Minority Stress and the Health of Sexual Minorities

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Minority Stress and the Health of Sexual Minorities

ILAN H. MEYER AND DAVID M. FROST

Minority stress refers to a conceptual model that describes stressors embedded in the social position of sexual minority individuals as causes of health-related conditions, such as mental disorders, psychological distress, physical disorders, health behaviors (e.g., smoking, condom use), and, more generally, a sense of well-being (Meyer, 2003a). The minority stress model suggests that because of stigma, prejudice, and discrimination, lesbian, gay, and bisexual people experience more stress than do heterosexuals and that this stress can lead to mental and physical disorders. We begin with a brief overview of the minority stress model and discuss the domains of health and well-being that are affected by minority stressors, including mental health, physical health, health behaviors, and well-being.

MINORITY STRESS PROCESSES

The minority stress model is based on general stress theory (Dohrenwend, 2000). Meyer (2003a) described minority stress processes that are unique to lesbian, gay, and bisexual populations. The model (Figure 18.1) shows stress and coping and their impact on mental health outcomes (box i). Minority stress emerges from general environmental circumstances (box a), which include advantages and disadvantages related to factors such as socioeconomic status. An important aspect of these circumstances in the environment is the person's minority statuses, for example, being lesbian, gay, or bisexual (box b). These statuses are depicted as overlapping boxes in the figure to indicate associations with other circumstances in the person's environment. For example, minority stress for a gay man who is poor results from both his sexual orientation *and* his poverty. Together these characteristics determine his exposure to stress as well as to coping resources (Díaz, Ayala, Bein, Henne, & Marin, 2001). Circumstances in the environment lead to exposure to stressors, including general stressors such as job loss or death of an intimate (box c), and stressors unique to minority group members, such as prejudice events (e.g., discrimination in employment) (box d). Similar to their source circumstances, the stressors are depicted as overlapping, representing their interdependence (Pearlin, 1999). For example, an experience of antigay violence (box d) is likely to increase vigilance and expectations of rejection (box f).

Prejudice-related stressors include the *structural* exclusion of lesbian, gay, and bisexual individuals from resources and advantages available to heterosexual people (e.g., marriage), as well as *interpersonal* events that disadvantage nonheterosexual people. There are numerous accounts of the widespread exposure of lesbian, gay, and bisexual people to such prejudice events (Herek, 2009a, 2009b; Meyer, Schwartz, & Frost, 2008). In addition to acute major stressful events, such as being a victim of antigay violence or losing a job, nonheterosexual people are exposed to minor incidents and chronic conditions that are related to prejudice. These forms of *everyday discrimination* or *heterosexist daily hassles* also constitute prejudice-related stressors. Verbal harassment and other instances of rejection and disrespect are examples of everyday discrimination (Swim, Johnston, & Pearson, 2009). Such incidents do not qualify as life events because they are minor in magnitude and require relatively little adaptation. But such seemingly minor events can be damaging because of the symbolic message of rejection that they convey, especially when they accumulate over time (Meyer, Ouellette, Haile, & McFarlane, 2011).

Often minority status leads to personal identification with a person's minority status (Figure 18.1,

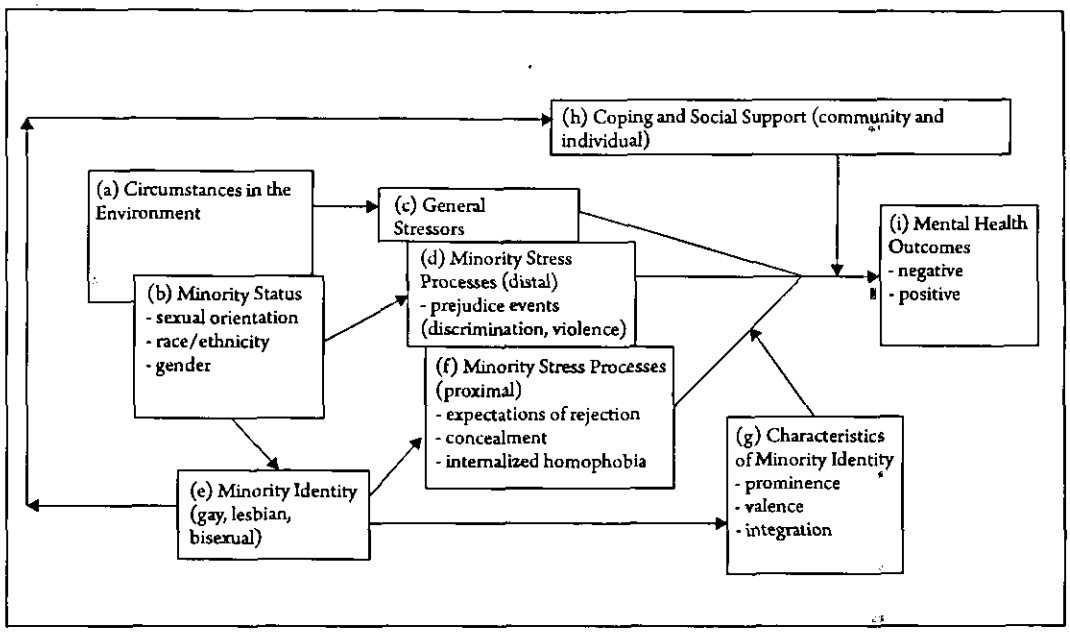

FIGURE 18.1. Minority Stress Processes and Health Outcomes. From Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. Published by the American Psychological Association. Reprinted with permission.

box e). This minority identity leads to additional stressors (box f) related to the individual's perception of the self as a stigmatized and devalued minority (Miller & Major, 2000), including expectations of rejection, concealment, and internalized homophobia, which is defined as a lesbian, gay, or bisexual individual's direction of negative social attitudes toward himself or herself.

