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Structural Stigma and the Health of Lesbian, Gay, and Bisexual Populations

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Abstract

Psychological research has made significant advancements in the study of stigma but has tended to focus on individual and interpersonal stigma processes. Recently, researchers have expanded the stigma construct to consider how broader, macrosocial forms of stigma—termed *structural stigma*—also disadvantage stigmatized individuals. In this article, I review cross-sectional, quasi-experimental, and longitudinal studies demonstrating that structural stigma is a risk indicator for psychiatric and physical-health morbidities among lesbian, gay, and bisexual populations. As this work is still in its infancy, the next generation of research will benefit from identifying mediators and moderators of the structural stigma–health association and from examining direct and synergistic relationships between structural and individual forms of stigma.

Keywords

stigma, health, sexual orientation

Psychologists have provided key insights into the process through which stigmatized people perceive and react to stigma and into the psychological and interpersonal consequences of this process (e.g., stress; Major & O'Brien, 2005). Despite these significant advancements, stigma research has been criticized for being too individually focused and for overlooking broader macrosocial forms of stigma that powerfully affect the lives of the stigmatized (Link & Phelan, 2001; Parker & Aggleton, 2003). Although this criticism largely emanates from other disciplines (e.g., sociology, anthropology), psychologists themselves have argued that more attention should be paid to structural issues—that is, supra-individual factors—that shape the stigma process (Fiske, 1998). These arguments stem from a growing recognition that addressing structural stigma can inform psychological inquiry in numerous ways, from elucidating environmental determinants of stigma-related stressors (e.g., self-stigma, concealment) to providing strategic circumstances for testing psychological theories about social contexts that moderate general psychological processes.

co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised. Drawing on theoretically similar frameworks, including institutional/systemic racism (Feagin, 2000), the authors further distinguished between discrimination at individual and structural levels and noted that the concept of structural stigma “sensitizes us to the fact that all manner of disadvantage can result outside of a model in which one person does something bad to another” (Link & Phelan, 2001, p. 382). Following this initial conceptualization, Corrigan and colleagues (2005) offered potential operationalizations of structural stigma, including the policies of private and governmental institutions, and noted that such policies can either be intentional or have unintentional consequences that nevertheless encumber stigmatized individuals. Because policies represent only one instantiation of structural stigma, we recently broadened the definition of this construct to include “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized” (Hatzenbuehler & Link, 2014, p. 2).

Structural Stigma: Definition and Examples

In one of the most influential conceptualizations of stigma, Link and Phelan (2001) defined stigma as the

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Examples of structural stigma include Jim Crow laws, which represented a prominent means of maintaining White privilege in Southern states from Reconstruction to the early 1960s (Van Woodward, 1955); the lack of mental-health-insurance parity for psychiatric relative to medical conditions (Corrigan, Markowitz, & Watson, 2004); and geographic variation in cultural norms surrounding the acceptability of homosexuality (Lax & Phillips, 2009).

Methodological Approaches and Challenges to Studying Structural Stigma

Most psychological research on stigma takes place either in the laboratory or in small-scale community studies. These methods are appropriate for research questions that focus on intra-individual processes or on intergroup relations. Because structural stigma includes processes that occur above the individual and interpersonal levels, however, the examination of structural stigma requires different measurement tools, methodological approaches, and data structures.

Existing measures of stigma were largely developed to query respondents about their perceptions of stigma and their experiences of interpersonal discrimination, rather than to investigate structural forms of stigma (Meyer, 2003). Consequently, studying structural stigma requires the development of new measures capable of capturing this construct (examples of such measures are described in the next section).

In addition to novel measurements, research on structural stigma necessitates different methodological approaches than are typically employed in psychological studies. As with other social-contextual exposures of interest to psychologists (e.g., childhood adversity), it is unethical to randomly assign individuals to environments with and without structural stigma. Consequently, the field must rely on observational and quasi-experimental designs (including “natural experiments”), in which the ability to draw causal inferences is more difficult (Shadish, Cook, & Campbell, 2002). For example, communities with high levels of structural stigma may differ from low-structural-stigma communities in other ways (e.g., level of gun ownership) that also influence the health outcome of interest (e.g., suicide attempts). Researchers have implemented multiple strategies to improve causal inference, ranging from controlling for confounders to conducting specificity analyses documenting that structural stigma is associated with health outcomes among stigmatized, but not nonstigmatized, groups.

Finally, there are unique issues with respect to data structures. To evaluate the impact of structural stigma, researchers require large-scale studies occurring over multiple geographic regions—neighborhoods, counties,

or states—that offer sufficient variation in levels of structural stigma. Further, to allow for the examination of structural stigma as a risk factor for the health of stigmatized individuals, data sets must have the following variables: (a) demographic measures of the stigmatized group of interest; (b) covariates to control for potential confounders and likely alternative explanations; (c) dependent variables (i.e., health outcomes); and (d) geographic information (e.g., zip codes) that enables researchers to link individual-level data to structural-stigma variables (i.e., the independent/predictor variables).

