JAAME
Journal of African American Males in Education
Spring 2014- Vol. 5 Issue 1

Factors Associated with Label Preference and Mental Health Quality of Life among College-Aged African American Sexual Minority Men

David L. Mount
Wake Forest University School of Medicine

Alethea Amponsah
Wake Forest University School of Medicine

Louis F. Graham
University of Massachusetts Amherst

Michael C. Lambert
University of North Carolina at Chapel Hill

In the post-secondary education environment, student organizations, faculty, and administers are seeking to identify strategies and programs that can reduce and/or eliminate disparities in prolonged mental health quality of life among sexual minorities. This observational study provides a preliminary needs assessment analysis of college-aged African American sexual minority males to inform community engagement best practice strategies and contribute to developing more appealing intervention packaging targeting this population of males who are at risk for diminished mental health quality of life. Specifically, this study documented attitudes about sexual orientation-identity label-preference and characterized the relationship between sexual orientation-identity label-preference and mental health quality of life. Participants completed a mental health quality of life measure and supplied sociodemographic data that included information about their sexual risk behaviours, relationship status and dynamics, and attitudes toward sexual orientation-identity label-preference. The study sample included 55 males who self-identified as a sexual minority and AA (94.5%). Participants were between 18 years and 29 years old (M = 21, SD=2.7) and classified as undergraduate students (84%). The study findings indicated that participants endorsed varying sexual orientation-identity preferences; however, 71% rejected all sexual identity labels. Factors more strongly associated with sexual orientation identity label-rejection included a higher likelihood to have sex outside of a relationship, history of depression, and a greater likelihood to disclose their sexual orientation-identity to a female. Comparatively, mental health quality of life symptom endorsement and intensity scores were higher than the normative sample scores. Overall, the findings may serve to better characterize the relationship between sexual orientation-identity label-preference and mental health quality of life, and improve our understanding surrounding sexual minority mental health and related health disparities with particular attention to developing acceptable mental health interventions targeting AA men with diverse sexual orientations.

Keywords: African American, bisexual, Black, college-aged, gay, male health

Correspondence regarding this article should be directed to David Mount at dmount@wakehealth.edu.

African American (AA) sexual minority men such as gay, bisexual, and other men who have sex with men (MSM) embody multiple challenges to sustainable mental health quality of life ranging from ambivalence about sexual orientation disclosure and labeling preferences to an array of cascading adverse mental health needs for which they are unlikely to report and/or seek help (Balsam, Beauchaine, Mickey, & Rothblum, 2005; Cochran, Mays, & Sullivan, 2003; D'Augelli & Hershberger, 1993; Gilman et al., 2001; Igartua, Gill, & Montoro, 2003; King et al., 2008; Marshal et al., 2011; McAndrew & Warne, 2004; Meyer, 2003; Russell & Joyner, 2001). Both heterosexual and openly gay college men (N=219) participating in the National Black Male College Achievement Study (Harper & Kuykendall, 2012) reported that there were enormous social risks associated with being gay and having a label accepting identity preference by being 'out', particularly in their campus environment. The majority of the self-identified gay, bisexual and MSMs suspected that other Black students would ostracize them, vote against them in campus elections, or discredit their leadership. Related to these and other factors, participants reported that many MSM claimed to be strictly heterosexual. Other researchers have reported similar findings related to AA sexual minority males experiences of racial and sexual prejudice at Predominantly White Institutions (PWIs) or Historically Black Colleges/Universities (HBCUs) (Goode-Cross & Good, 2009; Harris, 2003).

Concealment of sexual orientation is recognized as a predisposition to actively hiding personal information about sexual orientation identity that one perceives as distressing or negative, and is distinct from sexual orientation self-disclosure (Larson, 1990). Disclosing a sexual minority identity to others, or coming out is a complex process (Mills et al., 2004; Troiden, 1979) that is shown to have positive physical and mental health benefits (Cole, Kemeny, Taylor, & Visscher, 1996; Williamson, 2000). However, a large segment of sexual minorities do not experience the freedom of disclosing their sexual orientation without self and social censorship. With reference to Paul Lawrence Dunbar's poem "We Wear the Mask", Brown (2005) likened sexual orientation concealment among AA sexual minorities as a useless attempt to hide behind a façade free from orientation labels as a means for survival. Harper and Gasman (2008) found that homosexuality was cited as sexual misconduct in a HBCU's student handbook and that when asked to predict the response on campus if they were to announce they were gay or bisexual, most stated that they would be ostracized, persecuted and subjected to 'nonstop gossip' by everyone including both students and faculty.

AA men who have sex with, desire to have sex with, or eroticize men, and who embrace or accept homonormative labels may confront a unique set of socio-cultural challenges related to their position at the intersection of multiple marginalized identities (Goode-Cross & Good, 2009; Harris, 2003). In recent years, research has turned attention to the use of a multiple dimensions of identity approach when exploring how AA sexual minority males describe themselves and their characteristics (Patton, 2011). When reporting on the manner of self-identification, she found all of their descriptions rarely encompassed a sexual orientation-identity label, instead participants consistently referred to themselves using two descriptors, 'Black' and 'male.' They felt that their sexual identity was not what they perceived as a 'salient defining identity'. In spite of observations from research addressing the experiences of AA college-aged men (Harper & Kuykendall, 2012; Owens, Lacey, Rawls, & Holbert-Quince, 2011; Palmer & Gasman, 2008), few have focused specifically on developing mental health quality of life interventions that are responsive to a diverse range of AA sexual minority men attending PWIs and HBCUs. It is argued that the campus climate is central to psychosocial development, particularly given the homophobic and heterosexist attitudes that covertly and overtly influence campus environments

(Tomlinson & Fassinger, 2003). Thus, exploring the experiences of AA sexually marginalized men within the contexts of campus environments may lend critical insight into their psychosocial health and overall mental health quality of life (Bener & Ghuloum, 2011; Fisher & Goldney, 2003; Georges, Bolton, & Bennett, 2004; Graham, Braithwaite, Spikes, Stephens, & Edu, 2009; Jorm et al., 1997; Lauber, Carlos, & Wulf, 2005; Stansbury & Schumacher, 2008). Because most societal institutions such as colleges and universities exist as microcosms of American culture, they reflect the possibilities and prejudices that ethnic minority and sexually marginalized men navigate. Hence, the post-secondary educational environment is an ideal setting for studying issues of identity and mental health in institutional contexts that shape the racial, sexual, and gendered terrains men move through (Graham, Aronson, Nichols, Stephens, & Rhodes, 2011).

