

Applying a Black Queer Feminist Mental Health Framework to Explore the Experiences  
of Black Queer Women and Nonbinary People Living with Mental Distress

by

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## ABSTRACT

Black queer women and nonbinary people (BQWNB) living with mental distress are an important sub-group in the Black community in need of greater attention in mental health research. However, the majority of health research about the Black community focuses on Black cisgender men who have sex with men and people who have or are at risk of having HIV/AIDS. To expand the knowledge about BQWNB, I applied critical and transformative approaches to understand mental distress. Using a Black queer feminist mental health framework and transformative healing justice lens, this phenomenological qualitative study set out to explore and describe how BQWNB living with mental distress navigated their mental health and wellbeing with a sample of 17 participants. Data were collected using one-on-one audio-recorded semi-structured interviews. There were three major findings that emerged from participants' narratives: (1) contributors to mental distress, (2) impacts of mental distress, and (3) positive responses to mental distress. Contributors to mental distress included individual and collective trauma experiences, embodying strength and independence, and experiencing stereotypes about their sexual and multiracial identities. The impact of mental distress resulted in lowered quality of life and reported self-harmful thoughts and behaviors. Finally, positive responses to mental distress included body, mind, and spirit and community-centered responses as well as resistance to cultural norms and expectations and non-disclosure as a form of self-preservation. These findings led to an integrative (not) being-in-distress framework and a new critical approach to mental health and healing that informed anti-oppressive social work research, practice, and education.

## DEDICATION

I dedicate this work to:

My grandparents- Acie Lee George I and Mildred Chandler-Sumlin

My auntie- Bridget Collette Beed

My cousin and best friend- De'Zsanae Ratyse Zsanique Moses Beed

Rest well.

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## TABLE OF CONTENTS

	Page
LIST OF TABLES .....	viii
LIST OF FIGURES.....	ix
CHAPTER	
1 INTRODUCTION .....	1
Statement of the Problem.....	1
Prevalence of Mental Health Concerns in Black Communities .....	2
Theroetical Framework.....	2
Statement of Research .....	3
Importance to Anti-Oppressive Social Work .....	3
Recommendations for Anti-Oppressive Social Work .....	6
A Note on Terminology.....	8
Summary .....	10
2 BACKGROUND AND REVIEW OF THE LITERATURE.....	11
Theroetical Framework.....	11
BQFMH Framework.....	12
Background .....	22
Race/Ethnicity .....	22
Psychiatry and Anti-Black Sanism .....	25
Psychiatry and Anti-LGBTQ+ Discourse.....	27
Review of the Literature .....	29
Mental Distress.....	29

CHAPTER	Page
Multisystemic Interventions .....	41
Summary .....	51
3 METHODOLOGY .....	52
Research Question.....	52
Phenomenology .....	52
Post-Modern and Post-Structuralist Criticisms .....	53
Philosophical Foundations.....	54
Methods.....	59
Data Collection Procedures .....	60
Data Analysis .....	63
Ethical Issues and Considerations.....	65
Rigor in Qualitative Research.....	68
Summary .....	71
4 FINDINGS .....	73
Sample Description.....	73
Phenomonon Expansion: (Not) Being-in-Distress.....	76
Contributors to Mental Distress.....	76
Impacts of Mental Distress .....	87
Positive Responsnes to Mental Distress.....	89
Summary .....	99
An Intergative (Not) Being-in-Distress Framework.....	100

CHAPTER	Page
5 DISCUSSION .....	103
Contributors to Mental Distress .....	103
Impact of Mental Distress.....	105
Positive Responses to Mental Distress.....	106
Applying a Black Queer Feminist Mental Health Framework.....	109
Implications for Research .....	110
Implications for Anti-Oppressive Social Work Practice .....	114
Implications for Anti-Oppressive Social Work Education.....	118
Word of Caution for Anti-Oppressive Social Workers .....	120
Limitations and Strengths .....	120
Conclusion .....	123
REFERENCES .....	125
APPENDIX	
A CONSENT LETTER .....	140
B SEMI-STRUCTURED INTERVIEW GUIDE .....	143
C QUESTIONNAIRE.....	149
D QUESTIONNAIRE TERMINOLOGY SHEET .....	154
E SAMPLE MEMOS .....	157



## LIST OF TABLES

Table	Page
1. Participant Social Identities Information .....	74
2. Sample Characteristics.....	75

## LIST OF FIGURES

Figure	Page
1. Integrative (Not) Being-in-Distress Framework .....	102

# CHAPTER 1

## INTRODUCTION

### **Statement of the Problem**

Black queer women and nonbinary people (BQWNB) living with mental distress is an important sub-group in the Black community in need of greater attention in the field of mental health (Follins et al., 2016; National LGBT Health Education Center, 2019). According to the National LGBT Health Education Center (2019), helping professionals should understand the effect of structural discrimination on mental health, increasing their awareness of Black LGBTQ+ lived experiences including Black LGBTQ+ views and beliefs as individuals, cultural norms, community institutions, and the responses to mental distress (e.g., coping strategies), to promote mental wellbeing among members of this community. Follins et al. (2016) suggest that health equity research must center marginalized perspectives within Black LGBTQ+ experiences, stating that current research primarily looks at Black cisgender men who have sex with men and who have or are at risk for HIV/AIDS.

Considering these current limitations in research, I further problematize the field by highlighting the absence of critical and transformative approaches to mental health (Meerai et al., 2016; Morrow & Malcoe, 2017). Understanding mental health through a critical lens may consist of challenging “illness” and “disorder” paradigms by looking at mental health as both a social identity and system of oppression (Morrow & Malcoe, 2017; Morrow & Weisser, 2012), while also integrating transformative healing justice perspectives (see Destine, 2017; Green et al., 2018; Grills et al.,

2016). Thus, this study addresses these gaps in the literature by exploring mental distress among marginalized Black LGBTQ+ voices through a critical approach to mental health.

### **Prevalence of Mental Health Concerns in Black Communities**

To demonstrate the importance and pervasiveness of mental distress, I present national prevalence data. To my knowledge, there are no known national data specific to Black LGBTQ+ communities. I present prevalence rates of the larger Black community. In the U.S., approximately 16% (4.8 million) of Black people reported having mental distress over the past year (Substance Abuse and Mental Health Administration [SAMHSA], 2018). Black Americans are more likely to report feelings associated with mental distress such as sadness, hopelessness, and worthlessness compared to their white counterparts (Center for Disease and Control [CDC], 2019). While rates of mental distress are typically lower for Black people compared to other racial/ethnic groups in the U.S., there continues to be a steady increase in poor mental health outcomes (SAMHSA, 2018).

### **Theoretical Framework**

In this study, I created and applied a Black queer feminist mental health (BQFMH) framework as the guiding theoretical approach. Integrating major theoretical contributions from Black queer feminism (Bonsu, 2017; Carruthers, 2018; Sullivan, 2019) and mad studies (Meerai, 2016), BQFMH is a framework that aims for Black liberation by promoting transformation and healing among all Black people, with a particular focus on the most marginalized within Black communities. BQFMH also aims to transform and dismantle systems of oppression and institutions that further harm Black

people. To read more about this framework, please see chapter 2- background and review of the literature.

### **Statement of Research**

The purpose of this research is to explore and describe the experiences of BQWNB with mental distress. I aim to gain insights into these community members' experiences. To do this, the following research question was central to this study: How do BQWNB living with mental distress describe the experience of (not) being-in-distress?

### **Importance to Anti-Oppressive Social Work**

This study primarily has implications for social workers committed to anti-oppressive practice. One of the profession's core values is a commitment to social justice. In social work, social justice is the commitment to "pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people" and bring "sensitivity to and knowledge about oppression and cultural and ethnic diversity" (National Association for Social Workers [NASW], 2019, para 3) by addressing structural inequalities at the individual, interpersonal, community, and societal levels. More recently, social work has explicitly made efforts to acknowledge how the profession has historically contributed to the oppression of people of color—the people and communities it aims to help—despite the profession's commitment to social justice (NASW, 2021). Racist practices of the profession included the exclusion of Black people from attending social work programs and support for legislation that excluded Black people from receiving governmental assistance (NASW, 2021).

The renewed and urgent focus on racial equity and justice work in social work is due to the current sociopolitical context (NASW, 2021). Anti-Black and anti-

immigrant rhetoric during the Trump administration coupled with systematic killings of Black people by U.S. police officers, and the global COVID-19 pandemic have had a catastrophic impact on communities of color (see Gibbs et al., 2020; Moore, Jones-Eversley, et al., 2020). Since the COVID-19 pandemic and racial uprising of 2020, Black people and other people of color reported experiencing racist jokes and slurs and overall adverse experiences due to their racial/ethnic identities. Black people fear that they might be threatened or attacked by others and feared further discrimination due to others being suspicious of them while wearing masks to prevent the spread of COVID-19 (Pew Research Center, 2020). The Black community is also one of the most heavily impacted by the COVID-19 virus, experiencing higher rates of deaths in their families and communities (Gibbs et al., 2020; Moore, Jones-Eversley, et al., 2020; Novacek et al., 2020).

In addition, the killings of a number of Black people by police including George Floyd, Elijah McClain, Breonna Taylor, among others, was an added traumatic experience felt collectively in the Black community. This appears to have resulted in a massive outcry and support for the movements for Black lives on a global scale (e.g., Williams, 2020), also moving the field of social work to push for anti-racist work.

Social work has attempted to move the field towards social equity through cultural competency and efforts to increasing awareness about racial and social injustice.

According to the most recent updates to the National Association of Social Workers (NASW) Code of Ethics, cultural competency requires social workers to demonstrate:

... an understanding of culture and its function in human behavior and society....  
awareness and cultural humility by engage in critical self-reflection

(understanding their own bias and engaging in self-correction); recognizing clients as experts of their own culture...[and] obtain[ing] education about and demonstrate understanding of the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigrant status, mental or physical ability (Murray, 2021, p. 2).

As outlined, social justice and cultural competency highlight steps to enhance the professions' work with communities of color. However, these ethical standards and practices are not without limitations. First, while the commitment to anti-oppressive/anti-racist practice in social work is critical in advancing the profession and supporting the wellbeing of Black and other communities of color, continued work is needed to unpack the meaning of anti-oppressive/anti-racist work. For example, social work fails to explicitly acknowledge that not all Black people, especially those who are at the margins in Black communities, are represented equitably in anti-racist work. Women, people with disabilities, and LGBTQ+ members who experience a variety of social inequalities tied to discrimination are often invisible or disregarded in movements for Black lives (Barlow, 2018; Crenshaw et al., 2015; Destine, 2019). Instead, anti-racist work essentializes the experiences of Black cisgender heterosexual men and police brutality as the core of the work needed for Black liberation (see Barlow, 2018; Destine, 2019). The tendency to focus on Black men is not new. This has historically been the theme of past racial justice movements where women and LGBTQ+ people were at the front of social change efforts yet their concerns were often ignored, excluded or sidelined (Crenshaw et al., 2015; Destine, 2019). To ensure that social workers do not reproduce

and continue to erase and marginalize women, LGBTQ+ people, those with disabilities, mental health concerns, or other social identities, anti-oppressive social workers must look at how racism is interconnected with other systems of oppression (e.g., sexism, heterosexism, sanism) while also teasing out the nuanced nature of anti-oppression such as anti-racist, anti-heterosexist, anti-sanist and other practices.

Second, Jackson and Samuels (2019) note that the use of cultural competency is flawed for several reasons. Competency assumes that a person can develop proficiency in another's cultural identity and experience, lacks recognition of the uniqueness of people with multiracial experience, "centers whiteness as the dominate norm and cultural ideal of personhood against which all other groups are racialized and decentered as 'different' or 'diverse,'" does not outline steps to negotiate prior knowledge of oppression when applied to practice with others, and prioritizes social workers as the expert while minimizing the clients voice and expertise in their personal experiences (p. 4). Instead, the social work profession should embrace a more relational approach to culture that centers sensitivity towards oppression, engagement in humility, building mutual relationships, and letting go of being the "expert."

### **Recommendations for Anti-Oppressive Social Work**

Considering social workers' priority on social justice, attention to culture, and the limitations of the current state of anti-racist work in social work, there are several ways the findings from this research on BQWNB with mental distress can inform anti-oppressive social work. First, the findings describe the experience of being-in-distress among BQWNB living with mental health concerns. This may help social workers gain increased awareness about the causes and impact of mental distress among members of



this community. Furthermore, the findings can inform how social workers engage and integrate perspectives that promote wellbeing among BQWNB with mental distress (i.e., not being-in-distress). Recently, scholars noted the significance of perspectives such as healing-centered and trauma-informed care as ways to support the mental health of Black communities (Barlow, 2018; Carruthers, 2018; Destine, 2019). Focusing on healing of trauma by using affirming approaches to mental health may help social work advance their anti-racist work which is needed to aid in the wellbeing of Black people. Centering healing of trauma may also signal to the profession to engage in ethnocultural non-traditional medicines that may be important to some members of the community (see Meerai et al., 2016).

Second, the results from this study can help social workers identify ways to guide BQWNB with mental distress as individuals to navigate pathologizing and oppressive cultural and societal norms about their race/ethnicity, gender, sexuality, or mental health status to resist and/or redefine these norms to affirm their lived realities. Third, anti-oppressive efforts at the mezzo level may consist of intervening in Black, LGBTQ+, and/or mental health communities. Anti-oppressive/anti-racist social work may involve challenging anti-Black racism, anti-LGBTQ+, and sanist prejudice and discrimination within these settings. This might include aiding in the development of counterpaces/safe spaces that support people who are oppressed, educating others about the negative impact of oppressive discourses, and help challenge norms and stereotypes held within these communities about Black, LGBTQ+, and/or people living with mental distress.

Fourth, macro level practice through education, training, and holding service providers accountable is needed in the anti-oppressive/anti-racist social work. This may

involve U.S. medical health care, mental health care, and criminal justice systems to intentionally integrating anti-oppressive, anti-racist, anti-heterosexist, anti-cissexist, and anti-sanist language into their policies and practices. Finally, the results from this study also support engaging progressive critical perspectives to better capture the experiences of people from marginalized communities. This may include use of body and sex positive, mad studies and psychiatric survivor research, and holistic health perspectives that move the field forward to engage other perspectives that intersect with Black radical traditions.

### **A Note on Terminology**

Below I defined the key terms used to describe race/ethnicity, gender and sexual identities, and mental health status.

#### ***Race/Ethnicity***

In this study, *Black* denotes people who identify at least one of their identities as Black or who are from African ancestry. This is inclusive of not only African Americans, but also mixed-race, Afro-Latina/x/o, and others who are a part of the African diaspora. In addition, when referencing racial identity, I capitalize “B” in “Black” while leaving the “w” in “white” in lower case. The use of this technique is to point out and counter the unequal power balance between white and Black racial groups.

#### ***Gender and Sexual Identities***

To describe sexual and gender identities, I use the term queer and the acronym LGBTQ+ (lesbian, gay, bisexual, transgender, and queer+) interchangeably to refer to the sexual and gender identities of the study participants. A “+” is added at the end of LGBTQ to denote other expansive sexual and gender identities that are not captured by

the acronym including intersex, asexual, and two-spirit. I use the term *nonbinary* to describe gender identities that do not align with either man or woman and may include genderqueer, genderfluid, and other gender expansive identities.

### ***Mental Health Status***

Third, I use *mental distress* to disrupt *illness* and *disorder* paradigms and to describe people who are or are perceived to have mental health challenges or diverse mental and emotional states in a more affirming way. In the current study, not all participants aligned with medicalized understandings of mental health or had formal diagnoses. Thus, mental distress includes mad, psychiatric disabilities, consumers, survivors of psychiatric abuse, those who have mental health challenges but do not use institutional mental health care support, and people who identify themselves as having mental illnesses and disorders. I also used the terms *mental health concerns* and *mental health challenges* interchangeably with mental distress as alternative affirming terms to describe issues pertaining to mental health. The instances I use mental illness or disorder are to point out the biomedical nature of an article or to make a point to illustrate the pervasiveness of the illness/disorder paradigm. The term *mental health status* is used to indicate the social identity of people who have or are perceived to have mental distress and the larger mental health system that are imposed onto people with mental distress. It is used in conjunction with other categories such as race, gender, and sexuality. *Sanism*—the systemic discrimination and oppression of people with mental distress—is used to point out structural discrimination, similar to other systems of oppression (e.g., racism, heterosexism). Finally, the term *mental health* is used in an inclusive way to situate the writing in conversation with the larger field of mental health studies.

## **Summary**

This chapter introduced the need for critical approaches to mental health in social work research. A BQFMH theoretical framework was applied to describe how BQWNB living with mental distress experience (not) being-in-distress. The findings in this study may provide insights to advancing anti-oppressive/anti-racist social work practice with BQWNB living with mental distress at the micro, mezzo, and macro levels. In the next chapter, I will review the guiding theoretical framework then transition into describing the socio-historical contexts that shaped the social construction of race/ethnicity, gender, sexuality, and mental health status. I then move into a review of key literature relevant to mental distress for Black, LGBTQ+, and/or people of color. I conclude with a description of multisystemic interventions to alleviate mental health challenges.

## CHAPTER 2

### BACKGROUND AND REVIEW OF THE LITERATURE

I begin chapter 2 with an overview of the Black queer feminist mental health (BQFMH) framework that guided the study. Next, I move into the socio-historical context of race/ethnicity, gender, sexuality, and mental health status, followed by a review of significant concepts that provide context into the research phenomenon (not) being-in-distress.

#### **Theoretical Framework**

The purpose of this study is to explore and describe the experiences of BQWNB living with mental distress. I aim to gain insights from members of this particular community, whose voices remain ignored in social work. The articulation of new frameworks can help guide anti-oppressive efforts to dismantle anti-Black racism, anti-LGBTQ+, and sanist discrimination within their relationships and in U.S. community institutions. For this research, I made use of critical perspectives that describe concepts that guide my thinking about mental distress. These concepts are the foundation of my synthesized theoretical approach which I call Black queer feminist mental health (BQFMH) framework.

Below, I describe and outline my BQFMH framework with reference to Black queer feminism—a critical lens that emphasizes liberation of all Black people, and mad studies—a critical approach prioritizing concepts central to people with or perceived to have mental health concerns (LeFrancis et al., 2013). Using theoretical pluralism to integrate these perspectives (Borden, 2015), I created a critical and culturally responsive approach to mental distress. That is, people who experience mental distress cross multiple

social categories and systems of oppression and are positioned in situations where their differences in social identities are felt. Through these differences, people living with mental distress can make-meaning of their realities (Voronka, 2016). This level of complexity among people with mental distress requires the use of several theoretical approaches and concepts.

### **BQFMH Framework**

BQFMH framework is a critical lens and liberatory approach that merges Black feminist, queer, and mad studies perspectives and aims to promote a transformative healing justice lens and the mental wellbeing for all Black people but with a focus on “...historically silenced and vulnerable groups within Black communities, including those that are queer, trans\*, femme, poor, disabled,...[and] undocumented...” (Bonsu, 2017, p. 214; also see Carruthers, 2018) and those living with mental distress (Meerai et al., 2016). This framework includes approaches to “thought, expression, and political action that critiques structures of racism, sexism, heterosexism, classism...” (Sullivan, 2019, para 1) and sanism (Meerai et al., 2016) by emphasizing the interconnectedness of oppression (see Sullivan, 2019) with the intention to eliminate social injustice and barriers to achieving optimum mental wellbeing. A BQFMH framework brings forth important social identities, systems of oppression, and responses that are erased or ignored.

Adhering to these overarching characteristics, I applied the following five Black queer feminist concepts in this study: (1) intersectionality, (2) controlling images and stereotypes, (3) self-definition and group empowerment, (4) outsider/within standpoints, and (5) healing justice. These concepts incorporate components from mad studies. “Mad”

is an umbrella term to denote people who identify themselves as consumers, ex-patients, mentally ill, disabled, Mad, and others with dehumanized emotional responses such as anger or aggression (LeFrançois et al., 2013; Pickens, 2019). Similar to the way *normativity* is used to describe beliefs about heterosexuality as “normal” while same-gender loving people are “abnormal,” mad studies critiques the idea that being without mental distress or “mentally sound” is the “normal” or preferred state and living with mental distress is deemed “abnormal.”

### ***Intersectionality***

While theories of multiplicity and the interconnectedness of oppressions trace back to Black feminist scholarship in the 1960s and 1970s (see Beale, 1968/2008; Combahee River Collective, 1977/2014), the term intersectionality was coined by critical race scholar Kimberlé Crenshaw (1989) and further developed across various academic disciplines. As an analytical framework, intersectionality interrogates systems of power, privilege, and structural oppression across constructs of race, gender, sexuality, class, nationality, ability, and other social categories that are interdependent and that cannot be examined separately (Bowleg, 2008; Collins & Bilge, 2016; Crenshaw, 1989). The core elements underlying intersectionality are: (1) social inequity, (2) power dynamics, (3) binary frameworks, (4) socio-historical contexts, (5) human complexity, and (6) social justice (Collins & Bilge, 2016). These considerations suggest that an intersectional approach shifts through micro (e.g., intrapersonal), mezzo (e.g., interpersonal) and macro (e.g., structural/cultural; also see Bronfenbrenner, 1977) understandings of power, privilege, and discrimination to grapple with the pervasiveness of interlocking systems of oppression to promote social equity and justice.

However, most existing intersectionality scholarship does not fully conceptualize mental health status as a social identity or system of power, privilege, and discrimination (see Holley & Thomas, 2017, for an exception). Therefore, I integrate the concepts *sanism* and *anti-Black sanism* into the BQFMH framework. Sanism refers to discrimination of people who have or are perceived to have mental health concerns (see LeBlanc & Kinsella, 2016) while anti-Black sanism recognizes social injustice and medical abuses that historically discriminate against Black people in mental health care and other institutions and critiques the centrality of whiteness in issues of mental health and wellbeing (Meerai et al., 2016). Rather than looking at mental health as a pathology in the individual or as a single-axis issue, mental health-based discrimination is understood as a systemic problem that is interconnected with other forms of discrimination (LeBlac & Kinsella, 2016; LeFrancois et al., 2013). Sanism and anti-Black sanism are reflected in relationships, community institutions, and psych-disciplines/helping professionals (e.g., psychiatrists, psychologists, social workers, and nurses; LeFrançois et al., 2013) where social transformation is needed to create equitable treatment of BQWNB living with mental distress.

An intersectionality lens allows me to critically analyze inequalities in accessing quality mental health care and other social services that support the mental health and wellbeing of Black LGBTQ+ communities experiencing mental distress. Many of these social inequities are observable in the living conditions of Black LGBTQ+ people at the structural, interpersonal, and institutional levels, which are core elements of intersectional analysis. That is, systemic power and oppression based on race, gender, sexuality, and mental health status occur across institutions such as family, friendships, and romantic



relationships as well as work, criminal justice, and mental health care settings. Another core aspect of intersectionality is attention to issues of equity, power, privilege, and oppression as part of a larger socio-historical context that has historically dehumanized Black LGBTQ+ women and nonbinary people experiencing mental distress. This historical dehumanizing treatment traces back to U.S. chattel slavery, anti-Black, anti-LGBTQ+, and sanist rhetoric in early pseudoscience. Thus, intersectionality from a BQFMH lens disrupts these oppressive power structures and moves towards transformation of social institutions, supporting liberation for Black LGBTQ+ people across not only issues of race, gender, and sexuality but also mental health status.

