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Homeostasis, interrupted: Living with and recovering from a stigmatized identity

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Homeostasis, interrupted: Living with and recovering from a ‘spoiled’ identity

There is much to admire about Sedikides’ (this issue) homeostatic model of identity maintenance. In brief, Sedikides argues that people possess a psychological immune system that helps them to maintain psychological homeostasis; “a routine, adaptive, process by which people monitor their internal and external environments for threats to their self-views or, more generally, to their theories about their characteristics, relationships, and circumstances” (p. 215). The scope and complexity of the model effectively incorporate theories and empirical findings from the sprawling literature about the self, and thus provides an overarching structure apt to organize the field. The model’s focus on mind-body connections is also a welcome return to a holistic self-psychology that seemed lost for a while, but whose resurgence in recent years raises new questions and offers new opportunities for interdisciplinary cross-pollination. Framing the mechanisms that uphold a coherent sense of self as an immune system further emphasizes the inherently intertwined biological and psychological components of human life.

Yet despite all of these strengths and the importance of the model as a whole, if we are being totally honest – and that seems to be the goal here – we suspect that some people could feel alienated when reading this paper. We agree that most people must contend with daily feedback that refutes their generally-positive self-views, including negative feedback from an employer, poor performance on a task for which they believe they are highly skilled, and criticism by a friend – all examples that Sedikides uses to illustrate his model – and we agree that those kinds of experiences can be highly distressing. Yet, when some people read those examples, a tiny voice in their heads may whisper, “That must be nice!” It must be nice to live in a social world where identity-threats can be easily countered if one “construe[s] their experiences optimistically” or “recall[s] selectively favorable information” (Sedikides, this issue, p. 211). It

must be nice to enjoy positive self-views that meet “...survival and reproductive needs, including physical and social attractiveness, intellectual prowess, self-regulatory proficiency, and social status” (Sedikides, this issue, p. 197). It must be nice to have a psychological system whose primary goal is to simply feel good. Unfortunately, for people who possess one or more intersecting identities that are subject to social devaluation, or *stigma*, this is not their lived reality, and we think that this perspective is missing from Sedikides’ model.

This oversight is epistemologically costly, because from a population demographic perspective, most people possess characteristics or belong to groups that are subjected to stigma, and most of them belong to multiple stigmatized groups (Pachankis et al., 2018; Reinka et al., 2020). The proportion of the population that is disabled, fat, queer, or who are Black, Indigenous, or people of color living in postcolonial/settler societies like the US and Canada – to name just a few possible intersecting and stigmatized identities – far outnumbers the proportion of the population who belong to none of these groups, even in societies where each group is a “minority” on its own. Indeed, this is how hegemonic social systems that foster stigma are designed to operate: the few dominate the many, and part of that domination includes overlooking and excluding ‘non-normative’ lived experiences (e.g., Bos et al., 2013).

We would like to take this opportunity, then, to explore how Sedikides’ (this issue) impressive, thorough, and compelling homeostatic model of identity maintenance could be expanded to explain the experiences of people who not only must struggle to survive in social environments that would rather they did not exist, but must also struggle to live with and recover from the psychological consequences of that trauma. Thus, in the discussion that follows, we explore how Sedikides’ model can be expanded to explain the experiences of people who must live with, and hopefully one day recover from, social stigma.

“Spoiled” Identity

The term *stigma* is ancient, and originally referred to the practice of burning or marking the hands of people whom society deemed to be undesirable, dangerous, or immoral, so that those people could be avoided or ostracized (Goffman, 1963). In modern society, the term is no longer literal, but figurative, and refers to groups of people who possess physical or moral attributes that are considered to be tainted, and thus subject to widespread disapproval or disgust (Bos et al., 2013). In this way, people who are stigmatized embody social identities that have been ‘spoiled’ (Goffman, 1963). Their identities set them apart from the rest of society and mark them as deviant and therefore worthy of disdain and social exclusion. As this process implies, stigma is often triggered by a label. *Fat. Disabled. Queer.* These and other labels carry the weight of stigma, and thus may be considered unacceptable slurs when uttered by people who cannot claim the identity for themselves (though many have been reclaimed as sources of pride by their targets; e.g., Saguy & Ward, 2011). In turn, labels identify which groups should be subjected to the negative evaluations, stereotypes, and discrimination that follow from stigmatization (Major & O’Brien, 2005).

