

“There Are Not a Lot of Providers Who Look Like Me”: Identity and Therapy for Sexual
Minority Black, Indigenous, and other People of Color

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Abstract

Research suggests that sexual minority Black people, Indigenous people, and other People of Color (BIPOC) generally experience higher levels of psychological distress and depression, leading to poorer mental health outcomes (e.g., Sutter et al., 2017; Lim & Hewitt, 2018). However, little is known about how sexual minority BIPOC individuals cope and support their mental health. The purpose of this grounded theory study was to understand the nuanced narratives of sexual minority BIPOC individuals in seeking mental health support, including any barriers to accessing therapy as well as other identified sources of support. Fifteen sexual minority BIPOC individuals were interviewed about their perspectives of therapy. Using intersectionality theory as a framework, the following core categories emerged: *impact of identity and systems of oppression on mental health, mental health stigma, issues with accessibility, significance of shared identity with the therapist, hesitation with therapy/therapists because of a marginalized identity, negative therapist reactions, therapy is ineffective and/or harmful, importance of attending to identity in therapy, an unmet need for therapy, and coping with community*. Results of the present study suggest that therapy can be ineffective—or even harmful—for sexual minority BIPOC individuals when identity is not adequately addressed in the therapy room. Our findings prompt important directions for practice with sexual minority BIPOC individuals, including addressing program training for counseling students so that they can better provide services to sexual minority BIPOC clients.

Keywords: Sexual minority People of Color, therapy, grounded theory, intersectionality, mental health stigma

Public Significance Statement: This study presents the views of sexual minority BIPOC individuals on coping with mental health issues and therapy experiences. Results highlight the

impact of identity on sexual minority BIPOC individuals and indicate the potential harm experienced by sexual minority BIPOC clients in therapy. The findings provide important directions for practice with sexual minority BIPOC individuals, including developing trainings for therapists to provide more sufficient services to this group.

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Section 1: Introduction

Considerable research has utilized a minority stress framework (e.g., Velez et al., 2017; Ramirez & Galupo, 2019) to explore how the discrimination experienced by sexual minority BIPOC individuals negatively impacts their mental health (e.g., Sutter et al., 2017; Lim & Hewitt, 2018). Minority stress theory asserts that discrimination, prejudice, and stigma experienced by sexual minority individuals contribute to a stressful social environment, which exacerbates mental health problems (Brooks, 1981; Meyer, 2003). Despite research indicating that sexual minority BIPOC individuals experience increased mental health problems, little research has directly explored how therapy and other mental health resources are utilized by this population. Research on the therapeutic context has primarily focused on establishing guidelines and trainings for practitioners to work with sexual minority populations (e.g., Lytle et al., 2014; Hinrichs & Donaldson, 2017) and BIPOC communities (e.g., Miller et al., 2018). However, these guidelines seldom address the multiple systems of oppression impacting these groups. In order to change the trend of negative mental health outcomes, it is critical to use an intersectional framework to recognize that colonization, White supremacy, heterosexism, cissexism, and other systems of oppression operate collectively to disregard the wellness of sexual minority BIPOC individuals (Crenshaw, 1989; Moradi & Grzanka, 2017). The present study aimed to understand the various and nuanced narratives of sexual minority (including but not limited to lesbian, gay, bisexual, queer, and asexual) BIPOC individuals in seeking mental health support, including any barriers to accessing mental health treatment. It is important to note that while our sample included a significant number of gender diverse participants, we were aiming to center their experiences as sexual minority BIPOC individuals in this study.

An Intersectional Framework

Intersectionality was coined by Kimberlé Crenshaw (1989) to emphasize the unique way in which Black women experience racism and sexism collectively. This framework highlights how these two experiences cannot be separated from one another, and that these experiences are not additive (Lewis & Neville, 2015). Rooted in critical legal studies, *intersectionality* is better suited as a framework, rather than as a theory in psychological research (Syed, 2010). Since its inception, many scholars have used intersectionality to conceptualize how multiple overarching systems of oppression impact an individual at any given time (Collins, 2015). Scholars distinguish between “strong” and “weak” intersectionality, where “strong intersectionality” highlights multiple sociocultural dimensions, analyzing systems of oppression and identities as interdependent, while “weak intersectionality” is attuned to individual differences and identities (Dill & Kohlman, 2011, p. 20). In the therapy room, applying a “strong intersectionality” framework helps alleviate the client’s internalized blame due to systemic challenges (Adames et al., 2018).

Within the field of counseling psychology, intersectionality has been used to highlight topics such as sex positivity (Alexander, 2019), gendered racism (Lewis et al., 2017), and White supremacy (Grzanka et al., 2019). By applying intersectionality to research and practice, counseling psychologists can cement their roles as social justice activists (Moradi & Grzanka, 2017). Intersectionality is often used to understand the experiences of sexual minority BIPOC individuals, specifically in terms of their experiences with racism and heterosexism (Parent et al., 2013). However, there are other systems of oppression, such as classism or cissexism, that could be impacting sexual minority BIPOC people. By utilizing an intersectional framework for this

study, our goal was to promote a greater understanding of how interlocking systems of oppression shape sexual minority BIPOC individuals' experiences when seeking therapy.

Minority Stress for Sexual Minority BIPOC People

Minority stress theory posits that discrimination, prejudice, and stigma lead to a tense social environment, which worsens mental health problems (Brooks, 1981; Meyer, 1995; Meyer, 2003). Meyer (2003) identified two types of stressors: proximal and distal. *Distal* stressors are those that are external to the individual, such as workplace discrimination (Waldo, 1999; Velez et al., 2013), whereas *proximal* stressors are the subjective perceptions of societal attitudes (Meyer, 2003), such as internalized homophobia. For sexual minority BIPOC people, external stressors include experiences with both racism and heterosexism (Cyrus, 2017), and even cissexism for gender diverse sexual minority BIPOC individuals. Furthermore, gender diverse sexual minority BIPOC individuals report higher distress than White gender diverse people or cisgender BIPOC individuals (Lefevor, 2019). Although therapy has been suggested for sexual minority BIPOC people as a way to manage negative mental health outcomes as a result of minority stress (Sutter & Perrin, 2016), at the time of this writing, no studies have evaluated sexual minority BIPOC individuals' use of therapy or other wellness services. In a time period where sexual minorities experience more symptoms of depression and anxiety (Gonzalez et al., 2018) and racial and ethnic minorities report greater interpersonal tension (McCarthy & Saks, 2019) due to a changing social and political climate post the 2016 presidential election, it is imperative that researchers and practitioners attend to the mental health and psychological wellbeing of sexual minority BIPOC individuals and communities. Despite the recent presidential transition, there is still a need to be mindful of the lasting impact of oppressive policies on sexual minority BIPOC people.

Discrimination and Mental Health

Many researchers have found that stigma and discrimination are prominent factors in determining psychological well-being for sexual minority BIPOC people (e.g., Velez et al., 2017; Shangani et al., 2019). In a sample of lesbian, gay, and bisexual BIPOC people, Ramirez and Galupo (2019) found that distal stressors, such as microaggressions, and proximal stressors, such as self-stigma, predicted increased levels of depression and anxiety. Furthermore, when examining the relationships among perceived discrimination, expectation of stigma, coping self-efficacy, and psychological distress in a sample of sexual minority BIPOC individuals, Ouch and Moradi (2019) found that perceived discrimination had a unique direct link with increased psychological distress. These findings demonstrate the detrimental impact of discrimination on sexual minority BIPOC individuals. More scholarship is needed to explore how sexual minority BIPOC people actually cope with experiences of discrimination.

Additionally, the experiences of sexual minority BIPOC individuals may vary based on geographical locations. Though most studies on sexual minority individuals in rural locations are comprised of White individuals, some studies have shown that sexual minority BIPOC people in rural areas coped with mental health and substance use issues by seeking support from their families and nonbiomedical belief systems, such as community healers (e.g., Willging et al., 2006). However, studies on LGBTQ+ individuals in rural locations predominantly consist of White participants (e.g., Fisher et al., 2014). Nonetheless, even in diverse locations, sexual minority BIPOC individuals fear discrimination (Shangani et al., 2019). In a study comparing White, African American, and Latino LGB participants in New York City, researchers found that African American and Latino LGB participants reported greater mean scores of anticipated and internalized stigma than White LGB participants (Shangani et al., 2019). In rural and suburban

environments, these differences may be even more pronounced, and without the necessary support services, could possibly lead to worse mental health outcomes (Fisher et al., 2014). Moreover, in a qualitative study on the experiences of racially diverse sexual minorities, researchers found that Participants of Color uniquely experienced microaggressions that were directed at their sexual and racial or ethnic identities (Weber et al., 2018). For the BIPOC participants in this study, daily experiences with microaggressions led to various negative feelings, specifically with a concern for safety. These participants' worries about safety within their immediate environment indicate a need for strong support services that address both individual and systemic discrimination against sexual minority BIPOC people.

Socioeconomic status is a factor that can impact sexual minority BIPOC individuals' mental health as well. In a study examining the relationship among heterosexism, racism, depression, and socioeconomic status, Sutter and colleagues (2017) found that the relationship between heterosexism and depression was stronger among upper-class sexual minority People of Color. Similarly, Shangani and colleagues (2019) observed that upper-class African American LGB participants reported higher enacted stigma (i.e., everyday discrimination) than lower class African American LGB participants. On the other hand, White participants' reports indicated the opposite for their group. These findings suggest that higher socioeconomic status does not have protective effects against experiences of stigma and feelings of depression for sexual minority BIPOC individuals. Though it may be financially easier for sexual minority BIPOC individuals from upper-class backgrounds to access therapy, the salience of one's race and sexuality may overshadow their socioeconomic status. Specifically, the experiences of heterosexism and racism are more prevalent for sexual minority BIPOC people due to gaps in race and ethnicity at higher socioeconomic status (Sutter et al., 2017).

