TESIS DOCTORAL

EL ESTIGMA SOCIAL DEL ENANISMO ÓSEO

CONSECUENCIAS Y ESTRATEGIAS DE AFRONTAMIENTO

Saulo Fernández Arregui
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Director:
Profesor Dr. Ángel Gómez Jiménez

A mis padres

A la Fundación ALPE-Acondroplasia

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Muchas personas de talla baja han participado en este estudio. Especialmente quiero agradecer a los diecinueve participantes que tomaron parte en el estudio cualitativo preliminar y que desinteresadamente se prestaron a ser entrevistados en profundidad sobre asuntos muchas veces íntimos y algunos de ellos no muy agradables de ser recordados. A todas estas personas, a quienes debido al compromiso de anonimato adquirido no puedo nombrar aquí, quiero agradecerles de corazón su participación. También agradezco mucho la participación de las más de doscientas veinte personas con enanismo que de forma anónima han respondido a través de Internet a la extensa batería de cuestionarios que hemos diseñado para este trabajo.

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TABLE OF CONTENTS

Chapter *page*

List of tables and figures **xix**

Foreword (Spanish version) **xxi**

Foreword (English version) **xxix**

1 Dwarfism **1**

1.1 Causes of abnormal short stature 2

1.1.1 Growth hormone abnormalities 2

1.1.2 Skeletal dysplasias 3

1.2 Disproportionate vs. proportionate short stature 4

1.3 The scope of the present dissertation 5

1.4 Achondroplasia 6

1.5 The social stigmatization of dwarfism 8

2 Theoretical review **15**

2.1 Social stigma 16

2.1.1 A situational-specific understanding of stigmas 16

2.1.2 Consensus, social sharing, and pervasiveness in our understanding of stigmatization 17

2.1.3 Stigma as a threat to the self 18

2.1.4 Classification of stigmas 20

2.1.5 Stigma and related phenomena 23

2.2 Theoretical approaches to the consequences of interpersonal rejection and coping strategies 26

2.2.1 Ostracism 27

2.2.2 Threat to belonging and the self-regulation depletion 32

2.2.3 The attributional ambiguity model 35

The advanced attributional ambiguity model 36

The mediator approach to attributing to discrimination 39

The mediator approach to the self-protective properties of attributing to prejudice 39

Chapter *page*

2.2.4 The three stage model of perceiving and responding to discrimination of Stangor and colleagues 40

2.2.5 The pervasive approach to group based discrimination 42

2.3 Interpersonal rejection and humiliation 46

2.3.1 Humiliation, human dignity, and the vertical scale of human worth 46

2.3.2 Humiliation as a self-conscious emotion 47

2.3.3 Humiliation, self-respect, and social honor 48

2.3.4 Moral exclusion and our capacity to morally ignore the members of a social group 51

2.3.5 Social stigma and humiliation 52

2.4 The present dissertation 53

3 Study 1: Living with dwarfism 55

Abstract 55

Introduction 57

Method 59

Sample and procedures 59

Results 61

Experiencing the social stigmatization of dwarfism 61

Tactless looks and remarks 62

Verbal and physical aggression 63

Ostracism and social exclusion 64

Sexual exclusion 64

Positive experiences 64

Consequences of experiencing the social stigmatization of dwarfism 65

Cognitive consequences 65

Emotional consequences 66

Behavioral consequences 66

Limb-lengthening surgery 67

Chapter *page*

Discussion 69

4 Study 2: The "stigmatization potential" of physical conditions that deviate from the norm 73

Abstract 73

Introduction 75

Method 78

Participants 78

Procedure 78

Measures 84

Analytical Procedures 84

Results 87

Classification of the physical conditions: strong vs. weak stigmas vs. no-stigma 87

The categorization perspective: cluster analysis of the social categorization task 90

Means differences across groups 90

The relationship between categorizing and the negative consequences of stigmatization 93

Discussion 96

5 Study 3: Individual versus group-based strategies for coping with stigma: Dynamics of stigmatization in people with dwarfism in Spain and the United States 101

Abstract 101

Introduction 103

The social stigma of dwarfism 104

Experiencing social stigmatization as a form of humiliation 105

The present research 109

Method 112

Participants 112

Procedure 114

Chapter *page*

Measures *115*

Analytical Procedures *118*

Specification of the measurement model *119*

Results 120

Measurement model *121*

Structural models *125*

Discussion 127

Limb-lengthening surgery: An arduous process *129*

The attitude of people with dwarfism toward LL *131*

Spain and the US: two cultural contexts with different dominating coping strategies against dwarfism *134*

Classical minority vs. deviant individuals: a different way to experience rejection due to dwarfism *141*

6 Study 4: Higher moral expectations for victims: An extra burden on stigmatized groups 147

Abstract 147

Introduction 149

Theoretical approach to the HMO hypothesis *150*

The present research *152*

Experiment 1 153

Method *156*

Preliminary Analyses *159*

Results *160*

Discussion *166*

Experiment 2 168

Method *171*

Preliminary Analyses *173*

Results *175*

Discussion *181*

General discussion 181

Conclusions 184

Chapter *page*

7 General discussion 185

7.1 Review of the state of the science 187

7.2 The studies 188

7.3 Main conclusions 194

7.4 Future research 195

7.5 Practical implications 198

References 203

Appendix 219

Appendix A. Measures 219

Measures Chapter 4 219

Measures Chapter 5 221

Measures Chapter 6 225

Appendix B. Cluster analysis vertical icicle plots 229

Outcome variables 229

Categorization Task 230

LIST OF TABLES AND FIGURES

LIST OF TABLES

Tables *page*

Chapter 2

Table 2.1 The mediator approach to attributing to discrimination: List of mediators 39

Table 2.2 Factors that mediate the activation of discrimination 41

Table 2.3 Factors that mediate the attribution to discrimination once the concept is already activated 42

Chapter 4

Table 4.1 Grouping alternatives yielded by cluster analysis conducted to intergroup anxiety and social distance scales 87

Table 4.2 Means by groups of the 3-cluster solution 90

Table 4.3 Fit Indices for the Nested Sequence in the Confirmatory Factor Analysis. Outcome variables 91

Table 4.4 Fit Indices for the Nested Sequence in the Confirmatory Factor Analysis. Categorization task 91

Table 4.5 Paired sample tests 92

Table 4.6 Valence of categories 94

Chapter 5

Table 5.1 Participants’ type of dysplasia 113

Table 5.2 Fit Indices for the Nested Sequence in the Multiple Group Confirmatory Factor Analysis 123

Table 5.3 Results of Nested Chi-Square Tests for Latent R Level Differences 124

Table 5.4 Results of Nested Chi-Square Tests for Latent Mean Level Differences 124

LIST OF FIGURES

Figures *page*

Chapter 2

Figure 2.1 The attributional ambiguity model 36

Chapter 4

Figure 4.1 The categorization task 81
Figure 4.2 Questionnaires 83
Figure 4.3 Results of the cluster analysis 88
Figure 4.4 CFA alternatives for the outcome variables 89
Figure 4.5 Observed variables path analysis 95

Chapter 5

Figure 5.1 Specification of the measurement model 120
Figure 5.2 Final model 127

Chapter 6

Experiment 1

Figure 6.1 Expected attitude 161
Figure 6.2 Confirming Expectancies 162
Figure 6.3 Attitude x target group x expected and perceived tolerance attitude 3-way interaction 163
Figure 6.4 Simple mediations of perceived justice by target group 165
Figure 6.5 Simple mediations of perceived empathy by target group 166

Experiment 2

Figure 6.6 Expected attitude 176
Figure 6.7 Confirming Expectancies 177
Figure 6.8 Attitude x target group x expected and perceived tolerance attitude 3-way interaction 178
Figure 6.9 Negative emotions 179
Figure 6.10 Multiple mediated moderation 180

INTRODUCCIÓN

La presente tesis doctoral responde a la demanda realizada por familiares y afectados por acondroplasia para investigar, desde una perspectiva psicosocial, las implicaciones de vivir con talla baja patológica o enanismo óseo. En concreto, la tesis se centra en el estudio de la dinámica de la estigmatización social del enanismo, de sus consecuencias para las personas afectadas y de las posibilidades que éstas tienen para hacerle frente.

Si bien existen otras causas de enanismo, la acondroplasia es, tal como se explica en detalle más adelante (ver Capítulo 1), la más común de las condrodisplasias o mutaciones genéticas que afectan al normal desarrollo de los huesos causando talla baja. Esta mutación genética provoca algunas complicaciones médicas, las más importantes de las cuales se resumen en el Capítulo 1. Sin embargo, y aunque las complicaciones fisiológicas asociadas a la acondroplasia son importantes y en algunos casos pueden llegar a producir consecuencias muy graves, no son estas cuestiones las que normalmente interfieren más en la calidad de vida de las personas afectadas.

Tampoco son las barreras físicas lo que más preocupa a las personas con enanismo. Y lo cierto es que dichas barreras pueden llegar a ser muy molestas. La media de altura de las personas con acondroplasia es de aproximadamente 1,25 m., muy inferior a la altura mínima para la cual ha sido diseñado el entorno físico en el que nos desenvolvemos. Al menos en España, todavía son pocos los esfuerzos realizados para adaptar el entorno a personas adultas con una altura muy por debajo de la media. Esta circunstancia provoca que las personas con enanismo óseo se enfrenten a menudo a barreras y dificultades a la hora de, por ejemplo, pulsar los botones de un ascensor, los interruptores, timbres y alarmas, acceder a cajeros automáticos u otro tipo de expendedores, o cuando acuden a ventanillas y mostradores de atención al público.

Aunque las complicaciones médicas y las barreras físicas son problemas muy importantes para las personas con enanismo, sin lugar a duda lo que más preocupa a las familias y a las personas con enanismo óseo son las *dificultades que se derivan de la estigmatización social de esta condición física*. Sin embargo, así como en el campo médico y en el tema de las barreras físicas se van logrando poco a poco avances importantes dirigidos a mejorar la calidad de vida de las personas afectadas, en lo que concierne al estigma social los avances son mínimos. Hasta tal punto esto es así que las personas afectadas y sus familiares a menudo expresan un sentimiento de frustración fundamentado en su percepción de que educadores, médicos, políticos, empleadores, periodistas y demás colectivos importantes para el desarrollo y bienestar de cualquier individuo ni siquiera son conscientes de la importancia que el estigma asociado a la condición tiene en el bienestar de estas personas. Cuando no se es consciente de un problema, difícilmente se podrá hacer nada para prevenirlo o paliar sus consecuencias. Por lo tanto, a las personas con enanismo óseo no sólo les preocupa el estigma asociado a su condición física, sino también la falta de conocimiento que existe en la sociedad en general respecto a las *consecuencias psicosociales de la estigmatización y del rechazo*. Los efectos de esta falta de conocimiento sobre el tema se ven además amplificados por la desorientación respecto a cómo proceder una vez que se ha tomado consciencia del problema.

El principal objetivo de la presente tesis doctoral es, precisamente, profundizar en el estudio sistemático de la dinámica de la estigmatización social en las personas con enanismo. En concreto, pretendemos conocer mejor cómo se produce dicha dinámica, qué efectos tiene para las personas afectadas, y sobretodo cómo éstas pueden hacerle frente.

Con el fin de conseguir los objetivos mencionados se puso en marcha el proyecto de investigación entre la Fundación ALPE-Acondroplasia y la Universidad Nacional de Educación a Distancia (UNED) que ha dado lugar a la presente tesis doctoral y que se describe brevemente a continuación.

El proyecto de investigación

El proyecto de investigación que ha dado lugar a esta tesis doctoral ha sido posible gracias al establecimiento de un convenio de colaboración científico-técnico entre la Fundación ALPE-Acondroplasia y la UNED.

La Fundación ALPE-Acondroplasia es una organización sin ánimo de lucro cuyo patronato está formado fundamentalmente por familias de niños y niñas con acondroplasia. La misión principal de la fundación es informar, atender y apoyar a las personas afectadas por acondroplasia y otras condiciones que causan talla baja, además de promover la investigación médica y social sobre todo lo relacionado con la condición. La fundación también realiza una labor de *lobby* en defensa de los intereses del colectivo. Desde que fue establecida en el año 2000 hasta la fecha ha conseguido importantes logros, los cuales han merecido la concesión de la *Cruz de Oro de la Orden Civil de la Solidaridad Social 2006*, otorgada por el Ministerio de Trabajo y Asuntos Sociales.

El proyecto de investigación en el cual se enmarca la presente tesis está fundamentado en el convencimiento tanto de la Fundación ALPE-Acondroplasia como del equipo investigador de que el estudio sistemático de la dinámica de la estigmatización del enanismo y de sus consecuencias es importante para poder prevenirlo a través de acciones de concienciación, educación, sensibilización y reivindicación fundamentadas en un conocimiento científico y objetivo.

Para llevar a cabo el proyecto se formó un equipo investigador compuesto por los doctores Ángel Gómez, J. Francisco Morales – profesor y catedrático respectivamente del Departamento de Psicología Social y de las Organizaciones de la UNED-, la doctora Nyla R. Branscombe – profesora de Psicología Social en la Universidad de Kansas, Estados Unidos- y la doctora María Nieves Quiles, catedrática de Psicología Social en la Universidad de La Laguna, Tenerife, además de por Saulo Fernández Arregui, autor de esta tesis doctoral.

El proyecto de investigación ha producido dos tipos de resultados: por un lado están los trabajos de investigación realizados, los cuales componen esta tesis y se enumeran en el siguiente apartado. Por otro lado están las acciones llevadas a cabo con el fin de sensibilizar y educar sobre la dinámica de la estigmatización social. Dichas acciones se han dirigido principalmente a tres tipos de público:

a) *Las personas afectadas por enanismo óseo y sus familias*, con quienes se han realizado numerosos encuentros y charlas sobre el fenómeno de la estigmatización, sus consecuencias y las estrategias de afrontamiento para hacer frente a la estigmatización.

b) *Los equipos docentes y los alumnos de los colegios e institutos donde cursan personas con enanismo óseo*. Hasta la fecha se han realizado quince talleres en colegios e institutos basados en los trabajos de investigación que conforman esta tesis. El objetivo de estos talleres ha sido informar y sensibilizar sobre la dinámica de la estigmatización y sus consecuencias así como desarrollar recomendaciones para prevenirla.

c) *Las instituciones que toman decisiones que afectan al colectivo*, como por ejemplo las Administraciones Públicas o los medios de comunicación a quienes, en conjunto con la Fundación ALPE-Acondroplasia, nos hemos dirigido con el objetivo de sensibilizar y educar sobre la dinámica de la estigmatización social de la condición y sus implicaciones.

Además de estas acciones, cabe destacar la colaboración entre la investigación psicosocial y la aplicación clínica de la psicología materializada en el desarrollo de un protocolo de evaluación psicológica para personas con acondroplasia en el Servicio de Psicología Aplicada de la UNED, el cual también ha facilitado terapia a aquellas personas con enanismo que lo han solicitado y en la que han participado como asesores miembros del equipo de investigación.

Trabajos de investigación realizados y estructura de la tesis

Los trabajos de investigación llevados a cabo en el marco de este proyecto han sido agrupados en cuatro bloques, y son los que componen el cuerpo principal de esta tesis doctoral. A continuación se describen brevemente dichos trabajos, indicando el capítulo de la tesis que ocupa cada uno de ellos. Previamente a la presentación de estos trabajos de investigación, en el Capítulo 1 se presenta una introducción al tema del enanismo, resumiendo los tipos de causas que dan lugar a la baja estatura patológica y prestando especial atención a la acondroplasia. En el Capítulo 2 se presenta una revisión del estado actual de la ciencia en lo que se refiere a las líneas de investigación en Psicología Social sobre el estigma social, el rechazo, la exclusión social y otros fenómenos relacionados.

Los trabajos de investigación que conforman el cuerpo principal de la tesis son los siguientes:

- Capítulo 3: Consiste en un estudio que, utilizando una metodología cualitativa, se centra en la experiencia de vivir con enanismo óseo. Este capítulo resume los resultados de un estudio realizado con el objetivo de conocer las implicaciones psicosociales de vivir con enanismo óseo a partir del testimonio en primera persona de los propios afectados. Para ello se realizaron diecinueve entrevistas en profundidad a personas con acondroplasia u otras displasias óseas de entre 14 y 35 años de edad, que fueron grabadas en video, transcritas y analizadas. El estudio completo fue entregado a la Fundación ALPE-Acondroplasia y está disponible mediante petición expresa a la Fundación.
- Capítulo 4: Se centra en el estudio sobre el potencial estigmatizador del enanismo en comparación con otras condiciones físicas propensas a la estigmatización. Utilizando una metodología cuasi-experimental, el objetivo es estudiar cómo la población en general percibe a las personas con enanismo. En concreto, se mide hasta qué punto el enanismo provoca ansiedad intergrupal y deseo de distancia social en comparación a otras siete condiciones físicas tendentes a la estigmatización. El estudio también analiza el grado en que una serie de etiquetas ("personas raras", "personas diferentes" y "personas normales") se aplican al enanismo en comparación al resto de condiciones y cómo dicha categorización se relaciona con las medidas de ansiedad y distancia social.
- Capítulo 5: En este caso, el objetivo principal es el estudio comparado entre España y Estados Unidos de la dinámica de la estigmatización social del enanismo óseo, de sus consecuencias y, principalmente, de las estrategias de afrontamiento de dicha estigmatización. Para realizar este estudio se recopilaron las respuestas de más de doscientas personas con enanismo de Estados Unidos y de España a una extensa batería de cuestionarios sobre calidad de vida, bienestar psicológico y la experiencia

de rechazo y exclusión social. Los datos obtenidos fueron analizados utilizando la técnica de modelos de ecuaciones estructurales (SEM, por sus siglas en inglés), lo cual dio lugar a un modelo que compara la relación entre la altura, la experiencia de rechazo social y el bienestar psicológico entre España y Estados Unidos. El modelo también muestra hasta qué punto se utilizan estrategias de afrontamiento diferentes en función del contexto cultural y nacional.

- Capítulo 6: Finalmente, utilizando la metodología experimental, se estudia las expectativas de comportamiento y las actitudes morales de las víctimas de la estigmatización social. Este bloque aborda la dimensión más social de las consecuencias de la estigmatización. Dos experimentos ponen a prueba la hipótesis de que los miembros de los grupos mayoritarios tienen la expectativa de que las minorías que sufren exclusión y discriminación deben comportarse de acuerdo a un estándar de conducta moralmente superior que el de la mayoría. Cuando dichas expectativas se rompen, afloran en los miembros de grupos mayoritarios emociones negativas hacia dichas minorías.

La tesis concluye con una discusión general recogida en el Capítulo 7.

La cuestión del idioma

Con el fin de lograr la mayor difusión posible de los trabajos de investigación recogidos en esta tesis, tanto los estudios como la revisión teórica en los que se fundamentan y la discusión general se han redactado en inglés. A continuación se incluye también un resumen de esta introducción en inglés.

FOREWORD

The present dissertation results from a research project jointly developed by the Department of Social and Organizational Psychology of the National Distance Learning University of Spain (UNED) and the ALPE-Achondroplasia Foundation. The main goal of this collaboration between both institutions is to study the social stigmatization associated with dwarfing conditions, the consequences that stigmatization has for the well-being of affected individuals, and the strategies that can be used to prevent and cope with the dynamic of stigmatization.

The ALPE-Achondroplasia Foundation is a private non-profit organization made up of families of people with achondroplasia created in 2000 and based in Spain. Its mission is to support people with dwarfism and their families from around the world by providing services and information for improving their quality of life. The foundation also defends the interests and rights of Spanish people with dwarfism before public administrations and other institutions, and promotes medical and social research on dwarfism. In 2006 the ALPE-Achondroplasia Foundation was honored with the Gold Cross of the Civil Order of Social Solidarity, the highest recognition in the Spanish government that is awarded to organizations that demonstrate excellence in civil work.

There are two primary incentives motivating this research project. The first one is the conviction, held throughout the project, that in order to combat the negative consequences of social stigmatization it is first necessary to establish and quantify the extent to which people with dwarfism are affected by this circumstance. Researching the social stigmatization of dwarfism and the consequences resulting from it will help to raise awareness about the need to address this problem. This kind of research will provide useful evidence to bolster arguments about the need for collective prevention efforts against stigmatization that are aimed toward people and institutions that have an influence on the lives of people with dwarfism. The second guiding motive to this research project is our belief that research about the social stigmatization of dwarfing conditions can help the community of people with dwarfism to improve the effectiveness of their coping strategies against stigmatization.

In order to carry out these tasks, we formed a research team composed of professors Angel Gómez and J. Francisco Morales –both from UNED, Madrid, Spain-, Nyla R. Branscombe –University of Kansas, Kansas, United States of America-, María Nieves Quiles –University of La Laguna, Tenerife, Spain- and by Saulo Fernández Arregui, Ph.D. candidate at UNED of Madrid and the author of the present dissertation.

Apart from developing the studies that constitute this dissertation, the research project included carrying out other activities as well. Members of the research team have, for example, undertaken several meetings and workshops for people with dwarfism and their families to discuss the dynamics of social stigmatization and the main strategies available to cope with it. The author of this dissertation has carried out fifteen workshops with teachers and students of schools where a student with dwarfism is enrolled in order to raise awareness and sensibility about stigmatization, its consequences, and strategies to prevent it. Together with ALPE-Achondroplasia Foundation, we have also presented public authorities and other institutions with information about the impact that the social stigmatization of dwarfing conditions has on the quality of life of affected individuals and about the importance of adopting measures to prevent it. It is also worth mentioning that we have collaborated with the clinical psychology department of the UNED in a project directed at evaluating people with dwarfism in order to provide therapy to those in need of it.

The primary concern addressed within the framework of the research project has been the completion of four studies that make up the present dissertation:

In a preliminary study we carried out nineteen in-depth semi-structured interviews to people with dwarfism. The objective of this qualitative study was to obtain first hand testimonies about the experience of living with dwarfism. The interviews were recorded, transcribed and analyzed. From this analysis an extensive report about the experience of living with dwarfism was written and returned to the ALPE-Achondroplasia Foundation (Fernandez, 2008b). Chapter 3 includes a summary with the main results and conclusions drawn from this preliminary research.

The second study (presented in Chapter 4) adopts the observers' perspective to analyze the extent to which dwarfism is a socially stigmatized condition in comparison to other physical conditions that differ from the norm and that are also prone to be socially stigmatized.

The third study, presented in Chapter 5, returns to the target's perspective and uses quantitative-correlation data and structural equation modeling (SEM) to compare how people with dwarfism from the US and Spain experience and cope with the social stigmatization of the condition.

Finally, in Chapter 6 we present a study that addresses the consequences of the social stigmatization of dwarfism at a macro or societal level. In this chapter, we present two experiments testing whether belonging to a minority that suffers discrimination raises the expectations of majority group members regarding how members of that minority should behave. In particular, we wanted to test whether majority group members expect people with dwarfism to behave according to higher moral standards and, for example, to be more tolerant toward immigrants than majority group members.

Before presenting these studies, Chapter 1 reviews dwarfing conditions in general and, in particular, provides information about achondroplasia, the most common cause of dwarfism. In Chapter 2 we present a review of the most important theoretical approaches to the study of social stigmatization and related topics in social psychology upon which we base our studies. The dissertation ends with a final general discussion presented in Chapter 7.

CHAPTER 1. DWARFISM

The present dissertation focuses on the socio-psychological study of the stigma affecting people with dwarfism and the strategies used to cope with it. Dwarfism is a generic term referring to a heterogeneous group of people. It is therefore difficult to list a specific number of characteristics that define a person with dwarfism, except for the fact that all of them have abnormal short stature and usually lack of proportionality between the trunk and limbs.

The Medical Dictionary of the U.S. National Library of Medicine defines dwarfism as "the condition of stunted growth" and a dwarf or "little person" as "a person of short stature -under 4' 10" (125 cm.) as an adult". Still, this height limit is arbitrary and other definitions consider a larger range of heights. For example, the medical advisory board of Little People of America (LPA), the largest organization of people with dwarfism in the world, provides the following definition of dwarfism: "a medical or genetic condition that usually results in an adult height of 4'10" or shorter, among both men and women, although in some cases a person with a dwarfing condition may be slightly taller than that. The average height of an adult with dwarfism is 4'0" (121.9 cm.), but typical heights range from 2'8" (85.3 cm.) to 4'8" (146.3 cm.)". In the next pages, we will briefly review the different medical conditions that cause dwarfism.

Today, most cases of abnormal short stature are due to skeletal dysplasias, i.e. genetic disorders that affect the formation of the bones. Achondroplasia is the most common skeletal dysplasia causing dwarfism. Though there are no official records describing the population of people with dwarfism, LPA estimates that achondroplasia accounts for 70% of all cases. While it would be beyond the scope of this dissertation to describe the particularities of all conditions that cause dwarfism, we will dedicate some paragraphs in this introduction to summarize the most important medical and physiological aspects of achondroplasia.

1.1 Causes of abnormal short stature

There are many causes of abnormal short stature. Wheeler, Balk and Cole (2003) differentiated between cases of isolated short stature, for which there is no determinable medical cause, and abnormal short stature, which results from a determinable medical cause. Isolated short stature includes familiar short stature, which is short stature in adults because of their family background, and constitutional growth delay, which refers to children who are shorter than expected with no determinable medical cause. Children with constitutional growth delay usually reach normal adult height.

There are two main types of medically determinable causes of short stature: *growth hormone abnormalities* and *skeletal dysplasias* (Wheeler et al., 2003). Apart from these, nutritional deficiencies can also lead to abnormal short stature. Therefore, diseases and intestinal disorders that affect to the nutritional status of the child may lead to abnormal short stature (Wheeler et al. 2003).

1.1.1 Growth hormone abnormalities

Growth hormone abnormalities include decreased growth hormone production, diminished response to growth hormone and other endocrine abnormalities, such as hypothyroidism and Cushing disease. Abnormalities in growth hormone lead to proportional short stature. Nowadays it is usually possible to treat most of the growth hormone abnormalities, resulting in normal adult height.

1.1.2 Skeletal dysplasias

Skeletal dysplasias are a heterogeneous group of more than 200 rare genetic disorders that cause abnormalities in cartilage and bone growth (Baitner, Maurer, Gruen, & Di Cesare, 2000). Skeletal dysplasias usually lead to abnormal skeletal shape and size and disproportion between the long bones, spine, and head (Clark, 1990). Not all the skeletal dysplasias lead to short stature (Wheeler et al., 2003). According to LPA, the most common skeletal dysplasias that typically result in short stature are achondroplasia, spondyloepiphyseal dysplasia congenita (SEDc), diastrophic dysplasia, pseudoachondroplasia, hypochondroplasia, and osteogenesis imperfecta. Achondroplasia is the most common one among these, with an estimated prevalence varying from around 1 among 25.000 and 40.000 births (Alonso-Álvarez, 2007). The estimated prevalence of SEDc and diastrophic dysplasia is 1 per 100.000 births (Stoll, Dott, Roth, & Alembik, 1989).

No medical treatment for children with skeletal dysplasias enables significant growth, except the so-called limb-lengthening surgery (LLS). LLS is a traumatic process that consists of breaking apart bones in the limbs and stretching them with the help of external *fixators* at a path of half millimeter every twelve hours during several months (Ginebreda, Marlet, Cavalieri, & Vilarrubias, 1992). Bones suitable for lengthening are the femur and tibia, in the legs, and the humerus, in the arms. Because LLS requires bones to have fast regeneration capacity, this surgery usually begins when the person is around ten years old. The entire process usually takes from two to four years depending on any complications that may appear and on how many bones are lengthened. Not every person with a skeletal dysplasia is suitable for LLS, although most people with achondroplasia are, in principle, suitable for the procedure. LLS and its implications are described and discussed in more detail in Chapter 5, which addresses the different strategies used to cope with dwarfism.

1.2 Disproportionate vs. proportionate short stature

The Oxford Dictionary defines “dwarfism” as “the condition of being a dwarf” and a “dwarf” as “a person of abnormally small stature, especially one with normal-sized head and body but short limbs.”

It is interesting to notice that this non-technical definition specifies that the term dwarf is used to refer to people with *disproportionate* short stature. It seems as if the prototypical case of a person with dwarfism would be one with a skeletal dysplasia, which is the only cause of disproportionate dwarfism. In fact, most of the films that include people with dwarfism, for example, Willow (Ron Howard, 1988), are played by actors with skeletal dysplasias that result in disproportionate short stature. Even the famous Velazquez’s pictures of jesters in the Spanish court of the XVII Century portray persons with the features of achondroplasia (Bouza & Betran, 2005). TV shows, commercials and other spectacles that employ adults with dwarfism, like the sadly famous and anachronistic “bullfighter-dwarf” in Spain, are usually performed by people with a skeletal dysplasia, and therefore with disproportionate short stature. This seeming overrepresentation of disproportionate short stature is likely due to the fact that, in technically and economically developed countries, the conditions leading to adult *proportionate* short stature are usually medically treated during childhood, resulting in adult average height. In these countries, the nutritional habits have lead also to increasing average family height, so the only remaining cause of dwarfism is skeletal dysplasia, and, in particular, achondroplasia.

1.3 The scope of the present dissertation

The present dissertation addresses the issue of the social stigma of dwarfism without intentionally differentiating among different dwarfing conditions. However, more than 90% of the individuals which have taken part in the studies of this dissertation that include participants with dwarfism have a skeletal dysplasia; of these, around 70% have achondroplasia. As such, we are dealing mostly with disproportionate short stature in general and with achondroplasia in particular, which reflects the reality of dwarfing conditions.

In the study presented in Chapter 4, which investigated how participants without dwarfism perceived people with dwarfism, we used a picture of a person with achondroplasia as stimulus. We referred to this person as a “person with dwarfism” without specifying whether he had achondroplasia or any other type of dysplasia. In the studies presented in Chapter 6 about the moral obligations hypothesis, also carried out with participants without dwarfism, we referred first to the group of “people with achondroplasia”, briefly describing the most visible features that characterize the condition and explaining that is the most common cause of dwarfism. Then we used the terms “people with dwarfism” and “people with achondroplasia” interchangeably.

Although we have investigated the social stigmatization of dwarfism in general, achondroplasia is the cause most often represented in the studies presented here. Therefore, it could be argued that dwarfism in this dissertation is considered mostly as disproportionate short stature. Because achondroplasia is the most common cause of dwarfism and is also central to this dissertation, we devote the next pages to briefly describe the most important particularities of this condition.

1.4 Achondroplasia

Achondroplasia is the most common condition associated with disproportionate short stature and the most common cause of dwarfism (Nicoletti, Kopits, Ascani, & McKusick, 1989; Trotter & Hall, 2005). The estimated prevalence varies from around 1 among 25.000 and 40.000 births (Alonso-Álvarez, 2007). Horton, Hall and Hecht (2007) estimated that the global population of people with achondroplasia is around 250.000 persons. In Spain, it has been estimated that the current population of people with achondroplasia is around 1.000 persons (De Solà-Morales & Pons, 2003).

Achondroplasia is a skeletal dysplasia caused by a mutation in a gene that codes the development of the bone. In particular, achondroplasia is caused by the mutation of the fibroblast growth factor receptor type 3 (FGFR3) (Climent et al., 1998). The mutation of the FGFR3 impairs the process by which cartilage becomes bone, affecting the formation of long bones. This is why people with achondroplasia present unusually short arms and legs with particularly short upper arms and thighs, in contrast with an average-size trunk. Other visible characteristics of people with achondroplasia are enlarged head with prominent forehead, flattened bridge of the nose, narrower jaw and trident fingers (Alonso-Álvarez, 2007).

Achondroplasia is an autosomal dominant mutation, however 80% of the cases are caused by new spontaneous mutations (Climent et al., 1998). In other words, 80% of the people with achondroplasia are born from parents that do not have the condition.

Mean lifespan in achondroplasia has been estimated to be 61 years, compared with 71 years for the general population (Waller et al. 2008). Other authors report, however, that lifespan in achondroplasia is average (Trotter & Hall, 2005).

Achondroplasia has been associated with average intelligence and average cognitive abilities in children (Brinkmann, Schlitt, Zorowka, & Spranger, 1993; Rogers, Perry, & Rosenberg, 1979; Thompson et al. 1999). However, anomalies in the central nervous system that are associated to achondroplasia, such as larger overall brain volume, enlarged ventricles and arrested hydrocephalus, can contribute to low performance in some cognitive tasks in particular cases of people with achondroplasia (Thompson et al., 1999). Deficits in language skill have also been reported in people with achondroplasia (Brinkmann et al., 1993; Thompson et al., 1999). These deficits could be explained in part by hearing deficits, which are common in achondroplasia due to frequent mid ear infections (Brinkmann et al., 1993). Children with achondroplasia commonly have delayed motor milestones (Trotter & Hall, 2005; Todorov, Scott, Warren, & Leeper; 1981). They also present differences in limb and hand structure that can influence the performance of fine motor skills (Thompson et al., 1999). Therefore, although cognitive abilities and intelligence in people with achondroplasia are normal, the aforementioned difficulties must be monitored during childhood and, in some cases, may influence in the overall cognitive capacities of people with achondroplasia.

Achondroplasia is associated with medical complications other than those of the central nervous system and mid ear infections. One of the most common is compression of the spinal cord or nerve roots due to lumbosacral spinal stenosis (Trotter & Hall, 2005). This complication is usually treatable by surgical decompression, but compression of the spinal cord can sometimes cause severe consequences such as ataxia, incontinence, hypotonia and paresthesia (Alonso-Álvarez, 2007). Most people with achondroplasia also have bowing of the lower legs. Less commonly, they may have serious health problems related to hydrocepahlus, high cervical myelopathy due to small foramen magnum, upper-airway obstruction and thoracolumbar kyphosis (Alonso-Álvarez, 2007; Trotter & Hall, 2005). Unexpected infant death occurs in approximately 2% to 5% of all infants with achondroplasia because of central apnea due to compression of arteries at the level of foramen magnum (Trotter & Hall, 2005).

As we have seen, achondroplasia is more than a height issue. It implies some medical difficulties and, although most of them are treatable or do not have severe repercussions for the affected person, in some cases these complications can produce grave medical and cognitive consequences. Apart from the medical complications, people with dwarfism in general are subject to social stigmatization. As Trotter & Hall (2005) summarize, "most individuals with achondroplasia are of normal intelligence and are able to lead independent and productive lives. Because of their disproportionate short stature, however, a number of psychosocial problems arise." (p. 772). The study of those psychosocial problems is the main goal of the present dissertation.

1.5 The social stigmatization of dwarfism

To our knowledge, there have been no studies carried out in this field about the social stigmatization of the social group of people with disproportionate dwarfism due to a skeletal dysplasia. While there is some research about the stereotypes of shortness (Jackson & Ervin, 1991), people with skeletal dysplasias that cause dwarfism present a unique and different physical appearance. Extreme short stature is one of its most salient characteristics, but is not the only distinctive physical feature of people with skeletal dysplasias. The presence of disproportionate short limbs in relation to the trunk also clearly differentiates people with the condition.

Still, because extreme shortness is one of the most obvious and visible characteristics of people with skeletal dysplasia, we look the work by Jackson & Ervin (1991) that assessed height stereotypes on women and men on six dimensions: social attractiveness, professional status, personal adjustment, athletic orientation, femininity (e.g., warm), masculinity (e.g., assertive), and physical attractiveness. They found that tall men were perceived as more socially attractive and as having a higher status when compared to short men, but not when compared to men of average height. Tall and average height men were also perceived as better adjusted, more athletically orientated, and more masculine than short men. Tall men were perceived as more physically attractive than short and average height men. In regard to the stereotypes of women, tall women were perceived as having greater professional status than short women, but not than average height women. Tall and averaged size women were perceived as more physically attractive than short women. No results were provided for athletic orientation in women. Height did not significantly affect the perception of other three dimensions (i.e., social attractiveness, femininity, masculinity) in regard to women (Jackson & Ervin, 1991).

Several works have also demonstrated that extreme shortness tends to be discriminated in recruitments policies (Feldman, 1975; Miller, 1987). Still, we know that skeletal dysplasia that causes dwarfism is not just a height issue and literature on the social stigmatization of disproportionate short stature is scarce. This is not surprising because, in general, there is little literature on the population of people with skeletal dysplasias. In a recent review of the current literature in medical and social aspects of the life course for adults with a skeletal dysplasia, Thompson, Shakespeare and Wright (2008) pointed out that the available evidence tends to be clinical and that there is little reliable research on social aspects of living with skeletal dysplasia (Thompson et al., 2008, p. 2). The authors of this review concluded that, although there is a clear need for future research, “overall, there is strong evidence for some barriers to equal opportunity in education and employment, and these, together with increased social isolation, are highly likely to exert a strong influence on financial situation and therefore on quality of life.” (Thompson et al., 2008, p. 7). The few studies that have focused on people with achondroplasia and other skeletal dysplasias researched mainly quality of life and related topics.

Mahomed, Spellmann and Goldberg (1998) studied the functional physical and mental health status in a group of 437 adults with achondroplasia from the US. They found that scores concerning mental health did not significantly differ from those of the general population in the US. In contrast, the scores concerning physical health were significantly lower than the general population starting in the fourth decade of life. Apajasalo, Sintonen, Rautonen, and Kaitila (1998) also found that a group of 121 adults with skeletal dysplasias that caused dwarfism had significantly lower health-related quality of life.

Hunter (1998) researched different socio-psychological aspects in a group of 192 persons with skeletal dysplasias and compared them with their first-degree relatives (FDR). Overall, results showed a high level of satisfaction with many aspects of life, including friendship and employment (Hunter, 1998). However, Hunter (1998) found that adults, though not children, with skeletal dysplasia scored moderately higher in depression than their sibs. A similar result was found with the variable self-esteem, in which adults –but not children- with skeletal dysplasias scored lower than their siblings.

Of the existing research that has focused on social aspects related to people with skeletal dysplasias that cause dwarfism, probably the most complete and interesting work is the one done by Gollust, Thompson, Gooding, and Bieseck (2003). Gollust et al. (2003) compared a group of 189 affected individuals with achondroplasia (ACH) in the US to a group of 136 first degree relatives (FDR) in quality of life (QOL), self-esteem, their perception of achondroplasia, and demographic characteristics. The study was completed with qualitative data about the advantages and disadvantages of living with achondroplasia. QOL was measured with the Ferrans and Powers Quality of Life Index (QLI, Ferrans & Powers, 1985; Ferrans, 1996), which assesses total QOL as well as QOL in four specific sub-domains: Health and Functioning, Social and Economic, Psychological and Spiritual, and Family. Self-esteem was measured with the Rosenberg Self-Esteem Scale (RSE, Rosenberg, 1965). Perception of achondroplasia was measured with questions that asked whether participants saw advantages and disadvantages related to having achondroplasia.

The analysis of the demographic data of both, the ACH and the FDR groups, indicated that people with achondroplasia were significantly less marriage, had achieved a lower educational level, earn less annual income and attended more religious services than the FDR group. The ACH group scored too significantly lower in self-esteem than the FDR group. The results of the QLI indicated that people with achondroplasia had significantly less total QOL than the relatives. The differences were also significant across the four sub-domains of the QLI. However, the authors found that self-esteem and perception of severity were more strongly associated with QOL than the affected status (i.e., having achondroplasia or not). The affected status was only modestly associated with total QOL and with the sub-domain Health and Functioning. Affected status was not significantly associated with the other QOL sub-domains (i.e., Social and Economic, Psychological and Spiritual, and Family). According to the authors, these results suggest that factors other than having achondroplasia were more important in predicting QOL in psychological/spiritual, social/economic and family sub-domains. In regard to the perception of the condition, people with achondroplasia tended to view it as less serious than the FDR group (Gollust et al., 2003).

The analysis of participants’ answers to the open-ended questions about the advantage and disadvantage of living with achondroplasia indicated that the ACH and the FDR groups differed more in the advantages that they cited than in the disadvantages. In general, both the ACH and FDR groups cited most frequently disadvantages that were classified as health/functioning and social/economic than disadvantages that could be classified as psychological/spiritual or family-related. Individuals with achondroplasia cited health and functioning issues as disadvantages more frequently than did FDRs. In regard to the advantages, the ACH group cited more advantages related to interactions and friendship than the FDR did. The FDR group, on the other hand, cited more advantages related to psychological/spiritual traits such as having a special outlook on life, a unique perspective on diversity, personal strength, and a heightened sense of compassion than the ACH group did. The authors reported that a large number of participants of both groups (N=37, 11%) stated that disadvantages arise not from the condition of achondroplasia itself, but from the fact that the world is designed for and dominated by “average-sized” people (e.g., “Society creates circumstances that make short stature into a disadvantage”). Some of the affected individuals (N=8, 4%) used downward social comparison to cope with their condition (e.g., “There are many, many worse conditions than achondroplasia”). The authors also emphasized that other participants (N=11, 6%) expressed what the authors called “normalizing statements” indicating that every life circumstance has advantages and disadvantages (e.g., “Almost every trait/condition has disadvantages and most people have or get something, and achondroplasia has pluses too”) (Gollust et al., 2003). In general, the authors concluded that “society’s perception of individuals with achondroplasia, combined with the physical and medical hardships experienced daily in trying to adjust to a world that ‘‘doesn’t fit,’’ create significant challenges for affected individuals.” (Gollust et al., 2003, p. 456).

In general, the existing literature on social aspects of living with skeletal dysplasias tends to show that having disproportionate short stature is a factor that threatens a person’s quality of life. Still, none of the existing studies has addressed more in detail how people with achondroplasia and other skeletal dysplasias that cause dwarfism experience the social stigmatization of its condition, if they experience it at all.

CHAPTER 2. THEORETICAL REVIEW

This chapter reviews the general theoretical background that frames the studies in this dissertation. We understand that dwarfism has important socio-psychological implications firstly because it is a characteristic that clearly differentiates a person and secondly because dwarfism is devalued in some social contexts. In this sense we understand dwarfism as a condition that is prone to social stigmatization. The extent to which dwarfism is perceived as a stigmatized condition in comparison with other conditions also prone to stigmatization is a question that we address in the study presented in Chapter 4.

In the first part of this theoretical review, we outline the evolution of the concept of stigma in social psychology. We further propose that social stigmatization constitutes a clear antecedent of interpersonal rejection and discrimination. One of the main goals of the studies presented in Chapters 3 and 5 is to study the extent to which people with dwarfism experience interpersonal rejection, the consequences that this experience has on their psychological well-being, and how do they cope with it. For this reason, the second part of the present chapter addresses the existing models and research lines in social psychology that address interpersonal rejection from the victim's perspective and the coping strategies used by rejected individuals and groups to manage it. We hypothesise that within a social group, people who suffer pervasive personal rejection and thereby constantly experience that a fundamental aspect of their identity is devalued by majority group members, may over time develop a deep aversive emotion that we have related in a previous work with humiliation (see Fernández, 2008a). In this chapter we address the concept of humiliation and its relationship with interpersonal rejection and social exclusion.

In the last part of the chapter, we briefly introduce the studies which make up the present dissertation.

2.1 Social stigma

In his pioneering work about social stigma, Goffman (1963) defined this term as an attribute that negatively marks and differentiates a person, making him or her a less desirable individual in the eyes of others with whom he or she could interact. The person carrying the stigma "is thus reduced in our minds from a whole and usual person to a tainted, discounted one" (p. 3). The research on social stigmatization has grown dramatically since 1963 (Crocker, Major, & Steele, 1998; Heatherton, Kleck, Hebl, & Hull, 2000; Jones et al. 1984; Katz, 1981; Major & O'Braian, 2005; Schmitt & Branscombe, 2002a). An inspection of this literature indicates that our understanding of social stigmatization has significantly evolved since the first works on the subject. The following pages highlight and summarize the main aspects of this conceptual development.

