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Sexual Minority Men's Mental Health: Associations with Gay Community Intragroup Marginalization Beyond Heterosexist Discrimination

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ABSTRACT

Heterosexist discrimination is a known predictor of poorer mental health among sexual minority men (SMM), but it may not be the only social stressor influencing mental health. This study examined if intragroup marginalization within the gay community contributes to SMM's mental health after accounting for experiences of heterosexist discrimination. Study participants were 283 Australian SMM ($M_{age} = 32.12$, $SD = 10.81$) who completed an online survey of heterosexist discrimination and intragroup marginalization, as well as levels of depression, social anxiety, self-esteem, and outness. Intragroup marginalization was measured using a new scale assessing marginalization due to social (e.g., status), individual (e.g., physical appearance), and identity (e.g., race/ethnicity) attributes. Depression, social anxiety, and self-esteem were regressed on all other measures in three hierarchical models. Individual intragroup marginalization predicted greater depression, social anxiety, and lower self-esteem; identity intragroup marginalization predicted greater depression and social anxiety; and, unexpectedly, social intragroup marginalization predicted lower social anxiety and greater self-esteem. These associations persisted after considering heterosexist discrimination, which predicted poorer mental health outcomes, while outness was not a significant predictor. The results reveal varied associations between intragroup marginalization, heterosexist discrimination, and mental health, suggesting complex relationships between multilateral stressors and SMM's mental health.

KEYWORDS

Intragroup marginalization; heterosexist discrimination; minority stress; sexual minority men; male gay community; mental health; outness

Research consistently finds that sexual minority men (SMM; e.g., gay and bisexual men) report disproportionately higher mental health concerns compared to heterosexual men (e.g., Argyriou et al., 2021; Meyer et al., 2008). Stigmatization experiences from the heterosexual community are important contributors to this mental health disparity because they are stressful events that harm mental health (Meyer, 2003; Szymanski &

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Mikorski, 2016). Stigmatization occurs when individual differences between people are identified and labeled, and then associated with negative stereotypes, resulting in a separation of individuals into an "us vs. them" dynamic (Goffman, 2022; Link & Phelan, 2001). This process leads to discrimination and status loss, reinforces exclusion and inequality, and ultimately undermines mental health (Link & Phelan, 2001; Lucas & Phelan, 2012; Meyer, 2003; Szymanski & Mikorski, 2016). Minority stress theory (Meyer, 2003) has proven valuable in explaining SMM's mental health. The minority stress model suggests that SMM are exposed to additional stress experiences that are specific to their sexual minority status (e.g., heterosexist discrimination), which in turn predispose them to internal stress experiences (i.e., rejection sensitivity, internalized homonegativity, minority identity concealment efforts). These external and internal stressors are often interrelated, but also predict mental health independently (Meyer, 2003). Heterosexist discrimination, also referred to as heterosexism, is the "prejudice against any non-heterosexual form of behavior, relationship, or community, particularly the denigration of lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people" (APA Dictionary of Psychology, 2023), which includes systematic mistreatment, exclusion, or violence against non-heterosexual individuals. Notably, chronic stress from actual or anticipated heterosexist discrimination undermines SMM's well-being (Ngamake et al., 2016; Woodford et al., 2014), especially for those who are more "out" (i.e., more open about their sexuality) and therefore at greater risk of frequent discrimination (Chang et al., 2021).

The psychological mediation framework (Hatzenbuehler, 2009) extends the minority stress model, drawing attention to a mediational process whereby external minority stress induces internal minority stress responses and other general psychological processes (e.g., adverse cognitive and affective appraisal, social isolation), which in turn predict poorer mental health outcomes, such as depression and anxiety (e.g., Schwartz et al., 2016). Importantly, the psychological mediation minority stress framework highlights external stress as the initial trigger of this mediation process, emphasizing the detrimental role of heterosexist discrimination in the mental health disparity between SMM and heterosexual men. However, some studies show only small associations between heterosexist discrimination and SMM's mental health (e.g., Chan, 2021), and heterosexist discrimination consistently falls short of fully explaining the mental health gap between SMM and heterosexual men (e.g., Mongelli et al., 2019). Thus, researchers have turned to considering other sources of stress that could impact SMM's mental health, particularly concentrating on marginalization experiences *within* the gay community (e.g., Pachankis et al., 2020; Shepherd, Maki, et al., 2023). Thus, the overarching aim of the current study was to determine whether experiences of gay community intragroup marginalization

uniquely predict poorer mental health outcomes among SMM in Australia, above and beyond the effects of heterosexist discrimination.

Intraminority stress from within the gay community

Our recent qualitative study (Dellers et al., 2024) suggests that SMM's sexual minority status can be a double-edged sword, with stress originating both outside and within the gay community. Intraminority stress theory (Pachankis et al., 2020) focuses on the latter, proposing that certain social values found across gay communities (i.e., prioritizing sex over meaningful relationships; a focus on wealth and prestige; a culture of gossip and judgment; and exclusionary attitudes) are perceived as stressful by many SMM. In turn, higher reported intraminority stress correlates with poorer mental health (e.g., depression, anxiety, and somatization; Pachankis et al., 2020). While intraminority stress theory considers an additional source of stress for SMM, it emphasizes subjective stress appraisals within SMM, rather than focusing on marginalization between SMM (Parmenter et al., 2020), also termed intragroup marginalization.

Intragroup marginalization has been defined in past research as the rejection, ostracism, or exclusion of members of a social group by their in-group peers, if they do not meet the expected standards of the in-group (Castillo et al., 2007; Jetten et al., 2006). While intragroup marginalization can occur in any social group, this study focuses specifically on intragroup marginalization that occurs among SMM, which can be defined as the enacted prejudice or stigma of SMM against other SMM (e.g., communicating interpersonal dislike, ostracism, disapproval, or judgment), taking place in-person or online (Dellers et al., 2024; Hammack et al., 2022; Maki, 2018). Among SMM, social segregation in social and romantic contexts is linked to greater social isolation, depression, and anxiety (Flanders et al., 2019; Smit et al., 2012), and specific types of intragroup marginalization correlate with additional mental health issues. For example, among SMM it was found that frequent experiences of sexual objectification (e.g., judgment of weight or body shape) were associated with more body dissatisfaction and lower quality of life (Davids et al., 2015; Griffiths et al., 2018); sexual racism was associated with elevated depressive symptoms and lower self-esteem (Wade & Pear, 2022); and perceived stigma against positive human immunodeficiency virus (HIV) serostatus was related to greater levels of depression, anxiety, and loneliness in HIV-positive SMM (Smit et al., 2012). Meanwhile, qualitative studies of SMM suggest that intragroup marginalization due to gender expression, socio-economic status, or age, may also be related to depressive and anxiety symptoms, low self-esteem, loneliness, and relationship strain (Emlet, 2006; Green, 2008; Parmenter et al., 2020). More recently, Parmenter and Winter (2023) found

that experienced interpersonal and structural inequities within the broader LGBTQ+ community impacted mental health similarly to experienced heterosexism.

