



Unstable Housing and Homelessness

Psychiatric Risk in Unstably Housed Sexual Minority Women: Relationship between Sexual and Racial Minority Status and Human Immunodeficiency Virus and Psychiatric Diagnoses



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A B S T R A C T

Background: Stress associated with minority statuses has been linked to mental health disorders. However, research conducted exclusively among impoverished women, a population known to be at risk for poor health owing to overlapping risks, is sparse. We sought to determine if homeless and unstably housed sexual minority (i.e., nonheterosexual) women were at greater psychiatric risk than their heterosexual counterparts. We also sought to determine if racial/ethnic minority and human immunodeficiency virus status contributed to psychiatric risks.

Methods: Homeless/unstably housed women living in San Francisco between 2008 and 2010 were followed biannually over 3 years. Generalized estimating equation analysis identified significant correlates of any substance use, mood, or anxiety disorder, as well as the total number of psychiatric disorders.

Results: Among 300 women, 24% reported nonheterosexual identity at the first study visit. Consistent with minority stress theory, lesbian and bisexual identity were associated with higher levels of mental health comorbidity, and bisexual identity was related to greater rates of substance use disorders and mood disorders. Unique to this study, we found that identity assessed 1 or 2 years prior does not predict current substance disorders, but current identity does. In addition, women who were infected with the human immunodeficiency virus also had higher rates of mental health comorbidity and substance use disorders. Contrary to psychosocial stress theory, racial/ethnic minority status was associated with reduced odds of substance use disorder in this population. Recent homelessness was related to greater risk of anxiety disorder.

Conclusions: Best research and health care practices should include the assessment of sexual orientation and housing status when addressing risks for mental health and substance disorders among low-income women.

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Low-income individuals are at high risk for both mental health and substance use disorders (Sareen, Afifi, McMillan, & Asmundson, 2011), and this effect seems to be particularly true for women who are homeless or unstably housed (Greenberg & Rosenheck, 2010). For instance, an older study found that 80% of homeless women had an Axis I psychiatric disorder (based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition) and found high rates of comorbidity within the

population (Breakey et al., 1989). Similarly, a recent study of homeless and unstably housed women found that 97% of study participants had at least one current psychiatric disorder, with 85% meeting criteria for a substance use disorder, 70% for a mood disorder, and 74% for an anxiety disorder (Riley et al., 2014; based on data also used for the present study). Estimates of mental health disorders in the general United States female population are substantially lower, with only 22% experiencing a current mental health disorder (Substance Abuse and Mental Health Services Administration, 2013).

Epidemiological and meta-analytic studies have indicated that sexual minority (non-heterosexual in identity or behavior) women are at higher risk for mental health and substance use

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disorders compared with heterosexual women (Cochran, Ackerman, Mays, & Ross, 2004; Cochran, Keenan, Schober, & Mays, 2000; Cochran, Mays, & Sullivan, 2003; King et al., 2008). Although studies have found that homeless sexual minority adolescents are at higher risk than homeless heterosexual adolescents for substance use and poor mental health (Cochran, Stewart, Ginzler, & Cauce, 2002), the influence of sexual minority status on mental health among adult homeless and unstably housed women remains unexplored.

Unstably housed women may also be influenced by the intersection of multiple minority statuses. Minority stress theory posits that sexual minority individuals experience discriminatory events, expectations of discrimination, concealment of sexual orientation, and internalized stigma as a result of heterosexist environments, and that these stressors have deleterious impacts on mental health (Meyer, 2003). Psychosocial stress theory posits that stressors associated with both individual experiences and institutional discrimination based on racial or ethnic minority status are responsible for health disparities in minority groups compared with nonminority groups (Dressler, Oths, & Gravlee, 2005). Two contrasting hypotheses have been suggested and tested within limited populations: 1) the greater risk perspective proposes that lesbian, gay, bisexual (LGB) status and racial or ethnic minority status both put individuals at greater risk for poor health outcomes, and 2) the resilience perspective, which posits that LGB individuals of racial minority status may be more resilient than LGB individuals who are not racial minorities and therefore not at greater risk for poorer health outcomes than LGB nonracial minorities (discussed at length in Moradi et al., 2010). Research examining how racial and sexual minority statuses are related to psychiatric risk is limited. An existing study found that psychological distress was similar among sexual minority individuals irrespective of racial minority status (Hayes, Chun-Kennedy, Edens, & Locke, 2011), although the applicability of this study is unknown because it was conducted in a college student population. Discriminatory processes related to human immunodeficiency virus (HIV) status (Wingood et al., 2007) have also been associated with poorer mental health, and thus may confer additional risk.