2.1.1 A situational-specific understanding of stigmas

Modern approaches to the subject have emphasized that social stigmatization should be conceptualized as a context-specific phenomenon, rather than a matter of dispositional aspects or individual differences (Dovidio, Major & Crocker, 2000). As in the evolution of studies in related social-psychological phenomenon, such as prejudice and stereotypes, a stigma is no longer considered an individual trait that can *per se* evoke negative outcomes from majority group members. On the contrary, current approaches define stigmatized individuals as those people who "possess (or are believed to possess) some attributes, or characteristics, that convey a social identity that is devalued in a particular social context" (Crocker et al., 1998, p. 505). Assessing stigma contextually has important implications for understanding coping processes and also for the conceptualization of the phenomenon itself. A contextual understanding emphasizes that stigmatization emerges in the relationship between one person and others in a given social context. Reactions from majority group members to a characteristic that marks a person or a group can be negative in certain situations or under specific circumstances, but can be totally different within varied contexts (Crocker, 1999; Major, Quinton & McCoy, 2002). The experience of stigmatization is also contingent on the individual and his/her circumstances. Having a highly stigmatized quality does not necessarily result in low self-esteem or other pathological corollaries. Coping strategies, individual differences, and contextual factors all moderate the effects of and reactions to social stigmatization. In summary, as Dovidio et al. (2000) stated, “current views of stigma consider the process to be highly situationally specific, dynamic, complex and nonpathological” (p. 2).

2.1.2 Consensus, social sharing, and pervasiveness in our understanding of stigmatization

While situational factors are crucial to understanding stigmatization, social consensus plays an equally important role in the dynamics of this phenomenon. Crocker et al. (1998) argue that two important characteristics of stigmatization are, first, widespread agreement that the social identity of the stigmatized group is devalued by a culture and, second, that the negative stereotypes attributed to that group are also consensual. Stangor and Crandall (2000) claim that consensus and sharing make up one of the three basic components of stigmatization, together with function and perception. These three components are materialized in a three-step model describing the development of a stigma. The first step is the initial perception of a tangible or symbolic threat. According to these authors, in order for a characteristic to become a stigma, this characteristic must first be perceived as a threat to the self at either the individual or social level. In this way, the function of any stigma would be to protect the individual or the group from that threat. The second step involves perceptual distortions that amplify group differences. The third step would be reaching consensus among the group about the threat and perceived group differences. Blue eyes, for example, won't become a stigma just because a few others and I perceive blue eyes as a threat or as a devalued characteristic. A stigma and the threat that it poses to the people must be shared. Furthermore, to the extent that the stigmatized characteristic presents a threat shared among majority group members, the devaluation associated with it becomes a more serious problem for the stigmatized individual.

The sharing component of stigmatization is also a crucial aspect to take into account from the target's perspective. Schmitt, Branscombe and Postmes (2003) have demonstrated that the consequences of experiencing discrimination are quite different depending on whether the victim experiences that discrimination as an event isolated to a given moment of time or situation, or as a *pervasive* experience across time and social contexts. According to these authors, one of the main consequences of experiencing pervasive discrimination is that the victim may rightfully assume that his/her identity (at the individual or the group level) is devalued in the broader social context. Based on this assumption we can see that experiencing discrimination has different consequences when the target believes him/herself to have a narrowly versus broadly stigmatized characteristic. Details of this approach will be explained later in the dissertation.

2.1.3. Stigma as a threat to the self

Most of the existing literature considers stigmas to imply some kind of threat to non-stigmatized individuals who are exposed to them (see, for example, Crocker et al. 1998, Jones et al., 1984; Katz, 1981, or Major & Eccleston, 2005). Beyond this general consideration, some approaches suggest that threat is not just one aspect of stigmatization but rather the main basic component of the phenomenon (Blascovich, Mendes, Hunter & Lickel, 2000). The three step theoretical model about the development of stigmas by Stangor & Crandall (2000) described above also suggests that all stigmas are born when any given attribute characterizing a person or a group becomes a shared threat to the others. According to these authors, the main function of all stigmas is to protect people from that threat. This consideration fits well with some of the studies presented in this dissertation. For example, the results of the study about how dwarfism is perceived by majority group members presented in Chapter 4, show that pictures of different physical conditions that are prone to be socially stigmatized evoke higher levels of intergroup anxiety and social distance in majority group members than the picture of a non-stigmatized condition. This same study shows that dwarfism is among the stigmatized physical conditions that evoke higher levels of anxiety and social distance. Furthermore, many of the experiences related by participants in the preliminary study of this dissertation would be difficult to explain without considering that dwarfism pose a threat to those who do not have dwarfism.

The theoretical model presented by Stangor & Crandall (2000) suggests that the type of threats perceived as part of the stigmatization process can vary. The threat can be tangible or symbolic and can be experienced at the group or individual level. For example, in line with the intergroup conflict approach (Sherif & Sherif, 1953), Stangor & Crandall (2000) argue that groups that threaten our access to material resources are likely to be stigmatized. Illness and other conditions that threaten our health or conditions that make mortality more salient are also prone to stigmatization. The nature of the threat can also be moral. If people perceive that members of a particular group do not live according to one's ingroup moral principles, for instance, the appearance of stigmas against that outgroup is likely. Circumstances or conditions that threaten the belief in a just world (Lerner, 1980) are also prone to become stigmatized. Stangor & Crandall (2000) suggest cases in which poverty becomes stigmatized because it is easier to blame the victims of poverty than to accept the injustice of the situation. Similarly, Crocker et al. (1998) suggest that system justification (Jost & Banaji, 1994) and terror management (Solomon, Greenberg, & Pyszczynski, 1991) are also functions of stigmas. They help us to deal with the threats that would arise if we had to accept the existence of illegitimate group status inequality (system justification) and to deal with the uncontrollable and indeterminate nature of our existence (terror management).

To the extent that stigmas pose a threat to individuals, we can expect anxiety to emerge when interacting with stigmatized individuals (Stephan & Stephan, 1985). Anxiety can also result from ambivalent feelings when confronting stigmatized individuals (Katz, 1981).

2.1.4 Classification of stigmas

Goffman (1963) made a first pioneering classification of stigmas differentiating three main types: tribal stigmas, abominations of the body, and blemish of individual character. This distinction differentiates between stigmas due to racial, ethnic or religious characteristics, which are usually passed from fathers to sons (tribal stigmas), stigmas due to a physical condition deviant from the norm such as disabilities or disfigurements (abominations of the body) and stigmas due to devalued social behaviors as, for example, drug abuse, particular sexual practice or any kind of delinquency (blemish of individual character).

More recently, Crocker et al. (1998) suggest two basic dimensions crucial to our perception of stigmatized individuals and which are therefore useful to classify stigmas. The two dimensions are visibility (or concealability) and controllability. Visible stigmas are those who cannot be hidden, as, for example, race, gender and some physical conditions. Concealable stigmas, like homosexuality or many illnesses, can be hidden. According to Crocker et al. (1998) this distinction has important implications for the way stigmatized individuals cope with and feel about their stigma. Controllability is defined as the extent to which the stigmatized person is responsible for having the stigmatized condition or when the person can do something to eliminate it. According to Crocker et al. (1998), people who are perceived to have controllable stigmas are more rejected by majority group members than people with stigmas that are believed to be uncontrollable.

From a different perspective, and without the intention of proposing any kind of typology, Jetten, Branscombe and Spears (2006) presented a two dimensional model that can be used to frame the different kinds of rejection that a person can suffer. Although the dimensions are about rejection types and not about stigmas, the different kinds of stigmas can be classified according to the nature of rejection that the target suffers. If stigmatization is important it is because it results in rejection and other negative social outcomes. In this sense, the model posed by Jetten et al. (2006) could be understood as a categorization of stigmas from the victims' perspective, which is particularly useful because, as the authors argue, the coping strategy used to manage a given stigma would depend on the kind of rejection perceived. The two dimensions suggested by Jetten et al. (2006) to classify the experience of rejection are the source (intragroup vs. intergroup rejection) and stability (stable vs. unstable) of the rejection. The combination of these two dimensions yields four types of peripheral people/types as follows: Deviants (stable-ingroup rejection, e.g.: overweight, black sheep), Classic minorities (stable-outgroup rejection, e.g.: immigrants, racial minorities), Transition (ingroup-unstable, e.g.: newcomers) and Rebels (outgroup-unstable, e.g.: punks, hippies). The rejection suffered by Deviants would have normally serious consequences in terms of psychological well-being for the victims. One way in which Deviants could cope with rejection is to unidentify from the ingroup that rejects them and will probably continue to do so in the future. If the source of stigmatization is concealable, then they may try to hide it and in essence become impostors in order to be accepted. Someone falling in the Transitions type would cope with discrimination in different ways depending on whether or not they perceive that they can become an accepted member of the group in the future. If they believe that they can be accepted, they may try to identify with the group and make efforts to be seen as a good member by others. Classical minorities, who face stable discrimination and perceive the group boundaries to be impermeable, would tend to display collective responses to exclusion, particularly to the extent that the status inequality is perceived as illegitimate (Ellemers, van Knippenberg, & Wilke, 1990). Perceiving outgroup discrimination would have more negative consequences to the extent that one perceives the rejection as stable (see below the pervasiveness approach to perceiving discrimination). One of the coping strategies that Classical minorities may have to cope with the stigma is to identify with their in-group. Works based in the Rejection-Identification paradigm have accumulated evidence with different minorities that indicates that perceiving discrimination can lead to increased group identification which, in turn, may have benefits for psychological well-being (Branscombe, Schmitt, & Harvey, 1999; Jetten, Branscombe, Schmitt, & Spears, 2001; Schmitt et al., 2003; Schmitt, Branscombe, Kobrynowicz, & Owen, 2002; Schmitt et al., 2003). Finally, Rebels are groups that are rejected due to a voluntarily group belongings. In this sense the rejection is unstable and the identification with the ingroup is usually very high.

2.1.5 Stigma and related phenomena

If social stigmatization is an important socio-psychological issue it is, in part, because it is an antecedent of rejection. In other words, we, as social psychologists, are interested in the study of the social stigma of dwarfism not just because it is a distinct feature that differentiates some individuals from others, but mainly because that distinct feature is, in some contexts, socially devalued. This in turn causes people with dwarfism to be rejected, suffer social exclusion, ostracism, bullying and other related social negative outcomes. In this way, the focus inherent in the study of the social stigmatization of dwarfism is the rejection of people with dwarfism. Leary (2001, 2005) has suggested a conceptualization of social exclusion, ostracism, stigmatization and other related phenomena that considers interpersonal rejection as the central notion around which these concepts acquire meaning. His approach is based in the concept of evaluative valence or relational evaluation, which is defined as the degree to which a person considers his/her relation with other person as something valuable and important (Leary, 2005). This author differentiates between relational evaluation and perceived relational evaluation, which is the extent to which one thinks that other person considers the relationship to be something valuable and important. This distinction is useful to differentiate between people's perception of rejection on the one hand, and the extent to which they objectively are rejected, on the other. This is an important distinction when studying the consequences of rejection. By using this relational evaluation alongside three other complementary concepts--disassociation, prior belonging status, and comparison--Leary (2005, 2001) suggests a framework to distinguish terms that are often used interchangeably in the literature:

Exclusion: The author suggests using this term to describe the behavior of maintaining distance or avoiding contact with an individual, but not necessarily because we do not yield relational evaluation to the excluded person. Exclusion always implies disassociation, i.e. situations in which interaction with other people is avoided or restricted, but exclusion does not necessarily imply that others dislike or reject us. For example, a person can be excluded at random because there are not enough places for a trip in the public transport. If in fact exclusion takes place at random or according to any logic that does not imply low relational evaluation, the person is not being actually rejected. Whether the excluded individual perceives that the exclusion is due to low relational value or not is a different question.

Rejection: According to Leary (2005), rejection is a general term to describe those instances in which a person does not concede relational evaluation to another person. That is, rejection occurs when others do not value interacting with the rejected individual. Whether the low relational value is perceived by the rejected person or not would be, as said above, a different question. In this sense, it would be possible that a person confers low relation value to others, and thus reject them, but never has an opportunity to show his/her low relational evaluation in an actual interaction. People that give low relational value to people with dwarfism but never have the chance to actually interact with them is an example. These cases of rejection, however, can have indirect negative consequences for the targets through, for instance, the employment policies of some companies that may not consider people with dwarfism because a significant number of potential clients have low relational value towards them.

Abandonment: This term is suggested for situations that imply leaving a relationship with a person to whom one is legally or ethically obligated to maintain a relationship. A status of prior belonging is therefore a necessary condition when considering abandonment. Although most of the times the abandoned person would perceive low relational value and therefore would feel rejected, abandonment does not necessarily implies rejection. Take, for example, a case in which a parent becomes a fugitive and is forced to abandon his/her child while not actually rejecting the child.

Ostracism: This is a special case of rejection that inevitably implies disassociation from the rejected person. According to Leary, ostracism combines low relational value with psychological and/or physical distance from the ostracized person.

Apart from these four terms, Leary (2005) suggests the definitions of other constructs that involve interpersonal rejection as a secondary feature. *Stigmatization* is included here and occurs when there is consensus that a relationship with members of a particular category is not valued. *Loneliness* is another phenomenon that involves rejection as a secondary feature. It arises when those who would value a relationship with an individual are not available for social interaction and support. Loneliness does not imply always rejection. For example, an older person may not have any beloved people around because they have passed or moved away. On the other hand, rejection usually causes loneliness.

Finally, in his taxonomy of rejection Leary (2005) includes episodes of *bullying* and *betrayal*. The main characteristic of bullying is an aggressive behavior against a victim, but one of the most negative consequences of being bullied is the perception that one is being rejected. Betrayal is considered a behavior that implies disloyalty and the violation of trust; in this sense usually implies rejection.

Independently of the term we use to describe specific forms of interpersonal rejection, at a fundamental level, they share one commonality: low relational evaluation, that is, low motivation to interact with the devalued individual. In the next section we will focus on theoretical approaches to the consequences of experiencing interpersonal rejection as well as the possible coping strategies that rejected individuals or groups adopt to deal with it.

2.2. Theoretical approaches to the consequences of interpersonal rejection and coping strategies

To the extent that stigmatization implies low relational evaluation, stigmatized individuals are more exposed to rejection, ostracism, social exclusion and other related negative social outcomes than non-stigmatized individuals. In fact, probably the weightiest problem that accompanies a stigma is that the person faces a higher risk of experiencing negative social outcomes. Rejection, ostracism, social exclusion and related phenomena are extremely harmful and destructive social processes with serious consequences at both individual and social levels. Stangor et al. (2003) differentiate between the direct effects of discrimination for the victim (demonstrable effects that may occur with or without the target's knowledge) from the indirect ones (those that only appear via target's perception). Examples of the former include higher mortality rates of US Blacks than in Whites, as well as the fact that presently, Black people, as compared to Whites, have a higher probability of receiving a deficient health treatment, even when other variables such as level of health insurance are controlled. Other direct disadvantages that the African American community faces in the US, clearly related to prejudice and discrimination, are poorer education and housing facilities together with fewer and worse employment opportunities. These are some reasons why research about the effects of discrimination on its targets and how victims try to mitigate those effects is gaining increased attention.

Only recently, however, have social psychologists begun to focus their attention on indirect effects of discrimination, i.e. those that appear by virtue of the victim's particular perception of discrimination, rejection or social exclusion toward him or her. Because the indirect effects of discrimination are of psychological nature and mediated by cognition and emotion, they might be less visible, more subtle, and more difficult to quantify, but not necessarily less damaging for the well-being of the person. In fact, psychological research shows that the indirect consequences of rejection and related phenomena are as important as (if not more important than) the direct ones (see Williams, 2007).

The following pages summarize four of the most active existing research lines that study the indirect effect of discrimination and other forms of interpersonal rejection: works on ostracism, by Williams; research on threat to belonging and the impairment of self-regulation function of Baumeister, Twenge and colleagues; Stangor and colleagues' model of experiencing discrimination; the attributional ambiguity model by Major, Crocker and cols., and, finally, the *pervasiveness* approach by Branscombe and colleges.

2.2.1 Ostracism

During the last two decades Williams has developed an extensive research program studying ostracism. He defines this term as being ignored and socially excluded (Williams, 2001, 2007; Williams, Forgas, & von Hippel, 2005; Williams & Sommer, 1997). This definition, as the author acknowledges, conceptually overlaps with other related terms, such as social exclusion or rejection, which he often uses interchangeably (Williams, 2005). In a sense, Williams' research on ostracism can be viewed as a research line including rejection, social exclusion, ostracism, and related phenomena. Williams generally focuses on instances of rejection in which there is no violent or overt expression of dislike toward the target, but rather the *ostrizicer* behaves as if the target was non-existing, that is, as if he or she is not a possible partner for a social interaction. Williams argues that "unlike other forms of explicit rejection or derogation, such as verbal or physical aggression, ostracism could be considered a nonbehavior (or the absence of behavior) and as such is less tangible" (Williams, 2001,

p. 48). For this reason, some basic dimension of ambiguity usually underlies instances of ostracism because the target cannot be totally sure about of whether it is really occurring (Williams, 2001).

Williams (2001) draws distinctions between three types of ostracism: physical ostracism, which involves, for example, leaving a room during an argument; social ostracism, which implies psychological or emotional disengagement from the target that is physically present (e.g. avoiding eye contact); and cyberostracism, which are episodes in which a person is ignored without face to face interaction having place (e.g., in an Internet chat or in the context of on-line friend groups).

It is important to consider that when an individual is ostracized, he or she attribute some motive to the behaviour (or non-behaviour) incurred against him or her by the ostracizer. One insipidly problematic motive is the “role-prescribed” one, which implies that the person has been ostracized in a situation that socially endorses ignoring the presence of others like, for example, in an elevator. An alternative motive is the “defensive” one, in which the victims infers that the ostracizer fears being injured or ostracized him/herself and decides to preventively ostracize others. An attribution to a “punitive” motive implies the assumption that one is being ignored in order to be punished. The victim infers that the punishment is intended to correct his/her behavior, expel him or her from the group, or simply cause pain. Finally, victims also attribute ostracism to the belief that nobody cares about their existence, i.e. the “oblivious” motive. Attribution to the oblivious motive can be more harmful than the others because it implies that the person’s very existence is unworthy.

Williams’ model assumes that ostracism is gradable in a quantitative dimension, so that it is possible to distinguish between partial and complete episodes of ostracism depending on the level to which others are ignoring the target.

The model groups antecedents of ostracism into three main categories: characteristics of the source, of the target, and of the situation. A source that has low self-esteem would be more likely to ostracize others in order to protect him/herself from becoming victim to the derogation of others (Williams, 2001). Williams (2001) enumerates characteristics that make a target susceptible to ostracism as follows: insensitivity to others, obnoxiousness, chronic complaining, loudness, and being perceived as dangerous. The author also posits that, due to the unobservable and deniable nature of ostracism, some people decide that ostracism is an option more "suitable" than alterative negative social outcomes used to intentionally hurt others. For example, someone that wants to punish a colleague at work may chose to ostracize him or her before attacking this person in a more overt form, because the ambiguity that usually underlies ostracism protects the aggressor.

Williams proposes the idea that ostracism is one of the most powerful negative interpersonal behaviors because it can threaten up to four fundamental needs. They are the need to belong, self-esteem, control and meaningful existence. The need to belong (Baumeister & Leary, 1995) has been identified as a basic human need for "frequent and affectively pleasant interactions with a few other people […] in a context of a temporarily stable and enduring framework of affective concern for each other's welfare" (Baumeister & Leary, 1995, p. 497). The need to belong can be described as the need to be loved and accepted by others throughout one's life. Ostracism can be a significant threat to fulfilling this need. Ostracism can also seriously threaten self-esteem, particularly over the long run. According to Williams (2001), an individual's self-esteem is rather resilient to episodes of ostracism in the short run, but not over time. Therefore, if ostracism is experienced as a lasting circumstance in life, it could end up having profound negative consequences for self-esteem. This approach echoes the *pervasiveness* approach to discrimination by Branscombe and cols., which will be addressed later in this theoretical introduction.

Williams (2001) proposes that ostracism also threatens the target's ability to control because the ostracized individual perceives loss of control over their interactions with others. This may lead to negative consequences, such as learned helplessness and depression. Finally, Williams (2001) argues that "because ostracism involves a withdrawal of attention or recognition by others, individuals exposed to it may be reminded of their fragile and temporary existence, and its lack of meaning and worth" (p. 63). With this, we see how ostracism can threaten an individual's need for meaningful existence.

Williams (2001) distinguishes between immediate, short term, and long term reactions to ostracism, depending on the length of time that targets have been ostracized. In a more recent publication, Williams (2007) reviewed the consequences of ostracism by elaborating on these three stages: immediate impact of ostracism (called the "reflexive" stage, which would be equivalent to immediate responses), responses to ostracism following appraisal (the "reflective" stage, equivalent to short term reactions) and responses to chronic ostracism (the "acceptance" stage, equivalent to long term reactions).

Among the reflexive or immediate responses to ostracism, Williams (2007) differentiates between physiological responses and brain activation in response to ostracism (e.g., increased blood pressure, higher cortisol levels, and increased activation of the dorsal anterior cingulate cortex) and self-reported distress levels (e.g., low self-esteem, sadness, anger, etc.). Most of the studies reviewed by this author suggest that immediate responses to ostracism are quite automatic (i.e. not moderated by other variables or circumstances) and negative.

"Reflective" responses to ostracism present different qualities and follow the target's appraisal of the situation. The review of these studies suggests that these responses are moderated by individual differences and situational factors. Williams (2007) finds three global types of reactions in people after perceiving that they have become the target of ostracism: fight, flight, and freeze.

Fight responses include all reactions to ostracism that imply some kind of hostile behavior, for example, derogating or reacting violently against the source of the ostracism. A key individual difference that has been found to moderate fight responses is rejection sensitivity (Downey, Mougios, Ayduk, London, & Shoda, 2004), which is described as a tendency to perceive that one is being rejected even when it is not the case. Rejection sensitivity often arises as the result of a history of being rejected and it generally leads to maladaptive responses to rejection, like aggression or relational conflicts. Self-esteem is another individual variable that has being identified as a moderator of responses to rejection. Williams (2007) suggests that individuals with low self-esteem may perceive rejection even when it is not happening, which in turn can lead them to break their relationships with others. Other studies found that although everyone showed lower feelings of self-esteem after experiencing rejection, the impact was greater for people with low self-esteem. Cultural differences have also been found to moderate hostile reactions to ostracism. We should not expect identical reactions to interpersonal rejection in western societies than in eastern cultures, for example.

Flight responses to rejection are those in which the target avoids social situations that he or she thinks would result in rejection. Again, rejection sensitivity seems to be a key moderator of avoidances responses (Williams, 2007).

A third type of reaction to ostracism is the freeze response, which implies a lack of motivation and a decrease in effort used to obtain goals. Individual differences like self-esteem or a tendency to experience social anxiety have been identified as moderators of freeze reactions (Williams, 2007).

Gender seems to be also an important variable that moderates reactions to rejection. Williams and Sommer (1997) found that males tended to engage in more social loafing after experiencing ostracism, while females showed social compensating behaviors, like working harder on collective tasks. These studies also showed that males tended to make other-blame attributions, whereas females tended to make self-denigrating attributions.

Finally, Williams (2007) suggests that, although there is not much research about the consequences of chronic ostracism, we do know that individuals that suffer continuous rejection and social exclusion are likely to perceive that others do not value them. As a result, chronically excluded people can become hypersensitive to social threat and may tend to avoid the risk of having social interactions in order to avoid rejection. The author points out that learned helplessness and alienation are also consequences of chronic ostracism.

2.2.2 Threat to belonging and the self-regulation depletion

Baumesiter and colleagues have developed a rich body of work about the consequences that arise when a person feels that he or she has been socially excluded and/or is aware that he or she risks suffering social exclusion in the future (Baumeister, DeWall, Ciarocco, & Twenge, 2005; Baumeister, Twenge, & Nuss, 2002; Twenge, Baumeister, DeWall, Ciarocco, & Bartels, 2007; Twenge, Catanese, & Baumeister, 2002; Twenge, Catanese, & Baumeister, 2003; Twenge, Baumeister, Tice, & Stucke, 2001). Their research functions on the principle that belonging is a basic human need (Baumeister & Leary, 1995) and that fulfilling this need drives our cognitive, emotional, and behavioral efforts, particularly when the need is threatened.

All the experiments included in the above listed researches apply two experimental paradigms in order to manipulate participants' needs for belonging and feelings of social exclusion. One paradigm leads participants to believe that they have the kind of personality that typically characterizes people who end up alone in life. The other paradigm makes participants believe that all other participants in a group task have rejected them. Results of this research have shown that threatening a person's sense of belonging through either of these two experimental paradigms has the following consequences:

- A reduction in prosocial behavior, with a tendency to avoid cooperative and altruistic behavior (Twenge et al., 2007).
- A tendency to engage in unhealthy behaviors, such as impulsive eating of unhealthy food (Baumeister et al., 2005).
- A reduced capacity to persist in the achievement of goals (Baumeister et al., 2005).
- Avoidance of meaningful thought (Twenge et al., 2003).
- Lack of emotion (Twenge et al., 2003).
- Avoidance of self-awareness (Twenge et al., 2003).
- Lethargy and distorted time flow perception (Twenge et al., 2003).
- Impairments in intelligent thought, with low performance in complex cognitive tasks such as effortful logic and reasoning tasks (Baumeister et al., 2002).

Of particular interest are the efforts that these authors directed toward identifying a key mediator between the experience of social exclusion and the observed negative consequences. An initial intuitive candidate was negative mood, the hypothesis being that social exclusion caused a state of negative mood that would then cause the other negative outcomes. However, the results of the experiments showed that mood did not mediate the negative results caused by the threat to belong. Instead, it seemed that excluded participants showed a lack of emotion rather than negative mood (Baumeister et al., 2002; Twenge et al., 2003).

With negative mood ruled out as the main mediator, a second candidate for the role stood out: the capacity for self-regulation. Self-regulation is defined as “the effective capacity for altering our behavior so as to conform to externally (socially) defined standards,” such as “behaving in socially acceptable ways, acquiring marketable skills, cultivating good relationships, and building a favorable reputation” (Baumeister et al, 2005, p. 589). Several factors support the argument that self-regulation plays a crucial role in the consequences of social exclusion. First, impairment of self-regulation capacity explains two apparently contradictory effects of social exclusion: the reduction in prosocial behavior on one side, and the tendency to engage in self-damaging behaviors, such as eating unhealthy food, on the other. Reduction in prosocial behavior could be considered a selfish consequence of social exclusion. Selfish consequences of social exclusion are difficult to match with self-damaging behaviors. However, both these apparently paradoxical consequences of social exclusion are explained by impairments in the self-regulation capacity. Other observed consequences of social exclusion, such as low performance in complex cognitive tasks, could also be easily explained by a lack of self-regulation. The fact that exclusion did not affect performance in automatic cognitive tasks like, simple information processing, also supports the self-regulation hypothesis (Baumeister et al., 2002). Impairments in self-regulation capacity can also lead to altered sense of time, which is another observed consequence of social exclusion. Finally, the results of these experiments showed that socially excluded individuals tended to avoid self-awareness. A person is likely to deduce that something is wrong with him/herself when he or she is being excluded. Focusing the attention on the self at that moment would force the excluded individual to think about his/her shortcomings. In order to protect the self from that aversive experience, the excluded person avoids self-awareness (Twenge et al., 2003). A certain degree in self-awareness is necessary in order to have self-regulation because it is difficult to govern our actions without focusing our cognition on our own person, at least to some degree.

One question emerging from these studies is whether impairment of the self-regulation capacity is an inevitable consequence of experiencing social exclusion or if, on the contrary, the excluded individual intentionally avoids making the necessary efforts to self-regulate. The results of two studies specifically designed to answer this question showed that decrement in self-regulation was eliminated by offering excluded individuals a cash incentive or increasing self-awareness (Baumeister et al., 2005). The authors concluded that, although rejected individuals are capable of self-regulation, they are not motivated enough to expend that effort.

2.2.3. The attributional ambiguity model

Crocker and Major, in their well-known and pioneering study (1989), hypothesized that the negative effects of others' behaviour on the psychological well-being of a stigmatized individual are contingent on the attributions made by the stigmatized person.

Because persons who carry a social stigma are usually aware of the negative connotations for others of their social identity, Crocker and Major (1989) argue that stigmatized persons are likely to experience *attributional ambiguity* when confronting a negative outcome. Once the target experiences attributional ambiguity, they predict that their self-esteem will be higher when the ambiguity is solved, not in favour of an internal attribution, but in favour of an external one to prejudice (see Figure 2.1).

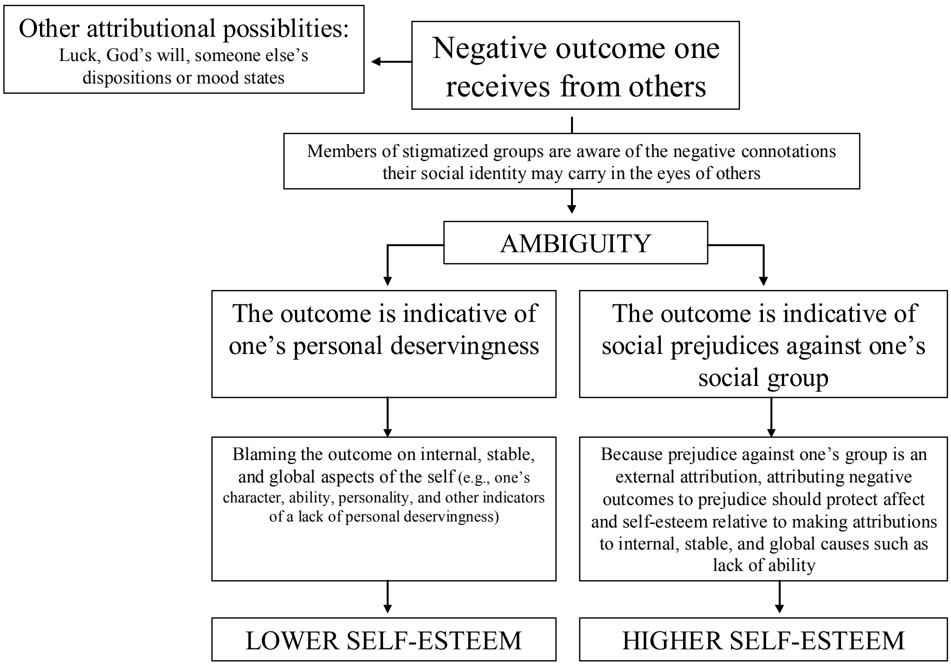


Figure 2.1. The attributional ambiguity model.

Despite the impressive evidence supporting the attributional ambiguity model, and perhaps due to the complexity of the indirect consequences of discrimination, there is also a lot of contradictory evidence challenging its predictions. After an extensive review done by Major et al. (2002) on the current state of the model and the evidence supporting it, the authors refined the original model and formulated the refined and more complex *advanced attributional ambiguity model.*

The advanced attributional ambiguity model

In the reformulation of their model, Major et al. (2002) make a general clarification and introduced four refinements and two mediator approaches.

A general misunderstanding that, according to the authors, is widespread among several works dealing with the issue motivates the general clarification: the authors argue that the attributional ambiguity model has never hypothesised that being a victim of discrimination, nor the fact of attributing it to the prejudice of others, could have any positive effect on the victim's self-esteem relatively to not being a victim of prejudice and discrimination. The attributional ambiguity model does focus, however, on a very specific and particular question related to experiencing a particular negative event of discrimination: whether or not attributing that particular event to the prejudice of others might protect the victim’s self-esteem and affect relatively to attribute the same event to internal and stable factors of the self.

Among the four “refinements” introduced in the advanced attributional ambiguity model, the first two could be considered minor changes, while the other two imply major changes to the original formulation. The first refinement proposes that an attribution to discrimination must always imply the assumption by the victim of injustice and moral wrongdoing. If, for example, a target attributes a negative outcome from others to his or her social identity, but thinks, however, that the negative outcome is somehow justified, then it would not properly be possible to talk about an “attribution to discrimination”. A target could justify being the victim of a negative outcome because, for example, he or she thinks that the objective characteristics of his or her group of belongingness justify the negative outcome or thinks that the discrimination is not unfair because the stigma is under his or her control. The second refinement, very related to the former one, proposes that an attribution to discrimination always implies blame on the victimizer. Blame connotes causality, responsibility and, furthermore, moral wrong-doing. If there is no moral wrong-doing, the victim of a negative outcome would not “blame” other person for that outcome (first refinement). But, moreover, if there is no causality or if the outcome is not under the responsibility of the victimizer, then the victimizer could never be “blamed” and an “attribution to discrimination” would not be possible.

The third refinement is motivated by Schmitt and Branscombe (2002) findings proving that attributions to prejudice are not exclusively external attributions, as originally proposed by the model, but may have, under some circumstances, an important internal component as well.

The fourth refinement takes account of the existing evidence suggesting that it is possible to attribute to external factors without necessarily discounting the role played by internal ones (see Major et al., 2002).

These two last refinements, by reformulating two nuclear aspects of the attributional ambiguity model, introduce major changes in the model that, under some circumstances, vary significantly the advanced model's predictions with respect to the original ones. As Major et al. (2002) state it, taking into account these findings leads to the conclusion that "the emotional consequences of attributing negative outcomes may be less straightforward than originally assumed (p. 266)." Not only have these findings leaded to that conclusion. There is as well an important amount of evidence, reviewed by the authors, suggesting that the predictions of the model are moderated by a significant number of contextual factors and individual differences which determinate its applicability. In order to account for this variability, Major et al. (2002) propose what actually constitutes the most important difference between the advanced and the original model: the consideration of two *mediator approaches* that account for an important amount of variables that moderate the applicability of the model at two different stages:

- At a first stage, when the problem is whether to attribute (or not) an outcome to prejudice (since an attribution to discrimination is not equally likely for everybody and under all circumstances).
- At a later stage, and once the negative outcome has been firmly attributed to prejudice, when the problem is whether or not the person is going to experience a positive effect on his/her well-being (bearing in mind that not for everyone and not

under all circumstances an attribution to discrimination would equally bring about the positive effects on well-being predicted by the model).

The mediator approach to attributing to discrimination

After a review of the available evidence, Major et al. (2002) proposed that whether or not an attribution to prejudice would be made depends mainly on three major factors: the extent to which that outcome is perceived as linked to group membership, the extent to which it is perceived as unjust, and the impact of social structures. Their mediator approach identifies a number of individual differences and situational or contextual cues that influence each of these three major factors. Table 2.1 summarizes these mediators.

Table 2.1
The mediator approach to attributing to discrimination: List of mediators

SITUATIONAL FACTORS
Saliency of group identity in the situation
Cues of blatant prejudice in the situation
Cues of biased attitudes of others in the situation
Situational cues of group boundaries permeability
INDIVIDUAL DIFFERENCES
Individual level of identification with the group
Group consciousness
Sensitivity to stigmatization
Endorsement of “legitimizing ideologies”
Endorsement of the ideology of individual mobility
STRUCTURAL FACTORS
Relative low status of one’s group

The mediator approach to the self-protective properties of attributing to prejudice

Once an attribution to prejudice is made, this attribution is not equally likely to have self-protective properties for every person and under all circumstances (Major et al., 2002). The authors also propose a second mediator approach that accounts for variables that mediate the effect that attribution to prejudice causes on the psychological well-being of the target. As in the preceding mediator approach (concerned with attribution to discrimination), the identified mediators can be individual differences, situational cues, or structural factors.

The proposal of this second mediator approach by Major at al. (2002) is accompanied by a new and powerful idea that goes beyond merely proposing of a number of mediators. From the authors' perspective (see Major et al., 2002), being a target of negative behavior from others is a serious potential stressor. For this reason, the authors resort to using Lazarus' well-known "stress and coping appraisal model" to analyze the indirect consequences for the well-being of the victim. They propose that people facing discrimination go through a process in which the first step would be equivalent to a primary appraisal (e.g. Do I perceive myself as a victim of discrimination?), the second step is a secondary appraisal (e.g. Do I have the necessary resources to cope with that discrimination?), and the third step is the coping process itself. Each of these three steps are mediated by some or all of the four mediators proposed for this second mediator approach: clues of blatant prejudice in the situation, individual level of identification with the group, individual endorsement of "legitimizing ideologies", and relative group status.

2.2.4 The three stage model of perceiving and responding to discrimination of Stangor and colleagues

Similar to the advanced attributional ambiguity model, Stangor et al. (2003) present a three-stage mediator model for understanding the process of perceiving and responding to discrimination. The three stages of their model are, however, different from the ones proposed in the attributional ambiguity model: i) Asking oneself whether or not the behavior of others towards the self has been discriminatory; ii) Answering that question and consequently attributing that particular event to the prejudice of others or to any other alternative cause; and iii) Publicly announcing the fact that he or she is a victim of discrimination. As explained earlier, these steps are not necessary for the victim to suffer from the direct consequences of the discriminatory episode.

According to this model, in order to make an attribution to prejudice, the concept "discrimination" needs first to be activated as a possibility in the mind of the victim (Stangor et al. 2003). Table 2.2 summarizes the contextual and individual factors proposed by the authors as variables that mediate the likelihood of activating the "discrimination" construct in a person's mind.

Table 2.2
Factors that mediate the activation of discrimination

SITUATIONAL FACTORS
Frequent or recent activation of the construct
Previous exposure to discrimination
"Solo"-status (i.e. being the only member of the in-group present in a given context)
The extent to what a particular behavior is prototypical of discrimination
The extent to what a particular type of discrimination is prototypical
INDIVIDUAL DIFFERENCES
Attention biases (hypervigilance) in members of stigmatized groups
High sensitivity to discrimination

Once an individual considers discrimination as a possibility, i.e., once this concept has been activated, whether he or she will actually attribute a particular incident to discrimination depends on a number of cognitive, motivational and emotional factors. Table 2.3 summarizes these factors.

Finally, Stangor et al. (2003) propose that, once an outcome has been attributed to the prejudice of others, the probability that the victim will publicly announce this circumstance depends on a cost-benefit assessment of announcing it. The authors identified research that provides evidence suggesting that making public attributions to prejudice leads victims to be rated less favorably by others (Dodd, Giuliano, Boutellm & Moran, 2001; Kasier & Miller, 2001). Conversely, Stangor and colleagues have obtained evidence that only partially confirms the Kaiser and Miller study: they found that claiming that a negative outcome was due to discrimination, instead of ability, had a negative impact on the perceived warmth of the target, making him/her appear to be a "complainer". However, this claim also had a positive effect, as others perceived the target as a more competent person. On the other hand, denouncing discrimination might also have benefits related to raising consciousness and educating about the problem.

Table 2.3
Factors that mediate the attribution to discrimination once the concept is already activated

COGNITIVE FACTORS
The existence of alternative justifying arguments and the cognitive load of the victim
The victim's assessment of the victimizer's intent and of the amount of harm done
The individual differences affecting the motivation to collect and process information (due to differences in harm experienced or to differences in pervasive perceived discrimination)
The individual level of identification with one's group
MOTIVATIONAL FACTORS
The goal of maintaining positive *self-regard*
Pervasive tendency to justify existing status hierarchies and outcomes distributions and motivation to think that individuals deserve their outcomes (belief in a just world, system justification, etc.)
Motivation to attribute to discrimination in order to maintain the perception of control
The personal-group discrepancy
Motivation to attribute to discrimination to protect self-esteem (attributional ambiguity model)
EMOTIONAL FACTORS
The current affective state

2.2.5 The pervasive approach to group based discrimination

Schmitt et al. (2003) argue that social psychologists studying the indirect effects of discrimination have focused mainly on the responses to isolated events of discrimination, without paying enough attention to the target's understanding of the larger social structural context in which individual instances of discrimination are embedded. It could be argued, however, that both models reviewed above do actually consider relative group status as an important moderator. For example, Major et al. (2002) predict higher individual costs of recognizing oneself as a victim of prejudice for members of low-status groups than for members of high-status ones, which, in turn, might reduce the likelihood that members of disadvantaged groups attribute a negative event to discrimination. Still, the mediator approach to the self-protective properties of attributing to prejudice surmises that members of low-status groups experience discrimination more frequently than members of high-status groups, which would inherently increase sensitivity to discrimination in members of low-status groups. Major et al. (2002) also find that the incidents of discrimination experienced by members of high-status groups are usually less serious than those experienced by members of low-status groups. Stangor et al. (2003) also take into account the structural social context in which a particular incident has taken place by suggesting that previous or frequent experiences of discrimination increase the likelihood that discrimination would become an active construct in the target's mind. They propose too that chronic-stigmatized individuals might differ from non-stigmatized ones in both the way they perceive and process a particular incident of discrimination, as well as in the incidental costs of publicly announcing it.

Although taking all these factors into account actually implies the consideration of the larger social context surrounding a discriminatory event in some way, there are major differences between the way in which the distinct approaches incorporate context into their analyses. One major difference is the consideration of *pervasiveness* that Schmitt et al. (2003) suggests is a crucial factor explaining the indirect effects of discrimination. This element is not considered in the other two approaches, at least not in the way that Schmitt, Branscombe and colleagues attend to it.

Pervasiveness is defined as the extent to which discrimination is spread across time and different social contexts in a person's life. While the attributional ambiguity model and Stangor's approach are focused on studying the effects and the processes related to isolated events of discrimination, Branscombe and colleagues are more interested in the effects of *pervasive* discrimination. According to these authors, the consequences that discrimination causes on its victims are quite different depending on whether discrimination is a pervasive circumstance in a person's life or is an event that is rare and atypical and/or happens in a very specific social context.

To test this hypothesis, Schmitt et al. (2003, study 2) measured women's private collective self-esteem and affect in three different experimental conditions: a situation of rare sexist-discrimination, in which participants faced sexist discrimination from a teacher, but were led to believe that the discriminatory attitude was an exception among teachers; a situation of pervasive sexist-discrimination, where participants were informed that most male teachers also discriminated against women; and a control situation, in which participants were unfairly treated by a male teacher, but this attitude was attributed to that particular teacher's personal disposition and not to sexist attitudes. As hypothesized by the authors, results showed that collective self-esteem and affect were significantly lower when participants experienced discrimination as a pervasive circumstance than when they experience it as a rare and isolated event. Moreover, rare sexist-discrimination and the control non-sexist conditions did not significantly differ with each other in either measure.

Although Branscombe and colleagues do not identify the processes underlying the pervasiveness mediator effect, their explanation of it turns to the theory of social identity (Tajfel, 1978; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). Taking the social identity theory perspective, they argue that "pervasive discrimination against one's ingroup implies that one's social identity is low status and devalued" (Schmitt, et al., 2003, p. 298). Moreover, Schmitt et al., (2003) argue that privileged groups, by pervasively rejecting disadvantaged groups, have in fact the structural power to impose who is valued in society and who is not.

The key question here seems to be the awareness that members of stigmatized groups would have of being devalued in general as individuals in the eyes of others because of their group of belongingness. The concept of generality or pervasiveness is therefore a crucial one, as it gives the victim a feeling of meaninglessness and insignificance that would permeate many of that person's social perceptions. This awareness could be described as a deep devalued self-consciousness in relation to dominant groups.

By considering these questions, Branscombe and colleagues are not only incorporating relative group status into their analysis, but they are giving the life-long experience of belonging to a group that has a devalued social identity a deep, basic, and structural role when it comes to understanding and explaining the consequences of discrimination on the victim's psychological well-being.

