A Theoretical Perspective on Coping With Stigma

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Stigmatized people have a vast array of responses to stressors resulting from their devalued social status, including emotional, cognitive, biological, and behavioral responses. This article uses existing theory and research on general stress and coping responses to describe responses to stigma-related stressors and to discuss the adaptiveness of these responses.

There is an increasing interest in the benefits of conceptualizing prejudice and discrimination as stressors in the lives of stigmatized people (Allison, 1998; Clark, Anderson, Clark, & Williams, 1999; Miller & Major, 2000). One advantage of putting stigma squarely in the domain of stress and coping is that it invites consideration of the many ways in which stigma can affect the stigmatized person, including psychological, social, and biological effects (Clark et al., 1999). Second, conceptualizing stigma as a stressor calls attention to the importance of cognitive appraisals in the experience of stigma-related stress and the coping responses made to that stress, just as such appraisals are important in responses to any type of stressor (Lazarus & Folkman, 1984).

A final benefit of thinking about stigmatization as a form of stress is that it calls attention to the ways in which stigmatized people may cope with the stress they endure as a consequence of their stigmatized status (Allison, 1998; Miller & Major, 2000). There have been recent theoretical developments in understanding how people respond to stress in general (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001) that may further our understanding of the kinds of coping efforts stigmatized people may make in response to stigma-related stress.

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Stigma and Stress

The core feature of stigma is that a stigmatized person has an attribute that conveys a devalued social identity within a particular context (Crocker, Major, & Steele, 1998). This devaluation leads to a variety of stressors. A stressor is an event in which environmental or internal demands tax or exceed the adaptive resources of the individual (Lazarus & Folkman, 1984). Prejudice can increase environmental demands by affecting access to educational and employment opportunities, confining stigmatized people to the lower rungs of the socioeconomic ladder, and affecting the quantity and quality of health care stigmatized people receive (Allison, 1998; Clark et al., 1999). Prejudice also results in psychological and physiological stress responses (Clark et al., 1999). The perception of racism by African Americans, for example, results in negative emotions such as anger, anxiety, hopelessness, resentment, and fear (Armstead, Lawler, Gorden, Cross, & Gibbons, 1989; Feagin & Sikes, 1994) and increases in cardiovascular activity (Krieger & Sidney, 1996).

Compared to other types of stressors, stigma may be especially stressful because it poses some unique demands on the individual (Miller & Major, 2000). Although stigma is defined as a devalued social identity in a particular context, for many stigmatized people the context in which they are devalued is pervasive. People with physically obvious stigmas, such as members of devalued racial groups, face potential prejudice and discrimination across a broad range of social contexts. Some stigmatized attributes are so powerful in the reactions they engender that they are "master status" attributes that become the core, identifying attribute of the person who possesses them (Goffman, 1963). Thus, stigma can increase the quantity of stressors stigmatized individuals experience.

Stigmatized people also may face different kinds of stressors than others do. Prejudice and discrimination, for example, are sources of stress for stigmatized people but not, except in rare circumstances, for nonstigmatized people. One stressful feature of prejudice is that there often is considerable ambiguity about whether events that occur are the result of prejudice and discrimination or are the result of some other factor (Crocker et al., 1998; Crocker & Major, 1989). Stigmatized people themselves may often be in doubt about whether a particular response was discriminatory (Ruggiero & Taylor, 1997). Other people may scrutinize their claims about the stress created by prejudice and discrimination and may devalue stigmatized people who claim that prejudice has affected them (Clark et al., 1999; Kaiser & Miller, 2001).

Stigma also is linked to the individual's social identity (Crocker et al., 1998). This feature of stigma can increase the potential for stress because unfair treatment or judgments can be triggered simply by group membership and thus have implications for collective as well as personal identity (Miller & Major, 2000). Threats to collective identity are multifaceted. Seeing other group members suffer from

unfairness due to stigma may result in vicarious stress responses. Other people's devaluation of the group may reduce the comfort and sense of belonging that group membership normally provides (Branscombe & Ellemers, 1998). Stigmatized people also may be pressured to be "a credit" to their group or to otherwise represent their group to the nonstigmatized world (Allport, 1954). These stressors arise precisely because stigmatized people have a devalued social identity.

Appraisals and Coping

Because the lives of stigmatized people can be more stressful than those of nonstigmatized people, it is easy to assume that stigmatized people must bear various "marks of oppression" (Allport, 1954). Numerous theoretical perspectives suggest that stigmatized people may suffer psychological consequences such as ego defenses, low self-esteem, external locus of control, and depression (Allport, 1954; Crocker & Major, 1989). Others have hypothesized that stigma has negative consequences for the physical health of stigmatized people. This hypothesis is derived from research showing that stress compromises immune system functioning, increases cardiovascular activity, and affects neuroendocrine responses, all of which have been implicated in important health outcomes such as cardiovascular disease and susceptibility to illness (Clark et al., 1999). Some of the physical health correlates of stress, including low birth weight and infant mortality, heart disease, and hypertension, are also correlated with membership in some stigmatized groups (Allison, 1998). For example, infant mortality and cardiovascular disease are more prevalent among African Americans than European Americans, and women suffer from clinical depression more than men do (Allison, 1998). One popular hypothesis about these outcomes is that they are in part the result of prejudice and discrimination (Clark et al., 1999).

In general, however, simple comparisons of the psychological and physical health outcomes of stigmatized and nonstigmatized people have not consistently, or even typically, revealed the hypothesized marks of oppression (Clark et al., 1999; Crocker & Major, 1989). Stigmatized people often are found to function as well as other people, despite the fact that they are disadvantaged in a variety of ways. The solution to this paradox lies in a greater understanding of how appraisals and coping shape the consequences of stressors.

Stress by definition occurs only when demands placed upon an individual exceed or tax the individual's coping resources (Lazarus & Folkman, 1984). Thus, stress always involves cognitive appraisals about the seriousness of the demand and about the resources the individual has available to cope with that demand (Lazarus & Folkman, 1984). A stress response occurs only if the individual perceives a self-relevant threat (i.e., something personally important is at stake) and also believes that he or she does not have the capacity to cope with the threat. In the case

of stigma-related stress, a stressor may include group-relevant as well as personally relevant demands that exceed coping resources.

