THE IMPACT OF MULTIPLE FORMS OF DISCRIMINATION ON MENTAL HEALTH AND WELL-BEING

by

MELISSA ROTHSTEIN

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Sponsor: Krystal Perkins, Ph.D.

Second Reader: Stephen Flusberg, Ph.D.

Abstract

Living with multiple stigmatized identities can have distinct effects on psychological life. Although previous research indicates that living with multiple stigmatized identities can have a negative impact on quality of life, other research posits that living with multiple stigmatized identities can have a positive impact on life. Given these findings, the present study examined if multi-stigmatized adults are at greater risk for poor mental health and well-being compared to those who are more privileged in regard to race and gender. An exploratory quasi-experimental study was conducted to assess discrimination, depression, anxiety, stress, and self-esteem in racial and gender minority individuals by using a variety of scales. Results indicated that multi-stigmatized individuals experienced more depression, lower self-esteem, and more discrimination in comparison to individuals with one form of stigmatization, but this difference was not statistically significant. However, multi-stigmatized individuals experienced less stress and anxiety in comparison to singularly stigmatized individuals. Implications for existing theories are discussed.

Keywords: mental health, well-being, discrimination, multi-stigmatized, positive marginality

The Impact of Multiple Forms of Discrimination on Mental Health and Well-Being

Discrimination occurs when individuals and/or groups are treated unfairly because of their group membership. People can be discriminated against on the basis of race, gender, religion, sexual orientation, among many other characteristics. Discrimination can occur in politics, workplaces, and schools at both individual and institutional levels and is often the result of stereotypes and prejudice. For example, previous research shows that institutional discrimination has a vast influence on mental health (Gee, 2002). Previous research, however, has tended to investigate these relationships at the individual level and among singularly stigmatized individuals (e.g., people who have one stigmatized identity). This research suggests that discrimination has a negative effect on mental health and well-being among members of minority groups and those who have a disadvantaged social status (Branscombe et al., 1999; Chae et al., 2011; Gayman & Barragan, 2013; Gee, 2002; Giamo et al., 2012; Grollman, 2014; Perry et al., 2013; Potter et al., 2019; Schmitt et al., 2002; Thoma & Huebner, 2013; Thompson et al., 2004). While important, few studies have examined the impact mental health and well-being among those who have multiple stigmatized identities and this research was conducted to help fill that gap. Specifically, the current study compared mental health outcomes among multi-stigmatized individuals and singularly stigmatized individuals. The next section provides an overview of the existing social psychological literature on the effects of prejudice, discrimination, and rejection experiences on mental health and well-being. Following this, the details of the current study are introduced.

Consequences of Perceiving Discrimination: Negative Experiences of Stigma

There is increasing evidence that experiencing prejudice, discrimination, stigma, and group rejection may contribute to poor mental health among Black Americans (Branscombe et

al., 1999; Chae et al., 2011; Gee, 2002; Perry et al., 2013; Potter et al., 2019; Thoma & Huebner, 2013; Thompson et al., 2004). For example, Black participants generally report more mistreatment than White participants (Potter et al., 2018). Other literature also finds that perceiving prejudice as pervasive (in comparison to perceiving it as rare) is associated with negative psychological outcomes (Branscombe et al., 1999; Schmitt et al., 2002). Specifically, Black participants completed measures of attributions to prejudice, past experience with racial discrimination, and collective well-being (Branscombe et al., 1999). This study found that among Black participants who experienced prejudice frequently, they reported lower self-esteem in comparison to those who experienced prejudice in rare circumstances. Hence, perceiving prejudice as pervasive can have harmful psychological consequences.

Consistent with this analysis, a number of studies have found attributing negative experiences to race and/or gender produces a threat to social identity that has mental health ramifications (Chae et al., 2011; Potter et al., 2018). For example, Black participants are more likely than White participants to attribute discrimination to race, gender, education status, and economic status (Potter et al., 2018) and these high levels of discrimination were associated with higher odds of serious psychological distress compared to those who report no experience of discrimination (Chae et al., 2011). Likewise, multiracial individuals' perceptions of discrimination have also been shown to be negatively related to life satisfaction (Chae et al., 2011).