In a different work, Schmitt et al. (2002) hypothesized that, because men and women occupy different positions in the social structure, perceptions of being targeted by prejudice and discrimination should have more severe effects on the psychological well-being of women than men. Moreover, according to the rejection-identification model (Branscombe et al., 1999), the authors predicted that the negative effect of discrimination on the victim's psychological well-being would be positively mediated in women, but not in men, by an increase in group identification.

As hypothesized, the authors found that a group of 220 women and 203 men significantly differ in their perception of discrimination (women higher than men) and in the negative effect that discrimination had in their psychological well-being (in women more negative effect than in men). The results also showed that perceptions of gender discrimination have a significant effect on women's psychological well-being and that this effect was partially suppressed by increased group identification in women. In men, however, perceived discrimination did not affect psychological well-being nor did it encourage group identification.

2.3 Interpersonal rejection and humiliation

One of the main hypotheses that underlies all the studies presented in this dissertation is that people with dwarfism can easily feel humiliated by the treatment and attitudes that they perceive they received from others in many of their daily social interactions. This hypothesis is based on a review of several works on humiliation that are summarized below.

2.3.1 Humiliation, human dignity, and the vertical scale of human worth

Lindner (2006) has published an extensive review on humiliation, which she refers as the "nuclear bomb of the emotions". She argues that humiliation is a rather modern concept, which has acquired its current meaning with the development of a relatively young ethic based on the moral principles of equal human dignity that inspired the Universal Declaration of Human Rights. These principles are based on the proposition that all human beings have the same moral intrinsic value. This ethic postulates that human beings should treat each other according to this intrinsic equal moral value, independently of any other difference in capacities, abilities, beliefs, culture, resources, physical condition, etc. Lindner asserts that during many centuries in our history the dominant ethic has been one based on a vertical scale of human worth, according to which there were people who simply had a higher intrinsic value than others. For example, in Europe during the Middle Age there was no question about the "fact" that nobility had more value than the ordinary people. Only seventy years ago, a powerful ideology conquered half of the continent and was based on the moral superiority of the so-called Aryans. Still today men have a higher rank in the vertical scale than women in many cultural contexts. So, although we may think that the dark period of history in which we followed a vertical scale of human worth is far past, the fact is that the Universal Declaration of Human Rights is quite recent. In fact, many areas of our social life are still driven according to the archaic principles of the vertical scale of human worth. According to Lindner (2006), the feeling of humiliation surfaces once humans have internalized the principle of equal human dignity, but still perceive that others treat them according to a vertical scale of human worth. In this context, Lindner defines humiliation "as the enforced lowering of any person or group by a process of subjugation that damages their dignity; "to be humiliated" is to be placed in a situation that is against one's interest (although sadly not always against one's will) in a demeaning and damaging way; and "to humiliate" is to transgress the rightful expectations of every human being and of all humanity that basic human rights will be respected" (p. xiv).

2.3.2 Humiliation as a self-conscious emotion

One of the first works with a clear empirical approach to the psychological study of humiliation is the one conducted by Hartling and Luchetta (1999), who developed a self-report scale to assess the internal experience of humiliation. Hartling and Luchetta (1999) define the internal experience of humiliation as "a deep dysphoric feeling associated with being, or perceiving oneself as being, unjustly degraded, ridiculed, or put down" (p. 264). In particular, the authors maintain that humiliation appears when one's identity has been demeaned or devalued. They further describe humiliation as a "self-conscious" emotion, closely related to other similar ones like shame, guilt, pride, and embarrassment. According to the authors, shame is the emotion most closely related to humiliation. Humiliation implies, however, a deeper and more essential experience than shame, because humiliation is more related to the essence of what one *is*, while shame is related to what one *does*. The role that others play in the emergence of both emotions is also an important aspect that differentiates humiliation from shame. Both emotions require the presence of others, but "humiliation involves more emphasis on an interaction in which one is debased or forced into a degraded position by someone who is, at the moment, more powerful. The experience of shame [on the other hand] emphasizes a reflection on the self by the self, in other words, the internal process of negatively evaluating oneself is accentuated. In contrast, the experience of humiliation draws more attention to an interpersonal event." (Hartling & Luchetta, 1999, p. 262).

2.3.3 Humiliation, self-respect, and social honor

Our understanding of the meaning of humiliation is enriched by considering the work of a moral philosopher on the issue. Margalit (1996) develops a solid and interesting thesis on what humiliation is in his book about the "decent society", which the author defines as the society in which those who have power do not give reasons for those who do not have it to feel humiliated. Margalit's approach to humiliation is included in this theoretical review because it provides an angle that is useful to the study of the indirect effects of discrimination and social exclusion from a social-psychological point of view.

Margalit (1996) defines humiliation as the emotion a person feels when, due to the action of others, that person finds reasons to lose his/her "self-respect". "Self-respect" is a different concept than "social honor". According to the author, we feel social honor through awareness that our virtues, capacities, abilities, or work are appreciated by the members of the society in which we live. A lack of “social honor” could easily lead to low self-esteem, but not to humiliation. “Self-respect”, on the other hand, is something we feel independently of any of our outcomes in society and independently of how others value our work, abilities, and capabilities. “Self-respect” is, therefore, a more basic and essential feeling than “social honor”. Self-respect is a feeling that all human beings should experience in normal circumstances simply by being aware of our membership in the human community. A loss of “self-respect” does not necessarily damage self-esteem, instead, it leads to a more basic and negative experience that we call humiliation. An interesting point that Margalit emphasizes about humiliation is that a person can only feel humiliated due to another human being’s actions. For example, someone can feel demeaned as an individual after a natural catastrophe has devastated all his/her property or taken away all his/her loving ones, but this person won’t feel humiliated because of that. The reason for this is that our sense of “self-respect” arises from our awareness of being potentially related to others. This awareness is damaged to the extent that others, in general, deny our moral inclusion in those social groups that are relevant for us. In other words, our dignity as human beings depends on our sense of potentially being accepted by others in order to maintain balanced social relationships, in other words, being socially included. If we feel that, due to an essential attribute (for example our gender, religion, ethnic origin, physical appearance, etc.), others deny our social inclusion, we will feel humiliated.

The feeling of being dignified as individuals or a person’s awareness of “self-respect” is, on the one hand, a very intimate and basic individual awareness that we usually take for granted, at least in normal situations. It is then hard to imagine how others, with their actions, could give us motive to lose what we usually experience as an intimate, basic, and given value of being what we actually are: people. Margalit (1996) refers to this apparent contradiction as the “paradox of humiliation”.

By explaining and resolving this paradox the author provides an understanding of humiliation that easily relates with the psychological approach to understanding the consequences of feeling socially excluded adopted in the present dissertation. The key element explaining the paradox lies in the complexity of the “self-respect” concept. “Self-respect” was described above as the intimate awareness of essential value that we all should feel in normal situations just by being conscious of our membership in the human community. Apparently, others should therefore not be needed in order to experience this basic and intimate awareness of feeling valuable. But, paradoxically, “self-respect” demands the existence of others. From a philosophical point of view the reasoning used to solve the paradox is simple: from a *solo* case it is not logically possible to form a category. Others, and a sense of being included by them, are therefore necessary conditions for “self-respect” to appear in our minds. From a psychological point of view, the paradox can be solved by arguing that pervasive social exclusion makes us feel excluded from the realm of social life and from social interaction. If pervasive enough in a person’s life, this feeling of exclusion can lead to a feeling of *not-being,* in relation to others. This feeling could affect our awareness of “self-respect” or our intimate sense of being dignified and valuable individuals by the simple virtue of being people. In this case, humiliation could arise.

In relation to Margalit’s perspective, our primary concern is the following: What would happen if others, through a pervasive discriminatory attitude toward us, make us feel that we are not considered to be as acceptable as individuals as others? The hypothesis we propose in the present investigation is that, in such a situation, “self-respect" would suffer and an intimate, basic, and structural negative emotion would arise. This emotion is humiliation.

2.3.4 Moral exclusion and our capacity to morally ignore the members of a social group

According to Opotow (1990), "moral exclusion occurs when individuals or groups are perceived as outside the boundary in which moral values, rules, and considerations of fairness apply" (p. 1). As a consequence, "those who are morally excluded are perceived as nonentities, expendable or undeserving by others" (Opotow, 1990, p. 1). Although Opotow's study is not focused on the consequences of perceiving social exclusion on the victim's well-being, which is our primary concern, the phenomenon of moral exclusion, described as perceiving others as "nonentities", "expandable" or "undeserving", refers to basic and essential aspects of *being* in relationship to others, and therefore also to the possibility of feeling *non-being* because of the exclusion by dominant others. It is in this last sense in which Opotow's approach is closely related to our hypothesis of the existence of an intimate and essential relationship between pervasive discrimination or social exclusion and humiliation.

Moral exclusion is possible because people do not actually consider all human beings to be equally deserving from a moral point of view (Bierbrauer, 2000; Opotow, 1990). In consequence, "moral values, rules, and considerations of fairness apply only to those within this boundary for fairness, called our "scope of justice" or "moral community". Membership within this boundary, therefore, has profound implications. "People who are slaves, children, women, aged, Black, Jewish, mentally retarded, physically handicapped, and insane constitute a partial list of beings whose rights have been abrogated or eliminated because of their exclusion from the scope of justice" (Opotow, 1990, p. 3). We tend to think that only extremely evil individuals exclude others, but in fact, it is not uncommon to find that we all set differences in the moral consideration that we offer to others. Opotow (1990) distinguishes between severe instances of moral exclusion (violations of human rights, political repression, religious inquisitions, slavery, and genocide) and mild ones, which occur "when we fail to recognize and deal with undeserved suffering and deprivation. The other is perceived as nonexistent or as a nonentity. In this case, harm doing results from unconcern or unawareness of others' needs or entitlement to basic resources, such as housing, health services, respect, and fair treatment" (Opotow, 1990, p. 2).

Similar to Opotows' arguments, we are interested in mild or subtle forms of moral exclusion of disadvantaged groups, as those that stem from the prejudice or discrimination toward a social group by majority group members (see Morales, 2003). We are especially interested in how victims perceive this situation. Our main hypothesis is that victims perceive pervasive stigmatization and discrimination as an essential feeling of being lesser "entities" in the eyes of the dominant group. In relationship with previous arguments, we hypothesize that if members of a human collective are aware of exclusion by the majority, i.e. of being ignored or considered as "nonentities", this awareness is likely to cause a global subjective experience of devaluation or demeaning that is essentially related to humiliation.

2.3.5 Social stigma and humiliation

In their review of the social psychology of stigma, Major and O'Brien (2005) found that most authors defined social stigma as an attribute that differentiates and devalues a person in the eyes of others. The authors remarked that a stigma is not considered an intrinsic characteristic of the person, but a phenomenon that emerges in a given social context. It is therefore necessary to approach its study considering the particular social relationships and social context in which it takes place. In an earlier revision on the same issue, Crocker et al. (1998) argue that social stigma results from an attribute that causes a person's social identity to be devalued in a particular social context. The authors also indicated that the problem of stigmatization is not any negative characteristic of the person who is doing the devaluing *per se*, but rather that the problem lies with the person who has a characteristic that, in a particular social context, leads to devaluation by others.

Schmitt et al. (2003) proved that the extent to which discrimination is experienced as a pervasiveness circumstance in a person's life is a crucial aspect to determine its impact on the victim's psychological well-being. These authors concluded that the effects of perceiving discrimination on account of the group to which he/she belongs were significantly worse for the victim's psychological well-being when discrimination was experienced as a pervasive attitude toward one's group, than when it was experienced as an isolated event of a particularly prejudicial person.

In line with this last finding, but not necessarily in contradiction with the understanding of social stigmatization as a context specific phenomenon, the present dissertation investigates the relationship between being aware of having a social stigma that leads to social exclusion in most social contexts and the feeling of humiliation.

2.4 The present dissertation

The starting point of the present dissertation is the assumption that members of groups with a devaluated social identity are exposed to a subtle, low-intensity, but still extended and damaging form of derogation. This derogation is not necessarily based only on explicit acts of devaluation carried out by a minority of cruel aggressors. Derogation can also be based on the victim's subtle awareness of being often avoided and ignored by others for social interaction, making very difficult for them to maintain balanced social relationships. This awareness is in itself damaging to the well-being of the excluded person and, furthermore, it is intrinsically connected with a deep feeling of humiliation.

We argue and will demonstrate (see Chapter 4) that dwarfism is a physical condition that is often perceived by majority group members as a strong stigma. Therefore, those who have dwarfism are often exposed to interpersonal rejection and to the derogation we have described in the above paragraph, as we will show in detail in Chapters 3 and 5. We assume that episodes of interpersonal rejection vary in nature and quantity and that individual differences and contextual factors will moderate the consequences that interpersonal rejection has on its targets. We predict that, in general, people with dwarfism will report relatively high levels of interpersonal rejection, which significantly damages their psychological well-being. We are particularly interested in the study of how this social group copes with social stigmatization (see Chapter 5). Finally, we hypothesise that the negative consequences of the stigmatization of dwarfism are not only observable in the episodes of interpersonal rejection that these people face, but also at a more general social level (see Chapter 6).

CHAPTER 3

STUDY 1: THE EXPERIENCE OF LIVING WITH DWARFISM

Abstract

This chapter presents the summary of a preliminary qualitative study in which nineteen adults with skeletal dysplasias that cause disproportionate dwarfism were interviewed. These interviews, which altogether accounted for 26 hours of video tape, were recorded, transcribed and analyzed. The interviews focused on the way people with dwarfism experienced their relationship with majority group members. From the analysis of this material, an extensive report about the experience of living with dwarfism was written in Spanish and returned to the ALPE-Achondroplasia Foundation, the organization that requested that we conduct the research that led to the development of the present dissertation. The conclusions drawn from those interviews have served as a basis from which to develop the studies that form the core of this dissertation and which will be presented in the following chapters. These interviews provided a good overview about the experience of living with dwarfism in general and, in particular, about the difficulties that arise in relationships between people with dwarfism and others. Because the conclusions obtained from these interviews are relevant to the contextualization of the subsequent studies that make up this dissertation, we summarize them in the present chapter.

Key words: social stigmatization, dwarfism, achondroplasia, target's perspective.

STUDY 1: THE EXPERIENCE OF LIVING WITH DWARFISM

Introduction

The main goal of the research project that resulted in the present dissertation was to study, from a socio-psychological point of view, the social stigmatization associated with skeletal dysplasias that cause dwarfism, its consequences on the psychological well-being of the victims, and the strategies used to cope with it.

As a first step in the research project, we conducted nineteen in-depth interviews with people with skeletal dysplasias that cause dwarfism in order to obtain first-hand testimonies of how their physical condition affects their relationships with others in their daily lives. There is some literature written by people with dwarfism or by close relatives that addresses, to some extent, the same issue (see, for instance, Adelson, 2005). However, this literature constitutes a personal narrative of the condition based on autobiographical experience, and is not intended to objectively research the socio-psychological aspects of living with skeletal dysplasias. As reviewed in more detail in the first chapter of this dissertation, there is also some research that gives us an idea of how skeletal dysplasia affects people living with this condition. For example, Jackson and Ervin (1991) studied the stereotype of shortness finding that, in general, shortness is associated with negative stereotypes in different domains such as low physical and social attractiveness, low professional status, and bad personal adjustment. Height has been identified as a crucial factor in recruitment and employment policies, which tend to favor tall candidates (Feldman, 1975; Miller, 1987). There are also several works that address quality of life in people with dwarfism by comparing a group of people with achondroplasia and other skeletal dysplasias to first degree relatives (see Chapter 1 of this dissertation). This research finds that people with skeletal dysplasias tend to have a lower quality of life than their first degree relatives (Gollust et al., 2003; Hunter, 1998).

Generally speaking, this literature leads us to the conclusion that that skeletal dysplasia causing dwarfism is an important factor in a person’s life that has a notorious impact on daily living.

Still, none of the existing literature analyzes in depth how affected individuals experience their relationships with people who do not have dwarfism. It is obvious that skeletal dysplasia affects a person’s life, but, to what extent does it interfere in their relationships with the others? What are the psychological consequences, if any, of experiencing social stigmatization of dwarfism? In order to answer these questions we decided to conduct semi-structured in-depth interviews with a heterogeneous group of nineteen individuals with disproportionate short stature.

We were also interested in studying the opinion that the affected individuals had about the limb-lengthening surgery (LLS). As we will explain in detail in Chapter 5, LLS is an important variable within this population with a deep impact in quality of life for many reasons. LLS is a long and arduous surgical process that allows people with achondroplasia to lengthen the lower limbs up to 30 cm. (0’98”) and the upper ones up to 14 cm. (0’46”). LLS begins when the person is around ten years old and usually takes between three and four years to complete the process. During this time the patient must make significant sacrifices in order to recover from the surgery. The use of LLS is a controversial issue among the community of people with dwarfism, which we will study in depth in Chapter 5. Because of the significant implications that LLS has on the lives of people with achondroplasia, we wanted to address how affected individuals perceived this issue during the interviews.

The interviews were recorded on video tape, then transcribed and analyzed with NVIVO7 from QSR International, a software package for the analysis of qualitative data. The interviews varied between one and two hours in length and altogether amounted to 26 hours of video tape. The results of this analysis were presented to the ALPE-Achondroplasia Foundation in a 123 page extensive report (Fernández, 2008b).

Through these interviews, we gained valuable insight into the social-psychological experience of living with dwarfism. Because they have to some extent inspired and guided the studies presented in the following chapters, we deem it appropriate to briefly schematize the main conclusions of this preliminary qualitative research.

Method

Sample and procedures

Nineteen Spanish persons (9 women and 10 men) with a skeletal dysplasia that causes dwarfism participated in the study. Participants' ages ranged from 14 to 35 years old, with a mean age of 20.2, *SD* = 7.0. Most of the interviewees had achondroplasia (*N* = 15), two had hypoachondroplasia and the other two had less common skeletal dysplasias (McKusick and dystrophic dysplasias). Due to the lack of a reliable register of people with skeletal dysplasia -there is not even any accurate register simply of how many people born in Spain have skeletal dysplasia-, it was impossible to select a sample that could be presented as representative in sociological terms. However, we did our best to form a heterogeneous pool considering several demographic criteria. We first established an age range. Although we were interested in studying the experience of living with a skeletal dysplasia across different social contexts, we were particularly interested in the educational context, as the ALPE-Achondroplasia Foundation was especially concern about the effects that stigmatization could have at school. Therefore we focused on people who attended school in relatively proximate time periods. We fixed 35 as the oldest age and avoided interviewing people younger than 13 years old because we concluded that it would be the minimum maturity level necessary to address the topics that we presented. We formed a heterogeneous sample in terms of age within this range. We intentionally selected individuals that lived in big cities (32%), smaller ones (37%), and in little towns or rural areas (32%). We also selected participants with heterogeneous family and cultural backgrounds in terms of socioeconomic status and religious beliefs. The educational and professional level of the participants themselves, as well as gender, was also intentionally made as heterogeneous as possible. Finally, we gathered a heterogeneous sample of people who had undergone LLS (47%) and those who had not (53%).

Participants were contacted by the author and explained that the objective of the research was to learn about how people with a skeletal dysplasia that causes dwarfism experience their relationships with other people and how the dysplasia affects their daily lives. We guaranteed that their participation, as well as their opinions and experiences, would be treated anonymously and would be used for research purpose only. Minors participated upon previous authorization from their parents. Participants were told that they could interrupt and abandon the interview at any time, though none of the interviewees did.

The interviews took place in a private room with only the interviewee and the interviewer present. They were recorded with an 8 mm video camera. The interviewer followed a semi-structured script, divided in 14 sections: opening, first years, school, negative experiences in relationships with others, positive experiences in relationships with others, romantic relationships, family, identity issues, self-concept, college/university, work, adult life, LLS, and future expectancies. All interviews were recorded in video, transcribed, and then analyzed with the program NVIVO7. This software is specifically designed for the analysis of qualitative data. It helps to sort and classify participants' experiences into different categories selected from an analysis of the data itself. The main output of the program consisted of a list of categories filled with the examples from participants' testimonies descriptive of each category.

Results

Our goal is to summarize the main conclusions obtained from the qualitative preliminary research. For a more detailed reading in Spanish, including examples of the testimonies given by participants, see Fernández (2008b).

We have grouped the results in two main sections, one referred to how people with dwarfism experienced the social stigmatization of their condition in relationship to others and a second one about the consequences that those experiences had for them, plus a brief final section about LLS.

Experiencing the social stigmatization of dwarfism

All the participants reported to have confronted, from an early age, different kinds of negative attitudes and behaviors from others (i.e., negative outcomes) that they attributed to the social stigmatization of their physical condition. We classified the reported negative outcomes in four categories: *tactless looks and remarks*, *verbal and physical aggressions*, *ostracism and social exclusion*, and *sexual exclusion*. In the following paragraphs we briefly describe and comment each of the four categories. Although our main goal with these interviews was to identify the main sources of difficulties arising in the relationships of the affected individuals with the others, we also obtained testimonies referring to positive experiences. In order to avoid providing only negative information in the final report with the results of the interviews returned to the ALPE-Achondroplasia Foundation, we added a section to that report called *positive experiences*, which incorporated the positive testimonies that we obtained from participants. We have also included a brief summary of that part at the end of this section.

Tactless looks and remarks

People with disproportionate dwarfism have a distinctive physical appearance that attracts the attention of others. All participants explained the undesirability inherent in the way people on the street have looked at them every single day of their lives. They described particularly indiscreet looks from others, for example, when anonymous people would turn around to stare at participants, sometimes even expressing surprise and calling attention of those around them to stare as well. Participants described how these surprise reactions were sometimes accompanied with expressions of joy, as if looking at them were funny. Participants referred also to instances in which anonymous people made indiscreet comments or directed questions at them like, “Why are you so small?” or “How old are you?”

Most episodes described took place on streets or at public places like markets, public transport, etc., but participants explained as well having to go through accommodation periods in which they noticed glances from others when beginning a new activity (a new course, for example) or when attending a social event that involved meeting new people. Although in school their classmates would become accustomed to participants’ different physical appearance, children from different courses or even the parents of students seeing the affected individuals for the first time would make comments such as “Look at that poor kid!”

Participants describe being aware that comments like these were usually not intended to be offensive, but they experienced them as aversive expressions of surprise and negative attitudes that made it clear that they are different from others. Particularly damaging were jokes about their physical condition or comments and reactions from others implying that the participants’ physical appearance is humorous.

Verbal and physical aggression

All participants reported having been victim of verbal aggression related to their condition such as being called “dwarf”, “midget”, “big-head,” and other names that negatively referred to their peculiar physical appearance. Most of these episodes took place at school. Some participants did not give these verbal slights much importance, while others reported suffering greatly because of verbal aggression. None of the participants found those incidents completely innocuous. Overall, it is remarkable to find how vulnerable people with dwarfism were to instances of verbal aggression. Up to 79% of the participants reported suffering very much due to having been called names that negatively referred to their skeletal dysplasia. It was obvious that insults referring to the dwarfing condition caused much more distress to participants than insults referred to any other aspect of themselves. The insults referring to their condition touched a highly sensitive aspect of participants’ self-concept and identity.

Four participants (21%) reported having being victims of more severe aggressive experiences due to their physical condition. Two of these participants reported experiences of bullying at school, in which they were the center of continuous mocking and derogatory treatment from a number of classmates, while the rest of the class and the teachers did nothing to stop the aggression. These participants felt extremely alone and hopeless because of this treatment, which produced negative psychological repercussions. One of these two participants also suffered physical aggression. Both required psychological counseling and eventually left their schools. Two different participants described two isolated aggressive attacks suffered as adults due to their physical conditions that they described to be extremely degrading. All the victims described the emotional consequences of aggression toward them as highly aversive and humiliating (see Fernandez, 2006).

Ostracism and social exclusion

Eight participants (42%) reported serious problems during school time due to social exclusion and ostracism. Particularly interesting was the fact that in four out of eight cases, ostracism was especially salient at the beginning of adolescence. Experiencing social exclusion and ostracism was described as a painful experience. One participant illustrated the impact that ostracism had on her psychological well-being during her school years as follows: “Social exclusion is much worse than if I would have been named “fat and ugly midget”. That would have hurt me less than the fact of always being there in the shadow.”

Of the nine participants that were not still studying, four (44%) referred to episodes of employment discrimination.

Sexual exclusion

Although it could be argued that not being taken into account by others as a possible partner for intimate relationships (i.e., sexual exclusion) could be considered social exclusion, we decided to separate these two experiences. We obtained testimonies showing that some participants were highly satisfied with their emotional lives, friendships, and relationships with others, except in romantic relationships. We were able to address the subject of romantic relationship with only eight participants. From those, three participants (38%), who reported general satisfaction with their social and professional lives, expressed concern about being in or around their thirties and having difficulties with romantic relationships. Four (50%) expressed less concern about the issue, but mentioned that it could become a problem in the future.

Positive experiences

Although the main goal of the interviews was to learn about the *difficulties* associated with the dwarfing condition, we also obtained clear evidence that people with skeletal dysplasia were able, in general, to overcome those difficulties. Although practically all participants expressed some kind of concern about the future, at least 47% of them appeared to be satisfied with their current social situation. Of the nine participants that were not students at the time of their interview, five (56%) were working and four of those were satisfied with their present jobs. Of the ten participants who were studying, eight (80%) were satisfied with their current situation at school.

Consequences of experiencing the social stigmatization of dwarfism

We have classified the consequences reported by participants of the negative outcomes in three main groups: *cognitive*, *emotional*, and *behavioral*.

Cognitive consequences

The most obvious cognitive consequence of experiencing the social stigma of dwarfism was *rumination.* Thirteen participants (68%) described periods of their lives in which they spent a lot of time thinking obsessively about their condition and their relationships with others. Some of these periods were preceded by serious problems in their relationships (ostracism, aggressions), while others came after experiencing isolated or/and ambiguous episodes that could be interpreted as interpersonal rejection. Considering that participants reported awareness of being different and feeling the threat of being rejected as an equal, it is apparent that experiencing an incident of stigmatization, e.g. everyday looks on the street, could lead to *rumination* about identity and relative status in relationship to others.

A second very clear cognitive consequence that we were able to observe in many participants was a decrease in achievement motivation. Seven participants (37%) described situations in which their motivation to work or study was impaired by the awareness of the social stigmatization of their condition.

Emotional consequences

Rage, pain, and hopelessness were the feelings most often fest as a result of awareness that one was rejected due to their physical condition. In at least 16% of the cases participants expressed fear and anxiety about social contexts in which they were experiencing interpersonal rejection. The feeling of being *humiliated* was referred to by 21% of the participants. Those who experienced humiliation shared feelings that others devalued their personal characteristics to a degree that implied that they held no value in the estimation of others.

Behavioral consequences

Probably the most serious behavioral consequence of experiencing the social stigmatization of the condition that we identified in the testimonies of the affected individuals was paradoxically a “non-behavior”. We named it *avoidance* of social situations in which the participant anticipated that he or she might experience social stigmatization. At least 58% of the sample referred to situations that we classified as avoidance, for example, choosing not to enroll at the university to avoid having to struggle to be accepted by others or avoiding going to unknown public places so as not to experience the looks and comments of people who are not used to seeing the participant.

Another behavior that was easily identified in 42% of the participants was the desire to hide the suffering felt because of interpersonal rejection or stigmatization. This behavior was usually reported in school experiences and was usually based on the participants’ concern that the problem would be made bigger if adults intervened. Participants often said that they tried to hide negative feelings caused by rejection so that their loved ones would not worry about them. We think, however, that this desire to conceal suffering can be seen as a strategy to repress their own experiences of scorn or degradation by others, because of the risk of deep emotional consequences related to feeling humiliation.

A further interesting behavioral consequence that was described by some participants was the strategy of gaining the favor of children that they identified as the potentially more dangerous ones. In particular two participants (11%) explained how, in order to prevent being the victims of rejection, they had tried to become friends with the children that they thought that could be the leaders of the “bad guys” in the class. Interestingly, the two participants who described this strategy were also two of the participants with more social ability. They also told in the interviews that they were successful in their attempts, but that in order to be successful they had overlooked some of their school obligations. Finally, seven participants (37%) indicated that experiencing social stigmatization in school negatively influenced their academic achievement because it had made them sad and they had lost motivation or could not concentrate on academic tasks because they were concerned about acceptance from others.

Limb-lengthening surgery

Participants who had gone through LLS were, in general, satisfied with the results. Lengthened participants mentioned that LLS had important adaptive advantages, for example, facilitating personal intimate hygienic routines that were difficult with shorter arms. They argued that 20 extra centimeters are significant when one is 125 cm tall. That marginal gain in height had important benefits, for example, riding without assistance in non handicapped-accessible elevators, reaching entry-buzzers or cash dispensers, or being able to gain attention at counters in rail stations, post offices, banks, bars, etc.

But adaptive advantages were not the only ones mentioned by interviewees. Participants also referred to stigma-related advantages, for example, attracting less attention from others in the street and therefore reducing the number of mocking episodes. Four participants (44%) mentioned directly that LLS concealed the condition. Two (22%) interviewees also referred to experiences in which surgical lengthening had helped them find employment. Almost all the lengthened participants thought that the surgery had reduced their subjective experience of being stigmatized and facilitated interpersonal relationships. Of the operated participants, 7 out of 9 (78%) were satisfied with their physical condition after the lengthening, although all said the process was long, hard, and painful. But not all of the lengthened participants were completely satisfied. One (11%) stated that he would not do it again if he could go back in time. The main reasons he gave was that he had lost ability in his legs. He explained that he is unable to play soccer as he used to and that he had not noticed sufficient advantages associated with being taller. A second participant, who began the lengthening process against medical advice at an extraordinary advanced age (when he was 23 years old), reported having experienced serious physical difficulty because of the surgery, having lost physical ability, and having lower self-confidence in his physical capability. Nonetheless, he said he had noticed crucial differences in his relationships with others, which he attributed to being taller. He mentioned most of the adaptive advantages described by others, and asserted that being taller had been crucial to finding his job.

All of the 12 non-lengthened participants had not been given the choice to be lengthened, either because their skeletal dysplasia was not suitable for lengthening or simply because the technique was not as common and accessible as it is now when they were at the appropriate age. All of them understood the reasons why, in the case of those who are eligible, they might choose to undergo LLS, although most of them thought it unnecessary.

Discussion

The main goal of this preliminary research was to deepen in our understanding of the psychological implications of living with a skeletal dysplasia that causes dwarfism. In particular, we wanted to study how affected people experienced their relationships with others and whether or not they perceived their physical condition to influence those relationships. The main conclusion we drew from the analysis of the nineteen interviews is that living with a skeletal dysplasia is not easy, as the physical condition creates important difficulties in the relationship between affected persons and others. However, we found that most of them demonstrated the ability to successfully overcome those difficulties and to make progress in life. This indicates the prevalence of many factors --individual and situational-- other than skeletal dysplasia that moderate the relationship of the affected individual with his or her social context. In this sense, although at least 14 interviewees (74%) reported to have experienced serious social difficulties of different kinds that they attributed to the social stigmatization of their condition, the majority of them (N = 9) seemed to have overcome those difficulties or were on the way to overcoming them as the interviews took place. However, all except two (10%) participants also expressed concern about encountering difficulties due to social stigmatization in the future. At the same time, almost all of them seemed to be optimistic about overcoming them.

One of the main conclusions that we have obtained from this preliminary research is that people with dwarfism confront different manifestations of interpersonal rejection due to their physical condition from an early age. Many of those manifestations are subtle behaviors that could be classified as *microaggressions* (see Sue et al., 2007). These behaviors are not necessarily negatively intended by the aggressors, but have a negative impact on the victim as they are easily interpreted by affected individuals as indicators that, in the eyes of others, something about their physical condition is wrong. Comments such as “Why are you so small?” and “Oh! Look at that person!”, or stares, even those made without harmful intentions, had been experienced as highly aversive by the targets.

As found by Schmitt et al. (2003), experiencing discrimination has more negative consequences for the victims’ self-esteem and psychological well-being if it is experienced as a pervasive circumstance than if it is experienced as an isolated event. From the analysis of the interviews, we can conclude that, in general, people with dwarfism experience social stigmatization of their condition beginning at early ages and across different social contexts, i.e. as a pervasive factor in their lives. According to Schmitt et al. (2003), when a person experiences pervasive interpersonal rejection due to group belongingness, this person may perceive that his or her social identity is devalued. This awareness has important consequences for the psychological well-being of the person. One of the most obvious consequences that we observed at the cognitive level was *rumination.* Treynor, González and Nolen-Hoeksema (2003) defined rumination as a coping method that is characterized by self-refection and passive and repetitive focus on one’s negative emotions. Andrew, Lyubomirsky, Sousa, and Nolen-Hoeksema (2003) found that rumination may impair instrumental behavior by increasing uncertainty, which causes more rumination and leads to behavioral paralysis. Participants in our interviews also reported a lack of motivation and lower academic achievement as a consequence of experiencing negative outcomes in relationships to others. Negative emotions such as rage, sadness, or feeling personal debasement (i.e., humiliation) were also easily identified during the interviews as a consequence of experiencing the social stigmatization of the condition.

Experiencing pervasive discrimination and being aware of holding a devalued social identity may raise concern in people with dwarfism about their capacity to be accepted by others. Many participants expressed concern about future acceptance, even if they felt well integrated and accepted. This concern was expressed with regard to particular domains of life, such as, within the context of romantic relationships, as well as with regard to their social lives in general. We think that these kinds of concerns can be understood as a threat to the need to belong (see Baumeister & Leary, 1995). The threat to the need to belong has been associated with reduced capacity to persist in the achievement of goals (Baumeister et al., 2005; Baumeister et al., 2002) as well as with a lack of emotion (Twenge et al., 2003). Both of these effects –low academic achievement and an intention to hide negative emotions arising from experiences of rejection, ostracism, or social exclusion- were also reported by participants as consequences of experiencing the social stigmatization of their condition.

Finally, the interviews indicated that participants that had undergone LLS found important advantages to having lengthened limbs. They reported having better adaptation to their physical environment as well as benefits of lessened social stigmatization. As such, LLS was, to some extent, perceived as a means to conceal the condition of dwarfism, which could be considered an individualistic strategy to cope with stigma (see Branscombe & Ellemers, 1998). All nine lengthened participants agreed that the process was hard and arduous and, excluding one who said it was not worthy, they all argued that the advantages compensated the sacrifices.

From this preliminary work, we conclude that people with dwarfism perceive that the particularities of their physical condition are not fully valued or accepted by many people. This awareness comes from experiencing, from early ages, pervasive negative outcomes in relation to others that often materialized as microaggressions, but that sometimes took form as serious expressions of interpersonal rejection such as, long-term ostracism, verbal and physical aggression, and discrimination. Although most of the participants have found ways to cope with the negative consequences of social stigmatization, it does not take away from the fact that these consequences were manifest and in some cases caused serious psychological damage.

CHAPTER 4

STUDY 2: THE ‘STIGMATIZATION POTENTIAL’ OF PHYSICAL CONDITIONS THAT DEVIATE FROM THE NORM

Abstract

Is it possible to sort out the different physical conditions that deviate from the norm according to the degree to which they are socially stigmatized? The present study analyzed the extent to which seven physical conditions considered deviant from the norm (dwarfism, cerebral palsy, facial disfigurement, paraplegia, amputee, blindness and obesity) plus one lacking deviance evoked perceived negativity, social distance, and intergroup anxiety in majority group members. Cluster analysis revealed that dwarfism, cerebral palsy and facial disfigurement form a cluster of conditions that evokes higher levels of social distance and intergroup anxiety relative to the other four deviant conditions, which formed a cluster on its own. Both of the stigmatized clusters differed from the non-stigmatized control condition by evoking more social distance and intergroup anxiety. The same grouping pattern was found for the degree that participants categorize those conditions as negatively different. The results of the present research support the hypothesis that, independently of the many situational factors and individual differences that mediate the consequences of being stigmatized, specific stigmatized conditions evoke higher levels of negative responses in majority group members than others. We have called to the quality of a given human condition to evoke higher levels of negative responses in others its *stigmatization potential*.

Keywords: Stigma, stigmatization potential, dwarfism.

STUDY 2: THE ‘STIGMATIZATION POTENTIAL’ OF PHYSICAL CONDITIONS THAT DEVIATE FROM THE NORM

Introduction

People have the desire to be unique, but only to a certain degree. That is the main conclusion of the uniqueness theory (Snyder & Fromkin, 1980), based on findings that show that the experience of being either extremely similar or extremely dissimilar to others is aversive (Lynn & Snyder, 2002, Snyder & Fromkin, 1980). Distinctiveness has been signaled as a main element of individual identity. According to Simon’s (2004) Self Aspect Model of Identity (SAMI), there are two basic components of individual identity: independence and differentiation. Differentiation is understood as the awareness of being unusual, unique, different from others, and having “rare characteristics” (Simon, 2004, p. 92). Both SAMI and the uniqueness theory implicitly assume that those aspects that make us distinctive are positively perceived by others or, at least, both approaches assume that there is not social consensus in the negative connotations of those unusual self-aspects that make us different, however, that is not always the case.

There are specific human characteristics that make people very distinctive and that tend to be perceived negatively by majority group members. In essence, that is the definition of a social stigma: an attribute that differentiates a group or a person and that, in a given social context, is devalued (Crocker & Major, 1989; Dovidio et al., 2000; Major & O’Braian, 2005). The present research studies how majority group members react to distinctiveness when those qualities that make targets different are perceived negatively. In particular, the seven groups selected for comparison are: dwarfism, cerebral palsy, facial disfigurement, paraplegia, amputation, blindness and obesity. All of these conditions are either considered disabilities or involve body asymmetries or disfigurements. They have been selected because they count among the most common types of physical conditions that deviate from the norm.

Evolutionary approaches to prejudice and stigma posit that we may have a natural instinctive tendency to avoid and to physically distance ourselves from individuals that appear unusual to us (Schaller, Park, & Faulkner, 2003). The more obvious forms of physical unusualness include asymmetries, disfigurements and disabilities (Schaller et al., 2003). The results of the studies based on this theoretical background have found evidence that indicates that reactions towards people with disabilities are similar to reactions toward illness (Park, Faulkner, & Schaller, 2003). According to these authors, reactions of avoidance and physical distancing from people with disability may be based “not so much on a thoughtful consideration of susceptibility to disease, but perhaps more on an affective response—probably disgust—to information connoting this form of vulnerability” (Park et al., 2003, p. 126).

The main hypothesis of the present research is that physical conditions that differ from the norm can be sorted out according to the extent to which they are perceived negatively (see Marichal & Quiles, 2000). We predicted that the extent to which those physical conditions are perceived as negatively different will predict majority group members’ anxiety responses and their desire to social distancing from the targets. We have named to the *capacity* of a given human condition to evoke anxiety and a desire of social distance the *stigmatization potential* of that particular condition. Whether or not those negative reactions to people with non-common physical appearance are due to some kind of basic biological response or to more social and cultural reasons is something beyond the scope of this study. However, we do propose that physical conditions that deviate from the norm can be sorted out according to their stigmatization potential, i.e. to their potentiality to evoke negative cognitive and behavioral responses in majority group members. These responses are antecedents of social exclusion, ostracism and interpersonal rejection. We further hypothesized that the stigmatization potential is predicted by the extent to which a given physical appearance is perceived as negatively different.

Results obtained in the first study of the present dissertation revealed that they emphasized the importance of being negatively categorized by others. Practically all of them reported believing they were perceived as *“weirdoes”*, which was described by the victims as a particularly aversive consequence of being stigmatized (Fernández, 2008b). Based on these interviews, we hypothesized that perceiving others as “weird” is a way of seeing that person as different from the norm, but in a negative way. Because being different can be good or bad, we propose that the term “weird person” is not just referring a different person. More specifically, we predicted that the term “weird” will be used to categorize a person who deviates from the norm when the particular characteristics that make that person different have a negative connotation for the perceiver.

We further hypothesized that applying the term “weird” to categorize physical conditions that deviate from the norm would predict intergroup anxiety and social distance toward such physical conditions. We also propose that being able to predict the negative response of majority group members toward different physical conditions based on the way their photos are categorized by them would have implications for the way social stigmatization is conceptualized. If, as we hypothesize, the extent to which some social groups evoke intergroup anxiety and social distance can be predicted just by how they are perceived by others (i.e., without any interaction having taken place) in a neutral context, this would be consistent with the argument that stigmatized people approach any social interaction with majority group members with a disadvantage in comparison to non-stigmatized groups members. Although we anticipate that whether stigmatization and its negative consequences appear or not in an actual interaction would be moderated by a number of contextual and individual differences (see Major & O'Brien, 2005), the fact that some physical conditions tend to evoke higher levels of negative outcomes in majority group members is an important aspect of the stigmatization dynamic. Members of such social groups would have a greater likelihood of suffering pervasive discrimination (see Schmitt et al., 2003).

Finally, and in terms of the global goal of the present dissertation (i.e., the study of the socio-psychological aspects of dwarfism), an important objective of the present research is to gain a quantitative reference of the stigmatization potential of dwarfism. By comparing dwarfism with the other conditions included in the analysis, we will be able to know how strongly stigmatized is dwarfism relatively to the other six different conditions that we have taken into account for the comparison.

Method

Participants

One hundred and eight psychology students from Universidad Nacional de Educación a Distancia, UNED, Spain, voluntarily participated on-line in the present study. Seven of them were excluded from the final sample because they either had a physical disability or/and considered themselves to have one of the seven physical conditions selected for the study. The remaining 101 participants (86 female and 15 male, *mean age* = 33.7, *SD* = 9.6) were considered for the analysis.

Procedure

The study was an 8 level repeated measures design divided in two main parts. In the first part participants completed a *categorization task*, which is described below. In the second part participants answered two scales of *social distance* and *intergroup* *anxiety*. The details of how these two parts were presented are described in the following paragraphs.