Internalized homophobia can be a particularly insidious stressor because it is directed by the person toward himself or herself due to years of socialization in a stigmatizing society even when no external stimulus is present (Meyer & Dean, 1998). Indeed, one of the developmental tasks faced by people upon identifying as lesbian, gay, or bisexual is learning to dissociate their sense of self from the negative messages they have learned about homosexuality, even if they are not aware that these messages have been learned (Eliason & Schope, 2007). We demonstrate the workings of internalized homophobia with research in the area of intimacy. In most states of the United States and in most other nations, lesbian, gay, and bisexual people are barred from marrying a person of the same sex. Marriage is an important status and highly valued goal for most people in our society. One of the core stigmas about homosexuality has been the denial of intimacy for same-sex couples. Because intimacy is a basic human goal, society has built social structures to support the achievement of lasting intimate bonds for heterosexual couples. But the achievement of similar intimacy goals is not available for most lesbian and gay people (Frost, 2011a; Meyer & Dean, 1998). The denial of the right to marry—a structural prejudice with specific legal consequences—is the most fundamental of such barriers. The significance of denial of marriage is three-pronged: It excludes lesbian and gay individuals from full participation in society, given that marriage and family are key components of citizenship (Herdt & Kertzner, 2006); it impedes the development of lasting intimate relationships by same-sex couples by removing the structural support that marriage affords; and it implicitly propagates the stigma that they are undeserving or incapable of attaining satisfying intimate family relations. This stigma can then be internalized by individuals who are in or seek to be in same-sex relationships, potentially resulting in their disengagement from intimate relationships (Frost, 2011a; Frost & Meyer, 2009).

Minority identity is not only a source of stress, but also has positive effects (Riggle, Rostosky, &

Danner, 2009; Meyer, et al., 2011). Characteristics of minority identity can augment or weaken the impact of stress (Figure 18.1, box g). For example, minority stressors may have a greater impact on health outcomes when a lesbian, gay, or bisexual identity is prominent than when it is secondary to the person's self-definition (Thoits, 1999). Nonheterosexual identity may also be a source of strength (box h) when it is associated with opportunities for affiliation, social support, and coping (Riggle, Whitman, Olson, Rostosky, & Strong, 2008), which mitigate the impact of stress (Crocker & Major, 1989; Miller & Major, 2000). In short, the minority stress model articulates how the effect of stressors on health outcomes is the net result of negative (stress) and positive (ameliorative) factors.

The positive effects of feeling connected to or being involved in sexual minority communities on the health of sexual minorities have been demonstrated in various studies. Sexual minority communities vary from specific groups of similar others (e.g., other black lesbians) to neighborhoods to larger geospecific communities (e.g., New York City's lesbian, gay, bisexual, and transgender communities). Engagement with sexual minority communities has been shown to be related to mental health and well-being (Kertzner, Meyer, Frost, & Stirratt, 2009; Ramirez-Valles, Fegus, Reisen, Poppen, & Zea, 2005), safer sex practices (Ramirez-Valles & Brown, 2003), sexual risk (Ramirez-Valles, 2002), medication adherence among HIV-positive men who have sex with men (Wolitski, Pals, Kidder, Courtenay-Quirk, & Holtgrave, 2009), and coping with chronic sorrow among those who are HIV positive (Lichtenstein, Laska, & Clair, 2002).

It is important to note that although some of the positive effects work through individual resources (Masten, 2001), many positive effects can be provided only by the community as a whole—through the person's affiliation and identification with the community. Two functions of coping achieved through minority group affiliations are to allow stigmatized persons to experience social environments in which they are not stigmatized by others, and to provide practical, emotional, and symbolic support for the consequences of external negative evaluation of the stigmatized minority group (Jones et al., 1984).

The distinction between personal and group-level coping may be complicated because even group-level resources (such as the services of a lesbian/gay-affirmative church) are accessed and utilized by individuals. Whether individuals can access and use group-level resources depends upon many factors, including personal strengths and resources. But it is also true that an individual with strong personal coping resources could be lacking minority coping resources. For example, a young lesbian in a rural community will likely have a more difficult time attending events at a lesbian/gay community center (one may not be available in his or her local area and the only available centers require considerable travel) than a similar young lesbian in a major metropolitan area (e.g., Hastings & Hoover-Thompson, 2011). Young people living in a rural area have less access to group-level resources, making them more vulnerable to adverse health outcomes, regardless of their personal coping abilities (D'Augelli & Hart, 1987).