### *Controlling Images and Stereotypes*

BQFMH framework acknowledges controlling images as a mechanism that marginalizes Black LGBTQ+ women and nonbinary people experiencing mental distress. Expanding on the work of Black feminist sociologist Patricia Hill Collins (2004), I describe controlling images as dehumanizing stereotypes that are forms of gendered racist, heterosexist, cissexist, and sanist beliefs about Black LGBTQ+ women and nonbinary people's gender, sexuality, and mental health status. Some of the well-known gendered racist images of Black LGBTQ+ women and nonbinary personhoods include mammy, jezebel, matriarch, welfare queen, angry, and strong Black woman (Cohen, 1997; Collins, 2000), as well as those of Black queer masculinities such as bulldagger (Cohen, 1997) and stud (Lane-Steele, 2011). These controlling images hyper-sexualize and masculinize the gender and sexual expressions as well as demonize the emotional/mental expressions and vulnerabilities of BQWNB with mental distress.

Stereotypical images also perpetuate beauty standards that render BQWNB less attractive and undesirable. BQWNB with mental distress may respond to these controlling images through resisting the stereotypes, creating positive definitions of self, as well as denying and rejecting the images as forms of separation or personal growth (see Collins, 2000). Yet, dominant narratives of race, sexuality, and gender identity and expression continue to be amplified and reinforced through the internet and social media (e.g., Stanton et al., 2017).

More recently, Bailey and Mobley (2019) highlighted how ableism, racism, and sexism were interconnected in the construction of controlling images, delineating other layers of nuance. On one hand, Black people are constructed to be “hyper-able bodied,” and able to withstand physical and mental distress while on the other hand, are perceived as being less than human and psychologically inferior to white people. The constructions of Black strength and hyper-ability are perpetuated in stereotypes such as the “strong Black woman” trope, which frames Black women as strong, independent, and resistant to harm. Yet, these superhuman accounts of Black personhoods perpetuate ableism for those with physical and psychiatric disabilities (Bailey & Mobley, 2019, p. 22). Instead of using the term ableism, I prefer sanism in the BQFMH framework because it more adequately speaks to the nuanced form of ableism that is represented in controlling images that depict the mental or emotional responses of Black people as “hyper-able minded” such as the “strong Black woman” ideology.

### ***Self-Definition and Group Empowerment***

Another BQFMH framework concept is self-definition. Self-definition refers to the power dynamics involved in BQWNB with mental distress defining themselves for

themselves, replacing external negative stereotypes that are imposed onto them, and creating spaces that reflect these affirming images of Black personhood. These self-defining practices—controlling the narratives about their bodies and sexualities—are acts of resistance (Collins, 1989; 2000). The use of empowering definitions of self and community is an ongoing concern. There are several social institutions that are identified as safe and affirming spaces for Black women in which they are not perceived as the “other” including nuclear and extended families, church communities, and Black community organizations. However, some of the institutions deemed as safe are susceptible to anti-Blackness, sexism, cissexism, cisgenderism, heterosexism, and sanism that leave these spaces not to be safe or affirming or free from harm (Collins, 2000). In this study, self-definition and group empowerment will allow me to see how participants self-define, find safe and affirming spaces, and identify or describe spaces that are unsafe and disaffirming as it pertains to their mental distress and other social identities.

### *Outsider/Within Standpoints*

Furthermore, BQFMH framework posits that the othering of certain Black experiences such as BQWNB who live with mental distress are due to their outsider/within positionalities. Outsider/within standpoints highlight the ways Black people work within dominant communities and institutions as insiders—giving them unique perspectives on white privilege—while also suggesting that Black women are outsiders because they could not fully participate in dominant institutions due to their outsider status (Collins, 1990). For Black women, working within dominant communities and institutions may involve a level of non-acceptance of their

race/ethnicity and/or gender identities and a lack of power compared to white heterosexual men. In other words, Black women might work within dominant white institutions and be familiar with white cultural norms yet cannot fully participate in dominant white institutions due to unequal power and white privilege.

Hammonds (1994) advanced a critique of the outsider/within standpoint stating, "...[the] stance does not allow space for addressing questions of other outsiders..." (pp. 135-136). She emphasized that Black LGBTQ+ women's experiences were not fully articulated in the outsider/within standpoint as conceptualized in Collins's work. Hammonds argued that Black LGBTQ+ women were not only outsiders to dominant white groups due to their race/ethnic identity but are also outsiders in Black spaces due to their sexuality. Expanding on these queer criticisms, other Black, queer, trans, and feminist scholars support the centering of other outsiders including Black queer cis and transgender women, nonbinary people (Bey, 2016; Green & Bey, 2017), those living with mental distress (Bailey & Mobley, 2019; LeBlanc & Kinsella, 2016; LeFrancis et al., 2013; also see Schalk, 2018; Schalk & Kim, 2020) and ethnically diverse Black women's experiences across the Black diaspora (Norwood, 2013; Rivera-Rideau et al., 2017) to further challenge normativity in race/ethnicity, gender, sexuality, and mental health status. Black trans scholars Green and Bey (2017) advocated for a broader definition of woman to reflect not only cisgender experiences but also transgender, genderqueer, and other nonbinary genders. Black feminist thought that is inclusive of Black trans and nonbinary genders "give organized existence" to Black trans and nonbinary lived realities such as experiences with mental distress and other health-related issues, non-disclosure of their gender and sexual identities, and violence that is perpetrated against

Black trans people, mainly by cisgender men (Bey, 2016, p. 36). Understanding gender in an expansive way allows for a robust Black feminist account of gender that is inclusive of trans and nonbinary genders.

Other outsider/within standpoints and experiences include ethnically diverse Black women's experiences, particularly Afro-Latinx people who are also overlooked (Norwood, 2013; Rivera-Rideau et al., 2017). The experiences related to Black women across the African diaspora including those who immigrated from countries such as Brazil, Cuba, Puerto Rico, and the Caribbean, are not captured in U.S. Black feminist thought nor in Chicana/Latina feminisms (Rivera-Rideau et al., 2017). Afro-Latina experiences as Black women within Latinx communities are impacted by the same anti-Blackness that effects Black women globally. Considering this tension and lack of Afro-Latinx representation, incorporating their voices is important to deepen the theorizing of Blackness. Overall, these othered positionalities were common among participants experiences with mental distress who expressed similarities and differences across race/ethnicity, gender, sexuality, and mental health status as well as across varying social institutions.

### ***Healing Justice***

Popularized by Black queer and people of color socio-political organizing (e.g., Kindred Southern Healing Justice Collective, n.d.), healing justice is a core value in Black queer feminism that is both a movement and a practice (Carruthers, 2018). A healing-centered approach addresses the “collective harm and trauma” through survivor-led responses to oppression to prioritize the wellbeing of people of color and other marginalized communities (Kindred Southern Healing Justice Collective, n.d) and

disrupts systemic barriers such as anti-Black racism and sanism that prevent Black people from healing (see Black Live Matter, n.d.; Meerai et al., 2016). Practices that support the resilience, physical and mental wellbeing, and increase the strength of communities are central to a healing-centered approach. These practices are a response to various forms of traumatic experiences including violence and trauma that occur in interpersonal relationships and because of white supremacy, heteropatriarchy, and capitalism. Rather than a reliance on commonly ascribed medical and social ideas of wellbeing, healing justice supports community defined understandings of healing and coping with trauma and violence (Astraea Lesbian Foundation for Justice, 2019). Specific practices that are in alignment with a healing justice framework include (but are not limited to) breathwork, chanting, acupuncture, altar building, therapy from culturally responsive therapists, and other “ethnic healing practices” (Black Lives Matter, n.d.; Meerai, 2016, p. 25).

With healing justice, I can recognize the healing-centered responses of coping, survival, and healing from trauma, harm, and violence and as a mode of identifying structures and institutions that are not conducive to the healing of Black people. In addition, I extend healing justice to also center social and transformative responses to promote change in institutions that prevent or create barriers to Black people from accessing the resources they need to heal. Specifically, healing justice emphasizes the elimination of systemic barriers such as laws that exist at the local, state, and federal levels as well as policies and procedures at the institutional and organizational levels that perpetuate and/or condone systemic racism, sexism, sanism, and heteronormativity and prevent BQWNB from access to institutions and practices that aid in their healing and wellness.

In summary, there is a critical need to apply theoretical frameworks that reflect the complex personhoods of BQWNB living with mental distress. To do this, I applied a BQFMH framework composed of Black queer feminism and mad studies perspectives and propose the following five tenets to explore mental distress to promote social and transformative responses to mental health inequities:

1. Observe the interconnectedness of oppression as it relates to race/ethnicity, gender, sexuality, and mental health status while also recognizing the social constructions of these social identity categories and systems of oppression through observing the socio-historical contexts.
2. Interrogate controlling images that stereotype and dehumanize the mental or emotional diversity of BQWNB as a racialized, gendered, and sanist discourse.
3. Describe the (dis)affirming communities and spaces of BQWNB living with mental distress.
4. Center outsiders/within standpoints.
5. Observe the healing-centered responses to trauma, harm, and violence.

In synthesizing these tenets, I advance the BQFMH framework that positions BQWNB living with mental distress at the center of analysis, allowing me to grasp the themes relevant in the participants' lived realities as outlined in their narratives. In addition, the BQFMH framework centers individual-level (e.g., helping-professionals) and structural/institutional (e.g., improving mental health care system, engaging anti-sanist practices) social change efforts that dismantle systems that marginalize the experiences of BQWNB with mental distress. That is, this framework supports identifying ways to improve social workers practice with BQWNB with mental distress,

changing how institutions respond to the needs of this community, and incorporating anti-oppressive approaches into mental health care, medical care, criminal justice, and other social welfare systems that may hold racist, heterosexist, and/or sanist beliefs and policies that further harm members of the Black LGBTQ+ community. Ultimately, the aim is to advance anti-oppressive and culturally responsive practices that are supportive of the mental health and wellbeing of BQWNB with mental distress.

### **Background**

In this section, I trace the socio-historical contexts that are core to the identities of BQWNB with mental distress and are in alignment with the BQFMH framework. In doing so, key historical events and institutions are highlighted. These historical events include (but not limited to) chattel slavery, pseudoscience, and psychiatric institutions. These historical events and institutions are examples of how anti-Blackness, anti-queerness, sexism, and sanism have historical roots in U.S. social systems.

### **Race/Ethnicity**

Race is a socially constructed Western concept that establishes differences between white Europeans and other racial/ethnic groups and assigns inferior/superior status to these differences. Race historically functioned to mark differently colored and shaped bodies (Collins, 1990; hooks, 2015). white-Black racial differences included phenotype characteristics such as skin color (e.g., dark skin of African people and light skin of white people), hair texture (e.g., kinky-curly), and body mass (Collins, 1990). Consequently, physical variations allowed whites to obtain social and moral superiority over Blacks (Collins, 1990; hooks, 2015), as they were deemed inferior due to their differences. (In the past, groups that were racialized as inferior included groups that we



now see as white, such as people of Irish descent, but they became white over time; see Takaki, 2008.)

Early pseudo-science provided “evidence” that people of African descent were biologically and genetically different from whites (Gravlee, 2009; Stephens & Phillips, 2003). Early scientists examined the reproductive organs, skull size, and bone density of people of African descent to determine their difference. These early “scientific” practices were grounded in social Darwinism, or the belief that Black people were at the “lowest on the hierarchy of humans in terms of intelligence, health, civility, and basic reasoning,” suggesting that they were more animal-like than human (Krieger & Fee, 1996 as cited in Stephen & Phillips, 2003, p. 6).

These earlier anti-Black notions of inferiority were used to justify the enslavement of African people. Race provided white people with hegemonic power to rule over people of color (Collins, 2004; hooks, 2015), resulting in the economic abuse and exploitation of Black labor during chattel slavery (Collins, 1990; hooks, 2015). Black people were used for the economic gains of whites (Collins, 1990; hooks, 2015), where men were denied male privilege because of their Blackness and women were deemed less than white men due to their femaleness and Blackness. Because of this gendered racist discourse, Blacks were denied privileges such as the right to marry and vote—practices that allow people citizenship in Western societies (Collins, 1990). In the case of Black women, the construction of race and sexuality during early chattel slavery had negative implications on their value in the U.S.

### *Racialized Genders and Sexualities*

hooks (2015) stated that early Christian beliefs uniquely positioned Black women in an inferior position in society:

Christian mythology depicted women as the source of sin and evil; racist-sexist mythology simply designated black women the epitome of female evil and sinfulness....Like the biblical figure Eve, black women became the scapegoats for misogynist men and racist women who needed to see some groups of women as the embodiment of female evil. (p. 85)

Black women were depicted as immoral due to the darkness of their skin and described as evil and sinful due to their gender. While Christian mythology disrupted the moral positioning of Black women by depicting them as evil, pseudoscience disrupted Black women's sexuality. The treatment of Saartjie Baartman was one of the earliest examples of dehumanizing Black women's bodies and sexuality (Collins, 2000; hooks, 2015; Stephan & Phillips, 2003). Saartjie Baartman, a South African woman, was placed on display for public consumption during the early 19<sup>th</sup> century in Paris, France. Baartman was put in a show advertised as "the Hottentat Venus" where she was mostly nude. These shows allowed Europeans to observe and even poke/touch Baartman's body, particularly her buttocks. Upon her death and despite her refusal, zoologists Georges Cuvier and Henri de Blainville examined Saartjie's buttocks and reproductive organs (e.g., "breasts, vaginal canal, and placement of urethral opening") to understand the uniqueness of her body. Cuvier and de Blainville determined that Baartman's body, along with all women of African descent, were "primitive, wild, sexually uninhibited, and exotic" (Fausto-Sterling, 1995 as cited in Stephan & Phillips, 2003, p. 7).

During chattel slavery, Black women were viewed as an economic resource. The exploitation of Black women was not limited to physical labor or work as domestic workers but also included exploitation of their sexual reproductive system (Collins, 1990; hooks, 2015). Specifically, Black women were used to breed; meaning women were used to produce offspring that would in turn, produce more workers and were depicted as “mules” and “jezebels” to provide justification for using them as “animals” for agricultural profit and a rationale to justify systematic rape and breeding practices (Collins, 1990, p. 59).

The justification for the dehumanizing treatment of Black women lies in “controlling images created by white elites” (Collins, 1990, p. 57) to provoke fear in the Black community (hooks, 2015). These “controlling images” were a mechanism to demarcate Black women from whites while simultaneously placing them lowest in the social hierarchy. As a result, Black women were stripped of the ability to engage in self-defining practices (Collins, 1990). That is, controlling images along with the imposed definitions of Black womanhood were created by whites in Western societies (Collins, 1990; hooks, 2015).

### **Psychiatry and Anti-Black Sanism**

In the 18<sup>th</sup> and 19<sup>th</sup> centuries, the dominant belief about people of African descent was that they were immune to “mental illness.” Davis (2018) wrote:

From 1700 to 1840, enslaved blacks were described as immune to mental illness. John Galt, M.D., medical director at Eastern Lunatic Asylum in Williamsburg, Va., hypothesized that enslaved Africans were immune from the risk of mental illness because they did not own property, engage in commerce, or participate in

such civic affairs as voting or holding public office. The immunity hypothesis assumed that the risk of “lunacy” would be highest in those populations who were emotionally exposed to the stresses of profit making—principally wealthy white men. (p.1)

This narrative of Black mental health led to restrictions in the admission of enslaved Africans into local asylums. The priority for asylum admission was given to white people. In addition, slave owners were required to provide upfront payment for treatment but were often not open to make these payments. Furthermore, census data were used to compare freed Black people in the north to those in the south; because free Black people used asylums more frequently than those in the south, this led to the conclusion that freed Black people were more prone to mental illness. However, Davis (2018) notes that the drastic difference between usages from freed and enslaved Blacks was due to barriers set in place that kept those who were enslaved from receiving care that were not present in the north.

In 1851, pro-slavery medical physician Samuel Cartwright published a report entitled “Diseases and Physical Peculiarities of the Negro Race” (Cartwright, 1851/1967 as cited in Jackson, 2002). In this report, Cartwright claimed a “disease of the mind” called *drapetomania* was spreading across the Negro people. Drapetomania, a mental disease which led enslaved Black people to run away from their masters, was caused by two types of slave masters who placed their slaves at risk of developing drapetomania. First, slave owners who viewed their slaves humanly and had close relationships with their slaves, were likely to have slaves run away. Second, extremely harsh punishment and inhuman living environments also led slaves to run away from their masters. To

prevent slaves from running away, Cartwright suggested that owners provide less harsh living environments and stable living spaces (see Jackson, 2002).

Early pro-slavery and anti-Black sanist practices did not recognize the humanity of Black people. Rather, the mental health of whites was prioritized over that of Blacks who were often denied mental health care when mental health challenges were apparent. In addition, practices such as better treatment of enslaved Black people was used in support of sustaining their economic exploitation. However, there appeared to be limited acknowledgement about how unethical chattel slavery was during the 18<sup>th</sup> and 19<sup>th</sup> centuries. There was also a lack of recognition of how traumatic enslavement was on Black people including the separation of families and witnessing the harms done to other enslaved people. While these anti-Black discourses in psychiatry are harmful to Black people, other narratives such as anti-LGBTQ+ practices may compound negative consequences for Black LGBTQ+ people with mental distress.

### **Psychiatry and Anti-LGBTQ+ Discourse**

In psychiatry, LGBTQ+ identities were also deemed as “mental illnesses.” Up until the 1970’s, *homosexuality* was defined as a disease and mental disorder. LGB identities were believed to be caused by internal or external deficits. According to Drescher (2015) there were three theories that described same-sex attraction. Normal variation refers to theories that perceived same-sex attraction as a part of diverse sexual identities and sexualities. These theories were tied to the belief that LGB people were born with their sexual identities. Second, pathologizing theories perceived same-sex attraction and identities as a disease that evolved from issues with hormones, problematic parenting behaviors and sexual abuse (Drescher, 2010; 2015). Third, immaturity referred

to early psychosexual development theories that perceived same-sex attraction in adults as a sign of “stunted growth” (Drescher, 2010, p. 432).

When applying a critical race lens to psychology and their anti-LGBTQ+ discourses, Abdur-Rahman (2012) found that early psychologists perceived same-sex attraction as an illness of Black people. In the book, *Against the Closet: Black Political Longing and the Erotics of Race*, Abdur-Rahman analyzed the early works of psychoanalyst Sigmund Freud and physician Havelock Ellis to capture the ways “sexual inversion,” or homosexuality was constructed in early science. Abdur-Rahman found that the earlier works of Freud and Ellis alluded to sexual inversion as an illness pervasive among Black people. Specifically, Freud wrote, “Inversion is remarkably widespread among many savage and primitive races” (Freud, 1920 as cited in Abdur-Rahman, 2012, p. 13) while Ellis stated:

Looking at the phenomena generally, so far as they have been recorded among various lower races, we seem bound to recognize that there is a widespread natural instinct impelling men toward homosexual relationships....Inversion is extremely prevalent among the American negroes, far more prevalent among them than among the white people of any nation. (Ellis, 1915 as cited in Abdur-Rahman, 2012, p. 14)

While homosexuality was removed from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973, transgender and gender non-conforming identities are still considered mental disorders in the DSM-5. In 1952, gender variant mental disorder entered the DSM under the category of sexual deviation and was referred to as “transvestitism” and later updated to “transsexualism” (Drescher, 2014). In the past,

psychiatrists often confused gender identity with sexual orientation. The popularization of “sex reassignment” surgery brought debates about the origin of transgender identities. Some psychiatrists and health care professionals did not believe in gender affirming surgery. Instead, they perceived transgender identities as a “...severe neurotic or psychotic, delusional condition in need of psychotherapy and ‘reality testing’” (Drescher, 2014 p. 139). Today, transgender and gender non-conforming identities are defined as gender dysphoria. There are continued debates on whether gender identities should be part of the DSM-5. Arguments for keeping the diagnosis is for medical access to gender affirming surgery and medical care, although it is questionable whether psych-disciplines should have the right to determine whether someone can receive gender affirming surgery (Drescher, 2010; 2014).

### **Review of the Literature**

In the review of the literature, I prioritize research that centered the experiences of Black, LGBTQ+, people of color, and people with mental distress whenever possible. I begin with an overview of mental distress, followed by a review of multisystemic interventions that support mental health.

#### **Mental Distress**

In the context of critical mental health studies, scholars perceive mental health as a social phenomenon that balances the social and biomedical needs of people with mental health concerns. Specifically, there is a focus on racialized and gendered notions of mental health, social inequalities, the interconnectedness of social identities and systems of discrimination including race/ethnicity, gender, sexuality, class, mental health status, and anti-oppressive approaches to mental health recovery (Beresford, 2005;

Beresford et al., 2010; Meerai et al., 2016; Morrow & Weisser, 2012). There is also an emphasis on recovery models of mental health that do not pathologize mental distress but center peer-based support and lived experiences (Morrow & Weisser, 2012). While a social model does not fully reject biomedical responses to mental distress, there is opposition to a biomedical-centric model that includes biological theories of mental health concerns such as mental distress as problems in neurochemistry—dysfunction in neuronal communication in the brain—and genetics, or the belief that there is a “genetic mutation involved in the [mental] disorder” (Kendler, 2005 as cited in Schwartz & Corcoran, 2010, p. 76), or preferences towards hospitalization and psychotropic medications to suppress disrupting mood, emotion, or behavioral signifiers of mental distress (Morrow & Malcoe, 2017) without prioritizing social aspects that marginalized and pathologize people with mental distress.

Morrow and Weisser (2012) discussed mental distress from a stance that acknowledged the social, cultural, and historical factors that impede on the mental wellbeing of people living with mental distress. These factors reflect the practices of institutions that affect people differently based on their social locations. For BQWNB living with mental distress, these practices may include access to quality mental health care and other barriers to receiving support. Using qualitative methods, Ayalon and Alvidrez (2007) examined barriers to and facilitators of the use of mental health care among a sample of 31 Black mental health service users who were “seriously mentally ill” and found that psychosocial factors such as stigmatizing beliefs about “mental illness,” values about family confidentiality, and systemic factors (e.g., not treated as a



person; receiving inadequate services) were barriers to receiving mental health care (p. 1325).

In Black communities, people refer to and make meaning of their mental distress in different ways that may not align with an “illness” or “disorder” model. For instance, using a sample of 25 racially/ethnically diverse people diagnosed with “severe mental illnesses,” Carpenter-Song et al. (2010) explored the perceptions and experiences about mental illness and mental health care services and found that compared to white people, Black and Latinx people were more hesitant with apply professional biomedical understandings such as clinical/diagnostic labels to describe their mental distress. Rather, Black and Latinx people more closely aligned with a social perspective with the belief that mental health diagnosis should be shared only with trusted friends and family and that mental distress was caused by spiritual and other character-related factors such as “laziness.” Another study found that Black people may also be vague about the cause and onset of their “mental illness,” refer to their “mental illness” as being “sick,” and believe that their daily living concerns such as housing, food, and racial discrimination were greater than or equal to managing concerns around their mental distress (Alvidrez et al., 2008).

### ***Contributors to Mental Distress***

Critical mental health scholars suggest that the causes of mental distress might be tied to shared trauma, images and stereotypes, and erasure of diverse Black experiences that is deeply felt among marginalized people in Black communities (e.g., Meerai et al., 2016). In this section, I review literature pertaining to the causes of mental distress among BQWNB people living with mental health concerns.

**Trauma.** A contributor to mental distress that is relevant to the experiences of BQWNB living with mental distress is trauma. According to Barlow (2018), trauma is “an emotional response to a phenomenon or event” that may manifest in changes such as presence of headaches, nausea, changes in mood, behaviors, and “changes in activity that may be unpredictable” (p. 902). Barlow also indicated that there are distinctions in various types of trauma including individual and collective forms of trauma. Individual trauma are events or instances that are intentional or happen by accident (Barlow, 2018). According to SAMHSA (2014) individual traumas are single or multiple prolonged events including rape, physical attack, sexual assault, or illness. Survivors of individual trauma may not reveal their trauma to others and may not receive needed emotional or mental health support and experience a sense of isolation.

