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The Hidden Costs of Hidden Stigma

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Given the choice, most of us would probably prefer that our stigmas were secret. The various social albatrosses we all carry with us would seem to be less weighty and might even fly away, perhaps, if no one else could see them. Social stigmas seem particularly likely to induce discrimination, maltreatment, and ostracism, after all—not to mention personal embarrassment and shame—when they are immediately perceptible to everyone. The ability to hide stigmas in a closet would seem to be a fine option, if we had that choice.

For some people, such a choice is available. As Goffman (1963) observed, people with stigmas that are not clearly visible to others—what we refer to as "concealable stigmas"—have the option of not telling. They can deliberately try to "pass" as "normal," unstigmatized individuals. In this way, it may be possible to exert some control over the prejudiced impressions that others may have. Under some circumstances, concealing one's stigma may be not only advantageous, but crucial to the ability to participate in social life. There are many kinds of stigmas, such as being gay or having certain mental or physical illnesses, for which concealment can prevent devastating personal consequences—including social rejection, loss of job, and even persecution (see Herek, 1996).

Even a concealable stigma can be costly, though, as aptly documented by Goffman (1963). In his book *Stigma: Notes on the Management of Spoiled Identity,* he described how people encounter psychological strain in the process of concealing their true identity. Through several examples, he illustrated how attempts to pass may lead to feelings of isolation, fraud, and fear of discovery. These difficulties may be compounded by the reactions of interaction partners, who may become suspicious of a relative lack of disclosure (Herek, 1996). Withholding personal information about oneself from others can impede the development and maintenance of social relationships, insofar as self-disclosure is considered one of the essential ingredients to having meaningful relationships (Derlega & Berg, 1987). There is more than this, however. Concealing a stigma leads to an inner turmoil that is remarkable for its intensity and its capacity for absorbing an individual's mental life.

A telling example of this struggle with a concealable stigma is offered by the former Olympic diver Greg Louganis. In a 1996 autobiography, *Breaking the Surface,* he describes the torment that he experienced in hiding both his homosexuality and his status as an HIV-positive person. A turning point occurred in the 1988 Olympics in Seoul, Korea, when he struck his head on the diving board during one of his dives. As he bled into the water and as doctors came to his aid, Louganis was overwhelmed with terror—not so much by his being hurt or by possibly losing his position in the competition, but instead by the fact that he was perhaps jeopardizing the lives of everyone who was coming into contact with his blood. This experience eventually prompted Louganis to abandon the secrecy of his dual stigmas:

> I also want to set the record straight about who I am, because my secrets have become overwhelming. I want to start living my life the way normal people do, without having to watch every word, without having to remember what I've shared with whom. I want never again to feel compelled to hide out in my house in the California hills, avoiding situations in which I have to edit what I say and lie about my life. (1996, p. xiii)

Much of what has been written about concealable stigmas has focused on the interpersonal costs for those who try to conceal their stigmas (Crocker, Major, & Steele, 1998; Gibbons, 1986). Less theoretical and research attention has addressed the intrapersonal, cognitive consequences of concealing a stigma. As Louganis states, trying to manage what is said (and what is kept from being said) in social interaction demands a great deal of mental control (see Wegner & Erber, 1993). In the effort to hide their true identities, those with concealable stigmas must face an internal struggle that leads to anguish and perhaps even to psychopathology. In what follows, we present evidence that as stigmatized people try to maintain secrecy about their stigmas, they become obses-

sively preoccupied with thoughts of their stigmas. Such effects have important implications for daily functioning, and for the psychological—and even physical—well-being of stigmatized persons.

SECRECY AND SUPPRESSION

A college professor we know once announced in a statistics class that a case of cheating had been detected from a pattern of unusual answers on the previous exam, and that the perpetrator could escape possible expulsion from college by confessing. Several days went by until, late on a Friday night, a student appeared unannounced on the professor's front porch. She was in tears, and explained as she stood under the porch light that she had been wracked with guilt all week. Even worse, she revealed, was that she hadn't been able to get the incident off her mind for a moment. She mentioned that just looking at the textbook on the shelf was enough to remind her of her offense, and that images of what she had done and what might happen to her kept intruding on her thoughts no matter what else she was doing. She said that she kept thinking about telling someone but could not, and that she had not slept for days. All this went away in minutes when she confessed, and it was really a shame that she was not the perpetrator the professor had been expecting to catch.

The point here is that a secret, guilty or not, can be a tremendous burden. This appears to be the case because keeping a secret becomes a preoccupation. In the "preoccupation model of secrecy," Lane and Wegner (1995; see also Wegner & Lane, 1995) propose that attempts at secrecy typically activate a set of cognitive processes that lead to obsessive thinking about the secret. This happens because when people try to keep a secret, they try to suppress their thoughts of the secret. Thought suppression can be an effective secret-keeping strategy at first, because temporarily pushing the secret thoughts out of mind may allow for more attention to be focused on attempting to appear as sincere and truthful as possible, or on redirecting the conversation away from the taboo topic. Such suppression is particularly important when the person is interacting with those from whom the secret must be kept, as there is the danger that these thoughts might bubble up into conversation. The tendency for secrecy to promote suppression has been observed in several studies (e.g., Lane & Wegner, 1995; Wegner, Lane, & Dimitri, 1994).