Community Support

Community support also affects the wellbeing of sexual minority BIPOC individuals. In a recent study focusing on the effects of community and individual resilience on the psychological wellbeing of sexual minority People of Color, researchers found that sexual identity outness was positively correlated with psychological well-being (Kavanaugh et al., 2019). Specifically, the more people that the participant was out to in a particular community, the more positive the participant reported feeling. For gender diverse sexual minority BIPOC students, being “out” requires a negotiation of outcomes (i.e., receiving acceptance or being misgendered) before deciding whether to disclose their gender identity (Garvey et al., 2019). This might indicate that being closeted causes mental harm for sexual minority BIPOC people, even if it allows individuals in this group to protect themselves from discrimination. In a qualitative study focusing on the experiences of accessing a safe space with LGBTQ Youth of Color, researchers found that the existence of such a space had a strong positive impact on developing feelings of belonging, resilience, and empowerment in spite of discrimination (Gamarel et al., 2014). The space’s importance to the relational health of this group exemplifies how systems-level public health initiatives, including mental health services, can improve wellbeing for sexual minority BIPOC individuals.

However, in an evaluation of the resources available for Bi+ People of Color and Indigenous People, Mosley and colleagues (2019) found that out of 1,693 groups offered by 139 university counseling centers across the United States, only two were groups for queer and trans People of Color and Indigenous People. Additionally, out of the 9,828 resources offered by these counseling centers, only 13 resources were specifically geared toward queer and trans People of Color and Indigenous People. Groups can facilitate a sense of community for sexual minority

BIPOC individuals experiencing isolation (Fenster, 1996; Jacobson & Donatone, 2009; Nerses et al., 2015). Considering the negative impact of discrimination on this group, it is necessary to explore the narratives of sexual minority BIPOC people in using groups and other community spaces to cope with adverse experiences.

Existing Research on Therapy Experiences

Common barriers to accessing therapy, regardless of identity, include high cost of treatment, insufficient health care coverage, limited options, lengthy wait, and social stigma around mental health (Cohen Veterans Network & National Council for Behavioral Health, 2018). Research on therapy for sexual minority and BIPOC populations has primarily focused on establishing guidelines and trainings for practitioners to work with these groups (e.g., Pepping et al., 2018; Dustrup, 2019). However, this research generally centers one identity and corresponding system of oppression, rather than utilizing an intersectional lens. Similarly, what little research does examine minority clients' narratives in therapy only analyzes the impact of a single axis of oppression (i.e., racism or heterosexism) in shaping their experiences (e.g., Israel et al., 2008; Chang & Yoon, 2011).

In a study by Israel and colleagues (2008), LGBT participants reported that a primary frustration in therapy was that their practitioners imposed their own views, including homophobia, urging clients to complete their college education, and accusing clients' parents of being unsupportive. These findings imply a lack of cultural competence on the practitioner's part. Furthermore, Spengler and colleagues (2016) identified that microaggressions from the therapist can contribute to negative therapy experiences for sexual minority clients. Additionally, among sexual minorities, sub-groups differ in the ways that they cope, seek help, and access mental health services (Baams et al., 2018). However, because these studies did not address

participants' racial and ethnic identity, there is a need for consideration of how those identities impact one's experiences in therapy. Considering this, it is essential to explore how and why holding a particular sexual orientation impacts the mental health-seeking process for different sexual minorities.

When examining the experiences of racial and ethnic minority clients who had White therapists, Chang and Yoon (2011) observed that the majority of their participants reported that their therapists could not fully comprehend key aspects of their experiences, and thus would avoid addressing racial-cultural issues in therapy. Yet, many participants also felt that racial differences were minimized when their therapist demonstrated compassion and was comfortable discussing racial, ethnic, and cultural differences. This suggests that naming one's positionality (Rose, 1997) can make therapy a more positive experience for racial and ethnic minorities.

The Present Study

Little is known about the experiences of sexual minority BIPOC individuals who seek mental health support. Although studies show that sexual minority BIPOC people do experience negative mental health outcomes as a result of minority stress (e.g., Ramirez & Galupo, 2019; Ouch & Moradi, 2019), no studies exist to understand how this group navigates their experiences with discrimination and distress through therapy. Very little institutionalized social support exists for sexual minority BIPOC individuals, whether that be at universities (Mosley et al., 2019) or in therapy research. It is crucial to address the narratives of sexual minority BIPOC people in therapy in order to highlight their voices, understand what might cause healthcare disparities, and accordingly develop guidelines for practitioners in supporting the unique needs of this group. This study aimed to explore the difficulties that arise when accessing therapy, positive and

negative experiences in therapy, and other mental health resources that sexual minority BIPOC individuals turn to in order to cope.

Section 2: Method

Given the lack of research on sexual minority BIPOC individuals' experiences, qualitative interviews were used to explore the worldviews, realities, and experiences of sexual minority BIPOC individuals. According to Syed (2010), qualitative methodology should be central to the approach of studies guided by an intersectional framework. Constructivist grounded theory is particularly useful to explore a social phenomenon for which no sufficient theory exists (Mills et al., 2006). Thus, the ultimate goal of constructivist grounded theory is to develop a model that adequately describes the social process in question. Charmaz's grounded theory posits that there is no objectivity or external reality within this approach, and that data are created as a result of the interaction between the researcher and the participant (Charmaz, 2000; Mills et al., 2006). Data from the current study were analyzed using constructivist grounded theory (Charmaz 2000; 2001), which addresses the ways in which researchers are influenced by their own social positions and make meaning of the data. In this study, constructivist grounded theory provided a platform for understanding the mental health support-seeking process for sexual minority BIPOC individuals through their own words. When this study was originally developed, the researchers conceptualized the questions with the term "sexual minority People of Color and Indigenous people" instead of "sexual minority BIPOC". The terminology was changed to better reflect how communities identify, as well as acknowledge the differences between the lived experiences of Black individuals, non-Black People of Color, and Indigenous people. Furthermore, although our sample included a significant number of gender diverse participants, we aimed to center their experiences as sexual minority BIPOC individuals in our analysis and subsequent findings.

Researcher Reflexivity

The research team included a counseling psychology doctoral student who self-identifies as a South Asian queer able-bodied cisgender woman (first author), an assistant professor of psychology who self-identifies as a Latinx heterosexual cisgender woman (second author), and a research assistant who self-identifies as a Black queer nonbinary person (third author).

Combined, the research team has over 10 years of clinical experience. The second author is an expert in the area of conducting qualitative research and qualitative data analysis, while the first author has been trained in qualitative research methods and has experience with qualitative data analysis. The third author was trained in qualitative data analysis before beginning the data analysis process. Within constructivist grounded theory, it is necessary to establish trustworthiness by evaluating subjective perspectives on the topic of exploration (Morrow, 2005). The authors were careful to examine their own assumptions during mutual construction of the meaning of participants' experiences.

When exploring our working assumptions about the data, all authors came to discussions with different perspectives about and experiences in therapy. Given our varied experiences with therapists who did and did not attend to identity or systems of oppression in personal therapy work, the authors engaged in multiple discussions of how each authors' assumptions would impact the data analysis. Based on these discussions, one of the working assumptions of the authors was that race and sexual orientation would be salient in therapy for all of the participants, as they were for the authors in their own therapy experiences. Before forming author memos and beginning data analysis, the authors were mindful of how this assumption would influence their perception of participants' narratives, specifically in terms of what aspects of their experiences

were significant to the authors. Furthermore, the authors were particularly attentive to narratives that challenged their working assumptions.

Participant Recruitment and Selection

Following institutional review board approval at the site of the study, fliers and advertisements were sent to LGBTQIA+ community agencies through email contacts, websites, listservs, and social media. After volunteers contacted the primary investigators via email, the principal investigators assessed their eligibility. Eligible participants were those who: (a) identified as a sexual minority, (b) identified as a BIPOC individual, (c) lived in the United States, and (d) were at least 18 years of age. Once a participant's eligibility was established, the principal investigators sent an informed consent form to the participant before proceeding with any part of the study. Although 24 individuals indicated interest in participation, nine of the participants did not respond to follow-up emails. After receiving the signed informed consent form back from the participant, the first author scheduled 60-90-minute phone interviews. Participants who participated in the interview received a 25-dollar Amazon gift card.

Participants

Participants ($n = 15$) in the study were self-identified sexual minority BIPOC individuals. All participants used self-identified labels to describe their sexual orientation, gender identity, race, ethnicity, religious affiliation, and political views. Participants ranged in age from 19 to 29 ($M = 22.53$, $SD = 2.15$), and identified as queer ($n = 7$), bisexual ($n = 4$), asexual ($n = 3$), and homosexual ($n = 1$). Seven participants identified as transgender or nonbinary (TNB), while the rest identified as cisgender. Participants represented eight states: California, Florida, New Jersey, New York, Pennsylvania, Tennessee, Virginia, and Washington. Participants reported being from a location that was either urban ($n = 5$), suburban ($n = 5$), rural ($n = 1$), metropolitan ($n =$

1), or a college town ($n = 3$). Participants self-described as being working class, ($n = 5$), low SES ($n = 3$), high SES ($n = 2$), middle class ($n = 2$), upper-middle class ($n = 1$), low-middle class ($n = 1$), and upper-lower class ($n = 1$). All participants were in the midst of completing a college degree or had already completed one. Twelve of the 15 participants had previous or current experience in therapy or with other mental healthcare (e.g., psychiatry, social work), while three had no previous mental healthcare experience. Participants' experiences with therapy ranged from four months to four years. Participants' demographics, along with participant pseudonyms, are provided in Table 1.

