Health Disparities Among Sexual Minority Women Veterans

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Abstract

Background: Lesbian and bisexual (i.e., sexual minority) identity is more common among women veterans than among male veterans. Unique health issues have been identified among women veterans and among sexual minority women, but little is known about women who are both sexual minorities and veterans. This study aimed to compare demographic and health information from sexual minority women veterans with sexual minority women non-veterans and heterosexual women veterans.

Methods: Behavioral Risk Factor Surveillance Survey data were pooled from ten U.S. states that elected to ask sexual identity during 2010. The analytic sample was comprised of women who identified both their sexual identity and veteran status ($n=1,908$). Mental health indicators were frequent mental distress, sleep problems, low social/emotional support, and low satisfaction with life. Health risk indicators included current smoking, overweight, and obesity. Physical health status was defined by three components: disability requiring assistive equipment, >14 days of poor physical health in the past 30 days, and activity limitations.

Results: Compared with heterosexual women veterans, sexual minority women veterans had higher odds of mental distress (odds ratio [OR]=3.03, 95% confidence interval [CI]: 1.61–5.70) and smoking (OR=2.31, 95%CI: 1.19–4.48). After adjusting for demographic correlates, sexual minority women veterans had three times the odds of poor physical health (OR=3.01, 95%CI: 1.51–5.99) than their sexual minority non-veteran peers.

Conclusions: Results suggest sexual minority women veterans may experience unique health disparities relevant to provision of care in both Veterans Affairs (VA) and non-VA healthcare systems. Future research requires availability of data that include sexual minority status.

Introduction

AS ONE OF THE FASTEST GROWING GROUPS of new users of Department of Veterans Affairs (VA) services, women veterans are projected to comprise over 14% of the veteran population by 2033 and constitute a population of special interest in the VA.¹ For instance, women veterans report poorer physical and mental health when compared with active duty service women, women in the U.S. National Guard and Reserves, and women with no military service history.² Moreover, sexual minority status (i.e., homosexual and bisexual sexual orientation) is associated with multiple health disparities,³ and is more common among female veterans than male veterans.^{4,5} As outlined in a recent Institute of Medicine report, sexual minority status has important implications for healthcare access and health behaviors.³ However, very little is known about the health status and needs of women who are both veterans and sexual minorities.

Women veterans are a unique sub-population both among women and among veterans in general. Compared with women non-veterans, women veterans report poorer physical and mental health,² have higher prevalence of experiencing trauma,⁶ and have higher rates of suicide.⁷ When compared with their male veteran peers, women veterans report poorer emotional health⁸ and have higher estimates of lifetime sexual victimization.^{9,10} Women veterans also have higher rates of military sexual trauma (MST). The Department of Veterans Affairs defines MST as “severe or threatening forms of sexual harassment and sexual assault sustained in military service,”¹¹ and MST is often associated with higher rates of mental and physical health problems.^{12,13} In terms of healthcare utilization, female veterans are less likely to use Veterans Health Administration (VHA) services than male veterans,¹⁴ and women veterans typically receive most or all of their care outside of VHA.¹⁵

Patterns of health inequities also are documented among sexual minority women. Compared with heterosexual women,

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sexual minority women have increased prevalence of poor mental health outcomes including depression and anxiety¹⁶ and suicidal behavior,^{17–19} as well as health risk behaviors such as smoking²⁰ and alcohol abuse.²¹ Sexual minority women are also more likely than heterosexual women to report early life stress and trauma, including childhood sexual abuse.²² Despite the prevalence of these negative health outcomes, sexual minority women tend to have less access to healthcare services and insurance coverage (particularly among bisexual women).²³ Moreover, the presence of these health disparities among sexual minority women veterans remains largely unexamined.

Theoretical framework for health disparities

The causes of health disparities among sexual minority populations are likely complex and multidimensional. However, the minority stress model offers a framework to understand the disproportionate negative physical and mental health burdens documented among sexual minority populations. The minority stress model posits that identifying with a socially persecuted and devalued minority status contributes unique, externally based, chronic stress (e.g., stigma, discrimination, victimization) that leads to elevated mental distress.²⁴ Sexual minority women with a history of military service may be particularly prone to minority stress and its related negative sequelae. Furthermore, since women in general are a minority group among veterans and activity duty military, it is unclear if minority stress among sexual minority women veterans may be further compounded by having multiple minority statuses.

