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Intersectional Invisibility of Black LGBTQIA+ Client Strategies for Bias and Discrimination Prevention

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This is to certify that the doctoral study by

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Abstract

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MSW, Eastern Michigan University, 2012

BSW, Marygrove College, 2003

Project Submitted in Partial Fulfillment

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Abstract

Those who identify as members of lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA+) communities have been victims of bias and prejudicial attitudes. Because LGBTQIA+ people embody all cultures, races, religious convictions, and socioeconomic statuses, this creates additional barriers for some community members who identify as both Black and LGBTQIA+. The purpose of this qualitative study was to explore social workers' perceptions of intersectional invisibility when working with Black LGBTQIA+ clients and the strategies that social workers identify as beneficial in averting discrimination and bias when working with this community. Implicit bias theory and intersectionality theory provided the framework for the study. Data were collected from semi-structured interviews with 11 master-level social workers. Themes emerged from the coding analysis: (a) lack of complete understanding of the term intersectional invisibility, (b) lack of perceptional understanding of intersectional invisibility and how it affects the Black LGBTQIA+ community, (c) witnessing any form of bias or discrimination toward Black or LGBTQIA people while in practice, (d) negative impact on this community because of discrimination, and (e) strategies to prevent bias and discrimination for this community. Findings may promote positive social change when social workers understand and acknowledge their ethical responsibility to protect and support vulnerable populations like the Black LGBTQIA+ community.

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Dedication

This research is dedicated to the members of the Black and LGBTQIA community who have had to endure discrimination and marginalization, all for living their authentic selves while trying to seek the mental health interventions that they need to be a better version of themselves. You are one of the motivations in this quest for my doctorate, to be a voice for the voiceless to bring about social justice for my community, to be a more prominent advocate in the field of social work, and to continue the fight for social change and inclusion for all.

Acknowledgments

First and foremost, I give honor to God for his grace and mercies in my life. Thank you to my wife, Shannon, for all her support and sacrifices to get me to whom God has called me to be, I am eternally grateful for your love. To my daughters, Arimah and Amayah, know that I did this for you to see what you can do if you believe you can. To my sister, Dr. Umeika, thank you for all your encouragement and kicks in the butt on this journey. To my mother, Marlene, thank you for making me believe that nothing beats a failure but a try and that no one can take what God has for me. To my dad, Wyatt, thanks for loving me. To my staff of intelligent and powerful women, I thank you for your support on this journey. Thanks to Dr. Powell, whose guidance and wisdom were a blessing on this journey. Finally, to the future Dr. Griffith: Always remember that you were the hopes and the dreams of a slave, and now you rise! Never forget this journey and the promises you made to help change the world; remember that a little brown girl is standing somewhere in the shadows who will need to see what you have become only because you believed. Find her and show her the path you cleared for her so she can dream big and believe because all things are possible for her!

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Section 1: Foundation of the Study and Literature Review

The lesbian, gay, bisexual, transgender, queer, or questioning, intersex, and asexual (LGBTQIA+) community endured many biases and prejudicial attitudes (Jackson, Mohr, Sarno, Kindahl, & Jones, 2020). This community has been analyzed and examined for many years through empirical observations (Bullard, 2020). In 2020, an estimated 11,334,000 LGB and 1,397,150 transgender individuals were living in the United States (Williams Institute, UCLA School of Law, 2020) of this number, there were about 1,210,000 adults who self-identified as both Black and LBGTQIA+ (Williams Institute, UCLA School of Law, 2020). LGBTQIA+ people embody all cultures, races, religious convictions, and socioeconomic factions, thus creating additional barriers for the community (Bristol, Kostelec, and MacDonald,2018). LGBTQ+ persons are resilient and flourish with their communities' support, yet studies have shown that LGBTQIA+ people seek mental health interventions higher than the straight community (Platt, Wolf, and Scheitle 2018). As the LGBTQIA+ population continues to grow in the United States, issues regarding not only sexual orientation but also race and mental health within this community need to be addressed (Kempf, 2020).

In Section 1, I introduce this qualitative study and discuss the obstacles that many Black LGBTQIA+ people face when seeking mental health services. I present the study problem, purpose, research questions, significance, and theoretical framework. Additionally, I provide a context for the study, the nature of the study, data types and sources of information, limitations, challenges, and barriers of the study.

Problem Statement

The social problem that prompted the need for this research concerned the effects of social workers' negative perceptions and how they can lead to deliberate or inadvertent negative judgment toward the Black LGBTQIA+ community (Holley, Tavassoli, & Stromwall, L.K.,2016). Bullard (2020) asserted that about 4% of the United States population identify as members of the LGBTQIA+ community. Nevertheless, no specific mental health services exist that meet the needs of race, orientation, and mental health. Social work clinicians need to understand the interconnecting societal identities of Black LGBTQIA+ people (Peek, Lopez, Williams, Xu, McNulty, Acree, and Schneider, 2016). These identities interact with the individual to amplify their subjugation threat, resulting in poor mental health outcomes when they seek treatment (Peek et al., 2016).

Research in social work practice related to implicit bias and intersectional invisibility for Black LGBTQIA+ is disintegrated (Holley et al., 2016). Researchers have not examined the causal dynamics of people with numerous denounced attributes (Jackson et al., 2020). Current clinical research has not addressed the poisonous effects that this could have on the marginalized Black LGBTQIA+ communities and their mental health.

This is linked to cultural, governmental, institutional, and interactive procedures of heterosexual privilege (Price-Feeney P, Green, and Dorison, 2020). Additionally, a a parallel connection could be made that asserts that because of these pilloried identities, Black LGBTQIA+ individuals are experiencing higher rates of depression, anxiety, and suicidal ideations when compared to their White LGBTQIA+ counterparts (Kulick, Wernick, Woodford, and Renn, 2017).

Purpose Statement and Research Questions

This qualitative study addressed social workers' perceptions of intersectional invisibility when working with Black LGBTQIA+ clients and the strategies that social workers identify as beneficial in averting discrimination and bias when working with this community. A social worker's negative opinions can aggravate the psychological disparities and generate impediments to accessing comprehensive mental health treatment, causing enduring exposure to prejudice and denouncing experiences (Holley et al.,2016). A social work clinician's negative perceptions and unaddressed bias can be detrimental to an individual's interpersonal and societal insinuations (Kempf, 2020). There needs to be logical and pragmatic support for mental health inequalities for the Lesbian, Gay, Bisexual, and Transgender People of Color (LGBT POC). This community faces more racial and ethnic stigmas than their White sexual minority counterparts (McConnell, Janulis, Phillips, Truong, and Birkett, 2018). The social worker's ethical responsibility is to identify and challenge their own biases related to sexual orientation and race (Bruster, Lane, and Smith, 2019). The following research questions (RQs) guided the study:

RQ1: What are social workers' perceptions of intersectional invisibility when working with Black LGBTQIA+ clients?

RQ2: What strategies do social workers identify as beneficial in averting discrimination and bias when working with this community?

Definitions of Key Terms and Concepts

Black or African Americans: Individuals with roots in any Black ethnic or cultural groups from Africa or identity as Black or African American (Census. gov, 2020).

Clinical social workers: Individuals who assist people in resolving and handling challenges in their lives. Social workers work in mental health hospitals, schools, human services and governmental organizations, clinics, community organizations, and private practices. All have master's degrees and must pass a national examination and complete a minimum of 2 years of postgraduate experience. Social workers are required to be licensed in the state where they practice if they provide clinical mental health services (Bureau of Labor Statistics, U. S. Department of Labor, 2021).

Intersectional invisibility: A hypothesis that retaining numerous subservient-group characteristics (i.e., Black or LGBTQIA+) renders an individual invisible or unseen compared to those with only a single subservient-group trait. Black LGBTQIA+ people have multiple secondary-cluster factors that do not fit their respective identity groups' archetypes; therefore, they experience intersectional invisibility (Coles and Pasek, 2020).

LGBTQIA+: An array of phrases, abbreviations, letters, and definitions when recounting the LGBTQ populations (GLLAD.org, 2021). The terms are exchangeable and have gradually shifted to incorporate and not incorporate other parts of the populace. Historically, some terms have been offensive and defamatory (GLLAD.org, 2021). Phrases such as gay, lesbian, bisexual (GLB) and lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) have been used throughout scholarly resources in the past

5 years (Bullard, 2020). I used the term LGBTQIA + to represent all facets of this community (see Merriam-Webster, 2021) to be inclusive of all aspects of self-identification (see GLLAD.org, 2021).

Unconscious bias: The discrimination in the propensity of a thing, a person, or a group compared with another unwarranted one. This can be in the direction of an individual, assemblage, organization, or society (Remedios and Snyder, 2018). Implicit bias, also known as unconscious bias, can lead to compromised clinical judgments and cause corrosion of confidence between professionals and clients due to inadequate interpersonal collaborations and prejudiced actions (Remedios and Snyder, 2018).

Nature of the Doctoral Project

I explored social workers' perceptions of the intersectional invisibility of Black LGBTQIA+ clients. Additionally, I explored strategies social workers identify as beneficial in averting discrimination and bias when working with Black LGBTQIA+ clients. Exploring the phenomenon of identified discrimination barriers based on ethnicity/race and orientation may aid in understanding whether there is a connection to deleterious mental health outcomes for this population (see Sutter and Perrin, 2016). I used a qualitative design through an action research approach to interview, collect, interpret, and analyze what strategies social workers identify as beneficial in averting discrimination and bias when working with this community.

Significance of the Study

This study may provide insight into social workers' perceptions of the intersectional invisibility of Black LGBTQIA+ clients and what strategies they identify

as being beneficial in averting discrimination and biases. Many researchers have documented the inequalities in mental health results in the United States for marginalized groups such as LGBTQIA+ and people of color. Previous research indicated that clinician prejudice plays a large part in contributing to those inequalities (Maina, Belton, Ginzberg, Singh, and Johnson, 2018). The significance of this study was related to the social work profession's need to examine and address systemic and structural concerns related to discriminatory practices for the Black LGBTQIA+ community when seeking mental health interventions (see Bruster, et al., 2019). This study may provide a new understanding of stimulating change in the subtleties of supremacy, privilege, and subjugation (see Moradi & Grzanka, 2017) in mental health treatment.

Theoretical Framework

I used implicit bias theory and intersectionality theory to frame the study. Implicit bias theory was created in 1995 by Greenwald and Banaji. This framework asserts that a person's social behaviors and biases are principally insentient. Greenwald and Banaji contended that a person's experiences influence their present judgment in a method not contemplated or predetermined by the person. (Greenwald and Banaji,1995).

Intersectionality theory was born out of critical race theory and the Black feminist thought movement (Jackson et al., 2020). Intersectionality theory hypothesizes the breakdown of tyranny and societal understandings. Crenshaw (1991) proposed that any forms of oppression, such as heterosexism, xenophobia, or patriarchy, were interlocking and inseparable systems and should be considered concurrently.

Intersectionality Theory

A theoretical framework is essential in conducting any research because it suggests the researchers' theoretical hypotheses, implementation, and distribution. (Lassiter, Jagadīśa-devaśrī, and Johnson, 2021). A black feminist theory such as intersectionality theory has been used more than any other alternative theory (Lassiter, et al., 2021). The intersectional theory provides a framework for understanding how people who live within the intersection of racism and homophobia can be harmed when their unique experiences are not recognized (Coles & Pasek, 2020). This is partly due to methodical persecution and bigotry based on race and sexual orientation (Garcia-Perez, 2020).

Intersectionality theory permits an examination of how structures of power and subjugation such as discrimination, sexism, and racism (Remedios and Snyder, 2018) connect to generate complicated and exclusive methods of systemic disenfranchisement (Garcia-Perez, 2020) for those who do not fit within the power structure (Coles & Pasek, 2020). Hallett (2015) asserted that intersectionality theory was developed as a theoretical hypothesis in the work of Crenshaw and noted that the original framework was concerned only with issues of race and gender bigotry against African American women. Further, it contends that this theory addressed only certain aspects of the Black woman's experiences and neglected the person's insight from other points of view of their identity including race and gender, disability and ability, sexual identity, and orientation.

