EXAMINING LGBT-POC MICROAGGRESSIONS, HELP-SEEKING, AND HEALTH OUTCOMES FOR BLACK SEXUAL MINORITY WOMEN: USING AN INTERSECTIONAL FRAMEWORK

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Abstract: Black sexual minority women (BSMW) continue to be understudied despite experiencing a myriad of physical, sexual, and mental health disparities which intersect with their triply marginalized identities (i.e., race, gender, and sexual orientation (Calabrese et al., 2014). Experiences of systemic oppression and discrimination experienced by Black sexual minority women significantly contribute to these disparities. The present study examines the impact of intersectional microaggressions (i.e., LGBT-POC microaggressions) on health help-seeking, suicide ideation, and self-reported health among Black sexual minority women. Racial and sexual discrimination has been associated with poorer health outcomes (i.e., suicide ideation) and lower health behaviors (i.e., help-seeking) among Black women. To date, no study has examined the impact of LGBT-POC microaggressions on suicide ideation, poor perceived health, and help-seeking behaviors in sexual minority Black women. Understanding the extent of LGBT Black women's experiences with sexual and racial discrimination impacts health outcomes and health behaviors will aid in developing culturally informed clinical interventions and increase knowledge surrounding minority stress, intersectionality, and health outcomes.

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CHAPTER I

INTRODUCTION

Black sexual minority women (i.e., Black/African American women that identify as lesbian, bisexual, or queer) experience a myriad of physical (Yette & Ahern, 2018), sexual (Agenor et al., 2016), and mental health (Calabrese et al.2014; Pollitt & Mallory, 2021) disparities. Additionally, Black sexual minority women lie at the intersection of their triply marginalized identities (i.e., race, gender, and sexual orientation; Calabrese et al., 2014). In 1970, Beale describes the experiences of Black women living in a racist and sexist society as a "double jeopardy". As research on Black women has continued, scholars have also used the term "triple jeopardy" to describe the additive experiences of discrimination that Black sexual minority women may face (Bowleg et al., 2003). Historically, racism and discrimination have been examined by focusing on one single identity at a time (Bowleg, 2008; Cole, 2009). However, intersectional scholars posit that focusing on one single identity oversimplifies the complex experiences of individuals who hold several marginalized social identities simultaneously (Cole, 2009; Dovidio & Gaertner, 2004).

Black sexual minority women's unique and multifaceted life experiences cannot be reduced to singular examinations of race, sex-gender, or sexual identity as this does not provide a holistic examination of risk and resilience factors that may contribute to health outcomes and health behaviors among Black sexual minority women.

Intersectionality Theory (Crenshaw, 1989) and Minority Stress Theory (Meyer, 2003) highlight the importance of examining multiple marginalized identities among racial-ethnic minorities and sexual minorities. Developed from Black Feminist theory, the term intersectionality describes the additive and interlocking systems of oppression and structural inequalities that Black women face (Crenshaw, 1989). For example, The Combahee River Collective wrote from the perspective of Black feminist lesbians and discussed the interlocking systems of oppression rooted in sexism and racism (Combahee River Collective, 1982). Over the past decade, psychological, public health, and behavioral medicine research has integrated intersectional approaches and methodology into research to examine health outcomes and health behaviors of individuals and communities that hold multiple marginalized identities (i.e., race, gender, class, sexual identity; Cole, 2009). Intersectional experiences of discrimination have been associated with worse mental and physical health outcomes for Black women (Lewis et al., 2017). Despite this knowledge, gaps in research still exist for examining the impact of intersectional experiences of discrimination on Black sexual minority women.

Minority stress was theorized by Meyer (2003) to describe the cumulative impact of stress and subsequent health disparities among lesbian, gay, bisexual, and transgender (LGBT) populations (Balsam et al., 2013; Wei et al., 2010). Extensive research demonstrates that minority stress significantly contributes to physical, mental, and sexual

health disparities for sexual minority populations (Lick et al., 2013). Health disparities that exist as a result of minority stress are exacerbated for individuals who identify as a sexual minority and racial/ethnic minority (Bowleg et al., 2003). Further, research utilizing minority stress theory posits that a functional definition of minority stress can be understood through chronic experiences of discrimination and specifically the distinct experiences of microaggression (e.g., Balsam et al., 2011; Bowleg et al., 2003; Wei et al., 2010).

While experiences of discrimination and oppression may be overt and direct (e.g., being called a racial slur, being denied a job or loan due to one's racial identity), experiences of discrimination may sometimes be subtle and harder to recognize (Pierce et al., 1978). Sue, 2010; Lewis et al., 2016). Sue et al. (2007) acknowledged that aversive racism (i.e., an internal conflict between the denial of personal prejudice and unconscious negative feelings and beliefs towards a racially marginalized group; Gaertner et al., 2005) and racial discrimination is "subtle, nebulous, and nameless in nature," thus making it difficult to "identify, quantify, and rectify" for victims of microaggressions (p. 272). While microagressions were initially used to describe the experiences of racially minortized individuals, previous research has demonstrated that individuals who are sexually minoritized (Nadal, 2018) or gender minoritized (Capodilupo et. al., 2010) or those who fit into a combination of minoritized social categories (e.g., gendered racial microaggressions; Lewis & Neville, 2015, LGBT-POC microaggressions; Balsam et al., 2011) may also experience microaggressions. Black sexual minority women may experience any combination of these microaggressions as their multiple marginalized identities are inseparable (Sarno et al., 2021).

For example, Black women may encounter gendered racial microaggressions, which are microaggressions that lie at the intersection of racism and sexism for Black women (Lewis et al., 2013; Williams, 2015). Experiences of gendered racial microaggressions negatively impact maternal mortality (Patterson et al., 2022), suicide risk (Vance et al., 2022), healthcare utilization (Cazeau-Bandoo & Ho, 2021), and psychological distress (Hill-Jarrett & Jones, 2022; Thomas et al., 2008; Lewis et al., 2018). Additionally, Black sexual minority women may experience heterosexist microaggressions (i.e., microaggressions related to sexual orientation and assumptions that being heterosexual is the social norm; Woodford et al., 2015). Experiences of heterosexist microaggressions among Black sexual minority women have been associated with increased psychological distress (Szymanski & Meyer, 2008). This research highlights that Black sexual minority women's experiences with microaggressions and the subsequent consequences should not be evaluated on a single identity. Limited to no research exists that examines the experiences of Black sexual minority women with both heterosexism and racism and how these simultaneous experiences impact health outcomes (i.e., suicide ideation and physical health) and health behaviors (i.e., help-seeking).

What limited research exists suggests that Black sexual minority women are more likely to report depression, poor health, riskier health behaviors, and an inability to access quality healthcare (Pharr et al., 2019). Understanding barriers to healthcare engagement and utilization among Black sexual minority women is an imperative first step towards increasing wellness and health equity for sexual minority Black women. Further, lower healthcare utilization and help-seeking behaviors may be negatively impacted by

intersectional experiences of discrimination (i.e., LGBT-POC microaggressions), which may explain increased reports of suicide ideation and physical health.