Data Collection

The first author created an interview protocol, including demographic and semi-structured interview questions (see Appendix). Two sets of questions were created: one for participants who had tried therapy, and one for participants who had not. The protocol also included follow-up questions for all participants regarding their suggestions for working with sexual minority BIPOC individuals. Semi-structured interview questions explored participants' various identities, their experiences utilizing mental healthcare services, as well as difficulties in accessing mental healthcare services. For participants who had not tried therapy, or were not currently in therapy, questions explored how they were coping with mental health struggles. Semi-structured interviews were conducted, recorded, and transcribed by the first author. Interviews lasted between 45 and 120 minutes. During interviews, participants who asked about the researchers' interest in the study were provided with information about the interviewer's identities and background.

The authors had originally planned to collect more data about the experiences of participants who had not yet tried therapy. Although interviews were conducted virtually, data

collection was halted shortly after the COVID-19 pandemic began, assuming that quarantining and social isolation would likely impact participants' and their need for therapy, thus shifting the focus of findings. According to Charmaz (2001), saturation is reached when similar concepts are identified through analysis of one transcript to the next, and no new findings materialize according to the researcher's subjectivity. During initial analysis, no new categories emerged for participants who had current and previous experiences with therapy by the time we had completed the final interview. For participants who did not have any prior experience with therapy, the themes from their narratives aligned closely with those of participants who are currently not in therapy but have tried therapy before. Thus, the authors felt confident about including all participants in final data analysis.

Data Analysis

The data were coded and organized using NVivo (March 2020), a qualitative data analysis computer software. The research team included a counseling psychology doctoral student (first author), an assistant professor of counseling psychology (second author), and research assistant (third author), who assisted in initial coding. Consistent with Charmaz's (2000; 2001) description of grounded theory research and analyses, data analysis began by coding the first interview, and then proceeding according to the constructivist paradigm. The constructivist approach emphasizes maximizing the amount of information that is provided about each of the participants' narratives, such that analysis and writing is evocative of participants' experiences whilst bridging connections between transcripts (Mills et al., 2006; Charmaz, 2008). Furthermore, the researcher's positionality impacts the data, which is co-constructed by the participant and the researcher through interaction during the interview, and data analysis (Charmaz, 2008). Each interview was coded line by line, converting raw data into phrases that

encompassed the meaning of the data unit at a conceptual level (Charmaz, 2006). Given the purpose of the study, analysis focused on the link between participants' identities and experiences.

After completing each interview, the first author completed memos, which contained initial reflections and reactions to participant's narratives (Charmaz, 2006). During data collection, the first author and second author met to discuss preliminary emerging themes. After data collection was completed, the first author and third author read transcripts independently. After reading each transcript, the first and third authors then met to discuss initial themes that were recurring within and between transcripts, and made memos containing reflections of the differences in perception of data and participant narratives based on each author's working assumptions, identities, and perspectives. After holding these discussions, the first author began open coding by solidifying recurring themes within and between interviews. Following this, the first author conducted axial coding by sorting related themes into concrete categories. To ensure rigor (Levitt et al., 2018), the second author served as an auditor by reading the transcripts independently and relaying identified categories, which were then confirmed by the first author. Finally, the authors engaged in selective coding to draw a theoretical connection between categories. Throughout this process, the authors examined their presumptions about the data before finalizing categories in order to establish trustworthiness (Morrow, 2005).

Section 3: Results

This study sought to explore narratives of sexual minority BIPOC individuals in seeking mental health support, including any barriers to accessing therapy and other sources of mental health support. Participants expressed various narratives related to their identities, their desires for therapy, and their experiences with seeking mental health support. After completing data analysis, the following core categories were identified: impact of identity and systems of oppression on mental health, mental health stigma, issues with accessibility, significance of shared identity with the therapist, hesitation with therapy/therapists because of a marginalized identity, negative therapist reactions, therapy is ineffective and/or harmful, importance of attending to identity in therapy, an unmet need for therapy, and coping with community.

Beyond these main categories, categories specific to certain identity groups also emerged during data analysis. Specifically, asexual participants, Black participants, and trans and nonbinary (TNB) participants reported experiences that were unique to those particular identities. All participants were asked to pick their pseudonyms at the end of the interview. Accordingly, all participant quotes will be presented using the pseudonyms selected by the participant.

Impact of Identity and Systems of Oppression on Mental Health

A central concept within the findings was the impact of one's identity on mental health. 14 out of 15 (93.3%) participants expressed that their identity played a role in their mental health broadly. Some participants voiced this by naming that they did not initially realize the impact of their identities on their mental health and wellbeing. Sunshine stated:

I honestly, at the time, I don't think I understood that race and ethnicity and being queer were huge factors impacting my mental health. I honestly don't think I knew. But that

was years ago. And then now, it's so evident. Like, right now, four years later, I fully, fully know.

For some, race and sexuality felt at the forefront of their life experiences because of how society's treatment of these identities led to feelings of isolation. For example, Chris explained:

Growing up, I was always the kid on my own because I just grew up in a very White town where everyone is White and Christian, and um, you know we, we were not. And so, I felt very, it just felt like, kind of devastatingly lonely there. It helped me build up a thick skin, over time, because I just. There was nothing. I knew there was nothing I could do to change that I was Middle Eastern, it's how I was born and so I just learned to live with it. And so, I think by the time, you know, when I came out to my, when my parents found out and everything. I felt very alone again, but it was, you know, it was a familiar feeling. I knew I wasn't going to be accepted, anyway, by people on both ends and so it was just, it was status quo, unfortunately, that feeling of loneliness.

Sofia came to realize that her feelings of anxiety were tied to the way she was treated because of her race. She stated:

I think that I've always been anxious, always . . . and I think that had to do with, I grew up in a predominantly, like, White conservative town in, like, Suburban New Jersey, and . . . I think that it definitely has to do with me sort of being . . . like vaguely ostracized because of my race, my whole life.

Skye spoke about the experiences of sexual minority BIPOC people more broadly:

I do know there are tons of gay, Asian people or gay, um colored people who are gay. They have tons of mental issues for their identity, so. I think that, that, that is a great connection between those because we are in America and there are some like, very racist

and homophobic people. And unfortunately, a lot of them are White. So I'm not saying like, you know, other Colored People can't also be racist and homophobic, but in America, I think the majority of White people are racist and homophobic. So that's kind of an issue and then a lot of gay Colored People have a mental issue, just because of that discrimination.

Other participants expressed there being “traumas” and “*crises*” around their racial identity and/or sexual orientation. More specifically, participants noted that “traumatic” experiences associated with one or both of these identities had a lasting impact on their understanding of themselves as sexual minority BIPOC individuals.

Mental Health Stigma

Ten participants (66.7%) expressed narratives about mental health stigma broadly. More specifically, participants discussed how difficult it can be to talk about mental health, and how mental health treatment is seen in a negative light. For some participants, this stigma impacted their mental health support-seeking processes. For example, AR stated:

Like, I struggled with mental health all my life, and I feel like for a long time, it made me feel like, really weird and really, really like, isolated from other people, especially like with, in regards to seeking treatment. Like I didn't really want to like, do therapy or like, do anything that might help me for fear of like, being, I don't know like being like, marked as weird amongst my peers or something like that.

Cloudy expressed that, “not even [my own father] who [I] looked up to, for so long, wanted [me] to get this help. [I] realized just how serious this erasure of mental illness runs in the world.”

Within this category, there were also two subcategories: 1) Cultural Stigma, and 2) Queer Encouragement.

Cultural Stigma

Seven participants (46.7%) named the ways in which their culture discouraged them from seeking mental health support. This discouragement is defined as cultural stigma against mental health. For example, Sofia stated:

In India, it's a very different society in which you don't talk about any of this, like you don't—mental health doesn't happen in India, people don't talk about it, that's just how things work.

Some participants named a clash between their sexual minority identity and racial minority identity when approaching therapy. AR explained:

I don't know. I think it's hard when you identify as both a person of color and like a sexual minority, because I think within different communities of color, like culturally, there can be a lot of stigma against mental health within those cultures.

Thus, participants in this subcategory explicitly identified how racial and/or ethnic culture played a role in deterring the mental health support-seeking process.

Queer Encouragement

Four participants (26.7%) named that, because queer communities as a whole promote seeking support for mental health, they felt encouraged by their “*queer side*” to consider going to therapy. For example, Michaella expressed how queerness played a role in her perception of mental health treatment:

I think my queerness has helped me to embrace the idea of overall mental health treatment more. I think that's due to like, social media. I think I've seen like, a lot of queer people who've gone through like a lot of dark times, a lot of therapy has been through mental health treatment.

Similarly, Sidney expressed how in, “the queer space and queer culture, seeking mental health, is very positive, and um, everyone kinda understands the need for it, we’re all trying to like work through these big identity issues.” In this subcategory, participants shared the explicit ways in which queerness and queer communities persuaded them to seek mental health treatment. This acted as a buffer against mental health stigma.

The stigma against mental health is prevalent in the experiences of these participants. While participants named how mental health stigma and cultural stigma play a role in hesitation around therapy, participants also noted that queerness can work against such stigma through queer community support.

Issues with Accessibility

Thirteen participants (86.7%) named issues with accessing therapy by identifying the barriers that exist when seeking mental health support. For example, Maria asserted, “[I] think that everyone should have access to therapy. And so [I] think talking about the fact that like, [I’m] putting in all this work. And yeah, [I] still don’t have a therapist and like [I’ve] needed one.”

