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Sexual Orientation as Social Justice Fault Line: The Role of Stigmatised Identities and Minority Community Solidarity in Social Inequalities in Wellbeing

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Introduction

On 1 April 2001, the Netherlands became the first country where same-sex couples could legally marry in the modern era. By 2020, this was possible in (parts of) 28 United Nation (UN) member states, mostly in Europe, the Americas and Australasia (Mendos et al., 2020). Over the past two decades, changes in social norms and laws occurred in many, mainly Western countries, reflecting increased social acceptance and equal rights of people in same-sex relationships (Poushter & Kent, 2020). However, heteronormativity, the presumption and privileging of **gender conformity** and heterosexuality (Oswald et al., 2009), prevails and affects the lives of lesbian, gay and bisexual (LGB) people, and of other sexual orientation (see Box 15.1) or **gender identity** minority people (Pollitt et al., 2021).

In this chapter, we address how sexual orientation acts as a social justice fault line. We limit ourselves to social science research and theory originating in Western countries to examine and explain the social inequalities experienced by LGB people. Our focus is on increased rates of adverse mental health outcomes of LGB people compared to their heterosexual peers. We recognise the manifold social injustices and their serious impacts experienced by transgender people but cannot appropriately cover these in the context of this chapter and in light of our own specific expertise. Occasionally we refer to research regarding LGB people that also includes **transgender people**, which we note explicitly. Drawing on contemporary theory and evidence, we address the psychosocial mechanisms underlying social inequality in mental health by sexual orientation, highlighting the role of stigmatised social identities that reflect negative stereotypes. We complete the chapter by exploring how various forms of solidarity are critical for rectifying social injustices and mitigating their impacts.

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Box 15.1 Defining Sexual Orientation

Sexual orientation is an enduring pattern of sexual interest directed towards people of one or more genders, which may be the same as or different from the individual's gender (cf. Bailey et al., 2016). Heterosexual (straight), homosexual (gay or lesbian), and bisexual are commonly used sexual orientation labels (Sell & Petrulio, 1996). Sexual orientation is a multidimensional construct (Ashmore et al., 2004), encompassing sexual attraction, sexual behaviour, and **sexual identity**. These components need not overlap, as, for instance, same-sex attracted people may not sexually act on their erotic desires, and people with same-sex experiences may not personally or publicly identify as lesbian, gay or bisexual.

Social Inequality Affecting Lesbian, Gay and Bisexual People

Surveys in Western societies generally find that less than 5% of people have a predominant same-sex interest (Bailey et al., 2016). It is then perhaps unsurprising that heterosexuality is socially expected and valued as the natural and normative sexual orientation. However, this heteronormativity devalues other expressions of sexuality (Warner, 1991), and LGB minority people have long remained unacknowledged and unaccepted, if not criminalised. According to a 2020 global overview of legislation related to sexual orientation (Mendos et al., 2020), 69 UN member states continued to criminalise consensual same-sex sexual activities. In addition, at least 41 UN member states had some legal barriers that affected freedom of expression related to sexual orientation and gender identity diversity. On a positive note, while only 11 UN member states provided constitutional protection from sexual orientation discrimination, 57 UN member states had laws providing broad protection from sexual orientation discrimination, and 81 UN member states had legal protections from sexual orientation discrimination in employment. Also, 28 UN member states allowed same-sex marriage, and 34 recognised same-sex partnerships.

Data from a 2019 survey conducted in 34 countries show a persistent divide between countries in the social acceptance of homosexuality, with highest rates in wealthiest countries (Poushter & Kent, 2020). Acceptance rates were above 80% in Western Europe, Canada and Australia, and higher than 90% in Sweden and the Netherlands. The survey data also showed that, in many countries, younger generations, women, higher educated people, people with a left-wing political preference and non-religious people are more accepting of homosexuality. Nevertheless, social acceptance is also increasing and conforming to dominant attitudes in minority population groups with traditionally more conservative views of homosexuality, including ethnic/racial minorities (e.g., Glick et al., 2015), religious people (e.g., Schnabel, 2016) and migrants (e.g., van der Bracht & Van de Putte, 2014).

