Comment

Does an improved social environment for sexual and gender minorities have implications for a new minority stress research agenda?

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Prejudice and stigma have been central to our understanding of the health and wellbeing of LGBT people using the minority stress perspective. Minority stress research has explained adverse health outcomes in LGBT populations and health disparities between LGBT and heterosexual cisgender populations. Recent shifts in the social environment of LGBT people in some regions of the world allow them to experience a more accepting and inclusive society. These changes require that social scientist adapt their research agenda. The author calls for researchers to explore changes in stigma and prejudice toward sexual and gender minorities; assess the impact of changes in the social environment on the lived experiences of LGBT persons across generations and intersections of race/ethnicity, gender and gender expression, and socioeconomic status; describe changes in stress and coping of LGBT people; and examine whether social changes lead to reduction in health disparities by sexual orientation and gender diversity.

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THE PUBLICATION of this issue of the *Review* coincides with the May 17, 2016 International Day Against Homophobia, Transphobia, and Biphobia (IDAHOT), which, according to its website, was 'created in 2004 to draw the attention of policymakers, opinion leaders, social movements, the public and the media to the violence and discrimination experienced by LGBTI people internationally.' Indeed, the experience of homophobia, transphobia, and biphobia has been central to our understanding of the health and wellbeing of LGBT people, leading to the formulation of minority stress theory (Meyer, 1995, 2003).

Minority stress is the most prominent conceptual model explaining the health and health disparities of LGBT populations (Bockting et al., 2013; Hendricks & Testa, 2012; Herek & Garnets, 2007). The Institute of Medicine (IOM, 2011) described minority stress as one of four core perspectives in the study of health and health disparities of LGBT populations (the others are life course, intersectionality, and social ecology). Essentially, the minority stress model states that social conditions characterised by prejudice and stigma – or in the IDAHOT parlance, 'homophobia, transphobia, and biphobia' – predispose LGBT people to greater exposure to stress compared with heterosexual cisgender individuals. In turn, this excess exposure to stress can cause adverse health outcomes (specifically, health outcomes that are caused by stress). Coping and social support, along with other forms of resilience, counteract the impact of stress and can have salutogenic effects (Meyer, 2015). The health and wellbeing of LGBT people depend on the balance of stress and resilience forces. Because prejudice and stigma are persistent, and are thought to overwhelm protective factors, hypotheses based on minority stress predict that excess stress would lead to excess disorders and, even though this relationship is ameliorated by resilience, stress exposure will yield health disparities between LGBT and heterosexual

cisgender populations (Meyer, Schwartz & Frost, 2008; Schwartz & Meyer, 2010).

If exposure to prejudice and stigma were eliminated, or even significantly reduced, then minority stress theory would predict that LGBT people would not be exposed to excess stress compared with heterosexual cisgender individuals (at least not significant excess stress) and, therefore, they would not suffer the ill effects of minority stress, reducing or removing health disparities between LGBT and heterosexual cisgender populations.

The shifting social environment: Greater acceptance of LGBT people

It is important to note that in many parts of the world, LGBT people continue to be subjected to stigma and prejudice leading to horrific violence and discrimination. In the past few years the world has seen draconian anti-LGBT laws pass in places as diverse as the Russian Federation and Uganda, among others. LGBT people in many places experience not only stress but acts that deprive them of their dignity, liberty and, sometimes, even life.

At the same time, in the 12 years since the launch of IDAHOT there have been significant improvements in the lives of LGBT people in many parts of the world – improvements that have affected primarily sexual minorities (lesbians, gay men, and bisexuals, or LGB) rather than gender minorities (transgender and genderqueer people), and mostly in North America, Europe, and South America. In these regions, legal protections for sexual minorities (and sometimes gender minorities) have been enacted along with greater inclusion in social institutions. For example, a 2014 study examining surveys conducted in 52 countries since 1981 showed that attitudes toward homosexuality have consistently and significantly improved in most countries (Smith, Son & Kim, 2014). Similarly illuminating is that by 2015 nearly two dozen countries had national laws allowing gays and lesbians to marry same-sex spouses (PEW, 2015). Improvements have also occurred in international bodies: A 2014 report by ARC International found that 'tremendous achievement has occurred in the past decade enabling human rights violations against lesbian, gay, bisexual, trans, and intersex (LGBTI) persons worldwide to be more effectively addressed by the UN' (ARC International, 2014, p.2)

Such developments have led some researchers to claim that sexual minority youth today experience such a radically different social environment than previous generations of sexual minorities that it calls into question everything we know about exposure to prejudice and stigma and its impact on health. Instead of the hostile and violent social environment we have seen in studies of LGBT individuals in the past, some researchers suggest, LGB, if not transgender, youth today experience an environment characterised by inclusion and acceptance.

