Mental Health for Men Who Have Sex with Men (MSM) and Women Who Have Sex with Women (WSW)

Anna C. Salomaa and Jes L. Matsick

Anna C. Salomaa, M.S.
acs312@psu.edu
370 Moore Building, University Park, PA 16801

Anna C. Salomaa, M.S. is a doctoral candidate at The Pennsylvania State University in the Department of Psychology (area: clinical psychology). The overarching goal of her research is to translate mapping the complexities of sexuality to the improvement of sexual minority health. Her primary areas of focus include (1) issues in measuring sexual orientation in clinical and research settings and (2) mechanisms behind and interventions against binegative attitudes in lesbian, gay, and heterosexual individuals that contribute to health disparities in bisexual people.

Jes L. Matsick, Ph.D.
jmatsick@psu.edu
416 Moore Building, University Park, PA 16801

Jes L. Matsick, Ph.D. is an Assistant Professor of Psychology and Women’s, Gender, and Sexuality Studies at The Pennsylvania State University. She studies sexuality, gender, and prejudice, and much of her research is centered on the perspectives and experiences of lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals. She uses social psychological and feminist theories and methodologies to examine contemporary social issues, such as heterosexism, bisexual prejudice, allyship, health disparities, and intergroup relations. Her work has been supported by the American Institute of Bisexuality, the Gay and Lesbian Medical Association, and the Society for the Psychological Study of Social Issues.
Abstract

This chapter reviews mental health research of sexual minorities who are defined by their same-gender sexual behavior. Women who have sex with women (WSW) and men who have sex with men (MSM) encompass not only those who identify as LGBQ+ but also people who identify as heterosexual or are unsure of their sexual orientation. The authors discuss the implications of this broad categorization on the study of mental disorders and psychological distress and present the typical rates of risk for WSW and MSM overall and within subgroups (e.g., heterosexual-identified WSW, Black MSM). This area of research is often hindered by the multiple ways in which MSM and WSW groups can be defined and the vast heterogeneity of people who fall within these categories. Further, because of the origins of WSW/MSM-terminology in HIV/AIDS research, there is a gendered imbalance in allocation of research funding toward MSM over WSW. Future research should address the limitations of this categorization system in understanding mental health by including multiple measures of sexuality to create a fine-grained understanding of which experiences of WSW/MSM transfer risk and by addressing the paucity of research on WSW and their mental health.

Keywords: sexual behavior, identity discordance, sexual identity, mood disorders, sexual minorities, heterosexual
Mental Health for Men Who Have Sex with Men (MSM) and Women Who Have Sex with Women (WSW)

The terms sexual minorities use to identify themselves are abundant, dynamic, and, most importantly, self-determined. In contrast to the challenge of cataloguing the vastness of queer identities, the labels women who have sex with women (WSW) and men who have sex with men (MSM) can provide researchers relief with their simplicity. Beyond ease of use, these categories capture a broader swathe of people who may not otherwise count themselves or be included in research analyses as sexual minorities. In this chapter, we focus on the current trends and implications of studying the mental health of sexual minorities from the perspective of their same-sex sexual behavior. Given the typically high mental health risks related to belonging to the sexual minority category, it is important that the manner in which this population is defined is inclusive of all of those experiencing detriments to mental health via minority stress. This chapter will (a) evaluate the use of WSW and MSM terminology across research approaches; (b) review mental health issues in the WSW and MSM literature; (c) analyze how WSW and MSM mental health patterns differ across sexual orientation, gender identity, race, ethnicity, and culture; and (d) look forward to future areas of inquiry regarding the mental health of WSW and MSM populations.

Defining Sexual Minorities by Sexual Behavior

Why and when should researchers identify sexual minorities as WSW and MSM rather than by their self-identified sexual orientation? The WSW and MSM terminology is most often used when the focus is on public health and epidemiology—when sexual behavior and its repercussions for health are at the center of the research question. MSM
was coined by researchers in the 1980s as a way to identify men who have sex with men in the context of HIV/AIDS research (Boellstorff, 2011; Young & Meyer, 2005). Under this lens, how these men identified—whether as heterosexual, gay, or bisexual—did not matter when the focus was tracking disease transmission; only same-gender sexual behavior with other high-risk men was considered of import (Boellstorff, 2011). Further, later efforts to reach these men for intervention that only focused on self-identified gay or bisexual men would exclude those who did not count themselves as part of the gay community, which was overrepresented by White, middle-class men; thus, many at-risk men would be underserved by intervention efforts. Using the term MSM, therefore, created a space for a wider variety of men who were overlooked and underserved by researchers. The term WSW, too, came from the field of public health; however, it would not emerge until the mid-1990s (Boellstorff, 2011), and the WSW group remains far more understudied than MSM. For example, MSM appears as a keyword approximately four times as often in 2018 scientific literature than WSW (Sullender, 2019).

