REPORT OF THE APA WORKING GROUP ON HEALTH DISPARITIES IN BOYS AND MEN

Health Disparities in Racial/Ethnic and Sexual Minority Boys and Men

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http://www.apa.org/pi/health-disparities/resources/race-sexuality-men.aspx

EXECUTIVE SUMMARY

Racial/ethnic and sexual minority males are two of the most persistently unhealthy groups in the United States. In fact, health disadvantages are even more pronounced among groups of boys and men who have not fully enjoyed the socioeconomic power and privilege typically conferred to males in this country. These are boys and men at the intersections of social identities, communities, or groups that have historically been oppressed, marginalized, and stigmatized. Moreover, they are boys and men with lived experiences, occupations, or material circumstances that disconnect them from day-to-day society. Often, these males have some of the most negative health-related outcomes, including shorter lifespans, more threats to their safety and well-being, and less access to health care and social supports.

In 2011, the American Psychological Association (APA) approved the support of a health disparities initiative as an activity of its recently adopted strategic plan. A multidisciplinary working group was formed and charged with preparing a report that summarizes critical factors contributing to health disparities in boys and men vulnerable to poorer health and negative life outcomes. The report would include recommendations for action that APA and others, such as researchers, health care providers, community leaders, and policymakers, can take to eliminate health disparities more effectively and improve the overall health and quality of life of these vulnerable boys and men.

Why Racial/Ethnic Minority and Sexuality Minority Boys and Men?

Racial and ethnic minority boys and men and sexual minority males are the focus of this report. Each group has some common, long-standing patterns of social marginalization and stigmatization experiences that have uniquely compromised their health, safety, and well-being. Each group also has different health and well-being profiles that have been shaped by their lived experiences, coping styles, and access to opportunities for upward social mobility.

Racial and ethnic minority males generally exhibit worse health profiles than non-Hispanic White men (Arias, 2006; Bonhomme & Young 2009; Courtenay, 2003; Griffith, 2012; Griffith, Metzl, & Gunter, 2011; Plowden & Young, 2003; Thorpe, Bowie, Wilson-Frederick, Coa, & Laveist, 2013; Treadwell & Braithwaite, 2005; Treadwell & Ro, 2003; Williams, 2003). These disparities are most apparent in life expectancy trends. African American males, for example, consistently have a life expectancy that is approximately eight years shorter than that of Hispanic males (70.7 and 78.7 years, respectively) and about six years shorter than that of White males (70.7 and 76.3 years,

respectively) (Kochanek, Xu, Miniño, & Kung, 2011). African American and American Indian males have higher age-adjusted death rates than any other U.S. population group (S. L. Murphy, Xu, Kochanek, Curtin, & Arias, 2017). The high-profile killings of African American males (e.g., Tyre King, Keith Lamont Scott, Terrence Crutcher, Philando Castile, and Trayvon Martin) illustrate the high-threat conditions under which they live.

Moreover, boys and men of color are more likely to live in poverty, to have poorer education and educational opportunities, to be under- and unemployed, to be incarcerated, to be exposed to toxic substances, to experience threats and realities of crime, to live with cumulative worries about meeting basic needs, and to have discrimination influence their capacity to achieve and maintain good mental and physical health (Bonhomme & Young, 2009; Sabo, 2005; Treadwell & Braithwaite, 2005; World Health Organization, 2008; Xanthos, Treadwell, & Holden, 2010; Young, Meryn, & Treadwell, 2008).

Sexual minority boys and men remain at highest risk for acquiring HIV/AIDS (Halkitis et al., 2011). They have higher rates of smoking (J. G. L. Lee, Griffin, & Melvin, 2009) and suicide (Paul et al., 2002), are more likely to be bullied and harassed (Rivers, 2001; Stall, Friedman, & Catania, 2008), and in contrast to heterosexual men, are more likely to experience mental health problems (Cook & Calebs, 2016; Lick, Durso, & Johnson, 2013). Sexual minority boys and men are more likely to be the victims of hate crimes, such as those that claimed the lives of Matthew Shepard, Mark Carson, and others. More alarming are the heightened rates of mental health and traumatic childhood events experienced by sexual minority men of color (Cook, Valera, Calebs, & Wilson, 2016). The challenges involved in being both a racial/ethnic and a sexual minority male may explain these heightened rates.

