

Multiple Minority Identities and Mental Health Service Use: A Mixed-Methods Study of Sexual
and Gender Minority Young Adults of Color

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ABSTRACT

Multiple Minority Identities and Mental Health Service Use: A Mixed-Methods Study of Sexual and Gender Minority Young Adults of Color

by

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Research on mental health outcomes among racial-ethnic, sexual, and gender minority young people indicates that they may be at increased risk for service use disparities when these identity statuses intersect. However, evidence of how having multiple minority identities is related to using mental health services is lacking. This dissertation used a mixed-methods, convergent design to explore and describe relationships between intersecting minority identities and mental health service use in the experiences of 31 Black and Hispanic, sexual and gender minority young adults. Consistent with an intersectional perspective, findings indicated that mental health service use was more strongly associated with minority identities collectively than with any single minority identity, and that experiences of intersecting minority identities could facilitate, as well as hinder, mental health service use among participants. A theoretical model was revealed in which participants negotiated multiple minority identities within four dimensions related to their service use: ethnic-racial culture, intersecting identities, family, and personal identities. Results suggested provider strategies that support intersecting minority identity strengths around culture, community belonging, and self-efficacy may encourage service use and engagement with treatment.

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Introduction

Background and Significance

Disparities in mental health outcomes and treatment have been documented among youth of color (U.S. Department of Health and Human Services, 2001) and sexual minority youth (Institutes of Medicine, 2011) respectively that suggest that they are at risk for poorer outcomes. These considerable obstacles can be compounded for sexual minority youth of color (SMYoC) with mental health disorders, leading to disparities in their use of mental health services and likelihood of dropping out of treatment (Russell & Fish, 2016; Substance Abuse and Mental Health Services Administration, 2015). Effective treatments for mental health disorders involve consistent service use, sustained engagement, and active participation in the various therapeutic components of care. Lack of engagement with services is associated with symptom relapse and poorer outcomes for youth, and presents a major barrier to effective mental health service delivery (Busby & Sajatovic, 2010; Kazdin & Mazurick, 1994; Mc Nicholas, 2012; Schwalbe & Gearing, 2012).

Cultural identity shapes the way individuals perceive mental illness, treatment, and treatment engagement (Abdullah & Brown, 2011; Aggarwal et al., 2016; Lewis-Fernández et al., 2014; Smith et al., 2014). Minority cultural identities are particularly important to consider when examining psychological factors related to mental health service use among SMYoC. Several studies of sexual minority youth (e.g., (Russell, Sinclair, Poteat, & Koenig, 2012; Saewyc, 2011) and youth of color (e.g., (Huynh & Fuligni, 2010; Simons et al., 2006) have found that discrimination and bullying related to minority identities uniquely contributed to mental health problems. The effort required of minorities to manage stigmatized and devalued identities diminishes their psychological resources (Hatzenbuehler, Phelan, & Link, 2013). SMYoC report

experiences of dual sources of stress that negatively impact their mental health (Craig, Mc Inroy, Austin, Smith, & Engle, 2012; Homma & Saewyc, 2007; Rivers & Noret, 2008). Yet, the impact of cultural identity is dynamic and unique to each individual. There are general trends among different minority groups regarding how they view their mental health symptoms and treatment, but this cannot be assumed for all members of a group and has to be considered individually (Dixon, Holoshitz, & Nossel, 2016).

Promising strategies have been developed to increase mental health service use among diverse youth using positive identity development, age-specific interventions, and structural supports (e.g., (Craig et al., 2012; Gearing, Schwalbe, Hoagwood, Guetta, & Moore, 2015; Kim, Munson, & Mc Kay, 2012; Lucksted et al., 2015; Munson et al., 2014). Yet, to effectively adapt strategies to meet the needs of multiple minority youth, providers must be able to consider the intersecting relationship among identity factors such as race, ethnicity, sexual orientation, gender identity, and developmental stage that constitute each individual's experience. Theories of emerging adult identity development (Arnett, 2000), minority identity development (Umaña-Taylor et al., 2014), and intersectionality of multiple marginalized identities (Collins, 2002; Crenshaw, 1991; Davis, 2008) provide a framework for examining the complex individual and collective identity domains that interact in the lives of multiple minority young adults (YAs). However, there have been very few analyses of sexual and gender minorities that are also racial-ethnic minorities during emerging adulthood, and research on the identity development of minorities has largely not focused on how it relates to mental health service use, contextual factors (e.g. social and economic class), multiple marginalized identities, or unique life experiences in young adulthood (Syed & Mitchell, 2013).

The significance of this study rests in the need to gain an understanding of multiple minority identities in YA mental health consumers that can be applied to reducing disparities in their service use. Strategies to improve engagement with services need to accommodate a vastly heterogeneous population of minority YAs at risk for poorer mental health outcomes. Many mental health providers working with diverse, underserved populations face the challenge of how to engage and retain clients (Interian, Lewis-Fernández, & Dixon, 2013). While culturally tailored, person-centered strategies may be effective for improving engagement (Dixon et al., 2016; Huey Jr, Tilley, Jones, & Smith, 2014), the convergence of multiple cultural identities present in the current YA population is the most diverse in U.S. history (Pew Research Center, 2015; Public Religion Research Institute, 2015). For example, according to the 2010 U.S. Census, the number of people who identified as multiracial has grown by 32% since 2000, more than any other single racial classification (Jones & Biullock, 2012). Furthermore, the minority YA population is growing in general. More than half (56%) of minorities in 2015 were Millennials or younger (Pew Research Center, 2016). Without a better grasp of how minority identities are related to engagement in mental health services, providers will struggle to culturally-tailor their strategies to meet their minority YA client's needs. Yet, little is known about how having multiple minority identities affects service use in YAs. This study addresses that gap by using an intersectional perspective to explore how YAs experience connections between multiple minority identities and using mental health services and how their experiences may promote or hinder service use. Information gained from this study can enhance the development of culturally-relevant engagement interventions to reduce disparities in service use.

Research Aims

This study used a mixed-methods approach to analyze data collected from 31 sexual and gender minority YAs of color. Qualitative interviews and responses to survey items provided information about YAs' minority identities and mental health service use. The study addressed the following research aims:

Aim 1: (Quantitative) To describe the association of minority identity and continuous mental health service use among a sample of sexual and gender minority YAs of color.

Aim 2: (Qualitative) To explore the experience of intersecting minority identities in the context of mental health service use. Related questions were: How are connections between minority identities and mental health service use experienced and expressed? From the perspective of participants, do experiences of minority identity facilitate and impede mental health service use?

Chapter 1: Literature Review

This chapter will present and review literature supporting the rationale and the research aims for this study of multiple minority identities and mental health service use among YAs. The prevalence of mental illness among multiple minority adolescents and YAs (collectively referred to as “youth” from this point forward), mental health outcomes, service utilization, and minority identities will be addressed. Finally, the conceptual framework and purpose of this study will be discussed.

Young Adulthood and Mental Health Problems

Behavioral health conditions, out of all types of illnesses, cause the greatest burden of disability in YAs (National Research Council, 2013). The 12-month prevalence of diagnosable mental illness among adults aged 18-25 in the U.S. is estimated to be 21.7%, with 5% of YAs reporting serious functional impairment, and 5.9% reporting co-occurring disorders, yet only about 32% of those YAs used mental health services in the past year (Center for Behavioral Health Statistics and Quality, 2016). Studies also show that YA men with mental health problems are less likely than women to receive mental health care (Gonzalez, Alegria, & Prihoda, 2005; Rowan, 2014). Compared to adults in other age groupings (26-49 and 50 years and older), YAs with serious mental illnesses are estimated to use mental health services up to 20% less annually and to have 14%-27% higher rates of co-occurring substance use disorders (Substance Abuse and Mental Health Services Administration, 2014). In addition, data from the 1999 Client/Patient Sample Survey found that mental health service utilization rates at ages 18-19 were about half the rate at ages 16-17, and rates remained low for ages 20-25 (Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2008), suggesting that YAs with mental health disorders may

be more likely to disengage from treatment than adolescents and more likely to experience a major decline in service use at a significant time in their development.

Developmental milestones such as identity exploration, independence seeking, and increased responsibility for their own well-being are essential to young people during this phase of life (Arnett, 2000; Clark, Unger, & Stewart, 1993). However, research has shown that approximately half of all lifetime mental disorders start by the mid-teens, three-fourths start by the mid-20s, and severe disorders are typically preceded by less severe disorders that are rarely brought to clinical attention (Kessler et al., 2007). Compared to their peers, YAs with mental illnesses have lower rates of education and employment, and higher rates of poverty, unplanned pregnancy, substance use disorders, homelessness, and criminal justice involvement that can interrupt their transitions to adulthood (Hoeve, McReynolds, & Wasserman, 2013; Sheidow, McCart, Zajac, & Davis, 2012; Vander Stoep et al., 2000).

Engagement with mental health services (i.e., choosing to seek treatment, to remain in treatment, and to actively participate in the therapeutic elements of care) is a particular challenge for youth in transition to adulthood (i.e. ages 16-25) and lack of engagement often presents a significant obstacle for YAs with mental health disorders. Researchers have cited various reasons for not using services among YAs, including cost, structural barriers, perceived discrimination, and low perceived need (Biddle, Donovan, Sharp, & Gunnell, 2007; Meadows, Brown, & Elder, 2006; Vogel, Wade, Wester, Larson, & Hackler, 2007). According to combined 2009 to 2013 National Survey on Drug Use and Health data, an annual average of 1.5 million YAs aged 18-25 felt they needed mental health services but did not receive any services in the past year (Center for Behavioral Health Statistics and Quality, 2015). These YAs were asked to identify reasons why they did not receive the services that they felt they needed. Cost/insurance issues were a

barrier to getting mental health services for 46% of YAs. About 36% of YAs believed that getting services would cause them to experience discrimination from others, such as employers, friends, or family. Many YAs (38%) had structural barriers to getting care, such as lack of transportation. Although these YAs acknowledged an unmet need for services, 36% indicated that they had a low perceived need (i.e., did not feel the need for treatment at the time and/or could handle the problem without treatment) and 12% indicated they did not think treatment would help.

Mental Health and Service Use Among Racial-Ethnic Minority Youth

Vulnerability to mental health problems for minority YAs often starts in childhood and adolescence. Many risk factors for mental illness disproportionately affect racial-ethnic minority youth, such as poverty and exposure to violence and discrimination. Black and Latino children are disproportionately affected poverty (Bishaw & Semega, 2008) and socioeconomic disadvantages of minority youth can have significant negative effects on their mental health (Alegria, Vallas, & Pumariega, 2010), including depression and behavior problems (Mollica, Poole, Son, Murray, & Tor, 1997) and anxiety disorders such as posttraumatic stress disorder (Kataoka, Zhang, & Wells, 2002). Many ethnic-racial minority youth also experience trauma related to witnessing violence in their homes and their neighborhoods (Cooley-Quille, Boyd, Frantz, & Walsh, 2001; Horowitz, Weine, & Jekel, 1995; Jaycox et al., 2002; Kodjo & Auinger, 2004), and this sort of trauma has been linked to high rates of mental illness, including posttraumatic stress disorder, depression, and externalizing behaviors (Flannery, Wester, & Singer, 2004). Additional factors that increase the risk for mental illness for ethnic-racial minority youth are repeated experiences of discrimination and chronic exposure to racism (Pumariega & Rothe, 2010; Sellers, Copeland-Linder, Martin, & Lewis, 2006; Umaña-Taylor & Updegraff, 2007).

Racial-ethnic disparities in mental health service use and factors associated with lack of engagement in services suggest that provider and health care system level factors, the environmental context, and individual level factors all play a significant role in heightening the risk of disengagement from services for minority children and adolescents (Alegria, Carson, Goncalves, & Keefe, 2011; Alegria et al., 2012; Garland, Lau, Yeh, & McCabe, 2005; Gearing, Townsend, Elkins, El-Bassel, & Osterberg, 2014; McKay, Stoewe, McCadam, & Gonzales, 1998; Merikangas et al., 2011). Despite evidence suggesting that the prevalence of psychiatric disorders in children does not appear to vary greatly by race or ethnicity (Alegria et al., 2012), several studies have found that ethnic-racial minority children with psychiatric disorders remain untreated (Alegria et al., 2010; Garland et al., 2005; Kataoka et al., 2002; Kodjo & Auinger, 2004; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003), are differentially referred within the child welfare or juvenile justice systems to receive treatment (Alegria et al., 2012; Langrehr, 2011; Spinney et al., 2016), and receive fewer options and resources for mental health services when they are treated (Bussing, Schoenberg, & Perwien, 1998; Cummings & Druss, 2011; Zito, Safer, Dosreis, & Riddle, 1998) compared to non-Latino Whites. In addition, the vast majority of psychiatric diagnosis and treatment science is derived from research primarily involving European-origin populations, so its validity for racial-ethnic minority populations is not fully established (Huey Jr & Polo, 2008). When minorities seek treatment, they may not remain engaged in outpatient services or use as many service units (Alegria, Greif Green, Mclaughlin, & Loder, 2015; Alegria et al., 2011). Treatment is often interrupted prematurely by financial needs, location of services and transportation, lack of adequate insurance, poorly understood administrative procedures, and lack of linguistic support (Snowden & Yamada, 2005).

There is less information about the prevalence and persistence of mental disorder among

racial and ethnic minority YAs, as opposed to children and adolescents. Studies that examined prevalence and persistence of mental disorders among diverse samples of adults and children provide most of the descriptive information relevant to minority YAs. Overall, research indicates that the prevalence of most psychiatric conditions is similar for Black, Hispanic, and White YAs (Frye & Liem, 2011; Harris, Gordon-Larsen, Chantala, & Udry, 2006; Merikangas et al., 2010). The lack of association of mental illness with race-ethnicity has been partly explained by the role of particular positive influences that buffer the effects of adversities or disadvantages faced by Black and Hispanic youth, such as cultural identity, self-esteem (Anderson & Mayes, 2010; Sellers, Copeland-Linder, Martin, & Lewis, 2006), religiosity, and relationships with peers and family members (Alegría et al., 2015; Gore & Aseltine Jr, 2003). However, various cross-sectional data indicate rates of mental illness are higher among Whites and Native Americans (Hasin, Goodwin, Stinson, & Grant, 2005) and lower among African-Americans, Hispanics, and Asians (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005; Gilman, Kawachi, Fitzmaurice, & Buka, 2003; Kessler, Chiu, Demler, & Walters, 2005). Regrettably, multiracial and multiethnic YAs are not represented well enough in the data to allow for inferences about rates of mental illness. Large enough samples to indicate prevalence for distinct multiracial and multiethnic groups of YAs are not currently available, as such, it is difficult to know how to identify them within or among racial or ethnic minority groups.

Data from the National Longitudinal Study of Adolescent Health (Add Health) and follow up into adulthood indicated few differences across racial groups in the prevalence of suicidal thoughts or feelings of depression at age 21 (Harris et al., 2006). Others using Add Health data found that symptoms of depression were higher among African-Americans and Hispanics compared to Whites, but more Whites reported actually being diagnosed with

depression (Broman, 2012). African-Americans and Hispanics were also more likely to have consistently elevated symptoms of depression between ages 15 and 21 compared to Whites (Wickrama, Wickrama, & Lott, 2009), but there were no differences among racial-ethnic groups in the likelihood of increasing or decreasing symptoms (Harris et al., 2006; Wickrama et al., 2009). Research among adults in the National Comorbidity Survey found that despite lower prevalence rates, non-White racial groups had more persistent disorders (Breslau et al., 2005). One study found lower rates of reoccurrence of depression among African-Americans between age 18 and 39 (Gilman et al., 2003). Researchers have also found that African-Americans and Hispanics are more likely to be in subgroups with elevated levels of depression (Costello, Swendsen, Rose, & Dierker, 2008) and that, compared to Whites, African-Americans were more likely to have increasing symptoms between age 18 and 22 (Frye & Liem, 2011).

Even though large epidemiologic studies report that Black and Hispanic YAs are often less likely to have a psychiatric disorder than those who are White, research indicates that African-Americans and Hispanics with mental health problems are less likely to obtain mental health care (Mojtabai, Olfson, & Han, 2016; Ringeisen, Casanueva, Urato, & Stambaugh, 2009; Simpson, Krishnan, Kunik, & Ruiz, 2007; Wang et al., 2005). Estimates of mental health service utilization are as low as 19% among Blacks and 22% among Hispanic YAs with mental illnesses, compared to Whites (38%) (Substance Abuse and Mental Health Services Administration, 2015). Outside of this general finding, racial-ethnic variation in treatment for specific disorders and treatment modalities has also been reported. Nationally representative data from the 2006–2012 Medical Expenditure Panel Surveys showed that racial-ethnic service use disparities among YAs (aged 18-34) were generally larger than those observed among children (Marrast, Himmelstein, & Woolhandler, 2016). For instance, Blacks made 68% fewer and Latinos made 62% fewer

visits to mental health professionals. The substance abuse counseling rate for Black YAs was 85% below that for Whites, and Hispanic and Black YAs had somewhat lower psychiatric inpatient and emergency department use rates than Whites. Among YAs, Add Health data indicated that, controlling for depressive status, African-Americans are less likely to receive mental health counseling for depression than Whites, but all other groups (Hispanics, Asians, Native Americans and others) are as likely to receive care as Whites (Broman, 2012). Olfson, Marcus, Tedeschi, and Wan (2006) found that Hispanics have higher rates of antidepressant discontinuity, after adjusting for mental health status, and Wang et al. (2005) found that Hispanics received less specialty care, but did not receive less care in the general sector compared to Whites.

Researchers have cited various reasons for differences in service use among racial-ethnic minority YAs, including structural factors, such as the affordability of care and knowing how and where to access services, as well as differences in perceived need, problem recognition and coping mechanisms, beliefs about the efficacy of services, and stigma (Biddle et al., 2007; Dobalian & Rivers, 2008; Meadows et al., 2006; Ojeda & Bergstresser, 2008; Padgett, Patrick, Burns, & Schlesinger, 1994; Vogel et al., 2007; Zuvekas & Fleishman, 2008). In addition, Williams (2014) found that being female and having an evaluated need for services were associated with greater odds of service use, which suggests gender differences in service utilization among minority YAs. Structural factors related to service use disparities are similar in many ways to those experienced by racial-ethnic minority children. However, minority YAs (along with non-minorities) with mental illness experience challenges with finding services tailored to their age range and navigating multiple programs and delivery systems now that they are no longer supported by caregivers, school, or social service systems (Davis & Vander Stoep,

1997; United States Government Accountability Office, 2008). For example, those who received free or low-cost services as children may not qualify for them as adults. Black and Hispanic YAs may also use less mental health care due to low quality of care (Ghods et al., 2008; Schneider, Zaslavsky, & Epstein, 2002), or low availability of formal and informal mental health care (Young, Klap, Sherbourne, & Wells, 2001).

Mental Health in Sexual and Gender Minority Youth

Many studies based on probability samples indicate that lesbian, gay, bisexual, and transgender (LGBT) adults are typically well adjusted and mentally healthy, and data from convenience samples similarly show that many do not report mental health problems (see review by Institutes of Medicine, 2011). However, findings from the 2015 NSDUH on substance use and mental health issues for adults by sexual orientation showed that LGB YAs had higher rates of mental illness compared to sexual majority YAs, with 42% of LGB YAs reporting any mental illness in the past year and 15% reporting a serious mental illness (Medley et al., 2016). Significantly higher rates of major depressive disorder were recorded for LGB YAs with 18% reporting severe impairment in the past year. Studies consistently report that LGBT youth report elevated rates of emotional distress, symptoms related to mood and anxiety disorders, self-harm, suicidal ideation, and suicidal behavior when compared to sexual/gender majority youth (D'Augelli, 2002; Fergusson, Horwood, Ridder, & Beautrais, 2005; Marshal et al., 2011; Russell & Fish, 2016). Results from a recent US study that interviewed a community sample of LGBT youth (aged 16-20) found that nearly one-third of participants met the diagnostic criteria for a mental disorder and/or reported a suicide attempt in their lifetime (Mustanski, Garofalo, & Emerson, 2010), 7% to 20% higher than mental health diagnosis rates in the general youth population. Almost 18% of lesbian and gay youth participants met the criteria for major

depression and 11.3% for PTSD in the previous 12 months, and 31% of the LGBT sample reported suicidal behavior at some point in their life. Additionally, suicidal thoughts, depression, and anxiety may be elevated among gay males who were gender-variant as children (Alanko et al., 2009).

Marshal et al. (2011) reported in a recent meta-analysis that sexual minority youth were almost three times as likely to report suicidality. Additionally, in the first nationally representative study on the health risks of U.S. LGB high school students, Kann et al. (2016) found that more than 40% of LGB students have seriously considered suicide, and 29% reported having attempted suicide during the past 12 months. Sixty percent of LGB students reported having been so sad or hopeless they stopped doing some of their usual activities. Studies on LGB youth suicide have found stronger associations between sexual orientation and suicide attempts for sexual minority males compared to sexual minority females (Fergusson et al., 2005; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999), including a meta-analysis using youth and adult samples (King et al., 2008).

Bisexual and questioning youth have been described as a subgroup. Many studies indicate that bisexual youth are at greater risk for poor mental health when compared to heterosexual and same-sex-attracted peers (Kann et al., 2016; Marshal et al., 2011; Medley et al., 2016; Saewyc et al., 2008; Talley, Hughes, Aranda, Birkett, & Marshal, 2014). In their meta-analysis, Marshal et al. (2011) found that bisexual youth reported more suicidality than lesbian and gay youth. There is also research on youth questioning their sexuality that indicate greater levels of depression than those reporting other sexual orientations (Birkett, Espelage, & Koenig, 2009) and show worse psychological adjustment in response to bullying and victimization than heterosexual or LGB-identified students (Poteat, Aragon, Espelage, & Koenig, 2009).

LGB YAs may be more likely than their sexual majority peers to use illicit drugs and to have a substance use disorder (Medley et al., 2016). Kann et al. (2016) found LGB youth are up to five times more likely than other youth to report using illegal drugs. Alcohol and drugs may be more present at social venues (bars and dance clubs) in which some youth explore their gay identities. Lesbian and bisexual youth describing themselves as “mostly heterosexual” (as opposed to unambiguously hetero- or homosexual) may be at increased risk for alcohol use (Ziyadeh et al., 2007). Some gay youth may use drugs and alcohol to achieve a sense of belonging or cope with the effects of shame, guilt, and a lack of confidence associated with their romantic and sexual feelings (Adelson, 2012; Faulkner & Cranston, 1998).

Most research to date on reasons for mental health disparities among LGBT youth has focused on victimization and discrimination based on sexual-gender minority status. This is because studies find that with adequate support, many of the mental health outcome disparities disappear (McGuire, Mahan, Lacey, & Hoelscher, 2017). LGBT youth face many risk factors for compromised mental health, such as the absence of institutionalized protections, biased-based bullying, and family rejection (Russell & Fish, 2016). When compared to non-biased-based victimization, youth who experience LGB-based victimization report higher levels of depression, suicidal ideation, suicide attempts, substance use, and truancy (Poteat, Mereish, Digiovanni, & Koenig, 2011; Russell et al., 2012), regardless of whether these experiences are in person or online (Sinclair, Bauman, Poteat, Koenig, & Russell, 2012). Robinson, Espelage, and Rivers (2013) found that although rates of bullying decrease over the course of the adolescent years, this trend is less pronounced for gay and bisexual males, leaving these youth vulnerable to these experiences for longer periods of time.

Medley et al. (2016) found that sexual minority YAs were more likely than their sexual majority counterparts to have received mental health care and substance abuse treatment in the past year. However, sexual minorities are particularly vulnerable to discrimination and negative experiences during encounters with health and social service providers which places them at risk for service disengagement (Cochran & Mays, 2006; Craig & Smith, 2014; Hoffman, Freeman, & Swann, 2009). Transgender people are subject to similar prejudices and challenges when engaging with mental health providers (Green, 2000). LGBT experiences of heterosexism and homophobia from society, family, or friends leads to the expectation that their sexual orientation or gender identity may result in negative scrutiny by mental health providers (Alexander, 1998) and many mental health service providers do not receive adequate, if any, education or training regarding the needs of LGBT individuals (Long, Bonomo, Andrews, & Brown, 2006). People experiencing a major mental illness may have their sexual orientation or gender identity attributed to their mental illness, rather than a legitimate part of their identity (Page, 2004). For example, gender non-conforming behavior or identity is still pathologized and considered a psychological disorder in the DSM, as well as by a number of mental health professionals (Lev, 2013). Heterosexism and anti-gay stigma within mental health care is expressed in the extreme through those practitioners who advocate and practice reparative or conversion therapies (Jenkins & Johnston, 2004), in spite of their harmfulness and ineffectiveness (Anton, 2010).

