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Beyond the Individual: Sexual Minority Help-Seeking and the Consequences of Structural Barriers

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Sexual minorities report more psychological distress, unmet mental health needs, and barriers to mental health care compared with heterosexuals, yet little is known about their barriers to seeking out mental health care. The present study reports the factors that influence intentions to seek out mental health care of a national survey of 398 sexual minorities. Structural equation modeling identified structural barriers, such as cost, time, and knowing how to access services, as the strongest predictor of sexual minorities' help-seeking intentions. Latent moderators indicated sexual minorities' help-seeking intentions varied depending upon their degree of psychological distress. This revealed a pattern where the most vulnerable participants (i.e., those with high structural barriers and negative help-seeking attitudes) were willing to pursue mental health care only when they were experiencing significant distress. Furthermore, nearly 40% of participants reported unmet mental health needs, and structural barriers were the primary reasons for this deficit. Findings from this study contrast with previous mental health help-seeking research by emphasizing the importance of structural vulnerability, which refers to the external forces that frame and constrain choices, thereby impeding decision-making and limiting life options for those who are in systemically disadvantaged social positions. These findings are discussed in terms of counseling psychology training, practice, social justice advocacy, and future health care research.

Public Significance Statement
This study suggests structural barriers play an integral role in help-seeking intentions and unmet mental health needs among sexual minorities. Greater attention to structural vulnerability by policy makers and health care professionals could facilitate sexual minorities' access to mental health treatment.

Keywords: sexual minority, help-seeking, mental health care, health equity, treatment gap

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Despite sexual minorities[1] attending mental health care at higher rates than their heterosexual counterparts, sexual minorities report more barriers to care, more unmet mental health needs, and a higher perceived need for mental health care (Burgess et al., 2007; Dahlhamer et al., 2016). Sexual minorities are also more than two times more likely to experience a mental health disorder and three times more likely to experience a serious mental health disorder (Medley et al., 2016). This elevated distress is the result of a complex interaction of stressors sexual minorities face, including discrimination and prejudice (Hatzenbuehler, 2016; Meyer, 2013). Despite the relatively recent paradigmatic shift toward affirmative therapy, help-seeking for sexual minorities must also be contextualized within the fraught history of psychology and other mental health disciplines producing and perpetuating heterosexism, heteronormativity, and other intersecting forms of inequality (American Psychological Association, 2021). The inequitable access and increased mental health risks for sexual minorities underscores a need to better

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[1] "Sexual minority" is a term to denote all those who identify as lesbian, gay, bisexual, asexual, demisexual, pansexual, or other sexual orientation that is not heterosexual.

understand the help-seeking process in order to target interventions to better meet sexual minorities' mental health needs.

A comprehensive review of the literature concluded "there is little agreement in terms of what predicts service use" among sexual minorities (Filice & Meyer, 2018, p. 183). Akin to other mental health research (e.g., Spengler et al., 2020), models of help-seeking[2] often negate to report or consider respondents' sexual orientation. The two help-seeking models that considered participants' sexual orientation (Spengler & Ægisdóttir, 2015; Vogel et al., 2011) did not account for key variables in other help-seeking models (e.g., Cramer, 1999), such as social support, self-concealment (i.e., withholding vulnerable information from others), and public help-seeking stigma (i.e., perceiving others to stigmatize seeking out mental health care). Moreover, unlike medical health help-seeking frameworks (e.g., Levesque et al., 2013), previous mental health help-seeking models assume volitional control of the individual without considering structural factors (e.g., cost) that may impede one's ability to receive services. This approach negates to account for the impact of structural vulnerability on who is willing and able to receive mental health care. Structural vulnerability represents the social, psychological, historical, economic, and cultural forces that frame and constrain choices (Bourgois et al., 2017). To help clarify factors that impact help-seeking for sexual minorities, this study tests a help-seeking model to inquire whether structural barriers predict help-seeking intentions more than traditionally included help-seeking factors. This study also examines how key help-seeking factors interact with psychological distress to predict help-seeking intentions and whether factors of structural vulnerability explain unmet mental health needs. In doing so, this could help counseling psychologists better understand the factors that influence whether sexual minorities are willing to seek out mental health services when they want or need them in order to help inform proactive mental health care efforts.

A Structural Vulnerability Framework

Medical sociology, medical anthropology, and public health researchers (Bourgois et al., 2017; Levesque et al., 2013; Pescosolido, 2006) have used the structural vulnerability framework to better illuminate how sociocultural factors can impede access to medical health care. This study seeks to extend this framework into mental health help-seeking. Nearly one-quarter (23.6%) of individuals with a mental health disorder reported they needed mental health services in the last year but did not receive them. Cost (40.7%), not knowing where to seek services (25.2%), and not having time (20.8%) were some of the most common reasons for these unmet mental health needs (Substance Abuse & Mental Health Services Administration, 2019). Despite this, help-seeking research often neglects the role of these structural factors. While previous research has examined structural barriers via descriptive, bivariate, or qualitative methods, we know of no study that compares variance accounted for by structural barriers relative to more traditionally studied help-seeking variables. Thus, previous help-seeking models assume "perfect volitional control" as they have not accounted for how "such barriers as lack of money, time, or other resources" (Ajzen, 2020, p. 613) contribute to help-seeking intentions and behaviors.

While structural barriers are certainly not unique to sexual minorities, they need to be considered as they are associated with lower intentions to seek out mental health care (Schomerus et al., 2012; Shea et al., 2019) and less future help-seeking behavior (Kung, 2004). Sexual minorities who report unmet mental health needs often cite structural factors, such as a lack of insurance, insufficient financial resources, absence of affirmative clinicians, and limited knowledge about services (Barefoot et al., 2015; Dahlhamer et al., 2016). Much like how Bowleg (2017) used structural vulnerability to frame health *disparities* as health *inequities*, help-seeking may be better understood through a lens of mental health inequity. Structural vulnerability may hinder members of marginalized social groups' access to mental health services due to structural inequality and institutional oppression. This lack of access could, in turn, contribute to increased mental health inequities (Romanelli & Hudson, 2017). Critically examining help-seeking also means accounting for the sociohistorical forces of structural vulnerability.

