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Social Stigma and Self-Esteem: The Self-Protective Properties of Stigma

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Although several psychological theories predict that members of stigmatized groups should have low global self-esteem, empirical research typically does not support this prediction. It is proposed here that this discrepancy may be explained by considering the ways in which membership in a stigmatized group may protect the self-concept. It is proposed that members of stigmatized groups may (a) attribute negative feedback to prejudice against their group, (b) compare their outcomes with those of the ingroup, rather than with the relatively advantaged outgroup, and (c) selectively devalue those dimensions on which their group fares poorly and value those dimensions on which their group excels. Evidence for each of these processes and their consequences for self-esteem and motivation is reviewed. Factors that moderate the use of these strategies and implications of this analysis for treatment of stigmas are also discussed.

For more than three decades, social psychological research on prejudice, stereotyping, and discrimination has examined both the content of stereotypes about a variety of social groups and the effects of these stereotypes on behavior toward members of those groups. Accumulated evidence has shown that many social groups or categories of people are stigmatized in our society. People hold generally negative stereotypes about such diverse groups as Blacks (Brigham, 1974; Hartsough & Fontana, 1970; Karlins, Coffman, & Walters, 1969; Samuels, 1973); women (Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972; Heilbrun, 1976; Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968; but see Eagly & Mladinic, in press); unattractive persons in general (Berscheid & Walster, 1974; K. K. Dion & Berscheid, 1974; K. K. Dion, Berscheid, & Walster, 1972) and facially deformed persons in particular (Edwards & Watson, 1980; Macgregor, Abel, Bryt, Lauer, & Weissmann, 1953); as well as physically disabled (Centers & Centers, 1963; Farina, Sherman, & Allen, 1968; Newman, 1976; Tringo, 1970; Wright, 1960), obese (Harris, Harris, & Bochner, 1982; Larkin & Pines, 1979; Maddox & Liederman, 1969), mentally retarded (Foley, 1979; Gibbons, Sawin, & Gibbons, 1979; Gottlieb, 1975; Severance & Gasstrom, 1977), homosexual (DeCecco, 1984; D'Emilio, 1983; Herek, 1984; Levitt & Klassen, 1974), blind (cf. Scott, 1969), and mentally ill (Cohen & Streuning, 1962; Ellsworth, 1965; Farina, 1982; Nunnally, 1961) persons.

Furthermore, it is well documented that members of these groups are relatively disadvantaged in American society, both in terms of economic opportunities and outcomes and in terms of interpersonal outcomes. For example, Blacks of both sexes have fewer economic opportunities and lower economic outcomes in terms of earnings than do Whites (U.S. Government, 1978). Obstacles to occupational achievement for Blacks and ethnic minorities at various stages of the employment process have been documented by Braddock and McPartland (1987). Blacks also have more negative interpersonal outcomes when interacting with the White majority group than do Whites (see Crosby, Bromley, & Saxe, 1980, for a review). Similarly, interpersonal as well as institutional barriers to women's economic advancement are well documented (e.g., Hoiberg, 1982; Kanter, 1977; O'Leary, 1974; Treiman & Hartmann, 1981). Full-time working women typically earn only about 59% of what men earn, in part because the majority of working women are concentrated in lower prestige, female-dominated occupations that pay less than comparable, male-dominated occupations (Treiman & Hartmann, 1981). Women working in the more prestigious male-dominated occupations also face a number of interpersonal barriers (cf. Kanter, 1977), which contribute to the striking underrepresentation of women at the higher ranks of these occupations.

Similar economic and interpersonal difficulties confront physically unattractive individuals. Physically unattractive persons receive less time and attention from others (Kleck & Rubenstein, 1975; Wilson, 1978); they are judged less likely to be hired (Cash, Gillen, & Burns, 1977); and their work is judged less favorably by others (Landy & Sigall, 1974). Unattractive children receive less attention and support in school (G. R. Adams & LaVoie, 1974), and they are judged more harshly for their transgressions (K. K. Dion, 1972). Facially disfigured individuals in particular appear to suffer the negative consequences of being physically unattractive. For example, individuals who are facially disfigured with cleft lip or cleft lip and palate—one of the most common congenital deformities with external manifestations—reported experiencing problems in relationships with the opposite sex (Birch & Lindsay, 1971; Heller, Tidmarsh, & Pless, 1981), were less likely to marry than were siblings or control subjects (Bjornsson & Agustsdottir, 1987; Heller et al.,

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1981; McWilliams & Paradise, 1973; Peter & Chinsky, 1974), and were teased more by their peers (Birch & Lindsay, 1971; Bjornsson & Agustsdottir, 1987).

Individuals with physical handicaps also are disadvantaged, both in terms of physical access to facilities and in interpersonal encounters (Kleck, Ono, & Hastorf, 1966; Marinelli, 1974; Richardson, Ronald, & Kleck, 1974). Similar analyses could be applied to obese (Allon, 1982; Jarvie, Lahey, Graziano, & Framer, 1983), blind (Scott, 1969), mentally retarded (Gibbons, 1981), mentally ill (Farina, 1982; Farina & Ring, 1965), and homosexual (D'Emilio, 1983; Rivera, 1979, 1980) persons, among others.

In short, there is no doubt that prejudice and discrimination have substantial negative social, economic, political, and psychological consequences for members of oppressed or stigmatized groups. The purpose of this article is not to review all of these consequences but to focus in detail on one possible consequence of membership in a stigmatized group, namely, lowered self-esteem and diminished self-concept. The effects of prejudice and discrimination on self-esteem have been the focus of theoretical and empirical interest for decades and continue to be a source of controversy. Self-esteem is widely recognized as a central aspect of psychological functioning (cf. Taylor & Brown, 1988; Wylie, 1979, for reviews) and is strongly related to many other variables, including general satisfaction with one's life (Diener, 1984).

Conceptualization of Self-Esteem

We are particularly concerned with the effects of social stigma on global feelings of self-worth, or a generalized feeling of self-acceptance, goodness, worthiness, and self-respect (cf. Rosenberg, 1965, 1979; Wylie, 1979). Global self-esteem can be distinguished from a number of related concepts, including dimension-specific self-evaluation, self-confidence, and racial or collective self-esteem. Although evaluations of the self on specific dimensions such as academic ability, social skills, physical appearance, and so on tend to be correlated with global feelings of self-worth, they are neither conceptually nor empirically identical (cf. Marsh, 1986; Rosenberg, 1979). One may evaluate the self negatively on a particular dimension such as athletic ability and be high in feelings of global self-esteem, or evaluate the self positively on a specific dimension and be low in self-esteem. Self-confidence is also conceptually and empirically distinct from global self-esteem or self-worth (cf. Franks & Marolla, 1976; Gecas, 1971; Shrauger & Schohn, 1989). Self-confidence refers to an appraisal of one's competence, skill, or ability, either in general or in a specific domain. It is more related to objective criteria and past performance than is self-esteem.

Global self-esteem can also be distinguished from racial or collective self-esteem or evaluations of one's social identity (cf. Crocker & Luhtanen, 1989; Luhtanen & Crocker, 1989; Porter & Washington, 1979; Tajfel & Turner, 1986). Whereas global self-esteem refers to feelings of personal self-worth, racial or collective self-esteem refers to evaluations of the worthiness or value of the social groups—such as racial, ethnic, or religious groups—of which one is a member. Conceptually, one may hold one's social group or category in low esteem, yet have high feelings of personal self-worth. Empirically, measures of collective self-esteem and personal self-esteem are only moderately correlated (much less than different measures of personal self-esteem) and interact in different ways with variables such as personal or group performance information (cf. Crocker & Luhtanen, 1989; Luhtanen & Crocker, 1989; Porter & Washington, 1979).

Some of the controversy surrounding the literature on social stigma and self-esteem stems from the failure to distinguish between these different aspects of the self-concept. For example, research on Black self-esteem has yielded inconsistent findings, with some authors concluding that Blacks are lower in self-esteem than Whites and others concluding that they are higher (cf. Adam, 1978, for a discussion). In general, those studies that have measured racial self-esteem, especially those conducted prior to the 1970s, have tended to find low self-esteem among Blacks, whereas those that measure global personal self-esteem have tended to find higher self-esteem among Blacks than among Whites (see Porter & Washington, 1979, for a review). Our focus is on the effects of social stigma on global self-esteem with respect to one's personal identity.

Definition of Stigmatization

We will be considering the self-esteem of individuals who are members of a stigmatized or oppressed social category. By this, we mean social categories about which others hold negative attitudes, stereotypes, and beliefs, or which, on average, receive disproportionately poor interpersonal or economic outcomes relative to members of the society at large because of discrimination against members of the social category. Thus, our analysis applies to individuals who by virtue of their membership in a social category are vulnerable to being labeled as deviant, are targets of prejudice or victims of discrimination, or have negative economic or interpersonal outcomes. It is useful to distinguish between a stigmatized group and an outgroup. A stigmatized group is an outgroup relative to the dominant group in a culture or society, whereas an outgroup is defined by reference to any particular ingroup, regardless of which group holds the dominant position in the social hierarchy. Although some of the dynamics of interaction between stigmatized and nonstigmatized individuals are generally characteristic of ingroup–outgroup relations, stigmatized groups are devalued not only by specific ingroups but by the broader society or culture.

Consistent with some other theoretical treatments (cf. Ainlay, Becker, & Coleman, 1986; Goffman, 1963; Jones et al., 1984), our analysis will include a wide variety of stigmatized or oppressed groups, from ethnic minorities to facially disfigured persons to mentally handicapped persons. Although there are obvious and important differences among the many groups that we will consider, they face the common obstacles of prejudice and discrimination. By considering a diverse set of stigmatized groups or social categories, we hope to suggest some general principles regarding the effects of prejudice and discrimination on self-esteem. Later in this article, we will consider variables that may account for some differences among stigmatized groups or categories.

Theoretical Perspectives on Social Stigma and Self-Esteem

Reflected Appraisals

Sociologists have emphasized the importance of "reflected appraisals" or the "looking-glass self" in the development of the self-concept (Cooley, 1956; Mead, 1934; see Shrauger & Schoeneman, 1979, for a review of empirical research). According to this view, the self-concept develops through interactions with others and is a reflection of those others' appraisals of oneself. Cooley (1956), for example, argued that the self-concept consists of "the imagination of our appearance to the other person; the imagination of his judgment of that appearance, and some sort of self feeling, such as pride or mortification" (p. 184). Thus, the self-concept is a product of both one's awareness of how others evaluate the self and the adoption of those others' views. According to this perspective, members of stigmatized and oppressed groups who are aware that they are regarded negatively by others should incorporate those negative attitudes into the self-concept and, consequently, should be lower in self-esteem.

The *other* whose views one incorporates into the self-concept may be either specific individuals with whom one interacts or a "generalized other," that is, one's entire sociocultural environment (Mead, 1934). Thus, this perspective suggests that members of stigmatized groups may develop negative self-concepts either because specific individuals with whom they interact (e.g., peers, teachers) hold negative attitudes toward them or because members of their group are generally devalued in the wider culture, as expressed in books, television shows, and so on.