This category was primarily represented through four subcategories: 1) Financial Difficulty, 2) Practitioner Specialties and Representation, 3) Waiting Lists and Lack of Availability, and 4) Location and Distance Issues. These themes emerged in response to questions about the therapy search process.

Financial Difficulty

Nine participants (60%) explicitly named the ways in which financial difficulties made it difficult to pursue therapy. For Maria, the high cost of therapy in the United States led her to try an alternative option:

Like I even, like, I flew back to my home country like I flew back to Peru, because therapy there was cheaper, which to me is like the wildest thing because like I flew to another country, right? To track a therapist in another country, because that would have been cheaper than having access to a therapist here.

For many participants, insurance coverage determined their ability to seek therapy. For those who had insurance coverage, access was a little easier. However, for others, lack of insurance was a barrier to seeking therapy. For example, on the one hand, S stated:

I feel like I have a lot of anxiety about money, even though I know, in reality, I'm in a financially stable place. But, so I think that made it kind of difficult trying to search for therapists because I was like, I used to have very good health insurance for my mom's employer and due to a lot of, changes in, government regulations and like just companies becoming, like cutting a lot of benefits so they stopped offering that plan.

On the other hand, good insurance coverage facilitated Sidney's mental health support-seeking process. They stated, "When [I] got on insurance, [I] was like [I] need to find a therapist and research for psychiatry. And since it was all included and free with [my] fellowship, [I] was immediately doing it." Through these narratives, it was clear that financial resources and insurance coverage were influential factors in participants' therapy-seeking process.

Practitioner Specialties and Representation

When discussing their search for a therapist, a common narrative that occurred was that participants experienced difficulty in finding a practitioner who shared one or more of their salient identities. Six participants (40%) expressed this sentiment. For example, Adriana stated:

I was trying to look at people who had like not-White-sounding names to find a Person of Color. Also, women only. But at a certain point, you gotta expand your taste, because there's not a lot of diverse, like therapists.

Cloudy echoed this statement, adding:

There are not many other options still, to have a therapist that better represents my identity. At least, like, within the therapists that are available. And it makes me think about, like, how therapy in many ways is still inherently like, formed on a White institution.

Additionally, participants expressed that along with representation, it was helpful to have practitioners list if they specialized in sexual orientation or race issues. Jay stated that, “there are not a lot of providers who look like me or who are well-versed in these topics.” Similarly, LaNya explained that this was a “barrier”, because, “there's not many people that typically specialize in People of Color, Black people and QTPOC individuals.” During the search process, if these participants were not able to find practitioners who specialized in these areas or practitioners who represented their identities, they noted it as a barrier to accessing therapy.

Waiting Lists and Lack of Availability

Six participants (40%) expressed how waiting lists and lack of practitioner availability made it difficult to even begin therapy. When reaching out to a therapist of her choice, Sofia experienced the following:

I emailed her, and she was like “Oh, my books are full, but like, let me know your availability and if I have an opening like, I’ll like, send you an email.” And there was nothing, I guess she either had no availability or she forgot.

Similarly, Jay pointed to the lack of availability of therapists on university campuses:

You know there's some, there's some therapists on campus, but it's, what we have right now it's very, [I] believe there's like six or seven counselors for over, like 14,000 students, it doesn't. You go, try to go to the University Counseling Center and get put on a waiting list for months, so if you have any issue it's not really addressed by them. For AR, who was still seeing a therapist at the time of the interview, availability was still an issue:

She seems to have like, increasingly limited availability, which kind of sucks. And so sometimes I won't even be able to get an appointment until like, a couple of weeks out, when I'm trying to do therapy, like, consistently every week, um, so that that kind of sucks. But again like, I don't think it's like her fault. It's just like, kind of the reality of it.

Thus, for these participants, even when they found a therapist they liked, or were currently in therapy, the practitioner's lack of availability made it hard to begin or continue services.

Location and Distance Issues

Three participants (20%) pointed out how location limits their ability to see therapists. LaNya stated:

And also, it's not accessible for people that like, don't have cars and stuff because of being in like a college town. And so there's these "services" quote, unquote, but they aren't, who are they actually serving? Is my question.

Sidney expressed similar sentiments:

There was [sic] like three people I would say like, in-network that I could have sought therapy services with that specialize in LGBT issues, and they were all in [a neighboring town]. My school was like an hour and a half away.

Distance clearly served as a barrier in being able to seek therapy, whether the therapist was in the same town as the participant, or a neighboring one. Without reliable transportation services, accessing therapy can be impossible, especially if telehealth services are not an option.

Overall, participants identified how these barriers prevented them from seeking therapy or made the therapy-seeking process much more difficult due to these barriers.

Significance of Shared Identity with the Therapist

Thirteen (86.7%) out of the 15 participant narratives pointed to the significance of a shared identity with the therapist. For example, Michaella stated:

I would like somebody that can identify with a minority group, because I feel like a lot of my issues stem from relations with, you know, within my minority group so I think that that's like an important perspective that I would like to share with that person.

This sentiment was expressed primarily through two subcategories: 1) Desire to See Therapist with a Shared Identity, and 2) Shared Identity with Therapist as an Experienced Benefit. These subcategories came from responses to questions about an ideal therapist and positive experiences in therapy.

Desire to See a Therapist with a Shared Identity

Twelve participants (80%) expressed that they would like to see therapist with a shared identity, whether they had prior therapy experience or not. For example, Sofia stated:

And so, it was a matter of, I wanted it to be a woman, and I preferred that it would be, like a Woman of Color, but um . . . the woman that I really wanted she was fully booked, so I ended up with this White lady, who was really sweet.

This theme was often expressed in consideration of either the participant's racial identity or queer identity. Some participants expressed that they "*can't imagine*" having therapists who

have “both” of their identities, or similarly, someone who is “versed in every single topic”.

Cloudy explained the reason for wanting a therapist with a shared identity when they said:

If I could find any therapist I wanted, I’d probably want one that better understands, like, the Southeast Asian identity. And, like, also just like diaspora. So like, sometimes speaking from a native Southeast Asian person, it’s not necessarily reflective of how, like, I feel because of being part of the diaspora. And also just really, because, one, they’re part of the culture you, it’s like a better way, from direct experience, to understand what traditions were in place and how those traditions and cultural expectations affected me.

Similarly, other expressed that therapists with a shared identity would inherently “understand” their lived experiences. Thus, this subcategory emphasizes participants’ hopes and reasonings for seeing someone with a shared identity.

Shared Identity with Therapist as an Experienced Benefit

For many participants, having at least one shared identity (whether that was a shared sexual orientation or racial identity) made therapy a better experience for them, either by way of increasing understanding between them or by helping the participant feel “seen” by the therapist. For example, Hana stated:

I also felt like there were times I would talk about things and she was like “Yeah, that’s definitely like an Asian family thing.” And that’s an example of something where she got that automatically, um, as opposed to someone who may not be as familiar with that.

S explained how having a therapist with a shared racial identity facilitated their comfort, especially in comparison to previous therapists they had seen. S said:

I feel like there's certain things I'm a little more comfortable to say [with the current therapist] . . . for instance, if I was expressing [that] I was in a lot of spaces surrounded by like, White people and feeling like they're taking up a lot of space or not really being like, self-reflective or being like, I guess racist I would feel more hesitation to even bring it up with the previous therapists.

Sunshine felt similarly:

So, for my individual therapist, the intake process was pretty, like, it was smooth, in that, because my therapist is trans. So I was really lucky in like, all the ways, like I had never had a trans therapist before. I had never had a queer therapist before. Like, that was really amazing, so they were really good with everything, so that went beautifully.

These participants had an actual experience with a therapist of shared identity and noted how this facilitated greater comfort in the therapy room. Whether it be through a desire for a therapist who fits this criterion, or an actual experience, a large majority of our participants felt strongly about the importance of a therapist with a shared identity.

Hesitation with Therapy/Therapists Because of a Marginalized Identity

Twelve participants (80%) expressed feeling hesitant discussing one or both of their marginalized identities due to a fear of how the therapist might react, or whether the therapist would have the ability to properly navigate their different identities. For LaNya, this hesitation kept them from even trying therapy:

I definitely have a lot of hesitation with trying therapy. Every single, like, like every two to three months, I try to build up the courage to like, reach out and like contact somebody or figure out who would be best suited for me. Because I know it's important, it would be really beneficial to me to have that in my life and to be able to access that. But also,

sometimes it's a very scary thing, and I am uncomfortable with just sitting down with somebody that I don't totally trust or know, or that might not understand my identity and who I am as a person.

This category was more commonly expressed through two subcategories: 1) Hesitation Because of their Own BIPOC identity, and 2) Hesitation Because of their Own Sexual Orientation.

Hesitation Because of their Own BIPOC Identity

Ten participants (66.7%) expressed hesitation with their therapists because of their own BIPOC identity. Specifically, these participants were worried about their White therapists' reactions to issues related to race. For example, Sidney stated:

I didn't even, bring up race stuff just because, I was thinking, okay, I want to talk about this, the systems of oppression and I'm doing this to this White therapist. And what if she doesn't understand, what if she, herself gets defensive?

Similarly, AR was worried about a “mixed-bag response” when bringing up issues with their White therapist:

I feel like I was, I felt less inclined to bring it up, or I was more hesitant to bring it up because . . . when you bring up being [a] Person of Color, like the issues tied to being a Person of Color, it's kind of a mixed bag response.

Overall, participants expressed hesitation where they were worried that a White therapist would not “*get*” the BIPOC experience or would react negatively when issues were brought up.