The purpose of this study was to provide empirical evidence for researchers and health care providers who assess health risks among women. Specifically, we sought to clarify the relationships between sexual minority status, racial minority status, HIV status, recent homelessness, and psychiatric disorders among homeless and unstably housed women. Consistent with minority stress theory (Meyer, 2003), we anticipated that sexual minority women would have more substance use and psychiatric disorders than heterosexual women in a population that is already experiencing significant risk, unstably housed women of extremely low socioeconomic status. Because few studies have examined the relationship between sexual orientation and psychiatric disorders among adult homeless populations, we first wanted to examine this bivariate relationship. Next, we wanted to examine the contributions of other minority statuses as well as recent homeless status. In accordance with psychosocial stress theory and previous research on HIV-related discrimination among women, we examined the individual contributions of racial minority status, HIV status, sexual minority status, and recent homelessness on mental health. Consistent with the theory that multiple minority statuses may impact mental health, we explored whether there were interactions between race, HIV, and sexual minority status in predicting mental health outcomes.

Methods

Three hundred homeless and unstably housed women were recruited by a mobile outreach team between June 2008 and August 2010 in San Francisco (methods are also described in Riley et al., 2014). Recruitment methods were based on work by Burnam and Koegel (1988) and included recruitment from homeless shelters, low-income single room occupancy hotels, free meal programs serving more than 100 meals per day, and a random sample of low-income single room occupancy hotels selected with probability proportionate to the number of women residing in the hotel. At small venues, all persons present on recruitment days were invited to participate in screening activities; at large venues, a subsample of individuals present (e.g., every third person) was invited to participate. Women were eligible for this study if they were greater than 18 years of age and reported past housing instability, defined as having slept in a shelter, or in public (e.g., on the street, in a park, in a car or in a stairwell), or with other people because they did not have a place to stay. This study oversampled HIV-infected women to have a large enough sample to conduct analyses based on HIV status. To be included in the study, women had to be assigned female sex at birth, 18 years of age or older, and have ever been homeless or unstably housed (which could include sleeping on the street, in a homeless shelter, or temporarily staying with a series of other people, also known as “couch-surfing”). Once recruited, women completed biannual regular study visits during which time social determinants of health were assessed (including sexual orientation and also including a range of other variables such as past and present trauma, income, substance use, social isolation, and resource availability). Separate annual visits to assess psychiatric diagnoses, which were timed just after baseline, and the 1-year and 2-year follow-up visits. Study participants completed up to seven regular study visit interviews and three psychiatric interviews over the 3-year study period. This study was reviewed and approved by the institutional review board at the University of California, San Francisco.

Measures

Psychiatric diagnoses

The outcomes of the current study were 1) any substance use disorder, 2) any mood disorder, 3) any anxiety disorder, and 4) the total number of psychiatric diagnoses, including both mental health and substance disorders (as in Riley et al., 2014). The Diagnostic Interview Schedule (DIS) was administered to assess for the following current psychiatric diagnoses based on the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (American Psychiatric Association, 2000): substance-related disorders (withdrawal, abuse, and dependence associated with alcohol, amphetamines, cocaine, opiates, and sedatives; abuse and dependence associated with hallucinogens, inhalants, marijuana, phencyclidine, and other drugs), mood disorders (major depressive episode, dysthymia, hypomanic episode, manic episode), and anxiety disorders (panic disorder, specific phobia, social phobia, agoraphobia, generalized anxiety disorder, post-traumatic stress disorder). Schizophrenia, dementia, schizophreniform, somatization, and pain disorder were also assessed for and included in the total number of psychiatric diagnoses out of a total possible of 40 different diagnoses.

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