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Structural stigma and the health and wellbeing of Australian LGB populations: Exploiting geographic variation in the results of the 2017 same-sex marriage plebiscite

Francisco Perales*, Abram Todd

Institute for Social Science Research, The University of Queensland, Building C, 80 Meiers Rd, Indooroopilly, QLD 4068, Australia

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ABSTRACT

Rationale: Lesbian, gay, or bisexual (LGB) people experience poorer life outcomes than heterosexual people, with ongoing debates about the aetiology of these differences. Minority stress theory draws attention to the importance of structural stigma, which concerns hostile social environments for sexual minorities that constrain their opportunity structures. Yet few studies have operationalised structural stigma and tested its influence, with most focusing on the US context; even fewer studies examine the underlying mechanisms.

Objective: This study expands the available evidence to Australia, which constitutes an interesting case study due to the implementation in late 2017 of a national postal plebiscite on same-sex marriage legislation. It also adds to knowledge by theorising and testing the mediating role of perceived social support in explaining the association between structural stigma and the life outcomes of LGB people.

Method: The analyses leverage geographical variation at the electorate level (n = 150) in the share of 'No' voters in the plebiscite as a measure of structural stigma. This aggregate-level information is merged to individual-level data from the Household, Income and Labour Dynamics in Australia Survey, a large, national probability sample (n∽15,000).

Results: Multilevel regression models yield results which are consistent with minority stress theory and previous US scholarship: LGB people report comparatively worse life satisfaction, mental health and overall health in constituencies with higher shares of 'No' voters, controlling for a large set of individual- and aggregate-level confounds. Perceived social support mediates a large portion of the effects of structural stigma on LGB outcomes.

Conclusion: These findings have significant implications for policy and practice, highlighting the need for interventions aimed at reducing community levels of structural stigma and increasing social support to LGB populations.

1. Introduction

Sexual minorities experience poorer outcomes than heterosexual people across different life domains, including mental and physical health, subjective wellbeing, employment, poverty, homelessness, and social exclusion (see e.g., Graham et al., 2011; Perales, 2016; Uhrig, 2015; Williams and Mann, 2017). The dominant approach to explain these deficits is the minority stress framework, which traces their origins to the existence of a hostile social environment that constrains opportunity structures for non-heterosexual people (Meyer, 1995, 2003). Minority stress operates at multiple levels: from interpersonal relationships at the micro-level to features of the institutional environment at the macro-level. The concept of 'structural stigma' (Link and Phelan, 2001) refers to structural conditions (e.g., legislative or cultural factors) that contribute to disadvantaging sexual minorities. While research aimed at explaining sexual-orientation differences in health and wellbeing often invokes this concept, few studies have operationalised it and tested its influence empirically (Hatzenbuehler et al., 2017). This study adds to the literature in three ways: it features analyses of a new country context (Australia), it operationalizes structural stigma using geographic variation in the results of a national same-sex marriage plebiscite with legislative ramifications (the *Australian Marriage Law Postal Survey*; n = 12.7 million), and it considers the role of social support as an intervening variable.

1.1. Minority stress theory and structural stigma: conceptual underpinnings

Minority stress theory (Meyer, 1995) provides a useful framework

* Corresponding author.
E-mail addresses: f.perales@uq.edu.au (F. Perales), abram.todd@uq.edu.au (A. Todd).

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to understand the comparatively poor outcomes observed amongst non-heterosexual compared to heterosexual people. This framework poses that the lives of people from sexual minorities take place within a social environment that is characterised by heteronormativity and homo(bi/trans)-phobia and in which non-heterosexual people are marked as less-than-equals (Pachankis et al., 2014). Due to their minority status, individuals from sexual minorities are continually exposed to distal stressors external to the individual (e.g., prejudice, discrimination and violence) as well as proximal stressors in the form of internal thoughts and feelings (e.g., rejection expectation, identity concealment and internalised homophobia) (Meyer, 2003).

The notion of 'structural stigma' is rapidly becoming an important component of the conceptual toolbox of minority stress theory (for an overview of its development, see Link, 2017). Structural stigma refers to "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized" (Hatzenbuehler and Link, 2014: 2). These macro-level circumstances can encompass tangible factors (e.g., intentionally or unintentionally discriminatory laws and practices) as well as less tangible factors (e.g., dominant cultural norms and implicit status hierarchies) (Hatzenbuehler, 2016). While structural stigma can operate at the national level, there is also recognition of within-country geographic variation at the *meso*-level, whereby different locales display different "community climates" concerning their degree of acceptance and support of sexual minorities (Oswald et al., 2010).

Structural stigma is a chronic stressor that makes constant adaptational demands on sexual minorities. One way via which structural stigma can "get under the skin" is by eliciting physiological stress responses and dysregulation amongst the stigmatized (Hatzenbuehler, 2009; Hatzenbuehler and McLaughlin, 2014). Structural stigma can also inhibit access to health care amongst sexual minorities (e.g., through policies limiting health insurance to opposite-sex or married partners or experiences of bias and discrimination by health-care providers) and via maladaptive health-related behaviours (e.g., substance abuse) (Fingerhut and Abdou, 2017; Smith and Turell, 2017). As such, structural stigma is routinely invoked as an explanation for the comparatively poor health and wellbeing outcomes of sexual minorities. Yet, empirical studies that directly link such outcome deficits to contextual measures of structural stigma remain scarce. The next section discusses the available evidence.