BQWNB living with mental distress may also have encountered trauma that is shared among their racial and/or LGBTQ+ community and can contribute to adverse mental health outcomes (Bartholomew et al., 2018; Kelly et al., 2020; Waldron, 2020). Collective trauma is characterized by group and community-wide traumatic events or experiences that can be historical and/or intergenerational in nature and are shared among a cultural group or ancestral and family lineage (see Barlow, 2018; Kelly et al., 2020; Mohatt et al., 2014), although collective trauma is not always historical or generational. Rather, collective trauma is simply a shared sense of trauma among a community of people (Mohatt et al., 2014). Common trauma that is collectively experienced in Black communities often are related to the shared history of chattel slavery and police brutality that has historically impacted their mental, physical, and economic wellbeing (see Bartholomew et al., 2018; Waldron, 2020). Waldron (2020)

argued that anti-Black police violence and the systematic killing of Black people is a structural problem that wounds and is deeply felt collectively among those in the Black community, deeming it a public health crisis. Other scholars and activists further speak to the violence perpetuated against Black women and LGBTQ+ people that is often ignored in current efforts to promote healing of collective trauma (Barlow, 2018; Bartholomew et al., 2018; Bunyasi & Smith, 2019).

Barlow (2018) and Bartholomew et al. (2018) suggested that examination of violence towards Black people often centers Black men with little to no recognition that Black women are affected by gendered racist violence. In a theoretical article focused on wellness issues among Black women, Bartholomew et al. (2018) set out to demonstrate a need to focus on the health and healing frameworks in movements for Black lives. The researchers determined that Black women experience several physical (i.e., heart disease, breast cancer) and mental health related concerns such as trauma exposure, resulting in poor outcomes that are not highlighted in current anti-Black racism work. Instead, Bartholomew et al. (2018) stresses the importance of healing justice frameworks to expand the issues addressed in Black Lives Matter movements.

In the context of the broader LGBTQ+ community, Kelly et al. (2020) conducted a qualitative study investigating the experiences of collective trauma among a sample of 80 queer people living in Portland, Oregon. The researchers found that collective trauma in LGBTQ+ communities consisted of external and internal forms of trauma. External trauma were traumatic experiences that were imposed onto LGBTQ+ communities including anti-LGBTQ+ violence such as hate crimes, hate speech, stereotyping, and prejudice, political violence including unequal protections for LGBTQ+ people,

discrimination in the health care system as well as inadequate care for HIV/AIDS, substance abuse and mental health needs, and heterosexism and cissexism in family and larger society. Internal trauma included trauma enacted within the LGBTQ+ community on their own members. Internal trauma in LGBTQ+ community included pressures to assimilate to the queer community, racism, cissexism, and interpersonal violence in LGBTQ+ relationships.

**Controlling Images/Stereotypes.** Since Collins (2000) coined the concept controlling images, scholars have sought to understand the concept's association with mental health outcomes (Abrams et al., 2014; Donovan & West, 2015; Flores et al., 2018). Jerald et al. (2017) conducted a quantitative study that examined the health consequences of awareness about stereotypes held by others among a sample of 609 Black women. The researchers determined that Black women who had an awareness that others held negative stereotypes about their “sexuality, dominance, and emotional resilience” had both direct and indirect effects associated with poorer overall wellbeing (p. 20). Black women who had an awareness of these stereotypes had poorer health, used more substances such as alcohol and drugs, and when mental health was impaired, Black women engaged less in self-care behaviors that were vital in sustaining their mental wellbeing (p. 494). Stereotypes also resulted in feelings of alienation from the LGBTQ+ community among bisexual women (Serpe et al., 2020).

The relationship between awareness of stereotypes and mental health outcomes is called stereotype threat (Jerald et al., 2017). Spencer and Colleagues (2016) defined stereotype threat as “...the situation in which there is a negative stereotype about a person's group, and [a person] is concerned about being judged or treated negatively on

the basis of [a] stereotype” (p. 416). Stereotypes that are made about a group of people place added pressure on people to perform successfully and might threaten a person’s sense of belonging in their community.

One of the most commonly explored controlling images/stereotypes in the current mental health literature is the strong Black woman (SBW) trope. The origins of the SBW trace back to the 1880s to 1914 during the “racial uplift movement.” Deriving from the work of W.E.B. Dubois, the primary aim of the racial uplift movement was to “defend the image and honor of black men and women” (Walker-Barnes, 2014, p. 95). In doing this, the concept of strength was adopted in efforts to push the Black community to respectable, moral, and self-regulatory behaviors (Walker-Barnes, 2014). Characteristics of SBW are rooted in strength, resiliency, independence, and an extreme ability to regulate or suppress their mental and emotional needs. In addition, those who ascribe to strength perform as if their “struggled and labored persistence and presentation of self [is] unaffected by human experiences of need or fatigue” (Beauboeuf-Laontant, 2007, p. 37). However, researchers found that embodying strength and independence has been associated with increased mental distress and a decrease in emotional support (Watson & Hunter, 2015; Watson-Singleton, 2017). For instance, Watson-Singleton (2017) explored the association between the SBW ideology and negative health outcomes among a sample of 158 African American women. The results revealed Black women who scored higher on a SBW scale also had less emotional support and higher levels of mental distress compared to those who had lower endorsements of the SBW ideology. In addition, perceived emotional support had a mediating affect between SBW and mental distress, suggesting that support is an important factor in the mental distress of Black women.

Racial and/or sexual identity stereotypes also may negatively impact BQWNB people living with mental distress. For instance, Flores et al. (2018) explored experiences of sexual objectification of transgender people of color ( $N=15$ ) and found that transgender people of color reported experiences of fetishization as well as racialized sexual stereotypes, particularly Black women, including the belief that Black women are promiscuous and hypersexual. Other sexualized identity beliefs that are placed on to bisexual women include the stereotype that bisexual women are hypersexual, not real, and are cheaters and disloyal to their partners (Brewster, & Moradi, 2010; Serpe et al., 2020). For example, Serpe et al. (2020) explored the sexual objectification of bisexual women ( $N=12$ ). The findings revealed that bisexual women experience discrimination and negative beliefs about their sexualities that were associated with increased psychological trauma and mental distress (Serpe et al., 2020).

**Multiracial and Mixed-Heritage Identities.** While issues of anti-Black racism in the larger communities including Black, LGBTQ+, and/or people with mental distress have received continued acknowledgement in social and racial justice work, less articulated are those from multiracial, mixed-heritage, and mixed-cultural backgrounds, particularly those whose social identities intersect with LGBTQ+ identities and mental distress. In a qualitative study that explored racial identity development among a sample of 10 multiracial people, Jackson (2012) found that multiracial people may embody their racial identity differently around their friends and family by shifting how they express their identities. Multiracial people may also experience the questioning of their racial/ethnic identity due to racial/ethnic ambiguity and might navigate one or more of their racial/ethnic communities as an outsider. These experiences of racial discrimination

due to multiracial identities was associated with higher rates of mental distress and other negative outcomes including negative affect like nervousness (Jackson et al., 2012).

### ***Impact of Mental Distress***

The impact of mental distress on the lived experiences of BQWNB with mental distress may include an overall lowered quality of life (Connell et al., 2012; Connell et al., 2014; Schalock et al., 2016; Yette & Ahern, 2018) and engagement in self-harm (Layland et al., 2020; Lytle et al., 2014). For example, Yette and Ahern (2018) conducted a quantitative study to investigate the association between health-based quality of life factors, race, and sexual orientation among a sample of Black and white women ( $N=154,995$ ). The researchers determined that overall, Black LGBTQ+ women with health-related concerns such as mental health, had lowered quality of life compared to Black heterosexual women, white LGBTQ+ women, and white heterosexual women. The impact of mental distress included poorer mental health and limited engagement in daily life activities. Quality of life, or “a multidimensional phenomenon composed of core domains that constitute personal well-being” (Schalock et al., 2016, p. 2), influences people living with mental distress in six life domains: (1) wellbeing, (2) sense of control of life, (3) perception of self, (4) sense of belonging, (5) engagement in life activities, and (6) sense of hope and hopelessness (Connell et al., 2012; also see Connell et al., 2014). Poor wellbeing was signified by experiences of psychosis or mania, fear, anxiety, worry, low energy, and increases in distress. Sense of control related to experiencing limits in finances, job opportunities, sense of independence, strength, and ability to manage mental health. A decrease in sense of self, internalization of stigma, and lowered

self-esteem were core to the life domain self-perception. Some may have issues with their sense of belonging, or ability to have good (i.e., loving, caring, affectionate) and supportive relationships. People with mental distress may lack a sense of being part of a community, experiences of stigmatizing beliefs (e.g., perceived as less than human) and feelings of isolation. Mental distress may also affect overall engagement in life activities such as doing tasks that are enjoyable and following a daily routine. Finally, lowered quality of life for people experiencing mental health challenges might include a sense of hopelessness or lowered sense of achievement.

Research on the impact of mental distress has found that Black LGBTQ+ people may not engage in practices that are supportive of their wellbeing and may use self-harmful behaviors as a response to their mental distress. In a quantitative study that examined self-harm, suicidality, and depression across different racial/ethnic groups among a sample of LGB and heterosexual people ( $N=89,199$ ), Lytle et al. (2014) found that overall, LGB people were more likely to report engagement in self-harm behaviors and experience depression compared to heterosexual people. Within the LGB community, Black and multiracial LGB emerging adults reported more suicide attempts compared to their Asian, Latinx, and non-Hispanic white counterparts (Lyle et al., 2014). Layland et al. (2020) tied higher rates of suicide attempts among Black and Latinx LGBTQ+ people to experiences of racist and heterosexist discrimination, determining that these members had 4.5 times higher odds of attempting suicide compared to white LGBTQ+ people who reported not experiencing discrimination.

### ***Responses to Mental Distress***

Researchers have acknowledged how violence, dehumanization, and collective



trauma are intergenerational phenomena that can be detrimental to the wellbeing of individuals and their communities (Bartholomew et al., 2018; Kelly et al., 2020; Waldron, 2020). The causes of mental distress may impact the overall sense of wellbeing, leading to several concerns including further depression, anxiety, poor social support, and sense of belonging, and experiences of racism, sexism, and sanism (Connell et al., 2014; Schalock et al., 2016; Yette & Ahern, 2018). The current social and political movements for Black lives recognize the ways relationships and community institutions that cause these harms and produce toxic and harmful environments for the most marginalized in Black spaces. As an effort to preserve and protect Black life, researchers and activists support healing and self-protective responses (Carruthers, 2018). In this section, I review positive responses to mental distress from a transformative healing justice lens. I discuss healing-centered approaches, acts of resistance, and non-disclosure of social identities for self-protection as a preservation practice.

**Healing-Centered Approaches.** The concept of healing of mental wounds is in alignment with the liberation of Black people (Bartholomew et al., 2018; Carruthers, 2018; Ginwright, 2015). Healing-centered approaches to mental distress refer to the ways people acknowledge and holistically (e.g., body, mind, spirit) respond to distressing life challenges with healing practices (Bartholomew et al., 2018). These healing-centered responses include micro and mezzo level practices such as seeking support, engaging in coping and self-care strategies, and centering holistic personal and collective recovery of Black people who are historically marginalized (Destine, 2019). Macro level change-making efforts are also part of a healing approach. That is, the focus of healing is on the dismantling of systems that harm and acknowledging the challenging social living

conditions Black communities navigate (Ginwright, 2015). Macro level healing can have a restorative impact on the social identities of people of color (Ginwright, 2018). In short, these healing-centered responses include personal practices, accessing resources from social support systems and/or institutions that provide mental health support, and other resources to alleviate social inequalities (Barlow, 2018; Bartholomew et al., 2018; Bowleg et al., 2004).

**Acts of Resistance.** BQWNB with mental distress must navigate the complexity of their intersecting identities and racist, heterosexist, cissexist, and sanist beliefs about their identities while also negotiating their support systems (Glass & Few, 2013; Moore, Camacho, et al., 2020). For example, Black lesbian couples and families may experience rejection in the larger Black community while their relationships are deemed “not real” (Glass & Few, 2013). Furthermore, Moore, Camacho, et al. (2020) conducted a study examining the identity negotiation strategies of Black and Latinx LGBTQ+ young adults ( $N=31$ ) as it pertained to their decision to use or not to use mental health care services. They found that participants’ racial/ethnic groups looked down on having a mental health concern and even perceived their LGBTQ+ identities as a “mental illness” (Moore, Camacho, et al., 2020, p. 30). Despite negative social and cultural norms about BQWNB with mental distress, members of this community engaged in acts of resistance to respond to unsupportive discourses about their social identities and narratives about mental health. Acts of resistances may include critically evaluating cultural and social norms of their identity groups, challenging and separating from those norms, integrating personal and affirming beliefs about mental health (Moore, Camacho, et al., 2020), and adopting positive self-defining practices and space such as creating

safety in their self-defined families (Glass & Few, 2013). Ultimately, resistance led to a greater sense of self-acceptance to counter negative cultural responses about mental health and a more favorable attitude towards seeking support for mental distress (Moore, Lopez, et al., 2020).

**Non-Disclosure and Self-Preservation.** Finally, some BQWNB with mental distress might engage in non-disclosure to preserve and protect themselves from negative outcomes of revealing one or more of their marginalized identities. BQWNB with mental distress may conceal their identities to gain external resources from their support systems (Selvidge, et al., 2008). Practicing non-disclosure of stigmatized identities (i.e., LGBTQ+ and mental health status) may be used to protect themselves against the impact of negative cultural and social norms (Moore, Camacho, et al., 2020). For example, Brooks (2016) explored how Black LGBT women stay-in their communities while navigating their sexual/gender identities. Using a sample of 23 Black LGBT women, Brooks found that for some Black LGBT women, blending into Black communities through aligning with social and political concerns and simply ignoring heterosexist beliefs was a way that Black lesbian and transgender women preserved their connection to their racial/ethnic communities.

### **Multisystemic Interventions**

BQWNB with mental distress may engage in responses to ensure optimal mental health. However, there are barriers to achieving positive mental health outcomes. Barriers to positive mental health for Black LGB young adults have been found to include feelings of shame about mental health and LGBTQ+ status, beliefs that their mental distress was not severe enough to necessitate seeking formal support (i.e., mental health treatment),

and cultural beliefs about the use of religious supports instead of professional mental health services (Moore, Lopez, et al., 2020).

In contrast to Moore, Lopez, et al. (2020) who prioritize and support the use of formal mental health care services, I do not prioritize institutionalized or formal responses to mental distress. Instead, I am guided by a transformative healing justice lens, which I understand to affirm all forms of coping, healing, and survival that does not further marginalize or impede on the wellbeing of others. Thus, in this section, I will describe multisystemic interventions designed to promote mental health equity and justice to dismantle barriers to receiving mental health support. I review four types of interventions that aim to decrease discrimination, increase knowledge, and provide positive and affirming support: (1) destigmatizing interventions, (2) mental health literacy, (3) peer support, and (4) culturally responsive and affirmative practice.

### ***Destigmatizing Interventions***

Destigmatizing interventions are efforts to reduce systemic discrimination (e.g., sanism) that create barriers to seeking support (Gulliver et al., 2012) and achieving optimal mental wellbeing. Specific types of messaging that are most beneficial in reducing mental health-related stigma are recovery-oriented (e.g., that people experiencing mental distress are living meaningful and hopeful lives), social inclusion or human rights focused (e.g., information about equality, disability justice, and/or problems with society and/or the environment), and that mental “disorders” are prevalent (e.g., mental distress is a common problem; Clement et al., 2010).

Advocating for multisystemic change occurs at the micro and macro levels. At the individual level, psychoeducation interventions are effective at decreasing sanist beliefs

and improving attitudes towards seeking support. Psychoeducational interventions consist of educating people about common signifiers of mental distress (Sharp et al., 2006) and the therapeutic process (Buckley et al., 2005; Sharp et al., 2006). In some cases, psychoeducational interventions use the people with lived experiences and similar cultural backgrounds to the intervention target community to encourage others to consider seeking support for their mental distress and to normalize the process (Buckley et al., 2005; Gulliver et al., 2012; Thornicroft et al., 2016).

Most of the information about destigmatizing interventions use a medical and person-centered (i.e., stigma) model to address mental health challenges among people living with mental distress. For instance, Alvidrez, Snowden, et al. (2009) conducted a study to evaluate the overall effectiveness of a psychoeducational mental health booklet in increasing mental health care service engagement and decreasing mental health stigma among a sample of 42 Black mental health care consumers. The intervention consisted of a booklet titled, “Getting Mental Health Treatment: Advice from People Who’ve Been There,” used to address mental health-based stigma. Three areas outlined within the booklet were (1) information before seeking mental health care, (2) challenges in receiving or staying in mental health care along with strategies to navigate the challenges, and (3) advice on how to make mental health care work for their needs. The researchers found that the booklet was effective at reducing stigma for people who had a greater need for and who were uncertain about receiving mental health care. While the intervention was found to reduce stigma, it is unclear whether taking a social justice approach that looks at sanism as a systemic problem and including affirmative practices (e.g., anti-

oppressive mental health language; integration of non-institutional support), would have reached a greater range of Black people with varying levels of need.

At the community and societal level, destigmatizing interventions emphasize decreasing the pervasiveness of sanist public and societal discourses about mental health through educating others and engaging in direct contact may be tools to reduce mental health stigma (Thornicroft et al., 2016). Other large scale destigmatizing interventions include use of mass media and campaigns that bring awareness about mental health which were found to improve mental health-based attitudes but only short term and did not increase knowledge about mental distress signifiers (Thornicroft, 2016). Saha et al. (2019) who used social media data to investigate self-reported usage of psychotropic medications and potential for education about medication, found that social media platforms such as Twitter were useful tools to promote mental health awareness and anti-stigma campaigns to clarify misconceptions about mental health. The study also found that social media was a good way to provide peer-based support and sharing of mental health resources. However, Saha et al. did not engage mental health through a critical or social perspective such as exploring what types of communities engaged social media to destigmatize mental health and whether these interventions were geared towards specific cultural groups.

Finally and most recently, scholars have considered the effectiveness of continuum belief approaches to decreasing mental health and mental “illness” stigma (Cole & Warman, 2019; Corrigan et al., 2017; Peter et al., 2021). Peter et al. (2021) described continuum beliefs as a concept that assumes “...every person is likely [to] experienc[e] symptoms of mental illness at some point during their life...imply[ing] that

someone's mental illness is not categorically distinct from normal behaviour but falls on a continuum of life experiences" (p. 716). In conducting a meta-analysis that explored the effectiveness of continuum belief approaches to decreasing mental health and mental "illness" stigma, Peter et al. found that a continuum belief approach was associated with lowered desire to social distance from people with mental health concerns, lowered beliefs that people with mental health concerns were dangerous or unpredictable, lowered level of fear, and increased pro-social reactions such as fostering personal connections with people experiencing mental health challenges. Overall, destigmatizing interventions that aim to reduce sanist beliefs and behaviors primarily use a biomedical and stigma-based model to increase awareness and attitudes about mental health and mental "illnesses" without attention to institutional policies and practices that limit the lives of people experiencing mental health challenges, suggesting a need to further look at the integration of anti-oppressive models that center social justice and equity for people living with mental distress.

### ***Mental Health Literacy***

Mental health literacy is another mental health-based intervention that may enhance the mental wellbeing of BQWNB with mental distress. The main objective of mental health literacy programs is to aid in increasing knowledge, shifting negative beliefs about mental health, and educate others to recognize and manage their mental distress (Jorm, 2000). There are four primary qualities of mental health literacy programs that assist others to: (1) recognize and understand mental distress signifiers, (2) be aware of the causes of mental distress to prevent further distress, (3) develop

knowledge about local mental health care services and other supports, and (4) engage in self-care and health promoting activities (Jorm, 2000).

Recently, Jones and Anderson (2020) used online-based videos to reduce stigma, increase mental health literacy, and disseminate information to mental health care resources for the Black community. To do this, Jones and Anderson created a series called “Our Mental Health Minute” where they released a series of videos that covered a range of topics on specific mental health concerns such as anxiety, posttraumatic stress disorder, and ADHD, advice for parents with children who have mental distress, and specific awareness campaigns that occurred during Black history month and mental health awareness month. However, it is unclear how effective these efforts were at increasing literacy or decreasing stigma.

Other mental health literacy efforts centering Black communities include the formation of grassroots mental health collectives that have integrated healing into their literacy programming using an approach that is congruent with a social model of mental distress. For example, Black Emotional and Mental Health (BEAM) collective created a framework called “social justice-informed mental health literacy” (SJM). SJM is “mental health education framed in the social-historical context of inequality that aids in the skill building, healing, and liberation of communities” and includes seven principles that are grounded in Black feminist/womanist knowledge (BEAM, n.d., para 2). The core principles for BEAM’s mental health literacy program are:

- Validate and give voice to the legacy of harm in Black communities.
- Affirm and acknowledge the historic and present-day resilience, defiance, coping skills, and strategies in Black communities.



- Coach community members on how to offer first-responder support to mental health challenges and crises.
- Cultivate skills that promote agency in engaging mental health professionals and basic knowledge of mental health interventions/treatments and systems.
- Facilitate consciousness-raising and direct action to address social inequalities and conditions that impact Black mental health— such as transphobia, racism, ableism, misogynoir (i.e., anti-Black racist prejudice against Black women, Bailey & Trudy, 2018), HIV/AIDS, and homophobia.
- Advocate and organize for accessible, innovative models of mental healthcare.
- Equip community members with knowledge and tools that support healthy mental health coping skills and healing (BEAM, n.d., para 3).

The engagement in social justice mental health literacy is relatively new. More recent intervention study implemented a mental health education conference to increase literacy among a sample of 249 Black conference attendees (Ormond et al., 2019). The study found that the mental health conference was helpful in sharing resources and information. In addition, participants expressed concerns about being labeled as having a mental “illness,” not being able to afford and/or not knowing where to receive mental health care. Yet, the focus of the intervention used a stigma-based model and did not specify whether there was an anti-oppressive approach to anti-LGBTQ+ beliefs and behaviors that are part of the experiences of BQWNB living with mental distress. Thus, there is a

need for research studies that explore the effectiveness of approaches similar to social justice-oriented approaches to literacy on alleviating mental distress and increasing wellbeing.

### ***Peer Support***

As a tool to create caring communities among people of color with mental distress, peer support is a method that has the potential to aid in Black liberation and collective healing (Bakshi, 2021). A peer—someone who is an equal and has shared lived experience with race/ethnic and mental distress identities, social or demographic identities (Bakshi, 2021)— may provide peer support in two different types of peer programs: (1) peer-developed support (i.e., social model) and (2) peer staff in mental health programs (i.e., medical model; Penney, 2018). Peer-developed supports are “...non-hierarchical approach[es] with origins in informal self-help and consciousness raising groups organized in the 1970s by the ex-patients’ movement” (p.1). This type of peer support operates as informal or non-institutional support that aids in helping people with mental distress outside of the diagnostic illness and disorder paradigm. On the other hand, peer staff in mental health programs including peer mentors, specialists, and coaches that are employed by mental health agencies and are most likely aligned with psychiatric systems.

Research that focuses on communities of color and LGB people experiences with peer-based support in professional mental health care settings has found several benefits of peer-based programs. For instance, a qualitative study by Corrigan et al. (2015), explored health risks and illnesses among a community-based sample of 42 African Americans experiencing homelessness and mental “illness” found that Black people with

mental distress may benefit from peer-based support. Effective peer support for Black communities include the ability to draw from the lived experiences of others who have useful “tricks-of-the-trade” knowledge to manage their lives and can assist with coping strategies (p. 128). Findings suggest that peers also were helpful with sharing needed resources and suggestions for how to access them. Likewise, Holley et al. (2019) who used qualitative data to explore experiences of mental illness discrimination among a sample of 20 self-identified people who were of color and/or LGB, found that peer programming may help with educating others about their mental health concerns and humanizing their experiences as people who are LGB and/or of color with mental distress. However, Holley et al. (2019) also found that programs can be discriminatory towards LGBTQ+ persons and may not fully support people of color.