Despite the positive developments in legal frameworks and social acceptance, social inequalities persist between LGB people and their heterosexual peers. Increasing evidence shows that sexual orientation is associated with social inequalities in physical health, including poor self-rated health, increased risk of cancer, and higher rates of diagnoses of chronic conditions, such as cardiovascular disease, asthma, and diabetes (Lick et al., 2013). LGB people also experience earlier all-cause mortality (i.e., they die at a younger age from any cause) than heterosexual people, controlling for differences in demographic characteristics and HIV-infection in men (Cochran et al., 2016). Findings also showed that higher death rates in LGB people were associated with worse self-rated health, more recent distress, more health risks (i.e., overweight and hypertension), and more health risk behaviours (i.e.,

tobacco use and binge drinking). LGB people are also more likely to use alcohol and other drugs, and to experience abuse or dependence on alcohol and other drugs (e.g., Roxburgh et al., 2016).

Most research regarding sexual orientation-related social inequalities has been concerned with mental health (Bränström et al., 2016). This found that LGB people are more likely to experience depression and anxiety than heterosexual people and are more likely to make use of mental health services (Filice & Meyer, 2018). Setting the stage for later research, an early study in a representative sample in the United States found that rates of depression, panic attacks, and distress were higher in gay and bisexual men than in heterosexual men (Cochran et al., 2003). Also, rates of anxiety-related problems were higher in lesbian and bisexual women than in heterosexual women (Cochran et al., 2003). Improvements in legal equality and social attitudes may positively impact the wellbeing of LGB people. A study in a representative sample in the Netherlands found, however, that social inequalities in mental health problems related to sexual orientation persisted in the years after same-sex marriage was recognised (Sandfort et al., 2014).

Several LGB demographic and sexual orientation subgroups are at increased risk of adverse mental health outcomes. Importantly, LGB youth, as well as transgender youth, are found to be particularly vulnerable to mental health problems (Russell & Fish, 2016). These encompass emotional distress, symptoms and diagnoses of depression and anxiety, and problematic substance use. They are also at higher risk of self-harm, suicide thoughts and attempts than non-LGB youth. Bisexual people are also especially at risk of poor mental health. A systematic review of 52 studies found that rates of depression and anxiety in bisexual people were similar to or higher than those for lesbian and gay people; rates were lowest for heterosexual people (Ross et al., 2018).

Mental health problems are also particularly pressing among LGB and other non-heteronor mative refugees, especially those originating from Muslim-majority countries (Alessi et al., 2018). Refugees are not only at risk of victimisation (i.e., cruel or unjust treatment) and trauma (i.e., an overwhelming response to an extremely distressing event) in their country of origin. In their host country, LGB refugees continue to be at risk of sexual orientation-related violence and abuse from other refugees, and can experience discrimination based on race, religion, and immigration status from the host country population (Alessi et al., 2020; see also Chap. 14, this volume). LGB refugees may also be treated negatively and unfairly by interpreters and immigration officials (Alessi et al., 2018). Furthermore, LGB refugees are likely to experience the double injustice of having been persecuted for their sexual orientation in their home country, which may have resulted in keeping a low profile, and then having to fit Western expectations of living openly as an LGB person in order to convince officials the persecution they suffered was indeed due to their sexual orientation (see Morgan, 2006).

Box 15.2 Societal Views of Sexual Orientations and Gender Identities

The social disapproval of LGB people is deeply rooted in many religious teachings, notably the prohibition of sodomy, in Judaism, Christianity and Islam, as immoral and against the laws of nature. This prohibition at some point became enshrined in criminal laws in many countries, and the criminalisation of consensual same-sex activities prevails in some former British colonies and Muslim-majority countries in Africa and Asia (see Mendos et al., 2020). In 2020, the death penalty was required or possible for consensual same-sex activity in 11 of the countries that criminalize same-sex practices.

With the advent of modern medical science in the mid-nineteenth century, the term homosexuality came in use to designate deviant behaviour (i.e., behaviour that violates laws or social norms), and mental disorder. The American Psychiatric

Association removed homosexuality from its list of mental disorders only in 1973 (Silverstein, 2009). Nevertheless, conversion therapies, that is, therapies to 'cure' homosexuality, continue to be practised. The American Psychological Association (APA) cautions its members that such sexual orientation change efforts are not evidence-based, and that homosexuality is a normal and positive variation of human sexual orientation (Anton, 2010).

Drescher (2010) distinguishes three conceptual perspectives on the causes of homosexuality. These reflect different cultural contexts that shape understandings, social attitudes, therapeutic practices and public policy on same-sex practices and relationships. Despite changes in expert views, a persistent view of homosexuality among lay people is that it is a mental disorder. According to a more benign, but nevertheless disapproving, view, homosexuality is a sign of immaturity, a phase some young people go through but grow out of. In many contemporary societies, mostly in Western countries, the dominant view of homosexuality is that it is a natural variation. People holding this view are most accepting and consider sexual orientation as something innate (i.e., 'born this way'), and not as a choice reflecting a changeable preference.