Other research also suggests that women who were led to perceive discrimination as pervasive, experienced a more negative emotional response compared to women who were led to see discrimination as rare (Schmitt et al., 2012). This research measured women's emotional responses to the pervasiveness of gender discrimination using two studies. In the first study,

undergraduate women were randomly assigned to read an essay suggesting that sexism was either rare or pervasive and then completed a measure on self-esteem. Findings from this study revealed that women who were manipulated to see discrimination against them as pervasive experienced a more negative emotional response and lower self-esteem compared to women who were led to see discrimination as rare. In a second study, a second set of undergraduate women received negative feedback from an evaluator who was biased against women in a mock job interview and then participants completed measures of self-esteem. The second study found that participants exhibited lower self-esteem and less positive affect when their negative evaluation was attributable to pervasive gender discrimination compared to a rare instance of discrimination.

While most research has examined the experience of stigma more generally, other research has explored the effect of multiple forms of stigma on mental health and well-being. Dowd & Bengston's (1978) double disadvantage hypothesis, for example, predicts that multi-stigmatized adults experience worse health than their privileged and singularly disadvantaged peers (Grollman, 2014). The theory argues that multiple stigmas may have a negative effect on individuals because the more disadvantaged statuses an individual has, the more likely they are to experience discrimination across multiple domains. One recent study examined the double disadvantage hypothesis among those who experience discrimination related to race, gender, ethnicity, sexual orientation, religion, physical disability, poverty, and nationality (Thompson et al., 2014). Participants completed a series of questionnaires, including the Everyday Discrimination Scale, on psychiatric symptoms, social inclusion, social acceptance, empowerment, and satisfaction. It was found that participants who identified themselves with more than one stigmatized group reported more experiences of discrimination and more stress

related to future experiences of discrimination in comparison to those who identified with only one stigmatized group. Specifically, individuals with a physical disability and who identified as gay, lesbian, or bisexual reported more experiences of discrimination and more stress of being discriminated against in the future in comparison to straight and able-bodied participants. In sum, participants who report multiple stigmatized identities reported more anxiety, depressive symptoms and more extensive and intense experiences of discrimination than participants who report discrimination to one stigmatized identity alone.

Prior research has also utilized the double disadvantage hypothesis to study the effects of inhabiting multiple stigmatized identities on health and experiences of discrimination on a broader, more representative scale. In a national survey, participants responded to measures on mental health and discrimination (Grollman, 2014). It was found that multi-stigmatized adults reported significantly more forms of discrimination, and more frequent every day and major lifetime discrimination in comparison to individuals who reported one form of discrimination and no forms of discrimination. Further analyses revealed that these experiences of discrimination were also more stressful. Subsequent work has examined the double disadvantage hypothesis across different groups and settings (Gayman & Barragan, 20013). For example, participants living in Miami-Dade County were interviewed and filled out measures of depression, number of and reasons for lifetime major discriminating events, and chronic stressors. It was found that individuals who perceived multiple reasons for discriminatory behavior (i.e., attributing discrimination to race, gender, and age) were at an increased risk for lifetime major depression, depressive symptoms, and chronic stressors compared to those who reported no experiences of discrimination and among those who reported one perceived reason for discrimination.

The influence of multiple forms of discrimination on health outcomes has also been studied in minority adolescents (Thoma & Huber, 2013). Black American lesbian, gay, or bisexual adolescents between the ages of fourteen to nineteen years old who reported experiencing both racist and antigay discrimination filled out questionnaires on discrimination, substance use, and depression. Results indicated that attributions to discrimination based on race and sexual orientation were associated with depressive symptoms and suicidal thoughts. Moreover, stress was found to be related to negative health outcomes of Black American LGB (lesbian, gay, bisexual) adolescents as a result of perceiving multiple reasons for discrimination as well. Though this study did not compare these experiences to heterosexual or White counterparts, these findings do suggest that when discrimination is attributed to both race and sexuality, it can negatively impact minority adolescents' mental health outcomes and may have an adverse effect on mental health if left ignored.