Black women have high risk factors for suicide behaviors (e.g., domestic violence, psychological distress, and depression; Kaslow et al., 2000), however, die by suicide at a much lower rate when compared to Black men and women of other ethnic groups (Spates, 2012). This phenomenon has been defined as the "suicide paradox" (Spates, 2012; Vance et al., 2022). These historically low rates of suicide among Black women have led to the understudy of Black women's mental health and emotional wellness. This issue is exacerbated for Black sexual minority women. Black women scholars, researchers, and advocates of Black women's health have continuously called for increased attention and representation of Black women in psychology, behavioral health, and public health research (Spates, 2012). Particularly as data suggests that Black women's rates of suicide ideation are on the rise (CDC, 2020). Further, scholars have suggested that current research evaluating suicide risk among Black women fails to capture the unique intersectional experiences of Black women (Vance et al., 2022). Taking an intersectional approach to examining the social categories among Black women is imperative for developing a holistic understanding of suicide risk and other mental health concerns among Black sexual minority women. Suicide risk, specifically suicide ideation may be significantly driven by experiences of intersectional microaggressions and lower-help-seeking behaviors.

The current study seeks to assess the relationship between LGBT-POC microaggressions, suicide ideation, poor physical health, and help-seeking behaviors. Based on previous research, it is hypothesized that LGBT-POC microaggressions will be

directly associated with suicide ideation and poor physical health. Additionally, two moderation models will be conducted to further explore relationships. Specifically, it is hypothesized that LGBT-POC microaggressions will moderate the relationship between lower help-seeking behaviors and self-reported poor physical health. Additionally, it is hypothesized that LGBT-POC microaggressions will moderate the relationship between lower help-seeking behaviors and suicide ideation. A cross-sectional study will be conducted to test the stated hypotheses.

CHAPTER II

REVIEW OF LITERATURE

Health Disparities and Health Outcomes

Numerous physical, sexual, and mental health disparities exist for individuals who hold multiple marginalized identities (Lick et al., 2013). Specifically, sexual minority individuals generally report their health to be poor (Fredriksen-Goldsen et al., 2012; Frost et al., 2011), report a higher number of acute physical symptoms and chronic health conditions (Sandfort et al., 2006), report that their health status limits their ability to engage in everyday physical activities (Conron et al., 2010; Fredriksen-Goldsen et al., 2012; Kim & Fredriksen-Goldsen, 2012), and engage in riskier health behaviors (i.e., excessive substance use; Scheer et al., 2022). Additionally, sexual minority individuals and those in a same-sex relationship report more asthma diagnoses than do people who identify as heterosexual (Heck & Jacobson, 2006). Sexual minority individuals also report more headaches (Cochran & Mays, 2007; Lock & Steiner, 1999), chronic diseases and allergies (Lock & Steiner, 1999), osteoarthritis, and serious gastrointestinal difficulties (Sandfort et al., 2006) than do their heterosexual counterparts. Collectively, these findings reveal notable physical health difficulties among sexual minority adults.

Regarding mental health, many studies have reported increased mental health difficulties among sexual minority individuals and communities (Kuyper et al., 2015). Previous studies and literature highlight that when compared to heterosexual individuals, sexual minority individuals report increased suicide risk, substance use disorders, and severe psychopathology (King et al., 2008; Marshal et al., 2008, 2011). Additionally, there are significant differences within sexual minority subgroups (i.e., lesbian, gay, bisexual). For example, individuals who identify as bisexual commonly have higher levels of mental health distress than individuals who identify as gay (Marshal et al., 2008, 2011). This body of research suggests that it is important to understand the nuanced experiences of sexual minority communities as they are non-monolithic. Further, it is imperative to understand the experiences of those who identify as a sexual, gender, and racial minority, as previous research suggests that health disparities may depending on the intersecting systems of oppression that one experiences based on the marginalized identities that they hold (Jackson et al., 2016). The complexity of disparities in mental and physical health when race, gender, and sexual identity are considered warrants a close examination to elucidate disparities and associated risk factors for health outcomes, especially for Black sexual minority women.

An estimated 1.2 million adults in the U.S. identify as Black and LGBT, with an estimated 61% of the Black LGBT population identifying as women (Choi et al., 2021). Data suggest that there has been an increase in the number of Black women that identify as a sexual minority and that Black sexual minority women experience a myriad of physical health disparities. In a sample of approximately 9,000 sexual and gender minority women, lesbian and bisexual women were more likely to be Black (24.3%) or

another racial/ethnic minority group (13.9%; Pharr et al., 2019). When examining health disparities among Black sexual minority women, Black sexual minority women are 3 times more likely to report depression, poor health, riskier health behaviors, less physical activity, being overweight and obese, and are more likely to delay health care due to cost when compared to lesbian and bisexual women of other racial/ethnic groups (i.e., White, Asian, Latina; Pharr et al., 2019). Black sexual minority women also report higher rates of obesity, hypertension, and diabetes compared to White sexual minority women (Caceres et al., 2019). These findings are consistent with additional research that demonstrated that non-Hispanic Black bisexual women had a significantly higher likelihood of obesity compared to their non-Hispanic White peers (Lew et al., 2018). Yet, research that highlights Black sexual minority women's experiences solely and that aims to understand the underlying mechanisms (i.e., microaggressions, help-seeking behaviors) that contribute to these significant physical health disparities are significantly understudied.

A limited number of studies have documented mental health characteristics of Black sexual minority women alone or in comparison to other sexual minority groups. Those studies reporting prevalence data have suggested a high level of depression among Black sexual minority women. For example, 32% (Dibble et al., 2012) and 38% (Mays et al., 2003) of two national samples of Black sexual minority women reported symptoms consistent with at least mild depression, and 47% of a community sample of Black sexual minority women met diagnostic criteria for depression at some point during their lifetime (Bostwick et al., 2005). When considered relative to White sexual minority women, Black sexual minority women have indicated poorer mental health in some domains but

not others. For example, Black sexual minority women have reported higher psychiatric distress on average (Morris et al., 2001) and been more likely to endorse symptoms of alcohol dependence in the past year but reported similar levels of depression in the past year and lower lifetime depression to White sexual minority women (Bostwick et al., 2005). Findings have been similarly mixed in mental health comparisons between Black sexual minority women and Black sexual minority men. For example, compared to Black sexual minority men, Black sexual minority women have reported greater overall depressive distress and more somatic complaints but a comparable level of interpersonal problems and frequency of suicidal thoughts (Cochran & Mays, 1994).

Significant research suggests that physical, sexual, and mental health disparities may be in part due to lower help-seeking behaviors and lower healthcare utilization (Peek et al., 2010), however, limited research exists on the help-seeking behaviors among Black sexual minority women. It is imperative that research aims to understand the barriers (i.e., experiencing discrimination) to help-seeking behaviors and healthcare utilization among Black sexual minority women that may aid in the development of targeted interventions.

