TESIS DOCTORAL

# EL ESTIGMA SOCIAL DEL ENANISMO ÓSEO

## CONSECUENCIAS Y ESTRATEGIAS DE AFRONTAMIENTO

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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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Many persons with a skeletal dysplasia that causes dwarfism participated in this research. I am particularly thankful to the nineteen persons with dwarfism who took part in the preliminary qualitative research. These persons, whose names I do not list to protect anonymity, took part in intensive interviews and were willing to share intimate and personal experiences, some of which were surely not very pleasant to recall. I am also grateful to the more than 220 anonymous persons with dwarfism from Spain and the United States of America that answered the on-line battery of questionnaires designed for this research.

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# TABLE OF CONTENTS

# LIST OF TABLES AND FIGURES

## LIST OF TABLES

*Tables* *page*

*Chapter 2*

*Chapter 4*

*Chapter 5*

# LIST OF FIGURES

# 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).

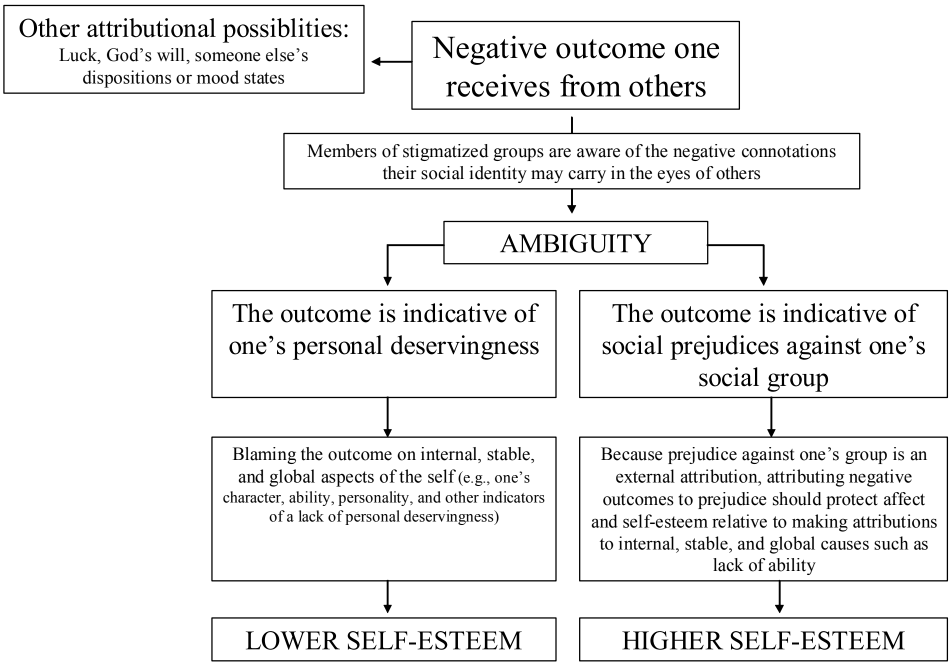

*Figure 2.1.* The attributional ambiguity model.

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 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.

# REFERENCES LIST

Adelson, B.M. (2005). *Dwarfism*: *Medical and psychosocial aspects of profound short stature.* Baltimore, MD: Johns Hopkins University Press.

Aldegheri, R., & Dall'Oca, C. (2001). Limb lengthening in short stature patients. *Journal of Pediatric Orthopedics, 10*, 238-247.

Alonso-Álvarez, C. (2007). *A new horizon. Guide to Achondroplasia. (Un nuevo horizonte. Guía de la acondroplasia).* Madrid: The Royal Board on Disability (Real Patronato Sobre Discapacidad).

Apajasalo, M., Sintonen, H., Rautonen, J., & Katilda, I. (1998). Health-related quality of life of patients with skeletal dysplasias. *European Journal of Pediatrics, 157*, 114-121.

Badia, X., Salamero, M., Alonso, J., & Olle, A. (1996). *La medida de la salud. Guía de escalas de medición en español.* Barcelona: PPU, S.A.

Baitner, A.C., Maurer, S.G., Gruen, M.B., & Di Cesare, P.E. (2000). The genetic basis of osteochondrodysplasias. *Journal of Pediatric Ortopedics*, *20,* 594-605.