Researchers consistently find help-seeking attitudes to be positively associated with help-seeking intentions (e.g., Cramer, 1999), yet these studies do not consider if or how these attitudes toward the "helper" are informed by historical (and ongoing) injustices. Psychologists historically pathologized same-sex desires and perpetuated stigma by attempting to "cure" these desires through heinous treatments, such as electroshock, nausea-inducing drugs, lobotomies, and castration (Katz, 1976). More recent studies document the ongoing mistreatment and maltreatment of sexual minorities in the process of seeking out mental health care. This includes clinical microaggressions (Spengler et al., 2016) recent legislation that undermines trust between sexual minority clients and potential providers (Grzanka, DeVore, et al., 2020; Grzanka, Spengler, et al., 2020), and sexual orientation change efforts (i.e., conversion "therapy"; Ryan et al., 2020).

Thus, depending on how they perceive the profession, sexual minorities' potential reticence to seek out mental health care could be framed as rational and justifiable, rather than misguided and uninformed. Indeed, research illustrates perceived prejudice and affirmativeness of mental health professionals are separate but related influential factors in the process of seeking and receiving mental health care. A synthesis of empirical research found the two most consistent themes that dictated the process and outcomes of clinical work with sexual minorities were the importance of an affirmative counselor and the harmful effects of a prejudicial counselor (O'Shaughnessy & Speir, 2018). Retrospective studies found sexual minorities purposefully sought out affirmative clinicians and/or delayed or avoided seeking out mental health care when they perceived clinicians as prejudiced (Barefoot et al., 2015; Romanelli & Hudson, 2017; Willging et al., 2006). The one help-seeking model with only sexual minorities found perceived counselor prejudice to be a significant predictor of help-seeking attitudes (Spengler & Ægisdóttir, 2015), although no study includes perceived counselor affirmativeness. In this sense, help-seeking research should recognize the reality that seeking out "help" for mental health "care" has been a source of harm for sexual minorities, particularly those who belong to other marginalized and stigmatized social groups (Grzanka & Miles, 2016; Hammack et al., 2013). Accordingly, a holistic construct of help-seeking attitudes for sexual minorities should consider how affirmative and prejudiced they perceive the helper.

[2] Unless otherwise noted, "help-seeking" refers to seeking out help for mental health care.

Help-Seeking and Distress: The Question of Moderation

Ideally, people would be willing and able to seek out the help they need when they begin to experience significant distress. The treatment gap—that over half (56.7%) of adults living in the United States with a diagnosable mental health disorder do *not* receive mental health care (Substance Abuse & Mental Health Services Administration, 2019)—indicate this is not the case. Although some help-seeking models find the relation between distress and help-seeking intentions to be significant (e.g., Cramer, 1999), it is often statistically nonsignificant or weak (e.g., Brenner et al., 2020; Lannin et al., 2014; Vogel et al., 2005). This understates a need to better understand factors that impact the willingness to seek out mental health care when experiencing distress for sexual minorities and in general. This reluctance or inability to engage in care is especially important to understand as clinical prognoses worsen the more distressed clients are upon starting services (Buckman et al., 2021; Robinson et al., 2020). Specifically, the dose–response curve illustrates that every standard deviation increase in psychological distress is related to 31% worse clinical prognosis 3–4 months into treatment and a twofold increase in symptom remission (Buckman et al., 2021). This raises important questions as to what factors interact with psychological distress to help explain this treatment gap (Kazdin, 2017).

Pescosolido (2006) provides potential insight into the treatment gap by posing that individuals dynamically navigate distress differently depending upon their sociocultural networks and structural factors. Pescosolido (2006) theorizes help-seeking as an interaction between an individual's illness characteristics (e.g., severity of psychological distress) and their sociocultural context, including attitudes toward health care, community beliefs about receiving health care (e.g., help-seeking stigma) and organizational constraints (e.g., cost). Researchers have used this framework to contextualize help-seeking in a more nuanced manner for other vulnerable populations, including older adults (Beatie et al., 2022) and youth at high risk for psychosis (Boydell et al., 2013). While some researchers have recently used moderation to investigate help-seeking patterns previously not uncovered via bivariate analyses (Booth et al., 2019; Brenner et al., 2020), no research has examined moderation in relation to help-seeking intentions. Moderation could provide a better understanding about what subsets of sexual minorities may be less willing to seek out mental health care when they are distressed.

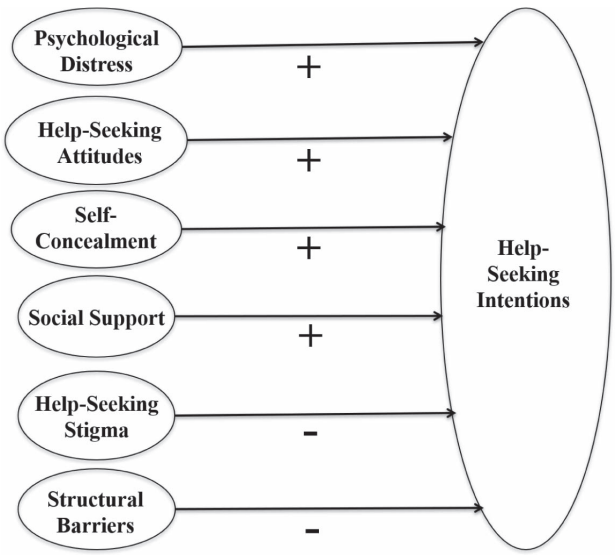
Given the lack of significant relationship between psychological distress and help-seeking intentions, it is feasible that moderating factors could elucidate patterns for sexual minorities that change this relationship in consequential ways. For example, should help-seeking stigma enhance the effect of distress on intentions in a negative direction, it would indicate sexual minorities high in help-seeking stigma avoid mental health care when they are most in need, thereby exacerbating the treatment gap. In addition, if interaction plots illustrate those with negative help-seeking attitudes are only willing to seek out mental health care when they are significantly distressed, it would indicate sexual minorities who perceive counselors as prejudiced and not affirmative are only willing to reach out when they are in dire need. This would likely decrease the effectiveness of treatment and potentially increase unmet mental health needs (Buckman et al., 2021). If either pattern emerges, this could help further clarify what factors impede sexual minorities from seeking out mental health care when they would most benefit. Moreover, this could guide psychologists and policy makers to tailor interventions and outreach efforts that help sexual minorities enter care earlier when there is a better clinical prognosis. Observing such novel dynamics could also inform research on help-seeking patterns among other populations.

