



Self-regulatory processes underlying structural stigma and health



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ABSTRACT

In this article, we examine self-regulatory processes that are initiated by structural stigma. To date, the literature on self-regulation as a mechanism that underlies stigma and health outcomes has focused primarily on harmful health-related behaviors that are associated with perceived discrimination. Numerous studies find that when people experience discrimination, they are more likely to engage in behaviors that pose risks for health, such as overeating and substance use. However, a large body of literature also finds that low power – which is also a chronic, though often more subtle, experience for stigmatized groups – is associated with a heightened activation of inhibitory processes. This inhibition system has wide-ranging influences on cognition, behavior, and affect. We provide an overview of these two literatures, examine synergies, and propose potential implications for measurement and research design.

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Introduction

When people experience low status through social exclusion, discrimination, ostracism, or other related processes, they are less able to maintain attention, resist temptation, and persist at difficult tasks. These varied responses have collectively been described as failures to self-regulate, which has been defined as the capacity to control or alter one's responses (Baumeister, DeWall, Ciarocco, & Twenge, 2005; Twenge, Catanese, & Baumeister, 2002), or disinhibition.

Despite numerous empirical studies finding that status threats are related to a reduced capacity to self-regulate, the scope of this research is narrowly focused. Several large-scale survey studies report associations between status threats and certain health behaviors (see Pascoe & Richman, 2009 for a review), but empirical findings on causal relationships are limited. The extant experimental research is primarily lab-based with non-stigmatized participants whose behavioral responses are measured after relatively mild and temporary status threats. For example, after being socially excluded, people perform worse on an assortment of self-regulation tasks (such as resisting unhealthy snack food and persisting on a frustrating puzzle) and pursue pleasurable activities despite the unfavorable long-term consequences (Baumeister et al., 2005). People are also more likely to procrastinate and engage in

other self-defeating behaviors after being excluded (Baumeister, Twenge, & Nuss, 2002; Twenge et al., 2002).

We propose that the empirical findings from the power literature can inform a broader understanding of how structural as well as interpersonal stigma affects health. The essential role of power in the stigmatization process has been a basic tenet of the stigma literature. Link and Phelan (2001) in their foundational *Conceptualizing Stigma* paper emphasized how power—social, economic, and political—is a critical ingredient in the production and enactment of stigma. They also noted that the degree of stigmatization that people experience will be profoundly shaped by the relative power of the stigmatized and the stigmatizer. Yet, power has been given little attention in the health disparities literature; individual's perceptions of social power are often not incorporated in analyses exploring disparities in health between advantaged and disadvantaged groups.

One particularly relevant theoretical perspective involves low power and the behavioral inhibition system. Several studies demonstrate that, when people feel relatively powerless, the behavioral inhibition system (BIS) is activated. The BIS has been likened to an alarm system that, once activated by threats or potential punishments, triggers heightened vigilance for threats, avoidance, action suppression, and negative affect (Anderson & Berdahl, 2002; Carver & White, 1994). In contrast, when people feel powerful, the behavioral approach system (BAS) is activated. This motivational system regulates behavior associated with rewards, and corresponds with seeking opportunities and engaging in behaviors that are related to reward outcomes such as safety, social attachment, and achievement. This “approach-inhibition” theory of power (Keltner, Gruenfeld, & Anderson, 2003) has

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generated a large body of empirical findings that substantiate and elaborate the original theory.

A full understanding of the ways structural stigma affects health behavior requires attention to the links between stigma and power, and the potential implications for inhibition and basic cognitive, behavioral, and affective processes. Previous work on health and stigma has primarily focused on discrimination and status, whereas a consideration of power highlights that stigma affects an individual's ability to attain desired outcomes, with consequences for health behavior. In addition, perceptions of low power may occur outside experiences of social exclusion or discrimination and may occur in more subtle, yet consistent and pervasive ways.

Studies have examined how power activation operates at an implicit level by varying such things as posture, gestures, clothing, and vertical positioning among non-stigmatized groups. Certain postures, for example, are associated with different levels of power. A comprehensive meta-analysis of nonverbal displays of power and other hierarchical processes showed that people associated this dimension of “verticality” with more bodily openness, smaller interpersonal distances, and certain features of speech such as heightened expressiveness, volume, and variability (Hall, Coats, & LeBeau, 2005). Given these assumptions that people hold about nonverbal displays of power, even posing in such postures for short periods of time reliably produces nonconscious internalization of different levels of power. In one study, posing for one minute in either a low-power posture, which was created by a contractive posture with arms and legs crossed, versus a high-power expansive posture with open arms and uncrossed legs, was causally related to neuroendocrine responses (Carney, Cuddy, & Yap, 2010). Similarly, Schubert and Koole (2009) found that making a fist led men to adopt more powerful self-concepts. Clothing, such as wearing a doctor's coat (Adam & Galinsky, 2012), and vertical position (Schubert, 2005) have also been used to nonconsciously activate power in an interaction.