Help-Seeking and Healthcare Utilization

For sexual minority women, help-seeking behaviors may vary by sexual orientation, age, and gender (Zaki et al., 2017). In a study that examined help-seeking for non-suicidal self-injury (NSSI) in young adult sexual minority women, researchers found that lesbian young adults reported higher NSSI and higher help-seeking behaviors from a professional, however, bisexual young adult women reported greater suicide ideation and a reluctance to seek professional help (Zaki et al., 2017). Additionally, older sexual minority women are less likely to report an inability to access needed services compared

to younger sexual minority women (Scheer et al., 2022). Further, research that examined gender and sexual identity demonstrated that bisexual and lesbian women who identified as more masculine were less likely to have routine gynecological examinations, perceived poorer treatment in healthcare settings, were more likely to be out within healthcare settings, placed more importance on securing LGBT-positive healthcare practitioners, and had more difficulty finding LGBT-positive medical doctors (Hiestand et al., 2007). Another study demonstrated that transgender sexual minority women were 2.4 times and bisexual minority women were 1.8 times as likely to report an unmet need for mental healthcare compared to heterosexual women. Lastly, research that has examined help-seeking behaviors among sexual minority women has also focused on drug and substance use (Corliss et al., 2006). Findings from this research suggest that sexual minority women are at higher risk for illicit substance use and often want professional treatment, however, do not receive professional treatment (Corliss et al., 2006). Sexual minority women may delay seeking help for mental or physical health concerns due to anticipated stigma, fears of discrimination in healthcare settings (Benz et al., 2019; Craig & Smith, 2014, Hoffman et al., 2009), negative experiences with providers related to their sexual identities (Eady et al., 2011; McCann & Sharek, 2014). This is amplified for sexual minority individuals of racial/ethnic marginalized groups (Wilson & Yoshikawa, 2007). As research continues to expand on help-seeking behaviors among sexual minority women, it is imperative that the experiences of Black sexual minority women receive additional attention due to their multiple marginalized identities and experiences of systemic oppression.

Black sexual minority women's help-seeking behaviors may be influenced by social (Moore et al., 2020), economic, and environmental factors (Li et al., 2015). Previous research highlights that Black sexual minority women may be less likely to have insurance, lack a regular primary care provider, part-time employment, and increased negative and discriminatory experiences with healthcare providers which all act as barriers to healthcare utilization (Li et al., 2015). Additionally, in a qualitative study that examined mental health engagement among Black and Hispanic sexual minority young adults, researchers found that Black and Hispanic sexual minority young adults reported significant disengagement with mental health services despite needing services due to stigma related to sexual orientation and cultural attitudes, difficulty in finding quality and affordable care, and a lack of family support (Moore et al., 2020). Black sexual minority women may also be less likely to seek help from healthcare professionals and more likely to seek help from religious/spiritual treatment (Meyer et al., 2015). Meyer and colleagues (2015) found that while Black sexual minority individuals who attempted suicide were underrepresented in mental health and medical treatment, they were overrepresented in religious or spiritual treatment. Additionally, they found that seeking religious or spiritual treatment was associated with higher odds of a suicide attempt (Meyer et al., 2014). This finding is comparable to previous research which suggests that African American/Black individuals are more likely to seek help from religious services rather than professional healthcare providers due to cultural norms (El-Khoury et al., 2004; Hays & Lincoln, 2017; Snowden, 1998). Further, Black sexual minority women are less likely to report satisfaction with treatment compared to White sexual minority women (Scheer et al., 2022). Lastly, research also suggests that cultural identity in combination with sexual

minority status may impact Black sexual minority young adults' help-seeking behaviors (Moore et al., 2020). There remain gaps in research to understand the association between health outcomes and health behaviors for Black sexual minority women. It is evident that discrimination and systemic inequalities contribute to differences in healthcare utilization for Black sexual minority women and that this cannot be reduced to a single identity that Black sexual minority women hold. It is important that further research takes an intersectional approach to understanding how Black sexual minority women navigate healthcare.

Multiple Marginalization, Intersectionality, and The Minority Stress Model

Due to their unique multiply marginalized position, Black sexual minority women may encounter experiences of racism (i.e., oppression based on one's racial and ethnic identity), sexism (ie., oppression based on one's sex and gender identity), and heterosexism (i.e., oppression based on one's sexual orientation based on the assumption that heterosexuality is the norm; Moore, 2012). Researchers have attempted to capture the unique historical and ongoing experiences of Black sexual minority women through various theoretical frameworks and models. Two prominent theories that describe the unique stressors of individuals who identify within multiple marginalized groups are Intersectionality Theory (Crenshaw, 1989) and Minority Stress Theory (Meyer, 2003). Intersectionality Theory posits that multiple marginalized social categories (i.e., race, gender, sex, sexual orientation, class, education) simultaneously intersect with multiple levels of systems of power (i..e., education, government, criminal) to create unique experiences of systemic inequality and oppression (Crenshaw, 1989). Minority Stress Theory posits that stressors associated with the social position of sexual minority

individuals are primary causes for health-related conditions, such as psychological distress, poor and risky health behaviors (i.e., lower help-seeking), and chronic physical health conditions (Meyer & Frost, 2013). Extensive research utilizing both frameworks demonstrates that individuals of multiple marginalized groups experience worse health outcomes and engage in riskier health behaviors due to discriminatory experiences, especially those which may be subtle in nature (i.e., microaggressions; Cyrus, 2017; Vargus et al., 2020).

Stemming from Black Feminist Theory and Black Feminist scholarship, the term intersectionality was coined to describe the multiple intersections of discrimination that occur for Black women (Collins, 1989, Crenshaw, 1989, 1991, 1994). Intersectionality theory posits that individuals with multiple marginalized identities (i.e., race, gender, sex, income, class) experience unique and chronic distress fueled by stigmatization and systemic oppression that maintain inequity and discrimination (Crenshaw, 1989). Additional theoretical frameworks and perspectives of intersectionality were developed to further understand the correlations between the impact of social stigma, discrimination, and racism on Black women's ability to obtain and sustain healthy, equitable, and self-sustained lives. Further, within the biopsychosocial model of racism developed by Clark et al. (1999), it was theorized that gender potentially influences the extent to which racial discrimination, racism, and stress associated with these experiences affect mental health. Clark and colleagues (1999) encouraged additional research in this area and in line with this, several theorists have argued that Black women's position at the intersection of racial and gender oppression creates a unique lived experience different from that of Black men (Jackson, 2002; Pieterse & Carter, 2007; Woods-Giscombe & Lobel, 2008).

Psychological and behavioral health perspectives of intersectionality have aimed to understand how the experiences of multiple disadvantaged or minority status individuals (i.e., being a woman of a racial/ethnic minority status or sexual minority) interact with poor mental health (i.e., increased psychological distress) and health behaviors (Cole, 2009; Cho et al., 2013; Warner & Shields, 2018).Taking an intersectional approach to research includes (but is not limited to) addressing social inequalities, intersecting systems of oppression, social context, and complexity of identities (Collins & Bilge, 2020). Particularly, these identities may precede differential social determinants of health (i.e., racism, racial discrimination, poverty, lower educational opportunities) that influence both physical and mental health outcomes (Standley, 2020).

The Minority Stress Theory posits that for sexual minority individuals, experiences of prejudice, stigma, and discrimination or even the fear of these experiences, create unique stressors and that these stressors cause adverse health outcomes and health behaviors (Meyer, 2015). Additionally, the theory proposes that sexual minority individuals face two types of stressors: distal and proximal stressors (Meyer, 2003, 2007). Distal stressors are external events that cause psychological distress and include discrete encounters (i.e., microaggressions) with victimization and structural forms of stigma (Meyer, 2003, 2007). Proximal stressors are internal conflicts that may be triggered by experiences of victimization and include behaviors such as identity concealment, anxiety about future experiences of discrimination, and negative feelings about one's sexual minority identity (Meyer, 2003, 2007). Minority Stress Theory highlights that stress experienced by those belonging to minority social identities is composed of both distal and proximal stressors that may overload available coping

resources and result in poor health outcomes and health behaviors. Initially, minority stress was developed specifically to highlight minority stress in the context of LGB individuals, however, the theory also applies to gender (i.e., transgender, non-binary, cisgender women)(Everett et al., 2019; Meyer, 2015). According to Meyer (2003), prejudice and discriminatory experiences elicit acute and chronic stress responses, which subsequently lead to poor mental and physical health outcomes.

