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Self-Reported Health Among Sexual Minorities in the United States

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by

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ABSTRACT

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Previous literature on LGBTQ+ people (lesbian, gay, bisexual, transgender, queer/questioning, and other sexual minorities) reports that this community experiences greater health problems than heterosexuals. LGBTQ+ people experience higher rates of chronic conditions, STIs, addiction, poor mental health, and cancer, which highlights the importance of capturing data regarding health. A growing concern is that social surveys fail to find meaningful ways to gather gender and sexuality data to understand possible health disparities for LGBTQ+ people. This study uses data from the General Social Survey to examine the physical and mental health outcomes of LGB people compared to straight people in a nationally representative sample of Americans. An analysis of potential disparities in the self-reported health of straight and LGB respondents finds that respondents who identified as bisexual reported significantly lower levels of self-rated health and more problems with mental health compared to respondents who identified as gay, lesbian, or heterosexual.

DEDICATION

To my best friend Chopper, without your never-ending love, excitement, and tail wiggles I would not have made it this far in life. You may be gone but forever you remain in my heart.

I love you always.

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CHAPTER 1. INTRODUCTION

LGBTQ+ people are more likely to live with various healthcare problems when compared to straight counterparts. For instance, gay and bisexual men are more likely to have gastrointestinal, liver, and kidney problems. Lesbian women are at higher risk for polycystic ovaries, overweight, and more likely to report cervical and breast cancer. Gay men are more likely to be overweight and report anal cancer. Bisexual people are at increased risk for obesity and anal cancer (Zeeman et al. 2019). Finally, the LGBTQ+ community is most often at risk for adverse psychological health problems due to entwined increases in homophobia, transphobia, and other antagonisms that have occurred through time (Rogers 2019).

Members of minority groups experience higher rates of psychological disorders than members of dominant groups. This is especially true for the LGBTQ+ community, but it is important to pay special attention to subgroups of sexual minorities who are marginalized from the rest of the community. For example, transgender people are more likely to deal with mental health problems when compared to lesbian or gay people (Fredriksen-Goldsen 2014). Following transgender people are bisexuals, who on average report worse levels of physical health than any other sexual minority group. Bisexual people are most likely to experience marginalization from members of the LGTQ+ community because bisexuality is seen as an unstable sexual orientation. Furthermore, bisexual people are often ignored from some research data since they can be accidently labeled as straight when in a relationship with a non-same sex significant other (Dyar et al. 2019).

One in five LGBTQ+ people report some form of discrimination committed against them by a medical provider. Transgender people are more likely to report physical victimization by healthcare providers than any other sexual minority group (Kattari and Hasche 2016). This

matches earlier research that found "transgender older adults had significantly higher risk of poor physical health, disability, depressive symptomatology and perceived stress than the nontransgender participants" (Fredriksen-Goldsen et al. 2013: 488).

The heterosexual population has long benefitted from inclusion in medical and genetic research. In contrast it is essential to remember that much less is known about the effects of structural and environmental contexts on health and the roles of social determinants for LGBTQ+ people (Fredriksen-Goldsen et al. 2014). Researchers are exploring whether the current quality of life for LGBTQ+ persons in the United States leads to a shorter lifespan (Begun and Kattari 2016; Fredriksen-Goldsen et al. 2017; Fredriksen-Goldsen et al. 2015; Fredriksen-Goldsen et al. 2014; Ham 2018).

The next chapter explores the theoretical explanations for various healthcare disparities for LGBTQ+ people. The review will focus on factors that may influence accessing health services, stigmas in the healthcare environment, and sociocultural problems that label this population as “other.” As increased awareness is brought to this subject, situational awareness will need to switch toward the methods we use to collect and analyze data in the social sciences. This pertains to social surveys and how questions about sexuality and health are worded in order to gather accurate information on the reality of people’s health.

CHAPTER 2. LITERATURE REVIEW

Effect of Stress on the Body

Minority stress theory, an extension of stress theory, occurs when "minority and dominant values…conflict with the social environment experienced by minority group members" (Meyer 1995:39). This power dynamic imbalance can lead to a high degree of stress in the day to day lives of minorities (Meyer 1995). While Meyer postulated that minority stress and its negative impacts on the body were limited to mental health, we now understand that stress can impact every aspect of the human body, and is a central theme in theories of health and disease (Slavich 2016). Evidence that stress is involved in the development, continuation, or exacerbation of mental and physical health conditions continues to emerge. Stress has also been identified as playing a key role in accelerated biological aging and a lowered life expectancy (Slavich 2016).