Sexual health remains a focus of studies that use WSW/MSM identification given the prioritization of sexual behavior in this categorization system; however, the use of these terms has spread to other domains as well, including mental health. One strength of focusing on sexual behavior in the context of mental health is that it leads to broader groupings of people that are inclusive of gay, bisexual, and queer people, as well as people who identify as heterosexual but engage in same-gender sexual behavior. In other words, the categories are not restricted by an individual’s social identity labels (e.g., pansexual, lesbian). When sampling from a population by first using WSW/MSM criteria, this inclusive sampling procedure then allows for further post–data collection
groupings by identity and attraction to be made if necessary (Salomaa & Matsick, 2019). However, this is not the case when researchers first restrict their population to participants’ self-identification with LGBQ+ labels (e.g., sampling participants who only identify as lesbian, gay, or bisexual). Many people with same-gender sexual behavior would be excluded by this approach: for example, researchers would overlook the health risks and outcomes of heterosexual-identified people with same-gender sexual behavior when behavior is not part of the inclusion criteria. Put simply, recruitment efforts that target the behavioral categories of WSW and MSM may yield a more inclusive and wider net of participants for studying sexuality and mental health.

Critiques of WSW/MSM Language

Despite the apparent strength of WSW/MSM terms as more inclusive of non-LGBQ-identified, non-Western, or non-White people’s experiences and language, some researchers argue that WSW/MSM terms are reductionistic and particularly problematic in the context of certain cultures, such as South Asia (Khan & Khan, 2006). For example, for some South Asian people, the act of penetration shapes a person’s gender identity—the person being penetrated is not seen as male, and therefore the MSM or WSW qualifiers could not adequately describe this population. Further, it creates gray areas for people who have sex with hijras (eunuchs and intersex or transgender people), as hijras exist outside of a gender binary and are therefore not captured with either MSM or WSW. Thus, there remain cultural considerations researchers must attend to in their choice of language.

Other issues include the lack of shared vocabulary between researcher and participant—rarely does a person self-identify as a “woman who has sex with women,”
despite their classification in a study as such. Further, as previously described, WSW/MSM also inherently highlights sexual practices over sexual identities; while this may be appropriate for certain kinds of research, WSW/MSM terms are often used as an easy oversimplification for researchers grasping at a shortcut at the expense of a fuller understanding of their participants. Though two people engage in similar same-gender behavior, their identities may contribute to how they construe or reflect on these sexual experiences; for example, same-gender behavior among a lesbian woman may present fewer internal conflicts than does the same-sex behavior of a heterosexual-identified man. These terms also exclude sexual minorities who have not had sex with their same gender, such as individuals who are not sexually active or women who exclusively have sex with men and are attracted to women.

WSW/MSM terminology is overly broad and, without further description of the sample, refers to a wide variety of experiences with important implications (e.g., people who have sex with one vs. more than one gender; all people who have same-sex behavior vs. only those who do not identify as LGBQ+). Without defining specifically who counts as WSW/MSM, it is impossible to compare across studies. This is not a monolithic identifier, and despite its apparent simplicity, it can create greater confusion. Two primary approaches are typically used in studies of WSW/MSM: (1) defining WSW/MSM to include any women or men with same-gender sexual behavior or (2) defining WSW/MSM to include only those who do not identify as LGBQ+ (DNI-WSW/MSM) but engage in same-gender sexual behavior. However, it should be noted that these terms are sometimes conflated with identity, such as when participants who
identify as LGB are coded as WSW or MSM (e.g., Brown, Masho, Perera, Mezuk, & Cohen, 2015).

Using only WSW/MSM language, therefore, is not a perfect solution for researchers seeking a simple question to add to questionnaires to assess sexual orientation. However, in situations in which the goal is to recruit across the range of sexual minority experiences, it is likely that sampling any people with same-gender sexual experiences is a useful strategy if supplemented with further sampling around self-identification, attraction, and context—allowing researchers to create more nuanced groupings than WSW/MSM.

**Who are WSW/MSM?**

Estimates of same-gender sexual behavior are regularly higher than prevalence of LGBTQ-identified individuals, with ranges of prevalence of WSW/MSM from 6.9 percent (Australian Longitudinal Study of Health and Relationships, 2005; Gates, 2011) to 8.8 percent (National Survey of Family Growth, 2006–2008; Gates, 2011). In the United States, approximately 5.7 percent of men and 3.9 percent of women report past-year same-gender sexual partners (Fu et al., 2018). Another epidemiologic survey from 2004 had a far lower estimate, reporting that 1.5 percent of U.S. adults had only had sex with the same gender, and 1.9 percent had sex with both men and women (Bostwick, Boyd, Hughes, & McCabe, 2010). A nationally representative sample of the United Kingdom found that 5.9 percent of men and 7 percent of women had had same-gender sexual partners in their lifetime (Hayes et al., 2012). These numbers are contrasted to the estimated 3.5 percent of individuals in the United States who identify as lesbian, gay, or bisexual (Gates, 2011) and suggest that there are as many or more heterosexual-identified
people with same-gender sexual behaviors than those who would claim a sexual minority identity. The terms WSW and MSM encompass most, if not all, of these individuals.