For example, negative stereotypes about their group can be stressful for stigmatized people because their performance in stereotype-related domains may be compromised by concerns about confirming negative stereotypes, even if they themselves do not actually believe that the stereotypes are accurate (Steele & Aronson, 1995). Stereotype threat effects are hypothesized to occur, however, only among stigmatized people who are identified with the stereotype-related domain (Steele & Aronson, 1995). Those who are not identified with the domain may not appraise the situation as stressful because they do not have important outcomes at stake (Crocker et al., 1998; Steele & Aronson, 1995).

Even if important outcomes are at stake, a stigma-related event may not be perceived as stressful if the stigmatized person has the adaptive resources to cope with the potential stressor. These adaptive resources can include psychological, social, behavioral, economic, or educational resources (Clark et al., 1999; Gaines, this issue; Miller, Rothblum, Felicio, & Brand, 1995). Thus, there is likely to be wide variability in how and with what effect stigmatized people cope with stressors (Clark et al., 1999). For example, in a study conducted on a sample of African American men living in rural southern states, a strong belief in self-sufficiency and the conviction that hard work brings desired goals was related to hypertension among African American men with relatively little formal education. Among relatively well-educated African American men, however, these beliefs, known as "John Henryism," were not related to hypertension, perhaps because they have more resources for coping with prejudice (James, Hartnett, & Kalsbeek, 1983).

In sum, a stress and coping perspective on stigma indicates that stigma-related events (for example, being stigmatized or suffering rejection due to prejudice) will be perceived as stressful only if they pose a threat that could exceed the person's resources for coping. Moreover, stigma-related stress will be detrimental to well-being only if the individual is unable to cope with it successfully.

Theoretical Models of Stress Responses

Having established that stigma can be a source of stress for stigmatized people, we can now examine their responses to this stress. The vast literature on stress and coping indicates that people have many responses to stress, which include physiological, cognitive, emotional, and behavioral responses (Holohan, Moos, & Schaefer, 1996). There have been several efforts to distinguish conceptually and empirically among the many different responses people may have to stress. Some of the distinctions that have been suggested as important include distinguishing between voluntary and involuntary responses, emotion-focused and problem-focused coping responses, primary versus secondary control coping efforts, engagement (approach) versus disengagement (avoidance) responses, active and

passive coping, and cognitive and behavioral coping (see Zeidner & Endler, 1996, for a review).

Consensus about which dimensions are fundamental to describing stress responses and the relationship of different dimensions to one another has not yet been achieved (Zeidner & Endler, 1996). Moreover, coping responses that are assumed to represent the same dimensions often are not strongly associated with each other, and there can be considerable overlap in coping responses across different dimensions.

In reviewing the diversity of ways in which stress responses and coping have been conceptualized and measured, Compas and his colleagues recently proposed a theory of coping and stress responses that organizes most of these dimensions into a coherent and empirically supported model (Compas et al., 2001; Connor-Smith, Compas, Wadsworth, Thomsen, & Saltzman, 2000). This model is summarized in Figure 1. According to this model, the most fundamental distinction between different responses to stress is between *voluntary coping responses* and *involuntary responses* (Compas et al., 2001). This distinction emphasizes the fact that not everything a person does in response to stress constitutes coping. People may have involuntary emotional, behavioral, physiological, and cognitive responses to stress that do not serve to regulate or modify stressful experiences. These involuntary responses may be conscious or unconscious, but they are experienced as being largely outside of the person's control (Connor-Smith et al., 2000). The term *coping* is reserved for "conscious volitional efforts to *regulate* emotion, thought, behavior, physiology, and the environment in response to stressful events or circumstances" (Compas et al., 2001, emphasis added).
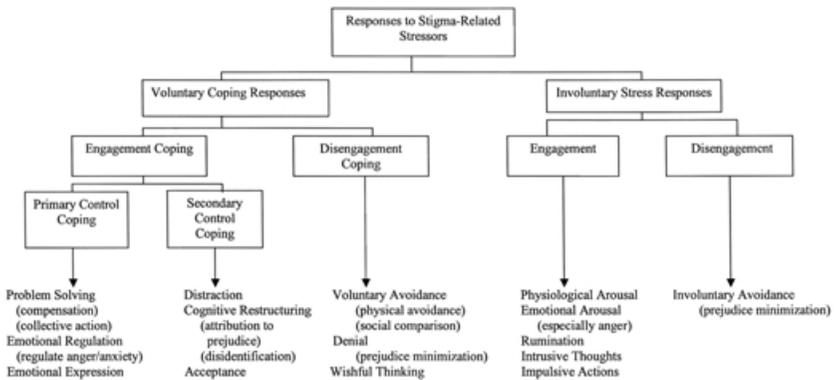
Responses in parentheses are stigma-relevant examples of types of responses from the stress and coping model.

Fig. 1. Adaptation of Compas et al. stress and coping models to stigma-related stress and coping. Figure adapted from "Responses to stress in adolescence: Measurement of coping and involuntary stress responses," by Connor-Smith et al. (2000), *Journal of Consulting and Clinical Psychology*, *68*, 976–992, copyright American Psychological Association. Adapted by permission of author.

Both voluntary coping responses and involuntary responses to stress can involve engagement or disengagement with the stressful event or problem (Compas et al., 2001). This distinction is derived from older distinctions between fight (engagement) versus flight (disengagement) responses and between approach and avoidance responses (see Compas et al., 2001). Thus, engagement with a stressor does not necessarily imply conscious, volitional, higher-order cognitive processing.

