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Perceptions of Health: Self-Rated Health among Black LGB People

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Chapter 12

Perceptions of Health

Self-Rated Health among Black LGB People

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One of the primary objectives of Healthy People 2020 is to eliminate health disparities facing racial and sexual minorities (U.S. Department of Health and Human Services, 2010). The 2011 Institute of Medicine's report on lesbian, gay, bisexual, and transgender (LGBT) health identified a need for more research highlighting the intersectional perspectives of those that have multiple stigmatized identities (e.g., racial + sexual minority statuses), particularly because members of these populations grapple with extensive and persistent health disparities that disproportionately impact them (Institute of Medicine, 2011). Several studies have identified adverse health outcomes among sexual minorities when compared to their heterosexual counterparts, which includes but is not limited to: mental health outcomes (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Duncan & Hatzenbuehler, 2013; Hatzenbuehler & Keyes, 2013; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012), physical health outcomes (Cochran & Mays, 2007), and tobacco and other substance use and abuse (Cochran, Bandiera, & Mays, 2013; Cochran, Grella, & Mays, 2012; Duncan, Hatzenbuehler, & Johnson, 2013; Ortiz-Hernandez, Gomez-Tello, & Valdes, 2009). As the number of sexual minorities continues to grow and their sociodemographic compositions continue to vary greatly, research agendas evaluating greater population level health indicators are needed.

Self-rated health (SRH) as an indicator of population level health has been used by public health researchers for over thirty years, particularly after the validation of its psychometric properties. As a measurement, SRH has consistently shown strong predictive validity, demonstrating its usefulness in accurately predicting several diseases. Sarkin et al. (2013) demonstrated that racial differences in SRH might be decelerating although racial minorities consistently report worse SRH among the general population (i.e., no stratifying by sexual orientation, identity, or behavior). Moreover, racial differences

in SRH are partially explained by social status, healthcare services, and health behavior measures (Lo, Howell, & Cheng, 2013). In the United States, racial minorities are less likely to report excellent SRH than their white counterparts and are more likely to report fair or poor health; this substantiates the significance of race in predicting reported appraisals of health statuses (Borrell & Dallo, 2008; Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006; Hudson, Puterman, Bibbins-Domingo, Matthews, & Adler, 2013; Lo et al., 2013).

SRH has also been used to understand differences in sexual minority status in comparison to heterosexual status (Cochran & Mays, 2007; Thomeer, 2013). Such studies have shown that some sexual minorities have worse SRH compared to their heterosexual counterparts, while other studies have found no difference. Researchers have found that men in same-sex couples were more likely to report excellent or very good health than men in different-sex couples (Heck et al., 2006; Tjepkema, 2008), while an inverse relationship between SRH and sexual minority status has been discovered among women. Thomeer (2013) discovered that respondents who were only behaviorally heterosexual and same-sex people reported similar levels of health. In addition, very little research has considered racial differences in SRH, particularly between Black sexual minorities and their white counterparts. However, no studies have explored within-group heterogeneity to determine whether race is statistically significant in explaining SRH and how sociodemographic characteristics interact with race to explain SRH among racially diverse sexual minority populations. Furthermore, no studies have assessed within group heterogeneity among Black sexual minorities in specifically.

The current study employs data from a 2010 study that examined SRH among Black sexual minorities (Social Justice Sexuality Project, "SJS Project"). The SJS Project is one of the largest community-based national surveys of Black, Latina/o, and Asian Pacific Islander, and multiracial sexual minorities aged 18 and older. Black sexual minorities occupy several different social statuses that are important in understanding how health is shaped among sexual minority populations. Thus, we utilize an intersectional approach by recognizing that sexual minority populations are not homogenous and that assessing the role of race in explaining SRH is a step toward understanding the heterogeneity among sexual minorities. Furthermore, contextualizing the experience of Black sexual minorities requires specific identification of divergent lived experiences, which can be achieved quantitatively by exploring heterogeneity within Black sexual minority populations. The rationale for focusing attention on the SRH of Black sexual minorities include, but are not limited to: (1) the health of Black sexual minorities has largely been viewed within public health through the lens of sexual health and sexual risk behaviors (e.g., HIV) in recent years, fueling continued fixation on Black sexuality

as a means for social control; (2) sociodemographic variations among Black sexual minorities has been largely an overlooked area of investigation; (3) understanding variations in SRH can produce a baseline measurement of how Black sexual minorities view their own health, outside of medicalized approaches. Thus, this could assist in producing person-centered knowledge in which Black sexual minorities can facilitate the development of targeted efforts to improve their own health; and (4) research on sexual minority populations has increasingly emphasized the need to apply nuanced research approaches that shed light on sociodemographic variation among sexual minorities, which is vital for achieving health equity among sexual minorities (Gates, 2013; Institute of Medicine, 2011; Kertzner, Meyer, Frost, & Stirratt, 2009; Wong, Schrage, Holloway, Meyer, & Kipke, 2013). The remainder of this chapter includes justification for the application of intersectionality theory to this secondary data analysis, a description of the methods used and the findings of this study, a discussion of the results, and suggestions for future health disparities research.

