them/theirs • Ze/zir/zirs • My pronouns are not listed here (please specify)
Sexual behavior	*Which of the following best describes the gender of the sexual partners you've had over the course of your life?*	• only men • only women • both men and women • never had sex
Sexual attraction	*Which of the following best describes your sexual attraction to other people?*	• only attracted to women • mostly attracted to women • equally attracted to women and men • mostly attracted to men • only attracted to men
Education	*What is the highest level of school that you have completed?*	• middle school • high school diploma/GED • some college • college degree (associate's or bachelor's) • master's degree • professional or doctorate degree
Relationship status	*Which of the following best describes your relationship status?*	• Single • in a committed relationship • married • divorced • widowed
Income	*Which of the following best reflects the total income of your household? (If you live with parents/guardians, please include their income. If you live on your own or*	• less than $20,000 • $20,000 - $49,999 • $50,000 - $74,999 • $75,000 - $99,999 • $100,000 or more

	with roommates, please only include your income)	
National origin	*Which country were you born in?*	Open-ended text box
Insurance coverage	*Have you been without health insurance for any part of the past year?*	• Yes • No
	Do you currently have health insurance?	• Yes • No
	Does your current health insurance provide any coverage for mental health services?	• Yes • No • Not sure
30-day psychological distress (Kessler-6)	*During the past 30 days, about how often did you feel…1) nervous 2) hopeless 3) restless or fidgety 4) so depressed that nothing could cheer you us 5) everything was an effort 6) worthless?*	• all of the time • most of the time • some of the time • a little of the time • none of the time

Interviews took place via Zoom and lasted approximately 2 hours. Originally, I proposed a three-part structure where I would meet with participants for a 30-minute rapport building session, a 90-minute interview, then the 30-minute member check. I learned after the first three interviews that people preferred to combine the first two steps into a 2-hour session and used this structure for the remaining interviews. Interviews were recorded using Zoom's in-app recording feature and transcribed using Rev.com.

Once all interviews were completed and analyzed, I created an infographic-style summary of findings, sent it to all participants via email, and encouraged them to schedule a 30-minute virtual member check meeting with me to discuss the findings. These meetings were not recorded or transcribed. Twenty of 24 participants (83%) engaged in the member check process. They were asked the following questions:

- After reading through the findings, what are your general thoughts?
- How accurately do you feel the findings captured your thoughts and experiences?
- What could be added to the findings to capture your experiences better?
- If there is anything you'd like removed, what would that be and why?

Responses to these questions informed revisions to the infographic summary before it was finalized and made available online.

All participants were compensated up to $50 for their participation – $40 for the interview and $10 for the member check process – with some receiving additional compensation for referring others into the study. All compensation was given as electronic gift cards of the participants' choosing.

3.2.3. Measures and Constructs

Interview protocols were semi-structured; I approached each interview with a set of questions and associated probes but remained flexible in my potential lines of inquiry to probe about experiences that may improve understanding of mental health management among Black LGB young adults. Despite the fact that this study eventually departed from a grounded theory approach, consistent with grounded theory methods (Charmaz, 2006; Strauss & Corbin, 1990), revisions to the protocol were made after some interviews depending on the content and process of the interview, and in response to emerging themes, hypotheses, or related questions that should be incorporated. The research questions necessitated interview questions that were both objectivist and constructivist in nature; they got at both chronology, events,

and behaviors as well as meanings and definitions of terms and events. The final version of the interview protocol is included as Appendix A.

3.2.4. Analytic Approach

Consistent with ground theory, data analysis and data collection occurred simultaneously and iteratively (Charmaz, 2006). I engaged in memoing – the process of writing informal analytic notes about everything from data, codes, and the research process itself – to facilitate a deeper familiarity and understanding of data throughout the data collection phase of the study. Starting with interview protocol development, I memoed about my thought processes, observations, and potential revisions to the tool. This resulted in multiple versions of the interview protocol throughout the data collection process. An example of how one question was revised along the way is provided below.

Table 3.9. Example Interview Protocol Revision History

Version	Date	Revision	Rationale
#1	10/18/2021	Original: Every person holds multiple identities. For example, I'm a cisgender, queer, Black woman. I'm also a student and a researcher, a daughter, a sister, etc. Which of your identities are most important to you?	--
#2	11/15/2021	Revision: We all have different aspects of who we are. For example, I'm a cisgender, queer, Black woman. I'm also a student and a researcher, a daughter, a sister, etc. Which aspects of you are most important to you?	Put the question in more "lay language" – asking about identities may lead some participants to ask me to rephrase the question.
#4	2/26/2023	Revision: We all have different aspects of who we are. Which	Because my social location was being

		aspects of you are most important to you?	covered in the introduction section, discussing it here was redundant. More importantly, I noticed that discussing my identities here might have been priming people to mention the same aspects of themselves, often in the same order.

Memoing and revising interview questions as needed also ensured that I was asking questions that supported the theory's development and resonated with the people whose experiences I sought to capture and understand. Throughout data collection, I documented initial theoretical connections, hypotheses, and ideas about the three topics of interest, and possible connections between them (See Appendix B).

As I approached the end of the interviews, I realized that I made a couple of theoretical assumptions in the framing of the project, development of the research questions, and the structure of the interview guide. Namely, I assumed that Black LGBTQ+ young people experienced intersectional bias and discrimination as we understand it theoretically. This was not the case for most of the people I spoke with; they easily identified instances of racism, homophobia, heteronormativity, etc. but struggled to identify times where they experienced bias or discrimination based on their positionality of being Black and queer. This led me to reconsider my analytic approach, moving away from grounded theory towards template analysis.

Template analysis is a type of thematic analysis for qualitative data that balances an etic approach (i.e., the application of a priori, theoretical understandings

of the data) with inductive processes. The key component of this approach is the development of a coding template that is then applied in the process of coding the data, while leaving room for the inclusion of inductive codes that are derived from the data during the coding process (J. Brooks, 2015; King, 2012). It differs from other analytic approaches in its use of a flexible coding structure (i.e., it does not prescribe a coding process like the open, axial, and selective coding process that characterizes grounded theory), the use of a priori themes, and the use of an initial coding template (King, 2012).

Brooks (2015) outlines the steps typically taken in template analysis. The researcher(s) will:

1) Become familiar with the data to be analyzed;
2) Carry out preliminary coding, typically using an inductive or deductive approach;
3) Organize the themes based on how they relate to each other, including hierarchical relationships, with narrower themes nested within broader ones;
4) Define the initial coding template;
5) Apply the template to the data and modify it as needed; then
6) Finalize the template and ensure that the final coding template has been applied to all data.

Often, the initial coding template is developed based on a subset of the data (Brooks, 2015; King, 2012). For example, a researcher might review a handful of interviews, develop the template based on the data therein, then apply that coding template to the remaining interviews. Because I conducted all of the interviews myself and created

analytic memos throughout the data collection process, which ostensibly served as an outline for the template, I did not utilize the typical approach of creating a coding template based on a sample of interviews for steps 1-4 above. Rather, I relied on my memos and familiarity with the data to create an initial coding template. I then engaged in "an iterative process of applying, modifying, and re-applying the initial template to all interviews" (King, 2012, p. 430). Thus, although the template guided the coding process, the final coding structure was more expansive and detailed than the initial template. Additionally, the interview guide that I created asked about constructs beyond the specific research questions for this project. Thus, the coding template (Appendix C) and final coding structure (Appendix D) include codes that may not be directly related to the research questions, but reflect important aspects of participants' experiences and were important for the development of the member check infographic (discussed below). Data management and coding processes were conducted in Dedoose.

To be mindful of data quality, I engaged participants in 30-minute member check interviews (Lincoln & Guba, 1985; Morse et al., 2002). After completing the template analysis process, I developed an infographic summary of findings for participants to review ahead of the member check meetings. This document included background information about the study, demographic information about the participants, the key themes from the data – many of which extended beyond the research questions – as well as the nuanced similarities and contradictions within those themes. Through this process, I invited each participant to contribute to the authorship of the narrative that is intended to represent their experiences as part of the

collective. I took notes about each participant's responses to the reflection questions and revised the infographic, where feasible, to reflect their feedback. The feedback was unanimously positive; interviewees stated that the infographic accurately represented their experience overall, even if some details didn't completely comport with their lived experience. Some participants' suggested revisions were too specific to their individual experience and were not appropriate for a document that represents aggregate findings. However, there were places where additional detail (e.g., the educational backgrounds of participants; a legend for interpreting graphics) was added. At the end of the member check meetings, I asked participants if they were interested in being connected to other interviewees. This decision was driven by how frequently participants described a lack of community with other Black queer people. I amended my IRB application and, with interviewee permission, sent an email inviting participants to engage with each other beyond the confines of the study. In this way, Study 3 served as both a data collection process and an unanticipated community-building intervention.

3.2.5. Positionality Statement

I come to this work as a 30-something, cisgender Black queer woman. I embraced my queer identity later in life and have not disclosed this identity to most people in my life. I have also been managing my own symptoms of anxiety and depression for over a decade. I am a licensed mental health professional (no longer in practice) whose clinical specialty was working with queer people of color and their families. My experience with carving out this niche has shaded my understanding of the important of LGBTQ-serving centers and the difficulties queer folks face in

finding affirming human services spaces. I hold strong convictions about the importance of accessible mental health care services and believe strongly that mental health professionals must be competent in working with queer clients. This is based on research about the positive impact of affirming, competent care as well as personal experiences with multiple therapists who were not equipped to understand or attend to my queerness, Blackness, and/or the intersection of those identities.

It is also incredibly important to me that research participants not be exploited in the process of research. This has directly informed the design of my qualitative study, including compensating participants for their time at an hourly rate that reflects a living wage ($50 for 2.5 hours of total time equates to $20/hour), starting the interview with un-recorded rapport building time to get to know participants before starting data collection in earnest, and building in member checks. I conducted interviews in the medium and location of the participants' choosing; this is another way of attempting to shift the power dynamics, even slightly, to make participants comfortable. Another aspect of the study that I hope helped prevent feelings of exploitation among participants was the choice to connect participants to each other once the interviews were complete. Not only were participants compensated for their time, but they were given an opportunity to build community with others who share racial and sexual identities with them.

During qualitative data collection, I relied on many of the skills used in therapy to build rapport. These include mimesis, active listening, reflecting, maintaining a curious stance, and comfort in taking a one-down position. The one-down position is important to me in these interactions because of the privilege and

power that has been ascribed to my multiple identities. I am a light-skinned, biracial Black woman who benefits from colorism in the Black community. I have also been raised in predominantly White places and spaces, which has led to Black folks – particularly Black women – challenging my Blackness because I "talk White" or "dress White." I anticipated that this questioning of my Blackness would come up in the course of conducting interviews with this study's sample of Black participants. To my relief, none of the Study 3 participants questioned or challenged – implicitly or explicitly – my "right to Blackness." In fact, discussions about colorism, when they happened, were quite validating for me. I found myself feeling a sense of connection and belongingness during these discussions. Although these interviews were conducted for the explicit purpose of gathering data for a dissertation project, I realized after the first few interviews that the process of engaging in vulnerable, open conversation with other queer Black people left me with a sense of comfort and assuredness in my own identities.

I also occupy other identities that may have influenced the way that I was perceived by participants. I can pass as heterosexual (i.e., I don't "look" queer [on most days], I'm partnered with a cisgender man), and there is power associated not just with being "well-educated" but with being embedded in academia with the political power and institutional "prestige" that that confers. These power and privilege dynamics influence how I see myself, how I am perceived, and the information that my presence/questions elicit.

Epistemologically, my stance falls in the area between objectivism and subjectivism. I think that meaning is the core of human existence in that it organizes

our perceptions of the world, how we measure things, and how we know what we know. Further, I don't think there is such a thing as Truth, and there is no way to completely separate "the knower from the known." That said, my epistemological and ontological perspective varies by research question. For example, documenting population-level disparities/inequities in a mental health outcome (like I did in Studies 1 and 2) makes different assumptions than a project interested in documenting the lived experiences of people as they manage their mental health (Study 3). Both of these continue to be of interest to me and will ultimately help inform efforts to improve the mental health of my population of interest (read: a community of which I am a part). For this project, my interest in the mental health management experiences of Black LGB young adults illustrates a more subjectivist approach given that I am gathering the subjective experiences of individuals, but also that in the analysis and interpretation of these data, I use my own understanding as a tool in developing the stories I will ultimately tell.

Study 1 -- Accounting for Sexual Identity in an Exploration of the Black-White Depression Double Paradox

4.1. Introduction

According to the 2019 National Survey for Drug Use and Health (NSDUH), 1.8 million Black or African American adults reported a major depressive episode (MDE) in the past 12 months (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020a). The 2019 NSDUH also found that 3.4 million LGB adults reported a past-year MDE (SAMHSA, 2020b). There are separate bodies of literature about mental health disparities affecting Black U.S. adults and LGB adults, but little is known about how race/ethnicity and sexual identity together might confer disproportional mental health risk. Understanding the confluence of risk for poor mental health outcomes allows for evidence-informed, targeted intervention in policy and practice.

4.1.1. The Black-White Depression Double Paradox

A substantial literature has documented the deleterious effects of race-based bias, stigma, and discrimination that Black people in the U.S. endure (Banks et al., 2006; Chae et al., 2011; Pittman, 2011; D. R. Williams & Williams-Morris, 2000). Although these experiences should logically confer disproportionate risk for mood disorders, the empirical findings are inconsistent resulting in the "Black-White depression double paradox" (Barnes & Bates, 2017). The first paradox states that because of elevated experiences of race-based bias and discrimination, and their deleterious effects on mental health, rates of mood disorders should be higher among

Black populations than their White counterparts. However, analyses of multiple population-based data sources consistently find rates of depression in Black adults that are equivalent to (Villarroel, 2020) or lower than (Center for Behavioral Health Statistics and Quality, 2019) White individuals. In a systematic review of the literature on the double paradox, Barnes and Bates (2017) found that Black individuals had a significantly lower prevalence of depression than their White counterparts in six of the nine comparisons they conducted.

The second paradox involves measures of general or non-specific psychological distress. Because measures of general psychological distress like the Kessler-6 (K6) are based on, and strongly correlated with, the diagnostic criteria for mood disorders (Andrews & Slade, 2001), patterns of psychological distress should mirror those of mood disorders. In their review of research on the double paradox, Barnes and Bates (2017) found that in 31 of 34 comparisons, a higher proportion of Black persons scored over the clinical cutoff than White individuals; in 15 of those 31 comparisons, this difference was statistically significant. Thus, where we would expect patterns of Black-White disparities in depression and severe psychological distress (SPD) to be similar, this is not consistently the case.

Barnes and Bates (2017) offer an artifactual explanation for the double paradox; the diagnostic criteria for MDE may lead to misclassification based on race. Given that many of the MDE criteria rely on psychological symptoms, and Black individuals may experience depression symptoms more somatically, diagnostic criteria may underestimate depression in Black individuals.

4.1.2. Mental Health Among Black LGB Persons

Because LGB individuals face similar identity-based bias, stigma, and discrimination, we would expect LGB individuals to experience worse mental health outcomes, and indeed they do; the deleterious effects of these experiences on the mental health of LGB people are well documented (Cochran et al., 2017; Kerridge et al., 2017; Plöderl & Tremblay, 2015; Rodriguez-Seijas et al., 2019). These findings reflect the major proposition of minority stress theory: that LGB individuals are subject to bias and stigma based on their identity and that these stressful experiences compromise their health (V. Brooks, 1981; Meyer, 2003).

There is limited disparities research on the mental health of LGB people of color (POC), and even less on Black LGB persons. Thus, this section summarizes the state of the science, drawing attention to research specifically about Black LGB adults when applicable. Generally, LGB POC experience simultaneous race- and sexuality-based bias and discrimination (Balsam et al., 2015) in addition to unique forms of oppression like racism within LGBT communities (Balsam et al., 2011; Chae et al., 2010; Han, 2007; J. Ward, 2008). Importantly, research on the discrimination experiences of LGB POC has typically focused on individual axes of oppression (i.e., racism in queer spaces or homophobia in non-White spaces); still, LGB POC experience racism and homophobia everywhere and not just in minoritized spaces. Although overt forms of racism are not uncommon, LGB POC have reported experiencing other forms of discrimination including microaggressions (Balsam et al., 2011; Crichlow, 2004; Nadal, 2011; Sue et al., 2007; E. G. Ward, 2005). These forms of discrimination are more subtle and include "commonplace statements or behaviors

that are derogatory, hostile, and insulting, yet often done without the intent to harm" (Ghabrial, 2017 p. 43). Racism in LGBT communities can also be systemic, reflected in things like community structure and one's environment. For example, non-White LGB people have reported feeling alienated by LGBT organizations and bars because they do not offer culturally specific services and events (Kudler, 2007; J. Ward, 2008). Relative to other non-White sexual minorities, Black LGB persons may be most likely to experience racism in LGBT communities. In one study of 589 sexual minority men, Black participants reported significantly higher race-based stigma in LGBT spaces than Asian and Latino/a/x participants (McConnell et al., 2018). Thus, community contexts that are generally thought to promote resilience may in some instances perpetuate racism and race-based stigma.

LGB POC also experience heterosexism within communities of color (Balsam et al., 2011; Bridges et al., 2003; Chae et al., 2010). In Black communities specifically, historically Black institutions (e.g., the family, the church, Black social groups) have been crucial supports for coping with stigma. However, these same institutions have not historically been supportive of LGB people (Mosley et al., 2016). Generally, LGB identities remain largely stigmatized in families, faith communities, and the larger Black community (Balaji et al., 2012). Much of the research about homophobia and heterosexism in Black communities has focused on messages from the church. Studies consistently find that, although there are some exceptions, Black churches overwhelmingly espouse homophobic and heterosexist beliefs and attitudes (Balaji et al., 2012; Harris, 2009; Walsh, 2016; E. G. Ward, 2005). A handful of studies have explored the impact of this marginalization

specifically for Black sexual minority men; these men must contend with the rigid norms of Black masculinity in addition to homophobia (Balaji et al., 2012; Bowleg, 2013; E. G. Ward, 2005).

Theoretically, there are a number of hypotheses about how this kind of victimization and discrimination might be related to Black LGB mental health (Mallory & Russell, 2021). For example, minority stress theory posits that Black LGB persons would experience "double jeopardy" whereby experiences of bias and discrimination based on both sexual identity and race would compound, resulting in compromised mental health above and beyond that experienced by people who occupy one of these identities alone (Meyer, 2010). Intersectional theory, however, problematizes this additive hypothesis and suggests that the experiences of Black LGB people should be understood as more than just Black + LGB (Bowleg, 2008; Crenshaw, 1991). Bostwick et al.'s (2014) analysis of an LGB subsample from 2004-2005 NESARC-II data illustrates the complexity of the association between multiple types of marginalization and mental health. They found that, compared to LGB persons who reported no experiences of discrimination, sexual orientation *or* racial discrimination alone were not associated with higher odds of a past-year mood or anxiety disorder. However, those who experienced sexual orientation discrimination *and* racial discrimination had 2.25 higher odds of a past-year mental health disorder compared to those who reported experiencing no discrimination. Bostwick et al. (2014) also found that gender discrimination was predictive of higher risk for a mental health disorder but was not a significant predictor when experienced alongside sexual orientation discrimination. Those who reported experiencing gender and race

discrimination had the highest odds of a mental health disorder (*aOR*=4.30), higher than those who reported experiencing all three types of discrimination. Further, in a critical review of literature about multiple types of discrimination and mental health, Vargas et al. (2020) found that participants who reported experiencing discrimination based on more than one identity – regardless of which combination of identities was attributed to these experiences – were 60-263% more likely to experiences depression symptoms or meet criteria for MDE than those who endorsed discrimination based on one identity.

Identifying Black LGB mental health inequities is further complicated by the importance of the comparison group used in a given study; comparisons between Black LGB and Black heterosexual individuals appear to generate different conclusions from comparisons to White LGB persons. For example, Hayes et al. (2011) found support for the double jeopardy hypothesis, but only for LGB students of color relative to heterosexual students of color; racial/ethnic minority LGB students and European American LGB students reported similar amounts of distress. These findings are similar to Platt & Scheitle's (2018) study using data from the 2013-2015 National Health Interview Survey to investigate differences in psychological distress between heterosexual, gay, lesbian, and bisexual individuals across gender and racial categories. They found that among Black LGB men and women, psychological distress was higher than their Black heterosexual counterparts.

4.1.3. The Present Study

Understanding whether holding multiple marginalized identities confers unique risk for mental health issues is important for informing policy and practice

interventions. Informed by the Black-White depression double paradox this study explores four research questions:

RQ1: To what extent do indicators of mental health (e.g., MDE and SPD) vary on the basis of sex, sexual identity, and race/ethnicity?

Hypothesis: Black LGB individuals will report higher rates of MDE and SPD than other subgroups, regardless of sex.

RQ2: Among LGB people, do Black and White adults differ in the prevalence of MDE and SPD?

Hypothesis: The prevalence of MDE and SPD will be higher for Black LGB people relative to White LGB persons.

RQ3: Among Black people, do heterosexual and LGB adults differ in the prevalence of MDE and SPD?

Hypothesis: The prevalence of MDE and SPD will be higher for Black LGB people than Black heterosexual persons.

RQ4: Within Black LGB populations, what sociodemographic indicators are independently associated with MDE and SPD?

Hypothesis: Among Black LGB individuals, sociodemographic indicators will predict MDE and SPD but the direction of these associations are exploratory.

4.2. Methods

4.2.1. Data Source and Sample

Data for this study were from years 2016-2019 of the National Survey of Drug Use and Health (NSDUH), an annual nationally representative surveillance survey

managed by SAMHSA using a probability sample of U.S. civilian, noninstitutionalized persons aged 12 years and older. The NSDUH does not collect sexual identity or mental health items from respondents aged 12-17. Thus, the analytic sample included respondents age 18+ who provided a valid response to questions about sexual identity, self-reported depression symptoms, self-reported psychological distress, and who identified as either non-Hispanic White or non-Hispanic Black (n=124,478).

4.2.2. Measures

Past-year major depressive episode (MDE) was determined using a series of questions covering nine symptoms of MDE based on DSM-IV diagnostic criteria: depressed mood; diminished interest or pleasure in activities; appetite and weight; insomnia or hypersomnia, psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness; diminished concentration or indecisiveness; and recurrent thoughts of death suicide ideation (SAMHSA, 2010). Despite updates to the DSM, NSDUH documentation ensures that this variable is comparable across data years (SAMHSA, 2019). Respondents were classified with past-year MDE if they were scored as having at least five of the nine symptoms and answered "yes" to the following question: *"In the past 12 months, did you have a period of time when you felt [affirmative symptom] for two weeks or longer while also having some of the other problems we asked about?"*

Past-year SPD was measured with the Kessler-6 (K6; Kessler et al., 2002), which asked participants how frequently they experienced symptoms of psychological distress in the past 30 days. Item assessed nervousness; hopelessness;

restlessness; sadness and depression; feeling that everything was an effort; and worthlessness. Response options ranged from "none of the time" (0) to "all of the time" (4). Respondents were then asked if there was a month in the past year when they felt more depressed, anxious, or emotionally stressed than they felt in the past 30 days ("worst month in the past year"). If they replied yes, they were then asked to complete the K6 thinking of the "month in the past 12 months when [they] were the most depressed, anxious, or emotionally stressed." Items were summed to create a composite score of psychological distress ranging from 0-24 defined to be the highest monthly K6 in the past 12 months. For this study, scores were dichotomized such that a sum ≥13 indicated past-year SPD (Kessler et al., 2003).

Sexual identity was measured with the following question: "*Which one of the following do you consider yourself to be?"* Respondents selected from the following choices: heterosexual, that is, straight; lesbian or gay; bisexual.

Race/ethnicity was measured with two questions. Race was measured by asking participants *"Which of these groups describes you?"* with response options: White; Black or African American; American Indian or Alaska Native; Native Hawaiian; Guamanian or Chamorro; Samoan; Other Pacific Islander; Asian; Other (specify). Ethnicity was measured by asking participants to respond with a yes or no to *"Are you of Hispanic, Latino, or Spanish origin or descent?"* The publicly available NSDUH data files offer a recoded race/ethnicity variable that aggregates some racial groups and combines responses to race and ethnicity questions. This seven-level variable includes Non-Hispanic White; Non-Hispanic Black or African American; Non-Hispanic Native American or Alaska Native; Non-Hispanic Native

Hawaiian or Other Pacific Islander; Non-Hispanic Asian; Non-Hispanic more than one race; Hispanic. This study utilized responses from all individuals who identified as non-Hispanic White or non-Hispanic Black.

Age was determined in the NSDUH based on the birthdate entered by each respondent. Each age from 12-21 is coded individually; the remaining age categories are 22 or 23 years old; 24 or 25 years old; 26-29; 30-34; 35-49; 50-64; and 65+. For this analysis, age was recoded to collapse ages 18-25 into a single category.

