Journal of Adolescent Health 59 (2016) 276–282

JOURNAL OF
ADOLESCENT
HEALTH

www.jahonline.org

Original article

Growing Up With the Right to Marry: Sexual Attraction, Substance Use, and Well-Being of Dutch Adolescents

Lisette Kuyper, Ph.D. [a,b,*], Simone de Roos, Ph.D. [c], Jurjen Iedema, Ph.D. [a], and Gonneke Stevens, Ph.D. [d]

[a] *Department of Education, Minorities and Methodology, The Netherlands Institute for Social Research, The Hague, The Netherlands*
[b] *Research Institute of Child Development and Education, Faculty of Social and Behavioral Sciences, University of Amsterdam, Amsterdam, The Netherlands*
[c] *Department of Care, Emancipation, and Time Use, The Netherlands Institute for Social Research, The Hague, The Netherlands*
[d] *Utrecht Centre for Child and Adolescent Studies, Utrecht University, Utrecht, The Netherlands*

Article history: Received January 7, 2016; Accepted May 16, 2016
Keywords: Lesbian; Gay; Bisexual; Sexual minority; Same-sex attracted; Questioning; Substance use; Well-being; Mental health

A B S T R A C T

Purpose: To assess the well-being and substance use of sexual minority adolescents growing up in a tolerant society, we examined differences among same-sex attracted (SSA), those who do not know their attraction yet (not yet attracted [NYA]), and heterosexual Dutch adolescents.
Methods: Unadjusted and adjusted logistic and linear multilevel analyses were performed using representative data of the 2013 Health Behaviour in School-Aged Children study (N = 5,995; 11–16 years old). The adjusted analyses controlled for sociodemographics (gender, age, education type, ethnicity, urbanicity, and religion).
Results: Adjusted results showed that SSA adolescents substantially more often reported alcohol use (adjusted odds ratio [AOR] = 2.01), tobacco smoking (AOR = 2.37), and cannabis smoking (AOR = 3.52) than their heterosexual peers, while NYA participants less often reported alcohol use (AOR = .57) and equal levels of tobacco (AOR = .71) and cannabis smoking (AOR = .87) compared with heterosexual adolescents. SSA adolescents reported lower levels of life satisfaction ($b = -1.25$) and higher levels of psychosomatic complaints ($b = .61$) and emotional problems ($b = 1.57$) than heterosexual adolescents. NYA adolescents reported equal levels of life satisfaction ($b = -.18$) and psychosomatic complaints ($b = .06$) as heterosexual adolescents, but higher levels of emotional problems ($b = .51$).
Conclusions: In Dutch society, with over 20 years of inclusive policies for sexual minorities and generally tolerant population attitudes toward sexual minorities, SSA adolescents are still at increased risk of substance use and have lower levels of well-being compared with peers.
© 2016 Society for Adolescent Health and Medicine. All rights reserved.

IMPLICATIONS AND CONTRIBUTION

In a country known for its equal legislation and long-standing tolerant attitudes toward sexual minorities, differences in substance use and well-being between sexual minority and heterosexual adolescents are found. These findings imply that notwithstanding legislation and positive population attitudes, additional interventions, and policies are needed to eliminate these health disparities.

Eliminating health disparities between minority and majority groups is an important public health goal. Even so, health disparities are prevalent between sexual minority and heterosexual youth. Recent population-based studies showed that sexual minority youth, compared with their heterosexual peers, reported higher levels of alcohol use [1,2], drug use [1,3,4], cigarette use [5,6], mental health problems [7], and suicidality [8,9]. Meta-analyses showed that these health differences are not only significant, but also quite substantial [1,7,10]. For example, sexual minority youth were almost three times as likely to report a history of suicidality and reported much higher levels of depression, and the average effect sizes of differences in

Conflicts of Interest: None of the authors has any potential, perceived, or real conflicts of interest to declare.

* Address correspondence to: Lisette Kuyper, Ph.D., The Netherlands Institute for Social Research, P.O. Box 16164, The Hague 2500 BD, The Netherlands.
E-mail address: l.kuyper@scp.nl (L. Kuyper).

1054-139X/© 2016 Society for Adolescent Health and Medicine. All rights reserved.
http://dx.doi.org/10.1016/j.jadohealth.2016.05.010

substance use were medium to large. The vast majority of these studies have been conducted in the United States, while a handful of studies has been performed in Canada, the UK, and continental Europe [7].

A central model explaining health disparities between sexual minority and heterosexual individuals is the minority stress framework [11–13]. In this framework, health disparities are explained by the institutional and societal stigma attached to sexual minorities and their accompanying stressors such as victimization and discrimination. Therefore, one way to overcome the sexual orientation–related health inequalities among youth would be to ban these stigmas and prejudices on the intrapersonal, interpersonal, and structural level [12,14]. For example, combatting the stigmas by changes in national legislation such as allowing same-sex couples to marry or obliging school curricula to address sexual minority issues might diminish the health disparities between heterosexual and sexual minority youth.

