HHS Public Access

Author manuscript

Am J Orthopsychiatry. Author manuscript; available in PMC 2024 January 17.

Published in final edited form as:

Am J Orthopsychiatry. 2021 ; 91(6): 724–737. doi:10.1037/ort0000570.

A Mixed-Methods Study of Social Identities in Mental Health Care Among LGBTQ Young Adults of Color

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Abstract

Social identities have been shown to reflect normative beliefs and practices that can impact important health behaviors. A better understanding of how this process unfolds among young people with marginalized identities can help inform strategies to decrease mental health disparities and improve their overall health outcomes. A mixed method, convergent parallel design was used to examine identity centrality, mental health treatment history, and cultural experiences of a purposeful sample, consisting of 31 Black and Latinx young adults (*M*age = 22.16) who identified as sexual and gender minorities in New York City. Data from validated measures and in-depth interviews were triangulated to strengthen and add context to findings. Participants with higher social identity centrality scores, particularly on community belonging and sexual identity, were more likely to continuously use mental health services. Seven social identities were prominent in qualitative data: Sexual, Ethnic–racial, Religious, Socioeconomic, Gender, Family, and Generational. These social identities were described as interconnected, and as both significant barriers and facilitators to participants' involvement in treatment. Results suggested that young lesbian, gay, bisexual, transgender, queer (LGBTQ) people of color seeking mental health care might need more support to navigate experiences related to intersecting identities. Interventions to improve services and maintain these youth in treatment should employ strategies to assess and support positive minority identity development, while also addressing self-stigma and discrimination experienced through culture, family, and mental health professionals. Considering social identity development is conceptually useful for adapting services for diverse youth because it is a major focus of transitioning to adulthood and calls attention to multiple minority identities impacting individual clients.

Keywords

LGBTQ; Black; Latino; mental health services; social identity

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We have no known conflict of interest to disclose.

Research indicates that being Black or Latinx[1] and a young adult (age 18–29) is associated with decreased mental health service use when compared to older Black and Latinx people, and compared to non-Latinx white people of any age (Blanco et al., 2008; Mojtabai et al., 2016; Substance Abuse and Mental Health Services Administration, 2015). Multiple barriers to service use are disproportionately experienced by Black and Latinx youth in need of mental health treatment, including lack of adequate insurance, lower socioeconomic status, difficulty navigating the health system, and lack of linguistic support (Broman, 2012; Snowden & Yamada, 2005; Walker et al., 2015). It has long been recognized that structural racism in health care in the U.S. is central to these barriers facing racial and ethnic minorities (Mensah et al., 2021). Likewise, the past and present mistreatment of people of color can lead them to mistrust mental health professionals (Scott et al., 2011; U.S. Department of Health and Human Services, 2001). Even so, having a perceived need for treatment has been cited as a strong predictor of service use among Black and Latinx young adults (Hayes et al., 2011; Williams & Cabrera-Nguyen, 2016), though cultural and family beliefs can influence whether symptoms are seen as a problem in need of treatment and which methods of coping with such problems are considered appropriate (Kleinman, 1980; Lê Cook et al., 2014; Lewis-Fernández & Díaz, 2002; Munson et al., 2019). Cultural beliefs and experiences can present as alternative interpretations of mental disorder (e.g., as due to supernatural, personality, or situational factors; Carpenter-Song et al., 2010), and can establish preferences for informal or culturally sanctioned help seeking (Cauce et al., 2002; Pumariega et al., 2013). For instance, research suggests that Black and Latinx young adults have been more likely to seek mental health services from religious or spiritual advisors (Chiang et al., 2004; Kouyoumdjian et al., 2003) than from specialty mental health providers. In addition, Black and Latinx individuals have been more likely to express negative attitudes and hold stigmatizing beliefs about mental health treatment (Conner et al., 2010; Menke & Flynn, 2009; Ojeda & Bergstresser, 2008; Rusch et al., 2008), and to associate help seeking with shame (Tucker et al., 2013) compared to other ethnic–racial groups. These factors all potentially contribute to differences in rates of service use among Black and Latinx young adults.

Black and Latinx young adults that identify as sexual and gender minorities[2] (SGM) might find fewer acceptable sources of help when they are experiencing a mental disorder, placing them at especially high risk for untreated mental illness during the transition to adulthood. Due to their multiple minority statuses, these young people can experience multiple forms of victimization and discrimination simultaneously (e.g., race/ethnicity-based, sexual/gender-based) that can increase their risk for poor mental health outcomes (Lytle et al., 2016; Thoma & Huebner, 2013). This might be compounded for some due to racism within lesbian, gay, bisexual, transgender (LGBT) communities, and heterosexism and anti-trans discrimination within communities of color (Balsam et al., 2011). While studies of SGM youth in the general population have consistently shown that parental and peer support are buffers that promote positive mental health, self-acceptance, and well-being (Russell & Fish,

[1]We use “Latinx” as a gender-inclusive term that acknowledges gender-expansive individuals of Latin American origin/decent.
[2]We use “SGM” and “LGBTQ” interchangeably, while variations (e.g., “sexual minority” or “LGB” or “LGBT” or “gender minority”) are intentionally used to reflect differences across specific study samples referenced in literature and in direct quotations from participants.

2016; Watson et al., 2019), those who are Black and Latinx may experience more rejection from their families and same-race/ethnicity peers (Frost et al., 2016). Conflict between their religious affiliation and sexual orientation is often reported by Christian sexual minorities (Schuck & Liddle, 2001) and SGMs may face rejection from churches within Black and Latinx communities (Frost et al., 2016). Preferred informal supports may be less available to Black and Latinx young people that are SGMs, creating additional barriers to seeking help.

