

Unique and Collective Impact of Interpersonal and Structural Stigma: Minority Stress Mediation
Framework with Latinxs

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ABSTRACT

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The purpose of the present study is to understand how interpersonal and structural ethnic stigma uniquely and collectively confer risk for adverse mental health outcomes in Latinx individuals living in the U.S. Employing a minority stress mediation framework with 639 self-identified Latinxs, the current study utilized manifest and latent variable correlations and latent variable structural equation modeling to examine distal stressors (interpersonal ethnic stigma, structural ethnic stigma) as predictors of mental health outcomes (psychological distress, psychological well-being), with proximal stressors (expectations of stigma, internalized stigma, perceptions of structural stigma) and a general psychological process (rumination) as potential mechanisms through which stigma experiences confer mental health risk. Findings were mixed in terms of their support for study hypotheses. Overall, results indicate that a minority stress mediation framework is applicable with a Latinx population. Interpersonal ethnic stigma yielded direct and indirect associations with proximal stressors, psychological processes, and mental health outcomes, and both proximal stressors and psychological processes emerged as potential pathways through which stigma experiences confer risk. However, associations among structural ethnic stigma and study variables were mostly nonsignificant. Findings are discussed in terms of their implications for clinical practice, education of mental health practitioners, and immigration policy, along with limitations and future directions.

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CHAPTER ONE

INTRODUCTION

On June 16, 2015, a billionaire businessman from NYC turned reality TV star gave a speech announcing that he would run for president of the United States, and in the same speech he exclaimed that “When Mexico sends its people, they’re not sending their best...They’re bringing drugs. They’re bringing crime. They’re rapists...It’s coming from more than Mexico. It’s coming from all over South and Latin America...” (Trump, 2015). During this 20-minute speech, the candidate who would eventually become the 45th president of the U.S. expressed belief in stereotypes that denigrate an ethnic group that comprises almost one-fifth of the U.S. population (Pew Research Center, 2017). Journalists and political pundits have cautioned that President Trump’s election not only reflected but legitimized and strengthened animus towards racial and ethnic minorities generally and Latinxs specifically.

Such claims may be supported by empirical research. One study of U.S. citizens with diverse political orientations found that the perceived acceptability of prejudice toward racial and ethnic minorities increased significantly after the 2016 presidential election (Crandall, Miller, & White, 2018). Furthermore, this increase in prejudiced attitudes coincided with post-election increases in stigma-related incidents (e.g., being called derogatory racial/ethnic epithets, having police called for speaking Spanish, being denied service due to perceived immigrant status) targeting racial/ethnic minorities in the U.S., with anti-immigrant bias incidents among the most reported (Southern Poverty Law Center, 2016). Although all racial and ethnic minorities reported increases in stigma-related incidents, it is especially important to highlight the impact of such increases on the mental health of Latinx or Hispanic people, who have been the focus of racially

charged rhetoric expressed by the current head of the executive branch of the U.S. government before, during, and after his election.

Racial animus and stigmatization of racial and ethnic minorities is not new. From its modern inception as a colonized land, the United States has been characterized by White supremacy, thus affording White, Anglo-Saxon, Protestant (WASP) individuals a powerful and privileged status, with all who deviate from this norm devalued, denigrated, and oppressed (Stewart & Bennett, 1991). White supremacy is a system defined by racial and cultural classification, devaluation of attributes and characteristics not aligned with those that fit within the WASP paradigm, and social stigmatization of all who exhibit those devalued characteristics. Stigma is a complex process characterized by distinguishing and labeling perceived human differences; assigning groups of people to allegedly discrete groups based on those perceived differences; devaluing some of these groups based on their perceived differences from a socioculturally or politically dominant group; and discriminating against devalued groups, leading to unequal outcomes (Link & Phelan, 2001). Stigma is enacted in a variety of ways, with discrimination experiences and enacting restrictive laws and policies among the most studied (Vines, Ward, Cordoba, & Black, 2017; Hatzenbuehler, 2010). Scholars have conceptualized discrimination as an interpersonal form of stigma and laws and policies as a structural form of stigma. Disparate disciplines, from anthropology to psychology, have been concerned with the impact of stigmatization on racial and ethnic minorities, and the field of psychology has focused on how such experiences impact the mental health and well-being of the stigmatized.

The field of psychology has been most interested in the component of stigma concerning status loss and discrimination of labeled individuals (Major & O'Brien, 2005), as this allows psychological scholars to employ their skills of understanding, interpreting, and intervening

where stigma experiences are adversely impacting the stigmatized, and the field of counseling psychology is well-suited to understand, interpret, and intervene where racial and ethnic minorities are experiencing stigma. Counseling psychology is an applied psychology field that is characterized by a multicultural, strengths-based, developmental, non-pathologizing perspective that is interested in conducting research to guide clinical practice, consultation, and sociopolitical advocacy with an understanding of the interplay between an individual and their environment (Society of Counseling Psychology, 2018). Considering counseling psychology's focus on the interplay between an individual and society through a multicultural and social justice lens, the field is well positioned to investigate how changing environments characterized by increases in stigma experiences are impacting the mental health and well-being of Latinxs.

Latinx or Hispanic individuals form a panethnic category comprised of racially diverse individuals who share ancestral connection to South or Central America, the Caribbean, and/or Spain, as well as common cultural values, languages, and religious backgrounds (Calderón, 1992). Despite many shared attributes and characteristics, Latinxs are a racially diverse group with a mixture of African, European, and Indigenous racial backgrounds (Rodríguez, 2000). In the most recent U.S. Census, almost half of all self-identified Latinxs identified their race as White, 30% identified as *some other race*, around 8% as Black, American Indian, or two or more races combined, and 13% chose not to identify a race (Ríos, Romero, & Ramírez, 2014). Despite the significant similarities and differences within the group of individuals who identify with the terms Latinx or Hispanic, all such individuals share a common, panethnic experience of stigmatization in the U.S. (Calderón, 1992). For the purposes of the current study, the term Latinx will be used to describe anyone who identifies as either Hispanic or Latinx.

The term Latinx, with the non-gendered –x at the end of the word rather than the gendered –o or –a (e.g., Latino or Latina), is used throughout this work to operate within a counseling psychology framework that values intersectionality and is in line with recent research terminology in the field (Santos & VanDaalen, 2016). Employing the non-gendered –x fosters gender inclusivity, recognizes the intersection of gender and ethnicity, and reflects solidarity with those fighting against oppressive forces that engender discrimination (Santos, 2017). Specifically, use the non-gendered term Latinx includes and provides visibility for individuals who do not identify with gender binaries (e.g., gender queer, gender non-conforming) and the term does not perpetuate masculinity as the norm.

Research supports the proposition that stigma experiences are indeed increasing for the Latinx population. In a qualitative study of Latinxs conducted following the presidential election, study participants believed that they experienced ethnic discrimination more frequently after the 2016 presidential election relative to their experiences during the Obama presidency (Ayón, Wagaman, & Philbin, 2018). Research has also documented an increase in discriminatory immigration policies that disproportionately impact Latinxs (Torres, Santiago, Walts, & Richards, 2018). Given that stressful experiences connected to one's race or ethnicity are associated with poorer mental health outcomes in the form of greater psychological distress (Pascoe & Smart-Richman, 2009), lower psychological well-being (Schmitt, Branscombe, Postmes, & Garcia, 2014), and symptoms of depression and anxiety (Carter, Lau, Johnson, & Kirkinis, 2017), it is important to understand the pathways through which such experiences lead to mental health outcomes for Latinxs specifically. While much research has been conducted investigating how interpersonal forms of discrimination confer risk for Latinxs (Lee & Ahn, 2011), there has been less research concerning the pathways through which structural forms of stigma confer risk for

adverse mental health outcomes in this population (Hatzenbuehler et al., 2017). As such, it is important to investigate both interpersonal and structural forms of stigma that impact Latinxs.

Research into the pathways through which interpersonal stigma in the form of ethnic discrimination experiences lead to adverse mental health outcomes for Latinxs have employed stress-coping models to explain the relations between discrimination and mental health outcomes (Lee & Ahn, 2011), with the biopsychosocial model of discrimination as stress being the most commonly used with racial and ethnic minorities (Clark, Anderson, Clark, & Williams, 1999). The biopsychosocial model put forth the idea that race- or ethnic-based discrimination represents a form of stress that racial and ethnic minority people must contend with in addition to the stressors of daily life (e.g., divorce, moving, job transitions) everyone experiences. In turn, this additional source of stress is hypothesized to precipitate mental health concerns among racial/ethnic minority people in the U.S.

Despite the large literature concerning the pathways through which interpersonal forms of stigma lead to mental health risk for Latinxs (Flores et al., 2008; Torres, Driscoll, & Voell, 2012; Molina, Alegría, & Mahalingam, 2013), there remains little research into how structural forms of stigma confer risk for Latinxs (Hatzenbuehler et al., 2017; Torres et al., 2018); however, a parallel literature with lesbian, gay, and bisexual (LGB) populations investigating the impact of both interpersonal and structural stigma point to similar pathways. A review of literature concerned with the impact of federal and state-level policies on the mental health of LGB populations, such as hate crime laws, employment discrimination policies, and anti-gay marriage amendments, provided evidence that such policies directly impact LGB mental health, and the research proposed a minority stress mediation framework consisting of individual and group-level psychological variables as pathways through which structural stigma confers risk

(Hatzenbuehler, 2010). As such, there is evidence for using the minority stress mediation framework to understand how both interpersonal and structural stigma experiences confer mental health risk for Latinxs.

Drawing from research on the mental health impact of interpersonal stigma for ethnic minorities and research on the mental health impact of both interpersonal and structural stigma for LGB and other marginalized populations (e.g., individuals with HIV, individuals with learning disabilities), the current study aims to investigate the unique and collective mental health impact of interpersonal and structural stigma for Latinxs with a focus on proximal stressors and psychological variables as potential pathways through which such experiences confer risk.

CHAPTER TWO

LITERATURE REVIEW

Latinx individuals account for more than 18% of the total U.S. population and are among the fastest growing racial or ethnic group in this country (Stepler & Lopez, 2016; Pew Research Center, 2017). However, Latinxs often face a hostile social environment due to interpersonal and structural ethnic stigma, thus increasing Latinx susceptibility to adverse mental health outcomes (Hatzenbuehler et al., 2017; Torres et al., 2018). For example, a nationally representative study of discrimination prevalence with 2,554 Latinxs in the U.S. found that over 30% of the sample reported experiences of everyday discrimination (Pérez, Fortuna, & Alegria, 2008). In a more recent sample of 5,291 Latinxs from a multi-site Hispanic Community Health Study, almost 80% of participants reported a lifetime prevalence of perceived discrimination (Arellano-Morales et al., 2015). In addition to interpersonal ethnic stigma in the form of discrimination faced by Latinxs, structural ethnic stigma in the form of restrictive and exclusionary laws and policies sanctioned by the highest levels of government also contribute to a hostile social environment (Pew Hispanic Center, 2017; Hatzenbuehler et al., 2017). As such, it is important to understand the impact of ethnic stigma experiences on the mental health and well-being of one of the fastest growing minority groups in the U.S. to inform clinical practice and sociopolitical advocacy with this population.

The research is clear that interpersonal ethnic stigma experiences increase risk for adverse mental health outcomes in stigmatized populations generally (Schmitt et al., 2014) and Latinx populations specifically (Lee & Ahn, 2012), but little research has addressed the impact of structural ethnic stigma on the mental health of Latinxs (Hatzenbuehler et al., 2017). Individual and group-level psychological mediators have been put forth by scholars to

understand how stigma experiences confer risk, but there is a paucity of psychological research that attempts to understand how structural stigma confers risk for mental health outcomes. Additionally, there is little research which attempts to understand the unique and collective impact of both interpersonal and structural ethnic stigma on Latinx mental health. Considering the increase in stigma experiences within the U.S. Latinx population after the 2016 presidential election, it is important to understand how stigma experiences impact mental health outcomes.

The following literature review aims to cover the psychological literature concerned with mental health outcomes resulting from stigma experiences. Specifically, the review will examine the interplay of individuals and their social contexts that influence mental health and well-being of Latinxs in the U.S. First, the review will summarize the history of Latinxs in the U.S. to demonstrate a unique, shared panethnic experience of stigmatization despite significant within-group differences. Next, the review will cover dominant psychological conceptualizations of stigma and research demonstrating the mental health outcomes for stigmatized populations generally, and for Latinxs specifically. The review will then provide a rationale for applying a minority stress mediation framework to better understand how interpersonal and structural ethnic stigma experiences lead to adverse mental health outcomes, with a focus on proximal stressors and psychological processes with potential to inform clinical work and sociopolitical advocacy with Latinxs in the U.S.

While discussing the history of Latinxs in the U.S., the review will note waves of Latinx immigration to the U.S. with a focus on the sociopolitical context surrounding such immigration to better understand the functional racial categorization of Latinxs. A case will be made for prioritizing the panethnic categorization of Latinxs in psychological research that attempts to understand the mental health and well-being of this population within a society characterized by

White supremacy. The overview of literature relevant to stigma processes will highlight various forms of stigma that impact all stigmatized groups generally, and Latinxs specifically, and will focus on both psychological disorders and symptom clusters as outcomes resulting from stigma processes. The review will then make a case for applying a minority stress mediation framework to better understand the ways in which ethnic stigma experiences impact Latinx mental health.

History of Latinxs in the U.S.

The population of individuals who identify as either Latinx or Hispanic in the U.S. are a racially and nationally diverse group of individuals who hail from more than 20 different countries and share some common cultural values and religious beliefs (Gutiérrez, 2016; Rodríguez, 2000). Despite significant within-group differences related to race and nationality, Latinxs share a common experience of stigmatization in the U.S. To understand how such a heterogeneous group of people has been lumped into a panethnic category in the U.S., I will review the waves of Latinx immigration, U.S. government attempts to categorize Latinxs using the census, and attributes and characteristics of Latinxs that are stigmatized within a White supremacist society.

The history of Latinxs in the U.S. began when the Mexican-American War (1846 – 1848) resulted in Mexico ceding land that we now know as Arizona, California, Colorado, New Mexico, Nevada, Texas, and Utah to the U.S. With the signing of the Treaty of Guadalupe of Hidalgo, thousands of Mexicans were forced to contend with a new nationality. Historian David Gutiérrez (2016) notes that up to 100,000 citizens of Mexico were now forced to travel south to different lands to maintain their nationality or continue to live on colonized land and identify as citizens of the United States. Colonization by force was the method through which Latinx people

in North America were confronted with subjugation and oppression and set the trajectory for the stigma that Latinxs face today.

Mexican migration to the U.S. remained relatively stable after the Mexican-American War leading up to the Great Depression, and despite a temporary reverse migration during the Great Depression where Mexicans in the U.S. returned to Mexico due to limited resources and local, state, and federal force, the introduction of the Bracero program during World War I in 1941 sharply increased Mexican migration to the U.S. (Gutiérrez, 2016). The Bracero program was a guest worker program whereby Mexican laborers could work in the U.S. to provide cheap labor in attempts to re-stimulate the economy after the Great Depression. This program increased both authorized and unauthorized migration of Mexican individuals to the U.S., with close to four million Latinxs living in the U.S. by the year 1960, most of whom were Mexican; however, the program also reified the idea of Mexicans as low-paid laborers susceptible to exploitation.

Puerto Ricans were the second largest Latinx group living the U.S. before the year 1960, with the island of Puerto Rico becoming a territory of the U.S. through the Spanish-American War of 1898 (Gutiérrez, 2016). Although the Puerto Rican population in the U.S. numbered a modest 53,000 in 1930, World War II and rampant unemployment in Puerto Rico due to ill-advised U.S. attempts to bring investment and industry to the island caused mass migration from Puerto Rico to the U.S. mainland, with the Puerto Rican population numbering 887,000 by 1960. Concurrently, individuals from Cuba began migrating to the U.S. in the early sixties due to U.S. intervention in the overthrow of their government, with nearly 2 million Cubans residing in the U.S. in 2018. While the Latinx population in the U.S. in 1960 was comprised mainly of Mexicans, Puerto Ricans, and Cubans, political and economic instability throughout Central and

South America and U.S. economic reliance upon authorized and unauthorized immigrant workers increased Latinx migration and diversified the nationalities of Latinxs in the U.S.

From before the Mexican-American War to the present, Latinxs have experienced economic exploitation in the form of low wages, inability to access socioeconomic benefits, and being treated as disposable without access to permanent employment (Gutiérrez & Almaguer, 2016). Although Latinxs are maligned, stigmatized, and oppressed within society, the U.S. economy has depended on Latinx workers and has a vested interest in their exploitation. With this brief overview of Latinx waves of immigration to the U.S., it is clear that colonization and economic exploitation have characterized Latinx immigration and continue to characterize the Latinx experience in the U.S. today.

More than 50 million people self-identified as Latinx in the 2010 Census. Of the 50 Latinxs residing in the U.S., 30 million (60%) are of Mexican descent, more than 4 million (8%) are of Puerto Rican descent, and 1.5 million (3%) each are of Cuban, Dominican, and Salvadoran descent. Smaller numbers of Latinxs are of Guatemalan, Colombian, Ecuadorian, Honduran, Peruvian, Nicaraguan, Venezuelan, Argentinian, Panamanian, Chilean, Costa Rican, Bolivian, Uruguayan, or Paraguayan descent (Ríos, Romero, & Ramírez, 2014). As noted previously, the panethnic group of individuals who identify with the label Latinx are racially heterogeneous, with European, African, and Indigenous influences; however, the shared history of colonization and attempts to maintain one's values within a White supremacist society create a shared, singular experience.

The U.S. government sought a way to categorize this new class of citizenry, which was heterogeneous in terms of skin color, country of origin, education level, and socioeconomic status, and applied the term Hispanic to denote people with origins in Spanish-speaking countries

(Calderon, 1992). In 1980, the U.S. Census attempted to account for the racial diversity within the U.S. by including questions about race and allowing individuals to indicate Hispanic or Spanish origin (Rodríguez, 2000). Notably, the results of the 1980 Census uncovered significant differences among those who identified Hispanic or Spanish origin and those that did not: Over 40% of such individuals marked *other race*, whereas less than 3% of the non-Hispanic population chose the *other race* option. Such findings indicate the inability of the current U.S. racial classification system to account for the racial diversity within the group of individuals that identify as Latinx. Additionally, the continued attempts by the U.S. government to categorize individuals as either Hispanic or not Hispanic assures that all such individuals will be seen as one large group, with within-group differences minimized. Although not a racial category in the strictest sense due to variability in physical features, the term Hispanic functioned as such due to the devaluation of shared characteristics among this group.

Devaluation and stigmatization creates a unique, collective experience for individuals who share features in common, and despite the immense within-group variability, people to whom the label Hispanic was ascribed began to unite under the common experience of devaluation, oppression, and stigmatization. Through this unity within activist circles, individuals developed the term Latinx to account for the common experience when interacting with educational, political, and economic institutions and systems (Padilla, 1985). As such, the terms Hispanic and Latinx are used to describe a diverse people who can trace their origins to South America, Central America, the Caribbean, and Spain, who share or once shared the Spanish language in common, and who share cultural values.

The review thus far has provided an overview of Latinxs in the U.S. and established the term Latinx as a panethnic category that functions as a racial category. The next section will

operationalize stigma and cover research investigating the impact of both interpersonal and structural stigma on the mental health of stigmatized populations generally and of Latinxs specifically.

Stigma Theory and Research

Psychological research has demonstrated that stigma experiences can lead to adverse mental health outcomes and has positioned stigma as a fundamental cause of physical and mental health inequalities; however, conceptual and measurement variation of stigma has led to competing hypotheses as to how stigma experiences confer risk (Major & O'Brien, 2004; Hatzenbuehler, Phelan, & Link, 2013; Schmitt et al., 2014). Stigma is experienced on both interpersonal and structural levels (Link & Phelan, 2001; Meyer, 2003; Hatzenbuehler, 2014), and although much research has assessed manifestations of stigma independently, a few studies have investigated their collective impact. To demonstrate the importance of studying the unique and collective impact of multiple levels of stigma on the mental health of Latinxs, the review will discuss literature by scholars who study the impact of stigma and present research demonstrating the deleterious impact of stigma experiences on the mental health of the stigmatized generally, and Latinxs specifically.

For the purposes of the current study, I will apply Link and Phelan's (2001) definition of stigma:

Stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination. Thus we apply the term stigma when elements of

labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold. (p. 367)

Importantly, the above definition incorporates the societal conditions necessary for stigma to occur and locates the problem within a societal context characterized by the affording or withholding of power and opportunity. Stigma occurs when attributes of an individual or a group are labeled, stereotyped, and ascribed an unprivileged status. Such a low status is reinforced through rejection, exclusion, and discrimination, and can lead to negative mental health outcomes in stigmatized groups and individuals. Ultimately, stigma is pervasive, punitive, and paralyzing for the stigmatized.

While comprehensive in scope, current conceptions of stigma do not reflect the unfolding of the concept within psychological literature that occurred in tandem with shifting societal trends. In the early sixties, prominent sociologist Erving Goffman published his seminal book *Stigma: Notes on the Management of the Spoiled Identity* in which he positioned stigma as a social relationship wherein an attribute of an individual is used to justify excluding the whole of that individual from full participation and acceptance in society (Goffman, 1963). He identified three types of stigma: abominations of the body, blemishes of the individual character, and tribal stigma. In other words, Goffman (1963) identified physical deformities, individual deviations from cultural norms, and individuals with membership in minority groups (e.g., race) as attributes that contribute to an individual's stigmatization in society. Inherent in this conceptualization of stigma is the idea that the problem resides within individuals and how they interact with the environment rather than within society. Goffman's (1963) explanations of stigma focused primarily on characteristics within the individual and he did little to explicate the

characteristics of a society that privilege some while stigmatizing others; however, modern conceptualizations of stigma more explicitly locate the problem of stigma within society.