One clear example is the military's overt history of discrimination against sexual minority persons through the "Don't Ask, Don't Tell" (DADT) policy, in which sexual minority servicepersons were prohibited from disclosing information or answering questions about their sexual orientation, lest they be discharged from the military, potentially with a dishonorable discharge.

During the 18 years of the DADT policy, sexual minority military personnel faced increased risk for blackmail or manipulation, compromised personal and unit relationships, and daily stress and anxiety.²⁵ High rates of discrimination and victimization related to sexual orientation have also been documented.²⁶ More specifically, summarizing data from 1994 to 2002 from the Servicemembers Legal Defense Network, Burks estimated that there were over 4,600 documented incidents of antigay harassment directed toward sexual minority military personnel.²⁷ While these estimated rates of discrimination and victimization related to sexual orientation are staggering, they are likely underestimates as issues of stigma and threats of being "outed" by perpetrators often contribute to underreporting.^{27,28} Fears of discharge and/or career loss, driven by the fact that 17,000 service members were removed from the military based on sexual orientation from 1980 and 1990,²⁹ may also influence likelihood of reporting.

Research is just beginning to explore how sexual minority military personnel may carry these experiences of harassment and violence with them as they transition to veteran status.³⁰ It is unclear how these experiences may impact their long-term health and how membership in multiple minority groups may exacerbate their effects. For example, chronic

stress, anxiety, and lowered social support are all factors associated with compromised immune system functioning.³¹

Sexual minority female veterans as a priority population

Given the unique health issues of women veterans and sexual minority women, women who stand at the intersection of sexual minority and veteran identities may have health needs that set them apart from both their sexual minority peers and their veteran peers. However, data about sexual minority women veterans are scant.

Similar to estimates based on Census data from 2000, recent survey data from 2008 estimate that approximately 2.2% of military personnel are sexual minority persons,³² and sexual minority status among military populations is more common among females than males.^{4,5} Since there are significantly more sexual minority women on active duty than sexual minority men (estimated at 2.9% and 0.6%, respectively), the VA is likely to see increasing numbers of sexual minority women veterans.

Though research is currently limited, recent studies report differences in health-related outcomes among sexual minority veterans. Among a sample of sexual minority male and female veterans, Blosnich et al. documented higher prevalence of suicidal ideation in sexual minority veterans than heterosexual veterans.¹⁸ From a large sample of female veterans, Booth and colleagues reported that sexual minority status was associated with increased risk of experiencing rape at multiple points throughout the lifespan, including during military service. Specifically, 73% of sexual minority women veterans reported lifetime rape compared to 48% of heterosexual women veterans.³³ While both rates are alarmingly high, the significant elevation in sexual minority women is striking given the known mental and physical health sequelae of sexual assault.¹³

To our knowledge, no studies have examined whether health disparities identified within the general population of sexual minority women also are present among women veterans, nor whether sexual minority women veterans have distinct, unique health burdens relative to their peers who share their sexual minority status (i.e., sexual minority women non-veterans) or their veteran status (i.e., heterosexual women veterans). Given the large gaps in knowledge about sexual minority women veterans' health, this paper aims to examine demographic (e.g., age, race, education, income) and mental and physical health-related characteristics (e.g., mental distress, life satisfaction, current smoking status, body mass index, physical disability) among a sample of sexual minority women veterans identified in a pooled multistate health surveillance dataset. Additionally, the characteristics of sexual minority women veterans are compared to information from heterosexual women veterans and sexual minority women non-veterans.

Materials and Methods

The data are derived from the 2010 Behavioral Risk Factor Surveillance System (BRFSS) surveys from ten states that elected to ask sexual identity: Alaska, Arizona, California, Maine, Massachusetts, Montana, New Mexico, North Dakota, Washington, and Wisconsin. The BRFSS is an annual survey of health and risk behaviors originating from the Centers for Disease Control and Prevention (CDC). Each year, the CDC dispenses a mandatory core questionnaire for administration

to probability-based samples of adults over the age of 18 in all U.S. states and territories.³⁴ States may elect to add items to the core survey. Data were procured from states that added sexual identity items to their core questionnaires and merged according to identical variables asked in the core questionnaire. The average response rate across states was approximately 56%.³⁵ With the focus on women in the present study, the sample was restricted to only females ($n=56,929$). The analyses included only sexual minority women veterans and women who shared identity components with them (i.e., non-veteran women who shared sexual minority status and heterosexual women who shared veteran status). Active duty personnel ($n=53$) were excluded from the analytic sample since they could neither be classified as veterans nor non-veterans.

