for example, that the degree of exclusion of individuals who are labeled mentally ill varies directly with the social marginality of the labeled individual. He writes, "However integration is indexed, people who are more marginal to the community are more likely to be excluded if they are labeled mentally ill" (p. 112). Also, the degree of exclusion of individuals that are labeled mentally ill varies directly with their cultural distance from conventional groups, and inversely with their social power. Lastly, research on mental illness shows that men are more likely than women to suffer exclusion and rejection if labeled.

To summarize, research on deviant behavior, mainly mental illness, supports the following conclusions about audience reactions toward people who possess attributes, traits, and qualities that may stigmatize: (1) With some exceptions, audiences of lay people respond differently to signs and symptoms of deviancy than do audiences of professionals. By and large, professionals tend to label such qualities as indicative of deviancy, whereas lay persons tend to respond to them by denying, ignoring or normalizing the behavior in question. (2) Among lay observers, the social distance between the audience and the person whose behavior and attributes are being observed affects the response of the audience to them. The closer the social distance between the two, the less likely the audience is to label the person as deviant, and, conversely, the greater the social distance, the greater the likelihood that labeling will occur. (3) Certain social characteristics, such as sex and the social class background of the observer affect the chances that they will recognize and label something as deviant. Specifically, the rejection of deviance varies directly with the social class of the labeler; that is, the higher the social class of the observer, the greater is the probability that they will recognize and label behavior as deviant. With respect to sex, the evidence is that women are more likely than men to recognize and label something as deviant. (4) The social cohesiveness of the group to which the audience belongs has a major impact on the responses they show to the deviancy they label. Cohesive social units tend to act inclusively and non-cohesive units exclusively to those they label as deviant. (5) Women are more tolerant and accepting of the deviants they label than are men. (6) Audience reactions to the deviant are also a function of the social integration, culture, and social class background of the person who is labeled.

Jones, et al. (1984) Social Stigma: The Psychology of Marked Relationships

• CHAPTER FOUR •

Stigma and the Self-Concept

THE DEVELOPMENT OF THE SELF-CONCEPT is a distinctly social process. Other people are essential to our efforts to acquire knowledge about the self and to the evaluation and interpretation of our life experiences. A discrediting mark or stigma necessarily modifies this social process and the interpersonal relationships that are so vital for self-knowledge and self-validation. For an individual with a stigmatizing condition, the construction or maintenance of a stable and coherent self-concept may be a particularly difficult and uncertain process.

One of the key differences between the unmarked individual and the markable in the construction of self is in the affective reactions that are received from others. For the stigmatized individual, the reactions, observations, and evaluations elicited from other people may be disproportionately negative. When this occurs, association with others becomes an ordeal, something to be dreaded and curtailed as much as possible. Millman (1980) illustrates this point repeatedly, as she chronicles the plight of women who are stigmatized because of their weight. The influence of the negative responses of others and the difficulties in coming to terms with them are vividly revealed in the stories told by the women Millman studied. Being fat in this culture means that one is fair game for taunts and unsolicited reactions of others. From the kids in the supermarket who cry out, "Hey Mom, look at the fat lady," or "Look at the blimp," or "Get a load of the monster," to the supposedly well-intentioned strangers who stop overweight women on the street and say, "Why don't you try Weight Watchers?" or "I have a fabulous doctor you could go to," it seems that obese women are locked into a social information environment that is almost uniformly negative.

These negative feelings, if not their exact expression, may work themselves deeply into the individual's self-evaluation. Markables may develop concepts of themselves as different from others, as marginal and not connected, and perhaps even as alien. Consequently, each decision to connect with the social world will involve a special effort, a conscious decision of whether the contact is worth the possible humiliation and further negative reaction. Millman writes: "These are hard decisions. They are never made once and for all. Each new social contact, each act committed in public,

no matter how trivial or superficial, is dominated by the fat person's concern about how she appears to others. Thus her participation in the world is often tentative, and filled with fear of being discovered, labeled as the freak she fears herself to be" (p. 73).

Millman also quotes from the autobiography of a young woman she has interviewed:

> I always felt, when I went into some boutique, that all the salesgirls were staring at me and snickering, knowing that nothing in the store would fit me. I always had to say, "I'm just looking." . . . I always felt that the first thing anyone would notice is that I was fat. And not only that I was fat, but that they would know why I was fat. They would know that I was neurotic, that I was unsatisfied, that I was a pig, that I had problems. They could tell immediately that I was out of control. I always look around to see if there was anyone as fat as me. I always wondered when I saw a fat woman, "Do I look like that?" (p. 74).

Millman also tells the story of several fat men. The contrast is startling. Fat men are not nearly as self-conscious about their weight as women, and weight is not as important in organizing their lives. Being overweight does not completely engulf the self-concept of men as it seems to with women. In stark opposition to the pain of social contact expressed by many women, Millman quotes men who report the social virtues of being fat. One man in her study expressed it quite directly: "If anything, my weight has helped me in business. People remember me, it breaks the ice—they feel they know me because I stand out" (p. 19). Millman is careful to point out that the differences between men and women with respect to weight stem from a number of sources. She reports, for example, that in the case of most men in her study, they did not become fat until later in life, and thus were spared the "fat child" and the "fat adolescent" experiences.

"Come Out, Come Out Wherever You Are"

(Some comments taken from an article by Margaria Fichtner, entitled "A Proverbial Fat Lady, and Jolly-Well Content," in *Hartford Courant*, date unknown. The article features Carole Shaw, author of *Come Out, Come Out, Wherever You Are*, American R. R. Publishing Company, 1982. The first three comments are taken from that book.)

—"Stand up straight, throw your shoulders back and look the world straight in the eye. Don't be afraid to take up space. You have a perfect right to it."

—"Nobody!—Not your doctor, your lawyer, your spouse, your inlaws—REPEAT, REPEAT—Nobody is entitled to demean you."