More recently, social psychologists Crocker, Major, and Steele (1998) defined stigma as a process that occurs when an individual attribute conveys a devalued social identity within society, thus providing a rationale for withholding opportunity and treating poorly stigmatized persons. This definition was significant in two important ways. First, it located the problem within society and not within the individual. Second, the definition recognized social positionality and power differentials. The work of these scholars paved the way for the comprehensive definition of stigma utilized in the current review.

Most applicable to the current study is the component of Link and Phelan's (2001) definition of stigma concerned with status loss and discrimination that lead to unequal outcomes. Despite being the largest ethnic minority group in the U.S. (Flores, 2017), Latinxs are portrayed as less than and undesirable by government officials (Rodríguez, 2000), thus contributing to the increase in interpersonal and structural ethnic stigma reported by the population within the past two years (Pew Research Center, 2017; Torres et al., 2018). As such, it is important to understand the nature of interpersonal and ethnic structural stigma before presenting conceptual models that attempt to explain the impact of such stigma on the mental health of Latinxs. The current definition of stigma incorporates the interplay of individuals with society and the power differentials inherent in group membership, and scholars have now turned their attention to specific stigmas and their impact on the mental health of stigmatized individuals. Scholars tend to investigate the impact of one type of stigma process in isolation (Hatzenbuehler et al., 2017; Torres et al., 2018), with experiences of racial and ethnic discrimination being among the most studied (Clark et al., 1999). Few studies to date have examined the unique associations of both

forms of stigma with psychological outcomes (Hatzenbuehler et al., 2017). As such, the review will now operationalize interpersonal and structural stigma and make a case for investigating the collective impact of both forms of ethnic stigma on the mental health of Latinxs living in the U.S.

Discrimination as interpersonal stigma. Interpersonal stigma is defined as the “unequal treatment that arises from membership in a particular social group” (Hatzenbuehler, Phelan, & Link, 2014). Interpersonal stigma is experienced in interactions between individuals in environments such as the workplace, in educational settings, in healthcare settings, and in the interactions that characterize daily life (Lee & Anh, 2012). Scholars note that racial or ethnic discrimination is one prominent manifestation of interpersonal stigma, and research has consistently demonstrated the negative impact of discrimination on one’s mental health in racial and ethnic minority populations (Carter et al., 2017; Clark et al., 1999; Lee & Ahn, 2012; Pascoe & Smart-Richman, 2009). Although experiences of discrimination are commonplace in society, such experiences disproportionally affect those with a disadvantaged social status. Despite scholarly consensus that discrimination experiences are harmful to one’s mental health, there is less consensus on conceptual measurement of discrimination in the psychological literature.

Racial or ethnic discrimination is among the most studied form of interpersonal ethnic stigma and is most often conceptualized as a stressful life event that occurs *because of* someone’s race or ethnicity (Landrine & Klonoff, 1996). As previously mentioned, phenotypic attributes such as skin color, facial structure, and hair texture are often used to categorize an individual’s race (Clark et al., 1999), but considering the racial diversity among Latinxs, markers such as English language ability, accent, values, and self-identification are additional attributes that mark an individual as stigmatized or not, and thus more or less susceptible to racial or ethnic discrimination (Calderon, 1992). Eighty percent of Latinxs report experiencing racial or ethnic

discrimination at some point in their life. Given the ubiquity of racial/ethnic discrimination and – as will be discussed below – its associations with poorer psychological functioning among Latinxs, it will be used to operationalize interpersonal ethnic stigma in the current study.

Laws and deportations as structural stigma. In addition to interpersonal ethnic stigma, scholars are increasingly turning their attention to systemic and institutional forms of ethnic stigma to better explain how stigma impacts the mental health of the stigmatized in this country (Feagin, 2001; Hatzenbuehler, 2014; Torres et al., 2018). Structural stigma is defined as “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized” (Hatzenbuehler & Link, 2014). Although not a psychological construct, structural stigma has proven to be important to consider when investigating the impact of stigma on mental health. The first research examining the mental health impact of structural stigma focused on laws pertaining to the rights of people with mental illnesses (Corrigan et al., 2005a). Investigators accessed all state laws produced within one year and coded those laws according to provision or reduction of liberty for persons with mental illness. Concepts of structural stigma were broadened from state laws and policies to include newspaper articles as a proxy for community attitudes, thus providing multiple avenues through which to study the impact of structural stigma for those with mental illness (Corrigan et al., 2005b). Studies with lesbian, gay, and bisexual populations have used social policies, community-level attitudes, and neighborhood-level hate crimes as indicators of structural stigma (Hatzenbuehler, 2010; Hatzenbuehler, 2014).

Scholars interested in the impact of the incendiary sociopolitical climate for Latinxs in the U.S. have also investigated structural ethnic stigma. Of note, while many of the current laws and policies targeting Latinx individuals disproportionately impact those who are unauthorized to

be in this country, scholars have demonstrated that all who identify as Latinx, regardless of immigration status, are impacted by such policies (Androff et al., 2011). For example, various states and municipalities have enacted laws permitting police officers to detain those suspected of being in the country without authorization, solely based on physical and cultural characteristics (e.g., skin color, language), and the negative impact of such policies is diffuse and extends to all who identify as Latinx, regardless of immigration status (Ayón et al., 2018; Nier, Gaertner, Nier, & Dovidio, 2012). Indeed, research investigating the impact of both supportive and restrictive immigration policies on the mental health of Latinxs found that restrictive policies can increase incidence of interpersonal discrimination for all who identify as Latinx, not just those directly impacted by the laws or policies themselves (Torres et al., 2018).

A study interested in the mental health of Latinxs in response to an incendiary sociopolitical climate operationalized structural ethnic stigma as state-level immigration policies that were either supportive (e.g., legislation designating a city or state as a sanctuary city/state) or exclusionary (i.e., legislation that restricts opportunities and resources), and found that Latinxs living in states with exclusionary policies were at an increased risk for self-reported poor mental health when compared to those living in states with more inclusionary policies (Hatzenbuehler et al., 2017). While this research investigated the collective impact of laws in multiple domains (e.g., labor, health, education), other studies have investigated the impact of specific laws.

One type of structural ethnic stigma that adversely impacts Latinxs is citizenship verification laws. For example, in 2010 Arizona instituted the Arizona Senate Bill 1070, which requires police officers to verify the citizenship of individuals they stop if there exists “reasonable suspicion” that the individual is unauthorized to be in the country. Scholars of structural stigma noted the law’s ability to adversely impact all Latinxs living in Arizona,

regardless of citizenship, due to fears of racial profiling (Nier et al., 2012). Another example of structural ethnic stigma is the Legal Arizona Workers Act (LAWA), which requires employers to confirm citizenship of their workers, thus making it more difficult for unauthorized immigrants to obtain employment. Research investigating the impact of this law found unintended consequences that adversely impacted all Latinxs irrespective of immigration status, such as increased racial profiling, increased raids on homes and businesses, and increased anti-immigrant sentiment and racist discrimination (Ayón, Gurrola, Salas, Androff, & Krysik, 2011). Such research made clear that incendiary immigration policies in the form of verification laws encourage racial profiling and discrimination and negatively impact not only those in this country without authorization, but also all who identify with the panethnic category Latinx.

Another type of state and city-level policy with the potential to impact the mental health of Latinxs are sanctuary laws. Sanctuary laws are those that provide social benefits and legal protections for immigrants who are unauthorized to be in the country (Sullivan, 2009). Additionally, such laws explicitly state that the state or city which enacted the law will not cooperate with federal immigration authorities in their attempts to deport individuals back to their country of origin. Within two years of the current presidential administration, states and cities have increasingly recognized the need to protect and support immigrants who are unauthorized to be in this country through law, and the Immigrant Legal Resource Center (2015) noted that the number of states and cities with such laws has nearly doubled. However, restrictive policies and deportations have also doubled. Mental health scholars note that the existence of sanctuary laws has the potential to promote mental health and well-being (Flaskerud, 2017), but no research to date has undertaken a quantitative analysis of the impact of the existence or absence of sanctuary laws on the mental health of Latinxs broadly.

In addition to verification and sanctuary laws, research has shown that the number of deportations in a state or city can adversely impact the mental health of Latinxs broadly due to the mixed immigration status common in Latinx families and the increase in hypervigilance and fear that such deportations create (Ayón et al., 2018; Society for Community Research and Action, 2018; Torres et al., 2018). For example, research investigating the impact of immigration actions on Latinx parents raising adolescents found that individuals with heightened awareness of Latinx deportations reported higher psychological distress than did those with decreased awareness (Roche, Vaquera, White, & Rivera, 2018). Another study investigating HIV vulnerability among Latinx migrants in the U.S. operationalized structural ethnic stigma as state and local policies in labor, health, education, language, community and neighborhood environments, deportation, and state-authorized identification, and found that Latinx migrants living in states with restrictive policies were more vulnerable to HIV than those living in states with more supportive policies as evidenced by hostile social climates and lack of access to supportive social institutions such as community healthcare clinics (Galeucia & Hirsch, 2016). Results found that both state-authorized identification laws and number of deportations influence HIV vulnerability.

Structural ethnic stigma is expansive and permeates federal, state, municipal, and community levels. Given the purported increase in restrictive policies towards Latinxs and increased deportations, structural ethnic stigma is an important variable to consider when attempting to understand how ethnic stigma broadly impacts the mental health of Latinxs. For the purposes of the current study, structural stigma will be analyzed on a state-level with an investigation into how designation as a sanctuary state, number of sanctuary cities within a state, and number of Latinx deportations within a state influences the mental health of Latinxs. Now

that interpersonal and structural ethnic stigma have been operationalized, I will present research on the impact of stigma on mental health among marginalized populations generally and Latinxs specifically.

Stigma and Mental Health

Psychological literature has long demonstrated the deleterious impact of interpersonal ethnic stigma in the form of discrimination. Research consistently finds that experiences of discrimination adversely impact one's mental health, and the relations among discrimination experiences and mental health outcomes are significantly stronger for those with a stigmatized group membership compared to those without such membership. For example, a meta-analysis that included 328 independent effect sizes ($N = 144,246$) found a significant negative association ($r = -.23$, 95% CI = $[-.24, -.21]$) between experiences of discrimination and overall psychological well-being (e.g., psychological distress, depression, anxiety, self-esteem), with the relationship between discrimination and psychological well-being significantly larger for stigmatized ($r = -.24$) individuals than non-stigmatized ($r = -.10$) individuals (Schmitt, Branscombe, Postmes, & Garcia, 2014). The findings clearly demonstrate that membership in a stigmatized group can lead to increased experiences of discrimination and diminished psychological well-being in comparison to those not holding stigmatized group membership.

Research supports this relationship for racial and ethnic minorities. A recent meta-analysis investigating the impact of racial discrimination on health outcomes for racial and ethnic minorities found significant relations ($r = .17$, 95% CI $[.15, .20]$) between ethnic discrimination and overall psychological distress, with the strongest effect found for Latinx samples ($r = .24$, 95% CI $[.16, .32]$) (Carter et al., 2017). A similar effect size ($r = .23$, $SE = .02$) was found in another meta-analysis of studies with Latinx samples (Lee & Ahn, 2011), which is an effect size like

those found in research with other homogenous samples (e.g., Black Americans, Asian Americans, Arab Americans) of racial and ethnic minorities (Pieterse, Todd, Neville, & Carter, 2012; Lee & Ahn, 2013; Moradi & Hasan, 2004).

Psychological literature focused on Latinx populations has identified an array of mental health outcomes when investigating the impact of interpersonal stigma, with depression, anxiety, psychological distress, and psychological well-being being most commonly examined. The previously mentioned meta-analysis with Latinxs found that ethnic discrimination was most strongly associated with depression ($r = .29$), anxiety ($r = .37$), and psychological distress ($r = .19$) (Lee & Ahn, 2011). Other studies with Latinx people have documented the association of ethnic discrimination with indicators of positive psychological functioning. For example, an empirical study of perceived discrimination experiences and mental health outcomes with 128 Latinx adults found that experiences of discrimination were negatively related to self-esteem (Moradi & Risco, 2006). Another study of 140 Latinx immigrants in the U.S. found that ethnic discrimination yielded a moderate negative association ($r = -.45$) with overall psychological well-being (Cobb, Meca, Xie, Schwartz, & Moise, 2017). Thus, research with Latinx people in the U.S. has documented the association of ethnic discrimination with a variety of indicators of negative and positive psychological functioning.

Regarding the mental health impact of structural forms of stigma, research is limited and confined mostly to research with individuals suffering with severe and persistent mental illness (Corrigan et al., 2005a; Corrigan et al., 2005b) and individuals who identify as lesbian, gay, and bisexual (Hatzenbuehler, 2010). In a public health study using national epidemiological data ($N = 34,653$) on psychiatric morbidity to investigate the mental impact of state-level policies on LGB populations, the authors found that LGB individuals living in states without policies

extending protections against hate crimes and sexual orientation employment discrimination evinced significantly stronger associations with psychiatric disorders in the past 12 months than individuals living in states with such protections (Hatzenbuehler, Keyes, & Hasin, 2009). The findings empirically demonstrated within a large sample that the presence or absence of policy providing protections for LGB individuals significantly impacts LGB mental health.

Although there is a paucity of structural ethnic stigma research with Latinx populations, structural stigma research with LGB populations influenced scholars to investigate the impact of structural ethnic stigma on Latinx populations within the current sociopolitical context that maligns Latinx individuals (Hatzenbuehler et al., 2017). For example, one study investigating the mental health impact of structural stigma with Latinxs from 31 different states found that Latinx people residing in states with restrictive immigration policies across four domains (e.g., immigration, race/ethnicity, language, agricultural protections) reported significantly poorer mental health (i.e., number of days of poor mental health within the past month) than Latinx people residing in states with less restrictive policies – even after controlling for immigration status (Hatzenbuehler et al., 2017). Importantly, this study provided evidence that incendiary immigration policies impact the mental health and well-being of Latinxs irrespective of immigration status.

Research with 213 U.S. Latinx parents living in a mid-Atlantic city employed self-reported reactions to knowledge of and exposure to increased deportations and restrictive immigration policies to empirically demonstrate that structural stigma impacts one's mental health (Roche et al., 2018). Specifically, study participants noted behavior modifications, such as avoiding authorities and warning their children to stay away from authorities, in response to increased deportations and reports of restrictive immigration policies, thus leading to increased

psychological distress. As with previous structural ethnic stigma literature with Latinxs, the current study notes that the strong associations found between structural ethnic stigma and mental health outcomes persisted even after controlling for immigration status, most likely due to the mixed legal status of many Latinx families living in the U.S. Such results further reinforce the idea that structural ethnic stigma is uniquely related to mental health outcomes.

The aforementioned research documented the mental health correlates of interpersonal and structural stigma among marginalized groups broadly and Latinx people. These findings are invaluable, because they suggest that psychologists should work to reduce the stigma encountered by these populations. However, stigma research with Latinx people is limited in two important respects. First, to date no study has tested if both interpersonal and structural stigma are uniquely associated with mental health outcomes or if one manifestation is relatively more salient. Testing the unique associations of these forms of stigma with mental health will help clarify which form of stigma psychologists should prioritize reducing. Second, research has not yet tested psychological or social processes that may mediate the associations of either interpersonal or structural stigma with mental health outcomes among Latinxs. I will now present theoretical models that attempt to explain how such forms of stigma impact mental health outcomes. I will then integrate the findings of research that tests these models with people of color and sexual minority people to derive hypotheses regarding potential mechanisms through which ethnic stigma is associated with poorer mental health among Latinxs.

How Stigma Confers Risk: Minority Stress Integrated Mediation Framework

An expansive psychological literature demonstrates that ethnic and race-based discrimination experiences are associated with adverse mental health outcomes, such as decreased psychological well-being and greater psychological distress, but conceptual clarity is

lacking as to how such experiences confer risk (Colella, Hebl, & King, 2017; Vines, Ward, Cordoba, & Black, 2017; Carter et al., 2017). To add to the existing literature that attempts to understand the pathways through which interpersonal and structural stigma impact Latinx mental health, I will present minority stress theory (MST) and an expanded mediation framework that addresses the questions of how or why stigma is associated with poorer mental health among Latinxs.

Minority Stress Theory. The term minority stress was first introduced in the psychological literature to understand the unique, double-minority experience of lesbian women who are forced to contend with stigmatization as women and as lesbians (Brooks, 1981). In her seminal book, Brooks (1981) proposed the idea that minority stress manifests as self-perceived inferiority based on one's lesbian identity through social and economic means such as discrimination and limited access to economic resources, through psychological methods such as diminished self-esteem, and through biophysical methods, such as experiencing chronic physiological stress reactions. Similar to the parallel stigma literature produced by social psychologists (Crocker et al., 1998; Link & Phelan, 2001), early minority stress literature made a concerted effort to locate the problem within society, not within the individual.

American psychiatric epidemiologist Ilan Meyer (1995, 2003) expanded upon the groundwork laid by Brooks in attempts to provide an explanation for why sexual minority individuals have higher incidences of mental health problems compared to their heterosexual peers (Cochran, 2001; Gilman et al., 2001). According to Meyer's articulation of MST, societal heterosexism produces social stressors with which only sexual minority people must contend. The addition of these minority stressors to the everyday stress everyone – regardless of their sexual orientation identity – experiences leads sexual minority people to develop more mental

health concerns relative to their heterosexual peers. Meyer also distinguished between two types of minority stressors: distal and proximal. Distal stressors (e.g., discrimination, hate crime victimization) are objective, not fully contingent upon one's perception of the stressor, and independent of how an individual identifies. In contrast, proximal stressors (expectations of stigma, concealment of stigmatized identity, internalized heterosexism) are subjective, identity-based, and situated within a societal context.

Subsequent research has provided ample support that both distal and proximal heterosexist minority stressors are associated with poorer mental health among sexual minority people (Brewster, Moradi, DeBlaere, & Velez, 2013; Velez & Moradi, 2016; Velez, Watson, Cox, & Flores, 2017; Wong, Schrager, Holloway, Meyer, & Kipke, 2014). More recently, scholars have focused on the interrelations of distal and proximal minority stressors, as well as social and psychological mechanisms that may mediate the associations of heterosexist stressors with poorer mental health. I discuss this work next to identify mechanisms that may mediate the associations of interpersonal and structural ethnic stigma with mental health among Latinx people.

Psychological mediation framework. While MST proposed distal and proximal stressors as predictors of mental health outcomes, scholars recognized the possibility that these stressors may be interrelated. Specifically, Hatzenbuehler (2009) hypothesized that distal stressors such as heterosexist discrimination may promote proximal stressors (which he labeled group-specific processes) such as expectations of stigma, internalized heterosexism, and identity concealment. In turn, greater expectations of rejection, internalized heterosexism, and identity concealment would promote poorer mental health outcomes among sexual minority people. Hatzenbuehler (2009) also proposed that another class of variables – which he called general

psychological processes – would also partially mediate the association of distal stress with mental health. General psychological processes refer to variables that have been identified as precipitants of psychopathology (e.g., emotion regulation, rumination) that operate across sociodemographic group membership.

MST with Latinx individuals. While the MST and the psychological mediation framework were initially developed to understand the experiences of sexual minority individuals, there is ample evidence for their application to other stigmatized populations who do not identify as sexual minorities. Conceptualizations of minority stress have been applied to people who are socioeconomically disadvantaged (Gamarel, Reisner, Parsons, & Golub, 2012), people who are obese (Sikorski, Luppia, Luck, & Riedel-Heller, 2015), people with learning disabilities (Geiger & Brewster, 2018), people living with HIV (Breslow & Brewster, 2020), and racial and ethnic minorities (Wei, Ku, & Liao, 2011); however, no studies to date have attempted to use MST and the integrated psychological mediation framework to understand how interpersonal and structural ethnic stigma confer risk for adverse mental health outcomes in Latinx populations. The following sections define group-specific stressors and general psychological processes, reviews research that supports the mediating role of these variables in the association of distal stress with mental health, and argues for the applicability of similar models to Latinx people.

Group-Specific Proximal Stressors

Initial formulations of MST organized stressful experiences along a distal-proximal continuum, with distal stressors (i.e., experiences of discrimination) characterized as external and objective, and proximal stressors (i.e., expectations of stigma, internalization of stigma, and concealment of stigmatized identity) characterized as internal and subjective (Meyer, 2003). Subsequently, Hatzenbuehler (2009) explicitly proposed that proximal stressors – or what he

called group-specific processes – may partially explain how distal stress “gets under the skin” and leads to poorer mental health among sexual minority people (Hatzenbuehler, 2009). In other words, negative stigma events activate internal processes within stigmatized individuals, and those individual processes partially explain how stigma produces adverse mental health outcomes. The current study will examine the potential of three group-specific proximal stressors – expectations of stigma, internalized stigma, and perceptions of structural stigma – to mediate the relations of interpersonal and structural ethnic stigma with mental health outcomes.

Expectations of stigma. Scholars have long recognized that experiences of stigmatization can lead to anxiety and vigilance as stigmatized individuals attempt to maintain a stable and coherent self-concept (Allport, 1954; Goffman, 1963). To capture this concept, Meyer (1995, 2003) defined expectations of stigma as the anticipation of stigma events and the vigilance necessary to confront and manage such expectations, and the construct has emerged as an important pathway through which stigma experiences impact mental health. Although widely used in current psychological research with stigmatized populations, the construct has gone through many iterations. Social psychological literature has demonstrated that experiences of stigma can lead marginalized individuals to be fearful of confirming stereotypes associated with their stigmatized group membership, known as stereotype threat (Steele & Aronson, 1995; Steele, 1997), and scholars influenced by this literature began investigating the differential impact of such fear on the targets of stigma. To address the criticism that stereotype threat and other related constructs assume uniform reactions to holding a stigmatized group status, Pinel (1999) put forth the idea of stigma consciousness as an individual difference variable that reflects the extent to which an individual is conscious or aware of their group’s stigmatization.

