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Pride Against Prejudice: A "Social Cure" for Minority Stress Among Lesbian and Gay Individuals

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Department of Social and Organizational Psychology

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“I delight in weaknesses, in insults,
in hardships, in persecutions, in difficulties.
For when I am weak, then I am strong”
— 2 Corinthians 12:10

Acknowledgements

Unlike this thesis, I will keep this section short but sweet.

Thank you to all those people who helped me get here.

These were long years of not only studying but also of enduring a global pandemic and resettlement. While bittersweet, I am grateful for this time which allowed me to ponder and explore.

It was like a second adolescence, a liminal stage that reconnected me with my past and allowed me to place my longings before me.

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Resumo

As disparidades de saúde mental entre pessoas lésbicas e gays (LG) e pessoas heterossexuais estão bem documentadas e são frequentemente atribuídas à experiência de *stress* minoritário resultante do estigma homofóbico. No entanto, a investigação tem dado menos atenção às estratégias eficazes que as pessoas têm para lidar com os efeitos negativos do *stress* minoritário na saúde mental particularmente a nível individual e interpessoal. Muitas pessoas LG são forçadas a gerir a sua identidade sexual como resposta ao *stress* minoritário, aproximando-se ou afastando-se da comunidade LGBTQ+, resultando em estratégias de *coping* individuais ou coletivas. No entanto, as condições que influenciam estas escolhas e a eficácia das mesmas, permanecem ainda incertas. Na nossa investigação estabelecemos uma ligação entre o modelo de *stress* minoritário e a abordagem da identidade social aplicado em contextos de saúde, testando estes princípios em quatro estudos. O Estudo 1 analisou como as perceções sociais da comunidade LGBTQ+ e as orientações culturais podem influenciar a predisposição para usar estratégias de *coping* específicas. O Estudo 2 explorou o papel destas perceções sociais na associação negativa entre o *stress* minoritário e a saúde mental. Finalmente, utilizámos dados transversais (Estudo 3) e longitudinais (Estudo 4) para avaliar a eficácia das estratégias de *coping,* individuais e coletivas como resposta ao *stress* minoritário. De um modo geral, os resultados revelam que as estratégias coletivas, como a identificação com a comunidade LGBTQ+ e o apoio social da mesma, estão associadas a resultados positivos de saúde mental, por comparação a estratégias como estratégias individuais como o distanciamento da comunidade LGBTQ+. Além disso, os nossos resultados indicam que a escolha e a eficácia das estratégias de *coping* são influenciadas pelas perceções sociais das pessoas LG sobre a comunidade LGBTQ+ e pelas suas orientações culturais. Esta tese contribui para a compreensão de como as pessoas LG lidam com o *stress* minoritário, fornecendo apoio a pessoas investigadoras e profissionais que abordam desigualdades de saúde mental relacionadas com a identidade sexual.

Palavras-chave: identidade social, LGBTQ+, stress minoritário, saúde mental, cultura.

PsycINFO Classification Categories and Codes:

2930 Cultura e Etnologia

2980 Comportamento Sexual e Orientação Sexual

3020 Processos Interpessoais e de Grupo

3040 Perceção Social e Cognição

Abstract

Mental health disparities between lesbian and gay (LG) people and heterosexual people are well-documented, and often attributed to minority stress stemming from homophobic stigma. However, less attention has been paid to the effective strategies enacted by people to cope with the negative effects of minority stress on mental health, particularly at the individual and interpersonal levels. Many LG people are forced to manage their sexual identity as a response to minority stress, either by connecting with or disconnecting from the LGBTQ+ community, resulting in individual or collective coping strategies. Yet, the conditions influencing these choices, and their effectiveness remain unclear. To investigate this, we bridge the minority stress model with the social identity approach to health, testing these principles across four studies. Study 1 examined how social perceptions of the LGBTQ+ community and cultural orientations may influence the inclination toward specific coping strategies. Study 2 explored the role of these social perceptions in the negative association between minority stress and mental health outcomes. Lastly, we used cross-sectional (Study 3) and longitudinal data (Study 4) to assess the effectiveness of individual and collective coping strategies. The overall findings reveal that collective strategies, such as engaging with and receiving support from the LGBTQ+ community, were associated with positive mental health outcomes compared to individualistic approaches, like presenting as heterosexual. Additionally, social perceptions and cultural values significantly determined the effectiveness and likelihood of engaging in these coping processes. This thesis enhances our understanding of how LG people cope with minority stress, providing valuable insights for researchers and practitioners addressing sexual identity-related mental health inequalities.

Keywords: social identity, LGBTQ+, minority stress, mental health, culture.

PsycINFO Classification Categories and Codes:

2930 Culture & Ethnology

2980 Sexual Behavior & Sexual Orientation

3020 Group & Interpersonal Processes

3040 Social Perception & Cognition

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- **LG**: lesbian and gay people.
- **LGBTQ+**: lesbian, gay, bisexual, transgender, queer, and other sexual and gender minorities.
- **MLM**: Multi-level modeling.
- **RIM**: Rejection-identification model.
- **SC**: Self-construal.
- **SIA**: Social identity approach.
- **SIA-H**: Social identity approach to health, or the “social cure”.
- **WEIRD:** Western, educated, industrialized, rich, and democratic.

Glossary

This section defines key variables to ensure consistency, as different terms may be used sparingly across the chapters of this thesis.

- **Cultural orientations**: Cultural values and norms that are internalized, incorporated, and expressed at the individual level.
- **Coping Strategies**: the degree in which those belonging to a low-status group individually or collective manage their stigmatized identity to cope with discrimination.
    - **Collective coping strategies**: Degree of closeness with a person's stigmatized group, often involving engagement, connectedness, or group identification.
    - **Individual coping strategies**: Degree of separation or distance from a person's stigmatized group, often referred to as disengagement, social mobility, individual mobility, or self-group distancing.
- **Mental health**: The presence of social, emotional, and psychological health, rather than the mere absence of mental health conditions.
- **Minority stress**: The degree to which sexual minority people experience distal and proximal stigma-related stressors.
- **Socio-structural contexts**: Individual perceptions of stigmatized people regarding the permeability of group boundaries, and the stability and legitimacy of their low-status group in relation to a high-status outgroup.
- **Sexual identity**: Synonymous with sexual orientation; used to describe how people self-identify regarding their sexual and/or romantic attraction towards others.
- **Queer**: Refers to individuals whose sexual orientation or gender identity does not conform to heteronormativity and cisnormativity. In this work, it is used as an umbrella term for a variety of non-cisgender and non-heterosexual identities, without engaging the theoretical aspects of queer theory.

Chapter 1

Introduction

Throughout the process of writing my thesis proposal back in 2019, conducting research, and completing this work, I have witnessed an alarming rise in anti-LGBTQ+ rhetoric. Opposition toward LGBTQ+ people and their rights has emerged from various corners of the world, fueled by a wide array of malicious actors and amplified both in real-world environments and online. Though hostility towards LGBTQ+ people is unfortunately nothing new, this resurgence feels peculiar. It is not just only an echo of previous anti-LGBTQ+ movements but also a reaction to the very progress that LGBTQ+ activism has achieved. The advances in visibility, legal rights, and social acceptance in some regions of the world have incited a sharp and targeted backlash, especially in countries that had once seemed to be moving forward, thus making this whole situation feel somehow paradoxical.

This time, the focus of this backlash is unmistakably aimed at trans and gender-diverse people. And yet, this wave of transphobia inevitably ripples out, impacting those who even by the nature of their existence oppose heteronormativity, such as sexual minorities. Same-gender attraction, too, is seen as a transgression, a deviation from prescribed norms, and thus perceived as a "threat." What is even more alarming is how quickly this homophobic and transphobic sentiment has crossed geographical boundaries. Whether in nations with progressive policies or those where rights are still severely restricted, this backlash has forced many members of the LGBTQ+ community to reexamine how they navigate their identities and cope with the new wave of hostility aimed at them.

What has struck me is that, despite varying legal frameworks regarding LGBTQ+ rights, the ways sexual and gender minorities navigate this pushback seem strikingly consistent. In the Dominican Republic, where I was born and raised, same-gender sexual behaviors are not criminalized, but LGBTQ+ people do not enjoy the same rights as others. Same-gender marriage remains illegal, and legal protections are nonexistent. LGBTQ+ individuals are routinely targets of violence and discrimination. Indeed, reports indicate that over 90% of this community has witnessed or experienced homophobic harassment or assault at some point in their lives, with 42% having encountered such incidents firsthand in the past year (de la Rosa et al., 2022). Despite this, many survive, and sometimes thrive, through a combination of avoidance and endurance. Some hide their LGBTQ+ identities, presenting themselves as heterosexual, while others embrace their identities and build communities for support. This

capacity to endure or evade stigmatization enables LGBTQ+ people in the Dominican Republic to cope, even in the face of adversity.

This pattern is not unique to the Dominican Republic. After immigrating to Europe in 2017 and living in countries like Portugal and Ireland, I observed similar behaviors among LGBTQ+ people, but this time in sociocultural contexts that are more supportive of queer individuals. Although many European countries and the United Kingdom differ in specific LGBTQ+-affirming policies, they generally offer robust legal protections and higher levels of social acceptance (European Union Agency for Fundamental Rights, 2024). However, in recent years, LGBTQ+ people have reported increased exposure to violence and harassment due to their sexual or gender identities across the European continent (ILGA-Europe, 2024; Government of the United Kingdom, 2023). This anti-LGBTQ+ backlash is not limited to Europe but also extended to other regions, such as North America and Australia, where LGBTQ+ people also report relatively higher levels of acceptance (American Civil Liberties Union [ACLU], 2024; Ellis, 2023; Pew Research Center, 2020). For these reasons, I found it intriguing and essential to examine how LGBTQ+ people in regions with greater acceptance and legal protections, especially compared to my home country, the Dominican Republic, respond with endurance and avoidance amid rising hostility. Despite being anecdotal, these observations reflect current realities for LGBTQ+ people and raise important questions about what drives them to either conceal or embrace their identities—not just why they do so, but how. These coping mechanisms are likely responses to stigmatization, but what prompts one strategy over the other? How do these behaviors impact mental health? Do perceptions of one's perceived social context shape these coping strategies? And, given the similarities across different countries, does culture play a role in these experiences? These are the questions this thesis seeks to answer.

It is important to acknowledge that, while the scope of this issue and the questions I have raised encompass the entire LGBTQ+ community, these experiences are likely to manifest differently across its many subgroups. Therefore, this thesis focused exclusively on the experiences of cisgender lesbian and gay (LG) people. This delineation of a specific target sample is not meant to imply that the experiences of cisgender LG people are more valuable than those of other sexual or gender minorities, nor does it question the validity of identities such as bisexual, pansexual, asexual, trans or other gender minorities. Instead, this decision was made for the following two reasons.

First, although the LGBTQ+ community unites individuals with shared struggles and political goals, the ways in which different sexual and gender minorities navigate and make sense of their identities can vary significantly. These differences make it challenging to draw

meaningful assessments or comparisons across the entire community. For example, bisexual, pansexual, and asexual individuals often experience invisibility and exclusion from other sexual and gender minorities, which can foster a sense of disconnection from the LGBTQ+ community (Parmenter et al., 2021). This is not typically an issue for cisgender LG people, who are often more visible and prominently represented in queer spaces. Moreover, the discrimination faced by bisexual, pansexual, and asexual people is frequently downplayed or ignored within LGBTQ+ spaces, leaving many feeling that their specific struggles, such as bisexual and asexual erasure, are not adequately acknowledged (e.g., Feinstein & Dyar, 2017; McInroy et al., 2022). Differences also arise in how underrepresented sexual minorities within the LGBTQ+ community may hide or express their sexual identity. For instance, while LG people in a heterosexual relationship might feel as though they are concealing their true selves, bisexual, pansexual, and asexual individuals may not experience this in the same way, as their sexual identities are not exclusively tied to attraction toward just one gender. This diversity makes it difficult to analyze monosexual identities alongside plurisexual and asexual identities as an equivalent and unified whole.

Similarly, the experiences of trans and gender-diverse individuals present complexities that make it challenging to group them with cisgender LG people. This is not to imply that trans and gender-diverse individuals cannot be gay or lesbian; these identities are not mutually exclusive. By not grouping trans and gender-diverse individuals, who may or may not identify as LG, with their cisgender counterparts, we aim to emphasize respect for their unique struggles. Trans and gender-diverse individuals face significant stigma and are heavily targeted in the current wave of anti-LGBTQ discourse, often lacking the legal protections and rights that affirm their identities, especially in comparison to cisgender LG people (e.g., Price et al., 2024). Moreover, cisgender sexual minorities may inadvertently or purposefully marginalize trans and gender-diverse people, which can leave them feeling less included in queer spaces (Parmenter et al., 2021). Navigating one's sexual identity as trans and gender-diverse individuals is intricately linked to their experiences as trans individuals, influenced by factors such as transphobia and gender dysphoria, issues not commonly encountered by cisgender LG people (Jacobson & Joel, 2019; Skrzypczak et al., 2024). For example, the concept of "passing" holds different meanings: whereas for cisgender LG people it typically means being perceived as heterosexual, for trans and gender-diverse individuals it refers to being perceived as cisgender. Although both groups may conceal their identity or alter aspects of their appearance to conform to societal norms, passing for trans and gender-diverse individuals can involve significant changes to their physiology, biology, or anatomy, serving both as a means of survival and as a way to address

gender dysphoria (e.g., Rood et al., 2017). This complex interplay requires a nuanced exploration of "passing" for trans and gender-diverse individuals, rather than conflating them with the experiences of cisgender LG people.

The second reason for the inclusion criteria is the belief that research on the experiences of bisexual, pansexual, asexual, and trans and gender-diverse individuals should, whenever possible, be conducted by and with those who belong to these communities. In an era marked by increasing hostility towards the LGBTQ+ population, it is essential that the voices of all identities under its umbrella are adequately portrayed, heard, and represented (Vincent, 2018). This is especially relevant given the goals of this thesis, which aims to document how minority individuals construe and understand their identities while shedding light on the reasons behind their responses to unique forms of stigmatization.

With the broader context of the issues at hand and the prior considerations in mind, this thesis aimed to closely examine how, and under what conditions, cisgender LG people are responding to homophobic stigma and its impact on their mental health. We were particularly interested in exploring how LG people navigate their sexual identities and relationships within the LGBTQ+ community while considering the contributions of various social and cultural factors. LG people are also the most visible subgroup in queer spaces and currently enjoy comparatively stronger legal protections and higher levels of societal acceptance than other sexual and gender minorities within the LGBTQ+ community. Our focus on individual and interpersonal responses to homophobic discrimination does not downplay the importance of systemic changes, nor does it imply that it is solely the responsibility of LG people to cope with these challenges. Instead, our goal was to understand how LG people can find respite in the face of pervasive homophobia, with the aim of using this knowledge to create the necessary conditions and initiatives that better support LG people during these challenging times.

To address these questions, this thesis was organized into three main parts across seven chapters. The first part comprises this chapter (**Chapter 1**) and the subsequent **Chapter 2**, where we frame the key issues at hand and examine the current state of the arts while considering the limitations of existing literature. The second part includes **Chapters 3**, **4**, **5**, and **6**, which present four quantitative, empirically driven studies designed to answer our main research questions and test the hypotheses established in Chapter 2. Finally, the last part of this thesis, **Chapter 7**, summarized the findings, insights, implications, and limitations from both the theoretical and empirical chapters.

Chapter 2

Literature Review

Mental conditions and psychological distress are pervasive issues faced by many LG people worldwide (Gmelin et al., 2022; Wittgens et al., 2022). In the United States (Bostwick et al., 2014), the United Kingdom (Chakraborty et al., 2011), the Netherlands (Sandfort et al., 2014), and China (Sun et al., 2020), among other countries, studies consistently show individuals who identify as gay men or lesbian women tend to disproportionately suffer more from mental health disorders than those who identify as heterosexual. There is an overwhelming and ever-growing amount of evidence stating that LG people are more likely than heterosexual individuals to suffer from anxiety and depression (Bostwick et al., 2010), obsessive-compulsive disorders (Pinciotti & Orcutt, 2021), eating disorders (Calzo et al., 2017), post-traumatic stress disorders (Roberts et al., 2010), and substance abuse disorders (Schuler et al., 2018). Similarly, LG people tend to also engage in higher rates of risk-taking behaviors (e.g., smoking, heavy drinking, unprotected sex), self-harm, suicidal ideation, and suicide attempts than heterosexual individuals (Cochran et al., 2000; Hatzenbuehler et al., 2008; Jamal et al., 2018; King et al., 2008).

Many researchers over the years have partially explained the mental health disparities between LG and heterosexual populations not as an inherited issue related to people's sexual orientation but as a byproduct of minority stress (Brooks, 1981; Hatzenbuehler, 2009; I. H. Meyer, 1995). Minority stress suggests that LG people experience chronic stress from navigating heterosexist social conditions, where homophobia-related stressors adversely impact their overall health and well-being (I. H. Meyer, 2003). The minority stress model has accumulated over two decades of empirical evidence and continues to inform policy and practice of the illnesses that stem from experiencing homophobic stigma and discrimination (Wittgens et al., 2022). Nevertheless, one of the most pressing critiques of this model is that not enough attention has been given to the strategies that can help people counteract such stigma-related stressors effectively (Frost & I. H. Meyer, 2023). Understanding how LG people cope with minority stress is particularly important since many sexual minorities are often left alone to fend for themselves against discrimination. Attitudes towards LG people in some countries have certainly changed towards more inclusion (Charlesworth & Banaji, 2019), but many are still victimized and excluded for who they are, regardless of LGBTQ+-affirming policies and laws (Flores, 2021; Mendos et al., 2020).

For this reason, we believe it is crucial to spotlight the peculiar strategies LG people use to respond to minority stress. Many LG people worldwide counteract minority stress by managing the exact source of their distress as a coping mechanism (i.e., their LG social identity; Krane & Barber, 2003). A growing body of research has suggested that social identities, in general, can positively impact people's overall health and well-being, also known as the social identity approach to health (SIA-H; Jetten et al., 2012). Yet, the relationship between identity and health is a complex one.

The influence of social identities on mental health is heavily dependent on many factors, such as the group in question (Jetten et al., 2017), the social context (Fernández et al., 2012), culture (Lam et al., 2018), and other intersecting identities (Jetten et al., 2015). This relationship between identity and mental health become even more convoluted when considering stigmatized groups such as LG people. The presence and effects of stigma in the lives of minority individuals vary according to how pervasive their discriminatory treatment is and how concealable their stigmatizing attribute is (Branscombe et al., 2012; Jetten et al., 2018; Quinn et al., 2014). Therefore, to understand people's sexual identity and its impact on mental health, we should also consider the intricacies of their socio-cultural context, the nature of their stigma, and group processes. In the present work, we want to grasp the nuances of the LG sexual identity and examine *how* it functions as a coping mechanism for the adverse mental health outcomes of minority stress.

2.1. The Minority Stress Model

The notion that navigating the world as a sexual minority can elicit stress, and thus, harmful to their health, was first documented by Virginia Brook (1981), later known as Winn Kelly Brooks, on samples of lesbian women. Brooks described minority stress as a "state intervening between sequential antecedent stressors of culturally sanctioned, categorically ascribed inferior status, resultant prejudice and discrimination, the impact of these forces on the cognitive structure of the individuals, and consequent readjustment or adaptational failure" (Brooks, 1981 cited in Rich et al., 2020). The work pioneered by Brooks in combination with a growing body of research examining the mental health of sexual minorities throughout the '80s and '90s was then systematized and expanded on by Ilan H. Meyer (2003) to propose the minority stress model.

The minority stress model converges different psychological theories that bridge social and health psychology literature (I. H. Meyer, 2003). The basis of the minority models stems from emulating Dohrenwend's (2000) general stress theory model, which argues that environmental

adversities function as psychosocial stressors contributing to development of mental disorders. I. H. Meyer built on this model by incorporating teachings from social psychology literature about how stigma (Crocker & Major, 1989; Goffman, 1963), prejudice (Allport, 1954), and homophobic discrimination (Herek et al., 1999) effectively function as potential environmental stressors in the lives of sexual minorities. To explain stigma as a stressor, the minority stress model draws from social identity theory and intergroup relations, highlighting the relationship dynamics of high-status and low-status groups in society often creates a toxic environment for minority people and leads to detrimental health outcomes (Tajfel & Turner, 1979; Turner et al., 1987). The author not only accounted for the health-damaging consequences of stress but also considered how people cope, appraise, and respond to general and stigma-related stressors (Lazarus & Folkman, 1984; Miller & Major, 2000). Lastly, the minority stress model delves into the literature on minority identity to understand the challenges of those coming to terms with their low-status identity (Branscombe et al., 1999; Miller & Major, 2000; Thoits, 1999).

I. H. Meyer (2003) depicts the complexities of minority stress through a conceptual model encompassing the above-mentioned theoretical frameworks and applying them to the experiences of sexual minorities through interconnected paths (see Figure 2.1.):

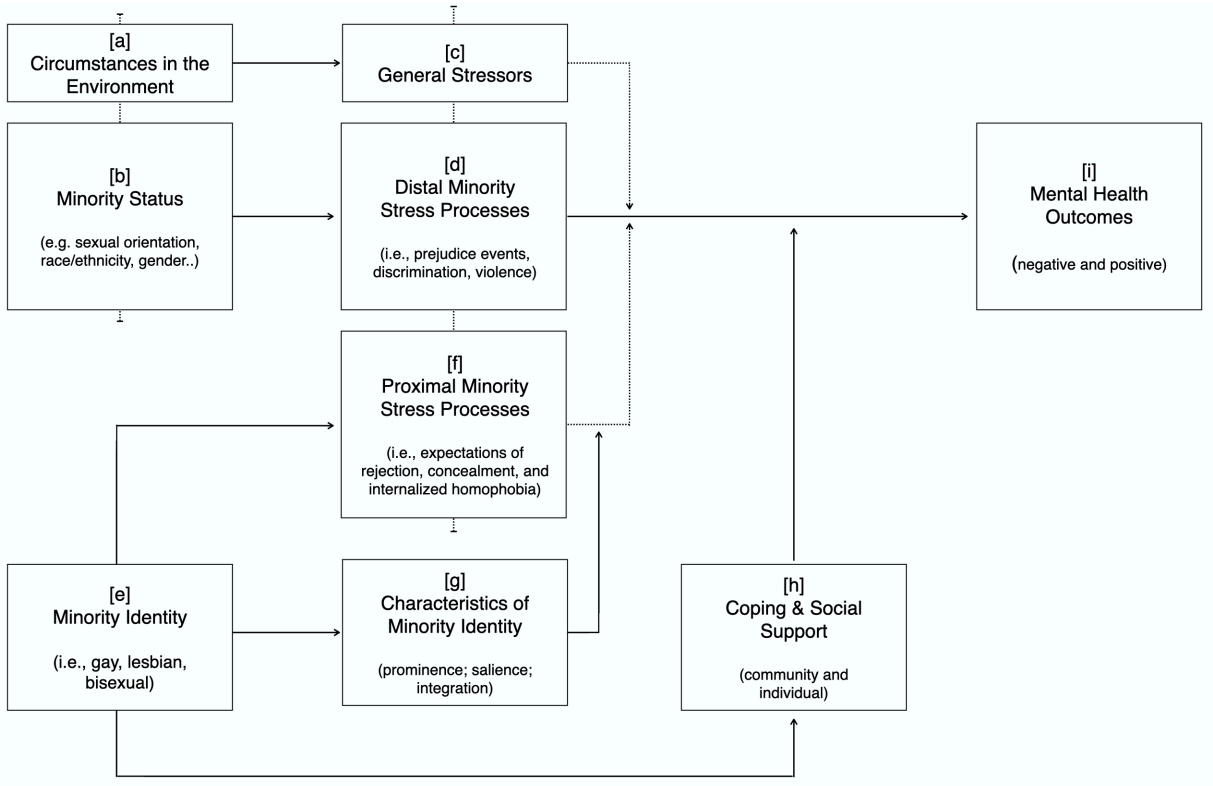

Figure 2.1. Minority stress model adapted from I. H. Meyer (2003)

1. General environmental circumstances (box a) that account for people's (dis)advantages and (lack of) privileges (e.g., socio-economic status).
2. Minority status (box b) encompasses possessing a stigmatizing attribute (e.g., same-gender attraction).
3. General stressors (box c) are common forms of stress people are exposed to due to their lack of advantages and privileges (e.g., financial problems).
4. Distal minority stress processes (box d) are the stressors that stem from violence and discrimination for having a stigmatized attribute (e.g., homophobic bullying).
5. Minority identity (box e) stems from people's minority status and entails when people's stigmatized attribute becomes a social identity (e.g., lesbian, or gay).
6. Proximal minority stress processes (box f) results from the internal experiences of people with a stigmatized identity (e.g., hypervigilance).
7. Characteristics of minority identity (box g), such as how integral (or not) is their minority identity, which can impact proximal minority stressors.
8. Coping and social support (box h) is the presence or lack of individual or collective resources stemming from people's minority identity (e.g., belonging to the LGBTQ+ community), which can improve or worsen the effects of stress on mental health.
9. Mental health outcomes (box i) are the positive and negative effects of the impact of all stressors and coping.

Despite its complexity, most of the research conducted using the minority stress model can be boiled down as trying to examine the relationship between minority stress processes and mental health outcomes (Mongelli et al., 2019; the paths between box d and box f on the box i in Figure 2.1.). Minority stressors are understood as part of a continuum spanning from a distal to a proximal positioning in relation to a sexual minority person (I. H. Meyer, 2003). Distal stressors refer to objective (i.e., they occur independently of people's perceptions and appraisals) and external stressful conditions originating from people or institutions against sexual minorities (Frost & I. H. Meyer, 2023). These stressors account for being at the receiving end of anti-LGBTQ+ laws and policies (Hatzenbuehler, 2014), victimization (Katz-Wise & Hyde, 2012), and everyday discrimination (e.g., microaggressions; Nadal et al., 2016). For example, someone yelling a homophobic slur at a gay man while they walk down the street.

Experiences of victimization among LG people are not only common but pervasive across their lifespan (Friedman et al., 2011; I. H. Meyer et al., 2021) and life domains (e.g., education,

work, health; Galupo & Resnick, 2016; van der Star et al., 2021; Zeeman et al., 2019). Evidence also supports that sexual minority people's experiences with distal stressors also occur across cultures (Moleiro et al., 2021; Pachankis & Bränström, 2018). Direct forms of violence against sexual minorities can be either physical, psychological, or even sexual and are often experienced in an episodic, continuous, or cyclical manner, leading to accumulative and acute forms of stress (Lund et al., 2021). Nonetheless, even witnessing homophobic discrimination and harassment can add ´ sources of stress among sexual minority people (Woodford et al., 2014).

Proximal stressors are subjective processes based on the perceptions and appraisals of certain events, such as objective experiences of homophobic violence and discrimination (I. H. Meyer & Frost, 2012). The minority stress model (I. H. Meyer, 2003) considers proximal stressors as personal to LG people since they rely on the state of mind and interpretation of experiencing stigma, prejudice, and discrimination related to their identity. Proximal stressors fall into one of three groups: (1) expectation and vigilance of stigma and discrimination (i.e., perceived discrimination), (2) internalization of the negative societal attitudes towards LG people (i.e., internalized homophobia), and (3) the anxieties of concealing LG people's sexual orientation (i.e., identity concealment). We will discuss each of the proximal stressors among LG people in the upcoming paragraphs.

Even though objective discrimination is overwhelmingly understood to be detrimental to LG people's mental health, perceiving oneself as the target of discrimination can also have pernicious consequences (Mays & Cochran, 2001). Encountering discrimination and perceiving oneself as a target of discrimination can be conceptualized as two different occurrences. Perceived discrimination does not have to be associated with a specific and objective bigoted encounter but rather is the perception, anticipation, and evaluation of certain experiences as (potentially) discriminatory (Schmitt et al., 2014). Such subjective experiences can be more than enough to elicit poorer health outcomes (Pascoe & Richman, 2009). Meta-analytic evidence suggests a clear and negative link between perceived discrimination and psychological well-being, especially for those who belong to a minority group (Schmitt et al., 2014). Notably, such harmful effects vary depending on the group in question. Indeed, Schmitt and colleagues' (2014) meta-analysis found a larger effect size in minority groups like LG people who can relatively conceal their stigmatizing attributes (i.e., sexual identity) than in African Americans and cisgender women who cannot hide it.

Perceived discrimination among LG people can take many shapes. Imagine, a newly hired lesbian woman employee is experiencing harassment in her workplace. This employee may

perceive that she is the target of discrimination because of her sexual identity or attribute it to being treated this way to the workplace's culture (or both). In this case, it is a subjective interpretation of an objective experience. Nevertheless, perceived discrimination experienced by LG people seems to lead to emotional distress (Almeida et al., 2009), psychopathology (Mays & Cochran, 2001), loneliness (Jackson et al., 2019), and even avoiding or underutilizing mental health services (even when needing them the most; Burgess et al., 2008). Levels of perceived discrimination among sexual minorities also vary across subpopulations, where queer women are more acutely aware of (possible) discriminatory experiences due to their double minority status in society (Heck et al., 2013). Yet, objective and perceived experiences of discrimination are not only detrimental by themselves but can also result in LG people internalizing homophobic stigma.

Internalized homophobia (i.e., internalized homonegativity, self-stigma) occurs when LG people direct anti-gay attitudes inward or outward due to them experiencing homophobic stigma and violence (McLean, 2021). Yet, it is vital to distinguish internalized homophobia from general negative attitudes toward LG people's sexual identity. As LG people receive overt anti-gay messages throughout their lives, many begin to internalize and endorse homophobic stigma as part of their sense of self (Newcomb & Mustanski, 2010). Hence, internalized homophobia can be understood as an internal conflict between someone's same-gender desires and feeling the need to be heterosexual. This conflict can manifest in an LG person having difficulties disclosing their sexual orientation to others and making deliberate efforts to separate themselves from other sexual minority individuals (Herek, 2009). It can also translate to LG people experiencing self-loathing, self-hatred, discomfort with same-sex sexual activity, and conscious effort and control of how they present themselves in social settings (e.g., minding their mannerisms; for review, see Newcomb & Mustanski, 2010). An example of internalized homophobia can be a gay man who feels ashamed and "less of a man" by being "recognized as gay" in social interaction. Self-stigma among LG people is associated with higher internalization of mental health disorders (e.g., anxiety), social isolation, sexual risk-taking behaviors, guilt, shame, and distress (McLean, 2021; Newcomb & Mustanski, 2010, 2011). Additionally, LG people's social and intimate relationships may suffer from self-stigma since it can deprive them of social support from the LGBTQ+ community, leading to greater relationship dissatisfaction, aggression, and violence (Frost & I. H. Meyer, 2009; Kelley & Robertson, 2008). In other instances, LG people can also feel the need to monitor and police other people's sexual identities, behaviors, and gender expressions (McLean, 2021). Taken together, research on self-stigma suggests it can result in adverse consequences for LG people

and those around them. The likelihood of developing a mental health disorder due to self-stigma can increase when coupled with LG people's ability to hide or conceal their sexual identity (Walch et al., 2016).

The remaining proximal stressor depicted in I. H. Meyer's (2003) model is identity concealment. Within the literature on stigma, researchers often distinguish between visible (e.g., apparent physical disability) and concealable (e.g., being HIV+) stigmas (Quinn et al., 2020). Concealable stigma refers to an identity that someone can hide, thus avoiding being stereotyped and discriminated against in public (Quinn, 2017). However, those with concealable identities face the unique challenge of having an internal conflict where the person consistently debates whether, when, how, and to whom they should disclose their stigmatized identity (Quinn et al., 2014).

The minority stress model (I. H. Meyer, 2003) focuses on the cost of these intrapsychic stressors in the lives of LG people. LG people are understood to have a concealable stigmatized identity since they can easily hide their sexual identity. Yet, many individuals can (often correctly) identify a person as LG through social cues (e.g., mannerisms) and gender nonconforming expressions, even without LG people disclosing their sexual identity (Rule, 2017; Sylva et al., 2010). The relatively concealable nature of LG people's sexual identity poses unique stressors and consequences to their mental health.

It is necessary to understand that identity concealment can elicit stress among LG people, but it also functions as a coping mechanism (I. H. Meyer, 2003). Many LG people often become aware of their sexual identity during adolescence and tend to disclose it (i.e., "come out") years after such realization during their early adulthood (Calzo et al., 2011). However, disclosure or "coming out" is far from a linear process or a single occasion since LG people conceal their sexual identity throughout their lives and across settings such as with their family and peers (Dewaele et al., 2013), workplace (Mara et al., 2021), and school (Chan & Suen, 2023). LG people's disclosure of their sexual identity can range from a simple statement to a lifelong conversation since it is usually not only a personal decision but an ongoing and continuous response to contextual demands (Pachankis et al., 2020). For a LG person, the concealment of their sexual identity can be a double-edged sword since concealing and disclosing one's sexual identity can imply affective, cognitive, and behavioral burdens resulting in stress (Brennan et al., 2021), but at the same time, withstanding these burdens and stressors can help LG people protect themselves from further stigma and discrimination (Pachankis & Bränström, 2018).

Due to the double-edged nature of concealment (and disclosure), the literature examining sexual identity concealment among LG people and its effects on mental health has yielded

mixed results. A meta-analysis conducted by Pachankis and colleagues (2020) with 193 studies suggests a small but positive effect size between sexual identity concealment and depression, anxiety, psychological distress, and eating disorders. The authors also found a small but negative effect size between concealment and substance abuse disorders among sexual minorities. These results emphasize the protective and damaging consequences of identity concealment among LG people. Notably, results also show that the effects of sexual identity concealment on mental health can also vary as a function of age and gender. For instance, gay men who disclose their sexual identity and young sexual minority people reported higher levels of mental distress than lesbian women and older LG people.

Research also suggests that social and cultural factors can influence the likelihood of LG people concealing or disclosing their sexual identity (e.g., Moleiro et al., 2021; Sun et al., 2020). For example, LG people living in homophobic contexts were much more likely to conceal their identity to protect themselves from discrimination and violence (Pachankis & Bränström, 2018; van der Star et al., 2021). Indeed, for someone living in rural Russia, concealing their LG identity might be the only way to go through their day without being victimized. Yet, someone living in San Francisco may have more leeway in disclosing or concealing their sexual identity since their social environment is less oppressive and punishing towards sexual minorities.

Taken together, the minority stress model presents a comprehensive picture of the experiences LG people undergo while navigating life as sexual minority individuals in a homophobic context. Specifically, literature from the past two decades consistently continues to show that minority stress leads to adverse mental health outcomes. One of the goals of the present research is to replicate the negative association between minority stress and mental health across all its studies. That is because the main objective of the thesis is to understand how LG people respond to minority stress. Taking inspiration from Jetten and colleagues' (2017) article, the present work will outline our hypotheses based on relevant literature to depict the theoretical basis of the model it will test. Here is the first hypothesis as it pertains to minority stress:

- Minority Stress Hypothesis (H1): Higher levels of minority stress will be negatively associated with mental health outcomes among LG people.

2.1.1. Minority Stress Model & Coping

The minority stress model (I. H. Meyer, 2003) captures the many complicated ways a stigmatized sexual identity can negatively impact the mental health of LG people. However, one of the main critiques that have followed the minority stress model for the past 20 years is it

primarily focuses on the adverse consequences of stigma-related stressors without giving sufficient attention to positive health outcomes (Frost & I. H. Meyer, 2023). Indeed, I. H. Meyer's (2003) original model includes and discusses the role of individual (e.g., personality variables) and group (e.g., social support) resources that can mitigate the harmful effects of stigma. Even though there seems to be a clear idea of what may help foster LG people's mental health, it is less specific what are the underlying processes and how to do so. Uncovering some of the underlying processes and better understanding how LG people may promote their mental health are the central questions the present work wants to answer.

Minority stress is not a single omnipotent phenomenon that is the cause of distress for many LG people. In fact, some authors have come to understand that minority stress can and should be addressed at three levels of intervention: macro level, interpersonal level, and individual level (van der Star, 2020). The macro level concerns the laws and policies protecting or criminalizing LG people's human rights and identities. For example, countries with LGBTQ+ affirming policies and same-sex marriage seem to promote life satisfaction, well-being, and acceptance of queer people in society, when compared to countries with structurally unsupportive policies aimed at sexual and gender minorities (Chen & van Ours, 2022; van der Star et al., 2021).

Macro-level interventions are essential to ensure LGBTQ+ people are structurally supported and diminish the effect of minority stress (Pachankis & Bränström, 2018). Even authors such as Frost and I. H. Meyer (2023) have noted that researchers should be aware of the potential pitfalls of overemphasizing the individual responsibility of LG people to manage minority stress rather than focusing on investing in systemic and institutional support for sexual and gender minorities. Yet, it is also essential to acknowledge that the effects of structural changes to law and policies are slow-moving (Chaudoir et al., 2017). At the same time, there is still a divide in the acceptance of sexual minorities worldwide, such that some countries have seen unprecedented progress while others have stagnated or regressed (Flores, 2021). Hence, fixating on macro level solutions, although important, may not offer much of an immediate relief to sexual minorities grappling with the effects of minority stress nor to the most vulnerable queer people.

In the present work, we take a closer look at some of the strategies LG people use at an individual and interpersonal level to foster their mental health even in the presence of minority stress. According to a systematic review examining 44 interventions addressing minority stress at different levels of analysis (Chaudoir et al., 2017), most interpersonal and individual-level strategies against minority stress often rely on reducing stigma-related stressors. For instance,

some interpersonal level strategies usually aim to reduce homophobic behaviors and attitudes among heterosexual individuals while promoting positive intergroup contact with LG people (e.g., Morris et al., 2019). Individual strategies often help address LG self-stigma through cognitive-behavior therapy, risk-reduction, and LGBTQ+-affirming practices (e.g., O'Shaughnessy & Speir, 2018). However, the meta-analysis points out that most individual- and interpersonal-level interventions for minority stress do not typically focus on strengthening coping mechanisms and strategies. The authors suggest that these interventions could be more effective in mitigating the negative effects of minority stress if they both raised awareness of how the socio-structural position of queer people can negatively impact the health of those experiencing homophobic stigma, while also supporting them in coping with and challenging these structures (Chaudoir et al., 2017). These strategies to cope with minority stress may be found in the central characteristic many use to stigmatize LG people, their sexual identity, and their LGBTQ+ ingroup.

As aforementioned, the minority stress model recognizes that LG people have both individual (e.g., personality variables) and group (e.g., social support) resources that can mitigate the harmful effects of stigma. Individual resources are factors that operate on a personal level and tend to differ across people (I. H. Meyer, 2003). For example, some studies have suggested that LG people who are more extroverted, hardier, and less fatalist tend to better cope with negative effects of minority stress (for review, see I. H. Meyer, 2015). On the other hand, group resources function as social structural factors that help LG people withstand minority stress and may be more readily available to all sexual minority members (I. H. Meyer, 2003). LG people may find group resources through affiliation with their minority group. For example, when a lesbian woman joins as a volunteer at her local LGBTQ+ community center. Through group resources, LG people can create a social environment where they are not stigmatized and support others who are just like them (e.g., Frost et al., 2016).

It can be very complicated to distinguish between individual and group resources to cope with minority stress. For instance, certain personal characteristics such as socio-economic status may prevent or allow LG people to access certain group resources (McGarrity, 2014). For this reason, I. H. Meyer (2003) points out that group resources can help us define the boundaries of what constitutes individual coping. LG people as individuals can only do so much to cope with stigma-related stressors. Even the most resourceful and hardy LG person will exhaust their resources at one point, and the absence of group resources would further expose them to poor coping responses and vulnerability to minority stressors (I. H. Meyer, 2015). Hence,

understanding how people connect (or not) to their group and use (or not) its resources is essential to grasp the intricacies of stigma, coping, and mental health among LG people.

The crux of the issue is not whether the LGBTQ+ community can help LG people cope with minority stress, but how. The minority stress model (I. H. Meyer, 2003) conceptualizes LGBTQ+ social support as a potential moderator in the relationship between minority stress and mental health outcomes. This conceptualization was later expanded on, and challenged by Hatzenbuehler (2009), who proposed that the relationship between minority stress and health outcomes is dependent on (or mediated by) LG people's general psychological processes, such as their coping, social, and cognitive responses (see Figure 2.2.).

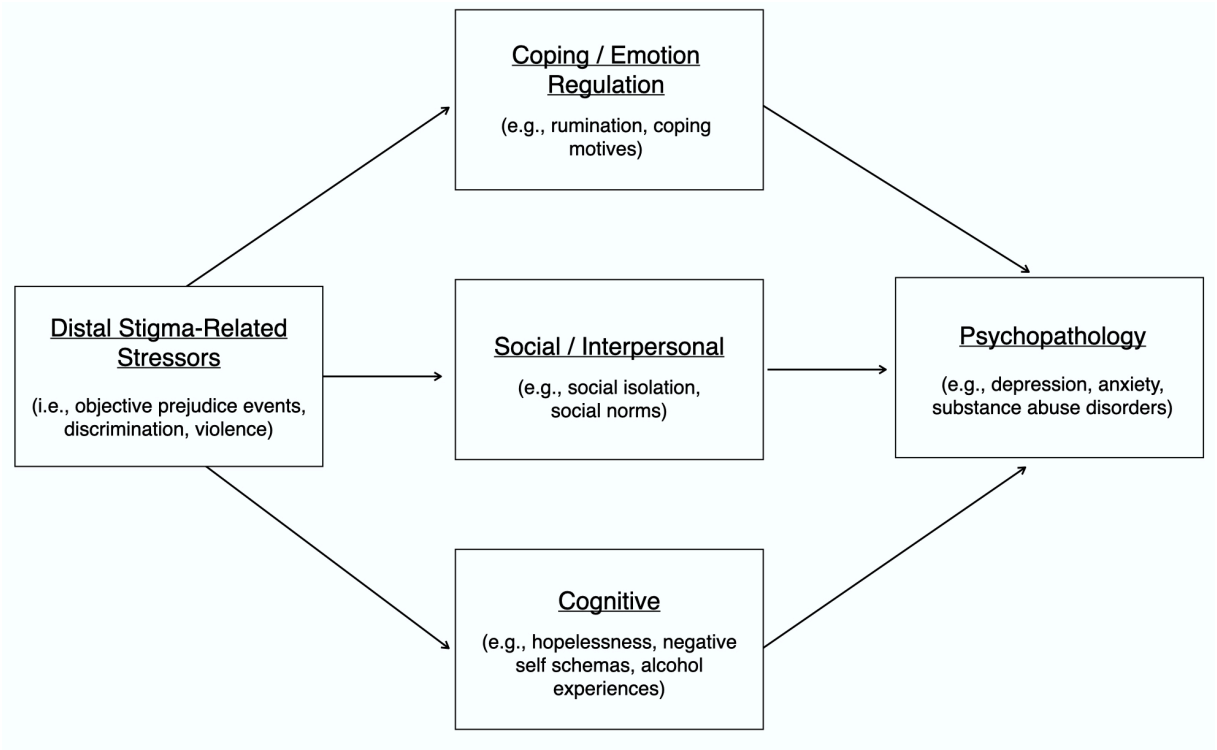

Figure 2.2. Psychological mediation framework adapted from Hatzenbuehler (2009)

Additionally, studies examining how LG people can cope with minority stress employ a variety of models, drawing from an array theories and test connection to and resources from the LGBTQ+ as moderators (e.g., Fingerhut et al., 2010; Sattler et al., 2016), mediators (e.g., Chong et al., 2015), or even both (e.g., Velez & Moradi, 2016). Hence, there is no concrete nor established theoretical model within LGBTQ+ literature examining how LG people cope with minority stress. On top of that, models such as those put forth by I. H. Meyer (2003) and Hatzenbuehler (2009) often ignore the nuances involved in prompting LG people to connect (or not) with the LGBTQ+ community, and its impact on their mental health. To answer these

questions, we aim to bridge the minority stress model to a well-established body of work that has examined in an array of groups how people can enhance their overall health through their social identities, that is, the "social cure".

2.2. The "Social Cure" Framework

As social animals, the quality of people's social relationships can profoundly impact people's mental health. Where loneliness and isolation can lead to depression, distress, and higher mortality, meaningful connections can enhance people's health (Holt-Lunstad et al., 2015; Park et al., 2020). The aforementioned points are the underlying premise of what some authors have come to know as the "social cure" (Jetten et al., 2012). The main idea of the so-called "social cure" is that how people build their sense of self is intertwined with the relationships they build with their social groups, significantly impacting their health (S. A. Haslam et al., 2009).

