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Sociodemographic Factors Contribute to Mental Health Disparities and Access to Services Among Young Men Who Have Sex with Men in New York City

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Abstract

Young men who have sex with men (YMSM) may be at increased risk for mental health problems including depression, post-traumatic stress (PTSD), and suicidality. The overriding goal of the current investigation was to examine mental health and mental health services in a diverse sample of YMSM. We analyzed cross-sectional data from a cohort study of 598 YMSM, including sociodemographics, mental health, and mental health care. We then tested for bivariate associations, and used multivariable modeling to predict depression, PTSD, suicidality and mental health care utilization. Lower socioeconomic status, unstable housing, and school non-enrollment predicted depression and PTSD scores, while unstable housing and school non-enrollment predicted recent suicide attempt(s). These recent suicide attempt(s) also predicted current utilization of counseling or treatment, any history of psychiatric hospitalization, and any history of psychiatric diagnosis. Black and API men were less likely to have ever accessed mental health counseling or treatment. There were significant class-based differences with regard to mental health outcomes, but not mental health services. Further, recent crises (i.e., suicide attempt, hospitalization) were strong predictors of accessing mental health services. Improving the mental health of YMSM requires addressing the underlying structural factors that influence mental health outcomes and service access.

Keywords

YMSM; Mental Health; Sociodemographics; Post-Traumatic Stress; Depression; Suicide

INTRODUCTION

While the majority of lesbian, gay, and bisexual (LGB) youth do not experience significant mental health problems, there is evidence that many experience heightened symptoms including depression, anxiety, and suicidality (Mustanski, Garofalo, & Emerson, 2010; Russell & Joyner, 2001). To date there are no epidemiological data on the mental health states of young men who have sex with men (YMSM) because large-scale, national data studies do not assess sexual orientation (Rhodes & Yee, 2008). However, community samples provide evidence that mental health disparities may be higher among LGB youth in general (Bontempo & D'Augelli, 2002; Mustanski, Garofalo, & Emerson, 2010), and young gay, bisexual, and other men who have sex with men in particular, than among their heterosexual peers (Mustanski, Garofalo, Herrick, et al., 2007).

Researchers have documented higher levels of depressive symptoms (Fergusson, Horwood, Ridder, et al., 2005; Salomon, Mimiaga, Husnik, et al., 2009; Skegg, Nada-Raja, Dickson, et al., 2003) anxiety disorders, and panic disorder (Gilman, Cochran, Mays, et al., 2001) among YMSM. While other investigations have demonstrated higher rates of sexual victimization and abuse among YMSM cohorts, as compared to heterosexual comparison groups (Herek, Gillis, Cogan, et al., 1997; Otis & Skinner, 1996), studies on post-traumatic stress disorder (PTSD) in the general population have yet to report evidence of a greater risk for the development of the disorder among YMSM, despite literature reporting higher rates of victimization among LGB youth (Cochran & Mays, 2008; D'Augelli, Grossman, & Starks, 2006). These heightened rates of victimization underscore the need to better delineate those factors associated with PTSD symptoms among YMSM.

There is also evidence for heightened risk for suicide among YMSM. According to the U.S. Surgeon General's Report on Suicide (U.S. Department of Health and Human Services [USDHHS], 2001) sexual minority youth demonstrated higher rates of suicide than their respective age group in the general population. Prevalence of prior suicide attempts among LGB youth range from 20–40%, with higher rates among subpopulations of high risk youth (e.g., homeless, survivors of violence) (D'Augelli, Hersherberger, & Pilkington, 2001; Remafedi, Farrow, & Deisher, 1991; Rotheram-Borus, Rosario, & Koopman, 1991). This is compared to the four percent of heterosexually identified men who reported a previous suicide attempt in the National Health and Nutrition Examination Survey (NHANES) (Cochran & Mays, 2000). Numerous studies have corroborated these findings, finding more suicide attempts in both YMSM and adult samples of MSM (Fergusson, Horwood, Ridder, et al., 2005; Garofalo, Wolk, Wissow, et al., 1999; Gilman, Cochran, Mays, et al., 2001; Remafedi, 2008; Skegg, Nada-Raja, Dickson, et al., 2003).