Since that time, the broader claim of intersectionality theory has become clear in addressing multiple systems of inequalities. Experiences of multiple dimensions of disenfranchisement have created mindfulness of interconnecting disparities (Hallett, and

Harnois, 2015). Intersectionality theory offers a practical context for analyzing labels accompanying the combination of gender, sexual identity, orientation, and culture (Ghavami & Peplau, 2013). The theory of intersectionality ensures that the subsequent distinctiveness is frequently more multifaceted due to the interface of conflict over incongruent values and beliefs and unique lived experiences that either group does not fully understand until the interaction (Dominguez, 2017; Garry, 2020).

Limits of Intersectionality Theory

Initially, the feminist theory of intersectionality fixated on the power disparity of Black women; this is the first limitation of this theory because an individual is more than any single identity (Hallett, 2015). Another criticism of the theory of intersectionality is its apparent mismatch with logical positivism, which is the investigation of what differentiates defensible principles from opinion and underlines the presentation of quantifiable study (Harari & Lee, 2021). Additionally, Carbado, Crenshaw, Mays, & Tomlinson, (2013) discussed limitations related to the theoretical interpretation of intersectionality as a never-ending work in progress. Carbado et al. (2013) contended that this sets up the theory as a regulated object, which it is not, and asserted that the limitation to using this theory is interpreting precisely what intersectionality is.

Moreover, it is not clear what intersectionality refers to when researchers use this framework (Carbado, et al., 2013). Other constraints to the theory of intersectionality lie not in the veracity of its claims but in the reality of the perception of societal existence (Hochman, 2019), indicating destructive consequences when put into social practice. As

the theory emphasizes, many victims of what intersectionality deems the victimized class are not persuaded that they are systematically oppressed (Hochman, 2019).

Strengths of Intersectionality Theory

Although there may be limitations to the theory of intersectionality, the strengths of this theory outweigh its limits; Crenshaw (1991) explained the theory was created to point out discrimination related to Black women. Black women were being victimized more frequently than any other legal classification based on racial bias or chauvinism, xenophobia, and bigotry (Smith, 2017). When Crenshaw invented the term intersectionality, she realized that intersectionality was not a theoretical concept but a depiction of the approach when numerous persecutions are faced simultaneously by an individual or a group (Smith, 2017). According to the theory of intersectionality, the subsequent distinctiveness is more multifaceted due to the interface of conflict over incongruent values and beliefs and unique lived experiences that either group does not fully understand until the interaction (Dominguez, 2017).

Implicit Bias Theory

According to Greenwald and Banaji (1995), implicit bias theory asserts that biases are omnipresent and that everyone in the world possesses them to a certain degree, even individuals with confessed allegiance to objectivity. From a psychological viewpoint, implicit bias theory asserts that bias and prejudices ensue when an individual's behavior focuses on the person, influenced by the recipient's membership based on their gender, ethnicity, or orientation (Gawronski et al., 2020). Greenwald and Banaji explained that explicit and implicit terms are often applied in defining the processes that expose mental

paradigms of implicitly vs. immediately. Greenwald et al. (2019) concluded that these terms are not synonyms for conscious and unconscious biases. Payne et al. (2018) claimed that implicit bias has been documented throughout historical disparities in slavery in America. Payne et al. asserted that historically, implicit bias has shaped this country's fundamental structure, institutions, financial systems, traditions, and culture that followed for generations. Implicit bias theory is used to explain how a person's lifetime accumulation of stored associative knowledge might produce conscious figments that can guide behavior in often helpful and unintentionally biased ways (Greenwald et al., 2019).

In the current study, I used implicit bias theory to examine prejudicial treatment against LGBTQIA+ individuals and how bias is rooted in sexual minority humiliation that can be transformed into mental health disparities. I sought to understand how implicit bias can cause a disproportionate prevalence of adverse mental health outcomes for this community (see Wittlin, Dovidio, Burke, Przedworski, Herrin, Dyrbye, Onyeador, Phelan, van Ryn, 2019). Implicit bias theory was also used to examine unspoken racial intolerance and measures of racial discrimination and homophobia for the Black LGBTQIA+ community by focusing on prejudice-driven conduct to conceal the intricacy of inequitable practices (see Hutchinson, 2018).

Values and Ethics

This qualitative action research study aligned with the National Association of Social Workers (NASW, 2017) Code of Ethics and the NASW (2015) Standards and Indicators for Cultural Competence in Social Work Practice. The Code of Ethics

mandates that social workers deliver essential ethical services that consider the individual's self-respect and dignity (NASW, 2017). A social worker must be culturally competent in social work practice and have a heightened consciousness of how culturally diverse populations experience their uniqueness within a larger social context (NASW, 2015). According to Section 1.05 of the Cultural Competence and Social Diversity manual (NASW, 2015), social workers must understand diversity and subjugation concerning orientation, ethnicity, and gender distinctiveness for all people. Further, as it relates to cultural humility, social workers must understand and examine all forms of persecution, bias, and supremacy through the lens of intersectionality (NASW, 2015).

Review of the Professional and Academic Literature

Library searches were conducted through the Walden University Library system. Additional search engines were used from the last 5-year range to find pertinent articles through Google Scholar, APA PsyNet, SocINDEX with Full Text, Taylor and Francis Online, and SAGE Journals. Any searches conducted beyond the last 5 years provided historical relevance and contextual and conceptual reference points. The keywords searched were *Black sexual minorities and intracommunity stigma, implicit bias: discrimination & intersectional invisibility of LBGTQ people of color*. I used Google Scholar to search for *intersectionality to promote social justice*. I also searched for qualitative studies on *Black LGBTQIA+ person, social workers and unconscious bias*, *Intersectionality Theory*, *Implicit Bias theory*, and *Action Research*. The literature yielded roughly 500 articles, with approximately 75+ scholarly peer-reviewed journal articles

selected for this literature search. There was a shortage of literature related to the intersectional invisibility of Black LGBTQIA +, mental health, and social workers.

Being Black and LGBTQIA+

Black people who identify as part of the LGBTQIA+ community experience higher mental illness rates than the overall LGBTQIA+ population due to additional risk factors such as ethnic xenophobia (Holley et al., 2016). Black people who categorize themselves as members of the LGBTQIA+ community may become ostracized from their Black community. Even as the same community advocates for other groups, such as the Black lives movement (Howard, 2019), the Black church is the most mentioned example of established homophobia (Gibbs and Jones, 2013). The sermons from the podiums that disparage and scorn the Black LGBTQIA+ community are deeply rooted in the Black church philosophy. The negative impact of the Black church, whose members have been known to encourage violence against LGBTIA+ people, intensifies, disseminates, and promotes the continuation of negative, homophobic mindsets, and ostracism of this community (Gibbs and Jones, 2013). This form of cultural community banishment and stigmatism plays a crucial role in some of this community's mental health concerns (Howard, 2019). Causal factors, including high rates of victimization, hate crimes, and murders of Black LGBTQIA+ people (Price-Feeney et al., 2020), are some of the results of the homophobic hate speech from the Black church community.

Statistics showed that 59% of Black LGBTQIA+ people have seriously considered suicide, and about 26% have attempted suicide due to emotional challenges they face from others within the Black community (Price-Feeney et al., 2020). The social

work community has no interventions and strategies that address these unique challenges (Price-Feeney et al., 2020). Many Black LGBTQIA+ people are often subject to various forms of victimization within the Black community, leading to higher adverse mental health outcomes. Black LGBTQIA+ people can be persecuted for their multiple minority statuses and for disrupting traditional societal norms (Garcia-Perez, 2020). Black LBGTQIA+ people also face hardship and emotional and socioeconomic difficulty, twice as much as those who identify with one minority group (Howard, 2019).

Black LGBTQIA+ and the Mental Illness Stigma

Minimal research has been done on the possible discernible homophobic attitudes that many Blacks who self-identify as heterosexual appear to have toward other Black Americans who self-identify as members of the LGBTQIA+ community (Elias, Jaisle, and Morton-Padovano, 2017). Much of the research demonstrated that racial/ethnic minority LGB+ individuals are at an increased risk of depression, anxiety, and suicide (Garcia-Perez, 2020). Black LGBTQIA+ individuals are forced into the complex fabric of interconnecting assemblies of subjugation that cross multiple factions, including xenophobia, bigotry, and transphobia homophobia ((Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2016). In a survey of Black LGBTQ+ people, more than half reported experiencing mental health providers who refused them clinical treatment (Kates et al., 2016). Some experienced discriminatory language or statements related to their gender identity and sexual orientation (Kates et al., 2016). These prejudices and destructive labels may have undesirably influenced marginalized, underserved, and denounced populations' mental health (Remedios and Snyder, 2018).

Additionally, when mental health social workers are unsure of how to provide culturally specific therapeutic services to those with multiple marginalized identities, this contributes to racial/ethnic disparities when they seek mental health interventions (Maina et al., 2018). A person is not only Black; they also possess sexual characteristics, sexual preferences, and identities: Several may also be pilloried, which can alter the understanding of being Black and LGBTQIA+ in America (Remedios & Snyder, 2018). The increasing intricacy of providing mental health interventions to Black LGBTQIA+ people prompts mental health social workers to the complex identity dynamics that must be expressly and separately addressed (Dominguez, 2017).

LGBTQIA+ people who identify as Black, do not represent a consistent or identical alliance. There are distinctions between those who identify as Black lesbian or Black transgender, Black gay, or Black bisexual individuals (Dudley, 2013). Mental health clinicians need to understand that variations inside these groups affect their world and self-perception, including their self-classification, socio-anthropological design, and sexual identity and orientation (Dudley, 2013). Individuals who identify with more than one marginalized group are overlooked in mental health treatment because of the inclination to detach one part of a person's identity. In quantitative studies, researchers must dismiss other social identities, such as race (Remedios and Snyder, 2018). Black LGBTQIA+ identifying people face unique stressors and have been historically underserved in the mental health field (Alberts and Rohrsetzer, 2020). McConnell et al. (2018) examined the mental health outcomes for LGBT people of color who have experienced discrimination, the anticipation of rebuke, and preconception-related life

events such as hate crimes. These factors intermingle within the person to intensify their subjugation risk, resulting in poor mental health outcomes when seeking mental health treatment (Peek et al., 2016). The fear of discrimination in this community can cause some to suppress or attempt to disguise their orientation or identity to get the mental health treatment they need or avoid seeking care altogether (Kates et al., 2016). This community's negative opinions can cause personal, interpersonal, organizational, and societal insinuations when a clinician working with this population has not addressed their own bias (Kempf, 2020).

Maina et al. (2018) discussed their research on minority health disparities in the United States, asserting that Black LGBTQIA+ people continue to face disproportionate rates of aggression and ostracization from both communities. They face higher rates of joblessness, abject poverty, and vagrancy attributed to their sexual orientation and race (Maina et al., 2018). One of the social work profession's central premises is advocacy based on a moral and ethical obligation to ameliorate human suffering and promote parity in society (NASW, 2017). Social work clinicians are supposed to espouse the belief that all people are entitled to human rights irrespective of ethnicity, nationality, socioeconomics, sexual assimilation, sexual characteristics, capabilities, spiritual dogma, race, or beliefs (Bruster et al., 2019).

Microaggressions

Social work clinicians need to understand the emotional and mental ramifications of all forms of microaggressions, including conscious actions such as avoidance of the person (Patterson, Jabson, and Treea, 2018). These microinvalidations can invalidate

LGBTQIA+ people's experiences. An example could be not asking about sexual orientation or identity during initial clinical assessments (Nadal, Davidoff, Davis, Wong, Marshall, & McKenzie, 2015). These microinsults transmit stereotypes and portray LGBTQIA+ individuals as abnormal, such as improperly using pronouns (Patterson et al., 2018). When Black LGBTQIA+ individuals seek mental health interventions, the social work clinician's destructive assessments can intensify psychological health inequalities and further establish impediments to accessing all-inclusive emotional well-being treatment for this population (Holley et al., 2018). Many Black transgender individuals have experienced systematic oppression and devaluation due to social stigma attached to their gender nonconformity within the mental health system's institutional policies/practices, including gender insensitivity, denial of services, and verbal abuse (White and Fontenot, 2019). There is a need for social work clinicians to understand how marginalized identities and stigmatized status affect Black LBGTQ people's daily lives due to their racial and sexual orientation identity population (Holley et al., 2018).