Barchard, K.A., & Williams, J. (2008). Practical advice for conducting ethical online experiments and questionnaires for United States psychologists. *Behavior Research Methods*, *40*, 1111-1128.

Baumeister, R.F., DeWall, C.N., Ciarocco, N.J., & Twenge, J.M. (2005). Social exclusion impairs self-regulation. *Journal of Personality and Social Psychology, 88*, 589-604.

Baumeister, R.F., & Leary, M.R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, *117*, 497-529.

Baumeister, R.F., Twenge, J.M., & Nuss, C.K. (2002). Effects of social exclusion on cognitive processes: Anticipated aloneness reduces intelligent thought. *Journal of Personality and Social Psychology, 83*, 817-827.

Bierbrauer, G. (2000). Social justice and political ideology in an immigrant country. In T. Baums, K.J. Hopt, & N. Horn (Eds.), *Corporations, capital market and business in law* (pp. 89-99). London: Kluwer Law International.

Blascovich, J., Mendes, W.B., Hunter, S.B., & Lickel, B. (2000). Stigma, threat, and social interactions. In T. Baums, K.J. Hopt, & N. Horn (Eds.), *Corporations, capital market and business in law* (pp. 307-333). London: Kluwer Law International.

Bogardus, E. S. (1925). Measuring social distances. *Journal of Applied Sociology, 9,* 299-308.

Bouza, F., & Betran, J.L. (2005). *Enanos, bufones, mosntrous, brujos y hechiceros.* Barcelona: Random House Mondadori.

Bowen, A.M., Daniel, C.M., Williams, M.L., & Baird, G.L. (2008). Identifying multiple submissions in Internet research: Preserving data integrity. *AIDS and Behavior*, *12*, 964-973.

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

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

Brinkmann, G., Schlitt, H., Zorowka, P., & Spranger, J. (1993). Cognitive skills in achondroplasia. *American Journal of Medical Genetics*, *47*, 800-804.

Britt, T.W., Boniecki, K.A., Vescio, T.K., Biernat, M., & Brown, L.M. (1996). Intergroup anxiety: A person x situation approach. *Personality and Social Psychology Bulletin, 22*, 1177-1188.

Brown, T.A. (2006). *Confirmatory factor analysis for applied research*. New York: Guilford Press.

Cheung, G.W., & Rensvold, R.B. (2002). Evaluating goodness-of-fit indexes for testing measurement invariance. *Structural Equation Modeling, 9*, 233-255.

Clark, R.N. (1990). Congenital dysplasias and dwarfism. *Pediatrics in Review*, *12*, 149-159.

Climent, C., Lorda-Sánchez, I., Urioste, M., Gairi, J.M., Rodríguez, J.I., & Rubio, V. (1998). Achondroplasia: molecular study of 28 patients. *Medicina Clinica*, *110*, 492-494.

Correia, I., Vala, J., Aguiar, P. (2001). The effects of belief in a just world and victim's innocence on secondary victimization, judgements of justice and deservingness. *Social Justice Research, 14,* 327-342.

Correll, J., & Held, P. (2000). Limb lengthening in dwarfism. (Die Gliedmassenverlängerung beim Kleinwuchs). *Der Orthopäde*, *29*, 787-794.

Crocker, J. (1999). Social stigma and self-esteem: situational construction of self worth. *Journal of Experimental Social Psychology, 35*, 89-107.

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

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In S. Fiske, D. Gilbert, & G. Lindzey (Eds.), *Handbook of social psychology, Vol. 2* (pp. 504-553). Boston, MA: McGraw-Hill.

Dakof, G. A., & Taylor, S. E. (1990). Victims' perceptions of social support: What is helpful from whom? *Journal of Personality and Social Psychology, 58*, 80-89.

De Solà-Morales, O. & Pons, J.M.V. (2003). *Evaluación de la necesidad clínica y de los criterios estructurales, técnicos y humanos de un centro de referencia para la atención de las personas con acondroplasia.* Barcelona: Agència d'Avaluació de Tecnologia i Recerca Mèdiques.

Dodd, H.E., Giuliano, T.A., Boutell, J.M., & Moran, B.E. (2001). Respected or rejected: Perceptions of women who confront sexist remarks. *Sex Roles, 14,* 637-646.

