VULNERABLE MINORITIES: SEXUAL ORIENTATION, MENTAL HEALTH ISSUES AND SUBSTANCE ABUSE

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ABSTRACT
Social stigma has been referred to as a primary force in sexual minority mental health issues in comparison to lower mental health prevalence rates in heterosexuals (Cochran et al., 2003). With mental health issues on the rise, and given that substance abuse and mental health problems are correlated in many ways (e.g. Hughes et al., 2010) this paper sets out to review the relevant research which focuses on sexual minorities and the mental health issues that members of the LGBTQ community may face.

INTRODUCTION
Human sexuality concerns the sexual experiences, behaviours and expressions that we evoke as human beings (Rathus, Nevid & Fichner-Rathus, 2008). Sexual identity plays an integral role in human sexuality. Definitions of male and female socio-cultural gender roles can dictate much of one’s experiences and behaviours. Sexuality in terms of sexual attraction and orientation has been a common theme throughout the ages and has been part of an enormous amount of debate within many an arena. Heterosexual orientation involves the attraction to, as well as a preference for, being involved in romantic relationships with a member of the opposite sex (Rathus et al., 2008), whereas homosexual orientation would refer to a member of the same sex. Those that express attraction to both their own and the opposite sex are commonly referred to as bisexual. Kinsey and his colleagues (1948, 1953) developed a 7-point sexual orientation continuum ranging from mostly heterosexual to mostly homosexual, with bisexuality located in-between. Results from their research suggested that 10% of the United States population were mostly homosexual.

Sexual minorities can be defined by way of three categories; sexual attraction, sexual self-identification and sexual behaviour (Haas et al.,
Sexual attraction refers to the sex to which the individual is most attracted to, or where both sexes are perceived as equally attractive by the individual. Sexual self-identification alludes to which sex an individual identifies themselves with, regardless of biological factors. Lastly, sexual behaviours and interactions might not always correspond to sexual self-identification therefore must also be considered. Minority individuals of these categories may be sexually orientated towards the same sex as themselves or the same sex as well as the opposite sex. They also may identify themselves with a gender different to their biological categorisation, sometimes referred to as transgender (Haas et al., 2011). Although it is clear that these individuals and groups are very diverse, they are often grouped together as can be seen by references to the LGB or LGBTQ (lesbian, gay, bisexual, transgender and queer) community. Being part of a minority group can lead to vulnerability. How are individuals in sexual minorities affected in terms of mental health matters and substance abuse due to their vulnerability? Are there support services available? And how can the situation be improved?

Mental Health and Sexual Minorities

It is estimated that in Ireland, 1 in 5 people between the ages of twelve and eighteen are experiencing a mental health problem at any one time (Get on Board, 2011). A mental health problem or mental illness can be defined as “a psychological or behavioural abnormality of sufficient severity that psychiatric intervention is warranted” (Reber, Allen & Reber, 2009, p.465). In 2006, the Health Service Executive (HSE), the Irish Government and a number of experts in the area of mental health collaborated in order to produce a Vision for Change, a detailed report on mental health services in Ireland and the recommended reforms to be introduced over a number of years. Referencing statistics from the World Health Organisation, it was found that mental health was ranked second highest in the international burden of disease (Vision for Change, 2006, p.17). Mental health is crucial for overall general health and has been incorporated into many definitions of general health, which define health as “the state of being bodily and mentally vigorous and free from disease” (World English Dictionary, 2009).

Many studies have indicated connections between minorities, prejudice and stigma, be it ethnic minorities (e.g. Agerstrom & Rooth,
2008), religious minorities (e.g. Saroglou, Lamkaddem, Van Pachterbeke, & Buxant, 2009) or sexual minorities (e.g. Parrott, Peterson & Bakeman, 2011). Furthermore others have identified the high prevalence of mental health issues within the LGB community (Hughes, Szalacha & McNair, 2010; Kuyper & Fokkema, 2011; Lehavot & Simoni, 2011). This has been noted to include men and women, from adolescents through to adulthood (Kuyper et al., 2011). A meta-analysis carried out by Meyer (2003) indicated that sexual minorities are approximately two times more likely to suffer from disorders of mood, anxiety or substance abuse than heterosexuals. Some studies have indicated that from sub-groups of sexual minorities, those that identify themselves as bisexual are at the highest risk of mental health problems (Marshal et al., 2008; Robin et al., 2002; as cited in Kuyper & Fokkema 2011) which will be discussed further.