—The most familiar type of discrimination large people face is bias during a job hunt. I don't know how you handle the bigot who objects to your weight. Maybe you can humor him into hiring you. 'Did you intend to pay me by the hour or by the pound?' Yet we all know this situation is no laughing matter.

"Don't think [says Carole Shaw in the interview] that the personnel director has any knowledge of what the world is like from a big person's point of view unless she or he is a big person too, or is related to one. They don't know, nor can they be expected to care, that it may be extra difficult for a large size person to find decent clothes. Do not think you are excused if you go to an interview with a stain on your blouse, or a run in your stocking, or so forth. No one can expect preferential treatment in a chic advertising agency . . . if she stumbles in wearing a polyester polonaise."

"You see, it's not just me and 12 other ladies. But even so, you do feel isolated. You never seem to see the other fat ladies on the street. Your eyes aren't tuned to see them. All you see is that everyone seems to look wonderful except you. . . . Maybe there's something wrong with our definition of beauty. You go into the supermarket, and there are 12 different cereals. You go out to buy a car, and there are all types to choose from. Why can't the same be true for people? We got fat; we didn't get stupid."

What is most apparent from these self-descriptions by fat men and women is the dramatic variation in the consequences of a specific stigma for the self-concept. When and how pervasively the self-concept will reflect the negativity produced by a stigma depends on the nature of the stigma and on the reactions of others in the social environment. But it also depends on when and how in the course of self-development the reactions of others are heeded and on how they are interpreted and evaluated. In Millman's

book, both the men and women are aware that they are fat and that this condition can produce hostile reactions in others. Yet the women are much more concerned with their weight, as they are likely to be about all aspects of physical appearance. They emphasize the importance of weight to their overall self-evaluation, and, consequently, they are decidedly more stigmatized by their obesity than are the men who do not consider their weight to be a particularly significant attribute in their self-definition.

CONSTRUCTING THE SELF-CONCEPT

The acquisition of knowledge about the self depends on the observation of one's own behavior, on comparison with others, and on seeing ourselves through the eyes of others. Depending on the exact nature of one's theoretical orientation, one of these factors may be given more emphasis and attention than the others in determining how the self-concept develops, but all of these modes of acquiring knowledge are fundamentally altered by stigma.

In this chapter, we will assume that an individual actively constructs a self-concept from the information contained in his or her unfolding experiences, particularly those that involve the self-relevant responses of other people. The self-concept in this culture is assumed to contain representations of our special abilities, achievements, and preferences, the unique aspects of our appearance, and the characteristic expression of our temperament. It is assumed to result from an elaborate interplay of one's own thoughts and feelings about the self with the thoughts and feelings that are elicited or inferred from others' reactions. A crucial feature of the self-concept is the sense of continuity it provides for our life experiences. We experience this continuity because the self-concept typically changes only very gradually over time. Moreover, the self-concept contains representations of the self in the past as well as ideas of the self in the future, both of which contribute to a sense of personal coherence and stability.

The amount of information about the self that is potentially available is vast, since almost all of our actions implicate the self in some way. An individual cannot possibly attend to all of the available information and must, therefore, be highly selective. What information an individual chooses to view as important or diagnostic for the self depends on an array of personal, situational, and historical factors. Of primary importance among these selective factors, however, are one's prevailing generalizations about the self—one's self-schemas (Markus 1977, 1980). These self-schemas allow us to attend to certain features of our behavior while disregarding others.

They can be viewed as summaries and constructions of past behavior that enable individuals to understand their own social experiences. Self-schemas are assumed to develop from the repeated similar categorization and evaluation of behavior by one's self. This process also incorporates the evaluations of others and eventually results in clearly differentiated ideas of the kind of person one is with respect to particular domains of behavior.

Not everyone organizes his or her own experiences in similar ways and not everyone develops the same self-schemas. One person may think about his behavior with respect to how shy he is, how productive he is, what a rotten husband he has been, or how in the future he'll slow down and enjoy things more. Another person may not organize her behavior in these terms at all. Instead she may think about how independent she is, what a good athlete she used to be, or what a creative photographer she is now. We do not all pay attention to the same type of events in our lives and we do not all use the same dimensions, categories, constructs, or metaphors to think about our lives. According to this theoretical orientation, self-schemas define those domains of behavior over which individuals believe they should have control or have claimed for their own responsibility. A self-schema emerges as one begins to experience some feelings of personal responsibility in a particular domain of behavior, and the development of a self-schema consolidates these feelings into a sense of control. Self-schemas are also assumed to contain representations of relevant goals and motives, and thus, in the domains of their self-schemas, people know what to expect for themselves and how to predict and interpret their behavior. In domains for which they do not have such well-established self-schemas for thinking about their behavior, people are likely to be relatively less self-regulated and much more reliant on the reactions and evaluations of others for self-definition. We also seek input from others in our self-schematic domains, but this input is very often tempered and modified by our own strong views about ourselves.

With respect to potentially stigmatizing attributes or qualities of the self, it follows from this reasoning that individuals may attend to a mark, build a self-schema around it, and thus ensure its position as an important element of the self-concept. Alternatively, the individual may choose to deemphasize the mark or even ignore it altogether. For example, some individuals are intensely concerned with their weight, while others who may be equally overweight are not. Some children dwell on the fact that they only have one parent rather than two, whereas others appear not to notice it. Some people continually concentrate on a previous bout with cancer or a prior nervous breakdown, while others appear to ignore these same events,

"healthy" and what the range of individual differences are with respect to this phenomenon. We are, of course, aware of the pathologies associated with extreme divergence between what others think of the self and what the individual thinks. There are, for example, those cases where there is virtually no overlap in the self/other construction of social reality, such as with those individuals who come to believe erroneously that they are Jesus Christ (e.g., Rokeach, 1964), but at the less extreme level, the self/other discrepancy in self-definition has not been a focal concern in social psychology. This discrepancy exists for all individuals, but it varies with the nature of the social context and the nature of the self/other relationship, and, under most circumstances, would be difficult to evaluate. With the presence of a mark, however, there is a referent or anchor for the difference between one's conception of self and other's conception of self. Studies of this divergence in stigmatized individuals might be a useful starting point for an exploration of this general problem.

