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For Better *and* Worse? The Divergent Associations of LGBTQ+ Identity Importance and Salience on Mental Ill-Health in the Context of Discrimination

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Lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) individuals experience disproportionate levels of mental ill-health, with elevated levels of discrimination being a key contributor. While it is well documented that group-based discrimination is strongly related to poorer health among LGBTQ+ individuals, research also suggests that strongly identifying and/or connecting with a marginalized identity group can mediate this relationship and, in turn, relate to better health outcomes. Drawing from social identity (e.g., rejection identification, social cure) and minority stress frameworks, this cross-sectional study explored the theorized mechanisms through which group-based discrimination and marginalized identity relate to mental ill-health among 1,060 LGBTQ+ Australians. Using structural equation modeling, we found evidence that LGBTQ+ discrimination relates to greater identity centrality (conceptualized as dimensions of identity importance and identity salience). Centrality was further associated with *better* mental health via increased LGBTQ+ community connectedness, and, simultaneously, *worse* mental health via increased stigma sensitivity ($R^2_{\text{mental health}} = .23$). Importantly, we found evidence that indirect associations with *better* health outcomes were only observed via identity importance, while indirect associations with *worse* health outcomes were only observed via identity salience, despite a strong positive correlation between identity importance and salience ($r = .65$). Model results also remained consistent after controlling for key demographic factors. Results from this study provide important preliminary insights on how LGBTQ+ identification can be simultaneously indirectly related to better *and* worse psychological health via distinct strength and stressor constructs. We discuss implications for the conceptualization of identity centrality, particularly in marginalized groups, where importance and salience relate to divergent outcomes.

Public Significance Statement
This study draws from several existing theoretical models and frameworks to develop and test new ways of understanding how discrimination relates to mental health outcomes for lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) individuals. We find that having an LGBTQ+ identity that is central to your sense of self can relate to mental health in both positive and negative ways.

Keywords: lesbian, gay, bisexual, transgender, queer, social identity, discrimination, mental health, social cure

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Discrimination is a common cause of stress and ill-health among marginalized group members. A large body of evidence indicates that the link between discrimination and mental ill-health is elevated among lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) diverse individuals (Herek & McLemore, 2013; Meyer & Frost, 2013). Research has highlighted several potential mediating mechanisms that may explain the discrimination–mental ill-health relationship within the LGBTQ+ community, including identity concealment (Pachankis et al., 2020; Walch et al., 2016), stigma sensitivity (Breslow et al., 2015; Feinstein, 2020; Helsen et al., 2022), and

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internalized stigma (Baiocco et al., 2023; Nguyen et al., 2024; Ramirez & Paz Galupo, 2019; Rogers et al., 2021). Notably, factors associated with better mental health for LGBTQ+ individuals have also been documented, including self-acceptance (Camp et al., 2020), community connectedness (Frost & Meyer, 2012; Sherman et al., 2020), social identification (Chan, 2022; Doyle & Molix, 2014; Scroggs & Vennum, 2021), a sense of pride/affirmation (Mohr & Kendra, 2011), and resilience (Baiocco et al., 2023).

While protective and adverse correlates of mental health for LGBTQ+ groups have been independently well documented, their concurrent inclusion in models on the relationship between discrimination and health is underexamined. That is, in the face of group-based discrimination, how do both strengths- *and* stressor-based factors relate to the mental health of LGBTQ+ individuals? This article aimed to answer this question by developing and evaluating a theory-driven, cross-sectional model that includes simultaneous mediation pathways of strengths and stressors within the discrimination–mental ill-health relationship for this marginalized group. Importantly, we further examined how subcomponents of identity centrality (importance and salience), which are theorized to drive these divergent outcomes among LGBTQ+ groups (for a meta-analysis, see Hinton et al., 2022), might explain this relationship to advance understandings of LGBTQ+ health.

Stigma and Mental Ill-Health

One of the most influential works attempting to explain the LGBTQ+ discrimination–health link is the minority stress theory (MST; developed by Brooks, 1981 and extended by Meyer, 2003). In evaluating the health disparities between heterosexual and sexual minority people, the MST documents the unique stressors that sexual minorities face, beyond general life stressors that are experienced by all. Meyer (2003) also proposed that sexual minority stressors fall on a distal–proximal spectrum, with both chronic distal stressors (e.g., systemic discrimination/victimization) and proximal stressors (e.g., stigma sensitivity) contributing to poorer health. Since its development, research has provided support for the relationships between minority stress and poorer health outcomes, and also the mechanisms through which this adverse relationship may be explained (e.g., Hatzenbuehler, 2009). For instance, meta-analyses have found moderate-to-strong associations between sexual minority stressors and poorer general mental health outcomes (Dürrbaum & Sattler, 2020), greater suicidal ideation (de Lange et al., 2022), and greater substance use (Goldbach et al., 2014). The associations between gender minority stressors (e.g., misgendering, binary normativity) and mental ill-health have also been evidenced in gender-diverse samples (Matsuno et al., 2024; Testa et al., 2015; see Pellicane & Ciesla, 2022 for a recent meta-analysis), providing support for the extension of the MST beyond just cisgender sexual minority groups.

MST also provides a theoretical understanding of the unidirectional pathways between distal and proximal stressors, and how this then influences mental ill-health (Meyer, 2003). As an extension of MST, Hatzenbuehler's (2009) psychological mediation framework also theorizes that experiencing distal stressors may indirectly harm the mental health of LGBTQ+ individuals via both intrapersonal (e.g., rumination) and group-based (e.g., proximal stressor) maladaptive factors. Recent cross-sectional research finds evidence for these claims. For example, Scandurra et al. (2020) found that internalized binegativity mediated the relationship between discrimination and mental ill-health among cisgender bisexual individuals. Jäggi et al. (2018) also found that the negative influence of distal gender-related stressors on the mental ill-health of transgender and nonbinary participants was mediated by increased proximal stressors (e.g., internalized transphobia, negative expectations about social interactions, and nondisclosure). These results imply that not only can distal and proximal stressors be important factors in determining LGBTQ+ health outcomes in isolation, but also that studying their combined influence can shed an important light on the discrimination–mental ill-health link. Collectively, this research suggests that when LGBTQ+ individuals experience discrimination, they can internalize these negative attitudes and/or have a heightened sensitivity and expectation of future discrimination. This, in turn, harms their mental health (Hatzenbuehler, 2009; Meyer, 2003; for a visual representation of these pathways, see Panel A of Figure 1). However, and as discussed next, factors that result from discrimination, such as social identification, can also relate to *better* health and well-being.