Evidence for Health Consequences of Structural Stigma

Several studies have begun to generate a tantalizing set of findings concerning the role of structural stigma in the production of negative outcomes for members of stigmatized groups. Specifically, structural stigma is associated with increases in felt stigma among individuals with mental illness (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012), with heightened disclosure concerns among individuals with HIV/AIDS (Miller, Grover, Bunn, & Solomon, 2011), and with elevated mortality risk among Blacks (Krieger, 2012). In a series of studies, my colleagues and I have extended this initial research by documenting the impact of structural stigma on morbidity and mortality in lesbian, gay, and bisexual (LGB) populations. In the following sections, I describe examples of the range of methodological approaches, data sets, and measures that we have employed to study this topic.

Social policies

Policies that differentially target stigmatized individuals for social exclusion or inclusion represent one indicator of structural stigma (Corrigan et al., 2004; Corrigan et al., 2005), and several of our studies have documented that social policies are strongly related to mental-health outcomes in LGB populations (for a review, see Hatzenbuehler, 2010). In one study, we coded states for the presence of policies that confer protection to gays and lesbians—namely, hate-crime statutes and employment-nondiscrimination policies that include sexual orientation as a protected class (Hatzenbuehler, Keyes, & Hasin, 2009). We linked this policy information to individual-level data on mental health and sexual orientation from a nationally representative survey of U.S. adults. The prevalence of psychiatric disorders was significantly higher among LGB adults living in states with policies that did not confer protection to gays and lesbians, compared with LGB individuals living in states with protective policies (Fig. 1). For example, sexual-orientation disparities in dysthymia (a mood disorder) were

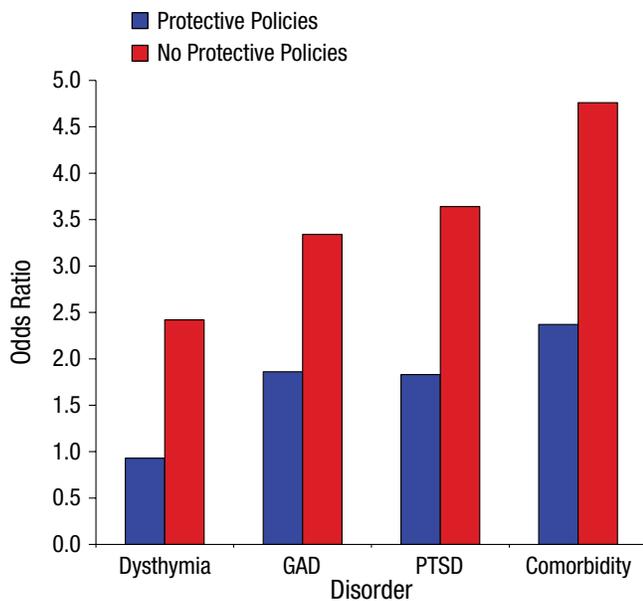


Fig. 1. Psychiatric morbidity as a function of structural stigma. “Protective policies” refer to either hate-crime statutes or employment-non-discrimination policies that include sexual orientation as a protected class; “comorbidity” refers to the presence of two or more co-occurring psychiatric disorders. Odds ratios indicate the likelihood that lesbian, gay, and bisexual respondents met criteria for a psychiatric disorder, relative to heterosexuals in the same state. GAD = generalized anxiety disorder; PTSD = post-traumatic stress disorder.

eliminated in states with protective policies; however, LGB adults who lived in states with no protective policies were nearly 2.5 times more likely to have dysthymia than were heterosexuals in those same states. Results remained robust after controlling for demographic covariates, as well as for perceived discrimination, which suggests that structural stigma contributes to psychiatric disorders over and above stigma at the individual level.

Although this study provided evidence that structural stigma was associated with deleterious mental-health consequences for LGB adults, it relied on cross-sectional data. Therefore, in a follow-up study, we used longitudinal, quasi-experimental data to evaluate the impact of structural stigma on mental health. During 2004 and 2005, 16 states passed constitutional amendments banning same-sex marriage. These events occurred in between two waves of data collection in a nationally representative, prospective study of U.S. adults. Respondents were first interviewed in 2001 and then re-interviewed in 2005, following the passage of the same-sex-marriage bans. This provided a natural experiment that enabled us to examine changes in the prevalence of psychiatric disorders among LGB respondents who were assessed before and after the bans were passed. LGB adults who lived in states that passed same-sex marriage bans experienced a 37% increase in mood disorders, a 42% increase in alcohol-use disorders, and a 248% increase in generalized

anxiety disorder between the two waves (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). In contrast, LGB respondents in states without these bans did not experience a significant increase in psychiatric disorders during the study period. Moreover, the mental health of heterosexuals in states that passed the bans was largely unchanged during this period, providing further evidence for specificity.