For example, more than a decade ago, Savin-Williams (2005) suggested that minority stress described social conditions that affected past generations of LGB people. He coined the phrase 'the new gay teenager' to refer to the experience of youth in this new era. The 'new gay teenager' is different from older generations of LGB people, Savin-Williams said, in that he or she is coming of age in a period of great optimism about the acceptance of homosexuality in US society. Savin-Williams claimed that 'many of the supposed ill effects of being gay are leftovers from previous generations, who were affected by the cultural and interpersonal stigma and prejudice of the 1950s, 1960s, and 1970s' (Savin-Williams, 2005, p.17). This old stigma and prejudice is now so diminished, if it exists at all, according to Savin-Williams, that 'today, no particular "gay agenda" exists, and sameness with the mainstream trumps differentness' (Savin-Williams, 2005, p.17). The '[new gay teenagers] world is permeated as never before by tolerance, if not by outright acceptance' (Savin-Williams, 2005, p.18). Because of the dramatic improvement in the

social condition of gay people, according to Savin-Williams, the new gay teenager is really more 'post-gay' than gay, in that a gay identity, in the sense that older generations of LGB people had experienced it, is less relevant. Indeed, Savin-Williams said, 'I believe that the gay adolescent will eventually disappear… Teens who have same-gendered sex and desires… will not need to identify as gay' (Savin-Williams, 2005, p.21).

More recently, another study reiterates Savin-Williams's findings. Reported in a book entitled *The declining significance of homophobia: How teenage boys are redefining masculinity and heterosexuality*, McCormack (2012) found evidence for the claim made in the book's title in a study of three British high schools. He introduced the results of his study saying, '…This is a good news story – a story of increasing equality for LGBT students and a story of increasing inclusivity among straight students' (p.xxv). 'I document how, in an era in which boys no longer fear being socially perceived as gay, heterosexual male students intellectualise and espouse pro-gay attitudes, esteeming the social inclusion of gay students. In addition to condemning overt forms of homophobia, heterosexual male students intellectualise the support of gay rights, and they are inclusive of their openly gay peers' (p.xxvii). And, like Savin-Williams, McCormack concludes 'Sexuality simply is not an issue in determining a student's popularity in these schools, and happiness and mental health are no longer predicated upon being heterosexual.'

Implications of the shifting social environment to minority stress

In the title of this paper I posed the question – Does an improved social environment for sexual and gender minorities have implications for a new minority stress research agenda? While changes in some areas of society are undeniable, I pose this as a question because I do not know if the social environment has improved significantly. This uncertainty guides the research agenda I propose here: I call on researchers to ask whether the social environment, as experienced by LGBT people today, has changed significantly enough to warrant a new research agenda on minority stress and to examine what such a research agenda would look like.

Observations about the changing social environment along with findings like those reported by Savin-Williams and McCormack alert us to two themes with important implications for the study of minority stress and health of LGBT people: First, these findings suggest that the levels of stigma and prejudice have been reduced for many, perhaps eliminated for some, LGB (and to a lesser extent, transgender and gender nonconforming) individuals. This implies that minority stress is no longer as strong a determinant of health disparities. Very simply, the main idea behind minority stress as an explanation of health disparities is that it identifies prejudice and stigma as sources of excess exposure to stress. If LGBT people do not experience stress related to prejudice and stigma, then they are unlikely to experience more stress than their heterosexual cisgender peers. All of this would lead us to hypothesise that sexual minorities do not experience the kinds of stressors highlighted by the minority stress model – prejudice events, expectations of stigma and discrimination, concealment, and internalised homophobia – and, as a result, they do not have excess health problems (Schwartz & Meyer, 2010).

Second, these studies suggest a change in how sexual minorities identify – that is, that they no longer identify primarily as lesbian, gay, or bisexual. Similarly, many gender minorities do not identify as transgender, transmen, or transwomen, preferring a nonbinary identity (e.g. genderqueer) or an identity as a man or a woman. More broadly, this could signal a deterioration in what we think of as the LGBT community. If sexual and gender minorities are not identified *as* LGBT, it is likely that they will not identify *with* the LGBT community. This could mean

that sexual and gender minorities may eventually cease to see themselves as part of an LGBT community. Such a development would have serious implications for how we think about the LGBT community as a source of resilience and, in the US at least, as a source of support and public health services. In the US, LGBT communities and institutions – including media, non-governmental organisations, community centers, and activist groups – have been central for providing knowledge and services to LGBT people. Examples include educating gay and bisexual men about HIV/AIDS before any governmental agency stepped in to do so; informal health care services, like peer support for addiction (e.g. 12-step programmes such as Alcoholic Anonymous) provided at many community centers; and formal health care services such as those provided by specialised community-based health clinics (Makadon et al., 2007).

