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The Role of Community Belongingness in the Mental Health and Well-Being of Black LGBTQ
Adults

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of
Philosophy at Virginia Commonwealth University.

by

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Abstract

THE ROLE OF COMMUNITY BELONGINGNESS IN THE MENTAL HEALTH AND
WELL-BEING OF BLACK LGBTQ ADULTS

By Keith J. Watts, MSW

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of
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Major Director: M. Alex Wagaman, Ph.D.
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The impact of racial and sexual minority stigma, prejudice, and discrimination on the mental health and well-being of Black and LGBTQ individuals, respectively, has been well documented in the literature. Research on these relationships for Black LGBTQ individuals who are multiply marginalized due to their position at the social intersections of gender identity, sexual orientation, and race/ethnicity is less common. Belongingness to identity-based communities can protect against the negative impact of these minority stressors for Black and LGBTQ individuals and aid coping processes. However, Black LGBTQ individuals often experience stigma and discrimination in their racial, sexual, and gender minority communities due to their multiple minority identities. They may choose instead to create Black LGBTQ communities as a strategy to access the group-level coping resources needed to support their mental health and well-being in the face of compounded minority stress. Thus, the present study aimed to explore the relationships between identity-based community belongingness, coping, minority stress, mental health, and well-being for Black LGBTQ individuals. Path and multiple regression analyses were conducted to test the hypothesized relationships between these variables in a sample (n = 345) of Black LGBTQ adults living in the United States. Study results found that: (1) community belongingness was associated better with mental health and well-being; (2) coping partially explained the relationships between community belongingness and well-being, but did not explain the relationship between community belongingness and mental health; (3) Black community belongingness was associated with better mental health; and (4) Black LGBTQ community belongingness was associated with better well-being. Implications for social work practice and education, and future research, are discussed.

CHAPTER 1: Introduction

Research Problem

The effects of racial discrimination on the mental health and well-being of Black individuals have been well documented in the literature (Bynum et al., 2007; Kessler et al., 1999; Klonoff et al., 1999; Krieger et al., 2011; Ong et al., 2009; Turner & Avison, 2003; Turner & Lloyd, 2004), including negative affect, distress, depression or depressive symptoms, anxiety, and psychiatric symptoms (Banks et al., 2008; Brondolo et al., 2008; Paradies, 2006; Pascoe & Smart Richman, 2009; Pieterse et al., 2012; Williams & Mohammed, 2009). For example, in their review of the empirical research on perceived discrimination and health, Williams and Mohammed (2009) found a consistent pattern of studies demonstrating an inverse relationship between discrimination and health. Similarly, Bynum et al. (2007) found that increased experiences with racism were associated with higher levels of psychological stress and distress in African American college students.

The effects of sexual minority prejudice and discrimination on the mental health and well-being of LGBTQ (lesbian, gay, bisexual, transgender, and queer) individuals has also been well documented in the literature (Cochran et al., 2003; King et al., 2008; McCabe et al., 2010; Meyer, 2003; NAMI, 2007; Seelman, 2016; Szymanski & Henrichs-Beck, 2014; Velez & Moradi, 2016). LGB individuals report greater exposure to both lifetime and day-to-day experiences with discrimination than heterosexuals (Mays & Cochran, 2001) and have shown higher prevalence of anxiety, mood, and substance use disorders than heterosexual individuals (Cochran et al., 2000; Cochran et al., 2003).

Although much less common, research on the mental health and well-being outcomes of Black LGBTQ individuals who are multiply marginalized due to their positioning at the social

intersections of gender identity/sexual orientation and race/ethnicity is growing. Black LGBTQ

people face the social stigma of racism within the LGBTQ community and homo- and

transphobia within the Black community and the larger society (Greene, 2000; Han, 2007; Meyer

et al., 2008). Indeed, Whitfield et al. (2014) found that Black LGBTQ individuals experienced

greater levels of ant-LGBTQ discrimination than their White counterparts, suggesting that their

intersecting racial and sexual/gender minority identities are related to the elevated levels of

discrimination that these individuals experienced. Though research has demonstrated the

importance of identity-based communities in supporting mental health, well-being, and the

processes of coping with these experiences of discrimination and stigma for minority individuals,

Black LGBTQ individuals face unique challenges in accessing these communities.

Racial Discrimination

Racism is an organized system that categorizes population groups into 'races', and uses

this ranking to arbitrarily allocate goods and resources to racial groups that are regarded as

superior (Bonilla-Silva 1996). A key aspect of the system of racism is the manifestation of

cultural racism which ranks some racial groups as inherently or culturally superior to other

groups and that supports the social norms and institutions, which enact this ideology (Jones

1997). What often follows is the adoption of negative attitudes and beliefs towards racial

outgroups (i.e., prejudice), such as Black people, and the differential treatment of such groups

and its members by individuals and social institutions (i.e., discrimination). In support of this

argument, a number of studies have found that White individuals report significantly less

discrimination experiences than do Black individuals (e.g., Brondolo et al., 2005; Crocker &

Quinn, 1998; Darity, 2003; Major et al., 2002). In fact, Brondolo and colleagues (2005) found

that Black people reported more frequent discrimination than did Latino and Asian individuals,

suggesting that perhaps Black people are discriminated against more frequently than other minority groups or perceive themselves to be. Such differences in discrimination experiences, perceived or actual, highlights its significance when examining the mental health and well-being of Black individuals. For individuals who are targeted for discrimination, becoming aware of some discriminatory behavior directed at them and such perceptions of unfair treatment can generate stress (Clark et al. 1999). Moreover, because racial discrimination targets both the individual and the group, it has implications for one's personal and collective identities (Miller & Kaiser, 2001). In addition to impacting an individual's self-perception, being targeted for racial discrimination can undermine the sense of identification with a larger identity community. The social isolation that results can be a significant source of stress. (Wei et al., 2010).

LGBTQ Discrimination

Sexual Stigma

The concept of stigma typically refers to the negative regard for people belonging to a particular group or category or possessing a particular characteristic in a given culture or society (Herek, 2015). Stigma is society's shared judgment that the possession of such characteristics or belonging to such groups renders people "different," and this phenomenon results in the marginalization of both individuals and groups (Goffman, 1963; Herek, 2015). This marginal status precludes stigmatized individuals from access to resources and power to control what happens in their lives. As it relates to sexual minorities, *sexual stigma* is defined as "society's negative regard for non-heterosexual behaviors, identities, relationships, and communities" (Herek, 2015, p. S33). On a societal level, sexual stigma produces imbalances of power in social institutions that disadvantage non-heterosexual individuals (e.g., law, public policy, science, medicine, language, and mass media; Herek, 2015). In addition to societal institutions, sexual

stigma also plays out through its legitimization and internalization by individuals. Whereas the internalization manifests primarily as sexual prejudice (attitudes and actions in line with society's hostility toward sexual minorities) for heterosexual individuals, it also can take the form of self-stigma or "internalized homophobia," as it is often called, among non-heterosexual people. The stress of experiencing sexual stigma has a negative impact on the mental health and well-being of LGBTQ individuals (Meyer, 2003) and is fundamental to understanding the mental health and well-being experiences of many LGBTQ individuals.

Gender Minority Stress

Transgender and gender expansive individuals report significantly higher levels of depression and anxiety than the average U.S. citizen (Clements-Nolle et al., 2001; Kessler et al., 2005). And compared to their cisgender peers, they are at an increased risk for mental health problems and this has been linked to minority stressors unique to these populations, such as societal transphobia, rejection, and gender-based victimization, and discrimination (Grant et al., 2011; Hatchel et al., 2018; Hendricks & Testa, 2012; Lombardi, 2009; Price-Feeney et al., 2020; Scandurra et al, 2017; Testa et al., 2015). Internalization of chronic exposure to gender minority-based discrimination has been linked to higher prevalence of psychiatric symptoms such as depression (Nemoto et al., 2011) and anxiety (Strain & Shuff, 2010). Moreover, these internalization processed may exacerbate mental health issues (Breslow et al., 2015) and have been associated with poor coping skills (Mizock & Mueser, 2014).

Black LGBTQ Minority Stress

Black LGBTQ individuals are exposed to multiple and unique sources of minority stress (Balsam et al, 2011; Han, 2007; Loiacano, 1989; Kudler, 2007; Wilson et al., 2009), and such stressors have been associated with increased depressive symptomology in Black LGBTQ people

compared to White LGBTQ people (Kertzner et al., 2009). Sexual stigma and marginalization, especially those experienced within the Black community, can negatively impact Black LGBTQ individuals' perceptions of their identity (Rust, 2000) and this may be related to findings that they identify more with their racial community than with the LGBT community (Moore, 2010). Similarly, research on the racial discrimination experienced by LGBTQ people of color in White LGBTQ communities has highlighted its negative ramifications on perceptions of self-worth and self-esteem (Flores et al., 2009). One explanation for this phenomenon is that which is asserted by Minority Stress Theory (Meyer, 2003).

Branching off from social stress theory – which posits that conditions in the social environment can be sources of stress that induce mental and physical illness – Minority Stress Theory asserts that individuals with stigmatized identities are exposed to unique forms of stress because of their social, minority status (Meyer, 2003). Distinguishing the relevance of proximal (subjective) minority stressors from those considered distal (objective) for individuals with stigmatized identities, Meyer (2003) argues that proximal stressors are more dependent upon an individual's perception or appraisal of stress and thus related to their self-identity. Minority status often leads to personal identification with one's minority status, leading to further stressors related to the perception of the self as a stigmatized and devalued minority (Miller & Major, 2000).

Intersectionality

Intersectionality Theory encourages an examination of how social identities (e.g., sexual identity and race) can intersect to produce unique, interlocking experiences of privilege and oppression within the lives of individuals (Crenshaw, 1989), including within-group differences

(Anthias, 2008). Such an approach is particularly salient when seeking to understand the identity-based experiences of individuals possessing multiple minority categories (i.e., identities). The application of an intersectional framework through the lens of Minority Stress Theory facilitates the conceptualization and understanding of how the social stressors generally experienced by both Black and LGBTQ individuals can interact to produce highly contextualized, distinct experiences of stigma, prejudice, and discrimination for Black LGBTQ people.

Affiliation with an identity-based group is one coping mechanism through which minority individuals are able to effectively ameliorate the impact of stressful experiences (Jones et al., 1984; Lehavot & Simoni, 2011). In identity-based communities, members can experience their minority identities as the norm, and a sense of belongingness to such communities can help alleviate experiences of stigmatization (Jones et al., 1984). To that end, a sense of community belonging has demonstrated an inverse relationship with depression for gay men (McLaren et al., 2008), and connection to the LGBT community was correlated with reduced gay-identity distress for African American young men who have sex with men (Wong et al., 2014) and better psychological well-being for LGBT individuals (Frost & Meyer, 2012).

Employing an intersectional lens, however, highlights that not all sexual minority individuals feel, or even have the opportunity to feel, connected to an LGBTQ community (Barrett & Pollack, 2005; Valocchi, 1999). Thus, the unique expectations and experiences of community belonging for Black LGBTQ individuals, which emerge at the intersections of race, sexuality, and gender may not be adequately accounted for by such broad categories as a racial minority (i.e., Black) or sexual/gender minority (LGBTQ) community. Exposed to the threat of marginalization and ostracization from both the Black community and the LGBTQ community at

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large, Black LGBTQ individuals may instead seek out or create communities that center and support their intersectional identities and experiences as Black *and* LGBTQ as an alternative source of coping resources and a sense of belongingness.

Study Aims

This study aims to explore the relationship between identity-based community belongingness, minority stress, coping, mental health, and well-being for Black LGBTQ individuals. The research questions guiding this study are: (1) What are the relationships between identity-based community belongingness and mental health and well-being for Black LGBTQ individuals? (2) To what extent does coping mediate the relationships between identity-based community belongingness and mental health and well-being for Black LGBTQ individuals? (3) What is the relationship between belongingness to a Black LGBTQ community and mental health and well-being compared to belongingness to a Black or LGBTQ community?

It is important to provide a note about language in this paper. The acronym LGBTQ is used in reference to the multitude of sexual and gender identities reflected among this population and in the study. However, the author acknowledges the limitations of any acronym that leaves out certain groups and consolidates people from diverse minoritized identities of sexuality and gender (MIoSG; Vaccaro et al., 2015). Some of the literature cited within this paper only identified LGBT or some subset of this population as being present in their research. The reader will therefore notice that the acronym may change in accordance with what is being referenced to honor and accurately represent prior research samples. Additionally, throughout this paper the term "Black" is used interchangeably with and, where possible, instead of "African American" as this research was not intended to be limited to the experiences of only African Americans.

Black is used as an "imperfect" synonym of African American and "replaces previous terms like Negro and Colored" (Dumas, 2016, p. 13). Black is "a self-determined name for a racialized social group" (Dumas, 2016, p. 12) with a shared kinship, cultural rites, and values. And while this study sampled individuals living in the United States, the term includes all identities that encompass the African diaspora.

CHAPTER 2: REVIEW OF LITERATURE

Introduction

This chapter will presents the existing theoretical and empirical literature on the minority stress, coping, and belongingness experiences of racial, gender, and sexual minorities. The relationships that have been identified between these variables will be discussed with a particular focus on the mental health and well-being outcomes of Black LGBTQ individuals. Finally, the rationale for this study will be presented.

Minority Stress Theory

Stress has been defined as "any condition having the potential to arouse the adaptive machinery of the individual" (Pearlin, 1999a, p. 163). *Stressors*, such as losing a job or the death of a friend, are events and conditions that are a common part of life for everyone and that create change and force an individual to adapt to the new a circumstance or situation (Dohrenwend, 1998). Social Stress Theory posits that stressful events (i.e., general stressors as well as experiences of prejudice and discrimination) which tax individuals and surpass what they have the capacity to endure can lead to disease and disorder, and that the social structure in which individuals live is at the root of this stress (Dohrenwend, 2000; Meyer et al., 2008; Thoits, 1999). The conditions of one's social environment are sources of stress that can lead to both physical and mental illness, and individuals who belong to stigmatized social categories (e.g., race/ethnicity, gender, or sexuality minorities) are thus likely to be heavily impacted by social stressors given their oppressed and marginalized status (Dohrenwend, 2000; Meyer, 2003). It then follows that prejudicial and discriminatory experiences of racism, homophobia, and transphobia require individuals to adapt and are thus understood as stressful (Allison, 1998; Clark et al., 1999; Meyer, 1995; Pearlin, 1999b).

Minority stress refers to this specific form of excess stress that individuals from stigmatized groups encounter due to their social position and examines the ways in which the unique stressors they experience are related to disparities in health (Meyer, 2003), including psychological distress (Krieger et al., 2008). For example, individuals identifying as LGBQ have a higher risk for elevated stress levels compared to those identifying as heterosexual (Herek & Garnets, 2007). To elaborate on the process by which individuals from stigmatized social categories are exposed to increased and unique stress, Meyer (2003) developed a model for minority stress. In this model, the processes of minority stress are described along a continuum from distal stressors – objective events and conditions – to proximal personal processes that rely on individual perceptions and appraisals and are therefore subjective. Distal stressors are independent of an individual's identification with the assigned minority category such that simply being perceived as LGBTQ may lead to encounters with prejudice towards LGBTQ people (e.g., harassment or violence). On the other hand, proximal stress processes, being subjective, are related to one's self-identification as LGBTQ (Meyer, 2003). For example, LGBTQ individuals may internalize social stigmas and develop feelings of shame, sadness, and/or anger directed at their sexual orientation (Meyer, 2003).

