Mental Health Treatment Services in LGBTQ+ College Students of Color

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Abstract

Marginalized communities have unique experiences and face unique challenges such as fearing discrimination/not being understood by mental health professionals, experiencing negative treatment from white and/or male therapists, inconsistent treatment, emotional responses, and financial obstacles within the mental health treatment community. This study explores the intersection of college students that are part of the LGBTQ+ community and also people of color in regards to their identity and how it connects and affects their exposure and experiences with mental health treatment services. Participants were interviewed and their responses were analyzed using thematic analysis which yielded a model that connected the different codes found in the data set. Relationships were found between three main sets of codes: identity, external factors, and mental health treatment exposure outcomes. These three interconnected sets of codes led to the conclusion that identity is closely connected to unique exposures and experiences with mental health treatment services in LGBTQ+ college students of color.

Keywords:

LGBTQ+

People of color

College Students

Mental Health

Access and exposure to mental health treatment services is important for individuals. The intersection between this exposure to mental health services and LGBTQ+ college students of color is also important. This study explored and found relationships between participants' identities as LGBTQ+ college students of color and their exposure to mental health treatment services. The findings of this study are shown in a model and conclude that the participants' identities are at the core and have a relationship with mental health treatment exposure outcomes. This study begins with a literature review that provides an overview of previous studies and definitions that were utilized in this study. I also included a methods section that describes how this study was conducted and analyzed, as well as a results section that provides an interpretation of the model (Figure 1). I concluded this study with a discussion section that provides a more in-depth analysis of the results, a reflection of my hypothesis and previous literature on the topic, and how this study contributes to the future of mental health services.

Literature Review

Initial Information & Definitions

There is little research on the exposure of mental health treatment for those in intersectional marginalized communities such as those in the LGBTQ+ community and the racial/ethnic minority in the United States. The exploration of college students identifying with both of those marginalized groups and their exposure to mental health treatment is a key topic in this literature review.

Intersectional Identities

The term *intersectionality* was coined by Crenshaw in 1989 in reference to taking into account both the black experience and the experience as a woman to better understand one's

experience with oppression and privilege in a society. Thus, *intersectionality* refers to the sum of an individual's identity through social groups to understand their experiences with oppression and/or privilege (Crenshaw, 1989). In Crenshaw's essay, they use race (black) and gender (woman) to explore these groups' subordination. However, in this study, the two groups that will be explored are college students in the racial/ethnic minority and the sexual/gender identity minority in reference to mental health exposure. These two groups are to be explored through an intersectional approach.

The LGBTQ+ Community

The LGBTQ+ community, also known as the queer community, faces unique challenges both in daily scenarios and more specifically, within the mental health treatment realm. Some of these challenges for LGBTQ+ people, specifically LGBTQ+ people of color, include fearing discrimination/not being understood by mental health professionals, experiencing negative treatment from white and/or male therapists, inconsistent treatment, emotional responses, and financial obstacles. First, the term *queer* is widely known within the LGBTQ+ community to mean any sexuality that is not heterosexual (Somerville, 2007). Queer identities encompass many non-heterosexual sexual orientations such as gay, lesbian, bisexual, pansexual, and asexual, etc… The term queer can also include gender identities other than cisgender due to the sociological concept that gender and sexuality cannot be isolated from each other (Butler, 1990). The term queer is inherently opposite from the terms heterosexual and cisgender. *Heterosexual* refers to a sexual orientation in which an individual is only attracted to a gender that is not their own. *Cisgender* refers to an individual who identifies as the gender (male, female, or intersex) that they were assigned at birth (The APA dictionary of psychology, 2007).

Racial/Ethnic Minorities

For purposes of this study, the terms racial/ethnic minority and person/people of color (POC) can be used interchangeably. In modern terms, *people/person of color (POC)* refers to an individual or group of people who are nonwhite, in which the term white refers to Europeans. This term can also apply to those who are mixed with nonwhite ancestry (The American Heritage Guide to contemporary usage and style, 2005). The subjects of this planned study will all identify as people of color in order to better understand LGBTQ+ POC's exposure to mental health treatment.

Mental Health Treatment

While a person or social group's experience of mental health treatment is a broad spectrum, the focus of the subjects' experience in this study will include *exposure* to professional mental health treatment. *Exposure* to mental health treatment in this instance has several variables such as: whether the subject has been to a mental health service at all, how often they go or have gone to seek these services, the method in which they discovered the mental health treatment provider, and whether their sexual/gender identity and/or race/ethnicity affects or corresponds to their exposure to mental health treatment services.

