Beyond ‘Help-Seeking,’ toward ‘Engagement’: Understanding Barriers to Mental Health Equity among Sexual Minority Individuals

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I am submitting herewith a dissertation written by Elliot Spengler entitled 'Beyond 'Help-Seeking,' toward 'Engagement': Understanding Barriers to Mental Health Equity among Sexual Minority Individuals." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

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Beyond ‘Help-Seeking,’ toward ‘Engagement’: Understanding Barriers to Mental Health Equity among Sexual Minority Individuals

A Dissertation Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Elliot Spengler

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Abstract

The finding that 57.4% of adults living in the United States with a diagnosable mental health disorder do not receive mental health care (Substance Abuse and Mental Health Services Administration, 2018) opens important questions as to what structural and individual factors contribute to this “treatment gap” and individuals’ willingness and/or ability to seek out traditional mental health care. Sexual minority (SM) individuals experience inequitable mental health outcomes and report more unmet mental health needs and more barriers to health care than heterosexual individuals. Thus, there is a need to understand the process of mental health care engagement (MHCE) for SM individuals in order to ensure accessible, affirmative, and effective treatment. MHCE is purposefully used as mental health reflects a complex, intertwined process of engagement between individual-, community-, and macro-level factors. A sample of 398 SM individuals completed an online, anonymous survey on Amazon Mechanical Turk. Informed by the theory of planned behavior (Ajzen, 1985), Network-Episode Model (Pescosolido & Boyer, 2010), and the threat-to-self-esteem model (Nadler & Fisher, 1986), a structural equation model with adequate model fit found intentions to seek out traditional mental health care dynamically shift across the trajectory of psychological distress in relation to Theory of Planned Behavior moderators (e.g., attitudes towards mental health care professionals, mental health stigma, structural barriers) and other variables (e.g., self-concealment, social support) commonly used in previous help-seeking studies. A substantial amount of the sample reported unmet mental health needs, engagement with alternative mental health care, and experiences with sexual orientation change efforts. The implications foreground the importance of structural vulnerability throughout the process of MHCE in terms of theory, practice, advocacy, education, training, and research.
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Chapter 1: Introduction

The finding that 57.4% of adults living in the United States with a diagnosable mental health disorder do not receive mental health care (Substance Abuse and Mental Health Services Administration; SAMSHA, 2018) opens important questions as to what structural and individual factors contribute to this “treatment gap” and individuals’ willingness and/or ability to seek out traditional mental health care (Kohn, Saxena, Levav, & Saraceno, 2004; Pescosolido & Boyer, 2010). In 2018, the SAMSHA reported 23.7% of respondents indicated they thought they needed mental health services in the last 12 months but did not receive them. This high level of unmet mental health needs makes examining these issues more pressing, especially for populations with inequitable mental health disparities. Sexual minority (SM) individuals face a complex interaction of distal and proximal stressors, including discrimination and prejudice, that are theorized to result in elevated rates of mental health distress (Hatzenbuehler, 2009; Meyer, 1995). While SM individuals report a higher perceived need for mental health care compared to heterosexual individuals, they also report more barriers to health care (Dahlhamer et al., 2016) and a higher prevalence of an unmet need for mental health care services with between 30.6% to 53.8% of SM individuals reporting an unmet mental health need (Burgess et al., 2008; Steele et al., 2017).

Health inequities between SM and heterosexual individuals underscore a need to understand the process of mental health care engagement (MHCE) in order to ensure accessible, affirmative, and effective treatment, especially for those with unmet mental health needs. MHCE is purposefully used as unmet mental health needs do not reflect upon only the “help seeker” and a binary choice of seeking help (Grzanka & Miles, 2016); rather, these unmet needs reflect a

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1Sexual minority is a term to include individuals who identify as lesbian, gay, bisexual, or any other sexual orientation that is not heterosexual (e.g., asexual, demisexual, pansexual)
complex, intertwined process of engagement between individual- (e.g., attitudes towards mental health care), community- (e.g., mental health stigma), and macro-level factors (e.g., structural barriers; National Alliance of Mental Health, 2016).

Although models of MHCE and help-seeking are prevalent in the psychological literature (e.g., Cauce et al., 2002; Cramer, 1999; Kuo et al., 2015; Mojaverian et al., 2013; Vogel & Wei, 2005), these models rarely capture system-level (e.g., cost, perceived prejudice) barriers to MHCE. This lack of consideration limits the generalizability of these models given that some of the most commonly endorsed reasons for having an unmet mental health need were individuals not being able to afford the cost (40.8%), not knowing where to go for services (24.6%), and not having time (21.1%; SAMSHA, 2018). Furthermore, there is a paucity of research examining MHCE models in SM individuals with one (Vogel et al., 2011) using a subsample of gay men and the other (Spengler & Ægisdóttir, 2015) neglecting to include common factors in other MHCE models (i.e., Cramer, 1999), such as psychological distress, self-concealment, and social support. This underrepresentation of empirical attention to the mental health needs of SM individuals is far too common, as a review of studies funded by the National Institute of Health from 1989-2011 found only 0.1% were SM health-related with only 23.2% of those studies focused on SM mental health (Coulter et al., 2014).

Although several studies examine MHCE in SM individuals (e.g., Spengler & Ægisdóttir, 2015), more studies are warranted to inform this socially dynamic and systemically layered process (Pescosolido & Boyer, 1999). Previous research on SM individuals’ attitudes and intentions towards traditional MHC is limited because researchers examined SM individuals’ MHCE in relation to conversion therapy (e.g., Tozer & Hayes, 2004), recruited small sample sizes (e.g., Sánchez et al., 2009), examined in relation to suicidality and self-harm (McDermott et
al., 2018), used qualitative methods with bisexual individuals only (MacKay et al., 2017), manipulated variables related to a hypothetical counselor (e.g., Dorland & Fischer, 2001; Borden et al., 2010), or asked participants to rate the valence of counselors characteristics (e.g., Burckell & Goldfried, 2006). After a robust review of the extant literature on the patterns and predictors of MHCE in SM individuals, Filice and Meyer (2018) concluded the “most readily apparent conclusion one would draw from the surveyed literature is that, with the exception that LGB individuals [sic] use mental health services more frequently than heterosexuals, there is little agreement in terms of what predicts service use” (p. 183). Nonetheless, the increased and inequitable mental health risks faced by SM individuals (Cochran et al., 2003) underscores a crucial need for psychologists to comprehensively understand the factors that impede or enable engagement with traditional mental health care (MHC) in order to ensure MHC services are accessible, affirmative, and effective.

The purpose of this study was to examine a structural model of MHCE with SM individuals from a health equity perspective informed by the theory of planned behavior (Ajzen, 1985), Network-Episode Model (Pescosolido & Boyer, 2010), and the threat-to-self-esteem model (Nadler & Fisher, 1986). More specifically, I examine what factors help explain the treatment gap (i.e., the lack of relationship between psychological distress and intentions to seek out traditional MHC); that is, I examine how intentions to seek out traditional MHC may dynamically shift across the trajectory of psychological distress in relation to Theory of Planned Behavior variables and other variables commonly used in previous help-seeking studies. Furthermore, I hypothesize that structural factors, sociocultural context, and alternative forms of MHC are integral to the dynamic process of MHCE in SM individuals, which extends beyond previous help-seeking literature. I examine the reasons for unmet mental health needs from
traditional MHC (e.g., psychotherapy) and what alternative forms of MHCE (e.g., friends, religious leader) SM individuals use. Identifying variables that may moderate the relationship between psychological distress and intentions to seek traditional MHC could lead to new targets for prevention and intervention. In doing so, this study directly supports two initiatives of the U.S. Department of Health & Human Services’ Healthy People 2020: improve the health, safety, and well-being of SM individuals and improve access to quality health care services to help achieve health equity (U.S. Department of Health & Human Services, 2015). The remainder of the introduction serves to illustrate how the minority stress model (Meyer, 1995) and the theory of planned behavior (Ajzen, 1985) inform MHCE and the ensuing research questions.

**Mental Health Care Engagement and the Minority Stress Model**

Because of psychologists’ fraught history of producing and perpetuating minority stress, SM individuals’ reticence to seek out traditional MHC could be framed as both rational and justifiable (i.e., not necessarily pathological or misguided). According to Meyer (1995), minority stress is caused by discriminatory, overarching social structures and institutions, such as occupying stigmatized social position in a heterosexist society. For example, upon this writing, it is legal in 28 states to evict someone based on sexual orientation and 27 states to be fired in non-federal jobs based on sexual orientation; moreover, 19 states do not address hate or bias crimes based on sexual orientation, thereby rendering hate crimes committed against SM individuals in those states invisible (Human Rights Campaign, 2020). Meyer’s minority stress model posits that chronic stress from these distal and proximal forces cause disparate rates of mental health disorders for SM individuals, such as depression, anxiety, substance abuse, and comorbid disorders (Cochran et al., 2003; Meyer, 1995; Marshal et al., 2008; Hatzenbuehler, 2009).
This history of mistreatment and maltreatment of SM individuals is fundamental to psychology’s past, present, and future (e.g., Hooker, 1957; Waidzunas, 2015). Psychologists institutionalized sexual prejudice through the medicalization of same-gender attraction until 1973 (American Psychiatric Association, 1973) and the implementation of cruel treatments to deter same-gender desires, such as lobotomies (Banay & Davidoff, 1942) and electric shock (Liebman, 1944). Mistreatment (e.g., clinical microaggressions, Shelton & Delgado-Romero, 2011) and maltreatment (e.g., discriminatory MHC professionals, Romanelli & Hudson, 2017; conversion “therapy,” Ryan et al., 2020) are not simply an artifact of psychology’s past, because they continue to impact the process of MHCE for SM individuals. In other words, encouraging SM individuals to engage in traditional MHC is a far cry from encouraging individuals to receive vaccines given the misinformation surrounding them (World Health Organization, 2019); rather, this process of whether to engage in traditional or alternative MHC is informed by the lived experiences and stories of harmful and inequitable MHC.

Although psychology and its institutions have engaged in advocacy efforts for SM individuals recently, including several amicus briefs for Supreme Court cases (e.g., Obergefell et al. v. Hodges, Director, OH Department of Health, et al., 2015), deleterious and ineffective care endure. Upon this writing, it is legal in 30 states for clinicians to engage youth clients in conversion “therapy,” reparative “therapy,” and/or sexual orientation change efforts (Human Rights Campaign, 2020). This so-called “therapy” uses aversion therapy techniques (e.g., administering electric shocks, inducing vomiting) in an effort to combat same-sex desires (Mallory et al., 2018). Not only has research shown conversion “therapy” to be ineffective in changing sexual orientation (American Psychological Association, 2009), psychologists have weaponized research to manipulate perceived efficacy and, thereby, allow these pervasive
damaging effects to continue (e.g., Spitzer, 2003). Although some of these researchers have apologized for manipulating their data and denounced the practice (Spitzer, 2012), the detrimental effects of conversion “therapy” are pervasive. SM individuals who engage in conversion “therapy” report elevated depression, less educational attainment, and five-fold increased odds of attempting suicide (Ryan et al., 2020). Nonetheless, it took decades for psychology or state governments to take a stand against this malpractice. The American Psychological Association did not formally denounce this harmful and ineffective practice until 2009 (Anton, 2010), and the first state to make conversion “therapy” illegal was California in 2012 (Human Rights Campaign, 2020). This lackluster response and disengagement by the field writ large has resulted in pervasive maltreatment of SM individuals by MHC professionals. The Williams Institute (Mallory et al., 2018) estimates that 6.7% (i.e., 700,000) of SM adults ages 18-59 in United States have received conversion “therapy,” and 20,000 SM youth ages 13-17 will receive conversion “therapy” from a licensed mental health professional before they reach the age of 18 in the states where it is legal. In other words, the legacy of sexual prejudice in psychology has felt consequences for contemporary care provision.

SM individuals’ MHCE occurs in the historical context of psychology’s changing relationship to sexuality, particularly non-heterosexual sexualities (Grzanka & Miles, 2016; O’Shaughnessy & Speir, 2018). In navigating the process of whether to engage with traditional MHC given psychology’s historical inconsistent relationship with SM individuals and the SM population writ large, the threat-to-self-esteem model (Nadler & Fischer, 1986) and the Network-Episode Model (Pescosolido & Boyer, 2010) provide a helpful framework. This threat-to-self-esteem model poses that a key component of developing positive attitudes towards a source of help is perceiving that source of help as supportive and nurturing towards one’s sense of self. In
contrast, if a person perceives the source of help as threatening to their sense of self, negative attitudes manifest and individuals avoid engaging with that source of help. The Network-Episode Model (Pescosolido & Boyer, 2010) frames the navigation of MHCE as a balance of how the structure and culture of treatment, as well as attitudes towards clients, may clash or reinforce with community systems and sociocultural factors to send varying messages towards potential clients.

Accordingly, both psychology’s perpetuation of sexual prejudice and the more recent paradigm shift toward an increased empirical focus on SM psychology and SM (i.e., “LGBT”) affirmative therapy are relevant and consequential (Grzanka & Miles, 2016; O’Shaughnessy & Speir, 2018). When retrospectively rating their MHC, SM clients viewed explicitly non-affirming MHC professionals as unhelpful in 90.5% of 49 studies systematically synthesized (O’Shaughnessy & Speir, 2018). SM individuals purposefully seek out MHC professionals that are SM-affirmative and rate MHC professionals who SM individuals prescreened for affirmativeness as significantly more helpful compared to MHC professionals who they did not prescreen (Liddle, 1997). The institutional shift towards effective and affirmative therapy with SM individuals (e.g., American Psychological Association, 2012) paired with recent legislation that promotes mistrust in the SM community of counselors (Grzanka et al., 2019; Grzanka et al., 2020) illustrates just a few of many factors SM individuals navigate in the complex and socially dynamic process of MHCE. Yet, only one study (Spengler & Ægisdóttir, 2015) included perceived MHC professional sexual prejudice in a model of MHCE and no studies have taken into account perceived MHC professional sexual affirmativeness. I pose these factors are integral constructs in a model of MHCE with SM individuals that previous help-seeking models have not acknowledged.
**Theory of Planned Behavior & Mental Health Care Engagement**

Although researchers often use the framework of the Theory of Planned Behavior (TPB; Ajzen, 1985) to understand why an individual does or does not engage in traditional MHC (e.g., Smith et al., 2008), they oftentimes lack the integral components of perceived and actual behavioral control that differentiates the TPB from the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980). Per the TPB, the decision to engage in traditional MHC is the result of a well-formulated cost-benefit analysis impacted by personal beliefs (e.g., attitudes towards traditional MHC) and subjective norms (e.g., public mental health stigma) as to the result of the behavior, as well as perceived and actual behavioral control (e.g., structural barriers). That is, individuals have to believe the benefits of engaging in traditional MHC outweigh the risks and that they have the perceived or actual control (i.e., information, resources, or abilities) to engage in that behavior.

