Stigmas and Prosocial Behavior
Are People Reluctant to Help Stigmatized Persons?

John B. Pryor, Glenn D. Reeder, Andrew E. Monroe, and Arati Patel

Introduction

The focus of this chapter is upon the relationship between stigma and prosocial behavior. According to Crocker, Major, and Steele (1998), “a person who is stigmatized is a person whose social identity, or membership in some social category calls into question his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others” (p. 504). In his pioneering treatise, Goffman (1963) identified three general types of stigma: abominations of the body (e.g., physical deformities, disease afflictions), moral character stigmas (e.g., a criminal record, addiction to drugs), and tribal stigmas (i.e., membership in a discredited social group). Prosocial behaviors may be generally defined as actions that benefit others. In this chapter, we argue that people display an inherent aversion to stigmatized persons and that this aversion represents a psychological barrier that must be overcome for prosocial behavior to take place. The aversion to stigmatized persons is found in both immediate affective responses and stereotypic beliefs about the potential hazards related to coming into contact with stigmatized persons. Below we will scrutinize evidence for these two types of aversion to stigmatized persons and will then examine the roles of attributions as potential contributors to and moderators of stigma aversion. Finally, we will describe a dual-process model of reactions to stigmatized persons that casts these psychological reactions into a framework of reflexive and deliberative processes. The relevance of reflexive and deliberative processes for prosocial behaviors toward stigmatized persons will be examined.
Aversion to Stigmatized Persons

I had a lot of friends and until I got older, it stayed that way. I guess what changed that was the fact that a lot of people didn’t want to be around my Daddy or when they would find out that he had schizophrenia they would stop coming around. (Quote from Living with Stigma, April 7, 2008)

Implicit Reactions to Stigma

A growing body of research suggests that people often have automatic affective reactions to stigmas. Though individual differences exist in the strength and valence of these affective reactions, they are typically negative. When compared to non-stigmatized persons, stigmatized persons are more likely to evoke negative affect. While people may be aware of these feelings, they are not necessarily based upon conscious beliefs about stigmas. Such spontaneous reactions to stigmas have been assessed through various methodologies used to measure implicit attitudes (e.g., the Implicit Associations Test [IAT], the Affective Misattribution Procedure, evaluative priming techniques; Fazio & Olson, 2003; Payne, Cheng, Govorun, & Stewart, 2005). In the domain of what Goffman termed abominations of the body, research has shown that people have negative implicit attitudes toward persons with disabilities (Pruett & Chan, 2006), people with AIDS (Neumann, Hulsenbeck, & Seibt, 2004), obese persons (Bessenoff & Sherman, 2000; Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, 2003; Wang, Brownell, & Wadden, 2004), and people with facial dermatitis (Grandfield, Thomson, & Turpin, 2005). In the domain of what Goffman termed moral character flaws, research has shown that people have implicit negative attitudes toward persons with mental illness (Teachman, Wilson, & Komarovskaya, 2006), drug abusers (Brener, von Hippel, & Kippax, 2007), homosexuals (Jellison, McConnell, & Gabriel, 2004), and people who smoke (Pryor, 2007). In the domain of what Goffman termed tribal stigmas, research has shown that White Americans have negative implicit attitudes toward Black Americans (Kawakami, Phillips, Steele, & Dovidio, 2007; Payne et al., 2005), Japanese have negative implicit attitudes toward Koreans and vice versa (Greenwald, McGhee, & Schwartz, 1998), Christians have negative implicit attitudes toward Muslims (Park, Felix, & Lee, 2007), and Hispanics have negative implicit attitudes toward other Hispanics who have a darker skin color (Uhlmann,
Dasgupta, Elgueta, Greenwald, & Swanson, 2002). These are just a few examples.

In some studies, dissociations have been found between explicit and implicit attitudes toward persons with stigmas. Those who profess positive attitudes toward stigmatized persons may or may not have positive implicit attitudes. A number of factors have been found to moderate the relationships between measures of implicit and explicit attitudes toward stigmatized persons (Hofmann, Gschwendner, Nosek, & Schmitt, 2005; Nosek, 2007), including political correctness concerns plus attitude strength and elaboration. People are often reluctant to admit to unfavorable attitudes toward many stigmatized groups, particularly those who are not blamed for their conditions (e.g., blind people). Such self-presentation concerns can skew explicit attitudes and create potential dissociations between explicit and implicit attitude measures. Also, explicit attitude measures can deviate from implicit measures when people have little experience with a particular stigma. With repeated experience, attitudes gain in strength and explicit and implicit measures tend to converge.

Recent research has examined the roles of specific behavioral information and stigma in forming impressions about strangers (McConnell, Rydell, Strain, & Mackie, 2008). While the valence and consistency of behavioral information about a stranger importantly determined people’s explicit attitudes, their implicit attitudes (as measured by an IAT) were more strongly connected to the presence or absence of a stigma. For example, participants formed more positive explicit attitudes about a stranger named Bob when his initial and subsequent behaviors were positive than when they were negative or became negative over time. Whether or not Bob was obese or African American made no difference in explicit attitude ratings. However, participants’ implicit attitudes were more negative toward Bob if he was obese or African American. When Bob possessed one of these stigmas, variations in his behavior failed to improve implicit attitudes.