Sex was collected with response options of male or female. Importantly, this is not a self-report item. Rather, this information is assigned by the interviewer (Centers for Medicare and Medicaid Services, n.d.).

Income was collected by asking participants to consider *"the total family income from all sources during [the survey year] before taxes and other deductions."* This data is then organized by the NSDUH into four categories: "less than $20,000," "$20,000 - $49,999," "$50,000 - $74,999," and "$75,000 or more." For those missing on income (n=1,721 in 2016; n=1,501 in 2017; n=1,544 in 2018; n=1,595 in 2019), values are imputed by the NSDUH administrators prior to public release.

Education was collected by asking *"What is the highest grade or year of school you have completed?"* Each grade from 5th to 12th (no diploma) is coded separately. For this analysis, these were collapsed into a "less than high school" group. The other education categories include high school diploma/GED; some college credit, but no degree; associate degree; college graduate or higher. For those missing on education (n=50 in 2016; n=35 in 2017; n=41 in 2018; n=36 in 2019), values are imputed by the NSDUH administrators prior to public release.

Relationship status is similarly imputed for missing values (n=10 in 2016 and 2017; n=15 in 2018; n=13 in 2019). Response options are married, widowed, divorced or separated, and never been married.

Survey year was also included as a covariate given that data were pooled across four years.

4.2.3. Analytic Strategy

To identify how mental health (e.g., depression and psychological distress) varies on the basis of sex, sexual identity, and race/ethnicity (RQ1), we fit unadjusted and covariate-adjusted logistic regression models, stratified by sex and utilizing an interaction term between sexual identity and race/ethnicity, to estimate odds of past-year MDE and SPD. Post-estimation methods were used to calculate predicted probabilities of reporting each mental health outcome. Then we conducted pairwise comparisons of these probabilities using Šidák's adjustment for family-wise error to test for differences between the reference group (White heterosexual individuals) and other groups at the intersection of sexual identity and race/ethnicity.

To identify Black-White differences in mental health outcomes within the LGB subgroup (RQ2), we created a subset of those who identify as LGB, then estimated unadjusted and covariate-adjusted logistic regression models using race/ethnicity as the predictor. To identify sexual identity-based differences in mental health outcomes within the Black subgroup (RQ3), we created a subset of those who identified as non-Hispanic Black and estimated unadjusted and covariate-adjusted logistic regression using sexual identity as the predictor.

To identify sociodemographic indicators that are independently associated with mental health outcomes, unadjusted and covariate-adjusted logistic regression models were run for an analytic sample of those who identify as both non-Hispanic Black and lesbian, gay, or bisexual. All analyses were conducted using Stata 17.0 (StataCorp, 2021).

4.3. Results

Approximately 95% of the sample identified as heterosexual; 1.93% identified as lesbian/gay and another 3.14% identified as bisexual. The majority (84.26%) of the sample racially identified as non-Hispanic White and 15.74% identified as non-Hispanic Black. Approximately half of the sample (49.88%) was age 50 or older. A plurality of the sample (41.18%) reported a household income of $75,000 or higher. One-quarter (25.26%) of the sample held a high school diploma and 33.42% held a college degree. The majority of the sample was married (52.03%). For the two mental health outcomes of interest, 7.62% of the sample reported an MDE in the past year and 11.72% reported past-year SPD. Full sample details, including male and female subsample descriptions, can be found in Table 1.

Regarding RQ1 (Table 2), relative to heterosexual White males, neither gay Black males (adjusted odd ratio [*aOR*]=1.13, 95% CI=0.63-2.03) nor bisexual Black males (*aOR*=1.07, 95% CI=0.58-1.97) differed in their reports of an MDE. Additionally, compared to heterosexual White males, neither gay Black males (*aOR*=1.24, 95% CI=0.79-1.93) nor bisexual Black males (*aOR*=1.00, 95% CI=0.61-1.64) differed in their reports of SPD. Relative to heterosexual White females, gay/lesbian Black females had lower odds of an MDE (*aOR*=0.60, 95% CI=0.37-

0.98); however predicted probabilities of a past-year MDE were not significantly different for heterosexual White (9.4%) and gay/lesbian Black (5.6%) females. Bisexual Black females did not differ from heterosexual White females in their reports of an MDE (*aOR*=0.95, 95% CI=0.73-1.24). Relative to heterosexual White females, gay/lesbian Black females (*aOR*=1.22, 95% CI=0.77-1.95) and bisexual Black females (*aOR*=0.98, 95% CI=0.78-1.22) did not differ in their SPD, however the predicted probability of bisexual Black females (19.5%) reporting past-year SPD was significantly higher than that of heterosexual White females (14.1%). Additional predicted probabilities of an MDE and SPD can be found in Figure 1.

In analyses restricted to LGB persons (RQ2), Black LGB males and females had lower odds of an MDE (*aOR* for males=0.56, 95% CI=0.37-0.85; *aOR* for females=0.44, 95% CI=0.35-0.55) and SPD (*aOR* for males=0.70, 95% CI=0.50-0.98; *aOR* for females=0.53, 95% CI=0.44-0.65) compared to their White LGB counterparts.

In analyses restricted to Black persons (RQ3), Black LGB males and females had higher odds of an MDE (*aOR* for males=2.61, 95% CI=1.72-3.95; *aOR* for females=2.26, 95% CI=1.80-2.84) and SPD (*aOR* for males=2.80, 95% CI=2.04-3.85; *aOR* for females=2.76, 95% CI=2.26-3.38) compared to Black heterosexual participants.

In analyses restricted to Black LGB persons (RQ4), bisexual identity (compared to gay/lesbian identity; *aOR*=2.12, 95% CI=1.42-3.17) and age were associated with reports of an MDE. Compared to Black LGB persons aged 18-25, those age 30-34 (*aOR*=0.41, 95% CI=0.23-0.74) and 35-49 (*aOR*=0.57, 95%

CI=0.33-0.97) were less likely to report an MDE. Within the Black LGB subgroup, age and education were associated with reports of SPD. Compared to Black LGB persons aged 18-25, those age 35-49 (*aOR*=0.61, 95% CI=0.39-0.94) and 50-64 (*aOR*=0.41, 95% CI=0.20-0.86) were less likely to report SPD. Compared to those who had not completed high school, Black LGB persons with a high school diploma (*aOR*=0.54, 95% CI=0.34-0.84) or an associate degree (*aOR*=0.34, 95% CI=0.15-0.74) were less likely to report SPD.

4.4. Discussion

In the Black-White depression double paradox, researchers observe that 1) unexpectedly, Black individuals consistently report similar or lower rates of MDE relative to their White counterparts, but 2) higher levels of SPD (Barnes & Bates, 2017). In our analyses, the first paradox was supported; compared to White heterosexual individuals, Black LG/B[3] people showed similar or reduced odds of an MDE. However, findings did not support the second paradox; there were no statistical differences in SPD between Black LG/B people and their White heterosexual counterparts; the prevalence of SPD among Black LGB people was significantly lower than that of White LGB persons.

The finding that Black LG/B people showed similar or reduced odds of an MDE relative to their White heterosexual counterparts aligns with existing mental health disparity literature. The present study adds to this literature, which

[3] LG/B indicates that the results being discussed held true for both the lesbian/gay and the bisexual identity subgroups which were analyzed separately.

counterintuitively finds that, despite presumed experiences of race-based bias, stigma, and discrimination, Black adults in the U.S. evidence similar or lower rates of major depression than their White peers (Center for Behavioral Health Statistics and Quality, 2019; Villarroel, 2020). The expectation that Black adults should have higher rates of mood disorders like depression is predicated on the assumption that Black adults experience race-based discrimination in a way or to a degree that White adults do not. Given that discrimination experiences were not directly measured, it is possible that 1) the Black adults in the sample did not experience discrimination to the degree we might expect 2) Black adults in the sample reacted or otherwise coped with experiences of race-based discrimination, perhaps due to racial socialization practices like preparation for bias, in ways that protected them from the deleterious mental health effects of bias (McLaughlin et al., 2010), or 3) White adults in the sample may perceive themselves as having experienced race-based discrimination with deleterious effects on their mental health, closing the expected gap in mental health outcomes. This last explanation is possible given the recent increase in White Americans perceiving "reverse racism" and resentment toward racial minorities (Bump, 2019; Hawkins & Saleem, 2022; Norton & Sommers, 2011).

The finding that there were no statistical differences in SPD between Black LG/B people and their White heterosexual counterparts is surprising based on the double paradox literature. It is possible that adding sexual identity has complicated the exploration of this double paradox in unexpected ways. There is some evidence that the theoretical explanation for the relationship between intersectional minority stressors and mental health varies depending on the mental health outcome of interest.

In Mallory and Russell's (2021) examination of three different hypotheses for the mental health of sexual minority youth of color, they found that while the multiplicative hypothesis (i.e., the idea that racial discrimination and LGB victimization interact to exacerbate their negative association with mental health) was supported for depressive symptoms, the additive hypothesis (i.e., racial discrimination and LGB victimization are independently associated with mental health) was supported for suicidal ideation. Thus, future research should include experiences of discrimination based on race/ethnicity and sexual identity and test various hypotheses for the relationship between that discrimination and mental health outcomes. Taking this approach to examining MDEs and SPD, in particular, could help clarify the findings of the present study.

The present analysis also highlights the importance of selecting a comparison group when describing mental health disparities for Black LGB populations. When compared to their White LGB peers (RQ2), Black LGB males and females were less likely to report a past-year MDE or SPD. This finding illustrates the first paradox; theoretically we would expect Black individuals to evidence worse mental health outcomes due to race-based bias. However, when compared to their Black heterosexual counterparts (RQ3), Black LGB males and females had higher odds of a past-year MDE and SPD. These findings align with previous research that find comparable rates of mental health issues between White and non-White LGB adults but suggest compromised mental health for LGB people, relative to heterosexual adults, within minoritized racial communities (Hayes et al., 2011; Platt & Scheitle, 2018; Rodriguez-Seijas et al., 2019). These researchers have posited that Black LGB

individuals experience support from other LGB people that may buffer against the effects of race-based stigma, or that the marginalizing effect of heterosexism within racially minoritized contexts has a more deleterious effect on mental health than racism in LGB contexts. Together, these findings suggest that the impact of holding multiple marginalized identities may depend on sociocultural context. Future research should examine how Black LGB adults understand and experience their intersectional identities in different contexts.

In analyses for RQ1-3, there were also consistent findings in the association between sociodemographics and mental health. For example, the odds of reporting a MDE or SPD were generally highest among the youngest participants (18-25); odds ratios generally decreased as participant age increased. This was true for male and female participants. In developmental science, it is well-understood that adolescence and young adulthood can be stressful as young people navigate issues of identity formation, independence, and normative separation from their family of origin (Becht et al., 2016; Klimstra et al., 2010; Meeus et al., 1999, 2005). One recent meta-analysis found that, across all mental disorders, the average age of onset was 14.5 years; nearly 35% of people who experienced a mood disorder experienced onset before the age of 25 with the most common age of onset being 20.5 years (Solmi et al., 2022). As such, it is not surprising that the risk for an MDE or SPD might be highest among participants ages 18-25.

A similar relationship was present for income, whereby higher income was associated with lower odds of MDE or SPD for males and females. For education, having some college was associated with higher odds of reporting a MDE for males

and females; having a college degree was associated with higher odds of reporting a MDE but only for males. For SPD, relative to those who did not complete high school, higher levels of education were associated with lower odds of distress. More generally, the relationship between income and education and mental health is complicated for Black adults. For example, Mouzon et al. (2016) analyzed data from the 2001-2003 National Survey of American Life and found that psychological distress (as measured by the K6) was lower for Black adults with higher levels of income and more years of education, as was generally the case in the present study However, the relationship between socioeconomic variables and depression may be more nuanced for Black men in particular. Assari (2017) found that, although each additional year of schooling reduces Black men's risk of depression, graduating from high school imparted additional risk of depressive symptoms over time. Similarly, although higher income is generally protective against depression, this protective effect is attenuated for Black adults relative to their White peers (Assari, 2018). In fact, high-income Black men may be more likely to experience an MDE in the past year relative to their lower-income counterparts (Assari et al., 2018). Assari (2017; 2018) explains the differential effects of education and income on Black mental health by pointing to increased opportunity and expectations for success that accompany higher education and income that are thwarted by structural and institutionalized barriers to meeting those expectations. Among the men in the full sample, higher income appeared to be protective against an MDE, but higher levels of education were not.

Being married was consistently associated with lower odds of reporting an MDE or SPD for males and females, whereas being divorced/separated was consistently associated with higher odds of reporting an MDE or SPD for males and females. Indeed, similar to the general population, there is evidence for LGB individuals that being in a partnered relationship serves a protective function against the mental health effects of minority stressors. For example, M. E. Williams & Fredriksen-Goldsen (2014) analyzed surveys from 2,150 LGBT older adults (50+ years of age) and found that those who indicated that they were in a same-sex partnership (i.e. married or partnered) reported experiencing fewer depressive symptoms compared to those who were not currently in a relationship (i.e. single, divorced, widowed, or separated).

Analyses for RQ4 identified social characteristics that, within the Black LGB subgroup, were associated with MDEs and SPD. Patterns in associations between sociodemographic indicators and mental health outcomes were less consistent than in this study's other analyses, perhaps because the sample was restricted to a substantially smaller group of 1,650 Black LGB persons. Bisexual identity (relative to lesbian/gay identity) was associated with higher odds of an MDE. This aligns with existing research that has found worse mental health outcomes, including depression, among bisexual individuals, compared to both heterosexual and lesbian/gay persons (Ross et al., 2018). This consistent disparity may be due to experiences of sexual identity-related bias, the invalidation or erasure of bisexuality as a sexual identity, and/or a general lack of bisexual-affirmative supports (Ross et al., 2018). Relative to those in the 18-25 age group, Black LGB adults aged 30-34 and 35-49 were less

likely to report a past-year MDE. Age played a similar role in the odds of SPD; those age 35-49 and 50-64 were less likely to report SPD compared to the youngest adults in the sample. Developmentally, this may be due to the increased levels of life stability that characterize this period as well as assuredness in one's identities. Lastly, two education levels were associated with lower odds of SPD compared to those with less than a high school degree: high school diploma/GED and associate's degree. Statistically, Black LGB adults with some college or a college degree or more had similar odds of SPD as those with less than a high school education. This may reflect the complex role of education outlined above wherein higher educational achievement brings higher expectations of success, but efforts to meet those expectations are impeded by interpersonal and/or institutional roadblocks (Assari, 2018). It should be noted that, to the authors' knowledge, there exists no research that documents the role of these and similar sociodemographic indicators in risk for poor mental health within Black LGB samples.

Together, these sociodemographic patterns add important context for our understanding of mental health risk at the intersection of sex, sexual identity, and race/ethnicity. Although quantitative analyses using identity categories as predictors provide important information about differential risk for mental health issues, individuals (and their identities) do not exist in a vacuum. Although it is beyond the scope of this study, researchers should consider ways to quantitatively model the additional aspects of Black LGB adults' lived experiences (e.g., age, socioeconomic indicators, etc.) that the present study indicates are associated with mental health risk.

4.4.1. Contributions and Limitations

This study contributes to the growing literature about the mental health of Black LGB adults in the U.S. Findings from this study can inform future research seeking to understand these disparities and policies and practices that aim to address them. Many existing efforts target the LGBTQ+ community as a whole and do not attend to variation based on race/ethnicity or are focused on the mental health of Black Americans without accounting for the unique role of sexual identity on mental health risk. Intersectionally-focused research can help inform more nuanced interventions that better attend to the unique experiences of people with multiple marginalized identities.

Although the study uses a nationally representative sample to make a meaningful contribution to the literature, there are limitations. First, although the NSDUH uses audio computer-assisted self-interviewing (ACASI) provides respondents with private and confidential means to increase the level of honest reporting of sensitive behaviors, the data are self-reported, thus their accuracy depends on the respondents' truthfulness and memory and may be impacted by social desirability and/or recall bias. Second, the NSDUH provides cross-sectional data and thus does not provide opportunities to explore how these things change in mental health arise and change over time. Third, in the measurement of MDE, no exclusions were made for MDE caused by medical illness, bereavement, or substance use disorders. Thus, the cause/context of each respondent's MDE is unknown. MDE and SPD are also measured as past-year variables; disparities identified in this analysis could look different if these outcomes were assessed over different time periods (e.g.,

lifetime, past month). For example, Black individuals generally experience more persistent mental health symptoms than their White peers due to factors like timing and quality of care (Breslau et al., 2005). Thus, groups with more persistent symptoms are more likely to be captured in shorter reference periods (e.g., last 30 days) than those with symptoms that are quickly treated. Additionally, given the strong empirical support for the role of stigma, bias, and discrimination in mental health outcomes, it is important that researchers consider these factors in future analyses. The NSDUH does not assess these experiences, thus they could not be included in the present study. This study also does not identify explanations for the double paradox. Future studies should examine the hypothesis that MDE criteria may differentially misclassify Black individuals. Finally, this study utilized a large, population-based survey that allows for confidence when generalizing the findings. However, it should be noted that the NSDUH samples noninstitutionalized, civilian populations excluding approximately three percent of the U.S. population (Lofquist et al., 2012), including members of the active-duty military and individuals in institutional group quarters (e.g., hospitals, prisons, nursing homes, treatment centers). These are populations where Black persons and LGB individuals may be overrepresented; thus, the inferences made may not generalize to members of the excluded populations.

Table 4.1 *Sample Demographics*

Variable	Total n=124,478	Male n=58,168	Female n=66,310
Sexual Orientation			
Heterosexual	94.93%	96.05%	93.90%
Lesbian/Gay	1.93%	2.17%	1.71%
Bisexual	3.14%	1.79%	4.39%
Race			
Non-Hispanic White	84.26%	85.15%	83.44%
Non-Hispanic Black	15.74%	14.85%	16.56%
Age			
18-25	12.40%	12.89%	11.94%
26-29	6.55%	6.71%	6.41%
30-34	8.10%	8.35%	7.86%
35-49	23.07%	23.56%	22.61%
50-64	26.74%	26.87%	26.63%
65+	23.14%	21.62%	24.55%
Income			
<$20,000	14.76%	12.79%	16.58%
$20,000-$49,999	27.92%	26.14%	29.56%
$50,000-$74,999	16.14%	16.29%	16.01%
$75,000+	41.18%	44.77%	37.85%
Education			
Less than high school	9.21%	9.94%	8.54%
High school diploma	25.26%	26.89%	23.76%
Some college	22.40%	21.54%	23.19%
Associate's degree	9.70%	8.38%	10.93%
College degree or higher	33.42%	33.26%	33.58%
Relationship Status			
Never married	26.97%	29.49%	24.63%
Married	52.03%	54.42%	49.81%
Widowed	6.62%	3.46%	9.55%
Divorced	14.39%	12.64%	16.00%
Major Depressive Episode			
No	92.38%	94.23%	90.76%
Yes	7.62%	5.77%	9.33%
Severe Psychological Distress			
No	88.28%	90.71%	86.03%
Yes	11.72%	9.29%	13.97%

Table 4.2 *Odds of MDE and SPD (Full Sample; n=124,478)*

	Past-Year Major Depressive Episode				Past-Year Severe Psychological Distress			
	Males		Females		Males		Females	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Race x Sexual Identity								
White heterosexual (ref)								
Black LG	1.13	0.63, 2.03	**0.60**	**0.37, 0.98**	1.24	0.79, 1.93	1.22	0.77, 1.95
Black B	1.07	0.58, 1.97	0.95	0.73, 1.24	1.00	0.61, 1.64	0.98	0.78, 1.22
Age								
18-25 (ref)								
26-29	0.95	0.81, 1.10	**0.88**	**0.78, 0.98**	0.95	0.85, 1.07	**0.85**	**0.77, 0.93**
30-34	1.00	0.87, 1.16	**0.85**	**0.76, 0.95**	0.93	0.83, 1.04	**0.69**	**0.63, 0.76**
35-49	**0.85**	**0.75, 0.98**	**0.79**	**0.72, 0.88**	**0.67**	**0.60, 0.74**	**0.59**	**0.54, 0.64**
50-64	**0.66**	**0.56, 0.79**	**0.62**	**0.54, 0.70**	**0.38**	**0.33, 0.44**	**0.35**	**0.31, 0.39**
65+	**0.29**	**0.23, 0.38**	**0.25**	**0.21, 0.30**	**0.16**	**0.13, 0.20**	**0.13**	**0.11, 0.16**
Income								
<$20,000 (ref)								
$20-49,999	**0.80**	**0.70, 0.91**	**0.77**	**0.70, 0.85**	**0.76**	**0.68, 0.84**	**0.78**	**0.72, 0.85**
$50-74,999	**0.60**	**0.51, 0.70**	**0.64**	**0.57, 0.72**	**0.55**	**0.49, 0.62**	**0.65**	**0.59, 0.72**
$75,000+	**0.46**	**0.40, 0.54**	**0.55**	**0.49, 0.62**	**0.47**	**0.42, 0.52**	**0.53**	**0.48, 0.58**
Education								
Less than high school (ref)								
High school diploma/GED	0.93	0.79, 1.09	1.02	0.88, 1.18	**0.87**	**0.77, 0.98**	**0.79**	**0.70, 0.88**
Some college	**1.46**	**1.24, 1.71**	**1.32**	**1.14, 1.52**	0.96	0.85, 1.09	0.92	0.82, 1.03
Associate's degree	1.15	0.92, 1.43	1.11	0.94, 1.32	**0.82**	**0.69, 0.97**	**0.80**	**0.70, 0.92**
College degree or more	**1.20**	**1.01, 1.43**	1.04	0.89, 1.21	**0.79**	**0.69, 0.91**	**0.71**	**0.63, 0.80**
Relationship Status								

Never married (ref)												
Married	**0.53**	**0.46,**	**0.61**	**0.70**	**0.64,**	**0.77**	**0.61**	**0.55,**	**0.67**	**0.69**	**0.63,**	**0.74**
Widowed	1.33	0.93,	1.91	0.93	0.74,	1.15	1.01	0.74,	1.37	0.96	0.80,	1.17
Divorced/separated	**1.27**	**1.07,**	**1.50**	**1.17**	**1.04,**	**1.31**	**1.21**	**1.06,**	**1.39**	**1.21**	**1.09,**	**1.34**

Bold numbers indicate significance at $p \leq 0.05$

Table 4.3. *Odds of MDE and SPD (LGB-Only Subsample; n=8,867)*

	Past-Year Major Depressive Episode						Past-Year Severe Psychological Distress					
	Males			Females			Males			Females		
	OR	95% CI		OR	95% CI		OR	95% CI		OR	95% CI	
Race/Ethnicity												
Non-Hispanic White (ref)												
Non-Hispanic Black	**0.56**	**0.37,**	**0.85**	**0.44**	**0.35,**	**0.55**	**0.70**	**0.50,**	**0.98**	**0.53**	**0.44,**	**0.65**
Age												
18-25 (ref)												
26-29	0.68	0.46,	1.01	**0.66**	**0.53,**	**0.84**	1.00	0.72,	1.40	**0.71**	**0.58,**	**0.87**
30-34	**0.61**	**0.39,**	**0.97**	**0.53**	**0.41,**	**0.69**	**0.58**	**0.40,**	**0.85**	**0.50**	**0.39,**	**0.63**
35-49	**0.48**	**0.32,**	**0.71**	**0.59**	**0.46,**	**0.76**	**0.47**	**0.34,**	**0.65**	**0.52**	**0.41,**	**0.64**
50-64	**0.38**	**0.23,**	**0.62**	**0.29**	**0.18,**	**0.47**	**0.23**	**0.15,**	**0.37**	**0.16**	**0.10,**	**0.24**
65+	**0.13**	**0.06,**	**0.28**	**0.29**	**0.14,**	**0.62**	**0.05**	**0.02,**	**0.14**	**0.23**	**0.12,**	**0.46**
Income												
<$20,000 (ref)												
$20-49,999	1.09	0.74,	1.59	0.84	0.68,	1.04	**0.68**	**0.48,**	**0.96**	1.01	0.83,	1.24
$50-74,999	0.78	0.49,	1.25	0.84	0.64,	1.10	**0.61**	**0.40,**	**0.92**	**0.78**	**0.61,**	**1.00**
$75,000+	**0.49**	**0.32,**	**0.73**	**0.73**	**0.57,**	**0.94**	**0.42**	**0.29,**	**0.61**	**0.66**	**0.52,**	**0.82**
Education												
Less than high school (ref)												
High school diploma/GED	0.95	0.54,	1.66	0.97	0.73,	1.27	0.87	0.54,	1.40	0.78	0.59,	1.02
Some college	**2.04**	**1.19,**	**3.48**	1.27	0.97,	1.66	1.12	0.72,	1.74	0.94	0.72,	1.24
Associate's degree	1.60	0.81,	3.15	1.24	0.85,	1.81	1.03	0.59,	1.79	0.86	0.60,	1.24
College degree or more	1.17	0.65,	2.10	1.00	0.73,	1.35	0.77	0.47,	1.24	**0.73**	**0.54,**	**0.99**
Relationship Status												
Never married (ref)												
Married	0.88	0.57,	1.34	**0.77**	**0.61,**	**0.97**	1.11	0.77,	1.60	**0.68**	**0.55,**	**0.84**
Widowed	**5.50**	**1.22,**	**24.69**	**2.51**	**1.03,**	**6.13**	1.15	0.23,	5.69	**2.80**	**1.21,**	**6.51**