**WSW.** Of the approximately 7 percent of U.S. women who have had sex with women, half self-identify as heterosexual, 32 percent as bisexual, and 18 percent as gay/lesbian (Xu, Maya, & Markowitz, 2010a). Of U.S. women between the ages of twenty and forty-four, an estimated 7.9 percent both identify as heterosexual and report having had a female sexual partner in their lifetime (Bauer, Jairam, & Baidoobonso, 2010). When defined as those who have had any same-sex behavior but did not self-identify as LGBQ+ (DNI-WSW), DNI-WSW were highly likely to report that they were primarily attracted to men, had only had a single female sexual partner in their lifetime, and had a greater number of overall sexual partners compared to other women, when considering a representative sample of U.S. adults (Bauer et al., 2010). In a California sample, WSW were on average of similar age compared to lesbian WSW and heterosexual-identified women who have sex with men (WSM), and older than the average bisexual WSW (Blosnich, Nasuti, Mays, & Cochran, 2016). When comparing DNI-WSW to WSM, these groups had similar rates of marriage, but DNI-WSW fell in between the WSM and LGB-WSW on demographic categories such as racial diversity, education level, and church attendance, as well as rates of discrimination experiences (Gattis, Sacco, & Cunningham-Williams, 2012).

**MSM.** Slightly fewer men report having a same-gender sexual experience than women in the United States (5 percent); of these MSM, roughly equal numbers identified as either heterosexual (40 percent) or gay (38 percent), whereas only 22 percent identified as bisexual (Xu, Maya, & Markowitz, 2010b). Similarly, Schick et al. (2016) found that
73 percent of all MSM self-identified as heterosexual in their U.S. sample. Heterosexual-identified MSM are typically older than gay- and bisexual-identified MSM, and heterosexual men who have sex with women, perhaps reflecting cultural trends that pressured older generations to maintain a visibly heterosexual lifestyle (Blosnich et al., 2016). This group is about as likely as men who have sex with women (MSW) to be married and attend church, but three times more likely to report past-year experiences of discrimination (Gattis et al., 2012). This suggests that while outwardly there may be few visible signs of difference between these groups, the impact of homophobia or discrimination is still present for heterosexual-identified MSM.

**Mental Health among WSW/MSM**

The minority stress model guides current understanding of how sexual minority status is linked to increases in psychopathology and poorer well-being (King et al., 2008; Meyer, 2003; Meyer & Frost, 2013). A central tenet of this theory is that the stigma experienced by non-majority members of society increases stress, via experiences of discrimination, aggression, and internalized homophobia. Minority stress has well-documented effects on the health of sexual minorities, including WSW and MSM (e.g., Przedworski, McAlpine, Karaca-Mandic, & VanKim, 2014; Wong, Schrager, Holloway, Meyer, & Kipke, 2014). However, in the case of WSW/MSM, the application of this model becomes complicated by the high proportion of individuals in these groups who do not self-identify as a sexual minority, and therefore may not relate to or experience the common stressors experienced by LGBQ+-identified individuals. Simultaneously, non-LGBQ+ WSW/MSM do not have the same level of access to LGBQ+ communities, which may increase their vulnerability to stressors. Factors such as outness or
discordance between identity and behavior play heavily into understanding how a marginalized sexual practice contributes to increased minority-based stress, and given this heterogeneity within WSW/MSM, it is important to consider subgroups when predicting mental health.

**General Trends in Mental Health Outcomes**

The well-documented pattern of poor mental health in LGBQ+ populations spans from youth (Russell & Fish, 2016) to older adults (Fredriksen-Goldsen et al., 2013) and across mood disorders (Lytle, De Luca, & Blosnich, 2014), trauma (Smith, Cunningham, & Freyd, 2016), and substance use (Lee, Gamaerel, Bryant, Zaller, & Operario, 2016). When taking a broad look at all WSW and MSM, the same general levels of risk emerge. Further, as described later in this section, this pattern extends to and changes for sexual minorities identified as WSW/MSM, with inconsistently both less and more extensive risk experienced by WSW/MSM who do not identify as LGBQ+.