The Present Study

The aim of this study is to better understand the role of structural vulnerability in help-seeking with sexual minorities. To do so, we inquired about the frequency of reasons for unmet needs (e.g., cost too high to seek services). We also tested a help-seeking model (see Figure 1) to examine the variance of help-seeking intentions accounted for by structural barriers compared to traditional help-seeking variables (e.g., help-seeking attitudes, public help-seeking stigma, social support, self-concealment; Cramer, 1999; Liao et al., 2005; Vogel et al., 2005). This will allow us to better understand the consequences of structural barriers, which have been historically neglected in empirical inquiry in mental health help-seeking. We predicted sexual minorities' help-seeking intentions would be associated with (a) higher psychological distress, (b) more positive attitudes toward help-seeking, including perceiving mental health professionals as having lower prejudice and higher affirmativeness toward sexual minorities, (c) higher self-concealment, (d) higher social support, (e) lower public help-seeking stigma, and (f) lower structural barriers. In addition to assessing frequency of unmet mental health needs and an extensive list of the reasons for them, we examined if or how help-seeking intentions may differ depending on how psychological distress interacts with latent moderators (see Supplemental Figure 1). Rather than include all variables, we used the preeminent paradigm of help-seeking (i.e., the theory of planned behavior; Adams et al., 2022) and a framework justifying interactions (Pescosolido, 2006) to guide selection of three latent

Figure 1

Hypothesized Conceptual Model Without Latent Moderators



Note. + and − indicate pathway loading hypothesized direction.

constructs that align with these theories for this initial inquiry to elucidate if more complex patterns would emerge. Specifically, we ran the structural model with interactions for the constructs associated with personal beliefs (i.e., help-seeking attitudes), subjective norms (i.e., public help-seeking stigma), and behavioral control (i.e., structural barriers). Given the exploratory nature of our work, we made no further hypotheses about potential relationships among the interaction effects in the model.

Method

Participants and Procedure

Survey respondents consisted of 398 individuals who self-identified as bisexual (64.1%), gay or lesbian (35.9%), queer (3%), pansexual (1.5%), demisexual (1.5%), and/or asexual (0.8%), and none "other."[3] Participants identified as man (61.3%), woman (35.9%), transgender (2.5%), and/or nonbinary (1.5%). No participants chose to write in an additional gender identity that applied to them. Participants were allowed to select as many gender identity categories as applied to them, and thus percentages are greater than 100%. Participants identified as White or European American (59.5%), Black or African American or African (29.5%), Latino or Hispanic (8.9%), Asian or Asian American or Asian Pacific Islander (4.1%), and/or Native American (2.8%). The mean age was 32.4 ($SD = 7.5$). Most participants (75.3%) had a college or postgraduate degree and reported living in urban (44.5%) or suburban (39.7%) areas. On a Likert-type scale ranging from 1 (*lower class*) to 10 (*upper class*) that assesses perceived socioeconomic status in relation to others, the mean socioeconomic status was 5.3 ($SD = 2.1$). Nearly half of participants (46.5%) reported receiving previous counseling from a mental health professional (e.g., psychologist, psychiatrist, social worker, counselor). For more detailed demographic information, see Supplemental Table 1.

After institutional review board approval, we recruited participants through Amazon Mechanical Turk (MTurk). MTurk is an online platform where workers are compensated for completing research tasks. Researchers have shown MTurk produces valid data from samples that are more socioculturally diverse than traditional Internet methods (Casler et al., 2013). After reading a short description of the study, inclusion criteria, and that participation was voluntary, participants provided online consent and completed the questionnaires using QuestionPro software. In addition to the measures listed below, we asked participants if they had an unmet mental health need in the last 12 months. If participants reported they had an unmet mental health need, we asked them to select from the 14 reasons for the unmet mental health need provided in the Substance Abuse and Mental Health Services Administration (2019) National Survey on Drug Use and Health. Participants received compensation directly through MTurk that was contingent upon survey completion and length (i.e., $4 for 20 min). We used attention checks (e.g., "Please select strongly agree for this item") at various points in the survey to ensure valid responses. We report all manipulations, all measures used in the study, all data exclusions, and we follow journal article reporting standards (Kazak, 2018). All data, analysis code, and research materials are available upon request. Data were analyzed using SPSS 26 (IBM Corp, 2019) and Mplus 8.1 (Muthén & Muthén, 2017). This study's design and analyses were not preregistered.

Measures

Psychological Distress

The Kessler Psychological Distress Scale (KPDS; Kessler et al., 2002) is a 10-item scale that measures the amount of psychological distress in the last 30 days (e.g., "During the last 30 days, about how often did you feel worthless?"). Items are rated using 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. Kessler et al. (2002) reported good internal consistency reliability in four studies ($\alpha = .89–.93$). Andrews and Slade (2001) showed evidence of convergent validity with the KPDS on scales measuring symptom severity and functioning. Scores on the KPDS range from 10 to 50; respondents who score under 20 are likely well, 20–24 are likely to have a mild mental disorder, 25–29 are likely to have a moderate mental health disorder, and over 30 are likely to have a severe mental health disorder. Internal consistency for this study was high ($\alpha = .96$).

Attitudes Toward Seeking Mental Health Care

The Mental Help-Seeking Attitudes Scale (MHSAS; Hammer et al., 2018) is a nine-item scale that measures attitudes toward mental health care. Items are organized with a preface (i.e., "If I had a mental health concern, seeking help from a mental health professional would be …") and rated by a 7-point semantic differential scale from −3 (e.g., useless) to 3 (e.g., useful). Higher scores indicate more favorable attitudes. Hammer et al. (2018) showed evidence of convergent validity with other help-seeking attitudes measures, public stigma, and help-seeking intentions. Hammer et al. also demonstrated high internal consistency ($\alpha = .93$) and temporal stability over 3 weeks; we observed a high internal consistency ($\alpha = .90$). This scale is one of three observed variables for the help-seeking attitudes latent construct.