Similarities Between the LGBTQ+ Community and Racial/Ethnic Minorities in Mental Health

Those in the LGBTQ+ community and people of color are both part of marginalized communities in society, which I hypothesize affects both groups' exposure to mental health treatment services in an intersectional manner.

In regard to mental health for both of these marginalized groups, a previous study by Bostwick et al. explored the correlation between suicidality in people of color in the LGBTQ+

community. This study proves that both POCs and the LGBTQ+ community are marginalized in regard to mental health issues, which could be a key factor to understanding this group's exposure to mental health services. The study found those in the sexual/gender minority (LGBTQ+) to be at a heightened risk for mental health issues such as suicidal thoughts and actions as an individual social group. The study also concluded that some groups of POC (such as Indigenous, Latino, and mixed-race groups) within the LGBTQ+ community are at an even more heightened risk for mental health issues than their queer, white counterparts (Bostwick et al., 2014).

Because both POCs and the LGBTQ+ community are marginalized groups which affects their mental health, they most likely experience different exposure levels to mental health treatment services than their white, cisgender, heterosexual peers. Sutter and Perrin (2016) explored how discrimination for both POCs and those in the LGBTQ+ community affect their mental health and suicidality. The study concluded that discrimination against POCs and those in the LGBTQ+ community affect both group's mental health and suicidality (Sutter & Perrin, 2016). Sutter and Perrin's study shows that POCs in the LGBTQ+ community suffer from mental health issues due to their marginalized status in society, which could affect their exposure to mental health services.

Both people of color and members of the LGBTQ+ community could feel misunderstood or not accepted by their mental health professionals or may even fear discrimination from their mental health professional, due to their race/ethnicity and/or sexual/gender identity. Foy et al. (2019) found that 41.9% of LGBTQ+ participants were concerned that they would experience stigmatization or discrimination from mental health professionals when seeking out psychological help. In addition, the LGBTQ+ participants who were also POCs felt "downplayed

and ignored" when they addressed racial issues with their mental health provider. This fear of discrimination or feeling of not being understood could potentially affect this intersectional social group's exposure to mental health treatment services because this group of people may seek out specialized services that cater to their racial/ethnic and sexual/gender identity experiences or avoid seeking out mental health treatment services in general.

Differences Between the LGBTQ+ Community and Racial/Ethnic Minorities in Mental Health

Despite both POCs and the LGBTQ+ community having a marginalized status in society which could affect their exposure to mental health services, they both face challenges unique to their specific social group, which could differentiate the two groups' exposure to mental health services. For example, LGBTQ+ people of color may experience racism in a medical or mental health setting, while white LGBTQ+ people do not. Some studies have proven that individuals that are part of these social groups have higher rates of mental health issues and suicidality (Bostwick et al., 2014).

Although both LGBTQ+ and POCs have higher rates of mental health issues, their exposure to mental health treatment services differs. Dunbar et al. (2017) shows that those in the LGBTQ+ community have higher rates of seeking out mental health treatment than those that are not in this community. One study explored the utilization of mental health services among college students in the sexual minority. However, this study only researched those in the sexual minority and did not consider POCs in the LGB community. The study concluded that college students in the sexual minority (not including those in the gender identity minority) have higher rates of seeking out mental health services but still experience greater amounts of mental health issues than their heterosexual counterparts (Dunbar et al., 2017). While this study is useful in

exploring both the exposure and effectiveness of mental health treatment in sexual minorities, it does not consider people of color in the LGBTQ+ community, which is what this study will aim to accomplish. However, this study does prove that those in the sexual minority have a different experience regarding mental health services exposure than their heterosexual peers.

People of colors' experience with mental health treatment services exposure differs greatly from those in the LGBTQ+ community because of several factors including discrimination in the medical/mental health field. One study found that therapists differed in treating their clients' psychological distress symptoms based on the clients' intersectional identities regarding their race and gender (Kivlighan, 2019). This could potentially deter POC who want to seek out mental health treatment from doing so because of the known bias against POC in the medical field. Although LGBTQ+ individuals may feel discriminated against by some mental health professionals due to homophobia, there is still statistical evidence that those in the sexual minority seek out mental health services at a greater rate than their heterosexual counterparts (Bostwick et al., 2017). Another factor that I believe could influence POCs' exposure to mental health services is racial income inequality. A study found that whites and Asians in the US have the least percentage of households making under $30,000 a year (28% and 21%), while other POC groups such as blacks, Latinos, and other/mixed groups have higher percentages of households making under $30,000 a year (53%, 48%, and 40%) (PEW Research Center, 2014). This shows that most POC groups in the US make less money than their white counterparts, which could be a contributing factor to mental health treatment exposure and access due to the costly nature of private mental health services.