INTERSECTIONALITY THEORY

Rooted in the histories of Black women in the United States, Black feminist scholars and activists have complicated notions of single identity issues (e.g., gender, race, sexuality, and class) that white feminists often employed, emphasizing that there is no hierarchy of identity and oppression (hooks, 1982; Lorde, 1984). It was Sojourner Truth who reportedly asked, "Ain't I a Woman" at the 1851 Ohio Women's Rights Convention where she challenged notions of single identity oppression and discussed her experiences as not just a Black *person* or a *woman*, but a *Black woman*. Over 100 years later, the women of the Combahee River Collective highlighted sexual and class oppression (Combahee River Collective, 1977). In 1989, Kimberle Crenshaw called this notion of power, identity, and oppression, "intersectionality." Harris and Bartlow (2015) explain that intersectionality refers to how "race, class, gender, sexual orientation, age, religion, and other locations of social group membership impact lived experiences and social relations. The term emphasizes the mobility of social group identities and locations, not simply of their appearances in individual bodies" (p. 261).

Intersectionality is not just a theoretical framework that improves comprehension of intersecting identities, it is also a methodology that helps the researcher take these identities into account during data collection and analysis. This is particularly the case in examining the experiences of Black lesbian, gay, bisexual, and transgender people of color, who often experience multiple and simultaneous forms of marginalization. Some Black LGBT individuals

experience not only racism within LGBT communities and homophobia and transphobia within communities of color, but some lesbians and other same-gender-loving women of color experience racism, homophobia, sexism, transphobia, and misogyny. Furthermore, some Black elderly LGBT experience age discrimination within both LGBT and Black communities. Using an intersectional approach to research aids in understanding the experiences of Blacks who have socially stigmatized identities such as racial minority and sexual minority.

Recent research utilizing an intersectional framework notes the resilience that Black LGBT often have developed as a result of their experiences with different group memberships. Fredriksen-Goldsen's (2011) research on resiliency and discrimination among elderly LGBT adults showed that racial minorities, particularly Black elderly LGBT folks, expressed unique forms of resiliency. Meyer (2010) found that LGB people of color have positive racial, ethnic, and sexual identities which could potentially explain why primary group membership (i.e., the group members in which one is primarily socialized and integrates within society) matters. Further research notes that often for Black LGBT individuals, community connectedness and sociopolitical involvement within communities are more likely to be dependent on their experiences within LGBT communities than their experiences within Black communities (Harris & Battle, 2013; Harris, Battle, Pastrana, & Daniels, 2013, 2015). However, this research begs the following question: Does primary group membership for one's racial identity matter more than one's sexual identity? While it is important to recognize that identities can change considerably across the life-course, typically one can easily identify a group membership for which they first experienced discrimination. Consequently, examining identity through an intersectional lens can facilitate understanding the contextual drivers that shape Black LGBT individuals' appraisal of their health.

The goal of this study was to understand SRH among Black sexual minorities across the nation. Since very little published research exists about racial differences or SRH among Black sexual minority populations, the following analyses are exploratory in nature. We center Black sexual minorities by comparing other racial/ethnic groups to Black sexual minorities in terms of SRH. Additionally, we conduct gender-stratified analyses illuminating an intersectional perspective on the gendered and racial/ethnic dynamics of SRH within sexual minority populations.

