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Mental Health Care Utilization and Unmet Needs for Health Care Among Lesbian and Bisexual Chinese-, Korean-, and Vietnamese-American Women

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Abstract

The extent to which sexual orientation is associated with receipt of mental health care, adequate mental health treatment, and unmet health care among Asian-American women is unknown. This study examined a relatively large sample of Chinese-, Korean-, and Vietnamese-American women ($n=701$) using Computer-Assisted Self-Interviews (CASI). After controlling for mental health status and other covariates, sexual minority women were more likely to have received any mental health services but still reported a greater unmet need for health care than their exclusively heterosexual counterparts. Among those who received mental health treatment, sexual minorities were no more likely to have received minimally adequate care. Given the high rates of mental health problems in Asian-American sexual minority women, efforts are needed to identify and overcome barriers to adequate mental health care and to minimize unmet health care needs.

Introduction

Meyer's minority stress model suggests that a dual minority status (i.e., race/ethnicity and sexual orientation) generates greater psychological vulnerability (1). Lee and Hahm demonstrated that Chinese-, Korean-, and Vietnamese-American lesbian and bisexual women have a greater likelihood of lifetime suicidal ideation, suicide attempt, and substance

Disclosures

The authors have nothing to disclose.

*Supplementary data associated with this article can be found in the online version.

use compared to their exclusively heterosexual counterparts (2). This finding calls for more attention to their mental health and health care needs; one study showed that Asian-Americans with depression have a lower rate of mental health treatment in the past 12 months compared to any other race (3). However, no prior studies have investigated the associations between sexual orientation and receipt of mental health care, adequate mental health treatment, and unmet health care needs among Chinese-, Korean-, and Vietnamese-American women. Despite an increased awareness of the importance of LGBT-affirmative service providers, mental health professionals often exhibit homo-negative attitudes or have little training in working with LGBT clients (4). LGBT individuals report being denied services, being discouraged from broaching sexuality and gender issues, and feeling isolated in treatment settings (5). Prejudicial behaviors and attitudes of mental health practitioners may predict premature termination of treatment among LGBT clients (6). Furthermore, sexual minority women encounter more barriers to receipt of medical services than heterosexual women. For Chinese-, Korean-, and Vietnamese-American sexual minority women, their multiple minority status and the stigma exacerbated by cultural norms may further hinder them from seeking needed medical care.

We hypothesize that, compared to their exclusively heterosexual counterparts, Chinese-, Korean-, and Vietnamese-American lesbian and bisexual women are less likely to report receipt of any mental health care, less likely to report receipt of minimally adequate mental health care once care is initiated, and more likely to report unmet needs for health care.

Methods

While the mental health status of first generation Asian immigrants is relatively well documented, we know little about whether the children of Asian immigrants have similar health statuses or health behaviors. The Asian Women's Health Initiative Project (AWSHIP) is the first study to investigate the mental health, sexual health, and sexual orientation of daughters of Chinese, Korean, and Vietnamese immigrants. The design of AWSHIP is detailed elsewhere (2). We surveyed 701 Chinese-, Korean-, and Vietnamese-American women in the Greater Boston area in 2010 using a convenience sampling strategy, recruiting participants through social media, group emails, and community outreach. The recruited sample was composed of a mix of 1.5 generation (immigrated before adolescence) and 2nd generation immigrants (children of immigrants) and was diverse in socioeconomic status. To be eligible, participants had to be: unmarried, aged 18 to 35 years, Chinese-American, Vietnamese-American, Korean-American or a combination thereof, and residing in Massachusetts. Since we were particularly interested in understanding sexual risk behaviors, we included single women only, as they are more likely to have more sexual partners than married women (7). Among 804 women who were screened, 2% ($n=17$) were ineligible and 10% ($n=83$) were lost to follow-up. Women who selected "not sexually attracted to men or women" ($n=2$), or "I don't know" ($n=1$) for the sexual orientation question were excluded from analyses, resulting in a sample of 701 women.

Ten community agencies and eight universities facilitated recruitment and provided space to conduct Computer-Assisted Self-Interviews (CASI). Surveys and consent forms were offered in English, Chinese, Korean, and Vietnamese, and outreach workers and interviewers

were bilingual. Twelve translators and back-translators conducted the multilingual CASI. The survey took 45 to 60 minutes to complete and \$20 compensation was provided for participants. Boston University's Institutional Review Board approved all protocols and procedures. We measured sexual orientation based on one of seven self-identified descriptions: exclusively heterosexual; mostly heterosexual; bisexual; mostly homosexual; homosexual or gay; asexual; or "I don't know." Those who identified as mostly heterosexual, bisexual, mostly homosexual, or homosexual were coded as 1 ("lesbian or bisexual") and those who identified as exclusively heterosexual were coded as 0. Those who identified as asexual or those who responded "I don't know" were excluded from analysis. This dichotomous conceptualization of sexual orientation was used in a prior study (2).