Yaribeygi et al. (2017) found that stress triggers the body to release hormones that trigger our "flight or fight" response and activate our immune system. In short term situations this effect is beneficial for avoiding harms that are a temporary threat to our bodies. In the long term it can lead people to feeling overwhelmed or unable to cope with basic tasks that often have no real threat on our physical being. Beyond our emotional response, our bodies continue to be in this state of "flight or fight." Prolonged periods consume massive amounts of energy; long-term exposure to stress hormones can lead to detrimental health outcomes (Yaribeygi et al. 2017).

Stress itself is a highly personal experience that can be caused by any number of inward or outward influences on the body and mind. Loneliness, for example, is a source of acute and chronic stress (Mushtaq et al. 2014). Loneliness is defined by feelings of dejection associated with isolation that persist even with company (Valtorta et al. 2016). Researchers have found that

increased rates of isolation and loneliness can result in an increased risk for cardiovascular accident or even stroke (Valtorta et al. 2016). Furthermore, increased periods of time where one is consistently alone are directly correlated with an increased risk for cardiovascular disease (Hegeman et al. 2017). However, it should be noted that future research needs to determine if reducing feelings of loneliness will decrease those risk factors (Valtorta et al. 2016).

Some studies indicate that the body and specifically the central nervous system can undergo structural changes (atrophy of the brain was most commonly seen) that may not revert to normal once stress is reduced. These changes can affect a person's memory, their immune response, their cognition, their cardiovascular system, their gastrointestinal system, and their endocrine system. Several dozen potential diseases can occur from any one of these bodily systems becoming dysfunctional (Yaribeygi et al. 2017).

LGBTQ+ Stress and Health

LGBTQ+ persons have higher risk factors for loneliness, which are heightened as they get older and are more likely to experience widowing, ageism, weak family ties, and consequently weak social support systems (Browne and Nash 2016; de Vries and Croghan 2014). Social support systems are defined as interpersonal bonds that helps satisfy some need(s) in the lives of those who are connected, ultimately maintaining a higher quality of life. Older LGBTQ+ people are three times more likely to live alone and four times less likely to have children than heterosexual individuals (Orel 2017).

Most gerontological research on family and social support networks has ignored sexual minorities, and consequently, the impact that being "out" has on their family-based social support systems is poorly understood. This research leaves a critical hole in our understanding of LGBTQ+ health because there is a strong association between social support networks and the

physical and mental well-being of patients of advanced age (Orel 2017). Older LGB adults are more likely to have limitations on their physical and mental health when compared to heterosexuals in similar age groups. By extension, older transgender adults are more likely to have a disability, poor physical health, and depression when compared to other LGB adults (Fredriksen-Goldsen et al. 2014).

As minorities, LGBTQ+ people tend to have experienced a lifetime of social, political, and economic strains that can prevent them from ever fully coming "out of the closet" or being open in specific spaces (de Vries & Croghan 2014). This midlife to elderly group were young adults during the AIDS pandemic, a time of heightened sociopolitical activation for sexual minorities (Fredriksen-Goldsen et al. 2014). Their cohort is often referred to as the "Lost Generation" within the LGBTQ+ community. From 1981 to 2000, 448,060 people died of AIDS (Centers for Disease Control 2001). AIDS reshaped many aspects of society; the initial pandemic transformed cultural, interpersonal, and institutional life in unprecedented ways (Nelkin, Willis, and Parris 1990). AIDS also influenced social research on the LGBTQ population, as people were previously unwilling to announce their sexuality due to social constrictions created by public and government response to the pandemic (Nelkin et al. 1990).

The AIDS pandemic in particular may explain why fear of discrimination and the suspicion that discrimination might occur in the healthcare setting is more common in LGBTQ+ populations than in heterosexual populations (Jackson, Johnson, and Roberts 2008). Another important factor predates the pandemic and contributes to the cumulative harm of discrimination, persecution, and abuse against LGBTQ+ people: The medical community's contention, until 1973, that homosexuality was a mental health condition. Decades after that discriminatory classification officially ended, some doctors have continued to stigmatize LGBTQ+ patients.