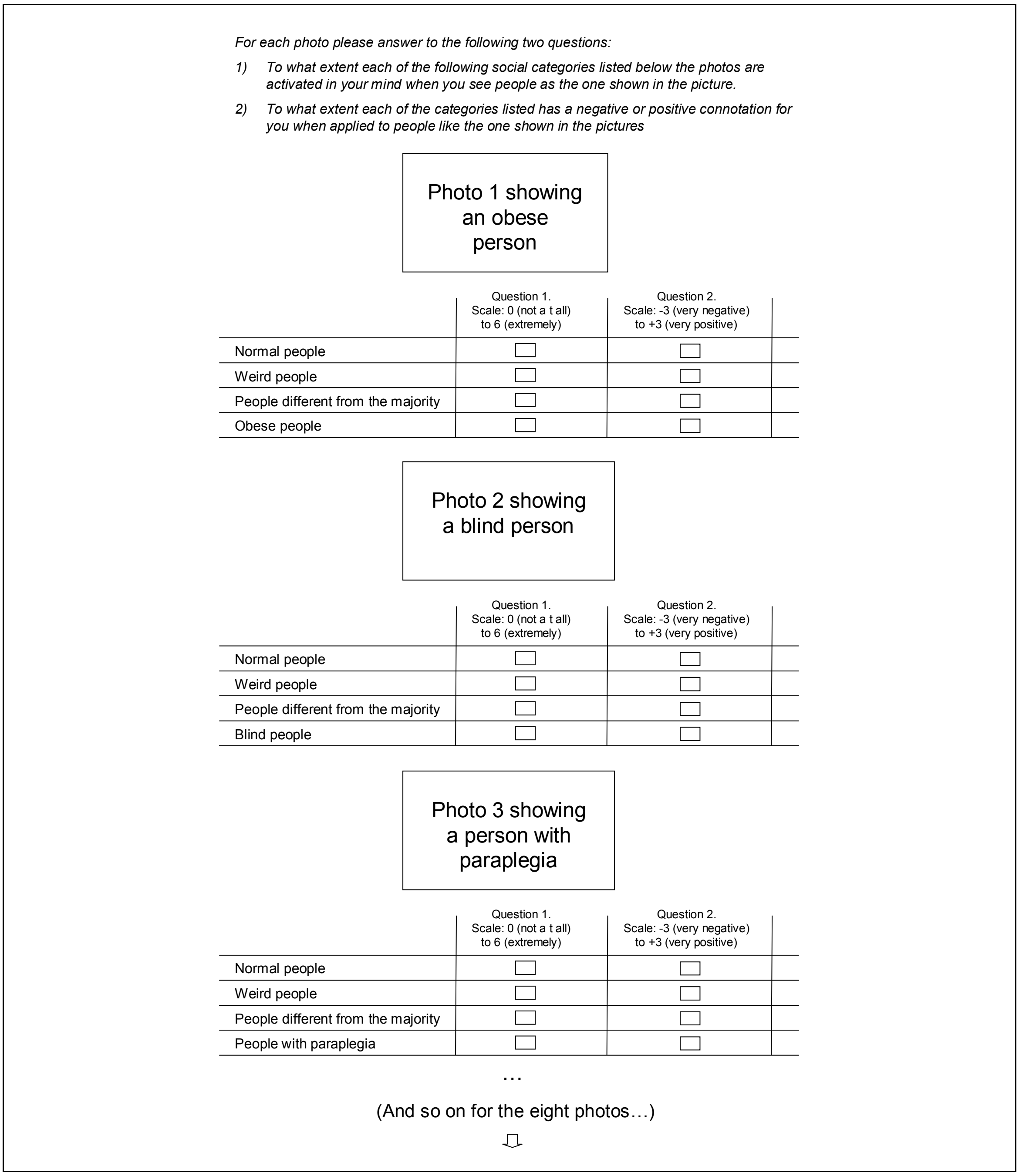
Categorization task. Participants were presented with eight different photos shown simultaneously in a screen. Each photo showed a young adult male in the foreground of a neutral context with a neutral facial and body expression. Seven of the photos portrayed a person with a visible physical characteristic that could be potentially the source of social stigmatization. In particular, these pictures showed an *obese* person, an *amputee* person without a leg, a person with *paraplegia* seated in a wheelchair, a *blind* person, a person with *cerebral palsy*, a person with a *facial disfigurement,* and a person with *dwarfism*. The eighth photo portrayed a person without any visible source of social stigmatization. This last picture was included with the intention to gain a non-stigmatized baseline reference for comparison with the stigmatized conditions. The photos were equal in size and they were presented together on a single screen.

We asked participants to rate on a 7-point scale ranging from 0 (not at all) to 6 (extremely) the extent to which four specific social categories could be applied to define each of the eight individuals that appeared in each of the photos (see Figure 4.1). Three of the four social categories that participants had to apply were the same for the eight photos. These three constant categories were “normal people”, “weird people” and “people different to the majority”. The fourth category that participants were asked to rate referred to the group of people represented in the photo by the differential and potentially stigmatized characteristic of the person shown in it (i.e., “obese people”, “people without a leg”, “people with paraplegia”, “blind people”, “people with cerebral palsy”, “people with facial disfigurement” and “people with dwarfism”). The group-specific category listed for the non-stigmatized picture was “student.” For example, for the picture showing a person with dwarfism, participants had to rate to what extent they thought that the categories “normal people”, “weird people”, “people different to the majority” and “people with dwarfism” could be apply to define the person shown in the photo; for the picture showing a blind person, participants had to rate to what extent they thought that the categories “normal people”, “weird people”, “people different to the majority” and “people with dwarfism” could be apply to define the person shown in the photo, and so on and so forth (See Figure 4.1).

In addition, participants were asked to report on a 7-point scale ranging from -3 (very negative) to +3 (very positive) the valence of each of those four categories when applied to each physical condition. For example, in the case of the photo of the person with paraplegia, participants first rated the extent to which the social categories “normal people”, “weird people”, “people different from the majority” and “people with paraplegia” could be applied to the person shown in the photo and, then, they indicated whether each of those four categories, when applied to the person with paraplegia, had a negative or positive connotation. They did the same task for each of the eight pictures. See Figure 4.1 for an example of how the task was presented.

The way we presented and explained this categorization task to participants was designed to encourage comparison among the eight physical conditions and also to avoid effects due to social desirability. The details of the specific procedure that we used are as follows. We first explained to participants that the study concerned people’s perceptions of social groups.

We told them that usually, when we see a person, several different social categories “are activated in our minds.” The categories that are activated in our mind – we further explained- can have a more positive or negative connotation. We provided the following trivial example to clarify what we mean:



For each photo please answer to the following two questions:

1) *To what extent each of the following social categories listed below the photos are activated in your mind when you see people as the one shown in the picture.*
2) *To what extent each of the categories listed has a negative or positive connotation for you when applied to people like the one shown in the pictures*

Photo 1 showing an obese person

	Question 1. Scale: 0 (not a t all) to 6 (extremely)	Question 2. Scale: -3 (very negative) to +3 (very positive)	
Normal people	☐	☐	
Weird people	☐	☐	
People different from the majority	☐	☐	
Obese people	☐	☐	

Photo 2 showing a blind person

	Question 1. Scale: 0 (not a t all) to 6 (extremely)	Question 2. Scale: -3 (very negative) to +3 (very positive)	
Normal people	☐	☐	
Weird people	☐	☐	
People different from the majority	☐	☐	
Blind people	☐	☐	

Photo 3 showing a person with paraplegia

	Question 1. Scale: 0 (not a t all) to 6 (extremely)	Question 2. Scale: -3 (very negative) to +3 (very positive)	
Normal people	☐	☐	
Weird people	☐	☐	
People different from the majority	☐	☐	
People with paraplegia	☐	☐	

…

(And so on for the eight photos…)

⇩

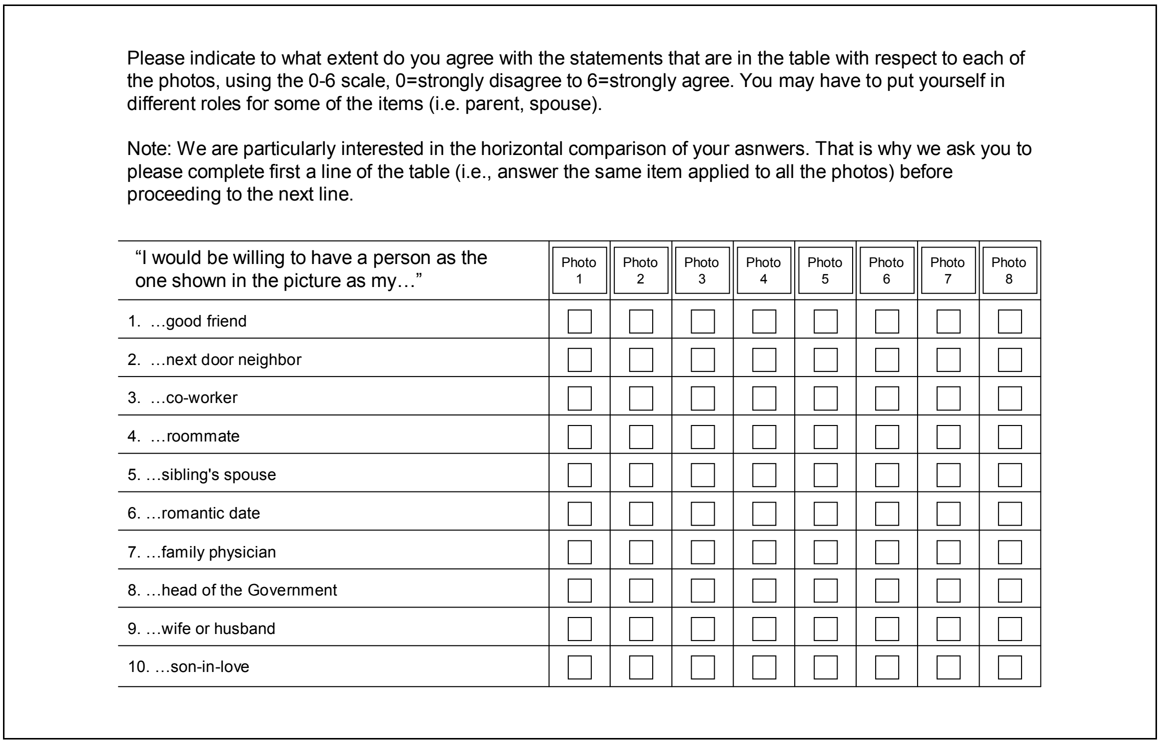
Figure 4.1. The categorization task. Eight photos –seven showing a person with the seven stigmatized conditions plus one showing a non-stigmatized person- were presented in the same screen. For each photo participants were asked to answer the two questions shown above.

“If, for example, you see an old woman on the street, thousands of potential social groups could be activated in your mind: “old people”, “women”, “retired people”, “people who need help to move”, etc. The list of social categories that could be activated in your mind to categorize that person has no end, and which particular categories will be actually activated would depend on a lot of personal

> and contextual factors. At the same time, the category “old people”, for example, could have a positive or negative connotation depending on the circumstances. Applied to another person or in a different situation, that same category may have a different valence for you.”

We then explained to participants that they would be presented with eight photos, each of which would show a different person. Participants were told that, although the number of potential social categories that could be activated to categorize each of the persons shown in the photos was unlimited, we were interested in the extent to which three common social categories (i.e., “normal people”, “weird people”, and “people different to the majority”) plus a picture-specific one (i.e., “people with dwarfism”, “blind people”, etc.) were activated in their minds as they viewed each photo and whether those four categories had a negative or positive connotations when applied to each of the photos. Participants were told that their answers were anonymous and they were encouraged to answer honestly. We provided another trivial example with a neutral picture to clarify the task they would be engaged in. After the participants had viewed the photos carefully, we requested that they proceed to the categorization task. Each of the photos was shown again and the following two questions were asked: “Please indicate to what extent each of the categories listed below the photos are activated in your mind when you see people as the one shown in the picture” and “Please indicate to what extent each of the categories listed has a negative or positive connotation for you when applied to people like the one shown in the pictures.” Participants answered the first question using a 7-point scale ranging from 0 (not at all) to 6 (extremely) and the second one using a 7-point scale ranging from -3 (very negative) to +3 (very positive), (see Figure 4.1).

Intergroup anxiety and social distance questionnaire. Once participants had finished the categorization task, they completed two scales, one concerning *social distance* and the other assessing *intergroup anxiety*. Participants answered each of the scales eight times, one for each of the physical conditions represented in each photo. As in the categorization task, the way we presented the scales encouraged comparison among the different physical conditions (see Figure 4.2).



Please indicate to what extent do you agree with the statements that are in the table with respect to each of the photos, using the 0-6 scale, 0=strongly disagree to 6=strongly agree. You may have to put yourself in different roles for some of the items (i.e. parent, spouse).

Note: We are particularly interested in the horizontal comparison of your asnwers. That is why we ask you to please complete first a line of the table (i.e., answer the same item applied to all the photos) before proceeding to the next line.

“I would be willing to have a person as the one shown in the picture as my…”	Photo 1	Photo 2	Photo 3	Photo 4	Photo 5	Photo 6	Photo 7	Photo 8
1. …good friend	☐	☐	☐	☐	☐	☐	☐	☐
2. …next door neighbor	☐	☐	☐	☐	☐	☐	☐	☐
3. …co-worker	☐	☐	☐	☐	☐	☐	☐	☐
4. …roommate	☐	☐	☐	☐	☐	☐	☐	☐
5. …sibling's spouse	☐	☐	☐	☐	☐	☐	☐	☐
6. …romantic date	☐	☐	☐	☐	☐	☐	☐	☐
7. …family physician	☐	☐	☐	☐	☐	☐	☐	☐
8. …head of the Government	☐	☐	☐	☐	☐	☐	☐	☐
9. …wife or husband	☐	☐	☐	☐	☐	☐	☐	☐
10. …son-in-love	☐	☐	☐	☐	☐	☐	☐	☐

Figure 4.2. Questionnaires. Example of the form in which the dependent measures were presented to participants. On the top of each column the same eight photos used in the categorization task were shown. Participants had to answer in horizontal order, from left to right, which encouraged comparison among the different physical conditions.

Each scale was presented in a table as the one shown in Figure 4.2 in which the rows contained the items and the columns were used to collect participants’ answers to each of the questions applied to the eight physical conditions. At the top of each column participants could see the same eight photos used in the categorization task. Therefore, by applying each item of the scale to each of the eight photos, each participant answered both scales eight times. We asked participants to answer in horizontal order from left to right as we were particularly interested in the horizontal comparison of their answers. Figure 4.2 shows the social distance scale as we presented it to the participants. The intergroup anxiety scale was presented following the same method.

Measures

Social Distance. Social distance was measured using eight items adapted from the Social Distance Scale (SDS; Bogardus, 1925), which has been used to measure prejudice against social minorities (e.g., Stewart, Weeks, & Lupfer; 2003). The scale asked participants to rate the extent to which they would like to have a person as the one shown in the photos in different social roles in their lives (see Figure 4.2). Therefore, lower scores indicated higher levels of social distance. Alphas for each time the scale was applied to the eight pictures were higher than .86.

Intergroup Anxiety. This construct was measured with the Intergroup Anxiety Scale (Britt, Boniecki, Vescio, Biernat, & Brown, 1996) including ten items adapted for Spain by Silvan and Huici (2006), (e.g., “I would feel nervous if I had to sit alone in a room with a person as the one shown in the photo and start a conversation”). Higher scores indicated higher state anxiety, meaning that the participant perceived the interaction with the outgroup member as most likely to provoke anxiety. Alphas for each time the scale was applied to the eight pictures were higher than .78.

Analytical Procedures

Cluster analysis. We first subjected participants’ responses to the categorization task and the social distance and intergroup anxiety scales to a cluster analysis. Cluster analysis, which has been defined as the art of finding groups in data (Kaufman & Rousseeuw, 1990), is a technique that allows researchers to assess the classifications used by participants (Everitt, 1993). In particular, we applied the *single linkage* algorithm, an agglomerative hierarchical technique for cluster analysis (Kaufman &

Rousseeuw, 1990). We then used confirmatory factor analysis (CFA) and nested chi-squared comparisons to determine which of the grouping options from the cluster analysis best fit the data. If, as hypothesized, the seven physical conditions prone to be stigmatized represented in the photos could be grouped according to their stigmatization potential, we predicted that the best grouping solution yielded by our analysis should have, at least, three different clusters: one cluster including the physical conditions with the highest stigmatization potential. Then, we expected at least one more group including the stigmatized physical conditions with a lower level of stigmatization potential. Finally, we predicted a cluster formed by the non-stigmatized condition on its own. If our hypothesis were to be confirmed, we should find the same grouping structure of strong, weak and non-stigmatized conditions in the categorization task as well as in participants’ answers to the social distance and intergroup anxiety scales. We therefore conducted five cluster analyses: one with the answers to the SDS, one with the answers to the anxiety scale, and one with the answers to each of the three common categories included in the categorization task (i.e., “normal people”, “weird people” and “people different to the majority”).

Test of mean differences among the groups. Once we grouped the stigmas, we performed paired-samples T-Tests to assess whether the means for all variables included in the study differed across the groups (i.e., strong, weak and no-stigma). We expected that the group of the strong stigmas would evoke significantly higher levels of social distance and intergroup anxiety than the group (or groups) of weak stigmas, which should evoke significantly more social distance and intergroup anxiety than the non-stigmatized condition. At the same time, the group consisting of the strong stigmas should be perceived as weirder, more different, and less normal than the group/s of the weak stigmas.

Path analysis. In order to accomplish our second research goal (i.e., to demonstrate the crucial role that negative categorization plays in the dynamic of social stigmatization) we used observed variable path analysis. Observed variable path analysis allows for testing models comprising theoretically-based hypothesized relationships among constructs (Kelloway, 1998). It is therefore a suitable technique to test the extent to which several independent variables (in our case, the extent to which participants reported that the social categories were important for them in categorizing the persons in the photos) predicted two dependent variables (the negative consequences of stigmatization, i.e. social distance and intergroup anxiety). We hypothesized that only the category “weird people” would predict the negative outcomes because this category implies seeing the other as different in a negative way. We expected that perceiving the other as different is not necessarily either good or bad, and therefore would not be an antecedent of the negative outcomes associated to stigmatization. Finally, perceiving the other as “normal” would have a positive valence and it would be negatively related to the negative outcomes of stigmatization. Before conducting the path analysis, we checked whether participant responses to the valence questions in the categorization task confirmed our supposition that “weird” has a negative connotation when used in reference to people, “different” has a neutral valence and “normal” has a positive one. In order to test this hypothesis, we averaged the responses to the perceived valence of the three common categories (i.e., “normal people”, “weird people” and “people different to the majority”) when applied to the seven stigmatized conditions and then tested whether the resulting means valence differed from the theoretical mean-point of the scale (0).

Results

We will first present the results of the cluster analysis and the confirmatory factor analysis that helped us to classify the eight physical conditions according to their stigmatization potential. Next, we will show mean differences across the groups on social distance and intergroup anxiety as well as the categorization task. Finally, we will present the results of the path analysis testing the expected relationships between categorization of the photos and the negative consequences of stigmatization.

Classification of the physical conditions: strong vs. weak stigmas vs. no-stigma

We conducted two agglomerative hierarchical cluster analyses on participants' scores on the social distance and intergroup anxiety scales applied to the eight physical conditions (see Figure 4.3).

Table 4.1
Grouping alternatives yielded by cluster analysis conducted to intergroup anxiety and social distance scales

2-groups solution	[Cluster 1: cerebral palsy, facial disfigurement and dwarfism] [Cluster 2: paraplegia, amputee, blindness, obesity and student]
3-groups solution	[Cluster 1: cerebral palsy, facial disfigurement and dwarfism] [Cluster 2: student] [Cluster 3: paraplegia, amputee, blindness and obesity]
4-groups solution	[Cluster 1: cerebral palsy] [Cluster 2: facial disfigurement and dwarfism] [Cluster 3: student] [Cluster 4: paraplegia, amputee, blindness and obesity]
5-groups solution	[Cluster 1: cerebral palsy] [Cluster 2: facial disfigurement and dwarfism] [Cluster 3: student] [Cluster 4: paraplegia, amputee and blindness] [Cluster 5: obesity]

The results of both measures yielded the grouping options presented in Table 4.1 (see also in Appendix B the vertical icicle plots). Results of the follow up CFA indicated that the 3-cluster solution was the best grouping alternative.

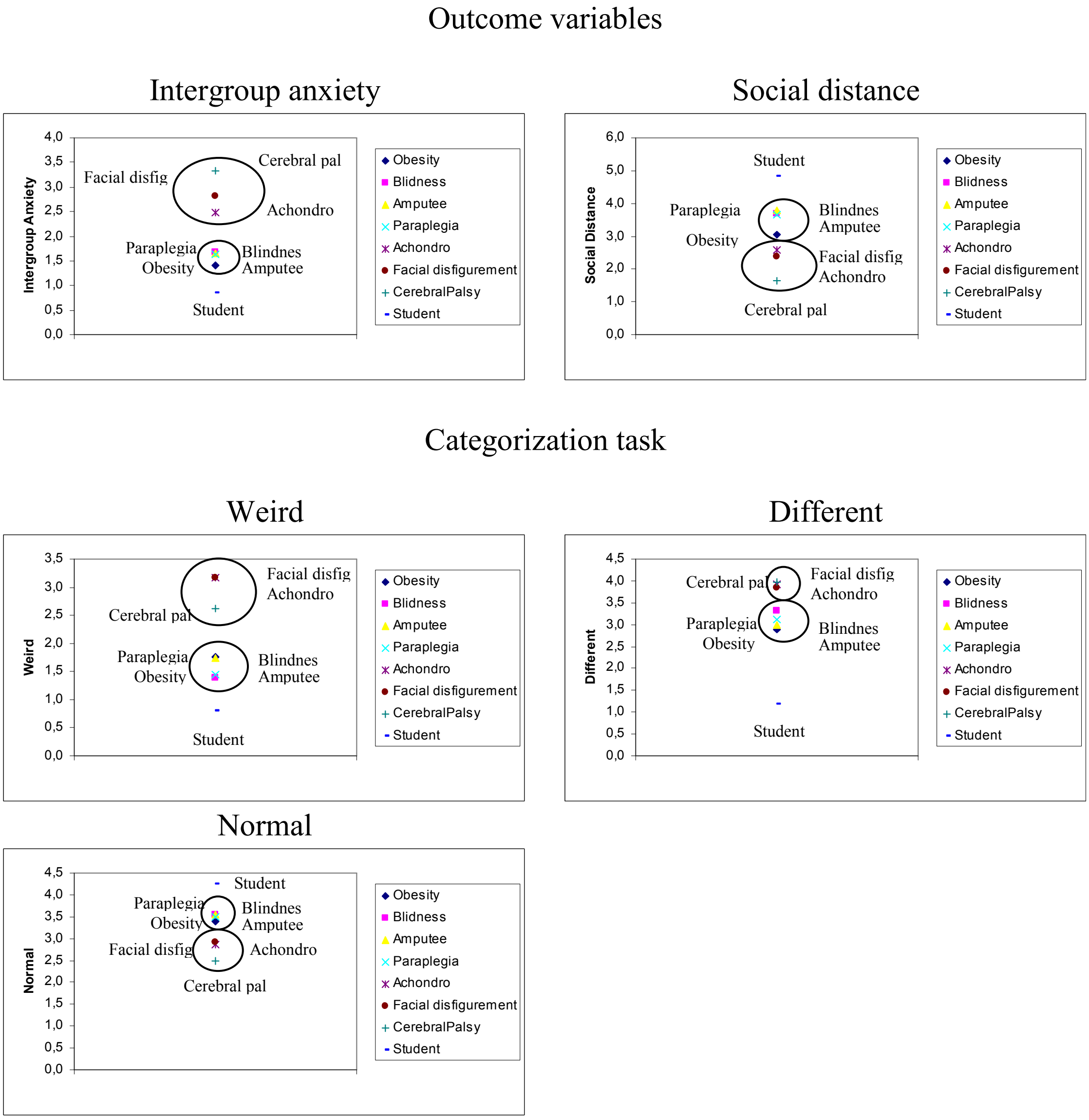


Figure 4.3. Results of the cluster analysis. The eight physical conditions were consistently grouped in the same three groups for all the measures: a group of strong stigmas, composed by Achondroplasia, Cerebral palsy and Facial disfigurement; a group of weak stigmas, composed by Paraplegia, Obesity, Blindness and Amputee; and the control condition on its own forming a group of no-stigma.

Table 4.3 contains the fit indices of the CFA for the three models represented in Figure 4.4, which represent the 2, 3 and 4-cluster solution of the cluster analysis. For both, the intergroup anxiety scale and the SDS, the 3-cluster solution fitted significantly better the data than the 2-cluster solution ($\Delta\ \chi^2(1, n = 101) = 8.1, p < .01$ and $\Delta\ \chi^2(1, n = 101) = 15.0, p < .001$, respectively). The fit indices for the 4-cluster solution did not differ significantly from those of the 3-cluster solution, however the 3-cluster solution is a more parsimonious model and consequently a preferable one (Brown, 2006).

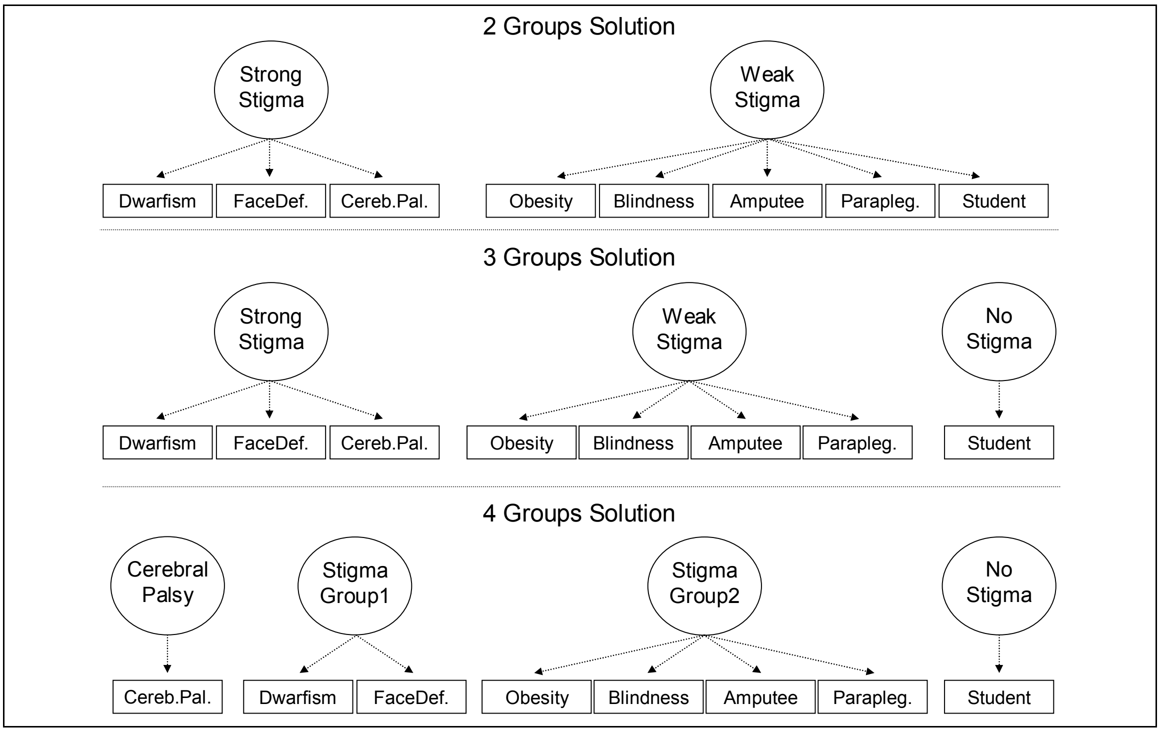


Figure 4.4. CFA alternatives for the outcome variables.

We can therefore conclude from these analyses that participants' scores to the SDS and the intergroup anxiety scale were best grouped in three clusters: one formed by the groups dwarfism, cerebral palsy and facial disfigurement; a second one formed by paraplegia, blindness, amputation and obesity; and a third one with the control condition (*student*) on its own. We have called these three groups *strong stigmas*, *weak stigmas* and *control*, respectively, because, as we will see below, the group of strong stigmas evoked significantly higher levels of intergroup anxiety and more desire to social distancing than the group of weak stigmas, which evoked significantly higher levels of intergroup anxiety and more desire to social distancing than the control condition.

The categorization perspective: cluster analysis of the social categorization task

The cluster analysis performed on the variables “weird people” and “people different from the majority”, as well as the subsequent CFA conducted to test the alternative grouping solutions, indicated that the same 3-cluster solution found for the SDS and the intergroup anxiety scale was the best grouping option also for the way participants perceived the conditions (see Table 4.4 for the results of the CFA and Appendix B for the icicle plots of the cluster analysis). For the case of the category “normal people”, the results of the analyses showed that neither the 3-cluster nor the 4-cluster solution was significantly better than the 2-cluster solution (see Table 4.4). We, however, maintained the 3-cluster solution for this category too in order to keep a homogeneous classification for all variables included in the study. As can be seen below, mean differences confirmed that the three group solution was an appropriate one for this category too.

Means differences across groups

We grouped the scores on the intergroup anxiety and social distance scales as well as the scores in the categorization task according to the 3-group solution. That is, we computed an average score for the group “strong stigmas”, another one for the group “weak stigmas” and kept the scores for the non-stigmatized group separated (see Table 4.2).

Table 4.2

Means by groups of the 3-cluster solution.

	Intergroup Anxiety		Social Distance*		Weird		Different		Normal*	
Group	*X*	*SD*	*X*	*SD*	*X*	*SD*	*X*	*SD*	*X*	*SD*
Strong	2.9	1.5	2.5	1.2	3.0	1.7	3.9	1.5	2.8	1.5
Weak	1.6	1.1	3.8	1.1	1.6	1.4	3.1	1.5	3.5	1.5
No-stigma	0.8	0.8	4.9	1.0	0.8	1.3	1.2	1.6	4.2	1.7

Note: scale inverse with respect to the other variables.

Table 4.3

Fit Indices for the Nested Sequence in the Confirmatory Factor Analysis. Outcome variables

	χ^2	*df*	*P*	$\Delta\chi^2$	Δ *df*	*p*	RMSEA	RMSEA 90% CI	NNFI	CFI	Better Solution
Intergroup Anxiety											
Two Groups Solution	69.74	19	<.001	---	---	---	.156	.116-.199	0.93	0.95	---
Three Groups Solution	61.64	18	<.001	8.1	1	<.01	.148	.105-.191	0.94	0.96	Yes
Four Groups Solution	61.17	16	<.001	0.5	2	>.50	.160	.116-.206	0.94	0.96	No
Social Distance											
Two Groups Solution	55.38	19	<.001	---	---	---	.133	.091-.177	0.94	0.96	---
Three Groups Solution	40.38	18	<.001	15.0	1	<.001	.112	.066-.158	0.96	0.98	Yes
Four Groups Solution	40.00	16	<.001	0.4	2	>.50	.120	.073-.169	0.96	0.98	No

Table 4.4

Fit Indices for the Nested Sequence in the Confirmatory Factor Analysis. Categorization task.

	χ^2	*df*	*P*	$\Delta\chi^2$	Δ *df*	*p*	RMSEA	RMSEA 90% CI	NNFI	CFI	Preferable Solution
Weird people											
Two Groups Solution	53.87	19	<.001	---	---	---	.127	.084-.171	0.91	0.94	---
Three Groups Solution	46.05	18	<.001	7.8	1	<.01	.115	.070-.161	0.92	0.95	Yes
Four Groups Solution	43.70	16	<.001	2.3	2	>.30	.121	.074-.169	0.91	0.95	No
Different from majority											
Two Groups Solution	40.45	19	<.01	---	---	---	.099	.051-.145	0.94	0.96	---
Three Groups Solution	31.08	18	<.05	9.4	1	<.01	.074	.000-.125	0.96	0.97	Yes
Four Groups Solution	27.56	16	<.05	3.5	2	>.15	.076	.000-.130	0.96	0.98	No
Normal people											
Two Groups Solution	43.57	19	<.01	---	---	---	.109	.063-.154	0.94	0.961	---
Three Groups Solution	40.91	18	<.01	2.7	1	>.01	.109	.063-.156	0.94	0.963	No
Four Groups Solution	35.52	16	<.01	5.4	2	<.01	.109	.059-.158	0.95	0.97	No

Table 4.2 contains the average scores by group (strong stigmas, weak stigmas and non-stigmatized) for the outcome variables (i.e. intergroup anxiety and SDS) and the three common categories of the categorization task (i.e., "normal people", "weird people", "people different from the majority"). In all of them, the strong stigma group had mean values indicating the highest degree of stigmatization, followed by the group of weak stigmas. The non-stigmatized condition always had the lowest mean level of stigmatization.

We conducted paired samples t-tests to check whether the mean differences across groups were significant. The results showed that all of the groupings significantly differed from each other (see Table 4.5).

Table 4.5
Paired sample tests.

Comparison Pairs	Paired Mean Differences	*t*(df=100)	*P*
Intergroup Anxiety			
Strong-Weak	1.3	11.76	<.001
Weak-No-stigma	0.7	6.71	<.001
Strong-No-stigma	2.0	11.74	<.001
Social Distance			
Strong-Weak	-1.3	-15.28	<.001
Weak-No-stigma	-1.1	-9.84	<.001
Strong-No-stigma	-2.4	-16.07	<.001
Weird			
Strong-Weak	1.4	8.57	<.001
Weak-No-stigma	0.8	6.38	<.001
Strong-No-stigma	2.2	10.71	<.001
Different			
Strong-Weak	0.8	6.08	<.001
Weak-No-stigma	1.9	11.05	<.001
Strong-No-stigma	2.7	12.75	<.001
Normal			
Strong-Weak	-0.7	-6.15	<.001
Weak-No-stigma	-0.7	-4.21	<.001
Strong-No-stigma	-1.5	-7.18	<.001

We therefore concluded that, as predicted, the seven physical conditions that differ from the norm included in our study evoked higher levels of negative responses in majority group members in comparison to the non-stigmatized control condition. Consistent with our hypothesis of the *stigmatization potential*, we can further conclude that those seven conditions can be sorted out attending to the degree to which they tend to evoke these negative responses in majority group members. The group composed by dwarfism, cerebral palsy and facial disfigurement evoked higher levels of negative outcomes than the group composed by blindness, amputation, paraplegia and obesity. Both these groups evoked higher levels than the non-stigmatized comparison target. The same effect was found for the categorization task: participants reported that “weird people” and “people different from the majority” were more applied to categorize the group of strong stigmas than to categorize the group of weak stigmas. These two category labels were applied to the weak stigmatized group more than to the non-stigmatized one. With the category “normal people” the inverse effect occurred: this category was more relevant to the non-stigmatized condition than to the weak stigmatized group and it was more important to perception of the weak stigmas than the strong stigmas.

All in all, the results showed that, as predicted, the different physical conditions included in the present study had different stigmatization potential. Dwarfism was among the strong stigmas, together with cerebral palsy and people with facial disfigurement versus the weaker stigmas consisting of obesity, paraplegia, blindness and amputee. Both types of the stigmatized groups differed from the non-stigmatized comparison target. This happened in the outcome variables (intergroup anxiety and social distance evoked by the photos) and in the categorization task.

The relationship between categorizing and the negative consequences of stigmatization

As predicted, the analysis (see Table 4.6) of the valence of the three different categories when applied to the stigmatized groups confirmed that perceiving people as "weird" has a negative connotation, perceiving people as "different" has a neutral connotation and perceiving people as "normal" has a positive connotation.

Table 4.6
Valence of categories.

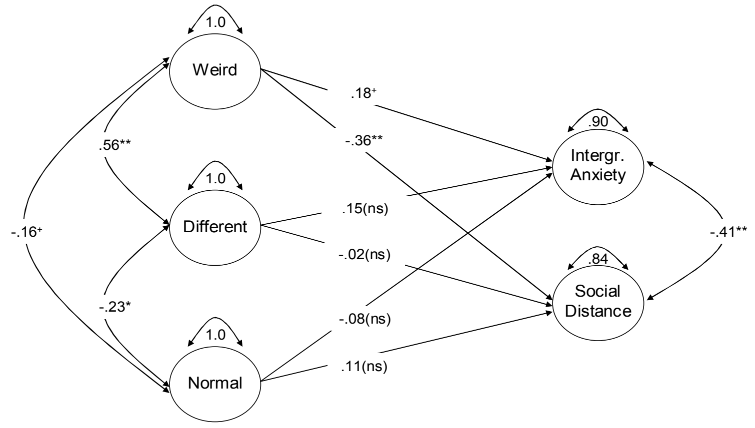
Category	Mean valence when applied to the photos	T-Test Difference from 0
Weird people	- 0.6	$t(100) = -5.3, p<.001$
People different to the majority	0.0	$t(100) = -0.3, p=.726$
Normal people	+ 0.7	$t(100) = 6.0, p<.001$

Table 4.6 presents the mean valence for each of these three categories when applied to the seven stigmatized conditions and the t-test for the difference between those three means and the theoretical mean-point on the scale (0).

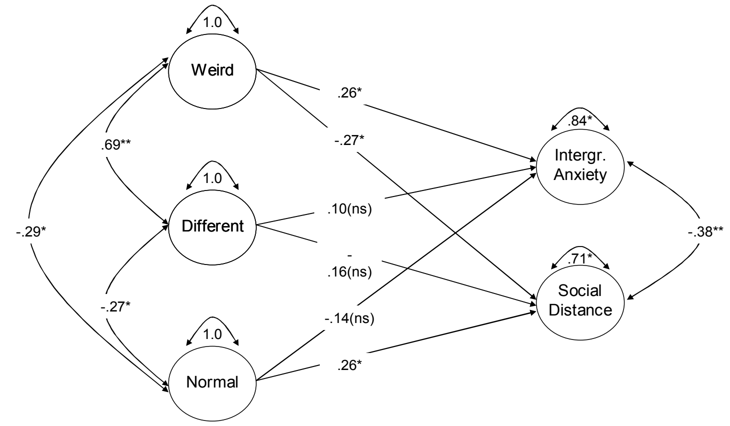
Once the valence of the categories has been established, we consider the results of the path analysis conducted to test weather, as expected, the extent to which participants categorized the different groups as negatively deviant from the norm (i.e., as "weird") predicted the negative consequences of stigmatization (i.e., participants' scores on social distance and intergroup anxiety). We anticipated that this negative relationship would not be present for the category "different from the majority" because being different does not have the negative connotation that being "weird" has. Similarly, we expected that the category "normal people" might predict less intergroup anxiety and social distance. We analyzed the relationships among the variables independently for each three groups.

Figure 4.5 shows the standardized path coefficients between the three independent variables (i.e., the extent to which the social categories weird, different, and normal, were important for categorizing the persons in the photos) and the outcome variables (i.e., intergroup anxiety and social distance) for the three groups separately. All the models are saturated with 0 degrees of freedom, as we freed the correlations among the social categories and among the two outcome variables so that all the

WEAK STIGMA



STRONG STIGMA



NO-STIGMA

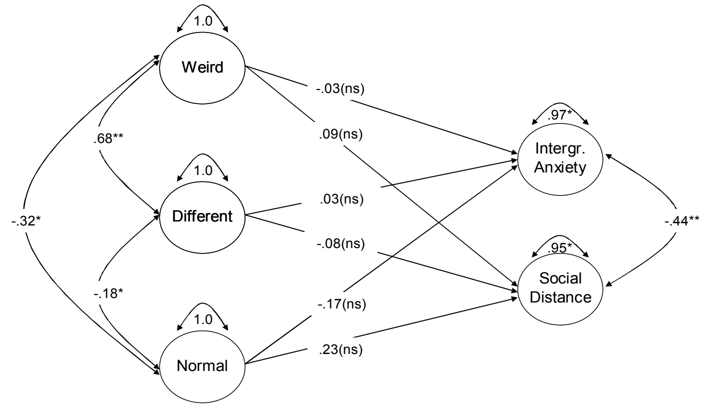


Figure 4.5. Observed variables path analysis. It shows the extent to which the labels “weird people”, “people different from the majority”, and “normal people” predicted participants’ levels on the dependent measures (straight arrows) as well as the relationships existing among the labels (curved arrows on the left) and the dependent measures (curved arrow on the right) for each group of conditions (i.e., strong stigmas, weak stigmas and no-stigma).

Note: Standardized coefficients. + = *P* <.10; * = *P* <.05; **= *P* <.001. The models are saturated (df = 0).

relationships existing among the variables were estimated. As predicted, perceiving others as "weird" was a significant antecedent of the negative consequences of stigmatization. This happened for both the group of weak and strong stigmas. Although the social categories "weird" and "different" were highly correlated, perceiving stigmatized people as "different from the majority" did not predict either intergroup anxiety or social distance. This indicates that, as hypothesized, perceiving the other as negatively different, and not just as different, is an antecedent of the negative consequences of stigmatization. The category "weird people" applied to the non-stigmatized person was unrelated to social distance and intergroup anxiety, showing that the relationship between perceiving someone as weird and the negative consequences of that perception is specific to the stigmatization dynamic. Figure 4.4 shows too that the extent to which participants perceived the people in the photos as "normal" reduced the social distance score, but only for the strong stigmas.

Discussion

In the context of the present dissertation, the main purpose of the research described in this chapter was to obtain a quantitative assessment of the strength that social stigmatization of dwarfism has in comparison to other physical conditions that are prone to be socially stigmatized. Our approach to this research question implied the hypothesis that social stigmas can be sorted according to their potentiality to generate negative reactions in outgroup members, including intergroup anxiety and social distance. We called to this quality of the stigmas the *stigmatization potential*, which could be understood as a beforehand tendency of some conditions that deviate from the norm to evoke negative responses in majority group members.

Although we acknowledge that social stigmatization is a context specific phenomenon, we argue that there are people with specific physical conditions that face a higher risk of being stigmatized and are therefore more likely to suffer the negative consequences of prejudice and interpersonal rejection. In this sense, we argue that not all the stigmas have the same potential to evoke negative reactions in majority group members. In other words, in terms of the negative social consequences to which a stigmatized person is exposed, it is not equally relevant to have, for instance, dwarfism or a facial disfigurement than to be obese or to have paraplegia. The results of the present research indicate that among the physical conditions included in the study, dwarfism has a strong stigmatization potential, together with cerebral palsy and facial disfigurements. The conditions blindness, paraplegia, amputation, and obesity would constitute weaker stigmas in comparison to the former group. This means that, other factors being equal, people with dwarfism have a higher risk of suffering ostracism and social exclusion than, for example, people with paraplegia.

It is important to note that we are not arguing that people with dwarfism are predestined to suffer necessarily ostracism and social exclusion. We acknowledge that social stigmatization is a context specific process and consequently a lot of factors could moderate the stigmatization potentiality of dwarfism (see Major & O’Brien, 2005). In this sense, it is perfectly possible that a person with dwarfism could live a fully satisfying life, be socially included in his or her social contexts and not experience unusually high levels of ostracism. However, the results of our research indicates that, all other factors being equal, a person with a strongly stigmatized condition would have greater chances of suffering ostracism and social exclusion than a person with a weak stigmatized condition, and this last group has greater risk of social exclusion and ostracism than non-stigmatized people.

We have conceptualized stigmatization as a social phenomenon in which the cognitive process of social categorization is intrinsically linked to the negative reactions directed toward those who are stigmatized. The data presented in this study indicates that the same classification that sorts participants’ anxiety and social distance responses, also group participants’ responses to the categorization task. In other words, the same way that dwarfism, cerebral palsy and face disfigurement made up a group that evokes stronger reactions in terms of social distance and intergroup anxiety, these same physical conditions also form a group that captures the extent to which they are perceived as different, not normal, and weird. Moreover, the extent to which participants perceive the physical conditions as different in a negative way (i.e., as a “weird person”) predicted participant responses to the social distance and intergroup anxiety scales. This intrinsic connection between cognition concerning outgroup members and reactions to them is a core process of the stigmatization dynamic.

The results of our study show that people who have rare and unique characteristics that have negative connotations for majority group members are more likely to evoke anxiety and the desire for social distancing. Simon (2004) proposed that being different is one of the two main components of the individual identity. The other one is independence. Simon’s argument implicitly assumes that being different or having rare characteristic should be positive. Snyder & Fromkin (1980) also assume that being unique has positive consequences. But, as we have proven in the present research, some people are different in a very obvious and non-concealable way, which has negative connotations for the way others perceive them.

We have studied in this research the consequences of negative uniqueness from the perceiver perspective. For future research we propose to study the consequences of experiencing negatively uniqueness from the target’s perspective. In this sense, we propose that being aware of having unique characteristics that are negatively perceived by others may pose important identity conflicts at the individual and the collective level.

For example, people with dwarfism that have the awareness of being rare (i.e., non-common) are also likely to feel that others attach negative connotations to that very salient characteristic that makes them distinctive. When this is the case, it is possible that people with dwarfism would experience their distinctiveness in a conflicting way. On the one hand it would be difficult for them to disengage “dwarfism” from their individual identity because that characteristic constitutes a very obvious distinctive self-aspect with important consequences in their daily lives. But, on the other hand, the fact that such a distinctive and important self-aspect is negatively perceived by others would be an aversive experience. Something similar could happen at the group level: in some social contexts it would be difficult for people with dwarfism to deny, even if they would like to do it, that the social group “people with dwarfism” is an important component of their social identity. However, being aware of the negative connotations that majority group members attach to that group would create an identity conflict when embracing dwarfism as a social identity.

