



Social Stigma and its Consequences for the Socially Stigmatized

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Abstract

This paper presents an integrative review of current and classic theory and research on social stigma and its consequences for the socially stigmatized. Specific attention is paid to stigma-related processes surrounding race/ethnicity, gender, and sexual orientation. The origins and perpetration of social stigma are discussed alongside perspectives on how stigmatized groups and individuals experience stigma-related stress. Consideration is given to responses to stigma in the form of coping, social support, and meaning-making processes. Both the potential negative and positive consequences of social stigma are highlighted in this review through the integration of predominant social psychological theory with emerging critical and feminist theories of positive marginality and resistance. The paper culminates in a theoretical process model designed to provoke future theory and research that share its integrative aims.

Overview

This article presents an integrative theoretical overview of classic and current perspectives on social stigma from psychology and related disciplines. Drawing mainly on current theories of stigma across race/ethnicity, gender, and sexual orientation, I attempt to join together models of the perpetration of stigma with models of the target's experience of stigma. I also aim to integrate findings from research on the negative consequences of stigma with work stemming from critical psychological and feminist perspectives on positive marginality. Going forward, I aim to distinguish between processes that *stigmatize* and the experiences of the *stigmatized*, all the while recognizing that these experiences are deeply embedded within one another and not entirely separable. Doing so gives rise to a critical social psychological perspective on social stigma and its many and varied consequences for the socially stigmatized.

The Perpetration of Social Stigma

Stigma

Goffman (1963) defined stigma as an attribute that can be deeply discrediting, which reduces whole persons to tainted and discounted others. Goffman's classic definition begins with the attribute as the source of discreditation; however, more recent definitions of stigma explicitly adopt a social constructivist frame. For example, Herek (2009a,b) defines stigma as “the negative regard, inferior status, and relative powerlessness that society collectively accords to people who possess a particular characteristic or belong to a particular group or category” (p. 441). This shift moves the source of stigma out of the bodies and identities of the stigmatized and places the origins of stigma at the societal

level (Fine & Asch, 1988). Meanings inherent to social stigmas are nested within historical contexts, and their meanings can change over time (e.g., Cross, 1991; Savin-Williams, 2005). Stigma is not limited to numerical minorities; yet stigma originates and is perpetuated by those with power against others with less power (Link & Phelan, 2001). Once established, social stigma manifests in a myriad of conceptually distinct stigma-related processes, which are outlined below.

Structural inequalities

Laws, policies, religions, and other institutional structures are constructed in ways that reflect the negative meanings attached to stigmatized groups and individuals. The rights, freedoms, and resources of the stigmatized are limited compared to the non-stigmatized. Structural inequalities both stem from and perpetuate social stigma by reinforcing negative connotations of stigmatized groups via limiting their participation in society. If certain groups are prevented from fully participating in society, their social status will remain 'less than' non-stigmatized groups, which is often perceived as legitimizing prevailing social stigma. Those who are allowed full participation in society become established as normal, and those who do not are othered and marginalized (Herek, 2007).

Stereotypes and prejudice

Stereotypes and prejudice exist at the psychological level and are often the product of social stigma. *Stereotypes* represent commonly held generalizations about qualities of people based on their membership in stigmatized groups or possession of a stigmatized attribute (Allport, 1954; Devine, 1989). Stereotypes are known by most people within a given culture due to the underlying stigma from which they stem. Although most people may be aware of a given stereotype, they may not necessarily personally believe the stereotype to be true (Devine, 1989). *Prejudice* occurs when people believe a stereotype to be true and apply its corresponding generalizations in their attitudes and judgments of others to whom the stereotype corresponds (Allport, 1954; Devine, 1989). Thus, stereotypes and prejudice are interrelated, though distinct, psychological processes stemming from social stigma. Prejudice is complex: it does not always operate at the conscious level (Greenwald & Banaji, 1995). Given stigma is ingrained within multiple aspects of societies, implicit forms of prejudice operate outside of people's awareness that can shape their behavior toward the stigmatized in unintended ways.