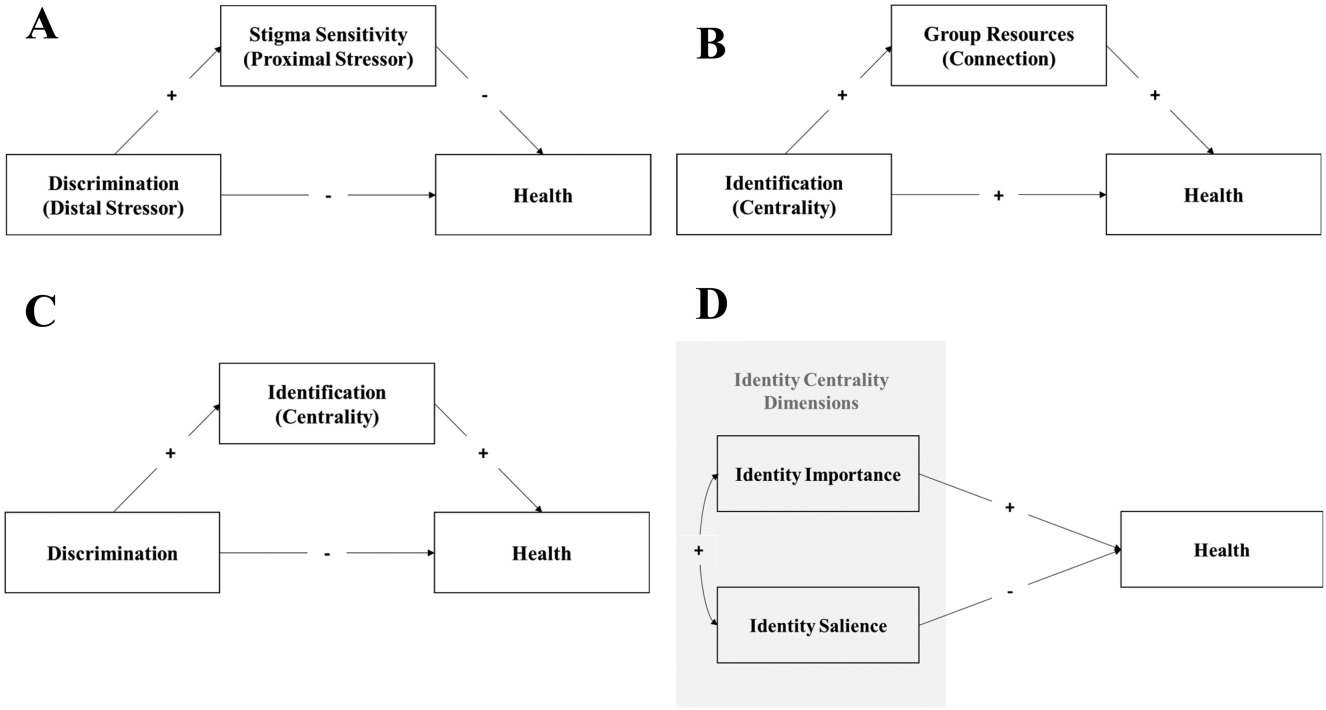
The Social Identity Approach to Health

A key factor in determining health outcomes among marginalized group members is the sense of connection and self-definition that is derived from their group membership. Seminal research on this proposition stems from social identity theory (Tajfel & Turner, 1979) and self-categorization theory (Turner et al., 1987)—collectively referred to as the social identity approach. While originally proposed to understand intergroup conflict, researchers have since applied this approach to understanding health disparities (Jetten et al., 2012, 2017). The social identity approach to health predominantly focuses on the concept of social identification (i.e., an internalized sense of affiliation to, and self-definition in terms of, one's social group), and how it relates to *better* health outcomes (i.e., the social *cure*; Jetten et al., 2012, 2017). However, it also acknowledges that factors such as perceived negative group norms (e.g., substance use or stringent body image ideals perceived as normative among some LGBTQ+ community members; Bajada et al., 2024; Feinstein et al., 2017) and stigma can be central to understanding when social identification relates to *worse* health outcomes (see Cruwys & Gunaseelan, 2016; Jetten et al., 2018; Kellezi et al., 2019; Walter et al., 2015)—sometimes referred to as a social *curse* (Kellizi & Reicher, 2012). Overall, however, meta-analytic evidence for the social identification–health relationship suggests a beneficial effect across both stigmatized and nonstigmatized identity groups (Brance et al., 2023; Postmes et al., 2019).

Social cure research has also documented the mechanisms through which social identification may explain health outcomes. Social identification allows individuals to access important psychosocial resources, such as a sense of group belonging and connection (e.g., Cruwys et al., 2014; Greenaway et al., 2016), and social support (e.g., Haslam et al., 2012; McNamara et al., 2021), which in turn improve their health and well-being (see Panel B of Figure 1). Stemming from adversity, stronger social identification has also been suggested to mediate the relationship between discrimination and poorer health outcomes (e.g., the rejection-identification model; Branscombe et al., 1999). In their seminal study, Branscombe et al. (1999) found that the positive association between discrimination and mental ill-health for African Americans was mediated by greater

Figure 1

Graphical Overview of Models and Frameworks From Previous Research



Note. The models and frameworks presented here were used as the basis for specifying the hypothesized model within the current study (see Figure 2). +/− represents the direction of relationships. Panel A: Visual depiction of the pathway between distal stressors (i.e., discrimination) and health via increased proximal minority stressors (e.g., stigma sensitivity in the minority stress model; Meyer, 2003. See also Breslow et al., 2015; Feinstein, 2020; Hatzenbuehler, 2009; Helsen et al., 2022). Panel B: Visual representation of key processes embedded within social cure theorizing. Specifically, this model depicts the importance of group-based resources (e.g., community connection) on enhancing the impact social identification has on better health (Jetten et al., 2012, 2017. See also Cruwys et al., 2014; Greenaway et al., 2016). Panel C: Visual depiction of the pathway between group-based discrimination and health via increased identification (e.g., rejection-identification model; Branscombe et al., 1999. See also Ramos et al., 2012). Panel D: Visual representation of the preliminary differential relationships between identity centrality dimensions (i.e., identity importance and salience) and health (as evidenced across some subsamples within Quinn et al., 2014; for similar results, see Begeny & Huo, 2017; Quinn & Chaudoir, 2009; Utku & Sayılan, 2023).

social identification. That is, although discrimination was associated with poorer mental health directly, its association with mental ill-health was significantly reduced because discrimination also related to stronger social identification, which in turn was related to better health outcomes (Panel C of Figure 1). The rejection-identification model has also been examined among LGBTQ+ groups, with some studies showing support for the indirect effect that social identification can have within the discrimination–health relationship (e.g., Ball et al., 2023; Chan, 2022; Scroggs & Vennum, 2021), but others showing that these relationships vary considerably according to how social identification is conceptualized (e.g., Begeny & Huo, 2017; Hambour et al., 2023; Utku & Sayılan, 2023). Notably, MST also theorizes that social identification might play a (moderating) role within the discrimination–health relationship for LGBTQ+ individuals (Meyer, 2003). However, research investigating this claim is scarce and presents no results that appear to indicate a significant moderation effect for LGBTQ+ social identification (see Macaulay et al., 2024, for a recent discussion and evidence among cisgender and trans Bi+ individuals). Hence, the current study takes a mediation approach to understand these associations in line with the evidenced rejection-identification theorizing consistent with Branscombe et al. (1999).

The cross-sectional evidence described so far is consistent with the claim that social identification may play a protective and explanatory role by subsequently reducing the negative health consequences that stem from adverse societal experiences (Branscombe et al., 1999; Jetten et al., 2018). However, further examination has found that the explanatory indirect associations of social identification vary as a function of how social identification is conceptualized. Longitudinal research by Ramos et al. (2012) found that when social identification was disaggregated into separate dimensions (e.g., ingroup ties, centrality, and ingroup affect), only the cognitive appraisals of the importance of the identity (a component of identity centrality, discussed further below) was predicted by previous group-based discrimination (see also Cruwys & Gunaseelan, 2016). Moreover, the cross-lagged effects found by Ramos et al. (2012)—and also evident among LGBTQ+ samples (e.g., Chan, 2022)—provide compelling evidence that group-based discrimination preceded (rather than resulted from) identity centrality, supporting rejection-identification theorizing (Branscombe et al., 1999). A key goal of the present study is to therefore interrogate the conceptualization of LGBTQ+ identity centrality within the discrimination–health relationship.

LGBTQ+ Identity Centrality and Psychosocial Outcomes

Identity centrality, a cognitive dimension of social identification (Ashmore et al., 2004; Cameron, 2004; Leach et al., 2008), has been conceptualized in multiple ways. Generally, it is defined as the subjective sense of the importance of an individual's group membership to their sense of self (Ashmore et al., 2004). Others note that centrality also comprises the degree to which individuals chronically think about, or are aware of, their social identities (Cameron, 2004; Hinton, Koc, et al., 2024; Leach et al., 2008). That is, the concept of centrality has been used to describe both identity importance (i.e., viewing the identity as an important part of the self) and identity salience (i.e., chronically thinking about the identity). Although these definitions appear to tap onto the same overall construct, we argue that they are different and that their distinction has important implications for psychosocial outcomes. This is consistent with findings from a recent meta-analytic review of LGBTQ+ identity centrality research (Hinton et al., 2022), which found that centrality was related to both strengths-based group resources (e.g., increased community connection) and minority stressors (the strongest of which being increased stigma sensitivity). However, the review found no evidence of bivariate associations between centrality and health outcomes. They argued that this observed null relationship may be, in part, due to previous research conflating the two components of identity centrality (importance *and* salience). Moreover, they speculated that the different associations between centrality and health outcomes might be driven by the level of LGBTQ+ identification endorsed within measures (e.g., whether measures assess the centrality of their superordinate [LGBTQ+ identity] or their ordinate [e.g., gay] level of identity). Recent research by Bajada et al. (2024) explored these differences and found that identification with the LGBTQ+ community related to better well-being outcomes, whereas identification with a gay or bisexual identity (among cisgender and trans men) was unrelated to well-being. Finally, Hinton et al. (2022) note that the relationships between centrality and health might be indirectly observed when accounting for centrality's positive relationship with LGBTQ+ community connectedness (resulting in better health), or by its positive association with stigma sensitivity (resulting in poorer health). To our knowledge, this proposition is yet to be explored.