Empirical evidence supports the general hypothesis of symbolic interactionists that self-perceptions and self-evaluations are related to how one believes others perceive or evaluate the self (see Shrauger & Schoeneman, 1979, for a review). Furthermore, although evidence is limited on this point, members of stigmatized or oppressed groups seem to be aware of the negative stereotypes that others hold of them and of discrimination against them. Blacks past the age of 14, for example, are generally aware that many people are prejudiced against Blacks (cf. Rosenberg, 1979); most women believe that women are discriminated against (Crosby, 1982); mentally retarded persons are aware of the negative connotations of their label (Gibbons, 1981), as are blind (Scott, 1969), obese (Jarvie et al., 1983), physically handicapped (Avillion, 1986), mentally ill (Link, 1987), and homosexual (D'Emilio, 1983) individuals. According to the looking-glass-self perspective, this awareness of negative stereotypes and discrimination against one's group should result in negative self-evaluations among stigmatized individuals.

Self-Fulfilling Prophecies

Merton (1948) proposed that self-fulfilling prophecies occur when a perceiver acts on his or her initially false beliefs about a target in such a way that those beliefs come to be confirmed by the behavior of the target. For example, a teacher who erroneously believes that a student cannot do well in class may ignore that student's questions and requests for help, or place that student in a slow group, and ultimately prevent that student from performing well. Eventually, the student may also come to regard him or herself as someone who cannot do well in class.

Considerable research on self-fulfilling prophecies has documented that targets often come to behave in ways that are consistent with the expectations of others and may alter their self-concepts as a result of this behavior (see Darley & Fazio, 1980; Deaux & Major, 1987; Jones, 1986; Miller & Turnbull, 1986, for reviews). According to this view, perceivers who hold negative stereotypes about stigmatized groups may alter their behavior toward members of those groups so that the stigmatized individuals come to behave and ultimately to see themselves in a manner consistent with those negative stereotypes (cf. Fazio, Effrein, & Falender, 1981). In contrast to the looking-glass-self perspective, the self-fulfilling prophecy perspective does not require that stigmatized individuals be aware of the negative attitudes of others toward their group for those negative attitudes to affect their self-concept. Rather, the self-concept may be diminished simply by self-perception processes (Bem, 1970).

Efficacy-Based Self-Esteem

A third theoretical perspective that predicts that members of stigmatized groups should have lower self-esteem is the view that the self-concept develops through efficacious interaction with the environment (Gecas & Schwalbe, 1983; White, 1959). This perspective can be contrasted with both the looking-glass-self and self-fulfilling-prophecy perspectives, which portray individuals as essentially passive victims of the attitudes of others. Self-esteem, according to this perspective, is not passively acquired, but is "earned through one's own competent actions" (Franks & Marolla, 1976, p. 326). By learning that one can control and manipulate one's environment, one acquires a view of the self as competent, successful, and able, and consequently, one has high self-esteem. Conditions that block the opportunity to interact successfully with the environment may prevent the development of high self-esteem.

According to this efficacy-based self-esteem view, members of stigmatized groups should have lower self-esteem than nonstigmatized individuals because of limitations on their opportunities to control and manipulate their environment. Social-structural conditions, such as segregation or discrimination against members of stigmatized or oppressed groups, "can limit the possibilities for the formation of efficacy-based self-esteem by limiting access to resources that are necessary for producing intended effects" (Gecas & Schwalbe, 1983, p. 82). Thus, this perspective is consistent with the looking-glass-self and self-fulfilling-prophecy approaches in predicting that members of stigmatized groups should be lower in self-esteem than members of more advantaged groups.

In addition to the theories reviewed here, other theories, such as equity theory (Walster, Walster, & Berscheid, 1978), social exchange theory (Thibaut & Kelley, 1959), social comparison theory (Festinger, 1954), and social identity theory (Tajfel & Turner, 1986) are also compatible with the prediction that social stigma has negative effects on self-esteem. This prediction has been widely accepted by social psychologists, to the point

that it has been assumed to be true (e.g., Allport, 1954/1979). For example, Cartwright (1950) argued that

> The Group to which a person belongs serves as primary determiners of his self-esteem. To a considerable extent, personal feelings of worth depend on the social evaluation of the group with which a person is identified. Self-hatred and feelings of worthlessness tend to arise from membership in underprivileged or outcast groups. (p. 440)

In a similar vein, Erik Erikson stated, "There is ample evidence of 'inferiority' feelings and of morbid self-hate in all minority groups" (1956, p. 155). Allport (1954/1979) noted that "group oppression may destroy the integrity of the ego entirely, and reverse its normal pride, and create a groveling self-image" (p. 152).[1]

Empirical Evidence on Social Stigma and Self-Esteem

Despite the strong theoretical support for such a prediction, empirical evidence that members of stigmatized groups have lower self-esteem than nonstigmatized individuals is remarkably scarce. A substantial body of research has measured the global self-esteem of members of a variety of different groups. With respect to Blacks, a host of studies have concluded that Blacks have levels of self-esteem equal to or higher than that of Whites (see Hoelter, 1983; Porter & Washington, 1979; Rosenberg, 1979; Wylie, 1979, for reviews of the literature). This pattern also applies to Chicanos, another ethnic minority (Jensen, White, & Galliher, 1982). Similarly, two major reviews (Maccoby & Jacklin, 1974; Wylie, 1979) have concluded that women do not have lower self-esteem than do men. Research also has failed to find consistently lower self-esteem as a result of an individual's being physically unattractive (Brzezicki & Major, 1983; Major, Carrington, & Carnevale, 1984; Maruyama & Miller, 1981), having facially disfiguring conditions such as cleft lip or cleft lip and palate (Clifford & Clifford, 1986), or being obese (Allon, 1982; Jarvie et al., 1983). Similarly, self-esteem is not consistently lower among those who are developmentally or learning disabled (Johnson, Johnson, & Rynders, 1981), mentally retarded (Fine & Caldwell, 1967; Gibbons, 1985; Stager, Chassin, & Young, 1983; Willy & McCandless, 1973), physically handicapped (Burden & Parish, 1983; but see Harvey & Greenway, 1984, for discrepant findings), homosexual (Carlson & Baxter, 1984; Greenberg, 1973; LaTorre & Wendenburg, 1983), or mentally ill (Wylie, 1961), or among juvenile delinquents (Hall, 1966; Kaplan, 1975). Indeed, several studies have provided evidence of higher self-esteem among stigmatized than among nonstigmatized groups, including Blacks (Hoelter, 1983; Porter & Washington, 1979), Chicanos (Jensen et al., 1982), and mentally retarded individuals (Fine & Caldwell, 1967; Willy & McCandless, 1973).

In short, this research, conducted over a time span of more than 20 years, leads to the surprising conclusion that prejudice against members of stigmatized or oppressed groups generally does *not* result in lowered self-esteem for members of those groups. These findings generalize across a variety of stigmatizing conditions, a variety of measures of global self-esteem, and a wide range of subject populations, from adolescents to college students to adults. Thus, these data contradict predictions derived from the looking-glass self, self-fulfilling prophecy, and efficacy-based self-esteem theoretical approaches. This is not to say, however, that prejudice and discrimination are not in other ways psychologically harmful to the victim. Indeed, members of stigmatized or oppressed groups may differ from members of more advantaged groups on other psychological dimensions such as task-specific self-confidence, performance expectancies, achievement motivation, and susceptibility to certain forms of mental and physical illnesses. Thus, we wish to emphasize that we are *not* arguing that prejudice has no detrimental psychological consequences for the targets of that prejudice. Rather, our focus here is on the mechanisms by which *global* self-esteem is protected despite evidence of more negative treatment of and outcomes for those who are stigmatized, relative to those who are not.

Explanations for the Failure to Find Low Self-Esteem Among the Stigmatized

One possible reason why self-esteem is not lower among stigmatized persons is that self-esteem is established very early in life, and once established, does not change in response to interpersonal or achievement situations. We find this explanation unconvincing, however, in light of empirical evidence that self-esteem can and often does change in response to the social environment. Several studies, using a variety of methodological techniques and deriving from different theoretical perspectives, have demonstrated that self-esteem varies as a function of age, performance feedback, educational transitions, the social context, and social structural variables (cf. Gergen, 1971; Harter, 1986; Rosenberg, 1979, 1986). For example, the self-esteem of intellectually gifted children has been found to vary as a function of whether they are placed in special classes for the gifted (Coleman & Fults, 1982). Similarly, self-esteem has been shown to drop among children moving from the 6th to 7th grade who must change from an elementary school to a junior high school, but to rise among same-age children who remain in the same middle school (Rosenberg, 1986).

Laboratory research by social psychologists also provides evidence of the effects of social situations on self-esteem. For example, a well-known study by Morse and Gergen (1970) found that the self-esteem of people who were applying for a job depended on whether another applicant for the job, waiting in the same room, appeared competent and poised or unprepared for the job interview. Many other studies also show that self-esteem is vulnerable to social context and situational forces (Gergen, 1971; see Wood, 1989, for a review).

A second explanation for the failure to find that members of stigmatized groups are not lower in self-esteem is the argument that the people who are prejudiced or who discriminate against members of stigmatized groups do not constitute "significant" others for the members of those groups. According to symbolic interactionists such as Cooley (1956) and Mead (1935), it is the

[1] Allport (1954/1979) recognized that members of stigmatized groups use a wide variety of coping strategies. Hence, he acknowledged that low self-esteem characterized some but not all minority group members.

appraisals of significant others that will become incorporated into one's self-view. For example, one's parents, who are important significant others, may not hold negative attitudes or discriminate on the basis of one's membership in a stigmatized group, of which they, too, may be a member. Although it is certainly the case that many individuals who are prejudiced are not significant others to the targets of their prejudice, it is equally certain that many prejudiced individuals *are* significant others. A variety of powerful figures in the lives of stigmatized persons, including teachers, employers, peers, coworkers, and so on, are likely to be members of the dominant, or nonstigmatized group, and are likely to communicate negative attitudes toward members of the group. Furthermore, the symbolic interactionist position stresses the importance of the generalized other to the self-concept. Considerable research, too extensive to review here, has documented the biased and negative depictions of women, Blacks, and a host of other stigmatized groups in media as diverse as textbooks and television. For members of stigmatized groups, the generalized other as revealed by media portrayals of the stigmatized is likely to be quite negative.