HEALTH OUTCOMES RELATED TO MINORITY STRESS

Mental Health

Minority stress causes serious injury in the form of psychological distress, mental health problems, suicide, and lowered psychological and social well-being. Studies have concluded that minority stress processes are related to an array of mental health problems including depressive symptoms, substance use, and suicide ideation. Studies of mental disorders, as defined by the *Diagnostic and Statistical Manual* (*DSM-IV*) of the American Psychiatric Association, have shown a higher prevalence of disorders among lesbian, gay, and bisexual compared to heterosexual populations (for reviews and meta-analyses, see Cochran & Mays, 2007; Herek & Garnets, 2007; King et al., 2008; Meyer, 2003a; see also Cochran and Mays, Chapter 15, this volume).

Diagnosed mental disorders are not the only measure of psychological distress; subthreshold mental health problems, such as depressed mood, anxiety, suicidal ideation, or substance use problems, that do not meet criteria for a formal psychiatric disorder are indicative of distress. Studies have shown that lesbian, gay, and bisexual individuals score higher than heterosexual people on such distress measures because of minority stress stemming from prevailing cultural stigma (Cochran, Sullivan, & Mays, 2003; Mays & Cochran, 2001).

Also, although less often studied, lesbian, gay, and bisexual individuals have lower levels of psychological and social well-being than heterosexual people because of exposure to minority stress, such as stigma and discrimination experiences (Frable, Wortman, & Joseph, 1997; Kertzner, Meyer, & Dolezal, 2004; Riggle, Rostosky, & Danner, 2009). This is not surprising because well-being, especially *social well-being,* reflects the person's relationship with his or her social environment: "the fit between the individuals and their social worlds" (Kertzner, Meyer et al., 2009, p. 500). Other studies have shown, for example, that stigma leads lesbian, gay, and bisexual persons to experience alienation, lack of integration with the community, and problems with self-acceptance (Frable, Wortman, & Joseph, 1997).

Minority stress is also associated with a higher incidence of reported suicide attempts among nonheterosexual as compared with heterosexual individuals (e.g., Cochran & Mays, 2000; Gilman et al., 2001; Herrell et al., 1999; Marshal et al., 2011; Meyer, Dietrich, & Schwartz, 2008; Safren & Heimberg, 1999). Higher rates of suicide attempts among members of sexual minorities are related to minority stress encountered by youth due to coming out conflicts with family and community (Ryan, Huebler, Diaz, & Sanchez, 2009). Youth is a time that can be particularly stressful, a time when young people realize they are lesbian, gay, or bisexual, and often disclose their sexual minority identities to parents, siblings, and others (Flowers & Buston, 2001).

Although most distal to the individual, minority stressors stemming from social structural discrimination have serious negative consequences for the mental health of sexual minorities. For example, lesbian, gay, and bisexual men and women who live in states without laws that extend protections to sexual minorities (e.g., job discrimination, hate crimes, relationship recognition) demonstrate higher levels of mental health problems compared to those living in states with laws that provide equal protection (Hatzenbuehler, Keyes, & Hasin, 2009). Furthermore, the denial of marriage rights for same-sex couples via U.S. federal and state policies has a demonstrated negative effect on the mental health of sexual minorities, regardless of their relationship status (Riggle, Rostosky, & Horne, 2010; Rostosky, Riggle, Horne, & Miller, 2009). Thus, minority stressors—ranging from distal structural discrimination, to interpersonal microagressions, to personal processes such as internalized homophobia—create a toxic everyday environment for lesbian, gay, and bisexual individuals, thereby increasing their risk for many kinds of mental health problems.

Physical Health

A number of studies have also demonstrated links between minority stress factors and physical health. In a recent study, we examined the impact of minority stress on physical health problems (e.g., flu, hypertension, sexually transmitted infections, tendonitis, and cancer) among a diverse group of lesbian, gay, and bisexual men and women (Frost, Lehavot, & Meyer, 2011). We found that lesbian, gay, and bisexual people who had experienced a prejudice-related stressful life event (e.g., assault provoked by known or assumed sexual orientation, being fired from a job because of your sexual minority identity) were about three times more likely than those who did not experience a prejudice-related life event to have suffered a serious physical health problem over a 1-year period. This effect remained statistically significant even after controlling for the experience of other stressful events that did not involve prejudice, as well as other factors known to affect physical health, such as age, gender, socioeconomic status, employment, and lifetime health history. Thus, prejudice-related stressful life events were more damaging to the physical health of lesbian, gay, and bisexual people than general stressful life events that did not involve prejudice.