Other literature has drawn on the theory of intersectionality to document experiences of discrimination (Potter et al., 2018). Similar to the double disadvantage hypothesis, intersectionality is a theoretical framework that posits people can be disadvantaged by multiple sources of oppression (such as race, gender, age, sexual orientation, and weight) and that all are interconnected and regarded as creating an overlapping system of disadvantage. Notably, the double disadvantage hypothesizes that adults who have more than one form of discrimination may experience worse health than individuals who are more privileged while intersectionality suggests a more structural approach, in which marginal aspects of oneself are said to intersect and create an interdependent system of discrimination. Prior research suggests that the interactive effects of gender, race, socioeconomic status, and age exacerbate social disparities, especially among younger adults (Ailshire & House, 2011; Gayman & Barragan, 2013; Potter et

al., 2018). For example, one study used an intersectional approach to examine the relationship between sociodemographic variables on the levels of mistreatment and attributions to discrimination (Potter et al., 2018). Participants were recruited via advertisements in local newspapers and flyers posted in public venues. As part of the study, participants completed the Everyday Discrimination Scale to assess perceived discrimination. Findings revealed discrimination was significantly attributed to the interactions of race, age, gender, and socioeconomic status. Specifically, discrimination was significantly attributed to the interactions of race and gender, age and socioeconomic status, and race and age. Similarly, African American women who experienced higher levels of racial and gender discrimination reported lower levels of well-being and higher levels of anxiety and health concerns in comparison to African American women who reported lower levels of racial and gender discrimination. Findings also indicated that older participants and participants with higher socioeconomic status were less likely to attribute race to discrimination. Further analyses revealed that the intersection between race and age suggests that race may remain a pertinent attribution for Black individuals when perceiving discrimination regardless of age. These findings further support the theory that multiple forms of discrimination have an adverse impact on mental health and well-being.

Redefining Stigma: Positive Marginality

Though there is a plethora of research that suggests living with multiple stigmatized identities can have a negative impact on quality of life, there is also research that posits living with multiple stigmatized identities is not all together psychologically debilitating and may have a positive impact on life. Positive marginality, for example, asserts that marginalization can produce strength rather than helplessness and that belonging to a non-dominant group can be advantageous rather than oppressing. Clara Mayo was one of the first women presidents of the

Society for the Psychological Study of Social Issues and coined the term, “positive marginality” (Mayo, 1982). Mayo argued that marginality can allow individuals to redefine what it means to be marginalized by rising above and thriving as a result of discrimination. In an analysis of these ideas, Unger (1998) analyzed the biographies of several famous female Jewish social psychologists (e.g., Nancy Datan and Carolyn Sherif). Unger (1998) found that many of these women exhibited resilience while living with marginal identities and utilized their marginal identity to question the status quo and devote their life’s work to social justice. In a more recent study, Unger (2000) has also noted that even among those who conceal their stigma, a sense of positive marginality can be cultivated.

Other research has examined the positive aspects of marginality more directly (Hall & Fine, 2005). In a qualitative study, two older Black lesbians (Portia and Dorthea) were interviewed about their activist work and 50-year friendship (Hall & Fine, 2005). It was found that Portia and Dorthea refused to internalize gender and race prejudices and did not accept the limits created by race, gender, socioeconomic status, or sexual orientation (Hall & Fine, 2005). Moreover, they broke down the barriers of marginality and did not view stigmatization as a negative factor for their lives or careers.

Research has also found that stigmatization can be mitigated and promote resilience through identity, competence, and compassion (Stringer et al, 2018). Some studies suggest that the impact of discrimination can be mitigated through group identification (Branscombe et al., 1999). The rejection-identification model, for example, suggests that perceived discrimination may lead to increased ingroup identification, which may support psychological well-being in the face of societal devaluation. Other research has proposed that in order to transcend stigmatization, the development of competence, compassion for others, and self-compassion are

fundamental (Stringer et al., 2018). It is proposed that competence, self-compassion, and compassion for others may moderate the detrimental effects of stigmatization.