The persistence of such disparities and the continuing increase in beliefs, practices, and policies that sustain and promote disparities within these groups (e.g., school suspension and expulsion rates, sentencing disparities, and incarceration rates) have sparked a deepening national interest in the well-being of these boys and men of color and sexual minority males. This deepening interest coincides with a growing recognition among scientific researchers that health disparities among this population create a significant burden not only for the boys and men themselves but also for their families, communities, and our nation.

Understanding Their Stress, Risks, and Resilience

Health disparities in boys and men of color and sexual minority men are viewed as being driven by myriad biological, social, psychological, behavioral, and structural factors but determined primarily by the social conditions in which these boys and men are born, grow, live, work, and age. Understanding the sources and consequences of health disparities in boys and men requires viewing them through a multisystems lens. To describe this complex web of determinants, this report relies principally on social ecological frameworks, which state that individual health and health behaviors are influenced by factors operating at multiple levels of their environments (e.g., individual, familial, structural, and cultural) (Bronfenbrenner, 1992; Stokols, 1992).

It is also important to recognize the profound influence of stress in the lives of these boys and men and its influence on health behaviors and outcomes and the multiple social roles they negotiate as they move through life or occupy different stages of normative development. It is equally important to discuss how life and role transitions shape risks and protections from health disparities, especially during sensitive periods of male development. Thus, we use the following conceptual frameworks to guide our understanding of health risks, behaviors, and outcomes:

- Life-course health developmental frameworks (Halfon & Hochstein, 2002; Thorpe, Duru, & Hill, 2015; Williams, 2003)
- The environmental affordances framework (Mezuk et al., 2010, 2013), which outlines a dynamic relationship between stress, biology, and individual motivation for, and availability to engage in, poor health behaviors
- Intersectionality theory, which helps to explain how social identities intertwine to produce compounded structural and individual vulnerability to health disparities (Cole, 2009; Crenshaw, 1991; Griffith, Ellis, & Allen, 2013; D. F. Warner & Brown, 2011)
- Theories of gender and power (Connell, 2012; Hammond, Fleming, & Villa-Torres, 2016), which describe how gendered structural arrangements produce inequities in exposures and risk factors and reinforce harmful norms that discourage positive health practices
- Resilience frameworks, which promote the ways boys and men might demonstrate positive development in the context of adversity and stress (Buttram, 2015; Masten & Wright, 2009)

Trauma, Substance Abuse, Depression, and Violence

We focus in this report on four outcomes impacting boys and men vulnerable to health disparities: trauma, substance abuse, depression, and violence. These outcomes were selected because of their prevalence and/or pronounced impact on health and their high association with other chronic diseases, psychological problems, and events and consequences that compromise health and life options of racial/ethnic and sexual minority boys and men (e.g., violence that leads to disability, death, or incarceration; addiction that increases other risky health behaviors; trauma that interferes with the ability to work or form meaningful personal relationships).

TRAUMA

We provide brief overviews of major types of trauma, including violence related to interpersonal violence (IPV) trauma in which males are victims; sexual assault–related trauma; combat-related trauma; historical trauma, a "macro-level temporal framework for examining how the life course of a population exposed to trauma at a particular point in time compares with that of an unexposed population" (Sotero, 2006); and race-based trauma, defined as exposures to racism that elicit profound emotional stress, fear, or physical harm (Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005). For example, estimates indicate that roughly 47% of males report IPV victimization (Kilpatrick et al., 2013). Sexual minority men are more likely to experience sexual violence victimization, such as childhood sexual abuse, sexual assault related to hate crimes; and intimate partner sexual assault, than are heterosexual men, with an estimated prevalence rate of 11.8–54% (Rothman, Exner, & Baughman, 2011). Moreover, compared with civilians, combat veterans present two to four times the rate of posttraumatic stress disorder (Richardson, Frueh, & Acierno, 2010).