Although the TPB is the most widely used theoretical model applied to understand engagement with traditional MHC, it is not the only theoretical model used to do so. Scholars originally designed and conceptualized other models that researchers have used for help-seeking for access to medical health care (e.g., Currin et al., 2018), including the health belief model (Rosenstock et al., 1988) and the behavior model (Andersen, 1995). The main critique of the other models is that they do not sufficiently account for the role of social context and surrounding systemic impact (Alang & McAlpine, 2019). Researchers have applied the general framework of engaging in a behavior (i.e., TPB) extensively to help-seeking with a variety of populations, including general community members domestically (e.g., Schomerus et al., 2009), general community members in other countries (e.g., Damghanian & Alijanzadeh, 2018; Mak & Davis, 2014), and college students (e.g., Bohon et al., 2016; Hess & Tracey, 2013; Hunt &
The TPB has also been used to effectively predict behavior change in intervention studies of both mental and physical health (Steinmetz et al., 2016). Another likely reason of TPB’s common association with engagement with traditional MHC (i.e., help-seeking) is that scales used to measure attitudes and intentions towards receiving traditional MHC (e.g., Ægisdóttir & Gerstein, 2009; Hammer et al., 2018) use the TPB as an integral part of the theoretical groundwork for the scale development.

The consideration of structural factors as pragmatic factors of perceived control are vitally needed in a robust model of MHCE. Most help-seeking studies using the TPB as a framework operationalize perceived behavioral control as a sense of self-efficacy or confidence in order to engage traditional MHC (e.g., Hess & Tracey, 2013). This omission negates the components of actual behavioral control included in Ajzen’s (2019) more recent version of the TPB (see Figure 1). It also may reflect an assumption that structural issues are anchored within subjective experiences and, thereby, undermine the critically influential pragmatic factors that deter individuals from receiving traditional MHC, such as the ability to afford MHC and having the time available to receive MHC. Furthermore, such approaches imply the decision to seek out traditional MHC is purely contingent upon individual agency rather than recognizing the influential structural forces that contribute to this decision-making process.
Figure 1: Theory of Planned Behavior.
These structural barriers must be considered in models of MHCE because they hinder individuals who want and/or need to receive traditional MHC from receiving them and, therefore, lead to further mental health disparities and inequities (Romanelli & Hudson, 2017). Furthermore, no model of help-seeking or MHCE with SM individuals incorporates structural barriers in the form of perceived or alternative behavioral control. In the 2017 National Survey on Drug Use and Health (SAMHSA, 2018), individuals with unmet mental health needs listed the following structural barriers as reasons they did not receive services: could not afford cost (40.8%), did not have time (21.1%), and not sure where to go for services (24.6%). In a longitudinal study, Kung (2004) found these three structural factors, as well as shared language of MHC professional, significantly predicted lower rates of receiving traditional MHC for a sample of Chinese Americans with a diagnosable mental health disorder, albeit they did not report the sexual orientation of their participants. Researchers have found that higher structural barriers, such as cost and accessibility, reduce individuals’ intentions to seek out traditional MHC (Mohr et al., 2010; Schomerus et al., 2012; ten Have et al., 2010), although these studies only examined these structural barriers in a bivariate manner so less is known with how structural barriers interact with other factors of engagement with traditional MHC.

When considering how structural and cultural factors impact the continuum of distress within the MHCE process, the Network-Episode Model (NEM) provides a good framework in conjunction with the TPB. Originally developed as a manner to understand how individuals respond and recognize health issues (Pescosolido & Boyer, 1999), it offers an alternative perspective to the dominant paradigm of the individually focused rational choice maker and, instead, prioritizes sociocultural networks. The NEM frames MHCE as the confluence of four interrelating parts: the illness career, the social support system, the treatment system, and the
social context. More specifically, MHCE is framed as a “socially embedded process tied not only to the actions of individuals with psychiatric problems but also to the networks and communities in which they live, the people who surround them, and those encountered in the treatment system” (p. 430; Pescosolido & Boyer, 2010). Given its origins in medical sociology, the NEM prioritizes that psychological distress and MHCE does not occur in a vacuum void of sociocultural factors; rather, it is best to understand individuals in a dynamic interaction with their surrounding systems. Furthermore, it poses that MHCE includes three other types of MHC in addition to traditional MHC, including the lay system (e.g., friends, family), the folk system (e.g., religious advisors, alternative healers), and the human-social service system (e.g., police, teachers). While the NEM does not include sexual orientation as a factor in MHCE, it does prioritize other forms of social location (e.g., gender, race/ethnicity, social class) and sets a context of how sexual orientation may play a role in MHCE.

The Gay and Lesbian Medical Association (2001) listed approachability, accessibility, acceptability, and availability of traditional MHC as fundamental contributors to the disproportionate MHC for SM individuals compared to heterosexual individuals. These closely align with public health researcher’s conceptualization of patient-centered health care access that postulates individuals engage in health care when it is approachable, acceptable, available, affordable, and appropriate (Levesque et al., 2013). SM individuals who report unmet mental health needs often cite structural factors, such as a lack of financial ability (e.g., lack of insurance or related insufficient financial resources), provider availability, and limited knowledge in services (Dahlhamer et al., 2016; Barefoot et al., 2015; Simeonov et al., 2015; Willging et al., 2006), as key barriers to engagement with traditional MHC. Although researchers are giving structural barriers and attitudinal factors more empirical attention recently with SM individuals
in their relation to MHCE, they have yet to be put into a model of MHCE in an attempt to explain the individual-, community-, and structural-levels that dictate the treatment gap in SM individuals. Simply put, “people may be unlikely to perform a behavior due to structural considerations even if they evaluate it positively and when they believe that important others think they should perform it” (p. 12; Ajzen, 1985).

With that limitation of previous literature noted, researchers have found personal beliefs and subjective norms do play a significant role in predicting intentions to seek out traditional MHC, although much less is known with SM individuals. One of the most commonly cited factors in the evaluation of the anticipated outcomes (i.e., benefits and risks) of engagement with traditional MHC is one’s overall attitudes towards it (i.e., believing it would be beneficial; Hammer & Spiker, 2018). Researchers have routinely found that individuals with more positive attitudes regarding MHC have significantly higher intentions to seek out traditional MHC (e.g., Lee et al., 2014; Vogel et al., 2005) and, in turn, have higher actual engagement in traditional MHC (Webb & Sheeran, 2006).

In addition to gestalt attitudes towards traditional MHC included in traditional models of help-seeking (e.g., Cramer, 1999), I suggest that SM individuals face a catch-22 of sorts when considering whether to engage in traditional MHC. This manifests as a kind of dialectic where psychology’s historical injustices sit alongside, and in tension, with the more relatively recent paradigmatic shift towards SM affirmative therapy. In their threat-to-self-esteem model, Nadler and Fisher (1986) help better understand how these opposing narratives can be mutually considered. They pose that in order to develop positive attitudes towards sources of help, one must perceive these sources as nurturing, appreciative, and supportive towards their sense of self (i.e., affirmative). In contrast, negative feelings toward a source of help develop if one perceives
the source of help to be threatening to their self-image (i.e., prejudiced). Thus, to maintain their self-esteem, whether SM individuals see traditional MHC as a viable source of help is contingent upon whether they view MHC professionals as affirmative or judgmental of their sense of self, including their sexual orientation.

Although research details the impact of prejudice or affirmation of MHC professionals on the therapeutic relationship and outcomes while individuals are actually or hypothetically receiving traditional MHC (Dorland & Fischer, 2001; Podchaski, 2008), less research explains how these variables inform whether or not SM individuals engage in traditional MHC. Previous studies illustrate that when SM participants consider traditional MHC, they simultaneously hold a fear of heterosexist bias and a desire for affirmative attitudes in counselors (e.g., Burckell & Goldfried, 2006; Willging et al., 2006). In a synthesis of 49 empirical studies on clinical research with SM individuals between 2000 and 2015, O’Shaughnessy and Spier (2018) reported the two most consistent themes that dictated the process and outcomes of clinical work were the importance of having a counselor who was knowledgeable and affirmative of the SM community, and the harmful effects of a counselor having negative attitudes toward SM identities. Notably, this review only cited four studies that were prospective and examined the MHCE process; furthermore, the studies that have examined the impact of perceived MHC professional affirmativeness or prejudice of SM factors on MHCE are limited by their univariate level of analysis, which means the amount of variance in accordance with other attitudinal variables (e.g., attitudes towards traditional MHC writ large) is not well known.

Another key component in models of MHCE with heterosexual samples (e.g., Cramer, 1999; Vogel & Armstrong, 2010) that is less understood for SM individuals is the desire to withhold distressing and potentially embarrassing information from others (i.e., self-
concealment). Spengler and Ægisdóttir (2015) noted that the lack of consideration of self-concealment was a limitation in their model with SM individuals and called on future research to include this variable in the process of MHCE. For SM individuals, self-concealment is directly related to their sexual orientation being an invisible stigmatized identity (Pitoňák, 2017) and previous research shows self-concealment is related to how SM individuals perceive MHC professionals. When hypothetical MHC professionals made heterosexist comments, SM individuals indicated they would be more likely to conceal their SM identity, withhold vulnerable emotions, and exhibit less willingness to seek out traditional MHC; furthermore, SM individuals who received traditional MHC reported being less likely to conceal when counselors had affirming environments (Dorland & Fischer, 2001; Podchaski, 2008; Shelton & Delgado-Romero, 2011). Given that intentions to engage in traditional MHC infer being emotionally open and vulnerable, researchers have included self-concealment as an integral component of MHCE models with all heterosexual (or assumed heterosexual) participants (e.g., Cramer, 1999; Liao et al., 2005). Yet, how self-concealment influences the consideration of engaging in traditional MHC for SM individuals is less understood.

Other factors that illustrate the dynamic process of MHCE that have been well-established in models of MHCE with heterosexual samples but less established with SM samples are social support and mental health stigma (Cramer, 1999; Lannin et al., 2014; Vogel et al., 2005). The process of MHCE is dynamic because, in addition to the individual perception of engaging in traditional MHC, the anticipated outcomes of engaging in MHC and intentions to do so are also intimately tied to individual’s interactions with their communities (i.e., social support) and the internalization of subjective norms or attitudes (Pescosolido & Boyer, 1999). This impact of the confluence of individual and systemic factors is showcased by the effects of mental health
Mental health stigma is rooted in a socially constructed medicalized model that suggests something is inherently wrong with individuals who exhibit psychopathology. The prejudice, discrimination, stereotypes, and other detrimental effects resulting from mental health stigma are still evident to the individual both individually and systemically. Moses (2010) found that mental health stigma leads to social rejection, unwarranted assumptions, pity, and distrust for individuals with mental health disorders. When mental health stigma is internalized, it can have detrimental effects, such as shame and even poorer treatment outcomes relative to those without internalized mental health stigma (Perlick et al., 2001), which suggests that mental health stigma impacts both psychological distress and intentions to seek traditional MHC. A lack of engagement in MHC, and thereby avoiding the label of someone with psychopathology, is one way that mental health stigma could manifest.

Whether an individual’s community and wider social systems encourage or discourage traditional MHC is one of the strongest components in their rationalization to engage in the behavior. For individuals who identified having a perceived unmet mental health needs, they reported the reason for the lack of MHCE was a fear that neighbors may have a negative opinion of them (10.8%) and they did not want others to find out (8.6%; SAMSHA, 2018). Willging and colleagues (2006) found viewing mental disorders as a sign of weakness was a main deterrent for engaging in traditional MHC for rural SM individuals. Moreover, racial and ethnic minorities, another stigmatized population, report being less likely to seek out traditional MHC because they view it as an additional stigma (Townes et al., 2009). In summary, I look to extend previous MHCE models and also incorporate the socially dynamic and systemically layered process. Inequitable mental health outcomes, higher reported barriers to traditional MHC, and higher levels of unmet mental health needs make access to engaging, effective, and affirmative MHC
for SM individuals an important social justice issue with consequences for individual mental health and mental health equity across groups (Romanelli & Hudson, 2017).

Present Study

The purpose of the study was to examine the degree to which the three factors of the TPB (Ajzen, 1985) explain the treatment gap (i.e., the lack of relationship between psychological distress and MHCE intention) in SM individuals using a structural equation model. Although there have been numerous studies examining mental health professionals’ attitudes towards SM individuals (e.g., Kilgore et al., 2005), I strive to provide voice to the SM community of their experiences of the process of MHCE in this study. In accordance with the TPB (Ajzen, 1985), the Network-Episode Model (Pescosolido & Boyer, 2010), and threat-to-self-esteem model (Nadler & Fischer, 1986), individuals’ intentions to seek out traditional MHC are predicted to be dictated by their attitudes towards the behavior (i.e., MHCE attitudes, perceived MHC professional prejudice and affirmativeness, self-concealment), subjective norms (i.e., public mental health stigma, self mental health stigma), and perceived and actual control over the behavior (i.e., structural barriers). In accordance with the only previous MHCE model theorized for SM individuals (Spengler & Ægisdóttir, 2015), previous traditional MHC is included as a variable that relates to intentions to seek traditional MHC. I follow the call of Spengler and Ægisdóttir (2015) to include the variables of self-concealment and social support, as they have been explanatory variables in other models of MHCE (e.g., Cramer, 1999). I seek to understand the lack of direct relationship between psychological distress and intentions to seek traditional MHC exhibited in other studies (e.g., Cheang & Davis, 2014; Morgan et al., 2003; Vogel et al., 2005). Because the presence of symptoms is not sufficient for people to desire or obtain MHC (i.e., treatment gap), understanding how people respond to and perceive symptomology at
differing levels is integral to the socially and structurally embedded process of MHCE. In accordance with the network-episodic model (Pescosolido & Boyer, 2010) and theory of planned behavior (Ajzen, 1985), I used moderation to see how the trajectory of distress interacts with intentions to seek traditional MHC with attitudes, subjective norms, and perceived control towards seeking out traditional MHC, as well as interacting with constructs (e.g., social support, self-concealment) commonly used in help-seeking models.

This study represents the first empirical examination of a model of MHCE in SM individuals that incorporates structural barriers, both perceived MHC professional sexual prejudice and affirmativeness, social support, and self-concealment and the first to test for moderation. Recent help-seeking models used moderation to help illustrate some of the dynamic interaction amongst variables (e.g., Heath et al., 2017; Booth et al., 2019) rather than the static, linear relationship prescribed by traditional modeling. This study also represents the first examination into other factors of the process of MHCE with SM individuals in conjunction with a model, including unmet mental health needs and alternative forms of MHCE beyond traditional MHC. My hope in examining these factors is to promote health equity by better understanding the individual-, community-, and structural-level factors that facilitate MHCE and eradicate the treatment gap. The research questions and associated hypotheses guiding this study are:

1. What is the association between psychological distress and intentions to seek out traditional MHC?

   *Hypothesis 1*: Psychological distress and intentions to seek out traditional MHC will not significantly relate to one another.

