Why Black sexual minority adults avoid professional mental health care

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ABSTRACT

Objective: To determine if Black sexual minority (SM) individuals are more likely than White SM people to postpone/avoid professional mental health care and, if so, to identify differences in the reasons for postponing/avoiding care.

Methods: Analyses were conducted using subsample of Black (n = 78) and White SM (n = 398) individuals from a larger survey of U.S. adults administered via MTurk in 2020 (n = 1,012). Logistic regression models identify Black-White differences in overall postponement/avoidance of care as well as Black-White differences in each of nine reasons for postponing/avoiding care.

Results: Black SM individuals were more likely than their White counterparts to report ever postponing/avoiding professional mental health care (average marginal effect [AME] = 13.67 percentage points [pp]; 95% confidence interval [CI]: 5.42, 21.92). Black SM people were more likely than White SM people to cite beliefs that they should work out their problems on their own (AME = 13.09 pp; 95% CI: 1.24, 24.94) or with family and friends (AME = 17.53 pp; 95% CI: 5.95, 29.11), as well as providers refusing to treat them (AME = 17.37 pp; 95% CI: 7.64, 27.11), as reasons for postponing/avoiding care.

Conclusions. Study results indicate that personal beliefs about managing mental health, as well as provider refusal, influence Black SM individuals' willingness or ability to seek professional mental health care at rates similar to their White SM counterparts.

Keywords: Black mental health, sexual minority, LGBT, mental health care access

Highlights

- Black sexual minority (SM) individuals were more likely than their White counterparts to report ever postponing/avoiding professional mental health care.

- Black SM persons were more likely than their White SM counterparts to cite beliefs that they should work out their problems on their own, beliefs that they should work out their problems with family and friends, as well as providers refusing to treat them as reasons for postponing/avoiding care.
- Understanding disparities in the use of professional mental health care, and intrapersonal reasons for these disparities, can inform efforts to support the mental health of Black SM persons, within or outside of traditional systems of professional mental heath care.

INTRODUCTION

Black sexual minority (SM) individuals experience marginalization and bias based on their race, sexual orientation, and the intersection of these identities.[1–7] These complex experiences of minority stress may confer unto Black SM individuals additional risk for mental health issues compared to their White SM peers.[8] Professional mental health care (PMHC; e.g., talk therapy, medication) is generally regarded as the standard course of action for managing clinically significant mental health issues. Generally, SM adults are more likely than their heterosexual counterparts to utilize PMHC services, with some variation across subgroups of SM individuals (i.e., gay, lesbian, and bisexual persons).[9–11] However, research examining the mental health management strategies of Black SM adults suggests that this population may avoid PMHC, with limited understanding regarding *why* Black SM populations might engage in PMHC at lower rates than their White sexual minority peers.[10,12,13] Identifying the reasons for racial disparities in PMHC utilization among SM individuals is necessary for alleviating barriers to mental health care access and utilization and subsequently improving the mental health of, and mental health care for, Black SM people.

Black Sexual Minorities, Intersectional Stress, and Mental Health Management

Black SM people experience simultaneous race- and sexuality-based bias and discrimination[1] in addition to unique forms of oppression like racism within lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities[2–5] and heterosexism within Black spaces.[6,7] These experiences of minority stress[14] have deleterious effects on the mental health of Black SM people. For example, compared to their Black heterosexual and White SM counterparts, Black SM persons report higher levels of psychological distress.[8] Additionally, Black SM adults who report experiences of sexual identity-based discrimination are more likely

to have attempted suicide in the past-five years relative to Black SM adults who have not had these experiences.[15]

These identity-based experiences create a need for PMHC. However, access to this care varies greatly across sociodemographic groups. Andersen's model of health services use[16] helps conceptualize the factors that influence use of mental health care. Demographic characteristics such as sexual and racial identity serve as predisposing individual characteristics;[17] these facets of one's lived experience can facilitate or impede access to services. Research about PMHC utilization by Black SM individuals is nascent and suggests that Black SM individuals may be less likely to seek services. Studies that utilized a community sample of sexual minority women and a sample of college students suggest that, compared to their White SM counterparts, Black SM people are no more likely to utilize mental health care.[10,12] Further, Meyer, et al (2015) found that Black SM participants were less likely than White SM adults to seek mental health or medical treatment prior to a suicide attempt.[13] Thus, additional research is needed to clarify potential racial disparities in PMHC utilization within SM samples.