### ***Culturally Responsive and Affirmative Practice***

Mental health interventions centering BQWNB with mental distress should be culturally responsive and affirming of their intersecting identities. Innovative strategies to intervene in mental distress, integrate affirmative approaches to trauma, healing, (Ginwright, 2018; Levenson et al., 2021), and positive sense of self through body and sex positivity (Casalheria et al., 2021; Matacin & Simone, 2019). Levenson et al. (2021) identified several LGBTQ+ affirmative approaches to trauma. In trauma-informed care, principles of safe space, trust and transparency, peer support, collaboration, empowerment, voice, choice, cultural relevance, and gender responsiveness, assist clinicians to help clients navigate their mental health challenges and traumatic experiences. Affirming the experiences of LGBTQ+ people (e.g., asking for personal pronouns, transparency, assisting with resources, experiences of discrimination), fosters

safe spaces with clinicians to feel validated and process their trauma. In addition, shifting the lens from focusing on trauma to one that centers healing is another affirming method, especially for Black people (Ginwright, 2018). Ginwright's (2018) healing-centered approach looks at Black people not as their harm or wound they experienced but through a strengths-based and asset approach. Helping professionals who take a healing approach focus on wellbeing and engage Black people through building empathy, encouraging dreaming, imagining, and engaging in critically reflecting on their experiences while also taking action to heal what comes up for them (Ginwright, 2018).

Considering body and sex positivity in affirmative practice can lead mental health professionals to hold space for clients to process their trauma in non-traditional ways. For example, Cascalherira et al. (2021) who used data from 20 adults who experienced early exposure to trauma, found that sexual practices like kink and BDSM were helpful for survivors of child abuse to heal their trauma. Mental health professionals who were kink-aware and affirming allowed participants to share openly about their sexuality in a nonjudgmental space and process trauma. The use of kink as a healing practice led to survivors of trauma to reclaim their power through setting healthy boundaries with others and regaining a sense of personal agency, develop liberation through their relationships by reconnecting with others, and able to have a positive sense of their sexual selves while also stepping back into their power. Furthermore, Matacin and Simone (2019) suggested that mental health professionals could integrate a number of fat activist strategies to increase sense of self including challenging sizeist discourse, working through toxic beauty standards, and integrating health at every size perspective to exercise and

nutrition. These body and sex positive strategies when paired with a trauma or healing-centered lens may further help BQWNB with mental distress.

## **Summary**

The existing literature on factors associated with mental health includes a diverse group of Black, LGBTQ+, and/or people living with mental distress. Specifically, scholarship highlights factors that cause, impact, and promote mental wellbeing among members of these communities. However, current research and their relevance to BQWNB living with mental distress is limited due to the lack of research that emphasizes BQWNB voices and perspectives on trauma, stereotypes, multiraciality, and healing. Furthermore, the conceptualization of mental distress in previous studies primarily engage medical models that center “illness,” “disorder,” and focus on professional mental health care as a source of treatment of mental health challenges. BQWNB with mental distress may hold unique perspectives on their lived experiences that derive from their cultural experiences, social identities, histories, and relationship to the world and how they understand their mental health challenges that are more congruent with a mad studies/critical approach to mental health. This study addresses these gaps and explores how BQWNB with mental distress describe (not) being-in-distress.

## CHAPTER 3

### METHODOLOGY

The study used qualitative methodology with a phenomenological design as guided by my BQFMH theoretical framework. In this chapter, I provide an overview of phenomenology, the methods and procedures, the data analysis process, ethical considerations, and strategies to enhance rigor. I also present a revised phenomenon expansion that is core to the phenomenological analysis— (not) being-in-distress—which was inspired by Ortega’s (2016) concept, being-at-ease. This expansion was used to capture the richness in the mental distress narratives among the participants.

#### **Research Question**

The following research question was central to this study: How do BQWNB living with mental distress describe the experience of (not) being-in-distress? This research question was designed to obtain a nuanced understanding of BQWNB with mental distress and their lived realities.

#### **Phenomenology**

To answer these questions, I used phenomenology, which is a philosophy and a methodological process used to explore lived experiences related to a phenomenon within one’s environment (Vagle, 2014). In the early 1900s, Edmund Husserl (1970/1954) introduced phenomenology to provide descriptive and rigorous understanding of “pure cognitive essences.” According to Husserl, phenomena were seen to have essential qualities that reside outside of time and social context. This pursuit captured the essential core of a phenomenon, to find objective forms of truth. However, shifts in thinking about human experience challenged Husserl’s philosophical ideas as being too detached from

social and cultural contexts (Van Manen, 2016). Specifically, Martin Heidegger, a student of Husserl, proposed a key criticism towards traditional understanding of experience (Van Manen, 2016). Heidegger suggested that observing pure essences of phenomena is unattainable. Rather, human experience occurs by way of *being-in-the-world*. Humans, or what Heidegger calls *Dasein* (i.e., being there), have encounters with phenomena that occur within-the-world. Humans reside and dwell in the world and their involvement in the world may take shape by being-with and being-in other entities. In other words, context of human experiences consists of who we are with, what we use, and where we are as we live out a social phenomenon.

### **Post-Modern and Post-Structuralist Criticisms**

Heidegger's (1962/2010) movement away from objective experience to subjectivity in philosophy made way for feminist and critical race perspectives to produce second wave critique. That is, phenomenology was further critiqued as being Eurocentric, masculinist, (Henry, 2005; Ortega, 2016), and excluding women of color perspectives on human experience through its elitist disciplinary divides between what is considered philosophy and theory (Dotson, 2015). Traditional phenomenology universalized white male subjects that centered debates on knowledge production and rationality, concerns central to white male experience as the core social phenomenon under exploration (Henry, 2005). Philosophers in africana, feminist, and queer thought were not concerned with knowledge production, but rather issues of racial, gender, sexual, and other forms of liberation for marginalized communities in efforts to make their lived realities more legible in academic scholarship and research. As such, this progressive shift in phenomenology allowed for the separation of a universal subject from the practice of

phenomenology (Henry, 2005), or separation of universal subject and phenomenological practice, creating space to conceptualize complex and intersectional ways people relate to the world around them (Vagle, 2010).

### **Philosophical Foundations**

Due to differences in experience and interests in phenomenological analysis, this study presents an approach that de-centers whiteness as the subject and centers Black LGBTQ+ experiences. Part of this decolonizing practice consists of writing in the histories of LGBTQ+ people of color, centering critical theories in phenomenology to bridge the philosophy-theory divide. To capture the complexities of BQWNB with mental health concerns, I used Ortega's (2016) Latina feminist phenomenology as a starting point. I expanded on her work to focalize BQWNB experiences with mental distress by describing three of her interrelated phenomena expansions that informed my analysis: being-at-ease, being-between-worlds, and being-in-worlds. While Ortega's (2016) philosophy speaks to several nuanced concepts to illustrate marginality and multiplicity, I focused on select concepts that are directly relevant to my participants. I end with a synthesized outline of the phenomenon expansion informed by the Black queer feminist mental health (BQFMH) framework that guided the data analysis: (not) being-in-distress.

### ***Latina Feminist Phenomenology***

In her book, *In-Between: Toward a Latina Feminist Phenomenology*, Ortega (2016) advanced phenomenological analysis by integrating women of color feminist perspectives on concepts of selfhood and subjectivity. Ortega places emphasis on women of color as the central subjects within Heideggerian thought. Heidegger's (1962/2010)



idea of selfhood pushed the field of phenomenology from the universalized and abstract self as suggested by Husserl (1982/2012), to selfhood and subjectivity being continuous and unstable. Where Heidegger and other earlier phenomenologists fall short were their beliefs that human experience and orientation in the world was practical and nonreflective, meaning people lack agency in the world around them (Ortega, 2016). Because earlier phenomenologists centered white universal subjects, their understanding of agency was not reflective of communities living at the margins. Marginalized communities have historically accessed agency as a tool to address oppressive and unjust systems. This resulted in efforts to improve their living conditions, as opposed to white universal subjects who have not experienced the need to improve the world around them due to their white privilege.

Ortega (2016) expanded the concept of selfhood through her perspectives on the multiplicitous self. A selfhood that is multiplicitous means that there is complexity in the self. This complexity is represented in the social identities and various worlds one navigates where a “singular self occup[ies] multiple social locations and a condition of in-betweenness” (p. 65). For example, Ortega shared that when navigating predominately white workplace settings, she is in a condition of in-betweenness in that her social location as a Latina must adapt to the cultural norms of the workplace, knowing that the workplace environment may or may not be familiar with cultural norms in her Latinx culture. In short, Ortega supported this point by stating “as a Latin American born in Nicaragua, I occupy [my workplace] differently than a white US-born citizen does” (p. 67). Ortega shared that being multiplicitous required her to shift in-between selves in

which she embodied certain aspects of selfhood within various environments (e.g., being playful in family and serious in the workplace).

Departing from Heideggerian phenomenology, Ortega (2016) articulates several advancements to Heideggerian philosophy on human experience that centers marginalized communities and integrates women of color feminisms, one of which is being-at-ease.

**Being-at-Ease.** Marginalized people may experience moments of being-at-ease where they identify and are embraced within cultures. However, many along the margins experience not being-at-ease. Ortega (2016) draws on the work of Latina feminist scholar Lugones (2003) to describe ease as being “the sense of familiarity the self has when fluent in the language, norms, and practices of her culture” (p. 60). For marginalized communities, there are moments of not being-at-ease. This consists of what Ortega describes as a *thin and thick sense*. A thin sense of not being-at-ease refers to “the experience of minimal raptures of everyday practices” while a thick sense refers to “the experience of a deeper sense of not being familiar with norms, practices, and the resulting contradictory feelings about who we are given our experience in the different worlds we inhabit and whether those worlds are welcoming or threatening” (p. 61). Put another way, not being-at-ease captures lived experiences of being unwelcomed or threatened which is deeply impacted by the locations a person occupies given their race, gender, sexuality, class, and other social identities. Being-at-ease are moments of being welcomed and embraced while also observing moments of not being-at-ease—unwelcoming, experiences of violence and further marginalization. The experience of not being-at-ease is a deep familiarity with the oppressive conditions of U.S. cultures and the many

worlds embedded within it that are unwelcoming, violent, and threaten the wellbeing of marginalized people. In addition, being-at-ease may also lead to “an avoidance of change and transformation” and is dependent on a person’s social locations and structural oppression, influencing their level of being-at-ease (Ortega, 2016, p. 71).

### ***BQFMH and Phenomenology***

As transgressive and expansive beings, Black LGBTQ+ women and nonbinary people living with mental distress have selfhoods that are multiplicitous. While Black LGBTQ+ people engage in shifting in-between selves, emphasis is also placed on integrating their multiple social identities. For some Black LGBTQ+ people, hiding parts of their identities and experiences may contribute to further mental distress. They are also navigating environments that encourage closeting parts of themselves for the respectability of their communities. With this in mind, I expand multiplicitous self and suggest that the type of in-betweenness that Black LGBTQ+ people occupy consists of embracing all aspects of their social identities and locations in dominant and othered worlds, integrating their multiple social identities as a singular self, without shifting in-between various aspects of the self. This is different from Ortega’s idea of multiplicity in which she suggests a shifting in-between different part of the self, depending on which worlds one navigates (Ortega, 2016),

Integrating the core tenants from the BQFMH framework presented in Chapter 2, I situated the being-at-ease in the experiences of Black LGBTQ+ people. In doing so, I create the expansion (not) being-in-distress as the starting point to describe the lived realities of BQWNB living with mental distress. While Ortega (2016) highlights expansions that situate and observe research phenomena in the context of their

communities, centering (not) being-in-distress takes a holistic approach that looks at multiple aspects of the lived experience. Below I provide a description of the phenomenon expansion.

**(Not) Being-in-Distress.** Black LGBTQ+ women and nonbinary people with mental distress may experience the meaning of being-in-distress when they experience racist, sexist, cissexist, heterosexist, and sanist dehumanization and further marginalized within their culture and broader society. Members of this community might also experience violence directed towards them due to their interconnected race/ethnicity, gender, sexuality, mental health status or other social categories. Cultural norms and practices that perpetuate stereotypes and actions towards Black LGBTQ+ people living with mental distress are harmful and further contribute to being-in-distress. Being-in-distress is felt as everyday acts of violence and abuse, as forms of collective trauma among people with similar lived experiences, and as a reflection of deeper systemic and structural issues of power, privilege, and oppression that Black LGBTQ+ people with mental distress are deeply familiar with and learn to navigate in their daily lives.

Members of this community may also have moments of not being-in-distress. Not being-in-distress are moments in which those who are marginalized feel a sense of being welcomed, affirmed, and understood. It also includes moments of responding in ways that are supportive of their mental health and using survival, coping, and healing practices that are supportive of their self-preservation and mental wellbeing. On a macro level, these responses may include dismantling barriers that hinder BQWNB with mental distress from accessing mental health and wellness promoting resources. Not being-in-

distress entails recognizing when there is resistance to transformative social justice and responding to this resistance with direct action to remove it.

## **Methods**

### ***Sampling Strategy***

The participants for this study were obtained through purposive and snowball sampling. These sampling methods were used due to the difficulty in locating potential participants from Black LGBTQ+ communities (Majied & Moss-Knight, 2012; Moore, 2011; Wheeler, 2003). Participants, community informants, and stakeholders were asked to share information about the study with their social networks to locate additional participants.

### ***Recruitment and Inclusion Criteria***

Participants were recruited from October 2017 to June 2018. The participants were recruited through social media platforms, online listservs, word of mouth, and local LGBTQ+ bars and nightclubs. Fliers that promoted the study were also used at local LGBTQ+ events and online platforms. To participate, the following criteria were met: (1) at least one primary racial/ethnic identity is Black and/or African American, (2) identify as a woman now or at some point in adulthood, (3) identify as lesbian, gay, bisexual, pansexual, transgender, and/or queer at some point in adulthood, (4) at least 18 years old, (5) speaks fluent English, (6) resides in the U.S., and (7) reports a history of living with mental distress such as (but not limited to) an addiction, anxiety, and/or depression. Minors, adults who were unable to provide consent, and prisoners were excluded from the study. If all study parameters were met, pregnant women, undocumented individuals, and those who identify as part Native American were eligible to participate in the study.

## **Data Collection Procedures**

I administered semi-structured interviews from October 2017 to June 2018. All interviews were conducted in English. With the participants' oral permission, I audio-recorded the interviews. Face-to-face interviews were recorded using a digital audio-recorder. Skype interviews were recorded using a computer software called *ecamm*. This computer software has both video and audio recording functions, however only the audio-recording function was used for this study. An audio-recorder was also used to record Skype interviews. Phone interviews were recorded using two recording methods: Google voice recording software and an audio-recorder. The purpose of using two recording methods was to have a back-up recording in case there were technological failures with the online or computer recording software. Immediately after the interview, I listened to one of the audio-recordings and immediately deleted the other if the first recording had no problems.

## ***Pre-Screening Questions***

When a potential participant initiated contact with me and expressed interest in interviewing for the study, I contacted them to complete the pre-screening process. To do this, I administered a 5 to 10 minute pre-screening questionnaire by email. Pre-screening questions were used to determine participants' eligibility for the study and for contact information to schedule semi-structured interviews. Thirty-two people expressed interest in the study and the final sample size was 17 participants. Pre-screening questions for this study included (1) How old are you today? (2) Do you identify at least one of your racial/ethnic identities as Black or African American? (3) Do you identify as a woman now or at some point during your adult life? (4) Do you identify as lesbian,

gay, bisexual, pansexual, transgender, or queer now or at some point in your lifetime?  
(5) Do you have a history of mental health concerns? If yes, what mental health concerns have you experienced? and (6) Have you ever received a formal diagnosis for a mental illness? If yes, what mental illness(es) were you diagnosed with? These questions were used to determine if participants met the eligibility criteria for the study.

### ***Consent***

Consent was obtained from participants prior to the start of the interviews. The consent forms were emailed to those who interviewed by Skype or phone and a hard copy was provided to participants who interviewed face-to-face (see Appendix A). All participants who interviewed by Skype, phone, and face-to-face were instructed to read a statement to provide oral consent. Upon reading the statement, I wrote the participants' chosen pseudonym and signed each consent form after receiving oral consent.

### ***Semi-Structured Interviews***

I contacted potential participants by phone or email to provide further information about the study and to respond to their questions. Interviews were conducted based on participants' location and preference for either a face-to-face, phone, or Skype interview. Face-to-face interviews took place at a location convenient and accessible to the participant. Three face-to-face interviews were conducted: two in participants' homes and one at their place of employment. Three interviews were conducted by Skype, and the remaining 11 were by phone. Interviews ranged from 45 to 100 minutes in length.

**Protocol for Semi-Structured Interviews.** I used a semi-structured interview guide to help guide me through each interview (see Appendix B). The

interview guide consisted of a written script that included an overview of the preliminary activities to complete prior to the start of the interview, an introduction to the researcher, invitation to participants to ask questions about the study, invitation to create a pseudonym to ensure confidentiality, and a description of the interview process.

Following the introductory script, there were a total of 9 interview questions along with 1 to 4 prompts for each question. The prompts were used to illicit richer responses from participants. I used the most current gaps in the literature and recent information about the phenomenon (i.e., mental distress) to create relevant interview questions that supported the goals of the research. Questions were further refined through conferencing with my advisor.

At the end of each interview, I administered a questionnaire (see below). All 17 participants agreed to be contacted for follow-up. I wrote down participants' information on a contact information card.

### *Questionnaire*

Participants were asked to complete a 5-to-10-minute questionnaire (see Appendix C). The purpose of the questionnaire was to collect information such as age, gender identity and expression, sexual identity, race/ethnicity, religion, education level, and work status. Other questions asked about their mental health concern (e.g., have you ever received a formal diagnosis for a mental illness?) and whom they were out to about their identities (e.g., Who knows that you have a mental health concern or mental illness diagnosis?). A terminology form accompanied the questionnaire to define and clarify terms that were unfamiliar to the participants (see Appendix D).



### ***Interview Compensation***

Each participant received a \$25 Visa gift card at the close of face-to-face interviews. Visa gift cards were sent by mail to participants who interviewed by phone or Skype. The gift card was an attempt to provide minimal compensation for time spent in the interviews.

### **Data Analysis**

The qualitative interviews were transcribed by a professional transcription service. After initial transcriptions, I re-listened to the audio-recordings to ensure accuracy and added participants' responses such as laughter that were not included in the initial transcription. I used Atlas.ti 8 qualitative data analysis software to upload and analyze the semi-structured interviews. In addition, I manually counted quantitative data for participants characteristic information.

### ***Memoing***

Throughout the research process, I used memoing in three primary ways. First, I used memos to write thoughts and ideas about participant narratives during and after the interviews. Initial memos were generally incomplete sketches and ideas from raw data (see Appendix E). I hand wrote early participant memos then typed them into Microsoft Word, organized by title, date, and pseudonym (see Strauss & Corbin, 1998). Second, I refined my thoughts and ideas in later memos to produce fuller and more detailed memos upon listening to audio-recorded interviews. These memos assisted in the coding and analysis of the data (Miles et al., 2014) and were later uploaded to Atlas.ti for further analysis. Finally, I used memos to document my reflections and thinking process

about how the narratives were similar or different, emergent patterns, and areas of concern (Creswell, 2013; Miles et al., 2014; Strauss & Corbin, 1998). I also explored how participant narratives impacted me, explored my personal biases, and related codes to theory and the literature.

### ***Coding Processes***

I completed three coding cycles. I first created a provisional start list of codes that were based on previous research and my knowledge about the topics of the study (Miles et al., 2014). Provisional codes included identities (e.g., race, gender, sexuality), types of disclosure (e.g., full disclosure, selective disclosure, non-disclosure), types of relationships (e.g., family, friends, romantic) and community institutions (e.g., church, school, mental health care system), and types of structural oppression (e.g., racism, cisgenderism, sanism). During my initial readings of the transcripts, I used an integrative reading and re-reading process to become acquainted with participants' narratives. I followed my initial readings with several closer readings of the transcripts to conduct three cycles of coding, using my provisional start list code as a guide. I expanded upon the codes as I saw fit and appropriate for the data.

**First Coding.** I conducted descriptive coding of the data using my start list codes and further refined codes that emerged from the raw data. Descriptive coding is the process of providing a topic phrase or descriptive word to summarize participants' responses (Saldaña, 2009). I used this method of coding to synthesize initial codes (e.g., family, friends, work, and mental health concern). Through this coding process, I was able to identify major categories (e.g., interpersonal relationship, community institution,

disclosure). Major categories were used to describe the larger unit of analysis (e.g., community institution) and initial codes (e.g., work) were used to denote sub-categories.

**Second Cycle Coding.** I used thematic coding methods for the second cycle of coding. Thematic coding was used to synthesize the codes into related categories of data (Saldaña, 2009). I used this coding process to create themes (e.g., addiction recovery group, “I don’t date Black girls,” and assumed to have anger issues) for a deeper coding analysis. Themes were then determined on by the number of participants who described the phenomenon (i.e., two or more) or if the concept was deemed important in previous literature on the topic on mental health.

**Third Cycle Coding.** I used the phenomenon expansion (not) being-in-distress to make sense of the initial coded data. I used memo writing to connect the codes with the larger historical, cultural, and social context that may explain how the categories related to each other (Bowleg, 2008). The expansion (not) being-in-distress involved seeing patterns and relationships between the categories to determine how they were connected. I specifically searched for patterns, connections, and/or tensions among participants’ narratives.

### **Ethical Issues and Consideration**

The Institutional Review Board (IRB) at Arizona State University (ASU) approved this study on May 5, 2017.

### ***Confidentiality***

To ensure confidentiality, I made sure to secure a location to maximize confidentiality for all phone and Skype interviews. In addition, as mentioned previously,

participants were asked to create pseudonyms and all identifiable information was removed from participant narratives.

### ***Data Storage and Security Procedures***

Pre-screening questions were saved on to the hard drive of a password-protected computer and an ASU-hosted Google drive. Pre-screening data of those who participated were destroyed immediately after the semi-structured interview but before audio-recorded interviews were uploaded. This was to uphold confidentiality and to ensure that pre-screening data cannot be linked to audio-recorded interviews. Pre-screening data from 3 people who were eligible but did not participate for any reason were destroyed upon learning they were not participating or after 30 days. Pre-screening data of the 2 people who were not eligible due to reporting no mental health concerns or were not a woman at the time of the interview or at some point into their lives. Pre-screening data were destroyed immediately after letting the person know they were not eligible.

Audio-recorded interviews were stored on the hard drive of a password-protected computer and an ASU-hosted Google drive. The audio recordings were deleted within 12 months of the interviews or when transcripts were completed and checked for accuracy. All personal information obtained were kept in a locked file cabinet, separate from interview data.