Research has supported relations among interpersonal stigma, stigma consciousness, and psychological distress and well-being with racially and ethnically diverse LGB populations. For example, a cross-sectional study with 514 sexual minority adults found that expectations of stigma were uniquely related to psychological distress and served as a mediator of the discrimination—distress link (Velez & Moradi, 2016). In yet another study with 411 bisexual participants, expectations of stigma partially mediated the discrimination—distress link and evinced unique, direct relations with anti-bisexual prejudice and psychological well-being (Brewster et al., 2013). Both studies provide empirical evidence for the relations among discrimination, expectations of stigma, and psychological distress and well-being with sexual minority populations.

To date, no study has tested stigma consciousness as a mediator of the association of interpersonal stigma with mental health in samples of primarily Latinx people. However, research with a sample of 455 Latinx college students documented significant, indirect relations between stigma consciousness and psychological distress, thus positioning stigma consciousness as an important variable of interest for Latinx populations (Selbo-Bruns, Molina, Bhandari, & Dibartolo, 2018). Furthermore, interpersonal stigma was positively associated with stigma consciousness in a racially diverse sample of women, a racially diverse sample of men and women, and a racially diverse sample of sexual minority men and women (Pinel, 1999). Importantly, these associations remained significant among the subsample of Latinx participants. In addition, the same research found that stigma consciousness was positively associated with social anxiety in each discrete sample in the study. These findings provide preliminary support for the contention that stigma consciousness may mediate the association of interpersonal ethnic stigma with mental health outcomes. Although there is no known research to have tested the

capacity of stigma consciousness to mediate the relations among structural ethnic stigma and mental health outcomes, structural ethnic stigma appears to be related to mental health in ways similar to interpersonal ethnic stigma (Hatzenbuehler, 2010; 2016; 2018). Furthermore, it seems possible that individuals' appraisals of the extent to which their group is devalued by society would be similarly impacted by interpersonal and structural manifestations of stigma. Thus, I contend that stigma consciousness mediates the relations of both interpersonal and structural ethnic stigma with mental health outcomes.

Internalized stigma. Social psychological scholars interested in the impact of stigma have identified internalized stigma as one possible effect of experiencing stigma (Crocker & Major, 1989; Major & O'Brien, 2005). Internalized stigma is defined as an acceptance and incorporation of stigmatized and oppressive experiences into one's identity, such that oppressed individuals begin believing that they are inherently inferior to the majority (Crocker & Major, 1989; Major & O'Brien, 2005; David, 2009; Speight, 2007). Scholars posit that internalization of stigma can result in assaults against an individual's self-esteem, thus serving as a causal pathway through which interpersonal stigma leads to internalizing mental health symptoms (Luhtanen & Crocker, 1992). Research supports this contention with sexual minority populations, racial and ethnic minority populations, and Latinx populations.

In a sample of 813 racially and ethnically diverse sexual minority adults, internalized stigma in the form of internalized heterosexism evinced positive correlations with heterosexist discrimination, psychological distress, and psychological well-being, and unique, direct relations with heterosexist discrimination, but not with the mental health outcomes (Velez et al., 2017). Additional research with 173 sexual minority Latinx adults found positive associations at the bivariate level among heterosexist discrimination, internalized heterosexism, and psychological

distress, and negative associations with life satisfaction and self-esteem (Velez et al., 2015). Furthermore, research with the same sample found that internalized racism yielded significant negative associations with life satisfaction and self-esteem. Both studies provide evidence that internalized stigma serves as an important mechanism through which interpersonal stigma impacts mental health outcomes for sexual minority individuals and provide partial support for internalized stigma as a mechanism of action with Latinx individuals.

Although internalized stigma as part of an integrated minority stress mediation framework has not been tested specifically with Latinx samples, research supports components of the model. In a sample of 500 Latinx undergraduate students, racist discrimination was uniquely and directly related to internalized racism (Hipolito-Delgado, 2010). Additional research investigating the impact of racist and heterosexist discrimination on substance use and sexual risk behavior in a sample of 643 sexual minority Latinxs provided evidence that greater exposure to racist discrimination is associated with higher levels of internalized racism (Ramirez-Valles, Garcia, Campbell, Diaz, & Heckathorn, 2008). Furthermore, research with a different sexual minority Latinx sample found negative associations between internalized racism and indicators of well-being (e.g., life satisfaction, self-esteem), thus providing evidence that internalized stigma is related to mental health outcomes (Velez et al., 2015). Taken together, these findings provide support for components of the integrated minority stress mediation model, and the current study will test all components together to provide empirical support for this model with Latinxs.

While the research is clear that experiences of interpersonal stigma can lead to increased internalization of stigma, which is in turn related to adverse psychological outcomes, it is less clear whether internalization of stigma mediates the relationship between structural forms of

stigma and mental health outcomes. As such, the current review will investigate internalized stigma as a mediator of the relations among both interpersonal and structural forms of stigma.

General Psychological Processes

In addition to group-specific proximal stressors, the psychological mediation framework put forth the idea that general psychological processes serve as mechanisms through which stigma experiences lead to adverse mental health outcomes (Hatzenbuehler, 2009). We focus on one such process, rumination, because it has received the most empirical support as a mediator of the distal stress-mental health association (McLaughlin & Hatzenbuehler, 2009; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008).

Rumination. Considered to be a general psychological process that is one of the most predictive of psychopathology, rumination is defined as a coping strategy whereby individuals repetitively and passively persevere on causes and consequences of one's problems (Aldao, Nolen-Hoeksema, & Schweitzer, 2010). There is evidence suggesting that stressful experiences, such as experiences of stigma, can lead to rumination among the general population (Monroe, 2008), among sexual minorities (Pachankis, 2008), and among racial and ethnic minorities (Michl, McLaughlin, Shepherd, & Nolen-Hoeksema, 2013). In addition, a significant body of research demonstrates that rumination is associated with psychological symptomatology (Nolen-Hoeksma, 2000; Nolen-Hoeksma & Davis, 1999; Nolen-Hoeksma et al., 2008). Taken together, research findings point to rumination as an important mechanism through which experiences of stigma impact mental health.

For example, results of a study with a sample of 245 Latinx adults attending a community-based primary healthcare clinic indicated that rumination was positively associated with diagnoses of mood and anxiety disorders and increased reports of depressive and anxious

arousal symptoms (Zvolensky et al., 2016). Research also provides support for rumination as a mediator of the association of stress with mental health. Results of a longitudinal study with large, racially and ethnically diverse samples of adolescents ($N = 1,065$) and adults ($N = 1,132$) indicated that self-reported stressors such as serious illness or injury of a family member, relocation, or divorce were associated with increases in subsequent use of rumination as a coping strategy (Michl et al., 2013). Furthermore, increases in rumination were associated with subsequent increases in anxiety symptoms. Importantly, longitudinal mediation analyses confirmed that rumination significantly mediates the relations between stressful life events and depression in the adult sample. Additional research with a sample of racial and ethnic minorities (35% Latinx) found that experiences of interpersonal ethnic stigma were positively associated with rumination, which in turn was positively associated with depressive symptoms, hostility, anger, and aggression (Borders & Liang, 2011). Importantly, rumination significantly mediated the relation between discrimination and depressive symptoms only in the racial and ethnic minority participants and not in the White American participants. In sum, there appears to be strong evidence that rumination is a general psychological process that links experiences of interpersonal ethnic stigma with mental health outcomes.

In contrast, to date no quantitative studies have examined either the association of structural ethnic stigma with rumination or rumination as a mediator of the association of structural ethnic stigma with mental health. However, findings from qualitative research may provide preliminary support for these relations. Specifically, focus group data from 27 Latinx men and women indicated that participants perseverated on fears of contact with police and immigration officials, access to social services for their children, and ability to maintain cultural traditions in the U.S. (Hernandez et al., 2017). The topics the participants ruminated on appear to

reflect fears of anti-Latinx and anti-immigrant policies and sentiment in the U.S. Thus, I contend that encountering structural stigma may also precipitate increases in rumination, which is itself a well-documented antecedent of mental health concerns.

Drawing from consensus within the psychological literature concerned with the mental health impact of interpersonal and structural stigma, the current study will apply an integrated minority stress mediation framework to better understand the pathways through which multiple forms of stigma impact the mental health of Latinxs. Drawing from literature concerning the mental health impact of structural stigma for both racial and ethnic minorities and sexual minorities, the current study will explore structural ethnic stigma as an important predictor of mental health for Latinxs. To counter criticisms that stigma as predictive of mental health is typically studied using singular forms of stigma rather than multiple forms in tandem, the current study will investigate the unique and collective ability of interpersonal and structural ethnic stigma to predict mental health outcomes for Latinxs, with proximal stressors (internalized stigma, expectations of stigma, perceptions of structural stigma) and psychological processes (rumination) as important mediators of interest. Finally, drawing on research implicating psychological well-being and psychological distress as outcomes of interest when studying the impact of ethnic discrimination, the current study will include both variables as mental health outcomes of interest.

Statement of the Problem

Latinxs in the U.S. have reported increases in interpersonal ethnic stigma experiences since the 2016 presidential election, and objective accounts of structural ethnic stigma in the form of laws and policies confirm that both restrictive and supportive laws and policies have increased during the same period (Pew Research Center, 2017; Roche et al., 2018). Because

Latinxs are among the fastest growing ethnic minority group living in the U.S., it is important to understand how such experiences impact their mental health. A long line of psychological research has demonstrated that ethnic discrimination is associated with poorer mental health (Carter et al., 2017), and scholars have used models of stress to understand how such experiences lead to adverse mental health outcomes (Meyer, 1995, 2003; Hatzenbuehler, 2009; Clark et al., 1999). Research has uncovered important group-specific proximal variables and general psychological processes that may mediate the associations of interpersonal and structural ethnic stigma with mental health outcomes. However, to date no research has examined the concomitant associations of interpersonal and structural ethnic stigma with mental health outcomes in racial and ethnic minority populations. Furthermore, no study has tested group-specific and proximal stressors as mechanisms through which interpersonal or structural ethnic stigma are associated with mental health among Latinxs. In light of the reviewed research and in order to address gaps in the literature, the current study will test three sets of hypotheses.

The first set of hypotheses (Hypothesis 1) are informed by the minority stress theory (Meyer, 1995), which considers the relations among distal and proximal stressors and mental health and well-being. Bivariate correlations were used to test the following hypotheses:

Hypothesis 1a: Interpersonal and structural ethnic stigma will be positively correlated with three group-specific processes (internalized stigma, expectations of stigma, perceptions of structural stigma), one general psychological process (rumination), and psychological distress, and negatively correlated with psychological well-being.

Hypothesis 1b: Internalized stigma, expectations of stigma, and perceptions of structural stigma will be positively correlated with psychological distress and negatively correlated with psychological well-being.

Hypothesis 1c: Rumination will be positively correlated with psychological distress and negatively correlated with psychological well-being.

The second set of hypotheses (Hypothesis 2) is also informed by the minority stress theory and assesses direct associations among variables of interest. Structural equation modeling was used to test the following hypotheses:

Hypothesis 2a: Interpersonal and structural ethnic stigma will be uniquely, positively related to internalized stigma, expectations of stigma, perceptions of structural stigma, rumination, and psychological distress, and uniquely, negatively related to psychological well-being.

Hypothesis 2b: Internalized stigma, expectations of stigma, and perceptions of structural stigma will be uniquely, positively related to psychological distress and uniquely, negatively related to psychological well-being.

Hypothesis 2c: Rumination will be uniquely, positively related to psychological distress and uniquely, negatively related to psychological well-being.

The third set of hypotheses (Hypothesis 3) was informed by Hatzenbuehler's (2009) psychological mediation framework of minority stress and mental health and assesses indirect associations among variables of interest. Structural equation modeling was used to test the following hypotheses:

Hypothesis 3a: Internalized stigma, expectations of stigma, and perceptions of structural stigma will mediate the positive indirect associations of interpersonal and structural ethnic stigma with psychological distress and mediate the negative indirect associations of interpersonal and structural stigma with psychological well-being.

Hypothesis 3b: Rumination will mediate the positive indirect associations of interpersonal and structural ethnic stigma with psychological distress and mediate the negative indirect associations of interpersonal and structural ethnic stigma with psychological well-being.

The current study will test the above hypotheses in hopes of bringing conceptual clarity to the body of literature investigating the pathways through which experiences of interpersonal stigma impact the mental health of Latinxs and to provide empirical evidence that structural stigma impacts Latinx mental health similarly to interpersonal stigma. See Figure 1 below for proposed model.

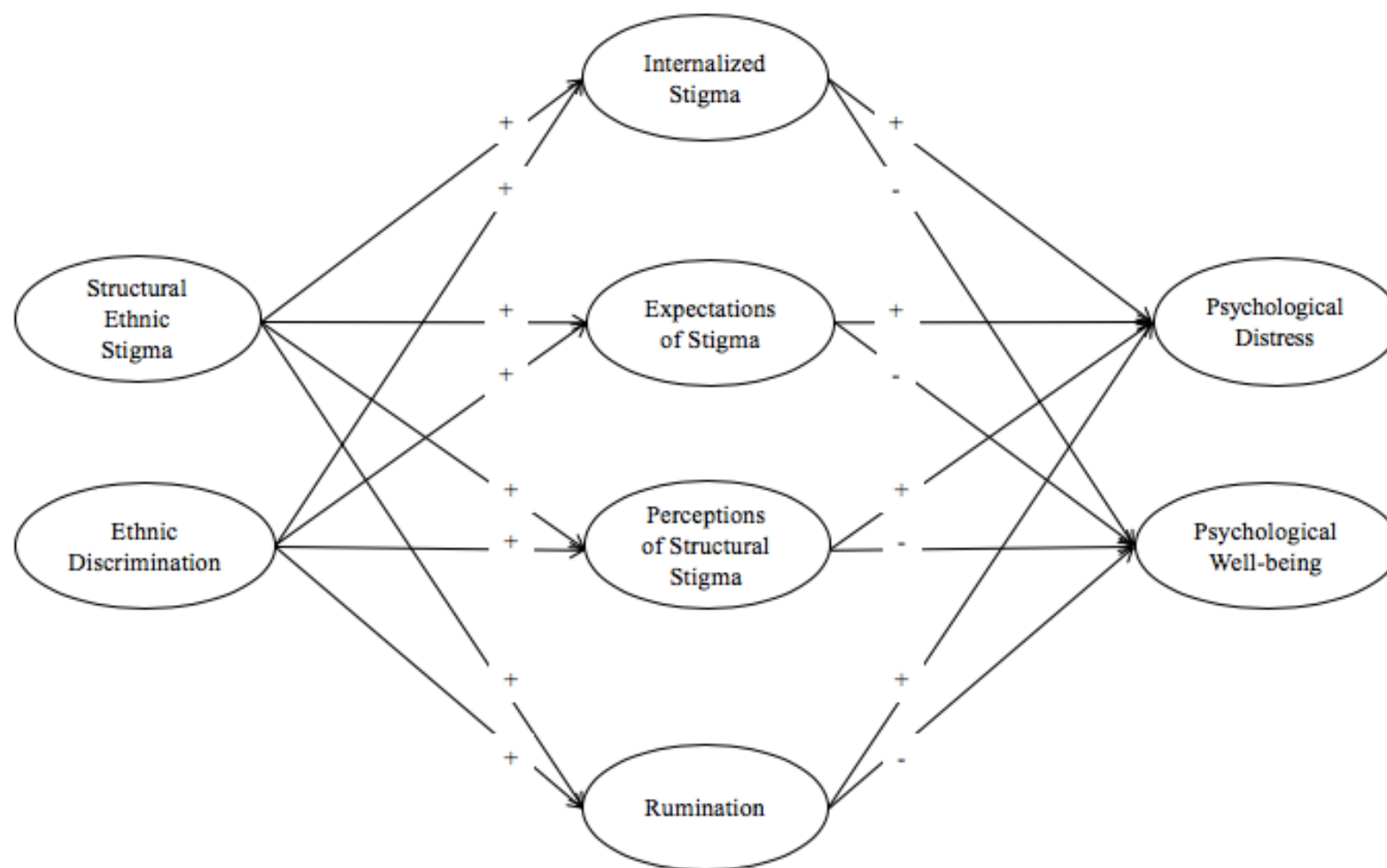


Figure 1. Hypothesized direct associations in model of Latinx minority stress.

Not depicted: (1) Structural Stigma by State with Psychological Distress (+), Psychological Well-being (-); (2) Ethnic Discrimination with Psychological Distress (+), Psychological Well-being

CHAPTER THREE

METHODOLOGY

Procedure

The current study obtained approval from the Institutional Review Board (IRB) at Teachers College, Columbia University. Qualtrics online research panels were chosen as the primary recruitment method to maximize participant variability in terms of demographic information and study variables of interest. The study author obtained a Dean's Research Grant to partially fund data collection, and each participant was paid an average of two dollars for survey completion; however, exact participant remuneration varied according to the specific panel from which Qualtrics recruited participants. Participants had the option of completing the survey in either English or Spanish, and all survey items without an established Spanish translation underwent a forward-backward translation process. Internet recruitment and self-report survey questionnaires were used to maximize potential for the sample to represent the general Latinx population, to assure equal representation from 20 states with highest proportion of Latinx individuals, and to increase ease of access to study participation.

Potential study participants were directed to a survey link, at which time they were informed that the purpose of the study was to investigate the impact of discrimination and restrictive immigration laws on overall well-being along with investigator information, inclusion criteria, and information about how data will be used (Appendix A). Participants were then presented with participant rights and given the option to provide informed consent to participate in the research study (Appendix B). Participants who confirmed they met the study's inclusion criteria (i.e., were 18 years of age or older, identified as either Hispanic or Latinx, and could read and understand English or Spanish) and provided informed consent were allowed to complete the

survey. Survey instruments were presented in random order with the exception of the demographics questionnaire, which was always presented last. Participants were also informed that validity check items (e.g., “Please select ‘Strongly agree’”) were dispersed throughout the survey to assure attentive responding. The online survey took participants an average of 20-30 minutes to complete.

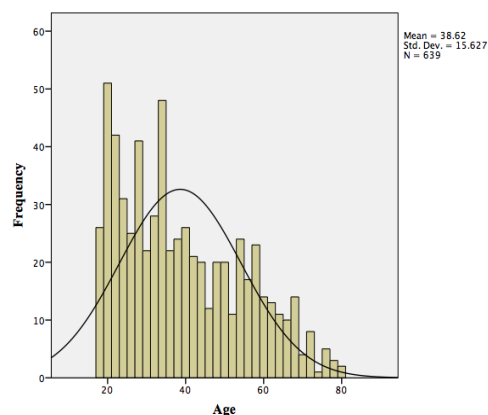
A total of 970 individuals accessed the study link. Of these individuals, 142 (15%) stopped the survey before providing informed consent. An additional 189 (19%) individuals were removed from the data set because they did not fully complete the survey. Of note, Qualtrics required that individuals answer all survey questions and validity check items to be included in the final data set and receive remuneration for their participation, and participants were able to discontinue their participation at any point. As such, the final data set comprised 639 participants (i.e., 66% of individuals who accessed the survey link) – all of whom responded to each survey item (i.e., there were no missing data).

Participants

The final sample included data from 639 self-identified Hispanic or Latinx individuals living in the United States. Participants were recruited through Qualtrics research panels to assure the sample contained both English and Spanish speakers who self-identified as Hispanic or Latinx living in the 20 states with the highest proportion of Hispanic or Latinx individuals. Each participant was paid approximately \$2 for their participation. This decision was guided by research noting that states with higher proportions of Latinxs relative to non-Latinxs report more hate crimes (Southern Poverty Law Center, 2016), frequently implement verification laws (Nier et al., 2011), and have higher numbers of Latinx deportations (Gelatt, Koball, Bernstein, Runes, & Pratt, 2017). Individuals were eligible to participate in the study if they (1) were 18 years of

age or older, (2) self-identified as either Hispanic or Latinx, and (3) could read fluently in the English or Spanish languages. Study author did not obtain any identifying information associated with participant responses to maintain confidentiality.

Sample demographics. Demographic characteristics of the sample are presented in Table 1. Approximately 476 (75%) of participants completed the survey in English and 163 (25%) of participants completed the survey in Spanish. In terms of age, participants ranged from 18 to 80 years old ($M = 38.62$, $Mdn = 35$, $SD = 15.63$). Importantly, age was not normally distributed, with the majority of the participants reporting their age as younger than 40 years old, as shown below:



However, such results are representative of the larger Latinx population in the U.S., with 61% of Latinxs in the U.S. reporting their age as 35 or younger (Pew Research Center, 2017). In terms of gender, approximately 1% of the sample identified as transgender, genderqueer, or gender non-conforming; 21% identified as cisgender men; and 78% as cisgender women. In terms of race, approximately 10% of the sample identified as Biracial, 10% as Black or Afrolatinx, 16% as Indigenous, 19% as other, and 44% as White or Caucasian. Regarding generation status, approximately 27% of the sample identified as 1st generation (i.e., foreign born), 25% as 2nd generation (i.e., U.S. born to foreign-born parents), 15% as 3th generation, (i.e., U.S. born,

foreign-born grandparents), and 32% as 4th generation (U.S. born, foreign-born great grandparents or beyond). In terms of sexual orientation, approximately 2% of the sample identified as asexual, 2% as Queer, 2% as lesbian or gay, 8% as bisexual, and 86% as straight or heterosexual.