Most of the research on the relationship between minority stress and physical health has been concerned with HIV/AIDS and has focused on men only. For example, studies examined the impact of concealing your sexual orientation—something unique to members of sexual minorities—as a stressor. Thus, HIV-positive but healthy gay men were followed up for 9 years to assess factors that contributed to progression of HIV (e.g., moving from asymptomatic HIV infection to a diagnosis with an AIDS-defining disease, such as pneumonia). The researchers showed that HIV progressed more rapidly among men who concealed their gay identity than among those who disclosed it. This was true even after the investigators controlled for the effects of other potentially confounding factors, such as health practices, risky sexual behaviors, and medication use (Cole, Kemeny, Taylor, Visscher, & Fahey, 1996). More recent studies, conducted in the context of the availability of more effective HIV medications than were available in 1996, similarly

found that concealment of gay identity was associated with lower CD4 counts, which measure the progression of HIV disease (Strachan, Bennett, Russo, & Roy-Byrne, 2007; Ullrich, Lutgendorf, & Stapleton, 2003).

The effects of concealment can be injurious in less medically vulnerable individuals too. In a study of HIV-negative gay men, Cole, Kemeny, Taylor, and Visscher (1996) showed that men who concealed their gay identity experienced a higher incidence of disease—including infectious diseases and cancer—than men who did not conceal their gay identity. As in the research on HIV-positive men, concealment was found to have a deleterious effect on health outcomes even after controlling for the effect of other potentially confounding factors, such as coping styles, health behaviors, and mental health problems. Other studies examined other aspects of the minority stress model. For example, Huebner and Davis (2007) studied the impact of experiences of discrimination on gay and bisexual men's health, and found that exposure to discrimination was related to outcomes such as number of sick days and number of physician visits.

Many other studies assessed the role of minority stressors in promoting risky behavior, especially HIV-related risk. For example, Hatzenbuehler, Nolen-Hoeksema, and Erickson (2008) assessed minority stress processes in a sample of bereaved gay men. They found that minority stressors, including internalized homophobia, discrimination experiences, and expectations of rejection, were associated with HIV risk behavior. Similar findings—assessing various aspects of minority stress processes and sexual risk outcome—were reported in other populations: Latino gay and bisexual men and transgender persons (Bruce, Ramirez-Valles, & Campbell, 2008; Nakamura & Zea, 2010); white and Latino lesbian, gay, and bisexual young adults (Ryan et al., 2009); gay/bisexual/two-spirit American Indian men (Lehavot, Walters, & Simoni, 2009); rural men who have sex with men (Preston, D'Augelli, Kassab, & Starks, 2007); and transgendered women of color (Sugano, Nemoto, & Operario, 2006).

One possible mechanism that explains how minority stressors increase high-risk sexual behaviors may be that they lead to the use of drugs and alcohol during sexual experiences, which reduces condom use (Kashubeck-West & Szymanski, 2008; Nakamura & Zea, 2010). For example, it is possible that drugs and alcohol may be used during sex to reduce the self-reproach associated with internalized homophobia (Meyer & Dean, 1998). Another possible explanation for this association is increased fatalism regarding HIV risk among men with high levels of internalized homophobia. Yi and colleagues found that men with high levels of internalized homophobia demonstrated high levels of fatalism regarding the eventuality of becoming infected with HIV, which were in turn associated with increased HIV risk behavior (Yi, Sandfort, & Shidlo, 2011). In other words, minority stress, in the internalization of the cultural stereotype about gay men as "disease vectors," may produce a self-fulfilling prophecy, increasing HIV risk-taking behavior among gay men. Johnson, Carrico, Chesney, and Morin (2008) extend this pattern of findings to explain further health risk in the form of nonadherence to antiretroviral therapy among HIV-positive gay men. Namely, increased internalized homophobia was associated with more anxiety and substance use, which resulted in increased sexual risk taking and decreased adherence to HIV treatment regimens among gay-identified men. It is important to note that much of this research is cross-sectional, and future research is needed to document the causal directions of these relationships.

Although few studies have examined the relationship between minority stress and physical health outcomes among sexual minority women, evidence suggests a pressing need for such research. Most notably, Cochran and Mays (2007) found more physical health problems among sexual minority women compared to heterosexual women, but sexual orientation differences were attenuated when feelings of distress were controlled for. Further evidence exists with regard to specific physical health conditions and negative health behaviors for which sexual minority women are at greatest risk. For example, rates of smoking are higher among lesbian and bisexual women compared to sexual minority men and heterosexual men and women (Blosnich & Horn, 2011; Hughes, Johnson, & Matthews, 2008). However, despite the higher prevalence of smoking behavior, sexual minorities do not differ from heterosexuals in terms of knowledge of the risks associated with smoking, a common determinant of smoking behavior (Pizacani et al., 2009). This suggests that other factors unique to the experiences of lesbian and bisexual women, including minority stress, may account for this disparity. Additionally, lesbian women tend to more often be overweight

compared to heterosexual women (see Bowen, Balsam, & Ender, 2008 for a review). Recent qualitative findings suggest that experiences of minority stress—in the form of concealment, shame, and general feelings of oppression—are major factors in producing this weight-related health disparity (Roberts, Stuart-Shor, & Oppenheimer, 2010). Further research is necessary to adequately understand the connection between minority stress and the physical health of sexual minority women.