Sexual minority and heterosexual youth growing up in the Netherlands today are living in abovementioned circumstances in a country with a long history of equal legislation and policies for sexual minority individuals [15]. For example, the Equal Opportunities Act including forbidding discrimination on sexual orientation in areas such as employment, housing, services and goods, education, health care, social work, and recreation came into force in 1994. On April 1, 2001, the first same-sex couples were officially married, and legal partnerships were possible since 1998. Discussing sexual orientation at schools is a mandatory part of the official school curricula since 2012. In addition, Dutch population attitudes toward sexual minorities have been among the most positive in the world for several decades [16–18]. This implies that early and mid-adolescents born and raised in the Netherlands have always lived in a society that has provided them with the right to marry regardless of their sexual orientation, where laws explicitly prohibit discrimination based on sexual orientation in almost every area in life, where the vast majority of the population holds positive attitudes toward sexual minority individuals and where sexual diversity is addressed at school. In other words, examining the well-being of sexual minority adolescents in the Netherlands could provide insight into the well-being of sexual minority youth growing up under relatively low levels of structural and societal stigma.

Unfortunately, the health status of today's Dutch sexual minority youth is currently unknown. Although several studies have been performed, these studies used convenience or local samples [19–23]. While these studies have been crucial for setting the agenda and exploring health issues and accompanying risk and protective factors, they are less suited for the exploration of prevalence estimates of health disparities since these findings cannot be generalized to the population of sexual minority and heterosexual youth in the Netherlands [24]. The Health Behaviour in School-aged Children (HBSC) study, which is representative for the Netherlands, does not have this limitation. The present study set out to examine whether there are disparities between Dutch sexual minority and heterosexual adolescents in substance use (alcohol, tobacco, and cannabis) and well-being (life satisfaction, psychosomatic complaints, and emotional problems) based on the HBSC data.

Methods

Data were drawn from the Dutch 2013 HBSC survey, a cross-sectional study involving adolescents aged 11–16 years, performed as part of the World Health Organization's cross-national HBSC Project. The study involved students in their last year of primary education and their first 4 years of secondary education. A two-stage random sampling procedure was used [25]. First, a random sample of schools was selected from a list of all schools providing primary and secondary education in the Netherlands; the selection was performed proportionally within urbanization strata. This resulted in a sample of 78 schools for primary education and 67 schools for secondary education (response rates of 61% and 40%, respectively). Reasons for nonresponse were primarily connected to other research going on in the schools already (47%), or frequently being asked to participate in studies (23%). Participating and nonparticipating schools did not differ in the type of education or in the ethnic background of the students, but smaller schools (<500 students) more often participated than large schools (>1,000 students). Second, from a list of all classes provided by each participating school, one class in each grade was randomly selected for participation. Within schools, the response rate of participants was 95%. Nonresponse of participants was mainly due to sickness during data collection. Self-report questionnaires were administered in classroom settings during a regular class. Parents of the pupils received a letter informing them about the study, and they were asked to inform the school in case they did not consent with the participation of their child. This procedure was based on the decision of the Ethical Advisory Committee and in accordance with prevailing Dutch law.

The initial sample consisted of 7,073 adolescents. Listwise deletion was used in case of missing values (n = 1,078), yielding a final sample size of 5,995 adolescents. For 596 cases (8.4%), missings were due to a lack of data regarding sexual attraction. The results did not change if pairwise deletion in case of missing values on the control or dependent variables was used instead. Since lifetime prevalence of cannabis use was not assessed in primary school participants, a sample size of 4,649 adolescents was used to analyze cannabis use. The final sample of 5,995 participants consisted of 50.5% boys and 49.5% girls. The mean age of the adolescents was 13.2 years (standard deviation = 1.6); and 26.7% were enrolled in primary school, 34.1% in lower types of secondary education (such as vocational schools), and 39.2% followed higher secondary education. A total of 15.3% belonged to nonwestern ethnic minority groups of which 15.3% was of Moroccan, 21.1% of Turkish, 15.1% of Surinamese, 8.2% of Antillean, and 40.4% of another nonwestern background.

Measures

Sexual attraction. Participants were asked whether they felt attracted to (1) boys; (2) girls; (3) boys and girls; or (4) do not know yet. Participants attracted to same-sex peers or to both sexes were considered same-sex attracted (SSA; n = 111, 1.9%), those who felt attracted to members of the opposite sex were considered heterosexual (n = 5,506, 91.8%), and those who did not yet know were seen as "not yet attracted" (NYA; n = 381, 6.4%).

Substance use. With respect to substance use, lifetime prevalence of adolescent alcohol use, tobacco smoking, and cannabis

Download English Version:

https://daneshyari.com/en/article/1078132

Download Persian Version:

https://daneshyari.com/article/1078132

Daneshyari.com