We have suggested that the self-concept of the markable person was most likely to be affected by consistent, negative feedback from others, and we have outlined some of the conditions that were likely to ensure this type of social information environment, as well as the factors that were likely to moderate its impact. It appears that a stigma will necessarily have some effect on the self-concept because a stigma interrupts and interferes with the social processes that attend the construction and maintenance of a self-concept. Because of the possible divergence between self-stigmatization and other stigmatization, it is not possible to make simple or straightforward predictions about the nature or extent of the influence of a mark on the self-concept. Theorizing about the self-concept of the stigmatized can begin, however, by speculating about the cluster of points representing one's stigma-relevant social interactions. This cluster can be analyzed for its range of emphasis, for the general level of self/other congruence, and for the particular way in which points are distributed within the cluster. This preliminary analysis will provide the basis for determining whether the markable person will indeed incorporate the stigma into his or her view of the self and the importance that will be assigned to this aspect of self.

In the following sections, we will assume a moderate level of agreement between self and other with respect to a marking condition and explore some of the specific ways that such conditions can have an influence on the self. We will consider their influence on self-esteem, on the structure of the self-concept, on the role of others in defining the self, and on past and future selves.

THE INFLUENCE OF STIGMA ON SELF-ESTEEM

The most direct effect of stigma on the self can be seen in the effects of the stigmatizing process on the markable person's self-esteem. This consideration is of primary importance because the nature of self-evaluation is likely to be related in an important way to both the structure and the content of the self, as well as to the coping strategies of the individual.

Self-esteem is usually considered to be a summary evaluation of the attributes of the self or the extent to which individuals are satisfied or pleased with themselves (Rosenberg 1965; Coopersmith 1967). High self-esteem implies that individuals feel positively about themselves, that they respect themselves and feel they are worthy. Low self-esteem suggests negative feelings about the self, a dissatisfaction, and a lack of respect or rejection of the self. Most of the empirical work on self-esteem has considered it to be a relatively stable or enduring quality of the self that refers to the individual's beliefs about himself or herself as a capable, significant, or worthy person. There are some aspects of one's overall evaluation of self, however, that are closer to what is meant by mood or temporary affective feelings about the self (e.g., how do I feel about myself as a person right now under current conditions, compared to how worthy or significant I generally consider myself to be). This affective component of self-esteem may be partially independent of one's set of beliefs or knowledge about the worth of the self, and may indeed be much more contextually dependent. In considering the relationship between stigma and self-esteem, this affective component may be particularly significant. As the element of self-esteem that is potentially the most easily modifiable, it is this aspect that may initially be most responsive to the negative evaluations of others with respect to the mark, perhaps causing individuals to feel depressed or angry when they realize that they have been stigmatized.

Social Support for the Stutterer

("Support Group Puts Stuttering in Its Place," *Hartford Courant*, November 18, 1982, by D. Morales)

Steven Sandler didn't like to talk when he was young. Other children would laugh at him and mimic him when he stuttered. Bullies would beat him up after school. . . .

> **Sandler said he remembers when family and friends reacted negatively to his early stuttering habits. "I became very anxious and nervous about it," he said. Stuttering persisted when he began attending elementary school. . . . "The other kids would laugh at me. I became more and more afraid to talk. . . ."**
>
> **In high school, he would be afraid to ask girls out for dates and didn't socialize much. . . . "I was afraid of rejection," he said. Once, in college, Sandler asked a girl out on a date. "She said no because I stuttered. That devastated me."**
>
> **[Finally, in graduate school, Sandler learned to deal with his speech habit.] "I realize [now] that it was other people's problem if they couldn't deal with my stuttering. Only I can hurt me."**
>
> **[As a result of his own experiences as a stutterer, Sandler holds support group meetings in his apartment for Hartford-area residents who stutter.]**

That a stigma is likely to have a compelling influence on self-esteem is apparent for a number of reasons. Stigmatizing an attribute or feature for an individual is likely to lead to lowered self-esteem because the average evaluation of the attributes comprising the self would change. Moreover, negative feelings about the self, even about aspects of the self that are relatively unimportant, are not easily contained or isolated. They often spread and create an overall negativity toward the self, because the mark is linked to underlying attributions of a more pervasive and general significance. In fact, in Chapter 1 the stigmatizing process was characterized as one in which the marked individual is negatively evaluated and seen as flawed or unworthy. The individual's very identity is at stake. Not surprisingly, then, acceptance of negative evaluations by others and stigmatizing one's self has particularly dire consequences for self-esteem. In stigmatizing one's self, the individual does just what the marker is presumed to do: He goes beyond the particular blemish or deviant attribute to infer underlying negative dispositions or person qualities. It is not just that one is fat or gay or blind or alcoholic, but rather that one is, therefore, fundamentally flawed as a person—sick, weak, immoral, or evil. In Goffman's terms, one has "a spoiled identity."

Sontag (1977), in writing about the metaphorical uses of cancer, quotes from a journal by Katherine Mansfield written as she was dying of cancer. Mansfield writes: "A bad day . . . horrible pains and so on, and weakness. I could do nothing. The weakness was not only physical, I *must heal my Self* before I will be well. . . . This must be done alone and at once. It is at the root of my not getting better. My mind is not controlled." The cancer here is not just a single quality or attribute of the self, it has possessed the self. Mansfield appears from this quote to have linked the cancer with underlying spiritual or mental weakness. Similarly, the fat woman who stigmatizes herself does not do so simply because she weighs too much, but because she is lazy, self-indulgent, secretive, and greedy. These are the kinds of negative thoughts that run deep and take root. They may so alter one's sense of self that even a drastic change in, or a removal of, the stigmatized condition may not shake them.