The particular characteristics and identities that are stigmatized vary across time and culture, but despite these variations, stigma reveals social hierarchies in every society. By its very definition, stigma involves a power differential between the stigmatizer and the stigmatized. Indeed, stigma can only exist, and be enforced, through social, economic, and political power. Or, put another way, “... stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them,” (Link & Phelan, 2001, p. 377). Powerful groups then use stigma to maintain their power and to exploit and dominate others (Phelan et al., 2008). Further, powerful groups use the threat of stigma to force

social “deviants” to conform, and more directly, stigma is used to exclude those who are perceived to pose a health or moral risk to others.

From this description, it should be clear that stigma represents a profound social identity threat that has a pervasive influence on the self. People who are the target of stigma are perfectly aware of the social devaluation ascribed to their ‘spoiled’ identity or identities (Bos et al., 2013), and devote considerable psychological energy to processing their stigmatizing experiences (Hatzenbuehler, 2009). Moreover, because social feedback provides the building blocks from which the self is constructed (Cooley, 1902; Mead, 1934), people who are subjected to public stigma often internalize the social devaluation they experience. That is, people develop a self-concept that includes the stigmatized identity and all of the negative stereotypes, emotions, and beliefs that society ascribes to that identity. To extend Sedikides’ (this issue) theorizing, internalized stigma is a kind of psychological autoimmune disease, whereby the “I” attacks, degrades, and devalues the “me.” This is a painful experience to endure. Because it resides in the self, this *internalized stigma* is immediate, personal, and seemingly inescapable, and it causes significant psychological distress that undermines well-being (Chaudoir et al., 2013; Pinel & Bosson, 2013). We propose two mechanisms by which internalized stigma may undermine well-being within the framework of Sedikides’ homeostatic model of identity maintenance: First, by suppressing the set point for well-being, and second, by disrupting self-regulation all-together.

Consequences of Stigma for the Self: Lower Set Point for Well-Being

The defining characteristic of internalized stigma is reduced self-worth (Bos et al., 2013). This should not be surprising to scholars of the self. As Sedikides (this issue) notes, most people “receive unfavorable feedback, accept it to a certain degree, and also harbor some negative self-views” (p. 200). But according to the sociometer model of self-esteem, people’s feelings of self-

worth also serve as a barometer of their perceived *relational value* – that is, their perceived worth as a social and interpersonal partner (Fisher et al., 2017; Leary, 2004; Stinson et al., 2015b). Over time, repeated experiences of social connection or exclusion crystalize to form a stable sense of self-worth, called *global* or sometimes *trait self-esteem*. This self-esteem set point then serves as an anchor around which in-the-moment feelings of self worth, or *state self-esteem*, may fluctuate in response to daily interpersonal slings and arrows (Kernis, 2005).

Thus, people who are the target of social stigma are especially likely to experience low global self-esteem (a state that may actually compound their stigma, since low self-esteem is also socially devalued; Cameron et al., 2016). This makes sense when we consider that stigma quite literally communicates that some people are not worthy and potentially should be expelled or eliminated from society. Internalizing that message may lead to self-esteem that is not only low, but is contingent on the stigmatized identity (e.g., Crocker & Wolf, 2001). “I am not worthy *because of my disability.*” “I am not worthy *because I am fat.*” “I am not worthy *because I am queer.*” Now, some people might be able to reduce the hit to their self-esteem if they identify highly with their stigmatized group (Crocker & Major, 1989; Schmitt & Branscomb, 2002), and thus tune their self-esteem system to focus on a reliable source of social acceptance (Anthony et al., 2007, Fisher et al., 2021). But most cannot escape the internalization process, and their experiences need to be considered when constructing a model of identity maintenance. We think this can be accomplished, in part, by considering how the set point for the identity-maintenance system may adapt to stigma over time, and by considering the consequences of such adaptations for well-being.