Dovidio, J.F., Major, B. & Crocker, J. (2000). Stigma: Introduction and overview. In T.F. Heatherton, R.E. Kleck, M.R. Hebl, & J.G. Hull (Eds.), *The social psychology of stigma* (pp. 1-28). New York, NY: The Guilford Press.

Downey, G., Mougios, V., Ayduk, O., London, B.E., & Shoda, Y. (2004). Rejection sensitivity and the defensive motivational system: Insights from the startle response to rejection cues. *Psychological Science*, *15*, 668–673.

Ellemers, N., Van Knippenberg, A., & Wilke, H. (1990). The influence of permeability of group boundaries and stability of group status on strategies of individual mobility and social change. *British Journal of Social Psychology, 29*, 233-246

Evans, D.C., Garcia, D.J., Garcia, D.M., & Baron, R.S. (2003). In the privacy of their own homes: Using the Internet to assess racial bias. *Personality and Social Psychology Bulletin*, *29*, 273-284.

Everitt, B.E. (1993). *Cluster analysis.* London: Edward Arnold.

Feldman, S.D. (1975). The presentation of shortness in everyday life –height and heightism in American society: Towards sociology of stature. In S.D. Feldman, & G.W. Thielbar (Eds.), *Lifestyles and diversity in American society* (pp. 437-444). Boston, MA: Little Brown & Co.

Fernández, S. (2005). *Mi in-dignidad en tus manos. Otra mirada a la exclusión social desde la experiencia de las personas con acondroplasia.* Gijón: Fundación ALPE-Acondroplasia.

Fernández, S. (2008a). Perceiving oneself as a victim of discrimination and social prejudice: The case of people with achondroplasia ("Percibirse víctima de discriminación y prejuicio social: el caso de las personas con acondroplasia"). In J.F. Morales, C. Huici, A. Gómez, & E. Gaviria (Eds.), *Método, teoría e investigación en psicología social* (pp. 417-428). Madrid: Pearson Educación.

Fernández, S. (2008b). *La experiencia del estigma del enanismo óseo en primera persona: Implicaciones para la adaptación psicosocial y el bienestar psicológico. (The experience of the social stigma associated to dwarfism: Implications for the psychosocial adaptation and for the psychological well-being).* Madrid, Spain: Department of Social and Organization Psychology, UNED.

Ferrans, C.E. (1996). Development of a conceptual model of quality of life. *Scholarly Inquiry for Nursing Practice, 10*, 293-304.

Ferrans, C.E., & Powers, M.J. (1985). Quality of life index: Development and psychometric properties. *Advances in Nursing Science, 8*, 15-24.

Garcia, D.M., Horstman, R.A., Amo, R.B., Redersdorff, S., & Branscombe, N.R. (2005). Perceivers' responses to in-group and out-group members who blame a negative outcome on discrimination. *Personality and Social Psychology Bulletin, 31,* 769-780.

Ginebreda, I., Marlet, V., Cavalieri, P., & Vilarrubias, J.M. (1992). Surgical lengthening of extremities in pathological short height ("Alargamientos quirúrgicos de las extremidades en la talla baja patológica"). *Revista Española de Cirugía Osteoarticular, 27*, 215-223.

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

Gollust, S.E., Thompson, R.E., Gooding, H.C., & Biesecker, B.B. (2003). Living with achondroplasia in an average-sized world: An assessment of quality of life. *American Journal of Medical Genetics*, *120*, 447-458.

Hartling, L.M., & Luchetta, T. (1999). Humiliation: Assessing the impact of derision, degradation, and debasement. *The Journal of Primary Prevention, 19,* 259-278.

Heatherton, T.F., Kleck, R.E., Hebl, M.R. & Hull, J.G. (2000). *The Social Psychology of Stigma.* New York, NY: The Guilford Press.

Horton, W.A., Hall, J.G., & Hecht, J.T. (2007). Achondroplasia. *Lancet*, *370*, 162-172.

Hunter, A.G., Bankier, A., Rogers, J.G., Sillence, D., & Scott, C.I. (1998). Medical complications of achondroplasia: A multi-center patient review. *Journal of Medical Genetics, 35*, 705-712.