Research on intracommunity dynamics among SMM has identified several personal attributes that contribute to intragroup marginalization. The literature emphasizes three key attribute domains, including SMM's social and cultural alignment with the gay community (i.e., social attributes), their physical appearance and expression (i.e., individual attributes), and their identity and health status (i.e., identity attributes). Factors related to social and cultural positioning, such as SMM's socioeconomic status (Levine-Murray, 2012; Pachankis et al., 2020) or their non-adherence to broader gay community norms (e.g., religious and political beliefs, interests, and hobbies; Maki, 2018) can shape experiences of intragroup marginalization, hinder a sense of community inclusion (Levine-Murray, 2012), and undermine mental well-being (Pachankis et al., 2020). Other research highlights how physical attributes and expression, such as body shape and weight (Foster-Gimbel & Engeln, 2016; Shepherd, Denning, et al., 2023) or varying levels of masculinity (Halkitis, 2001; Parmenter et al., 2020; Sánchez et al., 2009; Taywaditep, 2001), contribute to peer exclusion, thus reinforcing ideals of desirability, belonging, and masculine gender norms, with such experiences invoking issues with body image and self-esteem (Davids et al., 2015; Filice et al., 2019; Kousari-Rad & McLaren, 2013; Sánchez et al., 2009), and romantic relationship quality (Sánchez et al., 2009). Additionally, studies have found that SSM experience intragroup marginalization based on characteristics such as age (Emlet, 2006; Lyons et al., 2021), race (Han, 2008; MacCarthy et al., 2021; Parmenter et al., 2020), sexual orientation (e.g., bisexuality; McInnis et al., 2022; Mulick & Wright, 2002), and HIV status (Courtenay-Quirk et al., 2006; Emlet, 2006; Halkitis, 2001; Smit et al., 2012), with such experiences also having been linked to poorer emotional and social well-being (e.g., Lyons et al., 2021; McInnis et al., 2022; Parmenter & Winter, 2023; Smit et al., 2012). Most studies in the literature have focused on singular challenges within the gay community (e.g., ageism, HIV stigma), with few quantitatively examining their impact on SMM's mental and social health. This reveals the need for a more comprehensive approach that considers the collective of personal attributes that may result in intragroup marginalization, and a need for studies that explore their associations with SMM's well-being.

A recent study aimed to address this gap by gathering comprehensive reports from SMM about a variety of attributes that place them at risk of marginalization from within the gay male community, finding a range of personal attributes that underlie intragroup marginalization. In this study (Dellers et al., 2024), 19 personal attributes spanning five domains (i.e., physical, personal, social, behavioral, and sexual health) were identified by SMM as reasons for intragroup marginalization. Participants in this study also

recognized that intragroup marginalization might lead to adverse emotional, social, and behavioral outcomes. In the present study, this information was used to develop a measure that captured intragroup marginalization across several areas. These areas were analyzed to identify a smaller set of emergent factors representative of different manifestations of intragroup marginalization, and to subsequently examine them as correlates of SMM's mental health before and after accounting for the impact of heterosexist discrimination.

Given this focus on multiple manifestations of intragroup marginalization, the present study expands on past research that has tended to focus on specific types (e.g., Davids et al., 2015) or qualitative descriptions of intragroup marginalization (e.g., Parmenter et al., 2020), and explorations of the impact of general stress perceptions within the male gay community on mental health outcomes (e.g., Pachankis et al., 2020). While a recent study found that experienced inequity within the gay community predicts depression and anxiety beyond heterosexist discrimination (Parmenter & Winter, 2023), it is yet to be determined whether marginalization based on a combination of specific personal attributes adversely affects mental health in SMM, above and beyond the impact of heterosexist discrimination. Such results would extend our understanding of multilateral external stressors (such as heterosexist discrimination and intragroup marginalization) and their relationship with SMM's mental health. To further build on the existing literature, the conceptualization of mental health should align with previous research. Depression, social anxiety, and self-esteem seem especially well-aligned, given their well-documented relevance to SMM's mental health (Argyriou et al., 2021; Bridge et al., 2019; Pachankis & Goldfried, 2006; Smit et al., 2012). These variables have been found to capture the psychological impact of adverse social interactions (Bridge et al., 2019; Mahon et al., 2019; Szymanski & Ikizler, 2013) and, thus, allow for a nuanced examination of the association of intragroup marginalization with mental health among other minority stressors.

Current study

Heterosexist discrimination partially accounts for the disproportionate mental health challenges faced by SMM compared to heterosexual men, but recent research suggests that intragroup marginalization originating *within* the gay community could also contribute to SMM's poorer mental health. Few studies have explored the effects of gay community intragroup marginalization on SMM's mental health, and research has yet to determine the unique impacts of heterosexist discrimination and intragroup marginalization. Thus, the aims of the current study were to: 1) explore whether a comprehensive range of manifestations of intragroup marginalization (i.e., based on social, individual, and identity

attributes) are associated with SMM's poorer mental health (i.e., elevated depression and social anxiety, and lower self-esteem); and 2) to determine whether manifestations of intragroup marginalization remain uniquely associated with mental health, after accounting for the effect of heterosexist discrimination. In examining these associations, openness with sexual orientation (i.e., level of outness) was included as a covariate, due to its known correlations with experienced heterosexism (e.g., Chang et al., 2021), and higher social integration with the gay community (Suppes et al., 2021), thus potentially facilitating experiences of intragroup marginalization.

Method

Participants

The participants were 283 SMM, with an average age of 32.1 ($SD = 10.8$; range = 18 to 71 years). The study was restricted to respondents who identified as men (regardless of sex assigned at birth) and were sexually attracted to other men (e.g., gay, bisexual), reported prior or current involvement with the male gay community, and resided in Australia at the time of participation. Table 1 presents all demographic information. Most participants ($n = 265$; 93.6%) identified as men who were assigned male sex at birth, with 14 participants (5.0%) identifying as men who were assigned female sex at birth. Four participants (1.4%) who were assigned female sex at birth identified as trans-masculine or trans-male ($n = 3$) and demi-male ($n = 1$). Regarding sexual orientation, most participants were identified as either gay/homosexual ($n = 239$; 84.5%), bisexual ($n = 23$, 8.1%), or queer ($n = 13$, 4.6%). In reporting ethnicity, participants were able to specify more than one ethnic background. Although a majority described one background ($n = 212$, 74.9%), others reported two ($n = 68$, 24.0%) or three ($n = 3$, 1.0%). Among participants who indicated only one ethnic background, most identified as Australian ($n = 142$, 67.0%), European ($n = 28$, 13.2%), or Asian ($n = 18$, 8.5%), with some participants identifying as South American ($n = 4$, 1.9%), North American ($n = 4$, 1.9%), Indigenous Australian ($n = 2$, 0.9%), or other ethnicities ($n = 14$, 6.6%). Most participants indicated being born in the Oceania region ($n = 229$, 80.9%). Most respondents held a bachelor's degree or higher ($n = 180$, 63.6%) and earned a monthly income between $1,000 and $3,999 ($n = 98$, 34.6%) or $4,000 to $6,999 ($n = 102$, 36.0%). A majority of participants reported being single ($n = 173$, 61.1%), HIV-negative ($n = 269$, 95.1%), and being out to all queried social groups (i.e., family, friends, work colleagues, and acquaintances; $n = 160$, 56.5%).

