Treat Sexual Stigma to Heal Health Disparities: Improving Sexual Minorities’ Health Outcomes

Jes L. Matsick1, Britney M. Wardecker1, and Flora Oswald1

Abstract
Despite recent strides toward equality in the United States, lesbian, gay, bisexual, transgender, and queer (LGBTQ) people continue to report experiences of sexual stigma and psychological and physical health problems. This article reviews empirical evidence of sexual stigma and sexual orientation-based health disparities. The current framework proposes that sexual orientation does not cause health disparities; homophobic individuals and societies do. Social psychology, recognizing the power of the situation, suggests that changing the stigmatizing environments for LGBTQ people can effectively reduce health disparities. The science has policy implications—notably, for audiences at three levels (intraindividual, interpersonal, and institutional)—and provides recommendations for mitigating sexual stigma and improving health.

Keywords
sexual prejudice, homophobia, well-being, sexual orientation, LGBTQ

Introduction
The 21st century in the United States yielded notable social change for people who are lesbian, gay, bisexual, transgender, and queer (LGBTQ), in contrast to their history of criminalization, moral condemnation, and medicalization (Herek, 2010). The past two decades are marked by nationwide marriage equality, increased support for LGBTQ people (Charlesworth & Banaji, 2019), the repeal of “Don’t Ask, Don’t Tell,” advances in HIV prevention and treatment, the favorable campaign of an openly gay Presidential candidate, federal anti-discrimination employment protections, and widespread invalidation of conversion therapy by medical communities. However, despite strides toward equality, sexual minorities1 continue to report sexual stigma (e.g., discrimination) and a host of psychological and physical health problems (e.g., depression).

In 2011, the Institute of Medicine (IOM) released a report noting that sexual minorities’ health access and outcomes systematically trail those of heterosexual people. Likewise, Healthy People 2020 named addressing sexual orientation-based health disparities as central to enhancing population health (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Services, 2010). Health disparities are not simply born in the body but emerge from sexual minorities’ stigmatizing environments.

Key Points
• In the era of increased equality, sexual minorities still report sexual stigma and related psychological and physical health problems (e.g., psychological distress, suicide ideation, heart disease).
• Sexual minorities’ access to health care and resulting health outcomes systematically differ from those of heterosexual people; federal health agencies call for attention to sexual orientation-based health disparities.
• Health disparities are not simply born in the body but emerge from sexual minorities’ stigmatizing environments.
• Altering sexual minorities’ stigmatizing environments can reduce disparities while placing responsibility for social change on heterosexual members of society and not on sexual minorities.
• Evidence-based recommendations—to reduce sexual stigma and improve health—target (a) well-intended heterosexual individuals, (b) organizations and communities, and (c) research and social policy.

1The Pennsylvania State University, University Park, USA

Corresponding Author:
Jes L. Matsick, Department of Psychology, The Pennsylvania State University, 416 Moore Building, University Park, PA 16802, USA.
Email: jmatsick@psu.edu

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Promotion, 2015), and the National Institutes of Health designated sexual minorities as a health disparate population (National Institute of Minority Health and Health Disparities, 2016). Health is modifiable (i.e., disparities are not inevitable; Bränström et al., 2016), poor health taxes the health care system and economic infrastructure (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2015), and sexual minorities represent a growing percentage of the population (Newport, 2018); thus, sexual orientation-based disparities challenge society as a whole.

Social psychology offers a promising response: sexual orientation does not cause health disparities; homophobic individuals and societies do (for a parallel argument explaining racial disparities, see Jones, 2000). Given health disparities are not simply born in the body but emerge from people’s environments, the case of health disparities is not only a medical issue but a social one. Consistent with social psychology’s emphasis on the power of the situation, altering stigmatizing environments for sexual minorities can effectively lessen health disparities, according to the evidence. Efforts to reduce disparities can prioritize changing social contexts over earlier attempts to change stigmatized individuals’ psychological, behavioral, or physiological responses to stigma. The current article reviews sexual stigma and health disparities, recommending strategies for well-intended heterosexual individuals, organizations and communities, researchers, and policymakers to reduce disparities in the era of increased equality.