Although the pathways leading to heightened rates of psychiatric disorders among YMSM have yet to be clearly delineated, researchers postulate that social determinants such as structural discrimination (Collins, 1999; Gee, 2002; Mays & Cochran, 2001) and minority stress (Meyer, 2003) may help to explain these patterns. The challenges of developing a positive identity and sense of self for all adolescents is challenging, and can be especially problematic for YMSM who face externalized and internalized homophobia (Remafedi, 2008), or stigmas, rejections, and isolation imposed by families, friends, schools, racial or ethnic groups, and religious communities (D'Augelli, 1998; D'Augelli, Hersherberger, & Pilkington, 1998). As young gay and bisexual men experience a variety of differing social adversities and life events, it is likely that the observed disparities and mental health morbidities are a result of multiple factors (Cochran & Mays, 2008). A fundamental cause explanation would suggest that the stigma of being from a sexual minority group in and of itself could explain these disparities (Link & Phelan, 2001).

Sociodemographic Factors Associated with Mental Health Disparities

From a social determinants of health perspective (Marmot & Wilkinson, 2000), a number of fundamental causes have been associated with mental health problems among the general population, and plausibly have the same impact on YMSM vis-à-vis social resources and capital. For example, socioeconomic status (SES) and associated conditions may predispose one to mental burden, and concomitantly, existing psychiatric illness may cause economic hardship (thus impacting an individual's SES; Hudson, 2005). Previous research has found that among low-SES youth, parental history of incarceration, substance abuse, or mental health problems are shown to be common experiences, and as such are predictors of mental health disparities and behavioral problems (Buckner, Bassuk, Weinreb, et al., 1999). Such conditions would compound psychiatric comorbidities for YMSM, given the aforementioned risk factors. Housing stability, or lack thereof, has also been associated with mental health problems both in general populations (Folsom, Hawthorne, Lindamer, et al.,

2005), among youth (Buckner, et al., 1999; Masten, Miliotis, Graham-Bermann, et al., 1993; Wood, Halfon, Scarlata, et al., 1993), and among LGB youth (Clatts, Goldsamt, & Gwadz, 2005). Additionally, housing instability may increase the risk of incarceration (Greenberg & Rosenhack, 2008) which could further marginalize youth as it has implications for employment, housing, education, and social connectedness.

Arrest and incarceration have a complex relationship with mental health, where arrest may not be predictive of mental health problems, but may be a result of an undiagnosed mental health problem (James & Glaze, 2006). Mental health service utilization is uneven across racial/ethnic lines, with White youth having more access to hospitalization and health care, and African American youth entering the juvenile justice system (Atkins, Pumariega, Rogers, et al., 1999; Bishop, 2005). Recent National Health Behavior Survey (NHBS) data indicate that among MSM, Black men report higher arrest rates than White MSM (Lim, Sullivan, Salazar, et al., 2001). Individuals who fall through the cracks of mental health services or are unable to access these services may instead route through the criminal justice system by way of arrest; further the criminal justice system is under-equipped to address underlying mental health problems (Rawal, Romansky, Jenuwine, et al., 2004). Incarcerated youth, or youth who have encountered the criminal justice system, tend to exhibit higher rates of mental illness (Atkins et al., 1999; Fisher, Simon, Roy-Bujnowski, et al., 2011; Otto, Greenstein, Johnson, et al., 1992). Racial/ethnic minority youth experience disproportionality higher rates of arrest (Bishop, 2005; Fisher et al., 2011), suggestive of further structural discrimination and marginalization.

There are also documented racial/ethnic disparities in mental health in the United States' general population. According to the Surgeon General's Supplement on Mental Health (USDHHS, 2001) the prevalence of mental health disorders among community-dwelling individuals is comparable between racial/ethnic minorities and Whites. However, this finding does not apply to the vulnerable, high-need subgroups such as individuals who are homeless, incarcerated, or institutionalized where racial/ethnic minorities are overrepresented (USDHHS, 2001). Stress associated with racism and discrimination has also been linked to poorer mental health outcomes among racial/ethnic minorities (Williams, Yu, Jackson, et al., 1997). Finally, minority groups have less access to mental health care, are less likely to receive this care, and receive poorer quality of mental health care (USDHHS, 2001). Research assessing the mental health disparities among subsamples of racial/ethnic minority YMSM has yet to be conducted.