### ***Cultural Considerations***

In the past, research was used as a tool to dehumanize the experiences of Black people (Few et al., 2003; Huang & Coker, 2010). Many early academic work and research such as the Tuskegee Experiments, The Moynihan Report, and Bell Curve, demonstrate how anti-Black racism can be pervasive in scholarship on marginalized

communities, especially when scholars are not transparent about the process or intentions of their work. Much of this earlier research has led to the negative portrayal of Black people as abnormal in some way. Due to the racist practices of earlier research, attention to power dynamics in the research-participant relationship are important to consider when doing research in Black communities (Majied & Moss-Knight, 2012; Wheeler, 2003). Acknowledging these power dynamics (e.g., researcher privileges related to cultural differences, class, language, physical traits), are important to establishing trust and rapport with research participants of African descent (Few et al., 2003; Majied & Moss-Knight, 2012; Wheeler, 2003). Other ways to address the power dynamics in research include engagement in self disclosure and financial compensation for the time spent in the study (Few et al., 2003; Majied & Moss-Knight, 2012; Wheeler, 2003) and focusing on concerns in research held by persons who are members of the LGBTQ+ community. In response to these considerations, I was transparent about the purpose, aim, and risks and benefits to participating in the study prior to the interview. Throughout the interview process, I asked participants if they had any questions or concerns. Participants were reminded of their right to not answer questions they did not want to answer and their right to end the interview at any point in the process. None withdrew from the interviews. In addition, I made sure to use language that matched the participant's level of knowledge about the social issues that emerged during the interviews. I did this by using the words and terms they used to describe their experiences. As for dress, I wore casual clothing for all interviews. I also participated in some self-disclosure around my race/ethnic, gender, and sexual identities to help build rapport with the participants. Finally, all participants received a \$25 Visa gift card for their time spent in the study.

## **Rigor in Qualitative Research**

Rigor in qualitative research is used to ensure the production of quality research (Drisko, 1997; Golafshani, 2003; Lietz et al., 2006; Miles et al., 2014; Tracy, 2010).

To ensure the quality of my qualitative research study, I addressed trustworthiness of the data. Trustworthiness refers to the level of confidence in knowing the data accurately reflect participants' collective experiences (Lietz et al., 2006). I established trustworthiness through reflexivity, data richness, and thick description. Trustworthiness was also established by using ample quotes from participant narratives (Drisko, 1997).

### ***Reflexivity***

I engaged in a continuous reflexive practice to establish sincerity in the research process (D'Cruz et al., 2007; Drisko, 1997; Golafshani, 2003; Lietz et al., 2006). In qualitative research, sincerity helps build trust and connection with participants. I engaged reflexivity through an intersectional critical reflection which “focus[es] on a chosen event or situation and to analyze the feelings, thoughts, and actions it involves in a way that opens up alternative ways of understanding...to challenge social structures and oppression” (Mattsson, 2014, p.11). Self-reflexive practice consisted of three interrelated steps including selection and describing of a critical situation or event, applying an intersectional lens to identify power dynamics, and using reflection to compare across narratives (Mattsson, 2014). Reflexivity also included critical self-reflection to explore my subjective experiences, reasons for conducting the research, and personal biases (Tracey, 2010).

I crafted a critical self-reflection about my personal experience and connection to the Black LGBTQ+ community and research phenomenon. I processed my

outsider/within positionality as it related to mental distress. I used memos to journal my thoughts, feelings, and triggers as I engaged with the data.

**Reflexive Statement.** My path to exploring the lived experiences of Black LGBTQ+ women and nonbinary people with mental health concerns came from the lack of critical engagement of queer people of color perspectives in social work. It was not until my doctoral studies that I began my journey to the field of women and gender studies, in the hope of finding voice and perspective rather than the silence I found in social work. During this time, I was introduced to the Black lesbian feminist mother warrior poet, Audre Lorde, whose poetry and narratives were liberating and affirming of my lived experiences. Other critical theorists of color who shaped my critical consciousness included Patricia Hill Collins, bell hooks, Kimberle Crenshaw, Barbara Smith, Combahee River Collective, Gloria Anzaldua, Patrick E. Johnson, and Alice Walker, among others. These scholars shaped the meanings I attributed to my Black, queer, and woman experience within my respective communities and broader U.S. society. A key theme derived from this journey: the representations of Black LGBTQ+ people are at the intersection of larger systems of power and privilege which cannot be abstracted from historical or contemporary contexts.

Developing this critical lens not only transformed how I saw and felt about myself but how I engaged my scholarship. For instance, the mental health research lacked approaches that were responsive to lived realities of Black LGBTQ+ people with mental health concerns. With national research initiatives striving to understand social influences of mental health disparities, engagement with culturally relevant theories and methodologies seemed like an appropriate step to take. Yet, I continuously found myself

constantly shifting back and forth between various fields of study to capture the existing—or lack thereof—voices and perspectives of Black LGBTQ+ people who experienced mental distress. This bridge work was strenuous. Not strenuous in the sense that the work was taxing, though it was. Rather, the process of *reading, listening, watching, absorbing, and feeling* the voices and emotional labor of people of color was very triggering yet inspiring. Many of the stories told were intimate; stories that felt like windows or an extension of myself but in different variations, while others challenged my cisgender and social class privilege.

As a Black queer woman, I am intimately aware of the perceptions about mental distress within Black communities. In many of my family relationships, emotional vulnerability and intimacy amongst each other is discouraged. Yet, various forms of addictions, deeply internalized pain, and stoic efforts to appear “normal,” were unspoken rules to survival. However, I continuously centered and wrote about mental distress, theorizing the lived experiences of Black LGBTQ+ people with non-normative mental states in social work and the social sciences. I continue my timely journey—my acts of resistance and liberation—as a social work educator and researcher, to name and dismantle social injustices, especially those that create barriers to healing and being authentic to the diversity in race, gender, sexuality, and mental health status of Black life.

### ***Data Richness***

I used data richness as a method to establish trustworthiness. Richness was determined by the amount of data collected to support the research, time spent during the data collection process, and the appropriateness of the sample to the study and application



of analysis (Tracy, 2010). I interviewed 17 Black LGBTQ+ women and nonbinary people with mental health concerns and reached data saturation. Data richness was also achieved through the interview protocol. I used prompts and probing questions to illicit richer responses from participants. I used silence and repeating participant statements to ensure correct understanding. I also used structured, directive prompts to lead participants to provide direct responses to each question and gain more depth and richness in participant narratives (Hesse-Biber, 2007). Finally, I spent extensive time in the raw data by reading and listening to the interview's multiple times.

### ***Thick Description***

I established thick description of the data by describing and interpreting the phenomenon mental distress as well as by vividly describing mental distress (Ponteotto, 2006). That is, thick description brings depth and richness to participants' narratives. To do this, I reviewed the major themes that emerged from the data and considered my analytical framework to establish a fuller description of how participants navigated their lives while living with mental distress.

### **Summary**

In this chapter, I described the qualitative research methodology used in this study. I used a phenomenological design informed by my BQFMH framework to describe BQWNB living with mental distress experiences of (not) being-in-distress. I presented the data collection procedures, analysis process, ethical considerations, and strategies to enhance rigor and reflexivity.

## CHAPTER 4

### FINDINGS

The purpose of this study is to explore and describe the experiences of BQWNB who are living with mental distress. The research question was: How do BQWNB living with mental distress describe the experience of (not) being-in-distress? In this chapter, I describe the sample then present findings using the phenomenon expansion (not) being-in-distress that was outlined in Chapter 3.

#### **Sample Description**

I interviewed 17 participants who self-identified as BQWNB living with mental distress. Participants were 20 to 39 years old with an average age of 28.38. The majority of participants were women ( $n=15$ ), and others were transgender and nonbinary (i.e., genderqueer and genderfluid;  $n=3$ ). The majority of participants' sex assigned at birth was female ( $n=15$ ). Most participants described their gender expression as feminine/femme ( $n=13$ ) with other expressions being masculine/butch/stud ( $n=3$ ), androgynous ( $n=3$ ), and other ( $n=1$ ). Participants were asked to select all identities that applied to their experiencing, so some totals exceed 17. Most participants identified as Black or African American ( $n=14$ ) with others also identifying with African, Caribbean, Hispanic/Latina, Caucasian/White and other racial/ethnic identities. The majority of participants disclosed their mental health concern and sexual/gender identities to someone in their social support systems. Two participants did not disclose their mental health status to others while most participants were out to everyone about their sexual/gender identities (see Tables 1 & 2).

**Table 1***Participant Social Identities Information*

#	Pseudonym <sup>pron.</sup> age	Race/Ethnicity	Gender	Sexuality	Mental Health Status
1	Amari <sup>she/her</sup> age 20's	African	Female-ish	Queer	PTSD/Depression/ Anxiety
2	Anastasia <sup>she/her</sup> age 20's	Black	Woman	Queer	Outwardly Able-bodied/ADHD
3	Anna <sup>she/her</sup> age 20's	Black/ Caribbean	Woman	Bi+	Anxiety/Depression
4	Bee <sup>she/her</sup> age 30's	Black/ LatiNegra	Femme	Queer/ Pansexual	Depression/Anxiety
5	Bella <sup>she/her</sup> age 20's	Black	Cis-Woman	Pansexual	Histrionic Personality Disorder
6	Danielle <sup>she/her</sup> age 20's	Black/African American	Cis-Woman	Lesbian	Occasional Depression
7	Janis Joplin <sup>she/her</sup> age 30's	Black/Caribbean	Woman	Lesbian	Anxiety
8	Jennifer <sup>she/her</sup> age 30's	Black	Woman	Pansexual	OCPD/Depression/ ADHD/ PTSD
9	Keisha <sup>she/her</sup> age 30's	African American	Female	Queer	Depression/Anxiety/ PTSD
10	Marf <sup>they/them</sup> age 20's	Black/African	Nonbinary	Queer/ Lesbian	Anxiety/Disordered Eating/Dysthymia/PTSD
11	Rachel <sup>they/them</sup> age 20's	Mixed-Race/Black	Genderqueer/ Gender Fluid	Queer/ Pansexual	Generalized Anxiety/Depression
12	Roo <sup>she/her</sup> age 20's	Black/Mixed-Race	Cis-Woman	Queer/ Asexual	Bipolar Disorder
13	Sam <sup>she/her</sup> age 20's	Black	Cis-Masculine	Lesbian	Anxiety/Depression
14	Samii <sup>she/her</sup> age 20's	Afro-Latina/ Mixed	Trans Woman	Bisexual	Schizoaffective/BPD/ PTSD/ Panic Disorders
15	Sunday <sup>they/them</sup> age 30's	Black	Non-binary/ No label	Queer	Bipolar Disorder/ Complex PTSD
16	Vanessa <sup>she/her</sup> age N/A	Black	Cis-Woman	Bisexual	Anxiety/Depression
17	Whitley <sup>she/her</sup> age 20's	Black	Woman	Pansexual	Depression

**Table 2***Sample Characteristics (N=17)*

Characteristics	<i>n</i>	Range ( <i>M</i> )
Age		20-39 (28.38)
Sex assigned at birth		
Female	15	
Male	2	
Number of years LGBTQ+ identified		
1-2 years	1	
3-4 years	2	
Over 7 years	12	
Religion-family		
Christianity- Protestant/Catholic	17	
Islam	2	
Judaism	1	
Atheist/Agnostic	3	
Other	3	
Religion-self		
Christianity-Protestant/Catholic	3	
Atheist/Agnostic	4	
Other	9	
Formal diagnosis		
Yes	14	
No	2	
Who knows about mental health concern		
No one	2	
Family	8	
Friends	8	
Co-workers	0	
Everyone	4	
Others	7	
Who knows about sexual/gender identities		
No one	0	
Family	5	
Friends	9	
Co-workers	4	
Everyone	11	
Others	1	
Primary caregiver to:		
Child	3	
Parent(s)	1	
Romantic partner	1	
No one	13	
Other	2	

**Table 2***Sample Characteristics (N=17) cont.*

Characteristics	<i>n</i>	Range ( <i>M</i> )
Highest level of education		
Some college or education beyond high school	5	
Completed AA degree	2	
Bachelor's degree	2	
Some graduate education	1	
Graduate degree	7	
Current work status		
Employed full time	9	
Employed part time	3	
Not employed but looking for work	2	
Not employed and not looking for work	1	
Student	4	
Not employed due to a disability	1	

**Phenomenon Expansion: (Not) Being-in-Distress**

This section describes findings related to (not) being-in-distress. The concept mental distress is contextualized as a manifestation of dehumanization and further marginalization of Black LGBTQ+ women and nonbinary people. Three themes emerged from participants' mental distress narratives: (1) contributors to mental distress, (2) impact of mental distress, and (3) positive responses to mental distress.

***Contributors to Mental Distress***

Contributors to and causes of mental distress were factors that participants identified as part of their experience with being-in-distress. Participants described that their mental distress was caused by individual and collective experiences of trauma as well as negative images, stereotypes, and perceptions that dehumanize, stigmatize, and further marginalize their experiences. There were five contributors to mental distress that

emerged from participant narratives: (1) individual trauma experiences, (2) collective trauma experiences, (3) the embodiment of strength and independence, (4) experiencing sexualized identity stereotypes, and (5) racial ambiguity and not being Black enough.

**Individual Trauma.** Some participants conveyed that individual trauma experiences were the cause of mental distress. These individual trauma experiences were characterized by single or multiple instances of loss, illness, and violence that affected participants' mental health negatively. For instance, Bee and Rachel described the death of a parent as being a life event that caused their mental distress. Bee shared that the death of her mother has led her to grieve the loss of her mother and as she stated, “was the one big thing that erupted and shook my world in a different way.” As opposed to Bee who lost her mother in a more recent time frame, Rachel shared that the unexpected death of their father from a heart attack when she was five years old continued to contribute to her mental distress at the time of the interview, and often led them to have “really bad days.” Rachel also observed the on-going grief of their mother as it related to the death of her husband, which also increased her mental distress and concern for their mother’s mental wellbeing.

Another type of individual trauma that contributed to mental distress of participants was health diagnosis and conditions. Participants identified a range of physical health conditions that caused their mental distress including cancer, HIV diagnosis, fibromyalgia, and frequent eczema flares. These health conditions were either a personal diagnosis or an illness of a family member that ultimately caused their mental distress. Whitley shared that when she was diagnosed HIV-positive, she began to experience major depression due to the new health diagnosis. After finding out their

mother possibly had breast cancer, Rachel shared that they began experiencing intense anxiety, to the point that they called their mother in crisis and even checked themselves into the hospital thinking they were having a heart attack. This in turn put their mother in distress due to the severity of Rachel's anxiety. They stated:

I used to have really bad anxiety attacks about four or five years ago after [my mom] had a breast cancer scare. It was benign but that's when my anxiety attacks were triggered. I would call her saying that I was having a heart attack and that I couldn't breathe and be in tears and freaking out.

Several participants described domestic and sexual violence as the cause of their mental distress. Specifically, participants' narratives described a range of violence including child molestation, rape, inappropriate sexual comments, advances, and sexual assault, primarily by cisgender heterosexual men. These acts of violence were experienced in the social dynamics with a family member, romantic partner, and/or a stranger. Jennifer and Keisha's experiences related to instances of domestic violence. For Jennifer, her childhood abuse occurred because of her mental health status that in turn, caused her to develop another mental health concern. She stated:

I started to develop the OCPD as a result because I'm very forgetful, I misplace things a lot. I'm very forgetful about where I put things. That's a real typical symptom of ADHD. To combat that and to try to avoid the abuse [as a child], I became obsessive about how I did things. I had to do things the exact same way every time to make sure I didn't forget anything to the point where I became very distressed if something is different or I can't complete a task exactly how I want to

because in my mind as a kid, if I don't get everything done, I'm going to be in a lot of trouble. Now my brain is just wired that way.

Jennifer's narrative highlighted a biological contributor in conjunction with environmental/social contributors to mental distress. However, biology as a cause of mental distress was not a common response among participants.

Samii and Anastasia experienced violence from strangers. These acts of violence included inappropriate sexualized comments, sexual advances, and assault. For instance, Anastasia shared that cisgender heterosexual men would make inappropriate comments about her same-sex relationship, such as "you never been with a man" and "oh you must never had the right dick before." Anastasia found these instances of sexual violence contributing to her anxiety and fear for her safety within her neighborhood. Samii also shared a sexual assault situation perpetuated by a stranger that was tied to her coming out as a woman. The incident of sexual assault contributed to her depression, anxiety, and PTSD. She stated:

The first time I came out as a woman, this guy on the bus sat next to me and placed his hand up the skirt I was wearing. Because it was a college owned bus, when I told the person that was in charge, they just brushed it off. It wasn't important.

**Collective Trauma.** Several participants identified collective trauma shared among those in the Black and/or LGBTQ+ community as a cause of mental distress. Instances of violence were felt at a larger community scale, shared among racial/ethnic, gender, sexuality, and/or mental health-based groups. Based on the narratives, instances of collective trauma included instances of anti-Black racism, cissexism, and sanism.



Several participants described a sense of collective trauma as it pertained to anti-Black racism in U.S. policing. Keisha and Amari both experienced fear of dying or going to jail due to calling police for assistance during a time of crisis. Keisha called police in response to intimate partner violence. When the police officer arrived,

...a cop car roll[ed] up on me. [They were] like “drop all your stuff and put your hands on the hood of the car.” At that moment just freaked out...and I broke down crying.... I really thought that I was going to be going to jail.

When her brother who has schizophrenia had an episode and her family needed support, Amari and her family called 911 to receive assistance from the local police station. However, upon their arrival police officers had their guns drawn which caused intense fear and distress among herself and her family members. She stated:

This white police officer walks up [with] his gun already drawn. My [other] brother is like, "Don't shoot, don't shoot." The fear that you can get shot while calling for help...I don't think that's what law enforcement is supposed to be [like].

The initial fear Keshia felt when police officers showed up during a crisis was due to anticipation of anti-Black sanist response that might have led her to getting arrested. Similarly, Amari and her family’s interaction with the excessive police response during a time of a mental health crisis, is rooted in anti-Black sanist discrimination, or the interconnectedness of racism/sanism. These actions (and fear of action) may tie to historical notions that Black people are resistant to pain, are less than human, stereotypes that Black people and people with “mental illnesses” are dangerous, and stereotypes

about Black strength and resilience that lead to others not validating the mental/emotional wounds of members of Black communities.

Others shared that in the Black and LGBTQ+ communities, there is a general fear of law enforcement that connects to the historical anti-Black violence and anti-trans violence perpetuated at the hands of police officers. Vanessa shared that the fear of police officers is always at the back of the mind of Black people, even when there are positive interactions with them, stating that the fear “[is] always there...always.” Samii shared that police officers treat trans women of color inappropriately and perceives it as causing mental distress among trans women of color. In particular, her narrative points to the interconnectedness of racism/cissexist discrimination where police officers dehumanize trans women of color. She stated:

[Police officers] are really inappropriate with [trans women of color]...I feel like this happens because they see [trans women of color] as targets. They see us as people who they can clearly target and nobody would come to our rescue. They can harass us and...no one really cares about us.

Finally, Bella and Rachel shared that the socio-political climate was a form of trauma and contributed to their mental distress. Both participants described the Trump election of 2016 and anti-Black racism as the sources of distress. For example, Rachel connected the Trump elect with the larger sense of trauma for Black people:

I think a lot for me has changed after the [2016] election and understanding that for a lot of people, there's been trauma long-term and this is a culmination of something, not necessarily a surprise to most of the people I spend my time with. There's just added trauma of just being so— It's on the surface and this is in

our face and this is really happening now, and this isn't something that's like an undercurrent anymore. Just having that trauma and depression and hopelessness really seeps into most facets of my life sometimes. Thinking that there's people in power who are overtly trying [to get rid of] people similar to me, the people that I care about most.

**The Embodiment of Strength and Independence.** Participants described pressure to embody strength and independence as a contributor to mental distress. In particular, participants noted that embodying strength as a Black LGBTQ+ woman or nonbinary person with mental distress was not authentic to who they were and placed unrealistic expectations on them, speaking to the dehumanizing aspects of strength and independence as seen in the controlling image of “strong Black woman.” Several participants described the ways the concept of strength created unrealistic standards that are detrimental to their mental health. Anastasia and Vanessa spoke at length about their perceptions about the messaging of strength and independence through images such as “Black girl magic” and “strong Black woman.” Anastasia shared several instances of feeling the pressure that is placed on Black women within her family to perform strength and independence that she said caused intense anxiety. She described the stereotypes by stating:

It’s powerful...you get to hear about this “Black girl magic” and “oh my gosh Black women we’re strong” and dadadadadah but in a sense, I believe it’s become like this double-edge sword: we’re strong and it gets dismissed a little bit that maybe today I don’t feel magical or I don’t want to be independent. I would like to have some kind of support or I don’t want to fight. I would like someone to

step in and fight for me because I'm fucking exhausted. To be magical and be like this mythical creature [means] all this fucking pressure to do things that [are] fucking impossible. It's a lot of pressure.

Vanessa elaborated on the ways the embodiment of strength expectation emerged as part of her mental distress narrative through witnessing the emotional vulnerability of her mother. She shared in part of her narrative that the concept of strength and independence contributed to the mental distress of her mother, which in turn caused her some distress seeing her mother being emotionally vulnerable:

[The] majority of the women in my family are mothers, and they are extremely strong women so it's like we have to be that backbone for our family but if something happened and they're not okay it's like, "Oh, they'll get through it. they do every other time." It was always seeing my mom and my aunt—They were both single mothers. From what I remember, being young, they would always find a way to make things work and you would never see—Growing up, I can never think of a time I saw my mother cry, like at all. As I got older and I saw her cry one time, I freaked out because I'm like, "She doesn't do this at all." She does not cry. I didn't think she could cry, honestly. When I saw her do it, it scared the crap out of me.

Anastasia's and Vanessa's accounts of strength in Black communities illustrate the pervasiveness of needing to perform mental/emotional toughness and resilience. The notion that Black people with mental health concerns, particularly Black women and femmes, must have it together for not only themselves but their families and communities, are tied to racist/sexist/sanist ideals. Specifically, Black women and

femmes living with mental distress are pressured to embody a sense of hyper-able mindedness/hyper-able bodiedness and display an ability to withstand mentally distressing situations, and continuing with their daily activities, not allowing them to acknowledge, process, or even engage in healing.

**Experiencing Sexualized Identity Stereotypes.** A few participants identified sexualized identity stereotypes about race, gender, and sexuality as important contributors to mental distress. These stereotypes included beliefs that Black women in larger bodies are sexually dominant, trans women are sex workers, and bisexual people are selfish or cheaters. Reflecting on the mental distress experienced within her dating relationships, Bee shared that there are assumptions made about her sexuality due to her race/gender/body size that are tied to sizeist oppression and contribute to her distress. She shared that when dating, others often assume that she is sexually aggressive or assertive due to being a queer Black woman living in a larger body.

Others perceived stereotypes about their pansexual or bisexual identity contributing to their mental distress, particularly feelings of anxiety and depression due to these negative perceptions within LGBTQ+ community. Whitley and Jennifer, both of whom identify as pansexual, described biphobic stereotypes about bisexual people that affected them. Whitley stated that bisexuals are perceived as “being selfish because you didn’t choose [one gender]” and Jennifer experienced biphobia when her in-laws, who assumed since she was attracted to more than one gender, was going to cheat on her husband. She also shared that with men, she often receives the “threesome” stereotype, suggesting bisexual people have sex with more than one person at one time. In the

context of dating and family dynamics, these instances of biphobia caused mental distress when engaging in these social aspects of their lives.

Finally, Samii shared her experience as a bisexual Afro-Latinx trans woman who was assumed to be a sex worker, a common racist/cissexist stereotype about trans women of color. Because of this perception, Samii has experienced a few distressing situations including sexual violence primarily from cisgender men—an example of an everyday act of violence in broader society. Samii stated that as a trans woman, she is often assumed to be a sex worker which leads to being stopped and propositioned by male police officers. Collectively, these instances of sexualized identity stereotypes are examples of hyper-sexualizing and demonizing the sexuality and gender identities of bisexual and transgender people of color.

