Moving Toward or Away From a Group Identity:

Different Strategies for Coping with Pervasive Discrimination

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Being a member of a socially stigmatized group can entail considerable negative treatment and result in harm to well-being. Those who are stigmatized can find themselves overtly, or more subtly, rejected from a variety of important life domains, and experience discrimination in employment, housing, education, and outcomes received from the legal system, to name just a few. In some cases, those who are stigmatized may even be on the receiving end of public humiliation and disparaging media depictions that indicate that they are considered by others to be barely human. In this chapter we identify strategies that members of ethnic minority groups, women, the elderly, and people with physical disabilities employ in their efforts to cope with systematic discrimination. We also illustrate how the social context can influence which strategy is most likely to be favored by such targets of discrimination, and consider the implications of these different strategies for the psychological well-being of the individual and the group as a whole.

Considerable evidence has accumulated which shows that the more pervasive across time and contexts discriminatory treatment is, the greater the toll on the psychological and physical health of stigmatized group members (see Clark, Anderson, Clark, & Williams, 1999; Schmitt & Branscombe, 2002a). The devaluation that such discrimination reflects is an important stressor, which may help explain differences between stigmatized and non-stigmatized groups in a host of health outcomes (Clark et al., 1999; Contrada et al., 2000; Herek, Gillis, & Cogan, 1999; Krieger, 1990; Matheson & Anisman, 2009, this volume). Perceptions of the severity and frequency of discrimination

have been linked with lower psychological well-being on measures of self-directed

negative affect such as depression and self-esteem in a wide variety of social groups

including: women (Dambrun, 2007; Klonoff, Landrine, & Campbell, 2000; Schmitt,

Branscombe, Kobrynowicz, & Owen, 2002), African Americans (Branscombe, Schmitt, &

Harvey, 1999; Williams, Neighbors, & Jackson, 2003), Latino Americans (Armenta &

Hunt, 2009), Jewish Canadians (Dion & Earn, 1975), gays and lesbians (Herek et al.,

1999), international students (Schmitt, Spears, & Branscombe, 2003), and immigrants in

several different national contexts (Bourguignon, Seron, Yzerbyt, & Herman, 2006;

Jasinskaja-Lahti, Liebkind, & Perhoniemi, 2006).

In addition to such correlational evidence, experiments in which stigmatized

individuals are exposed to a single discriminatory outcome from another individual who is

prejudiced against their group also demonstrate that this can undermine psychological well-

being, with the degree of harm depending on the extent to which the experience is seen as

reflecting social conditions that are likely to be encountered again in the future (see

Schmitt, Branscombe, & Postmes, 2003). So, for example, not only do women who

experience more pervasive discrimination report worse negative affect following a

discriminatory outcome than men who experience gender discrimination infrequently

(Schmitt & Branscombe, 2002b), but when women attribute a single negative outcome to

pervasive discrimination their self-esteem suffers more than when they attribute that same

negative outcome to an isolated instance of discrimination (Schmitt et al., 2003). Thus, the

evidence is clear that experiencing discrimination that is perceived as pervasive harms self-

directed affect (i.e., people's positive feelings about themselves)—and this is the case

regardless of whether that perception stems from a single discriminatory event or it

represents a summary of the perceiver's past experiences and expectations of future discriminatory treatment.

Individualistic and Collective Coping Strategies

In this chapter we examine different strategies for coping with discrimination and devaluation that members of socially stigmatized groups employ—both individualistic and collective means—and their consequences for psychological well-being. We define individualistic strategies as those primarily aimed at protecting the stigmatized individual's personal self, which can be accomplished by either figuratively or literally leaving the stigmatized group. Such abandonment of one's stigmatized group can be personally protective of well-being by minimizing the likelihood of future discrimination based on that identity. To the extent that the individual successfully dissociates the self from an identity that elicits discrimination, and thereby avoids the source of suffering, the individual's well-being may be protected, even though the stigmatized group as a whole continues to be a target of discrimination. In contrast, collective strategies do not minimize the likelihood of future painful discrimination. Rather, reliance on one's group identity— indeed, taking pride in one's fellow groups members' ability to cope with and potentially overcome the discrimination directed toward the group—can protect well-being when discrimination is experienced. We describe evidence supporting the "adaptive" value of both individualistic and collective strategies, in terms of helping to alleviate the harm of experiencing discrimination, and illustrate how the means by which that protection is achieved can differ.