More frequently, empirical studies use explicit manipulations of power imbalances. For example, researchers may vary people's experiences of power by role assignments such as acting as either the boss (or other type of leadership role) or employee (or the follower or non-decision maker) on a joint task. In this way, participants may temporarily have the experience of high or low power.

These experimental studies demonstrate the relatively mild ways in which power has been manipulated in the lab. For the most part, they mirror the ubiquitous experiences that people encounter from time to time. We may sometimes be the one who makes decisions or otherwise exerts power, and other times, we respond to decisions or commands made by someone else. For stigmatized groups, however, experiences of relative powerlessness occur frequently and across multiple contexts and are not balanced or somehow offset by high power experiences. Although these effects occur at the interpersonal level, as when interacting with a potential employer or during encounters with the medical system, restrictive laws and policies directed at stigmatized groups (e.g., same sex marriage laws) can also signal low power even in the absence of interpersonal interactions. As we will describe, chronic experiences of low power predict a heightened activation of inhibition-related processes that influence cognition, behavior, and affect and have important implications for downstream health effects.

Power and status

The terms power and status are often used synonymously, but distinctions between the terms have implications for our proposed framework. Power has most frequently been conceptualized as

social influence stemming from asymmetrical control over valued resources that are physical (i.e., food and safety), economic (i.e., money and employment opportunities), or social (i.e., acceptance and support; Fiske, 1993, 2010). This conceptualization emphasizes that power is a social construct that emerges in interpersonal interaction and is exercised primarily via direct interpersonal influence. This definition does not map on well to many indirect forms of power relevant to intergroup relations such as institutional racism. Thus, we favor a definition of power suggested by Vescio and Guinote (2010) who conceptualized it as a force that emerges as one seeks desired outcomes in light of the social and nonsocial opportunities and constraints in the environment. By use of this definition, power dynamics can be understood as operating at the structural level, through governmental policies directed at disadvantaged groups. For example, state level bans on same sex marriage (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010), and imposed limitations on voting privileges for individuals diagnosed with a mental illness (Corrigan, Markowitz, & Watson, 2004). Also, power can be considered at the interpersonal level as with apparent power imbalances when a boss and employee or doctor and patient interact.

Alternatively, status is the term most commonly used in reference to stigma and is defined as the social value of a person or group (Fiske, 2010). By virtue of their position in a social hierarchy, members of marginalized groups such as the uneducated, poor, or overweight have lower status than their more educated, wealthy, thin, or otherwise better socially situated counterparts. Status dynamics also play out in the interpersonal relations among people. The belief that others hold about whether someone possesses resources and/or personal characteristics that are important for the achievement of collective goals also influences perceptions of status (see Leary, Jongman-Sereno, & Diebels, 2014). Members of stigmatized groups are unlikely to be viewed as contributors to these goals (Kurzman & Leary, 2001). Structural and interpersonal stigma, combining experiences of both a diminished control over resources and a devalued social identity, are defined by both low power and low status (also see Phelan, Lucas, Ridgeway, & Taylor, 2014).

Inhibitory-related processes and implications for disinhibition

Structural stigma creates environments that have increased threat, punishment, lack of resources, and other social constraints. Such environments should dispose people to elevated activity of processes that are related to the inhibition system. In this section, we review evidence that these experiences of low power promote a more active inhibition system. For each of the outcomes—cognition, behavior, and affect—we draw connections with possible health implications. We also emphasize connections between the power and stigma literature, focusing in particular on the interaction of inhibitory and disinhibitory tendencies that occur in response to low power and low status among stigmatized groups.

Attention and information processing

People attend to and process information differently depending on their level of power in an interaction. Attention strategies and goals are in part determined by asymmetrical outcome dependence—the extent one person or group must rely on another to achieve desired outcomes (see Russell & Fiske, 2010, for review). The powerless, whose outcomes can be greatly affected by the decisions and actions of those in power, are especially attuned to the powerful and are likely to engage in effortful, deliberate, and accuracy-oriented impression formation processes (Russell & Fiske,

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