Social Stigma, Minority Stress and Wellbeing of LGB People

Contemporary research and theorising of the increased mental health problems of LGB people sees these as caused by the social environments in which LGB people experience social disapproval (for a more extensive discussion, see Cochran, 2001). Various terms are used to refer to the social disapproval experienced by LGB people, including homophobia (i.e., negative feelings towards homosexual people), homonegativity (i.e., negative views of homosexuality), heterosexism (i.e., a bias in favour of heterosexuality), and heteronormativity (Lottes & Grollman, 2010). While distinct, these terms all reflect that non-heteronormative people often experience **social stigma**. Goffman (1963) originally defined social stigma as an attribute (i.e., bodily mark, behaviour or group membership) that is deeply discredited by society and reduces the person "from a whole and usual person to a tainted, discounted one" (p. 3). Socially stigmatised individuals are likely to experience societal rejection and a negatively evaluated, or 'spoiled', social identity (see Chap. 2, this volume).

Social stigma, including of LGB people, has been posited as a fundamental cause of social inequalities in health (Hatzenbuehler et al., 2013). Research has found that social stigma of LGB people is linked to their health behaviours, mental and physical health outcomes, and lack of resources that buffer or mitigate poor health (Hatzenbuehler et al., 2013; Rice et al., 2021). Link and Phelan (2001) posit that social stigma and its impacts results from consecutive social psychological processes that start with placing LGB people in a separate social category (i.e., a group of people that have one or more attributes in common), that is labelled as deviant in a society. Negative stereotypes (see Chap. 4, this volume) become attached to the label (e.g., gay, lesbian, bisexual), and the separation of 'us' from 'them' according to the label (i.e., ingroup-outgroup differentiation, see Chap. 4) results in status loss (i.e., devaluing) of LGB people. Status loss can result in discrimination of LGB people, which may be overt and blunt (e.g., physical violence) or covert and subtle (e.g., microaggressions – social interactions that contain, intentional or unintentional, denigrating messages). LGB discrimination is multidimensional, including general (public) discrimination (e.g., in stores, restaurants), verbal or physical victimisation (e.g., name calling, threats), and healthcare discrimination (e.g., with respect to insurance or treatment) (Rice et al., 2021).

Minority Stress Theory posits that social stigma and discrimination adversely affect the health and wellbeing of LGB people because they experience unique stressors related to their sexual orientation, in addition to general stressors

everyone can experience (Meyer, 2003). Minority Stress Theory distinguishes between distal and proximal minority stressors. Distal minority stressors are objective, stressful events and conditions (e.g., experiences of discrimination or violence), that can be one-off or repeat occurrences. Distal minority stressors affect the health and wellbeing of LGB people through proximal minority stressors. Proximal minority stressors are subjective experiences, and encompass expectations of rejection, concealment of one's sexual orientation, and internalised negative societal attitudes, commonly referred to as **internalised homonegativity**. The term **internalised homophobia** also remains in use and internalized biphobia/negativity are used to specifically refer to the experiences of bisexual people. The theory further posits that self-identification as a sexual minority can result in the experience of further stressors because of perceiving the self as socially stigmatised and devalued. Self-identification can also strengthen or weaken the impact of stressors, depending on the prominence (i.e., importance) of a person's LGB identity to themselves. Minority Stress Theory underscores that self-identification can also be a source of strength, by providing opportunities for affiliation, social support, and coping. Social support and coping resources, that may originate from community or family, can buffer the impact of minority stressors, and include individual strengths, such as self-esteem and pride.

Meyer (2003) provided an early overview of research into the relationship between minority stressors and the mental health of LGB people. More recently, a systematic review of 62 studies reported substantial support for associations between minority stressors and depression, suicide thoughts and attempts, and substance use among lesbian, gay, bisexual as well as transgender people (Mongelli et al., 2019). Internalised homonegativity is a particularly impactful minority stressor that is found to be associated with adverse mental health in a growing body of research (Berg et al., 2016). There is also much research into the association between efforts to conceal their sexual orientation and the mental health of LGB people. Sexual orientation concealment is hypothesised to have mixed effects, including protecting against discrimination, generating stress from hiding one's identity, precluding access to beneficial community supports, and reduced exposure to potentially harmful norms and practices, such as regarding substance use (Pachankis et al., 2020).