The consequences for the stigmatized group as a whole depends on whether its members systematically favor one strategy over the other. As Tajfel (1982) noted some

time ago, in contrast to the "self-hatred hypothesis" (Allport, 1954; Fanon, 1952; Lewin, 1948), members of stigmatized groups, even those facing severe devaluation, rarely simply internalize the dominant group's view of their group (see also Crocker & Major, 1989). Rather, those who are stigmatized can cope with their predicament in a range of ways, with different strategies being preferred depending on whether an alternative to the existing status relations can be envisioned or not. When stigmatized group members cannot imagine their group's position improving, individual stigmatized group members may be tempted to cope as individuals. In contrast, when members of the stigmatized group can imagine different relations existing between the groups, then stigmatized group members will be more likely to join forces with others with whom they share a common fate and attempt to work collectively to improve the position of their group as a whole.

The individualistic strategy that we consider—that of social mobility—involves attempting literally to leave the stigmatized group or, at a minimum, hide one's true group membership and "pass" as a non-stigmatized group member. By definition, this strategy for coping with stigma involves moving away from one's devalued group and, often, entails seeking acceptance among the majority. In contrast, the collective strategy for coping with discrimination that we consider involves increasingly moving toward and identifying with the stigmatized group, which is frequently reflected in greater contact with other members of the stigmatized group.

Using social identity theory (Tajfel & Turner, 1986) and the appraisal theory of stress and coping (Lazarus & Folkman, 1984) we argue that favoring an individualistic option in terms of attempting to leave the stigmatized group depends, in part, on appraisals of whether doing so will limit the individual's exposure to further harmful discrimination.

When the option of leaving the group is not feasible or desired, stigmatized group members can cope with the discrimination they encounter by moving closer to their group—by increasingly identifying with other stigmatized group members. Thus, when faced with pervasive discrimination, psychological well-being can be protected in either of two ways—by moving toward or away from a stigmatized group identity, with social structural conditions affecting which option is likely to be chosen.

Use of these two different strategies is not without consequences for the group as a whole. Branscombe and Ellemers (1998) described ways in which individualistic coping strategies can improve the individual's personal status and well-being, but do little to change the overall conditions of the devalued group. In contrast, employing a collective coping strategy has the potential to elevate the status of the group as a whole and ultimately change the existing relations between groups; but it too is not without risks. By increasingly moving toward the stigmatized group identity, there is the risk of being further marginalized from the mainstream and only feeling "safe" in the presence of other ingroup members (see Tatum, 1997). In other words, "seeking separatism" may limit the contexts in which discrimination is experienced *and* provide valued group members to rely on for solace when discrimination is encountered, but this strategy may also involve giving up rewards and opportunities that come from navigating and living within the mainstream world (see Postmes & Branscombe, 2002). Furthermore, when stigmatized group members give public indications that their stigmatized group identity is valued, there is an implied willingness to confront the dominant group's higher status position, and this may result in even more hostile reactions on the part of dominant group members. When stigmatized

group members seek equality through social change, they frequently encounter resistance and increased oppression from the dominant group, at least initially.

Although some researchers have suggested that devalued group members prefer individualistic coping strategies such as disengaging from the lower status group and attempting to gain entrance into the higher status group (Miller & Kaiser, 2001; Wright & Tropp, 2002), this may be most likely for those whose stigma can be easily hidden, and by those who experience discrimination infrequently, or in a limited set of contexts in which the exclusion may even be perceived as somewhat legitimate (e.g., young people being ineligible for certain age-based privileges and therefore attempting to 'pass' as older than they are). Stigmatized group members are most likely to prefer collective coping strategies when the group's subordinate position and the discrimination experienced is perceived as illegitimate, pervasive, difficult to avoid, and when disadvantaged group members believe their group's status can be improved by direct competition with the dominant group for social value (i.e., when the existing status relations are unstable) (Tajfel & Turner, 1986). In this chapter we will identify how additional aspects of the existing social structural context can affect which of these two distinct types of strategies are most likely to be employed by members of stigmatized groups in response to the stress of devaluation and discrimination.

