Understanding the antecedents of internalised stigma among multiple groups: The role of discrimination experiences, protective factors, and stigma characteristics

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Declaration

I, Diego Castro, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Abstract

Considering that most research on internalised stigma has focused on its negative outcomes, this thesis explored a rather neglected question about what its antecedents are. In addition, stigma research has usually focused on single groups at a time, without considering the commonalities and differences of internalised stigma across different groups. Focusing on the role of discrimination experiences, protective factors (including social support and coping strategies), and stigma characteristics, this thesis studied the processes leading to the internalisation of stigma among LGB, racial minorities, higher-body weight, and working-class people. Two main studies were conducted to achieve this objective: a measurement study, aiming at developing an internalised stigma scale that allows for direct group comparisons, and a mixed-methods longitudinal study, aiming at addressing the main research questions and hypotheses of the thesis.

The measurement study (n = 238) was conducted in the UK and Chile to develop a multiple-group internalised stigma scale in two languages (English and Spanish) and across the four groups mentioned. In this study, the scale was developed demonstrating good levels of reliability and validity, with two factors: self-focused and group-focused internalised stigma.

The longitudinal study was conducted with emerging adults in Chile from the same four groups (n = 729 in the first wave). This study aimed to understand what the antecedents of internalised stigma are, how internalised stigma changes over time and what the role of these antecedents is in such change. Participants completed a survey on three occasions over the course of one year. In this survey, participants also wrote brief narrative accounts of a recent discrimination experience. This study allowed for cross-sectional and longitudinal mixed-methods analyses, which shed light on the role of experiencing discrimination, social support, coping strategies, and stigma characteristics in the processes of stigma internalisation.

Impact Statement

This thesis proposes to contribute to the development of a model that explains the conditions under and processes through which stigma becomes internalised across multiple stigmatised groups. The results of this research contribute theoretically to the literature about stigma by integrating, in a conceptual framework, elements of the stage model of self-stigma (Corrigan & Rao, 2012), the psychological mediation framework (Hatzenbuehler, 2009), the social identity threat model (Major & Schmader, 2017), and the minority stress theory (Meyer, 2003). This combination promotes the integration of socio-cognitive and group levels into the analysis of stigma.

Considering that a small number of studies on internalised stigma have been developed in Chile, this thesis contributes to understanding the phenomena in this specific context. These results help to open new research topics about stigma for scholars in Chile and support the study of stigma in general through findings from a context that has been less studied. This research also aims to support the development of a conceptual model that can be applied to understand stigma experiences in different social contexts and among multiple stigmatised groups. Furthermore, this thesis opens a broader research program that can use multi-method approaches with longitudinal, experimental, and qualitative designs to understand the internalisation of structural stigma at different analytical levels.

The results of the measurement study of this thesis were written in an article published in the journal *Group Processes & Intergroup Relations* (Castro et al., 2025). This article will allow other researchers to have access to the scale developed in this thesis, which opens the door for measuring internalised stigma across multiple stigmatised groups. In addition, I am planning to develop a second paper that includes the results of the longitudinal study. This

article will engage in a broader discussion about the antecedents of internalised stigma and the role of time in stigma research.

Finally, the results of this research also have implications outside academia. This thesis provides valuable findings that can help to guide and design interventions that prevent, decrease, or suspend the internalisation of stigma. By understanding more how internalised stigma is produced and maintained, these findings bring crucial contributions to efforts aiming to reduce the negative effects of social stigma. The results of this project shed light on protective factors against minority stress among multiple marginalised groups, such as understanding the role of active coping strategies when facing discrimination. The results also point out the negative effects that perceptions of mutability can have, being associated with higher levels of internalised stigma. Thus, expanding knowledge in this field allows for strengthening policies aiming to promote resilience and positive self-beliefs among stigmatised groups.

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Preface

During the development of this thesis, I have encountered several readings about stigma that have deeply inspired my research and writing. One that radically stood out to me was an opinion article published in BMC Medicine by A. Janet Tomiyama and colleagues (2018), in which the authors strongly advocate for an eradication of weight stigma based on an assertion that challenges traditional understandings of the problem. They state that the negative health outcomes associated with higher-body weight are, in fact, more explained by prejudice and discrimination than by measures of weight, such as body mass index. Certainly, I knew about the harmful impact of stigma on people's well-being, but the authors' claim pointed out a deeper reality that involved all of us interested in the issue. Stigma can infiltrate into the very assumptions of practitioners and researchers and, consequently, into our intervention models and theoretical frameworks, conserving its pervasive and detrimental consequences.

Multiple scenarios came to my mind when reflecting on the implications of this claim. For LGBTQ+ people, for decades, it was thought that there had to be a biological reason that explained both their sexual orientation or gender identity and their increased rate of mental health symptoms. To this date, some research and interventions on economically disadvantaged people's health focus on their personal habits and behaviours, disregarding its contextual determinants. In the context of health inequalities, explanatory ideas of their causes seem to divert attention from their social nature and individualise it in the same people affected by them. During the development of this thesis, these reflections nurtured my research activities and fired up my motivations towards contributing to social change.

In fact, Tomimaya et al.'s opinion (2018) represented one of my early research interests in psychology and social sciences: the relationship between society and individuals. Particularly concerning for me were the links that explain the influence of society on

minoritised people's lives because of their remarkably harmful nature. The persistent discrimination enacted at every level of society, from institutional actions to interpersonal relationships, takes an enormous toll on the lives of minoritised populations. It was examining this association before starting this thesis when I found internalised stigma to stand out distinctively: a personal burden that is carried by minoritised people when applying negative social beliefs towards themselves. Although stemming from social stigma, internalised stigma individually echoes the social devaluation of minoritised people, but this time within themselves. Therefore, I decided to take a small step in the extensive enterprise of understanding the influence that society has on individuals' lives, particularly focusing on internalised stigma and minoritised people.

Internalised stigma presented me with puzzling questions that, if addressed, could shed light on the links between social stigma and minoritised individuals' lives. When having a stigma attached to their own identity, group membership, or personal characteristics, people live with persistent exposure to stigmatising experiences. For example, for Indigenous people, living in a racist society means facing historical oppression, lack of recognition, and prejudice. Paradoxically, even when exposed to the same stigmatising society, not all minoritised people internalise stigma at the same level or at all. In the same example, it is possible to imagine that an Indigenous person might feel ashamed of their racial background and hold negative stereotypes about other Indigenous people. In contrast, another person in the same community might feel pride in their Indigenous identity and celebrate it. Why are there differences between individuals regarding how much they endorse stigmatising beliefs? Is it just how much they have been exposed to stigma? What factors can put people at more risk of internalising stigma? What factors can protect them? In this thesis, I hope to elucidate some of these questions, developing a further understanding of stigma internalisation processes.

With these discussions, it became obvious to me that a better understanding of this phenomenon would not only serve as a relevant insight into the question about how stigma impacts minoritised people's lives but also it can inform efforts aimed at preventing stigma from being internalised and promoting factors associated with this reduction. Consequently, my intentions in this thesis were twofold. On an explicit level, I aimed to contribute to stigma literature by studying the antecedents of internalised stigma. As such, this discussion would also shed light on the relationship between society and individuals by exploring processes of internalisation of social structures. On the other hand, I sought to produce knowledge that was relevant to organisations and initiatives that aim to improve the well-being of minoritised people. Consequently, I hope the results of this thesis can engage in a greater effort to reduce social stigma and protect minoritised people from its negative impact.

CHAPTER I

Introduction

People who belong to marginalised groups can incorporate negative social attitudes about their identities and group memberships as part of their own value system and self-concept. We understand this as internalised stigma (Frost, 2011a; Herek et al., 2009). For example, when a Black person feels ashamed because of their hair texture, race-based stigma is being internalised. This phenomenon is not only the case for Black people internalising racism (James, 2020, 2021) but also for lesbian, gay, and bisexual (LGB) people internalising homo and biphobia (Frost & Meyer, 2009; Polihronakis et al., 2021), people with higher-body weight internalising weight bias (Pearl & Puhl, 2014, 2018), working-class people internalising classism (Inglis et al., 2019), among other groups. Several studies have found that internalised stigma is associated with negative mental health outcomes for these groups (Gale et al., 2020; Mickelson & Williams, 2008; Newcomb & Mustanski, 2010; Pearl & Puhl, 2018). Internalised stigma has also been associated with a range of other negative outcomes linked to people's physical health (Boyle & Fearon, 2018; Prunty et al., 2023), quality of life (Degnan et al., 2021), interpersonal relationships (Frost & Meyer, 2009), community integration (Brehmer et al., 2024), among others. Still, the antecedents of stigma internalisation have yet to be sufficiently examined.

Early theories suggest that an antecedent of internalised stigma can be experiencing discrimination (see, for example, Meyer, 1995). Recent empirical findings point to a similar relationship between these variables: experiencing discrimination and internalised stigma are associated when trying to explain their effect on mental health (H. Li et al., 2020; Magallares et al., 2017; Pérez-Garín et al., 2015; Timmins et al., 2020; B. Turan et al., 2017). However, these studies have only established an association between these variables through cross-

sectional studies, and researchers have not longitudinally tested the temporal ordering of this relationship.

Protective factors have also been found to be relevant in this process by reducing internalised stigma. Social support (Cohen & Wills, 1985) and active coping strategies (Suls & Fletcher, 1985) might decrease levels of internalised stigma among minoritised populations. In this thesis, I present a longitudinal mixed-method study aiming to identify whether experiencing discrimination, social support, and coping strategies work as antecedents to internalised stigma. This approach can also shed light on the mechanisms explaining this process and the conditions under which it occurs.

A second limitation in previous research on internalised stigma is that they have tended to focus on one minoritised group at a time. For example, a theoretical model explaining internalised stigma —the Stage Model (Corrigan & Rao, 2012)— has been developed through the study of people with mental illness. Although this model can reveal information about the internalisation of stigma, a single-group approach makes it unclear whether internalised stigma has convergent or divergent antecedents across groups. Moreover, previous research has not focused on the experience of intersectional minoritised identities. The present research addressed this gap by incorporating a multiple-group and intersectional approach to the research of internalised stigma.

Existing theories have tried to produce an integrative model aiming to understand how objective manifestations of stigma —such as experiencing discrimination— can 'get under people's skin', affecting their health and well-being (Hatzenbuehler, 2009; Major & Schmader, 2017). These theories show that internalisation processes depend on factors at multiple levels, including individual and group differences. However, they have not used these different levels to explain the processes that lead to internalised stigma; instead, they have only studied the

impact of discrimination on stress responses and health outcomes. Therefore, in this research, I aimed to integrate multiple levels into the analysis of internalised stigma through the complement of different models explaining the psychosocial processes of stigma, including the stage model of self-stigma (Corrigan & Rao, 2012), the psychological mediation framework (Hatzenbuehler, 2009), the social identity threat model (Major & Schmader, 2017), and the minority stress theory (Meyer, 2003).

In summary, as a core link in the process by which objective social practices (such as institutional or interpersonal discrimination) affect minoritised people's lives, internalised stigma deserves more attention. Unfortunately, previous cross-sectional and single-group approaches to this question have not allowed scholars to understand the complexity of stigma internalisation as a process in time. Thus, an integrated model that includes different minoritised groups and analyses why, how, and under which conditions people internalise stigma is needed.

In this project, I conducted a longitudinal mixed-methods study focused on the experiences of discrimination and internalisation of racism, classism, homophobia, and weight bias. These four forms of stigma were selected because they represent a broad spectrum of characteristics that I will describe in the next section. Variability between identifying with one or more than one minoritised group was a fundamental feature of this thesis: it allowed us to understand commonalities and differences of the process among four different minoritised groups and the role of intersectional stigma.

I conducted the main study in Chile because its cultural context is relevant and suitable for the study of social stigma: Large economic inequalities linked to spatial (Méndez & Otero, 2018) and educational segregation (Valenzuela et al., 2014) can differentiate and hierarchise social groups, leading to an environment whose psychological correlates require more

attention. Furthermore, the country has been going through social transformations due to large immigration processes during the last ten years (Government of Chile, 2024).

In addition, I studied internalised stigma among emerging adults. This age group presents higher levels of internalised stigma (Meyer et al., 2021) and represents a critical stage where minoritised people develop core dimensions of their identities and become more conscious of their stigmatised situation (Spencer & Patrick, 2009). Further research needed to be developed on how internalised stigma changes at this stage of the life course.

Research aims

The overarching research question of this thesis was *what are the antecedents of internalised stigma across multiple minoritised populations?* To answer this question, this thesis sought to address a variety of research aims.

First, I aimed *to develop and validate an internalised stigma scale that can measure and compare the construct across a variety of minoritised populations*. The development of that scale allowed me to *describe group differences in their levels of internalised stigma and assess the role of the stigma characteristics on those differences.* In addition, I sought *to analyse the association between internalised stigma and experiencing discrimination, protective factors and stigma characteristics.* Furthermore, I aimed *to explore and describe the role of discrimination events narratives and their association with internalised stigma.* Lastly, in this thesis, I proposed *to identify changes in internalised stigma over the course of one year,* to finally *analyse the predictive role of discrimination experiences, protective factors, and stigma characteristics on internalised stigma changes.*

Overview of the thesis

This thesis is completed by two main studies: a measurement study and a longitudinal study. The procedures, analyses and findings of these two studies are organised into three

empirical chapters that resemble the structure of journal articles, including their own literature review, methods, results, and discussion sections. The main purpose of this format is to facilitate the production of scientific articles from the results of the thesis. As outlined in the following paragraphs, general theoretical and methodological frameworks, as well as a general discussion of the results, are included in additional chapters of the thesis.

Right after this introductory chapter, Chapter II presents the main theories and concepts at the foundations of the thesis. Through this chapter, I define the concepts of stigma and internalised stigma, discussing the theoretical models behind them. I also examine the existing models and findings that explain how stigma is internalised. In this section, I present the main social groups I am studying in the thesis, describing the stigma attached to each one of them. Then, I present the main conceptual model of internalised stigma I am planning to study in the thesis. Finally, I describe the general epistemological and methodological approaches of the thesis.

Chapter III includes the design and results of the first study of this thesis: a measurement study aiming to develop a scale that allows for measuring and comparing levels of internalised stigma across various stigmatised groups. In preparation for the longitudinal study, a multiple-group scale for measuring internalised stigma was required, and this chapter presents the development and validation of the scale.

The results of the mixed-methods longitudinal study are contained in the fifth and sixth chapters of this thesis. In order to address my research questions, I conducted two phases of analysis, considering cross-sectional and longitudinal analyses. In Chapter IV, I present the cross-sectional analyses and findings, focusing on the association between internalised stigma and the studied factors and expanding on the qualitative data collected in the first wave of the

study. Similarly, the longitudinal analyses are presented in Chapter V, focusing on the changes in internalised stigma over time and the role of the predictors on such change.

Finally, in Chapter VI and the last of this thesis, I discuss the results presented across the three empirical chapters. Both theoretical and practical implications are examined. In addition, the general limitations of the thesis are discussed, considering the next steps for future research. Lastly, I reflect on the final remarks and conclusions that can be drawn from this thesis.

CHAPTER II

Theoretical Framework

Minoritised groups and stigma

Stigma is a social process by which people are labelled, stereotyped, separated, and discriminated against because of a particular characteristic or group membership (Goffman, 1963; Herek et al., 2009; Link & Phelan, 2001)[1]. The minority stress theory (Meyer, 1995, 2003) is a framework that explains that the inequalities in health and well-being affecting minoritised populations are produced by increased exposure to stressors tied to the stigma attached to people's identities. These stressors are manifestations of stigma that can be expressed in multiple forms on a continuum, from more objective and external forms of discrimination to more subjective and proximal forms, such as internalised stigma. Following this theory, these manifestations of stigma are understood as stigma-related stressors because they produce stressful responses in people who experience them. The stress that minoritised groups experience due to the stigmatisation of their identities, group memberships or social characteristics is what has been understood as minority stress (Meyer, 2003).

For example, people who migrate to a new country are stigmatised when society puts a specific label on them, which is linked to negative stereotypes associated with their migration status. An external manifestation of stigma in this example could be when someone yells and mistreats a person because of being an immigrant. An experience of stigma closer to the self

[1] This definition, originally presented within sociology by Goffman (1963) and then developed by Link and Phelan (2001), has been deeply influential in other disciplines and interdisciplinary research. In social psychology, it has been particularly valuable for emphasising the sociocultural dimensions and broader implications of stigma (Major et al., 2017).

could be internalised immigration prejudice when a migrant person thinks they are unintelligent because of their migration status.

It is important to note that the term "minoritised group" does not refer to a numeric factor, as it was early used in the study of social minorities. Instead, the term is closer to the notion of power (Selvarajah et al., 2020). Minoritised groups are those who are in a situation of less access to power and have a disadvantaged social status. Minority is a contextual and relational concept because minoritised groups can be defined as such only when considering their social context and relation to other groups. In our societies, groups that have been usually understood as minoritised are ethnic, sexual, and gender minorities, economically disadvantaged groups, higher-body weight people, migrants and refugees, people with disabilities, and people diagnosed with physical or mental conditions, among others.

From the minority stress theory (Meyer, 2003), stigma can be understood as the process explaining health and well-being inequalities between minoritised populations and people from the majority. The stigma-related stressors take an increased toll on people, triggering emotional, cognitive and behavioural processes that link these stigma experiences with negative health outcomes (Frost, 2011a; Frost & Castro, 2024). A recurring stigma stressor studied in the literature is internalised stigma because it highlights mechanisms by which stigma can also be interiorised and endorsed by the same people who suffer from it (Herek et al., 2009).

Internalised stigma: An initial conceptualisation

Minoritised people sometimes think about themselves in a negative way that reflects harmful social beliefs that other people and institutions hold. This phenomenon has attracted the interest of social research trying to visualise a more silent manifestation of stigma among minoritised people. As early theorised by critical educator Paulo Freire when conducting

popular education with working-class farm labourers, “self-depreciation is another characteristic of the oppressed, which derives from their internalisation of the opinion the oppressors hold of them. So often do they hear that they are good for nothing, know nothing and are incapable of learning anything—that they are sick, lazy, and unproductive—that in the end they become convinced of their own unfitness” (Freire, 1970, p. 63).

The process by which social beliefs and stereotypes can impact people's self-image is outlined by the labelling theory (Scheff, 1974), which suggests that being labelled as "deviant" leads to stigmatisation, reinforcing the labelled identity through self-fulfilling prophecies. The modified version of this theory (Link, 1987) indicates that individuals may internalise the labels placed upon them by society, being aware of social stigma and endorsing its negative stereotypes. In turn, the labelling process can erode self-esteem and perpetuate the stigmatised behaviour or status. Therefore, internalised stigma becomes a key section of the process by which stigmatisation and labelling impact people’s attitudes and behaviour.

Previous research studying internalised stigma has understood it as different constructs without outlining a clear distinction between them. Frost and Meyer (2009) have noted this limitation and encouraged scholars to distinguish internalised stigma from other phenomena related to social stigma as stressors. Particularly, literature needs to differentiate internalised stigma from other steps in the process of stigma internalisation, separating it from possible antecedents or correlates (e.g., the perception that others are prejudiced against oneself) and possible outcomes (e.g., experiencing distress or negative emotions due to a devaluing belief).

In this thesis, I understand internalised stigma as the individual’s personal acceptance of stigmatising beliefs as a part of their own value system and self-concept (Herek et al., 2009). Through this operationalisation, internalised stigma is constituted by social beliefs and attitudes that people endorse. An essential assumption of the concept is that it is not an inherent or

endogenous feature of individuals but a manifestation of the social stigma attached to minoritised groups' identities or conditions (Frost, 2011a).

To conceptualise internalised stigma, it is also necessary to distinguish the target of the attitudes endorsed. The negative attitudes believed by a person that internalises stigma can be directed to the self or one's own group, forming two distinctive forms of internalised stigma. For example, a person with higher-body weight can think that they are lazy because of their body weight or can think that people with higher-body weight, in general, are lazy because of the same reasons. These two different facets of internalised stigma can be defined as self-focused and group-focused internalised stigma, respectively (James, 2021). While self-focused internalised stigma takes the form of self-devaluing beliefs based on a stigmatised characteristic or identity, group-focused internalised stigma is closer to the endorsement of prejudice towards one's own group. Although most studies have not made this distinction, some recent studies have recognised it (Ciaffoni et al., 2021; James, 2021). In this research, I defined self-focused internalised stigma as the attitudes directed to the same individual that endorses such beliefs and group-focused internalised stigma as the attitudes targeted to the individual's own stigmatised group or community.

These two forms of internalised stigma should not be interchangeable because it is not clear that they share similar mechanisms. In fact, some recent studies have found that they may be related to different outcomes: group-focused internalised homophobia is associated with outcomes related to lower social engagement, such as collective action intentions, and self-focused internalised homophobia is linked to negative mental health symptoms (Ciaffoni et al., 2021). Considering these findings, I expected that the antecedents and conditions that explain them might differ. However, previous studies did not analyse this distinction, and there were no clear theories to hypothesise differences.

Another distinction that is relevant but should not be confused with self- and group-directed internalised stigma is the difference between self-perceptions and meta-perceptions. How stigmatised individuals view themselves concerning social stereotypes is not the same as how they believe others perceive them (Yzerbyt et al., 2009). This research focuses specifically on self-perceptions, as the concept of internalised stigma directly addresses individuals' views of themselves and the groups to which they belong.

Experiences of discrimination and internalised stigma

I mentioned that stigma can be studied through its different manifestations that are more external or closer to the self (e.g., experiencing discrimination or internalised stigma, respectively). These different manifestations of stigma are not independent but linked to each other. Hatzenbuehler (2017) identifies the need to develop studies that explain the causal relationship between these different layers. Therefore, if scholars want to understand the antecedents of internalised stigma, it is important to observe other manifestations of stigma that may explain why people endorse such beliefs.

Experiences of discrimination are an expression of stigma by which people or institutions enact negative social attitudes and unfairly treat a minoritised group (Williams et al., 1997). Discrimination can be experienced in different ways, from chronic to acute expressions. Everyday discrimination is a chronic and sometimes a more subtle form of discrimination that stigmatised people face and that can have an impact on their well-being (Williams et al., 1997). For example, a young man from a working-class background can have the experience of being overly followed by security when shopping in stores based on the prejudice that working-class people steal. On the other hand, stigmatised people can suffer a severe experience of discrimination in the form of a major life event (Williams et al., 1997).

For example, if the same person is stopped and assaulted because other people thought they were a burglar, that can become a traumatising experience based on social class discrimination.

Multiple studies have associated experiencing discrimination with internalised stigma, especially when explaining the relationship between discrimination and negative well-being outcomes. These findings were found among different stigmatised conditions or identities such as diverse sexual orientations (Timmins et al., 2020), higher-body weight (Magallares et al., 2017), HIV status (B. Turan et al., 2017), mental illnesses (Hing & Russell, 2017a; Vass et al., 2017; Villotti et al., 2018), and even other recent medical conditions that have been stigmatised, such as COVID (H. Li et al., 2020). In sum, these studies found that the more people reported being discriminated against, the more they presented internalised stigma beliefs. However, the cross-sectional nature of these studies does not allow scholars to establish an exact temporal ordering between experiencing discrimination and internalised stigma.

Few studies have looked at the longitudinal association between discrimination and internalised stigma. For example, experiencing discrimination was found to predict higher levels of internalised stigma after one year among people with mental illnesses (Chan & Tsui, 2023). Nevertheless, more research needs to be conducted to clarify if this longitudinal effect is found in other populations. Longitudinal studies including multiple groups—such as the one presented in this thesis— are required to test the direction and extent of this relationship.

The stage model of self-stigma (Corrigan & Rao, 2012) was developed to understand the process by which people with stigmatised mental illnesses apply devaluing social beliefs to themselves, obstructing their recovery and life goal achievement. This model supports the assumption that experiencing discrimination plays a predictive role in internalised stigma and includes a more detailed view of the mechanism. In the stage model, stigma internalisation is a three-step process by which people from minoritised groups must first be aware of the

existence of stigmatising beliefs, then agree with such beliefs to, finally, apply those beliefs to the self (Corrigan & Rao, 2012).

If experiencing discrimination works as the indicator of the existence of social stigma, the following two steps in the stage model (Corrigan & Rao, 2012) are the two different facets of internalised stigma previously presented: group-focused internalised stigma and self-focused internalised stigma, respectively. The model states that, for people to start self-devaluing themselves, they first must agree with negative social attitudes targeted against their conditions, identities, or group memberships. Therefore, group-focused internalised stigma might be a proximal antecedent of self-focused internalised stigma, and, at the same time, the latter is a more proximate antecedent of negative well-being outcomes for individuals. The process that links experiencing discrimination to self-focused internalised stigma was tested in this thesis.

Nevertheless, the mechanisms stated by the stage model (Corrigan & Rao, 2012) could be neglecting a more complex mechanism explaining group-focused and self-focused internalised stigma. As mentioned, the cross-sectional design of most studies testing the mechanisms related to internalised stigma does not allow us to establish a clear causal direction between variables. In addition, the two facets of internalised stigma might be linked to dissimilar mechanisms. Is it possible that different stigma manifestations explain group-focused and self-focused internalised stigma? Could certain factors or conditions explain that people internalise differently the stigma they face when experiencing discrimination? Is the process equivalent across different minoritised groups? There were no previous studies that allowed me to establish clear hypotheses around these questions. These interrogations required exploratory analyses and initial inductive approaches. This research was an excellent opportunity to explore if different antecedents could explain the two facets of internalised stigma.

The stage model of self-stigma is a helpful approach to understanding the process over time by which experiences of discrimination become internalised stigma. However, this model does not explain other factors and mechanisms that can explain why people internalise stigma. In other words, the question that continued to be rather obscure is what psychological processes are triggered by experiencing discrimination and explain further stigma internalisation. Although this is a question that has been explored to understand the stigma-stress relationship through the psychological mediation framework (Hatzenbuehler, 2009; Hatzenbuehler et al., 2009) and the social identity threat theory (Major & Schmader, 2017), these theories do not explain internalised stigma, but other outcomes, such as psychological distress or somatic symptoms.

The social identity threat model (Major & Schmader, 2017) posits that stigmatising situations can trigger concerns about being socially devaluated because of a feature that is relevant to the self. This model indicates that there are voluntary and involuntary responses to these triggering situations, which explain the negative effect of identity threats on health. On the other hand, the psychological mediation framework (Hatzenbuehler, 2009) presents that there are psychological mechanisms that explain how stigma 'gets under the skin' and affects people's mental health. In this framework, there are social, emotional, and cognitive responses to discrimination that explain its consequences on mental health and well-being.

These models describe the stigma-stress relationship as a process that strongly depends on individual and group differences rather than a uniform mechanism. Even when hypothesising the impact that experiencing discrimination can have on internalised stigma, it is unlikely that this effect is the same for every individual. In fact, although previous research consistently links experiences of discrimination to internalised stigma, the limited consideration of other relevant factors calls for a more thorough evaluation of this assumption.

As mentioned in the introduction, it is fundamental to incorporate the individual and group factors that explain differences in the process of internalising stigma.

Additional concepts and theories might also be relevant to understanding the process of internalisation. First, racial identity and centrality (Sellers et al., 2006) can influence the way experiences of racism impact on multiple psychological outcomes for Black, Indigenous, and People of Colour (BIPOC). Accordingly, the internalisation process may be shaped by how central racial identity is to an individual's self-concept (Willis et al., 2021). Secondly, system justification theory (Jost & Van Der Toorn, 2012) offers insight into why minoritised populations may endorse or justify unequal systems that discriminate against them; as a result, system-justifying beliefs may serve as a factor contributing to internalised stigma (Silva et al., 2024). Finally, identity process theory (Jaspal & Breakwell, 2014) explains how identity develops through processes of evaluation and assimilation-accommodation, guided by key identity principles. This suggests that the internalisation of stigma may be influenced by these principles, including prior levels of self-esteem or self-efficacy (Jaspal & Bloxsom, 2023).

Although deeply relevant, these concepts and theories were not directly included in this theoretical framework, as they only indirectly address the process of stigma internalisation. For this research, priority was given to theories that explicitly incorporate internalised stigma as a central component of the mechanism under study, enabling clearer hypotheses regarding its antecedents.

Resilience when facing discrimination: The role of protective factors

Resilience is the capacity of individuals to overcome situations that can threaten or damage their lives by accessing personal and interpersonal protective resources (Ungar, 2008). In the context of minoritised populations, resilience highlights the protective factors that allow people to overcome stigmatisation, preventing their negative impact (Earnshaw et al., 2013)

and thrive in the face of discrimination (Frost, 2011a). For example, higher-body weight people can attempt to reduce the stress stemming from weight stigma by talking and seeking support from others (Gerend et al., 2022). Even when there is research on the role of resilience as a protective capacity among minoritised populations, its association with internalised stigma require further attention.

The conceptual rationale around the function of protective factors usually lands on its moderating role by reducing the negative effect of discrimination. However, the association between these factors and the different outcomes can be more complex. In fact, there are long conceptual discussions about whether the positive effect of social support (see, for example, Cohen & Wills, 1985) and coping mechanisms (see, for example, Pakenham & Rinaldis, 2001) on health and well-being is a direct effect or a buffering effect on stressors. In this thesis, I understood protective factors in the broader sense, considering both their conceptually moderating role by buffering the effect of discrimination and their direct role as predictors of internalised stigma.

Two protective factors have been frequently included to test a buffer on the effect that discrimination has on individuals' negative well-being outcomes: active coping strategies and social support. These factors can be classified into individual and interpersonal dimensions, respectively.

At an individual level, people's strategies to respond and cope with stressful experiences vary, from avoidant forms to more active responses (Suls & Fletcher, 1985). Avoidant coping strategies are characterised by intentions of denying or evading the source of stress and its consequences, for example, trying to suppress negative feelings or deciding not to talk about them. This form of coping has sometimes been seen as a form of reducing stress responses (Waugh et al., 2020); however, it has also been found to be associated with multiple

negative well-being outcomes (Benatov et al., 2020). On the other hand, active coping is defined as the attempt to focus attention or address the source of stress and its effects, for example, confronting someone producing the issue or discussing with others about the situation. Active coping strategies are usually seen as more effective for reducing the negative effects of stress (Guan et al., 2020).

Similar to the role these coping strategies have with general life stressors, the way people cope with discrimination can have a role in shaping the individual impact of stigma (Hatzenbuehler, 2009). For example, Hing and Russell (2017b) found that people who cope with secrecy about their own problems are more at risk of internalising gambling stigma. In turn, active coping strategies have been studied as protective factors in the stigma-stress process, for example, having the potential to protect people from the negative effects of discrimination (Magallares et al., 2016). Although there are initial findings around this, further explorations are needed regarding the relationship between coping strategies and internalised stigma.

At an interpersonal level, access to different sources of social support can also play a role in buffering distressing events and reducing negative outcomes (Cohen & Wills, 1985). Support received from other people can help by enabling people to access tangible resources, appraise the situation in protective ways, or feel cared for and held in esteem by others (Cohen & McKay, 1984). However, the effects of social support can change depending on its source. For example, support from family seems to be more protective compared to support from friends in situations associated with cyberbullying among young adolescents (Hellfeldt et al., 2019). Moreover, the features and role of social support also vary across social groups (Frost et al., 2016). For example, among LGB+ individuals—whose families often do not share their stigmatised status—family support can differ significantly from that experienced by racially minoritised individuals, whose families typically share the same racial identity.

In general, social support has been found to be a protective factor in the face of social stigma (Hatzenbuehler, 2009). Trying to explain the relationship between internalised stigma and mental health problems, J. Li and colleagues (2020) found that social support had a buffering effect on its negative outcomes. Sommantico and colleagues (2020) also found that social support is negatively associated with internalised stigma when explaining its effect on relationship satisfaction among lesbians and gay men. However, these studies have not specifically looked at the predictive role of different sources of social support on internalised stigma or its impact on the relationship between discrimination and internalised stigma. In this thesis, as mentioned, I examined the role of both: social support as a direct antecedent negatively associated with internalised stigma and social support as a protective factor buffering the impact that experiencing discrimination can have on internalised stigma.

Multiple stigmatised identities and social status

Intersectionality (Collins, 1990; Crenshaw, 1989) is a perspective in social sciences that analyses the overlapping of multiple social categories, which creates unique experiences and situations that cannot be explained by just one social category by itself. For example, from an intersectional point of view, the experiences of being a Black lesbian woman must be analysed in the complex interrelation that those categories take (Bowleg, 2008). Nevertheless, in stigma research, there is a great number of studies focusing on how stigma is experienced, only considering a single stigmatised category and ignoring the role of others.

An intersectional approach in stigma research allows scholars to consider the multiple identities and categories that converge in people, moving away from single-axis approaches that examine stigmatised social categories in isolation. In addition, intersectionality claims that the interplay of different social categories transforms the experiences of people and cannot be reduced to an addition of the experiences of each category as if they were independent of each

other. In sum, an intersectionality perspective sheds light on how stigma processes are formed by different dimensions of people's identities that are interdependent (Earnshaw et al., 2015).

Following this perspective, I define intersectional stigma as the convergence of various stigmatised characteristics attached to an individual or group (J. M. Turan et al., 2019). Among groups with intersectional stigmas, their different experiences of internalised stigma are interrelated: for example, higher levels of internalised race and sexual orientation stigma were associated with higher levels of internalised HIV stigma after being diagnosed (Earnshaw et al., 2021). If this phenomenon happens across other forms of internalised stigma, it is a question that requires further attention.

Although the role of intersectional stigma in the stigma-health relationship has been less studied, group social status has received more attention, particularly in terms of how it shapes the effect of discrimination on the outcomes of stigma stressors (Major et al., 2003). Group social status can be defined as a social value assigned to a group or social characteristic, which provides people with prestige and worthiness as compared to others (Major et al., 2002). For example, considering sexual orientation in Chile, lesbian and gay people are a lower status group (Bahamondes-Correa, 2016) compared to heterosexual people. As an aspect of stigma is a lower status (Link & Phelan, 2001), when a single person belongs to different social minorities having attached to their identity more than one stigma, there is an even lower social status attached to their identities, compared to those who do not belong to such groups. The specific role that being part of multiple minoritised groups and its concomitant lower social status can have on internalised stigma when experiencing discrimination requires more attention. In this thesis, I examined if lower group social status —operationalised as multiple minoritised group membership— worked as a risk factor in the stigma internalisation process.

However, only studying intersectional stigma as a lower group social status can be interpreted as an additive approach to intersectionality. An additive approach means that the social status, discrimination experiences, internalised stigma levels, or other related variables, can be simply explained by adding or doubling the different experiences linked to each minoritised identity or group (J. M. Turan et al., 2019). Although an additive approach is a first step to understanding how being part of multiple minoritised groups can mean a greater risk of internalising stigma, it is not enough to achieve an intersectional approach.

Intersectional stigmas do not imply the mere sum of different stigmas, but new social identities and experiences of discrimination emerging from the combination (Bowleg, 2008; J. M. Turan et al., 2019). This challenge encouraged me to consider that stigma manifestations are complex and unique and, therefore, to adopt an inductive approach aiming to explore how people experience intersectional discrimination and internalised stigma due to their specific backgrounds, group memberships, and identities.

Group differences and dimensional characteristics of stigma

Although sharing their stigmatised situation, socially stigmatised groups differ in many aspects, including stigma dimensional characteristics that shape the way stigma is experienced (Jones et al., 1984; Pachankis et al., 2018). These characteristics can impact the process of internalisation because of how they are linked to specific forms of discrimination or reactions to discrimination. For example, when thinking of a stigmatised health condition, it is not the same if such a condition can be hidden from others or if it is constantly noticeable. In this thesis, two characteristics were considered because of their close relationship with the stigma internalisation process: perceived concealability and mutability. These and other dimensional characteristics of stigma were proposed in 1984 by Edward Jones and colleagues (1984) and

have had a significant and lasting influence on stigma research up to the present day (Diamond & Alley, 2022; Pachankis et al., 2018).

Concealability is the capacity to hide the features associated with stigma. Because it can be the actual capacity or the social expectations of being able to conceal such features, here it is studied as perceptions of concealability. Concealability is usually linked to attitudes and behaviours associated with the possibility of hiding the own identity or group membership (Jones et al., 1984; Pachankis et al., 2018). Identities that can be considered concealable are, for example, people stigmatised based on their sexual orientation, social class, drug use history, and HIV status, among others. Concealable stigmatised identities have received some attention in previous stigma research, and mixed results have been found regarding the potential negative effect of concealability (Pachankis et al., 2018). On one hand, it has been found that people with concealable stigmas have less access to support from others and more negative well-being outcomes (Hatzenbuehler et al., 2009). However, concealability can also allow people to avoid discrimination or the negative costs of stigma by hiding the stigmatised features (Quinn, 2018).

Additionally, concealability is strongly related to internalisation processes (Quinn & Earnshaw, 2013). Comparing different minoritised groups, Blankenship (2019) found that the effect of expectations of bias on internalised stigma was moderated by concealability, and people with perceived concealable stigmatised characteristics were at more risk of internalising stigma. However, more research needs to be conducted to understand these differences.

The second characteristic that this thesis focused on is mutability, which is the capacity of individuals to change their stigmatised identity (Jones et al., 1984; Pachankis et al., 2018). Like concealability, this characteristic refers to the actual possibility or the social expectations around being able to mutate the stigmatised features. Mutability can be described by individual or collective representations about how persistent or temporary the stigmatised features are,

therefore, here it will be understood as perceptions of mutability. Identities and features that can be classified as mutable are body weight, social class, employment status, and smoking behaviour, among others. Regarding groups seen as having a perceived mutable stigmatised feature, the perception of the persistence of such features is associated with higher levels of bias (Clark et al., 2001). Nevertheless, it is not clear what differences are present between people with perceived mutable and non-mutable stigmatised identities.

Although there are very few studies focusing particularly on perceived mutability and internalised stigma, there is recent and increasing literature focusing on how it is experienced by people with mutable stigmas, such as higher-body weight people (Pearl & Puhl, 2018). Particularly among higher-body weight people, the perception of mutability of their body weight has been found to be twofold. The asymmetry model (Hoyt et al., 2017) presents that the more people perceive they can change their weight, the more they internalise stigma via an increase in self-blame beliefs (Burnette et al., 2017). However, this perception of change can also be associated with a reduction of internalised stigma beliefs via a decrease in essentialist beliefs about weight (Hoyt et al., 2017). Unfortunately, research on mutability is scarce and recent, and more efforts need to be conducted across multiple groups to understand its role in stigma internalisation.

Considering the need for internalised stigma research that includes multiple groups and stigma characteristics, this thesis focused on four minoritised populations that face different forms of discrimination: LGB, racial minority, higher-body weight, and working-class people. For their selection, the main criterion was that the selected groups represent a complete diversity in the concealability and mutability perceived characteristics, considering all possible combinations between them (more about the group selection can be found in Chapter III). See Table II.1 for a summary of the dimensions and groups. In the following paragraphs, a short

review of existing research about these four groups and their experiences of internalised stigma is presented.

Table II.1.

Stigma characteristics and selected groups

	Perceived as concealable	Perceived as not concealable
Mutable	Working-class people	Higher-body weight people
Not mutable	LGB people	Racial minority people

Race-based stigma. The experience of internalised stigma among racial minoritised groups has been mainly studied in the form of appropriated racial oppression as a way of reflecting on how these negative beliefs come directly from a stigmatising environment (Banks & Stephens, 2018). In order to maintain a consistent terminology across groups, I use the term internalised racism.