The Present Research

Taken together, individuals who belong to a marginalized group and perceive discrimination based on their identity may suffer from a variety of poor well-being and mental health outcomes (Branscombe et al., 1999; Chae et al., 2011; Gayman & Barragan, 2013; Gee, 2002; Giamo et al., 2012; Grollman, 2014; Perry et al., 2013; Schmitt et al., 2002; Thoma & Huebner, 2013; Thompson et al., 2004). Likewise, research has also observed that living with multiple stigmatized identities negatively affects individual well-being to a greater degree in comparison to those who experience one form of stigmatization (Ailshire & House, 2011; Gayman & Barragan, 2013; Giamo et al., 2012; Grollman, 2014; Perry et al., 2013; Potter et al., 2019; Thoma & Huebner, 2013; Thompson et al., 2004). Few studies, however, have examined the effects of multiple forms on mental health and well-being.

While there is a plethora of research that suggests living with multiple stigmatized identities can have a negative impact on quality of life, there is also research that posits living with multiple stigmatized identities can have a positive impact on one's psychological life. The concept of positive marginality, for example, asserts that marginalization can produce strength rather than helplessness and that belonging to a non-dominant group can be advantageous rather than psychologically damaging (Hall & Fine, 2005; Mayo, 1982; Stringer et al., 2018; Unger, 2000; Unger, 1998). Given these findings, the purpose of the current study was to examine if multi-stigmatized adults are at greater risk for poor mental health and well-being compared to those who are more privileged in regard to race and gender. Because the previous literature is somewhat mixed, these issues were examined more exploratively.

Method

Participants

Fifty-two individuals (80.77% female) were recruited through the Psychology Participant Pool at Purchase College, announcements made in other psychology classes, by word of mouth, and snowball sampling methods. Participants who were recruited through The Psychology Participant Pool at Purchase College received one academic credit for thirty minutes of their time. Individuals were eligible to participate in this study if they were eighteen years of age and older and self-identified with a marginalized group, meaning they identify as a member of a minority group (e.g., racial/ethnic minorities), or have a disadvantaged social status (e.g., women). Participants were between the ages of 18 and 32 years old (M = 21.02, SD = 2.69). Participants self-identified as White (36.54%), Latinx (19.23%), Black (15.39%), Multiracial (15.39%), and Asian (13.46%). Please refer to Table 1 for the demographics of participants.

In regard to race and gender, about half of the participants in this sample reported one form of stigma (48.08%) and a little over half reported more than one form of stigma (51.92%). Participants were categorized for analysis as singularly stigmatized if they identified as a racial or gender minority. Participants were categorized as multi-stigmatized if they identified as both a racial and a gender minority. It is important to note that for the purposes of this study, individuals who indicated more than one minority racial status were categorized as singularly stigmatized.

Materials

Everyday Discrimination Scale (Williams et al., 1997)

The Everyday Discrimination Scale is one of the most widely and frequently used measures to gauge perceptions of discriminatory treatment in everyday life. Participants were

presented with nine questions and asked about how often they receive unfair treatment and what they believe the main reason is for such experiences. For example, participants read the statement, "You are threatened or harassed" and responded to statements such as this one using a Likert scale from *Almost every day* (1) to *Almost every day* (5). A higher score indicates the participant experiences little to no discrimination. Then, participants were asked the main reason for such experiences (e.g. age, race, etc.) and had the option to enter as many answers that apply. Fourteen possible reasons for such experiences were provided and students were given the options to enter another reason or no reason at all.

Depression, Anxiety, Stress Scale 21 (Lovibond, 1995).

This questionnaire measured depression, anxiety, and stress. Participants were asked twenty-one questions about their feelings and their actions related to depression, anxiety, and stress within the past week. For example, participants read the statement, "I couldn't seem to experience any positive feeling at all" and responded to statements such as this one using a Likert scale ranging from *Did not apply to me at all* (0) to *Applied to me very much, or most of the time* (3). A higher score indicates higher depression, anxiety, and stress.

Rosenberg Self-Esteem Scale (Rosenberg, 1965)

The Rosenberg Self-Esteem Scale measures both positive and negative feelings about the self and has been widely regarded for its good reliability and validity. Participants answered ten questions about their self-worth and self-acceptance. For example, participants read the statement, "I feel that I have a number of good qualities" and responded to statements such as this one using a Likert scale from *Strongly agree* (1) to *Strongly disagree* (4) to indicate how much they agree or disagree with each statement concerning their self-esteem. Negative items were reverse scored and higher scores indicate lower levels of self-esteem.

