**Commentary:**

**A Research Agenda for Improving LGB Health and the Social Environment**

Nathaniel M. Lewis\*(1)

1\* Corresponding author

Geography & Environment, University of Southampton, 2508 Shackleton Building, Highfield Campus, Southampton, UK SO17 1BJ; Email: N.M.Lewis@soton.ac.uk

**Abstract**

Researchers interested in sexual minority health are beginning to examine contextual and environmental determinants of health such as neighbourhoods, health services, and social policies. Efforts to catalogue and systematise policies relating to the health of lesbian, gay, and bisexual (LGB) individuals are therefore central in uncovering more comprehensive determinants of LGB health. This commentary identifies the links between social policy and LGB health, some methodological concerns of spatial analyses in this research area, and some future research directions. In particular, there is a need to integrate both migration and life course into understandings of the relationships between LGB health and jurisdictional policies.

**Introduction**

Researchers have begun to investigate the social and contextual factors associated with the health of lesbian, gay, and bisexual (LGB) individuals. This approach represents a shift away from a purely individual-level, psycho-social approach that that characterized LGB health research for much of the twentieth century but also from medicalized sexual non-normativity as a cause of ill health. In contrast, population-based approaches consider how LGB health outcomes are informed by social and historical contexts that also vary geographically. The article *State and Local Policies Related to Sexual Orientation in the United States[[1]](#endnote-1)* [[2]](#endnote-2)is a welcome addition to this growing body of research. While this work highlights the relevance of the geography of social policy to LGB health, it also makes clear the methodological challenges in this research area and suggests some additional factors that may also influence LGB health.

**Minority Stress, Microaggressions, and Syndemics**

LGB health researchers first suggested in the 1990s that disproportionately high rates of anxiety, depression, suicide, and substance use were at least partly attributable to social factors[[3]](#endnote-3). They suggested that factors such as discrimination, bullying, and unequal human rights contributed to a chronic, socially based *minority stress* that made LGB populations vulnerable to these health outcomes. The sources of this stress are manifold, including general social stigma, prejudice events such as verbal or physical attacks, informal prejudice from family and religious communities, and formal prejudice in the form of unequal laws and policies—the latter, the focus of the research by Cramer and his colleagues.

Since the early 2000s, researchers have proposed additional theories connecting social stressors to poor health in LGB populations. Some have suggested that even minor verbal slights, or ‘microaggressions’, contribute to mental distress, social isolation, and reduced self-esteem in LGB people[[4]](#endnote-4). Others have suggested that poor mental health outcomes in gay and bisexual men are co-occurring, or ‘syndemic’, with physical health outcomes such as HIV infection.[[5]](#endnote-5) Within this body of research there is often implicit acknowledgement that these stressors vary by place, but more systematic investigation of the geographic variation in LGB health outcomes is often lacking[[6]](#endnote-6). In this respect, the work of Cramer and his colleagues advances the field.

**The Role of Policy**

The clear contribution of the work is its success in collating and synthesizing the vast patchwork of policies in the United States related to LGB inclusion. While less attention is given to the potential health implications of these policies, potential pathways are implied. First, the authors delineate the ways in which *lack of* protection (e.g., from job termination on the basis of sexual orientation) systematically disadvantages LGB people socially and financially[[7]](#endnote-7). Less attention, with the exception of anti-marriage policy, is given to anti-LGB policies such as those in Michigan that allow for the refusal of professional services to LGB people on the basis of faith[[8]](#endnote-8) Although these types of policies are far rarer, they may have a more pronounced impact on LGB mental health. Second, social policies may be internalised by LGB people in less obvious ways, even if they do not suffer a specific adverse incident (e.g., rejection of a rental application) as a result of anti-LGB policies. As policies are often a reflection of cultural mores, which the authors note, anti-LGB policies may contribute to a sense of exclusion or invisibility in LGB populations. Third, there is opportunity to consider measurable elements of the social environment that can influence LGB health but are not encoded into policy, *per se*. These may include voting patterns, political affiliations, religiosity, or rural/urban classifications that may serve as proxies for any of these measurable indicators plus difficult-to-measure ones such as family/home environment or school climate[[9]](#endnote-9) [[10]](#endnote-10) [[11]](#endnote-11) [[12]](#endnote-12) [[13]](#endnote-13). Health services, that are enabled but not guaranteed by policy and funding regimes, may have an even more direct impact on LGB health.

Future research should consider concentrations of formal health services (e.g., counselling centres and clinics specifically serving LGB populations) as well as informal health promoting organisations (e.g., school-based gay-straight alliances) as well as the policies enabling or constraining these types of outlets. These latter types of analysis may be more sensible in countries where the policy landscape is more unified across jurisdictions [[14]](#endnote-14), though LGB health comparisons across regional units (e.g., England and Ireland) with different gay marriage policies may be possible.