Perceived Mental Health Professional Sexual Minority Affirmativeness

To assess participants' perceived level of mental health professionals' affirmative beliefs toward sexual minorities, we slightly modified a previously adapted version of the Gay Affirmative Practice Scale (Crisp, 2006) so that participants, instead of therapists, could evaluate their perceived level of mental health professionals' affirmative beliefs toward sexual minorities (Alessi et al., 2019). Items on the original 30-item scale are evaluated in two separately scored subscales: Beliefs (e.g., "Practitioners should be knowledgeable about gay/lesbian resources") and Engagement (e.g., "I inform clients about gay affirmative resources in the community"). We only used the 15-item Beliefs subscale as we were only concerned with perceived attitudes. The Beliefs subscale is anchored on a 5-point Likert-type scale from 1 (*strongly agree*) to 5 (*strongly disagree*) and assesses beliefs about affirmative practice with sexual minorities. We modified the reference to sexual minorities to be inclusive of all sexual minorities rather than just gay and lesbian individuals. For example, we changed the item "Practitioners make an effort to learn about the diversity of the gay/lesbian

[3] Participants were able to select multiple identities, including a write-in, for gender identity, sexual identity, and race and ethnicity.

community" to "Practitioners make an effort to learn about the diversity of the sexual minority community." Alessi et al. (2019) found their adapted subscale demonstrated evidence of high internal consistency (α = .95), good model fit for the adjusted subscales, and convergent validity with working alliance and the real relationship. Internal consistency for the present study was high (α = .93). This scale is one of three observed variables for the help-seeking attitudes latent construct.

Perceived Mental Health Professional Sexual Minority Prejudice

To assess participants' perception of heterosexism in professionals, we slightly modified a previously adapted version of the Attitudes Toward Homosexuality Scale (Kite & Deaux, 1986) to reflect how participants believe a counselor would answer the items (Spengler & Ægisdóttir, 2015). Items on the original 21-item scale are evaluated on a 5-point Likert-type scale anchored by 1 (*strongly disagree*) to 5 (*strongly agree*) to measure attitudes toward lesbian and gay individuals. Higher scores indicate a higher level of prejudice. We changed "sex" to "gender/sex" following recommendations by Hyde et al. (2019). For example, we reworded the item "Two individuals of the same-sex holding hands or displaying affection in public is revolting" to "A mental health professional believes that two individuals of the same gender/sex holding hands or displaying affection in public is revolting." Spengler and Ægisdóttir (2015) found their modified version demonstrated evidence of high internal consistency (α = .90) and convergent validity with attitudes toward counseling. Internal consistency for this study was high (α = .93). This scale is one of three observed variables for the help-seeking attitudes latent construct.

Self-Concealment

The Self-Concealment Scale (Larson & Chastain, 1990) is a 10-item scale that assess participants' concealment of personal information from others. Items on the scale (e.g., "When something bad happens to me, I tend to keep it to myself") are evaluated on a 5-point Likert-type scale anchored by 1 (*strongly disagree*) to 5 (*strongly agree*) with higher scores reflecting higher levels of concealment. Larson and Chastain (1990) found evidence of good internal consistency (α = .83) and construct validity by significant correlations with social support, distress, and secrecy. Internal consistency for this study was high (α = .92).

Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) is a 12-item scale that assesses perceived level of social support. Items are 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 MSPSS consists of three subscales: Friends (four items; e.g., "I have friends with whom I can share my joys and sorrows"), Family (four items; e.g., "I get the emotional help and support I need from my family"), and Significant Other (four items). We used only the friends and family subscales to assess social support, as participants may not have a significant other as part of their social support system. Zimet et al. (1988) found evidence for good internal consistency (α = .88) and divergent validity by negative correlations to anxiety and depression for the entire scale. Internal consistency for this study with the two subscales was high (α = .92).

Perceived Help-Seeking Stigma

The Stigma Scale for Receiving Psychological Help (Komiya et al., 2000) is a five-item scale that assesses perceptions of public stigma toward engaging in mental health care. Items (e.g., "It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems") are evaluated using a 4-point Likert-type scale ranging from 0 (*strongly disagree*) to 3 (*strongly agree*). Komiya et al. (2000) showed evidence the scale had adequate internal consistency (α = .72) and convergent validity with attitudes toward mental health care. Internal consistency for this study was good (α = .86).

Structural Barriers

The practical barriers subscale (Kung, 2004) of the Perceived Barriers to Mental Health Treatment Scale (Kung, 2004) is a four-item scale that measures structural barriers associated with seeking out mental health care, which we operationalized as distal social forces that influence help-seeking (e.g., being able to afford, knowing how to access services, having time). We used a three-item version of the scale for this study, as we removed an item about language issues ("When seeking help for problems with emotions, nerves, drug, alcohol, or mental health, language is a problem") and a cultural barriers subscale specifically in relation to Chinese Americans as these could be confusing taken out of context. Items on the original subscale (e.g., "It is too expensive to seek treatment for problems with emotions, nerves, drugs, alcohol, or mental health") are rated on a 4-point Likert-type scale ranging from 1 (*not at all true*) to 4 (*very true*). Kung (2004) found evidence the scale had adequate internal consistency (α = .68) and predictive validity of future use of counseling. Internal consistency for this study with the three-item scale was adequate (α = .68; Ponterotto & Charter, 2009).

Help-Seeking Intentions

The Mental Help-Seeking Intention Scale (Hammer & Spiker, 2018) is a three-item scale that assesses participants' intention to seek counseling. Items (e.g., "If I had a mental health concern, I would try to seek help from a mental health professional") are evaluated using a 7-point Likert-type scale ranging from 1 (*definitely false*) to 7 (*definitely true*). Hammer and Spiker (2018) found evidence for high internal consistency (α = .94), convergent validity with other help-seeking intention scales, and predictive validity with a correct classification rate near 70% of future help-seeking behaviors. Internal consistency for this study was high (α = .93).

Results

Data Cleaning and Initial Analysis

The final sample consisted of 398 participants after excluding 380 participants who identified as straight and 102 for failing at least one attention check or providing responses that suggested satisficing. Because all items had less than 1% missing data, we used expectation maximization in SPSS to impute missing data, which is an appropriate

procedure for data missing completely at random (Schlomer et al., 2010). Observed variables met assumptions of univariate normality and lacked multicollinearity (Kline, 2016). Means, standard deviations, and bivariate correlations are presented in Table 1.

Unmet Mental Health Needs

A substantial amount of the sample (n = 158; 39.8%) reported they had an unmet mental health need in the last 12 months. Out of the 120 participants who received mental health care in the last 12 months, they reported relatively more unmet mental health needs in the last 12 months (n = 82; 68.3%). Out of the 213 participants who had never received mental health care, they reported relatively less unmet mental health needs in the last 12 months (n = 48; 22.5%). Please see Table 2 for the reason(s) participants identified for their unmet mental health need.