**Racial Ambiguity and Not Being Black Enough.** Several participants described pressures to explain their racial identity or prove their Blackness to others as a factor that contributed to their mental distress. Instances of monoracist beliefs about multiracial and racially ambiguous people occurred in community with other Black people. In her interview, Roo was very open about her experience living as a mixed-race person. She shared that in Black spaces, she often found herself in debates about her Blackness and needing to prove she belonged. She described that debates about “who gets to be Black or not” were not uncommon for her. In addition, she stated that these experiences of continued denial of her Blackness were extremely stressful and caused her several mental distress episodes, stating “I cut off all my hair [and] I tried to strangle myself because someone told me that I wasn’t Black.” In contrast, Rachel discussed internalizing monoracist beliefs about their mixed-race identity where they feel strange navigating

Black spaces due to their phenotypical characteristics and how she grew up. They shared that self-imposed thoughts about how others in Black communities perceived their mixed-race identity contributed to some of their mental distress. They stated:

I've been trying to consciously spend more time in places centering Black folks for the past couple of years. Sometimes I still feel about it because I am light-skinned and I'm mixed and I grew up with a white parent in a white suburb. I feel really aware of all of that sometimes. In my experience, it's all been me projecting that onto myself and not anyone ever saying any of that to me. I think that's just my own insecurities. I've always been really affirmed and excited.... [There is] so much great energy in spaces that center Black women.

Samii and Bee, who are both Afro-Latinx, shared their experiences with anti-Blackness that was a cause of their anxiety and depression. As a racially ambiguous person, Samii shared that others often attempted to guess her racial/ethnic identity. She found that some would even “alternate between racial slurs for different groups of people.” Furthermore, being *Latinegra*—a term used to describe Latinx people of African ancestry—was central to Bee’s family experience. Specifically, she shared that her sense of Blackness was felt in her family because she was a racially Black-identified Latinx person who was raised by parents and other family members who were racially White and ethnically Latinx. She shared a time that she felt her Blackness in an experience she had with her grandmother:

Our parents would send us back to [Latin country] every summer until I was 16. We spent three months with family in [Latin country]. My paternal grandparents will be like, "You're playing in the sun too much. Come sit under the shade and

play in the sand here." My first memory as a child is being in [Latin country] and looking down at the floor and feeling and seeing all my curls fall from my head to the ground because my grandmother had my head shaved because she didn't like my curls. I remember looking in the mirror and crying.

For mixed-race and racially ambiguous participants, the meaning attached to their mental distress is tied to a sense of not belonging in Black or Latinx spaces. Not belonging was both explicit or anticipated. Furthermore, mixed-race and racially ambiguous participants appeared to experience disempowerment and were unsafe and disaffirmed due to their mixed-race identities—both expected or anticipated sense of safety. In other words, participants described experiences as being outsiders within Black or Latinx spaces.

### ***Impacts of Mental Distress***

Being-in-distress included negative outcomes in the thoughts, behaviors, and overall quality of life of the participants. Two sub-themes emerged as impacts of mental distress: (1) a lowered quality of life and (2) self-harmful thoughts and behaviors.

**A Lowered Quality of Life.** Lowered quality of life in one or multiple life domains was an outcome of mental distress. Several participants described overall difficulties and challenges in multiple parts of their lives due to their mental distress. For instance, Marf stated:

Living with [mental distress] impacts every aspect of my living. It impacts where I choose to live, where I choose to work, my relationships with other people...It basically impacts my quality of life in this world and how I'm able to engage with the world because if I didn't have mental distress then I would be able to navigate



very differently than how I am right now. They definitely have a major impact on my identity and how I live my life.

Others described the impact of being-in-distress as effecting the ways they navigated in the world. Rachel, Keisha, Jennifer, and Anastasia described navigating their worlds in two different yet similar ways. For Rachel and Keisha, they shared that navigating their lives involved not being able to bring themselves to live their daily routine (Rachel) and to “withdrawal from the social aspects of my life,” due to PTSD and depression (Keisha). In contrast, Jennifer described herself as having “functional anxiety,” and Anastasia shared that they are “able-bodied as far as my mental health,” even though it is difficult for them to complete daily tasks. Both Jennifer and Anastasia shared that others do not realize that they have mental health concerns because they are viewed as “functional.”

**Self-Harmful Thoughts and Behaviors.** Another outcome of mental distress is self-harmful thoughts and behaviors. Self-harm was described as thoughts or behaviors that were negative practices that were not supportive of mental health and often signaled that mental distress was a significant issue in the lives of the participants. Specifically, participants described suicidal ideation, binge/emotional eating, staying in bed, and suicide attempts as part of being-in-distress. For Rachel, binge eating was part of the behaviors signaling a mental health concern:

I definitely dealt with trauma and sadness in unhealthy ways .... For me, that was basically eating.... [I] was eating my feelings and my sadness and my grief.... I'm a very emotional eater still.

### *Positive Responses to Mental Distress*

Positive responses to being-in-distress are healing-centered practices and activities that aided in participants' mental wellbeing and movement towards not being-in-distress. Many of these practices were not mutually exclusive, meaning these responses were holistic and had many overlapping qualities. However, practices were themed according to the type of practice which collectively served the purpose of reducing and/or healing mental distress. Six sub-themes emerged as important responses to mental distress: (1) body-centered responses, (2) mind-centered responses, (3) spirit-centered responses, (4) community-centered responses, (5) resistance to cultural expectations and norms, and (6) non-disclosure for self-preservation.

**Body-Centered Responses.** Participants used body-centered practices to respond to their mental distress. Body-centered practices were physical activities done through the body with the intention to promote mental wellbeing. Drinking water, taking showers, physical activity, sleep hygiene, and taking psychotropic medication are body-centered practices that participants used to heal and move towards not being-in-distress. Some participants used physical movement such as walking, weight training, and yoga as their primary practice to not being-in-distress. Sam used walking to re-evaluate and manage her mental health. Rachel found physical movement to be essential to their healing process. They stated:

Exercise has been another invaluable part of me dealing with mental health....

Moving my body has been so important for me through all the iterations of my mental health and coping with anxiety and sequential depression and potential loneliness when I moved away from home, from where I grew up. If it's a bad

mental state, I almost always feel 100 times better when I've exercised or when I'm moving my body or worked up a sweat. I've gotten into weight training, which has helped me so much in feeling stronger internally and externally. Doing yoga is so great for me in terms of learning to slow down and focus on breathing, but also to feel like I'm doing something that's making me strong, and I really am into doing dance cardio classes....

Other participants found the use of psychotropic medications to manage their mental health. Medications were described as being part of a self-care regime (Bee). However, not all found medication to be helpful. Vanessa stated, "I don't want to take medicine for it because I don't like the feeling that the medicine gives me...."

A few participants found healing and empowerment through body and fat positivity and their erotic power. For example, Bee described the healing power of Bondage, Discipline/Dominance, Submission/Sadochisim, and Masochism (BDSM) which allowed her to move through her grief and pain. She stated:

BDSM was also part of my healing process and being able to feel something other than the numbness of grief. I was like, "I just need somebody to beat my ass so that I can just have a different experience than this grief and constant crying." I would love to be crying and then to move in a particular way and be like, "I got my ass beat the other day and I can still feel that bruise. I can look at it in the mirror and I can take a picture of it and I can post it." That process helped distract me and remind me that my body had the capacity to feel more things than numbness, to remind me that my pleasure looks many different ways and that's okay.

However, Amari did not find BDSM in LGBTQ+ community as a healing practice but rather tied to the oppression of Black people. Amari perceived the use of chains as being “not normal” and believed it looked like a “painful” practice. She felt that the practice of BDSM was connected to the oppression of Black people, describing it in light of slavery and the bondage of her ancestors. She posed the question, “Why would you want to... purposely bondage?”

**Mind-Centered Responses.** Mind-centered responses as mental wellness practice were activities that engaged and cared for the mind in some way. Most of the participants shared that their mind-centered responses to mental distress included seeking peer and professional support such as therapy. For example, Sunday described their experience in therapy in a positive light. Therapy was a space where Sunday could process their mental health concerns openly. Sunday stated that their therapist was “a good therapist...she’s very on top of her shit.” While Sunday found they needed to educate their therapist about trans and queer issues, the rapport they built with their therapist made the need to explain worth it. Keisha used therapeutic resources and a shift in mindset to cope with her mental distress:

When I was only receiving the state Medicaid, I took it upon myself to find additional support and resources in the community that could help me. I found a free art therapy group.... I’ve had a dog for the past four years and he’s been with me through some really tough times.... I really stay focused and motivated to keep pushing forward... even with my toughest days....I could be very depressed and I want to stay in bed all day but it’s like I’ll get up and go to work.

Other participants shared that formal support approaches to managing mental distress such as therapy were not helpful compared to non-traditional or creative ways of coping. For example, Bee and Vanessa shared their experiences with caring for their mental health through different coping practices that might not be in alignment with Western medicine. Bee shared that rather than seek Western bereavement care, she found different modalities that worked for her most of which related to spirituality. Vanessa shared that she opted for more art-based approaches to her mental health:

...Coping for me now is pretty much, is trying to calm myself down, listening to music, coloring, that seems to help a lot. The adult coloring books seem to help a lot. It's just trying to take my mind off of whatever is causing me to spiral downwards so quick..., trying to refocus that energy into something that won't cause me to sink deeper.

**Spirit-Centered Responses.** Some participants responded by using spirit-centered practices to support their mental wellbeing. Engagement of spirit-centered responses to mental distress were characterized by spiritual development activities that led to positive outcomes for participants' mental health. Spiritual practices included prayer, meditation, journaling, lighting incense, ancestral veneration, and connection to indigenous African spiritual practice. Keisha stated that her healing-centered responses to mental distress related to "My belief in god overall and try[ing] to stay positive even though sometimes my mind is going to negative places." Furthermore, Janis Joplin shared that spirituality was crucial to her mental health healing process:

The only thing that pulled me out of [mental distress] was reflecting back on a prayer that I knew which is a Buddhist meditation prayer where you have to do it

audibly.... It's a chant.... I have a room in my house that's a meditation room.... Ultimately, that's the thing that saved me, I truly believe. It's literally just a shift in perspective, a change in mood, it's something that now I feel like I can do on my own intention. I can just manifest that change pretty swiftly. Whereas if I feel like I have some level of control over it. Even though I have moments of anxiety and extreme anxiety where I'm shaking more, I'm on the brink of tears or I'm unable to breathe or there are moments where it's oh-so overwhelming. I feel closer to control now than I ever have before. I'm okay with having these moments of anxiety because I have these tools to manage it.

While practices to care for the mind, body, and spirit were healing for some participants, Roo expressed caution about using these practices in response to mental distress without addressing sanist behaviors. That is, practices that address spirit did not change the fact that Roo's boss made her choose between her mental or financial wellbeing. She stated:

Being mindful and breathing and going to therapy like that doesn't change the fact that like my boss said that I have to choose between therapy and going to work. It doesn't change that.

**Community-Centered Responses.** Healing from mental distress was also done in community with others, particularly in mental health, LGBTQ+, and women of color spaces. Participants who engaged community-centered responses to not being-in-distress did so with people who also had lived experience with mental distress. Those with lived experience also were those who were part of the LGBTQ+ of color community, mainly with close friends and virtual networks. For example, Anna taps into her group of lesbian

friends for socializing such as a game night. She described these events as starting off social then turning in to a space where lesbians can process their mental health journeys. She shared that at one of the events, a group member posed a question asking: "Does anyone have mental health issues?" Anna then stated that the conversation turned to "...basically talking about different [psychotropic] drugs [everyone] was on and things like that. It was just a nice, affirming conversation, just out in the open. In addition, Rachel, Anastasia, and Danielle's community responses to not being-in-distress included support that facilitated feelings of solidarity and emotionally supportive friendships that functioned as a method to reduce isolation from others. These communities were also included LGBTQ+ of color spaces where participants felt the most healing and not being-in-distress. For instance, Danielle stated her experience with navigating virtual space for community-centered ways to respond to her mental distress:

I join[ed] or have been invited to different online groups...more specific certain mental health networks for LGBT people of color. Black LGBT people have been really supportive if I'm having a bad day or something. I'm [also] realizing that my bad day doesn't compare to some other people's bad days that I've seen.... Certain online groups in terms of LGBT have been supportive because they also point me in the direction of some LGBT events where I could meet more people like myself. Those have been really helpful for learning about news and events and different things.

In women of color spaces, not being-in-distress took the shape of using practices that were healing though the body and sexuality with the intention to respond to cultural norms of and stereotypes about Black women and physical movement. These responses

included discussions about sexuality to facilitative submissiveness and sense of power for Black women who might have the ability to do so due to dehumanizing stereotypes about Black women being dominant, strong, and independent (Bee). In addition, group-based physical movement practice like dance classes with other women of color, facilitates a community healing space (Rachel). Accessing online groups specific for women of color to assist with mental health concerns was also a form of healing (Rachel). Finally, online communities assisted with navigating institutions to find social support and community with other LGBTQ+ of color communities (Danielle). For example, Rachel shared about their experience in virtual space to access community to respond to their mental distress:

I guess it sounds silly, but there's a couple of Facebook groups that I'm a part of but it's really— I'm part of a feminist of color coalition and a mental health group, too. I don't even particularly share a lot on those groups but just having a space that I know I can if I need to, and seeing other people going through things, and seeing other people support each other in various ways whether it's emotional and/or in a really tangible ways of sending someone money because they can't make their rent or helping someone with an emergency, health-related problem.

**Resistance to Cultural Expectations and Norms.** Resistance to cultural expectations and norms that contributed to their mental distress was another facet of their healing journeys. Some participants described resistance to the demands to be strong and independent and negative beliefs about having a mental health concern. For participants resistance was pushing back against sanist oppression within their social groups and communities. This included challenging ableist/sanist language, mentoring, and



educating young people have been taught sanist information about their mental health and being open about their mental health status with others to disrupt silence around mental health, particularly in Black spaces. For example, Roo discussed her views about countering the sanist expectation within Black communities that acknowledge mental distress demonstrates weakness. She described her mother and family ascribing to this norm. She stated:

My mom is greatly affected by the perception the Black community has on mental illness where my grandma, who is born in the 1920's definitely came from a point where if you expose that something is wrong with you, you're saying that you are weak.... Black people really don't have the ability to be weak. While I do not believe that disclosing mental illness status and talking about your experience makes you a weak person. I think it makes you a strong person.

Roo's narrative account suggests that Black people engage in sanist behaviors (i.e., not appearing weak) as a response to anti-Black racism, but this has the effect of advancing harmful assumptions of sanist norms such as strength.

Anna described the generational difference and changes in perception about being healthy as being a personal experience and use of formal support to respond to mental distress:

The idea being you need to be healthy, not for yourself but because we need you to do stuff. It's shifting to no, we need you to be healthy for you and if you, once healthy, decide you want to help folks out, that's great. You're moving to be yourself, not because the whole Black community needs you to put them on your back. Even going into those younger cousins, or tweens, teenagers, it's much more

commonplace. Like, "Oh yes, I see a therapist," for whatever frequency, or someone conducts themselves this way, they should probably go talk to someone or that kind of thing. Because they're closer in age to me and more of the millennial generation, it's more reasonable.

Anna continued to describe how her siblings were helpful in challenging the norms about having a mental health concern in their family. She stated:

I grew up with one brother, the other's a half-brother, and he grew up with his mother. The brother I grew up with, we would look at each other when we'd hear weird stuff and just be like, "No, that makes no sense," and push through. It was kind of the concept of standing in a crooked room, but you don't know it's crooked. Having each other to mirror was like, "No, no, this is silly." It'd be like, "No, sometimes people are sick, sometimes you need to go speak to someone or be on medication." That was what was reasonable to do. Going back to the cousin who was schizophrenic, being able to have another person to counter my mom. "No, praying won't stop him from having an episode. It's just something that he needs to manage."

**Non-Disclosure for Self-Preservation.** Non-disclosure of their social identities was an intentional act of self-preservation and a response to protect themselves from further mental distress. Participants engaged in non-disclosure because they recognized that cissexist, heterosexist, and sanist systems in their relationships and communities were contributors to mental distress. Thus, non-disclosure provided some level of protection from direct violence from others in their social support systems. Some participants described their self-preservation practices as distancing themselves

from people, situations, and/or environments that contribute to their mental distress.

Distancing occurred by avoiding, maneuvering away from situations, holding or pulling things back, or finding balance. These responses represented not being-in-distress.

Whitley and Bella shared their distancing practices which protect them from negativity.

They specifically speak about non-disclosure of their trans experience (Whitley) and sexuality (Bella):

I refuse to deal with anything that's not empowering or positive or that I want to deal with in general. I'm not going to deal with anything I don't have to or I'm going to maneuver my way around [cissexist situations] to where I don't have to deal with [cissexist situations]. That's absolute to me. That's a censored part of acceptance. It comes with some masking of issues, but in general, I try to help myself. (Whitley)

I try not to let the negative experiences really get to me or bother me. I try to avoid [negativity] in general so I just don't tell people. I do take the happy experiences at face value. I don't think that people are trying to really do anything mean if they say things like or if they're just like so accepting of me and my sexuality or something like that. I just take it as I'm trying to be a really good person and that makes me happy. I try not to dwell on the negative parts of it. (Bella)

Other participants shared non-disclosure as self-preservation that aimed to control a situation or their environment as a means of not being-in-distress. These practices included vetting out situations prior to committing, not being open about their mental health concerns, and taking control of situations even in unsupportive environments.

These self-preservation strategies helped with protection against external factors, which could trigger their mental distress. For example, Whitley shared that a key way she protects herself is not giving people too much power. She stated that “I shield myself a lot, I don’t let what people say really get to me.... I don’t hear it or I could care less.” Samii also described her experience with self-protection through control by managing her mental health challenges and controlling her interactions with other people by keeping her mental health status a secret that resulted in feeling drained:

It's really difficult to interact with other people because I have to suppress all of these symptoms of BPD and my other mental illnesses, and it's very draining to do that. I try to minimize my interaction with people that I don't really know very well and limit myself to people I already know.

## **Summary**

Participants’ mental distress narratives revealed that several contributors to their mental distress including individual and collective trauma, pressure to embody strength and independence, instances of sexualized identity stereotypes, and discrimination experienced by mixed-raced participants. The impact of these contributors impacted their lives in two ways: (1) lowered their quality of life and (2) led to engagement in self-harmful thoughts and behavior. Finally, participants’ narratives illustrated efforts to not be in distress through engaging positive responses to their mental distress. These responses were individual healing practices for the body, mind, and spirit. Participants also used community to heal from mental/emotional wounds. Other strategies related to resisting cultural norms and preserving the self through non-disclosure.

## **An Integrative (Not) Being-in-Distress Framework**

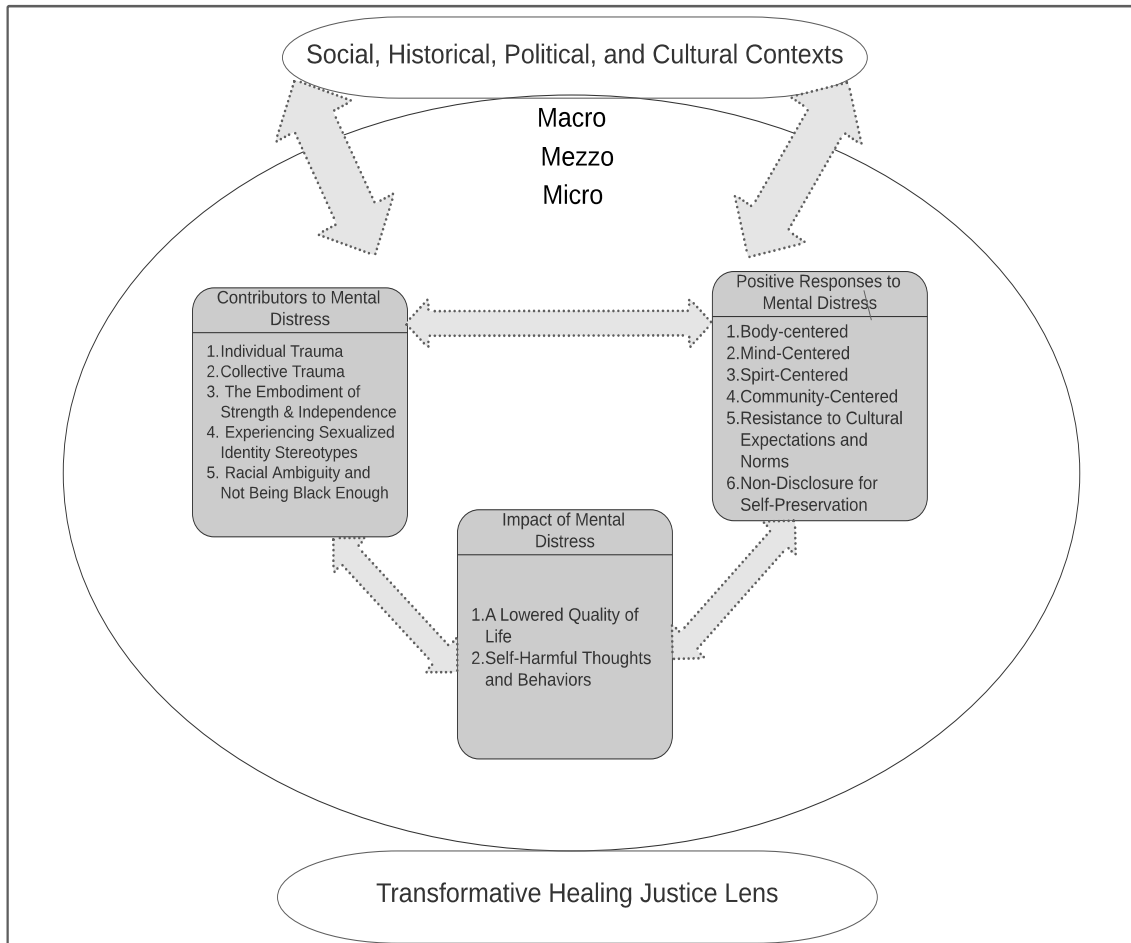
In Figure 1, I present the findings that emerged from participants' mental distress narratives, integrating concepts from my BQFMH framework. The framework presents each theme and subtheme and how they are interconnected. For example, contributors to mental distress (i.e., causes) negatively impacted participants' wellbeing (i.e., outcome), which resulted in the use of positive responses to heal and engage in protection strategies. In addition, the direction of the relationship flowed in the opposite direction where the causes of mental distress were associated with positive responses to mental distress for some participants. The use of healing and self-preservation led to improvements in quality of life. Finally, the impact and contributors of mental distress were interconnected in that the outcome emerged from the causes.

While the relationship between the themes and subthemes are positioned at the micro level (i.e., individual), it is important to note that mezzo level (i.e., institutions/community), and macro level (i.e., society/public) factors influence the participants mental distress, even if participants are unaware of how mezzo and/or macro levels impact them directly. External to the systems diagram, there is a two-way directional relationship between larger social, historical, political, and cultural contexts, and all three system levels where factors such as anti-Black racist, heterosexist, cissexist, and sanist histories; cultural norms and expectations; and violence towards BQWNB with mental distress affect all layers of lived experience. Changes that occur overtime though social change efforts can also shape and inform history, politics, and cultural norms and practices.

Finally, the (not) being-in-distress framework is situated in a transformative healing justice lens. The interpretation of the interaction between themes will be presented in chapter 5 are intended to move towards liberation for BQWNB with mental distress. Together, this framework informs the research question: How do BQWNB living with mental distress describe the experience of (not) being-in-distress? In summary, BQWNB living with mental distress navigate (not) being-in-distress by navigating various causes and impacts of their mental distress which also led to positive responses. This process was embedded in larger contexts and included multiple systems in their lives.

**Figure 1**

*Integrative (Not) Being-in-Distress Framework*



## CHAPTER 5

### DISCUSSION

In this study, I set out to investigate the research question: How do BQWNB living with mental distress describe the experience of (not) being-in distress? Findings revealed nuanced meanings to the concept of mental distress, based on personal narrative accounts. Participants were open to sharing their understanding of mental distress and the ways they navigated their distress and responses. Through their narratives, participants were able to voice their concerns, promoting awareness about issues important to BQWNB living with mental distress.