There is growing evidence that Black SM individuals may differ from their White SM counterparts with regards to another predisposing individual characteristic: beliefs about mental health care. Qualitative data indicate a general skepticism about using PMHC among Black SM persons. Moore et al.'s (2020) investigation of mental health service engagement among Black and Hispanic SM persons provides several critical insights into beliefs about mental health care seeking.[18] Themes included 1) reluctance to engage with services, or prematurely terminating services, due to personal factors (e.g. belief that treatment would not help, handling problems on their own, shame about symptoms and SM identity); 2) social influences (e.g. family members discouraging the use of traditional mental health services); 3) accessibility factors (e.g. lack of

knowledge about how to navigate the health care system, trouble affording care); and 4) provider characteristics (e.g. withholding information from providers who do not share their racial/ethnic or LGBTQ identity).

Given that PMHC is an important tool for supporting the mental health of Black SM populations, it is important to understand if, and why, Black SM adults may avoid care. There is limited research investigating potential racial disparities in SM utilization of PMHC. Additionally, quantitative studies have yet to examine why Black SM people might postpone/avoid mental health care. Thus, the current study uses survey data from an online sample of SM adults to explore racial differences in postponement/avoidance of PMHC. The analyses that follow seek to answer 1) *Are Black SM people more likely than White SM people to postpone/avoid mental health care?* and 2) *If so, are there differences in the reasons why Black SM people might postpone/avoid mental health care relative to White SM people?*

METHOD

Data source and Sample

Data come from a larger study with an online sample (n = 1,012 valid responses) gathered from February to July 2020 using Amazon Mechanical Turk (MTurk). MTurk is a task-based crowdsourcing platform whereby individual users can browse lists of tasks (i.e., HITs) and complete them for compensation. Although there have been recent concerns about the quality of data collected using MTurk, this study's inclusion criteria (e.g., MTurk workers must have completed 500 approved tasks and must have at least a 95% MTurk task approval rating) and screening of completed responses (e.g., declining to approve and pay workers who appeared to be bots; cleaning data from approved workers and removing data from workers whose responses are incoherent or inconsistent with survey items) increase our confidence in the quality of these

data.[19,20] The larger study used quota sampling to ensure diversity of sexual orientations and gender identities as well as a near-equal split of men and women. Participants were paid $4.50 to complete the survey which took approximately 20 minutes to complete. The analytic sample for this study (n=476) consists of complete cases from respondents who 1) indicated their race as Black or White, 2) indicated a non-heterosexual sexual identity, and 3) indicated a non-transgender identity congruent with their reported sex assigned at birth. Informed consent was obtained electronically from all participants. This study was approved by the [REDACTED] Institutional Review Board.

Measures

Race was measured with a single question asking, "If you had to choose, with which race do you identify most with? [select one]". Those who identified as White or Black/African American were included in this analysis.

Sexual orientation was measured with the following item: "Sexual orientation is often used to describe who you are emotionally, romantically, or sexually attracted to. What best describes your current sexual orientation? [select one]". Those who selected any identity other than "heterosexual/straight" (i.e. asexual, bisexual, lesbian/gay, pansexual, queer, questioning, and same-gender loving) were included in this analysis.

Family income was measured by asking participants to "Think about the family members in your household who live with you right now. About how much income did you and your family members make in the last year before taxes? (Include child support, cash payments and assistance from the government—for example, SNAP, TANF, SSI, or unemployment compensation)" Response categories were combined to create a five-level variable: *less than $30k; $30k-49,999; $50k-69,999; $70k-89,999; $90k+*.

Age was collected as a continuous variable with the question "On your last birthday, how old did you turn?".

Education was measured with the question "What is the highest level of education you've completed?" Responses were recoded to reflect *high school or less*, *some college*, and *college degree or more.*

Service utilization was measured with the following yes/no question: "Have you ever talked with a mental health provider because you were concerned about your mental health?"

Postponing/avoiding care was measured by asking "Have you ever postponed or not tried to get mental health care because..." where participants indicated *yes*, *no*, or *don't know* for the following reasons: I could not afford it; I did not have insurance; I think one should work out their mental health problems by themselves; I think one should work out their mental health problems with friends or family; a mental health care provider refused to see me; I don't trust that mental health care providers can help me; I am afraid that mental health care providers might treat me poorly; I am embarrassed about my issues; I have had a negative experience. These responses were recoded such that 0=no/don't know and 1=yes. We additionally coded an *ever postponed care* variable whereby 0=no/don't know to all reasons and 1=yes to any reason.

