RESPONSES TO STIGMATIZATION

The Moderating Roles of Primary and Secondary Appraisals[1]

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Abstract

The more that devalued group members experience stigmatization, the worse their physical and mental health, well-being, and performance will be. However, the effects of stigmatization are often mixed, weak, and conditional. We should expect such variability in how devalued group members respond to stigmatization because resilience in the face of challenges is possible, depending on how stressful stigmatization is for people. Using the transactional model of stress (Lazarus and Folkman, 1984) as an organizing framework, I provide evidence that people will have different reactions to stigmatization depending on *primary appraisals*—that is, how harmful and self-relevant they appraise it to be—and on *secondary appraisals*—that is, whether or not they believe that they have the resources to cope with it. My review of the literature suggests that a stronger ingroup identification, stronger identification with a negatively stereotyped domain, chronic beliefs about stigmatization, and beliefs about meritocracy create vulnerabilities to stigmatization because they lead people to appraise stigmatization as more harmful and self-relevant. Furthermore, psychological optimism, a sense of control, self-esteem, as well as high socioeconomic status, a stronger identification with one's ingroup, and positive evaluations of the ingroup create resilience to discrimination because they allow people to perceive themselves as having the resources needed to cope with stigmatization. In conclusion, people will respond to the same potential stressor in different ways, depending on how self-relevant and harmful they perceive it to be and whether or not they perceive themselves as having the resources to cope. Thus, attention should be directed to developing families, communities, institutions, and societies that can provide people with the resources that they need to be resilient.

Keywords: Stigma, Stress, Primary Appraisals, Secondary Appraisals, Responses to Discrimination

INTRODUCTION

The consequences of stigmatization for devalued group members can be adverse, wide-ranging, and intertwined. Groups can be devalued on the basis of their ethnic-

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ity, race, gender, sexual orientation, age, etc. There is evidence that, overall, the more devalued group members anticipate being stigmatized, perceive their group to be stigmatized, or experience being stigmatized themselves, then the worse their physical and mental health, well-being, and performance will prove to be (Pascoe and Smart Richman, 2009; Williams and Williams-Morris, 2000). However, the negative effects of stigmatization tend to be highly variable. The literature reveals that the effects of stigmatization are often mixed, weak, and conditional. This is not to say that stigmatization is an unimportant phenomenon. Rather, it is a complex phenomenon, which makes it difficult to draw conclusions about how people will respond to stigmatization.

In this paper, first, I review psychological conceptions of stigmatization. I present the argument that to understand the effects of stigmatization on important outcomes (i.e., health, well-being, and performance), we should focus on people's experiences of stigmatization rather than on group differences. Second, I outline the effects of devalued group members' experiences of stigmatization on health, well-being, and performance by exploring both experimental manipulations of stigma and self-reported perceptions of stigmatization. This review reveals that it is difficult to draw conclusions about the effects of experiencing stigmatization for devalued group members because there is great variability in people's responses. Third, I argue that such variability should be expected given what we know about resilience and stress processes. Resilience means that some people fare better than expected given the challenges they face (Masten 2001). However, in response to challenges such as stigmatization, not everyone is resilient. I propose that differences in resilience to stigmatization can be understood as a function of how stressful stigmatization is for people. Fourth, using the transactional model of stress (Lazarus and Folkman, 1984) as an organizing framework, I provide evidence that people will have different reactions to stigmatization depending on *primary appraisals*—that is, how harmful and self-relevant they appraise it to be—and on *secondary appraisals*—that is, whether they believe that they have the resources to cope with it. The major contribution of this paper is to classify the known moderators of the effects of stigmatization on health, well-being, and performance as those that affect primary versus secondary appraisal processes.

PSYCHOLOGICAL PERSPECTIVES ON STIGMATIZATION

According to social psychologists, people are stigmatized when they have an attribute that conveys a devalued social status in a particular context (Crocker et al., 1998). Stigmatization can involve prejudiced attitudes, stereotypes, and discrimination. Others may hold prejudiced attitudes, which are negative evaluations of outgroups (Son Hing and Zanna, 2010). In addition, negative (and positive) stereotypes about the traits and behaviors of a typical group member exist at the cultural level (i.e., cultural representations) and at the personal level (i.e., individuals' beliefs) (Devine 1989). Finally, discrimination involves treatment of stigmatized group members that disadvantages them in comparison to nonstigmatized group members. Discrimination can be systemic (i.e., institutional) or personal (i.e., enacted by specific people). Finally, discrimination may be blatant and obvious or subtle and ambiguous. Thus, a broad array of stigmatization is possible.

A wealth of research in the last twenty years has revealed that stigmatization processes can occur with or without the perpetrators' awareness. More specifically, prejudiced attitudes and stereotypes can be explicit (i.e., deliberative, controlled) or

implicit (i.e., automatic, uncontrollable) (Greenwald and Banaji, 1995). Because people's explicit and implicit attitudes can be in conflict, resulting discrimination patterns can be quite complex. For instance, perpetrators' levels of personal discrimination can depend on a combination of their explicit prejudiced attitudes, implicit prejudiced attitudes, as well as situational cues, making stigmatization difficult to discern (Son Hing et al., 2008). Consequently, targets may not recognize all instances of stigmatization that they experience. Although asking the targets of stigmatization about their subjective experiences is the only way to address certain questions, such as how cultural frameworks might influence interpretations of stigmatization, (Lamont and Mizhrachi, Forthcoming), it will not provide a complete or accurate picture of the effects of stigmatization that may be unnoticed.