Set Points in Homeostatic Systems

As Sedikides (this issue) points out, homeostatic systems typically work to maintain functioning within an optimal range. In biology, this optimal range is sometimes called the *set point range*, and it adapts to situational affordances. The metabolic system offers a good example of these processes. Here we loosely use the term *metabolism* to refer to the rate at which the body uses energy to perform the various acts that it needs to survive (Gaudiani, 2018). Every body has its own unique metabolic set point that it strives to maintain, and environmental stimuli that threaten to disrupt this homeostasis are typically met with reactive adjustments that speed or slow energy consumption to maintain optimal functioning – similar to the reactive adjustments the self makes to maintain its own homeostasis. However, when humans consume less energy than they need to maintain their bodily processes and meet their energetic needs for prolonged periods – either intentionally or unintentionally – the body slows its basic, life-sustaining processes to conserve energy. In essence, the body adapts to energy deficits by reducing the metabolic set point. This “works” in the short term, in that the body survives and, in many cases, maintains all of the essential life-sustaining processes, albeit at a much slower and/or reduced capacity. But maintaining a state of suppressed metabolism is costly over the long-term (Gaudiani, 2018). Non-essential physiological processes like the reproductive system are dramatically slowed and can be stopped completely, and even essential processes like the regeneration of cells and the functioning of the immune system are all inhibited. Eventually, these adaptations undermine health.

We suggest that similar processes characterize the kind of ‘well-being suppression’ that happens when global self-esteem crystalizes at a low set point in response to persistent social stigma (or persistent familial emotional abuse or neglect¹). As we described earlier, lower self-

esteem appears to be an adaptation to sustained and long-term negative relational-value feedback. We characterize this adaptation as a lower set point because people with lower self-esteem tend to engage in self-esteem maintenance strategies that serve to maintain their poor self-worth. For example, when people with lower self-esteem experience negative mood they forgo opportunities to feel better, preferring to maintain the negative mood that is comfortable in its predictability (Wood et al., 2009), and they often rebuff attempts by loved ones to make them feel better (Marigold et al., 2014). They also sometimes choose to interact with social partners who hold similarly negative views of their worth rather than interacting with social partners who can offer them positive, but self-esteem inconsistent, feedback (Swann & Pelham, 2002). People with lower self-esteem even discredit and reject compliments from friends and loved ones because they deem them to be inconsistent with their more negative self-views (Kille et al., 2017).

These and other self-esteem maintenance behaviors may be adaptive in some ways, and especially in the shorter term, just as metabolic suppression can be adaptive in some situations and in the shorter-term. For example, maintaining stable self-esteem, even at a lower set point, can help people to meet their epistemic needs for self-consistency and self-certainty (Hoplock et al., 2019; Stinson et al., 2010). After all, as Sedikides (this issue) points out, a stable and coherent self is required to make sense of past and current experiences, and to predict the future, and to engage in many of the core psychological feats that make humans, human. There are some well-being benefits to maintaining a lower set point for self-esteem, too. Lower self-esteem prompts people to become more vigilant for signs of rejection and to approach social situations, especially novel ones, with caution (Anthony et al., 2007; Cameron et al., 2013; Cameron et al., 2010; Stinson et al., 2015a; Stinson et al., 2015c). These adaptations may help lower self-esteem

people to avoid some threats to belonging, and thereby to protect the precious self-regard that they do possess from further declines. These benefits may be particularly salient and valuable for people who are subjected to social stigma, who must navigate and survive an essentially hostile social world.

