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Identity negotiation processes among Black and Latinx sexual minority young adult mental health service users

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Abstract

The transition to adulthood presents particular challenges for Black and Latinx sexual minorities in need of mental health services. Identity formation and marginalization during this developmental period can interfere with help-seeking and lead to health disparities. Identity-specific psychosocial supports are needed to assist young adults to successfully navigate these challenges, but research on identity processes, help-seeking, and service-utilization among sexual minority young people of color is very limited. To better understand how multiple minority young people navigate their identities in the context of using, or choosing not to use, mental health services, this study qualitatively explored the experiences of 31 emerging adults. Through in-depth interviews, analyses revealed that young adults negotiated social identity norms about mental health help-seeking by separating from unhelpful norms, managing stigmatized aspects of identity, integrating helpful identity alternatives, and forming individualized perspectives on help-seeking that allowed them to maintain important connections to their minority group identities. Findings are discussed in relation to previous research on ethnic and sexual minority identity development and service utilization. Practice and research recommendations for increasing knowledge, improving help-seeking, and promoting resilience around young adults' intersectional identities are offered.

Keywords

LGBTQ; mental health services; ethnic identity; qualitative methods; emerging adults

Introduction

Sexual minority (e.g., gay, lesbian, bisexual, queer, questioning) adolescents and young adults in the United States experience identity-related discrimination and victimization that negatively impacts their psychological well-being and mental health outcomes (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Mustanski, Andrews, & Puckett, 2016; Russell & Fish, 2016). Among dual minority individuals, combined racial and sexual orientation discrimination is a predictor of mental health disorders (Bostwick, Boyd, Hughes, West, & McCabe, 2014; Holley, Mendoza, Del-Colle, & Bernard, 2016; Sutter &

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Perrin, 2016), and those who are Black and Latinx (also referred to as Hispanic and Latino/a) are subjected to structural and interpersonal racism that poses risks for poorer mental health (Paradies et al., 2015; Sibrava et al., 2019). Studies of sexual minority youth of color have found overlap between race-ethnicity and sexual minority stressors (Kuper, Coleman, & Mustanski, 2014) and evidence for poor mental health outcomes (Toomey, Huynh, Jones, Lee, & Revels-Macalinao, 2017). The fact of belonging to multiple marginalized identity groups simultaneously can clearly present a need for mental health services in order to successfully transition into adulthood. Yet, among sexual minorities, young adults have the lowest rates of mental health help-seeking behaviors of any age group (Medley et al., 2016), and rates of service use among Black and Latinx young adults are significantly lower than among others in their age group (Broman, 2012; Substance Abuse and Mental Health Services Administration, 2015). This is particularly concerning for young adults whose identities overlap these sub-populations because it suggests they might be facing discrimination and mental health challenges without receiving appropriate care.

This vulnerability to mental health disparities is occurring during a period when young people are trying to achieve the important developmental task of forming positive and coherent adult identities (Erikson, 1968). Experiences of discrimination can pose significant challenges to dual minority youth's mental health during this process (Thoma & Huebner, 2013), when young people might be exploring their intersecting minority identities for the first time (Morgan, 2013).

As such, mental health services for sexual minority young adults of color need to offer identity-specific psychosocial supports that can increase their help-seeking and assist them to navigate this developmental period (Jamil, Harper, & Fernandez, 2009). However, research on help-seeking and service-utilization among sexual minority young people of color is extremely limited (Wagaman, 2014) and there are very few studies of identity development processes among Black or Latinx sexual minority youth (Syed, Santos, Yoo, & Juang, 2018) to inform the design of these needed services. To address this gap and enhance our understanding of how to better meet their service needs, this study qualitatively explored the mental health help-seeking experiences of Black and Latinx, sexual minority-identified young adults. The service use experiences and strategies for negotiating multiple minority identities discussed by participants in the study help illuminate the perspectives of marginalized young people which, in turn, can improve the capacity of providers to develop programs and services that are grounded in the experiences and insights of these understudied young adults.

Sexual and ethnic minority identity development in adolescence and early adulthood

Stemming from Marcia's (1980) conceptualization of identity formation, theories of ethnic-racial (Phinney, 1990) and lesbian, gay, and bisexual (LGB; (Toomey, Anhalt, & Shramko, 2016; Worthington, Navarro, Savoy, & Hampton, 2008) identity development have described these processes as an active exploration of one's needs, beliefs, values, and goals that leads to feelings of belonging, affirmation, and a demonstrated commitment to an identity. For young people who belong to multiple marginalized identity groups, developing a positive adult self-concept requires them to explore and integrate these multiple social identities,

even while experiencing multiple forms of identity-related oppression. Successfully integrated identity has been associated with mental health (Ghavami, Fingerhut, Peplau, Grant, & Wittig, 2011; Santos & VanDaalen, 2016) and feelings of social support (Gallor & Fassinger, 2010) in studies of ethnic minority LGB young adults. Three studies of Black and Latinx sexual minorities have found important differences in identity development in which LGB people of color (POC) required more time to self-identify and disclosed their sexual orientation to fewer individuals compared to White sexual minorities (Aranda et al., 2015; Balsam et al., 2015; Rosario, Schrimshaw, & Hunter, 2004). Jamil et al. (2009) found that ethnic and sexual minority identities developed concurrently among African-American and Latinx sexual minority adolescent males, but through different processes. Youth developed their ethnic identities within their immediate community, but developed their sexual identities through actively seeking and connecting with an external LGB community. In a study of identity integration among sexual minority adults of color, Kennedy and Dalla (2014) found that younger adults reported less deliberate identity exploration and greater compartmentalization of ethnic and sexual identities across key social contexts (family, ethnic community, religion, peers) compared to those that were older. Identity integration was prompted by self-acceptance and by acceptance from others, particularly in the family context. Taken together, these studies suggest that integrating sexual and ethnic minority identities into a coherent whole is a process that is substantially rooted in social context and relationships, requires effort and strategy, and presents greater difficulty for younger people. In all of these studies, authors suggested major differences in identity integration processes among ethnic minority LGB individuals were likely responses to heterosexism in their larger racial-ethnic communities and the risk of rejection from family.