Research investigating the crucial distinction between identity importance and salience (as defined here[1]) is scarce but seems likely to have important implications for psychosocial outcomes. For instance, Quinn et al. (2014) examined the differential relationships of identity importance and salience with psychosocial outcomes among several groups of participants with concealable identities (e.g., those with substance abuse, sexual assault survivors). Although they found that both constructs were positively correlated with adverse outcomes such as stigma sensitivity and psychological distress at the bivariate level (with stronger relationships observed for salience, see also Quinn & Chaudoir, 2009), when both were included as simultaneous predictors, only salience was significantly related to greater psychological distress. It is important to note that while identity importance was not significantly related to mental health (after controlling for salience), Quinn et al. (2014) did find that importance and salience differentially predicted psychological distress, but only among some subgroups within their sample. That is, this preliminary evidence suggests that even though identity importance, salience, and psychological distress were all positively correlated, identity importance predicted less, while salience (simultaneously) predicted more, psychological distress for survivors of sexual assault (as visually depicted in Panel D of Figure 1). Similarly, and among a sample of cisgender gay men, Begeny and Huo (2017) found that only (gay) identity importance (but not salience) was correlated with better mental health, and identity salience (but not identity importance) was correlated with increased group-based discrimination. More recently, results from Utku and Sayılan (2023), again among a sample of cisgender gay men in Turkey, found that although group-based discrimination positively predicted both (gay) identity importance and salience, only salience was found to relate to worse psychological well-being (whereas no relationship between well-being and importance was observed). These findings speak to the distinct nature of these constructs, with preliminary evidence suggesting that identity salience contributes more to adverse outcomes, while identity importance relates to more beneficial outcomes. Thus, further research investigating the differential contribution of these two constructs within the discrimination–health relationship is needed.

The Current Study

The current research aimed to advance understandings of the discrimination–mental ill-health relationship for LGBTQ+ individuals by investigating how identity centrality relates to the strengths- *and* stressor-based pathways within this association. Given the paucity of research that has (a) simultaneously examined how strength- and stressor-based factors relate to the health of LGBTQ+ people, and (b) differentiated components of identity centrality (i.e., importance vs. salience), this study aimed to develop and test a new mediation model (Figure 2) of the relationship between group-based discrimination and mental ill-health among LGBTQ+ people. Drawing from theoretical and empirical bodies of work (as visually depicted in Figure 1), such as the minority stress model and psychological mediation framework (Hatzenbuehler, 2009; Meyer, 2003), the rejection-identification model (Branscombe et al., 1999), the social cure approach (Jetten et al., 2017), and the recent meta-analysis by Hinton et al. (2022), we expected that LGBTQ+ discrimination would relate to identity centrality components, which would in turn relate to both better (Branscombe et al., 1999; Jetten et al., 2017) and poorer (Hatzenbuehler, 2009; Meyer, 2003) mental health outcomes via distinct strengths- and stressor-based pathways (Hinton et al., 2022).

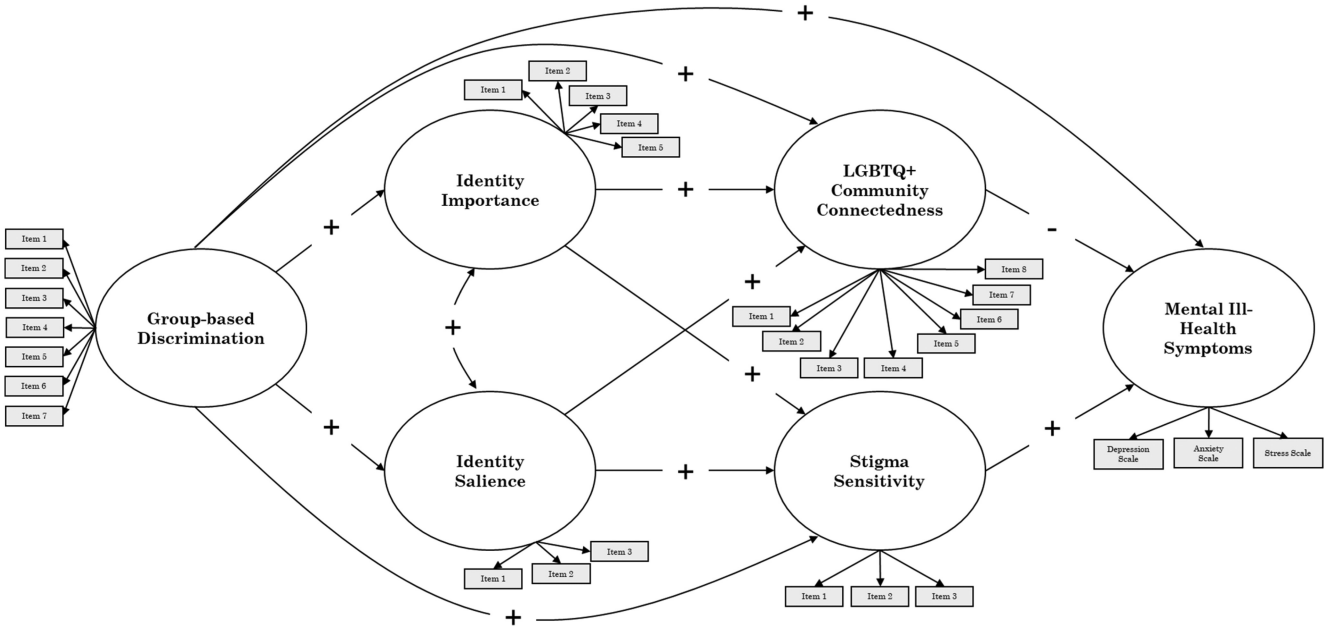
Stressor-Based Pathways (Hypothesis 1 [H1])

Hypothesis 1a (H1a): LGBTQ+ group-based discrimination will be positively related to mental ill-health symptomology, and stigma sensitivity will positively mediate this relationship.

[1] We only focus here on studies that conceptualise identity importance and salience in the same way as we have done within this article. Because there is no consensus about the meaning of these terms, some researchers have reported that they are measuring "identity salience" but do so using items that only reflect the *importance* of the identity to the individual's sense of self (e.g., Ramirez & Paz Galupo, 2019; Scroggs & Vennum, 2021). For a discussion on this incongruence, see Hinton, Koc, et al. (2024).

Figure 2

Hypothesized Model of the Discrimination–Mental Ill-Health Relationship



Note. +/− represents hypothesized positive/negative relationships between variables. Rectangles represent observed indicator variables (as either scales or items), and ovals represent latent variables (Kline, 2016). LGBTQ+ = lesbian, gay, bisexual, transgender, queer, and other.

Hypothesis 1b (H1b): LGBTQ+ group-based discrimination will be positively related to identity centrality dimensions (importance and salience), and both centrality and stigma sensitivity will positively serially mediate the discrimination–mental ill-health relationship. It is expected that this indirect relationship will be stronger via the identity salience dimension.

The above stressor-based pathway hypotheses (H1) align with (a) research that has found potential mediating effects of proximal stressors (particularly, stigma sensitivity) on the relationship between discrimination and health (Breslow et al., 2015; Feinstein, 2020; Helsen et al., 2022—see Panel A of Figure 1), and (b) the theorizing that stigma sensitivity (evidenced to have the strongest association with identity centrality among other proximal stressors; Hinton et al., 2022) would mediate the relationship between identity centrality and health. Furthermore, the expectation that discrimination would relate to greater levels of both centrality components (identity importance and salience) aligns with previous research documenting the temporal positioning of these variables (e.g., Ramos et al., 2012— Panel C of Figure 1). That is, both identity centrality factors *and* stigma sensitivity would serially mediate the discrimination–mental ill-health relationship. These hypotheses combine the theorizing outlined within the rejection-identification (Branscombe et al., 1999), minority stress (Meyer, 2003), and psychological mediation (Hatzenbuehler, 2009) models. Given the scarcity of research differentiating identity importance and salience within these relationships, we made no specific a priori predictions on how they would differentially relate to stigma sensitivity. However, based on results by Quinn et al. (2014), Begeny and Huo (2017), and Utku and Sayılan (2023; Panel D of Figure 1), we tentatively expected salience to emerge as a stronger predictor of stigma sensitivity, which would then adversely relate to health.