METHODS

Sample and Procedures

The current study did not have to obtain IRB approval because this study involves secondary data analysis of de-identifiable respondents. This secondary

data analysis used data from the 2010 Social Justice Sexuality Project (SJS Project). The purpose of the SJS project was to collect data on the experiences of sexual minorities of color in the following five areas: racial and sexual identity, physical and mental health, family, religion and spirituality, and sociopolitical involvement. Data collection efforts were employed to create a dataset that included an oversample of racial minorities. Data were collected from over 5,500 respondents throughout the United States (including Washington, DC, and Puerto Rico) from January 2010 to December 2010. The survey was administered in both English and Spanish. Several data collection strategies were used including venue-based sampling, snowball sampling, the Internet, and partnerships with community-based organizations, activists and opinion leaders. The dataset does not permit stratification by venue type and therefore, we did not do so in our analyses. The venues were primarily LGBT people of color Pride marches, parades, religious gatherings, festivals, senior events, and small house parties across the nation. The total sample consists of 4,953 valid surveys. We focused our analyses on both spectrums of SRH, as other researchers using SRH as a population level indicator have done previously. SRH is a 5-point Likert scale in which most researchers focus on either excellent or fair/poor reports of SRH. The current analyses specifically focus on a subsample of respondents who had complete data for the outcome variables of fair/poor or excellent SRH respectively yielding an analytic sample $N = 2,167$. This categorization follows standard approaches for studying SRH. If individuals did not report excellent SRH they were coded as 0 and excellent SRH was coded as 1; and the same was done for fair/poor SRH. Subsequent sensitivity analyses comparing our analytic sample to the entire sample of respondents indicated no statistically significant differences between those having complete information on our outcome measures compared to individuals that were missing data.

MEASURES

Dependent Variable

Self-Rated Health

For self-reported health status, respondents rated their health on a 5-point Likert scale from poor to excellent based on a single question: "In general, would you say your health is . . .?" Respondents could choose from: excellent, very good, good, fair, and poor. Consistent with previous research, we combined fair and poor for all racial groups, given that the number of respondents in each was relatively low (Frankenberg & Jones, 2004; Idler & Benyamini, 1997; Thomeer, 2013). SRH as a health indicator has usefulness for clinical, practice, and public health policy for its predictive ability among various sociodemographic groups.

Independent Variable

Race

Race was assessed using the question, "Which of the following racial groups comes closest to which you identify (choose all that apply)?" Respondents had the choice of responding to the following categories: Black, Latino/Hispanic, Asian Pacific Islander, Multiracial, Native Americans, white, and other. In our first model approach, we exclusively focus on the Black subsample, particularly Black women. Other models explicitly focus on comparing Blacks to other racial/ethnic groups (e.g., Latinos, Asian Americans, whites).

Covariates

Sex

Sex was assessed by the question, "What was the sex reported on your original birth certificate?" Respondents were able to choose from: male, female, unsure (not included in our analyses), which was coded accordingly as: male = 0 and female = 1.

Educational Attainment

Educational attainment was measured by the question, "What is the highest level of schooling you have completed?" Respondents were given the following response choices: less than high school; high school diploma or GED; some college, no degree; associates degree; bachelor's degree; some graduate/professional school; or graduate/professional degree. We sorted educational attainment into three categories: high school diploma/GED or less = 0; some college = 1; and bachelor's degree or higher = 2.

Health Insurance

Health insurance status was evaluated by the question, "Do you currently have health insurance?" This item was dichotomized as yes = 1 and no = 0.

Relationship Status

Relationship status was gauged by the question, "What is your current relationship status?" Respondents could choose from the following categories: not partnered; partnered with someone of the same sex; partnered with someone of a different sex; married to a same-sex partner, including civil union and/or domestic partnership; married to a different sex partner, including civil union and/or domestic partnership; and other. This item was dichotomized as single = 1 and partnered = 0.

Income

Household income was assessed by the question, "Including all income sources, what do you estimate was your household income last year?" Respondents could choose from one of 12 categories. We took the log of income to reflect income's curvilinear association with health (Ecob & Davey Smith, 1999).

Age

Age was reported in years and treated as continuous. Respondents ranged in age from eighteen to ninety-one years old.

Analytic Approach

We first calculated descriptive statistics for each variable, stratified by respondents' racial identification (Table 12.1). We then calculated simple bivariate analyses between study measures, in which we conducted χ^2 tests for categorical variables and *t* tests for continuous variables comparing racial minority groups to Whites (Gee, Ryan, Laflamme, & Holt, 2006). Then, we fit two series of regression models. The first series of regression models assessed reporting of excellent SRH. Three models were included in each series of regressions: (1) all respondents; (2) only male respondents; and (3) only female respondents. Log Poisson regression models were conducted, which allowed us to produce prevalence ratios (PR) with corresponding 95% confidence intervals. In our case, there were more than 20 percent of respondents reporting both excellent and fair or poor SRH; thus, substantiating our decision to utilize PRs. STATA 13.0 was utilized for all analyses in which we employed STATA's GLM package (for the binomial family with unbiased standard error estimates) for all logistic regression models (StataCorp, 2013).