2. Do these theoretically derived constructs/variables account for sufficient variance such that they constitute an appropriate model of MHCE with SM individuals?
Hypothesis 2a: The proposed conceptual model (see Figure 2) and statistical model (see Figure 3) will demonstrate a good model fit.

Hypothesis 2b: The proposed model will account for a significant amount of variance in intentions to seek traditional MHC.

3. When taking other variables into account in a structural model, what latent constructs significantly associate with intentions to seek traditional MHC?

Hypothesis 3a: Attitudes towards MHC professionals (i.e., operationalized by a latent construct consisting of attitudes towards MHC professionals writ large, perceived counselor sexual prejudice, perceived counselor affirmativeness) will uniquely and significantly associate with intentions to seek traditional MHC.

Hypothesis 3b: Mental health stigma (i.e., operationalized by a latent construct consisting of personal mental health stigma and public mental health stigma) will uniquely and significantly associate with intentions to seek traditional MHC.

Hypothesis 3c: Structural barriers will uniquely and significantly associate with intentions to seek traditional MHC.

Hypothesis 3d: Self-concealment will uniquely and significantly associate with intentions to seek traditional MHC.

Hypothesis 3e: Social support will uniquely and significantly associate with intentions to seek traditional MHC.

4. When taking other variables into account in a structural model, what factors explain the treatment gap among SM individuals? In other words, what factors moderate the relationship between psychological distress and intentions to seek traditional MHC?
Hypothesis 4a: The interaction between psychological distress and attitudes towards MHC professionals will be significant, such that the association between psychological distress and intentions to seek traditional MHC will be positive and strongest when attitudes towards MHC professionals is low.

Hypothesis 4b: This interaction will significantly associate with intentions to seek traditional MHC.

Hypothesis 5a: The interaction between mental health stigma and psychological distress will be significant, such that the association between psychological distress and intentions to seek traditional MHC will be positive and strongest when mental health stigma is high.

Hypothesis 5b: This interaction will significantly associate with intentions to seek traditional MHC.

Hypothesis 6a: The interaction between structural barriers and psychological distress will be significant, such that the association between psychological distress and intentions to seek traditional MHC will be positive and strongest when structural barriers is high.

Hypothesis 6b: This interaction will significantly associate with intentions to seek traditional MHC.

Hypothesis 7a: The interaction between self-concealment and psychological distress will be significant, such that the association between psychological distress and intentions to seek traditional MHC will be positive and strongest when self-concealment is high.
**Hypothesis 7b:** This interaction will significantly associate with intentions to seek traditional MHC.

**Hypothesis 8a:** The interaction between social support and psychological distress will be significant, such that the association between psychological distress and intentions to seek traditional MHC will be positive and strongest when social support is low.

**Hypothesis 8b:** This interaction will significantly associate with intentions to seek traditional MHC.

5. What factors explain the unmet mental health needs of SM individuals?

6. When participants have unmet mental health needs from traditional MHC, what alternative forms of MHC do SM individuals engage in?

7. How often have SM individuals received sexual orientation change efforts (i.e., conversion “therapy”)? What type of professional (e.g., medical, mental health, other) provided them?
Figure 2: Hypothesized Conceptual Model.
Note. MHCP = mental health care professional; MHSAS = Mental Help Seeking Attitudes Scale; MHS = mental health stigma; MHC = mental health care.

Figure 3: Hypothesized Statistical Model.
Note. PD = psychological distress; MHCP = mental health care professional; MH = mental health; SB = structural barriers; MHC = mental health care.
Chapter 2: Methods

Feminist Standpoint

Feminist reflexivity (Hesse-Biber & Piatelli, 2012) challenges so-called objective approaches to social sciences and demands that researchers examine how their subjectivity influences their standpoint, especially in relation to powers dynamics between researcher and those being researched. In this spirit, I recognize my epistemology and standpoint with this research project are inextricably bound to my identities and lived experiences (Else-Quest & Hyde, 2015; Haraway, 1988). I come to this research as a cisgender, heterosexual, White man who is a trainee in a counseling psychology department with a scientist-practitioner-advocate model (Mallinckrodt et al., 2014). I have had the ability by means of insurance and financial stability to access traditional MHC throughout my life. Cost, time, and knowing how to access traditional MHC have never hindered my ability and/or willingness to engage in traditional MHC. My current clinical work is in a community health setting where I work solely with individuals who are under- or uninsured and the factors of cost, time, and navigating how to receive traditional MHC regularly impact or delay their engagement with traditional MHC. I recognize I do not have membership in the sexual minority (SM) community; rather, I am mentored by and collaborate with various SM individuals whose input and partnership informs my work. I come to this research motivated by the promotion of mental health and reduction of mental health inequities. As the SM population experiences gross mental health inequities due to structural discrimination (Meyer, 1995), this research falls in line with social justice pillar of counseling psychology (Fouad et al., 2006).
Procedure

According to a power analysis for a model with 12 latent variables (7 latent constructs and 5 latent moderated structural equations), 22 observed variable (i.e., 3 loading onto each latent construct and prior counseling), and estimated loadings of 0.25, a sample size of 305 would be sufficient to detect effects with power of 0.80 at a probability level of .01 (Soper, 2019). A similarly sized (i.e., number of latent variables) structural model of MHCE with 15 latent constructs used 354 participants and found good model fit (Vogel et al., 2005).

After institutional review board approval, I recruited participants electronically through Amazon Mechanical Turk (MTurk) in October and November of 2019. MTurk is an online platform where workers are compensated for completing research tasks (e.g., surveys). MTurk can produce reliable data with samples that are more socioculturally diverse than samples recruited from colleges or traditional internet methods (Buhrmester et al., 2011; Casler et al., 2013). Researchers have used MTurk in previous studies to recruit SM samples (e.g., Choi et al., 2017). In order to be eligible, I required participants to: 1) be at least 18 years old, 2) self-identify as a SM (e.g., gay, lesbian, bisexual, etc.), 3) reside in the United States, 4) only take the survey once (i.e., not be utilizing an I.P. address that had already completed the survey), and 5) pass a series of three attention checks and four validity checks. While I did not explicitly exclude individuals who self-identify as a gender minority (e.g., transgender, non-binary), I also did not explicitly include individuals who self-identify as a gender minority. The mental health needs and associated barriers to MHCE experienced by gender minority individuals (e.g., gatekeeping hormone replacement therapy, gender dysphoria; Ashley, 2019) are distinct from SM individuals and, therefore, warrant a separate study (see Hunt, 2014). In this process, I seek to avoid
homogenizing the needs of sexual and gender minority individuals and, instead, recognize the distinct and nuanced experiences of these individuals and groups.

I provided the description of the study directly on MTurk and indicated participants must identify as a SM and over 18 to participate in the study. Participants interested in completing the study could then click a link to visit Qualtrics where I housed the measures. The first page of the Qualtrics survey was the informed consent form approved by the Institutional Review Board. Upon entering the survey, participants viewed an informed consent notice and had to click confirmation regarding acceptance of terms of study. The informed consent form again stated that individuals must be 18 and identify as a SM to participate. Similarly, I told participants in the informed consent that compensation depended upon passing a series of validity checks ensuring the truthfulness of their answers. After participants consented to participating, I immediately directed them to the demographic questionnaire page. For participants who were not at least 18 years old or who did not identify as a SM, the flow of Qualtrics immediately terminated them from completing the survey. If participants passed this point, the flow of Qualtrics presented them with the rest of the survey.

Participants completed a series of questionnaires starting with demographic questions and ending with MHC history. I presented all previously validated surveys in randomized order. Following completion of the study, Qualtrics provided participants with their unique response identification and instructed participants to enter this into the Amazon Mechanical Turk Portal if they desired to receive compensation. Following data collection, I analyzed the data to determine the consistency and validity of participant responses before compensating participants. I notated the response identification of participants who failed any validity check. I notated the response identification of participants that had previously been removed from completing the survey for
not identifying as a SM (i.e., only identifying as heterosexual). I specifically removed participants from receiving compensation who I notated their response identification during the process. I then went through and verified that the remaining response identification provided in Mechanical Turk by participants were indeed valid and had been participants in the study. Participants who I did not screen out (i.e., passed all three validity checks; e.g., “Select agree for this question”) received compensation that was contingent upon total survey length and above federal minimum wage (i.e., $4 for 20-25 minutes) directly through Mturk within 72 hours of completion.

Participants

The final sample consisted of 398 individuals who self-identified as a sexual minority; detailed demographic information is shown in Table 1. Participants’ history and experiences with traditional mental health care (MHC) is shown in
Measures

Psychological Distress

I used the Kessler Psychological Distress Scale (KPDS; Kessler et al., 2002) to measure the amount of psychological distress experienced by participants recently. Items on the 10-item scale (e.g., During the last 30 days, about how often did you feel worthless?) are evaluated by a 5-point Likert-type scale ranging from 1 (none of the time) to 5 (all of the time) with higher scores reflecting higher levels of psychological distress. Participants were asked how much they endorsed psychopathological symptoms (e.g., depressed, nervous, worthless) in the past 30 days. Kessler and colleagues (2002) reported good internal consistency reliability in four studies, with Cronbach’s α ranging from .89 to .93. Internal consistency for this study was high (Cronbach’s α = .96)
**Table 1: Demographic Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>M (Standard deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>398</td>
<td>100</td>
<td>32.4 (7.5); Range = 20-65</td>
</tr>
<tr>
<td>Gender (check all that apply)</td>
<td>398</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>143</td>
<td>35.9</td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>244</td>
<td>61.3</td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td>10</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>Non-binary</td>
<td>6</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>398</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Gay or lesbian/homosexual</td>
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<td>35.9</td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td>255</td>
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</tr>
<tr>
<td>Queer</td>
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<td></td>
</tr>
<tr>
<td>Asexual</td>
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</tr>
<tr>
<td>Pansexual</td>
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<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Demisexual</td>
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<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Race and Ethnicity (check all that apply)</td>
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<td>98.7</td>
<td></td>
</tr>
<tr>
<td>Asian/Asian American/Asian Pacific Islander</td>
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<td>4.1</td>
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<tr>
<td>Black/African American/African</td>
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<td>29.5</td>
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</tr>
<tr>
<td>Latino/a/x or Hispanic</td>
<td>35</td>
<td>8.9</td>
<td></td>
</tr>
<tr>
<td>Native American</td>
<td>11</td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td>White or European American</td>
<td>234</td>
<td>59.5</td>
<td></td>
</tr>
<tr>
<td>Subjective Social Status</td>
<td>395</td>
<td>99.3</td>
<td>5.3 (2.1)</td>
</tr>
<tr>
<td>(lowest to highest)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>33</td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>60</td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>53</td>
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<tr>
<td>5</td>
<td>66</td>
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<td>6</td>
<td>65</td>
<td>16.5</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>51</td>
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<td></td>
</tr>
<tr>
<td>8</td>
<td>34</td>
<td>8.6</td>
<td></td>
</tr>
<tr>
<td>9</td>
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<td>5.6</td>
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</tr>
<tr>
<td>10</td>
<td>7</td>
<td>1.8</td>
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<tr>
<td>Current Zip Code Description</td>
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<td></td>
</tr>
<tr>
<td>Urban</td>
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<td>44.5</td>
<td></td>
</tr>
<tr>
<td>Suburban</td>
<td>158</td>
<td>39.7</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>62</td>
<td>15.6</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Level of Education</td>
<td>398</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
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<td>0.0</td>
<td></td>
</tr>
<tr>
<td>High school degree or GED</td>
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<td>8.0</td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>66</td>
<td>16.6</td>
<td></td>
</tr>
<tr>
<td>2-Year College Degree</td>
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<td>11.8</td>
<td></td>
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<tr>
<td>4-Year College Degree</td>
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<tr>
<td>Post-graduate education</td>
<td>59</td>
<td>14.8</td>
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Table 2: History and Experiences with Traditional Mental Health Care

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever Utilized Mental Health Services</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>185</td>
<td>46.5</td>
</tr>
<tr>
<td>No</td>
<td>213</td>
<td>53.5</td>
</tr>
<tr>
<td>Number of Mental Health Professionals Visited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>65</td>
<td>35.1</td>
</tr>
<tr>
<td>2</td>
<td>60</td>
<td>32.4</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
<td>14.1</td>
</tr>
<tr>
<td>4 or more</td>
<td>8.5</td>
<td>18.4</td>
</tr>
<tr>
<td>Age of First Mental Health Care Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M = 21.9 (SD = 7.4); Range = 3-50</td>
</tr>
<tr>
<td>Received Mental Health Services in Last Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>120</td>
<td>64.9</td>
</tr>
<tr>
<td>No</td>
<td>65</td>
<td>35.1</td>
</tr>
<tr>
<td>Type of Services Received in Last Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>56</td>
<td>46.7</td>
</tr>
<tr>
<td>Outpatient</td>
<td>98</td>
<td>81.7</td>
</tr>
<tr>
<td>Medication</td>
<td>73</td>
<td>60.8</td>
</tr>
</tbody>
</table>

**Perceived Mental Health Care Professional SM Affirmativeness**

I used the Gay Affirmative Practice Scale (GAP; Crisp, 2006) to assess participants’ perceived level of SM affirmative beliefs from MHC professionals writ large. Items on the original 30-item scale are evaluated in two, separately scored domains. The Beliefs subscale (15-items; e.g., “Practitioners should be knowledgeable about gay/lesbian resources”) was anchored on a 5-point Likert-type scale from 1 (strongly agree) to 5 (strongly disagree) and assessed beliefs about affirmative practice with SM individuals. The Engagement subscale (15-items; e.g., “I inform clients about gay affirmative resources in the community”) was anchored on a 5-point Likert-type scale from 1 (always) to 5 (never) and assessed frequency with which therapists engage in affirmative practice with SM clients. For the purpose of this study, I only used the Beliefs subscale as I am only concerned with perceived attitudes.
Similar to Alessi and colleagues (2019), I modified the scale so that SM individuals, instead of therapists, could evaluate their perception of mental health counselors writ large and the reference to SM individuals were more inclusive of all SM individuals rather than just gay and lesbian individuals. For example, I changed the item “Practitioners should make an effort to learn about the diversity of the gay/lesbian community” to “Practitioners make an effort to learn about the diversity of the sexual minority community.” The original scale demonstrated high internal consistency for Beliefs (Cronbach’s α = .93) and evidence of convergent and construct validity (Crisp, 2006). The modified scale demonstrated high internal consistency for the Beliefs subscale (Cronbach’s α = .95), adequate model fit for the adjusted subscales, and convergent validity with working alliance and real relationship. Internal consistency for this study was high (Cronbach’s α = .93). In order to ensure unidimensional structure for the revised measure, I ran a CFA that demonstrated good model fit, χ² (90) = 165.881, p < .001, CFI = .974, TLI = .970, SRMR = .029, and RMSEA = .046 (90% CI [.035-.057]).

