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## Awkward Moments in Interactions between Nonstigmatized and Stigmatized Individuals

MICHELLE R. HEBL  
JENNIFER TICKLE  
TODD F. HEATHERTON

Most people can call to mind some interaction they have had with a stigmatized individual during which they said or did something that created some anxiety, discomfort, tension, or embarrassment to themselves and/or their stigmatized interactant. Recent descriptions of such transactions from our students have revealed a plethora of such examples. For instance, one student asked a paraplegic stranger who had fallen from his wheelchair how his legs felt. Another student told her facially scarred friend that the young man they were looking at would be attractive if only it weren't for his facial scar—a mark she realized immediately thereafter was almost identical to her friend's scar. One student recalled asking a blind person whether he had seen a hot-air balloon lift-off. Several White students recalled stuttering noticeably in deliberating whether to use the term "Blacks" or "African Americans" in conversations with Black individuals. Another student described staring at her interactant's stump of an arm that was slightly protruding from the sleeve. And one student stated that she remembered deliberately backing

away from shaking hands with a person she knew was HIV-positive. Although these particular examples of undesirable social exchanges may not be universal experiences, most people have experienced the overarching discomfort that accompanies such marred interactions. We call these feelings "awkward moments," and what seems to be a commonality across diverse experiences of these moments is the precursor or presence of interaction anxiety that directly or indirectly arises from the stigma.

In this chapter, we explore awkward moments that occur in "mixed interactions," or interactions that involve stigmatized and nonstigmatized interactants (Goffman, 1963). We begin by describing some features of stigma that influence the production of awkward moments. We then present a number of firsthand accounts of awkward moments from the perspectives of both types of interactants, together with empirical research that reveals the hesitation both sides have in pursuing social interactions with each other. Next, we gain insight into awkward moments by considering a number of reasons why tensions and anxieties are likely to occur; we present readers with a comprehensive, although not exhaustive, list of potential factors that may lead to or maintain awkwardness in both nonstigmatized and stigmatized individuals. Finally, we discuss strategies for alleviating awkward moments, which we believe will not only benefit social interactions but also lead to a more general mainstreaming of stigmatized individuals into our society. Such remediation strategies have been shown to immunize stigmatized individuals from threats and to enhance mixed interactions and dialogue, as well as to attenuate experiences of awkwardness. Our belief is that some very straightforward cognitive and behavioral interventions, targeted at both the dyadic and societal levels, can work to reduce anxiety and the presence of awkward moments in nonoptimal mixed interactions.

#### FEATURES OF STIGMAS INFLUENCING THE PRODUCTION OF AWKWARD MOMENTS

A general understanding of social stigma is helpful in understanding the dynamics of mixed interactions. As early as ancient Greek civilization, records indicate that individuals possessed "stigmas," defined as undesirable brands or marks connoting devalued differentness from others and from expectations (see Archer, 1985; Crocker, Major, & Steele, 1998; Goffman, 1963; Jones et al., 1984). In the last century, dozens of groups have been viewed as stigmatized, including individuals who are alcoholic (Dean & Poremba, 1983; Weinberg & Vogler, 1990), Black (Dovidio & Gaertner, 1986, 1993), blind (Albrecht, Walker, & Levy,

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1982), diagnosed with cancer (Bloom & Kessler, 1994; Muzzin, Anderson, Figueredo, & Gudelis, 1994), facially scarred (Bull & Rumsey, 1988), homosexual (Dunbar, Brown, & Amoroso, 1973; Neuberg, 1994), obese (Allon, 1982; Crandall & Biernat, 1990; DeJong & Kleck, 1986), physically disabled (Kleck, Ono, & Hastorf, 1966; Perlmán & Routh, 1980), stutterers (Woods & Williams, 1976), and female (Heilbrun, 1976). Because of the wide variation in stigmatized groups, researchers have attempted to classify stigmas into different typologies (see, e.g., Northcraft, 1980). Undoubtedly the most widely recognized classification is Goffman's (1963) conceptualization of three stigma categories: (1) "blemishes of individual character," such as alcoholism, homosexuality, unemployment, and addiction; (2) "abominations of the body," such as physical deformities and conspicuous disabilities; and (3) "tribal identities," such as race, nation, and religion.

An alternative way of conceptualizing stigmas is to consider specific features inherent in stigmas that may influence strongly how stigmatized individuals are perceived and treated. One such feature is the extent to which a stigma is perceived to be controllable (Weiner, 1995). Stigmas that society perceives to be largely controllable (e.g., obesity, alcoholism, homosexuality) tend to coincide with those viewed as character blemishes, and may be particularly aversive to nonstigmatized interactants because possessors tend to be held accountable for such conditions. In addition, most people believe that these conditions could be altered or prevented with some effort, but that this effort is not put forth. Thus these stigmatized individuals have been viewed as weak and undisciplined, and have been reacted to with greater hostility and less sympathy (Hebl, 1997; Farina, Holland, & Ring, 1966; Levine & McBurney, 1977; Weiner, Magnusson, & Perry, 1988). Perceptually, they are reduced from whole and "normal" people to contaminated, rejected ones (see, e.g., Herek, 1988; National Gay Task Force, 1988).

A second distinguishing feature of stigmas, particularly ones that might lead to increased awkward moments, is the extent to which stigmas are disruptive in a social interaction. Described as an important dimension by Jones et al. (1984), "disruptiveness" refers to the extent to which a stigma makes itself visible in an interaction. Disruptiveness is heightened, according to Jones et al., when a stigma is aesthetically unappealing, when a stigma is visible, and when the "peril" of a stigma (dangerousness of the stigma to the perceiver) is high. Disruptiveness, then, may be a direct gauge of the strain or difficulty characterizing interchanges between mixed interactants. Empirical evidence suggests that nonstigmatized individuals have strengthened stereotypes of individuals who possess disruptive stigmas (McGuire, 1998), which may directly lead to more aversive reactions in social interactions. In addition, those

who have less disruptive stigmas may even be able to hide the evidence of being stigmatized (see also Goffman's [1963] "discredited vs. discreditable" categorization).

When we consider different categorizations of stigmas and some of their defining features, it becomes clear that many factors about a stigma itself can affect mixed interactions, aside from the more standard social-psychological effects of expectancies, situational factors, and individual differences. It is also important to note that while categorizations and lists of distinguishing features of stigmas may be helpful as a cognitive framework, they are simultaneously somewhat arbitrary and may be misleading in terms of making specific predictions about social interactions and their outcomes. That is, some stigmas may have less impact than others on the production of awkward moments. People's experiences with and perspectives concerning a given stigma are diverse, and what creates an awkward moment for one pair of interactants may not create the same anxiety in another pair. Given such variation in stigmas and their impact on interactions, we still find Goffman's (1963) categories and the delineation of certain features helpful in drawing comparisons and general trends across the broad range of stigmatizing conditions. By considering a number of personal accounts concerning diverse sets of stigmatizing conditions, we can observe some of these trends and can begin to better understand awkward moments.