If these observations – about the reduction in exposure to stigma and prejudice and the decline in identification with an LGBT community – are correct, they are striking. That LGBT people do not experience excess prejudice and stigma is almost unbelievable to investigators who have studied LGBT health, especially those who applied minority stress perspectives. But considering the advances in LGBT rights in the US and some other countries, it is reasonable to ask whether minority stress is still relevant to the study of LGBT health.

Both these observations present various testable hypotheses. Before I try to delineate some issues that this raises, it is important to remember that, as already noted, despite all the changes in the situation of LGBT people, most LGBT people around the world continue to suffer stigma, prejudice, discrimination, and violence. To the extent that we can explore a new post-gay world, it is a world that only a minority of LGBT people occupy. Even within countries that have demonstrated remarkable progress, large swaths of the population are unaffected by the progress. For example, in the US, while people everywhere have benefited from changes that assured equality in marriage nationally, many LGBT people live in areas where they lack many other legal protections. For example, 35 per cent of the LGBT population in the US live in the south, where they are more likely to lack employment protections, earn less than $24,000 a year, and report that they cannot afford food or health care (Mallory, Flores & Sears, 2016). Beyond geographic regions, cultural and religious subgroups have different attitudes toward LGBT people and, in most places, LGBT people continue to experience prejudice and stigma from religious institutions (PEW, 2013).

A research agenda for a new social environment

Still, it is clear that social changes have occurred, improving the lives of many sexual and gender minorities. As the social environment changes, we ought to re-examine minority stress. I list a few broad questions that are central to explore.

1. Is the nature of stigma and prejudice against LGBT people changing?

Observation about the relatively rapid changes in prejudice and stigma in some parts of the world rely, primarily, on findings about attitudes changes toward homosexuality and standing of LGBT people under the law. Although these are important indicators of prejudice and stigma, they are not sufficient indicators. Social scientists ought to assess the nature of stigma and prejudice against sexual and gender minorities. Are homophobia, transphobia, and biphobia more like racism, which has shown tremendous persistence and resistance to change even in the face of many legal protections, or are they more like some ethnic prejudices that have all but dissipated over time? In the US, several ethnic groups – the Irish, Italians, Jews – have been subject to prejudice, stigma, and stereotypes, but these have eroded slowly. For example, anti-Irish prejudice and stigma would be unfamiliar to a

young person growing up in the US today (Ignatiev, 1995). It is hard to describe the Irish as stigmatised minority in today's US, whereas in the late 19th century, 'NINA', or 'no Irish need apply', was commonly proclaimed in employment advertisements (Fried, 2015).

The same is not true, of course, regarding African Americans in the US, where racism persists even if it takes different forms than it did prior to the passage of important civil rights legislation such as the Civil Rights Act of 1964 (Feagin, 2013). Today, in most civilised society, overt racism is censured, but covert forms of racism, sometimes termed 'modern racism' arise (Dovidio, Kawakami & Gaertner, 2002; Swim et al., 1995).

What can the social science of stigma and prejudice teach us about the future of homophobia, transphobia, and biphobia? Will prejudice and stigma against sexual and gender minorities seem as out of date in the future as Irish bias seems today? Or will we see a transformation of stigma and prejudice similar to more covert forms of racism as experienced by African Americans today? Although important, it is not sufficient to show improvement in public attitudes about homosexuality as captured, for example, by the General Social Survey's question about whether 'sexual relations between adults of the same sex' are wrong. Broader theory-based research on stigma, prejudice, and stereotypes is necessary to explore these issues. For example, Jones and colleagues (1984) proposed theoretical bases for understanding dimensions of stigma including disgust and aesthetics. Disgust has been a used to dehumanise stigmatised groups and justify stigma.

Researchers can study whether perceptions of disgust of same-sex relationships or diverse gender identities are waning or persisting? Such study would allow us to assess whether documented improved social attitudes toward same-sex marriages and other markers of growing acceptance of homosexuality reflect changes in deeply held beliefs and feelings, or if they reflect changes in social conventions and social desirability. What can shift in such perceptions – and whether they are deeply held or responsive to social conventions – tell us about the future of homophobia, transphobia, and biphobia?

Related to this, researchers have shown how racism and sexism get transformed into more 'acceptable' social attitudes in modern racism and sexism (Swim et al., 1995). We are used to thinking about gross acts of violence and discrimination against LGBT people because these have been done with impunity, but as laws and civil decorum change, will prejudice and stigma become covert and subtler?