SUBSTANCE ABUSE

Males in the United States tend to have higher rates of substance use than females and experience disproportionately greater consequences of substance abuse (Centers for Disease Control, 2014; Compton, Thomas, Stinson, & Grant, 2007; Kessler, Chiu, Demler, & Walters, 2005). Substance use is strongly influenced by masculinity beliefs (Blazina & Watkins, 1996). Use preferences and patterns vary across the lifespan by race/ethnicity (American Cancer Society, 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), sexual and gender minority (J. Hunt, 2012), and stress (Martin, Tuch, & Roman, 2003; Zemore, Karriker-Jaffe, Keithly, & Mulia, 2011). Moreover, there are disparate health and social outcomes experienced by racial/ethnic and sexual minority males as a result of drug use (e.g., Barnes & Kingsnorth, 1996; Burt, Simons, & Gibbons, 2012; Chartier & Caetano, 2010, Hattery & Smith, 2007; Iguchi, Bell, Ramchand, & Fain, 2005; Kakade et al., 2012; Provine, 2007). These include but are not limited to imprisonment (Pettit & Western, 2004); HIV acquisition (Halkitis et al., 2011); overdose (Bird & Hutchinson, 2003); and social, emotional, and physical deterioration (Halkitis, 2009).

DEPRESSION

Although men are less likely to suffer from depression than women, researchers estimate that more than six million men in the United States have a depressive disorder—about one third of all adults living with depression in any given year (National Institute of Mental Health, 2017b). Estimates of diagnosed depression likely underestimate the burden of depression among males because they are least likely to seek help for depressive symptomatology (Rosenfield & Mouzon, 2013). Affirming the probability that male depression is underestimated are statistics indicating that when compared with females, males have higher rates of suicide completion (Joe, Baser, Breeden, Neighbors, & Jackson, 2006; Pittman, Osborn, King, & Erlangsen, 2014)—an outcome closely linked to depression. This gender paradox in mental health suggests that many more boys and men are suffering in relative silence from depression. Research indicates higher levels of depression among gay/bisexual males when compared with heterosexual males (Cochran, Sullivan, & Mays, 2003). More research is needed to better understand depression in racial/ethnic and sexual minority males. Interestingly, racial and ethnic minority males appear to exhibit more resilience to depressive symptoms when they have a greater sense of control over social and political forces (Zimmerman, Ramirez-Valles, & Maton, 1999), access to culturally responsive interventions (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2012), healthy cultural identities (Cardoso & Thompson, 2010), and less rigid notions of masculinity (Iwamoto, Liao, & Lui, 2010).

VIOLENCE

Men represent more than 90% of the perpetrators of criminal violence in the United States and are also the victims of the large majority (78%) of that violence (Federal Bureau of Investigation, 2007; U.S. Bureau of Justice Statistics, 2008). The differences in exposure to violence that occur among men are due to complex interactions between race, sexuality, socioeconomic status, and geography. Boys and men from racial/ethnic and sexual minority populations are at increased risk for violence victimization and perpetration due in part to greater exposure to high-risk environments and less protection and support when violence is experienced. The following categories of violence are described in the report: physical fighting, weapon ownership and use, homicide, suicide, and intimate partner violence.

Approaches

We propose that health disparities can best be eliminated in racial/ethnic and sexual minority males by adopting upstream (i.e., policy), midstream (i.e., program/practice), and individual (i.e., downstream) approaches that (a) focus on strengths-based methods and those that emphasize optimal development as opposed to the mitigation of pathology; (b) address the social determinants of health, health disparities, and inequities; (c) improve cross-sector collaborations to maximize the impact of health-focused interventions; (d) apply interventions aimed at upstream, midstream, and downstream levels; (e) understand and appreciate the role of masculinity beliefs and norms on health behavior and outcomes; (f) address implicit racial and sexual orientations biases and the stress they induce; and (g) attend to the ways in which race/ethnicity, gender identity, and sexual orientation intersect.

