American Psychological Association

Translational Issues in Psychological Science

ISSN: 2332-2136

2019, Vol. 5, No. 4, 315–325
http://dx.doi.org/10.1037/tps0000207

Reducing Health Care Disparities Through Improving Trust: An Identity Safety Cues Intervention for Stigmatized Groups

Rebecca Cipollina and Diana T. Sanchez
Rutgers University

A vast literature examines the role of contextual cues in signaling identity safety for stigmatized group members in potentially threatening contexts. Yet, to date, a striking lack of research has utilized this literature to improve stigmatized populations' experiences in health care settings. This review discusses how identity cues embedded in medical contexts may signal safety or potential threat to varied stigmatized group members, including those with visible or concealable stigmas. We propose that identity safety cues have the potential to improve patient−provider communication and comfort and, moreover, rates of health care utilization and adherence to medical suggestions. We discuss factors that may promote or hinder the efficacy of such cues and the relative power of different identity safety cues in past research. Finally, we review limitations of the cue implementation approach and describe suggestions for implementation within medical contexts.

What is the significance of this article for the general public?
Varied stigmatized group members, for example, people who are overweight, those with chronic illnesses, and racial and sexual minorities, utilize health care services at lower rates and often have poorer physical and mental health than do their majority counterparts. Extending the psychological literature on identity safety cues to the medical context may improve stigmatized group members' health care utilization, visit satisfaction, adherence, and subsequent health.

Keywords: identity safety, health disparities, stereotypes, identity threat, stigma

Members of many stigmatized populations, that is, those who are socially devalued, stereotyped, or discriminated against (Goffman, 1963; Link & Phelan, 2001), are at higher risk for early mortality and comorbidity when compared to their majority counterparts (Hatzenbuehler, Phelan, & Link, 2013; Lick, Durso, & Johnson, 2013; Muehrer, 2002). Poorer overall health of stigmatized groups is linked to cultural and structural impediments (Hatzenbuehler, 2017; Quinn & Chaudoir, 2009), discrimination (Gee, 2008; Lick et al., 2013; Williams, Neighbors, & Jackson, 2003), psychological processes in coping with stigma (Major & Schmader, 1998; Miller & Kaiser, 2001), and poor health behaviors (Berrigan, Dodd, Troiano, Krebs-Smith, & Barbash, 2003; McCabe, Hughes, Bostwick, West, & Boyd, 2009).

Although members of many stigmatized groups experience poorer health throughout their lifetimes (Chaudoir, Earnshaw, & Andel, 2013; Mak, Poon, Pun, & Cheung, 2007) and could benefit from medical intervention, they often seek out health care at lower rates than do their majority counterparts (Burgess, Ding, Hargreaves, Van Ryn, & Phelan, 2008; Dovidio et al., 2008; Phelan et al., 2015). Disparities in health care utilization are seen among individuals with visible stigmas, for example, race,

Rebecca Cipollina and Diana T. Sanchez, Department of Psychology, Rutgers University.

Correspondence concerning this article should be addressed to Rebecca Cipollina, Department of Psychology, Rutgers University, 53 Avenue East, Piscataway, NJ 08854. E-mail: r.cipollina@rutgers.edu

weight, or physical disability, and those with nonvisible or concealable stigmas, for example, sexual orientation, mental illness history, or chronic illness (Byrne, 2008; Dovidio, Penner, Calabrese, & Pearl, 2017; Fujisawa & Hagiwara, 2015). Research has suggested that some health disparities among stigmatized groups can be reduced by improving stigmatized group members' experiences within health care settings, their health care utilization, and their adherence to medical advice (Dovidio et al., 2017; Farley, Dalal, Mostashari, & Frieden, 2010).

