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## Medical Mistrust Among a Racially and Ethnically Diverse Sample of Sexual Minority Men

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### Abstract

**Purpose:** Medical mistrust is a barrier to health care utilization and is associated with suboptimal health outcomes. Research on mistrust among sexual minority men (SMM) is limited and largely focuses on Black SMM and HIV, with few studies assessing mistrust among SMM of other race/ethnicities. The purpose of this study was to examine differences in medical mistrust among SMM by race.

**Methods:** From February 2018 to February 2019, a mixed-methods study examined the health-related beliefs and experiences of young SMM in New York City. The Group-Based Medical Mistrust Scale (GBMMS) was used to measure medical mistrust related to race, and a modified version of the scale assessed mistrust related to one's "sexual/gender minority" status (Group-Based Medical Mistrust Scale–Sexual/Gender Minority [GBMMS-SGM]). With an analytic sample of 183 cisgender SMM, a one-way multivariate analysis of variance was used to examine differences in GBMMS and GBMMS-SGM scores by race/ethnicity [Black, Latinx, White, "Another Racial Group(s)"].

**Results:** There were significantly different GBMMS scores by race, with participants of color reporting higher levels of race-based medical mistrust than White participants. This finding is supported by effect sizes ranging from moderate to large. Differences in GBMMS-SGM scores by race were borderline; however, the effect size for Black and White participants' GBMMS-SGM scores was moderate, indicating that higher GBMMS-SGM scores among Black participants is meaningful.

**Conclusion:** Multilevel strategies should be used to earn the trust of minoritized populations, such as addressing both historical and ongoing discrimination, moving beyond implicit bias trainings, and strengthening the recruitment and retention of minoritized health care professionals.

**Keywords:** GBMMS, Group-Based Medical Mistrust Scale, medical mistrust, sexual minority men

### Introduction

**H**OMOPHOBIA, STIGMA, AND socioeconomic inequality<sup>1-3</sup> place sexual minority men (SMM; e.g., gay, queer, bisexual, and other men who have sex with men) at higher risk

for various physical and mental health conditions, such as substance use disorders,<sup>4</sup> HIV and other sexually transmitted infections (STIs),<sup>5-7</sup> depression, anxiety, and suicidal ideation.<sup>4,5,7</sup> These disparities are particularly pronounced for SMM of color, who experience homophobia, systemic

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racism, and their intersections.<sup>1,8–12</sup> In addition, factors such as medical mistrust, for example, when patients suspect medical providers and health care organizations of ill will,<sup>13–15</sup> may explain the underutilization of health care and poorer health outcomes among SMM.

Medical mistrust stems from historical and ongoing structural inequalities and trauma.<sup>16–19</sup> Medical mistrust is robustly associated with suboptimal health outcomes across a range of health conditions, including HIV,<sup>20</sup> diabetes, and cancer,<sup>21–29</sup> and has been linked to willingness to attend regular health screening,<sup>26,27,29–32</sup> underutilization of health services,<sup>32</sup> suboptimal treatment adherence,<sup>21,33,34</sup> and satisfaction with health care services and providers.<sup>23,35,36</sup>

Medical mistrust varies by race, with people of color reporting higher average levels of medical mistrust than White people<sup>23,35,37,38</sup> and increased likelihood of endorsing “conspiracy beliefs” regarding the origin of HIV (e.g., HIV was manufactured and intentionally released by the government to harm minoritized populations, the cure for HIV is being withheld from the public).<sup>39,40</sup> As mistrust research primarily focuses on Black men,<sup>1,31,41–44</sup> less is known about mistrust among sexual minority people generally. Of the limited literature on medical mistrust among SMM, most studies focus on Black SMM and HIV,<sup>1,31,41</sup> finding that medical mistrust is associated with worse HIV health outcomes,<sup>31,45</sup> lower HIV testing and treatment adherence,<sup>33,46–48</sup> and low rates of pre-exposure prophylaxis (PrEP) uptake.<sup>49,50</sup>