**Sexual Stigma Today**

Stigma involves the interconnected processes of labeling, stereotyping, status loss, discrimination, and separation (Link & Phelan, 2001; Major & O’Brien, 2005). Sexual stigma, as conceptualized by Herek et al. (2007), refers to the devaluation of any nonheterosexual identities, behaviors, relationships, and communities; reflects a shared belief system that deems heterosexuality superior; legitimizes the social exclusion of sexual minorities; and promotes the invisibility of marginalized sexual orientations. Herek’s definition of sexual stigma accommodates individuals (e.g., intraindividual processes, interpersonal dynamics) and institutions (e.g., policies), and it captures the perspectives of people who are targeted by stigma as well as those who enact it. For example, when heterosexual people internalize sexual stigma, they endorse “sexual prejudice” (i.e., expressions of negativity otherwise known as “homophobia”; Herek & McLemore, 2013). When institutions internalize sexual stigma, “heterosexism” emerges (Herek, 2010). Heterosexism serves as a prominent ideological feature within law, medicine, religion, education, and other valuable social structures, and reinforces power differentials between those who are stigmatized and those who are not. Heterosexism ultimately creates a fertile landscape—one that casts heterosexuality as normative—for stereotyping, prejudice, and discrimination to occur.

Sexual minorities in the 21st century continue to encounter verbal and physical abuse, microaggressions and bullying, hate crimes, and rejection (e.g., Herek & McLemore, 2013; Nadal et al., 2016; Ryan et al., 2015). In a meta-analysis of victimization (Katz-Wise & Hyde, 2012), more than half of sexual minorities report encountering verbal harassment. Sexual minorities across the adult lifespan report discrimination within the past year (Extine Rice et al., 2019), and more than half experience discrimination on a daily basis (Harvard School of Public Health et al., 2017). Sexual minorities continue to lack federal protections against discrimination in public sectors (e.g., housing, public accommodations, education, business), face invalidation in family law (e.g., adoption), and contend with implicit biases in medical care (Sabin et al., 2015). In professional contexts, they experience hiring discrimination, heterosexist harassment, exclusion in valued domains (e.g., science, technology, engineering, and mathematics [STEM]), and a lack of support in education (Kosciw et al., 2012; Mishel, 2016; Patridge et al., 2014; Rabelo & Cortina, 2014). Furthermore, despite the legalizaton of same-sex marriage, same-sex couples continue to encounter bias in the wedding industry (Kroeper et al., 2019).

Evidence for contemporary sexual stigma is strong, and worsening in some data, perhaps as a backlash to sexual minorities’ recent political progress. Following same-sex marriage’s nationwide legalization in 2015, heterosexual people ages 18–34 reported less tolerance of sexual minorities between 2016 and 2018 (GLAAD, 2019), and anti-gay hate crimes rose from 2014 to 2017 (Federal Bureau of Investigation [FBI], 2017). Legal scholars have suggested that the emergence of religious freedom bills, on the coattails of marriage equality, provides an alternative path for discriminating against sexual minorities and reflects how stigma’s manifestations change over time (McMoiirck, 2017). Just as sexism and racism evolved from being historically overt to being currently subtler, novel forms of sexual stigma replace outdated versions (e.g., Hegarty et al., 2004; Katz et al., 2019) and explain the persistence of health disparities (Frost, 2017).

**Life Course and Intersectional Frameworks**

The IOM’s (2011) health report promoted life course modeling and intersectionality theory as useful conceptual frameworks for stigma and health. A life course approach elucidates cohort effects and historical contexts. For example, having lived through specific challenges (e.g., classification of homosexuality as a mental illness; the AIDS epidemic), older sexual minority adults cope and perceive stigma differently than younger generations (Fredriksen-Goldsen & Kim, 2017). Expanding on experiences and contexts, intersectionality theory recognizes how multiple identities and positions
of power interact to advantage and disadvantage individuals. For example, people of color who are sexual minorities can experience sexual stigma within communities of color, racism in White sexual minority communities, and sexual racism as a multifaceted stigma targeting their status as both racial and sexual minorities (Bowleg, 2013). Sexual minorities’ stigma and health vary by other identities and contexts, such as social class and geographic location (Movement Advancement Project, 2019), and across sexual minority subgroups. Bisexual people, for example, report less health compared with lesbian, gay, and heterosexual individuals (Wardecker et al., 2019), and experience stigma from both lesbian/gay and heterosexual groups (Matsick & Rubin, 2018). Life course analyses and intersectional perspectives thus signal how some groups exhibit greater risk for stigma and, in turn, experience poorer health.