Mental Health Among Sexual Minority Youth of Color

No nationally representative studies were found that reported mental health outcomes for sexual minority YAs of color. For example, in Medley et al. (2016) the sample size of sexual minority YAs did not allow for meaningful comparisons when data for sexual minority YAs

were further subdivided into groups defined by race or ethnicity. Studies of sexual minority youth of color (SMYoC) have found mixed evidence for mental health outcomes. Results from some studies indicated that Black and Latino sexual minority youth experienced greater mental health problems (e.g., suicide behaviors, hopelessness) compared to White (Ryan, Huebner, Diaz, & Sanchez, 2009; Seal et al., 2000). However, other studies found that White youth reported more mental health problems compared to youth of color (Burns, Ryan, Garofalo, Newcomb, & Mustanski, 2015; Levasseur, Kelvin, & Grosskopf, 2013; Poteat et al., 2009). Similarly, among Latino youth, sexual minority youth who reported bullying were less likely to experience suicidality than non-Latino youth (Levasseur et al., 2013). Others found no differences by race-ethnicity in feelings of hopelessness or suicidality (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Walls, Freedenthal, & Wisneski, 2008) or externalizing and internalizing symptoms (Marshal et al., 2013). Studies found that gender role strain due to the need to be hypermasculine may affect mental health, particularly among young Black males (Fields et al., 2015). Black youth also reported more cumulative risk (i.e., accumulation of stressors that increase the likelihood of negative outcomes) than Latino youth, and cumulative risk was associated with increased suicide risk (Craig & McInroy, 2013). Studies of substance use suggested there was no racial-ethnic difference in the prevalence of alcohol use among LGB youth (Rosario, Hunter, & Gwadz, 1997; Warren et al., 2008) and illicit drug use was lower among Latino and Black youth compared to White youth (Celentano et al., 2005; Newcomb, Ryan, Greene, Garofalo, & Mustanski, 2014). In a study using pooled 2005 and 2007 Youth Risk Behavior Survey data, Bostwick, Meyer, et al. (2014) reported that compared with White sexual minority youth, Asian and Black youth had lower odds of suicidal ideation, suicide planning, and self-harm, whereas

American Native/Pacific Islander, Latino, and Multiracial youths had higher odds feeling sad and suicide attempts.

Given the increased risks for mental health problems related to discrimination among LGBT individuals and among racial-ethnic minorities, some studies have begun to examine the resulting additive effects of multiple forms of discrimination on the mental health of LGBT people of color (POC). Bostwick, Boyd, Hughes, West, and McCabe (2014) utilized cross-sectional data from Wave 2 of the 2004–2005 National Epidemiologic Survey of Alcohol and Related Conditions to examine perceived discrimination based on sexual orientation, race-ethnicity, and gender (alone and in combination) and their association with past year mental health outcomes in LGB adults. Respondents who reported combined sexual orientation and racial-ethnic discrimination or combined sexual orientation, racial-ethnic, and gender discrimination were significantly more likely to meet criteria for a mental health disorder. Further, racial discrimination alone was not associated with mental health disorders, but the combination of this with gender discrimination or sexual orientation discrimination was significantly associated with increased odds of past year mental health disorder. Gender discrimination was the only single type of discrimination associated with an increased odds of past year disorder. Kattari, Walls, Whitfield, and Langenderfer Magruder (2016) found that transgender and gender non-conforming POC reported significantly higher rates of experiencing discrimination at mental health clinics (14.1%) than their White counterparts (9.1%), with Latino individuals being more than twice as likely to experience discrimination than Whites. In a mixed-methods study of LGB POC living with a mental health condition, Holley, Mendoza, Del-Colle, and Bernard (2016) found that participants experienced discrimination related to all three of these identities. Mental illness discrimination was found to share characteristics with racism

and heterosexism, and heterosexuals and POC reported more mental illness discrimination than their counterparts. Sutter and Perrin (2016) conducted an online survey with 200 LGBTQ POC on their experiences of LGBTQ-based discrimination, racism, mental health (depression, anxiety, satisfaction with life), and suicidal ideation. They found that, although racism and LGBTQ-based discrimination were associated with one another and both exerted a direct effect on mental health, only LGBTQ-based discrimination exerted a significant indirect effect on suicidal ideation via mental health.

No studies were found of SMYoC focused on the intersection of these identities and the effects of multiple forms of discrimination on mental health. In a systematic review of health and well-being among SMYoC samples, Toomey, Huynh, Jones, Lee, and Revels-Macalinao (2017) reported that the present research on SMYoC populations is mostly focused on sexual risk, substance use, and mental health problems rather than on normative developmental processes or positive youth development (e.g., protective factors or strengths). Further, the results of the review were limited by the number of studies that had examined the experiences of SMYoC. For example, only 28 focused on mental health exclusively and only a single report exclusively focused on mental health outcomes among Latino and Asian youth. The scope of current research is further narrowed by its emphasis on outcomes rather than on the processes that contributed to those outcomes, such as structural-level factors that perpetuate risk (e.g., discrimination, stigma, oppression).

Studies of the effects of discrimination on sexual minorities frequently use minority stress theory (Meyer, 2003) as a framework for understanding mental health disparities (Institutes of Medicine, 2011). It suggests that sexual minorities experience distinct, chronic stressors related to their stigmatized identities and these distinct experiences, in addition to everyday or universal

stressors, disproportionately compromise the mental health and well-being of LGBT people. LGBT POC experience racism both within LGB communities and the larger society, in addition to experiencing heterosexism within their racial-ethnic communities (Han, Proctor, & Choi, 2014; Harris, 2010; Valera & Taylor, 2011), which has been linked to psychological distress among POC (Szymanski & Gupta, 2009). In turn, having a psychiatric diagnosis while also being an LGBT person who is a racial-ethnic minority can create what is called dual stigma, making them feel marginalized by having to negotiate multiple identities that influence their mental health (Kapila, 2015).

Culture and Social Networks in Mental Health and Help-Seeking

Mental health service utilization differences in racial-ethnic minority youth related to perceived need, problem recognition and coping mechanisms, beliefs about the efficacy of services, and stigma are often related to their culture and social networks (Cauce et al., 2002; Yeh et al., 2003). The cultural values and norms associated with their race-ethnicity may impart risk or protective factors for mental health outcomes among sexual and gender minority YAs. Although many traditional cultural values and beliefs are a source of strength and support for diverse YAs, some can act as barriers to using mental health services. Culture refers to an integrated pattern of human behaviors including thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social nature. Culture influences patients' perceptions of mental health, the relevance and efficacy of mental health treatments, coping, and help seeking (U.S. Department of Health and Human Services, 2001). Furthermore, culture impacts care through influences on identity, such as those due to gender, age, class, race, sexual orientation, and religion (Lewis-Fernández et al., 2014).

The interpretation of mental health conditions as medical conditions varies widely across cultures (Good, 1992; Karasz, 2005). Racial-ethnic minority families appear less likely to recognize mental health disorders (Roberts, Alegría, Roberts, & Chen, 2005) or may feel that they can adequately provide care without formal providers (Pescosolido, Wright, Alegria, & Vera, 1998). Regarding differences in perceived need for mental health treatment, an early phase in the help-seeking process (Andersen, 1995; Edlund, Unützer, & Curran, 2006; Mechanic, 2002), several studies found that racial-ethnic minorities are less likely to consider themselves in need of mental health treatment than non-Hispanic whites (Apesoa-Varano et al., 2015; Breslau et al., 2017; Carpenter-Song et al., 2010; Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010), even after adjusting for mental health status. This suggests that even though sexual minority YAs are more likely to receive mental health services (Medley et al., 2016), this may not be as true for SMYoC, who may not perceive a need for services or may need to seek services on their own, outside of family and social network support.

Culturally influenced reluctance to use services due to social stigma or health care system mistrust can be obstacles to seeking mental health treatment. In many cultures, mental illness has highly negative connotations, leading to the fear of discrimination as a result of being culturally different or of being “crazy,” which prevents minority families from accessing services (Pumariega et al., 2013). For example, studies of Latinos find that barriers due to stigma and beliefs about causality, spirituality, “familism” (i.e., considering the family as the primary unit of help-seeking) (Snowden & Yamada, 2005), cultural commitment (e.g., using only culturally sanctioned helping approaches), as well as language proficiency (Kouyoumdjian, Zamboanga, & Hansen, 2003) affect their use of treatment. Thus, seeking treatment outside of the family or ethnic tradition may be problematic. In addition, Latinos face stigmatized stereotypes of the

LGBT community that could isolate them from family and the Latino community if they came out. This may cause them to feel a need to conceal their sexual orientation and/or gender identity as well as their need for mental health services in order to preserve a connection to their ethnic culture (Aguilar-Gaxiola et al., 2012).

Just as for sexual and gender minorities, experiences of incompetence and mistreatment by mental health professionals is an important factor that discourages racial-ethnic minorities from accessing mental health services (Breland-Noble, 2004; Snowden, 2003; Whaley, 2001). For African-Americans, Asians, and Latinos, mistrust of health care professionals and concerns about provider competence with their ethnic-racial group can decrease their sense of comfort in talking to professionals (Alegría et al., 2008; Scott, McCoy, Munson, Snowden, & McMillen, 2011; U.S. Department of Health and Human Services, 2001). In one example, Lindsey (2010) found that Black youth indicated a fear that mental health professionals will stereotype, misdiagnose them, and/or not understand their unique race-related challenges (e.g., experiencing harassment from law enforcement, negative interactions with school personnel) if they try to use mental health services. It is also true that expressions for psychological or emotional distress vary across cultures (Lewis-Fernández et al., 2010; Lewis-Fernández et al., 2002), and seen out of cultural context, such idioms of distress can lead to the misidentification of pathology or misdiagnosis of mental disorders (Pumariega et al., 2013).

Given additional concerns about heterosexism, homophobia, and pathologizing gender non-conformity by mental health professionals, LGBT YAs of color may be discouraged from seeking services due to multiple forms of discrimination (Gattis & Larson, 2016). For example, Black LGBT individuals and families are among people who belong to historically marginalized communities which have experienced poor quality of care and may not want to risk further

discrimination by coming out as LGBT individuals (Battle & Crum, 2007; Harper, Jernewall, & Zea, 2004). Given a history of Black individuals, families, communities, and institutions drawing strength and creating unity in confronting racism together, some Black LGBT individuals may be unwilling to jeopardize the support they receive from their own community by leaving that community for LGBT-oriented services (Harper et al., 2004; Rosario, Schrimshaw, & Hunter, 2004).

Cultural perceptions of mental health help-seeking among minority YAs are often transmitted by caregivers and social networks (Cauce et al., 2002). For example, Lindsey et al. (2006) found that negative expectations of mental health care were transmitted multi-generationally by caregivers and other adults in Black adolescents' social networks. In contrast, Ben-David, Cole, Spencer, Jaccard, and Munson (2017) found that a diverse sample of YAs heard more positive messages from family and friends about mental health service utilization than negative messages, most commonly about the advantages of seeking services (e.g., therapy, medication), indicating that their social norms supported formal services. Scott, McMillen, and Snowden (2015) found that among Black male child welfare system-involved youth there was greater help-seeking from informal sources (family and friends) than formal sources. Lindsey (2010) noted that adolescents, in particular, are in the unique position of increased autonomy from parents regarding whether to participate in particular behaviors that might be viewed as pathology and that adolescents and caregivers might disagree regarding mental health needs and whether formal mental health services are necessary. This is relevant to YAs who are newly independent and responsible for their own help-seeking. They might be even more strongly positioned to choose which sociocultural norms and messages will influence their help-seeking behaviors.

Social networks may facilitate or hinder help-seeking, depending on their sociocultural norms around help seeking (Cauce et al., 2002). In cultures where norms are not compatible with those of professional services, individuals are discouraged or prevented from seeking that type of help. Moreover, in cultures with strong community and familial networks, individuals and families may not seek out formal mental health services because their needs are met within the network. For example, cultural groups that explain mental illness using explanatory models of a spiritual, supernatural, social, and interpersonal nature often lead families to seek help for their children's problems from a spiritual healer, church elder, community leader, or relative, rather than from mental health professionals (Pumariiega et al., 2013). Reasons for such preferences include greater acceptability of the spiritual explanatory model of illness, greater family support, less stigma for seeking services, and perceiving greater effectiveness. This preference is seen particularly among first-generation immigrants, including Latinos, Asians, and American Indian groups (Snowden & Yamada, 2005). African-Americans have also historically relied more upon family and religious leaders, spiritual coping, and other informal help sources to address psychosocial problems (Blank, Mahmood, Fox, & Guterbock, 2002). However, religion can vary widely regarding tolerance for sexual minorities. Some minority denominations hold strong religious bans against homosexuality and strict views about gender roles that can lead to rejection of youth that are known or perceived to be LGBT (Adelson, 2012). As a result, members of certain religious groups can experience special challenges in integrating their sexual identity with family and community values. In one example, Durso, Kastanis, Wilson, and Meyer (2013) found that anti-gay stigma and prejudice among religious institutions have limited SMYoC access to services that are available within ethnic-racial minority communities. Where

such religious organizations are prominent in service provision, anti-gay attitudes limit these organizations' ability to serve SMYoC.

Studies of LGBT youth have consistently shown that social network factors such as parental and peer support are related to mental health, self-acceptance, and well-being (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Russell & Fish, 2016). Family connectedness, adult caring, and school safety are protective against suicidal ideation and attempts among LGBT youth (Eisenberg & Resnick, 2006). Studies that explicitly examine the benefits of LGB-specific support show that it buffers the negative effects of minority stressors (Rosario, Schrimshaw, & Hunter, 2009; Russell & Fish, 2016). Balsam et al. (2015) found that while YA sexual minority women of color did not differ from their White counterparts on involvement in LGBT activities and connectedness to the LGBT community, they did report being less "out" to family members. Rosario et al. (2004) reported that SMYoC in general may be less likely to be involved in gay-related social activities, to be comfortable with others knowing they are gay, or to disclose a gay identity than non-racial-ethnic minority youth. While this finding indicates a risk for poorer outcomes, Bostwick, Meyer, et al. (2014) referred to studies in which Blacks are more likely than their White counterparts to view suicide negatively and as immoral (Chu, Goldblum, Floyd, & Bongar, 2010) to explain Black LGB youths lower odds of suicidal ideation, suicide planning, and self-harm. Similarly, religious adherence among Latinos (U.S. born or foreign born) can lower the risk of suicide (Barranco, 2016). Thus, cultural and social network perceptions related to some aspects of mental illness (e.g., sanctions around suicide, or messages of disapproval of suicide) may serve as a protective factor or buffer against the effects of sexual minority stigma in SMYoC.

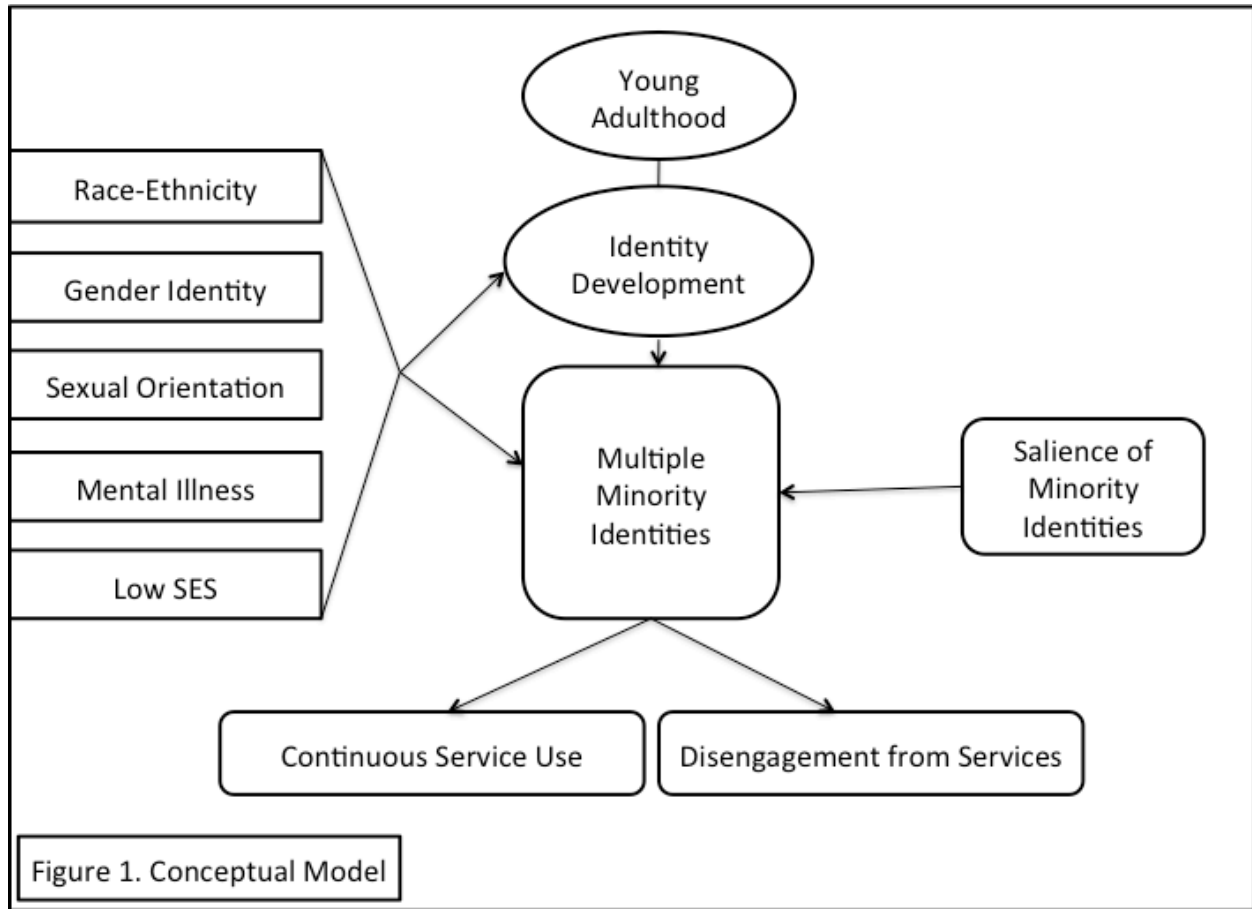
The roles of ethnic-racial culture and social networks may be unique for LGBT YAs of color. Members of racial or ethnic minorities generally share that culture (and their minority status) with members of their family. They likely grow up in an environment which offers at least some protection against racial-ethnic discrimination within families and social networks. This is not true for LGBT individuals, who are often the only one in their family or social network with an LGBT status (Cianciotto & Cahill, 2003; Safren & Rogers, 2001). Coming out as LGBT for individuals who are also members of a racial or ethnic minority may require them to choose between the safety of their family and cultural environment and their LGBT identity. Facing racism from within a predominantly white LGBTQ community, homophobia within their racial or ethnic groups, and a combination of the two from society presents a “tri-cultural challenge” (Cianciotto & Cahill, 2003; Han et al., 2014; Harris, 2010; Valera & Taylor, 2011). For LGBT YAs of color, the connection to racial-ethnic culture may be less central than the connection to the LGBT community. For example, LGBT people that face rejection by their families after they come out may choose to end those relationships. Families of choice may be the primary supports for LGBT YAs of color. A family of choice develops through finding others with shared experience, people who accept them, and take on the family role. These families can include friends, partners, ex-partners, and older friends with more established life experience who take on a mentoring or parenting role in their lives (Kapila, 2015). These families of choice may or may not reflect the racial-ethnic culture of one’s biological family.

Culturally-informed approaches to treatment are widely advocated and emphasized by mental health providers to address the needs of both ethnic-racial minority (Pumariega et al., 2013) and LGBT youth (Adelson, 2012). Mental health interventions require tailoring to address the diverse needs and circumstances faced by people with mental illnesses (National Advisory

Mental Health Council's Workgroup, 2010). Cultural adaptation is needed when distinct psychosocial processes function to disadvantage a particular population or when that population experiences barriers to benefitting from existing interventions. In addition, providing culturally competent care can increase mental health service use and enhance engagement with treatment (Dixon et al., 2016). Use of strategies explicitly designed to explore the client's culture (e.g., race/ethnicity, age, sexual orientation) (Lindsey et al., 2014), various types of racial-ethnic cultural adaptations (Breland-Noble & Board, 2012; Grote et al., 2009; Jackson-Gilfort, Liddle, Tejeda, & Dakof, 2001), and age-based adaptations (Gearing et al., 2015; Gilmer, Ojeda, Fawley-King, Larson, & Garcia, 2012; Munson et al., 2014) have been found to help facilitate engagement in mental health services among ethnic-racial minority youth. However, the majority of engagement interventions with evidence for efficacy in racial-ethnic minority youth include some form of family level engagement (Moore, 2017), which may be problematic for LGBT YAs of color due to dual stigma and to YAs being more independent of family because of their age. More information is needed on the intersection of these identities to understand how they affect mental health service use and to inform culturally-relevant interventions to improve mental health outcomes.

Conceptual Framework

Two theoretical frameworks undergird the research questions investigated in this study: identity development and intersectionality. Each perspective and its relationship to mental health and service use among sexual and gender minority YAs of color will be discussed in this section. See Figure 1 for conceptual model.



Ethnic Identity and Mental Health Service Use

Research points to important associations of ethnic identity, and the related process of acculturation, with mental health service utilization among racial-ethnic minorities. Ethnic identity refers to one’s sense of self in broad terms including culture, race, language, or kinship (Burlew, 2000) and applies across multiple racial and ethnic groups (Phinney, 1991). Key elements of ethnic identity include beliefs and attitudes that individuals have about their ethnic-racial group memberships, extent of ethnic knowledge, ethnic behaviors and practices, as well as the processes by which these beliefs and attitudes develop over time (Umaña-Taylor et al., 2014). Acculturation refers to a person’s acquisition of and adaptation to the cultural norms of the dominant society (Lara, Gamboa, Kahramanian, Morales, & Hayes Bautista, 2005). In a recent study, Burnett-Zeigler, Bohnert, and Ilgen (2013) examined the associations between ethnic

identity and acculturation and the prevalence of psychiatric disorders among Black, Hispanic, and Asian-American adults in the U.S. and found that in general, individuals with a stronger ethnic identity were less likely to have a lifetime psychiatric disorder and individuals who were more acculturated were more likely to have a lifetime psychiatric disorder. These results were consistent with prior research that found that a strong ethnic identity is associated with positive aspects of well-being (Smith & Silva, 2010) and reduced depressive symptoms (Mossakowski, 2003).

Some studies have examined the association of ethnic identity with mental health service use. Keyes et al. (2012) found that among those with any lifetime psychiatric or substance use disorder, individuals with stronger Hispanic ethnic identity and Hispanic social preference were significantly less likely to use mental health services. Richman, Kohn-Wood, and Williams (2007) found that the relationship between ethnic identity and mental health service utilization is mediated by experiences of discrimination. Black individuals with a stronger ethnic identity who experienced discrimination were less likely to use mental health services than those with weaker ethnic identity. Burnett-Zeigler, Lee, and Bohnert (2017) examined associations of ethnic identity, acculturation, and psychiatric service utilization among respondents with 12-month psychiatric disorders in the National Epidemiologic Survey on Alcohol Related Conditions who self-identified as Black and Hispanic, finding that stronger ethnic identity was associated with less use of psychiatric services among Black and Hispanic individuals. Studies have also found that Hispanic and Asian individuals who have lived in the U.S. for fewer years (Chang, Natsuaki, & Chen, 2013; Keyes et al., 2012), were foreign born (Chang et al., 2013; Lee & Matejkowski, 2012), and had poorer English language proficiency (Chu, Hsieh, & Tokars, 2011; Keyes et al., 2012) are less likely to use mental health services. These findings suggest that positive ethnic-

racial identity, participating in ethnic behaviors, belonging, and attachment to one's racial-ethnic group and is associated with lower rates of engagement with psychiatric services, but acquiring key elements of the U.S. culture is associated with greater engagement with services.

