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Association of Neighborhood Disorder and Minority Stress with Depression among Young Gay and Bisexual Males in Denver and Chicago

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ABSTRACT Excess risk for poor mental health outcomes has been found within sexual minority populations. This study aimed to examine factors that may contribute to depression rates within two populations of YMSM in Denver and Chicago. 100 HIV-positive and 100 HIV-negative young men who have sex with men (YMSM) completed a survey regarding demographic information, minority stress (such as same-sex stigma), and perceived neighborhood disorder. Chicago participants reported higher rates of neighborhood disorder, history of incarceration, and being kicked out of a parent's house, variables predicted to be positively correlated with depression. Surprisingly, it was found that YMSM in Denver were significantly more likely to have depressive symptoms than YMSM in Chicago. In addition, internalization of same-sex stigma, and more significantly city location, were found to increase depression odds. The results indicate that depression rates may be influenced by unmeasured variables that vary between the two cities. Further research should examine other variables that contribute to the difference in depression rates among YMSM in varying city environments.

INTRODUCTION

Sexual minorities in the U.S. have suffered from an ongoing history of discrimination, social stigmatism, and emotional abuse. LGB individuals have a 1.5 times higher risk for depression and anxiety disorders compared to heterosexual individuals as well as being more than 3 times more likely to attempt suicide. (IOM, 2011; Mustanski & Espelage, 2020). Understanding social and societal factors that contribute to this dramatic increase in depression

rates in the LGB community is crucial to constructing positive change.

Unsupportive social interactions have been found to have the greatest negative effect on mental well-being among LGB youth, followed by stigma consciousness and internalized homonegativity (Berghe, et al., 2010). Experiences of prejudice, rejection, and homophobia can be described by the minority stress model. Minority stress describes the

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premise that certain stressors are unique to a minority population and occur within social structures and through social processes. This model examines various stressors, such as sexual stigma, harassment, and discrimination, and their impact on mental health outcomes (Meyer, 2003). Experience of stigma is when stigma towards a group that one belongs to is physically manifested in ways such as antigay hostility or violence. Internalization of stigma occurs when an individual accepts society's negative attitudes towards them. Both stigmas can significantly alter one's mental well-being and daily life. Parallels have been drawn between HIV-stigma and homophobia in that both cause young men who have sex with men to have disclosure anxiety (Rai, et al., 2018). This in turn can lead to social isolation, stress, and a lack of retention to care. According to the National Child Traumatic Stress Network, caregivers have the greatest influence on a child's self-worth and value. LGB young adults who have had a history of rejection from their families have been found to be 5.9 times more likely to be depressed (Ryan et al., 2009).

Some studies have found that neighborhood disadvantage can decrease depression rates in that these communities can sometimes harbor enhanced social relationships (Joongbaeck, 2010). Yet, the majority find that neighborhood disorder and neighborhood disadvantage increases depression rates (Joonbaeck, 2010). Stress that occurs due to crime or feelings of endangerment is shown to contribute to worse health (Ross, 2001). These feelings can occur in neighborhoods that contain high amounts of vandalism and graffiti. Neighborhoods that are perceived as safe, clean, and quiet demonstrate the opposite effect on health in that residents are typically healthier (Ross, 2001). These conditions may also affect LGB individuals adversely, being that higher levels of neighborhood poverty have been shown to be significantly related to an increase in hate crimes that are gay-related (Dale et al., 2016).

Research has found that incarceration can damage the mental health of not only those imprisoned, but also of those residing in high-incarceration neighborhoods. This damage includes major depressive disorder and general

anxiety disorder (Hatzenbuehler et al., 2015). Young men who have sex with men (YMSM) of minority and low income status are less likely to acquire mental health services (Storholm, et al., 2013). One study conducted in New York City found Black and Asian/Pacific Islander men to be least likely to have accessed mental health counseling (Storholm, et al., 2013). Although Black YMSM have been found to perceive greater stigma, they have also not been found to have worse mental health outcomes as a result. It is hypothesized that this is due to resilience and coping skills built up from prolonged exposure to discrimination due to racial/ethnic status (David Knight, 2008; Lelutiu-Weinberger, et al., 2015).

The aim of this study was to determine the association between neighborhood disorder and minority stress with depression in YMSM from two cities: Chicago and Denver. A socioecological approach was emphasized while forming this study. This approach considers psychological, environmental and social factors when seeking to understand health and illness. Physical conditions, thoughts and beliefs, and social expectations are analyzed to examine how one's feelings influence their health. Additionally, a sociocultural approach was utilized by examining how social dynamics such as poverty, prejudice, and living conditions influence health. Two types of stigma within the framework of minority stress were thus chosen to be under investigation in this study. Similarly, being kicked out of a parent's home was examined as a variable possibly contributing to stigma levels and thus depression among YMSM. Incarceration was chosen to be examined as an indicator of neighborhood disorder.