Discrimination

Prejudice can, though not always, result in *discrimination*. Discrimination refers to instances when people or groups are denied equality and treated differently because of their stigmatized status (Allport, 1954; Major & O'Brien, 2005). Discrimination can occur at the institutional level, as described above, as well as at the interpersonal level (Frost, 2011b; Major & O'Brien, 2005). Furthermore, As it becomes increasingly socially unacceptable to act in overtly discriminatory ways, 'modern' racism and sexism persist in which stigmatized people are avoided or excluded in the absence of an individual's or institution's explicit endorsement of racist or sexist attitudes (McConahay, 1983; Swim, Aikin, Hall, & Hunter, 1995; Swim & Cohen, 1997). Discrimination brings the current discussion closest to the experiences of those people and groups who are targets of stigma.

Experiences of Stigma

Although the first wave of social psychological work on stigma focused mainly on the perpetration of stigma, there has been an increase in research on how people and groups that are stigmatized experience the effects of stigma (Swim & Stangor, 1998). Recent efforts have focused on how experiences of stigma confer excess social stress for stigmatized people, which can produce a myriad of negative consequences. Social stressors are factors or conditions that require an individual to adapt to changes intrapersonally, interpersonally, or in his or her environment (Meyer, 2003a; Pearlin, 1999).

Stigma-related stress

Much of the work on stigma-related stress has been done with regard to racial/ethnic minorities' experiences of racial discrimination stress (Clark, Anderson, Clark, & Williams, 1999) and sexual minorities' experiences of sexual minority stress (Meyer, 2003a,b). I draw mainly from Meyer's model of minority stress (Meyer, 2003a,b) in the sections that follow in an attempt to extend this model of stigma-related stress to account for the experiences of multiple and varied stigmatized experiences. Although experiences of racial, gender, and sexual minority stigmas are discussed separately below, they are not always mutually exclusive, and many experience stigma at the intersections of multiple stigmatized identities (cf. Bowleg, 2008; Collins, von Unger, & Armbrister, 2008; Meyer, 2010; Meyer, Dietrich, & Schwartz, 2008; Meyer, Schwartz, & Frost, 2008).

Stressful life events. Stigma-related stressors can take the form of event-based experiences of discrimination (Meyer, 2003a). Stigma-related stressful life events are acute stressors in that they occur relatively infrequently (compared to other stressors) and tend to stem from an isolated event. These manifest in direct experiences discrimination or other events brought on by prejudice. Hate crimes are a prime example of stigma-related stressful life events, and occur when a person or group is targeted, usually for assault or harassment, because of a stigmatized status or identity (Herek, 2009b; King, Messner, & Bailer, 2009). Other stigma-related stressful life events include being fired from a job because of one's race/ethnicity, gender, and/or sexual orientation. Stigma-related stressful life events, when they occur repeatedly over an extended period of time (e.g., bullying), can produce chronic stigma-related stress. Although laws exist prohibiting many kinds of discriminatory life events related to some stigmatized statuses (e.g., race/ethnicity, gender, age), many stigmatized individuals (e.g., sexual minorities) are not protected from multiple forms of discriminatory life events by policies, furthering social inequality (e.g., Herek, 2006, 2007).

Everyday discrimination. Stigma-related stress also exists in everyday forms of discrimination (Meyer, 2003a). These include receiving poorer services in restaurants or stores, being treated as threatening, and/or being assumed to be unintelligent as a result of one's stigmatized status (Williams, Yu, Jackson, & Anderson, 1997). Although forms of everyday discrimination may be of smaller magnitude than stigma-related life events, their chronicity produces a cumulative stress effect that can potentially be equally distressing.

Expectations of rejection. Not all forms of stigma-related stress involve identifiable forms of discrimination or even contact with a perpetrator of stigma. Because stigmatized individuals and groups live within societies structured in ways that perpetuate social stigma,

people who are stigmatized may enter into social interactions with an expectation that they will be rejected by others because of their stigmatized social status (Link, 1987; Meyer, 2003a). This expectation of rejection, regardless of whether or not rejection actually occurs, produces a cognitive burden that constitutes stigma-related stress.