Sexual and ethnic minority identities and mental health help-seeking

Mental health services can be a critical resource for helping sexual minority youth cope with distress related to discrimination and identity formation (e.g., LGB-affirming therapies; (Alessi, 2014; Ali & Lambie, 2018; O'Shaughnessy & Speir, 2018). But, LGB young people are more likely to report unmet need for services compared to heterosexuals (Williams & Chapman, 2011, 2012) and may delay seeking help for their mental health because they have fears of discrimination in healthcare settings (Craig & Smith, 2014; Hoffman, Freeman, & Swann, 2009). LGB individuals have reported negative experiences with providers related to their sexual identities (Jones & Gabriel, 1999; McCann & Sharek, 2014) that can lead to poor engagement with services (Eady, Dobinson, & Ross, 2011; Travers & Schneider, 1996; Willging, Salvador, & Kano, 2006), especially among LGB people of color (Wilson & Yoshikawa, 2007). Service providers vary in their respective LGB-related attitudes and competencies (Moe & Sparkman, 2015), and some mental health providers have not received sufficient, if any, education or training regarding the needs of LGB individuals (Long, Bonomo, Andrews, & Brown, 2006). As a result, the availability of appropriate supportive services for sexual minorities is often insufficient to meet the demand (McIntyre, Daley, Rutherford, & Ross, 2011). In addition, mental health interventions that are available are often not appropriate, relevant, or inclusive of young LGB individuals (Pepping et al., 2017). All of these obstacles may be compounded for LGB young adults who might have difficulty disclosing their sexual identities to providers and who are still learning to advocate for their own LGB-specific health needs (Macapagal, Bhatia, & Greene, 2016).

Previous empirical studies have not noted significant differences between the service needs of sexual minority youth of color and their White peers (Wells et al., 2013), but the actual service experiences of LGB youth of color have been largely unstudied (Wagaman, 2014). Among adults, LGB POC have experienced discrimination related to mental illness, race-ethnicity, and sexual orientation in their mental health treatment programs (Holley, Tavassoli, & Stromwall, 2016) and have been more likely to report dissatisfaction with mental health services compared to White LGB and heterosexual POC (Avery, Hellman, & Sudderth, 2001). Some studies have found that LGB POC were less likely to have used mental health services than White LGB people (Burns, Ryan, Garofalo, Newcomb, & Mustanski, 2015; Meyer, Teylan, & Schwartz, 2015; Razzano, Matthews, & Hughes, 2002), but other studies have found no racial or ethnic differences in service use or ongoing engagement with treatment (Salem et al., 2015; Williams & Chapman, 2012). In one study of Latinx LGBTQ+ young adults, Schmitz, Robinson, Tabler, Welch, and Rafaqut (2019) found that young people interpreted mental illness stigma among Latinx communities as tied to resisting historical ethnic marginalization, and that these perceptions could deter young people from accessing mental health care. Further research that directly addresses the intersection of race-ethnicity and sexual orientation is needed to get a more accurate understanding of service use for LGB young adults of color, particularly because most studies of mental health service utilization among sexual minorities fail to study samples further disaggregated according to intersections of age, gender, race, or socioeconomic status (Filice & Meyer, 2018). This significantly limits our ability to understand how help-seeking among youth that are LGB POC is impacted by interdependent and reciprocally formative systems of gender, race, class, and sexual orientation (Bowleg, 2012).

Studies that have linked identity integration with psychological health (Ghavami et al., 2011; Santos & VanDaalen, 2016) suggest that stressors unique to people with marginalized minority identities can be mitigated via identity-based processes (Meyer, 2003). Developing positive minority identities, resiliency skills, and creating supportive identity communities have helped LGB youth (Goldbach & Gibbs, 2015; Kuper et al., 2014; Schmitz, Sanchez, & Lopez, 2018) and adults of color (Meyer, 2010) to cope effectively with minority stressors. Seeking mental health services is consistent with these sorts of coping responses (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). Yet, while it is evident that identity can have a significant impact on help-seeking behaviors in early adulthood, we have found no studies specifically examining the relationship between multiple minority identity formation and mental health help-seeking to illustrate how those two processes might be operating among sexual minority young adults of color. A better understanding of how young sexual minority POC manage their minority identities in relation to their mental health help-seeking can shed light on opportunities for providers to foster coping and support resilience, and can offer important insights on how identity-related interventions might be beneficial for improving engagement with mental health services.

