Running Head: STIGMA MECHANISMS

Title: An integrated understanding of the mechanisms linking social stigma to mental health among marginalized populations

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Abstract

This paper presents a model that integrates the shared mechanisms explaining the association between stigma and mental health across multiple stigmatized populations. By distinguishing between mediating, protective, and intensifying factors, the model can be used to achieve two broad aims: (a) to understand the similarities and differences in common/comparable mechanisms explaining the effect of stigma on mental health; and (b) to understand how mechanisms linking stigma to mental health are experienced by individuals at the intersection of multiple stigmatized statuses. Applications and opportunities for new research within and across a variety of stigmatized populations are discussed in relation to these aims.

Introduction

Stigma is a social determinant of health contributing to mental health inequalities faced by marginalized populations across the globe[1]. For example, higher levels of mood and anxiety disorders consistently observed among sexual minorities (i.e., people who are not heterosexual, including but not limited to lesbian, gay, bisexual, pansexual or asexual individuals) and gender minorities (i.e., people whose gender differs from the sex they were assigned at birth, including but not limited to transgender, non-binary and gender-diverse people) relative to their heterosexual and cisgender peers are at least partially explained by the disadvantaged stigmatized social status afforded to sexual and gender minority individuals[2]. Alongside researchers examining these inequalities, a rapidly growing body of scholarship has focused on understanding the association between stigma and mental health. This invaluable work has resulted in explanatory models focused on delineating the links between stigma and health within specific marginalized populations (e.g., minority stress as an explanation for mental health inequalities faced by sexual and gender minority populations[2]; race-related stress and mental health among racial and ethnic minority populations[3]). Existing models of the relationship between stigma and health that have aimed to be inclusive of a variety of stigmatized populations, hereafter referred to as general models[1,4,5], have called for further recognition of common mechanisms linking the experience of stigma to negative health outcomes, including mediating and moderating factors.

This paper aims to build on and integrate models explaining the associations between stigma and mental health, focusing on common explanatory mechanisms that mediate and moderate the effects of stigma on mental health across a variety of stigmatized populations. By stigmatized populations, we broadly refer to populations that have identities and/or characteristics that have been socially devalued and marginalized. We offer an integrative

model of mechanisms that are not group-specific and thus can be used in efforts to (a) compare populations with differing stigmatized statuses to better understand the similarities and differences in common/comparable mechanisms explaining the effect of stigma on mental health; and (b) understand how the mechanisms linking stigma to mental health are experienced at the intersection of multiple stigmatized statuses.

Previous models that focused on specific groups in isolation admittedly cannot achieve these aims. Our focus is more expansive than previous group-specific models given its focus is on a variety of stigmatized populations that experience stigma attached to their socially disadvantaged group memberships, identities, and characteristics including, but not restricted to, marginalized populations based on sexual identity, gender identity, racial and ethnic identity, body size, (dis)ability, and class/socioeconomic status.

Importantly, our model includes and distinguishes between mediating mechanisms, protective factors, and intensifying factors drawn from across often disparate theoretical and research literatures. This offers an advantage over previous general models of stigma and health which identify the relevance of similar factors, but do not specify testable roles or directional influences within the relationship between stigma and mental health. Additionally, our model integrates findings from a variety of disciplinary, methodological, and epistemological traditions, and includes attention to "positive" responses to stigma (e.g., meaning making, community connectedness) which are often not emphasized in previous models with similar aims.

Our model also differs from previous general models in its focus mental health (as opposed to health more generally inclusive of physical and behavioral health outcomes). In order to maximize utility and parsimony, our integrative aims define mental health broadly, including not only illness/disorder-level outcomes and subthreshold symptomology, but also positive indicators of mental health like psychological well-being[6].