Ethnic-Racial Identity Theories

Existing models of ethnic and racial identity (ERI; Cokley, 2005; Cross, 1995; Knight, Bernal, Garza, & Cota, 1993; Phinney, 1992; Quintana, 1998; Sellers, Smith, Shelton, Rowley, & Chavous, 1998; Umaña-Taylor, Yazedjian, & Bámaca-Gómez, 2004), conceptualize ERI as both identity content and an identity developmental process. Content refers to attitudes and beliefs about one's group and its relations to other groups, while process reflects the mechanisms by which individuals explore, form, and maintain their ERI. Furthermore, ERI is informed by the social-environmental contexts in which identities are developed. Erikson (1968) theory of psychosocial development identifies the adolescent years as critical for identity formation. As such, most research on ERI has focused on adolescence when youth form their understanding of a shared experience based on ethnic or racial group membership and recognize that these shared experiences differ from the experiences of individuals from other groups (Syed & Azmitia, 2008). ERI formation during childhood primarily involves developing the ability to identify and categorize themselves and others according to ethnic and racial labels, but during adolescence increased social-cognitive maturity and the ability to understand how one's race-ethnicity impacts social experiences leads to exploring one's race-ethnicity and internalizing values from one's ethnic and racial groups (Quintana, 1998).

Individuals in late adolescence and young adulthood possess more advanced perspective-taking skills compared to younger adolescents that allow them to explore what ERI means to them, apart from what it means to their parents (Umaña-Taylor et al., 2014). This construct of

exploration is central in identity development theories and is considered a key developmental task of adolescence. Erikson (1968) suggests that through the exploration of options, followed by firm commitments to a career choice and a set of core beliefs, individuals come to achieve a secure identity. Marcia (1994) operationalized Erikson's ideas for empirical research by defining four identity statuses (i.e., achievement, moratorium, foreclosure, and diffusion). Achievement refers to commitments made following a period of exploration, moratorium indicates active identity exploration in the absence of commitments, foreclosure represents commitments made without much prior exploration, and diffusion represents an absence of commitments combined with an absence of exploration. Phinney (1990) extended those theoretical models to the domain of ethnic identity. According to Phinney, ethnic identity is a process that takes place over time as individuals explore and make decisions concerning the meaningfulness of their ethnicity in their lives. Individuals achieve a sense of ethnic identity only after they have explored their ethnicity and what it means to them, and after they have accepted and internalized their ethnicity (i.e., enacted commitments). Evidence suggests that ERI during young adulthood involves a continuation of the processes present during adolescence (Syed & Azmitia, 2009), and that ERI components similarly inform adjustment into adulthood (Bair & Steele, 2010).

ERI models for young adults have been proposed for specific ethnic-racial groups and for people of color in general. These models feature psychological dimensions in stages of identity change in five stages, starting with a description of the adult, achieved identity that will become the object of change (pre-encounter stage); a stage in which events or experiences trigger an epiphany, radicalization, and extreme consciousness raising (encounter stage); an in-between stage wherein the old and new sense of self struggle for dominance of the self-concept (immersion-emersion stage); a phase marking resolution and habituation (internalization stage);

and a culminating phase wherein the new identity becomes a foundation for long-term commitment to the group (e.g., Carter & Helms, 1992; Cross, 1995; Helms, 1990). Research on many historically marginalized groups (gays and lesbians, women, Native Americans, Latinas-Latinos, the disabled, and African Americans) have included a discussion of how adult members of their group experience ERI-related epiphanies (e.g., Cass, 1979; Gill & Cross, 2010).

During emerging adulthood, the period from ages 18 to 25, many individuals begin to experience new roles and responsibilities, as well as identity instability and exploration (Arnett, 2000; Azmitia, Syed, & Radmacher, 2008). While the family is often the most important proximal social context that guides ERI formation (Umaña-Taylor, Zeiders, & Updegraff, 2013), as young adults transition from family to more independent life situations, new opportunities for identity exploration become available outside of family influence. Influences outside the family context are critically important to identity formation during adolescence and emerging adulthood. Examples include peers, both in and out of school (Yip, Douglass, & Shelton, 2011), mentors (Hurd, Sánchez, Zimmerman, & Caldwell, 2012), and neighbors (Rivas-Drake & Witherspoon, 2013). Exploration can incorporate experimenting with new roles (i.e., college student, employee), identities, peer groups, as well as social and romantic relationships (Arnett, 2000). Increased autonomy and independence, increased resistance to peer pressure, and increased independence in decision making may lead YAs toward more individual exploration about their ethnicity, rather than relying on parental or peer influences (Umaña-Taylor et al., 2014).

Given the focus placed on ethnicity-race within U.S. society, individual and institutional discrimination and marginalization makes ERI particularly relevant for those who are members of minority groups. For example, exposure to discrimination is thought to stimulate exploration (Phinney, 1990), contestation, negotiation, or reexamination (Cross, 1995) of one's ERI.

Emerging adulthood is the age of possibilities and optimism, often marking an individual's first opportunity to make their own life-shaping decisions (Arnett, 2000). Emerging adults from low socioeconomic status backgrounds are even more likely than their more advantaged counterparts to feel that they will be better off than their parents, suggesting that there is a sense of optimism, not only felt by the most privileged (Syed & Mitchell, 2013). Interviews with emerging adults revealed that for some disadvantaged individuals, such as children of mentally ill, alcoholic, or abusive parents, emerging adulthood can provide unprecedented possibilities to leave troubled homes and build a new life (Arnett, 2003). However, their minority position within society causes racial-ethnic, sexual, and gender minorities to experience a greater number of societal barriers to realizing their dreams. This may diminish these feelings of optimism for the future. Minority YAs may have high hopes for the future, but such high hopes are in the context of social barriers that lower expectations, and the nature of what is possible for them may be qualitatively distinct from what is possible for majority groups (Syed & Mitchell, 2013).

The extent to which youth feel that others regard their ethnic-racial group positively or negatively is associated with perceived discrimination, both as an outcome and as a protective factor (Seaton, Yip, & Sellers, 2009; Sellers et al., 1998; Sellers, Copeland Linder, et al., 2006). The positive affect that individuals feel toward their ethnic-racial group has been demonstrated to be associated with positive adjustment across different developmental periods (Rivas-Drake & Witherspoon, 2013). However, positive feelings about race-ethnicity may be dependent on salience, centrality, and the specific situational context. For example, in a study of Latino adolescents, higher levels of positive affect were associated with decreases in academic performance (Umaña-Taylor, Wong, Gonzales, & Dumka, 2012). The authors suggested that students were noticing that Latinos were being segregated into lower achieving tracks, and then

started to underperform. The youth who felt a stronger connection with a negatively stereotyped group performed more poorly, consistent with the stereotype about their group. Conversely, youth who internalize negative public regard during late adolescence and emerging adulthood may engage in identity self-denial in which there is an attempt to hide or minimize their ethnic-racial backgrounds in order to manage negative affect about their ERI (Umaña-Taylor et al., 2014).

Research indicates that sexual minorities first experience many of the milestones of sexual identity development during late adolescence and young adulthood, including awareness of same-sex attractions, sexual behavior, romantic relationships, and self-identifying as LGB (D'Augelli & Hershberger, 1993; D'Augelli, Hershberger, & Pilkington, 1998; Parks, Hughes, & Matthews, 2004). A small number of studies have examined identity development in SMYoC. One study that examined how racial-ethnic and sexual identities develop simultaneously found that youth develop their racial-ethnic and sexual identities concurrently (Jamil, Harper, & Fernandez, 2009). In addition, youth identified families as important for racial-ethnic identity development, but identified community-based organizations and the Internet as important for sexual identity development, suggesting that predictors of identity development may differ across racial-ethnic and sexual identity development. Yon-Leau and Muñoz-Laboy (2010) found that cultural constructs, such as machismo (i.e., strong sense of being manly) and familism emerged when discussing the process of identity development with Latino youth. Latino youth indicated that the identity development process was inherently relational because of the central role of family relationships in Mexican families. Exposure to machismo and hypermasculine expectations has been found to influence sexual identity development among both Latino and Black youth (Fields et al., 2015; Wilson et al., 2010).

ERI development among mixed-ethnic or biracial populations presents a challenge to researchers to question many of the fundamental assumptions about race and ethnicity (Phinney, 1990). While the number of studies focusing on ERI among mixed-ethnic populations is increasing (e.g., Syed & Azmitia, 2008), this important group remains underresearched (Syed & Mitchell, 2013). In addition, researchers drawing from both Eriksonian identity theory and intersectionality have begun to look beyond demographic categories and examine the intersections among emerging adults' subjectively experienced identities. This research on the development of multiple identities has focused on domains including ethnic, national, career, family, and religious identities (Syed & Mitchell, 2013). Other research has explored multiple identities by studying how individuals from mixed ethnic backgrounds think about and integrate their multiple ethnicities into a coherent whole. Cheng and Lee (2009) found that multiracial identity integration consists of racial distance (perceptions of separation between different racial identities) and racial conflict (feelings of tension between different racial identities), with lower levels of distance and conflict corresponding to higher levels of integration. Renn (2003) studied the identities of mixed-race college students and found they can be grouped in five non-exclusive patterns (two or more racial categories, situational identity, multiracial, one racial category, and opt out/deconstruct racial categories). The ability of students to move among identities, or their decision not to, was related to two factors: permeability of boundaries around social and physical spaces defined in part by racial and ethnic identity, and the extent to which students felt like they fit in or belonged to those spaces. Developing a sense of integration and coherence among multiple identities is a central developmental task of emerging adulthood (Arnett, 2003; Azmitia et al., 2008; Erikson, 1968), however the research literature provides few examples of what this process looks like, how it progresses over time, and what it implies for YA mental health.

Intersectionality

Intersectionality is a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect in individual experience to reflect interconnecting systems of privilege and oppression (i.e., racism, sexism, heterosexism, classism) (Collins, 2002; Crenshaw, 1991; Davis, 2008). Intersectionality has been identified as an important conceptual framework for reducing health disparities in minorities (Bowleg, 2012) and for understanding minority identity development in young people whose multiple marginalized identities increase the psychosocial demands placed on them to cope with discrimination (Bostwick, Meyer, et al., 2014; Kuper, Coleman, & Mustanski, 2014).

Intersectionality may be concerned with multiple marginalized identities or with a more generalized theory of identity that involves the identity intersections of all individuals (Warner & Shields, 2013). The perspective regarding individuals with multiple marginalized statuses asserts that the effects of systems of inequality are additive (Collins, 1990), in which each socially subordinated identity increases the oppressive influence of the others. This view has been criticized as overlooking the relative nature of privilege and oppression, that no single intersectional position experiences only privilege or only oppression (Warner & Shields, 2013). Criticisms have led to expanding the perspective to consider the contextual nature of social power. For example, Bowleg (2013) used intersectionality to study identity formation as experienced by biracial and gay males, finding that the fluidity of their identities helped them navigate experiences of prejudice. They identified in an additive fashion in some situations and in an intersectional fashion in others, as needed to negotiate power relations. Bowleg suggested that belonging to multiple marginalized groups can reveal ways in which intersectional positions are characterized by resilience. Similarly, literature concerning people with minority identities

has consistently emphasized considerable heterogeneity in the salience of racial-ethnic and other minority identities, indicating that it differs among individuals and fluctuates over time (Carter, 1998; Greene, 2011). Minority experiences are irreducible to singular parts or identities, and collective identities considered prominent by some members of a group may not be endorsed as prominent by others (Bowleg, 2008; Narváez, Meyer, Kertzner, Ouellette, & Gordon, 2009).

Intersectionality is an appropriate theoretical framework for use in this study of YAs' multiple minority identities and mental health service use, particularly because information gained by this study can be used for enhancing the development of culturally-relevant engagement interventions to reduce service use disparities. Research on mental health in LGBT POC indicate patterns of complexity of multiple, intersecting identities and their interaction with mental health, mental health behaviors, and mental health outcomes (Kapila, 2015). When mental health care providers understand identity intersectionality, they are better able to optimize treatment outcomes with diverse LGBTQ individuals and groups. This may be especially true when working with LGBTQ YAs that are racial-ethnic minorities. Consistent with Erikson (1968), individuals begin to think about and experience the intersections among their multiple identities, how it intersects with sexual and gender identity, social class identity, cultural identity, career identity, and political identity during early adulthood (Bowleg, 2008; Syed & Mitchell, 2013). A provider's awareness of the ways in which intersecting minority identities influence perceptions of problems, care options, and utilization of mental health care may be as important as the provider's specific knowledge about any one fact about an LGBTQ YA of color (Wheeler, 2015). Intersectionality has been applied within scholarly contexts as a theoretical perspective, a mode of inquiry, and a methodological tool (Warner & Shields, 2013). As a theoretical framework, intersectionality serves as a useful strategy for studying identity (Syed, 2010) and

can offer insight into the process of identity development by focusing on people's awareness of how being, for example, "young," "Latino," "gay," and "a man" qualitatively inform each other and how they inform health behavior.

In the present study, intersectionality is used to consider the factors that both inform multiple minority identities and that place YAs at risk for service use disparities. The literature indicates that these factors, minority race-ethnicity, minority gender identity and sexual orientation, mental illness, and low socio-economic status are associated with marginalization and may, in turn, intersect to affect mental health service use. A better understanding of how these factors interact among YAs as they progress from childhood to adult identities can provide a framework for addressing mental health service use disparities for multiple minority YAs.

Chapter 2: Research Design and Methods

Mixed Methods Design

This study used a convergent parallel design (see Figure 2), one of the most frequently used approaches in mixed methods research (Creswell, Klassen, Plano Clark, & Smith, 2011). This design allowed for collecting and directly comparing different but complementary data on the same topic in order to fully understand the research problem (Kettles, Creswell, & Zhang, 2011). Quantitative and qualitative data were collected at the same time to maximize the amount of data collected in the field for the time spent and to minimize added burden placed on participants for multiple interviews. Quantitative data were collected via survey instruments, while qualitative data were collected via semi-structured interviews, using techniques from grounded theory (Corbin & Strauss, 2015). The convergent parallel design in this study enabled the integration of participants' experiences (emerging from interviews) with responses to structured survey questions about participants' minority identities and mental health service use.

The study was conducted within a constructivist paradigm in order to seek range and variation in findings and to discover and understand the meaning of experiences through an context-specific approach (Creswell, 2006). The central assumption of this paradigm is that reality is socially constructed, that individuals develop subjective meanings of their own personal experience, and that this yields multiple meanings (Lincoln & Guba, 2000). Thus, my role as the researcher involved working to understand multiple realities from the perspectives of participants and it was presumed that the process of inquiry was influenced by both the researcher and the context under study.

Sampling Approach

Chain sampling (Patton, 2002) was used to locate potential participants. A recruitment email was sent to various networks in the New York City area, including professional contacts in local educational settings, nonprofit organizations, and community organizing listservs likely to have contact with young adults that have had experiences with mental health services. The email explained the study and specifically encouraged the participation of young adults of color whose experiences fall at the intersections of other marginalized identities (i.e. LGBTQ and/or lower SES status). Fliers advertising the study were also posted within organization settings and provided for distribution to young adults interested in participating in the study. Since interviews were conducted in English, emails and fliers were only provided in English. Interested participants were asked to contact the researcher directly for more information.

Purposeful sampling was used to enroll participants with multiple minority identities and to reflect populations at higher risk for service disengagement in the study. Interested participants were pre-screened by phone, text message, or email to ensure that inclusion criteria was met, to answer questions they may have about the study, and to schedule an interview at a mutually agreed upon location. The procedures for maintaining confidentiality were explained to participants before they gave their consent to be interviewed. In order to protect participant confidentiality, their personal identities were not matched to any data collected. Participants were assigned an identification number that was linked to their interview responses. Staff at community agencies and professional contacts that assisted with chain sampling were not informed by the researcher about which young adults chose to participate in the study. Participants were compensated with \$40 for their interviews.

All willing participants that met inclusion criteria, attended the scheduled interview, and provided their written consent were enrolled in the study until the number of participants needed

for theoretical saturation in the qualitative components of the study was met. Two pilot interviews were conducted in-person. These key informants no longer qualified as study participants. The criteria for selection of the participants were:

- Between ages 18-29;
- Self-identify as minority race/ethnicity;
- Endorse symptoms of mood or anxiety disorder within the past two years
- Interested, willing, and physically able to talk about attitudes, beliefs, and experiences related to mental health services.

During initial screening, participants were asked if they had been diagnosed and/or treated for any mental health conditions in the past two years. Participants were also asked to describe symptoms they had experienced and any treatment they had received. Their descriptions were then evaluated by the researcher to establish whether symptoms of mood or anxiety disorder were endorsed. The researcher is a licensed mental health clinician with several years of psychiatric diagnostic experience to draw upon in making that determination. Once enrolled in the study, symptoms were measured using the Brief Symptom Inventory (BSI; (Derogatis & Melisaratos, 1983). Participants reporting only neurodevelopmental disorders (e.g., attention deficit hyperactivity disorders, autistic spectrum disorders, intellectual developmental disorders) were excluded because the mental health service use under investigation includes treatment for mood and anxiety disorders. All procedures were approved by the Columbia University Institutional Review Board.

Typical of grounded theory studies, the sampling plan evolved over the course of recruitment in response to new concepts that emerged during initial analysis. While the study originally planned to include both LGBTQ and non-LGBTQ young adults of color, initial coding

of interviews indicated that themes related to multiple minority identities emerged more clearly in LGBTQ participant interviews. Thus, theoretical sampling, the grounded theory strategy of obtaining further selective data to refine major categories (Charmaz, 2006), was used to select only participants reporting both racial/ethnic and sexual or gender minority identities.

Figure 2: Mixed-Methods Design

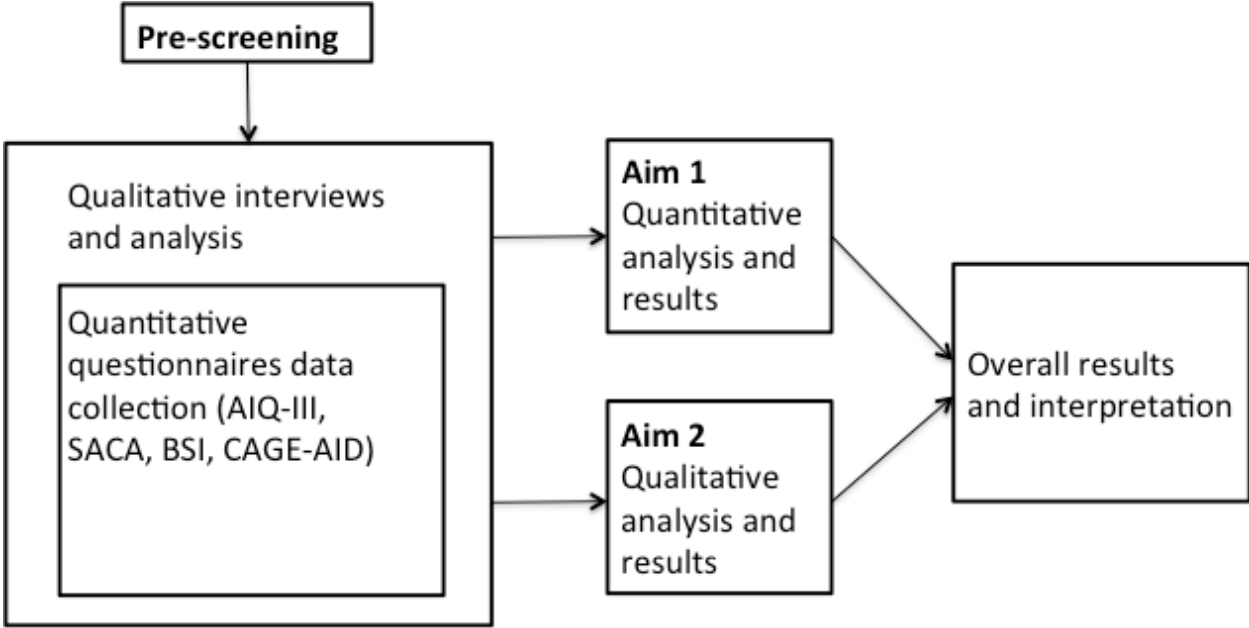


Figure 2

Data Collection

Interviews took place in January and February of 2017. All interviews were conducted by the researcher, in person, and were audio recorded. Because of the semi-structured nature of the interview protocol, the length of the interview varied by participant, ranging between 1 and 2 hours. Interviews took place at multiple locations including a community agency, the Columbia University School of Social Work, and the researcher’s private clinical office. All interviews were conducted in a private space, with only the interviewer and participant present. Upon the

completion of all interviews, the digital audio files were transcribed verbatim. Texts of interviews, digital audio files, and completed survey instruments were labeled with a participant identification number and the date of the interview to protect anonymity of data. Digital files were stored with at least two levels of password protection and paper files were stored in a locked cabinet in a secure area at the Columbia University School of Social Work.

Quantitative Measures

Demographic characteristics. Self-reported, socio-demographic characteristics included age, gender identity, racial/ethnic identity, sexual orientation, personal income and family income (if the participant lived with family) in the past year, current living situation, highest level of education, current student status, and current employment status.

Mental health characteristics. Severity of 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. Reliability for the Global Severity Index (GSI), the mean of all the subscale scores, is reported as .90 and validity for use with psychiatric populations is reported as .92 (Derogatis & Melisaratos, 1983). The BSI has nine subscales designed to assess individual symptom groups: somatization (e.g., "Faintness or dizziness"), obsessive-compulsive (e.g., "Having to check and double-check what you do"), interpersonal sensitivity (e.g., "Feeling inferior to others"), depression (e.g., "Feeling no interest in things"), anxiety (e.g., "Feeling tense or keyed up"), hostility (e.g., "Having urges to break or smash things"), phobic anxiety (e.g., "Feeling uneasy in crowds, such as shopping or at a movie"), paranoid ideation (e.g., "Others not giving you proper credit for your achievements"), and psychoticism (e.g., "The idea that something is wrong with your mind"). Two questions on the

depression subscale, “thoughts of ending your life” and “thoughts of death or dying” were reviewed during the interview. Affirmative responses to those questions prompted use of Columbia Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2011) to assess for suicide risk.

Symptoms of substance use disorder were measured by the CAGE-Adapted to Include Drugs (CAGE-AID) questionnaire (Brown & Rounds, 1994). The CAGE-AID is an adapted version of the original CAGE questionnaire (Ewing, 1984), which screened only for alcohol use, misuse, and dependence. With four items in total, a cut-off score of two has been found to yield good accuracy at detecting the presence (sensitivity of 91%) and absence (specificity of 98%) of substance use disorder (SUD) for adolescents receiving mental health care, good internal consistency with a Cronbach’s α of 0.77 (Couwenbergh, Van Der Gaag, Koeter, De Ruiter, & Van Den Brink, 2009), and a sensitivity of 88% and a specificity of 55% in adult psychiatric patients (Dyson et al., 1998). Brown, Leonard, Saunders, and Papasouliotis (1998) proposed that regarding one or more positive responses to the CAGE–AID as a positive screen is the best strategy, because other strategies can result in inadequate sensitivity. The CAGE-AID was also chosen for this study for its ease of use, brevity, and resemblance to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) criteria for SUD.

If participants responded *yes* to either “Do you drink alcohol?” or “Have you ever experimented with drugs?” they were then asked the additional four CAGE-AID questions on their alcohol and/or drug use in the past year. CAGE is an acronym for its four follow-up items: (1) Have you felt that you should **C**ut down on your drinking or drug use? (2) Has anyone **A**nnoyed you by criticizing your drinking or drug use? (3) Have you felt **G**uilty or bad about your drinking or drug use? (4) Have you ever had a drink or used drugs first thing in the morning

to steady your nerves or to get rid of a hangover (Eye opener)? If study participants had a score of two or more on the CAGE-AID, they were informed that they may have a problem with alcohol and/or drugs, respectively.

Multiple minority identities. Data for salience of minority identities were measured by the Aspects of Identity Questionnaire (AIQ-IIIx; (Cheek, Tropp, Chen, & Underwood, 1994). The AIQ-IIIx assesses the relative importance that individuals place on various identity attributes or characteristics when constructing their self-definitions. The collective identity sub scale (8 items) was used to assess the salience of aspects of minority identity including, 1) “my race or ethnic background;” 2) “being a part of many generations of my family;” 3) “my feeling of belonging to my community;” 4) “my religion;” 5) “places where I live or where I was raised;” 6) “my language, such as my regional accent or dialect or a second language that I know;” 7) “my commitments on political issues or my political activities;” and 8) “my feeling of pride in my country, being proud to be a citizen. Three additional single items were added to assess minority identity variables of interest, 9) “my gender, being transgender or cisgender;” 10) “my sexual orientation, whether heterosexual, homosexual, bisexual, or other;” and 11) “my social class, the economic group I belong to, whether lower, middle, or upper class.” The AIQ-IIIx includes single items such as these to provide ad hoc assessment of the subjective importance of dimensions that have been included in various theories and measurement models of multidimensional identity content (Briggs & Cheek, 1986). The AIQ-IIIx responses were elicited on a 5-point, Likert-type scale, ranging from 1) not important to my sense of who I am to 5) extremely important to my sense of who I am.