Receiving competent care from professional mental health care providers can be challenging for young Black and Latinx SGM adults. While sexual minorities have been more likely than heterosexuals to utilize professional support (Filice & Meyer, 2018; Li et al., 2016), discriminatory behavior from service providers and low availability of LGBT-affirmative services have been cited as barriers to effective treatment for SGMs (Burgess et al., 2007; Filice & Meyer, 2018; Kattari et al., 2017; Romanelli & Hudson, 2017). Many mental health service providers have not received education or training regarding the needs of SGM individuals (Alessi et al., 2015; Long et al., 2006). Further, Black and Latinx providers are vastly underrepresented among clinically trained mental health providers in general (Santiago & Miranda, 2014) and organizations that appear to cater to a predominantly white community may seem unwelcoming to Black and Latinx SGM young adults (Holley et al., 2019; Ward, 2008), leaving them with even fewer options for an accepting environment. As such, Black and Latinx SGM young adults may find it more difficult to engage with treatment when they encounter providers that do not sufficiently understand their life experiences or offer services that meet their needs.

Social Identity and Mental Health Service Use

Social identities and contexts shape the mental health and overall well-being of SGM youth, therefore considering the heterogeneity of their experiences is essential for building strategies to support their healthy development (Fish, 2020; Schmitz et al., 2019). For SGM individuals who are people of color, young adulthood is a critical developmental period for identity formation and identification with particular marginalized social groups (e.g., ethnic/racial identity, LGBT identity; Morgan, 2013; Testa et al., 2014; Umaña-Taylor et al., 2014). The socially constructed norms and expectations shared by members of their social groups provide critical information that helps young people make sense of their own experiences, who they are, and who they want to be (Umaña-Taylor et al., 2014). Early adulthood is also the time when young people begin to assume responsibility and autonomy in their own mental health treatment (Rickwood et al., 2005). This indicates social identities formed during this period could be key to understanding social and psychological factors that contribute to mental health service use disparities among marginalized minority young people. One’s social identity refers to those aspects of one’s self-concept that are based on affiliation with important social groups (e.g., ethnicity, religion, economic class) and the level of importance individuals assign to those group memberships (Tajfel & Turner, 1986). Social identities have been shown to reflect in-group normative beliefs and practices, providing a basis for behavior in a wide range of contexts (Abrams & Hogg, 1990; Tajfel, 1981). Existing frameworks for understanding mental health service utilization among diverse young adults indicate that social norms (i.e., the perceived typical attitudes/behaviors of social group members), along with perceived barriers, are important proximal

determinants of whether or not individuals decide to use services (Bohon et al., 2016; Munson et al., 2012). According to theories of identity development, *identity centrality*, or the value placed on identity aspects that make up one's sense of self, can vary according to how strongly individuals identify with a social group (Cheek & Briggs, 1982; Meca et al., 2015; Syed, 2010; Triandis, 1989). For instance, models of racial identity demonstrate heterogeneity across individuals in terms of the salience of race in each person's self-concept (Sellers et al., 1998). Some people of color view their race as highly central, while others view it as less fundamental to their identity. From a social identity perspective, young adults whose self-concepts are strongly based on belonging to specific marginalized groups might be significantly influenced by the social norms about using mental health services associated with those groups. Therefore, a better understanding of how social identities are shaping service use for Black and Latinx SGM young adults could be an important resource for developing services that are more likely to meet their needs and reduce disparities in treatment.

A small number of studies have examined relationships between social identities and mental health service use, reporting mixed results. The majority of research used quantitative methods to examine associations with ethnic identity. Two studies found that stronger identification, belonging, and attachment to one's ethnic group, and lower levels of acculturation were associated with lower rates of service use among Black and Hispanic adults (Burnett-Zeigler et al., 2018; Keyes et al., 2012). Richman et al. (2007) found the relationship between ethnic identity and mental health service utilization to be moderated by experiences of discrimination (i.e., stronger ethnic identity plus experienced discrimination made individuals less likely to use services). Cheng et al. (2013), reported that higher ethnic identity predicted lower levels of stigma in help seeking among African-American adults, while Yasui et al. (2015) found that African-American girls reporting a stronger sense of belonging to their ethnic group were less likely to use mental health services, citing stigma associated with mental health problems in the African-American community as a factor. Previous studies of service use and related social identities incorporating qualitative data have shown that help seeking among young racial/ethnic minorities is influenced by social norms in their communities (Breland-Noble et al., 2010; Lindsey et al., 2013; Lindsey et al., 2006) and attitudes communicated by peers and family members about using mental health services (Ben-David et al., 2017).

Studies of mental health service utilization that include Black and Latinx young adults identifying as SGMs are extremely limited (Medley et al., 2016) and we could not find any that specifically examined the impact of intersecting racial/ethnic and SGM identities on service use. Some studies have examined factors germane to SGM identity centrality and mental health help seeking more broadly. In a recent scoping review of mental health service use among sexual minority populations, Filice and Meyer (2018) reported that three studies found that *outness* (i.e., disclosure of sexual identity to family and social network) was positively associated with service use, and two studies found internalized homophobia (i.e., the extent to which lesbian, gay, bisexual (LGB) individuals experience negative feelings about their sexual orientation) to be associated with negative attitudes about help seeking. Having a sense of psychological connectedness to and participation in the LGBT community has been positively associated with service use (Flores et al., 2017;

Frost & Meyer, 2012) and individuals utilize LGBT community centers for counseling or support groups to manage stress related to SGM identities (Frost et al., 2016; Meyer, 2003; Toomey et al., 2018). Increased social support from friends and family has been associated with decreased service use among gay and bisexual men (Coleman et al., 2017; Salem et al., 2015) and SGM peers have been shown to provide more support for emotional distress to youth than parents and non-SGM peers (Doty et al., 2010). Religious affiliation was found to be both a source of support and a stressor. Participation in LGB-affirming religious organizations has been associated with higher levels of psychological health and lower levels of internalized homophobia (Barnes & Meyer, 2012; Lease et al., 2005), but some religious LGB individuals feel alienated and experience increased internalized homophobia when their religious organizations are not LGB-affirming (Barnes & Meyer, 2012; Lytle et al., 2015). In terms of impact on emotional health and needing services, minority stress theory (Meyer, 2003) posits that the centrality of one's SGM identity moderates the experience of minority stress-related mental health problems. That is, when individuals are exposed to a minority stressor (e.g., identity-related discrimination), the effect it has on their mental health can be related to the degree to which SGM identity is significant and integrated with their sense of self.