**Sexual Orientation-Based Health Disparities**

Groups that differ in social status tend to differ in health (Hatzenbuehler et al., 2013; Major et al., 2013; Richman & Hatzenbuehler, 2014). Along dimensions of gender, race, class, and sexual orientation, stigmatized groups report more depression than those who are not stigmatized (Cox et al., 2012); similarly, meta-analyses reveal robust associations between perceived stigma and negative health (Schmitt et al., 2014). A social psychological lens not only accounts for individuals’ experiences, but how they interact with others and within social systems. Psychological processes (categorization) and structural processes (hierarchies) lay the foundation for stigmatization, which categorizes some individuals into a devalued, low-ranking group and marks them as inferior. Intergroup relations may induce psychological and physiological responses (e.g., stress, vigilance) among low-ranking groups that can eventually deteriorate health (Major et al., 2013; Major & O’Brien, 2005).

Sexual minorities continue to endure social devaluation; therefore, they follow the same pattern of social status and negative health reliably observed in stigma research. Sexual orientation-based disparities are well-documented across psychological health problems (e.g., anxiety, substance disorders, suicide ideation; Salomaa & Matsick, 2020), physical health issues (e.g., diabetes, cardiovascular disease; Lick et al., 2013), and quality of health care (e.g., barriers to accessing care; IOM, 2011).

Stigma is credibly a fundamental cause of such disparities, given that stigma predicts health inequalities among a variety of disadvantaged groups, within numerous health outcomes, and across time (Hatzenbuehler et al., 2013). Fundamental cause theory is the notion that health and resources are proportionate to power and status. For example, in one test of fundamental cause theory (Brännström et al., 2016), Swedish sexual minorities demonstrated a greater risk of morbidity with highly preventable diseases (e.g., pneumonia, hypertensive heart disease) compared with heterosexual people. That is, those with more power, resources, and health care access avoided preventable diseases; whereas, those with less power encountered greater risk with preventable diseases.

**Minority Stress**

The minority stress model (Meyer, 2003) similarly addresses the relationship between stigma and adverse health but instead emphasizes how stress functions as a key mechanism. The minority stress model expanded on social stress theory to explain sexual minorities’ specific health risk (originally conceptualized by Brooks, 1981) and to account for unique stressors associated with the concealability of sexual minority status. Although various groups experience stressors (e.g., expectations of rejection), sexual orientation comprises a concealable status; therefore, sexual orientation presents additional stress related to disclosure decisions and changing one’s public identity within a heterosexist culture (e.g., coming out; Ryan et al., 2015). The concealability of sexual orientation can toll mental health because it can induce hypervigilance, feelings of shame, and impression management anxiety. Furthermore, unlike other stigmatized identities such as race, sexual minorities do not immediately access similar others, given they are unlikely to be born into families who share their stigmatized status. Strained family relations can thus emerge as stressors; moreover, sexual minorities must contend with debates as to whether the source of their stigma (sexual orientation) is uncontrollable or chosen. Sexual minorities’ stressors can be distal (i.e., prejudice-related events such as victimization) or proximal (i.e., internal responses such as expectations of rejection). Recent conceptualizations of minority stress also include structural stigma (i.e., institutionalized heterosexism; Richman & Hatzenbuehler, 2014).

Identifying mechanisms of stigma-induced health problems is a popular goal of intervention—one that requires an understanding of how stigma translates into health or “gets under the skin.” Stressors influence sexual minorities’ health through various mechanisms (Ryan et al., 2017): physiological reactivity to stress (e.g., cortisol; Lick et al., 2013), maladaptive coping (e.g., substance use; McCabe et al., 2010), and impaired health care interactions (e.g., experiences of bias; IOM, 2011; Sabin et al., 2015). Similar pathways from stigma to health include sexual minorities’ internal processes (Hatzenbuehler, 2009), such as hopelessness, low self-worth, and emotion dysregulation. Likewise important to health is sexual minorities’ internalized homophobia (e.g., Puckett et al., 2015). Interventions to change people’s reactions to stigma serve a significant role in improving health but are not the only solution. Some research, as reviewed in the next section, adopts another strategy for reducing health disparities and focuses on changing the social contexts in which sexual minorities live.
Policy Insights for Reducing Stigma and Improving Health