Analytic strategy

Frequencies and percentages for each variable were calculated for the total sample and, separately, for the Black- and White-identified subsamples. Next, chi-square tests of independence and *t*-tests were conducted to identify differences between the Black- and White-identified subgroups for all covariates and outcomes. We then ran both univariate and multivariate logistic regression analyses assessing postponement/avoidance of PMHC, and the reasons therein, as a function of race. Adjusted models controlled for age, sex, income,

education, and having ever talked to a mental health provider. Lastly, we used postestimation methods to calculate predicted probabilities of postponing/avoiding care for any reason, as well as by each of the nine reasons.

RESULTS

Table 1 lists full characteristics of the sample. The proportion of male and female respondents varied by race with a larger proportion of the Black SM subsample identifying as male (66.67%) than in the White SM subsample (51.26%). The subsamples also varied on education, with Black SM participants (78.21%) more likely than White SM participants (64.32%) to hold a college degree or more. No other statistical differences were found.

Table 2 outlines results from unadjusted and adjusted regression models. Black SM participants had higher odds than their White SM counterparts of having postponed/avoided PMHC for any reason (odds ratio [OR] = 1.96; 95% confidence interval [CI]: 1.04, 3.69; adjusted odd ratio [aOR] = 2.69; CI: 1.33, 5.41). Further, compared to White SM persons, Black SM participants had higher odds of reporting that they postponed/avoided mental health care because they think one should work out their mental health problems themselves (OR = 1.87; CI: 1.13, 3.09; aOR = 1.83; CI: 1.09, 3.06) or with friends and family (OR = 2.32; CI: 1.38-3.90; aOR = 2.46; CI: 1.43, 4.23). Black SM participants also had higher odds than their White sexual minority counterparts of postponing/avoiding care because a provider refused to see them (OR = 4.21; CI: 2.27-7.81; aOR = 4.20; CI: 2.18, 8.08). There were no Black-White SM differences for the other reasons for postponing/avoiding care.

Figure 1 illustrates the predicted probabilities of postponing/avoiding mental health care for Black and White SM people. Overall, our sample of SM individuals had high probabilities of avoiding/postponing care with 71% of White participants and 85% of Black participants

endorsing this behavior for any reason (average marginal effect [AME] =13.67 percentage points [pp]; CI: 5.42, 21.92). Predicted probabilities also illustrate the proportional differences between Black and White SM persons who were more likely to postpone/avoid care because they think one should work out their mental health problems themselves (40% vs. 27%, respectively; AME = 13.09 pp; 95% CI: 1.24, 24.94), with friends and family (38% vs 20%, respectively; AME = 17.53 pp; 95% CI: 5.95, 29.11), or a provider refused to treat them (26% vs 8%, respectively; AME = 17.37 pp; 95% CI: 7.64, 27.11). It is also notable that nearly 50% of the overall sample stated that they postponed/avoided care because they could not afford it.

DISCUSSION

This study sought to document Black-White differences in postponing/avoiding PMHC in an online sample of SM adults. Generally, Black SM persons were nearly two times as likely as White SM persons to postpone/avoid PMHC for any reason. They were also more likely to postpone/avoid care because they thought they should work out their mental health problems themselves or with friends and family, or because a provider refused to treat them. Our finding that, overall, Black SM persons were more likely than White SM persons to postpone/avoid care aligns with general research literature about racial/ethnic differences in PMHC utilization. Although little work has been done about PMHC utilization at the intersection of race/ethnicity and sexual orientation, results from general samples show that Black adults are reluctant to engage with traditional modes of mental health management.[21,22] Although Andersen's model of health services use[16] regards race as a predisposing individual characteristic, it may be more helpful to consider how identity-related beliefs (e.g. a distrust of the medical establishment among Black adults, doubts in the effectiveness of services) influence service utilization.[22]