The Present Study

Prior research suggests a need to better understand how marginalized social identities are shaping service use experiences among Black and Latinx SGM young adults. Despite the considerable implications for mental health disparities, little is known about how these young adults experience marginalized social identities as they manage their mental health. Interventions to increase service utilization and participation in treatment among multiple minority individuals need to consider their distinctive identity experiences in order to be effective. Yet, studies of service use among people with marginalized social identities have largely examined those identities separately, using primarily quantitative methods. This lack of research on intersectionality among minority youth has prompted identity development authors to articulate the need to integrate qualitative and quantitative approaches (Kuper et al., 2014; Mc Lean & Syed, 2015). This study addresses identified gaps in the literature by using a convergent, parallel mixed-methods design to simultaneously collect, analyze, and integrate both qualitative and quantitative data (Creswell et al., 2011). This approach allowed for a more in-depth understanding of complex identity and service use phenomena. Moreover, an intersectional lens (Bowleg, 2012; Crenshaw, 1991) was used to frame multiple marginalized identities as interrelated and reflective of larger structural systems of privilege and oppression, and to account for the fact that such identity experiences can be both empowering and oppressing to individuals (Warner & Shields, 2013). The present study explores how these dynamics operate among young adults with mental health conditions, guided by the following questions: (a) How are social identities represented in the mental health service use experiences of Black and Latinx SGM young adults? and (b) How important are social identities in relation to their patterns of service use?

Method

Participants and Data Collection

Our sample was drawn from a larger study of mental health service seeking and participation experiences among racial and ethnic minority young adults (aged 18–29), conducted between November 2016 and July 2017 in New York City (Moore et al., 2020). Participants were recruited through fliers explaining the study and sample criteria that were posted through social media and within educational settings, nonprofit organizations, and health care agencies likely to have contact with young adults. Respondents were invited to distribute fliers to others that they thought would be interested in participating. Potential participants that contacted the first author were briefly screened for eligibility. In order to capture a range of service use experiences, young adults were recruited who varied in whether they were in treatment at the time of the screening. Young adults were excluded if they had only used mental health services for neurodevelopmental disorders and if they could not communicate sufficiently to consent or answer questions for any reason. For the present study, purposive sampling was used to select young adults (ages 18–25), who self-identified as Black and/or Latino, Latina, Latinx, or Hispanic and sexual minorities (any non-heterosexual orientation), who reported they had received formal mental health services (i.e., assessment, referral, or treatment from a mental health professional), and who had endorsed symptoms of mood or anxiety disorder within the past 2 years. The human subjects review board at Columbia University approved all study protocols (Institutional Review Board; IRB-AAAR0325). Informed consent was obtained in writing from all individuals included in the study and they received $40 for their participation. All interviews were conducted in-person by the first author, a licensed social worker with extensive clinical and research experience. All data were collected concurrently, in one interview that lasted from 1–2 hr. Interviews were conducted at various sites (e.g., private offices, social service agencies, university offices) that were convenient for participants. Written data in measures and in notes taken by the interviewer were reviewed by participants at the end of each interview to confirm accuracy and all interviews were audio recorded and transcribed verbatim by the interviewer.

Measure

Following a brief demographic survey, we administered a semi-structured, in-depth interview protocol adapted from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) Cultural Formulation Interview (CFI; Lewis-Fernández et al., 2016) that focused on identity and help seeking in psychiatric care. Core open-ended questions and prompts were pilot tested for clarity and face validity, and revised before data was collected. Example questions included: *how has your identity impacted your experiences with mental health services?* and *how do people in your community think about getting help with emotional problems or stress?* Probing was used to explore content participants discussed in greater depth.

Mental Health Service Use.—The Service Assessment of Children and Adolescents (SACA; Stiffman et al., 2000) was used to assess lifetime, past year, and current service use. The SACA includes open-ended questions asking how often participants received treatment,

what they received treatment for, and reasons for initiating and discontinuing treatment, including any challenges to staying in treatment while it was still needed.

Social Identity Centrality.—Participants' scores on items from the Aspects of Identity Questionnaire (AIQ; Cheek et al., 1994) were used to measure social identity centrality in 12 domains. Response options are based on a 5-point Likert scale ranging from 1 = *not important to my sense of who I am* to 5 = *extremely important to my sense of who I am*, with higher scores indicating greater identity centrality. An overall social identity centrality score (possible range 12–60) and identity domain scores were calculated by summing the appropriate items. Chronbach's α for this sample was 0.79.

Mental Health.—Severity of current mental health symptoms was measured by the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), a 53-item self-report inventory in which participants rate the extent to which they have been bothered (0 = *not at all* to 4 = *extremely*) in the past week by various symptoms.

Data Analyses

Qualitative data were analyzed to provide detailed interpretations of participants' social identity content and how they related identity content to service use experiences. Interview transcripts were coded by the first author and a trained research assistant utilizing guidelines for thematic analysis described by Braun and Clarke (2006). Thematic analysis allowed for a more extensive elaboration of the social identity and service use concepts measured by the survey instruments. For instance, it enabled us to consider the various aspects of social identities participants thought were impacting their service use and make connections to specific examples from the participants' experiences. The literature on social identity and mental health service use provided sensitizing concepts that guided the coding process (Padgett, 2016). First, codes were developed by identifying and examining the data related to both social identity and service use (i.e., discussion of social identities in the context of using mental health services). Data were then organized based on codes to determine common and unique themes, overarching themes, and relation to the research questions. Next, coded segments were sorted into categories that corresponded to the social identity domains measured by the AIQ. Further steps involved capturing within-category descriptions (i.e., assessing qualities, similarities, and differences among content within a category); assessing the relative importance of categories (i.e., the incidence of and emphasis on content within a category); and assessing relationships among categories (i.e., how categories impacted one another). Analyses were organized using Atlas.ti Qualitative Data Analysis Software, Version 7.1.

Data from the SACA was used to characterize participants' service use patterns as either continuous or discontinuous. Continuous service users were defined as those that reported no significant interruptions in treatment since initiation of services, or between initiation and discharge if they were no longer in treatment at the time of the study. Discontinuous service users were those that reported interruptions or premature termination while treatment was still needed. Independent sample *t* tests and Pearson's chi-square tests were used to compare these two groups on demographic characteristics and social identity centrality. Pairwise

correlation was used to examine relationships between AIQ identity domain items. IBM SPSS Statistics for Macintosh, Version 26.0 was used for all quantitative analyses.