For dependent variables, receipt of any outpatient mental health care was assessed by the question, "How many times have you been treated for any psychological or emotional problem in outpatient counseling in the past year?" Answers were dichotomized as *none* or *any*. Minimally adequate care was measured by a positive response to either "Have you had at least eight outpatient mental health visits in the last year?" or "Have you had at least four outpatient mental health visits in the last year?", consistent with evidence-based treatment guidelines (8). Asian-Americans have low retention rates in mental health care (9); therefore, we included having at least four outpatient mental health visits as an additional measure of minimally adequate care. Unmet need for medical care was determined by a positive response to "Has there been any time in the past 12 months when you thought you should get medical care, but you did not?"

The following covariates were measured: insurance status (0=no insurance, 1=public or private insurance); age (0=18–27, 1=28–35); education (low=high school diploma or less, medium=some college or college degree, high=graduate school or higher); birthplace (U.S. born or foreign born); and ethnicity (Chinese-American, Korean-American, Vietnamese-American, and mixed among these three groups). Perceived physical health was measured by self-report; scores ranged from 1 (poor) to 5 (excellent). We dichotomized this variable as "poor or fair" (1) and "good, very good, or excellent" (0). Using multivariate regression models, we estimated the association between sexual identity and health care utilization controlling for ethnicity, age, education level, birthplace, insurance status, perceived physical health, and mental health indicators (Table 1).

Results

Our sample was composed of 701 women aged 18 to 35 years (mean, 23; SD, 3) who were Chinese-American (52%), Korean-American (19%), Vietnamese-American (19%), or a mix of these ethnicities (7%). Eighteen percent self-identified as lesbian or bisexual (n=129). Eighty five percent of our sample was enrolled in college or graduated from college. In unadjusted comparisons, sexual minority women reported a higher proportion of receiving outpatient mental health counseling compared to exclusively heterosexual women (22% vs. 10%, $p<.001$). Among women who utilized any mental health services in the last year, lesbian and bisexual women reported a higher prevalence of minimally adequate care, though these numbers were not statistically significant.

Table 1 presents results of our multiple logistic regression models examining the association between sexual orientation and the four health care utilization measures, controlling for age, education, birthplace, ethnicity, insurance status, perceived physical health, and three mental health indicators. In contrast to our hypothesis, these models indicated that identifying as lesbian or bisexual is significantly associated with increased odds of any access to mental health care in the past year (OR= 1.95). Among those who initiated mental health care, lesbian and bisexual women were no more likely than their heterosexual counterparts to receive minimally adequate care in the past year. Specifically, among those who received any mental health services, only one in two (47%, exclusively heterosexual vs. 54%, sexual minority) women reported receiving care at least four times in the past year, and the prevalence of having received care at least eight times in the past year was 31% for exclusively heterosexual women and 36% for sexual minority women. As expected, lesbian and bisexual women were significantly more likely to report an unmet need for medical care (OR=2.24).

Discussion

Contrary to our hypothesis, our results indicate that Chinese-, Korean-, and Vietnamese-American sexual minority women are nearly twice as likely to access any mental health care in the past year compared to their heterosexual counterparts, controlling for demographic covariates, perceived physical health status, and mental health status. Although our data do not provide direct evidence that allows us to explain this finding, one plausible explanation is that sexual minority women are more likely to reach out to mental health professionals for support because of the multiplicity of issues they face related to their sexual orientation, difficulty in negotiating HIV prevention efforts, or substance use/abuse problems (10). Future research is needed to gain a more comprehensive understanding of the various factors that contribute to help-seeking behaviors in Asian-American women who are sexual minorities.

We found no significant differences between groups in receipt of minimally adequate care after initiation of mental health treatment, even after controlling for mental health indicators. This finding suggests that Asian-American sexual minority women do not encounter additional barriers to mental health care. However, the prevalence of minimally adequate mental health care remains low for both groups. Specifically, the prevalence of having received mental health care at least eight times in the past year was 31% for exclusively heterosexual women and 36% for sexual minority women. This prevalence is lower than those among Whites (56%) or Blacks (45%) with any mood disorder reported in the National Comorbidity Survey Replication (2001–2003) (11).