An alternate way to gain insight to the problems associated with stigmatization is to compare stigmatized and nonstigmatized groups on important outcomes. For instance, in the United States, there is a Black-White life expectancy gap (advantaging Whites) of approximately 6.5 years for men and 4.5 years for women (Harper et al., 2007). How is this possible? Discrimination can affect stigmatized group members' life circumstances in multiple domains, such as employment, housing, education, and healthcare (Sidanius and Pratto, 2001). Consequently, compared with nonstigmatized group members, stigmatized group members face more daily stressors and have fewer resources on which they can draw (Williams et al., 1997). Chronic experiences of stress can deregulate the stress response, which impairs immune functioning, leading to illness such as heart disease and cancer (Glaser 2005; Miller and Blackwell, 2006). However, making group comparisons does not allow a precise test of the effects of stigmatization on people's outcomes. This is because we cannot discern the degree to which group differences are due to stigmatization directly. For instance, given that ethnicity, socioeconomic status (SES), and health are interrelated, we do not know the extent to which these health discrepancies are due directly or indirectly to stigmatization.

Therefore, in this paper I focus on outcomes of stigmatization that can either be linked directly to: (a) devalued group members' self-reported personal experiences of stigma, anticipation of stigma, and perceptions of stigma against their ingroup, as well as to (b) experimental manipulations of stigma. Although it is possible for typically valued group members (e.g., White men) to be stigmatized in particular situations, their outcomes are less adverse than those of devalued group members (Guyll et al., 2001; Schmitt et al., 2002). Consequently, I will focus on experiences of stigmatization for devalued members (e.g., women, ethnic minorities, gays, lesbians). I draw on research of various devalued groups, not just ethnic minorities, to broaden conclusions. Finally, I focus on the effects of such stigmatization on people's physical and mental health, well-being (e.g., negative affect, self-esteem, etc.), and performance (e.g., on cognitive ability tests). Thus, the conclusions that I draw are particular to how experimental manipulations and perceptions of stigmatization affect health, well-being, and performance for devalued members.

THE VARIED EFFECTS OF STIGMATIZATION ON DEVALUED GROUP MEMBERS

Self-Reported Experiences with Stigma

Reviews of self-reported experiences of stigmatization on markers of physical health (e.g., blood pressure, hypertension) reveal mixed findings (Harrell et al., 2003) or conditional effects (Williams and Mohammed, 2009). For instance, no consistent

effects are seen comparing the blood pressure of African Americans who report experiencing less stigmatization in the past to that of those who have experienced more stigmatization in the past (Harrell et al., 2003). A recent meta-analysis revealed that greater self-reported experiences of discrimination significantly but weakly predict greater stress responses ($r = -0.11$), and worse physical health ($r = -0.13$) (Pascoe and Smart Richman, 2009). Thus, an effect of perceptions of stigmatization on physical health is found but it is neither strong nor direct.

More consistent yet still weak effects are found when looking at the relations between people's self-reported stigmatization experiences and (a) mental health, and (b) well-being (Williams and Williams-Morris, 2000). Of course, cross-sectional research suffers from interpretation problems given potential confounds. Thus, it is important to note that longitudinal studies reveal that, when controlling for initial mental health, experiences of stigmatization predict later mental health (Pavalko et al., 2003). Also, the more people report that they have experienced stigmatization, the worse their psychological well-being (e.g., lower self-esteem and greater depression) (Schmitt et al., 2002; Williams and Williams-Morris, 2000). A recent meta-analysis revealed that regardless of their group memberships (e.g., ethnicity, mental disorder), the more people experience stigmatization, the worse their mental health ($r = -0.28$) (Mak et al., 2007). Thus, stigmatization is harmful for mental health and well-being. However, these effects are likely weak because they are conditional on other factors (to be reviewed later). Such conditional effects weaken the overall relation found between stigmatization experiences and mental health and well-being.

The anticipation of being stigmatized is also harmful for devalued group members. Stigma consciousness (Pinel 1999), stigma sensitivity (Inzlicht et al., 2006), and group-based rejection sensitivity (e.g., race-based rejection sensitivity) all refer to the degree to which devalued group members are chronically aware of their stigmatized status and expect to be devalued. Among devalued group members, those who more strongly anticipate stigma report that they struggle more with self-regulation (e.g., motivation) (Inzlicht et al., 2006), with academic performance (Brown and Lee, 2005), and with depressive symptoms (Lewis et al., 2003). Thus, the anticipation of being stigmatized negatively affects devalued members' mental health, and their cognitive and scholastic performance.

In summary, the effects of self-reported expectations and experiences of stigmatization are negative yet weak. Stronger effects are found for psychological outcomes (e.g., depression, well-being) than for physiological stress responses and physical health. Yet, effects are often still conditional. It is possible that a reliance on targets' self-reported experiences will distort the relation found between stigmatization and outcomes because such measurement excludes subtle and undetected stigmatization.[2] Therefore, I turn now to a consideration of the effects of experimental manipulations of stigmatization on devalued group members' health, well-being, and performance.

Experimentally Inducing Stigmatization

Experimental investigations consistently reveal that the experience of stigmatization (vs. no stigmatization) results in greater physiological reactivity, such as cardiovascular reactivity with moderate to large effect sizes (Blascovich et al., 2001; Murphy et al., 2007; Williams and Mohammed, 2009). Stigmatization experiences are manipulated in the lab by exposing devalued group members to prejudice, by reminding them of past experiences of discrimination, or by reminding them of their stigmatized group status, or of negative stereotypes about their group, etc.