**Perceived Mental Health Care Professional SM Prejudice**

I used the Attitudes Toward Homosexuality (ATH) scale (Kite & Deaux, 1986) to measure participants’ perceived level of sexual prejudice in mental health counselors. Items on the 21-item scale are evaluated on a 5-point Likert-type scale anchored by 1 (strongly disagree) to 5 (strongly agree) to measure an individual’s attitudes toward lesbian and gay individuals with higher scores indicating a higher level of sexual prejudice. In an attempt to assess participants’ perception of sexual prejudice in the mental health counselors and similar to a previous study (Spengler & Ægisdóttir, 2015), I revised the questionnaire to reflect how participants believed a counselor would answer the items. Additionally, I changed “sex” to “gender/sex” following the recommendations put forth by Hyde, Bigler, Joel, Tate, and van Anders (2018). For example, I
reworded the item “Two individual of the same sex holding hands or displaying affection in public is revolting” to “A counselor believes that two individual of the same gender/sex holding hands or displaying affection in public is revolting.” Kite and Deaux (1986) reported a high level of internal consistency with a Cronbach’s $\alpha$ of .93 and test–retest reliability over a 1-month period as .71. Kite and Deaux (1986) exhibited construct validity by significant correlations with a scale measuring attitudes toward traditional gender roles. In a published study using the revised version of the ATH (Spengler & Ægisdóttir, 2015), it demonstrated a high level of internal consistency (Cronbach’s $\alpha = .90$) and convergent validity with overall attitudes towards traditional MHC and prior counseling. Internal consistency for this study was high (Cronbach’s $\alpha = .93$).

**Attitudes towards Seeking Mental Health Care**

I used the Mental Help Seeking Attitudes Scale (MHSAS; Hammer, Parent, & Spiker, 2018) to measure participants’ overall attitudes towards engaging in traditional MHC. Items on the nine-item scale were organized on a semantic differential scale (i.e., If I had a mental health concern, seeking help from a mental health professional would be…) and were evaluated by a 7-point semantic differential scale from -3 (e.g., useless) to 3 (e.g., useful) where higher scores indicate more favorable attitudes. Hammer and colleagues (2018) demonstrated construct validity by significant correlations with other help-seeking attitudes measures, public stigma, and MHCE intentions. The MHSAS exhibited more stable unidimensional structure, stronger internal consistency, and incremental validity of predicting MHCE intentions than other help-seeking attitudes measures. Hammer and colleagues also reported good internal consistency (Cronbach’s $\alpha = .93$) and temporal stability over three weeks. Internal consistency for this study was high (Cronbach’s $\alpha = .90$).
**Self-Concealment**

I used the Self-Concealment Scale (SCS; Larson & Chastain, 1990) to assess participants’ active concealment of personal information from others that one perceives as negative or distressing. It is a 10-item scale (e.g., “When something bad happens to me, I tend to keep it to myself”) that measures level of self-concealment on a 5-point Likert-type scale anchored by 1 (**strongly disagree**) to 5 (**strongly agree**) with higher scores reflecting higher levels of self-concealment. Larson and Chastain (1990) exhibited construct validity by significant correlations with social support, distress, and secrecy. The instrument development study found a good level of internal consistency with a Cronbach’s α of .83 while other studies using LGBT+ participants (Jackson & Mohr, 2016) found higher levels of internal constancy with a Cronbach’s α of .89. Internal consistency for this study was high (Cronbach’s α = .92).

**Social Support**

I used the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) to assess participants’ perceived level of social support. Items on the 12-item scale were evaluated using a 7-point Likert-type scale ranging from 1 (**very strongly disagree**) to 7 (**very strongly agree**) with higher scores reflecting higher levels of perceived social support. The original scale consisted of three subscales: friends (4 items; e.g., “I have friends with whom I can share my joys and sorrows”), family (4 items; e.g., “I get the emotional help and support I need from my family”), and significant other (4 items). For the purpose of this subscale, I used only the friends and family subscales as having a significant other (i.e., a romantic partner) was not an inclusion criterion for the study. Zimet and colleagues (1988) reported good internal consistency reliability with Cronbach’s α of .88 and good test-retest reliability (r = .85). Zimet and
colleagues (1988) established construct validity for the instrument with a negative relation to anxiety and depression. Internal consistency for this study was high (Cronbach’s α = .92).

**Self Mental Health Stigma**

I used the Self-Stigma of Seeking Help Scale (Vogel et al., 2006) to assess individuals’ personal stigma towards engaging in psychological treatment. Items on the 10-item scale (e.g., I would feel inadequate if I went to a therapist for psychological help) were evaluated using a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Vogel and colleagues (2006) established good internal consistency (Cronbach’s α = .91), test-retest reliability (.72), and predictive validity of engagement in psychological services. Internal consistency for this study was adequate (Cronbach’s α = .81).

**Public Mental Health Stigma**

I used the Stigma Scale for Receiving Psychological Help (Komiya et al., 2000) to assess individuals’ perceptions of public stigma towards engaging in psychological treatment. Items on the 5-item scale (e.g., It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems) were evaluated using a 4-point Likert-type scale ranging from 0 (strongly disagree) to 3 (strongly agree). Komiya and colleagues (2000) found the scale had adequate internal consistency (Cronbach’s α = .72) and convergent validity with attitudes towards traditional MHC. Pinto and colleagues (2014) established test-retest reliability over eight weeks. Internal consistency for this study was adequate (Cronbach’s α = .86).

**Structural Barriers**

I used a modified version of the practical barriers subscale (Kung, 2004) of the larger Perceived Barriers to Mental Health Treatment Scale (Kung, 2004) to measure structural barriers toward MHCE, which I operationalized as distal social forces that influence MHCE. Items on the
4-item subscale (e.g., “It is too expensive to seek treatment for problems with emotions, nerves, drugs, alcohol, or mental health”) were evaluated on a 4-point Likert-type scale ranging from 1 (not at all true) to 4 (very true). Kung (2004) found the scale had adequate internal consistency (Cronbach’s $\alpha = .68$) and predictive validity of future engagement with traditional MHC. In the original study, Kung (2004) examined barriers to treatment for Chinese Americans and also included a cultural barriers subscale specifically in relation to Chinese Americans. Accordingly, I removed the cultural barriers subscale because the items were either irrelevant or conflated with other variables in the study (e.g., mental health stigma). The original scale included an item about language issues that could be confusing when taken out of context; accordingly, I removed that item as well for this study. Internal consistency for this study was adequate (Cronbach’s $\alpha = .68$). In order to ensure unidimensional structure for the revised measure as a single variable representing a latent construct, I ran a CFA that demonstrated good model fit, $\chi^2 (3) = 201.731, p < .001$, CFI = 1.000, TLI = 1.000, SRMR = .000, and RMSEA < .001 (90% CI [.000-.000]).

**Intentions to Seek Mental Health Care**

I used the Mental Help-Seeking Intention Scale (MHSIS; Hammer & Spiker, 2018) to assess participants’ intention to receive traditional MHC if they had a mental health concern. Items on the three-item scale (e.g., “If I had a mental health concern, I would try to seek help from a mental health professional”) were evaluated using a 7-point Likert-type scale ranging from 1 (definitely false) to 7 (definitely true). It should be noted that all three items have different anchors for their Likert-type scale. Hammer and Spiker (2018) adapted the scale from Ajzen’s (2006) three-item intention instrument in a guide to creating TPB questionnaires. Hammer and Spiker (2018) demonstrated high internal consistency, convergent validity with other help-seeking intention scales, and predictive validity with a correct classification rate near 70% of
future help-seeking behaviors which was higher than other help-seeking intention scales. Internal consistency for this study was high (Cronbach’s \( \alpha = .93 \)).

**Mental Health Care Experience**

In order to understand participants experiences with traditional MHC, I asked participants if they had received mental health counseling at any point in their life, the age of their first mental health counseling experience, how many mental health professionals they have seen in their lifetime, if they had received mental health counseling in the last 12 months, and what types of mental health counseling they received in the last 12 months (inpatient, outpatient, prescription medication). I also asked participants if they had received treatment in their lifetime that attempted to change their sexual orientation (i.e., sexual orientation change effort, conversion “therapy”); if they had, I asked participants if it was a MHC professional, medical health care professional, or other individual who provided the treatment.

**Unmet Mental Health Needs.** I asked participants who did not receive traditional MHC in the last 12 months if they perceived they had an unmet mental health need in the last 12 months. If they indicated they had an unmet mental health need, I asked participants to select the reason(s) for having an unmet mental health need, which were the same options provided in the SAMSHA (2018) National Survey on Drug Use and Health: could not afford cost, might cause neighbors/community to have a negative opinion, might have negative effect on job, health insurance did not cover any mental health services, health insurance does not pay enough for mental health services, did not know where to go for mental health services, concerned about confidentiality, concerned about being committed/having to take medicine, did not feel need for treatment at this time, thought could handle the problem without treatment, treatment would not help, did not have time, did not want others to find out, and no transportation/inconvenient.
**Alternative Mental Health Care.** In order to explain alternative forms of engagement in MHC outside of traditional MHC (e.g., psychotherapy) when participants have unmet mental health needs, I asked participants who/what they engaged about their mental health issues when they did not receive traditional mental health services. I provided participants a list and asked to select all that applied. Choices were friends, family, significant other, religious/spiritual leader, medical health professional (e.g., primary care physician), self-help book/podcast, self-care (e.g., exercise), n/a (i.e., no other person/activity), and other with an open-text option.

**Demographic Questionnaire**

I used a demographic and background sheet to ask participants to report their age, race, gender identity, level of education, description of area they spent growing up (e.g., suburban), the description of the area in which they currently live, socioeconomic status, and the state and zip code in which they currently reside. I allowed participants to select multiple identities, including a fill-in, for the following demographic variables: gender identity, sexual orientation identity, and race. I assessed family of origin socioeconomic status with the MacArthur Scale of Subjective Social Status (Adler et al., 2000), a Likert-type ranging from 1 (lower class) to 10 (upper class) that assesses individual’s perceived socioeconomic status in relation to others.

**Data Preparation and Initial Analysis**

I addressed all hypotheses and research questions using SPSS 26 (IBM Corp, 2019), PROCESS (Hayes, 2017), and structural equation modeling (SEM) using Mplus 8.1 (Muthén & Muthén, 2017). I excluded cases that did not meet inclusion criteria, met exclusion criteria, or did not complete portions of every questionnaire. The original sample consisted of 1000 individuals who clicked on the link. Ninety-five individuals did not complete any items beyond clicking on the link. I screened out 290 individuals who identified as straight and they did not
complete the survey. Six hundred and fifteen participants fully completed the survey. Of those who completed the survey, I excluded respondents for the following reasons: 1) 90 participants identified as straight/heterosexual at the time of first completing the survey screener and took the survey again with the same IP Address and/or Response ID, which infers the respondents were deceptive on the second completion; 2) 52 participants failed at least one attention check (e.g. “Select agree here”); 3) 50 participants answered that they had completed a developmental milestone (i.e., items for different study with same survey questions) at an older age than they currently held, which is impossible and thus suggests their responses were invalid or deceptive; 4) 18 participants could not complete an entire questionnaire due an overlooked error in survey logic, and 5) 7 participants due to their failure to correctly transpose their Question Pro ID into MTurk. In total, I excluded 217 completed surveys. The final sample consisted of 398 participants.

I examined missing data for individual items in SPSS 26 (IBM Corp, 2019). As all individual items had less than 1% missing data, which meets the recommendation of less than 5% missing data on any individual item, per best practices, I used expectation maximization to impute missing data (Parent, 2013; Schlomer et al., 2010). Next, I screened individual data for univariate normality and multicollinearity in order to ensure the accuracy of the statistical tests and meet their assumptions. None of the observed variables had absolute values of skewness greater than 3.0 or absolute values of kurtosis greater than 10.0, thereby not meeting extreme skewness or kurtosis according to Kline’s (2016) guidelines. Multicollinearity refers to two or more variables in a model being highly correlated and effectively measuring the same underlying latent construct (Bryne, 2016). As the correlations between all observed constructs was less than $r = .65$, multicollinearity was not an issue. Next, I calculated the internal consistency for each
scale, analyzed the descriptive statistics (i.e., frequencies, means, standard deviations), and estimated a correlation matrix. In order for the model to be just identified, I parceled individual items into three observed constructs that loaded onto each latent construct. I created these parcels based on item-to-construct rotated factor loadings (i.e., the serpentine method) to ensure all parcels had comparable cumulative rotated factor loadings (Little et al., 2002). Using parcels as indicators in structural models increases reliability and construct representation (Little et al., 2002; Little et al., 2013).

Following preparation of the data, I exported the data into Mplus 8.1 (Muthén & Muthén, 2017) to begin to conduct a structural equation model. The two main advantages for using SEM are assessment of an a priori specified model to test for relationships between multiple variables simultaneously and the correction for error variance that allows for more accurate identification of parameters. Prior to analyzing any structural model, I ran a measurement model to ensure sufficient model fit. I tested a hypothesized model of MHCE in which the latent constructs of attitudes towards MHC professionals, mental health stigma, structural barriers, self-concealment, and social support moderate the relationship between psychological distress and intentions to seek out traditional MHC (see figure 1). I used latent moderated structural equations (i.e., LMS method) to create a latent interaction from two latent constructs to examine moderating effects. In simulation studies comparing LMS method to other commonly used interaction methods, researchers note that the LMS method has less Type I error rates and better performance across a variety of other conditions (Jackman et al., 2011). Researchers note that the LMS method is consistent, asymptotically normally distributed, provide unbiased standard errors, and allows for multiple latent interactions to be tested simultaneously, although they note it is a computationally intensive procedure (Klein & Moosbrugger, 2000; Klein & Muthén, 2007). In order to have
interpretable interactions, I used the observed items of the latent constructs in SPSS using PROCESS (Hayes, 2017), as I could not produce interaction plots with simple slopes in Mplus. In PROCESS, I created a series of regression lines plotted at different levels of the moderators as they relate to psychological distress and intentions to seek traditional MHC. These values were set at the mean of the moderator and one standard deviation above and below the mean.