Covid-19 Questionnaire

Participants were asked if they would or would not have answered the questions in this study differently in 2019, before the pandemic. Participants were also asked, “in what way do you predict that you may have answered these questions differently? Do you predict more or less discrimination as a result of the pandemic? Do you believe the pandemic has not impacted you in such a way that it has affected your treatment and experiences?” Participants were provided with a text box to answer these questions. Responses were qualitatively analyzed. Responses fell into three categories: those who have experienced more discrimination and worse treatment, those who have experienced less discrimination because of less interaction with others, and those who have experienced no difference in treatment since the start of the pandemic.

Procedure

Participants were given a direct Qualtrics link to the experiment directing them to the webpage for the study. This study was conducted entirely online. First, participants consented to participate in the study by checking the appropriate box on an informed consent form. Participants were then presented with a series of questionnaires (e.g., the Everyday Discrimination Scale, the Depression, Anxiety, and Stress 21 scale, the Rosenberg Self-Esteem Scale, and a demographics questionnaire). The order of the Everyday Discrimination Scale, the Depression, Anxiety, and Stress 21 scale, and the Rosenberg Self-Esteem Scale were counterbalanced to limit order effects. The last questionnaire participants answered was the demographics questionnaire. Lastly, participants were directed to a page explaining the purpose of the study and if applicable, redirected to a separate Qualtrics survey that allowed them to receive course credit.

Results

The purpose of the current study was to examine if multi-stigmatized adults are at greater risk for poor mental health and well-being compared to those who are more privileged in regard to race and gender. Due to the previous research being somewhat mixed, the research was more explorative. The current study used an independent samples t-test to analyze self-esteem, discrimination, depression, stress, and anxiety scores to compare the well-being of individuals with one form of discrimination and more than one form of discrimination. Though most results were in line with what previous research has found about the negative experiences of stigma, some results supported what the literature has shown about positive marginality as well. However, none of the results were statistically significant.

An independent samples t-test was conducted comparing differences between multi-stigmatized and singularly stigmatized individuals on self-esteem. As shown in Table 2, there were no significant differences between multi-stigmatized individuals and singularly stigmatized individuals on self-esteem, $t(50) = 0.54$, $p = 0.59$. That is, the mean estimates of self-esteem among multi-stigmatized individuals ($M = 21.78$, $SD = 5.6$) were not significantly different from the mean estimates of singularly stigmatized individuals ($M = 22.72$, $SD = 6.94$). All participants reported on average a medium amount of self-esteem and scored intermediately on the scale. However, singularly stigmatized individuals reported higher self-esteem in comparison to multi-stigmatized individuals.

An independent samples t-test was conducted comparing differences between multi-stigmatized and singularly stigmatized individuals on discrimination. As shown in Table 2, there were no significant differences between multi-stigmatized individuals and singularly stigmatized individuals on discrimination, $t(50) = 1.26$, $p = 0.21$. The mean estimates of discrimination

among multi-stigmatized individuals (*M* = 29.92, *SD* = 8.16) were not significantly different from the mean estimates of singularly stigmatized individuals (*M* = 32.4, *SD* = 6.47). All participants reported on average a medium amount of discrimination and scored intermediately on the scale. On average, singularly stigmatized individuals reported less discrimination in comparison to multi-stigmatized individuals.

As part of the Everyday Discrimination Scale, participants were asked what they believe the main reasons are for experiencing discrimination. Participants predominantly attributed their experiences of discrimination to gender (22.22%) mostly. Participants also attributed the discrimination they experienced to age (15.34%) and race (12.16%). Participants attributed the discrimination they experienced to tribe (0%) the least. It is important to note that the majority of participants listed more than one attribution to discrimination (96.36%) from the fifteen provided options and very few participants listed only one attribution to discrimination (3.64%).