In our study, one in three sexual minority women reported an unmet need for medical care; this prevalence is higher than that among LGBT youth overall (23%) (12). Barriers to medical care may include provider bias, lack of provider knowledge of LGBT-specific health needs, and patients' fear of disclosing issues and mistrust toward providers (13). Disparities in unmet health care needs warrant further studies examining service use settings and barriers to health care among young Chinese-, Korean-, and Vietnamese-American sexual minority women. For example, the desire for confidential services among this population

may be important given the fact that young sexual minorities frequently seek mental health services in environments that promote higher levels of privacy and confidentiality (14). Furthermore, health care professionals should regularly screen Asian-American women for both physical and mental health symptoms, paying particular attention to sexual minority individuals, who appear to be at an especially high risk for having unmet health care needs and lacking adequate care.

This study has three key limitations. First, assessing sexual orientation with self-report measures may limit the comparability of our results, as sexual orientation can be defined in several ways and from a variety of survey methods. More precise identification of lesbian and bisexual women in health research requires a multi-dimensional standardized assessment of sexual orientation including sexual attraction, behavior, and identity (15). Second, reporting bias may lead to the misclassification of sexual orientation and mental health status; however, we do not believe this to be an issue because our study was confidential and CASI has been previously shown to be valid (16). Third, our sample consisted exclusively of 1.5 and 2nd generation Chinese-, Korean-, and Vietnamese-American unmarried women who tended to be highly educated. These sample characteristics may limit the generalizability of our findings to other Asian-American populations, given marked variation in socio-economic, ethnic, and immigration statuses. Despite these limitations, our findings support the need to enhance efforts in identifying and addressing barriers to adequate mental health care and reducing unmet health care needs among sexual minority women.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Logistic Regression Analysis Predicting Mental Health Care Access, Adequate Mental Health Care, and Unmet Needs for Health Care ($n=697$)

	Any mental health care access in last year		At least 4 outpatient mental health visits in last year		At least 8 outpatient mental health visits in last year		Unmet need for health care	
	OR	CI	OR	CI	OR	CI	OR	CI
Sexual minority (heterosexual: ref)								
Lesbian or bisexual	1.95 [*]	1.060–3.60	1.82	.80–4.12	1.63	.62–4.27	2.24 ^{***}	1.40–3.58
Age (old age: ref)								
Young age	.56	.27–1.15	.18 ^{*****}	.07–.46	.19 ^{***}	.066–.53	1.18	.63–2.19
Education (low education: ref)								
Mid education	.97	.45–2.07	.87	.29–2.57	1.19	.29–4.89	1.53	.81–2.89
High education	1.80	.60–5.44	.83	.20–3.57	1.00	.17–5.93	2.76 [*]	1.10–6.93
Birth place (foreign born: ref)								
U.S. born	1.59	.88–2.87	.96	.44–2.12	1.67	.62–4.53	.87	.57–1.34
Ethnicity (Chinese: ref)								
Korean	.74	.35–1.54	.64	.22–1.84	.69	.21–2.24	.96	.57–1.62
Vietnamese	.91	.44–1.87	1.15	.43–3.07	.76	.21–2.67	.57	.32–1.04
Mixed	1.28	.47–3.45	1.46	.35–6.07	1.20	.23–6.40	1.21	.56–2.63
Public or private insurance (no insurance: ref)	1.29	.61–2.71	.78	.31–1.99	.88	.29–2.62	.99	.57–1.73
Perceived physical health (low: ref)								
Mid	1.88	.73–4.81	.97	.30–3.15	1.41	.31–6.45	1.21	.59–2.48
High	1.79	.72–4.43	1.19	.39–3.62	1.58	.37–6.74	1.083	.55–2.15
Psychiatric diagnosis ^a (never: ref)	14.35 ^{*****}	8.09–25.44	16.77 ^{*****}	7.82–35.99	16.52 ^{*****}	6.59–41.40	1.75 [*]	1.03–3.00
Depressive symptoms ^b (minimal: ref)	1.98 [*]	1.13–3.48	2.76 [*]	1.25–6.06	1.61	.65–4.0088	2.35 ^{*****}	1.53–3.61

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	Any mental health care access in last year		At least 4 outpatient mental health visits in last year		At least 8 outpatient mental health visits in last year		Unmet need for health care	
	OR	CI	OR	CI	OR	CI	OR	CI
Suicide Ideation in last year (none: ref)	1.95	.77-4.36	1.43	.44-4.61	1.15	.26-5.14	2.15*	1.09-4.25

^a Ever having psychiatric diagnosis

^b Moderate to severe depressive symptoms

* p<.05

** p<.01

*** p<.005

**** p<.001