Triangulation of data sources and multiple analysts strengthened the methodological integrity of our analyses (Levitt et al., 2018; Saldaña, 2015). Triangulation was used to explore the logical relations between the qualitative and quantitative findings and to merge findings through the use of joint displays and matrices (Guetterman et al., 2015; Miles & Huberman, 1994). To further substantiate findings, mean scores of identity centrality domains were used to group participants with high or low scores (i.e., above or below the sample means) and then match scores with individual participant quotations to determine where findings were convergent or divergent (Östlund et al., 2011). Notes and memos created by the first author and subsequent notes by the second and third authors helped to shape the codebook and interpretations, and to decrease analyst bias. Co-authors read a subset of the transcripts at different stages of the coding process and identified unclear codes and discrepancies. Discrepancies and interpretations were discussed with co-authors, who have expertise in substantive areas of the present research, and revised accordingly. The authors had extensive training in qualitative methods and utilized the data analytic process to acknowledge and manage positionality and bias related to their own social identities (see authors' prior work in this area for examples, Camacho, 2016; Moore, 2016). For instance, all authors shared at least one marginalized identity with study participants. In addition, the authors explored how their experiences as social workers and mental health clinicians, as well as researchers that study ethnic and sexual minority health, and racial and economic injustice influenced their interpretations of the data. Ultimate findings reflected the authors' best efforts to reduce bias and remain faithful to the data and goals of the study.

Results

Sample Description.—As shown in Table 1, a sample of 31 young adults (*M*age = 22.16) were included in the study and a slight majority identified as Black, non-Latinx (55%). Twelve individuals identified as transgender or gender nonbinary (neither male nor female). All participants identified as sexual minorities and described themselves as lesbian, gay, or bisexual. Over a third ($n = 12$) also used the term "queer" to describe their sexual identities. At the time of the interview, 61% ($n = 18$) of the sample reported symptom severity at or above the normative BSI score of 1.32 for adult psychiatric outpatients (Derogatis & Melisaratos, 1983). Fifty-five percent ($n = 17$) reported patterns of continuous service use, while 45% ($n = 14$) reported delayed, interrupted, or prematurely terminated treatment. No significant differences (at ≤0.05 level) in participant characteristics were found between continuous and discontinuous service users.

Social Identities and Patterns of Service Utilization.—As shown in Table 2, continuous service users had significantly higher scores on the overall social identity scale: $t(29) = 2.16$, $p = .039$ and two identity domains, sexual identity: $t(29) = 2.12$, $p = .042$ and community belonging: $t(29) = 2.85$, $p = .008$. In addition, there was a positive correlation between community belonging and sexual identity items across participants ($r = 0.381$; $p = .017$). Qualitative findings described below contextualized these results, suggesting that a

strong sense of one's self as a member of an SGM community might be an important factor in consistently receiving treatment among participants.

Social Identities in Participants' Mental Health Service Use Experiences.— Participants discussed multiple ways in which social identities were interconnected and relevant to their perceptions of service use and their help-seeking behaviors. Seven of the AIQ social identity domains (Table 3) were prominent in the qualitative data: (a) Sexual, (b) Ethnic–racial, (c) Religious, (d) Socioeconomic, and subsequent subcategories (e) Gender, (f) Family, and (g) Generational. Participants specifically described how these aspects of their social identities both hindered and helped them to initiate and remain in treatment.

Sexual Identity.: Participants spoke about their SGM identities affecting their decisions to seek services, how they thought about their mental health, and their ability to receive treatment when they needed it. Consistent with an intersectionality framework (Bowleg, 2012; Warner & Shields, 2013), participants indicated that their SGM identities intersected with ethnic–racial, religious, and family identities in their experiences with mental health services. Of the participants who scored above the sample mean on sexual identity centrality, 11 (65%) spoke about their SGM identities affecting their experiences with using mental health services (i.e., coded as convergence; see Table 4). However, 57% of participants who scored below the mean ($n = 8$) also discussed SGM identities affecting service use (i.e., coded as divergence), primarily through social connections to the LGBT community that helped them access services. This suggests that one's sexual identity centrality alone may not be a good indicator of some important social aspects of SGM identity, and further supports our finding that feeling safe and accepted among an SGM community can promote service use.

Overall most participants ($n = 19$, 61%) discussed finding it easier to initiate and continue their treatment when the service providers were perceived as welcoming to the LGBTQ community. This was attributed to less anticipated discrimination and to having service providers that were also identified as sexual minorities. As one participant explained, "to go to some therapist that's straight and they might give them some bullshit. That's why I didn't want to go cause I didn't want someone to tell me that being who I was wrong or shameful or anything" (Black, bisexual, cis-male). Discrimination from service providers was discussed as a barrier to service use as some participants expressed the concern that they would be mistreated and others described experiencing discrimination first hand. Consistent with our quantitative findings and prior research on connectedness and participation in the LGBT community (Flores et al., 2017; Frost & Meyer, 2012), belonging to the LGBTQ community specifically helped participants locate and access services. As one participant described it, "just because I know other queer people, you can always find places to go that serve my community" (Black, lesbian, cis-female).

Consistent with prior research demonstrating their increased risk for poorer mental health outcomes (Lytle et al., 2016; Thoma & Huebner, 2013), 21 (68%) participants discussed experiences of discrimination due to their SGM identities as a stressor that negatively affected their mental health. For many, such experiences prompted seeking treatment to help them manage distress related to discrimination and coming out. This is aligned with studies

citing perceived need for treatment as a predictor of service use among Black and Latinx young adults (Hayes et al., 2011; Williams & Cabrera-Nguyen, 2016), and supports prior findings that identity-related stressors may lead young Black and Latinx sexual minorities to seek services more frequently than their non-sexual minority peers (Filice & Meyer, 2018; Li et al., 2016).