An independent samples t-test was conducted comparing differences between multi-stigmatized and singularly stigmatized individuals on depression, anxiety, and stress. As shown in Table 2, there were no significant differences between depression, $t(50) = -0.75$, $p = 0.46$, anxiety , $t(50) = 0.02$, $p = 0.98$ or stress scores, $t(50) = -0.3$, $p = 0.77$. That is, the mean estimates of depression for multi-stigmatized individuals (*M* = 28.19, *SD* = 6.32) were not significantly different from the mean estimates of singularly stigmatized individuals (*M* = 26.56, *SD* = 9.1). Moreover, the mean estimates of anxiety for multi-stigmatized individuals (*M* = 29.15, *SD* = 7.59) were not significantly different from the mean estimates of singularly stigmatized individuals (*M* = 29.2, *SD* = 10.26). Similarly, the mean estimates of stress for multi-stigmatized individuals (*M* = 26.74, *SD* = 7.8) were not significantly different from the mean estimates of singularly stigmatized individuals (*M* = 26, *SD* = 9.98). Singularly stigmatized individuals

reported roughly the same levels of anxiety and stress as multi-stigmatized individuals. In contrast, multi-stigmatized individuals reported more levels of depression in comparison to singularly stigmatized individuals. All participants scored high on this scale and reported on average an extremely severe amount of depression, anxiety, and stress.

Exploratory Analyses: COVID-19

Additional analyses were conducted to account for collecting data in the middle of a pandemic. When participants were asked if they would have answered the questions differently in 2019 before the pandemic, more than half of participants answered yes (51.92%) while the rest of participants answered no (48.08%). Participants were also asked, “in what way do you predict that you may have answered these questions differently? Do you predict more or less discrimination as a result of the pandemic? Do you believe the pandemic has not impacted you in such a way that it has affected your treatment and experiences?” Participants were provided with a text box to answer these questions and responses were qualitatively analyzed. Most individuals wrote that their treatment and experiences have not changed despite the pandemic (51.61%). A large proportion wrote that they have experienced more discrimination, have been negatively affected because of the pandemic, and would have answered these questions differently before COVID-19 (38.71%). Few participants wrote that they have experienced less discrimination because of less interaction due to the pandemic (9.68%).

Discussion

This study assessed if multi-stigmatized adults are at greater risk for poor mental health and well-being compared to those who are more privileged in regard to race and gender. This question was examined more exploratively instead of formulating hypotheses due to the nature of previous literature. Results did not reveal any statistically significant relationships between

inhabiting multiple forms of discrimination on self-esteem, depression, anxiety, or stress. Results did show multi-stigmatized individuals reported lower self-esteem levels, more discrimination, and more depressive symptoms in comparison to multi-stigmatized individuals. The majority of participants attributed their discrimination to their gender as opposed to race, age, sexual orientation, etc. In contrast, results indicated multi-stigmatized individuals reported less stress and anxiety in comparison to singularly stigmatized individuals. These findings support previous literature in both negative and positive experiences of stigma.

Participants generally scored intermediately on the Everyday Discrimination Scale and the Rosenberg Self-Esteem Scale. On the Everyday Discrimination Scale, the lowest score participants could receive was ten and the highest score participants could get was sixty. A higher score indicates the participant experiences little to no discrimination. On average, singularly stigmatized individuals received a score of thirty-two and multi-stigmatized received a score of thirty. Similarly, raw averages on the Rosenberg Self-Esteem Scale fell generally in the middle of the measure as well. The lowest score participants could receive was ten and the highest score was forty. Higher scores indicate lower levels of self-esteem. On average, singularly stigmatized individuals received a score of twenty-three and multi-stigmatized individuals received a score of twenty-two. Lastly, the averages from the Depression, Anxiety, and Stress Scale were all on the high end of the scale. A higher score indicates higher depression, anxiety, and stress. Generally, participants scored in the “extremely severe” range on the questions about depression, anxiety, and stress. The lowest score participants could receive on this measure was zero and the highest score was forty-two. On average, both singularly stigmatized individuals and multi-stigmatized individuals scored a twenty-nine on the anxiety questions and a twenty-six on the stress questions. To fall into the extremely severe range,

participants needed to score between twenty and forty-two on anxiety and between thirty-five and a forty-two on stress. Similarly, singularly stigmatized individuals scored a twenty-six on the depression questions and multi-stigmatized individuals scored a twenty-eight. To fall into the extremely severe range, participants needed to score between a twenty-eight and a forty-two on the depression questions. This can possibly be attributed to the fact that the participants are predominantly students who are living through a pandemic. This time has potentially added stressors for this sample relative to previous studies and could have impacted the results in a negative way if students have been negatively affected by COVID-19.