Findings determined that the phenomenon expansion (not) being-in-distress helped elucidate the role mental distress played in the lives of BQWNB. There were three major themes that emerged from the interviews:

1. Contributors to mental distress
2. Impact of mental distress
3. Positive responses to mental distress

(Not) being-in-distress provided a framework to grasp and make-meaning of mental distress through a transformative healing justice lens that infused Black queer feminist and mad studies theoretical concepts.

#### **Contributors to Mental Distress**

This study found that BQWNB with mental distress often understood their mental distress as being caused by traumatic experiences including individual trauma such as the death of a parent, health conditions, domestic violence, sexual assault or harassment,



and collective trauma such as the social political climate and anti-Black, sanist, and anti-trans responses in policing that for some participants formed barriers to receiving aid for their wellbeing. These findings align with research indicating survivors of individual trauma—incidents of events including sexual violence, attack, or illness or disease—may experience emotional or mental health challenges caused by these traumatic experiences. This finding is in alignment with research that suggest individual trauma, or instances of single or prolonged acts of violence, loss, and other experiences, may contribute to mental distress (SAMHSA, 2014). In addition, experiences of trauma at a cultural group level have also been found to lead to poor mental health outcomes (Barlow, 2018; Bartholomew et al., 2018; Flores et al., 2018; Kelly et al., 2020).

Findings also revealed that BQWNB with mental distress recognized dehumanizing images and stereotypes as a contributor to their mental distress. Consistent with other studies that found stereotypes of strength and independence associated with mental distress for Black women (Abrams et al., 2014; Donovan & West, 2015), this study determined that embodying strength in images like Black girl magic and the strong Black woman trope caused anxiety and depression and pressure to perform their gender in a particular way. Researchers have identified this phenomenon as stereotype threat, meaning stereotypes made about a particular group of people places pressure on them to perform or risk their sense of belonging in the group (Jerald et al., 2017; Spencer et al., 2016). Similarly, racial and/or sexualized identity stereotypes about bisexuality and transgender women of color such as bisexuals being selfish and cheaters and trans women of color being sex workers were highlighted in participant narratives. Consistent with existing studies, Black transgender, bisexual, and pansexual

women often experience stereotypes that portray them as hypersexual, promiscuous, and/or as unfaithful cheaters (Brewster, & Moradi, 2010; Serpe et al., 2020).

Finally, the results from this study showed that BQWNB with mental distress from mixed-race and mixed-heritage backgrounds understood their mental distress as being caused by anti-Blackness in mixed-race families, racial ambiguity, and monoracist responses from those in Black spaces. These findings are consistent with previous research on multiracial and mixed-heritage experiences, which found that multiracial people experience monoracial discrimination such as questioning of their racial/ethnic identity that was associated with higher rates of mental distress (Jackson, 2012; Jackson, et al., 2012).

### **Impact of Mental Distress**

This study found that BQWNB with mental distress understood that their mental health affected their quality of life. Mental distress lowered their overall engagement in the social aspects of their lives and the ability to engage in their daily activities. Additionally, BQWNB with mental distress have lowered engagement in safe spaces due to racist, heterosexist, and sanist discrimination, leading to a sense of distrust and avoidance of certain people and/or communities. This is consistent with empirical research that found people with mental distress might experience challenges in life domains such as sense of wellbeing, control, belongingness, and engagement in life activities. These life domains were characterized by challenges with fear, depression, anxiety, finances, sense of self, or ability to have supportive relationships with others, which were similar to the experiences of participants in this study. Previous research supports this finding in that Connell et al. (2012) article

highlighted six major life domains that are affected as a result of mental distress among people living with mental health concerns including wellbeing, sense of control of life, perception of self, sense of belonging, engagement in life activities, and sense of hope and hopelessness. Additionally, the current study found self-harmful thoughts and behaviors such as suicidal thoughts and attempts and emotional eating were an outcome of mental distress for BQWNB. Studies on self-harm have reported that LGBTQ+ people of color may experience higher rates of suicide attempts and depression compared to their white counterparts (Layland et al., 2020).

### **Positive Responses to Mental Distress**

This study found that BQWNB with mental distress engage positive holistic body, mind, and spirit healing practices to respond to their mental distress with the aim of not being-in-distress. These practices included physical movement, hydrating, hygiene, sexual and body liberation, and seeking support, therapy, and ancestral veneration (i.e., spiritual). These findings are consistent with research that suggests Black communities engage in self-care activities to heal (Bartholomew et al., 2018; Destine, 2019; Ginwright, 2018). Personal engagement in healing and accessing formal supports reduced distress (Barlow, 2018; Bowleg et al., 2014).

While some BQWNB with mental distress used holistic body, mind, and spirit healing as a personal and individual practice to not experience mental distress, findings revealed healing in community with other Black women and LGBTQ+ people, both online and face-to-face. Specifically, BQWNB with mental distress found safety in spaces that centered Black women, LGBTQ+ of color, and communities with progressive political stances. Conversely, BQWNB with mental distress felt unsafety in spaces such

as Black, LGBTQ+, or mental health communities that centered white experiences or did not affirm the lived realities of women, LGBTQ+ or people with mental health concerns. Instead, safety was found in mental health, LGBTQ+, and/or women of color space that were intersectional. These spaces provided BQWNB with mental distress with emotional and affirming support from those with similar lived experience. Specifically, this study found that BQWNB living with mental distress found face-to-face and online spaces as sources of support to heal their mental distress. Spaces that were the most helpful were those that were specific to LGBTQ+ people of color with mental distress, groups that held progressive ideals about liberation and healing for Black communities and provided general support for people of color. Consistent with scholarship on healing justice, researchers have described that healing is not only an individual practice but also one that can be done in community with others (Barlow, 2018; Bartholomew et al., 2018; Green, et al., 2018).

Furthermore, resisting oppressive norms about their race/ethnicity, gender, sexuality, and/or mental health status was also found to be a healing-centered response to mental distress among BQWNB with mental distress. This study found that BQWNB people living with mental distress experienced racism in LGBTQ+ communities and heterosexism and sanism in Black communities. In addition, members of this community also challenged sanist perceptions in their friend groups, mainly with other LGBTQ+ and/or people of color. Research supports that members of the Black LGBTQ+ community may experience cultural and societal expectations from their support systems and larger community institutions (Glass & Few, 2013; Moore, Camacho, et al., 2020). However, research highlighted that acts of resistance towards cultural and social

norms about mental health might look like evaluating the norms, challenging them, and replacing them with affirming norms (Moore, Camacho, et al., 2020).

Finally, the findings in this study showed that BQWNB with mental distress used non-disclosure for self-preservation as a response to their mental distress to protect themselves from further harm and distress. Previous studies showed that members of LGBTQ+ communities of color engage in non-disclosure strategies to receive support from their families for their survival and to protect themselves from heterosexism and sanism (Moore, Camacho, et al., 2020; Selvidge, et al., 2008). Interestingly, this study found that resistance was reflected a generational difference in the way seeking support was perceived as a healing practice. Younger generations were more accepting of support than older members of their families. In addition, there were instances when some participants disclosed their mental health status as a means of resistance towards silence while others did not disclose to protect themselves from sanist discrimination. A few participants engaged in disclosure when they felt it was necessary to disclose for accommodations, to find support, or when brought up in conversation with others. Some might have not disclosed due to not perceiving their mental health status as an identity that needed to be shared with others. In fact, during the interviews, multiple participants shared that they had never thought about their mental health status as an identity to disclose like their other social identities such as LGBTQ+ or racial/ethnic identities. Rather, participants viewed mental health status as one part of their lived reality not an identity.

## **Applying a Black Queer Feminist Mental Health Framework**

This study demonstrated the importance and necessity for the BQFMH framework—a critical approach to mental health—focused on mental health and BQWNB with mental distress. The primary aim of the BQFMH framework was to support the healing of BQWNB with mental distress through transforming oppressive communities and institutions by eliminating barriers to increased wellbeing. The BQFMH framework acknowledges the social and historical context including how science and religion put forth racist, heterosexist, and sanist beliefs about people who are Black, LGBTQ+, and/or have mental health concerns (Collins, 2004; Davis, 2018; hooks, 2015; Stephan & Phillips, 2003). Furthermore, scholars previously have pointed out the need for critical and transformative responses to the wellbeing of Black LGBTQ+ communities (Barlow, 2018; Carruthers, 2018; Green et al., 2018; Meerai et al., 2016). The findings in this study support the need for transformation considering the interconnectedness of oppressions and their impact on the lives of BQWNB with mental distress. More specifically, contributors of mental distress such as collective trauma were related to anti-Blackness and anti-LGBTQ+ discourse in criminal justice institutions that are intended to alleviate distress. Yet, the criminal justice institution was perceived as harmful and detrimental to their mental wellbeing. A BQFMH framework can also observe the nuances of the way some cultural expectations are tied to gendered racist and sanist systems that pose dehumanizing stereotypes that place unrealistic pressure and expectations on members of the community, which may lead BQWNB with mental distress to seek affirming communities and to engage in practices that heal and preserve their mental health. In this study, participants found these affirming communities. The

need to apply critical approaches to the experiences of BQFMH with mental distress is essential to understand the complexity and richness of their lives as it relates to the interconnectedness of their social identities based on race/ethnicity, gender, sexuality, and mental health status.

### **Implications for Research**

The study contributes to the literature on Black LGBTQ+ people experiencing mental health challenges and provides several implications for future research. First, future research should continue to apply critical approaches to mental health to accurately capture the interconnectedness of race, gender, sexuality, and mental health status at the individual, interpersonal, and institutional levels. In applying these critical frameworks, scholars can tease out the ways anti-sanist narratives intersect with other systems of oppression including systems considered in previous research. Similarly, researchers should consider deepening Black queer feminist and mad studies theorizing in the helping professions in three ways: (1) through creating and/or integrating other innovative theories within critical disciplines such as critical disability studies, fat studies, Black feminist/womanist, and transnational feminisms that can advance the field of critical mental health studies to look at Black LGBTQ+ mental health in a U.S. and transnational context; (2) consider looking at different sub-groups of Black LGBTQ+ people such as Black immigrant, Latinx, and those with more “stigmatized” mental health concerns with a fuller in-depth analysis of their social, historical, and cultural experiences; and (3) center macro level change efforts and use critical mental health perspectives to advance macro practice such as policy analysis, anti-Black sanism campaigning, and social political actions for Black lives that go beyond police brutality

and include other Black experience other than Black cisgender men. This study found police violence also an important concern in the lives of BQWNB with mental distress.

Second, future research should explore and describe experiences of BQWNB with mental distress within interpersonal relationships and larger social institutions with more depth to grasp how social environments are affirming or disaffirming of their social identities. Some research has begun this work, looking at oppression and/or overall experiences of people of color, LGBTQ+, and/or people with mental health concerns (e.g., Holley et al, 2019). However, these studies are limited in the sample size of Black LGBTQ+ people with mental distress or do not look at mental health status as an identity that is claimed or imposed onto BQWNB perceived to be in distress. Third, research should examine the effectiveness of continuum belief interventions using anti-oppressive methods at decreasing sanist prejudice and discrimination and promoting mental wellbeing among BQWNB living with mental health concerns. This study used the concept mental distress, which may be in alignment with the continuum belief approach to mental health that Peter et al. (2010) described as perceiving mental health challenges as a part of a shared life experience among people. Incorporating anti-oppressive concepts and tailoring intervention efforts to the needs of BQWNB with mental distress might improve the effectiveness of destigmatizing/anti-sanism responses.

Fourth, this study used semi-structured interviews to gain insights into the research phenomenon. While this method allowed for richness in the data, the use of research methods such as community based participatory action research (CBPAR) would have given a diverse group of BQWNB with mental distress direct involvement in all aspects of the research process, identifying concerns that I might not



have known about or come across in current literature. For example, according to Becker et al. (2014) the use of community-based participatory methods for people with mental health concerns such as photovoice provides a creative way for participants to be storytellers of their lived realities using visual forms of data. This method is also empowerment-based and leads to a collaborative partnership between researcher and participants. Similarly, Jackson (2012) illustrated the usefulness of “participatory diagramming” to capture the complexity of mixed-race people over a period of time. Diagramming might also be useful in illustrating how BQWNB with mental distress came to make-meaning of their race/ethnicity, gender, sexuality, and mental distress over time. CBPAR’s action-focused priority may lend itself useful to a transformative healing justice lens where action towards Black liberation at the individual or structural level may provide tangible experiences for BQWNB with mental distress and empower them to continue community engagement efforts in their local communities. Specifically, liberation for the most marginalized in Black communities includes freedom from anti-Black racism, anti-LGBTQ+ discrimination, and sanist violence such as hate crimes, emotional abuse, sexual assault, and anti-immigrant policies (Carruthers, 2016). This new “reimagining” of Black liberation is different from previous Black liberation movements that considered only race as the primary and sole issue important to freeing Black people from oppression (Carruthers, 2016, p. 43). Thus, critical methodologies that engage actual community members might be a great way to both empower and bring forth different results and ways to contribute to and reimagine/make-meaning of Black liberation through research.

Finally, future research should explore the effectiveness of anti-oppressive, affirming, and innovative peer support programming that might not have been explored with this community. BQWNB with mental distress may rely on their social support systems, particularly those who have past or current experiences with mental health challenges or experience with seeking support, suggesting that peer support might be a beneficial source of support for them. In addition, infusing social and healing justice frameworks into peer supports in Black communities may be one way to center culture in peer programming. While peer supports such as mental health literacy, education, and counseling are some of the most well-known peer support methods, less explored are how peer respite programs that are alternative crisis responses to psychiatric hospitals and police, might be an avenue for BQWNB with mental distress to receive non-institutional support. For instance, Ostrow and Croft (2015) identified peer respite programs as a potential peer-based response for people experience mental health crisis that is an alternative to police and mental health care systems, specifically psychiatric hospitals. Peer respites provide short-term non-institutional support in a community setting where all staff are people with lived experience. In fact, Croft et al. (2021) recently conducted a qualitative study among a sample of 10 peer respite guests to examine their experiences staying in peer respite residential programs. The findings revealed several positive outcomes such as sense of belonging, increased sense of confidence and hope, and mutual support. This might be a useful peer-based programming effort for BQWNB with mental distress.

## **Implications for Anti-Oppressive Social Work Practice**

Based on the findings from this study, there are several implications for anti-oppressive social work practice with BQWNB with mental distress. I organize these implications by micro/mezzo and macro level recommendations. At the micro/mezzo level, anti-oppressive social workers may consider shifting from a biomedical-centered model to a social model of mental distress. Social workers who lead with a social model may allow BQWNB with mental distress to use terms that affirm their lived realities. Specifically, anti-oppressive social workers may consider exploring the meanings attached to and preferred language of their mental distress in clinical practice, especially because some BQWNB with mental distress may not align with “illness” or “disorder” or even “distress.” Members of this community may or may not ascribe to cultural and societal norms about having a mental health concern or might experience a sense of being othered within their communities due to some aspect of their race/ethnicity, gender, sexuality, and/or mental health status. When working with clients on an individual level, being open to affirmative practices may help BQWNB with mental distress process cultural/social norms and create new self-defined norms and practices. Social workers who engage anti-oppressive approaches to mental distress may see the use of diagnostic tools such as the DSM-5 to provide access to medical care as opposed to pathologizing people with an “illness” or “disorder.”

Similarly, social workers might consider challenging sanist perspectives that are held by members of this community including cultural norms of strength, independence, and beliefs about Black people’s inability to show weakness or vulnerability. Social workers may challenge this perspective by processing the pervasiveness of strength in the

personal beliefs of BQWNB with mental distress while also working through identifying alternative or new affirming definitions of strength. Throughout this process, social workers might also connect the ideologies of strength among others in their families and communities as well as back to gendered racist histories that are tied to white supremacy. Discussing the history behind anti-Black and sanist discourses might introduce a new way of seeing the detrimental effect of controlling images/stereotypes that relate to Black mental/emotional health by relating it back to the larger oppressive system. This also aids in raising the consciousness of their clients as it relates to sanist beliefs in their clients' communities.

Second, anti-oppressive social workers should position their practice in critical perspectives that promote body, sexuality, and spiritual freedom as well as healing for marginalized communities. The body and sex positivity movements have expanded the notion of healing beyond the biomedical approaches such as therapy and medication. Instead, some find healing in resisting societal norms about their bodies and sexualities (Cascalheira et al., 2021; Matacin & Simone, 2019). Others might engage in spirituality as the source of healing. These might contribute to a holistic body, mind, and spirit healing of mental distress for some members of the community. Anti-oppressive practice should also emphasize healing justice lens by assessing for the self-preservation, coping, survival, and healing strategies of BQWNB with mental distress and engaging these practices in the recovery process that might help anti-oppressive clinicians to meet their clients where they are. This assessment might point out how anti-oppressive practitioners can recommend practices that are in alignment with their client's culture and social identities. Additionally, social workers who focus on healing must be prepared to address

individual and collective trauma histories of BQWNB living with mental distress. Navigating trauma might require social workers to have an awareness about how oppression and discrimination directly influence exposure to and experience of collective trauma such as police violence.

Third, anti-oppressive practice should include integrating peer and informal supports as a part of the therapeutic process. Participants in this study relied on those who had lived experience with mental distress. Using peer-based support can serve as an additional resource for BQWNB with mental distress and may enhance their healing. Anti-oppressive social workers should explore locating safe spaces that support BQWNB living with mental distress at local Black, LGBTQ+, or mental health serving organizations known for taking a liberatory approach to mental health and wellbeing. Social workers might also refer BQWNB with mental health concerns to online-based support such as Facebook groups that were created for LGBTQ+ people of color with mental health concerns. Furthermore, anti-oppressive social workers might consider following progressive grassroots, and community-based collectives on social media who are often connected to hard-to-find resources that might not be well advertised in institutional settings. If a need is identified, social workers may consider creating a space for clients with an expressed need for either face-to-face and/or online spaces, being mindful of their social identities and, if needed, finding LGBTQ+ people of color and/or people with lived experience to lead efforts to create safe space.

At the macro level, anti-oppressive social workers should consider efforts to eliminate systemic barriers in police responses to Black people experiencing mental distress through transforming how police respond to crises. Specifically, social workers

should support policies that require law enforcement to use different approaches in response to people in mental health crisis. This may include local crisis response teams being the primary responders. Social workers may also support alternatives systems to policing that are community-based and recovery focused. Addressing police responses to mental health crisis is particularly important considering that who people have or are perceived to have mental health challenges have a significantly higher risk of death at the hands of police officers (Saleh et al., 2018). Furthermore, anti-oppressive social workers can promote macro level change by participating and/or supporting anti-Black sanist campaigning that aim to educate others about strength. The use of social media platforms might be an avenue to engage in challenging norms about mental health. In efforts to shift sanism, social workers may find critical approaches to mental health (e.g., BQFMH framework) as a guide to make suggestions based on the continued liberation work of Black LGBTQ+ scholars and social movement leaders.

Second, anti-oppressive social workers should consider efforts to educate, train, and hold larger mental health care institutions and community leaders in affirming practices that can be written into policies and legislation. It might be helpful for social workers to either function as consultants or be involved in creating policies. Trainings might include increasing awareness of intersectional forms of oppression, anti-Black sanism, and other systems of oppression, and how they contribute to and impact the mental health of BQWNB with mental distress as well as educating about the positive ways they respond to their mental health needs.

Furthermore, social workers who might not have lived experience with mental distress or might be of a different racial/ethnic, gender, or sexual identity from BQWNB

with mental distress, can support members of these communities by speaking up about racist, sexist, heterosexist, cissexist, and sanist oppression, when it is apparent to them. People who work in solidarity with BQWNB with mental distress must also be willing to engage in continuous work to educate themselves about policies and practices that further marginalize certain voices and use their race/ethnic, gender, sexuality, or mental health-based privileges to offer suggestions, challenge beliefs systems, and infuse perspectives of those who are not represented in the policy or change-making process. This may also include suggesting that organizations and institutions bring in experts with lived experience to help with making affirming changes.

### **Implications for Anti-Oppressive Social Work Education**

Considering the social, historical, and political climate and the impacts on the wellbeing of Black, LGBTQ+, and people with mental distress, social work educators should engage anti-oppressive approaches to teaching mental health, cultural attunement, and/or cultural humility (Jackson & Samuels, 2019; Lerner, 2021). For example, Holley et al. (2015) suggest that social work educators should consider integrating a critical approach to mental health by integrating mental health status as a site of anti-oppressive work in diversity and oppression courses. To do this, social work educators should consider exploring incorporating content about mental health history and the socialization process that leads to producing sanist oppression, challenging mental health-based privilege, and being thoughtful about issues around disclosure of mental health status in the classroom. Bringing this content to the forefront in social work education will help expose how systemic racism, sexism, cissexism, heterosexism, sanism, and other “isms” are woven into the fabrics of social work and other related mental health and

social welfare disciplines. In addition, social work educations should write accessibility statements for students with mental health challenges who may not be registered with university accessibility and disability services. These statements are needed, especially for students who do not have formal diagnosis due several reasons such as resisting mental health systems that they might perceive as unsupportive of people with their identities or not having institutional access to receive the resources needed.

Finally, anti-oppressive social work educators should consider ways to navigate diversity and equity issues in social work education, particularly as it relates to challenging whiteness and “cultural competency” (Jackson & Samuels, 2019; Lerner, 2021; Teclé et al., 2020). For example, Teclé and colleagues (2020) conducted a qualitative study to explore field instructors’ understanding of diversity in field education. Teclé et al. found that social work students perceived diversity at the micro/individual level, saw simple awareness as diversity work, or held “color-blind” practices. (Note that the term “color-blind” is offensive to many of those with visual impairments; the term “color evasive” is more accurate and not ableist.) The results from this study supported the need for field instructors to infuse anti-oppressive approaches to their teaching to engage students in critical reflection and dialogue about how these practices are harmful. Similarly, social work educators might consider using strategies to challenge whiteness in the classroom including explicitly recognizing white supremacy, engaging theories that explain the pervasiveness of whiteness, and guiding white students to how racism operates at the institutional level (Lerner, 2021).



## **Word of Caution for Anti-Oppressive Social Workers**

Social workers who engage in anti-oppressive work must be cautious about how they engage liberation frameworks that emerged out of resistance to oppressive systems. For instance, the popularity of healing and transformative justice is rooted in the Black radical and/or liberation traditions and for many community members are grassroots responses of resistance to the medical-industrial complex which have historically pathologized Black bodies and other marginalized communities (e.g., Kindred Southern Healing Justice Collective, n.d.). As a profession, social workers must recognize possible ramifications of using anti-oppressive and social justice tools within an oppressive system and profession, risking re-colonizing, weaponizing, or watering down the radical potential of these practices for Black, LGBTQ+, and/or people with mental health concerns. Thus, it is critical that social workers who have privileged identities (e.g., white, heterosexual, cisgender, haven't experienced a mental health concern) must be mindful of how they engage the perspectives and ensure they continue to honor the grassroots origins. In addition, social workers must do their personal work and challenge racist, sexist, heterosexist, cissexist, or sanist beliefs and behaviors that might get in the way of them working with clients who have different and/or same lived experiences but have internalized oppressions. Implementing radical perspectives cannot occur without challenging the underlying systems that continue to be part of social work clinicians, organizations, and the larger profession.

## **Limitations and Strengths**

This study had several limitations. The study was administered in English only. This did not allow participants who might speak other languages including Spanish,

French, and other languages across the African diaspora to participant in the study, limiting the diverse perspectives of the participants represented in the sample. In addition, this study used a purposive and snowball sample to recruit Black LGBTQ+ women and nonbinary people living with mental distress primarily online using Facebook groups and LGBTQ+ listservs. While participants were from different geographic locations across the U.S., recruitment online limited reaching participants who do not use social media and networking sites.