Experimentally inducing stigmatization also causes devalued members to have worse well-being (Crocker et al., 1993). For instance, when imagining that they are rejected from a course by a sexist professor, women feel more hostility (Major et al., 2003a) and negative affect (Schmitt and Branscombe, 2002a) than those who are rejected without any suggestion of sexism. When devalued group members are reminded of prejudice toward their ingroup, similar negative effects are found for well-being. For instance, Latinos who read about prejudice toward their ingroup feel more hostility and depressed affect than those who read about prejudice toward the Inuit (McCoy and Major, 2003). Thus, experimental manipulations of stigmatization can lead to hostility, negative affect, and lowered self-esteem. However, as I will discuss later, these effects are often moderated by multiple factors.

Finally, experiences of stigmatization negatively affect people's performance in difficult test-taking situations. "Stereotype threat" occurs if, when struggling with a difficult test, a negative stereotype becomes salient concerning the ingroup's ability in a relevant domain (Steele 1997). Stereotyped group members can then fear they will be evaluated in terms of the stereotype or that they will confirm the stereotype; these threats cause underperformance, compared with the performance levels of nonstereotyped group members (Steele 1997). Importantly, when the threat of the stereotype is removed (e.g., by informing participants that tests are nondiagnostic or unbiased), so too is the performance gap between highly competent stereotyped and nonstereotyped group members (Steele et al., 2002).

Manipulations of stereotype threat affect performance for a variety of groups in stereotype-relevant domains, such as women's performance on math tests (Spencer et al., 1999), Blacks' performance on intelligence tests (Steele and Aronson, 1995), older adults' performance on memory tests (Hess et al., 2003), and gay and bisexual men's quality of interaction with children (Bosson et al., 2004). In addition to performance decrements on tests, among Blacks, stereotype threat has been shown to increase blood pressure (Blascovich et al., 2001), and activate self-doubt (Steele and Aronson, 1995). Among women, stereotype threat can lead to disengagement with quantitative majors and occupations (Davies et al., 2002). The effects of stereotype threat on stigmatized group members' test-taking performance are robust; however, they too are conditional on other factors (Schmader et al., 2008; Steele 1997).

To summarize, consistent negative effects of stigmatization are found with experimental studies for devalued group members' physiological reactivity and their performance on difficult tests. These effects are robust and they are of moderate magnitude. However, less consistency is found when investigating the experimental effects of stigmatization on people's well-being, as these processes are often conditional.

Taking Stock

Some might be tempted to conclude that due to findings for experiences of stigmatization that are often mixed and weak, we should not be too concerned with its consequences. Such a conclusion would be erroneous. The relation between self-reported experiences of stigmatization on health and well-being might be underestimated in part because stigmatization can be difficult to detect given its often subtle nature (Crosby 1984). Furthermore, when it is detected, devalued group members are often reticent to report that they have been victims of stigmatization (Crocker et al., 1998; Ruggiero and Taylor, 1997).[3] Finally, weak effects can be aggregated across domains and over time to have a large impact and great practical significance (Martell et al., 1996). Therefore, weak effects do not translate into unimportant phenomena.

Others might infer that, because the effects of stigmatization on devalued group members are often conditional, the phenomenon is too complicated to make conclusions about responses to stigmatization. However, we should expect the effects of stigmatization to be conditional (i.e., moderated) given what we know about psychological resilience: in the face of risks, protective factors or assets create opportunities for the achievement of positive outcomes, such as well-being (Armstrong et al., 2005; Masten 2001). Thus, responses to risks, such as stigmatization, should depend on people's assets, making resilience neither exceptional nor guaranteed. Although some of these assets are based in the individual (e.g., disposition or psychological outlook), others stem from the environmental context, such as social networks, local institutions, and cultural frameworks (Hall and Lamont, Forthcoming). Furthermore, I would suggest that the list of known moderators of responses to stigmatization is not a laundry list. Rather, it can be clearly organized into a framework to understand when and for whom the negative effects of stigmatization will be exacerbated or mitigated by drawing on the transactional model of stress and coping (Lazarus and Folkman, 1984).

TRANSACTIONAL MODEL OF STRESS AND COPING

Many have conceptualized experiences of stigmatization as a social stressor (Carter 2007; Miller and Kaiser, 2001). The social stressors that create the greatest physiological stress reactions are those that involve social evaluative threats and those that are uncontrollable (Dickerson and Kemeny, 2004). Thus stigmatization, which often involves negative evaluations of self or ingroup, and which is often uncontrollable, can be one of the most damaging of stressors. So why are the negative effects of stigmatization not ubiquitous?

According to the transactional model of stress and coping (Folkman and Lazarus, 1980), stress is caused by people's interpretations of their experiences, not the objective experiences themselves. The theory focuses on the in-the-moment psychological and physiological responses to a stressor while recognizing that the broader context, such as one's history with the stressor, affects the cognitive appraisals people make. The theory states that when faced with a potential stressor, people make primary appraisals: *is the potential stressor self-relevant and harmful?* If the potential stressor is not perceived to be self-relevant and harmful, people should not experience stress. For instance, if a woman finds a sexist joke to be funny, inoffensive, and unthreatening, she will not experience stress.