Participants were also asked about their experiences and treatment since the start of the COVID-19 pandemic. The majority of participants believe that they would have answered the questions in this study differently in 2019, before the pandemic. However, when participants were asked to elaborate as to how they would have answered these questions differently and how their treatment has differed since the pandemic, the majority of participants expressed that their treatment and experiences of discrimination have not changed despite the pandemic. Since this data was collected qualitatively and participants were given a text box to respond to these questions, it is possible that participants did not want to type out and explain their circumstances.

Implications

The implications of the current study may benefit stigmatized individuals. A plethora of the previous research focuses on individuals with one form of discrimination and the negative consequences surrounding stigma. This study aimed to broaden what previous research has covered and to expand the literature on individuals with multiple stigmatized identities. Multi-stigmatized individuals reported the same levels of anxiety and stress as individuals with one form of stigma. These findings suggest that although one form of discrimination can be

damaging to mental health and well-being, the combination of two forms of discrimination may not be significantly worse than the effect(s) of just one stressor.

In support of the positive marginality theory, some participants believe that the pandemic has allowed them to find strength and self-worth within themselves, despite perceiving discrimination throughout the COVID-19 pandemic. Moreover, these participants have dedicated time throughout the pandemic for introspection, increasing awareness, self-care, and developing self-compassion. Similar to the findings in Hall & Fine (2005), participants have found strength during these times to break down the barriers of marginality. These individuals have utilized a negative situation and have fostered their experiences into a positive learning experience in route to developing resilience.

Though some results were in favor of the positive marginality theory, results also portrayed negative consequences of inhabiting multiple stigmatized identities. Results showed that multi-stigmatized individuals perceived more discrimination, more depression, and lower self-esteem. As seen in previous literature, the relationship between experiences of discrimination, mental health, and well-being may be dependent on attributions and responses to such experiences (Grollman, 2014; Potter et al., 2018). In stride with the literature on discrimination and mental health, the findings from the current study also support the findings from a previous study that found individuals who perceived multiple reasons for discriminatory behavior were found to be at an increased risk for depressive symptoms compared to those reported one perceived reason for discrimination (Gayman & Barragan, 2013). Perhaps this is because the more experiences of discrimination a person has and the more distressing those experiences are, the more likely those individuals will face pervasive negative repercussions in their wake (e.g., depressive symptoms and low self-esteem).

Individuals with multiple stigmatized identities did not experience worse anxiety and stress, but did experience more discrimination, depression, and lower self-esteem. It is possible that multiple forms of discrimination may interconnect in such a way that intensifies or increases the effects of the interactions of different forms of discrimination. The findings of the current study suggest that different forms of discrimination may represent overlapping social stressors instead of independent stressors and thus, propose that perhaps an intersectional approach should be further explored. Given that the field of intersectionality is amplifying, this area of research could allow future studies to discover a link between mistreatment, attributions for discrimination, and health outcomes.

Strengths and Limitations

This study has several strengths. Participants were from diverse backgrounds and varying in age from 18-32 years old. The majority of participants were able to receive course credit for their participation in this study. Further, we were able to collect an equal number of individuals who have one form of discrimination and multiple stigmatized identities. This was a very important factor because we wanted around the same number of individuals with one form of discrimination and multiple forms of discrimination to accurately interpret and analyze the results. Ultimately, this study expanded the literature on multi-stigmatized individuals and contributed findings that promote both positive marginality and negative consequences of stigma that are often found in the literature.

Luckily, this study did not cost any money to create or implement. Furthermore, because this study was conducted entirely online to adhere by the COVID-19 restrictions and guidelines, it will be fairly easy to replicate. This standard design allows for other researches to test and check these results. Since the data was collected in numeric form, it was easy to interpret and

analyze. Also, this study did not rely on random assignment. If participants met the eligibility criteria, they were allowed to participate in this study.

Despite these strengths, the study also has limitations. This study was conducted in the midst of COVID-19, a global outbreak of the coronavirus. Therefore, the dependent variables were not only capturing experiences of stigma but of COVID-19 as well. COVID-19 has been a yearlong disruption to life thus far and hence, people may have gotten used to this new way of life (e.g., not leaving the house very often, social distancing, wearing a mask when outside, etc.). Subsequently, it is possible we have captured underestimated or overestimated data. It is recommended that researchers wait until the pandemic is over to collect more accurate data.