In preparation for planning a culturally-based depression risk reduction intervention targeting sexually diverse AA men, it seemed warranted to determine the variability in sexual orientation-identity labels acceptance. Specifically, this current cross-sectional exploratory study sought to characterize mental health quality of life, psychological distress endorsement patterns, explore and understand AA sexually marginalized males' perceptions about sexual orientation-identity label preference, and document the relationship between label preference and other factors that might inform the development of a depression risk reduction curriculum. Drawing on the review of literature, we devised the following research questions: what is the relationship between sexual orientation-identity label preference and variability in mental health quality of life symptom endorsement among college-aged AA gay, bisexual and MSM; and what are the factors associated with self-reported mental health quality of life?

Method

This cross-sectional research was approved by the Institutional Review Board (IRB). Following IRB approval, males between the ages of 18 to 29 years old were recruited to participate in this study. Conducted in an academic setting, participant recruitment strategies included flyers, word of mouth, and recruitment at community events. Eligibility for participation included being male, Black, African American, or multi-racial including black, self-identified as having sex with, desired to have sex with, or erotized sex with men, 18 years of age or older. Verbal screening was conducted with those expressing interest in participating in this research. In addition to completing a socio-demographic questionnaire, all participants engaged in a semi-structured interview including a mental health quality of life assessment by a licensed clinical psychologist.

The semi-structured, 30-45 minute, interview included questions designed to explore past and present experiences with depression, anxiety, and adjustment related problems, patterns of psychosocial quality of life as a AA gay, bisexual, MSM or other same-gender loving man, disclosure of same-sex behavior in general and in intimate relationships, self-identification, sexual health practice and beliefs (e.g. HIV beliefs and personal risk perception), beliefs about relationships and dynamics, and perceptions of adverse mental health susceptibility. Participants also completed a questionnaire about their demographic information. Utilizing previous research as a basis (Malebranche, Arriola, Jenkins, Dauria, & Patel, 2010; Rosenstock, 2000), the following domains were explored in the interview guide: (1) Orientation and Emotional Health, (2) Sexual Health practice and Beliefs, (3) Religion and Spirituality, and (4) Social Support Systems. The semi-structured format allowed participants to respond freely and elaborate on their responses.

Measures

Personal Characteristics. Respondents were asked their age, racial/ethnic background, medical health history, level of education, income, and relationship status. In addition, they were asked about their relationships with their families (parents, brothers, and sisters). Related questions included: 'What is your relationship with siblings and parents as it relates to your sexual orientation?', and 'As a gay, bisexual or MSM AA male, who is most supportive, your family members or friends?' Given that religion and religious activities exist as an integral part of AA communities (Brown & Gary, 1994), respondents were asked whether they attended church and what church environment they grew up in. To determine participants' sexual orientation-identity label-preference, they were asked a series of questions related to their sexual orientation identity including: 'Do you prefer to be defined as Gay/homosexual or other?' and 'What is your self-definition?' Answers to these questions were recorded into two categories: 'Label-Accepting' and 'Label-Rejecting' based on their responses.

Psychosocial Well-being. Participants were asked about their mental health history as it related to their sexual orientation-identity as a gay, bisexual and MSM. Relevant questions included: 'Have you ever been depressed because of your sexual orientation?', 'Have you ever been socially anxious as result of your sexual orientation?' and 'Have you ever experienced adjustment problems as a result of your sexual orientation?'

Psychological Distress Assessment. All participants completed the Belief Symptom Inventory, a mental health quality of life measure that screens for clinically elevated psychiatric symptoms and suicidal ideations. BSI is a short form of the Symptom Checklist 90-Revised (Derogatis, 1993; Derogatis & Melisaratos, 1983; Derogatis, Rickels, & Rock, 1976). The BSI is a 53-item scale that was developed for psychiatric and non-psychiatric populations that has been well validated (Johnson, Brems, Mills, & Fisher, 2007; May, Rakhlin, Katz, & Limandri, 2003; Meijer, de Vries, & van Bruggen, 2011; Piersma, Boes, & Reaume, 1994). Individuals endorse each item of the BSI on a 5-point Likert scale of distress where 0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, to 4 = extremely. The items yield the following nine scales: Somatization, Obsessive-Compulsiveness, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. The alpha coefficients ranging from 0.79 to 0.85 on the Depression scale. We assessed mental health quality of life with the BSI because evidence suggests that persons at risk for mental health problems and/or seeking mental health services may be more likely to respond to questions from a questionnaire assessing mental health wellbeing compared to participating in a formal clinical interview (Drake et al., 2001; Hesse, 2006; Joe, Simpson, Greener, & Rowan-Szal, 2004; Lê Cook, McGuire, Lock, & Zaslavsky, 2010; Smits, Smit, Cuijpers, & De Graaf, 2007; Williams et al., 2007). Furthermore, ascertaining perspectives on mental health wellbeing via questionnaire may be viewed by respondents as less invasive and non-confrontational (Mount, Lambert, Essau, Samms-Vaughan, & Bokszczanin, 2011). As it relates to sustaining public mental health outreach with limited funding and resource scarcity, psychometric tests save a great deal of time, are able to be administered to large groups, and can generate more objective assessment of individuals' needs.