Stigma management. In response to the potential for rejection and discrimination, people who are stigmatized face an additional chronic stressor with regard to their management of how and whether a stigmatized identity or characteristic is made visible to or concealed from others (Frost & Bastone, 2007; Goffman, 1963; Meyer, 2003a; Smart & Wegner, 1999). People with concealable stigmas (e.g., sexual minorities, people with mental health disorders), are constantly faced with the decision to conceal or make visible their stigmatized statuses. Although concealing one's stigmatized status from others can be protective, in that it may allow one to avoid discrimination, stigma concealment is stressful because it produces cognitive burden resulting from fear of discovery. People with visible stigmas (e.g., racial/ethnic minorities, women) do not have an option to conceal their stigmatized social statuses. However, they may manage others' reactions to their stigmatized statuses through various stigma management techniques. For example, Cross (forthcoming) described the strategy of code switching whereby racial/ethnic minority individuals switch between patterns of speech, behavior, and dress when interacting with in-group members (i.e., other racial/ethnic minorities) and members of the dominant majority (Whites). This is sometimes necessary in order to advance one's needs and desires within dominant social structures (e.g., employment, education), which are heavily shaped by stigma-related processes. Thus, demonstrating 'bicultural competence' (Cross, forthcoming) within mainstream or dominant social contexts is a way of managing characteristics of a stigmatized status, thereby potentially reducing the likelihood of rejection. However, the cognitive burden of determining when and how to implement code switching, like stigma concealment, may produce additional stigma-related stress.

Internalized stigma. The previous stigma-related stressors have been discussed along Meyer's (2003a) continuum of proximity to the self, starting with the stigma-related stressor most distal to the self (i.e., life events) and now ending with the stressor most proximal to the self: internalized stigma. Internalized stigma refers to the application of negative social meanings of stigma to one's self-concept. Internalized stigma manifests as internalized homophobia for sexual minorities (Frost & Meyer, 2009; Russell & Bohan, 2006), internalized racism (Wester et al., 2006) or racialized self-hatred (Cross, 1991) for racial/ethnic minorities, and internalized sexism for women (Bearman, Korobov, & Thorne, 2009; Szymanski & Kashubeck-West, 2008). As discussed above, stigma is socially constructed; not an inherently negative characteristic of individuals. However, given people who are stigmatized live their daily lives within societies that are shaped by social stigma, the socially generated negative meanings surrounding stigmatized characteristics and identities can easily be internalized and attached to the self. The result is socially generated but internally perpetuated self-devaluation. Internalized stigma can persist even in the absence of direct perpetrators of stigma, and is thought by some to never completely subside (e.g., Gonsiorek, 1988).

Consequences of Stigma-Related Stress

The negative consequences of stigma-related stress on women, racial/ethnic minorities, and sexual minorities have been well documented across various social scientific bodies of

research (see Chan, Lam, Chow, & Cheung, 2008; Conron, Mimiaga, & Landers, 2010; Meyer and Frost, forthcoming; Williams, Neighbors, & Jackson, 2008 for reviews). However, the types of negative consequences of stigma depend largely on the stigmatized population under investigation; suggesting that the negative consequences of stigma are contextually dependant and often domain-specific. Below, I briefly highlight some of the primary domains and outcomes in which stigma-related stressors have consequences for the stigmatized, emphasizing important population variability when appropriate.

Health and well-being outcomes

Mental health. Perhaps one of the most consistent findings in examinations of consequences of stigma-related stress is that increased exposure to stigma-related stress results in poorer mental health across a variety of outcomes. This is true for sexual minorities with regard to mental health disorders, suicide, and subthreshold symptoms (e.g., Frost & Meyer, 2009; Frost, Parsons, & Nanin, 2007; Hatzenbuehler, 2009; Mays & Cochran, 2001; Meyer, Dietrich, et al., 2008; Meyer, Schwartz, et al., 2008). The negative association between stigma-related stress and mental health has also been well demonstrated among women and racial/ethnic minority groups, especially with regard to perceived discrimination and depression (Brown, Williams, & Jackson, 2000; Corning, 2002; Fischer & Holz, 2007; Moradi & Subich, 2004; Paradies, 2006; Williams et al., 1997). Some studies have further demonstrated that stigma-related stressors largely account for disparities in mental health between sexual minorities and heterosexuals (Mays & Cochran, 2001). This has not been demonstrated in other stigmatized populations, and is not entirely relevant for racial/ethnic minorities given research has rarely documented race-based disparities in mental health (Schwartz & Meyer, 2010).