It is more difficult to assess the how social policies affect LGB people on a day-to-day basis. Two factors, the geographic scale and perceived intent of a policy, may affect the magnitude and direction of its impact on LGB people. Human geographers have long debated the utility of spatial analysis for analyzing social problems, suggesting that the scales at which social data are examined (or are available) are not always the ones that are most meaningful[[15]](#endnote-15). Research like that done by Cramer and colleagues might assess differences in policies at the broad regional level (e.g., Midwest vs. Northeast) because this is more feasible statistically, but the lived difference of LGB people may vary as much between conservative Indiana and more liberal Minnesota as it does between these broader regions. Similarly, state-level policies might be powerful in the sense that they affect jurisdictions at all lower spatial scales, but they may be felt less acutely than a local one. Researchers who work on local and regional immigration ordinances, for example, have argued that the spirit of these ordinances is important even if their policy impact is limited. Most anti-immigration ordinances in the United States, for example, are in older, whiter counties and some in Canada have been implemented in towns where there are no immigrants at all[[16]](#endnote-16) [[17]](#endnote-17). Given the limited sensibility and utility of such policies, the messaging and potential psychological impact on would-be immigrants is perhaps even greater than policies grounded in more econometric or cost-benefit analyses.

The meaning and intent of the policy as read by LGB people also has health implications. Policy ‘events’ might be more ephemeral and therefore more difficult to code and measure, but have a disproportionately greater psychological impact on LGB people. In Canada, for example, city government decisions to refuse Pride-related proclamations and flag-raisings have, in the past, greatly affected the perceived inclusion of LGB communities in locales such as London, Ontario, and Truro, Nova Scotia[[18]](#endnote-18) [[19]](#endnote-19). At the state level, Proposition 8 to ban previously legal gay marriage in California could be considered less damaging than the national-level Defense of Marriage Act (1996) or longer-term bans on gay marriage in southern and Midwestern states. Proposition 8 might be considered *more* damaging in the sense that it was a *voter-led* articulation of disapproval for the state’s previously inclusive marriage policy and for LGB people themselves.

It is worth considering, by the same token, how even pro-LGB policies affect LGB populations. Cramer and his colleagues suggest that LGB-inclusive or LGB-protective policies might foster the growth of LGB communities and associated ‘risky’ spaces such as bars and bathhouses. It is perhaps more likely, however, that pro-LGB policies in cities such as New York and San Francisco are *affirmations* of LGB communities that have existed long before such policies. In this sense, it is worth assessing—potentially through qualitative research—how LGB communities view and interpret policy. Are LGB-affirmative policies, for example, seen as necessary protections in city jurisdictions or as tools to attract LGB people and liberal urban cosmopolites as part of ‘creative city’ policies that came into fashion in the 2000s[[20]](#endnote-20)? In this sense, a very specific set of cities, such as New York, San Francisco, Chicago, and Miami may have both the most protective factors (e.g., supportive gay communities, LGB health services, LGB-affirmative policies) and risk factors such as more established cultures of partying, drug use, and casual sex.

**Considering Policy Implications across Place and Time**

Spatial analyses of social policy, as Cramer and his colleagues observe, can only capture snapshots of the social climate at given points in time. As the field progresses, research may also consider how the relationship between social policy and LGB health is influenced by both migration and ‘life course’, or the ways in which age and historical time influence life trajectories. Due to the unevenness of the social landscape that LGB people face, they often migrate during their lives to escape discrimination or pursue better work and social opportunities, including marriage and adoption of children[[21]](#endnote-21) [[22]](#endnote-22). Consequently, they may encounter several different social and political landscapes during their lives, leaving behind the friends and support structures in one location, then encountering new social environments in another. It may be migration, then, as much as place that influences the health of LGB people. Occasionally, migration may represent an unequivocal improvement of life potentials in terms of jobs, leisure activities, or partnerships. At the same time, relocating to a place where one social policy (e.g., adoption rights) is more equitable for LGB people may also involve dealing with new regimes of social welfare policies (e.g., pension benefits, health care policies) that are less advantageous than those in the place left behind. Migration often involves a type of social upheaval that results in LGB people temporarily losing social supports as they seek new ones or encountering new social and sexual settings (e.g., bar and club scenes) with which they may have little familiarity[[23]](#endnote-23). Migration and the initial post-migration period, specifically, may therefore have considerable implications for mental health as well as HIV and STI infection[[24]](#endnote-24) [[25]](#endnote-25) [[26]](#endnote-26).