Nadal et al. (2015) conducted a qualitative study to explore whether microaggressions are an intersectional reference point. Nadal et al. wanted to learn whether people from various identities could define microaggressions. The results included the identification of seven microaggression leitmotifs related to identity intersections, including stereotypes based on gender, condemnation of LGBT characters, men of color, and lawbreaking and typecasting of Muslim people. The study yielded several implications for clinical practice and research. Nadal et al. (2015) discussed the importance of clinicians having a basic understanding of how a client with multiple

intersectional identities feels when faced with demeaning and racist microaggressions daily and how microaggressions can affect their clients' lives, their view of the world, and healing subtleties of therapeutic interventions. These findings are significant because they suggest the need for social work clinicians to examine how microaggressions could negatively affect the therapeutic relationship. If the social work clinician is unaware of the implicit bias regarding the client's race, orientation, sexual identity, or gender, this can harm the client's progress (Nadal et al., 2015).

Intersectional Invisibility and Black LGBTQIA+ Individuals

Intersectionality theory reasons that people with several marginal statuses often experience mistreatment from numerous interlocking systems (Harnois, 2015). In their psychological research, Cerezo, Cummings, Holmes, and Williams, (2019) discussed the role of the intersectionality perception that had garnered extensive consideration in recent years. New research pointed to the significance of intensifying the research to tackle the intersectional lived experiences of marginalized diverse persons of color who identify as LGBTQIA+ (Cerezo et al., 2020). Research investigations have captured ethnicities, sexual orientation, identity, and gender characteristics that generate risk or protective factors for Black LGBTQ youths (Cerezo et al., 2020). Harnois (2015) discussed a trend known as multiple jeopardies. She contended that people who live through negative situations in which they experience continual mistreatment that stems from numerous interconnecting structures may develop an awareness of various systems of discrimination working with one another, known as multiple consciousnesses. Quantitative research on LGBTQ youths has neglected to address the encounters and

effects of Black LGBTQ youths specifically and instead have lumped all LGBTQ youths under one category instead of reviewing them as separate entities (Price-Feeney et al., 2020).

However, McConnell et al. (2018) examined how the intersectional theory could provide logical and pragmatic support for mental health inequalities in this community. This study also integrated intersectionality theory to explore how humiliation, tension, and community resilience are analogous and dissimilar for White sexual minority men. McConnell et al. (2018) also examined the mental health outcomes for LGBT POC who have experienced discrimination, the anticipation of rebuke, and preconception-related Life events such as hate crimes. They also examined unique stressors associated with xenophobia and heterosexism that could cause internalized homophobia. The results showed that LGBTIA POC reported the highest racial and ethnic stigmas, while White sexual minority men reported the lowest. These findings are substantial because they provided a crucial understanding of these unique forms of stigma that sexual minority men of color are more likely to experience McConnell et al. (2018). Additionally, these findings supported the need for continual research in social work practice to delineate how distinct characteristics such as sexual orientation and race can subjugate the lived experiences and psychosocial well-being of Black LGBTQ people (McConnell et al., 2018).

Black LGBTQIA+, Marginalized Identities, Implicit Bias, and Racial Stratification

Melamed, Munn, Barry, Montgomery, & Okuwobi (2019), discussed how racial stratification is vital in many social life spheres. Melamed et al. examined whether

implicit or explicit bias produces dissimilar racial consequences. They conducted two separate studies. Study 1 was an implicit status measurement to establish the measurement properties of racial status interrelated with negative societal beliefs. The results showed alterations in implicit status beliefs among Black, Hispanic, White, and Asian participants. Study 2 was conducted as a controlled experience to understand whether implicit status principles and discernments combined with social influences could change the respondent's biases. Melamed et al. (2019) findings suggested a new way to evaluate the apparatuses in the affiliation between race and incongruent consequences. These findings are significant because they provided a broader catalyst to understanding the implications of how race and implicit bias can equate to racial inequalities and subjugation in everything from income to education. Additionally, these findings are essential because the results addressed entrenched beliefs in a racialized societal scheme.

Jackson, et al. (2020) also sought to understand how marginalized identities and having a stigmatized status could affect the lives of Black LBGTQ people. The study addressed Black LGBTQ individuals' psychological well-being to understand these relationships' probable conciliation to cause conflict and contemplation. The sample consisted of 131 Black LGBTQ self-identified people living in the United States. The age range was 18 to 71 years. The study was adapted to use minority stress theory and mental conciliation. Some variables predict Black LBGTQ individuals' psychological distress with different intersectional experiences based on the diversity of their social situations or their comfort level as a sexual minority (Jackson et al., 2020). Their study found that

when connecting upon accruing exploration that links humiliation and well-being, numerous axes of coercion can shape daily life events and predict vacillations in the psychological and mental health of Black LBGTQ people.

Additionally, the findings of Lassiter, Jagadīśa-devaśrī, & Johnson (2021) delved into understanding marginalized identities and the intersections of those identities of same-sex couples who also identify as Black. They examined this group specifically, as this group is often left out of the research when exploring the routes between relationship health and individual health, including mental, financial, and physical health (Lassiter, Jagadīśa-devaśrī, & Johnson, 2021). Lassiter, Jagadīśa-devaśrī, & Johnson (2021) further asserted in their research that Black sexual minority people suffer more psychological health inequities than their White LGBTQIA counterparts. They contend these inequalities frequently happen due to extreme vulnerability to subjugation based on intersecting marginalized social identities. It is these tyrannical encounters that impact mental health treatment barriers and damage the patient-clinician interfaces that may destructively influence this group seeking mental health treatment (Lassiter, Jagadīśa-devaśrī, & Johnson.2021). These findings are significant as they provide essential background information for future research regarding the impact of intersectional invisibilities of Black LBGTQ people. Moreover, these findings suggested the need for more study on the vulnerabilities of people holding numerous marginalized identities to support inclusion and change how this population is viewed when seeking mental health interventions. (Jackson, Mohr, Sarno, Kindahl, & Jones,2020).

Social Workers Working in Sexual and Minority Communities

In the world and social work practice, it is routine to see terms such as Lesbian, Gay, Bisexual, and Transgender, collectively referred to as LGBT. The label can run the risk of blending identities leading to the neglect of important issues. Members of the LGBTQIA+ community, also Black Americans, symbolize a rare group of persons with intersectional identities (Dominguez,2017). McDowell, Goldhammer, Potter, & Keuroghlian (2020) contended that a clinician's unconscious bias against a stigmatized group negatively and adversely affects the client-clinician connections. According to Inch (2017), social workers need to comprehend the effects of unique facets of diversity, including sexual orientation, 'gender individuality, and race, when working with sexual and gender minority communities. (Inch, 2017). Destructive clinical decisions affect patient acuities about their mental health care.

McDowell et al. (2020) wanted to understand if the clinician's implicit bias could lessen the quality of mental health services provided to gender and sexual minority clients. They examined four case studies and offered strategies to mediate clinician implicit bases when working with this population. McDowell et al. (2020) also provided suggestions for clinicians to engage in exercises and mindfulness by contradicting labels and taking the person's perspective from a marginalized group to gain a different understanding. Clinicians must acknowledge their own bias, as this is essential for the growth in social work practice. These findings are significant as they provide a necessary look at interventions to reduce social workers' implicit bias when working with subjugated populations. Dominguez (2017) asserts an essential point regarding the

importance of the diversity of clinicians' identities. Sometimes when there is a cultural dichotomy between the therapist and patient, there is a possibility of confusion due to cultural vernacular or colloquialism. These miscommunications can worsen the mental health disparities between the dominant groups and Black LBGTQIA+ people (Dominguez, 2017).

Additionally, Reisner, White-Hughto, Gamarel, Keuroghlian, Mizock, & Pachankis (2016) discuss some of the discriminatory experiences that people who have a gender distinctiveness that is contradictory to their assigned sex at birth. They contend that transgender individuals experience discrimination, and emotional and physical violence at a rate might than CIS-gendered people. Many transgender people fit into multiple minority statuses, i.e., being a transgender person of color, leading to greater oppression and discrimination. Reisner et al. (2016) studied 452 transgender and gender-nonconforming people, 18 to 75 years, all Massachusetts residents.

The contributors were recruited online and in person. The participants completed the everyday discrimination scale, which entails eleven items evaluating the regularity of discrimination experienced in twelve months. In this sample of transgender adults, the study found connections between their everyday discrimination experiences and post-traumatic stress disorder symptomology. (Reisner et al.,2016) This study's conclusions are consistent with a cumulative body of indications authenticating the elevated risk for mental health problems among transgender individuals who experience discrimination. Reisner et al. (2016) cited that many study participants recounted childhood trauma experiences and intimate partner violence. However, the association between their

discrimination experiences and PTSD symptoms was the primary reason for gender identity discrimination experiences. This study's findings have implications for social work practice. There is a need to understand how multiple forms of discrimination experienced by traumatized transgender people already place them at a disadvantage in receiving needed mental health services from qualified practitioners. All the findings of these researchers are significant to my study. They provide a lens for understanding how detrimental implicit bias is in social work practice when social workers fail to deliver receptive cultural interventions to meet the unique needs of members of the LGBTQIA+ community. Further, this points to essential countertransference issues and implicit bias as detrimental to this already disenfranchised population (Reisner et al.,2016).

Summary

In the U.S., about 4 % population self-identify as LGBTQIA+; however, there is no identifiable mental health intervention that addresses the intersecting shared characteristics of the Black LGBTQIA+ community (Peek, Lopez, Williams, Xu, McNulty, Acree, & Schneider, 2016). While society has started to accept the LGBTQIA+ community in recent years, there is still prejudice and uncertainty for Black LGBTQIA + people seeking mental health treatment (Fallin-Bennett, 2015). This community is marginalized (Remedios and Snyder, 2018). It faces humiliation, psychosomatic and inequity (Remedios & Snyder, 2018), and a lack of understanding of their culturally and racially specific needs (Sabin, Riskind, and Nosek,2015). There are causational factors of being black and LGBTQIA+ that increase the need for a social worker to examine and understand the unique needs of this community. Including ethnic xenophobia (Holley,

Tavassoli & Stromwall, 2016), ostracization, and cultural community exclusion just for being a part of the LGBTQIA+ community (Howard, 2019). The community is at a greater risk of despair, apprehension, and self-destruction (Garcia-Perez, 2020). Their distinctive needs magnify their subjugation and relegation threat when seeking mental health services (Peek et al., 2016).

The NASW (2017) and the cultural Competence and Social Diversity manual (NASW, 2015) assert that social workers must aspire to be ethnically knowledgeable. As well as have an amplified perception of how culturally diverse people experience their distinctiveness within the larger society (NASW, 2015). Social work practitioners must understand issues related to diversity, marginalization, or subjugation concerning a person's sexual affinity, ethnicity, race, culture, and gender individualism (NASW, 2015). Then to push for the implementation of procedures and practices to enable better mental health treatment for members of the Black LGBTQIA+ community (Bullard, 2020).