METHODS

Study Procedures

Data was derived from a survey previously administered to both HIV-positive (n=100) and HIV-negative (n=100) young men who have sex with men (YMSM) in Denver and Chicago. The intention of the original survey was to examine factors associated with increased cannabis use among YMSM. Chicago and Denver were selected to be compared as medical and

recreational cannabis had differing legal status between the two cities during the time of the study. Clinics included in the original study were selected due to their already established connections with HIV-positive and HIV-negative YMSM from clinical research and outreach programs. Denver participants were recruited from an adolescent HIV clinic on the East side of the city. This subgroup consisted of equivalent proportions of Latinx and White YMSM, with smaller numbers of African American YMSM. The Chicago site was similarly an adolescent HIV clinic located on the South Side of the city. Participants from this area of Chicago were predominately African American YMSM. HIV-positive participants were acquired first via recruitment flyers residing at clinics and through peer referrals determining half the sample size. Secondly, HIV-negative participants were recruited in a sample matched in terms of age and ethnicity to the previously attained YMSM HIV-positive participants already enrolled in the study creating a total sample size of 200 participants.

Eligibility criteria required participants to have been born biologically male as well as be identified as male at the time of the study, be between the ages of 18 and 24 years old, and have a history of at least one sexual encounter, either anal or oral penetration, with a partner within the last 12 months of the study. Once informed consent was obtained, participants completed an audio computer-assisted survey interview (ACASI) and were subsequently compensated for their time and effort.

Measures

The data collected for this study included demographics, dimensions of minority stress including experience and internalization of same-sex stigma, depressive symptoms, and social disorganization. Demographic data of interest included race/ethnicity, age, HIV status, education level, employment, history of incarceration, and history of being kicked out of a parent's house due to sexuality. Self-reported education levels were dichotomized to High School Graduate/GED and lower or some college and/or Tech school and higher. Employment was assessed by asking participants whether they

were employed full-time, part-time, or unemployed.

Minority stress was analyzed within two domains: experience of same-sex stigma and internalization of same-sex stigma. Each domain was measured using 4-point agreement scales. Experience of gay stigma questions centered on hateful actions that participants had personally experienced from others, including rejection and violence, due to their sexual orientation or other behavior (Bruce et al., 2015). Experience response scales ranged from 1 (have never experienced) to 4 (have experienced many times). The internalization of same-sex stigma questions focused on possible psychological consequences of participants' anti-gay experiences such as having feelings of shame and thoughts of self-alteration. Internalization response scales ranged from 1 (strongly disagree) to 4 (strongly agree).

Social disorganization was measured using the Perceived Neighborhood Order/Disorder Scale (Ross, Mirowsky, 1999) consisting of 10 items with a 4-point scale. Scores ranged from 1 (strongly disagree) to 4 (strongly agree). Questions on social disorganization targeted participant perception of physical and social disorder within their neighborhoods. Examples of these questions include "Vandalism is common in my neighborhood" and "I can trust most people in my neighborhood." Depression was measured using the BSI global severity index, containing norms for adolescents and adults. Scores of psychological distress ranged from 1 (not at all) to 5 (extremely). BSI-Depression raw scores were transformed using Z-scores to obtain a cutoff for depressive symptoms in accordance with previous studies with adolescent and young adult populations (Derogatis, L & Spencer, M., 1982).

Analysis

Data in this study was analyzed using SPSS. A bivariate analysis was conducted on participant characteristics to determine significantly correlated variables. Race was examined separately along with depression via cross tabulation to determine any significant variations of depression rates across subgroups. Significant bivariate correlates were included in a

multivariate logistic regression model with depression as the dependent variable.

RESULTS

Demographic information and corresponding frequencies are displayed in Table 1. Of the 200 participants, 100 were from Chicago and 100 were from Denver. The mean age of Chicago participants was 22.07 years old ($SD = 1.69$) and the mean age of Denver participants was 21.80 years old ($SD = 1.91$). A majority of participants from Chicago were African American (83%) whereas Denver participants had a greater distribution in frequencies of race between African American (24%), White (38%) and Hispanic/Latino (37%). Participants displayed a significantly higher rate ($X^2=8.00$, $p<.01$) of depressive symptoms in Denver (28%) than in Chicago (12%).

Table 2 displays the results of the Pearson Correlation analysis run on participant characteristics. The city variable used for correlational analysis was a nominal variable (Chicago coded as “2,” Denver coded as “1”) . Living in Denver was found to be significantly associated with depression ($r = -0.200$, $p<0.01$). Depression was also found to be positively correlated with experience of same sex stigma ($r = 0.191$, $p<0.01$) and internalization of same sex stigma ($r = 0.296$, $r<0.01$). The bivariate Pearson Correlation revealed significant positive correlations between Chicago and neighborhood social disorder ($r = 0.445$, $p<0.01$), neighborhood physical disorder ($r = 0.359$, $p<0.01$), being kicked out of a parent’s home ($r=0.195$, $p<0.01$), and unemployment ($r=0.414$, $p<.01$).

