



Structural stigma and all-cause mortality in sexual minority populations



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ABSTRACT

Stigma operates at multiple levels, including intrapersonal appraisals (e.g., self-stigma), interpersonal events (e.g., hate crimes), and structural conditions (e.g., community norms, institutional policies). Although prior research has indicated that intrapersonal and interpersonal forms of stigma negatively affect the health of the stigmatized, few studies have addressed the health consequences of exposure to structural forms of stigma. To address this gap, we investigated whether structural stigma—operationalized as living in communities with high levels of anti-gay prejudice—increases risk of premature mortality for sexual minorities. We constructed a measure capturing the average level of anti-gay prejudice at the community level, using data from the General Social Survey, which was then prospectively linked to all-cause mortality data via the National Death Index. Sexual minorities living in communities with high levels of anti-gay prejudice experienced a higher hazard of mortality than those living in low-prejudice communities (Hazard Ratio [HR] = 3.03, 95% Confidence Interval [CI] = 1.50, 6.13), controlling for individual and community-level covariates. This result translates into a shorter life expectancy of approximately 12 years (95% C.I.: 4–20 years) for sexual minorities living in high-prejudice communities. Analysis of specific causes of death revealed that suicide, homicide/violence, and cardiovascular diseases were substantially elevated among sexual minorities in high-prejudice communities. Strikingly, there was an 18-year difference in average age of completed suicide between sexual minorities in the high-prejudice (age 37.5) and low-prejudice (age 55.7) communities. These results highlight the importance of examining structural forms of stigma and prejudice as social determinants of health and longevity among minority populations.

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Introduction

Stigma increases risk for deleterious mental and physical health outcomes across multiple groups, including racial/ethnic minorities (Paradies, 2006; Williams, 1999), sexual minorities (i.e., individuals who identify as lesbian, gay, or bisexual) (Meyer, 1995), individuals who are overweight/obese (Muennig, 2008), and those with mental illness (Link & Phelan, 2006). Stigma serves as a chronic source of psychological stress (Clark, Anderson, Clark, & Williams, 1999; Link

& Phelan, 2006; Major & O'Brien, 2005; Meyer, 2003a; Pachankis, 2007), which in turn contributes to the development of psychopathology (Brown, 1993; Dohrenwend, 2000) and disrupts physiological pathways that increase vulnerability to disease (Cherkas et al., 2006; Epel et al., 2004; McEwen, 1998).

As substantive evidence emerges that stigma represents an important social determinant of health (Hatzenbuehler, Phelan, & Link, 2013), researchers have begun to focus on the appropriate measurement and conceptualization of stigma and related constructs (Clark et al., 1999; Krieger et al., 2010; Lauderdale, 2006; Meyer, 2003b; Quinn & Chaudoir, 2009; Williams, Neighbors, & Jackson, 2008). It is widely recognized that stigma operates at multiple levels, including individual (e.g., self-stigma; Mittal,

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Sullivan, Chekuri, Allee, & Corrigan, 2012), interpersonal (e.g., hate crimes; Herek, 2009), and structural, which refers to societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatized populations (Corrigan et al., 2005; Link & Phelan, 2001). Although researchers have long theorized that structural stigma may exert deleterious consequences for health, there has been scant empirical attention paid to this topic. Indeed, a comprehensive review article identified only two studies on structural forms of (mental illness) stigma, leading the authors to conclude that “the under-representation of this aspect is a dramatic shortcoming in the literature on stigma, as the processes involved are likely major contributors to unequal outcomes” (Link, Yang, Phelan, & Collins, 2004, p. 515–516).

One reason for this dearth of research is the paucity of available measures of structural stigma. In the absence of such measures, researchers have relied on assessing structural sources of stigma at the individual level of analysis. One problem with individual-level measures, however, is that they cannot capture certain forms or dimensions of stigma, particularly those that exist at the structural level (Meyer, 2003b). An additional barrier to research on the health consequences of structural stigma is methodological. Given the pervasiveness of structural stigma, there is often little or no variation to study, which restricts the kinds of research questions that are possible to pursue. For example, research on structural racism and health has had to focus almost exclusively on racial residential segregation (Williams & Collins, 2001) because neighborhoods offer one of the few areas of analysis with adequate variation in structural discrimination.