RECOMMENDATIONS

FOR RESEARCH, PUBLIC POLICY, PRACTICE/EDUCATION/TRAINING, AND PUBLIC AWARENESS

RECOMMENDATIONS FOR RESEARCH

More research is needed on "normal" development and the socialization of boys and men of color and sexual minority males across the lifespan; how to prepare and improve the workforce that educates, treats, and provides services to boys and men of color and sexual minority men and their families; and development of strategies to keep them out of the criminal justice system. Additionally, better documentation of their experience of stress, trauma, and depression and the most effective coping and intervention strategies is crucial at the individual, family, and community levels. We encourage the use of community-based participatory methods in research with community stakeholders working in consultation with experts to develop quality prevention and treatment programs. We recommend that APA, research scientists, and other stakeholders:

Encourage increased funding and support for the National Institutes of Health (NIH) and other federal agencies to conduct more research on health disparities specific to boys and men from racial/ethnic minority populations.

Encourage increased funding and support for NIH and other federal agencies to conduct more research on health disparities specific to gender identity, particularly to health disparities faced by transgender and gender nonconforming individuals.

Continue to encourage funding for the Centers for Disease Control and Prevention to monitor gun violence and support firearm injury prevention research.

Conduct more research on normative and optimal development and the natural history of male role socialization of racial/ethnic and sexual minority males in families, within/across generations, and over the lifespan.

Investigate stress exposures (e.g., types of stress, chronic stress) experienced by racial/ethnic and sexual minority males, trauma (e.g., child sexual abuse), and their negative psychological consequences (e.g., depression) through methodologies that allow us to capture them in real-time.

Support studies addressing the preparation and improvement of the workforce that educates, treats, and provides services to racial/ethnic and sexual minority men and their families. These studies should address implicit bias and stereotyping in reference to racial, ethnic, gender, sexual minority status and the intersection of these identities and characteristics.

Conduct evaluation research that demonstrates the effects of programs and interventions.

Encourage and support research to determine the impact of proposed and current policies and programs likely to impact the health and well-being of racial/ethnic and sexual minority males.

Make funding available for research focused on the role of masculinity, chronic stress, trauma, depression, and substance abuse and their relationship to health status, health behaviors, and use of services in boys and men of color and sexual minority males across the lifespan; integrate these measures into the nation's Healthy People objectives.

Evaluate existing assessment measures of boys and men of color and sexual and gender minority males.

RECOMMENDATIONS FOR PUBLIC POLICY

Strong advocacy is needed to ensure that the health needs of racial/ethnic and sexual minority males are a priority agenda item (within APA and with policymakers) and to keep key political stakeholders aware of the impact of psychological factors on the long-term health and quality of life of these boys and men. We recommend that APA, research scientists, and other stakeholders:

Promote policies that reduce disparities and increase health equity among racial/ethnic and sexual minorities. Examples include expanding health insurance to include coverage for mental and behavioral health needs and providing civil rights protections, especially for sexual minority boys and men.

Develop policies that support holistic models of responsible fatherhood, family life, and sexuality. Such policies should emphasize economic and socioemotional contributions fathers make to family life.

Intensify adult and juvenile justice efforts to keep racial/ethnic minority males out of prisons and jails.

Identify existing levers within health care systems that can enhance access to care, improve processes of care, and minimize help-seeking barriers among vulnerable boys and men.

RECOMMENDATIONS FOR PRACTICE, EDUCATION, AND TRAINING

Psychologists, other health care providers, educators, and professionals who provide treatment and services to boys and men of color and sexual minority males can benefit from better understanding their clients' health care needs and barriers to providing care. We recommend that APA, research scientists, and other stakeholders:

Increase psychotherapeutic support for families in their efforts to promote optimal racial and gender socialization for racial/ethnic and sexual minority boys and men.

Address the stress-inducing implications of persistent exposure to implicit biases and the microaggressions they elicit in all the places racial/ethnic and sexual minority boys and men live, get educated, work, play, and acquire health care.

Integrate comprehensive assessments into clinical practice that include comprehensive screening for physical, medical, and mental health concerns during primary and specialty health care visits.