Under the pretense of religious freedom, a plethora of anti-LGBTQ+ laws have come into effect in recent years allowing physicians to deny medical services to anyone identifying as a sexual minority (Wang, Geffen, and Cahill 2016). These legislative moves threaten to worsen discrimination that sexual minority groups already face. Some laws go so far as to exempt physicians from offering lifesaving medical interventions if it goes against their religious moral code. "As a result, these laws inflict both material harm and dignitary harm--harms that exacerbate stigma and marginalization and reduce social status on other citizens" (Wang et al. 2016:1).

The literature on healthcare microaggressions notes a troubling trend in which 10 percent of LGB and 21 percent of transgender patients experience harsh or abusive language from their providers. While not every patient may experience such overt forms of aggression, practicing medicine with a heteronormative mindset creates an environment where LGBTQ+ people can feel unwelcomed (Rossman, Salamanca, and Macapagal 2017). In one study, 40 precent of participants feared accessing healthcare services due to the potential for experiencing discrimination (Fredriksen-Goldsen et al. 2013). Because of the possibility of microaggressions or discriminatory laws, some LGBTQ+ patients may decide not to disclose their sexual or gender identity. This problem increases for older LGBTQ+ people; de Vries and Croghan (2014) found that older lesbians were more hesitant to reveal their sexual orientation to healthcare providers than older gay men. Although not revealing one's sexual or gender orientation may offer *situational* protection during a healthcare encounter, keeping this information private may lead to adverse health outcomes for patients.

There are nearly 30 million LGBTQ+ persons in the United States, with 2.4 million over the age of 50, which will increase to over 5 million in the next couple of decades (Fedriksen-

Goldsen et al. 2014: Fredriksen-Goldsen et al. 2015). It is well known that the growing population over age 65 will impact the United States medical care system by 2024 (Mitchell 2014). This growing population also includes aging LGBTQ+ people who are still exploring and defining their sexual identity while wanting to remain sexually active as long as they physically can (Browne and Nash 2016). With the aging population rapidly increasing, our healthcare system is not ready to support this soon-to-be patient population as a whole, leading many to speculate that minority senior citizens will suffer disproportionately worse health than non-minority senior citizens (Mitchell 2014).

Due to these multiplying factors, over 80 percent of older LGBTQ+ people report feeling that they are incapable of being "out" within long term care facilities such as nursing homes or rehab centers (Justice in Aging 2015). In other research, 53 precent of LGBTQ+ individuals felt that current geriatric services do not meet the needs of the LGBTQ+ community. In the same study "42 percent [of older respondents] reported negative experiences with healthcare attributable to sexual orientation and gender identity" (de Vries and Croghan 2014: 12).

Some research finds that LGBTQ+ adults report some of the highest rates of life satisfaction and feel they are aging successfully when compared to heterosexual people (Fredriksen-Goldsen 2011). A full dive into this reporting, however, cannot be achieved as LGBTQ+ adults are also at increased risk of being overlooked in sociological research due to the assumption that their sexual identities are already matured and unchanging (Fredriksen-Goldsen et al. 2017). The idea that sexuality is fixed as we age is in direct contrast with other research, which postulates that our identities evolve through our entire life course (Browne and Nash 2016). A key drawback when researching the LGBTQ+ population, especially the older members of this group, is the heterosexism that pervades the current sociological research model and

ignores the need for 'queering' the research (Seidman 1994). Sociological research has increased its queerness when studying queer related issues, but, even today, certain sexual and gender minorities such as transgender, pansexual, and asexual people are still relatively absent in study populations (Pfeffer 2014).

Health Insurance and Employment

Another influence on LGBTQ+ health is access to health insurance and its association, in the United States, with employment. In the United States, having a job allows many people to have access to healthcare, thanks in part to the employment-contingent health insurance system, which has been in place since the end of World War II (Bradley, Neumark, and Motika 2012). Access to health insurance continues to be problematic despite the creation of the Affordable Healthcare Act (ACA) by the Obama administration in 2011 (JAMA 2011). A key goal of the ACA is to remove the employment restrictions to health insurance access and provide continuous coverage to individuals diagnosed with a chronic or serious disease. This eliminates the job lock, which traps people in full-time employment despite illness and disease (Bradley et al. 2012). Many people who cannot keep their jobs pay out of pocket and file bankruptcy when unexpected adverse life events occur (JAMA 2011).