Stereotypes about Stigma

In addition to the spontaneous aversion that people feel about stigmatized persons, people often hold conscious beliefs about why interacting with stigmatized persons is aversive. For example, the stereotypes that people hold about many illness-related stigmas often include an exaggerated sense of dangerousness. A modern case in point is HIV disease. In a 1999 national US survey, more than 40 percent of respondents indicated that they believed it possible to transmit HIV
through public toilet seats (Herek, Capitanio, & Widaman, 2002). Twenty-six percent said that they were uncomfortable using a restaurant drinking glass once used by someone with HIV. In a 2008 national US survey, 59 percent said they would be only somewhat comfortable or not at all comfortable with an HIV-positive woman serving as their childcare provider (amfAR, 2008). Despite public education campaigns regarding the actual routes of HIV transmission, many are still leery of transmission through casual contact.

Dangerousness is also part of the stereotype that people hold about many mental illnesses. For example, results from a national survey found that 61 percent of Americans believed that adults who have schizophrenia are likely to act violently (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). This same survey found that the perceived link between violence and mental illness is weaker for some mental illnesses than others. By comparison, only 33 percent indicated some likelihood of violence from a person who had major depression. Still, the expectation of violence from a depressed person was much higher than that from a troubled person. Only 17 percent expected a troubled person to be likely to exhibit violence. Substance abuse showed even stronger links to expectations of violence: 71 percent of the participants rated someone with alcohol dependence and 87 percent rated someone with cocaine dependence as prone to violence. In all cases, perceiving someone with these stigmas as more dangerous was related to a greater desire for social distance from them. The stereotype that persons with mental illnesses are prone to violence also extends to children and adolescents. Results from a recent national survey found that both 8-year-olds and 14-year-olds were believed to be more likely to be dangerous (i.e., more likely to be violent to others and to the self) if they had attention deficit hyperactivity disorder (ADHD) or depression than children and adolescents who had “normal troubles.” As with adults, the tendency to endorse these dangerousness stereotypes of mental illness was related to greater desires for social distance from these children and adolescents (Martin, Pescosolido, Olafsdottir, & Mcleod, 2007).

Research has documented a sense of dangerousness evoked by many other stigmas as well. For example, gay men are sometimes stereotyped as dangerous to children because they are assumed to be potential child molesters (Herek, 1991). Though recent public opinion polls show that most people in the US no longer openly endorse the view that homosexuals are likely child molesters (Herek, 2002), a majority still opposes adoption by gay parents (Pew Research Center, 2006). Also, more than one out of four people polled in the US feel
that school boards ought to have the right to fire teachers known to be homosexuals (Pew Research Center, 2007) and more than two out of five feel that homosexuals should not be hired as elementary school teachers (Gallup, 2008). So, many people still seem leery about children coming into contact with homosexuals. People who have moral character stigmas are sometimes perceived to be dangerous because they are believed to corrupt others (Jones et al., 1984). In the case of openly gay and lesbian soldiers in the US military, it has been argued by Pentagon officials that their presence represents a threat to morale and group cohesion, a contention not borne out in foreign militaries where gay and lesbian soldiers serve openly (Gade, Segal, & Johnson, 1996).

Origins of Stigma Aversion

Stigma aversion tendencies could potentially stem from several sources. Evolutionary psychologists have theorized that stigma represents an evolved mechanism for reducing the risk of contracting contagious pathogens (Kurzban & Leary, 2001; Schaller & Duncan, 2007). From this perspective, stigmas might instinctually evoke fear or a sense of dangerousness. Another possible evolutionary angle on the origins of stigma aversion is that humans might have evolved to avoid people who are incapable of reciprocal altruism. For example, people who are disabled might not be able to return prosocial behaviors directed toward them in kind. A third possible evolutionary origin of stigma aversion stems from humans’ desire to belong to groups (Baumeister & Leary, 1995). In-group membership is partially defined or at least accentuated by the presence of out-groups. One potential evolutionary advantage of forming coalitions or in-groups was the systematic exclusion and exploitation of other social groups (Kurzban & Leary, 2001). So, the aversion to people marked with tribal stigmas could derive from the sense that these groups seek to exclude and exploit you as a member of a rival group (Sidanius, Pratto, & Bobo, 1996).

In general, it might be argued that the evolutionary account of stigma aversion as an instinctual reaction seems consistent with the prevailing negative implicit reaction to stigma documented in the implicit attitude research described above. Spontaneous stigma aversion appears instinctual and universal, requiring no conscious deliberation and perhaps no specific prior learning experiences. On the other hand, implicit affective reactions to stigma also could be the products of evaluative conditioning (Walther, Nagengast, & Trasselli, 2005), a process that might account for the initial acquisition of a
stigma as well as stigma-by-association, the transmission of stigma to related persons.

Rozin and his colleagues have theorized that stigma aversion might stem from the perceived danger of contamination from stigmas (Rozin, Markwith, & McCauley, 1994). The fear of contamination is a superstitious sense that mere contact with a stigmatized person is sufficient to transmit all sorts of properties, including personal characteristics and moral standing. In Rozin’s research, people were found to be reluctant to come into contact even with objects somehow associated with stigmatized persons. For example, people were hesitant to wear a sweater once owned, but not even worn by, a person with HIV. Rozin, Millman, and Nemeroff (1986) suggested that such reactions to potential contamination from mere contact suggest that people implicitly follow laws of sympathetic magic such as *once in contact, always in contact*. Recent research on perceived evaluative contagion (Olson, Dunham, Dweck, Spelke, & Banaji, 2008) found that older and younger children (ages 4–12 years) believed that siblings of unlucky children were more likely to commit intentional bad acts (e.g., cheating on a test) than siblings of lucky children. So, even random events seem to have the power to transmit some favorable or unfavorable essence through social associations.