Table 1. Participant demographics ($N = 283$).

Characteristic	*n*	%
Age (Range = 18–71)		
18–29	135	47.7
30–39	86	30.4
40–49	34	12.0
50–59	23	8.1
60–69	4	1.4
70–79	1	0.4
Gender		
Man	279	98.6
Other gender (Trans-male/-masculine, Demi-Male)	4	1.4
Sex assigned at birth		
Male	265	93.6
Female	18	6.4
Sexuality		
Gay	239	84.5
Bisexual	23	8.1
Queer	13	4.6
Other (i.e., Pansexual, Asexual, Fluid, Questioning, Bi-romantic or Demisexual)	8	2.8
Ethnicity[a]		
White Australian	205	72.2
European	80	28.2
Asian	32	11.3
Indigenous Australian	10	3.5
South American	9	3.2
North American	6	2.1
Southeast Asian	4	1.4
Other ethnicities (i.e., New Zealand/Māori, Middle Eastern, African)	13	4.6
Place of Birth		
Oceania	229	80.9
Asia	20	7.1
Europe	16	5.7
Americas	12	4.2
Africa	5	1.8
Information not provided	1	0.4
State of Residence		
Queensland	81	28.6
New South Wales	72	25.4
Victoria	67	23.7
Western Australia	22	7.8
South Australia	20	7.1
Australian Capital Territory	17	6.0
Northern Territory	4	1.4
Education		
Year 11 or below	6	2.1
Year 12	52	18.4
Certificate III/IV	17	6.0
Diploma or Advanced Diploma (e.g., TAFE)	28	9.9
Bachelor's Degree or Equivalent Vocational Training	94	33.2
Graduate Diploma or Graduate Certificate	26	9.2
Master's Degree	47	16.6
Doctoral Degree	13	4.6
Monthly income		
<$1,000	25	8.8
$1,000–$3,999	98	34.6
$4,000–$6,999	102	36.0
$7,000–$9,999	28	9.9
$10,000–$12,999	15	5.3
>$13,000	14	5.0
Information not provided	1	0.4
Relationship Status		
Single	173	61.1
Partnered	82	29.0

(*Continued*)

Table 1. (Continued).

Characteristic	*n*	%
Married	18	6.4
Other Relationship Status		
Widowed	4	1.4
Open Relationship	2	0.7
Information not provided	4	1.4
HIV Status		
HIV-negative	269	95.1
HIV-positive, undetectable	12	4.2
Prefer not to say	2	0.7
Level of Outness[a]		
Out to family	222	78.5
Out to friends	266	94.0
Out to work colleagues	209	73.9
Out to acquaintances	194	68.6
Out to none of these groups	10	3.5

[a]Multiple-choice response resulted in total *n* that is larger than the sample size.

Measures

Intragroup marginalisation due to social, individual, and identity attributes

We developed the Gay Community Intragroup Marginalisation Scale (GCIMS) to measure intragroup marginalization in this study. This measure examines the frequency of a comprehensive range of intragroup marginalization experiences described during interviews with 30 SMM from Australia (Dellers et al., 2024), containing a total of 19 items. The identified grounds for intragroup marginalization spanned five domains, which included physical (e.g., "body shape/type—e.g., your height, body size, muscularity, body category [e.g., twink, bear, jock]"), personal (e.g., "gender identity, and expression —e.g., your gender pronouns, level of femininity or masculinity, mannerisms"), behavioral (e.g., "primary choice of sexual position—e.g., being bottom, top, or versatile"), social (e.g., "social status—e.g., your career/job, education, income, possessions [e.g., car, clothing], location of residence/origin"), and sexual health (e.g., "HIV-status or STI-status"). Importantly, the examples provided in the GCIMS are not exhaustive, rather, items were framed as broad categories, with the included examples intended to prompt individuals to reflect on their own experiences of marginalization. The items followed the prompt "*In the past year, how often have you been marginalised by other members of the gay community due to your . . .:*", with participants asked to indicate the frequency of experienced marginalization over the past year for each item, on a 6-point scale from 1 = *This has never happened to me* to 6 = *This happened to me very often or all the time* (see Table 2 for an overview of all items).

The GCIMS was pilot-tested with 12 gay and bisexual cis-gender men (M_{age} = 33.17, *SD* = 4.08, range = 26 to 41 years) with similar demographic attributes as the sample in the current study. The pilot study aimed to assess clarity of

Table 2. Results from the principal component analysis of the GCIMS.

		Components		
Items		1	2	3
Component 1: Social Attributes (27.6%)				
12	Lifestyle (e.g., your involvement in the gay community or "being in the scene," hobbies/activities, interests)	**.81**	−.04	−.04
13	Substance use (e.g., your level of alcohol consumption and/or illicit drug use, or types of drugs consumed)	**.75**	.07	−.04
14	Social network (e.g., your friendships with other sexual and/or gender minority individuals (e.g., lesbian women, drag queens), popularity, past sexual partners, membership in cliques or subgroups)	**.75**	.05	.03
15	Social media use (e.g., extent of your online presence, online popularity, number of followers, type or amount of content production)	**.70**	.06	.01
18	Sexual interactions (e.g., extent of your engagement in one-night stands/hookups, preference for dating and/or celibacy)	**.64**	.21	.06
11	Social status (e.g., your career/job, education, income, possessions (car, clothing, etc.), location of residence/ origin)	**.63**	.09	.01
16	Family status (e.g., your relationship status, having children)	**.58**	−.03	.18
17	Primary choice of sexual position (e.g., being bottom, top, or versatile)	**.57**	.36	−.04
19	Sexual preferences/kinks (e.g., your safe-sex/bareback practices, fetishes (e.g., chem-sex, leather, BDSM), being dominant/submissive)	**.57**	.20	.11
10	Religious or political affiliation (e.g., your level of liberalism/ conservatism, belief system)	**.49**	−.16	.32
Component 2: Individual Attributes (13.7%)				
8	Specific physical features (e.g., facial features, amount of body hair, penis size/shape)	.06	**.86**	−.01
9	Body shape/type (e.g., your height, body size, muscularity, body category such as twink, bear, jock)	.09	**.84**	−.05
7	Age	.10	**.55**	.12
6	Personality (e.g., your level of extraversion, shyness, or conversation skills)	.20	**.47**	.26
Component 3: Identity Attributes (10.5%)				
1	Ethnicity/Race (e.g., racist discrimination or sexual racism)	−.35	.31	**.66**
5	Gender identity and expression (e.g., transphobia/cis-sexism, your gender pronouns, level of femininity or masculinity, mannerisms)	.36	−.18	**.56**
4	Sexual orientation and expression (e.g., being bisexual, how out/closeted you are)	.28	−.12	**.56**
2	Disability (e.g., your visual/physical impairments, mental health problems, differently abled)	.24	−.01	**.53**
3	HIV-status or STI-status	.21	−.03	**.40**

Percentages in brackets describe overall variance explained by each component.
Factor loadings above .40 are in bold.

wording, ease of use, and appropriateness of items, and to obtain feedback on any additional items that should be included. Participant feedback resulted in some minor changes to the wording of single items (e.g., "sexual fetishization" to "sexual racism"), while ease of use, comprehensiveness, and appropriateness of items were unanimously endorsed. Participants did not suggest any additional items for inclusion.