Impact on Clinical Social Work Practice

This study will affect clinical social practice when social workers start to understand the intersectional experiences of living with community dishonor, microaggressions, and implicit bias when working with the Black LGBTQIA+ community (Jackson, Nadal, Davidoff, Davis, Wong, Marshall, & McKenzie, 2020) (Melamed et al., 2019). Using the theory of Intersectionality offers specifications for frameworks uses other than philosophies of control, subjugation, or uniqueness, that Intersectionality fragments both academically and ethically (Garry, 2020). The usage of

the theory of Intersectionality is even more essential in conducting research involving the Black LGBTIA+ population, given the marginalization of this group in spaces where European culture is prominent (Lassiter, Jagadīśa-devaśrī & Johnson,2021). In comparison, the theory of Intersectionality began as an examination of the experiences of Black women, distinct from men of color or white women. Their persecution was because of their racial and gender status. For the Black LGBTQIA community, it is about race and sexual orientation. This theory can impact clinical social work practice and change how social workers view and provide mental health treatment to this subjugated community and others with marginalized factions with numerous indicators of marginalized identities (Irazábal, & Huerta,2016). Intersectionality is crucial in awareness and provides best practice clinical mental health treatment for the Black LGBTIA+ community (Hallett, 2015).

Impact on Societal Change

Intersectionality is a way of understanding and examining intricacy in the world, individuals, and anthropological insights. It will help to positively affect social change by providing a broader agreement that society is shaped not by a single axis of race, sexual orientation, gender, or sexual identity. Instead, many pieces can collaborate and affect the needed change (Hochman, 2019) (Harari & Lee, 2021) by understanding the axes of Intersectionality that centers all lives as a societal construct. This needs to be nurtured and utilized to link and change fundamental prejudice and archaic policies that produce inequitable circumstances (Hallett, 2015) (Harari & Lee, 2021). By challenging structural power levels, society can address mental health inequity and promote social justice and

social change for the Black LGBTQIA+ community (Garry, 2020). Section 2 will describe the research design and data collection to answer the research questions proposed for this study, including all subheadings regarding the participant selection, recruitment, methodology of the study, and ethical techniques.

Section 2: Research Design and Data Collection

I explored how social workers define intersectional invisibility when working with Black LGBTQIA+ clients. I also explored what strategies social workers believe are beneficial in averting discrimination and bias in this community. The research questions were as follows:

RQ1: What are social workers' perceptions of intersectional invisibility when working with Black LGBTQIA+ clients?

RQ2: What strategies do social workers identify as beneficial in averting discrimination and bias.

Section 2 introduces the research design and methodology used to explore how social workers define intersectional invisibility and what strategies they identify as beneficial in averting discrimination and bias. I explain the data analysis, interview protocol, and ethical procedures to protect the participants and data. Section 2 also addresses other sources of data and their applicability to this study.

Research Design

One of the foundational principles of the social work profession is dignity, respect, and inclusion, with social workers trained to work within a culturally diverse environment. However, no identifiable mental health interventions address the interconnected shared attributes of those in the Black LGBTQIA+ community. This gap in practice is causing unresolved obstacles that can hinder a social worker's ability to provide adequate mental health services to the Black LGBTQIA+ community members. For this study, I explored what social workers know about intersectional invisibility and

its effects on this community. I wanted to understand any identified impediments they viewed as prohibiting them from delivering proficient, culturally competent mental health services. Additionally, I wanted to understand what strategies they use to reduce perceived bias or discrimination when working with the Black LGBTQIA+ community. A qualitative semi-structured individual interview protocol was the most suitable approach for this study due to an anticipated absence of understanding of the term intersectional invisibility related to the Black LGBTQIA+ community. I sought to provide real-world viewpoints from social workers currently working with mental health clients to gain a comprehensive understanding of their perceptions and opinions regarding the unique needs of this community (see Holley et al., 2016). This research design aligned with the problem statement, purpose statement, and methodology of the qualitative study.

Methodology

Data Collection

This study's participants have master's degrees in social workers (LMSWs) working in a clinical setting in Southeast Michigan. I used individual open-ended interview questions to guide the interview. I included follow-up inquiries, if needed, to acquire additional information from participants to ascertain what perceived barriers there may be to providing mental health intervention to members of the Black LGBTQIA+ community. I used a qualitative semi-structured interview framework to allow the interviews to include follow-up questions to clarify participants' responses if needed. Participation was voluntary.

I emailed the informed consent form and received acknowledgment of consent before scheduling interviews. All participants were interviewed using questions related to my research topic to understand the individual's views regarding barriers when providing mental services to the Black LGBTQIA community (see Jamshed, 2014). The individual interviews were recorded using the Microsoft Teams platform. That ensured that I could review all the information obtained from the participants for clarification purposes and accuracy. The individual interview time frame was between 30 and 60 minutes. This time frame was adjusted to allow any follow-up inquiries if answers were unclear or needed additional clarification. Additionally, I provided extra time if the participant wanted to expand on a previously given answer or retract any statements or responses. I started the discussion by explaining the nature and purpose of this qualitative study to the participants. Then I explained the study procedures and verified that the participants comprehended that this interview was voluntary. Then I reminded them that they could revoke their consent at any time. Finally, I reviewed the follow-up conditions with participants by reminding them that a copy of their interview transcript would be emailed to them to review. I requested that if they had any concerns regarding the transcript or needed to clarify anything please email me and that a follow-up call should not take more than an additional hour of their time to complete. No demographic information was requested.

Participants

I conducted semi-structured interviews with participants who met the study criteria: (a) LMSW, (b) previously worked or currently working in clinical mental health

settings, (c) currently practicing in one of these counties in Southeast Michigan: Lapeer County, Genesee County, Macomb County, Wayne County and Washtenaw County (Michigan.gov, 2021) for at least 5 years, (d) willing and able to participate in a qualitative semi-structured interview for 30 minutes to 1 hour, (e) willing to give the additional time of 30 minutes to 1 hour, if needed, to review their previous interview transcript for accurateness and for clarification purposed if needed, (f) willing to have their interview recorded, and (g) willing to give informed consent for participation.

Participant Sampling

Nonprobability purposive sampling was selected for this study to recruit participants who had experience working with the Black LGBTQIA+ community and were willing to contribute to the study. Purposive sampling enables researchers to obtain a controllable the volume of data (Ames, Glenton, and Lewin, 2019 .and to identify and select

individuals

who are knowledgeable and experienced with working with a specific population. (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015). Purposive sampling was used to allow for a standardized selection of professionals based on specific attributes such as clinical mental health professionals, LMSWs working in Southeast Michigan, and the most proficient individuals to aid in this study. The participants were from various counties in Southeast Michigan. A significant generalized area containing LMSWs from various counties was targeted to provide diversity to the participant pool. This purposive pool was sampled from multiple online social work groups geared to LMSWs in Michigan. I posted in the online LMSW group forum requesting participants for my study

and listed the requested criteria for participation. I asked any interested person to email me at the email address provided in the post. Once I received the email addresses, I sent an invitation email back to the interested LMSW and included a copy of the informed consent to review. I request that if they read the consent form and agreed, to reply to the email stating "agreed." Then the semi-structured interview was conducted with the participants based on their date and time preferences. They were informed that there was no compensation or benefits for participation in this study. I discussed confidentiality with each participant. Confidentiality was maintained by detaching or restricting any private, distinguishing data given by contributors from the records. Confidentiality needed to be upheld by the participants in my qualitative study (see Allen, 2017). It was essential that all participants felt free to openly discuss their experiences working with this population without disclosing any information outside of my study parameters.

Additionally, because I came from a similar educational and professional background as many participants, I ensured that all contributors enlisted in the study received only low-stress email communications. I worked diligently to ensure that all professional boundaries were maintained throughout the recruiting, interview, and collection of the data for this study. I functioned as the sole researcher on this project and not as a peer, friend, or colleague to safeguard not crossing any boundaries that needed to be unambiguously communicated to all contributors (see Sutton & Austin, 2015). I worked to ensure confidentiality and the protection of the identities of all participants. All participants were identified only by their participant numbers. All data obtained from

interviews were stored on a password-protected Excel spreadsheet on a password-protected laptop that only I had access to.

Instrumentation

Interviewing is the interactional process in the qualitative investigation procedure. Interviewing allows for the policies and guidelines to be recorded, achieved, questioned, and strengthened (Jamshed, 2014). Using an interview guide, the interviewer presents a set of questions that the interviewer would like to explore, eliciting detailed individual responses from each contributor (Jamshed, 2014). In the current study, the open-ended questions were designed to allow the participants to share their professional and personal experiences working with this population identifying any barriers they had observed and providing any strategies they deemed beneficial to avert bias or discrimination when providing mental health services to those in the Black LGBTQIA+ community. U.S. society in recent years has started to accept some factions of the LGBTQIA+ community, yet there is still apprehension for many in this community when seeking cognitive interventions from experienced mental health providers (Fallin-Bennett, 2015) who understand their intersectional lived experiences (Cerezo et al., 2020).

Social work research related to intersectional invisibility for Black LGBTQIA+ is either fractured or nonexistent (Holley et al., 2016). Moreover, researchers have not examined the origins and relational undercurrents of mental health factors within this community (Jackson et al., 2020). Intersectional invisibility needs to be discussed, along with co-occurring prejudice, the expectation of condemnation when seeking treatment, discriminatory language regarding identity or orientation (Kates et al., 2016),

microaggressions, macroaggressions, and being stigmatized by either the Black or LGBTQIA communities (McConnell et al., 2018). The interview questions for the current study were designed to elicit data to understand how social workers interpret the term intersectional invisibility and what barriers they perceived occur when providing mental health interventions for the LGBTQIA+ community, Black communities, and those in both groups.

Data Analysis

Creating order, configuration, and significance to a bulk of accumulated data is the essence of data analysis (Hilal and Alabri, 2013). The data analysis procedure focuses on reconstructing the data in an understandable manner that is clear, precise, and comprehensive, all while giving a true and accurate representation of the words and answers of the contributors (Noble and Smith, 2014). In the current study, the data were collected from individual interviews. All data were collected solely by the researcher. Using NVivo transcription software, I transcribed the audio files from the interviews recorded using Microsoft Teams. I then transferred those verbatim transcriptions into the NVivo software to be coded, evaluated, and synthesized. Then, all data were entered into a password-protected Excel spreadsheet for further evaluation. Finally, codes were used to establish themes and patterns within-participant interviews.

One method of analyzing qualitative data is the use of thematic analysis. Thematic analysis was applied in the study using interview transcriptions that needed to be analyzed (see Caulfield, 2019). Thematic analysis is used to examine participants' viewpoints, thoughts, expertise, or ideas from a determined set of qualitative data

(Komori, 2019). Using thematic analysis allowed me to examine the data to detect commonplace subjects, concepts, and examples that frequently appeared in the interviews. This allowed me to create a coherent knowledge base of terms and ideas from the participants regarding how they define intersectional invisibility and the alleged barriers they find when providing mental health interventions for the Black LGBTQIA+ community.

The first cycle of the data collected from participants' interviews was analyzed using NVivo, a qualitative data analysis software, to answer my research questions (see Hilal and Alabri, 2013). This computer software program is appropriate for qualitative exploration because it decreases the amount of labor-intensive manual tasks. The software provides the researcher with additional time to uncover trends, recognize subjects, and develop suppositions (Hilal and Alabri, 2013).

The second cycle of data analysis is the planning and administering step done by gathering and cleaning the collected information (Ahmed Al-Azawei, Serenelli, and Lundqvist, 2016) to assess the data's value created by patterns and connections between codes (Saldaña, 2017). The crucial part of this stage was ensuring that the information I collected was relevant to my study. Finally, once all themes were pinpointed and all applicable data were understood, I looked for themes that helped me answer my study's research questions by creating identified codes, and groupings, and developing subjects to retain and safeguard my data throughout the data analysis process (see Saldaña, 2016).

Establishing Trustworthiness

A qualitative study is believable if the explanations of experiences are identifiable by people who share a common understanding or experiences (Ames, et al., 2019). The truthfulness of the information or the explanations of the opinions of the investigator's contributors can help a study be deemed credible (Cope, 2014), including when the researcher expresses their experiences of being the researcher and authenticating the research's investigational findings with the contributors (Cope, 2014). To support the credibility of my qualitative study, I delivered an analysis of observed events and behaviors of individuals and factions in various situations (see Ames et al., 2019).