Extensive research has highlighted the impact of both gender, sexual, and racial discrimination on mental health outcomes such as depression, suicide ideation, and poor physical health (Polanco-Roman et al., 2019; Mouzon et al., 2016; Tucker et al., 2019; Walker et al., 2014; Wang et al., 2021; Williams, 1999). Additionally, while some research suggests that individuals that experience multiple types of discrimination are at higher risk for poor physical and mental health, other studies suggest that they may develop resilience against additional kinds of discrimination (Cyrus, 2017). Many studies that utilize a risk perspective, suggest that multiple discrimination has an additive effect (i.e., risk for poor health outcomes and health behaviors increases as additional forms of discrimination are experienced; Raver & Niishi, 2010). Further research is needed to understand the impact of these unique intersectional experiences on health outcomes (i.e., suicide ideation and poor physical health) and health behaviors (i.e., help-seeking) for Black sexual minority women.

Iintersectional experiences of discrimination may occur at individual and structural levels which in turn may create narrow opportunities for multiply marginalized individuals to support their health and wellbeing (McCoy, 1994; Pager & Shepherd, 2008; Perry, 2013). For example, studies have shown that racism, perceived racial

discrimination, and other experiences of discrimination associated with multiple social categories (i.e., race, gender, and class) is associated with worse health compared to those who do not experience perceived discrimination from multiple social categories (Grollman, 2012, 2014). Additionally, previous research that has taken an intersectional approach to examine health disparities and health outcomes for Black women has found that various combinations of marginalized identities for Black women predict health behaviors (i.e., lower health service utilization) and deleterious health outcomes (Hinze et al., 2012; Homan et al., 2021).

Microaggressions Across Intersectional Identities

Minority stress and intersectional experiences of discrimination can appear in many forms, including in the form of microaggressions (Sue et al., 2007). Originally theorized by Pierce and colleagues in 1978 and later expanded upon by Sue and colleagues in 2007, racial microaggressions are “subtle, everyday slights and insults that can include harmful comments centered around racial assumptions about criminality, intelligence, cultural values, and citizenship, as well as the minimization or denial of the racialized experiences of people of color” (Pierce et al., 1978; Sue et al., 2007; Sue, 2010; Lewis et al., 2016). Interpersonal exchanges involving microaggressions may not be perceived as discriminatory by perpetrators, who may perceive these slights to be innocent or harmless (e.g., Smith et al., 2007; Sue et al., 2008). These “slights” have the potential to have a significant and chronic impact on those who may experience them. There are three major types of microaggressions which include: micro assaults, microinsults and microinvalidation. Each has been associated with poor mental and physical health among marginalized groups. Overt or “old-fashioned” discrimination

(micro assaults) has been linked with poor mental health in sexual minority populations (Mays & Cochran, 2001) and racial/ethnic minority populations (Williams & Williams-Morris, 2000). Microinsults and microinvalidations are explained to be unintentional or unconscious acts by a perpetrator (Noh et al., 2007). Perpetrators may discredit an individual because of societal beliefs about his or her minority group (microinsults), resulting in psychological distress for recipients. For example, Constantine and Sue (2007) found that Black doctoral students encountered situations in which White supervisors made stereotypic assumptions about Black supervisees (e.g., "Don't be late for supervision. I know that Black people sometimes have difficult time orientation and think it's okay to be late for stuff."). These statements may be perceived as harmless by the perpetrators yet can have powerful psychological ramifications. Situations in which minority individuals are excluded or their experiences are negated (microinvalidations, e.g., "We are all human beings.") can also lead to reduced use of health services for sexual and racial/ethnic minorities (Sue et al., 2007; Nadal, 2008). The frequency with which these "slights" happen may be associated with the severity of psychopathology (i.e., depression and suicide ideation) and self-reported health.

Extensive research on microaggressions highlights that even if these slights are unintentional, microaggressions can have a significant impact on mental and physical health outcomes and behaviors of minority individuals (Balsam et al., 2014; Nadal et al., 2014). For example, Nadal and colleagues (2014) found that racial and ethnic microaggressions were associated with negative mental health symptoms (i.e., depression and anxiety). Additionally, Nadal and colleagues (2017) found that racial and ethnic microaggressions were associated with poor physical health such as chronic pain, lower

energy, and fatigue. Furthermore, research has found that racial microaggressions experienced in healthcare include but are not limited to; mistaken identity, mistaken relationships, fixed medical forms (i.e., not being able to select gender and race on forms), entitled examiner, pervasive stereotypes, and intersectionality (i.e., having multiple marginalized identities; Snyder et al., 2018). Racial microaggressions may also impact health-related behaviors and utilization of health services; Constantine (2007) found that African Americans' satisfaction with White counselors was negatively associated with the frequency of perceived racial microaggressions experienced during sessions. As research on racial microaggressions has expanded, researchers have called attention to the fact that the experience of microaggressions is dependent not only upon one's racial group but also other marginalized identities that one may hold (i.e., gender, income, sexual preference; Lewis et al., 2016; Sue, 2010).

Heterosexist or sexual orientation microaggressions, are subtle verbal or nonverbal slights that are directed towards individuals of sexual minority identities and may include things such as anti-LGBTQ language (i.e., describing something as "gay" inappropriately) and avoidance and exclusion behaviors (i.e., distancing oneself from perceived queer or gay people; Sue, 2010; Woodford et al., 2015). Sue (2010) theorizes that there are seven different types of sexual orientation microaggressions including, over-sexualization, homophobia, heterosexist language/terminology, sinfulness, assumptions of abnormality, denial of individual heterosexism, and endorsement of culture/behaviors (Sue, 2010). In a study that examined sexual orientation microaggressions among sexual minority individuals, researchers observed that sexual orientation microaggressions are associated with increased self-reports of poor health

(Platt & Lenzen, 2013). Research that examines heterosexist microaggressions and subsequent consequences of these experiences solely in Black sexual minority women is non-existent to the researchers' knowledge.

Black women may also experience gendered racial microaggressions (Lewis & Neville, 2015). Gendered racial microaggressions are described as the "subtle and everyday nonverbal, verbal, behavioral, and environmental expressions of oppression based on the intersection of one's race and gender" (Lewis & Neville, 2015), Additionally, researchers found that gendered racial microaggressions among Black women were associated with increased depression through disengagement coping (Williams & Lewis, 2019). Lastly, Balsam and colleagues found that racial and sexual minority microaggressions were associated with depression and that heterosexism in racial/ethnic minority communities may be particularly harmful to the mental health of LGBTQ-POC (i.e., individuals who are both a sexual minority and racial minority). The results also showed that racism, especially from loved ones, was associated with depression and increased rates of perceived stress for this multiply marginalized groups.

Examining intersectional microaggressions (i.e., LGBT-POC microaggressions) among sexual minority Black women is imperative as health disparities and poor health outcomes continue to exist among this population. As mentioned previously, experiencing a higher frequency of LGBT-POC microaggressions may be associated with higher reports of suicide ideation and self-reported health. Particularly as previous research has documented that a higher frequency of microaggressions is associated with higher self-reported depression, a significant risk factor of suicide ideation (Williams &

Lewis, 2019). As previously noted, an increased frequency of microaggressions is also significantly associated with lower help-seeking behaviors in Black (Taylor & Kuo, 2019) and sexual minority individuals (Mackay et al., 2017). These findings suggest that Black sexual minority women who experience intersectional microaggressions may be less likely to engage in health help-seeking behaviors, especially from healthcare professionals.