To determine whether items formed broader categories or factors representative of different manifestations of intragroup marginalization,

a principal component analysis (PCA) with oblimin rotation was performed on the 19 items of the GCIMS (see Table 2). Bartlett's test of sphericity ($p < .001$) and the Kaiser–Meyer–Olkin measure of sampling adequacy (KMO = 0.91) indicated factorability of the items. The initial analysis extracted four components with eigenvalues over 1, which explained 57.1% of the overall variance in the items. Two items ("race and ethnicity" and "HIV- and STI-status") were the only items loading highly on the fourth factor, with "HIV- and STI-status" additionally cross-loading (i.e., above .40) on a second factor. As these two items describe relevant grounds for intragroup marginalization (e.g., Emlet, 2006; Shepherd, Maki, et al., 2023), we retained them but repeated the PCA requesting a three-factor solution (see Table 2).

The second PCA with three components explained a total of 51.8% of the variance in the items, with all items loading equal to or greater than .40 and no cross-loadings exceeding .40. The first component (10 items; $\alpha = .89$) represented social grounds for marginalization, based on an individual's status, values, interests, and preferences (e.g., lifestyle). The second component (4 items; $\alpha = .79$) included items that described individual attributes that are readily observable by other SMM (e.g., specific physical features). The third component (5 items; $\alpha = .60$) centered on attributes relevant to an individual's sense of identity (e.g., ethnicity/race). Notably, while each of the components includes some items that tap demographic attributes (e.g., relationship status, age, ethnicity), the GCIMS goes beyond measuring these attributes, and instead focuses on their potential role in attracting marginalization from other SMM.

A mean score was subsequently calculated for each of the three subscales, with higher scores indicating a higher frequency of experienced intragroup marginalization. In the following sections, these three subscales are referred to as social intragroup marginalization (first component), individual intragroup marginalization (second component), and identity intragroup marginalization (third component).

Heterosexist discrimination

The gay and bisexual men's version of the Heterosexist Harassment, Rejection, and Discrimination Scale (HHRDS; Szymanski, 2009) was used to measure heterosexist discrimination. The HHRDS is a 14-item measure of experienced heterosexist harassment, discrimination, and rejection across various contexts (e.g., family, in public, in the workplace) in the past year (Szymanski, 2009). An example is "How many times have you been treated unfairly by your family because you are gay[1]?." Items are rated on a 6-point scale from 1 = *This has never happened to me* to 6 = *This happened to me very often or all the time*. A mean score was computed, with higher scores indicating a higher frequency of experienced heterosexist discrimination. The scale has been shown to have

a good internal consistency of α = .91 for gay and bisexual men (Szymanski, 2009), with a similar level found in the current study (α = .90).

Depressive symptoms

The 10-item short form of the Center for Epidemiologic Studies Depression Scale (CESD-10; Andresen et al., 1994) was used to measure depressive symptoms. Participants rated each item (e.g., "I felt depressed") as it occurred over the past week, on a 4-point scale from 1 = *Rarely or none of the time (less than 1 day)* to 4 = *Most or all of the time (5–7 days)*. A mean score was then computed for each participant, where higher scores indicated more elevated depressive symptoms. The scale has well-established validity and reliability in screening for depressive symptoms across populations (e.g., Cheng et al., 2006; Zhang et al., 2012). Internal consistency was previously shown to be adequate in a sample of older LGB individuals (α = .88; Hoy-Ellis & Fredriksen-Goldsen, 2016), with a comparable alpha obtained for the current sample (α = .88).

Social interaction anxiety

The 19-item Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998) was used to measure distress when meeting and interacting with other people (e.g., "I tense up if I meet an acquaintance in the street"). One item enquiring about interacting with "attractive persons of the opposite sex" was adapted to be more inclusive, with the wording changed to refer to "attractive persons." Items are scored by indicating how true each item is of the participant, using a 5-point scale from 1 = *Not at all true* to 5 = *Extremely true*. A mean score was computed for each participant, with higher scores indicating more elevated social anxiety symptoms. The scale showed high internal consistency in a sample of SMM (α = .92; Pachankis & Goldfried, 2006) and was similarly high in the current sample (α = .95).

Self-esteem

The Single-Item Self-Esteem Scale (SISE; Robins et al., 2001) was used to measure self-esteem. Participants were asked to indicate how true the statement "I have high self-esteem" was of them, by rating it on a 5-point scale from 1 = *Not at all true* to 5 = *Extremely true*, with a higher score indicating a higher level of self-esteem. Robins et al. (2001) showed that the reliability and validity of the SISE is comparable to a multi-item measure of self-esteem (i.e., Rosenberg Self-Esteem Scale; Rosenberg, 1979). The original authors also reported acceptable test–retest reliability across three points in time (Mean Heise estimate = .75).

Outness

Level of outness was measured through a single question asking participants to select all applicable social groups they are "out" to, including family, friends,

work colleagues, and/or acquaintances. Based on participants' selections, a total sum score was calculated ranging from 0 = *Out to none of the social groups* to 4 = *Out to all of the social groups*, with higher scores indicating greater level of outness. This measure was an adapted and simplified version of a similar measure used previously (Meyer et al., 2002). Such measures were shown to be a valid measure of sexual orientation disclosure (Durso & Meyer, 2013; Frost & Meyer, 2009).

Procedure

This study was approved by the Human Research Ethics Committee at Griffith University (GU Ref No: 2022/518). Participants were recruited from the general population ($n = 253$) through advertisements on social media (i.e., Instagram and Facebook) and snowball sampling. In addition, first-year undergraduate psychology students ($n = 30$) were recruited via an advertisement on a university-based research website. After seeing the advertisement, interested individuals accessed a weblink to a brief screening questionnaire (i.e., age, sex, gender, sexual orientation, involvement with the gay community, and current residence), and an informed consent section. Eligible and consenting participants were asked to answer demographic and social status questions (i.e., ethnicity, country of birth, level of education, income, relationship status, HIV-status), followed by the main study measures. Upon completion of the study, participants were offered the opportunity to enter a prize draw to win an online gift card and were provided with a debriefing flyer with contact details for relevant support services.

Data analysis

Data analysis was performed using the Statistical Package for the Social Sciences (SPSS v29). A total of 0.7% of data was missing across variables, with 2.5% of participants not having completed all items. Little's test revealed that data were missing completely at random (MCAR; $\chi^2 = 41.521$, $df = 47$, $p = .698$). All participants were maintained for all analyses by replacing missing values using mean substitution.