Physical health. Racial/ethnic disparities have been documented in physical health outcomes. Much of the research in this area has demonstrated that increased exposure to stigma-related stressors results in poorer cardiovascular health (Friedman, Williams, Singer, & Ryff, 2009; Harris et al., 2006; Smart Richman, Pek, Pascoe, & Bauer, 2010). Experiences of stigma-related stressors are also associated with decreased access to medical care and thus poorer physical health outcomes, particularly among racial/ethnic minorities (Piette, Bibbins-Domingo, & Schillinger, 2006). Similarly, stigma-related stressors are associated with decreased access to and quality of medical care among sexual minorities (e.g., Makadon, Mayer, & Garofalo, 2006; Steele, Tinmouth, & Lu, 2006). Among HIV positive gay men, stigma concealment is associated with accelerated disease progression (Cole, Kemeny, Taylor, & Visscher, 1996).

Risk behaviors. Research has established connections between stigma-related stress and health risk behaviors via decreased self-efficacy and maladaptive coping strategies (e.g., Ramirez-Valles, Kuhns, Campbell, & Diaz, 2010). For example, recent studies have demonstrated links between increased experiences of stigma-related stress and smoking (e.g., Borrell et al., 2010; Todorova, Falcón, Lincoln, & Price, 2010). Also, among diverse sexual minority populations, several studies have demonstrated links between a variety of stigma-related stressors and sexual health/HIV risk behavior (Bruce, Ramirez-Valles, & Campbell, 2008; Nakamura & Zea, 2010; Preston, D'Augelli, Kassab, & Starks, 2007; Ryan, Huebner, Diaz, & Sanchez, 2009; Simoni, Walters, Balsam, & Meyers, 2006; Sugano, Nemoto, & Operario, 2006). Thus, not only is stigma-related stress directly connected to mental and physical health outcomes, it also produces increased health risk,

which strengthens connections between social stigma and negative health outcomes for a variety of stigmatized individuals and groups.

Performance outcomes

In addition to health and well-being, the last few decades of research have demonstrated links between stigma-related stressors and performance outcomes across a variety of domains.

Academic performance. Perhaps one of the most significant social psychological advancements in the study of stigma's consequences has been research on stereotype threat (Steele, 1997; Steele & Aronson, 1995). Stereotype threat occurs when an individual becomes aware of a negative stereotype and his/her performance in that domain is diminished as a result of the interrupting cognitions produced from stereotype awareness. For Black and Latino individuals, stereotype threat has been consistently demonstrated to have a negative effect on performance across a variety of diagnostic standardized testing situations. Stereotype threat also negatively impacts women's arithmetic performance in diagnostic situations (Spencer, Steele, & Quinn, 1999). For sexual minority students, increased perceived stigma-related stress in the form of stigma concealment is associated with more absences in high school (Frost & Bastone, 2007).

Job performance. Discrimination often occurs in the hiring and interviewing of stigmatized individuals based on race/ethnicity, gender, and sexual orientation (Horvath & Ryan, 2003; Pager & Shepherd, 2008; Phelan & Rudman, 2010). However, the negative effects of stigma-related stressors persist beyond the hiring process. Three decades of research on sexual harassment in the workplace have consistently demonstrated the negative effects of stigma-related stress on women's job satisfaction and performance (Gutek, 1985; Schneider, Swan, & Fitzgerald, 1997; Schneider, Tomaka, & Palacios, 2001; Woodzicka & LaFrance, 2005). Further, sexual minorities also face the challenge of negotiating stigma-related stressors in the workplace (e.g., Fassinger, 2008; Huffman, Watrous-Rodriguez, & King, 2008; Ragins, Singh, & Cornwell, 2007). Stigma-related stressors have been negatively linked to a variety of job performance indicators among sexual minorities (Ragins et al., 2007) as well as their satisfaction with and perceived fit within the workplace (Lyons, Brenner, & Fassinger, 2005).

