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Original article

Associations of sexual and gender minority status with health indicators, health risk factors, and social stressors in a national sample of young adults with military experience

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A R T I C L E I N F O

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A B S T R A C T

Purpose: To assess the associations of self-identified lesbian, gay, bisexual, and questioning sexual orientation or transgender status (LGBTQ) and military experience with health indicators.

Methods: We used data from the Fall 2012 National College Health Assessment. The survey included self-identified sociodemographic characteristics, mental (e.g., depression) and physical (e.g., human immunodeficiency virus) conditions, health risk behaviors (e.g., smoking), and social stressors (e.g., victimization). We used modified Poisson regression models, stratified by self-reported military service, to examine LGBTQ-related differences in health indicators, whereas adjusting for sociodemographic characteristics.

Results: Of 27,176 in the sample, among the military-experienced group, LGBTQ individuals had increased adjusted risks of reporting a past-year suicide attempt (adjusted risk ratio [aRR] = 4.37; 95% confidence interval [CI] = 1.39–13.67), human immunodeficiency virus (aRR = 9.90; 95% CI = 1.04–79.67), and discrimination (aRR = 4.67; 95% CI = 2.05–10.66) than their non-LGBTQ peers. Among LGBTQ individuals, military experience was associated with a nearly four-fold increased risk of reporting a past-year suicide attempt (aRR = 3.61; 95% CI = 1.46–8.91) adjusting for age, sex, race and ethnicity, marital status, depression, and other psychiatric diagnoses.

Conclusions: Military experience may moderate health indicators among LGBTQ populations, and likewise, LGBTQ status likely modifies health conditions among military-experienced populations. Results suggest that agencies serving military populations should assess how and if the health needs of LGBTQ individuals are met.

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Introduction

In the United States, an estimated 9 million adults identify as lesbian, gay, bisexual, or transgender (LGBT or sexual and gender minority) [1]. These groups are vulnerable to disparities in several health risk behaviors, such as cigarette smoking [2], substance use [3], violence [4], and discrimination [5], and in adverse health outcomes, such as depression [6], respiratory illnesses [7], and sexually transmitted diseases [8]. In 2011, the Institute of Medicine recommended further research to explore how specific sociodemographic factors may further influence health among LGBT populations [9].

Current and former military experience is one example of a characteristic that may influence health because of the unique stressors (e.g., combat exposure, military sexual trauma, transitions between deployments [10–12]) and culture (e.g., norms and beliefs [13,14]) of military service. Several studies document elevated burdens of mental health problems among individuals with military service history, including suicide risk [15] and post-traumatic stress disorder (PTSD) [16]. LGBT persons who served in the U.S. military may have experienced more stressors, such as discrimination and harassment, than their non-LGBT peers because of the

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recently rescinded "Don't Ask, Don't Tell" policy that banned openly lesbian, gay, and bisexual people from military service [17,18]. Individuals can still be discharged from the U.S. military if they are transgender [19]. Despite these potential unique experiences and health needs, there is a paucity of health information about LGBT persons who have served in the U.S. military.

Data from the U.S. Census and general population surveys suggest that nearly 1 million U.S. military veterans identify as lesbian, gay, bisexual individuals, and recent findings suggest that more than 70,000 lesbian, gay, bisexual individuals and 15,500 transgender individuals serve in active duty, the guard, or the reserves [20,21]. To some extent, the sexual orientation–related and transgender-related health differences observed in general samples have also been documented in studies with veteran populations. For instance, studies comparing sexual minority with heterosexual veterans have documented higher prevalence of smoking [22,23], suicidal ideation [24–27], PTSD [28], and victimization [29,30]. There are, however, studies that suggest veteran status may moderate differences among sexual minority individuals. Blosnich et al. [31] noted that sexual minority veterans had twice the odds of keeping firearms in the home compared with their sexual minority nonveteran peers. In another study, lesbian and bisexual women veterans had significantly greater prevalence of mental distress, sleep disturbances, current smoking, and poor physical health than lesbian and bisexual nonveterans [22]. The few empirical studies about transgender veterans note a substantially higher burden of poor mental health compared with nontransgender veterans [32–34].

Relatively, very little is known about health risk behaviors and social stressors (e.g., violence and discrimination) among sexual and gender minority individuals with military experience. Research efforts have been hampered by the relative rarity of LGBT status in data collection systems.[35,36]. When LGBT status is collected, large sample sizes are necessary to find analyzable groups of persons who report both LGBT status and military experience. Moreover, many extant studies of LGBT veterans lack direct comparison groups of non-LGBT veterans or LGBT nonveterans groups. To address these gaps, we examine differences in a variety of health indicators (i.e., physical and mental health, health risk behaviors, and social stressors) by sexual and gender minority status among persons reporting a military experience in a large national sample of young adults.