Pearson's correlations were computed as a preliminary test of the associations between the variables of interest. To test the study hypotheses, three hierarchical regression analyses were performed, one for each of the mental health dependent variables (depression, social anxiety, and self-esteem). The independent variables in each model were entered in three steps. At Step 1, level of outness was entered as a control variable.[2] At Step 2, heterosexist discrimination was entered. At Step 3, the three intragroup marginalization subscales (social, individual, and identity intragroup marginalization) were entered. Prior to and throughout the regression analyses, assumption checks were performed, with assumptions found to be supported. Multicollinearity among the

predictors in the regression models was assessed by computing Variance Inflation Factors (VIFs). The VIFs for all predictors ranged from 1.05 to 2.08, indicating that multicollinearity was not a concern in these models (Kim, 2019). A post-hoc power analysis, using G*Power, was performed for the hierarchical regression models. Effect sizes for the three models ranged from medium to large (f^2 = .16–.22), resulting in an achieved power of .99 across models.

Results

Descriptive statistics and bivariate correlations

Table 3 shows the means, standard deviations, and bivariate correlations between the variables of interest. The distributions of the marginalization variables (i.e., heterosexist discrimination and intragroup marginalization scales) were positively skewed, indicating that participants tended to rate the frequency of experienced heterosexist discrimination and intragroup marginalization as relatively low. Out of the three intragroup marginalization subscales, individual reasons (e.g., body/shape) had the highest mean score, followed by social (e.g., sexual interactions) and then identity attributes (e.g., sexual orientation). Meanwhile, the mental health scores were more normally distributed. On average, participants had moderate levels of self-esteem and social anxiety symptoms. To compare the sample's average depression levels to the cutoff values suggested by Andresen et al. (1994), we recoded the CESD-10 items to align with the original scaling (from 0 = *Rarely or none of the time (less than 1 day)* to 3 = *Most or all of the time (5–7 days))* and calculated a mean sum score. The sum of the CESD-10 depressive symptom items indicated that the average participant fell above the commonly used cut-off score of 10 (M = 11.75, SD = 6.70; Andresen et al., 1994), suggesting the presence of significant

Table 3. Means, standard deviations, and correlations between study variables.

Variables	Mean (*SD*)	Possible Range	1	2	3	4	5	6	7	8
1. Heterosexist discrimination	1.70 (0.66)	1–6	—							
2. Social marginalization	1.93 (0.84)	1–6	.47**	—						
3. Individual marginalization	2.73 (1.09)	1–6	.22**	.56**	—					
4. Identity marginalization	1.61 (0.68)	1–6	.51**	.57**	.33**	—				
5. Depression	2.17 (0.67)	1–4	.30**	.24**	.31**	.32**	—			
6. Social anxiety	2.67 (0.88)	1–5	.27**	.05	.23**	.23**	.54**	—		
7. Self-esteem	2.41 (1.12)	1–5	−.18*	.00	−.22**	−.11	−.55**	−.49**	—	
8. Outness	3.15 (1.17)	0–4	−.06	−.18*	−.05	−.17*	−.02	−.03	−.11	—

*p < .01, **p < .001.

depressive symptoms in the sample. Level of outness was negatively skewed, indicating an overall high level of sexual orientation transparency (i.e., out to three or more social groups). The skewed distributional patterns observed for heterosexist discrimination, intragroup marginalization, and outness are comparable to previous research (e.g., Riggle et al., 2017; Shepherd, Maki, et al., 2023; Szymanski, 2009).

Bivariate correlations showed that heterosexist discrimination was significantly correlated with all intragroup marginalization and mental health indicators, so that it was associated with more frequent intragroup marginalization, more depressive and social anxiety symptoms, and lower self-esteem. The intragroup marginalization subscales showed a varied pattern of correlations with mental health measures. Social intragroup marginalization was significantly correlated with more depressive symptoms but not with social anxiety or self-esteem. Individual intragroup marginalization was significantly correlated with more depressive and social anxiety symptoms, and lower self-esteem. Identity intragroup marginalization was significantly associated with more depressive and social anxiety symptoms, but not with self-esteem. Finally, level of outness was negatively correlated with social and identity intragroup marginalization, but not with any other variables.

Hierarchical regression analyses

Table 4 shows the results of the three hierarchical regression models for the mental health measures of depression, social anxiety, and self-esteem. In the first model of depressive symptoms, level of outness was not significantly associated with depression at Step 1. At Step 2, heterosexist discrimination was associated with more depression (ß = .30, $p < .001$), accounting for a significant 9.0% of the variance. At Step 3, the three subscales of intragroup marginalization accounted for a significant additional 8.6% of the variance in depression, with individual (ß = .26, $p < .001$) and identity (ß = .20, $p = .005$) intragroup marginalization associated with higher levels of depression, accounting for 4.7% and 2.4% of variance, respectively. Social intragroup marginalization was not significantly associated with depressive symptoms. At this step, heterosexist discrimination remained a significant predictor (ß = .19, $p = .004$), accounting for 2.6% of the variance in depression. After Step 3, the overall model accounted for a significant 17.7% of the variance in depressive symptoms, $F(5, 277) = 11.92$, $p < .001$.

In the second model of social anxiety symptoms, level of outness was not significantly associated with social anxiety at Step 1. At Step 2, heterosexist discrimination was associated with more social anxiety (ß = .27, $p < .001$), accounting for 7.0% of the variance. At Step 3, the three subscales of intragroup marginalization accounted for a significant additional 9.9% of the

Table 4. Results of regressing mental health measures on outness, heterosexist discrimination, and intragroup marginalization ($N = 283$).

	Model 1: Depression					Model 2: Social anxiety					Model 3: Self-esteem				
Independent Variables	*B* (*SE*)	β	sr^2	R^2	ΔR^2	*B* (*SE*)	β	sr^2	R^2	ΔR^2	*B* (*SE*)	β	sr^2	R^2	ΔR^2
Step 1				.00	.00				.00	.00				.01	.01
Outness	−.01 (.03)	−.02	.000			−.02 (.04)	−.03	.001			−.11 (.06)	−.11	.013		
Step 2				.09***	.09***				.07***	.07***				.05**	.04**
Outness	.00 (.03)	.00	.000			−.01 (.04)	−.01	.000			−.12 (.06)	−.12*	.015		
Heterosexist discrimination	.31 (.06)	.30***	.090			.36 (.08)	.27***	.070			−.32 (.10)	−.19**	.035		
Step 3				.18***	.09***				.17***	.10***				.14***	.09***
Outness	.01 (.03)	.02	.000			−.02 (.04)	−.03	.001			−.10 (.06)	−.10	.009		
Heterosexist discrimination	.20 (.07)	.19**	.030			.36 (.09)	.27***	.049			−.37 (.12)	−.22**	.032		
Social marginalization	−.09 (.06)	−.11	.006			−.38 (.08)	−.37***	.066			.43 (.11)	.33***	.051		
Individual marginalization	.16 (.04)	.26***	.047			.25 (.05)	.31***	.064			−.34 (.07)	−.33***	.075		
Identity marginalization	.20 (.07)	.20**	.024			.26 (.09)	.20**	.023			−.16 (.12)	−.10	.006		