Methods

The current study is focused on young adults that are Black and Latinx sexual minorities, occupying at least two marginalized social locations. Therefore, it was essential to draw upon an intersectionality perspective (Collins, 1990; Crenshaw, 1989), and critically

consider how social inequalities were constructing and maintaining young people's membership in multiple social categories. Intersectionality offers a useful heuristic for examining how multiple minority identity processes are experienced simultaneously and how identity development and conditions of marginalization intersect in young people lives (Santos & Toomey, 2018). In contrast, researchers who want to assess multiple components of identity often resort to using additive, separate constructs for each (e.g., a measure for race/ethnicity and another for sexual orientation; (Narváez, Meyer, Kertzner, Ouellette, & Gordon, 2009). But, using separate constructs can miss elements that stem from the intersection of identities, interactions between identities and contexts, and related shifts in identity over time. To address this, qualitative methods were used in this study to capture the intersection of identities in an open-ended and semi-structured format. This allowed for detecting patterns that cannot be captured using quantitative methods and enabled us to attend to participants' experiences of the relationships between identities and service use. Together, these approaches provided a lens that can appreciate the complexity with which youth may experience and manage multiple minority identities in their mental health help-seeking. To build greater knowledge in this area, this study asked: How do Black and Latinx sexual minority young adults navigate these identities in the context of mental service use?

This study is part of a larger study examining mental health service utilization patterns among young adults with marginalized minority identities conducted November 2016–July 2017. The present study specifically concentrated on processes involving ethnic and sexual minority identities (i.e., identification, belonging, and attachment to a group) within the context of using (or choosing not use) mental health services. Because so little is known about multiple minority identity processes in mental health help-seeking, a constructivist grounded theory methodology (Charmaz, 2006) was used to analyze data in an effort to develop fundamental empirical knowledge on this topic.

Recruitment

A recruitment email explaining the study was sent to various networks in the New York City area identified by the first author as likely to have contact with young adults, including local educational settings, nonprofit organizations, healthcare providers, and community organizing listservs. Referral of young adults whose experiences fell at the intersections of marginalized identities (e.g., low socioeconomic status, racial, ethnic, sexual minorities) was requested. Although the study concerned experience with mental health services, recruitment sites were deliberately not restricted to mental health providers in order to include young adults that might have discontinued treatment. In addition, fliers advertising the study were posted within organization settings and were provided to respondents for distribution to others that they thought would be interested in participating. Potential participants that contacted the first author were given information about the study and briefly screened. Young adults were eligible for inclusion in the present study if they were between ages 18 and 29, identified as Black and/or Latinx (also referred to as Hispanic and Latino/a) and as sexual minorities (any non-heterosexual identity), endorsed symptoms of mood or anxiety disorder within the past 2 years, and had used professional mental health services (i.e., assessment, referral, or treatment). Young adults were ineligible if they had only used

services for neurodevelopmental disorders or if they could not communicate with the interviewer sufficiently enough for informed consent or to answer questions for any reason.

Data collection

An in-depth qualitative interview that included 5 core open-ended questions on minority identity and mental health help-seeking was used to allow participants to self-identify and to draw out their subjective understanding of their minority identities, as well as the impact identities had on their own personal experiences. Questions were based on the supplemental modules of the DSM-5 Cultural Formulation Interview (CFI (Lewis-Fern andez, Aggarwal, Hinton, Hinton, & Kirmayer, 2016) that focus on cultural identity and help-seeking in psychiatric care. The questionnaire was developed and further refined through pilot-testing with five young adults who met eligibility criteria for the study. Primary questions were: (1) Which minority communities do you identify with and what does that mean for you? (2) How do you think your identity has impacted your experiences with mental health services? (3) How have your views about getting help with emotional problems or stress changed over time? Primary questions were followed by probes to elicit additional information. During interviews, demographic information about race, ethnicity, and sexual identities was disclosed in response to question one above and a brief information survey. All interviews were conducted in person by the first author at various sites (e.g., private offices, social service agencies, university offices) and lasted from 1 h to 2 h. Respondents received $40 for their participation. Interviews were audio recorded, transcribed verbatim, edited, and entered into Atlas.ti version 1.5.0 software (Muhr, 1991). Informed consent was obtained in writing from all participants and the Human Research Review Board at Columbia University (approval # AAAR0325) provided approval for study procedures.

Data analysis

Data analysis began following the first interview and proceeded in an iterative process of alternating between data collection and analytic coding. Broadly, experiences were coded according to (1) the circumstances in which service use was impacted by minority identities; (2) participants' thoughts, feelings, and actions in those circumstances; and (3) the purpose and consequence of participants' responses in those circumstances. Initial open coding led to comparing, eliminating, and merging codes until a final list of categories and sub-categories was produced. In-vivo coding was used in order to better ground the analysis in participants' perspectives (Saldaña, 2015) and process coding, in which action is coded using gerunds, attuned the analysis to processes in the data (Charmaz, 2006) (e.g., *negotiating, separating, concealing, integrating*). Focusing strategies were used to prioritize among multiple categories and reflect on their essential meanings, including how they related to the research question for the present study, which major categories were dominant, and why (Saldaña, 2015). Theoretical coding was used to specify possible relationships between categories that developed in the focused coding (Charmaz, 2006). Integrating participants' descriptions of identity processes with their service use experiences was accomplished by looking for actions and processes through which one or more categories affected another. For example, participants described considering the perspectives on help-seeking of their identity groups, comparing those perspectives with their own personal goals, estimating the impact of discrimination, and strategizing about how to manage it before deciding whether or not to

use mental health services. These connections indicated identity processes operating within help-seeking processes.