Legal protections against LGBTQ+ employment discrimination are limited. Since 2018 only eighteen states plus the District of Columbia had full employee protections to prevent an individual from being fired for their sexuality (Ham 2018). Other states have some protections in place, but they often only cover state employees or only cover sexual orientation or gender identity, not both (Ham 2018). Compounding this factor, very few states have enacted policies that guarantee healthcare services to LGBTQ+ people. Advocates report that 45 percent of the LGBTQ+ population lives in states without inclusive insurance protections, 43 percent live in

states that prohibit transgender health insurance coverage, 46 percent live in states that deny Medicaid coverage for gender affirmation surgery, and 62 percent of LGBTQ+ people live in states without inclusive benefits built into their state employment benefits (Movement Advancement Project 2021).

In the U.S. employment status is directly tied to having insurance. Further, there are far more LGBTQ+ people who do not have insurance than heterosexual people (Gates 2014). This is compounded when multiple minority identities stack; for example, sexual minority women and sexual minority people of color are more likely than their heterosexual counterparts to be jobless and ultimately without health insurance (Charlton et al. 2018). Job discrimination based on one's sexuality thus can directly impact healthcare outcomes and quality of life for this community.

LGBTQ+ adults are at a significantly higher risk of not having the money to cover healthcare-related expenses. Up to a quarter of the LGBTQ+ population (approximately 7.5 million people) do not have enough money to cover emergency medical and preventative medical needs (Gates 2014). Finally, it should be noted that while this writing examines the entire LGBTQ+ spectrum, bisexual people, specifically bisexual women, are more likely to be uninsured and have compounding health problems than any other sexual minority subgroup (Charlton et al. 2018).

Once a person’s sexual identity becomes known to employers, there arises a risk of discrimination and employment termination (Ham 2018). Several contradictory court rulings have gone into effect, making it difficult to understand what sexual discrimination is and is not. An even grayer area concerns employers who fire employees because they oppose their minority sexual and or gender identity (Ham 2018). Such is the case in *Mickens v. General Electric CO* (2016) in which a federal judge ruled that GE was not in violation of sex discrimination laws

after denying a female to male (FtM) transgender employee the ability to use the men's restroom, requiring the individual to leave his primary area of work in order to use the women's restroom (Ham 2018).

Sexual and gender discrimination stances shifted after the Supreme Court's ruling in *Obergefell v. Hodges* (2015) which stated that marriage is a fundamental right for same-sex couples, granting them the legal right to marry across the US. That ruling paved the way for the Supreme Court to issue a series of groundbreaking rulings in the cases *Bostock v. Clayton County, Georgia* (2020); *R.G. & G.R. Harris Funeral Homes Inc. v. Equal Employment Opportunity Commission* (2020); and *Altitude Express, Inc. v. Zarda* (2020). In 6-3 rulings for each case, the court concluded that Title VII of the Civil Rights Act of 1964 protects employees against discrimination for being gay or transgender; that Title VII protects transgender people from employment discrimination; and that Title VII protected employees from discrimination on the basis of sexual orientation or gender identity, respectively. The Supreme Court's rulings, however, only go so far to offer protections to LGBTQ+ people. To solidify this into national law, a group of congresspeople created H.R.5-Equality Act. This bill is designed to strengthen the protections of Title VII of the Civil Rights Act of 1964 and make discrimination based on sexual or gender orientation illegal nationwide.

Minority stress is integral to the LGBTQ+ experience especially when it comes to accessing healthcare services. The consensus in the existing literature is that LGBTQ+ people's health outcomes are significantly worse health than for straight people. In the analysis that follows, I examine data from a nationally representative survey, the General Social Survey (GSS), to see if it supports the pattern of adverse physical and mental health for LGBTQ+ people. The GSS was utilized since it has been defined as the "gold standard" of social surveys

by the Consortium of Social Science Associations (Silver 2011; Silver 2013). The GSS implements free and easy access to its survey data which is utilized by thousands of scholars not just in the United States but around the world. Because of the quality of the work GSS produces it can be used to investigate any number of research interests.