Relational outcomes

Sexual minorities in same-sex relationships are stigmatized as a result of their sexual minority identity as well as their romantic involvement with a partner of the same gender. Stigma-related stressors have been demonstrated to negatively impact multiple indicators of relationship quality among same-sex couples (e.g., Frost & Meyer, 2009; Peplau & Fingerhut, 2007; Rostosky, Riggle, Gray, & Hatton, 2007; Todosijevic, Rothblum, & Solomon, 2005). The stigma-related stressors experienced by same-sex couples stem from both interpersonal sources of prejudice and discrimination, as well as structural inequities in the form lack of equal relationship recognition in the majority of counties world-wide (e.g., Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Rostosky, Riggle, Horne, & Miller, 2009). Same-sex couples are not the only couples that experience relational stigmatization. There are many types of couples that are stigmatized, including but not limited to interracial couples and age discrepant couples. Members of these marginalized

relationships (Lehmiller & Agnew, 2006) experience the gamut of stigma-related stressors discussed above. Some members of marginalized relationships are not stigmatized as individuals, but take on stigmatized statuses *relationally*, via their membership in a marginalized couple. For example, a White heterosexual man may not experience any stigma-related stressors as an individual. However, after marrying a Black women, he, and his wife, may experience discrimination and expectations of rejection as a result of their being in an interracial relationship.

Members of marginalized relationships have some experiences in common due to their stigmatized statuses (Lehmiller & Agnew, 2006). Marginalized couples typically experience more stigma-related stressors than non-marginalized relationships (Diamond, 2006; Frost, 2011b; Knox, Britton, & Crisp, 1997; Lehmiller & Agnew, 2006; McNamara, Tempenis, & Walton, 1999; Rosenblatt, Karis, & Powell, 1995). In other words, even though these three types of marginalized relationships all experience unique stressors, there are some issues that transcend all types of marginalized couples. Although limited research exists on overarching processes of stigma-related stress in marginalized couples, there is some evidence that stigma-related stressors can have a substantial impact on their relationship satisfaction and stability (Felmlee, 2001; Lehmiller & Agnew, 2006).

Responses to Stigma

The connections between social stigma and its consequences are not universal. There is a tremendous amount of variability in the ways stigmatized individuals and groups respond to experiences of stigma-related stress (Frost, 2011a). Understanding the ways people and groups respond to stigma-related stress is an important endeavor in the psychological study of stigma. Not only is it necessary to understand the damaging effects of social stigma, it is equally if not more important to understand how the stigmatized are able to cope with, resist, and overcome the limiting consequences of stigma.

Coping and social support

Individual-level coping. Much of the existing research on coping with stigma-related stress has focused on individual-level coping strategies and support seeking. In many ways, this body of research draws heavily from classic stress and coping models (Lazarus & Folkman, 1984). Individual-level coping strategies and support often focus on dealing with emotional aspects of the stress experience (e.g., meditation, expressive writing) or focus on changing the circumstances of the source of the stress (e.g., spending less time at work, asking a sibling to help with the care of a sick parent) (see the following for reviews: Carver & Connor-Smith, 2010; Coyne & Downey, 1991; Thoits, 1995). Some coping strategies can be effective in preventing the negative effects of stigma-related stress in one domain, while magnifying damage in another. Jackson, Knight, and Rafferty (2010) have demonstrated that Blacks may engage in passive/avoidant coping strategies, such as smoking, drinking, and unhealthy eating, which buffer the negative effects of stigma-related stress on mental health, but increase physical health problems. This potentially accounts for frequently observed disparities between Blacks and Whites in physical health problems and the lack of consistent differences based on race/ethnicity in mental health (Schwartz & Meyer, 2010).