In terms of social class, approximately 3% of the sample identified as upper class, 9% as living in poverty, 10% as upper-middle class, 33% as working class, and 45% as middle class. In terms of employment, approximately 13% of the sample identified as retired, 19% as employed part-time, 29% as unemployed, and 40% as employed full-time. Regarding highest level of education, approximately 6% of the sample completed some high school or less, 26% completed a high school diploma, 28% completed some college, 9% completed a two-year college degree (e.g., AA), 21% completed a bachelor's degree, 2% completed some postgraduate work, and 8% completed a postgraduate degree (e.g., MA, MA, PhD, MD). In terms of state of residence, participants were from the 20 states with the highest proportion of Latinx population relative to non-Latinx population: approximately 5% of the sample were from Arizona, 6% from California, 4% from Colorado, 4% from Connecticut, 8% from Florida, 6% from Georgia, 6% from Illinois, 4% from Maryland, 4% from Massachusetts, 4% from Michigan, 5% from Nevada, 6% from New Jersey, 4% from New Mexico, 6% from New York, 5% from North Carolina, 4% from Oregon, 4% from Pennsylvania, 7% from Texas, 5% from Virginia, and 5% from Washington.

The current sample resembles the general population of Latinx people residing in the U.S. in some respects and diverges from this population in others. The current sample resembles the general population with regard to age, foreign born status, and education level. However, race, gender, and sexual orientation appear to diverge from national estimates. For example, U.S. Census (2020) data indicate that over 75% of Latinx individuals identify their race as White,

over 13% as Black, 1.3% as Indigenous, and 2.7% as two or more races, whereas in the current sample, only 44.1% of participants identified their race as White, 10.6% as Black, and 15.6% as Indigenous, and 10.6% as two or more races. It may be that contemporary movements for self-determination and critiques of race as a social construct led individuals to more accurately self-identify their race in the current sample (Pew Research Center, 2017; Croll & Gerteis, 2019).

Additionally, though national estimates report that women comprise 50.8% of the Latinx population, cisgender women represented almost 78% of the current sample (U.S. Census, 2020).

Finally, though approximately 12% the sample identified as sexual minorities, national estimates indicate that only about 4% of Latinx or Hispanic people in the U.S. identify as a sexual minority – which is also the percent of the overall U.S. that identifies as a sexual minority (Pew Research Center, 2017; Newport, 2018).

Table 1

Identity-related Sample Demographics

Demographic Variable	Response Categories	<i>n</i>	%
Gender	Cisgender Woman	497	78
	Cisgender Man	136	21
	Transgender/Genderqueer/Non-Binary	6	<1
Race	Black/Afrolatinx/Latinegrx	68	11
	Indigenous	100	16
	White/Caucasian	282	43
	Biracial/Multiracial	188	30
Generation Status	1 st Generation (foreign born)	170	26
	2 nd Generation (parent/s foreign born)	161	25
	3 rd Generation (grandparent/s foreign born)	100	15
	4 th Generation (great grandparents foreign born)	206	32
Sexual Orientation	Gay or Lesbian	14	2
	Bisexual	59	9
	Asexual	11	<2
	Straight/Heterosexual	550	86
Social Class	Upper Class	16	3
	Upper-Middle Class	66	10
	Middle Class	287	50

	Working Class	212	33
	Living in Poverty	58	9
Annual Income	\$0 to \$20,000	171	27
	\$20,001 to \$40,000	191	30
	\$40,001 to \$60,000	101	16
	\$60,001 to \$80,000	75	12
	\$80,001 to \$100,000	48	7
	\$100,001 to \$150,000	33	5
	\$150,001 and above	20	3
Highest Education Completed	Some high school or less	35	5
	High School Diploma	169	26
	Some College	176	28
	Associates Degree	57	9
	Bachelor's Degree	135	21
	Some postgraduate work	14	2
	Postgraduate degree	53	8
State of Residence	Arizona	33	5
	California	35	5
	Colorado	25	4
	Connecticut	26	4
	Florida	48	7
	Georgia	38	6
	Illinois	35	6
	Maryland	26	4
	Massachusetts	26	4
	Michigan	25	4
	Nevada	33	5
	New Jersey	38	6
	New Mexico	25	4
	New York	38	6
	North Carolina	31	5
	Oregon	25	4
	Pennsylvania	25	4
	Texas	45	7
	Virginia	30	5
	Washington	32	5

Measures

Interpersonal ethnic stigma. The 18-item Recent subscale of the General Ethnic Discrimination Scale (GEDS; Landrine, Klonoff, Corral, & Roesch, 2006) was used to assess interpersonal ethnic stigma that participants had encountered within the last 12 months. Participants used a 6-point scale (1 = *Never* to 6 = *Almost all the time*) to respond to items (e.g., “How often have you been treated unfairly by teachers and professors because of your race/ethnic group?”). Item responses were averaged to obtain scale scores for recent discrimination, with higher scores indicating greater levels of ethnic discrimination. Validity of the GEDS was supported in the development study by large, significant correlations with a similar measure of ethnic discrimination, the Schedule of Racist Events, and by the fact that White individuals reported significantly fewer experiences of discrimination than their Latinx, Asian, and Black counterparts (Landrine et al., 2006). In a sample of Latinx college students, GEDS items yielded a Cronbach’s alpha of .91 (Cheng & Mallinckrodt, 2015). In the current sample, Cronbach’s alpha was .89.

Structural ethnic stigma. Structural stigma is defined as “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized” (Hatzenbuehler & Link, 2014, p. 2). Informed by research with Latinxs and sexual minority populations, structural stigma was assessed with four items that characterized states according to (1) the absence or presence of sanctuary law designation on the state level, (2) the absence or presence of sanctuary law designation in at least one city with a population over 500,000, (3) the absence or presence of immigration verification laws within a state, and (4) the absence or presence of publicized immigration raids during data collection. In these items, absence was coded as “0” and presence was coded as “1.” The first two indicators

related to absence or presence of sanctuary designation laws were reverse coded. Responses to the four items were summed for each state to create a structural ethnic stigma index score, with higher scores indicating a greater level of structural stigma within a state.

Designation as a sanctuary city or state is an official law or policy and is freely available information. This publicly available information is catalogued and frequently updated by multiple organizations. The current study utilized information from the Center for Immigration Studies (2020). Such a designation indicates the existence of laws, ordinances, resolutions, or policies that allow for social services for unauthorized immigrants and shields such individuals from immigration enforcement or removal. Verification laws refer to agreements between state and local law enforcement agencies and U.S. Immigration and Customs Enforcement (ICE) that permit such state and local law enforcement agencies to identify and remove unauthorized immigrants from the country. This information was obtained from the ICE website through a section titled Delegation of Immigration Authority Section 287(g) Immigration and Nationality Act (2019). To determine which states had publicized immigration raids during data collection, the principal investigator consulted the American Immigration Lawyers Association (2020), which tracks and catalogues immigration raids among all 50 states.

Nascent structural stigma research supports compiling immigration policy, state verification laws, and publicized deportations to create a single underlying structural stigma factor (Galeucia & Hirsch, 2016; Hatzenbuehler, 2017). In a population study of the association between structural stigma and mental health outcomes for Latinx individuals, the validity of compiling state-level policies was demonstrated through significant associations between poor mental health and structural stigma. Additionally, Latinxs living in states with higher rates of structural stigma reported significantly worse mental health than did Latinxs living in states with

less structural stigma (Hatzenbuehler, 2017). As such, compiling state-level policies to create a single structural ethnic stigma index has been shown to be a valid indicator of structural stigma.

In the current study, individual item correlations indicated that the first three items evinced large significant positive correlations with one another, whereas the fourth item related publicized immigration raids was negatively correlated with the first three. Additionally, all 4 items yielded a Cronbach's alpha of .26. After it was confirmed that there were no coding or recoding errors in the data, the fourth item was removed from the scale. Cronbach's alpha for the 3-item structural stigma indicator was .76.

Structural Stigma Perception. The extent to which participants were aware of various structural stigma (e.g., presence of sanctuary laws and verification laws on city or state level, knowledge of deportation raids) was assessed using four items (e.g., "To your knowledge, does the state in which you reside have sanctuary laws for individuals without authorization/documentation to be in the U.S.?"") with a dichotomous rating scale (0 = *No*, 1 = *Yes*). The two items assessing absence or presence of sanctuary laws were reverse-coded. Participant responses were summed to derive an overall scale score, with higher scores indicating greater perceptions of structural stigma within one's state.

In preliminary analyses, the structural stigma perception items demonstrated low reliability with a Cronbach's alpha of .24. Evaluation of inter-item correlations indicated that the first two items related to state and city sanctuary laws evinced large significant positive correlations with one another, whereas the second two items related to deportation knowledge and state verification law knowledge were significantly negatively correlated with the first two items and evinced small positive correlations with one another. After it was confirmed that there were no coding or recoding errors in the data, the two items related to deportations and

state verification laws were removed for preliminary, exploratory, and primary study analyses. Cronbach's alpha for the 2-item perceptions of structural stigma scale was .73.

Expectations of Stigma. The 10-item Stigma-Consciousness Questionnaire (SCQ; Pinel, 1999) was used to assess the extent to which study participants expect to experience stigma. Participants respond to items (e.g., "I never worry that my behaviors will be viewed as stereotypical of my race/ethnicity") using a 6-point scale (0 = *strongly disagree* to 6 = *strongly agree*). Seven scale items were reverse coded and item responses were then averaged to compute an overall SCQ score, with higher scores indicating higher expectations of stigma. In a sample of Latinx undergraduate students, SCQ scores were positively correlated with prior experiences of interpersonal ethnic stigma (Pinel, 1999). In a primarily Latinx (75%) sample of ethnic minority college students, SCQ items yielded a Cronbach's alpha of .72 (Burgess, Molina, Bhandari, & DiBartolo, 2018). In the current sample, Cronbach's alpha was .73.

Internalized Stigma. The four-item Private subscale of the Collective Self-Esteem Scale (Luhtanen & Crocker, 1992) was used to assess participants' personal evaluations of their social group. The current study used a version of the Private subscale that specifies race/ethnicity as the social group of interest (e.g., "I feel good about the race/ethnicity I belong to"). Participants responded to items using a 7-point Likert-type scale (1 = *strongly disagree* to 7 = *strongly agree*). Items responses were coded and averaged such that higher scale scores reflected more negative evaluation of one's racial or ethnic group. In a sample of Latinx undergraduate and graduate students, the race/ethnicity-specific version of the Private subscale of the CSES was negatively correlated with self-esteem and racial/ethnic centrality (Spencer-Rodgers & Collins, 2006). In the same study, Cronbach's alpha was .69. In the current sample, Cronbach's alpha was .78.

Rumination. The 22-item Ruminative Responses Scale (RRS; Treynor, Gonzalez, & Nolen-Hoeksema, 2003) was used to assess the extent to which study participants engage in repetitive thinking about past events and/or current feeling states assumed to be related to past events. Participants respond to items using a 4-point scale (1 = *almost never* to 4 = *almost always*). The RRS assesses two manifestations of rumination: reflection and brooding. Reflection is defined as neutrally-valanced rumination, contemplation, and coping in response to problems and difficulties (e.g., “Analyze recent events to try to understand why you are depressed”), whereas brooding is defined as moody pondering in response to problems and difficulties (e.g., “Think about a recent situation, wishing it had gone better”). Item responses were averaged to derive a RRS scale score, with higher scores indicating more rumination. In a sample of 276 Latinxs who attended a community-based primary health care clinic, rumination was positively correlated with a measure of negative affectivity and a measure of anxiety (Talavera et al., 2018). In the same study, Cronbach’s alpha was .96 for all participants. In the current sample, Cronbach’s alpha was .96.

Psychological Distress. The 21-item Hopkins Symptom Checklist -21 (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988) was used to assess overall psychological distress. Participants indicate the extent to which they have experienced a list of symptoms (e.g., “Trouble remembering things,” “Feeling blue”) during the previous week using a 4-point scale (1 = *Not at all* to 4 = *Extremely*). Item responses were averaged, with higher scores indicating greater psychological distress. HSCL-21 items evinced a similar factor structures across samples of White, Latinx, and Black college students (Cepeda-Benito, & Gleaves, 2000). HSCL-21 scores yielded small to medium significant positive correlations with measures of perceived racism for Latinxs, perceived stress, and negative affect in a sample of Latinx college students (Hosford,

2007). In the same sample, Cronbach's alpha for scale items was .90. In the current sample, Cronbach's alpha was .94.

Psychological Well-Being. The 18-item Psychological Well-Being Scale (PWBS; Ryff & Keyes, 1995) was used to assess overall positive psychological functioning. PWBS items reflect self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. Participants responded to items (e.g., "In general, I am in charge of the situation in which I live") using a 6-point scale (1 = *Completely Disagree* to 6 = *Completely Agree*). Appropriate items were reverse-scored and items were averaged to derive an overall scale score, with higher scores indicating greater psychological well-being. The use of full-scale scores has been supported by confirmatory factor analyses (Springer & Hauser, 2006). In terms of validity, PWBS scores positively correlated with life satisfaction, affective balance, and positive affect, and negatively correlated with depression and negative affect in the scale development study (Ryff & Keyes, 1995). In separate samples of Latinx male and female college students, PWBS items yielded a Cronbach's alpha of .84 and .71, respectively (Gloria, Castellanos, Scull, & Villegas, 2005; 2009). In the current sample, Cronbach's alpha was .82.

CHAPTER FOUR

RESULTS

Preliminary Analyses

The first phase of data analysis included procedures to prepare the data for analysis. These procedures include data cleaning, confirmation that data met statistical assumptions of the analyses used, evaluation of manifest variable correlations, and exploration of demographic covariates of the variables of interest.

Data cleaning procedures. IBM SPSS, version 22 (IBM Corp., 2017) was employed to clean the data in preparation for additional preliminary and primary data analysis. Data cleaning procedures consisted of conducting analyses to assure the sample did not contain missing data. There was no missing data and no participants were removed from the data set.

Normality assumptions. SPSS 22 was also employed to determine if the data met assumptions of normality. All variables met benchmarks for univariate normality (i.e., skewness < 3 , kurtosis < 10) (Weston & Gore, 2006). No case had significant Mahalanobis distances ($p < .001$), which suggests that no case violated assumptions of multivariate normality.

Descriptive statistics. SPSS 22 was employed to compute descriptive statistics (means, standard deviations) and Cronbach's alphas for all variables of interest, which are presented in Table 2. All study scales evinced acceptable internal consistency, with Cronbach's alphas ranging from .73 to .96 (Ponterotto & Ruckdeshel, 2007).

Correlation analyses. SPSS 22 was used to compute bivariate correlations among the manifest variables of interest, which are presented in Table 2. Cohen's (1992) guidelines were used to characterize the magnitude of effect sizes as small ($r \leq .10$), medium ($r \leq .30$), or large ($r \leq .50$). Results were mostly consistent with Hypothesis 1a. Interpersonal ethnic stigma evinced

significant small to medium positive correlations with internalized stigma, expectations of stigma, rumination, and psychological distress, and significant small negative correlations with perceptions of structural ethnic stigma and psychological well-being. Consistent with Hypothesis 1a, structural ethnic stigma evinced a significant small positive correlation with perceptions of structural stigma. However, contrary to prediction, interpersonal ethnic stigma evinced a significant small negative correlation with perceptions of structural stigma. Also contrary to prediction, the correlations of structural ethnic stigma with internalized stigma, expectations of stigma, rumination, psychological distress, and psychological well-being were each nonsignificant. Though not hypothesized, it was notable that the correlation of interpersonal ethnic stigma with structural ethnic stigma was also nonsignificant.

Manifest variable correlations of proximal stressors with mental health outcomes were partially consistent with Hypothesis 1b. Specifically, internalized stigma evinced a significant small positive correlation with psychological distress and a significant medium negative correlation with psychological well-being. Additionally, expectations of stigma evinced a significant small positive correlation with psychological distress and a significant small negative correlation with psychological well-being. However, contrary to expectation, the correlations of perceptions of structural stigma with psychological distress and psychological well-being were nonsignificant.

Hypothesis 1c received robust support. Specifically, rumination yielded a significant large positive correlation with psychological distress and a significant large negative correlation with psychological well-being. Hypothesized correlations are discussed in terms of their support for Hypothesis 1 in the Summary of Findings section.

Although not hypothesized, it was observed that internalized stigma yielded significant small positive correlations with expectations of stigma and rumination, but a nonsignificant positive correlation with perceptions of structural stigma. Expectations of stigma also yielded a significant small positive correlation with rumination, but a nonsignificant positive correlation with perceptions of stigma. Perceptions of stigma yielded a nonsignificant small negative correlation with rumination. Furthermore, psychological distress yielded a significant large negative correlation with psychological well-being.

Table 2

Descriptive Statistics and Cronbach's Alphas for and Bivariate Correlations Among Manifest Variables of Interest

Variable	1	2	3	4	5	6	7	Possible Range	<i>M</i>	<i>SD</i>	α
1. Interpersonal Ethnic Stigma	--							1-7	1.94	.96	.89
2. Structural Ethnic Stigma	.02	--						0-4	2.41	1.22	.76
3. Internalized Stigma	.29**	.03	--					1-7	2.23	1.23	.78
4. Expectations of Stigma	.36**	.05	.20**	--				1-7	3.79	.95	.73
5. Perceptions of Structural Stigma	-.16*	.17**	.01	.00	--			0-4	1.61	1.00	.78
6. Rumination	.40**	.04	.20**	.14**	-.02	--		1-4	2.10	.75	.96
7. Psychological Distress	.38**	.06	.22**	.20**	-.03	.79**	--	1-4	2.03	.67	.94
8. Psychological Well-Being	-.23**	-.03	-.36**	-.15**	.03	-.58**	-.59**	1-6	4.17	.68	.82

* $p < .05$. ** $p < .01$. *** $p < .001$

Exploration of Demographic Covariates

Prior research has found evidence that generation status, sexual minority status, racial minority status, gender, age, education level, social class, and acculturation are associated with mental health outcomes (Carter et al., 2017; Cervantes et al., 2018; Chang, Natsuaki, & Chen, 2013; Gamst et al., 2002; Velez et al., 2017). Additional research has found demographic differences in levels of internalized stigma, expectations of stigma, perceptions of stigma, and rumination (Cheref, Lane, Polanco-Roman, Gadol, & Miranda, 2015; Mendoza-Denton & Leitner, 2018; Molina, Lehavot, Beadnell, & Simoni, 2014). A multivariate analysis of covariance (MANCOVA) was conducted to determine if these demographic variables were associated with proximal stressors (internalized stigma, expectations of stigma, perceptions of stigma), psychological processes (rumination), and psychological outcomes (psychological distress, psychological well-being) in the current sample. Generation status (foreign born or U.S. born), sexual minority status (sexual minority or heterosexual), racial minority status (Person of Color or White), gender (cisgender man, cisgender woman, or trans* person), and education level (high school/some college, associates/bachelors, graduate education) were included in the analysis as categorical independent variables (IVs). Language of survey (Spanish or English) was included as a categorical independent variable to serve as a proxy for acculturation. Age and social class were included as continuous covariates. The dependent variables were internalized stigma, expectations of stigma, perceptions of stigma, rumination, psychological distress and psychological well-being. Interactions among IVs and covariates were not tested.

Results indicated that there were no significant multivariate associations of generation status [$F(6, 620) = .96$, Wilks' Lambda = .99, $p = .454$], sexual minority status [$F(6, 620) = 0.82$, Wilks' Lambda = .99, $p = .557$], gender [$F(12, 1242) = .92$, Wilks' Lambda = .98, $p = .523$], age

[$F(2, 620) = .77$, Wilks' Lambda = .99, $p = .595$], education level [$F(12, 1240) = .90$, Wilks' Lambda = .98, $p = .548$], or social class [$F(6, 620) = 1.49$, Wilks' Lambda = .99, $p = .181$]. However, there were significant multivariate associations for racial minority status [$F(6, 620) = 7.64$, Wilks' Lambda = .93, $p = .00$, $\eta_p^2 = .07$] and language of survey [$F(6, 620) = 2.56$, Wilks' Lambda = .98, $p = .02$, $\eta_p^2 = .02$].

Follow-up univariate analyses indicated that there was a significant association of racial minority status with internalized stigma [$F(1, 625) = 6.31$, $p < .01$, $\eta_p^2 = .01$], expectations of stigma [$F(1, 625) = 12.09$, $p < .001$, $\eta_p^2 = .02$], perceptions of structural stigma [$F(1, 625) = 11.27$, $p < .001$, $\eta_p^2 = .02$], and rumination [$F(1, 625) = 8.83$, $p < .01$, $\eta_p^2 = .01$], ($p = .01$), with racial minority participants reporting significantly higher levels of internalized stigma, expectations of stigma, perceptions of structural stigma, and rumination than White-identified participants. However, there was no significant association of racial minority status with psychological distress or psychological well-being. Univariate tests also indicated that language of survey, as a proxy for acculturation, was significantly associated with perceptions of structural stigma [$F(1, 625) = 4.84$, $p < .05$, $\eta_p^2 = .01$], with individuals who took the survey in Spanish ($M = 1.20$, $SE = .16$) reporting a greater perception of structural stigma than participants who took the survey in English ($M = .93$, $SE = .14$). However, there was no significant association of language of survey with internalized stigma, expectations of stigma, rumination, psychological distress, or psychological well-being. Because of the observed associations of racial minority status and language of survey with study variables of interest, they were both included as covariates in the primary analyses to provide more stringent tests of hypotheses.

Primary Analyses

Latent variable structural equation modeling (SEM) in Mplus 8.2 (Muthén & Muthén, 2017) was used to test the unique direct and indirect relations among the minority stress variables, rumination, and mental health outcomes that were described in Hypotheses 2 and 3. Structural models contain two types of variables: exogenous, or variables whose variances are not explained by other variables in the model; and endogenous, or variables whose variances are assumed to be explained, in part, by other variables in the model. Estimated associations among variables can be unidirectional (path coefficients) or bidirectional (covariances or correlation coefficients). The model tested the hypothesized direct and indirect relations between the two exogenous variables (interpersonal ethnic stigma and structural ethnic stigma) and the six endogenous variables (internalized stigma, expectations of stigma, perceptions of stigma, rumination, psychological distress, and psychological well-being).