If the potential stressor is perceived as self-relevant and harmful, people then make secondary appraisals: *do I have the capacity to cope with the potential stressor given my resources?* Personal resources could include economic resources or psychological resources. Social resources could involve social networks that provide social support and information. Institutional resources could involve agencies or policies for mitigating potential stressors. Finally, cultural resources might involve myths or ideologies that provide frameworks for understanding and combating potential stressors. Both an individual's personal resources and access to resources in the environment affect the secondary appraisal process (Lazarus and Folkman, 1984). For instance, if a woman is exposed to sexist jokes and she experiences a chilly workplace environment, she will consider her resources for coping (e.g., supervisor, Human Resources department, family support, ability to find alternate employment). If people perceive themselves as having the resources that enable them to cope, they should experience the potential stressor as a challenge and consequently should not experience stress.

However, if people perceive their resources as insufficient, then the stressor will be experienced as a threat and it will induce stress. When stress is experienced, it involves physiological, cognitive, emotional, and behavioral responses (Holahan et al., 1996). Research supports the notion that the balance between perceptions of threat and ability to cope predicts psychological stress and physiological reactivity (Tomaka et al., 1993). Therefore, depending on a person's primary and secondary appraisals, a potential stressor, such as stigmatization, will not necessarily be experienced as stressful.

Over time, stress can lead to psychological, physical, and behavioral strain (e.g., depression, illness). Thus, as suggested by others, stress should mediate the negative effects of stigmatization on health, well-being, and performance (Miller 2006; Schmader et al., 2008; Williams and Mohammed, 2009).

In the next sections of this paper, I will outline how variation in people's responses to stigmatization can be understood as resulting from differences in primary and secondary stress appraisals. More specifically, I will outline how factors that increase the likelihood that stigmatization is seen as self-relevant and harmful (primary appraisals) should exacerbate stress responses. In addition, personal and social assets that can be viewed as resources to be drawn on to cope with stigmatization (secondary appraisals) should mitigate stress responses.

MODERATORS AFFECTING PRIMARY APPRAISALS (I.E., ASSESSMENT OF SELF-RELEVANCE AND HARM)

I propose that some factors that moderate the effects of stigmatization on health, well-being, and performance can be understood to operate through the primary appraisal process, that is, assessments of self-relevance and harm (see Major et al., 2003b for a discussion of stress and self-esteem). I want to suggest that some known moderators (i.e., identification with the ingroup or with a negatively stereotyped domain, and beliefs about the pervasiveness of stigmatization or meritocracy) should increase the likelihood that stigmatization will be seen as self-relevant and as harmful. Stronger primary appraisals of self-relevance and harm should lead to more physiological and psychological stress (Folkman and Lazarus, 1980), which in turn should lead to worse physical and mental health, lower well-being, and worse performance (see Fig. 1).

Self-Relevance

A strong sense of *group identification* can, in some ways, make people more vulnerable to stigmatization (Major et al., 2003b). Identification can involve many elements; however, I will focus on the degree to which people see their group membership as central to their identity (McCoy and Major, 2003). The negative effects of stigmatization on cognitive processing (Bair and Steele, 2010) and on test-taking performance are stronger for those who are more identified with their ingroup (Schmader et al., 2008). Similar effects are found for well-being. For instance, among Latino Americans who read that prejudice toward Latinos is pervasive, the stronger their ingroup identification, the more depressed affect they feel (McCoy and Major, 2003). Thus, there is some evidence that stigmatization negatively affects well-being and cognitive performance more strongly for devalued group members who are more strongly identified with their ingroup.

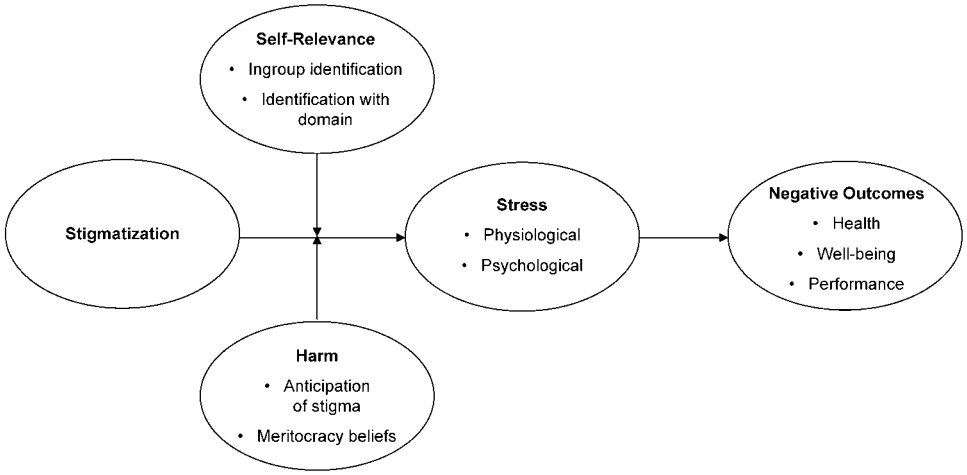

Fig. 1. Mediating mechanisms for moderators of primary appraisal processes.

There is some evidence that the interactive effects of ingroup identification and stigmatization operate through primary appraisals of harm and self-relevance. The more strongly people identify with their ingroup, the more they should perceive stigmatization as self-relevant and harmful; thus the greater stress they should experience (Branscombe et al., 1999). There is evidence that those with a stronger ingroup identification appraise stigma as more harmful (Rusch et al., 2009) and as more threatening, which leads to more negative effects on well-being (McCoy and Major, 2003). Thus, the more strongly people identify with their devalued ingroup, the more likely they are to perceive stigmatization as self-relevant and harmful; consequently, stigmatization leads to greater feelings of threat; as a result, well-being and cognitive performance are diminished.