The next step in the preoccupation model is that attempts at thought suppression lead to intrusive thoughts of the very thing that the person with the secret is trying to keep out of mind. This effect has been

documented in research as well (e.g., Wegner & Erber, 1992; Wegner, Erber, & Zanakos, 1993) and can be accounted for by the theory of "ironic processes of mental control" (Wegner, 1994). This theory suggests that when people try not to think about something (e.g., a personal, concealable stigma), two mental processes are initiated: an intentional operating process and an ironic monitoring process. The intentional operating process is conscious and effortful; it serves to keep the unwanted thoughts out of mind by searching for distractors or topics other than the suppressed thoughts. The ironic monitoring process is unconscious and requires little cognitive effort. It functions to search for exactly those unwanted thoughts that are under suppression, thus ironically making the unwanted thoughts accessible and making it likely that they will return to conscious awareness. This increased thought accessibility during suppression is especially likely that when a person is under some sort of cognitive load, because the operating process is not able to function as effectively and the monitoring process takes over. Someone with a concealable stigma, then, may not have thoughts of the stigma in consciousness all of the time, but rather as periodic intrusions that result from the ironic monitoring process.

These thought intrusions result in renewed attempts to try to keep the secret thoughts out of consciousness. The motivation for the suppression may again be to try to keep the thoughts out of mind in the service of trying to maintain the secret, or it might also be to try to reduce the distress and anxiety provoked by having the intrusive thoughts (see Wegner & Gold, 1995). Such motivated suppression completes the last stage of the model: a constant preoccupation with the secret thoughts, in which thought suppression and thought intrusion occur cyclically in response to each other. The thoughts pop into mind as attempts to suppress them increase, which fuels further attempts at suppression, which yields more intrusion, and so on. The secret becomes a fixed idea of sorts—a constant companion that becomes particularly unruly when audiences are encountered from whom the secret is to be kept.

The preoccupation model of secrecy provides some insight into why it is important to focus on the concealability dimension (Jones et al., 1984) in trying to understand the experience of being stigmatized. People with visible stigmas have to contend with the everyday negative reactions of others to their stigmas, and must deal with the assortment of prejudices that others hold about them. They have what Goffman (1963) referred to as a "discredited identity." Their challenges arise, then, in dealing with already "spoiled" social interactions. Although they may be thinking quite a bit about how their interaction partners perceive them, their thoughts are directed toward using this information to manage and repair the interactions. In addition, both people in such

interactions know about the stigma—so while fears or prejudices may need to be hidden, at least the topic itself can be addressed directly in the conversation.

When people try to conceal their stigmas, however, their struggles are different. The preoccupation model suggests that when one has a concealable stigma and actively tries to hide it, this secret can become highly accessible just when one is trying hardest not to think about it. Those with concealable stigmas need to grapple with the assortment of negative feelings that are evoked when they hide important information about themselves—but they must also contend with their own obsessive preoccupation with their stigmas. This preoccupation may itself become a problem, as it can permeate judgments and behaviors. Therefore, people with concealable stigmas are psychologically burdened in different ways than those with visible stigmas, which may lead to unique kinds of consequences.

There are many circumstances that may necessitate the concealment of a stigma, including formal settings (such as a job interview) or a variety of more informal settings (such as casual conversation with friends or acquaintances, the early stages of a romantic relationship, or family interactions). There are also situations that may not *require* hiding a stigma, but that may motivate a person to conceal it nonetheless. These situations often occur when the revelation of a stigma promises to disrupt a relationship; the alienation of a potentially understanding friend or family member through stigma disclosure may be especially undesirable. For people with concealable stigmas, a wide variety of "active concealment" situations will set into motion the cognitive processes of the preoccupation model.

DEEP COGNITIVE ACTIVATION

How could preoccupation with a stigma be a problem? It might seem that a person who thinks a lot about a secret stigma might simply be a bit withdrawn or inattentive, as the preoccupation might be no more debilitating than a pain in the neck or an annoying worry about a problem at work. As it happens, such mere inattention is only the simplest and least costly of the consequences of preoccupation. We suspect that a variety of further complications arise because the preoccupation has continued insidious effects. It is useful to describe these in terms of the state of "deep cognitive activation" (Wegner & Smart, 1997).

In deep cognitive activation, stigma-related thoughts are accessible and influential over behavior and judgment, although they are not currently conscious. Such a state may occur because of the initial suppression of thoughts about the stigma, and may be maintained by repeated attempts to suppress the thoughts during the course of preoccupation. The state of deep activation differs from one in which a thought is both conscious and accessible ("full activation"), such as times when people become strongly absorbed with a thought—both thinking of it in consciousness and tending to have it come into consciousness again. Deep activation is also different from a state when a thought is conscious but not currently accessible. Such surface activation occurs when people attempt to distract themselves with a conscious thought in order to avoid thinking about another, more accessible and perhaps unpleasant thought. Elsewhere, we (Wegner & Smart, 1997) describe deep activation as a motivated state of mind, in which a person is typically trying to keep something out of consciousness even while that object is made highly accessible by the suppression and so is inclined to pop into consciousness periodically.