In the U.S.’s current era of increased equality, well-intended individuals, organizations and communities, researchers, and policymakers can mitigate stigma and health disparities. A social ecological perspective accounts for the interconnectedness of stigma and interventions across levels (Cook et al., 2014; IOM, 2011; Jones, 2000). The intraindividual level of analysis can direct recommendations to heterosexual individuals; the interpersonal level targets organizations and communities; and the institutional level considers research and social policy. Some scientists posit that change at the institutional level will trickle down to influence other levels (Hatzenbuehler & Link, 2014; Herek, 2010; Jones, 2000), whereas others suggest changing individuals’ attitudes and interpersonal dynamics will affect high-level structures (Cook et al., 2014). Both perspectives point to a multi-level approach as most effective for disrupting the relationship between stigma and health.

Recommendations at the Intraindividual Level: Heterosexual Individuals

Reducing prejudice and enhancing allyship among heterosexual people addresses the well-established connection between experiences of stigma (e.g., stereotyping, discrimination) and health problems. Sexual minorities’ experiences of microaggressions correlate with depression (Nadal et al., 2016), and experiences of discrimination link to suicidal behavior and substance use (Fish et al., 2019; McCabe et al., 2010). Sexual minorities who encounter negative reactions in their “coming out” process report more depression and lower self-esteem than those who have neutral and positive reactions (Ryan et al., 2015); survivors of anti-gay hate crimes express greater anxiety, depression, and posttraumatic stress than nonvictims (Herek et al., 1999); and sexual minorities who experience a recent prejudice event have greater odds of experiencing physical health problems than those who do not (Frost et al., 2015).

Minimizing prejudice is thus a strategic goal for heterosexual individuals to narrow health disparities. Interventions to reduce sexual prejudice vary in effectiveness, but reviews identify intergroup contact, perspective taking, and empathy as promising objectives (Chaudoir et al., 2017; Cramwinckel et al., 2018). Facilitated exercises, for example, that guide heterosexual people to imagine sexual minorities’ hardships can strengthen intergroup perspective-taking and reduce prejudice toward sexual minorities (Hodson et al., 2013). Although some contest the effectiveness of most prejudice-reduction strategies (Paluck et al., in press), if these strategies can reduce prejudice toward any stigmatized group, the best case is for sexual minorities (Charlesworth & Banaji, 2019; Pettigrew & Tropp, 2006).

However, the absence of prejudice is neutrality and tolerance—not support and acceptance. Heterosexual people’s expressions of support for sexual minorities play a role in health and well-being; for example, supportive family relationships benefit sexual minorities’ mental health (e.g., Feinstein et al., 2014), people’s public displays of allyship (e.g., Facebook’s rainbow profile filters) induce sexual minorities’ feelings of belonging (Matsick et al., 2020), and affirmation from religious groups contribute to positive psychological health among sexual minorities (Lease et al., 2005). Well-intentioned heterosexual people should attend to their role as allies in health promotion.

One objective may be to shift low-prejudice heterosexual individuals from passive support to allophilia, defined as feeling “a sense of kinship, comfort, and engagement with and affection and enthusiasm for the out-group” (Fingerhut, 2011, p. 2235). By enacting allophilia, heterosexual people’s allyship can increase sexual minorities’ feelings of acceptance and safety. Sexual minorities perceive allies’ activism as essential for achieving equality, value allies’ support, and desire allies who will actively advocate for social change (Forbes & Ueno, 2020; Rattan & Ambady, 2014). Sexual minorities respond well to heterosexual allies who publicly support LGBTQ rights and equality, affirm and celebrate sexual diversity, and center their politics around supporting sexual minorities. Educating oneself by supporting advocacy events, participating in available bystander or allyship workshops, reading and learning about LGBTQ history, voting, and reflecting on heterosexual privilege can boost one’s ally development.