The limited literature suggests that medical mistrust among SMM is a concern, but there are two key gaps that need to be addressed to improve health outcomes among this population. First, more research is needed that assesses medical mistrust among SMM irrespective of a particular health status condition. The extant literature largely focuses on mistrust and HIV,<sup>33,46</sup> but health-related mistrust likely transcends specific diseases or illnesses and permeates other aspects of people’s lives (e.g., mistrust of social and government institutions such as health care systems, legal system and state agencies).<sup>51</sup> Second, more research examining differences in mistrust among SMM of various racial and ethnic groups is needed, as most studies have focused on Black SMM exclusively or in comparison to White SMM. Given that systemic racism affects non-Black communities of color,<sup>52</sup> it is necessary to examine mistrust as a potential phenomenon among a wide range of populations. As such, the purpose of this analysis was to examine how medical mistrust may vary by race among a diverse sample of SMM.

## Methods

The data analyzed in this study were collected as part of the Health-Related Beliefs Study, a cross-sectional substudy nested within the longitudinal P18 Cohort Study, which examined HIV, substance use, and mental health among young SMM in New York City who reported HIV-negative serostatus (information about the parent study can be found elsewhere<sup>53</sup>), with inclusion criteria requiring that all participants report having sex with men. The Health-Related Beliefs Study utilized a concurrent mixed-method design, which included a brief computer-based survey on sociodemographic information, experiences with health care providers and organizations, and beliefs, attitudes, and experiences around sexual health topics (e.g., HIV, STIs, and PrEP). Par-

ticipants were recruited from the P18 Cohort Study from February 2018 to February 2019 via phone, email, or during their biannual P18 study visit. All activities were approved by the New York University Institutional Review Board, and all participants provided written informed consent for this substudy.

## Measures

**Sociodemographics.** Race and ethnicity, gender, income, and health insurance status were assessed. Race and ethnicity were measured separately, with participants identifying race (“African American/Black,” “Asian or Pacific Islander,” “American Indian/Alaska Native,” “White,” “Hispanic/Latinx,” and/or “Other”) and ethnicity (“Hispanic” or “Non-Hispanic”). No respondents identified their primary race as being American Indian/Alaska Native. Due to small sample size, Asian/Pacific Islander and Multiracial were combined to create a single category, “Another racial group(s).” We combined these participants into a single group to avoid making potentially inappropriate conclusions about differences between them due to small and unbalanced sample sizes.<sup>54</sup> Sexual orientation (“straight,” “gay,” “bisexual,” “pansexual,” “queer,” “NA,” “refuse to answer”) was also assessed (participant eligibility required self-reporting having sex with men). Although all study participants were assigned male at birth, those who identified as trans women or nonbinary ( $n = 18$ ) were excluded. The final analytic sample comprised 184 cisgender men.

**Medical mistrust.** Respondents completed the original Group-Based Medical Mistrust Scale (GBMMS),<sup>29</sup> one of the most frequently used scales to assess medical mistrust,<sup>15</sup> which asks about mistrust based on one’s membership in a racial/ethnic minority group, as well as a modified version meant to examine medical mistrust based on membership in a sexual/gender minority group (Group-Based Medical Mistrust Scale–Sexual/Gender Minority [GBMMS-SGM]). The GBMMS has been validated among multiple racial and ethnic groups, including Black and Latinx populations.<sup>15</sup>

The GBMMS is a 12-item scale featuring a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) and a total summary score ranging from 12 to 60, with higher scores representing greater levels of medical mistrust.<sup>29</sup> Items assess mistrust of health care providers (e.g., “Healthcare providers sometimes hide information from my racial/ethnic group”), suspicion of health care providers and their actions (e.g., “People of my racial/ethnic group cannot trust healthcare providers”), and trustworthiness of health care providers (e.g., “Healthcare providers have the best interests of people of my racial/ethnic group in mind”). For this study, the phrase “doctors and health care workers” used in the original scale was replaced with “healthcare providers” for concision and inclusivity. Statements that relate trustworthiness (items 2, 8, 10, and 11) were reverse coded before analysis.

The GBMMS was modified, with “racial/ethnic group” changed to “sexual/gender minority group,” to create the GBMMS-SGM (e.g., “Healthcare providers have the best interests of people of my sexual/gender minority group in mind”), allowing for the examination of medical mistrust based on membership in a sexual/gender minority group.