Cross and colleagues (2017) point out that internalised racism is a way in which some Black people manage the stigma attached to their identity by oppressing others or feeling self-hatred. For these authors, the development of a strong ethnic and racial identity should decrease levels of internalised racism. Among Indigenous people, internalised racism has been understood as a form of colonialism (Pyke, 2010) that places the blame on the same oppressed population. It has also been associated with assimilationist attitudes that aim to deny indigenous heritage (Lewis et al., 2013). Special interest has attracted the phenomenon of lateral racism (Paradies, 2018), which is an enactment of group-focused internalised stigma characterised by harmful behaviour from racially minoritised people towards other people from their own group. Internalised racism seems to be strongly related to poorer health: a meta-analysis showed that

internalised racism is directly associated with mental and physical health problems among People of Colour (Gale et al., 2020).

Regarding stigma dimensional characteristics, most racially minoritised people's identities (e.g., Black and Indigenous people) are not usually perceived as concealable nor expected to change in time. Therefore, they represent a minoritised group that does not meet any of the two presented characteristics.

Sexual orientation-based stigma. Among socially minoritised groups that are not related to stigmatised health conditions, lesbian, gay and bisexual people (LGB) probably have received the most attention regarding the study of internalised stigma, specifically in the form of internalised homophobia or homonegativity. Although some research on this population also includes trans and non-binary people, in this thesis, I focused on sexual minority people for the specific features of stigma attached to sexual orientation.

Internalised homo- and biphobia are negative attitudes directed to the self or the group based on their identity, and it usually takes the form of internal conflict and desires to change one's sexual orientation (Frost & Meyer, 2009). Self-devaluation based on one's own sexual orientation can be a chronic stressor, taking a toll on people's well-being. In fact, internalised homophobia has an impact on multiple outcomes for LGB people, such as reducing relationship quality (Frost & Meyer, 2009) and increasing psychological distress (Timmins et al., 2020), risky sexual behaviour (Newcomb & Mustanski, 2010), among others.

The experience of being stigmatised based on sexual orientation is strongly related to the experiences of hiding and coming out about being LGB. As previously mentioned, people with concealable stigmatised identities face specific challenges (see Quinn & Earnshaw, 2013) related to concerns or decisions about identity disclosure. Concerns about disclosure of one's own sexual orientation have been associated with internalised homophobia (Frost & Meyer,

2009). Most of the time, people with perceived concealable stigmatised identities, such as LGB people, do not have family that shares their identity or group membership (Hatzenbuehler et al., 2009), which can increase isolation feelings or worries about disclosing their own stigmatised identity.

In this thesis, LGB people were considered to be a non-mutable stigmatised group. Although sexual orientation has been understood as a fluid dimension of people's identity (Diamond & Savin-Williams, 2000), identifying as a sexual minority is mostly experienced and perceived as stable in time (Pachankis et al., 2018). Identity fluidity and exploration during LGB people's development do not deny the consistency of their minoritised status, especially in regard to the refuted efforts to change people's sexual orientation (Andrade & Campo Redondo, 2022).

Weight-based stigma. Internalised stigma for people with higher-body weight is a more recent but rapidly increasing field of study. It has been mostly studied under the term of internalised weight bias.

Internalised weight bias has usually been characterised by a decrease in self-worth (Meadows & Higgs, 2019) and an increased criticism of the self or others based on body weight (Stewart & Ogden, 2021). The effect of internalised weight bias on well-being is similar to other forms of internalised stigma. Pearl and Puhl (2018) conducted a systematic review of the impact of internalised weight bias on health and noted that most studies found a strong and negative relationship between them.

Differentiating from the previous two groups, the possibility and its social expectations that weight can change over time might shape how people with higher-body weight experience and internalise stigma. Most times, stigma based on weight is more socially acceptable based on the presumption that such features are mutable and, therefore, depend on the individual's

responsibility (Solanke, 2021). In turn, weight-based stigma strongly builds on beliefs of blaming people with higher-body weight for their body weight (Dovidio et al., 2017), so the experience of internalised weight bias is tightly linked to blame feelings (Burnette et al., 2017).

Social class-based stigma. The final group I focused on in this thesis was working-class people. The stigma that economically disadvantaged people face has been studied by approaching different groups (e.g., people who are homeless, people who receive welfare, among others) or using different definitions to refer to that group (e.g., poor people, lower-class people, among others). In this research, I used the term working-class people in order to use a more inclusive, updated and broad concept. Unfortunately, stigma based on social class has received far less attention compared to the previous groups, both more generally regarding its role in the stigma-health relationship and more specifically regarding internalised stigma.

Like weight-based stigma, class-based stigma also includes stigmatising attitudes that can emerge from its mutability expectation, such as beliefs in individual blame for poverty (Shor et al., 2018). In addition, social class can be or is expected to be concealed (Simons et al., 2018), raising potential concealment concerns and decisions (Inglis et al., 2023). Social class stigma is also characterised by feelings of shame that stem from society's views on poverty, which can be, in turn, internalised (Sutton et al., 2014). Although this form of stigma has been less studied, internalised class stigma is also associated with negative well-being outcomes, poorer self-esteem, and depression (Inglis et al., 2023; Mickelson & Williams, 2008).

Emerging adulthood and internalised stigma

Emerging adulthood is defined as a phase of the life course between 18 and the mid to late 20s that forms the transition from adolescence to adulthood. Emerging adults face vital decisions in their lives linked to educational and residential changes, relational commitments,

and other individual explorations (Arnett, 2000). However, these decisions and changes seem to be subordinated to a psychological process of identity formation and development that establishes the possibility of further life commitments usually linked to adulthood (S. J. Schwartz et al., 2005).

Particularly for minoritised people, emerging adulthood is a critical phase in which their identity formation is also associated with a deeper understanding of their minority status and stigmatised situation (Spencer & Patrick, 2009). This is also a phase of the life course characterised by environmental transitions that might expose minoritised people to new stigmatising experiences or to new protective factors (Earnshaw et al., 2022). These elements might explain the particular conditions for stigma internalisation among emerging adults compared to other age groups.

When studying internalised homophobia across different cohorts, Meyer and colleagues (2021) found that older cohorts (aged 34-41 and 52-59) reported lower levels of internalised stigma when compared to younger ones (aged 18-25). Several studies researching internalised stigma have found similar results: among adults over 18 years old, age was negatively associated with levels of internalised stigma (Logie & Gadalla, 2009; Pribadi et al., 2020; Werner et al., 2008), that is, younger adults report higher levels of it. What happens with internalised stigma during emerging adulthood? Why do emerging adults report higher internalised stigma levels compared to mid and older adults? As previously discussed, emerging adulthood is a developmental stage of identity fluctuation and exploration, deeply linked to changing environments. Therefore, this period presents an excellent opportunity to investigate the factors that shape internalised stigma. Considering that stigma internalisation might also be different for each minoritised population, more research comparing emerging adults from different groups is needed.

Although research on internalised stigma during emerging adulthood has not received much attention, there are relevant elements to consider about how stigmatised emerging adults experience stigma. For example, among emerging adults from a working-class background, the mutable dimension of their social class is linked to ambivalent strategies to reduce the negative effect of discrimination (Radmacher & Azmitia, 2013). For Black people, different trajectories of perceived discrimination have been found during their emerging adulthood, which were linked to their psychological well-being (D. B. Lee et al., 2020). Particularly for higher-body weight emerging adults, perceived weight stigma was associated with higher internalisation of stigma, which, in turn, was linked to higher levels of depression (Decker et al., 2018).

A dimension that might be common across groups is that internalised stigma is more of an existing and ongoing process during the life course rather than a particular experience that happens at certain moments in life. In fact, Meyer (1995) noted when referring to internalised homophobia that "long before they begin to realise their own homosexuality, homosexually-oriented people internalise societal antihomosexual attitudes" (p. 40). That observation is likely to be shared for other discriminated identities, as Earnshaw and colleagues (2021) noted for people living with HIV/STI. Following the Institute of Medicine's (2011) suggestion regarding the use of a life course approach in the study of stigma, in this thesis, I included a perspective that studies change in internalised stigma considering the development of minoritised individuals.

Proposed conceptual model

This thesis' principal research aim is to understand the antecedents of internalised stigma, and it focuses on the predictive role of experiencing discrimination and on the moderating or direct predictive role of coping strategies, social support, intersectionality, and stigma characteristics. In Figure II.1, I include a summary of the proposed conceptual model,

highlighting the main constructs and relationships this thesis focuses on. Including protective factors at the individual and interpersonal level, and social status and stigma characteristics at the group level, this model aims to include potential antecedents of internalised stigma at different analytical levels. The inclusion of multiple stigmatised groups in the study will allow the testing of commonalities and differences in these processes across groups.

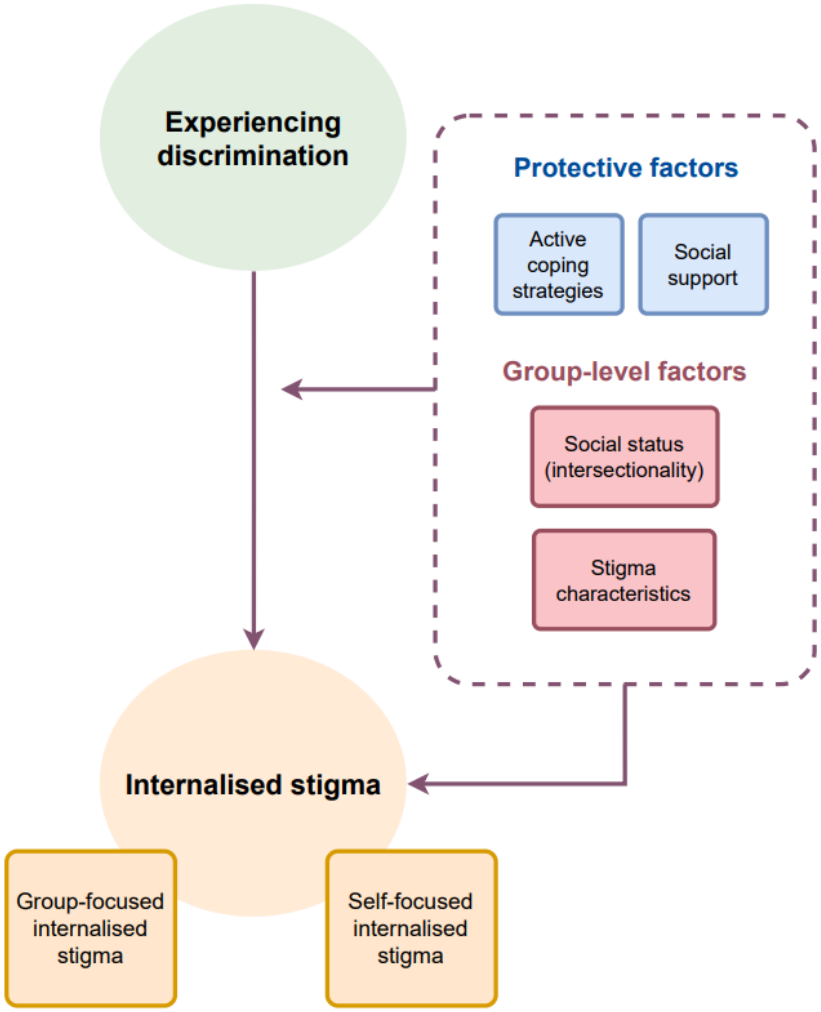
The conceptual model presented here does not represent the analytical plan, but a summary of the concepts and associations revised in this theoretical framework and that are at the foundations of this research. In Chapters III, IV and V, a specific literature review is offered to outline the respective research questions and hypotheses developed to address the research aims of this thesis. Therefore, each one of these three chapters will contain their specific plan for analysis.

At the top of the following conceptual model, experiencing discrimination appears as a main antecedent of internalised stigma. The vertical arrow in the centre of the model represents the expected association between the two variables, which states that the more people experience events of discrimination, the more they will internalise stigma. At the right of the figure, it is possible to see protective and group-level factors, including coping strategies, social support, social status, and stigma characteristics. The arrow that links these factors with the central arrow represents their expected moderating role. This association would mean that the factors will reduce or increase the effect of discrimination on internalised stigma. In turn, the arrow at the bottom of the factors represents their expected direct effect. This association would mean that they will be directly associated with lower levels of internalised stigma (in the case of active coping and social support) and higher levels of internalised stigma (in the case of having a lower social status and having a concealable or mutable stigmatised identity).

Finally, it is important to highlight that this conceptual model was developed based on existing evidence concerning internalised stigma reviewed earlier. However, the assumptions connecting experiences of discrimination to internalised stigma require further evaluation, as previous studies have not specifically focused on this process and its associated factors. Consequently, the present conceptual model is intended to critically explore and test these assumptions in this thesis.

Figure II.1.

Proposed conceptual model for studying the antecedents of internalised stigma. In the model, relationships between variables represent a conceptual relation and not the plan for analysis



Epistemological framework

This research project was constructed from a critical realist epistemological standpoint (Bhaskar, 1978; Zachariadis et al., 2013). From this perspective, the object of research is seen as both an objective reality that exists outside the research and a subjective reconstruction made by researchers in the process of conducting research. When applied directly to this thesis, through this framework, I understand internalised stigma as a real phenomenon that can shape people's lives and, as reviewed previously, in close association with stigmatised groups' health and well-being. On the other hand, internalised stigma is also experienced and interpreted via subjective processes, and my comprehension of the issue will be mediated by interpretations and their social context.

More generally, critical realism proposes a stratified ontology (Zachariadis et al., 2013) where different domains of knowledge are present. Although the claims stemming from the results of this research are not expected to be a direct reflection of reality, I proposed a framework that allows for a complex and integrative interpretation of the problem. In this thesis, I aimed to understand processes by which enacted forms of stigma (e.g., discrimination experiences) are internalised by minoritised individuals. Therefore, the focus of this research was not on internalised stigma only as an outcome but on internalisation as a psychosocial process that can reproduce social inequalities between groups.

The development of a critical realist epistemological standpoint for this research was not arbitrary nor a choice but rather a consequence of the research problem itself, as well as my own positionality as a researcher. Stigma internalisation operates as a key mechanism connecting social stigma to health inequalities and, therefore, includes elements from different dimensions, including social structures, interpersonal relationships, psychological mechanisms, and health outcomes. In addition, my training and experience as an

interdisciplinary social psychology researcher also directed me to an understanding of psychosocial phenomena that happen across these different levels.

Therefore, my positionality as a researcher shaped the way I interacted with the object of research. As a researcher, I share a dual space of insider and outsider of the research problem. On the one hand, I am not part of all minoritised populations studied here: I do not identify as a higher-body weight person, a working-class individual, or an emerging adult. My position as a researcher also occupied a place of privilege due to my academic formation on the topic. On the other hand, as a gay Latino adult from Chile living in the UK, I do share experiences of marginalisation with ethnic minoritised groups and LGB people. By reflecting on this dual positionality, I was able to consider its advantages (e.g., access to the sample, understanding of cultural differences) and its limitations (e.g., partial knowledge of the phenomena).

Considering this scenario, reflexivity became a useful tool for the research (Breuer, 2003). Through reflexivity, I critically examined how my position and background influence the research process as well as its social and historical context. Far from undermining the research process, reflexivity allowed for a source of information for methodological decisions and an enrichment of the interpretations that can be drawn from the results. In fact, a critical realist approach promotes a reflexive practice by acknowledging that researchers are embedded within the same social context they study.

The multiple dimensions associated with this research object and my stance towards it were the reasons why, while I was aware of the subjectivity and practised reflexivity, I also aimed for methodological rigour and quality (Fàbregues & Molina-Azorín, 2017). The methods employed in this thesis were designed and implemented to produce relevant results and interpretations of the research questions. Thus, it was by ensuring rigorous procedures that I was able to ensure the integrity of the research and the trustworthiness of its results.

General methodological framework

This research used a mixed-method approach that can be classified as a fully mixed concurrent dominant status design, following Leech and Onwuegbuzie's typology (2009). First, the research can be considered as fully mixed because the qualitative and quantitative sections share core elements of the research process, including data collection and analysis. For example, both qualitative and quantitative data were collected through the same survey and from the same participants. Secondly, the research can also be understood as concurrent because the quantitative and qualitative sections were conducted at the same time without sequential stages. Lastly, it can be considered to have a quantitative dominant status because most of its research aims needed to be addressed using quantitative methods and, in turn, more space was given to questionnaire data and statistical analyses. This dominant status can also be understood as a mixed embedded design (Creswell & Clark, 2017), considering the qualitative part of the project was a subcomponent inside the broader quantitative design.

Mixed methods research can be strongly aligned with a critical realist epistemological standpoint (Mukumbang, 2023; Zachariadis et al., 2013). Through an integration of deductive and inductive approaches, mixed methods allow for the inclusion of multiple sources of data. The data collected from the questionnaire's scales allowed me to measure, compare and assess change in levels of internalised stigma, while the narrative accounts captured lived experiences of discrimination and how people react and describe them. In addition to the test of associations between variables and the exploration of people's narrations, further interpretation of the results was drawn by discussing quantitative and qualitative findings together.

In order to complete the research aims of this thesis, two studies were conducted. First, a measurement study was designed to develop and validate an internalised stigma scale that can be used to compare multiple stigmatised groups. This study was conducted in two different

countries to develop the scale in two languages (the details of the methods for this study are presented in the next chapter). Secondly, a longitudinal study was designed as the core study of this thesis, aimed at addressing the main research questions. This longitudinal study was conducted with emerging adults in Chile over the course of one year with three waves of measurement (the details of the methods for the longitudinal study are presented in Chapters IV and V).

CHAPTER III

Development and validation of a multiple-group internalised stigma measure[2]

Introduction

Although the body of work reviewed in the theoretical framework suggests that internalised stigma is a risk factor for negative well-being outcomes across diverse groups, a core limitation is that previous research has tended to examine a single group in isolation using a scale specific to that group. Surprisingly, a scale that allows researchers to compare internalised stigma across groups has not been developed. As a direct consequence, existing research has not been able to assess if some stigmatised groups endorse higher levels of internalised stigma than others.

As a first step to address this gap in knowledge, I developed and validated a new internalised stigma measure that allows for direct comparisons across multiple stigmatised groups. As a second step, I used this scale to compare levels of internalised stigma across four social groups -including sexual minority, racial minority, higher-body weight, and working-class people- using samples collected in English- and Spanish-speaking countries.

The methodological challenge of studying internalised stigma across groups

Considering that previous researchers have studied the internalisation of stigmatising beliefs among different specific groups, there are theoretical and empirical reasons to think that internalised stigma is a shared phenomenon across them. Theoretically, there is a variety of models explaining the relationship between stigma and health across different groups (Frost, 2011a; Major et al., 2017). As reviewed previously, these models have conceptualised

[2] This chapter has been written into an article that is published in *Group Processes & Intergroup Relations* (Castro et al., 2025).

internalised stigma as an experience and stressor that stems from cultural and societal stigma and, in turn, it can cause negative health and well-being outcomes in multiple minoritised groups. Empirically, there is evidence applying these stigma and health models that illustrates the same negative effects of internalised stigma on health within a variety of different stigmatised populations (e.g., Gale et al., 2020; Pearl & Puhl, 2018). Nevertheless, despite the potential that studying internalised stigma as a shared phenomenon can have on the stigma literature, research on the phenomenon has predominantly focused on one single group at a time. Consequently, it has not been possible to determine the extent to which the effect of internalised stigma varies across groups with existing group-specific measures.

It is probable that the deficit of internalised stigma research studying multiple groups is explained by the absence of a scale that can measure internalised stigma across different populations. Currently, there are independent scales for internalised homophobia (Herek et al., 2009), internalised racism (Campón & Carter, 2015; James, 2021), internalised weight bias (M. S. Lee & Dedrick, 2016; Meadows & Higgs, 2019), and internalised classism (Mickelson & Williams, 2008). However, there is no common internalised stigma scale that can be utilised across all these or other groups.

Although there has been one attempt to integrate an internalised stigma measure across multiple groups, the scale presents fundamental shortcomings for the purposes of this thesis. The Self-Stigma Scale (SSS, Mak & Cheung, 2010) was developed to study internalised stigma among people with stigmatised identities or characteristics that can be concealable. Even when the SSS has been a valuable tool for scholars, specifically when studying people with stigmatised health conditions that can be concealable (see J. Li et al., 2017; Wu et al., 2015), its particular attention to concealable stigmas restricts its utility in research aimed at comparing various groups. Some items in the scale were not suitable for the purposes of this study, particularly those that explicitly refer to the ability to hide features or keep the stigmatised

identity as a secret. The inapplicability of these items to the objectives of this research demanded the development of a new scale for this thesis.

An additional limitation of the SSS is that, during its development, the authors validated the scale separately for each group in different studies and did not employ it for comparative analyses across multiple stigmatised groups within a single study (Mak & Cheung, 2010). Thus, research to date has not systematically studied internalised stigma across a variety of groups to address its commonalities and differences as intended in this research.

When internalised stigma is directed at the self and at the group

Probably due to researchers using different internalised stigma scales per group, the construct has not been conceptualised in comparable ways. Particularly, existing research has not systematically distinguished that internalised stigma can be directed to the self or one's own group (Ciaffoni et al., 2021; James, 2021). As reviewed previously, self-focused internalised stigma (SIS) takes the form of self-devaluing beliefs, while group-focused internalised stigma (GIS) is closer to prejudiced attitudes towards the own group or people sharing the same stigmatised characteristic (James, 2021). This two-folded dimension of internalised stigma addresses a meaningful conceptual difference and requires to be included in the development of a new scale.

Even though SIS and GIS have been distinguished when researching some stigmatised groups, including gay men (Ciaffoni et al., 2021) and Black people (James, 2021), the distinction has not been consistent in the study of other populations. In addition, the statements used to measure SIS and GIS change across the various group-specific scales. Therefore, there is still uncertainty regarding the role of SIS and GIS in their relationships with well-being and health outcomes across multiple groups. Although there is initial evidence about the differentiated effects of SIS and GIS for gay men (Ciaffoni et al., 2021), it has not been possible

to study this among other groups. In the study presented in this chapter, I aim to develop and validate a scale that measures internalised stigma across groups and that can assess both SIS and GIS. Such a scale will not only allow this thesis to understand potential differences in the antecedents of internalised stigma but will also benefit future research on understanding their particular role in explaining the health and well-being consequences of stigma.

The role of stigma characteristics: Perceived concealability and mutability

Without an integrated internalised stigma scale that can be utilised across groups, previous research has not been able to systematically analyse if some stigmatised populations present higher levels of internalised stigma compared to others. Considering that one of the research aims of this thesis is to compare groups, I address this gap in this chapter by developing and validating an integrated scale. Afterwards, I use this scale to analyse internalised stigma differences across multiple minoritised groups that vary in stigma characteristics. Particularly, in line with Chapter II, I focus on the role of perceived concealability and mutability.

Concealability is the capacity -or its expectations- to hide the features associated with one's stigmatised identity or group membership (Jones et al., 1984; Pachankis et al., 2018). Although there is no discrete division between concealable and non-concealable stigmas, it is possible to classify groups according to their perceived concealability. For example, sexual orientation and social class are socially perceived to be more concealable compared to body weight or racial identity (Pachankis et al., 2018).

Although not much is known about the association between concealability and internalised stigma, it is possible to hypothesise that people with more concealable stigmatised features experience heightened internalised stigma levels compared to people with less concealable features. Perceived concealability is linked to specific strategies of coping when

facing discrimination: for example, an individual might think they must hide their identity or avoid situations where their identity can be revealed (Quinn & Earnshaw, 2013). These strategies for managing concealment are associated with adverse health outcomes (Thoits & Link, 2016) and, consequently, may also be linked to internalisation processes. Consistent with this perspective, research indicated that individuals with perceived concealable stigmatised identities (such as LGB and working-class individuals) reported higher levels of internalised stigma compared to groups with non-concealable stigmatised identities (such as people of colour and women) who experienced similar levels of discrimination (Blankenship, 2019). However, in this study, collective self-esteem was used as a proxy for measuring internalised stigma, although these constructs are not necessarily equivalent. Further investigation is necessary to explore potential differences in internalised stigma between individuals with concealable versus non-concealable stigmatised identities. Building on the theoretical framework and findings of Blankenship (2019), it is possible that groups characterised by high socially perceived concealability may face heightened risks of internalising stigma compared to groups with lower perceived concealable characteristics – a hypothesis that the study presented in this chapter aims to test.

The second stigma characteristic addressed in this thesis is mutability, which refers to the possibility —or societal expectations— that individuals can alter the stigmatised attributes tied to their identity or group (Jones et al., 1984; Pachankis et al., 2018). For instance, social class and body weight are often perceived as features that can be changed in the future (Pachankis et al., 2018).

There is limited knowledge about the influence of perceived mutability on the internalisation of stigma. Nevertheless, I can hypothesise that individuals with perceived mutable stigmatised identities may experience greater levels of internalised stigma than those whose stigmatised identities are less mutable. First, prejudice and discrimination against people

with perceived mutable stigmas might be more widely accepted or justified, given that these traits are perceived as changeable rather than permanent (Solanke, 2021). Second, experiencing discrimination could activate self-blame beliefs: the responsibility for stigma experiences may be attributed to the individual rather than societal factors (Himmelstein et al., 2020).

To explore group-level differences in internalised stigma explained by perceived concealability and mutability, this chapter's study examines members of four minoritised groups that society typically regards as varying in these two stigma characteristics. By doing so, I aim to distinguish the effects of perceived concealability and mutability at the group level and determine whether these factors account for systematic differences in internalised stigma.

Internalised stigma measurement in Spanish- and English-speaking countries

Although there have not been extensive efforts in cross-cultural stigma research, some preliminary studies have explored differences in stigma between countries. For instance, one study identified both notable differences and similarities between France and Mexico in the context of weight stigma (Rojas-Sánchez et al., 2022). Although Mexican participants reported higher levels of felt stigma and stigma concerns, the mechanisms linking perceived discrimination to internalised stigma and physical activity were similar across both samples. The authors suggested that globalisation in countries like Mexico could explain the elevated levels of weight stigma in that sample. Globally circulated media images that idealise slender bodies conflict with the reality of diverse body sizes, with these limited standards of beauty being especially harmful to the population. However, this explanation is insufficient, as it does not clarify why the effect is stronger in Latin American countries compared to Europe. The authors also emphasised the need for more research on cross-country differences in the psychosocial processes associated with stigma, particularly in the Global South (Rojas-Sánchez et al., 2022).

Although these results show the potential of cross-cultural approaches in stigma research, more research focusing on internalised stigma is needed. In fact, internalised stigma has been considerably understudied in non-English speaking countries, particularly outside of Europe. This lack of attention is mirrored by the limited availability of scales to measure internalised stigma in these regions. For instance, while there are a few recently developed scales in Spanish for internalised homophobia (Gómez et al., 2023) and weight bias (Sarrías-Gómez & Baile, 2015), there are no equivalent measures for internalised racism or classism. For the objectives of this thesis that focuses on stigmatised groups in Chile, developing a scale in Spanish becomes a central task.

In addition, and because of the scarcity of internalised stigma scales in Spanish, developing the scale in English would support the scale development with a more extensive availability of existing group-specific scales. Moreover, developing the scale in English will contribute to cross-cultural research by including two languages in the new measure. A multiple-language approach to scale development broadens the reach of internalised stigma research in multiple contexts and facilitates cross-country comparisons.

In this chapter's study, I developed an internalised stigma scale in both English and Spanish, using it to investigate differences in internalised stigma across four groups, distinguished by perceived stigma concealability and mutability, in two countries: the UK and Chile. Compared to the UK and other European nations, Chile has been slower in developing and enforcing anti-discrimination laws and policies (Sánchez González, 2020) and is marked by significant socioeconomic inequality and segregation (Fernández et al., 2016). Focusing specifically on the Gini index, Chile (45.3 in 2017; 43.0 in 2022) has exhibited higher levels of income inequality compared to the UK in the last decade (32.6 in 2017; 33.1 in 2021; *World Bank Open Data*, n.d.). Given these contextual factors and the research aims of this thesis, Chile and the UK were chosen as appropriate settings for developing a new internalised stigma

measure in both Spanish and English. Based on evidence that internalised stigma is influenced by sociocultural factors and national differences—and that internalised stigma tends to be higher in countries less accepting of marginalised groups (Pachankis et al., 2021)—I hypothesise that levels of internalised stigma may be higher in Chile compared to the UK.

The current study

The present study sought to address key gaps in the literature on internalised stigma. Specifically, my goal was to create and validate a new internalised stigma measure that can be applied across various groups and includes two subscales in two different languages. I refer to this instrument as the Multiple-Group Internalised Stigma Scale (MGISS). In this study, I recruited individuals from four marginalised groups, chosen based on Pachankis et al.'s (2018) categorization of social perceptions of concealability and mutability: working-class (high concealability, high mutability), LGB (high concealability, low mutability), higher-body weight (low concealability, high mutability), and racially minoritised (low concealability, low mutability) groups, in both English- and Spanish-speaking countries (the UK and Chile). Racially minoritised people were Black people in the UK and Indigenous people in Chile because of being representative groups that experience parallel forms of racism in each context.

Although other groups could have been considered to reflect different combinations of social perceptions of concealability and mutability, the four selected groups have been widely studied in the stigma and health literature and possess existing group-specific internalised stigma scales, making them ideal candidates for this measurement study. Using this sample, I (a) identified the scale's factor structure, (b) evaluated its reliability and validity, taking into account internal consistency, as well as concurrent and predictive validity, and (c) used the scale to examine differences in internalised stigma between groups based on two stigma characteristics (concealability and mutability) and country (UK and Chile).

To achieve the third objective (c), I formulated two hypotheses regarding stigma characteristics. This approach allowed us to assess the scale's effectiveness in comparing groups and increased transparency by laying out my initial expectations about group differences. I hypothesised that internalised stigma levels would be higher among groups with stigmatised characteristics considered by society to be more concealable compared to those with less concealable characteristics. Additionally, I hypothesised that groups with stigmatised characteristics viewed as more mutable would experience higher levels of internalised stigma than those with less mutable characteristics.

Methods

Scale development

I aimed to develop a scale that integrated existing measures and research on internalised stigma. However, since all available scales contain group-specific references (e.g., being a Black person), I selected items from previous measures that could be easily adapted for use across different groups, modifying only one word or phrase related to the specific group when adapting the items for the new scale. The scale presented in this study contains items that can be answered by individuals from different social groups with only a single word change in each item depending on the individual responding the question. For instance, the item "I wish I were not a member of my race" from the POC Internalized Oppression Scale (Campón & Carter, 2015) was adapted into "I wish I were not…", where the underlined word varies depending on the respondent's group membership (e.g., overweight, LGB, Black/Indigenous, and working-class). Other possible words to adjust include the social category mentioned (e.g., body weight, sexual orientation, skin colour, and social class) and the outgroup reference (e.g., thin, straight, white, and upper class).

Initially, 30 items were chosen and incorporated into the new scale by adapting content from the Weight Self-stigma Measure (Durso & Latner, 2008, used in M. S. Lee & Dedrick, 2016), the POC Internalized Oppression Scale (Campón & Carter, 2015), Internalized Sexual Stigma (Herek et al., 2009), and the Internalized Stigma of Poverty (Mickelson & Williams, 2008).

Participants and procedure

With the objective of developing and evaluating the scale in both Spanish and English across two distinct cultural settings, I conducted a cross-sectional study in Chile and the UK. To determine the sample size, I followed the general guideline of having at least 200 participants for exploratory factor analysis (EFA) (de Winter et al., 2009). A total of 238 adult participants were recruited using a purposive sampling design with a minimum of 50 participants per group across four groups that are generally considered by society to vary in the stigma characteristics of concealability and mutability: working-class (high concealability and high mutability), LGB (high concealability and low mutability), higher-body weight (low concealability and high mutability), and Black individuals in the UK and Indigenous individuals in Chile (low concealability and low mutability). For LGB individuals, both the eligibility criteria and the focus of the measurement pertained to sexual orientation (being gay, lesbian, or bisexual), rather than gender identity. Similarly, for racial minority individuals, the eligibility criteria and the focus of the measurement were restricted to Black individuals in the UK and Indigenous individuals in Chile, excluding other racial or ethnic minorities, as stigma experiences and characteristics may differ among different groups.

Participants self-reported their category membership because their self-identification with each group further shaped how the measure was presented. They also had to be members of only one of the groups so they could respond to only one form of the measure unique to the

group they belong to. The only exception to this condition was for individuals from other racial or ethnic minorities who were not Black (in the UK) or Indigenous (in Chile) but belonged to one of the other targeted groups. For example, an Asian individual who identified as LGB would have been included in the study and answered questions related to sexual minority stigma. Further details about the sample characteristics are provided in Table III.1.

Recruitment took place online through social media platforms (Twitter, Facebook, and Reddit) and Prolific (2024). To incentivise participation, people who completed the survey received CLP 2.000 in Chile or GBP 2 in the UK via an electronic voucher for people recruited from social media and via Prolific for people recruited from that platform. Initially, the recruitment strategy was planned to be conducted only via social media, but the low response rate made it necessary to use an additional strategy, in this case, Prolific. The recruitment and data collection process occurred between June and December 2021. This study was fully approved by the UCL Institute of Education Research Ethics Committee.

Table III.1

Sample characteristics in the measurement study

	n (%)
Demographics	Study 1
Age, *M* (range, *SD*)	30.3 (18-73, 10.2)
Gender[a]	
Woman	125 (52.5%)
Man	106 (44.5%)
Nonbinary/Other	9 (3.8%)
Group	
LGB	63 (26.5%)
Black (UK) / Indigenous (Chile)	54 (22.7%)
Higher-body weight	63 (26.5%)
Working-class	58 (24.4%)
Country	
UK	132 (55.5%)
Chile	106 (44.5%)
Education	
Secondary ed.	44 (20.0%)
Short-cycle tertiary	28 (12.8%)
Bachelor's degree	99 (45.2%)
Postgraduate degree	46 (21.0%)

Note. a: Participants were allowed to mark more than option. Only two marked more than one.

Measures

Demographics. Sexual orientation was asked through a multiple-choice question that included the options "straight," "gay," "lesbian," "bisexual," "pansexual," "queer," and "something not listed." Race was categorised with the choices "White," "Black," "Indigenous," "Asian," "Mixed," and "something not listed." For body weight and social class, participants were required to self-identify to establish a clear distinction between groups. To achieve this,

and following self-perception questions similar to those used in the National Health and Nutrition Examination Survey (NHANES, see Kwak et al., 2021), respondents were asked whether they considered themselves to be overweight and whether they identified as working-class, with yes or no response options. Additionally, participants provided information on their income, education level, and perceived socioeconomic status.

Multiple-Group Internalised Stigma Scale (MGISS). All participants completed the new 30 internalised stigma items. The survey was programmed in a way that the items remained the same for everyone, with only a part of each item being modified depending on the participant's self-identified group. Table III.2 presents the specific items initially used for the scale. Agreement with each item was rated using a 7-point Likert scale, ranging from "strongly disagree" to "strongly agree."

Existing group-specific internalised stigma scales. To test concurrent criterion validity of the developed scale, I included four internalised stigma scales, each corresponding to a specific group. These scales were respectively presented according to the participant's self-identified group. Individuals with higher-body weight completed the Weight Bias Internalization Scale (M. S. Lee & Dedrick, 2016, Spanish version by (Sarrías-Gómez & Baile, 2015), which contained ten items (e.g., "I hate myself for being overweight"; Cronbach's alpha was .93). LGB participants completed the Revised Internalized Homophobia Scale (Herek et al., 2009, Spanish version by Gómez et al., 2023), which included five items (e.g., "I wish I weren't LGB"; Cronbach's alpha was .73). The wording of items for LGB participants specifically referred to sexual orientation and did not address gender identity. Black individuals in the UK and Indigenous individuals in Chile completed the Appropriated Racial Oppression Scale (Campón & Carter, 2015), and since no Spanish version was available, a translation was done for this study. This scale included 32 items (e.g., "I feel that being a member of my racial group is a shortcoming"; Cronbach's alpha was .94). Finally, working-class participants

completed the Internalized Stigma of Poverty measure (Mickelson & Williams, 2008), which was also translated into Spanish for this study, containing three items (e.g., "There have been times when I have felt ashamed because of my financial situation"; Cronbach's alpha was .75). A 7-point Likert scale of agreement was used for all scales.

The primary criterion for selecting existing scales for this study was that they were validated in both English and Spanish. For LGB and higher-body-weight populations, only one validated scale per group was available in both languages: the Revised Internalized Homophobia Scale and the Weight Bias Internalization Scale, respectively. For racially minoritised populations, no validated Spanish-language scale was available; thus, the secondary selection criterion was identifying a scale developed for broader racially minoritised groups, suitable for use with both Black and Indigenous populations. Although multiple scales measuring internalised racial oppression exist for specific groups (David et al., 2019), the Appropriated Racial Oppression Scale was chosen because it was specifically designed for general populations of colour, including Black and Indigenous individuals. Similarly, for working-class populations, no validated Spanish-language scale existed, and only one scale explicitly measuring internalised forms of social class stigma was available—the Internalized Stigma of Poverty Scale—which was consequently selected for use in this study.

Felt stigma. This scale was originally developed by Link (1987) to study perceived stigma among people with mental health conditions. Meyer et al. (2008) later adapted the scale for its use on individuals from various stigmatised groups, making it suitable for multiple group applications. It consists of 7 items (e.g., "Most people think less of someone like me") that address participants' beliefs about existing social perceptions of "someone like them". The instructions clarify that "someone like them" refers to the participant's specific social group, as previously reported. As with other measures, participants responded using a 7-point Likert scale of agreement. Cronbach's alpha was .87.

Psychological distress, K10. I utilised the Kessler-10 scale to evaluate psychological distress (Kessler et al., 2002). Participants reported the frequency of experiencing feelings described in 10 items, such as "nervous," "hopeless," and "worthless," on a 5-point Likert scale. Cronbach's alpha was .92.

Analysis

Factor structure. I carried out an exploratory factor analysis (EFA) on the complete set of 30 items used to develop the MGISS, incorporating parallel analysis to determine the appropriate number of factors to extract. Afterwards, I applied item retention rules (items with communalities greater than .5, primary factor loadings above .4, and cross-loading differences under .2; Worthington & Whittaker, 2006) and checked for correlated residuals (Ferrando et al., 2022). Additionally, a confirmatory factor analysis (CFA) was performed on the final structure of the scale as well as on the original set of items, testing both one- and two-factor models to compare fit indices.

Lastly, I tested for measurement invariance across both languages and groups. In terms of differences between marginalised groups, and aligned with current discussions about over-reliance on measurement invariance as a requirement for group comparisons (Robitzsch & Lüdtke, 2023), I acknowledge that some variance in measurement structures is expected and normal, as it will be discussed later.

Internal consistency reliability. Cronbach's alpha was calculated for the final set of items for each factor, following the interpretation guidelines from Ponterotto and Ruckdeschel (2007).

Validity. Concurrent criterion validity of the scale was evaluated by examining correlations (Lin & Yao, 2014) between the MGISS and existing group-specific internalised stigma measures. Predictive validity was also examined through correlations and regressions

(Lin & Yao, 2014) between the MGISS and both the felt stigma and psychological distress measures.

Group differences. To compare levels of internalised stigma across groups and countries, I used two-way analysis of variance (ANOVA). Additionally, three-way ANOVA was employed to compare internalised stigma as a function of the two stigma characteristics (perceived concealability and perceived mutability) and country. Although both analyses are similar, they are conducted using the same dataset but with different grouping variables. The two-way ANOVA looks at mean values disaggregated by each of the four groups, while the three-way ANOVA focuses on the combination of high- and low-concealability and mutability, allowing for testing the main effects of both stigma characteristics. I opted to conduct both analyses because the two-way ANOVA underscored the scale's use for comparing multiple groups with distinct social identities, while the three-way ANOVA directly tested my hypotheses related to stigma characteristics.