Importance of the Social Structural Context

The social context that different stigmatized groups find themselves in has important implications for the coping strategy used—individualistic or collective—when confronted with discrimination. Some theorists argue that disadvantaged groups only identify with their group and seek social change on behalf of their group when individual

mobility is almost completely impossible (Taylor & McKirnan, 1984). Certainly pervasive discrimination when *imposed* on a stigmatized group—in terms of physical and social segregation—is likely to result in greater minority group identification and perception of the relations between the groups in hostile intergroup terms. Consistent with this hypothesis, research has revealed that African Americans who have had to contend with racially segregated schooling and housing, and whose social relationships are also relatively segregated, report perceiving White Americans in intergroup terms, feeling greater hostility toward Whites, and experiencing more discrimination than those who have spent their lives in more racially integrated life contexts (Branscombe et al., 1999; Postmes & Branscombe, 2002).

In fact, a different psychological risk is faced by African Americans attempting to navigate their lives in primarily White worlds. Minorities attempting to assimilate or at least navigate within White worlds, or who otherwise find themselves in contexts in which they are few in numbers (sometimes tokens) risk feeling (and being) rejected by members of their own group. Such rejection—reflecting the perception that the individual is insufficiently loyal to their minority ingroup—is no less painful than rejection by the dominant group (Postmes & Branscombe, 2002). Indeed, perceived ingroup rejection might have even more negative psychological consequences than discrimination on the part of the dominant group because it blocks the individual's ability to cope in terms of increased minority group identification. When people feel rejected by their ingroup, they are unlikely to respond with greater ingroup identification; feeling rejected by one's minority group is, instead, likely to encourage greater movement toward and identification with the dominant

group. Thus, perceived ingroup rejection can block an important coping option for devalued group members, and encourage greater use of individualistic strategies.

Pervasive Discrimination

Perceiving pervasive discrimination can encourage greater alignment with the minority group because unfair treatment based on group membership represents rejection from the dominant society and means that the individual is unable to exert control over current and future outcomes. Increasing identification with one's stigmatized group represents an adaptive strategy in the face of pervasive discrimination because those who share one's stigma can be counted on to not reject the individual on that basis. A number of correlational and experimental studies have illustrated the 'rejection-identification-well-being protection' process (see Branscombe et al., 1999; Schmitt & Branscombe, 2002a). For example, when people are led to believe that they will be discriminated against in the future because of their subcultural group membership (i.e., having visible body piercings), they identify more strongly with others who share their category membership compared to when little discrimination in the future is expected (Jetten, Branscombe, Schmitt, & Spears, 2001). Likewise, when women in gender-segregated workplaces consider the negative treatment they experience at work to arise because they are women, they report greater identification with their gender group than when they do not consider discrimination as the reason for their negative experience or are in gender-integrated workplaces (Redersdorff, Martinot, & Branscombe, 2004). Thus, social conditions reflecting pervasive discrimination can certainly push disadvantaged group members toward a more collective psychological response—in part by blocking any perceived chance of individual mobility or the possibility of avoiding future painful discrimination.

Time Course of Discrimination Experiences

There are additional social structural factors, besides the degree to which discrimination is pervasive, that can affect people's likelihood of coping via increased identification with their stigmatized group. Even if discrimination is a relatively frequent occurrence in the present, if it is also seen as likely to be minimal in the future, greater identification with the stigmatized group may be unlikely to develop. Consider the responses exhibited by young and elderly people, both of whom report experiencing discrimination based on their age group membership (Garstka, Schmitt, Branscombe, & Hummert, 2004). A key factor for understanding why these two age groups respond differently to the discrimination that they experience is that these groups differ in the permanence of their membership in their devalued age group. For young people, the group boundaries are relatively permeable, but they are relatively impermeable for the elderly. Indeed, individual upward mobility to the higher status middle-aged group is effortless and inevitable for young adults, whereas movement back in age to the higher status middle-aged group is impossible for the elderly (see also Jetten & Pachana, this volume).

Given that the discrimination experienced by the elderly is likely to be seen as unavoidable and a negative consequence of a group membership they have little chance of leaving, the elderly should favor group identification as a means of coping. In contrast, among young adults, who can look forward to the cessation of the forms of discrimination they report experiencing (e.g., age restrictions on voting, alcohol use, driving and marriage rights) when certain chronological age markers are attained (e.g., reaching 18 or 21 years), they should favor individual mobility and not respond to discrimination with greater age group identification. This is precisely the pattern of effects that was obtained in research

with young and elderly adults (Garstka et al., 2004). Perceived discrimination did not predict group identification in young adults, but it did do so for elderly adults. In fact, overall, the elderly showed greater identification with their group than did young adults, and group identification was more strongly predictive of positive psychological well-being among the elderly than it was among young adults.