Regardless of whether someone personally endorses the magical power of a stigma to contaminate others, the expectation that others will look down upon people associated with stigmatized persons seems like a rational concern. Many studies have documented interpersonal stigma-by-association effects, the spreading of stigma from a “marked” person to people who are somehow associated with this person in the minds of others (Neuberg, Smith, Hoffman, & Russell, 1994; Ostman & Kjellin, 2002). While one of the most common routes for stigma-by-association seems to be through family ties (e.g., Corrigan, Watson, & Miller, 2006), even incidental associations have been found to be sufficient to transmit stigma from one person to another. For example, simply being seen in the proximity of an obese woman was found to result in the devaluation of a man interviewing for a job (Hebl & Mannix, 2003). Thus, stigma aversion sometimes could represent a conscious concern about sharing the stigma (Mehta & Farina, 1988).

In summary, aversions toward stigmas are in evidence in both the implicit affective reactions to stigma and in the stereotypic beliefs that people have about stigmas. While the stigma aversion may have evolved as an instinctual human reaction to many forms of deviance, modern people often incorporate reasons to avoid stigmatized persons into their stereotypes about stigmas. Also, people may be consciously
leery about the potential costs of interacting with stigmatized persons. For all of these reasons, people are often reluctant to help stigmatized persons in need.

**Attribution and Stigma**

Given the pervasive aversions that people feel toward stigma, it might seem unlikely that stigmatized persons would ever be the recipients of prosocial behaviors. This impression is far from true. For example, a field study of helping in 23 cities across the world found that 70 percent of pedestrians willingly helped a blind person cross a busy street and 64 percent offered to help a person with an obvious leg brace pick up some dropped magazines (Levine, Norenzayan, & Philbrick, 2001). It seems as though people often somehow manage to overcome their aversions to some stigmas.

The aversion to stigmatized persons can be ameliorated by a number of factors. Among the most widely studied are attributions of personal responsibility for the onset of the stigmatizing condition. When a stigma is perceived to have been due to factors beyond the control of the stigmatized person, negative reactions may be reduced. For example, Crandall and Moriarty (1995) examined the social acceptance/rejection of people with 66 different types of physical illnesses. College students rated their preferred social distance to stigmatized people described in case histories that included symptoms, disease vectors, treatments, and prognoses. Participants were less likely to socially reject those whose illnesses were perceived as less severe and less behaviorally caused. In multiple regression analyses, behavioral causality was the strongest predictor of social distance. Similarly, Feldman and Crandall (2007) examined factors that predicted college students’ social acceptance/rejection of people with 40 different mental illnesses. Descriptions of mental illnesses were based upon symptoms and diagnostic labels from the DSM-IV-TR. Once again, the degree of perceived personal responsibility for a mental illness was the strongest predictor of social acceptance/rejection followed by dangerousness and rarity.

Variations in perceived behavioral control are importantly related to reactions to many non-illness stigmas as well. For example, heterosexuals who believe homosexuality to be something over which people have no control (e.g., it is caused by biological factors) are less likely to express negative attitudes toward homosexuals than those who believe it is a behavioral choice (Herek & Capitanio,
Perceived behavioral control has also been linked to stigmatizing reactions to obese persons (Crandall, 1994). Crandall and his colleagues suggest that an ideology of blame derived from traditional American values of self-determination and individualism provides a psychological foundation for anti-fat attitudes. In a cross-cultural study of anti-fat prejudice in six countries, Crandall, D’Anello, Sakalli, Lazarus, Wicczorkowska, and Feather (2001) found that attributions of controllability and a negative cultural value toward fatness separately predicted anti-fat prejudice.

Helping and Attribution

One theoretical account that ties attributions of blame and responsibility for stigmas to emotions and prosocial behavior was offered by Weiner (Weiner, 1995; Weiner, Perry, & Magnussen, 1988). Weiner’s attribution-emotion-action theory postulates that people have an initial, typically negative affective reaction to a stigma followed by an assessment of the degree to which the onset of the stigma was controllable – was the stigma the foreseeable result of actions taken by the stigmatized person? When the onset of a stigma is perceived to have been brought on by factors beyond the control of the stigmatized person, then this person is unlikely to be blamed for his/her condition. The resulting emotional reactions are increased sympathy and less anger or feelings of irritation toward the stigmatized person. Feelings of sympathy subsequently predict a desire to help the stigmatized person. On the other hand, perceived onset controllability leads to blame, anger or irritation, and less desire to help.