Hesitation Because of their Own Sexual Orientation

Six participants (40%) named hesitation about bringing up their sexual orientation in therapy. For some, because race is more visible, disclosing their sexuality was a concern. Maria named being hesitant about disclosing her queer identity for the following reason:

I've also heard experiences from some people, like, some of my, like, QTPOC friends who are, like, "No, like I just disclosed my identity and like all my therapist wanted to do is talk about that one identity" . . . to me that also is, like, emotional labor because it was like, now your therapist was asking you all these questions . . . I'm not your guidebook on like, bisexuality. So sometimes I hesitate with, like, disclosing that. And it makes me, like, get nervous about like, oh is my therapist actually going to understand like how important my bisexuality is?

Hana explained that the fluctuating nature of her sexuality makes it difficult to disclose that identity:

As opposed to my sexuality, which I think I'm way more guarded of and more, and more protective of . . . I never felt confident in saying, I am this in terms of sexuality. But I definitely had like, no issues of talking about you know, my gender identity or all the other things that I've just talked about because they seem like fact. Sexuality is the only thing that doesn't feel like a fact, it feels like my own opinion of myself that changes like, you know, year by year, month by month. So, it's a little difficult to not have that confidence behind it, which I think is why I'm a little bit more shaky.

Thus, participants who named hesitation based on any of their identities identified that this was a barrier for them to be able to talk about themselves and life experiences wholly.

Importance of Attending to Identity in Therapy

Eleven participants (73.3%) discussed the necessity and/or benefit of attending to sexual minority BIPOC identity in therapy. Even when participants' therapists did not share an identity with them, it was important for participants that their therapists at least validated, affirmed, and attended to those identities. For example, when discussing what his therapist did well, Jay stated:

He validated my experience. And actually, like sat there, listened to me and was an active listener like, wasn't responding to diagnose me, or like, you know, to speak on his opinion he was really like listening, um, especially when it came to like issues surrounding my immediate family members or my identity. How he just interacted. Yeah, that was very good.

This category was expressed through three subcategories, including: 1) Success in Attending to Identity, 2) Failure to Attend to Identity, and 3) A Need to Attend to Identity.

Success in Attending to Identity

All participants who had overall positive experiences with therapy had one thing in common—their identities were sufficiently attended to in therapy. Ten participants (66.7%) expressed how validation of their experiences and identities was beneficial in therapy. For Chris, despite identity not being the focus of therapy sessions, her therapist's validation of her identity as a sexual minority BIPOC woman facilitated her healing:

I've talked to my therapist about being, you know bisexual and Middle Eastern. She kind of talked to me about being, those things being, feeling secure in those things, being a steppingstone to feeling secure about other things as well . . . It made me feel really, really good that she was understanding, and . . . not judgmental and it made me feel like

. . . it's okay to be, it's okay to be bisexual and it's okay to be Middle Eastern . . . not everyone is going to penalize me or count me out for that.

Of importance, in Chris's case, she did not know her therapist's identities. Sunshine felt particularly validated by one of their therapists in this instance:

And I remember like one of the good moments that I had with her was when I was, I brought up something about race, she named her positionality very quickly. She was like "How does it feel to be talking to a White lady about this?" and that felt really, really good like, I think that that was my highlight, in my time with her.

For participants, just having their identities validated and attended to made the experience of therapy heartening. Furthermore, attending to identity was integral to having a positive overall experience in therapy.

Failure to Attend to Identity

On the other hand, when participants' identities were not attended to, they noted the impact of this. For example, Sunshine stated, "I don't think that it had anything, I'm pretty sure she didn't say anything racist, homophobic, but it was mainly like that lack of being attuned to the nuances of living as a queer person." Similarly, Celeste noted that her therapist could have done better by, "taking that next step, seeing how [my] identities played a role" in her life.

Overall, when these identities were ignored or neglected, participants were able to identify this as something that the therapist should have done.

A Need to Attend to Identity

Four participants (26.7%) named that they would like for identity to be attended to in the therapy room. For example, Maria stated:

And then like, also now, seeking therapy, like, looks different for me because now I want a therapist who, like, actually understands my identities, and not just like talk to me about my anxiety and depression, but like understand that like, okay, what if I'm not anxious or depressed, my identities don't go away.

Similarly, Sidney stated:

They don't have to completely match my identities, because I tick a lot of boxes, but I do want them to like, potentially like nod, you know, or like say yeah, they actually understand, kind of. They understand, instead of having a relationship with the therapist where they just stare at me with a blank face.

In this case, when participants were identifying what would be helpful in therapy, they named the importance of the therapist recognizing that their identities play a role in their lives. Regardless of whether identities were attended to or not, participants' narratives highlighted that this is significant in making therapy a better experience for them overall.

Experience with Negative Therapist Reactions

Six participants (40%) noted negative therapist reactions, ranging from therapist discomfort, to microaggressions, to explicit aggressions. Adriana noted the way that her therapist questioned her mother's form of affection for her:

Like I was telling her, "oh I hung out with my mom, and we hugged, and oh, she rubbed my back," . . . she was like really prying on it, like assuming like these different things, like "Oh like maybe something's going on you know like some of abuse" but I'm like, you can tell by the way I'm speaking, I'm very, like, level . . . and I was like, "Oh no, like that's my mom, you know, Brazilians, they're super affectionate like you hug and kiss everyone, like that's not weird." And I told her that and it was like she's very fixated, and

like questioning and I'm like dude, I'm like telling you right now, there's nothing weird about my mom giving me physical affection. And I feel like that was very much of a cultural thing.

Sunshine named how their therapist explicitly invalidated and avoided them:

When I requested her support to write a letter, like, proving that I was seeing her and that I have mental health concerns, she didn't believe me. So she, she avoided me and she pretty much, like, ghosted. So, she just didn't respond to any of my emails or phone calls, and after I tracked her down and like and I went in person and I finally ran into her and was able to ask her, she, she wrote on my letter that I, um, claimed to have had experienced depression. And that I believed to have this and that. So she used language that showed that she didn't believe me, which I can't help but, like, think that it was racialized, the reason that she . . . I feel like, like, nobody would tell a White girl that she's not depressed and when I went she was so insensitive.

After Celeste dealt with a discomfoting response from her therapist when discussing sex, it turned her away from bringing it up again:

[I said] something about my, my partner does this, we're trying to get to this . . . intimacy stuff, in some inkling of that. And her eyes just got big . . . I don't think it was malintention . . . But that, I think I got conscious and I was like okay, this is no longer a person I want to share these parts with.

These narratives indicate the ways in which therapists can cause their clients pain and/or discomfort through their reactions.

Perspective that Therapy is Ineffective or Harmful

Within this category, eight participants (53.3%) expressed feelings related to therapy's ineffectiveness and purpose. When discussing how helpful therapy ended up being for her, Sofia likened her experience to that of SAT tutoring:

It wasn't that the SAT tutor did anything for me. It was that, I was setting a time, setting time aside for it and actually working on it. So therapy, in my case, I don't think that my therapist helped me a ton? Like she did help me. But I think the act of me, setting aside an hour every week or every other week, to think about my mental health and to challenge my anxiety . . . the fact that I set time aside for that and was actively pursuing help in it, made my brain, like, recognize, I was just thinking more about it.

Similarly, Cloudy stated that they have, "never experienced effective therapy before. [I] didn't know what it was supposed to be. [I] just knew that it could help."

Some participants expressed a worry that therapy might be harmful, based on others' experiences or their own. For example, Sunshine's experience in group therapy affected her mental health:

I took a risk, and I did a group that wasn't racialized and identity based. So, it was just, like open to anybody, whether they were straight, whether they were, like, White or not. And then that was, honestly, like it was harmful. It was like, I can like, I can even say that it's not even that it didn't help me, but it harmed me.

Along the same lines, Celeste named that, "everyone who's marginalized can benefit from restorative ways of being . . . therapy can be a part of it, but [it can] also be really harmful." Finally, some participants explicitly named that they felt as though therapy, "was not made for [me]", but that they also did not have other resources to cope with their mental health.

Coping with Community

In response to questions about how they are coping with mental health outside of therapy, six participants (40%) named the role of community support in fostering positive mental health, including “chosen family” and “friends.” Some participants reported engaging in community work as a way to support their own mental health. For example, Jay stated:

I do a lot of community organizing and the jobs that I do help people. You know, it can be taxing. But like, it helps my spirit, I think, you know, to know that I'm doing something and that's helping other people.

For these participants, turning to the sexual minority BIPOC community provided a sense of support that they were not able to find otherwise, especially when it came to seeking mental health resources.

Unmet Need for Therapy

Finally, participants expressed a need for and desire to go to therapy, despite all of the barriers and negative experiences. Sunshine stated needing therapy because:

Outside of therapy . . . I struggle to find wellness. because of, academia and, I struggle to find a way to accommodate, or to implement wellness and, care, into my, daily, or, even, weekly or monthly, or, all the time life. I think that in academia there's like, no room or time or, it's not conducive to do any of that, so I really struggle with that.

Michaela stated that, without therapy, she felt like she was at a “*standstill*”, adding:

Like, I don't know. I do feel like I'm missing a lot of, like, internal growth toward, kind of, the, I guess like everybody has this ideal, mental, and physical state that they would like to be in. And I do feel like I'm in a standstill, because I definitely think that I'm at the point where it's like, if I want to, you know, have days where I don't feel so dark, or sort

out my family issues or like remove these negative . . . motivations in my life. Just all these things if I want to sort those out, that's not going to be done alone.

Participants not currently in therapy, regardless of whether they have tried therapy previously or not, named that they needed therapy but are unable to meet that need due to these barriers.