Parallel analysis and CFA were performed using R software, while all other analyses were carried out using SPSS 27.

Results

Factor structure

To evaluate the factorability of the scale within this sample, I computed the KMO measure of sampling adequacy and Bartlett's Test of Sphericity. The results showed a KMO value of .95 and Bartlett's $\chi^2(435) = 5153$, $p < .001$, indicating that the data were suitable for factor analysis (Worthington & Whittaker, 2006). Parallel analysis suggested that two factors should be retained (see Appendix III. 1). Based on this outcome, I proceeded with an EFA constrained to a two-factor solution. The factor loadings for all items are displayed in Table III.2.

Using the item retention criteria, a preliminary set of 19 items was kept: 14 for the SIS subscale and 5 for the GIS subscale. The absence of additional subdimensions within the SIS subscale, along with its larger number of items relative to the GIS subscale, led me to investigate correlated residuals within this subscale. An initial CFA with the 19 items produced suboptimal fit levels (CFI = 0.90; RMSEA = 0.11; SRMR = 0.06) and revealed issues tied to accumulated correlated residuals, likely caused by the high similarity in meaning among the items in the SIS subscale (see Bandalos, 2021 for discussions on error related to similar items). To prevent overreliance on CFA results and maintain the scale's parsimony, I reduced the SIS subscale by half, cutting down on correlated residuals and balancing the number of items across both subscales. Following the same EFA-based item retention rules, I kept the seven items with the highest factor loadings from the SIS subscale.

Table III.2

Items and factor loadings of the Multiple-Group Internalised Stigma Scale (MGISS)

N°	Items	1	2
1	**I wish I could change my {field}.**	.88	.28
2	There is nothing I would change about my {field}. (R)	.76	.12
3	At times I would like to be {c-group}.	.77	.31
4	**I would not change my {field} even if I were given a chance. (R)**	.81	.14
5	Sometimes I think that if I were {c-group}, I could be happier.	.69	.26
6	**If someone offered me the chance to be {c-group}, I would accept.**	.80	.33
7	**I wish I weren't {group}.**	.85	.27
8	**There is nothing about my {field} that I would like to be different. (R)**	.80	.18
9	I embrace my {field} as it is. (R)	.79	.26
10	I hate myself because of my {field}.	.57	.44
11	**I am OK being the {group} person that I am. (R)**	.80	.34
12	I resent my {field}.	.78	.33
13	Because I am {group}, I don't feel like my true self.	.52	.50
14	I feel embarrassed about my {field}.	.69	.29
15	**I am glad to be {group}. (R)**	.82	.29
16	I deserve the same things in life as {c-group} people. (R)	.28	.58
17	I believe that being {group} is as fulfilling as being {c-group}. (R)	.69	.42
18	I feel that being {group} is a personal shortcoming.	.58	.50

19	As a {group} person, I deserve the respect of others. (R)	.31	.54
20	Life should be harder for me because of my {field}.	.11	.52
21	My {field} will hold me back in life.	.42	.33
22	My life will be just as fulfilling as someone who is {c-group}. (R)	.56	.46
23	I am proud of other {group} people. (R)	.59	.39
24	**{c-group} people are better at a lot of things than people of my {field}.**	.33	.70
25	**People of my {field} don't have much to be proud of.**	.24	.69
26	**{group} people are responsible for society's negative perceptions of them.**	.00	.71
27	It is a compliment to be told "You don't act like a typical person of your {field}".	.18	.55
28	**I don't like people associating me with other {group} people.**	.36	.66
29	**I feel that being similar to other people of my {field} is a shortcoming.**	.39	.68
30	When I think of other {group} people, I am glad we share a similar field}. (R)	.64	.31

Note. {field}: sexual orientation, skin colour, body weight, social class. {group}: LGB, Black, overweight, working-class. {c-group}: straight, white, thin, upper class. (R): Item with reversed score. (Item in bold): Item included in the final scale.

Next, I conducted a CFA (see Table III.3) with the final version of the scale (12 items across two subdimensions) and compared this model to an alternative 1-factor model using the same items. Additionally, two further models using all items were tested—one with a 1-factor solution and another with a 2-factor solution, following the originally hypothesised structure. The final 12-item structure achieved acceptable fit levels and performed better compared to the three alternative models. Full results of the CFA are presented in Table III.3, and appendices of the thesis include detailed information on the factor structure analyses, encompassing parallel, exploratory (Appendix III. 2), and confirmatory factor analyses (Appendix III. 3).

The scale showed acceptable to strong levels of configural invariance across languages, as well as borderline to acceptable levels of metric, scalar, and strict invariance (see Table III.4). In terms of group invariance, configural invariance indices were slightly below acceptable thresholds but were near the acceptable range (see Table III.5).

Table III.3

Confirmatory Factor Analysis

	Indices of fit					χ^2 Difference Test		
Model	χ^2	*df*	CFI	SRMR	RMSEA	AIC	BIC	χ^2 difference
Final	107.54**	53	.97	.05	.07	8732	8816	
Alternative 1	274.85**	54	.88	.10	.14	8898	8978	164.41**
Alternative 2	1410.06**	404	.80	.07	.11	21705	21908	
Alternative 3	1521.15**	405	.78	.08	.12	21814	22014	111.09**

Note. Final model: 12 items and 2 factors. Alternative model 1: 12 items and 1 factor. Alternative model 2: 30 items and 2 factors. Alternative model 3: 30 items and 1 factor. CFI = comparative fit index, SRMR = standardised root mean square residual, RMSEA = root mean square error of approximation, AIC = Akaike information criterion, BIC = Bayesian information criterion. $^{**}p < .01$.

Table III.4

Measurement invariance across languages (English and Spanish)

	Indices of Fit						χ^2 Difference Test			
Model	χ^2	*df*	CFI	SRMR	RMSEA	MC	$\Delta\chi2$ (Δdf)	Δ CFI	Δ RMSEA	Δ SRMR
1. Configural invariance	183.073**	106	.96	.057	.084					
2. Metric invariance	196.477**	116	.958	.071	.082	1	13.40 (10)	-0.002	-0.002	0.014
3. Scalar invariance	206.452**	126	.958	.074	.078	2	9.98 (10)	0	-0.003	0.003
4. Strict invariance	245.562**	138	.944	.073	.087	3	39.11** (12)	- .01	.008	-.001

Note. N = 208, English = 111, Spanish = 97. CFI = comparative fit index, SRMR = standardised root mean square residual, RMSEA = root mean square error of approximation. MC = Model comparison reference. $^{**}p < .01$.

Table III.5

Measurement invariance across groups (LGB, Black or Indigenous, higher-body weight, and working-class)

Model	Indices of Fit				
	χ^2	*df*	CFI	SRMR	RMSEA
1. Configural invariance	327.13**	212	.89	.09	.102

Note. N = 208, LGB = 55, Black or Indigenous = 52, higher-body weight = 56, working-class = 45. Configural invariance under level of acceptance, next models not tested. CFI = comparative fit index, SRMR = standardised root mean square residual, RMSEA = root mean square error of approximation. **$p < .01$.

Reliability

I computed Cronbach's alpha for each subdimension as well as for the overall scale. The final 7-item SIS subscale demonstrated excellent internal consistency (α = .95), while the 5-item GIS subscale showed good internal consistency (α = .83). The combined 12-item internalised stigma scale also exhibited excellent internal consistency (α = .93). Additionally, when evaluating reliability within each group and country subsample, all Cronbach's alpha values ranged from moderate to excellent (see Table III.6).

Table III.6

Cronbach's alphas (α) for final 12-item scale, disaggregated by group and by country

Grouping variables	SIS α	GIS α	Full scale α
Group			
LGB	.75	.70	.79
Black (UK) / Indigenous (Chile)	.80	.81	.83
Higher-body weight	.86	.81	.86
Working-class	.85	.79	.85
Country			
UK	.95	.87	.93
Chile	.95	.78	.93

Note. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma.

Validity of the measure

To evaluate concurrent validity for the SIS and GIS, I calculated Pearson correlations between these subscales and existing scales designed to measure self-focused and group-focused internalised stigma. Since participants only identified with one group, separate correlations were conducted for each subsample, comparing the previously established group-specific scale to the SIS and GIS. These results are summarised in Table III.7, and, as illustrated, the SIS and GIS exhibited moderate to strong, statistically significant associations with the existing scales, providing solid evidence of concurrent validity.

Table III.7

Pearson correlations between existing group-specific scales (rows) and new scales (columns)

	n	SIS	GIS
Weight Bias Internalization Scale (Lee & Dedric, 2016)	54	.69**	.68**
Revised Internalized Homophobia Scale (Herek et al., 2009)	55	.69**	.32*
Appropriated Racial Oppression Scale (Campón & Carter, 2015)	51	.51**	.64**
Internalized Stigma of Poverty (Mickelson & Williams, 2008)	45	.60**	.50**

Note. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. $^{*}p <$ .05. $^{**}p <$ .01.

I also conducted Pearson correlations between the new scales and related constructs to assess predictive validity. For this analysis, correlations were calculated using the full sample. The SIS and GIS both demonstrated significant, medium-sized associations with felt stigma and psychological distress, aligning with the hypotheses. These findings, summarised in Table III.8, provide good evidence supporting the predictive validity of the new scale.

Table III.8

Pearson correlations between new scales, felt stigma, and psychological distress

	N	*M*	*SD*	1	2	3	4
1. SIS	216	3.75	2.00	-			
2. GIS	209	2.55	1.31	.60**	-		
3. Felt stigma	204	5.13	1.12	.22**	.35**	-	
4. Psychological distress	203	2.34	0.87	.39**	.32**	.31**	-

Note. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. **$p <$ .01.

To further explore the relationships between these variables, I performed a multiple linear regression to assess how psychological distress is affected by two stigma experiences: internalised stigma and felt stigma. In the regression model, the two subscales of internalised stigma were entered in the first step, followed by felt stigma in the second step. As shown in Table III.9, Step 1 revealed that SIS was significantly and positively associated with psychological distress, whereas GIS was not. In Step 2, after adding felt stigma to the model ($\Delta R^2 = .05$, $p = .001$), the pattern persisted: SIS remained significantly positively associated with psychological distress, felt stigma was also significantly positively associated with psychological distress, and GIS remained non-significant. These associations were held even after controlling for group, age, and sex (refer to Appendix III. 4 for analyses including controls). The model did not present issues of multi-collinearity, with all VIFs below 5 (Kutner et al., 2005).

Table III.9

Regression Coefficients with Psychological Distress as dependent variable

		B	95% CI	β	*t*	*p*	R^2
1	Model Fit						.16
	(intercept)	1.61	[1.35, 1.87]		12.10	<.001	
	SIS	0.13	[0.06, 0.20]	0.29	3.58	<.001	
	GIS	0.10	[-0.01, 0.20]	0.14	1.75	.08	
2	Model Fit						0.20
	(intercept)	2.64	[1.98, 3.30]		7.91	<.001	
	SIS	0.13	[0.06, 0.20]	0.29	3.66	<.001	
	GIS	0.04	[-0.06, 0.15]	0.07	0.78	.44	
	Felt stigma	0.17	[0.07, 0.28]	0.23	3.34	<.01	

Note. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma.

Group differences

I hypothesised that groups perceived as more concealable by society would exhibit higher levels of internalised stigma compared to those seen as less concealable. Additionally, I expected that groups considered to be more mutable would display greater levels of internalised stigma compared to those viewed as less mutable.

To explore group differences in internalised stigma levels, I conducted two- and three-way ANOVAs. For the two-way ANOVAs, the grouping variables were the social group (LGB, Black/Indigenous, higher-body weight, and working-class) and country (UK and Chile). For the three-way ANOVA, the grouping variables were social perceptions of concealability (high vs. low), social perceptions of mutability (high vs. low), and country. To prevent redundant reporting, I present both types of ANOVA together, while independent full results are available in Appendix III. 5. Figures IV.1 and IV.2 illustrate the mean SIS and GIS levels, respectively, across social groups and countries.

SIS. In the two-way ANOVA, I found a significant main effect of social group, which accounted for 76% of the variance in SIS (F [3, 208] = 216.359, $p < .001$, $\eta p^2 = .76$). Bonferroni post-hoc tests revealed that the Black (UK)/Indigenous (Chile) group (M = 1.84, SE = 0.14) and LGB group (M = 2.34, SE = 0.13) did not significantly differ from one another. However, both groups reported significantly lower SIS levels than the higher-body weight group (M = 5.80, SE = 0.13) and the working-class group (M = 5.14, SE = 0.14), who also significantly differed from each other.

The three-way ANOVA tested my hypotheses more explicitly by organising groups based on combinations of the stigma characteristics of perceived mutability and concealability. A significant main effect of mutability emerged (F [1, 208] = 618.82, $p < .001$, $\eta p^2 = .75$): consistent with my expectations, groups with high perceived mutability (higher-body weight

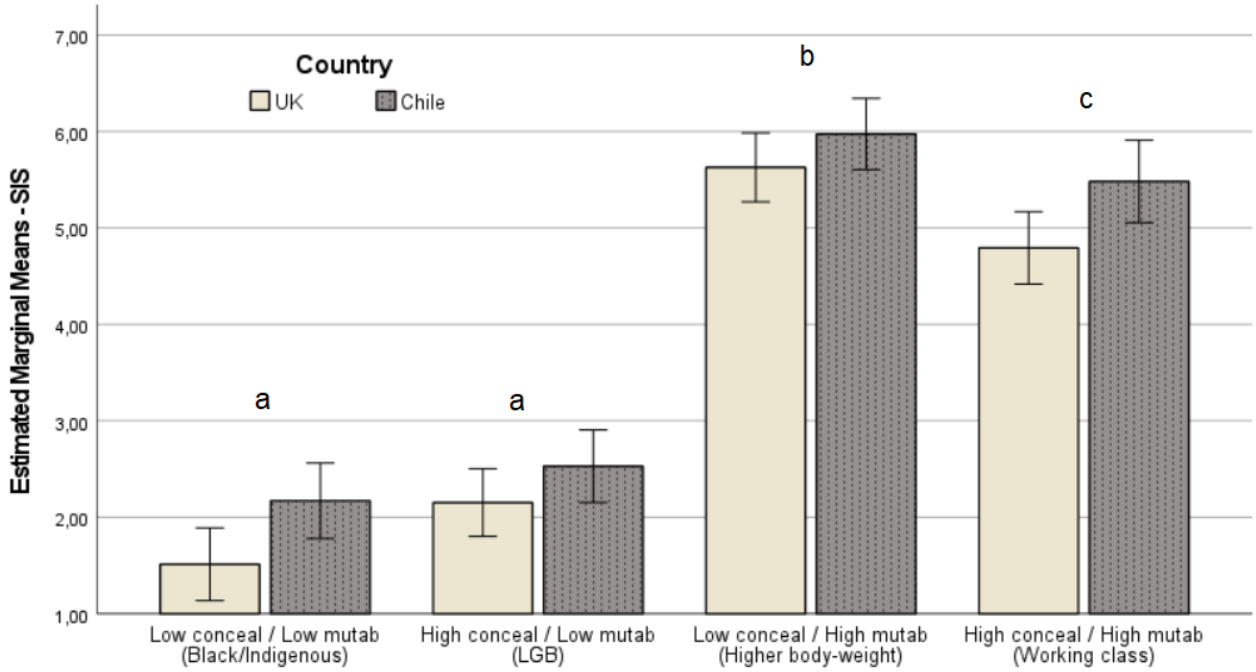
and working-class people; M = 5.47, SE = 0.10) reported higher SIS levels compared to perceived low-mutability groups (Black [UK]/Indigenous [Chile] and LGB people; M = 2.09, SE = 0.10).

Contrary to my predictions, there was no significant main effect of perceived concealability (F [1, 208] = .37, p = .544, ηp^2 = .002). Unexpectedly, however, there was a statistically significant interaction between perceived mutability and concealability (F [1, 208] = 18.284, p < .001, ηp^2 = .08). As illustrated in Figure III.1, concealability did not explain differences among groups with low perceived mutability, but it had a significant effect for groups perceived high in mutability. Contrary to the hypothesis, the low-concealability high-mutability group (higher-body weight individuals) reported significantly higher SIS levels compared to the high-concealability high-mutability group (working-class people).

Additionally, a significant difference in SIS levels was found based on country, with people in Chile reporting higher SIS (M = 4.04, SE = 0.10) compared to those in the UK (M = 3.52, SE = 0.09). However, this effect was smaller than that of social group, accounting for 7% of the variance (F [1, 208] = 14.526, p < .001, ηp^2 = .07). No significant interaction between social group and country was observed (F [3, 208] = 0.44, p = .722, ηp^2 = .01).

Figure III.1

Differences in SIS by social group and country



Note. Two-way ANOVA estimated marginal means of SIS by social group and country and 95% confidence intervals. Letters a, b, and c show post-hoc differences between social groups

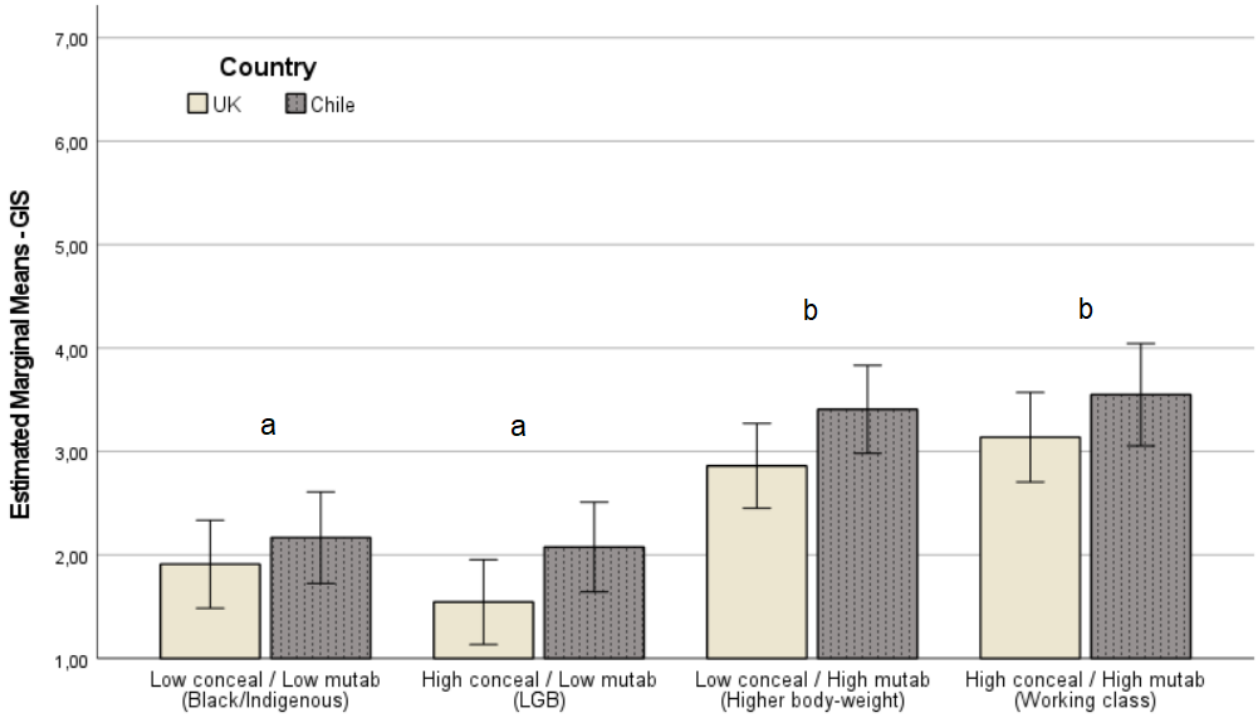
GIS. In the two-way ANOVA, there was a significant main effect of group on GIS (F [3, 201] = 24.163, p < .001, ηp^2 = .27), explaining 27% of the variance. In line with my hypothesis for social perceptions of mutability, Bonferroni post-hoc tests showed that groups low in mutability—Black (UK)/Indigenous (Chile) (M = 2.04, SE = 0.16) and LGB people (M = 1.81, SE = 0.15)—did not significantly differ from each other, but reported lower GIS levels compared to the high-mutability groups (higher-body weight (M = 3.14, SE = 0.15) and working-class people (M = 3.34, SE = 0.17)), who also did not significantly differ from one another.

The three-way ANOVA similarly showed a significant main effect of perceived mutability, explaining 26% of the variance (F [1, 208] = 70.932, p < .001, ηp^2 = .26). However, as with SIS, the pattern did not align with my predictions for perceived concealability. The three-way ANOVA did not reveal a significant main effect of concealability (F [1, 208] = 0.004, p = .951, ηp^2 < .01), nor was there a significant interaction between perceived mutability and concealability (F [1, 208] = 1.971, p = .162, ηp^2 = .01).

Additionally, GIS levels were higher among the Chilean participants (M = 2.80, SE = 0.11) compared to those in the UK (M = 2.36, SE = 0.11). The effect of country was smaller than the group effect, accounting for 4% of the variance (F [1, 201] = 7.823, p = .006, ηp^2 = .04). Lastly, no significant interaction between social group and country was observed (F [3, 201] = 0.19, p = .903, ηp^2 = .00).

Figure III.2

Differences in GIS by social group and country



Note. Two-way ANOVA estimated marginal means of GIS by social group and country and 95% confidence intervals. Letters a, b, and c show post-hoc differences between social groups

Discussion

In this chapter's study, I developed and validated the MGISS: an internalised stigma scale consisting of 12 items designed to explore and compare self-focused and group-focused internalised stigma across a variety of minoritised groups. The psychometric properties of the scale were evaluated using data from LGB, racially minoritised (i.e., Black [in the UK] and Indigenous [in Chile]), higher-body weight, and working-class participants, spanning both English- and Spanish-speaking contexts. The findings demonstrated that the scale and its subdimensions exhibited good to excellent levels of internal consistency. Additionally, I found evidence supporting the measure's concurrent and predictive validity: it showed strong associations with existing internalised stigma scales and was also linked to conceptually related variables such as felt stigma and psychological distress.

The final factor structure of the scale demonstrated an acceptable fit in two distinct samples and confirmed that internalised stigma can be measured using two subscales, SIS and GIS, in line with recent research findings (Ciaffoni et al., 2021; James, 2021). I observed that the relationship between internalised stigma and psychological distress was primarily driven by self-focused internalised stigma (SIS), whereas group-directed internalised stigma (GIS) did not significantly contribute to this relationship when accounting for SIS. These results are consistent with previous analyses showing that mental health issues are more strongly associated with SIS than GIS among gay men (Ciaffoni et al., 2021). It is plausible that negative beliefs aimed at the self are more damaging to mental health due to the closer connection between SIS and self-devaluation, a process that may undermine an individual's self-image and self-esteem. While my findings offer initial support for the hypothesis of differential

effects, future studies should continue exploring SIS and GIS to examine whether these two subdimensions are linked to distinct outcomes.

In terms of measurement invariance, I found that the scale demonstrated acceptable levels of structural equivalence between its English and Spanish versions, which suggests that the scale can be effectively used across different languages. Regarding group differences, there was no evidence supporting full measurement invariance[3]. Nevertheless, I do not interpret these findings as a shortcoming of the scale but rather as an indication of potential group differences and the specific nature of the stigma tied to their identities, which warrants further exploration. Recent scholars have critiqued the idea that measurement invariance is a necessary condition for using a scale across groups and making comparative analyses (Robitzsch & Lüdtke, 2023). In this study, near-acceptable levels of measurement invariance and consistent reliability across groups serve as preliminary evidence of the construct's equivalence. Future investigations should continue to examine the scale's commonalities and distinctions across different groups.

This research also uncovered significant group differences in internalised stigma levels, highlighting the analytical value of this new scale. Specifically, I found support for the hypothesis that groups with stigmatised characteristics that are socially perceived as mutable (higher-body weight and working-class individuals) exhibit higher levels of internalised stigma compared to those with characteristics perceived as less mutable (Black [UK]/Indigenous [Chile] and LGB individuals). This pattern was evident in both the SIS and GIS subscales, with large effect sizes, particularly for SIS. Based on the literature on stigma characteristics (Jones et al., 1984; Pachankis et al., 2018), it is possible to interpret that social perceptions of

[3] When testing measurement invariance in the scale with a larger sample (using the Longitudinal Study as a replication study, see Chapter V), I found borderline levels of configural and metric invariance in the scale. See Appendix III. 6 for replication analyses.

mutability acts as a risk factor for stigma internalisation. It may be the case that groups with perceived mutable stigmatised features not only face greater stigma but may also engage in maladaptive coping mechanisms like self-blame and the desire for change, which shift the responsibility for discrimination from society to the individual. Although more research is needed to better understand this process, these findings have important implications for how scholars conceptualise mutability in stigmatised identities and the harmful effects of social expectations around change. For example, mutability expectations might help explain the damaging effects of sexual orientation change efforts on sexual minorities (e.g., Dehlin et al., 2015).

Second, I did not find group differences in the stigma characteristic of perceived concealability. Although groups low in perceived concealability (Black [UK]/Indigenous [Chile] and higher-body weight people) presented higher levels of internalised stigma, on average, compared to groups high in perceived concealability (LGB and working-class people), this difference was not statistically significant. One possible explanation for this is the lack of statistical power to detect significance in this negligible difference[4]. The fact that I did not find evidence towards my hypothesis could also be explained by a dual dimension of concealability: on the one hand, it can create concealment concerns associated with internalisation processes; on the other, it may allow people to hide their identities avoiding discrimination and reducing the effects of stigma (Quinn, 2018). The scale developed here can allow for future research on the psychological mechanisms for these unexpected results.

[4] In fact, I was able to replicate these analyses in a bigger sample and found a small main effect of perceived concealability for both SIS and GIS (see Chapter V), in the direction of the descriptive difference found here (low concealability groups presenting higher levels of internalised stigma) and contrary to our initial hypothesis.

An especially unexpected finding emerged when examining group differences in SIS: I observed a meaningful interaction between group perceived mutability and concealability. The pattern of this interaction revealed that perceived concealability did not significantly relate to SIS among groups perceived low in mutability. However, perceived concealability was significantly linked to SIS among groups perceived high in mutability: the low-concealability, high-mutability group (higher-body weight individuals) exhibited higher SIS levels compared to the high-concealability, high-mutability group (working-class individuals). One plausible theoretical explanation could involve the role of high perceptions of mutability in amplifying the impact of discrimination on internalised stigma directed at the self. When perceived mutability is high, the increased discrimination faced by those with less concealable identities (Pachankis et al., 2018) may be perceived as being caused by the self rather than by societal factors, leading to higher internalisation of stigma. This may account for the higher SIS levels in the low-concealability, high-mutability group compared to their high-concealability, high-mutability counterparts. Conversely, when mutability is low, discrimination may be attributed more to societal factors rather than the self, shielding these individuals from further internalised stigma. This could explain why the low-concealability, low-mutability group exhibited similar SIS levels as the high-concealability, low-mutability group.

In terms of country-level differences in internalised stigma, there is evidence suggesting cultural differences between the two samples: the Chilean sample reported higher levels of internalised stigma than the UK sample. A possible explanation for this could be the differing levels of discrimination between Chile and the UK. Chile experiences high levels of social and residential segregation (Rasse Figueroa et al., 2021), and its anti-discrimination laws are more recent compared to those in the UK and Western Europe (Sánchez González, 2020). This might result in higher levels of perceived and experienced discrimination among marginalised groups

in Chile, contributing to elevated internalised stigma. Notwithstanding, my findings suggest that internalised stigma levels are more influenced by social group than by country.

The MGISS represents the first attempt to create a measure of internalised stigma that enables comparisons across different groups, and the results presented here demonstrate the scale's potential value for interdisciplinary research on stigma and mental health. Nonetheless, I do not anticipate that the MGISS will replace existing single-group scales. These may remain more suitable for within-group studies due to the way their items are tailored to capture the specific experiences of stigma. In fact, the results presented here highlight key group differences, demonstrating not only the value of the MGISS for comparative purposes, but also underscoring the importance of continuing focused research on individual groups to better understand the specific characteristics of internalised stigma within each.

The MGISS may be particularly beneficial for studies involving multiple marginalised groups, and its flexibility offers opportunities for research requiring both within-group and between-group comparisons (e.g., studies exploring social explanations for health disparities, S. Schwartz & Meyer, 2010). In addition, this new measure opens the door to research on stigmatised groups that have received less attention and for which no existing scale measures internalised stigma. By validating these items with less-studied populations, this scale can enable more efficient measure development and support future research on stigma internalisation among these groups.

Limitations and suggestions for research

As this study represents an initial effort to develop a measure of internalised stigma for various groups, some limitations should be acknowledged. The findings are constrained to the specific groups included in this research. Future studies should investigate whether the scale is applicable to other groups, such as gender minorities or individuals with physical disabilities.

Additionally, given that one of my hypotheses related to stigma characteristics yielded results contrary to expectations, future research would benefit from extending these findings to other populations that share similar characteristics (e.g., individuals with mental or physical health conditions that vary in social perceptions concealability and mutability). If the results are replicated, they would provide stronger evidence for the role of stigma characteristics; if not, further research would be needed to understand what explains the observed group differences.

One important limitation of the MGISS lies in the need to prioritise common dimensions of internalised stigma across populations to enable systematic comparisons. While this approach allows for cross-group analysis, it necessarily excludes group-specific aspects of stigma that may be relevant but are not shared across populations. As a result, the scale may overlook important nuances in how internalised stigma manifests within each group. Future research could benefit from incorporating multiple-group qualitative studies focused explicitly on describing the experiences and expressions of internalised stigma within each population. Such an approach would not only complement the MGISS by offering a deeper understanding of group-specific features but also provide context for interpreting the group differences observed in the quantitative findings.

Additional next steps following these results should be considering longitudinal and intersectional methods when examining internalised stigma, in line with the design of the following study in this thesis. Calls for greater attention to the role of time in stigma research (Earnshaw et al., 2022) indicate that longitudinal studies involving multiple groups are essential for understanding how internalised stigma affects health outcomes over time. Moreover, the study of internalised stigma should incorporate intersectional approaches that consider the coexistence of multiple stigmatised identities within a single individual (Earnshaw et al., 2021). Although the scale is not designed to measure intersectional forms of internalised stigma—given its focus on comparing different groups—it provides an initial foundation for

exploring how distinct forms of internalised stigma, such as internalised homophobia and internalised racism, may intersect in individuals with multiple marginalised identities. Future research grounded in intersectionality may focus on examining these within-subject associations or on developing new measures specifically tailored to capture the intersectional dimensions of internalised stigma.

In the next study presented in the following two chapters, I included longitudinal, mixed-methods, and intersectional approaches to address some of the remaining questions from this study. Considering the robust effect of stigma characteristics, I also included measures of subjective perceptions of concealability and mutability to assess if part of the effect I found in this study can be explained by the individual perception of how much the stigmatised features can be hidden or changed. In Chapter IV, the general design of the longitudinal study is presented, focusing on its first wave of measurement and conducting cross-sectional analyses of the data. In Chapter V, a deeper look is taken into the three waves of the study, using longitudinal analyses to explore internalised stigma changes over time.

Conclusion

Though this measurement study represents a preliminary step, it presents encouraging evidence of the reliability and validity of a new multidimensional internalised stigma scale. The MGISS shows significant potential for research focused on analysing internalised stigma across various groups and cultural contexts. Enabling more systematic comparisons between groups facilitates the integration of conceptual and methodological insights from diverse literature on marginalised populations. Additionally, the MGISS could enhance psychological research and interventions aimed at reducing internalised stigma and mitigating its harmful effects on the well-being of marginalised individuals.

CHAPTER IV

Understanding factors associated with internalised stigma among multiple groups

Introduction

Internalised stigma is a key component in the processes explaining health inequalities among different stigmatised populations (Gale et al., 2020; Pearl & Puhl, 2018). Moreover, internalised stigma has been associated with multiple negative wellbeing outcomes for people, including interpersonal relationships and community integration (Brehmer et al., 2024; Frost & Meyer, 2009). However, research in this field has yet to investigate the psychological and social processes that give rise to internalised stigma. Instead, most research has used internalised stigma as a predictor of these negative health outcomes or, to a smaller extent, as a mediator explaining the links between discrimination experiences and negative health outcomes (Magallares et al., 2017; Timmins et al., 2020). Because this phenomenon has been rather neglected as an outcome, less is known about the antecedents that can explain individual differences in levels of internalised stigma. Moreover, little effort has been made to understand how the process can be shared or not across different groups. Building on the scale developed in the previous chapter and its findings, this second study aims to take a first step toward addressing these problems. Using a cross-sectional design, I explored different factors associated with internalised stigma, including experiencing discrimination, social support, coping strategies, and different stigma characteristics by including multiple stigmatised groups.

Experiences of discrimination and internalised stigma

Although very little research has been conducted on the antecedents of internalised stigma, there are reasons to think that a relevant factor is discrimination experiences. As reviewed in the theoretical framework of this thesis, the stage model of self-stigma (Corrigan et al., 2006; Corrigan & Rao, 2012) might explain a positive association between

discrimination experiences and internalised stigma. This model states that, for applying stigmatising negative beliefs to themselves, people first need to be aware of the existence of stigma and then agree with those beliefs. However, this model has been developed focusing on stigma about mental health conditions and trying to understand barriers to the promotion of empowerment and life goal achievement in people with mental health problems (Corrigan & Rao, 2012), which makes it not necessarily applicable to other stigmatised groups. Still, through this model, I argue that the experience of discrimination operates as an indicator of societal stigma. By reinforcing a devalued status, experiencing discrimination might lead to more agreement with stigmatising beliefs.

The positive association between discrimination experiences and internalised stigma has been systematically found when studying the processes linking discrimination to health and well-being outcomes. Among LGB individuals, an increase in internalised homophobia partially mediated the positive link between experiencing prejudice events and psychological distress (Timmins et al., 2020). A similar result was found when studying higher-body weight people: an increase in internalised weight bias levels was found to have a mediational role in the positive association between discrimination experiences and depression and anxiety symptoms (Magallares et al., 2017). This mediating function has also been found when researching stigma about mental illnesses and other health conditions (e.g., H. Li et al., 2020; Vass et al., 2017).

This evidence enables me to directly hypothesise and test the relationship between experiences of discrimination and internalised stigma. However, as discussed in Chapter II, the assumption that greater experiences of discrimination result in increased internalisation of stigma has notable limitations. Specifically, it proposes a link without adequately accounting for underlying mechanisms or moderating factors at the individual and group levels. In this study, I have the opportunity both to empirically test the relationship between discrimination

experiences and internalised stigma and to explore additional factors that may influence this association.

The presented efforts studying the association between discrimination experiences and internalised stigma have further limitations. Core differences in study designs make the existing evidence less conclusive: previous research has focused on different groups using different measures of discrimination and internalised stigma. For example, Timmins and colleagues (2020) found the association using a latent variable made of measures of heterosexist experiences and microaggressions, while Magallares and colleagues (2017) used a different scale with two subdimensions, including blatant and subtle discrimination. By focusing on multiple groups with the newly developed internalised stigma scale (MGISS), in this study, I was able to study multiple groups using the same discrimination experiences scale.

Particularly, I focused on two dimensions that have been studied among multiple populations: major life events of discrimination and daily discrimination (Williams et al., 1997). As presented in the theoretical framework of this thesis, major life events are those severe experiences of discrimination, such as being assaulted. On the other hand, daily discrimination refers to everyday exposure to stigmatising situations, such as being overly stared at. I focused on these two forms of discrimination in line with previous stigma research because they directly address acute and chronic sources of stigma-related stress (Frost, 2011a).

Reacting and framing discrimination events: A narrative approach

It is unclear whether internalised stigma is mainly explained by experiencing discrimination or rather by the way people appraise and react to such events. In fact, how people appraise discrimination events (for example, as being more global and severe in their lives) was found to be associated with lower self-esteem (Eccleston & Major, 2006). However, it is not evident if these appraisals have a similar function in their relationship with internalised

stigma. This study brings an opportunity to explore the association that different appraisals of a recent discrimination event can have with internalised stigma.

The way people narrate past experiences can also have an impact on their present (Adler et al., 2015; McAdams & McLean, 2013). Narrative meaning-making is the process by which people reconstruct stories about their past and create new significative interpretations of it (McAdams & McLean, 2013). For minoritised populations, narratives about their life allow them to make meaning of stigmatising events linked to stigma and, in turn, produce unique strategies to frame and cope with discrimination (Frost, 2011b).

For example, Black Caribbean young men can produce unique counter-narratives that resist stigma and discrimination by highlighting the role of brotherhood and solidarity (Briggs, 2019). Among people in same-sex relationships, the discrimination they face is framed in different ways, including the redemption of negative elements of stigma by seeing in it an opportunity for strengthening their relationship (Frost, 2011b). Narratives can also shed light on how people experiencing poverty can internalise or distance themselves from self-loathing beliefs by taking different positions towards individual blame discourses of poverty (Pemberton et al., 2016).

Although these studies shed light on different narrative strategies and elements that shape the way people face stigma, more attention needs to be focused on its association with internalised stigma across multiple groups. Considering the potential role of discrimination experiences, the way people react and frame them needs to also be studied. By using mixed-method approaches, in this study, it was possible to explore narrative accounts that can shed light on psychological mechanisms that explain how stigma is internalised.

Protective factors: from social support to coping strategies

As revised in previous chapters, social support and coping strategies have usually been explored to understand what predicts better health and well-being and how the impact of discrimination can be alleviated. However, the role of these factors has not been systematically studied in relation to internalised stigma.

Regarding social support, there is abundant research on its protective role in the stigma-health relationship (see Hatzenbuehler, 2009). Although some research has found that social support can reduce the negative impact of internalised stigma on mental health symptoms (J. Li et al., 2020), this buffering effect has not been studied in the link between discrimination experiences and internalised stigma. Regarding active coping, the way people cope in the face of discrimination has been found to be a relevant predictor in well-being outcomes (Hatzenbuehler, 2009): the active coping responses are associated with a protective effect on health; and the avoidant ones, with a negative effect (Magallares et al., 2016). However, much less research has been conducted to understand its association with internalised stigma.

Following the theoretical framework of this thesis, I examined both the buffering effect, that is, if social support and active coping reduce the negative effect of discrimination on internalised stigma, and the direct effect, that is, if social support and active coping strategies have a negative direct association with internalised stigma.

The role of stigma characteristics and social status

Building on what was presented in previous chapters and the stigma dimensions (Jones et al., 1984; Pachankis et al., 2018), I focused on social perceptions of concealability and mutability as stigma characteristics that might have an effect on internalised stigma. In opposition to what previous research has found about concealability being associated with higher internalised stigma levels (Blankenship, 2019), results discussed in the previous chapter did not find evidence towards an effect of concealability. In fact, they showed that groups low

in perceived concealability presented levels of internalised stigma that were marginally higher compared to groups high in perceived concealability. Although this difference was not statistically significant, the results challenged my initial assumptions, and more research needs to be done to understand if concealability might be working reversely to what I expected. Regarding perceived mutability, there has been less research that allowed for clear initial hypotheses on its association with internalised stigma. However, the measurement study in this thesis found a large effect of perceived mutability, where groups high in mutability showed higher levels of internalised stigma compared to groups low in mutability.

However, it is not clear if the effects of perceived concealability and mutability on internalised stigma are mostly explained because of how the selected groups differ from each other, because of how society view and treats these groups differently, or because of how the individual perception of these characteristics plays a role in the internalisation process. Therefore, in this study, I also aimed to explore the role of subjective perceptions of concealability and mutability in their association with internalised stigma.