Minority-related stressors are a common feature in the lives of LGBTQ individuals, and they usually result in negative outcomes such as anxiety, depression, and other mood disorders (Hatzenbuehler et al., 2008; Herek & Garnets, 2007; Meyer, 1995). Furthering the conceptualization of Meyer's minority stress theory by examining how experiences of discrimination "get under the skin" and lead to adverse psychological outcomes among sexual minority people, Hatzenbuehler (2009) added that proximal minority stressors are more specific to sexual minority populations given the social and personal meaning attached to sexual

identities. Because LGBTQ members of racial/ethnic minority groups have to simultaneously manage multiple minority identities and their associated stressors, Black LGBTQ individuals may be exposed to an increased number of distal and proximal stressors that can impact their mental health, well-being, and social functioning (Meyer, 2003).

Minority Stress as Microaggressions

Though insufficient to encapsulate the full range of minority stress experiences, *microaggressions* are one major way that this stress takes form (Balsam et al., 2011). Microaggressions are brief, daily assaults on minority individuals that can be interpersonal or environmental, verbal or nonverbal, intentional or unintentional, and that communicate hostile or derogatory messages – particularly to members of targeted social groups (e.g., people of color and LGBTQ people; Nadal et al., 2016; Sue, 2010; Sue et al., 2007). In social interactions involving microaggressions, perpetrators may not understand their behaviors as discriminatory or the impact these behaviors can have on recipients (Smith et al., 2007; Sue et al., 2008); however, these exchanges can negatively affect the mental health of the target. And though much of the literature has focused on major discriminatory events, such as antigay violence (Garnets et al., 1990; Herek & Berrill, 1992; Herek et al., 1999) or state sanctioned racial segregation, examining the more frequent and subtle experiences of microaggressions for minority individuals is of particular importance when seeking to understand the overall impact of multiple minority identities on the mental health and well-being of Black LGBTQ people. For example, it has been found that recent experiences of discrimination can have a more significant negative effect on mental health than lifetime discrimination (Pascoe & Smart Richman, 2009).

There are three main types of microaggressions that have been discussed in the literature – microassaults, microinsults, and microinvalidation (Balsam et al., 2011; Sue, 2010; Sue et al.,

2007). Microassaults are characterized as overt discrimination, such as someone telling a racist joke and then saying, "I was just joking." Mircoassaults have been tied to reduced mental health for both LGB (Mays & Cochran, 2001) and racial/ethnic minority populations (Williams & Williams-Morris, 2000), and discomfort and perceived hostility in the school environment (Yosso et al., 2009). On the other hand, while microinsults and microinvalidations may be unintentional or unconscious by perpetrators, they can still distress the targets of these behaviors. For example, Black doctoral students described experiences in which white supervisors expressed stereotypical assumptions about their minority group (microinsults) that were perceived as discrediting (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.") (Constantine, & Sue, 2007). Such statements can have profound psychological consequences though perpetrators may perceive them as harmless. Similarly, Smith et al. (2007) found that African American male students who experienced hypersurveillance from campus police exhibited high levels of emotional stress. Microinvalidations, such as statements that "we are all human beings," exclude or negate the experiences of minority individuals and have been demonstrated to reduce utilization of health services for sexual and racial/ethnic minorities (Sue et al., 2007; Nadal, 2008).

Research has demonstrated that microaggressions detrimentally impact the mental health of individuals belonging to marginalized groups, as studies have correlated microaggressions with higher prevalence of depressive symptoms (Nadal et al., 2014a); lower levels of self-esteem (Nadal et al., 2014b); lower levels of psychological well-being (Nadal et al., 2015; Solórzano et al., 2000; Sue et al., 2008); higher prevalence of binge drinking (Blume et al., 2012); and higher negative emotional intensity (Wang et al., 2011). Thus, the pre-fix micro- is not meant to imply

the quality of the effect of the aggressions; instead, micro- characterizes the more subtle nature of this form of discrimination that can make it hard to detect, identify, and demonstrate (Sue, 2010).

Initial writings about microaggressions focused on racial microaggressions (Constantine, 2007; Pierce et al., 1977; Smith et al., 2007; Sue et al., 2007). For example, Smith et al. (2007) found that Black men who experienced microaggressions reported psychological distress, including anxiety, feelings of hopelessness, and fear. And even when seeking professional help with these challenges, African Americans' satisfaction with White counselors was negatively associated with the frequency of perceived racial microaggressions they experienced during sessions (Constantine, 2007). Literature on microaggressions has since grown to include gender and sexual orientation (e.g., Nadal et al., 2010; Sue, 2010; Wright & Wegner, 2012; Woodford et al., 2014) and other minoritized identities (Vaccaro & Koob, 2019). In a sample of 299 LGBTQ individuals, Woodford et al. (2014) found that almost all participants reported experiencing interpersonal microaggressions (96%) and environmental microaggressions (98%), while only 37% experienced blatant discrimination or were victimized due to their sexual orientation; microaggressions predicted both self-acceptance and distress (i.e., anxiety and perceived stress), while blatant discrimination did not significantly relate to either variable. Moreover, self-acceptance (i.e., internalized LGBTQ pride and overall self-esteem) mediated the relationship between subtle heterosexism and distress, suggesting that LGBTQ individuals are better able to contend with microaggressions the more secure they are in their identities (Woodford et al., 2014). In support of these findings, Wright & Wegner (2012) found that microaggressions based on sexual orientation were associated with poorer self-esteem, negative feelings about one's LGB identity (i.e., "internalized negativity"), and difficulty in the process of developing positive

feelings about one's LGB identity. Findings such as these help demonstrate the usefulness of examining microaggressions as an indicator of minority stress and the impact that this form of stress can have on the mental health and well-being of individuals who belong to and identify with minority groups.

Black LGBTQ individuals may simultaneously encounter different sources of microaggressions (i.e., minority stress) that are associated with their multiple minority identities. Beyond exposure to these daily assaults from the dominant groups in the larger society, within their minority identity-based communities, Black LGBTQ individuals must also contend with intragroup marginalization, "the downgrading and discrimination that more privileged group members have towards other, less privileged group members" (Harris, 2009, p. 431). This intragroup marginalization has often been reported as being an additional stressor for individuals who already face marginalization from the dominant groups in society (Harris, 2009; Rust, 2000). As racial minority LGBTQ community members, they may experience racism in the predominantly White LGBT community (Diaz et al., 2001; Flores et al., 2009; Han, 2007; Loiacano, 1989; Martinez & Sullivan, 1998), such as exclusion from LGBT community events and spaces (Kudler, 2007), being refused entry to gay bars (Han, 2007) and sexual objectification due to beliefs about racial/ethnic differences between Black people and other LGBTQ people (Wilson et al., 2009). Such marginalizing experiences of racism have been shown to result in racial minority LGBT individuals not being fully involved in the LGBT community (Loiacano, 1989; Martinez & Sullivan, 1998). Moreover, research on the racial discrimination experienced by racial minorities in White LGBT communities has highlighted the negative impact this discrimination has on their self-esteem and perception of self-worth (Flores et al., 2009).

Additionally, early studies indicated that Black individuals are inclined to homophobia and are likely to hold less favorable attitudes toward homosexuality than Euro-Americans (Dalton, 1989; Peterson, 1992). More recently, Glick and Golden (2010), using data from the General Social Survey (GSS) from 1973–2008, found that 72.3% of Black people (compared to 51.6% of White people) indicated that homosexuality is "always wrong," suggesting that such sentiments are still prevalent in this community. For Black LGBTQ individuals, heterosexist, homo-, and transphobic attitudes in African American communities can lead to concealment of sexual orientation (Corsbie-Massay et al., 2017; Mays et al., 1993; Malebranche et al., 2009). It is therefore necessary to employ a conceptualization of minority stress experiences for Black LGBTQ individuals that is undergirded by an intersectional analysis of the multiple minority identities they possess.

An Intersectional Lens

Intersectionality, first highlighted by Black feminist legal theorist Kimberlé Crenshaw (1989), theorizes that social categories such as class, race/ethnicity, sexuality, and gender interact concurrently to shape peoples' identities, lives, and social practices. It asserts that our social identities are not independent or additive, rather they interlock and are mutually constitutive (Bowleg, 2013), and that there are multiple modes of oppression structuring an individual's identity (Anderson & McCormack, 2010). Intersectionality calls out the use of unitary categories (e.g., race/ethnicity, sexual orientation, or gender) as doing so can obscure important within-group differences (Meyer et al., 2008), and instead focuses attention on how the differences in experiences of individuals at different social intersections are related to social power in structural and interpersonal contexts (Collins, 1991; Crenshaw, 1989). Accordingly, intersectionality encourages the consideration of identity differences within groups as it relates to their social and

cultural contexts (Jones & Abes, 2013), such as those nuanced differences in the experiences of Black LGBTQ compared to non-Black LGBTQ individuals and Black heterosexual individuals.

Interest in this theory emerged out of a critique of gender- and race-based research for neglecting to account for the complexity of lived experiences of people who identify and are labeled with more specific identity categorizations (Collins, 2000; McCall, 2005). It is argued that ignoring one mode of oppression weakens an analysis as doing so overlooks an integral, operative force (Anderson & McCormack, 2010). Calling for an intercategorical approach, McCall (2005) suggests that scholars "provisionally adopt existing analytical categories to document relationships of inequality among social groups and changing configurations of inequality along multiple and conflicting dimensions" (p. 1773). For example, this approach accounts for the discrete and supposedly oppositional (albeit constructed) nature of LGBTQ and Black cultures and the experiences of those within them (Anderson & McCormack, 2010). While people are *socially* marginalized by these identity categories, they have real, material impacts on people's lives (Cosgrove & Bruce, 2005; McCarthy et al., 2003). Central to this intercategorical approach is therefore the principle that regardless of how these identity categories (i.e., gender, race, and sexuality) are constructed, discrimination and marginalization are experienced as real (Collins, 2000; Crawley et al., 2008; MacKinnon, 2006).

Considering the intersectional contexts of minority stress for multiply marginalized individuals can help explain, for instance, findings that African American young men who have sex with men encounter significantly more minority stressors, such as homophobia and racism related to both their ethnicity and sexuality, compared to their Caucasian and Latino counterparts (Wong et al., 2010), and that serious suicide attempts were found to be higher among Black lesbian, gay and bisexual (LGB) individuals than White LGBs (Meyer et al., 2008). Similarly,

while the majority of LGBTQ individuals reported being victims of anti-LGBTQ discrimination, racial minorities reported greater levels of anti-LGBTQ discrimination than White LGBTQ people (Whitfield et al., 2014). Understanding the intersectional experiences of minority stress for Black LGBTQ individuals can help direct mental health interventions in improving health and effectiveness of health services, and can help identify effective coping strategies for managing the impact of microaggressions and other forms of minority stress.

Coping

Coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Individuals often respond to stressful events through a combination of coping mechanisms (Lazarus & Folkman, 1984), and such efforts have often been grouped as either adaptive or maladaptive – whether they decrease or increase a stressor (Clark et al., 1999; Folkman & Lazarus, 1980; Kaysen et al., 2014). Maladaptive coping mechanisms (e.g., self-blame) are seen as ineffective because while they may alleviate stress temporarily, they do not reduce stress and have the potential to exacerbate it (Clark et al., 1999; Folkman & Lazarus, 1980). Conversely, adaptive coping mechanisms (e.g., working to resolve a stressful situation and accessing social support) mitigate stress (Folkman & Lazarus, 1980) and have been linked to lower levels of depression, anxiety, and substance abuse among sexual minorities (e.g., Lehavot & Simoni, 2011).

Discrimination is a unique stressor that people with stigmatized identities cope with (Wei et al., 2010). As an often chronic stressor, discrimination targets an individual and their affiliated group(s), which, in turn, can affect how they feel about themselves and the community(ies) that they belong to. As members of a minority group, individuals may not see their own beliefs,

values, or life experiences reflected in the social norm (Meyer, 2003), and this lack of validation, coupled with experiences of stigma and discrimination, can result in a number of conflicts and stressors (Meyer, 2003; Sornberger et al., 2013). Wei et al. (2010) posited that people of color cope with discrimination in five distinct ways: internalization (i.e., blaming oneself for discrimination), drug and alcohol use, resistance (i.e., directly challenging perpetrators of discrimination), detachment (i.e., withdrawing from others and feeling "stuck" or unsure about how to handle discrimination), and education/ advocacy. This model has also been applied to sexual minorities (Ngamake et al., 2016). While scholars have tended to examine maladaptive coping mechanisms in the relationship between discrimination and stress, few have focused on the adaptive coping mechanisms. Research suggests that maladaptive coping mechanisms play a more significant role in the relationship between discrimination and stress than adaptive coping mechanisms (e.g., Szymanski & Lewis, 2016; Mereish et al., 2014; Ngamake et al., 2016; Wei et al., 2010), and that sexual minority people engage in maladaptive coping mechanisms more frequently than their heterosexual counterparts (Feldman & Meyer, 2007; Rosario et al., 2009); however, adaptive coping mechanisms, such as social support, may aid in abating the stress associated with prejudice and discrimination (Lehavot & Simoni, 2011) and thus deserves further attention.

As posited by feminist theorist Wendy Brown (1995), focusing on the pain and trauma of oppression alone, the "wounded" subject position overlooks people's ability to gain power. Further, developmental psychologist Savin-Williams (2008) notes that there has been an "irresistible and overpowering attention" to the negative aspects of LGBTQ populations rather than a focus on their ability to adjust and thrive. In recent LGBTQ mental health research, there has been a tendency for reporting disparate rates of health and mental health outcomes, service

utilization, and disease burden (Hudson & Romanelli, 2020). Indeed, it is critical to examine how systems of disadvantage and marginalization diminish the capabilities and opportunities within these communities in order to promote awareness and advocate for resources, programs, policies, and practices that work to address these disparities. At the same time, there has been a lack of attention to the mechanisms of mutual care and support by community members facilitated by feelings of belonging and connectedness.

Experiences of oppression can lead to identifying more strongly with the oppressed group as a way of adapting to this form of stress, and the resulting sense of belonging this may confer can serve as a buffer from the otherwise negative consequences of experiencing societal oppression and rejection (Branscombe et al., 1999). Coping through minority group affiliations allows individuals to experience social environments in which they are not stigmatized by others (Jones et al., 1984). Distinguishing personal- (e.g., personality) from group-level coping resources, Meyer (2003) asserts that individuals without group-level resources have deficient coping. For example, Postmes and Branscombe (2002) found that a racially segregated environment contributed to greater in-group acceptance and improved well-being and life satisfaction among a sample of African American students. Minority identity, while often directly linked to stressors, can serve to weaken the impact of stress when associated with opportunities for affiliation, social support, and coping (Meyer, 2003). Feelings of connectedness to identity-based communities allow members of minority groups to compare themselves with others who are like them, as opposed to members of the dominant culture, when making self-evaluations (Meyer, 2003). This sense of connection, or belonging, can diminish the impact of oppressive experiences and feelings experienced by minority persons by facilitating a reappraisal

of stressful conditions as less marginalizing and thus rendering them less harmful to psychological well-being (Thoits, 1985).