Divorced/separated	1.63	0.89,	3.00	1.08	0.81,	1.44	1.23	0.71,	2.15	1.16	0.90,	1.51

Bold numbers indicate significance at $p \leq 0.05$

Table 4.4 *Odds of MDE and SPD (Black-Only Subsample; n=21,579)*

	Past-Year Major Depressive Episode						Past-Year Severe Psychological Distress					
	Males			Females			Males			Females		
	OR	95% CI		OR	95% CI		OR	95% CI		OR	95% CI	
Sexual Identity												
Heterosexual (ref)												
Lesbian/Gay/Bisexual	**2.61**	**1.72,**	**3.95**	**2.26**	**1.80,**	**2.84**	**2.80**	**2.04,**	**3.85**	**2.76**	**2.26,**	**3.38**
Age												
18-25 (ref)												
26-29	1.17	0.79,	1.73	0.79	0.60,	1.03	0.80	0.60,	1.05	**0.72**	**0.59,**	**0.88**
30-34	0.71	0.47,	1.08	**0.61**	**0.46,**	**0.79**	0.78	0.60,	1.03	**0.57**	**0.45,**	**0.70**
35-49	0.82	0.59,	1.15	**0.62**	**0.49,**	**0.79**	**0.65**	**0.51,**	**0.82**	**0.54**	**0.45,**	**0.65**
50-64	0.87	0.58,	1.31	**0.45**	**0.31,**	**0.65**	**0.51**	**0.36,**	**0.73**	**0.28**	**0.21,**	**0.38**
65+	**0.27**	**0.13,**	**0.58**	**0.18**	**0.09,**	**0.36**	**0.19**	**0.09,**	**0.37**	**0.13**	**0.08,**	**0.23**
Income												
<$20,000 (ref)												
$20-49,999	0.77	0.57,	1.06	**0.64**	**0.51,**	**0.80**	**0.72**	**0.59,**	**0.89**	**0.79**	**0.67,**	**0.94**
$50-74,999	**0.63**	**0.42,**	**0.95**	**0.50**	**0.37,**	**0.68**	**0.52**	**0.39,**	**0.69**	**0.60**	**0.47,**	**0.77**
$75,000+	**0.68**	**0.46,**	**0.99**	**0.55**	**0.40,**	**0.74**	**0.45**	**0.34,**	**0.59**	**0.66**	**0.52,**	**0.84**
Education												
Less than high school (ref)												
High school diploma/GED	0.69	0.47,	1.02	0.98	0.70,	1.37	**0.76**	**0.59,**	**0.97**	**0.72**	**0.57,**	**0.92**
Some college	1.23	0.85,	1.78	**1.41**	**1.02,**	**1.96**	0.76	0.58,	1.00	0.89	0.70,	1.12
Associate's degree	0.92	0.48,	1.77	0.95	0.64,	1.41	**0.66**	**0.45,**	**0.99**	**0.66**	**0.48,**	**0.90**
College degree or more	1.24	0.80,	1.93	**1.46**	**1.01,**	**2.12**	0.86	0.62,	1.18	0.78	0.59,	1.02
Relationship Status												
Never married (ref)												

Married	0.72	0.49,	1.06	1.10	0.84,	1.44	**0.69**	**0.52,**	**0.93**	**0.78**	**0.63,**	**0.98**
Widowed	1.11	0.40,	3.13	1.12	0.60,	2.12	0.49	0.20,	1.20	1.03	0.62,	1.69
Divorced/separated	0.81	0.51,	1.28	1.23	0.89,	1.70	0.78	0.54,	1.11	1.09	0.84,	1.41

Bold numbers indicate significance at $p \leq 0.05$

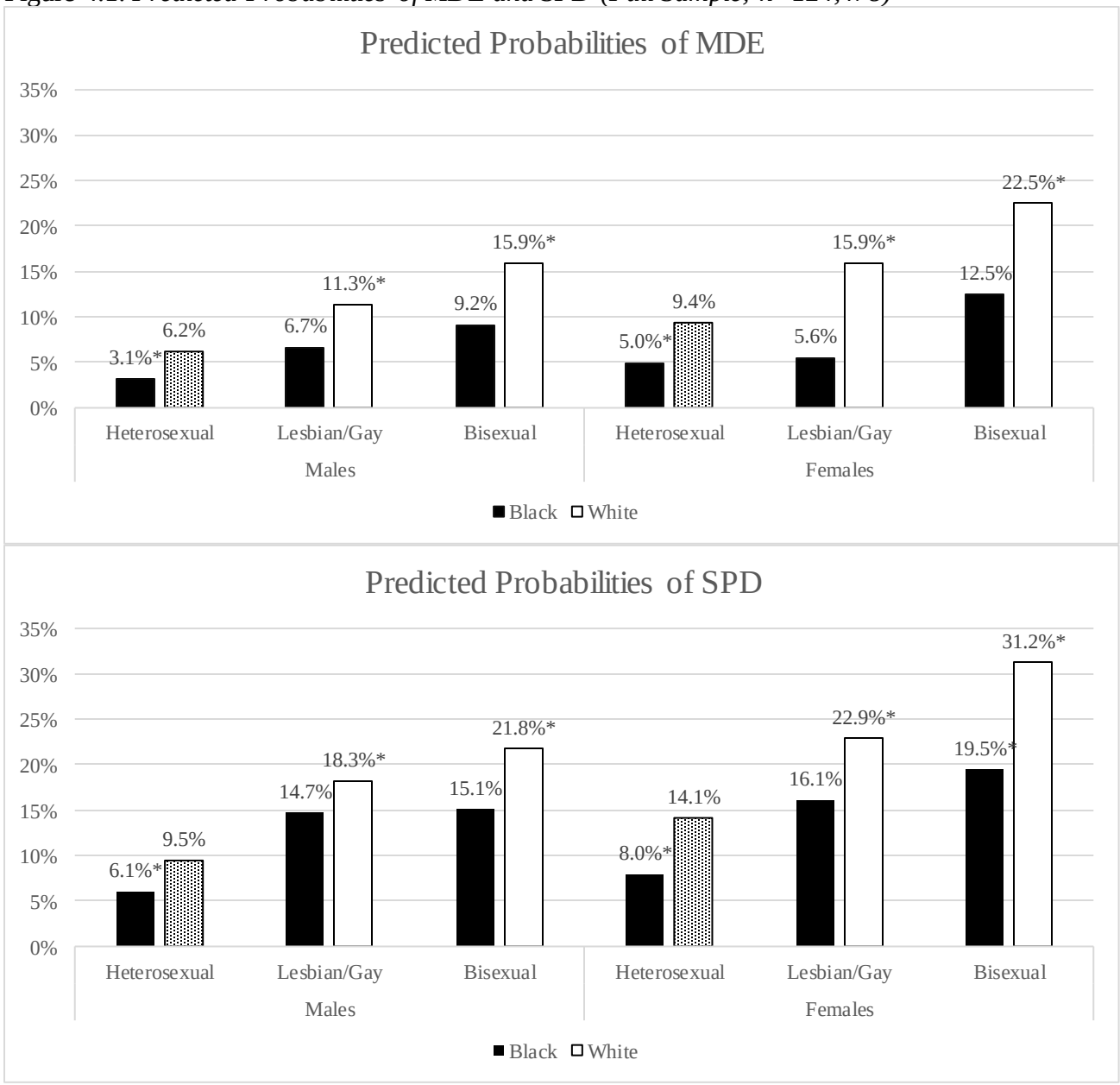
Table 4.5 *Odds of MDE and SPD (Black LGB-Only Subsample; n=1,650)*

	Past-Year Major Depressive Episode		Past-Year Severe Psychological Distress	
	OR	95% CI	OR	95% CI
Sexual Identity				
Lesbian/Gay (ref)				
Bisexual	**2.12**	**1.42, 3.17**	1.19	0.85, 1.67
Sex				
Male (ref)				
Female	1.13	0.73, 1.75	1.37	0.94, 1.99
Age				
18-25 (ref)				
26-29	0.80	0.50, 1.27	0.88	0.61, 1.28
30-34	**0.41**	**0.23, 0.74**	0.67	0.42, 1.07
35-49	**0.57**	**0.33, 0.97**	**0.61**	**0.39, 0.94**
50-64	0.76	0.31, 1.90	**0.41**	**0.20, 0.86**
65+	0.29	0.03, 2.62	0.60	0.18, 1.99
Income				
<$20,000 (ref)				
$20-49,999	0.69	0.46, 1.04	1.08	0.77, 1.50
$50-74,999	0.94	0.52, 1.67	1.09	0.65, 1.83
$75,000+	0.98	0.56, 1.70	0.85	0.54, 1.33
Education				
Less than high school (ref)				
High school diploma/GED	0.59	0.33, 1.05	**0.54**	**0.34, 0.84**
Some college	1.17	0.70, 1.96	0.68	0.44, 1.05
Associate's degree	0.69	0.30, 1.61	**0.34**	**0.15, 0.74**
College degree or more	0.87	0.43, 1.79	0.59	0.34, 1.03
Relationship Status				

Never married (ref)				
Married	0.67	0.34, 1.32	0.81	0.49, 1.32
Widowed	0.48	0.03, 7.32	1.76	0.35, 8.82
Divorced/separated	1.11	0.48, 2.57	0.78	0.41, 1.51

Bold numbers indicate significance at $p \leq 0.05$

Figure 4.1. *Predicted Probabilities of MDE and SPD (Full Sample; n=124,478)*



Bars with dots indicate referent group (White heterosexual individuals)
Asterisks (*) indicate a significant difference between predicted probability for that group and White heterosexual individuals of the same sex.

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Study 2 -- Patterns of Outpatient Mental Health Service Utilization at the Intersection of Sex, Sexual Identity, and Race/Ethnicity

5.1. Introduction

Research indicates that Black lesbian, gay, and bisexual (LGB) individuals may have elevated need for mental health services, especially compared to their Black heterosexual counterparts (Hayes et al., 2011; Platt & Scheitle, 2018; Rodriguez-Seijas et al., 2019). Inequities in mental health outcomes are generally attributed to multiple vectors of minority stress (Mallory & Russell, 2021). Typically, PMHS utilization indicates how people address their mental health needs. Research has identified PMHS utilization disparities between Black and White U.S. adults and, separately, between LGB and heterosexual adults. Still, little is known about how experiences related to both race/ethnicity and sexual identity might influence PMHS utilization. Understanding how social identities and other demographic factors facilitate or hinder PMHS utilization can inform policies and practices that make needed mental health services more accessible.

Black adults are generally less likely than White adults to utilize PMHS, even when accounting for their need for mental health services (Platt et al., 2018; Substance Abuse and Mental Health Data Archive, 2020). Despite national efforts to reduce racial disparities in PMHS, these disparities have remained wider than most other areas of health care services (Agency for Healthcare Research and Quality, 2013). The context for these patterns includes institutional mistrust based on contemporary and historical trauma that may dissuade Black adults from engaging

with PMHS, which some characterize as "a White system" (Alang, 2019; Gómez, 2015; Nicolaidis et al., 2010). Secondly, mental health stigma contributes to a reluctance to use PMHS by Black adults (Alang, 2019; Gonzalez et al., 2011; Wallace & Constantine, 2005; Ward & Mengesha, 2013). Lastly, Black individuals disproportionately experience barriers to accessing PHMS (e.g., cost, insurance coverage; Alang, 2019; Hunt et al., 2015) These experiences influence decisions to continue treatment or re-engage with formal systems of care in the future (Alang, 2019; Hines et al., 2017; Mowbray et al., 2017).

Generally, LGB persons utilize PMHS more than their heterosexual peers, even when accounting for their need for mental health services (Dunbar et al., 2017; Filice & Meyer, 2018; Medley et al., 2016; Platt et al., 2018). However, LGB individuals are more likely to report unmet mental health needs than heterosexual person (Dunbar et al., 2017; Filice & Meyer, 2018). This may reflect LGB persons' barriers to accessing PHMS. For example, mental health services that attend to the unique needs of LGB people (i.e., create space to address experiences of LGB identity-based bias; do not pathologize LGB identities) appear to be limited in their availability (Williams & Fish, 2020). LGB individuals may also face institutional mistrust issues based on how same-sex/gender attraction and behavior have been regarded by mental health fields historically (e.g., pathologization in the Diagnostic and Statistical Manual of Mental Disorders [DSM]; sexual orientation change efforts [i.e., conversion therapy]). Notably, LGB and heterosexual adults have comparable insurance coverage rates since the enactment of the Affordable Care Act; yet, studies

suggest that LGB individuals may be underinsured (i.e., high cost-sharing plans; Dawson et al., 2018; Fish et al., 2021).

Research about PMHS utilization by Black LGB persons is nascent and yields mixed findings. In one study, non-Hispanic Black LGB college students needing mental health treatment were no different in their service utilization from their White LGB counterparts (Dunbar et al., 2017). Among a sample of lesbian and bisexual women, Black and White women were no different in their lifetime use of mental health treatment (Jeong et al., 2016). However, in a community sample of LGB adults in New York City, Black LGB participants were less likely than White LGB adults to seek mental health or medical treatment prior to a suicide attempt (Meyer et al., 2015).

Understanding disparities and service utilization patterns is important for ensuring equitable access to PMHS regardless of sociodemographic background. Therefore, the present study seeks to examine 1) the extent to which outpatient mental health service utilization varies based on sex, sexual identity, and race/ethnicity; 2) outpatient mental health service utilization patterns among those with mental health need (e.g., severe psychological distress and/or major depressive episode); and 3) the sociodemographic indicators that are independently associated with outpatient mental health service utilization among Black LGB adults.

5.2. Methods

5.2.1. Data Source and Sample

Data for this study are from the 2016-2019 National Survey on Drug Use and Health (NSDUH), a serial cross-sectional study administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH does not collect sexual identity or mental health items from respondents aged 12-17. Thus, the analytic sample includes respondents age 18 and older who provided a valid response to questions about sexual identity, self-reported depression symptoms, self-reported psychological distress, outpatient mental health service utilization, and who identified as non-Hispanic White or non-Hispanic Black (n=122,836).

5.2.2. Measures

Sexual identity was measured with the following question: *Which one of the following do you consider yourself to be?* Respondents selected from the following choices: heterosexual, that is, straight; lesbian or gay; bisexual.

Race/ethnicity was measured with the following questions: *Which of these groups describes you?* and ethnicity was measured by asking participants to respond with a yes or no to *"Are you of Hispanic, Latino, or Spanish origin or descent?"* The publicly available NSDUH data files offer a recoded race/ethnicity variable that collapses some racial groups and combines responses to race and ethnicity questions. This analysis utilized responses from all individuals who identified as non-Hispanic Black or non-Hispanic White.

Covariates included age (18-25; 26-29; 30-34; 35-49; 50-64; 65+), sex (male; female), income (less than $20,000; $20,000 - $49,999; $50,000 - $74,999; $75,000 or more), education (less than high school; high school diploma/GED; some college credit, but no degree; associate degree; college graduate or higher), relationship status

(married; widowed; divorced or separated; never been married), insurance coverage (insured; uninsured), and survey year.

Mental health need was operationalized as 0=no major depressive episode or severe psychological distress in the past year and 1=at least one major depressive episode and/or severe psychological distress in the past year. Severe psychological distress was defined as a Kessler-6 score at or above 13 (Kessler et al., 2002). The methods used by the NSDUH for classifying major depressive episodes can be found in publicly available documentation.

Outpatient mental health service utilization was measured using the following question: *"During the past 12 months, did you receive any outpatient treatment or counseling for any problem you were having with your emotions, nerves, or mental health at any of the places listed below? Please do not include treatment for alcohol or drug use"* followed by various treatment setting options (e.g., an outpatient mental health clinic or center; the office of a private therapist, psychologist, psychiatrist, social worker, or counselor that was not part of a clinic; etc.). Respondents who reported receiving care from one or more settings were coded as 1=yes; respondents who answered no to all treatment settings were coded as 0=no.

5.2.3. Analytic Strategy

To identify how outpatient mental health service utilization varied based on sex, sexual identity, and race/ethnicity (RQ1), we fit unadjusted logistic regression models and logistic regression models adjusted for covariates, stratified by sex and utilizing an interaction term between sexual identity and race/ethnicity, to estimate odds of past-year service utilization. Additionally, post-estimation methods were used

to calculate predicted probabilities and 95% confidence intervals of service utilization across groups defined by the interaction between sexual identity and race/ethnicity. Subpopulation analysis was then conducted to fit the same unadjusted and adjusted models restricted to those categorized as needing mental health care (e.g., major depressive episode and/or severe psychological distress; RQ2).

To identify sociodemographic indicators independently associated with outpatient mental health service utilization among Black LGB persons (RQ3), a logistic regression model adjusted for covariates was fit using an analytic subpopulation of those who identify as both non-Hispanic Black and lesbian, gay, or bisexual.

The publicly available NSDUH datasets include imputation for missingness on covariates; therefore, all models were conducted using complete cases. All analyses were conducted using Stata 17.0 (StataCorp, 2021). This study was approved by the University of Maryland College Park Institutional Review Board.

5.3. Results

Approximately two percent (1.93%) of the sample identified as lesbian/gay, and 3.14% identified as bisexual. The sample was 15.74% non-Hispanic Black, and 8.49% reported receiving outpatient mental health services. Approximately 14% reported severe psychological distress and/or major depressive episodes in the past year. Sample statistics, including demographics for male and female subgroups, can be found in Table 5.1.

Regarding RQ1 (Table 5.2), in unadjusted models, Black males were less likely to use services than White males (adjusted odds ratio [*aOR*]=0.63; 95%

confidence interval [CI]=0.54-0.74). LGB males were more likely to use services than heterosexual males (*aOR*=3.04; 95% CI=2.60-3.57). The interaction between race and sexual identity was not significant in the unadjusted or adjusted model. In unadjusted models, Black females were less likely to use services than White females (*aOR*=0.47; 95% CI=0.42-0.52), and LGB females were more likely to use services than heterosexual females (*aOR*=2.82; 95% CI=2.58-3.09). The interaction between race and sexual identity was significant (*aOR*=0.68; 95% CI=0.52-0.89) in the unadjusted model such that Black LGB females had lower odds of utilization than their White heterosexual peers, but was no longer significant in the adjusted model. Predicted probabilities of outpatient service utilization based on adjusted models for all subgroups can be found in Figure 1.

Regarding RQ2 (Table 5.3), unadjusted models among males with mental health need showed that Black males were less likely to use services than White males (*aOR*=0.64; 95% CI=0.51-0.81; LGB males were more likely to use services than heterosexual males (*aOR*=1.49; 95% CI=1.21-1.85). The interaction between race and sexual identity was not significant in unadjusted or adjusted models. Unadjusted models among females with mental health need showed that Black females were less likely to use services than White females (*aOR*=0.54; 95% CI=0.47-0.63); LGB females were more likely to use services than heterosexual females (*aOR*=1.23; 95% CI=1.09-1.38). The interaction between race and sexual identity was significant (*aOR*=0.63; 95% CI=0.44-0) in the unadjusted model and remained significant (*aOR*=0.65; 95% CI=0.46-0.94) in the adjusted model, such that Black LGB females had lower odds of utilization than their White heterosexual peers.

Regarding RQ3 (Table 5.4), in the adjusted model limited to Black LGB individuals, those aged 35-49 were the only age group with significantly different odds of outpatient utilization compared to those aged 18-25 (*aOR*=1.86; 95% CI=1.01-3.41). Additionally, those with a household income of $20,000-$49,999 (*aOR*=0.56; 95% CI=0.34-0.91) and $50,000-$74,999 (*aOR*=0.45; 95% CI=0.21-0.99) were less likely than those with a household income of less than $20,000 to receive outpatient services. Relative to those with less than a high school education, Black LGB individuals with a college degree or more had higher odds of outpatient service utilization (*aOR*=2.48; 95% CI=1.12-5.47). Lastly, Black LGB individuals with mental health need had higher odds of service utilization than those without need (*aOR*=6.53; 95% CI=4.05-10.51).

5.4. Discussion

This paper explored patterns of outpatient mental health service utilization at the intersection of sex, sexual identity, and race/ethnicity. The interaction between race/ethnicity and sexual identity predicting service utilization was not significant for males or females in adjusted models. However, the unadjusted models showed that Black LGB females had lower odds of utilizing outpatient mental health services than their White heterosexual counterparts. Postestimation analyses provide novel findings about subgroup differences in service utilization by testing differences for Black LGB adults compared to White LGB adults and Black heterosexual adults. Additionally, among the subpopulation of individuals with mental health need, Black LGB females were less likely than White heterosexual females to utilize services in both unadjusted and adjusted models; this was not the case for males with mental health need. As

hypothesized, sociodemographic characteristics were independently associated with service utilization among Black LGB adults.

Odds of outpatient mental health service utilization were significantly lower for Black LGB females than White heterosexual females in the unadjusted model; this relationship was attenuated once covariates were included. Because race and sexual identity were the predictors of interest, rather than socioeconomic adjustment removing confounding, it likely removed potential mediating mechanisms. Thus, the unadjusted estimates likely reflect an actual association heavily driven by the socioeconomic disparities that are associated with race and sexual identity. This may also indicate the confluence of factors that affect service utilization. Certainly, there is reason to believe that the experiences of bias and discrimination that often accompany holding a minoritized race/ethnicity and/or sexual identity would serve as significant barriers to accessing services (Moore et al., 2020; Tabaac et al., 2020). However, in this sample, the interaction between Blackness and queerness was statistically overshadowed by sociodemographic indicators. For example, females over 50 years old were significantly less likely to utilize services compared to those aged 18-25. This could be due to cohort differences in the acceptability of seeking PMHS; stigma about mental health, in general, has eroded over time (Johnson, 2021; Mackenzie et al., 2008; Segal et al., 2005). Interestingly, females with an income of $20,000 or less were most likely to utilize services. Given that cost is a common barrier to accessing services (Alang, 2019), we expect this group to evidence lower odds of service utilization. The inclusion of insurance coverage as a covariate in this model indicates

that some other factor (e.g., access to university-based services among those seeking a college degree) might explain this finding.

Importantly, results from postestimation analyses show that Black LGB females (8.62%) were significantly more likely to utilize services than Black heterosexual females (4.92%) and significantly less likely than White LGB females (21.91%). These findings are consistent with existing literature but in a specific context. Generally, LGB individuals are more likely to utilize services than their heterosexual peers (Dunbar et al., 2017; Filice & Meyer, 2018; Medley et al., 2016; Platt et al., 2018) and Black individuals are less likely to utilize services than their White peers (Platt et al., 2018; Substance Abuse and Mental Health Data Archive, 2020). For males, Black LGB individuals (10.49%) were statistically more likely to utilize services than their Black heterosexual counterparts (3.60%), but there was no difference compared to White LGB individuals. It is possible that, for males but not for females, LGBTQ+ community norms destigmatize seeking help for mental health issues beyond the norms of the general public and certainly more than in Black communities. It is also possible that this phenomenon is present in men and not women because of public health and community efforts that specifically focus on men who have sex with men. Additionally, these findings reflect an important aspect of conducting quantitative modeling with intersectional identities: selecting a comparison group. Generally, studies examining PMHS utilization among Black LGB individuals make comparisons to White LGB individuals (Dunbar et al., 2017; Jeong et al., 2016; Meyer et al., 2015). The findings from the present analysis are

novel given the lack of studies of PMHS utilization comparing Black LGB individuals to their Black heterosexual peers.

Among the subpopulation of individuals who reported having mental health need (e.g., major depressive episode and/or severe psychological distress), Black LGB females were less likely than White heterosexual females to utilize services. This may be due to intrapersonal beliefs; in another study using the 2011-2015 NSDUH, researchers found that among Black individuals reporting unmet mental health need, women were more likely than men to endorse minimization (i.e., believe they could handle the problem without treatment or not feel the need for treatment at the time; Alang, 2019). Additionally, Black LGB females may be more inclined to seek support from other sources to manage their mental health. For example, general religiosity, connecting with the Black religious communities, traveling to Black lesbian events, and cultivating supportive relationships with Black family and friends have all been cited as strategies used particularly by Black lesbians to manage the effects of identity-based stigma (Follins et al., 2014).