In addition to these stigma characteristics, belonging to more than one of these groups might also have an effect on internalised stigma. Social status is a relevant factor in the stigma-health relationship (Major et al., 2003) and having a multiple stigmatised identity can be interpreted as an accumulated lower social status, as discussed previously in the theoretical framework of this thesis. Consequently, it is likely that groups belonging to more than one stigmatised group are at more risk of internalising stigma compared to people in only one stigmatised group.

Considering the conceptual model presented in Chapter II, it would be relevant to consider not only the direct effect of these group differences in internalised stigma but also the moderation effect. In fact, it would be possible to think that the differences in internalised

stigma based on these stigma characteristics and intersectional status are explained by an intensified association between experiencing discrimination and internalised stigma. Therefore, I tested both direct and moderated effect hypotheses of mutability, concealability, and intersectional stigmatised status.

Finally, as reviewed in the theoretical framework, intersectional stigma is a much more complex phenomenon that cannot be reduced only to a potential additive disadvantage (Bowleg, 2008; J. M. Turan et al., 2019). Therefore, in this study, I explored the association between different forms of internalised stigma that converge in the same individual and examined how experiences of intersectional stigma emerge in people's narratives.

The current study

Considering that previous research has not focused on the antecedents of internalised stigma, the first step in this question is to explore the multiple factors that can explain individual and group differences. This study aimed to explore the factors associated with internalised stigma among multiple stigmatised groups, focusing on discrimination experiences as the main predictor and social support and coping strategies as both correlates and moderators. This study included a variety of populations to explore group differences and understand the role of perceived mutability, perceived concealability, and intersectional groups in their association with internalised stigma. In addition, this study distinguished two forms of internalised stigma: when directed to the self and the group. As discussed in the theoretical framework, this study also focused on emerging adulthood (Arnett, 2000), considering it is a critical developmental stage for identity and change among different stigmatised populations and expecting to find meaningful variance in internalised stigma levels.

The hypotheses of this study were: a. higher levels of everyday discrimination and major life events of discrimination will be associated with higher levels of internalised stigma;

b. higher levels of social support and active coping strategies will be associated with lower levels of internalised stigma (direct effect hypothesis) and/or will moderate the discrimination-internalised stigma relationship, decreasing it (buffering effect hypothesis); c. mutable-perceived, non-concealable-perceived, and intersectional stigmatised groups will have higher levels of internalised stigma (direct effect hypothesis), and/or will experience an increased association between discrimination and internalised stigma (moderation effect hypothesis), relative to non-mutable, concealable, and non-intersectional stigmatised groups; d. higher appraisals of controllability, stability, globality, and severity of a recent experience of discrimination will be associated with higher levels of internalised stigma.

As previously discussed, these hypotheses were formulated based on existing research on the antecedents of internalised stigma. However, some of these associations rely on assumptions that require further clarification and empirical assessment, particularly the assumption connecting discrimination experiences to internalised stigma. This research provides an ideal opportunity to evaluate these assumptions comprehensively, incorporating moderating factors and employing a multi-group approach to examine this association.

Finally, I took an exploratory approach regarding how the way people narrate a past experience of discrimination can be associated with their levels of internalised stigma. As described in the following section, I explored narrative elements of these accounts to shed light on psychological mechanisms that might be linked with stigma internalisation.

Methods

This study took a mixed-method approach, which allows for addressing both the hypothesis-testing elements as well as the exploratory and narrative dimensions of the research problem. See Chapter II for more details about the methodological approach of this research. The study had a longitudinal design consisting of three waves of measurement over the course

of one year. The focus of this chapter is on the cross-sectional analyses of the first wave of that study. Details about the procedures for the initial wave can be found here, and details about the general procedures for the longitudinal design are presented in the next chapter.

Participants and procedure

Using the first wave of the longitudinal study, I collected data from 729 emerging adult participants of 18 to 21 years old in Chile (see Table IV.1 for further details of the sample characteristics). I followed a purposive sampling design aiming at recruiting people that belong to one or more of four different groups selected due to their variation in the social perceptions of two stigma characteristics: concealability and mutability. The selection of groups was the same as the one presented for the measurement study in the previous chapter. For the perceived high concealability and high mutability group, I recruited working-class people; for the perceived high concealability and low mutability group, LGB people; for the perceived low concealability and high mutability group, higher-body weight people; and for the perceived low concealability and low mutability group, Indigenous people. Because the internalised stigma measure is shaped by each category membership, participants were required to self-identify in the groups using self-report questions about these categories.

The sample size was estimated considering the design of the broader longitudinal study of this thesis, with an expected sample of a minimum of 600 participants (Curran et al., 2010). In the initial design of this study, I projected to sample 150 participants per targeted group to ensure statistical power for group comparisons. I was able to accomplish this aim for three groups, but Indigenous people were sampled just to this number (see Table IV.1), mainly because of recruitment challenges in reaching this group using the designed recruitment strategies.

Table IV.1.

Sample characteristic

Demographics	*n* (%)
Age, *M* (range, *SD*)	18.82 (18-21, .79)
Gender[a]	
Woman	496 (62.5%)
Man	227 (28.6%)
Nonbinary/Other	70 (8.8%)
Identify as trans	
Yes	52 (6.6%)
No	723 (91.2%)
Prefer not to answer	18 (2.3%)
Sexual orientation	
Heterosexual	314 (39.6%)
Lesbian	21 (2.6%)
Gay	45 (5.7%)
Bisexual	263 (33.2%)
Pansexual	92 (11.6%)
Queer	24 (3%)
Other	34 (4.3%)
Ethnic group	
White	51 (6.4%)
Latino	669 (84.4%)
Indigenous	61 (7.7%)
Black	3 (0.4%)
Other	9 (1.1%)
Do you consider part of any indigenous group?	
Yes	147 (18.5%)
No	646 (81.5%)
Do you consider yourself to be overweight?	
Yes	369 (46.5%)
No	424 (54.5%)
Do you consider yourself to be working class?	

Yes	464 (58.5%)
No	329 (41.5%)
Studying at	
Highschool	156 (19.7%)
Technical higher ed	14 (1.8%)
Professional institute	75 (9.5%)
University	305 (38.5%)
Not studying	164 (20.7%)
Other	79 (10.0%)
Working	
Full-time	39 (4.9%)
Part-time	99 (12.5%)
Not working	624 (78.7%)
Other	31 (3.9%)
First gen university	
Yes	476 (60%)
No	317 (40%)
Subjective SES, *M* (range, *SD*)	4.81 (1-10, 1.45)
Final Group - IS scale selected	
LGB	217 (27.4%)
Racial minority	150 (18.9%)
Higher-body weight	216 (27.2%)
Working-class	210 (26.5%)

Note. a: Participants were allowed to mark more than one option. Only two marked more than one. IS = internalised stigma.

Recruitment was conducted using Instagram ads, and six posts were uploaded and aimed at emerging adults in Chile. After clicking on a post, potential participants were directed to the survey in Qualtrics. Recruitment and data collection was completed between August and October of 2022. Participants read an information sheet and consented to participate prior to starting the survey. This study received full approval from the University College London

Institute of Education Ethics Committee and the P. Universidad Católica de Chile Social Sciences Ethics Committee.

Measures

Demographics. I included questions about sexual orientation (using multiple options including "straight", "gay", "lesbian", "bisexual", "pansexual", "queer", and "something not listed") and ethnicity (using multiple options including "White/European", "Latino/Mestizo", "Indigenous", "Afro-descendant/Black", and "something not listed"). About body weight and social class categories, I included two questions that created a precise distinction between groups and allowed participants to self-identify. Based on self-report questions as used in the National Health and Nutrition Examination Survey (NHANES, see Kwak et al., 2021), participants responded "yes" or "no" to two different questions about if they considered themselves to be overweight and working-class. These four self-reported questions about sexual orientation, ethnicity, body weight, and social class were utilised for presenting the internalised stigma scale (MGISS).

MGISS. Participants completed the Multiple Group Internalised Stigma Scale, developed for this thesis in Chapter III. The items in this scale use the same content across groups and change only one word to match the group the respondent belongs to. Items were measured using a 7-point Likert scale. The 7-item SIS subscale Cronbach's alpha was .95, the 5-item GIS subscale was .68, and the 12-item complete scale was .91.

Everyday experiences of discrimination. Using Williams et al.'s (1997) scale for measuring everyday forms of discrimination, participants responded about how often they experience ten different situations (e.g., "being treated with less respect than other people", "being followed around in stores"). The question uses a 4-point Likert frequency scale from never to four or more times. The Cronbach's alpha of the scale was .85.

Major experiences of discrimination. A second measure of discrimination experiences was used for major life events of discrimination (Williams et al., 1997). Participants responded if they had or not experienced nine situations (e.g., "being unfairly discouraged by a teacher from continuing education", "being unfairly stopped, searched, questioned, physically threatened, or abused by the police") in the last year. Each item was responded with yes or no, and the final scale was computed using the summed total. Cronbach's alpha was not calculated as the scale does not represent an overarching construct, but the exact number of events participants reported to have experienced in the last year.

Single discrimination event narration. Participants were asked to write a short entry about an event of discrimination they experienced in the last 12 months, if any, selecting the one that is most relevant to them. Participants wrote a brief description of the event and responded to three follow-up questions, including why they think that situation happened, what they did or thought about the situation during the event, and what they did or thought about the situation after the event. In addition, participants responded to four different appraisals about the situation, based on questions used by Eccleston and Major (2006): how much they feel they could personally control the situation (controllability), how much they feel this situation can repeat in the future (stability), how much they feel this situation affected multiple areas of their lives (globality), and how much they feel this situation had a severe impact in their lives (severity).

Social support. Using the multidimensional scale of perceived social support (Dahlem et al., 1991), participants responded about three different sources of social support, including their family, friends, and other meaningful person. Each source of support included four items, adding to a total of 12 items in the full scale ("My family really tries to help me", "I can count on my friends when things go wrong", "there is a special person who is around when I am in

need") using a 7-point agreement Likert scale. Cronbach's alpha was .91 in the family support subdimension, .94 in the friends subdimension, and .86 in the other subdimension.

Coping strategies. I used the coping with discrimination scale (Wei et al., 2010) to measure the different ways in which people respond and cope in the face of discrimination. The scale included four different subdimensions with five items each, including two active and two avoidant forms of coping. These subdimensions included education coping ("I try to educate people so that they are aware of discrimination"), confrontation coping ("I directly challenge the person who offended me"), internalisation coping ("I wonder if I did something to provoke this incident"), and detachment coping ("I do not talk with others about my feelings"). All items were measured using a 7-item agreement Likert scale. Cronbach's alphas were .88, .76, .78, and .83, respectively.

Subjective perceptions of concealability and mutability. In addition to the variables of social perceptions of concealability and mutability created by the groups people belonged to, I included two questions about how much participants themselves perceived their stigmatised identity or group membership could be concealable ("I can hide my [field] to other people") and mutable ("I could stop being a [group] person in the future"). These questions were asked using the same system as MGISS by changing one word to match people's groups. When participants responded to more than one version of these questions, I selected one for the analyses following the same criteria used for MGISS previously discussed, so there was an exact match between these questions and the internalised stigma scale.

Brief narrations coding procedure

A total of 471 participants wrote in the narration entries. However, only 355 were eligible after identifying 20.8% of entries that were about something different than a situation of discrimination and 4.8% of entries in which the situation happened more than 12 months

ago. Narrative data were collected in Spanish, and coding was conducted in the original language by Spanish-speakers. I translated the vignettes of the narrations used in this thesis into English.

A coding scheme was developed to assess key dimensions of the study. For the first category, regarding how people narrate and frame the story, redemption sequences were coded following McAdams' (1999) scheme. These redemption sequences are found when the narrator follows a negative situation with a positive one. Secondly, regarding how people thought about the causes of discrimination and based on how people cope in the face of discrimination (Wei et al., 2010), I coded two categories: interiorisation, if participants blamed themselves for the situation; and exteriorisation, if participants put the blame in others. Thirdly, about how they responded to the discrimination experience, I coded two additional categories: active response, if participants responded to the situation with a concrete action different to withdrawing (confronting, seeking help, or similar); and withdrawal response, if participants responded to the situation by leaving or escaping. Lastly, regarding the social categories targeted by the situation of discrimination, I considered nine different categories: race/ethnicity, sexual orientation, body weight, social class, age, sex/gender, gender identity, mental health conditions, and clothes. All material in this scheme was coded in each of the 14 categories as (1) when the respective code was present and (0) when it was not. See Table IV.2 for a summary of the coding scheme.

The material was initially coded by two independent coders to test for interrater reliability of the coding scheme. Considering most of the codes were expected to be scarcely found in the material, in addition to Kappa, I also used Delta, which is more appropriate for highly skewed material (Martín Andrés & Femia Marzo, 2004). Delta 5.0 software was used to calculate it (2022). The first round of coding was 100 entries. In this round, all categories were found to have acceptable to excellent levels of interrater reliability (Delta between .77

and .97) except one: exteriorisation (Delta: .5). In addition, four categories (interiorisation, sexual orientation category, gender identity category, and other category) although acceptable to good Deltas, did not show acceptable Kappas. After identifying the interrater mismatch in these categories was caused by unclear definitions in the coding scheme, it was refined in those categories to be more precise. A second round was conducted on these five categories, using 50 new entries and the refined coding scheme. All five categories reached acceptable to excellent levels of interrater reliability, considering both Kappas (between .6 and 1.0) and Deltas (between .73 and .94). With the final coding scheme refined and tested for interrater reliability, the rest of the material was fully coded by one of the coders.

Table IV.2
Coding scheme

	Definition
Framing of the event	
Redemption sequence	The speaker shows the story plot moving "from a negative to a positive valence, bad leads to good. Therefore, the initial negative state is “redeemed” or salvaged by the good that follows it (…) The positive state of B that follows the negative A state does not need to be as positive as the A state was negative. (...) The movement from A to B can take one of two forms. A may cause B (in the respondent’s view) or A may merely immediately precede B in time." (McAdams, 1999, pp. 1–3).
Ideas of the causes	
Interiorisation	The speaker attributes the blame or cause of the situation to themselves, considering that the direction for the causes is clearly on the speaker’s behaviour, decisions, or predisposition.
Exteriorisation	The speaker attributes the blame or responsibility of the situation to the aggressors, institutions, social norms, or society in general. The causes of the event are clearly identified in other people’s or society’s attitudes, decisions, or predispositions.
Responses to the event	
Active response	The speaker explicitly mentions that they reacted to the situation with their behaviour by informing, educating, or confronting the person or group, by complaining or telling others about this situation, or by actively concealing or changing behaviour. Withdrawing actions should not be coded in this category.

Withdrawal response	The speaker explicitly mentions that they reacted to the situation by escaping, withdrawing, or leaving the situation.
Attributions to social categories	
Ethnicity	Mentions the discrimination event was based on race, ethnicity, skin colour/tone, or nationality.
Sexual orientation	Mentions the discrimination event was based on sexual orientation or characteristics attributable to sexual minorities.
Body weight	Mentions the discrimination event was based on body weight or shape.
Social class	Mentions the discrimination event was based on social class, or characteristics attributable to being of from a working or lower social class background.
Sex/gender	Mentions the discrimination event was based on the individual sex/gender, considering mainly sex or gender inequalities.
Gender identity/expression	Mentions the discrimination event was based on gender identity or expression, considering mainly being trans, non-binary, or a gender non-conforming expression.
Age	Mentions the discrimination event was based on age or being treated or seen as a child or immature.
Mental health	Mentions the discrimination event was based on a mental health condition, disorder, cognitive or learning disability, or neurodivergence.
Clothes (other)	Mentions the discrimination event was based on the clothes the individual was wearing, without being evident it is an indicator of a previous category.

Data cleaning

Because participants could be part of one or more of the groups, some of them responded to two versions of the same scale. Having two scales for the same construct creates two variables for internalised stigma; therefore, for analytical purposes, I considered only their response to a single version of the scale, following the criterion of amplifying the balance between groups and ensuring data from the four different forms of the scale was preserved. Particularly, the ethnic minority people's data was prioritised (purposefully selecting that form of the scale when present) because that group was the smallest subsample and mainly formed by people in more than one group.

Selecting one of the scales randomly for participants with multiple versions of the scale was considered. However, this solution would have jeopardised the data about ethnic minority internalised stigma due to the reasons presented in the previous paragraph. On the other hand, by purposefully selecting one scale, it was possible to create a group identifier variable, which allowed me to control for the response target of the scale, having a unique variable with the four existing groups.

An additional alternative was to generate a mean score between the multiple versions of the scale within each participant. Nevertheless, exploratory analyses of the data showed that the correlation between different versions of scales within-subject was small to medium size, and most of them non-significant in the SIS subdimension (see Appendix IV.1 for these analyses). Therefore, creating a mean score of both was not justified because it was unclear what was being measured in said scale. In sum, purposefully selecting the scale with a balancing groups criterion was found to be the more optimal and beneficial mechanism for cleaning the data and using the scale.

Data analysis

For the relational analyses, I conducted bivariate Pearson correlations and multiple linear regressions. For the group comparison analyses, I conducted a three-way ANOVA including the main grouping variable of interests. For analysing the coded narrative entries, I used regressions and chi-squares on the different categories. Analyses were conducted using SPSS 27. Effect sizes are interpreted following Funder and Ozer's (2019) suggestions, considering r = .10, .20, and .30 for small, medium, and large effects, respectively.

Results

Descriptive statistics

Before testing each one of my hypotheses, I conducted descriptive analyses on all the variables used in the study (see Table IV.3 for all descriptive statistics and correlation estimates between variables in the study). Surprisingly, I found that the internalised stigma scale, especially the self-focused subdimension, had a bimodal distribution. For Indigenous and, to a greater extent, for LGB people, the distribution was positively skewed (showing low levels of internalised stigma); and for working-class people and, to a greater extent, for higher-body weight people, the distribution was negatively skewed (showing high levels of internalised stigma).

The cause of the bimodal distribution of the dependent variable is well-identified, revealing meaningful group differences that were hypothesised, that is, that high perceived mutability groups presented higher levels of internalised stigma compared to low perceived mutability groups. Because this type of distribution can potentially create issues regarding the assumptions of the statistical tests, it is critical to check if the residuals of the analyses are normally distributed to assess the violation of the assumptions (Kutner et al., 2005). As shown in Appendix IV.2, residuals of regressions and ANOVAs were normally distributed, which suggests that the model's assumptions have been met and that the results can be interpreted.

The distributions of the other variables in the analysis were closer to a normal distribution, without signs of problematic skewness or kurtosis (see Table IV.3).

Table IV.3

Descriptive statistics and bivariate Pearson correlation

	N	Range	*M* (*SD*)	Skewness	Kurtosis	1	2	3	4	5	6	7	8	9	10	11
1. SIS	731	1 - 7	4.09 (2.00)	-0.16	-1.44	1	.50**	.10*	.16**	-0.08	-.18**	-.11**	-.09*	.13**	-.01	.18**
2. GIS	729	1 - 6.4	2.63 (1.13)	0.49	-0.29		1	.07	.14**	-0.05	-.15**	-.12**	-.18**	.10*	.03	.13**
3. Daily discrimination experiences	646	1 - 4	2.48 (0.68)	-0.09	-0.71			1	.45**	-.28**	-.14**	-.18**	.16**	.16**	.18**	.19**
4. Number of major discrimination experiences	644	0 - 7	1.83 (1.63)	0.80	0.09				1	-.16**	-.12**	-.13**	.21**	.06	.13**	.17**
5. Support from family	654	1 - 7	4.16 (1.69)	-0.21	-0.92					1	.36**	.48**	.02	-.04	-.11**	-.40**
6. Support from friends	654	1 - 7	4.92 (1.63)	-0.69	-0.29						1	.65**	.13**	.03	.01	-.393**
7. Support from other	654	1 - 7	5.16 (1.39)	-0.68	-0.11							1	.12**	.00	-0.02	-.47**
8. Coping education	668	1 - 7	5.19 (1.21)	-1.03	1.19								1	.21**	.17**	-0.01
9. Coping interiorisation	668	1 - 7	4.81 (1.48)	-0.90	0.16									1	-.08*	.26**
10. Coping resistance	668	1 - 7	3.78 (1.24)	-0.04	-0.30										1	-0.08
11. Coping detachment	668	1 - 7	4.38 (1.46)	-0.39	-0.48											1

Note. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. * $p < .05$, ** $p < .01$.

The role of discrimination experiences, social support, and coping strategies

Regarding my first hypothesis about experiencing discrimination being positively associated with internalised stigma, I found partial evidence to support the hypothesis. Higher levels of everyday discrimination had a small significant association with higher levels of SIS (r = .10[644], p < .001), but the association was not statistically significant with GIS (r = .07[643], p =.07). In addition, a higher number of major life events of discrimination was linked with higher levels of SIS (r = .16[642], p < .001) and GIS (r = .14[641], p < .001), with small to medium size associations.

When including both forms of discrimination in the model, the number of major life events of discrimination kept an association with SIS (β = .15, t[643] = 3.36, p < .01), while everyday discrimination lost statistical significance (β = .03, t[643] = .68, p = .50). The overall regression model with these two variables explained only 2.6% of the variance of SIS (F[2, 641] = 8.68 p < .001, R^2 = .03). Following a similar pattern, major events of discrimination were associated with GIS (β = .13, t[642] = 2.95, p < .01) and everyday discrimination was no longer statistically significant (β = .01, t[643] = .28, p = .78). This model explained only 1.5% of the variance in GIS (F[2, 640] = 6.00, p < .01, R^2 = .02).

My second hypothesis was that higher levels of social support and active coping strategies would be negatively associated with levels of internalised stigma. I found evidence that supported the idea that some components of those two constructs were associated with internalised stigma. As Table IV.3 shows, support from friends and from other meaningful people in life showed significant and small to medium negative associations with SIS and GIS. However, family support did not show a significant bivariant association with internalised stigma. On the other hand, education coping was negatively associated with SIS and GIS, with small to medium effect size. Resistance coping was not significantly associated with SIS and

GIS. Regarding avoidant coping strategies, in line with my expectations, they were found to be positively associated with internalised stigma. Interiorisation and detachment coping responses to discrimination showed small to medium positive bivariate correlation indices with SIS and GIS.

When including the three sources of social support and the four coping strategies in two regression models predicting variance in SIS and GIS, minor changes were found. In the model predicting SIS (F[7, 646] = 6.96 p < .001, R^2 = .06), all associations found in the bivariate analyses were in the same direction and significant, but social support from others was no longer a significant predictor (β = .06, t[653] = 1.08, p = .28) when controlling for the other social support sources and coping strategies. In the model predicting GIS (F[7, 645] = 8.12 p < .001, R^2 = .08), social support from other relevant people was again no longer a significant predictor (β = -.01, t[652] = -0.10, p = .92) and detachment coping also lost its significant association with GIS (β = .07, t[652] = 1.59, p = .11), when controlling for the other predictors. Interestingly, resistance coping started showing a significant positive association with GIS (β = .09, t[652] = -2.21, p < .05), which is in the reverse direction of my hypothesis. There were no signs of multi-collinearity in these regression models (all VIFs under 5, Kutner et al., 2005).

Regarding the moderation effect in my second hypothesis, that is, that social support and coping strategies would moderate the discrimination-internalised stigma relationship, I did not find any evidence to support it. Interaction terms of the different subdimensions of social support and coping strategies with the two different measures of discrimination experiences did not show significant associations with SIS or GIS.

Considering that initial analyses showed that group differences are fundamental in explaining internalised stigma variance, a second step in examining my first and second hypotheses was to identify if these associations were present when controlling for the group

people belong to and that was the target of their responses in the internalised stigma scale. Two regression models were calculated (one for SIS, the other for GIS), each one including two steps: in the first step, I included all nine factors tested in the two hypotheses; in the second, I included the group variable for three groups (with LGB as reference).

The results of these two regression models are presented in Tables V.4 and V.5. In summary, I found that, when controlling for the group, the factors that maintained a significant association with both forms of internalised stigma are the number of major experiences of discrimination, education coping strategies, and interiorisation coping strategies, all in the hypothesised direction. For SIS, detachment coping strategies were also maintained as a significant factor positively associated with self-focused forms of internalised stigma. However, the size of the associations was notably reduced, especially for the association between major experiences of discrimination and internalised stigma. For GIS, the positive association found previously with resistance coping was no longer significant in the final model. This model did not present problems of multi-collinearity, and its residuals were normally distributed.

These models highlight that group differences explained a vast part of the variance in internalised stigma. Belonging to the body weight and the social class category groups was strongly associated with higher levels of internalised stigma when compared to the reference group (sexual orientation category group). Belonging to the racial category group did not show differences with the reference group. [5]

[5] Considering these large group differences can obscure the role of the other predictors in the model, I explored two additional aspects to provide more insight into these results. First, I examined group differences in the other variables of interest. Secondly, I explored group differences in the association between discrimination experiences and internalised stigma (see Appendix IV.3 for these analyses).

Table IV.4

Regression Coefficients of discrimination experiences, social support, and coping strategies, with SIS as dependent variable

		B	95% CI	β	*t*	*p*	R^2
1	Model Fit						.09
	(intercept)	3.84	[2.43, 5.26]			<.001	
	Daily discrimination experiences	0.01	[-0.25, 0.26]	0.00	0.04	.97	
	Number of major discrimination experiences	0.19	[0.08, 0.29]	0.15	3.54	<.001	
	Support from family	0.02	[-0.09, 0.13]	0.02	0.33	.74	
	Support from friends	-0.19	[-0.31, -0.06]	-0.15	-2.98	<.01	
	Support from other	0.09	[-0.07, 0.24]	0.06	1.09	.28	
	Coping education	-0.23	[-0.36, -0.09]	-0.14	-3.33	<.01	
	Coping interiorisation	0.18	[0.07, 0.29]	0.13	3.14	<.01	
	Coping resistance	0.01	[-0.12, 0.14]	0.01	0.13	.90	
	Coping detachment	0.14	[0.01, 0.27]	0.10	2.14	<.05	
2	Model Fit						.77
	(intercept)	1.68	[0.95, 2.40]		4.54	<.001	
	Daily discrimination experiences	-0.12	[-0.25, 0.01]	-0.04	-1.80	.07	
	Number of major discrimination experiences	0.06	[0.01, 0.11]	0.05	2.13	<.05	
	Support from family	0.03	[-0.03, 0.08]	0.02	0.96	.34	
	Support from friends	-0.02	[-0.09, 0.04]	-0.02	-0.73	.46	
	Support from other	0.04	[-0.04, 0.12]	0.03	0.95	.34	
	Coping education	-0.08	[-0.15, -0.01]	-0.05	-2.36	<.05	
	Coping interiorisation	0.11	[0.05, 0.16]	0.08	3.78	<.001	
	Coping resistance	0.00	[-0.07, 0.06]	0.00	-0.03	.98	
	Coping detachment	0.11	[0.05, 0.18]	0.08	3.46	<.01	
	Ethnicity (Indigenous = 1) [a]	0.06	[-0.18, 0.30]	0.01	0.50	.62	
	Body weight (Higher body weight = 1) [a]	3.72	[3.51, 3.93]	0.82	34.65	<.001	
	Social Class (Working-class = 1) [a]	3.14	[2.93, 3.35]	0.70	29.71	<.001	

Note. a = Group control (Sexual orientation = 1)

Table IV.5

Regression Coefficients of discrimination experiences, social support, and coping strategies, with GIS as dependent variable

		B	95% CI	β	*t*	*p*	R^2
1	Model Fit						.11
	(intercept)	2.99	[2.21, 3.78]		7.49	<.001	
	Daily discrimination experiences	-0.01	[-0.15, 0.13]	-0.01	-0.14	.89	
	Number of major discrimination experiences	0.11	[0.05, 0.17]	0.16	3.64	<.001	
	Support from family	0.04	[-0.03, 0.09]	0.05	1.15	.25	
	Support from friends	-0.08	[-0.15, -0.01]	-0.11	-2.25	<.05	
	Support from other	0.00	[-0.09, 0.09]	0.00	-0.05	.96	
	Coping education	-0.23	[-0.31, -0.16]	-0.24	-6.08	<.001	
	Coping interiorisation	0.10	[0.04, 0.17]	0.14	3.35	<.01	
	Coping resistance	0.06	[-0.02, 0.13]	0.06	1.56	.12	
	Coping detachment	0.04	[-0.03, 0.11]	0.06	1.18	.24	
2	Model Fit						.25
	(intercept)	2.49	[1.76, 3.22]		6.67	<.001	
	Daily discrimination experiences	-0.06	[-0.19, 0.07]	-0.04	-0.86	.39	
	Number of major discrimination experiences	0.08	[0.02, 0.13]	0.11	2.82	<.01	
	Support from family	0.04	[-0.02, 0.09]	0.06	1.31	.19	
	Support from friends	-0.04	[-0.10, 0.03]	-0.05	-1.13	.26	
	Support from other	-0.01	[-0.09, 0.07]	-0.02	-0.33	.74	
	Coping education	-0.19	[-0.26, -0.13]	-0.21	-5.55	<.001	
	Coping interiorisation	0.08	[0.02, 0.14]	0.10	2.75	<.01	
	Coping resistance	0.06	[-0.01, 0.12]	0.06	1.71	.09	
	Coping detachment	0.03	[-0.03, 0.10]	0.04	0.94	.35	
	Ethnicity (Indigenous = 1) [a]	0.16	[-0.08, 0.40]	0.05	1.34	.18	
	Body weight (Higher body weight = 1) [a]	1.11	[0.90, 1.33]	0.43	10.24	<.001	
	Social Class (Working-class = 1) [a]	0.68	[0.48, 0.89]	0.27	6.41	<.001	

Note. a = Group control (Sexual orientation = 1)

The role of concealability and mutability perceptions

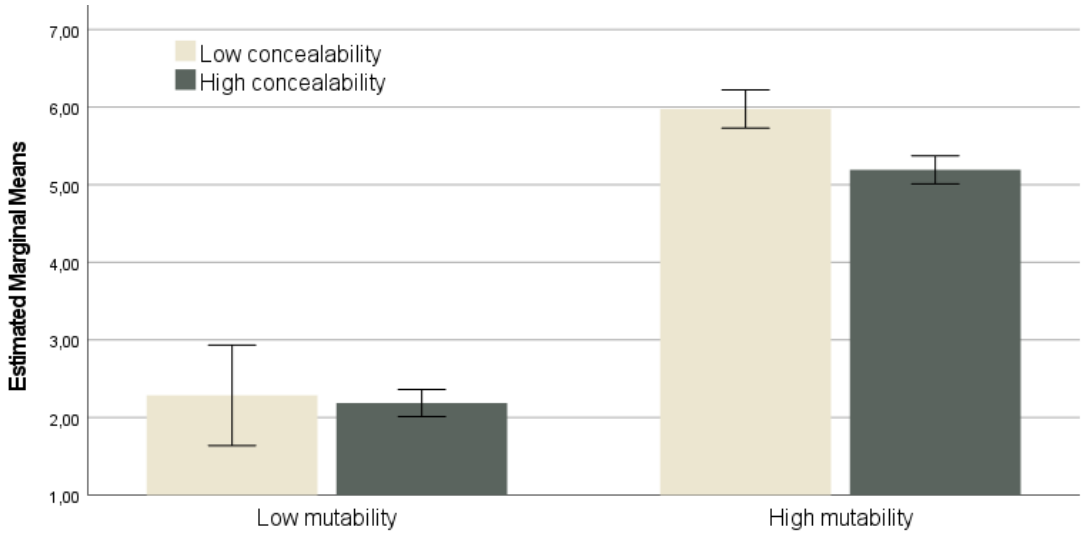
The third hypothesis of the study directly addresses group differences by testing the role of socially perceived concealability, socially perceived mutability, and intersectional stigmatised status (here operationalised as the number of stigmatised groups people belong to), in their association with internalised stigma. I conducted three-way ANOVAs of socially perceived mutability (low vs high mutability), socially perceived concealability (low vs high concealability) and intersectional groups (1 vs 2 or more stigmatised identities) on SIS and on GIS as dependent variables. Results showed support for my hypotheses about the effects of socially perceived mutability and concealability but not for the effects of intersectional groups. See Figures IV.1a, IV.1b, and IV.2a, IV.2b for a summary of these results.

There was a large and significant main effect of socially perceived mutability on SIS, explaining 60% of the variance (F (1, 730) = 1065.89, $p < .001$, ηp2 = .60), such that the high-mutability groups (M = 5.71, SE = .05) reported higher levels than the low-mutability groups (M = 2.24, SE = .09). There was also a small significant effect of socially perceived concealability on SIS explaining 1.5% of the variance (F (1, 730) = 11.33, $p < .01$, ηp2 = .02): low-concealability groups reported higher levels of internalised stigma (M = 4.16, SE = .09) compared to those high in concealability (M = 3.80, SE = .05). Intersectional stigma status was not found to be significant in explaining SIS differences (F (1, 730) = 1.57, p = .21, ηp2 = .00). I found a significant interaction between socially perceived mutability and concealability that replicated results found in the measurement study presented in the previous chapter. This interaction explained 0.6% of the variance of SIS (F (1, 730) = 4.06, $p < .05$, ηp2 = .01) and showed that concealability did not have a significant effect in explaining differences among the groups low in mutability; that is, LGB people did not differ significantly in SIS from indigenous people. However, socially perceived concealability showed a significant effect when explaining differences across high-mutability groups. Higher-body weight people

showed significantly higher levels of SIS compared to working-class people. The other interactions did not show statistical significance.

Figure IV.1a.

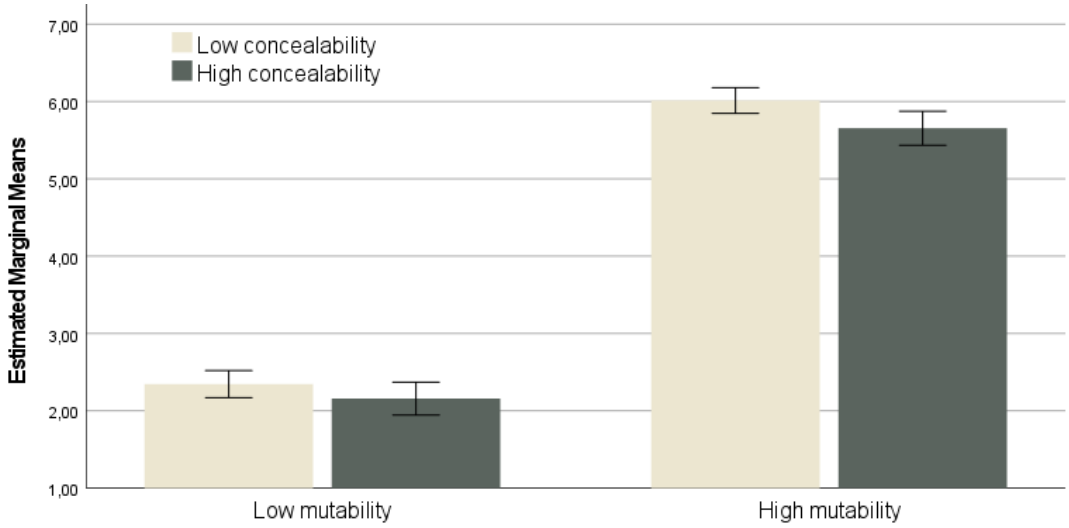
Differences in SIS by socially perceived mutability and concealability in non-intersectional condition



Note. Three-way ANOVA estimated marginal means of SIS by socially perceived mutability and concealability in non-intersectional condition (only 1 group), and 95% confidence intervals.

Figure IV.1b.

Differences in SIS by socially perceived mutability and concealability in intersectional condition



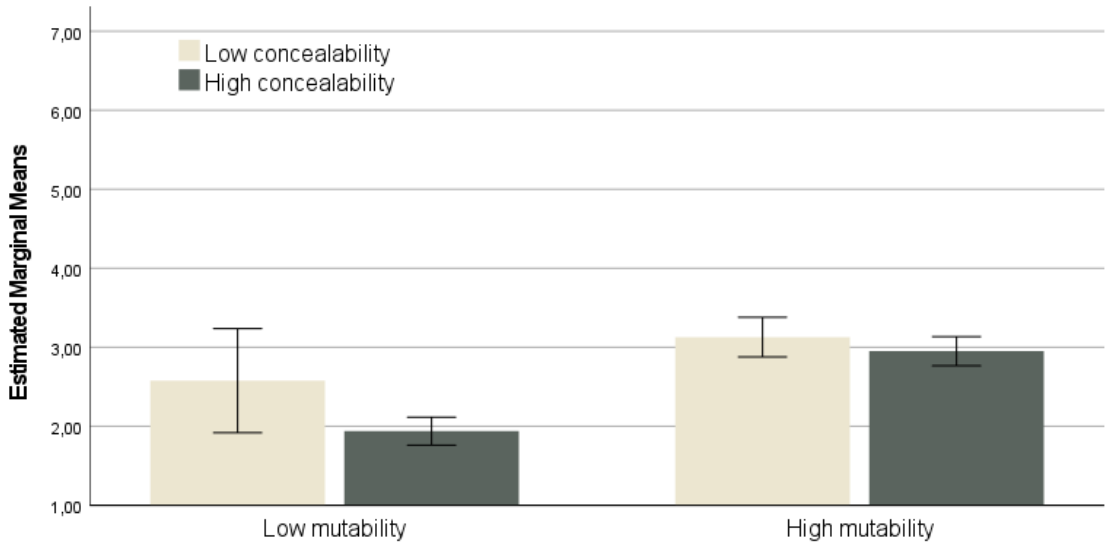
Note. Three-way ANOVA estimated marginal means of SIS by socially perceived mutability and concealability in intersectional condition (2 or more groups), and 95% confidence intervals.

Regarding GIS, I also found statistically significant main effects of socially perceived mutability and concealability but not intersectional groups. The effect of mutability explained 6.5% of the variance in GIS (F [1, 728] = 50.40, p < .001, ηp2 = .07). In line with my hypotheses, groups socially perceived as high in mutability (M = 3.01, SE = .05) reported higher levels of GIS than groups low in mutability (M = 2.25, SE = .09). I also found evidence of a significant main effect of socially perceived concealability on GIS explaining 1.9% of the variance (F [1, 728] = 14.07, p < .001, ηp2 = .02), in which low-concealability groups (M = 2.83, SE = 0.10) showed higher levels compared to high-concealability groups (M = 2.43, SE = 0.05). I did not find a statistically significant effect of intersectional group membership (F [1, 728] = 0.15, p = .70, ηp2 = .00). Differently to SIS, I did not find evidence supporting a

significant interaction between socially perceived mutability and concealability (F [1, 728] = 0.28, p = .59, ηp2 = .00), nor any additional two-way interaction. Surprisingly, I found evidence towards a small three-way interaction effect explaining 1% of the variance (F [1, 728] = 7.10, p < .01, ηp2 = .01): the differences in GIS explained by concealability, that is, that groups low in socially perceived concealability show higher levels of GIS compared to groups high in concealability, are only present in groups high in socially perceived mutability and with intersectional group membership. In other words, there was an interactional effect of mutability-concealability in the same direction that I found in SIS, but only in the condition of people belonging to more than one of the groups.

Figure IV.2a.