My expectation is that data from this robust survey should show that LGB people are more likely to report poor quality of health than straight people. While the GSS offers a plethora of questions to examine health and wellbeing, this study focuses primarily on physical and mental health using variables for respondents' overall self-reported health, days of poor physical health, and days of poor mental health.

CHAPTER 3. METHODOLOGY

Data

The My study is based on cumulative General Social Survey (GSS) data collected from 2008 to 2018. In 2008, the GSS added a question on sexual orientation to its demographic inventory. The GSS, a nationally representative survey of adults in the United States is conducted in person every other year under the auspices of the University of Chicago's National Opinion Research Center. It is available to the public and aims to be "the single best source for sociological and attitudinal trend data covering the United States" (NORC 2021:1).

Measures

Dependent Variables

A total of three dependent variables were analyzed to assess a person's overall self-reported health. Two variables assessed frequency of health-related problems directed towards how often in the past 30 days have respondents experienced: 1) days of poor physical health (M = 2.68, SD = 6.29); 2) days of poor mental health (M = 3.71, SD = 7.13). Response choices to these health-related questions were measured in days ranging from 0 to 30 days. Self-reported condition of health (M = 2.4, SD = 1.03) asked respondents "would you say that in general your health is (1) Excellent, (2) Very-Good, (3) Good, (4) Fair, or (5) Poor?"

Independent Variables

The key variable in this study is sexual orientation, asked in the GSS as "which of the following best describes you" with answers as (1) Gay, Lesbian, or Homosexual, (2) Bisexual, (3) Heterosexual or straight, (8) Don't know.

Gay, Lesbian, or Homosexual (M = .019, SD = .138), were recoded into Gay or Lesbian, following traditional community guidelines for acceptable terminology used in sexual

identification. Bisexual (M = .025, SD = .157), was left as-is, and Heterosexual or straight (M = .95, SD = .207), were recoded into Straight. Those who responded "don't know" were coded as missing.

Several control variables were assessed to account for any sociodemographic differences that may influence the relationship between sexual orientation and self-reported health. Race is measured as categorical with white (reference category) (M = .744, SD = .436), and dummy variables for Black (M = .156, SD = .363) and other races (M = .0994, SD = .299). Gender (M = 0.55, SD = 0.49) is measured as either male or female. Age (M = 48.57, SD = 17.65) is measured in an interval/ratio scale in years. Education (M = 13.61, SD = 3.05) is measured on an ordinal scale of years of schooling completed. Total household family income is reported in constant dollars to account for changes over time (M = 34,923.03, SD = 30,956.17). As a proxy for measuring access to health insurance, employment was recoded into a dummy variable for full time employment (M = 0.47, SD 0.5).

Table 1. Descriptive Statistics

Variables	Mean	SD	Min	Max
Health Measures				
Self-Reported Health	2.4	1.033	1	5
Days of poor physical health	2.68	6.292	0	30
Days of poor mental health	3.71	7.131	0	30
Demographics				
Gay or Lesbian	.019	.138	0	1
Bisexual	.025	.157	0	1
Straight	.95	.207	0	1
Respondent's sex	0.55	0.497	0	1
Age of respondent	48.57	17.658	18	89
Highest year of school completed	13.61	3.056	0	20
Total family income	34,923.03	30,956.17	227	162,607
Full Time	0.4725	0.49926	0	1
White	.7445	.43618	0	1
Black	.1562	.36302	0	1
Other races	.0994	.2992	0	0

Analytic Strategy

Preliminary Analysis

For bivariate analysis between sexual orientation and self-rated health I ran a contingency table between these variables and their expected values under the initial hypothesis of statistical independence.

Bivariate analysis continues with an ANOVA examining the relationship between reported days of poor physical and days of poor mental health for sexual minorities. This examined mean differences between the two dependent variables assessing health related outcomes and sexual orientation identification.

Finally, OLS models were created to determine health outcomes based on sexual orientation identification while placing control measures for other essential sociodemographic influences.

CHAPTER 4. FINDINGS

Bivariate

Table 2 shows the crosstab between sexual identification and self-rated health. The chi-square test shows that there is a significant relationship between sexual orientation and self-rated health. Gay and lesbian respondents were the most likely to say their health was excellent (34.2%), compared to 26.5% of straight respondents and only 20.1% of bisexual respondents.