There was slight variation in the sexual identity questions and response options across states. Alaska, Arizona, California, Montana, and Washington asked, "Now I'm going to ask you a question about sexual orientation. Do you consider yourself to be..." In Maine and North Dakota the item was worded as "Now I'll read a list of terms people sometimes use to describe themselves—heterosexual or straight; homosexual, gay, or lesbian; and bisexual. As I read the list again, please stop me when I get to the term that best describes how you think of yourself." Both Massachusetts and New Mexico interviewers asked: "Do you consider yourself to be..." Wisconsin's item was worded as: "Do you consider yourself to be heterosexual; attracted to people of the opposite sex; gay/lesbian, attracted to people of the same sex; or bisexual, attracted to people of both sexes?" All states had nearly identical response options, which were recoded to standardized categories of heterosexual, gay/lesbian, bisexual, and other. However, people who self-identified as "other" were excluded from the current analyses, and sexual identity for the remaining respondents was categorized as either heterosexual or lesbian/bisexual.

Veteran status was defined by a standard item in the core questionnaire that was asked identically across all states: "Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit? Active duty does not include training for the Reserves or National Guard, but DOES include activation, for example, for the Persian Gulf War." We considered veterans to be those who responded "Yes, on active duty during the last 12 months, but not now" and "Yes, on active duty in the past, but not during the last 12 months."

Demographic variables included age (in years), race/ethnicity (white vs. nonwhite), education (high school diploma or less vs. some post-secondary education), and income (<\$25,000/year, \$25,000–\$50,000/year, and >\$50,000/year); all of which were variables for which the CDC. Mental health indicators included frequent mental distress (i.e., 6+ days of poor, self-reported mental health in the last 30 days);³⁶ sleep problems (i.e., >14 days of inadequate rest/sleep in the last 30 days);³⁷ satisfaction with life (very satisfied or satisfied vs. dissatisfied or very dissatisfied); and frequency of getting social/emotional support (always, usually, or sometimes vs. rarely or never). Current smoking was defined as having smoked at least 100 cigarettes during one's lifetime and currently smoking some days or everyday.³⁸ Body mass index (BMI) was calculated from self-reported height and weight data and classified into overweight (BMI=25–30) and obesity (BMI≥30) categories. Three indicators of physical health

included: >14 days of poor physical health in the last 30 days; disability status (defined as having any health problem requiring the use of "special equipment, such as a cane, a wheelchair, a special bed, or a special telephone"); and any activity limitations due to "physical, mental, or emotional problems."

Across the three different categories of women, age was examined with *t*-tests, and categorical demographic and health variables were examined with Chi-square tests of independence. Adjustments for multiple testing were not employed because, in addition to inflating type II error,³⁹ sexual minority women veterans are a difficult-to-find population whose small sample size in the present analyses already impedes statistical power. Two sets of multivariable logistic regression analysis were used to examine the odds of health indicators, adjusted for demographic characteristics, among sexual minority women veterans compared with their sexual minority non-veteran and heterosexual veteran counterparts. Missing data were handled with listwise deletion. Since the CDC cautions against using weighted analyses of BRFSS data when analyzing subgroups of <50 respondents,⁴⁰ we opted for unweighted analysis due to the small sample size of women veterans ($n=53$). All analyses were conducted using Stata/SE version 12. This study was approved by the Syracuse Veterans Affairs Medical Center IRB.

Results

In the total sample of women, 969 (1.7%) identified as veterans and 1,067 (2.0%) identified as lesbian/bisexual. Across both sexual minority and veteran statuses there were 53 sexual minority veterans, 1,010 sexual minority non-veterans, and 845 heterosexual veterans (see Table 1). Sexual minority women comprised 5.9% of the women veteran sample. Sexual minority women veterans were similar to other groups of women in terms of demographics with the exception that they were significantly older than sexual minority non-veterans ($p<0.05$).