**Mood Disorders.** Compared to heterosexual WSM and MSW, there is a preponderance of evidence to suggest that WSW and MSM at a broad level are more likely to report symptoms of mood disorders (e.g., major depressive disorder, generalized anxiety disorder; Cochran & Mays, 2000a, 2000b; Pyra et al., 2014; Salomon et al., 2009. Further, both WSW and MSM are more likely to report use of mental health services in the past year (Cochran & Mays, 2000a). Similarly, DNI-WSW were more likely to report recent psychological distress and past-year major depression than heterosexual women (Blosnich et al., 2016).

While many studies focused on WSW and MSM compare those who identify as heterosexual to those with an LGBQ+ identification, far fewer examine the relevance of
having sex with more than one gender (i.e., WSWM/MSWM, or bisexual behavior).

However, concurrent with studies of bisexual identity and mental health risks, individuals who have had sex with both men and women are at higher risk for mood disorders, both across their lifetime and within the past year, when compared to those with only heterosexual behavior (Bostwick et al., 2010; Pyra et al., 2014). Echoing the importance of capturing the “WSWM” group distinctly from WSW-only, the relative risk of WSW, WSWM, and WSM is inconsistent across studies when mood is examined across these three groups (compared to the typical two WSW/WSM groups). Major depression was experienced by 52 percent of WSWM in their lifetime, 27 percent of WSM, and only 15 percent of WSW (Pyra et al., 2014); this suggests that collapsing into a single WSW group obscures a lower-risk group and dampens the ability to identify WSWM as a particularly high-risk group.

**Suicidality.** Rates of suicide-related experiences in WSW and MSM are closely linked to self-identification of sexual orientation and gender (Blosnich et al., 2016). Heterosexual-identified WSW are found twice as likely as heterosexual WSM to report lifetime suicidal ideation or suicidal attempts, which was on par with lesbian-identified WSW and less than bisexual-identified WSW. Heterosexual-identified MSM were four times more likely than heterosexual MSW to have suicidal ideation and seven times more likely to have made a suicide attempt; unlike WSW, these rates were higher than for gay- and bisexual-identified MSM. Comparatively, gay and bisexual-identified MSM experience similar rates of past-year suicidal ideation as heterosexual MSW, while heterosexual-identified MSM were nearly eight times more likely. A potential cause of this remarkably heightened risk for suicidality in heterosexual MSM could be the lowered
access to LGBQ+ communities and outreach, given the lack of identification as a sexual minority.

Consistent with U.S. samples, French WSW reported more physical violence and suicide attempts compared to WSM, although they notably did not report heightened general psychological distress (Lhomond & Saurel-Cubizolles, 2006). Similar patterns of suicidality were found in a Dutch sample, in which sexually active MSM had greater suicide symptoms (death ideation, death wishes, suicidal ideation, suicide attempts) and WSW had greater suicidal ideation compared to non-MSM and non-WSW (de Graaf, Sandfort, & ten Have, 2006). In a sample of Norwegian WSW/MSM youth, only same-gender sexual behavior was found to predict an increase in suicide attempts, but same-gender attraction and self-identification as LGBQ+ did not compared to heterosexual youth (Wichstrøm & Hegna, 2003). Suicidality is also high in Estonian MSM (Rüütel, Valk, & Lõhmus, 2017).

Interactions between Sexual and Mental Health

Sexual and mental health are deeply entwined for both MSM and WSW, given the etiology of these groupings in HIV/AIDS research. However, the focus of sexual and mental health research for MSM is on HIV/AIDS, while research on WSW tends to focus on general sexually risky behaviors and is sparser overall. Given that WSW and MSM experience high rates of mental health disorders, it is important to understand the link between mental health problems and increased risk of sexual health problems, such as HIV risk behaviors and engagement in prevention programs (e.g., Safren, Blashill, & O’Cleirigh, 2011).
Among WSW, increases in minority stress and mental health problems may be linked to avoidance of sexual health information, preventive care, and routine checkups; further, WSW are more likely to be uninsured if they hold a sexual minority identity (Baptiste-Roberts, Oranuba, Werts, & Edwards, 2017; Kerker, Mostashari, & Thorpe, 2006; Knight & Jarrett, 2017; Przedworski et al., 2014; Reisner et al., 2010). Despite this increased need for study and service, research on WSW and sexual health receives far less funding because of the lower HIV transmission rate in women compared to MSM. As a large portion of funding for LGBQ+ research comes from HIV prevention, other health concerns, such as mental health, are often understudied and underserved (Lenke & Piehl, 2009). This has led some to argue that WSW are therefore the most at risk for poor sexual health, given the paucity of research and subsequent intervention development and implementation (Johnson, 2009, as cited in Henderson, Cloete, & van Zyl, 2011). This assertion is supported by research, as the evidence suggests that WSW are more likely to have sexually transmitted infections and engage in sexually risky behaviors compared to WSM (Bauer et al., 2010; Fethers et al., 2000). However, the greatest degree of risk may be for WSW who identify as heterosexual or bisexual (Everett, 2013; Koh, Gomez, Shade, & Rowley, 2005).