However, just as metabolic suppression is costly in the long-term, maintaining lower self-esteem in the long-term may be fundamentally incompatible with human thriving. In an effort to protect the self, people with lower self-esteem often act cold and inhibited in social interactions, even when their interaction partner is behaving warmly (Cameron et al., 2010; Stinson et al., 2015a), and their cold behavior can create a self-fulfilling prophecy, leading to the very rejection that they fear (Stinson et al., 2015a; Stinson et al., 2009). Combined with their social avoidance (Anthony et al., 2007), these self-protective behaviors may help to explain lower self-esteem individuals' objectively impaired social skills and informants' reports that they are indeed liked less than their higher self-esteem counterparts (Cameron & Granger, 2019).

These examples suggest that some self-esteem maintenance behaviors can undermine the quality of lower self-esteem people's social bonds, which in turn can undermine their health and well-being (Stinson et al., 2008). Longitudinal studies confirm that people with lower self-esteem suffer from a range of psychological and health complications as they age that are either precipitated by or exacerbated by their poor self-worth – depression, anxiety, disordered eating, negative body image, suicidal ideation, suppressed immune functioning, poor outcomes when chronic health conditions develop, and even increased mortality among the elderly (Stinson & Fisher, 2020). So just as a suppressed metabolism can be a sign of a distressed physiological system in need of sustenance, so too can lower self-esteem be a sign of a distressed psychological system in need of relief. We will touch on ways to relieve this suffering in our

conclusions, but first we want to discuss a more extreme psychological consequence of social stigma that can not only shift the set point for identity-regulation but disrupt it all-together.

Specifically, we want to talk about trauma responses to social stigma.

Consequences of Stigma for the Self: Traumatic Dysregulation

Mainstream clinical definitions of trauma tend to focus on the psychological and physiological consequences of a single, time-limited, life-threatening situation (American Psychiatric Association, 2013). This definition is hard to reconcile with the claim that social stigma can be traumatizing, because stigma and its consequences are neither one-time experiences, nor are they time-limited. Instead, people who are subjected to stigma often experience repeated violence and abuse throughout their lifetimes (Burstow, 2003), and stigma is a pervasive daily presence in the lives of its targets. They experience its overt manifestations when they are overlooked, excluded, and abused by people in positions of power and the institutions they often control, and they suffer its daily indignities – a kind of death by a thousand cuts – in tense interactions with social partners who struggle to hide their disdain, fear, or disgust (Bos, 2013; Sue, 2010).

Yet there is a growing recognition that these kinds of persistent, daily, and pervasive stigmatizing and violent experiences can cause what Burstow (2003) calls *insidious trauma*, or what Herman (1992) calls *complex post-traumatic stress disorder*. This kind of trauma not only affects individuals, but it can also manifest among entire families and communities who share histories of oppression (e.g., Danieli, 1998). For example, Duran and colleagues (1998) use the term *soul wound* to refer to the intergenerational trauma suffered by the Indigenous Peoples of Turtle Island (i.e., North America) as a result of the ongoing colonization and attempted genocide of their Peoples. Furthermore, there is growing recognition that being subjected to the

insidious trauma of stigma undermines health and well-being. For example, stigma has been called the “fundamental cause” of population health inequities due to its pervasive deleterious effects on multiple life domains (Hatzenbuehler et al., 2013, p. 813). But we suggest that the insidious trauma of stigma also undermines the homeostatic self-maintenance processes that Sedikides (this issue) describes. There are a few mechanisms to explain why this may occur, all of which are predicated on the deep mind-body connections that are central to Sedikides’ model.

