

## **Social Support for Sexual Minority Families During the COVID-19 Pandemic**

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### **Abstract**

Social support, particularly support from family and close friends, is essential to mental health outcomes especially for members of the LGBTQ+ community (NSEM 2020). The COVID-19 pandemic has drawn attention to the important role of social support, especially for marginalized communities (Goldbach et al. 2020; Ruprecht et al. 2021). While social support is recognized as a critical resource, to date no research has examined access to support during the pandemic for gender and sexual diverse populations. We draw on a new population-based data source of 3,642 respondents, the National Couples' Health and Time Use Study (NCHAT), that oversampled sexual and gender diverse populations during the pandemic (September 2020-April 2021). The sample consists of respondents with a range of sexual identities including 55.4% heterosexual, 20.2% gay or lesbian, 9.5% bisexual, and 15.0% other or multiple sexual identities. We consider three sources of social support including, family (acceptance and emotional support), friends (emotional support), and community (residence is a good place for sexual minorities). We will employ regression models to examine differentials in sources and levels of social support for individuals who identify as gay and lesbian, bisexual, heterosexual, or multiple sexual identities. In our analyses, we will also account for key sociodemographic indicators including gender identity, union status (cohabiting/married), race/ethnicity, resident children, education as well as indicators of microaggressions. This work contributes to understanding of the social climate and resources available to sexual and diverse populations during a major public health crisis.

### **Social Support for Sexual Minority Families Amidst the COVID-19 Pandemic**

Social support is a key contributor to higher levels of mental and physical health and well-being and serves as a buffer in stressful circumstances (Sarason et al. 1990). Certainly, during the COVID-19 pandemic, the stress levels are elevated among adults, and among marginalized groups such as sexual and gender minorities (Goldbach et al. 2020; Manning and Kamp Dush 2021). Social support manifests in many different forms, including emotional support (discussing personal issues and/or worries), companionship or sharing social activities, informational support (receiving advice or guidance), and instrumental support (Frost et al. 2016). Social support can originate from multiple sources, such as friends, family members, and one's community. A large body of literature has focused on marginalized communities and demonstrated the importance of social support for sustaining mental and physical health (Donev 2005; Heaney and Israel 2008). The need for social support, and thereby the significance of studying the need for social support has substantially increased since the COVID-19 pandemic caused significant changes in our everyday lives.

Minority stress theory (Meyer 1995; 2003), an extension of social stress theory (Aneshensel 1992; Burke 1991), argues that members of marginalized communities experience more stress and increased barriers to obtain coping resources. Further, marginalized individuals experience unique forms of stress, typically in the form of various micro- and macro-aggressions. Microaggressions are "brief, everyday exchanges" that send "denigrating messages" to minorities and are often unconsciously delivered in the form of "subtle snubs or dismissive looks, gestures, and tones." (Sue et al. 2007: p. 273). Macroaggressions, however, occur at a structural level and encompass actions meant to exclude minorities, either by action or omission (Osanloo et al. 2016). Recent research has examined social support among sexual and gender minorities (Frost et al.

2016; Kamen et al. 2015) with particular attention to LGBT youth and young adults (McConnell et al. 2015; 2016; Ryan et al. 2010; Schmidt et al. 2011; Snapp 2015), but no research has examined differential access to social support for sexual and gender diverse populations amidst the COVID-19 pandemic.

The National Couples' Health and Time Use Study (NCHAT) is a new, population-based data source with oversamples of sexual and gender minorities during the COVID-19 pandemic. These data offer a unique opportunity to explore social support of sexual and gender minorities at a time when mental and physical health may be at risk. . Using the NCHAT, we examine differentials in levels and sources of social support for individuals identifying as gay or lesbian, bisexual, heterosexual, or multiple sexual identities. We also assess how social support is associated with depressive symptoms among sexual minorities. In doing so, this research contributes to our understanding of sexual and gender diverse populations and their levels of social support, particularly during a major public health crisis.