Among individuals who identified as non-Hispanic Black and LGB, age, income, and education were each independently associated with outpatient mental health service utilization. Relative to those aged 18-25, Black LGB individuals aged 35-49 were nearly twice as likely to engage in mental health services; it may be that this age group has the financial stability to access services that members of other age groups do not. Regarding income, Black LGB individuals making $20,000-$74,999 were less likely than those in the lowest income category to utilize services. This may indicate a “donut hole” in access to services. Although insurance coverage was

included as a covariate, the variable does not account for the quality of that coverage. Thus, people in middle-income categories may have insurance but have high co-pays, high deductibles, or limited mental health coverage that restricts access to services. Lastly, relative to individuals with less than a high school education, those with a college degree or more had higher odds of service utilization. Again, this could reflect the quality of health insurance that people with this educational background are afforded. Given that most adults in the United States get their health insurance through their employer, the difference between the types of jobs that are typical of those without a high school diploma and those with a college degree may be related to the quality of health insurance available to these individuals.

5.4.1. Limitations

This study has several limitations. First, the NSDUH, like most national surveillance surveys, operationalizes how people manage their mental health fairly narrowly. Although seeking PMHS can be an important mental health management strategy, there are several other ways people manage their mental health that is not captured by this definition. Black individuals(Hines et al., 2017), LGB persons (Martos et al., 2019; Meyer et al., 2015), and Black LGB people (Moore et al., 2020) may circumvent some of the aforementioned barriers to traditional care with non-traditional methods (e.g., using non-mental health and non-medical settings; support groups at LGBTQ community-based organizations, community engagement; social support from family; faith-based resources) of managing their mental health. To capture the mental health management of Black LGB individuals more comprehensively, measurement should include less "traditional" support sources.

This study is also limited by its narrow definition of mental health need. There are myriad indicators of mental health need beyond depression and psychological distress, especially among Black adults who are overrepresented among those with serious mental illness (e.g., bipolar disorder, schizophrenia). Future studies should explore disparities in service utilization when these other indicators of mental health need are considered. Lastly, although the findings in this study are relatively generalizable given the use of a nationally-representative sample, the NSDUH samples noninstitutionalized, civilian populations excluding approximately three percent of the U.S. population (Lofquist et al., 2012), including members of the active-duty military and individuals in institutional group quarters (e.g., hospitals, prisons, nursing homes, treatment centers). These are populations where Black persons and/or LGB individuals may be overrepresented; thus, the inferences made may not generalize to people in excluded contexts.

Table 5.1 Sample Demographics (n=122,836)

	Total n=122,836	Male n=57,498	Female n=65,338
Sexual Identity			
Heterosexual	94.93%	96.05%	93.90%
Lesbian/Gay	1.93%	2.17%	1.71%
Bisexual	3.14%	1.79%	4.39%
Race			
Non-Hispanic White	84.26%	85.15%	83.44%
Non-Hispanic Black	15.74%	14.85%	16.56%
Age			
18-25	12.40%	12.89%	11.94%
26-29	6.55%	6.71%	6.41%
30-34	8.10%	8.35%	7.86%
35-49	23.07%	23.56%	22.61%
50-64	26.74%	26.87%	26.63%
65+	23.14%	21.62%	24.55%
Income			
<$20,000	14.76%	12.79%	16.58%
$20,000-$49,999	27.92%	26.14%	29.56%
$50,000-$74,999	16.14%	16.29%	16.01%
$75,000+	41.18%	44.77%	37.85%
Education			
Less than high school	9.21%	9.94%	8.54%
High school diploma/GED	25.26%	26.89%	23.76%
Some college	22.40%	21.54%	23.19%
Associate's degree	9.70%	8.38%	10.93%
College degree or higher	33.42%	33.26%	33.58%
Relationship Status			
Never married	26.97%	29.49%	24.63%
Married	52.03%	54.42%	49.81%
Widowed	6.62%	3.46%	9.55%
Divorced	14.39%	12.64%	16.00%
Insurance Coverage			
No	7.43%	8.88%	6.09%
Yes	92.57%	91.12%	93.91%
Received Outpatient Treatment			
No	91.51%	93.90%	89.29%
Yes	8.49%	6.10%	10.71%
Mental Health Need[a]			
No	86.09%	88.99%	83.40%

	Yes	13.91%	11.01%	16.60%

[a] As defined by past-year severe psychological distress and/or major depressive episode in the past year

GED = General Educational Development Test (high school equivalency credential)

Table 5.2 Odds of Outpatient Mental Health Treatment – Full sample (n=122,836)

	Males (n=57,498)			Females (n=65,338)		
	OR	95% CI		OR	95% CI	
Unadjusted						
Race						
White (ref)						
Black	**0.63**	**0.54**	**0.74**	**0.47**	**0.42**	**0.52**
Sexual Identity						
Heterosexual (ref)						
LGB	**3.04**	**2.60**	**3.57**	**2.82**	**2.58**	**3.09**
Race x Sexual Identity						
White x Heterosexual (ref)						
Black x LGB	1.37	0.87	2.16	**0.68**	**0.52**	**0.89**
Adjusted						
Race x Sexual Identity						
White x Heterosexual (ref)						
Black x LGB	1.43	0.90	2.27	0.78	0.59	1.02
Age						
18-25 (ref)						
26-29	1.02	0.86	1.21	1.06	0.94	1.19
30-34	**1.56**	**1.34**	**1.82**	1.08	0.96	1.20
35-49	**1.44**	**1.25**	**1.66**	1.07	0.97	1.19
50-64	**1.22**	**1.02**	**1.46**	**0.84**	**0.75**	**0.95**
65+	**0.79**	**0.64**	**0.99**	**0.42**	**0.36**	**0.49**
Income						
<$20,000 (ref)						
$20-49,999	**0.62**	**0.54**	**0.72**	**0.67**	**0.60**	**0.74**
$50-74,999	**0.48**	**0.41**	**0.58**	**0.67**	**0.60**	**0.76**
$75,000+	**0.48**	**0.41**	**0.55**	**0.65**	**0.59**	**0.73**
Education						
Less than high school (ref)						
High school diploma/GED	**0.81**	**0.67**	**0.99**	0.98	0.85	1.14
Some college	**1.30**	**1.08**	**1.56**	**1.38**	**1.20**	**1.60**
Associate's degree	**1.38**	**1.09**	**1.74**	**1.33**	**1.13**	**1.58**
College degree or more	**1.72**	**1.42**	**2.08**	**1.86**	**1.60**	**2.15**
Relationship Status						
Never married (ref)						
Married	**0.60**	**0.52**	**0.69**	**0.72**	**0.66**	**0.79**
Widowed	0.86	0.60	1.23	0.83	0.68	1.02
Divorced/separated	0.91	0.76	1.09	**1.37**	**1.22**	**1.53**
Insurance Coverage						
No (ref)						
Yes	**1.86**	**1.55**	**2.24**	**1.80**	**1.56**	**2.08**

OR = odds ratio; 95% CI = 95% confidence interval; LGB = lesbian, gay, or bisexual
Bold text indicates statistical significance ($p \leq 0.05$)

Table 5.3 Odds of Outpatient Mental Health Treatment – Mental Health Need Subsample (n=23,073)

	Males (n=8,316)			Females (n=14,757)		
	OR	95% CI		OR	95% CI	
Unadjusted						
Race						
White (ref)						
Black	**0.64**	**0.51**	**0.81**	**0.54**	**0.47**	**0.63**
Sexual Identity						
Heterosexual (ref)						
LGB	**1.49**	**1.21**	**1.85**	**1.23**	**1.09**	**1.38**
Race x Sexual Identity						
White x Heterosexual (ref)						
Black x LGB	1.43	0.77	2.65	**0.63**	**0.44**	**0.89**
Adjusted						
Race x Sexual Identity						
White x Heterosexual (ref)						
Black x LGB	1.46	0.79	2.72	**0.65**	**0.46**	**0.94**
Age						
18-25 (ref)						
26-29	1.12	0.89	1.41	**1.24**	**1.05**	**1.45**
30-34	**1.49**	**1.19**	**1.87**	**1.46**	**1.23**	**1.72**
35-49	**1.85**	**1.50**	**2.28**	**1.56**	**1.35**	**1.81**
50-64	**2.30**	**1.74**	**3.02**	**1.40**	**1.15**	**1.70**
65+	**1.60**	**1.05**	**2.45**	1.14	0.86	1.52
Income						
<$20,000 (ref)						
$20-49,999	**0.74**	**0.60**	**0.91**	**0.75**	**0.66**	**0.87**
$50-74,999	**0.63**	**0.49**	**0.81**	**0.79**	**0.67**	**0.94**
$75,000+	**0.74**	**0.60**	**0.92**	0.89	0.76	1.04
Education						
Less than high school (ref)						
High school diploma/GED	1.06	0.80	1.41	1.13	0.93	1.38
Some college	**1.65**	**1.26**	**2.17**	**1.56**	**1.29**	**1.88**
Associate's degree	**2.17**	**1.54**	**3.05**	**1.58**	**1.26**	**1.99**
College degree or more	**2.19**	**1.65**	**2.92**	**2.09**	**1.71**	**2.54**
Relationship Status						
Never married (ref)						
Married	0.83	0.67	1.02	**0.78**	**0.68**	**0.90**
Widowed	1.07	0.61	1.87	0.84	0.61	1.16

Divorced/separated	0.92	0.71	1.21	**1.20**	**1.02**	**1.42**
Insurance Coverage						
No (ref)						
Yes	**2.05**	**1.59**	**2.63**	**2.06**	**1.71**	**2.47**

Bold text indicates statistical significance ($p \leq 0.05$)

Table 5.4 Odds of Outpatient Mental Health Treatment – Black Lesbian, Gay, or Bisexual Subsample (n=1,637)

	OR	95% CI	
Sexual Identity			
Lesbian/Gay (ref)			
Bisexual	1.04	0.68	1.59
Sex			
Male (ref)			
Female	0.71	0.45	1.13
Age			
18-25 (ref)			
26-29	1.01	0.56	1.81
30-34	0.81	0.39	1.67
35-49	**1.86**	**1.01**	**3.41**
50-64	1.46	0.63	3.37
65+	1.89	0.42	8.49
Income			
<$20,000 (ref)			
$20-49,999	**0.56**	**0.34**	**0.91**
$50-74,999	**0.45**	**0.21**	**0.99**
$75,000+	0.66	0.34	1.29
Education			
Less than high school (ref)			
High school diploma/GED	0.70	0.36	1.35
Some college	1.36	0.70	2.65
Associate's degree	1.37	0.47	3.95
College degree or more	**2.48**	**1.12**	**5.47**
Relationship Status			
Never married (ref)			
Married	0.74	0.37	1.47
Widowed	0.11	0.01	1.14
Divorced/separated	0.68	0.28	1.68
Insurance Coverage			
No (ref)			
Yes	1.31	0.65	2.65
Mental Health Need			
No (ref)			
Yes	**6.53**	**4.05**	**10.51**

Bold text indicates statistical significance ($p \leq 0.05$)

Figure 5.1 Predicted Probabilities of Outpatient Treatment Utilization (n=122,836)

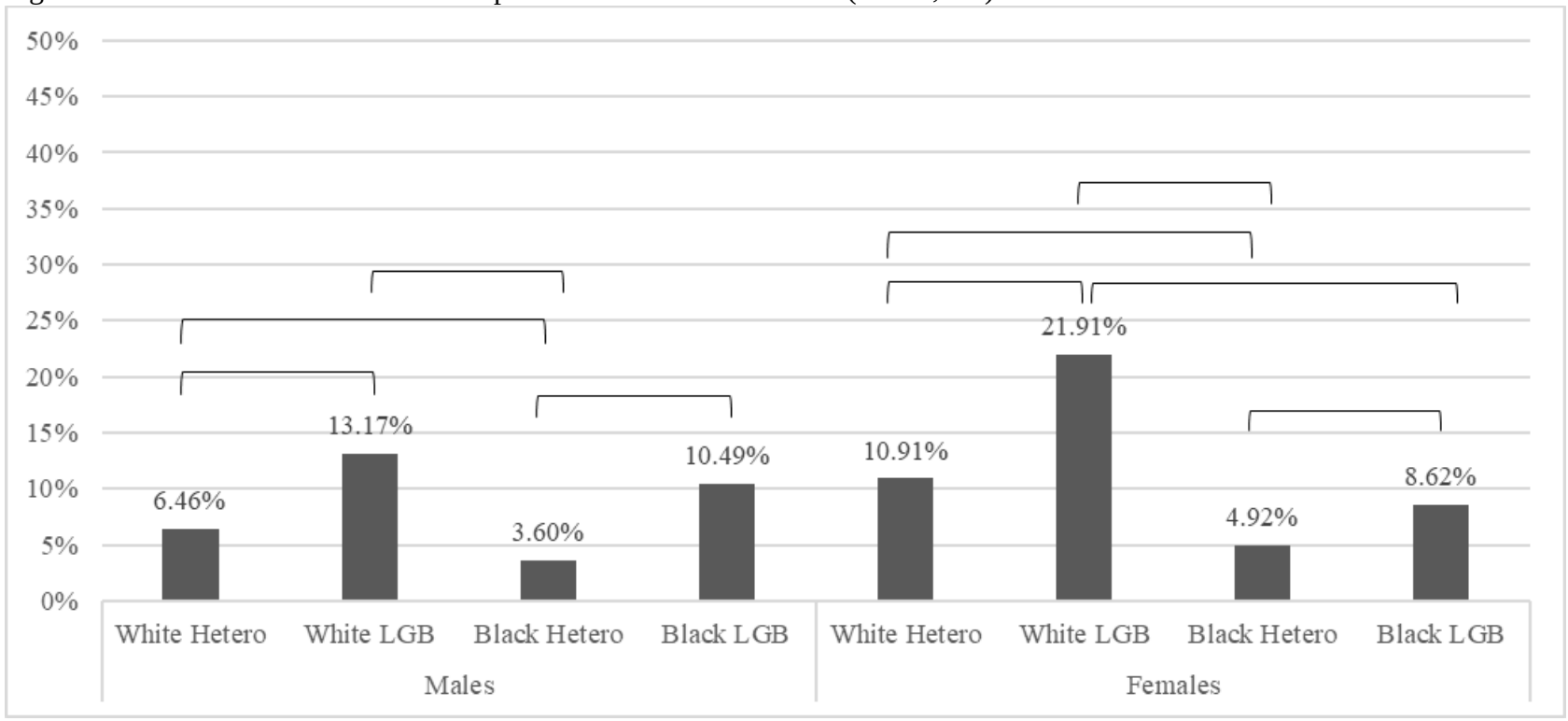

Figure 5.1 Note: LGB = lesbian, gay, and bisexual. Brackets indicate statistically significant differences between predicted probabilities ($p \leq 0.05$).

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Study 3 -- Intersectional Minority Stress and Mental Health [Management] among Black LGBTQ+ Young Adults: A Template Analysis

6.1. Introduction

Extant theories and empirical evidence point to complex and impactful experiences of stigma and discrimination for those who are both racial and sexual minorities (Meyer, 2003; D. R. Williams & Williams-Morris, 2000). For Black lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people, this includes racism within LGBTQ+ communities (Ghabrial, 2017), homophobia in Black communities (Chae et al., 2010), and unique stressors that emerge at the intersection of these identities (Balsam et al., 2015). These experiences are theorized to have deleterious effects on mental health (Bostwick, et al., 2014; Vargas, et al., 2020). However, research about these effects is nascent and sometimes conflicting. Gaining a qualitative understanding of intersectional minority stress experiences, how those experiences are related to individuals' mental health, and the ways that Black LGBTQ+ choose to manage their mental health has implications for social and health policy, as well as clinical and public health practice.

6.1.1. [Intersectional] Minority Stress

Minority stress theory posits that members of marginalized identity groups are subject to identity-based stigma in addition to general life stressors. These stigma experiences interact with characteristics of the individual's minority identity, and their coping and social supports, to influence mental health outcomes (V. Brooks, 1981; Meyer, 2003). Intersectionality is a natural extension of these processes;

individuals may hold multiple [stigmatized and marginalized] identities which situate them at the nexus of multiple forms of stigma related to these identities and their overlap (e.g., sexism, racism, and gendered racism; Crenshaw, 1991; Lewis, et al., 2016). Further, these experiences of sigma are mutually constituted, not additive. Although one or more identities may hold primacy or be more salient, intersectional identities reinforce each other; they cannot be parsed into distinct parts (Collins, 2014). Intersecting systems of oppression (i.e. racism, [hetero]sexism) shape how sexual, gender, and racial/ethnic identities are expressed and experienced (Crenshaw, 1991). Thus, it is theorized that Black lesbian, gay, and bisexual (LGB) people – above and beyond everyday racism and heterosexism – experience racism in LGBTQ+ communities, heterosexism within their racial/ethnic community, and "varying forms of oppression that interact in different contexts" (Ghabrial, 2017 p. 42).

Generally, LGBTQ+ people of color (POC) experience simultaneous race- and sexuality-based bias and discrimination (Balsam et al., 2015) in addition to unique forms of oppression like racism within LGBT communities (Balsam et al., 2011; Chae et al., 2010; Han, 2007; J. Ward, 2008). Importantly, research on the discrimination experiences of LGBTQ+ POC has typically split intersectional minoritized identities into pieces and focused on racism in queer spaces or homophobia in non-White spaces; it should be noted that LGBTQ+ POC experience racism and homophobia in myriad contexts and not just in minoritized spaces. Although overt forms of racism are not uncommon, LGBTQ+ POC have also reported experiencing implicit forms of discrimination including microaggressions

(Balsam et al., 2011; Crichlow, 2004; Nadal, 2011; Sue et al., 2007; E. G. Ward, 2005) – "commonplace statements or behaviors that are derogatory, hostile, and insulting, yet often done without the intent to harm" (Ghabrial, 2017 p. 43). Racism in LGBTQ+ communities can also be systemic, reflected in things like community structure and one's environment. For example, non-White LGB people have reported feeling alienated by LGBTQ+ organizations and bars because they do not offer culturally specific services and events (Kudler, 2007; J. Ward, 2008). Relative to other non-White sexual minorities, Black LGBTQ+ persons may be most affected by racism in LGBTQ+ communities. In one study of nearly 600 sexual minority men, Black participants reported significantly higher race-based stigma in LGBTQ+ spaces relative to Asian and Latino/a/x participants (McConnell et al., 2018). Thus, community contexts that are generally thought to promote resilience may in fact perpetuate racism and race-based stigma.

LGBTQ+ POC also experience heterosexism within communities of color (Balsam et al., 2011; Bridges, et al., 2003; Chae et al., 2010). In Black communities specifically, Black institutions of significance historically (e.g. the family, the church, Black social groups) have been crucial supports for Black people. However, these same institutions have not typically been supportive of LGBTQ+ people and others who face gender- and sexuality-based oppression (Mosley, et al., 2016). Generally, LGBTQ+ identities remain largely stigmatized in families, faith communities, and the larger Black community (Balaji, et al., 2012). Much of the research about homophobia and heterosexism in Black communities has focused on messages from the church. Studies consistently find that, although there are exceptions, Black

churches overwhelmingly espouse homophobic and heterosexist beliefs and attitudes (Balaji, et al., 2012; Harris, 2009; Walsh, 2016; E. G. Ward, 2005). A handful of studies have explored the impact of this marginalization specifically for Black gay and bisexual men, as well as men who have sex with men; these men must contend with the rigid norms of Black masculinity in addition to homophobia (Balaji, et al., 2012; Bowleg, 2013; E. G. Ward, 2005).

6.1.2. [Intersectional] Minority Stress & Mental Health

Theoretically, there are several hypotheses about how this kind of victimization and discrimination might be related to Black LGBTQ+ mental health (Mallory & Russell, 2021). For example, minority stress theory posits that Black LGBTQ+ persons might experience "double jeopardy" whereby experiences of bias and discrimination based on both sexual identity and race would compound, resulting in compromised mental health above and beyond that experienced by people who occupy one of these identities alone (Meyer, 2010). Intersectional theory, however, problematizes this additive hypothesis and suggests that the experiences of Black LGBTQ+ people should be understood as more than just Black + sexual minority (Bowleg, 2008; Crenshaw, 1991). Bostwick et al's (2014) analysis of an all LGB-identifying subsample from NESARC-II data (2004-2005) illustrates the complexity of the association between multiple types of marginalization and mental health. They found that, compared to LGB persons who reported no experiences of discrimination, sexual orientation or racial discrimination alone were not associated with higher odds of a past-year mental health disorder (defined as past year major depression, dysthymia, mania, hypomania, panic with and without agoraphobia, social phobia,

specific phobia, or generalized anxiety disorder). However, those who experienced sexual orientation discrimination and racial discrimination had 2.25 higher odds of a past-year mental health disorder compared to those who reported experiencing no discrimination. Adding the dimension of gender further complicated matters. Gender discrimination alone predicted higher risk for a mental health disorder but was not a significant predictor when paired with sexual orientation discrimination. Those who reported experiencing gender and race discrimination had the highest odds of a mental health disorder (aOR=4.30), higher than the odds for those who reported experiencing all three types of discrimination. Further, in a critical review of literature about multiple types of discrimination and mental health, Vargas et al. (2020) found that participants who reported experiencing more than one type of discrimination – regardless of the combination of identities attributed to these experiences – were 60-263% more likely to experience depression symptoms or meet criteria for major depression than those who endorsed solely one type of discrimination.

Intrapsychically, LGB POC may feel a tension between their communities and/or the interactions between their identities (Ghabrial, 2017). Identities may be in direct conflict with each other, compounding stressors and creating obstacles to mental wellness (Balsam et al., 2011; Bowleg, 2008). Findings from Jackson et al. (2020) provide evidence for the role of identity conflict in the mental health of Black LGB individuals. The authors adapted minority stress theory and the psychological mediation framework to examine the relationship between intersectional experiences and negative affect (as a measure of psychological distress). They found that identity conflict mediated the association between negative daily intersectional experiences

and negative affect. The same study also identified negative rumination as a mediator of the relationship between negative intersectional experiences and negative affect. Ajayi and Syed's (2021) phenomenological examination of what they call "dual minority stress" identified three manifestations of internalized oppression: psychological maladjustment, acting out (i.e., risky behaviors), and identity disintegration (i.e., struggling to integrate Black and LGB identities). The interview data from this study also illuminated three mechanisms by which oppression becomes internalized: notions of prototypicality (i.e., narrow ideals of Blackness and queerness), socio-political invisibility, and the absence of counterspaces (e.g., contexts and spaces for Black LGB individuals to be in community and challenge deficit-based notions of their existence). These studies provide insight into how [intersectional] minority stressors might "get under" Black LGB people's skin.

6.1.3. Black LGBTQ+ Mental Health Management

There is clear and consistent evidence for these systems of oppression conferring differential risk for mental health issues; less is known about how mental health management (i.e., the ways in which people manage their mental health) may be impacted, especially for Black LGB individuals. Certainly, coping strategies and social support – constructs that are explicitly included in the minority stress model at the community and individual levels – are mental health management strategies. Among the options for managing one's mental health is the use of traditional mental health services (e.g., talk therapy, medication, group therapy). Andersen's (1973) model of health service utilization is useful in understanding the factors that may influence the utilization of traditional mental health services. For example, individual

determinants of health service utilization include predisposing factors, like demographic characteristics, social structure, and personal beliefs, which may predict a propensity (or lack thereof) for use prior to the onset of a specific episode of illness. Individual determinants also include enabling factors at family (e.g., income, health insurance) and community (e.g., presence of health services) levels.

Research about traditional mental health service utilization by Black LGB persons is nascent and yields mixed findings. In one study of over 33,000 college students, non-Hispanic Black LGB individuals in need of mental health treatment were no different in their utilization of mental health services or on-campus mental health services compared to White LGB counterparts (Dunbar et al., 2017). Further, results from Jeong et al. (2016) indicate that, among a sample of lesbian and bisexual women, Black and White participants were no different in their lifetime use of mental health treatment. However, in a community sample of LGB adults in New York City, Meyer et al. (2015) found that Black LGB participants were less likely than White LGB adults to seek mental health or medical treatment prior to a suicide attempt. Notably, these studies compare Black LGB individuals to White LGB individuals; to my knowledge, no studies of PMHS utilization compare Black LGB individuals to heterosexual Black persons.