#### FIRSTHAND ACCOUNTS OF AWKWARD MOMENTS

In indirect ways, awkward moments have been described throughout history by both nonstigmatized and stigmatized interactants, and by observers of these interactions. We begin this section by presenting some firsthand experiences of nonstigmatized individuals. In particular, we asked college students to describe their personal experiences, observations, and expectations regarding social interactions with stigmatized individuals. Consistently across our sample, the students reported interactions that involved experiences of awkward moments. The types of stigmas and specific comments included the following:

*Albinism:* "In a conversation that I had with an albino, I was nervous because certain topics such as tanning, birthmarks, or color contacts seemed off limits, and I was so afraid I would accidentally bring them up."

*Being Black:* "Sometimes when I'm talking to them [Black people], I just feel angry at them. I know I shouldn't, but I just do."

*Blindness:* "In my experience, the seeing person is quite prone to ac-

identally referring to visual stimuli, such as 'What do you think of the decorations?' and 'Wow, that woman is wearing an ugly dress!' Also, the seeing person feels uncomfortable terminating the conversation, having to decide if they just walk away and leave them [the blind person] standing there or ask if they need help getting to their next destination."

*Obesity:* "I've noticed one usually has an immediate reaction of repulsion, almost as if what they see is grotesque. This repulsion, which one attempts to hide, can change to anger in the interaction if gluttonous behavior or lazy behavior is pursued by the obese individual."

*Physical Disability:* "I have felt nervous and apprehensive about offending or upsetting people in wheelchairs. I'm never sure whether to stand and look down upon the person, to kneel, or to sit. I never want to mention activities that I have done for fear that the handicapped person will envy me and wish to be able to do such activities. Often such conversations only reach surface issues. I avoid discussing anything about how the person ended up in a wheelchair."

*Stuttering:* "We had never met before, and I was thinking about his stutter the whole time. But at the same time, I was trying really hard to look like I did *not* notice the stutter."

Awkward moments are further illuminated by considering accounts from stigmatized individuals, who corroborate the occurrence of nonoptimal interactions. Perhaps the best-known accounts come from Goffman's 1963 book, *Stigma: Notes on the Management of Spoiled Identity*, which presents poignant descriptions, case studies, and autobiographical stories about the lives of stigmatized individuals and their mixed interaction difficulties. Such descriptions, however, can also be found in other published autobiographies and sources of nonfiction:

*Being Black:* "When you are harried by day and haunted by night by the fact that you are a Negro, living constantly at tiptoe stance, never quite knowing what to expect next, [you] are plagued with inner fears and outer resentments . . ." (King, 1986, p. 52).

*Facial Deformation:* "I like best to be out of sight of strange people. I envy to be normal like the other fellow. Ridicule is plenty and always" (MacGregor, Abel, Bryt, Lauer, & Weissmann, 1953, p. 94).

*Obesity:* "As a fat child (and even later as a fat adult) I have always

felt some degree of alienation from those around me" (Wiley, 1994, p. 96).

*Obesity:* "He was quiet for a moment, then said, 'This is embarrassing. I'm not attracted to you because of your weight.' His answer devastated me . . . . My worst fear had happened" (Wiley, 1994, p. 126).

*Physical Disability:* "Two contradictory themes in American life [are] sympathy and self-reliance. Outside rehab, self-reliance was a high-risk proposition. To people raised on telethons, it looks suspiciously like a chip on the shoulder" (Hockenberry, 1995, p. 33).

*Physical Disability:* "People in the apartment watched me come and go. I didn't know them. They didn't ask about me. I didn't ask about them. I was alone" (Hockenberry, 1995, p. 116).

*Stuttering:* "We who stutter speak only when we must. We hide our defect, often so successfully that our intimates are surprised when in an unguarded moment, a word suddenly runs away with our tongues and we blurt and blat and grimace and choke until finally the spasm is over and we open our eyes to view the wreckage" (van Riper, 1939, p. 601).

An examination of these accounts from both nonstigmatized and stigmatized individuals reveals two main themes. First, anxiety is present as a precursor or as a concomitant to each awkward moment. By "anxiety," we refer to Leary's (1983) definition of physiological arousal accompanied by uneasiness concerning an impending negative outcome that a person believes is unavoidable. Anxiety is directly associated with—either enveloping or initiating—additional feelings of discomfort, tension, and forced or strained interactions (e.g., Ickes, 1984). Such a description can readily be applied to an impending mixed interaction, in which a perceiver may have expectancies that the situation will be extremely difficult or negative simply because it involves interaction with a stigmatized person. Such an expectancy may serve to increase the anxiety and arousal, and may subsequently lead to the confirmation of this expectancy. The stigmatized individual may also experience this anxiety simultaneously. However, an awkward moment may also occur when only one member of the interaction experiences discomfort, and this need not be made public or obvious to the other interactant.

The empirical examination of anxiety per se in mixed interactions has not gained a great deal of attention. One exception to this is the examination of the phenomenon of "intergroup anxiety," which suggests that anxiety toward outgroups and outgroup members may be embodied in many different forms (Devine, Evett, & Vasquez-Suson, 1996). Fur-

thermore, Stephan and Stephan (1985) suggest that prior intergroup relations, intergroup cognitions, and situational factors lead to intergroup anxiety that has behavioral, cognitive, and affective consequences for the self and for the ingroup or outgroup. Recent research suggests that such consequences may include self-esteem loss (Crocker, Cornwell, & Major, 1993; Steele, 1988). In the following section, we describe precursors that lead one to become anxious.

The second theme that emerges in the personal accounts is avoidance. The very possibility of encountering a mixed interaction may lead both nonstigmatized and stigmatized individuals to arrange their lives so as to minimize or altogether avoid them. Goffman (1963) proposed that many stigmatized individuals remain at home and rarely enter the public eye of the nonstigmatized world, because they anticipate and dread the reactions of nonstigmatized individuals. A sizable amount of empirical research, particularly in the physical disability literature, also documents this tendency toward avoidance. For instance, Snyder, Kleck, Strenta, and Mentzer (1979) found that nondisabled persons avoided social interaction with disabled persons, particularly when a socially acceptable excuse was present. These researchers gave participants a choice between watching a movie together with a person wearing a metal leg brace or watching a very similar movie alone. Participants strongly preferred viewing the movie alone. However, if the movie was identical, then participants chose to watch it with the person wearing a leg brace. These results were interpreted to reveal nonstigmatized individuals' desire to avoid disabled persons, but only when the reasons for this avoidance could not have been attributed directly to prejudice or rejection of the disabled individual. Similarly, Kleck et al. (1966) examined a forced interaction in which participants were asked to interview a confederate who appeared either disabled or physically normal through the use of a specially designed wheelchair. Nonstigmatized individuals again appeared to avoid interaction by terminating the interview much sooner and showing more behavioral inhibition when interacting with the disabled versus the nondisabled individual (see Kleck, 1968a, 1968b). Additional research confirms this avoidance motivation (see, e.g., Belgrave, 1984; Devine et al., 1996; Mills, Belgrave, & Boyer, 1984; Stephan & Stephan, 1985).