The potential for deep cognitive activation to occur for those with concealable stigmas has far-reaching consequences. It suggests that this process of concealing a stigmatized identity may lead to behavioral and judgmental effects that are indirect—that is, not connected to the activated thought in a way that may be logical or obvious. Such indirect effects can be profound for the very reason that their origins are unclear to individuals. In the process of trying to hide stigmas, people may be cognitively affected in ways that are subtle and seem only loosely linked to the activated thoughts of the stigmas themselves, but that may still cause a great deal of distress. Furthermore, there may be times when such people are not even consciously aware that they are preoccupied with their stigmas. They may consider their attempts to suppress thoughts of their stigmas to be successful, although these thoughts may still be influencing their behaviors and judgments.

Deep activation is a useful way of conceptualizing how people respond to any thought that is unpleasant to think. So, for instance, we (Wegner & Smart, 1997) have proposed that thoughts of death are often deeply activated, as are thoughts of one's susceptibility to illness and thoughts of personal losses. Consistent with this first idea, Arndt, Greenberg, Solomon, Pyszczynski, and Simon (1997) have found that people who have been reminded of their own death exhibit increased accessibility of death-related thoughts (as measured by techniques that do not depend on self-reported thinking), while at the same time reporting no conscious thought of the topic. And consistent with the second idea, Swann, Morris, and Blumberg (1996) found that sexually active college students who had seen a film on AIDS experienced higher accessibility of AIDS-related thoughts on a Stroop-type interference task. People whose thoughts of AIDS were deeply activated in this way were slow to name

the colors in which these words appeared on a computer monitor, particularly when they were under cognitive load. In other research, Morris and Swann (1996) found that sexually active people reminded of AIDS by such a film did not express much conscious thought about AIDS.

The deep activation of thoughts of personal losses, in turn, was gauged in research by Wegner and Gold (1995). In these studies, people who had followed instructions to suppress thoughts of a past relationship that they still valued were given the opportunity to express their thoughts about it aloud after the suppression period was over. As compared to those who were not asked to suppress the thought beforehand, these individuals showed increased psychophysiological arousal (as indexed by skin conductance level)—all the while showing a marked tendency *not* to talk about the past relationship. They kept it out of consciousness, even though their bodies simultaneously revealed a deep concern with this loss. The state of deep cognitive activation appears to be prompted by circumstances that force people to think about what they would rather avoid. Under these conditions, people may show little conscious awareness of the unwanted thoughts, even while these are measurably present in the cognitive and psychophysiological responses over which they have less control.

Although there is as yet little research attempting to extend this analysis to the case of concealable stigmas, there is one promising line of inquiry. In a series of studies, Steele and Aronson (1995) found that when African American students focused their attention on the significance of their test performance in light of negative stereotypes about their racial group, their performance suffered considerably. The intriguing finding here, from our perspective, was that these students also showed evidence of increased cognitive accessibility for the negative stereotype. This is a hint that suppression was present (see Wegner, 1994). Although the degree to which the African American students could report these thoughts consciously was not assessed in this work, our guess is that such stigmatizing thoughts might well be ushered out of awareness by suppression in many cases. A full examination of the role of deep activation in this "stereotype threat" effect would be interesting indeed, as it might also uncover the degree to which visible stigmas such as race might suddenly come to behave like concealable ones when people are in situations (such as test taking) when previously visible stigmas are less evident.

The most interesting feature of deep activation is that people might, as a result of it, show predictable cognitive and behavioral effects of which they are oddly unaware. One such phenomenon has already been observed: the occurrence of the projection of suppressed personal characteristics onto others. A series of studies by Newman, Baumeister, and

Duff (1997) indicated support for a suppression model of "defensive projection." Their model departs markedly from a Freudian formulation by focusing on the implications of conscious suppression. It suggests that when people are faced with threatening information about themselves (e.g., negative feedback about their personalities), they will respond to this ego threat by denying the possibility and suppressing thoughts about it. These defensive processes should then result in both a belief that they do not possess the unwanted traits and chronic accessibility of the trait concepts that are being suppressed. Such enhanced accessibility, in turn, makes it likely that evidence of exactly these traits will be picked up in perceptions of *others*. The result of this defensive process is that the threatening traits are projected onto others. The lack of conscious awareness of the trait in themselves that comes from the denial and disbelief, in turn, makes it unlikely that those who are projecting will become aware of their own contribution to the perception.

The consequences of deep activation could very well be played out in the lives of those who conceal their stigmas. Deep activation could yield both a diminished capacity to process social information, and a pervasive tendency for such a person to interpret the social world in terms of the stigma and process stigma-relevant information quite readily. We would expect, too, that a person hiding a stigma might notice suppressing it, and so should report exerting this effort. It also makes sense that such a person would experience intrusive thoughts of the stigma and could report these. Measures tapping the degree of accessibility of thoughts of the stigma should be strongly affected for an individual hiding a stigma and indirect indications of preoccupation, such as defensive projection of the stigma, might be observed as well.