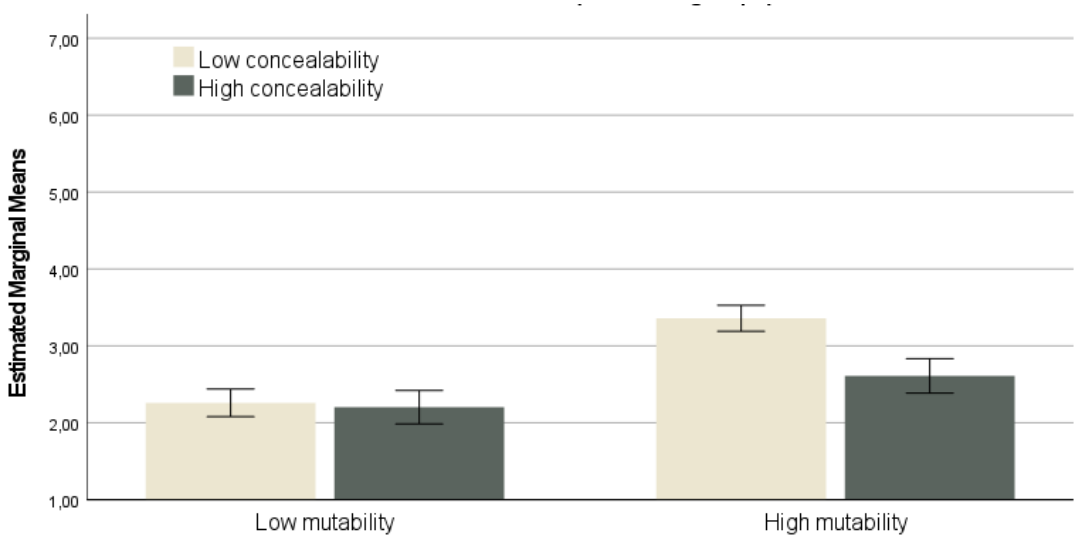
Differences in GIS by socially perceived mutability and concealability in non-intersectional condition



Note. Three-way ANOVA estimated marginal means of GIS by socially perceived mutability and concealability in non-intersectional condition (only 1 group), and 95% confidence intervals.

Figure IV.2b.

Differences in GIS by socially perceived mutability and concealability in intersectional condition



Note. Three-way ANOVA estimated marginal means of GIS by socially perceived mutability and concealability in intersectional condition (2 or more groups), and 95% confidence intervals.

In addition to the socially perceived variables of concealability and mutability constructed by group memberships, I assessed my hypotheses considering a subjective measure of these constructs. Using bivariate Pearson correlations, I tested the association between perceived concealability and mutability, and internalised stigma. Although I did not find a statistically significant effect in the association between subjective perceptions of concealability and SIS (r = .03[729], p = .38) nor GIS (r = .04[727], p = .35), I found a large-size association of subjective perceptions of mutability with SIS (r = .75[729], p < .001), and a medium-size association with GIS (r = .39[727], p < .001).

When including in a regression model the role of social and subjective perceptions of mutability and concealability, I found that both effects remain statistically significant when

controlling for each other (see Tables V.6 and V.7). In summary, these tables show that subjective perceptions mutability and socially perceived mutability were associated with higher levels of SIS and GIS; and only socially perceived concealability is associated with lower levels of SIS and GIS. The interaction terms of subjective perceptions of concealability and perceived mutability did not show a statistically significant association with SIS or GIS.

Table IV.6

Regression Coefficients of subjective and socially perceived mutability and concealability, with SIS as dependent variable

		B	95% *CI*	β	*t*	*p*	R^2
1	Model Fit						.56
	(intercept)	1.51	[1.23, 1.79]		10.72	<.001	
	Subjective concealability	0.01	[-0.05, 0.06]	0.01	0.25	0.80	
	Subjective mutability	0.66	[0.62, 0.70]	0.75	30.63	<.001	
2	Model Fit						.77
	(intercept)	1.95	[1.74, 2.17]		17.70	<.001	
	Subjective concealability	0.07	[0.03, 0.11]	0.06	3.37	<.01	
	Subjective mutability	0.15	[0.10, 0.20]	0.17	5.66	<.001	
	Concealable-perceived groups	-0.43	[-0.57, -0.29]	-0.11	-5.88	<.001	
	Mutable-perceived groups	2.88	[2.65, 3.11]	0.72	24.28	<.001	

Table IV.7

Regression Coefficients of subjective and socially perceived mutability and concealability, with GIS as dependent variable

		B	95% *CI*	β	*t*	*p*	R^2
1	Model Fit						.15
	(intercept)	1.83	[1.61, 2.05]		16.52	<.001	
	Subjective concealability	0.01	[-0.03, 0.06]	0.02	0.65	.52	
	Subjective mutability	0.19	[0.16, 0.22]	0.39	11.36	<.001	
2	Model Fit						.21
	(intercept)	2.07	[1.85, 2.30]		18.01	<.001	
	Subjective concealability	0.03	[-0.01, 0.08]	0.06	1.66	.10	
	Subjective mutability	0.08	[0.03, 0.13]	0.16	2.96	<.01	
	Concealable-perceived groups	-0.37	[-0.52, -0.22]	-0.17	-4.92	<.001	
	Mutable-perceived groups	0.59	[0.35, 0.83]	0.26	4.76	<.001	

To assess for group differences in these findings, I conducted a regression model on SIS and GIS with two interaction terms: one for subjective and socially perceived mutability and the other for subjective and socially perceived concealability. Interestingly, I found that the effect of subjective mutability on SIS was moderated by socially perceived mutability (β = .06, t[653] = 1.08, p = .28), but I did not find this interaction for concealability (β = .06, t[653] = 1.08, p = .28). The same interaction was found for GIS, where the effect of subjective mutability was moderated by socially perceived mutability (β = .06, t[653] = 1.08, p = .28), but not in concealability (β = .06, t[653] = 1.08, p = .28). In other words, I found that the positive association between subjective perceptions mutability and internalised stigma is only present among groups perceived as low in mutability (LGB and indigenous), but not among groups perceived as high in mutability (higher-body weight and working-class). The regression models presented in Tables V.6 and V.7, separated by each group can be found in Appendix IV.4.

In relation to the moderation hypotheses that concealability, mutability, and intersectional groups would interact with discrimination experiences in the association with internalised stigma, I did not find evidence to support them. The interaction of these stigma characteristics with the two measures of discrimination experiences when predicting internalised stigma was not statistically significant.

Narrating discrimination experiences and its role in stigma internalisation

When people narrated a recent experience of discrimination, they also indicated how much they appraised the situation as controllable, stable, global, and severe. I had one hypothesis regarding these: that higher appraisals of controllability, stability, globality, and severity of the experience would be associated with higher levels of internalised stigma. As displayed in Table IV.8, I found small positive associations between severity appraisals and SIS and GIS, as well as a small positive relationship between globality appraisal and GIS. Appraising the situation as severe continues to be associated with higher levels of SIS and GIS after controlling for group category (β =.05, t[354] = 1.98, $p < .05$; β =.10, t[354] = 2.2, $p < .05$, respectively). However, appraising the situation as having a global impact on life was not associated with GIS when controlling for group differences (β =.08, t[354] = 1.58, $p = .12$).

Table IV.8

Discrimination Event Appraisals. Descriptive statistics and bivariate Pearson correlation with SIS and GIS

	N	Range	Mean (*SD*)	Skewness	Kurtosis	SIS	GIS
Controllability	353	1 - 7	3.49 (1.87)	0.32	-1.14	-.10	-.04
Stability	352	1 - 7	5.89 (1.26)	-1.70	3.47	.02	-.04
Globality	355	1 - 7	4.19 (1.94)	-0.16	-1.16	.07	.11*
Severity	355	1 - 7	4.09 (1.93)	-0.14	-1.11	.12*	.16**

*$p < .05$, ** $p < .01$

The descriptive results of the 355 short narratives coding are displayed in Table IV.9 for the framing of the event, ideas of its causes, and responses to the experience, including example vignettes for each narrative dimension. In Table IV.10, the descriptive results of the reasons participants attributed to the discrimination events are presented. Although most of the codes, as expected, were not found to be predominant in each category, surprisingly, I found that 60% of the narratives contained exteriorisation, that is, ideas of identifying the blame or cause of the situation on other people or context different to the individual.

To explore the association between the narrative accounts and internalised stigma, I focused on four different dimensions: how the situation is framed (looking at redemption sequences), what participants think about the situation's causes (looking at interiorisation and exteriorisation ideas), how participants reacted to the situation (looking at active and withdrawal responses), and what reasons participants attributed to the discrimination event (looking at nine social categories, including the four pertinent to this study). For each one of these four dimensions, I conducted two linear regressions, looking at SIS and GIS as dependent variables and each category as binary independent variables. In addition, for each one of these dimensions, brief descriptions of the content are included to explore unique elements presented in the data and illustrate their narrative and psychological dimensions.

Table IV.9

Narrative codes frequencies - Framing of the event, ideas of causes and responses

	N	%	Example
Redemption sequence	35	9.9	"In itself, it seems quite discriminatory to me that EVERYONE places overweight as an inflexible category (…) More than once I have been told that "I look like a man", even by my own family. (…) [I felt] terrible, because it seems disrespectful to me that people assume that because I am overweight, I must feel bad about myself. Then: I remember that I do what I like, and I move on. In the long run I love being in very good physical condition (…) it is good that I can keep it cool and teach politely, with dynamic communication strategies, that being overweight is nothing to fear. In the end they almost always ask me about my routines."
Interiorisation	68	19.2	"[My teacher] told me that with my personality I was not going to achieve anything, that I should change, be more "strong-minded", in addition to my low income, she told me that [veterinary medicine] was not a good career for me (…) [This happened] because I did not put a stop to my bad friendships (which only made fun of me) (…) I felt lost, as if what that person said was true (…) I thought that I was never going to be able to achieve anything because I didn't have enough income or because I wasn't good enough at something."
Exteriorisation	213	60	"I was in an appointment with a gynaecologist, and throughout the consultation everything was going well, until he asked me if I had a boyfriend, to which I responded, yes, I have a partner, and I had to explain to him that she was a woman. A fact that immediately triggered his change of attitude, he began to be much sharper and treated me with a lot of indifference. Furthermore, he decided not to give me the pap test because he assumed that everything was fine with me because I did not have relations with a man, when he did not even know that I was bisexual. (…) I attribute this to the fact that perhaps the doctor was not necessarily homophobic, but he had it very internalised, and I think that if he is a gynaecologist he should inform himself and know how to act in these situations. (I thought) there is a lot left to teach society."
Active response	90	25.4	"A lady on the bus took my hand away from the bus-bell because she basically felt like it. I conclude that it was because she knew I was [a migrant person]. I didn't feel good or bad, I just told her to go to hell."

Withdrawal response	52	14.6	"While in the supermarket, the guard followed me through all the aisles, he clearly suspected me of possible theft of the products, and it was because of how I was dressed and my age. (…) Well, I felt discriminated against, I have never stolen, and it really bothered me that I was suspected just because of my age. What I did was to buy everything quickly and leave".

Regarding redemption sequences, I found they were not associated with SIS (β =-.03, t[354] = -.54, p = .59). However, I did find a statistically significant small association between redemption sequences and GIS (β =-.11, t[354] = -2.09, p < .05). In other words, people that wrote stories where the negative valence of the experience was redeemed by a positive framing, present lower levels of group-focused internalised stigma. Most of these narratives were characterised for including emotional tones as feeling initially “very sad”, “angry”, or “overwhelmed”, with an emotional change to feeling “better”, “calm”, or “happy”. Some of these narratives present this redemption as a change that happened because of time, because of being able to confront or escape the situation, or because of framing the negative elements towards a new understanding or position towards stigma, as presented in the example in Table IV.9.

Secondly, when looking at interiorisation and exteriorisation ideas, I found they were not associated with SIS (β =.01, t[354] = .15, p = .88; β =-.02, t[354] = -.39, p = .70, respectively). Regarding GIS, I did not find evidence supporting an association with interiorisation ideas (β =.01, t[354] = .26, p = .80), but there was a significant negative association between exteriorisation ideas and GIS (β = -.12, t[354] = -2.32, p < .05). These exteriorisation ideas were very frequent in the data, and they are mostly present in reflections about how their situation can be explained by harmful attitudes and beliefs of the people discriminating against them. Some participants explicitly recognised the existence of societal stigma by mentioning “discriminatory prejudices”, “society normalising stereotypes”, or “stigma and lack of information”.

The third dimension to explore was the role of active and withdrawal responses when facing discrimination. Similar to previous analyses, I did not find evidence supporting an association with SIS (β =.04, t[354] = .79, p = .43; β =-.05, t[354] = -.91, p = .37, respectively). Nevertheless, although I did not find a statistically significant association between active response and GIS (β =.03, t[354] = .60, p = .55), there was a significant negative effect of withdrawal responses to discrimination on GIS (β = -.11, t[354] = -2.14, p < .05). Withdrawal responses were usually presented as the action of leaving the situations because of reducing discomfort or potential risks. Although sometimes withdrawal responses were linked to detachment ("I decided to stay away, to block my social networks, and to isolate from the pain, thinking that maybe nobody would understand or help me"), most of the time are more explicitly referred to setting up boundaries ("I cut my ties with them [previous friends], because I could not keep being with people that mistreat me").

When looking at the different social categories participants attribute to being the reasons for the discrimination experience, I found diverse results. First, age was the most frequent category mentioned by the participants as a cause of the discrimination experience (see Table IV.10). Participants described being discriminated against because of being "young", "a minor", or "a high-school student", and mostly by "adults" or "older people" who represent the authority and have prejudice or bias against younger people. For example, one participant mentioned, "Once, at a job, they had to fire me for something that I know was unfair. Just because I was younger, they discriminated against me saying that I did not know [how to do or understand things] as others did, and I was still studying and working at the same time. (…) My colleagues took me less into account, that is to say that when I worked with them it was like I did not know how to do anything, but I did it anyway and I did it well (…). [The unfair dismissal] was all decided but only because I was a minor and because they thought I could not do anything about it."

Table IV.10.

Reasons attributed codes frequencies

	N	%
Ethnic/racial/skin colour	32	9
Sexual orientation	64	18
Body weight	48	13.5
Social class	61	17.2
Sex/gender	62	17.5
Gender identity/expression	38	10.7
Age	70	19.7
Mental health	12	3.4
Clothes (other)	33	9.3
Other	90	25.4

Secondly, a large number of the discrimination narratives attributed the experience to more than one reason, which highlights the data's intersectional nature. 35.8% of the cases presented two or more attributions to the same story. For example, one participant narrated, "I was walking down the street with my best friend by the hand, and people yelled homophobic things at us, and they messed with my body and his since I have more weight, and he is skinny. They yelled things like [slurs for gay people] and yelled that I should be careful not to crush or break him. (…) I felt very angry and helpless during it, but then I had a panic and anxiety crisis". Interestingly, multiple experiences show the intersection of age with social class (e.g., being kicked out of a store because looking like someone who does not have money to buy and would steal) or sex/gender (e.g., being ignored and not considered by adult men because being a young woman). The latter was also a commonly attributed cause that intersected with other categories, including experiences such as being discriminated against by health services professionals because of being a higher-body weight woman or a young mother. All these

accounts presented unique experiences of discrimination that were shaped by the intersection of two or more stigmatised features.

Lastly, regarding their relationship with internalised stigma, I did not find evidence of an association between ethnicity, sexual orientation and body weight discrimination attributions, and SIS (β =.06, t[354] = 1.03, p = .31; β = -.10, t[354] = -1.88, p = .06; β =.08, t[354] = 1.42, p = .16, respectively). However, I found a statistically significant positive relationship between social class attribution and SIS (β =.13, t[354] = 2.50, p < .05). Regarding GIS, I found evidence supporting positive associations with ethnicity, body weight and social class attributions (β =.11, t[354] = 2.00, p < .05; β =.15, t[354] = 2.83, p < .01; β =.18, t[354] = 3.45, p < .01, respectively). I did not find a statistically significant relationship between sexual orientation attribution and GIS (β = -.09, t[354] = -1.75, p = .08).

When controlling for group category, all statistically significant effects found in the association between redemption sequences (β =-.11, t[354] = -2.23, p < .05), exteriorisation ideas (β =-.10, t[354] = -2.05, p < .05) and withdrawal response (β =-.09, t[354] = -1.98, p < .05), and GIS, are maintained. However, most associations between social category attributions and SIS-GIS are not maintained after controlling. This may be explained by the expected unbalanced distribution in the intersection between the reason attributed and the individuals' groups, that is, that people from a particular group had an increased level of attribution of discrimination to such social category. In fact, chi-square analyses showed that there was some overlap between being LGB and attribution to sexual orientation (χ^2[1] = 33.74, p < .001), between being higher-body weight and attribution to body weight (χ^2[1] = 46.95, p < .001), and between being working-class and attribution to social class (χ^2[1] = 15.04, p < .001). Interestingly, I did not find this overlap between being indigenous and ethnicity (χ^2[1] = 2.11, p = .15).

Finally, in addition to testing direct associations between these narrative dimensions and internalised stigma, I also explored if there were moderation effects on the experiencing discrimination and internalised stigma relationship, following the rationale for the moderation effect tested for protective factors and stigma characteristics. Nevertheless, there was no evidence supporting a moderation effect in any of these narrative dimensions.

Discussion

In this study, I explored the role of multiple factors in their associations with two subdimensions of internalised stigma. Particularly, I assessed the effects of two forms of experiencing discrimination, three sources of social support, four different coping strategies, and three group-level characteristics. As I will discuss in this section, I found evidence partially supporting my four hypotheses and, particularly, large group differences in internalised stigma that emerges across most of my results.

Regarding my first hypothesis, I found initial evidence showing a positive association between reporting a higher number of major discrimination experiences and higher levels of internalised stigma. This is in line with previous research finding a similar association when studying the mediational role of internalised stigma between discrimination experiences and health outcomes (Magallares et al., 2017; Timmins et al., 2020). In these studies, the association between experiencing discrimination and internalised stigma present a variety of sizes, from small (Timmins et al., 2020) to large (Magallares et al., 2017). In my study, the association I found was small, and it decreased after controlling by group, probably because some groups had an increased rate of discrimination experiences reporting, which is not something previous research was able to account for. In addition, my findings highlight the role of major life discrimination experiences in their relationship with internalised stigma. Although more research is needed, following the self-stigma stage model (Corrigan et al., 2006;

Corrigan & Rao, 2012), it is possible to think that these impactful life events are more explicit indicators of the societal stigma that is being internalised.

Furthermore, when the discrimination-internalised stigma relationship is tested by group category independently, the association only reaches statistical significance among working-class people. Most likely, the association between discrimination experiences and internalised stigma is very small, and a higher statistical power is required to identify it. In addition, the distributions of internalised stigma and discrimination experiences were different across groups. For example, LGB people have low levels of both discrimination experiences and internalised stigma. Therefore, different types of analyses could be required to understand the association in a single-group focused study.

Regarding my second hypothesis, I found bivariate correlations between social support and coping strategies, and internalised stigma. However, when accounting for group differences, only some specific coping strategies were associated with internalised stigma in the hypothesised direction, but not social support. In line with previous findings (Hatzenbuehler, 2009; Magallares et al., 2016) showing the positive effect of active coping and negative effect of avoidant coping in the stigma health association, I found that education (a form of active coping) was associated with lower levels of SIS and GIS, and interiorisation (a form of avoidant coping) was associated with higher levels of SIS and GIS. Even more, detachment (as another form of avoidant coping) was found to be linked with higher levels of SIS. From a psychological mediation perspective (Hatzenbuehler, 2009), avoidant coping strategies can be associated with ruminating and emotional dysregulation responses to stigma that allow for it to be interiorised. Further research needs to be developed to disentangle the role of each one of these coping strategies. On the other hand, it is possible the measure of social support was too dependent on the sources of support (i.e., family, friends, others) which can be deeply different for each stigmatised group. It would be recommendable for future

research to explore the role of more structural measures of social support, including size and diversity of social support networks.

The fact that I was able to find some bivariate association between social support and internalised stigma reflecting similar results as previous studies (Sommantico et al., 2020; Villotti et al., 2018), but not after controlling for groups can be explained by a few reasons. First, previous studies did not compare this effect across multiple different stigmatised groups, which in my study explains a large amount of the variances in internalised stigma. In addition, it is possible that the different factors in the stigma-health relationship are strongly interrelated (as I found in bivariate associations between the variables in the study), diminishing the predictive power that these variables have when they are being studied separately.

I did not find evidence supporting the moderating expectations in the second and third hypotheses. Contrary to what I hypothesised, social support, coping strategies, and stigma characteristics did not interact with discrimination experiences in generating different outcomes in internalised stigma. Although more research is needed, these results point out that discrimination is not necessarily the main direct antecedent of internalised stigma as initially expected and, in turn, a more complex group of factors could be playing a role.

Regarding their last experience of discrimination, appraisals of globality and severity were associated with higher GIS, which aligns with my fourth hypothesis. This finding is aligned with previous research that found these exact two appraisals to be associated with self-esteem (Eccleston & Major, 2006). Furthermore, these results parallel the role of major life discrimination events previously discussed. However, it is surprising that they were associated with GIS over SIS, thinking that self-esteem could be more linked to self-focused forms of internalised stigma. The distinction between GIS and SIS is recent (Ciaffoni et al., 2021; James, 2021), and more research needs to be conducted on the association between these two

dimensions and other different well-being outcomes to clearly identify the reasons for these findings.

Regarding the exploratory approach to the discrimination event narration and internalised stigma, I found that narratives of redemption, exteriorisation and withdrawal were associated with lower GIS. This beneficial role of redemption is aligned with previous research showing its association with higher well-being when people recall low-point events in life (Adler et al., 2015). In addition, it is possible that redemption, exteriorisation and withdrawal in these stories are indicators of stigma resistance, that is, counteracting public stigma through multiple psychosocial mechanisms, including self-compassion (Chan et al., 2018) and positive in-group attitudes (Yip & Chan, 2022). Similar to what I found about appraisals of the event, more research is needed to understand why these narratives were associated with GIS over SIS. Considering the narrative data, it could be possible to interpret that these resistance narratives are more linked to a reduction of general prejudice targeted to the own group by, for example, identifying its societal causes, but not necessarily on how much these beliefs are applied to the self.

In addition, these results are aligned with previous narrative research on stigma, showing the variety of strategies that marginalised populations can use to frame and create new meanings in the face of discrimination (Frost, 2011b; Pemberton et al., 2016). At the narrative level, individuals are able to transform negative emotions stemming from stigma and setting up boundaries by identifying their social causes or leaving stigmatising environments. Although these narrative responses seem to play a protective role in the impact of stigma, more research needs to be conducted to understand how people get to develop and engage with these meaning-making strategies.

Findings from the narrative accounts also presented novel insights about intersectional stigma and highlighted its complex nature beyond the mere addition of stigmatising contexts (J. M. Turan et al., 2019). Participants in the study narrated discrimination experiences that could only be explained by the unique combination of stigmatised features, such as being verbally assaulted in the streets because of sexual orientation and body weight. In addition, considering that the sample was young emerging adults who have recently left adolescence, these experiences were also tied to their age group and how it is seen in this cultural context. In Chile, underage people are usually disregarded and seen as inferior from an adult-centric view (Terra Polanco et al., 2021). Results in this study show how age, among emerging adults, can operate as a stigmatised identity by itself or in combination with other discriminated features shaping an individual's experiences of stigma.

Beyond the partial evidence found towards my first, second, and fourth hypotheses, this study shows that most of the variance in internalised stigma was explained by group differences and stigma characteristics, especially perceptions of mutability. In line with my third hypothesis, groups high in socially perceived mutability and groups low in socially perceived concealability showed higher levels of internalised stigma. These findings replicated in a very similar way to what I found in the first study of this thesis. However, I did not find a relevant effect of lowered social status, which means that levels of internalised stigma did not differ between people with only one stigmatised identity compared to people with two or more. When exploring the role of subjective perceptions of mutability, I found unexpected and illuminating results. Among groups socially perceived as low in mutability, a higher subjective perception of mutability was also strongly associated with higher levels of internalised stigma.

The significant role of social and subjective perceptions mutability might be explained by the desires for change, an important component in the self-focused internalised stigma (Herek, 2004). The fact that the stigmatised identity is possible -or expected to be possible- to

change might be one of the core factors in allowing for increasing the desire to change one's identity or features associated with stigma. On the other hand, group-focused internalised stigma is less related to these desires and much closer to group prejudice and stereotypes, and even so it still is associated with subjective and socially perceived mutability. It is possible that mutability is strongly associated with self or in-group blaming of the disadvantaged status because, if change is possible, then the stigma causes can be located in the group or the individual. More research needs to be developed to explain this hypothesis further.

Limitations and suggestions for research

There are limitations that need to be considered in this research. It was not possible to recruit the ideal sample for the study's design. Specifically, I just completed the quota for Indigenous people in the sample, and most of them had identities intersecting with other targeted groups in the study. Although this challenge illustrates the reality of these groups where intersectional stigmatised identities are more common than usually thought, it also produced some limitations in my analysis. Especially when looking at group differences, important statistical power is lost when comparing groups based on stigma characteristics and the number of groups at the same time. Considering the large differences between groups, a bigger sample size could have helped in conducting more detailed analyses of different subgroups with multiple combinations of characteristics.

In addition, this study focused on experiencing discrimination as main antecedent of internalised stigma. Future research should include measures of perceived or felt social stigma to understand more if, beyond the direct experience of discrimination, the realisation of the existence of stigma can be enough in producing internalisation procedures, following one of the premises of the self-stigma stage model (Corrigan & Rao, 2012). Moreover, following my results on the strong association between subjective perceptions of mutability and internalised

stigma, it is possible that social stigma is linked to social and individual expectations that operate at a perceived level in the internalisation process.

Finally, this study only explored associations with cross-sectional data. Therefore, it is not possible to draw causal claims or temporal ordering of these processes. Future research should use longitudinal and experimental approaches that allow for more precise claims about the directionality of the relationships presented here.

Conclusion

By taking an exploratory, cross-sectional, and comparative approach, in this chapter I have been able to find enlightening evidence about the factors associated with internalised stigma. The findings highlight the role of stigma characteristics in their association with stigma internalisation. In addition, it indicates that experiencing discrimination, coping strategies, and narrative accounts might also explain part of the process. Thus, the results of this chapter draft a clearer direction for future hypotheses around the antecedents of internalised stigma. The next step in this thesis is understanding change over time, which will allow for assessing a potential accumulative effect of discrimination and having a more precise identification of the temporal order of these mechanisms.

CHAPTER V

Explaining changes in internalised stigma over time: A longitudinal approach

Introduction

The impact of stigma on people's lives is a process that happens and transforms over time. Historical context, human development, and stigma courses are constantly changing, shaping how people experience stigma (Earnshaw et al., 2022). However, more attention is needed to this temporal dimension, which sets up conceptual and methodological challenges for stigma research.

The antecedents and consequences of social stigma are usually studied using cross-sectional designs, and research on internalised stigma has followed this trend. However, most of the questions developed in the field focus on the outcomes or antecedents of internalised stigma. For example, scholars have been interested in the negative impact of internalised stigma on people's mental health or well-being. Longitudinal methods capable of understanding processes and changes over time are still required to address these questions. Considering the need for more research on the antecedents of internalised stigma and the relevance of using longitudinal approaches, this chapter aims to understand how internalised stigma changes over the course of one year and which factors explain such change.

Internalised stigma over the life course: Patterns of change over time

Researching the antecedents that explain why people internalise stigma might have the assumption that there are some events (e.g., experiencing discrimination) that cause people to internalise stigmatising beliefs. However, it is important to note that there is not an exact event that can be pinpointed as producing the existence of internalised stigma. Meyer (1995) reflected that gay people internalise homophobic beliefs from society long before they know about their sexual orientation. A similar conclusion can be drawn from initial research on internalised

racism when studying children reproducing racial bias at an early age (see Shellae Versey et al., 2019). Therefore, studying the antecedents of internalised stigma requires understanding the phenomenon as an existing and ongoing process during the life course.

As reviewed in the theoretical framework, previous research indicates that younger adults present higher levels of internalised stigma compared to older groups. Age is negatively associated with internalised stigma among HIV-positive individuals (Logie & Gadalla, 2009), higher-body weight people (Pearl et al., 2021), and people with schizophrenia (Pribadi et al., 2020; Werner et al., 2008), among others. Even more, older cohorts of sexual minority adults present lower levels of internalised homophobia compared to emerging adults aged between 18 and 25 years old (Meyer et al., 2021). These findings trigger questions about emerging adulthood and its relationship with internalised stigma.

Emerging adulthood is the phase of the life course between 18 and the mid to late 20s, characterised by individual exploration, establishment of new relationships, and changes in education and residence (Arnett, 2000). As discussed in the theoretical framework, stigmatised emerging adults start developing a deeper understanding of their identity and minoritised status (Spencer & Patrick, 2009). Moreover, they are exposed to new stigmatising experiences and protective factors due to the changing and transitional environments they navigate (Earnshaw et al., 2022). Consequently, emerging adulthood becomes a rich context for studying internalised stigma change and its antecedents.

Something that could explain why emerging adults report higher internalised stigma levels compared to people from older generations is the hypothesis that internalised stigma decreases over time. Earnshaw and colleagues (2021) studied levels of HIV/STI internalised stigma over one year, and they found that people between 18 and 50 years old diagnosed with HIV/STI endorse low levels of internalised stigma in general and that these levels tend to

decrease over the year. A potential explanation for this phenomenon is that an acute phase of applying existing stigmatising beliefs to the self unfolds when people know or recognise their stigmatised status (Meyer, 1995). This hypothesis suggests that these internalised stigmatising beliefs are likely to diminish throughout a person's life after that initial stage. However, these explanations were developed thinking in sexual minorities and coming-out processes, and less is known about these patterns for other stigmatised populations.

The influence of perceived mutability and concealability on internalised stigma

Some characteristics are socially associated with the stigma attached to people's identity, group membership, or health condition (Jones et al., 1984; Pachankis et al., 2018), for example, how much the stigmatised features are perceived to be able to change or to be hidden. Considering the large percentage of variance in internalised stigma explained by these stigma characteristics, particularly perceived mutability (see chapters III and IV), a primary question is what role these characteristics play in internalised stigma change.

Regarding mutability, I have found in the previous chapter that not only groups socially perceived to be high in mutability present higher levels of internalised stigma compared to groups low in mutability, but also that one's subjective perception of the mutability of their own identity was positively associated with internalised stigma. Possibly, mutability expectations are tied to self-blame beliefs (Burnette et al., 2017) because the individual is seen and made responsible for their stigmatised status (Solanke, 2021). These self-blame beliefs can be associated with further stigma internalisation (Burnette et al., 2017; Himmelstein et al., 2020). Unfortunately, there is little research on the association between perceived mutability and internalised stigma, especially using longitudinal studies. If perceived mutability is positively associated with internalised stigma, then I can hypothesise that it might also be

associated with increasing patterns of change or, at least, with a reduction in any decreasing pattern.

Perceived concealability, on the other hand, was found to be negatively associated with internalised stigma (see previous chapter): groups perceived to be low in concealability presented higher levels of internalised stigma compared to groups high in concealability. Although concealment strategies among sexually minoritised populations have usually been found to have a detrimental effect on health and well-being (Huang & Chan, 2022; Pachankis et al., 2020), there is also research pointing out that there are certain circumstances where hiding one's own identity can be protective against discrimination experiences (Legate et al., 2012). However, most of this research has been conducted on concealment strategies among concealable stigmatised identities, for example, by studying decisions and concerns about coming out. Further research is needed on perceived concealability as a group characteristic that distinguishes stigmatised features that are expected or not to be able to be hidden, such as social class and race. Even less is known about the role of concealability in explaining changes in internalised stigma over time. Following the previous findings in this thesis, I hypothesised that perceived concealability will be associated with a larger decrease in internalised stigma levels.

Factors associated with internalised stigma change

Although my first hypothesis stated that internalised stigma has a decreasing overall pattern in time, it is unclear what other factors can explain or modify this decrease. In the previous chapter, I focused on the role of experiencing discrimination and protective factors; in the current study, I tested their roles on patterns of change in internalised stigma.

There is little knowledge of the antecedents of internalised stigma, especially regarding factors associated with changes in internalised stigma over time. Among people with mental

disorders, it has been found that experiencing discrimination predicted higher levels of internalised stigma one year later (Chan & Tsui, 2023). However, it is unclear if this longitudinal effect can be found in other stigmatised populations. Considering existing evidence from the previous chapters in this thesis and the reviewed literature, I hypothesised that experiencing discrimination is associated with increasing levels of internalised stigma over time.

Regarding protective factors, social support has frequently been found to buffer the negative impact of stigma on minoritised populations (Hatzenbuehler, 2009; J. Li et al., 2017). There is also evidence pointing out the longitudinal effect of social support: among people with schizophrenia and bipolar disorder, social support predicted decreases in internalised stigma over the course of six months (Ma et al., 2024). I expected to find a similar effect of social support in other stigmatised groups, predicting decreasing internalised stigma over time.

Coping strategies when experiencing discrimination have also been found to be relevant factors (Hatzenbuehler, 2009; Hing & Russell, 2017b). Active responses to stigma are usually found to be protective against discrimination and stigma, while avoidant responses are linked to stigma internalisation (Hing & Russell, 2017b). Secondary control engagement coping (i.e., an active form of coping through favourable cognitive framing) was associated with a decreased level of internalised mental health stigma after six months among adolescents receiving psychiatric treatment (Moses, 2015). Following these findings, I hypothesised that active coping will be associated with decreasing levels of internalised stigma, while avoidant coping will be associated with increasing levels.

As discussed in the previous chapter, narratives also play a role in how people experience and internalise stigma. Although narrative redemption when telling a challenging life event is associated with higher levels of well-being over time in the general population

(Cox et al., 2019), less is known about this longitudinal impact among stigmatised people. For HIV-positive adults, participating in a stigma-reduction intervention was associated with changes in their narratives after one year, showing less internalised stigma and higher self-esteem in their stories (Tsai et al., 2017). While these results highlight how social interventions can change narratives associated with stigma, they do not explain how these narratives are associated with internalised stigma changes. This study was an opportunity to examine how narratives about discrimination change after one year and the effect of narrative dimensions on internalised stigma over time.

The current study

Considering the need for a deeper understanding of the patterns of change of internalised stigma in the life course, this study analysed how much it changed over the course of one year among emerging adults. Furthermore, this study addressed multiple stigma characteristics and related factors, aiming at producing an integrative understanding of the antecedents that can explain changes in internalised stigma across different minoritised groups of emerging adults. In order to achieve this, I conducted two follow-up waves of data collection with the same sample presented in the previous chapter, consisting of emerging adults in Chile who completed the survey on three occasions over the course of one year.

In this study, I hypothesised that: a. on average, levels of internalised stigma will tend to decrease over time among marginalised groups; b. perceived mutable and non-concealable groups will present less of a decrease in their levels of internalised stigma, compared to non-mutable and concealable groups; c. people who experience more discrimination will have less of a decrease in their levels of internalised stigma, compared to those who experience less discrimination; and d. protective factors (social support and active coping) will be associated with a larger decrease in levels of internalised stigma. Finally, I looked at narrative accounts to

explore how the way people frame and react to discrimination experiences can impact changes in internalised stigma and how these narratives of discrimination can change over time.

Methods

Participants and procedure

I conducted a longitudinal panel study of three waves over the course of one year. This is the same study used in the previous chapter, which focused on its first wave. I followed up with the same sample, adding two new waves of measurement (for more details about the initial study design and recruitment, see Chapter IV). The sample size was calculated to be 600 participants in the first wave and 400 to 300 participants in the last wave, estimating a potential 30% to 50% attrition. The purpose was to get nearly 100 participants per group, considering the requirements for fitting growth curve models (Curran et al., 2010).

The sample size in the first wave was 729 participants, consisting of emerging adults in Chile. All participants who completed the first wave were recontacted to participate in the second and third waves (see Table V.1 for further details of the sample characteristics). Each wave was separated by 6 months. Attrition was higher than expected, with 296 participants completing the second wave, 290 participants completing the third wave, and 206 participants completing all three waves[6]. Although the sample size was smaller than initially expected, this number of participants still allowed for the minimum requirements for growth curve modelling. A sample size of at least 100 participants is usually adequate for modelling a growth curve

[6] Attrition analyses were conducted to understand factors associated with retention and assess potential bias in the data. There were some demographic variables associated with higher retention (being older, being a woman, being LGB+, not being working-class). However, there were no variables of interest associated with retention (including SIS, GIS, discrimination experiences, social support, coping strategies, perceived mutability or perceived concealability).

(Curran et al., 2010); thus, the final sample size allowed for conducting the analysis on the full sample but not for fitting separated growth curve models per group.

Participants registered in the study using their email addresses, which were then used to contact them for each new wave and to link their responses across surveys. Recruitment and data collection were completed between August and October of 2022 for the first wave, between February and April of 2023 for the second wave, and between August and October of 2023. During the first wave, participants read an information sheet and consented to their participation prior to participating. Participants also consented to their participation at the beginning of the two remaining waves. This study received full approval from the University College London Institute of Education Ethics Committee and the P. Universidad Católica de Chile Social Sciences Ethics Committee.

Table V.1

Sample characteristics

	n (%)		
Demographics	w1	w2	w3
Age, M (range, SD)	18.82 (18-21, .79)	19.48 (18-21, .93)	19.96 (18-22, .88)
Gender identity [a]			
Woman	496 (62.5%)	251 (66.6%)	224 (64.6%)
Man	227 (28.6%)	87 (23.1%)	92 (26.5%)
Nonbinary/Other	70 (8.8%)	39 (10.4%)	31 (8.9%)
Identify as trans			
Yes	52 (6.6%)	-	31 (8.9%)
No	723 (91.2%)	-	309 (89.0%)
Prefer not to answer	18 (2.3%)	-	7 (2.0%)
Sexual orientation			
Heterosexual	314 (39.6%)	136 (36.1%)	131 (37.8%)
Lesbian	21 (2.6%)	12 (3.2%)	9 (2.6%)
Gay	45 (5.7%)	20 (5.3%)	24 (6.9%)
Bisexual	263 (33.2%)	137 (36.3%)	117 (33.7%)

Pansexual	92 (11.6%)	39 (10.3%)	38 (11.0%)
Queer	24 (3%)	13 (3.4%)	18 (5.2%)
Other	34 (4.3%)	20 (5.3%)	10 (2.9%)
Ethnic group			
White	51 (6.4%)	20 (5.3%)	26 (7.5%)
Latino	669 (84.4%)	323 (85.7%)	288 (83.0%)
Indigenous	61 (7.7%)	30 (8.0%)	29 (8.4%)
Black	3 (0.4%)	1 (0.3%)	1 (0.3%)
Other	9 (1.1%)	3 (0.8%)	3 (0.9%)
Do you consider part of any indigenous group?			
Yes	147 (18.5%)	66 (17.6%)	58 (16.7%)
No	646 (81.5%)	310 (82.4%)	289 (83.3%)
Do you consider yourself to be overweight?			
Yes	369 (46.5%)	165 (43.8%)	165 (47.6%)
No	424 (54.5%)	212 (56.2%)	182 (52.4%)
Do you consider yourself to be working class?			
Yes	464 (58.5%)	188 (49.9%)	160 (46.1%)
No	329 (41.5%)	189 (50.1%)	187 (53.9%)
Studying at			
Highschool	156 (19.7%)	10 (2.7%)	13 (3.7%)
Technical higher ed	14 (1.8%)	9 (2.43%)	2 (0.6%)
Professional institute	75 (9.5%)	40 (10.6%)	34 (9.8%)
University	305 (38.5%)	237 (62.9%)	221 (63.7%)
Not studying	164 (20.7%)	66 (17.5%)	58 (16.7%)
Other	79 (10.0%)	15 (4.0%)	19 (5.5%)
Working			
Full-time	39 (4.9%)	-	23 (6.6%)
Part-time	99 (12.5%)	-	52 (15.0%)
Not working	624 (78.7%)	-	255 (73.5%)
Other	31 (3.9%)	-	17 (4.9%)
First gen university			
Yes	476 (60%)	-	-

No	317 (40%)	-	-
Subjective SES, M (range, SD)	4.81 (1-10, 1.45)	-	5.08 (1-10, 1.62)
Final Group – scale selected			
LGB	217 (27.4%)	113 (31.6%)	117 (35.9%)
Racial minority	150 (18.9%)	67 (18.7%)	58 (17.8%)
Higher-body weight	216 (27.2%)	95 (26.5%)	83 (25.5%)
Working-class	210 (26.5%)	83 (23.2%)	68 (20.9%)
Full *N*	793	358	326
Partial *N* (internalised stigma scale completed)	729	296	290

Note. a: Participants were allowed to mark more than one option. Only two marked more than one. w1-w3 = waves of measurement 1 to 3. *Participants were all between 18 and 21 years old in Chile, so there is small to no variance in country and education level. ***206 participants with full responses across three waves.*

Measures

This study used the same measures included and described in the previous chapter, identically measured in the three waves of the study. For demographic information and group classification, I included self-report questions about sexual orientation, ethnicity, body weight and social class. I included the Multiple Group Internalised Stigma Scale (MGISS) developed in Chapter III with its two subdimensions: self-focused and group-focused internalised stigma (SIS and GIS), everyday forms of discrimination (Williams et al., 1997), major experiences of discrimination (Williams et al., 1997), three dimensions for social support (family, friends, and others; Dahlem et al., 1991), four subdimensions for coping strategies (education, interiorisation, resistance, and detachment; Wei et al., 2010), and participants reported subjective perceptions of concealability and mutability. Only in waves 1 and 3, I asked participants to write about a recent event of discrimination that they experienced over the last

12 months, and I followed up with four close-ended questions about how they appraised the situation (controllable, stable, global, and severe, based on Eccleston & Major, 2006). See Table V.2 for these measures' Cronbach's alpha per wave and between-waves correlations. A detailed description of the questions and measures used for this study can be found in the previous chapter.