In an effort to advance the literature on structural stigma and health, the current study developed a measure of structural stigma with adequate geographic variation and then linked this measure to individual health outcomes. We focused our inquiry on sexual minorities, a stigmatized group that currently and historically has confronted multiple forms of structural stigma. Since the social movements of the 1960s, homosexuality has gained gradual acceptance in mainstream society, as reflected through changes in the public’s perception of gays and lesbians as well as in recent policies extending protections to this group. This acceptance, however, has been far from uniform; consequently, there is substantial spatial and temporal variation in environments that are supportive of gays and lesbians. Recent studies conducted by Hatzenbuehler, Keyes, and Hasin (2009); Hatzenbuehler, McLaughlin, Keyes, and Hasin (2010); and Hatzenbuehler (2011) have indicated that sexual minorities who live in areas with greater structural stigma (e.g., states that initiated constitutional amendments banning same-sex marriage) have higher rates of psychiatric disorders and are more likely to attempt suicide than sexual minorities living in low structural stigma areas.

Although these studies have documented some of the negative mental health consequences of exposure to structural stigma, no research to date has examined whether variations in structural stigma influence other health outcomes among sexual minorities, including premature death. Answering this research question not only requires information on structural stigma over time, but also the ability to assess the mortality of sexual minorities who have been differentially exposed to environments characterized by high versus low levels of structural stigma. Such data is extremely difficult to procure and, until this point, has not existed. However, an innovative new dataset—the General Social Survey/National Death Index study—permits a novel test of the impact of structural stigma (operationalized as area-level anti-gay attitudes) on sexual minority mortality. Since 1972, the General Social Survey (GSS) has been the primary source of social indicator data for the social sciences. It contains questions surrounding a wide array of social

attitudes—including anti-gay prejudice—as well as measures of sexual orientation. Moreover, Muennig, Johnson, Kim, Smith, and Rosen (2011) recently linked the GSS to mortality data from the National Death Index (NDI) so that information on mortality is now available for participants across multiple waves of the GSS. Our study is the first to leverage the strength of the linked GSS-NDI data to assess whether structural stigma increases the risk of mortality among sexual minorities residing in areas of high stigma.

Methods

Data sources

The GSS is a representative sample of the U.S. non-institutionalized English-speaking population aged 18 and over. Originally an annual survey, the GSS became a biennial survey beginning in 1994. Response rates range from 70 to 82%; further information on the response rate and characteristics of non-response can be obtained from the National Opinion Research Center (NORC), which conducts the GSS. The sampling design has varied over the years, but the majority of years employed full probability sampling.

The General Social Survey/National Death Index (GSS-NDI) is a new, innovative prospective cohort dataset in which participants from 18 waves of the GSS are linked to mortality data by cause of death, which was obtained from the NDI. To link the two datasets, GSS provided identifiable information on the respondents. The linkage methodology that was employed has been well validated in other national surveys, including the National Health Interview Survey and the National Health and Nutrition Examination Survey (National Center for Health Statistics, 2009).

The GSS-NDI covers GSS survey years 1978–2002 linked to NDI data through 2008. The truncated years for this study (1988–2002) were selected given our focus on sexual minority populations, which were not available in the GSS survey until 1988, when questions related to the number and gender(s) of sexual partners were first included. More details on the GSS/NDI study, including the linkage methodology, can be obtained elsewhere (Muennig et al., 2011).

Sample and measures

Sexual minority status

Classification of sexual minority status was based on a behavioral measure of sexual orientation. Since 1988, respondents were asked whether their sexual partners were exclusively male, exclusively female, or both male and female. Gender of sexual partners was assessed over the past 12 months and the past 5 years. Some years also included questions asking the number of sexual partners the respondent had of each gender since age 18. If subjects had any sexual partners of the same sex in the past 12 months, the past 5 years, or since age 18, they were categorized as sexual minorities. We included all three time frames in case there were incongruent responses (e.g., someone who indicated a same-sex relationship in the past year, but not the past five years, which is logically impossible), to capture individuals with past but not current same-sex relationships, and to include respondents from years in which all three questions were not asked simultaneously. Of the 21,045 respondents assessed between 1988 and 2002, 914 (4.34%) engaged in same-sex relationships. These rates of same-sex sexual behaviors are comparable to those observed in other nationally representative surveys (Gilman et al., 2001).

Independent variable: structural stigma

Construction of the measure. In order to capture prejudicial social attitudes against sexual minorities, and to focus on community-level variations in these attitudes, we constructed a

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