Additional Critical Findings

While analyzing the data, distinct narratives emerged for: 1) Asexual individuals 2) Black individuals, and 3) Trans and Nonbinary (TNB) individuals. The participants who identified with these specific groups singled out these identities throughout their interviews, even when being asked about being racial and sexual minority experiences broadly. Furthermore, the experiences that these participants reported were, in many ways, unique to those identities. This indicates that these groups have experiences that are distinct from those of the larger subgroup and emphasizes the need for increased education and training focused on working with clients who hold these particular identities.

Asexuality

All three asexual-identifying participants noted discomfort in addressing sexual identity in therapy. While S had a therapist who was attuned to the nuances of asexual identity, Cloudy felt that non-romantic bonds seemed to be a “really big concept” for their therapist. Furthermore, all three participants identified a need for therapists to be, in particular, more knowledgeable about asexuality and the ace spectrum specifically. For example, Hana stated:

I wish for mental health, um, people, you know, like, a therapist or whatever. This kind of goes in the, in the line of like, just kind of knowing basic things about the queer community but I feel like, none of them so far have been well versed in asexuality.

From these participants' narratives, not having a therapist who was educated on asexuality led them to avoid bringing up that part of their identity at all in therapy.

Black Identity

Black women participants named the difficulties that accompany the strong-black-woman archetype. As Michaella put it:

Black women are just like, always viewed as this strong pillar of society, that cares and nurtures everybody else, but that doesn't mean much for themselves. And so, and then we get like praise for that, and that's not necessarily healthy.

Similarly, when Celeste was talking about her experience with her partner, who was also a Black woman, she stated:

I was like "okay this is the person that I love and care about, who's dealing with a lot of these mental um, illnesses, has been having a lot of distress, but like being Black women or Black femme people in America, is hard and distressing so it's like, we got each other very well and knew about the same things, and were kind of coming into consciousness together, and learning a lot about, you know all these things. But when they would be upset over something that affected me too. I was like I don't know how to carry this, because we're just carrying it together and both hurting a lot.

Jay noted that, despite having experiences with practitioners of Color, "it's still like, a little bit [culturally different than] the Black experience". Specifically, non-Black Practitioners of Color can still perpetuate anti-Blackness and White Supremacy in ways that only further harm Black individuals.

Trans and Nonbinary Identity

Lastly, participants identifying with the TNB umbrella noted many experiences, both in therapy and out in the world, that related to instances of transphobia. For example, when detailing a “traumatizing experience” with a therapist specializing in LGBT clients, Sidney explained:

Then, at one point she started talking about bottom surgery, and she kind of like went on this rant of like, “Oh, a lot of trans women get like bottom surgery and it turns out really great. But like, for trans men, I just really don't like the options that are out there. It doesn't look good” and she went on this whole rant.

When discussing how their identities shape their view of mental health treatment, AR stated:

I think especially with like transgender folks, it's like, just inherently being transgender is already so much like emotional labor, you know? To like, claim that identity already signals like so much, you know, like, that you're, that you're probably going through something. Just because again, it's like, you know, it's, it can often be like a really physical, like thing and physical representation of that identity.

Our TNB participants highlighted the emotional toll of being TNB as a result of transphobia and cissexism. Furthermore, their experiences pointed to the ways in which therapists make harmful assumptions about TNB individuals.

Section 4: Discussion

Many studies have called attention to the distress and discrimination experienced by sexual minority BIPOC individuals (Ramirez & Galupo, 2019; Velez et al., 2017). In particular, these studies point to the long-term detrimental impact of discrimination on sexual minority BIPOC individuals (e.g., Sutter et al., 2017). However, no research has examined this group's coping mechanisms or rates of support-seeking. Considering the breadth of research on the poorer mental health of sexual minority BIPOC people, the findings of this study provide important research and clinical implications for therapists working with this group. Participants' narratives suggest that therapy can be ineffective—or even harmful—for sexual minority BIPOC individuals when identity, as well as the systems of oppression impacting identity, are not attended to in therapy.

Our participants' narratives are consistent with intersectionality (Crenshaw, 1989) and minority stress (Brooks, 1981; Meyer, 1995) frameworks. Participants framed their narratives through the lens of their multiple identities, which highlighted how racism and heteronormativity impact their experiences. These systems functioned as distal stressors affecting their well-being, and ultimately, their need for therapy. Furthermore, our results elucidated the fact that an intersectional framework is especially necessary to understand the nuanced experiences of asexual individuals, Black individuals, and TNB individuals.

The Therapy Seeking Process for Sexual Minority BIPOC: An Emerging Model

Based on the present study's findings and recurring themes of negative experiences in therapy, as well as the importance of identity, the authors developed an exploratory model (Figure 1) to delineate the therapy-seeking process for sexual minority BIPOC individuals. Note that this is an emerging model based on our preliminary analyses of the narratives provided by

our sample of 15 sexual minority BIPOC individuals. More research is needed to expand on and test this model. Previous research suggests that sexual minority BIPOC people experience elevated levels of distress (Ramirez & Galupo, 2019), and this, combined with our participants' narratives, indicates that there is a need for therapy and/or other forms of mental health support. Furthermore, our participants named how distal stressors, including racism and lack of acceptance by family, impacted their mental health.

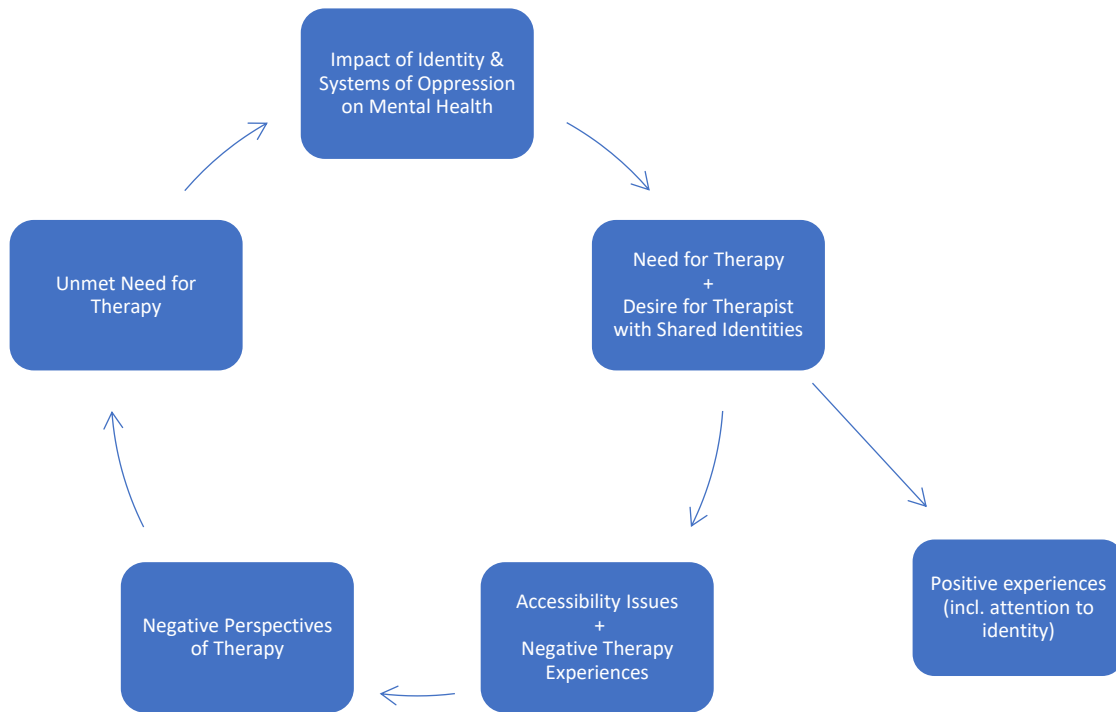


Figure 1. This is the emerging model of the therapy-seeking process for sexual minority BIPOC individuals

For many participants, this influenced their desire for a therapist with a shared identity, who would “understand” their experiences without requiring much explanation. Participants also named that these external experiences were reasons that therapists needed to attend to these specific aspects of identity in the therapy room.

However, many participants encountered issues with accessing therapy during their search process, including financial difficulties, lack of practitioner representation, and lack of availability. When participants had negative therapy experiences, or were not able to receive therapy, this led to negative perspectives of therapy. More specifically, participants expressed the view that therapy is ineffective and/or harmful. Ultimately, these participants’ therapy needs were unmet. On the other hand, for participants who had positive experiences, their needs for therapy were more effectively met, breaking out of this feedback loop. Furthermore, participants’ positive experiences were tied to whether their identities were adequately attended to by their therapist.

Research Implications

Since so few studies have examined BIPOC experiences through a grounded theory approach, this study shows how qualitative research can deepen our understanding of how BIPOC groups actually cope with both distal and proximal stressors. Many participants reported that cultural stigma made it difficult to address mental health and approach therapy, which is consistent with previous findings about mental health stigma among BIPOC communities (e.g., Ng, 1997; Amri & Bemak, 2012; Fripp & Carlson, 2017). However, it is important to contextualize this while understanding that many BIPOC individuals may worry about disclosing mental health problems to their peers since those communities normally provide a sense of safety for them as they experience racism (Krill Williston et al., 2019).

Additionally, as our participants also noted, their queer communities strongly encouraged mental health support, while their BIPOC communities did not. This created a sense of confusion when seeking mental health support—something that may be considered a *conflict in allegiances* (Morales, 1989). Both quantitative and mixed methods approaches can be useful in identifying what specific situations lead to such conflicts in allegiances for sexual minority BIPOC individuals, especially in relation to mental health.

For example, Sarno and colleagues' (2015) LGB culture and identity scale may be useful in quantitatively measuring this clash between cultural stigma and queer encouragement when sexual minority BIPOC people seek mental health support.