PAST RESEARCH ON COGNITIVE EFFECTS

Past research has yielded some evidence relevant to our predictions. First of all, possessing a stigma may lead to an impairment of cognitive abilities for the stigmatized person. Being a token member of a group (e.g., being the only female in an all-male discussion group) has been found to lead to memory deficits for the content of a group discussion (Lord & Saenz, 1985). This impairment effect has not been observed or even explored, however, for people who have concealable stigmas. There is evidence that deception takes cognitive capacity (cf. Gilbert, Krull, & Pelham, 1988; Lane & Wegner, 1995), but it is not clear that this effect extends to the case of simply remaining silent about a personal stigma.

Few studies have examined the dimension of visibility in determining the cognitive effects of stigmatization. This dimension was consid-

ered, however, in a study on "master status conditions" (Frable, Blackstone, & Scherbaum, 1990). A master status condition is related to stigma, in that it is something about a person that is statistically unusual and central to the understanding of his or her character—but, unlike stigma, it can be either positive or negative. For example, being gay is considered a master status condition, but so is having extremely wealthy parents. In the study by Frable et al. (1990), pairs of people (one with a master status condition and one without) sat in a room together for 5 minutes. Inevitably, the participants would begin to talk during this time period. Unbeknownst to them, each interaction was videotaped. When the participants were then separated and asked to recall everything that they could about the interaction, the researchers discovered that people who possessed master status conditions were more "mindful" in social interactions than those without such conditions. "Mindfulness" in this case was defined as paying greater attention to aspects of the situation.

When the master status people were further divided according to the visibility of their conditions, it was found that visible deviants tended to focus more on the environment (details of the experimental room) and on their partners' physical appearance than on the conversations that took place. Those with concealed master status characteristics tended to focus more on the conversation by often taking their partners' perspective, making frequent references to the conversations, and spontaneously remembering what their partners said. This difference reflects the shifts in attention depending upon the visibility of the master status. Frable et al. (1990) speculated that "visibles" need to focus on an already spoiled interaction and need to be alert for signs of true attitudes and feelings, while "invisibles," those with concealed master statuses, need to manage the conversation and pay close attention to what is being said. Perhaps, too, a person with a concealable stigma concentrates on what his or her partner is thinking in order to steer the interaction in ways that will allow the continued concealment of the stigma. This study, then, does not indicate that concealed stigma produces any general deficit in cognitive function; instead, it suggests that people in this circumstance may actually be focusing quite effectively on the interaction.

These past studies have not explored at all what we believe to be the most interesting and intense circumstance for a person with a concealable stigma: an interaction *about the concealable stigma*. This is the predicament in which the most flagrant consequences of preoccupation and deep activation should be observed. Interactions in a waiting room, after all, need not bring to mind a concealable stigma, or motivate much in the way of concealment. However, being asked direct questions relevant to the stigma should prompt several of the predicted effects. A former psychiatric patient being asked about mental stability, for example, or a closeted gay person being asked about sexual preferences, is pressed to begin an active form of concealment and so must engage in mental control. This condition was examined in the research we now describe.

THE "PRIVATE HELL" STUDIES

The preoccupation model of secrecy, and the notion of deep cognitive activation, provide some new ideas about the effects of concealable stigmatization. We (Smart & Wegner, 1999) conducted two studies to examine whether keeping a stigma hidden may lead to an obsessive preoccupation with the stigma. The studies also explored some of the cognitive and interpersonal effects that may accrue from such obsessive preoccupation, and focused in particular on the possibility that projection of the stigma onto others might occur as a result of deep cognitive activation. We call these "private hell" studies as a way of emphasizing what we believe to be the inner experience of the person who is hiding a concealable stigma.

Arranging a Concealed Stigma

In both of our studies, undergraduate women who had characteristics of anorexia nervosa and/or bulimia nervosa (referred to hereafter as eating disorders or EDs), or who did not have EDs, were recruited based on their responses in a mass pretesting session. Women in the first group endorsed items in a pretesting measure that captured thoughts and behaviors typical of EDs (e.g., "I am terrified of being overweight," "There have been times when I have vomited or taken laxatives after eating in order to purge," "I am always concerned with a desire to be thinner"). The women with EDs also indicated that no one or very few people in their lives knew this information about them, and that they would be moderately to extremely reluctant to disclose this information to another student chosen at random.

EDs were chosen as the concealable stigma in these studies because of the high prevalence of women in the mass pretesting session at the University of Virginia (approximately 5–7%) who admitted to having these thoughts and engaging in behaviors characteristic of EDs. The abnormal patterns of behavior and thought processes that are common to people with EDs often necessitate attempts to keep information about themselves hidden from others to avoid arousing concern and possible unwanted intervention. Persons with bulimia nervosa, for instance, frequently report preparing secretively for a binge or planning for it pri-

vately by hoarding food beforehand (Abraham & Llewellyn-Jones, 1992). Those who purge their food by vomiting or taking laxatives typically cloak these behaviors in secrecy as well.

When each participant arrived at the experimental session, she found another female "participant" also waiting; in actuality, the latter was a confederate of the experiment. Both were greeted by an experimenter, who told them that they were about to take part in an interview. For each experimental session, each participant was led to believe that she was randomly assigned to be either the interviewer or the interviewee. The situation in fact was prearranged so that the participant was always the one who was interviewed and the confederate was always the interviewer.