When negative stereotypes exist about an ingroup's abilities for a specific domain, *identifying with that domain* can exacerbate the negative effects of stigmatization. Many studies reveal that the effects of stereotype threat are most damaging to individuals who place great value on, or who are highly identified with, the domain being tested (Steele 1997). For instance, women who are told that a math test produces gender differences perform worse, compared with those who write the identical test but are told that the test does not produce gender differences; however, this effect is found only for those strongly identified with math (Keller 2007).

The more strongly people identify with the domain (e.g., cognitive ability, math) for which stigmatization occurs, the more self-relevant and harmful stigmatization should seem, and consequently the more stressful it should be. This is because a domain can become part of the self-concept (Keller 2007). The effects of stereotype threat on performance operate in part through an increased stress response (i.e., increased activation of the sympathetic nervous system and the hypothalamic-pituitary-adrenal axis), which impairs cognitive functioning (Schmader et al., 2008).[4] Interestingly, stereotype threat effects are not mediated by self-reported anxiety. Rather, stereotype threat affects indirect (or implicit) measures of anxiety because people under stereotype threat work hard to monitor and suppress their anxiety (Johns et al., 2008). Thus it seems reasonable to conclude that in the context of taking difficult tests, stereotyped group members who are more strongly identified with a relevant domain appraise poor performance as a more self-relevant and harmful

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threat; consequently, they experience greater stress and try to regulate it, which impairs their performance.

Harm

When experiencing negative treatment with ambiguous roots, that is, when it is unclear whether stigmatization is occurring, *anticipation of stigma or beliefs about how pervasive stigmatization is* can exacerbate its negative effects (Schmitt and Branscombe, 2002a). The negative effects of ambiguous instances of stigmatization are more adverse for those who more strongly anticipate negative treatment based on group memberships or who perceive their ingroup to face more chronic discrimination (Mendoza-Denton et al., 2002). For instance, the more Black Americans experience microaggressions (e.g., being mistaken for someone else of the same race), the worse their well-being, but only if they also believe that others have negative expectations of Blacks (Sellers et al., 2006).

Importantly, in ambiguous situations that might involve stigmatization, chronic beliefs about stigmatization drive stronger physiological stress responses (Townsend et al., 2011). This is likely because the more devalued group members attribute negative treatment to racism or sexism, the more they construe the negative treatment to be personally meaningful, and consequently, the more psychological stress they feel (King 2005). Thus, when devalued group members face ambiguous negative treatment, the more they perceive themselves and/or their group to be chronically stigmatized, the more likely they are to make attributions to stigmatization, which is construed as more harmful and self-relevant, leading to more stress; consequently, the worse their well-being.

In a seemingly contradictory way, when people clearly recognize that they *are* the targets of discrimination, the *belief that society is meritocratic* for all appears to make the experience of stigmatization worse for devalued groups (Major et al., 2007). Among American ethnic minorities and women who believe that they have been discriminated against a lot in the past, the more they believe that society is meritocratic for all, the lower their self-esteem (Foster et al., 2006; Major et al., 2007). Similar experimental effects on their well-being (i.e., mood, life satisfaction, and self-esteem) are found for women and ethnic minorities who are either induced to perceive more discrimination (Major et al., 2007) or who are the clear targets of discrimination (Foster and Tsarfati, 2005). Thus, devalued group members who experience discrimination have lower well-being if they have stronger beliefs that rewards, such as jobs and pay, go to the deserving. This might be because perceiving discrimination is in conflict with, and serves as a threat to, the worldview of those who believe that the world is a just place and that hard work is rewarded (Major et al., 2007).

Primary Appraisals Summary

I argue that some known moderators of the effects of stigmatization operate through the primary appraisal process, that is, they make people perceive stigmatization as more self-relevant (i.e., identification with the ingroup, or with a negatively stereotyped domain) and/or as more harmful (i.e., chronic beliefs about stigmatization, or about meritocracy), which leads to greater feelings of threat, experiences of stress, and consequently negative effects for health, well-being, and performance. However, there are also important differences in how these processes might operate depending on the moderator. For instance, people who chronically believe that they or their group face a great deal of stigmatization likely find ambiguous negative behaviors to

be more stressful than those less sensitive to stigmatization, perhaps because the former are more likely to interpret the event as discrimination. In contrast, people who believe that meritocracy exists likely find clear-cut, unambiguous experiences of stigmatization to be more threatening than those who believe that meritocracy does not exist, perhaps because the former experience a worldview threat that the latter do not. Finally, for some of the identified moderators there is solid evidence for the suggested mediated paths laid out in Figure 1 (i.e., ingroup identification), for some there is partial evidence (i.e., identification with the domain, anticipation of stigma), and for some, to date, no empirical evidence exists (i.e., the belief that meritocracy exists).