Mental Health Service Utilization Among YMSM

Just as men who have sex with men experience higher rates of mental health problems than their heterosexual counterparts (Gilman et al., 2001; Hatzenbuehler, 2009; Meyer, 2003; Sandfort, Graaf, Bijl, et al., 2001), it appears that they may also be more likely to seek diagnosis, treatment and care, than heterosexuals (Cochran et al., 2003). However, Salomon et al. (2009), found that YMSM were less likely to utilize services than adult MSM, even though they experience higher prevalence of depressive symptoms, substance use, and sexual risk. Seeking mental health care services may be of particular difficulty for YMSM due to the fear of discussing sexuality openly with doctors (Allen, Glick, Beach, et al., 1998) or based on perception of a lack of LGBT friendly medical services (East & Rayess, 1998; Stoddard, Leibowitz, Ton, et al., 2011). Mental health care for YMSM could also be limited due to high uninsurance rates among young adults in the United States (Callahan & Cooper, 2005). In one study of YMSM, 22% of participants reported having no health insurance and 12% perceived having no connection to any health care if sick or in need of health advice; 21% of this sample also showed signs of depression and 10% had seriously considered suicide (Kipke, Kubiczek, Weiss, et al., 2007).

Current Study

There currently is no evidence to suggest that the abovementioned sociodemographic factors that are often associated with mental illness among the larger population would not also be associated with mental illness among YMSM. In fact, we believe that these socially determined fundamental causes inextricably interact with and exacerbate those factors associated with mental health burden among YMSM (i.e., homophobia, discrimination, stress, etc.). For example, a young gay or bisexual man who is rejected by his family must not only contend with the discrimination and alienation from his primary support system, his family, but must also deal with the potential homelessness, instability, and lack of financial resources that result. Thus, social and structural factors likely compound the already elevated rates of mental illness among YMSM. Given these assertions the current investigation sought to 1) describe the prevalence of mental health burden among a large racially and ethnically diverse sample of YMSM; 2) compare differences in mental health by race/ethnicity, SES, and sexual identity within the YMSM sample, and 3) describe the differences in access and utilization of mental health services within the YMSM sample.

METHODS

Study design

Project 18 is a longitudinal cohort study of adolescent YMSM in New York City, ages 18–19. Full study design including participant recruitment procedure is described in detail elsewhere (Halkitis, Moeller, Siconolfi, et al., 2012). Eligibility criteria included being 18–19 years old, biologically male, sexually active with other men, New York City area residence, and a self-reported HIV-negative or unknown HIV status. Our baseline analytic sample consisted of 598 YMSM. All study procedures were approved by New York University's Independent Review Board and were protected by a Certificate of Confidentiality from the National Institutes of Health.

Data collection and measures

Audio computer-assisted self-interview (ACASI) software was used to collect all demographic, psychosocial, and mental health care data to reduce biases associated with reading ability, recall error, and socially desirable responses.

Sociodemographics—Sociodemographic measures included race/ethnicity (collapsed to Hispanic/Latino, Black, Asian-Pacific Islander [API], White, and mixed/other), perceived socioeconomic status (collapsed from lower, lower-middle, middle, upper-middle, upper to lower, middle, upper), sexual orientation (indicated on the 6-point Kinsey scale (Kinsey, Pomeroy, & Martin, 1948) and collapsed to “exclusively homosexual” or “not exclusively homosexual,” current educational enrollment, lifetime history of arrest, and housing status (based on the work of Aidala et al., 2005), collapsed to “stably housed” or “unstably housed.”

Mental health—Depression was measured using the 21-item Beck Depression Inventory, second edition (Beck, Steer, & Brown, 1996). In our study the inventory demonstrated high internal consistency reliability ($\alpha = .91$). Post-traumatic stress was measured using a 10-item scale (e.g. “In the past week, have you been avoiding things, places, or upsetting thoughts associated with the trauma?”) with responses on a 5-point Likert ranging from “not at all” to “extremely.” In the current study this measure demonstrated high internal consistency reliability ($\alpha = .88$). Finally, participants were asked if they had attempted suicide in the prior 12 months.