Model 1: $\Delta F(1, 281) = 0.10$, $p = .756$ (Step 1), $\Delta F(1, 280) = 13.95$, $p < .001$ (Step 2), $\Delta F(3, 277) = 9.70$, $p < .001$ (Step 3). Model 2: $\Delta F(1, 281) = 0.21$, $p = .650$ (Step 1), $\Delta F(1, 280) = 21.02$, $p < .001$ (Step 2), $\Delta F(3, 277) = 11.02$, $p < .001$ (Step 3). Model 3: $\Delta F(1, 281) = 3.57$, $p = .060$ (Step 1), $\Delta F(1, 280) = 10.27$, $p = .002$ (Step 2), $\Delta F(3, 277) = 9.45$, $p < .001$ (Step 3).
*$p < .05$, **$p < .01$, ***$p < .001$.

variance in social anxiety. All three intragroup marginalization subscales were significantly and uniquely associated with social anxiety, with social intragroup marginalization (ß = −.37, $p < .001$) accounting for 6.6%, individual intragroup marginalization (ß = .31, $p < .001$) accounting for 6.4%, and identity intragroup marginalization (ß = .20, $p = .006$) accounting for 2.3% of the variance. While individual and identity intragroup marginalizations were associated with higher social anxiety symptoms, social intragroup marginalization was unexpectedly associated with lower social anxiety symptoms. Heterosexist discrimination also remained significantly associated with social anxiety (ß = .27, $p < .001$), accounting for 4.9% of the variance. After Step 3, the overall model significantly predicted social anxiety symptoms, $F(5, 277) = 11.32$, $p < .001$, accounting for 17.0% of variance in scores.

Given the unexpected significant negative association between social intragroup marginalization and social anxiety, follow-up analyses were performed to test for patterns of associations that could indicate a suppression effect and to identify the independent variables that could be responsible for the effect (Pandey & Elliott, 2010; Watson et al., 2013). Suppression effects occur when the inclusion of additional predictors alters the direction or strength of a relationship between variables by controlling for shared variance (Pandey & Elliott, 2010). These analyses involved entering only one intragroup marginalization subscale with heterosexist discrimination and outness at Step 3. In these three follow-up models, individual intragroup marginalization (ß = .18, $p = .003$, $sr^2 = .029$ vs. ß = .31 in the above model) remained significantly associated with more social anxiety symptoms, whereas social intragroup marginalization (ß = −.11, $p = .106$ vs. ß = −.37 in the above model) and identity intragroup marginalization (ß = .13, $p = .056$ vs. ß = .20 in the above model) were not significantly associated with social anxiety symptoms. These follow-up analyses, as well as the moderate-to-high correlations of social intragroup marginalization with heterosexist discrimination and with individual and identity intragroup marginalizations (see Table 3), suggest that the other measures of intragroup marginalization are primarily responsible for the change in the association of social intragroup marginalization with social anxiety symptoms, from non-significant in the zero-order correlation (see Table 3) to negative and significant in the full model (see Table 4). These results could indicate the presence of noteworthy suppressor effects between the variables used in this study, indicating that social intragroup marginalization shares variance with the other predictors. When these variables are included in the model, they suppress irrelevant variance, allowing the unique contribution of social intragroup marginalization to emerge, thus resulting in a negative association with social anxiety. In any case, these results highlight that the relationship between intragroup

marginalization and mental well-being is more complex than initially anticipated.

In the third model of self-esteem, level of outness was not significantly associated with self-esteem scores at Step 1. At Step 2, outness (ß = −.12, p = .035) and heterosexist discrimination (ß = −.19, p = .002) were each associated with less self-esteem, accounting for 1.5% and 3.5% of the variance, respectively. At Step 3, the three subscales of intragroup marginalization accounted for a significant additional 8.8% of the variance. Of the three intragroup marginalization subscales, social intragroup marginalization (ß = .33, p < .001) and individual intragroup marginalization (ß = −.33, p < .001) both made significant unique contributions, explaining 5.1% and 7.5% of the variance, respectively. Whereas individual intragroup marginalization was associated with lower levels of self-esteem, social intragroup marginalization unexpectedly predicted higher levels of self-esteem. Identity intragroup marginalization was not significantly associated with self-esteem. Outness was no longer significantly associated with self-esteem, while heterosexist discrimination remained significantly associated with less self-esteem (ß = −.22, p = .002), accounting for 3.2% of variance. After Step 3, the overall model significantly predicted self-esteem scores, $F(5, 277) = 8.71$, p < .001, accounting for 13.6% of the variance in scores.

As done for social anxiety symptoms, the unexpected positive association between social intragroup marginalization and self-esteem was further explored using three follow-up regression models. Results indicated that only individual intragroup marginalization (ß = −.20, p < .001, sr^2 = .037 vs. ß = −.33 in the above model) remained significantly associated with lower levels of self-esteem, while the social (ß = .09, p = .181 vs. ß = .33 in the above model) and identity intragroup marginalization subscales (ß = −.06, p = .420 vs. ß = −.10 in the above model) were not significantly associated with self-esteem. Again, these follow-up analyses suggest that the other measures of intragroup marginalization are primarily responsible for the change in the association of social intragroup marginalization with self-esteem from non-significant in the zero-order correlation (see Table 3) to positive and significant in the full model (see Table 4). These findings suggest that suppressor effects among the variables are likely to be present, calling for caution when interpreting the results.

Discussion

In this study, we quantified SMM's experiences of intragroup marginalization within the male gay community using a new measure (GCIMS) developed for this research. The primary aim was to examine whether gay community intragroup marginalization predicted SMM's mental health (depressive symptoms, social anxiety symptoms, and self-esteem), after accounting for the

impact of heterosexist discrimination (e.g., Szymanski & Mikorski, 2016). The new measure captured three manifestations of gay community intragroup marginalization, including 1) social intragroup marginalization, based on social grounds such as individual's status, values, interests, and preferences (e.g., lifestyle); 2) individual intragroup marginalization, based on observable personal attributes (e.g., specific physical features); and 3) identity intragroup marginalization, based on attributes relevant to an individual's sense of identity (e.g., ethnicity/race). Multivariate analyses, after controlling for heterosexist discrimination and outness, showed that SMM who reported more individual intragroup marginalization were higher in depression and social anxiety symptoms, and reported lower self-esteem. Similarly, SMM who experienced more identity intragroup marginalization reported more depression and social anxiety, while self-esteem was not significantly associated with identity intragroup marginalization. Lastly, contrary to expectations, SMM who experienced more social intragroup marginalization were lower in social anxiety and reported better self-esteem, but social intragroup marginalization was not related to depression. As expected, heterosexist discrimination was a significant predictor of elevated depression and social anxiety symptoms, and lower self-esteem, at all stages of the analyses. Surprisingly, while outness was a negative covariate of social and identity intragroup marginalization, it was not associated with heterosexist discrimination and was rarely associated with mental health.

Intragroup marginalisation and mental health

This was the first study to include a comprehensive scale of gay community intragroup marginalization using items derived from interviews with Australian SMM (Dellers et al., 2024). The scale included 19 items, which coalesced into three components of intragroup marginalization separating into social (e.g., status), individual (e.g., physical appearance), and identity (e.g., race/ethnicity) domains. Subsequently, these three subscales of intragroup marginalization were found to be distinctly associated with SMM's mental health outcomes of depression, social anxiety, and self-esteem, even after controlling for the well-known detrimental contribution of heterosexist discrimination to SMM's mental health (e.g., Szymanski & Mikorski, 2016). Notably, SMM reporting more individual intragroup marginalization had poorer mental health across all three measures, while those reporting more identity intragroup marginalization reported poorer mental health in two out of three measures. In contrast, social intragroup marginalization was unexpectedly associated with better outcomes for social anxiety and self-esteem, once all other variables were controlled for in the multivariate analyses.