In support of this model, Weiner et al. (1988) found, through participants’ reports, that many physical illness stigmas such as blindness and paraplegia were perceived as onset uncontrollable and that people who had these conditions were not blamed for them. Such uncontrollable stigmas tended to elicit pity and no anger, and produced a willingness to help. On the other hand, many “mental-behavioral” stigmas such as drug abuse and obesity were perceived as onset controllable, elicited little pity and more anger, and produced an unwillingness to help. Weiner and his colleagues also showed that additional information can sometimes alter perceptions of onset controllability for a specific stigma and result in changes in emotions and willingness to help. For example, a person with AIDS was perceived as less responsible, elicited more pity and less anger, and more willingness to help if the person was described as having contracted HIV from a blood transfusion than from leading a promiscuous sex life.
Numerous subsequent studies examining various stigmas have found support for Weiner’s model (e.g., Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Research also supports the notion that factors besides just onset control can influence attributions of responsibility for a stigmatizing condition. For example, people are more likely to be blamed if a stigmatizing condition was caused by a criminal act than by an altruistic act (Dijker & Koomen, 2003) or if the person already had an otherwise stigmatized status. For example, people blame homosexuals more for sexually contracting HIV than heterosexuals (Seacat, Hirschman, & Mickelson, 2007). There also seem to be individual differences in the degree to which people blame stigmatized persons for their conditions. For example, Des Jarlais, Galea, Tracy, Tross, and Vlahov (2006) found that people who blame persons with HIV/AIDS (e.g., they “got what they deserved”) are also more likely to blame persons with SARS for their disease even though the means of contracting these two diseases are very different. The tendency to blame persons with HIV/AIDS for their illness has been associated with more general beliefs in a just world – a world where people get what they deserve and deserve what they get (Connors & Heaven, 1990). Lerner (Lerner & Miller, 1978) suggested that some people might blame and derogate victims as a way of preserving their beliefs in a just world. In essence, the notion that bad things could happen to good people may be threatening to people’s beliefs in a just world.

Some researchers have suggested that one avenue to reduce stigma might be to devise interventions that reduce the degree to which people perceive a stigma to be onset controllable. Thereby, blame would be reduced and sympathy plus a willingness to help would be increased. For example, educational programs that characterize mental illness as a “brain disease” might reduce public stigma by emphasizing the uncontrollable onset of mental illness (Corrigan & Watson, 2004). Those wishing to design anti-stigma interventions with such goals in mind should be cautious because the notion that mental illness is a “brain disease” could actually enhance public stigma by emphasizing the stability of the condition over time. People who have a “brain disease” may be perceived as unlikely to benefit from treatment or to get better over time. Consistent with this later notion, Dietrich, Beck, Bujantugs, Kenzine, Matschinger, and Angermeyer (2004) found that believing that mental illness has biological causes is actually associated with increased tendencies to avoid mentally ill persons. In other studies, attempts to reduce obesity-related stigma by interventions that emphasize the biological causes of obesity have found mixed results (DeJong, 1993; Teachman et al., 2003).
Alternatives to Weiner’s Theory

In Weiner’s model, affect (or emotion) comes into play at two junctures. First, people have immediate affective reactions to stigmas assumed to be related to factors like the severity of the stigma. Second, people have emotions that are derived from attributions based upon perceived onset control. More blame leads to less pity or sympathy and more anger or irritation. Prosocial behaviors toward the person are directly linked to the emotional reaction of pity or sympathy. An alternative explanation of the relationship between attributions and reactions to stigma is found in the justification-suppression model (JSM) of prejudice (Crandall & Eshleman, 2003). According to the JSM, some people have immediate negative emotional reactions to a target based upon a label or perceived group membership – called genuine prejudice. This emotional reaction may be based upon early learning experiences akin to evaluative conditioning. For some targets of prejudice, people have learned that it is socially unacceptable to experience or express negative reactions (Crandall, Eshleman, & O’Brien, 2002). In such cases, people attempt to suppress their negative feelings and refrain from acting upon them. For example, treating blind people in a negative way is considered by most people to be socially unacceptable. For other targets, most people feel it is socially acceptable to be prejudiced and to express that prejudice. For example, many people in the US feel that it is okay to be prejudiced against drug abusers. In the JSM, when people feel that their prejudices are justified, they express them in the form of discrimination against the targets of those prejudices. In contrast to Weiner’s model, the JSM does not portray emotions as derivative of attributions. In this model, attributions of blame based upon normative beliefs can provide justification for prejudicial emotions and thereby promote their expression in behavior. For example, following the JSM reasoning people might have negative emotional reactions to drug abusers and because social norms sanction blaming drug abusers for their stigmatized conditions, people feel justified in discriminating against them or not helping them.

Another possibility is that emotions actually determine attributional cognitions instead of being derived from them or moderating their expression (Haidt, 2001). In this view, when we have sympathy for a stigmatized person, we seek to justify it by formulating attributions absolving the person from blame. On the other hand, when we feel angry or irritated with a stigmatized person, we might be predisposed to blame the person for the stigma – blaming the victim in
many cases. So, in this view, the emotional tail can wag the cognitive
dog of rationalization.

Inducing Sympathy

People know how to feel sympathy and apparently can feel this emo-
tion for stigmatized persons when instructed to do so. For example,
instructing people to try to feel empathy (or sympathy) for a drug
addict can result in their reporting more empathy (or sympathy), de-
monstrating more willingness to help drug addicts as a social group
(through financial donations), and having more positive attitudes
toward the group as a whole (Batson, Chang, Orr, & Rowland, 2002).
Such empathy induction techniques seemed to work both when the
stigmatized person was perceived as responsible for his/her condition,
as in the case of someone with HIV from unprotected sex, and when
the stigmatized person was not perceived as responsible, as in the case
of someone with HIV from a blood transfusion (Batson, Polycarpou
et al., 1997). However, induced empathy did have less impact when
the stigmatized person was perceived as responsible than when he was
perceived as not responsible.