The "social cure" stems from an ever-growing body of literature applying the principles of the social identity approach comprised of the social identity theory (Tajfel & Turner, 1979) and self-categorization theory (Turner et al., 1987) on an array of different areas and contexts (see Jetten et al., 2017). Historically, the social identity approach has been mainly used to understand intergroup dynamics such as prejudice (for a detailed review, see Reicher et al., 2010) Even though the social identity approach was highly influential in our current understanding of many psychological phenomena, such as minority stress, its applications to people's health are relatively novel.

The central assumption from the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987) is that understanding someone's beliefs, thoughts, and actions first requires grasping how they define themselves. People can define themselves in two ways: in terms of their personal identity and what makes them unique (emphasizing "I" or "me"; e.g., "I am a fighter"), or in terms of their social identity and shared group membership (emphasizing "we" or "us"; e.g., "we shall never surrender"). People constantly balance their personal and social identities; however, specific contexts might make one form of self-definition more salient. For example, a job interview might make someone's personal identity more prominent, while a football match makes their social identity more salient.

According to the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987) someone's personal identity is more salient when their sense of self is centered around their unique characteristics. Nevertheless, when someone's social identity is salient, the self is aware of the common attributes shared with other members of the group and the different attributes shared by people outside the group. Going back to the example mentioned earlier, in a job

interview, the self focuses on what makes them the best fit for the job, while in a football game, the self aims at drawing a line on who is on their team and who is not.

As Reicher and colleagues (2010) note, social identities should not be considered a mere form of self-perception. A social identity stems from when a person internalizes a shared group membership, defining their sense of self around it. Since social identities are tethered to the self, people often ascribe emotional value and significance to the point where people's sense of esteem is attached to the fate of their group. The authors illustrate this point with people's feelings towards the Olympic Games. When someone's home country wins a gold medal in the Olympics, they may experience a sense of pride that bolsters their self-esteem. However, when their country misses the podium, some people can experience a sense of failure. Social identities allow society to inhabit within a person, shaping their values, attitudes, and behaviors according to their group and facilitating collaboration.

More recently, the "social cure" literature has found that social identities can impact people's health outcomes in a variety of ways, since a person's health is tied to the conditions of their group (Wakefield et al., 2019). Shared group memberships and the social identities that stem from them can make people healthier when their groups provide them with a sense of meaning, purpose, belonging, collective efficacy, perceived control, self-esteem, connectedness, and social support (Bowe et al., 2020; Çelebi et al., 2017; Cooper et al., 2017; Greenaway et al., 2015; Muldoon et al., 2017; Williams et al., 2020). In other words, through social identities, people can unlock positive psychological resources and benefit from their health-enhancing properties, functioning as a "cure". Research has found evidence of the health-enhancing benefits of social identities across various subpopulations (e.g., Haslam et al., 2009), from students moving abroad (Ng et al., 2018) to those recovering from a stroke (C. Haslam et al., 2008).

Even though the principles of the "social cure" can be generalized to many groups of people, it is essential to mention that not all groups are the same. Sometimes, people belong to and identify with groups that possess conditions that stress them rather than "cure" them. Indeed, there is a flip side to the "social cure" framework, which recognizes that sometimes groups can threaten people's health instead of improving them when possessing one of the following conditions: (1) are stigmatized or low-status (e.g., being an immigrant; Kellezi et al., 2019), (2) promote unhealthy norms (e.g., substance abusing behaviors; (Dingle et al., 2015), or (3) provide no or limited social support (e.g., acquired brain injury; Muldoon et al., 2019). When people categorize themselves and identify with a group that shares one of the conditions mentioned above, their sense of self will be threatened due to the status of the group

and, consequently, exposure to stress harming the person's health (for review, see Wakefield et al., 2019). Therefore, some social identities function as a "curse", where people's shared group membership causes more harm than good. For instance, research has found evidence of said "social curse" in groups such as Nepalese with leprosy expressing high levels of isolation (Jay et al., 2021) and war victims from Kosovo stating a lack of support and feelings of shame (Kellezi & Reicher, 2012). Further research has even suggested that the "social curse" is present in socially disadvantaged groups even if those groups do provide social support (Wakefield et al., 2019).

What the "social curse" framework and literature describe do resemble the experiences of stigmatized people such as LG people and their exposure to minority stress. That is, LG people's livelihoods are consistently negatively affected due to the stigma attached to their LGBTQ+ group. Therefore, is the health of LG people "cursed" from the get-go due to their minority position? Are there no health-enhancing properties for those who belong to the LGBTQ+ community? The answers to these questions are complicated.

The SIA-H (Jetten et al., 2012) provides a nuanced approach to unraveling the complexities between identity and health. However, said complexities are further complicated when talking about stigmatized groups. That is because for stigmatized groups such as LG people, their group membership functions as a mixed blessing, providing both social connections and minority stress. Therefore, to understand if having a queer group membership is a "cure" or "curse", we must first grasp how stigmatized people respond to stigma.

2.2.1. Stigma, Identity & Coping

Throughout history and across disciplines, one of the biggest hurdles when studying stigma is that different researchers define it in various ways (Link & Phelan, 2001). Initially, stigma was considered by authors such as Goffman, (1963) as an "attribute that is deeply discrediting" (p. 3). However, more modern definitions of stigma, such as the one from Andersen and colleagues (2022), argue stigma is not about the attribute but rather the intergroup dynamics between those with a high-status group and those with a low status. This perspective proposes a series of conditions that should be met for stigma to be present, such as (1) labeled differences (e.g., lesbian women are good at sports), (2) negative stereotypes (e.g., gay men are promiscuous), (3) linguistic "us" vs "them" separation (e.g., "the LGBTQ+ community is taking away *our* rights") and (4) power asymmetry (e.g., same-sex marriage is illegal). This definition emphasizes that stigma is not a personal failure or weakness, but a social phenomenon that targets low-status groups where individuals are the ones who bear the brunt of its effects. Hence,

stigma is intertwined with social identity processes, making it reasonable to assume that responses to stigma occur at both individual and interpersonal levels.

As mentioned earlier, the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987) stresses that when shared group membership is internalized, people's personal or social identity may become salient depending on the context. When a person from a stigmatized group encounters discrimination, their response might vary depending on whether they view themselves in terms of their personal or social identity. For instance, when a random stranger is hostile against a gay man in a public place for no apparent reason, if the gay man self-categorizes as part of the LGBTQ+ community, this interaction might be perceived as homophobic violence (i.e., intergroup hostility). However, if the same gay man categorizes himself in terms of other elements of their personal identity (e.g., body type, personality traits), said encounter might be attributed to other reasons or perceived as an isolated incident or a random act of violence. Whether someone's personal or social identity is salient in the context of stigma and discrimination will likely frame their response by moving towards (or away from) those who have experienced similar hardships (Jetten et al., 2018). Therefore, responses to stigma can be either individual or collective in nature, implying varying degrees of success in coping with the adverse effects of stigma on people's mental health (see Branscombe & Ellemers, 1998).

2.2.2. Individual Coping Strategies

Individual coping strategies prioritize protecting self or personal identity against the stigma targeted at their group. Branscombe and colleagues (2012) state that individual strategies occur when a person figuratively or literally distances themselves from their stigmatized group as a way to avoid being the target of further discrimination. Those who engage in individual coping strategies reject the stigmatized attribute shared by their group members by concealing it with the hopes of "passing" as a member of a high-status group (for review, see Ellemers & Laar, 2010). The pervasiveness of their group's discrimination and the degree to which a stigmatized person can conceal their stigmatized attribute makes them more likely to distance themselves from their low-status group and assimilate into a high-status group (van Veelen et al., 2020). This process of high-status assimilation is also known as social mobility (also referenced in the literature as upward mobility, individual mobility, or self-group distancing). In the case of LG people, that is concealing their sexual identity and distancing themselves from the LGBTQ+ community to "pass" as heterosexual to avoid homophobia (e.g., Bourguignon et al., 2020).

Through the lens of the social identity approach, social mobility has been investigated across various groups, such as those who suffer from obesity (Meadows & Higgs, 2022), have dwarfism (Fernández et al., 2012), or are HIV+ (Molero et al., 2011). Even though findings from these types of groups can be helpful when discussing the experiences of LG people with minority stress, their application might be somewhat limited for two reasons. The first is that, historically, engaging in social mobility and "passing" as heterosexual is not only about improving LG people's condition but also a matter of survival (Pachankis & Bränström, 2018). Being perceived as LG could and still leads to imprisonment and even death, from 12 states in the United States criminalizing consensual sodomy to Saudi Arabia, dictating death penalties to LG people.

The second reason is that even though Tajfel and Turner (1979) helped pinpoint the processes facilitating social mobility, the documentation and discussion of said strategies among LG people pre-date the social identity approach. As early as 1972, Humphreys (cited in Cox & Gallois, 1996) depicted four ways in which LG people engage in individual strategies to avoid homophobic discrimination (1) capitulating by avoiding all same-sex interaction (e.g., a lesbian woman marrying a heterosexual man), (2) passing by living between worlds, one heterosexual and the other queer (e.g., a gay man who exclusively mingles with other gay men during gay bar outings), (3) covering by hiding queer signifiers but disclose their sexual identity only when asked (e.g., an established public figure who comes out during a press conference), and (4) blending by acting according to their assigned gender but understand their sexual identity as an irrelevant part of their life (e.g., "being gay does not define me"). As Cox and Gallois (1996) state, these strategies are forms of social mobility and can be examined through the lens of the social identity approach. This thesis does not particularly assess these strategies due to its pragmatic constraints (i.e., studying people who actively avoid being identified as LG). Yet, these concepts highlight the nuances of how LG people individually respond to stigma.

Indeed, the social identity approach provides a valuable framework for understanding how stigmatized people cope with stigma, but it may overlook the idiosyncrasies of different groups (Brown, 2020). For example, a study found that self-group distancing predicted worse self-esteem and life satisfaction among LG people (Bourguignon et al., 2020). At the same time, passing as straight and LG identity concealment is exhausting but protective against homophobia (Beagan et al., 2022; Pasek et al., 2017). Hence, it is vital to balance the teachings from the social identity approach with the realities of certain groups, such as LG people. Based on classic social identity theorizing (Tajfel & Turner, 1979), recent work on the "social cure"

(Jetten et al., 2018), and LG "passing" literature (Bourguignon et al., 2020; Pachankis et al., 2020), our second hypothesis under examination is:

- Individual Coping Hypothesis (*H2*): Minority stress will be positively associated with an increased likelihood of engaging in social or individual mobility strategies, which will, in turn, be related to poorer mental health outcomes.

2.2.3. Collective Coping Strategies

In contrast to individual strategies, Branscombe and colleagues (2012) define collective coping as relying on people's stigmatized groups and the social identities that stem from them as a response to discrimination. Collective coping strategies do not seek immediate relief from discrimination but rather challenge the stigma and improve the condition of the group (Tajfel & Turner, 1979). To do so, stigmatized individuals reject the culture of oppression attached to their social identity and actively move towards and identify with their stigmatized group (for review, see Jetten et al., 2018). By doing so, stigmatized people are in a position where they can protect their health by receiving and providing support from like-minded people to collectively bear the brunt of stigmatization (Ball & Nario-Redmond, 2014).

The body of work on collective coping strategies underpins the research on the rejection-identification model (RIM; Branscombe et al., 1999). The RIM states that, when stigmatized people perceive they are the target of discrimination, they are more likely to increase identification with their group despite the stigma. This identification, in turn, will help them improve their mental health (Bogart et al., 2018; Giamo et al., 2012; Ramos et al., 2012). In conjunction with the RIM, the "social cure" framework helps understand how stigmatized groups can improve their mental health when faced with discrimination (Jetten et al., 2018). When those who are discriminated against increase identification with their stigmatized group, they can unlock the health-enhancing benefits of the positive psychological resources from their shared-group membership (Bobowik et al., 2017). Through collective strategies, not only can minority group members withstand the discrimination targeted at their group, but collectively, they can elevate the status of their group and challenge the status quo (Cronin et al., 2012; Stronge et al., 2016). However, it is crucial to note that evidence from the RIM has yielded inconsistent results. Indeed, some studies found that increased identification with a minority group was not associated with mental health outcomes or made them worse (Eccleston & Major, 2006; Wellman et al., 2022; Wiley et al., 2021).

In the case of LG people, collective coping resembles rejecting heteronormative and homophobic stigma by increasing identification with the LGBTQ+ community, seeking its

support, and advocating for equal rights (Chan, 2022). But why do LG people identify with and categorize each other with an array of sexual and gender minorities? The LGBTQ+ community is an umbrella acronym for people with various sexual and gender identities. Even though it is a very diverse group dealing with distinct forms of stigma (e.g., biphobia and transphobia, see Heck et al., 2013), its members have banded together since they shared similar forms of oppression and political goals.

LG people often find a haven by sharing spaces and identifying as part of the LGBTQ+ community. As LG people experience violence and exclusion from their families, they usually respond by building queer support networks and chosen families (Arnold & Bailey, 2009; Hailey et al., 2020). Such collective structures allow LG people to receive and provide care from their fellow queer peers (Frost et al., 2016). Evidence suggests that identification with the LGBTQ+ community can increase LGBTQ+ people's psychological well-being and life satisfaction (Fingerhut et al., 2010), while also reducing the mental health burden of minority stress (Kertzner et al., 2009; Petruzzella et al., 2019). These benefits of identifying with and connecting to the members of the LGBTQ+ have been found in an array of queer subpopulations such as younger people (Wagaman et al., 2020), older people (Gasteiger et al., 2024), racial or ethnic minorities (Frost et al., 2016), and across countries (Aybar Camposano et al., 2019)

Despite the plethora of scientific evidence regarding the benefits of identification and support with the LGBTQ+ community, there are still some caveats to point out. For example, connectedness with the LGBTQ+ community has been linked to mental health issues such as substance abuse (Demant et al., 2018) and body dysmorphia (Davids et al., 2015). These results, in conjunction with the mixed evidence of the RIM and lack of "social cure" research on queer populations, merit a closer examination of the effects of collective coping strategies on LG mental health outcomes. Informed by the RIM (Branscombe et al., 1999; Chan, 2022), "social cure" framework (Jetten et al., 2012, 2018) and classic social identity theory (Tajfel & Turner, 1979; Turner et al., 1987), our third is the following:

- Collective Coping Hypothesis (*H3*): When faced with minority stress, LG people will increase their identification with the LGBTQ+ community and utilize psychological group resources (e.g., social support), which will be positively associated with better mental health outcomes.

2.2.4. Individual vs. Collective Coping

Employing either individual or collective coping strategies against stigma, unfortunately, can also adversely impact people's health. The masquerading involved in individual coping

strategies can be mentally taxing on stigmatized people, leading them to feel less authentic and accepted, experience more shame and guilt, negatively impact their well-being, and prevent them from accessing the support of their stigmatized group (Barreto et al., 2006; van Veelen et al., 2020). For LG people, individual coping strategies and what they entail translate into hypervigilance of their gender presentation and expression (Krane & Barber, 2003), increased mental distress (Pachankis et al., 2020), and lesser psychological well-being (Bourguignon et al., 2020). Many stigmatized people, such as LG people, withstand many of these challenges for the chance to avoid or experience less bias and discrimination (see Quinn, 2017).

In the case of collective coping strategies, embracing their low-status identity places a figurative target on the back of stigmatized people, increasing the risk of marginalization (Branscombe et al., 2012). LG people who own their sexual identity are likely to experience violence (Lund et al., 2021) and rejection (Giano et al., 2021) as well as perceive and experience homophobic episodes more frequently (Begeny & Huo, 2017). Additionally, collective coping strategies do not guarantee that the stigmatized group or person will succeed in their plight for acceptance, having to put up with discrimination indefinitely.

Engaging in individual or collective coping strategies can be a tricky balancing act for stigmatized groups such as LG people, especially when dealing with the complexities of minority stress. It is important to note that no strategy is superior to the other. Both individual and collective forms of coping may be considered adaptive strategies that emerge as stigmatized people respond to the demands of their context (e.g., Fernández et al., 2012). As presented, both strategies have their virtues and limitations. However, how reliable individual and collective strategies are in protecting LG people from the harmful effects of minority stress throughout their lives is up for questioning.

"Social cure" theorizing suggests that collective coping strategies, despite their setbacks, may be more reliable in protecting LG people than individual ones as time progresses (Jetten et al., 2018). The idea is that, when presented with pervasive forms of stigma, such as minority stress, stigmatized people may be able to consistently rely on their group for support since it is readily available to them. The same logic cannot be applied to individual strategies since those coping with stigma may find it a solitary experience lacking a social safety net. Being unable to cope with stigma individually might feel like a personal failure, but for those engaging in collective strategies, the blame is usually ascribed to oppressive and unequal structures (Branscombe et al., 2012).

To our knowledge, only one study has attempted to assess collectivistic and individualistic identity management strategies among LG people. Bourguignon and colleagues (2020) found

that individual coping against perceived discrimination was negatively related to psychological well-being, but collective coping was not significantly associated with it. However, this study only focused on perceived discrimination and not on the multiple dimensions of the minority stress model. Therefore, the efficacy and reliability of individual and collective coping strategies against minority stress have yet to be compared and tested. Likewise, the referred study measures LG people's identification with their 'homosexual group' and not the LGBTQ+ community. This point is important given that the word 'homosexual' carries negative connotations among many LG people since it pathologizes their sexual identities, boiling it down to their sexual behaviors (American Psychological Association, 2020). The present thesis sets out to address the limitations of this study and expand our understanding of identity management strategies against minority stress. We aim to do this not only cross-sectionally but also longitudinally. This way, we can test and compare the effectiveness of individual and collective coping strategies among LG people and what that entails for their mental health outcomes. Therefore, the fourth hypothesis we aim to test is:

- "Social Cure" Hypothesis (*H4*): The use of collective coping strategies by LG people in response to minority stress will be more likely to consistently enhance mental health outcomes compared to individual coping strategies.

2.3. Bridging the "Social Cure" with the Minority Stress Model

It is essential to acknowledge that the minority stress model (I. H. Meyer, 2003) and the "social cure" framework (Jetten et al., 2012) share some overlap, since both stem from the same theoretical root–the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987). Both are aware that the health of minority people is dependent on the intergroup relationships between their low-status group and high-status outgroup. Additionally, these models mutually understand that stigmatized people balance individual and collective resources as strategies against stigma-related stress. Both theories acknowledge that shared group membership and its resources can benefit those withstanding stigma.

Even though the minority stress model (I. H. Meyer, 2003) and the "social cure" framework (Jetten et al., 2012) share many fundamental commonalities, research often fails to look at their intersection. For instance, literature on minority stress that focuses on belonging or connecting to the LGBTQ+ community does not make mention of the well-established principle of the SIA-H (e.g., Frost et al., 2016; Jaspal et al., 2022; Sattler et al., 2016). In that same vein, works using "social cure" principles rarely focus on queer participants, and those studies that do often do not address their unique experiences undergoing minority stress (e.g., Begeny & Huo, 2017;

Bourguignon et al., 2020; Chong et al., 2015). We believe there might be a disconnect since the two models have the same theoretical root and vernacular but are rarely applied together.

Despite the similarities, the minority stress model and the "social cure" framework present notable differences. Firstly, the minority stress literature overwhelmingly focuses on the adverse mental health outcomes of homophobic stigma and less attention is given to how to address this issue (see Frost & I. H. Meyer, 2023). The "social cure" framework, on the other hand, applies social psychology principles to improve people's health, even when faced with stigma (Jetten et al., 2018). Secondly, the application of the minority stress model outside a sexual minority population is quite limited. Only recently, the principles of the minority stress model have been applied to groups such as the gender diverse (Sarno et al., 2020), the relationally diverse (Rodrigues et al., 2024) and people within the autism spectrum (Botha & Frost, 2020). Yet, using social identity constructs in various groups is deeply rooted in the "social cure" framework (Jetten et al., 2017).

Thirdly, "social cure" theorizing dissects collective and individual coping strategies when discussing stigmatized groups (Jetten et al., 2018). The minority stress model (I. H. Meyer, 2003), however, limits its understanding of individual coping as pertaining to personality variables or traits, not social mobility. I. H. Meyer's model indeed recognizes that for LG people, concealment of their identities can be a psychological burden as well as a way to cope. Social mobility for LG people involves particular forms of concealment *and* active separation of the LG label (Ellemers et al., 1997; Krane & Barber, 2003; Mummendey et al., 1999). By focusing on social mobility rather than personal traits, as is often the case in the SIA-H, we can gain deeper insights into how individual coping strategies and behaviors impact health outcomes (e.g., Fernández et al., 2012; Molero et al., 2011).

Lastly, when discussing stigmatized identities, the "social cure" framework (Jetten et al., 2012) often falls prey to mechanistically applying the concepts of social identity theory of the realities of one group to another without adequate context (Brown, 2020). For instance, equating the stigma attached to smoking and being HIV+ (Jetten et al., 2018). These types of stigmatized intergroup comparisons are often not the case for the minority stress model (I. H. Meyer, 2003) since it was built from the ground up to depict the complex and unique processes of sexual minorities.

The present thesis proposes that bridging both models will allow the minority stress to take a more nuanced examination of how LG individually and collectively cope with minority stress under the lens of a well-grounded but malleable paradigm. At the same time, said bridge also

allows the "social cure" framework a more profound analysis of the unique forms of stigma certain groups face, such as LG people.

2.4. Why LG People?

So far, the present work has outlined the details that make up the minority stress model (I. H. Meyer, 2003) and the "social cure" framework (Jetten et al., 2012). We have also presented the strengths and limitations of both theoretical models. However, we have yet to answer why we deliberately apply these two models to LG people. One of the main reasons is that the content and context of LG sexual identity is an interesting one to dissect through the lens of the minority stress and "social cure" models.

As we have mentioned in the minority stress section, the attitudes towards LG people are rapidly changing and very volatile. In the past few decades, sexual minorities have gotten increased visibility but at the expense of encountering an immense amount of backlash (Edenborg, 2020). Despite LGBTQ+ attitude shifting for the better in some parts of the world (Charlesworth & Banaji, 2019; Flores, 2021; Pew Research Center, 2020), some authors are finding that minority stress has increased among the younger generation of LG people (I. H. Meyer et al., 2021). Therefore, more needs to be done to understand and help LG people cope with homophobic stigma.

Classic social identity theorizing (Tajfel & Turner, 1979; Turner et al., 1987), which guides and informs the "social cure" (Jetten et al., 2012) often fails to grasp the nuances of living with stigmatized identities. Like many other frameworks, the SIA-H tends to classify stigma as a binary between those living with a concealable or a non-concealable stigmatized identity (Branscombe et al., 2012; Jetten et al., 2018). This binary is based on how easy or difficult it is for a stigmatized person to leave their ingroup and join another outgroup (i.e., permeability), which is said to determine how stigmatized people ought to behave and respond to stigma (Tajfel & Turner, 1979).

The extent to which stigma is concealable is especially relevant for those experiencing pervasive discrimination. For instance, since black people cannot hide their stigmatized attribute, they have little to no option but to engage in collective coping strategies (e.g., Bourguignon et al., 2020; Branscombe et al., 1999). In contrast, those who can conceal their stigmatized attribute, such as those with psychosis, will engage in social mobility since it is preferable to being the target of prejudice and discrimination (e.g., Hogg et al., 2022). As depicted by these examples, the logical conclusion is classifying LG people's sexual identity as

a concealable stigmatized attribute as they can conceal or disclose their identity. However, this actually seems to contradict some of the experiences of LG people.

LG people often report being victims of homophobic violence by family and peers as early as the age of 5 for transgressing gender norms (Alessi et al., 2016; D'Augelli et al., 2006; Ortiz-Hernández & Granados-Cosme, 2006), regardless of whether the individual acknowledges or identifies as queer. Even as LG people grow older and identify as a member of the LGBTQ+ community, without disclosing their identity, others can clearly label them as queer through a combination of social cues (Barton, 2015; Rule, 2017; Sylva et al., 2010). Hence, many LG people's sexual identity throughout their lives cannot entirely conceal the source of their stigma. It will also be misleading to classify the LG sexual identity as a non-concealable stigma since it is not as salient as someone's skin color, gender expression, or body type. Instead, the present thesis would like to argue and explore an alternative.

The level of concealability of people's individual identity varies tremendously (Le Forestier et al., 2023), which makes the categorization of people's stigmatized attributes as concealable or not very reductive. The stigma attached to LG people cannot be easily assigned to the binary categories of concealable to non-concealable, but somewhere in between. Some authors have suggested terms such as 'relatively concealable' (e.g., sexual minority identity; Suppes et al., 2021), ambiguous' (e.g., bisexual identity; Garelick et al., 2017), or even 'liminal' (e.g., trans identity; Dentice & Dietert, 2015) to describe stigmatized identities that cannot be easily categorized. That is, a stigmatized identity that is somewhere between concealable and non-concealable. These categories of stigmas seem fitting to describe the experiences of LG people since something liminal requires ritual, such as "coming out of the closet", to transform the ambiguous into a defined category (Garrick et al., 1997). This specification is critical as it highlights that social identity theorizing tends to overlook the unique distinctions among members of a group and their specific context (Brown, 2020; Hogg et al., 2022).

Lastly, studies discussing concealable stigmatized identities (Jetten et al., 2012) often examine and exemplify the cases of people with health conditions or illnesses (e.g., Fernández et al., 2012; for review, see Jetten et al., 2018). The insights gathered from these groups are precious to unravel the intricacies of identity, stigma, and health. It is vital to acknowledge that living with a mental disorder (e.g., depression or psychosis; Cruwys et al., 2014; Hogg et al., 2022) or an invisible health condition (e.g., having HIV; Molero et al., 2011) does not equate to living with a stigmatized sexual identity, but still some studies group them (Quinn, 2017). Living with transient or chronic health conditions is often not welcomed, and those undergoing it seek treatment or learn to live with said condition. It goes without saying that identifying as

LG and the stigma attached to it does not resemble living with an illness, and there is no treatment or cure for it. Therefore, a closer examination of the specific ways LG people perceive and manage their identities is still very much needed in the "social cure" literature.

Combining all of these points prompts the question of how bridging the "social cure" framework and the minority stress model translates into tangible theoretical and practical contributions. One contribution is that when examining the role of group identification and the resources on how stigma shapes health-related outcomes, these variables should be analyzed as mediators, not moderators. The minority stress model (I. H. Meyer, 2003) understands LGBTQ+ identity only as a buffer or moderator between the relationship between minority stress and mental health outcomes. Yet, Jetten and colleagues (2018) point out the empirical evidence of group identification as a moderator has yielded little to mixed results in the context of stigmatized groups. Instead, the authors propose to adopt group identification and its resources as a mediator, as depicted by the RIM (Branscombe et al., 1999). This methodological difference challenges the original vision of the minority stress model and aligns more with Hatzenbuehler's (2009) conceptual framework. One of the main differences is that, unlike the Hatzenbuehler's model, group identification as a mediator then allows authors to examine the strength of how people individually identify with and perceive their group as a response to minority stress.

The second contribution of this work is to emphasize the importance of the social and cultural context in which stigma takes place. "Social cure" authors have suggested that to understand the role social identities play in mental health outcomes, we must go beyond just examining the strength of how minority people identify with their group (Jetten et al., 2018). The current SIA-H studies shows that the beliefs minority people hold in terms of how they perceive the broader social context and high- vs low-status intergroup relations (see Jetten et al., 2011), as well as cultural orientations (Lam et al., 2018), shape how people experience and respond to stigma. However, perceptions of the social and cultural context are understudied in "social cure" literature, often not measured but assumed (Bourguignon et al., 2020; Fernández et al., 2012; Muldoon et al., 2017) and have yet to be examined in the context of LG people. That is why this thesis includes and tests the individual perception of LG people's social context and their cultural orientation as possible moderators of the relationship between minority stress, coping, and mental health. The following sections will review the ways in which social and cultural realities impact the health and coping responses of stigmatized groups such as LG people.

2.5. Social Structural Context

According to social identity theorizing (Tajfel & Turner, 1979; Turner et al., 1987), one of the ways low-status group members strive to maintain or gain a positive sense of self in the presence of stigma is through intergroup comparisons. That is when a member of a low-status group compares its ingroup (i.e., LGBTQ+ community) with a high-status outgroup (i.e., heterosexual people). If a member of a low-status group perceives the status of their group as inferior, minority people often will rely on attributions of the characteristics of the social structure to direct their behavior (for review, see Reicher et al., 2010; Scheepers & Ellemers, 2019). These social-structural characteristics are how a person perceives their group's boundaries, position, and treatment in relation to another group, namely permeability, stability, and legitimacy (Ellemers, 1993). How people perceive these group structures will then dictate whether the member of a low-status group forms their social identity by either moving towards or away from their stigmatized group (Branscombe et al., 2012).

2.5.1. Permeability of Group Boundaries

Perceived permeability refers to the degree to which people deem how porous (vs. nonporous or impermeable) the boundary between their ingroup and an outgroup is (Ellemers, 1993; Tajfel & Turner, 1979). In other words, how easy (vs. difficult) it is for a low-status group member to successfully join or pass as a member of a high-status group. Perceived permeability of boundaries is often described in social identity literature as one of the key factors of whether stigmatized people engage in social mobility or individual coping strategies (Branscombe et al., 2012; Ellemers & Laar, 2010; Reicher et al., 2010; van Veelen et al., 2020). People's perceived permeability of their group boundaries, in turn, can have important implications for the mental health of members of a stigmatized group (Jetten et al., 2018; Scheepers & Ellemers, 2019).

Stigmatized people who perceive intergroup boundaries as permeable will likely distance themselves from their low-status group (see Dirth & Branscombe, 2018). For instance, when people with disproportionate short stature perceive boundaries as permeable, they are more likely to engage in limb-lengthening surgery to physically leave their stigmatized group (Fernández et al., 2012). When minority people such as the Roma perceive the boundaries of their ingroup with a relevant outgroup as porous, they are likely to decrease their identification with their Romani in-group (Reysen et al., 2016). Likewise, those who identify as furriers are more likely to conceal their identity, even if doing so takes a toll on their self-esteem (Plante et al., 2014). The experiences of the aforementioned stigmatized groups provide some insights

into the potential ways LG might perceive the boundaries of their group, the LGBTQ+ community, and how they respond to minority stress.

Research also suggests that the perceived permeability is contingent on how pervasive discrimination is for members of stigmatized groups (Branscombe et al., 2012). Jetten and colleagues (2011) in a series of experiments with women and people who smoke, found that when discrimination is perceived as a rare occasion enacted by a handful of outgroup perpetrators (or "bad apples"), those who are stigmatized are more likely to perceive boundaries as traversable. Since discrimination is sparse, stigmatized people believe they can avoid being discriminated against and, therefore, are less likely to identify with their low-status group. Conversely, this study also found that when discrimination is pervasive and enacted by several perpetrators, stigmatized people are more likely to perceive boundaries as fixed and difficult to cross. In these circumstances, stigmatized groups are more likely to identify with their group and respond collectively to discrimination (e.g., Branscombe et al., 1999; Dirth & Branscombe, 2018; Garstka et al., 2004; Ramos et al., 2016). However, responding to stigma, either individually or collectively, does not only rely on the degree of perceived permeability and pervasiveness of discrimination.

2.5.2. Status Legitimacy & Stability

The type of strategy a stigmatized person uses will also depend on how they perceive the social structure status between their ingroup and a relevant outgroup (Ellemers, 1993; Tajfel & Turner, 1979). That is, how secure are the status relations based on whether stigmatized people perceive the position and treatment as stable or legitimate. Stability refers to how likely it is for the position of a low status ingroup in relation to an outgroup to change in the foreseeable future. Legitimacy entails whether members of a stigmatized group perceive the hierarchy and treatment of their ingroup vs an outgroup as acceptable or not. Stability and legitimacy are different constructs, but they often appear highly correlated in the literature (Bettencourt et al., 2001).

Perceived legitimacy proves valuable to examine when analyzing how low-status group members respond to stigma. When minority people perceive the hierarchy between their ingroup and a relevant outgroup, as well as their treatment in society as illegitimate, they are more likely to label their experiences with stigma as discriminatory (Jetten et al., 2011). Therefore, status illegitimacy may prompt minority group people to respond to perceived discrimination through increased identification (Branscombe et al., 1999) and group efforts (Hersby et al., 2011). For example, when perceiving their status as illegitimate, people with

achondroplasia opted to connect with the "Little People" community instead of engaging in surgery to become taller (Fernández et al., 2012). Similarly, Roma high-school students showed more motivation to engage in collective action (Reysen et al., 2016), and plus-size individuals were more likely to change the connotation of their stigma with phrases such as "fat is beautiful" (Meadows & Higgs, 2022) when their status was perceived as illegitimate. The type of collective behaviors enacted will then depend on how stigmatized people perceive the stability of their societal position.

The social identity approach (Tajfel & Turner, 1979) usually classifies intergroup status relations between low and high-status groups as secure or insecure. A secure status implies that a member of a minority group perceives their position and treatment in society as stable and relatively legitimate. In such contexts, minority groups are less likely to challenge the high-status group but rather create a new form of intergroup comparison so that their ingroup is seen in a more positive light (i.e., social creativity; for review, see van Bezouw et al., 2021). Social creativity can be achieved through a variety of means. For instance, LG people positively recategorize their stigmatized identity (e.g., "Gay is Good") or shift the gaze of their intergroup comparison to more stigmatized groups such as trans people (e.g., "LGB Alliance"). In contrast, an insecure status occurs when stigmatized people perceive their position in opposition to the outgroup as unstable and their treatment in society as illegitimate (Ellemers, 1993). An insecure status often translates into stigmatized people directly challenging the outgroup through conflict and hostility in the form of collective action (i.e., social competition; for review, see van Zomeren et al., 2008). In other words, there is active opposition against the high-status group that undermines and stigmatizes the low-status group. For example, when 80s and 90s gay rights activists boycotted and protested the indifference of politicians during the AIDS crisis.

It is important to note that the present thesis does not differentiate between social creativity and social competition, but instead generally examines collective coping responses. Collective coping, or moving towards the group, usually entails both the redefinition of the stigmatized attribute and collective action. Furthermore, some authors, such as Brown (2020), have been critical of social creativity. Again, social creativity can imply many strategies, such as diverting the attention away from the stigma associated with minority groups or even selecting another outgroup to compare themselves (Jetten et al., 2018). Not only has social creativity been heavily understudied for a concept with over 40 years (van Bezouw et al., 2021), but Brown (2020) also points out that the preconditions for when stigmatized people will choose each strategy are not specified, calling into question the validity of the construct. Lastly, differentiating between social creativity and social competition might prove problematic when examining the

experiences of LG people, as the LGBTQ+ liberation movement often employs both strategies. This point is best illustrated with pride parades, arguably the most recognizable form of collective response by LG people. Pride parades are both an act of redefining stigma as something to be proud of *and* an act of protest against homophobia and transphobia.

2.5.3. Perceived Social Context & LG People

Social identity theory (Tajfel & Turner, 1979; Turner et al., 1987) seems very clear and tends to make definitive statements about the specific constellations of social structural characteristics that yield individual or collective coping strategies. When boundaries are perceived as permeable, stigmatized people engage in social mobility. Collective coping strategies are used when stigmatized individuals perceive boundaries as impermeable and view intergroup status as either illegitimate or unstable (e.g., social creativity) or both illegitimate and unstable (e.g., collective action). Therefore, perceived permeability seems to be the proxy that helps determine the behaviors of members of a minority group. By social identity logic, LG people should be more likely to engage in social mobility since homophobic discrimination is less pervasive than decades prior (Flores, 2021), and authors argue sexual identity can technically be concealed, making boundaries seem porous (Bourguignon et al., 2020; Quinn et al., 2017). But is this the case for LG people?

Modern social identity scholars such as Brown (2020) have been very critical of the role of permeability in general. Specifically, Brown rejects Tajfel's (1974) formulaic notion that the default option for stigmatized people who can conceal their identity is engaging in social mobility and abandoning their group. Brown even uses Henri Tajfel himself as an example, stating that Tajfel never concealed his Jewish identity as a response to the pervasive antisemitism of his time; instead, he was very open and proud of it. Brown tries to advocate with this point for scholars to avoid a 'one size fits all' attitude with the social identity approach, and instead take a closer look at the content and context of the groups being examined. This criticism of the social identity theory then begs the question, how do perceived stability, legitimacy, and permeability impact how LG people respond to minority stress?

To our knowledge, there is no study assessing how LG people perceive the boundaries and status between the LGBTQ+ community and heterosexual individuals. One of the only studies examining said phenomenon is an analysis by Krane and Barber (2003), who used the social identity approach as a lens to explain the experiences of lesbian women in sports. In their study, the authors argue that lesbian women who perceive the boundaries as permeable will engage in social mobility strategies that entail masking their sexual identity (e.g., avoiding she/her

pronouns when referring to partners) or altering their physical appearance (e.g., using makeup to appear more feminine). The authors continue their argument, stating that in impermeable, unstable, and illegitimate contexts, athletes could also come out publicly or advocate for social justice. Unfortunately, this study inferred how lesbian women may perceive the relationship between the LGBTQ+ community and heterosexual people but failed to empirically test it. Similarly, this issue of studies inferring how minority group people ought to perceive their low-status ingroup in relation to a high-status group is also present in the "social cure" and RIM literature analyzing the socio-structural realities of stigmatized groups (i.e., Bourguignon et al., 2020; Fernández et al., 2012; Molero et al., 2011).

This thesis argues that there is a need to empirically examine and test perceived permeability, legitimacy, and stability in groups such as LG people at an individual level. The degree of perceived permeability can widely vary within LG people, given that sexual identity is a relatively concealable or liminal form of stigma (e.g., D'Augelli et al., 2006). Therefore, boundaries between the LGBTQ+ community vs the heterosexual outgroup might be deemed as fixed or porous since trivial actions such as walking, speaking, mannerism, and styling can 'out" LG people as queer (Rule, 2017). There is also a case for examining the perceived stability and legitimacy of the social status of LG people at an individual level due to the polarized but volatile attitudes towards LGBTQ+ acceptance (Flores, 2021) and its backlash due to heightened visibility (Edenborg, 2020). The peculiar social standing of LGTBQ+ people make it noteworthy to individually examine how the dual realities faced by LG people influence their position and treatment in society and how they respond to it.

Overall, how LG people perceive the social standing of the LGBTQ+ community, compared to heterosexual people, might influence their experiences with minority stress. Yet, the tendency of the social identity approach to generalize all minority groups, the lack of individual assessment of social structural characteristics among stigmatized people, and the changing realities of the LGBTQ+ movement make it hard to predict how it may influence LG people. Based on the information available, perceived intergroup permeability, stability, and legitimacy seem to predict or even moderate how minority stressors impact the mental health of stigmatized individuals and how they respond to it. Therefore, our fifth hypothesis is more exploratory where we set to investigate whether:

- Socio-Structural Hypothesis (*H5*): Perceptions of the status legitimacy and stability and permeability of the boundaries between the LGBTQ+ community and the heterosexual outgroup will influence how LG people experience minority stress and whether they adopt individual or collective coping strategies.

2.6. Cultural Context

People's sense of self is not only influenced by social identities and the perceptions of their social context, but also by culture. Initially, social psychologists often understood the self as independent of people's social world, unintentionally reflecting many of these scholars' Anglo-American beliefs (Cross et al., 2011). As social psychology became more intercultural, the definitions and understanding of the self have expanded to include more diverse perspectives (e.g., Vignoles et al., 2016). It has come to the point that many social psychologists have attributed differences across people's sense of identity and behaviors to cultural variations (Markus & Kitayama, 2010).

Culture is a fuzzy concept and difficult to define. It can sometimes be understood, more broadly, as the "software of the mind" (Hofstede et al., 2010), and more specifically as a shared pattern of behaviors and cognitive constructs that impacts how people experience and engage with the world (Heine, 2010). Since culture cannot be directly observed, it usually is inferred through certain expressions (Schwartz, 2014). One of the most common ways to capture and measure how people manifest their culture is through values (e.g., Hofstede, 2001; Schwartz, 2012; Triandis, 1995). Cultural values or orientations are known as people's endorsement, or lack thereof, of a given set of shared beliefs shaping the attitudes and actions of individuals and groups (Hofstede, 2011). For instance, countries like the United States tend to value individual liberty, uniqueness, and competition since many US-Americans endorse individualism. In contrast, countries like China tends to value group harmony, obedience, and social interdependence, since the average Chinese person endorses collectivism (for a review on individualism and collectivism, see Morling & Lamoreaux, 2008; Oyserman et al., 2002; Vargas & Kemmelmeier, 2013).

Cultural values are instrumental in the study of cross-cultural differences, but it tends to generalize group behavior while overlooking individual differences. Indeed, people's endorsement of cultural values can vary tremendously even within countries (e.g., Green et al., 2005; Taras et al., 2016; Vignoles et al., 2016). Some studies have shown that people's individual-level endorsement of specific values, such as individualism or collectivism, can shape very personal outcomes such as their health (R. Fischer & Boer, 2011), self-concept (Markus & Kitayama, 2010), intergroup relationships (Yuki & Takemura, 2014), and coping responses (Kuo, 2013). That is why examining cultural values at an individual level of analysis can prove valuable when assessing social identity processes (Brewer & Yuki, 2007). The self and what it entails is tied to culture, and since culture expresses itself very differently across individuals, how they construe their sense of self will also vary. The aforementioned is the

premise of the self-construal theory, an individual-level construct of people's cultural selves (Markus & Kitayama, 1991).

The self-construal theory emerges due to the long tradition in social psychology of examining the existence of different representations of the self (Baumeister, 2010). One of the earlier iterations of this tradition is the distinction between the private and public self, which rarely accounts for the possible influence of culture or cultural variables on the various manifestations of the self (for review, see Cross et al., 2011). It was not until psychologist Harry Triandis (1989) distinguished between the private, public, and collective selves, arguing that these dimensions are not mutually exclusive but rather coexist and influence people's sense of self. People's endorsement of these three selves varies across cultures and, therefore, can be expressed differently based on cultural differences. Building and expanding on these works, Markus and Kitayama (1991) coined the term self-construal, referring to the distinct ways in which cultural values influence people in defining and understanding their sense of self. Self-construal theory illustrates that people's sense of self is tied to how they relate to those around them (see Figure 2.3.). Indeed, humans are social animals and require connecting with others regardless of their culture. However, people do vary in *how* they interrelate with their groups depending on the person's self-construal.

What is a self-construal? According to Markus and Kitayama (1991, 2010), there are two types of self-construal: independent and interdependent. An independent self-construal is often found in Anglo-American societies where the self is conceptualized as autonomous and separate for social groups. Those with an independent self-construal tend to emphasize their individuality and uniqueness as essential aspects of their sense of esteem. When asked to define themselves, people with an independent self-construal will often do so using internal and stable traits (e.g., "I am creative"). Conversely, an interdependent self-construal is more prominent in East Asia, Latin American, and some African countries, where the self is intertwined with others and dependent on social relationships. For those endorsing an interdependent self-construal social harmony, emotional regulation, interpersonal connections, and fitting in are meaningful qualities for their self-esteem. When those with an interdependent self-construal are asked to define themselves, they tend to do so by highlighting their social roles or group memberships (e.g., "I am a father").

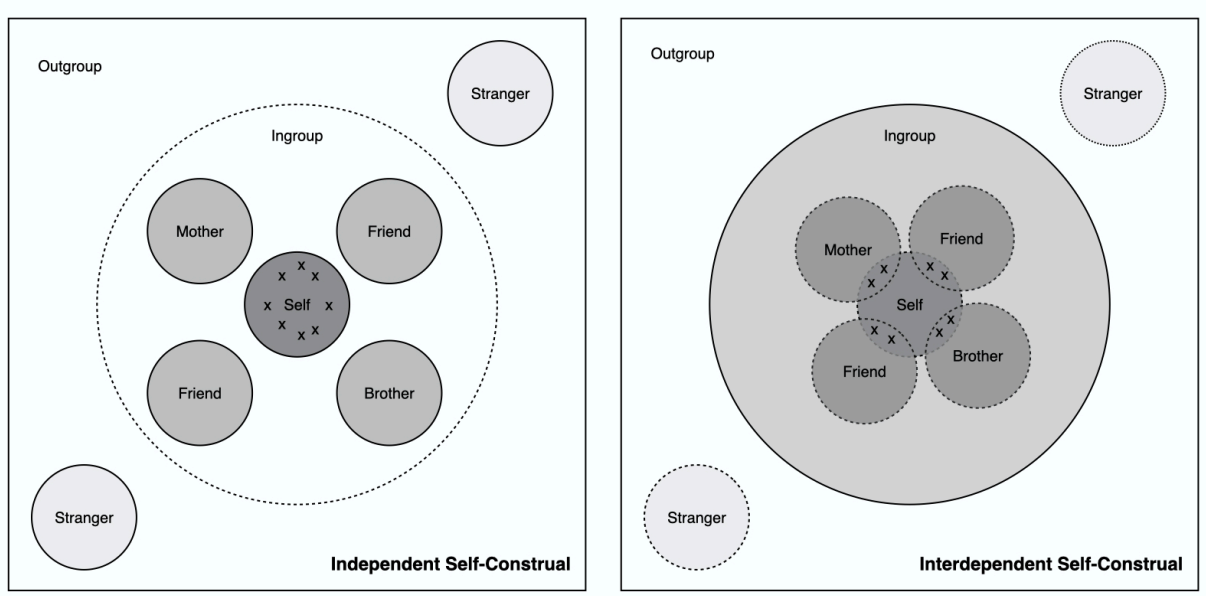

Figure 2.3. Independent and interdependent self-construal conceptual representation adapted from Markus and Kitayama (2010)

If the descriptions of the independent and interdependent self-construal seem to resemble those of individualism and collectivism, it is because they derive from them. While individualism and collectivism refer to broad cultural values, independent and interdependent self-construal are their respective individual-level constructs (Giacomin & Jordan, 2020). Unsurprisingly, because of this apparent connection between these concepts, it is more prevalent to find those with independent self-construal in individualistic societies while the interdependent self-construal in collectivistic ones (Oyserman et al., 2002). However, both independent and interdependent self-construal are said to coexist within people (Cross et al., 2011).