It seems to follow, therefore, that group-level resources are integral to adaptive coping. However, while Meyer (2003) highlights the importance of connectedness to an identity-based community as a group-level coping resource for minority individuals, an intersectional perspective underscores the difficulties Black LGBTQ individuals may face in developing a sense of belongingness and connection with both the Black and LGBTQ community. As belongingness to identity-based communities affords key coping resources for managing the unique stressors experienced by minority individuals, it is therefore imperative that we apply this intersectional lens to an examination of Black LGBTQ individuals' experiences accessing and connecting with these resources given the complex intragroup marginalization experiences that have been observed.

Belongingness

The concept of belongingness assumes that the need to belong is a basic human motivation and that humans have a constant desire to create and sustain interpersonal relationships that are significant, positive, and lasting (Baumeister & Leary, 1995). Part of belonging, feeling 'at home' in a community, is the perception that it is at once 'mine,' 'yours,' and 'ours' rather than 'theirs,' and that one has an automatic right to access the community by virtue of having participated in its reproduction and sustenance (Shotter, 1993). It is about experiences of being part of the social fabric (of a community) and the ways in which social bonds emerge as practices, experiences, and emotions of inclusion. To belong is to be accepted, feel safe within, and to have a stake in the future of a community as one of its members. (Anthias, 2008).

Maslow (1954) identified sense of belonging as a basic human need, ranking it third in his hierarchy behind physiological needs (e.g., hunger) and the need for safety and security. Anant (1966) proposed that sense of belonging is the missing conceptual link in understanding mental health and mental illness from a relationship/interactional approach, and the need for relatedness to others is cited as crucial for well-being (Deci et al., 1991). Indeed, the ability to form and maintain positive social connections is essential and has a range of benefits. Being positively connected with others provides a reliable source of group support, self-validation, and emotional security in the face of adversity (Majors, 2012), and allows for collaborations and the opportunity to achieve mutual goals (Roffey, 2013).

Community Belongingness

Feeling a connection to one's community is an extension of the fundamental human need to belong and is associated with positive individual and social outcomes (Baumeister & Leary, 1995). While the definition of what constitutes a community is not always clear, it is understood that members of a community share a sense of emotional connection, values, beliefs, interdependence, aspirations, knowledge, and like-mindedness (Dewey, 1916; Roffey, 2008). Further, in "strong" communities, members feel as if they matter and belong, and that their participation is facilitated (Barnes & Roffey, 2013; McMillan & Chavis, 1986). *Community belongingness* has to do with the social attachment among individuals in a community and the related social engagements and participation (Kitchen et al., 2012). Shields (2008) proposed that feeling connected to one's community can promote health through the building of mutual respect and by increasing self-esteem. Community belonging was found to be strongly related to self-perceived general and mental health when controlling for other factors such as SES, health behaviors, and the presence of chronic conditions (Kitchen et al., 2012; Shields, 2008). And

whereas social isolation can adversely affect health, social engagement and attachment can lead to positive health outcomes (Holt-Lunstad et al., 2010).

A sense of community belonging is important for psychological well-being and positive identity formation (Flores et al., 2009; Heath & Mulligan, 2008), and is as much about a feeling of safety as it is about emotional connections (Yuval-Davis, 2007). Connection to the LGBT community was correlated with reduced distress related to gay identification in African American young men who have sex with men (Wong et al., 2014) and greater psychological well-being in White LGBT-identified men and women and Latina LGBT-identified women (Frost & Meyer, 2012).

In Hudson and Romanelli's (2020) study of LGBTQ individuals of color, a predominately Black sample reported on the role of community in enhancing their health and well-being. Participants expressed that community acceptance promoted a sense of safety in physical spaces and allowed community members to feel emotionally safe. Additionally, the sense of interconnectedness they felt was cited as leading to the creation of networks that facilitated the exchange of resources and material support among community members. This interconnectedness supported the wellness of LGBTQ community members by promoting feelings of strength and empowerment and resulting in collaborative efforts to advance the community, which led to community members engaging in social justice advocacy efforts together.

Feelings of inclusion, exclusion, access, and participation are central aspects of belonging. Questions about the places, spaces, locales, and identities that we feel we can (or cannot) access or participate in are related to perceptions and experiences of belonging (Anthias,

2008). The exclusion that marginalized and stigmatized groups experience increases their need to belong to social groups (Gorman-Murray et al., 2008). For individuals in minority and marginalized groups, a sense of belonging may only be accessed within identity-specific communities. Both racial/ethnic minority and LGBTQ communities allow members to safely interact and socialize with each other without the fear of persecution. Involvement in these identity-based minority communities provides access to resources (Lehavot et al., 2009), including those group-level resources required to cope with social stressors (Meyer, 2003).

It is crucial that research examines the social relations that lead to differences in identity and experiences of exclusion or inclusion (Anthias, 2008). For example, White male sexual minority men may feel more connected to the LGBT community than female and racial/ethnic minorities because this community is perceived as primarily White and male-oriented (Han, 2007). Feelings of marginalization experienced outside of one's social group can also occur within one's social group (Harris et al., 2015). Black LGBTQ individuals may confront homophobia and transphobia in their racial/ethnic communities and racism in the LGBTQ community (Loiacano, 1993). A 'gay neighborhood' can be safe for wealthy gay White men (Knopp, 1990; Nero, 2005) and unsafe for poor Black LGBTQ people who have been displaced through policing (Eng, 2010; Mogul et al., 2011) and gentrification (Rothenberg, 1995; Knopp, 1995; Hanhardt, 2008; Gieseking, 2013). Further, moving out of Black communities means losing connection to relationships that alleviate racism (Bowleg et al., 2008; Bridges et al., 2003). In response to this conflict between race and LGBTQ identity, Black LGBTQ people may minimize their racial or sexual identity or find and create Black LGBTQ communities (Hawkeswood, 1996; Silberman, 2001). And even in these communities, they may still encounter

biphobia, racial and ethnic prejudice, classism, and an exclusionary environment for transgender and gender non-conforming people (Lehavot et al., 2009; McQueeney, 2009).

Study Rationale

While previous evidence supports the assumption that a sense of belongingness to an identity-based community can support the ability to adaptively cope with minority stressors and promote mental health and well-being for racial, gender, and sexual minorities, this sense of belongingness may be limited or insufficient for individuals who are socially located at the intersections of multiple minority identities. Further, research suggests differences in the way that sexual minority individuals of color define and experience community (Wilson, 2009). For example, the sex and gender roles typically found in White lesbian communities were not fully congruent with the experiences of Black Lesbians (Wilson, 2009), and in a 2000 national survey of Black LGBTQ individuals (n = 2,500), half of the respondents strongly agreed that racism was a problem in the LGBTQ community (Battle et al., 2002). This study therefore seeks to examine the relationships that may exist between a sense of belongingness to a Black, LGBTQ, and Black LGBTQ community, coping, minority stress, and the mental health and well-being of Black LGBTQ individuals.

CHAPTER 3: METHODOLOGY

INTRODUCTION

Accounting for experiences of minority stress, the present study was designed to investigate the relationships between community belongingness and mental health and well-being; the mediation of coping in the relationships between community belongingness and mental health and well-being; and the association of Black LGBTQ community belongingness with mental health and well-being when compared to other types of community belongingness. This chapter highlights the methodology used within the study. The research questions, hypotheses and hypothesized path model, study design, population, instrumentation, sampling and data collection procedures, and analysis procedures are discussed.

Research Questions

The research questions that guided this study are: (1) What are the relationships between identity-based community belongingness and mental health and well-being for Black LGBTQ individuals? (2) To what extent does coping mediate the relationships between identity-based community belongingness and mental health and well-being for Black LGBTQ individuals? (3) What is the relationship between belongingness to a Black LGBTQ community and mental health and well-being compared to belongingness to a Black or LGBTQ community?

Study Hypotheses

H_1 Higher levels of community belongingness are significantly correlated with lower levels of mental health.

H_2: Higher levels of community belongingness are significantly correlated with higher levels of well-being.

H_3: Coping significantly mediates the relationship between community belongingness and mental health.

H_4: Coping significantly mediates the relationship between community belongingness and well-being.

H_5: Mental health symptomology has a stronger significant negative association with Black LGBTQ community belongingness than other forms of identity-based community belongingness.

H_6: Well-being has a stronger significant positive association with Black LGBTQ community belongingness than other forms of identity-based community belongingness.

Study Design

To meet the aims of this exploratory study and answer the research questions, a quantitative cross-sectional survey design was utilized. Quantitative research is primarily concerned with the production of precise and generalizable statistical findings, especially when seeking to establish connections or relationships among variables that have been predicted in advance (Rubin & Babbie, 2007). This study aims to explore the relationships that exist between the variables of interest within a sample of Black LGBTQ individuals – an approach that has yet to be documented in the research literature. Exploratory research is essential when the subject of study is relatively new and a researcher is breaking new ground (Rubin & Babbie, 2007), and they "almost always yield new insights into a topic for research" (p. 91). Because there has been very little research examining the significance of community belongingness for the mental health and well-being of Black LGBTQ individuals, this is an area of research that remains underdeveloped and thus warrants an exploratory approach to the current study.

Surveys may be used for exploratory research, tend to be associated with quantitative research, and make large samples feasible (Babbie, 2016; Rubin & Babbie, 2007). For this study, an online cross-sectional survey was developed using existing measures of community belongingness, coping, minority stress, mental health, and well-being described later in this chapter. The survey was advertised by an electronic flyer describing the study aims and inclusion

criteria. The flyer was distributed via email and social media platforms (i.e., Facebook, Instagram, and Twitter) and provided a link to the online survey to be completed electronically, including on mobile devices. Survey responses were anonymously collected via the online survey software REDCap and data were exported directly into IBM Statistical Package for Social Sciences (SPSS) Version 27 for data preparation and then Mplus Version 8.5 for data analysis.

The quality of response in surveys on smartphones is comparable to web-based surveys completed on a personal computer (Conrad et al., 2017), and surveys administered on a smartphone allow for quick responses, are typically low-costs for the researcher(s) compared to in-person surveys, and can provide respondents a platform that they are both familiar with and to which they have access (Sonck & Fernee, 2013). Completing a survey online allows those participating to remain anonymous, and this is particularly important when recruiting individuals who may feel uncomfortable disclosing stigmatized identities; no one, including the researcher(s), needs to know or identify the individuals responding to the survey. Additionally, research has revealed that "mobile-only internet access" has risen sharply among Black Americans (Dunaway, 2016), the target population of this study.

This study employed two non-probability sampling procedures: web-based sampling and snowball sampling. Web-based survey methods include both the sampling of study respondents on the web and the use of the web to deliver surveys to study participants regardless of how they were sampled. Using the web allows researchers to reach populations that have previously been overlooked in LGBTQ research, such as LGBTQ people in rural areas and in towns and villages where only small numbers of LGBTQ individuals live (Meyer & Wilson, 2009). Similarly, snowball sampling emerged as a nonprobability approach to sampling "hard-to-reach, or equivalently, hidden populations" (Heckathorn, 2011, p. 1).

While non-probability sampling impacts the generalizability of study findings and exposes the study to the threat of sampling bias (Babbie, 2016; Meyer & Wilson, 2009), it may be necessary when recruiting from populations that are hard to define or access – namely, individuals with stigmatized and marginalized identities. Challenges such as the LGBTQ population's elusive definition, individuals not identifying as LGBTQ or considering themselves a sexual minority who may be considered sexual minorities by others, and the stigmatization of sexual and gender minority identities (Meyer & Wilson, 2009) make it difficult to access "all" of this population. Moreover, when working with marginalized, "hidden" populations, such as Black LGBTQ individuals, researchers have noted that "such studied invisibility made it particularly difficult…to access this population" (Carr, 2003, p. 10). Standard statistical sampling methods require a "sampling frame" (i.e., a list of population members), and such an approach is not feasible for hidden populations.

Sampling and Recruitment

In quantitative research, *power* refers to the probability of rejecting the null when a particular alternative hypothesis is true. (Cohen, 1988; Dattalo, 2018; Fisher, 1925; Huberty, 2002; Neyman & Pearson, 1928) Statistical power refers to the probability of detecting a pre-specified effect size. It is important to perform a statistical power analysis to determine the smallest necessary sample size for the models in the study to detect an effect. Applying the widely used G*Power analysis calculator for multiple regression models allowed power to be determined based on a number of factors, including the number of predictor variables in the model, alpha level, the desired statistical power level, and the anticipated effect size. Power analysis determined that the smallest sample size necessary for this study is N = 169 (see

Appendix B). Once it was discovered that study recruitment had surpassed this sample size, data collection ceased.

This study recruited 345 Black LGBTQ individuals in the United States. To participate in this study, individuals were required to meet the following criteria: (1) self-identifying as African American or Black; (2) self-identifying as LGBTQ; (3) 18 years of age or older; and (3) currently living in the U.S. Data for this study was collected between November 2020 and January 2021 via an online survey hosted by REDCap. Upon IRB approval (IRB HM20020418), individuals in the researcher's professional and personal networks were contacted via email with a prepared survey invitation. Contacts were asked to share the recruitment email and flyer within their networks and were invited to participate in the study if interested and met the inclusion criteria. Additionally, three separate social media accounts on Facebook, Instagram, and Twitter were created solely for the purpose of recruitment, and a website was created through VCU Ram Pages that provided information about the current study, the study researcher, and the researcher's goals and scholarship. This website was used to help promote recruitment – potential participants were able to see that the researcher is a member of the population of interest, as well as the study flyer and survey link – and this page will serve as a hub for the dissemination of current and future study findings.

The prepared survey invitation included a brief description of the study and an invitation to (1) participate by accessing the provided link and (2) a link to the aforementioned VCU Rampages created for this study which also contained a direct link to the survey. Once the link was accessed, before completing the survey, participants were presented with an Informed Consent Form that described the participation procedure. Those who agreed to participate were then instructed to proceed to the next page in order to initiate the survey. The estimated time for

the completion of the survey was 30 minutes, and this was indicated in the Informed Consent

Form. Participants were also informed about their right to withdraw from participation at any

time without penalty and to contact the researcher of the study or Virginia Commonwealth

University's IRB office in case they had any questions about the study. Participants were also

assured of confidentiality and anonymity. In order to elicit a higher response rate and

compensate some participants for their time, study participants were presented with the option of

being included in a random gift card drawing for one of twenty-five $25 gift cards upon

completion of the survey.

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Instrumentation

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As detailed above, data for the current study was collected through an online survey.

The survey consisted of a demographic questionnaire, four adapted measurements, and four

adopted measurements. Each measurement instrumentation is detailed below.

Participant demographics

Participants' age, ethnicity, gender identity, sexual identity, income, education level,

employment status, student status, and area of residence are the demographic characteristics of

the sample that were collected in the survey. In an effort to build on existing knowledge, the

demographics variables included in this survey (and their corresponding categories) reflect those

used in previous research with the same or similar populations (e.g., Battle et al., 2002; 2012;

2013; Craig et al., 2017; Whitfield et al. 2014; Sutter & Perrin, 2016). **Age** was collected with

one question by asking participants to provide their current age at the time of the survey.