RESULTS

Table 12.1 displays characteristics of the study sample as well as results from bivariate analyses. For study measures, the distribution of respondents was roughly similar between racial groups. Bivariate analyses revealed SRH, income and age to be strongly significant among all racial minority groups ($P < 0.001$ respectively). Table 12.2 provides analyses exploring sociodemographic contributions to SRH among the Black subsample solely. Among sociodemographic characteristics, in Model 1 women were statistically less likely to rate their health as excellent (PR = 0.66, 95% CI [0.53, 0.83]); those with some college were statistically more likely to report excellent SRH

Table 12.1 Descriptive Statistics of Participants by Race: Social Justice Sexuality Project, 2010 (N = 4091)

	White (n = 914)		Black (n = 1445)		Latino/ Hispanic (n = 619)		Asian American/ Pacific Islander (n = 250)		Native American (n = 75)		Multiracial (n = 508)		Other (n = 280)		
	No. or Mean (SD)	No. or Mean (SD)	t Value or x ² Statistic	No. or Mean (SD)	t Value or x ² Statistic	No. or Mean (SD)	t Value or x ² Statistic	No. or Mean (SD)	t Value or x ² Statistic	No. or Mean (SD)	t Value or x ² Statistic	No. or Mean (SD)	t Value or x ² Statistic	No. or Mean (SD)	t Value or x ² Statistic
Self-Rated Health			x ² = 560.00***		x ² = 250.00***		x ² = 100.00***		x ² = 300.00***		x ² = 200.00***		x ² = 100.00***		
Excellent	130	302		132		55		21		113		56			
Very Good	368	510		228		82		24		166		92			
Good	304	450		207		82		21		180		97			
Fair/Poor	92	132		52		31		9		49		25			
Sex			x ² = 20.74***		x ² = 15.27***		x ² = 11.24*		x ² = 3.11		x ² = 13.65**		x ² = 8.74		
Male	448	766		324		127		41		231		139			
Female	446	628		295		123		34		277		141			
Educational Attainment			x ² = 21.77**		x ² = 16.41*		x ² = 13.69		x ² = 7.78		x ² = 13.12		x ² = 7.59		
>High School Diploma/GED	321	545		284		91		37		232		120			
Some college/Associates Degree	260	440		198		94		20		146		89			
<Bachelor's Degree	313	409		137		65		18		130		71			
Health Insurance			x ² = 4.51		x ² = 9.31		x ² = 3.10		x ² = 5.59		x ² = 10.09*		x ² = 7.96*		
Yes	714	1135		450		211		53		381		220			
No	180	259		169		39		22		127		60			
Relationship Status			x ² = 16.54**		x ² = 1.91		x ² = 7.85		x ² = 4.39		x ² = 2.29		x ² = 2.03		
Single	340	698		265		127		37		231		108			
Partnered	554	696		354		123		38		277		172			
Log Income, \$	1.94 (0.76)	1.94 (0.76)	t = 95.64***	1.76 (0.88)	t = 49.60***	1.84 (0.82)	t = 35.03***	1.87 (0.71)	t = 22.31***	1.82 (0.85)	t = 47.61***	1.92 (0.72)	t = 43.60***		
Age, y	38.48 (14.40)	38.19 (12.49)	t = 114.44***	33.20 (10.50)	t = 79.25***	30.74 (10.28)	t = 46.98***	37.79 (14.72)	t = 21.77***	33.18 (11.95)	t = 61.94***	34.80 (12.50)	t = 46.23***		

Note: Descriptive Statistics are for respondents answering the self-rated health question.

*P < 0.05; **P < 0.01; ***P < 0.001, significance tests between racial/ethnic groups comparing to Whites for each measure separately.

Table 12.2 Log Poisson Regression Models Predicting Excellent and Fair/Poor Self-Rated Health (Black subsample): Social Justice Sexuality Project, 2010