Given research about racial disparities in mental health treatment quality (Gómez, 2015; N. D. Williams, et al., 2023) and how poorly equipped the mental health workforce is to work with LGB populations (Graham et al., 2012; Nowaskie, 2020; Rock et al., 2010; Shi & Doud, 2017), satisfaction with services, or lack thereof, may be an important factor in understanding mental health management

options for Black LGB persons. Among a sample of adults receiving inpatient or outpatient psychiatric services in New York City, Black LGBT participants were less likely to be satisfied with their care than Black cisgender, heterosexual participants (Avery et al., 2001). Further, Moore et al.'s (2020) qualitative investigation of mental health service engagement among Black and Hispanic LGB young adults provides insights into the treatment-seeking behaviors of this population. Themes included 1) reluctance to engage with services or prematurely terminating services due to personal factors (e.g., belief that treatment would not help, handling problems on their own, shame about symptoms and LGB identity); 2) the impact of the social environment (e.g., reliance on LGB peers to find affirming services/providers, family members discouraging the use of traditional mental health services); 3) accessibility factors (e.g., lack of knowledge about how to navigate the health care system, trouble affording care); and 4) provider characteristics (e.g., continued engagement when providers are "nonjudgmental" and knowledgeable about the LGBT community, withholding information from providers who do not share their racial/ethnic or LGBT identity). Many of these factors were consistent with Williams, et al.'s (2023) analysis of an online sample of 476 LGB adults. Regression analysis indicated that Black LGB individuals were more likely to postpone or avoid mental health care than their White LGB counterparts. Further, when asked why they postponed or avoided care, Black LGB persons were more likely to state that they believed they should work their problems out on their own or with family/friends and were more likely to report that a provider had refused to treat them.

These experiences may underlie a possible preference for "non-traditional" mental health services among Black LGB persons. These include community-based resources and faith-based resources. In a study of utilization of LGBT-specific clinics and providers (not necessarily for mental health, but in general), Martos et al. (2019) found that Black LGB persons had nearly three times the odds of White LGB individuals in expressing an interest in future utilization of LGBT healthcare; however, their past five-year use of LGB-specific clinics did not differ from White participants. This disconnect between higher interest and similar utilization levels suggests that Black LGB individuals may continue to experience barriers in accessing care (Martos et al., 2019). Research also indicates that Black LGB adults are more likely than White LGB adults to seek mental health treatment from religious or spiritual advisors (Meyer, et al., 2015).

Understanding the [intersectional] minority stress experiences of Black LGBTQ+ people, the impact of those experiences on their mental health, and how these individuals choose to manage their mental health can help inform social and health policy, including anti-discrimination efforts and mental health workforce development, as well as mental health provider training and changes to health surveillance systems. Therefore, the current study utilizes semi-structured interviews with Black LGBTQ+ young adults to examine the following research questions:

1. RQ1: How do Black LGBTQ+ young adults navigate the world, and their understanding of themselves, in the context of being both racial and sexual minorities.

2. RQ2: What meaning do Black LGBTQ+ young adults ascribe to experiences of [intersectional] minority stress?
3. RQ3: How do Black LGBTQ+ young adults manage their mental health?

6.2. Method

6.2.1. Data Source and Sample

Semi-structured interviews (n=24) were conducted to explore the meaning Black LGBTQ+ young adults ascribe to experiences of intersectional minority stress, how those experiences are perceived to impact their mental health, and how these young people manage their mental health. Interviewees were required to:

- Identify as Black or African American;
- Identify as lesbian, gay, bisexual, queer, or another non-heterosexual identity;
- Be between 18-26 years of age; and
- Live in a major metropolitan area in the United States.

There is evidence of this age range being developmentally significant for the onset of mental disorders, including depression (Beronio et al., 2014). Additionally, this is a critical period for identity development where young Black LGBTQ+ persons are making sense of their racial and sexual identities, and well as the intersectional complexities therein (Bishop et al., 2020; Martos et al., 2015; Umaña-Taylor et al., 2014). Relative to younger persons, young adults in this age range have more autonomy and independent control over whether to engage in services. Parents of minor children may prohibit youth involvement in mental health treatment or mandate that their child(ren) utilize services that are unwanted. Further, young adults between 18-26 may be less likely to contend with being uninsured given the ACA's

coverage for adults up to 26 staying on their parents' insurance (Kozloff & Sommers, 2017), a provision that impacts the accessibility of traditional mental health services (Ali et al., 2016). Finally, this cohort – born approximately between 1995 and 2003 – has come of age in a distinct sociopolitical environment. They were in their adolescence and early adulthood during the debate about and eventual passage of national marriage equality in 2015, while LGBTQ+ representation in popular media was expanding, and during a resurgence of calls for Black liberation with the birth of the Black Lives Matter movement in 2013.

Determination about participants' residence in major metropolitan city in the U.S. was based on the rural-urban commuting area (RUCA) code assigned to their zip code. The requirement that participants reside in a metropolitan area was important for ensuring a reasonable level of homogeneity of experience given the relatively small sample; LGBTQ+ people and Black people have different experiences of bias and discrimination, as well as access to mental health services, in rural contexts than their urban counterparts (Barefoot et al., 2015; Jenkins et al., 2022; Ji & Cochran, 2022). Additionally, traditional mental health services are generally more accessible in urban areas than rural contexts. Everyone included in the study listed a zip code corresponding to a RUCA code of one, indicating residence in a metropolitan area (United States Department of Agriculture, 2019).

6.2.2. Procedures

Participants were recruited through announcements and flyers disseminated at LGBTQ+ community centers and events in Washington, DC and Chicago, as well as online (e.g., Facebook, Twitter, Instagram, Tumblr, Craigslist). Given the

economic/resource differences among college samples relative to the general population (U.S. Department of Education, 2017), college campuses were regarded as a final recruitment option. Towards the end of recruitment, word-of-mouth from members of the listserv for Division 44 of the American Psychological Association resulted in a groundswell of participants. This included Division 44 members sharing recruitment materials with their university colleagues and campus-based LGBTQ+ student groups/organizations. Thus, the sample in this study is more likely to hold a college or graduate degree than the general population in the U.S. Additionally, to bolster recruitment efforts, I began to offer referral incentives to participants; for every completed interview with a person who listed them as the reason they heard about the study, participants could receive an additional $10, up to $50 total.

Recruitment began in April 2022 and closed in March 2023. All recruitment materials included a link to a screener form. Those who did not meet all of the basic eligibility requirements were thanked for their interest and the survey ended. Due to recruitment difficulties, some criteria were revised in July 2022 (e.g., allowing gender diverse participants). The screener made it clear that not everyone who was eligible would be selected for interviews. The screener form that all interested persons completed included the following constructs to determine eligibility and inform selection for inclusion (originally with purposive sampling in mind).

Table 6.1. Screener Constructs

Construct	Question	Answer Choices	Eligible if
Age	What is your age?	Drop down menu 18-30+	Response is 18-26
Race/ethnicity	*Which of the following best describes your*	• Asian • Black or African American	Black or African American is selected

	race/ethnicity? (Choose one)	• Hispanic or Latino/a/x • Native American or Alaska Native • Native Hawaiian or Other Pacific Islander • White • My race/ethnicity is not listed (please specify)	
Gender	*Which of the following best describes your gender? (Choose one)*	• Woman • Man • Nonbinary • My gender is not listed here (please specify)	Original: Woman or man is selected Revised: any gender accepted
Gender identity	*Do you identify as transgender, nonbinary, or gender nonconforming?*	• No • Yes (please specify)	Original: No is selected Revised: either answer accepted
Sexual identity	*Which of the following best describes your sexual identity?*	• Lesbian • Gay • Bisexual • My sexual identity is not listed here (please specify)	Original: Lesbian, gay, or bisexual selected Revised: any non-heterosexual identity accepted
Attention/validity check	*Attention check: what is your favorite color?*	Open-ended text box	n/a
Mental health service utilization	*In the time since your 16th birthday, have you gotten professional help for your mental health? This may include a therapist, counselor, pastor, or medical doctor*	• No • Yes	*Not used to determine eligibility; used for purposive sampling*

	If yes: *How often and for how long did you consistently receive professional help? For example, maybe you went to therapy every other week for 6 months.*	Open-ended text box	*Not used to determine eligibility; used for purposive sampling*
Zip code	*What is the zip code of the place you sleep most often?*	Open-ended text box	Original: Zip code falls within Washington DC or Chicago MSA Revised: Zip code corresponds to an area in the U.S. with a RUCA score of 1 (major metro)
Technological access	*Which of the following do you have access to? (Choose all that apply)*	• quiet place to talk alone for up to 90 minutes • laptop computer with reliable internet connection • desktop computer with reliable internet connection	Quiet place to talk + one of the other options selected
Attention/validity check	*The responses I have given on this survey are true and accurate*	• No • Yes	Must answer yes
Contact information	*Please enter your email and/or phone number below. This information will be used for scheduling and compensation purposes, as well as contact for follow-up*	Open-ended text boxes	*Not used to determine eligibility*
Referrals	*How did you hear about this study? If a previous participant*	Open-ended text box	*Not used to determine eligibility*

	referred you, please include their name.		

By the end of the study, 141 people had completed the screener. Early in recruitment, it became apparent that many of those who completed the screener had misrepresented themselves, likely in an effort to receive the participant incentive, or were bots. Thus, attention check items were added to the screener and the demographic survey (described below) to weed out bots and to allow me to compare responses to the same item at two points in time as a validity check. This effort to reduce the number of illegitimate screener responses was successful.

Those who were selected for interviews were emailed the link to an online consent form. If they consented to the study (including being recorded), the screen advanced to a demographic form which collected the following information:

Table 6.2: Demographic Information

Construct	Question	Answer Choices
Gender expression	*Using the sliders below, how would you describe your gender expression? Gender expression is the way you carry yourself, the way you dress, etc.*	• First slider with low feminine on the left, high feminine on the right • Second slider with low masculine on the left, high masculine on the right
Pronouns	*Which pronouns do you use?*	• She/her/hers • He/him/his • They/them/theirs • Ze/zir/zirs • My pronouns are not listed here (please specify)
Sexual behavior	*Which of the following best describes the gender of the sexual partners you've had over the course of your life?*	• only men • only women • both men and women • never had sex
Sexual attraction	*Which of the following best describes your sexual attraction to other people?*	• only attracted to women • mostly attracted to women

		• equally attracted to women and men • mostly attracted to men • only attracted to men
Education	*What is the highest level of school that you have completed?*	• middle school • high school diploma/GED • some college • college degree (associate's or bachelor's) • master's degree • professional or doctorate degree
Relationship status	*Which of the following best describes your relationship status?*	• Single • in a committed relationship • married • divorced • widowed
Income	*Which of the following best reflects the total income of your household? (If you live with parents/guardians, please include their income. If you live on your own or with roommates, please only include your income)*	• less than $20,000 • $20,000 - $49,999 • $50,000 - $74,999 • $75,000 - $99,999 • $100,000 or more
National origin	*Which country were you born in?*	Open-ended text box
Insurance coverage	*Have you been without health insurance for any part of the past year?*	• Yes • No
	Do you currently have health insurance?	• Yes • No
	Does your current health insurance provide any coverage for mental health services?	• Yes • No • Not sure
30-day psychological distress (Kessler-6)	*During the past 30 days, about how often did you feel…1) nervous 2) hopeless 3) restless or fidgety 4) so depressed that nothing could cheer you us 5) everything was an effort 6) worthless?*	• all of the time • most of the time • some of the time • a little of the time • none of the time

Interviews took place via Zoom and lasted approximately 2 hours. Originally, I proposed a three-part structure where I would meet with participants separately for a 30-minute rapport building session, a 90-minute interview, then the 30-minute member check. I learned after the first three interviews that people preferred to combine the first two steps into a 2-hour session and used this structure for the remaining interviews. Interviews were recorded using Zoom's in-app recording feature and transcribed by Rev.com.

Once all interviews were completed and analyzed, I created an infographic-style summary of findings, sent it to all participants via email, and asked them to schedule a 30-minute virtual member check meeting with me to discuss the findings. These meetings were not recorded or transcribed. Twenty of 24 participants (83%) engaged in the member check process. They were asked the following questions:

- After reading through the findings, what are your general thoughts?
- How accurately do you feel the findings captured your thoughts and experiences?
- What could be added to the findings to capture your experiences better?
- If there is anything you'd like removed, what would that be and why?

Responses to these questions informed revisions to the infographic summary before it was finalized and shared online.

Participants were compensated up to $50 for their participation – $40 for the 2-hour interview and $10 for the member check process – with some receiving additional compensation for referring others into the study. All compensation was given as electronic gift cards of the participants' choosing.

Interview protocols were semi-structured; I approached each interview with a set of questions and associated probes but remained flexible in my potential lines of inquiry to probe about experiences that may improve understanding of mental health management among Black LGB young adults. Even though this study eventually departed from a grounded theory approach, consistent with grounded theory methods (Charmaz, 2006; Strauss & Corbin, 1990), revisions to the protocol were made after some interviews depending on the content and process of the interview, and in response to emerging themes, hypotheses, or related questions that should be incorporated. The research questions necessitated interview questions that were both objectivist and constructivist in nature; they sought to capture chronology, events, and behaviors as well as meanings and definitions of terms and events. The final version of the interview protocol is included in Appendix A.

6.2.3. Analytic Approach

Consistent with ground theory, data analysis and data collection occurred simultaneously and iteratively (Charmaz, 2006). I engaged in memoing – the process of writing informal analytic notes about everything from data, codes, and the research process itself – to facilitate a deeper familiarity and understanding of data throughout the data collection phase of the study. Starting with interview protocol development, I memoed about my thought processes, observations, and potential revisions to the tool. This resulted in multiple versions of the interview protocol throughout the data collection process. An example of how one question was revised along the way is provided below.

Table 6.3 Example Interview Protocol Revision History

Version	Date	Revision	Rationale
#1	10/18/2021	Original: Every person holds multiple identities. For example, I'm a cisgender, queer, Black woman. I'm also a student and a researcher, a daughter, a sister, etc. Which of your identities are most important to you?	--
#2	11/15/2021	Revision: We all have different aspects of who we are. For example, I'm a cisgender, queer, Black woman. I'm also a student and a researcher, a daughter, a sister, etc. Which aspects of you are most important to you?	Put the question in more "lay language" – asking about identities led some participants to ask me to rephrase the question.
#4	2/26/2023	Revision: We all have different aspects of who we are. Which aspects of you are most important to you?	Because my social location was being covered during introductions, discussing it here was redundant. More importantly, I noticed that discussing my identities here might have been priming people to mention the same aspects of themselves, often in the same order.

Memoing and revising interview questions as needed also ensured that I was asking questions that both supported the development of the theory and resonated with the people whose experiences I seek to capture and understand. Throughout data collection, I documented initial theoretical connections, hypotheses, and ideas about the three topics of interest, and possible connections between them (See Appendix B).

As I approached the end of the interviews, I realized that I made theoretical assumptions in the framing of the project, development of the research questions, and

the structure of the interview guide. Namely, I assumed that Black LGBTQ+ young people experienced intersectional bias and discrimination as we understand it theoretically (e.g., attributing discrimination to both their sexual identity and their Blackness). This was not the case for most of the people I spoke with; they could easily identify instances of racism, homophobia, heteronormativity, etc. but struggled to identify times when they experienced bias or discrimination based on their positionality of being Black and queer. This led me to reconsider my analytic approach, moving away from grounded theory towards template analysis.

Template analysis is a type of thematic analysis for qualitative data that balances an etic approach (i.e., applying a priori, theoretical understandings of the data) with inductive processes. The key component of this analytic approach is the development of a coding template that is then applied in the process of coding the data, while leaving room for the inclusion of inductive codes that are derived from the data during the coding process (J. Brooks, 2015; King, 2012). It differs from other analytic approaches in its use of a flexible coding structure (i.e., it does not prescribe a coding process like the open, axial, and selective coding process that characterizes grounded theory), the use of a priori themes, and the use of an initial coding template (King, 2012).

Brooks (2015) outlines the steps taken in template analysis. Typically, the researcher(s) will:

1) Become familiar with the data to be analyzed;
2) Carry out preliminary coding, typically using an inductive or deductive approach;

3) Organize the themes based on how they relate to each other, including hierarchical relationships, with narrower themes nested within broader ones;
4) Define the initial coding template;
5) Apply the template to the data and modify it as needed; then
6) Finalize the template and ensure that the final coding template has been applied to all data.

The initial coding template is often developed based on a subset of the data (J. Brooks, 2015; King, 2012). For example, a researcher might review a handful of interviews, develop the template based on the data therein, then apply that coding template to the remaining interviews. Because I conducted all of the interviews myself and created analytic memos throughout the data collection process, which ostensibly served as an outline for the template, I did not utilize the typical approach of creating a coding template based on a sample of interviews for steps 1-4 above. Rather, I relied on my memos and familiarity with all interview data to create an initial coding template. I then engaged in "an iterative process of applying, modifying, and re-applying the initial template to all interviews" (King, 2012, p. 430). Thus, although the template guided the coding process, the final structure was more expansive and detailed than the initial one. Additionally, the interview guide I created asked about constructs beyond the specific research questions for this project. Thus, the coding template (Appendix C) and final coding structure (Appendix D) include codes that may not be directly related to the research questions but reflect important aspects of participants' experiences and were important for the

development of the member check infographic (discussed below). Data management and coding processes were conducted in Dedoose.

To be mindful of data quality, I engaged participants in 30-minute member check interviews (Lincoln & Guba, 1985; Morse et al., 2002). After completing the template analysis process, I developed an infographic summary of findings for participants to review ahead of the member check meetings. This document included background information about the study, demographic information about the participants, the key themes from the data – many of which extended beyond the research questions – as well as the nuanced similarities and contradictions within those themes. Through this process, I invited each participant to contribute to the authorship of the narrative that is intended to represent their experiences as part of the collective. I took notes about each participant's responses to the reflection questions and revised the infographic, where feasible, to reflect their feedback. The feedback was unanimously positive; interviewees stated that the infographic accurately represented their overall experience, even if some details did not completely comport with their lived experience. Some participants' suggested revisions were too specific to their individual experience and were not appropriate for a document that represents aggregate findings. However, there were places where additional detail (e.g., the educational backgrounds of participants; a legend for interpreting graphics) was added.

6.3. Results

The average age of the sample was 22.6 years old (standard deviation [*SD*] = 2.57 years). The sample was largely comprised of individuals who listed their gender

as woman (58%). Interviewees varied in their sexual identities; a plurality identified as bisexual (29%). An additional 21% identified as pansexual, and 21% identified as queer. Half of the sample held a college degree, and 17% held a graduate degree (i.e., master's, professional, or doctoral). Most (96%) interviewees had health insurance, and approximately two-thirds (63%) had mental health coverage. Three-quarters (75%) had utilized some form of PMHS since the age of 16. When asked about their mental health in the past 30 days using the Kessler-6, scores averaged 8.8 (out of 24; $SD = 4.4$); 21% of the sample had scores ≥ 13, indicating severe psychological distress. Additional demographic information about the sample is included in Table 6.2.

Understanding Identities

Generally, interviewees did not describe their own identities intersectionally. By and large, participants thought of themselves as Black first or, less commonly, queer first; their identity centrality was often discussed in terms of what other people "see" first or what others treat as most important, which was generally the color of their skin. Roderick, a 25-year-old bisexual man, discussed feeling like his Blackness is not something he can conceal and that, even though he believes his queerness is observable by others, it is a part of him that is less obvious to them.

> *"For me, I feel like in the world I will always present and know that people will perceive me as a Black man. So for me, I feel like my Blackness is something that is so salient and so in your face, hypervisibility wise, that I can't hide from it. I think in a way as well that my queerness, in my opinion, I don't know if it's the perception of other people, my queerness is clockable. I feel like I've always been clockable. It's not something that I can hide. Like I said, that whole closet, it was clear. You could see the clothes and everything. So for me, I feel like that aspect of my identity is just as salient, but in a way it works differently because the experiences I have in my Blackness as a Black man is so different than my experiences as a person who can outwardly*

> *express for instance, 'Oh, I'm queer, I'm bisexual. I think it's not until there's that confirmation that people then can shift how they want to interact with me, but otherwise it's just going off of perception what people see. I think Blackness for me is always a thing that's going to be like, 'Oh, you are a dark skin black man. This is what we think.'"*
>
> – Roderick, 25, bisexual, man

For a few others, their racial and sexual identities were inseparable in alignment with theoretical tenets of intersectionality. However, these individuals were the exception and tended to have a graduate degree or be in graduate school. Amaya, a 26-year-old queer woman with a master's degree, explained this perspective.

> *"It's hard to separate the Black and the queerness because they're both me, so I feel like it informs a lot of how I move in spaces."*
>
> – Amaya, 26, queer, woman

When asked about the best parts of being Black and queer, interviewees often mentioned that the connections they have with other Black queer people is the best part of being Black and queer. These connections bring them joy and validation that they are not alone in their experiences. The community, as Nicole described, is vibrant and lively. Even though interviewees discussed the joy they feel in the presence of other Black queer people using affirmative language, there was a subtext that the freedom and joy they feel is not possible or common when in community with other types of people.

> *"I think, I don't know, the community. Like I said, just the vibrancy of both aspects, pieces of my identity, and in the little spaces that I've been in, where I've been around people that carry these intersecting identities, it has just been the most affirming and supportive space that I've ever been in. There's, I don't know, it just feels comfortable and I can be wholly myself."*
>
> – Nicole, 24, queer, woman

Sidney spoke quite poetically about what it is like to love, and be loved by, other Black lesbian women. Because of how difficult it can be to find other people who truly understand her experiences, when she does, it bring her pure joy.

> *"The love, it's so nice. It's untapped, pure honey, it's so awesome. It's so sweet. It's just with all these identities, Black woman, lesbian, it's so hard to find your circle that when you find somebody who connects, it's like, I want to understand you. I want to love you. I want to do what I've seen, but in my way. And that's what makes it so special in particular. Yeah, it's the love in the community that comes with it."*
>
> - Sidney, 19, lesbian, woman

Some interviewees also answered this question by pointing to the contributions that Black queer people and culture have made to the larger culture in the United States (e.g., the use of specific parlance in general society, the popularity of music and other art forms that have origins in Black queer culture). Bridget specifically cited Beyoncé's 2022 album Renaissance, which was released just a week prior to her interview, when discussing this kind of cultural influence.

> *"I'm going to bring up Beyoncé, Renaissance album, that really was the peak example of the heightened joy that comes from the essence of what is created in a queer Black space"*
>
> – Bridget, 25, pansexual, woman

Intersectional Minority Stress

Experiences of identity-based bias and discrimination were not generally discussed in intersectional terms or attributed to overlapping systems of oppression. The vast majority of conversations about experiences of bias and discrimination focused on homo- or transphobia in Black spaces and, to a lesser extent, racism in queer spaces. Jayden, like many interviewees, discussed how queer identities are regarded by Black communities and spoke about this in quite sweeping terms. Rarely

did interviewees highlight the exceptions to this (unless they were describing Black family members who surprised them by affirming their queerness); most people spoke about Black culture's homo- and transphobia quite monolithically.

> *"I know in Black culture being gay is looked down upon. We're doing better now, but it's still, because of Christianity and how it's so heavy within our culture, it looks down upon us. Then just being gay is like, it's very racist in the gay community, but a lot of people don't talk about it as well. Being Black there also can be an issue."*
>
> – Jayden, 20, gay, man

Leilah was one of the handful of participants that spoke about race-based marginalization in [white] queer spaces. Like many others who shared minority stress stories, her experience featured a microaggression (as opposed to overt discrimination). She talked about how she and her partner – another queer Black woman – were made to feel when they walked into a queer establishment where they were the only non-white people in the room.

> *"I think I've gone to a gay bar that was all White and [my partner and I] received some looks and it's just the slight, 'I guess you can come in.' I don't think there has been anything that's been blatant and disrespectful, just more so micro."*
>
> – Leilah, 23, pansexual, woman

The minority stress experiences that interviewees shared took the form of both proximal and distal stressors. Commonly identified proximal stressors included those explicitly outlined in Meyer's (2003) minority stress model: expectations of danger or discomfort, identity concealment and code-switching, and internalized homophobia. These experiences can result in hypervigilance, as Amaya described, or expending extra energy self-censoring and policing oneself as they move through the world, as Olivia and Roderick discussed.

> *"[In White queer spaces] I feel like I'm always just on edge and listening to what people say. I never really feel comfortable because I feel like even though some people are very open-minded, I tend to listen a lot because I'm more introverted and I like to hear what people are saying, and it's just some microaggressions that it just doesn't feel always the most comfortable of places."*
>
> – Amaya, 26, queer, woman

> *"I think the most significant one that I would definitely change is with my aunt just because she is very unaware that I am queer. And I just preface, this is on the black side of my family. She grew up in that time period where everything was very strict and everything was black and White. And she's a lot older than my father, even though they're siblings. So I understand that even though I know she loves me and even if I told her she probably wouldn't hate me, it's just something that I choose not to tell her for the sake of our relationship because I know she'd probably see me differently."*
>
> – Olivia, 19, bisexual, nonbinary

> *"With my Black friends and stuff, we can talk in AAE [African American English]. With my queer friends, I feel like we talk in much more of the lingo, but we know that the lingo derives from Black women, Black queer people. So yeah, I think in the way, I'm just always code-switching. It's just how we navigate apparently in this world that we live in. And I just have to always, constantly, not I have to, I just find myself code-switching all the time. And I think that's just an aspect of just knowing how you present yourself in certain situations is sometimes a protective mechanism."*
>
> – Roderick, 25, bisexual, man

Some interviewees very explicitly discussed how mentally and emotionally taxing these proximal stressors can be. Even among those who did not outright discuss these impacts, many spoke about these experiences with a tone of voice or body language that I understood to mean "I shouldn't have to do all of this work."