Mental health care—Participants indicated which mental health services they had engaged with using dichotomous yes/no responses. Variables included any lifetime history of counseling or psychotherapy, currently being in any counseling or psychotherapy, any lifetime history of hospitalization for a mental disorder, and any lifetime history of being diagnosed with a mental disorder.

Analytic plan—The sample was described using descriptive analyses. We examined bivariate associations between sociodemographics and mental health, and between sociodemographic variables and mental health care using chi-square tests and analysis of variance (ANOVAs). Multivariable modeling was used to predict mental health states and mental health care utilization among the YMSM. For the linear regressions predicting PTSD and depression, and the binary logistic regression predicting previous suicide attempt, all sociodemographic variables were entered in a single block. Finally, for the binary logistic regressions predicting mental health care utilization, sociodemographic variables were entered in the first block, and mental health states were entered in the second block.

RESULTS

Sample Characteristics

Our sample consisted of 598 YMSM who were either 18 or 19 years old at the time of assessment. Table 1 illustrates the demographics of the sample. The majority of participants (85.6%, $n = 512$) were currently enrolled in school, with Asian/Pacific Islander and White YMSM having the highest rate of enrollment and Black YMSM having the lowest rate. In addition, about one-seventh (15.7%, $n = 94$) of the YMSM reported that they had previously been arrested, with Black and Hispanic/Latino men indicating the highest prevalence of arrest history. The majority of the sample (94.8%, $n = 562$) reported that they were stably housed, with Black YMSM indicating the highest rate of unstable housing.

Just under half of the YMSM (41.5%, $n = 248$) identified as exclusively homosexual with White YMSM being most likely to identify as such. Conversely, Asian/Pacific Islander and Black identified YMSM were least likely to endorse this identity. Finally, perceived familial SES was split fairly evenly across upper (29.4%, $n = 176$), middle (37.1%, $n = 222$), and lower (33.4%, $n = 200$) strata. White and Asian/Pacific Islander YMSM were the most likely to report upper SES, while Black and Hispanic/Latino were the most likely to report lower SES.

Mental Health

Table 2 illustrates that there were no significant differences found among racial/ethnic categories with respect to the mental health measures: depression total scores ($M = 9.95$, $SD = 8.79$) and PTSD total scores ($M = 6.85$, $SD = 7.07$). Notably, five percent ($n = 30$) of the YMSM in the sample reported that they had attempted suicide in the past year.

Mental Health Care Utilization

Rates of mental health service utilization are presented by race/ethnicity in Table 2. Half of the participants (51.0%, $n = 305$) had received counseling or psychotherapy at some point in their life. White YMSM were the most likely to have ever been in counseling/psychotherapy, while Asian/Pacific Islander and Black YMSM were the least likely to have ever engaged with these services. Approximately one-tenth (10.7%, $n = 64$) reported that they were currently in counseling or psychotherapy, with Hispanic/Latino YMSM being the most likely to report current engagement. Moreover, (4.5%, $n = 27$) reported that they had previously been hospitalized as the result of a mental disorder with Asian/Pacific Islander YMSM, followed by Hispanic/Latino YMSM, reporting the highest rates of psychiatric

hospitalization. Finally, about one-tenth (11.9%, $n = 71$) of the YMSM had previously been diagnosed with a mental disorder, with White YMSM most likely to report any diagnosis and Asian/Pacific Islander YMSM the least likely.

Multivariable Modeling of Mental Health

We developed and tested separate multivariable linear regression models to explain each of the mental health symptoms based on sociodemographic factors. For each of the models, all demographic variables were entered in a single block: race/ethnicity (White as criterion group), sexual orientation, SES (lower SES as criterion group), housing status, history of arrest, and school enrollment. For the model predicting any suicide attempt, we tested a binary logistic regression model with the same entry of variables. Regression results are detailed in Table 3.