Likewise, collecting data on sexual orientation would have been beneficial. Previous literature has found that individuals who identified as gay, lesbian, or bisexual reported more experiences of discrimination and more depressive symptoms in comparison to straight individuals (Thoma & Huebner, 2013; Thompson et al., 2004). We could have compared the findings across race, gender, and sexuality as well to discover if our findings would have aligned with past research. Also, it is possible that specific health outcomes may affect self-reports of perceived discrimination (e.g., depressed individuals may interpret others' behaviors more negatively and subsequently, would have reported more perceived discrimination). Hence, people could have misinterpreted situations because of their own preconceived notions that could have contributed to their feelings and interpretations of past events.

Future Research Directions

Future studies should consider the relationships among statuses, discrimination, and health over time. The cumulative impact of multiple forms of discrimination on health and well-being also warrants further research and should be employed as well. It is imperative to consider

the impact on all forms of discrimination and not just one to ensure that the relationship between discrimination and health is not misrepresented. In particular, it is important to assess the extent to which different forms of discrimination contribute to mental health and well-being disparities. There are multiple dimensions in the assessments of discrimination that should also be accounted for, including how frequently an individual experiences discrimination and how distressing those experiences are.

Future research should examine the quality of life for individuals with multiple stigmatized identities as well. Specifically, resilience and negative consequences of stigma should be explored to identify the patterns of developing resilience and impact of perceiving discrimination. This area of research would be beneficial especially if utilized in longitudinal studies. People may utilize a number of different coping strategies (such as social support) to manage perceiving, experiencing, and coping with discrimination stress. Stereotypes, prejudices, and discrimination all affect quality of life for minority individuals and the process of overcoming such experiences, coping with discrimination, and its effect on mental health should all be studied further.

The impact of multiple stigmatized identities on physical health should be explored as well. Perhaps experiencing discrimination can explain certain physical health disparities. But, how does someone document how such experiences affect health? The association between discrimination and physical health may be weak or take a longer time to develop in comparison to mental health. For example, perhaps the degree of discrimination experienced is enough to influence mental health but not physical health. Discrimination may only affect physical health when it is pervasive and future research should investigate this further. Utilizing a longitudinal

design to examine the relationship between discrimination and physical health may be beneficial in establishing a link.

Stigma should also be researched to assess how health is affected by both internalized and externalized stigma. Internalized stigma is the extent to which an individual adopts stigmatized views about their identity and externalized stigma refers to the shame and experiences of discrimination. Both types of stigma may be detrimental to health and should be further explored. More attention is required to these topics to understand how discrimination impacts self-perception and health. In stride with this, it would also be beneficial to examine what role the demographic characteristics of those who effectuate discrimination have on discrimination, stigma, and mental health.

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Table 1

Sociodemographic Characteristics of Participants

	Frequency	Percent
Stigma		
One	25	48.08
Multi	27	51.92
Race		
White	19	36.54
Black or African American	8	15.39
Asian	7	13.46
Latinx	10	19.23
Multiracial	8	15.39
Gender		
Female	42	80.77
Male	6	11.54
Non-binary	4	7.69

Note. $N = 52$. Participants were on average 21.02 years old ($SD = 2.69$).

Table 2

Means, Standard Deviations, and Measuring Stigma Across Various Scales

Scale	Measure	Stigma	N	M	SD
DASS 21	Depression	One	25	26.56	9.10
		Multi	27	28.19	6.32
	Anxiety	One	25	29.20	10.26
		Multi	27	29.15	7.59
	Stress	One	25	26.00	9.98
		Multi	27	26.74	7.82
RSES	Self-esteem	One	25	22.72	6.94
		Multi	27	21.78	5.60
EDS	Discrimination	One	25	32.40	6.47
		Multi	27	29.82	8.16

Note. $N = 52$. DASS 21 = Depression, Anxiety, Stress Scale 21; RSES = Rosenberg Self-Esteem Scale; EDS = Everyday Discrimination Scale. Stigma = One form of discrimination versus multiple stigmatized identities.