Defining social stigma

Stigma was originally conceptualized in the social sciences as an attribute that can be deeply discrediting, depending on the audience, that reduces whole persons to tainted and discounted others[7]. More recent definitions of stigma explicitly adopt a revised framing that locates the meaning of social stigma within cultural ideologies, historical traditions, and social discourses rather than within those individuals or groups who possess stigmatized identities or attributes. For example, Herek defined stigma as “the negative regard, inferior status, and relative powerlessness that society collectively accords to people who possess a particular characteristic or belong to a particular group or category”[8] and Link and Phelan have conceptualized the construct noting that “stigma exists when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold”[9]. Thus, the meaning of social stigma is socially constructed and can shift over time[10].

Although our current focus will be on explaining the link between the *experience* of stigma and mental health, it is important to note that the experience of stigma is often the result of various forms of stigma *perpetration* enacted within social structures and interactions between those who are stigmatized (i.e., the experience of stigma) and those who stigmatize (i.e., the perpetration of stigma). Processes of perpetration manifest in the form of structural stigma[11], stereotypes[12,13], prejudice[12,13], discrimination[12,14], and microaggressions[11,15,16]. The perpetration of stigma via these various multi-layered processes results in those who are the targets of stigma being “othered” and afforded a disadvantaged social status as a result of labelling processes focused on maintaining the power and privilege of dominant groups[9].

The experience of stigma and its impact on mental health

The impact of the experience of stigma on the mental health of individuals and groups who are socially stigmatized has most often been conceptualized within social stress frameworks. Specifically, the disadvantaged social status stemming from social stigma places individuals and groups who are stigmatized at an increased risk for exposure to a variety of social stressors, which, in turn, place them at greater risk for negative mental health outcomes compared to the general population[17]. We will use the term “stigma-related stressors” to refer to these forms of social stress stemming from stigmatized social status; however, it is important to note that other terms have been used to refer to these social stressors, including but not limited to minority stressors and race-related stress. Stigma-related stressors range from stressors emanating directly from the environment (e.g., experiencing discrimination) to those that are more psychological in nature and can exist even when not directly perpetrated by an external source (e.g., expectations of rejection or internalized stigma). Most distal is stress experienced in the form of discrimination, including event-based forms of discrimination such as being fired from a job or being kicked out of one’s home, and everyday discrimination such as being treated as if one is dangerous or being treated as unintelligent. A large body of evidence exists demonstrating an association between exposure to discrimination in its various forms and negative mental health outcomes across a variety of stigmatized populations[18–22]. These external forms of stigma-related stress are also experienced in multiple levels from structural inequalities, such as unequal access to healthcare, to interpersonal experiences, such as social exclusion.

More proximal to the self are stigma-related stressors stemming from individuals’ awareness of their stigmatized social status and expectations of rejection entering social interactions. Evidence exists for the negative association between expectations of rejection and a variety of mental health outcomes, even independent of actual experiences of discrimination[23,24]. Another proximal stigma-related stressor is internalized stigma. Stigma is

internalized when the devaluing components of the socially constructed meaning of stigma become applied to the minority group member's own sense of self, resulting in negative self-schemas and attitudes towards the features and group memberships that are the target of stigma. Internalized stigma, in the form of internalized homophobia, internalized racial oppression, internalized transphobia, or internalized sexism, is associated with a myriad of negative mental health outcomes[25–28].

Because stigma is attached to people's identities and group memberships, it can also constitute a threat to the actualization of fundamental social motives, such as self-image and sense of belonging. This process, known as social identity threat, is situationally triggered and does not require enacted forms of discrimination[29]. By knowing that society devalues people of one's own group, only a few cues are needed to trigger threat responses that are linked to negative mental health outcomes for stigmatized individuals.

When considered in aggregate, the experience of stigma-related stressors represents the potential for excess stress exposure placing socially stigmatized populations at greater risk for negative mental health outcomes relative to the general population[17]. However, the ways in which the impact of the experience of stigma-related stress on mental health may vary within and across various stigmatized populations has been the subject of less research.