While representing only a small portion of the U.S. population, half of those living with HIV/AIDS are MSM (O’Cleirigh et al., 2013). Among MSM, minority stress and mental health problems are linked to HIV risk and vulnerability, as well as the additional burden of HIV-related stigma (Chong, Mak, Tam, Zhu, & Chung, 2017). This link is not necessarily linear, as moderate levels of depression in HIV-infected MSM were found to predict poorer response to treatment of sexual risk-taking behaviors,
compared to those with mild or severe depression (O’Cleirigh et al., 2013). This finding parallels studies of general suicide risk, suggesting that while severe depression dampens motivation to engage in any behaviors, including sexual behaviors, moderate levels confer enough energy to act out maladaptive coping behaviors. Beyond the impact of mood disorders, MSM have extremely high rates of childhood sexual abuse and current posttraumatic stress disorder (PTSD), which leads to heightened risk for substance use and sexual risk behaviors (Boroughs et al., 2015). Further, having PTSD symptoms predicted an increased likelihood of having engaged in risky sexual behaviors among MSM (Reisner et al., 2009).

Mental health problems are further entangled with sexual health in MSM. Being HIV-positive doubles the risk of depression for MSM (Ciesla & Roberts, 2001). Younger MSM are particularly at risk, as they are more likely to report depressive symptoms and alcohol/drug use and less likely to use mental health services than older MSM; simultaneously, this group is also more likely to engage in sexually risky behavior (Salomon et al., 2009). Further, MSM who are HIV-positive and experience trauma and depression are more likely to not adhere to antiretroviral treatment medications (Gonzalez, Batchelder, Psaros, & Safren, 2011), perhaps because these symptoms reduce the likelihood of self-care behaviors and perceived self-efficacy (Kavanagh & Bower, 1985; Rabkin, 2008, as cited in White, Gordon, & Miniaga, 2014). This pattern has been replicated in prospective samples, where it was also found that HIV-related stigma perceptions increased transmission risk behaviors (Hatzenbuehler, O’Cleirigh, Mayer, Mimiaga, & Safren, 2011).

**Substance Use**
The gender of women’s sexual partner(s) is a strong predictor of drug use. Women who have sex either only with men or only with women have similar rates of drug use to each other; however, women whose sexual partners include both men and women have comparatively higher rates of substance use and dependence across multiple substances (e.g., Lhomond & Saurel-Cubizolles, 2006; McCabe et al., 2009). This same pattern was found for MSMW, such that partners of multiple genders led to far higher rates of substance use and abuse (Friedman et al., 2019).

A meta-analysis of substance dependence revealed that while MSM and WSW are both at higher risk compared to those with only different-gender sexual partners, WSW have a remarkably higher level of risk than MSM (King et al., 2008). However, these trends also depend on individuals’ sexual orientations. For example, heterosexual-identified WSW are four times as likely to use cannabis as WSM (Trocki, Drabble, & Midanik, 2009), and heterosexual-identified MSM are more likely to engage in sexual acts while intoxicated compared to both MSW and LGB-identified MSM (Pathela et al., 2006). Other results paint another picture, where rates of substance use by heterosexual-identified WSW and MSM lie between heterosexual WSM/MSW and LG-identified WSW/MSM (Gattis et al., 2012). Once dependent on substances, heterosexual-identified MSM are also less likely to complete substance use treatment compared to both heterosexual MSW and gay and bisexual men, a difference attributed to negative affectivity surrounding their same-gender activity (Senreich, 2015).

These differences are conceptually concordant with the minority stress model (Meyer, 2003), as it is expected that those with higher rates of environmental stressors and lower access to community supports would be more likely to seek out maladaptive
coping strategies, such as alcohol and drug use. Despite their lack of identification as a sexual minority, because heterosexual-identified MSM and WSW are less likely to have access to community support, it follows that they experience stressors that are often coped with through substances. The inconsistencies in where the rates of this substance use lie in comparison with LG-identified individuals is likely explained by the variety of experiences within the heterosexual-identified WSW/MSM groups—such as degree of internalized homophobia, same-gender attraction, or chronicity of behavior (i.e., the timing of being currently or previously sexually active with members of the same gender). Other individual differences such as personality have been explored to predict substance use in MSM; those who are dependent on methamphetamines are higher in neuroticism and lower in openness, agreeableness, and conscientiousness (Solomon, Kiang, Halkitis, Moeller, & Pappas, 2010). All of these components, and other individual difference variables, should be explored in greater depth in future research to more accurately identify risk within the vast categories of WSW and MSM.