A review of almost 200 studies found a small, positive association between sexual orientation concealment and mental health problems (i.e., depression, anxiety, distress) (Pachankis et al., 2020). These findings may reflect a negative effect of the stress of hiding one's sexual orientation, and/or absent or limited access to community support. A small, negative association was found between sexual orientation concealment and substance use problems. This may reflect that people who conceal their sexual orientation are likely less involved in LGB communities and less exposed to substance use norms and practices. In contrast, research has also shown that disclosure of one's sexual identity can have positive consequences, including less anxiety, more positive feelings, and greater self-esteem, social support, and involvement in the lesbian and gay community (Jordan & Deluty, 1998). There is also evidence that LGB people experience better mental health if they develop pride in their sexual identity and can integrate their sexual identity as one aspect of a broader self-concept (i.e., how someone thinks about themselves; Halpin & Allen, 2004).

Box 15.3 Sexual Identity Development

Conceptualising sexual orientation as a naturally varying, inborn characteristic implies that, at some point in their life, LGB people become aware that their sexual interests are different from the majority of people (Kitzinger & Wilkinson, 1995). This awareness typically arises during adolescence but may also occur at a later age. Awareness of one's non-normative sexual orientation poses psychological and social challenges related to self-acceptance as well as public disclo-

sure (Mosher, 2001). Coming to terms with one's sexual orientation is generally thought to require that LGB people accept and integrate their non-normative sexuality into their self-concept, which is seen as a precondition for 'coming-out (of the closet)' to others as an LGB person (Mosher, 2001). A supportive social environment can contribute to self-acceptance (Vincke & Bolton, 1994).

The process of sexual identity formation is predominantly captured in so-called stage models of sexual identity development that have been proposed and critiqued since the 1970s (Bilodeau & Renn, 2005). Focused on the resolution of internal conflict, these models have in common that they posit a series of identity development stages, although labelling may differ. As summarised by Bilodeau and Renn (2005), stage models start with a denial stage, followed by gradual recognition and acceptance. Subsequently, a period of experimentation with sexual attraction and/or sexual behaviour is thought to occur, as well as a growing sense of normality. Increasing self-acceptance enables a sense of sexual identity that becomes an integrated, positive aspect of one's self-concept.

While useful as a mental shortcut, stage models also have limitations. Sexual identity development is more fluid than discrete stages suggest, and not all individuals with same-sex sexual interest develop an LGB identity or publicly come out. Also, sexual identity development as a non-heterosexual person today is likely different from when stage models originated, and sexual identity development may differ between cultural settings.

Solidarity to Achieve Social Justice for LGB People

The past and present success of the quest for social acceptance and legal equality for LGB people is premised on the solidarity of LGB people with each other, and the solidarity of straight (i.e., heterosexual) allies. Straight allies can have diverse motives, which, as summarized by Russell (2011), reflect fundamental principles (e.g., social justice, civil rights) or personal experiences or roles (professional roles, family relationships). Gay-straight alliances are a prominent contemporary example of how LGB people work together with straight allies. Gay-straight alliances are student-led initiatives that aim to create safe and supporting school environments for LGB young people. Broader gender-sexuality alliances are explicitly inclusive of transgender young people. Research found that lesbian, gay, bisexual, transgender as well as questioning students attending schools with a gay–straight alliance experienced less bullying and reported less health and wellbeing concerns, such as depression, sleep problems, and unhealthy weight control (Lessard et al., 2020). Also, personal contact with LGB people promotes positive attitudes and ally behaviour in straight young people (Heinze & Horn, 2009; Scheer & Poteat, 2016), and adults (Henry et al., 2020).

Moreover, the coming together of LGB people, and their allies, enables the **social activism** that is critical to achieving social justice for LGB people. Notably, social activism requires and contributes to building, organising, and empowering **LGB(T) communities**, and LGB people link a sense of belonging to an LGB community to better wellbeing (Formby, 2012). LGB community activism encompasses promoting the visibility and self-affirmation of LGB individuals and communities. Pride events (e.g., the Pride Amsterdam Canal Parade) and organisations (e.g., Workplace Pride) are an important feature of this strengths-based (i.e., focused on positive

Fig. 15.1 LGBT-free zones sticker by Gazeta Polska. (Retrieved 24 July 2021, from https://commons.wikimedia.org/wiki/File:02019_1570_LGBT_free_zone,_cursed_rainbow,_Gazeta_Polska_stickers.jpg)

attributes) model of social activism. Research has found that the public disclosure of one's sexual orientation enabled by pride events and organisations can make important contributions to empowerment and reducing self-stigma in LGB people (Corrigan et al., 2013).