This reluctance to engage is further explained by our findings about Black-White SM differences in reasons for postponing/avoiding PMHC. Concerningly, Black SM participants were four times as likely as White SM participants to report postponing/avoiding care because a provider refused to treat them. Although these data did not assess perceptions of why providers refused to work with participants, the Black-White disparity indicates that institutional racism or unique intersectional experiences of bias likely play a role in Black SM people postponing/avoiding mental health care. Certainly, there is evidence of racism in the mental health care system, including not just refusal to treat Black clients but microaggressions from providers and a general lack of competence in attuning to the cultural needs and discrimination experiences of Black clients.[23] These experiences with the mental health care system likely reinforce distrust of formal systems of care. Further, research suggests that mistrust of the system and community mores about self-sufficiency contribute to Black persons' preference to work out their issues on their own or with their family and friends.[24,25] This is also evident in the present analysis. Although friends and family can be an important source of support regarding mental health, the expectation that they should preclude PMHC systems can do more harm than good in instances where PMHC is clinically indicated (i.e., when symptoms are too severe to self-manage). These findings support the importance of prioritizing cultural competency in how mental health providers deliver care to Black SM individuals. Such cultural competency efforts require an intersectional framework to effectively understand and meet the mental health needs of Black SM people.

There are other notable findings in this study. First, a large proportion (74%) of the total sample reported postponing/avoiding care for any reason. This is likely a reflection of the barriers that SM persons of any race face when seeking mental health care, which may include

limited availability of affirming providers, transportation challenges, and inability to afford health care, particularly related to a lack of health insurance.[9,26–28] Additionally, there were a number of reasons for postponing/avoiding care that did not evidence Black-White differences where, based on the literature, we might expect them to exist. For example, there is extensive literature about the stigma of mental health issues and PMHC utilization in Black communities.[22,29] However, Black individuals in this sample were no more likely than their White counterparts to postpone/avoid care because they were embarrassed about their mental health concerns. This may also be explained by distrust of medical systems; institutional distrust is not necessarily contingent on personal embarrassment. Thus, both the broader health care access issues and the specific intersectional challenges Black SM individuals contend with must be addressed to promote uptake of mental health services by Black SM individuals.

Limitations and Areas of Future Research

There are limitations to note in this analysis. The survey we used did not include a direct measure of need for mental health care; items about postponing/avoiding mental health care were presented to all respondents, not only those who reported a need for care. Thus, our conclusions might be stronger of this analysis was only among those who reported needing mental health care. Future studies should assess self-reported need for mental health care and include this factor in analyses. There is also a lack of specificity in the items used in this analysis. Use of PMHC is measured with a question about ever having "talked to a mental health provider because you were concerned about your mental health." It is possible, for example, that someone spoke with their pastor about mental health issues and was unsure about how to answer the question as it is worded. Items asked about lifetime behaviors, which limit our ability to make strong temporal inferences. Future studies should utilize items that are more specific to which,

whom, and when individuals seeks out mental health care and support. Furthermore, given the disproportionate numbers of Black individuals living with HIV, and the mental health services available to these individuals, future studies may also want to explore how HIV status might alter mental health care engagement.

Additionally, although the sampling for the larger study used a stratified quota approach to ensure representation from various sexual orientations and gender identities, there were no quotas for many other demographic characteristics, including race/ethnicity. One consequence of this is a low number of Black SM participants, and an even lower number of Black SM participants who had not postponed PMHC. With a larger sample, future analyses may have increased power to detect differences. Future research should also consider additional comparison groups (e.g., how Black SM PMHC utilization compares to Black individuals overall) to identify drivers of the observed inequities.

Finally, it should be noted that use of PMHC is one of many mental health management strategies at people's disposal. Generally, health services researchers and public health surveillance efforts operate from the assumption of PMHC utilization as *the* measure of mental health care. However, Black SM people and members of other marginalized communities often embrace less traditional mental health management strategies that are not captured in these measures (e.g. community-based supports, less formal conversations with faith leaders, barbers, etc.).[30,31] Not all PMHC meets the needs of members of marginalized communities and less traditional strategies may be sufficient alternatives to professional care. Future studies should use both qualitative and quantitative approaches to examine the ways in which Black SM individuals choose to manage their mental health, what makes traditional service utilization more or less appealing, and how effective less traditional strategies can be.