Some participants described families that helped them to access services through accepting and supporting their SGM identities. However, several participants identified anti-LGBTQ attitudes that made them feel a lack of support from family, ethnic–racial, and religious social identity groups. Previous research has identified similar disparities in social support (Frost et al., 2016) that, for participants, negatively affected their mental health and led them to seek treatment. One participant gave an example of how these factors were interconnected for her:

> I think that a lot of us do believe that something is wrong with another person if they're gay or bisexual or queer or trans. Like people think that it's a mental issue. It's like really looked down upon because a lot of Hispanic people are Catholic or that sort so it's like they don't condone that … My father hates it and he's extremely religious so I got kicked out of my house. I was homeless for a bit and I found the … center and they had a whole bunch of services that I just took advantage of (Latina, lesbian, cis-female).

Ethnic–Racial Identity.: Interestingly, identity centrality around ethnicity-race was rated highest by participants overall ($M = 3.70$, $SD = 1.4$) and was positively correlated with sexual identity ($r = 0.699$; $p < .001$), suggesting an intersection of identities was central to their self-concepts. While we found no difference in ethnic–racial identity scores between continuous and discontinuous service users, most participants ($n = 23$, 74%) identified factors affecting their ethnic–racial communities and their families as barriers to service use. Seventy-six percent of participants with ethnic–racial identity scores above the mean ($n = 16$) discussed it affecting their service use (convergent), along with most of those who scored below the mean (divergent; see Table 5). Notably, participant transcripts coded as divergent tended to discuss ethnic–racial identity in terms of family, as opposed to culture or communities more generally. Given the prominence of family attitudes and beliefs discussed in participants' help-seeking experiences, this finding points to the quality of family relationships and support as important factors linking social identities and service use among these young people.

Stigma.: Seeking help with mental health was described by some participants as a "sign of weakness" and something to be concealed in their ethnic–racial communities. These attitudes were discussed being transmitted through both communities and families, demonstrating how some participants were exposed to negative norms about the acceptability of service use described in prior research on Black and Latinx individuals (Conner et al., 2010; Holley et al., 2019; Lindsey et al., 2013; Menke & Flynn, 2009; Ojeda & Bergstresser, 2008; Rusch et al., 2008). As one participant disclosed, "I kept hearing that mental health issues are a weakness and it's just making excuses," (Black, gay, cis-male). However, some felt that younger people in their ethnic–racial communities are

more accepting of service use than older generations, allowing them to be more "open" and willing to "try and see if it can help."

Consistent with prior research on racism as a social determinant of behavioral health (Benner et al., 2018; Pieterse et al., 2012), participants identified racism as an underlying cause for mental health problems and lack of service use in their communities. Referring to increasing stress levels in her community due to recent instances of police violence and targeting of immigrants, one participant gave an example of how discrimination-related emotional stress can become "normalized" and decrease an individual's perceived need for treatment:

> I've experienced a lot of people who really don't realize that they have mental health issues, especially when it comes to getting help. But a lot of my community do need it because of what's going on in the world. Sometimes when people are frustrated they get called crazy for, like, all the wrong reasons and people really lose sight of what sanity is and you're automatically seen as aggressive or out of control (Black, bisexual, trans-female).

She conveyed how valid expressions of fear and anger in response to racial discrimination can be labeled as behavioral problems or character traits, leading individuals to disregard the impact such experiences have on their mental health and need for services.

Lack of Culturally Informed Services.: Similar to previous findings (Burnett-Zeigler et al., 2018), participants observed that attitudes about using professional mental health services varied according to acculturation, with lower levels of acculturation presenting barriers to service use, particularly among older generations. In one example, a participant described barriers she attributed to being a first-generation American that impacted her help seeking:

> My mom would tell me constantly, "oh this is not working, I don't know why you go to therapy, oh they just want your money." She kept thinking I can do it on my own, like it's something I can snap out of. It's an illness, but she didn't understand it in that way. And most of these doctors spoke in English and she speaks in Spanish, so with that it's more like me telling her what's going on (Latina, lesbian, cis-female).

Using professional mental health services was not the norm in her mother's culture of origin and without culturally and linguistically competent service providers, this participant lacked the family support to stay engaged with her treatment.

Participants also discussed lacking trust in mental health service providers. Some specifically expressed expectations that treatment would not be helpful due to a lack of cultural understanding among providers. Recalling his own experiences, one participant described the view that culturally sanctioned ways of coping are disparaged by service providers, which made him skeptical about staying in treatment:

> A lot of us within the Black community smoke marijuana as like, a coping mechanism for stress and trauma, right? So there's a lot of push back [about medication] because we believe that endorsing one drug and, like, banning another,

> that makes no sense. It's just not really trusting them to regulate how I live my life or how I seek help (Black, gay, cis-male).

As a way to mitigate stigma and the lack of culturally informed care, some participants also described cultural preferences for informal help seeking from family or other ethnic–racial community members, as described in prior research (Lindsey et al., 2013).

Religious Identity.: Identity centrality around religion was rated lower by participants overall ($M = 2.64$, $SD = 1.5$), possibly due to anti-LGBTQ attitudes. Religious identity was positively correlated with ethnic–racial identity ($r = 0.413$; $p = .010$), and as mentioned above, participants frequently discussed religious views as embedded within their ethnic–racial cultures. Some participants observed that beliefs about using formal mental health services in their ethnic–racial communities varied by religious involvement, and similar to previous studies (Chiang et al., 2004; Kouyoumdjian et al., 2003), some that had greater religious involvement reported preferences for faith-based help. Some also described their religious communities as facilitating access to professional services (e.g., referrals or pastoral counseling), while others described how their faith communities were barriers to professional service use. As one participant explained, seeking help in some faith communities could be detrimental when the community endorsed homophobic attitudes:

> Where we come from in Honduras, they believe in going to a pastor and letting a pastor cure you. But the pastor said that all I needed to do was to be involved in the church, pray to God, pray the gay away, and that my mental issues was gonna go away (Latino, gay, cis-male).

Socioeconomic Identity.: Socioeconomic identity was rated lowest by participants overall compared to other domains ($M = 2.48$, $SD = 1.5$) and was positively correlated with neighborhood/place identity ($r = 0.413$; $p = .010$). Although socioeconomic identity was rated as less central, participants had primarily low incomes at the time of the interview and, similar to prior findings (Broman, 2012; Walker et al., 2015), many noted how being from economically disadvantaged communities was a barrier to service use due to cost and fewer options for high-quality services. Some also discussed the impact of socioeconomic status on attitudes about using mental health services, suggesting that wealthier, more highly educated people in their families and ethnic–racial communities held less stigmatized views of professional service use. As one participant explained, "it seems like a class thing, like when you're more out in the world and a highly educated professional, then we're more knowledgeable and we'll get what we need and take care of our mental health" (Latina, lesbian, cis-female).