As mentioned above, distal stressors typically took the form of microaggressions. Participants described other Black people speaking negatively about queer people or using outright homo- and transphobic language in their presence, with or without knowing that they were in the presence of a queer person.

For Roderick, being in the barbershop – a place of deep social significance for Black men – is often fraught.

> *"There was this barbershop [where I grew up in the Midwest] and it was Black owned, and all the barbers were Black, of course. And one day we're talking about the hypotheticals of having a queer son. And they started talking about how if they have a queer son, the son would have to take the mom's maiden name because they don't want that queer son to have their name. And just all this really toxic stuff, this very homophobic stuff. And my barber at the time, I think clocked me. And because of that, was the only person in the whole barbershop who was not partaking in any of that. While I was in the chair, while he was lining me up and whatnot. And in my head I was like, 'This person has most likely seen in me or assuming in me queerness and is not particularly on this because they don't want to contribute to this'"*
>
> – Roderick, 25, bisexual, man

In the dating context, some interviewees described seeing anti-Black messages on dating apps (e.g., dating or hook-up profiles that say "no Blacks") or experiences of being othered while in public with their partner. For Amaya, she has had enough interactions with others on dating apps that she has started to question people's intentions, worried that she's being fetishized as a Black queer woman.

> *"Yeah, it was hard when I couldn't match with more Black queer people [on dating apps]. It was always White queer people and I was wondering is it a fetish or something? So I always kind of questioned the intentions behind why people liked me."*
>
> – Amaya, 26, queer, woman

For Bridget, geographic and political contexts influenced her comfort level when in public with her partner. She described the place she lived during college as "extremely racist" and discussed an overtly homophobic experience while living there. Interestingly, when Bridget mentioned this experience – which involved the use of a slur – it was almost treated like a throw-away comment. She spoke at greater length about the impact of the general climate on her willingness to engage in public displays of affection with her partner.

> *"Even just being in [a small mid-Atlantic town] we stopped showing any PDA very early, I remember probably within the first two weeks of moving here, I had never been gawked at like that in my life. The level of head turn, but excessive in an extremely uncomfortable way…I've definitely had the drive-by screaming, "faggot" out of the window. I've had that. I don't know, yeah, I think in college I was really scared, especially during the Trump election of showing PDA with my ex at the time because that campus was extremely racist, it already felt uncomfortable adding a queer layer to that. It was like I was just asking for it is what it felt like. So, we were very private then."*
>
> – Bridget, 25, pansexual, woman

In this instance, Bridget also discussed the impact of place, as well as the political climate at the time. Many interviewees had lived in multiple cities or states in their lives and discussed the differences in their comfort level, often due to the politics of each community, with being "visibly" or openly queer. For example, one interviewee grew up in a mid-sized town in Kansas where they feared social repercussions if they disclosed their sexual identity. Now, living in a major metropolitan city characterized by far more liberal politics, they feel far more comfortable living authentically.

Distal anti-queer stressors were also evident when interviewees were asked how they were socialized to queerness by family, community, and media. These discussions ranged from outright rejection of queer identities from family members, often due to religious beliefs, to a lack of Black representation in queer media. Tremaine very succinctly shared the way that he was socialized to queerness in his family. In fewer than a dozen words, he communicated how his family felt about LGBTQ+ people; they spoke in sweeping terms and assumed some level of "sexual deviance," all in the context of non-affirming religious beliefs.

> *Interviewer: "So, what kind of messages did you get growing up about either your own identities or the ways that LGBTQ folks and communities were talked about in general?"*

Tremaine: "They're all weirdos. They're perverts. They're going to burn in hell."

– Tremaine, 26, gay, nonbinary

Tianna struggled to understand why, despite her efforts to correct or educate her family, they continue to use homophobic slurs in her presence. During this portion of the interview, it was clear that Tianna was a bit exasperated as she did the work of trying to make her family more accepting of her identity, and ultimately her.

"But I think from those messages, it's 'Anything that's not straight is deviant, so don't' essentially. And then they've used a lot of derogatory terms, the F word, the D word, and even though I've told them like, 'Hey, that's not okay.' It's like why?"

– Tianna, 26, bisexual, woman

Interviewer: "It sounds like queer media was really instrumental in you understanding yourself. If queer folks were not being talked about, did you learn a lot about yourself from what you watched on TV? Or at least gain a language for what it was?"
Jayden: "Yeah, I did gain a language for what it was, but it's funny because now I guess I'm in a part of my journey where I'm learning, but that was the White language…To fill their quota of a gay person on TV, they're more likely going to be White. If they're going to put a Black gay person or a minority that is other than White, that's gay, what's going to happen is that they're going to be dating a White person or they going to be best friends with a White person. They can never just give people of color their chance to shine. It's always something. Glee, they were White people. I'm trying to think. Love Simon, it's a White person. It's one of those things. Mainly it was a White person. He was with a mixed guy or something like that, but it was starring a White person. That's just always White. Then there's Love, the other one. The remake was a Hispanic guy, but he's dating White person. It's never two. It's never two."

– Jayden, 20, gay, man

Hearing Jayden's discussion of the lack of Black queer representation, the idea of "it's never two" was reminiscent of the Bechdel test, a measure of female representation in media. So few films or television shows "pass the Bechdel test" and,

to Jayden's point, our popular media in the U.S. likely would not pass a similar measure for Black queer representation.

Anti-Black microaggressions tended to fall into one of two domains: White-dominant beauty standards and expectations of lower intelligence relative to White people. In Kandi's experience, despite her mother's efforts to proactively combat the negative messaging in our society about beauty standards, these messages were so pervasive that she still had moments as a child where she imaged looking more Eurocentric.

> *"I grew up in a very pro-Black household, so my Blackness was never something I was necessarily ashamed of. I realized very early on that a lot of people would consider me ugly because of my complexion. I can just remember my mom fighting so hard for me to love myself as I am. I wasn't allowed to play with non-Black dolls. I was not watching the Disney Princess movies…I kept Brandy's Cinderella on. And yet somewhere in the mix, I also had a towel on my head pretending it was hair."*
>
> – Kandi, 25, Pansexual, Woman

When listening to Olivia discuss her experiences with white-dominant beauty standards, and even when reading her quote below, the impact of the microaggressions she experienced was evident – in one breath she moves from trying to give people the benefit of the doubt, expressing frustration, downplaying the experiences as "annoying," and ending with a statement that indicates she has resigned herself to accepting that these experiences feel inevitable. Unlike Kandi, however, she did not discuss any thoughts or behaviors that indicated she wished she looked different.

> *"I've been told [by peers] that features on my face and my skin tone and my hair are ugly or my nose is really big, my lips are really big, my forehead's really big. And sometimes it's because they don't understand that the comment that they're making is because of, I have Afrocentric features. I don't know.*

> *It's very frustrating to deal with because they don't understand that it hurts a lot. It's a small comment, like 'Oh, your forehead's kind of big.' And like I said, it's not too bad, but it's just annoying things that I have to put up with sometimes that I just wish I wouldn't have to."*
>
> – Olivia, 19, bisexual, nonbinary

Intelligence-based microaggressions were prevalent, specifically in academic or professional spaces. Interviewees, especially those who identified as women, recounted experiences of having their intelligence and competence questioned by peers and superiors. In this instance, Amaya discussed the role of her gender in how she understands microaggressive interactions that may be based on her Blackness as well.

> *"I think just some instances where in college I was at office hours and I feel like it was more because I was a woman than anything else, that there were a bunch of men who were just like, 'How can you understand this chemistry stuff?' And I'm like, 'Because I can and I put in work to know it.' So I feel like that was more based on sex than on being Black. But then with some other people I could tell it's like, well, there were other women who were also clashing with people. And then when it feels like it's especially coming at me, then I feel like it's more of the Blackness. And being in especially higher education, there's not really, I can think of one other Black person in the department. So then it feels like more of a race thing."*
>
> – Amaya, 26, queer, woman

At this point in the interview, Amaya illustrates how difficult it is for multiply marginalized people to make sense of which part of them is being "othered" in a given scenario.

Minority Stress and Mental Health

Given how rarely intersectional minority stress was discussed by interviewees, it is difficult to discuss the relationship between intersectional minority stress and mental health. However, participants did make connections between race- or sexual identity-minority stressors and their mental health. Although these stressors were

experienced in a number of contexts, the most salient context for discussing their mental health impacts was social relationships and dating. Instances of identity-based bias and discrimination left interviewees feeling hopeless, lonely, and like they simply were not good enough. For some, like Tianna and Tremaine, these feelings lingered for quite some time.

> *"I think in dating, it makes me feel a little hopeless just because I cannot change the fact that I am a Black woman to get more respect from people, and I cannot change that I am bi to get more respect from people who are in the LGBTQ+ community who don't respect that identity, who completely want to erase the B. So it feels a little hopeless when it's like things that I literally can't change or control, or even if you try to educate others, it won't change their view. They either believe it or they don't. So I think in those ways it makes me feel hopeless and a little less excited to engage in any dating or romantic relationships because I'm just waiting to find out what the problem is."*
>
> – Tianna, 26, bisexual, woman

> *Interviewer: "Tell me a little bit more about what it's like to see 'no fats, no Blacks, no Asians' those sorts of things coming from people through a screen?*
> *Tremaine: "It's more exhausting, I think, because it is anonymous, because it is, 'Oh, this is how you actually feel.' It makes me wonder, 'Okay, how many people am I interacting with that hold these beliefs that aren't going to say them, because they don't have the freedom of being anonymous?' That's also kind of sad, because that's a queer space specific example. But, we all share these identities. Why can't we just get along? Why must these other prejudices come in here?*
> *Interviewer: "How do those experiences make you feel about yourself?"*
> *Tremaine: "Pretty bad. I'm not good enough. I'm never going to be good enough. I have a husband now, so, well, I don't have to worry about that. Before him, it's just, I guess I'm always going to be lonely. I guess I'm always going to have to have these extra burdens in order to find happiness."*
>
> – Tremaine, 26, gay, nonbinary

Although there was a level of exasperation from both Tianna and Tremaine as they discussed the way that these experiences made them feel about themselves, they spoke slightly differently about these impacts. Tianna spoke from a place of hopelessness, despite trying to educate people – a form of emotional labor that came

up in interviews with the women in the sample far more often than with the men. Tremaine appears more frustrated by the anonymity of many of these interactions and the hypervigilance that they subsequently experienced, wondering just how many other people hold anti-Black views.

For others, like Jayden, these experiences were the impetus for challenging the messages they were receiving and ultimately find confidence and self-worth. The ability to use oppressive experiences as a means of building positive self-concept, a process I would liken to post-traumatic growth, is evidence of the resilience of Black LGBTQ+ people to flourish in the face of minority stressors.

> *"It did used to take a toll on me. It really did. I used to look in the mirror and be like, no matter what I did, I would feel like if I changed my hairstyle, if I really took time to into my skin routine to make my skin glow up even more, and also look in the mirror and be like, 'It's just not as good.' But then as I looked at it, I'd be 'As good as what?' Then I'd be, 'Oh, okay. Now I see.' It really did used to weigh down on me, but I'm getting to the point now where sometimes it's just best to break things down and to be like, 'Okay, well why wouldn't you be as good as this White person? If you have a full ride to school and you're smart and you're very emotionally aware, a lot of people aren't as emotionally aware as you, and you have these things going for you, but for some reason you feel like you're not enough. But you check off a lot of boxes that people would objectively say, "So why wouldn't you think you're enough?"*
>
> – Jayden, 20, gay, man

Mental Health Management Strategies

In the exploration of how Black LGBTQ+ young adults manage their mental health, interviewees described using combinations of strategies, within and outside of traditional systems of professional care. There was evidence for the buffering role of individual coping and community supports, including social connections with other

Black queer people, using self-care habits, and, for some, a reliance on their faith or spirituality.

Social support from other people, whether they were explicitly discussed as other Black queer people or not, were a common source of support as people manage their mental health. Of note is how commonly this social support came from friends as opposed to family members or other members of interviewees' communities, even among those who have supportive and affirming families. For Keilani, her preference when her mental health is suffering is to isolate and withdraw. Her use of social supports, primarily from friends, is a second option for her.

> *"Oftentimes when I was feeling low, I wanted to feel low by myself and I also didn't want to be a burden and oftentimes when I felt low, I would deal with it by myself, but if I was seeking support, I often sought it from my friends. I oftentimes leaned into my friends for support."*
>
> – Keilani, 24, bisexual, woman

For Lashawn, his social groups have normalized conversations about mental health and rely on each other for support.

> *"Mental health has always been a really big thing with my friend group. Spiritual health and physical health. At least physical health, to me. For them, it's here and there. But the spiritual and mental health is something. We want to be able to go to bed at night like babies. I don't want to go to bed with stress, and feeling upset."*
>
> – Lashawn, 22, gay, man

Interviewees also mentioned myriad self-care and other habits that they utilize when managing their mental health. These included being mindful about meeting their basic needs for sleep, food, and physical activity; mindfulness, meditation, and journaling practices; and setting aside time for intentional rest. As evidenced by the excerpt from Justine's interview, many participants have spent time over the years

finding what strategies work for them, and generally building a "toolkit" of sorts rather than relying solely on any one approach.

> *"I don't know. I think for me, the way I manage my mental health I think is step-wise in terms of if this, then that, right? If you do this and you feel better, great. You don't have to keep going up. But if you do this and you're still not feeling great, okay, move up to the next level. So in terms of, I guess I can use Maslow's hierarchy for this. It's like if you eat and you sleep and you go and run outside and smell some flowers and pet a dog, how do you feel after that? Good? Well then maybe you were just hungry or you just needed to hang out with somebody. Get out of your own head. If you do that and you're still not feeling great, okay, what's the next thing? Are you feeling okay at work? Is your school work fulfilling you, whatever? Are you okay at home? Has some relative made some kind of comment to you that you didn't like and you've been ruminating on it? If you do all that, then you feel better. Okay, great. You don't have to go any further. If so, well now go up to the next thing. Should you tell someone about this? Should you go to your parents? Should you maybe start journaling about it to see if you can come to for yourself what's going on? If you do that, you feel better. All right, great. You don't have to go further. If not, what's the next thing?"*
>
> – Justine, 21, bisexual, nonbinary

The use of multiple strategies is also evident in Figure 6.1. All of the mental health management strategies mentioned by interviewees appear around the outside of the diagram. The ring can be read like a pie chart: The larger the segment, the more often that strategy was mentioned by participants. Pink segments reflect strategies typically thought of as traditional/professional mental health services. The purple segments reflect basic needs and green segments include self-care practices and other management strategies. The lines that create a "web" inside the ring indicate how often any two strategies were mentioned in tandem by the same participant. Thicker, darker lines indicate pairs of strategies that were mentioned more frequently (i.e., by multiple participants).

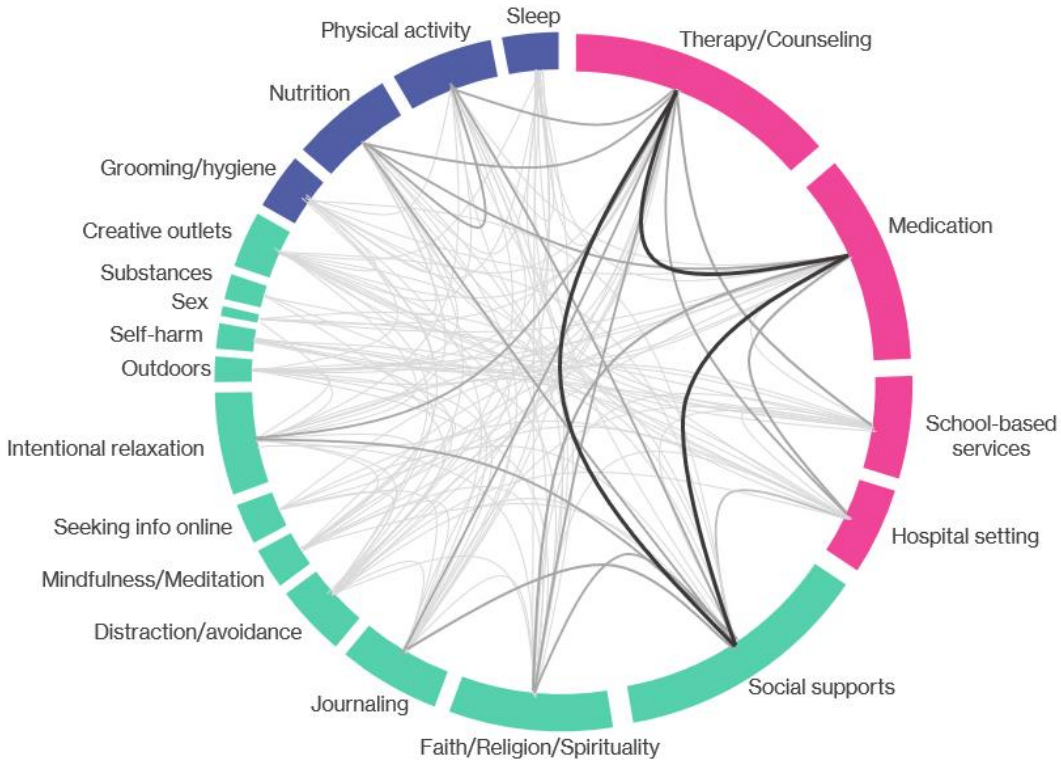

Figure 6.1. Interviewee Mental Health Management Strategies

The majority (75%) of the sample had utilized some form of professional mental health services (PMHS) since the age of 16. This included talk therapy in both outpatient and hospital settings, as well as the use of psychotropic medication. Thus, unsurprisingly, therapy and medication were commonly mentioned in tandem. Mia described her experience utilizing both strategies over the years and the non-linearity of the process.

> *"I have anxiety disorder. I know that that has came along with some panic attacks. I get anxiety attacks and panic attacks. They look different for me. And those are because of trauma. Well, I think the panic attacks started because of trauma. I think the anxiety attacks have always been there with reflection. I think I am when I'm... I've been told I intellectualize my feelings and my emotions. I'm currently in therapy trying to learn how to feel and trying to go on that journey. I've been medicated. I took myself off the daily anxiety medication and have just kept the pills for the panic, when I have panic attacks, I have medicine I could take that stops it essentially. And I got off medicine because I just wanted to try and go through the process and see if*

> *flushing it all out and going through it can alleviate some of this stuff. And if I realize it doesn't, then I have no problem getting back on medication. I just don't want to be on medication while I figure out, because I realize that all the medicine doesn't stop the symptoms. It doesn't stop the thoughts that I'm having. And then I feel crazy because I'm like, I want to freak out because of this, but I'm in this sedated space where in which I can't freak out because of this. Yeah, like I said, currently in therapy or I would probably say my fourth dose of therapy, trying to just find a good therapist to talk to and grow with but yeah."*
>
> – Mia, 22, lesbian, woman

Mia's experience highlights just how much effort she has put into managing her mental health over the years. She attributes her anxiety to past trauma; given that many people with unaddressed trauma tend to dissociate or struggle to "stay in their body," it is not surprising to hear Mia say that she intellectualizes her feelings and is learning to *feel* them. Mia also discusses the agency she has exercised in her mental health management process by making changes to her medication regimen and trying to do work with a therapist in the absence of anxiety medication.

College counseling settings were an often-mentioned setting for receiving mental health care. Not only were college students frequently using these centers, but they often served as entry points for additional forms of care. Sometimes, presumably unnecessary referrals to higher levels of care were made, resulting in traumatic experiences and a reluctance to re-engage with services in the future as was the case for Sammie. For others, talk therapy at the counseling center linked them to much-needed care, like psychiatric services for medication.

> *"Then I went to college and eventually I started having suicidal thoughts and I still had my therapist, but I had stopped for a little bit. And I was like, "Okay, I'm going go to the counseling center on campus and I'm going to see if I can get a therapist and continue on with these sessions." I think [the therapist] thought that I said that I actively wanted to kill myself. And so she sent me to the psychiatric unit."*
>
> – Sammie, 18, Lesbian, Woman

On the other hand, there were some people, like Ashlee, who got the stabilization they needed from the counseling center and expressed satisfaction with their experience.

> *"[I went to the] university counseling center. My parents had called. So they were contacting me, making sure that I came. It was pretty good. I enjoyed it. It helped me a lot, vote of self-confidence and it was good to have somewhere to go. So it helped a lot. Good advice. I think it was 12 sessions, but by the 12th one we were solid. She was like, "Okay, I just want you to work on being more social, doing things on your own." When I realized I could do things on my own, it was nice."*
>
> – Ashlee, 23, queer, woman

When asked to identify facilitators to utilizing PMHS, interviewees generally noted one main predisposing factor (beliefs about therapy) and one primary enabling factor (health insurance). Many of the people who had been to therapy mentioned knowing that therapy was an option, and a belief in its efficacy that came from their family or, later in life, other people around them who had sought PMHS before. In Leilah's interview, she discussed the nuances of family beliefs about therapy. Despite describing her mother as "pro-therapy," there still seemed to be a reluctance on her mother's part to seek services on Leilah's behalf when she was younger.

> *"I think it was one of those things that was like, I had no issue with therapy. I don't see why I wouldn't need it. But because my mom's sister has severe depression, and so I really wish she would've put me in therapy when I was younger because I think that I was also really depressed. And my mom has always been like, 'God puts things on this earth for a reason. It's no need to suffer talking about, I'm a pray it away. When you have doctors, you have therapists, you have all these things.' And so she's always been pro therapy. But I think the thought of us being having to be in therapy was a lot for her. Especially because my sister, her behavior just plummeted after she hit puberty. And so I think accepting that both of us would need therapy was a lot for her."*
>
> – Leilah, 23, pansexual, woman

Participants also identified barriers, some common in the United States across demographic subgroups (e.g., cost, insurance, trouble finding someone), and some more directly related to being Black and/or LGBTQ+ (e.g., fear of discrimination), or a combination of those things. Justine was one of the 25% of the sample who had never received PMHS. For her, she did not feel any stigma around therapy. The barriers for her were related to the practicalities of navigating the healthcare system.

> *"I think what's keeping me from pursuing therapy is just the US healthcare system. I'm just afraid it's going to be super expensive or it's not going to be covered under the insurance. Or maybe I'll find someone who looks really good on paper and then I go in the office and it's not a good match. Then I have to do the whole thing again of finding someone. It's really those US healthcare specific things. To me, there's no stigma in reaching out for it and wanting to do it."*
>
> – Justine, 21, Bisexual, Nonbinary

Not only did Amani discuss some of the more universal, practical barriers to care (insurance coverage), but she explained her preference for identity congruence with her provider.

> *"I'm struggling at first because I couldn't find someone that my insurance covered through my job and who also met all of my criteria being a person of color, preferably a Black person of color, someone who was either queer identified or was LGBTQ-friendly because those are the things they have on their profile sometimes. So there's in-network and out-of-network providers. And so my provider right now is an in-network provider, a therapist who is formally recognized by my health insurance provider as someone legitimate or credentialed or whatever else makes someone in network. They have some kind of contract. And in my early searches for therapists here, I kept finding providers who were out of my network. And so they weren't covered by my insurance, but they were so great. Black, lesbian. I was like, this is great. This is who I want to be my provider. I just want to feel inherently understood in certain ways. I wouldn't have to explain to a man, a Black man or a Black woman who was older or there were just so many different criteria when it came to age and identities and all these other kind of things that I was seeking. And so those are huge barriers because I don't want to be discriminated against by my therapist."*
>
> – Amani, 23, pansexual, woman

This was a common sentiment among interviewees – they generally desired for their providers to be other Black queer people to build a level of understanding of lived experience into their relationship. There was also a general recognition that this preference drastically limits the pool of potential providers or may not be realistic. Even still, interviewees might then widen their search by dropping the requirement that the therapist be Black and queer but still looking for providers who are Black and queer-affirming. As Amani alludes to, there was a sense among interviewees that going through the effort to find PMHS was taxing already; they did not want to then start a relationship with a provider who did not share some frame of reference for their lived experience.