Summary

Are the emotional reactions to stigmas relevant to prosocial behav-
ior the products of cognitive processes such as attributions about
blame and responsibility? Or do stigmatizing feelings come first, which
are then expressed or suppressed depending upon normative beliefs
about whether or not they are justified? Or are stigma attributions
driven by immediate emotional reactions and simply the epiphenom-
enal products of people justifying their feelings? At this point, it seems
likely that the cognitive and emotional reactions to stigmas can be
related in all of these ways. From Weiner’s early work, it seems clear
that empathy and anger concerning a specific stigma (e.g., HIV) can
be altered by manipulations that affect attributions of blame. At the
same time, people are quite capable of blaming disliked groups more
for their stigmatized conditions than liked groups (e.g., homosexuals
versus heterosexuals for HIV) independent of the perceived onset
controllability of the stigma. Furthermore, empathy for a stigmatized
person can be altered by empathy induction manipulations even when
the stigma is one for which the person is blamed. People seem capable
of feeling some empathy even for those they blame. So, while related
to attribution, empathic feelings are not tied in a lock-step manner to attributions of responsibility.

**A Dual-Process Model**

Katz (1981) suggested that affective reactions to stigmatized persons are often characterized by ambivalence. People might have both positive and negative reactions to stigmatized persons simultaneously. For example, the early work of Kleck and his associates (Kleck, 1969; Kleck, Ono, & Hastorf, 1966) indicated that people manifested both positive and negative reactions to people with physical disabilities. When asked to teach origami to someone in a wheelchair, able-bodied individuals displayed two distinct patterns of behavior: Verbal reports of their impressions of the physically disabled person were very positive, whereas non-verbal behaviors indicated anxiety and avoidance. Hebl and Kleck (2000) suggested that the verbal reports were the products of controlled processes and reflected people’s conscious efforts to conform to a norm of being “kind” to disabled people. Non-verbal behaviors, on the other hand, may have been more “automatic” and may have reflected “an underlying negative affective disposition toward physically disabled individuals” (p. 423). These studies imply that dual processes are involved in reactions to perceived stigma.

Social psychologists have formulated “dual-process” models of the psychological processes involved in a vast array of social cognitive phenomena (Chaiken & Trope, 1999). For example, dual processes have been found to be important in understanding racial attitudes (Devine, Plant, Amodio, Harmon-Jones, & Vance, 2002; Fazio, Jackson, Dunton, & Williams, 1995). Drawing on this research, Pryor and his colleagues (Pryor, Reeder, & Landau, 1999; Pryor, Reeder, Yeadon, & Hesson-McInnis, 2004; Reeder & Pryor, 2000) developed a dual-process model of psychological reactions to perceived stigmas. This model suggests that two psychological systems may be jointly involved in reactions to stigmas across a variety of social contexts. One system is primarily reflexive or impulsive, whereas the other is deliberative or rule-based (Gawronski & Bodenhausen, 2006; Lieberman, Gaunt, Gilbert, & Trope, 2002; Sloman, 1996; Smith & DeCoster, 2000; Strack & Deutsch, 2004).

**Reflexive Processes**

Reflexive reactions are fast. The reflexive system concerns instinctive reactions (Kurzban & Leary, 2001) or else spontaneous reactions that
have developed through evaluative conditioning (Walther et al., 2005). For example, people may have instinctive avoidance reactions to individuals perceived to be incapable of reciprocal altruism, to individuals perceived to be members of out-groups, or to individuals with signs of disease (Schaller & Duncan, 2007). A stigma label, like a stereotype label, may also evoke conditioned emotional reactions developed through learning (Biernat & Dovidio, 2000). People learn consensual, culturally held associations to a label or mark. For example, the sense of peril that people often associate with the label mental illness may have been learned from the frequent associations between dangerousness or violence and mental illness that are encountered in the media (Corrigan, Watson, Garcia, Slopen, Rasinski, & Hall, 2005). Research on implicit associations suggests that stigma associations can be very general or specific to the type of stigma. For example, while people implicitly associate obesity with general negative affect, they also associate obesity specifically with laziness (Teachman & Brownell, 2001).

Several specific emotions might be reflexively evoked by stigmas. For example, Rozin, Lowery, and Ebert (1994) suggest that disgust is a common emotion evoked by many stigmas ranging from abominations of the body such as physical deformity to moral character stigmas such as people who commit incest. Rozin and his colleagues conceptualize disgust as a defensive emotion: It conveys a rejection from the self. Things that elicit disgust are perceived as having the potential to physically or socially contaminate the self. A sense of disgust may lead to an immediate desire to avoid stigmatized persons.

Blascovich, Mendes, Hunter, Lickel, and Kowai-Bell (2001) found that people reflexively manifest cardiovascular reactivity patterns consistent with the experience of threat when interacting with stigmatized others. When participants interacted with either a person who had a facial disfigurement or an African American person, cardiovascular reactivity patterns indicated threat experiences. Interestingly, post-interaction self-reports of participants’ subjective states did not show any impact of stigma upon admissions of threat experiences, a finding that Blascovich and his colleagues attributed to social desirability demands. Also of interest, participants who reported greater intergroup contact experiences with African Americans (participants were all White) did not manifest threat reactions related to race.