A range of techniques were employed to ensure rigorous scholarship. Triangulation of data sources (transcripts and memos), and of multiple analysts, along with consistent documentation of the analytic process (Saldaña, 2015) strengthen the credibility of the study's findings. Analysts used memo writing throughout the data collection and analytic processes to reflect on their social positions and personal subjectivity. This increased their ability to identify how their own attributes, experiences, and assumptions influenced the research and to reduce biases. Expert checking enhanced validity of the results as the interviewer invited participants to correct her interpretations to ensure that the portrayal of participants' perspectives was accurate. Numerous peer reviews added to the trustworthiness of the results. Three colleagues read a sub-set of the transcripts at different stages of the coding process and identified unclear codes and discrepancies. Discrepancies that resulted from peer reviews were discussed and reconciled. Subsequent analytic assertions and theoretical findings were reviewed by the second and third authors, who are experts in substantive areas of the present research, and revised accordingly.

Findings

Participants

Table 1 presents participant demographics. Thirty-one young adults, all between ages 18 and 25, were included in the study. Slightly more participants identified as Black, non-Latinx (n = 17), which included African-Americans and other ethnic identities such as origins in Caribbean and African nations. Among those that identified as Latinx, any race (n = 14), seven participants identified as both Black and Latinx, and three of those participants identified as multiracial (had one Black, non-Latinx parent). All but one young adult was born in the United States. All participants identified as sexual minorities, with a variety of sexual orientations. In addition to identifying as sexual minorities, many participants (n 12) also identified as gender minorities (transgender and non-binary). At the time of the interview, participants were primarily low-income (81%) and many (61%) were experiencing clinically significant mental health symptoms (Derogatis & Melisaratos, 1983). Most (74%) had received some out-patient services in the past year, self-reporting that symptoms of mood disorders were their primary reason for seeking mental health services (84%).

Negotiating multiple identities

Analyses revealed that identity development processes were present in mental health service use experiences via minority identity group social norms (i.e., the perceived opinions of community members) and stigma, and participants used several processes of identity negotiation in the context of help-seeking. Participants described personal attitudes and behaviors around mental health help-seeking that were negatively affected by stigma, discrimination, and social norms. In those cases, managing their mental health required them to critically appraise identity group attitudes and norms, contrast them with personal goals, and navigate around circumstances that discouraged service use. Negotiation in this sense

referred to finding a serviceable middle path among social identities and personal goals that were in opposition. Participants also described discovering and adopting aspects of their minority identities that supported help-seeking, making their integration of multiple identities feel like less of a compromise. The identity negotiation processes used by participants were categorized as four dimensions: *separating from social norms*, *integrating alternative examples*, *concealing stigmatized selves*, *and greater self-acceptance*. Through these identity negotiation processes, participants constructed individualized perspectives on help-seeking, while maintaining important connections to their minority group identities. In the Discussion section we relate these negotiation processes to previous research on identity development and service use during young adulthood.

Stigma in ethnic identities

Participants consistently expressed that stigma about mental health problems was especially high in their own ethnic cultures and this was a barrier to their help-seeking.

> Because of the culture, I think there's such a stigma against mental illness and so nobody talks about mental issues or anything … And so because of all of this I never had the language to address my feelings or like, seek out help.
>
> (gay Latinx cisgender male)

Whether drawing upon personal experiences or experiences related to them by other members of their ethnic identity groups, participants perceived stigma around managing mental health problems as particularly affecting members of their own Black and Latinx ethnic groups.

Social norms among multiple identities

Participants described a complexity of social norms about mental health help-seeking among their intersecting minority identities. Participants observed that LGBTQ (lesbian, gay, bisexual, transgender, queer) POC might be less likely to use services due to ethnic cultural beliefs that stigmatize sexual and gender minorities. Some participants pointed out that being LGBTQ was associated with mental illness in their own ethnic communities and that presented additional identity and mental health-related stigma. As one participant explained:

> I feel like there's people who are more willing in the LGBT community to go and get services but in the same token, maybe they're not willing to talk about it or say that they're getting services because being gay was considered like a mental illness in our community.
>
> (bisexual Latinx cisgender male)

Notably, he expressed that sexual and gender minorities in general seemed more likely to use services, suggesting that mental health help-seeking is viewed more positively by that identity group. Compared to cisgender, heterosexual members of their ethnic groups, many perceived sexual minorities of any ethnicity as more open to service use and as having greater access to services through LGBTQ community resources:

> I know there are a lot of things like that, especially for homeless LGBTQ youth. I think there's a lot of community-based organizations that try to reach out and help people.
>
> (lesbian Latinx cisgender female)

Some participants also described experiencing a more complex form of discrimination from service providers from their own racial groups that could discourage service use. Giving her own experience as a Black, trans woman, one participant described intersectional discrimination that she thought was based on cultural stereotypes about masculinity in the African-American community:

> There was this Black nurse. I could tell she was looking at me like I was a Black man and she was refusing to treat me … And this was a situation where I was not the only trans person there, but I was the only Black one.
>
> (bisexual Black trans female)

She felt that this discrimination was due to the nurse being less accepting of her gender expression because she was not conforming to the nurse's norms about Black people, rather than a more generalized transphobia.

Some participants described difficulties accessing services within their racial-ethnic communities because of anti-gay beliefs among religious institutions that provided counseling and other social services. One participant described a horrific experience with help-seeking as it was recognized in his ethnic culture:

> I started seeing a therapist, a pastor, when I came out. My mom put me in conversion therapy and I know that she thought in her mind, it was the best, like, it was all she knew what to do.
>
> (gay Latinx cisgender male)

He said that during this time he did not know how to locate mental health services on his own and that he eventually made a suicide attempt out of desperation before finding appropriate care.