Strength-Based Pathways (Hypothesis 2 [H2])

Hypothesis 2a (H2a): LGBTQ+ group-based discrimination will be positively related to mental ill-health symptomology, and LGBTQ+ community connectedness will negatively mediate this relationship.

Hypothesis 2b (H2b): LGBTQ+ group-based discrimination will be positively related to identity centrality dimensions (importance and salience), and both centrality and LGBTQ+ community connectedness will negatively serially mediate the discrimination–mental ill-health relationship. It is expected that this indirect relationship will be stronger via the identity importance dimension.

These strength-based pathway hypotheses (H2) are derived from research highlighting the importance of group-based resources (e.g., community connectedness) for mental health (Jetten et al., 2017), particularly in the context of discrimination (Branscombe et al., 1999). Although many strength-based factors exist (e.g., social support, a sense of resilience, coping strategies; Baiocco et al., 2023; Jetten et al., 2017; McNamara et al., 2021), we specifically chose to focus on community connection given its strong positive associations with identity centrality among LGBTQ+ groups (Hinton et al., 2022), and evidence stemming from social cure theorizing that documents how identity centrality can enhance community connection, which in turn serves as an essential resource for better health (Cruwys et al., 2014; Greenaway et al., 2016; Jetten et al., 2017,

see Panel B of Figure 1). Again, given the scarcity of research differentiating centrality components (importance vs. salience) within these relationships, we made no a priori predictions about how these constructs would differentially predict LGBTQ+ community connectedness; however, we tentatively expected importance to emerge as having a stronger relationship with community connectedness, aligning with Begeny and Huo (2017), Quinn et al. (2014), and Utku and Sayılan (2023, Panel D of Figure 1).

Method

Open Science Practices

All data, codebooks, primary analysis syntax (i.e., *R* code), and supplementary analyses are available on the Open Science Framework (https://osf.io/986u5/; Hinton, Cruwys, et al., 2024). This study was not preregistered.

Participants

To determine the minimum sample size needed to estimate our hypothesized structural equation model (SEM), we followed the recommendations by Wolf et al. (2013). Specifically, among a series of simulation analyses with varying parameters, they suggest that sample sizes can range between 30 and 460 participants depending on expected parameter estimates and model complexity. Given the complexity of the hypothesized model, we therefore opted for the more conservative approach of recruiting at least double the largest sample size simulated in Wolf et al.'s (2013) study (i.e., at least 920 participants recruited). Participants were recruited either via Prolific ($n = 212$) or social media websites (e.g., Facebook; $n = 848$).[2] To be included, participants had to (a) be at least 18 years old, (b) identify as LGBTQ+, and (c) be born or currently residing in Australia. Several exclusions were made during data cleaning, including those who did not consent, meet eligibility criteria, had duplicate responses or were detected as bots by Qualtrics security measures, or had only responded to a small number of demographic and screener items, but did not respond to any other survey measures (see Hinton, Koc, et al., 2024 for a full list of exclusions), leaving a final sample of 1,060 participants.

Participants were aged between 18 and 95 years old ($M = 35.67$, $SD = 14.56$), with almost all (99.0%, $n = 1{,}049$) residing in Australia at the time of data collection. As an initial question assessing gender, we asked participants whether they best identified as either cisgender (i.e., having their assigned sex aligning with their gender identity; $n = 729$), or gender-diverse/transgender/nonbinary (i.e., having their assigned sex not aligning with their gender identity; $n = 331$). Participants then went on to select the gender and sexuality that best represented them, from a list of several options. Table 1 provides the frequency matrix of gender and sexuality endorsed in our sample, showing a sample comprising diverse LGBTQ+ identities. In response to an open-ended question, the vast majority of participants (82.6%, $n = 876$) identified their ethnicity as white (or with other Anglo-Saxon or European heritages). The remainder identified with East Asian, Southeast Asian, or Pacific Islander ethnicities (7.1%), as Aboriginal and/or Torres Strait Islander or Māori (2.9%), with multiethnic backgrounds (3.2%), or with Middle Eastern (1.1%), Black (0.6%), or Latinx (0.6%) ethnic backgrounds (with 1.9% declining to state or including unclassifiable responses). Moreover, approximately half the sample (51.0%) reported being in a relationship, including casually dating (5.7%), monogamous relationships (36.0%), open relationships (5.9%), or polyamorous relationships (3.4%), and the remainder (49.0%) reported being single.

Materials and Procedure

Ethics approval was first sought and approved at the primary author's institutional Human Research Ethics Committee. Upon starting the online survey, participants provided consent and then completed measures of mental ill-health symptomology. Participants then provided demographic information and responded to the other survey variables assessing their LGBTQ+ identity and related psychosocial outcomes in a randomized order. Of note, both identity centrality measures contained items that referred to the participant's specific LGBTQ+ identity (e.g., "trans-man"), aligning with research documenting the disparities between levels of LGBTQ+ group identifications (Bajada et al., 2024). These measures referred to either the participant's gender or sexuality, such that cisgender participants were asked about their sexuality identity, and gender-diverse participants were asked to respond to their gender identity (see Taylor et al., 2022, for a similar approach). This is represented by [X] in the sample items listed below. Aside from the mental health measures, all other measures asked participants to answer with respect to the superordinate LGBTQ+ group, as designed and validated by the measurement authors within LGBTQ+ samples. The mental health measures have also been validated among both sexual minority and gender-diverse samples (e.g., Begeny & Huo, 2017; McLemore, 2018; Woodford et al., 2015). All scales were mean scored with higher scores representing greater construct endorsement, and all showed acceptable estimates of internal consistency within the current sample (see Table 2).

Group-Based Discrimination

The blatant group discrimination subscale of Molero et al.'s (2013) Multidimensional Scale of Perceived Discrimination was used to measure LGBTQ+ discrimination. This scale was developed within sexual minority samples (see also Molero et al., 2017), and also validated among gender-diverse samples (e.g., Watson & Tatnell, 2022), and reflects the degree to which the broader LGBTQ+ community is discriminated against within society (e.g., "My society treats LGBTQ+ people unfairly"). Participants responded to this seven-item measure across scale anchors from 1 = *strongly disagree* to 5 = *strongly agree*.

Centrality (Identity Importance and Salience)

To measure identity importance, we used the centrality subscale of the Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011). We chose this scale specifically because its items only pertain to the importance of the identity, rather than also including reference to the frequency with which the identity is thought of

[2] The decision to recruit participants from both of these sources were primarily driven by our aims to maximise sample size (i.e., a relatively small pool of LGBTQ+ participants residing in Australia were available to be sampled from Prolific), obtain a more generalizable sample from multiple sources, and funding limitations. Due to these funding constraints, only participants recruited via Prolific were reimbursed for their participations (at the recommended rate of £9 per hour).

Table 1
Frequency (n) Matrix of Participants Gender (Rows) and Sexuality (Columns)

Gender	Gay	Lesbian	Bisexual	Pansexual	Queer	Asexual	Aromantic	Demisexual	Heterosexual	None of the above	Row (gender) totals
Man	271	0	51	7	6	4	1	0	1[a]	4	345
Woman	12	138	147	31	42	26	1	5	2[a]	7	411
Gender-diverse	3	3	3	2	2	0	0	0	0	0	13
Transgender	1	0	3	2	6	1	0	0	4	0	17
Trans-man	3	0	5	6	5	1	1	0	2	1	24
Trans-masculine	3	1	3	3	6	5	1	2	0	3	27
Trans-woman	1	7	5	5	0	3	0	0	2	0	23
Trans-feminine	0	3	4	3	4	0	0	2	0	0	16
Gender nonbinary	3	11	17	11	24	7	1	2	0	2	78
Gender queer	2	5	10	3	10	0	1	2	0	1	34
Agender	0	1	1	5	6	6	0	2	0	0	21
Gender-fluid	0	4	12	9	2	1	0	0	0	1	29
None of the above	2	7	3	5	4	0	0	0	0	1	22
Column (sexuality) totals	301	180	264	92	117	54	6	15	11	20	1,060

Note. Those who selected "none of the above" for gender and/or sexuality were determined to be LGBTQ+ by their responses on an open-ended question (not presented here for simplicity), where they described their LGBTQ+ identity with a different label (or mix of labels) that were not presented here. LGBTQ+ = lesbian, gay, bisexual, transgender, queer, and other.
[a] Participants with heterosexual man/woman identities also selected "gender-diverse" (not "cisgender") in the initial gender identity question and so were not excluded.