*Analytic procedure*

Analyses were conducted using IBM SPSS Statistics, version 27. First, assumption testing was conducted to evaluate the data set for outliers, multivariate normality, homogeneity of variance–covariance matrices, and multicollinearity. A single multivariate outlier was found via the Mahalanobis distance ( $D^2=30.793$ , critical value = 13.82,  $p < 0.001$ ); the participant was removed before further analysis ( $N=183$ ). Although Shapiro–Wilk’s test indicated a statistically significant violation of the multivariate normality assumption ( $p < 0.001$ ), visual inspection of GBMMS and GBMMS-SGM Q–Q plots indicated that the scores were approximately normally distributed. Both Box’s Test of Equality of Covariance ( $p < 0.001$ ) and Levene’s test for homogeneity of variance were statistically significant for the GBMMS [ $F(3, 179)=5.106, p=0.002$ ] and GBMMS-SGM [ $F(3, 179)=3.360, p=0.020$ ], indicating that the homogeneity of variance–covariance assumption was violated.

A one-way multivariate analysis of variance (MANOVA) test was conducted to examine the differences across two group-based medical mistrust scales (GBMMS and GBMMS-SGM) by race [Black, Latinx, White, and “Another racial group(s)”], followed by *post hoc* one-way analysis of variance (ANOVA) tests. Due to unequal cell size and Box’s Test of Equality of Covariance being statistically significant ( $p < 0.001$ ), Pillai’s Trace was used to examine significance in the MANOVA, as it is more robust when violations of assumptions of normality occur. *Post hoc* analysis featured Scheffe’s test and Games–Howell’s *post hoc* analysis. Scheffe’s test was utilized due to nonequivalent groups featured in the data; similarly, the Games–Howell *post hoc* analysis used does not assume homogeneity of variances or equal sample size. Multicollinearity was found not to be an issue based on Pearson’s correlation ( $r=0.868$ ) and variance inflation factor (4.043).

**Results**

*Sociodemographic characteristics*

The mean age of the sample of 183 cisgender SMM was 26 years (standard deviation = 0.91), ranging from 24 to 28 years. Approximately 33% of the sample were Black ( $n=61, 33.3%$ ), with the number of White ( $n=49, 26.8%$ ) and Latinx participants ( $n=45, 24.6%$ ) being nearly equivalent. Approximately 15% of participants reported another racial category and were coded as “Another racial group(s)” (Table 1). Most participants had insurance of some kind ( $n=155, 84.7%$ ) and had an income of \$25,000 or more ( $n=94, 51.4%$ ).

*Scale reliability*

Cronbach’s alpha for the GBMMS ( $\alpha=0.905$ ) and GBMMS-SGM ( $\alpha=0.906$ ) was high, indicating relatively high internal reliability for both scales. Inter-total correlations for the GBMMS ranged from 0.350 to 0.817, and inter-total correlations for the GBMMS-SGM ranged from 0.390 to 0.815.

*Multivariate analysis of variance*

Multivariate analysis indicated that there was a statistically significant difference in scores by race that corre-

TABLE 1. DEMOGRAPHIC CHARACTERISTICS OF THE ANALYTIC SAMPLE ( $N=183$ )

<i>Characteristic</i>	<i>n</i>	<i>%</i>
Race		
African American/Black	61	33.3
White	49	26.8
Latinx	45	24.6
Another racial group(s)	28	15.3
Asian/Pacific Islander	17	60.7
Multiracial	11	39.3
Health insurance status and type		
Yes	155	84.7
Employers	60	32.8
Medicare/Medicaid	50	27.3
Parents	29	15.8
Other	16	8.7
No	24	13.1
Not sure	4	2.2
Income total		
<\$5,000	19	10.4
\$5,000–\$24,999	58	31.7
\$25,000 or more	94	51.4
Missing data	12	6.6

*%*, valid percent of sample.