The Traumatized Self

Trauma is embodied, and so it is experienced by the self and body together. For example, trauma can lead to nervous system dysregulation characterized by swings between extreme states of hyper- and hypo-arousal, which are experienced psychologically as feelings of emotional volatility (Van der Kolk, 2015). Thus, traumatic nervous system dysregulation affects emotional self-regulation, which may help to explain why people who are subjected to stigma experience higher rates of mood disorders than their non-stigmatized peers (e.g., Pascoe & Smart Richman, 2009). Stigma can also trigger a maladaptive style of emotion regulation called *brooding rumination*, characterized by passive and repetitive self-focused thoughts, which in turn predicts heightened psychological distress (Hatzenbuehler et al., 2009) and an extended somatic stress response (Verkuil et al., 2010). Together with other maladaptive emotion-regulation strategies like suppression, rumination also increases stigma consciousness, which further erodes well-being (Pinel & Bosson, 2013). As Sedikides (this issue) notes, “Emotion regulation (i.e., psychological homeostasis) is no more or less biological than temperature or blood sugar regulation. Unsurprisingly, emotions and other physiological processes are strongly related” (p. 14). Thus, stigma-induced emotional dysregulation has the potential to interrupt the identity maintenance processes that Sedikides details, and ultimately, to undermine well-being.

Moreover, people who are traumatized often experience somatic dissociation that separates the mind from the body, called *disembodiment* (Herman, 1992). Adding insult to this psychic injury, public stigma often targets people because their bodies, specifically, are perceived to be ‘deviant’ (e.g., Pachankis et al., 2018). In turn, stigmatization relies on social mechanisms like violations of bodily ownership, body-based slurs and insults, and idealized images of bodies that constrain and disempower to exert social control, all of which further drive the dissociative wedge between mind and body (Piran, 2001). These processes undermine well-being by exacerbating trauma-induced nervous-system dysregulation, but they also disrupt people’s ability to connect to and interact with the world.

For example, when traumatic dissociation rends the mind from the body, room is made for *self-objectification* to occur, whereby the internalized oppressor fills the space between mind and body, between “I” and “me”, and thus the self is seen and evaluated through the internalized gaze of the powerful, stigmatizing observer (Fredrickson & Roberts, 1997). Disembodiment and self-objectification can also undermine interoception, making people insensitive to internal bodily states. As Sedikides (this issue) states, “I consider interoceptive cues to be fundamental to emotional experience, and to play a vital role in informing and influencing the self-views that identity comprises” (p. 24). Thus, it should be clear that stigma-induced disembodiment can disrupt psychological homeostasis, rendering identity-regulation difficult, if not entirely impossible. Indeed, phenomenologists like Merleau-Perry (1962) emphasize that the body is the principal foundation of knowledge, mediating people’s connection with the physical world. Furthermore, bodies help people to construct their identities through *performativity*, or acts and gestures, that demonstrate group memberships and social roles (Butler, 1993). All of this means that stigma-induced traumatic disembodiment can disrupt identity, self-regulation, and even a

person's understanding of reality (Frederickson & Roberts, 1997; Herman, 1992). At extremes, it may even undermine people's will to live.

Living with and Recovering from a 'Spoiled' Identity

Social identity theory points to a host of identity management strategies that people who are subjected to social stigma may employ to manage their 'spoiled' identities (e.g., Ellemers & Haslam, 2012; Scheepers & Ellemers, 2019), all of which fall under the broader umbrella of the psychological immune system as defined by Sedikides (this issue). People can try to shed their stigmatized identity and gain proximity to or membership within a more prestigious social group. If possible, they may try to conceal their identity in an effort to avoid prejudice and discrimination (e.g., Reinka et al., 2020). When they interact with outgroup members, they may try to deflect discrimination by invoking a common ingroup identity based on a shared, non-stigmatized characteristic (e.g., Schmader et al., 2013). They may also re-define the criteria for social comparison in ways that allow them to view their ingroup more positively, potentially by focusing on unique and valued characteristics of their devalued social group (e.g., resilience), or by shifting the focus of social comparisons away from the powerful group and towards other groups that share a similar position in the social hierarchy. Unfortunately, while these techniques may provide some personal relief from the consequences of stigma, those benefits can be short-lived (e.g., Quinn et al., 2013). Perhaps more importantly, none of these techniques improve outcomes for the stigmatized group as a whole, nor do they alter the cultural values that created the stigma in the first place.