Mechanisms linking the experience of stigma to negative mental health outcomes

What follows is an integrative discussion of the various mechanisms that theory and research have consistently identified as playing a role in explaining the association between the experience of stigma and mental health which can be generalized to a variety of stigmatized populations. Figure 1 provides a visual representation of the ways in which the experience of stigma (Figure 1, A), as previously described, works through a variety of mechanisms to exert a negative influence on mental health (Figure 1, F) of stigmatized populations. We aim to integrate often disparate theories and research within a variety of

stigmatized populations to provide a model outlining the mediating processes (Figure 1, C), protective factors (Figure 1, D), and intensifying factors (Figure 1, F) that explain and modify the association between the experience of stigma and negative mental health outcomes (Figure 1, B). Furthermore, we draw from various social and health science literatures to spotlight these mechanisms across individual, social, and cultural levels. As a complement to this integrative model, Table 1 provides a definition of each mechanism along with examples from research evidence drawn from within-group studies focused on a variety of stigmatized populations. To be included, mechanisms needed to be evidenced as performing the conceptualized role for at least two stigmatized statuses and be theoretically applicable to a variety of stigmatized populations.

[Figure 1. Mechanisms explaining and modifying the association between experiences of social stigma and mental health outcomes.]

Psychological mediating processes

Theory and research have established several psychological processes that result from the experience of stigma, which further exert an impact on mental health outcomes thus evidencing an indirect effect of stigma on mental health. These processes can be roughly categorized as emotional, cognitive, and behavioral in nature.

Emotional processes. Experiences of stigma can trigger emotional responses that explain its association with negative mental health outcomes. Particularly, rumination and emotion regulation have been highlighted in their role linking stigma to mental health. For example, ruminating and suppressing the emotions associated to experiencing stigma predicts higher psychological distress[30,31]. Interestingly, the impact of emotion regulation on mental health in response to stigma can be even more complex. Repeated exposure to stigma-related

stress can reduce individuals' emotion regulation capacity[31]. Evidence from a variety of stigmatized populations has shown that stigma exerts an indirect positive association with depressive symptoms via emotion regulation deficits[32].

Cognitive processes. Additional psychological mediators of the stigma—mental health association can be located in cognitive processes. Hopelessness, which has a long history of having a direct association with negative mental health outcomes in the general population, has also been highlighted as one cognitive process that is sensitive to exposure to stigma-related stress[33]. Thus, stigma can exert an indirect effect on negative mental health outcomes via increased hopelessness[34]. Similarly, exposure to stigma-related stress has been shown to be associated with increased levels of hypervigilance, which is, in turn, predictive of negative mental health outcomes[35]. Furthermore, qualitative research has highlighted the important of hypervigilance as an explanatory pathway linking stigma to mental health particularly among people with stigmatized statuses and identities that can be considered concealable[36].

Behavioral factors. When exposed to stigma-related stress, individuals may change their behavior in ways that further the deleterious impact of stigma on mental health. Socially isolating from others[37], having a poor diet[38], and using substances[39] including alcohol, drugs, and cigarettes, are responses that people may take when experiencing stigma. However, it is important to note that the association between these behavioral responses and mental health can be multidirectional: mental health symptoms also predict more engagement in risk behaviors[40] and risk behaviors can be indicators of underlying substance use disorders.

Protective factors

Several models focused on explaining the association between stigma and mental health have identified positive factors that, when available and accessible, are able to reduce or eliminate the negative impact of stigma on mental health. We refer to these generally as

"protective factors"; however, they are often discussed as "stress buffers" within frameworks employing stress and coping approaches to stigma and "resilience resources" in frameworks emphasizing personal and community strengths. Protective factors can be considered at the individual, social, and cultural levels.