**Intersecting Identities and Mental Health**

Because WSW/MSM groupings are deliberately broad, it is necessary to understand how specific intersections of identity can overlap with behavior to create unique challenges for mental health. Here, the overarching ways that sexual orientation, gender, and race/ethnicity relate to psychopathology and well-being are explored each in separate sections. However, the interactions across each of these domains will also be noted throughout—given that, for example, the typical experiences of a Black lesbian WSW that culminate to impact mental health are likely to be instrumentally different than those of a Latino bisexual MSM.
Sexual Orientation

Being “out” as a sexual minority is to be publicly identified as a lesbian, bisexual, gay, or queer individual. It would be easy to label heterosexual-identified WSW/MSM as LGBTQ+ individuals who are simply not out and are concealing their “true” identity; however, this assumes that their heterosexual identity is false. Outcomes for specific identifiers (e.g., lesbian, bisexual) are explored elsewhere in this chapter and in this Handbook. However, given the broad umbrella of the terms WSW and MSM, examining the intersection of self-identification and gender of sexual partners is a fruitful approach to further dividing these groups in meaningful ways. In particular, the idea of sexual identity and behavior discordance and concordance has been demonstrably important to reveal differences in mental health within WSW/MSM (Kerker et al., 2006). Discordance refers to the assumed “mismatch” between self-reports of sexual orientation and sexual behavior (e.g., identifying as heterosexual but reporting same-gender sexual behaviors), whereas concordance refers to the congruity between these components of sexuality (e.g., identifying as lesbian and reporting only female sexual partners; Gattis et al., 2012).

While discordance/concordance language, along with synonyms such as alignment or incongruence, is used extensively in studies of sexual behavior and identity (Brewster & Tillman, 2012; Korchmaros, Powell, & Stevens; 2013), these terms have also been critiqued as having inherent researcher judgment of what are “correct” or “natural” combinations of behavior and identity (van Anders, 2015). While beyond the scope of this chapter, sexual configurations theory (SCT; van Anders, 2015) is a comprehensive model of sexuality and its numerous moving parts that provides a useful alternative to terms such as “discordant.” Instead, SCT proposes using “coinciding” and
“branching” terminology to describe without value statements the manner in which sexual identity and behavior (as well as attraction, status, partner number, and other components) may combine to form an individual’s unique configuration of sexuality.

Across studies, identity–behavior discordance (or branching) uniquely predicts rates of mental health disorders and substance use (Gattis et al., 2012; Horn & Swartz, 2019; Krueger & Upchurch, 2019). The discordant/branching group is typically heterosexual-identified but engages in sex with either the same gender or multiple genders, and is sometimes referred to as “closeted” (e.g., Pachankis, Cochran, & Mays, 2015). Overall, discordant/branching MSM have rates of substance use (e.g., stimulants, cannabis, hallucinogens) and mental health disorders (major depressive disorder, general anxiety disorder, PTSD) that lie above those of coinciding heterosexual men and below coinciding gay men (Gattis et al., 2012). Discordant/branching WSW typically experienced the same pattern of substance use and mental health disorders as concordant/coinciding WSW; however, differences in risk are often found to be greater for WSW than MSM. Application of the minority stress model to these findings would suggest that the discordant/branching MSM/WSW do not experience the full extent of social stressors as LGB-identified MSM/WSW because they do not claim a marginalized identity, but are still harmed by expectations of social rejection or internalized homophobia linked to their discordant/branching experiences. This is supported by findings that heterosexual-identified MSM often experience and express shame regarding sex with men (Reback & Larkins, 2010).

Bisexual identity and behavior are consistent risk factors for substance use and dependence in women. Lesbian-identified WSW and WSW who have only had female
sexual partners use substances at lower rates than bisexual- or heterosexual-identified WSW and WSW with both male and female sexual partners (McCabe et al., 2009; Przedworski et al., 2014). Similarly, identifying as heterosexual while having a history of same-gender sexual partners is a profile of branching sexuality in women linked to higher risk in substance use and sexually risky behaviors (Bauer et al., 2010). Given the elevated health risks associated with discordant/branching sexualities, future research should better identify the psychological mechanisms that play a role in the relationship between discordant/branching status and health.

**Gender Identity**

As detailed earlier in the chapter, there are consistent yet diverging patterns in mental health outcomes between WSW and MSM—demonstrating that gender plays a moderating role in the transmission of risk via the minority stress model. However, a bias in the literature toward focusing on MSM over WSW limits our ability to fully compare these two populations; for example, a review of keywords used in Google Scholar reveals that in 2018, WSW was used approximately 6,000 times, but MSM was used about 23,000 times (Sullender, 2019).