With regard to depression, the model fit ($F(10, 582) = 5.00, p < .001, R^2 = 8.0\%$) with middle ($B = -3.05, p < .001$) and upper SES ($B = -3.43, p < .001$) predicting lower depression, and unstable housing ($B = 4.89, p < .01$) and school non-enrollment ($B = 2.99, p < .01$) predicting higher depression. The model for PTSD also fit ($F(10, 582) = 5.30, p < .001, R^2 = 8.0\%$) with unstable housing ($B = 4.92, p < .001$) and history of arrest ($B = 1.86, p = .03$) predicting higher scores, and middle ($B = -1.69, p = .01$) and upper SES ($B = -2.69, p = .001$) predicting lower PTSD scores. Finally, the model predicting any suicide attempts in the prior 12 months fit ($\chi^2(10) = 19.13, p = .04$; Nagelkerke $R^2 = 9.6\%$), with school non-enrollment ($B = 3.30, p = .01$) and unstable housing ($B = 3.45, p = .04$) predicting any recent attempt.

Models of Mental Health Care Utilization

We also tested the fit of binary logistic regressions models examining mental health care utilization. For these models, we entered predictors in two blocks -- all demographic variables were entered in the first block, and all mental health scores in the second block. These regression results are presented in table 4.

The model predicting any mental health counseling or treatment in the lifetime fit in two steps ($\chi^2(13) = 67.66, p < .001$; Nagelkerke $R^2 = 14.4\%$), with the second block improving the fit ($\chi^2(3) = 35.85, p < .001$). Black ($OR = 0.45, p = .01$) and Asian ($OR = 0.14, p < .001$) men were less likely than White men to have ever received counseling or treatment, as were men with higher depression scores ($OR = 1.04, p = .01$).

The model explaining current counseling or treatment fit in 2 steps ($\chi^2(13) = 51.86, p < .001$; Nagelkerke $R^2 = 16.9\%$), and the second block improved fit ($\chi^2(3) = 34.06, p < .001$) and men with a recent suicide attempt ($OR = 3.19, p = .02$) and depression scores ($OR = 1.05, p = .02$) were more likely to be in treatment.

The model predicting any hospitalization for a mental disorder in the lifetime also fit in 2 steps ($\chi^2(13) = 29.75, p = .01$; Nagelkerke $R^2 = 16.2\%$) and the second block improved fit ($\chi^2(3) = 15.75, p = .001$) with a recent suicide attempt ($OR = 3.68, p = .04$) and tangentially, higher PTSD scores ($OR = 1.07, p = .06$) predicting hospitalization.

Finally, the model predicting any diagnosis of a mental disorder fit in 2 steps ($\chi^2(13) = 35.13, p = .001$; Nagelkerke $R^2 = 11.2\%$) and the second block improved fit ($\chi^2(3) = 24.07, p < .001$), with recent suicide attempt ($OR = 3.03, p = .02$) and tangentially, high SES ($OR = 2.09, p = .05$), predicting any diagnosis.

DISCUSSION

We sought to delineate the mental health experiences of emerging adult YMSM in NYC using the baseline data of a prospective cohort study. The current analyses indicate a clear association between socioeconomic status (SES) and multiple mental health problems including depression and PTSD. As has previously been suggested (Meyer, 2003; Storholm, Halkitis, & Kupprat, et al., 2012), belonging to multiple marginalized identity groups is associated with increased risk for mental illness in an additive way. Within this YMSM sample, the effect of SES appears to trump other minority status categories (e.g., race) in its association with psychopathology. Previous work has shown the impact of race/ethnicity on mental health, but we posit that SES confounds the association between race/ethnicity and mental health; as we have shown here, when controlling for SES, race/ethnicity fails to achieve significance in predicting mental health problems. We do, however, acknowledge that the men of color in our study were more likely to be of lower SES than those white YMSM. The impact of socioeconomic conditions is further supported by our finding that unstably housed YMSM, as well as those not enrolled in school, are at greater risk for depression, PTSD, and suicide attempts.

Further to the point of social resources, recent PTSD symptoms were associated with a history of arrest. While there is a paucity of work examining arrest among gay and bisexual men, Kurtz (2008) found that a history of physical abuse, history of abuse as a child, and severe mental distress (depression, anxiety, and traumatic stress) were bivariate predictors of arrest history. Kurtz aligns these findings with syndemics theory, and posits that this cluster of arrest factors indicate a lack of social capital among these men.