Table 2. Cross Tab Between Sexual Identification and Self-Rated Health

Health Measures	**Gay or Lesbian**	**Bisexual**	**Straight**
Poor	.056	.059	.050
Fair	.177	.253	.201
Good	.424	.487	.483
Excellent	.342	.201	.265

Person Chi-Square: 15.712; p=.015

Table 3 represents a one-way ANOVA analyzing differences of health outcomes for days of poor physical and mental health by sexual orientation. There are two statistically significant findings between bisexuals and gay/lesbian and straight people on reported days of poor physical health ($F = 2.6$, $p<.1$) and poor mental health ($F = 12.49$, $p<.001$) respectively. A Tukey post-hoc test showed no significant difference between sexual minority groups regarding poor physical health. For mental health, bisexual respondents reported significantly more days with mental health problems in the past month (6.6) compared to both gay and lesbian respondents (4.8) and straight respondents (3.6).

Table 3. One-Way ANOVA for Health Outcomes and Sexual Orientation

Variables	Gay or Lesbian	Bisexual	Straight	F
Number of Poor Physical Health Days	2.78	3.78	2.6	2.6
Number of Poor Mental Health Days	4.81	6.6[ab]	3.59	24.02***

Sig at p<0.001***
a: Sig Difference from Straight at p<.05
b: Sig Difference from Gay/Lesbian at p<.05

Table 4 presents self-rated health, poor physical health over the past 30 days, and poor mental health over the past 30 days. After controlling for all sociodemographic variables, the model shows that bisexual people have significant differences between their straight counterparts when examining self-rated health (b = 0.035, p<.05) and poor mental health (b = 0.043, p<.01). The model further indicates that gay and lesbian people do not have significant differences in their overall health. Women are more likely to report a higher number of days with physical and mental health problems, but are not significantly different on self-rated health. Age, income, and education all play key roles in determining an individual's overall health. Race has a significant impact on mental health, with Black respondents less likely to report mental health problems, but race has non-significant impacts on the other two outcomes.

Table 4. OLS Regression for Self-Reported Health Measures

Variables	**Self-Rated Health**	**Poor Physical Health**	**Poor Mental Health**
Gay or Lesbian[a]	-.048	.621	1.060
Bisexual[a]	.200**	1.060	2.006**
Sex	-.042	.504*	.648***
Age	.007***	.027	-.025***
Income[b]	-.003***	-.011***	-.010***
Education	-.047***	-.151***	-.155***
Full Time[c]	-.161***	-1.190***	-.602**
Black[d]	.003	-.579	-1.040***
Other races[d]	.016	-.224	-.410
Model Stats			
Constant	2.680	4.188	7.480
N	5992	2948	4844
R2	.110	.026	.033

a: Ref group is straight
b: Coefficient was multiplied by 1000
c: Ref group is unemployed
d: Ref group is white
*p<0.05, **p<0.01, p<0.001***

CHAPTER 5. CONCLUSION

Discussion

In studying the sociology of health, we must consider some of the social determinants of health, particularly for social minorities. Although 23.3 percent of lesbian and gay people reported fair or poor quality of health, the majority were not at a significantly elevated risk of living with poor physical health in these data. The OLS regression indicates that gay and lesbian people are not significantly more likely to report differences in their overall health compared to straight people. The result of this non-finding was surprising. Given the body research on health disparities for the LGBTQ+ community, a non-finding of this nature was initially considered unlikely. Sex, age, income, and education all played significant roles in determining health status, but not identifying as gay or lesbian.

When accounting for mental health, which included stress, depression, and problems with emotions, bisexual people were more likely than lesbian and gay people to report more days of poor mental health. After controlling for sociodemographic variables, a significant difference was found between bisexual and straight individuals on self-reported health measures and poor mental health. Although not measured directly, a possible driver of this finding could be respondents' degree of social integration. Bisexuals in this study were less likely to possess conventional forms of social capital (e.g., higher education and income) and elsewhere they express less investment in LGBTQ+ subculture (Pew Research Center 2015). A reduced sense of belonging, either through achieving conventional social status or identifying with a subcultural community, could help explain why bisexual individuals reported experiencing poorer quality of mental and overall health. Bisexual people are more likely to lack a sense of identity acceptance and less likely to be out to important people in their lives, including physicians who may mistake