Once we have studied how people with dwarfism perceive the social stigmatization of the condition (Study 1, Chapter 3), and how majority group members perceive people with dwarfism (the present study), in the next chapter we will address how people with dwarfism cope with the social stigma in two different social context: Spain and the U.S.

CHAPTER 5

STUDY 3: INDIVIDUAL VERSUS GROUP-BASED STRATEGIES FOR COPING WITH STIGMA: DYNAMICS OF STIGMATIZATION IN PEOPLE WITH DWARFISM IN SPAIN AND THE UNITED STATES

Abstract

The present research explores the dynamics of social stigmatization in people with dwarfism by analyzing the interrelationships between the stigmatizing characteristic (i.e., height), the degree to which people with dwarfism have been humiliated based on the stigma, and their quality of life. Two samples of people with a skeletal dysplasia that causes dwarfism were obtained from the United States (*N*=143) and Spain (*N*=60) respectively. The comparative analysis of the two samples with structural equation modeling (SEM) allowed us to test the efficacy of two alternative coping strategies (positive ingroup contact versus limb-lengthening surgery) in reducing the negative consequences of stigmatization. Results showed that in the US sample, positive ingroup contact seems predominant as a coping strategy, whereas people with dwarfism in the Spanish sample are more committed to limb-lengthening surgery, which is an individualistic strategy that implies group abandonment. Each of the strategies seem to be effective—in the context it is primarily used—at buffering the negative effects that humiliation based on stigma has for the quality of life of people with dwarfism. In both the Spanish and the American samples there was a strong significant path between the extent to which people with dwarfism experience humiliation and their quality of life.

Key words: social stigma, coping, dwarfism.

STUDY 3: INDIVIDUAL VERSUS GROUP-BASED STRATEGIES FOR COPING WITH STIGMA:

DYNAMICS OF STIGMATIZATION IN PEOPLE WITH DWARFISM IN SPAIN AND THE UNITED STATES

Introduction

People with stigmatized characteristics or who belong to disadvantaged social groups are often exposed to negative attitudes and behaviors from majority group members (Schmitt & Branscombe, 2002b). These negative outcomes can come in the form of ostracism (e.g., being ignored by others), discrimination (e.g., not being offered a job for which one is competent), or any other kind of interpersonal rejection (e.g., not being accepted as a potential partner for a romantic relationship) (see Major & O'Brien, 2005; Swim & Stangor, 1998; Twenge et al., 2003; Williams, 2001). Social psychological research has addressed the consequences of those negative outcomes for the victims and, in particular, how stigmatized targets cope with those situations (see Chapter 2 of this dissertation). Very broadly, two main theoretical perspectives have been developed to address the process by which the stigmatized individuals cope with their plight: one based on Social Identity Theory (Tajfel & Turner, 1979), which emphasizes the importance that the group level plays in the dynamic of perceiving and confronting interpersonal rejection (Branscombe & Ellemers, 1998; Jetten et al., 2006; Taylor & McKirman, 1984), and the other that has concentrated its efforts on identifying a number of contextual and individual factors that affect the process of perceiving oneself as a victim of rejection and the consequences of making an attribution to prejudice for the psychological well-being of the victim (see Major et al., 2002).

The present research considers the consequences for the target's quality of life of experiencing ostracism, social exclusion and debasement –i.e. *humiliation*- as well as the strategies that the targets embrace to cope with such experience. We have studied this dynamic in a group that we have found in our previous studies to be highly stigmatized: people with dwarfism (see Chapter 4 of the present dissertation). A special circumstance makes the study of the coping process within this group particularly interesting: for reasons that will be discussed later, people with dwarfism in Spain tend to engage more in individualist coping strategies that imply group abandonment through limb lengthening surgery (LLS) (Alonso-Álvarez, 2007); in the US, on the contrary, the use of LLS among people with dwarfism is infrequent (Trotter & Hall, 2005), while there is a collective effort to create a group identity that people with dwarfism can take pride in.

Using Structural Equation Modeling (SEM), we compare the dynamic of social stigmatization and the efficiency of these two alternative coping strategies in two groups of people with dwarfism: those from the US and Spain. In particular, we have analyzed the role that gained height through LLS (an individualist strategy to cope) and contact with the ingroup (a group-based strategy) play in buffering the negative effects that humiliation has on the quality of life of people with dwarfism from Spain and the US (see Branscombe & Ellemers, 1998).

The social stigma of dwarfism

Skeletal dysplasias -i.e., genetic disorders that affect the formation of the bones- are currently the most common cause of dwarfism. People with dwarfism due to a skeletal dysplasia not only present an extremely short stature -usually not taller than 4'10''- but have also particularly short arms and legs, which contrast with an average-size trunk. People with achondroplasia -the most common skeletal dysplasia that causes dwarfism- usually have a disproportionately large head, with a narrow jaw, prominent forehead, and flattened bridge of the nose. The short stature, the lack of proportion, the unusual characteristics of the head and face, together with the low prevalence of the condition –the estimated global population of people with achondroplasia is 250,000 persons (Horton et al., 2007)- are all factors that contribute to the strong social stigma associated to dwarfism.

Previously we have found that the physical appearance of people with dwarfism tends to indeed evoke intergroup anxiety and a desire for social distancing among majority group members (see Chapter 4 of this dissertation). Although other conditions that deviate from the norm, such as paraplegia, blindness, obesity or amputee, evoked those same aversive responses, we found that dwarfism was a particularly strong source of social stigmatization. The strength of the social stigma associated with dwarfism -understood as the level of intergroup anxiety and the desire of social distancing that a particular condition evokes in majority group members- was found to be comparable to the strength of the social stigma associated to cerebral palsy and facial disfigurements, and significantly higher than the strength of the social stigmatization associated to obesity, paraplegia, blindness or amputee.

Experiencing social stigmatization as a form of humiliation

Social stigmatization is currently conceptualized as a context-specific phenomenon, rather than in terms of dispositional aspects or individual differences (Dovidio et al., 2000). In this sense, physical stigmas are not considered *per se* an inevitable threat to psychological well-being, belonging and social inclusion. On the contrary, modern approaches to the study of the consequences of interpersonal rejection have identified a large number of situational and individual variables that moderate perceptions of interpersonal rejection and the negative effects that such awareness has for the target's psychological well-being (see Major et al., 2002). However, experiencing social stigmatization and interpersonal rejection has been in general associated with important negative consequences for the well-being of the targets (Major & O'Brien, 2005; Swim & Stangor, 1998; Twenge et al., 2003; Williams, 2001).

Of particular interest for the specific group on which this research focuses – people with dwarfism- are the findings presented by Branscombe and colleagues on the role that *pervasiveness of discrimination* plays in the consequences of interpersonal rejection. *Pervasive discrimination* occurs when a person experiences interpersonal rejection across time and/or different social contexts (Schmitt et al., 2003). Schmitt et al. (2003) have found that interpersonal rejection has more negative consequences for the psychological well-being of the victims when it is experienced as a *pervasive* circumstance in a person's life than when it is an isolated event. The results of the interviews that we conducted on people with dwarfism presented in Chapter 3 indicate that people with dwarfism in general experience the social stigmatization of their condition as a pervasive basis of discrimination in their lives. In this sense, they report being aware of the stigma since a very young age—practically since they have sense of consciousness—and across very different social contexts (e.g., at school, in the streets, at work, in private contexts, etc.).

Branscombe and colleagues build on Social Identity Theory (Oakes, Haslam & Turner, 1994; Tajfel, 1978) in their explanation of the processes underlying the moderator effect of pervasiveness in the experience of discrimination. Based on Social Identity Theory, they argue that "pervasive discrimination against one's ingroup implies that one's social identity is low status and devalued" (Schmitt et al., 2003, p. 298). Groups such as people with dwarfism, which are exposed to pervasive ostracism and interpersonal rejection, may therefore have the awareness that their social identity is devalued. We argue that experiencing the social debasement of one’s social identity as a pervasive circumstance in life could, under specific circumstances, lead to a feeling of identity debasement that we have conceptualized here as humiliation.

In a previous work on the stigma of people with dwarfism, Fernandez (2005) found that the awareness of being ignored by others was the strongest predictor of the scores to the Humiliation Inventory (Hartling & Luchetta, 1999) in a group of people with dwarfism. The interviews conducted with people with dwarfism which have been summarized in Chapter 3 also indicated that perceiving that one is not acceptable to others because of one’s physical appearance or group membership was experienced as a very deep and aversive experience of being put down by others. In this sense, Williams (2007) suggested that, although there is not much research done about the consequences of chronic ostracism, people who suffer it are likely to perceive that others do not value them.

Opotow’s (1990) work on moral exclusion is also relevant for the relationship between social stigmatization and humiliation. Moral exclusion is described as the capacity that we have to exclude others “from the boundary in which moral values, rules, and considerations of fairness apply” (Opotow, 1990, p. 1). As a consequence of that, “those who are morally excluded are perceived as nonentities, expendable or undeserving by others” (Opotow, 1990, p. 1). Precisely the awareness of being perceived as nonentities, expendable or undeserving by others is what we propose as the basis of the humiliation feeling. We argue here that being aware that one has no value for the others at the individual level, or that one’s social identity is low status and devalued at the group level, is a powerful threat to our dignity as individuals. In line with Lindner (2006) we propose that when we are aware that others treat us as devalued, we will experience humiliation.

Lindner (2006) is one of the social scientists who more deeply has studied humiliation. She defines humiliation as “the enforced lowering of any person or group by a process of subjugation that damages their dignity” (Lindner, p. xiv). Accordingly, humiliation arises when people who have interiorized the principles of equal human dignity still perceive that others treat them according to what she calls *a vertical scale of human worth*. During centuries, humans have related to each other assuming the existence of a natural or divine *law* according to which some social groups simply have more moral value than others. Although the idea that all humans have the same value or dignity is present in many religious and moral systems, at least in Western societies we have maintained -and currently maintain- practices that imply that some people have more value than others. For example, the idea that women have the same rights and moral value as men and that therefore should not be discriminated against in professional and public life is widespread at the present time among Western societies. Nevertheless, not so long ago, women could not vote or withdraw money from their bank account without their husbands´ permission in many European countries. Even today many women are treated according to a vertical scale of human worth in many societies in the world, including some subcultures within Western countries. However, in the last Century, and more intensively in the last decades, the moral principles of equal human dignity that inspire the Universal Declaration of Human Rights have been internalized by more and more people around the globe (Lindner, 2006). People who have internalized these principles assume that all human beings have the same intrinsic moral value –i.e., equal dignity-, regardless of other difference in capacities, abilities, beliefs, culture, resources, opportunities, physical condition, and so on that may differentiate one person from another. According to Lindner (2006), humiliation arises when a person that has internalized the principles of equal dignity perceives that he or she is being treated by others according to a vertical scale of human worth. That is why, she argues, humiliation and its negative effects for psychological well-being will increase as the principles of Human Dignity becomes increasingly widespread, while practices based on the vertical scale of human value still prevails. We posit here that experiencing the social stigmatization of dwarfism can lead affected people to feel that they are being considered by majority group members according to a vertical scale of human worth.

Hartling and Luchetta (1999), the authors who developed the Humiliation Inventory -one of the scales we use to measure humiliation- define the internal experience of humiliation as "a deep dysphoric feeling associated with being, or perceiving oneself as being, unjustly degraded, ridiculed, or put down" (p. 264). These authors posit that humiliation is experienced when one's identity has been demeaned or devalued, which is one of the consequences of experiencing pervasive discrimination proposed by Schmitt et al. (2003). They further describe humiliation as a "self-conscious" emotion, closely related to shame. Humiliation implies, however, a deeper and more essential experience than shame, as the former would be more related to the essence of what one *is*, while shame is more related to what one *does* (Hartling & Luchetta, 1999)

In line with Schmitt et al. (2003) and Williams (2007), and in the framework of the concept of humiliation propose by Lindner (2003) and Hartling and Luchetta (1999), we have conceptualized the experience of ostracism, social exclusion and debasement as observable measures of a more global concept that we have called humiliation.

The present research

The research presented in this chapter studies the dynamic of social stigmatization of people with dwarfism from the target's perspective. It focuses on the relationship between height (considered the main objective source or cause of social stigmatization towards this particular group of people), the experience of humiliation, and the effects such experience has on the targets′ quality of life. We are particularly interested in investigating how two alternative coping strategies are embraced by people with dwarfism in the US and Spain: a group-based strategy based on the beneficial effects of having contact with other people with dwarfism and a more individualist strategy that consists in gaining height through the limb-lengthening surgery (LLS).

LLS is a long and traumatic surgical process by which people with achondroplasia can gain up to 30 cm. of height (Ginebreda et al., 1992). It is not practiced very extensively in the US compared to other countries (Trotter & Hall, 2005). The opposite occurs in Spain, where currently most children with achondroplasia undergo LLS (Alonso-Álvarez, 2007). In the US, on the other hand, the organization Little People of America (LPA) has operated since 1957 and it is the largest organization in the world of people with dwarfism with more than 7,000 members. The official mission statement of LPA says that the organization "is dedicated to improving the quality of life for people with dwarfism throughout their lives while celebrating with great pride Little People's contribution to social diversity" (LPA official mission statement; emphasis added. Retrieved April 15, 2009, from http://www.lpaonline.org/). In Spain, on the contrary, the main organizations of people with dwarfism (The ALPE-Achondroplasia Foundation and CRECER) are much more recent than LPA. CRECER was founded in 1985 and ALPE, which is the most active and successful of the two Spanish organizations, was created only nine years ago in January 2000. Furthermore, in comparison to the American organization, the Spanish ones are more focused on providing information – particularly medical, psychological, educational and legal information- and support to people with dwarfism and their families. These organizations are not aimed at creating a social identity of which people with dwarfism could be proud of. As we will discuss later more in detail, this does not mean that in Spain the organizations of people with dwarfism or the affected people themselves are against the development of such a group identity per se. However, the emphasis that people with dwarfism in Spain put on LLS, compared to the efforts that the community of people with dwarfism in the US put on group-reinforcement, constitutes a very obvious and important factor that differs between the two national groups. The coping strategy dominant in Spain based on LLS could be considered individual mobility because people are encouraged to ‘leave the group via surgery’ if they can. In contrast, the American group-based strategy could be considered social competition (Branscombe & Ellemers, 1998). According to Branscombe and Ellemers (1998), individual mobility is a strategy that is aimed at maintaining a positive personal identity and is likely to be preferred by people who self-categorize at the individual level, whereas social competition is a group-based means of maintaining a positive social identity and primarily occurs if people self-categorize at the group level (Branscombe & Ellemers, 1998).

We predicted that, due to the collective effort over several decades in the US to empower people with dwarfism, meeting and having contact with the ingroup would be an effective strategy in that country to cope with the negative consequences of stigmatization. In Spain, where the collective effort has been more concentrated on facilitating people with dwarfism with the possibility of undergoing LLS, we expected that positive ingroup contact would not be an effective coping strategy. To the extent that LLS eliminates or lessens the experience of discrimination or humiliation, it could be also an effective coping strategy. One of the main objectives of the present research was to test the extent to which LLS is an effective means of reducing the experience of humiliation in people with dwarfism and thereby improving their well-being. We predicted that, independent of the cultural context, people with dwarfism would report lower quality of life as a consequence of experiencing social exclusion, ostracism, and debasement (i.e. humiliation). Furthermore, while in Spain we expected quality of life to be improved indirectly through the use of LLS (an individualist coping strategy, which would reduce the feeling of humiliation), in the U.S. we expected quality of life to be increased through positive ingroup contact.

Method

Participants

Two groups of people with dwarfism participated in this study—those from the US and Spain. The US sample was composed by 143 participants (102 women and 41 men, mean age 38.8, *SD* = 15.0). The Spanish sample included 60 participants (33 women and 27 men, mean age 30.6, *SD* = 11.5). In the Spanish group, 30.0% of the sample had undergone through LLS. In contrast, only 2.1% were lengthened by surgery in the American group. Most of the participants in both groups had achondroplasia, although there were participants with other types of skeletal dysplasias (see Table 5.1 for a distribution of participants by type of dysplasia).

The data concerning participants' height are based on answers to a multiple choice question with eight height intervals, ranging from *less than 3'90"* (or its equivalent in the metric system in the Spanish questionnaire: *less than 1.20 m.*) to *between 5'11" and 5'25"* (*between 1.56m. and 1.60m.*) More information concerning the intervals used in this measure is provided below in the measures section. The mean selected answer to this question was 2.3 (*SD* = 1.3) in the US sample and 3.7 (*SD* = 2.2) in the Spanish sample. The mode in both samples was the second value, corresponding to the interval *between 3’90’’ and 4’10’’* in the US and its equivalent *between 1.20m. and 1.25 m*. in Spain.

Table 5.1
Participants’ type of dysplasia

	Percentage of the total sample	
Type of Dysplasia	US	Spain
Achondroplasia	42.9	53.8
Hypoachondroplasia	4.2	9.6
Pseudoachondroplasia	9.2	7.7
Other	32.8	15.4
Unknown	10.9	13.5

We used structural equation modeling (SEM) to study and compare across the two cultural contexts (i.e., Spain and the US) the means and the structural relationships existing among different variables involved in the stigmatization dynamic of dwarfism. We were interested in observing the extent to which humiliation due to short stature predicted quality of life. We also wanted to test the extent to which positive ingroup contact and gained height through LLS had a significant effect in buffering the negative effects of humiliation on quality of life. More specifically, we explored and compared across the two national groups the relationships and the means existing among height (i.e., the main source of social stigmatization in people with dwarfism), humiliation, quality of life and positive ingroup contact (i.e., having contact to other people with dwarfism). Limb-lengthening surgery (LLS) was introduced as a covariate in the resulting models to analyze its impact in the stigmatization dynamic.

SEM is an appropriate technique for our purposes as it allows for the comparison of the relationship between observed and latent variables as well as for the comparison of the mean of the latent variables and the relationships among them across different groups (Kline, 2005). In order to achieve our goals, we followed Little’s (1997) recommendations for the analysis of mean and covariance structures of cross-cultural data. The precise steps followed are described in detail in the section "Analytic procedures".

Procedure

The low prevalence and the geographic dispersion of the population of people with dwarfism complicated the process of reaching a significant sample of participants. In order to solve this problem we developed on-line questionnaires. In technologically-developed countries, where households with Internet access is dominant, on-line research is a useful tool for conducting psychological research if some specific methodological and ethical considerations are taken into account (Barchard & Williams, 2008; Bowen, Daniel, Williams, & Baird, 2008; Kraut et al., 2008). In particular, on-line research has specific advantages when addressing issues that could generate easily social desirability bias in participants' answers (Pequegnat et al., 2007), as it is the case with most of the questions addressed in the present research. We chose this method of administration because recent research indicates that Internet surveys can decrease demand characteristics on sensitive topics (Evans, Garcia, Garcia, & Baron, 2003).

We therefore developed a Website in English and an identical one in Spanish in which the instructions for the study were presented together with the on-line questionnaire for self-administration. The instructions and the scales included in the Websites were translated by a bilingual researcher into English or into Spanish (depending on the language of the original text). Two independent bilingual judges checked and adjusted separately the first translation, which was finally checked by a third independent American or Spanish judge. As explained later in the results section, the test for cross cultural invariance for the measures included was successful.

The two largest organizations of people with dwarfism in each country, the ALPE-Achondroplasia Foundation in Spain (www.fundacionalpe.org), and Little

People of America (http://www.lpaonline.org) in the US, helped us to distribute information about the study and the website among people with dwarfism of each country. The research was presented to participants as a project carried out jointly by a team of social psychologists from the University of Kansas in the US and the Universidad Nacional de Educación a Distancia, UNED, Spain. We stated that the main purpose of the Study was "to get to know, from a social psychological point of view, the current situation of people with dwarfism." The instructions emphasized that participation was totally anonymous and that the research was approved by the Human Subjects Committee of the University of Kansas, by the ALPE-Achondroplasia Foundation, and by the Medical Advisory Board of the Little People of America. Participants were requested to answer sequentially a series of questionnaires, which were listed on the main menu of the Study. Once participants completed a questionnaire, the answers were automatically sent to our computers at the university. An e-mail address was offered in case participants had any doubts or experienced any trouble while answering the questionnaires. Indicating the interest level in the study, some participants, after completing the study, did indeed correspond with the author.

Measures

The questionnaires included the following measures: height, quality of life, debasement, social exclusion, ostracism, positive ingroup contact and limb-lengthening surgery (LLS). Each of these measures is described below.

Height. Following the recommendations of the ALPE-Achondroplasia Foundation, we avoided asking directly participants' height, as this could be a sensitive matter which might have led to distress and early withdrawal from the study. Instead, we requested that participants select the interval which contained their height from eight choices: less than 3'90", 3'90" to 4'10", 4'11" to 4'26", 4'27" to 4'42", 4'43" to 4'59", 4’60” to 4’92”, 4’93” to 5’10”, and 5’11” to 5’25”. The Spanish version included equivalent intervals in using the metric system. The reason why we included the higher intervals is because, due to limb-lengthening surgery, persons with achondroplasia can gain up to 30 cm. of height (Ginebreda et al., 1992).

Quality of Life. We used the Quality of Life Questionnaire (CCV, Ruiz & Baca, 1993), a 39-item self-report measure developed by Spanish researchers with Spanish populations, with good psychometric properties (Badia, Salamero, Alonso, & Olle, 1996). The CCV has four subscales: general life satisfaction (e.g., “Do you think you have a pleasant life?”), physical/psychological well-being (e.g., “Are you currently satisfied with your health?”), social support (e.g., “Do you have friends on whom you can rely if necessary?”) and absence of work over-load (e.g., “Do you feel permanently stressed because of your work?”). We did not include the absence of work over-load subscale in our research to avoid making differentiations among participants who were employed from those who were not. Factor analysis indicated that the subscale physical/psychological well-being produced two independent factors, one corresponding to physical well-being and the other one to psychological well-being. This happened similarly in both the American and the Spanish sample. We therefore treated the items of this subscale as two separated subscales: physical well-being (e.g., “Are you currently satisfied with your health?”) composed of 3 items (Cronbach alphas = .89 and .87 in US and Spain, respectively) and psychological well-being (e.g., “Do you feel worried or distressed?”) composed of 4 items (Cronbach alphas = .80 and .87 in US and Spain, respectively). The internal reliability of the other two subscales was also satisfactory, with Cronbach alphas of .92 and .91 for US and Spain respectively in the general life satisfaction subscale, and of .93 and .90 in the social support subscale for US and Spain, respectively.

Debasement. This construct was assessed with the *Cumulative Humiliation Subscale* (CHS) from the *Humiliation Inventory* (HI, Hartling & Luchetta, 1999). The CHS includes 12 items that measure the extent to which a person has been harmed by other people's derogatory treatment (e.g. "Throughout your life, how seriously have you felt harmed by being ridiculed?"). The Cronbach alphas were .96 for the American sample and .94 for the Spanish sample.

Social exclusion. This experience was measured with a scale developed in previous research (Fernández, 2008a). The scale includes five items tapping the extent to which participants have felt rejected by others due to membership in the group people with dwarfism (e.g., "How often have you been treated by others without deference and without care for your emotions just because you are a person with dwarfism?"). The Cronbach alphas for this measure were .91 and .94 in the American and the Spanish sample, respectively.

Ostracism. The frequency of experiencing ostracism was measured with six items that asked how often participants have felt ignored and socially excluded in their personal interactions with others (e.g., "How often have you felt that you were ignored by others?") (see also Fernández, 2008a). Cronbach alphas were .95 and .97 for the American and Spanish samples, respectively.

Positive ingroup contact. Four items asked participants the extent to which they enjoyed the company of other people with dwarfism (e.g., "I usually enjoy being with other people with dwarfism"). The Cronbach alphas for this measure were .86 in both samples.

Limb lengthening surgery (LLS). A single dichotomous item asked participants whether they had undergone limb-lengthening surgery or not.

Analytic Procedures

We employed the program Lisrel 8.8. to conduct our analysis of the mean and covariance structures of the American and Spanish samples. Following Little's (1997) recommendations for the analysis of mean and covariance structures of cross-cultural data, we conducted the following steps in our analysis:

We first specified and tested the measurement model in the American and the Spanish group separately. The measurement model reflects the correspondence among observed variables (indicators) and the latent constructs, which are the hypothesized unobserved causes of the measured indicators (Kline, 2005; Little, 1997).

Secondly, we established *strong factorial invariance* across the American and the Spanish groups. Comparisons of latent constructs means across groups are meaningful only if the factor loadings and indicators intercepts in both samples have been found to be invariant, i.e. when strong factorial invariance has been established (Brown, 2006). Strong factorial invariance is therefore a way to confirm that the measurement instruments which were intended to be identical in both countries were in fact equivalent (Little, 1997). Establishing strong factorial invariance allows us to analyze and interpret differences in the latent factors means and in the pattern of relationships among the latent variables across groups (Brown, 2006; Little, 1997). In order to establish strong factorial invariance it is necessary to confirm two previous conditions, which are *configurial invariance* and *weak factorial invariance* (Brown, 2006; Little, 1997). Configurial invariance or equal forms of the measures across groups can be established when the number of factors and pattern of indicator-factor loadings do not differ across groups. Weak factorial invariance can be established when the factor loadings are equal across groups.

Once the previous steps were completed, we were able to test for differences across the two groups. Following Little (1997) we first tested for homogeneity of variances (i.e., we conducted the 'omnibus' test) (Did the variance of the latent constructs included in the models differ across the Spanish and the American groups?). Second, we tested for differences in the pattern of correlations (Did the relationships among the latent constructs differ across the American and the Spanish groups?). Then we tested for differences in the means of the latent constructs (Did the means of the latent constructs (i.e., height, quality of life*,* humiliation, and positive ingroup contact) differ across groups?). Finally, we tested and compared across groups the structural models that define the causal relationships between the latent constructs in the American and the Spanish group.

Specification of the measurement model

The measurement model included four latent variables: height, humiliation, positive ingroup contact and quality of life (see Figure 5.1). *Height* was treated as a latent variable with a single indicator in the measurement model. In those cases in which a structural model that contains single indicators and latent variables is going to be tested—as it was the case in the present study—it is important to include the single indicator in the measurement model to avoid specification error (Brown, 2006). The recommended means to do this is to create a single indicator latent variable by fixing its measurement error to a given level or to zero if, as in this case, the nature of the variable implies no measurement error (Brown, 2006). The measures *debasement* (DEB)*, social exclusion* (EXC) and *ostracism* (OST) were the indicators for the latent construct humiliation. The four items composing the measure *positive ingroup contact* were used as indicators for this latent construct. For the construct quality of life, the scores of four subscales from the CCV were used as indicators: general satisfaction (GEN), physical well-being (HEAL), psychological well-being (WB) and social support (SUP). We set the scale of the latent variables by setting their variance equal to 1.0.

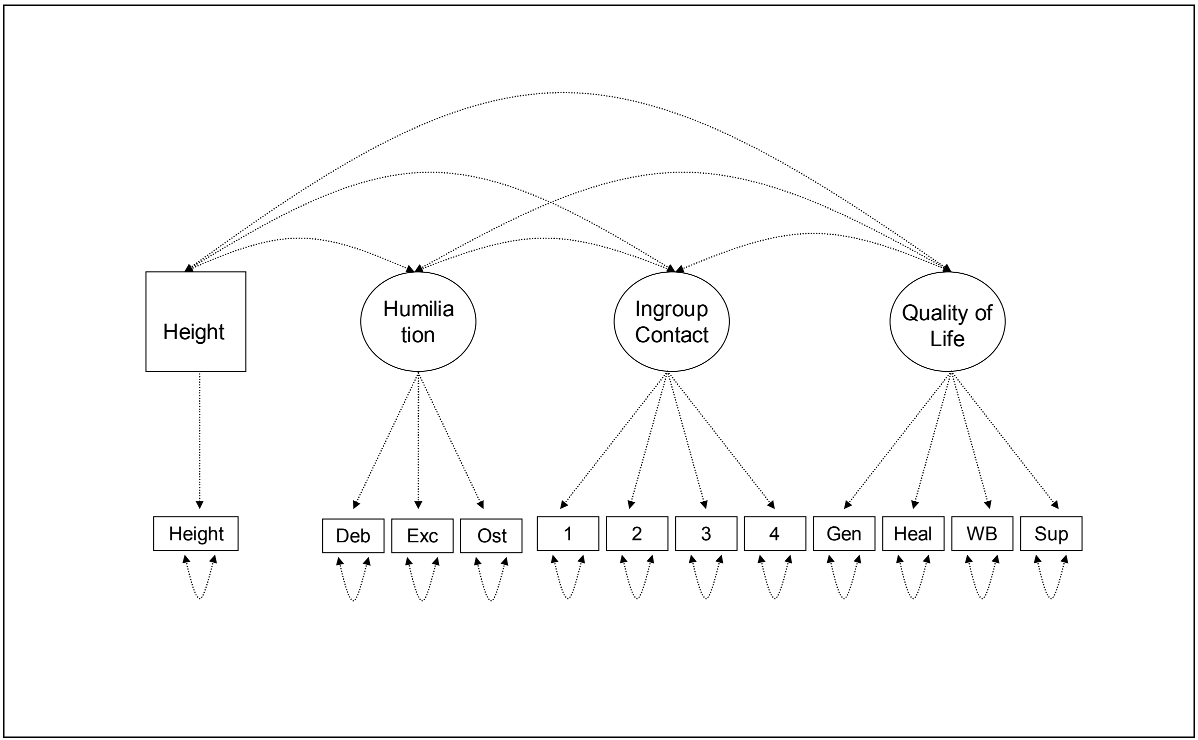


Figure 5.1. Specification of the measurement model. The latent variable Humiliation was measured with the observed measures debasement (Deb), social exclusion (Exc), and ostracism (Ost). The latent variable Positive Ingroup Contact was measured with the four single items composing the dependent measure with the same name. The latent variable Quality of Life was measured with the four subscales composing the CCV. Height was treated as a latent variable with a single indicator and no measurement error.

Results

We first present the results concerning the measurement model and then those regarding the structural model (i.e., tests of the causal relationship among the latent variables). Results concerning the measurement model include the establishment of strong factorial invariance across the American and the Spanish groups and comparisons of the latent mean variables and the relationship among latent variables across both groups. The results of the structural model include the comparison of the structural relationship across groups.

Measurement model

Following the standard procedures for establishing metric invariance, we tested a two-group means and covariances model adding sequentially the required constraints to test for weak and strong factorial invariance (Brown, 2006; Kline, 2005; Little, 1997). The results of each subsequent test are summarized in Table 5.2. The confirmatory factor analysis (CFA) previously conducted for each group separately showed an acceptable fit of the measurement models of the American and the Spanish groups independently. These results are also displayed in Table 5.2.

The starting two-group freely estimated model showed an acceptable fit (χ^2 (98, n = 203) = 163.53, p <.001, *RMSEA* = .076, *NNFI* = 0.94, *CFI* = 0.96), indicating that the number of factors and pattern of indicator-factor loadings did not differ across the American and the Spanish groups (i.e., that the measurement model in both groups were equivalent and therefore configurial invariance holds across groups). We then set the loadings across the two groups to be equal in order to test for weak factorial invariance. The nested comparison change in χ^2 between the model with equal loadings and the freely estimated two-group model was not significant (see Table 5.2), indicating that the constraint of equal loadings held and therefore that weak factorial invariance could be established. The next step was to equate the intercepts to test for strong factorial invariance. The nested comparison based on the comparison of the *RMSEA* (i.e., does the *RMSEA* value of the nested model fall within the 90% *RMSEA* confidence interval of the comparison model?, Little, 1997) and of the *CFI* (does the change in the *CFI* is less than .01?, Cheung & Rensvold, 2002) did not produce significant changes in fit (see Table 2), indicating that the constraint of equality of intercepts holds across the groups and therefore strong factorial invariance was established. These tests confirmed the invariance of the measurement of the constructs included in the model (height, humiliation, positive ingroup contact and quality of life) across the American and the Spanish groups, which confirms that the same constructs were measured in people with dwarfism from US and Spain.

Once factorial invariance was established, the next step in the analysis was to test whether the variance/covariance matrix differed across the American and the Spanish groups or if the matrix were equivalent (i.e., the 'omnibus' test) and therefore it would make sense to collapse both of the national groups' data into a single sample of people with dwarfism. As expected, the constraints for the 'omnibus' test did not hold, indicating that there were differences in the latent parameters and/or it interrelationships across both groups (see Table 5.2).

A follow up test showed that the constraints for equality of variance did not hold, indicating that two or more of the latent variables' variances differed across groups (see Table 5.2). Following Little (1997), we then created phantom variables in order to compare the interrelationships among the latent variables across groups. Phantom variables are second order latent variables created in such a way that mirror the original ones but with the scaling set at the unit variance (Little, 1997). This technique allows interpreting the relationship among the latent variables at the phantom level as correlations in both groups and it is recommended when the variance of the latent variables differ across groups (see also Rindskopf, 1984).

The tests for equality of correlations between groups did not hold, indicating that at least one correlation among the latent variables differed across groups; the same happened with the test for equality of means, indicating that one or more means of the latent constructs differed across groups (see Table 5.2).

Table 5.2

Fit Indices for the Nested Sequence in the Multiple Group Confirmatory Factor Analysis

	χ^2	*df*	*p*	$\Delta \chi^2$	Δ *df*	*p*	RMSEA	RMSEA 90% CI	NNFI	CFI	Constraint Tenable
Single Group Solutions											
US (143)	93.51	49	<.001	---	---	---	.077	.052-.102	0.95	0.960	---
Spain (60)	70.03	49	<.001	---	---	---	.073	.000-.118	0.94	0.953	---
Measurement Invariance											
Equal form (configurial)	163.53	98	<.001	---	---	---	.076	.052-.098	0.94	0.958	---
Equal factor loadings (weak) [2]	173.97	106	<.001	10.40	8	>.20	.074	.050-.095	0.95	0.958	Yes
Equal indicator intercepts(strong)[1]	203.55	114	<.001	---	---	---	.077	.056-.098	0.94	0.949	Yes
Population Heterogeneity											
‘Omnibus’ test[2]	224.88	116	<.001	50.90	10	<.001	.098	.079-.116	0.91	0.918	No
Homogeneity of variances[2]	209.47	110	<.001	35.50	4	<.001	.095	.075-.114	0.91	0.927	No
Equality of correlations[2]	188.95	112	<.001	14.98	6	<.05	.077	.055-.097	0.94	0.952	No
Latent mean invariance[2]	203.55	114	<.001	29.58	8	<.001	.078	.056-.098	0.94	0.950	No

[1] Evaluated with the RMSEA Model Test

[2] Evaluated with the χ^2 Difference Test

Note. Each nested model contains its constraints, plus the constraints of all previous, tenable models.

Table 5.3

Results of Nested Chi-Square Tests for Latent R Level Differences

Baseline model/ Correlated Pair of Constructs	Latent r^2 US	Latent r^2 Spain	χ^2	*df*	*p*	$\Delta\chi^2$	Δ *df*	*p*	Equivalent Across Groups
Weak factorial invariance (Baseline model)	---	---	173.97	106	<.001	---	---	---	---
Height – Humiliation	$.03^d$	$-.23^b$	176.90	107	<.001	2.93	1	<.10	*Marginal*
Height – Positive Ingroup Contact	$-.14^c$	$-.01^d$	174.57	107	<.001	0.60	1	>.40	Yes
Height – Quality of Life	$-.12^c$	$-.31^b$	180.30	107	<.001	6.63	1	<.01	No
Humiliation – Positive Ingroup Contact	$.04^d$	$.06^d$	173.97	107	<.001	0.00	1	1.00	Yes
Humiliation – Quality of Life	$.53^a$	$.36^a$	175.09	107	<.001	1.12	1	>.25	Yes
Positive Ingroup Contact – Quality of Life	$.31^a$	$-.08^d$	178.79	107	<.001	4.82	1	<.05	Yes

Note. a=correlation significant, $p<.001$; b=correlation significant, $p<.05$; c=correlation marginally significant, $0.05< p<.10$; d=correlation non-significant, $p>.10$

Table 5.4

Results of Nested Chi-Square Tests for Latent Mean Level Differences

Baseline model/ Constructs	Latent mean US	Latent mean Spain	χ^2	*df*	*p*	$\Delta\chi^2$	Δ *df*	*p*	Equivalent Across Groups
Strong factorial invariance (Baseline model)	---	---	203.55	114	<.001	---	---	---	---
Height	1.78	2.81	220.66	115	<.001	17.06	1	<.001	No
Humiliation	2.27	2.24	203.57	115	<.001	0.02	1	>.50	Yes
Positive Ingroup contact	3.88	3.61	205.53	115	<.001	1.98	1	>.25	Yes
Quality of life	3.94	3.87	203.75	115	<.001	0.20	1	>.50	Yes

The follow-up tests showed that there were significant differences between the American and the Spanish samples in the correlations among the following pairs of constructs: Height and Humiliation, Height and Quality of Life, and Positive Ingroup Contact and Quality of Life (see Table 5.3).

As can be seen in Table 5.3, in Spain there was a significant negative correlation between height and humiliation, while in the US this correlation was absent. Furthermore, the negative correlation between height and quality of life was significantly stronger in Spain than in the US. On the other hand, the positive correlation between positive ingroup contact and quality of life existed only in the US.

Finally, we evaluated which of the latent construct means differed across groups. Table 5.4 shows that, due to the effect of LLS, which was much more common in Spain than in the US, the Spanish respondents with dwarfism were significantly taller than the Americans ($\Delta\ \chi^2(1, n = 203) = 17.06, p < .001$). As for the rest of the constructs, the results of the nested Chi-square tests showed that there were no differences between the means across groups in humiliation, positive ingroup contact and quality of life (see Table 5.4). Thus, the only mean difference between the samples was in our main predictor variable—height.

Structural models

The main objective of this study was to analyze and compare across both countries the causal relationships existing among the four constructs, i.e. height, humiliation, positive ingroup contact and quality of life. In particular, we were interested in the extent to which humiliation negatively predicted quality of life and whether having positive ingroup contact could act as a buffer of the humiliation feelings by positively affecting quality of life. We were also interested in the extent to which the extent of the stigma (i.e., height) predicted humiliation and how height was related to the other two constructs involved (positive ingroup contact and quality of life). Because of the different attitudes toward LLS in the two countries, we included surgery as a covariate in the final model to check whether this crucial choice affected the above mentioned structural relationships or not.

An initial structural model that included all possible paths showed that, as hypothesized, humiliation predicted low quality of life in both countries, while positive ingroup contact predicted positive quality of life in the US, but not in Spain. Height significantly predicted humiliation in Spain, but not in the US. In neither of the two countries were the paths between height and positive ingroup contact and between height and quality of life significant. Finally, humiliation and positive ingroup contact were unrelated in both countries. This initial structural model, with the same degrees of freedom and identical fit as the measurement model with the equal loadings constraints (χ^2 (106, n = 203) = 173.97, p <.001, *RMSEA* = .074, *NNFI* = 0.95, *CFI* = 0.95), served as the baseline for comparing more parsimonious models. We then sequentially eliminated the non-significant paths, arriving to our final structural model with the following fit information: χ^2 (110, n = 204) = 179.79, *RMSEA* = .073, *NNFI* = .95, *CFI* = .96. Finally, we introduced surgery as a covariate in this final model. Figure 5.2 shows the final model with the surgery covariate included.

The structural model displayed in Figure 5.2 shows that in both countries, the US and Spain, humiliation in people with dwarfism is negatively related to quality of life. This relationship did not differ across groups ($\Delta\chi^2$ (1, n = 203) = 1.65, p >.20). However, the US and Spanish samples differed in three important respects. First, in the American sample, having contact with the ingroup attenuates the negative consequences of humiliation in quality of life, but contact does not have any effect in Spain. Second, in Spain, but not in the US, there is a significant relationship between the degree of stigmatization (i.e., height) and humiliation. Finally, when the covariate surgery was introduced, its effect only significantly influenced height in Spain. This effect, which is a consequence of the more extended use of limb-lengthening surgery in Spain, did not take away however the direct effect of height on humiliation.

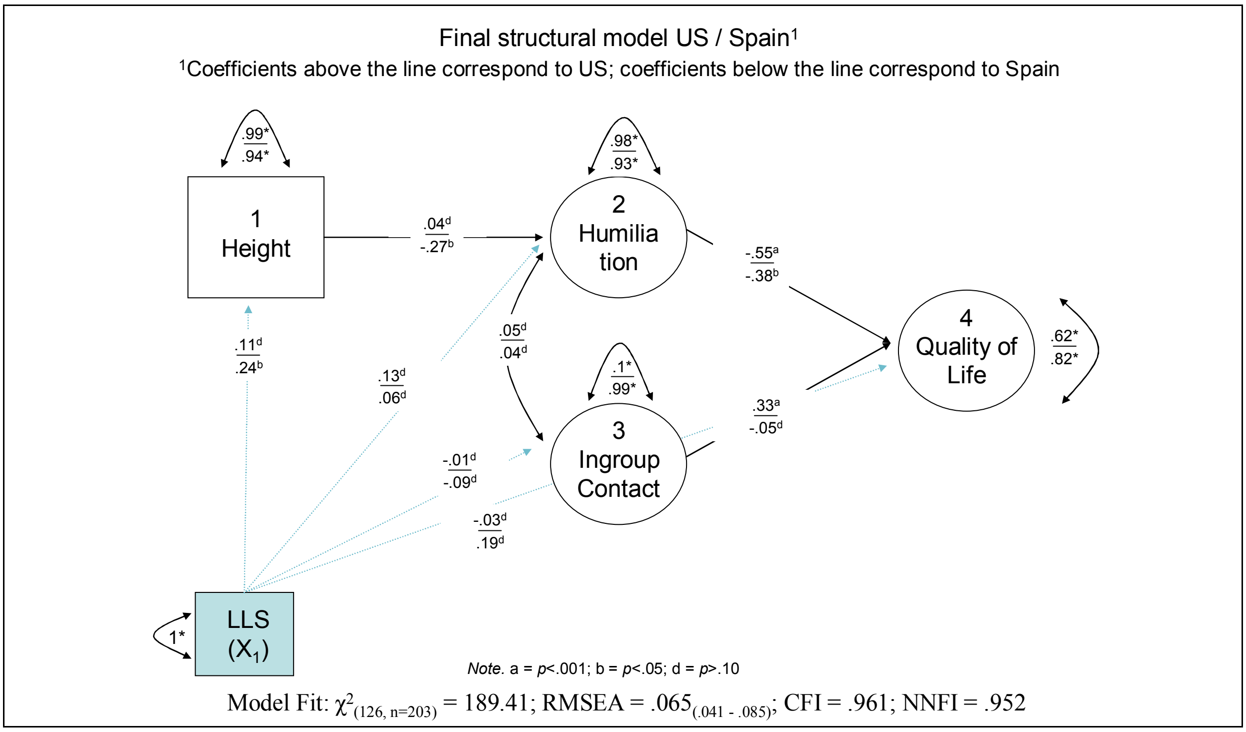


Figure 5.2. Final model (including the covariate, Limb-lengthening surgery, LLS). Coefficients above the line correspond to the US model; coefficients below the line correspond to the Spanish model.

