Over the past two decades, clinical and epidemiological research has consistently demonstrated poorer physical and mental health outcomes in sexual minority populations (i.e., lesbian, gay, bisexual, queer, and other individuals who do not identify as heterosexual) relative to their heterosexual peers (Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014; King et al., 2008; Lick, Durso, & Johnson, 2013; Semlyen, King, Varney, & Hagger-Johnson, 2016). Rather than inherent to differences in sexual orientation, these health inequalities are considered to be explained by the persistent stigmatized status afforded to sexual minority populations in most societies across the globe (Frost, 2011a, 2017; Hatzenbuehler, 2014; Herek, 2007; Meyer, 2003). In this chapter, we provide a brief review of the nature and types of health inequalities experienced by sexual minority populations. We then focus on the ways in which researchers in the health and social sciences have theorized and evidenced potential explanations for the existence and persistence of health inequalities experienced by sexual minority populations. We also discuss the individual and social psychological factors that may play a role in diminishing health inequalities, including resilience resources and aspects of sexual identity. Updating previous calls for sustained attention to the social conditions underlying health inequalities based on sexual orientation (Frost, 2017, Meyer, 2016; Meyer & Frost, 2013), we end by raising pressing questions about the potential health consequences of the rapidly changing social and policy context surrounding sexual minority rights and social inclusion.

Health Inequalities Faced by Sexual Minority Populations

Sexual minority populations report higher rates of mental health disorders relative to their heterosexual peers across a growing number of studies. For example, sexual minority individuals are one and a half times more likely to have mood, anxiety, and substance use disorders than heterosexuals, and nearly two and a half times more likely to attempt suicide than heterosexual individuals (see King et al., 2008 for a systematic review and meta-analysis). In addition to inequalities in mental health, a recent systematic review of the existing body of research on physical health and sexual orientation has shown that sexual minority men and women demonstrate poorer health than heterosexuals on general health indices (e.g., self-rated health, health-related quality of life) as well as specific physical health diagnoses and chronic conditions including respiratory conditions (e.g., asthma, allergies), gastrointestinal conditions, and headaches (see Lick et al., 2013 for a systematic review). Importantly, as noted by Lick and colleagues (2013) and the report on LGBT health from the Institute of Medicine (2011), these health inequalities are reflected across a number of studies,
using various indicators of health, within both probability samples and geographically specific community samples. Health inequalities in sexual orientation are evidenced throughout the life span, but are especially pronounced in sexual minority youth (Russell & Fish, 2016) and older adult populations (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013).

In addition to the increased mental and physical health burden faced by sexual minority populations, duplicated in the sentence sexual minorities report less frequent access to care and more unmet medical needs, compared to their heterosexual peers (e.g., Buchmueller & Carpenter, 2010; IOM, 2011). These differences in access to care have been attributed to the ways in which health care providers and institutions can both overtly and unknowingly marginalize sexual minority individuals (Mayer et al., 2008). For example, high levels of negative attitudes towards sexual minorities still exist among many health care providers, even though regard for sexual minority individuals has improved since the onset and height of the HIV/AIDS crisis (c.f., Eliason, Chinn, Dibble, & DeJoseph, 2013; Royce & Birge, 1987). Further, medical students still receive minimal formal education about the specific needs of sexual minority patients and they see little value of cultural competency to their actual work with patients (e.g., Beagan, 2003). Additional aspects of health care settings can marginalize sexual minority patients further, such as the lack of inclusion of civil unions/domestic partnerships in relationship status questions on intake forms.

Like sexual minorities, gender minority individuals evidence similar health inequalities. Specifically, gender minority individuals—a population inclusive of transgender, gender queer, and gender non-binary individuals—evidence consistently higher rates of mental and physical health problems compared to their cisgender peers (i.e., people who have a gender identity that is aligned with their sex assigned at birth). However, gender minorities may or may not also be sexual minorities and have unique experiences deserving of their own analysis (see Hendricks & Testa, 2012), and are thus not included in this chapter focused specifically on sexual minority health. Readers interested in further discussion of gender minority health inequalities and potential explanations should consult Reisner and colleagues’ (2016) review of transgender health concerns and Hendricks and Testa (2012) extension of the minority stress model to transgender populations.