Both individualism as a cultural value and self-construal theory have amassed extensive empirical evidence, making them two of the most well-known concepts in cultural psychology (Wong et al., 2018). This simple distinction between the cultural selves has been used to explain differences across psychological phenomena such as emotion, motivation, cognition, behaviors, intergroup processes, and health outcomes (Cross et al., 2011; Giacomin & Jordan, 2020; Markus & Kitayama, 2010). For instance, those with an interdependent self-construal tend to have more holistic cognitive processes (Masuda & Nisbett, 2001), experience more shame (Dean & Fles, 2016), report less self-esteem (Heine et al., 1999), and maintain social harmony but fear social rejection (Hashimoto & Yamagishi, 2013). Naturally, those who endorse an

independent self-construal tend to report the opposite experiences of those with an interdependent one.

As the body of work on the self-construal theory, continues to expand as an explanation for different behavioral outcomes, it is safe to assume that cultural selves may impact the experiences of minority groups like LG people. There has been growing awareness in recent years of the role of culture and cultural values in shaping LG people's experiences with stigma-related stressors, such as minority stress (Sun et al., 2020). Yet, it is less certain whether minority people's endorsement of a given self-construal can shape their responses to stigma, such as latching to the collective group resources depicted by the "social cure", or to an individual strategy such as social mobility. The following section will review the literature surrounding stigma, identity, and culture.

2.6.1. Cultural Differences, Minority Identity & LG People

Minority people's experiences with stigmatization are deeply embedded in the social space and, therefore, subject to cultural variability and expressions (Yang et al., 2007). For instance, some authors suggest that collectivistic societies, and those endorsing an interdependent sense of self, tend to devalue non-confirming individuals and those considered to embody fringe identities (e.g., Liu et al., 2011; Papadopoulos et al., 2013). There is evidence suggesting that those with concealable stigmatized identities (Ikizer et al., 2018), people living with HIV (Zang et al., 2014), and those with a mental illness (Ran et al., 2021) report more perceived stigma in collectivistic societies. Similarly, those endorsing an independent self-construal convey lesser self-stigma (Yalçin, 2016) and, in some instances, better mental health outcomes (Duncan et al., 2013).

It is also important to note that there is mixed evidence on the ways stigmatized people experience stigma across cultures. For instance, a study conducted with HIV+ men suggested that collectivistic orientations towards friends and neighbors help lessen the public and self-stigma they experience (Zang et al., 2014). In the same vein, an interdependent self-construal has been found to help protect those with a mental illness from self-stigma and the internal criticism surrounding their diagnosis (Aruta et al., 2021). Therefore, evidence seems to suggest that cultural differences impact stigmatized people, but it is unclear how they do so.

What about cultural differences in how minority people respond to stigma? Research has also yielded mixed results. Those from collectivistic societies have difficulties reaching out for help to deal with stressors (Taylor et al., 2004) as well as experience less trust from their peers (Li et al., 2022). Stigmatized people with a more interdependent sense of self are less likely to

risk “losing face” and, therefore, engage in collective action to a lesser extent (F. B. Fischer et al., 2017). This behavior could be because those with an interdependent self-construal want to be accepted and thus avoid conflict and arguments (Aune et al., 2001). Yet, an interdependent self-construal has also been related to a stronger collective identity and ingroup bias for their stigmatized group (Tawa & Montoya, 2019), and a greater sense of inclusion in their marginalized community (Ferenczi et al., 2015). In the same vein, cross-cultural evidence suggests that cultural values impact social identity processes (Yuki & Takemura, 2014). This notion applies to the “social cure”, which has come to understand that people’s health is not only structured by their identities but also by their culture (C. Haslam et al., 2018). Still, literature examining cultural variations on the social identity approach is very scarce. Exceptions are studies conducted by Lam and colleagues (2018) and Chang and colleagues (2016), which showed that people living in individualistic countries increased the health-enhancing benefits of having multiple identities.

Some “social cure” theorists have also suggested that those endorsing collectivism may allow people to reap more identity resources (Muldoon et al., 2017). For instance, a study has shown that sexual minorities were more likely to identify with and draw resources from the queer community in collectivistic countries in comparison to individualistic ones (Aybar Camposano et al., 2019). However, a recent study by Easterbrook et al. (2024) found that in cultural contexts offering greater autonomy and freedom in forming and maintaining interpersonal relationships (i.e., individualistic or "Western" societies), people with multiple social identities are less prone to depressive symptoms, more likely to benefit from social support as a way to mitigate depression, and less susceptible to the negative effects of societal normative pressures on mental health, compared to those in collectivistic cultures. A main problem with most of these studies is that cross-cultural and cultural examination of the “social cure” often assumes the cultural values of the group(s) they are examining. Therefore, it is difficult to assess how individual-level cultural differences relate to the interplay of identity and health, especially for stigmatized groups such as LG people.

The present thesis draws from cross-cultural examinations conducted with various stigmatized groups to understand the interplay between culture, stigma, and health since cultural psychology research on LG people is limited. Most literature intersecting culture with sexual identity stigma seems to stem from LGBTQ+ ethnic or racial minorities in Western countries (e.g., Szymanski & Sung, 2013), queer asylum seekers (e.g., Alessi et al., 2021) or gay men in Asian countries (e.g., Liang & Huang, 2022; Liu et al., 2011; Sun et al., 2021). Evidence from different parts of the world indeed shows that violence is rampant across cultures regardless of

whether people in certain societies endorse individualism (vs. collectivism) or an independent (vs. interdependent) self-construal (Aybar Camposano et al., 2019; Bayrakdar & King, 2023; Flores, 2021). The adverse effects minority stressors have on the mental health of LG people are cross-culturally robust, but still intercultural differences are to be expected (Sattler & Lemke, 2019).

There is research conducted on East Asian gay men suggesting that behavioral expression of collectivistic cultural values can worsen the harmful effects of minority stress (Sun et al., 2021). For example, collectivistic tendencies can further increase gay men's experiences with public and self-stigma (Liu et al., 2011) and worsen their conflicts in coming to terms with their sexual identity (Mao et al., 2002). Similarly, gay men who endorse an interdependent self-construal living in China reported higher rates of self-stigma (Ren et al., 2019). Interestingly, this study also showed that Chinese gay men conveyed less self-stigma when endorsing an independent self-construal and living in an LGBTQ+ affirming country in Western Europe. These insights highlight the nuances of how the social and cultural context of LG people can potentially impact how they experience minority stress and, therefore, how they respond to it.

From the studies presented, it could be inferred that LG people endorsing a collectivistic or interdependent self-construal are more likely to report worse mental outcomes due to minority stress and likely to conceal their identity. In contrast, those with an independent sense of self are likely to break ties with homophobic ingroups and move towards the LGBTQ+ community to remain authentic to their unique desires. Yet, the reversed argument could also be valid. The lack of individual-level assessments of cultural values and the limited evidence on cultural variability in stigmatized groups and sexual minorities makes it challenging to predict how LG people with an independent vs. independent self-construal might behave. Culture is indeed a fuzzy construct to examine, and its implications have been understudied in the context of LG people. That is why the present thesis is set to fill in some of the gaps in the literature by answering whether LG people's endorsement of an independent or interdependent self-construal may help explain if they move towards or away from their stigmatized identity. The sixth and last hypothesis of this thesis is also an exploratory one assessing:

- Cultural Hypothesis (*H6*): LG people's endorsement of independent versus interdependent self-construal will influence the extent to which they engage in individual or collective coping strategies.

2.7. Overview of Empirical Chapters

This thesis aimed to address the broad research question: *how* and *under which conditions* do LG people manage their sexual identities to cope with minority stressors? To explore this question, we applied the "social cure" framework to the minority stress model to examine the influence of individual and collective coping strategies on the mental health outcomes of LG people. Aligned with social identity theory, we also investigated how social conditions (i.e., perceived permeability, legitimacy, and stability of boundaries and status between LGBTQ+ and heterosexual groups) and cultural variables (i.e., independent and interdependent self-construal) shaped how LG people experience minority stress and whether they individually or collectively respond to it.

Informed by the literature, we developed a theoretical model that integrates the minority stress model with the "social cure" framework, taking into account the potential role of social-structural conditions and cultural values in shaping LG people's experiences (see Figure 2.4.). We set out to test this model and address the overarching research question of the thesis by examining six hypotheses across seven chapters, four of which are empirical studies (see Table 2.1.). To address our research questions and six hypotheses, we began by assessing the broader level of analysis, namely social perceptions of the LGBTQ+ community (H5) and cultural orientations (H6), and then worked our way to a more individual level (H1 – H4). While starting with the last two hypotheses presented in this thesis may initially seem counterintuitive, we chose to examine the social and cultural variables first, as they are the most exploratory aspects of this thesis. This approach allowed us to test them early on and gain a clearer sense of how they would perform, providing insights that could inform more individual-level processes such as identity-related coping strategies among LG people.

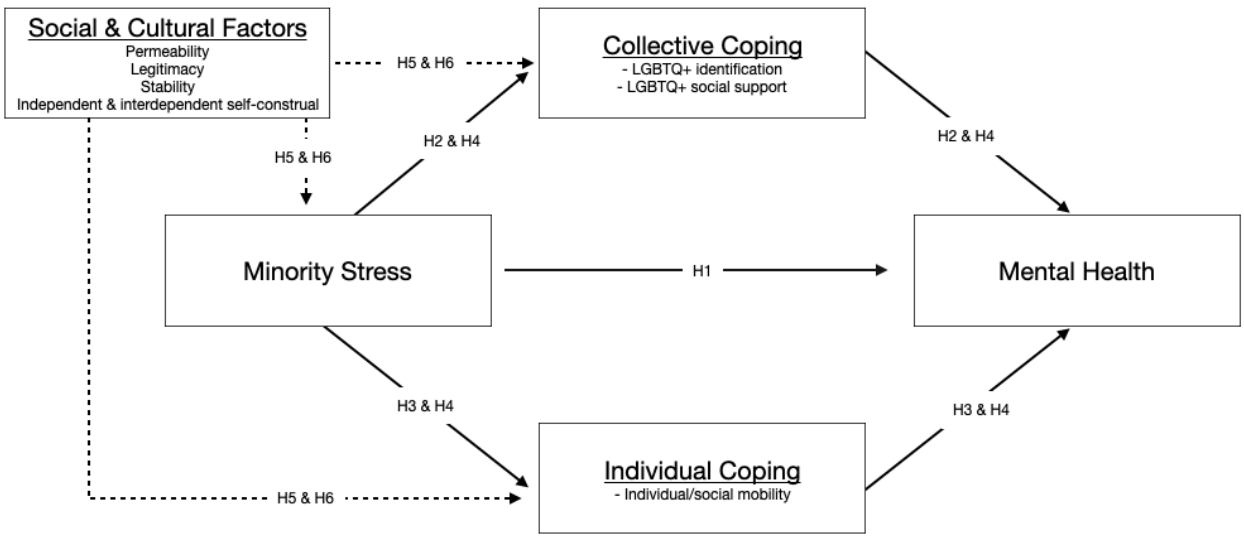

Figure 2.4. Conceptual model and hypotheses

Table 2.1. Overview of hypotheses

Hypothesis	Name	Description
H1	Minority Stress Hypothesis	Higher levels of minority stress will be negatively associated with mental health outcomes among LG people, replicating prior evidence of this relationship.
H2	Individual Coping Hypothesis	Minority stress will be positively associated with an increased likelihood of engaging in social or individual mobility strategies, which will, in turn, be related to poorer mental health outcomes.
H3	Collective Coping Hypothesis	When faced with minority stress, LG people will increase their identification with the LGBTQ+ community and utilize psychological group resources (e.g., social support), which will be positively associated with better mental health outcomes.
H4	Social Cure Hypothesis	The use of collective coping strategies by LG people in response to minority stress will be more likely to consistently enhance mental health outcomes compared to individual coping strategies.
H5	Socio-Structural Hypothesis	Perceptions of the status legitimacy and stability and permeability of the boundaries between the LGBTQ+ community and the heterosexual outgroup will influence how LG people experience minority stress and whether they adopt individual or collective coping strategies.
H6	Cultural Hypothesis	LG people's endorsement of independent versus interdependent self-construal will influence the extent to which they engage in individual or collective coping strategies.

In **Chapter 3** we explored the social and cultural correlates of identity-related coping strategies among LG people (Aybar Camposano et al., 2022). This chapter examined whether LG people were more likely to engage in individual or collective coping strategies based on their perceptions of the permeability of intergroup boundaries, as well as the stability and legitimacy of the group status between the LGBTQ+ community and heterosexual people (H5). It also assessed whether the use of one strategy over the other varied depending on LG people's endorsement of an independent or interdependent self-construal (H6).

Chapter 4 investigated how LG people's experiences of minority stress and their perceptions of the LGBTQ+ community were associated with their mental health outcomes (Camposano et al., 2024). It examined whether minority stress and perceived permeability, stability, and legitimacy of the boundaries and status between the LGBTQ+ ingroup and the heterosexual outgroup were related to the likelihood of engaging in individual or collective coping strategies (H1 and H5).

In **Chapter 5** we examined the impact that individual and collective coping strategies on the adverse mental health outcomes associated to minority stress (Aybar Camposano et al., 2024). Specifically, we tested if increased levels of minority stress were related to higher likelihood of engaging in social mobility or (2) greater of LGBTQ+ community identification and support and whether these factors were associated with positive mental health outcomes (from H1 to H4).

Chapter 6 presented a longitudinal study that investigated the effectiveness and reliability of individual and collective coping strategies in protecting LG people from the adverse effects of minority stress over a one-year period. Specifically, we examined the longitudinal mediations and temporal associations of (1) social mobility, (2) LGBTQ+ community identification, and (3) LGBTQ+ social support on the relationship between minority stress and mental health. We assessed whether these strategies were linked to positive mental health outcomes over time, both within individuals (i.e., the effects of a coping strategy on the same individual over time) and across different individuals (i.e., the effects of a coping strategy on different people over time; from H1 to H4) All of this while controlling for LG people's intergroup perception about the LGBTQ+ community in relation to the heterosexual outgroup (H5).

Lastly, **Chapter 7** summarizes and discusses the key findings, integrating their theoretical and practical contributions. It also draws conclusions regarding their implications for minority stress interventions at both individual and interpersonal levels. The chapter concludes by outlining the limitations of this thesis and suggesting future research directions for how to use the social identity approach to address mental health inequalities between LG and heterosexual individuals influenced by minority stress.

Chapter 3

Social & Cultural Correlates of Identity Management Strategies

This chapter was published as:

Aybar Camposano, G. A., Rodrigues, D. L., & Moleiro, C. (2022). Social and cultural correlates of identity management strategies among lesbian and gay people: The role of intergroup structure and self-construal. *Sexuality Research & Social Policy*, *19*, 1763–1777. https://doi.org/10.1007/s13178-022-00754-3

Introduction: Lesbian and gay (LG) people often respond to stigmatization by managing their sexual identity. LG people may disassociate from their LGBTQ + ingroup (i.e., individual strategies) or connect to it (i.e., collective strategies). Yet, many factors that may prompt LG people to use either strategy have been generally overlooked. We explored whether socio-demographic characteristics (i.e., age and gender), perceptions of the relationship between the LGBTQ + ingroup and heterosexual outgroup, and self-construal were associated with identity management strategies among LG people. **Methods:** A sample of 204 LG people (M_{age} = 29.78) was collected online via Prolific Academic between 2020 and 2021. **Results:** Hierarchical linear regressions showed that LG people who perceived the status of their LGTBQ + ingroup relative to the heterosexual outgroup as legitimate in (im)permeable and (un)stable, contexts reported engaging in more individual strategies. Those endorsing an independent self-construal were less likely to engage in individual strategies and conveyed more LGBTQ + social support. In contrast, those with higher interdependent self-construal were more likely to engage in collective strategies. Gay men were more likely to dissociate from the LGTBQ + ingroup, whereas lesbian women were more likely to seek its support. Older LG people reported lower engagement in collective strategies. **Conclusion:** These findings help paint a picture of how social and cultural variables factor in LG people managing their sexual identity as a possible response to stigma. **Policy Implications:** The results can help inform policies and interventions addressing sexual identity stigma and health inequalities by emphasizing the nuances of individual-level factors among LG people.

Keywords: Social identity; Lesbian and gay; Self-construal; Socio-structural context; Social mobility; Social support; Collective efficacy.

3.1. Introduction

Although there has been an unquestionable amount of progress in the last decades for sexual and gender minorities' rights worldwide, LGBTQ + people are still victims of stigmatization and discrimination (Mendos et al., 2020; Pew Research Center, 2020). Discrimination against lesbian and gay (LG) people has been shown to lead to a higher prevalence of physical (Cochran & Mays, 2007; Pachankis & Lick, 2018) and mental illnesses (Cochran et al., 2003; Gilman et al., 2001; Jorm et al., 2002; King et al., 2008; I. H. Meyer, 2003) At the same time, LG people often engage in various strategies to cope with the effects of discrimination (I. H. Meyer, 2003). Research has shown that LG people can detach (figuratively or literally) from their stigmatized group, concealing their identity to *pass* as heterosexual—an individual strategy—or build social bonds with those in a similar situation and embracing their identity to improve the condition of their group—a collective strategy (Branscombe et al., 2012; Branscombe & Ellemers, 1998; I. H. Meyer, 2003). However, studies have accumulated relatively little empirical evidence on the factors associated with LG people's identity management strategies.

Our study aimed to better understand what precedes using an individual or collective strategy among LG people, considering social and cultural factors. First, we studied how LG people perceive the features of the broader socio-structural context (Mummendey et al., 1999; Tajfel & Turner, 1979) regarding the relationship of their low-status ingroup with the heterosexual high-status outgroup. We assessed the specific nature of this intergroup relationship by understanding the extent to which LG people perceive how: (1) permeable the boundary, (2) legitimate the structure, and (3) stable the position is between the LGBTQ + community and their heterosexual counterparts. Stigmatized people engage in individual or collective identity management strategies depending on the socio-structural factors regarding the permeability, legitimacy, and stability of group relations (Branscombe et al., 2012; Verkuyten & Reijerse, 2008). For instance, when those who are stigmatized perceive the group relations of their low-status group with a high-status group as more permeable, stable, and legitimate, they tend to favor individual strategies (e.g., Fernández et al., 2012; Verkuyten & Reijerse, 2008). However, to our knowledge, no study has examined how LG perceived the permeability of group boundaries and the stability and legitimacy of the intergroup relations between their LGBTQ + (low-status) ingroup and heterosexual (high-status) outgroup. Lastly, we explored cultural orientations such as self-construal (i.e., how people define and make meaning of the self in terms of their relationship with others; Markus & Kitayama, 1991, 2010) and its relation to identity management strategies. Research on self-construal (SC) in low-status groups is scarce and has mixed results. Nonetheless, the research available suggests that SC is

associated with people concealing or not their stigmatized identity (e.g., Kocabıyık & Bacıoğlu, 2021; Zang et al., 2014) and how they engage with their ingroup (e.g., Bozdağ & Bilge, 2021; Kateri & Karademas, 2018). Hence, we use a more exploratory approach to assess whether LG people's self-construal contributes to the usage of individual or collective identity management strategies.

3.1.1. Socio-Structural Context and Identity Management Strategies

LG people are often targets of victimization and discrimination due to their sexual identity across their lifespan (Katz-Wise & Hyde, 2012; Lund et al., 2021) and different cultures (Kite et al., 2019; Moleiro et al., 2021). Discrimination and stigmatization against LG people can be both blatant (e.g., harassment) and subtle (e.g., microaggression) forms of violence, leading to cumulative and pervasive experiences of stress (Lund et al., 2021). LG people can repeatedly experience chronic stress throughout their life (i.e., minority stress; I. H. Meyer, 2003) which is linked to higher levels of anxiety and depression (Bostwick et al., 2010; Cochran et al., 2003), suicidality (King et al., 2008; Plöderl et al., 2013), risk of developing a disability (Fredriksen-Goldsen et al., 2012), and risk-taking behaviors (e.g., smoking, alcohol consumption, and substance abuse; (McCabe et al., 2018; Operario et al., 2015; Schuler et al., 2018; Trocki et al., 2009).

The minority stress model (I. H. Meyer, 2003) suggests that LG people's sexual identity is one of the main threats to their mental health due to the stigma attached to it. Yet, I. H. Meyer (2003) also argues about the paradoxes of LG people's social identity, recognizing that it can function not only as a threat but also as a source of strength. Social Identity Theory (SIT; Tajfel & Turner, 1979; Turner et al., 1987) proposes that people internalize the membership(s) of the group(s) they belong to and build identities from them. These identities provide people with positive psychological resources (e.g., self-esteem, support, and meaningfulness; Cooper et al., 2017; Greenaway et al., 2015; Kearns et al., 2017, 2018). When people belong to and identify with a stigmatized group, the positive benefits of their group membership can be threatened and hindered (Jetten et al., 2018). Yet, stigmatized people can use features of the intergroup context between their low-status groups compared to a high-status group to guide their behavior to maintain a positive and distinct social identity (Plante et al., 2014; Tajfel & Turner, 1979). For example, people with disproportionate short stature (or "dwarfism") manage their identity either by joining and taking pride in the "Little People" community or by concealing their stigmatizing attributes (i.e., undergoing limb-lengthening surgery), depending on how they perceive the context (Fernández et al., 2012). When members of stigmatized groups perceive a difference in

status with another relevant group, then the stigmatized ingroup members consider: (1) the permeability of group boundaries (i.e., the extent to which people can leave one group and join another), (2) the legitimacy of the group structure (i.e., how acceptable the hierarchy between the low- and high-status groups is), and (3) the stability of the ingroup position (i.e., the extent to which the position of the group is considered changeable; Mummendey et al., 1999; Plante et al., 2014; Tajfel & Turner, 1979; Verkuyten & Reijerse, 2008). These appraisals, in turn, will determine the engagement in individual or collective strategies.

Research has shown that when stigmatized people perceive the boundaries and structure between their low-status compared to a higher-status group as permeable, legitimate, and stable, they engage in individual strategies (Fernández et al., 2012; Tajfel & Turner, 1979). One of such strategies is social mobility, whereby people disengage from their ingroup and assimilate a high-status or majority group identity, conceal their stigmatized attributes, and act as high-status group members (Branscombe et al., 2012; Branscombe & Ellemers, 1998; Fernández et al., 2012). For example, lesbian women in sports often conceal their sexual identity by avoiding gendered language when talking about partners and presenting themselves as more stereotypically feminine (e.g., wearing makeup; Krane & Barber, 2003). Even though this strategy can help people avoid negative experiences and protect themselves from stigmatization (e.g., Crowell et al., 2015; Fuller et al., 2009), can also result in psychological distress and reduced well-being (D. Bruce et al., 2015; I. H. Meyer, 2003; Pachankis, 2007; Pachankis et al., 2020; Selvidge et al., 2008).

Stigmatized people engage in collective strategies when they perceive their low-status group in comparison to a higher-status group as having impermeable boundaries but, at the same time, an illegitimate and unstable structure (Branscombe et al., 2012; Tajfel & Turner, 1979). In collective strategies, people move toward their low-status group, reject the culture of stigmatization, and take pride in their stigmatizing attributes (Fernández et al., 2012). Through collective strategies, LG people can establish and draw social support from members who share the stigmatizing characteristic to help them counteract the negative effect of stigma (Frost et al., 2016; Sattler et al., 2016; Vincke & van Heeringen, 2004). By engaging in collective strategies, LG people can share feelings of collective efficacy (i.e., the belief that their ingroup position is changeable) and promote collective action to advance the condition and rights of sexual minorities (Chan & Mak, 2020). For instance, many countries worldwide celebrate Pride parades bringing people together as a form of group response against the mistreatment of the LGBTQ + community (Peterson et al., 2018). The drawbacks of collective strategies are that

low-status group members are still subjected to discrimination and give up the privileges of going through life as high-status members (Branscombe et al., 2012).

SIT provides a valuable framework for understanding and predicting identity management strategies used by members of stigmatized groups to potentially cope with discrimination. However, as Verkuyten and Reijerse, 2008 state, it is crucial to go beyond mechanistic readings of this theory and the intergroup structure between low-status and high-status groups and take a closer look at the context of the group identity in question. For LG people, group boundaries may be considered permeable between the LG ingroup and heterosexual outgroup due to sexual identity being a concealable attribute. Yet, others argue that sexual identity is also not imperceptible (Rule, 2017; Sylva et al., 2010), and specific cues can render the boundaries between both groups impermeable for some LG people. Moreover, subgroups within the LGBTQ + community may differ in how they experience and respond to discrimination. Lesbian women often face stigma at the intersection of their low-status gender and sexual identity and are more likely to suffer from economic hardships than gay men (Prokos & Keene, 2010). Therefore, it is crucial to recognize the unique social history and context of the subgroups that make up the LGBTQ + identity (Heck et al., 2013). It is also necessary to consider that intergroup relations between LG and heterosexual people are mostly context-dependent and may vary due to various factors (i.e., legal systems, cultural context; Kite et al., 2019).

LG people may perceive the legitimacy and stability of their ingroup concerning the heterosexual outgroup differently, even within the same cultural context. Thus, LG people could differ on the concealment or embracement of their sexual identity, depending on how they perceive the social context as well as their cultural orientations.

3.1.2. Self-Construal

Culture is an essential concept in understanding the experiences of LGBTQ + people worldwide since it is a central part of being human, allowing us to better comprehend intergroup relationships and social identities (Moleiro et al., 2021). It is not an easy concept to define, and it can manifest in many ways, such as in how we interact with others and construe ourselves. Markus and Kitayama (1991) coined the term self-construal (SC) to refer to how people define the self in relation to others, which can be more independently or interdependently. Compared to other cultural variables (e.g., individualism vs. collectivism) that aim to depict cultures, SCs describe people and are significant predictors of one's cognitions, emotions, and behaviors (for review, see Cross et al., 2011; Markus & Kitayama, 2010). According to this perspective (Markus & Kitayama, 1991, 2010), people who predominantly construe their self as internal

and stable traits based on their uniqueness and authenticity (e.g., "I am smart") have an independent SC. In contrast, people who have a predominant interdependent SC construe their self as external and malleable traits in relation to others, their group membership, and their social relationships (e.g., "I am a mother"). An independent SC tends to be more prominent in individualistic cultures (e.g., the USA), whereas an interdependent SC tends to be more pronounced in collectivistic ones (e.g., Japan; Oyserman et al., 2002). Even though people have both independent and interdependent SC, the broader cultural context tends to favor the development of a predominant SC (Cross et al., 2011).

SCs can shape intergroup relations and self-identification (Markus & Kitayama, 1991, 2010). Yet, research has yielded mixed results. People with a predominant independent SC tend to fear social stigma to a lesser extent and seek support from others to a greater extent (Yalçin, 2016). Individuals with an independent SC are also inclined to engage in collective action against discriminatory treatment (F. B. Fischer et al., 2017). Higher endorsement of an independent SC can also lead to feelings of exclusion from one's marginalized group (Ferenczi et al., 2015). In contrast, those with a predominant interdependent SC tend to have a stronger collective identity and favor ingroup attitudes to the detriment of outgroup members (Tawa & Montoya, 2019). Higher endorsement of an interdependent SC is also associated with stronger feelings of inclusion and connectedness to marginalized groups and identities (Ferenczi et al., 2015). In line with these findings, other studies suggest that sexual minorities in collectivistic cultures identify with and draw more support from the LGBTQ + community than those in individualistic countries (Aybar Camposano et al., 2019). Taken together, one could argue that LG people who endorse an independent SC may fight for their rights to demand better treatment of the self and preserve their authenticity. However, it could also be the case that those who endorse an interdependent SC may seek to maintain harmony with their national ingroup by passing as a heterosexual.

Research on cultural variables often overlooks minority and stigmatized groups (Tawa & Montoya, 2019). Exceptions are studies using a cultural perspective to understand violence and attitudes towards LGBTQ + people in different parts of the world (e.g., Kite et al., 2019; Moleiro et al., 2021). For example, culture has been used as a lens to understand why some countries have laws that are more accepting or punishing of LG people (Kite et al., 2019). And yet, no study to our knowledge took a closer look at how cultural variables—such as SC—are associated with how LG people manage their identities as a response to stigmatization. Thus, we conducted a study exploring whether an independent and interdependent SC relates to how dissociated or engaged LG people are with their LGBTQ + ingroup.

3.1.3. The Present Study

This study aimed to understand the extent to which social and cultural factors are associated with the likelihood of engaging in individual or collective strategies among LG people. We focused only on sexual identity rather than gender identity and expression. Drawing from the SIT, we examined how LG people perceive the factors of the socio-structural context regarding the relationship between their LGBTQ + ingroup and the heterosexual outgroup. We expected LG participants who perceive the intergroup structure between their LGBTQ + low status ingroup compared to the heterosexual high-status outgroups as more legitimate and stable and perceive group boundaries as more permeable to be more likely to engage in social mobility ($H1_A$). We also hypothesized that those who perceive the context as less legitimate, stable, and permeable are more likely to be involved in collective strategies (i.e., social support and collective efficacy from the LGTBQ + community; $H2_A$). Moreover, this study also built upon and expanded the work that bridges topics of identity, culture, and stigma by exploring the roles of independent SC and interdependent SC in attaching or detaching from the LGBTQ + ingroup. We advanced no a priori hypotheses due to a dearth of research examining SC on stigmatized groups such as LG people. We also accounted for possible differences within our sample by controlling for age and gender identity.

3.2. Method

A total of 258 people participated in this study, some of whom abandoned the survey before completion (n = 30). Those who identified as trans, non-binary, and other diverse gender identities (n = 24) and those who identified as bisexual and other sexual minorities were not included in the study as their unique experiences would add complexity to the issues of mobility and gender, among others. The final sample consisted of 204 people from 25 different countries aged between 18 and 74 (M = 29.78, SD = 10.26). Most participants identified as men (58.3%), were single and without a romantic relationship (49.0%), were currently employed (34.8%), held either a high school diploma (31.5%) or bachelor's degree (31.0%), and lived in the United Kingdom (36.8%). Participants identified as gay men (58.3%) or lesbian women (41.7%).

3.2.1. Measures

Perceived Socio-Structural Context.

We adapted items from Mummendey et al., (1999) to assess the perceptions of the low-status ingroup (i.e., the LGBTQ + community) concerning the heterosexual high-status outgroup. The perceived stability of the socio-cultural context was measured using one item ("I think the

relationship between the members of the LGBTQ + community and straight people will remain stable for the next few years"). Perceived legitimacy of the context was assessed using two items (e.g., "Straight people are entitled to be better off than the members of the LGBTQ + community"). Items were mean aggregated, $r = .44$, $p < .001$. Lastly, the perceived permeability of the context was assessed using two items (e.g., "In principle, it is not difficult for a member of the LGBTQ + community to be considered straight"). Items were also mean aggregated, $r = .31$, $p < .001$. Responses to all items were given in 7-point rating scales (1 = *Strongly disagree* to 7 = *Strongly agree*).

Self-Construal

Predominant SC was measured using the Short Version of the Self-Construal Scale proposed by D'Amico and Scrima (2016) based on the original scale developed by Singelis (1994). This scale measures people's frame of reference for their identity based on their connectedness or separateness from others in a given context. Items are divided into two subscales, one assessing an independent SC (five items; α = .68; e.g., "I do my own thing, regardless of what others think") and another an interdependent SC (five items; α = .69; e.g., "I will sacrifice my self-interest for the benefit of the group I am in"). Responses were given on 7-point rating scales (1 = *Strongly disagree* to 7 = *Strongly agree*).

Social Mobility

We used the social mobility scale developed by Blanz et al., 1998. Still, we adapted the items to the context and experiences of members of the LGBTQ + community (i.e., low-status group) in relation to straight people (i.e., high-status group). This scale included four items (α = .77; e.g., "I make an effort to be considered straight"), and responses were given in 7-point rating scales (1 = *Strongly disagree* to 7 = *Strongly agree*).

Social Support

Four items adapted from van Dick and Haslam (2012) were used to measure the perceived levels of social support from the LGBTQ + community (α = .94; e.g., "I get the help I need from other members of the LGBTQ + community"). Responses were given on 7-point rating scales (1 = *Strongly disagree* to 7 = *Strongly agree*).

Collective Efficacy

Five items adapted items from (Reicher and Haslam (2006) were used to measure the levels of collective efficacy among LG people (α = .88; e.g., "Members of the LGBT + community can remain calm when facing difficulties because we can rely on our coping abilities"). Responses were given on 7-point rating scales (1 = *Strongly disagree* to 7 = *Strongly agree*).

3.2.2. Procedure

The present study was conducted in agreement with the ethical guidelines issued by Instituto Universitário de Lisboa (ISCTE) (approval reference number 35/2020). Participants were recruited and pre-screened through Prolific Academic. Specifically, we filtered participants by sexual identity and fluency in English. Those who were eligible to participate were shown the announcement of the study and the link to the survey. After accessing the link, participants received information about the study's goals, the voluntary nature of their participation, that responses were confidential and anonymous, and that they could abandon the survey without their responses being considered. Participants were only allowed to proceed after providing electronic informed consent. The survey started with additional control questions (e.g., sexual identity), followed by standard socio-demographic questions and our main measures. The average time of completion was 8 min (M = 7.96, SD = 16.96). At the end of the survey, participants were thanked for their participation and debriefed. Those who completed the survey and met the inclusion criteria were financially compensated for their time.

3.2.3. Analytic Plan

Data were analyzed using the JASP (version 0.14.1) software. Initially, we conducted preliminary analyses by computing correlations and conducted a series of *t*-tests to compare participants across gender identities. To test our hypotheses, we conducted three five-step hierarchical linear regressions to examine the extent to which different groups of factors are associated with individual (i.e., social mobility) and collective strategies (i.e., social support and collective efficacy) among LG people. Our first step was to enter socio-demographic variables (i.e., gender identity and age) into the model before examining social and cultural factors (step 1). We then entered variables in our model assessing LG people's perceptions of the socio-structural context regarding their LGBTQ + ingroup and its relation to the heterosexual outgroup. We wanted to determine not only the contributions of stability, permeability, and legitimacy (step 2) but also their respective two-way (step 3) and three-way interactions (step 4). Since we are exploring the relationship between self-construal and identity management strategies, we wanted to assess if the inclusion of the independent SC and

interdependent SC in the model contributed significantly while considering social-demographic and contextual factors. Hence, our last step was to include cultural variables (i.e., independent SC and interdependent SC) in our model (step 5).

3.3. Results

3.3.1. Preliminary Analyses

Descriptive information and correlations among our main variables are summarized in Table 3.1. Results showed that higher levels of independent SC were positively related to stability, $p = .038$, and negatively related to social mobility, $p = .011$, while interdependent SC was positively associated with LGBTQ + social support, $p < .001$, and collective efficacy, $p = .007$. Additionally, perceived legitimacy was positively associated with social mobility, $p = .001$, and negatively correlated to permeability, $p = .012$. Stability was positively related to collective efficacy, $p = .001$. Social support from the LGBTQ + community was positively associated with collective efficacy, $p < .001$. Conversely, social mobility was negatively related to social support, $p < .001$, and collective efficacy, $p < .001$. Age was positively correlated to independent SC, $p = .017$, and stability, $p = .046$, but also negatively associated with perceived legitimacy, $p < .001$, and LGBTQ + social support, $p < .001$.

Table 3.1. Descriptive statistics and correlations

	M	(*SD*)	1	2	3	4	5	6	7	8
1. Independent SC	4.43	(1.09)	–							
2. Interdependent SC	3.89	(1.01)	− .15*	–						
3. Legitimacy	2.16	(1.44)	.02	− .05	–					
4. Stability	4.36	(1.34)	.15*	− .03	− .06	–				
5. Permeability	4.31	(1.22)	.05	.06	− .18*	.08	–			
6. Collective efficacy	4.79	(1.07)	.06	.19**	− .07	.23**	.09	–		
7. Social support	4.22	(1.54)	.06	.25***	− .01	− .02	− .03	.48***	–	
8. Social mobility	1.80	(1.00)	− .18*	.10	.22**	− .08	− .03	− .33***	− .24***	–
9. Age	29.78	(10.26)	.17*	− .01	− .23***	.14*	.04	− .08	− .23***	− .05

Note. $p < .050$; **$p < .010$; ***$p < .001$

As shown in Table 3.2., lesbian women perceived more social support from the LGBTQ+ community, $p = .025$, whereas gay men engaged more in social mobility strategies, $p = .025$.

Table 3.2. Comparisons between lesbian women and gay men

	Lesbian Women		Gay Men			
	M	(*SD*)	*M*	(*SD*)	*t*	Cohen's *d*
Independent SC	4.37	(1.04)	4.47	(1.12)	.62	.09
Interdependent SC	3.84	(1.03)	3.92	(1.01)	.54	.08
Legitimacy	1.95	(1.44)	2.32	(1.43)	1.83	.26
Stability	4.26	(1.36)	4.43	(1.32)	.89	.13
Permeability	4.39	(1.27)	4.26	(1.18)	-.80	-.11
Collective Efficacy	4.76	(1.05)	4.81	(1.09)	.36	.05
Social Support	4.51	(1.55)	4.02	(1.51)	-2.25*	-.32
Social Mobility	1.61	(.90)	1.93	(1.05)	2.26*	.32

Note. $^{*}p < .050$, $^{**}p < .010$, $^{***}p < .001$.

3.3.2. Main Analyses

Individual Strategies

Results of the hierarchical linear regressions are summarized in Table 3.3. The full regression model was significant, $F(11, 192) = 2.81$, $p = .002$, and explained 14% of the variance. The results from step 1 suggested that gender was significantly associated with social mobility, such that those who identified as lesbian women reported less social mobility, $p = .019$. Age was not significantly related to social mobility, $p = .314$. Step 2 showed a positive association between legitimacy and social mobility, $p = .006$. However, there were no significant associations between perceived permeability or stability on social mobility, all $p \geq .267$. These results show that those who perceived the socio-structural context between the LGBTQ + ingroup and heterosexual outgroup as legitimate reported higher levels of social mobility. None of the three two-way interactions (legitimacy × stability, legitimacy × permeability, or permeability × stability) added to the model in step 3 were significantly related to social mobility, all $p \geq .620$. The three-way interaction added in step 4 was significantly associated with social mobility, $p = .009$.

A subsequent slope analysis (see Figure 3.1.) showed participants reported higher social mobility when they perceived the intergroup context between their LGBTQ + low-status ingroup and the heterosexual high-status outgroup as stable, permeable, and legitimate, $b = .29$, $p < .001$. When participants perceived the context as unstable, impermeable, and legitimate, they also conveyed higher levels of social mobility, $b = .18$, $p = .001$. No other slopes were significant, all $p \geq .336$. The last step included in the model increased the explained variance. Results from step 5 suggested that an independent SC was negatively associated with social mobility, $p = .020$. An interdependent SC was not significantly related to social mobility, $p = .312$.

Table 3.3. Hierarchical multiple regression analyses (standardized regression coefficients)

	Social Mobility					Social Support					Collective Efficacy				
	Step 1	Step 2	Step 3	Step 4	Step 5	Step 1	Step 2	Step 3	Step 4	Step 5	Step 1	Step 2	Step 3	Step 4	Step 5
Step 1															
Gender (Women = 1; Men = 0)	-.17*	-.14 [a]	-.14 [a]	-.14 [a]	-.13[a]	.13	.13	.13	.13	.14*	-.03	-.04	-.04	-.04	-.03
Age	-.07	-.01	-.01	-.01	.01	-.22**	-.23**	-.22**	-.22**	-.24***	-.08	-.14	-.13	-.13	-.14*
Step 2															
Legitimacy (Leg)		.20**	.08	1.75*	1.61*		-.04	-.22	.43	.36		-.08	.14	-.12	-.18
Stability (Stab)		-.08	-.12	.79	.67		.02	.14	.50	.35		.24***	.48	.34	.22
Permeability (Perm)		.02	.02	.90*	.71		-.03	.12	.46	.33		.06	.35	.21	.09
Step 3															
Leg x Stab			.12	-1.69*	-1.59*			.14	-.56	-.47			-.06	.22	.29
Leg x Perm			.02	-1.86*	-1.66*			.06	-.67	-.64			-.18	.11	.16
Stab x Perm			-.01	-1.40*	-1.15			-.27	-.81	-.63			-.32	-.11	.05
Step 4															
Leg x Stab x Perm				2.08**	1.92*				.80	.76				-.32	-.38
Step 5															
Independent SC					-.16*					.16*					.08
Interdependent SC					.07					.27***					.19**
ΔR^2	.03	.04	0	.04	.03	.07	0	.01	.01	.08	.01	.07	0	0	.04
ΔF^2	3.07[a]	.02*	1.15	.62**	.25**	7.71***	4.54**	1.03*	.12*	1.20***	.78	2.52**	1.07*	.24*	.44**

Note. [a] $p = .050$ * $p < .050$, ** $p < .010$, *** $p < .001$

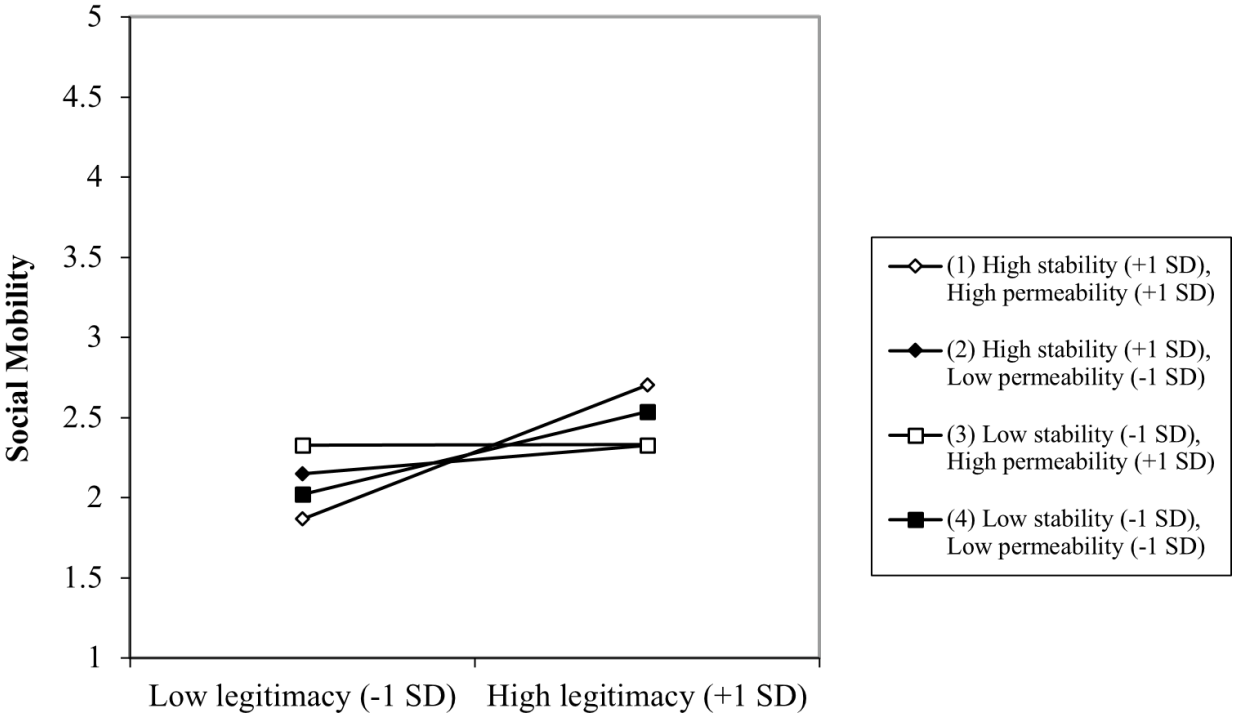

Figure 3.1. Three-way interaction (legitimacy × stability × permeability) on social mobility

Collective Strategies

Social Support. The five-step hierarchical linear regression model on social support was significant, $F(12, 191) = 3.22$, $p < .001$, and explained 17% of the variance. Results from step 1 showed a negative but significant association between age and social support, such that older participants reported lesser levels of social support from the LGBTQ + community, $p = .002$. However, there was not a significant association between gender identity and social support, $p = .056$. Neither of the effects of legitimacy, stability, and permeability (step 2), all $p \geq .537$, their respective two-way interactions (step 3), all $p \geq .433$, or three-way interaction (step 4), $p = .311$, were significantly associated with social support. The last step included in the model increased the explained variance. In step 5, the endorsement of both an independent SC, $p = .024$, and interdependent SC, $p < .001$, were positively and significantly associated with a higher level of social support from the LGBTQ + community. The inclusion of SC in the model also rendered the association between gender and LGBTQ + social support as positive and significant, $p = .039$. Hence, these results suggested that when controlling for cultural orientation, lesbian women report higher levels of LGBTQ + social support when compared to gay men.