Ethnicity was collected as a categorical variable with options of "African," "Afro-

Caribbean/African Caribbean," "Afro-American/African American," "Black," "Black African,"

and a write-in item that read "if your ethnicity was not provided as an item, please provide it

here". Participants were allowed to select one ethnicity. **Gender identity** was collected as a categorical variable with options of "woman," "man," "gender-nonconforming/non-binary," "gender queer," "two-spirit," and a write-in item that read "if your gender identity was not provided as an option, please provide it here". Participants were allowed to select multiple gender identities. **Sexual identity** was collected as a categorical variable with options of "asexual," "bisexual," "down low or DL," "gay," "in the life," "lesbian," "pansexual," "queer," "same gender loving," "straight/heterosexual" and a write-in item that read "if your sexual identity was not provided as an option, please provide it here". Participants were allowed to select multiple sexual identities. **Household income** was collected as a categorical variable with options of "less than $25,000", "$25,000 to $34,999", "$35,000 to $44,999", "$45,000 to $54,999", "$55,000 to $64,999", "$65,000 to 74,999", "$75,000 to $84,999", "$85,000 to 94,999", "$95,000 to $99,999", "$100,000 to $149,999", and "$150,000 or more." Participants were allowed to select one income category. **Education** was collected as a categorical variable with options of "less than high school," "high school diploma or GED," "some college, no degree," "trade school," "associates degree," "bachelor's degree," "some graduate /professional school," and "graduate degree/professional degree (e.g., MA, PhD, etc.)." Participants were allowed to select one education category. **Employment** was collected as a categorical variable with options of "employed part-time," "employed full-time," "retired," "self-employed," and "unemployed." Participants were allowed to select one employment category. **Student status** was collected as a categorical variable with options of "enrolled full-time," "enrolled part-time," "not enrolled", and by a dichotomous (yes/no) variable asking "are you a traditional student?" Participants were allowed to select one category for both student status and traditional student status. **Residence** was collected through a write-in item that asked "in which U.S. state do you

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currently live?" and as a categorical variable that asked "how would you describe the area where you live?" with the options "rural," "suburban," and "urban." Participants were allowed to select one category for residence.

Community Belongingness

Community belongingness is conceptualized in this study as an individual's sense of connection to an identity-based community. Community belongingness is about emotional connections and a feeling of safety (Yuval-Davis, 2007), and it includes the social attachments among community members and their participation and engagement with each other (Kitchen et al., 2012). Community belongingness was measured using items adapted from the 9-item Transgender Community Belongingness Scale (TCBS; Barr et al., 2016). Sample items of this scale include "I feel like a member of the transgender community," "In the company of trans people, I don't feel like I belong," and "There are places in the trans community where I feel understood and accepted," and items are scored along a 5-point Likert scale (1 = '*not at all*,' 5 = '*all of the time*'). In a sample of 571 transgender adults (n = 209 transgender women, n = 217 transgender men, and n = 145 nonbinary-identified individuals) the TCBS had a Cronbach's alpha of .90, demonstrating good reliability (Barr et al., 2016). Parameter estimates indicated a positive relationship of small to moderate size between community belongingness and well-being (B = 0.249, p < .001). In keeping with the aims of this study, participants' perceptions of their level of belongingness to each of the three identity-based communities of interest was measured using three separate scales – Black community belongingness, LGBTQ community belongingness, and Black LGBTQ community belongingness. Items for each scale were adapted from the TCBS such that the wording in each appeared almost identical except for the interchanging of the community labels. For example, the wording of the item "I feel like a

member of the Black community" on the Black community belongingness scale was worded as "I feel like a member of the LGBTQ community" on the LGBTQ community belongingness scale, and as "I feel like a member of the Black LGBTQ community" on the Black LGBTQ community belongingness scale. Responses to all 27 items were summed to create a composite total score variable for community belongingness, with higher scores indicating higher levels of community belongingness.

Coping

Lazarus (1966) posited that stress consists of three processes: primary appraisal, secondary appraisal, and coping. *Primary appraisal* is the process by which a threat to oneself is first perceived. *Secondary appraisal* is the process of considering potential responses to the threat. *Coping* is the process of executing that response. Undergirded by this understanding of coping, the 60-item COPE Inventory was developed by Carver et al. (1989) to assess a broad range of coping responses. Acknowledging the need for a shortened instrument, Carver (1997) developed the 28- item Brief COPE from the parent version, which is comprised of items assessing the frequency with which an individual uses different coping strategies. This instrument contains 14 subscales, two items per subscale. Items are rated on a 4-point scale ranging from (1) "not used at all" to (4) "used a great deal". According to Hooper and colleagues (2013), a principal components factor analysis of the subscales with Varimax (orthogonal) rotation indicated two factors among the subscales, explaining 44.36% of the variance for the set of variables. Factor 1 was labeled *adaptive strategies* due to high loadings on planning, active coping, positive reframing, acceptance, humor, religion, using emotional support, using instrumental support, venting, and self-distraction (26.26% of the variance). Factor 2 was labeled

maladaptive strategies due to high loadings on denial, substance use, behavioral disengagement, and self-blame (18.10% of variance; Hooper et al., 2013).

The adaptive coping subscale of the Brief COPE instrument was administered in this study to specifically assess participants' frequency of adaptive coping responses (i.e., active coping, planning, using instrumental support, using emotional support, venting, self-distraction, positive reframing, humor, acceptance, and religion subscales) to the identity-based stress they experience. These coping responses are likely to promote better mental health and well-being outcomes than maladaptive responses. To that end, adaptive coping sample items included "I've been getting help and advice from other people," "I've been trying to see it in a different light, to make it seem more positive," and "I've been getting emotional support from others." Participants scored themselves from 1 to 4 (1 = '*I haven't been doing this at all,*' 4 = '*I've been doing this a lot*'). Responses to all 20 of the adaptive coping items were summed to create a total score of coping, with higher scores indicating more frequent use of that strategy. The adaptive coping subscales demonstrated good reliability in a sample of 168 individuals identifying as African American/Black (α= .85; Hooper et al., 2013).

Minority Stress

Minority stress was operationalized in this study as *microaggressions*. While the literature on minority stress has focused largely on major discriminatory events, the daily experience of microaggressions as a particular source of minority stress has gained attention in the research literature (Balsam et al., 2011). Microaggressions are characterized as daily, brief assaults on minority individuals that can be social or environmental, verbal or nonverbal, as well as intentional or unintentional (Sue et al., 2007). Minority Stress was measured using the 18-item LGBT People of Color Microaggressions Scale (LGBT-PCMS; Balsam et al., 2011), which

includes three subscales: (1) Racism in LGBT communities, (2) Heterosexism in Racial/Ethnic

Minority Communities, and (3) Racism in Dating and Close Relationships. While

microaggressions do not fully encompass the many manifestations of minority stress, the

dimensions of microaggressions captured in the LGBT-PCMS largely reflect findings in

literature regarding the unique experiences of Black LGBTQ individuals. Sample items included

"White LGBT people saying things that are racist," "Not being accepted by other people of your

race/ethnicity because you are LGBT," and "Difficulty finding friends who are LGBT and from

your racial/ethnic background." Responses are scored on a 5-point Likert scale (0 = *Did not

happen/not applicable to me*" to 5 = "*It happened, and it bothered me EXTREMELY*").

Responses to all 18 items were summed to create a total score of minority stress; higher scores

indicated a higher frequency and magnitude of experiences of minority stress.

Mental health

Mental health was defined in this study as depression and anxiety symptomology. Mental

health was measured using the Hopkins Symptom Checklist-25 (HSCL- 25), a screening tool

designed to detect symptoms of depression and anxiety within the past two weeks, including the

day of administration (Derogatis et al., 1974). Considering the frequent nature of

microaggressions that Black LGBTQ individuals typically experience, assessing symptomology

within the past two weeks will better allow for current, and likely more accurate, accounts of

participants' experiences and indications of their mental health. The HSCL consists of 10

questions that measure anxiety and 15 questions that measure depression. Sample items included

"difficulty falling asleep or staying asleep," "feeling lonely," "blaming oneself for things," and

"feeling trapped or caught". Items were rated on a scale from 1 (*not at all*) to 4 (*extremely*). A

total score on the HSCL-25 was calculated where higher scores on the HSCL-25 corresponded to greater symptom severity.

Smith et al. (2020) found that the anxiety and depression subscales of the HSCL-25 demonstrated convergent validity with the 2-factor (*discrimination from family* and *general discrimination*) structure of the Heterosexist Harassment, Rejection, and Discrimination Scale (HHRDS) in a sample of LGBTQ individuals of color. Specifically, they found significant positive associations between each type of heterosexism and anxiety and depression, which echoes previous research demonstrating an association between heterosexism and mental health problems for LGBTQ individuals (Mays & Cochran, 2001) and provides justification for the use of HSCL-25 as a measure of mental health with the current study sample. Moreover, the HSCL-25 has shown good internal consistency for the total scale in a sample of 200 LGBTQ individuals of color, 33% of which identified as Black/African American ($\alpha = .94$; Smith et al., 2020), and in a sample of 97 transgender students ($\alpha = .95$; Anderssen et al., 2020). Concurrent validity has also been demonstrated through correlations with feelings of pressure in several life domains (Lazarus et al., 1985).

Well-Being

Well-being was operationalized in this study as *subjective well-being*. Well-being is primarily defined as an individual's perception of their overall existence in terms of the absence of malfunction (e.g., disease, disorder, and problems) and the presence of strengths, assets, and other attributes (Frisch, 2000; Keyes, 1998). Historically, the two most common ways of researching and conceptualizing well-being have been *hedonic well-being*, defined by the degree of positive feelings (i.e., emotional well-being; Diener et al., 1999; Gurin et al., 1960), and *eudaimonic well-being*, defined as positive functioning (i.e., psychological well-being and social

well-being; Jahoda, 1958; Keyes, 1998; Magyar & Keyes, 2019; Ryff, 1989; Ryff & Keyes, 1995). Subjective well-being is conceptualized as being comprised of an individual's emotional well-being (e.g., level of positive feelings and perception of their overall life satisfaction), psychological well-being (e.g., the belief that one's life is purposeful and meaningful and the capacity to manage effectively one's life and surrounding world), and social well-being (e.g., social acceptance and social integration), and individuals who are high in subjective well-being report feeling good and functioning well (Magyar & Keyes, 2019).

Assessing participants' subjective well-being in addition to the presence of mental health disorders – namely, depression and anxiety – allows for a more holistic measure of their overall well-being. Additionally, it accounts for the potential that Black LGBTQ individuals have a higher baseline of clinical symptoms on average due to compounded, intersectional experiences of minority stress. Subjective well-being was measured using the Mental Health Continuum—Short Form (MHC–SF; Keyes, 2002, 2005), a 14-item scale measuring subjective well-being which asks participants how they have been feeling or functioning during the past two weeks, including the day of administration. Sample items included "during the past two weeks, how often did you feel interested in life?," "during the past two weeks, how often did you feel that you belonged to a community (like a social group or your neighborhood)?", and "during the past two weeks, how often did you feel good at managing the responsibilities of your daily life?" Participants responded by scoring themselves on a scale of 0 to 6 (0 = *'never'* and 6 = *'everyday').* All 35 items were summed together to produce a total well-being score; higher scores indicated higher levels of well-being. The MHC-SF has previously demonstrated good overall internal reliability (α = .93) in a sample of 235 Black college students (Mushonga & Henneberger, 2020).

Data Analysis

Study data were transferred from REDcap to SPSS through a formatting option that ensured accurate data transfer and eliminated errors from human data entry. Data were first pre-screened in SPSS to identify study variables with coding irregularities or missing cases. A missing value analysis found that missingness of data ranged from 5% to 25% for all variables in the study. To address this issue, multiple imputation was conducted in SPSS on all variables in this study. Multiple imputation is an approach that replaces missing data with predicted values based on existing data and "has shown to produce valid statistical inference that reflects the uncertainty associated with the estimation of the missing data" (Kang, 2013, p. 405). A descriptive statistics analysis was then conducted to ensure all variables were within appropriate ranges, and means and standard deviations were analyzed to ensure the plausibility of options. For each of the three community belongingness scales, several items (2, 4, 6, and 9) were reverse-coded to maintain consistency with the original scale adapted (Barr et al., 2016).

Data were analyzed using univariate, bivariate, and multivariate statistics in SPSS and in Mplus – a computer software modeling program that has been specifically designed for operations such as path analysis. Sample characteristics are assessed using univariate statistics, such as frequencies and measures of central tendency (i.e., mean, median, and mode). Central tendency and variability (i.e., standard deviation, variance, the minimum and maximum variables, and skewness) were assessed for all scales in the survey.

Pearson's r and spearman's rho correlations were used to test significant differences in the variables of interest of this study and to determine any relationships between the independent variables or any interaction between different groups of variables. Bivariate correlations were conducted to test the hypotheses about relationships between all predictor and outcome variables.

A path analysis was conducted to test the hypotheses about the relationships between community belongingness and mental health (H_1) and well-being (H_2), as well as the mediation of coping in these relationships (H_3 and H_4). Finally, multiple regression analyses were conducted to test the hypotheses about the relationships between mental health (H_5) and well-being (H_6) with each measure of community belongingness (i.e., Black community, LGBTQ community, and Black LGBTQ community).

Path Analysis

A path analysis assesses whether the model developed for this study based on a priori hypotheses fits well with data observed within the study. This method of examining model fit is preferred by researchers because it allows one to explore intercorrelations between different sets of variables in a single analysis. To answer the first two research questions, a path analysis was conducted to test the relationships between community belongingness and mental health and well-being, as well as the mediation of this relationship by coping, when controlling for minority stress, age, sexuality, gender, income, employment, education, and student status.

Path analysis is a statistical technique originally developed in the 1920s by geneticist Sewall Wright and is used primarily to examine the comparative strength of direct and indirect relationships among variables (Wright, 1921). Specifically, it was intended to measure "… the direct influence along each separate path in such a system and thus of finding the degree to which variation of a given effect is determined by each particular cause" (Wright, 1921, p. 557). An extension of multiple regression analysis, this analytical method estimates the magnitude and strength of effects within a hypothesized causal system and can be used to test the fit between two or more causal models. Because relationships between variables in the path model are expressed in terms of correlations, the relationships or pathways cannot be statistically tested for

directionality and the models themselves cannot prove causation (Wright, 1960). The path models, however, can inform the researcher as to which hypothesized causal model best fits the patterns of correlations within the data. This approach is useful in that it allows the breaking down of various factors that affect an outcome into direct and indirect effects, and it requires the researcher to explicitly specify how each variable relates to the others and therefore facilitates the development of clear, logical theories about the processes influencing a particular outcome (Lleras, 2005).

Path analysis has several assumptions, including linearity, multicollinearity, and reliability. These assumptions were assessed during data preparation. Linearity, the assumption that there is a straight line relationship between variables, was checked with a plot of the observed versus predicted values and a plot of residuals versus predicted values; the plots demonstrated linearity. Multicollinearity was assessed by calculating the *variance inflation factor (VIF)*. The rule of thumb is that if VIF > 10.0 (Kutner et al., 2004) when multicollinearity is a problem, though a cutoff > 5.0 is common (Sheather, 2009). VIF for all variables was ≤ 2.5, thus meeting the assumption of multicollinearity. Reliability was tested using Cronbach's alpha.