In this article, we review the psychological literature on identity safety and highlight ways that identity cues in medical contexts may influence the quality of medical interactions between stigmatized group members and medical providers. We propose that identity safety cues embedded in medical contexts may have the potential to reduce health disparities of stigmatized group members by improving (a) health care utilization intentions, (b) visit expectations, (c) patient−provider communications, and (d) adherence to medical advice. Last, we discuss the limitations of identity cue interventions within medical settings and areas for future research.

Identity Threat in Health Care Settings

Past Experiences and Expectations

Because of their historical maltreatment, stigmatized group members may experience heightened apprehension about seeking heath care (Brandon, Isaac, & LaVeist, 2005; Love, 2015). For example, knowledge of the internment of the mentally ill, conversion centers, and the gross maltreatment of African American men during the Tuskegee syphilis experiment, may increase perceptions that medical providers at large hold negative biases toward varied stigmatized groups. Furthermore, previous discriminatory experiences within health care settings contribute to poor future visit expectations, an effect that has been seen extensively throughout past literature (Byrne, 2008; Hausmann et al., 2011; Hausmann, Jeong, Bost, & Ibrahim, 2008; Lee, Ayers, & Kronenfeld, 2009; Trippet & Bain, 1992).

In a variety of populations, patient evaluations of a provider as discriminatory reduces visit satisfaction ratings, future utilization intentions, and adherence to that provider's medical advice (Burgess et al., 2008; Dovidio et al., 2008; Gudzune, Bennett, Cooper, & Bleich, 2014; Hausmann et al., 2008; Phelan et al., 2015; Van Houtven et al., 2005). However, patients' expectations of medical community bias before visiting a provider have been shown to affect both self-report and the objective medical visit quality. As evidence, in racially discordant patient−provider visit, racial minority patients who anticipated provider bias displayed greater negative affect during the visit and were less engaged in the conversation, for example, asked fewer questions, compared to those who had lower expectations of bias (Hausmann et al., 2011). Taken together, historical knowledge, experiences within health care settings, and expectations of providers can incite identity threat in medical contexts (Burgess, Warren, Phelan, Dovidio, & van Ryn, 2010).

Identity Threat and Safety Cues

The literature on social identity threat has suggested that certain contexts can arouse threat concerns about the value of one's stigmatized identity, such as the threat of confirming stereotypes, being excluded, or being discriminated against (Steele, 1997; Steele, Spencer, & Aronson, 2002). Moreover, when stigmatized group members encounter identity threat they may have an increase in vigilance toward cues indicative of stigma (Kaiser, Vick, & Major, 2006; Pinel, 1999). Across a range of settings and populations, experiences of identity threat have been tied to (a) cognitive impairments and poor performance (Sekaquaptewa & Thompson, 2003; see Nguyen & Ryan, 2008, for a meta-analysis), (b) low feelings of belonging (C. Good & Inzlicht, 2006), (c) low levels of willingness to engage with outgroup members (Wout, Murphy, & Barnett, 2014), and (d) context disengagement (Major & Schmader, 1998).

Research on identity safety has examined when identity cues that signal low levels of stigma can reduce the negative effects of identity threat in traditionally threatening contexts (Davies, Spencer, & Steele, 2005). For example, identity safety cues, such as minority representation and expressions of allyship, have been shown to increase women's anticipated belonging at a science, technology, engineering, and mathematics (STEM) company

(Murphy, Steele, & Gross, 2007; Pietri, Johnson, & Ozgumus, 2018) and African Americans' organizational trust and comfort within corporate settings (Purdie-Vaughns, Steele, Davies, Ditlmann, & Crosby, 2008).