Primary Analyses

We conducted structural equation modeling using Mplus 8.1 (Muthén & Muthén, 2017). The following model fit indices were used: comparative fit index (CFI) ≥ .95, Tucker–Lewis index (TLI) ≥ .95, root-mean-square error of approximation (RMSEA) ≤ .06, standardized root-mean-square residual (SRMR) < .08 for good fit and CFI ≥ .90, TLI ≥ .90, RMSEA ≤ .10, SRMR < .10 for acceptable fit (Weston & Gore, 2006). According to best practices, we interpreted all model fit indices collectively. We used latent moderated structural equations (LMS) method to create a latent interaction from two latent constructs to examine moderating effects. In simulation studies comparing LMS method to other interaction methods, researchers found the LMS method had fewer Type I error rates and better performance across a variety of other conditions (Jackman et al., 2011). Researchers noted the LMS method is consistent, asymptotically normally distributed, provides unbiased standard errors, and allows for multiple latent interactions to be tested simultaneously (Klein & Muthén, 2007).

Measurement Model

Before examining the structural model, we evaluated the adequacy of the measurement model. For the scales that had more three items (i.e., psychological distress, self-concealment, social support, help-seeking stigma), we parceled individual items into three observed constructs that loaded onto each latent construct in order for the model to be just-identified. We 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., 2013). Using parcels as indicators in structural models increases reliability and construct representation (Little et al., 2013). Due to having three observed variables or scales, help-seeking attitudes, structural barriers, and help-seeking intentions were not parceled. The measurement model resulted in acceptable model fit, CFI = .934, TLI = .918, RMSEA = .080 (90% CI [.073, .087]), SRMR = .075. As the model was saturated and no other model modifications were justifiable with both theory and statistics (e.g., modification indices suggested loading observed items on different factors[4]), we deemed this model the final measurement model. The observed variables, including the parceled items, all significantly loaded onto their latent variable, β = .491–.943, 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 did not affect the model fit of the measurement model (Maslowsky et al., 2015).

Structural Model

As the model was saturated, the acceptable model fit of the final measurement model was the same as the structural model. The structural model (see Figure 2) accounted for 47.6% of the variance in help-seeking intentions. As hypothesized, structural barriers (β = −.705) was significantly related to lower help-seeking intentions. Social support (β = .442) and help-seeking attitudes (β = .247) were also significantly related to higher help-seeking intentions. Self-concealment (β = .111) was not significantly related to help-seeking intentions. Help-seeking stigma (β = .343) was significantly related to higher help-seeking intentions, which was the opposite relation as hypothesized. The structural model with moderators (see Supplemental Figure 2) accounted for 55.7% of the variance in help-seeking intentions. The interactions of psychological distress with structural barriers, help-seeking attitudes, and help-seeking stigma were not statistically significant. For cross-loadings and factor loadings of both structural models, please see Supplemental Tables 2–4.

Post Hoc Analyses

Considering the novel area of research (i.e., examining moderators with help-seeking intentions) and to gain a more complete understanding of the nature of the moderating variables, we conducted post hoc exploratory analyses. By evaluating the latent interaction effects independently across three structural models to see if evidence of moderation would emerge (see Supplemental Figures 3–5), this helped us examine whether the interaction terms were potentially competing for common variance in help-seeking intentions, which would increase the possibility of multicollinearity and obscure the findings.

When we examined the latent moderators independently in separate models, the association between psychological distress and help-seeking intentions was significantly moderated by structural barriers (β = .27, SE = .06, p < .01), help-seeking attitudes (β = −.24, SE = .07, p < .01), and help-seeking stigma (β = .17, SE = .07, p < .05). Probing the three significant interaction terms revealed the following results. Psychological distress was significantly positively associated with help-seeking intentions when scores on structural barriers were one standard deviation (SD) above the mean (b = 1.07, SE = .29, p < .01) and at the mean (b = .67, SE = .23, p < .01), but not when scores on structural barriers were one SD below the mean (b = .28, SE = .23, p = .21). Psychological distress was significantly positively associated with help-seeking intentions when scores on help-seeking attitudes were one SD below the mean (b = 1.0, SE = .22, p < .01) and at the mean (b = .67, SE = .22, p < .01), but not when scores on help-seeking attitudes were one SD above the mean (b = .34, SE = .23, p = .14). Finally, psychological distress was significantly positively associated with help-seeking intentions when scores on help-seeking stigma were one SD above the mean (b = .87, SE = .22, p < .01) and at the mean (b = .63, SE = .20, p < .01), but not when scores on help-seeking stigma were

[4] Notably, the modification indices included the observed items of perceived mental health professional sexual minority prejudice and affirmativeness loaded onto multiple other factors.

Table 1
Correlation Between Measured Variables, Means, and Standard Deviations

Measured variable	1	2	3	4	5	6	7	8	9	10	11	12
M (*SD*)	2.609 (1.131)	3.912 (.681)	2.2973 (.755)	5.274 (1.194)	3.161 (1.017)	5.181 (1.275)	2.489 (.767)	2.417 (.803)	2.250 (1.013)	2.820 (1.030)	2.180 (1.046)	5.119 (1.458)
1. KPDS	—											
2. MHCP Aff.	−.010	—										
3. MHCP Prej	.489**	−.556**	—									
4. MHSAS	−.296**	.393**	−.492**	—								
5. SCS	.637**	.104*	.341**	−.219**	—							
6. MSPSS	−.110*	.405**	−.135**	.222**	−.085	—						
7. SSRPH	.566**	−.029	.493**	−.321**	.606**	−.025	—					
8. SB: Total	.593**	−.066	.472**	−.381**	.549**	−.019	.583**	—				
9. SB: Time	.496**	−.076	.450**	−.349**	.491**	.049	.520**	.813**	—			
10. SB: Cost	.341**	.048	.183**	−.181**	.334**	−.037	.347**	.734**	.389**	—		
11. SB: How	.548**	−.125*	.470**	−.361**	.459**	−.054	.498**	.794**	.521**	.329**	—	
12. MHSIS	.084	.403**	−.136**	.437**	.074	.421**	.032	−.165**	−.044	−.199**	−.140**	—

Note. KPDS = Kessler Psychological Distress Scale; MHCP Aff. = Perceived Mental Health Professional Sexual Minority Affirmativeness (Gay Affirmative Practice Scale); MHCP Prej. = Perceived Mental Health 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; SSRPH = Stigma Scale for Receiving Psychological Help; SB = Structural Barriers; MHSIS = Mental Help-Seeking Intention Scale.
* $p < .05$. ** $p < .01$.

one *SD* below the mean ($b = .38$, $SE = .22$, $p = .08$). Examination of regions of significance revealed that psychological distress was significantly positively associated with health-seeking intentions at values higher than .61 *SD* below the mean for structural barriers, lower than .74 *SD* above the mean for help-seeking attitudes, and higher than .85 *SD* below the mean for help-seeking stigma. See Figure 3 for the plots of all three interactions. When reviewing these interactions, it is important to consider them in the context of the cutoffs of the distress scale.[5] Specifically, the mean response in this sample was of someone who likely has a moderate mental health disorder and those one standard deviation was of someone who likely has a significant mental health disorder (Andrews & Slade, 2001).