Voluntary efforts to cope with stress by engaging with the stressful event or problem can be further distinguished by whether coping is aimed at gaining primary or secondary control over the stressful event (Compas et al., 2001). Primary control includes coping efforts that are directed toward influencing objective events or conditions to enhance a sense of personal control over the environment and one's reactions (Compas et al., 2001). These include problem solving and efforts to directly regulate one's emotions or the expression of emotion. In previous discussions of primary-control coping (e.g., Miller & Myers, 1998), the emphasis has been on coping efforts that involve trying to change the situation. However, factor analysis of the relationships between coping responses consistently shows that emotional regulation loads with problem solving (Connor-Smith et al., 2000). For this reason Compas et al. (2001) argue that primary-control coping includes elements of control over the self as well as control over the situation. The measures of emotion regulation used in this research emphasize controlling one's emotions so that a bad situation does not escalate. In contrast, secondary-control coping involves efforts to adapt to the situation. It includes efforts to change the way one feels about the fact that a bad situation has occurred. The major coping responses that fall into this coping domain are distraction, acceptance, positive thinking, and cognitive restructuring.

Although empirical support for the validity of dimensions thought to underlie stress responses has sometimes been difficult to come by, the partially hierarchical factor structure suggested by the Compas model has held up well in different samples responding to different types of stressors (Connor-Smith et al., 2000). Moreover, the Compas model describes stress responses better than do several alternative models, including a simple engagement versus disengagement model or a simple problem-focused versus emotion-focused coping model.

Implications for Stigma

There also have been a number of efforts to conceptualize the dimensions that underlie coping responses to stigma. Consistent with the general coping literature, the distinction between reactions that involve approaching or avoiding situations or people that are contaminated by prejudice has been an important feature of several theoretical analyses (Crocker et al., 1998; Jacobson; 1977; Miller & Kaiser, 2001; Pinel, 1999; Swim, Cohen, & Hyers, 1998). Other theoretical analyses have

distinguished between action and inaction (Wright, Taylor, & Moghaddam, 1990), individualistic and collective actions (Branscombe & Ellemers, 1998; Wright et al., 1990) assertive and nonassertive confrontational responses and avoidance (Swim et al., 1998), mental models of self and others (Miller & Kaiser, 2001), problem- and emotion-focused coping (Miller & Major, 2000), primary- and secondary-control coping (Miller & Myers, 1998), and integrationism versus separatism (Jacobson, 1977). Although these distinctions are sensible and defensible, they may be insufficiently grounded on current theoretical developments in the stress and coping literature.

In the next section we will use the theory developed by Compas and his colleagues (2001) to organize and integrate what we know about how stigmatized people react to stigma-related stress. We also will use stress and coping research findings to predict what effects different stigma-related stress responses are likely to have. This analysis also will highlight some stigma-related stress responses that have thus far received little attention.

Although the Compas et al. (2001) model is a useful way to organize different responses to stigma-related stress, it is important to remember that stress responses are dynamic, multifaceted, and interdependent. People usually make several responses to stress, some of which are coping responses and some of which are involuntary emotional, cognitive, or behavioral responses (Compas et al., 2001). Feedback from one response may alter the next response, and several strategies may be used simultaneously. Moreover, although the model attempts to group responses into clearly defined categories, there can be overlap between categories, and it is not always clear how a particular response should be characterized. Consequently, some responses may play multiple roles in the person's response to a stressful event.

Voluntary Coping Responses to Stigma

Disengagement Coping: Avoidance, Denial, and Wishful Thinking

Recent stigma research has given considerable attention to a variety of ways in which stigmatized people may disengage from the stress resulting from stigma (Fiske, Morling, & Stevens, 1996; Pinel, 1999; Ruggiero & Taylor, 1997; Swim et al., 1998). The two main forms of disengagement coping that have been studied thus far are physical and social avoidance of situations in which stigma may be a problem (Pinel, 1999; Swim et al., 1998) and denial or minimization of prejudice and discrimination (Ruggiero & Taylor, 1997).

Avoidance coping involves physical and/or social withdrawal or disengagement from stigma-related stressors. For example, women avoid interacting with men who have reputations for being sexual harassers or sexists (Swim et al., 1998). Women who expect that they will be stereotyped (Pinel, 1999) and those lacking

self-confidence (Cohen & Swim, 1995) avoid stigma-tainted situations. This avoidance often goes hand in hand with selective affiliation with other stigmatized people or with nonstigmatized people who are relatively free of prejudice. For example, in the studies described above (Cohen & Swim, 1995; Pinel, 1999), women did not simply withdraw from the prejudice-tainted situations, but rather they also sought out the prejudice-free alternatives that were available. Thus, avoidance may be a starting point for other coping responses.

If stigmatized people cannot avoid or find alternatives to situations in which stigma may create stress, they may withdraw socially. One form of social avoidance is avoiding comparisons with nonstigmatized people. By avoiding social comparisons with outgroup members, stigmatized people are able to avoid the stress that might otherwise result from acknowledging that others are doing better than they are (Crocker & Major, 1989). However, ingroup social comparisons may be detrimental in the long run because they tend to maintain the status quo. Stigmatized people who avoid information about how they compare to nonstigmatized people may not be likely to challenge their devalued status.

Another type of disengagement coping response that has been investigated is denial or minimization of prejudice and discrimination. Ruggiero and Taylor (1997) demonstrated that stigmatized people do not make claims of discrimination even when the objective evidence points strongly to the possibility that the poor outcomes they have experienced were due to prejudice. This is disengagement coping, because it avoids stress by denying the existence of the problem. There may also be an element of wishful thinking in minimization of prejudice effects. The belief that others have behaved in a discriminatory fashion robs stigmatized people of the sense that they can control and be socially accepted by others (Ruggiero & Taylor, 1997). One way to cope with these unsettling perceptions is to wish that those with power are kindly disposed toward stigmatized people and therefore would not discriminate against them (Fiske et al., 1996).

In the general stress and coping literature, research on the adaptiveness of different coping responses suggests that disengagement coping responses have an overall poor track record. They are related to increased psychological distress, including maladjustment and physical symptoms (Holohan et al., 1996; Major, Richards, Cooper, Cozzarelli, & Zubek, 1998). It is no surprise, therefore, that there is some evidence that disengagement coping with stigma also is related to some adverse consequences. Several studies indicate that African Americans who say they do not experience racism are likely to be hypertensive (Kreiger & Sidney, 1996). We believe, however, that it would be premature to conclude that stigmatized people would be better off if they eliminated disengagement coping from their coping repertoires. There may be specific conditions under which disengagement coping could be effective. For example, if there is little hope for remedying an unjust pay scale, stigmatized people may be better able to increase personal well-being (although perhaps not collective well-being) by avoiding comparisons

with unfairly advantaged nonstigmatized people. Avoiding highly prejudiced people may also be an excellent strategy, particularly if the stigmatized person has little to gain by interacting with these people.