The vast majority of participants described mental health service use as being at odds with their ethnic identities. They discussed several social norms that were opposed to professional mental health service use that they perceived within their own ethnic groups through language and attitudes:

Low recognition of mental health problems and low perceived need for treatment

> We just think everything is genetic or just a part of life. It's just like normalizing sadness or misery … It's not, like, thought of as a real problem.

Using alternate/informal ways of coping

> Just keep going to church … see if talking to your pastor can help.
>
> We don't talk to strangers about personal problems, you talk to your family first.

Beliefs about the efficacy of services

> It's a waste of money and time.

> There's a lot of people that just believe that it's just entirely a farce. Like it's just shenanigans really.

Mistrust of services and providers

> A lot of African-Americans have a negative history with hospitals and medication and pills and all of that.

In contrast to norms about their LGBTQ identity communities, none of the participants expressed the view that being a person from their own ethnic group makes it easier to utilize professional mental health services.

Separating from social norms

Participants described developing divergent attitudes to contend with social norms that discouraged mental health help-seeking with a sense of empowerment. They discussed how they were able to form their own perspectives and make their own choices, even though members of their identity groups may not approve. One participant described how learning a contrasting view of help-seeking from peers outside of his ethnic group encouraged him to expand his own attitudes about mental health services:

> I remember hearing like, you have a therapist? Oh that's actually a thing? This is something that people actually do and it's just my community that's against it.
>
> (bisexual Black cisgender male)

Another participant described the need to move beyond his Latinx culture's norms as prompted by the stigma related to both mental health problems and being a sexual minority. He described learning to distinguish and attend to his personal needs, rather than the expectations in his culture as a means of coping with stigma:

> Even though my culture is really important to me, in terms of mental health and my own personal needs, it was really just all about like, separating from that because I couldn't handle the stigma. It was a lot of negotiation, a lot of coming to terms with myself and what I needed at the time.
>
> (gay Latinx cisgender male)

Participants described diverging from identity group norms about service use in terms of personal identity development, highlighting the importance they placed on differentiating themselves as individuals:

> Part of it was, learning to make my own decisions and learning to create my own identity, separate from what was perceived as the norm. And that's what I did.
>
> (bisexual Black non-binary)

Many related their decisions to seek help as motivated by wanting to address obstacles to goals they planned to pursue and they identified managing their mental health as something that would be an on-going priority in their lives:

> I knew that me trying to commit suicide wasn't the person that I was. I have goals in life that I wanna do.
>
> (lesbian Latinx cisgender female)

Integrating alternative examples

Participants discussed separating from negative social norms by integrating contrasting positive ones. Exposure to alternative attitudes about help-seeking within their minority identity groups modified participants' perceptions of social norms about using mental health services. They discussed how negative social norms about help-seeking were challenged by particular individuals from their identity groups (e.g., family members, peers, or in-group mental health professionals) that influenced them to consider other perspectives. One participant discussed receiving a generally negative impression of help-seeking within her African-American community that was diminished when her mother encouraged her to try therapy:

> They think it's stupid and it's a waste of time. It's not a very positive thing in the Black community. My mom's really the only one that's supportive of it. It definitely did help to know that regardless of how anyone else felt about it, my mom approved of it. That definitely did make me want to do it more.
>
> (lesbian Black cisgender female)

She discussed feeling more conflict with her ethnic identity and her service use, than with her sexual identity. Her mother was not supportive of her sexual identity, yet this participant described her relationship with her mother as highly significant for improving her motivation to use mental health services.

Some participants found that having a service provider with a similar ethnic background offered an alternative to negative ethnic group norms and many participants were positively affected by examples of mental health service use among sexual minority peers. Speaking about his decision to initiate mental health services at an LGBTQ-affirming agency, one participant described how he relied on the judgment of his peers:

> One of the young adults that I know from there, he came up to me and he told me that Doctor G. is really cool, he's really nice, just talk to him because I was the same way. So I was like, I kinda trusted his instincts.
>
> (gay Latinx cisgender male)

He described how this endorsement from a peer helped him to overcome negative past experiences with mental health providers that were causing him to anticipate mistreatment. It was impactful to this participant that the peer was able to empathize and acknowledged that he had felt "the same way." Peers with shared intersectional identities were positively influential due to relatable cultural backgrounds as well:

> There were some who I knew were also LGBT, who were also of my culture, Spanish and Caribbean. It kind of made me more comfortable.
>
> (gay Latinx cisgender male)

Nearly all participants expressed a preference for receiving services from providers that were known to be “LGBTQ-friendly”:

> I prefer it because it’s just like I’m more comfortable like that because they’re already expecting someone LGBT-identified to walk in through the door, rather than a regular program that’s for the youth wouldn’t know what’s coming.
>
> (gay Black cisgender male)

In contrast with separating from identity group norms, participants discussed service use experiences within identity-affirming agencies in terms of embracing an LGBTQ group identity. In these contexts, having a mental health condition and being LGBTQ actually reinforced their sense of belonging and decreased stigma because it highlighted participants’ similarities to other service users.

Participants described how incorporating select social norms that did not conflict with using mental health services permitted them to maintain important connections to identity groups. Many alternative examples described by participants allowed them to explore their identities and include a greater variety of views on using mental health services that already existed within their identity groups. Several examples involved negotiating religious expressions in their ethnic communities. One participant described choosing to identify with a more secular African-American culture that expressed greater acceptance of help-seeking outside of church:

> I recognized that, like, people do have different opinions about how they view mental health and things like that. The Black church is one of those things that very much affected how I saw mental health originally. It seems like secular people are still a little bit affected by it, just because a lot of us still grew up in the church, but we are more willing to go out and get help if it seems like there’s an issue.
>
> (bisexual Black non-binary)

This participant discussed their experience with anti-gay attitudes in church that made it undesirable for them to seek help for their depression from religious counselors. Alternate expressions of Black identity allowed them to extend their understanding of their identity group and to incorporate social norms that are less religious, and more supportive of other forms of help-seeking that would feel safer from discrimination.