MODERATORS AFFECTING SECONDARY APPRAISALS (I.E., ASSESSMENT OF RESOURCES)

I propose that other factors that moderate the effects of stigmatization on health, well-being, and performance play such an important role because they affect the secondary appraisal process (i.e., assessment of resources). When confronted with a self-relevant threat, people will consider the personal and social resources on which they can draw (e.g., disposition, SES, or ingroup memberships) to cope with the potential stressor. I want to suggest that those with more resources should appraise themselves as better able to cope with stigmatization. Secondary appraisals of being able to cope with a potential stressor should prevent the experience of stress and consequent strain (Folkman and Lazarus, 1980). Therefore, for those with greater personal and social resources, the negative effects of stigmatization on health, well-being, and performance should be diminished (Fig. 2).

Psychological Resources

One's disposition is a type of psychological resource that can aid resilience to stigmatization. Among people with a weaker sense of control, lower self-esteem, and less

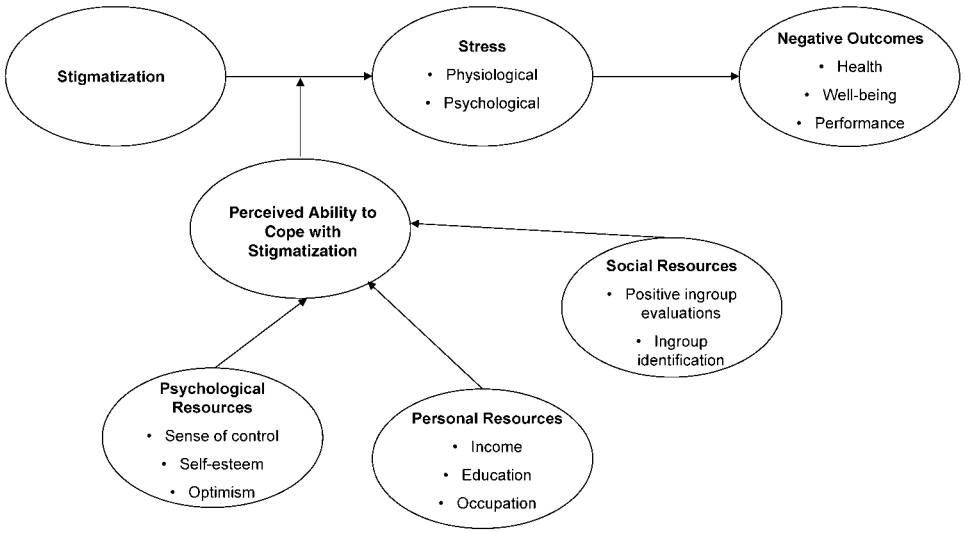

Fig. 2. Mediating mechanisms for moderators of secondary appraisal processes.

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optimism, more personal experience with discrimination is associated with lower well-being and more psychological symptoms. However, among those with a stronger sense of control, higher self-esteem, and greater optimism, the effect of experienced discrimination on mental health (Dion et al., 1992) and well-being (Jang et al., 2008) is greatly diminished. Thus, the negative effects of stigmatization are mitigated for those with a greater sense of control, self-esteem, and optimism.

Evidence suggests that people with greater psychological resources appraise stigmatization to be less threatening and themselves as better able to cope. For instance, very different reactions are found among women who read about sexism toward University students and alumni based on their general levels of optimism (Kaiser et al., 2004). Compared with those lower in optimism, those higher in optimism appraised sexism as less threatening and themselves as better able to meet the challenges of sexism, which led to better emotional well-being (Kaiser et al., 2004). Experimental manipulations can also affect these processes. For instance experimentally inducing participants to self-affirm, which raises self-esteem, can reduce the negative effects of stereotype threat on scholastic performance (Cohen et al., 2009). Thus, it appears that having a stronger sense of control, higher self-esteem, and greater optimism leads people to see themselves as possessing the resources to deal with the challenge of stigmatizations making it less stressful. Consequently, stigmatization has less aversive effects on mental health and well-being.

Personal Resources

Personal resources are those attributes of an individual (e.g., SES) that can be drawn on to cope with stressors and should help foster resilience to stigmatization. Devalued group members with higher incomes, education, and occupational status should be buffered from stigmatization, compared with those with lower SES. There is evidence that the negative effects of discrimination on mental health are stronger for those with a lower level of educational attainment or lower income and weaker for those with a higher level of educational attainment or higher income (Kessler et al., 1999). This is true even though devalued group members with higher SES report experiencing more discrimination that those with lower SES (Kessler et al., 1999). For instance, a study of Hispanic employees found that the more they experience discrimination at work, the worse their job satisfaction and the higher their work tension; however, these effects were weaker for those with higher salary levels (Sanchez and Brock, 1996). Thus, it appears that the effects of stigmatization on mental health and well-being are moderated by SES, but why?

Devalued group members with higher SES should be in a better position to respond to threats because they can harness economic and social resources to cope with stigmatization, compared with those with lower SES (Hall and Taylor, 2009). People with higher SES might have more control and flexibility in how they respond to stigmatization. In addition, people with higher SES also have more psychological resources (e.g., a greater sense of control and higher self-esteem) that help to buffer the impact of stigmatization (Dion et al., 1992). This could be because people with higher SES have jobs that involve more direction and control, so consequently they develop a greater sense of control (Link et al., 1993). Alternatively, having a higher SES could provide alternate means of recognition for devalued group members (Lamont et al., Forthcoming). Thus, there are multiple routes through which incomes, education, and occupational status help to buffer devalued group members from the damaging effects of stigmatization.