I used the following goodness-of-fit indices to evaluate model fit: 1) chi-square ($\chi^2$), normed chi-square ($\chi^2$/degrees of freedom), Tucker Lewis Index (TLI), Comparative Fit Index (CFI), Standardized Root Mean Square Residual (SRMR), and Root Mean Square Error of Approximation (RMSEA). Good model fit includes a non-significant $\chi^2$, $\chi^2$/DF less than 5, TLI of .90 or higher, CFI at .95 or higher, and RMSEA less than .08 (Wheaton et al., 1977); other scholars suggest adequate model fit with CFI at .90 or higher (Hu & Bentler, 1999; Rigdon, 1996). Although chi-square is a commonly reported model fit statistic, it is sensitive to sample size and considered a conservative indicator; therefore, all model fit indices should be interpreted collectively (Weston & Gore, 2006). The CFI and TLI help evaluate model fit by comparing proposed models to more restricted models (i.e., null models) and $\chi^2$/DF helps control for sample size (Weston & Gore, 2006). To measure effect size, I used the squared correlation statistic ($R^2$) to determine the total amount of variance for intentions to seek traditional MHC for which the model. After testing the initial hypothesized model, I refined the model in an iterative manner where I informed any decisions both analytically and theoretically. When I tested other models, I compared the model fit indices (i.e., RMSEA, CFI, TLI, SRMR) between the models and perform a nested chi-squared analysis to determine the best fitting model. Following the recommendations of Maslowsky and colleagues (2015), I only estimated model fit estimates for
the measurement models and structural models without the interaction terms, as model fit indices are not possible for LMS (Muthén & Muthén, 2017).
Chapter 3: Results

The means, standard deviations, and correlations between all observed variables are presented in Table 3. The results are presented in order of hypotheses that are separated by headings. First, the relationship between psychological distress and intentions to seek out traditional MHC is reported. Then, the model testing and model fit indices are reported of the measurement model, structural model, and structural model with moderators. This is followed by the significance of the association between latent constructs and intentions to seek traditional MHC within the structural model and the moderated structural model. Next, participants’ reasons for unmet mental health needs, alternative forms of MHC when they have unmet mental health needs, and experiences with sexual orientation change efforts are reported. Lastly, post hoc analyses are reported.

**Relationship between Distress and Intentions to Seek out Traditional MHC**

As predicted (hypothesis 1), the relationship between psychological distress and intentions to seek out traditional MHC was not statistically significant (see Figure 4), $r = .084, p = .096$. 
Table 3: Correlation between Measured Variables (Indicators) and Indicator Means and Standard Deviations

<table>
<thead>
<tr>
<th>Measured Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD)</td>
<td>2.609</td>
<td>3.912</td>
<td>2.2973</td>
<td>5.274</td>
<td>3.161</td>
<td>5.181</td>
<td>2.491</td>
<td>2.489</td>
<td>2.250</td>
<td>2.820</td>
<td>2.180</td>
<td>5.119</td>
</tr>
<tr>
<td></td>
<td>(1.131)</td>
<td>(.681)</td>
<td>(.755)</td>
<td>(1.194)</td>
<td>(1.017)</td>
<td>(1.275)</td>
<td>(.770)</td>
<td>(.767)</td>
<td>(1.013)</td>
<td>(1.030)</td>
<td>(1.046)</td>
<td>(1.458)</td>
</tr>
<tr>
<td>1. KPDS</td>
<td>- .010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. MHCP Aff.</td>
<td>.489**</td>
<td>-.556**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. MHCP Prej</td>
<td>-.296**</td>
<td>.393**</td>
<td>-.492**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. MHSAS</td>
<td>.637**</td>
<td>.104*</td>
<td>.341**</td>
<td>-.219**</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>5. SCS</td>
<td>-.110*</td>
<td>.405**</td>
<td>-.135**</td>
<td>.222**</td>
<td>-.085</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. MSPSS</td>
<td>.469**</td>
<td>-.301**</td>
<td>.557**</td>
<td>-.514**</td>
<td>.384**</td>
<td>-.161**</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7. SSSHS</td>
<td>.566**</td>
<td>-.029</td>
<td>.493**</td>
<td>-.321**</td>
<td>.606**</td>
<td>-.025</td>
<td>.560**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. SB: Time</td>
<td>.496**</td>
<td>-.076</td>
<td>.450**</td>
<td>-.349**</td>
<td>.491**</td>
<td>.049</td>
<td>.472**</td>
<td>.520**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. SB: Cost</td>
<td>.341**</td>
<td>.048</td>
<td>.183**</td>
<td>-.181**</td>
<td>.334**</td>
<td>-.037</td>
<td>.365**</td>
<td>.347**</td>
<td>.389**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. SB: How</td>
<td>.548**</td>
<td>-.125*</td>
<td>.470**</td>
<td>-.361**</td>
<td>.459**</td>
<td>-.054</td>
<td>.532**</td>
<td>.498**</td>
<td>.521**</td>
<td>.329**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. MHSIS</td>
<td>.084</td>
<td>.403**</td>
<td>-.136**</td>
<td>.437**</td>
<td>.074</td>
<td>.421**</td>
<td>-.398**</td>
<td>.032</td>
<td>-.044</td>
<td>-.199**</td>
<td>-.140**</td>
<td></td>
</tr>
</tbody>
</table>

Note. * p < .05 ** p < .01 level. KPDS = Kessler Psychological Distress Scale; MHCP Aff = Perceived Mental Health Care Professional Sexual Minority Affirmativeness (Gay Affirmative Practice Scale); MHCP Prej = Perceived Mental Health Care Professional Sexual Minority Prejudice (Attitudes Toward Homosexuality scale); MHSAS = Mental Help Seeking Attitudes Scale; SCS = Self-Concealment Scale; MSPSS = Multidimensional Scale of Perceived Social Support; SSSHS = Self-Stigma of Seeking Help Scale; SSRPH = Stigma Scale for Receiving Psychological Help; SB = Structural Barriers; MHSIS = Mental Help-Seeking Intention Scale.
Figure 4: Scatter Plot of Psychological Distress with Intentions to Seek Mental Health Care.

Model Testing

*Measurement Model*

Before examining the structural model, I evaluated the adequacy of the measurement model. I simultaneously used theory and statistics to inform any modifications in an iterative analytical process in order to find the best model. The original model resulted in poor model fit, $\chi^2 (255) = 1422.66$, $\chi^2$/DF = 5.579, CFI = .401, TLI = .295, RMSEA = .107 (90% CI [.102-.113]), SRMR = .112. As previous experience with traditional MHC was not correlated with all other variables, I pruned this observed construct from the model. The model without previous
MHC also resulted in poor model fit, $\chi^2 (231) = 1099.364$, $\chi^2/DF = 4.759$, CFI = .886, TLI = .864, RMSEA = .097 (90% CI [.091-.103]), SRMR = .095, although a chi-square difference test showed it resulted in significantly better model fit than the previous model, $\chi^2 (24) = 323.296$, $p < .001$. As informed by the Theory of Planned Behavior, the self mental health stigma items did not fit conceptually with subjective norms (i.e., perception of what others think, not oneself) as did public mental health stigma. When I took self mental health stigma items out of the mental health stigma latent construct, the model resulted in adequate model fit, $\chi^2 (168) = 600.163$, $\chi^2/DF = 3.572$, CFI = .934, TLI = .918, RMSEA = .080 (90% CI [.073-.087]), SRMR = .075, as well as a significantly better model fit than the previous model, $\chi^2 (63) = 499.201$, $p < .001$. As no other model modifications justifiable with both theory and statistics, I deemed this model the final measurement model. All loadings of the parceled items on their latent variables, $\beta = .491$ to .943, were statistically significant, $p < .001$. As the LMS method does not have a mean, variance, or covariance with other parameters and is done in a subsequent step, it should not affect the model fit of the measurement model and is not included in it (Maslowsky et al., 2015).

**Structural Model**

As the model was fully saturated, the adequate model fit of the structural model was identical to the model fit of the final measurement model (hypothesis 2a). For specific loadings of latent construct on intentions to seek traditional MHC, please reference results in next section. The structural model accounted for 47.6% of the variance in intentions to seek traditional MHC (hypothesis 2b). Next, for the LMS procedure, I added the interaction terms of the five moderators with psychological distress using the XWITH command in Mplus. The amount of dimensions of integration and integration points resulted in a “fatal error” due to the lack of computational power, which is a noted limitation of the LMS method (Klein & Muthén, 2007).
Following the Theory of Planned Behavior (TPB), I ran a model with three interactions for only the variables selected for personal beliefs (i.e., attitudes towards MHC professionals), subjective norms (i.e., public mental health stigma), and perceived and actual behavioral control (i.e., structural barriers). Additionally, this model included the other two variables (self-concealment and social support) core to previous help-seeking models and the Network-Episode Model as associated with intentions to seek traditional MHC (see Figure 6 for conceptual model). For specific loadings of latent construct on intentions to seek traditional MHC, please reference results in next section. The interaction of psychological distress with structural barriers ($\beta = .325$, $SE = .175$, $p = .063$), attitudes towards MHC professionals ($\beta = -.071$, $SE = .110$, $p = .522$), and mental health stigma ($\beta = -.117$, $SE = .163$, $p = .475$) were not statistically significant. In order to answer the research questions and per recommendations (Muthén & Muthén, 2017), I ran all interactions with the entire model individually (reported below). The structural model with TPB moderators accounted for 55.7% of the variance in intentions to seek traditional MHC, or an additional 8.1% of variance compared to the structural model without interaction terms. See

for the correlations between latent constructs in the structural model with TPB moderators and Figure 5 for a visualization of the statistical model with TPB moderators.
Figure 5: Statistical Model with Theory of Planned Behavior Moderators of Mental Health Care Engagement.

Note. Standardized estimates shown. MHC = mental health care; PD = psychological distress; Att MHCP = attitudes towards mental health care professionals; MH = mental health; SB = structural barriers.

Figure 6: Conceptual Model of Mental Health Care Engagement.

Note. MHC = mental health care; MHCP = perceived mental health care professional; MHS = mental health stigma; MHC = mental health care.
Table 4: Correlation Matrix of Latent Constructs (Standard Error)

<table>
<thead>
<tr>
<th></th>
<th>PD</th>
<th>Att MHCP</th>
<th>SC</th>
<th>SS</th>
<th>MH Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Att MHCP</td>
<td>-0.467 (.070)**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SC</td>
<td>0.675 (.032)**</td>
<td>-0.303 (.074)**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>-0.111 (.053)*</td>
<td>0.304 (.089)*</td>
<td>-0.092 (.063)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHS</td>
<td>0.646 (.043)**</td>
<td>-0.533 (.075)**</td>
<td>0.690 (.039)**</td>
<td>-0.033 (.067)</td>
<td></td>
</tr>
<tr>
<td>SB</td>
<td>0.737 (.044)**</td>
<td>-0.649 (.066)**</td>
<td>0.684 (.047)**</td>
<td>0.013 (.064)</td>
<td>0.795 (.052)**</td>
</tr>
</tbody>
</table>

Note. Matrix of structural model with moderators. Att MHCP = attitudes towards mental health care professionals; SC = self-concealment; SS = social support; MHS = mental health stigma; SB = structural barriers; PD = psychological distress; ** p < .001, * p < .05

Association with Intentions to Seek Traditional Mental Health Care

This section reports the significance of the association of each latent construct on intentions to seek traditional MHC in both the structural model and the structural model with TPB moderators.

**Attitudes towards Mental Health Care Professionals**

In the structural model, attitudes towards MHC professionals ($\beta = 0.247$, $SE = 0.122$, $p = 0.043$) significantly was positively associated with intentions to seek traditional MHC (hypothesis 3a), such that individuals reporting more positive attitudes towards MHC professionals reported a higher intention to seek traditional MHC. In the structural model with TPB moderators, attitudes towards MHC professionals ($\beta = 0.136$, $SE = 0.270$, $p = 0.616$) did not significantly associate with intentions to seek traditional MHC.

**Mental Health Stigma**

Due to issues with model fit in the measurement model, only observed variables of public mental health stigma (i.e., not personal mental health stigma) loaded onto the latent construct of mental health stigma. In the structural model, mental health stigma ($\beta = 0.343$, $SE = 0.118$, $p = 0.001$).
significantly positively associated with higher intentions to seek traditional MHC (hypothesis 3b), such that individuals reporting greater mental health stigma reported a higher intention to seek traditional MHC. In the structural model with TPB moderators, mental health stigma ($\beta = .333, SE = .181, p = .066$) did not significantly associate with intentions to seek traditional MHC.

**Structural barriers**

In the structural model ($\beta = -.705, SE = .204, p = .001$) and structural model with TPB moderators ($\beta = -.878, SE = .415, p = .034$), structural barriers significantly negatively associated with intentions to seek traditional MHC (hypothesis 3c), such that individuals reporting more structural barriers reported a lower intention to seek traditional MHC.

**Self-Concealment**

In the structural model ($\beta = .111, SE = .099, p = .261$) and the structural model with TPB moderators ($\beta = .227, SE = .148, p = .126$), self-concealment did not significantly associate with intentions to seek traditional MHC (hypothesis 3d).

**Social Support**

In the structural model ($\beta = .442, SE = .067, p < .001$) and the structural model with TPB moderators ($\beta = .417, SE = .137, p = .002$), social support significantly positively associated with intentions to seek traditional MHC (hypothesis 3e), such that individuals reporting more social support reported a higher intention to seek traditional MHC.

**Explaining the Treatment Gap**

Due to issues with lack of computational power and following recommendations (Muthén & Muthén, 2017), I ran each interaction individually with the structural model to test its significance. In order to have interpretable interaction plots, I used the observed items of the
latent constructs in SPSS using PROCESS (Hayes, 2017), as I could not produce interaction plots with simple slopes in Mplus. To plot the interaction between the moderators and psychological distress on intentions to seek traditional MHC, I used values one standard deviation above (high), the mean (average), and one standard deviation below (low) the moderators to create nine data points (i.e., one at each of those three points for psychological distress) to plot the interaction effect on intentions to seek traditional MHC.
Attitudes towards MHC professionals

When I included the latent interaction between attitudes towards MHC professionals and psychological distress with the structural model, the interaction significantly associated with intentions to seek traditional MHC ($\beta = -.235, SE = .071, p = .001$; hypothesis 4b). This model accounted for 49.4% of the variance in traditional MHC, which is a 1.8% increase from the structural model. For a visualization of the interaction between attitudes towards MHC professionals and psychological distress on intentions to seek traditional MHC, see Figure 7.

Simple slope analyses indicated the relationship between psychological distress and intentions to seek traditional MHC was significant for both individuals with low ($B = .602$, $t (398) = 6.816, p < .001$), and average ($B = .307$, $t (398) = 5.167, p < .001$), attitudes towards MHC professionals but not significant for individuals with high attitudes towards MHC professionals ($B = .01$, $t (398) = .146, p = .883$ (hypothesis 4a)).

Figure 7: Attitudes towards Mental Health Care Professionals as a Moderator.
**Mental Health Stigma**

When I included the latent interaction between mental health stigma and psychological distress with the structural model, the interaction significantly associated with intentions to seek traditional MHC \( (\beta = .172, SE = .067, p = .010; \) hypothesis 5b). This model accounted for 49.3\% of the variance in traditional MHC, which is a 1.7\% increase from the structural model. For a visualization of the interaction between mental health stigma and psychological distress on intentions to seek traditional MHC, see Figure 8. Simple slope analyses indicated the relationship between psychological distress and intentions to seek traditional MHC was significant for individuals with high mental health stigma \( (B = .354), t (398) = 3.728, p = .002, \) but not for individuals with low \( (B = -.198), t (398) = -1.805, p = .072, \) or average \( (B = .079), t (398) = 1.00, p = .317, \) mental health stigma (hypothesis 5a).