This research with different age groups provides clear evidence that being a member of a stigmatized or low status group does not alone determine whether group identification will serve as a way of coping with discrimination. The young and the elderly reported having similar low status compared to middle-aged adults, and experiencing similar levels of age discrimination. Yet it was primarily among the elderly that the negative psychological well-being effects of that discrimination were observed, and only among the elderly did group identification increase in response to perceived rejection based on their age. Thus, permanent group memberships—where individual mobility is completely blocked—are particularly likely to evoke collective responses. Moreover, when such stigma inescapability is coupled with a sense of collective efficacy to achieve social change, it is likely to be reflected in changes in the group identity itself (e.g., shifts from "the elderly" to "grey panthers").

Changing Contexts and Acquiring a Group Identity Across Time

When stigmatized groups expect to assimilate into the mainstream, as do Latino Americans who attend college (Deaux & Ethier, 1998; Sears, 2008), discrimination may be perceived as something that can be avoided in the future by conforming to mainstream social norms. Yet over time, as Latino Americans enter primarily White worlds—such as prestigious universities—they may come to realize that assimilation is more difficult than

they previously thought. Moreover, as these minority group members increasingly perceive discrimination as pervasive across contexts, regardless of individual efforts to assimilate to mainstream norms, perceived discrimination may come to be experienced as a critical barrier to their ability to move upward. Ultimately perception that their ethnic minority group membership cannot be overcome and will prevent assimilation, can result in the strengthening of a minority group identity, and, for some, a politicized minority group identity may develop over time (Simon & Klandermans, 2001).

To explore these ideas, we conducted a study with Latino students from Los Angeles County (Cronin, Levin, Branscombe, Tropp, & Van Laar, 2010). Although these students have primarily spent their early schooling in Latino-majority environments, they had just entered University of California at Los Angeles (UCLA) where they were a numerical minority. Among these students, perceived discrimination based on their ethnicity predicted greater minority group identification, which in turn positively predicted these Latino students' well-being during both their first and fourth years. Perceived discrimination also had a direct negative effect on Latino students' well-being during their fourth year, but not during their first year. Ethnic identification was a mediator of the relationship between perceived discrimination and well-being in the fourth year. By their fourth year in a White university environment, these Latino students exhibited all the components of the rejection–identification model, where greater perceived discrimination resulted in poorer well-being, but this negative effect of discrimination was partially alleviated to the extent that their Latino identification had strengthened. These findings with Latino students, navigating in a White institution for the first time, are consistent with other recent longitudinal research (Ramos, Cassidy, Reicher, & Haslam, 2010) which found

that international students at Scottish universities who similarly began by favoring an assimilation acculturation strategy displayed the rejection–identification pattern in response to perceived discrimination over time.

According to Taylor and McKirnan (1984), it is largely failed attempts at gaining entrance into the higher status group that lead to collective strategies as a response to disadvantage. Consistent with this idea, we found that for Latino students in the UCLA sample, it did take some time for these students to recognize the negative implications of discrimination for their future and for it to harm their self-esteem. When these negative effects were recognized, the rejection experienced on the basis of their ethnic group membership during their earlier years of study resulted in greater identification with their minority group and this served to protect their subsequent well-being. Perhaps after having expended futile energy in attempts to fully assimilate—toward the end of their educational experience they realized that complete acceptance was unlikely and that it was not possible to individually overcome discrimination in such White-dominated settings. As a result, across time they developed an adaptive response to perceived pervasive discrimination and turned toward their ethnic group as a means of alleviating the harm sustained to their well-being.

Structural Conditions Can Affect Coping Strategy Use Within a Single Stigmatized Group

The case of people with skeletal dysplasias that cause disproportionate short stature (dwarfism) is an interesting example of how structural factors in a given social context can influence the coping strategies of groups with a physical disability stigma. In a multi-nation study we investigated how people with skeletal dysplasias—a rare genetic condition

affecting the development of the long bones—cope with the severe discrimination that they experience (Fernández, Branscombe, Gómez, & Morales, 2010).