1.2. Structural stigma and the life outcomes of sexual minorities: empirical evidence

A small but rapidly growing literature examines how structural stigma, as captured by characteristics of the local, regional or national environment, moderates the relationships between sexual orientation and life outcomes. Most studies compare differences in the magnitude of outcome "gaps" between heterosexual and non-heterosexual people across US counties or states (Hatzenbuehler, 2011; Hatzenbuehler and McLaughlin, 2014; Hatzenbuehler et al., 2010, 2011, 2014a,2014b, 2017, 2018; Oswald et al., 2010; Pachankis et al., 2014; Regnerus, 2017; Rostosky et al., 2009; Solazzo et al., 2018) while two other studies compare European countries (Pachankis et al., 2015; van der Star and Bränström, 2015).

Some studies operationalize structural stigma using legislative variation across areas, (e.g., in same-sex marriage, anti-discrimination policies, and adoption rights for same-sex couples) (Hatzenbuehler and McLaughlin, 2014; Hatzenbuehler et al., 2010, 2014b; Pachankis et al., 2014, 2015; Rostosky et al., 2009) while others use measures based on community levels of homo-negativity derived from attitudinal information in surveys and polls (Hatzenbuehler et al., 2014a, 2017, 2018). Multi-dimensional measures are also emerging. For example, Hatzenbuehler et al. (2014b) combined state-level information on the density of same-sex couples, the presence of 'gay-straight school alliances', sexual orientation policies, and public opinion towards sexual minorities into a composite index of structural stigma.

The outcomes that have received attention in this literature include mental health measures, such as psychological distress and suicidal ideation (Hatzenbuehler, 2011; Rostosky et al., 2009), health-related behaviours and mortality (Hatzenbuehler et al., 2014a; Pachankis et al., 2014), and self-rated health and subjective well-being (Hatzenbuehler et al., 2017; van der Star and Bränström, 2015).

Most of these studies find that the outcomes of non-heterosexual people are worse when they live in communities, states, or countries with higher levels of structural stigma (Everett et al., 2016; Hatzenbuehler et al., 2010; van der Star and Bränström, 2015). For example, using data from the US National Epidemiologic Survey on Alcohol and Related Conditions, Hatzenbuehler et al. (2010) found decreases in psychological wellbeing amongst lesbian, gay, or bisexual (LGB) populations (but not heterosexual populations) living in American states that banned same-sex marriage through constitutional amendments. Similarly, Pachankis et al. (2014) found comparatively high tobacco and alcohol use amongst gay men living in American states with more prejudicial attitudes towards sexual minorities and without anti-discrimination policies. As an exception, Hatzenbuehler et al. (2014a) did not find effects of structural stigma on life expectancy (see re-analysis by Regnerus, 2017 and *corrigendum* by Hatzenbuehler et al., 2018).

Because most studies report significant associations between higher levels of structural stigma and lower health and wellbeing in LGB populations, it is also the expectation of the current Australian study.

1.3. The mediating role of social support

Identifying the mechanisms linking structural stigma to health disparities by sexual orientation is an important endeavour: It points to potential levers that can be pulled by interventions aimed at reducing disadvantage and adds confidence that the observed associations are not produced by unmeasured confounds. However, the literature on structural stigma and the health and wellbeing of sexual minorities has made limited progress in this regard (Hatzenbuehler et al., 2017). Exceptions include studies identifying cortisol levels (Hatzenbuehler and McLaughlin, 2014), rejection sensitivity (Pachankis et al., 2014), and identity concealment (Pachankis et al., 2015) as actual or potential intervening variables. This study tests whether social support (i.e., friendships, good social relations, and strong supportive networks) may be an additional pathway. The possibility that minority stressors affect distress by diminishing social networks was already present in Meyer's (1995) formulation of the minority stress model. The conceptual role of social support in the stigma/health association was further refined by Hatzenbuehler in his 'psychological mediation framework' (Hatzenbuehler, 2009).

Intervening factors linking exposure to structural stigma to the health and wellbeing of sexual minorities must satisfy two preconditions. First, the factor must be a resource that is directly related to health and wellbeing. Concerning this, social support is a key social determinant of health and wellbeing (Wilkinson and Marmot, 2003), with recognised benefits to both mental and physical health in general (Berry and Welsh, 2010) and LGB (Masini and Barrett, 2008; Watson et al., 2016) populations. Social support improves health and wellbeing by enhancing individual resources and promoting resilience to stressors, which makes it well-placed to explain the effects of structural stigma on the health and wellbeing of sexual minorities (Hatzenbuehler, 2009; Hatzenbuehler et al., 2013).

Second, intervening factors must be differentially distributed amongst sexual minority populations in low- and high-stigma environments. Consistent with this, evidence indicates that perceived social support by sexual minorities is positively associated with non-discrimination laws (Riggle et al., 2010) and negatively associated with minority stress indicators (Lehavot and Simoni, 2011), including perceived discrimination and stigma consciousness (Lewis et al., 2017).