Another limitation to the study is the demographic makeup of the sample. Participants were highly educated and younger in age with a mean age of 28.38. Most participants also had formal diagnoses, expressed familiarity with mental health concerns, and/or had some involvement in formal mental health care systems including use of therapy, psychotropic medication, and experience with hospitalization. Considering these demographic characteristics, these findings do not speak to those who are less educated, are older in age, who are not familiar with mental health diagnoses or the language describing mental health issues, and who have limited or no experiences seeking formal support-seeking experience. One solution is to use more expansive language other than mental distress, mental illness, disorder, or mental health concern to include somatic descriptors for those who might have experiences with mental health concerns yet do not use the language to describe their experience or who reject Western definitions and ways of responding to their mental wellbeing. Taking this approach may allow for a deeper analysis of mental distress among those who might ascribe to the aforementioned terms but might still have awareness about anti-Black racism, heterosexism, cissexism, sanism, and other systems of oppression that impede on their wellbeing.

This study also used self-reporting data which may pressure participants to respond in a socially acceptable way (Fisher, 1993). While this is considered a limitation for some researchers, others may consider self-reporting though less-structured interviews a way to promote rich and nuanced data that better illustrate the experiences of participants. Furthermore, this study did not triangulate the research findings with methods such as member checking. Not triangulating the results using technique such as member checking effects the validity and trustworthiness of the findings, or how reflective the findings are of participants' actual lived experiences (Carter et al., 2014). Finally, as a researcher involved in the data planning, collection, and analysis process, personal biases and perceptions may have both interfered with and enhanced in the research process. However, implementing techniques such as reflexivity, continuous memoing, and conferencing with my dissertation committee to process the data assisted in exploring my thoughts, feelings, and reactions to the raw data.

While there were several limitations, there were also strengths. First, this study took steps to enhance to rigor to maintain the confidentiality of research participants. I removed all information that might lead to the identification of participants such as age, location, and real names. Second, I created a social justice-oriented theoretical framework that was embedded in transformative and healing justice which are core to the socio-political and social change efforts of radical Black liberation traditions (see Carruthers, 2018). This places culture, equity, and social justice work at the forefront of the study, offering an anti-oppressive take on mental health in Black communities. Third, I applied a critical qualitative methodology that infused women of color feminisms, mad studies,

and phenomenology to construct a methodological framework that was in alignment with the goals and aims of the study as well as the anti-oppressive lens.

This study also included a range of participants across race/ethnicity, gender, sexuality, and mental health concerns that aided in the strength of the data. This diversity in the sample allowed for me to point out themes that are often rendered invisible due to the lack of representation of a range of Black LGBTQ+ experiences. Fourth, my shared identities with participants allowed me to pull from collective experiences especially as it relates to anti-Black and anti-LGBTQ+ discourses and assisted with using appropriate theories and methodologies that spoke to the core of Black LGBTQ+ women and nonbinary people living with mental distress. Finally, other strengths of the study included the use of open-ended questions which allowed participants to provide more in-depth and insightful responses, leading to richer data.

## **Conclusion**

In conclusion, this study explored and described the experiences of BQWNB living with mental distress related to (not) being-in-distress through a transformative healing justice lens. A major contribution of this work was the development of a critical approach to mental health that integrated core concepts from Black queer feminist and mad studies, leading to the creation of the Black Queer Feminist Mental Health Framework. In addition, the findings supported existing research on mental health and wellbeing as it related to Black, LGBTQ+, and/or people living with mental distress. Moving forward, anti-oppressive social workers should consider how contributors to, impacts of, and positive responses to mental distress can inform anti-oppressive practice at the micro/mezzo and macro level as well as efforts to incorporate anti-oppressive

approaches into social work education. Learning from the experiences of BQWNB living with mental distress will lead to anti-oppressive and affirming mental health care as well as guide macro level change efforts in policy, campaigning, and political action.

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APPENDIX A  
CONSENT LETTER

## CONSENT LETTER

I am De'Shay Thomas, a graduate student under the direction of Professor Lynn Holley in the School of Social Work at Arizona State University. I am conducting a research study to learn about the experiences of Black LGBTQ women who have experienced mental distress.

To participate in the study, you must be at least 18 years old, a U.S. resident, speak fluent English, and:

- Identify as Black/African American (though you might also claim another racial or ethnic identity)
- Identify as a woman now or at some point in adulthood
- Identify as Lesbian/Gay, Bisexual, Pansexual, Transgender and/or Queer at some point during adulthood
- Experience mental health concerns such as (but not limited to) an addiction, anxiety, bipolar disorder, and/or depression.

In this study, you will be asked to participate in a face-to-face, Skype, or telephone interview to talk about positive and negative experiences while living with mental distress. This interview will take approximately 1-2 hours.

As a token of appreciation, you will receive a \$25 gift card.

The information from the interview may help encourage people to develop better ways to support others in their communities who are living with mental distress.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. You have the right to not answer any question, and to end your participation in the interview at any time. There are no foreseeable risks to your participation, though it is possible that some participants may experience discomfort as they describe negative experiences.

We will keep all your information confidential. The results of this study may be used in reports, presentations, or publications, but your real name and any identifying information will not be used.

To remember our discussion correctly, I will audiotape the interview. You can let me know if you want a portion of the interview to not be taped; I will turn off the recorder for that portion of the interview. The audio recordings will be stored on the hard drive of a password-protected computer and a private folder using an ASU-Hosted Google drive. The audio recordings will be destroyed within 12 months of the interview.

At the end of the interview, you will have the option of filling out a contact information card to participate in a follow-up interview. Your name and contact information will be linked to your pseudonym created during the interview and will be kept in a locked filing cabinet, separate from the audio recorded interview. This is to ensure that your information is kept private. If you choose to fill out a contact card it will be shredded after the follow-up interview; it also will be shredded if I cannot reach you to invite you to participate in the follow-up interview or if, after I contact you, you decide to not participate in the follow-up interview.

If you have questions about or would like to participate in this study please contact De'Shay Thomas at (623) 349-4352 or at [hmv.study@gmail.com](mailto:hmv.study@gmail.com). If you have any questions, concerns, or complaints about this study please contact Professor Lynn Holley at (602) 496-0052 or [lholley@asu.edu](mailto:lholley@asu.edu) or De'Shay Thomas at (623) 349-4352 or [hmv.study@gmail.com](mailto:hmv.study@gmail.com).

If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

**Subject Statement:** "I understand the explanation provided to me. I have had all of my questions answered to my satisfaction. I voluntarily agree to participate in this study. I have been given a copy of this information form."

Pseudonym \_\_\_\_\_

Signature of Investigator \_\_\_\_\_ Date \_\_\_\_\_

APPENDIX B  
SEMI-STRUCTURED INTERVIEW GUIDE



## SEMI-STRUCTURED INTERVIEW GUIDE

### Preliminary activities

1. Complete screening interview.
2. Distribute/Email Consent Letter to participants.
3. Obtain verbal and/or written Consent from participants.

### Begin Interview

I really appreciate you for agreeing to share your experiences as someone living with mental distress! Before we get started, I would like to tell you a little bit about who I am and why I am interviewing you today:

My name is De'Shay Thomas, a social work graduate student at Arizona State University and I self-identify as a black queer-lesbian cisgender woman. I am interested in hearing about the experiences of African American/Black LGBTQ women living with mental distress because there is an absence of information in my field – social work. It is important that we hear the voices of LGBTQ people of color and how you navigate your lives to know how service providers can better serve this community. I am grateful that you have taken the time to speak with me today about your experiences living with mental distress.

Do you have any questions for me before we get started? What about any questions about the Consent Letter?

Before we proceed, I would like to ask you to create a fake name. Do you have a name in mind? This name is to ensure your identity remains confidential. I will refer to you by this name throughout the interview to keep your identity private.

I would also like to ask you for your personal gender pronoun. Are you familiar with personal gender pronouns?\* Great! What personal gender pronouns do you use? Your personal gender pronoun is to ensure that I refer to you by your correct gender. I will refer to you by your gender pronouns in any written reports to ensure you are not mis-gendered.

- **\*If unfamiliar with personal gender pronouns:** Okay, personal gender pronouns are words you would like me to use when referring to you and your gender identity. Examples include she/her/hers, he/him/his, and they/their/them. Your personal gender pronoun is to ensure that I refer to you by your correct gender. I will refer to you by your gender pronoun in any written reports to ensure you are not mis-gendered. What personal gender pronouns do you use?

With your permission, I will begin recording now. Is this ok? Remember that if at any time you're not comfortable with being recorded when you want to tell me something you can just tell me to stop recording. Then, with your permission I will turn the recorder back on when you're ready. How does that sound?

Remember that you can refuse to answer any questions. And as we talk, I will be referring to you by your fake name. If you mention other people, try to give them a made-up name. Don't worry if you slip and say their real names—I will change their names when I write up our conversation. This is to make sure that your and other people's identities are kept private.

Before we start I need to mention one more thing. I'm wanting you to answer lots of questions, and I'm hoping to not take more than an hour to an hour and a half of your time. So I may need to cut in sometimes so we can get to all of them. I wanted to warn you so you don't think I'm rude if I ask you to move on to another question. OK? [Smile]

Any more questions before we get started?

Okay. My first question is:

1. Describe how you identify so far as your race and ethnicity, sexual identity or orientation, gender identity and expression, and mental health status are concerned. Describe other identities that you consider central to who you are.

**Prompt 1:** If they don't address each of the listed identities ask what they think about those identities.

**Prompt 2:** If they don't specify, ask which of the following terms they prefer: sexuality, sexual identity or sexual orientation; mental distress or mental illness.

**Prompt 3:** If they don't specify, ask what nation or tribe they identify with if they say they are Native American or Indigenous; and what ethnicity and/or nation of origin if African, Asian or Asian American, Hispanic or Latina, Other Pacific Islander, or white.

2. Now that I know more about how you identify, tell me about what living with **[use their term for mental distress here]** means to you.

**Prompt 1:** If not mentioned, explore values and perceptions about mental distress.

**Prompt 2:** If participants mention certain meanings and perceptions ask "tell me a little more about [insert meaning/value/perception here]."

3. Think about your identity as [use their terms for intersecting identities here] that describe who you are. What has your experience been like telling others about these identities?

**Prompt 1:** If they do not discuss it, explore disclosure or conversations about mental distress, gender, sexual, racial/ethnic and other identities they mention.

**Prompt 2:** If they do not discuss it, ask participant to describe an experience or situation in which they disclosed or spoke about their identities with others.

4. Think about your interactions with the [**insert terms used for racial/ethnic, LGBTQ, and mental health group**] communities you are a part of, When it comes to the communities you are a part of, what have your experiences been like?

**Prompt 1:** If they do not discuss, bring up AA/Racial/Ethnic, LGBTQ, mental health, and other communities they mention.

**Prompt 2:** If they do not address, explore positive experiences with the following systems: family, friends, service providers (e.g., mental health and medical), AA/Ethnic communities, law enforcement (i.e., police officers) LGBTQ communities, religious communities, and online communities. Ask participants to give a positive example or describe a positive situation. “From your perspective, what are some positive

**Prompt 3:** If they do not address, explore negative experiences with the following systems: family, friends, service providers (e.g., mental health and medical), AA/Ethnic communities, law enforcement (i.e., police officers) LGBTQ communities, religious communities, and online communities. Ask participants to give a negative example or describe a negative situation.

**Prompt 4:** If participants do not address, ask “have you ever been treated negatively due to your race, gender, sexual identity, mental health status or other identities you possess? Tell me more about those experiences. **I want your opinion or perspective whether or not anyone else would agree with your perspective**”

- Explore whether they perceive these experiences as discrimination using the following definition: Discrimination refers to negative behaviors direct towards someone who is different because of their race, ethnicity, gender, sexual orientation, mental health status, class, nationality or other identities that make us different from other people. These actions tend to make others feel excluded or less than others because they may be different.

5. When it comes to these positive and negative experiences you have had in your

communities, describe how you reacted or responded to them.

**Prompt 1:** If they do not address it, ask “were these reactions or responses helpful? Were any of them unhelpful? Tell me more about how they were helpful or unhelpful”.

**Prompt 2:** If they mention positive experiences, explore who they shared these experiences with and to “tell me more about that”.

**Prompt 3:** If they mention seeking help from others, explore who they sought help from, what they sought help for, their experiences asking for help, and to provide an experience or situation in which they sought help.

**Prompt 4:** If they do not mention it, ask participants about their decision in not seeking help from others. “tell me more about your decisions not to seek help or support from others”.

6. Think about your identity as [use their terms for intersecting identities here]. What are some concerns or problems that you have with larger institutions or organizations such as law enforcement, schools, mental health treatment and physical health treatment, religious organizations, or other relevant institutions or organizations you are familiar with?

**Prompt 1:** If not addressed, ask about racial/ethnic communities, LGBTQ communities, religious communities, mental health communities, online communities, or other relevant systems participant has mentioned before.

**Prompt 2:** Ask participants about situations or concerns such as law enforcement and other situations or concerns in the broader society. If they talk about these topics, ask: “tell me more about your concerns related to [insert situation/concern here]”.

**Prompt 3:** If not addressed, ask participant how they have reacted or responded to the concerns facing their communities. How have these responses been helpful or unhelpful in changing and managing these concerns? Tell me a little more about how these responses have been helpful or unhelpful.

7. What supports, resources, and strengths have helped you navigate your life as an [insert identities here] living with [insert participants used terms here for mental distress]?

**Prompt 1:** If they don't address them, ask about types of support, resources, and strengths, who offered this support, and how support, resources, and strengths have been helpful. Ask them to provide an example or situation.

8. Now I would like to give you the opportunity to share anything else we did not talk about today that is important to you and your experience. What other information would you like to share with me about your experiences?
9. For my last question, how did you hear about this study?

**Prompt 1:** what led you to participate?

### **End Qualitative Portion of Interview**

I would like to thank you for your time and sharing your experiences with me! I truly appreciate your involvement in this study.

Before we end, I have a few background information questions for you. Some of these questions may have been addressed during the interview so I apologize if they seem repetitive. You'll note I have a list of definitions for you of some of the terms on the form. Feel free to ask me any questions about the form as you fill it out.

I want to also provide you with the opportunity to talk more about our conversation in a follow-up interview with me. This follow-up interview will allow you to look over my findings from your first interview. It will also allow you to provide your feedback and to share any additional information. Would you be open to being a part of this? It would take about 20-30 minutes of your time. [distribute contact card here if they say yes]

If you change your mind later about doing this follow-up interview, you can just tell me that when I contact you about it. No problem at all!

I will now turn off the recorder to end our interview.

[Distribute gift card if in-person interview; get mailing information if Skype or telephone interview.]

APPENDIX C  
QUESTIONNAIRE

## QUESTIONNAIRE

1. How old are you today? \_\_\_\_\_
  
2. What is your current gender identity? (Select all that apply.)
  - a. Woman
  - b. Transgender
  - c. Genderqueer
  - d. Genderfluid
  - e. Agender
  - f. Two Spirit
  - g. Questioning
  - h. Man
  - i. Other: \_\_\_\_\_
  
3. What sex were you assigned at birth?
  - a. Female
  - b. Male
  
4. How would you say you present or express your gender? (Select all that apply.)
  - a. Masculine/Butch/Stud
  - b. Androgynous
  - c. Feminine/Femme
  - d. Other: \_\_\_\_\_
  
5. Which of the following best describes your current sexual identity? (Select all that apply.)
  - a. Gay/Lesbian
  - b. Bisexual
  - c. Pansexual
  - d. Queer
  - e. Questioning
  - f. Straight/Heterosexual
  - g. Other: \_\_\_\_\_
  
6. How long have you identified this way?
  - a. Less than 6 months
  - b. 6-12 months
  - c. 1 -2 yeas
  - d. 3-4 years
  - e. 5-6 years
  - f. Over 7 years
  
7. Who knows that this is how you identify? (Select all that apply.)

- a. No one
- b. Close family
- c. Close friends
- d. Extended family
- e. Extended friends
- f. Co-workers
- g. Everyone
- h. Other: \_\_\_\_\_

8. What is your race/ethnic identification? (Select all that apply.)

- a. Black or African American
- b. African
- c. Haitian
- d. Caribbean
- e. Native American or Indigenous
- f. Hispanic or Latina
- g. Asian or Asian American
- h. Native Hawaiian or Other Pacific Islander
- i. Caucasian/White
- j. Other: \_\_\_\_\_

9. Do you identify with any religion?

- a. Christianity – Protestant
- b. Christianity – Catholic
- c. Islam
- d. Buddhism
- e. Judaism
- f. None (Atheist/Agnosticism)
- g. Other: \_\_\_\_\_

10. Does your family of origin identify with any religion? (Select all that apply.)

- a. Christianity – Protestant
- b. Christianity – Catholic
- c. Islam
- d. Buddhism
- e. Judaism
- f. None (Atheist/Agnosticism)
- g. Other: \_\_\_\_\_

11. Have you experienced any of the following mental health concerns in the past 12 months? (Select all that apply.)

- a. Depression
- b. Anxiety
- c. Bipolar Disorder
- d. Borderline Personality Disorder



- e. Posttraumatic Stress Disorder (PTSD)
- f. Schizophrenia
- g. Alcohol or other drug overuse
- h. Other: \_\_\_\_\_

12. Have you ever received a formal diagnosis for a mental illness?

- a. Yes
- b. No (skip to #14).

13. If yes, what mental illness(es) were you diagnosed with?

14. Who knows that you have a mental health concern or mental illness diagnosis?

(Select all that apply)

- a. No one
- b. Close family
- c. Close friends
- d. Extended family
- e. Extended friends
- f. Co-workers
- g. Everyone
- h. Other: \_\_\_\_\_

15. What is the highest level of education you have completed so far?

- a. Completed 8<sup>th</sup> Grade
- b. Some high school, but didn't graduate
- c. Graduated high school
- d. GED
- e. Technical or Professional School beyond high school
- f. Some college or education beyond high school (other than professional school)
- g. Completed an Associate's degree
- h. Graduated college (Bachelor's degree)
- i. Some graduate school beyond a Bachelor's degree
- j. Graduate degree (for example, MA, MS, MBA, MD, PhD, DDS)

16. As far as your current work status, which of the following choices would be most accurate? (Select all that apply)

- a. Employed full time (at least 35 hours per week)
- b. Employed part time
- c. Not employed but looking for work
- d. Not employed and not looking for work
- e. Full-time mother/caregiver
- f. Student

- g. Not employed due to a disability
- h. Retired

17. Are you the primary caregiver for anyone besides yourself? (Select all that apply)

- a. Child
- b. Parent(s)
- c. Romantic Partner
- d. Close family member
- e. Close friend
- f. Extended family member
- g. Extended friend
- h. None
- i. Other: \_\_\_\_\_

THANKS VERY MUCH!

APPENDIX D  
QUESTIONNAIRE TERMINOLOGY HANDOUT

## QUESTIONNAIRE TERMINOLOGY HANDOUT\*

### Item 2: Gender Identity Terms

- **Gender Identity:** how a person labels their gender. Common identity labels include man, woman, genderqueer, transgender, and others.
- **Transgender:** a person who lives as a member of a gender other than that assigned at birth.
- **Genderqueer:** a gender identity label often used by people who do not identify with the binary of man/woman; or as an umbrella term for many gender non-conforming or non-binary identities (e.g., a gender, bigender, genderfluid)
- **Genderfluid:** a gender identity best described as a dynamic mix of boy and girl. A person who is gender fluid may always feel like a mix of the two traditional genders.
- **Agender:** a person with no personal alignment with the concept of either man or a woman, and/or someone who sees themselves as existing without gender. Sometimes called gender neutral.
- **Two Spirit:** an umbrella term traditionally used by Native American people to recognize individuals who possess qualities or fulfill roles of both genders.
- **Questioning:** an individual who is unsure about or exploring their own *gender identity*.

### Item 4: Gender Presentation/Expression

- **Masculine/Butch/Stud:** a person who identifies themselves as masculine, whether it be physically, mentally, or emotionally.
- **Androgynous:** a gender expression that has elements of both masculinity and femininity
- **Feminine/Femme:** someone who identifies themselves as feminine, whether it be physically, mentally, or emotionally.

### Item 5: Sexual Identity/Sexual Orientation Terms

- **Sexual Identity/Sexual Orientation:** the type of sexual, romantic, emotional/spiritual attraction one has the capacity to feel for some others. Common sexual orientations include straight/heterosexual, gay, lesbian, and bisexual.

- **Questioning:** an individual who is unsure about or exploring their own *sexual orientation*.
- **Bisexual:** a person who is emotionally, physically, and/or sexually attracted to males/men and females/women.
- **Pansexual:** a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions.
- **Queer:** an umbrella term to describe individuals who don't identify as straight.

\* These terms were taken directly from: <http://itspronouncedmetrosexual.com/2013/01/a-comprehensive-list-of-lgbtq-term-definitions/#sthash.Z41TMBGF.dpbs>

APPENDIX E  
SAMPLE MEMOS

## SAMPLE MEMOS

Date: 10/17/17

Time: 7:45 PM

Topic: Keisha Interview

### Summary of Participant:

Keisha (She/her/hers) is a 33-year-old African American queer woman living with major depressive disorder, PTSD and undiagnosed anxiety. She reports a history of suicidality and suicide attempts. She describes her experience living with mental health concerns as challenging. Her mental health concerns have had a negative impact on her social life, dating and work. Keisha shared she experiences isolation, judgement, and lack of understanding from others around her cancelation or inability to show up social events with others. Keisha refers to perceived judgements from potential romantic partners, family and friends related to her struggles with mental illness. These perceived judgements include being perceived as “crazy”, comments such as “oh don’t date her”, “oh don’t be around her” and “that’s going to be alot of drama”. Keisha’s experience of isolation is related to her history of intimate partner violence which continued to her PTSD and Major depression disorder. Due to her mental health conditions, she has avoided interacting with others. Keisha also has a difficult time at work. She works as a mental health clinician working with folks with substance abuse and co-occurring disorders who often have trauma histories. As a result, she often experiences triggering situations in her work with clients.

### What’s happening?

- Isolation
- Abuse in their previous relationship
- States she does not fit in anywhere (in all her communities?)
- Negative experience in church: homophobia
- Some positive: spiritual center-welcoming
- What about family and friends?
- Connection to Black lesbian community via retreats but not in local community (possibly use this citation for social support?)
- Anticipates judgment from others (re: which identities?)

Date: 12/11/2017

Time: 11:30 AM

Topic: Feminist/Queer Phenomenology

Today I woke up with eagerness to work on my methodology section. I have so much passion for learning and working through my thoughts. I will spend this time writing through my thinking as it pertains to constructing a feminist and queer of color-informed phenomenology.

Might want to consider: Black feminist philosopher Kristie Dotson arguments for a “multistability of oppression”

- Multistability articulates intersectionality
  - Dotson used the work of Don Ihde – Multistability

Latina Feminist Philosopher: Latina feminist phenomenology by Ortega also articulates intersectionality. The book engages more completely with phenomenology whereas Dotson focuses on Black feminist philosophy in general—not specific to phenomenology. Might want to use Ortega’s work?

Explore the concept of “class”?

- Many research participants talk about class as a key factor in their experience with living with mental distress
  - Public assistance and poor quality mental health services
  - In ability to afford private practice
    - Transitional nature in class: some were able to get better insurance which resulted in better mental health care.
  - Interaction with therapists in predominately white neighborhood who, lacked understanding of oppression; their feelings of lower class were pronounced; having education, house yet still on public assistance, unable to pay bills, purchase medicine, etc. –who are these participants?