	(1) <i>Black Excellent Self-Rated Health</i>	(2) <i>Black Men Excellent Self-Rated Health</i>	(3) <i>Black Women Excellent Self-Rated Health</i>	(4) <i>Black Fair/Poor Self- Rated Health</i>	(5) <i>Black Women Fair/ Poor Self-Rated Health</i>	(6) <i>Black Men Fair/Poor Self-Rated Health</i>
Gender						
Male (ref)	—	—	—	—	—	—
Female	0.67*** (0.532–0.836)	—	—	1.24 (0.880–1.756)	—	—
Health Provider						
Yes (ref)	—	—	—	—	—	—
No	0.72 (0.522–1.003)	0.89 (0.609–1.309)	0.49* (0.272–0.884)	1.25 (0.734–2.128)	1.07 (0.510–2.242)	1.53 (0.731–3.208)
Educational Attainment						
< High School (ref)	—	—	—	—	—	—
Some College	1.34* (1.057–1.693)	1.50** (1.120–2.000)	1.12 (0.745–1.685)	0.66 (0.432–1.020)	0.49* (0.265–0.924)	0.88 (0.492–1.589)
College Graduate	1.09 (0.831–1.424)	1.28 (0.920–1.793)	0.84 (0.527–1.329)	0.92 (0.619–1.354)	0.90 (0.526–1.542)	0.94 (0.536–1.663)
Age (in years)	0.98*** (0.968–0.987)	0.97*** (0.961–0.984)	0.99 (0.972–1.002)	1.03*** (1.018–1.045)	1.03** (1.011–1.052)	1.03*** (1.016–1.052)
Health Insurance						
Yes (ref)	—	—	—	—	—	—
No	1.05 (0.774–1.418)	0.87 (0.593–1.284)	1.40 (0.885–2.213)	1.34 (0.811–2.204)	1.60 (0.823–3.093)	1.10 (0.531–2.286)
Relationship Status						
Partnered	—	—	—	—	—	—
Single	1.21 (0.974–1.499)	1.07 (0.829–1.383)	1.48* (1.032–2.113)	1.32 (0.933–1.853)	1.29 (0.801–2.086)	1.37 (0.828–2.252)
Current Smoking Status						
No (ref)	—	—	—	—	—	—
Yes	0.79 (0.605–1.038)	0.86 (0.626–1.176)	0.67 (0.412–1.087)	1.19 (0.810–1.749)	0.68 (0.373–1.240)	1.96** (1.192–3.219)
Constant	0.51** (0.341–0.763)	0.60* (0.371–0.971)	0.26*** (0.140–0.495)	0.02*** (0.011–0.042)	0.03*** (0.012–0.086)	0.01*** (0.006–0.037)
Observations	1,322	722	600	1,335	607	728

***p<0.001, **p<0.01, *p<0.05

(PR= 1.33, 95% CI [1.05, 1.69]) compared to their counterparts who had up to high school; and younger age was associated with a lower prevalence of reporting excellent SRH (PR= 0.97, 95% CI [0.96, 0.98]). In Model 2, there were two measures that were statistically significant: some college education and age. Model 3 revealed that not having a health provider and being single were the only significant measures for Black women's excellent SRH. Model 4 revealed that age was statistically significant in predicting fair/poor SRH among Black respondents. Model 5, assessing Black men's SRH, revealed that older respondents were at increased risk of identifying fair/poor SRH and current smokers were more likely to endorse fair/poor SRH. Model 6, assessing Black women's SRH, identified that having some college education decreased prevalence of identifying fair/poor SRH compared to their counterparts having only a high school diploma or less of educational attainment. Also older Black women had an increased prevalence of identifying fair/poor SRH than younger Black women.

When controlling for sociodemographic variables, we see that there are no significant racial differences in SRH between Black people and white Americans (Table 12.3) and Latina/o people (Table 12.4). However, there were significant differences in SRH between Black people and Asian Americans (Table 12.5). Specifically, Asian Americans had a higher prevalence of fair/poor SRH than Black Americans overall. Subgroup analyses revealed that significant differences in SRH varied by gender. Asian American men were more than 2 times more likely to report fair/poor SRH than Black men. There were no significant differences in SRH among Black and Asian American women.

DISCUSSION

Although multiple studies have examined differences in SRH with respect to sexual minority status in comparison to heterosexual individuals (Buchmueler & Carpenter, 2010; Heck, Sell, & Gorin, 2006; Liu, Reczek, & Brown, 2013; Ortiz-Hernández et al., 2009; Thomeer, 2013; Tjepkema, 2008), very few studies have explicitly examined the influence of race in predicting SRH among sexual minorities. This study is an effort to address this gap in the literature. Within group analyses among the Black subsample demonstrated that some sociodemographic characteristics are extremely salient when considering SRH. Particularly having at least some college education, age, and then specifically among Black women having a health provider and being single. Our findings indicate that Blacks do not have a higher prevalence of identifying fair/poor SRH and decreased prevalence of identifying excellent SRH for the most part. Interestingly analyses comparing Asian Americans to