Individual-level protective factors. In the last two decades, psychological research has increasingly adopted a resilience focus in understanding individual responses to stigma that may reduce its negative impact on mental health[41–43]. Although usually emphasizing the trait-level personal strengths that allow individuals to "bounce back" after experiencing stigma-related stress, resilience has increasingly been considered as a broader temporal and transactional construct focusing on individuals' access to and abilities to utilize a variety of individual, social and community level resources within the broader category of protective factors[44,45]. Also included in within-group research on the impact of stigma on mental health are protective factors in the form of mastery and coping strategies that individuals employ to reduce the negative impact of stigma. Mastery has received much attention in sociological research on stigma and mental health, with a body of research demonstrating how a higher level of mastery—or sense of one's circumstances as being under one's own control vs. externally determined—can reduce the negative impact of stigma on health[46,47].

Psychological research has tended to focus on individual coping. Just as in the general stress and coping literatures, coping strategies used by stigmatized individuals can be categorized broadly into engagement (e.g., taking legal action against workplace discrimination) vs. disengagement strategies (e.g., avoiding individuals and situations in which the perpetration of stigma is likely to occur)[48]. Although there is a large body of literature examining the potentially protective role of individual coping strategies, research evidence is mixed in its findings. For example, some studies show certain types of coping provide the hypothesized protective function (e.g., engagement control coping[48]), while

others (e.g., avoidance[49]) can intensify the negative effect of stigma on mental health. Ultimately, the effectiveness of individual-level coping is likely to depend on the nature of the experience of stigma and the context in which it is experienced. Thus, the field of research on stigma and mental health may require a shift away from the currently dominant generic focus on coping toward a focus on more stigma-specific coping strategies.

Research on meaning-making mechanisms does, however, account for variability on how individuals appraise and make sense of their experiences of stigma after such experiencing have taken place[4]. Specific types of meaning-making mechanisms have been shown to protect against and reduce the negative impact of stigma on mental health. For example, the potential protective effects of framing experiences of stigma as challenges that can be overcome (vs. fatalistic acceptance of the world as racist, sexist, or homophobic) and externalizing the source of stigma to its environmental causes (vs. self-blame) have been the subject of a growing body of research[50,51].

Social protective factors. A variety of social resources have also been shown to function as protective factors in reducing the negative impact of stigma on mental health. Most notable is social support. Although social support is a general resource shown to play a buffering role in the general association between stress and mental health, it plays a specific role in moderating the relationship between stigma-related stress and mental health[52,53]. For example, social support from family has been consistently shown to protect against the negative impact of stigma, especially for children and young adults[54–56]. Related to social support in its role as a protective social resource, is that of the presence of similar others within the lives of stigmatized individuals. Specifically, having other people in one's social network and environment who share the same stigmatized status, identity, or characteristic has been shown to reduce the negative impact of stigma on mental health[57,58]. Although positioned as a stress buffer by the preponderance of theory and research, emerging research

demonstrates the potential mediating role of social support in the relationship between stigma and mental health. For example, support deterioration has recently been identified as a mechanism explaining the association between perceived sigma and depression among people who have been diagnosed with substance use disorders[59].

Cultural-level protective factors. Beyond those resources available at the individual and social level, recent research has identified several important cultural and community-level resources that can play a protective role in the stigma—mental health association. Specifically, feeling a sense of connectedness to a community of other people who share one's stigmatized identity and group membership can not only exert a positive impact on mental health, but also reduce the negative impact of stigma on mental health[60,61]. Related to, but distinct from community connectedness, behavioral *participation* in a community of others with similar stigmatized identities can play a similar role in reducing the negative effects of stigma on mental health[62]. Finally, supporting and taking collective action to advance a cause or campaign for social change aimed at benefiting stigmatized populations has been shown to play a role in interrupting the deleterious impact of stigma on mental health[63,64]. Evidence generally supports the theorized protective role of these factors, however, some emerging research has indicated that the protective role of these cultural factors may vary by context and population of interest. For example, some research indicates that engagement in activism can lead to increased exposure to social stigma in some contexts, creating differences in the impact by group[65]. More comparative research is needed to understand why these cultural factors sometimes differ in their theorized protective functions.