We suspect that these identity management strategies fail to provide meaningful and lasting relief from the consequences of stigma because they frame stigma as an individual problem that has individual solutions. Indeed, this same individualistic focus also characterizes

Sedikides' (this issue) treatment of identity maintenance. Such approaches may be well-suited to responding to the kinds of daily fluctuations in well-being that occur within an otherwise coherent and generally positive self. But they seem ill-suited to the task of increasing a suppressed self-esteem set point, developing self-coherence, or mending a mind-body connection that has been severed through stigma-induced trauma. Reflecting these stark realities, radical social justice and decolonizing perspectives on trauma recovery take a decidedly different, and collective, approach to identity-repair and maintenance (e.g., Burstow, 2003; Gone 2013). These approaches emphasize that the strength that is needed to live with and recover from a 'spoiled' identity does not reside wholly within the self; rather, it is born from an interaction between the individual and the environments and communities to which they belong and on which they depend. Moreover, they acknowledge that an individual cannot be truly free while others who share their identity are still stigmatized. Thus, to achieve collective benefits, members of stigmatized groups may choose to disrupt the status quo and pursue social change through community building and collective action (e.g., van Zomeren et al., 2008).

Stigma does not reside in the self, but rather, it resides in the social context (Bos et al., 2013). This means that if someone leaves or minimizes exposure to a social context that endorses a stigmatized view of their identity, and joins a social context that values and affirms the worth of that identity, then they could potentially leave the social stigma behind and begin the process of healing. This is exactly what many people do (Dickins et al., 2011; DiFulvio, 2011; Singh & McKleroy, 2011). For example, cultural immersion is a commonly-accepted therapeutic intervention among First Nations and American Indian communities (Gone & Alcantara, 2007). Whereas existing in spaces that ignore the devalued aspects of one's identity can undermine belonging, connecting with communities that explicitly affirm the worth of shared identities can

increase feelings of belonging. Community immersion and identity affirmation can also make people feel safe. As the activist Imani Barbarin explains, “It’s important that people see and affirm me as a Black disabled woman, because I have to move about in the world as such. By not recognizing those things, people are either isolating me or putting me in danger” (as cited in Brown, 2021).

Therefore, the fundamental work of recovering from a spoiled identity involves reconstructing the self within the embrace of safe and welcoming relationships, including therapeutic relationships, personal relationships, and community relationships (Duran et al., 1998; Herman, 1992). During this process, people come to terms with their experiences of stigma, mourn the losses they have experienced as a result of stigma, and create a new vision of their future. They also develop an understanding of the social contexts and cultures that allowed the trauma to occur, and redefine a safer and more authentic place in the world that reflects their values. Consistent with Sedikides’ assertion that “...the psychological immune system develops narratives to counter or negate self-threats” (this issue, p. 206), recovery work also involves constructing new narratives. For example, in one type of constructivist therapy, called narrative therapy, the therapist and client work together to re-author the story of the client’s identity (Brown & Augusta-Scott, 2007). Ideally, this process involves “exorcizing” the internalized oppressor (Duran et al., 1998, p. 350). It may also involve acknowledging the many strengths that can be forged from trauma, including survival skills, empathy and understanding for other traumatized and oppressed people, and an investment in social justice activism (Burstow, 2003).

Conclusions

In sum, Sedikides’ (this issue) homeostatic model of identity protection offers to unify a diverse range of approaches to self psychology. Yet, we argue that the model would be

strengthened by considering how the self might adapt to the insidious and pernicious identity threats that are posed by social stigma, and by integrating research and theory on living with and recovering from social stigma that emphasize the interconnection of people and communities. In doing so, the model would provide a more comprehensive and unifying view of how the psychological immune system functions, day by day, for all people.

Footnotes

¹ Although our discussion focuses on the negative consequences of social stigma for self-esteem and the self, we assume that similar processes unfold when the source of low self-esteem is another form of persistent traumatic experience.

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