Whether or not the markable person accepts the negative evaluation of others and, indeed, comes to view the self as unworthy and contemptuous depends on how much emphasis is given to the mark by the self and others, and whether there is congruence between views of the mark held by self and other. Referring again to Figure 6, it is possible to make some predictions about how particular stigmatizing conditions may influence the self-esteem of the markable person. The individual is likely to feel the most devalued when there is a congruence between self and other, and when they both give a great deal of weight to the mark. We noted earlier that congruence between self and other was likely when the stigma was nonconcealable or socially disruptive. Giving a great deal of emphasis to the mark on the part of self and other is most likely when the stigmatizing condition is relatively new and knowledge about its full range of effects and the course it will follow is changeable and uncertain. The individual who experiences a severe accident and is left paralyzed or disfigured is an example that fits these criteria. Both the marked individual and the others surrounding him are likely to be horrified by the accident, and these feelings are likely to be fueled by ignorance and fear about the fate of the condition. Similar congruence in emphasizing the mark arises when an individual is diagnosed as having cancer. Not only do such diagnoses trigger the stigmatizing process in friends and relatives, many victims report severe battles with depression and entertain thoughts of suicide as an immediate response to the news that they have a life-threatening illness.

Congruence between self and other stigmatization is likely to be associated with lower self-esteem. It is only when markables can manage to give less weight to the mark than that given by others that they can maintain a relatively high level of self-esteem. Sussman (1973) found, for example, that the deaf have lower levels of self-esteem than those who can hear. To the extent that the mark becomes deemphasized, however, as is the case

when a deaf person becomes a member of a deaf community, self-esteem is increased. As part of a deaf community, individuals are able to view themselves as less marginal and to direct their attention away from their deafness to other qualities, thereby giving the mark less weight than it is given in the hearing world. By becoming members of a community of individuals who are similarly stigmatized, individuals, in terms of Figure 6, reduce the spread of their cluster of self/other points. There is less variation and the perceptions of self become more stable and sharply drawn. However, though living with others who are similar may ensure a higher self-esteem and a more stable self-perception, it may also create conditions that make change and growth particularly difficult. Great variation in how others perceive one may create uncertainty, but it also provides the possibility of seeing one's self in alternative ways, should this be desired.

Associating with others who have similar stigmas may serve to enhance or at least protect one's self-esteem, but there are still some differences within communities of stigmatized individuals that suggest that self-esteem continues to be a foundation of how one can relate to the dominant, nonstigmatized world. Thus, Sussman found that the better deaf individuals felt about their speaking and lip-reading capabilities, the higher the self-esteem. Also, Jacobs (1974) found that leaders of a deaf community accord themselves higher prestige and esteem if they have some oral skills. Higgins (1980), however, finds that those who sign have a higher prestige within the deaf community, suggesting that prestige among the deaf and self-esteem may not be automatically highly correlated.

As individuals work to create a discrepancy between self and other stigmatization so that they emphasize the negativity of their mark much less than others, they are likely to improve their levels of self-esteem, and, in some circumstances, they may even be able to achieve a level of esteem higher than the majority, nonstigmatized group. The most striking example of this is found in Rosenberg's study (1979) of self-esteem among blacks in various social environments. He finds that in some college communities where there are vigorous black support groups, the self-esteem of black students is higher than their white counterparts in other college communities. In this example we can speculate about whether these individuals have raised their self-esteem by making their potentially stigmatizable quality less salient, as members of the deaf community have done with deafness, or whether membership in the black community serves to emphasize blackness and strives to turn a potential stigmatizing mark into a virtue or an asset.

To the extent that individuals create a discrepancy between self and other perceptions by attaching a great deal of importance to their mark, they may radically lower their self-esteem, feeling more negatively about themselves than they could feel even if they completely internalized all of the potential negative reactions of others. A good example of this phenomenon can be found among young women who become anorexic. These women usually feel badly about their bodies and themselves, often to the point of self-hatred. Although often painfully thin, they may think of themselves as grossly obese and go to great lengths to arrange their lives so as not to eat.

Typically, most studies of self-esteem have not explored the antecedents, consequences, or correlates of lower self-esteem. It might be argued, as it has been following reports of relatively low levels of self-esteem among women and blacks, that the measures of self-esteem employed in these studies do not tap all aspects of one's self-knowledge about why one is a worthy or capable person. The most commonly used scales, the Rosenberg (1965) and the Coopersmith (1967), are very heavily slanted toward determining the individual's feelings about his or her competence, efficacy, or achievement. They include such yes-or-no questions as, "I am able to do things as well as most other people" and "I feel that my life is not very useful." They do not for the most part include questions about other aspects of one's view of self with respect to the social, emotional, or communal qualities of self. It is true that many stigmatizing qualities do indeed interfere with one's ability to be instrumental in certain ways, but, at the same time, they may not interfere with other aspects of the self-worth. It is even possible that a stigma could enhance one's feeling of self as a noble, long-suffering, or spiritual person, while at the same time rendering one occupationally helpless. Individuals who do manage to overcome some of the difficulties associated with a particularly severe stigmatizing condition and who serve as models and inspirations to others are reasonably likely to feel good about themselves, and perhaps to achieve a level of self-esteem they might not have realized as an unmarked and nondistinctive individual. Further study of the effects of stigma on components of self-esteem other than achievement is necessary here.

A consideration of the influence of stigma on self-esteem is critical because self-esteem is very strongly related to coping. Productive coping and a relatively high level of self-esteem can be viewed as mutually and reciprocally dependent on each other. Yet a positive relationship between these two phenomena may not always be observed, because there may be a divergence between self-judgments of coping and the coping that is apparent to others.

For example, a marked person may convince others that he is coping very well, thereby encouraging them to give less weight to the mark. Privately, however, the marked person may feel very troubled and threatened. Alternatively, over time another individual may perceive a great deal of progress in her own ability to cope with a stigmatizing condition, and finally succeed in attaching less importance to the mark in her view of self. Others, unable to assume this ipsative perspective, may only perceive that the individual is still not meeting normative standards for making the best of things. There also may be among some markers a type of irrational irritation for those marked individuals who appear insufficiently daunted by their conditions and who seem to violate the expected order by coping with or even overcoming them.