A third explanation for the failure to find low self-esteem among the stigmatized persons is that the affective reactions that many people have toward them are ambivalent, rather than uniformly negative (cf. Gergen & Jones, 1963; Jones et al., 1984; Katz, 1981). Feelings of revulsion, hostility, and avoidance may coexist with feelings of sympathy, nurturance, and the awareness of social norms against bigotry. Consequently, negative attitudes and feelings may be suppressed and not communicated either verbally or behaviorally to the stigmatized persons; hence, they cannot affect self-esteem. This argument is contradicted, however, by evidence that behavioral measures frequently reveal prejudice even when attitudinal measures do not, particularly when it is socially undesirable to express prejudice or when the behavioral measures are not under conscious control, or both (cf. Farina, Thaw, Felner, & Hust, 1976; Kleck, Ono, & Hastorf, 1966). For example, although survey research has indicated that the incidence of racial prejudice has declined dramatically in the past 20 years, behavioral indicators of prejudice, as well as more subtle attitudinal measures, continue to reveal a considerable degree of anti-Black sentiment in the United States (see Crosby, Bromley, & Saxe, 1980; Gaertner & Dovidio, 1986, for reviews).

Self-Protective Properties of Social Stigma

How then may we account for the discrepancy between theory and data on the consequences of social stigma for self-esteem? In the remainder of this article, we propose that there are several mechanisms that buffer the self-esteem of members of stigmatized or oppressed groups from the prejudice of others. This perspective is consistent with and adds to a large and growing body of research in personality and social psychology that is concerned with the maintenance or protection of self-esteem (cf. Snyder, Higgins, & Stucky, 1983; Taylor & Brown, 1988; Tesser & Campbell, 1980, 1982a). For example, research has documented the tendency of individuals to engage in self-handicapping behaviors to provide an excuse for failure (cf. Jones & Berglas, 1978), to make self-serving causal attributions for success and failure (cf. Bradley, 1978), and to make self-enhancing social comparisons (see Wood, 1989, for a review). Our focus differs from that of other researchers, however, in that we are concerned with the way that membership in a stigmatized group can protect one's self-esteem, not only from explicit prejudice or discrimination, but also in some cases, from daily setbacks, failures, and rejections. Thus, although members of stigmatized groups may engage in a variety of strategies of self-protection that also characterize nonstigmatized persons, our focus is on the special opportunities for self-protection that are afforded by membership in a group that is stigmatized. Specifically, we are concerned with three mechanisms, or processes, by which stigmatized individuals may protect their self-esteem: (a) attributing negative feedback to prejudice against their group, (b) selectively comparing their outcomes with those of members of their own group, and (c) selectively devaluing those attributes on which their group typically fares poorly and valuing those attributes on which their group excels.

Attributing Negative Feedback to One's Group Membership

One mechanism that may protect the self-esteem of members of stigmatized or oppressed groups is attributing negative feedback or relatively poor outcomes to the prejudiced attitudes of others toward their group. For example, if a Black person fails to get a job, is criticized, or undergoes some other negative experience, he or she may be uncertain whether the event occurred because of his or her personal inadequacies or whether it occurred because the evaluator was racist. This ambiguity about the causes of negative events may protect the self-concept of the Black person because a racism explanation may often be a plausible explanation for negative outcomes. Similar processes should apply for women and members of other stigmatized or oppressed groups.

This self-protective mechanism is particularly powerful because it may be used not only in response to negative evaluations or outcomes that do, in fact, stem from prejudice against the stigmatized group, but also in response to negative outcomes that do not stem from prejudice. Overuse of this self-protective attributional function of social stigmas has been noted by Goffman (1963), with respect to a variety of stigmatizing conditions, as well as by some medical researchers (Macgregor et al., 1953) in the context of the effects of plastic surgery. The following quote shows how facially disfiguring conditions may be used as an explanation for a variety of negative outcomes:

> For years, the scar, harelip, or misshapen nose has been looked on as a handicap, and its importance in the social and emotional adjustment is unconsciously all embracing. It is the 'hook' on which the patient has hung all inadequacies, all dissatisfactions, all procrastinations and all unpleasant duties of social life, and he has come to depend on it not only as a reasonable escape from competition, but as a protection from social responsibility. (Baker & Smith, 1939, p. 303)

The hypothesis that attributions for positive and negative outcomes mediate affective reactions to those outcomes is consistent with several theoretical approaches to emotional response (cf. Abramson, Seligman & Teasdale, 1978; Scheier & Carver, 1988; Weiner, 1980, 1982, 1985, 1986; Weiner, Russell,

& Lerman, 1978, 1979), as well as with empirical evidence (cf. MacFarland & Ross, 1982). Both the reformulated learned helplessness theory of Abramson et al. (1978) and Weiner's attributional analysis of emotion (Weiner, 1985, 1986) deal explicity with the implications for self-esteem of causal attributions for positive and negative outcomes. Internal attributions for negative outcomes and external attributions for positive outcomes are proposed to result in lowered self-esteem. Empirical research is generally consistent with this prediction (e.g., Brewin & Furnham, 1986; Crocker, Alloy, & Kayne, 1988; MacFarland & Ross, 1982; Tennen & Herzberger, 1987; Weiner et al., 1978, 1979).

For members of stigmatized groups, attributing negative outcomes or negative feedback to internal, stable, and global causes such as lack of ability should lead to lowered self-esteem, whereas attributing these same outcomes to external causes should protect self-esteem. Because prejudice against one's group is an external attribution for negative outcomes, making this attribution should protect the self-esteem of stigmatized individuals. Consistent with this reasoning, Jensen et al. (1982) found that students who had been insulted because of their race, religion, nationality, or residence (who could attribute such insults to prejudice against their group) were equivalent in self-esteem to students who had not received such insults. Insults to personal characteristics such as appearance, speech, or mental ability (which are less directly linked to prejudice against one's group), however, were related to lower self-esteem.

Further evidence for the self-protective function of attributing negative outcomes to prejudice has been provided by studies in which women or members of minority groups receive negative feedback or poor outcomes from an evaluator who might be prejudiced against them (see K. L. Dion, 1986, for a review). In one study, female subjects received negative feedback from a male evaluator. Following receipt of the feedback, those subjects who believed that they had been discriminated against were higher in self-esteem than were those who did not believe that they had been discriminated against (K. L. Dion, 1975; see also K. L. Dion & Earn, 1975).

Of course, the results of this internal analysis are also compatible with the hypothesis that subjects who are initially high in self-esteem are more likely to attribute negative outcomes to prejudice against their group. More direct evidence for the self-protective function of making attributions to prejudice was provided in a study that used a similar design but that experimentally manipulated the perception of prejudice (Testa, Crocker, & Major, 1988). In this study, female students wrote an essay that was subsequently evaluated either positively or negatively by a male evaluator. A previous exchange of an "opinion questionnaire" had revealed to the female subjects that the male evaluator either was or was not prejudiced against women. As predicted, women who received negative feedback from a nonprejudiced evaluator reported more depressed affect and showed a decrease in self-esteem, relative to women who received negative feedback from an evaluator who was prejudiced against women. Other research has found that Black children who could attribute failure to possible racial discrimination by White peers evaluated themselves more positively than did those who could not make this attribution (N. Miller, Boye, & Gerard, 1968; but see Boye & Miller, 1968, for inconsistent results with Jewish subjects).

In a conceptually similar study by Crocker, Voelkl, Cornwell, and Major (1989), Black students received either positive or negative interpersonal feedback from a White evaluator, who either could or could not see them. The authors reasoned that when Black subjects knew that the evaluator could see them, they would attribute negative feedback to prejudice against Black people, whereas when they could not be seen, this attribution would be difficult to make because the evaluator was blind to their race. As predicted, negative feedback lowered the self-esteem of Black subjects, but only when they thought the evaluator was blind to their race.

An intriguing implication of attributions as a self-protective strategy for stigmatized individuals concerns the consequences for self-esteem of receiving *positive* feedback or favorable outcomes. Consistent with Kelley's (1972) augmentation principle, when one can view positive feedback as occurring *in spite of* prejudice against one's group, one should be particularly likely to attribute the positive outcome to one's high level of skill, ability, or deservingness. Just this pattern was observed by Major et al. (1984). In their study, college women wrote an essay that was evaluated positively by a (bogus) male peer who the women believed could either see them or not see them. Under the "seen" condition, unattractive women were more likely than attractive women to believe that the feedback was due to the high quality of their essay (see also Sigall & Michela, 1976). We would predict that this augmentation of positive feedback among stigmatized individuals could lead them to have higher self-esteem than nonstigmatized individuals upon the receipt of positive outcomes under some circumstances. Thus, this mechanism may account for those studies that have found higher self-esteem among stigmatized individuals.

Although stigmatized individuals sometimes may benefit more from positive feedback than nonstigmatized individuals, this should not be true if they attribute the positive feedback to their stigmatizing condition, instead of their personal attributes unrelated to the stigma. Specifically, if stigmatized persons believe that others are being nice to them or are evaluating their work positively out of sympathy for their condition or fear of appearing prejudiced, then positive outcomes should not enhance and may even decrease self-esteem. Evidence for this process was found in the study by Crocker et al. (1989) described earlier. In conditions in which Black subjects received positive feedback from White evaluators, self-esteem increased when they believed the evaluator was blind to their race, but significantly decreased when they believed the evaluator knew their race. Furthermore, these subjects believed that evaluators who could see them liked them because of their race, but they did not make this attribution when the White evaluator was unaware of their race.

Under what conditions are members of stigmatized or oppressed groups likely to attribute negative outcomes or performance feedback to prejudice against their group? According to Kelley's (1967) model of the causal attribution process, people, like scientists, attribute causality to factors that covary with the event. Thus, if members of one's ingroup consistently receive negative outcomes or performance feedback and members of the outgroup do not, group membership would seem to be a

cause of the event. Furthermore, if the event does not covary with ability, effort, or objective performance, then prejudice would seem to be the cause of the event.

Often, people do not have access to or the inclination to use covariation information to assess the causes of an event (Taylor & Fiske, 1978). In such cases, they may attribute causality to the most salient or cognitively accessible cause. According to Higgins and his colleagues (Higgins, King, & Mavin, 1982), causes can be accessible either because they have recently or frequently been brought to mind (e.g., if one has just recently read about an instance of prejudice) or because they are chronically accessible for a particular person. Some people may be particularly vigilant for instances of prejudice against their group. According to our analysis, which is contrary to the predictions of the looking-glass-self approach, such individuals should tend to be high in self-esteem.

Self-Protective Properties of Ingroup Comparisons

The second self-protective mechanism that buffers the self-esteem of members of stigmatized or disadvantaged groups is the tendency to make ingroup social comparisons (cf. Festinger, 1954; Gibbons, 1986; Jones et al., 1984; Tajfel & Turner, 1986). By definition, members of stigmatized or oppressed groups are victims of prejudice and discrimination and hence are often relatively disadvantaged on a number of dimensions, compared with members of more dominant (and advantaged) outgroups. Consequently, members of stigmatized groups may find comparisons with members of these advantaged outgroups painful and potentially esteem lowering. We suggest, however, that for several reasons stigmatized persons tend to compare themselves with similarly stigmatized others, whose outcomes are also relatively poor. Specifically, we suggest that stigmatized individuals are particularly likely to compare themselves with others who share a common fate, for three reasons: (a) as a consequence of segregated environments (a proximity effect), (b) to obtain accurate self-evaluations (a similarity effect), or (c) to avoid unpleasant or painful social comparisons (a self-protective effect). As a result of any one of these processes, ingroup comparisons allow the stigmatized to avoid the self-esteem threatening consequences of outgroup social comparisons. Although the general tendency to make ingroup comparisons is not unique to stigmatized individuals and may be common to any ingroup–outgroup distinction, ingroup comparisons are particularly likely to protect the self-esteem of the stigmatized because they are generally disadvantaged in the larger culture or society.