2. How do apparent changes in the social environment affect the lived experience of LGBT people?

Researchers need to document how the lives of LGBT people are changing with the shifting social environment. In this, researchers have to be aware not only of generational and regional differences in the experiences of sexual and gender minorities, but also of differences related to race/ethnicity, gender and gender expression, socioeconomic status, and religiosity among people in any time and place. We can no longer portray LGBT people as one community, but need to recognise the multiple communities that LGBT people inhabit, and the multiple experiences they have in these varied environments.

In studying the lived experiences of LGBT people, it is important to keep the perspective of the historical time – how social attitudes affect people's experiences – as well as the lifespan perspective. Researchers can thus assess how historical changes affect people across the lifespan. Changes in the social environment do not impact only the young generation, such as documented by the research of Savin-Williams and McCormack cited above. Social changes have impact beyond current time to the personal development of members of all

generations in today's society. Liberalisation of attitudes toward homosexuality will affect both the queer teenage boy and the 83-year-old lesbian living in a facility for older adults. Because of their place along the lifespan, the impact of the social environment on their lives will be different. The young sexual minority person is being socialised in an environment where he or she learns very different things about what it means to be LGB than older generations of LGB people learned when they were young. The young person's sense of self and future will be impacted by the discourse he or she absorbs in their socialisation, possibly determining a lot of his or her life trajectory just as discourses in previous periods have affected earlier generations of LGB persons.

But older LGB persons will also be impacted: First, older LGB persons may re-evaluate what they had learned throughout their own lives in view of contemporary more liberal attitudes. An older person may acquire new role models who demonstrate greater comfort with the social environment than the older person had experienced in his or her life to date. Older persons, for example, may marvel at young LGB people's family aspirations that include same-sex marriage and children – something that was unimagined in previous generations. Second, by interacting with younger – more LGBT-friendly – members of general (non-LGBT) society, the older LGBT person may be treated differently than he or she had been treated in the past, being subject to more accepting and accommodating social institutions, and finding that they can find non-LGBT allies that they did not have before. These and many other experiences of LGBT persons in current diverse social environments need to be assessed before we can characterise the impact of social changes on LGBT people today.

3. Are there new minority stress and coping processes?

Minority stress defined several stress processes – prejudice events, internalised homophobia, concealment, and expectations of rejection (Meyer, 2003). For transgender people similar processes have been described with the addition of gender affirmation as an important stressor (Sevelious, 2013; Testa et al., 2015). These stress processes, by virtue of being social stress processes – that is, stressors that stem from social arrangements and the social environment – are subject to continuing changes. Here researchers ought to ask, as the social environment shifts, how are social stress processes affected? And similar to the discussion about the lived experiences of LGBT people, they ought to ask, are there differences relevant to different generations and other subgroups of LGBT people?

For example, internalised stigma reflects the LGBT person's internalisation through the socialisation process of antigay, biphobic, and transphobic attitudes, beliefs, and stereotypes. In the literature on sexual identity, especially, but also in the literature on transgender people, internalised stigma has been seen as a major insidious stressor that adversely affects the health of LGBT people (Frost & Meyer, 2009; Newcomb & Mustanski, 2010; Testa et al., 2015). But as attitudes, beliefs, and stereotypes are relaxed, or become more positive, and as positive role models exist, how do they affect the internalisation process? Are young people less vulnerable to internalised stigma than were young people in previous generations?

We know from research on coming out that coping with internalised stigma is a major developmental task for LGBT people (Eliason & Schope, 2007). Through interaction with a supportive community and role models, over time, they shed learned negative social perceptions about themselves and acquire positive, prideful, self-perceptions. For previous generations, this has been a long and difficult process. What is it like for today's youth? For example, how does a more positive social environment affect young LGB people's perceptions of what is possible for them in terms of intimacy and family (Frost, Meyer & Hammack, 2014)?

At the same time, it is possible that today's youth become more vulnerable to other stressors, such as rejection, discrimination, and violence. Having learned to expect an accepting social environment, they may be less well prepared to fend off prejudice than are their older LGBT peers. We know that youth today come out – disclosing their sexual and gender minority status to family, friends, and the world – at earlier ages than did previous generations (Grov et al., 2006). But being out leads to greater exposure to homophobia, biphobia, and transphobia. Does coming out early expose today's young LGBT people to experiences of rejection, discrimination, and violence that older generations were protected from by more strategically managing when and to whom they came out to?