Social stigma has been referred to as a primary force in sexual minority mental health issues in comparison to lower mental health prevalence rates in heterosexuals (Cochran et al., 2003). Meyer’s Minority Stress Model (2003) formulates a theoretical framework describing how societal stigma attached to homosexuality can negatively affect people from the LGB community. It depicts mental health outcomes in terms of a stress and coping model. This has been supported by other research such as Kuyper and colleagues’ (2011) report examining the findings of the model on a Dutch ‘gay-friendly’ population. This research was somewhat unique as other studies that had examined the model were mainly comprised of US populations.

The interesting outcome of this study was that even though a country such as the Netherlands, where homosexuality is more accepted in terms of governmental rule and societal attitudes than the United States, sexual minority stress was still apparent and it negatively affected mental health outcomes. Sexual minority men were shown to have higher levels of internalised homonegativity but there were no significant differences between sexual minority men and women in terms of openness about their sexuality. Internalised homonegativity refers to an individual’s development and how social stigma, homophobia or negative expression of homosexuality can be internalised into the image of one self in one’s mind (Gonsiorek, 1988). This can affect self-esteem and induce self-doubt or even self-hatred (Gonsiorek, 1988). Bisexual individuals expressed lower levels of people reacting negatively to them, they were found to be less
open and were shown to internalise homonegativity more so than gay men or lesbians. An interesting finding is that of the low levels of negative reaction affecting bisexual individuals.

Kuyper and colleagues (2011) speculated that this may be due to bisexual individuals “retreating into their opposite-sex attraction” (p.7) if negative reaction is expressed by another. This action can deflect any articulated negative feedback to the expression of their sexuality. It appears that minority stress is something that cannot be avoided. It is also clear that there are deficiencies in education which could be used to reduce prejudice, stigma and discrimination; sufficient and effective support services would be a priority here.

Studies conducted by Cochran and his colleagues have identified that sexual minorities are more likely to suffer from mood or anxiety disorders, as well as having more problems with substance abuse, which have resulted from prejudicial behaviour (Cochran, Sullivan & Mays, 2003; Cochran & Mays 2000). Eliason (2011) noted that research in this area has broadened from examining cases of “individual risk factors such as depression, to the larger social forces that create minority stress” (p.5). Many studies comparing the mental health of heterosexuals to members of the LGBTQ community show the latter to be at a higher risk of having depression, suicidal ideation and having problems with substance abuse (Eliason, 2011). What is emerging from these studies is the major impact that occurs with negative reactions from individuals close to those ‘coming out’, be it a family member, friend, relative or teacher. These studies have mostly examined the United States population. Gonsiorek (1988) developed a 4-step model used to describe the process of ‘coming out’: 1) denial of the individual’s own sexuality, 2) state of crisis, 3) experimentation with individual(s) from the same sex, which may again be followed by a state of crisis if the relationship ends, 4) integration occurs and identity is formed.

This 4-step model illustrates the issue of emotional distress that often occurs as part of this process. Gonsiorek (1988) also noted that adolescent males are especially high risk to succumbing to mental health issues during this period. In particular when they are not in the company of social support and when they have not been educated in sexuality and issues that may arise because of it. More recent support of these findings came in 2009 with Ryan, Huebner, Diaz and Sanchez. They reported
negative outcomes were apparent when families rejected a family member who ‘came out’. These negative outcomes included higher rates of depression, suicide attempts and substance abuse. It is suggested that family supports are improved by way of family education with regards mental health concerns of family members identifying with sexual minorities.

In the area of eating disorders, the majority of sufferers of both Anorexia Nervosa and Bulimia Nervosa are women. However, within the confines of the male population of sufferers, a large number are categorised as homosexual (Feldman & Meyer, 2010). It has been reported that up to 42% of the men suffering from an eating disorder are either gay or bisexual (Mosher et al., 2005; as cited in Feldman et al., 2010). Reports are mixed for samples of lesbian or bisexual women and a consensus has not yet been reached on whether this population are under, over or sufficiently represented in populations of eating disorder sufferers (Feldman & Meyer, 2010). LGB men and women who suffer from eating disorders are more likely to suffer from another comorbid disorder in comparison to LGB men and women that do not suffer from an eating disorder (Felman & Meyer, 2010).