Heterosexual allies can also use their platforms to support and promote policies that will benefit sexual minorities. For example, from local government (e.g., school boards, City Council) to national politics and global affairs, heterosexual people hold positions that empower them to make social and political change. Allies can put forward ideas that reduce sexual stigma and improve sexual minorities’ health. That is, as more heterosexual people learn how to become effective allies, they can use their status in various settings to advocate for change that best serves sexual minorities. Allies can be especially useful in decision-making situations in which sexual minorities are not present thus depend on knowledgeable allies to communicate their demands and needs.

Recommendations at the Interpersonal Level: Organizations and Communities

Organizations and communities can both facilitate intergroup dynamics and protect sexual minorities’ own spaces.

Facilitate education and positive intergroup dynamics in organizations. Most organizational interventions regarding sexual orientation focus on educational settings. In a review of “safe school” interventions (i.e., actions to enrich the climate for
sexual minorities; Black et al., 2012), various initiatives (e.g., educating staff, introducing curriculum, adopting anti-discrimination policies) improve psychological functioning among sexual minority youth. The 17 reviewed studies indicate that students in schools with at least one intervention perceive their environments as safer and less stigmatizing than students in other schools. For instance, establishing Gay-Straight Alliances (GSAs; clubs that build community across sexual minority students and allies) enhance sexual minorities’ well-being. GSAs mitigate the relationship between victimization and suicide ideation (Davis et al., 2014), and students in schools with GSAs overheard fewer homophobic remarks, feel safer, improve academically, feel more comfortable with their sexualities, and experience less victimization than students without GSAs (Kosciw et al., 2012). Educational workshops in university settings (e.g., “Safe Zone Project”) generate similar benefits for sexual minorities; in these trainings, participants learn how to create more inclusive campuses. Nonacademic organizations that aim to better their climates may be inspired by the positive effects of interventions found in educational settings.

Although scant data support the efficacy of sexual orientation-based trainings in nonacademic settings, workshops might raise awareness of microaggressions, sexual stigma, and bias. Indeed, such efforts would be useful for counteracting amnestic heterosexism (beliefs that sexual prejudice is not a serious problem; Katz et al., 2019). Educational interventions may be able to mobilize allies and empower bystanders. When lacking knowledge about subtle prejudice and the impact of stigma, heterosexual bystanders are less likely to recognize prejudice when it occurs, less likely to intervene, and more willing to express subtle prejudice (Katz et al., 2019). Initiatives to educate heterosexual people about sexual stigma provides a hopeful avenue for intervention; however, this requires testing interventions for their efficacy.

**Foster local community and space.** Heterosexual members of society can help to protect sexual minorities’ communities and spaces. Sexual minorities’ community connectedness (i.e., feelings of affiliation and solidarity) weakens the relationship between stigma-related stress and mental health (Frost & Meyer, 2012; Major & O’Brien, 2005; Meyer, 2003; Puckett et al., 2015). Beyond the social advantages to establishing community, community resources (e.g., recreational groups and facilities, Pride events, advocacy organizations, LGBTQ housing) yield benefits for sexual minorities, such as lower smoking rates (Watson et al., 2020), greater adjustment (e.g., less internalized homophobia; Puckett et al., 2017), and improved health care access (Fredriksen-Goldsen, 2018). A goal for improving health should be to strengthen community connectedness and protect local resources. Securing community and space requires cooperation between various parties. Allies, for example, can financially and politically support gay-affirming establishments (e.g., gay bars), as these are not merely places for socializing but sources of psychological wellness. Furthermore, therapists can actively help sexual minority clients build community connections (Puckett et al., 2015), and primary health practitioners can connect interested patients to local or virtual social groups and events (Wardecker & Matsick, 2020). Overall, supporting efforts to create more connected and inclusive environments for sexual minorities will lessen stigma’s impact on health.

**Recommendations at the Institutional Level: Academic and Legal Structures**

Academic and legal domains can respectively enhance research and establish protections.

**Enhance research attention.** Knowledge gaps remain in the health disparities literature that warrant researchers’ attention. First, the majority of research relies on White, young, educated, and urbanized sexual minorities (Chaudoir et al., 2017; Salomaa & Matsick, 2020), though sexual minorities at other social locations experience stigma and health problems (e.g., elderly individuals, people of color, rural communities). Likewise, subgroups of sexual minorities, such as bisexual people, are at risk but often omitted from research. Moreover, the health literature underrepresents sexual-minority women compared to sexual-minority men (Salomaa & Matsick, 2020). This disparity likely exists because of the sizable resources required to obtain representative samples. For example, scientists who target specific populations or aim to stratify subgroups of sexual minorities in analyses necessitate large-scale and time-consuming recruitment efforts. Although disparities are already well-documented across various health outcomes, health work is needed that diversifies who is represented in disparities research and tests the efficacy of interventions to reduce stigma and improve health.