In addition, I replicated the coding procedure used for the first wave on the qualitative data collected during the third wave. In wave 1, 471 participants wrote in the narration entries; however, only 355 were eligible. In wave 3, 181 participants wrote entries, but only 139 were eligible, after excluding those narrations that were not discrimination experiences and those that happened more than 12 months before the participant's response. See the previous chapter for a detailed description of the development of the coding scheme and its interrater reliability analyses.

Table V.2

Measures Cronbach's alpha per wave and between-wave correlations

	Cronbach's alpha			Between-wave correlation		
	w1	w2	w3	w1-w2	w1-w3	w2-w3
MGISS - SIS	.95	.96	.96	.93**	.93**	.94**
MGISS - GIS	.68	.78	.79	.67**	.68**	.71**
Daily discrimination experiences	.85	.86	.87	.66**	.70**	.76**
Number of major discrimination experiences	a	a	a	.69**	.68**	.72**
Support from family	.91	.91	.92	.77**	.72**	.72**
Support from friends	.94	.94	.94	.59**	.55**	.59**
Support from other	.86	.88	.89	.59**	.52**	.51**
Coping education	.88	.90	.89	.70**	.63**	.68**
Coping interiorisation	.78	.83	.78	.44**	.40**	.48**
Coping resistance	.76	.75	.81	.60**	.53**	.64**
Coping detachment	.83	.82	.83	.60**	.54**	.61**
Subjective concealability	a	a	a	.56**	.54**	.58**
Subjective mutability	a	a	a	.80**	.78**	.81**

Note. a: Alpha was not calculated for number of major discrimination experiences (it is not a scale, but a total number of different events) nor for single-item variables. w1-w3 = waves of measurement 1 to 3. MGISS = multiple-group internalised stigma scale, SIS = self-focused internalised stigma, GIS = group-focused internalised stigma.

Data analysis

Considering the scarcity of research about internalised stigma changes over time, three steps were taken to explore the phenomenon. First, at a descriptive level, I computed the mean scores of the within-person difference between waves in their levels of SIS and GIS. Second, to visualise the changes over time, I plotted the individual trajectories and calculated the overall linear trends. For the last step, to directly test the hypothesis on trends of change in internalised stigma, I conducted growth curve modelling (GCM) to fit an intercept and slope for SIS and

GIS. For testing the following hypotheses on the role of the antecedents of internalised stigma, I included predictors into the growth curve for SIS and GIS. Finally, the association between the narrative dimensions and internalised stigma was analysed using linear regressions. Descriptive and regression analyses were conducted using SPSS 27, and GCM analyses were conducted using R.

Growth curve modelling (GCM) is a statistical method for analysing repeated measures and estimating between-subject variability in within-subject patterns of change (Bollen & Curran, 2005; Curran et al., 2010). These growth curves are often known as latent trajectories as they represent an estimation of the intra-individual change. GCM includes fixed and random effects to fit an adequate representation of the baseline or intercept, as well as the rate of change or slope (Curran et al., 2010). This method is a flexible tool for analysing increasing or decreasing patterns of change, linear or curvilinear trajectories, and even the absence of change.

In the context of this study, GCM allowed me to estimate a linear trajectory of internalised stigma over three waves of measurement and assess the predictors of its variance. This method was appropriate for the research question as I aimed to understand and explain patterns of change. Considering the structure of my data, GCM also provided additional advantages above other approaches (such as regression or a repeated measures analysis of variance, RANOVA). GCM is characterised by being more flexible with partially missing data and presenting more statistical power when compared to other methods (Curran et al., 2010).

Results

Descriptive statistics

I conducted descriptive analysis on all variables across waves before testing my hypotheses. See Table V.3 for a summary of descriptives and bivariate correlations between variables within each wave. The distribution of each variable was mostly similar across waves

(see previous chapter for a description and discussion about these). The pattern of associations between variables was also consistent across waves.

Changes in internalised stigma

To test if internalised stigma decreased over the course of one year among marginalised emerging adults, the first step was exploring the data calculating the within-person differences scores (Δ) of SIS and GIS between each combination of two waves (w1 – w2, w2 – w3, and w1 – w3). As presented in Table V.4, although there were some individual variations in internalised stigma levels between the three pairs of each two waves, the averaged differences were negligible. The only mean difference, which 95% CI did not contain zero, was in the levels of GIS between waves 1 and 3, showing a slight average increase. More complex analytical approaches needed to be conducted to understand the overall change across waves.

Table V.3

Descriptive statistics and bivariate Pearson correlations

		N	Range	Mean (*SD*)	Skewness	Kurtosis	1	2	3	4	5	6	7	8	9	10	11	12	13
w1	1.a SIS	731	1 - 7	4.09 (2.00)	-0.16	-1.44	1	.50**	.10*	.16**	-0.08	-.18**	-.11**	-.09*	.13**	-.01	.18**	.03	.75**
	2.a GIS	729	1 - 6.4	2.63 (1.13)	0.49	-0.29		1	.07	.14**	-0.05	-.15**	-.12**	-.18**	.10*	.03	.13**	.04	.39**
	3.a Daily discrimination experiences	646	1 - 4	2.48 (0.68)	-0.09	-0.71			1	.45**	-.28**	-.14**	-.18**	.16**	.16**	.18**	.19**	-.09*	.01
	4.a Number of major discrimination experiences	644	0 - 7	1.83 (1.63)	0.80	0.09				1	-.16**	-.12**	-.13**	.21**	.06	.13**	.17**	-.05	.07
	5.a Support from family	654	1 - 7	4.16 (1.69)	-0.21	-0.92					1	.36**	.48**	.02	-.04	-.11**	-.40**	-.03	-.03
	6.a Support from friends	654	1 - 7	4.92 (1.63)	-0.69	-0.29						1	.65**	.13**	.03	.01	-.393**	.06	-.15**
	7.a Support from other	654	1 - 7	5.16 (1.39)	-0.68	-0.11							1	.12**	.00	-0.02	-.47**	.06	-.07
	8.a Coping education	668	1 - 7	5.19 (1.21)	-1.03	1.19								1	.21**	.17**	-0.01	-.03	-.08*
	9.a Coping interiorisation	668	1 - 7	4.81 (1.48)	-0.90	0.16									1	-.08*	.26**	.07	.05
	10.a Coping resistance	668	1 - 7	3.78 (1.24)	-0.04	-0.30										1	-0.08	.00	.01
	11.a Coping detachment	668	1 - 7	4.38 (1.46)	-0.39	-0.48											1	.06	.07
	12.a Subjective concealability	668	1 - 7	3.78 (1.24)	-0.04	-0.30												1	.04
	13.a Subjective mutability	668	1 - 7	4.38 (1.46)	-0.39	-0.48													1

w2	1.b SIS	296	1 - 7	3.96 (2.11)	-0.04	-1.53	1	.56**	.18**	.12*	-.03	-.24**	-.12*	-.16**	.11	-.03	.13*	.02	.76**
	2.b GIS	296	1 - 6.5	2.55 (1.28)	0.81	0.13		1	.16**	.15*	-.05	-.11	-.13*	-.24**	.12*	.07	.15**	.05	.43**
	3.b Daily discrimination experiences	330	1 - 7	2.36 (0.71)	0.08	-0.64			1	.53**	-.18**	-.14**	-.16**	.22**	.15**	.13*	.22**	-.05	.13*
	4.b Number of major discrimination experiences	329	0 - 9	1.67 (1.58)	1.16	1.57				1	-.14*	-.13*	-.16**	.18**	.17**	.13*	.23**	-.06	.16**
	5.b Support from family	333	1 - 7	4.51 (1.67)	-0.27	-0.97					1	.35**	.51**	.06	-.05	-.01	-.44**	-.02	.03
	6.b Support from friends	333	1 - 7	5.19 (1.50)	-0.94	0.47						1	.60**	.16**	-.13*	-.02	-.49**	.02	-.23**
	7.b Support from other	333	1 - 7	5.41 (1.32)	-0.93	0.60							1	.18**	-.19**	.00	-.57**	.03	-.10
	8.b Coping education	339	1 - 7	5.16 (1.28)	-0.85	0.51								1	.17*	.13*	-.06	-.11	-.03
	9.b Coping interiorisation	339	1 - 7	4.58 (1.31)	-0.86	0.36									1	-.13*	.30**	.08	.10
	10.b Coping resistance	339	1 - 6.8	3.82 (1.21)	-0.02	-0.27										1	-.10	.05	.01
	11.b Coping detachment	339	1 - 7	4.07 (1.44)	-0.18	-0.60											1	.05	.06
	12.b Subjective concealability	302	1 - 7	4.14 (1.87)	-0.28	-1.01												1	.05
	13.b Subjective mutability	301	1 - 7	3.72 (2.33)	0.09	-1.60													1

w3	1.c SIS	290	1 - 7	3.87 (2.12)	0.04	-1.55	1	.57**	.17**	.18**	-.20**	-.32**	-.29**	-.15*	.07	-.01	.30**	-.12	.76**
	2.c GIS	290	1 - 7	2.60 (1.27)	0.57	-0.23		1	.08	.12*	-.19**	-.34**	-.32**	-.21**	.04	.11	.23**	-.02	.48**
	3.c Daily discrimination experiences	307	1 - 4	2.36 (0.72)	0.24	-0.60			1	.53**	-.26**	-.13*	-.19**	.26**	.21**	.14*	.21**	-.10	.07
	4.c Number of major discrimination experiences	304	0 - 8	1.70 (1.68)	0.92	0.39				1	-.29**	-.19**	-.21**	.19**	.08	.12*	.17**	-.14*	.13*
	5.c Support from family	312	1 - 7	4.52 (1.69)	-0.52	-0.60					1	.44**	.50**	.14*	.04	-.11	-.43**	-.05	-.11
	6.c Support from friends	311	1 - 7	5.26 (1.52)	-1.09	0.81						1	.73**	.24**	.04	-.08	-.48**	.06	-.26**
	7.c Support from other	312	1 - 7	5.46 (1.31)	-1.11	1.33							1	.20**	-.01	-.02	-.56**	.04	-.22**
	8.c Coping education	313	1 - 7	5.11 (1.24)	-0.91	1.02								1	.27**	.12*	-.13*	-.15*	-.11
	9.c Coping interiorisation	313	1 - 6.8	4.63 (1.16)	-0.72	0.39									1	-.09	.19**	-.03	-.00
	10.c Coping resistance	313	1 - 6.8	3.74 (1.26)	-0.06	-0.46										1	-.12*	-.05	.02
	11.c Coping detachment	313	1 - 7	4.07 (1.44)	-0.06	-0.77											1	-.01	.15**
	12.c Subjective concealability	292	1 - 7	4.03 (1.93)	-0.22	-1.15												1	-.03
	13.c Subjective mutability	293	1 - 7	3.76 (2.39)	0.05	-1.65													1

Note. w1-w3 = waves of measurement 1 to 3. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. *$p < .05$, ** $p < .01$

Table V.4

Within-individual mean differences between waves

	SIS		GIS	
	M (*SD*)	95% CI	*M* (*SD*)	95% CI
Δ w1 - w2	.02 (.77)	[-.08, .11]	-.07 (.97)	[-.18, .05]
Δ w2 - w3	.08 (.76)	[-.02, .19]	.01 (.93)	[-.12, .14]
Δ w1 - w3	.04 (.78)	[-.05, .13]	-.13 (.96)	[-.24, -.02]

Note. w1-w3 = waves of measurement 1 to 3. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. CI = Confidence Interval.

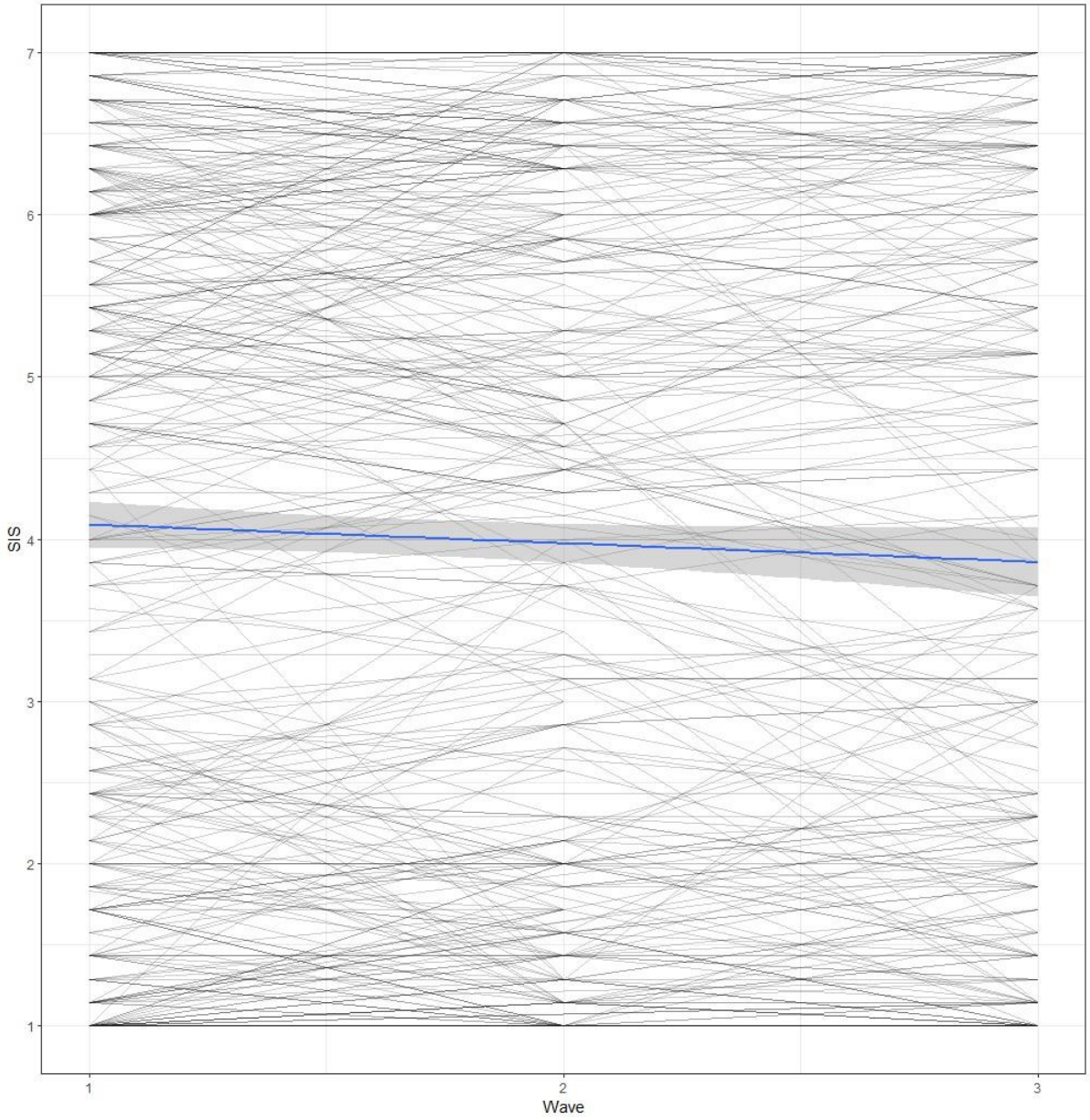
The second step was to plot the overall trends of SIS and GIS as a function of time. In Figures VI.1 and VI.2, the linear trends can be seen alongside the individual trajectories. By examining the 95% confidence interval of the lines, it is possible to see that for both subdimensions, there was negligible change. By looking at the individual trajectories, it was possible to distinguish variance in internalised stigma trends across participants, which might suggest there were differences that the hypothesised factors could further explain. In addition, the bimodal distribution of SIS found in the previous chapter can also be seen throughout the three time points (see previous chapter for a discussion about this). Although there was not a clear increasing or decreasing trend in the data, fitting a growth curve can help explain potential individual or group-level variances in the trajectories of change over time, which was the third and final step of this analysis.

The results of the growth curve model without predictors (M1) are presented in Table V.5. I did not find evidence supporting my first hypothesis regarding a decreasing trend of internalised stigma over the course of one year. The slopes for both SIS and GIS were not statistically significant and near zero in magnitude, which means levels of these variables were mostly consistent over time, in line with the descriptive findings presented in the previous paragraphs.

In sum, these different analytical approaches showed negligible to no increasing or decreasing trajectories in the sample's internalised stigma levels. However, despite the absence of a clear overall trend, there could still be predictors of individual or group differences in the slope that require to be analysed.

Figure V.1

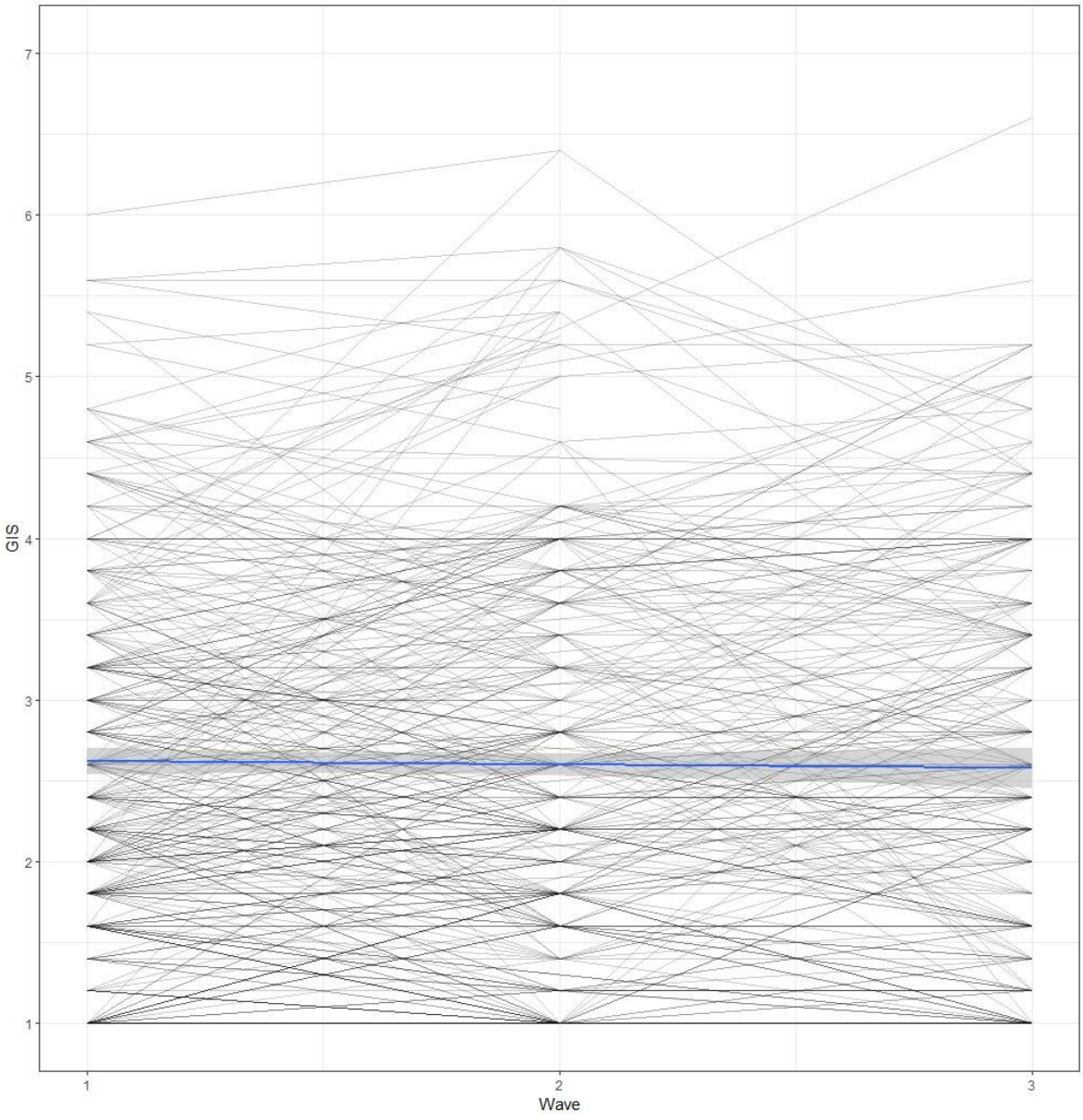
Trend of change for SIS over the course of one year



Note. Linear trajectory of SIS over three waves of measurement, 95% confidence interval. Individual mean score trajectories are represented in grey lines.

Figure V.2

Trend of change for SIS over the course of one year



Note. Linear trajectory of GIS over three waves of measurement, 95% confidence interval. Individual mean score trajectories are represented in grey lines.

Table V.5

Growth Curve Model of SIS and GIS without predictors

		SIS						GIS				
		β	*SE*	95% CI	*z*	*p*		β	*SE*	95% CI	*z*	*p*
M1	Intercept	4.08	.07	[3.94, 4.23]	55.70	<.001	M1	2.62	.04	[2.54, 2.70]	63.44	<.001
	Slope	-.03	.02	[-1.46, 0.15]	-1.46	.15		0.04	.03	[-0.01, 0.10]	1.50	.13
	Intercept (variance)	3.71	.16	[3.39, 4.03]	22.61	<.001		0.92	.13	[0.67, 1.18]	7.19	<.001
	Slope (variance)	0.01	.07	[-0.13, 0.14]	0.08	.94		0.08	.06	[-0.03, 0.20]	1.26	.21

Note. M1 = model without predictors. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. CI = Confidence Interval.

Perceived mutability, concealability, and internalised stigma change

Based on the findings presented in the previous chapter, I first tested the effect of the two stigma characteristics on the growth curve models (M2). As shown in Table V.6, groups socially perceived as high in mutability presented higher baseline levels of SIS and GIS compared to those perceived as low in mutability, in line with the findings presented in the second chapter. However, it was not possible to replicate the effect of perceived concealability or the interaction between characteristics.

Interestingly, the effect of socially perceived mutability was also found to be statistically significant on the slope of the trajectory of GIS, which aligns with my hypothesis. Groups perceived to be high in mutability presented a more inclined slope, increasing levels of GIS over time, compared to those low in mutability. By examining the linear projections of these trajectories (see Figure V.3), it is possible to see that groups perceived as high in mutability not only have higher levels of GIS at the first wave but also have a slightly increasing slope. In contrast, groups perceived as low in mutability have a decreasing slope, slightly

decreasing levels of GIS over the course of one year. In sum, even when, on average, the full sample does not present a decreasing or increasing pattern in their levels of internalised stigma, these results show group differences in the trajectories, explained by socially perceived mutability. I did not find evidence of this effect on SIS.

Table V.6

Growth Curve Models of SIS and GIS with social and subjective mutability/concealability

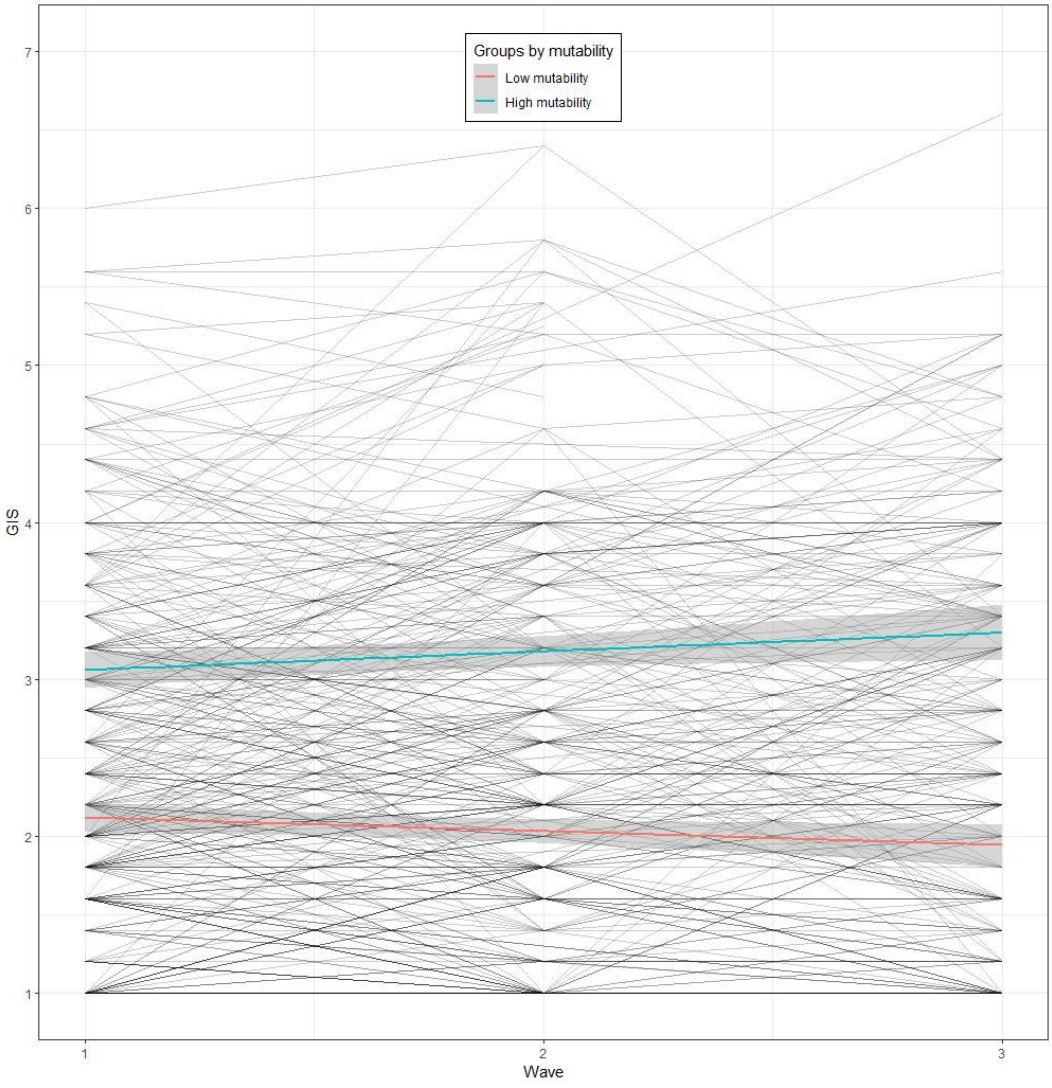
		SIS					GIS				
		β	*SE*	95% CI	*z*	*p*	β	*SE*	95% CI	*z*	*p*
M2											
Intercept	Mutable-perceived groups	3.97	.22	[3.54, 4.40]	18.17	<.001	0.85	.20	[0.47, 1.24]	4.34	<.001
	Concealable-perceived groups	-0.02	.20	[-0.41, 0.38]	-0.08	.94	-0.22	.18	[-0.58, 0.14]	-1.20	.23
	Mutability x concealability	-0.55	.30	[-1.13, 0.03]	-1.86	.06	0.18	.27	[-0.34, 0.70]	0.68	.50
Slope	Mutable-perceived groups	0.08	.08	[-0.08, 0.24]	0.95	.34	0.26	.09	[0.07, 0.44]	2.73	<.01
	Concealable-perceived groups	0.11	.08	[-0.04, 0.26]	1.44	.15	-0.003	.09	[-0.17, 0.17]	-0.03	.97
	Mutability x concealability	-0.07	.11	[-0.29, 0.15]	-0.63	.53	-0.23	.13	[-0.48, 0.02]	-1.82	.07
M3											
Intercept	Subjective mutability	0.70	.04	[0.62, 0.78]	17.06	<.001	0.18	.03	[0.13, 0.24]	6.45	<.001
	Subjective concealability	0.01	.05	[-0.09, 0.11]	0.16	.87	0.03	.04	[-0.04, 0.10]	0.78	.43
Slope	Subjective mutability	-0.01	.01	[-0.03, 0.02]	-0.63	.53	0.04	.01	[0.01, 0.07]	3.05	<.01
	Subjective concealability	0.01	.01	[-0.02, 0.04]	0.85	.40	0.00	.02	[0.48, 0.89]	0.03	.98

Note. M2 = model with socially perceived concealability/mutability; M3 = model with subjective perceptions of concealability/mutability predictors. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. CI = Confidence Interval.

Regarding subjective perceptions if mutability and concealability, they were not associated with SIS nor GIS after controlling for socially perceived mutability and concealability. Although subjective mutability presented an association with higher levels of SIS and GIS and with an increasing slope for GIS (see M3 in Table V.6), these associations were not maintained when accounting for social perceptions of mutability.

Figure V.3

Trend of change for GIS by groups with high and low social perceptions of mutability



Note. Linear trajectory of GIS by groups high (blue) and low (red) in social perceptions mutability, 95% confidence interval. Individual mean score trajectories are represented in grey lines.

Experiencing discrimination and protective factors

My third hypothesis focused on testing the role of discrimination experiences, social support, and coping strategies in shaping internalised stigma changes over time. I included the different factors in the growth curve model (M4) to understand their influence on base levels and changes over time in SIS and GIS. Results are presented in Table V.7.

Regarding the association with the initial levels of internalised stigma, two factors were relevant in explaining differences in initial levels of internalised stigma, aligning with the findings in the previous chapter. Having experienced a higher number of major discrimination experiences was associated with increased levels of SIS and GIS during the first wave of the study. In addition, education coping strategies in the face of discrimination were associated with lower initial levels of SIS and GIS. In this analysis, I did not find evidence supporting a statistically significant effect of the other factors on internalised stigma. As presented in the previous chapter, including these multiple factors did not generate multi-collinearity issues in their model predicting internalised stigma.

On the other hand, I did not find evidence supporting my hypothesis stating the effect of these factors on changes in internalised stigma. As presented in Table V.7, none of these factors presented a statistically significant effect on the slope of SIS or GIS.

Table V.7

Growth Curve Models of SIS and GIS with discrimination experiences, social support, and coping strategies

		SIS					GIS				
		β	*SE*	95% CI	*z*	*p*	β	*SE*	95% CI	*z*	*p*
M4											
Intercept	Daily discrimination experiences	0.31	.11	[0.09, 0.52]	2.78	<.01	0.12	.05	[0.01, 0.22]	2.15	<.05
	Number of major discrimination experiences	0.20	.26	[-0.30, 0.70]	0.78	.43	0.17	.13	[-0.07, 0.42]	1.38	.17
	Support from family	-0.08	.10	[-0.26, 0.11]	-0.82	.42	-0.02	.05	[-0.11, 0.08]	-0.34	.74
	Support from friends	-0.14	.11	[-0.35, 0.08]	-1.25	.21	-0.07	.06	[-0.18, 0.04]	-1.31	.19
	Support from other	0.24	.16	[-0.07, 0.54]	1.54	.12	0.04	.08	[-0.11, 0.19]	0.48	.64
	Coping education	-0.30	.12	[-0.53, -0.07]	-2.58	<.05	-0.23	.06	[-0.34, -0.12]	-3.97	<.001
	Coping interiorisation	0.15	.11	[-0.06, 0.35]	1.36	.17	0.10	.05	[-0.001, 0.21]	1.93	.05
	Coping resistance	-0.16	.11	[-0.39, 0.06]	-1.43	.15	0.02	.06	[-0.09, 0.13]	0.38	.71
	Coping detachment	0.19	.12	[-0.05, 0.43]	1.56	.12	-0.05	.06	[-0.16, 0.07]	-0.74	.46
Slope	Daily discrimination experiences	-0.01	.02	[-0.05, 0.03]	-0.44	.66	-0.001	.02	[-0.05, 0.05]	-0.03	.98
	Number of major discrimination experiences	-0.06	.05	[-0.15, 0.04]	-1.19	.24	-0.07	.06	[-0.18, 0.04]	-1.17	.24
	Support from family	0.002	.02	[-0.03, 0.04]	0.09	.93	-0.02	.02	[-0.06, 0.02]	-0.87	.39
	Support from friends	-0.004	.02	[-0.05, 0.04]	-0.21	.83	0.004	.03	[-0.05, 0.05]	0.14	.89
	Support from other	0.04	.03	[-0.02, 0.10]	1.44	.15	0.03	.03	[-0.04, 0.10]	0.93	.35
	Coping education	-0.03	.02	[-0.07, 0.01]	-1.41	.16	0.04	.03	[-0.01, 0.09]	1.49	.14
	Coping interiorisation	-0.002	.02	[-0.04, 0.04]	-0.13	.90	0.03	.02	[-0.02, 0.08]	1.30	.20
	Coping resistance	0.04	.02	[-0.01, 0.08]	1.68	.09	0.01	.03	[-0.04, 0.06]	0.41	.68
	Coping detachment	-0.01	.02	[-0.06, 0.04]	-0.44	.66	0.03	.03	[-0.02, 0.09]	1.19	.23

Note. M4 = model with additional factors. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. CI = Confidence Interval.

Narratives about discrimination and change in internalised stigma

Following my findings in the cross-sectional analyses of the narrative data, the next step was to explore the longitudinal effects of how people experience and frame discrimination events. A simpler analytical approach was decided because the number of participants was significantly reduced when considering those who completed brief narratives about discrimination experiences at both times. I replicated the analyses conducted in the previous chapter, looking at the effect of the recent event narrated in the third wave on internalised stigma levels (cross-sectional effect) and at the effect of the past event narrated in the first wave on internalised stigma levels in the later measurement (longitudinal effect).

First, I looked at the association between the appraisals of the discrimination event and levels of internalised stigma (see Table V.8 for the results). Looking at the recent event (appraisals on situations reported in the third wave and internalised stigma levels measured in the same wave), I found a similar pattern of results as in the previous chapter. Evaluating the situation as severe was associated with higher levels of SIS and GIS. There was also a small association between appraising the event as impacting different areas of one's life (i.e., globality appraisal) and GIS.

Interestingly, I found the same pattern of associations in the longitudinal effects: severity appraisals were associated with SIS and GIS, and globality appraisals were associated with GIS. However, when controlling for group differences in this longitudinal effect, the only effect that remained statistically significant was the severity appraisal on GIS.

Table V.8

Discrimination Event Appraisals. Bivariate Pearson correlation with SIS and GIS

		N	SIS - wave 3	GIS - wave 3
Wave 3 - Recent event (cross-sectional effect)	Controllability	126	-.09	-.11
	Stability	123	-.05	-.06
	Globality	126	.12	.23*
	Severity	126	.18*	.22*
Wave 1 - Past event (longitudinal effect)	Controllability	168	-.07	-.01
	Stability	168	.07	-.03
	Globality	168	.10	.16*
	Severity	168	.17*	.26*

Note. SIS = self-focused internalised stigma, GIS = group-focused internalised stigma. *$p < .05$.

Regarding the narrative qualities of the discrimination events, their distribution was also similar between waves (see Table V.9 with frequencies of use and illustrative vignettes from the third wave). As in the first wave, the narrative quality most used among participants was exteriorisation, which means they attributed the causes of the discrimination event to external causes, such as attitudes from people or society. For example, a participant explained that being rejected by a family member based on their sexual orientation has its causes in the religious and conservative beliefs of that family member.

I conducted four regressions for each one of these categories: considering SIS and GIS at the third wave as outcomes and including the recent event (cross-sectional effect) and past event (longitudinal effect) regressions. In the following paragraphs, I present these results in text, with each pair of regressions in parenthesis respectively representing the recent and past event effects.

Table V.9

Narrative codes frequencies - Framing of the event, ideas of causes and responses

	% Wave 1	% Wave 3	Example Wave 3
Redemption sequence	9.9	12.2	"More than once I have been rejected from jobs because of my body weight (…). I felt a lot of anger and sadness, but then I understood that it was better that they did not accept me if they were discriminating in that way. [I thought] that my skills and efficiency at work has nothing to do with how I look."
Interiorisation	19.2	16.5	"I was rejected from a tenancy in [city in Chile], because I was from a neighbourhood where a problematic ex-tenant also came from. (…) During the situation I felt I understood them [the landlords], then I felt bad because of that. "
Exteriorisation	60	56.1	"My dad showed rejection towards my sexual orientation some months ago, when I had to come out because he was suspecting too much. [This happened because] his religion and beliefs make him have a very closed vision about the world."
Active response	25.4	24.5	"I received poor service in a clothes store when I was buying a sweater because I tried it on, and it was the men's section. I have to buy men's clothes because it is bigger (…) I explained to the shop assistant that clothes are just fabric on the body, and that [her service] was not the right way to talk to people."
Withdrawal response	14.6	10.8	"Three weeks ago, a security staff did not leave me alone when I was looking at store products (because of my age, gender, and skin colour), when I said something, he just made me feel like I was imagining things (…). So, I left."

Regarding redemption sequences, it was not possible to replicate the effects found in the previous chapter. Although sizes of the recent event effects are similar, these did not reach statistical significance when using data from the third wave to explain variances in SIS at the cross-sectional and longitudinal effect (β =-.11, t[125] = -1.28, p = .20; β =-.05, t[80] = -.44, p

= .68). I did not find evidence of these two effects when explaining GIS levels (β =-.15, *t*[125] = -1.70, *p* = .09; β =.02, *t*[80] = .14, *p* = .89).

When analysing the effects of interiorisation, I did not find a statistically significant effect on SIS (β =.11, *t*[125] = -1.19, *p* = .24; β =.001, *t*[80] = .01, p = .99) nor GIS (β =-.16, *t*[125] = -1.64, *p* = .10; β =.09, *t*[80] = .81, *p* = .42) of the recent nor the past event, respectively. Interestingly, I was able to replicate the findings in the previous chapter regarding exteriorisation ideas: although not significantly associated with SIS (β =-.12, *t*[125] = -1.39, *p* = .17; β =-.15, *t*[80] = -1.37, p = .17), there was an association with GIS (β =-.28, *t*[125] = -3.24, *p* = <.01; β =-.22, *t*[80] = -2.04, *p* < .05). In other words, participants that explained the causes of their discrimination event on external reasons, presented lower levels of GIS at the third wave of the study.