Divided into nine primary dimensions, each BSI dimension explores a different aspect of mental health quality of life. Somatization reflects psychological distress arising from perception of bodily dysfunction. The obsessive-compulsive dimension focuses on thoughts and actions that are experienced as unremitting and irresistible by the patient but are of an unwanted nature. Examples include difficulty making decisions and trouble concentrating. Interpersonal-

Sensitivity focuses on feelings of personal inadequacy and inferiority. Self-deprecation, feelings of uneasiness and marked discomfort during interpersonal interactions are characteristic of persons with high levels of interpersonal sensitivity. Although broad, the depression construct reflects a wide range of signs and symptoms of the clinical depressive syndromes. Hopelessness, futility, dysphoric affect, and mood conceptualize this dimension. The anxiety dimension subsumes a set of symptoms usually associated clinically with high manifest anxiety. Hostility focuses on three categories of hostile behavior: thoughts, feelings and actions. Feelings of annoyance and irritability are characteristics often associated with high levels of hostility. The Phobic-anxiety dimension centers on frequently occurring conditions termed phobic anxiety states or agoraphobia. The primary characteristics of Paranoid Ideation are projections, hostility, suspiciousness, centrality, and fear of loss of autonomy. Among non-psychiatric populations, the psychoticism dimension measures social alienation and psychosocial stress. Forty-nine of the 53 BSI items measure the nine primary symptom dimensions labeled, Somatization (SOM: items 2, 7, 23,29, 30, 33, and 37), Obsessive-Compulsivity (OBS: items 5, 15, 26, 27, 32, 36), Interpersonal Sensitivity (INS: items 20, 21, 22, 42), Depression (DEP: items 9, 16, 17, 18, 35,50), Anxiety (ANX: items 1, 12, 19, 38, 45, 49), Hostility (HOS: items 6, 13, 40, 41, 46), Phobic Anxiety (PHOB: items 8, 28, 31, 43, 47), Paranoid Ideation (PAR: items 4, 10, 24, 48, 51), and Psychoticism (PSY: items 3,14, 34, 44, 53). It should be noted that the additional items do not form a unified symptom construct but are included in the test as configurable items; they are totaled to facilitate calculating the global indices: the global severity index and the positive symptoms total. Participants' mental health quality of life dimensions were based on the deviation from the study group norm.

Data Analysis

We used descriptive statistics including frequencies, means and cross-tabulation, to describe demographic, sexual, mental and physical health differences of the study sample. BSI scores from the study sample were compared with scores from the BSI normative sample population of non-psychiatric adult males (n=494, 15% non-White and 25% single; Derogatis, 1993). Univariate tests were conducted to compare BSI scores of the study sample and the BSI normative sample. BSI scores were transformed to t-scores so that each of the psychological distress symptoms could be compared. All other statistical analyses were computed using the BSI raw scores because the t-score transformation changes the distribution of scores. All univariate tests were analyzed at a 95% confidence interval and all analyses were conducted with SPSS version 14.0 (Statistical Package for the Social Sciences, SPSS Inc., Chicago, IL).

Results

Demographics

Fifty-five males between the ages of 18 years and 29 years old (M = 21, SD=2.7) participated in this study. Participants were predominantly African American (94.5%) undergraduate students (84%) living in the state of North Carolina. As seen in Table 1, although participants represented varying sexual identity preferences, the majority rejected all sexual identity labels (71%). Among our sample population, 71% of participants attended a PWI and

25% attended a HBCU. Overall, 81% of participants were undergraduate students and 10% were graduate level students.

Table 1
Participants' Overall Demographic and Health History

Demographic	Positive (%)
Age (Mean=21)	
18-21 Yrs	66
22 Yrs & Above	34
Ethnicity	
African American	95
Asian American	2
Multiracial	4
Sexual Orientation-Identity Preference	
Label-Rejecting	71
Label-Accepting	29
Gay	54
Bisexual	4
MSM	4
History of intimate relationships with a female	49
Level of Education	
Undergraduate Student	81
Graduate Student	10
High School Diploma	2
College Graduate	8
Live on Campus	30
Sexual Health History	
Practice safe sex	93
Presently in an intimate relationship	43
Are you worried about getting HIV?	72
Mental Health History	
History of Depression	11
History of Anxiety	6
History of Adjustment Problems	9
Ever seen for mental health counseling?	26
Mental Health Assessment Reponses	
Have you ever been depressed because you are gay?	55
Have you ever been socially anxious because you are gay?	33
Have you ever experienced adjustment problems because you are gay?	36
BSI Symptom Dimension T-Score Means	
Somatization	50
Obsessive-Compulsive	62
Interpersonal Sensitivity	61
Depression	57
Anxiety	54

Hostility	58
Paranoid Ideation	62
Psychoticism	61

Psychological Distress

Across all symptom dimensions of the BSI, study sample scores were higher than normative sample scores. Overall BSI results revealed that average depression raw scores were 41% higher than the norm group raw scores. A single-sample t-test comparing mean depression raw scores of our study sample to a population value of 0.23 revealed a significant difference ($t[54]= 3.959$, $p<.005$). Our sample mean of 0.58 (SD±0.65) was significantly greater than the normative group mean. Compared to the male normative mean obsessive-compulsive raw scores, our study sample mean of 1.08 (SD =.72) was significantly greater ($p<0.005$) than the normative group mean; revealing that overall, participants had mild to moderate obsessive-compulsion. Study sample paranoid ideation raw scores (M=1.15, SD =.94) were also significantly higher than the normative sample ($t[54]=6.442$, $p<.005$). Similarly, study sample mean raw scores for hostility of M=.71 (SD =.70) was significantly higher than the normative group mean ($t[54]=3.875$, $p<.005$).

Table 2
BSI Symptom Dimension Raw Score Comparisons between Study Sample and Normative Sample

	Normative Sample[a] (n=361)		Study Sample (n=55)		95% Confidence Interval for Study Sample
	Mean	σ	Mean	σ	
Somatization	.23	.32	.24	.31	-.07 to .10
Obsessive-Compulsive	.37	.41	1.08**	.72	.52 to .91
Interpersonal Sensitivity	.24	.38	.90**	.81	.44 to .88
Depression	.21	.33	.58**	.65	.17 to.53
Anxiety	.26	.31	.46*	.48	.07 to .33
Hostility	.34	.40	.71**	.70	.18 to .56
Paranoid Ideation	.33	.41	1.15**	.94	.56 to 1.07
Phobic Anxiety	.11	.25	.25*	.38	.04 to .24
Psychoticism	.15	.27	.61**	.65	.28 to .63

[a] Adult Male Nonpatients
* $p <0.05$
** $p <0.005$
Note. The normative sample size for males differs somewhat from overall BSI normative sample due to differential missing demographic and item data.