Suicide Ideation Among Black Sexual Minority Women

There has been a notable increase in suicide rates among Black women in the past twenty years. Starting in 1999 to 2019, there has been an increase in suicide rates from 2% to 4.5% in Black women and girls, ages 15-24 (CDC, 2020). Black women, ages 25-44 have had rates increase from 2.5% to 4.3% (CDC, 2020). Despite the rise in suicide rates among Black women , the overall death rates continue to be lower than other racial and ethnic groups and lower than Black men (CDC, 2020). Additionally, it is notable that suicide death rates are lower among Black women even when faced with established predictors of suicide risk (i.e., economic status, higher reports of trauma, increased concerns of physical and mental health concerns (Spates & Slatton, 2017). Previous research refers to this unexpected pattern of suicide deaths despite high risk among Black women as a Black-White suicide paradox (Spates & Slatton, 2017). This paradox has resulted in the understudy of Black women's suicide risk, especially from an intersectional perspective (i.e., examining suicide risk among multiple marginalized Black women; Spates, 2012).

Previous Black women scholars have continuously called for increased attention to address health concerns for Black women in psychology and public health research

(Spates, 2012). Thomas (2004) stated "The void in studying the lives of Black women within their own uniqueness calls for a repositioning of scholarship in the field of psychology in ways that make it more contextually responsive to the lived experiences of this population. Initially, this involves widespread recognition of the discipline's ethnocentrism and its failure to consider the sociocultural validity and generalizability of its research." Further, these scholars have suggested that current research that evaluates suicide risk among Black women fails to capture the unique intersectional experiences of Black women (Vance et al., 2022). As mentioned previously, the social categories of race, sexual orientation, and gender could be and have been evaluated on their own, however, taking an intersectional approach to examining the social categories among Black women is imperative for developing a holistic understanding of suicide risk and other mental health concerns among Black women.

While research has been limited in understanding intersectional risk factors for Black sexual minority women, there has been extensive research on suicide risk among sexual and gender minority populations. Sexual and gender minority individuals are at a disproportionately high risk of engaging in suicidal behaviors (Haas et al., 2011; King et al., 2008; Meyer, 2003; Ramchand et al., 2022; Russell, 2003). For sexual minority people, sexual orientation-related discrimination might be associated with feelings of thwarted belongingness. Discriminatory experiences can create significant psychological distress (i.e., internalized negative messages, depression, anxiety, and paranoia) which may be associated with the development and/or exacerbation of mental health problems, including suicide ideation (Bostwick et al., 2014; Meyer, 2003; Woodward et al., 2014). Additionally, suicide risk among sexual and racial/ethnic sexual minorities may be

associated with other negative mental health outcomes (.e., substance use, depression, anxiety; Ramchand et al., 2022). For example, in a study that examined substance use and suicide ideation among Black, Hispanic, and White LGB and non-LGB men and women, researchers found that Black LGB women showed higher odds of suicide ideation and substance use than non-LGB Black women (Kelly et al.,2021). Additionally, the rate of suicide ideation and substance use was three times higher in Black sexual minority women than in non-Black sexual minority women (Kelly et al., 2021). Recent concerns about elevated growth in suicide rates in certain cultural subgroups (e.g., older adult Asian Americans, sexual minority adolescents, and African American and Latino young adults), have led to increased attention toward understanding cultural risk factors that impact the development of suicidal ideation and behaviors (e.g., Bartels et al., 2002; Centers for Disease Control & Prevention, 2009; Choi, Meininger, & Roberts, 2006; Joe & Kaplan, 2001; King et al., 2008; Meyer, 2003). Additionally, a recent study that examined suicide risk among racial and ethnic sexual minority adults, found that for Black and Hispanic sexual minority adults, the odds of suicide attempts remained higher among those who reported sexual minority discrimination (Layland et al., 2020).

Collectively, previous research and literature highlights a need to examine suicide risk among Black sexual minority women using measures that capture their unique intersectional experiences. Examining the relationship between subtle experiences of intersectional discrimination (i.e., LGBT-POC microaggressions) and suicide ideation will increase knowledge about how racism, heterosexism, and gender-based oppression shapes suicide ideation and other health concerns.

The Current Study

The purpose of the present study is to examine the impact of intersectional microaggressions (i.e., LGBT-POC microaggressions) on health help-seeking, suicide ideation, and self-reported health among Black sexual minority women. As previously mentioned, racial and sexual discrimination has been associated with poorer health outcomes (i.e., suicide ideation) and lower health behaviors (i.e., help-seeking) among Black women. To date, no study has examined the impact of LGBT-POC microaggressions on suicide ideation, poor perceived health, and help-seeking behaviors in sexual minority Black women. Understanding the impact of sexual and racial discrimination on health outcomes and health behaviors for Black sexual minority women will aid in developing culturally informed clinical interventions and increase knowledge surrounding minority stress, intersectionality, and health outcomes.

CHAPTER III

METHODOLOGY

Study Hypotheses

The current study aims to examine two sets of hypotheses. The first group of hypotheses focuses on the relationship between LGBT POC microaggressions, health help-seeking, and poor physical health. Specifically, it is hypothesized that 1) a higher frequency of LGBT POC microaggressions is positively and significantly associated with lower help-seeking behaviors and self-reported poor physical health, 2) there is a direct relationship between LGBT POC microaggressions and self-reported poor physical health, and 3) LGBT-POC microaggressions will moderate the relationship between lower help-seeking behaviors and self-reported physical health. The second group of hypotheses aims to evaluate the relationship between LGBT POC microaggressions, health help-seeking, and suicide ideation. It is hypothesized that, 1) a higher frequency of LGBT POC microaggressions is positively and significantly associated with lower help seeking behaviors and higher self-reported suicide ideation, 2) there is a direct relationship between LGBT POC microaggressions and suicide ideation, and 3) LGBT-POC microaggressions will moderate the relationship between lower help-seeking behaviors and suicide ideation. A cross-sectional study was conducted to test these hypotheses.

Data Collection

Prior to participant recruitment, approval was obtained from the university's institutional review board (IRB). A purposeful snowball sampling method was used to recruit Black women from various geographical locations within the United States. Specifically, snowball sampling occurred through social media platforms (e.g., Instagram, Twitter, Facebook), listserv emails, and flyers. To further increase the size of the sample, participants were recruited from a large midwestern university utilizing an online psychology research portal (i.e., SONA system) to obtain Black women undergraduate students who are enrolled in psychology classes. The survey took approximately 30-40 minutes to complete.

Study Participants

To be eligible for the study, participants must identify as (a) African American/Black women including biracial individuals who self-identify predominantly as African American women, (b) as a sexual minority (i.e., lesbian, gay, bisexual, queer, asexual, pansexual, etc.), (c) have the ability to speak, write, read, and understand English in order to complete the self-report questionnaires, and (d) be at least 18 years of age.

Statistical Analysis

First, relationships between variables were assessed using two-tailed bivariate correlation analysis. To test the study's hypotheses, two moderation models with 5,000 bootstrapping samples, as outlined by Hayes (2013) were conducted. Bootstrapping was used as it does not assume normal distribution, uses resampling, and "may be used in samples of virtually any size" (Preacher, Rucker, & Hayes, p. 200, 2007).