Conclusion and Further Research

Because of the lack of research regarding people of color within the LGBTQ+ community and their exposure to mental health treatment services, this study will aim to explore the exposure to mental health treatment while considering these intersectional identities. Despite the finding that LGB people seek out mental health options at a greater rate than heterosexual people. I hypothesize based on previous studies and my own personal experience that college students of color within the LGBTQ+ community will not have as much exposure to mental health treatment options as their white, cisgender, and heterosexual counterparts. I believe the findings of this study will support this hypothesis due to familial cultural norms regarding mental health stigmas, racial income inequality within certain POC communities, and fear of discrimination within the medical/mental health field. Considering multiple identities while researching a topic such as exposure to mental health treatment options is an important step to understanding the marginalization that these two social groups face and how that can affect their access and exposure to mental health services.

Methods

Participants

The participants of this study were racial and/or ethnic minorities (people of color), a sexual and/or gender non-conforming minority (part of the LGBTQ+ community) and were currently enrolled in a university (college students). These three categories that the participants fit ensured that the findings of this study could be utilized to better understand mental health treatment services in certain demographics. The participants were also aged 19-21 so that I could generalize my findings to young adults in college. The participants attended various universities

in the United States for the results of this study to be more generalizable. I interviewed 10 participants for this study. The demographics for the participants are as follows:

Gender	Race/Ethnicity	Sexual Orientation
Female = 7	East Asian = 3	Gay/Lesbian = 3
Male = 1	South Asian = 2	Bisexual = 4
Non-binary = 2	Mixed Race = 2	No label/questioning label = 3
	Black = 1	
	White Hispanic/Latino = 2	

My sample size was 10 participants in order for this study to be conclusive yet attainable. I used convenience sampling to gather participants since the required demographics for this study were difficult to find and participate in. I used convenience sampling due to the small proportion of LGBTQ+ people of color in college within the 19-21 age range and the likelihood of possible participants that wanted to partake in this study.

Materials

A research script was used in this study. It included a welcome statement, an overview of the interview, questions, and a concluding statement. Question categories consisted of self-identification, mental health treatment exposure, and the participants' intersectional experience regarding their identities and mental health treatment exposure. These categories of questions were chosen in order to gather data about participants' self-identity and experience with mental health treatment.

After the interview, I gave each participant a digital counseling resource document containing contact information for various national mental health services such as the National Suicide Hotline, National Alliance for Mental Illness, and Mental Health America. This counseling resource document allowed participants to seek out mental health services if they experienced any mental distress.

I also gave each participant a $15 Amazon gift card to compensate them for their time. This amount of monetary compensation was small enough to incentivize college students to participate, but not large enough to coerce them into participating in this study.

Procedure

I conducted interviews over Zoom with the participants in order to determine if race/ethnicity and status as a member of the LGBTQ+ community affect exposure to mental health treatment services in college students that were aged 19-21. Each interview was expected to take less than one hour, and this goal was met.

Before I conducted the Zoom interviews with each participant, I sent a Google form to potential participants that reached out to me to see if the potential participants qualified. I asked questions about their basic contact information, their age, the university they attended, and if they identified as a person of color and part of the LGBTQ+ community. If the potential participant fit the criteria for this study, I allowed them to pick a time slot for their Zoom interview. I also emailed each participant an IRB consent form to sign before their Zoom interview to ensure that they were aware of the nature and risks of participating in this study. Once I obtained each participants' consent form, I proceeded with each individual interview.

I began each Zoom interview with a welcome statement, an overview of the questions that would be asked during the interview and asked if the participants had any questions. I also asked each participant to give a pseudonym so that any identifying information could not be traced back to them for their privacy.

During each Zoom interview, I asked participants questions about their racial/ethnic identities and sexual/gender identities, their exposure to mental health treatment services, and their intersectional experience with their identities and mental health treatment experiences.

These three categories of questions served as a baseline to understand the individuals' identities and experiences in order to determine if there is a correlation between race, ethnicity, gender, sexual orientation, and exposure to mental health treatment services. Before asking each question about the participants' identities, I gave definitions of each identity type. The questions asked that relate to each category are as follows (not including definitions in the identity section):