The experimenter then explained that during the interview, the interviewee would be asked to role-play someone either with an ED or without one. These roles were used to operationalize visibility of the stigma. The participants who were assigned to play the role of having an ED and who actually did have one were considered to have their stigma "visible." Those who actually had an ED and were instructed to play the role of not having one were considered to have their stigma "concealed." The purpose of this role-playing approach was to allow the participants to have the psychological experience of hiding or revealing details about their ED, but also to avoid having them feel as if they were forced to disclose information about themselves that they would have preferred to have kept hidden. In order to make it clear what exactly was meant by the term "eating disorder" in this context, the experimenter read two short paragraphs aloud that described someone with an ED and someone without one. The "ED profile" read:

> People with the eating disorders of anorexia nervosa or bulimia nervosa are generally characterized by obsessive–compulsive behaviors in relation to food and their bodies. Some behaviors that they typically may engage in are exercising for several hours a day, regulating their caloric intake daily, refusing to eat food even when they are hungry or eating excessively and then purging by vomiting, laxatives, or excessive exercise.

The "non-ED profile" read:

> People who do not have eating disorders generally eat for nourishment, enjoy eating, and if they exercise, they do so to maintain a healthy lifestyle.

Participants were told that the interviewer was not aware at this time whether or not they were playing a role. The participants were therefore under the impression that the interviewer would believe that they did or did not have an ED, depending on which role they were assigned to play. In fact, the confederate who played the interviewer was naive during the interview about each participant's ED status and role-playing assignment—although the role-playing assignment soon became clear as the participant began to answer the questions.

The interview began with several neutral questions (e.g., "Tell me about your morning routine, from when you wake up to when you go to class," "What do you like most so far about being in college?"). As the interview progressed, the questions became increasingly relevant to the participant's stigma. Examples of these items were as follows: "Does anyone [e.g., friends, roommates, family] ever tell you that you exercise too much?" "[If yes,] how do you typically respond?" "Does anyone [e.g., friends, roommates, family] ever tell you that you have strange eating habits?"

Following the role play, participants were asked to respond this time truthfully (i.e., no longer in their roles) to several self-report measures of their thought processes during the interview. After each participant had completed these measures, she was questioned for suspiciousness about the study and then was thoroughly debriefed. Those who experienced any distress about the topic or their current ED problem (and these were only a few) were given special attention and information, and, if they so desired, a referral for counseling and ED treatment.

The procedure was the same for both Studies 1 and 2, except that in Study 2, following the interview, participants completed a computerized Stroop-type measure (Stroop, 1935). It was adapted so that it was a measure of the accessibility of stigma-related thoughts (see Wegner & Erber, 1992; Wegner et al., 1993). At the start of the Stroop task, participants sat at a computer monitor, where they read the instructions: to respond quickly and accurately to a series of words, indicating whether each word was shown in red or blue by pressing one of the keys on the keyboard. Some of the words they saw were related to EDs (e.g., "flabby," "thighs," "diet"), but most were neutral words (e.g., "bird," "car," "radio"). Before each word appeared, either a two-digit number (low cognitive load) or a seven-digit number (high cognitive load) appeared on the screen. Participants were instructed to hold this number in mind while they were identifying the color of the word that followed. After identifying the color, they were asked to state the number into a tape recorder.

The results from these two studies provide some insight into the consequences of having a concealable stigma. Taken together, the results suggest that when people try to hide their stigmas from others, there is a lot more going on in their minds than we may suspect. To begin with, in both studies, the women whose stigma was concealed (having an ED but

playing the role of not having one) reported the highest amount of thought suppression about their ED. So, at a basic self-report level, participants verified the use of thought suppression as a strategy during the concealment of a stigma. Those with a concealed stigma also reported, in both studies, higher levels of intrusive thoughts about EDs than did participants in the other conditions. Thus we observed evidence for the notion that the same conditions that prompt suppression also prompt intrusion. It is interesting to note that the participants who concealed their stigma showed more suppression and intrusions than did those participants who were actively playing the role of someone with the stigma and professing to have this stigma. The results support the appropriateness of conceptualizing the processes of maintaining a concealable stigma as similar to those of keeping a secret (Lane & Wegner, 1995). It would appear that persons with concealable stigmas are plagued by mental control problems.

The Stroop task administered in Study 2 corroborated this idea. Recall that this task was used in the expectation that it would allow for the detection of uncontrollable expressions of the deep activation of ED-related thoughts—those (ED-related) thoughts that might be influencing behavior or judgment but were not currently conscious. Under high cognitive load, the women who had an ED and were role-playing not having one had a slower mean reaction time for naming colors of words that were body-relevant (e.g., "fat," "flabby," "thighs") than for naming colors of neutral words (e.g., "bird," "letter," "shelf"). This effect was not obtained for participants who had an ED but were not keeping it a secret (i.e., were role-playing having an ED) or for participants who did not have an ED. This indicates that people who were keeping their ED a secret had increased cognitive accessibility of thoughts related to their stigma. These results are consistent with evidence of the hyperaccessibility of unwanted thoughts following suppression. Using a similar Stroop paradigm, Wegner and Erber (1992) found that participants had slower reaction times for naming colors of words when they were asked to suppress thinking of the words and under conditions of high cognitive load than when there was not a cognitive load or when participants were instructed to concentrate on the words. Lane and Wegner (1995) observed a similar accessibility effect for participants who were specifically instructed to keep a particular thought secret from an inquisitive experimenter. In the current studies, it is interesting to note that the participants were not specifically instructed to suppress thoughts of their stigma or to keep it secret. In merely trying to play the role of someone without the stigma, participants suffered the same hyperaccessibility of the unwanted thoughts. This provides further evidence for the idea that people with concealable stigmas may suffer from a preoccupation with

their stigmas, and indicates, too, that this preoccupation introduces automatic and uncontrollable interference effects.