Transferability

A qualitative study has met the standard if the outcomes have significance to entities or individuals not engaged in the study. This is called transferability, and it occurs when entities can apply study findings to different situations or factions (Cope, 2014). Transferability encourages the readers of the study to create links between aspects of research and their personal experiences (Cope, 2014; Schloemer and Schröder-Bäck, 2018). The principle of transferability relies on the goal of the qualitative survey. Findings could apply to other subjects if the study's objective is to oversimplify the subject matter or experiences (Cope, 2014).

Dependability

Dependability is critical to research because it verifies the study's conclusions as reliable and able to be replicated (Nowell, Norris, White, and Moules, 2017) when referring to the reliability requirements of the data over comparable findings (Cope,

2014). The researchers should confirm that the research methods are plausible, observable, and detailed (Nowell et al., 2017). This can occur when another researcher concurs with the conclusions at every phase of the investigation process (Cope, 2014).

Confirmability

Confirmability implies the researcher's capability to confirm that the information and data provided from the study are participants' answers and are not from the researcher's point of view (Cope, 2014). Furthermore, confirmability focuses on the researcher's elucidations and conclusions derived from only the data (Johnson, Adkins, Chauvin,2020). For confirmability to be established, I must show how the suppositions and explanations have been authenticated and to what extent the conclusions made in the study can be substantiated by others (Nowell, et al. 2017). The researcher being visible to the contributors is also crucial for confirmability. Constant scrutiny of the targeted contributors was critical to meeting the confirmability benchmarks (Johnson, Adkins, Chauvin, 2020), (Cope,2014). Confirmability can only be established when integrity, transferability, and reliability are accomplished (Nowell, at al. 2017), (Johnson, et al. 2020). Researchers should include indicators such as the rationales for the theoretical, procedural, and systematic selections made during their study so that others can comprehend precisely how and why those yielded specific decisions. (Nowell, et al. 2017).

Ethical Procedures

This qualitative study aspires to investigate and comprehend how social workers define intersectional invisibility and understand what strategies social workers identify as

beneficial in averting discrimination and bias when providing mental health services to members of the Black LGBTQIA+ community. No data collection or contact with proposed participants will begin until IRB approval is granted.

IRB permission granted under # is 01-31-22-001877 on January 31, 2022. I collected the data from participants who are currently (a) Licensed Master Social workers (LMSW), (b) previously worked or currently working in clinical mental health settings, and (c) currently practicing in one of these counties in Southeast Michigan: Lapeer County, Genesee County, Macomb County, Wayne County, and Washtenaw County (Michigan.gov, 2021). I used individual semi-structured interview questions to guide the interview. This included consequent inquiries, if needed, to acquire additional information from contributors to ascertain what perceived barriers there might be to providing mental health intervention to members of the Black LGBTQIA+ community. I worked to ensure confidentially and protect the identities of all participants. All participants were known only by their assigned participant number to maintain confidentiality. All data obtained from interviews are stored on a password-protected excel spreadsheet, within a password-protected laptop, that only I have access to.

Summary

The specific problem that prompted the need for this research concerns the effects of social worker's negative perceptions that can lead to deliberate negative judgment towards the Black LGBTQIA+ community (Holley, et. al, 2016) and exacerbate mental health disparities creating barriers to accessing all-inclusive mental health treatment for this population (Holley et al., 2016). In an action research study, participants must

communicate their experiences and opinions. The exact number of participants cannot be specified before the study starts because the number of contributors needed is controlled by the degree to which the research question has been addressed and answered fully (Algeo, 2013). However, I would estimate that between 10 to 20 participants could be needed until saturation is reached. When the information comes to saturation and new trends stop emerging, I can presume that no more participant interviews are required (Algeo, 2013). Saturation is an essential concept as it delivers a signal of data's authenticity and includes measures to evaluate the quality of a qualitative research study (Hennink, and Kaiser, 2019). Once IRB permission is granted, all data will be gathered and coded using inductive examination to regulate chosen groupings and topics to answer this study's research questions. In section 3, I will present the results, including all themes and conclusions that develop.

Section 3: Presentation of the Findings

The objective of this qualitative study was to investigate social workers who hold LMSW credentials and provide mental health interventions to members of the Black LGBTQIA community in Southeast Michigan. I sought to answer the following research questions: What are social workers' perceptions of intersectional invisibility when working with Black LGBTQIA+ clients? and what strategies do social workers identify as beneficial in averting discrimination and bias against Black LGBTQIA+ clients? A qualitative examination was conducted using semi-structured individual interviews with 11 purposefully selected LMSWs. All interviewed social workers were either currently working or had previously worked providing mental health invention services in Southeast Michigan.

Nonprobability purposive sampling was selected for this study to recruit participants who had experience working with the Black LGBTQIA+ community and were willing to contribute to the needs of the study. Using purposive sampling enabled me to collect a manageable amount of data (see Ames, et al., 2019). The data analysis procedure focused on reconstructing the data points in a transparent, accurate, and complete manner, all while giving a precise description of the comments and responses of the participants (see Noble and Smith, 2014). I used NVivo transcription software to transcribe the audio files from the interviews recorded using Microsoft Teams. I then transferred those verbatim transcriptions into the NVivo software to be coded, evaluated, and synthesized. I entered all data into a password-protected Excel spreadsheet for further evaluation. Finally, I used these codes to establish main themes and define patterns

within-participant interviews. I then determined classifications and themes to encapsulate and integrate the meaning of these patterns to develop connections between codes (Saldaña, 2016). Section 3 presents the data compilation, evaluation procedure, and methods to answer the research questions. Section 3 incorporates a narrative of the results and themes from the information and provides a synopsis of the results.

Data Analysis Techniques

Upon approval by the Institutional Review Board of Walden University on January 31, 2022, I began the recruitment of LMSWs working in a clinical setting in Southeast Michigan. I recruited participants on Facebook via multiple professional social workgroups by identifying participants for my study based on established criteria. I received 22 emails from people wanting to participate. Only 11 participants met the inclusion criteria and decided to participate in the study after examining the informed consent form sent to them by email once they agreed to be study participants. These 11 contributors, who had previously worked or were currently providing clinical mental health interventions, were interviewed using a semi-structured qualitative interview design in February and March of 2022, following approval by the IRB on January 31, 2022.

The individual interviews were recorded using the Microsoft Teams platform to ensure that I would be able to review all the information obtained from the participants later for clarification purposes and accuracy if needed. The individual interview time frame was between 30 and 60 minutes per interview. I then asked for permission to record the session and had each participant verbally acknowledge their authorization. I

reviewed the informed consent information and asked each participant to admit that they had received the consent form verbally. I then discussed the purpose of the interview study and explained that the interview would only take 30 to 60 minutes to complete. An audio interview was conducted using the Microsoft Teams platform without video. Using this platform allowed me to record audio files and later transcribe them using transcription software.

Participants were asked open-ended questions to understand how long they had been practicing as an LMSW and in what capacities to gain insight into their clinical experiences working with both the Black and LBGTQIA+ community. It was essential to understand the level of firsthand knowledge from those working with these communities. During the interviews, I reviewed vital details that contributors made to safeguard correctness and clearness. After completing all the interview questions, I asked each participant if I had any additional thoughts or questions before I stopped the recording. I thanked each contributor for taking the time to assist me with this study and let them know that I would be sending a verbatim transcript from the interview to their email for their review. If they thought any of their statements needed additional clarification, I asked them to please reach out to me to review the questions and noted that this should not take longer than 30 minutes. At the end of the interview, participants were asked if they had any questions, comments, or concerns. If they had no questions or concerns, I thanked them and reminded them that they would be receiving a follow-up email with the verbatim transcription of the interview. Reviewing the document would take no longer than 30 minutes of their time to check for anything that should need to be clarified.

Lastly, I reminded them that there would be no reimbursement or direct benefit for participating in this study.

Using thematic analysis for the interview transcriptions (see Caulfield, 2019), I examined the participant's perspectives, opinions, proficiency, or principles from a determined set of qualitative data (see Komori, 2019). I used thematic analysis to analyze the information to distinguish familiar subjects, perceptions, and examples from the interviews. Also to be able to develop a comprehensive knowledge base of terms and thoughts from the contributors on intersectional invisibility. I also explored how participants identify the barriers they experienced when providing mental health interventions for the Black LGBTQIA+ community. After the interviews concluded, NVivo transcription software transcribed the audio files from the interviews recorded using Microsoft Teams. Then I transferred those verbatim transcriptions into the NVivo software. Using computer-assisted qualitative data analysis software, I uploaded the transcribed audio file directly within NVivo. This software does not analyze data but aids the analysis process, allowing the researcher to retain control of their research (Zamawe, 2015). When utilizing this software, I explored the themes that continued to appear when coding the data. Five themes emerged: (a) lack of complete understanding of the term intersectional invisibility, (b) lack of perceptional understanding of intersectional invisibility and how it affects the Black LGBTQIA+ community, and (c) witnessing any form of bias or discrimination toward Black or LGBTQIA people while in practice, (d) negative impact on this community because of discrimination, and (e) strategies to prevent bias and discrimination for this community.

All data were entered into a password-protected Excel spreadsheet for further evaluation to help me generate an order from the data collected (see Hilal & Alabri, 2013). Finally, to support and articulate the truthfulness and credibility of this qualitative study, I assessed the individual participants' reflected results and actions (see Ames et al., 2020). All records of this research, including documents, audio recordings, memos, academic journals, and drafts, will be kept for a minimum of 5 years in agreement with Walden University's IRB.

Limitations

Due to the lack of available research on how social workers define intersectional invisibility and what strategies social workers identify as beneficial in averting discrimination and bias when working with Black LGBTQIA clients, a qualitative examination using semi-structured interviews was suitable for this study. This study focused on LMSWs who had been in practice for 5 or more years and who were currently working or had previously worked providing clinical mental health interventions in Southeast Michigan. Although this study sample was small, I used it as a pedagogical exploration for clinical social workers who provide mental health interventions to members of the Black LGBTQIA community in Southeast Michigan. One limitation was the lack of expansive demographics due to the small sample for Southeast Michigan, which services a primarily urban area of the state with a more diverse population. The data collected could not be compared to LMSW providing clinical intervention services in the more rural areas of the state with a less diverse population. To preserve the privacy and secrecy of the contributors, I did not collect demographic data due to my use of a

specific geographical targeted location. However, future studies may expand the geographic locations for the inclusion of additional LMSWs in Michigan.

Findings

The problem that prompted the need for this research concerned the effects of social workers' negative perceptions that can lead to deliberate negative judgment toward the Black LGBTQIA+ community (Holley et al., 2016) and exacerbate mental health disparities. Research indicated that there is still prejudice and uncertainty against Black LGBTQIA+ people seeking mental health treatment (Fallin-Bennett, 2015), prompting the continual degradation, psychological inequity (Remedios and Snyder, 2018), and a lack of empathy for their ethnically and genealogically specific requirements (Sabin, Riskind, and Nosek, 2015). Social workers are trained to understand the needs of a multicultural world. However, institutional, and societal issues impede their ability to provide ethically appropriate mental health intervention services that overcome the barriers to delivering inclusive mental health treatment for this population (Holley et al., 2016).

The current study was conducted with 11 LMSW participants who met the inclusion criteria and decided to participate in the study. These 11 contributors, who had previously worked or were currently providing clinical mental health intervention, were interviewed using a structured semi-structured qualitative interview protocol in February and March of 2022, following approval by the IRB on January 31, 2022. According to the data analysis, many of the LMSWs interviewed did not completely understand the term intersectional invisibility. Some participants lacked a perceptional understanding of how

intersectional invisibility could negatively affect members of this community. Although 10 of the 11 participants admitted witnessing bias or discrimination toward Black or LGBTQIA people while in practice, most were perplexed about how they handled the negative situation when observing the practice at the hands of the professionals. There were, however, positive findings, especially related to strategies to prevent prejudice and discrimination, and bias in this community.