Instead of separating from religion, another participant discussed how finding alternative religious expressions within his Latinx culture helped him to find better ways to manage his mental health. He explained that his family and greater ethnic community viewed the church as the primary source for help-seeking, so he felt pressed to either continue subjecting himself to the anti-gay beliefs advocated in his ethnic community’s church or give up his religion in order to seek other mental health services. He described navigating this dilemma, first through anger and negation, and then through exploration:

> For a while, I was like, fuck religion. I don’t want anything to do with this, but now I’m holding on to what was meaningful and just letting go of the rest. They know my sexual orientation, my story. And despite the negative stigma surrounding religion and homosexuality, people are more compassionate. Then I was diagnosed

> by a real doctor with major depression and I could go on, like, Zoloft and finally tell somebody how I was feeling without being judged.
>
> (gay Latinx cisgender male)

He was able to connect with an identity-affirming church serving his ethnic community, which allowed him to maintain aspects of culture and faith that were beneficial to him and feel free to explore other options for mental health treatment.

Concealing stigmatized selves

Participants also discussed ways in which they tried to hide stigmatized aspects of themselves to avoid the impact of negative social norms around service use. They often described concealing their help-seeking to circumvent discrimination from their ethnic identity communities. As one participant expressed, this discrimination could be complex and multi-faceted:

> I wouldn't go around saying I'm seeing a therapist … I don't want people to think I'm going to see a therapist because I'm bisexual. And that's how people will interpret it … but it's not because I'm trying to get cured or fixed.
>
> (bisexual Black cisgender male)

His ethnic community stigmatized both needing help with mental health and being a sexual minority, and viewed them as related circumstances. He explained that he sometimes experienced guilt about concealing his participation in therapy because it seemed like he agreed with his community's attitudes. He thought that stigma delayed his own help-seeking and that he might have received help sooner if he had known other people like him went to therapy, and he did not want to perpetuate that stigma.

Some participants also concealed their sexual or gender identities to avoid anticipated discrimination and mistreatment by providers. For most it was for reasons similar to those described above, to avoid having their mental health struggles labeled as being due to their sexual or gender identities. They did not expect providers to understand experiences of discrimination and victimization unique to being sexual and gender minorities of color and anticipated having their identities "judged," negatively scrutinized, or questioned for validity. For participants that also identified as gender minorities, it could be somewhat more complex, as one participant explained:

> I worry about being discriminated against. What's gonna happen? I think about stuff like that all of the time. That's why females like me, go all the way, cover it up as best we can. If you don't, you're going to be discriminated against. I'm thankful that I got my bottom surgery and had my name change. Then I don't have to tell them anything.
>
> (bisexual Black transgender female)

She also pointed out that she usually anticipated racial discrimination from providers as well, but since she could not hide being Black, she tried to avoid mistreatment due to being trans. She expressed that concealing her identity as a trans person seemed necessary even

though it also required her to deny aspects of her medical history and current status that are critically important for receiving safe and effective mental health treatment.

Greater self-acceptance

Several participants described needing to understand and accept stigmatized aspects of themselves in order to counteract negative social norms about service use and seek help. For many this meant accepting that they had a mental health condition and that they were sexual minorities, in spite of messages from identity groups that stigmatized those qualities. One participant expressed that his help-seeking was changed through learning to accept this about himself:

> I feel like I'm very different now. It's ok to say that you're not ok. I had to teach myself that down for nothing. I had to teach myself it's fine to let people think whatever the hell they think about you. That's their opinion and opinion is like an asshole, everybody has one.
>
> (gay Black cisgender male)

He described being able to ignore others' negative opinions on telling his doctor about his depression once he had learned to ignore their negative opinions about his sexual identity. He felt that he came to a realization about both aspects of himself around the same time, and was able to apply strategies for managing stigma associated with one part of himself to managing stigma associated with another. While he felt that this was something he needed to accomplish on his own, another participant expressed how their connection with the LGBTQ community opened them up to thinking about managing their mental health:

> I think that's something that a lot of people in the queer community are really open about. Just because mental health and the queer community are so deeply intertwined. As I started to be more okay with being queer, that's when I found that I was able to get mental health help when I needed it. Sitting down and thinking about whether or not you identify with that particular gender that you've been raised in, there is more sensitivity to the other ways that you might be different mentally.
>
> (bisexual Black non-binary)

They described a process of exploring their personal identity that enhanced their understanding of how they fit or did not fit into the social norms they grew up with, and provided space to question those norms. The LGBTQ community was perceived as more accepting of having mental health problems, and so this participant found that accepting this identity provided a sense of belonging that helped them to overcome stigmatized attitudes about seeking help with their depression.

Discussion

The primary goal of this study was to explore ways in which Black and Latinx sexual minority young adults navigated those minority identities in the context of mental health help-seeking. The service use experiences discussed by participants in this study help to address a significant gap in our knowledge of how young people's multiple minority

identities shape their participation in mental health care. Notably, study findings were grounded in the experiences of young adults from typically understudied and under-resourced populations, facing multiple marginalized social locations due to their sexual, ethnic, and gender minority identities and lower socioeconomic statuses (Institutes of Medicine, 2011; Rodgers, 2017). Findings indicated all participants engaged in some degree of identity negotiation, in the form of extending or compromising how they thought about and presented themselves, in order to seek help with their mental health.