![Figure 8: Public Mental Health Stigma as a Moderator.](image-url)
**Structural Barriers**

When I included the latent interaction between structural barriers and psychological distress with the structural model, the interaction significantly associated with intentions to seek traditional MHC ($\beta = .265$, $SE = .059$, $p < .001$; hypothesis 6b). This model accounted for 54.8% of the variance in traditional MHC, which is a 7.2% increase from the structural model. For a visualization of the interaction between structural barriers and psychological distress on intentions to seek traditional MHC, see Figure 9. Simple slope analyses indicated the relationship between psychological distress and intentions to seek traditional MHC was significant for individuals with average ($B = .289$), $t (398) = 3.833$, $p < .001$, and high ($B = .660$), $t (398) = 7.246$, $p < .001$, structural barriers but not for individuals with low structural barriers ($B = -.081$), $t (398) = -.758$, $p = .449$ (hypothesis 6a).

![Figure 9: Structural Barriers as a Moderator.](attachment:image.png)
**Self-Concealment**

When I included the latent interaction between self-concealment and psychological distress with the structural model, the interaction did not significantly associate with intentions to seek traditional MHC (β = .102, SE = .063, p = .103; hypothesis 7b). This model accounted for 47.2% of the variance in traditional MHC, which is a 0.4% decrease from the structural model. For a visualization of the interaction between self-concealment and psychological distress on intentions to seek traditional MHC, see Figure 10. Simple slope analyses indicated the relationship between psychological distress and intentions to seek traditional MHC was significant for individuals with high (B = .284), t (398) = 2.930, p = .036, and low (B = -.313), t (398) = -2.45, p = .0147, but not for average self-concealment (B = -.015), t (398) = -.172, p = .864 (hypothesis 7a).

![Figure 10: Self-Concealment as a Moderator.](image-url)
Social Support

When I included the latent interaction between social support and psychological distress with the structural model, the interaction significantly associated with intentions to seek traditional MHC ($\beta = .153$, $SE = .064$, $p = .018$; hypothesis 8b). This model accounted for 52.6% of the variance in traditional MHC, which is a 6.0% increase from the structural model. For a visualization of the interaction between social support and psychological distress on intentions to seek traditional MHC, see Figure 11. As the interaction of social support and psychological distress on intentions to seek traditional MHC was not significant, $F(1, 394) = 1.271$, $p = .260$ (hypothesis 8a), I did not test the significance of the simple slopes.

Figure 11: Social Support as a Moderator.
Unmet Mental Health Needs

Nearly 40% of the sample reported needing traditional MHC in last 12 months but not receiving services (i.e., an unmet mental health need). See
Table 5 for the specific reason(s) participants provided for having an unmet mental health need (research question 5). A substantially higher percentage of individuals who had received traditional MHC in the last year reported having an unmet mental health need in the last year.
### Table 5: Unmet Mental Health Needs

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Total %</th>
<th>UMHN %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unmet mental health need in the last 12 months (N = 398)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>158</td>
<td>39.8</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>239</td>
<td>60.1</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unmet mental health need for those who had received traditional MHC in last 12 months (n = 120)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>82</td>
<td>68.3</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>37</td>
<td>31.1</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unmet mental health need for those who have never received traditional MH care (n = 213)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>48</td>
<td>22.5</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>165</td>
<td>77.5</td>
<td></td>
</tr>
<tr>
<td><strong>Reason for unmet mental health need</strong></td>
<td>N = 397</td>
<td>N = 158</td>
<td></td>
</tr>
<tr>
<td>Could not afford cost</td>
<td>70</td>
<td>17.6</td>
<td>44.3</td>
</tr>
<tr>
<td>Thought problem could be handled without treatment</td>
<td>52</td>
<td>13.1</td>
<td>32.9</td>
</tr>
<tr>
<td>Health insurance did not cover mental health services</td>
<td>51</td>
<td>12.8</td>
<td>32.3</td>
</tr>
<tr>
<td>Health insurance did not pay enough for mental health services</td>
<td>44</td>
<td>11.1</td>
<td>27.8</td>
</tr>
<tr>
<td>Concerned about confidentiality</td>
<td>38</td>
<td>9.6</td>
<td>24.1</td>
</tr>
<tr>
<td>Might cause neighbors/community to have negative opinion</td>
<td>35</td>
<td>8.8</td>
<td>22.2</td>
</tr>
<tr>
<td>Did not know where to go for mental health services</td>
<td>33</td>
<td>8.3</td>
<td>20.9</td>
</tr>
<tr>
<td>Might have negative impact on job</td>
<td>30</td>
<td>7.6</td>
<td>19.0</td>
</tr>
<tr>
<td>Concerned about being committed/having to take medication</td>
<td>26</td>
<td>6.5</td>
<td>16.5</td>
</tr>
<tr>
<td>Did not have time</td>
<td>25</td>
<td>6.3</td>
<td>15.8</td>
</tr>
<tr>
<td>Treatment would not help</td>
<td>22</td>
<td>5.5</td>
<td>13.9</td>
</tr>
<tr>
<td>Did not feel the need for treatment at the time</td>
<td>18</td>
<td>4.5</td>
<td>11.4</td>
</tr>
<tr>
<td>Did not have transportation</td>
<td>17</td>
<td>4.3</td>
<td>10.8</td>
</tr>
<tr>
<td>Did not want others to find out</td>
<td>15</td>
<td>3.8</td>
<td>9.5</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>6.8</td>
<td>17.1</td>
</tr>
</tbody>
</table>

*Note.* MH = mental health; UMHN = unmet mental health need.
Alternative Forms of Mental Health Care Engagement

For individuals who reported having an unmet mental health need in the last 12 months, see Table 6 for alternative MHC methods engaged in about their mental health issues (research question 6).

Sexual Orientation Change Efforts

For number of individuals who received treatment to attempt to change their sexual orientation and the type of professional who provided the treatment (research question 7), see Table 7. As I permitted individuals to select multiple options for who provided the treatment, results are not orthogonal
Table 6: Alternative Forms of Mental Health Care Engagement \((N = 158)\)

<table>
<thead>
<tr>
<th></th>
<th>(N)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>85</td>
<td>53.8</td>
</tr>
<tr>
<td>Family</td>
<td>66</td>
<td>41.8</td>
</tr>
<tr>
<td>Self-care (e.g., exercise)</td>
<td>45</td>
<td>28.5</td>
</tr>
<tr>
<td>Significant other</td>
<td>34</td>
<td>21.5</td>
</tr>
<tr>
<td>Self-help book/podcast</td>
<td>34</td>
<td>21.5</td>
</tr>
<tr>
<td>Medical provider (e.g., primary care physician)</td>
<td>23</td>
<td>14.6</td>
</tr>
<tr>
<td>Religious/spiritual leader</td>
<td>15</td>
<td>9.5</td>
</tr>
<tr>
<td>N/A (i.e., no other person/activity)</td>
<td>14</td>
<td>8.9</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Table 7: Sexual Orientation Change Efforts

<table>
<thead>
<tr>
<th>Received Treatment to Change Sexual Orientation</th>
<th>(N)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>76</td>
<td>19.1</td>
</tr>
<tr>
<td>No</td>
<td>310</td>
<td>77.9</td>
</tr>
<tr>
<td>Unsure</td>
<td>12</td>
<td>3.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Who Provided Treatment</th>
<th>(N)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Provider</td>
<td>70</td>
<td>92.1</td>
</tr>
<tr>
<td>Medical Provider</td>
<td>25</td>
<td>32.9</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.6</td>
</tr>
</tbody>
</table>
**Post Hoc Analyses**

In order to see the interaction of the novel attitudinal variables separate from attitudes towards MHCP writ large, I ran post hoc interactions in PROCESS for perceived counselor sexual orientation prejudice and affirmation. For a visualization of the interaction between perceived counselor sexual orientation prejudice and psychological distress on intentions to seek traditional MHC, see Figure 12. Simple slope analyses indicated the relationship between perceived counselor sexual orientation prejudice and psychological distress on intentions to seek traditional MHC was significant for individuals with high ($B = .6147$), $t(398) = 6.468$, $p < .001$, and average perceived counselor prejudice ($B = .213$), $t(398) = 3.023$, $p = .003$, but not for individuals with low perceived counselor prejudice ($B = -.190$), $t(398) = -1.792$, $p = .074$. For a visualization of the interaction between perceived counselor sexual orientation affirmation and psychological distress on intentions to seek traditional MHC, see Figure 13. As the interaction of social support and psychological distress on intentions to seek traditional MHC was not significant, $F(1, 394) = .365$, $p = .546$, I did not test the significance of the simple slopes.
Figure 12: Perceived Mental Health Professional Sexual Orientation Prejudice as a Moderator.

Figure 13: Perceived Mental Health Professional Sexual Orientation Affirmation as a Moderator.
Chapter 4: Discussion

The purpose of the present study was to test a model of mental health care engagement (MHCE) with sexual minority (SM) individuals from a health equity perspective informed by the Theory of Planned Behavior (TPB; Ajzen, 1985), Network-Episode Model (NEM; Pescosolido & Boyer, 2010), and the threat-to-self-esteem model (Nadler & Fisher, 1986). By testing a structural model with a series of potential moderators, I aimed to understand how the trajectory of distress interacted moderating variables in the process of MHCE associated with intentions to seek out traditional mental health care (MHC). Lastly, a goal of this study was to understand what contributes to unmet mental health needs, what SM individuals do for alternative forms of MHC, and how frequently individuals have received sexual orientation change efforts. As predicted, psychological distress was not significantly associated with intentions to seek traditional MHC (hypothesis 1), which illustrates a lack of relationship that could be further contextualized by the other findings. These findings and their implications are discussed in the context of existing research, theory, and practice.

Understanding Mental Health Care Engagement in Structural Relief

In addition to the structural stigma that contributes to inequitable mental health rates (Hatzenbuehler, 2016), the findings show that structural vulnerability plays a significant role in MHCE. I used an iterative analytic process guided by theory and data to find a model with TPB moderators that had adequate model fit and accounted for over half of the variance in intentions to seek traditional MHC (hypotheses 2a & 2b). In this model, lower structural barriers and higher social support significantly associated with higher intentions to seek traditional MHC (hypotheses 3c & 3e). A large proportion of this variance is accounted for via the interaction of structural barriers and psychological distress, which suggests the consideration of structural
barriers (i.e., cost, time, and how to engage) is instrumental in the process of understanding and conceptualizing MHCE. Moreover, nearly 40% of individuals reported having an unmet mental health need (research question 5); interestingly, respondents who had received traditional MHC in the last 12 months were more likely to report having an unmet mental health need in the last 12 months compared to respondents who had not received traditional MHC in the last 12 months. This reflects that not all mental health needs are met by traditional MHC. That three out of the top four most endorsed reasons for an unmet mental health need were structural barriers further emphasizes the importance of structural barriers in the process of MHCE.

These findings showcase how structural vulnerability impedes SM individuals who need or want MHC from receiving it. Structural vulnerability represents the forces that frame and constrain choices, thereby impeding decision-making and limiting life options for those who are in disadvantaged or marginalized social positioning due to oppressive forces (Quesada et al., 2011). The significant role structural barriers and their interaction with psychological distress play in negatively associating with intentions to seek out traditional MHC poses the question as to how we frame health differences. Rather than talking about health differences between populations as health disparities, psychologists should take a critical stance on how structural vulnerability makes these better understood as health inequities (Bowleg, 2017).

This is the first study to find that structural barriers and perceived MHC professional sexual orientation attitudes prospectively impede SM individuals’ intentions to engage with traditional MHC. This study also is the first model to include structural barriers with SM individuals. Previous correlational or qualitative studies show structural barriers (e.g., Barefoot et al., 2015; Dahlhamer et al., 2016) and perceived MHC professional sexual orientation prejudice or affirmation (Barefoot et al., 2015; Romanelli & Hudson, 2017; Willging et al.,
2006) as contributing factors to SM individuals reporting retroactively delaying or not receiving traditional MHC. The methodology of this past research risks inferring MHCE as a static, bivariate process. All latent constructs in the model in the present study significantly related to one another—with the exception of social support with mental health stigma and structural barriers. This significant relationship between latent constructs suggest that intentions to engage in traditional MHC is a dynamic, multifaceted, and interrelated process best understood in structural relief (Grzanka, 2020).

Given the impact of surrounding structures on individual intentions to seek out traditional MHC and on mental health writ large, psychologists should consider moving from the paradigm/construct of “help-seeking” and toward MHCE. Previous models of MHCE or help-seeking that overlooked the influence of structural barriers assume 100% of volitional control, decision-making, and responsibility for mental health is on rational, individual agents. Researchers have documented the influence of social, psychological, economic, and cultural factors as significant contributors to inequitable mental health outcomes (e.g., Hatzenbuehler, 2016; Grzanka et al., 2020). Findings from this study suggest structural factors and institutional contexts also play an integral role in how individuals navigate mitigating this distress, especially in regard to seeking out traditional MHC and reasons for unmet mental health needs. MHCE includes much more than just traditional MHC. Participants in this study were likely to engage other sources to help meet their MHC needs, including friends, family, and self-care (research question 6). Furthermore, nearly 20% of the sample reported receiving treatment to attempt to change their sexual orientation, and participants reported MHC professionals conducted the vast majority of this so-called “treatment” (research question 7). The deleterious effects of conversion
“therapy” may inform rational reticent attitudes to engage in traditional MHC again as it was likely previously a source of hurt and not help (Ryan et al., 2020).

The Importance of Sociocultural Context in the Continuum of Distress

The findings from this study illustrate how a continuum of psychological distress plays a role in the process of MHCE. The continuum of psychological distress has previously been emphasized in the NEM (Pescosolido & Boyer, 2010). Although the present study was cross-sectional, it illustrates a pattern that individuals’ different levels of psychological distress (i.e., NEM’s “illness career”) impact the process of MHCE. Interactions between psychological distress and moderating variables illuminate a pattern of reactive mental health care for participants who were most vulnerable (research question 4). Respondents with low attitudes towards MHC professionals, high mental health stigma, high self-concealment, and high perceived counselor sexual orientation prejudice were only as likely to seek traditional MHC as their counterparts when they regularly experienced distress in the last month. Psychologists have documented this concerning pattern of only seeking traditional MHC once an individual has reached a crisis point in previous studies examining suicidality, self-harm, and help-seeking in SM youth (e.g., McDermott et al., 2018). Although most factors significantly interacted with psychological distress, two variables were consistent across the continuum of distress: social support and perceived counselor sexual orientation affirmation had an impact on intentions to seek traditional MHC regardless of psychological distress. That is, respondents with low social support and low perceived counselor sexual orientation affirmation were the least likely to seek out traditional MHC consistently across all levels of psychological distress, and vice versa.
Limitations

The results from the current study should be interpreted cautiously and in terms of various limitations. Given the study was cross-sectional, correlational research, I am not able to establish temporal relationships between variables and cannot draw causal conclusions. Additionally, while MTurk allowed easy access and recruitment of SM participants, the majority of the sample was White, male, bisexual, living in an urban area, and 4-year college graduates; moreover, the entire sample was over 18, lived in the United States, and had internet access. Respondents self-selected to participate via MTurk, and there may be systematic differences between SM individuals who chose to participate and those who did not. Thus, caution should be used when attempting to generalize the results of our study to SM populations who are less well-represented in this sample.