The most common type of skeletal dysplasia that causes dwarfism is achondroplasia, with an estimated prevalence in the population of 1 in 26,000 births (Thompson, Shakespeare, & Wright, 2008). People with achondroplasia have abnormally short stature; their limbs are short in contrast to relatively normal-sized heads and trunks. Although there are several physical and medical difficulties associated with the condition, affected individuals are mobile on their own, score average on intelligence tests, and have an average life span (Gollust, Thompson, Gooding, & Biesecker, 2003; Trotter & Hall, 2005). Nonetheless, dwarfism is a socially stigmatized condition that tends to evoke particularly high levels of intergroup anxiety and social distancing in majority group members (Fernández, 2009).

Several factors make this group an interesting one in which to investigate the role of contextual factors that might influence the process of coping with social stigmatization. Due to the low prevalence of the condition and the absence of other affected individuals in the family—more than 80% of cases are due to a spontaneous genetic mutation that appears in families with no history of skeletal dysplasias—people with dwarfism are geographically widely dispersed. As a result, individuals with dwarfism are usually the only person with that physical condition in their near environment (i.e., the only affected person in their school, neighborhood, or town). Because of this isolation from others who share their condition, and the severe social stigma associated with it, for people with dwarfism rejection is often an individualistic experience. In this sense, it is easy for people with dwarfism to feel more like a *deviant* (i.e., individuals who are rejected by members of their

own group) rather than as members of a *classical minority* (i.e., groups that experience

rejection from outgroup members) (see Jetten, Branscombe, & Spears, 2006).

Another reason why people with dwarfism are especially informative for studying

the processes involved in coping with devaluation is that within this population there is the

possibility for young people with achondroplasia to undergo limb-lengthening surgery

(LLS) and gain up to 30 cm extra length in their lower limbs and 14 cm in their upper

limbs. LLS therefore, to some extent, can permit people with dwarfism to conceal their

stigmatized condition, which could be considered an individualistic strategy for coping

with severe and pervasive discrimination. However, LLS is a controversial issue within the

community of people with achondroplasia, and not all those with the condition decide to

undergo LLS.

One reason for the controversy is that the lengthening process is intensive and

requires several surgical interventions and long rehabilitation periods during which serious

complications can arise. Moreover, because the process must begin at a young age—

usually before 10 years old—the decision to undergo LLS is strongly influenced by the

parents of an affected individual. Consequently, surgery may be seen as an attempt by

parents to protect themselves and their child from the harmful effects of anticipated

discrimination based on this stigma, as much as a coping strategy selected by the actual

recipients of the discrimination. In addition, the fact that LLS can be seen as an attempt to

conceal the condition is probably another important reason why it is controversial within

the dwarfism community. Although it is by no means certain that LLS fully enables

"successful passing" for those with dwarfism (because there are other subtle physical cues

to the condition), it is almost certain that attempting to conceal the condition will make it more difficult to form a positive social identity based on this group membership.

It is particularly noteworthy that LLS is a *less* popular practice in the US than in many other countries (Trotter & Hall, 2005). Given that the US is typically seen to be characterized by its extreme individualism (e.g., Triandis, 1994), it might seem ironic that the individualistic strategy of LLS is least likely to be employed by those with dwarfism in the US. In contrast, in Spain, which has been described as a relatively collectivist country, LLS is now almost uniformly performed on children with achondroplasia (Alonso-Alvarez, 2007).

There are several economic and identity-relevant reasons why use of LLS by people with dwarfism differs across these two national contexts. The different health care systems—a publicly funded national one in Spain vs. a private system in the US—is undoubtedly an important factor. However, there are other important social psychological factors that influence the prevailing attitudes toward dwarfism in each country and that contribute to the differential use of LLS in these two national contexts. We argue that one of the crucial factors is the presence of different norms in relevant institutions. That is, in the US since 1957 there has been a large and active organization of people with dwarfism (e.g., "Little People of America" or LPA). LPA is an organization whose mission is to "improve the quality of life for people with dwarfism *while celebrating with great pride Little People's contribution to social diversity"* (from LPA's mission statement; emphasis added). A close examination of the LPA website shows that, in fact, their activities, their statements and positions about issues related to dwarfism, and even the motifs used on their website (e.g., lively photos of non-enlarged people with dwarfism communicating positive

feelings about their bodies) reflect a transformation of identity from "those with a genetic mutation causing dwarfism" to "Little People." Furthermore, and at least as important, the existence of LPA has facilitated contact between adults with dwarfism in the US.