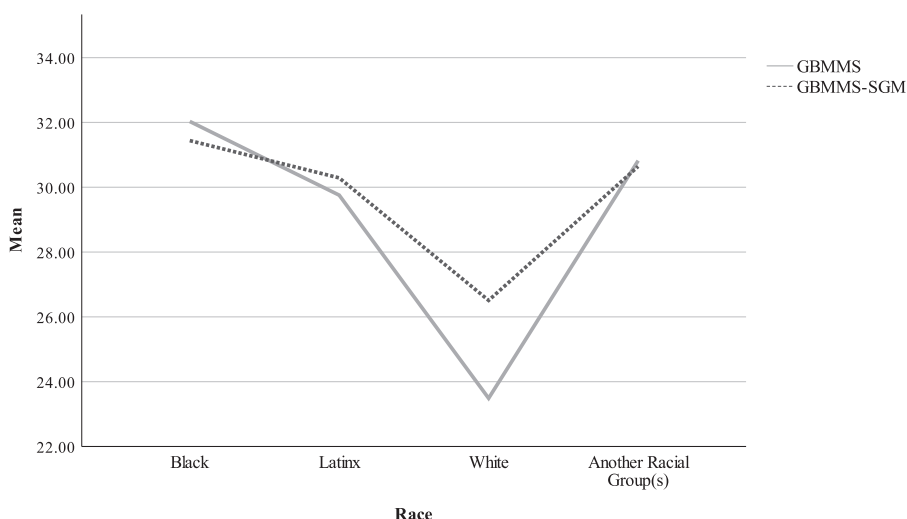
sponded to a small effect size:  $F(6, 358)=5.464, p < 0.001$ , Pillai’s Trace = 0.168, partial  $\eta^2=0.084$ . *Post hoc* one-way ANOVA indicated that GBMMS and GBMMS-SGM scores significantly varied by race (Fig. 1).

Racial/ethnic differences in GBMMS scores. The MANOVA indicated that there was a statistically significant difference in GBMMS scores by race [ $F(3, 179)=8.631, p < 0.001$ , partial  $\eta^2=0.126$ ], indicating that about 12.6% of the variance in GBMMS scores was predicted by participant race. Black participants had the highest GBMMS scores [mean ( $M$ ) = 32.033, standard error ( $SE$ ) = 1.171], whereas White participants had the lowest GBMMS scores ( $M=23.490, SE=1.307$ ) (Table 2).

A one-way ANOVA for the GBMMS by race indicated that White participants’ GBMMS scores were significantly lower than those of Black ( $p < 0.001$ ), “Another racial group(s)” ( $p=0.013$ ), and Latinx ( $p=0.011$ ) participants (Table 2). The Games–Howell analysis ( $\alpha=0.05$ ) indicated that White participants had significantly lower medical mistrust scores compared with Black ( $p < 0.001$ ), Latinx ( $p=0.009$ ), and “Another racial group(s)” participants ( $p=0.024$ ). Effect sizes (Cohen’s  $d$ ), calculated pairwise using GBMMS mean scores, were moderate ( $d \geq 0.500$ ) among Latinx and White participants ( $d=0.674$ ) and “Another racial group(s)” and White participants ( $d=0.736$ ), and large ( $d \geq 0.800$ ) among Black and White participants ( $d=1.090$ ).<sup>55</sup>

Racial/ethnic differences in GBMMS-SGM scores. Results of the MANOVA indicated that there were statistically significant differences in GBMMS-SGM scores between racial groups [ $F(3, 179)=2.692, p=0.048$ , partial  $\eta^2=0.043$ ]. However, the significance is best described as borderline, as it only slightly surpassed the threshold ( $\alpha=0.05$ ) and the effect size was small, with only 4.3% of

**FIG. 1.** GBMMS and GBMMS-SGM Mean Scores by Race. GBMMS, Group-Based Medical Mistrust Scale; GBMMS-SGM, Group-Based Medical Mistrust Scale–Sexual/Gender Minority; Another Racial Group(s) includes Asian/Pacific Islander and Multiracial.



the variance in GBMMS-SGM scores explained by participant’s race. Accordingly, pairwise comparisons between racial groups should be interpreted cautiously. Black participants had the highest GBMMS-SGM scores ( $M=31.443, SE=1.212$ ), with “Another racial groups(s)” ( $M=30.643, SE=1.790$ ) and Latinx participants ( $M=30.289, SE=1.412$ ) having slightly lower scores, and White participants having the lowest scores ( $M=26.510, SE=1.353$ ) (Table 3).

