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The impact of civil union legislation on minority stress, depression, and hazardous drinking in a diverse sample of sexual-minority women: A quasi-natural experiment

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ABSTRACT

Rationale: A small but growing body of research documents associations between structural forms of stigma (e.g., same-sex marriage bans) and sexual minority health. These studies, however, have focused on a limited number of outcomes and have not examined whether sociodemographic characteristics, such as race/ethnicity and education, influence the relationship between policy change and health among sexual minorities.
Objective: To determine the effect of civil union legalization on sexual minority women's perceived discrimination, stigma consciousness, depressive symptoms, and four indicators of hazardous drinking (heavy episodic drinking, intoxication, alcohol dependence symptoms, adverse drinking consequences) and to evaluate whether such effects are moderated by race/ethnicity or education.
Methods: During the third wave of data collection in the Chicago Health and Life Experiences of Women study ($N = 517$), Illinois passed the *Religious Freedom Protection and Civil Union Act*, legalizing civil unions in Illinois and resulting in a quasi-natural experiment wherein some participants were interviewed before and some after the new legislation. Generalized linear models and interactions were used to test the effects of the new legislation on stigma consciousness, perceived discrimination, depression, and hazardous drinking indicators. Interactions were used to assess whether the effects of policy change were moderated by race/ethnicity or education.
Results: Civil union legislation was associated with lower levels of stigma consciousness, perceived discrimination, depressive symptoms, and one indicator of hazardous drinking (adverse drinking consequences) for all sexual minority women. For several other outcomes, the benefits of this supportive social policy were largely concentrated among racial/ethnic minority women and women with lower levels of education.
Conclusions: Results suggest that policies supportive of the civil rights of sexual minorities improve the health of all sexual minority women, and may be most beneficial for women with multiply marginalized statuses.

Lesbian, gay, and bisexual (LGB; sexual minority) populations are at heightened risk for a variety of adverse health outcomes and have higher rates of negative coping behaviors, such as hazardous drinking, compared to heterosexuals (Hughes et al., 2010a, 2010b; Institute of Medicine, 2011). Sexual-orientation-related disparities in depression and hazardous drinking are particularly robust among women (Hughes et al., 2010a, 2016; Marshal et al., 2008, 2011). For example, a meta-review of 18 studies documented that sexual minority women (SMW) have 400% higher odds of substance abuse, including alcohol use and misuse, compared to heterosexual women (Marshal et al., 2008). Understanding the mechanisms that lead to such acute disparities between SMW and heterosexual women is critical.

Research on predictors of sexual-orientation-related disparities has largely focused on interpersonal discrimination and

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victimization and the negative psychological sequelae of such events (e.g., Feinstein et al., 2012; Mays and Cochran, 2001). A growing body of research, however, documents the influence of structural forms of stigma and discrimination—which include laws and policies, as well as cultural norms—on physical and mental health among sexual minorities (SM) in the United States (e.g., for reviews, see Hatzenbuehler, 2010, 2014). Although these studies provide important insights into social determinants of LGB health, important questions remain. First, theories of intersectionality (Bowleg, 2012) suggest that structural factors interact with individual characteristics in ways that could position some women *within* SM populations to benefit more or less from macro-level policy changes, such as those that legally recognize same-sex relationships. As such, some scholars have argued that SMW of color may benefit less than White SMW from such policy changes (Kandaswamy, 2008). Given small sample sizes of LGB respondents in existing studies on social policies and health, researchers typically combine subgroups of LGB respondents, such as Whites and people of color (e.g., Hatzenbuehler et al., 2009; Rostosky et al., 2009), or include only one demographic group (e.g., men; Hatzenbuehler et al., 2012). Consequently, research has yet to examine whether sociodemographic characteristics moderate the relationship between policy change and SMW health.

Second, previous research on the impact of social policy change on SMW health has focused on mental health variables, such as psychological distress (Rostosky et al., 2009) or psychiatric disorders (Hatzenbuehler et al., 2009). It is likely that social policies affect a broader range of health behaviors and outcomes, such as hazardous drinking, among SMW, but it has not been empirically examined.