Taken together, 20% of participants had mild to moderate interpersonal-sensitivity scores, 19% had mild to moderate somatization and 16% had mild to moderate anxiety symptom endorsement scores. Additionally, 11% of participants had mild to moderate hostility scores, 15% had mild phobic anxiety scores, 20% had mild paranoid ideation scores and 15% had mild to moderate psychoticism scores. Overall, participants endorsed higher levels of mild and moderate paranoid ideation, anxiety, obsessive-compulsion, somatization, and psychoticism. Participants were also more likely to report greater levels of high symptom severity on the Depression, Phobic Anxiety and hostility subscales.

Table 3
Overall Participants' BSI Dimension Score Descriptions

BSI Symptom Dimension	Normal %	Mild %	Moderate %	High %
Somatization	82	13	6	0
Obsessive-Compulsive	80	16	4	0
Interpersonal Sensitivity	80	18	2	0
Depression	91	6	0	2
Anxiety	82	15	2	2
Hostility	87	7	4	2
Paranoid Ideation	80	20	0	0
Phobic Anxiety	82	15	0	4
Psychoticism	84	13	2	2

Several differences between sexual orientation-identity label-preference groups were detected on the BSI dimensions. Overall, label-accepting participants (29%, n=16) were more likely to score within the normal range on the majority of psychological distress indicators. As reported in Table 4, label-rejecting subjects (71%, n=39) had a higher frequency of mild and moderate scores in most dimensions.

Table 4
Participants' BSI Symptom Dimension Score Levels Stratified by Label Preference

	Normal %		Mild %		Moderate %		High %	
BSI Symptom Dimension	Label Accepting	Label Rejecting	Label Accepting	Label Rejecting	Label Accepting	Label Rejecting	Label Accepting	Label Rejecting
Somatization	88	80	13	13	0	8	0	0
Obsessive-Compulsive	75	82	13	18	13	0	0	0
Interpersonal Sensitivity	82	80	13	21	6	1	0	0

Depression	94	90	6	5	0	0	0	5
Anxiety	81	82	13	15	0	3	6	0
Hostility	81	90	13	5	0	5	6	0
Paranoid Ideation	88	77	13	23	0	0	0	0
Phobic Anxiety	88	80	6	18	0	0	6	3
Psychoticism	94	80	6	15	0	3	0	3

Psychosocial Well-being

When asked about their mental health history, as it related to their sexual orientation identity, 55% of participants reported that they had a history of being depressed because of their sexual orientation, 33% had been socially anxious as result of sexual orientation and 36% had experienced adjustment problems as a result of their sexual orientation. However, only 26% of study participants had actually been seen for mental health counseling. Overall, label-rejecting participants were more likely to report a history of depression, or to have experienced social anxiety because of their sexuality.

Table 5

Participants' Mental Health History Stratified by Type of Label Preference

	Label Accepting (% - Yes)	Label Rejecting (% - Yes)
History of Depression	0	15
History of Anxiety	6	5
History of Adjustment Problems	13	8
Ever seen for mental health counseling?	23	24
Mental Health Assessment Reponses		
Have you ever been depressed because you are gay?	56	54
Have you ever been socially anxious because you are gay?	15	38
Have you ever experienced adjustment problems because you are gay?	44	33

As seen in Table 6, participants attending PWIs experienced higher rates of depression, social anxiety, and adjustment problems because of their sexual orientation, when compared to those attending HBCUs. When separating by label-preference; label-accepting participants from HBCUs experienced higher levels of psychosocial distress than their label-rejecting counterparts. Similarly, label-accepting participants from PWIs had higher indicators of psychosocial distress.

Table 6
Participants' Mental Health History Stratified by Type of Academic Institution

	Historically Black College/University *n=13* (% - Yes)	Predominantly White Institution *n=37* (% - Yes)
History of Depression	0	11
History of Anxiety	0	5
History of Adjustment Problems	8	8
Ever seen for mental health counseling?	23	24
Mental Health Assessment Reponses		

Overall, when asked if they believed being gay was a lifestyle, biological or a development of both, 50% believed that being gay was a biological phenomenon, 22% believed that being gay/homosexual was a lifestyle decision, while yet another 22% believed that it was a combination of both. However, when asked if they preferred to be defined as gay/homosexual 33% agreed, 7% responded 'no' but 40% of participants declined to answer this question. Label-Accepting participants attending PWIs exhibited higher rates of adjustment problems when compared to their Label-Rejecting counterparts, see Table 7.

Table 7
Participants' Mental Health History Stratified by Label Preference and College Environment

	HBCU		PWI	
	Label Accepting n (%)	Label Rejecting n (%)	Label Accepting n (%)	Label Rejecting n (%)
Have you ever been depressed because of your sexual orientation?	3 (60%)	3 (38%)	6 (60%)	14 (52%)
Have you ever been socially anxious because of your sexual orientation?	1 (20%)	1 (13%)	4 (40%)	10 (37%)
Have you ever experienced adjustment problems because of your sexual orientation?	2 (40%)	2 (25%)	5 (50%)	9 (33%)
History of Depression	0	0	0	(15%)
History of Anxiety	0	0	1 (10%)	1 (4%)
History of Adjustment Problems	1 (20%)	0	1 (10%)	2 (7%)

A factor associated with sexual orientation-identity label rejection was a higher likelihood to have sex outside of a relationship (38% vs 25%, $p < 0.026$). Other factors associated with sexual orientation-identity label-rejection that approached significance included a history of depression (11% vs 0%, p=0.09), and a greater likelihood to disclose their sexual orientation to a female than a male (40% vs 28%, p=0.076; See Table 8).

Table 8
Participants' BSI Score Levels Stratified by Label Preference

	Label Accepting (n=16)		Label Rejecting (n=39)	
BSI Symptom Dimension	No. of Items/Symptoms endorsed[1]	Emotional Distress Intensity Average Scores[2]	No. of Items/symptoms endorsed[1]	Emotional Distress Intensity Average Scores[2]
Somatization	9 (56%)	.21	26 (67%)	.26
Obsessive-Compulsive	12 (75%)	1.17	37 (95%)	1.06
Interpersonal Sensitivity	12 (75%)	.83	32 (82%)	.92
Depression	12 (75%)	.43	32 (82%)	.64
Anxiety	11 (69%)	.57	27 (69%)	.41
Hostility	13 (81%)	.79	34 (87%)	.68
Paranoid Ideation	15 (94%)	.88	35 (90%)	1.26
Phobic Anxiety	8 (50%)	.25	17 (44%)	.25
Psychoticism	10 (62%)	.46	29 (74%)	.67

[1] No. of symptoms reported = number of symptoms endorsed with answers greater than 1.
[2] Score ranges between 0-4. Emotional Distress Intensity = how high participants scored on the items they endorsed (0-4).