The self-esteem of stigmatized individuals will increase to the extent that the individuals come to view themselves as other than helpless, dependent, and worthless. This process is synonymous with removing the stigma associated with a particular mark and is at the heart of controlling the stigmatizing process. The mechanisms by which people come to terms with their stigma or even manage to remove or disassociate themselves from the discrediting aspects of the mark are somewhat curious and not well understood. There are those who come to view themselves as chosen and who see it as their mission to educate the rest of us about what is really important in life. Hunt (1966), who has spent much of his life in an institution for the disabled, writes about what he considers his project: "We have a special insight to offer, because our position gives us an extra experience of life in the passive aspect that is one half of the human reality. Those who lead active lives are perhaps especially inclined to ignore man's need to accept passivity in relation to so many forces beyond his control" (p. 150).

Others may feel that a stigma provides them with an opportunity to change their life course, to alter the flow of events, something that would not be possible without the special circumstances created by a stigma. In the film *Ikiru* by Kurosawa, the protagonist, after learning he has terminal cancer, quits his job and attempts to champion the cause of a slum neighborhood. He is driven by the hope of redeeming an undistinguished life and of doing something worthwhile. Presumably, in so doing, he will be able to accept the stigmatizing condition while simultaneously refuting through his actions the attributions that he is a worthless or spoiled person.

Some people, instead of turning a stigma into a virtue, shield themselves from negative self-evaluation by deciding to spend most of their lives among others who are similarly afflicted. Still others may attempt to educate both

themselves and others to the actualities of the mark that has elicited the stigmatizing reactions. In so doing, these individuals may work to disassociate the mark from the particular dispositions that may be erroneously assumed to underlie it. In this sense, cancer would be seen simply as a disease and not as a symbol of weakness, evil, or moral inferiority. How individuals will work to free themselves from negative feelings, or whether they will attempt to do so, depends on the structure and content of the self-concept and the role that is accorded the stigmatizing quality or condition.

THE INFLUENCE OF STIGMA ON THE STRUCTURE OF THE SELF-CONCEPT

Traditionally, the self-concept has been thought to be a complex of physical traits (tall, brown-eyed, blonde), attributes that summarize one's behavior (aggressive, compulsive, or outgoing), demographic characteristics (age, sex, family status), and roles (student, scientist, grandfather). In short, the self may be thought to contain all of the descriptors and attributes that can be elicited by giving an individual the Twenty Statements Test, an inventory that asks simply "Who am I?" twenty times in succession (Kuhn and McPartland 1954).

Investigating the influence of a stigma on the structure of the self-concept is particularly complex. With self-esteem, the primary concern is whether a mark of deviance will lead to a good or bad feeling about the self. With respect to the structure of the self-concept, the parallel concern is with how the mark influences the organization of the self, and the possibilities are infinite. Which aspects of the self are most directly influenced by the stigma? Does the stigma influence a physical characteristic, a pattern of behavior, a role, or all of these? These questions are difficult ones, and it is seldom that a mark will remain confined to just one aspect of the self. Marks are easily elaborated in the stigmatizing process to play a more central role in self-definition. If, for example, a woman has a mastectomy, it may appear that the mark concerns the physical self and that most of her many social roles or patterns of behavior will be relatively unaffected. Following her recovery from successful surgery, this woman should be able to continue in her roles of social worker, wife, mother, and marathon runner, and display her characteristic styles of behavior, thus indicating a self-concept relatively unaffected by the presence of the mark. But if the physical self is very important, perhaps central, in this woman's self-definition, her adjustment to the stigmatizing condition may be decidedly more problematic. In such a case, the stigma is likely to influence how she feels about

to create some type of structure around it; and the question is, what is the nature of this structure of self-knowledge?

It appears that individuals who are fat or crippled or deaf may think in terms of "what they are not" or "what they cannot do," such as "I am not thin," "I cannot wear nice clothes," "I cannot dance," and "I cannot be accepted as an equal at work." This type of self-knowledge explicitly invokes contrast with other people. Every cognition is tied to knowledge of what others have or can do. It may be that a structure based on such negative self-knowledge is intrinsically less stable than one based on positive self-knowledge, and more directly tied to social comparison with past selves.

It is difficult to construct a concept around a void, and it is cognitively easier to form a concept based on affirmation than on negation (Bruner, Goodnow, and Austin 1956). In this respect, it is noteworthy that the anecdotal evidence seems to suggest that, although the stigma may assume a master status immediately following a trauma, in the sense that the mark organizes all of one's thoughts and feelings about the self, it is not likely to continue to do so. The self-concept then appears to mirror one's actions in the world, and not one's inactions or inabilities. Individuals may feel negatively toward themselves but they are unlikely, except for the times immediately following trauma, to feel incomplete or less than whole. The self-concept, therefore, forms around the qualities, attributes, and abilities that one does have.

Quite surprisingly, many blind people and many deaf people, for example, report coming to experience no sense of handicap at all (Higgins 1980). Hunt (1966), in an essay on the role of stigmatized individuals in society, wrote about his life in an institution with people who had severe and often progressive physical disabilities. He was convinced that individuals who were denied some of the usual self-defining qualities, possessions, or roles find other domains in which to define a self. He writes,

> If the worth of human beings depends on a high social status, on the possession of wealth, on a position as parent, husband, or wife—if such things are all-important—then those of us who have lost or never had them are indeed unfortunate. Our lives must be tragically upset and marred forever, we must be only half alive, only half human. And it is a fact that most of us, whatever our explicit views, tend to act as though such "goods" are essential to a fully human existence. Their possession is seen as the key to entry into a promised land of civilized living. But set over against this common sense attitude is another fact, a strange one. In my experience even the most severely disabled people retain an ineradicable conviction that they are still fully human in all that is ultimately necessary (p. 147).