Although these various indications of preoccupation were measured at different points in the studies, and in different ways, it is worth taking a moment to recall the theoretical sequence of events. According to the preoccupation model, the need to conceal a stigma in an interview yields thought suppression. This, in turn, produces the accessibility of the thought. And finally, the intrusions experienced in this circumstance occur because the high levels of accessibility repeatedly thrust stigma-relevant thoughts into consciousness even when the conscious flow of thought is on topics quite unrelated to the stigma. One further effect of such accessibility was also observed in these studies—the projection we anticipated on the basis of the research by Newman et al. (1997).

The Projection of Stigma

In a novel called *The Dwarf*, Pär Lagerkvist (1953) provided an example of projection of stigma:

> I have noticed that sometimes I frighten people; what they really fear is themselves. They think it is I who scare them, but it is the dwarf within them, the ape-faced man-like being who sticks its head from the depths of their souls. They are afraid because they do not know that they have another being inside. And they are deformed though it does not show on the outside. (p. 20)

We see that the protagonist, the dwarf, rather than defining himself as deformed, projects onto those around him by stating that they are the ones who are physically or morally deviant. This way of viewing the world may be one of the unconscious byproducts of concealing a stigma (although in the case of the dwarf, his stigma is clearly visible), and it may be one of the indirect effects of the state of deep cognitive activation.

In our (Smart & Wegner, 1999) studies, this possibility was measured. Participants with EDs were provided with the opportunity to project their thoughts and behaviors concerning their EDs onto the interviewer, as their perceptions of the confederate were collected following the interaction; in particular, their perception that she might also have an ED was specifically assessed. And as it happened, women who were concealing their stigma projected their concerns onto the interviewer by rating her higher on a set of questions about her likelihood of having an ED (her perfectionism, concern with her body image, and control of eating) than did those with EDs who were playing the disordered role. This

suggests that the process of concealment and the resulting preoccupation with the secret are what stimulate this type of projective effect.

The desire to keep a stigma a secret may be coupled with a motivation for those with a concealable stigma to deny the stigma in themselves. Women with EDs seem to have relatively little insight into their distorted thinking and pathological behaviors. Since the women in our studies were self-identified as having thoughts and behaviors characteristic of EDs, their projection may have been motivated by a desire to deny the severity or abnormality of their thoughts and behaviors rather than the existence of them. The implications of the link between keeping secret a concealable stigma and distortions in how these people perceive others are intriguing. People with such stigmas may be constructing a world in which their stigmas are perceived as more common than they actually are. Perhaps this even ends up being useful. This way of thinking may serve a coping function and may temporarily relieve some of the stress that may arise from the unwanted thoughts (see Sherwood, 1981).

Interpersonal Skills

The possibility that the preoccupation with a concealable stigma would produce uneasy and stilted interactions was also examined in our (Smart & Wegner, 1999) studies. It would make sense, after all, that the burden of trying to keep information about themselves hidden, as well as the anticipation of the judgment of the interviewer if the stigma was revealed, might interfere with normative social behavior. As Goffman (1963, p. 88) put it, "He who passes will have to be alive to aspects of the social situation which others treat as uncalculated and unattended. What are unthinking routines for normals can become management problems for the discreditable." Jones et al. (1984) similarly suggested that social interactions between a person with a concealed stigma and a nonstigmatized person would be negatively altered (compared to an interaction between two nonstigmatized people), with the normal flow of conversation being hampered: "The effects of asymmetrical knowledge may show themselves in the awkward reticence of the markable, as he closes off entire areas of conversation to avoid revealing the nature of his mark" (p. 186).

We did not observe such effects. Although the participants in the "private hell" studies who had EDs and were concealing their stigma were indeed demonstrating stigma-related thought accessibility, thought intrusion, and projection, they appeared to be generally socially adept to independent judges who rated the taped interviews on many interpersonal dimensions. The results from the judges' ratings of the interviews showed that across both of the studies, people who were keeping their

EDs a secret did not appear to be interpersonally awkward or lacking in social skills in any way. Their inner struggles were not evident in their outward appearances. For example, the women with a concealed stigma were actually rated by the judges as being more likeable and less anxious than the women who had a visible stigma.