Differences also emerged with regard to mental health services. When we controlled for mental health symptoms among the YMSM in the current study, we found that Black and Asian men were less likely than White YMSM to have ever been in counseling or psychotherapy, and that higher SES was a predictor of having ever received a mental health diagnosis. This further supports the notion that mental health services are more accessible, economically or culturally, to White, middle and upper SES youth. These findings complement the effects of social resources noted with regard to mental health problems indicated earlier.

For YMSM, access to mental health services may also be associated with crisis. In our analyses we found that recent suicide attempts were the strongest predictor of mental health hospitalization and current counseling or psychotherapy services. While we cannot establish temporality with the present data, it may be that some YMSM access these services following a crisis (i.e., suicide attempt), or that these YMSM remain vulnerable to self-harm despite present access to care. Much has been written about suicide in gay, bisexual and other YMSM (Fergusson et al., 2005; Garofalo et al., 1999; Gilman et al., 2001; Remafedi, 2008; Skegg et al., 2003). The 5% prevalence of recent (12 month) suicide attempts is comparable to the 4.7% in a similar study of YMSM (Remafedi, 2002); however, this number is strikingly higher than the 2% prevalence of recent suicide attempts among 18–24 year old males (Meehan, Lamb, Saltzman, et al., 1992).

Over the last thirty years, the HIV/AIDS epidemic has demanded full priority in the gay men's health agenda, often at the expense of more holistic promotion of overall health (Halkitis et al., 2012). Our findings demonstrate that YMSM of low-income and racial/ethnic minority backgrounds, those disproportionately affected by HIV/AIDS, also carry the greater mental health burden and are also the least likely to receive counseling and mental health services. The increasing economic inequality in the American society appears to mirror existing inequalities and serves to further exacerbate mental health problems. The

current mental health disparities within this population of YMSM can be explained by past research initiatives that demonstrate the impact of structural inequality, and the link with poor health outcomes (mental, physical, violence, mortality) for racial/ethnic minorities (Collins, 1999; Gee, 2002; Hart, Kunitz, Sell, et al., 1998).

The effects of structural discrimination also extended to sexual minorities as homophobia and stigma related to sexual minority status is linked to negative mental health outcomes (Hatzenbuehler, 2009; Mays & Cochran, 2001). Indeed, from a social determinants of health perspective, it is generally not one's health that determines their social location; rather it is one's social location that determines their health (Marmot & Wilkinson, 2000). Without policy changes that support and affirm equal opportunity and seek to eliminate or reduce discrimination, YMSM will likely continue to shoulder excess mental health burden, including depression and other mental health disparities. The current analysis demonstrates that not being enrolled in school had an adverse impact on YMSM. This finding speaks to the need for gay/straight alliances and other in-school interventions that seek to reduce the number of YMSM who leave school prematurely. This is particularly relevant, as bullying and attacks in schools, media, and political arenas continue.

The evidence is clear: structural discrimination constrains the health, opportunities, and resources of groups of socially stigmatized individuals (Link & Phelan, 2001). Hatzenbuehler, Keyes, and Hasin (2009) found that LGB individuals living in states that did not have protective policy surrounding sexual and gender identity (measured by existence, or lack, of hate crimes and worker anti-discrimination laws) had increased prevalence of multiple psychiatric disorders when compared to LGB individuals living in states with protective policies, and compared to non-LGB individuals regardless of the states social policy. Hatzenbuehler et al. (2010) established over a 30% increase in the prevalence of mood disorders among LGB peoples living in states where anti-gay marriage amendments had been passed into law, when compared to LGB populations living in states without such amendments (which demonstrated a 20% reduction in mood disorders), or when compared to heterosexual populations in any state.

Limitations

The data for our analyses were drawn from the baseline assessment of a cohort study and thus causality cannot be inferred. However, we have indicated a number of strongly significant, consistent findings with regard to sociodemographics, mental health problems and services. Data were self-reported and subject to social desirability bias, though the use of ACASI has been shown to increase reporting of sensitive behaviors and reduce reading and reporting bias (Gribble, Miller, Rogers, et al., 1999; Kurth, Martin, Golden, et al., 2004; Tourangeau & Smith, 1996; Turner, Forsyth, O'Reilly, et al., 1998). It is still possible that participants underreported mental health symptomology, or sensitive behaviors such as suicide attempts, due to perceived stigma or concerns about mandated reporting. Along these lines, mental health data were self-reported and did not reflect clinical diagnoses. Still, our measures are robust, highly respected, and utilized often for research purposes, thus increasing our confidence in the findings.