Discussion

Our four primary findings were: 1) as compared to the BSI normative sample, item endorsement and intensity among our study participants was significantly higher among the majority of symptom dimensions, particularly depression, hostility and paranoid ideation; 2) majority of participants reported history for depression and social anxiety as a result of their sexual orientation-identity; 3) participants overwhelmingly rejected sexual identity-orientation labels; and 4) there was considerable variability regarding homonormative identity preference. Elevated rates of interpersonal sensitivity, paranoid ideation and phobic anxiety we observed suggesting that study participants may be impacted by both environmental and internal influences. An unanticipated finding from this study was the low endorsement of a homonormative identity, which suggests that existing identity designations may not be sufficiently inclusive of or adequately encompass AA men's experiences. This study did not elicit participants' perspectives as to whether and how avoiding the adoption of a homonormative identity might impact access to the potentially protective benefits of sexual minority in-group affiliation, solidarity, and cohesiveness. Label-rejecting participants' higher

frequency of mild to moderate BSI scores and greater likelihood to have a history of anxiety and/or have experienced adjustment problems, may limit access to a supportive sexual minority community that could facilitate sexual orientation affirmation, community connectedness, and decrease social isolation. Not having the language to name one's self and to identify with others of similar sexual identities may compromise resilience against mental health quality of life deterioration. Among our study population, sexual orientation label-rejecting participants were more likely to experience adverse psychological distress.

Strengths & Limitations

One methodological advantage of the current investigation was the word of mouth recruitment strategy that enabled participants to recommend study participation to male friends. This method allowed for a more robust representative sample of this population. Another unique strength of our study was the self-report mode of assessment for psychological distress levels. We were able to access exclusive quantifiable information, ordinarily unavailable through other methods of evaluation. Additionally, allowing participants to provide answers independently may have encouraged more honest endorsement of symptoms, free from immediate judgment or probing from a testing administrator. Furthermore, race concordance among staff and participants served as yet another advantage. Prior research has documented the benefits of incorporating such nuances when engaging with marginalized populations who tend to harbor stigma towards research participation. Regarding the use of our semi-structured interview, incorporating this component into the battery of assessments served as an additional methodological advantage. By exploring the (1) Orientation and Emotional Health, (2) Sexual Health practice and Beliefs, (3) Religion and Spirituality, (4) Social Support Systems of participants, we were able to gain valuable insight into the overall psychosocial development and experiences of this group. This information will be essential to the development of culturally tailored intervention and outreach initiatives. Generalizing our findings beyond the study sample is cautioned given the cross-sectional design and sample approach. Nevertheless, this study provides a pathway toward developing an intervention program that will address multiple domains believed to compromise mental health quality of life among sexual minority AA males, including label preference. That is, reducing the barriers to prolonged mental health quality of life is highly relevant to public health promotion among sexual minorities.

Conclusion

Our findings support prior literature indicating that this is a population subject to multiple minority and life stressors, reject homonormative labels, and struggle to maintain their mental health quality of life (Cochran, Mays, & Sullivan, 2003; Fingerhut, Peplau, & Gable, 2010; Graham, Braithwaite, Spikes, Stephens, & Edu, 2009; Jamil, Harper, Fernandez, 2009; Kuang, Mathy, Carol, & Nojima, 2003; Mathy, 2002; Wilkerson, Brooks, & Ross, 2010). As this observational research is translated into actionable intervention planning, it would behoove interventionist to address the intrapersonal and interpersonal dialogue as it relates to the struggle and management of multiple identities, and the mental health quality of life vulnerabilities embodied with a variety of stereotypes from every community with which AA sexual minority males interact. Among our study population, sexual orientation label-rejecting participants were more likely to experience adverse psychological distress.

A major goal of behavior change and/or health promotion risk reduction interventions are to affect judgment and decision making from a prior knowledge or justification to a posteriori knowledge or justification via the experiences obtained from the experimental intervention. There is unwavering evidence suggesting that educational and health-behavior change oriented programs are most effective when such programs are planned, built, and refined with attention to being targeted and tailored to specific end-users in different ways (Gray & Harrington, 2010; Rothman & Salovey, 1997). Recent research has documented the effectiveness of tailoring health behavior change messages to characteristics of the recipients (e.g., how they best learn information; locus of control; social-cognitive processing) (Bull, Holt, Kreuter, Clark, & Scharff, 2001; Holt, Clark, Kreuter, & Scharff, 2000; Kreuter, Bull, Clark, & Oswald, 1999; Kreuter & Wray, 2003).

Lastly, it is noteworthy that participants reported higher levels of paranoia symptoms, particularly given our observations regarding sexual orientation-identity label-rejecting vs. label-accepting attitudes. The paranoia symptom endorsement behavior may have indicated underlying beliefs about suspicion, mistrust, resentment and/or interpersonal experiences of hostility. Exploring and addressing factors potentially contributing to feelings of paranoia would likely assist in promoting realistic appraisal of danger in the environments of AA sexual minority males. Moreover, our study findings demonstrate the necessity for exploring normative values and health beliefs that may influence the perceived benefits for strengthening coping skills and emotional self-regulation when facing adversity associated with being an under-represented black male student who is also gay, bisexual or MSM. Further, community mental health outreach strategies targeting black males may need to consider the unique implications of self-identity labeling preferences on differential experiences in terms of the larger sociocultural environment experiences, such as attending a HBCU or PWI. Our educational intervention development will benefit from integrating these current findings. Given the psychosocial distress reporting among study participants, there is indication for the benefits of developing and promoting mental health education in this population that would include preventive mental health screening and foster collaboration between public health educators and mental health providers.