Discussion

This study presents some novel findings about how key social identities are related to on-going participation in mental health treatment among Black and Latinx, SGM young adults. Young adulthood is a crucial period for taking on responsibility for managing one's own mental health care that coincides with the formation of adult identities. Additionally, connections to particular marginalized social groups, being Black or Latinx, young adults, and SGMs can present significant barriers to receiving needed mental health treatment

and lead to poorer outcomes. Few studies have investigated these issues concurrently using a qualitative approach, and none of those studies to date have assessed identity centrality and service use. Our study makes a significant contribution to knowledge in these areas. Specifically, mixed-methods allowed us to demonstrate the content (i.e., importance, meaning, lived experiences) of participants' social identities and revealed rich, intersectional experiences occurring in conjunction with service use. The discussion of our results focuses on two main points that can inform research and practical approaches to treatment, in order to offer services more likely to increase participation among this population of young adults. First, social identities were significant contributing factors as to whether or not some participants continued to use services, highlighting the great potential in focusing on this aspect of young adult development. Second, social identities were most influential when there was a positive sense of community belonging, suggesting that services that emphasize social support of marginalized identities may improve participation.

Themes identified across social identity domains demonstrated that participants experienced social identities as influencing their beliefs and emotions surrounding mental health engagement. In this way, identities contributed to proximal determinants of mental health service use detected in previous studies of young adults (Bohon et al., 2016; Hayes et al., 2011; Munson et al., 2012; Narendorf & Palmer, 2016; Williams & Cabrera-Nguyen, 2016). For example, ethnic–racial identities influenced perceptions and feelings about mental health, stigma, and the value or usefulness of treatment primarily as potential deterrents to formal help seeking among participants. Importantly, ethnic–racial identity centrality was highly rated overall, indicating participants felt it was important to their self-concepts. Although we did not find differences in ethnic–racial identity centrality between continuous and discontinuous service users, it was clear that participants did not view it as facilitating their service use. They chiefly discussed barriers to service use such as those previously identified by studies in which higher ethnic–racial identity was associated with lower service use in representative samples of Black and Latinx adults (e.g., acculturation, racism, stigma; Burnett-Zeigler et al., 2018; Richman et al., 2007). As such, structural racism and its damaging effects on the health and health care of Black and Latinx Americans is one important target for improving their engagement with treatment. Regarding mental health care, the American Psychiatric Association recently published an apology for a history of racism, detailing racist practices that go back to the founding of the organization (Moran, 2021). It is clear that significant antiracist action and advocacy among mental health professionals is needed to identify and undo harmful policies and practices that perpetuate disparities in service use. Incorporating and attending to ethnic–racial community beliefs and norms could be another important target for culturally tailoring services for Black and Latinx, SGM young adults, especially those that are strongly identified with their ethnic–racial identities. Engaging young adults in an exploration of important systemic, social, and personal aspects of their ethnic–racial identities as part of treatment can help service providers identify strengths and needs in order to offer the most effective clinical interventions (Carter & Johnson, 2019). Furthermore, connections to family and religious groups were intertwined with participants' ethnic–racial identity-related service use experiences. Lacking support from those sources due to anti-SGM discrimination indicates the need for culturally tailored services that incorporate SGM-affirmative interventions,

including family interventions, (Alessi et al., 2019; Holley et al., 2019; Pachankis et al., 2015; Substance Abuse and Mental Health Services Administration, 2014) to overcome these intersectional barriers to receiving treatment.

Participants' experiences revealed layers of marginalization influencing their mental health and help seeking during a pivotal period of development. In addition to discrimination due to ethnicity-race and sexual-gender identities, many participants also cited their lower socioeconomic status as a hurdle to service use. Although socioeconomic identity centrality was rated lower, it was often linked to racial-ethnic identity by participants. While this reflects the lower socioeconomic make-up of the sample, it also mirrors the economic disparities faced by Black and Latinx individuals in the U.S. Strategies to improve mental health care among youth trying to manage multiple forms of marginalization will need to include services that are available at low cost and accessible through community mental health providers. Such services should also provide supports to help young people pursue educational and career goals that will improve their socioeconomic prospects (Biebel et al., 2018; Torres Stone et al., 2018). Despite experiences of marginalization, participants consistently observed that younger people, or people from their generation, had more positive attitudes about mental health treatment. Service providers should capitalize on this and offer programs that are designed with the developmental stage and needs of young adults in mind in order to improve engagement (Moore, 2018; Skehan & Davis, 2017).

When it came to participants' service use, ratings for community belonging and convergence-divergence analyses showed that the quality of social identity experiences was potentially more important than identity centrality. While participants with higher sexual identity centrality tended to be continuous service users and participants overall found their SGM identities helpful in facilitating their service use, this was typically due to being able to access services through the LGBTQ community without fear of discrimination. While consistent with research indicating that sexual minorities are high mental health service utilizers and often receive services at LGBT centers (Filice & Meyer, 2018; Medley et al., 2016), this also suggests mental health treatment is less stigmatized and more widespread within that community. A sense of belonging to the LGBTQ community may have led to a more positive view of mental health treatment for some participants. This was not the case for ethnic–racial minority identities due to mental health stigma and a lack of culturally informed options, especially options that felt inclusive to SGMs. Thus, our findings demonstrate that it is not only social identities, but also the norms and ability to participate in identity communities that are influential to service use. In order to seek out and remain in treatment, participants may have over-identified with their sexual identities, or de-emphasized their ethnic–racial identities, to overcome negative norms and stereotypes about mental health help seeking. This effect has been found among SGM youth of color as a way to cope with minority stressors coming from their ethnic–racial groups (Goldbach & Gibbs, 2015). On the other hand, having support networks of other sexual minorities of color is beneficial for many Black and Latinx sexual minorities negotiating identity-related stressors (Frost et al., 2016). Therefore, services that appeal to and build community around both ethnic–racial and SGM social identity groups have great potential for counteracting experiences of marginalization and improving engagement of Black and Latinx SGM young people. Findings from this study demonstrate tremendous resilience, resourcefulness, and

ability to turn marginalized identities into a strength among participants. Most were able to find ways to get their needs met despite significant barriers. Given the likelihood of experiencing multiple forms of marginalization during this key developmental phase, mental health services should be focused on promoting positive identity development among Black and Latinx SGM youth to further support this capacity.