In model 1, LGBT-POC microaggressions served as the moderator (W), help-seeking served as the first predictor variable (X), and self-reported physical health as the outcome variable (Y; see Figure 1). This moderation was run as a linear regression due to all variables being continuous. In model 2, LGBT-POC microaggressions served as the moderator (W), help-seeking served as the predictor (X), and suicide ideation served as the outcome variable (Y; see Figure 2). This moderation was run as a logistic regression due to suicide ideation being dichotomized.

Power Analysis

According to sample size recommendations for moderated analyses based on simulations using bias-corrected bootstrap resampling analytic procedures outlined by Preacher, Rucker, and Hayes (2007), a sample size of at least 200 is needed to detect a medium effect size with a power of .80.

Measures

Demographics Questionnaire. A demographics questionnaire will be administered to participants to obtain information about their ethnicity, age, gender identity, sexual orientation, income, and education. See Appendix for demographic questionnaire.

LGBT-POC Microaggressions Scale (LGBT-PCMS; Balsam et al., 2014). The LGBT-POC Microaggressions scale is an 18-item measure assessing the unique types of intersectional microaggressions (i.e., nonverbal, verbal, and behavioral slights) that are experienced by racial/ethnically marginalized LGBTQ adults. The measure includes three

subscales: 1) Racism in LGBT communities, 2) Heterosexism in Racial/Ethnic Minority Communities, and 3) Racism in Dating and Close Relationships. Participants are asked to rate the frequency and stress appraisal of their experiences of each microaggression in the past year. Each item is rated on a 5-point Likert-type scale ranging from 0 (*did not happen to me at all/not applicable to me*) to four (*it happened, and it bothered me extremely*). Scores on the LGBT-PCMS have been shown to have good construct validity as it was significantly and positively related to similar LGBT scales (i.e., Outness Inventory and Bisexual Identity Scale, and psychological distress(Jones, 2016). Scores on the LGBT-PCMS have demonstrated good reliability ($\alpha = .92$) in previous research (Balsam et al., 2011). An example item includes "Not being accepted by other people of your race/ethnicity because you are LGBT." Scores are summed to create a total score and higher total scores indicate a greater frequency of intersectional microaggressions (Balsam et al., 2011).

The General Help-Seeking Questionnaire (Wilson et al., 2005). The General Help-Seeking Questionnaire is an 18-item measure that assesses individuals help-seeking intentions from informal and formal sources for psychological difficulties. Wilson and colleagues (2005) developed the GHSQ using personal or emotional problems and suicide ideation as target problems. Within the current study, this measure has been adapted to include physical health. The GHSQ asks respondents to rate their responses using a 7-point Likert scale ranging from "Extremely Unlikely" to "Extremely Likely," the possibility of seeking help among eight professional (e.g., general practitioner or mental health professional) and lay (e.g., parents and friends) possible sources. The item, "I would not seek help from anyone," as well as an item asking for

other possible sources of psychological help other than the ones already included were added. For the suicide ideation subscale, previous studies have reported a Cronbach's α of .83 and the test-retest reliability as .88. Scores from each subscale are summed to create a total score where higher scores indicate greater help-seeking intentions. The current study is the first study to utilize the measure in a sample of Black women.

The Depressive Symptom Index-Suicidality Subscale (DSI-SS). The DSI-SS is a 4-item self-report measure that assesses for current suicide ideation and risk within the past 2 weeks. Each item has scores ranging from zero to three, with higher numbers indicating greater suicide ideation. The DSI-SS has had good internal consistency and validity. Additionally, the scale has demonstrated high internal consistency ($\alpha = .87$) in a sample of African American college students (Davidson et al., 2010). Suicide ideation is often a zero-inflated outcome, therefore scores for the DSI-SS were dichotomized into 1 indicating an endorsement of suicide ideation and 0 indicated no endorsement of suicide ideation.

The 12-item Short Form Health Survey (SF-12; Ware et al., 1996). The Short-Form Health Survey is used to assess self-reported mental and physical health. The measure includes two subscales: Mental Health (six items: e.g., "How much of the time during the last 4 weeks have you felt calm and peaceful?") and physical health (six items, e.g., "During the past 4 weeks, how much did pain interfere with your normal work?" [including both work outside the home and housework]). A total sum score will be calculated for each subscale, which has been used in previous research with African American populations (Guyll et al.,2010). Items were scored, such that, higher scores on

the mental health subscale indicated positive mental health (e.g., little or no psychological distress) and higher scores on the physical health subscale indicated positive physical health (e.g., little or no reported limitations in physical functioning; Maruish, 2012). These scores together create a total sum score. Previous research with an African American sample has reported reliability coefficients for the mental health subscale and physical health subscale of .76 and .81, respectively (Cernin et al., 2010). In a study that examined the impact of gendered racial microaggressions on physical health, the Cronbach's alpha coefficients were mental health ($\alpha = .83$) and physical health ($\alpha = .73$; Lewis et al., 2017).

CHAPTER IV

RESULTS

Participants

Participants consisted of 102 individuals who identified their race as African American/Black. 12.7 % of participants identified their ethnicity as Hispanic or Latinx. 89.4% of participants identified their gender assigned at birth as female. Additionally, 77.5% of participants identified as ciswomen, 10.8% identified as transgender (MTF), 6.9% identified as non-binary, 2% identified as agender, 2% identified as genderqueer, and 1% identified as third gender. For sexual orientation, 20.6% of the sample identified as Lesbian, 52% as Bisexual, 11.8% as Pansexual, 2.9% as Asexual, 10.8% as Queer, and 2.0% as Questioning. The average age of participants was 29 years old (SD = 6.18). For geographic location, 44% of participants were located in the Southeast (e.g., Alabama, Georgia, South Carolina), 33% of participants were located in the West (e.g., California, Nevada, Utah), 15% of participants were located in the Northeast (e.g., New York, Pennsylvania, Maryland) 6% of participants were located in the Midwest (e.g.,Ohio, Illinois, Missouri), and 2% of participants were located in the Southwest (e.g., Oklahoma, Texas, Arizona).

Correlations

Means, standard deviations, and bivariate correlation coefficients of study variables are presented in Table 1. Results indicated that LGBT POC microaggressions were significantly, moderately, and positively associated with suicide ideation (r = .42, p <.01). Additionally, LGBT-POC microaggressions was significantly, positively, and weakly associated to general help-seeking (r = .26, p = .012). However, LGBT POC microaggressions was not significantly associated with self-reported physical health. Suicide ideation was not significantly correlated with general help seeking or self-reported health. General help-seeking was not significantly correlated with self-reported physical health.

Moderating Effect of LGBT POC Microaggressions on General Help-Seeking and Physical Health

The first moderation was conducted to examine the moderating effect of LGBT-POC microaggressions of general help-seeking and physical health. Additionally, this moderation examined whether LGBT POC microaggressions strengthened the direct effect of general help-seeking on physical health. Results demonstrated that general help-seeking did not significantly predict physical health (β = -.0003, SE = .0097, 95% BC [-.0197, .0190]). LGBT-POC microaggressions did not significantly predict physical health (β = -.0014, SE = .0152, 95% BC [-.0316, .0287]). Lastly, there was not a significant moderating effect of LGBT POC microaggressions on the relationship between general help-seeking and physical health (β = .0011, SE = .0006, 95% BC [-.0024, .0001]). Results are presented in Table 2.