Lastly, many interviewees discussed the quality of the PMHS they received. Almost every person who had engaged with these systems of care had a negative experience at some point. These ranged from therapists who were "fine" but weren't a good fit (sometimes due to identity incongruity) to microaggressions from providers and unnecessary referrals (as described above). Sidney describes a series of experiences with providers where she felt like she [incorrectly] assumed that the identities of her provider would not impact the quality of her care. Her experience also highlights the trial-and-error than many people experience when seeking PMHS.

> *"I went to a psychiatrist…and I remember I went to the session and it was a White man, and I forgot to say I wanted a Black woman, but I was like, 'You know what? They all went through the same training. It should be the same. He should know what he's doing.' And throughout our very little conversation, he basically said, 'Do you think it's your period?' I tried again with somebody else. She was a woman, but she was also White. She would just try to make it very like DSM, 'Were you having a manic episode for at least two weeks?' And I was like, 'No, but sometimes that's not how it shows up in my body.' And I just remember I had a frustration…I think it's like White*

> *people really don't care, and they're in a system where they don't have to care. And it just upsets me."*
>
> – Sidney, 19, lesbian, woman

Still, there were people who found themselves thankful to have had some support during times of crisis, even if the providers weren't a great fit. Tianna talked about where therapy ranks in her go-to mental health management strategies. She values having another person to interpret some of her emotions and experiences, as well as psychoeducation.

> *"[Therapy is] probably number one or two [option]. I want to say number two, where number one is medication, because that allows me to have a clear head to work through the stuff that we talk about in therapy. But I do find it useful to have that... Because journaling is just me saying the things, which is great, but then having that reflection and have someone else listening and interpreting that, or even just saying it back gives me more insight or suggestions or psychoeducation. That all is really helpful."*
>
> – Tianna, 26, bisexual, woman

Even if it was after a period of medical mistrust or reluctance to re-engage, many people eventually tried therapy again to great success. Sometimes this simply meant finding a therapist with some identity congruity, even if it wasn't a perfect fit. For many interviewees, the ideal therapist was one who shared their racial, sexual, and gender identities. However, there was a general recognition that finding a therapist like that is quite difficult. Thus, even finding a therapist with one or two of these identities in common was important to people. Most seemed to have found a good match with therapists who are Black and queer-affirming, regardless of gender congruity. Both Mia and Bridget stated that their ideal therapist would be Black and queer. Beyond these two aspects of the therapists' social locations, Mia was also interested in finding a therapist of the same gender and faith background. Bridget explained the reality of having to move away from her ideal therapist and provided

some insight about which aspects of a potential therapist's identity were priorities for her.

> *"In the perfect world, it would probably be a Black gay woman who has the same faith as me. I don't have to explain that whole treacherous thing because a lot of people look at me, how are you a Christian and you're gay? I don't like explaining all of those things."*
>
> – Mia, 22, lesbian, woman

> *"So, dream of dreams would've been to have a Black queer therapist, that's not possible. So, then I would keep it to just women. I eventually expanded it beyond to women of color, broadly."*
>
> – Bridget, 25, pansexual, woman

6.4. Discussion

This study qualitatively explored experiences of intersectional minority stress among Black LGBTQ+ young people, how those experiences impact their mental health, and the strategies this population uses to manage their mental health. Interviewees largely did not conceive of their identities in intersectional terms; they acknowledged occupying identities at the nexus of multiple forms of oppression, but they tended to describe themselves as Black first. Thus, they rarely gave intersectional meaning to their experiences of bias and discrimination. They did, however, discuss instances of homo- or transphobia in Black spaces and racism in queer spaces, experiences which did have a deleterious effect on their mental health. To manage their mental health, interviewees discussed a number of strategies like social supports and self-care, as well as utilization of PMHS and the facilitators and barriers therein.

Most interviewees did not describe their understanding of their identities in ways that align with extant intersectionality research. Because their Blackness is something that they cannot shed or "hide" like they might be able to do with their

queerness, participants in this study often stated that they view themselves as Black first. Certainly, most participants stated that others tend to treat their Blackness as the most important aspect of who they are. Here, we see the potential for the way that people are perceived in the world affecting their self-described identity centrality (i.e., the looking glass self). This can be described as the "up-down" model outlined in Hunter (2010) whereby Black gay men express feeling "Black-then-gay" or "gay-then-Black" as approximately 50% of that study's sample did.

However, this does not necessarily mean that study participants move through the world in distinct parts. For example, Bowleg (2003) found that Black lesbian women "contextualized their experiences of sexism and heterosexism through the prism of racism." Similarly, the participants in this study may view their queerness or gendered identities as secondary but still related, to their Blackness. Notably, there were some interviewees who believed that their Blackness, queerness, and maybe even gender cannot be separated (i.e., interlocking identity conceptualization; Hunter, 2010). These individuals tended to be in graduate school or have advanced degrees, particularly in the social sciences. Thus, this subgroup difference may reflect a level of exposure to, and understanding of, intersectional theory.

This "up-down" conception of multiple identities also extended to attributions when discussing experiences of bias and discrimination. Interviewees struggled to recount instances of discrimination because they are both Black and queer. They did, however, offer numerous accounts of racism – including those in queer spaces – and homophobia, especially in Black spaces. Although there were some accounts of overt bias (e.g., having slurs directed at them), the experiences shared were largely

microaggressive. Numerous studies have documented Black LGTBQ+ people's experiences with microaggressions (Balsam et al., 2011; Crichlow, 2004; Nadal, 2011; Sue et al., 2007; E. G. Ward, 2005; R. Willams, 2023); the accounts in this study add to that body of evidence. Racism in queer spaces was typically described as a general sense of not belonging among White queer individuals; there is a disconnect in lived experience and, for some, a level of hypervigilance as Black queer people anticipate some kind of slight from White queer people. Sexual identity-based hypervigilance has been studied in general LGBTQ+ samples (Keating & Muller, 2019; Mink et al., 2014; Timmins et al., 2017) but, to my knowledge, race-based hypervigilance among Black LGBTQ+ people has not.

Similarly, the participants in this study shared numerous experiences of homo- and transphobia from Black communities. Sometimes this came from deeply rooted religious beliefs about homosexuality and gender diversity (Mosely, et al., 2016). For those in the study who were male-identifying in childhood, there were rigid notions about Black masculinity infused with heteronormativity (Ward, 2005; Watts & Bentley, 2021). Regardless of the form that the bias took, study participants discussed these experiences making them feel helpless and lonely and leaving them with lower self-worth. These effects are aligned with the psychological mediation framework (Hatzenbuehler, 2009) and minority stress theory (V. Brooks, 1981; Meyer, 2003) whereby stigma-related stress creates elevations in psychological factors that confer risk for clinically significant mental health problems, including in Black LGBQ samples (Jackson, et al., 2020).

Regardless of the role of minority stressors, almost every study participant mentioned at least one period of poor mental health. Thus, it is important to understand how Black LGBTQ+ young people choose to manage their mental health. In this study, 75% of participants had received PMHS of some kind since the age of 16, reflecting a general willingness to seek formal mental health supports (e.g., talk therapy, medication). However, doing so was not always simple. Study participants reported contending with stigmatization of therapy in their families and communities, cost and insurance barriers, and frustration with the process of finding a therapist. Still, for those who did "get through the door," there were issues of treatment quality. In this study, these included difficulties receiving the needed kind of care (e.g., navigating bureaucracy to get medication or psychological testing) or unnecessary referrals to higher levels of care (e.g., hospitalization). Additionally, provider fit was discussed often. For many, the ideal therapist was one who shared multiple identities with the client. This was generally difficult to find and many interviewees discussed needing to adjust the filters they used when looking for a therapist. Even still, some described experiences of microaggressions from providers based on sexuality, gender, or race, something that has been documented in the literature (Johnson, 2014; Owen, et al., 2014). This was enough for some to keep them from seeking services when needed.

Based on Andersen's (1973) model (see Figure 6.2), facilitators of receiving this care primarily included a predisposing factor (positive beliefs about therapy) and an enabling factor (having health insurance). Although these views may change over time, PMHS utilization remains stigmatized in many Black communities. These

beliefs are sometimes rooted in institutional mistrust (i.e., therapy will do more harm than good), negative views of mental illness, or views that therapy will not work (Moore, et al., 2020). Additionally, mental health services are often in conflict with Black sociocultural beliefs about self-reliance (N. D. Williams, 2023) and/or religious beliefs (Lukachko et al., 2015). Thus, participants for whom therapy and medication were destigmatized seem to have been predisposed to view these interventions as options for managing their mental health. Additionally, cost is a common barrier to accessing PMHS; having health insurance that includes coverage for mental health services (as most participants did) enabled them to access services when they otherwise may not have been able to.

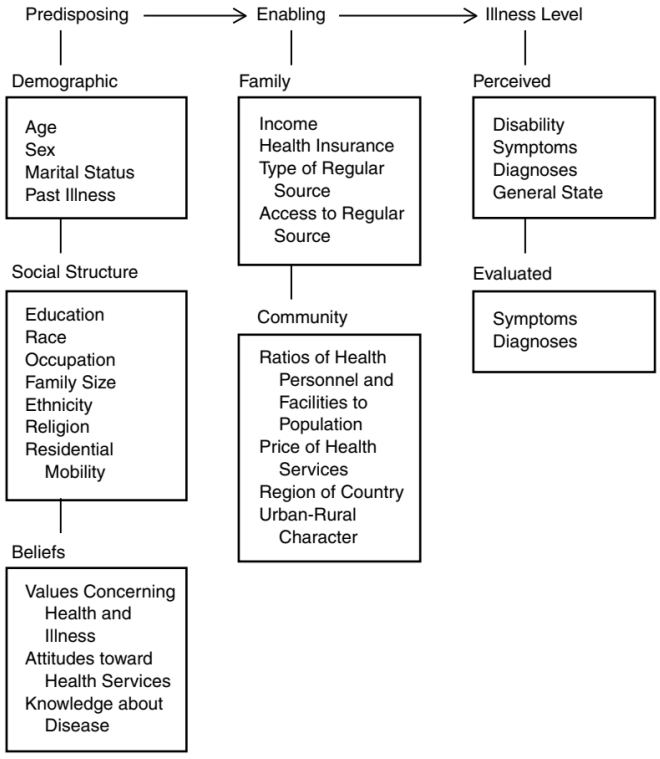

Figure 6.2. Andersen's Model of Health Service Utilization: Individual Determinants

PMHS were one component of the constellation of strategies study participants used to manage their mental health; they were rarely used in isolation. Participants mentioned mindfulness, medication, and journaling practices, as well as other self-care strategies like making sure their basic needs (e.g., sleep, nutrition, physical activity) are met or finding time for intentional relaxation. Seemingly, these tools were commonly used as supplements to, not substitutes for, PMHS.

6.4.1. Limitations

There are limitations to the study that should be noted. First, this was a highly educated sample, with 25% of people currently pursuing a college degree and 67% holding a college degree or higher. This may have led to a more critical understanding of the theoretical tenets underlying this study for some participants (i.e., intersectionality) and higher access to PMHS by way of university counseling centers. Additionally, the mental health needs and management strategies of this sample may be different from people with lower levels of education and, by proxy, economic resources. Things like therapy are viewed by many Black people as "something for White people" or "bougie." Additionally, as mentioned above, therapy does not align with Black cultural norms of self-sufficiency, a belief that may be more prevalent among lower-income people. Lastly, the strategies used by lower resourced individuals outside of traditional systems of care may look different than those employed by this sample. For example, substances like alcohol and recreational drugs are commonly used to cope with [minority] stressors, including economic ones, that may not have been as prevalent for people in this sample. It is also possible that

social desirability bias preventing many of those in this sample from disclosing these types of coping.

Additionally, this study's sample included only a small subsample of people who had never sought PMHS. Thus, while we have an understanding of the other mental health management strategies used, we do not have many accounts of what people are doing instead to take care of themselves. Future research should include more participants who have not engaged with these formal systems of care.

There are also limitations related to the data collection structure and processes. Although changes were made to the interview protocol as a consequence of the memoing process, it is possible that participants may have spoken about their identities or their minority stress experiences differently if I had phrased the questions differently. For example, the interview questions about minority stress specifically use the word "discrimination." As a research construct, discrimination is only one form of minority stress; I could have revised the wording and used language like "bias" or "stigma" when discussing these experiences. Perhaps using less specific language would have elicited different responses, including more intersectional minority stressors. Additionally, conducting focus groups instead of individual interviews may have allowed for the collection of more process-oriented data as participants discuss their responses with each other. Participants also may have learned from each other through a focus group format, whereby those with more exposure to, or knowledge of, intersectional theory might have challenged others to view themselves and their experiences more intersectionally than they did in the interview context.

Lastly, future qualitative research on this subject may take a life course and/or longitudinal approach that attends more to the temporality of experiences, more concretely linking minority stress processes (distal and proximal) to mental health management and service utilization. In addition to different methods, future research questions may explore the specific experiences of people with additional intersectional identities (the role of masculinity, Black + queer + religious, added layer of gender diversity).

Table 6.4. Interviewee Demographic Characteristics (n=24)

	n	%
Sexual Identity		
Bisexual	7	29%
Gay	4	17%
Lesbian	3	13%
Pansexual	5	21%
Queer	5	21%
Gender		
Man	5	21%
Nonbinary/Genderqueer	5	21%
Woman	14	58%
Sexual Behavior		
Never had sex	6	25%
Only men	7	29%
Mostly men, some women	4	17%
Equally men and women	3	13%
Mostly women, some men	2	8%
Only women	2	8%
Sexual Attraction		
Only attracted to men	4	17%
Mostly attracted to men	2	8%
Equally attracted to men and women	11	46%
Mostly attracted to women	6	25%
Only attracted to women	1	4%
Education		
High school diploma/GED	2	8%
Some college	6	25%
College degree (Associate's or Bachelor's)	12	50%
Master's degree	3	13%
Professional or doctorate degree	1	4%
Relationship Status		
Single	12	50%
In a committed relationship	10	42%
Married	2	8%
Income		
Less than $20,000	4	17%
$20,000 - $49,999	7	29%
$50,000 - $74,999	5	21%
$75,000 - $99,999	5	21%
$100,000 or more	3	13%
Health Insurance		

Yes	23	96%
No	1	4%
Coverage Gap (Past-Year)		
Yes	2	8%
No	21	88%
Not sure	1	4%
Mental Health Coverage		
Yes	15	63%
No	1	4%
Not sure	8	33%
Mental Health Service Use		
Yes	18	75%
No	6	25%
Severe Psychological Distress		
Yes	5	21%
No	19	79%
	Mean	SD
Age	22.6 years	2.57 years
Feminine Gender Expression (0-100)	61.1	23.4
Masculine Gender Expression (0-100)	42.8	26.1
Psychological Distress (K6)	8.8	4.4

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Concluding Remarks

7.1. Summary of Major Findings

In summary, findings highlight the role of sociocultural experiences and context (e.g., identity centrality in discrimination experiences, cultural stigma around mental health and help-seeking) in understanding differences in risk for major depressive episodes (MDE) and severe psychological distress (SPD), as well as differences in professional mental health service (PMHS) utilization. Models in Study 1 suggest that LGBTQ+ identity (and likely, by proxy, heterosexism) is associated with poorer mental health among Black people but that Black identity (and the racialized experiences therein) may be protective among LGBTQ+ people. For example, in models limited to Black respondents, Black males and females had higher odds of both MDE and SPD relative to their heterosexual counterparts. Yet, in models limited to LGB individuals, Black males and females had lower odds of both outcomes. The full sample models in Study 1 did not illuminate any clear patterns in heightened mental health risk among Black LGB adults (as compared to White heterosexual individuals). However, in models restricted to LGB participants, Black LGB males and females were less likely to report MDE and SPD relative to their White LGB counterparts. This aligns with the first of the two paradoxes outlined previously; although Black people experience anti-Black racism, these experiences do not appear to confer risk for depression. However, the second paradox, that Black people evidence higher rates of SPD, was not supported.

Although identity-based bias happens in many social contexts, heterosexism in Black spaces may be more common, and/or have stronger deleterious effects on mental health, than racism in queer spaces. If we consider a frequency hypothesis that heterosexism from Black people may be more common than racism from queer people, which was certainly true among participants in Study 3, consistently being othered by Black people based on your sexual identity would theoretically confer higher risk for mental health issues relative to that of heterosexual Black people (Hatzenbuehler, 2009). Another hypothesis is based on identity theory and the function of identity centrality as an explanation for heterosexism from Black people having a stronger deleterious effect. If we assume high levels of Black identity centrality, as was evidenced in Study 3 interviews, heterosexism from Black people may create a dissonance of sorts whereby Black LGBTQ+ people are rejected by their primary in-group, leading to elevated risk for mental health symptomology. Identity centrality could also help explain the lower prevalence of MDE and SPD among Black LGB people relative to White LGB people. In Black racial identity literature, identity centrality has long been seen to buffer the effects of anti-Black discrimination on mental health outcomes like psychological distress (Haeny et al., 2023; Sellers et al., 2003). Given how commonly Black identity centrality was discussed by interview participants, this could be the case in the Study 1 sample. Future quantitative research should include measures of identity centrality to explore this hypothesis. A third explanation for these findings is related to socialization. Based on the experiences of Study 3 participants, Black queer young people are being actively and positively socialized to their Blackness by their families. Black racial socialization often

includes preparation for bias and other processes that can buffer against the negative mental health effects of anti-Black racism (Reynolds & Gonzales-Backen, 2017). However, analogous protective LGBTQ+ socialization processes were not taking place for Study 3 interviewees. Thus, for example, when Black queer people are faced with anti-queer comments from Black folks, they have not been equipped to cope with homophobia in the same way they have been socialized to cope with anti-Black racism.

In Study 2, LGB people were consistently more likely to use PMHS than heterosexual people of the same race and sex. This may speak to a general destigmatizing of seeking services in queer communities. Even among Black people, for whom mental health need and help-seeking are generally stigmatized, holding an LGB identity may weaken this barrier. Indeed, 75% of the Study 3 sample had utilized PMHS since the age of 16, a proportion that is likely not typical in general samples of Black adults. This may be due to characteristics of the sample. For example, there may be a generational effect whereby help-seeking is less stigmatized among Black young people relative to their elders. Additionally, as people work to integrate the sociocultural norms of both Blackness and queerness, the relative normalization of therapy among queer persons may override the stigma that characterizes Black culture. This may especially be the case if one's mental health struggles are caused, maintained, or exacerbated by heterosexism coming from other Black people (e.g., family members) in your life as was often the case for Study 3 participants.

7.2. Strengths and Limitations

This investigation has limitations to note. First, the data from the NSDUH are self-reported, thus their accuracy depends on the respondents' truthfulness and memory and may be impacted by social desirability and/or recall bias. The administration of most questions by ACASI is designed to provide respondents with private and confidential means to increase the level of honest reporting of sensitive behaviors. Second, the NSDUH provides cross-sectional information about the variables of interest. Thus, data provides a prevalence of constructs like mental health outcomes and service utilization at one point in time rather than a view of how these things change over time for specific individuals. Third, in the measurement of MDE, no exclusions were made for MDE caused by medical illness, bereavement, or substance use disorders. Thus, the cause/context of each respondent's MDE is unknown. It should also be noted that both MDE and psychological distress are measured as past-year variables; any disparities identified in this analysis may look different if the questions assessed these variables over different time periods (e.g. lifetime, past 30 days). Further, to my knowledge, the Kessler-6 has not been validated on U.S. samples of Black adults. Thus, as we continue to interrogate the mental health of Black communities and the disparities therein, assessing the construct and internal validity of our measurement tools remains crucial. Additionally, given the strong empirical support for the role of stigma, bias, and discrimination in mental health outcomes, it is important to note that the NSDUH does not measure these experiences; thus they cannot be included in Study 1 and Study 2 models. Finally, this study utilizes a large, population-based survey that gives

confidence when generalizing the findings. However, it should be noted that the NSDUH samples noninstitutionalized, civilian populations excluding approximately three percent of the U.S. population (Lofquist et al., 2012), including members of the active-duty military and individuals in institutional group quarters (e.g., hospitals, prisons, nursing homes, treatment centers). These are populations where Black persons may be overrepresented; thus, the inferences made may not generalize to members of the excluded populations.

To address some of the limitations of Studies 1 and 2, Study 3 sought more nuanced and contextualized information about identity, mental health, and mental health management among Black LGB young adults. However, this approach also has limitations. First, participants did not have to be "out" in order to participate in interviews. Although identity disclosure was not directly captured (in demographic questionnaires or the interview protocol), all participants were "out" in at least one context, most often with friends and, for many, with family. Thus, the mental health outcomes and management strategies of Black LGB young adults who have not disclosed their sexual identity – and therefore may suffer more compromised mental health, added barriers to accessing traditional mental health services, etc. – are not adequately captured in the data. Similarly, the inclusion criteria included having a non-heterosexual sexual identity. Other research has examined the experiences of sexual minorities based on self-reported attraction or sexual behavior. The decision to only interview those who have adopted an LGBTQ+ identity label may have excluded those who have, for example, same-sex attraction or have engaged in sexual behavior with people of the same sex/gender, but do not identify as LGBTQ+. Additionally,

transgender, nonbinary, and other gender diverse individuals were allowed to participate, but the interview protocol was focused on their experiences as sexual minorities. Future qualitative examinations of mental health [management] may intentionally incorporate experiences related to gender identity to illuminate any unique mechanisms therein. Finally, screening-in required internet or mobile internet access which may have excluded many lower-resourced individuals.

Despite these limitations, the current study has notable strengths. First, it heeds the call of researchers who encourage the use of multiple methods of investigation to make sense of the complexity of the Black LGB experience (Cyrus, 2017). Additionally, it makes unique contributions to the literature by examining disparities in mental health and treatment utilization at the nexus of sex, sexual identity, and race/ethnicity. This kind of public health-style disparities study has not yet been done with the NSDUH. Further, the inclusion of within-Black LGB analyses is a novel contribution to our understanding of Black LGB mental health. The qualitative approach in Study 3 centers the voices and lived experiences of Black LGBTQ+ young adults, something that is rare in the literature.

7.3. Implications & Future Directions

Mental health and how individuals manage it are key topics of interest in public health. Given the longstanding inequities in both of these domains (i.e., indicators of mental health and utilization of PMHS) based on race/ethnicity and, separately, sexual identity, understanding patterns of risk and utilization can advance health equity in the US. First, these findings challenge prevailing conceptualizations of Black LGBTQ+ mental health [management]. Common measures of mental health

in population-level surveillance systems, like the Kessler-6, may not accurately capture the symptomology of constructs like depression and anxiety, particularly given their somatic nature in Black bodies (Barnes & Bates, 2017). This investigation also challenges the narrow definition of mental health management as being synonymous with the use of PMHS. Although many of the people in both Study 2 and Study 3 reported using PMHS, they are not to only way to manage mental health. Further, Study 3 participants often use PMHS in conjunction with other strategies. Thus, Black LGBTQ+ people may view things like therapy as necessary, but not sufficient whereas our large surveys seem to assume that PMHS is always sufficient. To that end, findings can inform targeted interventions aimed at supporting the mental health of Black LGB persons, including professional, therapeutic interventions as well as those outside traditional mental health care systems. Cultivating social connections, especially with other Black LGBTQ+ people and making sure to take care of one's basic needs for nutritious food, adequate sleep, etc. may also bolster mental health. Lastly, mental health professional disciplines are still working to cultivate a competent workforce that meets the needs of racial and sexual minority individuals (N. D. Williams, et al., 2022). The findings from this study can also inform workforce development and training efforts about the mental health needs and management strategies of Black LGBTQ+ persons, including those that may be different from heterosexual Black persons and/or White LGB individuals.

More detailed suggestions for future research directions are provided at the end of Chapters 4-6. However, additional suggestions based on the investigation as a whole are offered here. First, given the significance of covariates in many of the

Study 1 & Study 2 models, future research should consider more sophisticated statistics that can explore the extent to which these variables moderate or mediate these associations. This will result in a more nuanced, causal understanding of the disparities observed in this investigation. Additionally, neither Study 1 nor Study 2 directly measured identity-based discrimination. Thus, interpretation of the associations observed is limited to theoretical explanations (e.g., minority stress, intersectionality). Future large-scale, representative studies should measure identity-based discrimination, including measures of intersectional microaggressions, to draw more direct conclusions about the role of these experiences within the healthcare system and in general life in poor mental health and management strategies. Additional future lines of inquiry may include longitudinal, mixed methods studies that elucidate changes in how people understand their sexual and racial/ethnic identities over time, changes in mental health over time, the role of [intersectional] minority stressors in those mental health changes, and real-time mental health management decision-making processes. As the mental health workforce continues to make progress in training providers who are competent in working with sexual and/or racial/ethnic minorities, especially if institutional policy is enacted in support of this progress, there are also opportunities to explore client satisfaction with providers/services (e.g., perceptions of provider competence) and effectiveness of the services they receive.