Table 12.3 Log Poisson Regression Models Predicting Excellent and Fair/Poor Self-Rated Health (White/Black Analyses): Social Justice Sexuality Project, 2010

	(1) <i>All Excellent Self-Rated Health</i>	(2) <i>Men Excellent Self-Rated Health</i>	(3) <i>Women Excellent Self-Rated Health</i>	(1) <i>All Fair/Poor Self-Rated Health</i>	(2) <i>Men Fair/Poor Self-Rated Health</i>	(3) <i>Women Fair/Poor Self-Rated Health</i>
Race						
Black (ref)	—	—	—	—	—	—
White	1.04 (0.879–1.222)	0.99 (0.811–1.217)	1.11 (0.842–1.458)	1.04 (0.803–1.354)	0.97 (0.644–1.450)	1.11 (0.786–1.575)
Gender						
Male (ref)	—	—	—	—	—	—
Female	0.66*** (0.556–0.786)	—	—	1.30 (0.995–1.700)	—	—
Health Provider						
Yes (ref)	—	—	—	—	—	—
No	0.70** (0.540–0.904)	0.75 (0.542–1.024)	0.62* (0.403–0.953)	1.10 (0.731–1.658)	1.64 (0.886–3.031)	0.79 (0.464–1.349)
Educational Attainment						
< High School (ref)	—	—	—	—	—	—
Some College	1.38*** (1.143–1.659)	1.52*** (1.208–1.912)	1.15 (0.833–1.587)	0.58** (0.412–0.809)	0.69 (0.427–1.120)	0.51** (0.317–0.819)
College Graduate or above	1.26* (1.019–1.546)	1.39* (1.072–1.812)	1.10 (0.783–1.551)	0.87 (0.634–1.182)	0.84 (0.526–1.343)	0.90 (0.589–1.367)
Age (in years)	0.98*** (0.974–0.988)	0.97*** (0.961–0.980)	1.00 (0.985–1.008)	1.02*** (1.011–1.031)	1.03*** (1.018–1.045)	1.01 (0.999–1.028)
Health Insurance						
Yes (ref)	—	—	—	—	—	—
No	0.97 (0.761–1.225)	0.83 (0.612–1.123)	1.23 (0.848–1.799)	1.38 (0.944–2.020)	1.20 (0.665–2.153)	1.58 (0.980–2.549)
Relationship Status						
Partnered (ref)	—	—	—	—	—	—
Single	1.11 (0.940–1.306)	1.00 (0.826–1.222)	1.29 (0.981–1.692)	1.34* (1.027–1.755)	1.30 (0.871–1.954)	1.39 (0.975–1.995)
Current Smoking Status						
No (ref)	—	—	—	—	—	—
Yes	0.93 (0.776–1.125)	0.94 (0.748–1.176)	0.90 (0.658–1.233)	1.34* (1.014–1.763)	1.64* (1.086–2.467)	1.16 (0.799–1.689)

*** p<0.001, ** p<0.01, * p<0.05

Table 12.4 Log Poisson Regression Models Predicting Excellent and Fair/Poor Self-Rated Health (Asian/Black Analyses): Social Justice Sexuality Project, 2010