When conducting a path analysis, there are four sequential steps that must be performed, including : (1) model specification and identification, (2) estimation, (3) test/evaluation of parameter estimates, and (4) model modification if required (Bowen & Guo, 2012). Each of these steps was performed in the current study and is discussed below.

Model Specification and Identification

A path analysis requires relationships in the model to be specified and all parameters to be estimated. Additionally, path analysis requires the model to be identified. Model identification

assesses whether a unique value for each and every unknown parameter can be estimated from known or observed data, and thus whether the specified model is estimable. To determine whether a model is over-identified (has more than enough information to reproduce the matrix), justified (enough information to reproduce the matrix), or under-identified (not enough known information to reproduce the matrix), degrees of freedom (df) were calculated by subtracting unknown parameters needed to be estimated from the unique known pieces of information.

To calculate the number of unique pieces of information, a rule of thumb is to use the $p(p + 1)/2$ formula, where p is the number of variables included in the analysis. In the current path analysis, there were 351 unique pieces of information, and 79 free parameters needed to be estimated. The model was over-identified because there is more than enough information to reproduce the matrix (Weston & Gore, 2006). Another method of checking model identification is to determine if $t \leq u$ where t is the number of parameters in the model needed to be estimated and u is the number of known unique pieces of information using the aforementioned $p(p + 1)/2$ formula. In the current model, t (79) is less than u (351), confirming that the model is indeed over-identified.

Model Estimation

The second step in path analysis is to select an estimator. This allows the examination of the parameters specified in the a priori model. Specifically, the selection of an appropriate estimator enables values to be generated for the free parameters specified in the model. The current study used robust maximum likelihood (MLR) estimation. Although maximum likelihood (ML) estimation is the default estimator utilized in Mplus, ML methods assume multivariate normality of data (Weston & Gore, 2006). MLR allows for a more robust estimation of standard errors when data are not completely normal (Muthén & Muthén, 2017).

Model Fit and Evaluation of Parameter Estimates

While providing no straightforward tests to determine model fit, the best way to evaluate the model fit of a path analysis is to examine multiple tests (Suhr, 2008). Fit refers to the ability of a model to reproduce the data (i.e., usually the variance-covariance matrix). A good-fitting model is one that is reasonably consistent with the data and does not necessarily require respecification. The fit of the hypothesized model was evaluated using chi-squared, the Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), and Root Mean Squared Error of Approximation (RMSEA; Suhr, 2008). The chi-square test indicates the amount of difference between expected and observed covariance matrices. A chi-square value close to zero indicates little difference between the expected and observed covariance matrices. Also, the probability level must be greater than 0.05 when chi-square is close to zero. The Comparative Fit Index (CFI) is equal to the discrepancy function adjusted for sample size. CFI and TLI range from 0 to 1, with a larger value indicating better model fit. Acceptable model fit is indicated by a CFI value of 0.90 or greater (Hu & Bentler, 1999; Bentler & Bonett, 1980). Root Mean Square Error of Approximation (RMSEA) is related to residuals in the model. RMSEA values range from 0 to 1, with a smaller RMSEA value indicating better model fit. Acceptable model fit is indicated by an RMSEA value of 0.06 or less (Hu & Bentler, 1999).

Model Modification Indices

If model fit statistics indicate a poor model fit, model modification indices are utilized to make adjustments to the model. Modification indices are suggestions that are produced to help improve a specified a priori model, and they are reported with every analysis output. Mplus generates modification indices by identifying parameter estimates that would improve overall model fit.

Hypothesized Path Model

Figure 1 illustrates the path model that was being tested in this study. In this model, the pathways examine the effect of community belongingness on (1) mental health, (2) well-being, and (3) coping; coping on (4) mental health and (5) well-being; minority stress on (6) mental health and (7) well-being; and (8) the correlation between mental health and well-being. Additionally, this model controls for the variables age, sexual identity, gender identity, income, education, employment, and student status

Figure 1
Hypothesized Path Model (with Mediation of Coping)
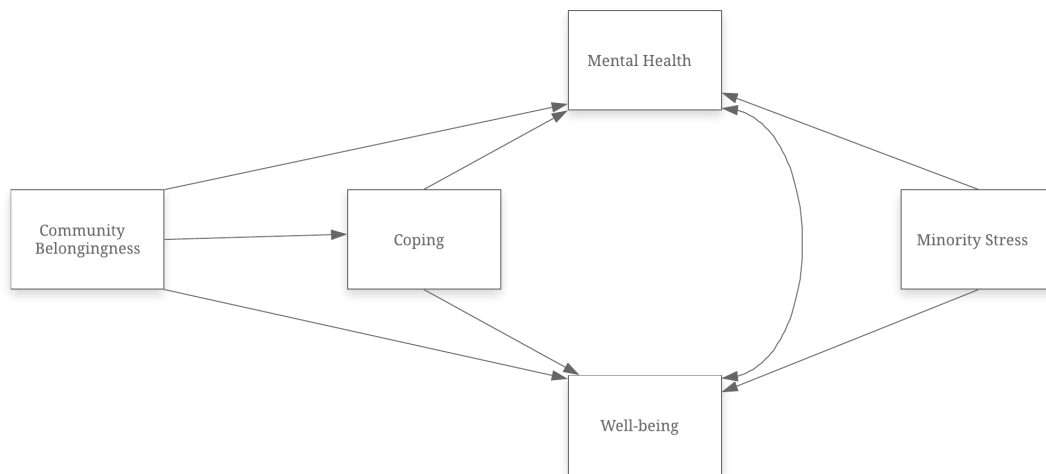
Figure 1. The hypothesized path model representing the relationships between community belongingness and mental health and wellbeing, as well as the mediation of coping.

Multiple Regression

To answer the third and final research question, a multiple regression analysis was conducted to determine whether Black LGBTQ community belongingness was more strongly associated with mental health and well-being than Black and LGBTQ community belongingness, controlling for minority stress. Multiple regression analysis has several assumptions, including

linearity, multivariate normality, homoscedasticity, and no multicollinearity. These assumptions were assessed during data preparation. Linearity was checked with a plot of the observed versus predicted values or a plot of residuals versus predicted values. Multivariate normality exists when each variable has a normal distribution of fixed values on all other variables. This assumption was checked with an omnibus test of multivariate normality based on Small's statistics (Looney, 1995). Homoscedasticity is the assumption that the variability in scores for one variable is equal at all values of another variable. Homoscedasticity also can be considered as a kind of equality-of-variance assumption. Homoscedasticity was assessed through a plot of standardized predicted values as a function of standardized residual values; the model demonstrated moderate homoscedasticity. Multicollinearity was assessed by calculating the *variance inflation factor (VIF)*.

Regression analyses are a set of statistical techniques that allow for the assessment of the relationship between one dependent variable and multiple independent variables (Tabachnick & Fidell, 2007). When researchers want to test the assumption that a given dependent variable is affected simultaneously by several independent variables, multiple regression analysis is one technique that can be used to analyze such relationships (Babbie, 2016). Utilizing a multiple regression analysis will help identify which type of community belonging in this study explains the greatest amount of variance observed in mental health and well-being outcomes. Similar to path analysis, which is essentially a series of regressions in one model, a limitation of multiple regression analysis is that while it reveals relationships among variables, causality cannot be established using this statistical technique. Also, this approach is based on the assumption that all participants will have had access to each of the communities being included in this study. For example, some participants may never have had access to a Black LGBTQ community.

Summary

This chapter described the methods used in this study. This study investigated the impact of community belongingness, coping, and minority stress on mental health and well-being; then examined which type of community belonging was most strongly associated with mental health and well-being outcomes. These variables have been measured by the following measures: **1)** a demographic questionnaire; **2)** a Black Community Belongingness Scale, **3)** LGBTQ Community Belongingness Scale, **4)** Black LGBTQ Community Belongingness Scale, and **5)** total community belongingness scale (items adapted from *Transgender Community Belongingness Scale* (TCBS; Barr et al., 2016); **6)** the Brief COPE (Carver, 1997); **7)** the LGBT People of Color Microaggressions Scale (LGBT-PCMS; Balsam et al., 2011); **8)** the Hopkins Symptom Checklist-25 (HSCL- 25; Derogatis et al., 1974), and **9)** the Mental Health Continuum—Short Form (MHC–SF; Keyes, 2005). Participants were recruited online through email and social media accounts created specifically for this study, and via snowball sampling methods. After data collection was completed, analyses were conducted using SPSS and Mplus. The next chapter will report results of study analyses with respect to the research questions and hypotheses.

CHAPTER 4: RESULTS

Introduction

This chapter will present the results of this study, including the sample demographics, correlational analysis, the reliability of the analytic scales, path analysis, and multiple regression. There will be a description of the participating sample and demographics of this study. Then a report of the analyses and findings from the data. Finally, study results will be presented along with the associated hypotheses.

Description of the Sample

Table 1 presents the demographic characteristics of the participants. Three hundred and forty-five individuals participated in this study. Regarding ethnicity, participants identified as 47% Afro-American/African American, 28% Black, 14% Afro-Caribbean/African Caribbean, 6% African, and 4% Black African. In terms of gender, participants identified as 34% men, 24% gender-nonconforming/non-binary, 19% women, 8% transgender men, 7% gender queer, 5% transgender women, and 4% two-spirit individuals when prompted to "select all that apply." In terms of sexuality, participants identified as 33% gay, 30% bisexual, 15% queer, 13% pansexual, 12% lesbian, 10% asexual, 4% in the life, 4% same gender loving, 3% Down Low/DL, and 2% straight/heterosexual when prompted to "select all that apply." The average age of participants was 27.95 years (SD = 6.37), with the youngest participant being 18 years old and the oldest 64 years old.

Participants reported a range of household incomes. Thirty percent reported $44,999 or less, 50% reported an income between $45,000 and $74,999, 15% reported an income between $75,000 and $150,000, and 4% reported an income of $150,000 or more. Regarding education,

11% of participants reported having completed less than a high school diploma, 19% high school

diploma or GED, 12% some college, no degree, 8% trade school, 5% associate degree, 23%

bachelor's degree, 8% some graduate/professional school, and 20% graduate degree/professional

degree. Regarding employment status, 60% of participants reported full-time employment, 20%

part-time employment, and 8% were unemployed. Participants reported student status as 60% not

enrolled in school, 36% enrolled full-time, and 13% enrolled part-time; of those enrolled, 51%

reported being traditional students. Regarding area of residence, 49% reported living in a

suburban area, 39% in an urban area, and 12% in a rural area.

Table 1.
Sample Demographics (N = 345)

Demographic characteristic	N	% / M (SD)
Age	345	27.95 (6.37)
Ethnicity		
African	20	6.1
Afro-Caribbean/African Caribbean	47	14.3
Afro-American/African American	155	47.3
Black	94	28.7
Black African	12	3.7
Gender identity		
Woman	66	19.1
Man	118	34.2
Gender-nonconforming/non-binary	81	23.5
Gender queer	24	7
Transgender man	28	8.1
Transgender woman	16	4.6
Two-spirit	15	4.3
Sexual identity		
Asexual	34	9.9
Bisexual	103	29.9
Down Low or DL	11	3.2
Gay	115	33.3
In the life	15	4.3
Lesbian	40	11.6

Pansexual	46	13.3
Queer	52	15.1
Same gender loving	15	4.3
Straight/Heterosexual	6	1.7
Income		
Less than $25,000	33	10.2
$25,000 to $34,999	26	8.1
$35,000 to $44,999	36	11.2
$45,000 to $54,999	87	27
$55,000 to $64,999	52	16.1
$65,000 to $74,999	17	5.3
$75,000 to $84,999	14	4.3
$85,000 to $94,999	22	6.8
$95,000 to $99,999	8	2.5
$100,000 to $149,999	15	4.7
$150,000 or more	12	3.7
Education		
Less than high school	36	11.2
High school diploma or GED	60	18.6
Some college, no degree	37	11.5
Trade school	15	4.7
Associates degree	17	5.3
Bachelor's degree	75	23.3
Some graduate /professional	24	7.5
Graduate /professional school	58	18
Employment		
Part-time	68	21
Full-time	211	65.1
Retired	6	1.7
Self-employed	12	3.7
Unemployed	27	8.3
Student status		
Full-time	89	28.4
Part-time	39	12.5
Not enrolled	185	59.1
Traditional	160	50.8
Nontraditional	155	49.2
Area of residence		
Rural	40	12.4

		157	48.6
Suburban		157	48.6
Urban		126	39

Table 2.

Descriptives and Reliability for Analytic Scales

Scale	No. of items	Cronbach's Alpha	M(SD)	Range	Skewness (Kurtosis)
1. Black Community Belongingness	9	.828	31.46 (5.60)	16-45	.55 (-.08)
2. LGBTQ Community Belongingness	9	.815	30.94 (5.38)	18-45	.71 (.11)
3. Black LGBTQ Community Belongingness	9	.861	30.39 (6.02)	15-45	.60 (.30)
4. Total Community Belongingness	27	.921	92.80 (14.78)	57-135	.87 (.33)
5. Adaptive Coping	20	.813	48.77 (7.11)	19-76	.44 (2.00)
6. LGBT-PCMS	18	.882	42.47 (13.05)	1-81	-.78 (1.3)
7. HSCL-25	25	.927	54.68 (11.54)	26-91	-.27 (.68)
8. MHC–SF	14	.893	54.92 (10.32)	21-84	.20 (.59)

Note. Ranges reported are representative of sample scores.

Scale reliability

Table 2 presents the descriptive statistics and reliability of all analytic scales in the current study. Internal consistency reliability was assessed for the purposes of this study on Black community belongingness, LGBTQ community belongingness, Black LGBTQ community belongingness, total community belongingness, coping, minority stress, mental health, and well-being. As noted in Table 2, all final Cronbach's alphas were good, with estimates ranging from .81 to .92. The widely-accepted social science cut-off is that alpha should be .70 or higher (George & Mallery, 2003; Schmitt, 1996).

Correlational Analyses

Appendix C presents the bivariate correlations of all study variables. The current study included nominal, ordinal, and interval variables, therefore bivariate analyses were performed using both Pearson's and spearman rho coefficients to ascertain whether predictor and outcome variables (i.e., mental health and well-being) were significantly correlated. Regarding the study hypotheses, note that the results of the correlation analysis supported H_1 and H_2. What follows is a listing of key significant correlations.

Age ($r = -.27, p < .001$), education ($r_s = -.16, p = .004$), employment ($r_s = .18, p = .002$), Black community belongingness ($r = -.36, p < .001$), LGBTQ community belongingness ($r = -.31, p < .001$), Black LGBTQ community belongingness ($r = -.38, p < .001$), community belongingness total score ($r = -.38, p < .001$), wellbeing ($r = -.49, p < .001$), and minority stress ($r = .28, p < .001$) were statistically significantly correlated with mental health. That is, increases in mental health were correlated with older age, more education, being unemployed, increased community belongingness, increased well-being, and decreased minority stress.

Age ($r = .19, p < .001$), Black community belongingness ($r = .22, p < .001$), LGBTQ community belongingness ($r = .27, p < .001$), Black LGBTQ community belongingness ($r = .31, p < .001$), community belongingness total score ($r = .32, p < .001$), coping ($r = .25, p < .001$), mental health ($r = -.49, p < .001$), and minority stress ($r = -.20, p < .001$) were statistically significantly correlated with well-being. That is, increases in well-being were correlated with older age, increased community belongingness, increased coping, increased mental health, and decreased minority stress.