The first impetus to ingroup social comparisons is structural and could be termed a "proximity" effect. The premise here is that ingroup members are more available for social comparison purposes because they tend to be more prevalent in the immediate environment (Runciman, 1966). For example, Black persons frequently live in neighborhoods that have predominantly Black residents, and attend schools that have predominantly Black students. Similar circumstances apply to other ethnic minorities. Some stigmatized groups, such as the blind, deaf, and mentally retarded, attend special schools or classrooms. Although women typically are not segregated from men in terms of housing in the U.S. culture, the overwhelming majority of women work in jobs that are highly sex segregated (Treiman & Hartmann, 1981), and same-sex affiliation is more common than cross-sex affiliation, at least among college youth (Wheeler & Nezlek, 1977). In general, either as a result of a preference to affiliate with similar others (e.g., Schachter, 1959), or forced segregation, those who are stigmatized or otherwise disadvantaged are more likely to be exposed to ingroup members than outgroup members and hence are more likely to compare themselves with others who are similarly disadvantaged.

Evidence for the proximity hypothesis can be seen in findings that structural factors, such as the salience, availability, and number of ingroup versus outgroup members in the immediate environment, affect with whom individuals compare themselves. People in natural settings report making comparisons with others who are physically close or readily accessible, such as family or friends or coworkers (Singer, 1981).

A second impetus to ingroup comparisons among stigmatized individuals is the "similarity principle." That is, stigmatized individuals are apt to seek out others who are similarly stigmatized, because they are assumed to be more similar to the self on relevant attributes and, hence, more informative and appropriate for accurate self-appraisal (e.g., Festinger, 1954; Goethals & Darley, 1977). For example, a woman evaluating her pay would be more likely to compare her pay with that of other women because women are more similar on a variety of attributes related to pay, such as type of job held or family constraints.

There is ample empirical support for the similarity principle. Sociologists working in the tradition of reference group theory (e.g., Hyman & Singer, 1968; Merton, 1957; Runciman, 1966; Stouffer, Suchman, DeVinney, Star, & Williams, 1949) have found that people spontaneously report comparing their living standards and social status with others whose class or role situation is similar to their own (see Singer, 1981, for a review; also Ross, Eyman, & Kishchuk, 1986). Social psychologists testing implications of social comparison theory (Festinger, 1954) have demonstrated that people prefer to compare their abilities and performances with others who are similar to themselves in attitudes, values, or personality traits (cf. Suls & Miller, 1977, for a review). More recently, researchers have demonstrated that this preference also extends to comparison of outcomes (e.g., pay; Major & Forcey, 1985), as well as abilities, and to dimensions of similarity based on social category membership, such as gender (Major & Forcey, 1985; C. T. Miller, 1984) and physical attractiveness (C. T. Miller, 1982), even when these ingroup attributes are not explicity related to performance or outcomes. This preference for comparing with similar others may explain why, even when the outgroup constitutes a numerical majority in the immediate environment, individuals often compare with distant but more similar ingroup members in lieu of proximal, but dissimilar, outgroup members. This pattern has been observed among blind (Strauss, 1968) and aged respondents (Rosow, 1974) and among women working in male-dominated occupations (Crosby, 1982).

Stigmatized or disadvantaged individuals may also prefer to compare themselves with ingroup rather than outgroup members to protect the self-concept or self-esteem from threatening comparisons. Thus, in addition to considerations of convenience (the proximity effect) or informativeness (the similarity effect), stigmatized individuals may deliberately avoid compari-

sons with advantaged group members because they know such comparisons would have painful consequences for self-esteem (Brickman & Bulman, 1977; Jones et al., 1984). Wills (1981) has suggested that social comparisons motivated by self-enhancement needs are particularly likely when the comparer faces a situation that involves "frustration or misfortune . . . that is difficult to remedy through instrumental action" (p. 145), a condition that we would argue is likely to characterize the stigmatized chronically. This tendency to avoid painful comparisons with outgroup members may be especially pronounced for dimensions that are personally important or self-relevant and, hence, most likely to affect self-esteem (see Wood, 1989, for a review). Comparisons with other stigmatized individuals allow the stigmatized person to focus on attributes and qualities other than the stigmatized ones and, hence, provide an opportunity to compare favorably with others on alternative dimensions (cf. Jones et al., 1984).

In short, we have argued that several factors produce a tendency for the stigmatized to make ingroup rather than outgroup social comparisons. Furthermore, we suggest that these ingroup comparisons protect the self-esteem of the stigmatized individual.

The affective consequences of social comparisons of outcomes have been addressed by relative deprivation theory (e.g., Crosby, 1976), equity theory (J. S. Adams, 1965; Walster et al., 1978), and the status-value formulation of equity theory (Berger, Cohen, & Zelditch, 1972; Berger, Fisek, Norman, & Zelditch, 1977). These theories assume that evaluations of outcomes (e.g., satisfaction, perceived fairness) are based less on objective outcomes than on subjective judgments that result, to a significant extent, from comparisons of one's own inputs and outcomes with those of others. By noting that members of disadvantaged groups frequently compare within their own group (i.e., with other disadvantaged individuals), such theories can explain the "paradoxical contentment" frequently displayed by members of underprivileged or disadvantaged groups (see Major, 1987, and J. Martin, 1986, for a fuller discussion of this issue). Results of both survey and experimental research support the basic proposition that felt contentment is relative to the comparison standard used (see A. Campbell, Converse, & Rodgers, 1976; Crosby, 1976, 1982; J. Martin, 1986, for reviews).

The affective consequences of social comparisons of *abilities* have also been addressed (cf. Wills, 1981; Wood, 1989, for reviews). Researchers have demonstrated that self-esteem and affective state are strongly related to beliefs about how one's abilities and attributes compare with those of others (cf. Alicke, 1985; Brown, 1986; J. D. Campbell, 1986; Crocker, Alloy, & Kayne, 1988; Tabachnik, Crocker, & Alloy, 1983). Experimental studies have demonstrated that manipulating information about how one has performed relative to others has consequences for self-esteem and affective state, especially when those others are similar and the ability dimension is personally important (cf. Salovey & Rodin, 1984; Tesser & Campbell, 1983). Field research has shown that one's ability relative to others in one's social context is related to the self-concept. For example, controlling for individual ability, children's academic self-concept is higher when they attend relatively low-ability schools than when they attend high-ability schools (Bachman & O'Malley, 1986; Marsh & Parker, 1984; Soares & Soares, 1969; Trowbridge, 1972). This phenomenon, called the "frog pond" effect by Davis (1966), presumably results from the fact that individuals evaluate themselves relative to others in their social environments, rather than on the basis of objective criteria (see also Pettigrew, 1967). Thus, as with evaluations of outcomes, this research illustrates the extent to which self-evaluations are based on relative, as well as absolute criteria.

Although the self-protective properties of social comparisons have been well documented at the individual level, direct evidence that social comparison processes buffer the self-esteem of disadvantaged or stigmatized groups is limited. Most relevant is research on the consequences for self-esteem of segregating versus integrating stigmatized and nonstigmatized individuals. Segregation of stigmatized individuals inhibits comparison of one's abilities and outcomes with outgroup members because they are physically unavailable for comparison. In such settings, members of the stigmatized group may be unaware when their outcomes are lower than those of the nonstigmatized group and, hence, may feel no threat to their self-esteem (an "ignorance is bliss" effect). Integration, on the other hand, should facilitate such comparisons. To the extent that stigmatized individuals have more negative outcomes than, or in other ways compare unfavorably with, nonstigmatized individuals, integration should result in lower self-esteem among the stigmatized.

Research on the effects of segregation versus integration is consistent with this prediction. For example, Rosenberg and Simmons (1972) found that Black school children in segregated settings had higher self-esteem than those in integrated settings, presumably because the former were more likely to compare themselves and their situations with similar (Black) others than with dissimilar and advantaged (White) others (although some studies have found no differences—see Stephan, 1978, for a review). However, because Black persons tend to be higher in self-esteem than White persons, integration appears to lower Black self-esteem to a level comparable with White self-esteem (Rosenberg & Simmons, 1972). Among the mentally retarded, it is the least retarded individuals who have the most contact with nonretarded individuals and the most preference for interactions with nonretarded persons (cf. Gibbons, 1981). These same least retarded individuals have the lowest self-esteem among retarded persons (see Gibbons, 1985, for a review). Presumably, it is this greater contact with, and hence comparison with, nonretarded persons that accounts for the lower self-esteem of the least retarded individuals. The least retarded individuals may also see themselves as more similar to nonretarded individuals than do those who are more severely retarded; as a result, the former may be more likely to compare themselves with the nonretarded.

Research by Harter (1986) provides further evidence of the importance of similarity, as well as proximity, in governing social comparisons and consequent self-perceptions among the stigmatized. Paradoxically, she found that "mainstreamed" mentally retarded children's perceptions of their scholastic competence were equal to those of normal-IQ children, whereas mainstreamed learning-disabled (but normal-IQ) children's perceptions of their scholastic competence were lower than those of normal-IQ, nonlearning-disabled children. This paradox was explained by examining the reference groups these

children reported using. The mentally retarded children reported routinely comparing themselves with their retarded peers, whereas the learning-disabled children reported routinely comparing themselves with normal-IQ children who did not have learning disabilities.

Further evidence concerning the effects of segregation versus integration on self-esteem is provided by studies of those who are relatively advantaged. Members of advantaged social categories should benefit from comparisons with the disadvantaged groups. Hence, in contrast with the disadvantaged, they should have higher self-esteem when they are in integrated, rather than segregated settings. Consistent with this line of reasoning, research shows that academically gifted children have higher self-esteem when they are in mainstreamed or integrated academic settings, relative to similarly gifted students who are placed in separate programs or classes for at least part of their academic schedule (Coleman & Fults, 1982). Furthermore, this research shows that when special programs for the gifted end and the students return to completely integrated settings (because they move to a new grade level), their self-esteem rises (Coleman & Fults, 1982).

It is important to note that although segregation may foster the social comparison strategy, it may simultaneously inhibit the self-protective strategy of devaluing those outcomes on which one's group fares poorly because this mechanism requires knowledge about how one's group performs relative to outgroups. This may increase the vulnerability of members of disadvantaged groups when they enter desegregated settings. Thus, the self-esteem-buffering consequences of segregation may be temporary and context specific. Indeed, a longitudinal study of the effects of racial desegregation by Gerard and Miller (1975) found that Black persons from segregated backgrounds experienced an initial drop in self-esteem following desegregation, but their self-esteem rebounded to initial levels within 2 years.