Engagement Coping

Engagement coping can be distinguished by whether it is aimed at gaining primary or secondary control over the stressful event. Primary-control coping involves changing the stressful situation (by controlling the situation or the self in the situation), whereas secondary-control coping involves adapting to the stressful event. A great deal of the research on stigma has focused on secondary-control coping strategies through which stigmatized people can psychologically adapt to the stigma-related stressors that confront them (Crocker et al., 1998).

Secondary-control coping: Distraction, cognitive restructuring, and acceptance. Distraction involves engaging in cognitions or behaviors that draw attention away from the stressor. Coping researchers initially assumed that distraction was a way of avoiding the stressor and thus would be associated with relatively poor adaptation to stress (Conner-Smith et al., 2000). Recent research (Compas et al., 2001; Conner-Smith et al., 2000), however, shows that distraction is correlated with other engagement coping responses, not with disengagement coping responses. Moreover, Nolen-Hoeksema and Morrow (1993) have shown that distraction effectively prevents ruminative thinking or intrusive thoughts, which often result in negative psychological consequences.

The key to understanding the beneficial effects of distraction is that it involves a substitution of other thoughts and activities for stress-related ones rather than an effort to stop thinking about the stressor or to deny it (Smart & Wegner, 1999). Distraction generally is adaptive, whereas thought suppression is not (Nolen-Hoeksema & Morrow, 1993). This suggests that stigmatized people may be better served by distracting themselves from stigma-related stressors than by trying to suppress thoughts about them.

One important secondary-control coping response is cognitive restructuring, which is generally shown to be adaptive in the stress and coping literature (Gottlieb, 1997). In fact, this strategy is a major component of cognitive behavioral psychotherapy, whereby the meaning of threatening and stressful events is redefined (Gottlieb, 1997). Likewise, cognitive restructuring has been one of the most frequently investigated strategies for coping with stigma-based stressors (see Crocker et al., 1998, for a review). This research suggests that stigmatized people can cope with others' discriminatory behavior by reframing their thoughts through self-protective attributions and changing the value they place on domains in which their group fares poorly.

Stigmatized people who attribute poor outcomes to prejudice are restructuring the way they think about the outcomes (Crocker & Major, 1989). Instead of placing responsibility on themselves, they place it (often correctly) on the unfairness of other people. In many circumstances, making an attribution to prejudice can protect the self-esteem of stigmatized people (Crocker et al., 1998). There are situations, however, in which attributions to prejudice may be less beneficial or even harmful (Branscombe & Ellemers, 1998; Branscombe, Schmitt, & Harvey, 1999; Crocker, Cornwell, & Major, 1993; Ruggiero & Taylor, 1997). For example, people with stigmas for which they are blamed (e.g., people who are considered overweight) and people who do not identify strongly with their stigmatized group may be unable to benefit much from attributing poor outcomes to prejudice (Branscombe et al., 1999; Crocker et al., 1993; Miller & Downey, 1999).

Another form of cognitive restructuring is *devaluation* of domains in which one's group is reputed by stereotypes to be unsuited (Major & Schmader, 1998; Schmader, Major, & Gramzow, this issue; Steele & Aronson, 1995). This can include devaluation of the importance of a stereotyped domain (Crocker & Major, 1989) or ceasing to base one's personal identity or self-worth (Crocker et al., 1998) on that domain, a process often referred to as *disidentification*. By reducing the importance of the domain to the self, devaluation can protect self-esteem in the face of poor outcomes in that domain (Crocker & Major, 1989) and reduce the stress that would otherwise be created by stereotype threat (Crocker et al., 1998). However, if the stereotyped domain is one that is highly valued by society at large, devaluation and disidentification can have maladaptive consequences (Crocker et al., 1998; Major & Schmader, 1998). There is little doubt, for example, that disidentification with academic domains has adverse consequences for the social and economic well-being of African Americans (Crocker et al., 1998).

Acceptance is another strategy for gaining secondary control over stressors. Research on the adaptive effects of acceptance is somewhat mixed. Acceptance has been related to rapid mortality from HIV (Reed, Kemeny, Taylor, & Wang, 1994) but also to positive psychological adjustment among cancer patients (Carver, Pozo, Harris, & Noriega, 1993) and women who have had abortions (Major et al., 1998). Stigmatized people may also cope with stigma by accepting their lot. Research on stigma suggests this may be a somewhat less adaptive strategy for stigma than for other types of stressors, perhaps because stigma-related stressors may be more constant and pervasive than some other types of stressors. For example, African American women who reported that they accepted unfair treatment "as a fact of life" (Krieger & Sidney, 1996, p. 1373) had higher blood pressure than did those who said they took some action. Acceptance is also costly because it can prevent collective action and eventual societal changes (Wright et al., 1990).

Despite some of the disadvantages that these secondary-control coping responses may have when used to cope with stigma-related stress, the general stress and coping literature suggests that secondary-control coping is often

adaptive. This is especially the case for stressors that are not controllable (Kohn, 1996). To the extent that prejudice is difficult if not practically impossible to eradicate, secondary-control coping responses will be important to the personal well-being of stigmatized people.

Primary-control coping: Problem solving, emotion regulation and expression. Stigmatized people can exert primary control over stigma-related stressors through individual or collective action (Wright et al., 1990). These coping responses can include problem solving, emotional expression, and emotion regulation. For example, one strategy for dealing with the threat of prejudice is compensation. Compensation involves adapting one's social interaction strategies in an attempt to achieve goals despite the existence of prejudice (Miller & Myers, 1998) by behaving in a socially skillful (Miller et al., 1995; Miller & Rudiger, 1997) or stereotype-disconfirming fashion (Kaiser & Miller, in press). For example, women (but not men) spoke more competently during interactions with employers than during interactions with peers (Steckler & Rosenthal, 1985), and women who believed they would be evaluated by a sexist grader created less feminine impressions on a self-descriptive essay compared to women who did not anticipate sexist graders (Kaiser & Miller, in press).