INTERPERSONAL RELATIONSHIPS: INTIMACY AND WORK ENVIRONMENT

The discussion of minority stress processes and outcomes above focuses on mental and physical health outcomes. However, there is a growing body of research aimed at extending the minority stress model to explain outcomes in other areas central to the health and well-being of lesbian, gay, and bisexual individuals. These include interpersonal romantic relationships (e.g., Frost, 2011a, 2011b; Frost & Meyer, 2009), parenting (e.g., Bos & van Balen, 2008; Weber, 2008), the workplace (e.g., Fassinger, 2008), and crime and incarceration (e.g., Jones et al., 2008).

Intimate Relationships

Lesbian, gay, and bisexual individuals in interpersonal romantic relationships are subject to minority stressors that are distinctively products of the social, political, and cultural devaluation of same-sex sexualities, relationships, and intimacy (Frost, 2011a, 2011b; Frost & Meyer, 2009; Rostosky, Riggle, Gray, & Halton, 2007; Todosijevic, Rothblum, & Solomon, 2005). Minority stressors may affect lesbian, gay, and bisexual people's experiences within and in pursuit of relationships because of discrimination and stigmatization from other people in their lives. Sexual minority individuals in same-sex relationships experience stigmatization specific to their relationships on an interpersonal level (Diamond, 2006; Green & Mitchell, 2002; Peplau & Fingerhut, 2007). Compared to single lesbian, gay, and bisexual individuals, those in relationships may experience greater stress related to not being accepted, especially by their families (Lewis, Derlega, Berndt, Morris, & Rose, 2001). These types of minority stressors make it difficult for individuals in, or desiring to be in, same-sex relationships to achieve their needs and goals for intimacy (Frost, 2011a), which puts them at risk not only for poorer well-being and mental health, but also for decreased relationship quality (Caron & Ulin, 1997; Frost & Meyer, 2009; Meyer & Dean, 1998; Otis, Rostosky, Riggle, & Hamrin, 2006; Todosijevic, Rothblum, & Solomon, 2005).

These findings can extend to the sexual domain as well (McClelland, 2010). For example, although similar factors predict sexual satisfaction for heterosexual and sexual minority women, internalized homophobia exerts an additional negative influence on sexual minority women's sexual satisfaction. Although very little research has focused on experiences of intimacy for lesbian, gay, and bisexual individuals not in relationships, preliminary findings suggest experiences of internalized homophobia can have a negative effect on intimacy-related outcomes such as generalized sexual problems, loneliness, and other relational strains (Frost & Meyer, 2009).

In the late 1990s and early 2000s public debate on same-sex marriage was ignited by election campaigns and court decisions that suggested that such marriages may become legal in some states. Such public debate and legal battles about the place of same-sex marriages in American society, which often took overtly hostile tones, exacerbated stress faced by lesbian, gay, and bisexual persons, including those in intimate relationships. Voter initiatives such as California's Proposition 8, which added to California's constitution a definition of marriage as only between a man and a woman, and the Defense of Marriage Act, passed by Congress in 1996, which prohibits the United States from recognizing same-sex marriages performed in states or other nations, add to minority stress for lesbian, gay, and bisexual people by reminding them of social disapproval of their relationships (Herek, 2006; Riggle, et al., 2010; Russell & Richards, 2003). The passage of anti-same-sex marriage policies frustrates and devalues the pursuit of same-sex intimacy (Frost, 2011a). Furthermore, the uncertainty of the legal status of same-sex partnerships creates relational uncertainty regarding couples' lives together, including raising children and property rights. Particularly painful is the effect on end-of-life planning, as uncertainty and hostile laws disrupt the protective functions that relationships serve (de Vries, Mason, Quam, & Acquaviva, 2009).

Minority Stress at the Workplace

Lesbian, gay, and bisexual people face high levels of discrimination and harassment in the workplace

when compared with heterosexual people. Analysis of data from the General Social Survey (GSS), a national probability survey representative of the U.S. population, found that, 27% of lesbian, gay, and bisexual respondents had experienced at least one form of sexual orientation-based discrimination during the 5 years prior to the survey (Sears & Mallory, 2011). Research has consistently demonstrated that lesbian, gay, and bisexual people frequently face the challenge of negotiating minority stressors in the workplace (e.g., Fassinger, 2008; Ragins, Singh, & Cornwell, 2007; Huffman, Watrous-Rodriguez, & King, 2008). Waldo (1999) showed a relationship between employers' organizational climate and the experience of heterosexism in the workplace, which was related to adverse psychological, health, and job-related outcomes in lesbian, gay, and bisexual employees. Heterosexual and nonheterosexual individuals do not receive equal protection under the law regarding workplace rights. Although some states in the United States have laws protecting workers' rights, no Federal law exists to protect lesbian, gay, and bisexual workers from employment discrimination. Thus, minority stress persists in many job-related contexts in both structural and interpersonal forms. Structurally, such stress may result from the sense that an employer treats lesbian, gay, and bisexual persons and their families unfairly when, for example, an employer denies health and other benefits to nonheterosexual employees. Stressors may also include being treated with disrespect by supervisors and other employees.