(c.f., Cameron, 2004; Leach et al., 2008). The five items in this scale (e.g., "Being a [X] person is a very important aspect of my life") were scored on scale anchors from 1 = *strongly disagree* to 6 = *strongly agree*. We measured identity salience using the chronic salience subscale of the Identity Salience Questionnaire (ISQ; Hinton, Koc, et al., 2024). The ISQ captures identity salience, focusing solely on the frequency of awareness of (or how often individuals think of) their social identity (e.g., "My [X] identity is often at the forefront of my mind"). This three-item subscale was scored on scale anchors from 1 = *strongly disagree* to 7 = *strongly agree*.

Stigma Sensitivity

The acceptance concerns subscale of the LGBIS (Mohr & Kendra, 2011) was used to measure stigma sensitivity. We note that although Mohr and Kendra (2011) conceptualize this subscale as acceptance concerns among LGBTQ+ individuals, others have conceptualized the items used in this scale (e.g., "I often wonder whether others judge me for my [sexual orientation/gender-diversity]") as measuring the construct of stigma sensitivity (de Oliveira et al., 2012). That is, the items reflect the degree to which "respondents experience anxious expectations of rejection based on their sexual orientation [or gender-diversity]" (de Oliveira et al., 2012, p. 336). This three-item subscale was scored on anchors from 1 = *strongly disagree* to 6 = *strongly agree*.

LGBTQ+ Community Connectedness

We used the eight-item Connectedness to the LGBTQ+ Community Scale (Frost & Meyer, 2012) to measure community connection within the broader LGBTQ+ group. Items (e.g., "You feel you're a part of your LGBTQ+ community") were first adapted to reflect the geographical context of the current study (i.e., original items that referenced the "New York" LGBTQ+ community were replaced with "your" LGBTQ+ community), and were responded to on a scale from 1 = *strongly disagree* to 4 = *strongly agree*.

Mental Ill-Health

We measured mental ill-health with three scales. Depression symptoms were measured with the Centre for Epidemiologic Studies Short Depression Scale (Andresen et al., 1994), which instructed participants to respond to 10 items (e.g., "I felt depressed") within the timeframe of the past week from 0 = *rarely/none of the time* to 3 = *all of the time*. Symptoms of anxiety were measured with the Generalized Anxiety Disorder Questionnaire (Spitzer et al., 2006), which instructed participants to respond to seven items (e.g., "Not being able to stop or control worrying") within the timeframe of the past 2 weeks from 0 = *not at all* to 3 = *nearly every day*. Lastly, stress symptoms were measured with the Perceived Stress Scale (S. Cohen et al., 1983), which instructed participants to respond to how often 10 items (e.g., "… felt nervous and stressed?") reflected their experience within the timeframe of the past month from 0 = *never* to 4 = *very often*.

Analytic Approach

Preliminary analyses and checks of data were conducted in SPSS (V28.0). To explore our hypothesized model (Figure 2) we conducted SEM using the R package *lavaan* (Rosseel, 2012). In line with common practices that use a two-step approach in SEM (Anderson & Gerbing, 1988), we first estimated the measurement model (i.e., without regressive paths) to determine the initial model fit, and then estimated the full SEM. Both models were tested using the marker method of identification (i.e., constraining first indicator variables to loadings of 1) to determine the suitability of our observed variables fitting their assigned latent constructs. Specifically, group-based discrimination was observed by the seven items of the blatant group discrimination subscale (Molero et al., 2013), identity importance was observed by the five items of the LGBIS centrality subscale (Mohr & Kendra, 2011), identity salience was observed by the three items of the ISQ chronic salience

Table 2

Descriptive Statistics, Internal Reliability (α), and Correlations Among Observed Indicator Variables and Observed Covariates

Observed variables	*N*	*M* (*SD*)	α	1	2	3	4	5	6	7	8	9	10	11	12
1. Age	1,058	35.67 (14.56)		—											
2. Gender identity (0 = *cisgender*, 1 = *TGD*)	1,060			−.06*	—										
3. Ethnic identity (0 = *white*, 1 = *POC*)	1,045			−.17***	.01	—									
4. Relationship status (0 = *single*, 1 = *in a relationship*)	1,060			.05	−.08**	−.09**	—								
5. Recruitment source (0 = *social media*, 1 = *Prolific*)	1,060			−.34***	−.15***	.14***	.01	—							
6. Group-based discrimination	965	3.46 (0.86)	.92	−.11***	.28***	.02	.02	−.07*	—						
7. Identity importance	1,037	3.99 (1.15)	.86	.15***	.15***	−.01	.04	−.25***	.32***	—					
8. Identity salience	1,034	3.32 (1.43)	.84	.05	.12***	−.01	−.08*	−.22***	.25***	.57***	—				
9. Stigma sensitivity	956	3.74 (1.37)	.87	−.24***	.26***	.04	−.09**	−.08*	.36***	.25***	.36***	—			
10. Community connectedness	957	2.87 (0.68)	.92	−.10**	.23***	−.02	.05	−.08*	.36***	.42***	.25***	.22***	—		
11. Depression	1,060	1.26 (0.68)	.88	−.25***	.20***	.09**	−.11***	.08*	.30***	.08*	.11***	.35***	.04	—	
12. Anxiety	1,060	1.13 (0.81)	.92	−.32***	.18***	.06	−.08*	.08**	.27***	.05	.15***	.37***	.09**	.80***	—
13. Stress	1,060	1.97 (0.79)	.91	−.35***	.20***	.07*	−.08**	.09**	.30***	.07*	.14***	.38***	.08*	.84***	.79***

Note. TGD = transgender and/or gender-diverse; POC = person of color.
* $p < .05$. ** $p < .01$. *** $p < .001$.

subscale (Hinton, Koc, et al., 2024),[3] stigma sensitivity was observed by the three items of the LGBIS acceptance concerns subscale (Mohr & Kendra, 2011), LGBTQ+ community connectedness was observed by the eight items of the Connectedness to the LGBTQ+ Community Scale (Frost & Meyer, 2012), and mental ill-health was observed by three indicator measures of depression (Centre for Epidemiologic Studies Short Depression Scale; Andresen et al., 1994), anxiety (Generalized Anxiety Disorder Questionnaire; Spitzer et al., 2006), and stress (Perceived Stress Scale; S. Cohen et al., 1983; see Figure 2).

Once the measurement model was confirmed to have an appropriate fit, regressive and correlational paths were included to estimate the hypothesized model (Figure 2). Specifically, regressive paths were specified such that (a) discrimination preceded all other latent variables, (b) both importance and salience preceded both stigma sensitivity and LGBTQ+ connectedness, and (c) both stigma sensitivity and LGBTQ+ connectedness preceded mental ill-health. In addition, we allowed importance and salience to covary given their overlapping conceptualization noted by previous research (Hinton et al., 2022). Notably, we did not specify a direct path between either centrality dimension and mental ill-health in line with the abovementioned evidence that observed no relationship between these variables (e.g., Hinton et al., 2022). This also allowed us to avoid oversaturation of the hypothesized model (Kline, 2016). Finally, we also examined two alternative models for comparison against the hypothesized model: one for which the order between discrimination and centrality variables (importance and salience) was reversed (aligning with Begeny & Huo, 2017; Suppes et al., 2021), and another that included demographic covariates to account for any influence they may have on model results (described further below and in the online supplemental materials).

As some observed variables contained a small amount of missing data (ranging from 2.2% to 9.8%; see Table 2), we conducted a Little's missing completely at random test to determine any influential patterns. The missing data in the hypothesized observed variables were likely to be missing completely at random, $\chi^2(55) = 53.96$, $p = .514$. Subsequently, we conducted our SEM using full information maximum likelihood estimation (Kline, 2016). Model fit was deemed acceptable by the following metrics: comparative fit index (CFI) values $\geq .90$, root-mean-square error of approximation (RMSEA) value $\leq .06$ (with the upper-bound 90% confidence interval [CI] not exceeding .10), and the standardized root-mean-square residual (SRMR) value $\leq .08$ (Hu & Bentler, 1999; Kline, 2016). Finally, we examined all possible indirect associations within the model by estimating the bias-corrected 95% CIs of 5,000 bootstrap samples. The significance of these associations was determined if the bias-corrected 95% CIs did not include 0, and effect size estimates (R^2 and Cohen's f^2) are reported alongside

[3] Given that there is only preliminary evidence to suggest identity importance and salience should be considered as separate constructs, we also tested an alternative measurement model using just these two constructs (with confirmatory factor analysis [CFA]), in which both salience and identity importance items loaded onto the same factor (i.e., identity centrality). The results of this one-factor CFA indicated poor fit to the data, $\chi^2(20) = 823.86$, $p < .001$, CFI = .83, RMSEA (90% CI) = .196 [.185, .208], SRMR = .08. By comparison, the two-factor model (as originally posited in this paper) showed excellent fit to the data, $\chi^2(19) = 168.61$, $p < .001$, CFI = .97, RMSEA (90% CI) = .087 [.075, .099], SRMR = .04, and was significantly stronger in fit compared to the one-factor model, $\Delta\chi^2(1) = 655.26$, $p < .001$. Thus, a two-factor approach was retained.

each endogenous latent variable, with their magnitudes interpreted according to J. Cohen's (1992) classifications, that is, small (>0.02), moderate (>0.15), and large (>0.35) f^2 effect sizes.