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Table 1. Sample Characteristics with Black-White Sexual Minority (SM) Subgroup Differences

	Total (n=476)		Black SM (n=78)		White SM (n=398)			
	n	%	n	%	n	%	X2	*p*
Sex								
Male	256	53.78	**52**	**66.67**	**204**	**51.26**	**6.14**	**0.01**
Female	220	46.22	**26**	**33.33**	**194**	**48.74**		
Family income								
Less than $30k	98	20.59	14	17.95	84	21.11	1.89	0.75
$30k-49,999	132	27.73	24	30.77	108	27.14		
$50k-69,999	100	21.01	18	23.08	82	20.60		
$70k-89,999	72	15.13	13	16.67	59	14.82		
$90k+	74	15.55	9	11.54	65	16.33		
Education								
High school or less	45	9.45	**3**	**3.85**	**42**	**10.55**	**6.33**	**0.04**
Some college	114	23.95	**14**	**17.95**	**100**	**25.13**		
College degree or more	317	66.60	**61**	**78.21**	**256**	**64.32**		
Ever talked to mental health provider								
No	212	44.54	40	51.28	172	43.22	1.71	0.19
Yes	264	55.46	38	48.72	226	56.78		
	M	SD	M	SD	M	SD	*t*	*p*
Age	33.92	8.84	32.65	7.68	34.16	9.04	1.38	0.17
	n	%	n	%	n	%	X2	*p*
Postponed (any reason)								
No	125	26.26	**13**	**16.67**	**112**	**28.14**	**4.43**	**0.04**
Yes	351	73.74	**65**	**83.33**	**286**	**71.86**		
Can't afford								
No	258	54.20	43	55.13	215	54.02	0.03	0.86
Yes	218	45.80	35	44.87	183	45.98		
No insurance								
No	286	60.08	52	66.67	234	58.79	1.69	0.19
Yes	190	39.92	26	33.33	164	41.21		
Work out on my own								
No	336	70.59	**46**	**58.97**	**290**	**72.86**	**6.06**	**0.01**
Yes	140	29.41	**32**	**41.03**	**108**	**27.14**		
Work out with family/friends								
No	366	76.89	**49**	**62.82**	**317**	**79.65**	**10.39**	**<0.01**
Yes	110	23.11	**29**	**37.18**	**81**	**20.35**		
Provider refused								
No	423	88.87	**57**	**73.08**	**366**	**91.96**	**23.50**	**<0.01**
Yes	53	11.13	**21**	**26.92**	**32**	**8.04**		
Don't trust they can help								
No	350	73.53	52	66.67	298	74.87	2.26	0.13
Yes	126	26.47	26	33.33	100	25.13		
Afraid of poor treatment								

	No	348	73.11	52	66.67	296	74.37	1.97	0.16
	Yes	128	26.89	26	33.33	102	25.63		
Embarrassed about issues									
	No	291	61.13	48	61.54	243	61.06	0.01	0.94
	Yes	185	38.87	30	38.46	155	38.94		
Prior negative experience									
	No	353	74.16	58	74.36	295	74.12	0.00	0.97
	Yes	123	25.84	20	25.64	103	25.88		