**Minority Stress as an Explanation for Health Inequalities**

The health inequalities experienced by sexual minority populations are not likely to be caused by, or inherent to, sexual minority identities in and of themselves. Scholars working across psychological, sociological, policy, and public health perspectives have historically examined sexual minority health disparities using social stress paradigms (Aneshensel, Rutter, & Lachenbruch, 1991; Frost, 2017; Meyer, 2003). These models recognize that sexual minority populations are exposed to excess social stress stemming from the stigmatized status afforded to their identities by society. They also may experience decreased access to individual and social coping resources compared to their heterosexual peers as a result of social exclusion and marginalization (e.g., Frost, Meyer, & Schwartz, 2016; Meyer, Schwartz, & Frost, 2008). This excess exposure to social stress and reduced access to stress-ameliorating resources puts sexual minority individuals at heightened risk for negative health outcomes and thus potentially explains the existence of health inequalities based on sexual orientation.

Meyer (2003) developed the minority stress framework in order to account for the ways in which exposure to social stressors unique to the sexual minority experience potentially explain the higher rates of health problems typically observed among sexual minority individuals compared to heterosexuals (see also Brooks, 1981; DiPlacido, 1998). The minority stress framework articulates five minority stressors that sexual minority individuals are potentially exposed to as a result of their stigmatized social status: Event based forms of discrimination (i.e., prejudice events), chronic and everyday forms of discrimination, expectations of rejection, stigma concealment, and internalized stigma.
Prejudice events are one-off experiences of discrimination that are caused by prejudice against sexual minority individuals (Meyer, 2003). These events typically take place within interpersonal interactions (e.g., between colleagues, family members, or strangers out in public) and may sometimes be illegal depending on the social context. For example, physically assaulting someone because they are a sexual minority is illegal in contexts where physical assault is illegal and may be considered a hate or bias crime when such statues exist. However, being fired from one’s job is also considered a prejudice event, but is legal in many countries that do not protect against employment discrimination based on sexual orientation. Unlike the prejudice events experienced by racial and ethnic minority individuals, prejudice events experienced by sexual minorities can occur at home and be perpetrated by family members. For example, sexual minority youth are often forced to leave their homes and may face becoming homeless due to family rejection of their sexual identity (Ryan, Huebner, Diaz, & Sanchez, 2009). Prejudice events have been demonstrated to have a negative impact on sexual minority individuals’ health, above and beyond the impact of general life events that are not caused by, or involve, prejudice (e.g., Frost, Lehavot, & Meyer, 2015).

In addition, everyday forms of discrimination, which may manifest in harassment (such as being insulted or called names) and other instances of devaluation, rejection, and disrespect (e.g., being treated with less courtesy in stores or restaurants) are stressful even if they are not major life events (Swim, Johnston, & Pearson, 2009). This type of minority stress includes microaggressions, aversive homophobia, and everyday insults such as being ignored, stared at, or being treated with disgust and fear. (Mayer et al., 2008; Nadal, 2013; Nadal et al., 2011). Although less severe in comparison to the types of prejudice events noted previously, everyday discrimination experiences are often chronic and can accumulate over time. As a result, experiences like these, which may individually be low impact in the moment, can add up and contribute to the cumulative stress burden faced by sexual minorities relative to their heterosexual peers.

Even in the absence of actual experiences of discrimination, sexual minority individuals may approach social interactions anticipating being treated negatively. These expectations of rejection may be the result of hypervigilance on the part of individuals due to their awareness of their stigmatized status in society and that commonly held stereotypes and prejudice exist about their minority group (Meyer, 2003). Such expectations of rejection constitute minority stress, even when actual differential or negative treatment does not transpire, due to the cognitive burden and anticipatory stress inherent to expectations of rejection.

Concealing their sexual minority identities is a way in which some people seek to protect themselves from prejudice and discrimination. Sexual minorities may conceal their sexual orientation from others across several areas of life, including at school, their jobs, within health care contexts, and amongst family. Concealment can be thought of as a “double-edged sword” (Smart & Wegner, 2000) in that keeping one’s sexual as this chapter is focused on sexual minority identity a secret can shield people from overt forms of minority stress (Rosario, Hunter, Maguen, Gwadz, & Smith, 2001; Swank, Fabs, & Frost, 2013), but concealing does require a significant cognitive effort on the part of the individual which is demanding and thus stressful (Pachankis, 2007).