Themes

Data collection and evaluation started once the qualitative interviews revealed five emergent themes: (a) lack of complete understanding of the term intersectional invisibility, (b) lack of perceptional understanding of intersectional invisibility and how it affects the Black LGBTQIA+ community, (c) witnessing any form of bias or discrimination toward Black or LGBTQIA people while in practice, (d) negative impact on this community because of discrimination, and (e) strategies to prevent bias and discrimination for this community. The 11 participants were identified only by their participant numbers throughout the study to maintain their confidentiality. All participants were LMSWs who worked or provided clinical mental health intervention services. Participant quotes are provided in the following sections, with only minimal editorial adjustments for legibility.

Theme 1: Understanding of the Term Intersectional Invisibility

This theme was discussed by participants regarding their understanding of the term intersectional invisibility. Intersectional invisibility is a term that refers to having numerous subservient-group characteristics (i.e., Black or LGBTQIA+), which renders an

individual invisible or unseen compared to those with only a single subservient-group trait (Coles & Pasek, 2020). Three of the 11 participants reported that they did not know what the term meant, two provided a vague understanding, and one guessed the correct answer. The other five participants defined the term with a few missing elements-based years of experience providing clinical intervention services:

- “Um, you know, to be honest with you, I don’t understand it.” (Participant 1)
- “My summation of that would be the understanding that it’s a system of power and oppression where the intersectional group of individuals; male or female, black or white, are marginalized because of their gender. They are invisible people, and nobody seems to understand the complications of being just invisible.” (Participant 2)
- “My understanding is that a person has different dynamics, for example being a female, being black, and being gay. So, when treating that individual, you’re not looking at all the different facets of who that person is or just being female black. So, there are different dynamics to that process. When you are treating, or you are working with that individual, you are not you’re not looking at all the facets at the whole person.” (Participant 3)
- “OK, I’m looking at this from my understanding it would be people of The community who are otherwise invisible or discriminated against, where there are multiple things that come together to make them even more invisible or even more discriminated against.” (Participant 4)

- “My initial thought was that we’re talking about maybe members of an oppressed population, for instance, the LGBTQ or black community or any kind of minority the community feel like they are They’re feeling invisible basically because they’re because of their status as being a minority. So, they they’re marginalized and oppressed.” (Participant 5)
- “So, my understanding of it is that it refers to when various aspects of a person’s identity that are kind of overlooked by other groups like doctors or, you know, other providers, people in their lives, and they’re not looked at as a whole person. So, somebody could be, for example, a bisexual Hispanic woman. But you know, only one of those identities is being considered. Let’s say, for example, the fact that they’re a woman when they go in for a medical visit, the doctor might not ask questions, you know, related to their sexuality or how that impacts their life or their treatment or their outcomes and bypassing the whole person in favor of just focusing on one thing.” (Participant 6)
- “You know, what my understanding was is that, you know, let’s just use to demographics and maybe if I was working with somebody who was an African American in the community who was also LGBTQIA.” (Participant 7)
- “I don’t know. That’s the only thing that comes to mind when I think of this is like you’re intersecting with people and maybe trying to understand. I don’t

know how that pertains to social work in the sense of are you providing intersectional invisibility to your clinical interventions?" (Participant 8)

- "Sure, my understanding, I guess, belonging to or having multiple identities from different subordinate groups. Mm-Hmm, and maybe that it could kind of make you feel or make you invisible to people that don't belong to multiple support groups, I guess." (Participant 9)
- "I like the word understanding. It's not something that I have utilized often, but my understanding would be dealing with, I would say, individuals that fit in. And I want to say certain classes who say whatever. That's what I'm saying. OK, I'm sorry. Well, as a black woman, I would consider my intersectional because I'm a black female. I'm looking at it to be different categories to this to describe myself meaning a minority." (Participant 10)
- "I have never heard of that term before now." (Participant 11)

When examining the overall comments from the participant, there appeared to be an understanding of the two words that individually make up the definition of intersectional and invisibility. However, there appears to be a practical disconnect as to what this would mean in clinical practice working with members of the Black LGBTQIA+ community. Their understanding would need to capture racial, sexual, and gender identities as they co-occur and intersect to produce risk or protective factors for Black LGBTQIA people (Cerezo et al., 2020); this was missing from the participant's understanding of the term.

Theme 2: Lack of Perceptional Understanding of Intersectional Invisibility and How It Affects the Black LGBTQIA+ Community

The participants were asked about their perceptual understanding of intersectional invisibility. Moreover, how it affects their understanding affects the Black LGBTQIA+ community. All the participants but one was able to provide an answer to the question:

- "They are a double minority." (Participant 1)
- "Oppression in the hundredth degree, it would just be a combination of like a double whammy the bomb and the nuclear bomb. Because you're not only identifying yourself, if you have been comfortable identifying yourself as LGBTQIA, you've identified yourself, you come out if they still use that term. I don't want to be inappropriate. No, I need to come out. And you're a minority. Oh my gosh. I mean, yeah. Double whammy." (Participant 2)
- "I feel it's an obligation, as a social worker does not have a perception and just are people, the whole person no matter what or who they are." (Participant 3)
- "So that would be like, you can be invisible, but this is like the worst of kind of invisible." (Participant 4)
- "So that, you know, makes me kind of think back to any of my experiences working with any population in general, right? Just understanding why some people, especially, you know if I go back to the start of my career working with the kids, it could be vicious. There needs to be is understanding of this community." (Participant 5)

- “I like this question and I think it’s an important question, I don’t know if this is something you can include in your writing, but I am Caucasian, circling back to my earlier point, you know, growing up where I did and kind of having the experiences, as a gay person. In my first semester, I joined an LGBT student union. And at the time, I hadn’t. It never occurred to me that the coming out process and the way a person views and responds to their sexuality would be different based on race, you know because we all kind of know that coming out is hard. But you know, there is an added stressor. I think when a person has, you know, is a minority in other categories or has other, challenges whether it be, you know, racial or maybe they have a disability, you know, any of those things gender identity, different gender or be non-conformity. So, the more of those essentially boxes you chopped, the harder it is. So that was a good lesson that I have been grateful to learn because again, it kind of helps you recognize your privilege because I think also when you are part of a minority community, you sometimes forget that even though. You do have this one thing. You know, somebody else might have been more difficult because of their other, the other aspects of their identity.” (Participant 6)
- “Yeah. I don’t know what my perception is of what it would be like. Maybe I can get one point for part one, right?” (Participant 7)
- “If I have a perception, there would be a lot of things to think about. You know, you have your ethnic background, you have who you identify as, you

know, as a person? Sexual orientation when they recognize this is their life and who they are as a person? And like, how did that go for them in their own family? So, their family dynamics." (Participant 8)

- "Well, I guess my perception would be that specifically with the black community that there they are, they're fitting into at least two different groups, different subordinate ones because it could also be three, maybe four black LGBTQ and then also female two or three. So I mean, it could be, you know, more, you know, different groups. That's all right, right? And that that would kind of make them, I guess, have them have their different needs invisible to, OK? You know, the two groups, those two individuals that don't belong to all those different groups." (Participant 9)
- "Well, I guess my perception would be that specifically with the black community that they're fitting into at least two different groups, different subordinate ones because it could also be three, maybe four black LGBTQ and then also female two or three. So, I mean, it could be, you know, more, you know, different groups. That's, right? That would kind of make them, I guess, have different needs." (Participant 10)
- "Well, I mean if I'm seeing someone face to face, I will see their skin color. Right? But I would not know anything about their sexual orientation or mental health problems or anything unless it's verbally told to me what their issues are." Participant 11)

Most of the participants could verbalize their thoughts and feelings about the oppression of clients, being either black or a member of the LGBTIA community, however vague that definition was presented. It stressed the need for mental health clinicians to comprehend the disparities of this group and how they can affect their self-awareness, including their self-classification and self-worth (Dudley,2013).

Theme 3: Witnessing Any Form of Bias or Discrimination Toward Black or LGBTQIA People While in Practice

As practicing clinicians, all eleven participants were asked if they ever witnessed any forms of bias or discrimination toward Black or LGBTQIA people while in practice**.** Only one participant denied ever witnessing any forms of prejudice or discrimination toward Black or LGBTQIA person:

- "I'm going to say no." (Participant 1)
- "I would say yes but not a significant amount. One thing I know from working in the field, many black and where people were just pushed through the system like a factory line or production line and only provided cookie-cutter services because of their race or socioeconomic levels. Get them and get them out and move on to the next one. Because in my opinion, the institution, or the system, just lumped them all together as being, OK, this is a black person with mental illness. Here's your medication. There you go. See you next time or next week, that type of thing, again, cookie-cutter, a production line. There was no individuality." (Participant 2)

- “There would be. I’ll give you an instance where you would have an individual come in with substance abuse and being either poor or black, and there were many. There were instances where the interventions were not delivered properly, the patients would have come in with pain or they would be going through psychosis. However, the provider would deem the individual as just seeking pain medication or seeking housing.” (Participant 3)
- “OK, at a psych hospital, there is quite a lot of bias and discrimination. I don’t know if it was necessarily related to ethnicity, race, or culture. I think it was much more related to their financial or socioeconomics. I think there were several comments a lot, oh, this person’s just here for three “hots and a cot” or it’s the end of the month, so his Social Security must have run out.” (Participant 4)
- “So, yes, I did. I would say I did. I have witnessed bias and I feel somewhat, it could have been some discrimination, especially for the elderly, certain services that I was that I would try to put in place for them if they weren’t a certain age, for instance, they could not get those services. Also, in my previous setting, when I was working with the delinquent boys, I did notice that there seemed to be a bias among my program directors. These boys should be managed, I guess. OK. Meaning that they just had their minds set on a certain that they had to meet these certain goals. It wasn’t always possible for some of them, being that their home situation didn’t necessarily work for that. So, they have this opinion on how they felt that things should

be. And if the boys didn't live up to that, they wouldn't advance into the program. This was it was a progressive program." (Participant 5)

- "Do you mean like towards clients? Yes. Typically, doctors, either superior, psychiatrists, or other medical providers, generally tend to assume that anyone who's taking pain meds or certain treatments like substance use disorder must be like, quote "a drug addict". There was a lot of bias and negative opinions held for people that would come in with those sorts of issues. Oftentimes, particularly when it came to like pain management, it was very dismissive. They wouldn't even want to deal with those people. OK, so there was a lack of compassion and understanding there, and certainly some bias, for sure." (Participant # 6)
- "I would say yes. Working within multidisciplinary teams within the hospitals, I think that that was very common. I don't think it was intentional, but I think it was common to have a lot of bias. You know that there would always be. This is what I think you want. Why can't you get it? Why can't you get yourself therefrom whether it's from the nurse, from the students, social workers, from the doctors, you know, just kind of a lot of bias in how services are provided." (Participant 7)
- "OK, that's a good question. Yeah, I would say, like bias discrimination based on socioeconomic status, I don't know if that would be that does count. You know, I think sometimes there's that, that if you come from a lower economic

status, you don't care as much. I have seen that, but then I also have seen. You know, from affluent aspects to, you know." (Participant 8)

- "I would witness things like especially with minority populations, I would witness things like, you know, my patients would tell me things like they weren't being heard. Nobody was listening to what they were saying, and things like they were being told what to do instead of asking what they wanted to do, what their treatment was, OK, like the kind of didn't have a choice in the matter, almost." (Participant 9)
- "I think I have experienced biases, I would say, initially biases by being an African American woman, providing the services. I've encountered, you know, several times individuals thinking or doubting the fact that my credentials are that I was a therapist. I had individuals think I was in certain facilities for treatment myself and not as the clinician. I've seen what I consider as biases with some of my co-workers and working with individuals that are lower socioeconomic class as well as race. For some African American clients, as well, as far as giving them just a blanket diagnosis or considering that therapy may not be beneficial for them. And I think a lot of times the biases that I've experienced are always an undertone, not necessarily very overt or something that you wouldn't necessarily notice if you weren't in that class. I've had to take some patience sometimes, and some of my co-workers were unable to me work with or they felt they were unable to work

with me. The client was just considered lazy and not interested. I see a lot of times some of the same diagnosis within the community." (Participant 10)

- "Oh lord yes. I mean, you know, I got a 26-year career. I can tell you one that stood out. I did a brief stint at a local hospital, with an adolescent psych unit. We would get kids from all different faiths, different backgrounds or socioeconomic backgrounds and races and things like that. So, a lot of most of the kids also on the unit were from families with a lot of money. This was back in the 90s, I part-time time there and I did individual and group work there. Kids with a whole lot of traumas from within the tri-county area. One group leader would say a lot of inappropriate stuff about the other kids who were from other areas that we're not so affluent. She made a lot of assumptions, and some of the kids would be afraid to speak up because she was focusing on what she thought was most of the group and her background, rather than the minority part of the group's background." (Participant # 11)

All but one of the eleven participants recounted witnessing discrimination or bias against either black or LGBTQIA clients. There was also another theme the participants discussed; lower socioeconomic backgrounds that were in addition to being either black or LGBTQIA. Social worker clinicians must promote the principles of our code of ethics; that all individuals are allowed fundamental human civil rights, notwithstanding culture, nationality, socioeconomics, sexual identity, sexual orientation, race, or religious philosophies (Bruster, Lane, & Smith, 2019). The profession of social work must remember that the overall objectives of our profession mandate a moral and ethical duty

to eradicate any human anguish and endorse equivalence in our society (National Association of Social Workers (NASW, 2017).