Research Questions 1 and 2

Path analysis was conducted to assess the fit of the hypothesized model to the sample data using Mplus 8.5. Figure 2 illustrates the hypothesized model investigated via path analysis in this study. Particular focus is given to the direct relationship between community belongingness and mental health and well-being outcomes and the mediating role of coping in these relationships. The hypothesized directions of the path coefficients in each model are indicated.

This study assessed multiple fit indices for the model, as displayed in Table 3. Fit indices (x^2 = 28.475, df = 22, p = .16, RMSEA = 0.029, CFI = 0.973. TLI = 0.913, and SRMR = 0.035) indicated that all indices fit well with the hypothesized model and no modification of the hypothesized model was necessary.

Table 3
Path Model Fit Statistics

	x^2(df)	RMSEA [90% CI]	CFI	CFI	SRMR
Path Model					
	28.475(2)*	0.029 [0.000-0.057]	0.973	0.913	0.035

Note. *p = 0.16

Path Analysis Results

Path analysis was utilized to examine the relationship between community belongingness and mental health and well-being as mediated by adaptive coping mechanisms. It was hypothesized that community belongingness would have a significant negative relationship with mental health and a significant positive relationship with well-being. Additionally, it was predicted that coping would mediate these relationships.

Figure 2
Hypothesized Path Model (with Mediation of Coping)
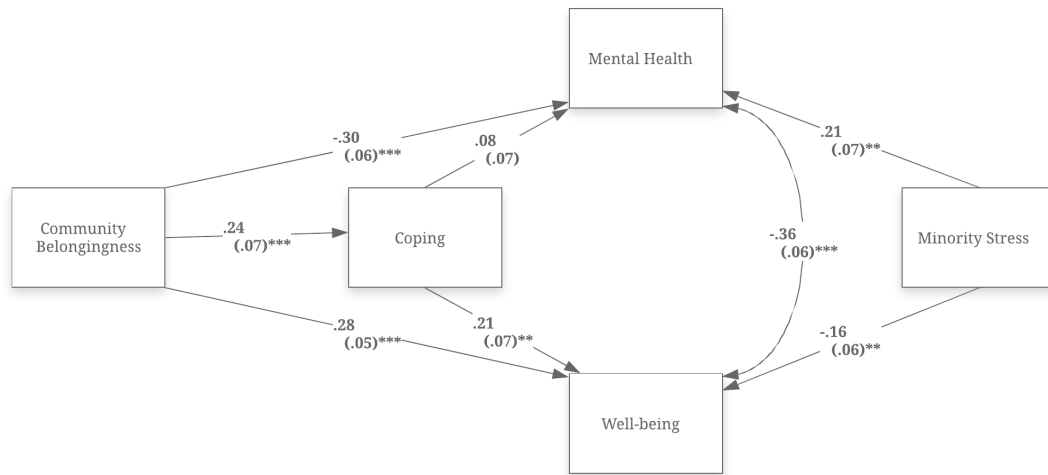
Figure 2. The hypothesized path model representing the relationships between community belongingness and mental health and wellbeing, as well as the mediation of coping, accounting for minority stress.
Note. *p< .05, **p< .01, ***p< .001. N = 345. Standardized coefficients are shown with standard errors in parenthesis. In this path analysis, age, gender, sexuality, income, education, emloyment, and student status were controlled for. See Appendix F for full path model.

Community Belongingness and Mental Health

H_1: Higher levels of community belongingness are significantly correlated with lower levels of mental health.

H_3: Coping significantly mediates the relationship between community belongingness and mental health.

The results of the path analysis (Table 4) revealed that community belongingness negatively predicts mental health (B = -.29, SE = .06, p = < .001). Analyzing the indirect effect, results reveal that coping did not mediate the relationship between community belongingness and mental health (ab = .02, SE = .02, p = .25, 95% CI, -.023 – .060). Whereas community belongingness positively impacts coping (B = .24, SE = .07, p = < .001), coping, in turn, did not significantly affect mental health (B = .08, SE = .07, p = .25). Nevertheless, the results suggest

that even after accounting for the mediating role of coping, community belongingness had a negative impact on mental health ($B = -.31$, $SE = .06$, $p = < .001$).

Community Belongingness and Well-Being

H_2: *Higher levels of community belongingness are significantly correlated with higher levels of well-being.*

H_4: *Coping significantly mediates the relationship between community belongingness and well-being.*

The path analysis results also revealed that community belongingness positively predicts well-being ($B = .33$, $SE = .05$, $p = < .001$). Analyzing the indirect effect, results reveal that coping partially mediated the relationship between community belongingness and well-being (*ab* $= .05$, $SE = .02$, $p = .03$, 95% *CI*, $-.010 – -.161$). Community belongingness positively impacts coping ($B = .24$, $SE = .07$, $p = < .001$) and coping, in turn, positively impacts well-being ($B = .212$, $SE = .07$, $p = .002$). Nevertheless, the results also suggest that even after accounting for the mediating role of coping, community belongingness had a positive impact on wellbeing ($B = .28$, $SE = .05$, $p = < .001$). Coping accounted for 6% of the total effect in this model (R2 $= .06$, $SE = .03$, $p = .078$).

Table 4
Standardized Total, Direct, and Indirect Effects for Path Model

Path	Total Effect		Direct Effect		Indirect Effect		
	B (SE)	*p*	*B (SE)*	*p*	*ab (SE)*	*p*	95% CI
CB → C → MH	-.29 (.06)	< .001	-.31 (.06)	< .001	.02 (.02)	.25	-0.008, 0.045
CB → C → WB	.33 (.05)	< .001	.28 (.05)	< .001	.05 (.02)	.03	0.012, 0.089

Note. C = Coping. CB = Community belongingness. MH = Mental health. WB = Wellbeing.

H_5: *Mental health symptomology has a stronger significant negative association with Black LGBTQ community belongingness than other forms of identity-based community belongingness.*

H_6: *Well-being has a stronger significant positive association with Black LGBTQ community belongingness than other forms of identity-based community belongingness.*

Multiple regression analyses were conducted to compare the association of each community belongingness subscale with both mental health and well-being, controlling for minority stress. It was hypothesized that Black LGBTQ community belongingness would have the strongest negative association with mental health and the strongest positive association with well-being, compared to other forms of identity-based community belongingness in the model.

Multiple Regression Analyses

Regression analyses revealed that for mental health, Black community belongingness (b = - .20, p = .008) was the only statistically significant form of community belongingness in this model, and had a stronger association than LGBTQ community belongingness (b = -.12, p = .08), and Black LGBTQ community belongingness (b = -.08, p = .40) when controlling for minority stress (b = .21, p = .003). Regression analyses also revealed that for well-being, Black LGBTQ community belongingness (b = .23, p = .009) was the only statistically significant form of community belongingness in this model, and had a stronger association than Black community belongingness (b = -.03, p = .66) and LGBTQ community belongingness (b = .13, p = .08), when controlling for minority stress (b = -.17, p = .02).

Summary

The hypothesized path model (Figure 2) provides a close fit to the sample data. Results of the analysis found that community belongingness positively impacts mental health and well-being (Table 4). Further, it was found that while coping partially mediated the relationship

between community belongingness and well-being, it did not mediate the relationship between

community belongingness and mental health. A multiple regression analysis revealed that Black

community belongingness was most strongly associated with mental health while Black

LGBTQ+ community belongingness was most strongly associated well-being, accounting for

minority stress. The next chapter will discuss the findings of this study as it relates to existing

literature and the implications for social work practice, education, and future research.

CHAPTER 5: DISCUSSION

Introduction

The purpose of this quantitative study was to examine the relationships that exist between community belongingness, coping, minority stress, mental health, and well-being among Black LGBTQ individuals living in the United States. Specifically, the hypothesized relationships among these variables were tested via path analysis, including the direct connections between community belongingness and mental health and well-being, and the mediating role of coping in these relationships. This chapter includes a discussion of significant findings within the context of existing literature on these variables and what implications may be valuable to inform services, programs, and practices targeting the mental health and well-being needs of Black LBGTQ individuals, and forsocial work education. The chapter concludes with a discussion of the study limitations, areas for future research, and a summary.

Overview of Significant Findings

The results of this study reveal that in a sample of Black LGBTQ individuals, community belongingness is associated with reduced mental health (i.e., anxiety and depression) symptomology and increased well-being (i.e., emotional, psychological, and social) outcomes. And whereas adaptive coping partially explained the variance in the connection between community belongingness and well-being, it did not explain the connection between community belongingness and mental health. When comparing feelings of belongingness to three different identity-based communities (i.e., Black, LGBTQ, and Black LGBTQ community), accounting for experiences of minority stress, Black LGBTQ community belongingness was most strongly promotive of well-being and Black community belongingness was most strongly promotive of mental health.

Minority Stress, Mental Health, and Well-being

Minority stress negatively affected mental health and well-being in this sample of Black LGBTQ individuals. These findings support previous research about the impact of minority stress on mental health (Brown et al., 2000; Fields et al. 2008; Gaylord-Harden & Cunningham, 2009; Hendricks & Testa, 2012; Hightow-Weidman et al. 2011; Hoggard et al., 2015; Pascoe & Smart Richman, 2009) and well-being (Branscombe et al., 1999; Nadal et al., 2015; Meyer, 2003; Solórzano et al., 2000; Sue et al., 2008). The LGBT-PCMS was developed to measure experiences of microaggressions that are specific to the experiences of LGBT people of color, such as Black LGBTQ people. Study findings demonstrate that the experiences of microaggressions unique to LGBT people of color are significantly related to mental health and well-being outcomes of Black LGBTQ individuals, and that these brief, daily assaults are useful for examining the minority stress experiences of Black LGBTQ people. Findings also support the assertions of intersectionality theory. The significant and negative impact of these microaggressions on the mental health and well-being of this population further supports the idea that there are unique intersectional experiences of minority stress that are experienced by LGBT people of color, which would be overlooked if researchers are not intentionally considering the influence of multiple minority identities. It also clarifies that intersectional dynamics are relevant and matter, as they directly impacted the mental health and well-being of Black LGBTQ individuals.

The Impact of Community Belongingness on Mental Health

As hypothesized, findings of this study support previous evidence that perceptions of one's belongingness to identity-based communities play an important role in mental health generally (Kitchen et. al, 2012; Shields, 2008), and that connectedness to LGBT community

could protect against the negative impact of minority stress on the mental health of LGBTQ individuals (Major & O'Brien, 2005; Meyer, 2003). This study extends such research by demonstrating that even for Black LGBTQ individuals who may experience challenges in belonging to their racial, sexual, and gender identity communities, community belongingness remains a critical protective factor in mental health.

Mental health was measured in this study by symptoms of anxiety (e.g., worrying too much, feeling trapped and caught, feeling tense or keyed up) and depression (e.g., feelings of worthlessness, feeling lonely, feeling hopeless about the future). Targets of frequent microaggressions (i.e., minority stress) related to their racial, sexual, and gender identities, Black LGBTQ individuals' perception of belongingness in many social environments are negatively affected. These minority stress experiences contribute to and exacerbate symptoms of anxiety and depression (Hatzenbuehler et al., 2010; Hoggard et al., 2015; Nadal et al., 2014a; Smith et al., 2007) specifically, and reduce mental health generally (Mays & Cochran, 2001; Williams & Williams-Morris, 2000). However, community belongingness has been found to have an inverse relationship to depression in a sample of gay men (McLaren et al., 2008) and helped protect against depression in a sample of bisexual women (Lambe et al., 2017). In a sample of Black LGBTQ individuals, findings from the current study support previous evidence that minority stress negatively impacts mental health, and that community belongingness reduces the negative impact of minority stress on mental health.

Community Belongingness and Mental Health: The Mediating Role of Coping

In this study, while coping was significantly associated with community belongingness, it did not demonstrate a significant impact on mental health and did not mediate the relationship between community belongingness and mental health. These findings conflict with previous

research that adaptive coping mechanisms have been linked to lower levels of depression and anxiety (Lehavot & Simoni, 2011) and reduced psychological symptoms (Park et al., 2001). Mediation models seek to examine whether and to what degree the process or mechanism underlying the relationships between two variables can be explained by the inclusion of a third variable – the mediator variable. One explanation for the finding that coping did not mediate the relationship between community belongingness and mental health is that coping accounted for a small amount of the variance observed in the overall model, suggesting that other variables are impacting this relationship that have not been accounted for.

Another explanation is that other coping strategies are more culturally relevant for this sample of Black LGBTQ individuals. It may be that the adaptive coping strategies measured in this study are less relevant to those more typically employed by individuals in this particular community. Similarly, maladaptive coping may be more relevant to this population than adaptive coping. Previous research has highlighted that the relationship between discrimination and stress is better explained by maladaptive coping mechanisms than adaptive coping mechanisms (e.g., Szymanski & Lewis, 2016; Mereish et al., 2014; Ngamake et al., 2016; Wei et al., 2010), and that maladaptive coping mechanisms are used by sexual minority people more than their heterosexual peers (Feldman & Meyer, 2007; Rosario et al., 2009). This may be the case for Black LGBTQ individuals as well. It may also be that maladaptive coping mechanisms are more common or have been normed in these minority communities, thus influencing its members' likelihood to engages in similar strategies. Future research can explore the connection between identity-based communities and coping strategies employed by Black LGBTQ individuals and the potential impact this has on mental health.

It is also important to consider the differential impact on coping that may exist between anxiety and depression, given that these are separate and distinct constructs and experiences. The lack of significance found in the relationship between coping and mental health in this study may related to the use of both anxiety and depression scales in the measurement of mental health. Perhaps examining the impact of coping on anxiety and depression separately would have led to significant findings for one or both of these relationships that were not present in the model when assessed conjointly. Future research should examine the impact of coping on anxiety and depression, as well as its role in mediating the relationship of community belongingness with anxiety and depression, individually.

Mental Health and Black Community Belongingness

It was hypothesized that mental health symptomology has a stronger significant negative association with Black LGBTQ community belongingness than other forms of identity-based community belongingness. However, belongingness to the Black community was the only form of belongingness in this study that demonstrated a significant impact on mental health. Because racial identity is something you typically develop very early in life (Phinney, 1989, 1990), and can be more apparent than other identities in a social environment (e.g., an LGBTQ identity), Black LGBTQ individuals may be more likely to attribute experiences of discrimination and prejudice to their racial identity. It has also been found that recent experiences of discrimination more negatively impact mental health than lifetime discrimination, so it may be that the individuals in this sample experienced discrimination that they perceived to be related to their racial identity more recently than other forms of discrimination they might encounter. This study was conducted shortly after a worldwide "Black Lives Matter" movement in response to the continued killing of Black people by law enforcement officers. This moment was characterized

by social media (e.g., Twitter and Instagram) and the larger news media outlets (e.g., CNN and Fox News) being flooded with videos of Black people experiencing violence and death by state agents, and such images and conversations likely had a negative influence on the participants' feelings of what it meant to belong to this community.