Identity	Mental Health Treatment Exposure	Intersectional Experience
State your name, age and what year of college you are in, and the name of the university that you attend.	If you are currently seeking out mental health services, did you run into any obstacles when seeking out treatment? How did running into those obstacles make you feel?	Have you encountered any forms of discrimination based on your race, ethnicity, gender, and/or sexual identity while seeking out or receiving mental health services? If so, tell me about the discrimination you have faced and how it made you feel.
Are you currently receiving mental health treatment?	If you are currently not receiving mental health treatment, did you attempt to seek out mental health services at any point in your life? If so, at what age?	If you have not sought out mental health services, have you purposely avoided seeking out mental health services in order to avoid being discriminated against because of your race, ethnicity, gender, and/or sexual identity?
How do you identify racially and/or ethnically?	If you are currently not receiving mental health treatment, what are the main reasons you are not receiving treatment currently?	If you have sought out mental health services before, were you nervous that your mental health provider would treat you differently based on your race, ethnicity, or sexual/gender identity?
How do you identify your sexuality? How do you identify your gender? Does your gender match with your sex assigned at birth?	If you have received treatment in the past but not presently, what are the reasons you stopped receiving treatment?	

After I asked all the questions to each participant, I ended the interview with a follow up question and concluding statement. The follow up question is as follows:

Is there any additional information about your identity, mental health treatment experience, or anything else relevant to this study that you would like me to know?

The concluding statement consisted of thanking the participant for their time and willingness to participate in the study, asking the participant if they would like a copy of the research results once completed, and information about the counseling resource sheet and Amazon gift card.

Analysis

I used a hybrid coding approach to analyze this qualitative data. First, I used a hypothesis coding approach in which I created codes that I hypothesized would appear in the transcript data. I then used an emergent coding approach in which I analyzed the transcript data and created new codes based on information in the transcripts. I wrote a definition for each code I created to establish what each code means in the context of the data presented. I also included an example for each code from the transcript data. The coding table is as follows, which includes the code name, definition, and example:

Code	Definition	Specific Example
Sexual minority / LGBTQ+	Any sexuality that is not heterosexual In opposition to heterosexuality Complicated attachment to non-heterosexual labels	"I usually just use the term Queer as like an umbrella term because labeling has always really stressed me out." (Sarah- female, queer/no label, Asian/Taiwanese/white)
Gender identity	Includes perception of oneself in regards to - Societal roles and	"Not cisgender- not entirely sure at the specific labeling of that, but I think the closest I could say would probably be

	expectations - Self-expression - Self-identification Can be binary or outside the binary	gender-fluid, but I'm not the most keen on labels personally." (Katrina- not cisgender/gender-fluid, no label, Asian)
Nonwhite racial/ethnic identity	Individuals who are nonwhite, in which the term white refers to European Within the sample, different terms were used to describe similar racial/ethnic identities	"I identify as a biracial or multiracial person. And to be more specific, maybe Euro-African American. But generally biracial or mixed." (Jay- male, gay, biracial/European/ African American)
Mental health treatment exposure	Has several variables such as: - whether the subject has been to a mental health service at all - how often they go or have gone to seek these services - the time period in which the individual sought out services in their life - whether their sexual/gender identity and/or race/ethnicity affects or corresponds to their exposure to mental health treatment services (THESIS)	9 have sought it out in the past (All participants except Rebecca) 1 is currently seeking out for the first time (Rebecca- female, bisexual, Chinese American) 0 are currently receiving treatment
Emotional responses	Emotions such as fear, nervousness, and frustration that correspond to fear of discrimination/prejudice/ not being understood and financial obstacles	"I guess I am a little bit scared because I don't know, I usually not very comfortable around white people. I've always been, I had it. She's been through this communication, that makes me not want to buy."

		(Aris- non-binary, gay, South Asian/Indian)
Fear of discrimination/not being understood	Fear or nervousness caused by the fear of being discriminated against / not being understood by a mental health professional because of - race/ethnicity (includes colorism) - sexuality - gender identity Doesn't necessarily translate to actual discrimination or prejudice that occurs	"I haven't experienced discrimination directly while um looking through this process, but it's something that I, is always on my mind when I'm seeking out new forms of mental health um assistance." (Jay- male, gay, biracial/European/ African American)
Financial obstacles	The lack of access to mental health treatment services due to financial reasons such as - Low insurance coverage - Lack of insurance - Copays	"It's a little frustrating to pay that much money. And if he did seek it out, what age did you see get out? Im from the ages of 16, 17, 18. Im honestly and do anything without having insurance or parents are willing that I have insurance for you, so it was hard like getting shut down, to make his never know. There was no free therapy. Honestly, or that I can find." (Aris- non-binary, gay, South Asian/Indian)