## **Background**

### *COVID-19*

The coronavirus outbreak was declared a global pandemic by the World Health Organization (WHO) in March of 2020 (WHO 2020). The United States imposed travel restrictions, curfews, stay at home orders, and contact bans and closed nonessential public institutions to decrease the spread of the virus. Many political, cultural, religious, and sporting events were canceled or postponed, and individuals were advised to take several precautions, such as wearing a mask, staying 6 feet apart, and staying home if possible. The COVID-19 pandemic has caused one of the world's largest economic crises, as well as significantly affecting the well-being of individuals both mentally and physically (Doring 2020).

Sexual and gender minorities have been differentially affected by the COVID-19 pandemic (Goldbach et al. 2020; Manning and Kamp Dush 2021). In this paper, we argue that the gap in levels in social support among sexual and gender minorities, and therefore the disparities in mental and physical health of sexual and gender minorities, increased substantially during the COVID-19 pandemic.

### *Minority Stress Theory*

The minority stress theory (MST), as developed by Meyer (1995, 2003) in the study of sexual and gender minorities is the most prominent approach used to assess the well-being of sexual minorities. MST posits that stigma-related stress associated with sexual-minority status drives increased risk among LGBT individuals. MST operates under the assumptions that minority stress is (a) unique, (b) chronic, and (c) socially-based (Meyer 1995; 2003). Meyer (1995; 2003) argues that stressors faced by minorities are additive to stressors faced by all people, is related to underlying social and cultural structures, and stems from social processes, institutions, and structures (p. 676). Further, minority stress can be both distal and proximal. Distal minority stressors do not depend on an individual's perceptions and are objective, whereas proximal stressors are subjective and are related to one's self-identity as a lesbian, gay, or bisexual individual (Meyer 1995; 2003). These may be framed as more macro (distal) and micro (proximal). There are four principle components of minority stress: (a) general external pressures (i.e., lack of legal recognition of same-sex marriages) and specific instances of stress (i.e. violence), (b) expected stigma, (c) concealment of one's sexual orientation or identity, and (d) internalized homophobia (Peleg and Hartman 2019).

### *Stress and Social Support*

Social support is crucial when coping with the stress of everyday life, chronic stress, and acute stressful events (Thoits 1986). Wheaton and colleagues (2013) define stress as "...a discrete and observable event representing change and thus requiring some social and/or psychological adjustment on the part of the individual." (p. 303). Stress can manifest itself in terms of a mental, emotional, or physical toll and is typically described as an event or condition that causes change and requires adaptation by an individual (Meyer 1995; 2003). Traumatic events, daily hassles, and chronic stress are all components of stress. Daily hassles are usually associated with mundane realities of daily life, rather than stress related to severe social disadvantage, such as traffic jams, losing things, waiting in lines, etc. (Wheaton et al. 2013: p. 305). Chronic stress, however, typically develops slowly as a continuing and problematic condition and has a longer time course from onset to resolution (Wheaton et al. 2013: p. 303). The conditions in our social environments lead to stress or strain, and as a result, individuals who are stigmatized and confront discrimination based on their membership in specific social categories, including categories related to race/ethnicity, gender, low socioeconomic status, and sexual orientation must cope with additional stress (Meyer 1995; 2003).

Social support is a valuable resource and serves to help ameliorate the negative impacts of stress. A large body of work has shown the importance of social support for well-being (Donev 2005; Heaney and Israel 2008). Social support can manifest itself in many forms, including emotional support, companionship, informational support, and instrumental support (Frost et al. 2016). Emotional support can occur day-to-day and involves discussing personal issues and worries, whereas companionship includes shared social or recreational activities. Informational support is typically seen in the form of offering advice in making decisions, while instrumental support is reserved for major life events where one may need financial support or caregiving when

ill. For socially marginalized populations at greater risk for negative physical and mental health outcomes, social support is key for their coping and survival. In this paper, we focus primarily on emotional support with particular attention to *sources* of support, such as one's family, friends, and/or community.

Social support takes on many different forms and can be provided by one's family, friends, and/or community. While Snapp et al. (2015) established family, friend, and community support to be strong predictors of positive outcomes, family acceptance had the strongest overall influence when other forms of support were considered.