The social climate of different places, including their policies, also changes across historical periods. As LGB individuals rarely stay anchored in one place for their entire lives, it is also necessary to consider the influence of social policy on their health from a life course perspective. Health researchers have suggested that traumatic experiences from earlier in life can resurface later in life or accumulate across the life course in an additive way. In this sense, LGB individuals may still suffer from stress of being part of a minority group even if the social context in which they live has improved over time or if they have moved to a better environment. Many LGB individuals may have delayed ‘coming out’ (openly identifying themselves as LGB) because they previously lived in a discriminatory environment. Coming out later in life may make it more difficult for older gay men and lesbians to partner and establish social supports as they are often left on the social periphery of nightlife-centred urban gay communities[[27]](#endnote-27).

Others who come of age in anti-LGB social climates (e.g., prior to the decriminalization of homophobia or during the AIDS crisis) may continue to experience internalized homophobia and fear of intimacy as they age[[28]](#endnote-28). In a study of London, Ontario, Canada, Lewis et al. (2015) found that gay and bisexual men in their 40s and 50s had more pessimistic perceptions of social acceptance for LGB people compared to both younger and older men. Notably, many of these men would have come of age during a time of extreme homophobia in London, marked by the Pride proclamation refusal (1995) and the public scrutiny of dozens of gay men under a failed child pornography investigation (1993)18. In the British context it could be equally worthwhile to investigate the health outcomes of LGB individuals who came of age under Section 28 (1988–2003), that outlawed discussion or printed material on homosexuality or LGB health in schools and other publicly supported settings, compared to those of older and younger men.

**Moving Forward**

The emerging field of research on the relationships between social policy and LGB health presents extensive opportunities for further investigation. Social scientists, who are well positioned to do this research, often remain uncomfortable categorizing both sexualities and locations into measurable attributes (and occasionally even with the study of sexual health itself)[[29]](#endnote-29). At the same time, taking seriously the role of social policy as a determinant of LGB health is a key step in ‘de-pathologizing’ LGB health disparities as products of individual ‘behaviour’ and creating a baseline of necessary data for future population health interventions. When conducted carefully and comprehensively, as Cramer and his colleagues have done, systematic analysis of the social environment has the potential to transform the understanding of LGB health in the United States and elsewhere.

About the author:

Nathaniel M Lewis, PhD, is Lecturer (Assistant Professor) in Human Geography in the Population, Health and Wellbeing (PHeW) research group within the Geography & Environment Unit at the University of Southampton, UK.