Struggling with mental health problems introduced another element of stigmatized identity that participants needed to integrate. They considered the beliefs and norms about mental health and help-seeking that they had absorbed from their identity groups, sorted out what was helpful from what was harmful, and began to create their own individualized perspectives on how to address their own needs. Many participants accomplished this while maintaining meaningful connections to their minority identity communities. This finding supports theories of identity development during the transition to adulthood (Erikson, 1968; Marcia, 1994), and theories of ethnic-racial (Phinney, 1990) and LGB (Toomey et al., 2016; Worthington et al., 2008) identity development in which individuals explore and integrate their social identities into a positive, coherent self-concept, and acquire a sense of belonging and affirmation through corresponding needs, values, and goals. In addition, a sizable percentage of participants identified as queer or other non-heterosexual (39%) and with an experienced/expressed gender other than the one they were assigned at birth (39%). This implies that many had actively engaged in exploration of their identity and multiple identity categories in addition to LGB that enabled them to locate themselves not only as sexual minorities, but also in more distinct dimensions based on their internal senses of self.

Consistent with prior research on identity formation among African-American and Latinx sexual minorities (Jamil et al., 2009; Kennedy & Dalla, 2014), participants discussed identity-related mental health and help-seeking content as embedded in their social contexts. Previous studies of help-seeking among young people of color (Breland-Noble, Burriss, & Poole, 2010; Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013; Lindsey et al., 2006) have shown that social norms influence their perceptions of how positively or negatively using mental health services is viewed by their communities. For participants, mental health and help-seeking norms from their ethnic communities and that of their sexual minority communities were distinct, with the former derived from family and the immediate community and the latter as something they needed to seek through peers and LGBTQ-friendly agencies. They also described identity negotiation processes with a sense of agency, suggesting that integrating positive identity-related mental health content was deliberate and accomplished through substantial effort.

Overall, findings indicated that these young people experienced stigma and discrimination based on their sexual, gender, and ethnic/racial identities, and that this was intertwined with, and often negatively impacting their mental health, their experiences, and their attitudes about using mental health services. This is consistent with ample research on the detrimental effects of discrimination on the mental health (Burton et al., 2013; Mustanski et al., 2016; Russell & Fish, 2016) and health behaviors (Hoffman et al., 2009) of sexual and gender minority young people. However, minority identities were discussed as intersectional and

conferring differential effects and stigma on participant's help-seeking. Sexual minority identities were linked with more positive notions about help-seeking and with improving access to services. This aligns with previous research that has found the process of being able to come out and to access mental health resources through the LGBTQ-affirming providers to be motivators for help-seeking and mental health service utilization among those who feel connected to the LGBTQ community (Dunbar, Sontag-Padilla, Ramchand, Seelam, & Stein, 2017; Flores, Santos, Makofane, Arreola, & Ayala, 2017). In contrast, participants related their ethnic identities to more negative attitudes and obstacles to service use, and they described distancing themselves and altering their conceptions of their ethnic identities in order to counteract negative social norms about mental health help-seeking. This is consistent with research finding that LGBTQ + youth of color engage in "cultural negativity management" to cope with impacts of cultural discrimination on their health (Schmitz et al., 2018). Given research that has found stronger ethnic identity in Black and Latinx adults to be associated with lower rates of engagement with psychiatric services (Burnett-Zeigler, Lee, & Bohnert, 2017; Keyes et al., 2012), it is possible that participants' ethnic identities were becoming less salient, or they were over-identifying with LGBTQ identities when they could, in order to get their mental health needs met through using services.

Identity negotiation processes coincided with help-seeking in several key social contexts where participants needed to cope with stigma and discrimination (e.g., family, peers, ethnic and religious communities, healthcare system). This suggests that identity negotiation processes used by participants functioned as adaptive skills for coping with discrimination (experienced or anticipated) in their help-seeking. As described in prior studies of identity integration processes among ethnic minority LGB individuals (Aranda et al., 2015; Balsam et al., 2015; Rosario et al., 2004), participants' mental health-related identity negotiation processes were often prompted by heterosexism and trans-prejudice in their racial-ethnic communities. By adjusting the salience of these unhelpful aspects of identity, *separating from social norms* helped participants to manage fears of rejection by their ethnic communities. Identity processes such as *concealing stigmatized selves* were mobilized to avoid discriminatory experiences, while *integrating alternative examples* and *self-acceptance* processes were working to form or maintain supportive social connections and enhance in-group minority identities. These findings support prior literature asserting that stressors related to minority identity are moderated by the level of salience and integration of one's identity, and can be ameliorated by social supports such as identity-affirming communities (Meyer, 2003, 2010).

Participant identity negotiation processes are also evocative of research on code switching and identity buffering used for stigma management in identity-challenging situations (e.g., Strauss & Cross, 2005). Having intersecting identities was key for enabling participants to modify their attitudes regarding mental health service use by considering multiple perspectives, without becoming dominated by negative social norms from their ethnic identity group. Past research on having multiple social identities highlights how they can facilitate a more integrated or versatile self-concept (regarding race or identity more broadly) and increase flexible thinking regarding problem-solving and navigating between identities as circumstances require (Gaither, Remedios, Sanchez, & Sommers, 2015; Gaither,

Sommers, & Ambady, 2013; Rockquemore, Brunsma, & Delgado, 2009). Similarly, participant expressions of empowerment and self-acceptance suggest what Ghabrial (2017) termed "positive intersectionality" in which finding ways for their marginalized identities to support one another offered a protective narrative for LGBTQ POC and helped them to preserve their well-being in the face of stigma and discrimination. The identity processes used by participants in this study suggest that strengthening the development of integrated identities for sexual minority young people of color might help them make the most out of their intersecting identities and could be a powerful way to support their resilience and positive mental health help-seeking.