Social Resources

Social resources are those attributes of a collective that can be drawn on to cope with stressors (e.g., group identity, networks, cultural repertoires, etc.) and should help foster resilience to stigmatization. To the extent that they are valued and a source of identification, people's ingroups can be social resources (Correl and Park, 2005), which can facilitate resilience to stigmatization. First, let us consider how having *positive evaluations of one's ingroup* can be an important resource for coping with stigmatization.[5] Among devalued group members, having more positive evaluations of the ingroup is associated with lower levels of depression and anxiety (Cassidy et al., 2004). Furthermore, the negative effects of discrimination on mental health are mitigated for devalued group members who feel more positively toward their ethnic group (Rivas-Drake et al., 2008). Thus, the negative effects of stigmatization on mental health and well-being are lessened for those who positively evaluate their ingroup.

Importantly, there is evidence that these effects operate through stress processes (Neblett et al., 2008). For instance, the more mentally ill people value their ingroup (e.g., believe that the mentally ill are good), the more they perceive themselves as able to cope with stigma (Rusch et al., 2009). This could be because when the self has been threatened (e.g., due to stigmatization), the self can be buffered by drawing on positive identities (Steele 1988), and valued group memberships provide people with a sense of self-worth (Tajfel and Turner, 1986). Thus, devalued group members who value their ingroup should be more likely to see themselves as having the resources to cope with the challenge that stigmatization presents and consequently experience less stress and strain on mental health and well-being.

Second, let us consider how *ingroup identification* can be an important resource for coping with stigmatization. There is some evidence that the damaging effects of stigmatization are weaker for devalued group members who have a strong ingroup identification (Wong et al., 2003).[6] For instance, among Filipino Americans, the more they experience discrimination, the more depressive symptoms they have, but this effect is mitigated for those with a stronger group identification (Mossakowski 2003). In addition, much research has shown that perceiving more discrimination against one's group leads to greater ingroup identification, which in turn buffers negative responses to perceived discrimination, such as lowered self-esteem (Branscombe et al., 1999; Schmitt and Branscombe, 2002b). Thus, either as a moderator or a mediator, ingroup identification can buffer the negative effects of stigmatization on mental health and well-being.[7]

How might ingroup identification be a coping resource? Multiple potential processes might facilitate coping for devalued group members. First, group identification might promote access to cultural repertoires that provide alternate sources of group recognition (Lamont and Mizrachi, Forthcoming). Indeed, among African American youth, the typical effect of experiences of discrimination on felt stress is entirely mitigated for those who were frequently socialized by their parents to value Black culture, to be aware of discrimination, and to believe in racial equality (Neblett et al., 2008). Second, group identification might play such a beneficial role because it creates a sense of belonging or acceptance, which is a critically important human motive (Baumeister and Leary, 1995). Third, ingroup identification might go hand in hand with having a better social network to draw on: the social support and material support offered by ingroup members can provide important coping resources (Schmitt and Branscombe, 2002b). Social support from ingroup members can alleviate the negative effects of stigmatization on physiological stress responses (McNeilly et al., 1995) and on psychological stress responses (Utsey et al., 2000; but see

Brondolo et al., 2009). In addition, being active in group-based organizations mitigates the negative effects of discrimination on well-being (Ramirez-Valles et al., 2005). Importantly, there is evidence that those who identify more with their ingroup are more likely to appraise themselves as having the resources they need to cope with stigma, compared with those who are less identified (Rusch et al., 2009). Thus, for those with a stronger ingroup identification, stigmatization is less stressful and has less adverse consequences because devalued group members perceive themselves as having the resources needed to cope.

Secondary Appraisals Summary

In summary, I suggest that some moderators of the effects of stigmatization (namely, optimism, sense of control, self-esteem, high SES, evaluations of the ingroup, identification with the ingroup) operate through the secondary appraisal process. For those with higher levels of personal and social resources, sometimes the effect of stigmatization on outcomes is weakened and sometimes it is eliminated. This suggests that having more resources helps when facing challenges even if they are not sufficient to outweigh potential threats. For all these moderators, having greater resources makes people more likely to perceive stigmatization as a challenge rather than a threat; thus less stress is experienced; consequently, negative effects for health, well-being, and performance should be lessened. Some of these moderators might operate in a similar fashion. For example, optimism, a sense of control, and income might all affect people's beliefs about whether they have the resources they need to contend with stigmatization and whether they can do so effectively. However, other moderators might operate differently and through multiple mechanisms. For instance, ingroup identification might provide a cultural tool kit for understanding and responding to stigmatization (Swidler 1986), or access to social and material resources (e.g., social networks) that help devalued group members cope with the daily challenges created by stigmatization (Fleming et al., Forthcoming). Although there is consistent evidence that the proposed psychological, personal, and social resources outlined here affect secondary appraisals of ability to cope with stigmatization, the exact means through which people use such resources to cope are unclear (Fig. 2).

CONCLUSION

Stigmatization in housing, education, the labor market, and health care clearly has negative consequences for devalued group members (Sidanius and Pratto, 2001). Yet, the effects of self-reported experiences of stigmatization are often weaker than one might expect. This could be due to the difficulty devalued group members have in detecting and reporting subtle discrimination or implicit prejudice and stereotyping. Such problems can be bypassed by considering the experimental evidence. Stronger and more consistent effects are found on health, well-being, and performance with experimental manipulations of stigmatization. Still, they are often conditional, particularly when considering people's well-being. What should we make of such conditional effects? I argue that we should expect a great deal of variability in how devalued group members respond to stigmatization because resilience in the face of challenges is possible.