Jackson, L.A., & Ervin, K.S. (1991). Height stereotypes of women and men: The liabilities of shortness for both sexes. *The Journal of Social Psychology, 132,* 433-445.

Jetten, J., Branscombe, N.R., Schmitt, M.T., & Spears, R. (2001). Rebels with a cause: Group identification as a response to perceived discrimination from the mainstream. *Personality and Social Psychology Bulletin*, *27*, 1204-1213.

Jetten, J., Branscombe, N.R., & Spears, R. (2006). Living on the edge: dynamics of intragroup and intergroup rejection experiences. In R. Brown, & D. Capozza (Eds.), *Social identities: Motivational, emotional and cultural influences*, (pp. 91-107). London: Sage.

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

Jost, J.T., & Banaji, M.R. (1994). The role of stereotyping in system-justification and the protection of false consciousness. *British Journal of Social Psychology, 33,* 1-27.

Katz, I. (1981). *Stigma: a social psychological analysis*. Hillsdale, NJ: Erlbaum.

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

Kaufman, L., & Rousseeuw, P.J. (1990). *Finding groups in data: An introduction to cluster analysis.* New York, NY: Wiley-Interscience Publications.

Kelloway, E.K. (1998). *Using lisrel for structural Equation modeling.* Thousand Oaks, CA: Sage Publications.

Kline, R.B. (2005). *Principles and practice of structural equation modeling*. New York, NY: Guilford Press.

Kraut, R., Olson, J., Banaji, M., Bruckman, A., Cohen, J., & Couper, M. (2008). Psychological research online: Report of board of scientific affairs' Advisory group on the conduct of research on the Internet. In D.N. Bersoff (Ed.), *Ethical conflicts in psychology* (4th ed., pp. 426-433). Washington, DC: American Psychological Association.

Lindner, E. (2006). *Making enemies. Humiliation and international conflict.* Westport, CT: Praeger Security International.

Little, T.D. (1997). Mean and covariance structures (MACS) analyses of cross-cultural data: Practical and theoretical issues. *Multivariate Behavioral Research, 32*, 53-76.

Leary, M.R. (2001). Toward a conceptualization of interpersonal rejection. In M.R. Leary (Ed.), *Interpersonal rejection* (pp. 3-20). New York, NY: Oxford University Press.

Leary, M.R. (2005). Varieties of interpersonal rejection. In K.D. Williams, J.P. Forgas, & W. von Hippel (Eds.), *The social outcast. Ostracism, social exclusion, rejection, and bullying* (pp. 35-51). New York, NY: Psychology Press.

Lehman, D.R., Wortman, C.B., & Williams, A.F. (1987). Long-term effects of losing a spouse or child in a motor vehicle crash. *Journal of Personality and Social Psychology, 52,* 218-231.

Lerner, M.J. (1980). *The belief in a just world: A fundamental delusion.* New York, NY: Plenum Press.

Luhtanen, R., & Crocker, J. (1992). A collective self-esteem scale: Self-evaluation of one's social identity. *Personality and Social Psychology Bulletin*, *18*, 302-318.

Lynn, M., &. Snyder, C. R. (2002). Uniqueness seeking. In C. R. Snyder, & S. J. Lopez (Eds.), *Handbook of positive* psychology (pp. 395-410). New York, NY: Oxford.

Magallares, A. (2009). *La salud psicológica de los obesos ante situaciones de discriminación por el peso.* Unpublished doctoral dissertation, UNED-University, Madrid, Spain.

Mahomed, N.N., Spellmann, M., & Goldberg, M.J. (1998). Functional health of adults with achondroplasia. *American Journal of Medical Genetics, 78*, 30-35.

Major, G., & Eccleston, C.P. (2005). Stigma and social exclusion. In D. Abrams, M.A. Hogg, & J.M. Marques (Eds.), *The social psychology of inclusion and exclusion* (pp. 63-87). New York, NY: Psychology Press.

Major, B., Quinton, W.J. & McCoy, S.K. (2002). Antecedents and consequences of attributions to discrimination: Theoretical and empirical advances. In M.P.

Zanna (Ed.), *Advances in experimental social psychology*, *Vol. 34* (pp. 251-330). San Diego, CA: Academic Press.