The AIQ-IIIx has established norms distinguishing racial/ethnic minority young adults from non-minority young adults that make it appropriate for detecting collective identity salience

for this study. The AIQ-IIIx scale has been used frequently with adolescents and young adults and has demonstrated significantly higher mean scores on the salience of collective identity among Asian-American (25.16), African-American (27.76), and Hispanic/Latino (28.25) young adults compared to Non-Hispanic Whites (22.94) (Cheek, Smith, & Tropp, 2002; Cheek et al., 1994; Lutwak, Ferrarib, & Cheek, 1998). The AIQ-IIIx collective identity sub scale had reported reliabilities of .77 and factor validities of .84 to .86 as a measure of the importance one places on aspects of cultural identity (Berzonsky, 1994; Joukar & Latifian, 2007; Kowalski & Wolfe, 1994; Mehri, Salari, Langroudi, & Baharamizadeh, 2011; Triandis & Gelfand, 1998; Wink, 1997).

Mental health service use. Data for service use were measured by the Service Assessment of Children and Adolescents (SACA; Horwitz et al. (2001). It obtains lifetime and past year use of school-based, outpatient and inpatient, and substance abuse services. Mental health service use in this study is defined as use of any of those service types. The SACA is a valid and reliable measure (Hoagwood et al., 2000; Stiffman et al., 2000) used to assess the types of mental health services youth use, the rationale for service use, the specific treatments received, and the quality of services. It has demonstrated good to excellent test retest reliability, between .63 to .96, (Horwitz et al., 2001). It has also been used successfully with adolescents and young adults (McMillen & Raghavan, 2009; Munson et al., 2012). The SACA includes a checklist to record treatment episode and duration and open-ended questions allowing participants to provide information on reasons for service use.

Challenges to mental health service use. To measure challenges affecting service use, eighteen barriers to using mental health services were drawn from the literature on common reasons for not using mental health services among adults with unmet need (see measures in Substance Abuse and Mental Health Services Administration, 2015). Reasons that were

presented to participants included cost or insurance coverage (could not afford cost, health insurance does not cover mental health services, or insurance does not pay enough for mental health services), a low perceived need (did not feel the need for services or felt that they could handle the problem without treatment), a concern over prejudice and discrimination (felt that provider could not understand them or their culture, mental health service use might cause family/community to have a negative opinion, might have a negative effect on employment, concerns over confidentiality, did not want others to find out, or concerns over being committed or having to take medication), structural barriers to service use (no transportation, inconvenient, did not know where to go for services, or did not have time), and concerns over efficacy (i.e., did not think it would help), as well as an open-ended response option for other reasons. Participants were asked, “have any of these challenges affected whether or not you sought or are now seeking mental health care for your experiences?” Responses were elicited on a 4-point, Likert-type scale, ranging from 1) not true at all to 4) very true.

Quantitative Analysis

Continuous service use. Using the thorough mental health service use histories collected in the SACA, a dichotomous variable, *service use* was constructed as: *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. Participants that reported interruptions in care were categorized as discontinuous. A significant interruption was identified when participants discontinued services while still impaired by symptoms or did so without the recommendation of their provider. Interruption of services could be due to lack of access to services or to the participant’s own decision not to use services.

Differences were identified between continuous and discontinuous service users by using logistic regression for continuous variables and by using chi-square tests of independence for some categorical variables. Fisher's exact test for categorical variables was used for cell counts of less than 5. Descriptive statistics were generated for participant sociodemographic characteristics, mental health characteristics, mental health service use, and minority identity salience. Next, descriptive statistics were stratified by whether the participant reported continuous or discontinuous services. For greater specificity in describing participant characteristics and in testing their associations with continuous service use, several variables were constructed from the data.

Minority identity variables. Four variables were created to test the relationship between minority identity salience and continuous service use. The salience of participants' collective identity was measured by the AIQ-III collective identity subscale score. Collective identity salience was also measured as a dichotomous variable where scores above the sample mean AIQ-III score were considered "more salient" and scores below the mean were considered "less salient." Dichotomous variables were also created from individual scale items to measure the identity salience of race/ethnicity, sexual orientation, gender, socioeconomic status, and community belonging. Items scored as 1-2 (not important or slightly important) were categorized as "less salient," while items scored as 3-5 (somewhat important, very important, or extremely important) were categorized as "more salient."

Sociodemographic characteristics. Minority racial/ethnic identities, participants identifying as more than one race/ethnicity were counted in each of the categories they reported and also in the multiracial category. A dichotomous variable, non-binary, was created to test whether identifying as neither male nor female was associated with continuous service use. A

dichotomous variable, less than \$10,000, was created to include all participants reporting their annual personal income as less than \$10,000 to test whether having very low income was associated with continuous service use. A dichotomous variable, permanent housing, was created including those that reported living with family and living with a roommate or their own home to test whether having permanent housing was associated with continuous service use. High school only, was created to include only those participants reporting high school graduation as their highest level of education. Current student, included participants reporting that were currently or had been students in the past six months. Finally, currently employed, included those participants that reported at least part-time employment within the past three months.

Mental health characteristics. Three variables, symptom severity, symptoms of substance use disorder, and mood disorder symptoms were created to test whether participant's mental health characteristics were associated with continuous service use. The BSI score, captured by the mean of all the subscale scores, was used to create the continuous variable symptom severity. Per Brown et al. (1998), symptoms of substance use disorder was created as a dichotomous variable to include those participants that had a score of one or more affirmative responses to CAGEAID. Participants reporting that they were referred or received mental health services primarily for symptoms of mood disorders (e.g., depression and bipolar disorder), as opposed to anxiety or psychotic disorders, were included in the dichotomous variable mood disorder symptoms.

Types of mental health service use. Types of mental health services used were captured by data from the SACA to test whether service type was associated with continuous service use among participants. Three service type groupings (inpatient mental health services, outpatient mental health services, and school-based mental health services) were modeled after the

organization scheme used in the SACA (Horowitz et al., 2001). Inpatient mental health services included services that required one or more overnight stays in a number of settings (e.g. psychiatric hospital, psychiatric unit within a hospital, residential treatment center, and inpatient substance abuse treatment). Outpatient services included those received from a mental health care professional (e.g. psychiatrist, psychologist, social worker, or counselor) in specialty outpatient care such as community mental health clinics or private providers. Non-specialty outpatient care (e.g., family doctor or general practitioner) for emotional or behavioral problems were also classified in this category. School-based mental health services included those received from a mental health care professional in the school setting for emotional, behavioral, or substance use problems. This may consist of counseling received in a special school or special classroom in a regular school, special help in a regular classroom, or counseling/therapy with a school psychologist or counselor. These three service types were further categorized according to whether participants reported ever received (any lifetime use), received in the past year, or received in the last three months.

Challenges to mental health service use. To test whether challenges identified by participants were associated with continuous use, responses on the 4-point, Likert-type scale, ranging from 1) not true at all to 4) very true were transformed into a dichotomous variable that included responses 1-2 in “not true” and 3-4 in “true.”

Qualitative Data Collection

Individual interviewing was the primary method used to collect qualitative data, allowing participants to convey their thoughts, feelings, and experiences in their own terms (Creswell, 2006). The qualitative interview protocol consisting of five core open-ended questions on minority identity and mental health services was used. Primary questions were as follows: 1)

Which minority communities do you identify with and what does that mean for you? 2) How do people in your community think/feel about getting help with emotional problems or stress? 3) Is how you think/feel about getting help with emotional problems or stress the same as your community or different? If different, how so? 4) How have your thoughts/feelings about getting help with emotional problems or stress changed over time? 5) How does getting help with emotional problems or stress affect your goals or plans for the future? Primary questions were followed by probes to elicit additional information.

Questions were designed to allow participants to self-identify and to draw out participants' understanding of their minority groups' perspectives, and any distinctions participants make between that and their own personal perspectives. Primary questions were based on the supplemental modules of the DSM-5 Cultural Formulation Interview (CFI) (Lewis-Fernández, Aggarwal, Hinton, Hinton, & Kirmayer, 2016) that focus on cultural identity and help-seeking in psychiatric care. Cultural identity questions in the CFI start with assessing how people identify, without making general assumptions, and go on to address the relevance of a person's cultural identity to the mental health problems he or she experiences. Aspects of cultural identity covered in the CFI include ethnic and racial background, spirituality, religion, sexual orientation, and gender identity. CFI questions on cultural factors affecting past help-seeking and current help-seeking provide information on how people conceptualize problems, treatments, and stigmatization. Responses to CFI questions offer insight into perceptions of treatment barriers and factors that promote treatment adherence.

The interview protocol was a semi-structured, rolling guideline that changed depending on the responses, the form, and the direction of each interview, allowing for new ideas and directions to emerge (Charmaz, 2006). Minor adjustments were made to the protocol after the

first two pilot interviews were completed to allow more opportunities for participants to self-identify how much they felt a part of the various minority communities in which they endorsed membership. For example, participants could expand on what being part of a given minority community meant to them, rather than just identifying which communities they belonged to.

Qualitative Analysis

Grounded theory analysis was used to explore emerging themes and patterns in the data. Grounded theory was chosen because it was deemed to be most appropriate for this study in which so little is known about the phenomenon of interest. As discussed in the review of literature, there is very limited knowledge of how minority identity affects mental health service use in young adults. Mental health service use and cultural identity are complex and personal processes that involve multiple dimensions of experience, changing over time. Discovering a theory of minority identities affecting mental health service use that remains grounded in the views of young adult participants offers a significant contribution to our understanding of those processes. Using grounded theory is advantageous as the goal of grounded theory is to move beyond description and to inductively generate theory that is grounded in, or emerges from, the data (Corbin & Strauss, 2015). Participants in this study all had some experience with minority identity and with mental health help-seeking, and the development of theory based on their experiences can help explain how cultural identity operates within help-seeking and provide a framework for further research on how to support the process in ways that increase service use.

Data analysis began following the first interview and proceeded in an iterative process of alternating data collection with coding, using Atlas.ti version 1.5.0 software (Muhr, 1991) to aid in the process. In general, all coding incorporated two basic analytic procedures to develop conceptual accuracy and specificity: asking questions and making comparisons. I asked

questions of the data to stimulate thinking about the data and develop a greater sensitivity to concepts (process, variation, connections between concepts) rather than simply creating a series of labels. I asked *who, what, when, and where* to determine intensity, frequency, and context; *why* to determine purpose and consequence; and *how* to determine means and manner. In order to think more conceptually and less specifically, I asked questions of the data such as, *what is really going on here* and *what is this really all about?* I also utilized constant comparisons and theoretical comparisons to facilitate moving from pure description of the data to analysing on a more abstract level. The constant comparison process involved comparing incidents in the data to examine similarities and differences in order to develop categories and/or themes and ascertain their properties and dimensions.

Coding

As each interview was transcribed, it was loaded into Atlas-ti for initial coding. Initial coding was the first level of analysis, wherein units of meaning in the interview transcripts were organized, combined, and differentiated to form broader conceptualizations (Padgett, 2016). Codes were developed after several readings of the transcripts and were labeled and counted using the Atlas-ti code management functions. Coding began as descriptive but quickly moved on to in-vivo coding, using the direct language of participants as codes rather than researcher-generated words and phrases, in order to better ground the analysis in participants' perspectives (Saldaña, 2015). I also used process coding, in which action is coded using gerunds, as a method of attuning my analysis to processes in the data (Charmaz, 2006). Initial coding yielded 178 codes. Codes with too few excerpts, or with content that was too thin, were dropped or merged into other codes. Second-level analysis included organizing codes into themes and categories. As suggested by Saldaña (2015), I only coded the parts of the data that were most relevant to the

research questions in the second-cycle analysis to allow for more detailed analytic work to be reserved for those portions. Focusing strategies were used to prioritize the multiple observations and reflect on their essential meanings, including asking how they related to the research questions, which major codes, categories, themes, and/or concepts were dominant and why (Saldaña, 2015).

The initial and intermediate phases of coding pointed to several core categories (seven code groups, 26 individual codes) that became the focus of advanced analysis using theoretical coding. Theoretical sampling was used to ensure full theoretical saturation of each core category. Theoretical sampling pertains to conceptual and theoretical development and is used to obtain data to help explicate categories (Charmaz, 2006). For example, it became apparent during the interviewing process that intersecting minority identities had differential effects on services use, so I began enrolling only participants that identified themselves as both LGBTQ and as racial/ethnic minorities in order to be able to capture rich data on the concept of intersecting minority identities. This strategy was used to fit emerging theories about the differing impacts of multiple minority identities on service use with the data. Saturation of core categories, where no new properties of the pattern observed in the data emerge (Glaser, 2003), was accomplished when no fresh examples of minority identities affecting service use came up in interviews. I then used axial coding to specify the characteristics of each category and its sub-themes (Corbin & Strauss, 2015).

Following identification and saturation of the core categories, coding focused on theoretical integration and generating theory. Theoretical coding was used to specify possible relationships between categories that developed in the focused coding (Charmaz, 2006). Looking for actions and processes through which one or more categories affected another led to creating a

preliminary theoretical framework. Consistent with the constructivist paradigm of this study, I approached theorizing as an interpretive explication of a process in context, with the process being minority identities affecting service use, and the context being the subjective experiences of the participants. The theoretical framework was developed from the distinct and convergent themes that emerged from the data, from applying theoretical codes that indicated relationships among categories, and from incorporating existing theory on service use and identity development. In the end, categories began to appear more as aspects or dimensions of a central process, with sub-themes running through each dimension. Thus, the theoretical framework was interpreted as a process occurring within four major dimensions of participants' experiences, in which minority identities influenced how they acted and were acted upon regarding mental health service use.

Trustworthiness

Lincoln and Gube (2000) described trustworthiness as means for reassuring the reader that a qualitative study is credible and dependable and identified criteria for evaluating the trustworthiness of qualitative research. Credibility is supported by the researcher's accurate portrayal of what the participants think, feel, and do. Evidence in support of credibility can take several forms: self reflection to manage researcher bias, triangulation of findings through multiple sources of data and methods, presenting negative instances and discrepant findings, "member checks" in which participants review findings for accuracy, and "peer debriefing" in which colleagues examine findings to help consider alternative ways of looking at data.

Dependability refers to whether the reader can track the processes and procedures used to collect and interpret data and is evidenced by 1) detailed explanations of how the data were collected and analyzed and; 2) using multiple raters to check the consistency of coding interviews.

I employed a range of techniques to enhance the trustworthiness of this study and to ensure rigorous scholarship. As evidence of dependability, I documented my processes and procedures regularly. I used analytic memo writing to promote reflexivity and to document the analytic process (Saldaña, 2015). I used memo writing to capture my overall impressions of individual interviews and to make notes of important topics that came up during the interviewing process. After each day of interviewing I made notes about possible codes and categories that data were gathering in and elaborated on what categories needed to be more fully explored. I also began theorizing in the memos early in the interviewing process so that I could determine and document the breadth and scope of patterns as they emerged. Periodically, I wrote out rationales comparing emergent categories to concepts from identity development theories and to existing knowledge about mental health service use. This was helpful for making note of how data did or did not fit into existing theory and for directing my attention to distinctions between existing theory and the contextualized theory that was emerging from the data. I also asked three colleagues to read several of the interview transcripts to test my codes at different stages of the coding process and identify any discrepancies. Exploration of discrepancies help the researcher to refine findings and subsequent analysis (Creswell, 2013). Discrepancies that resulted from my colleagues' reviews were discussed and reconciled. I also shared and discussed the theoretical framework with colleagues familiar with the substantive area and revised it accordingly.

I used memo writing and note taking to support the credibility of the study. Using memo writing throughout the data collection and analytic processes helped me to reflect regularly on my own knowledge and information sources and how they could be biasing the analysis. For instance, my clinical practice experience and study of theories of identity development, intersectionality, and mental health service use highly sensitized me to the constructs associated

with the conceptual model for this study. Further, as I ended up generating a sample that included participants from multiple minority groups, I need to expand my research about some populations. Developing familiarity with relevant literature during the early stages of the research process in order to cultivate theoretical sensitivity and insight has been suggested by researchers using grounded theory (Heath, 2004; Strauss, 1998). While this sensitization allowed me to readily identify relevant data, grounded theory involves allowing theoretical categories and relationships to emerge from the data, rather than from existing categories. As suggested by Corbin and Strauss (2008), I consciously employed memo writing as an analytic strategy to first examine the language and concepts that I was using and then, to distance myself from technical literature or reliance on conventional thinking during the coding process. I tried to avoid labeling individual participant's experiences with broad concepts from the research literature and instead used as much of the participants' own language for codes.

As a researcher using a constructivist paradigm for this study, it was important for me to try to adopt an *emic* or insider point of view, a flexible stance that was open to change, and a reflexive acknowledgement of my own personal values and experiences as they impacted the study (Denzin & Lincoln, 2013). I worked from the assumption that the insider point of view was the primary source of knowledge and that data collection and analysis would attempt to capture the participants' perspectives. I used memoing to reflect on ways in which my own background was shaping my interpretation and to maintain my awareness of my own cultural and social experiences. For example, I am a person of color (African-American), but I do not identify as a sexual or gender minority, and I am not a YA. While I may share some experiences related to race with participants, I needed to consciously identify any assumptions I had of a common understanding of those experiences and challenge them. In order to describe participants' points

of view that may differ from my own, I needed to maintain an awareness of my own perspective. Furthermore, as a mental health clinician, my biases favor clinical assessment and intervention as a path to improved mental health. It was important for me to continually monitor that assumption so that I could be better able to consider participants' perspectives that expressed contrary views. I did disclose my perspective to participants when asked and made an effort to express curiosity and to emphasize that I was very interested in understanding perspectives different from my own. Additionally, my research and clinical work has exposed me to a significant amount of evidence indicating the detrimental influence that structural discrimination has on minorities' mental health and disparities in service use. I needed to take care to allow participants to express their own experiences of discrimination, rather than making assumptions about how it has impacted them. To ensure that my portrayal of participants' perspectives were accurate, I would often repeat back to them what I thought they meant at points during the interview and allow them to correct me if needed. This was valuable as a form of member checking (where participants' views are solicited regarding interpretation of qualitative data) to maintain accuracy of the findings and to help support credibility.

Chapter 3: Results

Description of the Sample

Theoretical saturation, with no new categories emerging out of the qualitative data, was reached after interviewing 31 LGBTQ young adults of color. The average age of participants was 22 years (SD=1.8). The sample was evenly divided on gender identity between those identifying as male (42%; n=13) and those identifying as female (42%; n=13), however 16% (n=5) identified as neither male nor female (non-binary). Participants' race and ethnicity was counted for each category in which they identified. This allowed for more accurate descriptions of personal identity. The majority of the sample identified as Black/African-American (90%; n=28)

and as Hispanic/Latino (42%; n=13). Nearly half of participants (45%; n=14) identified as multiracial, most of whom identified as both Black/African-American and Hispanic/Latino (79%; n=11). Participants reported several LGBTQ identities, with the largest number (32%; n=10) identifying as bisexual. Twenty-three percent (n=7) identified as gay, 23% (n=7) as transgender, 16% (n=5) as queer, and 7% (n=2) as lesbian.

Participants were primarily low SES. Most (81%; n=25) reported incomes below the poverty threshold at less than \$10,000 per year and more than half of participants (58%; n=18) were unstably housed (living in a shelter or homeless) at the time of the interview. The majority of participants had completed high school (77%; n=24), with 23% (n=7) not having completed high school or its equivalent yet. Almost a third were students (29%; n=9) and fewer than half (42%; n=13) were employed. Table 1 presents differences in mental health service use according to demographic variables. No significant differences were found between continuous and discontinuous service users in terms of demographic characteristics.

Table 1: Sample Demographics

Variable	Total (N=31)		Service Use			
			Continuous (n=17)		Discontinuous (n=14)	
	N	% / Mean (SD)	N	% / Mean (SD)	N	% / Mean (SD)
<i>Demographics</i>						
Age	31	22.16 (1.8)	17	21.76 (1.8)	14	22.64 (1.6)
Gender identity						
Male	13	42%	7	41%	6	43%
Female	13	42%	7	41%	6	43%
Non-binary	5	16%	3	18%	2	14%
Racial/ethnic identity						
Black/African-American	28	90%	15	88%	13	93%
Hispanic/Latino	13	42%	8	47%	5	36%
Asian	2	7%	0	0	2	14%
Multiracial	14	45%	8	47%	6	43%
LGBTQ identity						
Lesbian	2	7%	1	7%	1	6%
Gay	7	23%	6	35%	1	7%
Bisexual	10	32%	3	18%	7	50%
Transgender	7	23%	4	23%	3	21%
Queer	5	16%	3	18%	2	14%
Income						
Less than \$10,000	25	81%	14	82%	11	79%
\$10k - \$19k	4	13%	1	6%	3	21%
\$20k - \$39k	2	7%	2	12%	0	0
Living situation						
Permanent Housing	13	42%	7	41%	6	43%
With family	2	7%	2	12%	0	0
Own apartment	4	13%	2	12%	2	14%
Shared apartment	7	23%	3	18%	4	29%
Shelter	16	52%	9	53%	7	50%
Homeless	2	7%	1	6%	1	7%
Education						
High school only	20	65%	13	77%	7	50%
Some high school	7	23%	4	24%	3	21%
College	2	7%	0	0	2	14%
Trade school	2	7%	0	0	2	14%
Current student	9	29%	6	35%	3	21%
Currently employed	13	42%	6	35%	7	50%

Mental Health Characteristics

As seen in Table 2, the majority of participants (84%; n=26) reported symptoms of mood disorder as their primary concern. Severity of symptoms among participants was clinically significant, indicating that they were among those in need of mental health interventions. Symptom severity in the sample (M=1.41; SD=.68) did not differ significantly from the BSI normative sample of adult psychiatric outpatients (M=1.32; SD=.72), which demonstrates that symptom severity in the study sample is comparable to the clinical population of interest. While not significant at $p \leq .05$, symptom severity among discontinuous service users (M=1.62; SD=.63) was slightly higher ($p = .10$), possibly due to lack of consistent treatment and/or severe symptoms that interfered with help-seeking. All participants had received some form of outpatient services, with 71% (n=22) having received outpatient services in the last 3 months. Most of the continuous service users (82%; n=14) had received outpatient services within the past 3 months, compared to about half (57%; n=8) of discontinuous service users. This may be due to patterns reported among continuous service users indicating that some had started using services for the first time recently (within the past year). About two-thirds of both those participants that had received inpatient mental health services (n=10) and those that reported symptoms of substance use disorder (n=11) were continuous service users, suggesting a trend toward association of co-occurring disorders ($\chi^2(1) = 2.58$; $p = .10$) and inpatient treatment ($\chi^2(1) = 1.65$; $p = .20$) with continuous service use in this sample.

Table 2: Mental Health Characteristics

Variable	Total (N=31)		Service Use			
			Continuous (n=17)		Discontinuous (n=14)	
	N	% / Mean (SD)	N	% / Mean (SD)	N	% / Mean (SD)
<i>Symptoms of mental disorder</i>						
Symptom severity (BSI)	31	1.41(.68)	17	1.23(.68)	14	1.62(.63)
Symptoms of substance use disorder (CAGEAID)	16	52%	11	65%	5	36%
Mood disorder symptoms (primary)	26	84%	13	77%	13	93%
<i>Sources of services received</i>						
Inpatient						
Ever received	15	48%	10	59%	5	36%
Past year	4	13%	2	12%	2	14%
Outpatient						
Ever received	31	100%	17	100%	14	100%
Past year	23	74%	14	82%	9	64%
Last 3 months	22	71%	14	82%	8	57%
School-based						
Ever received	10	32%	4	24%	6	43%

Salience of Minority Identities in Continuous Mental Health Service Use

Table 3 presents differences in mental health service use according to minority identity salience. There were no significant differences in service use, but the collective identity mean score was higher among the continuous service users and collective identity tended to be more salient in continuous service users when it was measured as a dichotomous variable ($\chi^2(1)=2.58$; $p=.10$). Thus, it is possible that this trend would be more robust in a moderately larger sample. Also, there was no significant difference between the sample mean score on the collective identity sub-scale ($M=27.61$; $SD=7.8$) and the AIQ-III collective identity normative sample for African-American young adults ($M=27.76$; $SD=5.5$), suggesting that average collective identity salience in the study sample is comparable to that of similar populations.