Table 3 displays the results from the cross tabulation conducted to determine if race demonstrated an impact on depression rates. The cross tabulation of depression and race showed no significance, meaning that the frequency of depressive symptoms within racial subgroups were not significantly different from one another. This indicates that race does not influence depression rates within these two populations.

The multivariate logistic regression model, including significant correlates from the Pearson

Correlation model, is shown in Table 4. The logistic regression model found that the internalization of same-sex stigma was significantly associated with the highest odds of depression (O.R. = 1.933, $p<0.05$). The city location of Denver was also found to be significantly associated with higher odds of depression (O.R. = 0.258, $p<0.01$).

DISCUSSION

While Denver participants reported higher rates of depression, participants in Chicago reported higher rates of neighborhood disorder (both physical and social), history of incarceration and being kicked out of parents’ homes. Based on literature review and socioecological and sociocultural thinking, neighborhood disorder and same-sex stigma were predicted to have an impact on mental health status among YMSM.

Internalized homophobia has been hypothesized to disrupt positive identity development in LGB youth (Bruce et al., 2015). Feelings of animosity and disapproval may cause sexual minorities to feel inclined to conceal their true sexual orientation in an effort to conform to societal standards and thus feel more accepted. Similarly, emotionally absorbing homophobic attitudes can cause a lowering of one’s self-esteem as well as the perception that one’s sexual orientation is wrong and should be changed. This internalization of stigma has been found to be significantly correlated with poor mental health. One study found that this stigma increased the likelihood of developing depression by 2.5 times (Bruce et al., 2014). Internalized homophobia has been observed to be alleviated by strong social support from family and friends of LGB youth. Correspondingly, LGB youth who have had experience of familial rejection have been shown to also exhibit depressive symptoms. Literature has shown that verbal and physical harassment from family and peers is linked to running away from home (Bruce et al., 2014). Although being kicked out of one’s home and being unemployed were more prevalent among Chicago participants, these variables were curiously not found to be associated with depression in this study.

Table 1: Participant Characteristics (N=200)

Variable	Chicago (N=100)		Denver (N=100)		Total (N=200)			
	M	SD	M	SD	M	SD	t	p
Age	22.07	1.69	21.80	1.91	21.94	1.80	-1.05	N/S
Perceived Neighborhood Disorder								
Social Disorder	2.54	0.57	1.98	0.56	2.26	0.63	-6.87	.000
Physical Disorder	2.18	0.63	1.72	0.56	1.95	0.64	-5.32	.000
Same-Sex Stigma								
Experience of same-sex stigma	1.67	0.71	1.76	0.64	1.72	0.67	0.96	N/S
Internalization of same-sex stigma	1.72	0.78	1.76	0.79	1.74	0.78	0.32	N/S
	N	%	N	%	N	%	χ^2	p
Men with Depressive Symptoms	12	12	28	28	40	20	8.00	.005
HIV Positive	50	50	50	50	100	50	.000	N/S
Race/Ethnicity							78.34	.000
African American/Black	83	83	24	24	107	53.5		
White	5	5	38	38	43	21.5		
Hispanic/Latino	8	8	37	37	45	22.5		
Multiracial/Other	4	4	1	1	5	2.5		
Education Level							6.29	N/S
Less than High School	14	14	4	4	18	9.0		
High School Graduate/GED	39	39	42	42	81	40.5		
Some College/Tech School	33	33	36	36	69	34.5		
College/Associates Degree or Higher	14	14	18	18	32	16.0		
Currently Employed	49	49	81	81.8	130	65.3	42.04	.000
Have been arrested, detained, or spent time in jail	36	36.7	25	25.3	61	31.0	5.58	N/S
Have been kicked out of parent's home due to sexuality	39	39	18	18	57	28.5	11.44	.003

Table 2: Correlations (N=200) * $p < 0.05$, ** $p < 0.01$

	1	2	3	4	5	6	7	8	9	10	11
1. Depression	1										
2. City	-.200**	1									
3. HIV Status	-.025	.000	1								
4. Education level	-.130	-.122	-.266**	1							
5. Unemployment	-.102	.414**	.141*	-.156*	1						
6. Kicked out of Parent's Home	.032	.195**	.081	-.070	.149*	1					
7. History of Incarceration	.026	.021	.099	-.155	.163*	.249**	1				
8. Experience of Same-Sex Stigma	.191**	-.069	-.062	.025	-.022	.203**	-.082	1			
9. Internalization of Same-Sex Stigma	.296**	-.023	.053	-.064	.076	.071	.098	.359**	1		
10. Neighborhood Physical Disorder	.021	.359**	-.006	-.092	.302**	.227**	.134	.161*	.177*	1	
11. Neighborhood Social Disorder	-.060	.445**	.094	-.162*	.284**	.222**	.186**	.050	.170*	.734**	1