Third, although the economic benefits of supportive policy changes, such as those that legally recognize same-sex relationships, are not likely to be immediate, such changes may have immediate psychological benefits. Indeed, polices that prohibit the legal recognition of same-sex relationships serve as a constant reminder of the devalued status of same-sex relationships (Herek, 2006). Importantly, prior studies have demonstrated a relationship between same-sex marriage policy and mental health within relatively short time-frames, both positive in the case of legalization (e.g., less than one year Hatzenbuehler et al., 2012) and negative in the case of marriage bans (e.g., one month Rostosky et al., 2009 and less than one year Hatzenbuehler et al., 2010). However, factors responsible for these more immediate psychological impacts of same-sex marriage, such as reductions in perceived discrimination and stigma consciousness, have rarely been addressed. We address these gaps in the literature by examining data from a quasi-natural experiment involving passage of the 2011 civil union act in Illinois.

1. Structural discrimination, minority stress, and health

Minority stress—the excess stress that minorities face due to their stigmatized status—has been identified as a key mechanism underlying sexual-orientation-related health disparities (Meyer, 2003). Perceived discrimination, the feeling of being treated unfairly or poorly due to an individual characteristic, and stigma consciousness, the expectation of being discriminated against by others (Pinel, 1999), are two forms of minority stress that are robust predictors of poorer mental health among SMs (Feinstein et al., 2012; Mays and Cochran, 2001). Both perceived discrimination and stigma consciousness have been previously linked to mental health and substance use among LGB populations (Mays and Cochran, 2001; McCabe et al., 2010).

Recently U.S. researchers have expanded the minority stress framework to include structural-level sources of discrimination, such as state-level policies that differentially target sexual minorities for social exclusion (Hatzenbuehler, 2014). For instance, using a quasi-experimental design, Hatzenbuehler and colleagues (2010) found that LGB adults who lived in states that passed constitutional amendments banning same-sex marriage experienced a significant increase in psychiatric morbidity; these increases were not observed among LGB respondents in states that did not ban same-sex marriage. Further, the amendments did not negatively affect the mental health of heterosexuals, indicating that the results were specific to LGB respondents. An online survey similarly showed that SMW and men in U.S. states that passed same-sex marriage bans reported more minority stressors and greater levels of psychological distress than those in states without marriage bans (Rostosky et al., 2009).

Conversely, state-level policies can also represent positive change and inclusion, thereby improving the health of stigmatized individuals. Indeed, passage of legislation that legally recognizes same-sex relationships has been associated with decreased use of healthcare services and healthcare costs, as well as decreases in stress-related conditions such as depression and hypertension, among SM men (Hatzenbuehler et al., 2012). This research also showed that the health benefits of same-sex marriage are comparable for partnered and non-partnered SM men, suggesting that these benefits are, in part, accrued through mechanisms unrelated to marital status (Hatzenbuehler et al., 2012).

The passage of major supportive social policies in the U.S., such as civil union legislation, result in symbolic and concrete reductions in discrimination and stigma and consequently in better mental health (Hatzenbuehler, 2010) and fewer negative coping behaviors such as hazardous drinking among SMs (e.g., Hatzenbuehler et al., 2011). Textual analyses of open-ended responses to survey questions related to the legalization of same-sex civil unions in Vermont indicated that this policy change was associated with increased psychological benefits and family acceptance, in addition to financial benefits (Rothblum et al., 2011). Other research, conducted in the U.S. and in the Netherlands, has found that same-sex marriage legalization is associated with feelings of greater social inclusion (Badgett, 2011).

Taken together, these findings suggest that legal recognition of same-sex relationships increase feelings of belonging—a fundamental human need and an essential component of mental health (Baumeister and Leary, 1995). Thus, in addition to financial benefits, state policies that legally recognize same-sex relationships may also confer immediate psychological benefits due to the lessening of perceived and actual discrimination and stigmatization at the macro-level (Hatzenbuehler, 2010). We test this hypothesis by examining legislative changes on both perceived discrimination and stigma, in addition to mental and behavioral health outcomes.

2. Civil union legislation and intersectionality

Theories of intersectionality highlight the importance of considering multiple minority identities in studies of health disparities (Bowleg, 2008; Warner and Shields, 2013). Broader social systems, such as those that impose differential treatment based on race, class, or sexual orientation, can undermine or exacerbate the health effects of specific events. That is, although SMW share their sexual minority status, they may differ on other sociodemographic characteristics associated with privilege and disadvantage. In fact, race/ethnicity and socioeconomic status (SES) may be more relevant to SMW's experience of minority stress and health than their shared experience of SM status (Breines, 2002).

Whether the benefits of policies that recognize and support same-sex relationships extend to all SMs regardless of gender, race/ethnicity, or SES—or whether they differentially benefit certain