Internalized stigma, also referred to as internalized homophobia, refers to what happens when sexual minority individuals direct the negative social attitudes prevalent in society about sexual minorities toward the self (Frost & Meyer, 2009; Meyer, 2003). In some of its most dangerous forms, it can lead to the condemnation of a person’s own sexual orientation identity. Internalized homophobia is further characterized by an internal and psychological discrepancy between experiences of same-sex attraction and sexual desire and feelings that one “ought” to be heterosexual in order to conform to heteronormative expectations imposed by society (Herek, 2004, Herek, Gillis, & Cogan, 2009). Developmental models of sexual orientation identities have suggested that internalized stigma
is often experienced in the process of developing a sexual minority identity. Overcoming internalized stigma is essential to the achievement of a healthy self-concept as a sexual minority person, which is theorized to be further marked by the coming out process (see Eliason & Schope, 2007 for a review). Research has shown that internalized homophobia can have a negative impact on multiple indicators of mental health and psychological well-being (Frost & Meyer, 2009; Perez-Bruemer et al., 2015).

Scholars have begun to document social stressors that were not initially accounted for within the five categories of minority stressors described earlier (Meyer et al., 2011). For example, non-events—or anticipated events or experiences that do not come to pass—can also have damaging effects on the health of individuals (Gersten, Langner, Eisenberg, & Orzech, 1974; Neugarten, Moore, & Lowe, 1965). Non-event stress can be seen in the form of milestones in life that were delayed or prevented from happening, like a job promotion that was not granted when earned (Neugarten, Moore, & Lowe, 1965). Non-events also occur in the familial and relational domain. For example, “normative” milestones, such as getting married, having children, having grandchildren, are among the most widely expected events in the course of family and relationships. Not achieving these milestones, and/or experiencing significant delay in their achievement, can thus be stressful (Frost & LeBlanc, 2014). Although it is difficult to measure non-events, some research suggests that non-events in the form of frustrated goal pursuit can lead to decreased mental health and psychological well-being (Frost & LeBlanc, 2014). Non-event stress may be the result of discriminatory social policies. Hatzenbuehler (2014) has pointed to how discrimination at the level of policies and institutions (e.g., ban on same-sex marriage, criminalization of homosexuality, discriminatory hiring practices) constitutes structural stigma, which can have a negative impact on the health of sexual minorities. Indeed, not being able to achieve desired or hoped for events or goals because of legal barriers can be stressful and thus further contribute to the total stress burden associated with the disadvantaged social status afforded to sexual minorities in most parts of the world. Additionally, preliminary work on anticipatory stress has shown that sexual minorities sometimes imagine their future as involving a high degree of minority stressors, which can potentially play a detrimental role in their lived experience of the present (Thomeer, LeBlanc, Frost, & Bowen, 2018).

Studies that have utilized the minority stress framework have produced a growing body of evidence that exposure to minority stressors, in a variety of forms, is associated with mental health problems ranging from DSM-diagnosable mood and anxiety disorders, symptoms of depression, substance use, and suicide ideation, as well as lower levels of psychological and social well-being (see Meyer & Frost, 2013 for a review). Exposure to minority stress has also been shown to result in increased physical health problems (Frost et al., 2015). Thus, minority stress has been hypothesized to be an explanation for elevated rates of physical health outcomes and health risk behaviors observed in sexual minority populations (Lick et al., 2013). Some studies investigating disparities that have employed a minority stress approach have even shown that when exposure to factors indicative of minority stress are analytically controlled, differences between heterosexual and sexual minority individuals in negative health outcomes are substantially attenuated (e.g., Frisell, Lichtenstein, Rahman, & Langstrom, 2010; Frost & LeBlanc, 2014 Mays & Cochran, 2001). Additionally, the minority stress framework is useful because it specifies the stress and coping pathways thought to impact health and can therefore guide clinical interventions aimed at interrupting such pathways in order to improve health (Chaudoir, Wang, & Pachankis, 2017).

Most studies rooted in the minority stress framework have historically been conducted in the US, which has prompted the question whether the minority stress model is equally relevant in a more tolerant social climate, or simply outside of the US. In recent years, several European population studies on sexual health have addressed this concern by examining the robustness of the minority stress model within various European countries. Population studies in Sweden (Branstrom, 2017), the Netherlands (Kuyper & Fokkema, 2011), as well as Germany (Sattler, Franke, & Chistiansen, 2017),
all arguably more “LGBT-friendly” social climates, reported poorer mental health among sexual minority individuals, and provide evidence that suggests these disparities were attributed to minority stress factors. Similar studies in Australia (Bariola, Lyons, & Leonard, 2016) and Israel (Shilo & Mor, 2014), which also report greater mental health problems among sexual minorities, provide evidence that these differences in health are explained by the mechanisms of minority stress.