Both emotional expression and emotional regulation may be critical to gaining primary control through compensation. Stigmatized people may feel angry (Clark et al., 1999; Swim, Hyers, Cohen, & Ferguson, this issue) or anxious (Steele & Aronson, 1995), but expressing these emotions could be detrimental to overcoming others' prejudiced responses. Failure to regulate these emotions also could be detrimental to successfully overcoming prejudice. For example, anxiety may interfere with optimal performance in a way that makes it impossible to disconfirm stereotypes (Steele & Aronson, 1995). For this reason, stigmatized people may regulate their emotions so that they do not become angry or anxious. By not allowing their emotions to reign, they are better able to concentrate on behaviors that will reduce the impact of prejudice on the situation.

The problem of prejudice is a difficult one. Many problem-solving efforts may be required before stigmatized people hit upon strategies that will accomplish whatever their interaction goals may be with prejudiced people (Miller & Myers, 1998). Consequently, coping by compensation may be a skill that stigmatized people develop as they cope with prejudice across many situations. One important implication of this reasoning is that stigma researchers would be ill advised to try to understand how stigmatized people cope with prejudice by examining the coping responses of nonstigmatized people who are asked to temporarily play the role of a stigmatized person in an experimental setting (Miller & Myers, 1998). For the sake of convenience and experimental control, many stigma researchers have done just that. Nonstigmatized college students, for example, have been portrayed (falsely) to interaction partners as overweight, physically unattractive, facially disfigured,

gay, or African American (see Miller & Myers, 1998, for a review). The popularity of these "Black like me" experiments may explain why primary-control coping has not been observed much in previous research. Nonstigmatized people may simply not have developed these coping responses to stigma.

Problem solving, emotion regulation, and emotional expression also are important in collective actions to try to change the status quo. Organizing for collective action may require the sharing of hostile and dissatisfied feelings about the current situation (Branscombe & Ellemers, 1998; Brewer & Brown, 1998). Problem solving is required to identify and implement actions that will improve the group's status, and regulation of emotions such as fear may be necessary to carry out these actions (Brewer & Brown, 1998). For example, at various times in the history of the civil rights movement, some leaders, such as Martin Luther King Jr., advocated a nonviolent approach that emphasized the control of anger, whereas others, such as those involved in the Black Panthers, gave center stage to the expression of rage.

Problem solving also occurs as stigmatized people decide what form of collective action will succeed in improving their group's status. When stigmatized people have positive expectations about society and the prospects for change, they may respond to collective threat through normative channels, such as the legal system or political lobbying. In contrast, when stigmatized people's expectations for change are bleak, they may choose nonnormative channels of collective action, such as riots (Brewer & Brown, 1998).

Although some research suggests that stigmatized people are more likely to respond individually than collectively to stigma-related stressors, this may depend on whether prejudice and discrimination are perceived as individual- or group-level stressors (Wright et al., 1990). This perception can be influenced by the strength of one's identification with a stigmatized group (Branscombe & Ellemers, 1998). For less identified group members, the chief problem is that their personal outcomes are affected by the stigma associated with their group, and coping efforts are more likely to focus on changing or altering these personal sources of stress. For highly identified group members, the chief problem is that the group is devalued, and coping efforts are more likely to focus on raising the status of the group or helping the group as a collective (Branscombe & Ellemers, 1998).

There are some costs to engaging in primary-control coping with stigma. Individual coping responses, such as efforts to compensate for prejudice by altering behavior and controlling emotions and their expression, can tax the resources of stigmatized people (Crocker et al., 1998) and alienate them from their group (Branscombe & Ellemers, 1998). Collective action risks social upheaval and alienation from the larger society (Branscombe & Ellemers, 1998). Nevertheless, the general stress and coping literature suggests that primary-control coping can promote adaptation to stressful events. It is therefore disappointing that relatively little research has been conducted on this important topic.

Involuntary Responses to Stigma

Engagement Responses: Physiological Arousal, Emotional Arousal, Rumination, Intrusive Thoughts, and Impulsive Action

Involuntary engagement responses to stigma can include cardiovascular activation (Armstead et al., 1989; Krieger & Sidney, 1996), emotional arousal (Armstead et al., 1989), intrusive thoughts, and rumination about the event or problem (Smart & Wegner, 1999). For example, blood pressure rises among African Americans who view racist scenes (Armstead et al., 1989), and anger is one of the most frequent responses stigmatized people have to prejudice (Clark et al., 1999; Swim et al., this issue). Intrusive thoughts are a factor in stereotype threat effects. The stigmatized person begins thinking about the possibility of confirming negative stereotypes, even though such thoughts may be distracting to performance and create anxiety (Steele & Aronson, 1995).

Research on general stress reactions suggests that certain types of involuntary engagement responses to stigma-related stressors may be maladaptive. Rumination and intrusive thoughts in particular are related to depression and psychological distress (Nolen-Hoeksema & Morrow, 1993). This suggests that stigmatized people who cannot free themselves from thoughts about prejudice-inspired mistreatment or who worry about confirming stereotypes may be less resilient with respect to their stigmatized status than are those who do not have these involuntary engagement responses. Other involuntary engagement responses may produce better outcomes. For example, emotional and physiological arousal may alert the stigmatized person about threats to the self and motivate coping responses that alleviate those threats (Swim & Hyers, 1999). Impulsive behavioral reactions to prejudicial events also may serve an adaptive function. For example, women who interacted with a confederate who made blatantly sexist remarks sometimes responded with surprised exclamations (Swim & Hyers, 1999). Although it was perhaps not the intended effect, these exclamations could serve as a protest against the remark. Such impulsive responses may be especially important because stigmatized people may be otherwise reluctant to confront prejudice, even if they are very offended and upset by it (Swim & Hyers, 1999).