Collective Efficacy. The full regression was significant $F(11, 192) = 2.43$, $p = .007$, and explained 12% of the variance. Step 1 indicated that gender and age were not significantly associated with LGBTQ + collective efficacy, all $p \geq .234$. Results from step 2 suggested that stability was positively and significantly related to collective efficacy, $p < .001$, such that perceiving the position of the LGBTQ + community in relation to their heterosexual counterparts as stable increased LG people's collective efficacy. The relationships between permeability and legitimacy with collective efficacy were not statistically significant, all $p \geq .253$. Neither the two-way interactions (step 3), all $p \geq .344$, nor the three-way interaction (step 4), $p = .685$, between legitimacy, stability, and permeability were significantly associated with collective efficacy. Step 5 showed an increase in the variance of the model with the inclusion of the independent SC and interdependent SC. An interdependent SC was positively and significantly related to LGBTQ + collective efficacy, $p = .006$. This finding suggests that when LG people's sense of self endorses group or social traits, this is likely to increase feelings of collective efficacy from the LGBTQ + ingroup. However, this was not the case for an independent SC, $p = .225$. Notably, the inclusion of SC in the model rendered the association between age and collective efficacy negative and significant, $p = .049$, such as that older LG people report lower feelings of collective efficacy.

3.4. Discussion

Navigating life with a stigmatized identity can pose a complex challenge, leading minority group members to engage in various strategies to respond to the adverse effects of stigma. SIT (Tajfel & Turner, 1979; Turner et al., 1987) proposes that the perceptions of the socio-structural context of the relationship between a low-status and high-status group can help researchers understand how stigmatized group members manage their identity as a response to stigma. Additionally, cultural variables and orientations can also impact the groups we belong to and the identities that stem from them. The present study explored how perceptions of the social-structural context and self-construal correlate with LG people's identity management strategies.

Our findings showed that when LG people perceived the socio-structural context of their LGBTQ + low-status group in comparison to their heterosexual high-status group as stable, permeable, and legitimate, they were more likely to engage in social mobility. Interestingly, this was also the case for LG people, who perceived the context as unstable, impermeable, and legitimate. It seems to be the case that accepting one's position and treatment as a minority group (i.e., legitimacy) can lead to more engagement of social mobility in contexts perceived as either stable and permeable or unstable and impermeable. This finding is particularly

interesting when considering past studies showing that what leads stigmatized groups to more social mobility is the perceived permeability of group boundaries in legitimate and stable contexts (Fernández et al., 2012; Mummendey et al., 1999; Verkuyten & Reijerse, 2008). SIT also argues that those who can conceal their stigmatized attributes tend to engage in social mobility to escape the detrimental effects of stigma and discrimination, whereas those who struggle to conceal their identity tend to engage in collective strategies. However, we found that the condition consistently associated with social mobility was perceiving the context as legitimate, suggesting legitimacy as the driving force underlying this process among LG people. It could be the case that stigmatized groups such as LG people that possess a relatively concealable stigmatized attribute (Rule, 2017) and have increasingly gained awareness and legal recognition (Pew Research Center, 2020), legitimizing their minority position and treatment in society could be a proxy for trying to *pass* as heterosexual.

Notably, our results showed a non-significant three-way interaction between perceived socio-structural context (legitimacy, stability, and permeability) and collective strategies among LG people (i.e., social support and collective efficacy). SIT (Tajfel & Turner, 1979; Turner et al., 1987) argues that when members of a minority group cannot conceal their stigmatizing attributes (e.g., sexual identity), they tend to build a positive group identity and join fellow ingroup members to fight against discrimination. Minority people also find ways to identify with and join groups of people who like them when they perceive the intergroup structure between low-status and high-status groups as unstable or illegitimate (Mummendey et al., 1999; Verkuyten & Reijerse, 2008). Yet, our findings do not align with this premise. It could be the case that for members of a stigmatized group to unlock social support and feelings of collective efficacy is first to necessary increase identification with their ingroup. Socio-structural variables have been associated with predicting people's ingroup identification (Ellemers, 1993; Verkuyten & Reijerse, 2008). Thus, one could argue that ingroup identification explains the association between perceived socio-structural context and collective strategies. Studies on SIT applied to the health of stigmatized people have suggested that a person who perceives to be a target of discrimination starts by increasing their identification with the ingroup in question (Branscombe et al., 1999; Jetten et al., 2018). In turn, group identification favors social support (Crabtree et al., 2010) and collective efficacy (Klandermans, 2002; Muldoon et al., 2017) from the ingroup. Drawing from this reasoning, the way LG people perceive the intergroup structure between their ingroup, and heterosexual outgroup can determine the social support they receive and their collective efficacy because they start to identify more with the LGBTQ + community. More research is still needed to support this claim.

We also found differences within our sample. Older LG people were more likely to report less social support and collective efficacy from the LGBTQ + community. These findings are consistent with previous research suggesting older LG people report higher levels of loneliness and detachment from the LGBTQ + community (De Vries, 2014; de Vries & Megathlin, 2009; Ribeiro-Gonçalves et al., 2022). We also found evidence that gay men reported higher levels of social mobility, whereas lesbian women (when controlling for SCs) reported higher levels of social support from the LGBTQ + community. For men, concealing their low status sexual identity while complying with the expectations of their high-status gender group can increase their likelihood of engaging in individual strategies. Lesbian women, at the intersection of low-status groups such as gender and sexual identity, may be more likely to engage in collective strategies. Compared to gay men, lesbian women passing as heterosexual may be unable to avoid the stigma and discrimination targeted at them due to their gender. Thus, lesbian women might be more prone to building stronger ties with others who share their stigmatizing attributes. Research shows lesbian women are inclined to befriend other lesbian women (Stanley, 1996) and often create alternative communities with active and supportive networks (Wayment & Peplau, 1995). However, a more nuanced examination of the different ways LG people with other intersecting low-status attributes manage their identities when faced with discrimination is still needed.

This study also provided evidence of how cultural orientations among LG people may lead to different identity management strategies. Interestingly, we found that endorsing an independent SC was negatively associated with social mobility and positively related to LGBTQ + social support. Those who endorse an independent self-construal are characterized by striving to promote their individual goals and express their opinions (Markus & Kitayama, 1991). Given that individual strategies generally imply concealing one's identity to avoid discrimination (Branscombe et al., 2012), people with an independent SC may prioritize the self instead of the ingroup and avoid social mobility if it threatens their sense of individuality and authenticity. It could also be the case that LG people engage in other forms of social mobility. Some authors have argued that there could be many ways for an LG person to conceal their sexual identity and *pass* as heterosexual. For example, some sexual minority people may opt to marry a different-sex person and live as a heterosexual person (i.e., capitulating), while others may accept their sexual identity but regard it as an irrelevant aspect of their life (i.e., blending; Cox & Gallois, 1996).

Other authors suggest different types of individual social mobility, such as ingroup social mobility. Whereas LG people may embrace their sexual identity and their individuality by

distancing themselves from the prototypical notion of what it is to be gay or lesbian (e.g., Sánchez & Vilain, 2012; Taywaditep, 2002). For instance, LG people could engage in upward mobility or identification with high-status identities (e.g., white, wealthy, high social status) to shield themselves against violence and discrimination (D. Meyer, 2017; I. H. Meyer, 2015). In contrast, endorsing an interdependent SC was significantly and positively associated with social support and collective efficacy from the LGBTQ + community. Our findings are consistent with research suggesting that people with an interdependent SC seem to build stronger ties with their ingroup (Markus & Kitayama, 2010) and can feel connected with their ingroup despite the stigma attached to their identity (e.g., Ferenczi et al., 2015; Tawa & Montoya, 2019). Collective strategies look for the group's improvement as opposed to the self (Branscombe et al., 2012). Thus, LG with higher interdependent SC may draw support from each other within the LGBTQ + community and believe their group has all it takes to change its stigmatized condition.

3.4.1. Implication for Social Policies

The present study primarily focused on understanding and dissecting the factors of how individual LG people manage their identities as a response to discrimination. We hope it goes without saying that the results of this study do not endorse holding LG people the sole responsibility to endure and minimize the adverse effects of homophobic and oppressive social policies. Even though LG people find ways to cope with discrimination, policies aimed at the LGBTQ + are vital to guarantee some type of systemic change and create supportive structures for sexual and gender minorities. Evidence has repeatedly shown that policies are needed to lessen the stigmatization, increase awareness, and improve the overall health and well-being of LG people (Chen & van Ours, 2022; Hagen & Goldmann, 2020; Hatzenbuehler, 2014; Pachankis & Bränström, 2018). Thus, social policies and policy reforms addressing mental health disparities between sexual minorities and heterosexual people are imperative. Our findings want to help inform such social policies by providing a more nuanced understanding of the diversity and various individual-level factors of LG people to make them potentially more applicable.

We believe the findings of this study can help inform social policies targeted at improving the health of LG people in three ways. First, policymakers must distinguish between the specific and unique needs of older and younger LG people, as well as gay men and lesbian women. For instance, designing an intervention for older lesbian women could benefit from fostering social support and relationships with other lesbian women to mitigate the adverse effects of the stigma associated with their gender and sexual identity. Second, how LG people perceive the

(il)legitimacy of the group status between their low-status group and the high-status heterosexual group seems to be related to the extent to which they conceal or not their sexual identity. Policies and intervention programs addressing stigma and sexual identity-based health inequalities could benefit from helping LG people challenge their perceptions of legitimizing the position of the LGTBQ + group as inferior to the heterosexual one. Lastly, policymakers ought not to overlook how cultural orientations can construe the self, shape identity, and influence how LG people might respond to stigmatization. Our findings indicate that those with a more interdependent SC could value more programs and interventions involving their LGBTQ + ingroup. We recognize there is still a need for more research on cultural orientation among LG people. Nevertheless, a crucial first step is acknowledging cultural differences within the LGBTQ + community and how culture can shape how LG people manage their sexual identity.

3.4.2. Limitations & Future Studies

The present study had some limitations that we must acknowledge. First, this study's cross-sectional and exploratory nature does not allow us to determine causation. However, we explored potential correlates of identity management strategies among LG people and established a rationale based on theoretical assumptions. Future studies should consider conducting more studies to replicate our findings using alternative and complementary methodologies (e.g., qualitative analyses; longitudinal studies). Researchers could conduct longitudinal studies to examine the effects over time of the constructs tested in this study and establish links between social and cultural factors as possible predictors of individual and collective strategies among LG people.

Second, we collected data from a demographically and geographically diverse sample but did not account for potential differences in the political, social, and legal realities of LGBTQ + people. This diversity among our participants can potentially have its fair share of limitations and opportunities. Legal frameworks and social policies may shape how LG people perceive the intergroup structure between the low-status LGBTQ + ingroup and heterosexual high-status outgroup, thus engaging in different identity management strategies. A study examining LG people across 28 countries suggests that identity concealment can function as a more adaptive strategy since it is associated with greater life satisfaction in structurally homophobic contexts, but this is not the case in structurally supportive ones (Pachankis & Bränström, 2018). Nevertheless, by assessing social and cultural factors at an individual level and across countries, we observed some consistencies, regardless of the context, in the ways LG people manage their sexual identity. Despite differences across legal frameworks and borders, the life experiences

of open and closeted LG people in different parts of the world seem to share similar stories. Hence, perceptions of the socio-structural context between the LGBTQ + low status and heterosexual high-status groups and cultural orientations may provide a more nuanced understanding of LG people's identities and experiences across countries with different LGBTQ + legal frameworks and social policies. For instance, a detailed examination of such social and cultural variables can help us better understand why and how closeted people are present in countries that protect LGBTQ + rights and why LGBTQ + activists exist in oppressive ones. Future studies should seek to cross-culturally replicate our findings by examining the perceived intergroup structure between LG people and heterosexual groups. It could also be interesting to compare LG people's (vs. heterosexuals') perception of intergroup relations across countries with progressive and oppressive LGBTQ + legal frameworks and policies.

In the same vein as the second point, in this study, we did not assess the levels of minority stress among our sample. LG people across different countries and contexts may vary in how they experience stigma and respond to it. For instance, LG people in Poland can be exposed to a greater extent to violence and discrimination than those living in the United Kingdom. Even though there is still a great divide in acceptance of sexual and gender minorities worldwide (Mendos et al., 2020; Pew Research Center, 2020), LG people seem to consistently experience the effects of minority stress regardless of where they are located (I. H. Meyer et al., 2021; Sattler & Lemke, 2019; Sun et al., 2020). How stigmatized people respond to discrimination also seems consistent across contexts and groups (for review, see Jetten et al., 2018). It could be of interest for future studies to examine and compare the effectiveness of individual or collective management strategies as a response to minority stress. Future studies could be conducted with LG people from the same country or cross-culturally to understand better how LG people navigating different LGBTQ + social and legal realities respond to a similar threat (i.e., minority stress).

Lastly, this study did not account for the intersection of different stigmatized identities. By grouping gay men and lesbian women in our analyses, we may have not accounted for the sexism experienced by lesbian women or other intersecting stigmatized identities. Additionally, due to the international nature of our sample, we did not control variables such as race, ethnicity, and social class. Evidence shows that perceptions of the intergroup structure may differ across low-status ethnic groups and high-status white people (e.g., Verkuyten & Reijerse, 2008). Moreover, people from low social class status tend to have higher levels of interdependent SC in comparison to those from a high social class who have higher levels of independent SC (for review, see Cohen & Varnum, 2016). Race and ethnicity also factor into the lives of many LG

people. Experiences of racism and xenophobia intersect and add to the homophobia and lesbophobia faced by LG people of color (e.g., (David & Knight, 2008; I. H. Meyer, 2015), thus possibly impacting their identity management strategies. It can be of great interest and value to further explore the perception of the intergroup socio-structural context of low-status and high-status groups and SC among and across different gender identities and sexual orientations. Future studies could assess the perceptions of the intergroup structures of low-status and high-status groups and cultural differences between gay men and lesbian women more in-depth. Other studies could also examine the intergroup relations between stigmatized groups and identities within the LGBTQ + community, such as *trans* and nonbinary people (vs. *cis* high-status group) and bisexual people (vs. monosexual high-status group). Doing so can help us better understand the potential cultural differences, intergroup relations, and identity management strategies used by the diverse people that make up the LGBTQ + community.

3.5. Conclusion

This study goes beyond existing research, taking a close look at the LGBTQ + ingroup by examining how social and cultural variables are associated with individual and collective strategies among LG people. LG people tend to engage in more social mobility when they perceive the intergroup structure between the LGBTQ + community and heterosexuals as legitimate in (un)stable and (im)permeable contexts. LG people who endorse an interdependent SC are more likely to engage in collective strategies. At the same time, those with a more independent SC are less likely to engage in individual strategies and report higher levels of LGBTQ + social support. In this study, we also found differences across age groups and genders where gay men reported higher levels of social mobility and lesbian women stated more social support from the LGBTQ + community. In the same vein, older LG people conveyed less LGBTQ + social support and collective efficacy than younger LG people. This study helps support social identity theory and better understand how LG people's perceptions of socio-structural factors concerning the heterosexual high-status outgroup, self-construal, and socio-demographic characteristics may result in different responses towards stigma. Our results can help the development of socially and culturally sensitive interventions, clinical practices, and policies aimed at helping LG people cope with stigma and improve their overall health.

Chapter 4

Implications of Intergroup Perceptions on Minority Stress

This chapter was published as:

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Lesbian and gay (LG) people overwhelmingly report higher rates of mental health disorders than their heterosexual counterparts due to living in homophobic contexts. However, little attention has been given to how LG people perceive their identity and group under said conditions. In this study, we used social identity theorizing to understand if minority stress and LG people's perception of the status and boundaries between their ingroup, the LGBTQ + community vs. the heterosexual outgroup, worsens or improves mental health outcomes. A sample of 202 LG people from the United Kingdom responded to an online survey through Clickworker between January and March 2022. A three-step hierarchical linear regression showed that LG people experiencing higher minority stress reported adverse mental health outcomes. Additionally, LG people with elevated minority stress conveyed worse mental health outcomes when they perceived the group status between their LGBTQ + ingroup and heterosexual outgroup as either stable or illegitimate. Our findings suggest that adverse mental health outcomes among LG are explained by minority stress and how they perceive their identity within a broader social context. Our results propose tackling homophobic conditions while also challenging the perceived stability and illegitimacy of the LGBTQ + community by supporting its spaces and members.

Keywords: Minority stress; Mental health; LGBTQ+; Socio-structural context; Social identity.

4.1. Introduction

Lesbian and gay (LG) people are not particularly vulnerable to developing mood disorders (Semlyen et al., 2016), substance abuse (Schuler et al., 2018), or suicidality (Kaniuka et al., 2019) solely because of their sexual identity. And yet, they have a higher risk of being diagnosed with a mental health disorder when compared to those who identify as heterosexual (Booker et al., 2017; Mongelli et al., 2019; Wittgens et al., 2022). Adverse mental health outcomes among LG people may emerge from their exposure to the minority stress of navigating life as a sexual minority in largely homophobic social contexts (Frost & I. H. Meyer, 2023; Hatzenbuehler et al., 2013).

Minority stress is a specific and unique form of stress resulting from exposure to distal (e.g., violence) and proximal (e.g., internalized homophobia) stigma-related stressors (I. H. Meyer, 2003). LG people experience minority stress at every stage of their development (see I. H. Meyer et al., 2021) and across many social domains, including the school context (van der Star et al., 2021), workplace environment (Galupo & Resnick, 2016), and health care settings (Zeeman et al., 2019). Sexual identity stigma also occurs at different levels, namely individual (i.e., concealment; Pachankis et al., 2020), interpersonal (i.e., victimization; Katz-Wise & Hyde, 2012), and structural (i.e., laws and policies; Mendos et al., 2020). Therefore, the mental distress and adverse health outcomes faced by LG people largely depend on their context. Nevertheless, mental health inequalities based on people's sexual identity persist, even in structurally accepting and supportive countries (Moreno et al., 2020).

Minority stress is a complex and multifactorial issue that should be understood and addressed at multiple levels (Chaudoir et al., 2017). Evidence suggests that LG people experience higher life satisfaction (Pachankis & Bränström, 2018), more acceptance (Hagen & Goldmann, 2020), and less victimization (van der Star et al., 2021) in countries with LGBTQ + supportive policies in comparison to countries with structurally stigmatizing laws. However, when examining intergroup relations (i.e., low- vs. high-status groups), we must consider not only the context but also how individuals perceive those relations (Branscombe et al., 2012).

Past research has already used perceptions of the structural context between minority and majority groups to the health outcomes of those with stigmatized identities (e.g., Aybar Camposano et al., 2022; Jetten et al., 2018). To our knowledge, however, these intergroup perceptions have yet to be explored in the context of LG people and minority stress. In this study, we examined the ways in which LG people perceive the social context between the LGBTQ + community and heterosexual people. Specifically, we tested if said perceptions may intensify the negative association that minority stress has on LG mental health.

4.1.1. Social Identity Approach & Minority Groups

The social identity approach is a theoretical framework stemming from social identity theory (Tajfel & Turner, 1979) as well as self-categorization theory (Turner et al., 1987). The social identity approach has accumulated a vast body of research examining multiple intergroup phenomena, particularly focused on the relations between low- and high-status groups. The main tenet of the social identity approach is that humans seek out or preserve social identities that positively impact their sense of self, even when confronted with stigma. To do so, they engage in intergroup comparisons to evaluate their ingroup's status in relation to an outgroup's (Reicher et al., 2010).

When the status of ingroup members differs from that of outgroup members, people from the minority group rely on perceived social-structural characteristics to guide their behavior and manage their identities (Branscombe et al., 2012). Specifically, people rely on their perceptions of the (1) stability of intergroup status differences, i.e., perceptions of whether the ingroup's position in society is considered fixed or changeable; (2) legitimacy of intergroup status differences, i.e., perceptions of whether the ingroup's low-status is fair or unreasonable; and (3) permeability of the group boundaries, i.e., perceptions of how easy or difficult it is for a member of a low-status group to change their membership to a high-status group (Reicher et al., 2010; Tajfel & Turner, 1979).

The way people from minority groups perceive the structural context in relation to a high-status group has been commonly used to examine how stigmatized people respond to stigma (e.g., Dirth & Branscombe, 2018; Fernández et al., 2012; Meadows & Higgs, 2022; Reysen et al., 2016). Such perceptions have also been shown to moderate the association between stigmatization and health outcomes (Jetten et al., 2018). For example, Plante et al., (2014) found that people who belong to a stigmatized minority (i.e., furries) perceived the socio-structural context as more permeable, stable, and illegitimate in relation to a high-status group (i.e., non-furries). As a result, these minority people were not only more likely to conceal their identity but also to report lower self-esteem. Results from this study make us question whether LG people perceive the boundaries and status between the LGBTQ + community and their heterosexual peers may interact with minority stress and shape their mental health outcomes.

4.1.2. Perceived Socio-Structural Context & LG People

We must contextualize the social identity approach (Tajfel, 1974; Tajfel & Turner, 1979) in the realities of the minority group, especially when the group is threatened by stigma. Despite the progress in the social and political equality of sexual minority people in the last few decades,

homophobia is still rampant (Charlesworth & Banaji, 2019; Flores, 2021). Hence, how LG people perceive their position in society regarding the heterosexual majority might vary tremendously, even within the same structural context.

Compared to other stigmatized groups (e.g., Black or people with disabilities), LG people can work to conceal the stigmatized attribute (i.e., their sexual identity). With the possibility of having a concealable stigmatized identity, the permeability of boundaries between those who identify as LGBTQ + and those who identify as heterosexual may be deemed porous. However, in some cases, LG people's sexual identity may not be entirely concealable due to specific social cues such as a combination of how they look, speak, act, and adorn themselves (for review, see Rule, 2017). In these cases, group boundaries may be deemed impermeable. This ambivalence between concealing LG people's sexual identity has been linked to higher distress (Pachankis et al., 2020).

A similar paradox occurs with whether LG people perceive the status of their LGBTQ + ingroup as legitimate or illegitimate. For example, Aybar Camposano et al., (2022) found that LG people who perceive the group status of the LGBTQ + community (vs. heterosexual group) as illegitimate were more likely to conceal their sexual identity. Hence, the ways LG people perceive the status and treatment of their LGBTQ + ingroup in a given context determines how they respond to and experience minority stress. Considering this, we argue that perceptions of intergroup socio-structural contexts (LGBTQ + community vs. heterosexual group) strengthen or weaken the negative association that minority stressors have on LG mental health outcomes.

4.1.3. Current Study & Hypotheses

Framed by the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987), we conducted a cross-sectional study examining if the way LG people perceive their low status LGBTQ + ingroup in relation to the high-status heterosexual outgroup (i.e., intergroup permeability, stability, and legitimacy) interacts with their experience of minority stress. We also examined the implications of this interaction on mental health. Replicating past research (Booker et al., 2017; Mongelli et al., 2019), we expected LG people experiencing elevated minority stress to report worse mental health ($H1_B$). Building upon research showing the interplay between individual and socio-structural factors among minority groups (Aybar Camposano et al., 2022; Plante et al., 2014), we also expected perception of the intergroup context as more stable (vs. unstable), permeable (vs. impermeable), and illegitimate (vs. legitimate) to amplify (vs. buffer against) adverse mental health outcomes ($H2_B$).

4.2. Method

4.2.1. Participants

Of the 277 participants who took part in our online survey, we removed those who did not complete the study (n = 46) and those who identified as gender minorities (n = 21) since their experiences with transphobia could add more intricacies to our analyses on sexual identity. The final sample included 202 participants from the United Kingdom (52.5% lesbian women) with ages between 18 and 55 years old (M = 31.43, SD = 8.56). Most participants reported being single (38.6%), currently employed (59.4%), and holding a bachelor's degree (40.1%). Subsequently, we examined differences in the sociodemographic data across sexual identity to help us determine what variables to control for in our analyses. To do so, we conducted a t-test to explore age differences and a series of chi-squares tests to assess differences across our lesbian and gay sample regarding their partnership status, employment status, and level of education. See Table 4.1. for more sociodemographic details about the sample.

Table 4.1. Sociodemographic data stratified by sexual identity and gender

Variable	Gay men (n = 96)	Lesbian women (n = 106)	Group Differences (t or X^2)
Age	33.57 (SD = 9.53)	30.12 (SD = 8.39)	$t = 2.34^*$
Relationship Status			$X^2 = 10.70$
Single	39	39	
Living with partner(s)	19	36	
In a relationship but not living together	19	10	
Married / Civil partnership	16	18	
Divorced / Separated	0	2	
Prefer not to say	3	1	
Working Status			$X^2 = 12.08$
Employed	61	59	
Self-employed / Freelancer	18	9	
Part-time	3	8	
Unemployed	6	10	
Studying	8	17	
Not able to work	0	2	
Other	0	1	
Educational Level			$X^2 = 13.25$
No formal education	2	0	
High school diploma	16	21	
College degree	14	15	
Vocational training	13	5	
Bachelor's degree	33	48	
Master's degree	16	10	
Professional degree	2	5	
Doctoral degree	0	2	

Note. $^*p < .050$

4.2.2. Measures

Minority Stress

We used the short version of the LGBTQ + Minority Stress Measure developed by Outland, (2016). Participants were asked to report their experiences with stigma and discrimination by indicating their agreement (1 = *Strongly Disagree* to 7 = *Strongly Agree*) with 25 items. The scale assesses experiences with identity concealment (four items), everyday discrimination/microaggressions (four items), rejection anticipation (four items), discrimination events (four items), internalized stigma (three items), victimization events (three items), and LGBTQ + community connectedness (three items reversed). We average all items into a single index (α = .89).

Stability, Legitimacy, & Permeability

We asked participants to indicate how stable, legitimate, and permeable were status differences between the LGBTQ + community and the heterosexual majority using five items. These items were initially developed by Mummendey et al., (1999) and later adapted to a sexual minority sample (Aybar Camposano et al., 2022). One item measured perceived stability, two items measured perceived legitimacy, and two items measured perceived permeability of group boundaries. Responses were given in 7-point rating scales (1 = *Strongly Disagree* to 7 = *Strongly Agree*). Mean scores were computed for perceived legitimacy, $r = .35$, $p < .001$, and permeability, $r = .25$, $p < .001$.

Mental Health

We used the short version of the Mental Health Continuum scale developed by Keyes (2009) to measure participants' overall mental health. Across 14 items, participants were asked to indicate how often during the past month they experienced certain feelings associated with their overall emotional well-being (three items), psychological well-being (six items), and social well-being (five items). Responses were given on 6-point rating scales (0 = *Never* to 5 = *Every day*). We average all items into a single index (α = .92), with higher scores denoting favorable mental health outcomes.

4.2.3. Procedure

We recruited a sample of LG people through Clickworker between February and April 2022. A crowdsourcing sampling method (Stewart et al., 2017) was chosen to collect the data from a diverse sample of LG people, a population that is already hard to access. Those interested were

invited to complete an online survey aimed at better understanding the perceptions and experiences of LG people and the LGBTQ + community. To participate, people had to be over the age of 18, identify as gay or lesbian, and reside in the United Kingdom. Using Clickworker's filters, we screened our target sample based on their location, age, and English fluency. Prospective participants were informed about the aims and inclusion criteria of the study as well as their rights (i.e., confidentiality, anonymity, and chance to abandon the study at any point). To proceed to the survey, people had to give their informed consent. Participants were first asked to answer sociodemographic and pre-screening questions (i.e., sexual identity). Eligible participants could then complete the measures. Participants who completed the survey were thanked, debriefed, and rewarded (1.25€). The ethical committee at Iscte - Instituto Universitário de Lisboa (approval reference number 35/2020) approved this study before data collection.

4.2.4. Analysis

The present study draws from and bridges three theoretical frameworks. The first is the minority stress model (I. H. Meyer, 2003), which depicts the adverse effects that homophobic stigma-related stressors have on LG people's mental health. The second is the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987), where we examine its framework on the perceptions between low-status and high-status groups in the LG population. Lastly, we draw from the social identity approach to health, or "social cure," applied to stigmatized groups (Jetten et al., 2018), theorizing that intergroup perceptions moderate the relationship between stigma and health outcomes.

First, we evaluated the normality assumption of the data distribution using a Kolmogorov-Smirnov test. Minority stress and mental health outcomes were normally distributed ($p \geq .200$), but legitimacy, permeability, and stability were not ($p < .001$). However, we moved forward with our analyses due to the theoretical assumptions underpinning our model and by testing our hypotheses with 95% confidence intervals from 5000 bias-corrected bootstraps to increase the robustness of the results. Second, we computed overall correlations between the variables and compared scores according to sexual identity (0 = Gay men vs. 1 = Lesbian women) using t-tests.

Lastly, our main hypotheses were then tested using a three-step hierarchical linear regression to examine whether minority stress and perceived socio-structural conditions were associated with mental health outcomes. In Step 1, we entered minority stress while controlling for age and partnership status (see Table 4.1.). In step 2, we added perceived stability,

legitimacy, and permeability scores. In Step 3, we added three two-way interactions between minority stress and each of the perceived socio-structural characteristics. We conducted simple slope analyses when significant interactions were found (Preacher et al., 2006). All variables were standardized before the analysis and before computing the interactions. Sociodemographic variables such as partnership status (0 = single vs. 1 = partnered) and level of education (0 = no higher education degree vs. 1 = higher education degree) were dummy coded to ease the interpretation of the results.

4.3. Results

4.3.1. Preliminary Analyses

Overall descriptive statistics and correlations are summarized in Table 4.2. As expected, minority stress was correlated with poorer mental health, $p = .003$, higher perceived legitimacy, $p = .001$, and lower perceived permeability of boundaries, $p = .002$. Perceived stability was correlated with higher perceived legitimacy, $p = .005$, and better mental health, $p < .001$. When examining correlations and differences in main variables according to sociodemographic data, results showed that older LG people reported less minority stress, $p < .001$. Additionally, partnered LG people reported better mental health outcomes, $p < .001$, and higher levels of perceived stability, $p = .006$.

Table 4.2. Descriptive statistics and correlations

	M	*(SD)*	1	2	3	4	5	6	7
1. Minority Stress	3.30	(.95)	—						
2. Stability	4.65	(1.35)	− .11	—					
3. Legitimacy	2.21	(1.25)	.23**	.20**	—				
4. Permeability	4.34	(1.30)	− .22**	.11	− .11	—			
5. Mental Health	37.01	(14.48)	− .21*	.29***	.04	.10	—		
6. Age	31.43	(8.56)	− .24***	.09	− .04	− .02	.12	—	
7. Partnership Status (Single = 0, Partnered = 1)	—	—	− .14	.19**	− .04	.19	.24***	.10	—
8. Education (No University Degree = 0, University Degree = 1)	—	—	− .03	.09	− .02	.06	.07	.13	.10

Note. $^{*}p < .050$, $^{**}p < .010$, $^{***}p < .001$.

To compare our main variables and participants' sociodemographic data across sexual identity, we computed a series of t-tests (see Table 4.3.). Our results showed no significant differences between lesbian women and gay men in any of the main variables, all $p \geq .210$, nor across sociodemographic data, all $p \geq .058$. Taking the results of all our preliminary analyses

together, we decided to control for our participants' partnership status and age in the main analysis.

Table 4.3. Comparisons between lesbian women and gay men

	Gay men		Lesbian women			
	M	(*SD*)	*M*	(*SD*)	*t*	Cohen's *d*
Minority Stress	3.21	(.95)	3.38	(.95)	−1.26	− .18
Stability	4.68	(1.35)	4.63	(1.35)	.24	.03
Legitimacy	2.28	(1.27)	2.14	(1.23)	.79	.11
Permeability	4.39	(1.28)	4.30	(1.31)	.51	.07
Mental Health	37.89	(14.31)	36.21	(14.65)	.82	.12
Partnership Status (Single = 0, Partnered = 1)	—	—	—	—	− .59	− .08
Education (No University Degree = 0, University Degree = 1)	—	—	—	—	−1.22	− .17

4.3.2. Minority Stress & Socio-Structural Characteristics

Results of the final regression model (see Table 4.4.) were significant $F(9, 192) = 5.15$, $p < .001$, and explained 19% of the variance. Results from our three-step hierarchical linear regression showed that the association between higher levels of minority stress and worse mental health outcomes observed in step 1, $p = .022$, and step 2, $p = .043$, was no longer significant in step 3, $p = .067$. Results also showed that the positive relationship between perceived stability and mental health found in step 2, $p = .001$, remained significant in step 3, $p = .003$.

Table 4.4. Hierarchical multiple linear regression (unstandardized regression coefficients)

Predictors	Outcome: Mental Health		
	Step 1	Step 2	Step 3
Step 1			
Partnership Status (Partnered = 1; Single = 0)	.42**	.33*	.33*
Age	.01	.01	.01
Minority Stress	− .17*	− .15*	− .13
Step 2			
Legitimacy		.03	.04
Stability		.23**	.21**
Permeability		.02	.02
Step 3			
Minority Stress x Legitimacy			.15*
Minority Stress x Stability			− .17*
Minority Stress x Permeability			− .07
ΔR^2	.09	.06	.04
ΔF^2	6.55***	1.02***	.38***

Note. $^{*}p < .050$, $^{**}p < .010$, $^{***}p < .001$.

Directly related to our hypotheses, we found significant interactions between minority and stability, p = .012, and between minority stress and legitimacy, p = .046. In contrast, the interaction between minority stress and permeability was non-significant, p = .308. Simple slope analyses showed that LG people with elevated minority stress reported worse mental health outcomes when they perceived more stability in the socio-structural context, $b = -.432$, $p < .001$ (see Figure 4.1.). This association was non-significant when LG people perceived instability, b = .192, p = .207. LG people with elevated minority stress also reported worse outcomes to their mental health when they perceived more illegitimacy in the socio-structural context, $b = -.275$, p = .006, but not when they perceived more legitimacy, b = .210, p = .276 (see Figure 4.2.).

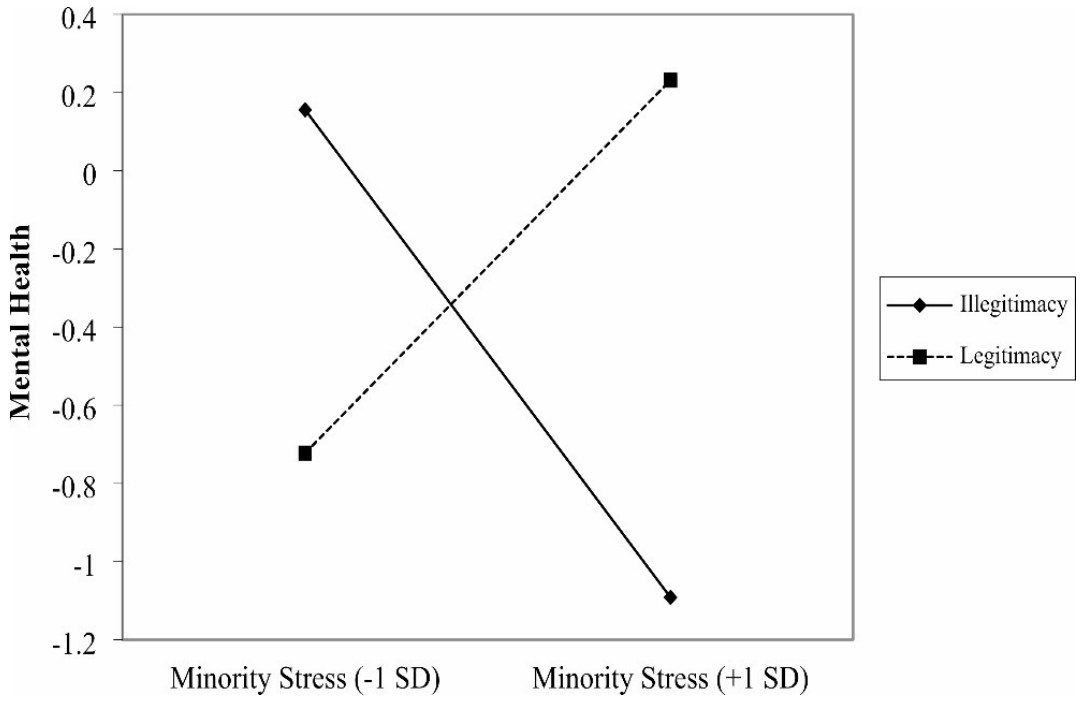

Figure 4.1. Two-way interaction (minority stress x legitimacy) on mental health outcomes

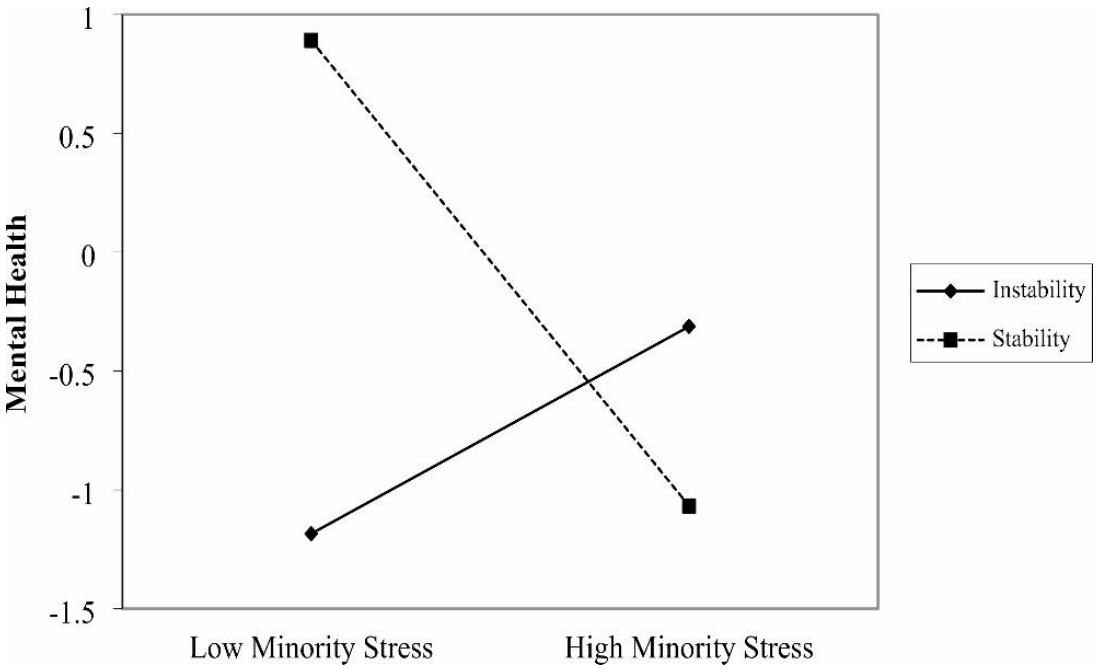

Figure 4.2. Two-way Interaction (minority stress x stability) on mental health outcomes

4.4. Discussion

Our main goal was to better understand the unique experiences of LG people with minority stress (I. H. Meyer, 2003) in light of the social identity approach (Tajfel & Turner, 1979; Turner et al., 1987). We examined whether socio-structural characteristics (i.e., stability, permeability, and legitimacy) about the relations between the LGBTQ + minority group and the heterosexual majority could shape the relationship between minority stress and mental health among LG people. As hypothesized, our results align with past research (Booker et al., 2017; Frost & I. H. Meyer, 2023; Mongelli et al., 2019; Wittgens et al., 2022), showing that minority stress was negatively associated with LG people's mental health outcomes. In addition, we found that LG people who experienced higher levels of minority stress *and* perceived the status of the LGBTQ + community as stable or illegitimate reported worse mental health outcomes.

Our findings also aligned with social identity theory applied to health (Jetten et al., 2018). Specifically, our results add to the body of research examining the influence perceptions of the social context can have on the health of groups with stigmatized attributes (Fernández et al., 2012; Meadows & Higgs, 2022; Plante et al., 2014). More importantly, our findings go beyond mechanistic readings from the social identity approach, which tends to generalize social identity theorizing to groups as if they were all equal at the expense of overlooking individual group differences and the context where they are situated (Brown, 2020). Instead, this study helps advance our knowledge by focusing on the nuances of living with a stigmatized sexual identity

in contexts where the perceptions of LG people are rapidly changing (Flores, 2021). Hence, our study emphasizes that the adverse relationship between minority stress and mental health is not only associated with having a particular sexual identity but also with how people perceive their identity within a broader social context.

Our findings have three main implications. First, to address mental health inequalities based on sexual identity, we must also account for how LG people perceive the status of their group. The present study shows that those who perceive the LGBTQ + community's position in society as stable for the foreseeable future in conditions of higher minority stress showed worse mental health outcomes. Even though structural changes are effective in promoting the acceptance and well-being of sexual minorities (e.g., Hagen & Goldmann, 2020; Pachankis & Bränström, 2018; van der Star et al., 2021) most focus on reducing stressors rather than fostering individual responses to stigma (see Chaudoir et al., 2017). Structural changes are needed, but widespread and sustainable changes are a slow-moving process (Charlesworth & Banaji, 2019). Hence, structural level changes could benefit from LGBTQ+ affirming interventions (Pachankis et al., 2022) and individual-level strategies (e.g., Helminen et al., 2023) to not only reduce stigma but also help LG people cope with it. For instance, connecting LG people with LGBTQ + community centers can help challenge their notion of the LGBTQ + community being of inferior status to those who identify as heterosexual.

Second, those LG persons perceiving the status of the LGBTQ + community as illegitimate may require additional mental health support. When historically oppressed minorities perceive their status in society as illegitimate, they tend to label the treatment and exclusion of their group as discrimination (e.g., Dirth & Branscombe, 2018). In turn, minorities are more likely to engage in collective action to enhance their group's condition (Branscombe et al., 2012; Meadows & Higgs, 2022; Reysen et al., 2016). Our findings suggest that those who perceive the minority status and treatment of the LGBTQ + community as illegitimate are more aware of and susceptible to minority stressors. Hence, laws and policies challenging the legitimacy of the LGBTQ + group status could be accompanied by support and resources to reprieve LG people from minority stressors at an individual level. Such support and resources could translate into more resources for local LGBTQ + organizations and activists since they are often underfunded (Howe & Frazer, 2018).

Third, our study did not find evidence that minority stress and perceived permeability interacted with LG people's mental health outcomes. These results do not entirely align with social identity theorizing since the social identity approach states that those who can conceal their stigmatized identity usually due to "pass" as a member of a high-status group (for review,

see (Jetten et al., 2018). Said active concealment is done by LG people even if it harms their health (Pachankis et al., 2020). Yet, as acceptance of LG people increases in the United Kingdom (Flores, 2021), their perceived ability to conceal their low-status group membership might not aggravate the health-damaging effects of minority stress as much as their perceived group status in society. Overall, our findings suggest that it could be more beneficial to LG people's mental health to challenge their perceived illegitimacy and stability of the LGBTQ + group status rather than tackle its alleged boundaries with the heterosexual outgroup.

4.4.1. Limitations & Future Studies

Given the study's correlational nature, we are unable to draw causation between the variables and interactions. Also, the generalizability of the results is limited since we only examined the perceptions of LG people in the United Kingdom. Moreover, LG people are diverse and have countless social identities, some of which are stigmatized and intersect with the experiences of sexual identity. For example, we did not account for how race, ethnicity, culture, and gender identity interact with intergroup perceptions of the socio-structural context, minority stress, and mental health (e.g., Schmitz et al., 2020). Future studies could aim to conduct longitudinal studies to draw causation between the variables examined in this study. Other avenues of research could explore the perceived permeability, stability, and legitimacy of LG people outside the United Kingdom or even contrast the perceptions of those living in countries with more vs. less LGBTQ + structural stigma (e.g., Pachankis & Bränström, 2018).