The ability of individuals to achieve personal meaning and understanding, even in the face of severe disability, may attest to the difficulty of constructing a self-concept around a void. Some present and positive qualities must be seized upon as the basis of self-definition.

We suggest then that the self-concepts of stigmatized individuals are also built around the traits, abilities, and qualities they do possess. This point is emphasized here because it is with respect to this issue that actors and observers often differ dramatically. The observer, or the marker, focuses on the potentially stigmatized individual and sees what the individual does *not* have or is *not* capable of doing. This lack is figural, in that it dominates the marker's conception of the markable. For the markable, however, the focus is more likely to be on new or different abilities that represent an adaptation to the mark. This potential asymmetry between the actor and the observer in what each assumes about the markable and what is central to the self-conception is one of the stumbling blocks to relationships between markers and those who are marked. It is difficult for each to grasp the assumptions of the other.

THE INFLUENCE OF STIGMA ON HOW OTHERS ARE USED TO DEFINE THE SELF

Avoidance is at the heart of the stigmatizing process. Very often the most appropriate way for markers to cope with the discomfort, revulsion, or hostility they feel toward various marked individuals is to minimize social contact and interaction. As we have stressed repeatedly, the self is a social product and self-definition is heavily dependent on social consensus. In previous sections, we have discussed how other people are critical for validating one's view of one's self, for eliciting and maintaining various aspects of the individual's social behavior. Other people are also vitally important as standards of comparison for one's attitudes, abilities, and attributes. The avoidance produced by the stigmatizing process directly impedes all of these processes and can radically alter the way in which others are used in defining the self.

In his theory of social comparison, Festinger (1950, 1954) postulated a drive to evaluate one's opinions and abilities, a drive giving rise to social comparison efforts. When there is no objective, nonsocial means of eval-

uating one's opinions and abilities, it is necessary to do so through comparison with the opinions and abilities of others. Specifically, Festinger stated, "Where the dependence upon physical reality is low, the dependence upon social reality is correspondingly high. An opinion, a belief, an attitude is 'correct,' 'valid,' and 'proper' to the extent that it is shared by a group of people with similar beliefs, opinions, and attitudes" (1950, p. 272). As Kelley (1952) further noted, reference groups can perform "normative" functions or "comparison" functions. The normative function comes into play when individuals attempt to gain acceptance in a reference group and feel pressure to behave as the group desires. The comparison function of reference groups is a more purely informational one in which groups serve as a standard by which to judge the correctness of one's thoughts and feelings.

A stigma establishes a barrier between the marker and the marked, thereby interfering with the natural course of the social comparison process and the dependence on social reality. For both the stigmatized individual and the marker, social contact may become stressful, even painful, and if both seek to avoid it, it will be impossible for the stigmatized person to compare adequately his own opinions and abilities to the others'. As a result, marked persons are likely to feel adrift and uncertain about many of their thoughts and feelings. Of course, with television, popular magazines, and mirrors, some amount of comparison can be accomplished without direct social contact. Individuals can engage in a type of *comparative appraisal*, in which they try to estimate where they stand on some attribute relative to other people (Jones and Gerard 1967). As with imitation and modeling, the referent others need not be aware they are being used as a referent. When social interaction is painful, markables may engage primarily in such comparative appraisal.

Some social comparison needs, however, particularly those concerned with evaluating the subtle nuances of self-referent feelings, beliefs, and abilities, cannot be satisfied through comparative appraisal and can only be fulfilled through fairly extensive social contact that directly engages the referent others in social interaction. In that process of *reflected appraisal*, we infer evaluations about ourselves from the behavior of others toward us (Jones and Gerard 1967). The socially isolated, stigmatized person may not only be denied such reflected appraisal with respect to the particular stigmatized attribute, but also on nonstigmatized qualities and traits. Failure to make the necessary social comparisons will further contribute to the markable person's feelings of alienation and estrangement. The inability to test the social reality of one's attitudes and abilities is likely to lead to the construction of a self-concept that lacks coherence or stability.

Moreover, it is not sufficient for the marked individual to have just any social contact; it must be social contact of a certain nature. Individuals need particular others for their comparison. A major hypothesis of social comparison theory states that "given a range of possible persons for comparison, someone else close to one's ability or opinion will be chosen for comparison" (Festinger 1954, p. 121). "If the only comparison available is a very divergent one, the person will not be able to make a subjectively precise evaluation of his opinion or ability" (p. 121). What constitutes a "similar" other and the ease or difficulty with which one can be selected is related to the type of stigma, to its course and origin, and to its centrality or importance to the self-concept.

The first social comparison impulses of the individual who becomes a paraplegic through an automobile accident may be to compare herself with others who were formerly similar—those who served as useful anchors or standards of comparison for abilities and opinions before the accident. The focus of the comparison is likely to be with respect to mobility and independence, and the stigmatized individual will, inevitably, as a result of the comparison, see herself as "one down" or spoiled, incomplete, or broken (cf., Kelley et al. 1960). This can readily lead to feelings of despair, depression, and withdrawal from everyday activity. As a result of the accident, the formerly similar others have now become very divergent, and the divergence serves to underscore the severity and negative consequences of the trauma. With time, however, the individual may begin to cope with her disabled state and to view herself as a paraplegic. She may now want another type of "similar other" for comparison. This similar other may be another paraplegic who has suffered from a similar paralyzing accident, typically one with a longer history of paraplegia than the individual herself. Social comparison information of this type will be crucial for determining her own rate of adjustment and adaptation, and also in determining levels of aspiration for future development. Within the groups of individuals who share particular types of disabilities, this type of comparison is inevitable and leads to some very clear in-group categories. For example, it leads to in-group terms such as "super crips," which is applied to those who can jump curbs and negotiate stairs while in their wheelchairs. At some point and for some aspects of the self, others who are similarly afflicted will be the most useful comparison others.