Disengagement Responses: Avoidance

One recent development for understanding the adaptiveness of different stress responses is that that there is an important difference between voluntary and involuntary avoidance. As we described before, *voluntary* avoidance of thoughts and emotions related to a stressor is associated with greater psychological distress and poorer adaptation to the stressor. Deliberate suppression of thoughts about the stressor, for example, is notorious for producing rebound effects, resulting in

intrusive thoughts about it (Smart & Wegner, 1999). However, *involuntary* avoidance responses may be a different story. Researchers have found evidence that some people may disengage with stressors by successfully screening them out at the preattentional level, and that those who do this successfully experience reduced levels of psychological distress (Mogg, Bradley, & Hallowell, 1994).

For example, high- and low-trait-anxious college students differed in whether they unconsciously avoided attending to words related to threatening experiences (e.g., the approach of final exams or bogus negative feedback). Low-anxious students avoided attending to nonconsciously presented threat-related words (that is, words presented too quickly to be recognized). High-anxious students gave *more* attention to unconsciously presented threatening words when they were under stress (Mogg et al., 1994). This suggests that involuntary avoidance of threat may be psychologically adaptive (Mogg et al., 1994). In a recent study, Glinder and Compas (2000) showed differences in the relationship between voluntary and involuntary avoidance and psychological adjustment following a major stressor. Whereas psychological adjustment following a diagnosis of breast cancer was not correlated with avoidance of cancer-related words that were presented at the conscious or attentional level (that is, at a speed that allowed recognition), adjustment to breast cancer was *positively* correlated with avoidance of cancer-related words that were presented at the unconscious or preattentional level (that is, too quickly to be recognized). These studies suggest that involuntary avoidance may be adaptive, whereas voluntary avoidance is not.

This distinction between voluntary and involuntary disengagement may be important for understanding how the perception of prejudice affects the psychological and physical health of stigmatized people. Stigmatized people who tune out the daily slights and hassles that arise from prejudice or experience a dampening of emotional response to these events may maintain emotional equilibrium without taxing their coping resources. Stigma researchers usually assume that disengagement is a voluntarily chosen conscious strategy. Ruggiero and Taylor (1997), for example, suggest that minimization of prejudice occurs because the benefits outweigh the costs, implying a weighing of costs versus benefits. Current research raises the possibility that some stigmatized people may avoid thoughts of prejudice at the involuntary, preconscious level. This would mean that cues indicating the presence of prejudice or discrimination would not even enter into the stigmatized person's conscious awareness. This type of "minimization" of prejudice may help stigmatized people avoid a great deal of stress.

Multiple Roles for Stress and Coping Responses

The Compas et al. (2001) stress and coping model we just described is useful in organizing the wide variety of responses people have to stigma-related stress into a small number of empirically supported dimensions. One caveat to keep in

mind in thinking about how stigmatized people respond to stigma-related stressors is that a particular response can serve multiple roles.

A good example of this is seeking social support (see Gaines, this issue). Social support figures prominently in virtually any discussion of coping, but it has been notoriously difficult to pin social support down to a single function. It can help people solve problems, provide them with a way to express or vent their emotions, help them redefine the stressful event, or distract them from the event (Compas et al., 2001). Thus, there may be many reasons why stigmatized people access social support. Stigmatized people who have social support from other stigmatized people are less likely to use denial to cope with discrimination and more likely to make attributions to prejudice (cognitive restructuring; Ruggiero, Taylor, & Lydon, 1997). Supportive others provide a safe environment for expressing emotions arising from prejudice. Problem solving, particularly collective efforts to make societal changes or demands for redress for discrimination, often depends upon having social support.

A case also could be made that devaluation of/disidentification with stereotyped domains (which we classified as secondary-control coping) involves disengagement. Once the domain ceases to be important for self-evaluation, the stigmatized person may withdraw efforts from the domain. Thus, devaluation/disidentification can easily lead to avoidance coping, which is one of the disengagement coping responses described by the Compas model (Compas et al., 2001; Connor-Smith et al., 2000). In fact, stigma researchers often use the term *disengagement* to refer to the process of reducing the importance of the domain to the self (Crocker et al., 1998; Major & Schmader, 1998; Schmader, Major, & Gramzow, this issue).

Some avoidance coping responses, in turn, could involve changes in how one thinks about the situation and thus could be considered to have elements of cognitive restructuring. For example, physical avoidance of prejudiced people likely involves devaluing the benefits of associating with them, a form of cognitive restructuring (Cohen & Swim, 1995; Miller & Kaiser, 2001). In sum, any particular response to stigma-related stress could play a number of roles.

Lessons to Be Learned From the Stress and Coping Literature

As research on stress and coping has matured, researchers have had to grapple with a number of theoretical and methodological issues. In doing this, they have encountered a number of pitfalls, blind alleys, and dead ends. Although these issues have by no means been completely resolved, progress has been made. Familiarity with the problems and issues that have arisen in the general stress and coping literature should help stigma researchers avoid some of these problems.

Ever since Lazarus and Folkman (1984) published their seminal work on coping, it has been clear that responses to stress can be best understood by a

transactional, process-oriented model. People do not do just one thing in response to stress; they usually try several alternatives, and feedback from one response alters other responses that are made (Lazarus & Folkman, 1984). Not only are there large differences among people in how they respond to and cope with stress, but the same person may have different responses depending on specifics of the stressor and the situation in which it is encountered.

The chief problems that have arisen in stress and coping research include the following. First, there has been a proliferation of dimensions used to describe stress and coping responses that rest on insufficient theoretical and empirical foundations (see Compas et al., 2001, for a review). Second, coping researchers made many efforts, mostly unsuccessful, to identify coping styles and relate them to adaptive outcomes. The failure of these efforts often is attributed to the fact that individuals have repertoires of stress and coping responses that are adaptive for different stressors under different circumstances (Gottlieb, 1997). Third, the stressors studied by coping researchers range from daily hassles to major life events. Ignoring differences among stressors may explain why findings so often are inconsistent (Gottlieb, 1997).

Research on coping with stigma is in its infancy, but some of the pitfalls that befell research on general stress and coping are already apparent. Research on coping with stigma has not yet taken advantage of what is now known from the general stress and coping literature about the dimensions that underlie stress and coping responses. Stigma researchers often use dimensions that have been neither theoretically nor empirically derived. For example, Krieger and Sidney (1996) asked African Americans how they cope with racism, and the response options were simply accepting it, doing something about it, or ignoring it (all single items). Other researchers have tried, without much success, to assess stigma-specific coping styles and relate them to adaptation to stigma-related stressors (Clark & Harrell, 1982). The experience of the general stress and coping literature suggests that these efforts are not sufficiently sensitive to the dynamic interrelationships between stress and coping responses and the situations in which they occur.