### *Family*

Social support received from one's family members plays a key role in the lives of sexual minorities. Familial support and acceptance have been linked to higher self-esteem, better physical and mental health, and lower suicidality, distress, depression, hopelessness, and substance use. Bouris et al. (2010) reviewed 31 quantitative articles and noted a positive association with LGB youth and young adult's substance use and parental rejection of the child's sexual orientation. Similarly, Newcomb et al. (2012) observed a negative association between alcohol use and perceived family support among LGBT youth, using the Multidimensional Scale of Perceived Social Support. Padilla and colleagues (2010) noted a positive coming out reaction from the GLB youth's mother decreased stress and suicidal ideation, and significantly reduced risk of drug use. Additionally, they found evidence that parental acceptance of sexual identity is an important aspect of a strong family relationship and has 'important ramifications' for their healthy development (Padilla et al. 2010).

Bouris et al. (2010) also reported negative parental responses to be inversely associated with young people's mental well-being. Suicidal thoughts and attempts among LGB youth and

adolescents were lower for those with close, supportive parent-child relationships and higher levels of family connectedness (Bouris et al. 2010). McConnell et al. (2016) cited lower family support, measured via the 12-item Multidimensional Scale of Perceived Social Support, to be indicative of higher psychological distress. Wang et al. (2021) also confirmed a negative association between family support and depression.

### *Friends*

Another key source of social support are friends. Tebbe and Moradi (2016) employed the Multidimensional Scale of Perceived Social Support (MSPSS) and reported a positive association between support from friends and lower suicide risk and reduced depressive symptoms for transgender individuals. Frost et al. (2016) used question prompts to assess the support networks and source(s) of support for gay and bisexual men, indicating that gay and bisexual men relied more on friends and coworkers when in need of major support, rather than family members. Support from friends (measured using MSPSS) can also foster positive interactions that buffer the negative effects of experiencing and internalizing sexual orientation stigma for sexual minority male youth (Bruce et al. 2015).

### *Community*

Pearson and Wilkinson (2013) emphasized the essentiality of systems of support in schools and other community organizations to protect the well-being of sexual minority youth, primarily due to families offering less social support. Interaction with other LGB people and communities help young LGB individuals build social support networks with friends who affirm their sexual orientation (Bruce et al. 2015). Turell and Herrmann (2008) revealed that lesbian and bisexual women who have experienced abuse prefer peer support within the LGBT community, or their euphemistic “family.” Even on the campuses of Historically Black Colleges and Universities



(HBCU) meant to foster a unique collegiate experience for African Americans, the LGBT community has struggled to integrate with the larger community of the university (Coleman 2016). Coleman (2016) noted that HBCU administrators may lack the language and understanding of the unique needs of the LGBT community on these campuses. This, in turn, further pushes members of the LGBT community to seek out each other for support.

Living in neighborhoods and communities that are LGBTQ+ accepting and affirming also constitutes community support. Being able to live with or around others and share experiences of discrimination and microaggressions without fear of rejection contributes to health and well-being (Lawrenz and Habigzang 2020). Wienke et al. (2021) reported significantly better mental health outcomes, specifically lower rates of depression and higher levels of self-esteem, for sexual minority young adults living in neighborhoods with higher concentrations of same-sex couples. This may be influenced by the more supportive social context they are in, which is also indicative of higher likelihood of forming a same-sex union, particularly for male sexual minorities (Prince et al. 2017). Following the COVID-19 pandemic, Miles et al. (2021) argues that place and the higher concentration of LGBTQ+ people will continue to be an important factor on one's mental health and well-being.

### **Current Study**

The objective of this study is to assess social support levels during the pandemic among sexual minorities and sexual majorities. We consider variation among sexual minorities as well, distinguishing gays and lesbians, bisexuals, and other identifying individuals. Secondly, we assess whether social support influences depressive symptoms among sexual minorities. In this paper, we propose the following two hypotheses:

Hypothesis 1: Social support is lower for gender and sexual minorities during the COVID-19 pandemic than cisgender, heterosexual individuals (n=3,636).