Finally, it is also possible to understand community connectedness, participation, and collective action beyond their potential roles as moderators. These factors also serve as group-level responses to experiences stigma, thereby accounting for an indirect association between stigma and mental health[66].

Intensifying factors

Contrary to the buffering effect of the protective factors previously discussed, there are conditions that can reinforce or exacerbate the negative association between stigma and mental health. These intensifying factors can also be located at the individual, social and cultural level.

Individual-level intensifying factors. Group identification plays a particular role in the stigma and mental health association. The more people identify with their stigmatized minority group and feel that such group identity is central for them, the more likely it is that an external devaluation of group identity can be detrimental to their mental health[67,68]. This is likely due to an increased relevance placed on the experience of stigma making it more threatening to mental health[67,69]. Group identification can also serve as a protective factor reducing the negative effect of discrimination on mental health[70]. These discrepancies may be explained by internalized stigma, which in low levels can reverse the negative impact of group identification[71]. In addition, marginalized individuals also endorse different beliefs around the social system within which the stigma attached to their identities is embedded. Believing in ideologies that legitimatize social hierarchies or individualist mobility intensifies the negative effect of discrimination[67,72]. On the other hand, beliefs that justify the system may also have a buffering effect when their role allows the individual to psychologically distance themselves from their stigmatized group[73,74], in line with the potential negative effect of group identification.

Social-level intensifying factors. Additional factors that can increase the detrimental effect of stigma are located at the social level, mainly in the form of group status and stigma characteristics. Regarding group status, research has found that among members of groups with lower social status (e.g., women), the association between experiencing stigma and negative mental health outcomes was stronger, compared to members of high-status groups

(e.g., men) [67,75,76]. In addition, the characteristics of the stigma attached to one's group can also play an intensifying role[30,77]. Although research around the role of stigma characteristics in the association between stigma and mental health is recent, Pachankis and colleagues found that groups with stigmatized characteristics that are highly visible, persistent, and disruptive, but innocuous and uncontrollable, are the groups that experience stronger links between perceived stigma and negative health outcomes[77]. Furthermore, the intersection of multiple minoritized statuses creates unique individual experiences of stigma that can also worsen the negative effect of stigma on mental health[78,79].

Cultural-level intensifying factors. As previously presented, structural stigma is one form of stigma perpetration and has been shown to be directly related to mental health[80,81]. Conditions of structural disadvantage (e.g., discriminatory laws and policies, neighborhood quality) can also increase the negative effect of stigma on mental health. Relatedly, structural disadvantage can reduce the efficacy of social interventions[82]. This last point is crucial in understanding the association between stigma and mental health: social disadvantage also produces mental health inequalities by reducing the availability, quality, access, acceptability, and adherence to healthcare for stigmatized people[83]. Unfortunately, research on the psychological mechanisms that link stigma to mental health has not always been closely connected with literature researching healthcare inequalities. Thus, several questions remain unanswered regarding the ways in which mechanisms linking structural and individual-level processes further shape the impact of experiences of stigma on negative mental health outcomes.

Application and Utility of the Integrative Model

The present integrative model is intended to provide a foundation for future research aimed at understanding similarities and differences across groups in the processes that the model has identified. For example, the model provides the ability for researchers interested in

examining whether the individual-level mediating processes specified in the model explain the association between stigma and mental health equally well across sexual and gender minority compared to racial and ethnic minority populations. Without the ability to do this, the mediating role of these explanatory processes are assumed to function the same way across groups as previous studies have separately tested these processes in one group at a time. Group-specific research can also use this model as a foundation on which to build stronger explanatory models for the influence of stigma on mental health. For example, familial acceptance of sexual minority identities has been identified as an important protective factor for sexual minority adolescents[84]. This is a unique factor given the fact that adolescents do not typically share the same sexual orientation as their parents (unlike racial minority adolescents for example). This group-specific mechanism can be examined to establish the extent to which it provides a buffering effect relative to other commonly shared protective factors identified in the present integrative model.