Overall, only about half of participants reported that collective identity was important (52%; n=16). However, a clear majority reported that specific minority identities of interest in this study, their racial or ethnic backgrounds (77%; n=24), their sexual orientations (74%; n=23), and their genders (77%; n=24), were important aspects of their identities. None of these variables were significantly associated with continuous service use in the sample, although more of the continuous service users reported that sexual orientation was salient (82%; n=14), compared to only 64% (n=9) of discontinuous service users. Socioeconomic status was least important to participants overall, perhaps due to stigma related to their current economic situations. As young people, participants also may have viewed their current economic situations as temporary and, as such, not important to their personal identities. Participants might have been expecting their economic circumstances to change over time as they progress in employment and education. Interestingly, slightly less than half of participants (48%; n=15) rated feeling like they belong to their communities as an important aspect of their identities, and those that found community belonging important were more likely to be continuous service users. The association between community belonging and continuous service use was stronger than in the other minority identity variables (FET; $p=0.04$), suggesting that this is another trend that may be more robust in a moderately larger sample.

Table 3: Minority Identity Variables

Variable	Total (N=31)		Service Use				Test Statistic
			Continuous (n=17)		Discontinuous (n=14)		
	N	% / Mean (SD)	N	% / Mean (SD)	N	% / Mean (SD)	
<i>Minority identity salience</i>							
Collective identity subscale (AIQ-III)	31	27.61(7.8)	17	28.59(8.4)	14	26.43(7.2)	$\beta=.04(.05)$; $p=.44$
Collective identity salient	16	52%	11	65%	5	36%	$\chi^2(1)=2.58$; $p=.10$
Ethnic/racial identity salient	24	77%	13	77%	11	79%	$\chi^2(1)=.019$; $p=.88$
Sexual orientation salient	23	74%	14	82%	9	64%	$\chi^2(1)=1.30$; $p=.25$
Gender identity salient	24	77%	13	77%	11	79%	$\chi^2(1)=.019$; $p=.88$
SES salient	13	42%	9	53%	4	29%	FET; $p=.15$
Community belonging salient	15	48%	11	65%	4	29%	FET; $p=.04$

FET: Fisher's Exact Test, 2-sided

Challenges to Mental Health Service Use

Several barriers to using mental health services were reported by participants that either prevented them from initiating treatment or from adhering to treatment once it had been initiated. As presented in Table 4, more than half of participants (61%; $n=19$) reported that concerns over not being understood by mental health professionals because of their cultural backgrounds presented a challenge to seeking mental health care. This concern was significantly more likely among discontinuous service users, suggesting that it was strongly related to service use in the sample (FET; $p=.02$). Other factors related to culture were also reported as challenges. Eighty-one percent ($n=25$) reported that their spiritual/religious traditions discouraged them from seeing a mental health professional, and about half (55%; $n=17$) said that their families did not want them to seek treatment. The majority of participants reported that feeling ashamed of their problems (71%; $n=22$), not believing that treatment would help (77%; $n=24$), and thus, refusing to go (71%; $n=22$) prevented them from using mental health services. About two thirds (68%; $n=21$) reported that not believing a mental health professional could understand their needs had been a barrier, and about half (52%; $n=16$) reported that knowing people who had bad

experiences with mental health professionals made help-seeking more difficult. None of these challenges were significantly associated with continuous service use. It is important to note that many of the challenges participants reported may have prevented them from initiating treatment as well as from continuing in treatment. That is to say, some participants may have experienced these challenges up until they initiated treatment and then remained in treatment consistently from that point on. Others may have experienced these challenges after they began receiving treatment, which resulted in discontinuation.

Interestingly, several common challenges to mental health service use were not reported as frequently by participants. Fewer participants reported that cost of services (36%; n=11), distance to services (23%; n=7), lack of transportation (32%; n=10), not having enough time to access services (42%; n=13), and loss of confidentiality (32%; n=10) were a barriers. The lack of challenges related to cost may be due to several factors: receiving services at no cost to themselves because they were children or adolescents; being covered by parents or state health insurance; receiving mental health services at no cost from LGBT youth shelters and housing support programs; and receiving services at no cost from school. In addition, the sample participants were living in a dense, urban setting with ample public transportation, so distance and lack of transportation would likely pose less of a problem for them. Many participants were not employed or students, so they may not have had as much difficulty scheduling to attend appointments for mental health services. Regarding confidentiality, although they may have been concerned about other people knowing that they used mental health services, it seemed that most participants were not concerned that mental health professionals would break confidentiality.

Participants' responses indicated that they felt familiar with the nature of mental health services. Only 6 (19%) reported that not knowing what to expect was a challenge to help-seeking.

Only about half (48%; n=15) reported that not knowing how to access mental health services had been a challenge, and this response was more frequent among discontinuous service users ($\chi^2(1)=2.58$; $p=.10$). This may be reflective of participants that discontinued services for reasons beyond their control (e.g., aged out of a program, moved to another area, agency closed).

Table 4: Challenges to Mental Health Service Use

Challenge	Total (N=31)		Service Use			
			Continuous (n=17)		Discontinuous (n=14)	
	N	%	N	%	N	%
*I was afraid they would not understand me because of my cultural background.	19	61%	7	41%	12	86%
I couldn't afford it.	11	36%	6	35%	5	36%
My family didn't want me to.	17	55%	10	59%	7	50%
I refused to go.	22	71%	11	65%	11	79%
I didn't know where to go or who to ask about mental health services.	15	48%	6	35%	9	64%
I was ashamed of my difficulties.	22	71%	13	77%	9	64%
The places to go were too far away.	7	23%	3	18%	4	29%
I didn't know anyone who had seen a mental health professional to tell me what to expect.	6	19%	4	24%	2	14%
I did not think that I had a mental health problem.	19	61%	11	65%	8	57%
I didn't believe the mental health professional could understand my needs.	21	68%	10	59%	11	79%
I didn't think it would help.	24	77%	12	71%	12	86%
I didn't have time because I had too many responsibilities.	13	42%	8	47%	5	36%
My spiritual/religious tradition discouraged me from seeing a mental health professional.	25	81%	14	82%	11	79%
I was afraid the people at the agency would tell other people about my difficulties.	10	32%	5	29%	5	36%
I had no transportation available.	10	32%	6	35%	4	29%
I knew people who had bad experiences with mental health professionals.	16	52%	9	53%	7	50%

*p≤.05

Qualitative Findings

Data from this study revealed a central theoretical thread, multiple minority identities require a process of negotiation from young adults in need of mental health services. Participants

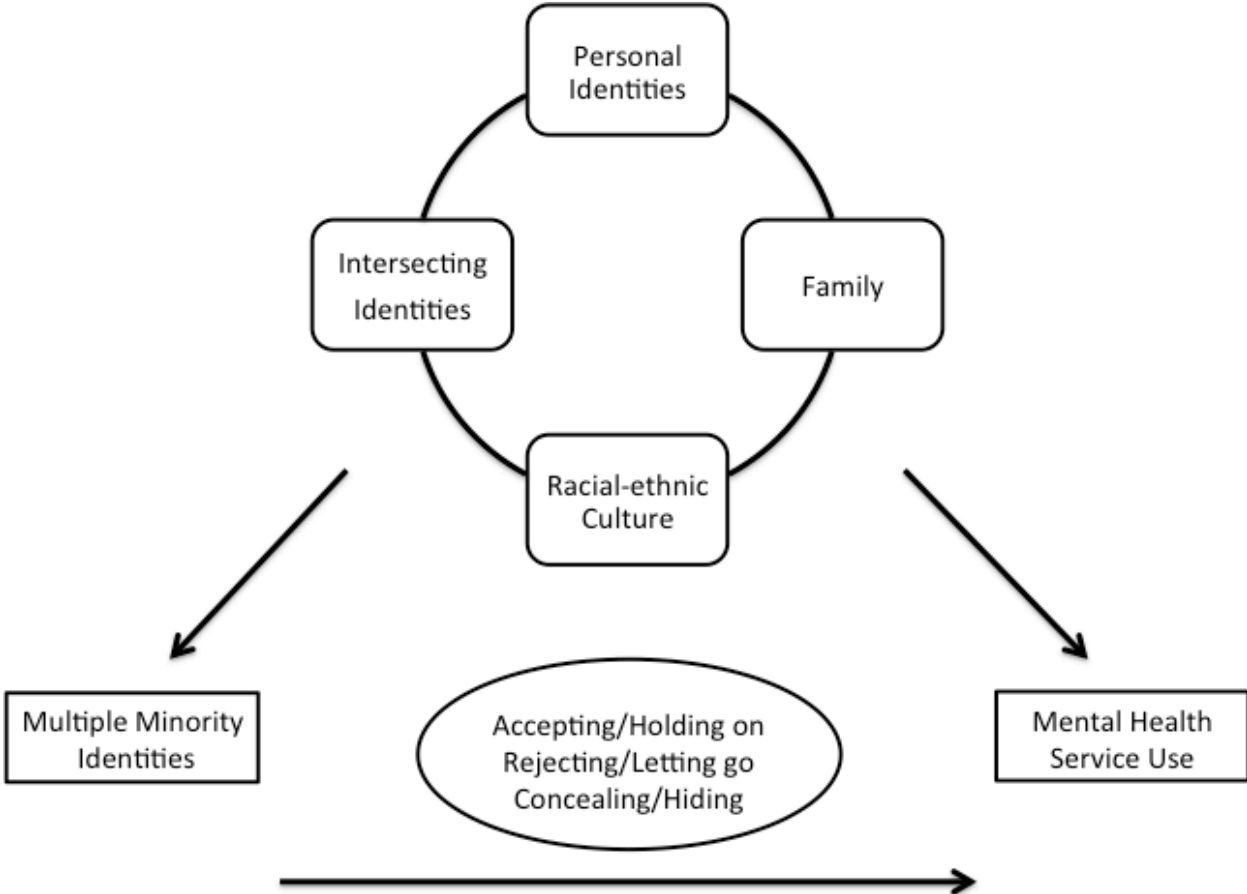
described how mental health and using services was understood and regarded by minority groups in which they included themselves and how that compared to their own personal understanding and choices about mental health services. What emerged was a distinct pattern in which participants' minority identities became salient in attitudes and behaviors related to managing their mental health and participants needed to navigate aspects of their minority identities that had become obstacles to mental health service use. Data was varied and contradictory, suggesting individualized processes of wrestling with competing influences on help-seeking.

Overall, participants described using services as involving a process of negotiation (see Figure 2) in which they were *accepting* or *holding onto* aspects of identity that facilitated management of their mental health and *rejecting* or *letting go of* aspects that became barriers. This process of negotiation also involved *concealing or hiding* aspects of identity that presented temporary barriers to managing their mental health. Adolescence and young adulthood is a time when personal identity emerges from an exploration and synthesis of sets of potential goals, values, and beliefs (Erikson, 1968), many of which flow from minority identities. Consistent with this developmental concept of identity formation, participants described integrating a variety of attitudes and experiences related to their minority identities to form their personal approaches to using mental health services.

The effect of multiple minority identity on mental health service use was interpreted as a process of negotiation because it involved participants developing the flexibility to appraise influences from their cultures, minority statuses, and family relationships in order to integrate those that were beneficial and to separate from aspects that seemed to be hindering their own well-being. Negotiation in this sense refers to finding a serviceable middle path among social identities and personal goals that are in opposition. Negotiation also involves compromise, and

participants demonstrated that they sometimes needed to tolerate difficult circumstances, learn to accept stigmatized aspects of themselves, and take on responsibility for their own well-being in order to address their mental health issues. The process of negotiating minority identities emerged from the data in two parts: 1) dimensions in which minority identity and mental health help-seeking intersect (i.e. what was being negotiated) and 2) ways of negotiating (i.e. how negotiation was accomplished) in those dimensions. In the following sections, I introduce the properties of each dimension and explore how participants spoke of minority identities becoming salient in their attitudes and behavior around mental health help-seeking. After each dimension, I discuss ways of negotiating, along with excerpts from the data that provide examples of empirical instances.

Figure 3: Negotiating Aspects of Minority Identities in Mental Health Help-Seeking



Dimensions of Minority Identity in Mental Health Help-Seeking

Four dimensions in which minority identity and mental health help-seeking intersect became visible in participant responses: *racial-ethnic culture, intersecting identities, family, and personal identities* (see Table 5). Sub-themes emerged within each dimension that captured how participants expressed and experienced minority identity in service use, and their perspectives on experiences of minority identity facilitating and impeding mental health service use. Consistent with the intersectional perspective used in this study, dimensions were inter-related and some properties identified in one dimension are also relevant in others. For example, experiences of family and of sexual and gender minority statuses are influenced by and situated within participants' racial and ethnic cultures, while racial-ethnic culture and attitudes about sexual and gender minorities are transmitted through family, etc. While the dimensions of experience can be distinguished from one another, there is some necessary over-lap as participants were speaking about multiple factors impacting their experiences simultaneously. In addition, some properties were more frequently represented in the data (i.e. had a larger number of quotations associated with the code) than others, but because properties were often inter-related, it would not be quite accurate to infer that those individual properties were more important or more representative of participants' experiences. So, for purposes of interpretation from a social constructionist standpoint, the descriptions of dimensions are ordered here according to the way they related to one another in the participants' descriptions of the negotiation process, rather than according to the sizes of each code category. Following each description of dimension, I discuss processes participants used to negotiate identity in that dimension.

Table 5 Dimensions of Minority Identity in Mental Health Help-Seeking, Properties, and Themes

Dimension	Properties	Sub-themes	Number of Quotations
<i>Racial-Ethnic Culture</i>	Culture, history, values, and behaviors that characterize racial/ethnic groups' mental health help-seeking	<i>Conceptualizations of emotional distress,</i>	23
		<i>High stigma within groups,</i>	19
		<i>Stigmatized by outsiders,</i>	15
		<i>Mistrust</i>	14
<i>Intersecting Identities</i>	Intersection of sexual, gender, and racial/ethnic identity in mental health help-seeking	<i>Intersecting identities as a barrier,</i>	27
		<i>As a facilitator</i>	35
<i>Family</i>	Family attitudes and behaviors in mental health help-seeking	<i>Family as a barrier,</i>	28
		<i>As a facilitator,</i>	16
		<i>Family mental health,</i>	9
		<i>Family religious beliefs</i>	11
<i>Personal Identities</i>	Intersection of minority identity and personal actions, thoughts, feelings, and beliefs in mental health help-seeking.	<i>Being understood,</i>	14
		<i>Accepting distinctiveness,</i>	22
		<i>Accepting responsibility</i>	30

Racial-Ethnic Culture

Participants expressed strong impressions of attitudes and values concerning mental health services within their racial and ethnic in-groups. These impressions were formed by their knowledge of culture, history, values, and behaviors that characterize their in-groups in relation to mental health help seeking. Their responses were consistent with models of ethnic-racial identity development in which adolescence and young adulthood signals the capacity to internalize values from ethnic and racial in-groups and to form an ethnic-racial group consciousness, or shared perspective that is based on their in-group membership (Quintana,

1998; Syed & Azmitia, 2008). In the data, participants used language that implied that there were psychological and ideological similarities among in-group members and provided examples of common understanding among in-group members because of their shared experiences. Use of the pronouns “us” and “we” when referring to their own racial or ethnic group provided additional support for labeling participants’ responses as reflections of their in-group identities. It is important to note that *racial-ethnic culture* reflects participants’ conceptualizations of mental health and help-seeking in their racial and ethnic in-groups that are constructed through personal experiences, generalizations, and even stereotypes. Thus, racial-ethnic culture should be understood as communicating more about participants’ experiences within their in-groups than about values or attitudes held by members of those groups as a whole.

Participants expressed a general impression that mental health service use was in some ways at odds with aspects of their racial-ethnic identities. They were conscious of stereotypes of in-group attitudes and when asked about what members of their in-groups thought about mental health service use, they repeated common aphorisms such as “Black people don’t go to therapy,” “Hispanics don’t believe in mental illness,” “we don’t talk to strangers about personal problems,” “you talk to your family first,” “African-Americans don’t trust doctors,” and “we handle our own problems.” While they varied in the degree to which they agreed with those generalizations, the vast majority described members of their racial-ethnic in-groups as less likely than those of other groups to seek help for mental health issues. Their perceptions of a conflict between racial-ethnic identity and mental health help-seeking were suggested by feelings that merely being a member of their groups (i.e. being a racial-ethnic minority) created a potential barrier that could lead to unmet need for treatment. Further, many described feelings of having acted against in-group norms when they did use mental health services.

Participants discussed factors that they thought explained their in-groups' differences in mental health treatment, including differences in perceived need, problem recognition and coping mechanisms, beliefs about the efficacy of services, as well as structural factors, including the affordability of care. These factors have been associated with demographic group disparities in treatment cited in previous research (Biddle, Donovan, Sharp, & Gunnell, 2007; Dobalian & Rivers, 2008; Meadows et al., 2006; Ojeda & Bergstresser, 2008; Padgett et al., 1994; Vogel et al., 2007; Zuvekas & Fleishman, 2008). Participants described situations in which their knowledge of attitudes held by their in-groups affected their individual attitudes and experiences with help-seeking, and how they negotiated those situations.

Sub-theme: Conceptualizations of Emotional Distress

Participants noted differences between their in-group's cultural conceptualizations of distress and those of out-groups or majority groups that affected their thinking about service use. Examples included idioms to describe symptoms (e.g. "we just say she has a temper"), explanations (e.g. "it's genetic, she just takes after her father"), and perceived causes (e.g. "it's just part of life").

In the black community, we just think everything is genetic or just a part of life. It's just like normalizing sadness or misery. So, like, since everybody thinks this is how life is, like, dealing with stuff like rape and stuff like that are kind of a part of life. It's not, like, thought of as a real problem. We don't really get into bipolar and all that stuff. (28)

This participant described how his in-group sees mental health problems as normal reactions to difficult situations in life. He was also indicating that these reactions have been normalized as common experiences for people in the black community. He was discussing why he thought his in-group was less likely to seek help for mental health problems and he suggested that they do

not view them as “real” health problems. This difference in problem recognition and perceived need for treatment was a common response from participants reflecting on how people from their racial-ethnic in-groups think about getting help with mental health problems. When emotional distress is viewed as a normal part of life, it will not be conceptualized as a medical problem that is in need of treatment. Views expressed by participants described their in-groups’ as seeing emotional distress as situational, often related to traumatic experiences and grief, as well as to economic inequities, racism, and discrimination. Participants also identified an interpretation of distress as being a spiritual problem that is due to lack of connection with faith or religious practices. Thus, instead of needing to seek medical help, appropriate ways to address emotional distress were conceptualized as needing to change one’s situation or of needing to seek spiritual or faith-based solutions.

Sub-theme: High Stigma Within Groups

Because of the culture, I think there’s such a stigma against mental illness and so nobody talks about mental issues or anything. It’s really, really frowned upon and I think there’s a sense of like, if you suffer from any type of sadness or anything, you’re bringing shame to your family and so because of all of this I never had the language to address my feelings or like, seek out help. (51)

In addition to cultural conceptualizations of distress, participants emphasized the effect of high levels of stigma around mental health problems. Participants suggested that high stigma within racial-ethnic in-groups often prevented direct communications of distress. In the excerpt above, the participant expressed a lack of language or explanation for his experience of depression such that he did not develop a sense of perceived causes or appropriate responses to emotional distress from his culture.

Many participants observed that their own racial-ethnic minority groups held a highly stigmatized view of mental health problems and getting help for those problems, especially compared to the majority population (non-Hispanic whites). There was a perception among participants that white people are more likely to seek treatment for mental health problems, at least in part, because they experience less stigma about mental illness. Interestingly, participants from all ethnic and racial groups in this study held the impression that their own in-groups were especially affected by stigma. This is notable given that a number of participants (12) had dual-minority multiracial identities (i.e. both parents are people of color and from different racial-ethnic groups). As such, many were drawing upon personal experiences of more than one racial-ethnic minority identity.

High stigma around having mental health problems was conceptualized as fear of being viewed within one's own community as weak or defective, while the stigma of seeking treatment was described as deviant behavior, contrary to cultural norms. Speaking about his African-American community, one participant said:

Certain things are like, culturally looked down upon so it's like, showing that type of weakness, it's like, oh you vulnerable or you trying to do something that's outside of the box in the community. In our community we like to keep ourselves in a certain box, in the same comfort zone, whether it's good or bad, it's the comfort zone cause it's familiar, you understand. (34)

In this excerpt the participant described an aspect of his internalized African-American identity in which belonging to the group meant concealing vulnerability and not engaging in behaviors like mental health treatment that would expose that vulnerability. He illustrated a viewpoint common in the data, that there is something inherently culturally unfamiliar about mental health

help-seeking and that to participate in it is a sort of out-group behavior, or not something “we” do. In another example of associating mental health help-seeking with out-group behavior, one participant described it bluntly by saying, “they feel like mental health was something that was created by white people,” (26). These discouraging views about mental health help-seeking as an out-group behavior has potential to put minority young people engaged in the process of identity development in a bind. To seek help is to act against racial-ethnic in-group’s norms and to risk having one’s belonging to the group, one’s in-group identity, called into question.

Sub-theme: Stigmatized by Outsiders

I think that sometimes when people are frustrated they get called crazy for like all the wrong reasons. Like in my community, I personally think that so many of them who wasn’t crazy been called crazy or unruly or whatever. I feel like sometimes they lose their sense of what’s crazy cause they’ve been called crazy all the time. And we’re supposed to act like animals and stuff like that in some people’s eyes and sometimes I feel like people really lose sight of what sanity is and you’re automatically insane or aggressive because you’re born in a certain type of situation. Things that’s like, cultural to some people are crazy to other people. (33)

When discussing impressions of their racial-ethnic in-groups as less likely to seek help for mental health issues, participants spoke of being aware that their groups’ cultures could be pathologized by outsiders. In the excerpt above, the participant described people in her in-group being mislabeled with having a mental health problem when they were responding to distressing experiences in ways that were inline with in-group behavioral norms. She offered this as a possible explanation for differences in problem recognition and perceived need for treatment among her in-group. She suggested that majority group members have used the concept of

mental health disorder to incorrectly label phenomena in minorities so frequently that it has ceased to have a valid meaning. Further, she understood this kind of labeling as racist, pointing out that what might look like a culturally appropriate response to another African-American person, could be misinterpreted as disordered by an out-group member.

Other participants spoke about societal stigma and concerns about how their racial-ethnic minority groups were negatively portrayed in media and perceived in public by out-group members. This was a special concern for participants reflecting on recent, publicized acts of police violence against African-Americans. There was a sense that to acknowledge mental health problems would be to collude with culturally biased and racist judgments about one's group as being "crazy," "aggressive," or as deserving of this violent victimization.

Sub-theme: Mistrust

Participants described their in-groups as lacking trust in mental health professionals. Mental health professionals were often viewed as part of the majority culture by way of their training, and thus, were expected to act according to the majority culture's values. Mistrust of mental health professionals was characterized as fear of mistreatment (e.g. "they just experiment on you"; "they just lock you in a hospital"), discrimination (e.g. historical abuses by medical professionals and scientists), and clinician bias (e.g. "the therapist's white, so she wouldn't understand"). These observations by participants are widely supported in research on disparities in the U.S. that identifies mistrust as a major barrier to receiving mental health treatment for racial and ethnic minorities (see Department of Health and Human Services (2001)).