There are several possible explanations for this discrepancy between the inability to keep stigma-related thoughts out of mind and apparent ease in social interaction. The one we favor involves a practice effect. Perhaps those women with a concealable stigma had integrated secrecy into their lives for so long that they had become very skilled at hiding their stigma so as not to disrupt their social functioning. The participants with EDs in the study were generally viewed as socially skilled, and it is quite possible that individuals who develop EDs are unusually sensitive to others and even more socially motivated and adept than the usual research participants. The moments of concealment we engineered in the laboratory may have been no great challenge for women who had been doing this for a long time, and may instead have merely engaged their usual social coping skills. This interpretation is consistent with the notion of deep cognitive activation, in that the surface and conscious indications of stigmatization were not present.

It is also possible that the judges were responding to the heightened sense of arousal that those with a concealable stigma may have been experiencing in this type of interview situation. If this were the case, then these participants may have appeared more sociable and more expressive to the judges, which may have led to more positive ratings of their interpersonal functioning (e.g., Friedman, Riggio, & Casella, 1988; Sabatelli & Rubin, 1986). The key comparison for this research was between women with EDs who were revealing their stigma and those who were concealing it, of course, and perhaps revealing it was so disturbing that it disrupted these otherwise highly composed participants. Thus the participants who were concealing EDs may not have appeared particularly nonplussed by the situation because they were perhaps less flustered than those who were revealing.

Perhaps concealing a stigma affects long-term social relationships more than it does short-term interactions with strangers. Having a concealable stigma may affect the types of social relationships in which stigmatized people choose to become involved; for example, they may opt for shallow relationships in which hiding is relatively easy. Hiding their stigma may allow them to assimilate into the mainstream community life. At the same time, one of the consequences may be that they avoid associating with other similarly stigmatized people. In doing so, they deny themselves many of the benefits—the social support, social services, and social relationships—that come with being open about a

stigma (Gibbons, 1986). In addition, they are unable to engage in downward social comparison because they are likely to want to avoid others who may be more clearly stigmatized than they are, in an effort to avoid being associated with the stigma and possibly implicated in also possessing it (Crocker et al., 1998).

The tendency to employ defensive projection raises an interesting issue regarding the social relationships of those with concealable stigmas. As suggested earlier, the increased use of projection by people with concealable stigmas may be evaluated on different levels in terms of effectiveness. With regard to initial interactions, projection may serve an adaptive function. It may allow people to rationalize their behaviors to themselves and reduce the negative affect that may be associated with repeated intrusive thoughts about their stigmas. In longer and perhaps more meaningful relationships, however, this kind of projection could well be disconfirmed repeatedly and serve as a barrier to relationship development.

Our studies shed some light on the consequences of leading a double life—presenting an "unmarked" image to those with whom one interacts, while keeping an important part of oneself hidden. The data suggest that while people with concealable stigmas may appear at ease in an interaction, they experience deep cognitive activation of their stigmas. Thus the preoccupation model, although developed to account for the cognitive consequences of secrecy in general, has much to offer in terms of insights pertaining to the specific effects of keeping a stigma secret from others.

HEALTH IMPLICATIONS AND CONCEALABLE STIGMAS

There is some evidence that keeping a stigma hidden may also take its toll on physical health. HIV infection, for example, has been found to advance more rapidly in HIV-positive men who conceal their homosexual identity than in men who are more open about their identity (Cole, Kemeny, Taylor, Visscher, & Fahey, 1996). Similarly, Crandall and Coleman (1992) have found that HIV-positive people who do not disclose their status to significant others are likely to become more isolated, more depressed, and more anxious than those who selectively confide in people whom they feel they can trust.

It has been argued that it may be beneficial to keep a secret concealed (Kelly & McKillop, 1996; Vangelisti, 1994). Of course, people do not usually keep secrets for imaginary or unimportant reasons, and it makes sense that there are often good reasons to hide a stigma. The reasons for secrecy may include the possibilities of receiving nonsupportive

responses, for example, or disrupting personal boundaries that may be desired by the listener. Indeed, fear of a poor reception if concealed stigmas are revealed is likely to be what motivates the majority of people who are able to conceal their stigmas to perpetuate their assimilated status. Someone admits a stigma, for example, but the person to whom he or she has revealed this information is not able to handle this revelation and closes off future discussion of it. In this kind of situation, the person with the concealable stigma is still required to hide the stigma, but now his or her worst fear has been confirmed: People really do not understand. Secrecy attempts may then be renewed with even more zeal.

Under certain conditions, as in the presence of a safe and supportive audience or when one is able to preserve anonymity, making a concealed stigma visible may be highly beneficial. The health benefits of disclosing traumatic experiences have been researched extensively by Pennebaker and his colleagues (see Pennebaker, 1990). In one such study (Pennebaker, Kiecolt-Glaser, & Glaser, 1988), participants wrote in detail about events (many of which were potentially stigmatizing—e.g., incest victimization, perpetrating violence, having a spouse commit suicide) that they had not talked about with others. People who wrote more about concealed events (high disclosers) showed an improved immunological response relative to low disclosers and to controls. Pennebaker and his colleagues argue that the mechanism underlying this effect is that emotional expression involves confronting thoughts and feelings about stressful events. Through this process, people may be able to cognitively restructure the events and better understand them. It is also possible that the act of expression works its magic by allowing people to relax their pursuit of mental control, and so eliminates the costs of continuous deep activation.