Discussion

The results of the present study indicate that having a skeletal dysplasia that causes dwarfism has similar psychological consequences in Spain and the US. However, the cultural context does have an important influence on the way people with dwarfism cope with the stigmatization. In this sense, we have found that there are not significant differences in the means of the latent constructs for quality of life, humiliation and positive ingroup contact across the two countries, but there are, however, important differences in the structural relationships among these constructs. In particular, the results show the existence of important differences in the roles that height and contact with the ingroup play in the dynamic of stigmatization of people with dwarfism in each country: while in the US there is a significant positive path between positive ingroup contact and quality of life, there is no such relationship in Spain. In Spain, on the other hand, the role that height plays in the structural model is quite different from the role that this variable plays in the US. Due to the more extended use of limb lengthening surgery (LLS) in Spain, the Spanish sample is significantly taller than the American; moreover, in Spain height negatively predicts the extent to which people with dwarfism feel humiliated, something it does not happen in the US. The small amount of variance in the variable height in the American sample in comparison to the Spanish sample is probably one of the factors that explain the lack of a significant path between height and humiliation in the US.

These two particularities considered together –i.e., the role that height plays in Spain vs. the role that having contact with the ingroup plays in the US- point to a crucial difference in the way that the communities of people with dwarfism in the US and Spain cope with the social stigmatization of dwarfism. Evidence was found in Spain for use of an individualistic strategy based on an attempt to leave the stigmatized group—i.e. LLS-, and a more collective strategy in the US materialized in the positive effect that positive ingroup contact had for the quality of life of the American people with dwarfism.

Beyond these differences, an important resemblance was found across the national contexts: being excluded due to belonging to a stigmatized group, being ignored and being debased (i.e. being *humiliated*) lead people with dwarfism to report a lower quality of life. The fact that the path between humiliation and life satisfaction is equally strong and negative in both countries is an argument in favor of the consistency of this relationship across cultural contexts. Furthermore, the existence of a significant path in Spain between height and humiliation, with the subsequent negative effect of humiliation on quality of life, clarifies the causal direction of this relationship, indicating the existence of an indirect effect between the stigmatized characteristic (i.e., height) and its negative psychological consequences (low quality of life) which occurs through the social process of experiencing humiliation.

Height is the only latent construct of the four variables included in the model that differed across countries, with a significantly taller group in Spain than in US. The reason that explains this singularity is the different attitude toward LLS prevailing in the two cultures: while LLS is an extended practice in people with dwarfism in Spain, it is not so common in US (Trotter & Hall, 2005).

In order to understand the implications and the costs of the two alternative coping strategies, it is worth describing in greater detail the LLS process itself.

Limb-lengthening surgery: An arduous process

Limb lengthening surgery is an arduous and painful surgical process that provides between 20 and 30 extra cm. of length in the lower limbs and between 9 and 14 cm. in the upper limbs (Alonso-Álvarez, 2007; see also Aldegheri & Dall'Oca, 2001 and Ginebreda et al., 1992). According to Correll and Held (2000), limb-lengthening has become in recent decades a standardized procedure with good prognosis in people with dwarfism, although it is not without complications, risks and sacrifices. The recommended age to begin with LLS is between 8 and 12 years, as the speed of bone consolidation is still fast, while the maturity of the patient is usually enough to be submitted to the process (Ginebreda et al., 1992). This circumstance, together with the fact that the technique has improved very much in the last two decades, explains why the number of lengthened people with dwarfism older than 35 years old is extremely low. The complete process of LLS involves several interventions to install the so called *external fixators* to the bones, which are then used to enlarge the limbs (Ginebreda et al., 1992). The fixators are external metal devices that are joined by surgical nails to the top and the bottom of bone. Very basically, LLS begins with a surgery to break the bones, which are then fixed with the external fixators. The fixators have a crank-mechanism by which the bone is lengthened ½ mm. every 12 hours. The lengthening begins 24 hours after the surgery has been completed. After the patient has recovered from the initial intervention, the lengthening process continues at home and is done usually by the parents. Every time the crank is manipulated, the two parts of the bone are pulled apart while the bone tissues are gradually regenerated and the bone consolidates. Several months are needed until the planned length is achieved. Then, it is necessary to maintain the fixators during two or three extra months. When the fixators are removed by surgery, the limbs need to be put in plaster for several weeks while the bones continue their consolidation. Intensive physiotherapeutic exercise is crucial during and after the lengthening process to achieve rehabilitation. The most common sequence of surgeries begins with the shinbones of both legs simultaneously. When the patient recovers completely from this intervention, either the humerus of both arms are done first and then the femurs or the other way around: first the femurs and then the humerus. Not everyone undergoes the lengthening of the three bones (shinbones, femurs and humerus), however most of the patients do at least shinbones and humerus. The lengthening of the shinbones and the femurs interferes more with daily life than the lengthening of the humerus, as the legs need to be completely immobilized for several months, while the patient maintains most of the arms´ mobility during lengthening of the upper limbs. During the lengthening of the lower limbs, the patient has to move around in a wheelchair first and with the assistance of crutches afterwards. Rehabilitation from the leg surgery is also more complex as the patient has had reduced mobility during a long period of time and needs to recover the muscles and to reeducate the body to a new centre of gravity. The whole process can take around three or four years if everything goes smoothly. In 130 cases of patients with skeletal dysplasias that underwent symmetrical limb-lengthening, Aldegheri & Dall'Oca (2001) reported an average treatment time of 31 months and 9 months for the lower and upper limbs, respectively. Complications are usual during the process. Aldegheri & Dall'Oca (2001) reported complications in 43.8% of the cases of the lower limbs' lengthening, which left after-effects in 3.8% of the cases. None of the patients that underwent humerus lengthening experienced any complications or after-effects (Aldegheri & Dall'Oca, 2001).

The attitude of people with dwarfism toward LLS

Limb-lengthening is a controversial issue among affected persons and their families. In a different study about the implications of stigmatization on people with dwarfism, one the authors interviewed 19 Spanish persons with achondroplasia and other skeletal dysplasias that cause dwarfism (see Chapter 3 of this dissertation). The 9 participants who had the limb-lengthening surgery stated that, in general, they were satisfied with the results. They argued that lengthening had important adaptive advantages, as, for example, facilitating personal intimate hygienic routines that with the shorter arms were difficult to accomplish. They also argued that the marginal difference between a height of 130 and 155 cm. is very significant when it comes, for example, to be attended to in public places (e.g., at a counter in a rail station, the post office, the bank, a bar, etc.), to ride without assistance in elevators that are not handicapped-adapted, or to reach entry-phones or cash dispensers, to cite only the most common instances provided by people with dwarfism. Those interviewed not only mentioned adaptive advantages of surgical lengthening, but also most referred to stigma-related advantages, as, for example, attracting less attention from others in the street and therefore reducing the number of mocking episodes. Two (22%) interviewed also referred to experiences in which surgical lengthening had facilitated them in finding employment. Almost all the lengthened participants thought that the surgery had reduced their subjective experience of being stigmatized and facilitated interpersonal relationships. Of the operated participants, 7 out of 9 (78%) were satisfied with their physical condition after the lengthening, although all said the process was long, hard and painful. But not all of the lengthened participants were completely satisfied. One (11%) stated that he would not do it again if he could go back in time. The main reasons he gave was that he had lost ability in his legs (for example, he mentioned that he was not able to play soccer as he used to) and that he had not noticed sufficient advantages associated with being taller. A second participant, who began the lengthening process against medical advice at an extraordinary advanced age (when he was 23 years old), reported having experienced serious physical difficulties related to the surgery and also having lost physical abilities and self-confidence in his physical capability. Nonetheless, he also said he had noticed crucial differences in his relationships with others, which he attributed to being taller. He mentioned most of the adaptive advantages described by others, and he was one of the participants who thought that the fact of being taller was crucial to having found the job he had.

All of the 12 non-lengthened participants had not been given the choice to be lengthened, either because their skeletal dysplasia was not suitable for lengthening or simply because when they were young enough to do it the technique was not so common and accessible as it is now. All of them understood the reasons why those who can do it undergo surgical lengthening, although most of them thought it is not necessary and they argue there are other ways to cope with the disadvantages related to dwarfism besides lengthening.

The controversy over surgical lengthening in Spain is, however, not as strong as it is in the US. The main organization of people with achondroplasia in Spain (the ALPE-Achondroplasia Foundation) has a positive attitude toward limb-lengthening surgery and, in fact, the majority of children with skeletal dysplasias in Spain currently undergo limb-lengthening surgery. In the US, the main organization (LPA) is not officially against it, but their position about LLS is not particularly positive. Several journal articles have covered the controversy of LLS in the US. One of these articles was written by Paul Payne and published in The Los Angeles Times in July 2001. In the following paragraph, Payne captures very accurately the controversy of limb-lengthening among affected people with skeletal dysplasias in the US:

> “[…] The [limb-lengthening] operation isn't just about the physical, though. Those who make the hard choice to undergo the procedure say dwarfs can face a life of limitations and abuse--from finger-pointing by children to humiliating pranks such as so-called "dwarf tossing." They consider surgery a way to change how others see them, to cast off self-doubt and to join the mainstream in the quest for jobs, mates and money. But decisions by some dwarfs to alter their bodies put them at odds with others and with the largest organization representing those with achondroplasia. The 7,400-member Little People of America says the risk of nerve and vascular damage in the years after the surgery is great. Besides, they say, a short stature makes them unique, and limb lengthening implies there's something wrong with being "a little person." "Do you just go along with the crowd or teach people difference is OK?" said LPA activist Colleen Gioffreda. She, her husband, Jim, and their 2-year-old son,

> Connor, all were born with achondroplasia." It scares me to think people want to become more and more the same," she said."

Spain and the US: two cultural contexts with different dominating coping strategies against dwarfism

There are neither published data nor any official records that document how many people with skeletal dysplasias undergo LLS in Spain or in the US. There is, however, clear evidence that this practice is much more popular in Spain than in the US (Trotter & Hall, 2005). The data that we have collected for this study, although perhaps not representative of the respective populations, is indicative of this trend: 30% of the participants in the Spanish sample were lengthened, versus only 2% in the American sample. It is important to note that no particular instructions were given about any issue related to LLS in order to participate in the study and therefore that the obtained distribution of lengthened participants is due only to the randomly received answers after a general call for participation. Other evidence that gives an idea of how different is the attitude towards LLS in both countries is the information that the two most active organizations of people with dwarfism in the US and in Spain (LPA and ALPE, respectively) provide about this matter. The decision to be subjected to limb-lengthening surgery is complicated and implies a lot of aspects that every family needs to weigh. Therefore, neither LPA nor ALPE states absolute positions toward symmetric limb-lengthening. However, it is easy to observe the different attitudes toward this issue by closely examining the information that these organizations provide on their websites about it.

LPA includes an official position statement about limb-lengthening approved by their medical advisory board (http://www.lpaonline.org). The statement begins by saying that they do not intend to either advocate for or condemn LLS, but only to provide information about the issue. It further explains that this technique was originally developed for correction of limb length discrepancy and is, according to them, an accepted therapy for this. Then, the statement continues with the following lines:

> "Over the past two decades the procedure has been expanded to allow for symmetric lengthening in individuals of short stature. Although this newer application has generated widespread interest, it has also created controversy among both medical professionals, and persons of short stature and their families. There are no established medical indications for symmetric extended limb lengthening (ELL). While it may have benefit in preventing certain orthopedic and neurological complications in some skeletal dysplasias, the procedure is primarily being performed for adaptive, cosmetic, and psychosocial reasons. Research is being done on the safety and long-term functional outcome of this procedure. Currently no prospective, randomized studies have yet been completed. The possible complications of ELL are numerous." (Retrieved April 15, 2009, from http://www.lpaonline.org/).

A list of medical complications is listed afterwards, including, among others, nerve injury, increased muscle spasms and unequal limb-length. The statement indicates then that although the acute complication rate associated with LLS has been reduced, it is still substantial. Prospective patients and their families are therefore encouraged to search for professional advice and professional evaluation, including orthopedic assessment, physical therapy assessment, neurological evaluation, peripheral vascular evaluation and psychological evaluation, including "self-image, body image, peer-relationships, and family-relationships." The statement ends with the following paragraph:

> "Complete success of LLS is not guaranteed. Furthermore, LLS will not change other health related needs of individuals of short stature. They will still need to have ongoing care by someone knowledgeable about the natural history of their specific diagnosis. LLS is a complex procedure with far-reaching implications. Interested individuals should carefully assess the institution and personnel, as well as all risks and benefits of LLS prior to committing to this procedure." (Retrieved April 15, 2009, from http://www.lpaonline.org/).

The ALPE Foundation of Spain provides information about limb-lengthening in a complete guide about achondroplasia addressed to families that contains general information about all issues related to the condition (Alonso-Álvarez, 2007). The part of the guide dedicated to limb-lengthening begins with the following paragraph (translation from the Spanish by the authors):

> "Limb-lengthening surgery is the only currently effective therapeutic treatment to normalize the limbs in people with achondroplasia, improving the axial alienation and the functional limitations associated to skeletal deformities. Several circumstances concurring in achondroplasia encourage the lengthening methods due to the great laxity of the tissues, the hypertrophy of the soft parts and the speed of bone-consolidation. Limb-lengthening provides to the person an extra height that allows the overcoming of physical and architectonic barriers, eliminating or reducing his or her disability grade and improving development and social integration. However, it is a controversial practice among orthopedic professionals and also among the affected persons themselves. Not every one should undergo a process of limb-lengthening surgery. Prospective patients should be carefully informed of the advantages and disadvantages of the

> procedure, verifying the suitability of the intervention based on the specific circumstances of the particular case." (Alonso-Álvarez, 2007, p. 52)

Additional information indicates that LLS is a complex process that requires long treatment and recovery periods and that therefore strong commitment and motivation from the patient and his or her family is necessary. They further explain that it is a multidisciplinary process involving different professionals that have to assess the patient before proceeding. They then remark that the psychological aspects are crucial in the process. The three most common medical techniques to do it are briefly described afterwards, specifying that they provide 20 to 30 cm. extra length of the lower limbs and between 9 and 14 cm. of the upper ones. The information specifies the following:

> "The improvement of the techniques in the last decades has reduced hospitalization time, which, on average, is currently greater than two years, although the time of the whole process depends on the planned lengthening and on whether possible complications concur." (Alonso-Álvarez, 2007, p. 54)

The risk and complications of the process are described afterwards, but their low probability of occurrence is emphasized:

> "Like any other orthopedic surgical intervention, limb-lengthening could involve some risks and complications (surgical wound infection, pulmonary embolism, neurological injuries and peripheral vascular problems). However, these complications happen in less than 1% of the cases. Other complications related to the technique itself, as axis deviations of the lengthened bone, are usually solved during the process itself." (Alonso-Álvarez, 2007, p. 54)

The information about LLS finishes by emphasizing how important rehabilitation is to the whole process.

Finally, another important factor that surely contributes to the greater popularity of this surgery in Spain is the difference in the health care systems between the two countries. The American health system is mostly private and the cost of the surgery, which is usually above USD 100,000, has to be assumed entirely by the families. Such costs preclude the LLS option for all but the wealthiest families in the US. In Spain, on the other hand, the public health system acknowledges that LLS is a treatment that improves quality of life in people with skeletal dysplasias and therefore covers its costs.

The less frequent use of LLS in the US is accompanied by what could be described as a more group-pride oriented strategy of the main organization of people with dwarfism in the US, in contrast to the more medical-technical orientation of the main organization in Spain. This difference is subtle and also difficult to document, but, again, a comparative look at the websites of both organizations provides clues to the differences. For example, the mission of LPA is concise but very clarifying:

> "LPA is dedicated to improving the quality of life for people with dwarfism throughout their lives while celebrating with great pride Little People's contribution to social diversity. LPA strives to bring solutions and global awareness to the prominent issues affecting individuals of short stature and their families." (Retrieved April 15, 2009, from http://www.lpaonline.org/).

ALPE provides no mission in their website, but describes four main organizational goals: to promote scientific research in both the bio-medical and social branches; to raise social awareness; to support the adaptation of people with dwarfism to the educational system; and to help to achieve optimal health assistance of people with dwarfism by advising and guiding both the community of people with dwarfism and the health professionals and authorities. Of particular interest to our discussion is how their scientific research goal in the bio-medical branch is described: they explain that, among others, ALPE collaborates and supports research projects, which main goals is literally described as “to find a medical solution to achondroplasia.” In general, all the bio-medical research projects supported by ALPE are directed toward identifying the biological mechanisms that cause achondroplasia with the final goal of *healing* it, that is, to find a treatment that helps bones to develop as similar to *normality* as possible, once the mutation that produce the dysplasia has appeared. In this sense, one of ALPE’s goals is to ensure that achondroplasia will disappear in the future, which is very much in contrast with LPA mission statement of “celebrating with great pride Little People’s contribution to social diversity.”

Finally, another interesting difference among the websites of both organizations is the images and pictures that they use to decorate the pages. LPA’s site, renewed in March 2009, is illustrated with artistic and very lively pictures of non-lengthened people with skeletal dysplasias who appear to be happy. These pictures transmit precisely the celebration of diversity idea about which they talk in their mission statement. None of the 27 persons with short stature that illustrate LPA webpage has been enlarged. The ALPE website, renewed in September 2008, in contrast, is illustrated with neutral landscape pictures.

The differences in the broader cultural context that we have referred to here reflect two different strategies of coping with dwarfism. The structural models that we fitted in our study with the data using participants from the US and Spain captured these divergences in the different effects across countries that positive ingroup contact and LLS have in quality of life. While in the US there is a direct positive relationship between having positive ingroup contact and quality of life, in Spain this path does not exist. On the other hand, in Spain LLS has an indirect positive effect on quality of life which does not exist in the US. In the US, the community of people with dwarfism seems to be more concentrated on pursuing a more group-based strategy to cope with the negative consequences of stigmatization. They appear to be particularly involved in creating a social identity based on their ‘different condition,’ of which they can be proud. As predicted by the rejection-identification model (Branscombe et al., 1999; Jetten et al., 2001; Schmitt et al., 2002; Schmitt et al., 2003; Schmitt, Spears, & Branscombe, 2003), the data we have presented in this study shows that having positive ingroup contact increases quality of life in Americans with dwarfism. The ingroup in America serves as a kind of buffer for the negative consequences that stigmatization has for the quality of their lives. In Spain, on the other hand, a strategy based on individual social mobility (Branscombe et al., 1998; Jetten et al., 2006; Taylor & McKirman, 1984) through limb-lengthening surgery seems to prevail. It is important to remark, however, that the path between height and humiliation found in Spain is not completely explained by LLS. That is, although part of the variance of height in Spain was explained by LLS, when LLS was introduced in the model as a covariate the significant path between height and humiliation still remained. This could be indicating three things: that other reasons beyond LLS explained the significant path between height and humiliation in Spain, that LLS does not lessen the stigma enough so humiliation is still being experienced, albeit at a lower rate, or that lengthened participants were reporting humiliating experiences previous to having undergo LLS. A future longitudinal study about the effect of LLS on the amount of humiliation experienced by people with skeletal dysplasias would be necessary in order to better understand the impact of LLS.

The fact that there were no differences across both countries in the outcome variable—quality of life—is an interesting result, for which multiple conclusions could be drawn. One of them is that both strategies for coping with stigma, each in its own particular social context, are having positive results for the quality of life of people with dwarfism.

Classical minority vs. deviant individuals: a different way to experience rejection due to dwarfism

Jetten et al. (2006) presented a two factor model to classify the kind of interpersonal rejection that a person can experience and, as a consequence, the type of coping strategy that targets would most probably embrace. These two factors are stability (i.e., whether rejection is a stable or a circumstantial problem in a person's life) and the source of rejection (i.e., whether the rejection comes from the ingroup or from the outgroup). Assuming that people with dwarfism confront, in general, *pervasive* or stable rejection, the remaining factor (i.e., source of rejection) combined with stable discrimination would lead to two possible kinds of rejected individuals: the so called *classical minorities,* which imply stable discrimination from the outgroup, and the *deviants,* which are those who suffer stable discrimination from the ingroup (Jetten et al., 2006).

The different structural relationships that we have found between our American and Spanish models could be reflecting two alternative ways of experiencing the rejection of the dwarfing condition in each country: while in the US people with dwarfism may have a consciousness of being a *classical minority* (i.e., of being a group that suffers discrimination from an outgroup), in Spain people with dwarfism could be experiencing the rejection more in an individualistic form, that is, as individuals who are rejected from their ingroup (i.e., as *deviants*).

In fact, several circumstances that co-occur with dwarfism may impair the development of a group consciousness among people with dwarfism. One of these factors is the low prevalence and the high geographical dispersion of the condition, which reduces the opportunities of people with dwarfism to meet and stay in contact with other people with the same condition. Furthermore, around 80% of all cases of people with skeletal dysplasias are born from parents that do not have the condition. It is therefore very likely that a person with dwarfism is the only member of its family, school, place of work, and neighborhood who has the condition. Consequently, it is not difficult to see why people with dwarfism might have no or very little contact with other people with dwarfism, and instead feel more as members of a community that rejects them (i.e., as *deviants*), rather than as members of a group that is rejected by a more privileged group (i.e., a *classical minority*).

Jetten et al. (2006) proposed that if the source of stigmatization is concealable, *deviants* may try to hide it and become impostors in order to be accepted (Jetten et al., 2006). In this sense, LLS may be seen by many people with dwarfism who feel as deviants within their communities as a mean to try to be more similar to their perceived ingroup (i.e., people without dwarfism). In contrast, people with dwarfism who feel they are members of *classical minority* may see LLS as a kind of betrayal to the group and therefore feel pressure from other ingroup members to avoid LLS.

The data that we have obtained suggest that people with dwarfism in Spain tend to feel more as *deviants* than as members of a community that suffer discrimination from the outgroup. The presence in the US of an active and successful organization such as LPA for more than fifty years, whose main mission is that people with dwarfism may feel proud of their condition, is surely contributing to American people with dwarfism developing a sense of community and feeling more positive when they get together, which, in turn, has a positive effect in their quality of life. In Spain, the ALPE-Achondroplasia Foundation, which is the most successful organization of people with dwarfism in the country, has existed for only nine years (it was created in January

2000). The other main organization of people with dwarfism in Spain, CRECER, was created in 1985. It could be argued therefore that people with dwarfism in Spain may have felt more alone and underrepresented than in the US. This circumstance could have, in turn, contributed to people with dwarfism in Spain experiencing rejection more as individuals, while Americans experiencing it more as members of a *classical minority*.

One limitation of the present research is that we have not obtained a measure of the extent to which people with dwarfism consider themselves as deviants or as members of a classical minority (i.e., how they self-categorize and who they consider their ‘ingroup community’). Identification with the group of people with dwarfism could be a way to measure it, but we propose that it would be necessary to develop a procedure to capture specifically the awareness of people with dwarfism of belonging to a *classical minority* or, on the contrary, being *deviants*. Obviously, people with dwarfism that considered themselves as *deviants* are unlikely to be identified with the group of people with dwarfism. However, just as it is plausible that, for example, African-American individuals in the US might conceptualize “black people” as a *classical minority* without being particularly identified with that group, people with dwarfism who conceptualize dwarfism as a classical minority do not necessarily have to be identified with it. As future research we propose to focus on analyzing whether the consciousness of being a *deviant* predicts the extent tow which people with dwarfism desire to undergo LLS, while greater awareness of being member of a classical minority would impair the motivation for LLS. More specifically, taking into account that the LLS begins when the person with dwarfism is still a child (around 10 years old), it would be particularly interesting to study whether the extent to which the parents of people with dwarfism consider their children as deviants or as members of a classical minority predicts LLS. The fact that around 80% of the children with dwarfism have parents without the condition, can cause the parents to perceive their children more as deviants than as members of a *classical minority* to which they –the parents- do not even belong. In this sense, we think it would be worth considering the extent to which the group "people with dwarfism" is perceived by affected individuals and their parents as a group with positive characteristics of which they could feel proud. In the US, where LPA mission's is to "celebrate with pride Little People's contribution to social diversity", it is very likely that parents with a child with dwarfism will contact LPA searching for information and support. Doing so would result in them being exposed to the message that Little People are a "special" minority group. In Spain, in contrast, parents of people with dwarfism may tend to see their children as deviant and may therefore feel more motivated to do all they can to avoid their rejection. LLS, although has other adaptive advantages and does not completely *delete* the stigmatized characteristic of the target, can be seen also as a way to make the person with dwarfism less deviant from the norm and therefore increasing his or her chances to be accepted by the ingroup (i.e., by people without dwarfism).

A second limitation of the present research is that, although we have conceptualized the experience of perceiving pervasive social exclusion, ostracism and debasement as a deeper global feeling of having a devalued identity, i.e. as humiliation, our data by itself cannot support whether the latent construct that we have called here humiliation is something conceptually different from the experience of interpersonal rejection. Future research should determine whether ostracism, pervasive social exclusion and debasement due to one's physical condition (or any other stigmatized characteristic) lead people with dwarfism to the awareness that their identity -at the individual or collective level- is devalued, which, in turn, may produce a feeling of humiliation. If that is the case, it should be possible to conceptually differentiate humiliation from the aversive negative consequences of experiencing interpersonal rejection. People who have the awareness of devalued social identity may have conflicting feelings about identifying with a group that is seen as bringing about their humiliation, particularly when the possibility of resisting this conception of their group is not available (i.e., no efforts to instill pride in ‘little people’ status).

Finally, it is worth mentioning that in both the American and the Spanish samples there was a strong and negative path between humiliation and quality of life. In Spain, there was also a positive path between height and the extent to which people with dwarfism feel humiliated. The low variance in height found in the American sample is a factor that it is probably contributing to this path not to be significant in that sample. The indirect effect of height, which is the most obvious source of stigmatization in people with dwarfism, on quality of life through the experience of humiliation is an important result of the present research. This result is consistent with the results of the previous works presented in this dissertation that indicated that dwarfism is a highly stigmatized condition that results in particularly high levels of rejection. In this sense, it is understandable that people with dwarfism undergo the traumatic and very costly process of LLS, if, as the results of the present research indicates, lengthened individuals do experience less humiliation.

Up to this point we have studied the social stigma of dwarfism, its consequences for the quality of life of affected individuals and the effectiveness and use of two different coping strategies. In the next chapter we will address the consequences of the social stigmatization from a more macro perspective. In the previous chapters we have analyzed the consequences of stigmatization at the individual level. In the experiments presented in the next chapter we will study the consequences of stigmatization at the group-social level, by testing the "higher moral obligations hypothesis" when applied to people with dwarfism.

CHAPTER 6

STUDY 4: HIGHER MORAL OBLIGATIONS FOR VICTIMS: AN EXTRA BURDEN ON STIGMATIZED GROUPS

Abstract

The treatment received by stigmatized minorities is often judged according to strict moral standards, especially when the source of that behavior is also a member of a stigmatized group. When a stigmatized person displays prejudice toward a member of a different stigmatized group, this violation of perceived moral obligations can have negative consequences for the transgressor and also for the group he/she belongs to. The study of this process is the main goal of the present chapter.

Two experiments illustrated that majority group members expect people with dwarfism to be particularly tolerant toward members of another stigmatized minority, as compared to people who belong to a non-stigmatized group. In Study 1, when the group behaving intolerantly was people dwarfism, observers' negative reactions toward their intolerant attitude were mediated by justice-related perceptions of the transgressors (i.e., people with dwarfism). In contrast, when the group behaving intolerantly was a non-stigmatized group, observers' negative reactions were mediated by a lack of perceived empathy in the transgressors. Experiment 2 showed that negative emotions toward a victimized-stigmatized group that displayed intolerance were particularly high when that group had overcome their suffering. Confirming the findings of Experiment 1, the process underlying the observers' negative reaction was related to higher moral expectations for the conduct of victimized groups rather than an empathy-related process.

The results suggest that stigmatized groups are judged according to stricter moral standards than non-stigmatized groups. We conclude that the higher moral expectations placed on victims can be understood as a secondary victimization process that victims experience in a form of greater social pressure to conform to the social norms.

Key words: moral obligations, social stigmatization, indirect effects of prejudice.

STUDY 4: HIGHER MORAL EXPECTATIONS FOR VICTIMS: AN EXTRA BURDEN ON STIGMATIZED GROUPS

Introduction

Previous chapters of this dissertation have addressed the issue of the social stigmatization associated to dwarfism from both the targets' and the observers' perspectives. We began with the targets' perspective in the preliminary qualitative research (see Chapter 3), then turned to a study of the strength of the social stigma of dwarfism from the observers' point of view (see Chapter 4), to adopt again the targets' perspective in the study concerning the dynamics of stigmatization and its consequences for the quality of life of the affected persons as well as the different coping strategies used in two different cultural contexts (the US and Spain) (see Chapter 5).

In this final chapter we return to the observers' perspective to address a process related to the social stigmatization of dwarfism, using a more macro and subtle approach than the previous studies presented in the preceding chapters. We focus this investigation on the *higher moral obligations hypothesis* (the HMO hypothesis, Warner & Branscombe, 2009).

The *higher moral obligations hypothesis* basically suggests that majority group members expect higher moral standards of conduct from victimized groups than from non-victimized groups. When these expectations are disconfirmed, majority group members will respond negatively toward the victimized group. This process constitutes a subtle burden related to social stigmatization, as it implies that victimized groups face greater social pressure than majority group members to behave according to social norms. In other words, this process implies that breaking social norms can be more costly for victimized groups than it is for majority groups.

According to the HMO hypothesis, majority group members should expect people with dwarfism to be particularly tolerant toward other stigmatized minorities as compared to majority group members. If such expectations are disconfirmed, and people with dwarfism are actually intolerant, a negative reaction toward the minority transgressor group on the part of majority group observers is expected (Experiment 1). In addition, this negative reaction should increase when the victimized group has overcome their suffering (Experiment 2). Testing this hypothesis is the focus of this investigation.

Theoretical approach to the HMO hypothesis

From a social identity theory perspective (SIT, Tajfel & Turner, 1986), the HMO hypothesis could appear to be counter-intuitive. According to SIT, people are motivated to achieve and protect their group identity. Therefore, in a context that accentuates the categorization of a stigmatized minority group versus a non-stigmatized group, the most straightforward prediction based on SIT would be that majority group members would tend to expect the non-stigmatized group to be particularly tolerant. This would be the prediction especially if the non-stigmatized group is similar to the ingroup and the stigmatized group is perceived as particularly different, as it is the case with people with disproportionate dwarfism (see Chapter 4 of the present dissertation).

However, contrary to this theoretical prediction, there is a quite extended and popular idea according to which victims become better persons through their suffering (Warner & Branscombe, 2009). Even victims seem to feel this expectation: When the media covers victims, they often focus on “supercopers” who end up with a better life than they had before they went through their trauma (Wood, Taylor, & Lichtman, 1985). Victims do report that those around them expect them to find benefits (Dakof & Taylor, 1990; Taylor, Wood, & Lichtman, 1983). In fact, victims often experience "implicit social pressures to be recovered" (Lehman, Wortman, & Williams, 1987). Thus, victims are aware that they are expected to come to terms with their victimization and to find meaning in it.

Warner and Branscombe (2009) argued that observing the suffering of innocent victims can threaten majority group members' belief in a just world (Lerner, 1980). By expecting victims to obtain benefits from their suffering in the form of growing as individuals and becoming better persons, the distress of observing the suffering of innocent victims could be reduced. In a set of experiments designed to test this hypothesis, Warner and Branscombe (2009) found that observers placed higher moral obligations on victims when the situation emphasized the lessons of victimization. They also found that this effect was mediated by the extent to which victims were expected to have found benefits from their suffering.

Warner and Branscombe (2009) presented, therefore, the HMO hypothesis as an observer-driven phenomenon, as they -the observers- develop higher expectations of victims in order to satisfy their own needs, in particular, in order to protect their belief in a just world. Whether or not victims do actually show growth or obtain benefits from their suffering is not relevant for the HMO hypothesis, as long as they –the observers- feel better following confrontation with the suffering of the victims. Therefore, following Warner and Branscombe (2009), the negative effect of violating expectancies on the perception of the minority should be mediated by perceived justice, i.e. by the extent to which observers perceive the victimized group's behavior as particularly unfair. However, the mediating role of perceived justice has not been tested thus far, and this is one of the main goals of the present research.

An alternative explanation for the HMO effect would be that victims do actually become better persons as a result of their suffering. That is, expecting higher moral standards of conduct from victimized groups would be based on a kernel of truth, as we could have learned through our own experience that suffering makes us actually grow as individuals. Staub and Vollhardt (2008) argue that there is in fact such a thing as *altruism born of suffering* (ABS). These authors describe ABS as a response to victimization that comes in the form of becoming more caring and helpful towards others (Staub & Vollhardt, 2008; Staub, 2003, 2005). However, the literature supporting the ABS hypothesis is strictly based on correlational data. These authors have found that altruistic behavior has been observed in victims of natural disasters as well as victims of intentional harm doing, such as victims of terrorist acts. Although there are several reasons given to explain those reactions (for example, reducing survivor guilt), Staub and Vollhardt (2008) argued that the motivations underlying the helping behaviors born of suffering are to a great extent lacking research. However, these authors posit that people who have suffered do develop a sense of empathy for other victims, which in turn produces ABS.

Another alternative explanation would be that majority group members simply demand more from minority or victimized groups. That is, in a process related to secondary victimization (see Correia, Vala & Aguiar, 2001), majority group members might place higher moral obligations on victimized groups because they do not expect victims to break social rules and behave in ways that are inconsistent with socially accepted standards of justice. In other words, majority group members may expect stigmatized minorities to be docile and behave according to accepted norms to a greater extent than they expect majority group members to do.

The present research

The present research addresses the question of whether majority group members actually expect victimized groups to behave according to a higher moral standard of conduct and what are the consequences for the victims who disconfirm those expectations. Furthermore, we wanted to deepen our understanding of the processes underlying these expectations by testing whether higher empathy expectations underlay the process as suggested by Staub and Vollhardt (2008) or, on the contrary, whether observers simply demand more in terms of moral behavior on the part of victims compared to non-victims. More specifically, we wanted to test whether perceived justice is the mediator of negative reactions generated toward a stigmatized minority that disconfirms the expectations to behave better toward other stigmatized minorities – supporting therefore the HMO hypothesis.

In two experiments we hypothesized that people with dwarfism would be expected to be more tolerant toward immigrants than majority group members. Furthermore, when this expectation is disconfirmed, we predicted that participants would perceive victimized minority groups to have behaved particularly unfairly, which in turn would evoke negative emotions toward the victimized group.

We predicted that higher moral demands placed on victims would be the basic underlying process. Higher empathic feelings would be the expected underlying process if the HMO would be explained by either expecting victims to find benefits from suffering or if the HMO would be based in a kern of truth, according to which victims do actually become more altruistic through the experience of pain. However if, as we hypothesize, higher moral obligations are placed on victims and this is a form of secondary victimization, then victims should be expected to behave according to higher moral standards because they are held to stricter principles of justice than non-victims.

Experiment 1

In this experiment we tested the hypothesis that a highly stigmatized group (people with dwarfism) would be expected to behave according to a higher moral standard of conduct than a non-stigmatized group. In particular, we tested whether the stigmatized group would be expected to be more tolerant than the non-stigmatized group toward another stigmatized minority (immigrants in Spain). To address these questions, participants were randomly assigned to a 2 (Target group: stigmatized vs. non-stigmatized) X 2 (Group attitude toward a stigmatized minority: negative vs. positive) factorial design.

Participants were asked to predict the results of a prior research concerning the attitudes that two different social groups (i.e., people with dwarfism vs. young people aged 17 to 23) hold toward immigrants. Participants assigned to the stigmatized condition were instructed that the results of the fake research to which they were going to have access concerned the group of people with dwarfism, whereas participants assigned to the non-stigmatized condition were informed that the results concerned the group of young people.

Once we obtained a pre-measure of the extent to which participants in each condition expected the attitude of their respective target group (i.e., people with dwarfism vs. young people) toward immigrants to be positive or negative, participants learned the ostensible results of the prior research, which was either positive or negative depending on the condition to which participants were assigned (positive vs. negative attitude toward another stigmatized minority). Participants in the positive attitude condition learned that the attitude of the target group toward immigrants was positive, whereas participants in the negative attitude condition learned that the attitude of the target group toward immigrants was negative.

After both manipulations (i.e. target group and type of attitude) were conducted, we measured how participants perceived the target group's attitude, the extent to which their expectancies were confirmed and the extent to which they perceived justice and empathy in the target group's attitude toward immigrants. Finally, participants reported the extent to which they felt negative emotions after having learned the attitude toward immigrants that the target group displayed.

Based on the HMO hypothesis, we predicted that participants would expect the stigmatized group to be more tolerant than the non-stigmatized group. In addition, we expected an attitude x target group interaction in the extent to which participants reported their expectancies to have been confirmed. In particular, we predicted participants would report that their expectancies had been disconfirmed when the stigmatized group holds a negative attitude toward another victimized minority. We further predicted that negative attitudes toward the stigmatized minority would evoke negative emotions in participants, regardless of whether the stigmatized or the non-stigmatized group holds those negative attitudes. However, and in line with the secondary victimization hypothesis, we predicted that the underlying process that explains the effect that a negative attitude has on negative emotions would be contingent on whether the target group was a stigmatized minority or a non-stigmatized group. We hypothesized that higher moral expectations placed on victimized groups is a process that is driven by higher moral expectations, and not by higher empathy expectations. We therefore expected that perceived justice would play a mediating role in the effect of the attitude manipulation on negative emotions contingent on target group, i.e., we predicted a moderated mediation effect of perceived justice. Therefore, we expected perceived justice would mediate the effect of the attitude manipulation on negative emotions only when the target group was stigmatized, but not when the target group was non-stigmatized.

Method

Participants and Design

Ninety undergraduate Spanish students older than 24 years old (74 women and 16 men, mean age = 32.9, *SD* = 7.9) enrolled in UNED completed this research on the internet for course credit. None of the participants categorized him or herself as belonging to the group “immigrants” or “people with a disability”. Participants were randomly assigned to conditions in a 2 (Target group: stigmatized vs. non-stigmatized) X 2 (Group attitude toward a stigmatized minority: negative vs. positive) between-subjects factor design.

Procedure

Participants learned that the aim of the study was to assess their opinions about the results of a research project concerning the attitudes that different social groups in Spain hold towards immigrants.

The research was described as an important project supported by the European Commission that “involved more than 25 researchers and 4,000 participants”. It was emphasized that the researchers were able to reach “highly representative samples of each studied target group, which lead to very reliable results that could be considered representative of what the whole social group in question thinks and feels towards immigrants.” It was explained to participants that they were going to be presented with a summary of some of the main results obtained in that research. Participants then randomly received the materials from one of the four experimental conditions.

Manipulation of the target group. Participants assigned to the *stigmatized group condition* learned that they would be presented with the results of the study concerning the group of people with dwarfism. Participants assigned to the *non-stigmatized group condition* learned that they would be presented with the results of the study concerning the group of young people aged 17 to 23. To ensure that participants could not dismiss the information they received as an unusual result, subjects in both conditions were further informed that the results of their correspondent target group were considered one of the most reliable of the whole research project.

Participants then were asked to indicate their expectations about the attitude that the target group would show toward a specific stigmatized minority (immigrants in Spain). On a scale ranging from 0 (totally disagree) to 6 (totally agree) participants indicated the extent to which they expected the attitude of the target group toward immigrants to be *Tolerant*, *Racist* (reverse scored), *Generous*, *Biased* (reverse scored), *Egalitarian*, and *Supportive* ($\alpha = .88$).

Manipulation of the target group's attitude toward a stigmatized minority. Once the participants answered the expectancy measure, they read a summary of the results of the survey. Participants in the *negative attitude* condition learned that the attitude of the target group toward immigrants in Spain was negative. We included some fictitious data that supported this conclusion. For example, it was said that the results of the survey indicated that "70% of the group [people with dwarfism] vs. [people aged 17 to 23] think that "illegal" immigrants should be expelled out of Spain". We further explained that an overall analysis of the data showed that the target group had a deep and visceral refusal to accept people with different cultural habits and customs. In contrast, participants in the positive attitude condition were told that the attitude of the target group toward immigrants in Spain was positive. Again, we supported this conclusion with fake data. We further explained that an overall analysis of the data showed that the target group had a deep and sincere acceptance of people with different cultural habits and customs.

After reading the results of the fake survey, participants responded to the questionnaire including all mediators and dependent measures. At the end of the study, participants were debriefed and thanked.

Measures

Participants responded to all items on a scale ranging from 0 (totally disagree) to 6 (totally agree).

Dependent measures

Expected Attitude. Prior to the experimental manipulation of attitude toward immigrants, participants were asked to indicate to what extent they expected the attitude of the target group toward immigrants to be *Tolerant*, *Racist* (reversed scored), *Generous*, *Biased* (reversed scored), *Egalitarian*, and *Supportive*, $\alpha = .88$.

Perceived Attitude. The same scale we used for expected attitude was presented after the manipulation to measure how participants perceived the target group's attitude towards immigrants, $\alpha = .96$.

Confirming Expectancies. A single item asked participants the extent to which the results of the research had confirmed their previous expectancies about the target group's attitude: "To what extent do you agree with the following statement: the expectancies I had about the attitude that [people with dwarfism] vs. [people aged 17 to 23] would have toward immigrants was confirmed".

Negative Emotions. Participants were asked to report how they felt after having learned the attitude that the target group had toward immigrants on each of the following emotions: *Disappointed*, *In a good mood* (reverse scored), *Sad*, *Cheerful* (reverse scored), *Angry*, *Happy* (reverse scored), *Uncomfortable*, $\alpha = .94$.

Mediator variables

Perceived Justice. Using a scale adapted from Bauer, Truxillo, Sanchez, Craig, Ferrera and Campio (2001) and Truxillo and Bauer (1999), participants were asked to indicate the extent to which the target group's attitude towards immigrants was *Fair*, *Disloyal* (reverse scored), *Respectful*, *Honest*, and *Objective*, $\alpha = .92$.

Perceived Empathy. Participants were asked to rate the extent to which they found the target group empathetic toward immigrants on five items, (e.g. "To what extent do you agree or disagree with the following statement: [people with dwarfism] vs. [people aged 17 to 23] have difficulties to adopt the point of view of immigrants?" (reverse scored), $\alpha = .95$.

Preliminary Analyses

Credibility of the cover story

Five items were included to check whether participants considered the results of the research a reliable and valid description of the group's attitude toward immigrants (e.g., "To what extent do you agree or disagree with the following statement: the conclusions of the research showed a representative picture of the attitude that the group [people with dwarfism] vs. [people aged 17 to 23] has toward immigrants?"), $\alpha = .88$.

A 2 x 2 ANOVA on the credibility of the manipulation showed no main or interaction effects, $Fs < 1.4$, which indicates that the manipulation was equally credible in all conditions. The mean of the scale was higher than the theoretical mid-point of the scale (3), $M = 3.5$, $SD = 1.1$, $t\ (89) = 4.5$, $p < .001$. Thus, our cover story was perceived as credible.

Manipulation check for the Target Group

Two items asked the extent to which participants thought that the target group could be considered a discriminated group and a group with disability, $\alpha = .88$. A 2 x 2 ANOVA showed a main effect of the target group, $F(1,86) = 121.8$, $p < .001$.

Participants in the stigmatized condition scored higher *M* = 3.3, *SD* = 1.4, than participants in the non-stigmatized condition *M* = 0.6, *SD* = 0.9. Neither the main effect of attitude condition, nor the interaction, were significant, *Fs* < 1.2. Thus, our target group manipulation was successful, with participants perceiving the targets with dwarfism as more victimized than young adults.