Finally, minority stress processes include the important role of coping and social support, and the important role of community resources (Meyer, 2015). If studies show, as some have hypothesised, that LGBT youth are less likely to identify with LGBT communities, what can we make of the lessening of commitment to an LGBT identity? Will we see a transformation of the LGBT community and its institutions to accommodate the broadening of social identities – becoming more inclusive of genderqueer, queer, pansexual, same-gender loving, and many other identities? Or will the plethora of identities lead to disillusionment with and dissolution of the LGBT community as we have known it? This question has important symbolic meanings related to identity and affiliation; it also has many tangible implications. For example, specialised public health services in the US are delivered through a network of clinics and services that cater to an LGBT client. What if LGBT youth no longer search for and prefer services that are identified as LGBT? Will they be served as well in general practice clinics and centers or will they suffer ill effects from the loss of connection with LGBT institutions?

4. Are health disparities persisting or are they declining?

Minority stress is a theory of disease causation and, therefore, of explaining health disparities between heterosexual cisgender and LGBT populations. To the extent that social environments are improving, we would expect to see corresponding reduction in health outcomes and health disparities (for any health outcome that is purportedly caused by stress). Theory predicts that if an exposure (prejudice and stigma) causing adverse health is removed, related health outcomes would be impacted, thus, leading to a reduction in health disparities.

Indeed, consistent with theory, several ecological studies have shown that LGB people who reside in more friendly regions – for example, where LGB people have more protections under the law and where a mass of LGB residents exist, which provide more opportunities for affiliation with the community and socialisation – fare better than LGB people who reside in less friendly environments. For example, youth residing in more LGBT-friendly regions have fewer suicide attempts compared with their peers in more antigay regions (Hatzenbuehler, 2011). And LGB people in gay friendly regions have lower levels of mental health problems and lesser disparity with heterosexual residents (although both regions still had health disparities) (Hatzenbuehler, Keyes & Hasin, 2009). (Studies on transgender populations that test these relationships are not yet available.)

Studies comparing LGBT and cisgender heterosexual populations are necessary to assess the hypotheses that positive changes in the social environment has led to a reduction of health disparities (Meyer, 2010; Schwartz & Meyer, 2010). Findings from population studies have not yet supported Savin-Williams's and McCormack's assertions. To the contrary, studies in the US and Europe have persistently shown, and continue to show, that LGB populations fare worse than heterosexual cisgender populations. For example, data from youth at

schools in the US, using the Youth Risk Behavior Surveys, collected in 2005 to 2007, show sexual minority youth to have more stress and more adverse health outcomes than heterosexual youth. Sexual minority youth had higher risk for victimisation (fighting, skipping school because they felt unsafe, and having property stolen or damaged at school) and risk behaviours (including substance use, sexual behaviors, and diet and physical activity) (Russell et al., 2014). Studies of suicide attempts occurring as recently as 2001 to 2009 show that sexual minority youth continue to be at high risk for suicide ideation, plans, attempts, and medically serious attempts compared with heterosexuals (Stone et al., 2014).

To address the question whether health disparities are reduced consistently with improvement in the social environment, studies need to assess stress exposure, disease outcomes, and whether stress is the mediating factor explaining the relationship between LGBT status and health outcomes.

To the extent that studies confirm that sexual or gender minorities have no elevated levels of minority stress related to prejudice and stigma, then minority stress hypotheses would be supported if they show no health disparities between sexual and gender minority and heterosexual cisgender populations.

Conclusions

In many regions of the world sexual and gender minorities witness changes that were unimagined just a few decades ago, when homosexuality was considered a mental disorder and same-sex behaviour and gender nonconformity were criminalised. These changes ought to lead researchers to ask questions about vicissitudes of prejudice and stigma; the impact of the social shifts on the lived experiences of LGBT people; and the impact of these changes on exposure to stress, opportunities for coping and social support, and disparities in health outcomes between sexual and gender minorities and heterosexual cisgender populations.

At the same time, researchers ought to remember that LGBT people live across the globe, where many seem far from gaining basic freedoms and dignity. Researchers also have to remember that even in regions where LGBT people enjoy greater equality and experience greater acceptance, this may not reflect the experience of all LGBT people in these areas. LGBT communities are diverse, intersecting with many statuses and identities including gender, race/ethnicity, and socioeconomic status, among others. Such intersections may have greater impact on the lived experience of the LGBT person than broader social conditions. In studying the impact of prejudice and stigma on health, all these intersections ought to be considered as relevant for the population under study.

Still, there are clear changes in the status and experiences of LGBT persons in society. Such changes require that minority stress, which highlights the importance of the social environment to understanding LGBT populations, be regularly reassessed and expanded to account for the shifting social context.

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