Attributing experiences of minority stress to their racial identity above and beyond other minority identities may be another explanation for Black community belongingness solely relating to symptoms of anxiety and depression for the Black LGBTQ individuals in this study; that is, experiences of minority stress may be unevenly internalized as stemming from their racial identity. For Black LGBTQ individuals who have been raised and socialized in the Black community, connecting with an LGBTQ or Black LGBTQ community likely occurred later in life as they developed their sense of self and identities. Choosing to connect with these communities, regardless of sexual and gender identity, may feel like a more autonomous process. Conversely, the divisive system of race in our society that is based on phenotypical features, such as skin color, typically precludes Black LGBTQ people – and all Black people – the opportunity to independently decide or discover their racial identity.

The Impact of Community Belongingness on Well-being

As individuals identify as both Black and LGBTQ in a larger racist and cis/heteronormative society, they will likely encounter many messages and interactions that would suggest, implicitly or explicitly, that they do not belong. Having an accepting community of people who share one or more minority identities, and similar experiences of minority stress (e.g., discrimination and prejudice), can provide a sense of belonging that is important for well-being (Flores et al., 2009; Heath & Mulligan, 2008; Hudson & Romanelli, 2020). For this sample of Black LGBTQ individuals, even in the face of minority stress, belongingness to identity-based

communities supported their well-being as hypothesized. Well-being includes feeling that one

belongs to and contributes to a community (Keyes, 1998). Further, feeling a sense of mutual

ownership of a community through participation in its development and maintenance is a part of

feeling as if one belongs (Anthias, 2008; Shotter, 1993).

However, access to an identity-based community that fully accepts, understands, and

supports all of their marginalized and stigmatized identities – because of or despite them – can be

quite the challenge for Black LGBTQ individuals (Bowleg, 2013; Frost & Meyer, 2012; Meyer

& Ouellette, 2009; Moore, 2010). Further, it may be difficult for Black LGBTQ individuals to

feel as if they are active participants in a social environment where they experience

discrimination and stigmatization related to any number of their identities. Exposure to this

minority stress can happen in Black and LGBTQ communities, in addition to the larger society.

In communities of Black LGBTQ peers, there are likely more opportunities to participate in

community development and sustenance processes. Indeed, previous research has discussed

Black LGBTQ individuals choosing to create communities of their own as a strategy to meeting

these needs (Hawkeswood, 1996; Silberman, 2001).

Supporting these ideas, the current study found that perceptions of belongingness to the

Black LGBTQ community was associated with higher levels of well-being when compared to

the Black or LGBTQ community, as hypothesized. Such findings suggest that belonging to a

community of individuals sharing multiple minority identities, as opposed to one, was essential

to the well-being of the Black LGBTQ individuals in this study. Moreover, given that this study

accounted for minority stress experiences unique to LGBTQ people of color (Balsam et al.,

2011), it can be inferred from these findings that feelings of belongingness to the intersectional

community of Black LGBTQ people was most helpful in buffering against the deleterious effects

of these social forces. In addition to stressors that are a common feature of everyday life for all people in our society, the experiences of stress that are particular to multiply marginalized LGBTQ individuals of color had the least impact on the well-being of those individuals who belonged to a Black LGBTQ community.

Community Belongingness and Well-being: The Mediating Role of Coping

Supporting the hypothesis that coping mediated the relationship between community belongingness and well-being, study findings revealed a partial mediation of coping. These findings echo previous evidence that community belongingness can serve to support minority individuals in coping with experiences of minority stress (Hudson & Romanelli, 2020; Jones et al., 1984; Lehavot et al., 2009; Meyer, 2003), and that coping via a sense of belonging to identity-based communities can help to mitigate the impact of minority stress (Hudson & Romanelli, 2020; Meyer, 2003; Thoits, 1985). While research on coping mechanisms for sexual minority individuals has largely focused on maladaptive approaches (e.g., Szymanski & Lewis, 2016; Mereish et al., 2014; Ngamake et al., 2016; Wei et al., 2010), coping was measured in this study specifically by engagement with adaptive coping mechanisms given the understanding that they are more likely to mitigate stress (Folkman & Lazarus, 1980) and reduce levels of depression and anxiety among sexual minorities (e.g., Lehavot & Simoni, 2011). Adaptive coping mechanisms consist of proactive behaviors such as active coping, planning, positive reframing, acceptance, humor, religion, seeking emotional support, seeking instrumental support (e.g., getting advice or help from others), self-distraction, and venting (Folkman & Lazarus, 1980). It has been suggested that adaptive coping mechanisms may help to reduce the stress associated with prejudice and discrimination for sexual minorities (Lehavot & Simoni, 2011), and that people of color cope with discrimination through resistance (i.e., directly challenging

discrimination) and education/advocacy (Wei et al., 2010) – behaviors similar to those employed in adaptive coping mechanisms.

Perceiving a sense of belongingness to a community of individuals with whom you can connect and commiserate, and who likely have similar experiences of minority stress, may promote the ability to reframe or even to make fun of (e.g., humor) stressful situations in a way that reduces the negative impact of this stress on your well-being. In a community of individuals with a shared sense of belongingness, one is more likely to be supported in taking action to address situations (e.g., social interactions) and circumstances (e.g., institutional oppression) that induce minority stress. Members of a minority community can support in planning the most effective strategies to resolve issues that arise related to minority identities. For example, if a Black trans individual loses their job due to employer discrimination, a community of people who empathize with and understand this experience can help strategize ways to work around the sudden loss of income and address the employer's decision more effectively – and feel empowered to do so. Moreover, simply having access to a community that one is comfortable reaching out to for support because of a shared sense of belonging can mean the difference between choosing to engage in adaptive instead of maladaptive coping strategies (e.g., self-blame and disengagement) – an approach which might contribute to feelings of isolation and thus impact perceptions of belongingness and well-being (Crocker & Major, 1989; Herek & Glunt, 1995; Meyer, 2003).

Implications for practice

This study has several practical implications for social work practitioners working with Black LGBTQ individuals. First, the considerable influence that perception of belongingness to identity-based communities has on the mental health and well-being of Black LGBTQ

individuals is evident and deserves careful attention. Higher levels of belongingness to these communities were associated with better mental health and well-being outcomes. It is therefore important for practitioners servicing individuals in this population to emphasize belongingness with others whom they share minority identities. Encouraging Black LGBTQ clients to connect with such communities as a way to harness group-level resources can aid in coping with the unique intersectional minority stressors they encounter more effectively than individual coping strategies. This is especially true if the relationship with such communities is perceived to be beneficial by the individual. Similarly, the use of group therapy – in addition to or instead of individual therapy – holds promise for improved mental health and well-being outcomes among Black LGBTQ individuals.

Practitioners developing programs, services, and interventions for this community should consider the benefits of working alongside Black LGBTQ individuals to support the creation and sustenance of community. Black LGBTQ individuals continue to create and sustain identity-based communities for themselves as a way to address this crucial human need, and participation in these processes is vital for individuals to feel as if they belong. Centering the development of community for Black LGBTQ individuals and working to assist these clients in establishing connections with individuals who share their minority identities while allowing them to determine how they want to operate as a community is one approach that may be useful. In keeping with the principles of intersectionality, practitioners working with Black LGBTQ individuals should seek to understand how their multiple minority identities contribute to the minority stressors that they experience in the larger society and within identity-based communities (i.e., Black and LGBTQ) they belong to. It is likely that there are very few spaces where these individuals feel fully accepted and are not exposed to messages and interactions that

marginalize and stigmatize one or more of their identities. While Black community belongingness was related to mental health and Black LGBTQ community belongingness was related to well-being, LGBTQ community belonging was not significantly related to either. Such differences highlight the importance of evaluating the relative influence and impact of intersecting identities on mental health and well-being outcomes. For example, it would be important to know whether a client is attributing the experiences of prejudice and discrimination to a particular minority identity more than the others they hold. This would be helpful in identifying coping strategies that are useful in ameliorating the particular forms of minority stress that an individual experiences relative to the identities perceived as most salient.

Finally, when working with Black LGBTQ clients to establish, improve, or sustain identity-based communities, it is important to keep in mind that perceptions of belongingness are likely to be impacted by the other identities (e.g., sexual and gender) that individuals hold. For example, even within LGBTQ communities, issues such as gender- or sexual identity-based discrimination exist, and this can impact an individual's sense of belonging in these spaces (Balsam & Mohr, 2007; Heath & Mulligan, 2008; Lehavot et al., 2009; Mitchell et al., 2015; Nadal et al., 2016; Roberts et al., 2015). Thus, it is imperative that these dynamics are considered and discussed with Black LGBTQ clients when developing treatment plans and coping strategies that emphasize connection with identity-based communities. As individuals who experience a variety of identity-related stress, it could be harmful to experience further rejection and stigmatization when seeking to build community with individuals who only ostensibly share your identities and experiences.

Implications for Social Work Education

The findings from this study make clear that social work education and training should highlight the importance of intersectionality when working to address the social issues that plague the clients and communities we serve. In addition to preparing social workers to work knowledgeably and competently with racial, sexual, and gender minority populations, there should be an emphasis on the consideration of how these and other identities may intersect to complicate or exacerbate the minority stress experiences that individuals and communities experience. It is important for social workers to receive training that encourages a critical approach to assessing how all of the identities of clients being served are important and likely impacting their experiences and circumstances.

Social work curriculums should intentionally incorporate the importance of community belongingness, especially for minority individuals. In addition to training related to work with individual clients, social workers should be trained to understand and engage with the communities we serve. As the findings of this study suggest, identifying ways to support the creation or sustenance of communities may be equally or more valuable in the service of clients experiencing any degree of minority stress. This can be achieved through the intentional inclusion and promotion of practicum sites that engage community-level social work for students enrolled in social work programs and the requiring of classes that focus on community-level social work (e.g., macro social work courses).

Limitations

This study offers insight into the mediating role of coping in the relationships between belongingness to identity-based communities and both mental health and well-being with the following limitations. The cross-sectional design of this study design does not meet the criteria

of temporal precedence required to establish causal relationships among the variables being tested. The convenience sample precluded a random sample and may have led to homogeneity in this sample. Similarly, the snowballing may have increased bias and sample homogeneity. A limitation of survey research is that the context of social life is often not captured (Babbie, 2016). While questionnaires can provide highly useful information, it is difficult to develop a sense of the total life situation in which participants are thinking and acting, something that some qualitative approaches can better achieve. People's perceptions of an issue seldomly take the form of a scale (e.g., strongly agreeing, agreeing, disagreeing, or strongly disagreeing) and responses in such cases must be regarded as approximate indicators of what the researcher(s) had in mind when framing the questions (Babbie, 2016).

Data collection occurred during the 2020 COVID-19 pandemic, which had a wide range of social consequences that could have affected participants' responses. While it is difficult to measure the full consequences of the pandemic, this likely impacted the mental health and well-being of participants. More than half of the sample reported an income over $45,000 and full-time employment, and 36% had a college degree. As previous research has highlighted the effect of class on within-group relations for LGBTQ individuals (Gattis & Larson, 2016; Gattis & Larson, 2017; Hanhardt, 2008; Lehavot et al., 2009), there may be differences in the relationships observed for Black LGBTQ individuals from a lower socioeconomic status. Generalizations of study results should therefore be made with caution.

Measurement and statistical error may limit the validity of study findings. Although all scales in this study demonstrated acceptable reliability, many were adapted from similar, though different, scales and some were subscales of a larger measurement instrument. For example, although minority stress was measured using a microaggressions scale reflecting the experiences

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unique to LGBT people of color, this was a proxy measurement that does not capture the entirely of minority stress. Similarly, conceptualizing and measuring identity-based community belongingness via measures of Black, LGBTQ, and Black community belongingness precludes the larger range of identities that Black LGBTQ individuals may hold and the corresponding communities they may belong to. Also, a number variables in this study had significant missingness before this was addressed statistically, limiting the data accuracy. The use of multiple imputation allowed for a complete dataset and the statistical power required to detect effects in the model, however many values in the sample data are estimations of what participants' actual responses might have been.

Future Research

The current study revealed important findings regarding the significance of belongingness to identity-based communities and adaptive coping in the mental health and well-being of Black LGBTQ individuals. However, multiple gaps remain in the literature that warrant further investigation of these relationships among this understudied population. First, future studies should account for other variables in the relationship between community belongingness, coping, minority stress, mental health, and well-being. For example, this study only included adaptive coping as a measure of coping mechanisms. Given what the previous research has found regarding the relevance of maladaptive coping for minority populations, future research should also include maladaptive coping as a way to further investigate the mediating effect of coping on community belongingness and mental health, and to better understand if there are differences in the types of coping mechanisms employed by Black LGBTQ individuals based levels of belongingness and mental health and well-being. Future studies can investigate whether there is an interaction between levels of community belongingness and the effectiveness of

adaptive and maladaptive coping. In other words, the capacity for these coping mechanisms to successfully reduce mental health symptoms may be dependent upon the level of community belongingness.

In keeping with an intersectional approach, it would be important to examine the impact of other minority identities that may intersect in the lives of Black LGBTQ individuals (e.g., age, ability status, socioeconomic status, sexuality and gender) on Black LGBTQ individual's ability to feel that they belong in identity-based communities. There may be important differences in the benefits of community belongingness related to the outcomes in this study. For example, the ability of a cisgender gay Black man to feel a sense of belongingness and be valued and accepted by a community may differ from that of a nonbinary Black person in a society still characterized by patriarchal, cis/heteronormative values and practices. Understanding these potential within-group differences will contribute to our understanding of intersectional identity experiences.

Similarly, generational differences may reflect differences in community belongingness as well, which needs further exploration. Research suggests, for example, that many LGBTQ young people are accessing community in online spaces in addition to offline, in-person community (Wagaman et al., 2020). Indeed, this study was conducted entirely online, including recruitment and data collection, which likely influenced the study sample. It would be essential to know the different types of community Black LGBTQ people are accessing to broaden our conceptualization of community and its connection to mental health and well-being. It may therefore be useful for future studies to examine the moderating effect of different intersecting identities on the relationships examined in this study.

When compared to other forms of identity-based community belongingness, LGBTQ belonging was the only form that was not significantly related to mental health or well-being.

These findings have important implications about the differential impact of racial, sexual, and gender identity-based community belongingness for Black LGBTQ individuals. Such findings point to the predominance of a racial identity over other minority identities for this population, given that Black and Black LGBTQ community belongingness were the only significant forms of belongingness in mental health and wellbeing, respectively. Future research should test these relationships further to determine if similar findings emerge in subsequent studies with this population.

Future research should also explore the meaning and experience of community for Black LGBTQ individuals. While the study measured perceptions of belongingness to identity-based communities, it is also important to explore the mechanisms of community belonging in order to better understand the processes that work to support feelings of belongingness and promote mental health and well-being. To aid practitioners working with members of this community, it would be useful to distinguish the components of belonging that can be specifically targeted when developing treatment programs and services that aim to improve mental health and well-being outcomes. It would also be important to ascertain how a Black LGBTQ community is accessed, as well as how communities are built and maintained.