Theme 4: Negative Impact on This Community Because of Discrimination

All eleven participants agreed that there is a negative impact on this community due to discrimination:

- "Yeah, absolutely. Yeah. It absolutely could. You're not being heard. I guess being looked over too." (Participant 1)
- "I think I touched on that a little bit, Tonya, about as far as language would be what we want on choosing your words very carefully. Words have power, putting the stereotypes out there right off the bat can cause pain. Try to come from a perspective of understanding or removing my unconscious bias or being stereotypical." (Participant 2)
- "Absolutely, look at the whole person, so if you are working with them and if you're not seeing them, then are some there are barriers that they're facing that you're not addressing." (Participant 3)
- "I would think that you already have whatever discrimination exists because of your ethnicity or the color of your skin or what side of town you're from and then grow. On top of that, also being part of the LGBTQ plus community seems like it would be even harder to find a place where you fit in or where you feel heard or seen or confined to a provider who is like you or understands you." (Participant 4)

- “I do believe that it can have a negative effect because, I think it provides a barrier to them being able to get the support that they need barriers if they’re not honest or they’re not willing to accept, you know, help because they think they think they’re being judged, then that’s absolutely a barrier.” (Participant 5)
- “So, I think so. And working with the clients I have and even, you know, people I know in my personal life there are aspects of being both black and LGBTQ plus that makes it more challenging for them. A lot of it, from what I’ve been told, like their family of origin, stuff like spiritual or religious beliefs. And then specifically for men, because I tend to work with a lot of men, more so about this gender non-conformity. The way that that is viewed among black men has come up a lot in my work so those are all things that I think providers need to consider and be aware of.” (Participant 6)
- “When we think about what social workers do and how we look at a whole person, if we if somebody, you know only focus in on one part of it, we look at, you know, you’re black and we’ve got that, but we don’t look at the rest or they don’t feel comfortable to share that. That leaves a spot for shame or vulnerability.” And so, you can’t make all the progress that you need to because maybe they’re not there because of the color of their skin and the other things that are going on within them. All of that, you know, all the rest. And so, I think that there is that opportunity to hurt the community because it

does create what is out there, right, that continues that cycle, right? They don't know. Change is the right word." (Participant 7)

- "I believe so because, you know, I don't think everybody. Wants to look at things past the surface sometimes, and so and we can. Really must even myself, I mean, you know, we must be cognizant of that and just not get caught up. And the response that we get or how that we must think about that, we can't just keep it as a base level because there's more to it than that. Right. So, I could see how people could get treated negatively or have negative consequences." (Participant 8)
- "I just definitely think it would be a negative. I mean, if you feel like you're invisible, nobody wants to be invisible. You know, it kind of takes away your voice. Everybody deserves to be heard and feel represented. So, it just seems like it would just you'd be extra marginalized. You know, that's not great." (Participant 9)
- "I think it can have a negative effect in the community by not dealing with a person as a whole and expecting them to just fit in one subgroup." (Participant 10)
- "Well, yeah, and I mean, if you're a therapist and they're coming in and you're seeing them for the first time and you don't ask enough questions or the person is not very revealing, sometimes it affects their treatment plan. You know, it'll affect how you interact with them, maybe depending on the type of

therapist you are or what you need, what they're coming in for. Right. I mean, a lot of factors. Right." (Participant 11)

All eleven participants agreed that there is a negative impact on this community because of discrimination. Social workers need to examine how microaggressions and macroaggressions (Jackson, et al., 2020) are causational subtleties of this community. That can lead to the intersectional invisibility of persons who hold numerous denounced identities (Jackson et al., 2020). These can lead to destructive adverse emotional impacts on the clients of this community. (Nadal et al., 2015).

Theme 5: Strategies to Prevent Bias and Discrimination

All eleven participants were able to provide strategies to prevent bias and discrimination in this community:

- "To prevent bias, learn their culture, try understanding their experiences and making them feel like they're a part of something and not alone. Be that advocate." (Participant 1)
- "In a professional realm and just be very cognizant that we are professionals. We should treat our clients, our members, our patients, whatever, you know, whatever the terminology is or your affiliation is with the company or what have you all to assess, but to understand that assessment that you've taken with that person. A client could be Asian-American, Mexican American, or Haitian American. It starts as we've been taught in our training, it should be in the assessment. But also, I'll find out other avenues through that assessment so you can identify or that person can relate to you to some degree and be

more open with you and you be more open with them. I'm not saying that you must love them, you know, and there are those are, you know, those boundaries, of course, professionally that we must keep in mind. But I think it starts with assessing the person as a person." (Participant 2)

- "I think. Well, understood. It comes down to things that you need to do for yourself, such as identify any type of. Ethical dilemmas you have or what your barriers are, your morals, your values, being in touch with those so they will not be transferred until how you're engaging with that. I do believe that there needs to be more education." (Participant 3)
- "Hmm. Well, the thing that immediately jumps out to me is, any therapist, any person who says, I know what you're, I know what it's like. Don't make any kind of assumptions, any kind of assumptions pretending that I'm like an insider on any of this. OK, but I think even if I were in that, that community, even pretending that I have any idea what their experience is like would not be helpful. That is not helpful. Right, right. If you take this deadline instead of letting it, I make sure I understand instead of letting the person let the client be the expert. Don't make any assumptions that you know, a person's experience." (Participant 4)
- "Well, I just think we need to think about their strengths, and you know. I think we need to build on their abilities and find ways to help them. When you're thinking about social work, or our profession in general, our job is to put ourselves out of a job, right? Right. So, we're trying to help people. We're

trying to help people. The goal overall goal of social work is to try to empower people to be able to solve their problems. So, I guess when we're working with a particular community the goal is we need to focus on their strengths and their abilities and use that as empowerment started to build on strategies to empower them so that they can bring about change in their life that they would like." (Participant 5)

- "I think, just talking about it. It's not enough. I think people, especially clinicians and people working with the public or in any kind of helping profession need direct exposure. You know, it's not I don't think it's enough to just sit through slides on how not to be racist. You know, I think people need diverse workplaces and diverse populations that they interact with on the job to challenge having implicit biases they may have. Because if we're not getting that exposure, it's, you know, that's it's just not enough people are just going to click through. I also think having good internships is vital. You know, as we are studying and, you know, students are getting set up with those and especially at that time, because even when people are in school, they're in learning. Ideally, they're in a learning mindset. They're open to learning." (Participant 6)
- "Understanding the whole person is not just listening to the person and just going off what we perceive and being so focused on our questions. Forgetting to listen to the real answer that they're giving us. We have educated ourselves and we educate the people that work underneath us and educate the

institutions that we are part of, and we get our voice to be stronger. I like that." (Participant # 7)

- "Because it doesn't feel normal and is comfortable to you, that's how you were raised to think, for example, I've heard this before with even in my own family, I have people who are transgender. They want to change their name to fit who they are because that's who they identify as, Family members say, they're always going to be Jennifer to me and not Jeremy. I said, OK, to my family, but you know, what does that hurt that person? Right. So, I mean, just start having like those conversations because they are important. I think it's so freeing that somebody can explore their identity because when I was growing up, I didn't hear that. I knew it existed. But now that I'm older and I am working in the field, gosh, it is nice that kids communicate with their family members and society, so that they can be their authentic selves." (Participant 8)
- "So, I think you just I think it's best if we just try to advocate for, you know, anybody that we feel like is being discriminated or are facing some type of bias because, you know, it just happens so frequently. Going back to the past a little, I witnessed biases among some nurses on the unit. Sometimes when it comes to adoption by same-sex couples, you could hear them say how where they can get this baby, as opposed to you know, a heterosexual couple like, Okay I just had to advocate for them. Advocacy is the strategy to change things." (Participant 9)

- "I think that if we as social workers stop looking at things as cookie cutters to understand that people are more into subgroups that I belonged to." (Participant # 10)
- "If you're going to be the clinician, I think you must do a lot of self-identification in terms of where you are right and what your beliefs are and what you've been educated with, depending on how you grew up. You know, because we carry that with us every day, with every day of our lives. Right? We do. So, I think you need to take a mirror and look at what's going on with you. before meeting with your client. Just to make sure that you're talking in the right frame of mind and have the passion to know about this client and how best to work with them. Clients will tell you if you ask them, how would you like to be addressed or how would you like dialogue to go on? Well, I mean, right, right? You must go where the client can be comfortable, but I think you must look at yourself a lot before you do that." (Participant 11)

All eleven participants agreed that there are some strategies to prevent discrimination and bias in this community: by understanding the whole person and focusing on the strengths and abilities of this community. Also, remember to empower the client, start to build on strategies to empower them to bring about the change in their life that they would like, and stop making any kind of assumption that the clinician knows about this community and the issues they face. In summation of all these statements is the word; advocacy for this community that continues to face marginalization.

Unexpected Findings

Marginalization of the Black and LGBTQIA communities has been researched and empirically recognized for many years (Bullard, 2020). Yet, one unexpected finding was that many of the participants discussed their feelings when they witnessed the subjugation and discrimination of Black or LGBTQIA patients at the hand of psychiatrists or hospital charge nurses. Many voiced feeling helplessness to stop the discrimination due to the perceived hierarchy of the institutional system that places doctors in the role of leaders. Research shows that prejudices and negative stereotypes amongst health professionals, including doctors and nurses, towards the Black or LGBTQIA communities are commonplace and can be explicit or implied towards a patient seeking treatment (Rowe, Ng, O'Keefe, & Crawford, 2017). These communities already deal with substantial discrimination and ostracism that can contribute to their adverse mental health outcomes (Rowe et al., 2017). These biases directly correlate with poorer mental health services and adverse health outcomes (Morris, Cooper, Ramesh, Tabatabai, Arcury, Shinn, Im, Juarez & Matthews-Juarez, 2019). It is startling that many participants shared similar negative experiences as social worker clinicians and how they felt that they could not voice their concerns to anyone in the hospital or facility who would listen.