Of course, self-esteem is only one variable that may be affected by integration or segregation of the stigmatized. Although desegregation has potentially negative consequences for self-esteem, it can have positive consequences for achievement and expectations and expand perceived options and opportunities (see Stephan, 1978). Marsh and Parker (1984), for example, found that although children in high socioeconomic status (SES)–high-ability schools had more negative academic self-concepts, they also had somewhat higher levels of academic achievement than did children of comparable ability in low SES–low-ability schools. These findings prompted Marsh and Parker to ask "Is it better to be a relatively large fish in a small pond even if you don't learn to swim as well?" (p. 213).

Selectivity of Values as Self-Protection for the Stigmatized

A third mechanism by which members of stigmatized or oppressed groups may protect their self-esteem from negative feedback or negative comparisons with others is by *selectively devaluing,* or regarding as less important for their self-definition, those performance dimensions on which they or their group fare(s) poorly, and selectively valuing those dimensions on which they or their group excel(s). This hypothesis is based on the proposition that the impact of performance or outcome feedback on self-esteem is mediated by the psychological centrality, or importance, of the dimension to the self-concept, a proposition that dates back at least to William James (1890/1950). This proposition has been elaborated more recently by Rosenberg (1979; Rosenberg & Simmons, 1972) and by Harter (1986), who have argued that it is necessary to know whether an individual values a quality to know whether that individual's self-esteem will suffer as a consequence of being deficient in that quality. In addition, Rosenberg has proposed that self-values are heavily influenced by the values of society and by the system of rewards and punishments that an individual experiences.

We suggest that group differences in the degree to which attributes are valued, or are psychologically central, are critical to understanding why members of stigmatized and nonstigmatized groups do not differ in self-esteem. In particular, we hypothesize that (a) members of stigmatized or oppressed groups tend to regard those attributes or dimensions on which they or members of their group fare poorly, relative to others, as less personally important or psychologically central to their self-definition and those attributes or dimensions on which they or their group excel as more important to their self-definition; (b) this selective valuing is socially produced, that is, caused by receiving negative (or positive) feedback, comparing unfavorably (or favorably) with others, and being discriminated against (or advantaged) in certain areas; and (c) this selective valuing process protects the self-esteem of stigmatized or oppressed group members.

It is surprising that relatively little research has directly addressed whether members of stigmatized or oppressed groups differentially value those dimensions or attributes on which they or their group fare poorly or well relative to the dominant or majority group. Several research findings, however, are tangentially relevant. For example, relative to men, women tend to be somewhat less likely to report valuing high pay and promotional opportunities and somewhat more likely to report valuing interesting work and comfortable working conditions (Nieva & Gutek, 1981). Women are also less likely than men to receive high pay or to be promoted and are somewhat more likely than men to occupy jobs that rate highly on "comfort factors" (Nieva & Gutek, 1981). Thus, gender differences in job-related values parallel gender differences in obtained job-related outcomes.

A second type of evidence for devaluing those dimensions on which one or one's group fares poorly comes from research on coping with physical disability. Theoretical perspectives on coping with physical disability have emphasized the importance of devaluing physical attractiveness or physical accomplishments as a strategy for maintaining self-esteem (cf. Wright, 1960). Research on coping with physical disability has documented the tendency of these victims to change their value structure (Lichtman, 1982; Taylor, 1983). For example, Taylor, Wood, and Lichtman (1983), quoted a breast cancer patient:

> You take a long look at your life and realize that many things that you thought were important before are totally insignificant. That's probably been the major change in my life. What you do is put things into perspective. You find out that things like relationships are really the most important things you have—the people you know and your family—everything else is just way down the line.

> It's very strange that it takes something so serious to make you realize that. (p. 33)

The second component of the selective valuing hypothesis is that the psychological centrality, or importance, of certain dimensions to the self, is socially constructed so as to maintain or enhance self-esteem. This hypothesis suggests that personal values are caused, in part, by the patterns of positive and negative feedback that members of a group receive. A number of lines of research support this hypothesis on the individual level. In general, people tend to regard as more important those things at which they are personally proficient (Taylor & Brown, 1988). For example, Rosenberg (1965) found that adolescents who rated themselves favorably on a variety of characteristics also considered those characteristics more personally important than did adolescents who rated themselves unfavorably on the same characteristics. Similarly, Harter (1986) has demonstrated that children, especially those high in self-esteem, tend to regard as most important those domains in which they regard themselves as especially competent.

The work of Tesser and his colleagues (e.g., Tesser & Campbell, 1980, 1982a, 1982b) on self-evaluation maintenance provides a more direct test of this hypothesis. They have shown experimentally that individuals will devalue, or regard as less personally relevant, those performance-relevant attributes on which they compare unfavorably relative to a close (e.g., similar) other. Hence, their work demonstrates that personal values are sensitive to relative performance feedback. Thus, this research predicts that to the extent that individual members of a stigmatized or oppressed group do poorly, are the targets of negative feedback, or are the recipients of poor outcomes on some dimension as the result of prejudice, they will place less importance on this dimension than will individuals who are not discriminated against or who are not the victims of prejudice.

The hypothesis that personal feedback influences the value the individual places on particular performance or outcome dimensions can be extended beyond the individual level, however. Specifically, we predict that, *in the absence of any individual performance or outcome information,* people may come to devalue those dimensions on which they know their group fares poorly and value those dimensions on which they know their group fares well. This may occur because poor (or good) outcomes or performance of one's group is seen as predictive of poor (or good) outcomes or performance for oneself. Thus, the individual may devalue those dimensions on which his or her group fares poorly in anticipation of his or her own poor outcomes or performance. For example, girls may devalue performance in math or science before they have ever taken math or science classes, because they observe that high achievers in math and science are more typically men than women (cf. Eccles, 1987).

Like the social comparison strategy, this group-based selective valuing strategy appears to apply to any ingroup–outgroup distinction and not merely to stigmatized individuals. Nevertheless, the implications and consequences of this strategy are different for members of stigmatized groups than for members of dominant or advantaged groups. Indeed, the strategy of devaluing attributes or abilities on which one's group fares poorly may be particularly difficult for stigmatized individuals in the face of the contradictory values of the larger culture. It may also be particularly important, however, as it involves relatively long-term changes in the self-concept.

Indirect evidence for the hypothesis that in the absence of individual performance feedback or outcomes, people will devalue those dimensions on which their group fares poorly and value those dimensions on which their group fares well comes from several sources. Research on ingroup bias, for example, demonstrates that application of an ingroup versus outgroup label leads to more positive evaluation of things associated with the ingroup and more negative evaluation of things associated with the outgroup (cf. Brewer, 1979; Brewer & Kramer, 1985; Tajfel & Turner, 1986). Also relevant are theories and research on the development of sex-typed preferences and values. Cognitive developmental (e.g., Kohlberg, 1966), gender schema (Bem, 1981; Martin & Halverson, 1981), and gender identity (Spence, 1984) theories have noted that children categorize themselves as male or female at an early age and that this self-categorization motivates children to learn what behavior is appropriate for their own sex, preferentially value these behaviors, and act accordingly. According to Kohlberg (1966), "Basic self-categorizations determine basic valuings" (pp. 164–165). Martin and Halverson (1981) observed that

> When children can identify gender and reliably place themselves in the salient gender category, they recognize that they belong to one group (in-group) and not the other (out-group). For young children, evaluation follows in that the in-group is positively evaluated and the out-group is negatively evaluated. (p. 1129)

Consistent with this view, research has demonstrated that sex-typed labels affect the activity, toy, and occupational preferences of children as young as 3 years of age (Huston, 1983; Ruble & Ruble, 1982).

This selective valuing process was tested directly in a recent study by Peterson, Major, Cozzarelli, and Crocker (1988). Men and women who participated in this study completed a measure of a fictional trait and then received bogus feedback informing them that their own sex did better, that the other sex did better, or that the sexes scored equally. Their own score was ostensibly subtracted from the group averages, so that no personal performance feedback was provided. As predicted, both men and women valued the trait most when they were told that their own sex group had outperformed the cross-sex group, and men valued the trait least when they were told that their sex group had been outperformed by women. Contrary to predictions, however, women who were told that their own sex had been outperformed by men did not devalue the trait relative to women who were told that the sexes had performed equally. This asymmetrical pattern suggests that the self-protective strategy used by members of some disadvantaged or stigmatized groups may consist more of relatively overvaluing those attributes or domains in which their own group excels than of devaluing those attributes at which the dominant group excels, in part because of the realities of power held by the dominant outgroup. For example, it may be difficult to devalue achievement in a society that places great emphasis on individual success, but one can nevertheless place a greater value on domains in which ones' own group appears to be advantaged (e.g., nurturance, sensitivity to others). Recent research suggests that the stigmatized may

also deemphasize differences between their ingroup and the outgroup on attributes on which their group is disadvantaged and enhance differences between their ingroup and the outgroup on attributes on which their group is advantaged. For example, Eagly and Mladinic (in press) found that both men and women perceive sex differences to be larger on dimensions on which their own sex is viewed more positively and smaller on dimensions on which their own sex is viewed more negatively.

Perhaps because of the constraints placed on values by the larger culture or society, the effect of personal and group outcomes on values emerges more clearly in *relative* values, or the ranking of values, rather than on some absolute rating of values. In other words, personal and group feedback may affect which dimensions are rated as more important, rather than which are rated as unimportant. For example, among college students, both women and men rate academic performance and social interactions as the two most important domains to their self-confidence, but men rate academic performance ahead of social interactions, whereas women show the reverse pattern (Shrauger & Schohn, 1989). Even these subtle differences in the relative importance of values can moderate the effects of performance feedback on the self-concept (cf. Tesser, Millar, & Moore, 1988).

The third hypothesis is most central to our current analysis. Like James (1890/1950), we expect that the impact of negative feedback or unfavorable comparisons on an individual's self-concept is moderated by the importance or centrality of the relevant dimension for the individual's self-concept. Thus, negative feedback, poor performances, or unfavorable comparisons should lower global self-esteem only to the extent that the feedback occurs in valued or important dimensions. Negative feedback that occurs in less central or important areas of the self should not have a particularly detrimental effect on global self-esteem.

Correlational evidence is consistent with this argument. Rosenberg (1965), for example, found that adolescent boys who evaluated themselves negatively on a variety of attributes (e.g., likeable, dependable, intelligent) had lower global self-esteem than did those who evaluated themselves positively on these attributes. The strength of this relationship, however, depended on the importance attached to each of these attributes. Among those who cared about being likeable, intelligent, and so forth, the relationship was strong; among those who did not care, the relationship between self-perceived possession of an attribute and global self-esteem was weak. Similarly, Harter (1986) found that childrens' ability to discount the importance of areas in which they were not competent was strongly associated with their level of self-esteem. Experimental evidence for the moderating role of personal importance in affective response to performance feedback has been provided by Tesser and his colleagues (Tesser, Millar, & Moore, 1988). They showed that when outperformed by a close other on dimensions that were important to the self, subjects experienced negative affect. When outperformed by the same person on dimensions that were less important to the self, however, subjects actually experienced positive affect (due to "basking in reflected glory").