Although beyond the scope of this chapter, evidence is emerging that the minority stress model can be extended to explain health inequalities stemming from stigma in other populations. For example, gender minority individuals (e.g., non-binary, transgender, and gender queer individuals) are exposed to chronic social stress due to their minority gender identity (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Scandura, Amodeo, Valerio, Bochicchio, & Frost, 2017; Testa, Habarth, Peta, Balsam, & Bockting, 2015). These studies generally found that exposure to everyday discrimination and internalized transphobia was associated with increased mental health problems and indicated that the minority stress model could be usefully applied to the transgender population.

**Psychological and Physiological Pathways Linking Minority Stress to Health**

Although the research previously reviewed provides ample evidence for linkages between exposure to minority stress in various forms and mental and physical health outcomes, less research has been done investigating the pathways that link exposure to minority stress to health outcomes. Frameworks that have developed subsequent to the minority stress model (Meyer, 2003) have attempted to add nuance to the overall causal mechanisms of the theory. For example, Hatzenbuehler (2009) has proposed a psychological mediation framework which attempts to explain how stigma and minority stress “get under the skin” and subsequently effect mental health. This mediation framework contends three psychological pathways via which exposure to minority stress produces deleterious effects on mental health. Specifically, exposure to minority stress is thought to induce detriments to health via impaired emotion regulation (i.e., rumination, maladaptive coping strategies), lower quality social and interpersonal interaction (e.g., social isolation), and maladaptive cognition (e.g., hopelessness, negative self-schemas) (Hatzenbuehler, 2009).

Additional physiological pathways linking exposure to minority stress to physical health outcomes have been outlined by Lick and colleagues (2013), drawing from general research on the physiological pathways linking stress to health. For example, minority stress may lead to negative health outcomes by affecting hormone regulation and the dysregulation of the hypothalamic–pituitary–adrenal axis, altering the functioning of the autonomic nervous system, and suppressing immune function (see Lick et al., 2013 for a review).

**Minority Stress-Ameliorating Factors**

Although mental and physical health outcomes are on average poorer in sexual minority populations compared to heterosexual populations, sexual minority individuals are generally able to lead lives that are not characterized by ill health, and many are thriving even though they continue to face persistent stigma and resulting minority stressors. A resilience perspective has been used to account for intragroup variability in health responses to minority stress. Namely, sexual minority individuals mobilize individual, social, and community-level resources to resist minority stress in multiple ways (Kwon, 2013; Meyer, 2015).

The minority stress model has usefully distinguished between individual and community-level forms of coping (Meyer, 2003; Meyer & Frost, 2013). Sexual minority individuals utilize a range of individual-level coping mechanisms, such as mastery and resources to withstand stressful experiences
However, there may also be components of sexual minority individuals’ identities that allow them to construct a positive sense of self in the face of devaluing social stigma. Indeed, a highly salient sexual minority identity that is also positively valued has been theorized to diminish the potential negative impact of minority stress on health (Meyer, 2003). Additionally, such personal resources may allow for sexual minority individuals to make meaning of their experiences of minority stress in ways that externalize rather than internalize, the cause of the stress and derive personal growth from the challenge presented by minority stress (Frost, 2011b).

In addition to such individual-level coping, feeling part of a community of similar others may also allow sexual minorities to make positive social comparisons to other people like them, instead of making negative comparisons, based on heterosexist stigma, to members of the out-group (Meyer, 2003). For these reasons, connectedness to sexual minority communities represents a community-level coping strategy and may play an ameliorative role in the relationship between minority stress and health (Frost & Meyer, 2012; Major & O’Brien, 2005). Community connectedness has been shown to function in such a way in relation to various health outcomes, including but not limited to mental health and well-being and sexual risk-taking behaviors (see Meyer & Frost, 2013 for a review). Additionally, connectedness to sexual minority communities has been shown to be an antecedent to volunteerism and the provision of social support, which likely play a role in improving community-level health and well-being (Omoto & Snyder, 2002).