To improve the generalizability of our results, researchers could take a closer look at the intergroup perceptions of different subpopulations of the LGBTQ + community. For instance, examining how trans or gender non-conforming people perceive their ingroup with cis-gender high-status outgroup influences the association between transphobic stigma and health. Said examination can prove helpful in understanding and tackling gender-based health inequalities (Lefevor et al., 2019). Lastly, future studies could examine how minority stress and the various constellations of the interactions between legitimacy, stability, and permeability relate to health outcomes among those with plurisexual, asexual and gender diverse identities.

4.5. Conclusion

This study applied and extended social identity theorizing of how minority stress and how LG people perceive the context of the LGBTQ + ingroup in contrast to their heterosexual outgroup are related to mental health. LG people with higher levels of minority stress and who perceive the minority position of the LGBTQ + community with the heterosexual group as remaining

stable for the foreseeable future reported worse mental health scores. Similarly, perceiving the intergroup status and treatment of the LGBTQ + community as illegitimate while also conveying elevated minority stress worsens their mental health outcomes. Our results can help inform policymakers and practitioners about individual-level strategies, such as challenging how LG people perceive their position and treatment in society. Said strategies can prove helpful in addressing the mental health inequalities caused by minority stressors.

Chapter 5

Individual & Collective Identity Strategies on Mental Health Outcomes

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Lesbian and gay (LG) people experience minority stressors, resulting in adverse mental health outcomes. To cope, many LG people engage in individualistic or collectivistic strategies, that is, self-distancing or connecting with their in-group, the LGBTQ+ community. Even though research suggests what may help LG people cope with minority stress, it is less clear *how* and *under which conditions* they do so. In this study, we examine how LG people employ individualistic and collectivistic strategies and what that entails for the negative relationship between minority stress and mental health. A total of 199 responses from British LG people were collected via the online crowdsourcing platform Clickworker. A custom mediation model indicated that, for collectivistic strategies, higher levels of minority stress were associated with increased LGBTQ+ community identification, and LGBTQ+ identification was positively related to high LGBTQ+ social support; in turn, LGBTQ+ social support was associated with positive mental health outcomes. For individualistic strategies, results show higher minority stress was related to an increased likelihood of individual mobility, but individual mobility was not associated with mental health outcomes. These findings highlight how collectivistic responses to minority stress might prove more reliable than individualistic ones in enhancing the mental health of LG people.

Keywords: Mental health; minority stress; LGBTQ+; social identity; coping.

5.1. Introduction

The overall state of rights and protection for lesbian and gay (LG) people worldwide is better than in prior decades (Pew Research Center, 2020). Yet, many LG people still face multiple forms of stigmatization and discrimination due to their sexual identity, both subtle (i.e., microaggressions, internalized homophobia, and rejection-anticipation) and blatant (i.e., violence, harassment, and exclusion; for a review, see (Lund et al., 2021). Navigating life with a stigmatized sexual identity has been consistently linked to poor mental health outcomes (for a review, see Mongelli et al., 2019; Wittgens et al., 2022). Indeed, LG people are more likely than the general population to be diagnosed with psychopathologies such as anxiety and depression, eating disorders, and substance abuse (Krueger et al., 2020; Parker & Harriger, 2020; Semlyen et al., 2016). There is also evidence that LG people are more likely than heterosexual people to engage in self-harm, suicide attempts, and sexual risk-taking behaviors (Fox et al., 2018; Layland et al., 2020; Sarno et al., 2020).

Researchers over the last 40 years have consistently found evidence that LG people are not inherently predisposed to mental health disorders, but instead, homophobic social conditions create unique stressors for LG people due to their minority position, leading to psychological distress (i.e., minority stress; see (Brooks, 1981; Frost & I. H. Meyer, 2023; Hatzenbuehler, 2009). The results of this growing body of work were systematized and popularized by I. H. Meyer (2003) minority stress model. Studies framed by this model, however, tend to focus on the *factors that explain* mental health inequalities rather than examining *how to address* these inequalities.

Mental health inequalities between LG and heterosexual people can be addressed at the macro, interpersonal, or individual level (van der Star, 2020). Policies and structures that support LG people are essential and likely to improve their life satisfaction and reduce their experiences with victimization (Pachankis & Bränström, 2018; van der Star et al., 2021). Macro-level interventions are invaluable in the prevention, reduction, and elimination of the root causes of minority stressors, heterosexism, and heteronormativity. Yet, as some authors have pointed out, interventions at a macro or systemic level are a slow-moving process and fail to offer immediate relief from the effects of minority stress (Chaudoir et al., 2017). Hence, researchers should focus on achieving systemic changes *as well as* striving to understand and promote the individual and interpersonal strategies LG people use to cope with minority stress.

LG people are not powerless and find various ways of dealing with stress (Hatzenbuehler, 2009; I. H. Meyer, 2003). For instance, LG people might respond to minority stress by managing their sexual identity by embracing their LGBTQ+ identity or concealing it depending

on the context (e.g., Fuller et al., 2009; Krane & Barber, 2003). These strategies offer some protections against minority stress but, at the same time, present unique challenges for LG people (e.g., increased visibility vs. hypervigilance; Hinton et al., 2022; Pachankis et al., 2020). Hence, living with a stigmatized sexual identity and minority stress is complex and nuanced.

Even though the minority stress model (I. H. Meyer, 2003) outlines the causes of minority stress and some of its buffers, it is less clear how and under which conditions LG people cope with this stress and what it entails for their mental health. One exception is a study conducted by (Camposano et al., 2024) in which the authors found that the negative association between minority stress and mental health outcomes is dependent on how LG people perceive the group dynamics between the LGBTQ + community and heterosexual people. Specifically, LG people reported worse mental health outcomes when they perceived the position of the LGBTQ+ community as likely to remain inferior to heterosexual people (i.e., stability). LG people also seem more susceptible to the adverse outcomes of minority stress when they perceive the lower status of the LGBTQ+ community concerning heterosexual people as unfair (i.e., illegitimacy). If perceptions regarding the LGBTQ+ community may influence the adverse outcomes of minority stress, the same could be true for the various ways LG people build their sense of self in relation to their group. Extending these findings, the current study examines how LG people's relationship with their LGBTQ+ identity and group functions as a coping mechanism for minority stress and whether this has implications for their mental health. To do so, we used the social identity approach to health (SIA-H; Jetten et al., 2012) in conjunction with the minority stress model (I. H. Meyer, 2003) to provide a better understanding of the complexities and nuances of stigma, sexual identity, and health.

5.1.1. Social Identity, Stigma, & Mental Health

Stemming from classic social identity theorizing (Tajfel & Turner, 1979; Turner et al., 1987) the SIA-H is a theoretical framework emphasizing how social identities and groups shape peoples' health- related behaviors and outcomes (S. A. Haslam et al., 2009; Jetten et al., 2012). People belong to different groups based on their beliefs, behavior, or characteristics (e.g., sexual orientation). When these groups are internalized as integral to the sense of self, people develop social identities (Reicher et al., 2010), which, in turn, are deeply embedded in how people experience and understand the world and shape their attitudes, beliefs, and behaviors (Scheepers & Ellemers, 2019). Through group memberships and the social identities that stem from them, people can connect with and rely upon fellow group members and, as a result, impact their overall health (Jetten et al., 2018).

A growing body of research has shown that social identities can provide an array of psychological resources that enhance people's mental health, including higher self-esteem, reduced stress levels, collective efficacy, and social support (e.g., Haslam et al., 2005; Jetten et al., 2015; McNamara et al., 2013). This has been referred to as the 'social cure' (Jetten et al., 2012). For example, a systematic review showed that ethnic minorities and migrants who had an increased identification with their national or ethnic social identities also reported fewer symptoms of anxiety and depression (Brance et al., 2023). However, when people's social identity is attached to a low-status or stigmatized group, this can have adverse mental health outcomes, functioning as a 'social curse' (Jetten et al., 2018; Wakefield et al., 2019). This 'social curse' can be illustrated with groups such as people with leprosy living in Nepal who often experience isolation and depleted social resources due to their social group (Jay et al., 2021). The duality of the SIA-H emphasizes that living with stigmatized social identities, such as those of LG people, functions as a double-edged sword for their well-being (Jetten et al., 2018).

Insights from the SIA-H might sound paradoxical, but they also capture the nuances of living with a stigmatized identity and what that entails for people's overall health (Çelebi et al., 2017; Cooper et al., 2017; McNamara et al., 2013). Additionally, the 'social cure' framework allows us to go beyond mechanical readings of classic social identity theory and examine the specific groups and identities we aim to better understand, in this case, LG people. For these reasons, using the SIA-H as a lens can be helpful in disentangling LG people's relationship with their LGBTQ+ group membership and the social identities that stem from this, even while experiencing minority stress.

5.1.2. LGBTQ+ Social Identity, Coping, & Minority Stress

As mentioned earlier, many LG people experience various minority stressors across different life stages, domains, and countries, resulting in mental distress (Casey et al., 2019; Moleiro et al., 2021; Rice et al., 2021). I. H. Meyer (2003) model distinguishes between minority stressors based on how distal or proximal they are concerning LG people. Distal minority stressors entail violence and discrimination perpetuated by individuals and oppressive systems against LG people. Conversely, proximal stressors are the internal interpretations of said homophobic oppression, such as LG people perceiving themselves as a potential target of discrimination, internalizing homophobia, and the anxieties associated with concealing their sexual identity. Aside from helping identify various minority stressors and how they negatively impact LG

people's mental health outcomes, I. H. Meyer's (2003) model also proposes that LG people's connectedness to the LGBTQ+ community can help buffer this relationship.

Being connected to the LGBTQ+ community can help function as a form of collective resilience, alleviating some of the adverse outcomes of minority stress (I. H. Meyer, 2015). Studies show that connectedness to the LGBTQ+ community can improve LG people's mental health and well-being (see I. H. Meyer & Frost, 2012). LGBTQ+ community connectedness can also lessen the risk of developing psychopathologies (Petruzzella et al., 2019), engagement in risky sex practices (Hammack et al., 2018), and suicidal behavior (Kaniuka et al., 2019). Conversely, certain ways of engaging with the LGBTQ+ community can have damaging consequences to the health of LG people. For instance, finding a community within LGBTQ+ nightlife spaces can increase LG people's substance abuse (Demant et al., 2018) and eating disorders (Davids et al., 2015).

The health-enhancing properties and some of the risks of being connected (or not) to the LGBTQ+ community are well documented (for a review, see Foster-Gimbel et al., 2020). Nevertheless, we are less certain about the underlying processes of LGBTQ+ community connectedness that can help (or not) LG people manage the mental distress evoked by minority stressors. That is because the relationship between identity and health is complex, and it is further complicated when factoring in people's experiences with stigmatization. In this study, we propose using the SIA-H to dissect and closely examine the components that allow LG people to connect (or not) to the LGBTQ+ community – specifically, LGBTQ+ identification and social support, as well as distancing from the LGBTQ+ community as ways to cope with minority stress.

Classic social identity theory posits that people are motivated to maintain a positive social identity even when a group membership is of lower status or stigmatized by engaging in different strategies to manage their social identities (Scheepers & Ellemers, 2019). When minority or stigmatized people experience group-based discrimination, they generally engage in collectivistic or individualistic identity management strategies to cope with the stigma (Jetten et al., 2018). That is, when a member of a stigmatized group confronts discrimination by actively distancing themselves from their minority identity (i.e., individualistic strategy) or by embracing it and connecting to others who share that identity (i.e., collectivistic strategy).

On the one hand, collectivistic strategies refer to when the stigmatized person rejects the stigmatization culture and aligns themselves with others who share similar characteristics rather than the dominant group (Branscombe et al., 2012). This premise underpins and expands on the rejection-identification model proposed by Branscombe et al., (1999), which suggests that

people identify with a low-status group as a response against perceived discrimination to enhance their health and well-being. Identification with their stigmatized group can allow people to redefine their low-status identities and establish social connections with like-minded peers, enabling them to reap the health-enhancing benefits of the 'social cure' (e.g., Bogart et al., 2018; Brance et al., 2023; McNamara et al., 2013). Group strategies function as a social safety net and help improve the status of the stigmatized group (Branscombe et al., 2012; Krane & Barber, 2003).

For example, LG people may oppose a heteronormative culture and join their sexual and gender minority peers to build their own spaces and communities (Hailey et al., 2020). In addition to social support, through the LGBTQ+ community, LG people can redefine their stigmatized social identity from a shameful characteristic to something to be proud of and celebrated (e.g., (K. M. F. Bruce, 2013). Even though collectivistic identity management strategies may seem helpful in unlocking the benefits of the 'social cure' for LG people, the increased visibility of their sexual identities and association with the LGBTQ+ community may also increase their exposure to homophobic violence and discrimination (Hinton et al., 2022).

On the other hand, individualistic strategies are when those with a stigmatized social identity reject their group membership and instead identify with a high-status out-group (Branscombe et al., 2012). By doing so, some stigmatized people hope to avoid discrimination by not being labelled as members of a stigmatized group (Jetten et al., 2018). To this end, stigmatized people engage in individual mobility to navigate life by masquerading as high-status group members (Scheepers & Ellemers, 2019). In the case of LG people, individual mobility often translates to cutting ties with the LGTBQ+ community, acting as a heterosexual person (i.e., passing), and desiring to 'become' straight or even actively working it (Krane & Barber, 2003).

For many LG people, individual mobility can take many forms. For example, a gay man actively conceals his sexual orientation and tries to 'pass' as heterosexual in the workplace to avoid harassment from his colleagues. Individual mobility could also present itself as a lesbian woman marrying a heterosexual person to escape homophobic discrimination. Even though individual mobility can protect LG people from discrimination, it usually does not reprieve them from its more subtle iterations (Fuller et al., 2009). When LG people engage in individual mobility to conceal their sexual identity, they may experience feelings of shame, guilt, and hypervigilance, which can contribute to depression and anxiety (Pachankis et al., 2020).

Overall, both collectivistic and individualistic identity management strategies provide members of minority groups with their fair share of protection against and exposure to stigma.

Nevertheless, some authors suggest that collectivistic strategies might be more reliable than individualistic ones for those with stigmatized identities, as in-group social resources are more readily available (Jetten et al., 2018). Also, when those engaging in collectivistic strategies cannot cope with discrimination, the fault is attributed to an (Branscombe et al., 2012) oppressive system, but those employing individualistic strategies take it as a personal failing. A sense of personal failure, a lack of social safety nets, and a lack of community might leave those engaging in individualistic strategies more vulnerable to minority stress when compared to collectivistic ones. Both these strategies have been examined among other social groups who experience discrimination (e.g., Bobowik et al., 2017; Fernández et al., 2012; Molero et al., 2011), but to our knowledge, no study has studied them in the context of LG people, the LGBTQ+ community, and their unique experiences with minority stress.

5.1.3. The Present Study

We conducted a cross-sectional study framed by the SIA-H (Jetten et al., 2012), examining how and under which conditions LG people use different identity management strategies to cope with the adverse effects of minority stress. We specifically examined whether the negative relationship between minority stress and mental health among LG people was mediated by both increased LGBTQ+ community identification and LGBTQ+ social support as a collectivistic strategy, as well as individual mobility as an individualistic strategy. Based on insights from the rejection-identification model (Branscombe et al., 1999) and 'social cure' framework (Jetten et al., 2012), we hypothesized that higher levels of minority stress were associated with greater identification with the LGBTQ+ community, greater identification with the LGBTQ+ community will be related to higher perceived LGBTQ+ social support, and in turn, this will be associated with better mental health outcomes ($H1_C$). Lastly, we posit that minority stress will be related to higher levels of individual mobility, and individual mobility will be negatively associated with mental health outcomes ($H2_C$). Our hypotheses are depicted in Figure 5.1.

The present study is informed by and expands the data from a previous article by (Camposano et al., 2024) to better examine how LG people use their social identity to cope with minority stressors. Results from that study showed that partnered and older LG people reported less minority stress.

Additionally, LG people who perceived the status between the LGBTQ+ community and heterosexual people as illegitimate and stable reported more adverse mental outcomes while experiencing minority stress. Hence, the present study controlled for socio-demographic data

such as partnership status and age, as well as the degree to which LG participants perceived the low-status position of the LGBTQ+ community as illegitimate and stable.

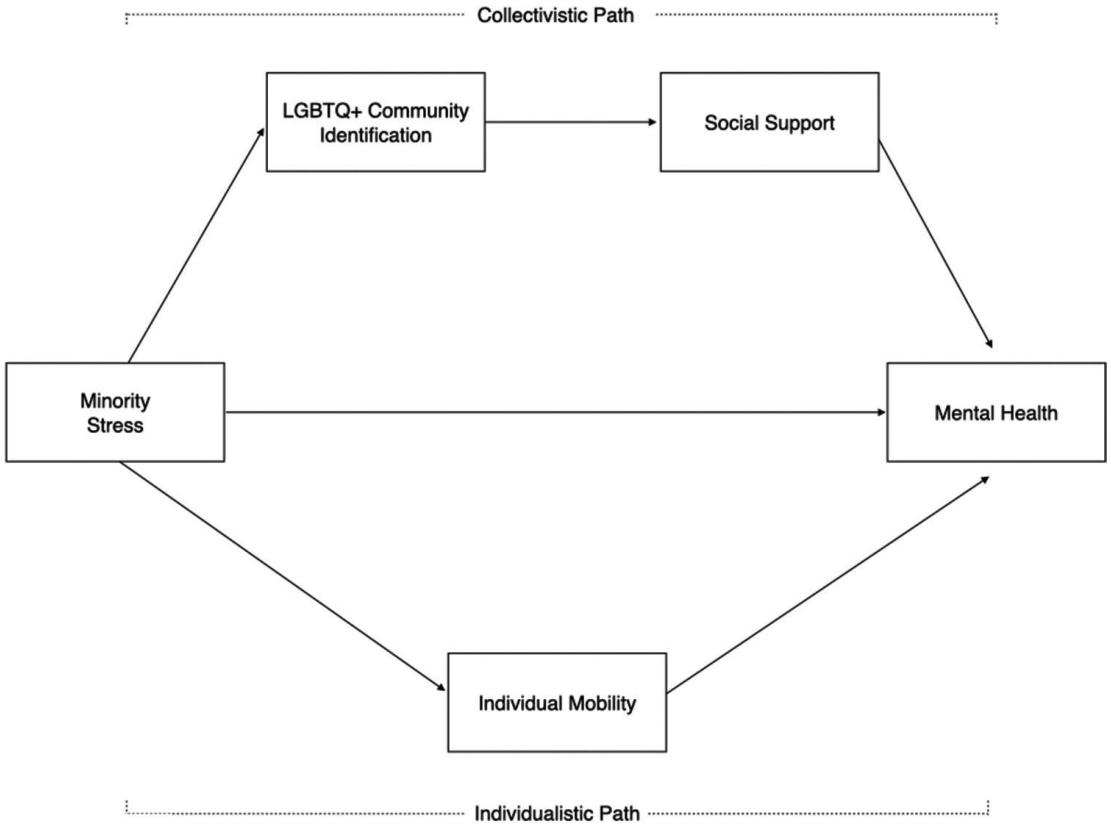

Figure 5.1. Conceptual model of custom parallel mediation model

5.2. Methods

5.2.1. Participants

We used data from a previous study (Camposano et al., 2024). A total of 277 people participated in this study. However, those who did not complete the survey (n = 46), sped through it in an unfeasible amount of time (i.e., $M_{\text{Time}} \leq 2$ minutes; n = 8), and failed commitment checks (n = 3) were excluded. In addition to this, other members of the LGBTQ+ community (n = 21) who self-identified as being a sexual minority other than gay or lesbian (e.g., bisexual) or as a gender minority (e.g., trans), regardless of their sexual orientation, were not included in the final analyses. We made this decision since the experiences with phenomena such as biphobia or transphobia could intersect and add further complexity to our examination of sexual identity. Additionally, our sample of this population was too small to compare with the LG group. Our final sample consisted of 199 British lesbian women (52.8%) and gay men (47.2%) aged

between 18 and 55 years old (M = 31.27, SD = 8.47). Most participants reported having a bachelor's degree (40.7%), being single (38.7%), and currently employed (58.8%).

5.2.2. Measures

Minority Stress

We assessed the levels of minority stress by using the short version of the LGBTQ+ Minority Stress Measure (Outland, 2016). The scale consists of 25 items assessing participants' level of agreement (1 = *Strongly disagree* to 7 = *Strongly agree*) regarding sexual identity-based stigmatization across seven subscales. We decided to drop the Community Connectedness subscale (three items, e.g., 'I feel that I could find a public space that is supportive of LGBTQ+ activities') because we were particularly interested in assessing LG people's experiences with stigma-related stressors. The remaining 22 items used in this study measured LG people's experiences with victimization (three items; e.g., 'Others have bullied me because I am LGBTQ+'), internalized stigma (three items; e.g., 'If I was offered the chance to be someone who is not LGBTQ+, I would accept the opportunity'), discrimination events (four items; e.g., 'I have been excluded from an organization [e.g., a religious group, sports team, etc.] because I am LGBTQ+'), rejection anticipation (four items; e.g., 'I expect that others will not accept me because I am LGBTQ+'), everyday discrimination/microaggressions (four items; e.g., 'I am expected to educate non-LGBTQ+ people about LGBTQ+ issues'), and identity concealment (four items; e.g., 'I do not bring a date to social events because I do not want others to know I am LGBTQ+'). Responses were mean averaged into a single index (α = .90), with higher scores indicating an increased level of minority stress.

LGBTQ+ Community identification

We used the Multidimensional Scale of Social Identification (Leach et al., 2008) to measure how participants identify with a specific in-group. This scale can be adapted to any given in-group. For this study, we focused on the LGBTQ+ community. The scale has a total of 14 items distributed in five subscales assessing different aspects of in-group identification such as solidarity (three items; e.g., 'I feel committed to the LGBTQ+ community'), satisfaction (four items; e.g., 'I am glad to be LGBTQ+'), centrality (three items; e.g., 'The fact that I am LGBTQ+ is an important part of my identity'), individual self-stereotyping (two items; e.g., 'I have a lot in common with the average LGBTQ+ person'), and in- group homogeneity (two items; e.g., 'LGBTQ+ people have a lot in common with each other'). Responses were given on seven-point rating scales (1 = *Strongly disagree* to 7 = *Strongly agree*). We average items

into a single index (α = .95), with higher scores indicating greater identification with the LGBTQ+ community.

Social Support

We used four items adapted from van Dick and Haslam (2012) to measure the perceived levels of social support from the LGBTQ+ community (e.g., 'I get the help I need from other members of the LGBTQ+ community'). Responses were given on seven-point rating scales (1 = *Strongly disagree* to 7 = *Strongly agree*). We average items into a single index (α = .94), with higher scores indicating perceived support from the LGBTQ+ community.

Individual Mobility

We used the four items proposed by Blanz et al., 1998 adapted to sexual minorities (Aybar Camposano et al., 2022) to assess the likelihood of LG people engaging in individual mobility (e.g., 'I try to live as straight rather than as a lesbian or gay individual'). Specifically, individual mobility in this study refers to distancing from the LGBTQ+ in-group to 'pass' as a member of the heterosexual out- group. Responses were given on seven-point rating scales (1 = Strongly disagree to 7 = Strongly agree). We average all items into a single index (α = .86), with higher scores indicating a higher likelihood of engaging in individual mobility.

Mental Health

To measure the mental health of LG people, we used the Mental Health Continuum Short Form (Keyes, 2009).This instrument has 14 items comprised of three subscales assessing participants' levels of emotional (three items; e.g., 'During the past month, how often did you feel happy?') social (five items; e.g., 'During the past month, how often did you feel happy that people are basically good?'), and psychological well-being over the past month (six items; e.g., 'During the past month, how often did you feel confident to think or express your own ideas and opinions?'). Responses were given on seven-point rating scales (0 = *Never* to 6 = *Every day*). We summed all items into a single index (α = .92), with higher scores indicating participants reporting positive mental health outcomes.

5.2.3. Procedure

Prior to data collection, this study was approved by the ethical committee at Iscte - Instituto Universitário de Lisboa (reference number 35/2020). LG participants were recruited on the online crowdsourcing platform Clickworker. To narrow our search for prospective participants,

we used Clickworker's built-in pre-screeners to filter participants over 18 who were in the United Kingdom and fluent in English. Those eligible were presented with the possibility of participating in an online study, advertised as seeking to better understand the experiences of lesbian women and gay men with the LGBTQ+ community. Those interested had to electronically sign an informed consent form outlining the study's goal before proceeding to the study. This contained information about inclusion criteria, anonymity, confidentiality, and the possibility of dropping out of the study at any moment. Afterwards, participants were tasked to provide socio-demographic information about themselves and answer a series of pre-screening questions that we included to ensure participants were over the age of 18, self-identified as cisgender gay men or lesbian women, and lived in the United Kingdom. Then, participants answered questions regarding their experiences with minority stress, their relationship with the LGBTQ+ community, and mental health. At the end of the survey, participants were thanked for their time and were credited with €1.35 in their user account as compensation for their time.

5.2.4. Analytic Plan

As preliminary analyses, we computed correlations and *t*-tests to compare participants across their sexual identities. Using the PROCESS macro (Hayes, 2017), we conducted a custom parallel mediation model in our main analysis. We centered the means, and the indirect effects were tested with 5,000 bias-corrected bootstrapping and 95% confidence intervals (CI) for the indices. One model with two parallel mediation paths was tested. One path examined whether the relationship between minority stress and mental health was mediated by identification with the LGBTQ+ community and then by social support (i.e., collectivistic strategy path). The other path tested whether individual mobility mediated the relationship between minority stress and mental health (i.e., individualistic strategy path; see Figure 5.1.). Based on the results of the previous study conducted with this data (see Camposano et al., 2024), we controlled for how LG perceived the group status of the LGBTQ+ community (i.e., illegitimacy and stability), partnership status, and age in both models.

5.3. Results

5.3.1. Preliminary Analyses

An overview of the descriptive statistics and correlations can be found in Table 5.1. The results indicate that all expected correlations among our main variables were significant. Minority stress was correlated with poorer mental health outcomes, $p < .001$, higher LGBTQ+

community identification $p < .001$, increased levels of perceived social support, $p = .007$, and a higher likelihood of engagement in individual mobility, $p < .001$. Additionally, LGBTQ+ community identification was correlated with more LGBTQ+ social support, $p < .001$, but also with a lower likelihood of engagement in individual mobility, $p < .001$, and poorer mental health, $p < .001$. Perceived social support from the LGBTQ+ community was correlated with less engagement with individual mobility, $p = .024$, and positive mental health outcomes, $p < .001$. Lastly, individual mobility was correlated with adverse mental health outcomes, $p = .009$.

We conducted a series of *t*-tests to examine possible sexual identity differences across our sample (see Table 5.2.). Our results show no significant differences between gay men and lesbian women in any of the major variables, all $p \geq .202$.

Table 5.1. Descriptive statistics and correlations

	M	*(SD)*	1	2	3	4	5
1. Minority Stress	3.34	(1.08)	—				
2. LGBTQ+ Community Identification	4.82	(1.25)	.27***	—			
3. Social Support	4.73	(1.51)	.19**	.60***	—		
4. Social Mobility	2.32	(1.31)	.42***	−.27***	−.16*	—	
5. Mental Health	37.17	(14.38)	−.20**	.27***	.25***	−.19**	—

Note. *$p < .050$, **$p < .010$, ***$p < .001$.

Table 5.2. Comparisons between gay men and lesbian women

	Gay men		Lesbian women			
	M	(*SD*)	*M*	(*SD*)	*t*	Cohen's *d*
Minority Stress	3.23	(1.09)	3.43	(1.06)	−1.28	−.18
LGBTQ+ Community Identification	4.71	(1.28)	4.92	(1.22)	−1.20	−.17
Social Support	4.64	(1.46)	4.81	(1.56)	−.79	−.11
Social Mobility	2.30	(1.40)	2.34	(1.23)	−.22	−.03
Mental Health	38.15	(14.03)	36.30	(14.70)	.91	.13

5.3.2. Main Analysis

Results from the mediation analysis (see Figure 5.2.) indicate a negative and significant total effect (i.e., when none of the mediators are accounted for) between minority stress and mental health, $b = -.20$, $SE = .07$, $p = .005$. When accounting for the mediators in our analysis, known as its direct effect, this association remains negative and significant, $b = -.17$, $SE = .08$, $p = .023$. When focusing on the collectivistic strategy mediation path, results showed that higher levels of minority stress were related to higher LGBTQ+ community identification, $b = .25$, $SE = .07$, $p = .001$. In turn, higher LGBTQ+ identification was associated with more perceived social support, $b = .59$, $SE = .06$, $p < .001$. Lastly, higher levels of perceived LGBTQ+ social support were related to positive mental health outcomes, $b = .30$, $SE = .07$, $p < .001$. Analysis

of the indirect effects showed that the path between minority stress and mental health while controlling for LGBTQ+ community identification and social support was significant, b = .04, SE = .02, 95% CI [.01, .08].

Examining the individualistic strategy mediation path, we found that higher levels of minority stress were associated with a higher likelihood of engaging in individual mobility, b = .32, SE = .06, p < .001. However, individual mobility was not significantly related to mental health outcomes, b = −.04, SE = .09, p = .633. Further analysis of the indirect effect shows that the path between minority stress —> individual mobility —> mental health was not significant, b = −.01, SE = .03, 95% CI [−.07, .09].

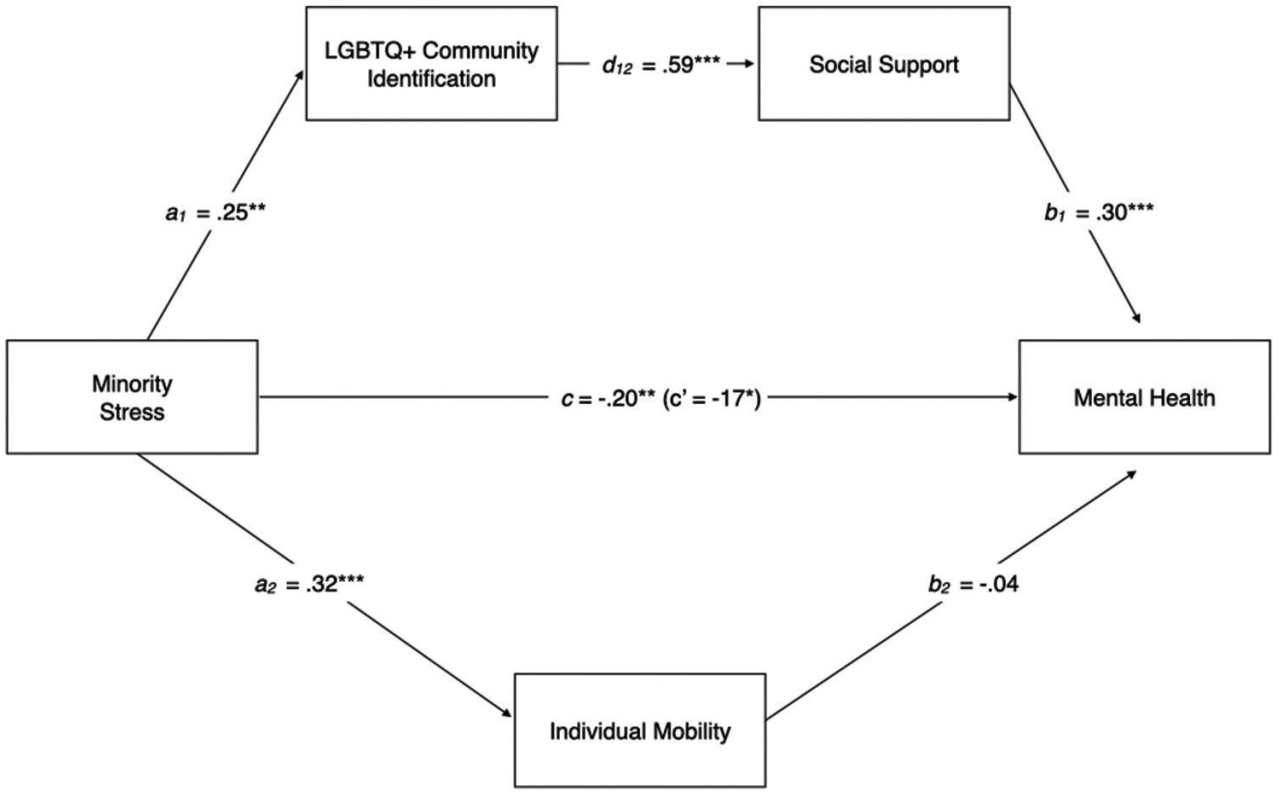

Figure 5.2. Parallel mediation model.

5.4. Discussion

Living with a stigmatized sexual identity is a complex endeavor, resulting in LG people negotiating their social identities to endure the effects of minority stress. In this study, we took a closer look at how LG people can cope with minority stress. Specifically, we examined the usage of individual mobility as an individualistic strategy and LGBTQ+ identification and social support as a collectivistic one. LG people maneuver to manage their social identities as a response to minority stressors and what that entails for their mental health. As expected, we

found evidence that higher levels of minority stress increased identification with the LGBTQ+ community, unlocking perceived social support from its members, which was associated with positive mental health outcomes. Our results also show that when faced with minority stress, LG people are likely to engage in individual mobility. However, individual mobility was not associated with their mental health outcomes. These results not only align with literature from the 'social cure' framework (Jetten et al., 2012), rejection- identification model (Branscombe et al., 1999), and minority stress model (I. H. Meyer, 2003), but also extend it by applying the SIA-H to the unique experiences of LG people with minority stress. The findings of this study have two main implications. One is the benefits of bridging the SIA-H (Jetten et al., 2012) with the minority stress model (I. H. Meyer, 2003). The second is to contrast the potential effectiveness of individualistic coping strategies with collectivistic ones among LG people.

We would like to reiterate that sexual identity-based mental health inequalities are mainly due to the pernicious consequences of heterosexism and heteronormativity in the lives of LG people. Frost and I. H. Meyer (2023) warn researchers working with minority stress interventions about the perils of emphasizing LG people's resources instead of investing in institutional solutions supporting LGBTQ+ communities. This article and its results do not state that dealing with minority stress is the sole responsibility of LG people. Instead, we argue that individual and community-level solutions should also be accounted for when dealing with the border issue of homophobia and its stressors. In addressing the multifactorial phenomena of minority stress, frameworks such as the SIA-H can help researchers and practitioners make sense of how to better support LG people and what tools can be used to do so.

Coupling the minority stress model (I. H. Meyer, 2003) with the 'social cure' framework (Jetten et al., 2012) and the rejection-identification model (Branscombe et al., 1999) proves beneficial for those attempting to bridge the mental health gap between LG and heterosexual people at a community or individual level. The minority stress model (I. H. Meyer, 2003) provides a solid framework to understand how homophobic stigma yields adverse mental health outcomes. Furthermore, the SIA-H (Jetten et al., 2012) and the rejection-identification model (Branscombe et al., 1999) can outline how LG people respond to such stressors and what that entails for their overall health and well-being. It is important to note that the minority stress model draws from classic social identity theory and overtly states the LGBTQ+ group and identity functions as a protective factor against minority stress (see I. H. Meyer, 2003). Hence, the protective properties of LGBTQ+ social identities against minority stress are not novel. Nevertheless, using the 'social cure' framework in this study allowed us not only to identify that the LGBTQ+ community can help alleviate the adverse mental health outcomes of minority

stress but also *how* it does it. Specifically, we found that minority stress can lead LG people to identify more with the LGBTQ+ community, which provides them with a source of social support that affirms their identity despite the stigma attached to it, and in turn is associated with better mental health outcomes. Understanding these underlying processes enables us to dissect LG people's social identification to better understand the best avenues for them to reap the socially derived resources from the LGBTQ+ community. For instance, for practitioners working with LGBTQ+ health, a good place to start may be to increase LG people's identification with the LGBTQ+ community and connect them with it as a potential intervention to promote their mental health (e.g., Chaudoir et al., 2017; Snapp et al., 2015). In doing so, practitioners should also be aware of the minority stressors that arise from being a visible LGTBQ+ person navigating heterosexist and heteronormative contexts and equipped to support LG people in dealing with them.

Bridging the minority stress model (I. H. Meyer, 2003) with the 'social cure' framework (Jetten et al., 2012) and the rejection identification model (Branscombe et al., 1999) also enables a comparison of individualistic and collectivistic identity management strategies. In this study, we found evidence that collectivistic identity management strategies, such as identification with the LGBTQ+ community and social support, were positively associated with LG people's mental health outcomes. Yet, an individualistic strategy such as individual mobility was not related to mental health outcomes. When faced with stigma, minority groups likely maintain a positive sense of self by embracing or forgoing their low-status identities (Reicher et al., 2010; Scheepers & Ellemers, 2019). 'Social cure' research with stigmatized people shows that certain social identities can unlock their groups' 'curative' properties by increasing identification with them and reaping their social resources (e.g., (Bogart et al., 2018; Brance et al., 2023; Cooper et al., 2017; S. A. Haslam et al., 2009; Jetten et al., 2018). However, this is not the case for most groups, as identification with some in-groups can likely threaten their overall health and well-being (Jay et al., 2021; Jetten et al., 2015; Kellezi & Reicher, 2012). Despite facing minority stressors that impair their mental health, LG people may find relief in the LGBTQ+ community and its members rather than being left to fend for themselves.

In our study, individual mobility was not negatively or positively related to mental health outcomes among LG people experiencing minority stress. This result was interesting because individual mobility is a strategy which many LG people employ with varying degrees of success (Fuller et al., 2009; Krane & Barber, 2003). Individual mobility functions as a double-edged sword for LG people, allowing them to avoid being discriminated against at the expense of increased mental distress (Pachankis et al., 2020). Nevertheless, individual mobility should not

be considered an inherently flawed or inferior way of coping with minority stress, as its effects vary from person to person and differ across contexts (e.g., Bry et al., 2017; Riggle et al., 2016). For instance, countries with laws and policies that fail to support LG people show that individual mobility is an adaptive and protective coping strategy against homophobic stigma (e.g., Sun et al., 2020). It could be the case that in countries with greater acceptance of LG people, individual mobility could be less successful in protecting their mental health. Therefore, our nonsignificant association between individual mobility and mental health could be partially explained by our sample being in the United Kingdom, a country which is generally supportive of LG people (Pew Research Center, 2020).

It could also be theorized that we could have found a nonsignificant association since individual mobility could be considered a less reliable strategy. The 'social cure' framework posits that individualistic strategies, such as individual mobility, may be less reliable than collectivistic ones since communities and social relationships are consistently more available (Jetten et al., 2018). In individualistic strategies, coping with stigma is a personal responsibility, while in collectivistic ones, the community shares the burden (Krane & Barber, 2003). We found preliminary evidence of the reliability of collectivistic strategies in our study, where LGBTQ+ community identification and social support among LG people seem to translate to positive mental health outcomes compared to individualistic ones. Hence, increasing the identification with and connectedness to the LGBTQ+ community of LG people who actively avoided it seems a reliable way to help them cope with minority stressors and reduce the mental health inequalities between LGBTQ+ and heterosexual people. However, more research is still needed to accurately pinpoint the reliability and effectiveness of collectivistic strategies vs. individualistic ones.

5.4.1. Limitations & Future Studies

As with many other studies, the present study has limitations we would like to acknowledge. First, we recognize a degree of bias from our sample since those who participated already identify as LG. This limitation is noteworthy as this study examined LG people's degree of identification of or distance from the LGBTQ+ community. Those who openly identify as gay or lesbian and willingly participate in a survey about their sexual minority group and identity might already be connected to the LGBTQ + community to a certain extent and are less likely to engage in individual mobility. Researchers examining 'passing' and individual mobility have already acknowledged that recruiting and studying groups of people actively trying to conceal their identity is a circular problem (for a review, see Pachankis et al., 2020). In this study, we

attempted to overcome some of these limitations by using online crowdsourcing platforms to recruit a diverse sample of LG people instead of contacting them using more conventional ways, such as convenience or snowball sampling methods. Future studies focusing on better understanding individual mobility and 'passing' might consider using unconventional recruitment methods and assessments of people's sexual identity to gather a wide range of LG participants with varying relationships to the LGBTQ+ community.

The second limitation is the cross-sectional nature of this study, which prevents us from establishing causation between our variables. Even though the model and paths tested in this study shed light on how LG people can cope with minority stress, it does not allow us to directly compare individualistic vs collectivistic identity management strategies. It also does not allow us to accurately assess how reliable these coping strategies are at enhancing the mental health of LG people over time. Said comparison can be interesting to examine since despite the benefits of collective coping these strategies can further expose LG people to minority stress (see Begeny & Huo, 2017). Likewise, while individual strategies have the short- term benefits of escaping homophobic treatment, they may also lead to long term psychological distress for hiding their LG identity (see Pachankis et al., 2020). Future studies could use more robust methods to test the proposed model and paths for a 'social cure' for minority stress. For instance, conducting a longitudinal study with LG people could provide us with better clues for how reliable collectivistic and individualistic strategies are and establish causal links between social identity processes, minority stress, and mental health outcomes.

At the same time, this study exclusively focused on LG people's sexual identity and not on other stigmatized groups (e.g., nationality, social class, ethnicity). People who are LG but also belong to racial, ethnic, or gender minorities often report experiencing multiple minority stressors due to the combination of homophobic stigma and other forms of discrimination (Cyrus, 2017). LG people who are people of color often feel excluded by white LGBTQ+ people due to other stigmatizing attributes (e.g., Han, 2007). Hence, LG people with different stigmatized identities usually build support systems within the LGBTQ+ community but outside mainstream LGBTQ+ spaces (e.g., black LGBTQ+ families; Hailey et al., 2020). In this study, we examined the LGBTQ+ community and identity as one cohesive group and did not account for how LG people who belong to other stigmatized groups cope with minority stress. Future research should study how the most stigmatized members of the LGBTQ+ community individually or collectively respond to minority stress. It could be interesting for researchers to examine 'social cure' processes attached to LGBTQ+ people's social identity within countries which are blatantly unsupportive of their sexual identity. These lines of research could help

paint a clearer picture of the strategies used by LGBTQ+ people and ascertain what the best ways are to support all who are fighting against heteronormativity and heterosexism.

5.5. Conclusion

The present study examined how LG people manage their sexual identity to potentially cope with the health-damaging consequences of minority stress by bridging the SIA-H and the minority stress model. We found evidence suggesting that when LG people experience minority stress, they reported increased identification with the LGBTQ+ community, followed by higher perceived support from its members and subsequent positive mental health outcomes (i.e., collectivistic strategy). LG people who reported high levels of minority stress also conveyed a higher likelihood of engaging in individual mobility as an individualistic strategy, yet this was neither positively nor negatively associated with their mental health outcomes. These results help illustrate the individual and collective ways LG people manage their social identity in hopes of dealing with minority stressors by highlighting their potential benefits and limitations. The findings of this study can help inform policies and interventions to improve the mental health of LG people, and that social connections and resources from the LGBTQ+ community can prove to be an effective strategy.

Chapter 6

Longitudinal Examination of Individual & Collective Identity Coping Strategies Against Minority Stress

This chapter was submitted for publication:

Aybar Camposano, G. A., Rodrigues, D. L., & Moleiro, C. (2024). A longitudinal examination of individual and collective identity coping strategies against minority stress among lesbian and gay young adults.

Lesbian and gay (LG) people are at a high risk of developing mental health problems due to minority stress. To protect their mental health, many LG people manage their stigmatized sexual identity by engaging or disengaging from the LGBTQ+ community through collective or individual coping strategies. The present study used longitudinal data (N = 403 LG young adults) collected over one year to examine whether the temporal association between minority stress and mental health was mediated by LGBTQ+ identification, social support (i.e., collective coping strategies), and individual mobility (i.e., individual coping strategy). A multilevel parallel mediation model showed that LGBTQ+ identification (within-person effect) and individual mobility (between-person effect) were significant mediators, whereas social support was not. Specifically, higher minority stress among LG people increased their likelihood of either identifying with, or distancing themselves from, the LGTBQ+ community, which in turn was associated with improved mental health. However, the mediation of individual mobility became non-significant after controlling for LG people's perception of the low status of the LGBTQ+ community as stable (i.e., changeable) and legitimate (i.e., justifiable). The present study contributes to clarifying how and under which conditions collective and individual coping strategies can protect LG people from the adverse effects of minority stress.

Keywords: minority stress; mental health; social identity approach; coping; LGBTQ+ community.