Major, B., & O'Brien, L.T. (2005). The social psychology of stigma. *Annual Review of Psychology*, *56*, 393-421.

Margalit, A. (1996). *The decent society.* Cambridge, MA: Harvard University Press.

Marichal, F. & Quiles, M.N. La organización del estigma en categorías: actualización de la taxonomía de Goffman (The organization of the stigma in categories: actualization Goffman´s taxonomical). *Psicothema, 12,* 458-465.

Miller, P.S. (1987). Coming up short: Employment discrimination against little people. *Harvard Civil Rights—Civil Liberties Law Review*, *22*, 231-271.

Morales, J.F. (2003). El estudio de la exclusión social en la psicología social (The study of social exclusion in social psychology). In J.F. Morales, & C. Huici (Eds.), *Estudios de psicología social* (pp. 509-538). Madrid: UNED.

Muller, D., Judd, C., & Yzerbyt, V. (2005). When moderation is mediated and mediation is moderated. *Journal of Personality and Social Psychology*, *89*, 852-863.

Nicoletti, B., Kopits, S., Ascani, E., & McKusick, V.A. (1989). *Human achondroplasia*: *A multidisciplinary approach.* New York, NY: Plenum Press.

Oakes, P. J., Haslam, S. A., & Turner, J. C. (1994). *Stereotyping and social reality.* Oxford: Blackwell.

Opotow, S. (1990). Moral exclusion and injustice: An introduction. *Journal of Social Issues, 46,* 1-20.

Park, J. H., Faulkner, J., & Schaller, M. (2003). Evolved disease-avoidance processes and contemporary anti-social behaviour: Prejudicial attitudes and avoidance of people with disabilities. *Journal of Nonverbal Behavior*, *27*, 65-87.

Pequegnat, W., Rosser, B., Bowen, A., DiClemente, R., Elford, J., Gurak, L., et al. (2007). Conducting Internet-based HIV/STD prevention survey research: Considerations in design and evaluation. *AIDS and Behavior*, *11*, 505-521.

Preacher, K., & Hayes, A. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods*, *40*, 879-891.

Preacher, K., & Hayes, A. (2004). SPSS and SAS procedures for estimating indirect effects in simple mediation models. *Behavior Research Methods, Instruments & Computers*, *36*, 717-731.

Preacher, K., Rucker, D., & Hayes, A. (2007). Addressing moderated mediation hypotheses: Theory, methods, and prescriptions. *Multivariate Behavioral Research*, *42*, 185-227.

Rindskopf, F. (1984). Using phantom and imaginary latent variables to parameterize constraints in linear structural models. *Psychometrika, 49,* 37-47.

Rogers, J.G., Perry, M.A., & Rosenberg, L.A. (1979). IQ measurement in children with skeletal dysplasia. *Pediatrics*, *63*, 894-897.

Rosenberg, M. (1965). *Society and the adolescent selfimage.* Princenton, NJ: Princenton University Press.

Ruiz, M.A., & Baca. E. (1993). Design and validation of the 'Quality of Life Questionnaire' ('Cuestionario de Calidad de Vida', CCV): A generic health-related perceived quality of life instrument. *European Journal of Psychological Assessment*, *9*, 19-32.

Schaller, M., Park, J.H., & Faulkner, J. (2003). Prehistoric dangers and contemporary prejudices. *European Review of Social Psychology*, *14*, 105-137.

Schmitt, M.T., & Branscombe, N.R. (2002). The internal and external causal loci of attributions to prejudice. *Personality and Social Psychology Bulletin,* 28, 620-628.

Schmitt, M.T., & Branscombe, N.R. (2002). The meaning and consequences of perceived discrimination in disadvantaged and privileged social groups. In W. Stroebe, & M. Hewstone (Eds.), *European review of social psychology*, *Vol. 12* (pp. 167-199). Chichester, UK: Wiley.

Schmitt, M.T., Branscombe, N.R., Kobrynowicz, D., & Owen, S. (2002). Perceiving discrimination against one's gender group has different implications for well-being in women and men. *Personality and Social Psychology Bulletin, 28,* 197-210.

Schmitt, M.T., Branscombe, N.R., & Postmes, T. (2003). Women's emotional responses to the pervasiveness of gender discrimination. *European Journal of Social Psychology, 33,* 297-312.