Discussion

The purpose of this study was to better understand help-seeking and unmet mental health needs among sexual minorities. We examined this by testing a help-seeking model, assessing latent moderators, and investigating reasons for unmet mental health needs. To the best of our knowledge, this is the first empirical examination of a mental health help-seeking model that includes structural barriers (e.g., cost, time, knowing how to access services). Moreover, this study represents the first examination of help-seeking among sexual minorities that accounts for variables traditionally included in previous help-seeking models (e.g., social support, self-concealment, help-seeking stigma) and the first to include perceived prejudice and affirmativeness of mental health professionals as part of help-seeking attitudes. The model exhibited acceptable fit and accounted for nearly half of the variance in intentions to seek out mental health care. Similar to previous research and in support of our hypotheses, higher help-seeking intentions significantly related to lower structural barriers, higher social support, and more positive help-seeking attitudes. In relation to traditional help-seeking factors, structural barriers were the strongest predictor of sexual minorities' help-seeking intentions. These findings support the structural vulnerability framework that emphasizes the influence of sociocultural factors on impeding access to health care (Bourgois et al., 2017). These findings also align with previous qualitative research with sexual minorities that help-seeking intentions were related to higher social support (MacKay et al., 2017; McNair & Bush, 2016) and more positive help-seeking attitudes (Spengler & Ægisdóttir, 2015).

This study found cultural factors inform help-seeking attitudes and intentions. Sexual minorities' help-seeking intentions were positively related to help-seeking attitudes, which we conceptualized considering participants' perception of mental health professionals as prejudicial and affirmative toward sexual minorities. Bivariate correlations found all three variables significantly correlated with help-seeking intentions. These findings complement research that shows sexual minorities' perception of mental health professionals influence whether they delay or receive mental health care at all (Barefoot et al., 2015; Romanelli & Hudson, 2017). Because sexual minorities are more than *just* sexual minorities, all of these dynamics may intersect with other systems of inequality (e.g., racism, sexism) that may likewise inform how they experience these

[5] This is approximate as latent factors' means and standard deviations cannot be directly translated to the cutoffs of the original distress scale.

Table 2
Unmet Mental Health Needs

Reason for unmet mental health need	*N*	Total (%) *n* = 397	UMHN (%) *n* = 158
Could not afford cost	70	17.6	44.3
Thought problem could be handled without treatment	52	13.1	32.9
Health insurance did not cover mental health services	51	12.8	32.3
Health insurance did not pay enough for mental health services	44	11.1	27.8
Concerned about confidentiality	38	9.6	24.1
Might cause neighbors/community to have negative opinion	35	8.8	22.2
Did not know where to go for mental health services	33	8.3	20.9
Might have negative impact on job	30	7.6	19.0
Concerned about being committed/ having to take medication	26	6.5	16.5
Did not have time	25	6.3	15.8
Treatment would not help	22	5.5	13.9
Did not feel the need for treatment at the time	18	4.5	11.4
Did not have transportation	17	4.3	10.8
Did not want others to find out	15	3.8	9.5
Other	27	6.8	17.1

Note. UMHN = unmet mental health need. One participant did not answer these questions.

institutions and seek help from varied intersectional standpoints (Bowleg, 2017).

Contrary to our hypothesis and previous research, help-seeking stigma was positively associated with help-seeking intentions. In addition, the latent moderator illustrated help-seeking intentions increased as individuals reported more distress only for those high in help-seeking stigma. These findings are contrary to previous qualitative research that found sexual minorities delayed or impeded seeking out mental health care due to a fear of increased stigma or judgment by their support system (MacKay et al., 2017; McNair & Bush, 2016). In the face of stigma, the findings from this study suggest sexual minorities may cultivate resilience due to experiences of (multiple) minority stress (Vogel et al., 2011). These findings are similar to the results of a previous help-seeking model with sexual minorities that found help-seeking intentions were related to more negative perception of one's sexual minority identity, which included internalized homonegativity, a difficult process of coming out, and wondering about acceptance by others (Spengler & Ægisdóttir, 2015). These findings underline how imperative it is that clinicians are prepared to work with clients who are accustomed to managing stigma from others due to oppressive circumstances. Previous research suggests public help-seeking stigma does not always show a link to intentions as this relationship is more often mediated by self-stigma (i.e., the internalization of public stigma applied to oneself; Lannin et al., 2014). Thus, in addition to replicating these results with public stigma, future research is needed to understand how internalized stigma about help-seeking may influence sexual minorities' help.

Similar to previous research, the correlation between psychological distress and help-seeking intentions was nonsignificant, although the nuance of this relationship was illuminated in the model when accounting for other variables via latent moderation. None of the latent moderators of psychological distress with help-seeking attitudes, help-seeking stigma, and structural barriers significantly predicted help-seeking intentions when included simultaneously. As these were exploratory analyses, we conducted post hoc analyses examining the latent moderators independently in separate models that revealed significant interactions.