Strack and Deutsch (2004) also theorized that the reflexive (or impulsive) system may be directly associated with motor schemata that may elicit overt behavior. Approach and avoidance motor tendencies, such as pulling something or someone toward one’s body versus pushing
the object or person away, can be automatically evoked by positive or negative attitudes toward the object or person. For example, Neumann et al. (2004) demonstrated that participants’ implicit attitudes toward people with AIDS, as measured by the IAT (Greenwald et al., 1998), were significantly correlated with avoidance behaviors as indexed by the speed with which a subject pushed a computer mouse away from him- or herself when presented with a photograph of a person with AIDS. Recent research by Kawakami et al. (2007) found that inducing people to simulate approach to stigmatized groups can result in a reduction of implicit negative attitudes. Specifically, participants who were instructed to pull a joystick toward them every time they saw photographs of African Americans projected on a computer screen came to evidence less negative implicit attitudes toward African Americans as measured by the IAT.

Deliberative Processes

The deliberative or rule-based system, in contrast to the reflexive system, involves thoughtful reactions (Sloman, 1996). People may reflect upon the appropriateness of their spontaneous emotional reactions as well as their overt behavioral responses to a stigmatized person. Deliberative processes feel volitional, controllable, and effortful to the person who is engaged in them (Lieberman et al., 2002). While reflexive processes are continuously engaged during consciousness, deliberative processes may be turned on and off. Even in circumstances where perceivers have a negative reflexive reaction to someone with a stigma, if perceivers have enough time, motivation, and cognitive resources, they may adjust or suppress their initial reactions. Devine, Fazio, and their colleagues found that individual differences in European Americans’ motivations to control racial prejudice are related to more positive reactions to African Americans. Similarly, research by Pryor et al. (1999) found that individual differences in motivations to control stigma-related prejudice were linked to more positive reactions to persons with HIV stigma as well as other stigmas.

Not all emotional reactions to stigmas need to be considered reflexive. Deliberative processes may also lead to emotional reactions to stigma. Weiner’s attribution-emotion-action model of stigmatization (Weiner, 1995; Weiner et al., 1988) suggests that the emotional reactions of pity and anger may be derived from an attributional consideration of stigma. Pryor et al. (1999) theorized that such attributional considerations – whether a stigma is perceived to have a controllable or uncontrollable onset – often take time to entertain.
Rule-based reflections upon the uncontrollable origins of a stigma may provide a rationale for formulating positive feelings. Thus, Pryor and his colleagues predicted that people would show more positive reactions to a person with an uncontrollable stigma when given time to consider their responses than when they were asked for immediate responses. Consistent with these predictions, the prospect of having lunch in the company of a little girl with AIDS (an uncontrollable stigma) was rated more positively by people who delayed their responses (by 15 seconds) than by people who responded immediately. For a controllable stigma (drug addiction), delay made no difference.

Testing the Dual-Process Model of Reactions to Stigma

This dual-process model of stigma reactions is outlined in Table 3.1. Theoretically, reflexive reactions may be characterized as faster than deliberative reactions. Reflexive processes are particularly important when a stigmatized person is first encountered. Rule-based or deliberative processes are slower to come on line. In essence, deliberative processes may represent people thinking about their reactions to stigmatized persons. Am I justified in my immediate reactions to this person? Are my immediate reactions consistent with how I think I should act according to my personal values? Are my reactions socially appropriate? These are the types of thoughts that may occur when people have the time, opportunity, and cognitive resources to engage in deliberative processes. These two systems are assumed to interact dynamically over time to produce not only subjective states in the perceiver (such as emotional experiences), but also overt behaviors. While the emotional and behavioral responses to stigma may be very complex, a basic underlying dimension of both emotions and behaviors is one of approach and avoidance (Bargh, 1997; Cacioppo, Gardner, & Berntson, 1999; Neumann & Strack, 2000). Thus, stigma approach/avoidance behaviors can be driven theoretically by both reflexive and deliberative processes.

In an empirical test of this dual-process model of stigma, Pryor et al. (2004) asked college students to consider how comfortable they might feel in interacting with individuals who had a variety of stigmatizing conditions. The cover story of this study asked participants to imagine interactions with patients in a hospital setting where participants had a job that involved helping patients in and out of wheelchairs during discharge. Photographs of patients were presented on a computer screen along with a label of their conditions (i.e., a stigma label). Participants were asked to move a cursor toward
Table 3.1 A dual-process model of stigma reactions

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<th>Reflexive processes</th>
<th>Deliberative processes</th>
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<td>Onset</td>
<td>Spontaneous when stigma is encountered</td>
<td>Requires time, motivation, and cognitive resources</td>
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<td>Role of emotion</td>
<td>Emotions are evoked by the stigma</td>
<td>Emotions are the products of cognitive processes</td>
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<td></td>
<td>Emotions are often negative (e.g.,</td>
<td>Emotions may be positive (e.g., sympathy) or negative (e.g., irritation)</td>
</tr>
<tr>
<td></td>
<td>disgust, fear, uneasiness)</td>
<td></td>
</tr>
<tr>
<td>Role of cognition</td>
<td>Cognitions (e.g., labels) trigger</td>
<td>Attributional cognitions moderate reflexive reactions</td>
</tr>
<tr>
<td></td>
<td>emotions and motor responses</td>
<td>Consideration of personal values and social appropriateness</td>
</tr>
<tr>
<td>Characteristic behavior</td>
<td>Avoidance</td>
<td>Approach or avoidance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prosocial behavior or social exclusion</td>
</tr>
<tr>
<td>Theoretical origins</td>
<td>Associative learning or evolved</td>
<td>Socialization</td>
</tr>
<tr>
<td></td>
<td>instincts</td>
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</tr>
</tbody>
</table>