Moderating Factors

Although we believe that the use of these self-protective strategies is widespread among members of stigmatized groups, we do not suggest that they are used by every member of every stigmatized group every time a negative outcome occurs or a negative interpersonal or performance feedback is received. Stigmas vary considerably on a number of dimensions, such as severity, concealability, and social disruptiveness (cf. Jones et al., 1984). Hence, neither reactions of others to stigma nor the reactions of the stigmatized themselves are uniform. Indeed, there is evidence that members of some stigmatized groups do, in fact, have lower self-esteem than members of nonstigmatized groups. For example, self-esteem may be lowered by such stigmatizing events as going on welfare (Briar, 1966), losing one's job (Scholzman & Verba, 1979), developing a malignancy (Abrams & Finesinger, 1953), and being raped (Burgess & Holmstrom, 1979). In the next section we consider dimensions on which these stigmatizing conditions differ from those reviewed earlier, in an attempt to clarify the conditions under which members of stigmatized groups are vulnerable to low self-esteem and the conditions under which their self-esteem may exceed that of members of nonstigmatized groups. Our intent is not to consider the full range of dimensions on which stigmas differ (see Jones et al., 1984, for a fuller discussion of this issue), but to consider factors such as features of the stigma or its acquisition, characteristics of the stigmatized person, and social-structural or contextual variables that moderate the use of the strategies we have outlined earlier.

Time Since Acquisition of the Stigma

One variable that may influence the use of the self-protective strategies and, hence, explain why some stigmatizing conditions appear to lead to low self-esteem, whereas others do not, is the length of time since acquisition of the stigmatizing condition. The extreme of this variable is the stigmatizing condition that one has had since birth. Many conditions that lead to stigmatization or oppression are characteristic of the individual from birth onward, such as gender, racial, ethnic, or (usually) religious group membership, and many physical handicaps. Other conditions are acquired later in life, such as physical disabilities due to accidents or disease, victimization by rape, incest, and so on. As Janoff-Bulman and Frieze (1983) and Jones et al. (1984) have noted, the psychological consequences of stigmatizing conditions that date from birth are likely to be quite different from those that are acquired later in life.

We would argue that individuals who have been recently stigmatized lack the strategies of self-protection that membership in a stigmatized group can provide. That is, when a stigmatizing event occurs, it may take time for the individual to learn to devalue outcomes that are no longer attainable or likely, to attribute negative outcomes and negative feedback from others to the stigmatizing condition, and to compare his or her outcomes with those of other similarly stigmatized individuals. Consistent with this reasoning, in her attempt to explain why mentally retarded and learning-disabled children differed in their reference groups (and in their self-perceived competence), Harter (1986) proposed that

> It is likely that the retarded pupils have been identified and labeled at a much earlier age, and have required special educational placement for most of their academic lives. The learning-disabled child's history is often less clear-cut. . . . Thus, they may not have been

> singled out for intellectual deficits until well into their elementary years. Thus, it is understandable why learning-disabled children should view the regular classroom pupils as their primary reference group with regard to their scholastic competence. (pp. 149–150)

Thus, we would argue that the course of successful coping with stigmatizing events later in life involves acquiring these self-protective strategies that membership in a stigmatized group affords. Length of time that has elapsed since the stigma was acquired is probably more important than age at acquisition of the stigma in predicting whether or to what extent these self-protective strategies are used. In a similar vein, Jones et al. (1984) suggested that stigmatizing conditions that manifest themselves gradually may be more endurable to the stigmatized person than stigmas that occur suddenly, because the former permit time to adapt to the stigma.

Concealability of the Stigma

The visibility of the stigma to others plays a central role in producing the negative social reactions that the stigmatized endure. In general, individuals with concealable stigmas face less prejudice and fewer negative interactions than do those with nonconcealable stigmas (Jones et al., 1984). Furthermore, evidence suggests that stigmatized individuals (people who had been in a mental hospital and physically disabled individuals) behave more competently in social interactions when they believe their interaction partners are unaware of their stigma (Comer & Piliavin, 1972; Farina, Gliha, Boudreau, Allen, & Sherman, 1971). On the basis of these data, Jones et al. (1984) concluded that "in general, individuals who have concealed marks [are] better adjusted than people whose blemish is apparent" (p. 35).

Individuals with concealed stigmas, or those who attempt to conceal their stigmas and "pass" as members of the dominant group, however, are denied the use of the attributional strategy that we have outlined. Thus, if they receive unfavorable treatment by another who presumably does not know of their condition, they cannot attribute the treatment to prejudice. Individuals with concealed stigmas may also be less able to use the ingroup comparison strategy, in part because identification of similarly stigmatized individuals may be more difficult and in part because association with others similarly stigmatized might reveal their own stigma. These limitations may explain why some researchers argue that in some cases visible stigmas are more preferable than invisible ones (cf. Jones et al., 1984).

Acceptance of Negative Attitudes Toward the Stigmatized Group

A third variable that may predict when stigmatizing conditions lead to low self-esteem is whether the victim accepts the negative attitudes that others hold toward his or her stigmatized group (Jones et al., 1984; Rosenberg, 1979). Those who have internalized society's negative views of their group should be at particular risk for low self-esteem. For example, the victim of unemployment who believes that unemployed persons are lazy, incompetent, or a drain on society is more vulnerable to low self-esteem than the unemployed person who holds a more positive or sympathetic view of the unemployed. Prior victim prejudice against members of the stigmatized group may make the individual particularly vulnerable to low self-esteem when the stigmatizing condition strikes him or her. Goffman (1963) has noted this pattern:

> A third pattern of socialization is illustrated by one who becomes stigmatized late in life, or learns late in life that he has always been discreditable—the first involving no radical reorganization of his view of the past, the second involving this factor. Such an individual has thoroughly learned about the normal and the stigmatized long before he must see himself as deficient. Presumably he will have a special likelihood of developing disapproval of self. (p. 34)

This acceptance of negative stereotypes before one becomes a member of a stigmatized group may account for the effects of labeling on self-esteem. For example, persons who are diagnosed as mentally ill show lower self-esteem than do individuals with comparable symptomatology who have not been labeled as mentally ill (Link, 1987). Presumably, this effect should be most pronounced immediately after being labeled and should dissipate over time as the individual abandons his or her negative stereotypes and develops a repertoire of self-protective strategies. A similar process may explain the finding that low self-esteem is common among homosexual individuals during adolescence, when sexual preference is typically discovered and, hence, the homosexual label is first applied to the self (Bell, Weinberg, & Hammersmith, 1981), but not during adulthood (Carlson & Baxter, 1984; Greenberg, 1973; LaTorre & Wendenburg, 1983). Correlational evidence that acceptance of negative stereotypes is related to low self-esteem among stigmatized individuals was provided by Chassin and Stager (1984). They found that juvenile delinquents who agreed with negative evaluations of delinquents had lower self-esteem than those who did not agree with the negative evaluations. Specifying the individuals or groups most likely to internalize society's negative view of their group is an important issue for future research. Jones et al. (1984) suggested that internalization of the stigma may be more prevalent among individuals with nonconcealable or socially disruptive stigmas or among those who have recently been stigmatized.

Responsibility for the Stigmatizing Condition

A fourth factor that should affect the vulnerability of an individual to a stigmatizing condition is the extent to which one is held responsible for the stigma by self and others. Stigmas vary widely in the degree to which they are perceived to be personally caused by or under the control of the stigmatized individual (Jones et al., 1984). In general, evidence suggests that stigmatized individuals are treated better and elicit less anger and more pity when they are judged not to be personally responsible for their condition (e.g., Farina, Holland, & Ring, 1966; Levine & McBurney, 1977; Vann, 1976; Weiner, Perry, & Magnusson, 1988).

Blaming oneself for a stigmatizing condition may make a stigmatized individual particularly vulnerable to low self-esteem (cf. Kerbo, 1975). Researchers have noted the tendency for victims of accidents, rapes, and other threatening events frequently to accept more blame for their condition than seems objectively warranted (Bulman & Wortman, 1977; Janoff-Bulman, 1979; Wortman, 1976). As we have noted in our discussion of causal

attributions for negative outcomes, individuals who blame stable aspects of themselves (e.g., their character) for negative events are vulnerable to low self-esteem (Abramson et al., 1978; Weiner, 1985). Individuals who have had their stigmatizing condition since birth, however, should be unlikely to feel responsible for their stigmatizing condition, particularly when that condition is what Goffman (1963) called a "tribal" stigma (i.e., membership in a stigmatized ethnic, racial, or religious group). As a result, they should be less vulnerable to low self-esteem than those who become stigmatized later in life. As Brickman et al. (1982) pointed out, however, it is important to distinguish between responsibility for *causing* a stigmatizing condition and responsibility for *maintaining* it. Whereas the person who is born into poverty may not be blamed for his or her condition, both observers and poor people themselves may attribute blame for not rising above it. The effects of perceived responsibility on reactions to stigma are complex and deserve further study.

Centrality of the Stigma in the Self-Concept

The use of all three self-protective mechanisms that we have discussed may depend, in part, on the centrality or importance of the stigmatizing condition in the self-concept of the individual. For some individuals, a stigmatizing condition may be a central or core aspect of the self-concept, whereas for others the same condition may be relatively peripheral to their identity (Jones et al., 1984). This perspective is consistent with the view that the self-concept is hierarchically structured (cf. Epstein, 1973; L'Ecuyer, 1981; Shavelson, Hubner, & Stanton, 1976). Note the distinction we are making between the importance or centrality of the stigmatizing condition to the individual's identity and the importance or value the individual places on a particular dimension of feedback or specific outcomes, discussed under Selectivity of Values as Self-Protection for the Stigmatized. For example, physically disabled individuals may vary greatly in the extent to which their self-concept is organized around their disability. This centrality of the disability is distinct from the relative importance they place on outcome dimensions that may or may not be affected by their stigma, such as athletic prowess or intellectual achievement.

The more central the stigmatizing condition is to the individual's self-concept, the more likely it is that similarly stigmatized individuals will be regarded as an ingroup. This should affect the tendency to devalue dimensions on which the ingroup fares poorly, the tendency to attribute negative outcomes to prejudice against the group, and the tendency to compare outcomes with ingroup members. For example, an individual with a physical handicap who does not regard himself as a handicapped person may not view the outcomes of other handicapped individuals as relevant to his own anticipated outcomes and, hence, may not devalue dimensions on which handicapped persons fare poorly. Similarly, the individual may not think of prejudice against the handicapped as applying to him or her and, therefore, may not attribute his or her negative outcomes to prejudice against the handicapped. Finally, the handicapped person may compare his or her outcomes with those of nonhandicapped individuals, and consequently may feel dissatisfied with those outcomes. In short, such an individual should be relatively unlikely to use the self-protective strategies we have described and, hence, should be vulnerable to low self-esteem in the face of prejudice and discrimination.