Individual and identity intragroup marginalization were most consistently related to poorer mental health. Both types of marginalization targeted observable and stable attributes, such as physical appearance and personality, or ethnicity and gender identity, respectively. Marginalization based on individual and identity attributes—which are vital for social, sexual, and romantic inclusion (e.g., Shepherd, Denning, et al., 2023)—may undermine an individual's sense of worth, desirability, and social acceptance (Flanders et al., 2019; Soulliard et al., 2023), potentially leading to increased depressive symptoms. The rejection sensitivity model (Downey & Feldman, 1996; Feinstein, 2020) also serves as a potential explanation for these links with poorer mental health. Rejection sensitivity is a disposition characterized by anxiously expecting, readily perceiving, and overreacting to social rejection, which could develop from marginalization based on individual and identity attributes, and in turn could spark depression and anxiety symptoms (Feinstein, 2020). Similarly, persistent marginalization based on overt characteristics (e.g., physical appearance, ethnicity) can cultivate expectations of future rejection (Pachankis & Goldfried, 2006), leading to social anxiety symptoms such as avoidant behavior, hypervigilance, and intense cognitive, emotional, and physical reactions to perceived rejection (Mahon et al., 2021), associations that were replicated in the current study.

Individual intragroup marginalization, but not identity intragroup marginalization, was associated with lower self-esteem. Attributes like physical attractiveness and age are uniquely important for sexual capital in the gay community (Hammack et al., 2022; Shepherd, Denning, et al., 2023). Marginalization based on such traits might undermine individuals' sense of social worth and acceptance, especially in romantic and sexual contexts, which are directly linked to self-esteem (Breslow et al., 2020). Conversely, identity intragroup marginalization targets core identity attributes, such as ethnicity, gender and sexual identity, or disability. While identity intragroup marginalization may increase disconnection from the mainstream gay community (e.g., Parmenter et al., 2020) it may not impact global self-esteem, as measured in this study. Self-esteem is the cognitive and affective evaluation of oneself, shaped by external validation and feedback (Leary & Baumeister, 2000). Individuals with intersecting identities often belong to multiple groups (e.g., gay *and* ethnic communities); therefore, identity intragroup marginalization from the gay community alone may not affect one's overall self-image, if ongoing validation and support is found elsewhere (e.g., in ethnic communities) (Flanders et al., 2019).

Finally, social intragroup marginalization was not significantly associated with depression but showed a significant association with greater self-esteem and less social anxiety, when all other measures were considered in the analyses. In contrast, in the zero-order correlations, social intragroup

marginalization was significantly positively associated with depression but was not associated with social anxiety or self-esteem. This pattern of findings, as well as follow-up models that considered only one form of intragroup marginalization at a time, suggest that suppression effects could explain these opposing results (Pandey & Elliott, 2010). The evidence for statistical suppression in the social anxiety and self-esteem models complicates the interpretation of the results. On the one hand, these findings could suggest that the most accurate results emerged when all forms of intragroup marginalization, heterosexist discrimination, and outness were considered. In this case, after the associations of individual and identity intragroup marginalization with SMM's poorer mental health are partialed out, social intragroup marginalization is linked to SMM's better mental health. On the other hand, this interpretation is tentative given the use of a new measure of intragroup marginalization, as well as the moderate-to-high intercorrelations between the three intragroup marginalization subscales as well as their correlations with heterosexist discrimination. Overall, these findings deserve replication.

The findings do point to a net positive association of social intragroup marginalization on SMM's mental health, and such an effect could seem reasonable. Social intragroup marginalization relates to personal choices (e.g., lifestyle, substance use, sexual preferences, social relationships, etc). Although these choices can attract marginalization from some, these social values and behaviors all suggest ties to social and sexual relationships, which could be positive for mental health. Alternatively, SMM may perceive some controllability over such attributes, which may serve to minimize adverse mental health effects, compared to marginalization based on less controllable factors (e.g., race, age, HIV-status, etc). Individual's lifestyle choices are usually guided by personal values and beliefs, and maintaining value-based lifestyle choices, even in the face of marginalization, would indicate a strong sense of individuality, autonomy, self-acceptance, and self-worth (Leary & Baumeister, 2000). Consequently, experiences of social intragroup marginalization may be more positively appraised, diminishing negative impacts on mental health.

Overall, the current findings extend previous research identifying intragroup marginalization as a prevalent issue among SMM (e.g., Shepherd, Maki, et al., 2023), and build on studies exploring the adverse impacts of specific types of intragroup marginalization in isolation (e.g., weightism; Griffiths et al., 2018). This study contributes to the emerging literature by conceptualizing intragroup marginalization as a composite of adverse interpersonal experiences, thereby positioning it as an additional minority stressor that is a pervasive, community-wide issue, rather than an isolated stressor affecting only a subset of SMM. Consequently, our findings add to our understanding of the psychological mediation minority stress framework

(Hatzenbuehler, 2009; Meyer, 2003), wherein intragroup marginalization and other minority stressors should be jointly considered.

Heterosexist discrimination and mental health

As expected in the present study, SMM who reported more heterosexist discrimination had more elevated depressive and social anxiety symptoms, as well as lower self-esteem. This finding is consistent with past studies of sexual minorities' mental health (e.g., Carson et al., 2024; Szymanski & Mikorski, 2016). Moreover, past research suggests that some of the mechanisms accounting for the detrimental impact of heterosexist discrimination are general psychological processes (e.g., cognitive, affective, or social processes; Hatzenbuehler, 2009) or internalized self-stigma (Feinstein et al., 2012). While our study findings do not directly speak to any underlying mediating mechanisms, they do support that, in our sample of Australian SMM, heterosexist discrimination is linked to poorer mental health outcomes.

Heterosexist and intragroup marginalization subscales shared some variance in the present study; we found moderate to high positive associations among all these measures. Heterosexist discrimination and intragroup marginalization, though conceptually different, can co-occur, as both stem from societal prejudices and exclusionary norms and some of these prejudices and norms can be found among heterosexual and non-heterosexual groups. For example, a gay man who is marginalized within the gay community due to not conforming to dominant gay male stereotypes (such as body type, behavior, or interests) could also experience heterosexism due to both sexual orientation and not conforming to male stereotypes (Branscombe et al., 1999; Meyer, 2003). Another explanation may be that individuals who experience and notice more marginalization may share some underlying characteristics, such as heightened rejection sensitivity (Feinstein, 2020), rendering them more sensitive to both heterosexist discrimination and intragroup marginalization. Importantly, however, this explanation is not completely disconnected from the first explanation, given that rejection sensitivity can develop from frequent experiences of marginalization and discrimination (Feinstein, 2020; Pachankis et al., 2008). Future research could consider the role of rejection sensitivity in the reporting of discrimination and marginalization, as well as in explaining how these experiences impact SMM's mental health.