The present study had some limitations that are important to consider. First, the study was conducted in New York City, a demographically diverse, and relatively service-rich environment where participants might have been more likely to find SGM-affirming mental health care, as well as service providers that were Black or Latinx. Continuous service use among similar participants might have been decreased if the study had been conducted in another part of the U.S. Second, although interviews with 31 participants led to rich qualitative data related to the research questions, and were appropriate for the qualitative analysis in the study, the small sample prevented analysis by specific social identity intersections (e.g., Black and gay vs. Latinx and bisexual) and limits inferences about larger populations. Third, data were collected in the community (not from clinical settings) and this provided important variation in service use experiences, but it required us to rely on self-report rather than clinical records for data on service use patterns. Fourth, the AIQ did not assess implicit interrelationships between multiple identities in ways consistent with theories of intersectionality, but in the absence of validated instruments to measure identities of interest as they interact with each other, this was effectively addressed by qualitative data and the strength of the mixed-methods design. Fifth, while written data in measures and in interviewer's notes were reviewed by participants, we were unable to include young people from the study population in the data analytic process due to limited resources. Lastly, while participants discussed their experiences with service use over time, the study was cross-sectional and did not directly capture how their perceptions may have changed over time.

Engagement and on-going participation with needed mental health treatment is a key factor for reducing the risk for mental health disparities among young adults from marginalized minority groups. Experiences or expectations of structural discrimination, as well as discrimination through culture, family, and mental health professionals all present potential barriers to service use among Black and Latinx SGM youth. Strategies that offer identity affirmation, protection from discrimination, and foster connections to important identity communities may be needed to maintain these young adults in treatment and to support positive mental health outcomes. More research is needed to identify key principles for designing engagement interventions that target identity-related content in youth. At the clinic and community level, offering competent, personalized care means service providers first need to understand how identities are being formed by life experiences and context, and which aspects of their identities are important to young adults in their mental health care. Providers need to assess for the degree to which stigma, mistrust, and culture are negatively impacting service use in Black and Latinx young adults, especially if they are also SGMs, because these factors tend to impact participation in treatment. In addition, psychotherapeutic interventions that challenge the legitimacy of discrimination and reduce self-stigma could be promising for young adults coping with distress related to marginalized identities (e.g., Corrigan et al., 2013; Yanos et al., 2015). Participants in this study

demonstrated that their social identities were important to their senses of who they are. This suggests that an understanding of identity, how it develops, changes, and impacts young adults is essential information for providers looking to form positive therapeutic relationships with them. The variability among participants' experiences of social identity and service use indicates that it is an individualized process. Considering social identity development is a useful concept, not only because it is a major focus of transitioning to adulthood, but also because it allows for consideration of how an individual personally relates to their culture and social groups. Rather than looking to ethnicity-race or sexual orientation or gender identity, providers will need to appreciate how multiple minority identities are intersecting within each individual client in order to be flexible and adapt service delivery.

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Public Policy Relevance Statement

Despite potentially heightened risks for mental health disparities, little is known about how Black and Latinx young adults that identify as sexual and gender minorities experience professional mental health care. This study highlights important factors affecting treatment participation and healthy development among this marginalized population. Results can inform public health care strategies to improve mental health and overall health outcomes among this group.

Table 1

Sample Characteristics (N = 31)

Characteristic	*n* (%)/*M* (*SD*)
Age	22.16 (1.8)
Gender identity	
Cisgender male	12 (39%)
Cisgender female	7 (23%)
Transgender female	6 (19%)
Nonbinary	5 (16%)
Transgender male	1 (3%)
Racial/ethnic identity	
Black, non-Latinx	17 (55%)
Latinx, any race	14 (45%)
Sexual identity	
Bisexual	14 (45%)
Gay	10 (32%)
Lesbian	7 (23%)
Economic status	
Annual income <$12,000	25 (81%)
Employed	14 (42%)
Transitional housing	18 (58%)
Independent housing	11 (35%)
Living with family	2 (7%)
Mental health	
Symptom severity (BSI)	1.41 (.68)
Service use, past year	23 (74%)

Note. BSI = Brief Symptom Inventory (Derogatis & Melisaratos, 1983). Global severity index scores range 0–4, with higher scores indicating greater symptom severity.

Table 2

Social Identity Centrality by Service Use Pattern (N = 31)

Social Identity	Operationalization	Continuous (*n* = 17), *M* (*SD*)	Discontinuous (*n* = 14), *M* (*SD*)
Social identity (full scale)		30.59 (8.4) *	24.43 (7.1)
Domains			
Family identity	Being a part of many generations of my family	2.82 (1.2)	2.78 (1.5)
Ethnic-racial identity	My race or ethnic background	3.88 (1.4)	3.50 (1.3)
Sexual identity	My sexual orientation, being homosexual, bisexual, or another	3.88 (1.1) *	2.92 (1.3)
Gender identity	My gender, being male, female, transgender, or another	3.58 (1.5)	3.85 (1.2)
Socioeconomic identity	My social class, the economic group I belong to	2.64 (1.6)	2.28 (1.4)
Community belonging	My feeling of belonging to my community	2.94 (1.3) **	1.64 (1.1)
Religious identity	My religion or religious group	2.76 (1.7)	2.50 (1.4)
Neighborhood/place identity	Places where I live or where I was raised	3.11 (1.4)	3.35 (1.3)
Generational identity	Belonging to my age group or being part of my generation	2.70 (1.3)	2.64 (1.2)
National identity	My feeling of pride in my country, being proud to be a citizen	3.29 (1.3)	2.28 (1.4)
Political identity	My commitments on political issues or my political activities	2.88 (1.4)	3.21 (1.5)
Linguistic identity	My language, such as my accent or dialect, or a second language I know	2.82 (1.1)	3.22 (1.5)

* $p < .05$.