Within medical contexts, the impact of identity threats may explain a part of stigmatized group members' poor experiences during medical visits. Within medical settings, stereotypes of varied stigmatized groups, such as those depicting African Americans as lazy and unintelligent (Ghavami & Peplau, 2013) or those assuming that individuals who are overweight are unwilling to change their behavior (Puhl & Heuer, 2009), may be salient and elicit identity threat. Indeed, the threat of confirming stereotypes may make patients less willing to discuss their health behaviors and symptoms with their providers (Burgess et al., 2010). Impeded communication may be especially damaging for those with concealable stigmatized identities, who may need to feel comfortable to disclose their identity to their provider to receive culturally competent care (Butler et al., 2016) and effective (Petroll & Mosack, 2011; Ruben & Fullerton, 2018) health suggestions.[1]

Moreover, the threat of confirming stereotypes or being subject to prejudice within a medical setting may reduce a patient's cognitive resources, as empirically demonstrated within other evaluative domains like academic settings (C. Good & Inzlicht, 2006; Sekaquaptewa & Thompson, 2003; Steele, 1997). Such impairments can reduce a patient's ability to recall questions for the medical provider or to remember treatment regimens (Aronson, Burgess, Phelan, & Juarez, 2013; Burgess et al., 2010). The potential effects of identity threat on medical visit communication may be especially important for individuals with chronic illnesses, who may need to recall more information during and after their medical visits. Thus, disparities in the quality and efficacy of obtaining medical care may be influenced by social identity threats.

We suggest that identity safety cues within medical contexts may reduce expectations of stigma from the medical provider and improve stigmatized group members' experiences within health care settings. Below we review the extant literature on identity safety cue research and discuss applications to the medical setting.

Representation Cues

Research across a range of settings has shown the positive effects of increased minority representation on stigmatized minority group members' sense of belonging and performance in potentially threatening intergroup contexts (C. Good & Inzlicht, 2006; Sekaquaptewa & Thompson, 2003). When a context lacks representation, minority group members' desire to engage within such settings decreases due to a heightened experience of identity threat (Purdie-Vaughns et al., 2008). Conversely, women's interest in attending a STEM conference has been shown to increase if the conference consisted of equal gender representation rather than low female representation (Murphy et al., 2007). In another domain, minority representation on a company brochure improved African American participants' perception of the organization as fair and welcoming (Purdie-Vaughns et al., 2008). As such, within medical spaces, the diversity of an office's clientele or people present within the waiting room may influence stigmatized group members' feelings of belonging and identity safety at that office.

According to past research, both stigmatized group members within a context, for example, students in a classroom, and the evaluators in those contexts, for example, teachers, may serve as identity safety cues. Past psychological research has suggested that ingroup evaluators can serve as identity safety cues by reducing the probability and expectations that stereotypes will be used (Chaney, Sanchez, & Remedios, 2018; Wout, Shih, Jackson, & Sellers, 2009). Within medical settings, ingroup medical providers or office staff may, similarly, signal identity safety. An abundance of research has supported this claim. For example, sharing a racial identity with one's medical provider was related to higher utilization of health services and comfort and to greater medical visit satisfaction among racial minorities (Cooper et al., 2003; LaVeist, Nuru-Jeter, & Jones, 2003). Similarly, lesbian, gay, and bisexual (LGB) patients reported more trust in their provider and were more likely to disclose their sexual orientation if

[1] Concealing a stigmatized identity causes greater identity-related thoughts, which can reduce cognitive resources (Pachankis, 2007; Smart & Wegner, 1999).

they shared an LGB identity with the medical provider (Petroll & Mosack, 2011). Moreover, some research has suggested that stigmatized group members receive identity safety from stigmatized evaluators that do not share their stigmatized identity (Chaney et al., 2018). As such, within medical contexts, seeing a medical provider who also has a stigmatized identity may serve as an identity safety cue and improve visit outcomes. This suggestion is supported by reported higher levels of comfort and trust between LGB patients and their heterosexual female providers compared to heterosexual male providers (Petroll & Mosack, 2011).

