Evidence is irrefutable that homosexuals and bisexuals suffer higher rates of psychiatric disorder, substance abuse, suicide and deliberate self-harm than heterosexuals. Research hitherto has focused almost solely on individual-level risk factors that may explain the excess of such psychiatric morbidity in homosexual and bisexual populations. Common factors explored include stigma, social isolation, prejudice and discrimination. The paper from Hatzenbueer, Keyes and McLaughlin is to be commended for advancing scholarship on the mental health of homosexuals and bisexuals in diverse manners.

First, they measured contextual-level factors and link this to psychiatric outcomes, namely whether a higher density of same-sex couples modifies risk for mental illness among homosexuals and bisexuals. This is a welcome development, shifting the focus away from traditional risk factor epidemiology to a more modern multi-level approach. Secondly, through this design and conceptualization, they were able to focus on resiliency and protective factors, shifting the pathological gaze that is often disparagingly fixed on homosexual and bisexual populations. Thirdly, they examined the interaction between a protective factor (density of same-sex couples) and risk factors (namely social isolation and economic adversity), as such testing both a main effect and a buffering hypothesis for the above-named protective factor.

Hatzenbueuer et al. found that homosexual and bisexual respondents living in states with a low density of same-sex couples were at increased risk for psychiatric morbidity when compared with homosexuals living in states with a high density. Homosexuals and bisexuals living in states with a low density of same-sex couples were particularly vulnerable to mood and anxiety disorders when exposed to economic adversity or social isolation. Indeed, homosexuals and bisexuals exposed to economic adversity and social isolation experienced increased risk for psychiatric morbidity only in states with a low concentration of homosexuals. In other words, being gay in straight places was worse for the mental health of homosexuals and bisexuals therein.

In response to their findings, authors note that there is a large extant literature implying that the mental health of ethnic minorities is worse where they comprise a smaller proportion of the local population—the so-called ‘ethnic density effect’. Authors then speculate whether mechanisms thought to underpin the ethnic density effect can be at work explaining geographical variations in the mental health of homosexuals and bisexuals. To my knowledge, this is the first time that density effects have been posited as applying to a group bound together not by ethnicity, but by a behavioural characteristic that brings with it a strong sense of social identity and what Meyer labels ‘minority stress’.

Whitley et al. propose an empirically grounded model with four mechanisms through which ethnic density can influence mental health and psychological well-being. These are (i) exclusion from local networks; (ii) a need to rely on geographically dispersed culturally specific services and facilities; (iii) physical and psychological intimidation; and (iv) damaging effects of everyday racism. Could these mechanisms (or variants thereof) explain the worse mental health of homosexuals and bisexuals living in places where they comprise a smaller proportion of the population?

There may well be a real or perceived exclusion from local networks where there are few other homosexuals and bisexuals, lacking the ‘safety in numbers’ characteristic of high-density areas. This may lead to social isolation, discrimination and stigma. Indeed Whitley and McKenzie note that regional ‘social capital’ may sometimes be reliant upon homogeneity and obedience to social and behavioural norms, which may be asphyxiating, constraining and exclusionary for those who deviate from these norms.

Do homosexuals and bisexuals living in low-density areas need to rely on geographically dispersed
culturally specific facilities and services? In their original study, Whitley et al.\textsuperscript{7} found that ethnic minority immigrants would prefer statutory and voluntary services delivered in their native tongue (or by their own ethnic community), which was only provided at certain non-local outlets. Likewise, practising deeply held religious beliefs often required considerable travel to mosques, temples and the like for ethnic minorities. All this incurred temporal, financial, psychological and economic costs. These services also could not be accessed under certain conditions, for example during adverse weather, sickness or during time of financial hardship. Homosexuals and bisexuals do not necessarily have such basic religious or linguistic needs. However, socializing with other homosexuals and bisexuals may be very difficult in areas with a low proportion of these populations. Further work exploring the lived experience of homosexuals and bisexuals in low- or high-density areas is necessary to explore the two above mechanisms.

Whitley et al.\textsuperscript{7} found that ethnic minorities living in low ethnic density neighbourhoods reported being at a significantly increased risk of psychological and physical intimidation, as well as suffering from everyday racism and regular micro-aggressions. They believed they were singled out solely because of their skin colour, which made them easily identifiable to racist aggressors. It may be that homosexuals and bisexuals suffer from similar intimidation and micro-aggressions where they comprise a smaller proportion of the population. Nevertheless, it should be noted that ethnic minority status is immediately obvious to an observer, whereas homosexuality and bisexuality are not. For example, a racist policeman can quite easily stop and search a Black person in order to harass, and a racist employer can screen out candidates based on their surnames. It would be more difficult to enact these common and insidious forms of harassment and discrimination against homosexuals and bisexuals, especially those who do not disclose their sexuality to third parties. This variation in experience may be reflected in the fact that (unlike many ethnic minorities) homosexuals and bisexuals as a group do not suffer from significant economic marginalization, and indeed appear to have higher incomes than the general population.\textsuperscript{9}

What this brief discussion suggests is that the comparison between ethnic minority status and homosexual/bisexual status works at some levels, but breaks down at others. Scrambler and Hopkins\textsuperscript{10} make a distinction between felt (internal) and enacted (external) stigma. Both forms of stigma are probably active in explaining geographical variations in the mental health of ethnic minorities and homosexuals/bisexuals. However, the balance may be different, with felt stigma being more powerful for homosexuals and bisexuals living in low-density areas. Whatever, if ethnic density theory is to be applied to the mental health of homosexuals and bisexuals, it needs to be appropriately tailored to account for the differences between ethnicity and sexuality as exposure variables. This should preferably be done through mixed-methods research, rather than through theoretical speculation.

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References