In addition to identifying intersectional stigmatized statuses as an intensifying factor in the link between stigma and mental health (Figure 1, E), our model facilitates at least three applications of an intersectionality framework in future research. First, exploring the mental health implications of the same process within individuals with multiple stigmatized statuses (e.g., the extent to which internalized HIV-based stigma is associated with internalized race and sexual stigma[85]) can be streamlined by an integrated model. For example, researchers can select specific protective factors that previous research have found relevant to certain groups and evaluate if those function to reduce the negative effect of other forms of stigma among people that share the two stigmatized statuses. A second contribution facilitates the development of intersectional measures around a particular stigma process. This effort has been started through the development of measures of intersectional microaggressions[86] or enacted and anticipated stigma[87]. Using the present integrative model, future research can

locate specific shared constructs that require intersectional measure development, such as community connectedness. Finally, quantitative analytical strategies aimed at delineating the effects of intersectional stigma[88] on mental health may also benefit from the present model. For example, researchers can use a three-way decomposition analysis[89] to distinguish the direct effect of stigmatized status on mental health, the indirect effect, and mediated moderation via the common comparable processes specified in the present integrative model.

Limitations

Although the present model seeks to address some limitations of existing frameworks, it is not without its own limitations. Specifically, as noted in the review above, some components of the model may serve more than one function (e.g., collective action can be both a protective factor and a mediator). We have placed constructs in the model where the preponderance of theory and research across stigmatized populations has located the construct to offer future research a testable role for each; however, the individual aims of any given study should ultimately dictate the role of such constructs. More research is needed to delineate the multiple and shifting roles that some components may play in explaining the link between the experience of stigma and mental health. In terms of outcomes, we have focused on producing a model relevant to a spectrum of indicators of mental health in the spirit of parsimony, using disorders, subthreshold symptomology, indicators of general distress, and psychological well-being. More work is needed to test the model's applicability to clinical and disorder-level outcomes as well as other positive indicators of mental health such a social well-being, which is increasingly becoming the focus of stigma research. Finally, some theorized pathways linking the experience of stigma to mental health outcomes have not been included (e.g., physiological pathways) due to the lack of consistent evidence for such pathways within a variety of stigmatized populations [90]. Thus, the proposed model

will need to be expanded/extended if consistent evidence for such theorised pathways emerges from future research.

Conclusions

The present integrative model has potential to be useful in unifying theory and directing new research aimed at understanding and explaining the mechanisms that account for the negative impact of the experience of stigma on mental health within and across a variety of stigmatized populations. The model integrates common mechanisms linking the experience of stigma to mental health among a variety of stigmatized populations. It incorporates and distinguishes between mediating processes explaining this association, protective factors that reduce this association, and intensifying factors that exacerbate this association. It further integrates theory and evidence across methods and disciplines to highlight how these mechanisms exist at individual, social, and cultural levels. This integrative model can be used to in future research comparing a variety of stigmatized populations to better understand the similarities and differences in mechanisms explaining the effects of stigma on mental health. The model can also be used to understand how the mechanisms linking stigma to mental health are intersectionally experienced by individuals with multiple stigmatized statuses. Finally, clinical and public health interventions aimed at reducing the negative effect of stigma on mental health among multiply marginalized individuals and population may benefit from using the model to target mechanisms that are amenable to change.

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Table 1.

Mechanisms linking the experience to stigma to mental health outcomes among marginalized populations.