In sum, both stigmatized and nonstigmatized individuals report the presence of anxiety and avoidance in mixed interactions. We believe that this emotion is responsible for initiating and perpetuating awkward moments. In the following section, we explore a number of explanations for the anxiety that arises and the awkward moments that result. In describing these cognitions, we consider both the perspective of both the nonstigmatized and stigmatized interactants.

## WHY DO AWKWARD MOMENTS OCCUR?

### Reasons for Nonstigmatized Individuals' Anxiety

#### *Fear of Danger*

Nonstigmatized individuals may experience anxiety because of an underlying fear they possess of stigmatized individuals. This fear may arise from a number of sources, the first of which is a fear tied to Jones et al.'s (1984) dimension of "peril," or danger to the perceiver. Certain stigmas convey either an imagined or a real threat to one's physical health, and are thus perilous. For instance, stereotypes of Blacks and of persons with characterological stigmas (e.g., imprisonment or addiction) lead many to believe that these people are dangerous to one's well-being. Although such individuals are not necessarily dangerous, the associated stereotypes may consolidate a nonstigmatized individual's experience of discomfort and anxiety in a mixed interaction. Fear may also be aroused in response to stigmas that have aggression or unpredictability tied to their stereotypes. For instance, persons with mental illness are often feared because of the unpredictability of their actions.

Second, nonstigmatized individuals may fear social or interpersonal contagion (Haidt, McCauley, & Rozin, 1994; Rozin, Markwith, & McCauley, 1994). This anxiety may arise from a fear that a stigma might spread merely because of an association with a stigmatized individual (Hastorf, Wildfogel, & Cassman, 1979). Although most people wish to avoid the possible contagion of stigmas, certain people voluntarily take on "courtesy stigmas" (Goffman, 1963). Such individuals include relatives of stigmatized individuals, as well as those individuals who work in settings that cater to stigmatized individuals (i.e., a nurse working with disabled patients, a heterosexual bartender working in a gay bar). Fears of spreading may take a "physical" or a "social" form. Fear of physical spreading is a fear of actual physical contamination. For instance, some people fear that they will contract AIDS or cancer from physical contact with those who already have these conditions. In some cases, this fear may be accurate. Fear of social spreading, by comparison, has more to do with the feared loss of social status or contamination of one's attitudes through contact. For instance, dating an overweight partner can portray negative characteristics and attributions about the other partner. Recent investigations affirm the notion that social spreading actually does occur in the case of the homosexuality stigma; hence, nonstigmatized individuals may actually be justified in maintaining distance from some stigmatized individuals (Sigelman, Howell, Cornell, Cutright, & Dewy, 1990). In particular, Neuberg, Smith, Hoffman, and Russell (1994) demonstrated that male individuals were rated less posi-

tively by participants if they associated with a homosexual man than if they associated with a heterosexual man. The stigma-by-association phenomenon is a condition, then, that fosters avoidance of and awkwardness in mixed contacts (see Bull & Rumsey, 1988).

Not only is the contagion of stigmatizing conditions sometimes based on faulty knowledge about stigmatizing conditions, but it is also often based on a lack of experience in interacting with members of stigmatized groups. This lack of experience does not necessarily stem from active avoidance of mixed interactions; it may also result from the fact that some types of stigmas are statistically infrequent.

*Statistical Infrequencies of Some Stigmas, and General Lack of Experience and Knowledge*

Certain types of stigmas in our world are statistically infrequent. This infrequency not only makes individuals with such stigmas more salient (see Zebrowitz-McArthur, 1982), but also results in a lack of contact with such persons and an uncertainty in how exactly to respond and behave once contact with them is established. Consider that a substantial percentage of individuals in our country is obese (approximately one out of every four), but that the number of disabled handicapped individuals in our country is far less than this. For example, approximately 0.6% of Americans use wheelchairs (McNeil, 1993), and 0.6% of Americans have an absence of major extremities (Dorgan, 1995). According to the theoretical contributions of Zebrowitz-McArthur (1982), different interaction dynamics in mixed contacts should be expected in nonstigmatized individuals' interactions with obese persons versus physically disabled persons. The uncertainty is simply not there in mixed interactions with obese individuals; rather, their heightened prevalence in society reduces the uncertainty in interacting with them. Exceptions might include exposure to individuals who are grossly obese or who have disproportionate distributions of weight. But overall, people seem to have less uncertainty in interactions with obese individuals because they come in contact with obese individuals so frequently.

In interactions with physically disabled individuals, however, there may be much more uncertainty and lack of know-how. Most individuals have simply had very limited experience in interacting with these and certain other types of stigmatized individuals. One reaction to this limited interaction is for nonstigmatized individuals to proceed with a degree of hesitancy. Because nonstigmatized individuals have been in so few similar situations, they are uncertain as to how they should respond. For instance, should they offer to push a person in the wheelchair if this person is having trouble? Should they be sympathetic, ask questions, be

overly optimistic? Should they guide a blind person across the street? Research on bystander intervention (Latané & Darley, 1970) suggests that people are less likely to help others or to take risks if the situation is ambiguous, if the others are deindividuated, or if the others may be embarrassed by their actions. In the same way, nonstigmatized individuals may refrain from action because the ambiguity is heightened.

Given that most nondisabled individuals (and many disabled individuals themselves) have little to no contact with physically disabled persons and are uncertain about how exactly to respond and behave once contact with such individuals is established, it is understandable that anxiety and awkwardness will emerge. Such uncertainty and lack of know-how have been labeled "interaction pathology" (Davis, 1961; Goffman, 1959, 1963).

#### *Violation of Norms and Expectations*

The lack of experience that many nonstigmatized individuals have in mixed interactions is compounded by the fact that such individuals bring prior expectations to mixed interactions and have schemas for how interactions should proceed. For instance, nonstigmatized individuals may expect their interactants to be likewise nonstigmatized and for interactions to proceed smoothly. When interactants meet expectations, the resulting behavior on the part of the nonstigmatized individuals may be routinized and predictable. However, when interactants are stigmatized and interactions become mixed, expectations are violated. Suddenly, nonstigmatized individuals may find themselves scriptless, their schemas having been disrupted. One result of such scriptlessness is a heightened attention to both their interactants' behavior and their own behavior. In the service of maintaining a posture of normality, nonstigmatized individuals may increase their self-monitoring, think more about their word choices and responses, and feel restrictions in their normal range of verbal and nonverbal behaviors. Given such violations in expectations and the possibility of a sudden focus on behaviors that are not normally considered, it is easy to understand how awkward moments might emerge.