Results

Descriptive statistics and correlations among observed indicator variables and covariates are reported in Table 2.

The Measurement Model

The measurement model, which assessed the suitability of the observed variables to their respective latent constructs, showed good fit to the data, $\chi^2(362) = 1{,}431.65$, $p < .001$, CFI = .94, RMSEA (90% CI) = .053 [.050, .056], SRMR = .05. Observed indicator variables for group-based discrimination ($\lambda = .68$–.82), salience ($\lambda = .75$–.87), stigma sensitivity ($\lambda = .76$–.88), community connectedness ($\lambda = .64$–.88), and mental ill-health ($\lambda = .87$–.92) indicated strong loadings. For identity importance, indicator loadings ranged from .43 to .91. As the first item had a relatively weaker, but still significant, factor loading (.43, $p < .001$), and the rest were all strong (>.70), we decided to retain all items as originally intended by their development authors (Mohr & Kendra, 2011). All factor loadings were significant at $p < .001$.

The measurement model also provides information on latent variable correlations (Table 3). While no evidence of a relationship was observed between mental ill-health and importance, nor between mental ill-health and community connectedness, all other correlations between latent variables were positive and significant. Put simply, and of particular relevance to this study, our key variables of discrimination, identity importance, and salience were each associated with greater LGBTQ+ community connectedness *and* greater stigma sensitivity at the bivariate level.

The Structural Model

The SEM, including regressive and correlational paths, also showed good fit to the data, $\chi^2(365) = 1{,}440.42$, $p < .001$, CFI = .94, RMSEA (90% CI) = .053 [.050, .056], SRMR = .05. Figure 3 displays the model's standardized path coefficients. As shown, group-based discrimination was moderately-to-strongly associated with greater levels of identity importance, salience, community connectedness, stigma sensitivity, and mental ill-health. Both importance and salience were strongly positively correlated, identity importance was strongly related to greater levels of LGBTQ+ community connectedness, and salience was strongly related to greater stigma sensitivity. No evidence of a relationship was observed between identity importance and stigma sensitivity ($p = .166$), nor between identity salience and community connectedness ($p = .118$), in the current model. Finally, stigma sensitivity was strongly associated with greater mental ill-health, and LGBTQ+ community connectedness was weakly related to less mental ill-health symptoms. Overall, the variables within the model accounted for a moderate-to-strong proportion of variance in mental ill-health symptomology (23.0%, $f^2 = 0.30$), and the effect sizes among other endogenous variables ranged from small (salience, $f^2 = 0.08$) to large (community connectedness, $f^2 = 0.37$; see Figure 3).

Table 3
Latent Variable Correlations From the Measurement Model

Latent variables	1	2	3	4	5
1. Group-based discrimination	—				
2. Identity importance	.34***	—			
3. Identity salience	.28***	.68***	—		
4. Stigma sensitivity	.39***	.30***	.43***	—	
5. LGBTQ+ community connectedness	.37***	.46***	.28***	.23***	—
6. Mental ill-health symptoms	.34***	.07	.14***	.43***	.05

Note. LGBTQ+ = lesbian, gay, bisexual, transgender, queer, and other.
*** $p < .001$.

Indirect Effects

Finally, all possible indirect associations within the model were examined (see Table 4). As shown, group-based discrimination was indirectly and *positively* associated with mental ill-health such that greater group-based discrimination was associated with *increased* stigma sensitivity, which in turn was associated with increased mental ill-health symptoms. This indirect relationship was further observed by group-based discrimination relating to greater levels of identity salience, with salience yielding a positive association with stigma sensitivity. Concurrently, group-based discrimination was indirectly and *negatively* related to mental ill-health. That is, group-based discrimination was related to greater community connectedness, which in turn was associated with *less* mental ill-health symptoms. Furthermore, evidence of an indirect relationship was also observed by the positive relationship between discrimination and identity importance, with importance yielding a positive relationship with community connectedness, which in turn was associated with less mental ill-health symptoms. No evidence of the indirect relationships between group-based discrimination and mental ill-health was observed via the importance-stigma sensitivity relationship pathway ($p = .229$), nor between the salience-community connectedness pathway ($p = .211$).

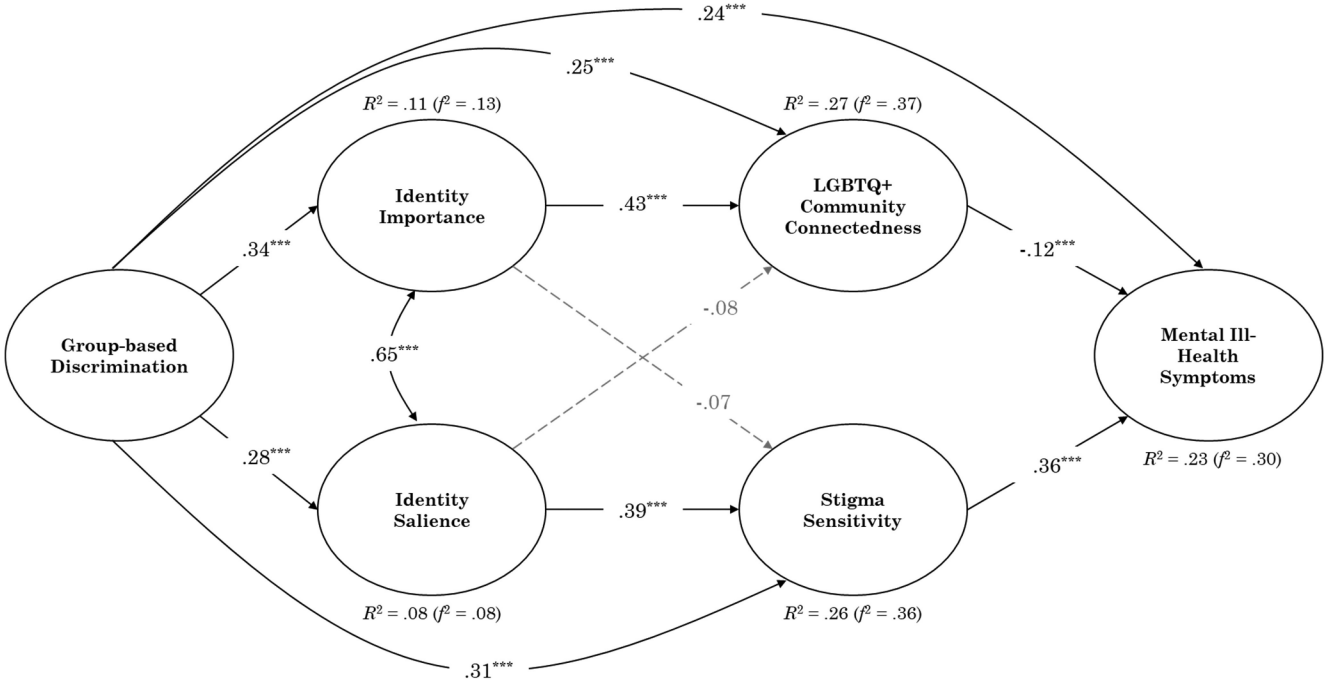
Supplementary Analyses

To explore the alternative that greater levels of identity centrality relate to increased group-based discrimination among LGBTQ+ community members (see Begeny & Huo, 2017; Suppes et al., 2021), we tested another cross-sectional model by which both importance and salience were specified to precede discrimination, with discrimination then specified to precede stigma sensitivity, community connectedness, and mental ill-health as originally hypothesized. This model showed good fit across some indices (e.g., RMSEA), but poor fit in others (e.g., SRMR) overall, $\chi^2(369) = 1{,}657.29$, $p < .001$, CFI = .93, RMSEA (90% CI) = .057 [.055, .060], SRMR = .09, and was significantly poorer in fit compared to the hypothesized model, $\Delta\chi^2(4) = 216.88$, $p < .001$, ΔCFI = .011. Hence, the results suggest that the hypothesized model (whereby group-based discrimination was specified to precede identity centrality) showed better fit to the data.