Those who work with various stigmatized groups report very positive effects from bringing together people who have similar problems. These types of support groups function to provide the needed similar others and to set the stage for the necessary social comparison. Very often, stigmatized

individuals, particularly those who have been afflicted with behavioral stigma, such as wives who are abandoned or battered by their husbands, experience tremendous anguish, emotional turmoil, and loss of self-esteem. Initially, many such women fail to realize that as a result of their stigmatized role, they are no longer precisely the *same* individual, and thus, different others may be needed to validate and anchor this somewhat different self. The rejected women may find others in the group who are not completely divergent from themselves on this key aspect of self-relevant experience. This may enable them to begin to define themselves somewhat differently, to construct a new self-concept in this domain.

When individuals become stigmatized as a result of a trauma, it may be particularly important then for them to have contact with others who are similarly marked, even though their most common reaction may be to withdraw from social contact altogether. Exposure to others with similar problems has a least two important consequences. It allows for comparison with respect to coping with the stigma. Second, comparison with others who are similarly marked or stigmatized should allow individuals to focus on attributes and qualities other than the stigmatized ones, and thereby provide the opportunity for them to view themselves as complex and differentiated individuals with valued attributes and abilities. Moreover, social comparison with others who are similarly afflicted may lead to the discovery of divergence from others with similar stigmatizing conditions. This discovery may in turn lead the stigmatized person back into social interaction with former similar others, in an attempt to find individuals more appropriate for comparison. Thus, a teacher who gives birth to a handicapped child may find after some period of time that she has a much greater need for and use for interaction with a former group of teacher friends than with a support group for parents of children with birth defects. This return to a former reference group may provide the individual with an opportunity to divert some attention away from the stigmatizing condition and focus it on other more positive features of the self. These generalizations about the consequences of social comparison only hold, of course, if the comparison others are models in the sense of coping well.

The role of others in defining the stigmatized self is a problem worthy of further study and may be critical for understanding the impact of a stigma on the self-concept. One of the most dramatic examples of the pernicious consequences of a failure to find similar others comes from individuals who have spent time in hospitals for mental disorders. Very often individuals who are widely different from one another and who suffer

from every type of problem, from relatively mild neurosis to severe psychopathology, are treated as one similarly afflicted group. They are, for example, taken en masse on field trips to a museum or to shopping centers. These patients are thereby forced to see themselves as others (i.e., normals in the outside world) see them. The neurotic may then take on some of the stigma of the schizophrenic because the outside visit forces him to take the role of the normal and to realize that in some respects he is indeed similar to these others. It is on these occasions that many patients may feel the most "crazy" and the most uncertain about their progress, precisely because of the lack of appropriately similar others to help achieve a meaningful social reality and to help them diffuse the effects of taking the role of the outside other. Under these circumstances the tendency to cease comparison altogether may increase, and one of the major forces ensuring this individual's link to the larger social community may be removed. Once other people are no longer used as direct-comparison others, interaction with them may cease altogether, and this is particularly so if interaction is likely to lead to further stigmatization (as may be the case with a nonconcealable, aesthetically displeasing, or socially disruptive stigma). The individual may then have little choice except to adjust to less social interaction than is desired or to become part of a social milieu in which the stigma is not salient.

The extent, nature, and variety of social comparison that is necessary for any one aspect of the self is highly dependent on how this aspect of the self has become incorporated into the self-concept. If the stigma relates to an aspect of the self that the individual does not consider central to self-definition, presumably there will be little drive to evaluate this aspect of self. If, however, the stigmatized attribute is considered important to self-definition, other people will be essential, at least until the markable develops a self-schema with respect to this aspect of self. As discussed earlier, self-schemas indicate that an individual has come to terms with a particular quality, trait, or attribute of the self and has established a relatively stable and enduring view of the self in this regard. Self-schemas represent those aspects of the self that are anchored by past experience and, thus, those that are not readily mutable. In the domain of their schemas, individuals are likely to behave consistently in a variety of divergent situations. This does not imply that individuals will be free from a self-serving bias or distortions of social reality in their schematic domains. It means only that they know what to expect for themselves and how to understand and explain their reactions in these domains. In contrast, those aspects of self for which

the individual does not have a self-schema are much more the province of the social environment, and in these non-schematic areas of the self other people are necessary to provide structure and meaning.

The person who has been stigmatized since birth with an unalterable condition is likely to have developed a self-schema with respect to the stigma and will not be constantly driven toward social comparison with others on this aspect of self. Achieving a framework of understanding about one's stigmatized quality or attributes is difficult, however, and those marked later in life are much more likely to seek out others to reach a socially confirmed self appraisal. Some of the most critical aspects of successful coping may involve decisions about appropriate comparison others and decisions about shifts in comparison—when and with regard to what shall the markable person compare himself with whom? Timing factors are undoubtedly important, since, as we have noted before, it may be very useful to compare with others who are in the same boat initially, but equally adaptive to shift toward a broader base of social comparison at some later point in time.

The choice of comparison others is not entirely up to the markable person, however. Higgins (1980) reports the difficulties that those deaf people with good speech and some usable hearing have in finding appropriate comparison others. Such hearing-impaired people may first seek to compare themselves with others in the hearing world, only to discover that, despite their ability to speak and to hear somewhat, they are still widely discrepant from most "normal" others, and cannot really evaluate their hearing ability. Those hearing-impaired people may then turn to deaf communities, where their skills of the hearing world will at least provide them some measure of superiority and perhaps some feelings of achievement. Their reception in the deaf community may not be a warm one, however, and they may be viewed as "putting on airs" (Schowe 1979) because of their skills. Higgins quotes a woman experiencing just such difficulties in trying to find appropriate comparison others: "Some of the deaf people feel that I'm hearing and I'm not totally accepted by them. And then again I'm not really accepted by hearing people. So I'm right in the middle. [The deaf] don't really accept me. They say 'You're hearing.' [They say that] because they know I can hear and I can talk" (p. 84). Until this person comes to terms with her disability and develops some fairly stable conception of her hearing ability and its role in her self-definition, she may continue to experience uncertainty over how to evaluate her ability and may be taken to task for her attempts at comparative or reflected appraisal. If a referent other assumes that the individual is too discrepant in ability, and if the discrepancy is such that the referent other appears superior, the individual may well be rejected as deviant.