Group-level coping. Meyer's (2003a) minority stress model highlights important distinctions between individual-level and group-level coping processes. Specifically, sexual

and other numerical minority stigmatized populations often rely on minority communities to provide physically and psychologically safe and supportive environments. Not only do minority communities provide spaces safe from aspects of prevailing social stigma, but feelings of psychological connectedness also have the potential to be stress-ameliorative.

Having and perceiving support from similar others have been shown to reduce the negative effects of stigma on health and well-being across a variety of stigmatized groups and individuals (e.g., Frable, Platt, & Hoey, 1998). Although less research has been conducted on group-level coping compared to individual-level coping with stigma-related stress, some studies have shown positive associations between connectedness to minority communities and mental health and well-being (Frost & Meyer, 2011; Kertzner, Meyer, Frost, & Stirratt, 2009; Ramirez-Valles, Fergus, Reisen, Poppen, & Zea, 2005) and risk behaviors (Ramirez-Valles & Brown, 2003). Additionally, perceived support within one's own racial/ethnic community has been found to moderate the effect of perceived discrimination on depression (Noh & Kaspar, 2003).

Beyond Stress and Coping: Making Meaning of Stigma-Related Stress

Thus far, stigma has been portrayed as having a unidirectional and negative effect on the lives of the stigmatized. In cases where individuals or groups are able to cope with their experiences of stigma-related stress, the negative effects of stigma can be diminished or neutralized. By examining the many ways in which experiences of stigma-related stress are made more or less meaningful in the lives of stigmatized individuals, a more nuanced person-centered understanding of the effects of stigma can be achieved.

Insight into how stigmatized individuals make meaning of stigma-related stress can be found in the early formulations of stress appraisals. The foundational work of Lazarus and Folkman (1984) articulated how people perceive stressors as either threats or challenges, and that this attribution of meaning to the stressor determines how the stressor will affect the individual. If stigmatized individuals are able to engage in meaning-making processes that reduce the threat of stigma to their lives, they may be able to diminish and/or overcome its delimiting effects. Evidence for this hypothesis can be seen in the classic analysis of stigma and self-esteem by Crocker and Major (1989). Specifically, they show that stigmatized individuals may attribute the cause of stigma to a fault of society (i.e., the out-group; perpetrators of stigma), not of themselves or other members of their in-group. They also discuss how people may selectively make domains in which they are limited by stigma-related stressors less meaningful than domains in which they are not as limited by stigma-related stress. These meaning-making processes of reframing causes and the (de)valuation of life domains lead to a great degree of individual variability in the consequences of stigma-related stress, including gains in self-esteem (see also Shih, 2004).

Additional work from a critical social psychological perspective has identified other meaning-making processes through which stigmatized individuals are able to make meaning of stigma in ways that allow them to not simply cope with, but overcome and even thrive in the face of stigma-related stress. Unger's (2000) work on positive marginality provides a critical framework from which to evaluate predominant models of social scientific research on stigma and its consequences. Unger argues that laboratory-based experimental and quantitative survey methods provide a limited picture of how social stigma affects the lives of the stigmatized. Critical feminist and qualitative methods have since been applied in emerging theory and research on the lived experiences of marginalized

individuals and groups (Fine, 2006; Frost & Ouellette, 2004, 2011; Ouellette, 2008; Ouellette & Frost, 2006). These approaches reveal agency and resiliency by highlighting the processes through which marginalized individuals make meaning of and respond to their experiences of stigma-related stress. Additional perspectives, drawing from community psychology emphasize further how those at the margins can thrive and achieve well-being in life through active resistance of stigma-related stress (e.g., Campbell & Deacon, 2006; Nikora, Rua, & Awekotuku, 2007).