Experience with white and/or male therapists	Female and non-binary individuals having negative experiences with white and/or male therapists because of - Fear of being misunderstood or not being understood at all due to racial/ethnic/sexuality/gender issues - Being misunderstood or not understood at all due to racial/ethnic/sexuality/gender issues	"The first concert I ever had was like an old white man, and I definitely feel like he wasn't really able to understand my perspective. Like, in terms of like giving you not just an eraser but also just like as a woman like her, as a young teenage girl, he was just kind of like, you didn't like, dismiss my problems. Obviously, that would be really unprofessional. But like, I just feel like he didn't really understand what I was trying to say where I was coming from." (Summer- female, lesbian, Asian/Chinese)
Minority mental health professionals	The desire for a mental health professional whose identity is similar or aligns with the patients' identity regarding race, gender, and sexuality	"I wanted to find one who was like a person of color and someone who is a woman you just because they are going to mor likely to experience it." (April- female, bisexual/questioning, white Hispanic)

Inconsistent mental health treatment services experiences	Relationship with mental health treatment services is unstable and/or inconsistent because of - Individual resistance - Financial barriers (talked about later) - Location (talked about later) - Status as a student	My parents were going to send me to some sort of therapy, but I somehow convinced them that I didn't need it. This was kind of a recurring pattern all the way up until I was roughly 18 and about to leave for college. [My doctor] was going to refer me to a therapist or psychologist...In response I ended up ghosting her and moving to another state, and this happened again, when I was, I believe, 20 where I actually got into outpatient treatment where I was seeing someone to discuss that. We had two sessions and then I moved across the country." (Katrina- not cisgender/gender-fluid, no label, Asian)
Location	Location can cause barriers for access to mental health treatment services because of - Perceived fear of discrimination/prejudice/not being understood because of their location in the United States - Moving to a different location which inhibits access	If you have sought out mental health services before, were you nervous that your mental health provider would treat you differently based on your race, ethnicity, or sexual/gender identity? "I think definitely in Alabama, yes...But I think being in the south, um would, I think it's more, more so an issue here." (Elizabeth- female, bisexual, white Hispanic)
Societal racial expectations	Expectations from within and outside cultural and racial communities that influence how members of certain races/ethnic groups are expected to behave and feel in society	"Do you know like the model minority myth? That kind of idea. I guess there's like a thought like when I was still in high school or I didn't really want to because of that whole like Miss like, oh, you know, like you guys are doing fine. You're making good grades.

		So, like, why are you like, why are you feeling this way? Would you call it discrimination or just like? I'm not sure how that would fit, but I know that did have an impact on it." (Rebecca- female, bisexual, Chinese American)

This study was approved by the University of Alabama in Huntsville Institutional Review Board (EE202128).

Results

This study aimed to explore the exposure to mental health treatment services that LGBTQ+ college students of color in the United States have. Before I conducted this study, I hypothesized that college students in the US that are both people of color and part of the LGBTQ+ community will not have as much exposure to mental health treatment services due to marginalization in their communities. However, there may be some disparities depending on specific races/ethnicities due to the average socioeconomic classes associated with different races/ethnicities. The results and relationships found in this study are depicted in Figure 1 and are stated below.

Identity Codes

The sexual minority/LGBTQ+, gender identity, and non-white racial/ethnic identity codes are three codes that were central to the relationships found in this study. These three codes can be categorized as all being "identity codes," or codes that relate to the participants self-

identification. These three codes that fall under this "identity code" category are the basis for which the relationships form between these unique identities and five other external codes.