	(1) <i>Asian Excellent Self-Rated Health</i>	(2) <i>Asian Men Excellent Self-Rated Health</i>	(3) <i>Asian Women Excellent Self-Rated Health</i>	(1) <i>Asian Women Fair/ Poor Self-Rated Health</i>	(2) <i>Asian Fair/Poor Self-Rated Health</i>	(3) <i>Asian Men Fair/Poor Self-Rated Health</i>
Race						
Black (ref)	—	—	—	—	—	—
Asian	0.87 (0.661–1.140)	0.84 (0.594–1.179)	0.90 (0.574–1.420)	1.14 (0.620–2.083)	1.68** (1.153–2.433)	2.23** (1.376–3.621)
Gender						
Male (ref)	—	—	—	—	—	—
Female	0.66*** (0.536–0.812)	—	—	—	1.08 (0.794–1.461)	—
Health Provider						
Yes (ref)	—	—	—	—	—	—
No	0.69* (0.511–0.938)	0.84 (0.590–1.199)	0.47* (0.264–0.835)	1.43 (0.751–2.714)	1.50 (0.965–2.331)	1.54 (0.847–2.794)
Educational Attainment						
< High School (ref)	—	—	—	—	—	—
Some College	1.35** (1.088–1.685)	1.48** (1.127–1.939)	1.21 (0.828–1.762)	0.48* (0.267–0.850)	0.60** (0.409–0.884)	0.71 (0.415–1.205)
College Graduate	1.14 (0.888–1.471)	1.29 (0.939–1.760)	0.97 (0.631–1.485)	0.87 (0.533–1.432)	0.91 (0.641–1.299)	0.95 (0.578–1.569)
Age (in years)	0.98*** (0.971–0.988)	0.98*** (0.965–0.987)	0.99* (0.971–1.000)	1.03*** (1.009–1.047)	1.03*** (1.014–1.039)	1.03*** (1.010–1.043)
Health Insurance						
Yes (ref)	—	—	—	—	—	—
No	1.04 (0.785–1.390)	0.94 (0.661–1.346)	1.24 (0.786–1.961)	1.53 (0.816–2.888)	1.23 (0.784–1.927)	1.01 (0.537–1.886)
Relationship Status						
Partnered (ref)	—	—	—	—	—	—
Single	1.16 (0.955–1.417)	1.06 (0.837–1.345)	1.36 (0.977–1.884)	1.20 (0.769–1.858)	1.33 (0.983–1.799)	1.51 (0.970–2.344)
Current Smoking Status						
No (ref)	—	—	—	—	—	—
Yes	0.81 (0.633–1.037)	0.90 (0.670–1.201)	0.67 (0.433–1.041)	0.70 (0.407–1.201)	1.13 (0.802–1.587)	1.70* (1.092–2.631)
Constant	0.48*** (0.330–0.709)	0.52*** (0.329–0.838)	0.28*** (0.155–0.498)	0.04*** (0.015–0.088)	0.03*** (0.015–0.051)	0.02*** (0.009–0.047)
Observations	1,560	843	717	727	1,576	849

*** p<0.001, ** p<0.01, * p<0.05

Table 12.5 Log Poisson Regression Models Predicting Excellent and Fair/Poor Self-Rated Health (Latino/Black Analyses): Social Justice Sexuality Project, 2010

	(1) <i>Latino Excellent Self-Rated Health</i>	(2) <i>Latino Men Excellent Self-Rated Health</i>	(3) <i>Latina Women Excellent Self-Rated Health</i>	(1) <i>Latina Women Fair/ Poor Self-Rated Health</i>	(2) <i>Latino Fair/Poor Self-Rated Health</i>	(3) <i>Latino Men Fair/Poor Self-Rated Health</i>
Race						
Black (ref)	—	—	—	—	—	—
Latino	1.00 (0.829–1.214)	1.01 (0.805–1.272)	0.99 (0.707–1.381)	1.21 (0.793–1.833)	0.95 (0.690–1.295)	0.70 (0.438–1.128)
Gender						
Male	—	—	—	—	—	—
Female	0.64*** (0.531–0.777)	—	—	—	1.38* (1.033–1.838)	—
Health Provider						
Yes (ref)	—	—	—	—	—	—
No	0.73* (0.554–0.961)	0.81 (0.580–1.135)	0.61* (0.381–0.971)	0.86 (0.476–1.552)	1.23 (0.825–1.844)	1.74* (1.017–2.986)
Educational Attainment						
< High School (ref)	—	—	—	—	—	—
Some College	1.35** (1.103–1.655)	1.51** (1.175–1.934)	1.12 (0.788–1.581)	0.64 (0.399–1.013)	0.68* (0.479–0.958)	0.74 (0.442–1.236)
College Graduate	1.24 (0.990–1.554)	1.45** (1.103–1.918)	0.96 (0.652–1.424)	0.79 (0.495–1.268)	0.82 (0.585–1.163)	0.86 (0.518–1.421)
Age (in years)						
	0.98*** (0.976–0.992)	0.98*** (0.968–0.987)	0.99 (0.981–1.007)	1.02 (1.000–1.034)	1.02*** (1.011–1.036)	1.03*** (1.015–1.049)
Health Insurance						
Yes (ref)	—	—	—	—	—	—
No	1.00 (0.775–1.302)	0.87 (0.626–1.210)	1.26 (0.836–1.893)	1.64 (0.957–2.817)	1.39 (0.940–2.043)	1.21 (0.705–2.075)
Relationship Status						
Partnered	—	—	—	—	—	—
Single	1.14 (0.951–1.360)	0.96 (0.781–1.180)	1.53** (1.131–2.063)	1.28 (0.865–1.888)	1.35* (1.015–1.794)	1.52 (0.980–2.370)
Current Smoking Status						
No (ref)	—	—	—	—	—	—
Yes	0.82 (0.660–1.013)	0.82 (0.629–1.059)	0.79 (0.552–1.141)	0.62* (0.387–0.988)	1.14 (0.834–1.553)	2.10*** (1.389–3.183)
Constant						
	0.40*** (0.281–0.582)	0.52** (0.343–0.794)	0.18*** (0.102–0.331)	0.06*** (0.028–0.124)	0.03*** (0.016–0.050)	0.02*** (0.007–0.035)
Observations						
	1,913	1,030	883	892	1,932	1,040