Finally, our non-random sampling may limit generalizability; however, targeted sampling can be used to gather a robust sample when studying hidden populations (Watters & Biernacki, 1989). Though we utilized active and passive targeted community recruitment, participants self-selected to participate. This method, complemented by the racial and economic diversity of our sample, enhances the external validity of our study.

Conclusions

YMSM live in a generally homophobic culture and also must contend with racial, ethnic, and class discrimination as well. As such they are presented with a multitude of stressors that detrimentally affect mental health. Studies of Black LGB populations have shown that the combined impacts of homophobia and racial discrimination increase prevalence of psychological distress (Krieger, 1999). Further, research has also shown that combined impacts of homophobia, poverty and racism are associated with increased psychological distress among gay and bisexual Latino men (Diaz, Ayala, Bein, et al., 2001). Further, it is these YMSM of color that are least likely to receive mental health services as they often lack the resources to do so. Facilitating access to quality mental health care by reducing barriers and increasing uptake may help foster resilience and provide a buffer for the stressors that YMSM face.

We also contend that much of the social and structural change that is needed requires psychologists to step outside of their more traditional clinical roles and engage more broadly with other systems (e.g., housing systems, social assistance) when working with YMSM, and more broadly, to act as advocates for social policy change. As clinicians, we need policy changes that promote holistic approaches to the overall health care (mental, physical, and sexual) of all YMSM. Central in this holistic approach is the consideration and incorporation of the context (i.e., class, culture, families) in which the individual is nested.

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Table 1

Demographic variables by race/ethnicity (N=598).

	Race/ethnicity					Total n = 598 % (n)
	Hispanic/Latino n = 229 % (n)	Black n = 89 % (n)	Asian/Pacific Islander n = 29 % (n)	Mixed Race/Other n = 78 % (n)	White n = 173 % (n)	
School enrollment ***						
Yes	81.2 (186)	76.4 (68)	100.0 (29)	84.6 (66)	94.2 (163)	85.6 (512)
No	18.8 (43)	23.6 (21)	0.0 (0)	15.4 (12)	5.8 (10)	14.4 (86)
History of arrest *						
Yes	18.8 (43)	21.3 (19)	6.9 (2)	16.7 (13)	9.8 (17)	15.7 (94)
No	81.2 (186)	78.7 (70)	93.1 (27)	83.3 (65)	90.2 (156)	84.3 (504)
Current housing status *						
Stable	94.3 (211)	90.9 (80)	96.6 (28)	93.5 (72)	98.8 (171)	94.8 (562)
Unstable	6.6 (15)	9.1 (8)	3.4 (1)	6.5 (5)	6.5 (5)	5.2 (31)
Sexual orientation						
Exclusively homosexual	40.6 (93)	34.8 (31)	34.5 (10)	38.5 (30)	48.6 (84)	41.5 (248)
Not exclusively homosexual	59.4 (136)	65.2 (58)	65.5 (19)	61.5 (48)	51.4 (89)	51.4 (350)
Perceived SES ***						
Upper	17.0 (39)	12.4 (11)	41.4 (12)	29.5 (23)	52.6 (91)	29.4 (176)
Middle	41.9 (96)	33.7 (30)	37.9 (11)	35.9 (28)	32.9 (57)	37.1 (222)
Lower	41.0 (94)	53.9 (48)	20.7 (6)	34.6 (27)	14.5 (25)	33.4 (200)

* p .05,

** p .01,

*** p .001

Table 2

Mental health and mental health care utilization variables by race/ethnicity (N= 598).