Stigmatized group members may also have better experiences in health care settings with similarly stigmatized providers because those providers serve as a role model. Counterstereotypical role models, for example, women in high-status positions in male-dominated fields, can signal identity safety to other women because they reduce the expectation that stereotypes will be viewed as rules (J. Good, Woodzicka, & Wingfield, 2010). Research has shown that presenting a successful stigmatized group member on a poster in a potentially threatening context can significantly improve the engagement of stigmatized group members within such spaces (Marx, Ko, & Friedman, 2009). Within the medical context, exposure to medical providers with stigmatized identities may also improve patients' feelings of identity safety through reducing expectations that stereotypes will be pervasive during the medical visit.

Anticipated levels of stigma from a medical provider can also be signaled by the diversity of the staff at the medical office. Research on social networks as identity safety cues has suggested that college minority students' expectations of racially discordant interactions are influenced by the racial diversity of the majority students' social network (Wout, Murphy, & Steele, 2010). Indeed, social network diversity is viewed as an indicator of beliefs toward others with stigmatized identities. Along this vein, having a diverse staff may improve other staff members' comfort and confidence in discussing issues central to stigmatized groups (Stevens, Plaut, & Sanchez-Burks, 2008). Thus, diversity of staff members can improve not only perceptions of the office as welcoming but potentially the quality of care can be had within them.

Diversity Philosophy Cues and Policies

Across different domains, varied types of diversity statements have been used in attempts to increase stigmatized group members' participation and comfort. Statements that recognize the value of having a collective with diverse identities that seeks to acknowledge group differences are typically characterized as multicultural approaches (Plaut, Thomas, & Goren, 2009; Stevens et al., 2008). Other statements that emphasize the value of multiple viewpoints but suggest that each person (e.g., employee, student, patient) shall be treated equally, regardless of the person's group identity, minimize the importance of acknowledging diversity and are referred to as a colorblind approach. If viewed in conjunction with other types of identity safety cues, for example minority representation, multicultural messages can predict minority group members' trust, comfort, and sense of belonging (Purdie-Vaughns et al., 2008), suggesting that diversity messages need to be viewed in conjunction with a diverse setting to be effective.

Past research on the efficacy of multicultural and colorblind statements in promoting identity safety has been mixed. Some research has identified individual beliefs that influence preferences for one type of statement over another (Apfelbaum, Grunberg, Halevy, & Kang, 2017), whereas others have suggested that generally, minority group members prefer a multicultural strategy to a colorblind one (Ryan, Hunt, Weible, Peterson, & Casas, 2007; Trawalter & Richeson, 2008). Moreover, other research has suggested that multicultural strategies have the potential to increase feelings of being under a minority spotlight (Crosby, King, & Savitsky, 2014). This research has suggested that a tailored approach that recognizes the importance of discussing group differences but acknowledges the unique obstacles faced by different groups may be needed to elicit identity safety (Davies et al., 2005; Stevens et al., 2008). As such, cues that signal a medical provider's willingness to promote minority group involvement and perspectives, or that express allyship, may be better suited to improve stigmatized patients' perceptions of trust in medical settings.

Multicultural and colorblind messaging can be found within a provider's mission statement and during conversations with patients. Re-

search has documented that medical providers prefer a colorblind strategy to a multicultural one (Burgess et al., 2010). Although not tested empirically in this context, this preference can interfere with the provider's ability to provide care. Specifically, providers who utilize a colorblind strategy may be more cognitively taxed, due to suppressing race-related thoughts, and have fewer resources to process information discussed within their encounters compared to providers who use a multicultural strategy (see West & Schoenthaler, 2017, for review). Thus, it is important for providers to be aware of how their diversity philosophy on office statements and within their delivery of care can influence the quality of their care and patients' feelings of identity safety.

Other visual symbols of diversity, such as rainbow flags or interlocking hands representative of different races, can also be used on recruitment flyers or websites to display an organization's inclusive diversity philosophy. However, sometimes visual diversity cues on recruitment materials are viewed negatively by stigmatized group members when the image appears to be staged (Roediger, 2005). Instead, policy changes that display the organization's philosophy in a more concrete fashion may be preferable. For instance, having a gender-neutral bathroom and including inclusive questions on patient intake forms may improve the comfort of populations who do not fit into traditional gender-binary models. Further, having office decor and furnishings suitable for individuals from varied groups, such as waiting room chairs and wheelchair-accessible examination beds for people who are overweight or for people with a physical disability (Iezzoni & O'Day, 2006; Phelan et al., 2015), is another step toward facilitating identity safety in medical spaces.