Before testing the structural model, a measurement model was estimated to determine if the latent variables were adequately measured by their manifest variable indicators. For the General Ethnic Discrimination Scale, the Stigma Consciousness Questionnaire, the Ruminative Responses Scale, the Hopkins Symptom Checklist -21, and the Psychological Well-Being Scale, exploratory factor analyses with principle axis factoring was used to create three item parcels per scale. Following procedures outlined by Weston and Gore (2006), item factor loadings per scale were ordered from largest to smallest. Subsequently, items within a scale were assigned to one of three item parcels in countervailing order to balance the strength of item factor loadings across parcels. Responses to items assigned to the same parcel were averaged to derive parcel scores. These procedures resulted in fifteen item parcels, with three item parcels each defining the interpersonal ethnic stigma, expectations of stigma, rumination, psychological distress, and the psychological well-being latent variables. Because the structural stigma scale (three items),

Private subscale (four items), and perceptions of structural stigma scale (two items) each consisted of a small number of items, individual items within these scales served as manifest variable indicators of the structural ethnic stigma, internalized stigma, and perceptions of structural ethnic stigma latent variables, respectively. Altogether, 24 manifest indicators were used to estimate eight latent variables in the measurement model. The manifest racial minority status and language of survey manifest demographic variables were also included in the measurement model.

Measurement Model

All subsequent analyses were conducted in Mplus v. 8.2 (Muthén & Muthén, 2017) using maximum likelihood estimation. Following Weston and Gore (2006), the following fit indices were utilized to evaluate model fit: the chi-square test (χ^2), the comparative fit index (CFI), the root mean square error of approximation (RMSEA), and the standardized root-mean-square residual (SRMR). The χ^2 is a test of model misspecification in which a nonsignificant result indicates a model that fits the data well; however, χ^2 is almost always significant with large sample sizes, which means that the outcome of the additional three fit indicators carry more weight when determining goodness of fit (Tabachnick & Fidell, 2001). The CFI is an incremental fit index, with values greater than or equal to .95 indicating a better fit. The RMSEA is a fit index that corrects for a model's complexity, with values and 90% confidence interval (CI) upper bound less than or equal to .06 indicating excellent fit. The SRMR is a fit index that summarizes the difference between the observed data and the model, with values less than .08 indicating good fit (Weston & Gore, 2006).

The measurement model yielded excellent fit to the data, $\chi^2(256) = 665.14, p < .001$, CFI = 0.96, RMSEA = 0.05 (90% CI = 0.05, 0.06), SRMR = .05. Additionally, all factor loadings

were significant ($ps < .001$). Factor loadings of manifest indicators ranged from .50 to .96. Correlations among latent variables are presented in Table 3. Consistent with Hypothesis 1a, interpersonal ethnic stigma yielded significant positive small to medium correlations with internalized stigma, expectations of stigma, rumination, and psychological distress, and a significant small negative correlation with psychological well-being. However, contrary to prediction, the correlation of interpersonal ethnic stigma with perceptions of structural ethnic stigma was in the opposite direction from prediction, and the correlations of structural ethnic stigma with internalized stigma, perceptions of structural stigma, rumination, psychological distress, and psychological well-being were each nonsignificant. Of note, there were differences between manifest and latent variable correlations for Hypothesis 1a. Whereas the manifest variable correlation of structural ethnic stigma with expectations of stigma was nonsignificant, the analogous latent variable correlation was significant and positive. Of note, the latent variable correlation effect size was significantly larger than the manifest variable correlation effect size. Similarly, whereas the manifest variable correlation of structural ethnic stigma with perceptions of structural stigma was significant and positive, the analogous latent variable correlation was nonsignificant and negative.

Consistent with Hypothesis 1b, internalized stigma yielded significant small positive correlations with expectations of stigma, rumination, and psychological distress, and a significant medium negative correlation with psychological well-being. Also consistent with Hypothesis 1b, expectations of stigma evinced small significant positive correlations with rumination and psychological distress and a significant small negative correlation with psychological well-being. However, contrary to Hypothesis 1b, the correlations of perceptions of structural stigma with

rumination, psychological distress, and psychological well-being were nonsignificant. Of note, these results are consistent with the manifest variable correlations.

Consistent with Hypothesis 1c, rumination yielded a significant large positive correlation with psychological distress and a significant large negative correlation with psychological well-being. Latent variable correlations for Hypothesis 1c were consistent with manifest variable correlations for Hypothesis 1c. Hypothesized correlations are discussed in terms of their support for Hypothesis 1 in the Summary of Findings section.

Table 3

Correlations Among Latent Variables

Variable	1	2	3	4	5	6	7	8	9
1. Interpersonal Ethnic Stigma	--								
2. Structural Ethnic Stigma	.03	--							
3. Internalized Stigma	.24**	.04	--						
4. Expectations of Stigma	.40**	.23***	.23**	--					
5. Perceptions of Structural Stigma	-.18*	-.05	.06	.01	--				
6. Rumination	.41**	.05	.15*	.17**	-.01	--			
7. Psychological Distress	.40**	.07	.17*	.19**	-.01	.83**	--		
8. Psychological Well-Being	-.25**	-.01	-.34**	-.16**	.01	-.67**	-.67**	--	
9. Language of Survey ^a	.01	.05	-.04	.03	-.02	-.02	-.02	.01	--
10. Racial Minority Status ^b	-.02	-.01	.03	-.02	.11**	-.01	-.02	.02	-.50*

Note. ^a0 = Spanish, 1 = English. ^b0 = Racial Minority, 1 = White.

* $p < .05$. ** $p < .01$. *** $p < .001$

Structural Model

Because the measurement model was deemed to be a good fit to the data, the structural model was evaluated. The correlations between outcome variables and the correlations among hypothesized mediating variables were also estimated. The structural model also estimated paths from racial minority status and language of survey to each of the latent endogenous variables, as well as the correlations of racial minority status and language of survey with the two latent exogenous variables. The structural model yielded excellent fit to the data, $\chi^2(256) = 665.14, p < .001$; CFI = 0.96, RMSEA = 0.05 (90% CI = 0.05, 0.06), SRMR = .05. The structural model explained 6% of the variance in internalized stigma, 16% of the variance in expectations of stigma, 17% of the variance in rumination, 70% of the variance in psychological distress, and 52% of the variance in psychological well-being.

Unique direct relations. Direct relations are presented in Figure 2. Results partially supported Hypothesis 2a. Interpersonal ethnic stigma evinced significant positive unique direct associations with internalized stigma ($\beta = .23, p < .001$), expectations of stigma ($\beta = .40, p < .001$), and rumination ($\beta = .41, p < .001$), and a significant negative unique direct association with psychological well-being ($\beta = .12, p < .05$). Also consistent with Hypothesis 2a, structural ethnic stigma evinced a significant positive unique direct association with perceptions of structural stigma ($\beta = .24, p < .001$). Contrary to Hypothesis 2a, the hypothesized unique direct association of interpersonal ethnic stigma with psychological distress was nonsignificant. Also contrary to Hypothesis 2a, the hypothesized direct associations of structural ethnic stigma with internalized stigma, expectations of stigma, rumination, psychological distress, and psychological well-being were each nonsignificant.

Results partially supported Hypothesis 2b. In terms of proximal stressors, internalized stigma yielded a significant negative unique direct association with psychological well-being ($\beta = -.25, p < .001$). Also in support of Hypothesis 2b, perceptions of structural stigma yielded a significant negative unique direct association with psychological well-being ($\beta = -.50, p < .001$). Contrary to Hypothesis 2b, the hypothesized unique direct relation of internalized stigma with psychological distress was nonsignificant. Also contrary to Hypothesis 2b, the hypothesized unique direct associations of expectations of stigma with psychological distress and psychological well-being were nonsignificant, and the hypothesized unique direct association of perceptions of structural stigma with psychological distress was nonsignificant.

Results fully supported Hypothesis 2c. In terms of general psychological processes, rumination evinced a significant positive direct association with psychological distress ($\beta = .80, p < .001$) and a significant negative direct association with psychological well-being ($\beta = -.67, p < .001$).

Although not hypothesized, associations between proximal stressors, between mental health outcomes, and among demographic covariates and study variables were calculated. In terms of predictors, the association of interpersonal ethnic stigma with structural ethnic stigma was nonsignificant. In terms of mental health outcomes, psychological distress evinced a large significant negative association with psychological well-being. In terms of demographic covariates, direct relations of racial minority status and language of survey with proximal stressors, general psychological processes, and mental health outcomes were nonsignificant.

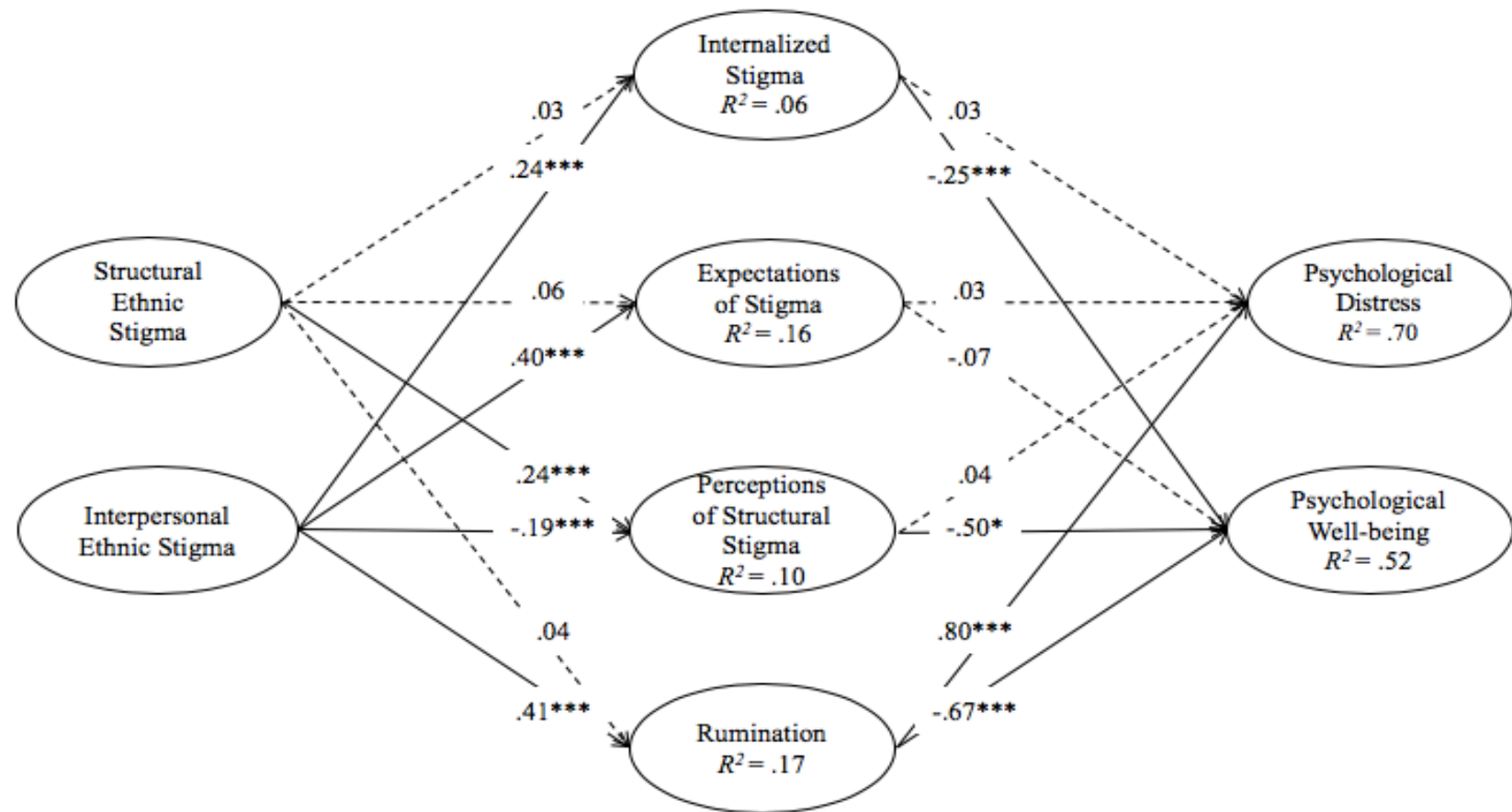


Figure 2. Final model of Latinx minority stress. Values reflect standardized coefficients; dashed lines indicate nonsignificant paths.

The following parameters were estimated, though are not depicted for sake of parsimony:

- (1) Structural Ethnic Stigma by State to Psychological Distress: (.03), Psychological Well-being(.02).
- (2) Interpersonal Ethnic Stigma to Psychological Distress, (.05), Psychological Well-being (.12*).
- (3) Internalized Stigma with Expectations of Stigma (.15*), Perceptions of Structural Stigma (.10), Rumination (.06)
- (4) Expectations of Stigma with Perceptions of Structural Stigma (.08), Rumination (.01)
- (5) Perceptions of Structural Stigma with Rumination (.07)
- (6) Structural Ethnic Stigma with Interpersonal Ethnic Stigma (.03)
- (7) Psychological Distress with Psychological Well-Being (-.67***)

* $p < .05$; ** $p < .01$; *** $p < .001$.

Indirect relations. To address Hypothesis 3, Mplus was used to test proximal stressors (i.e., internalized stigma, expectations of stigma, and perceptions of structural stigma) and a general psychological process (i.e., rumination) as mediators of the indirect associations of interpersonal and structural ethnic stigma with mental health outcomes (i.e., psychological distress, psychological well-being). To determine the significance of indirect associations, 95% CIs were estimated through bootstrapping with 5,000 samples. If the 95% CI of the unstandardized indirect relation does not contain zero, the indirect relation is significant at least $p < .05$ (Mallinckrodt, Abraham, Wei, & Russell, 2006). Tests of unique indirect relations are presented in Table 4, which includes effect sizes for all significant and nonsignificant associations.

Results yielded mixed support for Hypothesis 3. There was a significant total indirect relation between interpersonal ethnic stigma and psychological distress [$B = .25$, (95% CI = .20, .30), $\beta = .35$]. Partially consistent with Hypothesis 3b, interpersonal ethnic stigma yielded a significant positive unique indirect association with psychological distress through rumination. However, contrary to Hypothesis 3a, the unique indirect relations of interpersonal ethnic stigma with psychological distress through the proximal stressors (i.e., internalized stigma, expectations of stigma, perceptions of structural stigma) were each nonsignificant. There was also a significant total indirect relation of interpersonal ethnic stigma with psychological well-being [$B = -.31$, (95% CI = -.39, -.24), $\beta = -.37$]. Providing partial support for Hypotheses 3a and 3b, interpersonal ethnic stigma yielded significant negative unique indirect relations with psychological well-being through internalized stigma and rumination; however, the unique indirect relations of interpersonal ethnic stigma with psychological well-being through expectations of stigma and perceptions of structural stigma were both nonsignificant.

Regarding structural ethnic stigma, the total indirect relation of structural ethnic stigma with psychological distress was nonsignificant [$B = .05$, (95% CI = $-.07, .18$), $\beta = .03$]. Contrary to Hypothesis 3a and 3b, the unique indirect relations of structural ethnic stigma with psychological distress through internalized stigma, expectations of stigma, perceptions of structural stigma, and rumination were each nonsignificant. The total indirect relation of structural ethnic stigma with psychological well-being was also nonsignificant [$B = -.06$, (95% CI = $-.20, .08$), $\beta = -.03$]. Contrary to Hypothesis 3a and 3b, the unique indirect relations of structural ethnic stigma with psychological well-being through internalized stigma, expectations of stigma, perceptions of structural stigma, and rumination were each nonsignificant.

Table 4

Magnitude and Significance of Unique Indirect Relations

Predictor	Mediator(s)	Criterion	Standardized Indirect Relation		Unstandardized Indirect Relation		95% CI of Unstandardized Indirect Relation	
			β	SE	B	SE	Lower Bound	Upper Bound
Structural Ethnic Stigma	Internalized Stigma	Psychological Distress	.00	.00	.00	.00	-.00	.02
	Expectations of Stigma	Psychological Distress	.00	.00	.00	.01	-.00	.02
	Perceptions of Stigma	Psychological Distress	-.00	.01	-.00	.01	-.03	.02
	Rumination	Psychological Distress	.03	.03	.05	.06	-.07	.17
	Internalized Stigma	Psychological WB	-.01	.01	-.02	.03	-.07	.03
	Expectations of Stigma	Psychological WB	-.00	.01	-.01	.01	-.04	.00
	Perceptions of Stigma	Psychological WB	.01	.01	.02	.03	-.02	.08
	Rumination	Psychological WB	-.02	.03	.05	.09	-.17	.07
Interpersonal Ethnic Stigma	Internalized Stigma	Psychological Distress	.01	.01	.01	.01	-.00	.02
	Expectations of Stigma	Psychological Distress	.01	.01	.01	.01	-.01	.03
	Perceptions of Stigma	Psychological Distress	.00	.01	.00	.00	-.01	.01
	Rumination	Psychological Distress	.33	.03	.23	.02	.19	.28*
	Internalized Stigma	Psychological WB	-.06	.03	-.05	.02	-.11	-.02*
	Expectations of Stigma	Psychological WB	-.03	.02	-.02	.02	-.05	.00
	Perceptions of Stigma	Psychological WB	-.01	.01	-.01	.01	-.03	.01
	Rumination	Psychological WB	-.28	.03	-.23	.03	-.28	-.18*

Results of the current study were mixed in terms of their support for the three sets of hypotheses; however, the overall model demonstrated good fit to the data, thus confirming that the minority stress theory has the potential to aid understanding of the ways that interpersonal and structural stigma impact the mental health and well-being of Latinx individuals living in the United States. See Table 5 for a breakdown of study variables and their support for proposed study hypotheses. The following chapter will provide a full discussion of significant and nonsignificant results with a focus on future research, clinical practice, and pedagogical and policy implications.

Table 5

Results of Tests of Three Sets of Hypotheses: Bivariate Correlations, Direct Associations & Indirect Associations

Hypothesis	Predictor	Mediator	Outcome	Direction of Relation	Support YES	Support NO
Hypothesis 1: Bivariate Correlations	Structural Ethnic Stigma		Ethnic Discrimination	+		x
			Internalized Stigma	+		x
			Expectations of Stigma	+		x
			Perceptions of Stigma	+	x	
			Rumination	+		x
			Psychological Distress	+		x
			Psychological WB	-		x
	Interpersonal Ethnic Stigma		Internalized Stigma	+	x	
			Expectations of Stigma	+	x	
			Perceptions of Stigma	+		x
			Rumination	+	x	
			Psychological Distress	+	x	
			Psychological WB	-	x	
	Internalized Stigma		Expectations of Stigma	+	x	
			Perceptions of Stigma	+		x
			Rumination	+	x	
			Psychological Distress	+	x	
			Psychological WB	-	x	
	Expectations of Stigma		Perceptions of Stigma	+		x
			Rumination	+	x	
			Psychological Distress	+	x	
			Psychological WB	-	x	
	Perceptions of Stigma		Rumination	+		x
			Psychological Distress	+		x
			Psychological WB	-		x
	Rumination		Psychological Distress	+	x	
			Psychological WB	-	x	

Hypothesis 2: Unique Direct Associations	Structural Ethnic Stigma		Ethnic Discrimination	+		X
			Internalized Stigma	+		X
			Expectations of Stigma	+		X
			Perceptions of Stigma	+	X	
			Rumination	+		X
			Psychological Distress	+		X
			Psychological WB	-		X
	Interpersonal Ethnic Stigma		Internalized Stigma	+	X	
			Expectations of Stigma	+		X
			Perceptions of Stigma	+		X
			Rumination	+	X	
			Psychological Distress	+		X
			Psychological WB	-	X	
	Internalized Stigma		Psychological Distress	+		X
			Psychological WB	-	X	
	Expectations of Stigma		Psychological Distress	+		X
			Psychological WB	-		X
	Perceptions of Stigma		Psychological Distress	+		X
			Psychological WB	-	X	
	Rumination		Psychological Distress	+	X	
			Psychological WB	-	X	
Hypothesis 3: Indirect Relations	Structural Stigma by State	Internalized Stigma	Psychological Distress	+		X
		Expectations of Stigma	Psychological Distress	+		X
		Perceptions of Stigma	Psychological Distress	+		X
		Rumination	Psychological Distress	+		X
		Internalized Stigma	Psychological WB	-		X
		Expectations of Stigma	Psychological WB	-		X
		Perceptions of Stigma	Psychological WB	-		X
		Rumination	Psychological WB	-		X
	Ethnic Discrimination	Internalized Stigma	Psychological Distress	+		X
		Expectations of Stigma	Psychological Distress	+		X
		Perceptions of Stigma	Psychological Distress	+		X

		Rumination	Psychological Distress	+	x	
		Internalized Stigma	Psychological WB	-	x	
		Expectations of Stigma	Psychological WB	-		x
		Perceptions of Stigma	Psychological WB	-		x
		Rumination	Psychological WB	-	x	

CHAPTER FIVE

DISCUSSION

The purpose of the current study was to determine if a minority stress mediation framework (Hatzenbuehler, 2009; Meyer, 1995, 2003) sheds light on how interpersonal and structural ethnic stigma are associated with the mental health and well-being of Latinx individuals living within the U.S. In particular, the current study sought to expand the minority stress mediation framework by applying it to a Latinx population and combining literature on both interpersonal ethnic stigma (Carter et al., 2017; Clark et al., 1999; Lee & Ahn, 2011, 2012) and structural ethnic stigma (Galeucia & Hirsch, 2016; Hatzenbuehler et al., 2017) in one model. The current study investigated the associations of two distal stressors (interpersonal ethnic stigma, structural ethnic stigma) with two mental health outcomes (psychological distress, psychological well-being) as mediated by three proximal stressors (expectations of stigma, internalized stigma, perceptions of structural stigma) and one general psychological process (rumination).