7.4. Conclusion

In conclusion, in the context of minority stress theory and tenets of intersectionality, this investigation highlights the importance of social context and

identity-based factors in the risk of mental health issues and patterns of PMHS utilization among Black LGBTQ+ adults in the United States. The experience of being a sexual minority in Black contexts appears to have more serious deleterious effects on mental health than being Black in queer contexts. This investigation sought to illuminate the inequities in mental health risk and PMHS utilization at the intersection of race/ethnicity and sexual identity; these results should help spur future research to replicate the findings of this study with other samples, or examine potential explanations for the inequities observed.

APPENDIX A: FINAL INTERVIEW PROTOCOL

Interviewer instructions are in [brackets]. All numbered questions should be asked directly to participants. Questions beginning with letters are suggested/optional probes and only need to be asked if the participant's response to the preceding numbered question is insufficient.

INTRODUCTION [interviewer let participant know:]

- Interview will last about 2 hours
- We're going to start by just getting to know each other. This part of the interview will not be recorded.
- I'll then turn the recording on and we'll talk about who you are and how you came to understand different aspects of who you are. Then we'll discuss some things related to mental health and the way you manage your mental health. There are no right or wrong answers, we're just having a chat about your thoughts and experiences.
- We'll take a break midway through the interview, but you can also take a break at any time
- You're also welcome to skip any questions or stop participating whenever you'd like
- A quick reminder that when you signed the consent form you agreed to the "formal interview" portion of today's conversation being recorded. This is just for me to go back to as I write up this project; my research advisor may hear some of it but it'll be kept private.
- Just a reminder that what we discuss today will be kept confidential. When I write these interviews up, nothing you say will be attached to your name and I will only use direct quotes when it's necessary to communicate exactly what was said. That said, we are going to discuss topics that some people find sensitive or difficult to talk about. I am required to report any information you share about a desire to hurt yourself or someone else, as well as suspected past/current child abuse or neglect, to the proper authorities.
- Any questions before we get started?

GETTING TO KNOW YOU

Interviewer introduces herself (including name, pronouns, program of study, hometown, etc.)

Participant introduces themself (will likely mirror information provided by the interviewer but will not be required to disclose anything in particular)

Interviewer will then lead the conversation around general getting-to-know-you type topics, including (but not limited to):

- Have you ever lived anywhere else?

- Favorite sports teams
- Recent TV/movies seen
- Have pets growing up?
- Any siblings?
- Hobbies and leisure activities

About 25 minutes into the conversation, interviewer will ask the participant if they have any questions about their participation in the study.

[Answer participant questions and confirm that they are ready to shift into interview questions]

[Tell participant that you'll start the recording now and being recording on appropriate device(s)]

PART 1. IDENTITY

This first set of questions are about who you are.

1. **We all have different aspects of who we are. ~~For example, I'm a cisgender, queer, Black woman. I'm also a student and a researcher, a daughter, a sister, etc.~~ Which aspects of you are most important to you?**

2. **How do you see yourself racially? How would you describe your sexual orientation? (if not mentioned above)?**

3. **How would you describe the relationship between your Blackness and your sexual orientation?**

    a. **Do you feel like you're Black first, [LGB] first, or is it even possible to separate these identities?**

    b. **Do you feel like being Black and being [LGB] work together or are they ever in conflict with each other?**

    c. **Are there spaces or relationships with people where being Black or being [LGB] is expressed differently?**

4. **Which parts of you do you think other people treat as most important? ~~What do they see first?~~**

5. **When you were growing up, what messages did you get about being Black?**
   [Probe for socialization messages from family, peers, community, and media]

    a. **How did those messages about being Black affect you back then?**

b. **In what ways do they impact your life today?**

6. **When you were growing up, what messages did you get about being [LGB]?**
   [Probe for socialization messages from family, peers, community, and media]

   a. **How did those messages about being [LGB] affect you back then?**

   b. **In what ways do they impact your life today?**

Thank you for sharing these experiences with me. We may come back to some of these later in the interview.

PART 2. INTERSECTIONAL EXPERIENCES

Now we're going to shift gears a bit and instead of asking you to discuss yourself in parts, I'd like you to think about your experiences being Black and [LGB].

1. **First, what are the best parts of being a Black [LGB] person?**

2. **How have you found community among other Black [LGB] people?**

   a. If yes: **What do those community connections look like? What do they mean to you?**

   b. If no: **Do you wish you had community with other Black [LGB] people? Why or why not?**

3. **In what ways do you feel connected to the broader LGBTQ community?**

4. **In what ways do you feel connected to Black communities?**

5. **In what ways is being a Black [LGB] person difficult?**

6. **How have you ever experienced discrimination because you're a Black [LGB] person?**
   [Probe for discrimination across domains of life e.g. while socializing/dating, in healthcare, in faith communities, etc.]

   a. **What was that experience like for you?**

   b. **How did that experience make you feel about yourself?**

7. **Is there anything else you'd like to share about how you think about your identities?**

Thank you for sharing that part of yourself with me. We're about halfway done. Would you like to take a break?

PART 3. MENTAL HEALTH EXPERIENCES

The next set of questions are about your mental health.

1. **What comes to mind when I say "mental health"?**
   [Probe for comfort with the topic, personally-held stigma or stigma in their community/environment]

2. **How would you describe your mental health in general?**

3. **How has your mental health changed over time?**
   [Probe for improved and/or worsened mental health around key developmental milestones e.g. during middle school, during high school, during awareness of LGB identity, during LGB identity disclosure, etc.]

4. **Have you ever had an experience related to you being a Black [LGB] person that you feel boosted or improved your mental health?**

5. **What kinds of experiences might boost or improve your mental health as a Black [LGB] person?**

6. **How have you seen discrimination affect the mental health of other Black LGB people you may know?**

7. **Thinking about the discrimination you mentioned previously, how did that experience affect your mental health?**

I really appreciate your transparency about this stuff. I know it can be hard to talk about.

PART 4. MANAGING MENTAL HEALTH

Our last set of questions is about how you manage your mental health.

1. **If you've ever struggled with your mental health, how did you deal with that experience?**
   [Give space to discuss multiple periods of poor mental health, if applicable, and how each was dealt with]

   If help-seeking not mentioned: **Did you seek help from anyone around you?**

   If help-seeking behavior mentioned: **How did you know when you needed help?**

2. **How did you decide what kind of help made the most sense?**

a. **What was going on in your life at the time that made it easier to get that help?**
   [Probe for insurance, distance to services, beliefs about effectiveness of help, etc.]

b. **What was going on in your life at the time that made it harder to get that help?**
   [Probe for insurance, distance to services, mental health stigma, previous bad experiences seeking services, etc.]

3. **If you were struggling with your mental health to the point of needing help today, where would you turn for help?**

   a. **Talking to a therapist is one of the ways that people manage their mental health. How high/low is therapy on that list?**

   b. **Why is therapy more/less desirable compared to other options?**

4. **How would you describe the mental health resources available where you live?**
   [Probe for knowledge of existing services, accessibility/distance]

5. **If you lived in a different place, do you feel like you would have different options for help?**
   [Probe for certain parts of town or certain parts of the country]

   a. If yes: **What options do you wish you had where you live?**

6. **If you had the power to support the mental health of people in your community, what would you change?**

7. **Is there anything else you'd like to share about your mental health or the ways you manage it?**

PART 5. WRAP UP

Thanks so much for your time today. I just want to ask two wrap up questions before we hop off the call.

1. **First, I'm curious how you found out about this study and what motivated you to participate?**

2. **Once all of the interviews are over, I'm going to go back through them and find themes and draw some conclusions about the experiences of the people I've talked to. Before I write the final paper though, I want everyone I've talked to to hear my conclusions and tell me if I accurately synthesized what**

we talked about. Would you be willing to hop on Zoom in a month or two to have this conversation individually with me?

That's all on my end. Anything else before we go?

APPENDIX B: EXAMPLE MEMOS

2/25/2023

Blackness and queerness are the most common identity parts that people describe as being most important to them, but most people think that others see their Blackness first.

> See what happens if I don't prime them by leading my list of identities with race and sexed and see if this changes
>
> Tried this with interview SS and got a similar response as other interviews " I'm Black first, then woman, then gay" In AB interview, the open-ended approach seemed to work well.

There seems to be general consensus that Blackness and queerness are often in conflict with each other

> Feeling like you don't fit fully within either Black communities or queer communities (Anti-Black racism in LGBTQ spaces and homophobia in Black spaces)

When people were able to identify ways that these identities work together, there was discussion of Black queer joy that was tied to community connections with other Black queer folks (for the few who had these connections) and feeling like the unique intersection of oppression experienced by Black queer people can be a superpower.

People do a lot of monitoring, policing, and code switching based on social context and individual relationship

> A number of people discussed White dominant norms re: professionalism and academia

Differences in socialization to Blackness (respectability or predominantly White contexts growing up preventing people from knowing popular Black cultural references)

Very few people were raised in contexts that viewed LGBTQ people positively

> Often there was overt homophobia growing up
>
> > This played out differently for some people when they came out; for some their families maintained this kind of bias, for others it was like "gay people are okay but not my child" and for others, coming out eventually eroded some of the bias their parents/families expressed while they were growing up.

Variability in the stigma attached to mental health growing up – for some it was definitely stigmatized, for some it just wasn't talked about, and some had environments that were open about mental health

> This same kind of variability applied to sentiments/stigma around seeking professional mental health help.

2/24/2023

Respectability politics from parents/older generations (Black socialization)

Only a couple of people felt like their Blackness and queerness were inseparable

Similarly, folks have struggled to discuss intersectional discrimination experiences. There seems to be some recognition that this kind of discrimination is possible/that maybe they had experienced it but didn't perceive it that way. This is often discussed

in terms of Blackness being more visible than queerness so they attribute these experiences to racism, not homophobia or intersectional minority stress.

2/10/2023
Isolation, lack of community, loneliness

2/6/2023
The role of Black Christianity
Ease discussing identities separately. Some folks had a challenge discussing intersectional discrimination. Much more commonly discussed racism in gay communities and homophobia in Black communities

2/5/2023
Not Black Enough and Not Gay Enough
    There's a lot of similarities in the sentiment that biracial folks feel about not fitting in with either community
The influence/pressures of Black Masculinity
The role of Black Christianity
Struggling to find community with Queer Black folks outside of ballroom/night club scenes
Smaller social circles, in present day and growing up
Loneliness
Ease discussing identities separately. Some folks had a challenge discussing intersectional discrimination. Much more commonly discussed racism in gay communities and homophobia in Black communities
Outness in middle and high school was a mixed bag for folks. For some, mental health was compromised by being closeted during this time and for some being out made things rough. Also, stories of being outed (I think mostly by peers) were fairly common
People struggled to identify things as Black queer folks that boosted/improved their mental health

APPENDIX C: CODING TEMPLATE

The template below was developed using interviewer familiarity with the data gained over the course of conducting interviews, as well as the interview guide itself, and memos drafted throughout the interview process where the interviewer documented preliminary themes based on similarities and differences in people's accounts.

1. Availability of MH services where you live
2. Best parts of Black queerness
    a. Black queer culture
    b. Connection with other Black queer people
    c. Existence as resistance
    d. Joy in Black queerness
3. Blackness in higher ed context
    a. Connecting with Black ppl
    b. PWI struggles
4. Changes in mental health over time
    a. ADHD
    b. Anxiety
    c. Depression
    d. Identity-related mental health struggles
    e. Suicidality
    f. Worsening mental health in college
5. Connection to broader Black community
    a. Connection = safety
    b. Cultural disconnect
    c. Dependent on geography
6. Connection to broader LGBT community
    a. Shared struggle/oppression
7. Context-dependent identity expression
    a. Adjusting gender expression (e.g. dress)
    b. Black code switching
        i. Blackness in predominantly White contexts
    c. Family contexts
    d. Notions of professionalism
    e. Safety/protection
8. Descriptions of recent mental health
9. Difficulties of Black + Queer
    a. Anticipating bias/discrimination
10. Discrimination experiences
    a. Anti-Black racism
    b. Dating context
    c. Differences in various locales
    d. Healthcare context
    e. Homo/transphobic discrimination
    f. Intersectional discrimination
    g. Mental health impact
        i. Confidence
        ii. Loneliness
    h. Microaggressions
    i. Overt bias/discrimination
    j. Sexism
    k. The role of other's religion
11. Finding community w/ other Black queer ppl
    a. Benefits of community with Black queer ppl
    b. Don't/didn't have this community
    c. Finding community in college
    d. Lack of shared interests
    e. Work in progress/ongoing effort
12. Great quotes
13. Identity concealment
14. Identity Salience
    a. Gender [identity]
    b. Profession
    c. Racial identity
    d. Relation to others
    e. Sexual identity
15. Internalized homophobia etc.
16. Intersectional mental health boosts
    a. Representation
17. Magic wand
18. Meaning attached to Blackness
19. Meaning attached to LGBTQ+ identity
20. Meaning of "mental health"
    a. Access to services
    b. Important/serious topic
    c. Stigmatized topic?
21. Mental health management strategies
    a. Faith/Religion/Spirituality
    b. Help-seeking decision making
    c. Hospitalization

    d. Medication
    e. Poor quality care
        i. Harm/trauma during treatment
    f. Self-care/coping skills
        i. Creative outlets
        ii. Journaling
        iii. Nutrition
        iv. Physical activity
        v. Sleep
    g. Social supports
    h. Therapy
        i. Cost
        ii. Institutional distrust
        iii. Insurance
        iv. Preference for identity congruence
        v. Scheduling/time
        vi. Use of college counseling centers
    i. Tools for managing crisis
22. Nationality
23. Not queer enough
24. Observed impact of others' discrimination
25. Preference for identity congruent spaces
26. Racism in queer spaces
27. Relationship between Blackness and queerness
    a. Black first
    b. Double "burden"
    c. Identities work together
    d. Identity conflict
    e. Inseparable identities
    f. Queer first
28. Sexual Identity Disclosure
    a. Being outed
    b. Familial reaction
        i. Eventual acceptance
        ii. it's a phase
        iii. It's no big deal
        iv. What did we do wrong
    c. Out to family
    d. Out to peers
    e. Role of religion
29. Skin tone/colorism/privilege
30. Socialization to Blackness
    a. Black = dumb/uneducated
    b. Black is ugly
    c. Didn't fit in with Black peers
    d. Preparation for bias
    e. Pro-Black messaging
    f. Racial microaggressions
    g. Respectability
    h. School contexts
    i. Socialization and self-concept in youth
        i. "not Black enough"
        ii. Black identity as positive
        iii. Low self esteem
    j. Socialization impacts today
        i. Grief
        ii. Hypervigilance in White spaces
        iii. Loneliness
        iv. Unlearning internalized racism
31. Socialization to queerness
    a. Ambiguity from family (partially accepting)
    b. Being outed
    c. Identity concealment in youth
    d. Making fun of "gay stuff/people"
    e. Proactive affirmation
    f. Queer media
    g. Queerness wasn't talked about
    h. Rigid gender norms
    i. Role of peers
    j. Role of religion
    k. Socialization and self-concept in youth
        i. Queer shame
        ii. Viewed queerness positively
    l. Socialization impacts today
        i. Comfort with who I am
        ii. Don't talk about sex/gend identity
        iii. No impact
    m. Unacceptable
32. Timing of LGBTQ+ identity milestones
    a. Attraction/interest in peers of both genders
    b. Coming out

33. What do people treat as most important
    a. Gender [identity]
    b. Gender expression
    c. Racial identity
    d. Sexual identity

APPENDIX D: FINAL CODING STRUCTURE

The coding structure outlined below is the result of coding all interviews. There are codes in this scheme that were added throughout the coding process and do not appear in the initial template above.

1. Availability of MH services where you live
2. Best parts of Black queerness
    a. Black queer culture
    b. Connection with other Black queer people
    c. Existence as resistance
    d. Feeling comfortable in multiple spaces
    e. Joy in Black queerness
    f. Strength through adversity
    g. Unique perspective from oppression
3. Black masculinity
4. Blackness in higher ed context
    a. Connecting with Black ppl
    b. PWI struggles
5. Changes in mental health over time
    a. ADHD
    b. Anxiety
    c. Depression
    d. Identity-related mental health struggles
    e. Solid mental health when younger
    f. Suicidality
    g. Specific traumatic events
        i. Bullying
        ii. Sexual assault
    h. Taking time away from school for MH concerns
    i. Worsening mental health in college
    j. Worsening mental health in emerging adulthood
6. Connection to broader Black community
    a. Connection = safety
    b. Cultural disconnect
    c. Dependent on geography
7. Connection to broader LGBT community
    a. Foundation for the movement
    b. Shared struggle/oppression
8. Context-dependent identity expression
    a. Adjusting gender expression (e.g. dress)
        i. Gender roles
    b. Black code switching
        i. Blackness in predominantly White contexts
    c. Family contexts
    d. Military context
    e. Notions of professionalism
    f. Safety/protection
    g. Stifling joy
9. Dating/relationships with White people
10. Descriptions of recent mental health
11. Difficulties of Black + Queer
    a. Anticipating bias/discrimination
        i. Anticipating anti-black racism
        ii. Anticipating homophobia
        iii. Anticipating physical violence
    b. Hypervigilence
    c. Outness as double-edged sword
    d. Political climate
        i. Political climate + toll on mental health

        ii. Potential criminalization of queerness
    e. Worry about future
12. Discrepancy in self-concept vs perception by others
    a. Blackness
13. Discrimination experiences
    a. Anti-Black racism
    b. Behavior change as a consequence
        i. Taking up as little space as possible
    c. Coming from partner(s)
    d. Coming from strangers/community
    e. Dating context
    f. Differences in various locales
    g. Healthcare context
    h. Homo/transphobic discrimination
        i. Biphobia from queer ppl
    i. Intersectional discrimination
    j. Mental health impact
        i. Confidence
        ii. Hopelessness
        iii. Loneliness
        iv. Sadness
        v. Self-doubt/not enough/unwanted
        vi. Unwanted/inevitable resilience
        vii. Wanting to reject one or both identities
    k. Microaggressions
    l. Misgendering
    m. Non-inclusive structures/systems
    n. Overt bias/discrimination
    o. People assuming identity congruence and saying biased things
    p. Relational impact
    q. Sexism
    r. The role of other's religion
14. Finding community w/ other Black queer ppl
    a. Benefits of community with Black queer ppl
    b. Dating [apps]
    c. Don't/didn't have this community
    d. Easier or harder in different locales over time
    e. Finding community in college
    f. Happened organically
    g. Lack of shared interests
    h. Need to be intentional
    i. Role of college/higher ed contexts
    j. Work in progress/ongoing effort
15. Great quotes
16. Identity concealment
17. Identity Salience
    a. [Dis]ability
    b. Artist
    c. Gender [identity]
    d. Gender expression
    e. Homophobia in Black spaces
    f. I'm just me
    g. Immigrant
    h. Neurodivergence
    i. Personality traits
    j. Profession
    k. Racial identity
    l. Relation to others
    m. Sexual identity
    n. Social class
    o. Spirituality
    p. Student
18. Internalized homophobia etc.
    a. Bisexuality as a phase
19. Intersectional mental health boosts
    a. Ballroom
    b. Representation

20. Magic wand
    a. Address social services/inequality
    b. Better understanding of self
    c. Black elders/mentors
    d. Discrimination
    e. Insurance/cost
    f. Know your people's history
    g. Rapid crisis response
    h. Self esteem/worth
    i. Spaces to be free
    j. Therapist licensing process
21. Meaning attached to Blackness
22. Meaning attached to LGBTQ+ identity
    a. Changing nature of queer identity/labels
    b. Complexity of sexid/label
23. Meaning of "mental health"
    a. Access to services
    b. Important/serious topic
    c. Influences way you see the world
    d. Journey
    e. Mental health as a field of study/profession
    f. Stigmatized topic?
        i. Queerness viewed as mental illness
    g. Taking care of yourself
    h. Wellbeing
24. Mental health management strategies
    a. Faith/Religion/Spirituality
    b. Grade school-based supports (e.g. guidance counselor)
    c. Help-seeking decision making
        i. Didn't feel safe enough to ask for help
        ii. Knowing others who have found success in treatment
        iii. Parental support/encouragement to seek services
        iv. Wanted non-judgmental space
    d. Hospitalization
    e. Medication
        i. Medication has been helpful
        ii. Poor medication experiences
        iii. Trial and error
    f. Poor quality care
        i. Harm/trauma during treatment
    g. Positive self-talk/self-regard
    h. Seeking out info online
    i. Self-care/coping skills
        i. Creative outlets
        ii. Distraction/avoidance
        iii. Grooming/hygiene
        iv. Intentional relaxation
        v. Journaling
        vi. Nutrition
        vii. Physical activity
        viii. Sleep
    j. Social supports
    k. Therapy
        i. Anxiety about getting started
        ii. Cost
        iii. Evolving goals for therapy
        iv. Getting help finding a therapist/navigating processes
        v. Institutional distrust
        vi. Insurance
        vii. Knowledge that therapy was an option

viii. Lack of knowledge about therapy processes
ix. People recommending therapy
x. Perceptions of therapy in Black communities
xi. Perceptions of therapy in queer communities
xii. Preference for credential/background
1. Averse to faith leaders
2. PhD
xiii. Preference for identity congruence
1. Black and queer is ideal
2. Same gender
3. Woman of color
xiv. Scheduling/time
xv. Struggling with therapist fit
xvi. Therapy has been helpful/effective
xvii. Transportation
xviii. Use of college counseling centers
xix. Use of telehealth

l. Tools for managing crisis

25. Nationality
26. Not queer enough
27. Nuances of sexual identity
28. Observed impact of others' discrimination
29. Perfectionism
30. Poor mental health in family members
31. Preference for identity congruent spaces
    a. Blackness
    b. Q Black spaces
    c. Queerness
32. Racism in queer spaces
33. Relationship between Blackness and queerness
    a. Black first
    b. Double "burden"
        i. Triple burden for Black queer women
    c. Identities work together
    d. Identity conflict
    e. Inseparable identities
    f. No relationship
    g. Queer first
34. Sexual Identity Disclosure
    a. Being outed
    b. Familial reaction
        i. Eventual acceptance
        ii. Fear for future
        iii. HIV
        iv. it's a phase
        v. It's no big deal
        vi. What did we do wrong
        vii. Worried about community reactions
    c. Feeling people out before disclosing
    d. Out to family
    e. Out to peers
        i. Peer reaction
            1. Sexualizing of queerness
    f. Role of religion
35. Sexual insecurities
36. Skin tone/colorism/privilege
37. Social isolation
    a. Isolated from other Black people
    b. Isolated from other queer people
38. Socialization to Blackness
    a. Black = dumb/uneducated
    b. Black is ugly

    c. Didn't fit in with Black peers
    d. Lack of Black socialization
    e. Limited life choices (athlete etc.)
    f. Preparation for bias
    g. Pro-Black messaging
    h. Racial microaggressions
    i. Respectability
    j. Role of White parent(s)
    k. School contexts
    l. Socialization and self-concept in youth
        i. "not Black enough"
        ii. Black identity as positive
        iii. Don't want to be Black
        iv. Individuality/self-reliance
        v. Low self esteem
    m. Socialization impacts today
        i. Grief
        ii. Hypervigilance in White spaces
        iii. Loneliness
        iv. Neg. messages lead to strength/knowing self
        v. Stunted relationship with White parent
        vi. Taxing emotional processes
        vii. Thought I had to be Christian
        viii. Unlearning internalized racism
        ix. Unlearning strong black women expectations
    n. Steeped in Blackness
    o. Strong Black woman trope
    p. Work twice as hard
39. Socialization to queerness
    a. Ambiguity from family (partially accepting)
    b. Being outed
    c. Family treatment of queer family members
    d. Identity concealment in youth
    e. Making fun of "gay stuff/people"
        i. Slurs/pejorative language/"that's so gay"
    f. No queer family members
    g. Noticeable absence of affirming imagery
    h. Proactive affirmation
    i. Queer media
        i. Mostly White media
        ii. Social media
    j. Queerness wasn't talked about
    k. Rigid gender norms
    l. Role of peers
    m. Role of religion
    n. Socialization and self-concept in youth
        i. Queer shame
        ii. Viewed queerness positively
    o. Socialization impacts today
        i. Comfort with who I am
        ii. Don't talk about sex/gend identity
        iii. Efforts to educate family
        iv. Neg. messages lead to strength/knowing oneself
        v. No impact
    p. Unacceptable
40. Timing of LGBTQ+ identity milestones
    a. Attraction/interest in peers of both genders
    b. Coming out
    c. Identity confusion

41. What do people treat as most important
    a. [Dis]ability
    b. Gender [identity]
    c. Gender expression
    d. Identities don't come up much
    e. Racial identity
    f. Relation to others
    g. Sexual identity

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