Additionally, our findings convey the hesitation felt by sexual minority BIPOC individuals when seeking therapy, both due to previous experiences but also due to fear of a negative therapist reaction. As previous research has also suggested, this anticipation can increase distress (Ouch & Moradi, 2019). Our participants' narratives are consistent with this, since the inability to disclose aspects of their lived experiences meant that their needs were not fully addressed, and that they had to cater to their therapists' reactions before their own feelings.

Practice Implications

Our participants' negative experiences with therapy result in an urge for therapists to return to issues of competence when working with sexual minority BIPOC clients. Various researchers have proposed guidelines for practitioners to work with sexual minority clients in order to make mental health treatment more fitting to their needs (e.g., Lytle et al., 2014; Hinrichs & Donaldson, 2017). Broadly, these guidelines focus on the effectiveness of affirmative psychotherapy and incorporating positive psychology into mental healthcare for sexual minority clients, and do not utilize an intersectional approach.

Furthermore, just as asexual people are often excluded from research about sexual minority BIPOC individuals, they are also forgotten in guidelines created for practitioners to better support sexual minorities. This was echoed by our asexual participants, who expressed a desire for therapists to better understand asexuality and the asexual spectrum. Steelman and Hertlein (2016) provide suggestions for addressing asexuality in couples' counseling, including normalizing asexual clients' experience and orientation. Beyond this, very few guidelines have been created to support this population in therapy. With the existing diagnosis of hypo-active sexual desire disorder, which is often conflated with asexuality, it is critical that therapists educate themselves on the experiences of asexual individuals.

Additionally, our trans and nonbinary participant experiences highlight that gender minorities have therapy needs that are unique from those of our cisgender participants. Guidelines for working with TNB individuals have largely addressed the need for trans-affirmative care (Austin & Craig, 2015; Edwards-Leeper et al., 2016) and have also emphasized incorporating case management and advocacy within psychotherapy work for TNB clients (Mizock & Lundquist, 2016). Psychotherapy for TNB sexual minority BIPOC individuals needs to address issues through the understanding that racism, cissexism, and heterosexism collectively impact their lived experiences. Considering the gatekeeping role that therapists often play in TNB individuals' access to hormone therapy and medical transition (Ashley, 2016), when clients name the distress that accompanies being under the trans umbrella, this must be closely attended to in therapy.

Similarly, there are proposed guidelines for understanding and working with racial and ethnic minorities, specifically at the individual level through practice (Miller et al., 2018). However, these guidelines do not consider the impact of both racism, heterosexism, and

cissexism on sexual minority BIPOC collectively. Our findings illustrate how systems of oppression continually impact sexual minority BIPOC people, and if not addressed adequately in the therapy room, therapist negligence can contribute to the trend of negative mental health outcomes for this group. Almost all of our participants named that their identities impact their mental health out in the real world. Some participants pointed out they did not even realize the full impact of their identities until later in life, and this provides insight into the way that therapists might be able to support their clients. It is important to note that, it is not the identities per se, but rather the systems of oppression operating against these identities that impact mental health. Thus, therapists can play a role by increasing sexual minority BIPOC clients' awareness of the systems around them, which is consistent with a Feminist therapy approach (Brown, 2018). Therapists can explicitly point out to clients that their experiences are shaped by these systems of oppression, rather than their marginalized identities. As a result, sexual minority BIPOC clients can avoid attributing negative experiences to a fault of their own.

Participants who had positive experiences with therapy explicitly noted that their identities were adequately attended to in therapy. To better attend to the needs and experiences of sexual minority BIPOC clients, therapists may first want to begin by creating an open space for clients to share and explore their identities. For currently licensed therapists—specifically, White, heterosexual cisgender therapists working with sexual minority BIPOC clients—it can be helpful to begin by naming positionality, which mirrors the suggestion made by Chang and Yoon (2011). By naming positionality, the therapist lets the client know that they are aware of their own experiences with privilege and oppression, which can make it easier for the client to name experiences of marginalization without worrying about the therapist's defensiveness or ignorance. For sexual minority BIPOC clients experiencing elevated distress around these

identities, therapists can focus on identity affirmation, which has been identified as a crucial element between minority stress and wellbeing for this group (Ghabrial & Andersen, 2021).

Furthermore, many of our participants named the importance of community, chosen family, and groups to get their needs met. Therapists can play a role in facilitating healing for sexual minority BIPOC individuals by beginning groups or holding spaces that are meant for this population in particular. In this realm, it would be important for the therapist leading these spaces to also identify as sexual minority and BIPOC. This would provide sexual minority BIPOC clients with a safe space to seek relief from everyday experiences of discrimination and prejudice. However, practitioner availability was also a significant barrier for clients. Virtual options, including web-based interventions, support groups, or workshops, can help to address this barrier. A web-based intervention may focus on alleviating minority stress experienced by sexual minority BIPOC individuals. Since our participants highlighted the importance of community in their lives, support groups and workshops can provide a space for them to meet others experiencing mental health struggles, without having to continually explain the impact of their identities. Note that the sentiment that our Black participants echoed about needing to be “strong” is something that is often reproduced in the therapeutic room, just as what happened with Sunshine’s experience in a group. Thus, even in groups, facilitators would have to be cognizant of anti-Black rhetoric that can make group an unsafe space for Black sexual minority individuals.

When participants discussed their desire for a shared identity with a therapist, a majority of them named their racial and sexual minority identities separately. This suggests that it is difficult enough for sexual minority BIPOC individuals to find someone with one of those identities, thereby making it feel impossible to have someone who would represent both of these

identities. For sexual minority BIPOC individuals who have not yet tried therapy or are not in therapy currently, the mere search for therapy is difficult due to lack of practitioner representation. Participants wanted practitioners with shared identities because they felt that their lived experiences would be inherently understood. Although recent research has emphasized multicultural competence over client-therapist “match” (Ertl et al., 2019), both competence and practitioner representation may be necessary in order to provide sexual minority BIPOC effective therapy services. If participants are hesitating to go to therapy because of lack of representation, either because of previous experiences with therapy or general experiences in society, then we are already doing a disservice to sexual minority BIPOC individuals by not increasing representation in the field. Thus, mental health practitioners must address the difficulty experienced by sexual minority BIPOC individuals in approaching therapy due to lack of representation.

Training Implications

Our findings imply a strong need to restructure clinical training programs to better support the needs of sexual minority BIPOC individuals. To begin addressing the lack of representation of sexual minority BIPOC therapists, it is first necessary for counseling and counseling psychology programs to begin recruiting more sexual minority BIPOC students. Programs can do this by highlighting the need and demand for therapists holding marginalized sociocultural identities. In relation to this, they also must provide more structural support for trainees identifying with these identities. This requires program directors to not only be educated about how sexual minority BIPOC people often face racism, homophobia, and heteronormativity collectivity, but also to be proactive about making sure that programs are a safe place for sexual minority BIPOC trainees. Singh and Chun (2010) suggest a Queer People of Color (QPOC)

Resilience-Based Model of Supervision, which highlights how to effectively train and support QPOC supervisors in training programs by harnessing their experiences with resilience in the face of oppression to be better equipped when working with supervisees. This model provides a framework for training sexual minority BIPOC students in a way that empowers them within their identities.

When training students, programs must also address the fact that that psychotherapy and conceptualization of mental well-being is based in White masculine norms (Liu et al., 2019; Dustrup, 2019). This is a way to attend to the feeling echoed by our participants that therapy was not effective or was not, “*made for [me]*.” Given this, the authors suggest that training programs highlight the ways in which therapy research was normed and founded on the experiences of heterosexual White people. For example, certain approaches, including relational cultural therapy (Comstock et al., 2011), feminist therapy (Brown, 2018), and multicultural psychotherapy (Comas-Díaz, 2014), move away from Eurocentric therapy frameworks that are typically covered in training programs. By centering these approaches and encouraging students to integrate these approaches with future clients, programs can help their trainees develop cultural humility. Cultural humility (Hook et al., 2014) highlights maintaining an interpersonal stance that emphasizes the cultural identities that are most important for the client. Cultural humility is an essential component of the multicultural orientation framework (Owen et al., 2011; Davis et al., 2018), which highlights how the client and therapist’s cultural worldviews and beliefs interact and influence the therapeutic relationship. Programs can encourage development of cultural humility by providing training on how to foster identity exploration with clients, which would allow clients to feel more comfortable when bringing up any sexuality or race-related issues. For example, one way of encouraging identity exploration is by giving clients

the opportunity to share the identities that are most salient for them and letting them know that this can be an ongoing conversation. This allows clients to know that they can share about their identities, but that they also have agency around what experiences will be most beneficial for them to share. It is imperative for students in training to be equipped with this understanding so that they are better able to approach conversations around identity and oppression once they begin seeing clients, especially sexual minority BIPOC clients.

Advocacy

Our participants noted a number of barriers to accessing therapy. In order to begin addressing the access issues highlighted by our participants, it is necessary to start by restructuring the ways in which we offer services. Many participants experienced financial difficulty, and this suggests a need for reducing the cost of services. Therapists in private practice may consider providing services at a reduced rate for sexual minority BIPOC individuals or working with clients' insurance companies so that financial burden is as low as possible for their clients. In addition, another way to ease financial burden for clients is to advocate for mandated healthcare coverage of mental health services. At the national level, counseling psychologists can work with health policy organizations to highlight the need for mental health care. However, for those who do not have access to health care, either through the government or their employer, this would not resolve the issue of financial difficulty.

We previously addressed ways to increase practitioner representation at the training level. At a systemic level, counseling psychologists can advocate for increased hiring of sexual minority BIPOC therapists at university counseling centers and community mental health programs, including at hospitals and substance abuse centers. At university counseling centers where availability for individual therapy is very limited, it is necessary to offer different types of

services for sexual minority BIPOC students. For example, these services could include offering groups specifically for sexual minority BIPOC students or working with the university's LGBTQIA+ office to offer a space for sexual minority BIPOC individuals.