Second, many scholars recognize the evolution of sexual prejudice (Frost, 2017; Hegarty et al., 2004; Katz et al., 2019). Researchers must redefine and revalidate measures of prejudice and discrimination. Whereas today’s sexual minorities may be less likely to encounter overt bias (e.g., violence), they may endure subtle and multidimensional forms of stigma (e.g., prejudice involving support for equality but moral disapproval of sexual minorities; Cramwinckel et al., 2018). To understand connections between stigma and health, researchers need to appreciate modern manifestations of prejudice.

Finally, sexual minorities have positive psychosocial experiences that research may overlook but could harness to improve health. Among sexual minorities’ strengths are “families of choice” and diverse support networks (Wardecker & Matsick, 2020). Further, the “health equity promotion model” incorporates resilience into theories of health (Fredriksen-Goldsen & Kim, 2017), and being a sexual
minority has positive aspects (e.g., gender role flexibility; Riggle et al., 2008). Moving beyond a minority-as-a-deficit model (Herek, 2010), research priorities should identify sexual minorities’ strengths and seek to capitalize on them.

**Establish legal protections.** Extending rights to sexual minorities is sound public health policy. The legalization of same-sex marriage on a state-by-state basis and at the federal level was associated with better health among sexual minorities, such as a decline in adolescent suicide attempts (Raifman et al., 2017) and a decrease in sexual minority men’s medical visits and health care expenditures (Hatzenbuehler et al., 2012). States with policies that protect sexual minorities (e.g., hate crime statutes, nondiscrimination policies) have lower rates of psychiatric disorders among sexual minorities than states without policies; more specifically, counties with more structural stigma (e.g., lack of bullying policies, fewer schools with GSAs) have higher suicide risk among sexual minority teenagers than counties with more affirming structural features (as reviewed by Hatzenbuehler & Link, 2014). In contrast, in the aftermath of 16 states’ decisions to implement bans on same-sex marriage, sexual minorities in states with bans had higher rates of psychiatric disorders (e.g., mood disorders) compared with hetero-sexual counterparts and compared with sexual minorities in states without bans (see Hatzenbuehler & Link, 2014 for review). Inclusive policies and structures promote sexual minority health, whereas discriminatory policies and a lack of protections contribute to health disparities. Lawmakers considering the expansion of civil rights protections (i.e., the Equality Act), inclusive family policies, and religious freedom bills that permit the refusal of services to sexual minorities on religious grounds (i.e., Religious Freedom Restoration Acts) should reflect on the empirically established connection between policy and health. Expanding legal protections may promote health, whereas policies that permit discrimination will contribute to poorer health and greater disparities.

**Conclusion**

Discussing social action research and minorities’ problems, Lewin (1946) said “there exists a great amount of good-will, or readiness to face the problem squarely and really to do something about it” (p. 34), but that people require direction. Lewin suggested well-intentioned actors need social scientists to (a) define the social problem and (b) orchestrate what we, as a society, can do about it. This article aimed to address both goals: reviewing the persistent problems of sexual stigma and health disparities and identifying broad recommendations for individuals, organizations, communities, researchers, and policymakers to consider. Minorities should not have to fix social problems that they had little hand in creating. This review provides various considerations, in hope that well-intentioned heterosexual people can act from at least one recommendation to help reduce sexual stigma and health disparities.

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**ORCID iD**

Jes L. Matsick  [https://orcid.org/0000-0003-4368-3211](https://orcid.org/0000-0003-4368-3211)

**Note**

1. We use “sexual minority” to refer to people who commonly self-identify as LGBTQ and/or express behaviors or attractions that are nonheterosexual. We echo Herek and colleagues (2007) that the “T” represents an array of gender identities and expressions distinct from sexual orientation and sexual minority status; thus, we emphasize that this article most accurately addresses social issues related to sexual orientation and not those of gender identity, though overlap may exist between the two.

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