Another central issue with gender is that WSW and MSM categories inherently reinforce a gender binary: while one benefit of the WSW and MSM terminology is that the terms are quite broad, these categories often make invisible people or partners outside of man/woman labels. In doing so, researchers are overlooking subgroups of WSW/MSM that are likely at the greatest levels of mental health risk: transgender or gender nonbinary individuals (Su et al., 2016). There is also a problem with the conflation of gender and sex that is not adequately addressed via these labels, which fails to account for
contemporary understanding of gender/sex and theories of sexuality (see SCT; van
Anders, 2015). Further, it has been common practice to either overlook transgender
participants in studies of WSW/MSM or to group cisgender MSM with transgender
women who have sex with men, in studies published as recently as 2015 (Muessig,
Baltierra, Pike, LeGrand, & Hightow-Widman, 2014; Peacock, Andrinopoulos, &
Hembling, 2015; Zea et al., 2015, as cited in Poteat, German, & Flynn, 2016).

Racial and Ethnic Minorities

Using WSW/MSM sidesteps Global West–centric assumptions that sexuality is
deﬁned by ﬁxed identities; therefore, some argue that these ﬂexible terms can better
encompass the sexual practices found in other cultures (Blackwood, 2000). WSW and
MSM of color in the United States and elsewhere experience high levels of
discrimination, which impact mental health; however, the pathways of sexual minority
stress differ across different race/ethnicity groups. Overall, homophobia expressed by the
surrounding LGBQ+ community and from friends leads to poorer well-being in
WSW/MSM of color; interestingly, homophobia from family members was not found to
impact the well-being of MSM (Choi et al., 2013).

Black WSW/MSM. The consequences of using the term “MSM” are particularly
problematic for Black MSM, many of whom use self-identiﬁcation labels that do not
decontextualize or further reinforce the minority status given to this group; some have
suggested using “same-gender-loving” or “SGL” in place of MSM (Truong, Perez-
Brumer, Burton, Gipson, & Hickson, 2016). Unique identiﬁers used by men of color who
do not identify as gay or bisexual (e.g., “same-gender-loving,” “on the down low”) may
impede efforts to target this population for mental (and sexual) health interventions when
not accounted for. While large-scale epidemiological research can help researchers and health providers understand general risks for this group, our understanding would be incomplete without supplementation of qualitative-driven studies that can account for subjective experiences and information outside of researcher-identified questions.

Interviews with Black MSM support other evidence that this group experiences depression and anxiety at high rates, for reasons related to rejection from family and community, cultural messages about expectations of Black men, experiences of violence and discrimination, and high rates of involuntary early sexual experiences (Graham, Braithwaite, Spikes, Stephens, & Edu, 2009). Further, the internalized conflicting expectations of their gender, race, and sexuality often complicated the process of identity formation: it was difficult for some men to integrate hegemonic masculinity with the feminine stereotypes of having sex with men. Notably, participant descriptions of poor mental health were typically characterized by somatic symptoms and irritability, rather than cognitive or emotional experiences. Black MSM also face additional burdens, particularly that of a disproportionally high HIV infection rate (Centers for Disease Control and Prevention, 2013), which in turn increases the burden of mental illness via additional experiences of stigma. The experiences HIV-positive Black men have with stigma predict both depression and PTSD (Galvan, Landrine, Klein, & Sticklor, 2011).

Black MSM in African countries may experience a heightened burden in their mental health. Approximately half of a sample of South African MSM met criteria for depression, suicidality, and alcohol and drug use disorders; they also experienced increased rates of personality and neuropsychiatric disorders (Stoloff et al., 2013). Gender nonconformity in Black South African MSM has an unexpected relationship to
anxiety and depression: contrary to findings in Western countries, feminine South African MSM do not experience a higher risk of depression or anxiety despite more experiences with discrimination (Cook, Sandfort, Nel, & Rich, 2013; Sandfort, Bos, Knox, & Reddy, 2016). It was suggested that because gender-nonconforming MSM were less likely to be perceived as having dissonant gender and sexual identities, they experienced less internal distress compared to gender-conforming MSM who may be more likely to try to pass as straight.

**Latinx WSW/MSM.** Beyond quantitative, epidemiological data on Latina WSW, interviews with Puerto Rican women with severe mental illness illuminate the tangled nature of their difficulties with intimate partner violence, religiosity, and identity (Loue & Mendez, 2006). Common themes emerged from this qualitative study, including historical and current experiences of physical and sexual abuse from men, which motivated some women to seek exclusive or near-exclusive sexual behavior with women. Many of the women were Christian and relied on their religiosity to manage their mental health symptoms. However, having sex with women in conjunction with high religious values was reported to be a source of distress, particularly given the role that Christianity plays in Latina communities. These women reported that they were reluctant to identify as lesbian or bisexual because these identities were not consistent with the expectations of their families.