In 2011, the Journal of Homosexuality published a special edition focusing on sexual minorities and mental health issues that members of the LGBTQ community may face. In the previous year 2010, in the United States, between the 9th of September and the 1st of October, seven young gay men, as young as 13 years of age, took their lives due to harassment, bullying and other difficulties that they may have faced in their own lives due to their sexual orientation. Ratner et al.’s (2003) research on suicide rates within the male gay community found that suicidal ideation was 55.3% while 14.7% of the sample had attempted suicide (Herrell et al., 1999; Bagley & Tremblay, 1997; as cited in Ratner et al., 2003).

We should note however that there is a difficulty in determining the sexual orientation of individuals that are deceased by way of suicide, as this is not a figure generally recorded. Some psychologists have overcome this issue by way of interview with both family and friends of those deceased. However, results from these ‘psychological autopsies’ did not indicate sexual minorities to be at a higher risk e.g. only 7% of the suicides examined in Quebec (Renaud, Berlim, Begolli, McGirr & Turecki, 2010).
and only 2.5% of adolescent suicides in the New York area (Shaffer, Fisher, Hicks, Parides & Gould, 1995) were indicated as being classed as sexual minorities. There is therefore some disagreement over the prevalence of suicide in the LGB community and further clarification is needed on the issue.

**SUBSTANCE ABUSE AND SEXUAL MINORITIES**

Issues of substance abuse and mental health issues are correlated in many ways (e.g. Hughes et al., 2010). The issue of addiction is concerned with the physical and psychological dependence on a substance. Many reports support the notion that women from sexual minorities are more likely to be at risk of alcohol abuse than heterosexual women (e.g. Hughes et al., 2010; Meyer, 2003). As with other mental health issues, bisexual women are at a higher risk than others of developing issues around alcohol (Hughes et al., 2010). There has been speculation for the reasons for this high risk factor.

Some have commented that those individuals attracted to both their own sex and the opposite sex are sometimes excluded or marginalised by both heterosexual communities and homosexual communities (Hughes et al., 2010). Hughes and her colleagues examined a sample of Australian women to evaluate the influence that sexual orientation can have on mental health issues and substance abuse. Participants ranged from exclusively heterosexual to exclusively homosexual on a 5-point scale. As the study indicated, mental health issues and other factors have been shown to predict substance abuse. Therefore depression, anxiety, self-harm, perceived stress and social support were used as predicting variables of substance abuse in this study. Sexual minority women were again shown to have higher stress levels and lower mental health levels than those classed as ‘exclusively heterosexual’, with bisexuals scoring lowest on both. Lesbian women were shown to have the highest levels of social support than any of the sexual identity groups. As this was a long-term study, it was also shown that as these women aged, sexual minority women’s intake of alcohol and other drugs were slower to decrease than heterosexual women’s. Bisexual women were more likely to binge drink and use marijuana as well as other illicit drugs.

The findings again supported Meyer’s (2003) Minority Stress Model, as perceived stress was found to be the most important indicator of alcohol
and drug abuse. Baiocco, D’Alessio and Laghi (2010) found high rates of binge drinking in a population of gay and lesbian Italians. This was apparent in 43.6% of the sample. This is significantly higher in comparison to a previous study on a heterosexual Italian sample (D’Alessio et al., 2006), especially in terms of those from the LG group that were heavy drinkers (18.8% vs. 7.4%). Baiocco et al.’s (2010) data expressed the correlations between amount of internalised homonegativity, negative reactions and alcohol consumption. Substance abuse within the LGB community is of clear concern from the above findings. Individuals from this community have been found to consume more alcohol, more frequently than their sexual majority counterparts (e.g. Baiocco et al., 2010; D’Alessio et al., 2006; Hughes et al., 2010). Also, illicit drug use within this population has been shown to be more prevalent than in heterosexual populations (e.g. Hughes et al., 2010).

**CONCLUSION**

It is clear that there is an enormous body of research suggesting the relationship between sexual minorities, mental health and substance abuse. Members of the LGB community face similar struggles to those of other minority groups. As the WHO have reported, mental health is integral to our overall health, and the fact that there is an enormous body of work suggesting the high prevalence in sexual minorities is a clear indication of the focus that practitioners and clinicians should take. These issues range from depression, to substance abuse to eating disorder to suicide. The importance of family and social support during the coming out phase has been identified as an area that needs targeting. Also a valuable and realistic suggestion is to include the question of sexual identity/orientation during intake interviews with clinicians. Through this, mental health or substance abuse issues could be more easily identified within these populations and those at a higher risk could be targeted for additional attention and supports. Further research into other possible ways to target high risk individuals would also benefit the comprehensive body of research already compiled.

**REFERENCES**