Furthermore, the hypothesized model including age, LGBTQ+ identity group memberships, ethnic identity, relationship status, and recruitment source as covariates showed equally good fit to the data, with all indices being within their acceptable ranges. Moreover, there was no observed change to the direction, magnitudes, or significance of the pathways. Given the similarities

Figure 3

Standardized Path Coefficients for the Structural Equation Model on the Relationship Between Discrimination and Mental Ill-Health



Note. Dashed arrows represent nonsignificant pathways ($p > .05$). Effect size estimates (R^2 and Cohen's f^2) reported alongside each endogenous variable for interpretation. LGBTQ+ = lesbian, gay, bisexual, transgender, queer, and other.
*** $p < .001$.

between the models with and without covariates, we only report results from the model without covariates here (Figure 3) for simplicity (i.e., the more parsimonious model without the additional estimated parameters). See the online supplemental materials for the full results pertaining to the covariates model.

Discussion

This study provides important preliminary insights on the theory-driven pathways through which group-based discrimination may indirectly relate to mental ill-health for LGBTQ+ individuals. We demonstrate that when identity centrality is conceptualized by its subdimensions of identity importance and salience, discrimination positively relates to these constructs, and in turn they simultaneously and differentially relate to mental ill-health. That is, greater LGBTQ+ discrimination is (directly and indirectly) associated with poorer mental ill-health outcomes. This was indirectly observed via greater stigma sensitivity (supporting H1a), and the relationship between greater salience and greater stigma sensitivity (supporting H1b). Simultaneously, greater LGBTQ+ discrimination was also indirectly associated with less mental ill-health symptoms via greater connectedness to the LGBTQ+ community (supporting H2a), and the observed relationship between identity importance and greater LGBTQ+ community connectedness (supporting H2b; see Table 4). This novel cross-sectional mediation model accounted for a substantial proportion of shared variance with mental ill-health

Table 4

Summary of All Model Indirect Effects, With 95% Bias-Corrected Bootstrap CI on the Discrimination–Mental Ill-Health Relationship

Mediator on the discrimination–health relationship	*B* (*SE*)	β	Bootstrap 95% CI (β)	*p*
Stigma sensitivity	0.09 (0.02)	.11	[.08, .14]	<.001
LGBTQ+ community connectedness	−0.02 (0.01)	−.03	[−.05, −.01]	.003
Identity importance → stigma sensitivity	−0.01 (0.01)	−.01	[−.02, .01]	.229
Identity importance → LGBTQ+ community connectedness	−0.01 (0.01)	−.02	[−.03, −.01]	.004
Identity salience → stigma sensitivity	0.03 (0.01)	.04	[.02, .06]	<.001
Identity salience → LGBTQ+ community connectedness	0.002 (0.002)	.002	[−.001, .01]	.211

Note. CI = confident intervals; LGBTQ+ = lesbian, gay, bisexual, transgender, queer, and other.

for LGBTQ+ individuals, and while the causal pathways stipulated within this model may only provide one explanation of their effects, the observed direct and indirect relationships appear consistent with a broad range of theoretical and evidence-driven frameworks (e.g., Begeny & Huo, 2017; Branscombe et al., 1999; Hatzenbuehler, 2009; Jetten et al., 2017; Meyer, 2003).

Simultaneous Strength and Stressor Relationships

It is well documented that LGBTQ+ people experience numerous adverse health outcomes (e.g., Borgogna et al., 2019; de Lange et al., 2022; Dürrbaum & Sattler, 2020; Goldbach et al., 2014; Hill et al., 2020; Meyer, 2003; Pellicane & Ciesla, 2022; Scandurra et al., 2019) and heightened experiences of discrimination (e.g., Campbell et al., 2019; Hill et al., 2020; Hinton et al., 2022; Meyer, 2003). Recently, however, there is a growing interest in understanding how LGBTQ+ individuals can benefit and flourish from within their communities (see Salvati & Koc, 2022). In this study, we observe that people with marginalized social identities may simultaneously derive both beneficial and detrimental health outcomes from their identification with their group, in the context of group-based discrimination. While researchers, policy makers, and the LGBTQ+ community themselves continue to fight and advocate for the reduction of LGBTQ+ discrimination at its source, our results show that heightened levels of identification within this community need not only relate to mental health in adverse ways. Indeed, we observe that alongside the direct adverse association between discrimination and mental health, factors such as community connection and an internalized sense of LGBTQ+ identity importance may indirectly explain better mental health outcomes that can stem from group-based discrimination. Although preliminary, these results may contribute to the understanding of how identity and discrimination can have important impacts on the health and well-being of LGBTQ+ individuals. For example, identifying with a marginalized community group can enhance the fundamental human need of belonging to likeminded communities as well as the preoccupation of thought pertaining to the stigma toward this same community—areas we believe that health care workers and policy makers could potentially target to enhance psychological betterment.

Although others have studied the associations of LGBTQ+ identity and both beneficial and detrimental health outcomes (e.g., Begeny & Huo, 2017; Chan, 2022; Hinton et al., 2022; Suppes et al., 2021), this study advances the literature by demonstrating that different dimensions of identity centrality may each play an essential and, importantly, unique explanatory role in determining these outcomes (aligning with recent research by Utku & Sayılan, 2023). A key strength of this study is its integration of several theoretical and empirical models, including the MST (Meyer, 2003), the psychological mediation framework (Hatzenbuehler, 2009), social cure (Jetten et al., 2017), and rejection-identification (Branscombe et al., 1999) frameworks.

Our finding that both distal and proximal stressors related to poorer mental health among LGBTQ+ individuals is consistent with the minority stress and psychological mediation frameworks. Aligning with previous research (e.g., Jäggi et al., 2018; Scandurra et al., 2020), our results indicate that greater group-based discrimination is associated with greater anticipation of, and sensitivity toward, future stigma experiences, which in turn related to poorer mental health. This observed indirect relationship was further mediated by greater identity centrality (aligning with Hinton et al., 2022), specifically through increased levels of identity awareness (or chronically thinking about the identity). These results extend upon the minority stress and psychological mediation models by suggesting that LGBTQ+ people whose identity is chronically salient may have poorer psychological health that is driven by minority stress processes. Moreover, these results align with past research by suggesting that this chronic degree of thought (but not the internalized sense of identity importance, where no evidence of a relationship was observed within the current study) can play a key role in accounting for variance in adverse outcomes (Begeny & Huo, 2017; Quinn et al., 2014; Utku & Sayılan, 2023), as when individuals are chronically thinking about their marginalized social identity, they are also more aware of (and therefore more sensitive to the effects of) the identity-related stigma that is prevalent within their environments. Finally, these latter results pertaining to identity salience also mirror similar research exploring the construct of rumination either broadly (e.g., Hatzenbuehler, 2009; Sarno et al., 2020) or in direct relation to an LGBTQ+ identity (e.g., Bauerband & Galupo, 2014; Galupo & Bauerband, 2016). That is, similarly to identity-based rumination, higher levels of LGBTQ+ identity salience might adversely relate to poorer mental health due to a preoccupation of thought pertaining to the marginalization experiences that are often experienced by LGBTQ+ individuals.

Our results also support the premise of the social cure framework (Jetten et al., 2017) and rejection-identification literature within LGBTQ+ samples (Utku & Sayılan, 2023). While both frameworks document the beneficial relationship between social identification and health, a recent meta-analysis by Hinton et al. (2022) found no evidence of a bivariate relationship among these variables for LGBTQ+ groups. They speculated that this could be, in part, due to the conflation of identity importance and salience as a unitary construct of identity centrality. However, they also hypothesized that identity centrality might indirectly relate to mental health outcomes via specific strength- and stressor-based mechanisms (particularly, community connection [strength] and stigma sensitivity [stressor], respectively). Here we have provided cross-sectional evidence in support of this hypothesis. LGBTQ+ individuals who reported greater group-based discrimination also reported greater levels of identity centrality, across both dimensions of importance and salience. Centrality then related to greater connectedness to the LGBTQ+ community, which further related to better mental health outcomes, but this was only observed for identity importance. These results support the fundamental tenets of social cure theorizing such that when individuals more strongly identify with their social group, it can increase their access to group-based protective resources (e.g., greater connection, Cruwys et al., 2014; Greenaway et al., 2016), which can act as a brake on the negative impact of discrimination on health. That is, when people see their LGBTQ+ identities as important reflections of themselves (which importantly, is not the same as chronically thinking about their LGBTQ+ identity), this may indirectly relate to better health and potentially provide them with protection against the pervasive discrimination that is prevalent in their environment.