It will be important examine how the salience of racial, sexual, and gender minority identities for Black LGBTQ individuals impact the relationship between belongingness to the corresponding identity-based communities and mental health and well-being. The salience of an identity may exacerbate experiences of stress because "the more an individual identifies with, is committed to, or has highly developed self-schemas in a particular life domain, the greater will be the emotional impact of stressors that occur in that domain" (Thoits, 1999, p. 352). Moreover, individuals with multiple minority identities may not perceive or appraise the salience of each

identity equally (Massey & Ouellette, 1996). Indeed, Bowleg (2013) found that Black gay and bisexual men perceived their racial identity as most central to their overall identity, and this led to minority stressors often being attributed to their racial group membership. Accounting for the salience of minority identities while assessing their impact on community belongingness may provide important insights into our understanding of its role in the coping, mental health, and well-being of Black LGBTQ individuals.

Finally, in an effort to emphasize strength-based approaches to studies examining the role of community belongingness in the mental health and well-being of Black LGBTQ individuals, it would be useful to include measures of resilience in addition to, or instead of, deficit-based approaches such as the minority stress model. For example, Perrin et al. (2020) recently developed a minority strengths model for LGBTQ individuals which demonstrated the potential for social support and community consciousness to promote resiliency and, thereby, mental health for these individuals. While the minority stress model focuses on the deleterious impact of the unique stressors that individuals from minority groups encounter, a model such as the minority strengths model can be useful in expanding research on the mental health and well-being of LGBTQ individuals to include a focus on the factors that support resilience. Future research should explore the role of community belongingness in the promotion of resiliency for Black LGBGTQ individuals, and the impact this may have on mental health and well-being outcomes.

Conclusion

This study established relationships between community belongingness, coping, minority stress, mental health, and well-being. Data was collected from a sample of Black LGBTQ individuals and utilized in a path analysis of a hypothesized model. The study hypotheses were

partially confirmed. The study revealed key findings, including: (1) community belongingness was associated better with mental health and well-being; (2) coping partially explained the relationships between community belongingness and well-being, but did not explain the relationship between community belongingness and mental health; (3) Black community belongingness was associated with better mental health; and (4) Black LGBTQ community belongingness was associated with better well-being. The findings from this study provide important insights into the role of identity-based communities in the mental health and well-being of Black LGBTQ individuals and contribute to our limited knowledge about the community belongingness experiences of this understudied population. While confirming much of what we know about the impact of minority stress and minority group affiliation on the mental health and well-being of racial, sexual, and gender minorities, this study highlights the importance of intersectional approaches in examining these relationships. Black LGBTQ individuals benefitted most from belonging to communities that centered their Black identity, even in spaces that were likely cis/heteronormative. These findings provide important implications for clinical services and programs, social work education, and future research.

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Hypothesized Path Model (with Mediation of Coping and Controls)

Age | NBinary | GenQr | Man | TransM | TransW | TSpirit | Woman | Asexual | Bisexual | DL | Gay | InLife | Lesb | Pansx | Queer | Samegen | Income | Educat | Employ | Student

-.16 (.06)* | -.05 (.06) | .02 (.05) | -.05 (.06) | -.03 (.05) | .00 (.04) | -.06 (.03) | -.03 (.07) | .04 (.05) | .07 (.05) | -.10 (.06) | .03 (.06) | -.09 (.04)* | -.01 (.06) | .03 (.05) | .01 (.06) | -.03 (.05) | .01 (.05) | -.09 (.05) | -.12 (.05)* | .06 (.05)

Mental Health

Community Belongingness

-.30 (.06)*** | .08 (.07)

.24 (.07)***

Coping

.28 (.05)*** | .21 (.07)**

Minority Stress

.21 (.07)**

-.36 (.06)***

-.16 (.06)**

Well-being

.03 (.07) | -.12 (.08) | .07 (.05) | -.04 (.07) | .20 (.06)** | .05 (.07) | .14 (.05)** | -.03 (.07) | -.00 (.05) | -.10 (.06) | .14 (.05)** | 0.06 (.06) | .05 (.04) | -.04 (.06) | -.03 (.06) | -.07 (.06) | .02 (.05) | (.01 (.05) | -.04 (.06) | .07 (.05) | -.07 (.05)

Age | Nbinary | GenQr | Man | TransM | TransW | Tspirit | Woman | Asexual | Bisexual | DL | Gay | InTheLife | Lesbian | Pansex | Queer | SameGen | Income | Edu | Employ | Student

Appendix A. The hypothesized path model representing the relationships between community belongingness and mental health and wellbeing, as well as the mediation of coping.

Note. *$p < .05$, **$p < .01$, ***$p < .001$. $N = 345$. Standardized coefficients are shown with standard errors in parenthesis.

Appendix B

G*power Analysis

F tests - Linear multiple regression: Fixed model, R² deviation from zero

Analysis: A priori: Compute required sample size
Input: Effect size f²   =   0.15
                    α err prob   =   0.05
                    Power (1-β err prob)   =   0.8
                    Number of predictors   =   24
Output: Noncentrality parameter λ   =   25.3500000
                    Critical F   =   1.5932284
                    Numerator df   =   24
                    Denominator df   =   144
                    Total sample size   =   169
                         Actual power   =   0.8003620

critical F = 1.5932
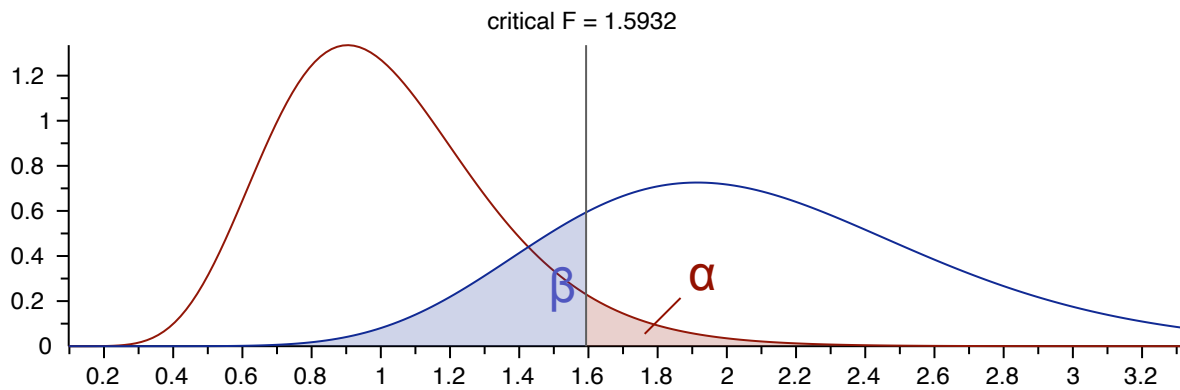
Appendix C

Correlation Matrix for All Study Variables

	.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.
1. Age	-	-.41**	-.03	.12	.07	.11*	.11*	.11*	-.27**	-.02	-.01	.04	-.03	.10	.05	.12*	.15**	.11*	.2*	.46**	.01	.15**	.24**	.23**	.17**	.25**	.17**	-.29**	.19**	-.08
2. Nonconforming/Non-binary	.41**	-	.01	-.37**	-.12*	-.09	-.05	-15**	.48**	.07	-.10	-.07	-.09	-.07	.04	.13*	.02	-.07	-.09	-.32**	-.08	-.14*	-.13*	.04	.04	-.02	-.05	.14*	-.23**	.12*
3. Gender queer	-.03	.01	-	-.13*	-.08	-.06	-.06	.04	-.09	-.03	.21**	-.12*	.17**	.08	.09	.27**	.05	.14*	-.02	-.04	.01	-.03	-.04	.03	.03	.02	.01	-.03	.08	.03
4. Man	.12*	-.31**	-.13*	-	-.17**	-.16**	-.15**	-.32**	-.20**	-.14*	-.03	.50**	.09	-.09	-.20**	-.08	.06	-.00	.06	.18**	.09	.16**	.05	-.03	-.00	.00	.05	-.01	-.04	-.7
5. Transgender man	.07	-.12*	-.08	-.17**	-	-.07	.04	-.15**	-.10	.11*	.07	-.17	.04	-.01	.07	-.07	-.06	-.04	-.09	-.08	-.06	-.20**	-.16**	-.09	-.06	-.12*	-.03	-.09	.17**	.06
6. Transgender woman	.11*	-.01	-.06	-.16**	-.07	-	.02	-.11*	-.07	-.11*	.04	-.07	.09	.01	.12*	-.05	.02	.18**	-.04	-.02	.03	.01	-.12*	-.03	-.03	-.06	.04	-.02	.08	-.05
7. Two-spirit	.11*	-.05	-.06	-.15**	.04	.02	-	-.07	-.07	.17**	-.04	-.12*	-.05	.01	.08	-.01	.02	-.03	.05	.09	-.2	.03	.06	.06	.07	.08	.01	-.1	.16**	.09
8. Woman	.11*	-.15**	.04	-.32**	-.15**	-.11*	.07	-	-.09	.10	-.05	-.17**	-.07	.38**	.11*	.29**	.19**	-.01	.03	.27**	.04	.12*	.26**	.03	.05	.12*	.03	-.10	.01	-.17**
9. Asexual	-.27**	.48**	-.09	-.20**	-.10	-.07	-.07	-.09	-	-.17**	-.01	.10	-.07	-.09	-.10	-.06	-.02	-.04	-.03	-.22**	.03	-.11	-.25**	-.11*	-.12*	-.19**	.00	.24**	-.19**	.26**

#	Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
10.	Bisexual	-.02	.07	-.03	-.14*	.11*	-.11*	.17**	.10	-.17**	-	.01	.41**	.11*	.18**	.09	.01	.08	.04	.09	.00	-.18**	-.1	.12*	.10	.08	.11*	-.09	-.06	-.05	.04
11.	Down low	-.00	-.10	.21**	-.03	.07	.04	-.04	-.05	-.01	-.01	-	-.13*	.04	-.01	-.02	.02	-.04	.10	.01	-.08	-.00	-.10	-.08	-.14**	-.12*	-.13*	-.10	-.09	.16**	.08
12.	Gay	.04	-.07	-.12*	.50**	-.17**	-.07	-.12*	-.17**	.10	-.41**	-.13*	-	.06	-.12*	-.26**	-.11*	.09	-.09	.06	.03	.09	.08	-.06	-.05	-.06	-.05	-.01	.06	-.10	.01
13.	In the Life	-.03	-.09	.17**	.09	.04	.09	-.05	-.07	-.07	-.11*	.04	.06	-	.01	-.04	.03	.02	.08	-.02	-.09	-.02	-.14*	-.10	-.04	-.03	-.06	-.04	-.10	.10	.07
14.	Lesbian	.10	-.07	.08	-.09	-.01	.01	.01	.38*	-.09	-.18**	-.01	-.12*	.01	-	-.01	.13*	.23**	.02	.10	.13*	.01	.02	.02	-.01	.03	.03	.04	-.06	.04	-.12*
15.	Pansexual	.05	.04	.10	-.19**	.07	.12*	.08	.11*	-.10	-.09	-.02	-.26**	-.04	-.01	-	.22**	-.04	-.05	-.03	.10	.02	.07	.06	.00	.04	.04	.07	-.05	.08	-.09
16.	Queer	.11*	.13*	.27**	-.08	-.07	-.05	-.01	.29**	-.06	-.01	.02	-.11*	.03	.13*	.22**	-	.11*	.01	-.04	.31**	.04	.14*	.14**	.11*	.06	.12*	.11*	-.09	-.01	-.03
17.	Same gender loving	.15**	.02	.05	.06	-.06	.02	.02	.19**	-.02	-.08	-.04	.09	.02	.23**	-.04	.11*	-	-.03	-.03	.12*	.07	.03	.17**	.16**	.18**	.21**	.09	-.18**	.10	-.05
18.	Straight/Heterosexual	.11*	-.07	.14*	-.00	-.04	.18**	-.03	-.01	-.04	-.04	.10	-.09	.08	.02	-.05	.01	-.03	-	.02	.05	-.02	.06	-.06	-.06	-.04	-.05	-.01	-.02	.05	-.04
19.	Income	.20**	-.09	-.02	.06	-.09	-.04	.05	.03	-.03	-.09	.01	.06	-.02	.10	-.03	-.04	-.03	.02	-	.26**	-.03	.14*	.02	.09	.04	.05	-.04	.01	-.01	.05

#	Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
20.	Education	.46**	-.32**	-.04	.18**	-.08	-.02	.09	.27**	-.22**	.00	-.08	.03	-.09	.13*	.10	.31**	.12*	.05	.26**	-	.16**	.28**	.22**	.010	.07	.16**	.22**	-.16**	.08	-.12*
21.	Employment	.01	-.08	.01	.09	-.06	.03	-.02	.04	.03	-.18**	-.00	.09	-.02	.01	.02	.04	.07	-.02	-.03	.16**	-	.04	-.14**	-.10	-.10	-.13*	.17**	.18**	.01	.03
22.	Area of residence	.15**	-.14*	-.03	.16**	-.2**	.01	.03	.12*	-.11	-.10	-.10	.08	-.14*	.02	.07	.14*	.03	.06	.14*	.28**	.04	-	.15**	.01	.07	.08	.08	-.03	-.05	-.04
23.	Black Community Belongingness	.22**	-.13*	.04	.05	-.16**	-.12*	.06	.26**	-.25**	.12*	-.08	-.06	-.10	.02	.06	.14**	.17**	-.06	.02	.22**	-.14**	-.15**	-	.56**	.66**	.85**	.17**	-.36**	.22**	-.19**
24.	LGBTQ Community Belongingness	.15**	.04	.03	-.03	-.09	-.03	.06	.03	-.11*	.10	-.14**	-.05	-.04	-.01	.00	.11*	.16**	-.06	.09	.10	-.10	.01	.56**	-	.68**	.85**	.18**	-.31**	.27**	-.10
25.	Black LGBTQ Community Belongingness	.15**	.04	.03	-.00	-.06	-.03	.07	.05	-.12*	.08	-.12*	-.06	-.03	.03	.04	.06	.18**	-.04	.04	.07	-.10	.07	.66**	.68**	-	.90**	.27**	-.31**	.31**	-.10
26.	Total Community Belongingness	.22**	-.02	.02	.00	-.12*	.06	.08	.12*	-.19**	.11*	-.13*	-.05	-.06	.03	.04	.12*	.21**	-.05	.05	.16**	-.13*	.08	.85**	.85**	.90**	-	.24**	-.38**	.32**	-.15**
27.	Coping	.24**	-.05	.01	.05	-.03	.04	.01	.03	.00	-.10	-.10	-.01	-.04	.04	.07	.11*	.09	-.01	-.04	.22**	.17**	.09	.17**	.18**	.27**	.24**	-	-.02	.25**	-.01
28.	Mental Health	-.28**	.14*	-.03	.01	-.9	-.02	-.10	-.10	.24**	-.06	-.09	.06	-.10	-.06	-.05	-.09	-.18**	-.02	.01	-.16**	.18**	-.03	-.36**	-.31**	-.31**	-.36**	-.02	-	-.45**	.28**
29.	Well-Being	.25**	.23**	.08	-.04	.19**	.08	.16**	.01	-.19**	-.05	.16**	-.10	.10	.04	.08	-.01	.10	.05	-.01	.08	.01	-.05	.22**	.29**	.31**	.32**	.25**	-.45**	-	-.20**

30.	Minority Stress	-.11	.12*	.03	-.07	.06	-.05	.09	-.17**	.26**	-.04	.08	.01	.07	-.11*	-.09	-.03	-.05	-.04	.05	-.12*	.03	-.04	-.19**	-.10	-.10	-.15**	-.01	.28**	-.20**	-