Material and methods

Data

Data are from the National College Health Assessment Fall 2012 survey sponsored by the American College Health Association (ACHA). Postsecondary educational institutions purchase the National College Health Assessment, and ACHA aggregates data collected from institutions that use probability-based sampling methods. The Fall 2012 data set had a total of 28,237 respondents from 51 institutions in the United States. Most institutions ($n = 48$) used Web-based surveys and three used paper administration. The mean response rate was 20%. Further details about the Fall 2012 survey administration and survey items have been published previously by ACHA [37].

Sociodemographic information

Our two independent variables of interest were military experience and sexual or gender minority status. Military experience was assessed with the item: "Are you currently or have you been a member of the United States Armed Services (Active Duty, Reserve, or National Guard)?" Response categories were as follows: no; yes and I have deployed to an area of hazardous duty; and yes and I have not deployed to an area of hazardous duty. We dichotomized these response categories as yes versus no. Sexual minority status was assessed with the item: "What is your sexual orientation?" to which respondents could indicate heterosexual, gay or lesbian, bisexual, or unsure (i.e., questioning). In a separate item, respondents indicated their gender as female, male, or transgender. Because of the small sample of persons with military experience who identified as having lesbian, gay, bisexual, or questioning (LGBQ) sexual orientation or having a gender identity of transgender, the sexual orientation and gender identity responses were classified as any person who identified as lesbian, gay, bisexual, and questioning sexual orientation or transgender (LGBTQ). We abstracted additional sociodemographic covariates, including age, race and ethnicity, and relationship status. Race and ethnicity were categorized as nonminority (white, non-Hispanic) versus minority (African American or black; Hispanic or Latino and/or Latina; Asian or Pacific Islander; American Indian, Alaskan Native, or Native Hawaiian; biracial or multiracial; or other). Relationship status was classified as married or partnered versus not partnered or married.

Health indicators

We assessed several self-reported indicators of mental health, physical health, health risk behaviors, and social stressors. Mental health indicators were self-reported as follows: (1) lifetime diagnosis of depression; (2) past 12 months diagnosis or treatment for depression; and (3) past 12 months diagnosis or treatment of other psychiatric conditions (i.e., anorexia, anxiety, attention deficit and hyperactivity disorder, bipolar disorder, bulimia, insomnia, other sleep disorder, obsessive compulsive disorder, panic attacks, phobia, schizophrenia, substance abuse or addiction, other addiction, or other mental health condition). We also included two items about suicidal ideation and suicide attempt in the past 12 months. Each of the five mental health indicators was dichotomously coded as yes or no.

We assessed six physical health indicators based on previous literature suggesting sexual or gender minority-based disparities for the following medical conditions: asthma [38], acute respiratory infections (i.e., bronchitis, sinus infection, or strep throat) [7], sexually transmitted diseases (i.e., chlamydia, herpes, human papilloma virus, or gonorrhea), hepatitis B or C [39–41], human immunodeficiency virus (HIV) [42–44], and cardiovascular risk factors (i.e., high blood pressure, high cholesterol) [45–47]. Participants indicated if they have been diagnosed or treated by a professional in the past 12 months for each condition, with response categories of yes versus no.

Health risk behaviors included alcohol, tobacco, and illicit drug use. Binge drinking was defined as at least one episode of consuming five alcoholic drinks or more in one sitting in the past 2 weeks. We assessed three types of tobacco use in the past 30 days: (1) cigarettes; (2) cigars, cigarillos, or clove cigarettes; or (3) hookah. We created a global measure of any of these types of tobacco use. Smokeless tobacco use was coded as a separate category of any use versus no use in the past 30 days. We assessed three types of illicit drug use in the past 30 days: (1) marijuana, (2) other drugs (i.e., cocaine, methamphetamines, sedatives, hallucinogens, steroids, opiates, inhalants, ecstasy, other club drugs, and other illegal drugs), and (3) prescription misuse. Prescription drug misuse was defined as any use in the last 12 months of prescription drugs that were not prescribed to the respondent, including antidepressants, drugs for erectile dysfunction, pain relievers, sedatives, or stimulants. We created a global measure of any of the three categories of illicit drug use.

We assessed four social stressors based on sexual and gender minority individuals' high risk of experiencing discrimination and violence [4,48–50]. These included self-reported (1) physical

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