One example of such an approach can be seen in the application of narrative analyses to the meaning-making processes that same-sex couples employ in negotiating stigma-related stress within romantic relationships (Frost, 2011a). Such an approach emphasizes the meanings that the stigma-related stressors themselves take on in individuals' lived experiences. Frost (2011a) showed that members of same-sex couples utilize multiple meaning-making strategies to negotiate the potential effects that stigma-related stressors can have on their experiences of intimacy. Some strategies emphasized a negative, delimiting, and contaminating effect of stigma on their relationships, as is common in existing research. However, other strategies emphasized how stigma can be made sense of in ways that allow individuals to overcome its negative effects. For example, some constructed meanings of stigma-related stressors as challenges that reaffirmed their commitment to and bond with their partners. These narrative strategies for making meaning of stigma-related stressors represent more than coping (Shih, 2004). They represent agentic attempts to reclaim experiences of being marginalized in ways that allow individuals to resist and even thrive in the face of social stigma. Thus, through individual and group-level meaning (re)making processes of stigma-related stressors, social stigma can, indirectly, result in positive outcomes.

These positive outcomes include social creativity that manifests as activism and attempts at social change (Frost, 2011a; Hall & Fine, 2005; Jewkes, 2006; Riggle, Whitman, Olson, Rostosky, & Strong, 2008). Theories of positive marginality predict that, by reclaiming one's position as marginal as an advantage instead of a disadvantage, marginalized groups and individuals are able to reframe experiences of stigma-related stress as opportunities for activism and social change to improve their social positions. In this regard – aided by enhanced community connectedness – marginalized communities become spaces for affirmation of stigmatized identities and characteristics. Furthermore, it is this kind of social creativity that may lead to policy reform efforts, which, if successful, can potentially alter discriminatory social structures and diminish the underlying negative meanings of social stigma.

Summary: An Integrative Model of Social Stigma

This paper aimed to provide an integrative overview of existing social scientific perspectives on social stigma and its consequences for the socially stigmatized. In accomplishing this task, the predominant literatures portraying the negative effects of stigma on the lives of stigmatized individuals was positioned in relation to emerging perspectives on positive marginality. These discourses that emphasize damage and resistance, respectively, are rarely discussed in relation to one another. What follows is a theoretical model (Figure 1) designed to integrate these two perspectives and provide a holistic perspective on the perpetration and experience of social stigma.

Social stigma occupies the majority of the left side of the model, as it is the foundation for stereotyping, prejudice, and discrimination. Stigma, stereotypes, and prejudice are represented as partially nested within one another given the extent to which they are often

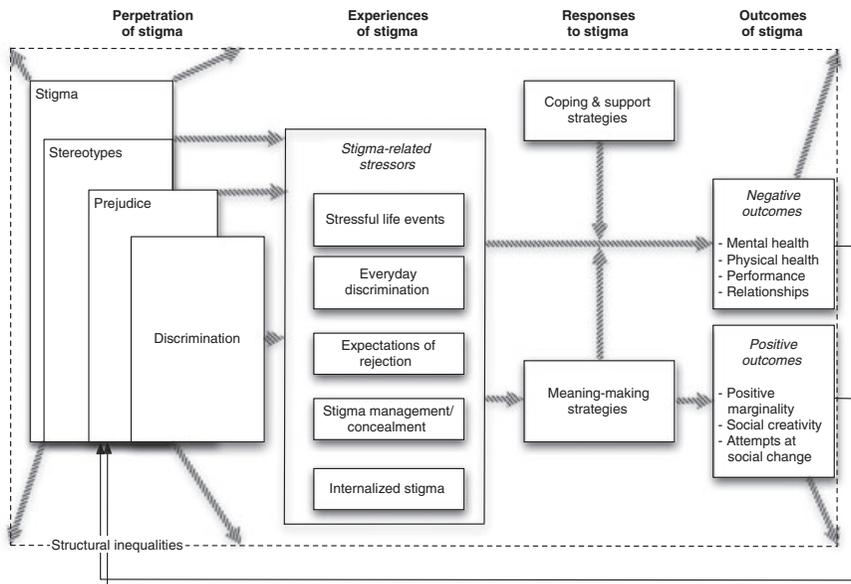


Figure 1 Process model of social stigma and its consequences.

inseparable from one another. Stigma further results in structural inequalities that prevent stigmatized groups from full participation in society. This is represented by the dotted box surrounding all processes in the model. All elements of the perpetration of, experience of, and response to stigma are embedded within the ways societies are structured. Structural manifestations of stigma shape the life opportunities of stigmatized individuals (for better or worse), even in the absence of others who are prejudiced or act in discriminatory ways toward them.