Lepore (1997) also found health benefits for disclosing to a supportive audience in response to a stressful event. Participants in his experimental group who were instructed to write their deepest thoughts and feelings about an upcoming graduate exam had a decline in depressive symptoms from 1 month (Time 1) to 3 days (Time 2) before the exam. Those in the control group wrote about a trivial topic maintained a relatively high level of depressive symptoms over this same period of time. Like Pennebaker, Lepore maintains that being able to express one's thoughts and feelings about a particular stressor promotes emotional adaptation to the stressor by lessening the emotional impact of the intrusive thoughts. Our interpretation is that expression diminishes the deep cognitive activation of the stressor, and so eliminates the cognitive preoccupation and its costs.

Advancing technology may provide additional ways to reveal stigmas. There is some evidence that the Internet may be a valuable resource

for "identity demarginalization" for people with concealable stigmas. McKenna and Bargh (1998) found that becoming a member of a newsgroup related to a marginalized aspect of one's identity led to greater self-acceptance, as well as an increased likelihood to reveal the concealable stigma to family and friends.

CONCEALABLE STIGMAS AND MENTAL CONTROL

Is there any way that concealable stigmas can be erased in the mind? Perhaps the greatest wish a person with a concealable stigma might have is not for the stigma to go away, but for the thought of it to go away. One wonders whether there might be conditions under which thoughts actually could be wished into oblivion—when personal stigmas could be forgotten and life could go on without the mental turmoil that regularly surrounds preoccupation. We can envision several ways in which this might happen.

One possibility is "automatization of suppression." If a person becomes highly practiced at mental control, it may come to be done expertly and efficiently. An individual with a sordid past that he or she wants to hide, for instance, may find that after many years of hiding it, the hiding gets easier. Just as riding a bicycle is learned and then not forgotten, the person with effective suppression strategies that are well practiced may be quite able to control the expressions and consciously perceptible repercussions of preoccupation. There is almost no current research on this possibility, but the notion that conscious mental control may become automatic and thus more effective deserves investigation in the area of stigma (see Smart & Wegner, 1996; Wegner, 1994; Wegner & Bargh, 1998). A person often has a stigma for life, after all, and it seems reasonable to expect that the person who has to rehearse suppression may become good at it.

A second way in which stigma may be forgotten is through "situation management." An individual with a concealable stigma may keep from being put in the position of having to pursue secrecy and suppression by avoiding situations in which the stigma must be hidden. This may involve, on the one hand, an engagement in only the most superficial relationships—ones that require almost no interaction about oneself. This is perhaps what we think of most readily when we consider a person who is in the process of avoiding an unwanted aspect of self. On the other hand, a situation management strategy may also prompt just the opposite kind of behavior. Interactions and settings may be sought out that maximize the degree of explicit focus on the stigma, as such circumstances will also free the person from the needs for secrecy and suppression. Becoming immersed in a homosexual lifestyle, for example, may well provide significant relief from secrecy to someone who has been hiding this identity.

A third strategy that may often succeed in reducing the pain of constant secrecy involves "redefinition of the stigma." If one can interpret a stigma in such a way that it is no longer stigmatizing, or perhaps at least no longer relevant to questions that may arise about one's identity, then it can be forgotten because active secrecy will no longer be needed. The utility of this strategy will depend, of course, on the nature of the stigma. A person who formerly abused drugs, for example, may be able to identify the self as a "convert," as having come clean and adopted a new identity. With this conversion comes a partition of the person's autobiography into a "former self" and a "current self," and secrecy need no longer be focused on the current self. The former identity can be talked about freely, or for that matter it can be kept secret—but it is not seen as highly relevant to the current self. Interactions that focus on the concealable stigma may not yield the need for concealment when the stigma is understood to be applicable only to one's former self, the owner of a spoiled identity that is no longer present.

Ultimately, the methods people use to manage their concealable stigmas will be many. In this chapter, we have examined some key phenomena that motivate such management. We have seen that a concealable stigma is a constant source of psychic pain: It requires work to suppress; it returns to mind in the form of intrusive thoughts that derail one's preferred course of thinking; and it can metastasize in a way, promoting projection and other insidious expressions of its extremely high levels of cognitive activation.

In a very clever experiment, Kleck and Strenta (1980) once made people think that they were visibly stigmatized in an interaction, even though no such stigma was present. The researchers attached false scars to participants' faces before an interaction, and then surreptitiously removed the scars in a flourish just before the interaction began. Those who thought they were stigmatized in this way reported being uncomfortable, and even were seen as ill at ease by observers—none of whom, of course, saw any scar. In a way, a concealable stigma perpetrates a similar hoax on the person who hides it. Although the person may have no stigma at all in others' eyes, he or she becomes preoccupied and ultimately devastated by the chore of trying to cover up something that cannot be seen.

ACKNOWLEDGMENT

Research reported in this chapter was supported by a National Institute of Mental Health (NIMH) predoctoral National Research Service Award (No. MH 11443-01) and by NIMH Grant No. MH 49127.

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The Social Psychology of Stigma

Edited by

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Robert E. Kleck
Michelle R. Hebl
Jay G. Hull

THE GUILFORD PRESS
New York London
2000