Stigma concealment is a commonly experienced minority stressor for lesbian, gay, and bisexual people within the workplace. Analysis of the 2008 GSS data showed that more than a third of lesbian, gay, and bisexual employees had not disclosed their sexual identities to anyone at work and that only 25% were out to all of their co-workers (Sears & Mallory, 2011). The 2008 GSS data showed that lesbian, gay, and bisexual employees who were more open experienced more discrimination and harassment at work than those who were less open (Sears & Mallory, 2011). Lesbian, gay, and bisexual people who successfully conceal their sexual identity at work do not, however, avoid the harm of minority stress (Pachankis, 2007). The cognitive burden associated with hypervigilance and concealment can have negative effects on various indicators of job performance and satisfaction (Ragins et al., 2007). Lyons and colleagues found that greater heterosexism in the workplace led to a decreased perceived fit within the workplace, which in turn predicted lower job satisfaction among lesbian, gay, and bisexual employees (Lyons, Brenner, & Fassinger, 2005). It is in many companies' and employers' social and economic best interests to address the needs of nonheterosexual workers (King & Cortina, 2010) because minority stress remains a persistent hindrance to workplace performance and satisfaction for lesbian, gay, and bisexual workers (Fassinger, 2008).

Structural interventions to reduce workplace minority stress would enact laws and regulations that protect lesbian, gay, and bisexual persons at the workplace. At present, some states and localities within the United States have enacted laws against sexual orientation-based workplace discrimination, and some have also enacted laws that protect against discrimination based on gender identity, but there is as yet no national law to prohibit workplace discrimination based on sexual orientation and gender identity in the United States.

DISCUSSION

The minority stress model has guided research in many areas documenting the impact of the social environment on lesbian, gay, and bisexual people's health and well-being (Institute of Medicine, 2011). Minority stress is helpful as an organizing model that can point researchers to the various factors that affect lesbian, gay, and bisexual people's health and well-being, such as trauma, internalized homophobia, or coping. The model can be useful for both research and interventions.

Interventions based on Minority Stress

The minority stress model can be used as a framework to guide multiple forms of interventions targeted at reducing the negative effects of minority stress (Ouellette, 1998). Figure 18.2 shows how elements of the model can point to various interventions sites and delivery methods (in the ovals), such as structural changes or service provision. The minority stress model reminds us that any one intervention site may not suffice and that multiple sites ought to be considered. An organized approach to prevention and intervention that uses the minority stress model would address the various areas impacted by minority stress and do so at various levels of intervention. Interventions

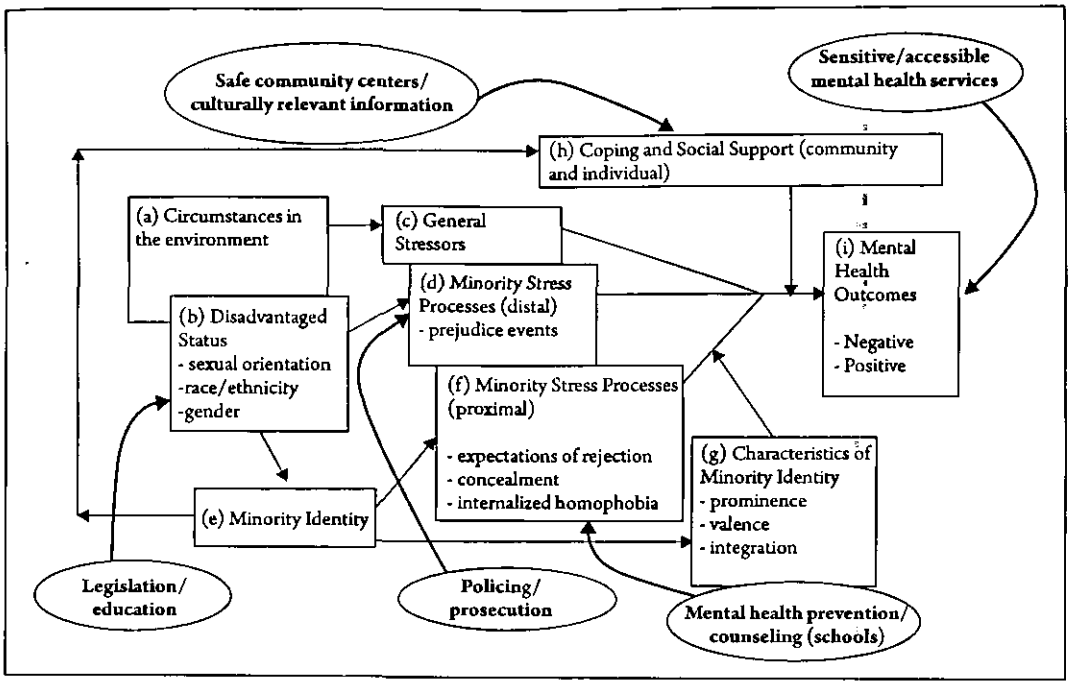

FIGURE 18.2. Intervention Sites Suggested by the Minority Stress Model (in the Oval Boxes).

at the structural level would institute protections from a stressful environment. For example, laws that protect lesbian, gay, and bisexual people from prejudice, discrimination, and violence would help to reduce the occurrence of prejudice-related stressors. Among such structural interventions are laws that respect gay men and lesbians' intimate relationships by providing them access to marriage and the benefits afforded to heterosexual married people and their families. The current version of a federal Employment Non-Discrimination Act (ENDA) would protect lesbian, gay, bisexual, and transgender people from discrimination in the workplace—another example of a legislative intervention that would protect lesbian, gay, bisexual, and transgender people at the structural level.