The Role of Identity in the Experience of Minority Stress

“Coming out,” or disclosing one’s sexual orientation as a sexual minority person, is a process that unfolds over the life course and is conceptualized as a fundamental feature of healthy identity development (Meyer, 2003). This process is generally associated with positive health outcomes by providing the person with a more authentic, positive and stable self-concept, boosting general self-esteem. A positive sexual minority identity may also lead to stronger affiliations with one’s community, which, together with bolstered self-esteem, may reduce minority stress processes, such as internalized stigma and expectations of rejection. However, a paradoxical association between outness and health suggests that a more positive sexual minority identity is not necessarily uniformly healthy. Fingerhut, Peplau, and Shelly (2010) found that strength of minority identity was associated with significantly higher levels of reported discrimination, as living as an “out” individual may increase exposure to minority stress factors, such as derogative slurs or homophobic violence.

Characteristics of sexual minority identity may also influence behavioral health outcomes (Meyer, 2003). The centrality of one’s minority identity — how important it is to one’s overall sense of self — has been theorized to have both positive and negative mental health outcomes. In a study about stigmatized identities, Quinn and Chaudoir (2009) found that heightened sexual identity centrality magnified the negative impact of discrimination and stigmatization on mental health. As self-concepts, such as a strong sexual minority identity, are closely linked to psychological states, they are likely to predict mental health problems when exposed to stress factors (Thoits, 1999). Other scholars theorize that it is mostly when a sexual identity centrality is combined with identity concealment that negative health outcomes become more likely to occur (Griffith & Hebl, 2002; Mohr & Kendra, 2011). According to these scholars, a strong minority identity centrality more commonly is associated with decreased concealment of one’s minority identity, which may lead to stronger affiliation with one’s minority community, which in turn is associated with positive psychosocial outcomes (Griffith & Hebl, 2002; Mohr & Kendra, 2011). Evidence suggest that an individual’s sense of strong community support buffers against stressors such as stigmatization and victimization (Frost & Meyer, 2012).

There are three specific characteristics of sexual minority identity that are suggested to influence the impact of stressors on health: salience, valence, and integration with other held identities (Meyer,
Salience, or prominence, of the individual’s minority identity within an overall sense of self can be viewed as a measure of centrality. Minority identity prominence might appear stronger to observers than to minority group members themselves. In a study about gay men’s appearance and presentation, Clarke and Smith (2015) found that the visual expression of a prominent minority identity was carefully considered and balanced to negotiate potential external stressors, such as stigmatization or direct homophobia, with a sense of being true to one’s internal self.

Valence refers to the evaluative features of one’s identity and is often referred to in coming-out models. Negative valence is associated with negative self-evaluation and internalized homophobia, typically experienced prior to minority identity acceptance and disclosure, while positive valence is associated with a sense of pride in one’s minority identity (Meyer, 2003). In a study about the positive aspects of being a lesbian woman or gay man, Riggle, Whitman, Olson, Rostosky, and Strong (2008) found that positive valence of one’s minority identity resulted in heightened empathy for self and others, as well as a sense of freedom from societal norms and expectations.

Furthermore, the level of integration of the minority identity with an individual’s other identities influences the magnitude of minority stress factors. Research in identity intersectionality suggest that having to integrate multiple minority identities might result in double stigmatization and marginalization. Bowleg (2013) found that black gay and bisexual men reported having to play down their racial identity in white sexual minority communities and de-emphasize, or even conceal, their sexual identity within their ethnic community. On the contrary, complex identities may also be associated with positive health outcomes. In optimal identity development various identities, for example gender, ethnic, cultural and sexual, become fully integrated, and the sexual identity becomes one part of the integrated total identity.

Although characteristics of sexual minority identity have been featured in the minority stress model since Meyer’s (2003) articulation, inconsistent findings have been produced regarding the role of identity characteristics in the pathways leading from minority stress to health. For these reasons, much remains to be understood about the role of sexual minority identity characteristics in the minority stress model, for which health psychologists are apt to contribute. This is especially true given the proliferation of new identity forms within the rapidly changing social and policy climates in which sexual minority youth come of age today (Hammack et al., 2018).