The research design and data analytic process also come with limitations that should be considered. I made modifications to three previously validated measures based on results from measurement models (structural barriers, perceived counselor sexual prejudice, perceived counselor sexual affirmation). It would be important to replicate these findings to ensure the psychometric properties found in the current sample hold across other samples and sampling contexts. The structural barriers scale exhibited only adequate internal consistency in this sample, which is a common pattern in measures of perceived and/or actual behavioral control (Ajzen, 2002). In this study, the sub-optimal internal consistency for structural barriers may be due to the three items reflecting both perceived (i.e., knowing how to seek traditional MHC) and actual behavioral control (i.e., cost, time). As this study was the first study with SM individuals to incorporate either variation of behavioral control in a model in the form of structural barriers, I decided to include them as one latent construct. Whether or not it is best to collapse variables
measuring self-efficacy (i.e., perceived behavioral control) and controllability (i.e., actual behavioral control) into one latent construct in MHCE remains an empirical question (Ajzen, 2002). I relied upon self-report measures in this study which are susceptible to biases including social desirability. Although I analyzed the statistical interaction for each moderator variable with psychological distress on intentions to seek traditional MHC with the variance accounted for by other latent constructs and latent TPB moderators, I ran the visualization and reporting of the simple slope plots in PROCESS without accounting for the variance accounted for by other variables. This should be considered when interpreting the simple slope plots.

Variable measurement and selection influenced every aspect of these findings. For instance, the present study did not collect behavior on participants’ actual future engagement with traditional MHC and, instead, used behavioral intentions as a proxy for actual behavior. While this is common practice in TPB research and research has shown that current intentions predict future use of traditional MHC (Damghanian & Alijanzadeh, 2018), the lack of longitudinal data limits the conclusions that can be drawn regarding the variables’ predicting SM individuals actually engaging in traditional MHC. Only participants who identified having an unmet mental health need in the last year answered the questions about alternative MHC, so the alternative MHC practices of SM individuals without an unmet mental health need remains unknown. Additionally, structural equation modeling is a variable-centered research methodology which restricts the results based on pre-determined research questions or hypotheses, as opposed to a more person-centered statistical techniques, such as latent profile analysis. As I examined participants in one group through a variable-centered approach, structural equation modeling inherently cannot model MHCE for multiply marginalized populations without reducing demographic variables to a covariate (Else-Quest & Hyde, 2015).
Person-centered statistical techniques would allow for the methodology to better reflect an intersectional approach while also maintaining statistical rigor and feminist objectivity (Grzanka, 2016).

Although the structural TPB model did account for a large proportion of variance in intentions to seek traditional MHC (55.7%), a substantial amount of variance remains unknown. There are other variables that could potentially account for additional variance. For example, mental health literacy is often discussed as an implication to improve intentions to seek traditional MHC (e.g., Vogel et al., 2011) but not often included in models of MHCE. This is an example of a variable that could be included in future models, especially as not much is known about the mental health literacy of SM individuals (Wang et al., 2014).

**Implications and Future Directions**

The findings and limitations are discussed further as implications and future directions for theory, practice, advocacy, education, training, and research.

**Theory**

When considering the treatment gap, psychologists need to break out of the traditional paradigm of help-seeking that focuses on individual attitudes as the main contributor to future behavior (Sugarman & Thrift, 2017). Instead, psychologists should look toward an interdisciplinary approach to help inform the process of MHCE, including public health (e.g., Agurs-Collins et al., 2019; Levesque et al., 2013; Metzl & Hansen, 2014), critical race theory (e.g., Bonilla-Silva, 2003), and medical sociology (e.g., Pescosolido & Boyer, 2010). The most influential deterrent from individuals seeking out MHC in this study was not factors within the individuals themselves, but the structural barriers they faced in the process (hypothesis 3c).
These findings echo public health researchers’ conceptualization of patient-centered health care access and its focus on structural barriers (e.g., access, cost, time; Levesque et al., 2013).

Much like Bowleg (2017) used structural vulnerability to better frame health disparities as health inequities, the importance of structural barriers as an impediment in the process of MHCE suggests that it may not be a treatment gap but a treatment inequity. Previous research shows this treatment inequity is reflected in other disadvantaged populations in addition to SM individuals. For example, in the United States, White individuals are more likely to have access to traditional MHC than Black individuals and more likely to receive adequate care than Latinx individuals (McGuire & Miranda, 2008; Wells et al., 2001). Furthermore, treatment inequity should be contextualized beyond domestic research (e.g., SAMSHA, 2018). In comparing individuals who met mental health diagnostic criteria in 14 countries, the World Mental Health Survey Consortium (2004) found substantial variance in respondents who received traditional MHC with respondents in the United States reporting the highest amount (15.3%) and Nigeria reporting the lowest (0.8%). This understanding of the importance of structural vulnerability in regard to treatment inequity poses the question if “help-seeking” frames the problem in an insufficient manner.

In moving away from help-seeking and toward MHCE, this conceptualization aims to integrate a synergistic lens of engagement from all stakeholders from individual- to macro-level (Bronfenbrenner, 1973). Through a lens of health equity, MHCE can better understand the etiology of distress (e.g., structural stigma; Hatzenbuehler, 2016), the navigation of seeking alternative or traditional MHC (e.g., structural barriers; SAMSHA, 2018), and the remedy for distress (e.g., radical healing; French et al., 2020). In continuing to frame and develop this theoretical conceptualization, psychologists should engage in interdisciplinary work. For
instance, public health researchers often discuss inequitable physical health outcomes (e.g., heart disease) as the result of social conditions and policies as “upstream” forces, social and cultural context in the middle, and genetic and biological influences as “downstream” forces (Warnecke et al., 2008). This framework allows for a more nuanced approach to intervention rather than simply focusing on the “downstream” forces that is typical to the dominant paradigm of traditional MHC (see also Cole, 2009).

Whether an individual merely steps foot into traditional MHC should not be considered a rational, individually based choice. Any theory of MHCE use should consider why an individual would prefer not to engage in traditional MHC in order to support viable alternative MHC options. For instance, the high unmet mental health needs in SM individuals from traditional MHC found in this and other studies (Burgess et al., 2008; Steele et al., 2017) may be completely “rational” and adaptive due to previous mistreatment or maltreatment in traditional MHC, such as conversion “therapy” (Ryan et al., 2020) or discrimination by MHC professionals (Romanelli & Hudson, 2017). Moreover, operationalizing the dependent variable as simply receiving traditional MHC does not help understand the engagement quotient (Tryon, 1985), including reasons why SM individuals report early drop-out rates (Eady et al., 2011; Simeonov et al., 2015). Thinking about engagement with MHC beyond entering the room will allow the theory to inform more affirmative, accessible, and approachable MHC (Levesque et al., 2013).

This study’s findings of the influential observed variables of cost and time emphasize the importance of considering actual behavioral control in addition to perceived behavioral control when applying the TPB. Although Ajzen’s (2019) most recent model of TPB includes actual behavioral control as an influential factor, there seems to be a mismatch between theory and measurement. In Ajzen’s (2006) widely cited guidance on how to construct a questionnaire using
TPB, nearly all the guidance relies upon perceived behavioral control (i.e., self-efficacy) items rather than actual behavioral control (i.e., controllability). This mismatch between theory and measurement assumes an individual’s beliefs to engage in a behavior include their awareness of the structural vulnerability that may confine decision-making. Using only self-efficacy in measurement and theoretical consideration of MHCE is akin to a medical doctor prescribing a healthy diet to an individual without considering their access to nutritious food (i.e., if individual is in a food desert). A meta-analysis revealed that studies that use TPB as a theoretical framework often do not measure both perceived and actual behavioral control with most studies only measuring perceived behavioral control and most others conflating the two (Cheung & Chan, 2000). Thus, it is necessary for future application of the TPB to measure both perceived and actual behavioral control in order to further understand, modify, and apply the theory for specific behaviors in order to inform necessary interventions. In terms of TPB as it relates to MHCE, this means separately measuring self-efficacy (e.g., mental health literacy) and controllability (e.g., cost, time, accessibility) to better understand their unique and related contributions to engagement with traditional and alternative forms of MHC (Ajzen, 2002).

**Practice**

Although increasing affirmative and accessible care should remain a priority, another priority in the midst of the large number of people in need of services not receiving them should be alternative MHC and structural interventions (Kazdin, 2017). Given that researchers estimate 25% of the United States population has a diagnosable mental health disorder in any given year (Kessler et al., 2005) and there are an estimated 700,000 MHC professionals (Hoge et al., 2007), the dominant paradigm is simply not feasible pragmatically to meet everyone’s needs (i.e., each
MHC professional would need to see ~120 individuals annually). Moreover, it often leaves those with subclinical issues disregarded.

Psychologists need to consider a flexible array of services that go beyond the dominant paradigm of traditional MHC, such as community mental health (Metzl & Hansen, 2014), multilevel interventions (Brown et al., 2019), and radical healing (French et al., 2020). When considering mental health within interacting and nested systems (cf. Bronfenbrenner, 1979), the need for a diversity of stakeholders in effective MHCE becomes quite apparent. The two significant latent constructs in associating with intentions to seek traditional MHC, social support and structural barriers (hypotheses 3c & 3e), are relatedly ripe for practical implications. For instance, psychologists should consider focusing on ways to bolster alternative MHC as it is an integral part of MHCE. This study’s findings support a qualitative study of bisexual individuals’ experiences navigating the process of MHCE illustrated that found bisexual individuals oftentimes use their social networks prior to engaging in traditional MHC (MacKay et al., 2017).

Community-based collaboration provides an avenue to practice promoting community mental health. These are “collaborative efforts that are anchored in partnerships among individuals and groups within the community and, as such, bring together those stakeholders who affect and are affected by the issue at hand” (p. 568; Bond & Hauf, 2007). In engaging in preventative and proactive community-based efforts, psychologists can practice meeting the treatment inequity further upstream. Furthermore, this sense of working with communities and not for them allows a sense of empowerment and ability to sustain engagement and dialogue around mental health beyond simply attending traditional MHC. These community-based collaborations could take on the shape of engaging in radical healing, especially with SM people of color (French et al., 2020), through collaboration with community healers to help promote
critical consciousness (e.g., Jabson Tree & Patterson, 2019; Mindfulness for the People, 2020; National Institute of Minority Health and Health Disparities Intervention Portal). The collaboration with community members in designing and evaluating interventions recognizes the multifaceted systemic, cultural, and historical forces that impact human functioning and, in turn, MHCE (Bond & Hauf, 2007). Furthermore, investing into community-based collaboration also has a tertiary remedy of an increase in social support, which has long been established as a buffer against mental health symptomology (e.g., Kessler & McLeod, 1985).

On the other hand, structural interventions, which are frequently discussed in public health circles, engage upstream forces by attempting to change the “social, physical, economic, or political environments that may shape or constrain health behaviors and outcomes, altering the larger social context by which health disparities emerge and persist” (p. S72; Brown et al., 2019). Structural interventions could address structural vulnerability illustrated by structural stigma’s impact on mental health inequity and structural barriers impact on treatment inequity (Bowleg, 2017; Quesada et al., 2011). Although social justice advocacy is sometimes considered a distinct domain from practice, they should, instead, be considered as mutually reinforcing and operating in concert with one another (Mallinckrodt et al., 2014). From a lens of structural competency (Metzl & Hansen, 2014), psychologists should conceptualize each individual’s presenting issues and symptomology (i.e., the “downstream” implications) contextually within the wider-level sociocultural and environmental “upstream” forces (Warnecke et al., 2008). Specifically, to help foster engagement with clients, psychologists could inquire as to the client’s process of MHCE to see if any structural or attitudinal barriers may impede continued engagement with traditional MHC. Furthermore, psychologists should be cognizant of the impact past experiences with traditional MHC of the client or those within their social network may have on their current
perception of it, especially with the continued prevalence of sexual orientation change efforts illustrated in this study. It goes without saying that MHC professionals need to stop engaging in sexual orientation change efforts and familiarize themselves with the deleterious effects (Ryan et al., 2020) and history of misconstrued research findings (Spitzer, 2012). Given the impact of structural vulnerability in both mental health and treatment inequity, psychologists should shift their understanding of the clinical encounter beyond only two individuals in a room toward a collective encounter of the organizations, institutions, culture, and larger structural contexts in which the interaction takes place (Metzl & Hansen, 2014).

It is imperative MHC professionals stay up to date on guidelines and recommendations for working with SM individuals (e.g., ACA, 2012; APA, 2012), as well as guidelines for other marginalized communities. This includes approaches to SM affirmative therapy with recent randomized control trials illustrating promising results (e.g., Pachankis et al., 2015; Reback & Shoptaw, 2014). Other scholars do not frame SM affirmative therapy as a distinct form of therapy but more as an orthogonal approach to existing therapies (Grzanka & Miles, 2016; O’Shaughnessy & Speir, 2018). When engaging in clinical work with SM individuals, couples or groups, MHC professionals should be aware of how their biases, consciously or subconsciously, may impact their therapeutic practice. Researchers have found biased therapeutic practices with SM individuals result in increased stereotypical diagnoses (Eubanks-Carter & Goldfried, 2006), biased clinical ratings of psychological functioning (Biaggio et al., 2000), and microaggressions (Kelley, 2015; Shelton & Delgado-Romero, 2011). Thus, I urge MHC professionals to practice reflexivity in their clinical practices through prioritizing a cyclical feedback loop from clients to avoid the detrimental impacts of biased practices (Spengler et al., 2016). Given the large percentage of individuals in the study who did not identify as monosexual (i.e., gay, lesbian), the
perception of MHC professionals’ prejudice or affirmativeness may be the result of experiences with MHC professionals engaging in monosexism, thereby erasing their identities (i.e., assuming a heterosexual identity due to an other-gendered partner; Gonzalez et al., 2017). Practical examples of this would be to foster more affirmative environments for SM individuals through inclusive forms, affirmative language, and representative display materials. In addition to the importance of fostering healthy and affirmative clinical experiences with SM individuals, it may also help shape attitudes of those in their social network (Alang & McAlpine, 2019).