Lastly, looking at the responses to the event of discrimination, I tested the role of active and withdrawal. Interestingly, for the recent event, but not for the past event, the effects of active responses were statistically significant for SIS (β =-.20, *t*[125] = -2.32, *p* < .05; β =-.03, *t*[80] = -.23, *p* = .82) and for GIS (β =-.18, t[125] = -2.06, *p* < .05; β =-.24, t[80] = -.74, *p* = .46). However, these effects did not remain statistically significant when controlling for group differences, which could be confounding these two variables. On the other hand, I did not find evidence that replicated the findings around the effect of withdrawal responses and GIS (β =-.08, *t*[125] = -.87, *p* = .39; β =-.07, *t*[80] = -.63, *p* = .53). Withdrawal was not significantly associated with SIS at the cross-sectional level, but there was a statistically significant longitudinal effect (β =-.07, *t*[125] = -.78, *p* = .44; β =-.23, *t*[80] = -2.12, *p* < .05). Nevertheless, this effect did not hold after group control.

In summary, regarding the replication analyses of the narrative categories and their association with internalised stigma levels, I found mixed results, some of which replicated

previous findings. Notably, the only effect that remained statistically significant after controlling for group category was the negative cross-sectional effect of exteriorisation ideas on GIS. This is in line with the findings in the previous chapter, suggesting a relevant association between how people attribute external causes to a recent discrimination event and their levels of internalised stigma.

As an additional exploratory analysis, I looked at how narratives changed after the course of one year. Although the sample size among these subgroups was too small for conducting meaningful statistical analyses, noteworthy descriptive insights about these changes emerged. Even when percentages per category stayed similar (see Table V.9), there were relevant shifts of people starting or stopping using a particular narrative dimension. A surprising example was redemption sequences, in which none of the 87 participants who wrote narrations on both waves used redemption sequences twice. In the case of interiorisation, only 10.3% of them presented this form of narrative in both waves, while 19.5% presented it only in wave 1, and 11.5% presented it only in wave 3. A similar pattern can be seen in the other narrative categories.

An example of these narrative shifts can be seen in withdrawal responses: In wave 1, a participant described being discriminated against because of their social class by a teacher and wrote, “I felt awful and for a moment I thought it was me to blame (…) I could not do much because he was an authority [the teacher]”. In wave 3, the same participant also described being discriminated against because of their social class, but this time by a friend, and wrote, “I felt relief because I stop meeting with these people. (…) I left and thought about pushing them away from my life”. This case showcases that the narrative accounts were deeply contextual and could depend on multiple factors, including the people enacting discrimination, the individual and their access to resources, and the relationship between them, among others.

Discussion

In this study, I analysed the antecedents of internalised stigma, looking at how it changes over the course of one year and which factors can explain such change. To do that, I modelled the trajectories of change in levels of internalised stigma and analysed the role of multiple antecedents in predicting the baseline levels and rates of change. In addition, I explored how narratives about discrimination changed over time and analysed the association of narrative dimensions with internalised stigma levels. This study addressed gaps in the literature by studying the antecedents of internalised stigma using a longitudinal design, considering self and group forms of internalised stigma, and focusing on multiple stigmatised groups.

First, I did not find evidence supporting my first hypothesis stating that internalised stigma had a decreasing pattern over time. Although there were some time variations on both subdimensions, these were negligible and not statistically significant. Looking at the inter-wave correlations (see Table V.2), it is possible to see that internalised stigma is remarkably consistent over the course of one year, especially SIS. It is feasible that internalised stigma, at least for emerging adults, is persistent and not easy to change. Another possible explanation for this stability and consistency is that decreasing patterns are present in more extended periods or later in life. Previous studies indicating that age was negatively associated with internalised stigma included adult samples from all ages (Logie & Gadalla, 2009; Pribadi et al., 2020; Werner et al., 2008), which could indicate that meaningful changes in internalised stigma happen over longer periods. In addition, previous research findings that examined changes over one year (Earnshaw et al., 2022) focused on changes right after knowing about the stigmatised condition (i.e., HIV status diagnosis), which created a unique scenario regarding the attitudes associated with the stigmatised identity. It is possible to think that, beyond a general phase in the life course, each group could face critical milestones where more

substantial changes in internalised stigma happen (Earnshaw et al., 2022), for example, coming out for LGB people or going into university for first-generation working-class people.

Although a general trend was not found in the sample, I did find differences in the trajectories according to social perceptions mutability, which was in line with my second hypothesis. Groups perceived to be high in mutability (i.e., higher-body weight people and working-class people) not only presented higher baseline levels of internalised stigma compared to low mutability groups but also an increasing pattern of change for GIS while groups perceived to have low mutability, on the other hand, seemed to present a decreasing trajectory. This finding might be explained by self-blaming beliefs associated with the expectations of being able to change their identity (Burnette et al., 2017; Himmelstein et al., 2020). In a context where the stigma attached to mutable perceived features is more socially acceptable because such features are the individual's responsibility (Solanke, 2021), these groups might be at a higher risk of increasing their levels of internalised stigma over time. More research must be conducted to understand why these effects were found on internalised stigma targeted at the group over the self.

On the other hand, the increasing trajectories among mutable-perceived stigmas could contrast with the assertion that age is negatively associated with internalised stigma, which has also been found among higher-body weight people (Pearl et al., 2021). The results of this study might show a more complex trajectory that only longitudinal studies covering longer periods could reveal. For example, it is possible that internalised stigma decreases later in life for these groups and that, at the beginning of their emerging adulthood, it may have not reached its peak yet.

In line with the findings presented in the previous chapter, some other factors were relevant to predicting baseline levels of internalised stigma, including experiencing

discrimination and education coping strategies. However, I did not find evidence supporting the third hypothesis stating an effect on internalised stigma changes over time. Although there was existing evidence supporting a longitudinal effect of discrimination experiences (Chan & Tsui, 2023), social support (Ma et al., 2024), and coping strategies (Moses, 2015) on internalised stigma, the findings of this research did not replicate these results.

A potential explanation for these discrepancies might be found in the differences between sampled groups. The existing research has focused on the stigma attached to mental health conditions, whereas this research focused on other stigmatised social statuses. Further research needs to be conducted to explore differences across populations and the role that internalised stigma plays in the stigma-health association among them. In addition, other differences between this study and previous research could explain why I did not find evidence supporting these hypotheses, including the age group of my sample and the cultural context where the study was conducted.

I also replicated the findings from the previous chapter regarding the effect of exteriorisation beliefs on internalised stigma. People who narrated a recent experience of discrimination and located the responsibility of the event on society or other people presented lower levels of group-focused internalised stigma. This result is aligned with the hypotheses around self-blaming beliefs: the more people identify discrimination stems from external causes, the less they internalise the stigma they experience.

Limitations and suggestions for research

Some limitations need to be considered when interpreting these results. One of them is the timeframe of the study's design. It is possible that one year was not enough time to identify a clear overall trend in a diverse sample as mine. Although I was able to identify some variation

in trajectories when considering group characteristics, it is possible that covering more extended periods could show additional patterns.

Another limitation of this study was its attrition levels and final sample size. The ideal number for modelling a growth curve would be 100 participants (Curran et al., 2010), and due to attrition, the sample size in the last two waves was less than that per group. Considering the substantial group differences in internalised stigma, a larger sample across waves and groups could have allowed me to conduct growth curve modelling and other complex analyses per group, exploring the role of the factors in each population when relevant. In sum, a larger sample with a broader timeframe and more waves of data collection probably could identify with more detail intricate and divergent trajectories for different groups.

Notwithstanding these limitations, the results of this study open new opportunities and questions for future research. Notably, the consistent results around perceived mutability indicate that its role requires further attention in the stigma literature in general. Special attention must be paid to how social perceptions of mutability might produce self-blaming beliefs that put people at more risk of internalising stigma. Scholars using experimental and cross-cultural methods can shed light on the detailed mechanisms explaining the association between perceived mutability and internalised stigma. Finally, future research can focus on the role of active coping strategies to understand more the protective factors that might help reduce the internalisation of stigma.

Conclusion

In this study, I was able to study trajectories of change in internalised stigma and the factors that explain them. The findings give important insights for this thesis' overarching research question and for internalised stigma research in general. These results, in line with previous evidence found in this thesis, point out relevant differences in internalised stigma

across groups, explaining most of its variance. In addition, while detecting an important consistency in internalised stigma levels over the course of one year, this study also pointed out that perceived mutability might explain slight differences in patterns of change.

In sum, this study shows that, by expanding the inclusion of multiple groups and longitudinal approaches, it is possible to extend the understanding of the diverse and complex mechanisms that explain how stigma is internalised. In the following chapter, I will discuss the results of the three chapters presented in the thesis, addressing the initial objectives and reflecting on their findings.

CHAPTER VI

General Discussion

Summary of research aims and main results

This thesis sought to answer the question: *What are the antecedents of internalised stigma across multiple minoritised populations?* To develop meaningful insights about this question, five research objectives were set and accomplished in this thesis, as presented in the previous chapters.

The first objective was to develop and validate a scale for measuring internalised stigma across multiple minoritised populations. As presented in Chapter III, the results of the measurement study developed and validated a flexible scale that can be used to make direct group comparisons, considering stigma attached to LGB, Black or Indigenous, higher-body weight, and working-class people. This study found evidence supporting the two dimensions of internalised stigma, considering its self-focused (SIS) and group-focused (GIS) elements.

Building on this new scale, the second objective of this thesis was to describe group differences in their levels of internalised stigma. Considering groups' dimensional stigma characteristics, comparing groups based on perceived concealability and mutability was possible. Results from different cultures (Chile and UK, in Chapter III), different samples (study in Chapter III, and study in Chapters IV and V), and different analytical approaches (cross-sectional in Chapters III and IV, and longitudinal in Chapter V) systematically found large group differences in internalised stigma levels explained by perceived mutability. Groups socially perceived as being high in mutability (higher-body weight and working-class people) presented higher levels of both forms of internalised stigma compared to groups perceived to be low in mutability (LGB and racial minoritised people). There were also group differences depending on socially perceived concealability. In Chapter IV, I found that groups with more

perceived concealable stigmatised features presented lower levels of internalised stigma than groups high in concealability. Finally, there was an interaction between perceived mutability and concealability found in Chapters III and IV, where the difference in SIS explained by perceived concealability was particularly salient among people in groups perceived as high in mutability. These same results, in terms of group differences, showed that higher-body weight people presented the highest levels of internalised stigma out of the four groups, followed by working-class people. In comparison, LGB and Indigenous people showed lower levels of internalised stigma, with small to negligible difference between them.

The third objective was to examine the association between internalised stigma and experiencing discrimination, protective factors, and stigma characteristics to better understand the factors associated with the phenomenon. In Chapters IV and V, I found evidence supporting a positive association between the number of major life events of discrimination and internalised stigma. In addition, there were active coping strategies that were negatively associated with internalised stigma and avoidant coping strategies positively associated with internalised stigma. Surprisingly, there was no meaningful association between social support and internalised stigma. The role of group stigma characteristics was summarised in the previous paragraph but, interestingly, in Chapter IV I also found an association between subjective perceptions of mutability and internalised stigma among groups socially perceived as non-mutable, showing that perceptions of mutability could also be playing a role at the individual level.

As a fourth research objective, I aimed at exploring and describing the role of discrimination events narratives and how they are associated with internalised stigma. When asked about a situation where they have been discriminated against in the last year, participants presented a variety of stories with unique narrative framings, attributions, and responses to the event. The exploratory analyses of the narratives highlighted unexpected findings around the

discrimination events. Chapter IV shows that there was a high rate of events happening because of age and several intersectional experiences of discrimination, in line with the demographic profile of the sample. Moreover, presenting narrative redemption, exteriorisation ideas, and withdrawal responses were all associated with lower levels of internalised stigma. These results shed light on the narrative dimension of stigma and helped to illustrate some of the mechanisms found in the correlational results.

The fifth objective of the thesis was to explore changes in internalised stigma over the course of one year. Results presented in Chapter V showed little to no changes in internalised stigma levels. On the contrary, both forms of internalised stigma presented high levels of consistency across waves of measurement. Although these results differed from the initial expectations, the stability of internalised stigma levels during emerging adulthood is a novel finding that requires further research.

Finally, I aimed to analyse the predictive role of discrimination experiences, protective factors, and stigma characteristics on internalised stigma changes. In line with what has been discussed previously, there was little room for predicting changes in internalised stigma levels due to its high consistency over the course of one year. Some variables of interest were associated with baseline levels of internalised stigma but not with changes over time, as presented in Chapter V. However, results showed that socially perceived mutability as a group stigma characteristic played a role in showing small differences in the trajectory of GIS. Groups perceived as high in mutability presented a slight increasing pattern of change in their levels of GIS, while groups perceived as low in mutability presented a slight decreasing pattern.

Contributions to theory, method and research on internalised stigma

The general findings of this thesis have repercussions for stigma literature that allow for a deeper understanding of stigma internalisation. Particularly, in this section, I discuss the

findings about stigma characteristics being a large explaining factor of internalised stigma; about the existing but smaller role of experiencing discrimination and how coping, responding and framing discrimination can be associated with internalisation of stigma; about the measurement of internalised stigma across groups; about the contributions of using a mixed-method approach; and about the importance of the developmental context of the phenomenon.

The prominent role of stigma characteristics

The role of stigma characteristics, particularly perceived mutability, is one of this thesis's most systematic and clear findings. Surprisingly, almost no previous research points out this association, probably because of the scarcity of comparative studies. Prior research had identified that a persistent course of stigma (i.e., low mutability) was associated with lower health impairment and stigma perception (Pachankis et al., 2018). These associations are aligned with this thesis' findings about the harmful role of perceptions of mutability. Consequently, groups perceived as mutable may be at more risk of being individually blamed for their stigmatised status, and the stigma attached to their identities might be more socially acceptable (Himmelstein et al., 2020; Solanke, 2021).

Additional evidence about the role of individual blame in this effect can be found in the stigma-asymmetry model (Burnette et al., 2017; Hoyt et al., 2017). This model states that, among higher-body weight people, beliefs of mutability are linked to higher or lower weight bias (Hoyt et al., 2017) and body shame (Burnette et al., 2017) via a two-folded mechanism: the increase of essentialist beliefs about the nature of weight and the increase of self-blame beliefs. These findings might not only explain the group differences found in internalised stigma but also could be associated with the findings about subjective mutability: a higher subjective perception of mutability was associated with internalised stigma among LGB and Indigenous people. Though more research is needed, it is possible that for groups perceived as

low in mutability, the primary mechanism of this association is through an increase in self-blame beliefs.

Regarding perceived concealability, the results of this thesis are less clear: there is some evidence showing an association between groups perceived as concealable and lower levels of internalised stigma; however, in some of the analyses, this effect was only found as an interaction present among groups perceived as having high mutability. Previous research has highlighted the fact that concealability can have potential benefits when allowing people to hide their stigmatised features to reduce discrimination or its adverse outcomes (Quinn, 2018). As a consequence, it is possible that this protective dimension of perceived concealability is operating to reduce stigma internalisation.

In sum, the results of this thesis reveal core group differences in internalised stigma that might be explained by the groups' stigma characteristics. Although levels of internalised stigma can be comparable, it becomes crucial for stigma research to acknowledge these group differences when aiming to understand the antecedents, correlates, and consequences of internalised stigma.

The complex role of experiencing discrimination

The stage model (Corrigan et al., 2006; Corrigan & Rao, 2012) states that for people to internalise stigma, they first need to be aware of the existence of such social stigma. In addition, previous research has systematically found that experiencing discrimination is associated with internalised stigma (H. Li et al., 2020; Magallares et al., 2017; Timmins et al., 2020; Vass et al., 2017). Consequently, there has been a general assumption in stigma research that the experience and perception of discrimination are the primary antecedents of internalised stigma. Although I found evidence supporting this association in this thesis, the small sizes of the effects also indicate that there are other variables that previous research has rather neglected.

These findings support the idea that simply assuming discrimination experiences will result in increased internalised stigma may be insufficient to fully explain the internalisation process. Remarkably, the way people cope with and react to discrimination was found to also play a role in the process, alongside experiencing discrimination. In line with existing research about active and avoidant coping strategies (Hing & Russell, 2017b; Magallares et al., 2016), educating others when facing discrimination was associated with lower internalised stigma and blaming oneself when being discriminated against was associated with higher internalised stigma.

Interestingly, the effect of coping strategies was not found to operate as a moderation with discrimination experiences but as a direct effect. Although protective factors have been conceptually theorised as moderators in the stigma-health relationship (Meyer, 2003), this thesis' results align with previous research finding a direct effect of these protective factors in their association with internalised stigma (Hing & Russell, 2017b; Sommantico et al., 2020). If stigma is a constant social process experienced from multiple stigmatising sources (Link & Phelan, 2001), then how minoritised people experience it might have a direct impact on them beyond the amount or magnitude of discrimination experiences. Although these strategies can be understood as protective factors buffering the effect of stigma conceptually, further research needs to continue assessing the direct effects of protective factors, such as active coping strategies.

The thesis' exploration of discrimination event narratives and their relationship to internalised stigma contributes to the narrative dimension of stigma research. These findings build on theories of narrative identity (McAdams, 2001; McAdams & McLean, 2013) and suggest that how people interpret and recount their experiences of discrimination can influence their internalisation of stigma. In addition, narrative research has the potential to find unique strategies for coping and making meaning of discrimination experiences (Frost, 2011b;

Pemberton et al., 2016). In this thesis, some participants presented redemption arcs in their stories by shifting negative emotions into positive ones, exteriorisation ideas by identifying social causes of discrimination, and withdrawal responses as a way of setting up boundaries and protecting themselves.

In summary, the results of this thesis highlight the relevance of the strategies people use to cope, react, and frame previous discrimination experiences, alongside the levels of discrimination they experience. Models explaining the impact of stigma on individuals can benefit by adding a further focus on how people face stigma, shifting the emphasis from the extent of the experiences to the way they are experienced.

Multiple group internalised stigma scale

The development and validation of the MGISS can contribute significantly to the broader literature on internalised stigma measurement. Previous research has often focused on population-specific scales (Campón & Carter, 2015; Herek, 2004; James, 2021; M. S. Lee & Dedrick, 2016; Meadows & Higgs, 2019), but this new scale offers an integrative approach. In the context of this thesis, the MGISS made it possible to find novel evidence regarding the factors associated with internalised stigma. Notably, most of the variance in internalised stigma levels was explained by group differences that were only comparable due to this new scale.

The MGISS is also a methodological contribution to stigma research, especially to those efforts aimed at developing a common understanding of stigma processes and their impact on minoritised individuals across different groups (Frost & Castro, 2024; Major et al., 2017). Using this scale, future scholars can systematically compare the impact of internalised stigma among multiple stigmatised populations to analyse commonalities and differences across groups.

Mixed-methods approach for the study of stigma

The mixed-methods approach of the thesis was key for enriching its contributions. By integrating quantitative and qualitative methods, the thesis results provided richer insights into the stigma internalisation process. This design allowed for examining the extent of the associations between constructs, assessing group differences in internalised stigma levels, describing unique experiences of discrimination, and analysing the relationship between narrative dimensions and stigma internalisation, among others. Including these different data sources and analyses made it possible to understand more about how discrimination is associated with internalised stigma.

Based on existing narrative research (McAdams, 1999), the approach for coding specific narrative dimensions into a larger dataset on internalised stigma was specifically developed to address this thesis' research questions. Through this method, it was possible to study the association between internalised stigma and various narrative elements, including redemption, ideas of the causes, and responses to a recent discrimination event. This approach joins previous efforts that integrate narrative analyses and quantitative methods, broadening the possibilities for future mixed-methods stigma research.

Stigma internalisation in the life course

Existing models of stigma have highlighted that stigma is dynamic and constantly transforming due to historical changes, individual development, and stigma courses (Earnshaw et al., 2022), and research has pointed out that internalised stigma is different across life course stages (Meyer et al., 2021). Interestingly, this thesis' findings indicate that internalised stigma can be remarkably stable over the course of one year during specific developmental periods, particularly emerging adulthood. Contrary to denying previous findings, the presented results might indicate a more complex relationship between time and internalised stigma that requires

further attention, considering other stages of people's development, the historical context and group differences.

On the other hand, emerging adulthood has usually been described as a highly transitional stage in life, considering changes in residence and education, identity explorations, and novel interpersonal commitments (Arnett, 2000). This stage can be associated with new understandings of their stigmatised identities (Spencer & Patrick, 2009) or new discriminating or protective contexts (Earnshaw et al., 2022) among minoritised emerging adults. The results of this thesis give more insights into the diverse experiences of these populations, particularly about the several experiences of discrimination intersecting the studied stigmatised statuses with their age. For early emerging adults recently going through adolescence, their experiences of discrimination were also based on their age in a society that can devalue young people (Lenta & Zaldúa, 2020; Terra Polanco et al., 2021).

Policy and intervention implications

This thesis' findings also shed light on psychosocial mechanisms of stigma internalisation that can be relevant to the design of social policies and psychological interventions aiming at preventing or reducing internalised stigma.

The high levels of internalised stigma found among higher-body weight people and working-class people might indicate a particularly concerning issue about the current state of these groups. Although this thesis' samples are not representative of the population and these findings are not generalisable, they could reflect an issue that requires further examination. If confirmed, more efforts need to be dedicated to reducing the existing stigma attached to body weight, social class, and potentially other stigmatised identities perceived as mutable.

At the institutional level, policies should be concerned with reducing stigma by addressing structural discrimination and considering their stigmatising discourses. In fact, for

working-class people (Hansen et al., 2014) and higher-body weight people (Monaghan, 2017), there are policies supposedly aimed at improving their well-being that can reproduce stigmatising beliefs. For example, policies aimed at preventing obesity at the family level can reproduce moral judgements and individual blaming, ignoring the social determinants associated with weight (Aamann & Erlik, 2023). Therefore, it becomes relevant that social policies include a critical assessment of their assumptions and train professionals to ensure their services are free of stigma.

Some implications might be relevant for LGB, racially minoritised people, and other groups with stigmatised characteristics perceived as non-mutable. For them, a higher subjective perception of the mutability of their stigmatised identity seems to be associated with higher internalised stigma. Therefore, it is possible that interventions aimed at changing people's non-mutable features can promote mutability beliefs and, in turn, produce higher internalised stigma. Previous research has shown that these interventions (e.g., conversion therapies) can produce negative consequences in health among LGB (Przeworski et al., 2021) and transgender people (Campbell & Rodgers, 2023). Consequently, these initiatives should be restricted, and the dissemination of mutability discourses should be reduced through public campaigns and institutional monitoring led by governments and third-sector organisations.

For stigmatised features that are seen as mutable, a different scenario needs to be considered, as the intention of reducing weight or improving a disadvantaged economic situation is not necessarily tied to self-devaluation and negative well-being outcomes. In fact, the asymmetry model shows that mutability subjective perception can predict lower body shame via an increased sense of offset efficacy towards weight (Burnette et al., 2017). However, this mechanism does not rule out the fact that mutability can be tied to individual responsibility and, in turn, increase body shame (Burnette et al., 2017). Considering these results and this thesis' findings, future interventions at the organisational and community level

should focus on reducing the stigma attached to stigmatised features perceived as mutable, especially aiming to reduce individualising and blaming discourses.

The findings also align with existing psychoeducational interventions to reduce internalised stigma by promoting active coping strategies (Díaz-Mandado & Periáñez, 2021). Community-based initiatives in health services and educational institutions can lead to applying this knowledge into practice. These initiatives can help people develop externalising beliefs about stigma, understand its social roots, promote their educational and advocacy coping strategies against discrimination, and reduce avoidant and internalising forms of coping.

Particularly promising are narrative approaches when designing interventions. Previous research has found that promoting positive narrative framing can be associated with positive well-being outcomes (Cox et al., 2019; Dunlop & Tracy, 2013). Considering this thesis' findings, counsellors and therapists can develop individual or group narrative-based interventions. These interventions might use narrative redemption to make meaning of discrimination experiences and, in turn, reduce their negative consequences.

In sum, by understanding more about the antecedents of internalised stigma, future policies and interventions can have more effective results. These efforts can be put in place considering multiple levels of action: structural, institutional, community, interpersonal, and individual levels (Heijnders & Van Der Meij, 2006). Finally, depending on the needs of specific populations, these interventions could be planned as direct programs among high-risk people with elevated levels of internalised stigma or as a preventive complement in programs aimed at improving the well-being of a minoritised group.

Limitations and suggestions for future research

The results of this thesis need also to be interpreted considering the limitations of the research. Although the specific limitations of each study were discussed in the respective

empirical chapter, I summarise the main general limitations here to draw attention to the next steps for future research.

First, it is important to consider that the results of this thesis showcase specific cultural backgrounds, especially the Chilean context, since it was present in both studies. Although conducting stigma research in Latin America addresses relevant needs in the literature (Barrientos et al., 2024; Flint & Vila, 2024), more research from other countries within the region and in the Global South is still relevant to ensure these findings can be replicated in other contexts. Particularly, results that were contrary to my expectations, such as the high consistency of internalised stigma over the course of one year for emerging adults, require exploration in other countries to assess how shared this phenomenon is across cultures. Even more, the samples in this thesis do not necessarily represent the population from which they were drawn. Therefore, replication studies would greatly benefit from probability-based sampling to ensure the representativeness of the findings.

Secondly, some of the associations found in the data were very small and, consequently, a lack of statistical power could explain non-significant results in certain hypothesised associations. This limitation was particularly salient when trying to replicate analyses separated per each one of the four groups. Moreover, these subsample sizes were reduced in waves 2 and 3 of the longitudinal study because of attrition, which limited the possibility of conducting specific longitudinal analyses per group. In sum, a larger sample size in the studies could have helped to ensure a higher capacity for conducting more complex group analyses and detecting small-size associations.

In line with the previous limitation, further analytical efforts could have been conducted to explore the intersectional nature of the data. Although some intersectional experiences of stigma were described in the narratives, less was known about its role in the studied

mechanisms of stigma internalisation. Beyond an additive approach when comparing people with one stigmatised identity compared to people with two or more in Chapter IV, this thesis is limited in its intersectional statistical analyses. This limitation is mainly explained by the presented sampling constraints. Analyses based on decomposition analyses (Bauer & Scheim, 2019) or clustering methods (Bauer et al., 2022) were not able to be conducted as they required a larger and more balanced sample across groups.

Although my hypotheses presented directionality in the associations between variables, the analyses presented were cross-sectional and longitudinal without the ability to claim causality in their findings. Thus, concepts such as 'effect' and 'predictors' used when describing correlational associations should be considered only theoretically-guided. More longitudinal and experimental designs are required to assess causality between variables. Experimental designs for studying the effect of subjective perceptions concealability and mutability on internalised stigma and other outcomes are auspicious for future research. Following what has been studied among higher-body weight people (Burnette et al., 2017), scholars can use the findings in this thesis to develop experimental designs, including a more complex combination of multiple stigma characteristics and experimentally manipulated perceptions of such characteristics, to assess their impact on people.

Considering the responses to the stories about discrimination were short, more extensive individual narrative data could have been valuable to address some of the thesis questions. Previous narrative research on stigma has conducted semi-structured interviews (Judd et al., 2023) and life stories (Rance et al., 2017), which can give more details about the experiences narrated by participants. Future research could combine the approach taken in this study with more extensive narrative data collection strategies. This approach could allow scholars to identify complex narrative strategies and understand their association with relevant outcome variables. Moreover, the results in this thesis also suggest that stigma research should

pay more attention to how people react and cope with stigma beyond the amount of discrimination they experience. Qualitative approaches could help not only with understanding multiple and unique ways in which people face social stigma but also with developing multi-group measures relevant to the study of individual, interpersonal, and community forms of reacting and coping with discrimination.

In addition, future research should pay closer attention to the affective dimension of the internalisation process, specifically examining how emotions influence internalised stigma. Although the role of emotions fell beyond the scope of this thesis, and the qualitative questions were not designed to systematically assess the impact of emotions, my findings related to redemption sequences highlight their relevance. Future studies should incorporate scales designed to measure emotional responses, facilitating an understanding of their relationship with internalised stigma, and formulate narrative research questions aimed directly at assessing the impact of emotionality in the internalisation process.

Regarding the study of the antecedents of internalised stigma, in this thesis, I focused on those factors that were particularly pertinent for understanding the phenomenon, following the literature review presented in Chapter II. However, there are other dimensions that this thesis did not focus on and that future research on the topic could consider. First, the system justification theory (Jost & Van Der Toorn, 2012) could be relevant considering my results around perceived mutability, and more efforts can be made to understand how internalised stigma is associated with processes of diminishing the extent of discrimination and justifying the system (Suppes et al., 2019). On the other hand, scholars should consider studying earlier socialisation processes focusing on family, school, and cultural context to understand how they are associated with internalised stigma. For example, it is possible that narratives within the family intergenerationally reproduce or protect people from stigmatising beliefs that individuals can internalise (Flood-Grady & Koenig Kellas, 2019). Finally, dimensions as racial

centrality (Sellers et al., 2006) for Black and Indigenous people, and previous levels of identity principles such as self-esteem, self-efficacy, and continuity (Jaspal & Bloxsom, 2023), also could be addressed to consider the complex processes linking identity and stigma internalisation. In sum, the approach taken in this thesis can also support future research on exploring other factors that can be comparable across multiple stigmatised populations.

Conclusions

In summary, in this thesis, I addressed the research aims to expand the understandings we have as scholars about the antecedents of internalised stigma. Without having the final answer to the question about why minoritised people internalise stigma, the findings of this thesis contribute methodologically and theoretically to stigma research and move forward current discussions in the field. By doing so, I expect this thesis' results to motivate and inform future initiatives seeking to reduce internalised stigma and promote minoritised populations' health and well-being. Beyond its core role in the stigma-health association, internalised stigma is also relevant to other spheres of people's lives, including their social and community relationships. Therefore, these findings can support multiple efforts aimed at promoting social integration of marginalised populations.

Furthermore, beyond the attention that stigma research can put on the affected individuals, this problem has structural root causes that should not be kept invisible. As discussed at the beginning of this thesis, considering Tomiyama et al.'s (2018) opinion on how stigma can explain more of higher-body weight people's increased health issues over actual measures of weight, social stigma can obscure its social nature by placing the problem in the individual. Stemming from individualising beliefs that locate the blame of discrimination in the affected people, the internalisation of stigma then operates as a mechanism that can

reproduce social stigma itself. Consequently, the burden of stigmatisation becomes both the cause of social inequalities and the protector of its reproduction.

Finally, the work presented here addressed the impact of stigma in people's lives by understanding its internalisation across multiple minoritised populations. Through the scale developed in this thesis, researchers now have the tools to test the efficacy of interventions aimed at reducing internalised stigma across multiple groups. Even more, this flexible measure makes it now possible to include internalised stigma in health and social research at the population level. The results also call for prioritising attention to the harmful role of perceptions of mutability, guiding research to focus on stigma characteristics as protective and risk factors of internalisation. Ultimately, this thesis opens up new opportunities for stigma research and contributes to the broader endeavour of preventing internalised stigma and promoting well-being.

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Appendices

Chapter III

Appendix III. 1 Parallel Analysis

Table A.III.1

Results of Horn's Parallel Analysis for component retention

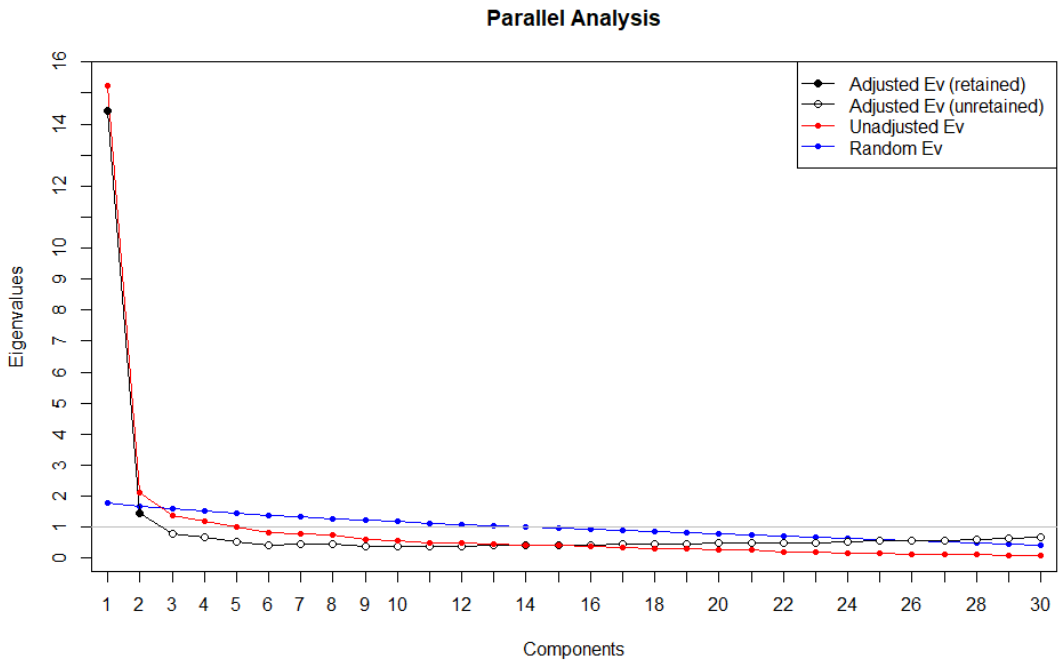
Component	Adjusted Eigenvalue	Unadjusted Eigenvalue	Estimated Bias
1	14.44	15.22	.78
2	1.44	2.11	.67

[a]900 iterations, using the mean estimate.

Adjusted eigenvalues greater than 1 indicate dimensions to retain and unadjusted eigenvalues over the randomized curve of eigenvalues (2 components retained).

Figure A.III.1

Parallel Analysis



Appendix III. 2 Exploratory Factor Analysis

We found a KMO measure of 0.95 and Bartlett's of $\chi 2(435) = 5153$, $p < 0.001$, showing that the data is factorable. Exploratory Analysis was conducted with Varimax rotation and constraining to two components (following parallel analysis results). The item retention rules were: items with commonalities over .5, main factor loading over .4, and differences between cross-loading under .2.

Table A.III.2

Items, communalities, and factor loadings

N°	Items	Communalities	1	2	Dif. (1-2)
1	**I wish I could change my {field}.**	.85	.88	.28	.60
2	There is nothing I would change about my {field}. (R)	.60	.76	.12	.64
3	At times I would like to be {c-group}.	.69	.77	.31	.46
4	**I would not change my {field} even if I were given a chance. (R)**	.67	.81	.14	.67
5	Sometimes I think that if I were {c-group}, I could be happier.	.54	.69	.26	.43
6	**If someone offered me the chance to be {c-group}, I would accept.**	.75	.80	.33	.47
7	**I wish I weren't {group}.**	.79	.85	.27	.58
8	**There is nothing about my {field} that I would like to be different. (R)**	.66	.80	.18	.62
9	I embrace my {field} as it is. (R)	.70	.79	.26	.53
10	I hate myself because of my {field}.	.52	.57	.44	.13
11	**I am OK being the {group} person that I am. (R)**	.76	.80	.34	.46

12	I resent my {field}.	.71	.78	.33	.45
13	Because I am {group}, I don't feel like my true self.	.52	.52	.50	.02
14	I feel embarrassed about my {field}.	.56	.69	.29	.40
15	**I am glad to be {group}. (R)**	.76	.82	.29	.53
16	I deserve the same things in life as {c-group} people. (R)	.41	.28	.58	.30
17	I believe that being {group} is as fulfilling as being {c-group}. (R)	.65	.69	.42	.27
18	I feel that being {group} is a personal shortcoming.	.58	.58	.50	.08
19	As a {group} person, I deserve the respect of others. (R)	.28	.31	.54	.23
20	Life should be harder for me because of my {field}.	.39	.11	.52	.41
21	My {field} will hold me back in life.	.28	.42	.33	.09
22	My life will be just as fulfilling as someone who is {c-group}. (R)	.52	.56	.46	.10
23	I am proud of other {group} people. (R)	.50	.59	.39	.20
24	**{c-group} people are better at a lot of things than people of my {field}.**	.60	.33	.70	.37
25	**People of my {field} don't have much to be proud of.**	.54	.24	.69	.45
26	**{group} people are responsible for society's negative perceptions of them.**	.50	.00	.71	.71
27	It is a compliment to be told "You don't act like a typical person of your {field}".	.33	.18	.55	.37
28	**I don't like people associating me with other {group} people.**	.56	.36	.66	.30
29	**I feel that being similar to other people of my {field} is a shortcoming.**	.61	.39	.68	.29

30	When I think of other {group} people, I am glad we share a similar {field}. (R)	.50	.64	.31	.33

Note. {group}: LGB, Black, higher-body weight, working class. {c-group}: straight, white, thin, upper class. (R): Item with reversed score. (Item in bold): Item included in the final scale.

Table A.III.3

Retained items (in English and Spanish) by component and factor loadings

N°	Items	1	2
1	I wish I could change my {field}. Me gustaría poder cambiar mi {categoría}.	.88	
7	I wish I weren't {group}. Desearía no ser {grupo}.	.85	
15	I am glad to be {group}. (R) Me alegra ser {grupo}. (R)	.82	
4	I would not change my {field} even if I were given a chance. (R) No cambiaría mi {categoría} incluso si tuviera la oportunidad. (R)	.81	
6	If someone offered me the chance to be {c-group}, I would accept. Si alguien me ofreciera la oportunidad de ser {grupo-c}, aceptaría.	.80	
8	There is nothing about my {field} that I would like to be different. (R) No hay nada de mi {categoría} que me gustaría que fuese diferente. (R)	.80	
11	I am OK being the {group} person that I am. (R) Estoy bien siendo la persona {grupo} que soy. (R)	.80	
26	{group} people are responsible for society's negative perceptions of them.		.71

	Las personas {grupo} son responsables de la percepción negativa que tiene la sociedad sobe ellas.	
24	{c-group} people are better at a lot of things than people of my {field}. Las personas {grupo-c} son mejores en muchas cosas comparadas con las personas de mi {categoría}.	.70
25	People of my {field} don't have much to be proud of. Las personas de mi {categoría} no tienen mucho de qué enorgullecerse.	.69
29	I feel that being similar to other people of my {field} is a shortcoming. Siento que ser similar a otras personas de mi {categoría} es una limitación	.68
28	I don't like people associating me with other {group} people. No me gusta que la gente me asocie con otras personas {grupo}.	.66

Note. {group}: LGB, Black, higher-body weight, working class. {c-group}: straight, white, thin, upper class. (R): Item with reversed score.