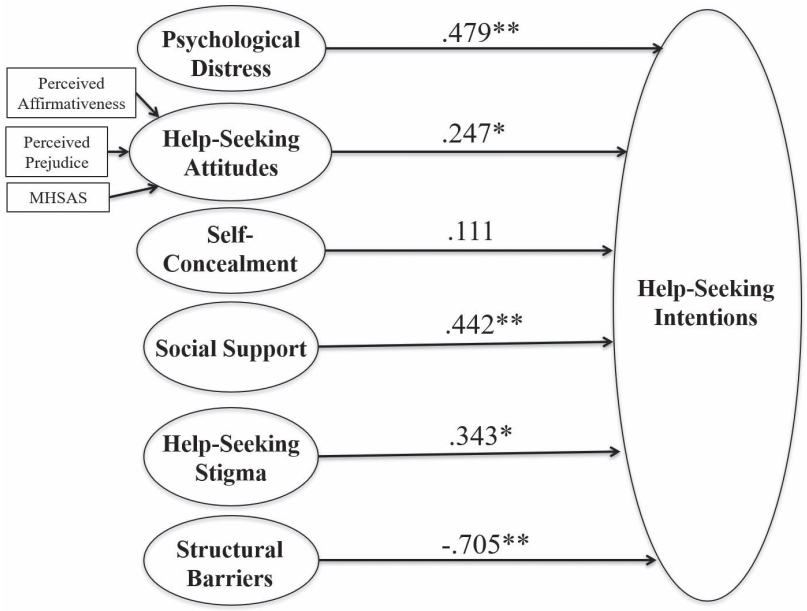
Collectively, the interactions illuminated a pattern of *reactive*, rather than *proactive*, mental health care among the most vulnerable participants. As opposed to seeking care at the emergence of distress, these participants were willing to pursue mental health care only when they were experiencing significant distress. Specifically, these moderators illustrated participants with high structural barriers and negative help-seeking attitudes (i.e., perceived mental health professionals as prejudiced and nonaffirmative) were only as likely to intend to seek mental health care as their counterparts when they were likely experiencing a severe mental health disorder. Alternatively, the help-seeking intentions of individuals with low structural barriers, positive help-seeking attitudes, and low help-seeking stigma were consistent regardless of their level of psychological distress. This pattern of reactive mental health care has significant clinical implications as symptom severity is the strongest indicator of prognosis. Individuals only being willing to seek out help when they are in dire need, in turn, increases the length of needed treatment and amount of required resources when individuals in (Buckman et al., 2021; Robinson et al., 2020). Especially considering the nonsignificant initial latent moderator analyses, future work is needed to replicate these findings and explore other factors (e.g., self-concealment, social support, perceived prejudice and affirmativeness as independent factors) that may interact with psychological distress to predict when sexual minorities and other populations are willing to seek out treatment.

Nearly 40% of respondents reported an unmet mental health need in the last 12 months. These findings are substantially higher than the rate reported by Substance Abuse and Mental Health Services Administration (2019) national sample (23.8%), which neglected to assess respondents' sexual identities. Three of the four most endorsed reasons for an unmet mental health need were structural barriers (e.g., could not afford cost, health insurance did not cover, health insurance did not pay enough). Along with the finding that structural barriers are the strongest predictor of sexual minorities' help-seeking, this showcases how *structural vulnerability* impedes sexual minorities who need or want mental health care from receiving them.

Implications

The integral role structural barriers play in help-seeking intentions and unmet mental health needs should inform how counseling psychologists and allied social scientists critically evaluate health differences and the treatment gap (Kazdin, 2017). Previous help-seeking models that overlooked the influence of structural barriers assume 100% of volitional control, decision-making, and responsibility for mental health is on rational, individual agents. Instead of the traditional help-seeking paradigm that focuses on individual attitudes as the main contributor to future behavior (cf., Sugarman & Thrift, 2017), we encourage counseling and other psychologists to move toward an interdisciplinary approach to inform the help-seeking process from more of a structural and cultural lens, including public health (e.g.,

Figure 2
Statistical Model Without Moderators



Note. MHSAS = Mental HelpSeeking Attitudes Scale; CI = confidence interval. model fit: comparative fit index (CFI) = .934, Tucker–Lewis index (TLI) = .918, root-mean-square error of approximation (RMSEA) = .080 (90% CI [.073, .087]), standardized root-mean-square residual (SRMR) = .075. Standardized loadings. All latent factors included single scale items as observed indicators, except help-seeking attitudes which had three scales as observed indicators.
* $p < .05$. ** $p < .01$.

Levesque et al., 2013), medical sociology (e.g., Pescosolido, 2006), and medical anthropology (Bourgois et al., 2017). Given the confluence of our results illustrating the importance of structural barriers in the help-seeking process, future research with other populations should likewise consider the potential impact of structural vulnerability on other groups' help-seeking practices.

Moreover, sexual minorities often do not get their needs entirely met in mental health care, as 68.3% of participants who received mental health care in the last year reported an unmet mental health need. Future training and outreach efforts should focus on promoting culturally affirmative psychologists and reframing psychotherapy and counseling as approachable and nondiscriminatory (Levesque et al., 2013). These efforts should also recognize the meaningful reasons individuals may be reluctant to pursue psychotherapy, including microaggressions that may happen within therapy (Spengler et al., 2016) and the harm done by psychology and psychologists in enacting and exacerbating heterosexism (Hammack et al., 2013), among other intersecting forms of oppression (American Psychological Association, 2021).