A one-way ANOVA for the GBMMS-SGM by race was conducted to allow for *post hoc* analysis. Scheffe’s analysis ( $\alpha=0.05$ ) for pairwise comparison and homogeneous subsets indicated that there was no statistically significant difference in GBMMS-SGM scores by race. However, the Games–Howell analysis ( $\alpha=0.05$ ) indicated that there were significant differences in scores between White and Black participants ( $p=0.021$ ), with Black participants having significantly higher scores than White participants. This result is congruent with pairwise effect sizes for GBMMS-SGM scores, which were small ( $0.200 \leq d \leq 0.499$ ) for all comparisons, except for the effect size among Black and White participants ( $d=0.570$ ), which was moderate.<sup>55</sup>

**Discussion**

The purpose of this study was to examine racial differences in two types of group-based medical mistrust among SMM, race-based medical mistrust, and medical mistrust based on participants’ sexual orientation. First, it is critical to point out that mistrust is not caused by an individual’s race and/or sexual orientation. Researchers and clinicians often use sociodemographic identifiers and pseudobiological categories as shorthand for complicated social phenomena, namely “race”/systemic racism.<sup>56,57</sup> In this sense, the “risk factors” are not race or sexual orientation, but rather systemic racism and white supremacy, and pervasive homophobia.<sup>51,58</sup>

Although research on medical mistrust among Black populations is relatively extensive, few studies have utilized the GBMMS to examine these differences by race,<sup>24,59</sup> as most studies utilizing the GBMMS focus on relationships between medical mistrust and health within a single racial/ethnic group.<sup>27,34,36,60</sup> Furthermore, the majority of studies that examined differences in medical mistrust across racial groups have focused on Black and White participants,<sup>24,26,61</sup> with few studies examining differences in medical mistrust across

**TABLE 2.** DIFFERENCE IN GROUP-BASED MEDICAL MISTRUST SCALE MEAN SCORES BY RACE

Race	Mean score	Mean differences in GBMMS scores			
		Black	Latinx	Another racial group(s)	White
Black	32.033	—	2.277	1.211	8.543**
Latinx	29.756	—	—	−1.066	6.266*
Another racial group(s)	30.821	—	—	—	7.322*
White	23.490	—	—	—	—
F ratio	8.631**				
df	3				

\* $p < 0.05$ ; \*\* $p < 0.01$ .

df, degrees of freedom; GBMMS, Group-Based Medical Mistrust Scale; Another racial group(s) includes Asian/Pacific Islander and Multiracial.

**TABLE 3.** DIFFERENCE IN GROUP-BASED MEDICAL MISTRUST SCALE–SEXUAL/GENDER MINORITY GROUP MEAN SCORES BY RACE

Race	Mean score	Mean differences in GBMMS-SGM scores			
		Black	Latinx	Another racial group(s)	White
Black	31.443	—	1.154	0.800	4.932*
Latinx	30.289	—	—	−0.354	3.779
Another racial group(s)	30.643	—	—	—	4.133
White	26.510	—	—	—	—
F ratio	2.692*				
df	3				

\* $p < 0.05$ .

GBMMS-SGM, Group-Based Medical Mistrust Scale–Sexual/Gender Minority.

three<sup>21,37</sup> or more racial groups. This study provides a novel approach to examining differences in medical mistrust across race among SMM and is one of the first studies to examine medical mistrust attributed to sexual/gender minority status.

Overall, participants of color reported higher levels of race-based medical mistrust than White participants, with moderate-to-large effect sizes indicating that the differences in GBMMS scores between participants of color and White participants may be meaningful. This key finding is supported by Bazargan et al.,<sup>37</sup> who found a significant difference in Black and Hispanic/Latinx medical mistrust scores compared with White participants. The lack of significant difference in GBMMS scores among participants of color (Black, Latinx, and “Another racial group(s)”) in our study may indicate that levels of medical mistrust are similar across these groups. The lack of difference in GBMMS-SGM scores between participants of color warrants further investigation as well; specifically, the examination and comparison of antecedents of medical mistrust among and across different racial/ethnic groups.