Overall, results were mixed in terms of their support for individual hypotheses, but study findings suggest that a minority stress mediation framework (Hatzenbuehler, 2009) that investigates both interpersonal and structural ethnic stigma of Latinxs in the U.S. contributes to understanding of how ethnic stigma correlates with mental health. Specifically, interpersonal ethnic stigma emerged as a significant predictor of Latinx mental health, and both proximal stressors and general psychological processes emerged as pathways through which such experiences may confer risk; however, structural ethnic stigma – as measured by structural ethnic stigma by state and perceptions of structural ethnic stigma in the current study – did not emerge as significant predictors of Latinx mental health and well-being. In the following sections,

findings of the study will be further explained in terms of their support for study hypotheses and their implications for clinical practice, immigration policy, and future research.

Overview of Findings

Bivariate Correlations

Manifest and latent variable correlations among variables of interest in the study were informed by minority stress literature (Hatzenbuehler, 2009; Meyer, 1995, 2003) and research on the impact of interpersonal and structural ethnic stigma with Latinx populations (Galeucia & Hirsch, 2016; Hatzenbuehler et al., 2017). Findings were mixed in terms of their support for Hypothesis 1.

First, in terms of distal stressors, interpersonal ethnic stigma yielded significant positive correlations with proximal stressors (internalized stigma, expectations of stigma), a general psychological process (rumination), and psychological distress, and a significant negative correlation with psychological well-being, all consistent with Hypothesis 1. That is, the more one experiences stigma because of one's Latinx identity, the greater the tendency to internalize that stigma, to expect to experience such stigma in the future, and to ruminate on negative emotions. Furthermore, experiencing more ethnicity-based interpersonal stigma is associated with poorer mental health – that is, greater psychological distress and lower psychological well-being. This is consistent with research concerning the impact of interpersonal stigma experiences for Latinx individuals (Lee & Ahn, 2012). Such findings also provide support for using a minority stress framework (Hatzenbuehler, 2009; Meyer, 1995, 2003) in research investigating the impact of interpersonal ethnic discrimination with a Latinx population.

Also in terms of distal-related stressors, structural ethnic stigma evinced a significant positive correlation with perceptions of structural stigma. That is, participants in states with

higher degrees of structural stigma reported greater perceptions of structural stigma than did participants living in states with less structural stigma. Such findings are consistent with expectations, as legal scholars have noted that Latinx immigrants in states with the harshest immigration laws are often aware of those laws (Saenz, 2014).

However, contrary to prediction, interpersonal ethnic discrimination evinced a significant negative correlation with one proximal stressor (perceptions of structural stigma). Perceptions of structural stigma was included as a mediating variable in the current study because prior research has demonstrated that structural stigma is more robustly associated with mental health and well-being when one is aware of that structural stigma (Breslow & Brewster, 2020). Also contrary to prediction, the correlations of structural ethnic stigma with internalized stigma, expectations of stigma, and rumination were nonsignificant. Given that Latinx immigrants without authorization are less likely to participate in online research than those with authorization, it is likely that the majority of participants in the current study had legal status. (Lahman, Mendoza, Rodriguez, & Schwartz, 2011). Research has noted that Latinx immigrants without legal authorization to be in the country are not often represented in online research due to inequality in access to technology, incendiary immigration rhetoric, and fear of deportation (Doran, Castelblanco, & Mijanovich, 2018). The current study did not explicitly assess legal status to prevent instilling deportation fear in participants. Despite the lack of explicitly assessing for legal status, it is likely that most study participants had legal status due to the online nature of the research. Thus, because of their protection against immigration-based structural stigma, it is possible that structural ethnic stigma was not personally salient for participants in the current study, and thus not a major source of stress associated with poorer mental health and well-being (Galeucia & Hirsch, 2016; Hatzenbuehler et al., 2017).

Direct Relations

Unique direct relations among study variables of interest were tested with a path model (Figure 2). Specially, Hypothesis 2 investigated the unique direct relations of distal stressors (interpersonal ethnic stigma, structural ethnic stigma) with proximal stressors (internalized stigma, expectations of stigma, perceptions of stigma), a psychological process (rumination), and mental health outcomes (psychological distress and psychological well-being). Though the results both align and diverge with manifest and latent variable correlations in important ways, the overall pattern of findings for unique direct associations among study variables support the foundational claims of the minority stress theory (Meyer, 1995, 2003) and provide evidence that the theory is applicable with a Latinx population.

In partial support for Hypothesis 2a, interpersonal ethnic stigma evinced significant direct positive associations with internalized stigma, expectations of stigma, and rumination, and a significant direct negative association with psychological well-being. Even when controlling for racial minority status and language of survey, higher levels of interpersonal ethnic stigma were directly and uniquely related to higher levels of internalizing that stigma, a greater expectation of future stigma experiences, higher levels of rumination, and less psychological well-being. Such findings are consistent with prior research investigating the impact of interpersonal ethnic stigma with Latinx populations (Cobb et al., 2017; Lee & Ahn, 2011; Moradi & Risco, 2006) and emphasize the potential deleterious impact of interpersonal ethnic stigma for Latinxs. Although interpersonal ethnic stigma was significantly related to psychological distress at the bivariate level, the unique direct association with psychological distress was nonsignificant in the primary analyses. This is most likely due to the conceptual overlap between rumination and depressive symptoms (Treynor et al., 2003), as previous research has found a strong association between

rumination and psychological distress with ethnic minority populations when removing rumination scale items that are strongly correlated with depressive symptoms (Cheref et al., 2015).

Also in partial support of Hypothesis 2 and consistent with manifest variable correlations, structural ethnic stigma evinced a unique direct positive association with perceptions of structural stigma. In other words, participants living in states with higher levels of structural stigma reported greater perceptions of structural stigma, which has been previously demonstrated (Hatzenbuehler et al., 2017). However, contrary to prediction, but consistent with manifest and latent variable correlations, all other hypothesized unique direct associations of structural ethnic stigma with study variables were nonsignificant. As previously mentioned, one potential explanation for such unexpected findings is the immigration-focused nature of the structural stigma indicators in the current study. Previous structural stigma research with a Latinx population has investigated the impact of structural stigma along multiple dimensions (e.g., language, worker protections, community-level attitudes, healthcare, education) (Galeucia & Hirsch, 2016; Hatzenbuehler et al., 2017), and perhaps the exclusive focus on immigration-specific structural ethnic stigma in the current study did not adequately capture the ways in which Latinx individuals with legal authorization to be in the U.S. (for whom immigration policies may be less personally relevant) experience structural ethnic stigma.

In terms of proximal stressors and their relations with mental health outcomes, results were mostly consistent with manifest and latent variable correlations. In partial support of Hypothesis 2, internalized stigma and perceptions of structural stigma evinced significant unique direct negative associations with psychological well-being, but not with psychological distress. The relation between internalized stigma and psychological well-being, but not psychological

distress, is aligned with evidence that psychological well-being may be particularly influenced by internalized stigma (Velez et al., 2014), as both internalized stigma and psychological well-being involve self-evaluation. Additionally, whereas the relation between perceptions of structural stigma and psychological well-being was nonsignificant at the bivariate level, the unique relation is significant and large. It is possible that a suppressor effect caused the difference between bivariate correlations and unique direct associations. A suppressor effect occurs in path models when one variable is correlated with a predictor to such a degree that the elements the variables share in common are suppressed in one variable in a path analysis, thus allowing for the unique association of two other variables to become significant (Maassen & Bakker, 2001).

Inconsistent with manifest and latent variable correlations and contrary to prediction, the relations of expectations of stigma with psychological distress and psychological well-being were nonsignificant. Perhaps the unique association was nonsignificant in the path model due to the influence of rumination, as expectations of stigma and rumination were correlated at the bivariate level. Expectations of stigma can be conceptualized as ruminating on the prospect of encountering stigma in the future based on past experiences of encountering stigma. Indeed, some scholars have put forth the related concept of race-based rejection sensitivity, which is defined as hypervigilance about being rejected due to one's race or ethnicity (Mendoza-Denton, Downey, Purdie, Davis, & Pietrzak, 2002). It is possible that such a construct might better capture elements of both rumination and expectations of stigma, thus providing a clearer understanding of how expecting ethnic based stigma uniquely and directly impacts the mental health and well-being of Latinx individuals.

In terms of general psychological processes, rumination evinced a unique direct positive

association with psychological distress and a unique direct negative association with psychological well-being. Findings fully support Hypothesis 2 and are consistent with prior research with Latinx populations that position rumination as a signification indicator of one's mental health and well-being (Borders & Liang, 2011; Zvolensky et al., 2016). Furthermore, the current findings solidify rumination as an important predictor for ethnic minority individuals generally and Latinx individuals specifically, as previous research has found that rumination is uniquely predictive of ethnic minority mental health in the context of experiencing stigma, but not for White individuals (Miranda, Polanco-Roman, Tsypes, & Valderrama, 2013). As such, rumination continues to be especially predictive of Latinx mental health and well-being.

Although not hypothesized, correlations among proximal stressors (internalized stigma, expectations of stigma, perceptions of structural stigma) and general psychological processes (rumination) were estimated. Internalized stigma evinced significant positive correlations with expectations of stigma and rumination, and expectations of stigma evinced a significant positive correlation with rumination, whereas the correlations of perceptions of structural stigma with internalized stigma, expectations of stigma, and rumination were nonsignificant. The findings support an underlying principle of the minority stress mediation framework, which posits that proximal stressors and general psychological processes work in tandem and influence one another due to a similar underlying cause—distal stressors (Hatzenbuehler, 2009). The associations between proximal stressors and general psychological processes underscores the deleterious impact of distal stigma experiences. Furthermore, the associations between proximal stressors and general psychological processes provide support for multifaceted clinical interventions designed to assist Latinx individuals in their attempts to confront stigma experiences while maintaining their mental health and well-being.

Indirect Relations

Indirect associations between distal stressors (interpersonal ethnic stigma, structural ethnic stigma) and mental health outcomes (psychological distress, psychological well-being) through proximal stressors (internalized stigma, expectations of stigma, perceptions of stigma) and general psychological processes (rumination) were hypothesized. Results partially supported Hypothesis 3, thus demonstrating multiple pathways through which stigma experiences confer mental health risk for Latinx individuals. Interpersonal ethnic stigma yielded a significant positive indirect association with psychological distress through rumination. Additionally, interpersonal ethnic stigma yielded significant negative indirect associations with psychological well-being through internalized stigma and rumination. The indirect associations implicate both proximal stressors and general psychological processes as important pathways through which distal stressors confer mental health risk for Latinxs.

For Latinx populations, ethnic stigma has emerged as a significant predictor of internalized stigma (Hipolito-Delgado, 2010), and internalized stigma has evinced significant associations with indicators of mental health and well-being for Latinx populations (Velez et al., 2015). As such, the significant negative indirect association of interpersonal ethnic stigma and psychological well-being through internalized stigma is consistent with prior research and positions internalized stigma as an important target of clinical intervention for Latinxs contending with ethnic stigma. Furthermore, the current findings provide additional evidence for the robust impact of rumination as an important pathway through which stigma experiences confer risk for Latinx mental health. Indeed, both cross-sectional and longitudinal research has implicated rumination as an important mediator of the discrimination-distress link for Latinx populations in the U.S. (Borders & Liang, 2011; Michl, McLaughlin, Shepherd, & Nolen-

Hoeksema, 2013). One potential explanation for the robust impact of rumination is that stressful life events, such as stigma experiences, generate negative affect, and it is the negative affect that leads to rumination and internalizing experiences rather than the stigma experiences themselves (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Michl et al., 2013).

In sum, the significant indirect associations in the current study provide evidence that a minority stress psychological mediation framework is applicable with a Latinx population and further positions proximal stressors and general psychological processes as important pathways through which stigma experiences confer mental health risk and ‘get under the skin’ (Hatzenbuehler, 2009).

Exploratory Analyses

In the service of assuring the most stringent tests of study hypotheses in the primary analyses, exploratory analyses were conducted to examine potential group differences among proximal stressors and mental health outcomes. Specially, generation status, sexual minority status, racial minority status, gender, age, education level, social class, and acculturation were examined for significant group-level differences with respect to levels of internalized stigma, expectations of stigma, perceptions of stigma, and rumination, along with the mental health outcomes psychological distress and psychological well-being.

Findings revealed significant differences among variables of interest for racial minority status and language of survey. However, there were no significant differences among variables of interest according to generation status, sexual minority status, gender, age, education level, or social class. Particularly unexpected was the absence of gender differences among study variables of interest. Prior research has noted that girls and women may be more likely to internalize ethnic stigma and report lower psychological well-being in the context of contending

with ethnic stigma experiences than boys and men (Lorenzo-Blanco, Unger, Ritt-Olson, Soto, & Baezconde-Garbanati, 2013), but the current study did not find such results. It is notable that the current sample was comprised of more than 70% cisgender women and lacked transgender and gender non-binary representation. Future research with Latinx individuals should obtain greater gender diversity and more equal samples of genders to better understand how gender influences perception and impact of ethnic stigma.

Consistent with research, racial minority participants reported significantly higher levels of internalized stigma, expectations of stigma, perceptions of stigma, and rumination than White participants (Cheref, Lane, Polanco-Roman, Gadol, & Miranda, 2015; Mendoza-Denton & Leitner, 2018; Molina, Lehavot, Beadnell, & Simoni, 2014). Contrary to prior research, however, there were no significant differences in levels of psychological distress and psychological well-being for racial minority participants when compared to White participants. Still, such findings are aligned with previous research indicating similar rates of depression and anxiety across races, and when significant differences were found, they were typically explained by social factors such as stigma, exclusion, and bias (Brenes et al., 2007; Latzman et al., 2011). As such, racial differences in psychological distress and psychological well-being might have been neutralized due to the shared ethnic stigma that all study participants experience as Latinxs within a system dominated by White supremacy (Lee & Ahn, 2011).

Language of survey served as a proxy for acculturation, and individuals who took the survey in Spanish reported significantly greater perceptions of structural stigma than did participants who took the survey in English. This finding is aligned with research that demonstrates the additional stigma and stress that Latinx individuals may face in the U.S. while speaking the Spanish language. Research has found that speaking Spanish is stigmatized for

children within school contexts (Dawson & Williams, 2008), makes individuals more susceptible to hate crimes (Southern Poverty Law Center, 2016), and compounds barriers to accessing quality healthcare (Yeo, 2004). This finding also aligns with research demonstrating that individuals with lower levels of acculturation report more experiences of stigma (Lee & Ahn, 2012). Considering the significant differences in study variables of interest by racial minority status and language of survey, both demographic variables were included in the primary analyses to provide more stringent tests of study hypotheses.

Implications of Findings

Implications for Practice

Theoretical findings from the current study present several practical implications for mental health practitioners, educators, and policy makers. Results confirm that interpersonal ethnic stigma experiences directly and indirectly adversely influence the mental health and well-being of Latinxs living in the U.S. Specifically, results indicate that both interpersonal and structural ethnic stigma confer mental health risk, and they may do so through internalized stigma and rumination. As such, practical interventions that target distal stressors, proximal stressors, and general psychological processes are indicated for practitioners working with Latinx clients.

First, mental health providers would benefit their Latinx clients by assessing for external sources of distress to inform clinical interventions (Sue & Sue, 2016). Study findings demonstrate that interpersonal ethnic stigma is associated with lower psychological well-being, and internalizing ethnic stigma experiences and ruminating about those experiences are pathways through which stigma experiences impact Latinx mental health. As such, clinicians should assess for stigma experiences, learn ways that Latinx clients confront and cope with those stigma

experiences, and intervene through guiding clients in acquiring more adaptive methods of coping with ethnic stigma (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015; Sue & Sue, 2016). Furthermore, study findings indicated that the impact of ethnic stigma experiences may manifest differently in intensity across Latinx populations, with racial minorities and Spanish speakers reporting greater levels of internalizing symptoms than White participants and English speakers, respectively. As such, mental health practitioners working with Latinx individuals should take an intersectional approach when assessing for stigma experiences with their clients. Specifically, intersectional scholars of Latinx psychology encourage mental health practitioners to consider how one identity (e.g., White race) might afford a Latinx individual power and privilege, thus buffering that individual from the deleterious effects of ethnic stigma (Adames, Chavez-Dueñas, Sharma, & La Roche, 2018).

Second, clinicians working with Latinx clients who are experiencing ethnic stigma should work to help their clients resist internalizing stigma experiences. Study findings highlighted internalized stigma as an important pathway through which stigma experiences confer risk, and practitioners have put forth multiple approaches to combat internalized stigma. Some scholars within the field of counseling psychology have pushed for a multicultural and racial-cultural focus, which emphasizes the need for clinicians to validate client distress that stems from external experiences of stigma and oppression and aid clients in locating those experiences in systems of oppression rather than engaging in self-attribution (Alvarez & Piper, 2005; Sue & Sue, 2016). Additional research has noted the utility of critical race theory and the enhancement of critical consciousness of oppression to assist Latinxs in navigating a culture characterized by White supremacy where ethnic stigma runs rampant (Cerezo, McWhirter, Peña, Valez, & Bustos, 2013). Specifically, the researchers note the importance of guiding Latinx clients in obtaining

greater awareness of how U.S. legal structures and U.S. values of meritocracy and fairness maintain oppressive structures and foster ethnic stigma. Indeed, research has shown that such awareness has the potential to buffer Latinx individuals from the harmful nature of ethnic stigma experiences (Cerezo & McWhirter, 2012). Finally, research has noted the utility of cognitive behavioral therapy (CBT) approaches to assist clients in externalizing stigma experiences (David, 2009). Specifically, CBT approaches recommend conceptualizing internalized stigma as self-defeating thoughts and beliefs about the self that can be disputed through highlighting evidence that directly contradicts such thoughts. As such, study findings implicate a racial-cultural approach, a critical consciousness approach, and a CBT approach in combatting internalized stigma.

Third, clinicians should work to assist their Latinx clients in directly disrupting ruminative coping styles when confronting stigma. Study findings positioned rumination as an important pathway through which stigma experiences confer risk, and research has consistently noted that ruminative coping styles are strongly related to psychological distress and depression (Nolen-Hoeksma, 2000; Nolen-Hoeksma & Davis, 1999; Nolen-Hoeksma et al., 2008). Two potential approaches to tackling rumination in therapy are derived from CBT principles: mindfulness-based CBT and rumination-based CBT (Watkins, 2015). Mindfulness-based CBT incorporates mindfulness practice into traditional CBT approaches, whereas rumination-based CBT harnesses the power of functional analysis to refute ruminative coping styles. Both approaches have demonstrated efficacy in reducing ruminative coping styles and increasing psychological well-being (Segal, Williams, & Teasdale, 2002; Watkins et al., 2011). As such, clinicians working with Latinx clients who exhibit ruminative coping styles would do well to apply mindfulness-based CBT and cognitive bias reduction in therapy.

Fourth, clinicians can benefit their Latinx clients contending with stigma experiences through fostering processes that weaken the discrimination-distress link for Latinxs (Clark et al., 1999; Sue & Sue, 2016). Research has noted that ethnic identity (Torres, L., Yznaga, S. D., Moore, K. M., 2011) acculturation (Lee & Ahn, 2012), biculturalism (Carrera & Wei, 2014), and *familismo* (Becerra, Androff, Cimino, Wagaman, & Blanchard, 2012) have the potential to buffer the relation between ethnic stigma and mental health. Indeed, research notes that individuals with greater levels of ethnic identity, acculturation, biculturalism, and *familismo* are buffered from the deleterious impact of stigma experiences. When working with Latinx individuals who are internalizing about and ruminating on stigma experiences, clinicians can guide clients in considering how such cultural factors might aid in confronting discrimination experiences.

Fifth, study results also highlight educational implications for mental health clinicians, who are uniquely positioned to guide their Latinx clients contending with ethnic stigma experiences in disrupting the discrimination-distress link. Graduate programs that train mental health practitioners should assure that multicultural education is a core component of training programs. Indeed, research has noted that multicultural education can increase practitioner efficacy in aiding clients who are contending with ethnic stigma experiences, which has been found to lead to better patient outcomes (Matthews, Barden, & Sherrel, 2018; Renzaho, Romios, Crock, & Sonderlund, 2013; Smith, Constantine, Dunn, Dinehart, & Montoya, 2006). Additionally, multicultural education should consist of examination of one's own racial and ethnic identity and cultural biases so as not to prevent clinicians from perpetuating systems of oppression during therapeutic encounters (Sue & Sue, 2016). This point is emphasized by the American Psychological Association's (APA) multicultural guidelines and guidelines on race and ethnicity (APA 2017, 2019), which strongly encourage mental health practitioners generally

and psychologists specifically to engage in self-examination of power and oppression across multiple contexts before and during their clinical work with stigmatized populations. Indeed, research notes that lack of clinician cultural competence is a factor that may lead Latinx clients to access mental health services at lower rates than their White peers and to drop out of therapy earlier than their White peers when they do access services (Hatzenbuehler, Keyes, Narrow, Grant, & Hasin, 2008; Kim, Park, La, Chang, & Zane, 2016; Malhotra et al., 2015; Owen, Tao, Imel, Wampold, & Rodolfa, 2014). As such, mental health training programs should incorporate multicultural education that encourages clinical self-reflection.

Finally, study findings also highlight important policy implications. Although the current study did not find significant associations between indicators of structural stigma and mental health outcomes, indicators of structural stigma in the current model contributed to the variance in proximal stressors, psychological processes, and mental health outcomes. As such, policy aimed at providing protections and equity for Latinxs is indicated. Indeed, recent research has noted that the presence of sanctuary laws for immigrants can promote health equity (Aery & Cheff, 2018). Additionally, structural stigma research has noted that community-level attitudes of Latinxs are influenced by language used by politicians (Wei, López, & Wu, 2019). Additional research has noted the utility of bias-reduction programs that focus on the language of perspective taking and empathy (Miklikowska, 2018). As such, policy geared towards making bias-reduction programs free and readily available has the potential to decrease ethnic stigma incidents and foster Latinx well-being.