Giving an example of the effect mistrust had on his own help-seeking experience, one participant said:

I think it's just not really trusting other people to regulate how I live my life or how I seek help. This is definitely within African-American culture, this where I got it from, a lot of us smoke a lot of marijuana as like a coping mechanism for like stress and trauma and whatever these terms are, right? And my issue with the medical establishment is, because we believe they, you know, sanction their drugs and tell you not to do this. That makes no sense to me. Especially when I'm functioning. Like, I've been smoking for years, doing ok, and then I start taking these pills and I'm sleeping all day and like, a symptom of depression is sleeping all day. So I think a lot of African-Americans would prefer, and there are roots in traditional Afro-Caribbean culture, to self medicate and like, seek alternative medicine instead of like, medically sanctioned and federally approved things like pills or doctors. Also a lot of African-Americans have a negative history with hospitals and medication and pills and all of that. All of that equals bad to me and a lot of African-Americans...That's really real in African-American culture. (29)

He explained how his in-group culture supplied some of the mistrust and his own experience seemed to reinforce it. He saw his own negative experience as linked to other African-American's experiences and to their preferences for self-medicating. He understood his own mistrust as mutually informed by his racial in-group and by his individual experience. He explained how mistrust presents as a kind of dilemma. Attempting to cope with his problems in a way that was culturally accepted by his in-group drew negative feedback from mental health professionals, but when he tried the pills they prescribed, he ended up feeling worse. Coping mechanisms that were commonly used in his racial-ethnic group, and that felt helpful to him, were labeled by the majority culture as inferior. In addition, following a medical professional's advice could feel like colluding with a view that his own group was limited, mistaken, or

inferior. This represented a negation of his own culture or of a part of his own identity. Deciding whether to use professional mental health services put him in a position of having to decide whether to trust or deny the knowledge he internalized from his culture.

Negotiating Racial-Ethnic Culture

It takes a strong individual...I went through barriers in my mind. I was a firm believer in, it doesn't do shit. Like, somebody sitting in front of me as if I'm crazy and I know I'm not. I avoided appointments for the longest, I'm not gonna lie to you. (23)

When participants were asked about ways in which their personal attitudes about mental health help-seeking were the same as their in-groups', and about ways that they were different, many described going through a kind of a change in their individual attitudes over time. Participants recalled grappling with negative attitudes and beliefs about getting treatment they had learned from their racial-ethnic in-groups before they were able to participate in services. In the excerpt above, the participant discussed a lengthy process of being referred for individual psychotherapy, making appointments and not attending before he was able to maintain his engagement in treatment. He struggled with stigma and mistrust before finally attending an appointment. It was his impression that it takes "a strong individual" to act in spite of internalized negative attitudes about mental health help-seeking. Some participants currently in treatment acknowledged still holding onto, in varying degrees, attitudes that discouraged help-seeking. However, many were able to identify ways of negotiating racial-ethnic culture that presented barriers to getting help. In discussing how he negotiated stigma, one participant said:

When you start going to therapy you realize you're getting help but instead, in that community, it's like pointing out that there's something wrong rather than pointing out the fact that you're trying to fix something. So it's hard to for anybody to reach out and

say I think I need help with stress or I'm not having the safest thoughts, or whatever the case may be, because you're constantly worried about being judged for trying to get help. I think I'm the same in that I wouldn't admit it. I wouldn't go around saying I'm seeing a therapist. Which is kinda bad because they might be that one person like I was who's waiting for someone to, but because of the stigma and everything I don't. (25)

Along with several other participants, he described negotiating racial-ethnic culture as concealing his participation in therapy. This was his way to get around the barrier presented by stigma in his community. Even though he was seeking help, he still felt his in-group's attitudes affecting him. He felt that, by hiding the fact that he was going to therapy, he was still holding on to some of his in-group's negative attitudes, even though he was acting against them. He expressed his conflicting feelings about not being able to be a positive example to someone else that is struggling with stigma. Yet, he negotiated a compromise that allowed him to get the help he needed and avoid the negative consequences of his in-group's attitudes.

In another example of negotiating racial-ethnic culture, a participant described finding alternative examples of attitudes about mental health help-seeking in their¹ community. Finding in-group members that had different beliefs than the ones that they had internalized previously helped them to take a more nuanced view of how to integrate being African-American and using mental health services.

I recognized that like, they do have their own personal opinions about how they view mental health and things like that. I found that like, it's split generally between secular and non-secular. So people within the church generally, I have found in my history, are really like, just keep going to church pray it away, see if talking to your pastor can help.

¹ This participant preferred gender neutral pronouns, and is referred to as they/their/them

It's one of those things that very much affected how I saw mental health originally. And then within non-secular groups it seems like there's more of an open discussion even though a lot of people also came from church. 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 and get help if it seems like there's an issue...(22)

While acknowledging that faith-based conceptualizations of distress and help-seeking greatly affected them and still continues to do so, they described choosing to identify more with a secular aspect of their African-American culture that is accepting of professional help-seeking outside of the church. They explained a helpful perspective that they discovered, saying "God wouldn't have created, you know, psychology if he didn't want you to actually use it." By adopting a secular aspect of their culture, the participant was able to hold on to their sense of in-group identity. They found a way to receive mental health services and let go of attitudes that produced conflict and stigma.

Negotiating Intersecting Identities

Participants in this study reflect double or triple minority status (e.g., racial-ethnic minority LGBT individuals, queer/trans people of color). From an intersectional perspective, it is essential to consider participants' sexual and gender minority identities together with their ethnic-racial identities to explore connections between minority identity and mental health service use. While they did describe situations in which their multiple minority statuses were barriers to service use and situations in which being LGBTQ was a facilitator, participants did not have fixed impressions of in-group attitudes about mental health help-seeking among LGBTQ people of color. Some thought sexual minorities in general were more open to service use and had greater access to services through LGB community resources than heterosexual

members of their racial-ethnic minority groups. Others thought that sexual and gender minorities that were people of color were less likely to use services due to concerns about anti-transgender discrimination and heterosexism being more intensified within their ethnic-racial communities. It is important to note that many of the participants only very recently began exploring their sexual and gender identities, in contrast to racial-ethnic identities that have been developing since early childhood. This sometimes led to difficulty reflecting on integrated multiple minority statuses, as they related to mental health help-seeking for some participants.

Sub-theme: Intersecting Identities as a Barrier

Participants observed that anti-gay and anti-transgender attitudes affect how LGBTQ youth of color access mental health services. Overall, participants reflecting on how their intersecting identities influenced their experiences with mental health help-seeking presented them as complicating service use due to compounded stigma and discrimination. Many participants believed that their own racial-ethnic groups were highly homophobic when compared to non-Hispanic Whites. This was due to the combination of religious and other racial-ethnic cultural beliefs stigmatizing sexual and gender minorities. Some participants described difficulties accessing services within their racial-ethnic minority communities because of anti-gay stigma among religious institutions that provided counseling and other social services.

Participants were aware that being LGBTQ was considered a form of mental illness in the past and pointed out that it still was in some of their own racial-ethnic minority communities. As such, acknowledging a mental health problem and seeking services could feel like or be viewed as confirming that idea. Participants were clear about their personal disagreement with this prejudicial, outmoded view, but many still felt affected by it when receiving services. One participant highlighted the issue clearly, saying:

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. It's hard to admit that oh I'm going to a therapist because it's like, they'll just look at your sexuality and be like, oh well it makes sense. But that's not the reason why I'm going to see a therapist. Some nuances might have to do with certain things, parts of my life, but it's not because I'm bisexual and I'm trying to get cured or fixed and that's how people kinda take that. (26)

He felt that there was a lack of understanding among his racial community that distress that accompanies being LGBT arises as a result of a culture that stigmatizes people for being LGBT, and that LGBT people use therapy to cope with other issues in life that are not exclusively related to sexuality or gender identity. He was frustrated by the fact that his using mental health services would appear to be confirming a connection between being bisexual and having a mental health disorder, and this made it more difficult for him to seek services.

One participant illustrated the impact of intersecting identities and the stigma associated with having a mental health problem, saying:

The really like, strict cultural forces, that alone is really difficult to deal with and then on top of that, having to hide the fact that I'm gay and always being afraid of being persecuted or punished because of that? Yeah, that's definitely made it a thousand times more difficult than I think it would've been if I were only gay or only Black. (51)

He said that he had needed help for his depressed mood for several years, but his fear of the stigma around depression in his ethnic culture had merged with his fear of the stigma around being gay. Rather than being one issue or the other, it was both, simultaneously. The need to conceal one stigmatized aspect of himself was emotionally linked to the need to conceal the

other. He described stigma related to those intersecting identities as a primary reason that he delayed using mental health services, which contributed to his symptoms worsening over time.

Another participant described an incident in which she could clearly identify discrimination due to her multiple minority status. Being both black and transgender, she was a minority among minorities:

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. I had to complain and she got removed from the floor. And this was a situation where I was not the only trans person there, but I was the only black one. There's a big difference with how a black transgender person gets treated. They just think ok, you're gay and then you're black. (24)

She experienced discrimination by a medical professional from her own racial-ethnic group, and described it as feeling harsher and more isolating than a single incident of racism or anti-trans bias. She related this experience to anti-gay attitudes present in the African-American community and said that it caused her to be even more wary of black mental health professionals. Her experience is consistent with reports that up to 25% of transgender people experience discrimination in a doctor's office or hospital, with the combination of anti-transgender bias and structural racism causing transgender African-Americans to fare even worse (Grant, 2011). One can easily imagine the difficulty of other LGBTQ youth of color, already cautious due to mistrust of mental health professionals, having to manage additional vigilance for potential sexual and gender prejudice.

Anti-transgender bias and heterosexism among members of their own racial-ethnic culture had some participants affirming that they personally chose to identify more strongly with being LGBT than with their racial-ethnic cultures. The participant quoted above described

negotiating her situation by advocating for herself at the hospital and holding on to her intersecting identities in that moment, but speaking of seeking help in the future she said:

I would feel uncomfortable because they would try to go into my background history. 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....I can't just be honest about it because there's always that look, you don't know how it's going to be. Why would I tell them something that's going to not get me care? (24)

She explained that it would be impossible to hide her dark skin but that she plans to conceal her history and her identity as a trans person if she needs to seek treatment again. When speaking about her personal identity, she indicated that she was still sorting out whether she even considered herself to be trans since having reassignment surgery. She mentioned that she still valued her friendships with other trans women and felt that she and they have a shared history, but when it comes to seeking mental health services, she was clear about preferring that her service providers only know her as a black, cisgender female in order to avoid compounded discrimination. Having a trusting relationship with a provider is considered essential to effective mental health treatment, so feeling discomfort in being honest about personal history with a mental health professional has the potential to significantly limit the quality of treatment she receives.

Sub-theme: Intersecting Identities as a Facilitator

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. (33)

Many of the participants in this study were receiving mental health services from programs designed to serve LGBTQ youth or had been referred to services through such an agency in the past. They described these services as “safe,” “welcoming,” and “supportive,” where they felt “much more open” and “less concerned of people judging me.” Some participants had been initially referred to mental health services for reasons specifically related to their sexual or gender identities (e.g. bullying or gender dysphoria) and expressed that this had been a pathway to receiving help with other issues such as trauma, anxiety, and mood disorder in an LGBT-affirming environment. Participants agreed that experiencing acceptance of their sexual and gender identities in these welcoming service settings actually helped them to let go of racial-ethnic group norms that discouraged professional help seeking. In many ways, their LGBT identities were directly facilitating their mental health service use.

One participant eloquently expressed the connection between intersecting identities and mental health help-seeking. Contrasting being queer with being African-American, they² said:

I think that’s something that a lot of people in the queer community are really open about. Just because there is so much that is...because mental health and the queer community are so deeply intertwined. Sitting down and thinking about whether or not you identify with that particular gender that you have been raised in...There is more sensitivity to the other ways that you might be different mentally...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. (21)

They described their experience of feeling different from cisgender people as bringing on greater introspection and self-awareness. They described accepting their queer identity as enabling them to be more accepting of other aspects of their self that were outside of the norm, such as the

² This participant preferred gender neutral pronouns, and is referred to as they/their/them

distressing thoughts and emotions they had been having. It also allowed them to feel less stigmatized about having depression and to start viewing the depression as just part of being mentally different, as opposed to defective or deficient in some way.

Negotiating Family

The influence of family was a defining feature of the connection between minority racial-ethnic identity and help-seeking. When describing the role played by racial and ethnic identity in their ideas about mental health and service use, participants overwhelmingly identified with and referenced their own racial-ethnic groups through family connections, supporting many studies that have identified familial ethnic socialization as a critical influence on ethnic and racial identity (e.g., Hughes et al. (2006); Umaña-Taylor, Gonzales-Backen, and Guimond (2009). The family is vital for helping children learn values and behaviors that facilitate their adaptation to a particular environment (Parke & Buriel, 1998), suggesting that the family is perhaps the most important proximal social context that guides ethnic-racial identity formation (Umaña-Taylor et al., 2013). Family, and parents in particular, were also the primary medical decision-makers in most of the participants' treatment histories, giving them a major influence over participants' help-seeking experiences.

Participants discussed how their parents or other members of their family experienced and understood mental illness. They also described family encounters with treatment as shaping their own attitudes. Cultural concepts of mental health problems, help-seeking, and religious beliefs and practices were intertwined with participants' family experiences. Family for some offered a support or a facilitator to help-seeking. For others, family was a barrier, especially when family explicitly invalidated the experience of having a problem or of needing help.

Participants spoke about anti-gay and anti-transgender stigma and prejudice that caused family rejection, which, in turn, had severe consequences, including homelessness, either because they had been thrown out of their home or because they had found the climate so intolerable that they chose to leave. Even without contributing to homelessness, family rejection sometimes restricted access to LGBT-related programs that offered mental health services either because parents blocked them from participating or because they chose to avoid LGBT-identified programs and stay closeted in order to prevent confrontations with family. These experiences greatly affected their experiences with seeking and using mental health services.

Sub-theme: Family as a Barrier

I know my father was very, very disappointed, upset. He was like, legitimately hurt when he found out that I was seeking therapy. He used words like “sold my family out” and “threw them under the bus,” “talking to a stranger” and all of this, it’s really weird. (39)

This participant described a family reaction to help-seeking as a betrayal of the family by talking about personal problems with a stranger. As discussed in the dimension of racial-ethnic culture, their family valued keeping personal problems within the family. Thus, in order to use mental health services, they³ had to risk the disappointment of their father and feeling that they had been disloyal to the family, creating a significant emotional barrier to seeking professional help.

The same participant described additional examples of how their family attitudes about seeking professional help became a potential barrier in their own thinking.

³ This participant preferred gender neutral pronouns, and is referred to as they/their/them

I haven't opened up to my family about my mental health struggles because they will all stress that mental health professionally is a farce or a sham. Like, you can talk to us but you don't really need all that. For them it's mostly, they're just trying to sell you some drugs, is a real thought. Like, I truly have that thought half the time. I think a lot of academia is a sham and a farce. Maybe it comes from marginalization and disenfranchisement, but I think that like, a lot of licensed work is just a farce. I don't know. (39)

In-group ideas of mistrust of the medical establishment, viewing it as exploitative and marginalizing, were transmitted and reinforced through family. Potential barriers increased as this participant had to contend not only with family's disappointment and betrayal, but also consider whether their family's mistrust was warranted and whether it was wise to risk seeking help and being exploited. This participant acknowledged that their family had some valid reasons for mistrust and readily admitted to ongoing deliberation on the value of mental health treatment. Here, they recounted experiences outside of the family that helped them to reconsider:

You know what though, a lot of my peers like, had therapy. 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 family that's against it. And my family is backwards in a hundred different ways. (39)

Consistent with the increased influence of peers during adolescence, they described interacting with peers as an influence that countered ideas about mental health treatment held by family. In this case, the participant noted that they had transferred to a school outside of their neighborhood where most of their classmates were white and from

wealthier families than their own. They emphasized how exposure to attitudes about mental health outside of the family made it easier to let go of their family's influence. They distinguished their self from family and chose to affiliate with peers on the issue of how to manage mental health. The participant described it as moving toward a personal identity they aspired to have, and which was in contrast to identifying with their family.

Sub-theme: Family as a Facilitator

The only person that knew about it was my mom and she was the first one to say, maybe if you talk to someone, it would help. (47)

While many participants described family as a barrier to be negotiated, some expressed a profound sense of support from family that encouraged them to seek help at times when it was difficult to do it on their own. This participant discussed her own struggle to seek psychotherapy after a sexual assault she had been keeping secret out of feelings of shame and a distorted perception of responsibility for her trauma. She had been increasingly isolated and unable to receive needed comfort and acceptance from peers, and for her, as it was for other participants, keeping problems within the family had been the norm. However, being able to tell her mother what had happened to her generated a different response than she had expected.

My mom's really the only one that's supportive of it. I have a few friends, who are also African-American, and they think it's stupid and it's a waste of time. It's not a very positive thing in the Black community. (47)

The participant described this as a sort of turning point that challenged the messages she had been receiving about using mental health services in her community.

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 a little bit more. It does help to

know that you have a good support system that regardless of what you're going through, they'll be there, they'll understand. It definitely does help. (47)

In this instance, the support of her family allowed her to let go of some social and cultural attitudes that were adding to the already daunting burden of getting help with her trauma. Through her trusting relationship with her mother, she was able to accept her mother's perspective on help-seeking and take steps to engage with treatment.

Sub-theme: Negotiating Family's Mental Health

Family mental health was an important subtheme that characterized and gave shape to the dimension of family. Several participants had parents or other close family members that struggled with mental illness and these experiences affected attitudes about mental health and help-seeking held by the family. Some participants recalled family experiences as a motivating factor to receive treatment for themselves. For others, family mental health contributed to mistrust and stigma.

My mother, she herself went through a lot of mental health issues. She was admitted and medicated when she was younger. She gave a lot trouble with treatment so anytime I asked a question, she would always respond with what she went through. So that gave me a predetermined idea that mental health treatment was bad, it was control. (27)

This participant described his mother's mental health history as an early influence on his ideas about the nature and function of mental health services. Family in this account was offering in-group ideas of mistrust combined with personal experience as a protective warning against harm associated with help-seeking. The participant was put in the position of having to disregard warnings from his mother and overcome fears of being

“controlled” if he were to seek treatment when he needed it. His mother’s belief that mental health treatment was undesirable, if not downright dangerous, presented a barrier to his future service use.

In a contrasting example, one participant discussed negative experiences with mental illness in his family as a facilitator to his own service use:

My mother eventually did get help, but that’s not a role model for me. When you see role models inside your house doing the wrong thing, it’s either one of two things, you’re going to follow down that pattern or you’re going to do the exact opposite. That’s where I came into, I don’t want to end up like my mom or like my dad and find twenty years of my life wasted. So I was like, what can I do that will help me not fall into those traps and not get to that point? (25)

This participant beautifully described the process of negotiating family mental health. He experienced significant hardship growing up due to the lack of mental health help-seeking in his family. He felt that it was important for him to do the opposite and make different choices than his parents made. He negotiated his family’s example by rejecting their approach.

Sub-theme: Negotiating Family Religious Beliefs and Practices

My parents poured more trust into the pastor than they did into medical professionals. That’s why they were like, we’re not going to pay for something we don’t believe in. The pastor told them that all I needed to do was to be involved in the church, pray to god, and that my mental issues was gonna go away. (40)

The influence of family on help-seeking was intimately tied to religious beliefs and practices within the family for many participants. Many such family beliefs prominent in the data were also identified as emerging from racial-ethnic culture. Some participants found personal religious beliefs to be supportive to their mental health, while several participants described their family's religious beliefs as antithetical to seeking professional treatment. In one common example, participants' families transmitted the cultural conception that mental health problems are actually spiritual problems that are best addressed with prayer and increased dedication to faith activities. Other family religious beliefs explained mental health problems as "demons to be exorcised," while others described problems as a moral failure to adhere to religious tenets. Intersecting LGBTQ identities became especially problematic for some participants whose family religious beliefs viewed their sexual orientations or gender identities as a spiritual problem or moral failure, and thus, interchangeable with their mental health symptoms.

I started seeing another therapist, a pastor, when I came out and my eldest sister and 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. She's like, "ok we can cure this." During the sessions I was very quiet, I only spoke when I needed to. I was just being told over and over again that, you know, I'm wrong, I'm wrong but I didn't...it was just very conflicting and it really, it was just breaking me down...after like three months of that, I tried to take my own life. (38)

This participant described a horrific experience with help-seeking as it was recognized by his family's religious beliefs and practices. He had already been struggling with depression when he came out to his family. They conflated the depression with his sexual

orientation, and he was told to see a pastor for therapy. In spite of his experience, he said that he continued to consider himself a “spiritual person” and that he holds on to many aspects of his family’s faith. He engaged in the process of negotiating religious aspects of his identity. Like many of the participants, he needed to let go of aspects of his family’s religion that were detrimental and presented barriers to his mental health. He learned to distinguish his personal faith from his family’s and by holding on to aspects that were meaningful and beneficial to him, he formed his own notion of a satisfying spiritual life.

Negotiating Personal Identities

I fit in with the community. But I believe that I’m special. (32)

Throughout the dimensions discussed above, participants described mental health help-seeking as a process of trying to integrate what they had learned about mental health from their racial-ethnic cultures, from being LGBTQ, and from their families to develop their own personal perspectives. Demonstrating parallels to identity development in the transition to adulthood, participants described needing to start sorting out who they are, what they value, and what their goals in life were in order to decide to use mental health services. That often meant accepting that they had a mental health problem and needed treatment, in spite of messages from their social identity groups that made it difficult and undesirable to accept. It also involved accepting that they were different in from members of their minority groups or from family in ways that shaped their personal identity. Participants spoke about ways in which they started to understand themselves differently through their help-seeking experiences. They described learning that they could still have a connection to their social identities and also have distinct personal identities at the same time. They also described needing to accept responsibility for solving their own problems, in ways that worked for them personally, in order to get the help that they needed.

Sub-theme: Being Understood

Being understood was a key factor for participants trying to integrate opposing aspects of their identities around mental health treatment. Experiences with racism, sexism, transphobia, and homophobia caused participants to value circumstances in which they were allowed to self-identify. Due to the many barriers to mental health help-seeking, participants were highly sensitive to instances of being misperceived or misunderstood, and finding a person or treatment environment that made them feel understood was extremely important to participation in treatment. By the same token, assumptions that mental health professionals would not be able to understand was a central reason participants gave for not engaging in psychotherapy. Several participants described staying in treatment when they felt that they were connecting with people who had similar cultural experiences and identities, although most participants said they had never had a doctor or therapist that had the same multiple minority identities as themselves.

As mentioned above, receiving services from a program or agency that was LGBTQ-friendly made participants expect that there was a greater chance of being understood by a mental health provider. There was little agreement about how important it was to have a mental health provider that was LGBT, a member of their racial-ethnic groups, or who was both. Some participants said they did not think it would matter if their provider had the same minority identities as they had, while some thought that it would be helpful. Participants also voiced concern that having a therapist from their own racial-ethnic background would create a higher risk of experiencing the same stigmatized attitudes they had experienced from their families and communities, as one participant explained:

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 like, I couldn't handle the stigma. I just wanted to find something very different. (51)

Participants were also very concerned about being understood as individuals. Many expressed discomfort with assumptions or generalizations being made about them due to their minority identities. As one participant, explained:

I mean, one of the reasons I stopped going to the psychologist I first saw...it seemed like you read a book about who I'm supposed to be but when I told you my experiences you're like "yeah but that doesn't match what I've read, therefore I'm going to treat you based on that." It's like, but can you hear what I'm saying though? (22)

They emphasized that their identity as a queer person of color should be taken into consideration by mental health professionals, but that their own personal relationship to those identities was equally important. They understood their experiences of mood disorder as being related to their cultural background and to their queerness, but they thought that they were not being acknowledged as a unique individual. They felt that the psychologist did not seem to be listening and trying to understand the way that they personally related to those identities. This experience highlighted how the intersection of multiple social identities needs to be understood in individual terms rather than solely collective terms in order to avoid stereotyping, an issue that has been recognized by researchers studying the impact of cultural factors on mental health help-seeking behavior (Lewis-Fernández & Díaz, 2002).

Sub-theme: Accepting Distinctiveness

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.

(25)

Most participants, when asked how their own attitudes about mental health help-seeking compared with their racial-ethnic in-groups' attitudes, accentuated how they were different from their in-groups. They described their own distinctiveness as an important factor that helped them to negotiate cultural stigma around using mental health services. There was a sense of empowerment around seeking services when participants discussed realizing that even though members of their cultural groups or families may not approve, they were able to form their own ideas and make their own choices. One participant described his personal attitudes by saying,

I feel like I'm very different. 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.

(23)

This participant described teaching himself to dismiss discouragement and stigma around getting mental health treatment from his community. He said that he had to learn to accept that some members of his community would continue to have negative opinions about him because he was different and choosing to do something outside of the norm.