#### *Thought Suppression*

In addition to simply not knowing how to act and being suddenly overly cognizant of what is typically routinized behavior, many nonstigmatized individuals try not to say the wrong thing, although they may simultaneously never be sure exactly what the right or wrong thing is. A nonstigmatized individual rarely introduces the subject of a stigma, as a societal norm governs that the topic of stigma should be introduced only

by the stigmatized individual. The nonstigmatized individual may also attempt to suppress all thoughts concerning the stigma and may try to avoid referring to any topic even marginally related to it. He or she may avoid staring or showing any evidence of disruption potentially caused by the stigma. Although such behavior is intended in most cases to assist and smooth the interaction, research on thought suppression (Wegner, 1994) suggests that those who attempt to suppress unwanted thoughts often ultimately experience a "rebound" effect, whereby they experience a substantial number of such thoughts later. If a mixed interaction is still ongoing during this rebound phase, awkwardness seems unavoidable. Research by Macrae, Milne, and Bodenhausen (1994) found that individuals who were instructed not to think about stereotypes regarding one's devalued mark (e.g., being a "skinhead") were more likely to engage in increased stereotyping than were those who were given no suppression instructions. This finding was manifested in that those who suppressed, relative to those who did not, chose to sit farther away from an actual "skinhead" whom they later encountered. The researchers suggested that the thought suppression of the "skinhead" stereotype created tension in the form of a "bottling up" that later erupted.

#### *Misinterpretations*

In addition to thought suppression, nonstigmatized individuals possess some invalid assumptions about stigmatized individuals that may lead to awkward moments. For instance, nonstigmatized individuals may react with uncertainty and hesitation to stigmatized individuals because they believe that those possessing stigmas, particularly physically disabled individuals, are bitter, emotional, and morose about their stigmas (see Belgrave, 1985; Belgrave & Mills, 1981; Mills et al., 1984). In addition, nonstigmatized individuals avoid certain topics and sometimes interactions altogether because they believe that stigmatized individuals will be overly sensitive about their stigmas and readily offended on topics both related and unrelated to the stigmas. As Belgrave and Mills (1981) suggest, such expectations may arise from nonstigmatized individuals' trying to imagine themselves with similar stigmatizing conditions. But such misinterpretations may block interactants from getting to know each other and may have negative attributional consequences for interactions.

#### *Hostility and Just-World Beliefs*

Whereas some stigmatized individuals' awkward moments arise from the lack of experience, others' arise from deep-seated hostility and antipathy toward individuals who possess stigmas. In particular, nonstigma-

tized individuals report feeling the greatest amount of hostility toward persons who are alleged or known to abuse children or misuse drugs. This finding is probably due to the fact that such stigmas are perceived to be controllable in comparisons with other stigmas, such as AIDS, blindness, paraplegia, or obesity (Hebl, 1997; Weiner et al., 1988). In fact, increasing perceived responsibility for the onset of AIDS increases affective anger responses (and decreases sympathy) for those stigmatized with AIDS (causes ranked from least to most responsibility: blood transfusion, conventional sex, promiscuous sex, homosexuality, drug use) (Graham, Weiner, Giuliano, & Williams, 1993). Increasing one's hostility may lead directly to problematic mixed interactions, given that angry people have been shown to use stereotypes more than those who are not angry (Bodenhausen, Sheppard, & Kramer, 1994).

Nonstigmatized individuals may also express anxiety in mixed interactions because such interactions make them realize their own vulnerabilities. Individuals in the United States tend to ascribe to the belief that the world is just and that people not only get what they deserve but deserve what they get (see Crandall, 1994; Crandall & Martinez, 1996). Maintaining this ideology may be difficult for individuals who interact with stigmatized individuals and are forced to observe that many are innocent victims dealt a clearly undeserved fate (e.g., those with birth defects, those plagued with rare and unpreventable diseases) (see Lerner, 1980). For the most part, people do not want to have their values and beliefs challenged; in fact, individuals are likely to feel hostility toward minority groups that threaten their values (Haddock, Zanna, & Esses, 1993).

Fears associated with invulnerability are likewise embodied in the terror management theory of stigma (Greenberg et al., 1990; Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989). This theory also proposes that people have a strong need to feel that the world is a just place. The derogation of stigmatized persons upholds a personal theory of the world that protects nonstigmatized persons against existential fear and anxiety. Nonstigmatized individuals alter their typical behaviors, then, because interactions with stigmatized individuals make them realize their own vulnerabilities. Empirical evidence supports this view by showing that individuals who have a great fear of someday becoming severely incapacitated elderly folks tend to blame currently elderly persons for problems associated with their age (Snyder & Miene, 1994).

#### *Approach-Avoidance Mechanisms*

Many nonstigmatized individuals report neither solely negative nor solely positive feelings, but rather the presence of competing sets of be-

liefs and experiences regarding stigmatized individuals. Such a phenomenon has been termed "ambivalence amplification" by Katz and his colleagues (Katz, 1981; Katz, Glass, Lucido, & Farber, 1979; Katz & Hass, 1988), and it describes how White individuals in a research context simultaneously offer more help and yet also deliver more shocks to Black than to White individuals. Feelings of hostility or disgust toward a stigmatized individual (e.g., a grossly obese individual, an AIDS patient) may be accompanied with a sincere interest in and desire to learn more about the condition. For instance, Langer, Fiske, Taylor, and Chanowitz (1976) proposed that discomfort toward stigmatized individuals arises because of the conflict between a desire to stare at a novel stimulus and the suppression of that desire for social acceptability's sake. They found that people stared at a photo of a disabled person longer when no observer was present with them. Other emotions also preside in creating awkwardness. Sympathy and guilt are two such emotions that nonstigmatized individuals commonly report (Scheier, Carver, Schulz, Glass, & Katz, 1978; Gibbons, Stephan, Stephenson, & Petty, 1980). Supporting this notion of ambivalence, Monteith (1993) found that guilt was more likely to be prevalent in people who were randomly told that they might possess subtle prejudice than in people who were not told they had such prejudice.

That ambivalence results in anxiety is not surprising. Among the earliest and most prominent social-psychological examinations was one revealing that anxiety may result when two dissonant emotions, cognitions, or behaviors are evoked (Festinger, 1957). More recently, Izard (1991) proposed that a combination of the emotions of fear and (to a lesser degree) sadness, shame and guilt may result in anxiety. When one considers the hesitations that a nonstigmatized person may have about interacting with a stigmatized person, the guilt and shame that arise from not wanting to show negative affect that does exist, and the fear that this negative affect (or cognitions) will become known to the target or to others, it is no surprise that anxiety occurs and awkward moments arise.