The study presented here is one of the few studies to examine medical mistrust attributed to sexual orientation,<sup>31,62,63</sup> and potentially the first to examine how sexual orientation-based medical mistrust may vary by race. We found that medical mistrust related to sexual minority status averaged around the midpoint of the GBMMS-SGM score range, with people of color reporting higher levels of medical mistrust based on their sexual minority status than White participants. Although overall statistical significance was borderline and should be interpreted cautiously, pairwise analysis indicated that there was a statistically significant difference in GBMMS-SGM scores between Black and White participants.

In addition, the effect size for Black and White participants’ GBMMS-SGM was moderate, indicating that there was a substantive significant difference in GBMMS-SGM scores between Black and White participants and that the difference is likely meaningful. Furthermore, this borderline *p* value may be attributed to the small sample size; future studies with larger samples sizes that use the GBMMS-SGM should examine differences by race if possible.

There was no other significant difference in GBMMS-SGM scores between racial groups; in addition, the corresponding effect sizes were small, indicating that there may be no meaningful differences in GBMMS-SGM scores between these groups. Future studies with a larger sample size and/or more homogeneous group sizes should examine potential differences in medical mistrust attributed to sexual orientation by race.

Furthermore, the moderate effect size indicates that the difference in the GBMMS-SGM between Black and White participants may be meaningful and warrants additional investigation. These racial differences in medical mistrust related to sexual minority group may be attributed to the intersectional nature of structural racism and homophobia, which has been found to be a barrier to health care utilization among Black SMM.<sup>1,12,58,64,65</sup> Intersectional stigma, defined as the coexistence of multiple stigmatized identities, can occur across multiple levels (e.g., interpersonal, structural).<sup>65–67</sup> For example, intersectional stigma experienced by Black SMM influences their health care behaviors and utilization and contributes to medical mistrust;<sup>12,65</sup> specifically, experienced or anticipated racism and/or homophobia has been linked to lower engagement in health care.<sup>12</sup>

The lack of strong statistically significant differences in GBMMS-SGM scores by race does not diminish the importance of this finding. Rather, this finding indicates that across racial and ethnic subgroups, SMM experience medical mistrust related to their sexual orientation. This is supported by Fisher et al.,<sup>62</sup> who found that adolescent SMM endorsed statements pertaining to medical mistrust attributed to being an adolescent SMM or as identifying as LGBTQ. Both Fisher et al.’s<sup>62</sup> findings and ours demonstrate the need to examine medical mistrust among SMM.

### Limitations

This study has some important limitations to note. First, the generalizability of this study is limited due to the non-probability sample. In addition, regional differences and specific factors unique to New York City, such as the availability of LGBTQ-specific resources and accessible public transit options, may impact participants’ experiences with the health care system and with health care providers. For example, although homophobia and systemic racism certainly exist in New York City, SMM in less diverse and more rural locations likely experience heightened stigma and discrimination.<sup>68,69</sup> These differences, which may influence medical mistrust, may not be representative of experiences of other SMM in other parts of the United States, thereby limiting the generalization of the findings.

Another limitation is the nonequivalent groups, as this study featured unequal groups and unequal variance, which can affect statistical power and type 1 errors. To control for this, the racial and ethnic groups with the smallest cell sizes (i.e., Asian/Pacific Islander and Multiracial participants) were collapsed to form “Another racial group(s).” Although this method is standard practice, it limits the generalizability of this study’s findings for any population included in the collapsed group. The Games–Howell test for *post hoc* analysis was also used to control for nonequivalent groups and decrease the likelihood of type 1 errors, as it considers unequal group sizes during the analysis. Future studies should endeavor to include larger samples that are approximately equal for all racial and ethnic groups.