Moderating Effect of LGBT POC Microaggressions on General Help-Seeking and Suicide Ideation

A simple moderation was conducted to examine the moderating effects of LGBT-POC microaggressions on general help-seeking and suicide ideation. Additionally, this moderation examined whether LGBT POC microaggressions strengthened the direct effect of general help-seeking on suicide ideation. Results demonstrated that general help-seeking did not significantly predict suicide ideation (β = .0006, SE = .0135, 95% BC [-.0260, .0271]). However, LGBT-POC microaggressions did significantly predicted suicide ideation (β = .0808, SE = .0227, 95% BC [.0362, .1253]). Lastly, there was not a significant moderating effect of LGBT POC Microaggressions on the relationship between general help-seeking and suicide ideation (β = .0015, SE = .0011, 95% BC [-.0006, .0035]). Results are presented in Table 3.

CHAPTER V

CONCLUSION

The purpose of this study was to examine the impact of LGBT-POC microaggressions on Black women's health help-seeking behaviors, suicide ideation, and self-reported physical health. The study consisted of two sets of hypotheses. In the first group of hypotheses, it was hypothesized that a higher frequency of LGBT-POC microaggressions would be significantly and positively associated with health help-seeking, and self-reported physical health in LGBTQ Black women. Results indicated that LGBT-POC microaggressions were significantly, positively associated with general health help-seeking. This may indicate that LGBTQ Black women who have experienced an increased frequency of intersectional (i.e., sexual, gender, and racial) microaggressions may be more likely to seek help for health-related issues from various sources (i.e., health professional, friend, community member, internet, family member). However, further examination of the correlational analyses show that this was a weak correlation which may have been due to the low sample size. Additionally, LGBT-POC microaggressions were not significantly associated with self-reported physical health. It was also hypothesized that LGBT-POC microaggressions would predict self-reported physical health and moderate the relationship between general help-seeking and self-reported physical health.

Results of the moderation analyses indicated that LGBT-POC microaggressions did not significantly predict physical health nor did it moderate the relationship between general help-seeking and physical health.

The second group of hypotheses aimed to examine the impact of LGBT-POC microaggressions on general help-seeking and suicide ideation. Results of the bivariate correlational analyses indicated that LGBT-POC microaggressions was significantly, moderately, and positively associated with suicide ideation, indicating that LGBTQ Black women who reported a higher frequency of intersectional microaggressions also reported experiencing increased suicide ideation. Further, results indicated that LGBT-POC microaggressions significantly predicted suicide ideation. This is notable as this relationship exists despite the study being underpowered. This finding is consistent with previous studies that have found that LGBT-POC discrimination is associated with suicide ideation in LGBT People of Color. While not specific to suicide ideation, this finding is also consistent with a recent study that demonstrated that heterosexism and racism are associated with psychological distress in LGBTQ people of color (Huynh & Lee, 2022). To the author's knowledge, there are currently no empirical studies that explicitly examined this relationship in Black LGBTQ women. Additionally, these studies have examined broader experiences of discrimination and have not specifically examined the subtle and daily experiences of microaggressions in relation to suicide ideation. The subtlety and frequency of which these microaggressions occur is in part what makes them increasingly harmful compared to broader experiences of discrimination (Sue, 2007). Lastly, the results indicated that LGBT-POC microaggressions did not significantly moderate the relationship between help-seeking

and suicide ideation. Similar to the previous non-significant findings of the current study, this may be due to the study's low sample size.

LGBT-POC microaggressions predicting suicide ideation in LGBTQ Black women may have important clinical, policy, and practice implications. Risk for suicide attempts significantly increases for Black sexual minority adults who have experienced discrimination related to their sexual orientation (Layland et al., 2020). Further, in a recent study, Black LGB women did not demonstrate significantly elevated rates of suicide ideation when compared to White LGB women and LGB women of other racial/ethnic identities, however, Black LGB women had significantly increased rates of suicide attempts when compared to White LGB women (Ramchand et al., 2022). For research, clinical practice, and policies aimed at developing suicide prevention strategies for Black sexual minority women, mitigating the impact of experiences of discrimination on psychological distress may be important. For example, for mental healthcare professionals working with Black sexual minority women, may use cognitive behavioral strategies aimed at creating an affirming space for Black sexual minority women (Carvalho et al., 2022) Additionally, perspectives of minority stress and intersectionality should be included in a mental health or behavioral health professional's case conceptualization to ensure consideration of the unique stressors that Black sexual minority women face (Carvalho et al., 2022). An example of an affriming cognitive behavioral intervention with sexual minority women can be seen in the Empowering Queer Identities in Psychotherapy (EQuIP) intervention, a CBT intervention aimed at mitigating the impact of minority stress on depression, anxiety, and alcohol use for sexual minority women (Pachankis et al., 2020). Currently, EQuIP is the only CBT intervention

that utilizes minority stress and considers intersectional discrimination; however, this intervention does not consider that there may be differences in experiences for women of sexual and racial minoritzed backgrounds. While this intervention is a starting point in addressing minority stress for sexual minority women, the findings of the current study illuminate the importance of including the unique experiences of racial and sexual minority individuals. The current findings further emphasize the importance of suicide prevention and interventions among minoritized communities but especially LGBTQ Black women. While this population demonstrates a low suicide death rate, the current study demonstrates that suicide ideation is still prevalent. Jobes & Joiner (2019) emphasize the importance of targeting suicide ideation as integral part of suicide intervention, even among populations that are not actively engaging in suicide behaviors. Health professionals should be actively screening for suicide ideation for Black LGBTQ women. On the level of policy and practice, these findings can be used to provide justification for implementing policies that provide increased funding initiatives for research and clinical interventions aimed at addressing the impact of intersectional experiences of discrimination on mental health for LGBTQ Black women. Further research is needed to replicate these results and further understand the mechanisms of this relationship.

Limitations

The current study utilized an internet-based survey platform (i.e., Qualtrics) for data collection. While internet-based survey platforms are inexpensive, quick, and accessible for data collection, these platforms are not free from limitations. Internet-based

surveys are commonly used to conduct research among minoritized and underserved populations (e.g., LGBTQ + populations (Guillory et al. 2018) ,and racial/ethnic populations) due to these populations often being perceived as harder to recruit due to increased barriers and justified skepticism (i.e., mistrust due to historical research malpractice) to participating in research (Das et al. 2018). However, internet-based platforms are susceptible to being targeted by internet bots. Internet bots are defined as "computer software designed to perform automated tasks for users often to find and target surveys offering incentives" (Griffin et al., 2022). As aforementioned a major limitation of the study was being underpowered. Due to the infiltration of internet bots on data collection despite following recommendations for reducing susceptibility to internet bots (e.g., utilizing bot detection, using a raffle instead of instant compensation, thorough data cleaning; Griffin et al., 2022) the needed sample size was unable to be collected. According to sample size recommendations for moderation analyses based on simulations using bias-corrected bootstrap resampling analytic procedures outlined by Preacher, Rucker, and Hayes (2007), a sample size of at least 200 is needed to detect a medium effect size with a power of .80. The current sample was only 102 participants. Additionally, 10.8 of the sample identified as transgender which is a higher percentage than most national studies (Dowers et al., 2020). While data was cleaned, this high percentage of transgender Black women may be due to internet bots. More extensive data cleaning procedures may help to determine the validity of these responses. Future studies may consider including a qualitative component (i.e., an interview) which may help to reduce the likelihood of bot infiltration, albeit this approach may be more time intensive,

it may also provide more meaningful data for complex culture-specific psychological and public health research (Bartholomew & Brown 2012).