In line with the idea of ambivalence, verbal and nonverbal behaviors emitted in mixed interactions often contradict each other. Nonstigmatized people's verbal behaviors directed toward stigmatized individuals tend to be positive and to credit the stigmatized individuals for the burdens they bear (Barker, Wright, Meyerson, & Gonick, 1953; Belgrave, 1985; Hastorf, Northcraft, & Picciotto, 1979). A study examining both verbal and nonverbal behaviors of nonstigmatized persons, however, revealed avoidant nonverbal behaviors, such as maintenance of a greater interaction distance and more rigidity in movement. The inconsistencies in behaviors directed toward stigmatized individuals sup-

port a two-factor phenomenon (Kleck et al., 1966; Kleck, 1969): Overt verbal behaviors directed toward stigmatized individuals (e.g., feedback, public attitudinal measures, the help they receive) seem to have an at least initially positive connotation, whereas covert, nonverbal behaviors (e.g., decreased spontaneity, less acceptance, increased social distance) seem to have an indisputable negative connotation.

Such conflicting behaviors may result in part from the fact that nonstigmatized individuals are able to regulate their verbal behaviors but are less skilled at regulating their nonverbal behaviors. This theory, however, does not by itself explain the observed discontinuity. Thus an approach-avoidance mechanism may be at work, and we observe this with the physical disability stigma. On the one hand, nonstigmatized individuals may be attuned to societal norms to be kind to disabled people (Kleck, 1969); on the other hand, they are motivated to avoid interacting with such people altogether. What results is inconsistency. A nonstigmatized individual can adeptly present a facade of acceptance for a stigmatized individual through very positive verbal behaviors, but negative nonverbal messages simultaneously resonate from the nonstigmatized interactant and create a mixed message.

Feelings of approach-avoidance may be very common to the experience of awkward moments. We should point out that if a nonstigmatized individual's feelings about or behaviors toward a stigmatized individual are entirely negative, awkwardness may still not result. Both interactants may be aware of and strongly disagree about each other's perspective, but this need not result in an awkward moment. What seems likely to instigate an awkward moment is the presence of this approach-avoidance, in which the nonstigmatized individual has very conflicting desires and beliefs.

### **Reasons for Stigmatized Individuals' Anxiety**

#### *Fear of Rejection*

A stigmatized individual has a number of goals in any given interaction, and reducing the extent to which he or she is avoided seems to be foremost (e.g., Belgrave & Mills, 1981). In fact, stigmatized individuals define success in part by the extent to which they are successful at affiliating with and being accepted by nonstigmatized others (Wright, 1983). Recognizing this motivation, Goffman (1963) introduced the concept of "normalization" to refer to the extent to which a nonstigmatized individual treats a stigmatized person as if he or she does not have the stigma. Clearly, most stigmatized individuals aspire toward normalization. Such individuals often experience anxiety in interactions because

each interaction is a potential threat to their self-esteem and happiness, since normalization may not occur. Rather, the smallest hint of rejection may create tension in stigmatized individuals, and lead to awkward moments in mixed interactions. As in a chain reaction, the initial sense of rejection may cause stigmatized individuals to act awkwardly, and ultimately reinforce and perpetuate nonstigmatized individuals' rejection behaviors.

### *Being "on Stage"*

The fear of being rejected and viewed as flawed or abnormal (see Herek, 1988) is compounded by the fact that stigmatized individuals report being unable to avoid attentional focus once an interaction has been initiated. Stigmatized individuals report feeling that they are constantly "on stage" in conversations, meaning that they have heightened self-consciousness and continuously feel the need to create impressions of being normal despite their stigmas (Goffman, 1963; Wright, 1983). They report having less privacy and are treated as low-status individuals by nonstigmatized others (Wright, 1983). In addition, a stigmatized person is often reduced to the stigma itself (e.g., "the deaf-mute"), rather than conceptualized as a person who has a stigma ("Bob, who cannot hear"). Any difficulty observed by a nonstigmatized individual tends to be attributed to the presence of the stigma, even if the stigma is completely irrelevant. For instance, a disabled person who makes a bad decision is believed to make it because he or she has physical limitations, not because of the standard situational and personality influences that affected the decision. Similarly, a Black person who acts in a reserved manner may be interpreted as being "lazy" or "hostile." A nonstigmatized individual may also assume that because a person possesses a stigma, he or she simultaneously possesses other, additional problems. Hence, an interactant talks very loudly to a blind person or very slowly to a person who stutters. The sum of these behaviors places a great deal of emphasis on the verbal and nonverbal actions of stigmatized individuals. Such individuals are indeed "on stage," and an exaggerated attention to their behaviors may promote interaction awkwardness, confirm their feelings of rejection, and add to their insecurities and feelings of inferiority.

### *Self-Loathing*

It may not be surprising, then, that stigmatized individuals themselves often view stigmas negatively, and that their interactions with other stigmatized individuals may also produce negative outcomes. For example, Comer and Piliavin (1972) found that physically disabled subjects termi-

nated the interview sooner, were more inhibited in their gross motor movements, and engaged in less eye contact when they interacted with a disabled interviewer than with a nondisabled interviewer. Such negative reactions from members of their ingroup as well as from their outgroup may lead stigmatized individuals to experience decreases in mood and self-esteem, and increases in self-consciousness, social isolation, and discrimination (Bull & Rumsey, 1988; Crandall, 1994; Wright, 1983). Stigmatized individuals may enter interactions expecting to be treated badly, and thereby may engage in behavioral choices that are self-fulfilling and increase levels of anxiety.

#### *Overinterpretation*

The nonoptimal interaction dynamics and the self-loathing that stigmatized individuals experience may lead them to generalize and believe that all individuals are viewing them negatively. That is, not only do stigmatized individuals suffer at the hands of others, but stigmatized individuals may create a whole set of undesirable expectations themselves. Research confirms this, showing that stigmatized individuals sometimes interpret nondiscriminatory actions by nonstigmatized individuals as discriminatory actions against their stigmatized status. In particular, Kleck and Strenta (1980) found that subjects who believed that facial scars had been applied to their faces (with the help of cosmetics) prior to interactions with other individuals interpreted a number of neutral signs from their interactants as being signs of prejudice and antipathy against their deviant status. In reality, the facial scars could not explain interactants' behavior because the scars were removed, unbeknownst to the subjects, before the subjects ever interacted with the nonstigmatized individuals. Hence, subjects found evidence to confirm negative reactions to their stigma when no such reactions existed.

Although in many cases negative reactions do occur, this study showed that nonstigmatized individuals are not the only ones who exhibit biased behavior in mixed interactions. Rather, stigmatized individuals themselves share part of the responsibility for the negative reactions they accrue, particularly by overinterpreting or misinterpreting others' behaviors. Such conjectures may create a social reality of their own. It would be best if stigmatized individuals could realize that initial reactions against them are not necessarily signs of rejection, but represent either uncertainty as to how best to behave or some other not necessarily negative reaction. Instead, the sum of the interactional setbacks explains why stigmatized individuals often react by experiencing a great deal of anxiety within interactions and attempting to avoid such interactions altogether.