Several significant differences surfaced across the health variables, setting sexual minority veterans apart from both their veteran and sexual minority peers. On mental health variables, significantly more sexual minority women veterans indicated frequent mental distress, low satisfaction with life, and sleep problems than either sexual minority non-veterans or heterosexual veterans. Notably, over 40% of the sexual minority women veterans in this sample reported frequent mental distress and >14 days of sleep problems. Sexual minority women veterans had nearly twice the prevalence of current smoking when compared with heterosexual veterans. More sexual minority women veterans reported activity limitations and poor physical health than the other groups of women ($p<0.05$).

In models adjusted for age, race/ethnicity, education, and income, sexual minority women veterans had higher odds of several health indicators (Table 2). Compared with sexual minority women non-veterans, sexual minority women veterans had over two-fold increase in odds of frequent mental distress, sleep problems, current smoking, and poor physical health. Compared with their heterosexual veteran peers, sexual minority women veterans had over three times the odds of reporting frequent mental distress and nearly three times the odds of reporting low satisfaction with life.

TABLE 1. DEMOGRAPHIC AND HEALTH INDICATORS AMONG WOMEN, BY VETERAN STATUS AND SEXUAL MINORITY STATUS

	Lesbian/bisexual veterans (N=53)	Lesbian/bisexual non-veterans (N=1,010)	Heterosexual veterans (N=845)
	n (%)	n (%)	n (%)
Demographics			
Non-white	11 (21.1)	194 (19.0)	121 (14.4)
> High school diploma	7 (13.2)	240 (23.8)	173 (20.5)
< \$25,000/year	14 (27.5)	333 (35.5)	200 (26.7)
\$25,000–\$50,000/year	15 (29.4)	244 (26.0)	224 (29.9)
> \$50,000/year	22 (43.1)	360 (38.4)	325 (43.4)
Age (mean, SE)	54.0 (1.58) ^{a,b}	48.8 (0.51)	58.2 (0.60)
Mental health indicators			
Frequent mental distress	22 (42.3) ^{a,b}	257 (25.7)	143 (17.1)
Low social/emotional support	15 (29.4) ^b	195 (19.8)	147 (17.9)
Low satisfaction with life	10 (19.2) ^{a,b}	99 (10.1)	47 (5.7)
Inadequate sleep	23 (44.2) ^b	327 (32.8)	218 (26.2)
Health risk indicators			
Current smoking	18 (34.0) ^{a,b}	219 (21.8)	145 (17.2)
Overweight	17 (32.1)	312 (31.8)	264 (32.6)
Obese	19 (35.8)	324 (33.0)	215 (26.5)
Physical health indicators			
Activity limitations	27 (50.9) ^{a,b}	373 (37.1)	289 (34.4)
> 14 days poor physical health	14 (26.4) ^{a,b}	142 (14.3)	116 (14.0)
Disability requiring assistive equipment	11 (20.7)	126 (12.5)	148 (17.6)

^a*p* < 0.05 when compared with lesbian/bisexual female non-veterans.^b*p* < 0.05 when compared with heterosexual female veterans.

SE, standard error of the mean.

TABLE 2. ADJUSTED ODDS RATIOS OF HEALTH INDICATORS AMONG WOMEN, BY VETERAN STATUS AND SEXUAL MINORITY STATUS

	Lesbian/bisexual veterans vs. lesbian/bisexual non-veterans AOR (95%CI)	Lesbian/bisexual veterans vs. heterosexual veterans AOR (95%CI)
Mental health indicators		
Frequent mental distress	2.78 (1.46–5.32)*	3.03 (1.61–5.70)*
Low social/emotional support	1.88 (0.91–3.88)	1.77 (0.87–3.62)
Low satisfaction with life	2.26 (0.98–5.22)	2.95 (1.25–6.94)*
Inadequate sleep	2.10 (1.16–3.83)*	2.26 (1.24–4.15)*
Health risk indicators		
Current smoking	2.70 (1.40–5.18)*	2.31 (1.19–4.48)*
Overweight	1.13 (0.62–2.08)	1.06 (0.58–1.96)
Obese	0.87 (0.46–1.63)	1.18 (0.62–2.21)
Physical health indicators		
Activity limitations	1.59 (0.87–2.89)	1.73 (0.95–3.15)
> 14 days poor physical health	3.01 (1.51–5.99)*	2.83 (1.44–5.56)*
Disability requiring assistive equipment	2.03 (0.96–4.33)	1.87 (0.86–4.07)

All models adjusted for race/ethnicity, education, income, and age.
**p* < 0.05.