Future Directions

Despite these methodological weaknesses, the current study underscores the importance of examining experiences of discrimination from an intersectional lens, in addition to the impact of these experiences on health outcomes and health behaviors among LGBTQ Black women. Future research aimed at understanding the impact of intersectional experiences of discrimination on mental and physical health should utilize a mixed methods approach (i.e., qualitative and quantitative data) to capture the unique experiences of LGBTQ Black women and reduce the likelihood of internet bots. Additionally, future research may aim to examine the long-term impact of intersectional microaggressions on health outcomes and health behaviors through the use of longitudinal studies. Lastly, future research should examine additional forms of coping instead of help-seeking that LGBTQ Black women may be engaging in to cope with intersectional microaggressions and suicide ideation, as results from this study indicate that help-seeking is not associated with physical health or suicide ideation.

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APPENDICES

Table 1. *Correlations Between the Variables and Their Means and Standard Deviations (n = 102)*

Variable	1	2	3	4
1. Suicide Ideation	-			
2. Physical Health	-.025	-		
3. LGBT-POC MS	0.42**	-0.086	-	
4. GHSQ	0.04	0.003	0.26*	-
M	0.69	11.38	47.20	115.74
SD	0.46	1.96	14.12	21.66

Note: ** $p < 0.01$, * $p = 0.05$, LGBT-POC MS = LGBT-POC Microaggressions Scale, GHSQ = General Help Seeking Questionnaire.

Table 2. *Moderation Analyses of LGBT-POC Microaggressions on General Help-Seeking and Physical Health (n=93)*

Outcome	Predictor	*β*	*se*	*t*	*p*	LLCI	ULCI
Physical Health	GHSQ	-.0003	.0097	-.0345	.9725	-.0197	.0190
	LGBT-POC MS	-.0014	.0152	-.0955	.9241	-.0316	.0287
	GHSQ x LGBT-POC MS	-.0011	.0006	-1.802	.0750	-.0024	.0001

Table 3. *Moderation Analyses of LGBT-POC Microaggressions on General Help-Seeking and Suicide Ideation (n=93)*

Outcome	Predictor	*β*	*se*	*z*	*p*	LLCI	ULCI
Suicide Ideation	GHSQ	.0006	.0135	.0434	.9654	-.0260	.0271
	LGBT-POC MS	.0808	.0227	3.551	.0004**	.0362	.1253
	GHSQ x LGBT-POC MS	.0015	.0011	1.377	.1685	-.0006	.0035

Figure 1. *Relationship Between Help-Seeking and Self-Reported Physical Health Moderated by LGBT-POC Microaggressions*

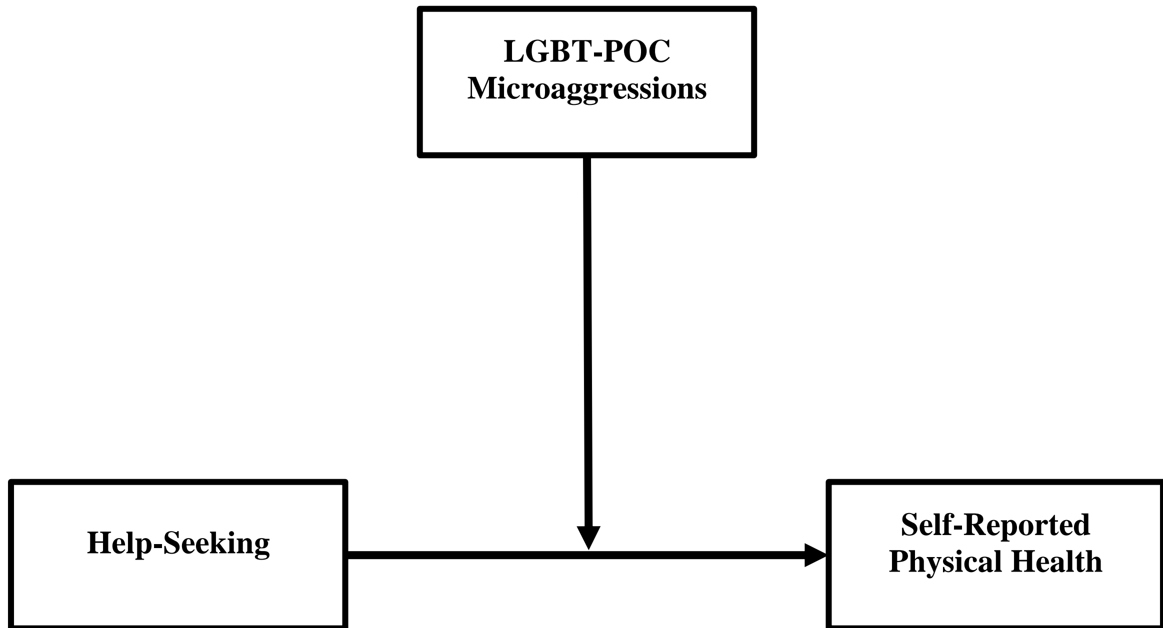
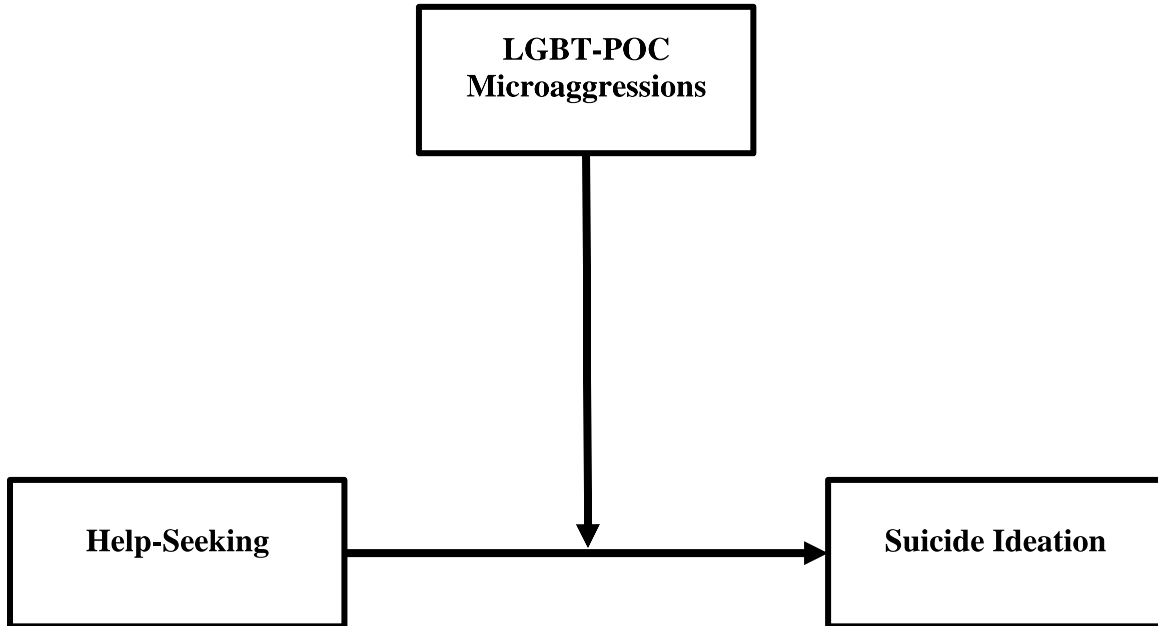


Figure 2. *Relationship Between Help-Seeking and Suicide Ideation Moderated by LGBT-POC Microaggressions*



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