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Sexual minority youth continue to smoke cigarettes earlier and more often than heterosexuals: Findings from population-based data

Ryan J. Watson^{a,*}, Nathaniel M. Lewis^b, Jessica N. Fish^c, Carol Goodenow^d^a Department of Human Development and Family Studies, University of Connecticut, Storrs, CT, United States^b Department of Geography and Environment, University of Southampton, United Kingdom^c Population Research Center, Human Development and Family Sciences, University of Texas at Austin, TX, United States^d Independent Research/Evaluation Consultant, Northborough, MA, United States

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ABSTRACT

Background: An established body of research documents that sexual minority (i.e., lesbian, gay, and bisexual) populations are at higher risk for several adverse health behaviors and outcomes compared to their heterosexual counterparts. Smoking is one behavior where the gap is especially large, particularly among youth. Researchers have increasingly drawn attention to contextual determinants of health behaviors affecting sexual minority youth.

Purpose: Although these factors have evolved over time, few scholars have examined time as a contextual factor that affects sexual minority health behaviors or the level of inequality with heterosexual populations. We aimed to fill this gap.

Procedures: We used eight years of data from the Massachusetts Youth Risk Behavior Survey (MYRBS), pooled into four waves, to determine whether gaps between sexual minority and heterosexual youth have widened or narrowed for three different indicators of smoking: having ever smoked, early onset smoking, and daily cigarette smoking in the past 30 days.

Results: We find that, though rates of smoking for all youth in Massachusetts have declined since the late 1990s, significant disparities remain between sexual minority and heterosexual youth.

Conclusions: Findings may suggest that targeted tobacco control programs in Massachusetts are needed; perhaps shifts in social attitudes toward smoking have affected smoking behaviors in diverse segments of society.

1. Introduction

An extensive body of research has established that lesbian, gay, and bisexual (LGB) populations have poorer health outcomes than their heterosexual counterparts (Meyer, 2003; Lewis 2009; Hatzenbuehler et al., 2009). Recent studies have observed elevated risk in LGB populations for mental health outcomes such as anxiety and depression (Bybee et al., 1999) as well as risk behaviors such as alcohol and other substance use (Lee et al., 2009; Boehmer et al., 2012). Cigarette use has emerged as a behavior for which the disparities between LGB and heterosexual populations are consistently large. The likelihood of smoking has been estimated at up to 2.5 times higher in sexual minority compared to heterosexual populations, though studies have observed odds of smoking up to 3.5 times higher in bisexual populations (Lee et al., 2009). The scope of the tobacco problem among LGB communities in the United States is large, with smoking prevalence estimated recently at 25–30% in gay and bisexual men compared to 14–16% in heterosexual men and 25–35% in lesbian and bisexual women

compared to 13–15% in heterosexual women (Pizacani et al., 2009; Balsam et al., 2012; Fallin et al., 2015).

There are differences in smoking outcomes that depend on sexual orientation group and the indicator of smoking used. In adult studies, bisexual men and especially bisexual women are more likely to be smokers than their gay and lesbian counterparts (Balsam et al., 2012; Boehmer et al., 2012), potentially because they begin smoking earlier in life and attempt to quit less frequently (Fallin et al., 2015). While rates of *lifetime* smoking (i.e., ever having smoked) are understandably higher for all populations since the indicator captures a longer time-frame, the sexual orientation disparities for lifetime smoking tend to be smaller (Balsam et al., 2012; Boehmer et al., 2012). This tighter gap may be due to more heterosexual people and especially heterosexual men quitting smoking after early experimentation compared to LGB people (Boehmer et al., 2012; Fallin et al., 2015).

LGB youth are a population of special interest given their vulnerability to tobacco use at early developmental stages. Patterns of use across sex and sexual orientation groups are different in youth

* Corresponding author at: 348 Mansfield Rd U1058 Storrs, CT, 06269, Department of Human Development and Family Studies, University of Connecticut, United States.

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compared to adults. Sexual minority youth are more likely than both their heterosexual peers and sexual minority adults to be current smokers (Boehmer et al., 2012). Self-identified gay and lesbian youth also smoke at a higher rate (i.e., more cigarettes per week or month) than those who are bisexual (Newcomb et al., 2014) and may smoke with progressively greater frequency as they age through their teens and into their twenties (Marshal et al., 2009; Corliss et al., 2012). In addition, gay and bisexual boys have, in some cases, reported more tobacco use than lesbian and bisexual girls (Newcomb et al., 2014). Tobacco use behavior may therefore evolve differently across the life course depending on sex and sexual orientation. Although the gap in smoking between gay or bisexual men and heterosexual men tends to narrow progressively with age, it may persist or grow for lesbian women and especially bisexual women (Boehmer et al., 2012; Fredriksen-Goldsen et al., 2013; Newcomb et al., 2014).