Mechanisms	Definition	Example
Psychological Mediation Processes		
Emotional		
-Rumination	"The process of thinking perseveratively about one's feelings and problems rather than in terms of the specific content of thoughts."[91]	- Rumination mediated of the effect of minority stressors on distress among lesbian, gay, and bisexual people.[92] - Rumination after experiencing discrimination predicted higher levels of psychological distress among African American and lesbian, gay, and bisexual people.[30]
-Emotion Regulation	"Emotion regulation occurs when one activates—either implicitly or explicitly—a goal to influence the emotion-generative process."[93]	- Suppression predicted higher level of distress after 10 days of experiencing a stigma-related stressor among lesbian, gay, and bisexual and African American people.[30] - Ethnic discrimination had an indirect effect on depression through expressive suppression among Latina women.[94]
Cognitive		
-Hopelessness	"(a) negative expectations about the occurrence of highly valued outcomes (a negative outcome expectancy), and (b) expectations of helplessness about changing the likelihood of occurrence of these outcomes (a helplessness expectancy)."[95]	- Higher levels of discrimination were linked to suicidal ideation through an indirect effect of hopelessness about belonging among sexual and gender minority adults.[96] - Hopelessness mediated the association between ethnic and sexist discrimination and depression symptoms among Latina women.[97]
-(Hyper) vigilance	"… living in a state of psychological arousal in order to monitor, respond to, and attempt to protect oneself from threats linked to potential experiences of discrimination and other dangers in one's immediate environment."[98]	- Heightened vigilance partially mediated the effect of police brutality on depressed mood and generalized anxiety among US Black adults.[99] - Hypervigilance mediated associations between perceived discrimination and internalizing symptoms in a longitudinal study of sexual minuity young adults.[35]

Behavioral		
-Substance Use & Poor Diet	The use/misuse of alcohol, cigarettes, and/or drugs; eating unhealthy foods and/or amounts of food.	- Alcohol and drug use mediated the association between perceived discrimination and symptoms of depression and anxiety among lesbian, gay, and bisexual individuals.[39] - Maladaptive eating mediated the association between weight stigma and self-esteem.[38]
-Social Isolation	"The inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment)."[100]	- Among people living with HIV in China, the negative association between perceived discrimination and mental health was mediated by social isolation and loneliness.[37] - Among sexual minority men in Europe, the negative association between structural stigma and depression and suicidality was mediated by internalized stigma and social isolation.[101]
Protective Factors		
Individual		
-Trait/ Dispositional Resilience Resources	"The ability to bounce back from negative emotional experiences and flexibly adapt to the changing demands of stressful experiences"[102]	- Among sexual minority men in Brazil, the association between stigma concealment and depression was present only for those low in individual resilience.[103] - Higher levels of individual resilience significantly reduced the negative association between everyday discrimination and depression and suicidal ideation among Italian transgender individuals.[104]
-Coping	"Thoughts and behaviors used to manage the internal and external demands of situations that are appraised as stressful"[105]	- Among Black women, problem-focused coping reduced the negative effects of discrimination on symptoms of depression, while avoidant coping increased the negative effects of discrimination on symptoms of depression.[106] West et al., 2009) - High levels of spiritual coping strategies were found to reduce the effect of HIV stigma on depressive symptoms.[107]

-Mastery	"The extent to which one regards one's life chances as being under one's own control in contrast to being fatalistically ruled"[108]	- The negative effect of stigma on distress among people living with HIV was not present among individuals with high levels of mastery[47] (Rueda et al., 2012) - High levels of mastery reduced the effect of experiencing discrimination on symptoms of depression and anxiety among Black Americans[109]
-Meaning-Making	"Processes of semiotic mediation, through which individuals negotiate and confer new meanings to their experiences and regulate thoughts, feelings and actions through meaning complexes."[50]	- Women who engage in benefit-finding strategies when making meaning of past experiences of discrimination show higher levels of psychological well-being compared to those in experimental control conditions.[110] - Autistic people use "person-first" language and reframing techniques to externalize stigma, increase feelings of power, and weaken the negative effects of stigma[111]
Social		
-Social Support	"...the positive, potentially health promoting or stress buffering, aspects of relationships such as instrumental aid, emotional caring or concern, and information."[112]	- Social support that directly addressed racial discrimination reduced the negative effect that discrimination had on depressive symptoms for African American women.[52] - Social support reduced the negative effects of perceiving discrimination on wellbeing among gay men and lesbian women.[113]
-Presence of Similar Others	"Other people who belong to the socially stigmatized group furnish information for evaluating the self with respect to group membership"[114]	- Among ethnic minority people, the negative effect of everyday discrimination on mental health was alleviated by having and spending time with same-ethnic friends.[57] - Among gay men, use of Facebook to engage with other LGBQ+ people was found to be a protective factor in the association between experiencing discrimination and mental distress.[58]