Social Change and Sexual Minority Health

Although sexual minority health disparities persist, there is clear evidence that the social climate for sexual minority individuals in Western contexts has drastically improved over the past two decades (e.g., Brewer, 2014; Lax & Phillips, 2009). Legislation to support and protect LGBT individuals, particularly in the US with a passage of hate crime legislation and marriage equality, has resulted in sexual minority youth today maturing in a different social climate compared to previous generations (Hammack, Frost, Meyer, & Pletta, 2018). The effects of these social changes on health must be accounted for in inequalities research given their impact on health may not be universally positive. First, it remains to be seen whether these changes in public opinion translate to the level of diminished prejudice and discrimination at the interpersonal level. Just as racism has changed over time from overt to implicit forms, stigma and prejudice against sexual minority individuals may be changing form as well and thus new measures may be needed to assess such experiences (e.g., see Krieger et al., 2010). Take also, for example, findings that young sexual minority individuals are coming of age in a time when sexual orientation and sexual minority statuses are potentially not as defining of differentness in lived experience in the ways they have been for previous generations (e.g., Cohler & Hammack, 2007; Frost, Meyer, & Hammack, 2015; Ghaziani, 2011; Savin-Williams, 2005). Additionally, sexual minority seniors are more “out” about their sexual orientation within the health care system and assisted living contexts, while previous generations
have not been as visible (e.g., Hillman & Hinrichsen, 2014). These two examples, drawing on the unique experiences of different age cohorts, highlight the potential importance of utilizing a life course developmental framework in studying the relationship between sexual orientation and health (Graham et al., 2011).

A changing social climate in many developed countries has also allowed for sexual orientation groups other than gay men, lesbians and bisexuals, to more freely express and shape their sexual minority identities. There is evidence to suggest that youth develop their sexual identities differently today compared to previous generations, with, for example, one in two British, and one in three American, 18 to 24-year-olds identifying as not 100% heterosexual (YouGov, 2015a; YouGov, 2015b). In a progressively individualistic society, where minority identities are being formed and negotiated in novel ways within their social and historical circumstances, it is important to understand whether the minority stress model is equally suitable for “non-traditional” sexual minority groups, such as queer, pansexual, and sexually fluid individuals.

A handful of studies has been conducted assessing the fit of the minority stress model for emerging non-traditional sexual identities, such as queer, pansexual, and sexually fluid individuals (Goldbach & Gibbs, 2017; Morgan, 2012; Shilo, Antebi, & Mor, 2015). While these studies provide support for a minority stress-informed understanding of sexual identity of emerging subgroups, they also highlight the complexities and multidimensional nature of sexual identity development, and the importance of social context in understanding both stress experiences and coping resources available to youth shaping their sexual identity in today’s social climate. For example, Goldbach and Gibbs (2017) noted that queer and pansexual individuals reported stigma and discrimination from within sexual minority communities, relating to being “a minority within a minority,” while Shilo and colleagues (2015) identified a slight shift from community-based support, significant in older sexual minority cohorts, to family-based support as a resilience factor against psychological distress. This shift may be partly attributed to a social environment where being a sexual minority is not perceived as negatively by family members, teachers, and peers on one end, and a wider society that favors individualism over collectivism at the other end. While the more salient stress factors and resilience resources may have changed or evolved in today’s social climate, it is evident that the minority stress model remains relevant as a framework for understanding the ill health effects of social stigma in emerging non-traditional sexual minority groups (Russell & Fish, 2016).

Conclusion

Despite many positive social and policy changes, which have undoubtedly improved the lives and health of sexual minority individuals, health inequalities based on sexual orientation continue to persist, even in some of the most accepting social contexts (e.g., the Netherlands, see Aggarwal & Garrets, 2014). Based on nearly two decades of theory and research, it is likely that the persistence of these health inequalities is caused by excess exposure to social stressors that stem from stigma (Hatzenbuehler, 2014; Meyer, 2003). The social stress stemming from stigma in the form of minority stress places sexual minorities at added risk for negative health outcomes via a variety of psychological and physiological mechanisms (Hatzenbuehler, 2009; Lick et al., 2013). Resilience resources at the individual- and community-level have proven to be important in interrupting the negative effects of minority stress, however, such resources are not always available, especially in conditions of structural stigma (Meyer, 2015; Mayer et al., 2008). In addition to removing the laws and policies that continue to place sexual minority populations in a disadvantaged social status (Meyer, 2016), the minority stress framework will undoubtedly continue to prove useful in research aimed at documenting the stigma-related factors contributing to diminished health, and target relevant interventions to improve health in sexual minority populations across the globe (Frost, 2017; Meyer & Frost, 2013).
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