Manipulation check of the attitude toward immigrants

Participants were asked to rate the extent to which they agreed with the following statement: "[People with dwarfism] vs. [People aged 17 to 23] have a negative attitude towards immigrants." A 2 x 2 ANOVA revealed a main effect of the attitude manipulation, *F* (1,86) = 68.0, *p* < .001. Participants in the negative attitude condition showed a more negative attitude toward immigrants *M* = 4.3, *SD* = 1.4, than participants in the positive condition *M* = 1.9, *SD* = 1.4. Neither the main effect of the target nor the interaction were significant, *Fs* < 1.1.

Perception of "Immigrants in Spain" as a victimized group

Participants were asked to rate the extent to which they considered immigrants as suffering from discrimination. A 2 x 2 ANOVA showed no main or interaction effects, *Fs* < 1.0. The mean of this measure was higher than the theoretical mid-point of the scale (3), *M* = 4.4, *SD* = 1.4, *t*(89) = 9.6, *p* < .001, indicating that participants perceived immigrants in Spain to be victims of discrimination.

Results

As a general analytic strategy, we conducted a series of 2 (Attitude toward immigrants: positive vs. negative) x 2 (Target group: stigmatized vs. non-stigmatized) ANOVAS on the outcome measures, except for the expected attitude measure, which was taken before the manipulation of attitude. For this measure we conducted a one way ANOVA to test whether participants' expectations of the target group's attitude differed depending on whether the target group was stigmatized or non-stigmatized. We further conducted tests of conditional indirect effects to test the underlying process of the higher moral obligation hypothesis.

Expected attitude

As predicted, the one way ANOVA showed a main effect of the target group, *F*(1,88) = 8.5, *p* < .01 (see Figure 6.1). Participants in the stigmatized condition expected that the target group would have a more positive attitude toward immigrants than participants in the non-stigmatized condition, *M* = 3.4, *SD* = 0.9 vs. *M* = 2.9, *SD* = 0.9.

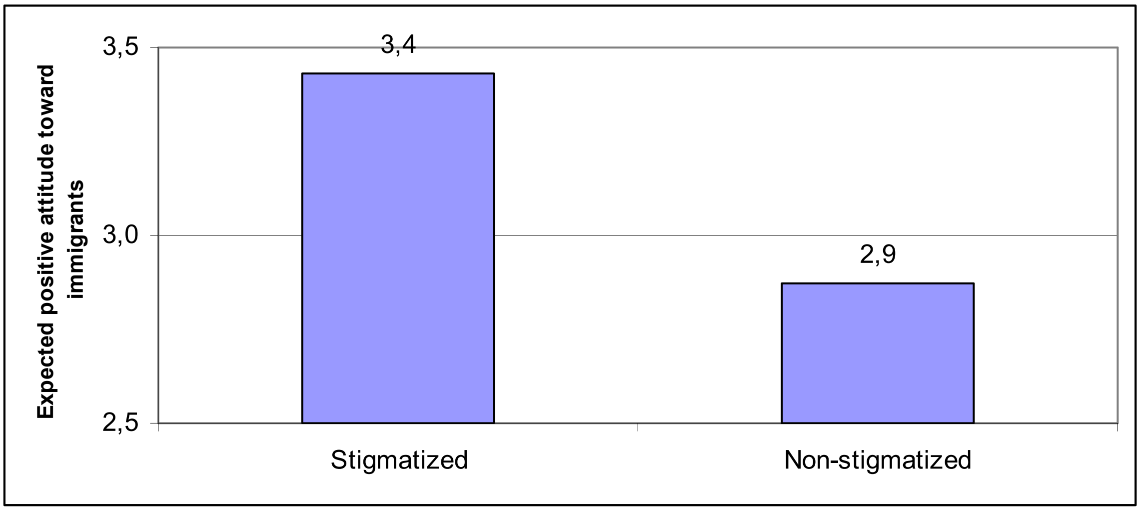


Figure 6.1. Expected attitude. Participants' expectation about how tolerant was the attitude of the target groups toward immigrants.

Confirming Expectancies

The 2 x 2 ANOVA showed the predicted attitude x target interaction was significant, *F*(1,86) = 5.9, *p* < .05 (see Figure 6.2). There was no difference in expectancies when the attitude of both target groups toward immigrants was negative, *t*(45) = 1.1, *p* = .29. However, when the attitude was positive, expectancies were confirmed to a greater degree in the stigmatized than in the non-stigmatized condition, *t*(41) = 2.4, *p* < .05. The main effect of attitude was marginally significant, *F*(1,86) =

3.2, p = .08. In general, expectancies were confirmed to a greater extent when the attitude was positive (M = 2.9, SD = 1.6) than when it was negative (M = 2.3, SD = 1.6).

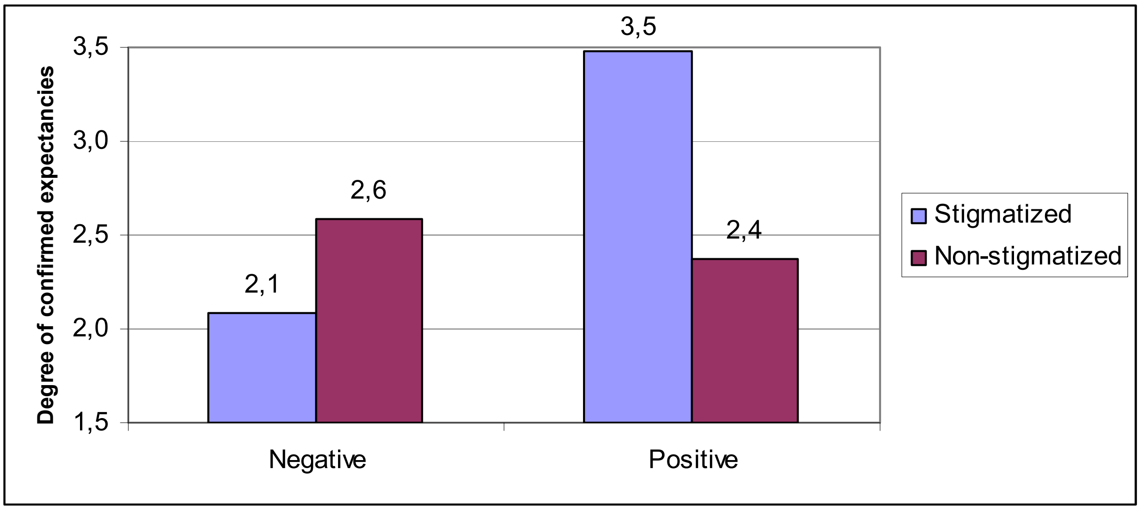


Figure 6.2. Confirming Expectancies. Degree to which participants reported their expectancies about the target group's attitude toward immigrant to have been confirmed.

Violating expectancies: Expected vs. perceived attitude

A 2 (Attitude toward immigrants: positive vs. negative) x 2 (Target group: stigmatized vs. non-stigmatized) x 2 (Violating expectancies: expected vs. perceived attitude) mixed model ANOVA with repeated measures on the last factor was conducted on violating expectancies. As predicted, the 3-way interaction was significant, $F(1,85)$ = 5.7, p < .05. As illustrated in Figure 6.3, a different pattern of results emerged in the positive attitude condition as compared to the negative attitude condition. Participants in the positive attitude condition perceived a more positive attitude than they expected, both for the stigmatized and the non-stigmatized groups, $t(18)$ = -3.9, p < .001, and $t(23)$= -3.0, p < .01, respectively. However, in the negative attitude condition, the difference between the expected and the perceived attitude was higher for the stigmatized group, $t(22)$ = 7.3, p < .001, than for the non-stigmatized group, $t(23)$ = 4.7, p < .001.

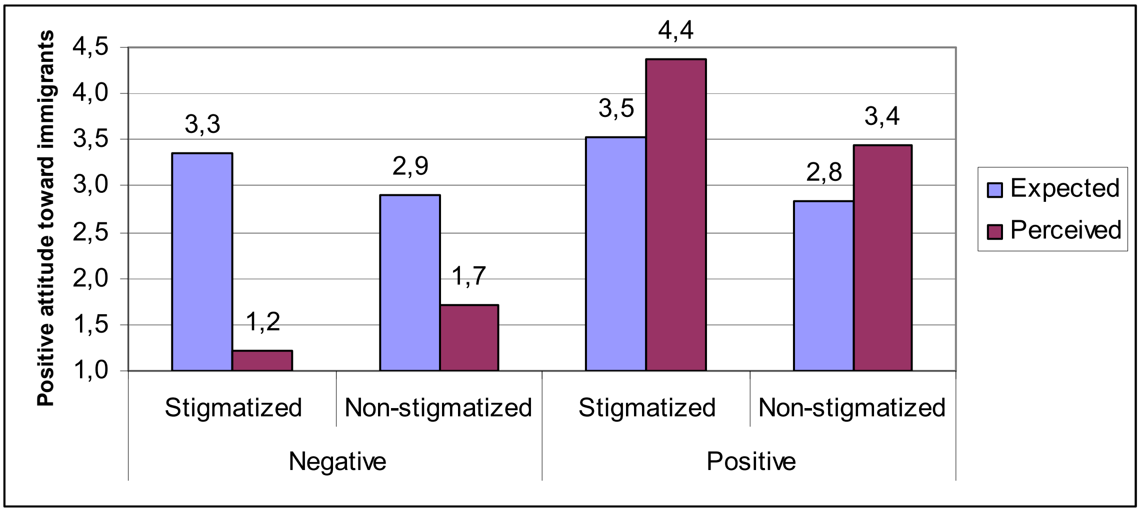


Figure 6.3. Attitude x target group x expected and perceived tolerance attitude 3-way interaction.

Negative Emotions

As predicted, the 2 x 2 ANOVA showed a main effect of the attitude manipulation, *F* (1,86) = 269.0, *p* < .001. Negative attitudes elicited more negative emotions (*M* = 4.0, *SD* = 0.9) than positive attitudes (*M* = 1.1, *SD* = 0.7). Neither the main effect of the target group nor the interaction were significant, *Fs* < .71.

Underlying processes: Justice vs. empathy-based processes

We hypothesized that the reason why participants expected the stigmatized group to be more tolerant toward immigrants was because victimized groups are judged according to a higher moral standard of conduct than non-victimized groups, and not because victimized groups are expected to be more empathetic toward other victimized groups. We therefore predicted that the mediation effect of perceived justice on the overall effect that the negative attitude had on negative emotions would be contingent on target group. In particular, we expected the mediation effect of perceived justice to be present only in the stigmatized condition, but not in the non-stigmatized condition. In addition, we predicted that the opposite would happen with perceived empathy: we expected that the extent to which participants perceived the target group to be empathetic towards immigrants would mediate the negative emotions evoked by the negative attitude only for the case of the non-stigmatized group, but not for the case of the stigmatized group.

Test for moderated mediation of perceived justice

Following Preacher, Rucker and Hayes (2007), we first tested whether the main effect of the tolerance manipulation on negative emotions was mediated by perceived justice only in the stigmatized condition, but not in the non-stigmatized condition (see also Muller, Judd & Yzerbyt, 2005). We used the *beta* version of the SPSS macro provided by Preacher et al. (2007) for tests of moderated mediation and specified Model 5 to run the bootstrapping tests with a boot N set to 5,000 for both values of the moderator (i.e., target group stigmatized vs. non-stigmatized) separately. The results confirmed that the indirect effect of perceived justice was significant when the model was specified for the stigmatized target group (99% *CI* = -1.3869 to -0.6064), but was not significant when the model was specified for the non-stigmatized target group (95% *CI* = -0.4909 to 0.0146). Following Preacher and Hayes (2004), we further tested for simple mediation of perceived justice for each target group separately. Figure 6.4 shows that in both, the stigmatized (Figure 6.4a) and the non-stigmatized (Figure 6.4b) conditions, the manipulation of attitude significantly predicted negative emotions and perceived justice (*c* and *a* paths, respectively). However, when controlling for the attitude manipulation, perceived justice predicted negative emotions (*b* path) only in the stigmatized condition, but not in the non-stigmatized condition. These findings illustrate that, as predicted, the mediation effect of perceived justice on the effect that the manipulation of attitude had on negative emotions was contingent to whether the target group was stigmatized or not. In particular, the effect that the negative attitude has on negative emotions was explained by the extent to which participants perceived the target group's attitude as unfair when the target group was stigmatized, but not when the target group was non-stigmatized.

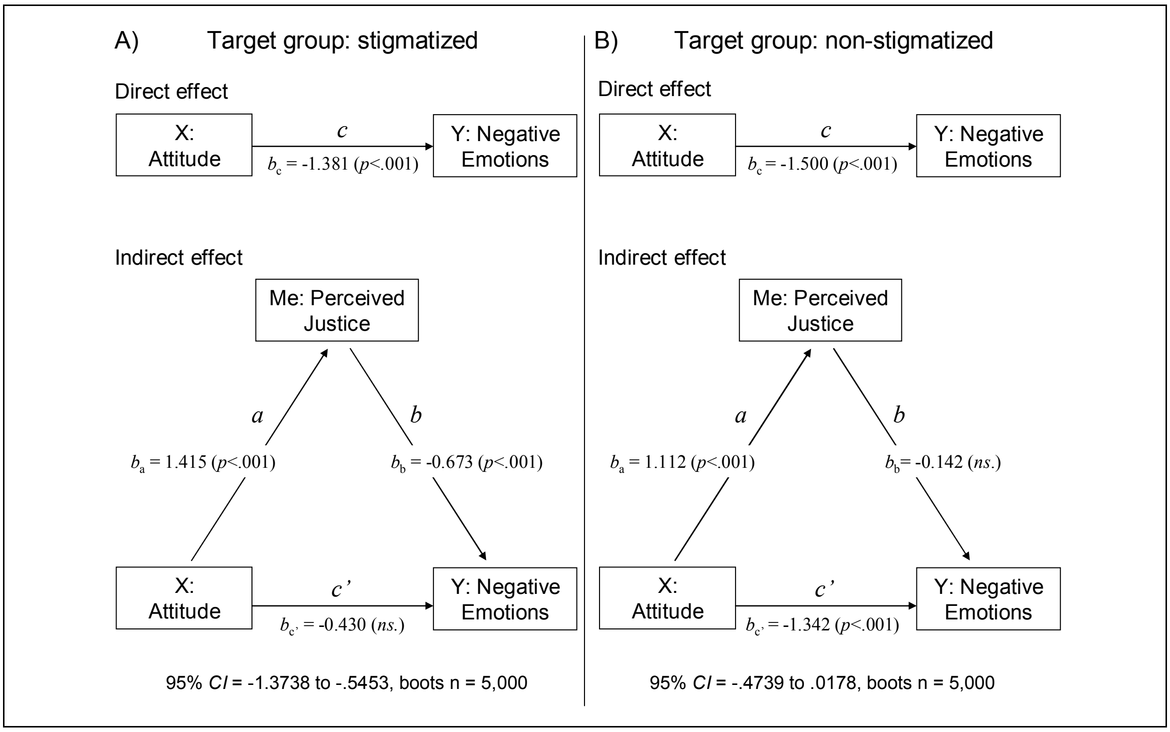


Figure 6.4. Simple mediations of perceived justice by target group. The left panel shows the significant mediation of perceived justice on the main effect of the attitude manipulation on negative emotions when the target group is stigmatized. This mediation does not exist when the target group is non-stigmatized (right panel).
Note. X = independent variable; Y = dependent variable; Me = mediator.

Test of moderated mediation of Perceived Empathy

To test whether the indirect effect of perceived empathy on the main effect that the manipulation of attitude had on negative emotions was contingent on target group, we followed again Preacher et al. (2007). The bootstrap 95% confidence interval for the conditional indirect effect of perceived empathy when Model 5 was specified for the stigmatized target group included 0 (-.7257 to .4036, boots n = 5,000). The bootstrap 95% confidence interval for the conditional indirect effect when the model was specified for the non-stigmatized group did, however, not include 0 (-.4611 to -.0630, boots n = 5,000). These results indicated that, as predicted, the indirect effect of perceived empathy on the main effect that the manipulation of attitude had on negative emotions was not significant when the target group was stigmatized, but it was significant when the target group was non-stigmatized.

The follow up tests for simple mediation showed that in the non-stigmatized condition there was a partial mediation effect of perceived empathy on the main effect that the manipulation of attitude had on negative emotions (see Figure 6.5b). As predicted by the higher moral obligations hypothesis, there was no mediation effect of perceived empathy when the target group was stigmatized (see Figure 6.5a).

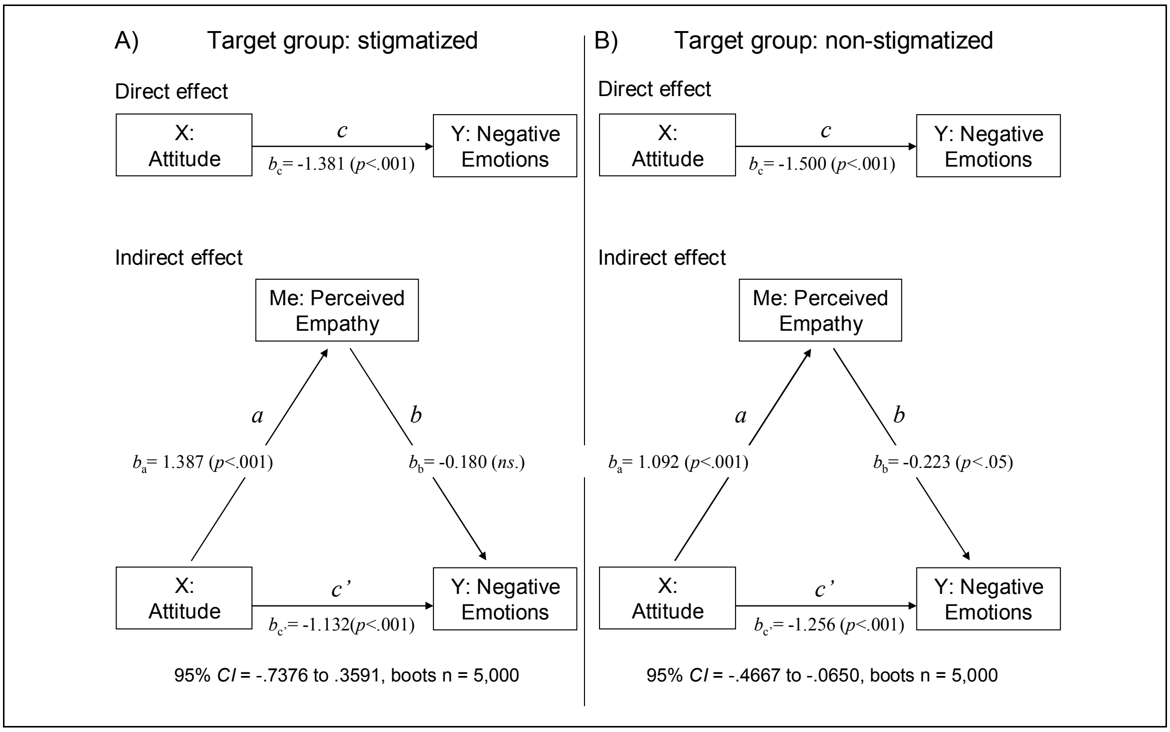


Figure 6.5. Simple mediations of perceived empathy by target group. The right panel shows the significant mediation of perceived empathy on the main effect of the attitude manipulation on negative emotions when the target group is non-stigmatized. This mediation does not exist when the target group is stigmatized (left panel).
Note. X = independent variable; Y = dependent variable; Me = mediator.

Discussion

Study 1 was designed to test whether individuals apply more demanding moral standards to stigmatized groups than to non-stigmatized groups when it comes to judging their behavior toward other stigmatized minorities. The results confirmed that participants expected stigmatized groups to behave toward another stigmatized group according to a higher moral standard of conduct than non-stigmatized groups. Participants expected the stigmatized group to have a more tolerant attitude toward immigrants than the non-stigmatized group and they showed the highest levels of expectancy-violation when they learned that the stigmatized group held negative attitudes toward the other stigmatized minority.

Negative attitudes toward immigrants had a strong negative effect on the negative emotions reported by participants, independent of the target group that expressed those attitudes. Further, this effect was mediated by the extent to which participants perceived the attitude of the target group as unfair in the stigmatized condition only; no such meditation of perceived justice was found in the non-stigmatized condition. Perceived empathy, on the other hand, did not mediate the effect of the attitude manipulation on negative emotions when the target group was stigmatized, but it did mediate the effect when the target group was non-stigmatized.

These results indicate that the processes responsible for the negative effect that intolerant attitudes toward a minority group produces in observers' emotional state are different depending on whether the intolerant group is a stigmatized group or a non-stigmatized one. If the group that holds negative attitudes toward another stigmatized minority is also stigmatized, observers feel negative emotions because they perceive the intolerant stigmatized group as unfair. If the intolerant group is a non-stigmatized group, the negative emotions are not mediated by the perception of justice. Perceived empathy, on the other hand, partially mediates the effect of negative attitudes toward a stigmatized minority on negative emotions when the target group is non-stigmatized, but it does not mediate that relationship when the target group is stigmatized.

We can conclude that people expect stigmatized groups to be kinder and nicer toward other stigmatized minorities than non-stigmatized groups, and perceivers find it especially unfair if members of a stigmatized minority become victimizers themselves. This indicates that, given the same unfair behavior, participants judge more severely stigmatized than non-stigmatized groups, signaling that the moral standards put on stigmatized groups are higher than the ones used to judge the non-stigmatized group. On the other hand, we found that an empathy-based process underlies the negative emotions evoked by the non-stigmatized groups. This indicated that, when participants needed to explain the negative attitude of the non-stigmatized group, they did not judge them according to a higher moral standard of conduct, but they perceived a lack of empathy in their behavior, which, in turn, caused the negative emotions toward the target group.

It might be argued that predictions according to HMO effect are reserved for groups that are perceived as victimized and that participants might not perceive people with dwarfism as a victimized minority. In addition, even when perceiving such a group as a victimized minority, some participants could consider that some individuals with dwarfism may have overcome such victimization while others have not. According to the HMO hypothesis, a member of a perceived victimized group who has overcome the suffering experienced but who is intolerant toward another victimized group, should evoke even more negative emotions than a victimized group member who has not overcome such suffering. The following experiment was designed to test these two possibilities.

Experiment 2

Similar to Experiment 1, our main goal with the present study was to test whether a higher moral standard of conduct is placed on victims and to assess the underlying process suggested by the HMO hypothesis. However, in contrast to

Experiment 1, we wanted to focus on a group that has been the target of intentional harm doing.

The focus of the present experiment is a victimized group that had either overcome or not overcome past victimization. That is, when a victimized group is in the middle of its suffering, people's emotional responses toward that group could be easily affected by compassion toward the victims. In this sense, although we may tend to demand more from victims in general, we may be less demanding if we see that the victims have not overcome or fully recovered from their suffering. Likewise, if the underlying process of the HMO effect was actually empathy related, participants might expect that the victims would develop higher empathic feelings once they have had time to overcome their suffering, but not before. In other words, both of these process perspectives suggest that if victims have not overcome their victimization experience, the hypothesized process may not operate to affect observer reactions. Accordingly, in Experiment 2 we manipulate whether the victimized group is said to have overcome their early trauma or not.

In all conditions people with dwarfism serve as the target group that has been a victim of discrimination in the past. We manipulated the extent to which the victimized group has overcome the past victimization or has not overcome it, as well as the attitude that the victimized group holds toward another victimized minority. As in Experiment 1, prior to the manipulation of the target group's attitude, we measured moral expectations of the victimized target group. After the manipulation of the attitude, we measured how participants perceived the target group's attitude, the extent to which their expectancies were confirmed, and the extent to which participants reported negative emotions because of the attitude of the target group toward another minority.

We also measured the extent to which participants perceived justice and empathy in the target group's attitude toward immigrants.

We predicted that the overcome victimized group would be judged according to a higher moral standard of conduct, whereas the not overcome victimized group would not be. We therefore predicted that participants would expect the overcome victimized group to be more tolerant than the non-overcome victimized group and that, when this expectation is disconfirmed, participants would show particularly high levels of violated expectancies.

We further predicted that participants would feel especially uneasy when the victimized target group had a negative attitude toward another victimized group and had overcome their past experiences. Thus, we predicted an overcome x attitude interaction on negative emotions.

Because we argue that the HMO hypothesis is based on higher moral demands put on victims and not in an expected higher empathic capacity in victims, we further predicted that the expected interaction in negative emotions would be explained by the extent to which participants negatively judged the target group's attitude in terms of moral aspects and not by the extent that they considered the target group lacking empathic feelings toward the other victimized group. We therefore predicted that, in a multiple mediation model that includes perceived justice and perceived empathy as potential mediators of the expected overcome x attitude interaction effect on negative emotions, perceived justice -and not perceived empathy- would appear as the basic mediator accounting for that interaction.

Method

Participants and Design

Ninety four undergraduate students (79 women and 15 men, mean age = 30.5, *SD* = 6.9) enrolled in UNED completed this research on the internet for course credit. None of the participants categorized him or herself as belonging to the group "immigrants" or "people with a disability". Participants were randomly assigned to a 2 (Overcome victimization: overcome vs. non-overcome) X 2 (Group attitude toward a stigmatized minority: negative vs. positive) between subjects factorial design.

Procedure

Similar to Experiment 1, participants were told that the aim of the study was to learn their opinion about the results of a research project about people with dwarfism. The fake research was described as an important project granted by the European Commission that "involved more than 25 researchers and 648 adult participants with dwarfism in Spain". It was emphasized that the sample size was very large and that, therefore, the results obtained could be considered representative and highly reliable. Participants in all conditions learned that they were going to have access to the results of the survey concerning two different aspects of the many issues addressed by the researchers: the extent to which people with dwarfism suffered discrimination and the attitudes that this group holds toward immigrants in Spain.

Presenting the target group as a victim of past victimization. Participants across all conditions were first presented with a summary of the results of the research concerning the level of discrimination that people with dwarfism confront in life. In all four conditions, participants were told that people with dwarfism face high levels of discrimination and social exclusion during their childhood and adolescence, but that in their adult life those problems no longer exist. Participants were told that this result was explained because children and teenagers are on average more intolerant toward differences in physical appearance than are adults. Some fake data about the suffering during the earlier life time was provided to make the information more credible, e.g.: “82.4% of people with dwarfism had faced serious or very serious difficulties in their relations during childhood with peers.”

The overcome vs. non-overcome manipulation. Participants then received a second piece of information concerning the consequences of the past discrimination for people with dwarfism when they were adults. Participants in the *overcome condition* learned that the majority of adults with dwarfism had overcome all negative consequences of past discrimination, while participants in the *non-overcome condition* learned that the majority of adults with dwarfism had not overcome this past discrimination. We provided some fake data to illustrate this conclusion, which was supposedly obtained from a representative sample of 648 adults with dwarfism, e.g.: “The majority of adults with dwarfism (73.4%) state that they are highly satisfied with their lives” (overcome condition) vs. “The majority of adults with dwarfism (73.4%) state that they are highly unsatisfied with their lives” (non-overcome condition).

The manipulation of the group’s attitude toward a stigmatized minority. Similar to Experiment 1, participants were provided with the results of the false research concerning the attitude that adults with dwarfism have toward immigrants, which was either described as positive or negative. At the end of the study, participants were debriefed and thanked.

Measures

Similar to Experiment 1, participants completed several scales assessing the expected attitude, perceived attitude, whether their expectancies were confirmed or not, negative emotions, perceived justice and perceived empathy, all alphas > .85. All scales ranged from 0 (totally disagree) to 6 (totally agree) and all were identical to the ones used in Experiment 1, except for confirming expectancies, which in Experiment 2 consisted of two items: "The results of the research confirmed my expectancies about how the attitude of people with dwarfism toward immigrants was going to be" and "The attitude of the target group toward immigrants has surprised me" (reverse scored), α = .86.

Preliminary Analyses

Credibility of the cover story

The same scale as was used in Experiment 1 was included, α=.89. A 2 x 2 ANOVA on the credibility of the manipulation showed a main effect of attitude, $F(1,89) = 4.03$, $p < .05$, indicating that credibility was higher when the attitude was positive ($M = 4.1$, $SD = 1.0$) than when it was negative ($M = 3.7$, $SD = 1.1$). No other effects were significant, $Fs < .31$. In addition, the mean of the scale was higher than the theoretical mid-point (3), $M = 3.9$, $SD = 1.0$, $t(92) = 8.62$, $p < .001$, indicating that the cover story was generally seen as credible.

Check of past victimization assumption

One item assessed whether participants perceived people with dwarfism as having suffered discrimination in the past ("People with dwarfism suffer discrimination during their childhood and adolescence."). A 2 x 2 ANOVA revealed that neither the main effects nor the interaction were significant, $F < 3.35$. In addition, the overall mean of this measure was higher than the theoretical mean of the scale (3), $M = 5.0$, $SD = 1.2$, $t(90) = 16.34$, $p < .001$, indicating that the information provided was understood.

Manipulation check of the overcome manipulation

One item assessed whether the overcome manipulation was effective ("The majority of people with dwarfism are able to overcome the social problems they have with peers during childhood and adolescence”). A 2 x 2 ANOVA showed a significant main effect of the overcome factor, *F*(1,87) = 18.57, *p* < .001. Participants in the overcome condition agreed more with the overcome statement (*M* = 3.6, *SD* = 1.4) than participants in the non-overcome condition (*M* = 2.2, *SD* = 1.5), *p* < .001. Neither the main effect of the attitude manipulation nor the interaction were significant, *Fs* < .05.

Manipulation check of the attitude toward immigrants

Participants were asked to rate the extent to which they agreed with the following statement: “People with dwarfism have a negative attitude towards immigrants.” A 2 x 2 ANOVA showed a significant main effect of the attitude manipulation, *F*(1,89) = 204.53, *p* <.001. Participants in the negative condition agreed more with the statement (*M* = 4.3, *SD* = 1.5) than participants in the positive condition (*M* = 1.0, *SD* = 0.8). However, results showed also an interaction effect, *F*(1,89) = 4.09, *p* <.05. A follow up analysis indicated that participants agreed particularly with the statement (i.e., perceived more negatively the attitude of the target group) when the attitude was negative and the group had overcome (*M* = 5.0, *SD* = 0.8), than when the group had not overcome (*M* = 3.7, *SD* = 1.7), *t*(42) = -3.25, *p*<.001. However, no difference in the extent to which they agreed with the statement between the overcome (*M* = 1.2, *SD* = 1.0) and non-overcome (*M* = 0.8, *SD* = 0.6) conditions were observable when the attitude was positive, *t*(47) = -1.73, *p*<.001. This interaction is consistent with the expected results, as the negative attitude toward a stigmatized minority from a victimized group that has overcome was perceived as particularly negative. The strong main effect of the attitude manipulation indicated that our attitude manipulation was effective.

Perception of "Immigrants in Spain" as a victimized group

Participants were asked to rate the extent to which immigrants in Spain suffer discrimination. A 2 x 2 ANOVA showed that neither the main effects nor the interaction was significant, $F<.05$. The overall mean of this measure was higher than the theoretical mid-point of the scale (3), $M = 4.5$, $SD = 1.2$, $t(90) = 12.10$, $p < .001$.

Results

We conducted a series of 2 (Overcome victimization: overcome vs. non-overcome) X 2 (Group attitude toward a stigmatized minority: negative vs. positive) ANOVAS on the outcome measures, except for the expected attitude measure which was rated before the manipulation of attitude. For this latter measure, we conducted a one way ANOVA to test the hypothesis that expectancies were contingent to the overcome vs. non-overcome manipulation. We further conducted a test of mediated moderation with perceived justice and perceived empathy included simultaneously in a multiple mediation model.

Expected Attitude

The one way ANOVA on expected attitude showed that, as predicted, the overcome manipulation significantly affected participants' expectancies about how the attitude of the target group toward another stigmatized group would be, $F(1,93) = 13.97$, $p < .001$ (see Figure 6.6). Participants in the overcome condition expected a more tolerant attitude $M = 4.1$, $SD = 0.9$, than participants in the non-overcome condition $M = 3.4$, $SD = 1.0$.

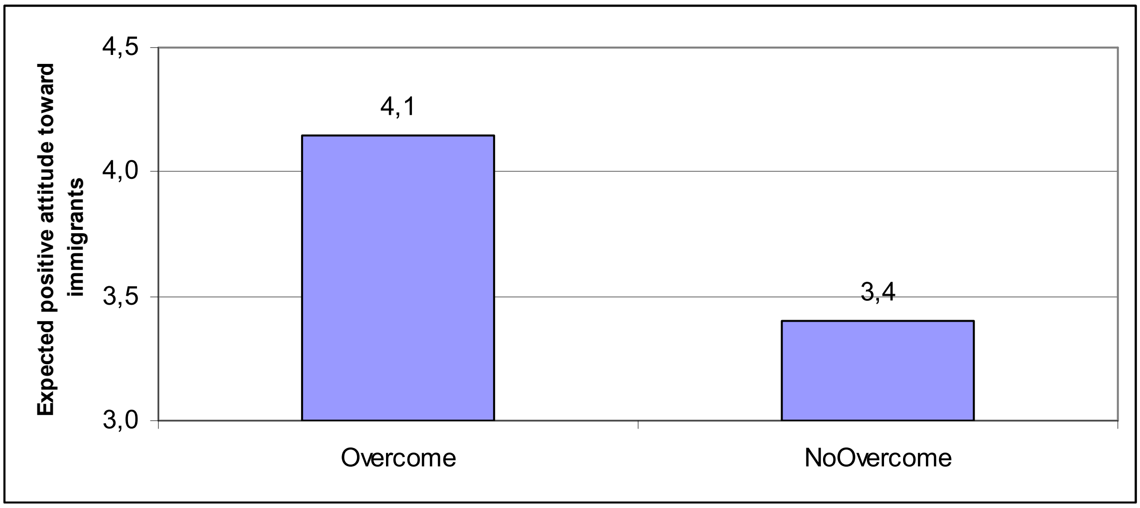


Figure 6.6. Expected attitude. Participants' expectation about how tolerant was the attitude of the target groups toward immigrants.

Confirming Expectancies

As expected, the 2 x 2 ANOVA on participants' expectancies revealed an overcome by attitude interaction, $F(1,89) = 22.75$, $p < .001$. As depicted in Figure 6.7, when the attitude was positive, participants reported their expectancies to be more confirmed in the overcome condition ($M = 4.0$, $SD = 1.4$) than in the non-overcome condition ($M = 3.0$, $SD = 1.5$), $t(47) = -2.31$, $p < .05$. When the attitude was negative, the opposite pattern was found: participants reported that their expectancies were less confirmed in the overcome condition ($M = 0.7$, $SD = 0.8$) than in the non-overcome case ($M = 2.5$, $SD = 1.6$), $t(42) = 4.53$, $p < .001$. Results also showed a significant main effect of the attitude manipulation, $F(1,89) = 45.23$, $p < .001$. In general, participants' expectancies were more confirmed when the attitude was positive ($M = 3.5$, $SD = 1.5$) than when it was negative ($M = 1.6$, $SD = 1.6$). There was no main effect of the overcome manipulation, $F(1,89) = 2.08$, $p > .15$.

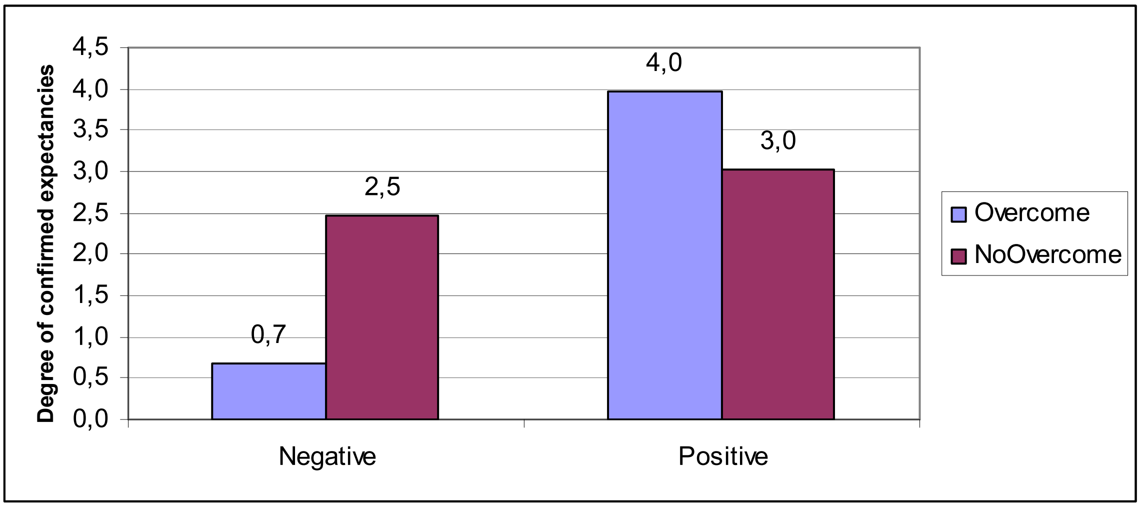


Figure 6.7. Confirming Expectancies. Degree to which participants reported their expectancies about the target group's attitude toward immigrant to have been confirmed.

Violating expectancies: Expected vs. perceived attitude

A 2 (Overcome victimization: overcome vs. non overcome x 2(Group attitude: negative vs. positive) x 2(Violating expectancies: expected vs. perceived) mixed model ANOVA with repeated measures on the last factor was conducted on violating expectancies (see Figure 6.8). Consistent with the results obtained in Experiment 1, the attitude by overcome by the repeated measures three-way interaction was significant $F(1,89) = 4.23$, $p < .05$. In line with our hypothesis, the greatest difference between expected and perceived attitudes was found when the target group had a negative attitude and had overcome, ($M = 4.3$, $SD = 0.8$ vs. $M = 1.0$, $SD = 0.5$, respectively, $t(20) = 15.31$, $p < .001$). When the attitude was negative, participants perceived the attitude significantly more negatively when the target group had overcome ($M = 1.0$, $SD = 0.5$) than when it has not overcome ($M = 2.3$, $SD = 10.5$), $t(42) = 3.62$, $p < .001$. In contrast, when the attitude was positive no difference was found between perceived attitude across the overcome conditions, $t(47) = .71$, $p > .47$. This fact, together with the higher expectations put on overcome victims (see above the results about Expected attitude) made that the discrepancy between expected and perceived attitude was the greatest in the overcome-negative condition. This result shows that, as predicted, in particular those victimized group members who have overcome prior victimization and who then express negative attitudes toward other victimized minorities violate our moral expectations of them.

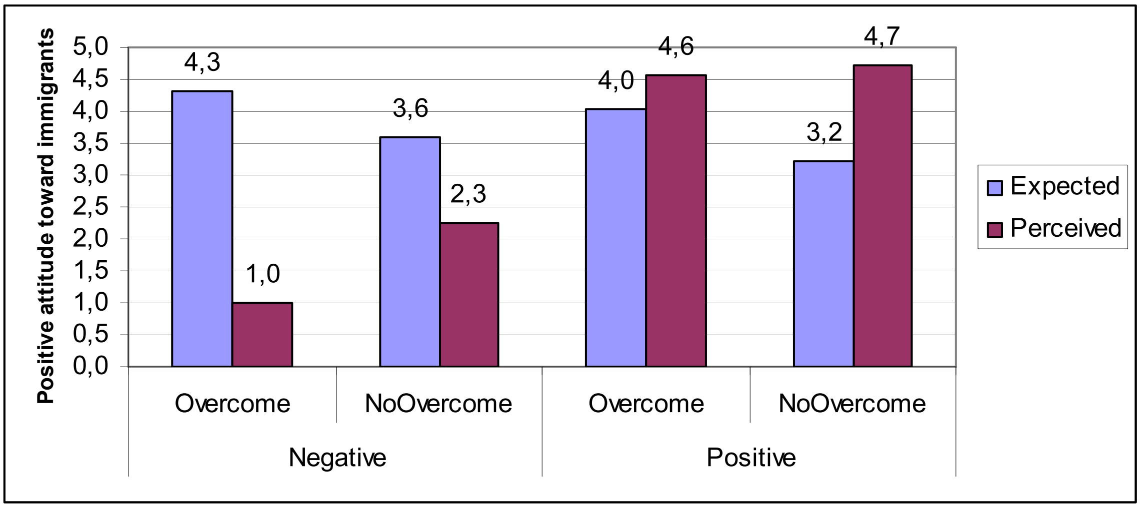


Figure 6.8. Attitude x target group x expected and perceived tolerance attitude 3-way interaction.

Negative Emotions

The 2 x 2 ANOVA showed the predicted attitude x overcome interaction, $F(1,87) = 5.65$, $p < .05$ (see Figure 6.9). As expected, while participants reported more negative emotions when the victimized group had a negative attitude toward immigrants and had overcome ($M = 4.0$, $SD = 0.8$) than when it had a negative attitude but had not overcome ($M = 3.1$, $SD = 1.0$), $t(41) = -3.18$, $p < .01$, there was no difference in negative emotions between the overcome and the non-overcome conditions when the attitude was positive, $t(46) = 0.09$, $p = .93$.

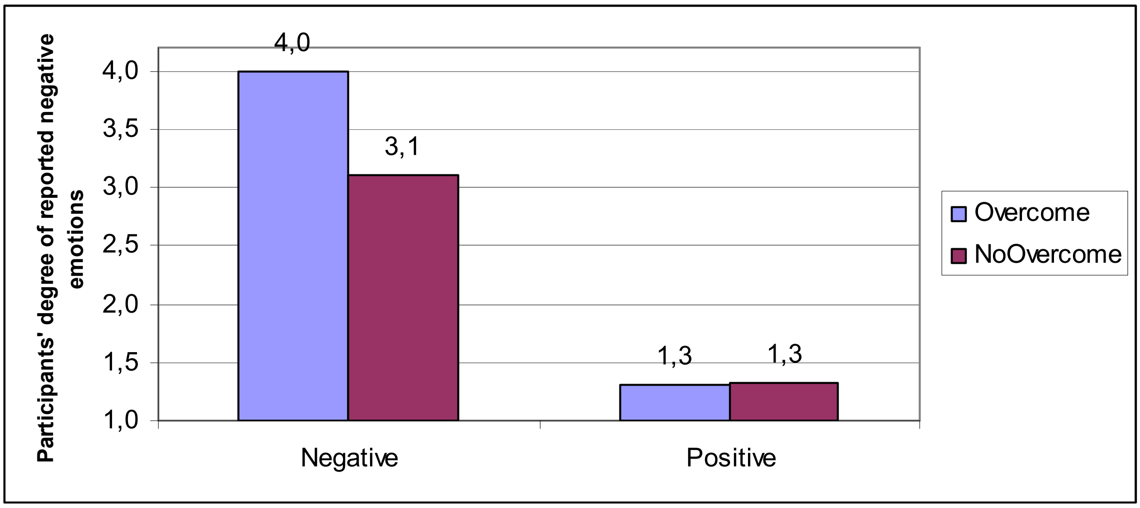


Figure 6.9. Negative emotions. Participants' emotional reaction toward the target group's attitude regarding immigrants.

Underlying processes: Perceived justice vs. perceived empathy as mediators of the attitude x overcome interaction on negative emotions

Two alternative underlying processes could explain the higher moral obligations assigned to victimized groups. First, the moral-based explanation implies that we judge victimized groups according to a more demanding standard of conduct than non-victimized groups. Second, the empathy-based explanation implies that victimized groups are expected to be more tolerant toward minority groups because they are expected to have developed empathetic feelings toward other groups that also suffer. We argue that a moral-based process underlies the overcome x attitude interactive effect obtained, which would support the moral obligations hypothesis.