Cultural		
-Community Connectedness	"...the convergence of individuals' desires to belong to a larger collective, establish a mutually influential relationship with that collective, satisfy their individual needs and be rewarded through their collective affiliation, and construct a shared emotional connection."[115]	- Sense of community reduced the harmful effects of perceived discrimination on mental health outcomes among migrants in Spain[116] - Community connectedness buffered the association between antibisexual discrimination and psychological distress (the link disappeared among high community connectedness).[61]
-Community Participation	"...participating in a community through professional groups or recreational activities to build reciprocal relationships with that community."[62]	- Community participation is a protective factor of depressive symptoms of sexual and gender minority people in Europe. Interactional analyses shows that community participation is particularly effective as protective factor in low-stigma countries.[62] - Community involvement buffers the negative effect of stigma and depression and loneliness among HIV-positive Latino gay men.[117]
-Collective Action	"...any action that aims to improve the status, power, or influence of an entire group, rather than that of one or a few individuals"[118]	- Collective action was found a protective factor in the direct association between discrimination and internalized heterosexism; and in the indirect association between discrimination and wellbeing among sexual minorities.[63] - Support for Black Lives Matter reduced the negative association between racial discrimination and depressive symptoms among Black people (longitudinal data).[64]

Intensifying Factors		
Individual		
-Legitimizing ideologies	"Attitudes, beliefs, and stereotypes serve to legitimize social arrangements and to provide ideological support for social and political systems."[119]	- The effect of discrimination on self-esteem and wellbeing was stronger when higher body weight women were primed with individual mobility ideology[72] - Perceiving a discrimination experience as legitimate was associated with higher levels of self-directed anger; while perceiving discrimination as illegitimate was associated with lower levels of self-directed anger.[120]
- Group identification	"The extent to which the individual is identified with the targeted group. The more identified one is with a group, the greater likelihood that negative group-related events will be appraised as self-relevant."[67]	- Women with higher levels of group identification had longer negative effects (cardiovascular reactivity and anxiety) after reading about the prevalence of sexism.[68] -Ingroup identification was associated to depressive symptoms among Latino-Americans when reading about prejudice against the ingroup.[69]
Social		
-Stigma characteristics	Different dimensions in which features associated to stigma can differ, including concealability, course, disruptiveness, aesthetics, origin, and peril [121]	- Concealability was found to be associated to higher levels of psychological distress among stigmatized people when experiencing discrimination[30] - The link between perceived stigma and health was stronger for people with "awkward stigmas" (that are highly visible, persistent and disruptive, but innocuous and uncontrollable)[77]
-Group status	"Group status refers to the value or prestige typically accorded to one social group or category compared with another (...) People who belong to one category are widely perceived to be more socially worthy and competent than are those who belong to another category. They also typically hold more power."[122]	- Perceiving discrimination has a negative effect on psychological wellbeing among women and not men, due to the different groups statuses of women and men in society.[76] - Members of a low-status group (experimentally manipulated) evidenced decreased self-esteem after experiencing discrimination, while people in a high-status group did not.[75]

Cultural		
-Structural disadvantages	"Conditions where people have unequal access to valued resources, services, and positions in the society"[123]	- The negative association between teacher discrimination and depression among migrant adolescents was stronger amongst those living in poverty than those living above the poverty line.[124] - Among US same-sex couples attempting to adopt children, the association between internalized stigma and symptoms of anxiety was exacerbated among those who lived in states with more discriminatory social policies.[125]