Implications

Not only is it feasible to recruit AAs to participate in research, the sexual orientation-identity label preference focus of this research provides a unique understanding that will enhance the development of a psychoeducation intervention. By focusing on preference for and acceptance of labeling, this research has expanded the body of knowledge among college aged AA sexually marginalized men. Although participants were not found to be clinically depressed based upon the clinical interview, their psychological distress symptom reporting suggested that they were at risk for potential worsening in their mental health quality of life.

Given the complex socio-cultural ramifications of their dual-minority status, understanding the conditions under which AA sexual minority men accept label referencing can provide unique insights into the mental health quality life. Homonegativity may hurt more or may be felt more severely when it comes from fellow AA community members and institutions despite being regarded as places of refuge from racism, networks of support, and groups with which black sexual minorities strongly identify (Battle & Crum, 2007). Though little is known about factors that may influence the relationship between self-identification and mental health

qualify of life among AA sexual minority men, previous studies point to key areas for ongoing inquiry. The mental health quality of life risk associated with sexual orientation-identity label preference among AA males remains poorly characterized among college-aged students, particularly as it relates to their attendance at either PWIs or HBCUs. This issue is concerning as there is evidence to suggest that AA sexually marginalized men are more likely to experience elevated rates of adverse psychological development, particularly when considering their sexual orientation-identity and acceptance of labels (Lapinski, Braz, & Maloney, 2010). Problem solving with college-aged sexual minorities to support them through the challenges of accepting and embracing their same-gender loving or other non-straight identities is critical as this is a critical stage of psychosocial development layered with relationships matters (e.g., social identity vs. role confusion; intimacy vs. isolation) and potential overexposure to adverse changes in mental health quality of life, social context, and health-promoting behaviors(Elifson, Klein, & Sterk, 2010; Floyd & Stein, 2002; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006; Wickrama & Baltimore, 2010). Further, de-identification with sexual minority specifying labels is an aspect of minority sexual identity development process that surfaces at various points (Icard, Zamora-Hernandez, Spencer, & Catalano, 1996). That is, early on men may find that alternate orientations or identities embraced may not be adequate or best fit. When this is experienced, such persons may be motivated to engage in a process of de-identification and re-identification until comfortable and acceptable designations and communities are found or created.

The social and emotional trauma experienced by many individuals can cause an array of physical and mental health concerns and is a growing problem, particularly among AA sexual minority males that is likely exacerbated via a strained socio-emotional reserve against the cognitive background of a double minority status. The implications from this research seems to warrant concern that a population of college students may be disadvantaged from fully accessing the college environment, as well as the social environment in which they work, play, and live. The central question is not whether improved socio-emotional support can improve overall academic quality of life and social inclusion, but rather, whether those benefits transfer equally and/or lead to any general improvement in the level of perceived quality of life for the most vulnerable in this community. Hence, future programmatic efforts must extend full community engagement in all essential program planning and implementation action-taking. Further, ongoing scientific attention in this area may benefit from exploring opportunities for developing peer support programs and evaluating such services on critical outcomes, such as posttraumatic stress recovery, improved self-concept, interpersonal relationships, and sense of belonging; as well as academic performance and reduction in premature college education termination.

This research is relevant to a diverse stakeholder group as well as agencies and institutions that interact with the sexual minority community. As more sexual minorities refuse to conceal their sexual orientation, and mental health quality of life is more effectively addressed, the sociopolitical climate as it relates to equal rights for sexual minorities will have a greater chance for advancement. This line of research will compliment organizations that take social policy action to recognize, acknowledge and interrupt all forms of oppression, including internalized oppression. Expanding the pool of AA sexual minorities disclosing persons is beneficial for additional reasons. That is, AA sexual minorities who want to help reduce prejudice and discrimination can be open about their sexual orientation, even as they take necessary precautions to be as safe as possible. Hence, the intervention program to be developed will help AA males examine their own belief systems for the presence of antigay stereotypes,

how they can leverage support through increased involvement in the sexual minority community and from supportive heterosexual people.

References

Balsam, K. F., Beauchaine, T. P., Mickey, R. M., & Rothblum, E. D. (2005). Mental health of lesbian, gay, bisexual, and heterosexual siblings: effects of gender, sexual orientation, and family. *Journal of Abnormal Psychology, 114*(3), 471-476.

Battle, J., & Crum, M. (2007). Black LGB health and well-being. In Ilan Meyer & M. E. Northridge (Eds.), *The health of sexual minorities* (pp. 320-352). New York, NY: Springer.

Bener, A., & Ghuloum, S. (2011). Gender differences in the knowledge, attitude and practice towards mental health illness in a rapidly developing Arab society. *International Journal of Social Psychiatry, 57*(5), 480-486.

Brown, D. R., & Gary, L. E. (1994). Religious involvement and health status among African-American males. *Journal of the National Medical Association, 86*(11), 825.

Brown, E. (2005). We wear the mask: African American contemporary gay male identities. *Journal of African American Studies, 9*(2), 29-38.

Bull, F. C., Holt, C. L., Kreuter, M. W., Clark, E. M., & Scharff, D. (2001). Understanding the effects of printed health education materials: which features lead to which outcomes? *Journal of Health Communication, 6*(3), 265-279.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, *71*(1), 53-61.

Cole, S. W., Kemeny, M. E., Taylor, S. E., & Visscher, B. R. (1996). Elevated physical health risk among gay men who conceal their homosexual identity. *Health Psychology, 15*(4), 243-251.

D'Augelli, A. R., & Hershberger, S. L. (1993). Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *American Journal of Community Psychology, 21*(4), 421-448.

Derogatis, L. (1993). *BSI Brief Symptom Inventory: Administration, scoring and procedures manual* (4th ed.). Minneapolis, MN: National Computer Systems.

Derogatis, L., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine 13*(3), 595-605.

Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *The British Journal of Psychiatry, 128*(3), 280-289.

Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, A. F., Dixon, L., Mueser, K. T., et al. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services, 52*(2), 179-182.

Elifson, K. W., Klein, H., & Sterk, C. E. (2010). Factors associated with condom use among young adult ecstasy users. *International Journal of Public Health, 55*(6), 571-579.

Fingerhut, A. W., Peplau, L. A., & Gable, S. L. (2010). Identity, minority stress and psychological well-being among gay men and lesbians. *Psychology & Sexuality, 1*(2), 101-114.