Appendix III. 3 Confirmatory Factor Analyses Full R Studio Prints (2-factors, 12 items):

```
lavaan 0.6-12 ended normally after 37 iterations

  Estimator                                         ML
  Optimization method                           NLMINB
  Number of model parameters                        25

                                                  Used       Total
  Number of observations                           208         238

Model Test User Model:

  Test statistic                               107.539
  Degrees of freedom                                53
  P-value (Chi-square)                           0.000

Model Test Baseline Model:

  Test statistic                              1957.339
  Degrees of freedom                                66
  P-value                                        0.000

User Model versus Baseline Model:

  Comparative Fit Index (CFI)                    0.971
  Tucker-Lewis Index (TLI)                       0.964

Loglikelihood and Information Criteria:

  Loglikelihood user model (H0)              -4341.384
  Loglikelihood unrestricted model (H1)             NA

  Akaike (AIC)                                8732.769
  Bayesian (BIC)                              8816.207
  Sample-size adjusted Bayesian (BIC)         8736.995

Root Mean Square Error of Approximation:

  RMSEA                                          0.070
  90 Percent confidence interval - lower         0.051
  90 Percent confidence interval - upper         0.089
  P-value RMSEA <= 0.05                          0.042

Standardized Root Mean Square Residual:

  SRMR                                           0.050

Parameter Estimates:

  Standard errors                             Standard
  Information                                 Expected
  Information saturated (h1) model          Structured
```

Full CFA print

Latent Variables:

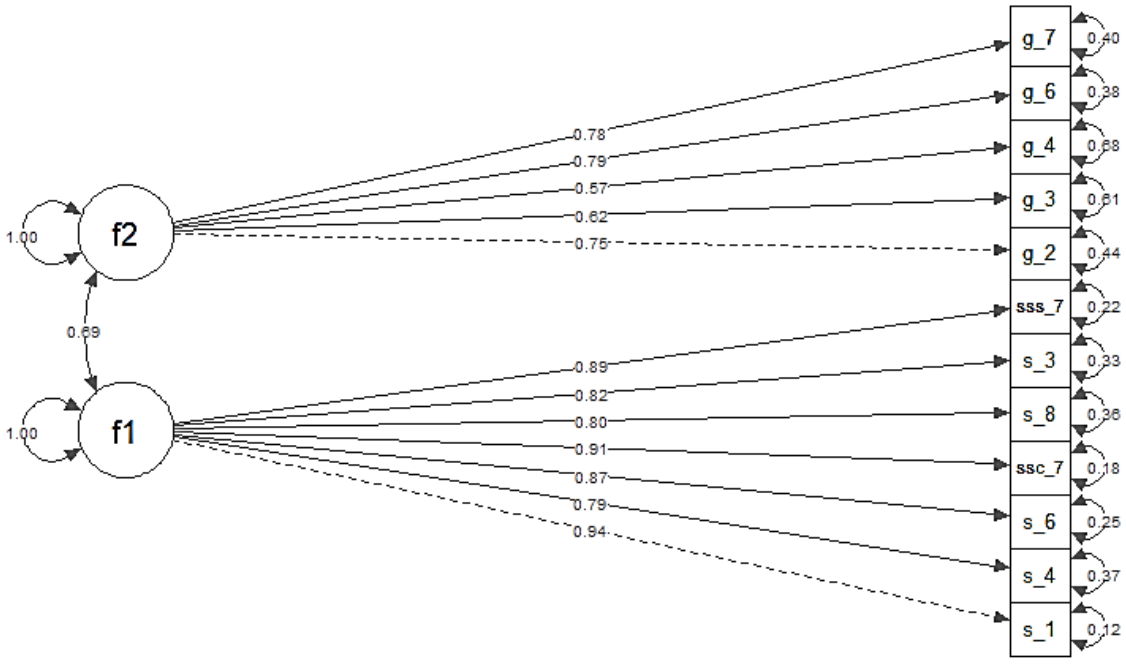
	Estimate	Std.Err	z-value	P(>|z|)	Std.lv	Std.all
f1 =~						
sisch_1	1.000				2.245	0.940
sisch_4i	0.845	0.051	16.478	0.000	1.897	0.792
sisch_6	0.889	0.043	20.466	0.000	1.995	0.866
sisch_7	0.952	0.041	23.482	0.000	2.138	0.906
sisch_8i	0.792	0.047	16.845	0.000	1.777	0.800
sissa_3i	0.701	0.039	17.871	0.000	1.575	0.821
sissa_7i	0.895	0.041	21.825	0.000	2.009	0.885
f2 =~						
gis_2	1.000				1.298	0.746
gis_3	0.742	0.087	8.487	0.000	0.963	0.623
gis_4	0.694	0.090	7.741	0.000	0.901	0.569
gis_6	1.129	0.105	10.744	0.000	1.466	0.789
gis_7	1.000	0.095	10.572	0.000	1.299	0.776

Covariances:

	Estimate	Std.Err	z-value	P(>|z|)	Std.lv	Std.all
f1 ~~						
f2	2.019	0.295	6.846	0.000	0.693	0.693

Variances:

	Estimate	Std.Err	z-value	P(>|z|)	Std.lv	Std.all
.sisch_1	0.668	0.095	7.044	0.000	0.668	0.117
.sisch_4i	2.137	0.225	9.504	0.000	2.137	0.373
.sisch_6	1.329	0.148	8.954	0.000	1.329	0.250
.sisch_7	0.996	0.120	8.276	0.000	0.996	0.179
.sisch_8i	1.775	0.188	9.464	0.000	1.775	0.360
.sissa_3i	1.198	0.128	9.343	0.000	1.198	0.326
.sissa_7i	1.114	0.128	8.687	0.000	1.114	0.216
.gis_2	1.343	0.165	8.138	0.000	1.343	0.443
.gis_3	1.465	0.160	9.172	0.000	1.465	0.612
.gis_4	1.695	0.180	9.425	0.000	1.695	0.676
.gis_6	1.301	0.174	7.476	0.000	1.301	0.377
.gis_7	1.117	0.145	7.714	0.000	1.117	0.398
f1	5.039	0.560	8.999	0.000	1.000	1.000
f2	1.686	0.284	5.932	0.000	1.000	1.000



Appendix III. 4 Regression analyses with control

Table A.III.4

Regression Coefficients with Psychological Distress as dependent variable, and control.

	b	95% CI	β	T	*p*	R^2
Model Fit						.33
(intercept)	1.86	[1.39, 2.32]		7.88	<.001	
SIS	0.17	[0.07, 0.26]	0.39	3.51	<.01	
GIS	0.05	[-0.06, 0.15]	0.07	0.86	.37	
Felt stigma	0.18	[0.08, 0.28]	0.24	3.62	<.001	
Group: working class = 1	-0.09	[-0.37, 0.18]	-0.05	-0.68	.50	
Group: higher-body weight = 1	-0.36	[-0.73, 0.02]	-0.19	-1.90	.06	
Group: ethnic minority = 1	-0.26	[-0.52, -0.01]	-0.14	-2.01	<.05	
Age	-0.02	[-0.03, -0.01]	-0.23	-3.75	<.001	
Sex	-0.02	[-0.23, 0.19]	-0.01	-0.19	.85	

Note. SIS = Self-focused internalised stigma. GIS = Group-focused internalised stigma. Dependent variable: Psychological Distress. Grouping variable reference: LGB people = 1.

Appendix III. 5 Additional ANOVAs

In the following Tables and Figures, I present the results of the three-way ANOVAs. These ANOVAs present a different approach to the same analysis presented on the article: it directly estimates differences in internalised stigma levels as a function of concealability and mutability characteristics.

In summary, these results show that mutability was factor explaining group differences on all analyses across SIS and GIS. In line with my hypotheses, groups with high mutability (higher-body weight people and working-class people) showed higher levels of internalised stigma compared to groups low in mutability (LGB people and ethnic minority people). Concealability did not show a statistically significant effect on internalised stigma in this study. I found an interaction effect between concealability and mutability when explaining SIS group differences. Groups high in mutability and low in concealability showed the higher levels of SIS, compared to all other groups. Interestingly, this effect was not found for GIS.

Table A.III.5

Three-way ANOVA explaining SIS group differences

	F	*p*	ηp2
(intercept)	3099.75	<.001	.94
Mutability	618.82	<.001	.75
Concealability	0.37	0.54	.002
Country	14.53	<.001	.07
Mutab * conceal	18.28	<.001	.08
Mutab * country	0.0	1	0
Conceal * country	0.01	.91	0
Mutab * conceal * country	1.32	.25	.006

Figure A.III.2

Mean levels of SIS by stigma characteristic and 95% confidence interval in UK sample

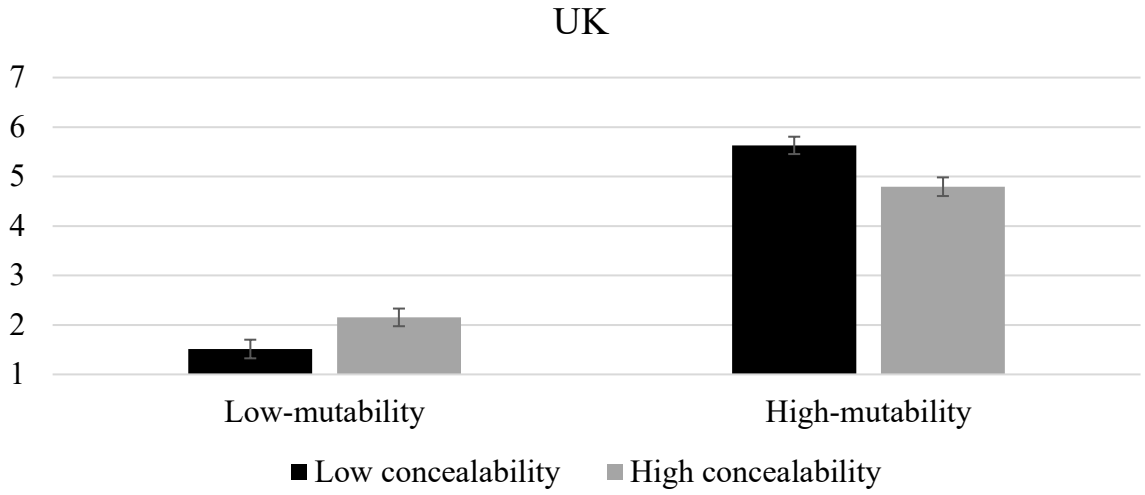


Figure A.III.3

Mean levels of SIS by stigma characteristic and 95% confidence interval in Chilean sample

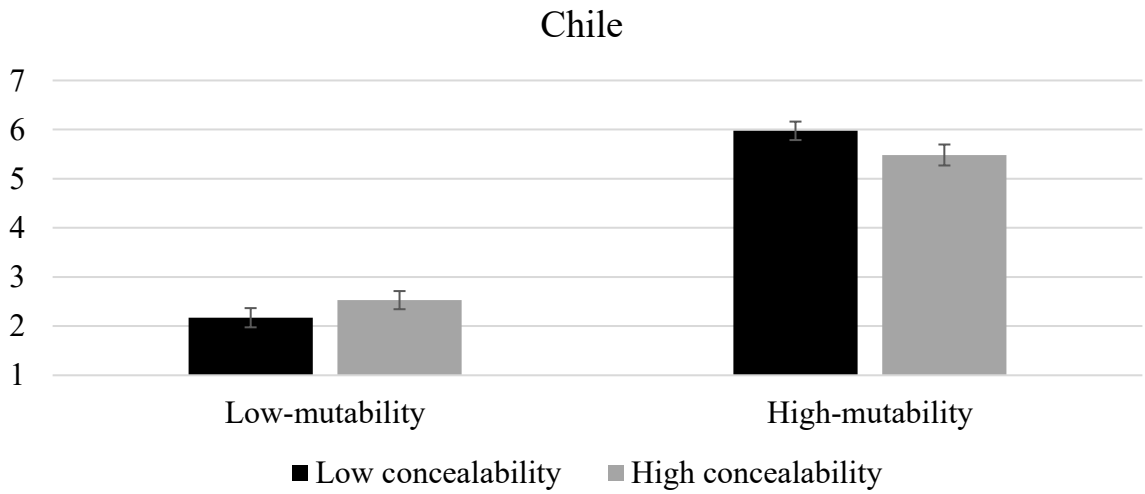


Table A.III.6

Three-way ANOVA explaining GIS group differences

	F	*p*	ηp2
(intercept)	1095.38	<.001	.85
Mutability	70.93	<.001	.26
Concealability	0.004	.95	0
Country	7.82	<.01	.04
Mutab * conceal	1.97	.16	.01
Mutab * country	0.07	.79	0
Conceal * country	0.05	.82	0
Mutab * conceal * country	0.43	.51	.002

Figure A.III.4

Mean levels of GIS by stigma characteristic and 95% confidence interval in UK sample

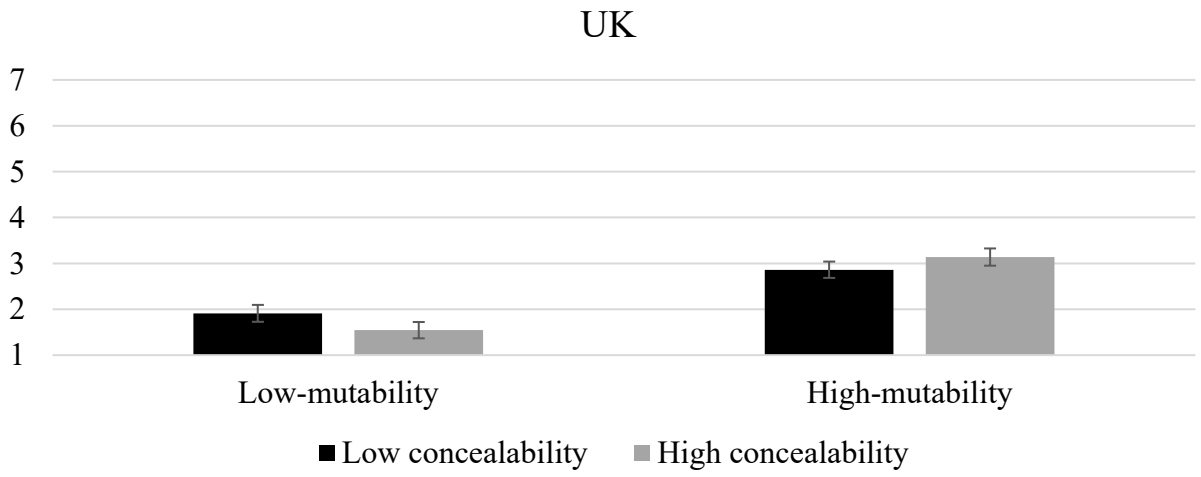
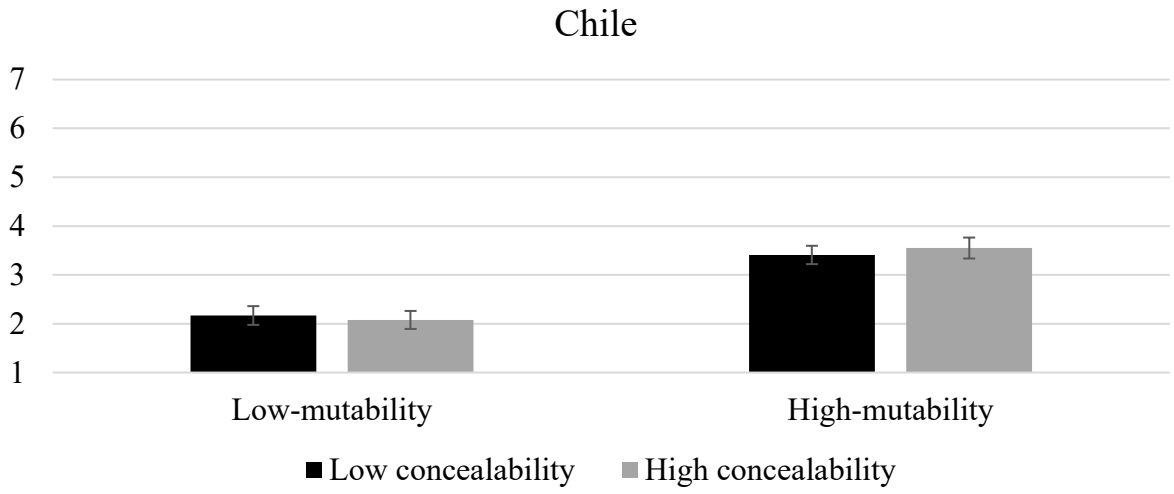


Figure A.III.5

Mean levels of GIS by stigma characteristic and 95% confidence interval in Chilean sample



Appendix III. 6 Replication Analyses Chapter III with longitudinal study sample.

Confirmatory Factor Analyses Full R Studio Prints (2-factor, 12 items) – Replication Analyses.

```
lavaan 0.6-12 ended normally after 29 iterations

  Estimator                                         ML
  Optimization method                           NLMINB
  Number of model parameters                        25

                                                  Used       Total
  Number of observations                           728         793

Model Test User Model:

  Test statistic                               240.861
  Degrees of freedom                               53
  P-value (Chi-square)                          0.000

Model Test Baseline Model:

  Test statistic                              5913.075
  Degrees of freedom                               66
  P-value                                       0.000

User Model versus Baseline Model:

  Comparative Fit Index (CFI)                   0.968
  Tucker-Lewis Index (TLI)                      0.960

Loglikelihood and Information Criteria:

  Loglikelihood user model (H0)            -15617.125
  Loglikelihood unrestricted model (H1)    -15496.694

  Akaike (AIC)                              31284.249
  Bayesian (BIC)                            31399.007
  Sample-size adjusted Bayesian (BIC)       31319.624

Root Mean Square Error of Approximation:

  RMSEA                                         0.070
  90 Percent confidence interval - lower        0.061
  90 Percent confidence interval - upper        0.079
  P-value RMSEA <= 0.05                         0.000

Standardized Root Mean Square Residual:

  SRMR                                          0.048

Parameter Estimates:

  Standard errors                            Standard
  Information                                Expected
  Information saturated (h1) model       Structured
```

Latent Variables:

	Estimate	Std.Err	z-value	P(>|z|)	Std.lv	Std.all
siscfa =~						
sis1	2.286	0.071	32.016	0.000	2.286	0.914
sis4i	2.071	0.070	29.722	0.000	2.071	0.875
sis6	2.047	0.069	29.684	0.000	2.047	0.874
sis7	2.118	0.066	32.210	0.000	2.118	0.917
sis8	-1.730	0.068	-25.623	0.000	-1.730	-0.795
sis11i	1.581	0.062	25.648	0.000	1.581	0.796
sis15i	1.872	0.064	29.287	0.000	1.872	0.867
giscfa =~						
gis2	1.225	0.062	19.787	0.000	1.225	0.738
gis3	1.007	0.057	17.534	0.000	1.007	0.664
gis4	0.564	0.068	8.283	0.000	0.564	0.339
gis6	1.007	0.078	12.957	0.000	1.007	0.511
gis7	0.776	0.066	11.676	0.000	0.776	0.466

Covariances:

	Estimate	Std.Err	z-value	P(>|z|)	Std.lv	Std.all
siscfa ~~						
giscfa	0.642	0.030	21.597	0.000	0.642	0.642

Variances:

	Estimate	Std.Err	z-value	P(>|z|)	Std.lv	Std.all
.sis1	1.034	0.069	14.929	0.000	1.034	0.165
.sis4i	1.319	0.080	16.424	0.000	1.319	0.235
.sis6	1.298	0.079	16.442	0.000	1.298	0.236
.sis7	0.850	0.058	14.748	0.000	0.850	0.159
.sis8	1.740	0.098	17.683	0.000	1.740	0.368
.sis11i	1.448	0.082	17.678	0.000	1.448	0.367
.sis15i	1.161	0.070	16.616	0.000	1.161	0.249
.gis2	1.256	0.104	12.085	0.000	1.256	0.456
.gis3	1.283	0.089	14.421	0.000	1.283	0.559
.gis4	2.443	0.133	18.344	0.000	2.443	0.885
.gis6	2.869	0.168	17.051	0.000	2.869	0.739
.gis7	2.173	0.124	17.498	0.000	2.173	0.783
siscfa	1.000				1.000	1.000
giscfa	1.000				1.000	1.000

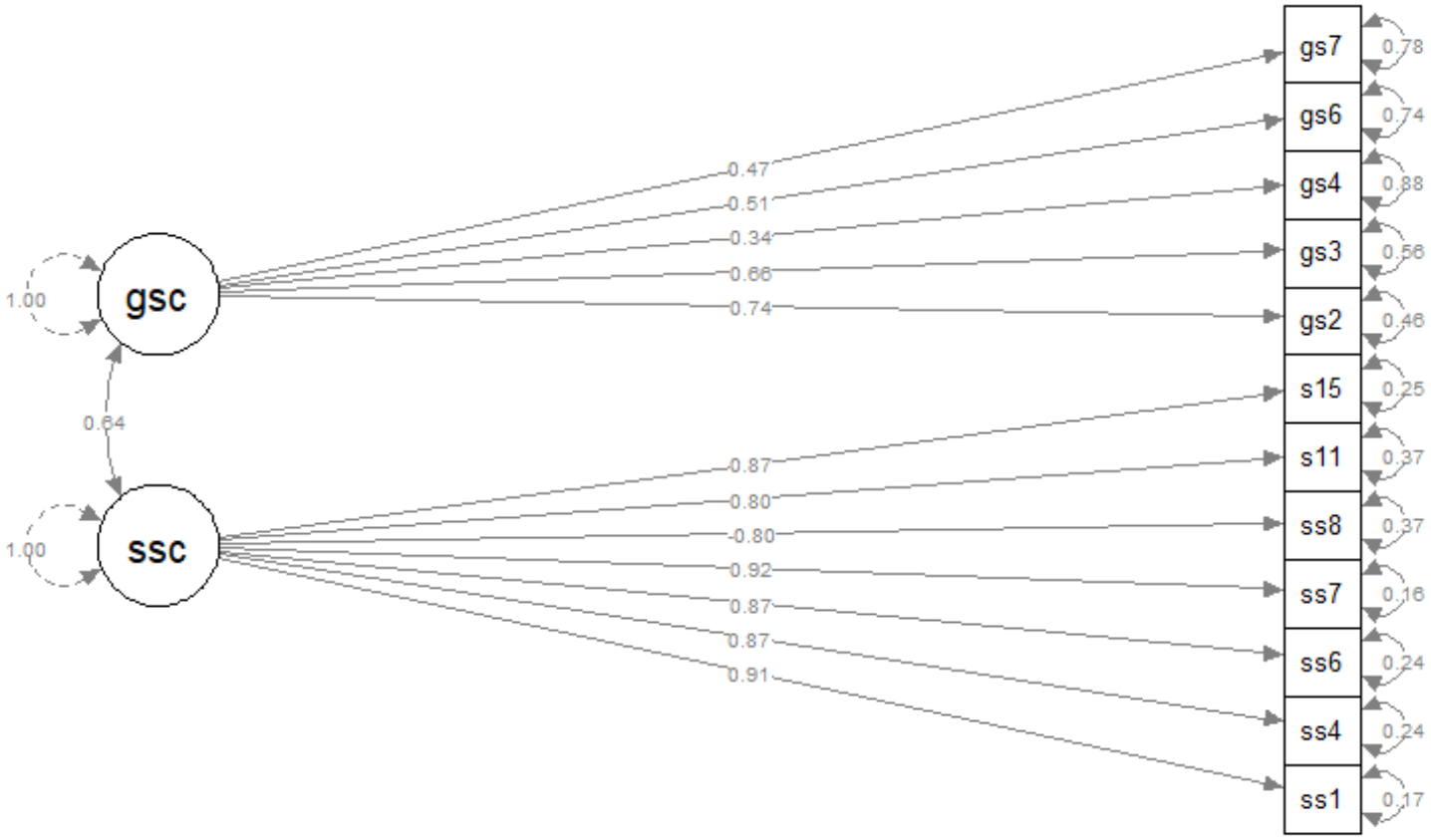


Table A.III.7

Measurement invariance across groups (LGB, Black or Indigenous, higher-body weight, and working-class) – Replication Analyses (Longitudinal study)

	Indices of Fit						χ^2 Difference Test			
Model	χ^2	*df*	CFI	SRMR	RMSEA	MC	$\Delta\chi2$ (Δdf)	Δ CFI	Δ RMSEA	Δ SRMR
1. Configural invariance	480.62**	212	.88	.07	.08					
2. Metric invariance	548.62**	242	.86	.09	.08	1	67.99**	-0.17	0.0	0.02
3. Scalar invariance	809.51**	272	.76	.11	.10	2	260.89**	-0.1	0.02	0.03

Note. N = 728, LGB = 207, Black or Indigenous = 130, higher-body weight = 199, working-class = 192. *p < .05. **p < .01. MC = Model comparison reference. CFI = comparative fit index, SRMR = standardised root mean square residual, RMSEA = root mean square error of approximation. Scalar invariance under level of acceptance, strict invariance model not tested.

Chapter IV

Appendix IV.1 Within-subject correlation of internalised stigma scales

Table A.IV.1.

Within-subject correlation of different internalised stigma scales completed.

	SIS				GIS			
	1	2	3	4	1	2	3	4
1. Sexual orientation	1	.30	-.03	.20	1	**.60****	**.33****	**.42****
2. Race		1	.31	**.32***		1	**.49****	**.50****
3. Body weight			1	**.26****			1	**.40****
4. Social class				1				1

Note. SIS = Self-focused internalised stigma. GIS = Group-focused internalised stigma. *p < .05, ** p < .01

Appendix IV.2 Residuals of regressions and ANOVAs SIS and GIS

Figure A.IV.1

Residuals distribution - Regression multiple predictors on SIS

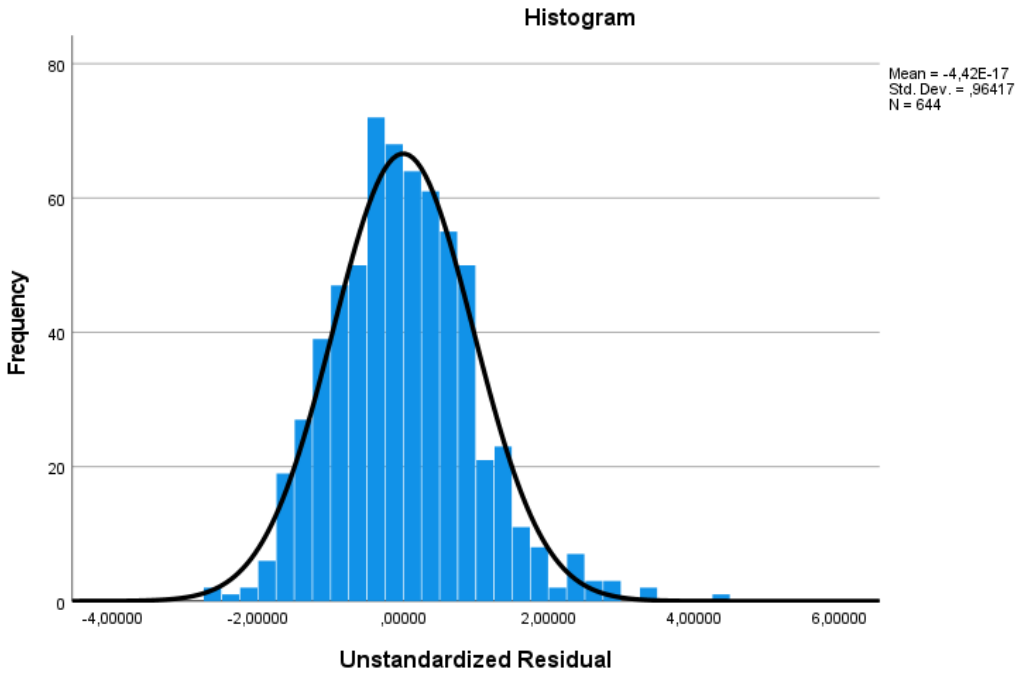


Figure A.IV.2

Residuals distribution - Regression multiple predictors on GIS

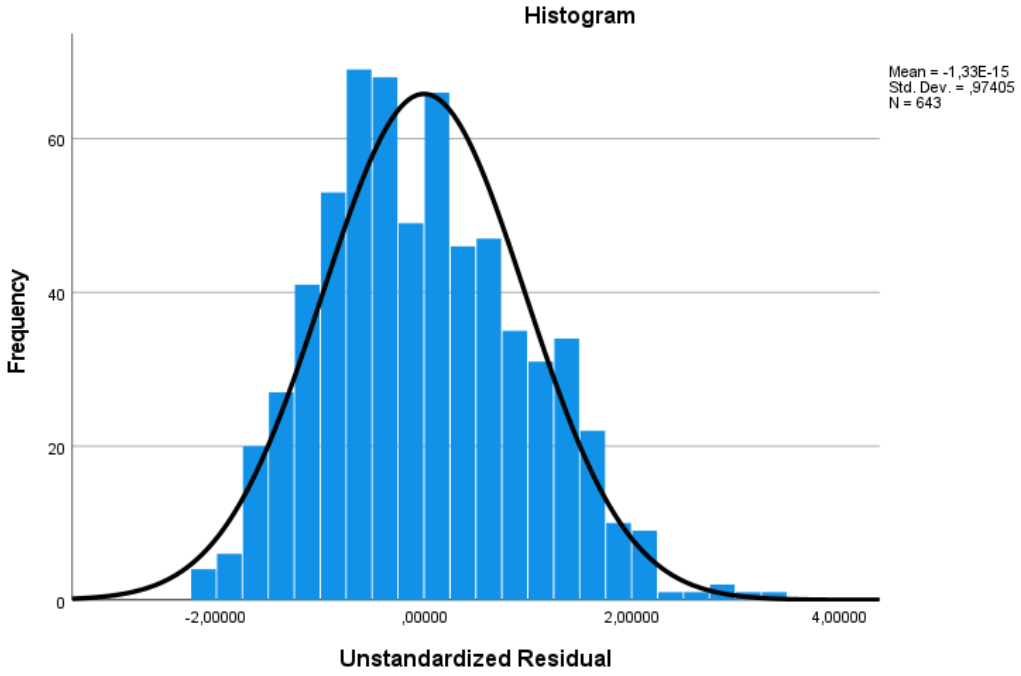


Figure A.IV.3

Residuals distribution – ANOVA stigma characteristics and SIS

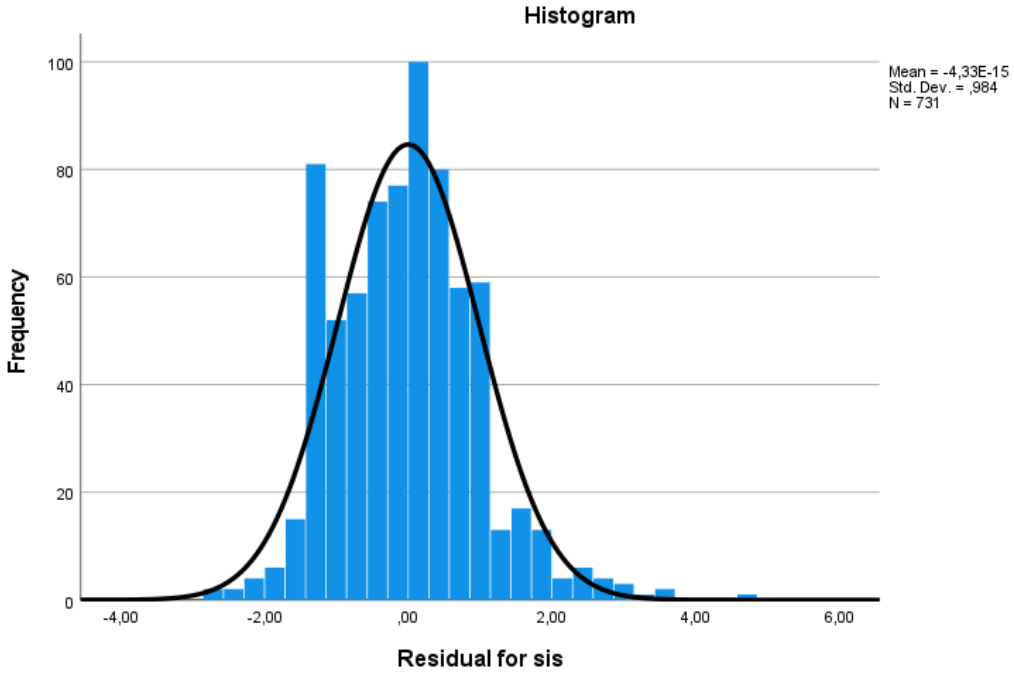
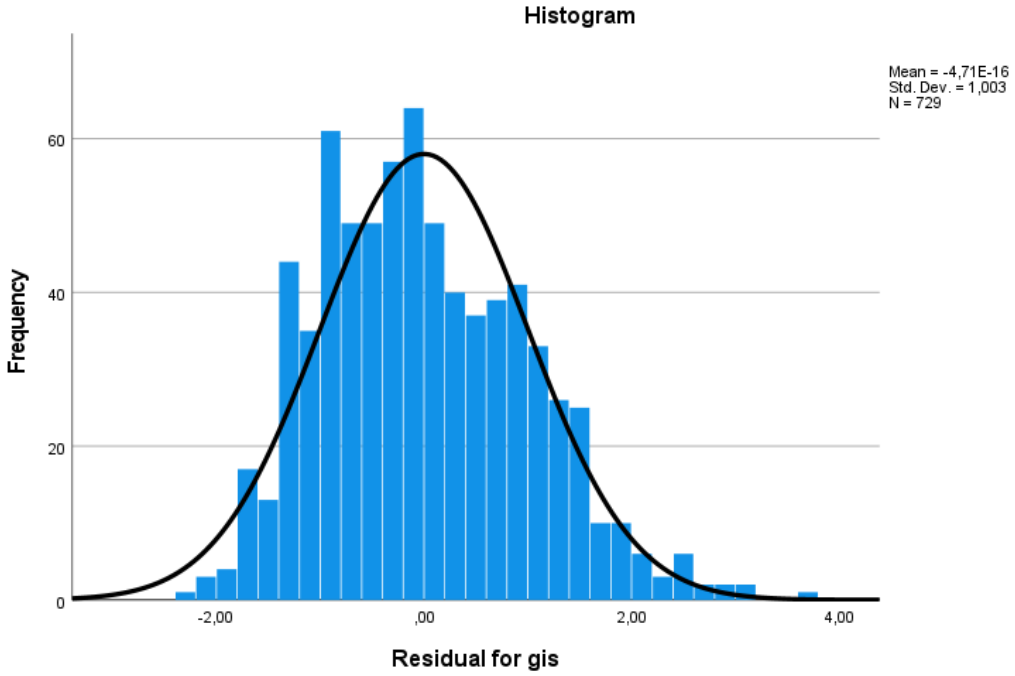


Figure A.IV.4

Residuals distribution – ANOVA stigma characteristics and GIS



Appendix IV.3 Exploring group differences

In relation to the group differences in the explored factors, I was able to find some relevant differences that can explain some of the presented results. Regarding everyday discrimination experiences, there was a significant effect of group but only explaining 3% of the variance (F [3, 642] = 7.57, p < .001, ηp2 = .03). Post-hoc analysis shows that statistically significant differences were only found between LGB people (M = 2.30, SE = .05) and indigenous and higher-body weight people (M = 2.56, SE = .07; M = 2.63, SE = .05), but not to working-class people (M = 2.48, SE = .05). Regarding major experiences of discrimination, there was also a small but significant effect of group explaining 3% of the variance (F [3, 640] = 7.36, p < .001, ηp2 = .03). Bonferroni post-hoc test shows that statistically significant differences were only found between LGB people (M = 1.38, SE = .10) and each one of the

other three groups (indigenous people, M = 1.90, SE = .16; higher-body weight people, M = 2.07, SE = .13; and working-class people, M = 2.05, SE = .13).

Regarding social support, group was statistically significant to explain differences when social support was from friends (F [3, 650] = 10.40, p < .001, ηp2 = .05) and other (F [3, 650] = 5.55, p < .01, ηp2 = .03), but not when it was from family (F [3, 650] = 2.46, p = .06, ηp2 = .01). Bonferroni post-hoc analysis shows that, regarding support from friends, LGB people showed higher levels (M = 5.45, SE = .10) compared to each one of the other groups (indigenous people, M = 4.83, SE = .16; higher-body weight people, M = 4.68, SE = .13; and working-class people, M = 4.64, SE = .12). Regarding support from others, the pattern is similar: LGB people reported higher levels (M = 5.50, SE = .09) compared to the other groups (indigenous people, M = 5.02, SE = .14; higher-body weight people, M = 4.98, SE = .11; and working-class people, M = 5.07, SE = .10).

In relation to group differences in coping strategies when facing discrimination, I did not find statistically significant differences in education coping (F [3, 664] = 2.45, p = .07, ηp2 = .01) and resistance coping (F [3, 664] = 0.95, p = .41, ηp2 = .00). I found statistically significant differences between groups according to interiorisation coping (F [3, 664] = 5.16, p < .01, ηp2 = .02). Bonferroni post-hoc tests show that higher-body weight people presented higher levels of interiorisation coping (M = 5.16, SE = .09) compared to LGB people (M = 4.75, SE = .12) and working-class people (M = 4.57, SE = .11), but not to indigenous people (M = 4.76, SE = .13). I also found statistically significant differences in detachment coping across groups (F [3, 664] = 5.70, p < .01, ηp2 = .03). Similarly, Bonferroni post-hoc analysis show that the statistical significance difference is only between higher-body weight people showing an increased level in this detachment coping (M = 4.71, SE = .10) compared LGB people (M = 4.11, SE = .11), but these two groups did not significantly differed from indigenous people (M = 4.47, SE = .14) and working-class people (M = 4.31, SE = .11).

When examining group differences in discrimination and internalised stigma relationship, I focused on bivariate correlations between the number of major experiences of discrimination, and SIS and GIS, separating the analyses in the four groups. Surprisingly, I found that the association was present for SIS in working-class people (r = .18[175], p < .001), but I did not find evidence supporting this association in the other groups (LGB people, r = -.09[182], p = .21; indigenous people r = .11[106], p = .25; higher-body weight people, r = .02[167], p = .23). I did not find statistically significant results in the association between major experiences of discrimination and GIS when separating the analysis between multiple groups. These results will be discussed in the discussion section considering the role of sample size and distribution in the two variables.

Appendix IV.4 Effects of perceived concealability and mutability separated per group

Table A.IV.2

Regressions of perceived concealability and mutability on SIS – separated per group

		B	95% CI	β	*t*	*p*	R^2
LGB	Model Fit						.19
	(intercept)	1.1	[0.68, 1.52]		5.2	<.001	
	Perceived concealability	.10	[0.03, 0.18]	.17	2.62	<.01	
	Perceived mutability	.32	[0.22, 0.42]	.39	6.24	<.001	
Indigenous	Model Fit						.16
	(intercept)	1.60	[1.23, 1.98]		8.34	<.001	
	Perceived concealability	.05	[-0.04, 0.15]	.09	1.08	.28	
	Perceived mutability	.30	[0.17, 0.41]	.38	4.62	<.001	
Higher-body weight	Model Fit						.00
	(intercept)	6.00	[5.44, 6.53]		21.70	<.001	
	Perceived concealability	-.00	[-0.08, 0.07]	-.01	-0.12	.90	
	Perceived mutability	.01	[-0.08, 0.09]	.01	0.15	.88	
Working-class	Model Fit						.01
	(intercept)	5.19	[4.60, 5.78]		17.39	<.001	
	Perceived concealability	.04	[-0.03, 0.12]	.08	1.11	.27	
	Perceived mutability	.01	[-0.09, 0.11]	.01	0.12	.90	

Table A.IV.3

Regressions of perceived concealability and mutability on GIS – separated per group

		B	95% CI	β	*t*	*p*	R^2
LGB	Model Fit						.19
	(intercept)	1.81	[1.47, 2,14]		10.62	<.001	
	Perceived concealability	-0.01	[-0.08, 0.05]	-0.03	-0.40	.69	
	Perceived mutability	0.16	[0.08, 0.24]	0.26	3.81	<.001	
Indigenous	Model Fit						.16
	(intercept)	1.89	[1.51, 2.26]		9.96	<.001	
	Perceived concealability	-0.03	[-0.13, 0.06]	-0.06	-0.71	.48	
	Perceived mutability	0.25	[0.13, 0.37]	0.34	4.03	<.001	
Higher-body weight	Model Fit						.00
	(intercept)	3.02	[2.34, 3.71]		8.70	<.001	
	Perceived concealability	0.07	[-0.03, 0.16]	.10	1.42	.16	
	Perceived mutability	0.00	[-0.11, 0.10]	.00	-0.01	.99	
Working-class	Model Fit						.01
	(intercept)	2.72	[1.99, 3.44]		7.36	<.001	
	Perceived concealability	0.08	[-0.01, 0.18]	.12	1.70	.09	
	Perceived mutability	-0.04	[-0.16, 0.09]	-.04	-0.57	.57	