Table 3: Cross Tabulation of Race and Depression

		White	Black/African American	Latino/Hispanic	Multiracial/Other	Total	X ²	Sig.
Depression	No Symptoms	35	90	31	4	160		
	Depressive Symptoms	8	17	14	1	40		
Total		43	107	45	5	200	4.655	N/S

Table 4: Logistic Regression Model

	<i>B</i>	<i>SE</i>	<i>Wald</i>	<i>DF</i>	<i>SIG</i>	<i>O.R.</i>	95% <i>C.I.</i>	
							<i>Lower</i>	<i>Upper</i>
<i>Kicked out of Parent's House</i>	.262	.367	.507	1	.476	1.299	.632	2.669
<i>History of Incarceration</i>	.188	.379	.246	1	.620	1.207	.574	2.535
<i>Neighborhood Physical Disorder</i>	.618	.535	1.331	1	.249	1.855	.650	5.295
<i>Neighborhood Social Disorder</i>	-.785	.581	1.831	1	.176	.456	.146	1.422
<i>Experience of Same Sex Stigma</i>	.194	.334	.338	1	.561	1.214	.631	2.335
<i>Internalization of Same-Sex Stigma</i>	.659	.273	5.832	1	.016	1.933	1.132	3.300
<i>City</i>	-1.353	.515	6.892	1	.009	.258	.094	.710

Considering the negative effect neighborhood disorder and unstable housing can have on LGB individuals, we were surprised to observe that Chicago participants displayed lower depression rates than those in Denver. Race was not determined to be a significant factor influencing depression rates; therefore, it is meaningful to more closely examine differences in city location. One explanation for this finding may be the forming of social ties within disadvantaged Chicago neighborhoods as a buffering effect to mental illness. In neighborhoods where physical disorder is highly perceived, residents may form informal ties with their neighbors. These alliances may lessen fear and increase feelings of social control within the community (Ross & Jang, 2000), thereby keeping poor mental health outcomes at bay. Another explanation could be a built-up resilience among YMSM in Chicago. As Chicago is known to be one of the most segregated cities in the United States, YMSM

here may be more accustomed to social isolation and prejudice. Those who have experienced stigma and discrimination in other forms besides sexual orientation, such as race or ethnicity, may be more likely to have built up coping mechanisms to manage adversity (Lelutiu-Weinberger et al., 2015). Therefore, Chicago participants may be more equipped to ameliorate depressive symptoms.

YMSM in Denver were significantly more likely to display depressive symptoms compared to YMSM in Chicago. From the logistic regression model results, it was predicted that stigma levels would contribute notably to depression rates. Yet experience of stigma and internalization of stigma levels were only slightly higher in Denver than Chicago, and not at a significant level. Therefore, it was not statistically sound to propose that stigma levels were the cause of higher depression rates in YMSM residing in

Denver. Instead, the logistic regression model results indicate that the variance in depression rates relied more on the difference in city location between YMSM in the study. Accordingly, depression rates may have been influenced heavily by unmeasured variables differing between the two cities.

There were several limitations for this study. Data from this study was pulled from a survey previously administered to investigate motives behind increased cannabis use among YMSM living with HIV-AIDS. Therefore, further research could benefit by structuring a study focusing mainly on mental health outcomes and socioeconomic factors, rather than drug use. The survey administered relied on self-reported data, which may be influenced by recall bias. Additionally, as a cross-sectional study any implications drawn from the results must be described as relational rather than causal. The study sample size consisted of a small proportion of the LGB population in Denver and Chicago,

possibly underestimating or overestimating the magnitudes between associated variables. Similarly, the results yielded in this study apply to YMSM within these two cities specifically and are restricted by this limited scope. An additional limitation can be attributed to the differences in clinic populations between Denver and Chicago. Whereas the Denver HIV adolescent clinic served the entire city, there are multiple HIV adolescent clinics residing in Chicago. As a result, the chosen clinic in Denver served a more diverse clientele than the clinic in Chicago, which served a less diverse population, mostly from the South Side of Chicago. Future research on this particular population could possibly identify other variables unique to these cities that influence disparities in depression rates. Despite the vast research demonstrating that LGB individuals have higher rates of mental illness, these findings indicate that further research is necessary to examine the life-long impacts of discrimination and prejudice due to sexual orientation as well as socioeconomic factors that may relate to worse mental health outcomes.

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