Fisher, L. J., & Goldney, R. D. (2003). Differences in community mental health literacy in older and younger Australians. *International Journal of Geriatric Psychiatry, 18*(1), 33-40.

Floyd, F. J., & Stein, T. S. (2002). Sexual orientation identity formation among gay, lesbian, and bisexual youths: Multiple patterns of milestone experiences. *Journal of Research on Adolescence, 12*(2), 167-191.

Georges, C. A., Bolton, L. B., & Bennett, C. (2004). Functional health literacy: An issue in African-American and other ethnic and racial communities. *Journal of National Black Nurses' Association, 15*(1), 1-4.

Gilman, S., Cochran, S., Mays, V., Hughes, M., Ostrow, D., Kessler, R. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. *American Journal of Public Health, 91*(6), 933-939.

Goode-Cross, D. T., & Good, G. E. (2009). Managing multiple-minority identities: African American men who have sex with men at predominately white universities. *Journal of Diversity in Higher Education*, *2*(2), 103-112.

Graham, L., Braithwaite, K., Spikes, P., Stephens, C.F, & Edu, U.F. (2009). Exploring the mental health of black men who have sex with men. *Community Mental Health Journal, 45*(4), 272-284.

Graham, L. ., Aronson, R. E., Nichols, T., Stephens, C. F., & Rhodes, S. D. (2011). Factors influencing depression and anxiety among Black sexual minority men. *Depression Research and Treatment, 2011*. Retrieved from http://www.hindawi.com/journals/drt/2011/587984/

Gray, J. B., & Harrington, N. G. (2011). Narrative and framing: A test of an integrated message strategy in the exercise context. *Journal of Health Communication , 16*(3), 264-281.

Harper, S. R. & Gasman, M. (2008). Consequences of conservatism: Black male undergraduates and the politics of historically Black colleges and universities. *Journal of Negro Education*, *77*(4), 336-351.

Harper, S. R., & Kuykendall, J. A. (2012). Institutional efforts to improve Black male student achievement: A standards-based approach. *Change: The Magazine of Higher Learning, 44*(2), 23-29.

Harris, W. (2003). African American homosexual males on predominantly white college and university campuses. *Journal of African American Studies, 7*(1), 47-56.

Hesse, M. (2006). The Beck Depression Inventory in patients undergoing opiate agonist maintenance treatment. *British Journal of Clinical Psychology, 45*(3), 417-425.

Holt, C. L., Clark, E. M., Kreuter, M. W., & Scharff, D. P. (2000). Does locus of control moderate the effects of tailored health education materials? *Health Education Research, 15*(4), 393-403.

Icard, L. D., Zamora-Hernandez, C. E., Spencer, M. S., & Catalano, R. (1996). Designing and evaluating strategies to recruit African Americans for AIDS/HIV interventions: targeting the African-American family. *Ethnicity & Disease, 6*(3-4), 301-310.

Igartua, K. J., Gill, K., & Montoro, R. (2003). Internalized homophobia: A factor in depression, anxiety, and suicide in the gay and lesbian population. *Canadian Journal of Community Mental Health, 22*(2), 15-30.

Jamil, O. B., Harper, G. W., & Fernandez, M. I. (2009). Sexual and ethnic identity development among gay–bisexual–questioning (GBQ) male ethnic minority adolescents. *Cultural Diversity and Ethnic Minority Psychology, 15*(3), 203-214.

Joe, G. W., Simpson, D. D., Greener, J. M., & Rowan-Szal, G. A. (2004). Development and validation of a client problem profile and index for drug treatment. *Psychological Reports, 95*(1), 215-234.

Johnson, M. E., Brems, C., Mills, M. E., & Fisher, D. G. (2007). Psychiatric symptomatology among individuals in alcohol detoxification treatment. *Addictictive Behaviors, 32*(8), 1745-1752.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia, 166*(4), 182-186.

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC psychiatry, 8 (1)*, 70.

Kreuter, M. W., Bull, F. C., Clark, E. M., & Oswald, D. L. (1999). Understanding how people process health information: a comparison of tailored and nontailored weight-loss materials. *Health Psychology, 18*(5), 487-494.

Kreuter, M. W., & Wray, R. J. (2003). Tailored and targeted health communication: strategies for enhancing information relevance. *American Journal of Health Behavior, 27(Supplement 3)*, S227-S232.

Kuang, M. F., Mathy, R.M., Carol, H.M, & Nojima, K. (2003). The effects of sexual orientation, gender identity, and gender role on the mental health of women in Taiwan's T-Po lesbian community. *Journal of Psychology & Human Sexuality, 15*(4), 163 - 184.

Lapinski, M. K., Braz, M. E., & Maloney, E. K. (2010). The down low, social stigma, and risky sexual behaviors: Insights from African-American men who have sex with men. *Journal of Homosexuality, 57*(5), 610-633.

Larson, D. G., & Chastain, R. L. (1990). Self-concealment: Conceptualization, measurement, and health implications. *Journal of Social and Clinical Psychology, 9(4)*, 439-455.

Lauber, C., Carlos, N., & Wulf, R. (2005). Lay beliefs about treatments for people with mental illness and their implications for antistigma strategies. *Canadian Journal of Psychiatry, 50*(12), 745-752.

Lê Cook, B., McGuire, T.; Lock, K.; Zaslavsky, A. (2010). Comparing methods of racial and ethnic disparities measurement across different settings of mental health care. *Health Services Research, 45*(3), 825-847.

Malebranche, D. J., Arriola, K. J., Jenkins, T. R., Dauria, E., & Patel, S. N. (2010). Exploring the "bisexual bridge": A qualitative study of risk behavior and disclosure of same-sex behavior among Black bisexual men. *American Journal of Public Health, 100*(1), 159-164.

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., et al. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health, 49*(2), 115-123.

Mathy, R. (2002). Transgender identity and suicidality in a nonclinical sample: Sexual orientation, psychiatric history, and compulsive behaviors. *Journal of Psychology and Human Sexuality, 14*(4), 47 - 65.

May, B. A., Rakhlin, D., Katz, A., & Limandri, B. J. (2003). Are abused women mentally ill? *Journal of Psychosocial Nursing and Mental Health Services, 41*(2), 21-29.