**South and East Asian WSW/MSM.** The experiences of South and East Asian WSW/MSM are understudied, particularly those of WSW; however, there are a few studies that indicate this diverse population is subject to unique stressors that impact mental health (das Nair & Thomas, 2012). For example, same-gender sex is still subject
to stigma in China through conflict with traditions around marriage, gender roles, and childbirth (Liu & Choi, 2006), which contributes to an estimated 16 million gay men in marriages with women (Juan, 2012, in Ren, Howe, & Zhang, 2019). In Chinese MSM, minority stress is experienced through the process of anticipated stigma leading to increases in avoidant coping strategies, which in turn predicted greater anxiety and depressive symptoms (Choi, Steward, Miege, Hudes, & Gregorich, 2016). Similarly, Indian MSM also experience greater rates of suicidal ideation and mood disorders (Sivasubramanian et al., 2011). Interestingly, South and East Asian MSM in the United Kingdom were found to report having mostly White sexual partners (57 percent), and 17 percent did not identify as gay or bisexual (das Nair & Thomas, 2012).

**Summary and Conclusions**

While the very names of these groups provide seemingly comprehensive definitions, WMW and MSM are broad populations containing a vast expanse of experiences, whose only overlapping quality is their history of sexual behaviors with same-gender partners. When attempting to understand the trends in mental health in WSW/MSM, issues with these terms being both too broad and too narrow emerge, as does the problem of heterogeneity of defining further parameters on these categories. Sampling men and women with same-gender sexual behavior may include both LGBQ+ and heterosexual-identified people, but also excludes sexual minorities who have not engaged in same-gender sexual behaviors and people whose gender (or gender of sexual partners) falls outside binary lines. These terms make room for some culturally specific experiences that LGBQ+ language fails to encapsulate while simultaneously excluding other culturally bound practices where defining acts within female/male language limits
understanding. These problems culminate in the variety of qualifiers used to define WSW/MSM in research; some studies sample any people who have same-gender experiences, and others limit samples to those who do not identify as LGBQ+. This variation makes comparisons across research difficult, as differing rates of outness and identity likely impact the degree and manner in which minority stress affects mental health.

Despite these difficulties, important trends across studies emerge to outline typical problems WSW and MSM experience with their mental health. While often these trend lines fall in parallel to those of LGBQ+-identified individuals, some important discrepancies emerge when LGBQ+-identified people are contrasted with heterosexual-identified WSW/MSM. For example, heterosexual-identified WSW/MSM are often likely to experience mental health disorders at the same rate as or lower than LGBQ+-identified WSW/MSM, and consistently more often than WSM and MSW. However, having sex with both men and women increases this level of risk beyond that of people who have sex with only one gender regardless of self-identification.

**Future Directions**

As detailed in this chapter, predicting specific mental health outcomes may depend on the way sexual minorities are defined. Using behavior as a measure of sexual minority status is clearly important for predicting rates of mental disorders; however, it is unlikely to be sufficient as the sole marker of sexuality. More research is needed to know which groupings are most predictive in which areas of mental health (e.g., chronicity of behavior, identity). One trend identified in this literature is that, typically, DNI-WSW/MSM experience risk at rates lower than LGBQ+-identified groups, but higher
than WSM and MSW. Whether there is a protective quality to identifying as heterosexual while having a history of same-gender sexual experiences, and whether there are subgroups within DNI-WSW/MSM for whom the risk transferred by minority stress is minimal and who therefore obscure others with much higher levels of risk, are questions that cannot yet be answered. To do so, researchers must consistently take a fine-grained approach to examining mental health and the variety of intersections within sexual identity and experiences.

Not unlike much of health research, there is a historical and contemporary bias toward studying and funding research centered on men over those that focus on women. The distribution of funding around HIV prevention in MSM has increased this bias toward studying men; however, this has resulted in a paucity of research around WSW and their particular experiences surrounding minority stigma and mental health. As such, future research cannot continue to overlook WSW—greater efforts should be made to increase our knowledge of the unique struggles experienced by women with same-gender sexual partners, especially as the intersection of gender and sexuality places this group under the influences of multiple types of stressors. Similarly, WSW and MSM of color and across cultural and racial groups demand more focus in research. The use of WSW/MSM language may be particularly helpful in this area, as defining sexual minorities by sexual behaviors negates the need to rely solely on language that may fail to capture non-Western experiences of sexuality.
References


https://doi.org/10.1007/s10508-018-1162-2


https://doi.org/10.1007/s10508-018-1319-z


https://doi.org/10.1097/QAI.0B013E31822D490A

https://doi.org/10.1007/s12160-011-9275-z

https://doi.org/10.1007/s10508-011-9856-8

Henderson, J., Cloete, A., & van Zyl, M. (2011). “We women are women with a different manner:” Sexual health of WSW in four Western Cape communities. (Commissioned by Triangle Project, December).

https://doi.org/10.3390/ijerph16081399