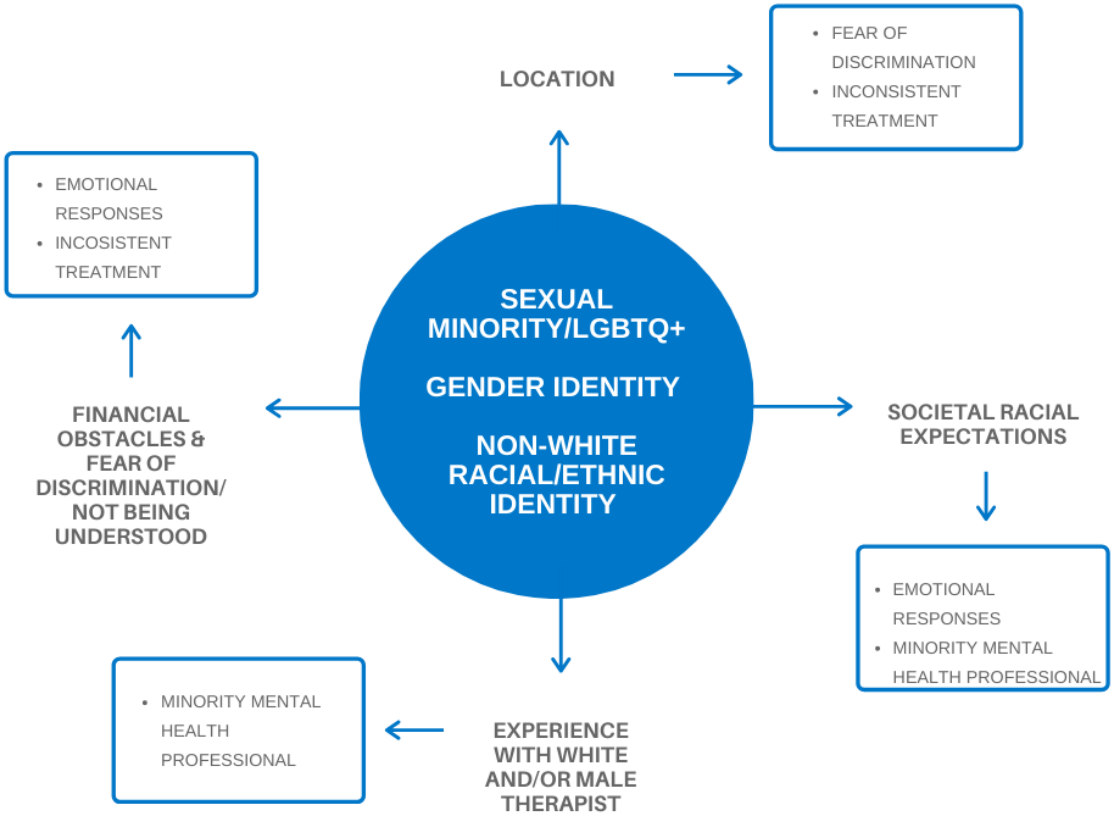
External Codes

The five codes that have a direct relationship with the identity codes are: location, societal racial expectations, experience with white and/or male therapist, and financial obstacles and fear of discrimination/not being understood. Each of the five codes are understood to be separate, yet still connected to the central three identity codes. The financial obstacles and fear of discrimination/not being understood codes are separate codes, but they both have a relationship to the next set of codes to be discussed. These five codes ultimately connect to a final set of codes that describe the mental health treatment exposure outcomes.

Mental Health Treatment Exposure Outcomes Codes

I named the final set of codes mental health treatment exposure outcomes because they show the relationship between the participants identities and external factors they face, which ultimately contributes to their exposure to mental health treatment services. The location code has a relationship with two codes: participants' fear of discrimination/not being understood and their inconsistent treatment. The societal racial expectations code has a relationship with two codes: emotional responses and minority mental health professionals. The experience with white and/or male therapists code has a relationship with the minority mental health professionals code. Finally, the financial obstacles code and the fear of discrimination/not being understood code have a relationship with two codes: the emotional responses code and inconsistent treatment.

Figure 1



Discussion

Identity Codes Interpretation

The identity codes that are at the core of the model serve as the basis for which all other codes are connected. I call these identity codes because they relate directly to how the participants self-identify. The sexual minority/LGBTQ+ code is the identity code that relates to the participants' non-heterosexual sexuality. The gender identity code is the identity code that relates to the participants' gender expression and identification which may or may not fall within

the gender binary. The non-white racial/ethnic identity code relates to the participants' racial/ethnic identities that are non-white. Overall, these codes serve as a representation that the participants are minorities in at least two of these categories/codes. These three identity codes show that the participants' self-identification as a racial/ethnic and sexual/gender minority affect their exposure to mental health treatment services. This is because the participants' unique identities are shown to have relationships with other external factors that ultimately affect this exposure.

External Codes/Mental Health Treatment Exposure Outcomes Interpretation

The three identity codes explained above are connected to five external codes. I call these "external codes" due to these codes being external situations that participants faced in relation to their identities and their mental health treatment exposure outcomes.

The first external code, location, is connected to the three identity codes and two mental health treatment exposure outcome codes. Location can be interpreted two ways. First, location could mean physical location. In other words, living in certain regions of the United States in which participants may experience mental health treatment services differently. Second, location could also mean moving to different locations. Location connects two mental health treatment exposure outcomes codes. First, location has a relationship with participants' fear of discrimination code because some participants noted that they might fear being discriminated against or not being understood by their mental health provider because of living in certain regions of the US (i.e., the South). Second, location has a relationship with the inconsistent treatment code because some participants noted that moving to a different location while seeking out mental health treatment services inhibited them from seeing a mental health provider due to

the difficulty of finding a new provider in a new location. Therefore, the location code affects the outcome of participants' mental health treatment services exposure.

