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The Right Comparisons in Testing the Minority Stress Hypothesis: Comment on Savin-Williams, Cohen, Joyner, and Rieger (2010)

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Savin-Williams, Cohen, Joyner, and Rieger (2010) suggest that purported "mental health discrepancies among male sexual orientation groups are illusory." They suggest that their findings regarding gay men's depressive symptoms rebut minority stress explanation of sexual orientation mental health disparities. But as it pertains to minority stress theory, their rationale is flawed.

Minority stress is a frequently used framework for understanding observed health disparities between sexual minority and heterosexual populations (Herek & Garnets, 2007). Minority stress suggests that (1) lesbians, gay men, and bisexuals (LGB) comprise a disadvantaged social group that is subject to stigma and prejudice; (2) stigma and prejudice related to sexual orientation predispose LGB to excess stress; and (3) in turn, this excess stress may lead to adverse health outcomes and, thus, observed health disparities (Meyer, 2003). Studies using the minority stress perspective have consistently documented mental health disparities between LGB and heterosexual populations. This is evidenced, for example, in studies that used meta-analysis to summarize this literature (King et al., 2008; Meyer, 2003).

Savin-Williams et al. argued that the observed disparity is faulty because researchers have used an inappropriate reference group in studying mental health outcomes in gay and bisexual men. Typically, researchers compare gay and bisexual men with heterosexual men when they document mental health disparities; Savin-Williams et al. suggest that gay and bisexual men should be compared with heterosexual *women*, not men. The reason for this is that "cross-sex comparisons are more suitable for situations in which nonheterosexual men are assessed on sexually dimorphic variables." This claim is based on vast research that showed that gay and bisexual men are more like heterosexual women than heterosexual men on various measures (e.g., Bailey, 2009; Bailey & Zucker, 1995). For example, Savin-Williams et al. cite Bailey (2009), who has showed that "same-sex oriented men are, on average, more sex atypical in their self-concepts, motor behavior, body movements, occupational careers, and recreational interests than heterosexual men." Following this rationale, Savin-Williams et al. go on to show that gay and bisexual men's level of

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depressive symptoms is not different from that of heterosexual women. Thus, they conclude "once recontextualized, the depressive symptoms reported by nonheterosexual men are not remarkable or even unexpected."

Even if one would concede the premise of the argument— that "same-sex oriented men are more similar to heterosexual women than heterosexual men"—there is no merit to the claim that these findings undermine the minority stress perspective. The main reason for this is that Savin-Williams et al. make their argument based on one sexual minority subgroup—gay and bisexual men, excluding lesbians and bisexual women— and one outcome—depressive symptoms, excluding anxiety and substance use disorders. This cherry-picked comparison is not sufficient to test minority stress theory. Minority stress rests on sociological theory that links social structure with health outcomes (through the impact of stress). Therefore, it makes predictions about differentially situated groups (disadvantaged versus advantaged groups) and predicts similar patterns across various mental disorders (Schwartz & Meyer, 2010). Savin-Williams et al. err on both counts.

First, minority stress suggests that sexual minorities are socially disadvantaged in our society due to homophobia and heterosexism as a *group*—that is, across all subgroups, such as those defined by gender, race/ethnicity, etc. For the study of minority stress, therefore, the groups compared ought to be all sexual minorities—men *and* women—versus all heterosexuals. Similarly, if gender inequality was studied, the reference group for women would be men; if race/ethnic inequality was studied, the reference group for race/ethnic minorities would be whites. This is because in each comparison we are interested in the *average* effect on the disadvantaged versus advantaged, that is, across diverse subgroups within (Schwartz & Meyer, 2010). Savin-Williams et al.'s hypothesis is refuted when one examines LGB as a group versus heterosexuals as a group. Consistent with the minority stress hypothesis, in such comparisons, LGB populations have higher rates of mental disorders than heterosexuals (King et al., 2008; Meyer, 2003).