** $p < .01$.

Table 3

Social Identity Domains, Themes, and Representative Quotes

Social identity/theme	Percent (participants)	Representative quotation by sub-theme
Sexual-gender identity/ attitudes about SGMs among service providers	61 (*n* = 19)	(Positive) A lot of people who associate as lesbian, gay, bisexual, transgender, queer (LGBTQ) experience a lot of discrimination, so in the center that I'm at, they're really open in seeking help if you feel unsafe. It's the fact that it's LGBT friendly, that I can go there (Latinx, bisexual, nonbinary) (Negative) The way someone who has to service you but doesn' t want to talk and look at you, like, it's just, that's a lot. Sometimes I had people looking at me like they're disgusted or something (Black, bisexual, trans-female)
Perceived need for services	42 (*n* = 13)	The depression was just about my insecurities, about how everybody view me as, and that's about it. I was just trying to cope with it myself and I could see that it wasn' t working. So that's what made me look into therapy (Latina, lesbian, cis-female)
Attitudes about SGMs within families	42 (*n* = 13)	(Positive) It was when me and my mom was doing the whole research into starting my hormones. I have my days that I feel down or I feel depressed and in the facility someone was like, they have a program and it would be great for your daughter. We went and I was welcome and it was really amazing (Latina, bisexual, trans-female) (Negative) I know my therapist wanted to do a lot more for me but my mom just wasn' t with it. Just like, meetings for LGBT people with mental disorders, there was one at that center and my mom just didn' t want me to go cause she didn' t want me to be surrounded by those people (Latino, gay, cis-male)
Attitudes about SGMs within racial-ethnic communities	35 (*n* = 11)	(Negative) You don' t see a lot of African-American LGBT that are very open about it. There are some, but there's a lot of homophobic people. There's a lot of violence over that. I don't feel safe (Black, bisexual, trans-female)
Ethnic–racial identity/ mental health stigma	55 (*n* = 17)	(Weakness) When you start going to therapy, in my community it' s like pointing out that there' s something wrong rather than pointing out the fact that they're trying to fix something … because you're constantly worried about being judged for trying to get help (Black, bisexual, cis-male) (Generational) I think in my generation there' s a push back but, traditionally in the Black community, there's stigma against mental health disorders and seeking help (Black, bisexual, nonbinary) (Stress normalized) A lot ofus is going through it out there and need the help, but we just see it as normal life (Latino, gay, cis-male)
Lack of culturally informed services	39 (*n* = 12)	(Acculturation) If they' re way more Americanized their view is different, but like, a lot of Hispanic people that aren't really from here would probably laugh and not take it seriously (Latino, bisexual, cis-male) (Mistrust) A lot of psychologists and psychiatrists are White and there should be more study in terms of cultural background because mental health professionals seem to have a bit of a disconnect when it comes to patients like us (Black, lesbian, cis-female) (Preference for informal help) We don' t talk to strangers about personal problems, you talk to your family first or keep it in the community (Latina, lesbian, cis-female)
Religious identity/ preference for faith-based help	29 (*n* = 9)	A lot of people draw comfort and calm from believing in a higher power that wants to see them do better and is willing to help them with things like that and churches have resources available and they'll link up with different mental health services (Black, gay, cis-male)
Varies by religious participation	26 (*n* = 8)	Within more secular groups, it seems like there's more of an open discussion. We' re more open to getting help outside the church (Black, lesbian, cis-female)
Socioeconomic identity/ lower quality of services	55 (*n* = 17)	I think a lot of times it's about priorities. So we will want to get help at a certain point but rent' s due so maybe I'll wait. But then if it's free, there's along wait to see someone or you get an intern or something (Latinx, bisexual, non-binary)
Varies by income and education	26 (*n* = 8)	I would say my dad' s side is more open to it than my mom's side. My dad' s side is the more educated, Black cultural, like, historical Black colleges, bankers, more successful side of my family. It shows them having the knowledge of it, treating it and taking care of it, and being able to rise above. (Black, bisexual, trans-female)

Note. SGMs = sexual and gender minorities; LGBT = lesbian, gay, bisexual, transgender; LGBTQ = lesbian, gay, bisexual, transgender, queer.

Table 4

Convergence and Divergence on Sexual Identity Centrality (N = 31)

Construct	Percent	Example quotation
High identity centrality (convergence)	65	“Because everyone there’s kinda going through it and not even just the clients but the staff as well, it helps. It would be different at, like, another hospital or a therapists office because it’s not as friendly and you don’t get as much overall support from everyone.”
Low identity centrality (convergence)	43	“I would definitely say that being Black informs my decisions more than being queer. It’s not something that I have to necessarily worry about as much. Whereas I can’t escape being Black.”
High identity centrality (divergence)	35	“It doesn’t make a difference … It’s one of those things that doesn’t much affect how I navigate things. I feel like they all got the same mentality toward emotions and stuff. So that wouldn’t really matter.”
Low identity centrality (divergence)	57	“I always knew about services because I was a runaway youth and you always get services like that. You always know places to go, you talk to people, they tell you where to go that caters to my community.”

Note. Sexual identity centrality (range 1–5; $M = 3.45$, $SD = 1.3$).

Table 5

Convergence and Divergence on Ethnic–Racial Identity Centrality (N = 31)

Construct	Percent	Example quotation
High identity centrality (convergence)	76	“Because of my culture, I think there’s such a stigma against mental illness. And so because of all of this I never had the language to address my feelings or like, seek out help.”
Low identity centrality (convergence)	30	“There’s a lot of stigma against mental health disorders and seeking help in the American community … and we’re just like other Americans.”
High identity centrality (divergence)	24	“I’ve heard people jokingly say that Black people don’t like to go to therapy. But that’s not my experience … my family never really had an issue with that cause several people in my family suffer from that.”
Low identity centrality (divergence)	70	“If you’re Hispanic and grew up in a family like I did, it’ s gonna be so tough for you to get help. My dad was totally against it. He didn’t give me any information. He didn’t believe in it.”

Note. Ethnic identity centrality (range 1–5; $M = 3.70$, $SD = 1.4$).