	Hispanic/Latino n = 229 % (n)	Black n = 89 % (n)	Asian/Pacific Islander n = 29 % (n)	Mixed/Other n = 78 % (n)	White n = 173 % (n)	Total n = 598 % (n)
Ever Been in Counseling/Psychotherapy***	52.0 (119)	40.4 (36)	17.2 (5)	53.8 (42)	59.5 (103)	51.0 (305)
Currently in Counseling/Psychotherapy*	14.8 (34)	4.5 (4)	3.4 (1)	6.4 (5)	11.6 (20)	10.7 (64)
Ever Been Hospitalized as the Result of a Mental Disorder	5.7 (13)	2.2 (2)	6.9 (2)	3.8 (3)	4.0 (7)	4.5 (27)
Ever Been Diagnosed with a Mental Disorder	11.4 (26)	6.7 (6)	3.4 (1)	12.8 (10)	16.2 (28)	11.9 (71)
Any Suicide Attempt (12 mo.)	5.7 (13)	4.5 (4)	0.0 (0)	7.7 (6)	4.0 (7)	5.0 (30)
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
Depression Total Score	10.6 (9.5)	10.0 (9.4)	8.24 (7.7)	10.4 (8.0)	9.2 (7.9)	10.0 (8.8)
PTSD Total Score	7.3 (7.5)	6.8 (7.6)	5.0 (4.8)	8.1 (7.9)	6.1 (5.9)	6.9 (7.1)

* p .05,

**

p .01,

p .001

Table 3

Measures of mental health (N =598).

	Mental health measure					
	Depression		PTSD		Any suicide attempt (12 mo.)	
	B	SE	B	SE	OR	95% CI
Race/ethnicity						
White					1.00	
Black	-1.81	1.20	-1.20	0.97	0.60	0.16, 2.27
Latino	-0.43	0.92	-0.33	0.75	0.90	0.33, 2.43
API	-1.14	1.71	-1.29	1.38	0.00	0.00
Mixed	-0.14	1.19	0.88	0.96	1.30	0.40, 4.23
SES						
Lower					1.00	
Middle	-3.05 ***	0.85	-1.69 *	0.68	1.00	0.43, 2.31
Upper	-3.43 ***	0.95	-2.69 ***	0.77	0.46	0.15, 1.40
Unstably housed	4.89 **	1.62	4.92 ***	1.30	3.45 *	1.09, 10.91
History of arrest	1.81	1.03	1.86 *	.83	0.53	0.18, 1.63
Non-enrollment	2.99 **	1.08	1.83 *	0.87	3.30 *	1.32, 8.25
Exclusively gay	-0.78	0.72	-0.04	0.58	0.64	0.28, 1.42

[†]White and Lower SES are the criteria groups

* p < .05,

** p < .01,

*** p < .001

Table 4

Mental health care utilization (N = 598).

	Mental Health Service					
	Ever counseling/treatment		Currently in counseling/treatment		Ever hospitalized for mental health	
	OR	95% CI	OR	95% CI	OR	95% CI
Race/ethnicity						
White [‡]	1.00		1.00		1.00	
Black	0.45**	0.25, 0.80	0.40	0.12, 1.34	0.42	0.07, 2.63
Latino	0.70	0.45, 1.09	1.34	0.68, 2.65	1.25	0.41, 3.82
API	0.14***	0.05, 0.39	0.33	0.04, 2.63	2.43	0.45, 13.04
Mixed	0.71	0.40, 1.26	0.46	0.15, 1.36	0.67	0.14, 3.16
SES						
Lower [‡]	1.00		1.00		1.00	
Middle	1.02	0.70, 1.55	1.86	0.93, 3.72	0.59	0.19, 1.86
Upper	1.13	0.70, 1.81	1.52	0.68, 3.40	1.84	0.63, 5.33
Unstably housed	1.91	0.81, 4.49	1.17	0.37, 3.64	1.90	0.49, 7.40
History of arrest	1.10	0.66, 1.83	1.28	0.59, 2.81	0.53	0.14, 1.99
Non-enrollment	0.59	0.34, 1.01	0.47	0.18, 1.24	2.21	0.72, 6.84
Exclusively gay	1.18	0.83, 1.68	1.26	0.71, 2.22	1.06	0.45, 2.52
PTSD	1.03	0.99, 1.07	1.04	0.99, 1.09	1.07	1.00, 1.14
Depression	1.04**	1.02, 1.08	1.05*	1.01, 1.09	1.01	0.95, 1.07
Any suicide attempt (12 mo.)	1.43	0.58, 3.49	3.19*	1.26, 8.09	3.68*	1.05, 12.89

[‡]White and Lower SES are the criteria groups

* p < .05,

** p < .01,

*** p < .001