

Anxiety and Depression Among Sexual Minority Women and Men in Sweden: Is the Risk Equally Spread Within the Sexual Minority Population?

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ABSTRACT

Introduction: Sexual minority individuals have a higher risk of anxiety and depression compared with heterosexuals. However, whether the higher risk is spread equally across the sexual minority population is not clear.

Aim: To investigate the association between sexual orientation and self-reported current anxiety and a history of diagnosis of depression, paying particular attention to possible subgroup differences in risks within the sexual minority population, stratified by sex and to examine participants' history of medical care for anxiety disorders and depression.

Methods: We conducted a population-based study of 874 lesbians and gays, 841 bisexuals, and 67,980 heterosexuals recruited in 2010 in Stockholm County. Data were obtained from self-administered surveys that were linked to nationwide registers.

Main Outcome Measures: By using logistic regression, we compared risks of current anxiety, histories of diagnosed depression, and register-based medical care for anxiety and/or depression in lesbian and gay, bisexual, and heterosexual individuals.

Results: Bisexual women and gay men were more likely to report anxiety compared with their heterosexual peers. Bisexual individuals and gay men also were more likely to report a past diagnosis of depression. All sexual minority groups had an increased risk of having used medical care for anxiety and depression compared with heterosexuals, with bisexual women having the highest risk.

Conclusion: Bisexual women appear to be a particularly vulnerable sexual minority group. Advocating for non-discrimination and protections for lesbian, gay, and bisexual people is a logical extension of the effort to lower the prevalence of mental illness. **Björkenstam C, Björkenstam E, Andersson G, et al. Anxiety and Depression Among Sexual Minority Women and Men in Sweden: Is the Risk Equally Spread Within the Sexual Minority Population? J Sex Med 2017;XX:XXX–XXX.**

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Key Words: Bisexual; Lesbian, Gay, and Bisexual; Anxiety; Depression

INTRODUCTION

Accumulating evidence shows that sexual minorities, including lesbian, gay, and bisexual (LGB) individuals, have higher rates of psychiatric disorders, such as depression and

anxiety, and suicidal behavior compared with their heterosexual peers.^{1–7} However, the literature to date has rarely made a distinction among LGB identities; hence, less is known about disparities in psychiatric problems in the LGB population.^{8–11}

However, a couple of studies have found higher levels of suicide in bisexual women compared with lesbians.^{8,11} We recently found that recurrent medical care for intentional self-harm was markedly high in bisexual women and gay men, but not in lesbian women, compared with heterosexuals.¹² A British study found that bisexual women were 37% more likely to have a history of intentional self-harm in the past year compared with lesbians.¹³ An American study that examined associations among three dimensions of sexual orientation, including identity, attraction, and behavior, and lifetime mood and anxiety disorders found LGB identity to be associated with higher odds of mood or anxiety disorder, regardless of sex.⁹ However, sexual minority men showed higher rates of mood and anxiety disorders than

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sexual minority women and bisexual behavior conferred the highest odds of any mood or anxiety disorder for men and women.

The increased risk for mental health disorders among sexual minorities might be explained in part by a common genetic or environmental liability for minority sexual orientation and psychiatric morbidity.³ For psychosocial mechanisms that might explain the increased risk for internalizing mental disorders in LGB individuals, the minority stress model developed by Meyer¹⁴ posits that experiences of social exclusion, victimization, discrimination, low self-esteem, early experiences of stigma, and internalized homophobia underlie at least some of the higher risks for mental disorders found in previous studies.¹⁵

Further, Meyer's¹⁴ theory suggests that social support from peers within LGB networks might alleviate the burden of minority stress in these individuals. Supportive relationships within the LGB networks, and therefore levels of experienced minority stress, would naturally vary among individuals and among subgroups of the sexual minority population. Previous studies have found that bisexual women tend to engage more often in health risk behaviors, such as smoking¹⁶ and binge drinking,¹⁰ than lesbians do. Whether this is related to stress is less clear. Another risk indicator might be that bisexual women and men appear to have lower levels of education¹² compared with lesbians and gay men.¹⁷ Low educational level has consistently been linked to increased risks of mental health disorders.^{18,19} Thus, it could be hypothesized that the risk of anxiety and depression might be higher in certain sexual minority subgroups, unless one controls for the effect of socioeconomic status.

However, these studies have indicated that having neither a clear heterosexual nor a lesbian or gay orientation is associated with greater risk of self-harm and self-reported mood and anxiety disorders.¹² More research on heterogeneity in health and health determinants among sexual minorities has been called for.¹⁰

None of the available population-based studies have examined differences in medical records of psychiatric treatment for anxiety and depression among heterosexual, gay, and bisexual women and men. Medical records permit investigation of sexual orientation-related differences in psychiatric problems untarnished by recall bias and therefore are a valuable complement to self-reported data.

In the present study, we used data drawn from the Stockholm Public Health Cohort (SPHC),²⁰ a longitudinal, population-based sample of nearly 90,000 adults surveyed in 2010. Our purpose was to investigate the association between sexual orientation and self-reported current anxiety and a history of diagnosis of depression, paying particular attention to possible subgroup differences in risks within the sexual minority population, stratified by sex. We also examined the participants' history of medical care for anxiety disorders and depression through linkage to nationwide Swedish health care registers.

METHODS

Study Population

We used data from the SPHC, a population-based longitudinal panel study (N = 89,268) with recruitment occurring in three successive cycles (2002, 2006, and 2010).²⁰ The SPHC sampling frame consisted of all adults listed in the Swedish Total Population Register and residing in one of Stockholm's 39 municipalities or urban districts. For each wave, an area-stratified random sample of approximately 50,000 adults 18 to 84 years old (2002 and 2006) or at least 18 years old (2010) was invited to complete self-administered questionnaires assessing different health, lifestyle, and social characteristics. Respondents recruited in 2002 were resurveyed in 2007 and 2010 and individuals enrolled in 2006 were resurveyed in 2010. Across the three waves, the average response rate was 59.7%. The three waves have been pooled into a common cohort and individuals are followed up longitudinally. In 2010, all SPHC participants (N = 72,261) were assessed for sexual orientation. We included only respondents who reported an answer that could be coded to the question on sexual orientation. Thus, 2,566 respondents who did not answer the sexual orientation item or responded "none of the above" were excluded from our analyses. There were 69,695 individuals who provided usable information on their sexual orientation identity (eg, LGB or heterosexual) and represent our final analytical sample.

Registers

SPHC data are further enriched by linkage to Sweden's extensive health and administrative registers, including the Longitudinal Integration Database for Health Insurance and Labor Market Studies (LISA)²¹ and the National Patient Register (NPR).²² The LISA register integrates existing data from the labor market, educational, and social sectors and is held by Statistics Sweden. The NPR includes all individuals admitted to psychiatric or general hospitals, with complete coverage for all inpatient care since 1987 and outpatient care since 2001. The NPR is held by the National Board of Health and Welfare.^{22,23} Only care given by physicians is registered in the NPR as an *International Classification of Diseases* code (ie, reports on care provided by other health providers, including psychologists, are excluded). Because Sweden legally mandates reporting of medical care rendered in institutional environments, the NPR captures the majority of visits to emergency rooms, outpatient departments, and inpatient settings in which medical care is delivered. We obtained information on medical care for anxiety and depression during a 6-year period (2006–2011).

Sexual Orientation

Sexual orientation was assessed with a single item ("What is your sexual orientation?"), with four response alternatives ("heterosexual," "homosexual," "bisexual," "none of the above"). From this we classified individuals into one of three groups:

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