Hypothesis 2: Social support is an important predictor of well-being (depressive symptoms) among sexual minorities (n= 1,579).

This research will contribute to our assessments of the health and well-being of sexual minorities during the pandemic. To date no studies were conducted during the pandemic and have ample sample sizes of sexual minorities to support our research questions. Further, these data provide a new opportunity to examine social support differentials among sexual minorities and how these levels affect depressive symptoms among sexual minority individuals. Implications of social support levels and depressive symptoms in the midst of a global pandemic provide insights into potential ways to ensure the health and well-being of sexual minorities.

### **Data and Methods**

The National Couples' Health and Time Study (NCHAT) is a nationally representative sample of 3,642 respondents with oversamples of racial and ethnic minorities and sexual minorities. Respondents' ages ranged from 20-60 years old and included individuals that were married or cohabiting at the time of data collection. The sample consists of oversamples of respondents with a range of sexual identities including 55.4% heterosexual, 20.2% gay or lesbian, 9.5% bisexual, and 15.0% other or multiple (1,621 sexual minorities). Data were collected from September 2020 to April 2021, during the COVID-19 pandemic. These data are especially suited for these analyses because of the breadth of questions, timing of data collection, and the large, population-based sample of sexual and gender minorities.

There are two key analytic samples. The first consists of the full sample of respondents with valid responses on social support and sexual identity (n=3,636). The second analytic sample

is limited to sexual minorities and includes respondents who had valid responses to the depressive symptoms items (n=1,579).

### **Measures**

*Sexual identity.* The identification of sexual orientation was based on a series of questions and not a single item based on the gender composition of the couple or one question about sexual orientation. Importantly, bisexuals are a critical and large share of sexual minorities and represent the majority of women who are sexual minorities (Williams Institute 2019). Further, we include respondents who do not identify with the more traditional categories of heterosexual, gay/lesbian, or bisexual. The question used for these analyses appeared in the middle of the survey and was “What do you consider yourself to be? Select all that apply” with eleven responses including ‘heterosexual or straight’ ‘gay or lesbian’ ‘bisexual’ ‘same-gender loving’ ‘queer’ ‘pansexual’ ‘omnisexual’ ‘asexual’ ‘don’t know’ ‘questioning’ ‘something else’ with an option to specify. We coded respondents into four mutually exclusive categories ‘heterosexual’ ‘gay/lesbian’ ‘bisexual’ and ‘other/multiple.’

*Depressive Symptoms.* Depression was measured using the 10-item CES-D Short Form (Andresen et al. 1994). Respondents were asked how often they felt certain ways (e.g., lonely, depressed) in the past seven days on a 3-point scale from Rarely or none of the time (less than 1 day) to Most or all of the time (5-7 days). The items were summed ( $\alpha = .87$ ).

*Social Support* was measured with two questions identifying the source of support (Procidano and Heller 1983), “How much do you rely on each of the following people for emotional support ... I rely on my family for emotional support, I rely on my friends for emotional support.” Responses ranged from 1 ‘Not at all’ to 5 ‘A great deal’.

Community support LGB was measured by respondents reporting the city or area where they live a good place to live for individuals who are gay, lesbian, or bisexual with responses ranging from 1 indicating not a good place and 5 a good place (Meyer et al. 2016, Poll 2008).

Control variables. The models will include sociodemographic indicators measuring gender identity (man, woman, and other), racial/ethnic identity (Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Asian, Hispanic/Latinx, Non-Hispanic Multirace, and other), age as a continuous variable, cohabitation status (married, cohabiting), number of children under age 18 (none, one, two, three or more), education level (high school or less, some college, college degree), and month of interview.

### **Analytic Strategy**

Two sets of models will be estimated. First, ordinary least squares regression models will be estimated with social support as the dependent variable and sexual identity will be the key independent variable. The bivariate and multivariable models will be presented. The second set of analyses focuses on sexual minorities and relying on ordinary least squares regression models will determine how social support is associated with levels of depressive symptoms. Both bivariate and multivariable models will be presented. The analysis will be weighted in accordance with weights established by Gallup.

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