Other areas for intervention at the personal level would include, for example, culturally competent health and mental health services. The minority stress model points to resources that help members of sexual minorities cope with minority stress. Few researchers have developed and assessed interventions that explicitly address minority stress processes. However, a good example of an intervention that has proven impact in the area of HIV/AIDS prevention is the Mpowerment intervention (Hays, Rebchook, & Kegeles, 2003). By seeking to empower young gay and bisexual men, this intervention targets some core minority stress processes. Unfortunately, little intervention research has addressed issues other than HIV/AIDS prevention in lesbian, gay, and bisexual populations.

Critiques of Minority Stress Theory

It is important to consider critiques of minority stress theory. By addressing and considering critiques, a theory can be better articulated and, hopefully, improved. One critique of the minority stress model is a general one that notes that there has been much positive change in the social environment of sexual minorities, and that lesbian, gay, and bisexual people—especially sexual minority youth—are no longer exposed to minority stress. Because of social changes over the past few decades in Western societies, with social attitudes becoming more accepting of homosexuality, this critique suggests that lesbian, gay, and bisexual people no longer encounter the minority stressors as described by the model. The critique suggests that the minority stress model is no longer a viable psychological model. As Savin-Williams, one proponent of this view, wrote in *The New Gay Teenager* (2005), "The culture of contemporary teenagers easily incorporates its homoerotic members. It's more than being

gay-friendly. It's being gay-blind" (p. 197). He also states, "What if young people with same-sex desires are basically content with modern culture...? Maybe real changes in society's politics, laws and consciousness toward gay people have raised the possibility that sexual orientation is or will soon be irrelevant in all important respects" (p. 194).

This critique is correct to some degree because as a social theory, minority stress assumes the existence of certain stigmatizing social conditions. If these have changed, then the theory would require revision. But any theory should be assessed based on empirical evidence. New evidence would provide a good direction for future research and for elaboration and growth of theory. For example, if this critique is fundamentally correct, research should find no differences among lesbian, gay, bisexual, and heterosexual youth in their levels of stress and related mental health outcomes.

Empirical findings do not support this view. Neither condition outlined above—that lesbian, gay, and bisexual people experience no more stress than heterosexual people, or that they do not have more health and mental health problems—is satisfied. Thus, to conclude that we live in a gay-blind (*some say, postgay*) society that *is* equally accepting of heterosexual and nonheterosexual people is simply wrong (Herek, 2009b). Even with the many advances in social acceptance of sexual minorities over the past few decades, there is still considerable evidence of pervasive bullying of school children because they are perceived to be lesbian, gay, or bisexual (Blow, 2009; Tharinger, 2008). Surveys of sexual minority youth report that they are more likely than their peers to encounter chronic harassment, such as being called derogatory names, and that such name-calling is in fact commonplace. A survey by the Gay, Lesbian, and Straight Education Network found that as many as 85% of sexual minority students were called names or were threatened at school (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010). Friedman and colleagues (2011) conducted a meta-analysis of studies examining antigay environments in schools. Compared to heterosexual youth, sexual minority youth were 170% more likely to be assaulted at school and 240% more likely to miss school due to fear that they would be unsafe at school or on their way to or from school. In particular, 40% of lesbians, 44% of bisexual females, 43% of gay males, and 50% of bisexual males were assaulted at school and 16% of lesbian females, 23% of bisexual females, 14% of gay males, and 23% of bisexual males missed school because they feared for their safety.

Studies have also shown that unlike other minority groups, rejection can occur at home, and antigay victimization can be perpetrated by family members of sexual minority children and youth (D'Augelli, Hershberger, & Pilkington, 1998; Diamond et al., 2011; Ryan, et al., 2009). For example, in one study, a gay man recalled being raped and brutally beaten to unconsciousness at age 13 by a family member who, in the respondent's words, "raped me because I was gay and to teach me what a faggot goes through" (Gordon & Meyer, 2008, p. 62). There is strong evidence as well of boys and girls who were thrown out of their homes and became homeless because of their family's rejection of their homosexuality (Ryan et al., 2009). In one probability study of high school students conducted in Massachusetts, 16% of sexual minority youth as compared with 3% of heterosexual youth were homeless for various reasons, although not necessarily as a result of being rejected by their families (Fournier et al., 2009). In short, research has found that stigma and discrimination against nonheterosexual youth still exist, and that many lesbian, gay, and bisexual adolescents and young adults suffer from minority stress.

Future Directions

Although researchers have developed many areas of study, there are areas of minority stress research that need to be addressed in the future.