McAndrew, S., & Warne, T. (2004). Ignoring the evidence dictating the practice: sexual orientation, suicidality and the dichotomy of the mental health nurse. *Journal of Psychiatric Mental Health Nursing, 11*(4), 428-434.

Meijer, R. R., de Vries, R. M., & van Bruggen, V. (2011). An evaluation of the Brief Symptom Inventory-18 using item response theory: Which items are most strongly related to psychological distress? *Psychogical Assessment, 23*(1), 193-202.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bullentin, 129*(5), 674-697.

Mills, T. C., Paul, J., Stall, R., Pollack, L., Canchola, J., Chang, Y. J., et al. (2004). Distress and depression in men who have sex with men: The Urban Men's Health Study. *American Journal of Psychiatry, 161*(2), 278-285.

Mount, D. L., Lambert, M. C., Essau, C. A., Samms-Vaughan, M. E., & Bokszczanin, A. (2011). Using IRT-DIF methodology in detecting and evaluating Brief Symptom Inventory item response differences among Afro-Caribbean and European adults. *Caribbean Journal of Psychology, 4*(1), 29-42.

Owens, D., Lacey, K., Rawls, G., & Holbert-Quince, J. A. (2010). First-Generation African American Male College Students: Implications for Career Counselors. *The Career Development Quarterly, 58*(4), 291-300.

Palmer, R. T., & Gasman, M. (2008). It takes a village to raise a child :The role of social capital in promoting academic success for African American men at a Black college. *Journal of College Student Development, 49*(1), 52-70.

Patton, L. (2011). Perspectives on identity, disclosure, and the campus environment among African American gay and bisexual men at one historically Black college. *Journal of College Student Development, 52*(1), 77-100.

Piersma, H. L., Boes, J. L., & Reaume, W. M. (1994). Unidimensionality of the Brief Symptom Inventory (BSI) in adult and adolescent inpatients. *Journal of Personality Assessment, 63*(2), 338-344.

Rosenstock, I. M. (2000). Health belief model. In *Encyclopedia of psychology, (Vol. 4,* pp. 78-80). New York, NY: Oxford University Press.

Rothman, A. J., & Salovey, P. (1997). Shaping perceptions to motivate healthy behavior: The role of message framing. *Psychological Bulletin, 121*(1), 3-19.

Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, 91*(8), 1276-1281.

Sandfort, T. G., Bakker, F., Vanwesenbeeck, I., & Schellevis, F. G. (2006). Sexual orientation and mental and physical health status: Findings from a Dutch population survey. *American Journal of Public Health, 96*(6), 1119-1125.

Smits, N., Smit, F., Cuijpers, P., & De Graaf, R. (2007). Using decision theory to derive optimal cut-off scores of screening instruments: An illustration explicating costs and benefits of mental health screening. *International Journal of Methods on Psychiatric Research, 16*(4), 219-229.

Stansbury, K., & Schumacher, M. (2008). An exploration of mental health literacy among African American clergy. *Journal of Gerontological Social Work, 51*(1-2), 126-142.

Tomlinson, M. J., & Fassinger, R. E. (2003). Career development, lesbian identity development, and campus climate among lesbian college students. *Journal of College Student Development, 44*(6), 845-860.

Troiden, R. R. (1979). Becoming homosexual: a model of gay identity acquisition. *Psychiatry, 42*(4), 362-373.

Wickrama, T., Wickrama, K. A. S., & Baltimore, D. L. (2010). Adolescent precocious development and young adult health outcomes. *Advances in Life Course Research, 15*(4), 121-131.

Wilkerson, J. M., Brooks, A. K., & Ross, M. W. (2010). Sociosexual identity development and sexual risk taking of acculturating collegiate gay and bisexual men. *Journal of College Student Development, 51*(3), 279-296.

Williams, D. R., Gonzalez, H. M., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., et al. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results From the National Survey of American Life. *Archives of General Psychiatry, 64*(3), 305-315.

Williamson, I. R. (2000). Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research, 15*(1), 97-107.

Author Note

David L. Mount, PsyD, MA, is the founder and CEO of MindBodyInstituteBeyond and the author the book "Waking Up in College." He is also an assistant professor in the Department of Internal Medicine at Wake Forest University School Medicine. He holds adjunct faculty positions in the Wake Forest University Graduate School, the Department of Public Health Education at the University of North Carolina-Greensboro, and in the Department of Behavioral and Social Sciences at Winston Salem State University. Dr. Mount's narrative and quantitative research is enriched through his community engagement short film documentary work. He is an African American clinical health psychologist with postdoctoral training in qualitative and quantitative neuropsychological methods. Dr. Mount is the director for community partnerships in the Maya Angelou Center for Health Equity at Wake Forest University Health Sciences.

Alethea Amponsah is a health equity ambassador and project management who specializes in community outreach activities. She is a graduate from Tufts University and has published in many areas of health disparities.

Louis F. Graham, DrPH, MPH, is an assistant professor in the School of Public Health and Sciences at the University of Massachusetts Amherst. Graham's scholarship uses community-based participatory research (CBPR) to understand psychosocial health determinants among ethnic, gender and sexually marginalized groups – including mental health promotion and HIV prevention among black and Latino gay and bisexual men and transgender women. He is a co-principal investigator of a four-year, Ford Foundation funded ethnographic research project, "Detroit Youth Passages," which seeks to examine and positively transform structural conditions that contribute to sexual vulnerabilities. In this role, he is the director of all research, communication, and dissemination activities in partnership with the Ruth Ellis Center and African-American transgender communities in Detroit. His areas of specialization include health inequities, CBPR, psychosocial health, LGBT health, and cultural studies.

Michael Lambert, PhD, is a professor in the School of Social Work at the University of North Carolina at Chapel Hill (UNC). As a scientist-practitioner, Dr. Lambert has researched and is published in multiple areas of the behavioral sciences, including behavioral and emotional functioning in children, adolescents, adults and families nationally and internationally. He has published works on psychological assessment of different demographic groups across nations within Europe, North America and the Caribbean. Dr. Lambert is a senior psychologist specializing in assessment and treatment of children, adolescents, adults, couples, and families. His clinical expertise includes the treatment of depression, anxiety, severe psychological disorders such as bipolar disorder and schizophrenia in children, adolescents and adults.