bisexual people as straight (Pew Research Center 2015). From a deviance perspective, bisexuals occupy a marginalized position in contrast to heterosexual people and lesbian and gay subcultures. If one applied Bader and Baker's (2019) theoretical framework for understanding deviance, bisexuals would more likely be in the "drifter" category. Drifters have higher levels of suicidal ideation, substance use, and more extensive histories of violent victimization (Bader and Baker 2019). Low social support and lack of community might help explain the disparities in health outcomes for people who identify as bisexual in my research. A reduced sense of community and belonging could have a major impact on personal mental wellbeing (such as increased loneliness), which could amplify negative physical health conditions.

This study's finding of no significant disparities between lesbians and gay men's self-reports and straight respondents' may be due to the use of the GSS instead of a survey that is dedicated to behavioral health and general health measures. There are some shortcomings in the GSS that may help explain why the results here differ from literature. The GSS, like other large-scale surveys, tends to rely on a one-dimensional definition regarding sexual orientation, treats sexual minorities as a homogenous group, and fails to account for intersectionality (Dyar et al. 2019). For the question regarding sexual orientation— "which of the following best describes you?"—respondents must choose from 1) Gay, Lesbian or Homosexual; 2) Bisexual; 3) Heterosexual or straight, or 4) don't know. The first answer assumes lesbians and gay people are similar and misses an opportunity to capture a larger sample of sexual minorities. It also uses outdated terminology by including "homosexual," a word that has been described for decades in the United States as being connected to a horrible sin, or a psychological condition that needs treatment (Edsall 2003). The use of this terminology could cause people to answer dishonestly

regarding their sexual orientation. A statement by Dyar, et al. (2019:226) summarizes this critical point:

> How researchers define sexual orientation is important and can lead to meaningful differences in study findings. Thus, it is critical to inclusively examine health disparities across all dimensions of sexual orientation to develop a more complete understanding of the physical health disparities affecting sexual minorities.

That the GSS offers a cross-sectional survey of the United States population but uses a smaller overall sample size than other surveys may also explain the unexpected findings. This strategy makes assessing patterns within subgroups more difficult. Also, the GSS does not utilize newer methods in cross-sectional survey design. Given the complexity of assessing and measuring health, the GSS may not be best equipped to capture multidimensional physical and behavioral health data.

The small sample size might explain why patterns in the literature on LGBTQ+ health were not found in this study. While many researchers report that the LGTBQ+ community may be at higher risk for mental health disorders, sexually transmitted infections, substance use and abuse, obesity, heart disease, and cervical and breast cancers, this does not mean that every LGBTQ+ person will face these problems. Throughout the life course there will be people who do not encounter such health problems. Their comparatively good physical and mental health may be in part due to other social conditions.

Limitations

As I mentioned above, this study is limited in size, with 231 respondents identified as gay or lesbian and 273 respondents identified as bisexual. Future research could utilize data from

more up-to-date versions of the GSS if the survey expands options for sexual orientation and gender identity. Ideally, data from other major surveys could provide a useful comparison to this research. A further study limitation comes from self-rated measures of health. While some studies have found that these reports are increasingly valid, they fail to capture a pathophysiological assessment of health measures (Schnittker and Bacak 2014). Future studies could also analyze what protective factors might be at play in shielding gay, lesbian, and bisexual people from negative health outcomes.

Further complicating this study is the lack of transgender participants, a group besieged with health-related problems that was not included in the GSS until recently. In 32 years of surveying, the GSS only started asking about transgender identity in 2018 on ballots B and C. In those ballots, 939 people responded to the question regarding transgender identity with choices limited to: 1) Woman, 2) Man, 3) Transgender 4) A gender not listed here. This measure comes with limited research application and is likely to impede sociological analysis of disparities between transmen, and transwomen, their cisgender counterparts, and people who identify as nonbinary.

A key recommendation from this study is for qualitative research on LGBTQ+ people's mental and physical health that also asks them to discuss their resources for social support. The stronger the social network, the less one is likely to suffer from loneliness. A study employing mixed methods and social network analysis would be an ideal way to address the strength of LGBTQ+ people's relationships in networks; qualitative questions could help gauge the durability or instability of those social relationships and explore possible consequences.

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