Note that this hypothesis is counterintuitive. We are suggesting that the more an individual has structured his or her self-concept around membership in a group that is devalued, deprived, or discriminated against, the better that individual feels about him or herself in terms of global self-esteem. This occurs, we suggest, because identification with the stigmatized group allows the individual to use the group-level self-protective strategies that we have described. Consistent with this reasoning, Hammersmith and Weinberg (1973) found that increased commitment to a homosexual identity was associated with higher self-esteem, and Hall (1966) found that increased identification with a delinquent subculture was associated with higher self-esteem (see Chassin & Stager, 1984, for a discussion).

Implicit in this prediction, however, is the assumption that the individual does *not* accept or has not internalized negative attitudes toward the stigmatized group. An individual who both endorses negative attitudes toward the stigma *and* regards the stigma as a central aspect of the self may be particularly vulnerable to low self-esteem (Chassin & Stager, 1984; Jones et al., 1984). For example, Chassin and Stager (1984) found that juvenile delinquents for whom the delinquent label was personally relevant had lower self-esteem than did those for whom it was not relevant. Although Chassin and Stager did not test this hypothesis, we would predict that the effects of the centrality or personal relevance of a stigmatizing condition on self-esteem would depend on acceptance of negative attitudes toward the stigma. It should also be noted that one way of coping with stigma is to make the stigma peripheral to ones' self-concept. We would argue that this strategy is more likely to be successful for those individuals whose stigma is concealable and who are, hence, less likely to face the negative feedback and outcomes that stigmatized individuals generally endure.

Very little research has investigated the role of centrality of a stigmatizing condition or group membership to the self-concept as a moderator of the use of self-protective strategies. Some evidence relevant to this issue was provided by C. T. Miller (1984), who showed that the tendency to compare with gender ingroup members was related to gender schematicity. Individuals who are self-schematic with respect to gender are defined as those for whom gender is a centrally important and organizing component of the self-concept (cf. Bem, 1981; Markus, Crane, Bernstein, & Siladi, 1982). Miller found that individuals who were gender schematic compared themselves with same-sex others regardless of the relevance of gender to the dimension under evaluation. People who were gender aschematic, in contrast, compared themselves with same-sex others only when gender was related to the dimension under evaluation. We would predict that gender schematic individuals are also more likely to devalue outcomes on which their gender group fares poorly and (among women) to attribute negative outcomes to prejudice against their gender.[2] Similar predictions could be

[2] There is some controversy in the literature about the nature and consequences of gender schematicity (cf. Bem, 1981; Markus, Crane, Bernstein, & Siladi, 1982). The precise predictions one would make regarding the effects of gender schematicity on the use of these self-pro-

made for those who are self-schematic with regard to other stigmatizing conditions.

Token or Solo Status

In settings in which the stigmatized or oppressed have token or solo status (i.e., they are the only one or one of very few members of their category), two contradictory dynamics may operate to affect the use of self-protective strategies. First, the only standard for evaluating one's outcomes is provided by outgroup members, decreasing the viability of the ingroup comparison and devaluing strategies. With respect to social comparison, when the nonstigmatized are relatively advantaged, this setting forces painful self-esteem-lowering social comparisons on the stigmatized individual. In addition, the solo status individual lacks access to information about the relative performance of the ingroup versus the outgroup and, hence, should be less likely to devalue those dimensions on which the stigmatized group fares poorly, increasing the vulnerability of self-esteem.

However, because individuals with solo or token status are distinctive in their environment, they may also find their group membership particularly salient, both to the self (cf. McGuire & Padawer-Singer, 1976) and others (cf. Kanter, 1977b; Taylor & Fiske, 1978), thereby increasing the likelihood of identification as a member of that group. This may increase the salience of group membership as an attribution for personal negative outcomes, should they occur. However, unless the individual is able to observe that treatment covaries as a function of group membership, (i.e., could invoke prejudice or discrimination as a viable explanation for his or her own disadvantaged state), the cause of his or her own poorer outcomes could be ambiguous in such circumstances. Furthermore, the increased salience of group membership also makes the interpretation of positive feedback ambiguous. As noted previously, to the extent that positive feedback is seen as due to group status, it may be discounted, but when it is seen as occurring in spite of group status it may be augmented.

The preceding discussion implies that occupying positions of token or solo status may make stigmatized individuals vulnerable to lowered self-esteem if they are the recipient of negative feedback or compare unfavorably with the dominant group. We are unaware, however, of any evidence regarding this hypothesis. When the stigmatized are in solo status situations, even a small cohort of similarly stigmatized peers may be sufficient to enable self-protective strategies to function effectively (Pettigrew & Martin, 1987).

The moderating variables discussed earlier have general implications for the use of self-protective strategies among the stigmatized and for the effects of stigma on self-esteem. An additional set of moderating variables applies more specifically to the use of particular self-protective strategies.

Moderators of Self-Protective Attributions

People who believe that they personally are frequent victims of discrimination should be particularly likely to attribute negative outcomes or performance feedback to prejudice or discrimination against their group and, hence, may have high self-esteem. This prediction is contrary to the predictions of the looking-glass-self perspective, which predicts that awareness of prejudice will result in lower self-esteem among the stigmatized. It may be relatively uncommon for members of at least some stigmatized or oppressed groups to believe that they personally are victims of discrimination. For example, Crosby (1982) has found that although most women believe that women as a group are discriminated against, they do not believe that they personally have been victimized by discrimination. According to our analysis, these women should be vulnerable to low self-esteem when faced with negative outcomes (although note that the other self-protective properties of social stigma may continue to buffer self-esteem).

Second, our analysis suggests that overt prejudice or discrimination should be less damaging to the self-esteem of its targets than is prejudice or discrimination that is disguised or hidden behind a cloak of fairness. When one is faced with blatant prejudice or discrimination (e.g., "We don't hire women in our sales force"), it is clear that the proper attribution for negative outcomes is prejudice. However, in cases of disguised prejudice (e.g., when women and minorities are encouraged to apply for positions, but somehow are never deemed the best qualified candidate), it may be uncertain whether discrimination is the cause of negative outcomes for women and minorities. In these cases, the possibility of discrimination may not occur to most individuals (cf. Crosby, 1984). Note that although overt racial prejudice has declined over the past 20 years, disguised prejudice, termed "modern racism" (McConahay, 1986; Pettigrew & Martin, 1987), does not seem to be on the decline (see Gaertner & Dovidio, 1986, for a discussion). As we noted previously, the ambiguity surrounding both positive and negative treatment that may result from covert prejudice is problematical for the stigmatized individual.

Moderators of Ingroup Social Comparisons

Just as a recognizable group identity makes it easier for someone to stigmatize members of a group, so will that visibility make it easier for members of the group to identify one another, to affiliate with each other, and hence, to compare with ingroup members. Thus, we suggest that stigmatizing conditions that are either visually identifiable or clearly labeled or that lead to affiliation with ingroup members should facilitate ingroup comparisons. Specifically, stigmatizing conditions accompanied by a recognizable group identity may foster more frequent affiliation with similar others. For example, comparisons with ingroup members may be more prevalent among women, Blacks, mentally retarded people, and other group members who are identified and labeled early in life, than among those who suffer from more rare stigmatizing conditions or who are stigmatized by less visible or clearly labeled stigmas (e.g., epileptic individuals).

The beneficial effects of support groups for individuals who have been victimized may be due in large part to the ingroup social comparison opportunities such groups provide. Within such groups the salience of the stigma is reduced, and individuals are more likely to recognize and focus on other positive char-

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tective strategies depends on the version of gender schema theory to which one subscribes.

acteristics (Gibbons, 1986; Jones et al., 1984). Support groups also provide members with information that can help them cope with the stigma and its effects. Such groups may also provide a context for changing the "stigma" from a drawback to an asset, so that comparisons that were previously negative are now positive (Tajfel & Turner, 1986). A classic example of this is the "Black is beautiful" movement. Festinger (1954) speculated that members of minority groups should be more likely than members, of majority groups to seek support among themselves, and should be less tolerant of ingroup differences of opinion or ability relevant to the group.

Moderators of Selective Valuing

Some dimensions or attributes are more culturally valued in our society than are others and, hence, are more difficult to devalue. As a result, the devaluing strategy may be more effective for some types of stigmatized groups than for others. Harter (1986), for example, found that regardless of their own level of perceived competence in a particular domain, children found it difficult to discount the importance of cognitive competence, behavioral conduct, and physical appearance. All of these domains are highly valued and emphasized in elementary school settings. Hence, children who evaluated themselves poorly on these dimensions suffered from low self-esteem. Children were more able, however, to discount the importance of athletic performance and social acceptance if they did not regard themselves as particularly athletic or popular. Thus, devaluing may be a less viable strategy for members of certain stigmatized groups. For example, it may be difficult for mentally retarded persons to devalue intellectual achievement because so much emphasis is placed on cognitive competence in our culture. The other self-protective mechanisms, however, particularly the social comparison mechanism, may be effective alternatives. For example, social comparison processes have been shown to buffer the self-esteem of retarded individuals (cf. Gibbons, 1981; Harter, 1986).

Whereas the preceding discussion suggests that some dimensions may be chronically more valued in society than others, it is also the case that social contexts differ in the extent to which they stress or emphasize the importance of certain dimensions or attributes. For example, academic settings emphasize cognitive abilities, sporting events emphasize athletic prowess, certain work contexts stress toughness and aggressiveness, and the singles bar stresses physical attractiveness. A second implication of the devaluing mechanism is that the self-esteem of stigmatized or oppressed individuals may be particularly vulnerable when they find themselves in social contexts that provide strong messages that the attributes or performance dimensions on which they fare poorly are highly valued or that the dimensions on which they excel are not valued. As a consequence, stigmatized or oppressed individuals may avoid situations that emphasize the disadvantages of their stigma or remind them of their oppression. For example, obese and unfit persons may avoid the fitness and exercise club, and unattractive individuals may avoid the bar scene. One reason why association with similarly stigmatized others may be effective in protecting self-esteem is that such association provides a supportive context in which to emphasize and value alternative dimensions of the self unaffected by the stigma.

Negative Consequences of the Self-Protective Strategies

Although our discussion to this point has focused on the positive consequences of these self-protective mechanisms for self-esteem, they may also have several undesirable or negative consequences. Perhaps the most obvious negative consequence concerns the undermining effects each of these mechanisms has on motivation.

A pattern of devaluing domains or attributes on which one's group is disadvantaged has the potential to lead eventually to systematic group differences in aspirations, skills, and achievements, even when individual capabilities do not warrant these differences. It has long been recognized that motivation to achieve is a function of both the value of the goal and the perceived likelihood of attaining the goal (cf. Atkinson & Feather, 1966; Eccles, 1987). Thus, even though a person might be capable of performing competently in some domain, he or she will not be motivated to do so if he or she does not value the domain. Thus, the likelihood of attaining the goal will be imperiled. For example, Eccles (1987) has argued that gender differences in math achievement are, to a significant extent, due to differences in the instrumental value that girls and boys place on math.