In sum, clinicians can aid their Latinx clients who are contending with stigma experiences through assessing for ethnic stigma experiences and fostering adaptive methods of coping with such experiences, through assisting clients in directly combatting internalized stigma

and rumination, through assessing for and facilitating connection to cultural factors as a means of buffering the discrimination-distress link for Latinx people, through education of mental health providers, and through policy aimed at promoting equity and reducing bias and stigma against Latinx individuals.

Implications for Research

The current study provides evidence that a minority stress mediation framework is applicable with Latinx populations and sheds light on the pathways through which stigma experiences confer mental health risk. Although previous studies have applied a full minority stress mediation model to ethnic minority and sexual minority individuals (Velez et al., 2017; Zelaya, 2019), no study known to the author has applied a full minority stress mediation model with a primarily Latinx sample. As such, the current work underscores the benefits of additional research with Latinx populations informed by minority stress mediation frameworks. Additionally, study findings underscore the importance of considering both interpersonal and structural forms of ethnic stigma, proximal stressors, and general psychological processes.

In the current study, support for the hypothesized relations of structural ethnic stigma with study variables was mixed. One potential explanation for the mixed findings lies in the measurement of structural ethnic stigma. While indicators of structural ethnic stigma in the current study were solely immigration-focused, previous research has found that diverse indicators of structural stigma (e.g., language policy, community-level attitudes, equity in access to education and healthcare, worker protections) adversely influences Latinx mental health (Galeucia & Hirsch, 2016; Hatzenbuehler et al., 2017; Morey, Gee, Muennig, & Hatzenbuehler, 2018). Despite such research that includes policy across multiple dimensions, structural stigma research with Latinxs is still narrowly focused on immigration-related policies (Hatzenbuehler,

2018). Such a limitation may account for the nonsignificant relations between structural ethnic stigma and study variables of interest in the current study. Future structural stigma research with Latinx populations would benefit from distinguishing between structural stigma associated with immigration status, with one's race, and with one's ethnicity to better understand which indicators of structural stigma are most strongly associated with Latinx mental health outcomes. Additionally, future research could examine the impact of structural stigma on a federal, state, and local level to further clarify the most useful ways of measuring structural stigma for Latinxs. Varied dimensions across multiple levels and an increased quantity of indicators of structural stigma might better elucidate how structural stigma impacts Latinx mental health.

Moreover, future research attempting to understand the pathways through which stigma experiences confer mental health risk for Latinx individuals would benefit from investigating additional Latinx-specific proximal stressors. The current study provides evidence for internalized stigma as a potential proximal stressor that serves as a pathway that confers mental health risk; however, future studies should investigate diverse operationalizations of proximal stressors (Hatzenbuehler, 2009; Meyer, 2003). Research with Latinx participants has noted the ability of acculturative stress (Torres et al., 2012), *familismo* (Ponting et al., 2018), and ethnic identity (Smith & Silva, 2011) to serve as additional pathways through which ethnic stigma experiences confer risk. Indeed, such Latinx-specific constructs might better capture how ethnic stigma is associated with Latinx mental health. Measures of acculturative stress, for example, often include components of ethnic discrimination, and longitudinal research with Latinxs has found that acculturative stress mediates the relations of acculturation and depression (Driscoll & Torres, 2019). Similarly, measures of ethnic identity conceptually overlap with measures of internalized stigma and might provide an avenue for future research. As such, scholars should

undertake research on Latinx-specific proximal stressors that might mediate the relation between stigma experiences and mental health outcomes.

While the current study provided evidence for the applicability of a minority stress mediation framework with Latinx individuals, it did not investigate stress-ameliorating processes that may serve to weaken the discrimination-distress link for Latinx individuals. Minority stress literature with lesbian, gay, and bisexual individuals implores scholars to investigate individual and group-level factors that might ameliorate the mental health impact of distal stressors (Hatzenbuehler, 2003; Meyer, 1995, 2003). Indeed, research with Latinx populations has identified both individual-level and group-level factors that may serve to moderate the relations between stigma experiences and mental health outcomes for Latinxs. As noted above when discussing clinical implications of results, ethnic identity, biculturalism, acculturation, and *familismo* are factors that may serve as moderators of the discrimination-distress link (Becerra et al., 2012; Carrera & Wei, 2014; Lee & Ahn, 2012; Torres et al., 2011), so future research should test a moderated mediation model of minority stress to further investigate such factors.

Finally, the current study demonstrates an association between stigma and mental health outcomes, and additional research investigating the impact of ethnic stigma for Latinx populations in the U.S. should examine additional outcomes, such as physical health, academic performance, and vocational variables. Examining additional outcomes will provide further clarity on the ways in which both interpersonal and structural stigma impact the lived experiences of Latinxs living in the U.S. Indeed, research with Latinxs has found that interpersonal ethnic stigma experiences are associated with poorer physical health, lower academic outcomes, and greater career barriers (Holloway-Friesoen, 2018; McDermott, Umaña-Taylor, & Martinez-Fuentes, 2018; McWhirter, Garcia, & Bines, 2018; Molina et al., 2019).

In sum, findings from the current study suggest that future ethnic stigma research would benefit from clarifying measurement of structural stigma, from studying Latinx-specific proximal stressors and protective factors, and from examining additional outcome measures.

Limitations and Future Directions

Study findings must be interpreted through the lens of study limitations related to recruitment methods, variable measurement, and nature of the data. First, participants for the current study were recruited solely via Qualtrics online marketing panels. Although research has demonstrated the reliability of data from participants recruited via online marketing research panels (Barnhoorn, Haasnoot, Bocanegra, & Steenbergen, 2015; Holden, Dennie, & Hicks, 2013), online methods of research participant recruitment undoubtedly limit research samples to individuals with access to a computer, the internet, time to complete a survey, and literacy. In the current study, it is likely that the online recruitment method under-recruited Latinx individuals without authorization to be in the U.S. and Latinx individuals living in poverty. Considering Latinx individuals without authorization to be in the U.S. are more impacted by immigration-related structural ethnic stigma, recruitment method might account for the nonsignificant relations among structural ethnic stigma, proximal stressors, general psychological processes, and mental health outcomes. Future research with Latinx individuals should diversify participant recruitment methods to include the experiences of individuals without authorization to be in the U.S. and those living in poverty.

Second, variable measurement limited the ability of the current study to investigate the impact of nationality, diverse indicators of structural stigma, and Latinx-specific proximal stressors on Latinx mental health and study variables of interest. In terms of nationality, the online research study did not require participants to identify their country of origin and did not

provide Latinx countries of origin as options. As a result, more than half the sample did not identify their country of origin, and among those that did complete the open-ended question asking about nationality, almost half indicated Hispanic or Latinx, which is an ethnicity. Due to incomplete and incorrect data regarding country of origin, the study author was unable to determine national group differences among study variables. Given that prior research has found differences in distal and proximal stressors according to Latinx people's country of origin (Alegría et al, 2007), future research should more specifically collect nationality data. In terms of diverse indicators of structural stigma, the immigration-specific nature of structural ethnic stigma in the current study limits understanding of how other forms of structural stigma impact Latinx mental health. In terms of Latinx-specific proximal stressors, the measures in the current study were created with and for sexual minorities or for the general population. As such, future research should utilize Latinx-specific proximal stressors proven to be reliable and valid.

Finally, the cross-sectional design of the current study was a significant limitation. Although investigating relations among study variables at one point in time offers invaluable insight into the ways in which ethnic stigma experiences impact Latinx mental health, a cross-sectional design does not allow for temporal claims related to mediators. In other words, the cross-sectional nature of the current data prohibits testing causal hypotheses and directionality. However, longitudinal research has implicated both proximal stressors and psychological processes as important mediators of the relations between ethnic stigma and mental health outcomes (Cheng & Mallinckrodt, 2015; Driscoll & Torres, 2019; Michl et al., 2014). As such, future research should consider applying longitudinal and quasi-experimental designs to examine causal relations among variables of interest and their hypothesized relations utilizing a minority stress mediation model. Such future research foci have the potential to more directly inform

therapeutic interventions for Latinxs contending with multiple forms of ethnic stigma.

Summary and Conclusions

The purpose of the current study was twofold: (1) to determine if a minority stress mediation framework is applicable with a primarily Latinx sample, and (2) to elucidate the pathways through which both interpersonal and structural ethnic stigma confer mental health risk for Latinxs living in the U.S. with manifest and latent variable correlations, demographic exploratory analyses, and structural equation modeling, the current study investigated associations among distal stressors (interpersonal ethnic stigma, structural ethnic stigma), proximal stressors (internalized stigma, expectations of stigma, perceptions of stigma), a psychological process (rumination), and mental health outcomes (psychological distress, psychological well-being).

Study results confirm that a minority stress mediation framework that includes both interpersonal and structural forms of stigma is applicable to a Latinx population and has the potential to shed light on pathways through which stigma experiences confer mental health risk. Specifically, interpersonal ethnic stigma was significantly related to proximal variables, psychological processes, and mental health outcomes. Structural ethnic stigma was significantly related to perceptions of structural stigma, but its relations with other study variables of interest were nonsignificant. Furthermore, both internalized stigma and rumination emerged as significant pathways for risk conferral. Overall, study findings demonstrate robust support for applying a minority stress mediation framework to understand that ways that interpersonal and structural ethnic stigma experiences are associated with the mental health and well-being of Latinx people.

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APPENDECIES

APPENDIX A

Informed Consent

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

RESEARCH STUDY: Unique and Collective Impact of Interpersonal and Structural Stigma: Minority Stress Mediation Framework with Latinxs

PRINCIPAL INVESTIGATOR: Robert A. Cox, Jr., M.A., & Brandon L. Velez, Ph.D.

DESCRIPTION OF THE RESEARCH: You are invited to participate in a research study about your experiences of discrimination as a Latinx or Hispanic person and how these experiences may be related to your well-being. You will be asked to complete an Internet survey. To participate, you must:

- 1) Identify as Hispanic or Latina/o.
- 2) Reside in the United States.
- 3) Be 18 years of age or older.

This study is being conducted by Robert A. Cox Jr., M.A., a counseling psychology doctoral candidate in the Department of Counseling and Clinical Psychology at Teachers College, Columbia University, and Brandon L. Velez, Ph.D., who is a counseling psychology faculty member of the department. This study has been approved by the Institutional Review Board of Teachers College, Columbia University (Protocol #_____).

RISKS AND BENEFITS: No more than minimal risk is anticipated with this study. Such risks may include mild discomfort when thinking about aspects of your identity. There are no assured benefits from participating in this study.

PAYMENTS: Participants will not receive any payment for their participation.

DATA STORAGE TO PROTECT CONFIDENTIALITY: Your responses to this survey will be private and anonymous. All data will be kept confidential and will only be reported in aggregate format (i.e., only reporting combined results and never reporting individual results). Only the Principal Investigators will have access to the data. The collected data will be stored in the HIPAA-compliant, Qualtrics-secure database until they are deleted by the Primary Investigators.

TIME INVOLVEMENT: Your participation will take approximately 30 minutes.

HOW WILL RESULTS BE USED: Results from this study may presented at conferences or meetings or used for articles or educational purposes.

APPENDIX B

Consentimiento

525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

ESTUDIO DE INVESTIGACIÓN: Estigma y salud mental de Latinxs

INVESTIGADORES PRINCIPALES: Robert A. Cox, Jr., & MA Brandon L. Velez, Ph.D.

DESCRIPCIÓN DE LA INVESTIGACIÓN: Usted está invitado a participar en un estudio de investigación acerca de sus experiencias de discriminación como Latinx o Hispano y cómo estas experiencias pueden estar relacionadas con su bienestar. Se le pedirá completar una encuesta por Internet. Para participar, es necesario:

- 1) Identificar como hispano o latina/o.
- 2) Residir en los EE.UU. continentales
- 3) Tener 18 años de edad o más.

Este estudio está siendo realizado por Robert A. Cox Jr., un candidato de doctorado de psicología de consejería en el Department of Counseling and Clinical Psychology en Teachers College, Columbia University, y Brandon L. Velez, un miembro de la facultad en el departamento. Este estudio se ha sido aprobado por el Institutional Review Board de Teachers College, Columbia University. (Protocolo #_____).

RIESGOS Y BENEFICIOS: No hay más que un riesgo mínimo se prevé con este estudio. Estos riesgos pueden incluir un malestar leve cuando se piensa en los aspectos de su identidad. No hay beneficios asegurados de participar en este estudio.

PAGOS: Los participantes van a recibir un pago mínimo (\$1-5) por su participación de Qualtrics.

ALMACENAJE DE DATOS PARA PROTEGER LA CONFIDENCIALIDAD: Sus respuestas a esta encuesta estarán confidenciales y sólo se comunicarán en forma agregada (es decir, solamente comunicar los resultados combinados y nunca comunicar los resultados individuales). Sólo los investigadores principales tendrán acceso a los datos. Los datos recogidos estarán almacenados en la base de datos Qualtrics, una base que es obediente con HIPAA, hasta que se eliminan por los investigadores principales.

TIEMPO DE PARTICIPACIÓN: Su participación se llevará aproximadamente 30 minutos.

CÓMO SE UTILIZARÁN LOS RESULTADOS: Los resultados de este estudio pueden estar presentados en congresos o reuniones o usados por artículos o por fines educativos.

APPENDIX C

Participants Rights

- I have read the Research Description above and understand that my participation in this study is completely voluntary.
- I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care, employment, student status or other entitlements.
- The researcher may withdraw me from the research at his/her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the principal investigators – Robert Cox, Jr., MA (rc2813@tc.columbia.edu) or Brandon L. Velez, Ph.D. (velez3@tc.columbia.edu) – who will answer my questions.
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teacher College, Columbia University Institutional Review Board (IRB). The phone number for the IRB is (212) 678-4105. Or, I can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY, 10027, Box 151.
- For my personal records, I should print a copy of the Research Description and this Participant's Rights document.

By checking the box below and clicking “Next,” I confirm that I meet the inclusion criteria of this study (i.e., identify as Latina/o or Hispanic, reside in the U.S., and are 18 years of age or older) and I willingly agree to participate in this study.

YES, I have read and understand the above, and I agree to participate in this study.

[[NEXT]]

APPENDIX D

Los derechos del participante

- Yo he leído la descripción de la investigación y entiendo que mi participación en este estudio es completamente voluntaria.
- Puedo negar de participar o dejar de participar en cualquier momento, sin afectar el acceso de servicios médicos en el futuro, del empleo, el estatus estudiantil, o de otros derechos.
- El investigador me puede retirarse de la investigación a su discreción profesional.
- Cualquier información derivada del proyecto de investigación que me identifica personalmente no se dará sin mi consentimiento, excepto lo que se requiere específicamente por la ley.
- Si en algún momento tengo preguntas con respecto a la investigación o mi participación, puedo ponerme en contacto con los investigadores principales – Robert A. Cox Jr., M.A. (rc2813@tc.columbia.edu) or Brandon L. Velez, Ph.D. (velez3@tc.columbia.edu) – quienes responderán a mis preguntas.
- Si en algún momento tengo comentarios, o preocupaciones con respecto a la realización de la investigación, o preguntas sobre mis derechos como sujeto de investigación, debo ponerme en contacto el Teachers College, Columbia University Institutional Review Board (IRB). El número de teléfono del IRB es 212.678.4105. También puedo escribir el IRB: Teachers College IRB, 525 W. 120th St., New York, NY, 10027, Box 151.
- Para mi documentación personal, debo imprimir una copia de la descripción de la investigación y este documento con los derechos del participante.

Al marcar la opción SÍ, confirmo que cumpla los criterios de inclusión de este estudio (es decir, se identifica como Latina, Latino, o Hispano, reside en los EE.UU., y de buena gana de acuerdo en participar en este estudio.

SÍ, Yo he leído y comprendo lo anterior, y acuerdo en participar en este estudio.

APPENDIX E

General Ethnic Discrimination Scale (GEDS; Landrine et al., 2006)

We are interested in your experiences with racism/discrimination. For each question, **please select the number** that best captures the things that have happened to you. Use the following scale to indicate how often each event has happened to you **IN THE PAST YEAR**.

Select 1 = If the event has *NEVER* happened to you

Select 2 = If the event happened *ONCE IN A WHILE* (less than 10% of the time)

Select 3 = If the event happened *SOMETIMES* (10-25% of the time)

Select 4 = If the event happened *A LOT* (26-49% of the time)

Select 5 = If the event happened *MOST OF THE TIME* (50-70% of the time)

Select 6 = If the event happened *ALMOST ALL OF THE TIME* (more than 70% of the time)

1. How often have you been treated unfairly by *teachers or professors* because of your race/ethnic group?
2. How often have you been treated unfairly by *your employer, boss, or supervisors* because of your race/ethnic group?
3. How often have you been treated unfairly by *your co-workers, fellow students or colleagues* because of your race/ethnic group?
4. How often have you been treated unfairly by *people in service jobs* (by *store clerks, waiters, bartenders, waitresses, bank tellers, mechanics and others*) because of your race/ethnic group?
5. How often have you been treated unfairly by *strangers* because of your race/ethnic group?
6. How often have you been treated unfairly by *people in helping jobs* (by *doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, social workers, and others*) because of your race/ethnic group?
7. How often have you been treated unfairly by *neighbors* because of your race/ethnic group?
8. How often have you been treated unfairly by *institutions* (*schools, universities, law firms, the police, the courts, the Department of Social Services, the Unemployment Office, and others*) because of your race/ethnic group?
9. How often have you been treated unfairly by *people that you thought were your friends* because of your race/ethnic group?
10. How often have you *been accused or suspected of doing something wrong* (such as *stealing, cheating, not doing your share of the work, or breaking the law*) because of your race/ethnic group?
11. How often have people *misunderstood your intentions and motives* because of your race/ethnic group?
12. How often did you *want to tell someone off for being racist but didn't say anything*?
13. How often have you been *really angry about something racist that was done to you*?
14. How often have you been *forced to take drastic steps* (such as *filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions*) to deal with some racist thing that was done to you?

15. How often have you *been called a racist name*?

16. How often have you *gotten into an argument or fight about something racist that was done to you or done to another member of your race/ethnic group*?

17. How often have you been *made fun of, picked on, pushed, shoved, hit, or threatened with harm* because of your race/ethnic group?

18. How *different* would your life be now if you *HAD NOT BEEN* treated in a racist and unfair way?

In the past year?

The same
as it is now

1

A little
different

2

Different in
a few ways

3

Different in
a lot of ways

4

Different in
most ways

5

Totally
different

6

APPENDIX F

General Ethnic Discrimination Scale (GEDS; Landrine et al., 2006)

Estamos interesados en sus experiencias con el racismo/discriminación. Para cada pregunta, por favor seleccione el número que mejor capta las cosas que le han sucedido. Utilice la siguiente escala para indicar con qué frecuencia cada evento ha ocurrido a usted en el último año.

Seleccione 1 = Si el evento NUNCA ha sucedido a usted

Seleccione 2 = Si el evento ocurrió DE VEZ EN CUANDO (menos del 10% de las veces)

Seleccione 3 = Si el evento ocurrió A VECES (10-25% de las veces)

Seleccione 4 = Si el evento ocurrió MUCHO (26-49% de las veces)

Seleccione 5 = Si el evento ocurrió MAYOR PARTE DEL TIEMPO (50-70% de las veces)

Seleccione 6 = Si el evento pasó CASI TODO EL TIEMPO (más de 70% de las veces)

1. ¿Cuántas veces ha sido tratado injustamente por *los maestros o profesores* a causa de su raza/grupo étnico?

2. ¿Cuántas veces ha sido tratado injustamente por *su empleador, jefe, o supervisores* a causa de su raza/grupo étnico?

3. ¿Cuántas veces ha sido tratado injustamente por *sus compañeros de trabajo, compañeros de estudio o compañeros de trabajo* a causa de su raza/grupo étnico?

4. ¿Cuántas veces ha sido tratado injustamente por *la gente en trabajos de servicio (por empleados de las tiendas, camareros, camareros, camareras, cajeros de banco, mecánicos y otros)* a causa de su raza/grupo étnico?

5. ¿Cuántas veces ha sido tratado injustamente por *desconocidos* debido a su raza/grupo étnico?

6. ¿Cuántas veces ha sido tratado injustamente por *la gente en trabajos de ayuda (por médicos, enfermeras, psiquiatras, trabajadores sociales, dentistas, consejeros escolares, terapeutas, trabajadores sociales y otros)* a causa de su raza/grupo étnico?

7. ¿Cuántas veces ha sido tratado injustamente por *los vecinos* a causa de su raza/grupo étnico?

8. ¿Cuántas veces ha sido tratado injustamente por *las instituciones (escuelas, universidades, bufetes de abogados, la policía, los tribunales, el Departamento de Servicios Sociales, la Oficina de empleo, y otros)* a causa de su raza/grupo étnico?

9. ¿Cuántas veces ha sido tratado injustamente por *la gente que pensaba que eran sus amigos* a causa de su raza/grupo étnico?

10. ¿Cuántas veces has sido *acusados o sospechosos de haber hecho algo malo (como el robo, el engaño, no hacer su parte del trabajo, o violar la ley)* a causa de su raza/grupo étnico?

11. ¿Con qué frecuencia *habían personas que no entienden sus intenciones y motivos* a causa de su raza / grupo étnico?

12. ¿Con qué frecuencia usted *quiera decir algo a alguien por ser racista, pero no dijo nada*?

13. ¿Cuántas veces ha sido *muy enojado por algo racista que se hizo a usted*?