6.1. Introduction

Coping with the effects of stigmatization can pose a complex challenge for those belonging to a social minority group, such as lesbian and gay (LG) people. For many, it involves employing strategies to manage their sense of self or identity and how they relate to others within and outside their group (Branscombe et al., 2012; Tajfel & Turner, 1979) According to the Social Identity Approach (Tajfel & Turner, 1979; Turner et al., 1987), people respond to discrimination by engaging or disengaging with their historically stigmatized groups and identities (Reicher et al., 2010). For LG people, that means the LGBTQ+ community and their sexual identities.

Engaging with one's stigmatized identity and group is a collective coping strategy in which a person increases their identification with their ingroup and connects with fellow group members (Bourguignon et al., 2020). However, there is also an opposite response, through which stigmatized people disengage from their community by hiding their identity and actively trying to become part of a high-status group (i.e., individual coping strategy; for review, van Veelen et al., 2020). An example of this latter strategy is when a LG person conceals their sexual identity in an effort to "pass" as heterosexual. Although engagement with one's low-status group and identity can provide stigmatized people with a sense of community that can enhance their mental health (Brance et al., 2023), disengaging from it can help them to avoid the adverse effects of discrimination (Derks et al., 2016). In other words, both strategies have their benefits and shortcomings when helping protect the mental health of stigmatized people.

Despite engagement (i.e., collective coping) or disengagement (i.e., individual coping) strategies being studied across various groups (see (Jetten et al., 2017), research on the Social Identity Approach has not given enough attention to how LG people employ them (one exception is Bourguignon et al., 2020). Understanding the nuances of the LG experience is essential since stigmatized groups experience and respond to stigma differently (e.g., Hogg et al., 2022). LG people are consistently exposed to unique forms of stress due to navigating life in homophobic and heteronormative conditions, also known as minority stress (for review, see Frost & I. H. Meyer, 2023). On top of that, LG people in certain parts of the world are living in a time where they are experiencing increased acceptance (Flores, 2021) while simultaneously dealing with anti-LGBTQ+ backlash (Edenborg, 2020). The present study draws from the Social Identity Approach to health (Jetten et al., 2012) and minority stress literature (I. H. Meyer, 2003) to assess how and under which conditions LG people's engagement or disengagement from the LGBTQ+ community can buffer minority stressors and promote

positive mental health outcomes. To do so, we conducted a longitudinal study following a cohort of LG people over one year to assess and contrast the effectiveness of each strategy.

6.1.1. Minority Stress & Mental Health

A growing body of research shows that sexual minority groups such as LG people are at a higher risk of developing psychopathologies (for a meta-analysis of population-based studies, see (Wittgens et al., 2022) and are more likely to engage in risk-taking behaviors than those identifying as heterosexual (Schuler et al., 2018). Many researchers have often attributed said mental health disparities to minority stressors stemming from their low-status position in society (Frost & I. H. Meyer, 2023; Hatzenbuehler, 2014). The concept of minority stress and its pernicious consequences have been evidenced over the past 40 years (see Rich et al., 2020), gaining widespread recognition with the minority stress model (I. H. Meyer, 2003).

The minority stress model (I. H. Meyer, 2003) conceptualizes two distinct types of minority stressors: distal and proximal. Distal and proximal stressors are based on the position of stigma-related stressors concerning LG people. Distal stressors, or those outside of the individual, refer to objective discriminatory events perpetuated by homophobic people and systems. On the other end of the spectrum are proximal stressors, those occurring within the individual, referring to subjective interpretations of homophobic stigma. I. H. Meyer (2003) differentiates between three proximal stressors such as internalized stigma (i.e., accepting homophobic societal evaluations), perceived discrimination (i.e., interpreting certain events as potentially homophobic), and expectations of rejection (i.e., the anxieties of concealing/disclosing one's sexual identity).

I. H. Meyer's model (2003) also illustrates what can help LG people respond to stigma-related stressors by distinguishing personal and group resources. On the one hand, personal resources refer to individual characteristics (e.g., socio-economic position) or personality traits (e.g., extraversion). In contrast, collective resources refer to social support from and LG people's relation to the LGBTQ+ community. These types of resources can help buffer the negative relationship between minority stress and mental health (see I. H. Meyer, 2015). However, both of these resources can have important limitations. For example, relying on personal resources and non-LGBTQ+ affirming coping strategies can place a burden on LG people, which can then be negatively associated to their well-being (Toomey et al., 2018). In the case of group resource, some LG people may have limited access to LGBTQ+ group resources, particularly those living in rural areas where LGBTQ+ spaces and connections are scarce, leaving them reliant on personal coping strategies (Giano et al., 2021; Woodell, 2018).

Personal and group resources for coping with minority stress are not inherently better or worse than one another. LG people often have to respond to their environment using whatever resources are immediately available to them. However, distinguishing between personal and group resources in the context of coping with minority stress can prove useful. I. H. Meyer (2003) highlights that group resources allow us to draw a line between where LG people's resources start and end. LG people will often resort to using their personal resources to cope with minority stress once group resources are depleted or inaccessible. Therefore, by understanding how LG people engage or disengage from their group and its resources, we can unravel some of the complexities of homophobic stigma, coping, and mental health.

The health-enhancing benefits of engaging with the LGBTQ+ community for LG people have been well-documented in the literature (see Foster-Gimbel et al., 2020; Frost & I. H. Meyer, 2012). Connecting with and receiving social support from the LGBTQ+ community can protect LG people from the adverse effects of minority stress (Kaniuka et al., 2019; Petruzzella et al., 2019) while prompting collective action (Chan, 2022). However, engagement with the LGBTQ+ community is often accompanied by the increased visibility of people's stigmatized sexual identities, which can heighten their perception of being the target of discrimination (Begeny & Huo, 2017) and further expose them to homophobia (Krane & Barber, 2003). Some studies have found that a high level of LGBTQ+ community connectedness has also been associated with a greater risk of developing body dissatisfaction (Davids et al., 2015), substance abuse (Demant et al., 2018), internalized homophobia and suicidal ideation (Rogers et al., 2021).

In a similar vein, the mental health outcomes of disengaging from the LGBTQ+ community have also yielded mixed results. On the one hand, studies show that disengagement strategies are related to increase life satisfaction in contexts that are oppressive against sexual and gender minorities (Pachankis & Bränström, 2018). That is, avoiding LGBTQ+ labels and spaces can help LG people prevent victimization, exclusion, and even imprisonment in certain contexts (Alessi et al., 2017). However, on the other hand, evidence also shows that disengaging from their community can reduce LG people's self-esteem and life satisfaction (Bourguignon et al., 2020) while also increasing psychological distress (Petruzzella et al., 2019) and substance use (Buttram et al., 2013). Furthermore, meta-analytic findings show that when LG people do not disclose their sexual identity to those around them, it can increase the internalization of mental health problems (see Pachankis et al., 2020).

The different ways LG people engage with the LGBTQ+ community to cope with minority stress are not straightforward and yield mixed outcomes. That is why a closer examination of

said coping strategies and their impact on mental health outcomes is still needed. Despite the wide variety of research examining LG people's (dis)engagement with the LGBTQ+ community as a response to minority stress and their outcomes on mental health, these studies also present some important limitations. First, many of these studies relied on cross-sectional data and have not been able to establish causal inferences between minority stress, coping strategies, and mental health outcomes. Second, studies examining different coping strategies against minority stress tend not to compare them to assess their effectiveness or consistency (for exceptions, see Bourguignon et al., 2020; Molero et al., 2011). Lastly, literature on minority stress tends to overlook some insights from the Social Identity Approach to health (SIA-H), examining how groups navigate their identities to enhance their health (Jetten et al., 2012).

6.1.2. Social Identity Approach to Health & Coping

The SIA-H (Jetten et al., 2012) posits that group memberships and the identities that stem from them function as psychological resources, allowing people to enhance their health. The idea here is that social identities enable people to access social-derived resources from their groups (e.g., social support), positively impacting their mental health (Jetten et al., 2017). The health-enhancing benefits of social identities have been studied in various populations, from survivors of an earthquake in Nepal (Muldoon et al., 2017) to people with autism in the United Kingdom (Cooper et al., 2017). However, not all groups are the same, and the impact of social identities on people's health also varies.

In recent years, research on the SIA-H has focused on understanding the experiences of stigmatized groups (Jetten et al., 2018). For stigmatized people, most of the distress negatively impacting their mental health stems from the stigma attached to their social identities and groups (Wakefield et al., 2019). Hence, accessing the "curative" properties of the social identities can become challenging for stigmatized people. For instance, when those getting treatment for substance abuse disorder continue to affiliate themselves with people who use substances, it can reduce their life satisfaction and rate of recovery (Dingle et al., 2015). Yet, for groups such as people with disabilities, group identification can help them improve their overall sense of esteem (Bogart et al., 2018). Overall, the SIA-H is not a clear-cut process for those with stigmatized identities. Its double-edged nature can vary depending on the group in question and whether people manage their identities individually or collectively (Jetten et al., 2018; Wakefield et al., 2019).

Coping strategies outlined by the SIA-H (Jetten et al., 2012) mirror to an extent the personal and group resources outlined by the minority stress model (I. H. Meyer, 2003), as well as the

ways LG people engage with or disengage from the LGBTQ+ community (e.g., Foster-Gimbel et al., 2020). Despite their similarities, both the minority stress model and the SIA-H have some crucial differences. Mainly, in the minority stress model, group resources are treated as moderators, while SIA-H research (Jetten et al., 2018) defines social identity processes as mediators. This reasoning is because studies examining the moderating effect of group identification on the relationship between discrimination and mental health have yielded mixed results (Schmitt et al., 2014).

Another distinction between these models is that the SIA-H theorizes that individual coping strategies might not help stigmatized people protect their mental health in the long term (Jetten et al., 2018). It is argued that collective coping can be more consistent over time since it is the group's responsibility to protect its members through its resources, functioning as a safety net. However, for those engaging in individual coping strategies, the task of coping with minority stress relies only on them. Given the lack of research bridging the minority stress model and SIA-H, the mediating role of LGBTQ+ social identity processes between minority stress and mental health and their temporal associations merits further examination.

6.1.3. LG Young Adults

Young adulthood is a vital stage for understanding how lesbian and gay (LG) individuals navigate their sexual identities, especially in the context of minority stress (Kaestle, 2019). Research indicates that LG people ages 19 to 27 report significantly higher levels of minority stress compared to older cohorts aged 54 to 61 (I. H. Meyer et al., 2021). During this period, younger generations also reach important sexual identity milestones (e.g., self-realization) earlier, often in their early to mid-adolescence, unlike older generations who typically achieve these milestones in their early to mid-twenties (Bishop et al., 2020; Hall et al., 2021). Consequently, many LG people are likely to actively engage with the LGBTQ+ community as young adults, prioritizing the formation of kinships and connections with their peers (Wagaman, 2016).

Additionally, young adulthood often marks a shift away from reliance on family support, as LG people increasingly seek connections within their networks of friends, peers, and community members (Snapp et al., 2015). This stage is characterized by elevated levels of minority stress alongside a focus on building support networks, which may include connections within the LGBTQ+ community. Longitudinal studies examining the social identity processes related to sexual identity among LG people during this developmental phase could effectively

examine the various ways in which young adults manage their identities and engage with their LGBTQ+ ingroup as a coping strategy.

6.1.4. Intergroup Perceptions & Coping Strategies

The SIA-H also highlights that when examining how stigmatized people manage their identities, it is crucial to account for how they perceive the relative status of their minority ingroup as compared to a relevant majority outgroup (Jetten et al., 2018). When two groups differ in status, members of a minority group will often make a series of attributions about the stability and legitimacy of said relationship (Reicher et al., 2010). Stability refers to whether stigmatized persons believe that the lower-status position of their ingroup is likely to be fixed or immutable over time. Legitimacy refers to whether or not stigmatized people perceive that the lower status of their minority group relative to the dominant majority outgroup is justified. While these intergroup perceptions may resemble some experiences of people who are the target of stigma (e.g., internalized stigma), there is evidence suggesting that perceived stability and legitimacy are theoretically different (van Zomeren et al., 2008).

When a minority person perceives a status difference between two groups, their behavior is often guided by perceptions of permeability, legitimacy, and stability, influencing whether they cope with the being from a low-status individually or collectively (Branscombe et al., 2012; Mummendey et al., 1999). Studies show that LG people who perceive that the minority position of the LGBTQ+ community, relative to a heterosexual outgroup, was likely to change (i.e., instability) and that its low status was unjustified (i.e., illegitimacy) were less likely to experience adverse mental health outcomes from minority stressors (Camposano et al., 2024). Further, perceived legitimacy and stability of stigmatized social status were associated with a greater likelihood of engaging in individual mobility strategies among LG people (Aybar Camposano et al., 2022). Based on these previous studies, we opted to include stability and legitimacy as control variables in our analysis to examine whether these variables influence how LG people cope with minority stress.

6.1.5. Overview of the Present Study

In this study, we aimed to bridge the LG health nuances of the minority stress model (I. H. Meyer, 2003) with the broader framework of the SIA-H (Jetten et al., 2012) to understand how LG young adults cope with minority stress. Specifically, we tested whether the negative association between minority stress and mental health outcomes was mediated by LGBTQ+ community identification (M1) and social support (M2) as collective coping strategies or by

individual mobility (M3) as an individual one. We hypothesized that more minority stress would be associated with a higher likelihood of engaging in collective coping strategies such as identification ($H1_D$) with and social support from ($H2_D$) the LGBTQ+ community, which in turn would be related to positive mental health outcomes. However, we theorized that individual mobility (i.e., individual coping) would be associated with adverse mental health outcomes ($H3_D$). These mediations were tested across three measurement times throughout one year with LG young adults and across five different countries (i.e., the United States, the United Kingdom, Germany, the Netherlands, and Australia).

The aforementioned five countries were selected for the following reasons. First, these countries tend to be generally accepting of LGBTQ+ people and these levels of acceptance have generally increase along the past decades (Flores, 2021; Pew Research Center, 2020). Second, they tend to share similar cultural values such as higher levels of individualism (Hofstede, 2001). Lastly, higher individualism has been associated with having a more independent sense of self, which is related to how LG people relate to the LGBTQ+ community (Aybar Camposano et al., 2022; Cross et al., 2011).

Informed by previous research (see Aybar Camposano et al., 2022; Camposano et al., 2024) we also follow up on our analysis by testing our model with control variables. With this add-on analysis, we wanted to assess whether the strength and direction of the coping strategies remained significant even when controlling for the previous variables.

6.2. Methods

6.2.1. Participants & Procedure

This study was approved by the ethical committee at Iscte - Instituto Universitário de Lisboa (approval reference number 89/2022). We conducted a longitudinal study using the online crowdsourcing platforms Prolific (www.prolific.com) and Clickworker (www.clickworker.com) to recruit participants throughout one year between November 2022 and December 2023. Data were collected at three time points every six months: Time 1 was conducted between November 16 and December 14, 2022; Time 2 took place between May 2 and May 30, 2023; and Time 3 occurred between November 15 and December 13, 2023.

Prospective participants were invited to take part in a study aimed at understanding the experiences of lesbian and gay individuals within the LGBTQ+ community. The study, along with all related materials, was available exclusively in English. We used the built-in filters in both crowdsourcing platforms to narrow our target group. Specifically, we filtered our sample by age (i.e., being over 18 and under 35), sexual identity, fluency in English, and geographical

location (i.e., residing in the United Kingdom, the United States, Germany, the Netherlands, or Australia). It is important to note that the assessment of sexual identification as an inclusion criterion varied across the two crowdsourcing platforms used. On Prolific Academic, a built-in filter allowed the online survey to be specifically targeted to those who had previously self-identified as gay or lesbian. In contrast, Clickworker lacked this feature, so we included a pre-screen question following the informed consent, asking participants to self-identify (e.g., "Do you consider yourself to be... (1) lesbian, (2) gay, (3) bisexual...").

The online survey provided to participants included an electronic informed consent form detailing the purpose, nature of participation, content, benefits, and potential risks of the study. The survey also included a socio-demographic questionnaire that served as a pre-screener (i.e., age, location, sexual identity) to corroborate participants as part of our target demographic. Participation in this study was voluntary and anonymous. To ensure participants' anonymity while conducting our longitudinal study, we asked participants to provide us with their anonymous Clickworker or Prolific Academic IDs, which functioned as unique codes for each participant. This allowed us to track participants across the study's time points. At the end of the survey, participants were debriefed, and we provided more information about the study. All participants received monetary compensation of 1.25€, 1.35€, and 1.55€ for completing the questionnaire at each measurement point.

A total of 821 responses from 502 LG young adults were collected throughout the entire longitudinal study. However, responses that were incomplete ($n = 2$), failed commitment checks ($n = 1$), and were completed in an unreasonable amount of time ($n = 18$; $M_{Time} \leq 2$ minutes) were excluded. Responses from participants self-identifying as other sexual minorities (e.g., bisexual) and as gender minorities (e.g., trans) were not included ($n = 115$). This decision was made since people's experiences with transphobia and other forms of discrimination could add more complexity to our analysis of minority stress and examination of sexual identity processes. Our final sample consisted of a total of 685 responses collected from 403 participants over one year. From these responses, 403 were collected in Time 1 (T1), 176 in Time 2 (T2), and 106 in Time 3 (T3). All 106 participants at T3 had completed the measures at both T2 and T1. At T1, the mean age of the participants was 27.32 years (SD = 4.72). Most of the participants self-identified as cisgender gay men (53.3%), were single (50.1%), currently employed (73.2%), and held a higher education degree (68.2%). At T1, most participants (34.8%) were residing in Germany. By T2 and T3, however, a larger portion of the sample reported living in the United Kingdom, with 39.8% at T2 and 45.3% at T3. See Table 6.1. for a summary of the characteristics of our sample at each time point.

Table 6.1. Socio-demographic characteristics of the sample.

Characteristics	Time 1 (n = 403)	Time 2 (n = 176)	Time 3 (n = 106)
Age	27.32 (SD = 4.72)	28.18 (SD = 4.66)	28.83 (SD = 4.59)
Gender			
Men	216 (53.3%)	107 (60.8%)	65 (61.3%)
Women	187 (46.2%)	69 (39.2%)	41 (38.7%)
Sexual Identity			
Gay	216 (53.3%)	107 (60.8%)	65 (61.3%)
Lesbian	187 (46.2%)	69 (39.2%)	41 (38.7%)
Partnership Status			
Single	202 (50.1%)	98 (55.7%)	59 (55.7%)
Partnered	201 (49.9%)	78 (44.3%)	47 (44.3%)
Employment Status			
Employed	295 (73.2%)	137 (77.8%)	86 (81.1%)
Studying	62 (15.4%)	18 (10.2%)	10 (9.4%)
Unemployed	33 (8.3%)	17 (9.7%)	9 (8.5%)
Other	13 (3.2%)	4 (2.3%)	1 (0.9%)
Highest Educational Level Attained			
Higher education	275 (68.2%)	118 (67%)	72 (67.9%)
Secondary education	103 (25.6)	45 (25.6%)	25 (23.6%)
Vocational education	19 (4.7%)	10 (5.7%)	7 (6.6%)
Other	6 (1.5%)	3 (1.7%)	2 (1.9%)
Country			
United Kingdom	119 (29.5%)	70 (39.8%)	48 (45.3%)
Germany	141 (35%)	67 (38.1)	29 (27.4%)
United States	125 (31%)	32 (18.2%)	22 (20.8%)
Netherlands	11 (2.7%)	4 (2.3%)	4 (3.8%)
Australia	7 (1.7%)	3 (1.7%)	3 (2.8%)

As evident in the previous paragraph, there was a significant dropout rate throughout the study. Specifically, 227 participants (56.33%) dropped out between T1 and T2, and 70 (39.77%) between T2 and T3. This resulted in a total loss of 297 participants, or 73.70% of the initial sample, from the start to the end of data collection. A closer analysis revealed that the dropout rates varied between the two crowdsourcing platforms used. Clickworker had a much higher dropout rate of 86.30% (n_{T1} = 270, n_{T2} = 77, n_{T3} = 37), while Prolific Academic's dropout rate was 48.12% (n_{T1} = 133, n_{T2} = 99, n_{T3} = 69). This discrepancy can likely be attributed to differences in how each platform manages follow-ups in longitudinal studies. For the 6-month and 1-year follow-ups, new orders were created on both platforms, allowing only participants who had completed Time 1 and met the study's inclusion criteria to take part. Prolific Academic facilitates follow-up participation in longitudinal studies by notifying users via email if they have opted to receive such notifications. In contrast, Clickworker lacks this feature, making it more difficult to retain participants, as only those actively seeking tasks would have found the follow-up study. This may account for the sharp decline in participation on Clickworker across time points.

Given the notable differences in dropout rates between the crowdsourcing platforms, we examined whether participants from Clickworker and Prolific varied across several socio-demographic variables. To do so, we conducted a series of chi-square tests to compare gender, sexual identity, partnership status, employment status, highest level of education attained, and country of residence at T1. Additionally, a t-test was performed to compare the mean age of participants between the two platforms. The results indicated significant differences in country of residence, χ^2 (1) = 261.04, $p < .001$, and employment status, χ^2 (1) = 12.94, $p < .005$. No significant differences were found in the other socio-demographic variables (all $p \geq .153$). Likewise, there were no significant differences in mean age between participants on Prolific and Clickworker, $p = .808$.

6.2.2. Measures

Minority Stress

The LGBTQ+ Minority Stress Measure (short version; Outland, 2016) assessed participants' experiences with distal and proximal minority stressors. The original short version of this scale is comprised of seven subscales with a total of 25 items. However, we opted not to include the three-item subscale of community connectedness (e.g., "I feel that I could find professional services for LGBTQ+ issues if I needed to") since this study was focused on assessing the degree to which LG people identify with and draw support from the LGBTQ+ community (and not their integration into local communities). The final scale included 22 items (e.g., "Others have threatened to harm me because I am LGBTQ+") measured on a seven-point rating scale (1 = *Strongly disagree* to 7 = *Strongly agree*). The scale showed high reliability across measurement points ($\alpha \geq .92$).

LGBTQ+ Community Identification

The Multidimensional Scale of Social Identification (Leach et al., 2008) was used to measure people's identification with the LGBTQ+ community. This scale included 14 items (e.g., "I often think about the fact that I am LGBTQ+") measured on a seven-point rating scale (1 = *Strongly disagree* to 7 = *Strongly agree*). The overall instrument showed high reliability across measurement points ($\alpha \geq .94$).

LGBTQ+ Social Support

An adapted version of the Perceived Social Support Scale (van Dick & Haslam, 2012) was used to measure the extent to which LG people feel supported by the LGBTQ+ community. This

measure has a total of four items (e.g., "I get the resources I need from members of the LGBT+ community") measured on a seven-point rating scale (1 = Strongly disagree to 7 = Strongly agree). This scale showed high reliability across measurement points ($\alpha \geq .92$).

Individual Mobility

We used an adapted version of the Individual Mobility (Blanz et al., 1998) to assess the likelihood of LG people detaching from the LGBTQ+ community and their desire to join the heterosexual outgroup. This scale has four items (e.g., "I make any effort to be considered straight") measured on a seven-point rating scale (1 = *Strongly disagree* to 7 = *Strongly agree*). The scale showed high reliability across all three measurement points ($\alpha \geq .91$).

Mental Health

The Mental Health Continuum Short Form (MHC-SF; Keyes, 2009) was used to measure how LG people individually assess their overall mental health. This 14-item non-clinical scale is a self-report measure of subjective well-being over the prior month including 3 items assessing emotional well-being (e.g., “During the past month, how often did you feel satisfied with life?”), 5 items on social well-being (e.g., “During the past month, how often did you feel that you had something important to contribute to society?”) and 6 items on psychological well-being (e.g., “During the past month, how often did you feel that you had experiences that challenged you to grow and become a better person?”). This instrument was measured on a six-point rating scale (0 = *Never* to 5 = *Every day*). Items were summed into a single index showing high reliability across measurement points ($\alpha \geq .94$).

Legitimacy & Stability of LGBTQ+ Status Within Society (Control Variables)

An adapted version of the Legitimacy and Stability Scales (Mummendey et al., 1999) was used to assess how LG people perceive the group status of the LGBTQ+ community concerning the heterosexual majority. One item measured whether LG people perceive how likely their status as a minority group will change (or not) over time (e.g., I think the relationship between LGBTQ+ people and straight people will remain stable for the next years"). Two items measured how legitimate the current treatment of the minority LGBTQ+ group is in relation to the heterosexual outgroup (e.g., Straight people are entitled to be better off than the LGBTQ+ people"). The items of the Legitimacy Scale were mean aggregated, showing a strong association between them across all measurement points, $r \geq .60$, $p \leq 001$. All items from the

Legitimacy and Stability scales were measured on a seven-point rating scale (1 = *Strongly disagree* to 7 = *Strongly agree*).

6.2.3. Data Analytic Plan

We first computed correlations between the major variables and stratified them by time measurement point. For our main analysis, we used multilevel modeling (MLM). We opted for this strategy because it helps us analyze all valid data entry points and minimizes the steep drop-off rates. MLM also allows us to disaggregate the within and between-person effects of our variables of interest, which are frequently confounded in other analyses. With MLM, we can disentangle how different coping strategies among LG people function within and between individuals over time. MLM within-level effects pertain to the changes experienced by individuals over time (i.e., intra-individual), such as how engaging or disengaging from the LGBTQ+ community may impact a LG person across different measurement points. At the same time, MLM between-level effects focus on inter-individual differences, such as how social identity processes may differ between participants throughout time. Given the significant socio-demographic differences across the crowdsourcing platforms, we opted to include the platform used to complete the survey as a Level 2 (between-group) control variable in our main analyses.

In our analyses, we first conducted a two-step (i.e., time [Level 1] nested within people [Level 2]), 1-1-1 multilevel parallel mediation model using the computational macro MLmed for SPSS (see Figure 6.1. for conceptual model). MLmed allows the fitting of multilevel mediation and moderated mediation models on PROCESS for SPSS (Hayes & Rockwood, 2020). We included minority stress as the predictor (X), with LGBTQ+ community identification (M1), LGBTQ+ perceived social support (M2), and individual mobility (i.e., self-distancing from the LGBTQ+ community as a way to insert themselves into the heterosexual outgroup; M3) as three simultaneous parallel mediators, and mental health (Y) as the outcome variable.

Second, we tested the same multilevel parallel mediation model but included control variables. We included LG people's perceived legitimacy and stability of the status of the LGBTQ+ community within society as Level 2 covariates. In both models, the means of all main variables were centered. Socio-demographic variables such as age, educational level, partnership status, gender identity, and employment status were not included in this analysis, as previous studies have shown that most of these characteristics had little to no relationship with the main variables of interest (Aybar Camposano et al., 2022, 2024; Camposano et al., 2024) Effect parameters were based on restricted maximum likelihood (REML). Indirect effects were

assessed with 10,000 Monte Carlo sampling simulations and 95% confidence intervals (CI) for the indices.

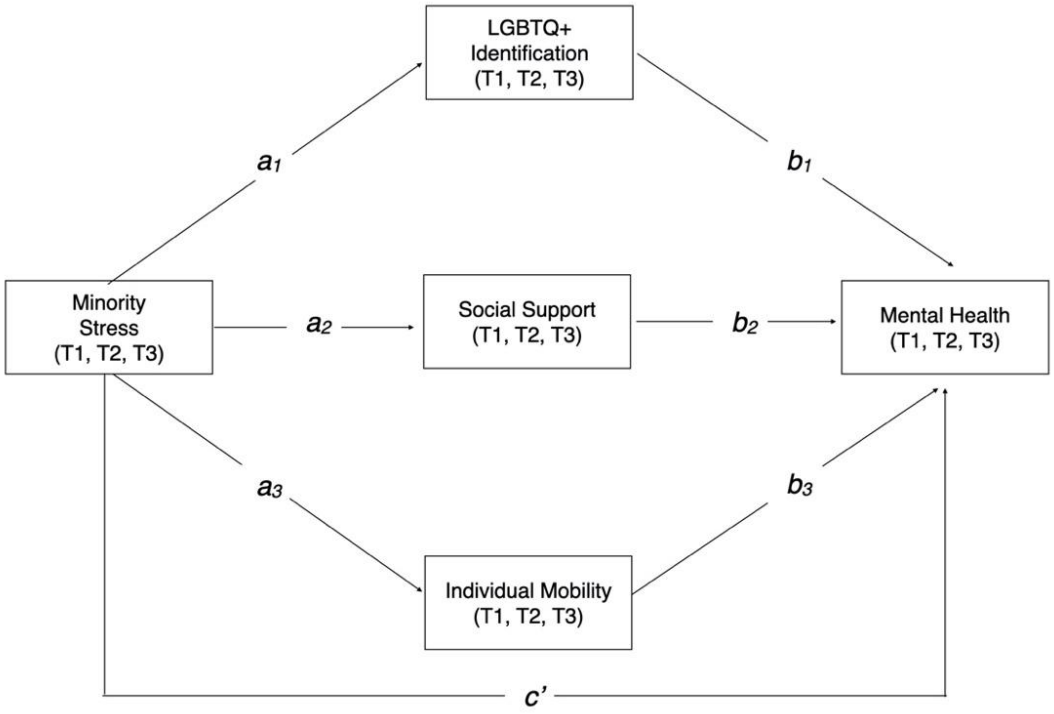

Figure 6.1. MLM conceptual model

6.3. Results

6.3.1. Descriptive Statistics

The means, standard deviations, and correlations of the main variables of this study are displayed in Table 6.2. As expected, we found a negative and significant association between minority stress and mental health, but only at T3, $p = .001$. Minority stress was also negatively related to LGBTQ+ identification but only at T3, $p = .017$, and positively associated with individual mobility across all measurement points, $ps \leq .008$. Increased identification with the LGBTQ+ was positively associated with perceived social support from the LGBTQ+ community, $ps \leq .001$, and mental health outcomes, $ps \leq .002$. Likewise, LGBTQ+ social support was positively related to mental health outcomes across all measurement points, $ps \leq .002$. Individual mobility at T1 was positively associated with mental health outcomes, $p = .011$. Regarding the control variables, stability was positively associated with LGBTQ+ identification, $p \leq .001$, and social support, $p \leq .001$, but only at T1. Legitimacy was positively related across all measurement points to individual mobility, $ps \leq .001$, and minority stress, $ps \leq .002$.

We also examined dropout rates across time points, focusing on the mean scores of our key variables. This analysis revealed a significant decline in participants' self-reported legitimacy perceptions as well as in their mental health scores. Specifically, those who completed all measures were more likely to report poorer mental health outcomes and to perceive the status of the LGBTQ+ community in comparison to their heterosexual outgroup as more illegitimate.

Table 6.2. Descriptive statistics and correlations

	M	*(SD)*	Scale Range	1	2	3	4	5	6
Time 1 (*n* = 403)									
1. Minority Stress	3.60	(1.25)	1 - 7	—					
2. LGBTQ+ Community Identification	4.72	(1.24)	1 – 7	.08	—				
3. Social Support	4.69	(1.46)	1 – 7	.07	.64***	—			
4. Individual Mobility	2.71	(1.58)	1 – 7	.57***	-.07	.04	—		
5. Mental Health	39.60	(15.68)	0 – 70	.03	.33***	.34***	.13*	—	
6. Legitimacy	3.02	(1.75)	1 – 7	.41***	.01	.13**	.56***	.20***	—
7. Stability	4.46	(1.48)	1 – 7	-.07	.18***	.18***	.07	.30***	.17***
Time 2 (*n* = 176)									
1. Minority Stress	3.44	(1.16)	1 - 7	—					
2. LGBTQ+ Community Identification	4.57	(1.16)	1 – 7	-.02	—				
3. Social Support	4.46	(1.43)	1 – 7	-.10	.66***	—			
4. Individual Mobility	2.55	(1.53)	1 – 7	.67***	-.20**	-.13	—		
5. Mental Health	35.99	(16.20)	0 – 70	-.06	.24**	.31***	.06	—	
6. Legitimacy	2.57	(1.67)	1 – 7	.49***	-.01	.03	.58***	.11	—
7. Stability	4.39	(1.49)	1 – 7	-.02	.07	.01	.13	.18*	.20**
Time 3 (*n* = 106)									
1. Minority Stress	3.19	(1.15)	1 - 7	—					
2. LGBTQ+ Community Identification	4.61	(1.16)	1 – 7	-.23*	—				
3. Social Support	4.27	(1.63)	1 – 7	-.14	.65***	—			
4. Individual Mobility	2.33	(1.55)	1 – 7	.64***	-.36***	-.20*	—		
5. Mental Health	33.48	(15.54)	0 – 70	-.31**	.29**	.45***	-.16	—	
6. Legitimacy	2.31	(1.51)	1 – 7	.47***	-.10	.05	.59***	-.07	—
7. Stability	4.42	(1.54)	1 – 7	-.13	.01	.14	.14	.21*	.23*

Note. $^{*}p < .050$, $^{**}p < .010$, $^{***}p < .001$.

6.3.2. Longitudinal Multilevel Mediation Model

The results from the MLM are displayed in Figure 6.2. First, at Level 1 or within-person analysis, results showed a significant indirect temporal association through LGBTQ+ community identification as a mediator, β = .61, *SE* = .26, 95% CI [.17, 1.19], *p* = .020. Specifically, higher levels of minority stress were positively associated with increased identification with the LGBTQ+ community, β = .21, *SE* = .06, 95% CI [.08, .33], *p* = .001, and, in turn, better mental health outcomes, β = 2.97, *SE* = .86, 95% CI [1.28 4.66], *p* = .001.

However, there was no evidence of an indirect effect when accounting for social support, β = .05, *SE* = .11, 95% CI [-.15, .30], *p* = .671 or individual mobility, β = .09, *SE* = .22, 95% CI [-.34, .54], *p* = .682, as mediators. When we looked closely at both paths, there was only evidence of a positive association between minority stress and individual mobility, β = .29, *SE* = .07, 95% CI [.15, .43], $p \leq .001$. Lastly, for our analysis of a within-person effect, there was no evidence of a direct effect between minority stress and mental health, β = .33, *SE* = .88, 95% CI [-1.41, 2.06], *p* = .713.

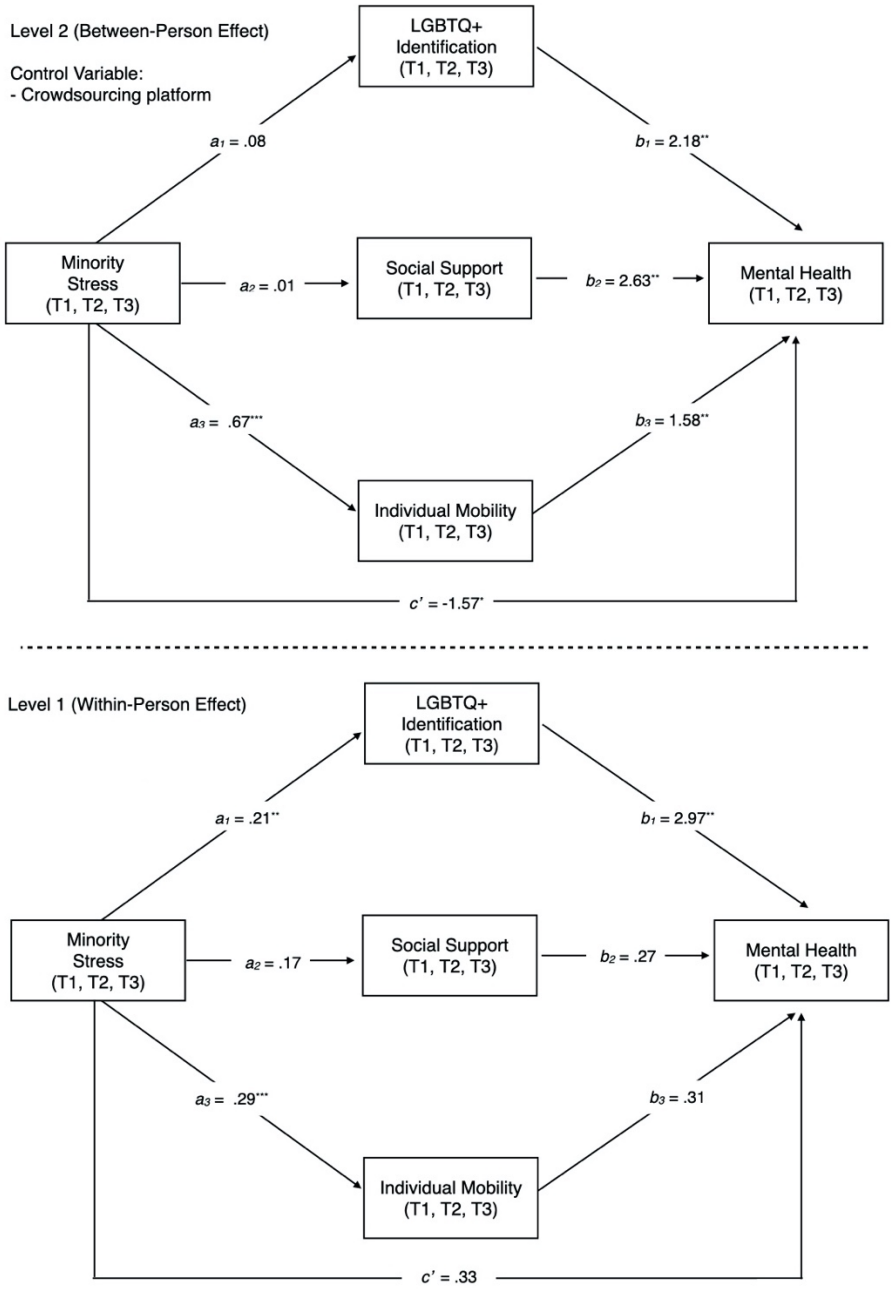

Figure 6.2. Longitudinal multilevel parallel mediation model.

Note. $^{*}p < .050$, $^{**}p < .010$, $^{***}p < .001$.

The between-person analysis showed evidence that individual mobility mediated the relationship between minority stress and mental health, β = 1.06, *SE* = .41, 95% CI [.28, 1.88], *p* = .009. A closer look at this path shows that more minority stress was associated with a higher likelihood of engaging in individual mobility, β = .67, *SE* = .05, 95% CI [.57, .77], $p \leq .001$. Subsequently, individual mobility was associated with better mental health outcomes, β = 1.58, *SE* = .60, 95% CI [.42, 2.75], *p* = .008. There was no evidence of indirect effects for the LGBTQ+ community identification, β = .17, *SE* = .13, 95% CI [-.05, .47], *p* = .211, and social support paths, β =.03, *SE* = .16, 95% CI [-.30, .36], *p* = .866. Finally, there was evidence of a significant and negative direct effect between minority stress and mental health, β = -1.57, *SE* = .72, 95% CI [-2.99, -.15], *p* = .031.

6.3.3. Model with Control Variables

Results summarized in Figure 6.3. showed that most of the associations of this model were similar to the ones we found in our previous analysis. A notable difference was that when including the previously mentioned variables in our analysis, the between-person indirect effect for the individual mobility path was no longer significant, β = .56, *SE* = .35, 95% CI [-.11, 1.25], *p* = .110. More specifically, the associations between individual mobility and mental health outcomes were rendered non-significant with the inclusion of control variables, β = .98, *SE* = .60, 95% CI [-.21, 2.16], *p* = .106.

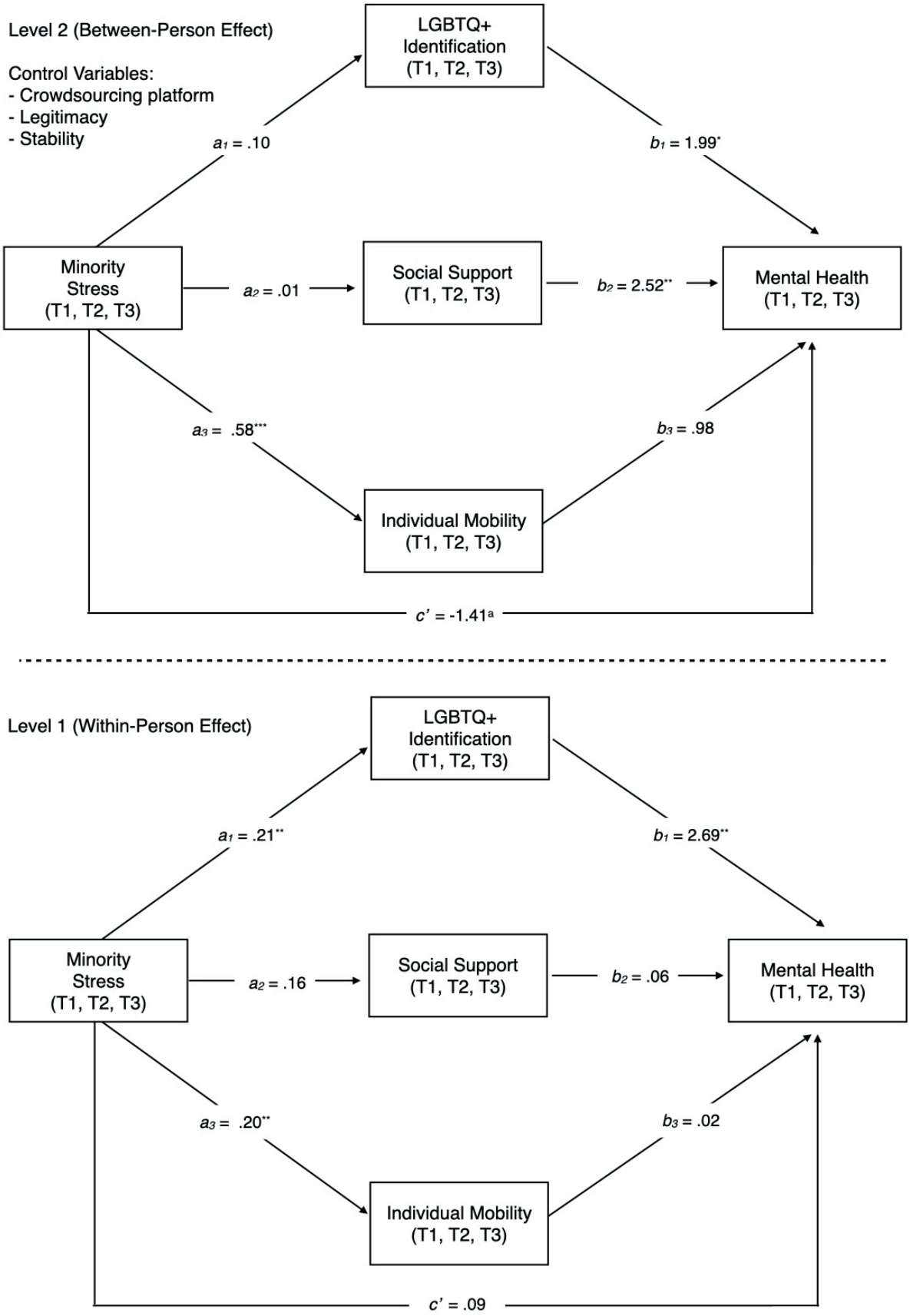

Figure 6.3. Longitudinal multilevel parallel mediation model with control variables.

Note. $^{a}p = .050$, $^{*}p < .050$, $^{**}p < .010$, $^{***}p < .001$.

6.4. Results

By bridging the minority stress model and the SIA-H (Jetten et al., 2012, 2018), the present study examined how LG people manage their identities to cope with minority stress and their implications for their mental health outcomes. Specifically, we took a closer look at how LG people individually and collectively respond to minority stressors by respectively disengaging or engaging from the LGBTQ+ community. This study was one of the first to assess and compare said coping strategies using longitudinal data. Another contribution of this study was using MLM to disentangle the effectiveness and consistency of individual and collective coping strategies at intra- and inter-individual levels. Overall, this study sheds light on some of the different coping strategies LG people use to cope minority stress and identifies specific conditions that can influence the consistency of these approaches over time. In the following paragraphs, we will expand on the theoretical and practical contributions of this study and review its hypotheses.

We found evidence of the "curative" properties of identifying with the LGBTQ+ community ($H1_D$). Our results show that experiencing minority stress can lead LG people to increase identification with the LGBTQ+ community, which in turn has positive mental health outcomes. These findings are consistent with the SIA-H (Branscombe et al., 2012; Jetten et al., 2012, 2018), which suggests that experiences of discrimination can result in stigmatized groups identifying with their minority group, enhancing their mental health (Bogart et al., 2018; Brance et al., 2023). Our results also go in line with cross-sectional (Bourguignon et al., 2020) and longitudinal (Chan, 2022) research discussing that minority stress can increase LG people's identification with the LGBTQ+ community. They were also consistent with studies that have found that ingroup identification could have positive mental health outcomes (Frost & I. H. Meyer, 2012; Kaniuka et al., 2019; Petruzzella et al., 2019).

