Stigma and Health-Related Quality of Life in Sexual Minorities

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Introduction: Stigma against sexual minorities is well documented, but its long-term consequences for health-related quality of life (HRQL) are unknown. This study examined stigma-related predictors of sexual orientation disparities in HRQL and their contribution to young adult HRQL disparities.

Methods: In 2013, participants (N=7,304, aged 18–31 years) reported sexual orientation (completely heterosexual [CH], mostly heterosexual, bisexual, and lesbian/gay). The EQ5D-5L, preference weighted for the U.S. population, was used to assess HRQL (range, –0.109 [worse than dead] to 1 [full health]). In prior waves conducted during adolescence, participants reported past-year bullying victimization (range, 1 [never] to 5 [several times/week]) and subjective social status (SSS) in their school (range, 1 [top] to 10 [bottom]). Analyses conducted in 2016 used longitudinal, multivariable linear and logistic regression to assess the contribution of bullying victimization and SSS in adolescence to sexual orientation disparities in HRQL in young adulthood, controlling for confounders and stratified by gender.

Results: Compared with CHs, both female and male sexual minorities reported more bullying victimization and lower SSS in adolescence and lower HRQL in young adulthood (HRQL score among women: mostly heterosexual, 0.878; bisexual, 0.839; lesbian, 0.848; CH, 0.913; HRQL score among men: mostly heterosexual, 0.877; bisexual, 0.882; gay, 0.890; CH, 0.925; all p-values < 0.05). When bullying and SSS were added into multivariable models, orientation group effect estimates were attenuated substantially, suggesting bullying and lower SSS in adolescence partly explained HRQL disparities in young adulthood.

Conclusions: Stigma-related experiences in adolescence may have lasting adverse effects on sexual minority health in adulthood.


INTRODUCTION

Health-related quality of life (HRQL) is an important global measure of health status, allowing for monitoring of population trends over time and comparisons across subpopulations to identify disparities.1 In addition, HRQL measures provide important information needed for cost-effectiveness evaluation of programs and policies designed to improve population health or redress disparities.2 Sexual orientation–related disparities are increasingly recognized as a priority public health concern,3 yet only a handful of...
studies have examined sexual orientation differences in quality of life and fewer still in HRQL specifically.

In the Nurses’ Health Study 2 (NHS2), a national cohort of U.S. women, lesbian and bisexual compared with heterosexual women aged 31–49 years scored lower on the SF-36 measure of HRQL. In the representative California Quality of Life Survey of adults aged 18–72 years, bisexual women and heterosexual men with same-sex sexual experience, compared with same-gender heterosexuals with no same-sex experience, scored lower on the SF-12 measure of HRQL, though no significant differences in HRQL were found for other sexual minority subgroups. Two studies of young adult university students, one conducted in Nigeria using the WHO QOL-BREF and another conducted in Cuba, Norway, India, and South Africa using other quality of life measures found that both female and male sexual minorities scored lower on quality of life than same-gender heterosexuals.

A number of social-contextual factors have been found to influence HRQL, including absolute and relative poverty, social stratification, social exclusion, and more. In marginalized populations, such as sexual minorities, stigma-related social-contextual experiences, including bullying victimization and low subjective social status, may also be important influences on HRQL. In the general population, bullying victimization in childhood has been negatively associated longitudinally with quality of life. For instance, Takizawa and colleagues found that both female and male sexual minorities scored lower on quality of life than same-gender heterosexuals.

Sexual orientation identity was assessed in 2013 (when aged 18–31 years) with the item Which one of the following best describes your feelings? Response categories were: completely heterosexual, mostly heterosexual, bisexual, mostly homosexual, completely homosexual/gay/lesbian, and not sure. For analysis, mostly and completely homosexual/gay/lesbian were combined into a “gay/lesbian” category, and individuals identifying as unsure were excluded.

In 2013, HRQL was assessed using the validated and generic EQ5D-5L measure of current health status. EQ5D-5L consists of five dimensions (mobility, self-care, usual activities, pain or discomfort, and anxiety/depression). For each dimension, participants endorse one of five levels of functioning (no problems, slight problems, moderate problems, severe problems, and unable to/extreme problems). As EQ5D-5L value sets are not yet available for the U.S., the present study relied on a crosswalk value set, which maps EQ5D-5L responses to EQ-5D-3L.

All five dimensions in EQ5D-3L are then used to create a summary score, which is preference weighted for U.S. populations using a valuation set derived from a probability sample of U.S. adults. This allows for the calculation of health utility scores calibrated to reflect the degree to which different health statuses are valued by the U.S. population overall. Health utility scores for the U.S. population range from health states worse than dead (~0.109), as characterized by a sample of U.S. adults, to full health (1).

METHODS

Study Population
Participants were from the U.S. Growing Up Today Study (GUTS), a prospective cohort study of children of women in NHS2. The cohort was initiated in 1996 with 16,882 girls and boys aged 9–14 years (GUTS1) and expanded in 2004 with the addition of 10,923 children, aged 9–15 years, of NHS2 nurses (GUTS2). Questionnaires have been sent to all participants annually or biennially. The sample is predominantly white (93%) and has a restricted socioeconomic range as all participants’ mothers have 4-year nursing degrees. In 2013, the year in which the outcomes for the present study were collected, GUTS participants were aged 18–31 years. The study protocol was approved by the IRB of the Brigham and Women’s Hospital.

Measures

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