Rejecting cultural attitudes that discouraged mental health help seeking seemed to flow alongside rejecting negative cultural attitudes about participants' sexual and gender minority identities. As mentioned above regarding intersecting identities, becoming comfortable with themselves as distinct from others in terms of sexual orientation or gender identity seemed to allow participants to accept their distinctiveness in other ways as well. In spite of potentially

compounded stigma and discrimination, multiple minority status seemed to convey an upside to being different. Participants communicated a sense of being different as indicating to them that they have different needs. Thus, they questioned whether their family's or racial-ethnic identity group's opinions about how to solve personal problems were always valid. By virtue of being different, participants expressed feeling less compelled to conform to unhelpful attitudes about mental health help-seeking, and freer to develop their own personal attitudes. As one participant put it,

...it's difficult. There's a lot of negativity around. But who says that you have to just go with the flow? You can be your own self and be positive.... I don't have time for negativity. (31)

As in negotiating racial-ethnic culture and family, participants discussed their acceptance of distinctiveness as a sense of being separate from and having let go of values and beliefs that presented barriers to help-seeking. Discussing barriers presented by his family and ethnic culture, one participant said:

I think what I first had to do was sort of feel independent from my family. And so I think that was one reason why I couldn't stick with therapy...so now, like, I don't care what my family thinks anymore. Like, they don't have to know, it's not really any of their business and I'm doing this for me. (51)

Overall, accepting distinctiveness refers to participants encountering aspects of their cultural identities that present barriers to help-seeking and then recognizing themselves as having distinct personal identities that can reject unhelpful cultural attitudes.

Sub-theme: Accepting Responsibility

I wanted to go because the drugs scared me and I knew that wasn't the person that I was.

I knew that me trying to commit suicide wasn't the person that I was. So I knew that

something was wrong and I had to fix it before something bad would happen. I have goals in life that I wanna do. (36)

Speaking about their own decisions to use mental health services, participants highlighted experiences in which they came to understand that their personal well-being was partially or completely up to them. They described recognizing that their emotional distress or limited functioning was interfering with their goals and that they needed to take steps to address their problems.

Accepting responsibility for managing mental health problems often brought with it a feeling of being on one's own to figure out how to solve problems. For participants facing significant barriers, this often meant taking action with limited support from family or community and employing their own personal perspectives to make decisions about seeking help with mental health problems. They spoke about hardships they endured related to being different and how those experiences forced them to see that they had to be responsible for their own well-being. As one participant put it:

I got used to looking out for me. After a while, it becomes like second nature. As opposed to like, a thought of let me just do this because it's going to help me, it's just, let me just do this because I have to, this is what I need to do for me, you know what I'm saying? (34)

Several participants described how they had to take the initiative to ask for help and seek out treatment on their own. One participant described how he got around his mother's disapproval of using psychiatric medication, saying:

I had to ask my doctor to speak with me privately so my mom wouldn't be in the room so that I could go on, like, Zoloft or something and finally tell somebody how I was feeling without being judged. (38)

Another participant discussed language barriers that made it difficult for her mother to help her and necessary for her to contact mental health providers on her own:

Most of these doctors spoke in English and she speaks in Spanish...with the psychiatrists, I think all of them have only spoken English. So with that it's more like me telling her what's going on. My mom would try to help me but didn't know how. A lot of people give me a lot of credit for that but I don't see it that way. I really feel like, I didn't have a choice. Most of the places you call only speak in English, my mom doesn't really speak in English, who else was gonna do it? (50)

She discussed her first experience, at age fifteen, of having to figure out how to find additional resources when the referral she received did not accept her insurance. She looked up mental health service providers in her area on the internet and began calling them one by one. While she was reluctant to acknowledge this as an accomplishment, she identified her initiative as the primary reason she was able to use mental health services.

Participants also viewed accepting responsibility for their own mental health as part of becoming an adult. One participant conceptualized this as "changing your perspective in life," explaining that she began to understand that maturing offered more responsibility, but also more control over her treatment. It allowed her to participate in treatment on her own terms and to have more of a choice about how to engage and which services to use than she had as an adolescent. She said:

I couldn't identify what the issues were when I was a kid. Now I can plead my case and tell them how I feel when I'm not on meds and what I might need meds for and what I don't need meds for, what I can manage and what I can't cope with.

(54)

Accepting responsibility was viewed as a positive step toward mental health help-seeking. Participants were often proud of their decisions and the action they took to take care of themselves. Conversely, many participants who discussed periods of time in the past when they were not receiving needed treatment, and those not currently participating in treatment, expressed regret about not taking better care of themselves. Discussing his appreciation for being back in services and the impact that being able to return to treatment had on his life, one participant said:

I'm just hopeful for the future. I think I have a lot to offer. I don't think I would be in the same situation I'm in right now without the medication. I wish I would've tried it sooner. I wish I could've done it sooner. I don't know if it's because I'm Hispanic or gay but it was hard trying to find a place where I could feel like I could really trust someone. (40)

In accepting responsibility for overcoming barriers to service use due to his multiple minority identities, he expressed the feeling that he had done something beneficial for himself.

Participants discussed accepting responsibility as having a rewarding effect on their personal identities. It provided a sense of independence and of agency that brought them closer to achieving goals. Many participants viewed taking care of their mental health as essential to future achievements. As one participant pointed out:

Now I think of my mental health like I think about my heart or my liver. Whereas before it never, you know, you just don't think about it. But now it's just like making sure I'm in

a good head space is very, very important to me. I'm thinking about before, well how did I ever just keep going without checking in that I'm ok? Going forward it will be very important. (25)

He noticed that his own thinking about mental health treatment had changed as he matured and he felt that it was going to improve his life in the future.

Accepting responsibility for their own mental health also led some participants to paying more attention to how to improve themselves as people. One participant said:

Now I'm trying to be a better person. I try to work on myself every day. I take a step back and analyze myself. Like, maybe this is why I do this. I see little patterns, every time somebody does this, this makes me angry, this makes me happy, this makes me sad. It makes me more able to be honest with myself about what's wrong with me, things I need help with, things that I'm willing to face that I wasn't able to face before. (34)

He described going to therapy as a catalyst for learning about himself as a person and why he way he thinks and acts as he does. He spoke about wanting to learn from mistakes he had made and to develop skills for self-improvement. Working to improve his mental health was acting as a means of forming his adult identity into being a person that he wanted to be.

Like accepting distinctiveness, accepting responsibility referred to participants' expressions of individual agency in dealing with mental health problems. Feeling a sense of personal responsibility for their lives gave them a sense of hope, that they could take steps to change their lives, and that problems could be solved. It also referred to the actions they were currently taking, or had taken previously, to address their problems such as accessing services and making efforts to actively participate in treatment. In terms of minority identities, accepting

responsibility referred to realizations that in order to be well, it is possible, and often necessary, to make decisions and act according to personal values, while still being part of the community.

Chapter 5

This chapter integrates the findings of this study and links them to prior research. A discussion of the study's contributions to research, its limitations, and its implications for mental health service delivery and social work practice are also included.

Discussion

This study utilized an intersectional lens to explore and describe connections between multiple minority identities and mental health service use among YAs. As a theoretical perspective, intersectionality suggests that having multiple minority identities qualitatively changes an individual's experience of any one minority identity and that identities interact in complex patterns with mental health behaviors (Kapila, 2015). Consistent with that perspective, findings from this study revealed that mental health service use was more strongly associated with multiple minority identities collectively than with any one minority identity, and that experiences of intersecting minority identities both facilitated and hindered mental health service use among participants. Multiple minority identities were negotiated by LGBTQ YAs of color within four dimensions: ethnic-racial culture, intersecting identities, family, and personal identities. The negotiation process paralleled processes described by minority identity development theories of emerging adulthood (Bowleg, 2008; Syed & Mitchell, 2013; Umaña-Taylor et al., 2014) in which emerging adults explore and construct, or potentially revise their identities in order to achieve adult identity statuses.

High salience of ethnic-racial identity was present in both types of service users and was not associated with continuous service use among study participants. While the quantitative

results must be interpreted with caution due to small sample size, this finding is in contrast to research indicating that higher ethnic-racial minority identity is associated with being less likely to use services (Burnett-Zeigler et al., 2017; Keyes et al., 2012). On the other hand, concerns over not being understood by mental health professionals because of their cultural backgrounds were significantly associated with discontinuous service use among participants, suggesting that their strong connections to their racial-ethnic identities may have prompted their concerns that those identities would not be supported by mental health professionals. It is also important to note that almost half (45%) of participants were multiracial, most identifying as both Black and Hispanic. While these are both minority groups in the U.S., there is very limited research on service use among multiracial individuals, or Hispanic and Black multiracial individuals in particular. Therefore, it is difficult to interpret how participants' responses compare to other similar samples. In general, when race and ethnicity are salient to one's identity, it stands to reason that it would be an important aspect of what needs to be understood by a service provider. However, the finding that only about half reported collective identity as important (52%) might reflect the literature on cultural differences in which factors related to culture can vary in the role that they play for individuals (Lewis-Fernández & Díaz, 2002; Snowden & Yamada, 2005). For example, among participants in this study, race-ethnicity was important to most (77%), but social class (42%) and community belonging (48%) were less important to their senses of identity.

The majority of participants described members of their racial-ethnic groups as less likely than those of other groups to seek help for mental health issues, and factors related to racial-ethnic identity were described more often as barriers (e.g., mistrust, discrimination, low perceived need, negative beliefs about treatment efficacy, stigma) than as facilitators to mental health service use in qualitative interviews. Aligned with the literature on the role of culture in

service use (Lewis-Fernández et al., 2014; U.S. Department of Health and Human Services, 2001), participants described negative perceptions about mental health help-seeking as transmitted through their ethnic-racial communities and families via attitudes, social norms, and religious beliefs. Yet, while participants felt strongly connected to their racial-ethnic groups, this did not predict whether they used services continuously. This also supports research stating that there is some variability in the influence of these factors on individual health behavior.

About half (52%) of participants had symptoms of substance use disorder and they were slightly more likely to be continuous service users. The trend toward an association of co-occurring substance use with continuous service use was unclear. It may indicate that participants initiated services because of their substance use problems or that they were “self-medicating” a mood disorder with substances. While substance use disorders are often more stigmatized than mental illnesses as being a person’s own fault (Corrigan, Kuwabara, & O’shaughnessy, 2009), participants described intense stigma of mental illness within their racial-ethnic communities. It may have been less stigmatizing for some to acknowledge needing treatment for a drug or alcohol problem than it was for a mood disorder. It could also imply problem recognition and perceived need for treatment are higher when there was a substance or co-occurring disorder observed. In either case, using mental health services for substance use problems may have made it easier for participants’ to seek help for mood problems.

The present study differs from other studies of minority identity and service use in that it measures continuous service use, a type of on-going engagement with treatment, rather than mental health service utilization (e.g., number of services used in the past 12 months). Since most participants had received some form of outpatient treatment in the past year, their responses may be more reflective of issues related to treatment engagement than to service utilization in

general. For example, fewer participants reported affordability as a challenge (36%), but many did report that not believing mental health professionals could understand their needs presented a barrier to using services (68%). While the former would likely impact service utilization in general, the latter coincides with the negative experiences participants described in interviews in which they felt misinterpreted in by clinicians. Finding a person or treatment environment that made them feel understood was extremely important to participation in treatment. This distinction suggests that participants were revealing experiences related to treatment engagement and insufficient use of practices such as cultural competence and rapport building that influence engagement in psychosocial treatment (Gearing et al., 2014; Lindsey et al., 2014).

Participants in the present study reported that their LGBTQ identities facilitated access to and participation in mental health services. In addition, sexual orientation identity was slightly higher among continuous service users. These findings suggest that LGBT identity may be an important mediating factor for LGBTQ YAs of color. While sexual and gender minorities' experiences of discrimination when contacting service providers places them at risk for service disengagement (Cochran & Mays, 2006; Craig & Smith, 2014; Green, 2000; Hoffman et al., 2009), study participants described experiencing less discrimination and feeling welcomed when receiving services from LGBTQ-affirming providers. This is consistent with literature that has demonstrated that LGB-specific support buffers the negative effects of discrimination (Rosario et al., 2009; Russell & Fish, 2016) and LGB individuals are more likely than sexual and gender majority groups to use needed mental health services (Medley et al., 2016).

Although the questionnaire did not specify which community participants were being asked about, participants that reported high salience of community belonging were also more likely to be continuous service users ($p \leq .05$). Given that several participants believed that their

own racial-ethnic groups were highly homophobic compared to non-Hispanic Whites and that their racial-ethnic groups were less likely to use services, it is possible that the association of community belonging with service use can be understood as participants' connection to LGBTQ communities in which they felt welcomed and that had linked many of them to supportive services, rather than to racial-ethnic communities in which they experienced greater discrimination. This supports research suggesting that discrimination is a mediating factor for mental health outcomes among SMYoC (Bostwick, Boyd, et al., 2014; Sutter & Perrin, 2016).

Some participants were able to let go of cultural messages discouraging service use in order to initiate and continue in treatment. These findings speak to the strengths/assets afforded by intersecting minority identities. Just as intersectionality asserts that identities are not independent and additive, but multiple, interconnected, and mutually formed (Collins, 1990; Crenshaw, 1991), participants' intersecting identities operated as an advantage to their help-seeking in some cases, rather than as a additive burden. Some participants described their intersecting identities as making them "different" and how that could be a strength, bringing on greater introspection and self-awareness that allowed them to challenge racial-ethnic group norms that discouraged professional help seeking. By giving them a perspective of being outside of the norm for their racial-ethnic identities, intersecting LGBTQ identities provided freedom to expand beyond normative attitudes about mental health help-seeking. Rejecting cultural attitudes about mental health help seeking also seemed to mirror rejecting negative cultural attitudes about sexual and gender minority identities. For some participants, accepting their own distinctiveness meant accepting themselves and looking for alternative, more helpful ways to solve their own problems.

Overall, participants described multiple minority identities and mental health help-seeking as a process of negotiation with their racial-ethnic cultures, with their families, and with being LGBTQ to develop their own personal perspectives. Participants discussed needing to retain aspects of identity that facilitated management of their mental health and letting go of aspects that became barriers. Developing a sense of integration among multiple identities is a central developmental task of emerging adulthood (Arnett, 2003; Azmitia et al., 2008; Erikson, 1968). Marcia (1980) proposed that identity formation comes about through two interrelated processes: exploring alternative possibilities and making a commitment. The negotiation process described by participants parallels the tasks of identity development in that they explored the possibilities for addressing mental health problems available through their multiple minority identities and made choices about which to enact and which to avoid. In this way, participants were attempting to integrate multiple aspects of their minority identities. They were building their own attitudes and behaviors about mental health help-seeking from aspects of their own identities, as well as from their social networks, cultures, and society in general.

This process of negotiation also involved concealing or hiding aspects of identity that presented temporary barriers to managing their mental health. Some participants discussed hiding their mental health or LGBTQ status as a part of their negotiation with stigma in their ethnic-racial groups. This is consistent with research on Black and Hispanic populations in which both mental illness and sexual and gender minority statuses are stigmatized within the family and the larger community (Adelson, 2012; Kapila, 2015). Research on minority identities suggests that internalizing negative views of one's in-group during emerging adulthood may result in attempts to hide or minimize aspects of identity in order to manage negative social effects such as discrimination and rejection (Cianciotto & Cahill, 2003; Han et al., 2014; Harris, 2010;

Umaña-Taylor et al., 2014; Valera & Taylor, 2011). While participants valued being accepted and understood, those that negotiated their multiple minority identities by concealing some aspects can be viewed as engaging in an adaptive behavior. This allowed them to get their mental health needs met while avoiding rejection and discrimination, and still maintain their connections to identities that were important to them.

Increased responsibility for their own well-being is a vital developmental milestone for YAs (Arnett, 2000; Clark et al., 1993). Emerging adulthood is characterized by possibilities and optimism, as individuals have their first opportunities to make their own life-shaping decisions. Theories of identity development in the transition to adulthood describe a process in which individuals decide who they are, what they value, and what their goals in life are in order to achieve an integrated adult identity (Erikson, 1968; Marcia, 1994). Participants described accepting responsibility for mental health help-seeking as part of this process, in which they accepted that they needed help, wanted to feel better, and chose to take action to address their mental health problems. This was especially key for those participants that experienced family as a barrier to help-seeking because they were most responsible for accessing services on their own. Speaking about their own decisions to use mental health services, participants described recognizing that their mental health problems were interfering with their goals and that their well-being was their own personal responsibility. Some felt that improving their mental health was a means of forming their identities into being a person that they wanted to be. Accepting responsibility for their mental health offered some participants a sense of agency, control, and independence, and many viewed taking care of their mental health as essential to future achievements.

Contributions to Research

This study makes several contributions to the existing literature. First, little is known about how having multiple minority identities affects mental health service use in YAs. This study addresses that gap by using an intersectional perspective to describe minority YAs experiences as a process of negotiation in which identity and help-seeking behaviors are jointly explored and developed. This study also identified how facilitators and barriers to mental health service use that are related to identity were experienced among a sample of LGBTQ YAs of color. To my knowledge, this study is the first to investigate these factors among this population, and the first to do so using an intersectional perspective. Outside of providing information on an understudied group, the negotiation process described by this study has the potential to be tested as a theoretical framework in future research on mental health outcomes for minorities during emerging adulthood. Furthermore, this study suggested that intersecting minority identities can act as strengths/assets for traditionally marginalized individuals. Additional research is warranted to test this finding as it may prove to be an untapped resource for improving outcomes among underserved populations.

The information provided by this study substantially adds to our knowledge about individuals from underserved populations. Participants in this study resembled populations at high-risk for disparities in mental health service use due to several demographic factors. Most were Black/African-American and Hispanic YAs with low-incomes, more than half (58%) of them were unstably housed, and most (84%) had symptoms of mood disorder at the time of the interview. Research has demonstrated that being a YA (Substance Abuse and Mental Health Services Administration, 2014), being Black or Hispanic (Substance Abuse and Mental Health Services Administration, 2015), and being unstably housed or low-income (United States Government Accountability Office, 2008) can make individuals with mental health disorders

vulnerable to treatment disparities. Descriptions and insights offered in this study add to the limited data on vulnerable individuals.

The mixed methods approach used in this study allowed for greater depth of analysis on a complex, understudied issue. The dearth of research on intersectionality in identity development for minority youth has prompted authors to articulate the need to integrate qualitative and quantitative approaches to more fully understand the phenomenon (Kuper et al., 2014; McLean & Syed, 2015). The convergent parallel design allowed for comparing different but complementary data on minority identity and service use in order to better understand their relationships. The integration of quantitative and qualitative data in this study provided the opportunity to compare findings to existing quantitative studies of identity and mental health service use, and to elaborate on those findings through participants' subjective meanings of their own personal experiences. Qualitative results provided context to survey items and allowed for greater interpretation of their meaning. Quantitative methods have been used in the majority of studies of emerging adulthood, however qualitative inquiry has been advocated as an essential method for examining the process and content of identity development during that phase (Arnett, 2006; Munson, 2007; Schwab & Syed, 2015). The quantitative analysis in this study addressed the content of minority identities by measuring their salience and the qualitative analysis explored both process and content of identity among participants.

This study also extended findings beyond service use to capture some elements of treatment engagement and how it functions with multiple minority identities. The measurement of continuous service use provided information about on-going service use, rather than number of services used in total. Unlike previous studies of minority identity and mental health service use, this study provided information on how cultural psychosocial experiences of identity are

related to continuous participation in psychiatric services. This study highlighted the importance of feeling understood and of cultural competence as factors impacting the relationship between minority identities and treatment engagement.

Limitations

Several limitations are important to consider. This study only captures a few multiple minority racial-ethnic identities and the sample was drawn from one U.S. urban area. Although the sample was diverse in sexual orientation and gender identity, future studies are needed to examine the experiences of multiple minority YAs at particular intersections of identities (e.g., Black gay versus Hispanic bisexual versus multiracial trans). In considering experiences with mental health services, culture, and LGBTQ identity, participants were required to recall events, form opinions and judgments about them, and be willing to report them to the interviewer. The researcher, who conducted all interviews, appears racially ambiguous and did not disclose her identities related to the minority groups considered in this study. Thus, it is possible that some participants underreported negative experiences with discrimination if they assumed she did not share the focal identities with them. In addition, the researcher did not disclose (except for when she was specifically asked) that she was a mental health service provider. This may have had an effect on participants' willingness to report negative experiences with providers.

While interviews with 31 participants led to rich qualitative data related to the research questions and was appropriate for the qualitative component of the study (Janesick, 2000), the small sample prevented analysis by specific racial-ethnic community and by sexual orientation and gender identity groups. This dictates caution in interpreting quantitative results. Furthermore, many of the participants identified as multiracial and multiethnic, and the sample size limited analysis of differences in their experiences of ethnic-racial identity. Also, individuals who were

more concerned with issues related to multiple minority identities and/or more likely to use mental health services may have been more likely to participate. However, their perspectives are still critical for informing this emergent field of research.

In keeping with a constructivist paradigm, it is important to recognize the temporal context of this study. For example, participants might have been mindful of law enforcement mistreatment of Black men and women frequently reported in the news and motivating social justice movements (e.g. Black Lives Matter) during the time that interviews took place. Experiences with discrimination based on LGBTQ statuses may have also been prominent for participants as the interviews were conducted amid significant political upheaval across the United States due to the 2016 presidential election that threatened to undermine recent advances in civil rights for sexual and gender minorities. For example, in June 2013 the U.S. Supreme Court struck down the law barring federal recognition of same-sex marriage, inspiring optimism in many that equality under the law signified a major blow to discrimination faced by LGBTQ populations. However, the subsequent election of an administration with a record of opposition to gay and transgender rights has been cause for alarm among many LGBTQ Americans. As such, findings must be interpreted in light of current events that may have heightened participants' sensitivity to issues related to the research more than would have been present even one year prior to this study.

This study was also limited by the measurement of multiple minority identities. The collective identity scale of the AIQ-IIIx is not able to assess implicit interrelationships between multiple identities held by an individual. Individual minority identity items were analyzed as variables of interest in this study, but the AIQ-IIIx itself does not estimate whether particular target identities are combined, compartmentalized, or interconnected in ways consistent with

theories of intersectionality. The AIQ-IIIx was chosen because it has sufficient reliability and validity, established norms for collective identity salience among racial-ethnic minority YAs, and because it had one scale (collective identity scale) that could measure multiple minority identities simultaneously. Current quantitative measures of sexual, racial-ethnic, and gender identity in the social psychological literature cannot readily accommodate these concepts. Measures of identity multiplicity and intersectionality are few and they have minimal validation (Stirratt, Meyer, Ouellette, & Gara, 2008). Other frequently used measures of racial-ethnic identity (e.g., Multigroup Ethnic Identity Measure, Phinney, 1992 or Racial Identity Attitude Scale, Parham & Helms, 1981) and of LGB identity (e.g., Gay Identity Questionnaire, Brady & Busse, 1994 or Homosexual Identity Questionnaire, Cass, 1984) measure those identities independently and cannot assess intersectional identity content. Thus, the limitations of the collective identity measurement used in this study dictate that findings should be compared with caution to other studies assessing independent minority identities.

Implications for Practice

An overarching purpose of this study was to gain an understanding of multiple minority identities in YA mental health consumers that can be applied to reducing disparities in their service use. Strategies to improve engagement with services need to accommodate a vastly heterogeneous population of minority YAs at risk for poorer mental health outcomes. Findings from this study of sexual and gender minority YAs of color can inform strategies to improve engagement and minimize disparities for diverse YAs in several ways.

First, mental health service providers need to assess for the degree to which stigma, mistrust, and cultural conceptions of emotional distress are negatively impacting service use in racial-ethnic minority YA clients, especially if they are also sexual or gender minorities.

Participants in this study reported needing to overcome these factors in order to initiate and maintain their use of services. Experiences or expectations of discrimination, through family, culture, and/or mental health professionals all presented barriers to service use. Cultural ideas about mental health problems as moral failures or as irrelevant to people of color negatively impacted minority YAs perceived need for treatment and their expectations that it would be effective. Use of strategies such as cultural assessment (e.g., Cultural Formation Interview for DSM-5) to identify cultural factors and psychoeducation to alleviate misunderstandings and to orient clients to the purpose and procedures of treatment would help to alleviate barriers related to multiple minority identities.