Thus, the selection of comparison others for the stigmatized individual is a process that challenges one's view of self and that importantly implicates others' view of the self. But the selection process is not left entirely to the individual's discretion. The individual with paralyzed legs who attempts to walk with braces and become a "walker" may be disdained by other wheelchair users who feel that he is using an inappropriate comparison group to define himself. Anybody who is deviant in some respect may have experienced this type of difficulty in finding referent others and may only cease to have conflict when he develops a personal framework or self-schema that is somewhat autonomous and not completely linked to the potentially negative reactions and evaluations of others.

To this point, we have implied that the major obstacle for the stigmatized individual was in locating an appropriate set of comparison others. We must also consider what happens if the individual is not pleased with the results of the comparison. Put in other terms, what happens to the self-concept of an individual who constantly suffers by comparison with others? In any discussion of social comparison, it is important to note that although individuals may indeed be driven to evaluate their abilities and opinions, they also are undeniably concerned with seeing themselves in a good light and feeling good about themselves. Thus, the stigmatized individual may experience a tension between seeking out comforting comparison others (e.g., those who are worse off) and those who are better off and who, therefore, provide some realistic insight into one's degree of disability. In a discussion of this fact, Brickman and Bulman (1977) have noted that hedonic pressures push individuals to avoid social comparison situations in which they might feel insecure, insensitive, guilty, or deviant. Because of these pressures, comparison with inferior others, although in some respects less useful for information about one's relative standing, may have much greater hedonic value than comparison with superior others. Given this, the marked individual, who may already feel unworthy or discredited by the reactions of others, may be understandably reluctant to engage in social comparison that further contributes to these negative feelings. He or she may instead choose comparison with inferior others or cease comparison altogether. This is yet another reason why the marked person may be likely to use other people less than the unmarked person in constructing the self-concept.

Given the difficulties associated with the reactions of others that are likely to be experienced by a markable person, it is hardly surprising that many stigmatized individuals may alter their comparison strategies so that

they are no longer comparing themselves with others, but rather with themselves at earlier points in time. To the extent that one is divorced from a great deal of social interaction, this may become an adaptive strategy, and the one most likely to provide accurate information. Unlike comparison with others, even fairly appropriate others, comparison with one's self at an earlier time is likely to generate positively valued information for many stigmatized conditions. A plastic surgeon recounts the story of a small boy with a terribly disfiguring facial tumor who played freely, happily, and unselfconsciously with the other children, stopping only to tell an adult onlooker who was staring, "You think I'm ugly? You should have seen me before my operation" (Chase 1981). Relying on the power of comparison with the former self to make one feel good, the team of plastic surgeons who operate on cleft-palate children at Stanford University Hospital reports that they routinely wait several months before repairing the cleft palate (Chase 1981). The available technology makes this operation feasible almost immediately following birth, but the surgeons choose to postpone this operation because at birth the child is almost universally viewed as an extension or an aspect of the selves of the parents. If the operation is performed immediately, parents appear to spend their time endlessly comparing their children (and implicitly themselves) with other children and are very seldom completely satisfied with the outcome of the cleft-palate operation. Yet, when the operation is performed after the child has been at home with the disfigured face for a few months, the comparison process is fundamentally altered. Following the operation, the parents tend to compare the child primarily with the former self and are universally pleased with the outcome of the operation. It is important to note, however, that comparison with the self at an earlier time may also generate very negative information. The gymnast who dwells on his life before his trampoline accident may simply make his current disability all the more salient.

The Stigma of Being Normal

("Bodybuilder Wins $210,000 for Physique-Ruining Wreck," *New York Times*, March 21, 1983, an AP dispatch)

A jury has awarded $210,000 to a bodybuilder who lost his perfect physique in a motorcycle accident.

Matthew DeCaprio blamed the driver of a school bus for making him look like a normal person. Friday, a Circuit Court jury agreed, ordering King's Academy to compensate the 21-year old for his loss of capacity to enjoy life.

His attorney, James Tuthill, showed pictures of his client in bodybuilding poses before the accident. "Look at the size of those muscles," Mr. Tuthill said. "He's 100 percent disabled."

In sum, the process of successfully coping with a stigma can perhaps be seen as the process of finding appropriate different others. Social comparison with these appropriate others should enable one to construct a positive, coherent, and stable self-concept. In exploring the use of other people in defining the self, it may be important to examine the antecedents and consequences of various comparison strategies and how they may vary across behavioral domains and across people. A clear agenda for future research in social comparison processes would be to identify the condition under which the markable compares himself or herself with (1) normals, (2) other, more miserable markables, (3) markables who are doing well (supercopers), and (4) the previous self. It should also be possible to identify individual differences in social comparison strategies. There are, for example, those individuals who always compare themselves with others who seem better off, or whose fate in life appears more favorable. Others, however, seem riveted to comparison with the relatively downtrodden. Those who face life with a "there but for the grace of God go I" perspective are likely to spend relatively more time feeling good about themselves and their accomplishments and achievements, regardless of their stigma, than are those who feel that everyone else but them has it made. Finally, it should be possible to determine how the social context affects comparison choices for the same person.

INFLUENCE OF STIGMA ON PAST AND FUTURE SELVES

Another very important aspect of the self that must be considered in a discussion of stigma is the role of "other selves"—selves of the future and selves of the past (Markus and Nurius 1982). The role of these other selves is critical to our understanding of the impact of a particular stigma on the self-concept. These selves are not indicated by our usual measures of self-concept, which typically ask the individual to describe his or her present self, but they form the basis for our personal history as well as the essence of our future perspective. The past selves that are incorporated within the self-concept allow the individual to hold onto a self that may have existed