### Summary

In sum, nonstigmatized individuals may experience fear, lack of knowledge, violations of expectations, a rebounding of suppressed thoughts, misinterpretations, prejudiced sets of beliefs, and ambivalence regarding stigmas and individuals who possess them. Furthermore, stigmatized individuals feel the pressures of rejection; feel that they cannot avoid being judged, at least in part, on the basis of their stigmatized status; have self-esteem issues; and sometimes react with hostility and/or misinterpretations toward their nonstigmatized interactants. In sum, many forces combine to create anxiety in mixed interactions, and the reasons behind the occurrence of awkward moments are manifold. Any given awkward moment may have a number of sources causing or maintaining it. The aforementioned factors do not constitute an exhaustive list, but are intended to provide readers with a general impression regarding some of the causes of interaction anxiety and awkward moments. Awkward moments, in turn, may perpetuate the negativity associated with mixed relations and lead to further misunderstandings between mixed interactants.

### THE IMPORTANCE OF EXAMINING AND ATTENUATING AWKWARD MOMENTS

The descriptions we have provided serve as guidelines for thought and provide an impetus for future research concerning awkward moments. Future research might carefully examine the emotional states of the interactants by attempting to describe and clarify their presence and influence in mixed interactions. Rather than naively believing that a single precursor leads to an awkward moment, we believe that many of these forces act together and reinforce each other, making interactions uniformly difficult. We hope that future research will continue to identify and analyze the building blocks of these awkward moments, and to determine their impact on interactants as well as on larger issues, such as intergroup attitudes and behaviors.

Each of the mechanisms we have described proposes some degree of anxiety, an emotional reaction to stigmatized persons. Yet almost no research has systematically examined the emotional responses of nonstigmatized people toward stigmatized people. Zajonc (1980) stated:

There are practically no social phenomena that do not implicate affect in some important way. Affect dominates social interaction, and it is the major currency in which social intercourse is transacted. . . . One cannot be introduced to a person without experiencing some immediate

feeling of attraction or repulsion and without gauging such feelings on the part of the other. We evaluate each other constantly, we evaluate each other's behavior, and we evaluate the motives and the consequences of their behavior. (p. 153)

This perspective articulately reflects the notion that emotions play a central role in interactions with others, including stigmatized individuals. Anecdotal reports of perceivers in interactions with stigmatized persons suggest that in addition to anxiety, other emotions influence mixed interactions. Archer (1985) describes stigmas as affecting communication mechanisms as well as producing strong effects in the perceiver such as aversion, anxiety, fear, loathing, pity, and panic. Our review has touched upon these emotions, but future research might further examine how specific emotions intertwine with the experience of awkward moments.

It is also important to examine other aspects associated with mixed interactions—those at the behavioral and cognitive levels—and to examine whether and how individual-difference variables influence the emotional manifestation of awkward moments. Monteith, Devine, and Zuwerink (1993) discuss how highly prejudiced individuals may experience an outward-directed negative affect (including disgust, anger, and irritation), as compared to low-prejudice individuals, who experience a "diffuse discomfort." Clearly, emotional states color perceptions and the way information is processed and interpreted, just as cognitions do—by influencing encoding and subsequent recall, affecting the valence of evaluative judgments, being used to infer judgments, or narrowing the cognitive focus of the perceiver (see Clore, Schwarz, & Conway, 1994, for a discussion; see also Mackie & Hamilton, 1993; Forgas, 1992).

In addition to providing research with a new direction, research on awkward moments can work to attenuate the very nature and occurrence of interaction strain. Specific strategies that can be adopted by both stigmatized and nonstigmatized individuals have gained recent research attention. These strategies can be categorized by their focus on a dyadic interactional level or on a larger, societal level. The implementation of both interactional-level and societal-level strategies, we believe, can serve to reduce the occurrence of anxiety and awkward moments in mixed interactions.

### **Interactional-Level Strategies**

Most of the strategies that work to reduce awkward moments attempt to reduce avoidance and to increase contact and dialogue between mixed interactants. Since the majority of the burden in possessing a stigma lies

with the bearer of this stigma (Goffman, 1963), we first focus on strategies that stigmatized persons might undertake. Because self-acceptance and openness have been found to be predictive of the well-being of stigmatized individuals, we believe that stigmatized individuals should work toward these goals not only for their own well-being, but also for the well-being of social interactions. Wright (1983) has proposed that the way for disabled individuals to gain self-acceptance is to retreat from the negative social images regarding disability and to accept differences as nondevaluating. In essence, there is a need to effect changes in stigmatized individuals' belief systems. With regard to physical disability, Wright believes that most individuals focus on the debilitating side of disability rather than the salient, unique status it offers and that for disabled individuals to do anything less than accept their situation would be disastrous to themselves and to their relationships with others. Disabled and other stigmatized individuals therefore should work to possess and maintain high levels of self-esteem as a buffer against interaction anxiety.

Self-acceptance also seems to predict other-acceptance. That is, the specific interpersonal manner (e.g., stereotyped, depressed style vs. socially appropriate and open, accepting style) that a physically disabled individual adopts in a given social interaction may influence the nondisabled individual's behaviors (Elliott & MacNair, 1991; Elliott, MacNair, Herrick, Yoder, & Byrne, 1991). A socially appropriate, nondepressed interpersonal style adopted by physically disabled individuals corresponds significantly with an enhanced amount of conversation, an increase in eye gazes, and greater positivity in social evaluations from nondisabled interactants. Thus it seems advantageous for some members of stigmatized groups to portray satisfaction to others.

Satisfaction may be garnered in part through a strategy referred to as "attributional ambiguity" (Crocker & Major, 1989, 1994; Snyder et al., 1979), which is one way individuals work to maintain and protect their self-esteem. Specifically, when stigmatized individuals are rejected or receive negative feedback from others and there is ambiguity about this feedback, one strategy is for them to attribute the negativity not to their own shortcomings but to the prejudice of others. Recent research has demonstrated that both women and Blacks who experience such ambiguity are able to attribute unfavorable feedback successfully to the other persons' reactions against them, rather than to their own lack of personal deservingness (Crocker & Major, 1994). Such a strategy not only alleviates a person's sense of being at fault, but it also transfers the feedback from the individual person to the stigmatized subgroup (i.e., women or Blacks) and creates a shift that can actually strengthen the self-concept of the individual (see Dion, 1986).