Of course, even though a person may value some goal, he or she will not be particularly motivated to strive for it if the individual believes that there is no probability of attaining it. Furthermore, as Kanter (1977) and others have pointed out, blocked opportunities to attain a goal can decrease the perceived value of the goal, an argument that is consistent with our position here. Thus, a vicious cycle may be created in which discrimination and blocked opportunities in a particular domain lead to a devaluing of that domain to protect self-esteem, which may then produce decreased motivation to achieve in that domain. Any lack of achievement may then be erroneously interpreted by members of the majority, or nonstigmatized group, as reflecting a lack of ability or a lack of interest. For example, many observers of the absence of women in upper management positions have interpreted this as reflecting the inadequacies of women for these positions or their lack of interest in these positions, rather than as evidence of the structural barriers facing them (see Riger & Galligan, 1980, for a review). As a consequence, the majority group may feel justified in their exclusion of the stigmatized from certain domains.

The tendency to attribute negative outcomes or interpersonal feedback to prejudice against one's group may also undermine motivation. According to Abramson et al. (1978), the tendency to attribute negative events to causes that are external, stable, and global leads to "universal helplessness," which is associated with the motivational and cognitive deficits of depression but not with low self-esteem. Thus, to the extent that stigmatized individuals believe that prejudice (an external cause of negative events) is both widespread (global) and enduring (stable), they should be vulnerable to universal helplessness. The tendency to attribute positive feedback to group membership may also undermine motivation because such feedback is not seen as a true reflection of one's abilities.

A second negative consequence of attributing negative out-

comes to prejudice may occur when this strategy is overused (i.e., is used in conditions in which it is not objectively warranted). To the extent that negative performance feedback on dimensions that are controllable is attributed to prejudice, the stigmatized individual may miss opportunities to learn or improve.

The social comparison mechanism also has implications for motivation. Although the tendency to compare with ingroups may prevent painful comparisons with outgroup members and, hence, buffer the self-esteem of the stigmatized or oppressed, it may also lower one's motivation to improve and, hence, one's achievement. For example, controlling for individual ability, children who attend high-ability schools show somewhat higher performance on standardized tests than do children who attend low-ability schools (Marsh & Parker, 1984).

In addition to undermining motivation to improve one's individual performance, ingroup comparisons also undermine the motivation to effect social change. The tendency to make ingroup comparisons may result in a lack of knowledge of the extent of discrimination, thereby perpetuating a socially unjust system. Even if one is aware of discrimination, the tendency to regard only ingroup members as relevant comparisons may undermine the motivation to correct discrimination. Awareness of injustice and a desire to correct it are necessary to produce social change (cf. Martin, 1986).

Implications for Treatment of Stigmatizing Conditions

A final implication of the self-protective strategies concerns treatment for the stigmatizing condition. Although many stigmatizing conditions, such as racial, sexual, and ethnic group membership, are relatively immutable characteristics of the individual, some stigmatizing conditions, most obviously physically disfiguring conditions and obesity, are amenable to treatment through surgery, orthodontics, diet and exercise, and so on. Despite the obvious differences between these types of stigmas, consideration of the research on treating stigmas may reveal some further general principles of stigmatization.

It is frequently assumed that treatment has desirable psychological consequences for the stigmatized individual, particularly for self-esteem (see Shontz, 1977, 1982, for a discussion regarding physical disability). This assumption is consistent with the theoretical positions reviewed earlier, which predict that stigmatization leads to low self-esteem. Our analysis of the self-protective strategies used by members of stigmatized groups has implications for the consequences of treatment for self-esteem, as well as for who will seek treatment.

Consequences of Treatment for Self-Esteem and Self-Protection

One possible consequence of treating a stigmatizing condition is improved social interactions of the stigmatized individual. Research on the consequences of plastic surgery, for example, indicates that those who have been treated may be evaluated much more positively by others following treatment (cf. Macgregor et al., 1953). Hence, one might expect that individuals who have received treatment for disfiguring conditions or disabilities would show greatly enhanced self-esteem.

A second consequence of treating stigmatizing conditions, however, is removal of the self-protective mechanisms that stigmatization affords, as the following statement about the facially disfigured suggests

> When one removes this factor [i.e., disfiguring condition] by surgical repair, the patient is cast adrift from the more or less acceptable emotional protection it has offered and soon he finds, to his surprise and discomfort, that life is not all smooth sailing even for those with unblemished, "ordinary" faces. He is unprepared to cope with this situation without the support of a 'handicap'. (Baker & Smith, 1939, p. 303)

Furthermore, to the extent that one's outcomes actually do improve, these enhanced outcomes may be attributed to one's physical attractiveness, rather than to one's innate positive qualities (cf. Major et al., 1984). Consider the responses of this woman who had plastic surgery for her disfiguring condition:

> People did not like me before but now they've changed and become more friendly. I don't know whether to resent it or take it as a compliment. If you like a person, an external defect should not make any difference. I want to be liked for myself. (Macgregor et al., 1953, p. 36)

As this example illustrates, treatment for a stigmatizing condition may particularly undermine the attributional self-protective strategy of attributing negative outcomes to prejudice and augmenting positive outcomes. As a result, treatment for a stigmatizing condition may have the somewhat paradoxical effect of lowering self-esteem, at least temporarily.

Empirical research on the consequences of treatment of stigmatizing conditions for self-esteem is mixed. Whereas some studies show improved self-esteem following treatment for facial deformities (Arndt, Travis, Lefebvre, Niec, & Munro, 1986), others show no improvement (Burk, Zelen, & Terino, 1985), and still others show decreased self-esteem following treatment (Kiyak, Hohl, West, & McNeill, 1984; Tedesco, Albino, Lopes, Cornell, & Green, 1987). It is interesting to note that Kiyak et al. (1984) found that self-esteem went up in anticipation of surgery to correct developmental deformities, but decreased following the surgery, and 24 months later remained lower than initial levels. Just as the effects of a newly acquired stigma on self-esteem may depend on the length of time the victim has had to adjust to the stigma, the effects of treatment on self-esteem may also depend on passage of time and cognitive adaptation to the new, nonstigmatized self. When self-esteem suffers as a result of treatment, the effects may be transitory.

Seeking Treatment

When a stigmatizing condition can be treated, which individuals are particularly likely to take advantage of opportunities for treatment? Previous research on dental–facial deformities such as malocclusions (Albino et al., 1981) has suggested that the primary determinant of seeking treatment is the objective severity of one's stigmatizing condition. Holding objective severity constant, however, there remains enormous variance in who seeks treatment.

Although we know of no data on this point, we hypothesize that the individuals most likely to seek treatment for their stigmatizing condition are those who predominantly use the self-

protective strategy of attributing negative outcomes to prejudice against their group. Such individuals tend to see the stigmatizing condition as a major cause of their difficulties; hence, they may believe that treatment of the condition will greatly enhance their social or occupational outcomes. Individuals who predominantly use the strategy of devaluing, on the other hand, place little importance on the outcomes that they do not obtain as a result of their stigmatizing condition. Hence, we would suggest that these individuals are relatively unlikely to seek treatment for their stigmatizing condition. Similarly, stigmatized individuals who primarily compare with others who are similarly stigmatized (e.g., the mentally retarded) or with others who are even worse off, may not see their stigma as particularly severe or debilitating and, hence, may be less motivated to seek treatment.

Conclusions

Some additional questions about the use of the strategies remain. One concerns the interrelations among the strategies themselves. Are the strategies mutually exclusive, or can more than one strategy be used by a stigmatized individual in any particular circumstance? Consistent with Taylor's (1983) theory of cognitive adaptation to threatening events, we would suggest that people may be quite adept at using multiple strategies (Tesser, 1986) or at switching to a new strategy should one be undermined or discredited. The attributional strategy may be the most flexible because it is relatively easy to arrive at new explanations for events or outcomes (cf. Wortman & Dintzer, 1978), whereas the devaluing strategy, which involves changes in the self-concept, may be relatively resistant to change.

A second question concerns whether these mechanisms are self-protective, or whether they are self-presentation strategies, intended to enhance the impression the stigmatized individual makes in the eyes of others. The devaluing and attributional mechanisms, for example, might be effective impression-management strategies, providing others with reasons or excuses for one's poor outcomes. It is more difficult to interpret the social comparison mechanism as an impression-management strategy.

The tension between self-enhancement and impression-management interpretations of social psychological findings is a long-standing one. Tetlock and Manstead (1985) have convincingly argued that pitting self-enhancement and impression management interpretations against each other is unproductive, both theoretically and empirically, in part because behaviors that are intended to serve self-enhancement functions may also serve impression management functions, and vice versa. We share Tetlock and Manstead's position on this issue and would add only that although these strategies may sometimes be used in the service of impression management, our particular interest is in their self-enhancing properties and, in particular, their implications for global self-esteem.

A third issue concerns the extent to which the use of these strategies is motivated by the desire to protect or enhance self-esteem or is a more "accidental" information-processing consequence of membership in a stigmatized group. We have interchangeably used the terms *mechanism, property,* and *strategy* to describe these processes, reflecting our belief that these processes either may be used as strategies or may be unintended consequences of information processing. For example, attributing negative outcomes to prejudice may be a reasonable inference if one knows that one's group is discriminated against and sees that outcomes or performance feedback covary by group membership and need not reflect the motivation to protect the self. On the other hand, it is also possible that such attributions have the function of reducing negative affect or unpleasant states of arousal and, hence, are sometimes motivated by the desire for self-enhancement. Even if these processes are used as strategies of self-enhancement, stigmatized individuals need not be aware of using them as a strategy.

In general, empirical attempts to distinguish between cognitive and motivational explanations of apparently self-enhancing cognitions have been unsuccessful (see Tetlock & Levi, 1982, for a discussion). We would suggest that these processes may reflect either information-processing or self-enhancement processes, or both simultaneously. Empirical investigations of their arousal-reducing properties may shed further light on this issue. A consideration of the self-protective functions of social stigma can help to explain many anomalies in the literature on social stigma and self-esteem. First, the departure between earlier theoretical perspectives on stigma and self-esteem and empirical research is accounted for by the failure of earlier approaches to incorporate the active self-protective and self-esteem-maintaining strategies that are widely characteristic of the stigmatized and nonstigmatized alike, and the special opportunities for self-protection and self-enhancement afforded by membership in a stigmatized group. Furthermore, by considering the conditions that facilitate or inhibit the use of these self-protective strategies, we can begin to specify when stigmatized groups would be expected to have higher self-esteem than nonstigmatized groups, when they should be comparable in self-esteem, and when they should have lower self-esteem than nonstigmatized groups.

Finally, we wish to reemphasize a point we made earlier. Self-esteem is but one of many variables that are likely to be affected by prejudice and discrimination. Our somewhat optimistic position that stigmatized individuals are not merely passive victims but are frequently able actively to protect and buffer their self-esteem from prejudice and discrimination, should in no way be interpreted as an argument that prejudice and discrimination are not in other ways psychologically damaging.

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