*** p<0.001, ** p<0.01, * p<0.05

their Black counterparts, revealed that both Asian American men and women were more likely to report fair/poor SRH compared to their Black counterparts. This novel finding could be explained by many factors. For example, future research should assess immigration processes such as country of origin and variations in acculturation processes once in the United States; especially in terms of length of time in the United States. It is well documented that racial/ethnic immigrant populations experience American society differently than non-immigrant populations (e.g., varying experiences of interpersonal and institutional discrimination) and thus this could be extremely salient when comparing Asian Americans to their Black counterparts. Interestingly, sociodemographic characteristics in our regression models revealed patterns which mirrored those previously found in the literature, namely, age and educational attainment.

These results raise important directions for future research, including identifying mechanisms through which other societal influences may mediate the relationship between race and SRH which will provide greater insight into the heterogeneity among sexual minorities. As it has been identified that SRH is only partially explained by healthcare related factors (Lo et al., 2013), it is important to consider other social issues that may explain SRH more precisely than race alone. Recent research examining the important role by which stigma and discrimination can negatively impact the health of sexual minorities is one such direction (Doyle & Molix, 2015; Earnshaw, Rosenthal, & Lang, 2016; Gattis & Larson, 2016). Black sexual minorities may be at increased risk of psychological impairment and physical health by virtue of simultaneously occupying multiple marginalized social positions, such as facing discrimination within sexual minority communities and within their racial primary group membership. It has been postulated (Nieblas, Hughes, Andrews, & Relf, 2015) that this in turn, may result in internalized racism and homophobia, although this has not been assessed in terms of SRH among Black sexual minorities. It is also possible that there are underlying mechanisms at play, such as resiliency, which can help researchers, community members, and policy makers understand these counterintuitive findings.

A resilience perspective counteracts the narrative of Black sexual minorities being at increased risk for *double jeopardy* (the state of having multiple marginalized identities resulting in increased stress that manifests in riskier health behaviors; Herrick, Stall, Goldhammer, Egan, & Mayer, 2014). Some of this work has suggested that there might be other factors impacting one's appraisal of one's health in relation to other pressing issues (Herrick et al., 2014). It is also important to recognize that resiliency may manifest differently depending on contextual factors and while our study includes a large sample, our findings are not generalizable. The SJS Project did not ask many questions about sexual health and since Black sexual minorities are

disproportionately burdened with negative health outcomes relative to sexual health (e.g., HIV and other STIs), it could be surmised that if such questions were included along with SRH then the results might differ. Nonetheless, within the public health literature, resilience is a relatively nascent area of inquiry in sexual minority health (Herrick et al., 2014), and unfortunately the SJS Project did not collect information on resiliency constructs previously used within the literature.

Future research is needed not only in terms of resilience and SRH in general, but also to determine if there are specific elements of resilience among Black sexual minority communities that can inform the general population (e.g., non-sexual minority population). Moreover, in applying concepts of resilience it is extremely important to approach such discussions with appropriate cultural sensitivity and structural competency, so as to not perpetuate pathologizing ideas concerning racial minorities (e.g., racialized notions of survival of the fittest). For example, historically, scientists suggested that Blacks have extra bones which contributed to athletic prowess. Such negative racialized suggestions could be used if work seeking to integrate resilience are not applied with cultural specificity and structural competency. Future research should explore other influences such as nativity and length of time in the United States among Black sexual minorities to assess whether this impacts appraisal of health; these influences have been shown to be important among the general population (Huh, Prause, & Dooley, 2008). The acculturation processes of Black foreign-born sexual minorities may impact their appraisal of their health differentially than those born in the United States (Todorova et al., 2013). Additionally, research should assess how income and age moderate the relationship between SRH among racial sexual minorities in which not only merely stratifying by race is considered by the interaction between race and these factors. The findings demonstrated that there is variability within Black sexual minority populations. Furthermore, they highlight differences between Blacks and other racial groups in terms of SRH. Contextualizing among sexual minority populations can produce the knowledge necessary for developing specified targeted interventions aimed at decreasing disparities within Black sexual minority populations.

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