If implementing structural stigma exerts negative mental-health consequences, can reducing structural forms of stigma improve health? To answer this question, we used quasi-experimental data from a longitudinal sample of gay and bisexual men living in Massachusetts, which in 2003 became the first state to legalize same-sex marriage. In the 12 months after the legalization of same-sex marriage, there were substantial reductions in several mental- and physical-health problems—including a 14% reduction in depression and an 18% reduction in hypertension—compared with the 12 months before the legalization of same-sex marriage (Hatzenbuehler et al., 2012). Further, gay and bisexual men experienced a 15% reduction in mental and medical health care utilization and costs in the 12 months following the legalization of same-sex marriage, which indicates that the improvements in health translated into reduced need for health care. In contrast, during this same period, health care costs increased for the general population in Massachusetts, documenting the specificity of these effects to gay and bisexual men.

Community-level attitudes

Social policies not only influence but also reflect and codify existing attitudes toward stigmatized groups, which suggests that community-level attitudes represent another important index of structural stigma. To address whether such attitudes shape the physical health of LGB populations, we constructed a measure capturing the average level of anti-gay prejudice in the communities where LGB individuals lived, using data from the General Social Survey (respondents’ individual prejudicial attitudes were aggregated up to the community level, which included metropolitan statistical areas or rural counties). This information on sexual orientation and community-level prejudice was prospectively linked to mortality data via the National Death Index to create the General Social Survey–National Death Index data set (Muennig, Johnson, Kim, Smith, & Rosen, 2011).

LGB individuals who lived in high-structural-stigma communities—operationalized as communities with high levels of anti-gay prejudice—had increased mortality risk compared with those living in low-structural-stigma communities, controlling for individual- and community-level covariates (Hatzenbuehler et al., 2014). Specifically, LGB individuals living in the most prejudiced communities had a shorter life expectancy of 12 years on average

(range = 4–20 years) compared with those living in the least prejudiced communities, which is similar to life-expectancy differences between individuals with and without a high school education (Muennig, Fiscella, Tancredi, & Franks, 2010). Analysis of specific causes of death revealed that suicide, homicide/violence, and cardiovascular diseases were substantially elevated among LGB individuals in high-structural-stigma communities, suggesting potential mechanisms linking structural stigma to mortality risk. Further, among LGB individuals who committed suicide, those living in high-stigma communities died on average at age 37.5, compared with age 55.7 for those in low-stigma communities, a striking 18-year difference. There was no association between geographic mobility and mortality among LGB individuals, which demonstrates that the results cannot be explained by healthier respondents' moving to low-stigma communities.

Neighborhood-level hate crimes

Community-level attitudes shape and reinforce behaviors targeting stigmatized individuals, which suggests that

measures of community-level behaviors capture another dimension of structural stigma. In a recent study, we obtained data on lesbian, gay, bisexual, and transgender (LGBT) hate crimes between 2005 and 2008 from the Boston Police Department (Fig. 2), which were linked to individual-level data on suicidality and sexual orientation from a population-based sample of Boston adolescents (Duncan & Hatzenbuehler, 2014).

LGB youth residing in neighborhoods with higher rates of LGBT assault-based hate crimes were significantly more likely to report suicidal ideation and suicide attempts than were LGB youth residing in neighborhoods with lower LGBT assault-based hate crime rates (Duncan & Hatzenbuehler, 2014). No associations between LGBT assault-based hate crimes and suicidality among heterosexual adolescents were found, which indicates that the results were specific to LGB respondents. Further, no relationships were observed between overall neighborhood-level violent crimes and suicidality among LGB adolescents, which provided evidence for the specificity of the results to LGBT assault-based hate crimes.