The transactional model of stress and coping (Folkman and Lazarus, 1980) can be used as a lens through which to view variability in responses to stigmatization. This idea is not new. However, to my knowledge, this paper is the first to classify the mod-

erators of stigmatization effects on health, well-being, and performance *as those that affect primary versus secondary appraisal processes*, and review findings to support such assertions. My review of the literature suggests that a stronger ingroup identification, stronger identification with a negatively stereotyped domain, chronic beliefs about stigmatization, and beliefs about meritocracy create vulnerabilities to stigmatization because they lead people to appraise stigmatization as more harmful and self-relevant (Fig. 1). Furthermore, psychological optimism, a sense of control, self-esteem, as well as high socioeconomic status, a stronger identification with one's ingroup, and positive evaluations of the ingroup create resilience to discrimination because they allow people to perceive themselves as having the resources they need to cope with stigmatization; thus it is experienced less as a threat and more as a challenge (Fig. 2). For some of the moderators identified here, there is good empirical evidence for causal links I have outlined, whereas for others more research is needed to test the mediating role of primary and secondary appraisals as well as stress on health, well-being, and performance. Finally, I have focused on the factors investigated in experimental and survey studies that moderate responses to stigmatization, yet there is good reason to believe that other resources stemming from the environmental context, such as social networks, local institutions, and cultural frameworks should also modify responses to threats such as stigmatization (Hall and Lamont, Forthcoming).

Interestingly, it appears that ingroup identification can serve as both a vulnerability—making primary appraisals of self-relevance and harm more likely—and as a source of resilience—creating perceptions that one has the resources needed to cope with stigmatization. So overall, does ingroup identification help or hurt devalued group members? It probably depends on the extent to which ingroup identification leads to a sense of meaning, involvement, recognition, belonging, and social support, as they are key coping resources (Haslam et al., 2009).

Coping behaviors are a central component of the transactional model of stress and coping (Lazarus and Folkman, 1984). According to the model, when stress is experienced, those who engage in more effective coping responses will exhibit less subsequent psychological (e.g., depression), physical (e.g., illness), and behavioral (e.g., performance) strain, compared with those with less effective coping. Therefore, it is possible that the moderating effects of personal and social resources affect health, well-being, and performance, *not only through the prevention of stress but also through the prevention of strain*. In other words, perhaps people with more resources are more resilient to stigmatization because they are able to draw on more effective coping responses, which mitigate the negative effects of stress on health, well-being, and performance.

I chose not to focus on coping responses for two reasons. First, others have explored this possibility in depth (Brondolo et al., 2009; Miller and Kaiser, 2001). Second, reviews reveal that it is difficult to make generalizations about the efficacy of different coping responses to stigmatization because they are effective to the extent that they help people to reach their goals in a particular context (Folkman and Moskowitz, 2004; Miller 2006). Furthermore, effective coping for one outcome (e.g., a sense of justice) might diminish effective coping for another (e.g., social relations at work). Given the highly contextualized nature of this phenomenon, qualitative methodologies might be best suited to explore these issues. I want to suggest that personal and social resources diminish the experience of stress through secondary appraisals. Yet, in addition, *when used effectively*, they should diminish the likelihood that experienced stress will result in psychological, physical, and behavioral strain.

This paper focuses on vulnerabilities and resilience to challenges created by stigmatization. To what extent might the moderators of stigmatization effects operate similarly in the face of challenges that are unrelated to stigmatization? Some of

the factors that create vulnerabilities to stigmatization are likely to create vulnerabilities for people to other forms of challenge. For instance, people with a stronger belief that the system is meritocratic are likely to be more threatened by inequities even when they are not group-based. However, others, such as beliefs about discrimination, might be less likely to generalize to challenges unrelated to stigma. Turning now to sources of resilience, only some of the factors explored here have been investigated in relation to non-stigma-related stressors. For instance, there is a great deal of evidence that a sense of control, optimism, self-esteem (Taylor and Brown, 1988), and ingroup identification (Haslam et al., 2009) aid resilience to a wide variety of challenges. In future research, it would be interesting to test when and in what ways resilience processes in relation to stigmatization are unique.

How does stigmatization affect people's mental and physical health, well-being, and their performance? Psychological and physiological stress appears to play a critical role (Cohen et al., 2007). What the transactional model of stress and coping (Lazarus and Folkman, 1984) highlights for us is that people will respond to the same potential stressor in different ways depending on how self-relevant and harmful they perceive it to be and whether they perceive themselves as having the resources to cope. That individual differences allow us to predict more and less resilient responses to stigmatization does not mean victims of discrimination should be blamed if they fail to demonstrate resilience. Rather, attention should be directed to developing families, communities, institutions, and societies that can provide people with the psychological, social, material, and cultural resources that they need to be resilient.

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NOTES

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2. The relations between self-reported measures of stigmatization and outcomes do not appear to be conflated by confounds with negative affect (Williams and Mohammed, 2009).
3. Those with previous experiences of stigmatization are more likely to detect it (Major and O'Brien, 2005).
4. This is true given difficult tests and moderate to high arousal levels (Yerkes and Dodson, 1908).
5. It is important to note that pride is not protective: in fact, it appears to exacerbate the negative effect of racism on depression (Lee 2005).
6. This is true despite the fact that a stronger ingroup identification predicts greater perceptions of discrimination (Major et al., 2003c).
7. It appears that a strong ingroup identification can help foster resilience for those experiencing lower levels of discrimination but those who face more extreme threats are not protected (Yoo and Lee, 2005).

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