The second external code, societal racial expectations, is also connected to the three identity codes and two mental health treatment exposure outcome codes. Societal racial expectations can be defined from the code chart as: expectations from within and outside cultural and racial communities that influence how members of certain races/ethnic groups are expected to behave and feel in society. This codes heavily relates to the non-white racial/ethnic identity code because the societal racial expectations occur for non-white participants. Societal racial expectations have a relationship with mental health treatment exposure outcome codes. First, societal racial expectations invoked emotional responses from participants such as fear, nervousness, and frustration. Second, societal racial expectations also have a relationship to the minority mental health professionals code. The minority mental health professionals code can be defined as the desire for a mental health professional whose identity is similar or aligns with the patients' identity regarding race, gender, and sexuality- in this case, similar racial professionals. Therefore, societal racial expectations have a relationship with the participants having emotional responses and their desires for a minority mental health professional that aligns with the participants' own racial/ethnic identity.

The third external code, experiences with white and/or male therapists is connected to the three identity codes because the participants' unique identities in terms of race/ethnicity and sexuality/gender did not translate well with their experience with a white and/or male therapist. The experience with white and/or male therapists code consists of female and non-binary individuals having negative experiences with white and/or male therapists because of fear of being misunderstood or not being understood at all due to racial/ethnic/sexuality/gender issues or

being misunderstood or not understood at all due to racial/ethnic/sexuality/gender issues. These negative experiences with white and/or male therapists contributed to the connection that participants had with the code of wanting a minority mental health professional. Participants that noted they had a negative experience with a white and/or male therapist also stated they would want a minority therapist whose identity aligns more with theirs. Therefore, the experience with a white and/or male therapist is connected to the want for minority mental health professionals.

The final two external codes, financial obstacles and fear of discrimination/not being understood have a relationship with two mental health treatment exposure outcomes: emotional responses and inconsistent treatment. Financial obstacles can be defined as the lack of access to mental health treatment services due to financial reasons such as low insurance coverage, lack of insurance, and copays. These financial obstacles have a relationship with emotional responses such as fear, nervousness, and frustration due to not having resources to seek out mental health treatment services. Financial obstacles also have a relationship with the code of inconsistent treatment because of the participants' lack of financial resources to seek out treatment in a consistent manner. The last external code, fear of discrimination/not being understood also has a relationship with these two mental health treatment exposure outcome codes. The fear of discrimination/not being understood code can be defined as fear or nervousness caused by the fear of being discriminated against / not being understood by a mental health professional because of race/ethnicity (includes colorism), sexuality, and/or gender identity. This fear doesn't necessarily translate to actual discrimination or prejudice that occurs. However, this fear has a relationship with emotional responses such as fear, nervousness, and frustration. This fear of discrimination/not being understood also has a relationship with inconsistent treatment.

Therefore, financial obstacles and fear of discrimination/not being understood have a relationship with the same two codes.

Hypothesis Interpretation

My initial hypothesis was that college students in the US that are both people of color and part of the LGBTQ+ community will not have as much exposure to mental health treatment services due to marginalization in their communities. However, there may be some disparities depending on specific races/ethnicities due to the average socioeconomic classes associated with different races/ethnicities. My hypothesis was partly incorrect because I hypothesized that the participants would not have much exposure to mental health treatment services. However, the participants did have exposure, but the exposure was rooted in negative experiences and feelings that they had with previous mental health treatment services. My hypothesis was partly correct, however, because participants of certain races and ethnicities reported having different experiences with mental health treatment services that differed from participants with other races. However, this was not indicated to be because of socioeconomic factors associated with different races and ethnicities. This study was also meant to explore how unique identities regarding race, gender, and sexuality intersect with the topic of mental health treatment services. Overall, this goal was met because I was able to connect different topics (codes) that were found in the transcripts to each other to create a model that shows the relationship between the codes.

Previous Research in Relation to this Study

I hypothesized that LGBTQ+ people of color experience more marginalization in society which may reduce their exposure to mental health treatment services. While this study disproved the part of my hypothesis that states the participants would have less exposure to mental health services, the participants did experience marginalization in their lives. One study that is

connected to my hypothesis states that LGBTQ+ and people of color (especially black and Indigenous) experience higher rates of mental health issues (Bostwick et al., 2014). While my study focused more on the experience of mental health treatment instead of mental health itself, Boswick's study makes the connection that marginalized groups may seek out more mental health treatment which disproves my initial hypothesis that my participants would have less exposure to mental health services.

Another study concluded that discrimination against POCs and those in the LGBTQ+ community affect both group's mental health and suicidality (Sutter & Perrin, 2016). While this study's outcome is mental health instead of mental health treatment services, the results still reflect what I concluded in my study about the participants having marginalized identities and experiences. If marginalization can affect mental health, it is likely to affect the treatment of the individuals' mental health as well, which I found in my study.