Since the 1990s, explanations of health disadvantage in LGB people have focused on minority stress, or the chronic, unique, socially based stressors that non-heterosexual people experience in societies where they are stigmatized (Meyer, 2003). Many studies have measured individual and interpersonal experiences of discrimination as well as other aspects of minority stress to explain unhealthy behaviors in LGB people. For example, LGB youth who smoke also tend to report mental health symptomology, life dissatisfaction, or experiences of victimization. Increasingly, victimization and adverse mental health outcomes in LGB people are considered 'syndemic' (i.e., co-occurring and mutually reinforcing) with substance use (Stall et al., 2003). There may also be other factors associated with sexual orientation that increase the risk of smoking. Both truancy and alcohol use have been found to be associated with smoking in youth populations (Brown et al., 2001). Among LGB youth, truancy may be elevated due to being bullied at school (Baams et al., 2017). Alcohol use might also be elevated due to perceptions that bars and clubs are the only social spaces earmarked specifically for sexual minority individuals (Balsam et al., 2012). Supportive family relationships, in contrast, may reduce the risk for smoking in LGB youth (Newcomb et al., 2014; Ryan et al., 2010).

Increasingly, health researchers are seeking to measure the contextual (i.e., non-individual) determinants of minority stress that affect LGB populations. Minority stress is, to some extent, rooted in policies and social mores (Hatzenbuehler et al., 2009), and these are in turn mediated by place (Lewis, 2009). Consequently, the level of stress that LGB youth experiences may be informed by religious climate (Hatzenbuehler et al., 2012), policies that discriminate against sexual minorities (Hatzenbuehler et al., 2009), or other place-level factors. Hatzenbuehler (2014), for example, found that LGB youth were less likely to smoke in jurisdictions with policies that explicitly prohibited discrimination against sexual minorities but found no such association in heterosexual youth (Hatzenbuehler, 2014). Similarly, communities with higher concentrations of LGB people (Hatzenbuehler et al., 2011) or LGB organizations (Mustanski et al., 2013) may also have a protective effect on the mental health and substance use behaviors of LGB youth.

History is an important, but often overlooked mediator of these contextual factors. Although new legal equalities and increasing social acceptance for LGBTQ people have precipitated a more positive discourse for and about LGB youth, disparities between LGB and heterosexual youth remain for smoking and other health outcomes (Homma et al., 2016; Fish et al., 2017). At the same time, legal equalities such as same-sex marriage may have less meaning for LGB youth who are at relatively early developmental stages. Many LGB youth may carry trauma from events (e.g., school bullying or parental rejection) that occurred earlier in their lives or that are relatively uninfluenced by policy changes (Newcomb et al., 2014; Homma et al., 2016; Russell and Fish, 2016).

Policies related to smoking have also changed. In the United States, the prevalence of smoking dropped from 20.9% in 2005 to 16.8% in 2014, with the largest drop occurring in 2013–2014 (Jamal et al.,

2015). This change is attributable, at least partially, to the tobacco control efforts instituted in many states starting in 2000. California's Tobacco Control Program, which included a media campaign, bans on smoking in many public places, and targeted youth prevention efforts, was successful in reducing both smoking prevalence and cigarette consumption between 1998 and 2008 (Lightwood and Glantz, 2013). Orbell et al. (2009) found that England's 2007 ban on smoking in pubs was a particularly effective intervention, with 15.5% of survey participants quitting smoking within 6 months of the ban despite some relapse in the following year. Bans on smoking in drinking venues are thought to be particularly effective because they help smokers to dissociate the activity from alcohol use (Marshal et al., 2009; Orbell et al., 2009).

Massachusetts, the site of the current study, has taken a strong stance on tobacco use. State residents voted to increase the cigarette tax to fund the Massachusetts Tobacco Cessation and Prevention (MTCP) Program in 1992 and for all tobacco revenues to fund tobacco control in 1999. The state legislature banned smoking in all indoor workplaces in 2004 and mandated tobacco cessation coverage for all citizens receiving state-funded health care (Aldrich et al., 2015). Since many LGB youth continue to use smoking as a means of coping with the stressors of identity development or social exclusion (Rosario et al., 2011), broader tobacco control policies and school-based interventions may have less of an effect on LGB youth compared to heterosexual youth. Temporal changes in smoking across sexual orientation groups are often uneven and inconsistent rather than downwardly convergent (Newcomb et al., 2014). Homma et al., (2016) found in their study of Minnesota that the gap in smoking prevalence between gay/lesbian and bisexual youth widened between 1998 and 2004 and then persisted from 2004 to 2010. We have designed a similar study with representative data from a different state to assess whether these trends are consistent.

2. Method

2.1. Data

Data were drawn from the Massachusetts Youth Risk Behavior Survey (MYRBS), a population-based survey developed by the U.S. Centers for Disease Control and Prevention (CDC); the CDC administers a similar survey in nearly all states across the US through a systematic sampling method with probability proportional to enrollment in grades 9 through 12. We chose the Massachusetts survey because it has been one of the few to include a sexual orientation item for over fifteen years. The MYRBS was given in Massachusetts schools every two years. For more information on the MYRBS survey and sampling/weight information, see Matthews et al. (2014).

2.2. Sample

To increase numbers of sexual minorities in each wave for our study, we pooled eight bi-annual surveys from 1999 through 2013 into four analytic waves: 1999/2001 through 2011/2013. We excluded participants who did not provide responses on the item that assessed sexual orientation ($n = 991$). In sum, our sample included 26,002 participants aged 12–18 ($M = 16.06$). Participants were 72.9% White, 8.5% African American, 7.9% Hispanic/Latino, 0.5% Native American, 3.3% Asian American, and 6.9% Other race/ethnicity.

2.3. Measures

2.3.1. Age and sex

Participants indicated their age in number of years, and their sex as male or female

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