Schmitt, M.T., Spears, R., & Branscombe, N.R. (2003). Constructing a minority group identity out of shared rejection: The case of international students. *European Journal of Social Psychology, 33,* 1-12.

Sherif, M., & Sherif, C.W. (1953). *Groups in harmony and tension.* New York, NY: Harper & Row.

Silván-Ferrero, M.P., & Huici, C. (2006). Attitudes toward disability: Emotional ambivalence, anxiety and interference in the social interaction. (Actitudes hacia la discapacidad: ambivalencia afectiva, ansiedad e interferencia en la interacción). Unpublished doctoral dissertation, UNED-University, Madrid, Spain.

Simon, B. (2004). *Identity in modern society. A social psychological perspective.* Oxford: Blackwell.

Snyder, C.R., & Fromkin, H.L. (1980). *Uniqueness*: *The human pursuit of difference.* New York, NY: Plenum.

Solomon, S., Greenberg, J., & Pyszczynski, T. (1991). A terror management theory of social behavior: The psychological functions of self-esteem and cultural worldviews. In M.P. Zanna (Ed.), *Advances in experimental social psychology*, *Vol. 24* (pp. 93-159). San Diego, CA: Academic Press.

Swim, J.K., & Stangor, C. (Eds.). (1998). *Prejudice: The target's perspective.* San Diego, CA: Academic Press.

Stangor, C., & Crandall, C.S. (2000). Threat and the social construction of stigma. In T.F. Heatherton, R.E. Kleck, M.R. Hebl, & J.G. Hull (Eds.), *The social psychology of stigma* (pp. 62-87). New York, NY: The Guilford Press.

Stangor, C., Swim, J.K., Sechrist, G.B., DeCoster, J., Van Allen, K.I., & Ottenbreit, A., (2003). Ask, answer, and announce: Three stages in perceiving and responding to discrimination. *European Review of Social Psychology, 14*, 277-311.

Staub, E. (2003). *The psychology of good and evil: Why children, adults and groups help and harm others.* New York, NY: Cambridge University Press.

Staub, E. (2005). The roots of goodness: The fulfillment of basic human needs and the development of caring, helping and nonaggression, inclusive caring, moral courage, active bystandership, and altruism born of suffering. *Moral motivation through the life span* (pp. 33-72). Lincoln, NE US: University of Nebraska Press.

Staub, E., & Vollhardt, J. (2008). Altruism born of suffering: The roots of caring and helping after victimization and other trauma. *American Journal of Orthopsychiatry*, *78*, 267-280.

Stephan, W.G., & Stephan, C.W. (1985). Intergroup anxiety. *Journal of Social Issues, 41*, 157-175.

Stewart, T.L., Weeks, M., & Lupfer, M.B. (2003). Spontaneous stereotyping: A matter of prejudice? *Social Cognition, 21,* 263-298

Stoll, C., Dott, B., Roth, M.P., Alembik, Y. (1989). Birth prevalence rates of skeletal dysplasias. *Clinical Genetics*, *35*, 88-92.

Sue, D.W., Capodilupo, C. M., Torino, G.C., Bucceri, J.M., Holder, A.M., Nadal, K.L., et al. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*, 271-286.

Tajfel, H. (1978). *Differentiation between social groups.* London: Academic Press.

Tajfel, H., & Turner, J.C. (1986). The social identity theory of intergroup behavior. In S. Worchel, & W. Austin (Eds.), *Psychology of intergroup relations* (pp. 7-24). Chicago, IL: Nelson-Hall.

Tajfel, H., & Turner J.C. (1979). An integrative theory of intergroup conflict. In W.G. Austin, & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33-48). Monterey, CA: Brooks/Cole.

Taylor, D.M., & McKirman, D.J. (1984). A five-stage model of intergroup relations. *British Journal of Social Psychology, 23*, 291-300.

Taylor, S.E., Wood, J.V., & Lichtman, R.R. (1983). It could be worse: Selective evaluation as a response to victimization. *Journal of Social Issues, 39,* 19-40.

Thompson, N.M., Hecht, J.T., Bohan, T.P., Kramer, L.A., Davidson, K., Brandt, M.E., & Flechter, J.M. (1999). Neuroanatomic and neuropsychological outcome in school-age children with achondroplasia. *American Journal of Medical Genetics*, *88*, 145-153.