or away from the photos to indicate their comfort levels. They were asked to move the cursor quickly in the direction of their immediate feelings (closer for more comfort and further for less comfort) when the patient photo first appeared and then to adjust the cursor/photo distance to “fine tune” the approximation of their feelings as they thought about them. They were given 10 seconds to adjust the cursor/photo distance for each stigma. Reflexive processes were hypothesized to influence initial approach/avoidance behaviors as evidenced by
cursor movements. Deliberative processes were hypothesized to be more influential in cursor movements as time passed. Several variables related to reflexive and deliberative processes were examined in connection to the cursor distance to the photos over time. Consistent with the notion that emotions might be reflexively evoked by stigmas, individual differences in disgust sensitivity (Rozin, Haidt, McEachron, Dunlop, & Ashmore, 1999) were correlated with early movements of the cursor (within the first 3 seconds). Participants who had more disgust sensitivity kept the cursor farther from the stigma photos than those with less disgust sensitivity – thus indicating more initial stigma avoidance for people who readily experienced disgust. The correlations between cursor/photo distance and disgust sensitivity dissipated over time.

In contrast, deliberative processing showed a different pattern. Consistent with the notion that deliberative processes might be more likely to come into play after sufficient time had passed, the correlations between cursor/photo distance and individual differences in participants’ motivations to control stigma prejudice slowly grew over time and then leveled off, reaching an asymptote around 6–7 seconds. Participants who were more strongly motivated to control stigma prejudice moved the cursor more closely to the stigma photos – thus indicating more stigma approach for people who tried to control their prejudicial reactions to stigmas.

This study also provided evidence that attributional considerations about stigmas represent deliberative or rule-based processes that require time to unfold. The 15 stigmas that were used in this study were selected on the basis of pre-testing to represent three levels of perceived onset controllability: controllable (e.g., addicted to drugs), neutral (e.g., depressed), and uncontrollable (e.g., legally blind). Analyses of cursor movements over time revealed that participants kept more distance from controllable onset stigmas than either neutral or uncontrollable. This difference in avoidance tendencies increased over time. Participants ultimately moved the cursor closer to uncontrollable than to neutral stigmas, but this differentiation only happened after about 5 seconds. Such a pattern suggests that participants needed time to consider the adjustments they made when the stigmatized persons were not to blame for their conditions.

Dual Processes in Ongoing Interaction

The study just described was unique in that reflexive and rule-based processes were found to influence the same behavior over time. More commonly, reflexive and deliberative processes might influence different
aspects of ongoing behavioral interactions with stigmatized persons. For example, Dovidio, Kawakami, Johnson, Johnson, and Howard (1997) found that implicit racial attitudes were important predictors of White students’ non-verbal behaviors in a group discussion with a Black student, while explicit racial attitudes were better predictors of self-reports of how much they enjoyed the interaction. Thus, measures of reflexive processes such as implicit attitudes seemed better predictors of more automatic behaviors, whereas measures of deliberative processes such as explicit attitudes were better predictors of more controlled behaviors.

A similar set of findings emerged in a recent study that examined game-playing behaviors in an online computer game of catch (called Cyberball). Pryor, Reeder, Wesselmann, Williams, and Wirth (2007) found that implicit anti-fat attitudes were important predictors of hesitancy (a latency measure) in throwing the virtual ball to an obese woman, while explicit anti-fat attitudes were important predictors of choosing to delay her inclusion in the game. Both of these relationships only emerged when two other players excluded the obese woman from play. As in the study by Dovidio and his colleagues, measures of reflexive processes were better predictors of more automatic behaviors, whereas measures of deliberative processes were better predictors of more controlled behaviors. Additionally, this study points to the contributing role of social influence in mistreatment of a stigmatized person.

Stigma’s Impact on Prosocial Behavior

In a recent review of the research on prosocial behavior, Penner and his colleagues suggested three levels of analysis of prosocial behavior: a micro level that focuses upon the origins of prosocial behavior and psychological processes that give rise to prosocial behavior, a “meso” level that focuses upon prosocial behavior in the context of interpersonal interaction, and a macro level that focuses upon prosocial behavior in the context of groups or large organizations (Penner, Dovidio, Piliavin, & Schroeder, 2005). At a micro level of analysis, the core behavioral response to stigmas seems to be social avoidance or exclusion. This core response seems likely to be most important when contact is involved in interpersonal interactions – the meso level of prosocial behavior. At the macro level, sometimes basic avoidance tendencies are translated into support for policies that are harmful to stigmatized persons or deny them human treatment.
The dual-process model outlined above provides a useful account of how basic reflexive processes can initiate stigma avoidance behaviors as well as how rule-based processes can either serve as countervailing forces to reflexive avoidance reactions or else perpetuate them through blame and justification. The Cyberball study (Pryor et al., 2007) described above showed how reflexive and rule-based processes can be interwoven in the subtle and overt social exclusion of stigmatized persons that takes place in ongoing interpersonal interactions.