Another study found that 41.9% of LGBTQ+ participants were concerned that they would experience stigmatization or discrimination from mental health professionals when seeking out psychological help. In addition, the LGBTQ+ participants who were also POCs felt "downplayed and ignored" when they addressed racial issues with their mental health provider (Foy et al., 2019). The findings from this study are similar to the results of my study because some participants noted a fear of discrimination or not being understood by their mental health provider because of their race/ethnicity and/or gender/sexuality.

While I hypothesized that the participants would have less exposure to mental health treatment services, one study found that LGBTQ+ people are more likely to seek out mental health services due to higher amounts of suicidal ideation in this group (Dunbar et al., 2017). While this study did not consider LGBTQ+ people that were also college students and people of

color, Dunbar's findings were proven correct in this study because nine out of ten participants had sought out mental health treatment services at some point in their life. However, at the time that the interview occurred, none of the participants were currently receiving mental health treatment.

Limitations

The results of this study show the different connections and relationships that the participants' identities have with their experiences with mental health treatment services. However, I believe more discoveries could be made if the sample size was larger and if there was more gender diversity. Because my sample size was only 10 participants, there is room to grow the sample size in future studies. In addition, the gender diversity could be improved on in future studies since seven out of ten participants were cisgender females. In addition, more questions could be added to the research script to get a more in-depth understanding of how identities relate to mental health treatment services exposure. For example, more questions about intersectional experiences could be added so that more relationships can be drawn between identities and mental health treatment exposure.

The Future of Mental Health Treatment Services

The findings of this study raise several questions for the future of mental health treatment services in the United States. First, how can mental health professionals be better trained to serve minorities? According to this study, many participants feel uncomfortable talking to some mental health professionals because of the fear of discrimination or not being understood by their provider. Therefore, mental health professionals should receive more training in areas that can affect their clients' mental health such as race/ethnicity, sexuality, and gender identity/expression.

Second, how can more racial and gender minorities become mental health providers? Many of the participants indicated in this study that they would only seek out or attempt to seek out mental health services from a provider whose identity aligns with their identity gender and race-wise. These participants felt as if they could be better understood and not be discriminated against if their mental health provider had an identity close to theirs. Therefore, it is crucial not only for the clients, but also for society to have more mental health providers that are racial/gender/sexual minorities so that clients can feel like they have representation and can be understood and so that minorities can have the opportunity to pursue this career without racial and gender barriers.

References

Bostwick, W. B., Meyer, I., Aranda, F., Russell, S., Hughes, T., Birkett, M., & Mustanski, B. (2014). Mental health and suicidality among racially/ethnically diverse sexual minority youths. *American Journal of Public Health, 104*(6), 1129-36. https://doi.org/10.2105/AJPH.2013.301749

Butler, J. (1990). Gender trouble: Feminism and the subversion of identity. *Routledge, Chapman, & Hall Inc.*

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*(1).

Dunbar, M. S., Sontag-Padilla, L., Ramchand, R., Seelam, R., & Stein, B. D. (2017). Mental health service utilization among lesbian, gay, bisexual, and questioning or queer college students. *Journal of Adolescent Health, 61*(3), https://doi.org/10.1016/j.jadohealth.2017.03.008

Foy, A. A. J., Morris, D., Fernandes, V., & Rimes, K. A. (2019). LGBQ+ adults' experiences of Improving Access to Psychological Therapies and primary care counselling services: informing clinical practice and service delivery. *Cognitive Behaviour Therapist*, 12, 1–23. https://doi-org.elib.uah.edu/10.1017/S1754470X19000291

Kivlighan, D. M., III, Hooley, I. W., Bruno, M. G., Ethington, L. L., Keeton, P. M., & Schreier, B. A. (2019). Examining therapist effects in relation to clients' race-ethnicity and gender: An intersectionality approach. *Journal of Counseling Psychology*, 66(1), 122–129. https://doi-org.elib.uah.edu/10.1037/cou0000316

Pew Research Center. (2014). *Income distribution among the unaffiliated by race/ethnicity*. [Data set]. The Pew Charitable Trusts. https://www.pewforum.org/religious-landscape-study/compare/income-distribution/by/racial-and-ethnic-composition/among/religious-tradition/unaffiliated-religious-nones/

Somerville, S. B. (2014). Queer. In G. Hendler & B. Burgett (Eds.), *Keywords for American cultural studies.* NYU Press.

Sutter, M. & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of Counseling Psychology*, *63*(1), http://dx.doi.org/10.1037/cou0000126

The American Heritage Guide to contemporary usage and style. (2005). Houghton Mifflin Company.

The APA dictionary of psychology. (2007). American Psychological Association.