The current results also provide some support for the rejection-identification model (Branscombe et al., 1999). However, since the rejection-identification model posits that it is identity centrality that can explain, and thereby attenuate the effects of discrimination on adverse health outcomes (Branscombe et al., 1999; Cruwys &

Gunaseelan, 2016; Ramos et al., 2012), and our study did not test a direct link between identity centrality components and health (aligning with recent evidence of null relationships among LGBTQ+ samples; Hambour et al., 2023; Hinton et al., 2022), the results of this study serve to suggest an extension of the rejection-identification model, rather than a direct replication. These results provide crucial insights into advancing social cure and rejection-identification literature among LGBTQ+ groups, while also detailing that marginalized group members can simultaneously experience poorer health outcomes, potentially as a function of increased identity salience and stigma sensitivity.

The Identity Importance Versus Salience Distinction

A particularly important finding of the current study is the differentiation of identity centrality components. As stated, given the scarcity of research that does not conflate these constructs, we made no a priori predictions about their differential associations in our model. However, we suggested that identity salience would more strongly relate to the negative outcomes within the model (and vice versa for identity importance, aligning with Begeny & Huo, 2017; Quinn et al., 2014; Utku & Sayılan, 2023). Our results support this contention. We first provide evidence that identity importance and salience should be considered as separate, but strongly related, constructs (as noted in our CFA results). When included in the model separately, we find that identity salience appears to be the factor that may help explain the adverse relationship between group-based discrimination and poorer health. In contrast, identity importance appears to be the key factor that may help explain the indirect associations between group-based discrimination and better health for LGBTQ+ individuals.

Recent research has found that identity centrality (when operationalized as the combination of importance and salience) has a complex relationship with health, particularly among LGBTQ+ minority groups (Hinton et al., 2022; Tuthill, 2023). Here, we provide evidence that a key reason for this complexity is how researchers have treated identity centrality—as a unitary construct, rather than comprising distinct dimensions. Further supporting this, our results show that while both constructs are strongly and positively related to one another ($r = .68$; Table 3), when controlling for the variance within the other variable, their indirect associations with mental health are in opposing directions. The robustness of these diverging relationships also remained stable after accounting for differences between subgroups within the LGBTQ+ community, among other demographics (see the online supplemental materials).

These results have important implications for researchers who study the effects of identity centrality, because using measures that aggregate these distinct constructs (e.g., Cameron, 2004; Leach et al., 2008) conflate their important differential ability to relate to key outcomes. These results also provide important insights into how LGBTQ+ people internalize their group memberships. Although viewing an LGBTQ+ identity as an important reflection of a person's sense of self, and thinking about their identity often, are related, we only observe evidence that the importance placed on this identity relates to better health. In contrast, chronically thinking about one's LGBTQ+ identity indirectly relates to poorer health outcomes. This is, in our view, a construct that lends itself to intervention to improve outcomes, as chronic salience might not be dissimilar to negative and repetitive cognitive processes, such as rumination and intrusive thoughts, which are known to relate to adverse health outcomes (e.g., Bauerband & Galupo, 2014; Galupo & Bauerband, 2016; Hatzenbuehler, 2009; Nolen-Hoeksema, 2000; Sarno et al., 2020).

Limitations and Future Directions

This study has several strengths, including the recruitment of a large and diverse sample of LGBTQ+ individuals, and the interrogation of identity centrality as a dual-dimensional construct. However, it is also not without its limitations. First, this study is cross-sectional, and therefore correlational in nature. While we designed our model in a way that is consistent with longitudinal research that demonstrates the temporal positioning of these variables (e.g., Begeny & Huo, 2017; Chan, 2022; Ramos et al., 2012), and we believe the structure of our model accurately reflects this (especially compared to the alternative model tested), we cannot interpret our findings through the lens of causality. Moreover, some of the measures we used assess their respective constructs within a given timeframe, implying that our results could be interpreted as general levels of group-based discrimination, identity centrality, community connectedness, and stigma sensitivity being related to recent mental ill-health symptomology. We encourage future researchers to further interrogate the replicability of our model in ways that will allow for causal inference, such as designing interventions that aim to enhance the internalized sense of importance of an LGBTQ+ identity and using longitudinal designs (e.g., experience sampling) with more clearly defined measurement timepoints.

A second limitation was that this study may have omitted measures reflecting distinctions that are critical for advancing LGBTQ+ scholarship. For instance, (a) a measure of individually experienced (rather than group-based/perceived) discrimination (and one that accounts for both inter- and intragroup discrimination sources) may have provided better insight for understanding minority stress processes, and (b) the decision for the centrality items to only focus on one LGBTQ+ identity for each participant may have subsequently excluded important nuances within these relationships that unfold at the intersections of gender and sexuality (e.g., by assessing the centrality of identities across these diverse intersections) as well as the sources of interlocking privilege and systemic oppression that can affect these outcomes for different LGBTQ+ community members. We encourage future research to explore, expand upon, and replicate this model by utilizing measures that account for these nuances. Relatedly, researchers who study the LGBTQ+ community have encouraged authors to consider the differential effects of LGBTQ+ subgroups (e.g., Hinton et al., 2022). Although we provide a brief exploration into this gap in the online supplemental materials (e.g., exploring the model while including broad identity groups as a covariate) and the purpose for which was to simply examine the robustness of the model itself, examining the more nuanced distinctions between specific LGBTQ+ identity groups was beyond the scope of this article and something we believe can be afforded more depth, attention, and discussion by future researchers. Similarly, some of the validated measures in this study refer to LGBTQ+ identities at different levels of group identification (i.e., at either the superordinate or ordinate level of LGBTQ+ identity). Hence, there may be subtle differences in relationships between these constructs that our model did not account for. We encourage researchers to examine these potential nuances further.

Research indicates that levels of discrimination and health outcomes differ across gender-diverse and cisgender individuals (e.g., Hill et al., 2020), but their differing relationships among variables such as the ones included in this study are yet to be explored. Moreover, LGBTQ+ individuals are not just a homogenous community of individuals but are each diverse regarding their social positioning and status of privilege. While our model assumes a level of homogeneity, and we believe that doing so provides an essential foundation for future adaption, its applicability to all LGBTQ+ individuals may be limited. Indeed, advancing this model by exploring how the interlocking systems of oppression and power that can shape how some community members experience discrimination and evaluate the importance and salience of their identities is of paramount importance (e.g., systems and structures that intersect across gender, sexuality, ethnicity, age, ability status, and socioeconomic status). Hence, we encourage future researchers to explore this model among diverse LGBTQ+ community members and examine its replicability by considering the different social contexts and structures of marginalization (and resilience).

Finally, this study only focuses on one specific (dual-dimensional) factor of social identification—centrality. Other social identity dimensions exist and might also differentially explain the discrimination–mental ill-health relationship (see Lashkay et al., 2023 for a recent example of the differential effects of identification and disidentification on mental ill-health). As recently evidenced in Utku and Sayılan (2023), which explored multiple social identification constructs within this relationship, there is a clear need to differentiate social identification constructs to provide further insight into how they might explain both better and worse health outcomes.

Conclusion

This study paints an important picture of how LGBTQ+ discrimination may influence critical psychological health outcomes for this marginalized community. By expanding on theoretical and empirical research that examines the explanatory mechanisms that link discrimination and mental health, this study provides correlational evidence suggesting that LGBTQ+ discrimination is associated with identity and mental health in complex ways. Specifically, LGBTQ+ individuals can report better *and* worse mental health outcomes when they identify with their LGBTQ+ group, through simultaneous pathways of greater stigma sensitivity and greater community connection. Importantly, this study interrogates different dimensions of identity centrality and finds that it is the internalized sense of identity importance that can indirectly be related to *better* health, while being chronically aware of one's stigmatized identity appears to indirectly relate to more *adverse* outcomes—a distinction we believe future researchers should pay closer attention to.

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