1. Cramer, R. et al (2016)[Typesetters please add reference] [↑](#endnote-ref-1)
2. Meyer, I.H. (1995) Minority stress and mental health in gay men. Journal of Health and Social Behavior 36(1): 38–56. [↑](#endnote-ref-2)
3. Meyer, I.H. (2003) Prejudice, social stress and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychology Bulletin 129(5): 674–697. [↑](#endnote-ref-3)
4. Nadal, K., Y. Wong, M-A. Issa, V. Meterko, J. Leon, M. Wideman. (2011) Sexual orientation microaggressions: processes and coping mechanisms for lesbian, gay, and bisexual individuals. Journal of LGBT Issues in Counseling 5(1): 21–46. [↑](#endnote-ref-4)
5. Stall, R, C. Mills, J. Williamson, et al. (2003) Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. American Journal of Public Health 93: 939–942. [↑](#endnote-ref-5)
6. Lewis, Nathaniel M. Mental Health in Sexual Minorities: Recent Indicators, Trends, and their Relationships to Place in North America and Europe. Health & Place 15: 1029–1045. [↑](#endnote-ref-6)
7. Hatzenbuehler, M., K. Keyes, and D. Hasin. 2009. State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. American Journal of Public Health 99(12): 2275–2281. [↑](#endnote-ref-7)
8. Herdt, G., and R. Kertzner. (2006) I do, but I can’t: the impact of marriage denial on the mental health and sexual citizenship of lesbians and gay men in the United States. Sexuality Research and Social Policy 3(1): 33–49. [↑](#endnote-ref-8)
9. Hatzenbuehler, M. (2010) Social factors as determinants of mental health disparities in LGB populations: implications for public policy. Social Issues Policy Review 3: 31–62. [↑](#endnote-ref-9)
10. Hatzenbuehler, M., K. Keyes, K. McLaughlin. (2011) The protective effects of social/contextual factors on psychiatric morbidity in LGB populations. International Journal of Epidemiology 40: 1071–1080. [↑](#endnote-ref-10)
11. Hatzenbuehler, M., J. Pachankis, and J. Wolff. (2012) Religious climate and health risk behaviours in sexual minority youths: a population-based study. American Journal of Public Health 102(4): 657–663. [↑](#endnote-ref-11)
12. Poon, C. and E. Saewyc. (2009) Out yonder: sexual-minority adolescents in rural communities in British Columbia. American Journal of Public Health 99(1): 118–124. [↑](#endnote-ref-12)
13. Wienke, C., and G. Hill. (2013) Does place of residence matter? Rural-urban difference and the wellbeing of gay men and lesbians. Journal of Homosexuality 60(9): 1256–1279. [↑](#endnote-ref-13)
14. Berg, R.C., M.W. Ross, P. Weatherburn and A.J. Schmidt. (2013) Structural and environmental factors are associated with internalised homonegativity in men who have sex with men: Findings from the European MSM Internet Survey (EMIS) in 38 countries. Social Science & Medicine 78: 61–69**.** [↑](#endnote-ref-14)
15. Dixon, D.P., and J.P Jones III. (1998) My dinner with Derrida or spatial analysis and poststructuralism do lunch. Environment and Planning A 30(2): 247–260. [↑](#endnote-ref-15)
16. Walker, K.E., and H. Leitner. (2011) The Variegated Landscape of Local Immigration Policies in the United States. Urban Studies 32(2): 156–178. [↑](#endnote-ref-16)
17. Pottie-Sherman, Y. & R. Wilkes. 2014. Good code bad code: Exploring the immigration-nation dialectic through media coverage of the Hérouxville ‘Code of Life document’. Migration Studies 2(2): 189–211. [↑](#endnote-ref-17)
18. Lewis, Nathaniel M., Greta R. Bauer, Todd A. Coleman, Soraya Blot, Daniel Pugh, Meredith Fraser, and Leanne Powell. (2015) Community cleavages: gay and bisexual men's perceptions of gay and mainstream community acceptance in the post-AIDS, post-rights era. Journal of Homosexuality 62(9): 1201–1227. [↑](#endnote-ref-18)
19. Lewis, Nathaniel M. (2015) Placing HIV beyond the metropolis: risks, mobilities, and health promotion among gay men in the Halifax, Nova Scotia region. The Canadian Geographer 59(2): 126–135. [↑](#endnote-ref-19)
20. Peck J. (2005) Struggling with the creative class. International Journal of Urban and Regional Research 29: 740–770. [↑](#endnote-ref-20)
21. Knopp L. (2004) Ontologies of Place, Placelessness, and Movement: queer quests for identity and their impacts on contemporary geographic thought. Gender, Place and Culture 11: 122–134. [↑](#endnote-ref-21)
22. Gorman-Murray, A. (2009) Intimate mobilities: emotional embodiment and queer migration. Social & Cultural Geography 10(4): 441–460. [↑](#endnote-ref-22)
23. Bruce, D., and G. Harper. (2011) Operating Without a Safety Net: Gay Male Adolescents and Emerging Adults’ Experiences of Marginalization and Migration, and Implications for Theory of Syndemic Production of Health Disparities. Health Education & Behavior 38 (4): 367–378. [↑](#endnote-ref-23)
24. Egan, J., V. Frye, S. Kurtz, C. Latkin, M. Chen, K. Tobin, C. Yang, and B. Koblin. (2011) Migration, neighborhoods, and networks: approaches to understanding how urban environmental conditions affect syndemic adverse health outcomes among gay, bisexual, and other men who have sex with men. AIDS and Behavior 15, S35–S50. [↑](#endnote-ref-24)
25. Lewis, Nathaniel M. (2014) Rupture, Resilience, and Risk: Relationships between Mental Health and Migration among Gay-Identified Men in North America. Health & Place 27: 212–219. [↑](#endnote-ref-25)
26. Lewis, Nathaniel M. (2016) Urban Encounters and Sexual Health among Gay and Bisexual Immigrant Men: Perspectives from the Health and Settlement Sectors in Ontario, Canada. Geographical Review 106(2): 235–256. [↑](#endnote-ref-26)
27. Floyd, F., and R. Bakeman. (2006) Coming-out across the life course: implications of age and historical context. Archives of Sexual Behaviour 35(3): 287–296. [↑](#endnote-ref-27)
28. Hammack, P.L., and B.J. Cohler. (2011) Narrative, Identity, and the Politics of Exclusion: Social Change and the Gay and Lesbian Life Course. Sex Research and Social Policy 8: 162– 182. [↑](#endnote-ref-28)
29. Del Casino, Jr., (2007) ‘Health/sexuality/geography’ in K. Browne, J. Lim and G. Brown (eds.) Geographies of sexualities: theory, practice and politics. Farnham, UK: Ashgate. [↑](#endnote-ref-29)