Improved measures. First, researchers need to develop more focused measures of minority stress. For example, one area that has not been well described is the experience of minor stressors, also referred to as daily hassles or everyday discrimination. Such stressors can have a great impact on well-being by reminding the lesbian, gay, or bisexual person of his or her disadvantaged status. Filling out an administrative form that inquires about marital status by asking about "spouse" but does not provide language that accounts for long-term same-sex partners is something that many lesbians and gay men describe as distressing. We do not have well-developed quantitative measures and do not fully understand the impact of such minor events. Are they merely annoyances that can be easily shrugged off, or do they have a more profound

and cumulative impact on the well-being of lesbian, gay, and bisexual individuals?

On the other end of the stress continuum, researchers have not yet developed measures that assess the social environment without relying on self-report data. Subjective assessments of exposure to prejudice may be biased both by overreporting and underreporting exposure to negative prejudice-related stress (Meyer, 2003b). For example, Meyer et al., (2008) found that lesbian, gay, and bisexual people experience more minority stress than heterosexual people when stress was assessed objectively by the researchers, but when the researchers assessed subjective experiences of stress, sexual minority individuals did not report greater exposure to stress than did heterosexual people. One example of an objective measure is the categorization of states with and without laws that protect members of sexual minorities (Hatzenbuehler, et al., 2009). The authors found a more pronounced minority stress effect on mental health in states without protections as compared with states with protections for lesbian, gay, and bisexual people (see also Hatzenbuehler, 2011). Another example is research (Heck, Flentje, & Cochran, 2011) that assessed the mental health of youth in schools that have a Gay-Straight Alliance compared with those that do not. These studies found that students in schools with a Gay-Straight Alliance reported lower psychological distress, less alcohol use, and higher self-esteem than did those in schools without these groups.

Minority stress across the life course. Two other areas that are underdeveloped are interrelated. We need to better understand minority stress across the life course, and contextualize minority stress within a continually shifting social environment. Clearly the social environment of lesbian, gay, and bisexual persons has been shifting in many important ways. This is true both in terms of global historical social changes and developmentally during an individual's lifespan. As a person moves across the lifespan he or she can change the social environment significantly. For example, peer environments of young people may be more accepting than the environment they will find as they enter the work force. In contrast, older lesbian, gay, and bisexual people moving to retirement homes and related facilities may find them less accommodating.

The role of identity in minority stress. Another area that is not well understood is how identity dimensions are related to the experience and impact of minority stress. Identity dimensions include prominence (how central a person's sexual minority identity is to their sense of self), valence (how positive or negative the identity is), and integration (how strongly connected to one another are sexual minority and other identities) (Meyer, 2003a; Stirratt, Meyer, Ouellette, & Gara, 2008). There are two questions that need elaboration. First, what is the impact of prominence of identity? Although the model (Figure 18.1) suggests that identity will interact with the effect of stress on health outcomes—for example, the greater a person's identification with a sexual minority identity, the more harm there is from a stressful event in that area—little research has examined this relationship. Moreover, there are conflicting hypotheses and evidence regarding this relationship. One hypothesis suggests that a prominent identity may make someone more sensitive to stress in that realm, and therefore there would be greater impact for a stressor in an identity area. The other hypothesis is that a more prominent identity will generate better coping and resources to ameliorate the impact of stress. Little evidence exists to answer these questions. Models of identity integration have yet to be developed that take into account the complexities of the process. Models of coming out employed relatively simplistic notions of identity, focusing on sexual minority identity alone with little consideration of its relationship to other social identities. A more useful model involves identity hierarchies that encompass various identities and their intersections (Rosenberg, 1997; Eliason & Schope, 2007). Stemming from this recognition is the intersectionality perspective, which suggests that the experience of diverse groups, such as those defined by gender, race/ethnicity, class, and sexual orientation, cannot be easily captured by adding knowledge about each group alone. That is, combining of separate knowledge about black women with knowledge about lesbian women is not sufficient to understanding the unique experiences of black lesbian women (Bowleg, 2008). Other aspects of diversity include bisexual men and women, nongay identified men who have sex with men and women who have sex with women, urban/rural lesbians and gay men, those of varying socioeconomic levels, immigrants, and so forth. Research in this area is

growing (e.g., Bowleg, 2008; Purdie-Vaughns & Eibach, 2008; Stirratt et al., 2008). Greater attention to how minority stress processes impact various intersectional groups would, however, help to achieve better understandings of health and well-being within these populations.

CONCLUSIONS

The minority stress model has been a useful and productive model to understand and address disparities in health outcomes among lesbian, gay, bisexual, and heterosexual populations. The model points to social stress processes caused by prejudice and stigma, such as experiences of victimization of different types, ranging from harassment to hate crimes, and the internalization of negative social attitudes. The model also points to the importance of considering resiliency factors—such as social support and coping resources—in considering causes of health outcomes. Ultimately, according to the model, health outcomes are determined by the balance of positive (coping and social support) and negative (stressors) effects. Future work must take this balance into account to better understand and improve the health and well-being of lesbian, gay, and bisexual individuals and communities.

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