Finally, the modified GBMMS-SGM featured the language “sexual/gender minority group,” thereby creating doubled-barreled items. Although we attempted to control for this by excluding participants who identified as trans women or nonbinary, future studies should assess medical mistrust attributed to sexual orientation or gender minority group separately in the scale items.

### Implications for public health practice and future research

Public health and medicine should consider multilevel strategies to earn the trust of minoritized populations. Although provider and staff implicit bias<sup>70–72</sup> undoubtedly negatively impacts health care communication, recommendations, and services provided,<sup>70,73,74</sup> recent scholarship indicates that implicit bias trainings are largely inadequate in effecting change and fostering diversity.<sup>75</sup> Thus, while actions should be taken to reduce stigma and discrimination at an individual level (e.g., provider trainings<sup>76–78</sup>), it is critical to emphasize the role of structural inequities in driving mistrust. Rather than interventions and programming asking

patients to trust, the onus should be on institutions to earn trust and become trustworthy.<sup>17</sup> There are myriad strategies to begin the process of earning trust, including, but not limited to, meaningfully acknowledging both historical and present-day exclusion and discrimination,<sup>79</sup> strengthening the recruitment and retention of minoritized health care professionals,<sup>80</sup> and adopting strengths-based models that move beyond the problematic poles of deficit and resilience.<sup>81,82</sup>

The findings presented here suggest that a more nuanced and intersectional understanding of medical mistrust is long overdue.<sup>18</sup> Current research predominantly examines medical mistrust in relation to a single group membership (e.g., race) and largely does not consider how minoritized people may experience intersectional oppression and marginalization.<sup>65,66,83</sup> Thus, future research should endeavor to elicit a multidimensional and intersectional understanding of mistrust among a wide range of populations. Although there has been an increase in research examining medical mistrust among two racial and ethnic groups, little research has been conducted on the differences in medical mistrust among three or more racial and ethnic groups,<sup>21,37</sup> sexual orientation differences, regional differences in medical mistrust,<sup>58</sup> potential differences in medical mistrust due to age or generation,<sup>84</sup> or in relation to socioeconomic status.

Fisher et al.'s<sup>62</sup> use of items from Thompson et al.'s<sup>29</sup> GBMMS support this study's argument that modified versions of the GBMMS can be used with other populations. For example, the GBMMS could be modified to examine group-based medical mistrust among other groups who may experience high levels of medical mistrust, such as sex workers,<sup>85</sup> undocumented immigrants,<sup>86</sup> people who use drugs, and currently or formerly incarcerated individuals.<sup>87,88</sup> Although initial research indicates that medical mistrust impacts health behaviors for these populations, these populations' health experiences remain underexamined.

Finally, the extant literature on SMM's health robustly reveals the negative impacts of stigma and discrimination on health and well-being,<sup>1,89</sup> which has been shown to drive mistrust among various minoritized groups.<sup>31,90</sup> Thus, future research should examine medical mistrust, as well as the factors and drivers associated with mistrust among this population and other minoritized populations, to understand its impact on health behavior and health outcomes. Qualitative research in particular is well suited to explore and elucidate not only the impact of intersectional and multifaceted mistrust on people's lives but also the underlying drivers that shape mistrust as well (e.g., experiences with the correctional system). These more nuanced insights are essential to effect meaningful policy and institutional changes.

## Conclusion

Although medical mistrust has been studied relatively extensively among Black populations, less is known about how other minoritized populations experience mistrust. This study suggests that medical mistrust varies by race but is also prominent among young SMM as a population. To address the many health inequities facing SMM, there is a need for institutional changes to earn patients' trust, and for research examining the multidimensional and intersectional nature of medical mistrust among myriad communities and subpopulations.

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## Authors' Contributions

A.B.C.: Conceptualization, data analysis, writing. J.J.: PI of the substudy from which the data used originate, contributed to writing, review, and editing of the article. C.L. and M.G.: Contributed to writing, review, and editing of the article. T.W.: Conceptualization, review and editing of the article. S.W.: Contributed to the analysis, review and editing of the article. P.N.H.: PI of the parent study (P18 Cohort Study), contributed to review and editing of the article.

## Disclaimer

The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Mental Health or the National Institute on Drug Abuse.

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