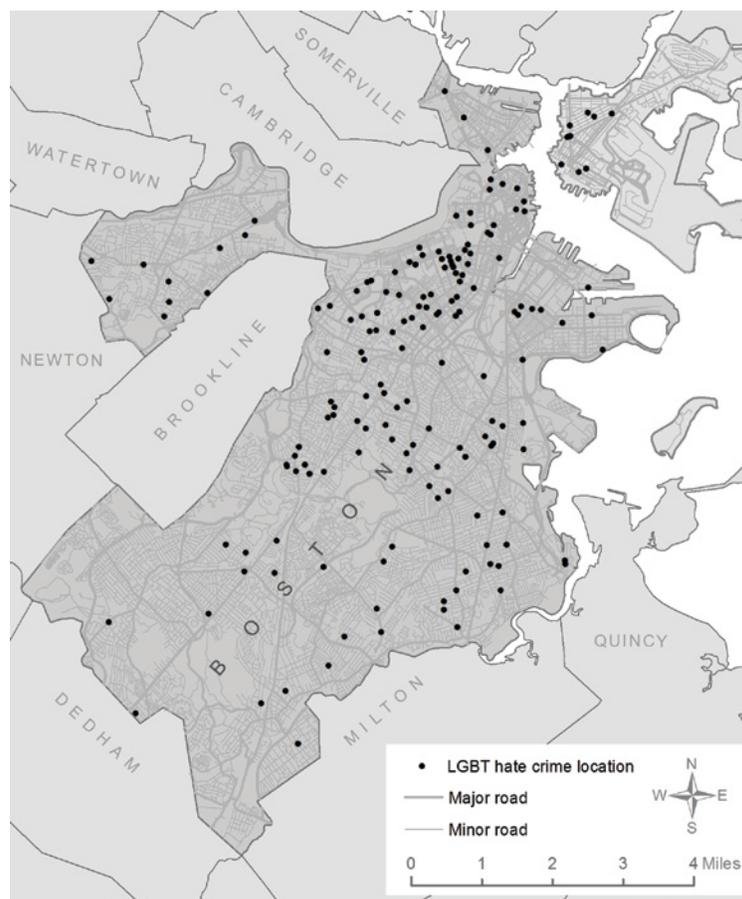


Fig. 2. A map showing the locations of neighborhood-level lesbian, gay, bisexual, and transgender (LGBT) hate crimes in Boston from 2005 to 2008 (Duncan & Hatzenbuehler, 2014).

Future Directions

At first glance, it may appear that research on structural stigma falls outside the purview of psychologists, who tend to study individuals and groups rather than social structures. However, psychologists have long theorized that structural factors initiate or intensify stigma processes at the individual level, indicating the centrality of structural issues to stigma theory (Meyer, 2003). Until recently, the field lacked the measures and data sets necessary to incorporate structural stigma into psychological research on stigma. Consequently, stigma processes (e.g., an individual's sensitivity to stigma-based rejection) have largely been predicted by individual- or interpersonal-level factors (e.g., parental rejection of one's sexual orientation; Pachankis, Goldfried, & Ramrattan, 2008).

With the advent of innovative methods and data structures that permit the examination of structural stigma, however, it is now possible to conduct novel tests of the relationship between stigma processes across levels of analysis. For instance, do structural forms of stigma generate stigma-related stressors at the individual level (e.g., "internalized stigma"; Berg, Ross, Weatherburn, & Schmidt, 2013)? Further, does structural stigma interact with individual-level stigma processes, such as sensitivity to status-based rejection (Pachankis, Hatzenbuehler, & Starks, 2014), which in turn magnify the negative health effects of structural stigma? Examining these direct and synergistic relationships across different levels of stigma opens up previously unexplored areas for psychological research on stigma.

Psychologists have an essential role to play in addressing these and other topics related to structural stigma. In particular, the mechanisms through which structural stigma contributes to poor health remain inadequately understood. Theoretical work has suggested several psychosocial pathways linking sexual-orientation stigma to health (Hatzenbuehler, 2009), but few of these mechanisms have been explicitly connected to structural stigma. For example, similar to individual and interpersonal forms of stigma, structural stigma may elicit chronic psychological and physiological stress responses (Hatzenbuehler & McLaughlin, 2014), which in turn contribute to health disparities between stigmatized and nonstigmatized groups (Major, Mendes, & Dovidio, 2013). This research on mechanisms can illuminate the full cascade of determinants of health disparities by linking social structures to health via individual biopsychosocial pathways. Additionally, research is needed to determine what psychosocial factors moderate the structural stigma–health association. Stigmatized individuals who engage in maladaptive emotion-regulation strategies (e.g., rumination and suppression; Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009), for example, may be at elevated risk for negative health outcomes in high-structural-stigma environments.

Conclusions

Link, Yang, Phelan, and Collins (2004) argued that the underrepresentation of structural stigma, relative to other forms of stigma, is "a dramatic shortcoming in the literature . . . as the processes involved are likely major contributors to unequal outcomes" (pp. 515–516). Exciting advancements in the nascent field of structural stigma are beginning to address these shortcomings, with important theoretical and practical implications. Theoretically, this research complements and enriches existing psychological work on intra- and interpersonal stigma (Major & O'Brien, 2005), thereby contributing to a more comprehensive understanding of the stigma process. Practically, this research suggests new avenues for the development of public-health and psychosocial interventions that can reduce persistent social inequalities in health.

Recommended Reading

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- Hatzenbuehler, M. L. (2011). The social environment and suicide attempts in a population-based sample of LGB youth. *Pediatrics*, *127*, 896–903. One of the first empirical studies to link a measure of structural stigma to suicide attempts among lesbian, gay, and bisexual youth.
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Declaration of Conflicting Interests

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