For clients who are unable to access therapy due to location and/or distance, we urge therapists to consider one of multiple ways to increase accessibility. First, therapists can consider offering virtual services. At the time of writing this, the COVID-19 pandemic is still requiring people to work from home. This pandemic has emphasized our ability to provide services virtually, and this should be made possible in the future when things resume in-person as well. However, for individuals who do not have access to a computer or smartphone to receive services in this way, another option is to consider home-based therapy service. In home-based therapy (c.f., Musaeus & Brinkmann, 2011), the therapist goes to the home of the client to provide services. Although generally, community agencies provide such services, clinicians in private practice can also do so.

Limitations and Strengths

Our study had multiple limitations, specifically in terms of demographics. All of our participants were young and college-educated, which likely influences their experiences with accessing therapy, especially financially. Furthermore, our participants were limited to specific geographic locations, although they represented urban, suburban, and rural settings. An additional limitation within the demographic portion of our questionnaire was that we did not ask about ability and/or disability. Ableism is one of the many systems of oppression that might have had an impact on participants' mental health. However, since we did not explicitly ask about this, and participants did not bring it up on their own, we cannot draw any conclusions about how this may have influenced our participants' experiences with therapy, as well as any issues with

accessibility of therapy. Additionally, as we were aiming to highlight the experiences of sexual minority BIPOC individuals, we did not attend to or highlight the nuanced experiences of TNB individuals as we would have if this were focused solely on gender diverse BIPOC people.

Another limitation was that we did not have an equal ratio between participants who had tried therapy and participants who had not. Although our study aimed to get a better understanding of the experiences of sexual minority BIPOC individuals who have not yet tried therapy, we were not able to adequately capture those experiences in the ways we would have liked due to data collection being halted during the COVID-19 pandemic. While we did have sufficient data to understand the difficulties that arise when approaching therapy and what sexual minority BIPOC individuals might want from their therapists, it could have been beneficial to hear from more individuals about why they decided not to seek therapy. Future studies should explore why sexual minority BIPOC individuals choose not to go to therapy. Furthermore, as a grounded theory study with only 15 participants, our preliminary suggested model of the therapy seeking process for sexual minority BIPOC individuals should be tested by further research that includes participants from various geographical locations belonging to other age groups.

Nonetheless, our findings have also provided significant contributions. Our study is, at the time of this writing, the first of its kind in exploring the experiences of sexual minority BIPOC individuals seeking therapy. Our study centers the narratives of this group by highlighting actual experiences with interlocking systems of oppression, and challenges within the mental healthcare system. These findings provide important implications for working with sexual minority BIPOC individuals by emphasizing the flaws within the existing approach to therapy. Additionally, our study provides concrete directions for improving clinical training in order to better serve the needs of sexual minority BIPOC individuals.

Future Directions

The narratives of our participants' stress the ways in which their identities shape their lives and experiences in therapy. In order to test our proposed model, future research should begin by assessing experiences of sexual minority BIPOC individuals on a larger scale. This can be done through replication of this study, or through a web-based qualitative survey that assesses sexual minority BIPOC individuals' therapy experiences. Additionally, future research may focus on testing whether our proposed categories are endorsed by sexual minority BIPOC people more broadly.

Furthermore, since so many participants expressed a desire to see a therapist with a shared identity, future research can focus on sexual minority BIPOC individuals who have experiences with sexual minority BIPOC therapists. A mixed-methods approach would be able to assess satisfaction through quantitative measures and explore positive and negative experiences in the therapy room through open-ended responses. This would more concretely address the importance and impact of client-therapist identity match on therapeutic outcomes for this group.

Future studies can also center the ways that sexual minority BIPOC individuals cope with minority stress outside of therapy. Researchers using mixed methods may choose to measure levels of multiple minority stress (Balsam et al., 2011) and explore sexual minority BIPOC individuals' coping mechanisms outside of therapy. This would provide more insight into the ways that this group manages their mental health, especially if they do not have access to therapy. In addition, future research can focus on testing the efficacy of web-based interventions in supporting the mental health of sexual minority BIPOC individuals. This would be a way to directly provide more accessible services to this group, and also further research on their positive wellbeing.

Section 5: Conclusion

Our findings inform important directions for practice with sexual minority BIPOC individuals, including ways for practitioners to better connect with their clients and improve training for current counseling students to provide more sufficient services to this group. Our research shows the continued importance of conceptualizing the experiences of this group through intersectional and minority stress frameworks. The recommended suggestions for improving clinical work and training programs to accommodate the needs of this group are imperative in order to meet their goals for therapy. Future research should continue to explore the experiences of this group in therapy and in coping with their mental health. Moreover, online options should be expanded in order to increase accessibility of services to this group. Understanding the narratives of sexual minority BIPOC individuals allows researchers, clinicians, and advocates to take concrete action to improve the wellbeing of this group.

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Appendices

Table 1: Participant Demographics

Pseudonym	Age	State	Race/Ethnicity	Sexual Orientation	Gender
Sofia	20	California	Indian American	Queer	Female
Sunshine	22	Florida	Black, Afro-Latinx	Queer	Genderqueer
Maria	22	Florida	Indigenous, Latina	Bisexual	Cis Woman
Celeste	23	Virginia	Black	Queer	Woman
Sidney	25	California	Half-White, half-Black	Queer	Female, genderqueer
Chris	26	New Jersey	Middle Eastern	Bisexual	Female
Hana	23	California	Korean American	Asexual, Queer	Female
LaNya*	19	Florida	Black	Bisexual	Nonbinary
Skye*	29	Tennessee	Chinese	Homosexual	Male
Cloudy	19	Pennsylvania	Burmese Chinese	Asexual	Trans Masculine
Adriana	22	California	Half-Brazilian, half-Japanese	Queer	Woman
S	23	California	Chinese American	Asexual	Nonbinary
Jay	21	New York	Black	Queer	Genderqueer
AR	22	California	Half-White, half-Black	Queer	Transgender
Michaela*	22	Washington	Black	Bisexual	Woman

Participants with an asterisk () next to their pseudonym are those who have not tried therapy or other mental healthcare services.*

Brief Demographic Questionnaire and Interview Protocol

Interview Questions:

- 1) Demographic questions:
 - a. What is your age?
 - b. What is the State you currently reside in?
 - c. Is the place you live in urban, rural, suburban, metropolitan, or something else?
 - d. What is your socioeconomic status?
 - e. Are you a Person of Color?
 - f. What is your race and/or ethnicity?
 - g. What is the highest level of education you have received?
 - h. Do you identify as Asexual?
 - i. What is your primary sexual orientation? Any others?
 - j. Do you identify with the trans umbrella or have a transgender or transsexual history?
 - k. What is your primary gender identity? Any others?
 - l. What was your sex assigned at birth?
 - m. Do you identify as intersex?
 - n. How did you hear about this study?
 - o. What is your religious affiliation? To what extent does this play an important role in your life?
 - p. What are your political views?
- 2) Which of these identities do you feel are most salient for you in your day-to-day life? Whether it's how much you think about these identities, or how much they are brought up by other people?
- 3) What do you do for a living? Are you a student, do you work a job, etc? (Figuring out access/healthcare?)
- 4) What are your thoughts about mental health?
- 5) How important is mental health to you?
- 6) Have you ever tried therapy before?

If yes, then proceed with the following questions:

- 7) How long were you or have you been in therapy?
- 8) What kind of mental health provider did you work with?
- 9) How did you hear of this mental health provider?
- 10) What was the intake process like? Did any issues come up for you?
- 11) Why did you seek therapy? Would you say that it had anything to do with any of the identities you talked about earlier?
- 12) How did your initial meeting with your mental health provider go?
- 13) What do/did you feel like your mental health provider did well?
 - a. Specific examples – elaborate
- 14) Is/Was there anything that you feel like mental health provider did not do well?
 - a. Specific examples – elaborate
- 15) If you do not go to therapy anymore, what made you decide to stop going? Do you feel like you got what you wanted out of your sessions?

- 16) As a sexual minority person of color or indigenous person, how do your identities impact your view of mental health treatment?

If no, then proceed with the following questions:

- 7) What are your thoughts about trying therapy?
- 8) Do you have access to therapy or other mental health resources?
- 9) Why do you feel like you should or should not seek therapy? Does it have anything to do with any of the identities you talked about earlier?
- 10) What has prevented you from trying therapy?
- 11) What are some things that you would look for in a mental health provider (that you believe would make the relationship with your therapist better, or just make therapy an overall better experience for you?)
- 12) Are there mental health providers who you would not want to see? If so, why?
- 13) How is your mental health affected by not going to therapy, if at all?
- 14) As a sexual minority person of color or indigenous person, how do your identities impact your view of mental health treatment?

Overall follow-up questions:

- 1) How do you support your mental health outside of therapy?
- 2) How would you suggest that the field of counseling be improved, specifically, for people of color and indigenous people who identify as a sexual minority?
- 3) What would be your recommendations for mental health providers who work with sexual minority people of color and indigenous people?
- 4) Do you think there is anything else I should know about mental health as it relates to sexual minority people of color and indigenous people?
- 5) Do you have any questions for me?

Vita

Originally from California, Saumya Arora completed her undergraduate degree in psychology at the University of Minnesota, Twin Cities. She chose to attend the University of Tennessee, Knoxville to pursue a Doctor of Philosophy degree in Counseling Psychology. Her research interests include access to mental health services for LGBTQIA+ People of Color, South Asian mental health, and advocacy through research. She is incredibly grateful for all the support from her family as she pursues her degree.