Stigma and Health-Related Quality of Life in Sexual Minorities

S. Bryn Austin, ScD,1,2,3,4 Allegra R. Gordon, ScD, MPH,1 Najat J. Ziyadeh, MPH,1 Brittany M. Charlton, ScD,1,4 Sabra L. Katz-Wise, PhD,1,3,4 Mihail Samnaliev, PhD1,4

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.

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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 in the prospective British National Child Development Study that bullying victimization in childhood was associated with reduced quality of life at age 50 years and the more frequent the bullying had been, the larger the decrements in quality of life. In a study of sexual orientation–related bullying, Patrick et al. found in cross-sectional analyses that roughly 13% of U.S. youth in Grades 8–12 reported being bullied because of their perceived sexual orientation, and these youth had substantially reduced quality of life compared with non-bullied youth. Subjective social status, defined as internalized perceptions of one’s social ranking relative to peers or others in society, has also been found to be a predictor of HRQL in adults and adolescents.

In prior research, gender has been found to modify sexual orientation–related associations with psychological indicators, such as anxiety and conduct problems, illicit drug use, eating disorder symptoms, and obesity. With regard to quality of life, Patrick and colleagues found evidence of effect modification by gender, where the reduction in quality of life for girls who were bullied for their perceived sexual orientation was of larger magnitude than seen in boys bullied for their perceived sexual orientation.

Despite the growing literature on sexual-orientation health disparities, little is known about long-term effects of stigma-related social-contextual experiences in adolescence on sexual minority HRQL. Furthermore, it is not known whether gender may moderate sexual orientation–related differences in HRQL. Given these gaps in the literature, the aims of this study were to (1) examine sexual orientation disparities in HRQL in young adulthood; (2) evaluate the contribution of stigma-related social-contextual experiences in adolescence to sexual orientation disparities in HRQL in young adulthood; and (3) assess gender moderation of associations between sexual orientation and HRQL.

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

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).
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