Thompson, S., Shakespeare, T., & Wright, M.J. (2008). Medical and social aspects of the life course for adults with a skeletal dysplasia: A review of current knowledge. *Disability and Rehabilitation*, *30*, 1-12.

Todorov, A.B., Scott, C.I., Warren, A.E., & Leeper, J.D. (1981). Developmental screening tests in achondroplastic children. *American Journal of Medical Genetics*, *9*, 19-23.

Treynor, W., Gonzalez, R., & Nolen-Hoeksema, S. (2003). Rumination reconsidered: A psychometric analysis. *Cognitive Therapy and Research, 27*, 247-259.

Trotter, T.L., & Hall, J.G. (2005). Health supervision for children with achondroplasia. *Pediatrics*, *116*, 774-783.

Truxillo, D., & Bauer, T. (1999). Applicant reactions to test scores banding in entry-level and promotional contexts. *Journal of Applied Psychology*, *84*, 322-339.

Truxillo, D., Bauer, T., & Sanchez, R. (2001). Multiple dimensions of procedural justice: Longitudinal effects on selection system fairness and test-taking self-efficacy. *International Journal of Selection and Assessment*, *9*, 336-349.

Turner, J.C., Hogg, M.A., Oakes, P.J., Reicher, S.D., & Wetherell, M.S. (1987). *Rediscovering the social group: A self-categorization theory.* Oxford: Blackwell.

Twenge, J.M., Baumeister, R.J., DeWall, C.N., Ciarocco, N.J., & Bartels, J.M. (2007). Social exclusion decreases prosocial behavior. *Journal of Personality and Social Psychology*, *92*, 56-66.

Twenge, J.M., Baumeister, R.F., Tice, D.M., & Stucke, T.S. (2001). If you can’t join them, beat them: Effects of social exclusion on aggressive behaviour. *Journal of Personality and Social Psychology, 81*, 1058-1069.

Twenge, J.M., Catanese, K.R., & Baumeister, R.F. (2002). Social exclusion causes self-defeating behaviour. *Journal of Personality and Social Psychology, 83*, 606-615.

Twenge, J.M., Catanese, K.R., & Baumesiter, R.F. (2003). Social exclusion and the deconstructed state: Time perception, meaninglessness, lethargy, lack of emotion, and self-awareness. *Journal of Personality and Social Psychology, 85,* 409-423.

Waller, D.K., Correa, A., Tuan, M.Vo., Wang, Y., Hobbs, C., Langlois, P.H., Pearson, K., Romitti, P.A., Shaw, G.M., & Hecht, J.T. (2008). The population-based prevalence of achondroplasia and thanatophoric dysplasia in selected regions of the US. *American Journal of Medical Genetics*, *146*, 2385-2389.

Ward, A., Lyubomirsky, S., Sousa, L., & Nolen-Hoeksema, S (2003). Can't quite commit: Rumination and uncertainty. *Personality and Social Psychology Bulletin*, *29*, 96-107.

Warner, R.H., & Branscombe, N. (2009). *Benefit finding in victimization: Consequences for the perceived moral obligations of victims.* Manuscript submitted for publication.

Wheeler, P., Balk, E., & Cole, C. (2003). *Criteria for determining disability in infants and children: Short stature.* Rockville, MD: Agency for Healthcare Research and Quality.

Williams, K.D. (2001). *Ostracism: The power of silence.* New York, NY: Guilford Press.

Williams, K.D. (2007). Ostracism. *Annual Review of Psychology*, *58*, 425– 452.

Williams, K.D., Forgas, J.P, & von Hippel, W. (2005). *The social outcast. Ostracism, social exclusion, rejection, and bullying.* New York, NY: Psychology Press.

Williams, K.D., & Sommer, K.L. (1997). Social ostracism by one’s coworkers: Does rejection lead to loafing or compensation? *Personality and Social Psychology Bulletin*, 23, 693-706.

Wood, J.V., Taylor, S.E., & Lichtman, R.R. (1985). Social comparison in adjustment to breast cancer. *Journal of Personality and Social Psychology, 49,* 1169-1183.

# 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

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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

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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.