Some stigma researchers have recognized the importance of distinguishing among different kinds of stressors. For example, Swim et al. (this issue) point out that sexism includes a diversity of hassles—traditional gender role beliefs, demeaning behaviors, and sexual objectification—each of which may create different levels of stress and require different responses. Others (Allison, 1998; Clark et al., 1999) have emphasized that the gamut of stigma-related stressors ranges from daily hassles (being ignored in a store) to major life events (being denied a job, education, or critical health care). Stigma researchers also have been quick to appreciate the importance of different types of stigmas (Crocker et al., 1998; Jones et al., 1984). The effects of stigma controllability and visibility have been particularly well-documented (Crocker et al., 1998). Other differences may be rooted in the unique histories of different stigmatized groups and the particular

forms of prejudice and discrimination they face. Some of the coping responses of African Americans, for example, their use of extended family networks and religion for social support, have been traced to adaptations they made to specific historical and cultural circumstances (Clark et al., 1999). Despite differences among different types of stigma, what all stigmatized people have in common is that they have a devalued social identity that exposes them to stressors they would otherwise not experience. Because one limitation of the general stress and coping literature is the broad range of stressors under investigation, stigma researchers may have the advantage of having a relatively well-defined type of stressor to investigate.

Summary and Conclusion

Our purpose in this article has been to show how developments in research on stress and coping can guide our thinking about coping with stigma-related stress. We have assumed that there is some common ground between stress and coping in general and stigma-related stress and coping in particular. Although this is undoubtedly true, one of the major lessons the general stress and coping literature provides is that different stressors evoke different responses from different individuals. Stigmatized people have different life experiences than nonstigmatized people, and because of this they are likely to have at least some different coping skills (Miller & Myers, 1998). Understanding how stigmatized people cope with stigma requires that we take their perspective and study their responses to stress.

The general stress and coping literature has established that cognitive appraisals are essential to whether a potentially stressful event is experienced as stressful. Stigmatized people's appraisals of stigma-related stressors and the resources available for coping will be critical to understanding how they are affected by their stigmatized status. The array of responses stigmatized people have to stigma-related stressors is vast, including emotional, cognitive, physiological, and behavioral responses that can occur both voluntarily and involuntarily. Consideration of the diversity of stress and coping responses will be necessary to gain a complete understanding of the consequences of stigma.

Additionally, it is important for policymakers to appreciate that the physical and psychological impact of exposure to discrimination depends in part on how stigmatized people respond to stigma-related stressors. Policymakers need to understand that mitigating the detrimental effects of societal discrimination will involve more than simply focusing on the structural inequalities that result from prejudice and discrimination. By recognizing that perceived discrimination is itself a stressor, policymakers may understand the need for policies and interventions that enhance the likelihood that stigmatized people are able to cope adaptively with the stressors they encounter.

In this article we have presented an adaptation of a general stress and coping model (Compas et al., 2001; Connor-Smith et al., 2000) that organizes this diversity of responses into a framework of empirically validated dimensions. These response dimensions may be critical to understanding the circumstances under which a particular response to stigma-related stressors, for example, minimization of prejudice, will be related to positive adaptive outcomes. Our hope is that stigma researchers can jump-start their efforts to understand the consequences of the stressors associated with having a devalued social identity by making good use of this wealth of accumulated theory and research.

References

Allison, K. W. (1998). Stress and oppressed category membership. In J. K. Swim and C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 145–170). San Diego, CA: Academic.

Allport, G. (1954). *The nature of prejudice*. New York: Doubleday Anchor.

Armstead, C. A., Lawler, K. A., Gorden, G., Cross, J., & Gibbons, J. (1989). Relationship of racial stressors to blood pressure responses and anger expression in Black college students. *Health Psychology*, *8*, 541–556.

Branscombe, N. R., & Ellemers, N. (1998). Coping with group-based discrimination: Individualistic versus group-level strategies. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 243–266). San Diego, CA: Academic.

Branscombe, N. R., Schmitt, M. T., & Harvey, R. D. (1999). Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology*, *77*, 135–149.

Brewer, M. B., & Brown, R. J. (1998). Intergroup relations. In D. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *Handbook of social psychology* (4th ed., pp. 554–594). Boston: McGraw Hill.

Carver, C. S., Pozo, C., Harris, S. D., & Noriega, V. (1993). How coping mediates the effect of optimism on distress: A study of women with early stage breast cancer. *Journal of Personality and Social Psychology*, *65*, 375–390.

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist*, *54*, 805–816.

Clark, V. R., & Harrell, J. P. (1982). The relationships among Type A behavior, styles used in coping with racism, and blood pressure. *Journal of Black Psychology*, *8*, 89–99.

Cohen, L. L., & Swim, J. K. (1995). The differential impact of gender ratios on women and men: Tokenism, self-confidence, and expectations. *Personality and Social Psychology Bulletin*, *21*, 876–884.

Compas, B. E., Connor-Smith, J. K., Saltzman, H., Thomsen, A. H., & Wadsworth, M. E. (2001). Coping with stress during childhood and adolescence: Problems, progress and potential in theory and research. *Psychological Bulletin*, *127*.

Connor-Smith, J. K., Compas, B. E., Wadsworth, M. E., Thomsen, A. H., & Saltzman, H. (2000). Responses to stress in adolescence: Measurement of coping and involuntary stress responses. *Journal of Consulting and Clinical Psychology*, *68*, 976–992.

Crocker, J., Cornwell, B., & Major, B. (1993). The stigma of overweight: Affective consequences of attributional ambiguity. *Journal of Personality and Social Psychology*, *64*, 60–70.

Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review*, *96*, 608–630.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *Handbook of social psychology* (4th ed., pp. 504–553). Boston: McGraw Hill.

Feagin, J. R. & Sikes, M. P. (1994). *Living with racism: The Black middle-class experience*. Boston: Beacon.