Despite prior research suggesting a link between heterosexist discrimination and outness (e.g., Chang et al., 2021), this association was not observed in the current study. One possible explanation is that there is greater societal acceptance of same-sex attraction in recent decades (Smith et al., 2014). In Australia specifically, increasingly positive attitudes toward sexual minorities have been reported recently (Bettinsoli et al., 2020). These positive attitudes may explain the low reports of heterosexist discrimination found in the

current study, irrespective of level of outness. Infrequent experiences of heterosexist discrimination in this sample also align with international statistics suggesting that exposure to heterosexism is lower in Australia compared to other countries (Ipsos, 2021). Additionally, level of outness in the current sample was relatively high, indicating that most participants were open about their sexuality with friends, family, and work colleagues, which could further suggest that participants were situated within supportive and accepting environments, minimizing their experiences of heterosexist discrimination.

Practical implications

The reported results have important clinical implications. The novel GCIMS could help identify SMM's specific stress experiences within their gay communities, highlighting areas for clinical intervention alongside existing treatment approaches. For example, stress from intragroup marginalization could be integrated into an affirmative cognitive-behavioral treatment module (Pachankis, 2014) addressing components of the psychological mediation minority stress framework (Hatzenbuehler, 2009; Meyer, 2003). Specifically, our findings could inform additional treatment principles focusing on cognitive (e.g., reframing negative evaluations of intragroup rejection), affective (e.g., exploring SMM's unique strengths and qualities), and social processes (e.g., assertive communication training to foster meaningful relationships) to further promote individual resilience toward sexual minority-specific multilateral stress experiences. Further research is required to determine whether such treatment principles would prove useful in alleviating psychological distress in SMM facing ongoing intragroup marginalization.

Strengths, limitations, and future directions

The current study expands on emerging evidence describing the adverse mental health impact of intragroup marginalization among SMM in Australia. The study introduced the GCIMS which assesses a comprehensive range of personal characteristics that are grounds for intragroup marginalization within the male gay community (Dellers et al., 2024). This scale offers an innovative approach to assessing SMM's stress experiences related to their unique combination of personal attributes. Unlike conventional surveys that merely identify personal characteristics (e.g., sexual preferences), behaviors (e.g., lifestyle choices), or demographic information (e.g., age), the GCIMS reveals adverse intragroup marginalization experiences based on these attributes that may otherwise escape detection in traditional demographic surveys. We encourage further testing of the scale to determine applicability, validity, and reliability in research and clinical settings, across a broader range of national and international sexual and gender minority groups.

Although the current study adds to our understanding of the mental health disadvantages of SMM, the employed cross-sectional design limits inferences of causality. We cannot definitively conclude that intragroup marginalization causes mental health symptoms, leaving room for alternative interpretations. For instance, while we designed one of our models to test whether intragroup marginalization predicts greater depressive symptoms, it is also possible that individuals with depression report more intragroup marginalization experiences, due to negative cognitive biases commonly observed in depressed individuals (LeMoult & Gotlib, 2019). Longitudinal studies could explore directional links between intragroup marginalization and mental health outcomes more definitively.

Furthermore, the generalizability of findings is limited by the relative homogeneity of the current sample, which predominantly consisted of young adult, white Australian, gay cis-gender men, with tertiary education, and a monthly income similar to the Australian median salary (Australian Bureau of Statistics, 2022). The vast diversity of the global gay community includes variations in backgrounds, values, experiences, and geographical locations—all factors that could influence the prevalence and impact of intragroup marginalization (Shepherd, Maki, et al., 2023). Further research should assess the generalizability of our findings across more diverse sexual and gender minority groups (e.g., lesbian women) and different geographical regions.

Similarly, this study did not include a specific measure of race, instead assessing ethnicity, which is a commonly used demographic measure in Australian research. Ethnicity captures aspects of cultural identity, self-presentation, and values, which were deemed relevant in the context of the various forms of intragroup marginalization that exist within the gay community. On the other hand, this measure does not directly account for racial identity, which may influence experiences of discrimination in distinct ways, and as a result, this study is unable to draw direct conclusions about the specific role of race in participants' experiences of heterosexist discrimination and intragroup marginalization. Future research would benefit from incorporating measures of both race and ethnicity, to better capture Australia's diversity.

Finally, the current study employed an additive approach when assessing experiences of intragroup marginalization, relying on the mean frequency of endorsed items. This approach does not account for the potential influence of various personal characteristics (e.g., sexual and gender identities, socioeconomic status, and ethnicity) that may intersect and influence how individuals experience, perceive, and interpret intragroup marginalization. According to intersectionality theory (Crenshaw, 1991), the unique combinations of intersecting identities shape an individual's privilege and exposure to overlapping stigma, thus predicting varied levels of mental

well-being (e.g., Denise, 2014). Further research is required to determine how the interaction of personal attributes influences the unique experience and appraisal of intragroup marginalization, and, in turn, its association with psychological well-being.

Future research should aim to uncover the mechanisms through which intragroup marginalization affects mental health. While intragroup marginalization is conceptualized as an external stress experience stemming from within the gay community, the previously noted external-to-internal stress pathway (Hatzenbuehler, 2009) suggests that internal appraisal processes are critical for determining individual well-being. For example, Pachankis et al. (2020) showed that gay community intraminority stress is associated with poorer well-being, with such stress perceptions likely rooted in personal experiences of rejection, ostracism, and discrimination (e.g., LeBeau & Jellison, 2009). However, intraindividual differences in cognitive, affective, and social processes are also relevant factors to consider (Hatzenbuehler, 2009), because they can determine individual's level of susceptibility and resilience toward stress. Future research should investigate if intragroup marginalization predicts other psychological processes, such as cognitive (e.g., pessimistic cognitive style), affective (e.g., intraminority stress), or social processes (e.g., social isolation), which in turn could be associated with poorer mental well-being.

Conclusion

The current study provided initial support for the associations between gay community intragroup marginalization and poorer mental well-being of SMM, above and beyond heterosexist discrimination. An innovative measure to assess the frequency of intragroup marginalization was introduced, with items encompassing a broad range of personal attributes that could attract marginalization from other SMM. The results highlight that intragroup marginalization based on individual and identity attributes, in addition to heterosexist discrimination, is uniquely associated with poorer mental well-being. Surprisingly, social intragroup marginalization had a net-beneficial effect on mental health, with further research being required to understand the complex mechanisms underlying this association. We propose that intragroup marginalization be considered as part of the current psychological mediation minority stress framework, with further research testing its role in SMM's mental health outcomes within this comprehensive framework. Such advances in the literature could subsequently inform the development and extension of existing clinical interventions that aim to support SMM who are adversely affected by multilateral minority stress experiences.

Notes

1. Although the original HHRDS items referred to gay and bisexual men, items were modified to only use the term "gay men," to enhance consistency in the wording across measures in this study. However, as our sample did include SMM with different identities, preliminary instructions directed participants to interpret items according to their unique sexual and gender identities.
2. No other control variables (e.g., age, ethnicity, sexual orientation) were included because these attributes were identified as grounds for intragroup marginalization and, as such, accounted for (and were confounded with) the measure of marginalization.

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