Experiences of stigma for stigmatized groups and individuals can be usefully framed in terms of stigma-related stress. Stigma-related stress exists as acute and chronic discrimination, expectations of rejection, management and concealment of stigma, and internalized stigma. These processes range from very distal to the self and perpetrated by outside social sources (e.g., discrimination) to internalized forms of stigma that are proximal to the self and persist outside of the presence of a direct source of discrimination (Meyer, 2003a,b). These proximal sources of stigma-related stress still stem from the prevailing culture of social stigma, and should not be reduced to personality traits or internally generated processes (Frost & Meyer, 2009; Russell & Bohan, 2006).

The extent to which experiences of stigma-related stressors impact important positive and negative outcomes is dependent on a number of intervening and moderating factors. Generally, stigma-related stress is a negative force in the lives of stigmatized groups and individuals, and can result in a number of negative mental health, physical health, performance, and relational outcomes. However, individual and group-level coping and support mechanisms can moderate the negative effect of stigma, buffering the overall impact of stigma-related stress on these negative outcomes. Further, meaning-making processes that focus on attributions of the source of stigma-related stress can buffer stigma's negative effects by attributing the source to a fault in society instead of one's self or group membership. Meaning-making strategies that focus on (re)defining the meaning of

stigma-related stressors themselves can potentially result in positive outcomes for marginalized individuals in various forms of positive marginality, such as social creativity, social change, and thriving in the face of stigma. Just as negative outcomes can perpetuate negative social stigma via self-fulfilling prophecies, positive outcomes may have the potential to change social stigma and structural inequalities for the better through social policy reform and collective action.

Conclusions and Suggestions for Future Research

This paper constructed an integrative review of classic and current theory and research on social stigma and its consequences for the socially stigmatized. Careful attention was paid to both the origins and perpetration of social stigma alongside how stigmatized groups and individuals experience and respond to social stigma. Both the potential negative and positive consequences of social stigma were highlighted in this review through the integration of predominant social psychological theory and findings with emerging critical and feminist theories of positive marginality and resistance. Many nuances of the theories and studies reviewed have been omitted in favor of theoretical parsimony. Furthermore, much of the work reviewed stems from research on stigma as it applies to race/ethnicity, gender, and sexual orientation; leaving out other important social stigmas (e.g., stigma related to weight, social class, mental illness).

The resulting process model is intended to provoke future theory and research that share its integrative aims. Social scientific efforts are often divided in terms of a focus on either the damage that stigma can have on the stigmatized or the ways in which socially stigmatized groups and individuals resist marginalizing conditions. Critical steps need to be taken to design approaches that can holistically – and in the same study – examine the conditions under which stigma leads to positive and/or negative outcomes. Current directions in the social scientific study of stigma are undoubtedly important and must continue. However, the kind of integrative approach put forth in the preceding discussion is necessary to build a useful science of stigma that is responsive to both the basic scientific questions at stake in academia, as well as the pressing needs of those most affected by the consequences of social stigma.

Short Biography

David M. Frost's research focuses on how stigma, prejudice, and discrimination constitute minority stress and, as a result, affect the health and well-being of marginalized individuals. His research has been published in several interdisciplinary outlets including the *Journal of Counseling Psychology*; *Culture, Health, and Sexuality*; the *Journal of Family Psychology*, and the *Journal of Social Issues*. His work on stigma and minority stress has been recognized by grants and awards from the Society for the Psychological Study of Social Issues and the New York Academy of Sciences. He is currently an Assistant Professor of Sexuality Studies at San Francisco State University and Research Faculty at the Center for Research on Gender and Sexuality (CRGS). He received his PhD in Social and Personality Psychology from the Graduate Center of The City University of New York.

Endnote

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