14. ¿Con qué frecuencia *ha estado obligado a tomar medidas drásticas (como la presentación de una queja formal, presentación de una demanda, dejar su trabajo, alejándose, y otras acciones)* para hacer frente a alguna cosa racista que se hizo a usted?

15. ¿Cuántas veces ha sido llamado un nombre racista?

16. ¿Cuántas veces *has tenido una discusión o pelea sobre algo racista que se hizo a usted o hecho a otro miembro de su raza/grupo étnico*?

17. ¿Con qué frecuencia *se le ha burlado, recogido en adelante, empujado, empujado, golpeado o amenazado con hacerle daño* a causa de su raza / grupo étnico?

18. ¿Qué tan *diferente* sería su vida si ahora no habían sido tratados de una manera racista e injusto? ¿En el año pasado?

- (1) Lo mismo (2) Un poco diferente (3) Diferente en pocas maneras (4) Diferente en muchas maneras (5) Diferente en la mayor manera

APPENDIX G

Structural Stigma Perceptions

1. To your knowledge, does the state in which you reside have sanctuary laws for individuals without authorization/documentation to be in the U.S.?
2. To your knowledge, does the city in which you reside have sanctuary laws for individuals without authorization/documentation to be in the U.S.?
3. To your knowledge, does your state and/or city have verification laws that allow police officers to verify the immigration status of individuals during traffic stops?
4. Do you know of anyone who identifies as Latinx or Hispanic that has been deported within the past year?

APPENDIX H

Structural Stigma Perceptions

1. Según su conocimiento, ¿el estado en el que reside tiene leyes de santuario para individuos sin autorización / documentación para estar en los EE. UU.?
2. Según su conocimiento, ¿la ciudad en la que reside tiene leyes de santuario para individuos sin autorización / documentación para estar en los EE. UU.?
3. Según su conocimiento, ¿su estado y / o ciudad tiene leyes de verificación que permitan a los agentes de policía verificar el estado migratorio de las personas durante las paradas de tránsito?
4. ¿Conoce a alguien que se identifique como latino o hispano que haya sido deportado en el último año?

APPENDIX I

Stigma Consciousness Questionnaire (SCQ; Pinel, 1999)

Please carefully read and answer the following statements in correspondence with your agreement toward each item. Each item is answered on a scale of 0 (strongly disagree) to 6 (strongly agree).

1. Stereotypes about my race/ethnicity have not affected me personally.
 2. I never worry that my behaviors will be viewed as stereotypical of my race/ethnicity.
 3. When interacting with others who know of my race/ethnicity, I feel like they interpret all my behaviors in terms of the fact that I am a part of my racial/ethnic group
 4. Most people do not judge people of my race/ethnicity on the basis of their race/ethnicity.
 5. My being a member of my racial/ethnic group does not influence how others act with me.
 6. I almost never think about the fact that I am a member of my racial/ethnic group when I interact with others.
 7. My being a member of my racial/ethnic group does not influence how people act with me.
 8. Most people have a lot more racist thoughts than they actually express.
 9. I often think that people are unfairly accused of being racist.
- Most people have a problem viewing members of my racial/ethnic group as equals.

APPENDIX J

Stigma Consciousness Questionnaire

Lea atentamente y responda a las siguientes declaraciones en correspondencia con su acuerdo para cada artículo. Cada declaración se responde en una escala de 0 (muy en desacuerdo) a 6 (muy de acuerdo).

1. Los estereotipos sobre mi raza / etnicidad no me han afectado personalmente.
2. Nunca me preocupa que mis comportamientos se vean como estereotipos de mi raza / etnia.
3. Al interactuar con otras personas que saben de mi raza / etnia, siento que interpretan todos mis comportamientos en términos del hecho de que soy parte de mi grupo racial / étnico
4. La mayoría de las personas no juzgan a las personas de mi raza / origen étnico porque de su raza / origen étnico.
5. El hecho de ser miembro de mi grupo racial / étnico no influye en cómo otros actúan conmigo.
6. Casi nunca pienso en el hecho de que soy miembro de mi grupo racial / étnico cuando interactúo con otros.
7. El hecho de ser miembro de mi grupo racial / étnico no influye en cómo las personas actúan conmigo.
8. La mayoría de las personas tienen muchos más pensamientos racistas de los que realmente expresan.
9. A menudo pienso que las personas son acusadas injustamente de ser racistas.
10. La mayoría de las personas tienen problemas para ver a los miembros de mi grupo racial / étnico como iguales.

APPENDIX K

The Collective Self-Esteem Scale (CSES; Luhtanen & Crocker, 1992)

We are all members of different social groups or social categories. We would like you to consider **your racial/ethnic group** when responding to the following statements. There are no right or wrong answers to any of these statements; we are interested in your honest reactions and opinions. Please read each statement carefully, and respond by using the following scale:

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Somewhat Disagree
- 4 = Neutral
- 5 = Somewhat Agree
- 6 = Agree
- 7 = Strongly Agree

Private Esteem Subscale

- 1. I often regret that I belong to my racial/ethnic group.
- 3. In general, I'm glad to be a member of my racial/ethnic group.
- 5. Overall, I often feel that my racial/ethnic group is not worthwhile.
- 7. I feel good about the race/ethnicity I belong to.

Public Esteem Subscale

- 2. Overall, people in my racial/ethnic group are considered good by others.
- 4. Most people consider people in my racial/ethnic group, on the average, to be more ineffective than other groups.
- 6. In general, others respect people in my racial/ethnic group.
- 8. In general, others think that people in my racial/ethnic group are unworthy.

APPENDIX L

The Collective Self-Esteem Scale (CSES; Luhtanen & Crocker, 1992)

Nos gustaría que conteste las siguientes preguntas de acuerdo a cómo se siente acerca de ser parte del grupo de **Hispano o Latinx**

Por favor marque la respuesta que mejor describa su situación.

Muy en desacuerdo	En desacuerdo	Algo en desacuerdo	Neutral	Algo en acuerdo	En acuerdo	Muy en acuerdo
1	2	3	4	5	6	7

Private Esteem

1. A menudo me avergüenza pertenecer al grupo al que pertenezco.
3. En general, me alegro de pertenecer al grupo al que pertenezco.
5. En general, pienso que mi grupo no vale la pena.
7. Me siento bien de pertenecer al grupo al que pertenezco.

Public Esteem

2. En general, mi grupo es bien visto por otros.
4. Usualmente, la mayoría de la gente considera que mi grupo es menos efectivo que otros grupos.
6. En general, la gente respeta el grupo al que pertenezco.
8. En general, la gente piensa que el grupo al que pertenezco no vale la pena.

APPENDIX M

Ruminative Responses Scale (Treynor, Gonzalez, & Nolen-Hoeksema, 2003)

People think and do many different things when they feel depressed. Please read each of the items below and indicate whether you almost never, sometimes, often, or almost always think or do each one when you feel down, sad, or depressed. Please indicate what you generally do, not what you think you should do.

1 almost never 2 sometimes 3 often 4 almost always

1. think about how alone you feel
2. think "I won't be able to do my job if I don't snap out of this"
3. think about your feelings of fatigue and achiness
4. think about how hard it is to concentrate
5. think "What am I doing to deserve this?"
6. think about how passive and unmotivated you feel.
7. analyze recent events to try to understand why you are depressed
8. think about how you don't seem to feel anything anymore
9. think "Why can't I get going?"
10. think "Why do I always react this way?"
11. go away by yourself and think about why you feel this way
12. write down what you are thinking about and analyze it
13. think about a recent situation, wishing it had gone better
14. think "I won't be able to concentrate if I keep feeling this way."
15. think "Why do I have problems other people don't have?"
16. think "Why can't I handle things better?"
17. think about how sad you feel.
18. think about all your shortcomings, failings, faults, mistakes
19. think about how you don't feel up to doing anything
20. analyze your personality to try to understand why you are depressed
21. go someplace alone to think about your feelings
22. think about how angry you are with yourself

APPENDIX N

Ruminative Responses Scale (Treynor, Gonzalez, & Nolen-Hoeksema, 2003)

La gente piensa y hace muchas cosas diferentes cuando se siente deprimida. Por favor, lea cada una de las declaraciones a continuación e indique si casi nunca, a veces, a menudo, o casi siempre piensa o haz cada una cuando te sientas triste o deprimido. Por favor, indique lo que generalmente hace, no lo que piensas que debes hacer

1 casi nunca 2 a veces 3 a menudo 4 casi siempre

1. piensa en cómo te sientes solo
2. piensa "no podré hacer mi trabajo si no salgo de esto"
3. piensa en tus sentimientos de fatiga y dolor
4. Piensa en lo difícil que es concentrarse.
5. Piensa: "¿Qué estoy haciendo para merecer esto?"
6. Piensa en lo pasivo y desmotivado que te sientes.
7. Analiza los eventos recientes para tratar de entender por qué estás deprimido.
8. Piensa en cómo parece que ya no sientes nada.
9. Piensa "¿Por qué no puedo irme?"
10. piensa "¿Por qué siempre reacciono de esta manera?"
11. Vete por tu cuenta y piensa por qué te sientes así.
12. Escribe en qué estás pensando y analízalo.
13. Piensa en una situación reciente, deseando que haya ido mejor.
14. Piensa: "No podré concentrarme si sigo sintiéndome de esta manera".
15. piensa "¿Por qué tengo problemas que otras personas no tienen?"
16. Piensa "¿Por qué no puedo manejar mejor las cosas?"
17. piensa en lo triste que te sientes.
18. piense en todas sus deficiencias, fallas, fallas, errores
19. piensa en cómo no te sientes capaz de hacer nada
20. analiza tu personalidad para tratar de entender por qué estás deprimido
21. ir a algún lugar solo para pensar en tus sentimientos
22. piensa en lo enojada que estás contigo misma

APPENDIX 0

Hopkins Symptoms Checklist 21 (*HSCL-21*; Green, Walkey, McCormick, & Taylor, 1988)

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please fill in one of the numbered spaces to the right that best describes HOW MUCH THAT PROBLEM HAS BOTHERED OR DISTRESSED YOU DURING THE PAST WEEK INCLUDING TODAY. Mark only one numbered space for each problem and do not skip any items.

- 1 = Not at all
- 2 = Somewhat
- 3 = Moderately
- 4 = Extremely

- 1. Difficulty in speaking when you are excited
- 2. Trouble remembering things
- 3. Worried about sloppiness or carelessness
- 4. Blaming yourself for things
- 5. Pains in the lower part of your back
- 6. Feeling lonely
- 7. Feeling blue
- 8. Your feelings being easily hurt
- 9. Feeling others do not understand you or are unsympathetic
- 10. Feeling that people are unfriendly or dislike you
- 11. Having to do things very slowly in order to be sure you are doing them right
- 12. Feeling inferior to others
- 13. Soreness of your muscles
- 14. Having to check and double check what you do
- 15. Hot or cold spells
- 16. Your mind going blank
- 17. Numbness or tingling in parts of your body
- 18. A lump in your throat
- 19. Trouble concentrating
- 20. Weakness in parts of your body
- 21. Heavy feelings in your arms or legs

APPENDIX P

Hopkins Symptoms Checklist 21 (*HSCL-21*; Green, Walkey, McCormick, & Taylor, 1988)

A continuación se muestra una lista de problemas y quejas que a veces las personas tienen. Por favor, lea cuidadosamente cada uno. Después de haber hecho, por favor rellene uno de los espacios numerados a la derecha que mejor describe LO MUCHO QUE ESO PROBLEMA LE HA MOLESTADO O ANGUSTIADO DURANTE LA SEMANA PASADA, HOY INCLUIDO. Marca solamente un espacio numerado para cada problema y no se salte ningún artículo.

- 1 = Nada
- 2 = Algo
- 3 = Moderadamente
- 4 = Extremadamente

1. Dificultad para hablar cuando está emocionado
2. Dificultad para recordar cosas
3. Preocupado por desorden o descuido
4. Culpar a sí mismo por cosas
5. Los dolores en la parte baja de la espalda
6. La sensación de soledad
7. Sentirse triste.
8. Sus sentimientos están heridos fácilmente
9. Sensación de los demás no se entienden o están indiferentes
10. Sensación de que las personas son antipáticos o no les gusta
11. Tener que hacer las cosas muy lentamente con el fin de asegurarse de que está haciendo bien
12. Sentirse inferior a los demás
13. El dolor de los músculos
14. Tener que verificar y verificar de segunda vez lo que hace
15. Hechizos calientes o fríos
16. Su mente en blanco
17. El entumecimiento u hormigueo en las partes de su cuerpo
18. Un nudo en la garganta
19. Dificultad para concentrarse
20. Debilidad en partes de su cuerpo
21. Sentimientos pesados en los brazos o las piernas

APPENDIX Q

Psychological Well-Being Scale (PWB; Ryff & Keyes, 1995)

Instructions: Please indicate which answer best describes your present agreement or disagreement with each statement below.

- 1 = Completely Disagree
- 2 = Disagree
- 3 = Slightly Disagree
- 4 = Slightly Agree
- 5 = Agree
- 6 = Completely Agree

- 1. I tend to be influenced by people with strong opinions.
- 2. I have confidence in my opinions, even if they are contrary to the general consensus.
- 3. I judge myself by what I think is important, not by the values of what others think is important.
- 4. In general, I am in charge of the situation in which I live.
- 5. The demands of everyday life often get me down.
- 6. I am quite good at managing the many responsibilities of my daily life.
- 7. I think it is important to have new experiences that challenge how you think about yourself and the world.
- 8. For me, life has been a continuous process of learning, changing, and growth.
- 9. I gave up trying to make big improvements or changes in my life a long time ago.
- 10. Maintaining close relationships has been difficult and frustrating for me.
- 11. People would describe me as a giving person, willing to share my time with others.
- 12. I have not experienced many warm and trusting relationships with others.
- 13. I live life one day at a time and don't really think about the future.
- 14. Some people wander aimlessly through life, but I am not one of them.
- 15. I sometimes feel as if I've done all there is to do in life.
- 16. When I look at the story of my life, I am pleased with how things have turned out.
- 17. I like most parts of my personality.
- 18. In many ways I feel disappointed about my achievements in life.

APPENDIX R

Instrucciones: Por favor, indica la respuesta que mejor describe su actual acuerdo o desacuerdo con cada declaración.

- 1 = Completamente en desacuerdo
- 2 = En desacuerdo
- 3 = Ligeramente en desacuerdo
- 4 = Ligeramente en acuerdo
- 5 = De acuerdo
- 6 = Totalmente de acuerdo

1. Me tienden a estar influenciados por las personas con opiniones fuertes.
2. Tengo confianza en mis opiniones, aunque sean contrarias al consenso general.
3. Me juzgo por lo que creo que es importante, no por los valores de lo que otros piensan que es importante.
4. En general, yo estoy a cargo de la situación en la que vivo.
5. Las exigencias de la vida cotidiana a menudo se me pone triste.
6. Soy bastante bueno en el manejo de las muchas responsabilidades de mi vida diaria.
7. Creo que es importante tener nuevas experiencias que desafían la forma de pensar sobre sí mismo y el mundo.
8. Para mí, la vida ha sido un proceso continuo de aprendizaje, cambio y crecimiento.
9. Me dejó de intentar hacer grandes mejoras o cambios en mi vida hace mucho tiempo.
10. El mantenimiento de relaciones estrechas ha sido difícil y frustrante para mí.
11. La gente me describirían como una persona que da, dispuesto a compartir mi tiempo con los demás.
12. No he experimentado muchas relaciones cálidas y de confianza con los demás.
13. Yo vivo la vida un día a la vez y realmente no pienso en el futuro.
14. Algunas personas vagan sin rumbo por la vida, pero yo no soy uno de ellos.
15. A veces me siento como si yo he hecho todo lo que hay que hacer en la vida.
16. Cuando miro a la historia de mi vida, estoy contento de cómo han ido las cosas.
17. Me gusta la mayor parte de mi personalidad.
18. En muchos aspectos me siento desilusionado por mis logros en la vida.

APPENDIX S

Demographics Questionnaire

Please tell us a little about yourself. This information will be used to describe the sample as a group.

Please note that for each of the questions below, we have tried to provide a number of options. However, we recognize that these options will not capture everyone's identities or characteristics. Therefore, for some questions, we have also included an "Other" option for you to describe in your own words your identity if the categories provided do not capture it. Thank you for telling us about yourself!

1. What is your gender?
 - a. Man
 - b. Woman
 - c. Man of transgender experience (Trans man, FtM)
 - d. Woman of transgender experience (Trans woman, Transsexual woman, MtF)
 - e. Other:
 - i. Please type in your gender identity: _____
2. What is your age?
3. How do you identify your race?
 - a. Black or Afrolatino/a or Latinegro/a
 - b. Indian or Indigenous
 - c. White or Caucasian
 - d. Biracial/Multiracial
 - e. Race not listed:
 - i. Please type in your race: _____
4. How do you identify your ethnicity/nationality (country of origin)?
 - a. Please type in your ethnicity/nationality: _____
5. What is your generation status?
 - a. 1st generation (Foreign born)
 - b. 2nd generation (U.S. born, parents foreign born)
 - c. 3rd generation (U.S. born, grandparents foreign born)
 - d. 4th generation (U.S. born, great grandparents foreign born)
 - e. Other
 - i. Please type in generation status: _____
6. How do you identify your sexual orientation?
 - a. Lesbian or gay
 - b. Bisexual

- c. Straight or Heterosexual
 - d. Queer
 - e. Asexual
 - f. Sexual orientation not listed:
 - i. Please type in your gender identity: _____
7. What is your relationship status?
- a. Single
 - b. In a relationship but not married
 - c. Married or Civil Union
 - d. Other _____
8. What is the highest level of education you have completed?
- a. Some high school or less
 - b. High School Diploma
 - c. Some college
 - d. Two year college degree (e.g., AA)
 - e. Bachelor's degree (e.g., BS, BA)
 - f. Some postgraduate work
 - g. Postgraduate Degree (e.g., MA, MS, PhD, MD)
9. What is your current employment status?
- a. Full-time
 - b. Part-time
 - c. Unemployed
 - d. Retired
10. What is your annual household income?
- a. 0-20,000
 - b. 20,001-40,000
 - c. 40,001-60,000
 - d. 60,001-80,000
 - e. 80,001-100,000
 - f. 100,000-150,000
 - g. 150,000 and above
11. How would you best characterize your social class?
- a. Upper Class
 - b. Upper-Middle Class
 - c. Middle Class
 - d. Working Class
 - e. Living in Poverty
12. In what environment do you currently reside?
- a. Urban
 - b. Suburban

c. Rural

13. In what state do you currently reside?

a. State: _____

14. In what city do you currently reside?

a. Zip Code: _____

APPENDIX T

Cuestionario demográfico

Cuéntenos un poco sobre usted. Esta información será utilizada para describir los participantes del estudio como un grupo.

Tenga en cuenta que para cada una de las siguientes preguntas, hemos tratado de ofrecer una serie de opciones. Sin embargo, reconocemos que estas opciones no capturar identidades o características de cada uno. Por lo tanto, para algunas preguntas, también hemos incluido una opción "Otros" para que describa con sus propias palabras su identidad si las categorías previstas no captan la misma. Gracias por decirnos acerca de si mismo!

1. ¿Cuál es su género?
 - a. Hombre
 - b. Mujer
 - c. Hombre de experiencia transgénero
 - d. Mujer de experiencia transgénero
 - e. Otro:
 - i. Por favor, indica su identidad de género
2. ¿Cuál es su edad?
3. ¿Cómo identifica su raza?
 - a. Negro o afrolatino/a o Latinegro/a
 - b. Blanco o caucásico
 - c. Indio o indígena
 - d. Birracial / multirracial
 - e. Otro:
 - i. Por favor, indica su identidad racial
4. ¿Cómo se identifica su nacionalidad (país de origen)?
 - a. Por favor, indica su nacionalidad
5. ¿Cuál es su nivel de generación?
 - a. 1ª generación (Nacido afuera de los EE.UU.)
 - b. 2ª generación (Nacido en los EE.UU., padres afuera)
 - c. 3ª generación (Nacido en los EE.UU., abuelos afuera)
 - d. 4ª generación (Nacido en los EE.UU., bisabuelos afuera)
 - e. Otro:
 - i. Por favor, indica su nivel de generacion

6. ¿Cómo se identifica su orientación sexual?
- a. Lesbiana o gay
 - b. Bisexual
 - c. Heterosexual
 - d. Asexual
 - e. Otro:
 - i. Por favor, indica su orientación sexual
7. ¿Cuál es su estado civil?
- a. Soltero
 - b. En una relación, pero no se ha casado
 - c. Casado o unión civil
 - d. Otro:
 - i. Por favor, indica su estado civil
8. ¿Cuál es el nivel más alto de educación que ha completado?
- a. Algunos estudios secundarios o menos
 - b. Diploma de escuela secundaria
 - c. Algunos estudios universitarios
 - d. Título universitario de dos años (Por ejemplo, AA)
 - e. Licenciatura (Por ejemplo, BA o BS)
 - f. Algunos estudios de posgrado
 - g. Maestría o doctorado
9. ¿Cuál es su situación laboral actual?
- a. Empleado a tiempo completo
 - b. Empleado a tiempo parcial
 - c. Desempleado
 - d. Retirado
10. ¿Cuál es su ingreso anual?
- a. 0-20,000
 - b. 40,001-60,000
 - c. 60,001-80,000
 - d. 80,001-100,000
 - e. 100,001-150,000
 - f. 150,001- y más
11. ¿Cómo caracteriza mejor su clase social?
- a. Clase alta
 - b. Clase media alta
 - c. Clase media
 - d. Clase obrera
 - e. Vive en pobreza

12. ¿En qué entorno reside actualmente?

- a. Urbano
- b. Suburbano
- c. Rural

13. ¿En qué estado reside actualmente?

- a. Estado: _____

14. ¿En qué ciudad reside actualmente?

- a. Zip code: _____