Summary

This qualitative examination aimed to investigate social workers who hold the LMSW credentials and provide mental health interventions to members of the Black LGBTQIA community in Southeast Michigan. To understand the following research

questions: How do social workers define the term intersectional invisibility? What strategies do social workers identify as beneficial in averting discrimination and bias against Black LGBTQIA clients? A qualitative examination was conducted using semi-structured individual interviews with guide questions from eleven purposefully selected Licensed Master Social Workers LMSW). All eleven social workers interviewed have at least five years of clinical experience and either currently work or have previously worked providing mental health invention services in Southeast Michigan. The themes that emerged were (a) lack of complete understanding of the term intersectional invisibility. (b) lack of perceptional understanding of intersectional invisibility and how it affects the Black LGBTQIA+ community (c) witnessing any forms of bias or discrimination toward Black or LGBTQIA person while in practice (d) negative impact on this community because of discrimination (e) strategies to prevent bias and discrimination in this community. Section 4 will present pertinent information regarding recommendations for social work practice based on findings and the professional ethics in social work practice—the usefulness, transferability, limitations, suggestions for additional exploration studies, and dissemination.

Section 4: Application to Professional Practice and Implications for Social Change

Application to Professional Ethics in Social Work Practice

The objective of this qualitative study was to investigate social workers who hold the LMSW credentials and provide mental health interventions to members of the Black LGBTQIA+ community in Southeast Michigan. I sought to gauge their understanding of the term intersectional invisibility and to identify the strategies they consider beneficial in averting discrimination and bias against Black LGBTQIA+ clients. A qualitative study was conducted using semi structured individual interviews with 11 purposefully selected LMSWs. All 11 social workers interviewed had at least 5 years of clinical experience and were either currently working or had previously worked providing mental health intervention services in Southeast Michigan. Five themes emerged from the study (a) lack of complete understanding of the term intersectional invisibility, (b) lack of perceptional understanding of intersectional invisibility and how it affects the Black LGBTQIA+ community, and (c) witnessing any forms of bias or discrimination toward Black or LGBTQIA people while in practice, (d) negative impact on this community because of discrimination, and (e) strategies to prevent bias and discrimination in this community.

This study validated the NASW (2017) Code of Ethics objectives to safeguard impartiality and promote societal fairness through activism provided to this marginalized community. This study also supported the principles of advocacy and social change by accomplishing the desire for all social work clinicians to perform analytically based studies to circulate knowledge to promote growth and change within social work. These findings may provide aid in recognizing the experiences and support in understanding

how social workers can further address these issues going forward and build on them to stimulate constructive societal transformation.

This qualitative action research study aligned with the NASW (2015) Standards and Indicators for Cultural Competence in Social Work Practice and the NASW (2017) Code of Ethics. The Code of Ethics mandates that social workers deliver essential ethical services that consider the individual's self-respect and dignity (NASW, 2017). A social worker must be culturally competent in social work practice and have a heightened awareness of how culturally diverse populations experience their distinctiveness within a larger social context (NASW, 2015). According to Section 1.05 of the Cultural Competence and Social Diversity manual (NASW, 2015), social workers must understand diversity and subjugation concerning orientation, ethnicity, and gender distinctiveness for all people. Further, as it relates to cultural humility, social workers must understand and examine all forms of persecution, bias, and supremacy through the lens of intersectionality (NASW, 2017).

Exploring these questions with mental health social worker clinicians helped display the misalignment when members of the Black LGBTQIA+ seek cognitive intervention services. Social workers must understand that this community has lived intersectional experiences of microaggressions and implicit bias (Jackson et al., 2020; Melamed et al., 2019). It is the responsibility of the social work profession to provide equal access to mental health services without oppression.

Recommendations for Social Work Practice

The significance of this study is directed at the profession of social work and the need to examine and address systemic and structural concerns related to discriminatory practices for the Black LGBTQIA+ community when seeking mental health interventions (see Bruster et al., 2019). Social workers need to understand the perception of intersectional invisibility and identify beneficial strategies for averting discrimination. Social workers need to be able to identify strategies that can help prevent prejudice and bigotry, pointing to the need for the profession to understand the subtleties of supremacy, privilege, and subjugation (see Moradi & Grzanka, 2017), when working to provide mental health treatment. To meet the ethical principle of competency, social workers should make sure they are informed and culturally competent regarding the specific needs of the clients they are servicing (Melamed et al., 2019). In the current study, all participants pointed to the need for social workers to become more vocal advocates. Understanding that the vocation of social work encourages societal transformation with activism for social integrity and societal shift is a necessary and fundamental professional action for any clinician or social worker (NASW, 2017). Current findings indicated that social workers should be vocal in putting this principle into action no matter the cost to them professionally.

Eight out of the 11 participants correctly reported the meaning of the term intersectional invisibility. Only three admitted they did not have a contextual understanding of the term. This underscores the need for continuing education for social workers related to working with LGBTQIA+ and Black communities. Some participants

reported that they had not recently worked with the community. One contributor admitted that she had not worked with the LGBTQIA community since her internship many years ago. Social workers are an essential part of most interdisciplinary teams in hospitals, schools, private foster care agencies, the military, and prisons, and must ensure that they have the most up-to-date education and training to understand current terms and trends to be ready to advocate for those from marginalized communities (Bullard, 2020; NASW, 2017). The current study promotes the professional value of cultural competence. According to Section 1.05 of the Cultural Competence and Social Diversity manual (NASW, 2015), social workers must recognize diversity and suppression relating to sexual preference or sexual identity, culture, and gender individuality for all. Further, social workers must understand and examine all forms of discrimination, prejudice, and hegemony (NASW, 2015).

The usefulness of the Findings

This study's results may assist social workers working with the Black LGBTQIA+ community in navigating and understanding the intersectional invisibility this community faces when seeking mental health interventions. Because social work clinicians regularly provide one-to-one therapeutic intervention to disadvantaged individuals more than any other associated health specialist, social work clinicians must be able to meet the needs of this specific population (Bullard, 2020). Using intersectionality as a base point of understanding emphasizes the significance of having multiple intersecting identities such as class, race, sexual identity, and orientation. Findings may inspire social work clinicians to focus on the numerous connections

between the client's interconnecting characteristics and the institutional and societal edifices that generate the experience of subjugation. Findings may also empower social work clinicians to become more powerful allies and advocates (see Rosenthal, 2016).

Transferability of the Findings

A qualitative study has met the standard of transferability if the outcomes have significance to entities or individuals not engaged in the study who can apply the study findings to different situations or factions (Cope, 2014). The current study was designed for social workers providing mental health intervention for members of the Black LGBTQIA+ community in Southeast Michigan. Nevertheless, these findings can be shared with the social work profession to focus on other significant disparities in practice related to marginalized groups experiencing similar bias and discrimination. These findings may further facilitate social work research in the field. This qualitative study included 11 participants who work in Southeast Michigan as LMSWs. These findings could improve and increase knowledge about the barriers of other marginalized communities globally.

Limitations of the Findings

This study's limitations were due to the geographic location, Southeast Michigan. Additionally, the study included a small purposive sample of 11 LMSWs; hence, these findings may not be generalized to all social workers providing mental health interventions to members of the Black LGBTQIA+ community. External validity for this study was restricted; nevertheless, based on the comprehensive explanation of the methodology procedures, extensive contributor inclusion standards, instrumentation, and

information examination, future social work investigators could imitate the design of this study. However, the outcomes with other populations may yield separate and distinct conclusions. All participants in the current study LMSWs working in Southeast Michigan. Given that the social work licensure requirements are different in every state, these results may not be generalized to all social workers with different credentialing standards or job obligations. Future researchers may want to include years of clinical experience or expand participants' geographic and demographic range to explore this phenomenon.

Recommendations for Further Research

Future studies could focus on the needs of Black LGBTQIA+ people with more specialized resources exclusively tailored to them. Future studies could examine the race and orientation of the participants and look at additional causational factors that can contribute to bias and discrimination based on the clinician's ethnicity, sexual identity, or gender. These findings may inform the expansion of diversity-related curricula in colleges and the workplace environment to address the intersectionality of a person and not just be limited to basic cultural diversity training. Future research and training should look to include this type of research in the diversity-related curricula to reach social workers at the bachelor's level and continue to be required every 3 years when social workers renew their social work license (see Howard, 2019). Additionally, future research needs to consider the changing societal terrain and its effect on Black LGBTIA+ individuals seeking mental health interventions by examining the institutional and systemic hierarchy that continues to cause this community's continual subjugation.

Dissemination of the Research

This research project's findings will be disseminated on multiple platforms, including digital and in-person presentations. This will be done to expand the knowledge base of social workers regarding the intersectionality of the Black LGBTQIA+ community. Following degree conferment, I will submit the final paper and findings and make them available to the Walden students and the social work community as part of Walden University's social change mission. As part of disseminating this research project's findings, there is also a plan to include the research findings in training with continuing education credits and make that training available for the social work profession. Finally, the plan is to publish the study in a peer-reviewed social work academic journal that advances the knowledge base of the social work profession and expands the understanding of intersectionality and the Black and LGBTQIA+ communities. This may improve understanding of the obstacles that can lead to continual subjugation of this community and other marginalized and oppressed communities that the social work profession serves.

Implications for Social Change

This study's results may contribute to the betterment of society through a greater understanding of the unique perceived barriers that members of the Black LGBTQIA+ community face when seeking mental health interventions. Examining these barriers through the lens of intersectionality may provide a way of interpreting and analyzing the intricacy of the world and human beings and offer an anthropological perception of how society views this community. This study's results may also positively affect societal

transformation by offering a more precise understanding of intersectionality. Looking through the lens of intersectionality allows many people to collaborate and effect the needed change (Harari & Lee, 2021; Hochman, 2019). The axes of intersectionality center all life as a societal construct that must be nurtured and utilized—connecting and shifting structural bias and antiquated strategies to generate equitable circumstances (Harari & Lee, 2021; Hallett, 2015). By challenging hierarchies, society can continue to address mental health inequity and stimulate social fairness and transformation for the Black LGBTQIA+ community (Garry, 2020).

Summary

In the United States, 4% of the population self-identify as LGBTQIA+; however, there is no identifiable mental health intervention that addresses the intersecting shared characteristics of the Black LGBTQIA+ community (Peek et al., 2016). There is still prejudice and uncertainty for Black LGBTQIA+ people when seeking mental health treatment (Fallin-Bennett, 2015). There is an increased need for social workers to examine and understand the unique needs of this community. A conversation is needed regarding the causal factors contributing to ostracization and discrimination (Holley et al., 2016; Howard, 2019). As part of the code of ethics, social workers are mandated to be ethnically knowledgeable and have an amplified perception of how culturally diverse people experience their distinctiveness within the larger society (NASW, 2015). The current study pointed to the need for social work clinicians to comprehend topics connected to diversity, relegation, or suppression regarding an individual's sexual affinity, culture, racial class, cultural philosophy, and gender (see NASW, 2015).

Findings may promote the enactment of institutional and societal changes to enable better mental health treatment for members of the Black LGBTQIA+ community (see Bullard, 2020). A core aspect of intersectionality is its focus on interlocking systems of oppression and social justice and equity goals. Large and growing bodies of work demonstrated the wide-ranging adverse consequences of structural and interpersonal oppression, inequality, and stigma for the mental health and well-being of this community. More work needs to be done on the clinical and macro levels if the change is to come in time to meet the mental health needs of the Black LGBTQIA+ community.

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Appendix A: Interview Questions

IQ1: How long have you been a licensed master level social worker (LMSW)in the state of Michigan?

IQ2: Do you now or have you ever provided individual or group mental health therapy? If so, where, and for how long?

IQ3: Have you ever witnessed bias or discrimination in mental health intervention treatment? If so, please explain?

IQ4: Have you ever provided clinical interventions for members of the Black community? If so, please describe those interactions?

IQ5: Have you ever provided clinical interventions for members of the LGBTQIA+ community? If so, please describe those interactions?

IQ6: What is your understanding of the term intersectional invisibility?

IQ7: What is your perception of intersectional invisibility when working with the Black LGBTQIA+ community?

IQ8: Do you believe that intersectional invisibility negatively affects this community? If so, please explain.

IQ9: Do you believe that intersectional invisibility positively affects this community? If so, please explain.

IQ10: Based on your experiences, what strategies do you believe are not beneficial to prevent bias and discrimination when working with the community?

IQ11: Do you think some strategies are beneficial to prevent bias and discrimination when working with the community?