Interestingly, we only found evidence suggesting that identifying with the LGBTQ+ community was a collective coping strategy at a within-person level. That is, when a LG person experiences minority stress, they increase identification with the LGBTQ+ community, and doing so can improve the mental health of this individual. By assessing within and between effects through our MLM, we observed that LG people's identification with the LGBTQ+ community remained a consistent coping response across measurement points. This distinction is crucial since it allows us to extend previous research beyond identifying what helps a LG person cope with minority stress and how they do so. That is, despite minority stress remaining a persistent issue across a LG person's life, identifying with the LGBTQ+ community can be a dependable way to help them improve their overall mental health.

We also found evidence suggesting that individual mobility (i.e., individualistic coping strategy) was associated with positive mental health outcomes ($H3_D$). Our results show that increased experiences with minority stress were associated with a higher likelihood of LG people disengaging from the LGBTQ+ community to "pass" as heterosexual, which, in turn, enhanced their mental health. These results do not align with our initial hypothesis grounded on previous research that found that identity concealment (Pachankis et al., 2020) and distancing (Bourguignon et al., 2020) from the LGBTQ+ community can harm the health and well-being of sexual minorities. In addition, SIA-H theorizing (Branscombe et al., 2012; Jetten et al., 2018) posits that individual coping strategies among stigmatized groups are less consistent over time. Despite the setbacks from individual coping strategies, some studies suggest these strategies are still adaptive ways in which LG people respond to the contextual demands of living in homophobic and heterosexist social conditions (Beagan et al., 2022; Krane & Barber, 2003; Pachankis & Bränström, 2018). LG people are not misguided for engaging in individualistic strategies, but instead, they often must balance collective and individual forms of coping throughout their lives (Bry et al., 2017).

Nevertheless, individual coping strategies were only significant at an inter-individual level (i.e., between effects). Individual differences were observed in how LG people engage in individual mobility, which is an effective coping strategy for some but not others. Subsequently, when controlling for how LG people perceive the position (i.e., stability) and treatment (i.e., legitimacy) of the LGTBQ+ community to the heterosexual outgroup, these observed individual differences were rendered non-significant. Previous studies have shown that how LG people perceive the LGBTQ+ community can help determine whether they will engage with it or not (Aybar Camposano et al., 2022). These perceptions can also heighten how they experience the adverse effects of minority stress (Camposano et al., 2024). Taken together, these findings suggest that, while individual mobility might seem a viable strategy for some LG people to cope with minority stress, it becomes less consistent than collective ones when we account for their perceptions of the LGBTQ+ community. In terms of practical implications, our results highlight that those engaging in individual coping strategies and perceiving the status of the LGBTQ+ community (vs. the heterosexual outgroup) as stable and/or legitimate might require extra support since their ways of coping are not as consistent. It can also mean that challenging the assumptions of some LG people about the stability and legitimacy of the LGBTQ+ community can be beneficial since it potentially allows them to become closer to their ingroup and sexual minority peers.

Lastly, we did not find evidence that LGBTQ+ social support mediated the relationship between minority stress and mental health ($H2_D$). However, we were able to observe that social support from the LGBTQ+ community was associated with positive mental health outcomes for some LG people (i.e., between-person effect). This specific association aligns with research examining LGBTQ+ social support among sexual minorities (Frost et al., 2016). Even though the results go against our initial hypothesis, it could be the case that social support by itself cannot buffer the adverse outcomes of minority stress, but rather, it is contingent on identification with the LGBTQ+ community. In other words, LGBTQ+ group identification may be a precursor for LG people to access the benefits of social support.

Research from the SIA-H (Jetten et al., 2012) has often found that group identification can allow people to unlock the "curative" properties of their group (see Häusser et al., 2020). For example, group discrimination can increase ingroup identification, unlocking collective action as a positive psychological resource for a given ingroup (Chan, 2022; Molero et al., 2011). There is even cross-sectional research with LG samples suggesting that the relationship between minority stress and mental health is mediated by LGBTQ+ social support only when accounting for LGBTQ+ identification (Aybar Camposano et al., 2024). Our findings regarding LG people's social support help us better uncover consistent ways they can cope with minority stress. While LGBTQ+ social support can have positive mental health outcomes for some, it could be more worthwhile for those working with and for the health of sexual minorities to prioritize approaches to strengthen or help maintain LG people's identification with their local LGBTQ+ community. Doing so could potentially allow LG young adults to unlock socially derived psychological resources that could enable them to better withstand stigma-related stressors over time. Yet, more robust research is still needed.

6.4.1. Limitations & Future Directions

We must acknowledge limitations and propose future avenues for research. The first limitation is the challenges of studying individual mobility strategies among LG people. Even though we used crowdsourcing platforms, ensured anonymity, and provided financial incentives to recruit a diverse pool of LG participants, they also have their fair share of limitations and biases (Rea et al., 2020). In the case of our study was that our sample could be biased toward those already connected to the LGBTQ+ community. This potential bias can be evident in participants' low scores regarding their desire to engage in individual mobility. These results make sense since the study was advertised to assess the experiences of LG people and their relationship with the LGBTQ+ community and filtered participants who did not identify as LG. This limitation is not

exclusive to our study but is common in research assessing the experiences of LG people who actively do not want to be labeled as one (Pachankis et al., 2020).

The second limitation is the retention of participants from a particular demographic. In the methods section, we mentioned that a significant number of participants recruited through Clickworker dropped off the study across measurement points, specifically between T1 and T2. Further examination showed that T1 participants reported higher self-rated mental health outcomes and perceived the low status of the LGBTQ+ community as legitimate. Although drop-off rates are usual in longitudinal studies, difficulties in retaining and following up with participants from Clickworker made it difficult to better examine how said demographic progressed over time. With the use of MLM, we were able to include the data of said participants in our analysis, offsetting some of the potential bias in our sample. However, future studies should be mindful of their retention strategies and how crowdsourcing platforms handle longitudinal follow-ups, such as increasing incentives, reminding participants to complete follow-up surveys, or waiting less between measurement points.

Thirdly, our study did not examine how intersecting social identities (or intersectionality) impact LG people's coping strategies against minority stress. Studies have shown that belonging to multiple groups and the identities that stem from them are also beneficial, and their health-enhancing properties can compound (Jetten et al., 2015). Yet, having multiple stigmatized identities can also allow certain minority people to experience intersecting forms of oppression. Multiple minority stressors are often experienced by sexual minorities with other intersecting low-status identities, such as LG people of color (Cyrus, 2017), who face exclusion from white heterosexual and LGBTQ+ people. Future studies should question what the LGBTQ+ community means specifically to LG people from diverse backgrounds. By doing so, researchers can closer look at the different groups that make up the LGBTQ+ community and examine how they can enhance or hinder the ability of diverse LG people to cope with minority stress.

The last limitation is the potential lack of generalizability of our results in distinct socio-cultural contexts. Although we examined the experiences of LG people across five different countries, these countries are Western, educated, industrialized, rich, and democratic (WEIRD) and have a generally high acceptance for LG people (Flores, 2021). Our results might need to be interpreted with caution when applying them to LG people living in countries where LGBTQ+ identities are criminalized. Individual coping strategies have been associated with positive health outcomes in countries with lesser acceptance of LGBTQ+ people (Pachankis & Bränström, 2018). Therefore, we should not assume collective coping strategies are inherently

superior to individual ones among LG people across contexts. Instead, future research could examine which strategies are successful in what context, how LG people balance these strategies in different parts of the world, and the cross-cultural reliability of minority stress coping strategies. Other lines of research could focus on the best ways to support LG people engaging in individual mobility in countries supportive of the members of the LGBTQ+ community to prevent them from exhausting their personal resources. Likewise, studies could also look at the best ways to support LG people in less accepting contexts to engage in collective coping strategies to reliably protect their mental health and potentially challenge the homophobic status quo.

6.5. Conclusion

The present study ties in and extends literature from the minority stress model (I. H. Meyer, 2003) and the SIA-H (Jetten et al., 2012) by assessing and comparing how consistent were LG people's individualistic and collectivistic coping strategies against minority stress. Results from this study highlight that while individual mobility and identification with the LGBTQ+ community can enhance LG people's health even in the presence of homophobic stressors, they achieve it in different ways. On the one hand, LGBTQ+ identification serves as a coping response for a LG person and is consistent over time. The success of individual mobility as an individualistic strategy, on the other hand, seems to vary across LG people and becomes less consistent when we account for the ways they perceive the status of the LGBTQ+ community.

Overall, our results have important implications for theory and practice. In this article, we helped bridge theorizing from the SIA-H and the minority stress model, which allows us to go beyond identifying what can help LG people protect their mental health and instead focus on understanding how and under which conditions they cope. The findings of this study highlight the consistency and benefits of LGBTQ+ identification as a coping strategy for minority stress. Our results can help inform policies and interventions about the long-term benefits of LG people identifying with the LGBTQ+ community to counteract the adverse effects of minority stress. While individual mobility can be an effective coping strategy for some LG people, some practitioners may find it beneficial to challenge LG people's assumptions about the low status of the LGTBQ+ community. Doing so can potentially allow LG people in specific contexts to engage with the LGBTQ+ community to enhance their mental health.

Chapter 7

General Discussion & Conclusion

This thesis aimed to clarify how and under which conditions LG people manage their stigmatized sexual identities to cope with minority stress. To answer this question, we drew from the SIA-H (S. A. Haslam et al., 2009; Jetten et al., 2012) and the rejection-identification model (RIM; Branscombe et al., 1999) and applied them to the minority stress model (I. H. Meyer, 2003). By combining the teachings of these three theoretical frameworks, we aimed to dissect the underlying mechanisms that would enable (or not) LG people to either embrace or disregard their stigmatized sexual identity and LGBTQ+ group.

Across four empirical chapters, we tested six hypotheses pertaining to the association between minority stressors, LGBTQ+ social identity processes, and mental health outcomes among LG people. In addition to this, we expanded the theoretical frameworks by examining the ways cultural orientations (i.e., self-construal), and perceptions of the status and boundaries of the LGBTQ+ community (vs. a heterosexual outgroup) intersect with LG people's experiences and responses to minority stressors. Our hypotheses were the following:

- Minority Stress Hypothesis (H1): Higher levels of minority stress will be negatively associated with mental health outcomes among LG people, replicating prior evidence of this relationship.
- Individual Coping Hypothesis (H2): Minority stress will be positively associated with an increased likelihood of engaging in social or individual mobility strategies, which will, in turn, be related to poorer mental health outcomes.
- Collective Coping Hypothesis (H3): When faced with minority stress, LG people will increase their identification with the LGBTQ+ community and utilize psychological group resources (e.g., social support), which will be positively associated with better mental health outcomes.
- "Social Cure" Hypothesis (H4): The use of collective coping strategies by LG people in response to minority stress will be more likely to consistently enhance mental health outcomes compared to individual coping strategies.
- Socio-Structural Hypothesis (H5): Perceptions of the status legitimacy and stability and permeability of the boundaries between the LGBTQ+ community and the heterosexual outgroup will influence how LG people experience minority stress and whether they adopt individual or collective coping strategies.

- Cultural Hypothesis (H6): LG people's endorsement of independent versus interdependent self-construal will influence the extent to which they engage in individual or collective coping strategies.

Overall, our findings supported most of our hypotheses (i.e., H1, H3, H4, and H5), partially aligned with them (i.e., H2) or yielded mixed results (i.e., H6). Although the findings of each empirical chapter have already been discussed, a summary is offered in Table 7.1. Here we go beyond the individual findings of each chapter and instead engage with their broader implications. Subsequently, we will answer the main research question of this thesis by proposing a cohesive, evidenced-based model for how and under which conditions LG people cope with minority stress (see Figure 7.1.) and its impact on theory and practice. We will also address some of the limitations of this work while exploring potential avenues for future research.

Table 7.1. Overview of hypotheses, main findings, and implications

Name	Hypothesis	Main Variables	Main Findings	Chapter	Implications
H5: Socio-Structural Hypothesis	Perceptions of the status legitimacy and stability and permeability of the boundaries between the LGBTQ+ community and the heterosexual outgroup will influence how LG people experience minority stress and whether they adopt individual or collective coping strategies	Legitimacy x Stability x Permeability	Legitimacy was related to higher levels of individual mobility in both stable and unstable contexts and regardless of whether the boundaries were perceived as permeable or impermeable.	#3	LG people who perceive the low status of the LGBTQ+ community as stable and illegitimate need additional mental health support. Challenging perceived legitimacy and stability of the low status of the LGBTQ+ community can potentially prevent LG people from disengaging from their ingroup. Perceived permeability between the boundaries of the LGBTQ+ community and heterosexual outgroup doesn't help predict how LG people cope with minority stress.
		Legitimacy	Perceived illegitimacy in high minority stress contexts was related to worst mental health outcomes.	#4	
		Stability	Perceived stability in high minority stress contexts was related to worst mental health outcomes.	#4	
		Permeability	Permeability did not influence or moderate the relationship between minority stress and mental health.	#4	
		Legitimacy x Stability	Controlling for stability and legitimacy rendered the significant mediation effects of individual coping strategies non-significant.	#6	
H6: Cultural Hypothesis	LG people's endorsement of independent versus interdependent self-construal will influence the extent to which they engage in individual or collective coping strategies	Independent Self-Construal	LG people who endorse an independent self-construal were less likely to engage in individual mobility	#3	LG people's self-construal appears to influence how people engage with the LGBTQ+ community
		Interdependent Self-Construal	LG people who endorse an interdependent self-construal were more likely to draw resources from the LGBTQ+ community.	#3	
H1: Minority Stress Hypothesis	Higher levels of minority stress will be negatively associated with mental health outcomes among LG people, replicating prior evidence of this relationship	Minority Stress	Minority stress negatively predicted adverse mental health outcomes.	#4 - #6	Minority stress is still harmful towards LG people's mental health.
		Mental Health			
H2:	Minority stress will be positively associated with an increased likelihood of engaging in	Individual Mobility	Individual mobility was not associated with positive mental health outcomes	#5	Individual coping is not harmful to LG people; it is just

Individual Coping Hypothesis	social or individual mobility strategies, which will, in turn, be related to poorer mental health outcomes		Longitudinal evidence indicated that individual mobility enhanced LG people's mental health. However, this association became non-significant when accounting for the perceived status legitimacy and stability of the LGBTQ+ community.	#6	not a consistent strategy contingent to how they perceive the low status of the LGBTQ+ community.
H3: Collective Coping Hypothesis	When faced with minority stress, LG people will increase their identification with the LGBTQ+ community and utilize psychological group resources (e.g., social support), which will be positively associated with better mental health outcomes	LGBTQ+ Community Identification	Minority stress was associated with increased LGBTQ+ identification, which positively impacted LG people's mental health.	#5 - #6	LGBTQ+ identification helps LG people cope with minority stress and enhance their health. The health benefits of social support can be unlocked by first identifying with the LGBTQ+ community
		LGBTQ+ Social Support	Social support mediated the relationship between minority stress and mental health **only** when it was unlocked by LGBTQ+ identification.		
H4: "Social Cure" Hypothesis	The use of collective coping strategies by LG people in response to minority stress will be more likely to consistently enhance mental health outcomes compared to individual coping strategies	LGBTQ+ Community Identification LGBTQ+ Social Support Individual Mobility	Collective coping strategies consistently enhanced LG people's mental health outcomes than individual ones.	#5 - #6	Collective coping strategies are more consistent in protecting the mental health of LG people over time than individual ones.

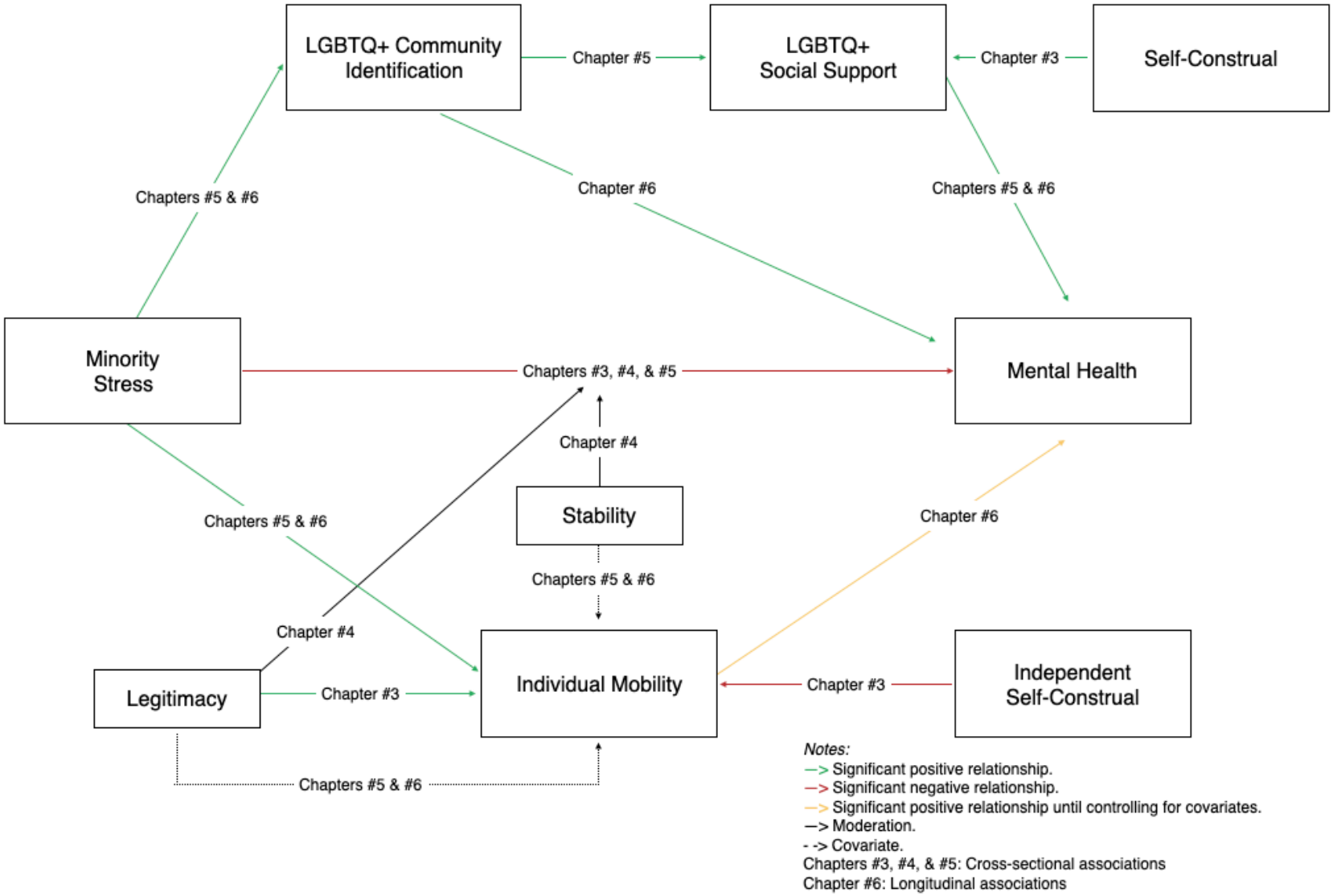

Figure 7.1. Thesis conceptual model: Evidence from empirical chapters

7.1. Minority Stress Hypothesis

An ever-growing body of research has consistently shown that minority stressors are associated with poor mental health outcomes for LG people (Mongelli et al., 2019; Plöderl et al., 2013; Semlyen et al., 2016; Wittgens et al., 2022). Throughout Chapters 4, 5, and 6, we replicated this negative association with cross-sectional and longitudinal data across LG people from five different countries and age groups. More specifically, we found that some LG people tend to experience more negative outcomes of minority stress than others (Chapter 5) and this is consistent over time (Chapter 6). We also put forth some insights into why this might be the case (Chapter 4), by highlighting that the insidious health consequences of minority stress can differ depending on whether LG people perceive the low status of the LGBTQ+ community (in relation to a heterosexual outgroup) as stable or illegitimate.

Taken together, our findings show that some LG people under certain conditions are more vulnerable to suffering the damaging health consequences of minority stress than others. While there is ample evidence documenting how LG people from specific demographics (e.g., being a young adult or a person of color) are more vulnerable to minority stress (e.g., Everett et al., 2019; Kertzner et al., 2009; I. H. Meyer et al., 2021), this thesis extends the current literature by evidencing how beliefs about the LGBTQ+ community can have health consequences. This result emphasizes two crucial implications. First, assessing how LG people perceive their community can help us identify those needing additional support. Based on our findings, these seem to be the case of LG people who perceive the low status of their community as stable (i.e., unchangeable) or illegitimate (i.e., unfair). Second, our results also open the possibility for minority stress interventions at an individual and interpersonal level to consider challenging some of these perceptions to foster positive mental health outcomes among LG people, specifically perceived status illegitimacy. Even though we found that perceived illegitimacy was associated with worse mental health outcomes, it is also related to incentivizing collective action among stigmatized people (Jetten et al., 2011; Meadows & Higgs, 2022; Reysen et al., 2016). Moreover, low-status groups tend to mobilize in favor of social change when they perceive the structural conditions of their group as illegitimate *and* unstable (Ellemers et al., 1990). However, perceived stability and illegitimacy have been associated with people disengaging from their group by concealing their identity (Plante et al., 2014). Therefore, we believe it could be worthwhile to investigate whether challenging LG people's perceptions of the stability of their group’s low-status position in society could be more impactful than focusing solely on perceptions of status illegitimacy.

7.2. Individual Coping Hypothesis

When stigmatized groups such as LG people are exposed to discrimination, a common response to it is to distance themselves from their group and the identities that stem from them (Branscombe et al., 2012; van Veelen et al., 2020). Many studies from classic social identity theory (Tajfel & Turner, 1979; Turner et al., 1987) and the SIA-H (Jetten et al., 2012) have found that for a variety of stigmatized groups, distancing from their ingroup can have beneficial or damaging consequences for their mental health (Bourguignon et al., 2020; Derks et al., 2016; Molero et al., 2011; Quinn et al., 2017). Our work extended this literature by cross-sectionally and longitudinally examining the aforementioned claims, while testing them with LG people's unique experiences with minority stress. Specifically, we found evidence suggesting that experiences of minority stress increased the likelihood for LG people to engage in individual mobility. Although individual mobility was not cross-sectionally related to mental health outcomes (Chapter 5), we found evidence of a temporal and positive relation between these two variables (Chapter 6). By disaggregating within and between-person effects through multilevel modeling, we observed that individual coping was an effective response against minority stress for some LG people but not others. Interestingly, when we controlled for perceived status legitimacy and stability, the positive association between individual mobility and mental health became non-significant. Taken together, our findings go against our initial hypothesis that individual mobility led to adverse mental health outcomes among LG people. However, these results also provided much-needed nuance on under which conditions individual strategies can and cannot be effective against minority stress.

The findings reported in Chapters 5 and 6 mirror research documenting the complicated ways in which LG people manage their identities to cope with minority stressors (Beagan et al., 2022; Bry et al., 2017). There seems to be no straightforward or "correct" way of individually responding to minority stress. The success of this strategy appears dependent on LG people's social context (Chaudoir & Fisher, 2010; Y. T. Huang & Chan, 2022; Pachankis et al., 2020) and on the individual employing said strategy. On the one hand, LG people who attempt to avoid being labeled as a sexual minority and evade homophobic discrimination, can become hypervigilant. This can heighten stress experiences while reducing their access to potential sources of social support and resources (see Bry et al., 2017) On the other hand, strategies involving LG people concealing their identity, "passing", and distancing from their sexual minority peers tend to be successful in contexts with pervasive LGBTQ+ discrimination (Hatzenbuehler, 2016; Pachankis & Bränström, 2018; van der Star et al., 2021). This makes sense not only for LG people to avoid discrimination but also to strive to maintain a positive

sense of identity (see Krane & Barber, 2003; Reicher et al., 2010). However, it is critical to acknowledge that while improving the social environments of LG people to be less homophobic is vital, it is also quite challenging and a slow-moving process (Chaudoir et al., 2017). Therefore, attention should also be given to understanding how to support and intervene with LG people experiencing these pervasive minority stressors.

Our empirical chapters extend some of this previous literature by evidencing the role perceptions about the LGBTQ+ community can have on LG people disengaging from their community. Specifically, the effectiveness of individual coping strategies depends on whether a LG person perceives the low status of their community as stable and legitimate. Our results helped better understand that challenging LG people's assumptions about their ingroup can be beneficial in contexts somewhat supportive of the LGBTQ+ community, such as the ones examined in this thesis (e.g., the United Kingdom and Germany). Challenging the perceived legitimacy and stability of the low status of the LGBTQ+ community can potentially allow LG people to reevaluate the assumptions that can heighten the harmful effects of minority stress. At the same time, it could also sway LG people to engage in coping methods that tend to be consistent over time.

7.3. Collective Coping Hypothesis

While the "curative" properties of identifying with one's group have been well documented (Jetten et al., 2017), the ways to access these positive health benefits are less straightforward for stigmatized groups like LG people (e.g., Dingle et al., 2015; Hogg et al., 2022; Jetten et al., 2018; Kellezi & Reicher, 2012; Wakefield et al., 2019). We clarified some of the ways LG people can achieve the so-called "social cure" and reap the benefits of being a member of the LGBTQ+ community. On top of that, our work was one of the first to examine cross-sectionally and longitudinally social identity processes among LG people as a potential coping response for minority stress. Our main results investigating the collective coping hypothesis can be broken into three implications.

The first implication is that we found that LG people who experience minority stress are more likely to identify with the LGBTQ+ community (Chapters 5 and 6). This result aligns with evidence from the SIA-H (Bourguignon et al., 2020; Brance et al., 2023; Molero et al., 2011) and the RIM (Bogart et al., 2018; Giamo et al., 2012; Ramos et al., 2012; Wellman et al., 2022) across various low-status groups. Our findings further extended the state of the art from the SIA-H and RIM beyond just focusing on perceived discrimination (Branscombe et al., 1999) and stigmatization (Jetten et al., 2018), to include LG people’s unique and personal experiences

with minority stress. Most notably, we observed a positive and significant temporal mediation (Chapter 6), thus suggesting that the health benefits of identifying with the LGBTQ+ community remained consistent over one year. From our perspective, this is robust evidence that collective coping is a reliable response to minority stress.

Second, our results show that social support only enhances LG people's mental health when it is unlocked by LGBTQ+ identification. We did not find evidence that LGBTQ+ social support mediated the relationship between minority stress and mental health, but that social support was positively related to mental health outcomes for some LG people (i.e., between-person effect; Chapter 6). And yet, we also found that the negative relation between minority stress and mental health was sequentially mediated by LGBTQ+ identification and social support (Chapter 5). These results combined align with the SIA-H assumptions, suggesting that identification is a necessary precursor or vehicle to unlock the socially derived psychological resources from one's group (Bowe et al., 2020; Häusser et al., 2020; McNamara et al., 2013). This appears to be the case, as LG people who embrace their sexual identities, rather than renouncing them, may be better positioned to connect with peers, access support and resources, and benefit from having more opportunities to engage with their ingroup, the LGBTQ+ community (Hinton et al., 2022). Identifying which paths foster positive mental health outcomes is particularly significant and can offer valuable insights for theories and practices focused on supporting LG populations.

Literature from the minority stress model has found that LGBTQ+ social support (sometimes referred to as community connectedness) is vital in promoting the health of LG people (Frost et al., 2016; Frost & I. H. Meyer, 2012; Montagno & Garrett-Walker, 2022; Petruzzella et al., 2019; Rogers et al., 2021). Our results align with this reasoning, while also underscoring that social support can help LG people cope with minority stress under certain conditions. Experiencing minority stress, then, does not seem to lead to feelings of support from the LGBTQ+ community. Therefore, interventions and policies should move beyond just fostering a sense of support among LG people. Practice should focus more on promoting LGBTQ+ identification among LG people and be proactive in helping them maintain a strong bond with it.

Lastly, the third and last implication of our results is that we did not find evidence that the ways LG people perceive the low status of their group impact their likelihood of engaging with the LGBTQ+ community. Specifically, we found no evidence that legitimacy, stability, or permeability was related to LGBTQ+ social support (Chapter 3), nor that LG people's perceptions of the legitimacy and stability of the LGBTQ+ community's lower status, compared to the heterosexual outgroup, influenced the effectiveness of collective coping strategies in

protecting their mental health from the adverse effects of minority stress (Chapters 5 and 6). These results do not entirely align with classic social identity theorizing (Reicher et al., 2010; Tajfel & Turner, 1979), suggesting that certain constellations of socio-structural characteristics can predict how stigmatized people respond to stigma. For instance, perceived impermeable group boundaries tend to increase stigmatized people's use of individual mobility (van Veelen et al., 2020), while perceived permeability, in both stable and unstable, legitimate and illegitimate contexts, encourages collective strategies (Ellemers et al., 1990).

Classic social identity research often makes assumptions about how certain stigmatized groups perceive their ingroup concerning a high-status outgroup but does not assess it. This lack of assessment of stigmatized groups' socio-structural conditions has been the case even for studies centered around LG people (see Bourguignon et al., 2020; Krane & Barber, 2003). Additionally, the evidence used to predict the behaviors of specific social minorities tends to be based on studies evaluating the behaviors of non-minority participants in trivial experimental conditions (Ellemers et al., 1990), those with superficial physical characteristics (e.g., body piercing; Jetten et al., 2001) or those with medical conditions (e.g., achondroplasia; Fernández et al., 2012). Unfortunately, these studies often fail to assess the identity management strategies of politized groups such as the ones of LG people. This thesis was among the first to empirically evaluate this structural condition among a LG population and test its effects on their identity-related coping responses. Our results also highlight that, unlike individual coping strategies, collective ones are not so contingent on how the status of the LGBTQ+ community is perceived (Chapters 5 & 6). Therefore, initiatives that want to help LG people identify with their community should focus not on challenging their assumptions but on fostering opportunities for them to identify with their ingroup.

7.4. "Social Cure" Hypothesis

The fourth hypothesis of this thesis assessed whether collective coping strategies were more effective and reliable over time than individual ones. This hypothesis was based on Jetten and colleagues' (2018) rationale that individual coping might not be sufficient to protect the stigmatized people who engage with them in the long term. Individual coping is often a lonely experience (Y. T. Huang & Chan, 2022), where a stigmatized person is responsible for bearing the burden of discrimination alone by cutting social ties with their peers (van Veelen et al., 2020). Therefore, when a minority person is unable to cope with stigma individually, the blame is not attributed to oppressive social conditions but to a sense of personal failure (Branscombe et al., 2012). In contrast, those engaging in collective coping are more exposed to stigma but

share a social safety net where the inability to cope with discrimination can lead to collective action, improving the conditions of the group (Chan, 2022).

Our findings helped us corroborate Jetten and colleagues' (2018) predictions. Specifically, we found that while individual and collective coping strategies have positive mental health outcomes for LG people experiencing minority stress, the conditions that make them possible differ (Chapter 6). First, the benefits of individual coping vary between people (i.e., between-person effect), but collective strategies do not. In fact, increased LGBTQ+ identification as a response to minority stress significantly predicted better mental health outcomes for LG persons over one year (i.e., within-person effect). Second, the efficacy of individual strategies depended on how LG people perceive the social conditions of the LGBTQ+ community. Yet, this was not the case for collective coping strategies. Therefore, collective coping in some contexts seems to be a more consistent way to buffer the adverse outcomes of minority stress over time.

Our thesis helps extend the SIA-H literature by being the first to test the benefits of the "social cure" among LG people through longitudinal data. This work also took a step further and empirically compared the efficacy of individual and collective strategies over time (Chapter 6). Our findings help inform that advising LG people to connect with their community can be a cost-effective intervention in reducing the burden of minority stress (e.g., Snapp et al., 2015; Wakefield et al., 2022).

We would like to emphasize that the results of this thesis do not say that it is the sole responsibility of LG people and their communities to cope with minority stress. Systemic changes achieved through advocacy, policies, and reforms are vital to ensure the protection of the LGBTQ+ community and reduce the harmful consequences of homophobic and heterosexist social conditions (Bränström & Pachankis, 2023). What this thesis and its results suggest is that, while working for macro-level solutions that bridge the mental health gap between LG people and heterosexual persons, individual and interpersonal-level interventions could also be implemented. According to our results, these interventions can benefit most from incentivizing and creating ways for LG people to cope collectively. They could also benefit from assessing how LG perceives the status of the LGBTQ+ community to create better conditions for some of them to avoid individual coping, when possible, and opt for more consistent collective coping strategies.

7.5. Socio-Structural Hypothesis

On top of the various health implications discussed about the perceived legitimacy and stability of the low status of the LGBTQ+ community, we would also like to underscore the role of

permeability. We found evidence that perceived legitimacy, in both unstable and stable, impermeable, and permeable conditions increase the likelihood of LG people engaging in individual mobility (Chapter 3). Additionally, our results showed that the permeability of group boundaries between LG people's LGBTQ+ ingroup and heterosexual outgroup did not relate to the adverse effects of minority stress on mental health, unlike perceived illegitimacy and stability (Chapter 4). These findings showed that whether the boundaries between the LGBTQ+ community and heterosexual people are porous or not, it matters little to LG people's experiences and responses to minority stress. This is why we opted to drop perceived permeability from Chapters 5 and 6.

We bring attention to our lack of consistent and significant findings for perceived permeability since this goes against one of the central tenets of classic social identity theory (Tajfel & Turner, 1979). The social identity approach consistently states that the perceived permeability of intergroup boundaries is the proxy determining whether minority groups will engage in individual or collective strategies (Reicher et al., 2010). When people from low-status groups can hide their stigmatized attributes, they will distance themselves from their ingroup rather than embrace it (van Veelen et al., 2020). This reasoning often leads researchers to conclude that groups with concealable stigmatized identities, such as LG people, are less likely to engage in collective action than ones with visible stigma (e.g., Bourguignon et al., 2020) While it is apparent that some stigmatized attributes are more concealable than others, some researchers make assumptions about how certain minorities perceive the boundaries and status of their ingroup with a relevant outgroup (e.g., Fernández et al., 2012; Krane & Barber, 2003). Not many studies measure these perceptions of stigmatized groups such as LG people, which can lead to studies making generic readings of social identity theory (for some exceptions, see Meadows & Higgs, 2022; Plante et al., 2014; Reysen et al., 2016; Verkuyten & Reijerse, 2008).

Examining the socio-structural conditions among LG people is not only interesting but essential due to the many circumstances surrounding their position in society. LG people in many parts of the world are living in a time with unprecedented levels of acceptance in society (Charlesworth & Banaji, 2019; Flores, 2021) while also experiencing increased homophobic backlash for their visibility (Edenborg, 2020). Sexual identity is also concealable (compared to attributes such as skin color; Pachankis et al., 2020; Quinn et al., 2017) but easily recognizable through social cues (Rule, 2017) even in early childhood before LG people self-identify as LGBTQ+ (Alessi et al., 2016; D'Augelli et al., 2006; Friedman et al., 2011). At the same time, "passing" is a response to the demands of homophobic contexts varying in how (Cox & Gallois, 1996) and where (Bry et al., 2017; Pachankis & Bränström, 2018) it is implemented. Therefore,

for LG people's sexual identity to be classified in the binary of concealable (vs. not concealable) and the boundaries of their group to be deemed permeable (vs. impermeable) with no proper assessment is, in our opinion, too simplistic.

A critical contribution of this thesis is that it was one of the first empirical works to measure how LG people perceive the status of and boundaries between the LGBTQ+ community and heterosexual people (Chapters 3 & 4). While we recognize that the role of perceived permeability in the lives of LG people merits further investigation, this thesis helps to understand the consequences socio-structural conditions can have on LG people's health and coping strategies. Our results show that legitimacy, not permeability, can be the proxy for guiding LG people to engage in individual mobility (Chapter 3). These results align with the research suggesting that stigmatized people experiencing pervasive discrimination and appraising their treatment as legitimate lessen their intent to engage in collective action (Jetten et al., 2011). However, appraising said pervasive discrimination as illegitimate can prompt ingroup identification. We hope that the results from these chapters can also serve as a basis to bring more attention to better understand the precise antecedents (see Jetten et al., 2013) of what allows LG people to perceive the status of the LGBTQ+ community as illegitimate in the first place.

7.6. Cultural Hypothesis

The last hypothesis we tested in this thesis examined the role of self-construal on LG people's enactment of individual or collective coping strategies. This hypothesis was one of the most exploratory in this work since cross-cultural research on LG people is very scarce. Based on self-construal theory (Markus & Kitayama, 1991, 2010) and evidence from individualism as a cultural value (Oyserman et al., 2002), we initially theorized that LG people who endorse an interdependent self-construal would be more inclined toward collective coping strategies, as their sense of self is deeply tied to how they relate with those around them. Conversely, those endorsing an independent self-construal might gravitate toward individual mobility, given their focus on uniqueness and authenticity. However, an independent self-construal might also afford LG people greater freedom, enabling them to manage their sexual identities with more autonomy, unburdened by the need to maintain harmony within close-knit groups such as family or neighborhood. On the other hand, an interdependent self-construal could bind LG people to more conservative norms, potentially discouraging open affiliation with the LGBTQ+ community and limiting their expression of sexual identity. Given these complexities and lack of concrete evidence, no specific a priori hypothesis was put forward regarding the direction of

this relationship, though it was expected that cultural orientation would influence how LG people relate to their LGBTQ+ ingroup.

Our results partially supported our supposition since we found evidence that an interdependent sense of self was positively associated with engaging with the LGBTQ+ community (Chapter 3). However, we also found that those who endorsed an independent self-construal were less likely to engage in individual mobility. We also observed that the instruments used to measure self-construal were only marginally reliable (see Chapter 3). Taking these results together, we decided against including culture in Chapters 4, 5, and 6 due to the mixed findings and low reliability of the instruments.

Although independent and interdependent self-construal are orthogonal (i.e., related but independent) rather than opposites (Cross et al., 2011), it is still challenging to make sense of the direction in which culture guides the behaviors of LG people. In this regard, results from Chapter 3 resemble some of the mixed findings from cultural psychology examining stigmatized groups. For instance, some studies observed that endorsement of interdependent self-construal and collectivistic tendencies can heighten (Ikizer et al., 2018; Papadopoulos et al., 2013; Zang et al., 2014) as well as protect (Aruta et al., 2021; Zang et al., 2014) people from stigma.

Culture is a complicated construct that stems from a collection of patterns of behaviors that can be expressed in various ways at different levels of analysis (Heine, 2010; Schwartz, 1994). This is one of the reasons why culture is often measured at a group level instead of an individual one (Taras et al., 2009, 2016). The individual endorsement of self-construal can be difficult to assess since people have to balance their personal interests with the ones of their group (Cross et al., 2011). It could be the case that evaluating cultural differences among minority groups can be even more challenging since the mainstream way of thinking and behaving can lead to the stigmatization of certain groups, such as LG people.

We found the low performance of the scales and mixed findings identified in Chapter 3 interesting in the case of LG people. It could be the case that the theory and measurement of self-construal are not fuzzy, but how it is operationalized may need further clarification when examining stigmatized groups. For instance, LG people in collectivistic cultures often tend to live a sense of a double life, being "closeted" to maintain harmony with their family and friends (Chan & Suen, 2023; Y. T. Huang & Chan, 2022; Zhu et al., 2022) but also living their authentic self on LGBTQ+ spaces (Chong et al., 2015). Considering all of this, we believe it could be worthwhile to examine stigmatized people's self-construal across various defined ingroups (e.g., family, friends, neighbors, LGBTQ+ community). It could also be that LG people might

endorse authenticity and individuality by openly engaging with the LGTBQ+ community while at the same time upholding traditional values through individual mobility when dealing with their family. Yet, further research is still needed to substantiate any of these claims.

Furthermore, Chapter 3 examined the individual endorsement of an independent or interdependent self-construal among LG people in over 20 countries. We find this detail worth mentioning since significant findings in cross-cultural psychology are often found when comparing Asian countries with North American and Western European countries (e.g., Baiocco et al., 2023), or between racial and ethnic groups (e.g., White Americans vs. Asian Americans; Kim et al., 2006). Robust cross-cultural research often does not compare the individual manifestations of cultural orientations across a wide range of countries. Undoubtedly, culture at an individual or group level influences how stigmatized people make sense of their identities (Li et al., 2022; Sun et al., 2020; Zang et al., 2014). However, in cross-cultural studies, cultural orientations such as self-construal are often not measured but assumed by the researcher. This can be problematic since it can reinforce stereotypes and arbitrary division of "East" and "West" instead of analyzing the complex ways selfhood is expressed across and within cultures (Vignoles et al., 2016). Said assumptions can even be more damning when trying to apply them to the people who are considered to be on the fringes of society due to their stigmatized identities. Therefore, we call for researchers to pay more attention to the individual expression and measurement of cultural constructs among those stigmatized rather than relying on assumptions of how certain groups are set to behave.

All in all, the insights of Chapter 3 mirror the implications we found about assessing perceived permeability, stability, and legitimacy (i.e., H5). Researchers can, and should get a more accurate and nuanced assessment of how LG people perceive their immediate cultural and social contexts instead of relying on their own assumptions and generalizations. While more research is still needed, this thesis was an excellent first step in examining the individual expression of self-construal among LG people and their relationship with the LGBTQ+ group. The theorizing and evidence of this thesis help provide a good starting point of why it can be worthwhile to assess LG people's cultural orientations and what that entails for their experiences with and responses to minority stressors.

7.7. Theoretical Contributions and Practical Applications

After a detailed overview of the results of each of the hypotheses tested in this thesis, we wanted to answer the broad question that guided this work: *how* and *under which conditions* do LG

people use their sexual identity to cope? This section will answer the question and highlight its potential implications for theory and practice.

LG people respond to minority stress by engaging or disengaging from the LGBTQ+ community. While both of these strategies are effective in enhancing their mental health, collective coping strategies seem more reliable over time. A key factor that influences some LG people to distance themselves from their ingroup is the perception that their low-status group is legitimate. Conditions of perceived illegitimacy and stability also tend to amplify the negative effects of minority stress and undermine the effectiveness of individual coping strategies (see Figure 7.1 for the full evidence-based model). It is also the case that certain cultural (i.e., self-construal) and demographic variables (i.e., partnership status and age) also seem to guide how LG people respond to minority stress and engage with their ingroup. However, more research is still needed to clarify the specific influence of societal perceptions and endorsement of cultural values.

7.7.1. Theoretical Implications

From a theoretical standpoint, this thesis highlights that LGBTQ+ identity-related variables best function as mediators, as depicted by the SIA-H (Jetten et al., 2012) and RIM (Branscombe et al., 1999), and not moderators. Our theorizing and results go against and expand the minority stress model (I. H. Meyer, 2003), which only considers individual and group resources as moderators. We believe this is important, because identity-related variables often yield mixed results when used as moderators in the relationship between stigma and mental health (Schmitt et al., 2014). LGBTQ+ social identity processes do not just merely buffer the adverse effects of minority stressors but help explain the precise mechanism that can enhance the mental health of LG people (Häusser et al., 2020). What serves as a moderator of the relationship is LG people's perceptions about the status of the LGBTQ+ community and their cultural orientations. Perceived status illegitimacy and stability help explain whether LG people will disengage from the LGBTQ+ community and experience minority stress, again aligning with the SIA-H (Jetten et al., 2018). Expanding the SIA-H, LG people's self-construal can help them further engage with the LGBTQ+ community.

Furthermore, our findings expand on Hatzenbuehler's (2009) model, as it emphasizes the mediating role of individual mobility and disentangles the many components that comprise connectedness with the LGBTQ+ community. Specifically, the health-enhancing benefits of being connected to the LGBTQ+ community can be achieved by identifying with it first. Only by identifying with members from their ingroup, can LG people receive the benefits of social support.

Our results help build a model bridging at least three theoretical frameworks, whose findings have been replicated with cross-sectional and longitudinal data as well as holding some cross-cultural validity. Doing so allows us to lay the groundwork for establishing a conversation between the minority stress and "social cure" literature, two orthogonal research fields. At the same time, this model helps make sense of the complex interplay between identity, stigma, and health. The visual depiction of each of the tested variables from the three different theoretical models is presented in Figure 7.1. This model has the potential to structure LGBTQ+ social identity processes for researchers who wish to use it as guidelines and test these variables in their studies. It can also allow researchers to dissect the many components that precede and follow LG people's (dis)engagement with the LGBTQ+ community.