Provide graduate and continuing education (CE) training to all psychologists and other health care providers working with racial/ethnic and sexual minority males. Such training ensures that providers are highly competent and skilled in approaches proven to be the most effective in improving the health of these individuals and in treatment issues associated with gender, race, ethnicity, and sexual orientation, and in how their intersectionality impacts treatment process and outcomes.

Provide postgraduate and CE training to psychologists and other health professionals working with racial/ethnic and sexual minority males, particularly those working in elementary schools, high schools, junior colleges, universities, and communities.

Design youth mentoring programs that move beyond the establishment of bonds with role models toward those that also provide bridges to the social capital critical to accessing networks that enhance upward social mobility. Incorporate more reflexive examples of demonstrating manhood or masculinities into existing rites-of-passage mentoring programs to reflect a wider range of options for expressing masculinities.

Services are limited in rural and in low-income urban areas (SAMHSA, 2014). Treatment services for sexual minority and ethnic minority males are sparse and sorely needed (Healthy People 2020; U.S. Department of Health and Human Services, 2018). Provide quality and culturally appropriate assessment of trauma exposure and mental health needs as well as mental health and addiction care to vulnerable boys and men, especially incarcerated men, men from rural and low-income settings, and racial/ethnic and sexual minority males.

Increase access to interventions that assist vulnerable men in substance abuse recovery in the criminal justice system during the transition from incarceration and as they reintegrate in their communities and families. Increase and improve programs designed to ease reentry into society and the labor force.

Develop treatment services and modalities that attend to sexual identity and the complex interplay between persons and behavioral, psychosocial, and social stressors that place sexual minority men at risk and predispose the syndemic of substance use, HIV, and other sexually transmitted diseases, violence, and mental health concerns (Halkitis, Wolitski, & Millet, 2013).

Provide rehabilitative and supportive services to vulnerable boys and men who have been impacted by trauma and violence. Assure that such services attend to the unique ways in which such events impact masculine role identity. Integrate those services in spaces where racial/ethnic and sexual minority boys and men live, work, play, pray, are educated, and acquire health care. Provide support also for families and friends who are close to those who are impacted by trauma and violence.

Develop gender-based prevention programs and other interventions aimed at men involved in violence as perpetrators or peer bystanders (e.g., Coaching Boys Into Men).

Incentivize, expand, and support state and local programs to assist boys and men who are reentering communities from prisons and jails. In addition, develop and evaluate strategies to keep boys and men of color and sexual minority males retained and engaged in schools, family and community life, and the workforce.

RECOMMENDATIONS FOR PUBLIC AWARENESS

A well-informed, aware community is critical to improving the health of racial/ethnic and sexual minority males. We adopt a broad definition of community to include family, peers, teachers, religious leaders, schools, the media, civic associations, community groups, fraternities and sororities, and employers. Partnering with community-based organizations to plan strategic collaborative efforts to disseminate information on the mental and physical health of racial/ethnic and sexual minority males is needed. We recommend that:

APA work with other professional organizations (e.g., the American Public Health Association, American Medical Association) to develop and disseminate a variety of web-based materials and resources on topics pertaining to racial/ethnic and sexual minority men covered in this report.

APA and other professional organizations collaborate with community groups and stakeholders working with boys and men to provide technical assistance and expertise on the health of racial/ethnic and sexual minority males.

APA establish a systematic means to keep abreast of emerging needs and challenges facing vulnerable boys and men. We believe that what gets measured, gets done.

We believe that we need more than simple public narrative change to eliminate health disparities in racial/ethnic and sexual minority boys and men. Rather, we need narrative disruption to bridge the existing empathy gaps in our society for boys and men at the margins of opportunity. Our report was designed in many ways to bridge such gaps. We view this document as an initial effort by APA to ignite and sustain commitment among psychologists and other health care professionals to work collectively to eliminate health disparities in racial/ethnic and sexual minority boys and men.

Full report and references available online at http://www.apa.org/pi/health-disparities/resources/race-sexuality-men.aspx

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