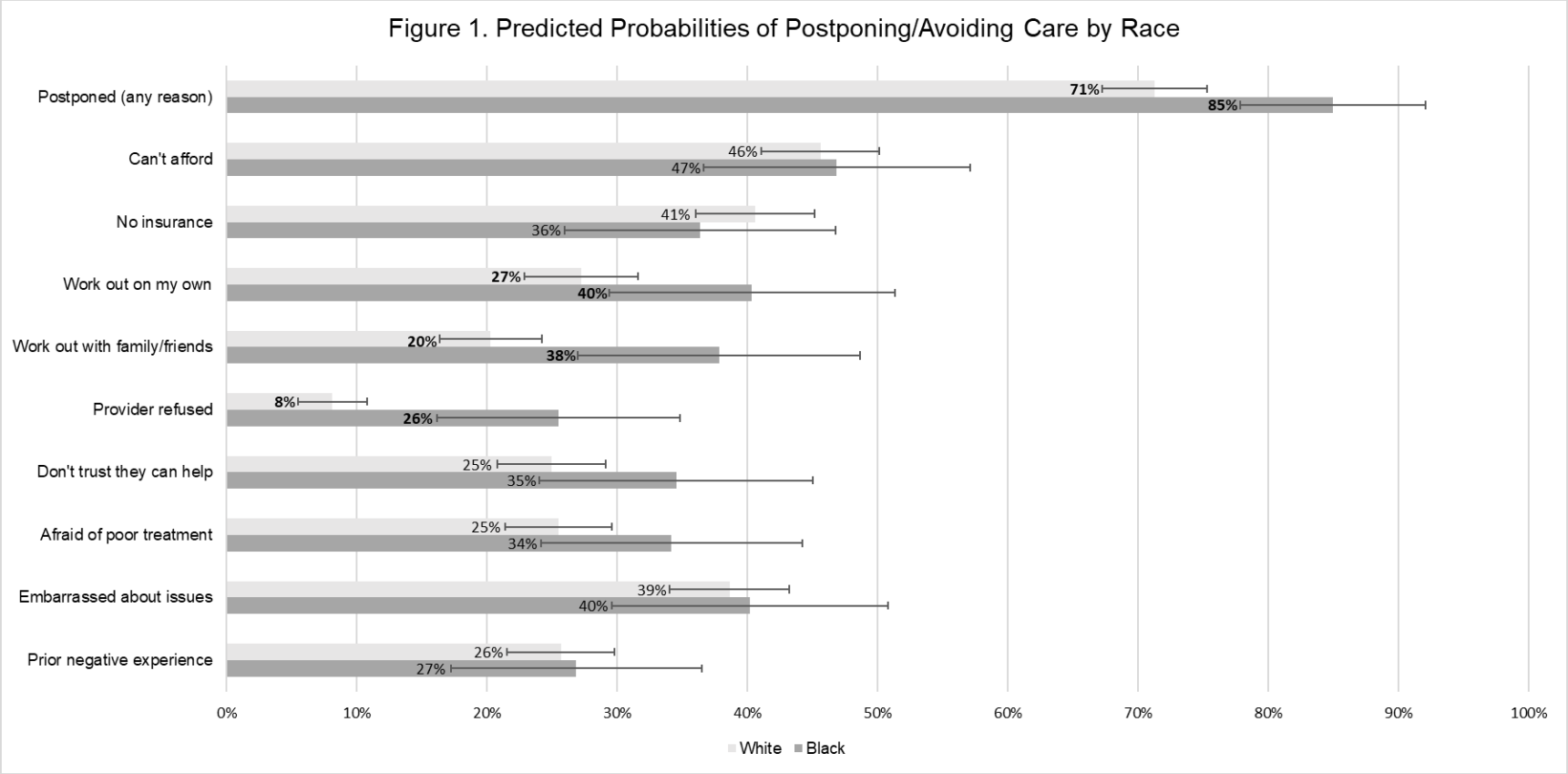
Abbreviations: M, mean; SD, standard deviation

Table 2. Odds of Postponing or Avoiding Care and Average Marginal Effects

	OR	CI	aOR[1]	CI	AME	CI
Postponed (any reason)						
White (ref)						
Black	**1.96**	**(1.04, 3.69)**	**2.69**	**(1.33, 5.41)**	**0.14**	**(0.05, 0.22)**
Can't afford						
White (ref)						
Black	0.96	(0.59, 1.56)	1.06	(0.62, 1.82)	0.01	(-0.10, 0.12)
No insurance						
White (ref)						
Black	0.71	(0.43, 1.19)	0.82	(0.47, 1.42)	-0.04	(-0.16, 0.07)
Work out on my own						
White (ref)						
Black	**1.87**	**(1.13, 3.09)**	**1.83**	**(1.09, 3.06)**	**0.13**	**(0.01, 0.25)**
Work out with family/friends						
White (ref)						
Black	**2.32**	**(1.38, 3.90)**	**2.46**	**(1.43, 4.23)**	**0.18**	**(0.06, 0.29)**
Provider refused						
White (ref)						
Black	**4.21**	**(2.27, 7.81)**	**4.20**	**(2.18, 8.08)**	**0.17**	**(0.08, 0.27)**
Don't trust they can help						
White (ref)						
Black	1.49	(0.88, 2.51)	1.62	(0.94, 2.81)	0.10	(-0.02, 0.21)
Afraid of poor treatment						
White (ref)						
Black	1.45	(0.86, 2.44)	1.59	(0.91, 2.80)	0.09	(-0.02, 0.20)
Embarrassed about issues						
White (ref)						
Black	0.98	(0.60, 1.61)	1.07	(0.63, 1.81)	0.02	(-0.10, 0.13)
Prior negative experience						
White (ref)						
Black	0.99	(0.57, 1.72)	1.07	(0.59, 1.93)	0.01	(-0.09, 0.12)

Abbreviations: OR, odds ratio (unadjusted); CI, 95% confidence interval; aOR, adjusted odds ratio; AME, average marginal effect

[1]Models adjusted for sex, income, education, age, and ever talked to a mental health provider.



Bolded percentages indicate significant Black-White differences at $p<0.05$.