7.7.2. Applied Implications

The model developed in this thesis also has implications beyond the theoretical realm across the following areas of intervention:

Policy

A key insight from this thesis is how LG-affirming policies can benefit from adopting the "social cure" approach (S. A. Haslam et al., 2009; Jetten et al., 2012) when addressing minority stress. The findings suggest that collective coping strategies, where LG people connect with and feel supported by the LGBTQ+ community, can provide a reliable means to enhance their mental health. Such community and socially inclined strategies could provide a cost-effective means of addressing mental health disparities related to sexual identity (Snapp et al., 2015). While structural or macro-level interventions may not directly influence individual coping preferences, they can still play a significant role by creating opportunities for social connections within the LGBTQ+ community (Chaudoir et al., 2017). For instance, policies could focus on establishing and maintaining spaces where LG people can meet, build relationships, and find support from their peers.

Though it may be challenging and perhaps even inappropriate for policymakers to mandate social connection among members of stigmatized groups like LG people, despite its evident health benefits across various settings (Jetten et al., 2017), there are still ways to indirectly apply some of the evidence of the “social cure” for minority stress found in this thesis. For example, policymakers can allocate resources to support local LGBTQ+ centers, venues, and community leaders, enabling them to host events such as support groups, social gatherings, conventions, or other activities. This approach is especially vital given the impact of the COVID-19 pandemic, which forced many queer spaces into financial instability are still trying to return to full or pre-

COVID capacity (Center for LGBTQ Economic Advancement & Research and Movement Advancement Project, 2022; Movement Advancement Project and CenterLink, 2022). By investing in and revitalizing these community spaces, policymakers can facilitate environments where LG people can build meaningful connections, enhancing their capacity to benefit from the "curative" power of their group identity.

Lastly, our findings suggest that policymakers should consider providing additional support for individuals working on LGBTQ+ issues. As noted in Chapter 4, those who perceive the low status of the LGBTQ+ community as stable and illegitimate often experience higher levels of minority stress. Interestingly, individuals with such beliefs are also more likely to engage in collective action and community initiatives (Chan, 2022; Jetten et al., 2011), indicating the possibility that working in LGBTQ+ centers and advocacy may hold these beliefs and, thus, experiencing heightened minority stress themselves. While the chapters in this thesis did not directly assess this and further research is needed, these insights can help build a case for supporting LG people engaged in LGBTQ+ collective action, such as working in LGBTQ+ community centers and advocacy. Policymakers could focus on designing initiatives that address the mental health needs of LG people working to challenge the low-status position of the LGBTQ+ community in society. This may involve creating programs that offer mental health services as well as training, self-care initiatives and community support tailored to those actively involved in LGBTQ+ advocacy and community work.

Social & Community

The findings of this thesis can also be used to inform social and community-level initiatives. A meta-analysis of minority stress interventions revealed that while most focus on reducing homophobic and heterosexist stressors, fewer emphasize strengthening LG people's coping mechanisms (Chaudoir et al., 2017). Addressing minority stressors is undeniably crucial for fostering the well-being of LG people; however, this gap underscores the need for interventions that also enhance the strategies they use to protect themselves and mitigate the harmful mental health effects of minority stress.

Furthermore, the same meta-analysis by Chaudoir and colleagues (2017) indicates that many interventions are primarily applied at the individual level, with few addressing multi-level initiatives that involve or utilize community or group resources. This represents a significant gap, as highlighted by the findings of this thesis, since social or group-based strategies can offer more consistent mental health benefits. By focusing solely on individual strategies, these

interventions may overlook the broader resources available within the LGBTQ+ community, which play a vital role in mitigating the effects of minority stress.

We propose that the "social cure" (Jetten et al., 2012) could effectively bridge this gap by integrating both individual and interpersonal approaches. This approach would promote evidence-based strategies that assist LG people in confronting minority stressors while enhancing their abilities to cope with it. The SIA-H emphasizes the “curative” power of social connections and group belonging, with interventions shown to improve mental health outcomes (C. Haslam et al., 2016; Jay et al., 2021; Steffens et al., 2021). In some cases, social connections have even been "prescribed" as a means of enhancing well-being (Wakefield et al., 2022). However, much of this research has centered on specific health issues, with less attention given to stigmatized groups like LG people.

By examining LGBTQ+ social identity processes, this thesis provides a framework for applying "social cure" principles to help LG people navigate minority stress. Our findings suggest that interventions could focus on two levels. At the individual level, they can challenge perceptions about the legitimacy and stability of the low status of the LGBTQ+ community. Simultaneously, at the interpersonal level, they can foster meaningful local connections within LGBTQ+ networks among LG people. These approaches could facilitate interventions that address individual, interpersonal, and community levels, thereby providing multi-dimensional support in managing minority stress.

Additionally, there is growing evidence that “social cure” interventions can be effectively implemented in online spaces (Finn et al., 2023). This is particularly relevant for LG people, as the benefits of the “social cure” have been demonstrated in digital contexts, potentially enhancing their health and prompting collective action (Chong et al., 2015). Consequently, the insights from this thesis can be applied in social and community initiatives hosted on digital platforms. This is noteworthy as it could serve as a way to reach LG people who are disconnected from LGBTQ+ spaces for various reasons. It could be especially beneficial for those living in rural or isolated areas, where access to LGBTQ+ communities and resources is more limited (Giano et al., 2021; Woodell, 2018). For those residing in overtly homophobic contexts, where association with the LGBTQ+ community may result in legal repercussion (see Flores, 2021; Mendos et al., 2020), online initiatives can provide a means of maintaining anonymity. This approach can also support those who wish or need to engage in individual mobility while minimizing the risk of being easily identified as a LG person or outed.

Educational

The insights from this thesis can also be applied to education, particularly in designing training programs for individuals working and providing services to LG people. Our findings provide empirical evidence for a "social cure" for minority stress within an LG sample, emphasizing the vital role those social connections play. While the health benefits of these types of connections and the harmful effects of social isolation may seem evident, they are often underestimated and overlooked (S. A. Haslam et al., 2018). Training programs should emphasize how fostering social ties can help LG people develop effective and consistent coping strategies for managing minority stress. Additionally, this framework can assist in the teaching of trainees how to support LG people in accessing the benefits of their group membership, underscoring the importance of initiatives like support groups and community engagement.

Another contribution of this thesis is its focus on how social and cultural differences influence LG populations. Recognizing the complexities in working with these communities is crucial. While existing research shows that factors such as race, ethnicity, gender, social class, and age significantly impact the experience of minority stress (Everett et al., 2019; I. H. Meyer et al., 2021; Shangani et al., 2020), our thesis also highlights how individual perceptions of the LGBTQ+ community, cultural orientations, and identity management strategies affect these experiences. Raising awareness of these nuances is vital for developing effective intercultural competency training for those working with and for LG people. By integrating these considerations into training programs, professionals may be better equipped to support the diverse needs of LG people.

Clinical

The findings of this thesis can also be implemented with, and by mental health practitioners, such as psychotherapists, by offering an evidence-based framework to better support LG people. Even though there are no one-size-fits-all solutions for addressing minority stress due to the diversity within the LGBTQ+ community, our findings can serve as a useful foundation. Practitioners have the opportunity to adapt the following three insights to the unique needs and circumstances of each LG person, ensuring intersectional as well as tailored approaches to support their mental health and well-being (see Huang et al., 2020)

First, mental health professionals working with LG clients may find it beneficial to encourage them to seek out and connect with the LGBTQ+ community as a means to enhance their overall well-being. Although this might seem evident, this thesis clarifies that there are concrete steps to achieve the benefits of the “social cure.” Collective coping can help mitigate the adverse effects of minority stress; however, practitioners should be mindful that merely

visiting LGBTQ+ spaces or meeting others from the community may not fully unlock the psychological benefits. It's essential to work with LG clients on developing a stronger identification with the LGBTQ+ community, while addressing any preconceptions they might have about its status and position in society. These steps can facilitate access to psychological resources, such as social support.

Second, our results can aid mental health practitioners in supporting individuals who engage in individual mobility strategies. While such coping mechanisms are not inherently harmful, they may be less consistent than collective coping in protecting LG people from minority stressors. Psychotherapeutic interventions should consider the unique needs of LG clients who either choose or feel compelled to "pass" in hostile or homophobic environments. This may involve providing tailored support for clients using individual mobility strategies while contemplating ways to connect them with the LGBTQ+ community, if desired.

Lastly, this thesis opens new avenues for interventions that address how LG people perceive the status of their community. Mental health practitioners could develop initiatives aimed at reshaping clients' beliefs about the legitimacy and stability of the LGBTQ+ community. By challenging negative perceptions and providing support to those who view the community as illegitimate, practitioners can foster more reliable coping mechanisms. This approach may also reduce feelings of powerlessness and encourage clients to engage in collective efforts that enhance their well-being and improve the broader status of the LGBTQ+ community.

7.8. Limitations and Future Directions

Even though our findings helped expand our understanding of how LG people cope with minority stress, they also presented limitations. In the following section, we will discuss some of the overarching limitations of the present thesis. Subsequently, we will expand upon how said limitations can open other lines of research and present possible ways in which some of the lingering questions left unanswered by our thesis can be examined in future studies.

One of the most pressing limitations found across this thesis was the difficulty of reaching LG people who did not want to be labeled as such. Throughout our empirical chapters, we noticed that our participants tended to report lower levels of individual mobility but expressed moderate to high levels of identification with the LGBTQ+ community. These findings could suggest that our sample was biased towards being already connected to the LGBTQ+ community. Said bias could partially explain why we found consistent evidence of the protective properties of LGTBQ+ identification and why individual mobility was more of an inconsistent strategy. The obstacles of studying the effects of individual mobility, identity

concealment, or "passing" among LG people are not unique to our thesis. These challenges are documented in Pachankis et al.'s (2020) meta-analysis on identity concealment, where they state that "studies of sexual orientation concealment will always be biased by the very phenomenon under investigation" (p. 834). Additionally, using LG self-identifications as a pre-screen question and filtering for sexual orientation on crowdsourcing platforms could have amplified some of the challenges of recruiting LG participants engaging in individual mobility. We were aware of the bias and tried to minimize it by avoiding convenience and snowball sampling methods, typically used in studies with LGBTQ+ populations (I. H. Meyer & Wilson, 2009). Instead, we opted for online crowdsourcing platforms to recruit a wide range of LG participants while guaranteeing their anonymity. We recommend future studies examining individual mobility among LG people to be aware of the inevitable sample bias and seek strategies to minimize it. Some strategies could include moving away from using self-identification as an inclusion criterion and instead broadening their operationalization of what classifies (or not) as a LG person. For instance, Pachankis et al. (2020) suggest using methods that assess "a recent and/or persistent pattern of same-sex behavior or same-sex attraction" (p. 833). While this method also has limitations, as not all people who experience same-gender attraction are LG people or even sexual minorities, it does open the possibility to examine in more detail how people respond to homophobic and heterosexist stressors. Future studies could also focus on assessing the experiences of LG people who engaged in some of the most extreme forms of individual mobility. For instance, using retrospective qualitative methods to uncover the specific ways individual mobility impacted the health of LG people who used to be in a heterosexual marriage. Alternatively, future studies could employ longitudinal approaches to investigate the ways through which some LG people abandon the LGBTQ+ label and what are the impacts of such decision on their mental health. While these may be exceptional cases, these experiences could shed light on the nuanced ways individual mobility shapes people's mental health.

A second limitation is the lack of methodological diversity throughout the thesis. Across our four empirical chapters, self-reported measures, quantitative, and regression models were the primary form of methodological design and analysis used to assess individual and collective coping strategies among LG people. Our choice to go with mediation and moderation models stems from the long tradition of minority stress and SIA-H literature to examine said processes through these types of models. Although such bias and methodological limitations may still be present, we sought to mitigate them by including a 1-year longitudinal study, which provides

robust evidence for our findings and allows us to assess the temporal associations among our main variables of interest.

The lack of generalizability of our results has been discussed in more detail in the limitation section of each of our chapters (see Chapters 3 to 6). Some of our findings regarding the benefits of collective coping strategies should be extrapolated with caution to LG people outside of Western, educated, industrialized, rich, and democratic (WEIRD) countries (Henrich et al., 2010), and to the different subpopulations that make up the LGBTQ+ community. For instance, our methodology was likely insufficient to grasp the nuanced ways LG people outside of WEIRD countries (e.g., Sun et al., 2020), people of color (Cyrus, 2017), gender-diverse people (Lefevor et al., 2019), and people with disabilities (Fredriksen-Goldsen et al., 2012) cope with multiple minority stressors. At the same time, many LG people in many real-life settings do not use one coping strategy over another, but often a combination of both (Beagan et al., 2022). Therefore, regression models might also be insufficient in identifying the many complex ways LG people respond to different contextual demands across their lives. Future research could use this thesis' theoretical contributions and findings and examine their generalizability to LG people from non-WEIRD countries. Our models can also be tested with LG people belonging to different marginalized groups. For instance, it could be interesting to assess how LG people of color perceive the legitimacy, stability, and permeability of their LGBTQ+ ingroup, and how that influences the ways they manage their racialized sexual identity. Other studies could examine and even compare the benefits and limitations of individual and collective coping across countries with different acceptance levels towards LG people (e.g., Taiwan vs. China). Our results could also help guide future qualitative studies examining social identity processes among LG people. By using qualitative studies, researchers can take a close look at the complicated and sometimes contradicting ways LG people balance both individual and collective coping (e.g., being "out of the closet" with friends and family but "in the closet" at work). Qualitative studies can also explore what being part of the LGBTQ+ community means to different LG subpopulations. These types of distinctions can be crucial to disentangle LGBTQ+ social identity processes between White cis-men-dominated mainstream spaces vs alternative trans-inclusive queer families (e.g., Arnold & Bailey, 2009; Levin et al., 2020). Doing so could also help disentangle what forms and under which conditions engagement with the LGBTQ+ community is harmful to different sexual and gender minorities, and which are not (see Foster-Gimbel et al., 2020). It could also be of great interest for future studies to expand our model and hypotheses by applying them to other LGBTQ+ subpopulations (e.g., bisexual and gender-diverse people).

The third limitation is our inability to examine the experiences of minority stress and identity management strategies among bisexual, pansexual, trans, and gender non-conforming individuals as well as other sexual and gender minorities. While we collected data from bisexual, pansexual, transgender, and gender non-conforming individuals, the subsample sizes were too small to enable meaningful comparisons with LG populations. Additionally, this thesis focused on sexual identity-related processes, and the methods used to operationalize and measure these processes in our studies may not fully capture the experiences of underrepresented sexual and gender minorities within the LGBTQ+ community. For instance, bisexual individuals often face unique stigmas, such as bisexual erasure, that can influence their connection with the LGBTQ+ community (Feinstein & Dyar, 2017). Similarly, trans and gender non-conforming individuals have distinct experiences regarding minority stress that differ from those of cisgendered LG people (Lefevor et al., 2019). The minority stress model developed by I. H. Meyer (2003) does not adequately address the complexities of navigating transphobia, thus requiring adaptations and extension to adequately capture the experiences of gender-diverse people (Hendricks & Testa, 2012). Furthermore, how gender-diverse individuals make sense of their sexual orientation seems to be intertwined and influenced by their trans experience (Jacobson & Joel, 2019; Skrzypczak et al., 2024), making it difficult to separate experiences related to transphobia or gender dysphoria from those tied to sexual identity. We hope that future research can take some of the insights and the theoretical model presented in this thesis, and adapt them to meet the needs of other LGBTQ+ members. Specifically, examining how bisexual and trans individuals cope with their unique minority stressors would be valuable. For instance, it would be interesting to explore how these individuals embrace or distance themselves from their respective stigmatized identities. Additionally, future studies could delve deeper into how bisexual and trans people conceptualize individual mobility and their connection to the LGBTQ+ community. For instance, investigating how trans and gender-diverse individuals relate to "passing" could provide important insights into their experiences of minority stress and mental health outcomes, particularly given the changes in body, presentation, and appearance that may accompany these experiences.

The fourth limitation pertains to certain instruments we used throughout our thesis, and more specifically, the scales we used to measure minority stress and perceived stability. One of our main goals was to assess how LG people respond to minority stress (including proximal and distal stressors). Despite the minority stress model being one of the most well-researched frameworks in LGBTQ+ literature (Frost & I. H. Meyer, 2023), after 20 years of its conception, validated instruments that can reliably measure all its constructs are scarce (Schrager et al.,

2018). Studies examining minority stress tend to assess one of its many components or focus on either proximal (e.g., Dyar et al., 2018) or distal stressors (e.g., Lattanner et al., 2022). The studies that measure all minority stress variables ask participants to fill in a battery of four or more psychometric tests of theoretically distinct but interconnected stressors (e.g., Bauerband et al., 2019). In this thesis, we used the short version of the Minority Stress Scale developed by Outland, (2016) as it succinctly measured all components of minority stress. Despite being used across various studies (e.g., Jaspal et al., 2022), this scale has yet to be validated outside the United States and with more extensive and diverse samples. While Chapters 4 and 5 confirmed the harmful effects of minority stress on the mental health of LG people, as previously reported (Mongelli et al., 2019; Wittgens et al., 2022), evidence from Chapter 6 was less clear. Specifically, the association between minority stress and mental health was non-significant at Time 1 and Time 2 but became significant at Time 3. These weak and inconsistent findings in Chapter 6 raise questions about this measure's reliability, especially when we compare it to some of the more established measures we used across our thesis, such as the one from Leach et al. (2008). The other scale that raised some questions was stability. This comprises two items, one of which is reversed (Mummendey et al., 1999). However, after reversing the item and examining its correlations with the other items, we found that they were often negative and significant, which contradicts how the measure was intended to function. As a result, we decided to drop one of the items and adopt a single-item measure, consistent with approaches used in previous studies (see Plante et al., 2014). Therefore, using a single-item measure that is not intended to be used as such may raise questions about the construct validity of this scale. By highlighting the potential limitations of some of the scales used, we do not intend to suggest that they are inherently flawed. Instead, we would like to encourage researchers to conduct more thorough studies examining the reliability and validity of these instruments. Doing so can help reduce some uncertainties and methodological questions about using these scales outside their intended context and target group. We would also like to encourage researchers to focus on developing more comprehensive psychometric measures for minority stress.

Similarly, the fifth limitation is the operationalization of cultural orientations and their measurement across our empirical chapters. As mentioned in the cultural hypothesis section, the measures used to examine self-construal yielded mixed results and had questionable reliability. While our research was one of the few to examine cultural variability among LGBTQ+ social identity processes against minority stress among LG, more cross-cultural research and LGBTQ+ culturally sensitive instruments are very much needed. We highlight the need for LGBTQ+ culturally sensitive instruments because some of the items of self-construal

measures (D'Amico & Scrima, 2016; Singelis, 1994) often refer to the participant's relationship with the biological family ingroup (e.g., "If my brother or sister fails, I feel responsible"), a particularly volatile or hostile bond among LG people (e.g., Carastathis et al., 2017). Other questions also involve asking participants about expressing their true authentic selves across different contexts (e.g., "I act the same way at home that I do at school or work"), something that may not be possible for many LG people because of the presence of homophobia (e.g., Pachankis et al., 2020; Sun et al., 2020). Future studies might investigate adapting said instruments to assess the self-construal of LG people or other stigmatized groups in relation to other ingroups, such as their LG peers and chosen families.

The sixth limitation is the importance of accounting for how multiple social identities and their intersections impact the mental health of LG people. Across our empirical chapters, we found mixed evidence that characteristics such as age, partnership status, and sometimes gender were correlated or associated with mental health outcomes, individual or collective coping strategies, and the perceptions of the status between the LGBTQ+ community and heterosexual people. In our chapters, we tended to report some of these relationships or account for them by adding covariates in our various models. However, we did not engage with these results in more depth. Evidence from the SIA-H does suggest that the benefits of belonging to multiple social groups can "add up" positively impacting people's mental health (Jetten et al., 2015; Lam et al., 2018). It could be of interest for researchers to take a closer look at how LG people's identifications with the LGBTQ+ community *and* with their gender, age, and partnership status can shape their mental health outcomes and the ways they respond to minority stress. Future studies could also examine how the intersection of being an LG individual who is young and single—demographics often associated with experiencing heightened minority stress—affects their experiences and coping strategies (Laming et al., 2023; I. H. Meyer et al., 2021), make sense of their multiple social identities, and what that entails for how they experience and cope with minority stress.

Lastly, we would like to acknowledge that using crowdsourcing platforms offered significant benefits but also some limitations (see Rea et al., 2020; Stewart et al., 2017). One limitation is that these platforms have limited access to participant pools outside of Anglo-American and European countries. In our case, this limited our ability to meaningfully assess experiences outside of the United States, the United Kingdom, or parts of central and northern Europe (see Clickworker, 2024; Prolific, 2024). Unfortunately, these regions tend to dominate the participant bases on crowdsourcing platforms like Prolific and Clickworker. As a result, we were unable to thoroughly examine the minority stress experiences of LG people in countries

such as Portugal or other Southern European regions, which often have limited research output on LGBTQ+ issues compared to Anglo-American countries. We hope that future research finds creative and innovative ways to examine the experiences of LG people navigating minority stress in these underrepresented geographical locations. One approach could be better utilizing the targeting features available on crowdsourcing platforms like Prolific to reach desired populations more precisely. Additionally, those with more extensive research funding could consider investing in services that can help them obtain representative samples from countries outside of Anglo-American contexts (e.g., Qualtrics research panels). This would allow for greater geographical diversity and a more nuanced understanding of minority stress across different cultural settings. Lastly, we recommend that future studies who want to use crowdsourcing platforms to gather participants beyond the United States, United Kingdom, and Northern Europe to allocate time and resources to include a thorough pre-screening phase as a way to gather sufficient data. This would help ensure that researchers can reach their intended sample size, allowing for more robust data analysis and findings that document the experiences of LG people outside the Anglo-American context. Expanding the geographical scope of research in this way would provide a more comprehensive understanding of how minority stress impacts LG people in under-studied cultural and social environments.

7.9. Concluding Remarks

In the current global climate, LGBTQ+ people, including but not limited to those identifying as lesbian and gay, find themselves navigating a complex and often contradictory social and political landscape. While many countries around the world are reaping the benefits of years of LGBTQ+ inclusive policies and increased levels of acceptance for LG people, these advances coexist with an increase in homophobic and heterosexist backlash (Edenborg, 2020; Flores, 2021). LG people must now balance greater visibility and societal recognition with the harmful effects of this backlash, which can significantly impact their mental health and well-being. This tension is further heightened by the rise of anti-LGBTQ+ hate speech, interpersonal violence, political actors, and legislation (European Union Agency for Fundamental Rights, 2024; Mendos et al., 2020; Velasco, 2023) in various countries threatening not only the livelihoods of LGBTQ+ people but also undermining the progress made in securing their rights.

At a time when large-scale, macro-level policies supporting LGBTQ+ rights are increasingly under threat, it is crucial to safeguard and expand these protections. However, it is equally important to explore strategies that provide LG people with individual and community-based avenues for preserving their mental health. The present thesis contributes to this ongoing

conversation by offering empirical insights and evidence-based guidelines for possible ways of strengthening the coping strategies of LG people against minority stress. Our findings underscore the importance of providing LG individuals and their communities with the resources and support needed to navigate and challenge societal forces that perpetuate sexual identity-related mental health inequalities between LG and heterosexual people.

Addressing the mental health inequalities between LG people and heterosexual individuals caused by minority stress can be daunting. However, the complexity and difficulties of this issue should not prevent researchers or practitioners from dissecting these processes to better understand how to support LG people. To make sense of and structure the complicated ways through which LG people manage their LGBTQ+ identities, we drew from the board framework of the SIA-H (Jetten et al., 2012) and RIM (Branscombe et al., 1999). Subsequently, we applied these frameworks to the nuanced theoretical underpinning of the minority stress model (I. H. Meyer, 2003).

Across four empirical chapters with over 800 LG participants, we identified that collective coping responses (i.e., engaging with the LGBTQ+ community through identification and social support) are more of a reliable strategy against minority stress when compared to individual ones (i.e., disengagement through individual mobility). Our findings also highlighted the critical role of perceived social conditions and cultural orientations on LG people's coping responses. Overall, these results were compiled on an evidence-based model that can guide researchers and practitioners alike to assess and intervene in LG people's experiences with minority stressors at an individual and interpersonal level of analysis. We believe that the results of this thesis and its model extend the existing knowledge of the minority stress literature and the SIA-H by bridging both frameworks while also including the influence of the socio-structural and cultural context.

Knowing how and under which conditions LG people cope with minority stress can allow us to create better initiatives that connect them to their LGBTQ+ communities, unlocking its positive psychological resources. We also hope the findings of this thesis can stimulate new avenues of research experimenting with interventions that support or challenge some of LG people's beliefs about the legitimacy and stability of their low-status group. Lastly, we hope our findings can motivate upcoming researchers to help clarify how cultural orientations impact the lives of LG people.

Minority stressors are a pervasive struggle in the lives of many LG people. It is an omnipresent phenomenon that must be addressed and intervened at all levels. While there is still a long battle ahead to minimize the suffering caused by homophobia and heterosexism,

works like this shed light on how resourceful LG people are. We hope that the findings of this thesis can grant researchers and practitioners evidence-based and practical ways to harness LG people's resourcefulness in solutions that create a respite from minority stress even in these paradoxical and uncertain times. It is vital to ensure that LG people use their resources to the best of their capacities to improve their mental health, not only as individuals but also as a collective.

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Appendix A: Questionnaire for Chapter VI

Start of Block: Informed Consent

Survey: Perceptions and Experiences of Lesbian and Gay People This study is being conducted by Gustavo Aybar Camposano from CIS-Iscte - Centre for Social Research and Intervention (CIS-Iscte) at Iscte – Instituto Universitario de Lisboa under the supervision of Carla Moleiro, Ph.D. (CIS-Iscte), David Rodrigues Ph.D. (CIS-Iscte), and Andrea Carnaghi, Ph.D. (University of Trieste). This study aims to understand how the perceptions and experiences of lesbian and gay people ages 18-35 change over one year. We are looking for participants who are proficient in English and live in the United Kingdom, the United States, Australia, Germany, and the Netherlands. Your participation in the study, which is highly valued as it will contribute to advancing knowledge in this field of science, consists of completing an online survey. The survey will take approximately 10 minutes to complete. If you meet all the criteria to participate in this study and fill in the present survey, you will be paid for your time. As this is a longitudinal study, the research team will contact you in four to six months to complete a follow-up study. Your participation in the forthcoming and last follow-up is also voluntary and anonymous, and you will also be paid for your time. Iscte is responsible for the processing of your personal data that are collected and processed exclusively for the purposes of the study, legally based on Article 6(a) of the GDPR. The study is conducted by Gustavo Aybar Camposano (email: garou@iscte-iul.pt), who you may contact to clear up any doubts, share comments or exercise your rights in relation to the processing of your personal data. You may use the contact indicated above to request access, rectification, erasure, or limitation of the processing of your personal data. Your participation in this study is confidential. Your personal data will always be processed by authorised personnel bound to the duty of secrecy and confidentiality. Iscte assures the use of appropriate techniques, organisational and security measures to protect personal information. All investigators are required to keep all personal data confidential. In addition to being confidential, participation in the study is strictly voluntary: you may choose freely whether to participate or not. If you have decided to participate, you may stop your participation and withdraw your consent to the processing of your personal data at any time without having to provide any justification. The withdrawal of consent shall not affect the lawfulness of processing based on consent before its withdrawal. All of your responses to this survey will remain anonymous and cannot be linked to you in any way. No identifying information about you will be collected at any point during the study. There are no expected significant risks associated with participation in the study. However, when filling out the survey, you may come across a question that you find unpleasant or upsetting. Thus, it is not necessary to answer all of the questions. Iscte does not disclose or share with third parties information related to its personal data. Iscte has a Data Protection Officer who may be contacted by email: dpo@iscte-iul.pt. If you consider this necessary, you also have the right to submit a complaint to the Portuguese Data Protection Authority (CNDP).

Electronic Consent I declare that I have understood the aims of what was proposed to me, as explained by the investigator, and that I was given the opportunity to ask any questions about this study and received a clarifying reply to all such questions. I accept participating in the study and consent to my personal data being used in accordance with the information that was given to me.

- ○ Yes
- ○ No

End of Block: Informed Consent

Start of Block: No

Thank you

As you do not wish to participate in this study, please return your submission on Prolific Academic by selecting the 'Stop without completing' button.

Thanks again for your interest.

End of Block: No

Start of Block: Sociodemographic

Please answer the following information about yourself:

What is your gender identity?

- ○ Man
- ○ Woman
- ○ Trans Man
- ○ Trans Woman
- ○ Non-Binary or Genderqueer
- ○ Not listed above (please state)
  _____

What sex were you assigned at birth, meaning on your original birth certificate?

- ○ Male
- ○ Female

What's your current relationship status?

- ○ Single
- ○ Living with partner(s)
- ○ In a relationship but not living together
- ○ Married / Civil Partnership
- ○ Divorced / Separated
- ○ Widowed
- ○ Prefer not to say

Are you currently…?

- ○ Employed
- ○ Self-Employed / Freelancer
- ○ Interning
- ○ Part-time
- ○ Unemployed
- ○ Studying
- ○ Millitary / Forces
- ○ Retired
- ○ Not able to work
- ○ Other

Highest level of education obtained?

- ○ No formal education
- ○ High school diploma
- ○ College degree
- ○ Vocational training
- ○ Bachelor’s degree
- ○ Master’s degree
- ○ Professional degree
- ○ Doctorate degree

What is your age?

_____

In which country do you currently reside?

- ○ Afghanistan
- ○ Albania
- ○ Algeria
- ○ Andorra
- ○ Angola
- ○ Antigua and Barbuda
- ○ Argentina
- ○ Armenia
- ○ Australia
- ○ Austria
- ○ Azerbaijan
- ○ Bahamas
- ○ Bahrain
- ○ Bangladesh
- ○ Barbados
- ○ Belarus
- ○ Belgium
- ○ Belize
- ○ Benin
- ○ Bhutan
- ○ Bolivia
- ○ Bosnia and Herzegovina

- ○ Botswana
- ○ Brazil
- ○ Brunei Darussalam
- ○ Bulgaria
- ○ Burkina Faso
- ○ Burundi
- ○ Cambodia
- ○ Cameroon
- ○ Canada
- ○ Cape Verde
- ○ Central African Republic
- ○ Chad
- ○ Chile
- ○ China
- ○ Colombia
- ○ Comoros
- ○ Congo, Republic of the...
- ○ Costa Rica
- ○ Côte d'Ivoire
- ○ Croatia
- ○ Cuba
- ○ Cyprus

- Czech Republic
- Democratic People's Republic of Korea
- Democratic Republic of the Congo
- Denmark
- Djibouti
- Dominica
- Dominican Republic
- Ecuador
- Egypt
- El Salvador
- Equatorial Guinea
- Eritrea
- Estonia
- Ethiopia
- Fiji
- Finland
- France
- Gabon
- Gambia
- Georgia
- Germany
- Ghana

- ○ Greece
- ○ Grenada
- ○ Guatemala
- ○ Guinea
- ○ Guinea-Bissau
- ○ Guyana
- ○ Haiti
- ○ Honduras
- ○ Hong Kong (S.A.R.)
- ○ Hungary
- ○ Iceland
- ○ India
- ○ Indonesia
- ○ Iran, Islamic Republic of...
- ○ Iraq
- ○ Ireland
- ○ Israel
- ○ Italy
- ○ Jamaica
- ○ Japan
- ○ Jordan
- ○ Kazakhstan

- Kenya
- Kiribati
- Kuwait
- Kyrgyzstan
- Lao People's Democratic Republic
- Latvia
- Lebanon
- Lesotho
- Liberia
- Libyan Arab Jamahiriya
- Liechtenstein
- Lithuania
- Luxembourg
- Madagascar
- Malawi
- Malaysia
- Maldives
- Mali
- Malta
- Marshall Islands
- Mauritania
- Mauritius

- ○ Mexico
- ○ Micronesia, Federated States of...
- ○ Monaco
- ○ Mongolia
- ○ Montenegro
- ○ Morocco
- ○ Mozambique
- ○ Myanmar
- ○ Namibia
- ○ Nauru
- ○ Nepal
- ○ Netherlands
- ○ New Zealand
- ○ Nicaragua
- ○ Niger
- ○ Nigeria
- ○ North Korea
- ○ Norway
- ○ Oman
- ○ Pakistan
- ○ Palau
- ○ Panama

- ○ Papua New Guinea
- ○ Paraguay
- ○ Peru
- ○ Philippines
- ○ Poland
- ○ Portugal
- ○ Qatar
- ○ Republic of Korea
- ○ Republic of Moldova
- ○ Romania
- ○ Russian Federation
- ○ Rwanda
- ○ Saint Kitts and Nevis
- ○ Saint Lucia
- ○ Saint Vincent and the Grenadines
- ○ Samoa
- ○ San Marino
- ○ Sao Tome and Principe
- ○ Saudi Arabia
- ○ Senegal
- ○ Serbia
- ○ Seychelles

- ○ Sierra Leone
- ○ Singapore
- ○ Slovakia
- ○ Slovenia
- ○ Solomon Islands
- ○ Somalia
- ○ South Africa
- ○ South Korea
- ○ Spain
- ○ Sri Lanka
- ○ Sudan
- ○ Suriname
- ○ Swaziland
- ○ Sweden
- ○ Switzerland
- ○ Syrian Arab Republic
- ○ Tajikistan
- ○ Thailand
- ○ The former Yugoslav Republic of Macedonia
- ○ Timor-Leste
- ○ Togo
- ○ Tonga

- ○ Trinidad and Tobago
- ○ Tunisia
- ○ Turkey
- ○ Turkmenistan
- ○ Tuvalu
- ○ Uganda
- ○ Ukraine
- ○ United Arab Emirates
- ○ United Kingdom of Great Britain and Northern Ireland
- ○ United Republic of Tanzania
- ○ United States of America
- ○ Uruguay
- ○ Uzbekistan
- ○ Vanuatu
- ○ Venezuela, Bolivarian Republic of...
- ○ Viet Nam
- ○ Yemen
- ○ Zambia
- ○ Zimbabwe

Do you consider yourself to be

- ○ Lesbian
- ○ Gay
- ○ Bisexual
- ○ Heterosexual (or straight)
- ○ Prefer not to answer
- ○ Not listed above (please state)

_____

End of Block: Sociodemographic

Start of Block: Pre-Screening

We Are Sorry Unfortunately, you are not a match for this study since it only focuses on the experiences of a specific subset of people which were outlined in the electronic consent form at the beginning of this study. Please return your submission on Prolific Academic. Thanks again for your interest in this study!

End of Block: Pre-Screening

Start of Block: Prolific ID

Please enter your Prolific ID:
Please note that this response should auto-fill with the correct ID'

_____

End of Block: Prolific ID

Start of Block: Commitment Check

We care about the quality of our survey data. For us to get the most accurate mesures of your opinions, it is important that you provide thoughtful answers to each question in this survey.

Do you commit to providing thoughtful answers to the questions in this survey?

- ○ I can't promise either way
- ○ Yes, I will
- ○ No, I will not

End of Block: Commitment Check

Start of Block: Fail Attention Check

JS

We Are Sorry
Thank you for your honesty and time. However, you are not a match for this study since you stated you would not commit to providing thoughtful answers to the question in this survey.

Please return your submission.

Thanks again for your interest in this study.

End of Block: Fail Attention Check

Start of Block: Self-Construal Scale (SCS)

Listed below are a number of statements. Read each one as if it referred to you.
Besides each statement please indicate the extent to which you agree or disagree with each of the statements below:

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
I do my own thing, regardless of what others think.	○	○	○	○	○	○	○
I'd rather say "No" directly, than risk being misunderstood.	○	○	○	○	○	○	○
I prefer to be direct and forthright when dealing with people I've just met.	○	○	○	○	○	○	○
I act the same way no matter who I am with.	○	○	○	○	○	○	○
I act the same way at home that I do at school (or at work).	○	○	○	○	○	○	○
I will sacrifice my self-interest for the benefit of the group I am in.	○	○	○	○	○	○	○
If my brother or sister fails, I feel responsible.	○	○	○	○	○	○	○
I often have the feeling that my relationships with others are more important than my own accomplishments.	○	○	○	○	○	○	○
My happiness depends on the happiness of those around me.	○	○	○	○	○	○	○

I will stay in a group if they need me, even when I am not happy with the group.	○	○	○	○	○	○	○

End of Block: Self-Construal Scale (SCS)

Start of Block: Stability, Legitimacy and Permeability (SLP) & Social Mobility (SM)

Please indicate the extent to which you agree or disagree with each of the statements below:

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
I think the relationship between the members of the LGBTQ+ community and straight people will remain stable for the next years.	○	○	○	○	○	○	○
Straight people are entitled to be better off than the members of the LGBTQ+ community.	○	○	○	○	○	○	○
It is justified that straight people are currently doing better than the members of the LGBTQ+ community.	○	○	○	○	○	○	○

In principle, it is not difficult for a member of the LGBTQ+ community to be considered straight.	○	○	○	○	○	○	○
For a member of the LGBTQ+ community, it is nearly impossible to be regarded as straight.	○	○	○	○	○	○	○

Please indicate the extent to which you agree or disagree with each of the statements below:

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
I make any effort to be considered straight.	○	○	○	○	○	○	○
I try to live as straight rather than as a lesbian or gay individual	○	○	○	○	○	○	○
In the future, I would like to regard myself as straight.	○	○	○	○	○	○	○
It is my very wish to be straight.	○	○	○	○	○	○	○

End of Block: Stability, Legitimacy and Permeability (SLP) & Social Mobility (SM)

Start of Block: Collective Efficacy & Social Support

Express how you feel in relation to the LGBTQ+ community, what is your degree of agreement or disagreement with the following statements:

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
Members of the LGBTQ+ community are confident that they could deal efficiently with unexpected events.	○	○	○	○	○	○	○
Members of the LGBTQ+ community can remain calm when facing difficulties because they can rely on their coping abilities.	○	○	○	○	○	○	○
Members of the LGBTQ+ community can always manage to solve difficult problems if they try hard enough.	○	○	○	○	○	○	○

When members of the LGBTQ+ community are confronted with a problem, they can usually find several solutions.	○	○	○	○	○	○	○
Members of the LGBTQ+ community can usually handle whatever comes their way.	○	○	○	○	○	○	○

Please indicate the extent to which you agree or disagree with each of the statements below:

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
I get the emotional support I need from other members of the LGBTQ+ community.	○	○	○	○	○	○	○
I get the help I need from other members of the LGBTQ+ community.	○	○	○	○	○	○	○
I get the resources I need from members of the LGBTQ+ community.	○	○	○	○	○	○	○
I get the advice I need from members of the LGBTQ+ community.	○	○	○	○	○	○	○

End of Block: Collective Efficacy & Social Support

Start of Block: Minority Stress

Please read each statement carefully, and then indicate how much you agree or disagree with the statement.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
I avoid telling people about certain things in my life that might imply I am LGBTQ+.	○	○	○	○	○	○	○
I avoid talking about my romantic life because I do not want others to know I am LGBTQ+.	○	○	○	○	○	○	○
I do not bring a date to social events because I do not want others to know I am LGBTQ+.	○	○	○	○	○	○	○
I limit what I share on social media, or who can see it, because I do not want others to know I am LGBTQ+.	○	○	○	○	○	○	○
I am expected to educate non-LGBTQ+ people about LGBTQ+ issues.	○	○	○	○	○	○	○
People have re-labeled my identity, or referred to me by a name/pronouns that are different than how I identify myself.	○	○	○	○	○	○	○

When in an organization or activity that is sorted by gender, I feel out of place because I am LGBTQ+.	○	○	○	○	○	○	○
I have been accused of being too defensive or politically correct when talking about LGBTQ+ issues with someone who is not LGBTQ+.	○	○	○	○	○	○	○
When I meet someone new, I worry that they secretly do not like me because I am LGBTQ+.	○	○	○	○	○	○	○
I brace myself to be treated disrespectfully because I am LGBTQ+.	○	○	○	○	○	○	○
I expect that others will not accept me because I am LGBTQ+.	○	○	○	○	○	○	○
I worry about what will happen if people find out I am LGBTQ+.	○	○	○	○	○	○	○
I have been excluded from an organization (e.g. a religious group, sports team, etc.) because I am LGBTQ+.	○	○	○	○	○	○	○

I have been pressured to receive unnecessary services or been denied service, by a healthcare professional because I am LGBTQ+.	○	○	○	○	○	○	○
I have received poor service at a business because I am LGBTQ+.	○	○	○	○	○	○	○
I have been treated unfairly by supervisors or teachers because I am LGBTQ+.	○	○	○	○	○	○	○
If I was offered the chance to be someone who is not LGBTQ+, I would accept the opportunity.	○	○	○	○	○	○	○
I wish I wasn't LGBTQ+.	○	○	○	○	○	○	○
I envy people who are not LGBTQ+.	○	○	○	○	○	○	○
I have been verbally harassed or called names because I am LGBTQ+.	○	○	○	○	○	○	○
Others have threatened to harm me because I am LGBTQ+.	○	○	○	○	○	○	○

I have been bullied by others because I am LGBTQ+.	○	○	○	○	○	○	○
I feel that I could find information and pamphlets on LGBTQ+ issues.	○	○	○	○	○	○	○
I feel that I could find professional services for LGBTQ+ issues if I needed to.	○	○	○	○	○	○	○
I feel that I could find a public space that is supportive of LGBTQ+ activities.	○	○	○	○	○	○	○

End of Block: Minority Stress

Start of Block: Degree of Outness

I would say that I am open (out) as gay, lesbian or same-sex attracted person

- ○ Not at all open (out) to most people I know
- ○ Open (out) to a few people I know
- ○ Open (out) to half the people I know
- ○ Open (out) to most people I know
- ○ Open (out) to all or most people I know

End of Block: Degree of Outness

Start of Block: LGBTQ+ Identification

Express how you feel in relation to the LGBTQ+ community, what is your degree of agreement or disagreement with the following statements:

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
I feel a bond with the LGBTQ+ community	○	○	○	○	○	○	○
I feel solidarity with the LGBTQ+ community.	○	○	○	○	○	○	○
I feel committed to the LGBTQ+ community.	○	○	○	○	○	○	○
I am glad to be a member of the LGBTQ+ community.	○	○	○	○	○	○	○
I think that the LGBTQ+ community has a lot to be proud of.	○	○	○	○	○	○	○
It is pleasant to be a member of the LGBTQ+ community.	○	○	○	○	○	○	○
Being a member of the LGBTQ+ community gives me a good feeling.	○	○	○	○	○	○	○

I often think about the fact that I am a member of the LGBTQ+ community.	○	○	○	○	○	○	○
The fact that I am a member of the LGBTQ+ community is an important part of my identity.	○	○	○	○	○	○	○
Being a member of the LGBTQ+ community is an important part of how I see myself.	○	○	○	○	○	○	○
I have a lot in common with the average member of the LGBTQ+ community.	○	○	○	○	○	○	○
I am similar to the average member of the LGBTQ+ community.	○	○	○	○	○	○	○
The members of the LGBTQ+ community have a lot in common with each other.	○	○	○	○	○	○	○

The members of the LGBTQ+ community are very similar to each other.	○	○	○	○	○	○	○

End of Block: LGBTQ+ Identification

Start of Block: Mental Health Short Continuum

Please answer the following questions about how you have been feeling during the past month. Select the option that best represents how often you have experienced or felt the following:

	Never	Once or Twice	About Once a Week	About 2 or 3 Times A Week	Almost Every Day	Every Day
... happy?	○	○	○	○	○	○
... interested in life?	○	○	○	○	○	○
... satisfied with life?	○	○	○	○	○	○
... that you had something important to contribute to society?	○	○	○	○	○	○
... that you belonged to a community (like a social group, your school, or your neighborhood)?	○	○	○	○	○	○
... that our society is a good place, or is becoming a better place, for all people?	○	○	○	○	○	○
... that people are basically good?	○	○	○	○	○	○
... that the way our society works made sense to you?	○	○	○	○	○	○
... that you liked most parts of your personality?	○	○	○	○	○	○
... good at managing the responsibilities of your daily life?	○	○	○	○	○	○

... that you had warm and trusting relationships with others?	○	○	○	○	○	○
... that you had experiences that challenged you to grow and become a better person?	○	○	○	○	○	○
... confident to think or express your own ideas and opinions?	○	○	○	○	○	○
... that your life has a sense of direction or meaning to it?	○	○	○	○	○	○

End of Block: Mental Health Short Continuum

Start of Block: Clickworker Check

Have you completed this survey in the past month?

○ Yes

○ No

○ I don't remember

End of Block: Clickworker Check

Start of Block: End of Survey

Thank you for your participation!
We want to reiterate that your responses to this survey will remain anonymous and cannot be linked to you in any way.

If you have any questions regarding this study, please get in touch with us via e-mail at garou@iscte-iul.pt. The survey has ended. **Please click the "Next" button to be redirected to Prolific Academic.**

End of Block: End of Survey