Another strategy that can maintain and even bolster a stigmatized person's sense of self-esteem is based on Steele's (1988) theory of "self-affirmation." This theory suggests that individuals can continue to view themselves positively when one aspect of their personhood is threatened by creating or focusing on another aspect of themselves that is positive. Self-affirmation processes are activated by information that threatens the perceived integrity of the self—for instance, when an obese individual is ridiculed by others for being overweight. The obese individual realizes that obese people in general are viewed as self-indulgent and undisciplined. Realizing that such views poses a threat to his or her perception of self-integrity, the individual is motivated to reduce the threat by engaging in some other affirmation of general self-integrity (i.e., joining a valued cause, spending more time with children, accomplishing more at the office). An article by Miller, Rothblum, Felicio, and Brand (1995) suggests the power of compensation as utilized by stigmatized individuals. Specifically, they found that obese women who were unaware that their partners could see them received low ratings of likability and social skills by such partners. Interestingly, however, such findings were not obtained when obese women were aware that their partners could see them. These results suggest that overweight women actively compensate when they know that other people can see them and discriminate against their size.

One way of compensating may involve a stigmatized individual's expressing some interests in common with a nonstigmatized individual. For example, walking a pet has been shown to provide a nonverbal statement of shared interest that can facilitate conversation between stigmatized and nonstigmatized individuals (Hart, Hart, & Bergin, 1987). Such increased conversation on a joint topic may be a gateway to uniting individuals in a superordinate interest, rather than pitting them against each other in a social interaction.

One strategy that seems particularly beneficial in fostering positive mixed-interaction dynamics is the "acknowledgment" strategy, or the tactic of disclosing a stigma to a nonstigmatized interactant. One of the earliest studies conducted on such a strategy revealed that a stigmatized individual's sensitivity about the stigma might reveal to nonstigmatized others whether the topic of the stigma was an open or closed one (Farina, Sherman, & Allen, 1968). If the stigmatized individual merely mentioned that his or her stigma caused some difficulties and then switched the topic, as in the Farina et al. (1968) article, the stigma topic was not clearly a safe one for nonstigmatized others to broach. Consequently, nonstigmatized individuals were left feeling that the topic was closed. However, if the stigmatized individual revealed information surrounding the possession of the stigma, recognized that others probably had ques-

tions about the stigma, and encouraged others to ask questions that they might have, the stigmatized individual was demonstrating less reactivity and a great deal of openness toward possessing the given stigma. Therefore, an acknowledgment devoid of defensiveness and hints of maladjustment leads to greater acceptance on the part of others.

Similarly, Hastorf, Wildfogel, and Cassman (1979) examined a physically disabled individual who either did not acknowledge being in a wheelchair, or acknowledged that being in the wheelchair was problematic but that he was learning to accept it and the difficulties associated with it. In addition, he acknowledged that he realized other people were afraid to talk about the handicap but that he encouraged others to ask questions, as he believed talking about it allowed others to set aside his handicap and eventually see him as a person. The experimenters found that 71% of the time the physically disabled individual who acknowledged his stigma was chosen as the preferred work partner by non-stigmatized others, whereas only 29% of the time the physically disabled individual who did not acknowledge his stigma was chosen as the preferred work partner.

Because the acknowledging partner might have been chosen as the preferred work partner simply on the basis that he made a personal disclosure, these investigators conducted a second study in which the acknowledgment condition was compared with another personal disclosure condition. Specifically, a male confederate either acknowledged his condition as in the first study, or described his relatively ordinary life (e.g., a girlfriend, some friends, parents). Again, the individual who acknowledged his stigma was preferred over the individual who personally disclosed other information.

In Hastorf, Wildfogel, and Cassman's (1979) third study, a "nervous mention" condition was compared with the personal disclosure condition. In this study, the confederate mentioned the stigma in a manner that conveyed tension by running his hand through his hair, avoiding eye contact, and clasping his hands tightly together. The results continued to reveal that mentioning the stigma was preferred over not mentioning it, despite the presence of tense behavior.

The acknowledgment strategy has been shown to be successful not only for physically disabled individuals, but also for individuals who have had laryngectomies and who stutter. In particular, 84% of subjects in one study indicated a strong preference for working with a laryngectomized individual who acknowledged the stigma over an individual who did not (Blood & Blood, 1982). Subjects rated the acknowledger as more pleasant, positive, calm, active, likeable, well-adjusted, hardworking, stronger, and tougher than the nonmentioning person. Similarly, 71% of subjects in another study indicated a strong preference for work-

ing with a stutterer who mentioned the condition over one who did not (Collins & Blood, 1990). Subjects described the acknowledger as having a greater ability to cope, overall ease in the speaking situation, [and] positive attitude and as being more of a "real person" than the nonmentioning person.

Before adopting the acknowledgment strategy as a way to reduce awkwardness, one must first consider the particular stigma. Recent research by Hebl (1997) suggests that acknowledgments may be beneficial for some stigmatized individuals but may actually be liabilities for others. Whereas acknowledging seems to yield positive outcomes (e.g., on person perception measures) for physically disabled individuals, stigmatized individuals who have more "controllable" stigmas (e.g., obesity) are not accorded more positivity and rather are denigrated for mentioning their stigmas. Thus acknowledgments may be limited in the benefits they provide in reducing awkward moments. Acknowledgments may be particularly beneficial for disruptive, visible stigmas such as disabilities, as they can provide a nonstigmatized interactant with information. In the absence of this information, the subject of an obvious stigma remains a subterranean topic. For instance, an individual with a missing arm may realize that the nonstigmatized individual is looking at and wondering what happened to the arm; in turn, the nonstigmatized individual may realize that he or she has been caught looking. This "I know that you know that I know" interplay serves to get the social interaction off to a weak start, because a focal point of the interaction has been passed over or omitted.

Additional research on the acknowledgment strategy suggests that more interactional success occurs when stigmatized individuals provide a context for the acknowledgment (Belgrave & Mills, 1981; Belgrave, 1984). That is, rather than the individual's mentioning the stigmatizing condition alone, requesting assistance and *then* mentioning the stigmatizing condition have been shown to facilitate acceptance of the stigmatized individual (Belgrave & Mills, 1981; Mills et al., 1984). For example, an individual in a wheelchair might be unable to utilize a pencil sharpener and thus ask a nonstigmatized interactant whether he or she would mind sharpening the pencil, because "there's just some things you can't do from a wheelchair" (Belgrave & Mills, 1981, p. 48). Asking for assistance prior to mentioning the stigma is hypothesized to work as a remediation strategy because acknowledgments of stigmas in the absence of requests are often perceived by nonstigmatized others as coming "out of the blue" (Belgrave & Mills, 1981, p. 46). Inappropriate acknowledgments may be deleterious if they indicate the presence, and not absence, of emotional duress associated with possession of a stigma. On the other hand, acknowledgments made after a request are thought to be

perceived as being based less on emotions and more on the functional purpose (e.g., "I need to tell him why I can't open the door myself").