In Western countries, social activism of LGB communities has been critical to successful **LGB emancipation** (Bernstein, 2002), which is reflected in increasing social acceptance and legal equality, including the abolishing of criminalising and discriminating laws. However, the social environment in many countries continues to be unsupportive or may even be increasingly hostile of LGB people. This is, for instance, the case in countries in Central and Eastern Europe, where conservative municipalities and regions declared themselves 'LGBT free' (see Fig. 15.1). Unsupportive and hostile social environments reflect a lack of solidarity and can adversely affect the health and wellbeing of LGB people. This is underscored by a study of gay, bisexual, and other men who have sex with men in 38 European countries, which showed that the national social environment was associated with differences in sexual identity concealment or disclosure that affected HIV risk and prevention behaviours (Pachankis et al., 2015).

Conclusion

Sexual orientation is a social justice fault line associated with social inequalities in the health and wellbeing of LGB people. Social activism is required to address sexual orientation-related health gaps, similar to social action on social inequalities in health related to socio-economic position (Marmot, 2017; see Chap. 11, this volume). Sexual orientation stigma in particular is a fundamental cause of social inequalities in health (Hatzenbuehler et al., 2013), which adversely affects LGB people through the additional stressors they face (Meyer, 2003). Mitigating social stigma is an essential social policy goal to promote the health and wellbeing of LGB people, and a critical component of interventions to promote the health of LGB people that might otherwise be less effective (Layland et al., 2020). LGB communities founded on the solidarity between LGB people, and of their allies, are essential to enabling social activism for equal rights and creating supportive environments. Social activism is especially needed to address the LGB-related social stigma that remains structurally embedded in the laws, policies, and norms of many societies (Hatzenbuehler, 2016). Ultimately, the health and

wellbeing of all people benefits from living in a society with a high level of social acceptance of LGB people (van der Star & Bränström, 2015).

Glossary

Gender conformity: people's behaviours that are in accordance with culturally prescribed gender roles, that is, expectations for how men and women are expected to behave.

Gender identity: people's personal sense of being female, male or something else, which can be aligned with or differ from their assigned sex (i.e., based on physical characteristics), and need not be binary female or male (e.g., nonbinary).

Internalised homonegativity: subjective experiences that include expectations of rejection, concealment of one's sexual orientation, and internalised negative societal attitudes related to (also) being attracted to people of one's own gender.

Internalised homophobia: older term sometimes considered synonymous with internalized homonegativity, which has been criticised for a limited focus on experiences of fear and avoidance.

LGB communities: more broadly referred to as LGBT (lesbian, gay, bisexual, and transgender) communities (historically: gay communities); loose groupings of organizations and subcultures that can be geographically bounded (e.g., city, country) as well as internationally connected.

LGB emancipation: also LGBT emancipation or (historically) gay liberation; the social process (including social activism and advocacy) through which lesbian women, gay men, bisexual, and transgender persons have sought equal rights and social opportunities.

Sexual identity: how a person thinks about their own sexual orientation, that is, the gender(s) to which they are (mostly) attracted (e.g., gay, lesbian, bisexual, pansexual).

Social activism: a form of working together with others that challenges existing social structures and beliefs (i.e., the status quo) to bring about social change, typically to improve the situation of more disadvantaged groups in society.

Social stigma: the social discrediting of people based on a specific, perceivable characteristic, notably a bodily mark, behaviour, or group membership.

Transgender people: transgender (also: trans) refers to people whose gender identity differs from the sex they were assigned at birth.

Comprehension Questions

1. Explain in your own words what sexual orientation means. Include how this is similar to, or different from, sexual attraction, sexual behaviour, and sexual identity.
2. What is social stigma according to Goffman (1963)? How do Link and Phelan (2001) explain the relationship between social stigma and discrimination? Use your own words.
3. How does Minority Stress Theory explain differences in health between sexual minority and sexual majority people? Mention specific distal and proximal minority stressors.

Discussion Questions

1. Pride events are annual festivals or parades in cities around the world to celebrate social and self-acceptance and underscore the importance of equal rights of lesbian, gay, and bisexual people as well as transgender people. Pride events are sometimes criticised for having too much of a focus on sex and eccentricity, which gets highlighted in the media and may not do much good for the social acceptance of lesbian, gay, bisexual, and transgender people. What is your view on pride festivals and their contribution to self- and social acceptance? What do you base your view on?
2. Addressing social injustices related to sexual orientation can be done through multiple

forms of solidarity, including the solidarity of LGB people with each other, the solidarity of straight (i.e., heterosexual) allies, or combinations of solidarity. Which form of solidarity do you think is most critical for rectifying social injustices related to sexual orientation? Why?

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