AOR, adjusted odds ratios; CI, confidence interval.

Discussion

The findings from this sample of women provide preliminary information about the health of sexual minority women veterans. Broadly, some findings corroborate sexual minority health disparities in the general population, such as increased prevalence of smoking and poor mental health.²³ However, when looking at distinct groups, the results suggest that sexual minority women veterans are different from both their sexual minority non-veteran and heterosexual veteran peers, a finding that has not yet been documented in the literature. Specifically, elevated odds of frequent mental distress, sleep problems, smoking, and poor physical health were noted in sexual minority veteran women as compared with both sexual minority non-veterans and heterosexual veterans.

The causal factors of health disparities among sexual minority women veterans are poorly understood. One possibility is that constellations of risk factors identified among sexual minority civilian samples (e.g., minority stress) may be amplified among sexual minority women veterans, which may be attributable to additive experiences of MST and other unique experiences related to their military service.^{30,33} These experiences include increased vulnerability to investigation and discharge under DADT, relative to sexual minority men.⁴¹ Unfortunately this dataset did not contain measures for such analyses, such as dates of service or exposure to DADT-related experiences. The legacies of such experiences may play unique and significant roles in the health of sexual minority women veterans and warrant further research.

The health disparities in sexual minority women veterans noted here have implications for prevention initiatives and healthcare services. For instance, although the current data

did not explicitly assess suicide risk, the four mental health indicators included in the analyses are associated with elevated risk for suicide,^{42,43} and previous evidence suggests higher prevalence of suicidal ideation among sexual minority veterans.¹⁸ The VA has implemented many initiatives directed at suicide prevention and surveillance,^{44,45} but it is currently not possible to identify sexual minority status in VA datasets, which precludes both enumeration of a potential high-risk population and evaluation of the relative effectiveness of such prevention efforts in this population. Furthermore, since women veterans utilize both VHA and non-VA healthcare systems, clinicians should be aware that sexual minority women are at risk for more medical and psychiatric comorbidities and complex presentations than their heterosexual peers.^{23,46}

Several limitations must be noted. Although the data were derived from probability-based samples, the analyses were unweighted due to the small size of the subsample of sexual minority women veterans.⁴⁰ Thus, these results may not generalize to all sexual minority women veterans and did not take into account the complex sampling design and nonresponse of the BRFSS, and thus should not be misinterpreted as representative beyond the sample. Despite being one of the first samples in which sexual minority women veterans could be identified, the sample is small, which limited statistical power. The measure of self-reported sexual identity was not standard across states, inviting measurement bias. Selection bias is also possible since identity encompasses only one domain of sexual orientation, whereas a more nuanced operationalization of sexual orientation may have resulted in different findings.¹⁶ Measures in the BRFSS are broad and do not capture specific conditions. For example, there is no explicit measure of depression, although these symptoms could have been captured in the general mental distress question. Finally, the measure of self-reported veteran status could not be verified with official records of military service, nor was additional veteran-related information available (e.g., era of service, exposure to combat, nature of trauma history), which might have modified health profiles.

Conclusions

In spite of these limitations, this report offers a first examination of demographic and health information about sexual minority women veterans relative to their sexual minority non-veteran and heterosexual veteran peers. Although the repeal of DADT ended one form of silencing sexual minority military servicepersons, their health issues remain muted, undetectably embedded within current data sources and continually overlooked with each new wave of data collection. However, the VA stands in a unique position to change this by examining methods for systematically collecting information about sexual minority status and assessing the effectiveness of VA initiatives and prevention efforts in this population.

With the shift of decreasing social stigma against sexual minority populations (e.g., repeal of DADT), both VA and non-VA healthcare settings are likely to see increasing numbers of sexual minority women veterans.^{30,32} Moreover, women's roles in the military are changing (e.g., the Department of Defense allowing women to serve in combat roles⁴⁷), and different risk factors may become more prevalent among young women veterans. Such developments may suggest generational differences among women veterans and highlight the need for incorporating information about dates of service to enhance research

initiatives. In light of these changes, the results of the present study are an important precursory step in documenting the needs of sexual minority women so we can more effectively serve those who bravely served their country.

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