Clinicians and organizations that work with sexual and gender minority YAs of color should encourage and foster the positive side of intersectionality. Participants in this study demonstrated that there were strengths/assets of intersectionality alongside the deficits of intersecting marginalized identities. Assisting multiple minority YAs to draw upon their intersections can promote resilience and help them cope with experiences of discrimination. Working with YA clients to help them appreciate being “different” and to explore aspects of themselves that offer alternative, positive possibilities for the future is consistent with successful identity development (Marcia, 1980), strengths-based social work (Graybeal, 2001), and empirically supported interventions for emerging adults (Walker, 2015).

Treatment engagement strategies for LGBTQ YAs of color should probably involve peers and/or members of the LGBTQ community. Participants reported that LGBTQ-friendly service providers often assisted them to participate in treatment. However, most evidence-based engagement interventions for racial-ethnic minority youth involve parents or caregivers (Moore, 2017). Participants in this study highlighted ways in which family presented barriers to help-

seeking, and their LGBTQ identities were not something they had in common with their families. Rather, their LGBTQ identities would be something they have in common with peers. Peer support is an emerging strategy to enhance engagement among people with serious mental health disorders (Dixon et al., 2016). Mentoring is promising treatment engagement strategy for YAs in particular that allows them to develop health behaviors observationally through role models (Munson et al., 2014). These strategies may be especially appropriate for sexual and gender minority YAs of color as they negotiate help-seeking via multiple identities to have peers and mentors with similar identity experiences to consult.

Participants' experiences of accepting responsibility for their mental health stressed the importance of developmentally tailored services that facilitate YAs transitions to adulthood and foster independence. Minority YAs exposed to multiple forms of marginalization are at risk for diminished optimism for the future and limited self-efficacy (i.e. belief in one's own capacity to influence one's life and experiences) (Syed & Mitchell, 2013). Yet, the process of negotiating personal identities and taking steps to improve their mental health helped some participants feel as though they could shape their own lives. Empowering participants and building their self-determination and are key features of mental health interventions for YAs (Walker, 2015). Services that include a focus on developing adult identity, self-efficacy around addressing mental health problems, and increasing responsibility for health decisions could be especially beneficial to clients experiencing challenges similar to participants in this study. Many were dealing with unstable housing, low incomes, strained family relationships, and multiple forms of discrimination. Developing the adult skills needed to access supports and to care for themselves would be crucial to promoting well-being and quality of life among participants.

Person-centered strategies could help address service use disparities related to feeling that treatment providers do not understand the needs of multiple minority YAs. Services that actively incorporate an individual's identity, culture, life experiences, and immediate goals into treatment would be better able to address the needs of diverse YAs. This is especially relevant for sexual and gender minority YAs of color, who's understanding and experience of these factors may still be fluctuating due to age, identity development, and changes in social roles. Shared decision making, in which clinician and client both take part in exchanging information and making a collaborative decision for treatment (De Las Cuevas & Peñate, 2014), may promote a sense of being heard by their providers and encourage self-efficacy with regard to treatment for YAs.

Lastly, participants in this study demonstrated that their minority identities were important to their senses of who they are. This suggests that an understanding of identity, how it develops, changes, and impacts minority YAs is essential information for providers looking to form positive therapeutic relationships with them. The variability among participants' experiences of minority identities and service use indicates that it is an individualized process. Rather than looking to racial-ethnic cultures or LGBTQ statuses, providers will need to appreciate how multiple minority identities are intersecting within each individual client in order to be flexible and adapt deliver services to those with multiple minority identities. Considering minority identity is a useful concept, not only because its development is a major focus during emerging adulthood, but also because it allows for consideration of culture and how an individual personally relates to their culture. A focus on identity draws closer attention on the personal experience of the individual, which is necessary for personalized treatment and therapeutic relationships that encourage engagement with treatment.

Conclusion

The primary basis for this study was that a better understanding of multiple minority identities in YA mental health consumers offers insights that can be applied to reducing disparities in their service use. Previous research provided evidence that multiple minority statuses can affect mental health outcomes and service use, as well as individual well-being. Yet, interrelationships among multiple minority identities as they relate to using services and participating in treatment have been understudied and are not sufficiently understood. This study found that multiple minority YAs mental health service use parallels the process of identity development during the transition to adulthood and involves a negotiation of culture, family, and identity intersections as they mature and form their adult selves. These findings suggest that identity may be an important dimension to consider in interventions to improve minority YA treatment engagement. Further research to test and develop the theoretical framework presented here could broaden our understanding of how to support multiple minority identities among underserved YAs.

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APPENDICES

Appendix A.1

Pre-Screen Questionnaire

1. Do you have any questions about the study?
2. Are you between the ages of 18-29?
3. Do you identify yourself as a racial or ethnic minority (such as Asian, African-American, Black, Hispanic, Latino/a, Multiracial, etc.)?
4. Do you have a current or past mental health issue? How long has it been? Were you given any diagnosis or treatment? What did you experience?
5. Are you able to speak and read English?
6. We can meet at my office or you can choose some place else where we can speak privately for about two hours. Which would you prefer?
7. When would you like to schedule an interview?

Appendix A.2

Columbia University Consent Form

Protocol Information

Attached to Protocol: IRB-AAAR0325

Principal Investigator: Ellen Lukens (el19)

IRB Protocol Title: A Mixed-Methods Study of Minority Identities and Mental Health Service Use in Young Adults

General Information

Consent Number: CF-AAAT7135

Participation Duration: 2 hours

Anticipated Number of Subjects: 30

Research Purpose: The purpose of this research is to learn about the experiences young people of color have with mental health services. Understanding how being both a young person and a minority affects getting help with stress or emotional issues can lead to improving services.

Information on Research

Information on Research

Why are we interested in talking with you?

We are asking you to participate in this research because you are a young adult of color, between the ages of 18-29, who has had a mental health issue.

Before agreeing to participate in this study, it is important that you read this form and talk with the research staff. You should only take part in this study if you want to. This form will explain why we are doing the research and what will happen to you if you are in this research study. We would like to discuss the study and review this form with you. You can ask questions at any time before, during or after our discussion. You will also have time to read this form and ask any questions about the research study. At the end, we will ask you to sign this form if you agree to participate.

It is okay to ask questions about what we are telling you. If you do not understand something, just ask us. We want you to ask any time you think of a question.

What is this research study about?

In this research study, we want to find out how to make mental health services better for young people of color by asking you questions about your own experiences. We want to find out what helps you to get services and what makes it harder to get services. We also want to find out how being a person of color might be especially important when you are trying to get help with emotional problems or stress.

What will happen if you are in this study?

If you want to be in this study, we will ask you questions about your own mental health, your history of getting treatment, your experiences with counseling, therapy, and medication, and your opinions about getting help with mental health issues. We will also ask you about the opinions of other people you know. Some of the questions will be on forms for you to read and fill out. Some of the questions will be asked by the interviewer for you to talk about while your voice is being recorded.

Recording of your voice is required for this study. So, you must agree to having your voice recorded in order to participate in this study.

Answering these questions will take about two hours.

Risks

Are there any risks of the study?

Because we will ask questions about your mental health issues, there is a chance that during the study you could feel uncomfortable, embarrassed, sad, or stressed. We will help you with these feelings and you can stop at any time if you want to. We also will give you information on how to get help with mental health issues in the future.

Another risk of participating in this study is the possibility of a loss of confidentiality. Loss of confidentiality includes having your personal information shared with someone who is not supposed to see or know about your information. The study team plans to protect your confidentiality. Their plans for keeping your information private are described in the Confidentiality section of this consent form.

Benefits

Will you benefit from being in this study?

You will not benefit directly from this study, but we hope to learn something that could help other young adults of color in the future.

Alternative Procedures

The alternative is not to participate.

Confidentiality

What about confidentiality?

To protect you, the information collected in this study will not be shared with anyone unless required by law. For example, we would be required by law to report it if you tell us about child abuse or that you are going to hurt yourself or someone else. Otherwise, the researchers will not talk about you with anyone else except the people working on the study.

If you decide to participate in the study, you are giving us your permission to use the information you give us about your mental health for research. This is protected health information and we will do everything we can to keep it private. Even though it is very unlikely, problems like a stolen computer can happen that might stop your information from staying private.

None of the written or recorded information that you give during the study about your mental health, your experiences, or your opinions will have your name on it. We will give you a number instead, and keep your name and contact information separate from your interview in a locked file. Only the study staff and authorities from the Columbia University Institutional Review Board will be able to look at your research records.

If information from this study is made public, in writing or talked about at scientific meetings, your name and personal information about you will not be used.

Compensation

You will be paid \$40 for your interview.

Voluntary Participation

Do you have to be in this study?

You do not have to be in this study. If you decide not to participate, you will not lose any services or benefits that you have.

Additional Information

If at any time you have questions or concerns about your rights or welfare as a research subject, contact the Columbia University Morningside Human Research Protection Office (HRPO) at 212-851-7040 or email askirb@columbia.edu.

Participant Signature Lines

Study Participant

Print Name _____ Signature _____
_____ Date _____

Research Signature Lines

Person Obtaining Consent

Print Name _____ Signature _____
_____ Date _____

Appendix A.3

Demographic Questionnaire

SUBJECT ID:

DATE:

1) Sex ___ Male ___ Female, Other: _____

1a) Gender ___ Male ___ Female, Other: _____

1b) Sexual Orientation ___ Gay ___ Straight ___ Other: _____

2) Date of birth (MM/DD/YYYY):

3) Age in years:

4) What is your first language?

5) What is your preferred language?

6) If English is not your 1st language, age that you learned English _____ check if not applicable

7) How would you describe your racial background? Circle as many as apply:

1. First Nations (e.g., North American Indian, Métis, Inuit)
2. East Asian (e.g., Chinese, Japanese, Korean)
3. Southeast Asian (e.g., Cambodian, Indonesian, Vietnamese)
4. South Asian (e.g., East Indian, Pakistani, Sri Lankan)
5. Black (e.g., African, African Caribbean)
6. Central / South American
7. West/Central Asia and Middle East (e.g., Egyptian, Lebanese, United Arab Emirates, Afghanistan, Iranian)
8. White (European)
9. Native Hawaiian or Pacific Islander
10. Multiracial

8) Are you Hispanic or Latino Yes = 1 No = 0

9) People can think of themselves in various ways. For example, they may feel that they are members of various ethnic groups, such as [ethnic group selected above], and that they are part of the larger American society.

9a) How do you think of yourself?

	Not at all	A Little	Somewhat	Mostly	Completely
I think of myself as [selected group].					
I think of myself as [selected group].					
I think of myself as [selected group].					
I think of myself as American.					

9b) People differ in how important they consider aspects of themselves to be. How important are the following aspects of yourself to you?

	Not at all Important	A Little Important	Somewhat Important	Important	Very Important
That I am [selected group].					
That I am [selected group].					
That I am [selected group].					
That I am American.					

10) Town of birth: _____

11) Country of birth: _____

12) Born in USA Yes = 1 No = 0

13) Age when came to USA: _____ check if not applicable

14) Immigrant status:

1.	Born in USA and not 1st or 2nd generation
2.	1st generation migrant (subject and parents born abroad)
3.	1st generation migrant plus (subject and parents born abroad; subject came to USA before age 5)

4. 2nd generation migrant (born in USA, one or both parents born abroad)

15) Citizenship status

1. US citizen
2. Permanent resident
3. Refugee
4. Temporary resident (work / study)

Family

16) What is the highest level of formal education completed by your father (child-rearing)?

1. No schooling
2. Some primary school
3. Completed primary school
4. Some high school
5. Completed high school
6. Some college/technical school/undergraduate
7. Completed college/technical school/undergraduate
8. Some graduate/professional school
9. Completed graduate/professional school

17) What is the highest level of formal education completed by your mother (child-rearing)?

1. No schooling
2. Some primary school
3. Completed primary school
4. Some high school
5. Completed high school
6. Some college/technical school/undergraduate
7. Completed college/technical school/undergraduate
8. Some graduate/professional school
9. Completed graduate/professional school

18) What is your current marital status?

1. Single, never married
2. Married / Common law
3. Cohabiting with significant other
4. Separated
5. Divorced
6. Widowed

19) How many children do you have? _____

20) Current ZIP code (postal code): _____

21) Town where you spent the majority of your childhood : _____

22) Biological Father's current age (if deceased, age they would be today): _____

23) Biological Mother's current age (if deceased, age they would be today): _____

Finances and Living Situation

24) What best describes your current living arrangement?

1. Living with family
2. Living with spouse/partner
3. Living on own in apartment/house
4. Living in a group/boarding/rooming house
5. Living with other(s), not spouse/partner
6. Living in a shelter
7. Living on the street
8. Other: please specify _____

25) What is the household income before taxes, from all sources?

1. Less than \$10, 000
2. \$10, 000 to \$19, 999
3. \$20, 000 to \$39, 999
4. \$40, 000 to \$59, 999
5. \$60,000 to \$99,999
6. \$100,000 and above
7. Don't know or refused

26) What is the main source of your personal income?

1. Contributions from Family / Spouse / Partner
2. Disability Income
3. Gross Earnings (self)
4. Social Support
5. Pension / Insurance
6. Personal Needs Allowance (e.g., if living in a shelter)
7. Student Loan
8. Other Income: Please specify _____

27) What category best represents your total personal income before taxes, from all sources?

1. Less than \$10, 000
2. \$10, 000 to \$19, 999
3. \$20, 000 to \$39, 999
4. \$40, 000 to \$59, 999
5. \$60, 000 to \$99, 999
6. \$100, 000 and above
7. Don't know or refused

Employment History

28) Are you currently working?

1. Yes, working full time
2. Yes, working half time
3. No, but I have worked in the past year
4. No, and have not worked in the past year
5. Full time parent

29) Are you currently volunteering?

Yes = 1 No = 0

Education

30) How many years of education have you completed? (Circle your choice)

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

31) What is the highest level of formal educational you have completed?

1. Some grade schooling but not completed high school
2. High school
3. College
4. Technical school
5. University
6. Graduate school
7. Professional school

32) Are you currently enrolled as a student (within the past 6 months)?

Yes = 1 No = 0

33) Where have you been enrolled in the past 6 months? Check if not applicable

1. Elementary, junior high, or middle school
2. High School
3. Adult Education
4. Community College
5. Vocational / Technical / Trade School
6. University
7. Learning Disability or Special Education Class
8. Other: Please specify
- 9.

Was the program: Check if not applicable 1. Full-time 2. Part-time

34) How regularly did you attend classes in the past 6 months?

Check if not applicable

1. All of the time
2. Most of the time

3. About half of the time
4. Less than half of the time
- 5.

Medical

35) Please rate your physical health problems in the past 6 months:

1. No physical health problem
2. Minor health problems (e.g. cold, non-serious fall, etc.)
3. Physical health problem imposes mild restriction on mobility and activity
4. Moderate degree of restriction on activity due to physical health problem
5. Severe or complete incapacity due to physical health problem

36) Do you have any physical health conditions?

1. No physical health conditions
2. Any major physical health conditions: Please specify

Have any of your health care providers (such as a doctor or nurse practitioner) or other professionals (such as a school counselor) ever treated you for, or given a diagnosis of any of the following disorders?

NO

YES - Check all that apply:

- Reading Disorder
- Mathematics Disorder
- Disorder of Written Expression
- Autistic Disorder
- Asperger's Disorder
- Conduct Disorder
- Expressive Language Disorder

- Oppositional Defiant Disorder (ODD)
- Developmental Coordination Disorder
- Learning Disorder – Not specified
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Pervasive Developmental Disorder (PDD)

Appendix A.4

Brief Symptom Inventory (Derogatis & Melisaratos, 1983)

“Here I have a list of problems people sometimes have. As I read each one to you, I want you to tell me HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. These are the answers I want you to use. Do you have any questions?”

0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Extremely
R = Refused

DURING THE PAST 7 DAYS, how much were you distressed by:

1.	Nervousness or shakiness inside	0	1	2	3	4	R
2.	Faintness or dizziness	0	1	2	3	4	R
3.	The idea that someone else can control your thoughts	0	1	2	3	4	R
4.	Feeling others are to blame for most of your troubles	0	1	2	3	4	R
5.	Trouble remembering things	0	1	2	3	4	R
6.	Feeling easily annoyed or irritated	0	1	2	3	4	R
7.	Pains in the heart or chest	0	1	2	3	4	R
8.	Feeling afraid in open spaces	0	1	2	3	4	R
9.	Thoughts of ending your life	0	1	2	3	4	R

DURING THE PAST 7 DAYS, how much were you distressed by:

10.	Feeling that most people cannot be trusted	0	1	2	3	4	R
11.	Poor appetite	0	1	2	3	4	R
12.	Suddenly scared for no reason	0	1	2	3	4	R
13.	Temper outbursts that you could not control	0	1	2	3	4	R
14.	Feeling lonely even when you are with people	0	1	2	3	4	R
15.	Feeling blocked in getting things done	0	1	2	3	4	R
16.	Feeling lonely	0	1	2	3	4	R
17.	Feeling blue	0	1	2	3	4	R
18.	Feeling no interest in things	0	1	2	3	4	R

DURING THE PAST 7 DAYS, how much were you distressed by:

19. Feeling fearful	0	1	2	3	4	R
20. Your feelings being easily hurt	0	1	2	3	4	R
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4	R
22. Feeling inferior to others	0	1	2	3	4	R
23. Nausea or upset stomach	0	1	2	3	4	R
24. Feeling that you are watched or talked about by others	0	1	2	3	4	R
25. Trouble falling asleep	0	1	2	3	4	R
26. Having to check and double check what you do	0	1	2	3	4	R
27. Difficulty making decisions	0	1	2	3	4	R

DURING THE PAST 7 DAYS, how much were you distressed by:

28. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4	R
29. Trouble getting your breath	0	1	2	3	4	R
30. Hot or cold spells	0	1	2	3	4	R
31. Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4	R
32. Your mind going blank	0	1	2	3	4	R
33. Numbness or tingling in parts of your body	0	1	2	3	4	R
34. The idea that you should be punished for your sins	0	1	2	3	4	R
35. Feeling hopeless about the future	0	1	2	3	4	R
36. Trouble concentrating	0	1	2	3	4	R

DURING THE PAST 7 DAYS, how much were you distressed by:

37. Feeling weak in parts of your body	0	1	2	3	4	R
38. Feeling tense or keyed up	0	1	2	3	4	R
39. Thoughts of death or dying	0	1	2	3	4	R

40. Having urges to beat, injure, or harm someone	0	1	2	3	4	R
41. Having urges to break or smash things	0	1	2	3	4	R
42. Feeling very self-conscious with others	0	1	2	3	4	R
43. Feeling uneasy in crowds	0	1	2	3	4	R
44. Never feeling close to another person	0	1	2	3	4	R
45. Spells of terror or panic	0	1	2	3	4	R

DURING THE PAST 7 DAYS, how much were you distressed by:

46. Getting into frequent arguments	0	1	2	3	4	R
47. Feeling nervous when you are left alone	0	1	2	3	4	R
48. Others not giving you proper credit for your achievements	0	1	2	3	4	R
49. Feeling so restless you couldn't sit still	0	1	2	3	4	R
50. Feelings of worthlessness	0	1	2	3	4	R
51. Feeling that people will take advantage of you if you let them	0	1	2	3	4	R
52. Feeling of guilt	0	1	2	3	4	R
53. The idea that something is wrong with your mind	0	1	2	3	4	R

Appendix A.5

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>

(Brown & Rounds, 1994).

Appendix A.6

Adapted from Service Assessment for Children and Adolescents (SACA) (Horwitz et al., 2001)

Because it's easy to forget, I'm going to go through a list of places where you might have gotten help or treatment (for any concerns or problems you might have experienced).

I want you to tell me whether you have been to any of them in your life, how many times, and if you have been to any in the last 3 months. Have you ever gone to or used (service provider)?

FOR SERVICE TYPES ATTENDED

When did you first (go there/use services)? Have you (been there/used services) in the last 3 months? Are you still (going there/using services)?

What were the main reasons that you went to (service type)? Were there any other reasons? What were they?

Are you still going? When did you stop? What were the reasons you stopped?

Service Type	Ever in Lifetime	Number Visits	Treatment Duration	Last 3 Months	Current
1. Psychiatric Hospital					
2. Hospital Psychiatric Unit					
3. Inpatient Drug/Alcohol Unit					
4. Residential Treatment Center					
5. Group Home					
6. Therapeutic Foster Care					

7. Boarding School					
8. Day/Partial Hospitalization					
Service Type	Ever in Lifetime	Number Visits	Treatment Duration	Last 3 Months	Current
9. Outpatient Drug/Alcohol Clinic					
10. Mental Health Center					
11. Crisis Center					
12. In-Home Counseling Services					
13. Private Professional Treatment					
14. School Guidance Counselor/Psychologist/ Social Worker					
15. Family Doctor/MD					
16. Hospital Emergency Room					
17. Religious Counselor					
18. Alternative Medicine/Healer					
19. Crisis Hotline					
20. Self-help/AA or NA					

21. Internet Support Group					
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The following statements are what people give as reasons for challenges seeking help from mental health professionals. Please indicate using the choices below, whether any of the following were challenges that affected whether or not you sought or are now seeking mental health care for your experiences.

	Not at all True	Somewhat True	True	Very True
a. I couldn't afford to do so.				
b. My family didn't want me to do so.				
c. I refused to go.				
d. I didn't know where to go or who to ask about mental health services.				
e. I was afraid they would not understand me because of my cultural background.				
f. I did not have time because I had too many responsibilities.				
g. I was ashamed of my difficulties.				
h. I couldn't take off work/school to see someone.				
i. I knew people who had bad experiences with mental health professionals.				
j. The places to go for services were far away.				

k. I didn't know anyone who had seen a mental health professional to tell me what to expect.				
l. I was in poor health.				
m. I did not think that I had a mental health problem.				
	Not at all True	Somewhat True	True	Very True
n. I had no transportation available.				
o. I didn't believe the mental health professional could understand my needs.				
p. My spiritual leaders discouraged me from seeing a mental health professional.				
q. I was afraid people at the mental health agency would tell other people about my difficulties.				
r. I didn't think it would help.				

Appendix A.7

Qualitative Questionnaire

Date:

ID Number:

You mentioned that you identify yourself as being part of the following community/communities: [minority collective identities endorsed in demographic survey].

What does being part of that community mean for you?

I'm going to ask you some questions about your community and about your own personal views on getting mental health services.

1) How do people in your community think/feel about getting help with emotional problems or stress? [specify for each community endorsed]

1a) Who do they go to for help?

1b) Is it easy for them to get help? How so? What makes it easy?

1c) Is hard for them to get help? How so? What makes it hard?

1d) Are they likely to get help when they need it?

2) Is how you think/feel about getting help with emotional problems or stress the same as your community or different? How so?

2a) What makes you different?

2b) What makes you the same?

3) Can you give an example of how you approached getting help?

3a) What was that experience like?

3b) Is there anything that would have made it easier for you to get help?

3) How have your thoughts/feelings about getting help with emotional problems or stress changed over time?

3a) Is it the same now as it has always been?

3b) Have any of your experiences changed how you think/feel about getting help?

4) How does getting help with emotional problems or stress affect your goals or plans for the future?

4a) Is taking care of your mental health an important part of your life?

Appendix A.8

Side 1 Description of the Research

The purpose of this research is to learn about the experiences young people of color have with mental health services. Understanding how being both a young person *and* a minority affects getting help with stress or emotional issues can lead to improving services. The goal of this study is to learn directly from young people of color and gather information that can make counseling services more relevant to them.

To participate, you need to:

- Be between the ages of 18-29
- Identify as a racial or ethnic minority (such as Asian, African-American, Black, Hispanic, Latino/a, Multiracial, etc.)
- Have a current or past mental health issue
- Be able to speak and read English

If you participate, you will be asked questions about your personal mental health history, your experiences with counseling, therapy, and medication, and your views about your own culture and identity.

Interviews take about 2 hours and can be conducted at a location that is convenient for you.

You will receive \$40 for your participation.

Confidentiality is very important for this study so your name and identifying information will be protected by the researcher.

Please contact Kiara Moore at KLM2198@columbia.edu for more information.

Appendix A.8 Continued

Side 2

Did you ever...
Need Help? Did you get it?

**Young people of color
share your experiences with
mental health counseling.**

You will receive \$40 for your interview.
Contact Kiara ~ call or text 646-598-6134
KLM2198@columbia.edu

To participate, you need to:
Be between the ages of 18-29
Identify as a racial or ethnic minority
Have a current or recent mental health issue

Columbia University IRB
IRB APPROVED
IRB Approval Date: 12/15/2010
BY: JESSICA L. SPENCER