In Spain, on the other hand, the comparison organization of people with dwarfism (ALPE-Achondroplasia Foundation) was created relatively recently, in 2000. ALPE's agenda is to assist and support the families and people with dwarfism. ALPE, like LPA, aims to improve the quality of life of people with dwarfism and it also provides information and services to affected individuals and their families. However, consistent with our hypothesis that institutional norms can affect coping strategy preferences, there are some subtle but important differences between ALPE and LPA which parallel the differential use of individualistic versus group-based strategies among people with dwarfism in each country. For example, one interesting difference between these organizations is the support that ALPE provides for genetic research, which is aimed at ensuring that people who are born with the genetic mutation that produces skeletal dysplasias are provided with available treatments to develop and lengthen their bones. Indeed, such genetic and medical research projects *have as their goal the elimination of dwarfism*. In contrast, such research is neither publicized, nor is it officially supported, by LPA. Moreover, while the position of ALPE toward LLS is clearly favorable, LPA spends little time on the issue and when it is mentioned, the organization is considerably more skeptical about the value of this surgery. We think these visibly observable differential approaches within each of these national organizations are good indicators of two rather different norms for how the stigma of dwarfism is best coped with.

In order to investigate the extent to which these organizational and structural differences observed between Spain and the US are reflected in how people with dwarfism cope with the social stigma of the condition, coping and well-being data were collected from people with dwarfism in both countries (Fernández et al., 2010). The results illustrate important differences in the coping strategies that prevail in each of these national contexts. In the Spanish sample of people with dwarfism, there was significantly more use of LLS than in the American sample. Interestingly, in Spain height predicted the extent to which people with dwarfism reported feeling socially excluded, ostracized and derogated by others due to their physical condition—with those who were taller reporting lower levels of such treatment than those who were shorter. In other words, in Spain, those who did have LLS to increase their height, reported experiencing less discrimination than those who did not do so, whereas in the US this path between height and lower discrimination was absent because very few people had chosen to have such surgery to gain greater height. In both countries, the extent to which participants reported experiencing discrimination based on their physical condition negatively predicted quality of life. However, in the American sample, having positive contact with other members of the ingroup (i.e., other people with dwarfism) buffered the negative effect of discrimination experiences on quality of life, although this was not the case in Spain.

These results suggest that in Spain a more individualistic coping strategy based on LLS prevails, while in the US a collective strategy involving greater positive contact with other ingroup members is preferred. It is interesting to note that the study revealed no overall difference in the quality of life reported in the Spanish and American samples, suggesting that both strategies can be effective at protecting psychological well-being.

Individual social mobility—favored in Spain—protects well-being by decreasing the likelihood of the individual experiencing discrimination, whereas group-based strategies protect well-being—and are favored in the US—because they provide solace when discrimination that is difficult to avoid is encountered.

Thus, social structural conditions can afford people the opportunity to cope with stigma by either moving toward the group or away from the group. The group that officially represents people with dwarfism (LPA) in the US has not only been in existence for some time, it is organized by adults with dwarfism rather than the parents of children with dwarfism as is the case in Spain. LPA facilitates long-distance contact among its members, and has clear norms that are supportive of strong identification with others who share the stigmatized condition. For these reasons alone, it is not surprising that formation of a positive identity as a "little person" in the American sample proved to be an important means of coping with discrimination. In addition, in the US case, there is little ability to leave the stigmatized group—because LLS is not supported by the group and is not affordable or widely available within the American health care system. In Spain, where it is possible to leave the stigmatized group via LLS—because it is both financially feasible and is favored by the affected individual's own family and the national organization representing the group—people with dwarfism appear to cope with discrimination by attempting to avoid the discrimination by masking their stigmatized condition. Both of these strategies—individualistic and collective—appear to be adaptive for individual members of stigmatized groups in terms of protecting their well-being—with strategy preference depending on the structural conditions in which the stigmatized find themselves.