Second, minority stress (and social stress theory more generally) is a sociological theory that predicts that disadvantaged social status affects the aggregate of mental disorders, rather than any particular disorder—we are interested in whether a disadvantaged group member has *any* disorder that is caused by minority stress. This is because social disadvantage and resultant stress are thought to be *generic* pathogens. Minority stress does not predict a *specific* impact on, say, depression versus anxiety and substance use disorders. Although this is not an infallible rule, researchers should provide a good reason to exclude one disorder or another. A reason to exclude a disorder would be, for example, that stress has no part in causing the disorder. In such a hypothetical situation, if stress does not play a causal role, the researcher could not reasonably hypothesize that minority stress would lead to excess disorder in the disadvantaged group.

This problem in Savin-Williams et al.'s proposed reference group hypothesis is reminiscent of a 1970s debate in the sociology of mental health about gender role stress and disorder. Gove and Tudor (1976) claimed that a higher level of depression in women compared with men is evidence of women's gender role stress. Critics argued, as we argue here, that selecting depression alone of all mental disorders is wrong because it provides opportunistic

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support for a favorite theory. When all mental disorders were compared, it became evident that women and men have similar levels of disorders, refuting the proposed gender role hypothesis (Dohrenwend & Dohrenwend, 1976). An alternative hypothesis was offered for the differing patterns of disorders, suggesting that men and women's stress response differed: Women internalize stress, resulting in higher levels of mood disorders, and men externalize stress, resulting in higher levels of substance use disorders and antisocial behaviors (Rosenfield, 1999).

If we relied on these gendered patterns of difference between internalizing and externalizing disorders that are characteristic of men and women in the general population, we would expect, based on Savin-Williams et al.'s proposed hypothesis, that gay and bisexual men would be similar to heterosexual women in patterns of substance used disorders. In fact, this is not the case: gay and bisexual men have a much higher prevalence of substance use problems, including substance use disorders, than heterosexual women (King et al., 2008; Meyer, 2003). As a result, when *all* mental disorders are considered, gay and bisexual men have higher levels of disorder than heterosexual women. This finding is consistent with the minority stress hypothesis but not with Savin-Williams et al.'s reference group hypothesis.

In summary, examining the evidence on sexual orientation, stress, and disorder, we find that sexual minorities have greater exposure to stress (Meyer, Schwartz, & Frost, 2008) and they have the expected resultant higher rates of disorder when compared with heterosexuals (King et al., 2008; Meyer, 2003). When we examine Savin-Williams et al.'s reference group hypothesis carefully in light of this evidence, we must refute it.

Finally, Savin-Williams et al. contend that their arguments "contribute to a growing call for depathologizing individuals who are not heterosexual." I reject the implication that minority stress theory pathologizes LGB individuals. Minority stress theory positions the source of stress, and therefore mental health problems, as stemming from prevailing societal-level sexual stigma, prejudice, and discrimination and not a reflection of individual traits. Although some politically-motivated persons may use evidence that LGB individuals have a higher prevalence of disorder than heterosexuals to pathologize, stigmatize, and discriminate against LGB persons, such arguments are misguided as they defy logic. During the debates that led to the removal of homosexuality as a mental disorder from DSM-II in 1973, Marmor (1980) noted how illogical it is to associate findings about prevalence of pathology in the group with pathologizing the group itself:

> …the basic issue…is not whether some or many homosexuals can be found to be neurotically disturbed. In a society like ours where homosexuals are uniformly treated with disparagement or contempt—to say nothing about outright hostility—it would be surprising indeed if substantial numbers of them did not suffer from an impaired self- image and some degree of unhappiness with their stigmatized status….It is manifestly unwarranted and inaccurate, however, to attribute such neuroticism, when it exists, to intrinsic aspects of homosexuality itself. (p. 400)

Minority stress theory points to pathogenic social conditions that stigmatize LGB people and treat them as inferior to heterosexuals. Even at the risk that research findings can be misused by some, studies on the psychiatric epidemiology of LGB individuals are important to help

guide funding by governmental and other agencies and to direct research and prevention efforts.

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