Macro-Level Processes

While it is beyond the scope of this chapter to scrutinize at length a macro-level analysis of the relationship of stigma to prosocial behavior, the concept of *institutional stigma* provides some useful insights into how stigma affects prosocial behavior at a macro level. Institutional stigma is the legitimatization and perpetuation of a stigmatized status by society’s institutions and ideological systems (Herek, 2009). For example, the stigma of HIV disease is perpetuated by US policies that discriminate against persons with HIV such as the US government ban on individuals with HIV from entering the United States as tourists, workers, or immigrants. Another example is the US Foreign Services ban on hiring applicants with HIV (Lambda Legal HIV Project, 2007). Both of these policies convey the idea that it is acceptable to discriminate against persons with HIV under some circumstances.

Self-Stigma

Stigmas have an impact not only upon the potential performance of prosocial behavior, but also upon people’s willingness to seek help. Seeking help related to a stigmatizing condition sometimes entails disclosing an otherwise concealable stigma to others – an enterprise often seen as risky by people who possess a stigma (Pachankis, 2007). For example, people who are at risk for HIV infection are often reluctant to be tested for HIV or to seek treatment because of concerns about being stigmatized (Brown, Macintyre, & Trujillo, 2003). The very act of admitting that one needs help also can be stigmatizing. For example, combat veterans who suffer mental health problems are often reluctant to seek psychiatric treatment because of concerns about being stigmatized (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). These concerns include being viewed by others as weak, a person who is incapable of handling his or her problems without the
assistance of others. Among college students, anticipated self-stigma is a significant determinant of attitudes toward seeking counseling for psychological problems (Vogel, Wade, & Hackler, 2007). Students who believe that they would suffer a loss of self-esteem or that others would look down upon them for seeing a mental health professional are reluctant to do so.

Self-stigma involves the internalization of societal reactions to a stigma. In self-stigma, those with stigmatizing attributes come to base their sense of self upon the reflected appraisals of others (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). The dual-process model outlined above may have relevance for understanding self-stigma as well as the stigmatizing reactions that people have to others. From the perspective of deliberative processes, self-stigma entails an awareness of the societal reactions to a stigma, believing that those reactions are to some extent justified, applying the stigma to the self, and a resulting diminished sense of self-esteem or self-efficacy (Corrigan, Watson, & Barr, 2006). Research has also shown that the implicit valence associations that people have to social groups (as measured by the IAT) combined with their implicit associations of their self-concepts to those groups predict their senses of implicit self-esteem (Greenwald, Banaji, Rudman, Farnham, Nosek, & Mellott, 2002). Implicit self-esteem represents the degree to which people implicitly associate themselves with positive versus negative valence. Greenwald and his colleagues found that people seem more strongly prone to achieve a balance among the implicit associations relevant for self-esteem than parallel explicit evaluations and beliefs. How reflexive and rule-based processes jointly influence a sense of self-stigma represents a promising avenue for future research.

Conclusions

Stigmas seem to evoke spontaneous aversion responses. In addition, people often hold stereotypes that interacting with stigmatized persons can be perilous. For these reasons, people seem to be predisposed to socially avoid stigmatized persons. Avoidance tendencies can be exacerbated when stigmatized persons are blamed for their conditions. Conscious deliberations about one’s reactions to stigmas potentially function as double-edge swords. Deliberation can reduce stigma blame and create conditions for increased empathy and prosocial behavior when a stigma’s onset seems to have been uncontrollable. It can also entail mustering prejudice control processes for those who are
motivated to control their negative reactions to stigmatized persons. On the other hand, deliberative processes do not represent a panacea for stigma amelioration. Sometimes increased thinking about a stigma seems to result in coming up with reasons that initial negative reactions seem justified.

Stigma may be rooted in naturally selected predilections that helped our ancestors survive, but it is defined proximally in modern social contexts and involves a series of higher-order reasoning processes as well as some that seem more instinctual. One paramount reason to further study how stigma relates to prosocial behavior is that stigmatized persons are often those who are in the most need of help from others. The study of stigma is often the study of factors that cause people to turn their backs on people who are in need of help.

Some future directions for the study of stigma and prosocial behavior might include the study of how people react to stigmas in combination with other social information. Recent work by Stürmer and his colleagues (Stürmer, Snyder, Kropp, & Siem, 2006; Stürmer, Snyder, & Omoto, 2005) found that the degree to which people felt empathy for a stigmatized person (e.g., a person with AIDS) was more predictive of prosocial behaviors when the person was an in-group member (e.g., someone of the same sexual orientation) than when the person was an out-group member. For out-group members, variations in attractiveness were more strongly predictive of prosocial behavior. Dijker and Koomen (2007) have suggested that in addition to an instinctive aversion reaction to stigmas, people also might react instinctively with empathy and care, especially when the stigmatized person is kin or a member of one’s in-group. While Stürmer and his colleagues did not find that people felt more empathy for stigmatized in-group than out-group members, they did find that differences in empathy were more likely to moderate prosocial behaviors when the stigmatized person was an in-group member. The strength of this empathy-helping relationship among in-group members systematically varied as a function of the degree to which people saw the in-group member as similar to themselves. Future studies might examine whether the emotional reactions that people have to in-group members are indeed, as Dijker and Koomen speculated, the products of reflexive processes. Are people reflexively empathic to some stigmatized persons and reflexively threatened by others? Do people sometimes experience both of these reactions in parallel, creating ambivalence as Katz theorized? Recent research by De Liver, van der Pligt, & Wigboldus (2007) has found that people can have both strong
implicit positive and negative associations to some stigmatized groups such as immigrants. So, ambivalence can exist on an entirely implicit level, not just in dissociations of implicit and explicit reactions as depicted by the dual-process model.