To test this hypothesis we followed Preacher and Hayes (2008) and defined a multiple mediator model in which we compared simultaneously perceived justice and perceived empathy as potential mediators of the overcome x attitude interaction effect found on negative emotions. We controlled the main effects of both manipulations by including them as covariates (see Figure 6.10). Using the SPSS macro provided by Preacher & Hayes (2008) we conducted a bootstrapping test (n boots = 5,000) for the model specified in Figure 6.10. In addition, we required the macro to contrast both indirect effects. Results showed that, as presented previously, the main effect of attitude on negative emotions was contingent on whether the target group had overcome or not (i.e., the *c* path was significant, p <.05). When controlling for the indirect effects, the direct effect of the attitude x overcome interaction on negative emotions was no longer significant (i.e., the *c'* path was not significant, $p = .32$) and, as predicted, perceived justice (95% *CI*: -.2432 to -.0487) but not perceived empathy (95% *CI*: -.1043 to .0020) mediated the attitude x overcome interaction on negative emotions. The contrast of both indirect effects further indicated that they differed significantly (95% *CI*: -.2275 to -.0107). None of the main effects introduced as covariates were significant, *p*s > .11.

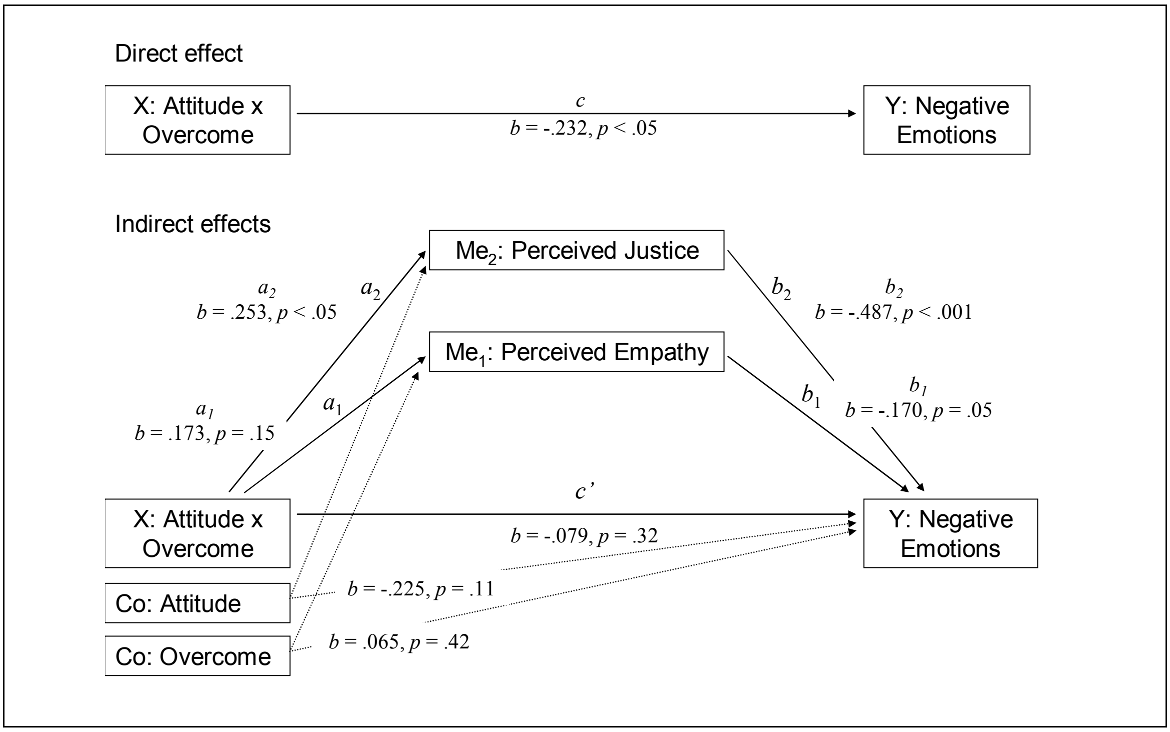


Figure 6.10. Multiple mediated moderation. A model testing for *multiple mediation* indicates that the Attitude x Overcome interaction effect on Negative emotions is mediated by Perceived Justice, but not by Perceived Empathy.
Note. X = independent variable; Y = dependent variable; Me = mediator; Co = co-variable.

These results indicate that, as predicted, groups with a victimized past that have overcome those experiences but who now exhibit negative attitudes toward other victimized groups evoke negative emotions to the extent that we perceive their attitudes as unfair, and not to the extent that we consider them as not empathizing with other victimized groups.

Discussion

As predicted, the results of Experiment 2 show that victimized groups that have overcome their suffering are expected to behave according to higher moral of behavior than those who have not overcome such suffering. When overcome victimized group members are intolerant toward a social minority, negative emotions in observers are higher than when the non-overcome victimized group is intolerant. As predicted, this interaction effect on negative emotions was mediated by the extent to which the victims were perceived as unfair, but not by the extent to which the victims were perceived as not empathic.

These results clearly replicate with a victimized minority target the results obtained in Experiment 1 regarding the underlying process of the HMO effect. The results indicate that the HMO effect is based on a higher moral demand placed on victims and not in expecting that victims should be more empathic due to their suffering, even when they had overcome that suffering and had had enough time to grow from the experience.

General Discussion

The two experiments presented in this chapter indicate that people with dwarfism are expected to behave according to a higher moral standard of conduct than people without dwarfism. In Experiment 1, we found evidence indicating that participants have greater expectations that the stigmatized group should be more tolerant toward another stigmatized minority than a non-stigmatized group. Although participants responded similarly with negative emotions toward both target groups when they were portrayed as intolerant, the process underlying these responses varied depending on the group. In the case of the stigmatized target group, the process underlying participants' negative responses toward the intolerance of the target group was perceived justice, while in the case of the non-stigmatized group the underlying process was perceived empathy. That is, participants responded with negative emotions to the negative attitude of the stigmatized group to the extent that they perceived the intolerant stigmatized group to be particularly unfair toward another minority. In contrast, participants' negative emotions in response to the negative attitude of the non-stigmatized group toward immigrants was mediated by a lack of perceived empathy. Experiment 2 are consistent with such findings, with perceived justice, and not perceived empathy, mediating the particularly negative reaction that participants had when a victimized group that had overcome their prior suffering but who appeared to be intolerant toward another minority.

Confirming the HMO hypothesis, the results of both experiments indicate that stigmatized groups are judged by majority group members with a more demanding moral standard than the one applied to non-stigmatized groups. These higher moral expectations are not explained because majority group members think that stigmatized group should have developed an especially high degree of empathy due to its suffering, but because majority group members judge social victims more severely than non-victims.

In this sense, from the observers' point of view, stigmatized groups are not expected to have developed an altruism born of suffering (see Staub & Vollhardt, 2008). On the contrary, the evidence about the underlying processes of the HMO effect suggests a secondary victimization process in observers, by which stigmatized groups not only face interpersonal rejection, but are also more severely demanded by majority group members to be moral in their treatment of others.

One limitation of the present research is that we have studied the HMO effect by manipulating the attitude that a stigmatized minority (people with dwarfism) exhibited toward another stigmatized minority (immigrants in Spain). It would be necessary to research in the future whether the higher moral expectations are also disconfirmed when minorities behave against the accepted social norms in a situation unrelated to other stigmatized minorities. We chose that particular manipulation because we were interested in mainly testing whether moral judgments or empathic judgment underlies the HMO hypothesis. We thought that if an empathy related process were the basis of the HMO effect, it would be particularly evident when a stigmatized minority was intolerant toward another stigmatized condition. However, it would be also interesting to see whether stigmatized minorities are expected to conform more strictly than non-stigmatized minorities to social norms in general, such as for example how one is expected to behave in a restaurant or any other social context that is not related to the treatment of another stigmatized minority.

An important limitation on the potential generalization of the current results is that we considered only one sort of stigmatized minority group–people with dwarfism. Therefore, future research should conceptually replicate the current studies with a different stigmatized minority as target group.

Another interesting and related research question for the future would be to test the extent to which majority group members expect stigmatized minorities not to protest or demand in a particularly strong way for their rights. Were they to do so, they might risk being seen as ‘whiners’ and ‘complainers’, which too could lead to negative emotional reactions in observers (Kaiser & Miller, 2001). In fact, an important issue is whether such expectations and potential social costs would be found among members of the stigmatized group itself. Some research has revealed that social costs are extracted more readily by ingroup members than outgroup members, who by their deviant behavior, place the overall group identity at risk (see Garcia, Horstman, Amo, Redersdorff, & Branscombe, 2005). One could easily infer, based on the HMO hypothesis, that stigmatized minority group members themselves would react negatively to an ingroup member who violates moral expectancies for the ingroup, and ironically enough who complains very strongly in the defense of their rights.

Conclusions

The present research has shown that emotional responses toward a stigmatized minority group reflects use of stricter moral standards compared to when the actions being judged are performed by a non-stigmatized group. Two experiments illustrated that majority group members expect people with dwarfism to be particularly tolerant toward other stigmatized minorities. Such expectancies were especially high when the victimized group was believed to have overcome their suffering. In addition, consistent with the higher moral obligation hypothesis, observers' negative reactions toward a stigmatized group member who was intolerant were driven by justice-related perceptions about the target group.

CHAPTER 7. GENERAL DISCUSSION

The present dissertation is the result of a demand done by the ALPE-Achondroplasia Foundation to research the extent to which the social stigmatization of dwarfism affects the life of people with skeletal dysplasias. The ALPE-Achondroplasia Foundation is an organization of families of people affected by skeletal dysplasias that cause dwarfism, which mission is to provide information and support to people with dwarfism, to promote scientific research on the subject, and to defend their interest in their relationship with the Public Administrations and with the society as a whole.

The demand of the ALPE-Achondroplasia Foundation to research the social stigma associated to dwarfism was motivated by their conviction that, although the community of people with dwarfism is slowly making important progress in different domains that affect their quality of life such as, for example, health related issues or the acknowledgement by the Government of some of the special needs that are derived from their particular physical condition, they are making in contrast little progress in their efforts to confront one of the most important barriers that threatens their quality of life: the social devaluation of the dwarfing condition.

Carmen Alonso, the Managing Director of the ALPE-Achondroplasia Foundation, often says that skeletal dysplasias that cause dwarfism are the only kind of disabilities that still makes people laugh today. And in fact, many people with dwarfism have found a way to earn a living in the show business by exploiting the mix of morbid curiosity and comedy that their disproportionate dwarfism still evokes in many people. This kind of shows are often of erotic or/and comic nature and, according to the ALPE-Achondroplasia Foundation, most of them exploit commercially a social consensus about the debasement of the dwarfing condition which creates a grotesque effect of comedy based usually in mocking or ridiculing the condition. Shows that use the dwarfing condition in this way, denigrate this condition and damage the social identity of the whole group. The fact that this kind of shows are widely socially accepted (in Spain groups of people with achondroplasia are even employed with public money for local celebrations in many village and cities all around the country) points to a particular circumstance that occurs with respect to dwarfism, but not with other kind of disabilities: in contrast to other disabilities, the dwarfing condition has still not been taken in many social contexts with the seriousness and respect that it deserves.

The main underlying motivation of the ALPE-Achondroplasia Foundation to promote independent and objective research about the social stigmatization of the dwarfing condition was to get the scientist community involved in a problem that has received little attention and awareness. By promoting social psychological research on this issue, the community of people with dwarfism will gain independent references that can be cited in order to persuade the authorities and the society about the seriousness of a problem which consequences for the affected individuals are easily underestimated.

From a more health-related perspective some studies have researched the quality of life of people with skeletal dysplasias that cause dwarfism, usually by comparing it with the quality of life of their first degree relatives (Apajasalo et al., 1998; Gollust et al., 2003; Hunter, 1998). However, to our knowledge, there is not any work that has addressed the extent to which the social stigmatization of the condition may be contributing to that result. The main objective of the present dissertation was to focus on that specific problem (i.e., the social stigmatization of the condition and the consequences it has), as well as on the different strategies that people with dwarfism use to cope with it.

It could be argued that the researches presented in this dissertation have focused on the negative side of the reality of people with dwarfism, which could lead to a quite dark, sad and pessimistic perspective of the lives of people with skeletal dysplasias. Advancing already some of the limitations of this work, it would be necessary that future research focus on the positive experiences of living with dwarfism and in the successful coping efforts that lead people with dwarfism to have highly satisfying lives. Although we support the idea that a more positive psychological approach should be carry out, we are also convinced that independent studies like this one about the extent to which the dwarfing condition is stigmatized and about the negative consequences that devaluation can have for the affected individuals are necessary in order to educate and make people aware of a reality that should not be hidden if we want to overcome it. With that goal, we have conducted the research project that has resulted in this dissertation.

7.1. Review of the state of the science

We have devoted the first two chapters of the present dissertation to review the state of the science. The first chapter contains a detailed review about the dwarfing conditions in general and more in particular about achondroplasia, the most common among the skeletal dysplasias that cause dwarfism. We have included a brief summary of some of the studies that, from a health psychology approach, have investigated the quality of life of people with dwarfism. In the second chapter we presented a theoretical approach to the process of social stigmatization, defined as a context-specific phenomenon that implies the social devaluation of a given social group, which requires social consensus and implies a threat to the self for the observers. We have presented social stigmatization as a process close related to other social phenomenon that also imply interpersonal rejection, such as social exclusion or ostracism. We have focused then our interest in the review of the main theoretical approaches to the consequences that experiencing interpersonal rejection has for the victims, as well as the possible coping strategies that rejected individuals or groups adopt to deal with it. As proposed by Branscombe and colleagues, we have differentiated the consequences for the psychological well-being of experiencing isolated events of interpersonal rejection from the consequences of experiencing *pervasive rejection* due to the belonging to a stigmatized social minority. We have argued that this last kind of experience can be perceived by the victim as if one's social identity is devalued, which in turn can lead to a deep feeling of humiliation. We have therefore also reviewed some theoretical approaches to the concept of humiliation.

7.2. The studies

The main body of the present dissertation is composed by four researches that address four different aspects related to the social stigmatization of the condition. Two of them address the question from the perspective of the victim, while the other two adopt the perspective of the victimizer. Each of these studies has been done with a different method –qualitative, correlational and experimental-, the one which was most convenient for the particular objectives that we wanted to accomplish.

The first step in the research project was to interview people with skeletal dysplasias that cause dwarfism in order to deepen our understanding of how affected individuals experience the social stigmatization of their condition. The objective of these interviews was to identify the main sources of difficulties that people with dwarfism encounter in their relationships with others. Although our main focus was on the negative consequences of living with dwarfism, we also obtained insides of how most of the interviewees had been able to successfully cope with those difficulties. However, the interviews were very clarifying about how strongly the dwarfing condition is stigmatized in our current modern societies and about the many instances and circumstances of everyday life in which the negative consequences of the stigmatization arise. The results of these interviews indicated that people with disproportionate dwarfism confront since very early ages a significant number of *microaggressions* (see Sue et al., 2007) in the form of uncomfortable surprising looks from anonymous people on the street, jokes and derogatory comments related to their condition. Although participants thought that those behaviors were often done without the intention to hurt, they still suffered them as a signal that, in the eyes of others, there is something *wrong* with their bodies. In a minority but still significant number of cases the interviewees reported particularly hard episodes that implied bullying at school or isolated events of physical violence related to their physical condition. Most of the participants in this study reported to have suffered ostracism and social exclusion of different nature and severity, including *sexual exclusion*. These negative experiences had, according to participants, important negative consequences for their psychological well-being. Among the reported consequences we distinguished those of cognitive nature (e.g., rumination, lack of motivation), emotional consequences (e.g., negative mood, rage, anxiety) and behavioral consequences (e.g., avoidance of social contexts in which interpersonal rejection was anticipated, disengagement, poor academic performance, hiding the suffering related to interpersonal rejection).

In general, the interviews confirmed that dwarfism was a condition that, from the perspective of the affected individuals, was strongly stigmatized, which often lead to ostracism and other instance of interpersonal rejection. The negative consequences of ostracism for the psychological well-being of the targets have been largely studied by social psychology (see Williams, 2001, 2007). But even if participants did not directly experience interpersonal rejection, their awareness of the high social stigma associated to their condition, together with their own past experiences of interpersonal rejection, lead them to feel a threat to their need to belong (Baumeister & Leary, 1995). It has been demonstrated that simply by feeling that one's belonging may be threaten -without necessarily having to experience social exclusion-, has a large number of negative effects for the psychological well-being of the targets (Baumeister et al., 2005; Baumeister et al., 2002; Twenge et al., 2007; Twenge et al., 2003; Twenge et al, 2002; Twenge et al., 2001).

The perceptions about the highly social stigma associated to the dwarfing condition reported by interviewees were consistent with the results of our second study, in which we measured, from the observers' perspective, the strength of the social stigma of dwarfism. The results indicated that dwarfism, together with cerebral palsy and face disfigurement, formed a group of strong stigmas in comparison to a group of weaker ones formed by blindness, amputation, paraplegia and obesity. The group of strong stigmas evoked in majority group members higher levels of interpersonal anxiety and a higher desire to social distancing than the group of the weak stigmas. Moreover, majority group members applied the label "weird people" (a label that has a negative connotation) and "people different to me" (with a neutral connotation) more intensely to the group of strong stigmas than to the group of weak stigmas. In contrast, the label "normal people" (that has a positive connotation) was applied more to the group of weak stigmas than to the group of strong stigmas.

As predicted, we found that the extent to which majority group members perceived the stigmatized groups as "weird" predicted their desire of social distancing and the amount of interpersonal anxiety that they reported. We concluded that disproportionate dwarfism accounts among the highly stigmatized physical conditions in the context of our modern societies. One of the consequences of that circumstance is that majority group members may tend to negatively perceive people with dwarfism and experience higher levels of anxiety and a stronger desire of social distancing in their presence than in the presence of people with other physical conditions that deviate from the norm.

Our third study approaches the dynamic of stigmatization in people with dwarfism from two different national contexts (Spain and the US). Using structural equation modeling (SEM), we studied how people with dwarfism from both countries experience the stigmatization of the condition, what consequences this experience has for their quality of life, and how do they cope with it. Due to a number of circumstances, the use of limb-lengthening surgery (LLS) is more extended among people with achondroplasia in Spain than in the US. On the other hand, in the US there is a quite successful organization of people with dwarfism (Little People of America, LPA) that has been working since 1957; in Spain the existence of organizations that collectively protect the interest of people with dwarfism is much more recent: the ALPE-Achondroplasia Foundation was created in 2000 whereas the other main organization in Spain –CRECER- was founded in 1985. It is also interesting to observe that while LPA is clearly orientated to "improving the quality of life for people with dwarfism throughout their lives while celebrating with great pride Little People's contribution to social diversity" (literally from LPA mission statement; the emphasis is added), the organizations in Spain put more the accent on providing medical, health related and other kind of practical support and services to people with dwarfism and their families. Although the Spanish organizations make also efforts to protect the collective image of people with dwarfism, it seems as if they approach this objective from a more defensive attitude, rather than a positive one based on pride. Another interesting difference among the organizations of both countries is their different positions toward LLS. While the Spanish organizations seem to completely support LLS, LPA position is vaguer, to the point that they seem to be against it. Due to these attitudinal difference across the countries and probably also due to other more pragmatic reasons related to each country's heath systems, the fact is that LLS –an individualist coping strategy - is much more extended in Spain than in the US. These differences made especially interesting to compare how the social stigmatization of the condition affected the quality of life of people with dwarfism from both countries and how alternative coping strategies were implemented. In particular, we compared the use in both countries of a more collective coping strategy (i.e., having positive contact with other people with dwarfism) with a more individualist one (i.e., LLS). Through multi-group SEM we studied the extent to which experiencing social exclusion, ostracism and derogatory treatment due to their physical condition (i.e. experiencing humiliation) affected the quality of life of people with dwarfism. As expected, the extent to which people with dwarfism felt humiliated due to its group belonging had a strong negative effect on their quality of life. No differences across countries were observed in either the amount of humiliation reported by people with dwarfism, in the amount of quality of life, or in the relationship existing among these two constructs. However, we found a significant difference in the use of LLS among both countries. The sample in Spain was significantly taller than the sample in the US due to the more extended use of LLS in Spain than in the US. Moreover, while in Spain height predicted the amount of humiliation reported by participants, in the US that path was non-significant. The second interesting difference among both countries was the effect that positive contact with the ingroup had in buffering the negative effects of humiliation on quality of life in one country, but not in the other. While in the US there was a significant positive path between having contact with the ingroup and quality of life, this relationship did not existed in Spain. We concluded that the broader cultural context has an important influence in the coping strategies that prevail in each country: while in the US a more group orientated coping strategy seems to be dominant, in Spain an individual coping strategy based on individual social mobility through LLS prevails. However, in both countries, and independently of the dominant coping strategy and the rest of the national differences that exists across both countries, there was a strong and significant negative relationship between the extent to which people with dwarfism experienced humiliation due to its group belonging and their quality of life.

Finally, in the last chapter presented in the dissertation, we addressed the issue of the negative consequences of belonging to a stigmatized minority from a more social or macro perspective by testing the higher moral obligations (HMO) hypothesis applied to the group level (Wagner & Branscombe, 2008). The HMO hypothesis posits that majority group members expect victims to behave according to higher moral standard of conduct than non-victims. In two experiments we tested whether majority group members put higher moral obligations on people with dwarfism than in non-stigmatized groups and what were the consequences that breaking those expectancies had for the target groups. In the first experiment we found that majority group members expected people with dwarfism to be more tolerant toward other stigmatized minority than a non-stigmatized group. When both the stigmatized and the non-stigmatized targets groups were presented as holding negative attitudes toward the stigmatized minority, participants responded with higher levels of negative emotions. In the case of the stigmatized target group, the negative reactions were mediated by the extent to which majority group members perceived the target group's behavior to be unfair, while for the non-stigmatized group the negative reaction was mediated by the extent to which majority group members perceived the target group's behavior as non-empathetic. In a second experiment we presented people with dwarfism as either a social minority that has overcome past victimization (overcome) or as minority that has not overcome past victimization (non-overcome). Participants expected the overcome victimized minority to be more tolerant toward a stigmatized minority than the non-overcome minority. Replicating the results found in the first experiment about the underlying process of the HMO hypothesis, we found that the extent to which participants perceived the victimized minority to be unfair was the process underlying their negative reactions toward the intolerant overcome victimized group. These results led us to the conclusion that people with dwarfism are judged according to a more demanding moral standard than majority group members.

7.3. Main conclusions

Overall, the main conclusion that we have obtained from the present dissertation is that people with skeletal dysplasias that cause disproportionate dwarfism perceive since very early ages a pervasiveness devaluation of their physical condition by majority group members. Due to the social devaluation of their physical condition, the risk of suffering ostracism, social exclusion, discrimination, and verbal and physical aggressions is high. These experiences have important negative effects for the psychological well being and for the quality of life of affected individuals and their families.

In order to cope with those negative experiences we have investigated how people with dwarfism embrace two alternative coping strategies, which seems to be influenced by the broader cultural context in which the person lives: in Spain, where the use of LLS is more extended, people with dwarfism develop more individualist strategies that imply group abandonment and individual mobility (see Branscombe & Ellemers, 1998; Jetten et al., 2006; Taylor & McKirman, 1984). While in the US, where the use of LLS is less extended, there has been for longer an organized effort to give people with dwarfism reasons to be proud of their group belonging, people with dwarfism embrace more collective coping strategies.

7.4. Future research

In comparison to other stigmatized groups that have been studied, we have observed an interesting distinctiveness in people with dwarfism that deserves future research. Branscombe and colleagues found that different stigmatized groups cope with discrimination through the so called rejection-identification model (Branscombe et al., 1999, Jetten et al., 2001, Schmitt et al., 2003; Schmitt et al., 2002, Schmitt et al., 2003). This model, tested with different stigmatized groups, posits that experiencing discrimination due to group belonging leads victims to more strongly identify themselves with their group, which in turn produces a positive effect in their psychological well-being. In our research of the stigmatization dynamic we have found evidence that, in the US, meeting the ingroup has a positive effect on the quality of life of people with dwarfism, buffering the negative effect of humiliation. This result supports the basic idea of the rejection-identification model according to which the social group protects against group-based rejection. However, we have also found evidence that suggests that in both, the American and Spanish samples, the extent to which individuals identify themselves with the group of people with dwarfism -as measured by the Identity subscale of the Collective Self Esteem Scale (Luhtanen & Crocker, 1992)- negatively correlates with their psychological well-being, instead of having a positive correlation as predicted by the rejection-identification model. Moreover, we have not found any significant path between the extent to which people with dwarfism experience interpersonal rejection and identification with the group. We have not included this evidence in this dissertation as we want to research more deeply this phenomenon to understand better what it is happening.

Interestingly, a similar negative correlation between identification with the group and psychological well-being has been recently found in a group of people with morbid obesity (Magallares, 2009). People with dwarfism and morbid obesity share some characteristics: both are relatively low prevalence conditions; both face high levels of social stigmatization; both are geographically spread and both constitute often isolated cases in a given family, neighborhood or village. In this sense, we think it would be necessary to further research why in both these groups there is a negative relationship between identification and psychological well-being. We think the reason could be related with not being able to find any advantages of the fact of belonging to that particular group, while, at the same time, continuously having to confront the disadvantages of belonging to it. Living isolated from other people with the same condition and not having many opportunities to build up a sense of community around the share physical condition may be also a factor contributing to the explanation of this phenomenon. Furthermore, the widely social extended belief that dwarfism or morbid obesity are negative body abnormalities –a belief that we presume is shared by many affected individuals and their families- could be also contributing to this negative identification phenomenon. In this respect, it would be worth to study the extent to which people with dwarfism -and their families- categorize themselves as *deviants*, i.e. isolated members of a majority group which pervasively reject them (see Jetten et al., 2006), rather than as members of a *classical minority* called “people with dwarfism” or “morbid obese people”.

Both these groups (i.e. “people with dwarfism” and “morbid obese people”) may have in fact a totally different meaning for their members than other classical minorities studied in social psychology, such as Afro-American, women or even obese people who are not morbidly obese. Future research should study whether people with dwarfism, even if they think of themselves as members of a majority group that rejects them (i.e., as *deviants*), may be forced through the experience of pervasive social stigmatization and interpersonal rejection based on their dwarfing condition to see themselves as members of a rejected minority toward which they themselves do not have any positive feelings. If a process like that is taking place, people with dwarfism may feel forced to accept that others’ rejection of their dwarfing condition force them into a group so-called “people with dwarfism” towards which they themselves do not have any positive feelings. This kind of rejection-forced identification with a highly stigmatized group may function as social exclusion or debasement process, which in turn would explain why identification with the group leads to negative psychological well-being.

Another issue that would also require future research is the influence that the efforts of organizations such as LPA may have in developing a group identity of which people with dwarfism could feel proud of. As said above, the negative relationship between identification and psychological well-being has been found in both, the American and the Spanish samples. However, while in the US having contact with the ingroup seems to have a buffering effect against interpersonal rejection, this relationship does not exist in Spain. We have argued that the collective effort that LPA has developed in the US to build up a social identity of which people with dwarfism could be proud of, could explain that circumstance to some extent. However, we think that further research is needed to study in detail how collective efforts like the one conducted by LPA can affect the way a highly socially stigmatized minority cope with rejection.

7.5. Practical implications

From the results obtained in this research we can drawn some implications that concern both, the community of people with dwarfism, as well as to the society in general.

In regard to the implications for the community of people with dwarfism, it seems clear that the efforts directed to develop a sense of connection or belonging among affected individuals would probably render important benefits for their quality of life. That is, in fact, one of the main tasks that organizations such as the ALPE-Achondroplasia Foundation or LPA undertake. These organizations build up a network of affected people and families that found in each other existence and experiences an important support to overcome the difficulties associated with dwarfism.

But the low prevalence of the condition, the geographical dispersion, the usual absence of other affected individuals in the near context, and the strong stigma associated to the condition contribute to people with dwarfism to often living their condition by themselves, surrounded by other individuals that do not share their physical condition. An individualistic approach to the problems derived from the social stigmatization of the condition is therefore the automatic and more probable response if efforts to support group-based strategies are not strongly endeavored. Individualistic responses can easily lead to the development of a feeling of being a "weirdo" or a *deviant* member of a group that pervasively reject the affected individual. To avoid these feelings of loneliness, we think it is advisable to try to build up since very early age a sense of group belongings among people with dwarfism. This does not mean that people with dwarfism should aim to have relationships only with affected individuals. On the contrary, we think that it is possible and advisable that, while people with dwarfism carry out their normal social lives in their natural contexts with people without dwarfism, they accomplish parallel efforts to maintain contact with other affected individuals that probably live in a different geographical context. The current development of Internet-based communications can surely facilitate very much these efforts. We think that individuals' motivation to keep in contact with other affected individuals would be facilitated too by a more overall group driven attempt directed to make people with dwarfism to feel proud of their group identity.

It is not easy to achieve that people who confront since very young age aversive looks at the street, verbal aggressions, and interpersonal rejection due to its physical appearance may develop a kind of pride about their different physical condition. Still we think it is very important to make efforts to achieve that young people with dwarfism are exposed to positive information related to their condition. Connection with the broader community of people with dwarfism may facilitate the flow of this positive information in the form of positive personal and group life stories that illustrate the many reasons that people with dwarfism have to be proud as a social group. Access to this positive information can be very important for people with dwarfism that are undergoing negative experiences related to interpersonal rejection. Through the experiences of others, people with dwarfism can learn about the possibilities to overcome those negative experiences. In this sense, a positive approach to the issue of the social identity of dwarfism would be surely helpful. As explained above, the present research has focused on the negative aspects of the social stigmatization and we think it would make no sense to underestimate the negative potential that the stigmatization has for the quality of life of affected individuals. It would be of little help to spread the message that the social stigmatization of the dwarfing condition does not exist or does not have the serious negative consequences for the psychological well-being that it in fact has. To this respect, more concrete collective efforts to fight against those negative consequences in the form of support groups specifically created for this purpose could be also very positive.

In summary, acknowledging the negative impact that social stigma has on the quality of life of people with dwarfism and the need to direct efforts to cope with those negative consequences, we strongly recommend the community of affected people to work in the development of a group identity base on pride, to focus on the positive aspects of living with dwarfism and on the successful coping strategies that have lead many people with dwarfism around the world to have very satisfying lives.

From the results of the present research we can also extract some implications for the society as a whole. One of the main reasons that lead the ALPE-Achondroplasia Foundation to promote the present research project was the low academic achievement that they had been observing in people with dwarfism. This observation is congruent with researchers that have found that people with achondroplasia, although have an average IQ, obtained lower achievement in school-related tasks than expected (Thompson et al., 1999). Many reasons are surely accounting for this fact. The slower motor development in people with achondroplasia and other specific physiological factors could be among them (De Solà-Morales & Pons, 2003). However, the strong impact that the social stigmatization of the condition may have in the psychological well-being of affected individuals at school is also a factor contributing to that situation. Although we think more research should be done on this specific area, we have found that people with dwarfism reported rumination, lack of motivation and even the desire to avoid the school as a consequence of experiencing interpersonal rejection. In this respect, we think more efforts should be done at the school level in order to prevent the stigmatization dynamic. The subtle nature which often characterizes the stigmatization dynamic, together with the motivation expressed by affected individuals to hide their suffering produced by social exclusion, make it not always easy to detect these processes at school. Furthermore, teachers are not always prepared to handle complex social situations that result in a student being ignored or rejected by the group due to his or her personal characteristics. Therefore, it would be advisable to promote policies and projects directed to provide school teachers with the necessary resources and knowledge to identify the dynamics of social stigmatizations in their classrooms, as well as to prepare them to handle and prevent those situations when they appear. A group based strategy to intervene in the schools directed to provide targets, victimizers and teachers with recommendations and behavioral suggestions to better handle this kind of situations could lead, in our opinion, to a reduction of the negative impact of stigmatization at school.

We also think that a debate would be needed about the ethics of exploiting in the show-business the morbid curiosity that disproportionate dwarfism still causes in many people. To the extent that the dwarfing condition is a share characteristic that dramatically determinates the social identity of affected individuals, we think that the commercial use in a derogative way of the differences that mark and define the group should be put into question. Following a similar reasoning, we also argue that majority group members that pay money and enjoy shows that are based in the denigration or ridiculing of a physical condition such as dwarfism should consider the ethics of attending, supporting and enjoying those shows.

Finally, the results of the studies presented in this dissertation rise also the more overall question of the importance to pay attention to social processes that tend to ignore or collectively devaluate a social group. As in the case of people with dwarfism, social stigmatization is a powerful circumstance that seriously damages the quality of life of many people. Social Psychology has extensively researched the nature of social stigmatization and related processes, their consequences for the victims and the way they have to cope with them. Psychological research has demonstrated how easily -and often how subtly- humans tend to stereotype and reject minorities, which may threaten majority group members' identities, resources or beliefs. In the last decades there has been also an important increase in the amount of researches directed to study the consequences for the victims of this kind of negative behaviors. However, there is still an obvious lack of education and sensibility about how powerful the processes of social stigmatization are and about the consequences that they have for the well-being of many affected individuals and, in general, for the well-being of the society as a whole. We still know little about the consequences that experiencing the social devaluation of one's collective identity has, not only for the affected individuals, but also for the whole society in the form, for example, of violent reactions of social groups that feel derogated. To this respect, we want to make a final consideration about the importance that it should be given to develop collective efforts directed to study the negative consequences of social processes that imply the derogation of social groups of any nature, as well as the possible strategies that can be developed to prevent these processes.

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APPENDIX A: MEASURES

Measures Chapter 4

Social Distance

The Social Distance Scale (SDS; Bogardus, 1925), adapted by Stewart, Weeks, & Lupfer (2003)

I would be willing to have a person as the one shown in the picture as my…

1. …good friend
2. …next door neighbor
3. …co-worker
4. …roommate
5. …sibling's spouse
6. …romantic date
7. …family physician
8. …head of the Government
9. …wife or husband
10. …son-in-love

Intergroup Anxiety

The Intergroup Anxiety Scale (Britt, Boniecki, Vescio, Biernat, & Brown, 1996)

1. I would feel nervous if I had to sit alone in a room with a person as the one shown in the photo and start a conversation.
2. I can interact with people as the one shown in the photo without experiencing much anxiety.
3. Although I do not consider myself an intolerant person, I do not know how to present myself around people as the one shown in the photo.

4. My lack of knowledge about the particularities of people as the one shown in the photo prevents me from feeling completely comfortable around people as the one shown in the photo.
5. I would experience no anxiety if I talked to people as the one shown in the photo.
6. If I were at a party, I would have no problem with starting a conversation with a person as the shown in the photo.
7. I just do not know what to expect from people as the one shown in the photo.
8. The tension I would feel with a person as the one shown in the photo would impair the development of a normal interaction.
9. I would experience some anxiety if I were in a place surrounded by people as the one shown in the photo.
10. I would worry about coming across as an intolerant person if I talked to people as the one shown in the photo.

Measures Chapter 5

Quality of Life

The Quality of Life Questionnaire (CCV, Ruiz & Baca, 1993)

1. Do you enjoy your work? (or your studies)
2. Are you satisfied with your performance at work? (or with the results from your studies)
3. Do you feel you have enough free time besides work (or besides studies) to do the rest of the activities that you enjoy in life?
4. Are you satisfied with your work environment? (or the environment of your studies)
5. Do your problems at work prevent you from enjoying your free time? (or your problems at studies)
6. Do you end your working day so tired, that you only want to rest?
7. Do you feel permanently stressed because of your work? (or your studies)
8. Do you currently feel overwhelmed by work? (or by studies)
9. Do you feel healthy?
10. Do you feel you have enough strength for your everyday life?
11. Do you feel you are a failure?
12. Do you feel worried or distressed?
13. Do you have problems that prevent you from sleeping or resting well?
14. Do you suffer from insomnia or have serious sleep problems?
15. Do you feel tired most of the time?
16. Are you currently satisfied with your health?
17. Do you feel that you achieve the goals that you set yourself in life?
18. Does life give you what you expect from it?
19. Do you feel capable of accomplishing your goals in life?

20. Are you satisfied with the quality of the relationships that you have with the people with whom you share your time?
21. Do you feel loved by the people that are important to you?
22. Are you satisfied with the relationship you have with your family?
23. Do you have friends on whom you can count/rely if necessary?
24. Do you have anyone you can turn to when you need the support or the company of others?
25. Are you satisfied with your sexual relationships or, if you do not have sexual relationships, would you like to have them?
26. Do you find people to share your free time or your hobbies with easily?
27. Are you satisfied with the friends you have?
28. Are you satisfied with your social life?
29. Do you have enough time every day to relax and amuse yourself?
30. Are you able (do you have enough time, resources, etc.) to do your hobbies?
31. Do you think you have a pleasant life?
32. Do you think you have an interesting life?
33. Are you satisfied with the life you have?
34. Are you satisfied with your income?
35. Are you satisfied with your personality or with the way you are?

(Please, answer the following questions if you have a partner:)

36. Are you satisfied with your partner?
37. Do you feel physically attracted to your partner?
38. Does your partner satisfy your sexual wishes and necessities?
39. Are you satisfied with your family (partner and/or sons and daughters)?
40. Does your partner also have a physical condition that causes short stature?

41. Does your partner have any physical disability?

Debasement

The *Cumulative Humiliation Subscale* (CHS) from the *Humiliation Inventory* (HI, Hartling & Luchetta, 1999)

Throughout your life how seriously have you felt harmed by being...

1. ...teased?
2. ...bullied?
3. ...scorned?
4. ...excluded?
5. ...laughed at?
6. ...put down?
7. ...ridiculed?
8. ...harassed?
9. ...discounted?
10. ...embarrassed?
11. ...cruelly criticized?
12. ...called names or referred to in derogatory terms?

Social exclusion

(Fernandez, 2008a)

Please assess how often you have experienced the following situations throughout your life:

1. Noticed that people in general see people with dwarfism as a threat to their culture and way of living.
2. Been treated by others without deference and without care for your emotions just because you are a person with dwarfism.

3. Been the target of insults, physical aggression or threats just because you are a person with dwarfism.
4. Been the target of hostility never used against other people.
5. Been made aware that you are a threat.

Ostracism

Fernandez, (2008a)

Throughout your life how often have you felt that you were...

1. ...rejected by other people?
2. ...not considered when others look for someone with whom to relate?
3. ...excluded by others when it comes to participating in social activities?
4. ...ignored by others?
5. ...unequally treated when it comes to establishing social relationships?
6. ...isolated from others?

Positive ingroup contact

1. I usually enjoy being with other people with dwarfism
2. Being in contact with people with dwarfism is beneficial for myself
3. I feel especially comfortable when I am with other people with dwarfism
4. I usually prefer NOT to attend the events that are set up by the organizations of people with dwarfism

Measures Chapter 6

Expected attitude

Please, indicate to what extent you expect that the following adjectives could be applied to describe the attitude of [the target group] toward immigrants.

I expect that the attitude of [target group] toward immigrants will be:

1. Tolerant
2. Racist
3. Generous
4. Biased
5. Equalitarian
6. Supportive

Perceived attitude

Now that you have read the results of the survey describing the attitude of [the target group] toward immigrants, please describe how you think that their attitude toward immigrants is:

I think that the attitude of [target group] toward immigrants is:

1. Tolerant
2. Racist
3. Generous
4. Biased
5. Equalitarian
6. Supportive

Confirming expectancies

1. The expectancies I had about what would be the attitude of the people with dwarfism toward the immigrants have been confirmed

2. I was by the results of this research about the attitude of people with dwarfism towards immigrants

Negative emotions

Learning the attitude that [the target group] has toward immigrants has made me feel:

1. Disappointed
2. In a good mood
3. Sad
4. Cheerful
5. Angry
6. Happy
7. Uncomfortable

Perceived Justice

Adapted from Bauer, Truxiloo, Sanchez, Craig, Ferrera and Campio (2001) and Truxillo and Bauer (1999)

To what extent have you experienced the [target group's] attitude towards immigrants as:

1. Fair
2. Disloyal
3. Respectful
4. Honest
5. Objective

Perceived Empathy

To what extent do you agree or disagree with the following statement:

[The target group]…

1. show compassion towards immigrants that suffer

2. have difficulties to adopt the point of view of immigrants
3. worry about the problems of the immigrants
4. try to imagine how things look like from the immigrant-s point of view
5. worry about the problems the immigrant may have

APPENDIX B: CLUSTER ANALYSIS VERTICAL ICICLE PLOTS

Outcome variables

Intergroup Anxiety

		Case														
		Cereb		Face		Dwarf		Stud		Amput		Parap		Blind		Obese
Number of clusters	1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	2	X	X	X	X	X		X	X	X	X	X	X	X	X	X
	3	X	X	X	X	X		X		X	X	X	X	X	X	X
	4	X		X	X	X		X		X	X	X	X	X	X	X
	5	X		X	X	X		X		X	X	X	X	X		X
	6	X		X		X		X		X	X	X	X	X		X
	7	X		X		X		X		X		X	X	X		X

Social Distance

		Case														
		Cereb		Face		Dwarf		Stud		Parap		Amput		Blind		Obese
Number of clusters	1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	2	X	X	X	X	X		X	X	X	X	X	X	X	X	X
	3	X	X	X	X	X		X		X	X	X	X	X	X	X
	4	X		X	X	X		X		X	X	X	X	X	X	X
	5	X		X	X	X		X		X	X	X	X	X		X
	6	X		X		X		X		X	X	X	X	X		X
	7	X		X		X		X		X	X	X		X		X

Note: Cereb=Cerebral palsy, Face=Face deformity, Dwarf=Dwarfism, Stud=Student, Amput=Amputee, Parap=Paraplegia, Blind=Blindness, Obese=Obesity.

Categorization Task

Categorization as “Weird people”

		Case														
		Cereb		Face		Dwarf		Stud		Parap		Amput		Blind		Obese
Number of clusters	1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	2	X	X	X	X	X		X	X	X	X	X	X	X	X	X
	3	X	X	X	X	X		X		X	X	X	X	X	X	X
	4	X	X	X	X	X		X		X	X	X	X	X		X
	5	X		X	X	X		X		X	X	X	X	X		X
	6	X		X	X	X		X		X		X	X	X		X
	7	X		X	X	X		X		X		X		X		X

Categorization as “Different”

		Case														
		Stud		Face		Cereb		Dwarf		Parap		Amput		Blind		Obes
Number of clusters	1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	2	X		X	X	X	X	X	X	X	X	X	X	X	X	X
	3	X		X	X	X	X	X		X	X	X	X	X	X	X
	4	X		X	X	X	X	X		X	X	X	X	X		X
	5	X		X	X	X	X	X		X	X	X		X		X
	6	X		X		X	X	X		X	X	X		X		X
	7	X		X		X		X		X	X	X		X		X

Categorization as “Normal”

		Case														
		Stud		Cereb		Face		Dwarf		Amput		Parap		Blind		Obese
Number of clusters	1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	2	X		X	X	X	X	X	X	X	X	X	X	X	X	X
	3	X		X	X	X	X	X		X	X	X	X	X	X	X
	4	X		X		X	X	X		X	X	X	X	X	X	X
	5	X		X		X	X	X		X	X	X	X	X		X
	6	X		X		X		X		X	X	X	X	X		X
	7	X		X		X		X		X		X	X	X		X

Note: Cereb=Cerebral palsy, Face=Facial deformity, Dwarf=Dwarfism, Stud=Student, Amput=Amputee, Parap=Paraplegia, Blind=Blindness, Obese=Obesity.