Study limitations and recommendations for future research

The current study has some limitations that are important to consider. Our study did not inquire specifically about how participants arrived at their identity statuses more generally, unconnected to their participation in mental health services. Although those experiences did emerge in these data, sexual and gender identity might have still been forming among some participants and they may have been at various points in exploring and integrating their identities at the time of interview. As such, self-identified labels could change as young people accumulate more adult experiences. Future research should include questions/measures that can better capture fluctuations in identity among emerging adults over time and might be more accurate and meaningful for capturing where they are in their identity formation and how that impacts their mental health help-seeking.

Although participants were allowed to self-identify, broad categories such as Latinx and Black, may not fit them well as individuals. For instance, some participants were multiracial or Afro-Latinx, with various levels of acculturation. Their experiences may significantly differ from those described in existing literature about groups of Black, African-American, and Latinx adults due to differences in culture and representation within racial-ethnic identity groups. This has relevance for describing and understanding the relationship between ethnic identity and mental health service utilization and should be examined in future research, especially because it is a growing trend among young people in the U.S. (Pew Research Center, 2015). Finally, because our data were collected at one time point, it did not allow us to follow participants as they implemented their identity negotiation processes for moving away from norms about treatment toward new beliefs, attitudes, and behaviors of their own. Further research using longitudinal data to investigate the relationship between minority identity development processes and mental health behaviors would strengthen theoretical findings about these processes.

Implications for practice

Young adulthood can be a pivotal developmental period for navigating mental health and treatment options when individuals are forming their values, attitudes, and adult selves. As such, service providers should recognize that young LGBTQ people of color might need support in negotiating the complex relationship between multiple identities. This highlights the need for provider training in health settings to increase their responsiveness toward individuals entering treatment with multiple marginalized identities. This is especially critical given the great variability in attitudes and competencies for working with sexual

minorities among providers (Moe & Sparkman, 2015) and the harmful practices such as conversion therapy that continue to be used with youth in the U.S. by licensed health care professionals (Mallory, Brown, & Conron, 2018). Increasing provider knowledge and sensitivity regarding intersectional identities has great potential to decrease discrimination experiences and improve engagement with mental health services. To start, providers can advertise themselves as LGBTQ-friendly and use culturally competent intake materials to assert their commitment to identity-conscious services and to reduce fears of discrimination and mistreatment that prevent young people from even initiating care.

Our findings also underscore the importance of prevention and psychoeducation programs in minority communities that can counteract dominant narratives around mental illness and mental health treatment, including those that portray homosexuality and gender non-conformity as a mental disorder. Service providers can be sources of support, affirmation, and knowledge for sexual and gender minority young people and their families. Making information on minority stress and positive identity development available to minority communities should be part of prevention and health education efforts. Mental health service engagement programs for young adults might be more effective when they utilize role models or public figures from minority communities whose courageous alternative narratives discuss mental health diagnosis and recovery (e.g., Los Angeles County Department of Mental Health, 2013). Exposure to those stories can stimulate identity exploration and encourage young people to challenge dominant stigma and help-seeking norms.

Finally, both clinicians and researchers should place more focus on processes of resilience among young sexual and gender minorities, particularly LGBTQ young adults of color. Understandably, the vast majority of scholarly research to date has documented their health disparities, risk factors, and stressors. Yet, the present study adds to a growing number (e.g., Balsam et al., 2015; Chiang et al., 2017; Ghabrial, 2017; Schmitz et al., 2018) that point to multiple marginalized identities serving as protective factors that might be mobilized into prevention and intervention programs. The data also imply that aspects of identity can be modified with respect to mental health services decision-making during young adulthood. Assessment of how minority identity is impacting young peoples' lives can assist providers to work with minority identity-related factors and can inform ways to support young adults that are negotiating norms that are directing their health decision-making. More research is needed to determine how assessments and interventions that promote a multiple-identity mindset may positively affect decision-making, levels of treatment engagement, and overall wellness among diverse sexual and gender minority young adults.

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Table 1.

Participant Characteristics (n = 31).

	Percent/Mean (SD)
Age	22.16 (1.8)
Gender identity	
Cisgender male, (n = 12)	39%
Transgender male, (n = 1)	3%
Cisgender female, (n = 7)	23%
Transgender female, (n = 6)	19%
Non-binary - AMAB, (n = 3)	10%
Non-binary - AFAB, (n = 2)	6%
Race/ethnicity	
Black, non-Latinx, (n = 17)	55%
Latinx, any race, (n = 14)	45%
Sexual orientation	
Bisexual, (n = 14)	45%
Gay, (n = 10)	32%
Lesbian, (n = 7)	23%
Economic status	
Income <$12,000 annually, ($n$ = 25)	81%
Mental health	
Symptom severity (BSI)	1.41 (.68)
Service use, past year, (n = 23)	74%

Notes. Global Severity Index cutoff score for adult psychiatric outpatients = 1.32 (Derogatis & Melisaratos, 1983).

AMAB: assigned male at birth; AFAB: assigned female at birth; BSI: Brief Symptom Inventory.