Advocacy

Given intentions to seek traditional MHC were strongly influenced by the extent to which respondents perceived MHC professionals as discriminatory or affirmative towards sexual orientation (hypothesis 3a), it is essential to improve the visibility of SM affirmative MHC professionals through outreach and other innovative strategies. Within the context of the threat-to-self-esteem model (Nadler & Fischer, 1986), outreach efforts would allow MHC professionals individually or collectively to be perceived as more affirmative and, therefore, increase approachability of traditional MHC for SM individuals. More importantly, these outreach efforts could help promote health equity and mental health writ large. Outreach efforts could materialize in fostering engagement with alternative MHC through community-based options (e.g., SM mentorship programs), psychoeducation on how to navigate the process to seek traditional MHC (i.e., mental health literacy), and advocating for legislation and funding to cultivate MHCE writ large. In all social justice efforts to promote MHCE, whether that is social marketing or otherwise, collaboration with SM community members and advocacy organizations is crucial (Collins et al., 2018).
Mental health literacy promotion could mitigate some barriers to MHCE. Jorm (2012) defined mental health literacy as the “knowledge and beliefs about mental disorders which aid their recognition, management, or prevention” (p. 182). An Australian clinical study that found an average delay of 8.2 years between the manifestation of psychopathology and receiving treatment (Thompson et al., 2008), including an average of 6.9 years to recognize the symptoms as a disorder. This clearly illustrates the important role of collective and individual mental health literacy in MHCE. A lack of collective mental health literacy in society is likely a contributing factor to the pattern of reactive mental health care seen in this study. If psychologists participate in advocacy efforts to promote mental health literacy, this can facilitate the dialogue around mental health prevention and cultivate MHCE.

In collaboration with SM community members, psychologists should think of innovative strategies beyond traditional MHC to foster alternative MHC, promote the visibility of affirmative MHC, and eradicate the likelihood of harmful MHC. An effective example of this is a training program for SM mental health peer advocates for roles as paraprofessionals in a rural area (Israel et al., 2016) or mentorship programs for SM individuals at universities across the nation. Moreover, it is important for psychologists to be aware of the legislation (or lack thereof) in their state in order to advocate for affirmative, accessible, and approachable MHC (Levesque et al., 2013). The Tennessee Equality Project (TEP) has two ongoing projects to promote affirmative MHC in a state with various legislation (or lack thereof) in place to infringe upon SM individuals’ civil rights, including as it relates to MHCE (Grzanka et al., 2020). In 2016, legislators passed a law that allows MHC professionals to deny services to clients based on the MHC professional’s “sincerely held principles.” In direct response, the TEP built an interactive, geographic information system map named “Counseling Unconditionally” to help link SM
individuals with MHC professionals that have pledged to engage in SM affirmative services (TEP, 2020). This map helps improve accessibility and also improves SM individuals’ perceived and actual behavioral control of finding an affirmative therapist. Additionally, the TEP has an ongoing project to collect stories of survivors of sexual orientation change efforts to spread awareness of its ongoing, negative impacts (DeVore & Fry, 2020). The ultimate goal of collecting these stories is to build public awareness to help advocate for a law prohibiting sexual orientation change efforts with minors in Tennessee, a practice that remains legal with minors in 30 states (Human Rights Campaign, 2020). Furthermore, psychologists should familiarize themselves with other laws in place that contribute to structural stigma and structural vulnerability towards SM individuals in their states (Human Rights Campaign, 2020). Public health researchers have demonstrated advocating for legislators to put appropriate and affirmative laws in place can have beneficial impacts on the mental health of SM individuals in those states (Hatzenbuehler et al., 2009).

The community mental health movement of the 1950s and 1960s provides a relatively recent historical example of how advocacy can change MHCE nationally. The community mental health movement and the ensuing War on Drugs are also good illustrations of how a problem is defined can lead to diverging questions and proposed solutions within MHCE (Humphreys & Rappaport, 1993). Following the deinstitutionalization of MHC, political activists, MHC professionals, and MHC paraprofessionals advocated the government fund a flexible array of services within the community. An integral part of this advocacy was the notion that taking clients away from their community may be part of the problem (Cumming & Cumming, 1957). Advocates in the movement geared the thrust of focus towards reaching underserved populations and framing mental health issues as always contextualized within
environmental contexts (Smith & Hobbs, 1966). This was a large paradigm shift from the previous internal deficit model that framed the problem that those with mental health disorders were weak or immoral (Foucault, 1965). In addition to propagating mental health stigma, this internal deficit model perpetuated psychology’s ugly historical “solution” of ostracizing individuals with psychopathology in asylums.

After Presidents Kennedy and Johnson were vocal in their support for the community mental health movement, President Reagan stifled the movement by using the War on Drugs to again orient the problem towards the individual (Humphreys & Rappaport, 1993). At this time, only 750 of the envisioned 2,000 community mental health centers were built. The National Institute for Mental Health reflected this shift by explicitly stating attention should be focused on the biomedical functions and not the social issues in mental health disorders (Humphreys & Rappaport, 1993). Moreover, while the Decade of the Brain in the 1990s provided ample beneficial evidence, this drastic shift in funding took away the focus from the “upstream” structural forces that inform these “downstream” biomedical impacts.

In order to resist this trend, psychologists should use our collective knowledge and resources through interdisciplinary teams to advocate for funding geared towards community mental health and structural interventions. An integral issue is that the current typical funding timeline of three to five years is much too short to assess the long-term outcomes that structural interventions often require (e.g., Chetty et al., 2016). In sum, advocacy efforts are needed to foster a collective dialogue around mental health that de-centralizes the blame placed on the individual, which includes decreasing mental health stigma. This will help co-create a culture of MHCE between individuals, communities, treatment settings, and higher-level structures (National Alliance for Mental Illness, 2016).
**Education/Training**

The detrimental effects of prejudicial practices and the beneficial effects of affirmative practices highlight the importance of SM affirmative therapy both in the public’s perception and therapists’ training (hypothesis 3a & research question 7). A survey of 169 graduate training programs in professional psychology found that a majority of programs only offered one class that addressed SM issues (American Psychological Association, 2009). This lack of quality training likely results in MHC professionals reporting a low self-efficacy when working with SM clients (Dillon & Worthington, 2003; Graham, Carney, & Kluck, 2012). More importantly, this lack of quality training could contribute to the mistreatment (e.g., clinical microaggressions, Shelton & Delgado-Romero, 2011) and maltreatment (e.g., discriminatory MHC professionals, Romanelli & Hudson, 2017; conversion “therapy,” Ryan et al., 2020) of SM individuals in therapy.

More mental health training programs need to orient their training towards a framework of cultural humility and structural competency in order to better understand how structural vulnerability impacts collective mental health and clinical encounters (Hook et al, 2017; Mallinckrodt et al., 2014; Quesada et al., 2011). Structural competency, which scholars originally developed for medical health care, is the trained ability to discern how individual symptomology is the result of structural forces, including resource allocation, wealth distribution, and legislation’s impact on MHC (Metzl & Hansen, 2014). This means MHC professionals should be trained to conceptualize all clinical encounters and presenting issues in structural relief through a lens of intersectionality (Grzanka, 2020). In practical terms, this means training individuals to not engage in individual personality assessments without first understanding the contextual systemic circumstances of that person’s life. Training programs
should also incorporate the cultural humility to help MHC professionals engage in the reflexivity to be open to the role oneself and one’s communities (i.e., field of psychology) may play or have played in reinforcing or enabling (consciously or unconsciously) injustices and oppression (Hook et al., 2017; Spengler et al., 2016). This humility and reflexivity will better allow psychologists-in-training to honestly examine how ongoing injustices in therapy writ large (e.g., sexual orientation change efforts) or therapeutic encounters (e.g., microaggressions) may impact the therapeutic relationship or perception of traditional MHC.

Training programs should train students to be attuned to the sociological and educational messages framed in the guise of mental health that, in turn, negatively impact MHCE. According to sociologists, a more covert way individualized approaches (i.e., not structural or cultural) to MHC are reinforced is through the rise of the wellness industry (i.e., self-help books and motivational speakers). In what Davies (2015) calls the “Happiness Industry,” subjective experiences of internal grit and emotional fortitude are sold as resiliency factors against structural conditions, effectively eliding the structural dynamics that lead to health inequities (Meyer, 1995). The pervasive belief that those suffering from psychopathology are lacking grit promotes an arsenal of means by which to judge those seeking traditional MHC as bad choice makers and psychologically inferior. Instead, training and education should promote a critical, structural lens to examine asymmetries of power and systemic inequality that happen both inside and outside clinical encounters (e.g., Aschoff, 2015).

Research

As researchers, we need to be cognizant of how we define a problem, as it directly informs the research questions we ask, the findings, and the solutions to offer. In doing so, we need to be aware of how the dominant paradigm in psychology focusing on the individual (e.g.,
lack of character, poor decision-making) can reduce complex social issues to an oversimplified solution, thereby stifling more creative solutions (Humphreys & Rappaport, 1993). In the realm of MHCE, the problem is not only the individual’s link to traditional MHC; rather, it is how people, communities, and structures collectively respond to distress whether or not an individual chooses to not seek out traditional MHC. In an effort to disrupt the individualized ideology that has historically been the status quo in psychological research, collaboration with public health, medical sociology, and other fields can help inform the efforts to better understand treatment inequities and health inequities (Brown et al., 2019; Pescosolido & Boyer, 2010).

In accordance with the Network-Episodic Model (Pescosolido & Boyer, 2010), more research is needed to understand how SM individuals engage in both traditional and alternative MHC, including models with structural variables and intentions to seek out alternative MHC as a predicted variable. This research, as well as research with multiply marginalized populations or populations often systematically erased, needs to include structural barriers as an integral component of the models. Given the substantial proportion of sexual minority people of color and non-monosexual people, this study takes a step in recognizing the lived experience of groups whose identities that often systemically experience erasure (American Psychological Association, 2012; Dworkin, 2001). Additionally, more research on MHCE is very much needed with gender minority (e.g., transgender, non-binary) individuals. Although SM individuals are often conflated with gender minority individuals (e.g., ACA, 2012), there are significant parts of the current and historical process of MHCE with gender minority individuals that are unique (e.g., gatekeeping hormone replacement therapy, gender dysphoria; Ashley, 2019) from SM individuals and, therefore, warrant separate empirical inquiry (see Hunt, 2014).
Future research needs to include both perceived (i.e., self-efficacy) and actual (i.e., controllability) behavioral control to better understand the role of the full TPB in MHCE and other areas of research using TPB (Cheung & Chan, 2000). As Ajzen (2002) wrote, “rather than making a priori assumptions about the internal or external locus of self-efficacy and controllability, this issue is best treated as an empirical question” (p. 680). While this study’s findings illustrate the importance of structural barriers in SM individuals’ process of MHCE, this empirical question still remains in MHCE and help-seeking research writ large. Given the complexity of the process of MHCE, models of MHCE and help-seeking should go beyond the individually-oriented, rational, and attitudinal variables. Researchers should consider that all decisions are not necessarily the result of individual actors making calculated decisions. For example, less than half of individuals in the Indianapolis Network Mental Health Study who entered traditional MHC reported they came close to a cost-benefit assessment (Pescosolido et al., 1995).

In order to better understand the nuanced and dynamic process of MHCE, we need to move away from static, bivariate quantitative methods. Researchers have noted these have “limited explanatory potential as complex beliefs and actions become reduced to descriptive categories” (p. 985; Biddle et al. 2007). Researchers should consider statistical techniques that incorporate social structures, such as hierarchical linear modeling, or ones that incorporate intersectionality and are more person-centered, such as latent profile analysis (Grzanka, 2020). An intersectional approach using person-centered statistics could better account for the experience of multiply marginalized SM individuals without reducing race, ethnicity, and other salient dimensions of difference into overly simplistic comparisons (Cole, 2009). Researchers could also consider statistical methods that capture multivariate relations to emerge (e.g.,
structural equation modeling, moderation) and methods that allow participants’ answers to better inform interpretations rather than the subjectivity of the researcher (e.g., qualitative and/or mixed methods). Furthermore, longitudinal research is needed to inform whether these relationships that exist in cross-sectional research actually predict or mediate future behavior. These paradigm shifts are likely to be difficult, which is why interdisciplinary teams and a diversity of research approaches are required to overcome challenges in research design and assessment (Pescosolido, 2006).

As counseling psychologists, we need to engage in social justice research that can inform legislation and policy in order to lead to systems-level changes in regard to MHCE. Community-based participatory research is an example that aligns with the social justice, person-centered, and strength-based values of counseling psychology in both research and practice. Community-based participatory research is a form of research methodology that involves community members in an equitable manner throughout all stages of the project in order to promote “sustainable change together, with, for, and in communities” (p. 885; Collins et al., 2018). Through a perspective of cultural humility (Hook et al., 2017), community-based participatory research avoids the colonizing role of research through recognizing the wealth of knowledge inherent in the community. Community-based participatory research strives to integrate the lived experiences of community members and their perspectives on MHCE throughout the research process (Fine & Torre, 2019; Kidd & Kral, 2005). A defining characteristic of community-based participatory research is that it recognizes all individuals are embedded in larger communities through which meaning making, strengths, and challenges are shared and co-created. It recognizes that research questions should acknowledge that health status and inequities are not only individually determined but also greatly shaped by larger systems.
Lastly, research can help inform other parts of the process of MHCE, including the etiology of distress and SM individual’s experiences in traditional MHC. While researchers have produced a plethora of research describing the mental health disparities of SM individuals, more research is needed to inform the structural factors that better inform these disparities (i.e., differences) as inequities (e.g., Hatzenbuehler, 2016). Furthermore, there is relatively little research that examines SM individuals’ experiences in therapy (Simeonov et al., 2015) and a historical pattern of SM individuals and couples not being considered in outcome studies (Spengler et al., 2020). In conjunction with structural and community interventions, future research is also needed to build upon existing clinical trials (e.g., Pachankis et al., 2015) to look at process and outcome research for SM individuals.

**Conclusion**

Informed by the theory of planned behavior (Ajzen, 1985), Network-Episode Model (Pescosolido & Boyer, 2010), and the threat-to-self-esteem model (Nadler & Fisher, 1986), I examined a structural model with TPB moderators and other variables influencing intentions to seek traditional MHC for SM individuals. SM individuals with higher social support and lower structural barriers had higher intentions to seek traditional MHC. The moderating variables revealed a pattern of reactive mental health care for individuals with low attitudes towards MHC professionals, high mental health stigma, high self-concealment, and high perceived counselor sexual orientation prejudice. Additionally, a substantial number of participants reported an unmet mental health need in the last year, engagement with alternative forms of MHC, and experience with sexual orientation change efforts. The findings suggest future MHCE research and interventions should focus on structural and community-based interventions through a
framework of cultural humility in order to collectively promote mental health equity and treatment equity.
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Vita

Elliot S. Spengler was born in Albany, New York to two wonderful parents who both spent their professional lives simultaneously in health care and education. He moved to Muncie, Indiana at a young age and went kindergarten through the 12th grade at Burris Laboratory School where he learned the many benefits of a community engaged around mental health. Prior to attending and completing coursework in the Counseling Psychology program at the University of Tennessee, Knoxville, he graduated from Butler University with a Bachelor of Arts majoring in psychology and minoring in sociology and Ball State University with a Master of Arts in clinical mental health counseling. Through clinical work with his valued clients and his own experiences, he continually came to understand the influential power of structures impeding growth or promoting resilience. In his career, he envisions working with clients to strengthen relational bonds with oneself and others (clinical), communities to facilitate a more socially just world (advocacy), students to enhance critical thinking (teaching), and social action research to promote mental health care engagement (research).