Disadvantages of Individualistic Versus Collective Coping Strategies

While attempting to leave one's stigmatized group, even through extreme measures such as surgery, has the potential virtue of lessening the personal experience of discrimination, it continues to make clear that one's stigmatized group membership is fundamentally devalued in the wider society. To the extent that exiting the stigmatized group is successful, those individuals who do engage in social mobility may suffer less from discriminatory outcomes. Nevertheless, they may continue to be exposed to others' derogatory attitudes toward their stigmatized group. Consider the plight of gay and lesbian members of the American military under the current policy of "don't ask, don't tell." Although concealing one's homosexual identity can prevent what is ostensibly the worst outcome from occurring—losing one's job and being dismissed from a valued institution— it also undermines the formation of a positive group identity. Furthermore, there is evidence that individuals who attempt to conceal a devalued group membership have lower self-confidence and report more guilt and shame than participants who do not conceal their devalued group membership (Barreto, Ellemers, & Banal, 2006). Indeed, attempting to conceal one's stigmatized group identity (e.g., having AIDS) predicts more rapid HIV disease progression and death (Cole, Kemeny, Taylor, Visscher, & Fahey, 1996). Thus, although avoiding discrimination may have some immediate benefits, even among people with HIV disease (Molero, Fuster, Jetten, & Moriano, in press), failure to identify with and reach out to members of one's own group can also have critical and negative health consequences.

As we suggested earlier, coping with devaluation by moving toward a stigmatized identity and increasing one's investment in that group identity is not without potential

disadvantages. Doing so could be seen as the pathway to separatism, which can entail both economic and social costs for stigmatized group members. But it is also—through constructive engagement with the dominant group's values—a critical step toward changing the status relations between groups. Certainly the ability to conceal one's group membership will not be feasible for all devalued groups, nor will it be deemed desirable, even if available. For many members of disadvantaged groups, despite the potential costs of identifying with and acting collectively on behalf of their group, abandoning or disengaging from it is simply inconceivable.

Conclusions

Across diverse stigmatized groups—from women, who constitute a numerical majority, to people with a specific physical stigma such as dwarfism who constitute a small minority—perceiving and experiencing pervasive discrimination has negative implications for psychological well-being. How the threat stemming from group-based devaluation is most likely to be managed—in terms of moving toward or away from the devalued identity—depends on aspects of the social structural context. We presented evidence that both individualistic and group-based responses in the face of discrimination can be adaptive *in the sense of protecting the individual's well-being*. But, how that protection is achieved— by either moving toward or away from a group identity—reflects different strategies that have implications for the likelihood of change occurring in terms of the status position of the devalued group as a whole.

Each of the following conditions are likely to *tempt* stigmatized group members to move away from their group identity: 1) when discrimination is seen as limited to particular contexts or period in the life of the individual, 2) when the differential treatment

is seen as having some legitimacy, 3) when there is little contact with other ingroup members who share the stigma, or 4) when existing social conditions are perceived as impossible to change but the stigma itself can be concealed. In such circumstances, people may be inclined to perceive the group identity as the problem and therefore focus on minimizing their exposure to discrimination based on it. This can be accomplished by attempting to figuratively or literally change group memberships in order to prevent the discrimination itself, and its painful implications. Thus, by moving away from their stigmatized group identity, individuals may lessen the likelihood that they will continue to experience discrimination on that basis. By pursuing this strategy, however, the situation of the group as a whole will go unchanged.

On the other hand, when a stigmatized group membership cannot be hidden and pervasive discrimination cannot be avoided, research has revealed that the primary means by which members of a host of devalued groups protect their well-being is by increasingly moving toward their stigmatized group identity. Indeed, doing so is the critical means by which the devalued can convert their 'mark of shame' into a 'badge of honor.' We consider movement toward stigmatized group identities as consistent with the "social cure" for two reasons. First, others who share one's stigmatized group identity serve as a coping resource when the stressor of discrimination and devaluation are experienced. As a result, psychologically, the individual is no longer alone. Indeed, research has thus far revealed this to be the *only replicable mechanism by which the psychological harm stemming from discrimination can be alleviated.* Second, it is through identification with one's stigmatized group and taking pride in one's group (including its ability to withstand the injustice of discrimination) that hope for a more just future can be achieved. Coupled with a sense of

efficacy to bring about such social change, group identities—even those that are devalued in the broader society—can lead to actions aimed at improving the position of the group as a whole.

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