Fiske, S. T., Morling, B., & Stevens, L. E. (1996). Controlling self and others: A theory of anxiety, mental control, and social control. *Personality and Social Psychology Bulletin*, *22*, 115–123.

Glinder, J. G., & Compas, B. E. (2000, April). Attentional bias to threat in women with newly diagnosed breast cancer. Poster session presented at the 21st annual meeting of the Society of Behavioral Medicine, Nashville, TN.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Gottlieb, B. H. (1997). Conceptual and measurement issues in the study of coping with chronic stress. In B. H. Gottlieb (Ed.), *Coping with chronic stress* (pp. 3–42). New York: Plenum Press.

Holohan, C. J., Moos, R. H., & Schaefer, J. A. (1996). Coping, stress resistance, and growth: Conceptualizing adaptive functioning. In M. Zeidner & N. S. Endler (Eds.), *Handbook of coping* (pp. 24–43). New York: John Wiley & Sons.

Jacobson, C. K. (1977). Separatism, integrationism, and avoidance among Black, White, and Latin adolescents. *Social Forces*, *55*, 1011–1027.

James, S. A., Hartnett, S. A., & Kalsbeek, W. D. (1983). John Henryism and blood pressure differences among Black men. *Journal of Behavioral Medicine*, *6*, 259–278.

Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships*. New York: Freeman.

Kaiser, C. R., & Miller, C. T. (in press). Reacting to impending discrimination: Compensation for prejudice and attributions to discrimination. *Personality and Social Psychology Bulletin*.

Kaiser, C. R., & Miller, C. T. (2001). Stop complaining: The social costs of making attributions to discrimination. *Personality and Social Psychology Bulletin*, *27*, 254–263.

Kohn, P. M. (1996). On coping adaptively with daily hassles. In M. Zeidner & N. S. Endler (Eds.), *Handbook of coping* (pp. 181–201). New York: John Wiley & Sons.

Krieger, N., & Sidney, S. (1996). Racial discrimination and blood pressure: The CARDIA Study of young Black and White adults. *American Journal of Public Health*, *86*, 1370–1378.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Major, B., Richards, M. C., Cooper, M. L., Cozzarelli, C., & Zubek, J. (1998). Personal resilience, cognitive appraisals, and coping: An integrative model of adjustment to abortion. *Journal of Personality and Social Psychology*, *74*, 735–752.

Major, B., & Schmader, T. (1998). Coping with stigma through psychological disengagement. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 191–218). San Diego, CA: Academic.

Miller, C. T., & Downey, K. T. (1999). A meta-analysis of heavyweight and self-esteem. *Personality and Social Psychology Review*, *3*, 68–84.

Miller, C. T., & Kaiser, C. R. (2001). Implications of mental models of self and others for the targets of stigmatization. In M. R. Leary (Ed.), *Interpersonal rejection* (pp. 189–212). New York: Oxford University Press.

Miller, C. T., & Major, B. (2000). Coping with stigma and prejudice. In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma* (pp. 243–272). New York: Guilford.

Miller, C. T., & Myers, A. (1998). Compensating for prejudice: How obese people (and others) control outcomes despite prejudice. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 191–218). San Diego, CA: Academic.

Miller, C. T., Rothblum, E. D., Felicio, D., & Brand, P. (1995). Compensating for stigma: Obese and nonobese women's reactions to being visible. *Personality and Social Psychology Bulletin*, *21*, 1093–1106.

Miller, C. T., & Rudiger, L. (1997, October). *Compensation for prejudice: How the stigmatized obtain desired outcomes despite prejudice*. Paper presented at the annual meeting of the Society of Experimental Social Psychology, Toronto, Ontario, Canada.

Mogg, K., Bradley, B. P., & Hallowell, N. (1994). Attentional bias to threat: Roles of trait anxiety, stressful events, and awareness. *Quarterly Journal of Experimental Psychology*, *47A*, 841–864.

Nolen-Hoeksema, S., & Morrow, J. (1993). Effects of rumination and distraction on naturally occurring depressed mood. *Cognition and Emotion*, *76*, 561–570.

Pinel, E. C. (1999). Stigma consciousness: The psychological legacy of social stereotypes. *Journal of Personality and Social Psychology*, *76*, 114–128.

Reed, G. M., Kemeny, M. E., Taylor, S. E., & Wang, H. J. (1994). Realistic acceptance as a predictor of decreased survival time in gay men with AIDS. *Health Psychology*, *13*, 299–307.

Ruggiero, K. M., & Taylor, D. M. (1997). Why minority group members perceive or do not perceive the discrimination that confronts them: The role of self-esteem and perceived control. *Journal of Personality and Social Psychology*, *72*, 373–389.

Ruggiero, K. M, Taylor, D. M., & Lydon, J. E. (1997). How disadvantaged group members cope with discrimination when they perceive that social support is available. *Journal of Applied Social Psychology*, *27*, 1581–1600.

Smart, L., & Wegner, D. M. (1999). Covering up what can't be seen: Concealable stigma and mental control. *Journal of Personality and Social Psychology*, *77*, 474–486.

Steckler, N. A., & Rosenthal, R. (1985). Sex differences in nonverbal and verbal communication with bosses, peers, and subordinates. *Journal of Applied Psychology*, *70*(1), 157–163.

Steele, C. M., & Aronson, J. (1995). Stereotype threat and intellectual performance of African Americans. *Journal of Personality and Social Psychology*, *69*, 797–811.

Swim, J. K., Cohen, L. L., & Hyers, L. L. (1998). Experiencing everyday prejudice and discrimination. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 37–60). San Diego, CA: Academic.

Swim, J. K., & Hyers, L. L. (1999). Excuse me—What did you say?! Women's public and private responses to sexist remarks. *Journal of Experimental Social Psychology*, *35*, 68–88.

Wright, S. C., Taylor, D. M., & Moghaddam, F. M. (1990). Responding to membership in a disadvantaged group: From acceptance to collective protest. *Journal of Personality and Social Psychology*, *58*, 994–1003.

Zeidner, M., & Endler, N. S. (1996). *Handbook of coping.* New York: John Wiley & Sons.

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