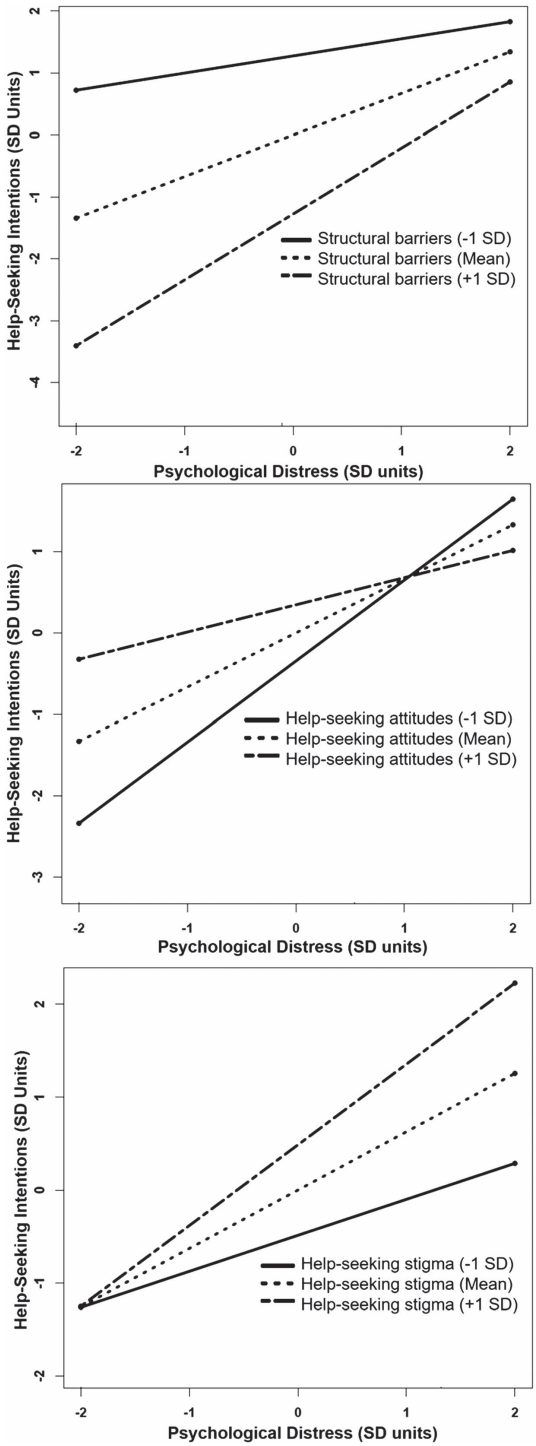
Counseling psychologists are uniquely positioned to organize with community partners and other professionals to enact social change (DeBlaere et al., 2019). Much like the paradigm of medical health care is moving from a reactive approach to a proactive approach (Waldman & Terzic, 2019), proactive structural interventions may interrupt the pattern of reactive mental health care observed in this study. Outreach efforts could include advocacy for structural vulnerability assessments in health care settings (Bourgois et al., 2017), interventions about how to look for and evaluate mental health care options, consideration of insurance parity, and using community-based participatory efforts with sexual minorities (Fine et al., 2021). Moreover, community-based interventions could foster increased social support, which also was a significant predictor of help-seeking intentions. Conceptualizing individuals' presenting issues and symptomology (i.e., the "downstream" implications) within the wider level sociocultural and historical contexts (i.e., the "upstream" causes) would allow for a more equitable and efficient mental health care system (Metzl & Hansen, 2014; Warnecke et al., 2008). For example, the community mental health movement (Humphreys & Rappaport, 1993), which gained momentum in the 1960s and the 1970s before federal funding was diverted to individually based treatments and research, is a framework for promoting structurally sensitive mental health care equity.

Limitations and Future Directions

These findings may not be generalizable to the population of sexual minorities. The entire sample was over 18, lived in the United States, and had Internet access; most of the sample lived in an urban area, completed higher education, and identified as White, man, and bisexual. In addition, more research on help-seeking is needed with gender-diverse (e.g., transgender, nonbinary) individuals. Although sexual minority identities are often conflated with gender-diverse identities (Hyde et al., 2019), gender-diverse people encounter unique structural barriers to help-seeking (e.g., gatekeeping hormone replacement therapy, transphobia and cisgenderism; Ashley, 2019) warranting separate empirical inquiry (see Hunt, 2014).

Figure 3

Latent Moderated Structural Equations Plots



Note. Plots are mean-centered for the latent variables.

Despite having the number of latent variables and similar sample size as other help-seeking models (Vogel et al., 2005), our observed acceptable model fit may be impacted by limited power due to lower than expected loadings. This misspecification could also be due to lower than expected factor loadings for some of the observed variables (e.g., structural barriers items, help-seeking attitudes scales). Future studies could work on model and scale refinement, including using separate latent constructs for general help-seeking attitudes and perceived prejudiced/affirmativeness of mental health professionals. Our structural barriers measure conflated the theory of planned behavior constructs of perceived (i.e., self-efficacy) and actual behavioral control (i.e., controllability), which is common in the application of this theory (Cheung & Chan, 2000). Moreover, the three-item scale we used for structural barriers was limited in content validity as it did not encapsulate all structural barriers that accounted for unmet mental health needs (e.g., health insurance, transportation). Future help-seeking studies include a more comprehensive structural barriers measure, including separately measuring self-efficacy (e.g., knowing how to access services, mental health literacy; Jorm, 2012) and controllability (e.g., cost, time, transportation) to better understand their unique and related contributions. Given our decision to include affirmativeness, prejudice, and attitudes in one latent variable, it remains unclear the unique relationship between these variables and help-seeking intentions. The significant correlations of all three variables with help-seeking intentions suggest it would be a worthy pursuit for future help-seeking models to use separate latent factors for each construct for sexual minorities and other marginalized populations.

As we examined participants in one group through a variable-centered approach, structural equation modeling inherently cannot model help-seeking for multiply marginalized populations without reducing demographic variables to covariates (Else-Quest & Hyde, 2015). Researchers should consider statistical techniques that incorporate social structures, such as hierarchical linear modeling, or an intersectional approach using person-centered statistics, such as latent profile analysis. These could better account for the experience of multiply marginalized sexual minorities without reducing salient dimensions of difference into overly simplistic comparisons while also maintaining statistical rigor (Grzanka, 2020).

We also made slight modifications to three previously validated measures (i.e., structural barriers, perceived counselor sexual prejudice, perceived counselor sexual affirmation). It is important to replicate this approach to ensure the psychometric properties found in the current sample hold across other samples and contexts. While using help-seeking intentions as a proxy for actual behavior is common practice in this domain, our cross-sectional, self-reported data limit conclusions that can be drawn regarding actual behavior. We operationalized help-seeking intentions as only related to one particular type of help. Given that individuals evaluate alternative options when considering a behavior (Ajzen, 2020), future help-seeking models should also account for intentions to engage in alternative mental health care systems, including friends, family, faith leaders, and teachers (Pescosolido, 2006).

Conclusion

This study's findings underscore the notion that help-seeking is a dynamic, multifaceted, and interrelated process best understood in structural relief (Grzanka, 2020). Foregrounding attention to structural vulnerability in the study of mental health care equity can help to shift our collective focus beyond the individual and onto the systemic contexts that shape clinical encounters (Metzl & Hansen, 2014). In this sense, social justice advocacy, clinical practice, and

research should be conceptualized as mutually reinforcing and operating in concert with one another (Miles & Fassinger, 2021). Simply put, help-seeking does not occur in a vacuum void of sociocultural and historical factors; rather, individuals' interactions with mental health care systems and professionals are best conceptualized as intimately tied to the context of these social systems.

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