### Societal-Level Strategies

Additional strategies, focused on a more global level, may also remediate the occurrence of awkward moments. These strategies tend to share the goals of making mixed contact more accessible and more likely, and reducing obstacles that restrict stigmatized individuals' access to resources. More societally focused strategies may at first seem like lofty goals in addressing remediation of problems at the dyadic level. However, we believe that interaction problems, such as awkwardness, cannot fully be attenuated without examining and addressing the larger, more complex societal influences and forces.

Perhaps the most widely examined strategy involves the "contact hypothesis," which is that simply increasing the contact between stigmatized and nonstigmatized individuals should facilitate ease of interaction. Early studies found a positive relationship between contact and acceptance of stigmatized individuals. For example, Deutsch and Collins (1951) found that amount of contact with Black women was positively correlated to the favorable attitudes that White women held toward Black women. While the contact hypothesis leads to favorable attitudes, many conditions (e.g., cooperative activities, personal interactions) are necessary (see Stephan, 1986). It may be especially important to increase nonstigmatized individuals' exposure to stigmatized individuals who are happy. This exposure allows others to learn that this oxymoron ("happy and stigmatized") can and does occur in many cases, and that the stereotype that stigmatized individuals are always morose and unhappy people is in many cases simply unfounded (Elliott & Frank, 1990; Elliott, Yoder, & Umlauf, 1990).

However, other early studies failed to find an increase in acceptance as a result of increased contact. In a classic study, Richardson, Goodman, Hastorf, and Dornbusch (1961) asked 10- and 11-year-old children from diverse backgrounds to view a standardized set of six pictures depicting a child who (1) had no physical disability, (2) had crutches and a leg brace on the left leg, (3) was sitting in a wheelchair with a blanket covering both legs, (4) was missing a left hand, (5) had a facial disfigurement on the left side of the mouth, or (6) was obese. Subjects were asked to rank-order the children according to whom they liked the most; not surprisingly, the child with no physical disability was consistently ranked first, indicating that this child was liked by others the most. What was surprising, however, was that this and other studies revealed that such rank orderings were not affected by increased contact with dis-

abled children (for a review, see DeJong, 1980). The continued possession of negative beliefs about other groups of stigmatized people (e.g., obese individuals) by medical professionals who must work with such clients on a regular basis also suggests the lack of a positive relationship between contact and acceptance (see Allon, 1982).

Some of the contradictory findings may be clarified by Kleck (1968a), who suggested that the quality and not the quantity of contact is the important determinant in ascertaining the impact of increased contact on acceptance. In particular, close social and personal contact may result in greater acceptance than medical or rehabilitative contact (see Kleck, 1968a, for a review). A sizable literature on the contact hypothesis reveals necessary conditions for contact to reduce hostile intergroup relations. These conditions include groups having mutual goals (Sherif, Harvey, White, Hood, & Sherif, 1961), having equal status (Aronson, 1984), and engaging in actual social interactions (Cook, 1978).

A second societal-level strategy is to increase legislation concerning stigmas. In the past decade, awareness of the needs and rights of stigmatized individuals has grown tremendously. For example, laws mandate that new buildings must be constructed to be accessible to those in wheelchairs; nondiscriminatory policies on hiring are ubiquitous in corporations and institutions; and the presence of individuals with stigmatizing conditions is at an all-time high on college campuses. The early Civil Rights Act of 1964 was the first of these laws, and was expanded in 1972. The Age Discrimination in Employment Act of 1967, and the Americans with Disabilities Act of 1990, also paved the way for the removal of barriers faced by stigmatized individuals. State laws, too, are changing in a way advantageous to stigmatized individuals. This currently may be happening most dramatically with the stigma of homosexuality: A growing number of states have repudiated laws restricting gay rights, have increased civil rights protections for homosexuals, and are even beginning to outlaw discrimination against gays and lesbians in public schools. Such advances are resulting in much higher visibility for stigmatized individuals in our society. As such trends proliferate, the very nature of stigmas may be altered (see, e.g., Archer, 1985). For instance, being gay was once viewed as a psychiatric disorder and ridiculed; now being gay is not only more widely accepted, but is the basis of a growing community and culture. Moreover, gay people are playing recognized roles in politics, the media, and religion (for a review, see Miller, 1995).

At the societal level, dispelling the myths surrounding stigmas will also help to reduce problems at the interaction level. One arena in which stereotypes seem to be accentuated is that of the mass media. People tend to form attitudes and exhibit behaviors in line with media presenta-

tions. Studies spanning over the last several decades have revealed consistently negative depictions of stigmatized groups, including Blacks (Leab, 1975), Native Americans (Trimble, 1988), elderly people (Harris & Feinberg, 1977), physically disabled individuals (Hockenberry, 1995), and women (McArthur & Resko, 1975). Rather than presenting stereotypic portrayals of stigmatized individuals, the media have the power to normalize stigmatizing conditions. The media can inform and break down barriers by revealing and disproving many of our negative stereotypes concerning stigmas. Individuals who are quadriplegic are attending medical school; disabled individuals are driving taxis; individuals who are mentally retarded are holding down corporate jobs; and women are running for President. Stigmas can be "destigmatized," and the media are very powerful instruments for doing this.

Dispelling the myths also involves supplanting untruths with accuracies concerning stigmatizing conditions and the lives of those who are stigmatized. One attempt to give greater exposure to individuals who have had little exposure until now is the establishment of courses and, in some cases, even departments for the study of stigmatized groups within college and university settings (e.g., women's studies, African American studies, disability studies). Such courses and departments offer those who have little experience with or knowledge about such groups the opportunity to learn more; they give those who belong to such groups the opportunity not only to learn more, but to celebrate, respect, and destigmatize their groups. It is unclear what effects the development of such classes and departmental programs have had at either the societal or the interactional level, but we believe that providing some forum for learning about and gaining more exposure to stigmas can do much to alleviate the negativity experienced by stigmatized individuals, even at the level of awkwardness created in a dyadic social interaction.

### CONCLUSION

This chapter has attempted to clarify the nature of "awkward moments" between stigmatized and nonstigmatized individuals. Such experiences are diverse; they are initiated by various factors, perpetuated by the same and other factors, and influenced by additional situational and personality variables. Stigmatized and nonstigmatized individuals have much in common in mixed interactions: They fear and are uncertain about each other, and they often experience anxiety. This anxiety, unfortunately, may perpetuate one of the main goals of the interactants, which is to avoid each other.

We believe that awkward moments are important experiences to

understand. The affective, cognitive, and behavioral reasons for them, their impact on both individuals and groups, and the consequences of awkward moments are all areas that we hope will be illuminated by future research. We propose that an understanding of more global issues such as stereotyping, prejudice, and discrimination will be facilitated by a continued focus on understanding what transpires at the level of a single mixed interaction. Awkward moments have far-reaching consequences in the lives of both stigmatized and nonstigmatized individuals. But the research that is conducted and the strategies that are implemented in the future may reduce much of the anxiety and awkwardness that nonstigmatized and stigmatized individuals alike experience.

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