Transferring Cues

There is an expanding literature on how identity safety cues can transfer across identity dimensions (Chaney, Sanchez, & Remedios, 2016). This work has suggested that identity cues signal the underlying philosophy of an organization, and thus, perceivers infer the attitudes that the organization has toward other stigmatized groups. For example, a company that advertised receiving an award for being a top company for working mothers was perceived as being a more trustworthy office by African American and Latino men (Chaney et al., 2016). Within a medical practice, diversity-recognizing awards or posted accomplishments for a staff member with a stigmatized identity may similarly signal identity safety to a patient from either a similar or a different stigmatized group. Further studies in this line of research have revealed that gender-neutral bathrooms improved nonqueer women and racial minorities' anticipated comfort and trust in an organization that had such bathrooms (Chaney & Sanchez, 2018). Thus, safety cues in medical spaces directed toward one stigmatized group may have expansive effects, altering feelings of identity safety for other stigmatized groups as well.

Discussion

We suggest that the presence of identity safety cues in medical settings has the potential to reduce stigmatized patients' expectations of encountering stereotypes and prejudice, ultimately improving their feelings of belonging and expectations of medical visits. Identity safety cues can be used both within medical settings and before patients schedule appointments, via brochures or websites, to improve health care utilization. Specifically, we propose that identity safety within medical visits can promote future health care utilization; improve patient−provider communication quality, including disclosure of concealable stigmatized identities; and adherence intentions. Last, we suggest that identity safety may reduce vigilance to identity threat cues and free up cognitive resources during medical visits to improve recall of medical information and, consequently, adherence ability. Thus, identity safety cues within medical spaces may have an important impact on reducing stigmatized group members' disparities in medical visit quality and utilization (Farley et al., 2010). Because quality of medical care is implicated in health outcomes (Betancourt & King, 2003; Fujisawa & Hagiwara, 2015; Stewart, 1995), we suggest that identity cues that improve health care quality may also indirectly improve poor health outcomes experienced by varied stigmatized groups (Gee, 2008; Hatzenbuehler, 2017; Hat-

zenbuehler et al., 2013; Muehrer, 2002; Williams et al., 2003).

Limitations of Approach and Future Directions

Provider bias and conflicting cues. Despite the benefits of diversity cues in promoting identity safety among stigmatized individuals, they should be viewed as only one avenue through which providers can express genuine motivations to generate an inclusive medical setting. Critically, discrimination against and bias in treating stigmatized group members persist and hinder medical care quality (Balsa & McGuire, 2001; Van Ryn, Burgess, Malat, & Griffin, 2006). For example, provider bias has been shown to influence medical visit quality and treatment decisions for women, racial, and sexual minorities (Chapman, Kaatz, & Carnes, 2013; Sabin, Riskind, & Nosek, 2015). In discriminatory environments, identity safety cues can cause harm by setting false expectations of safety and by reducing the perception of bias (Kirby, Kaiser, & Major, 2015). Identity cues can be helpful in the recognition of identity safe contexts and promoting identity safety, but interactions with medical providers will ultimately determine whether patients feel safe and receive quality care. Thus, identity safety cue interventions should be implemented only when they match the intentions and behaviors of office staff. Indeed, prior to providers' implementing identity safety cues within an office, efforts should be made to increase knowledge of how to best serve stigmatized group members, to create a diverse staff, and to increase the inclusivity goals of office staff.

Research has suggested that the efficacy of varied diversity-valuing cues and practices depends on other cues present, such as the perceived inclusivity of office staff (Downey, van der Werff, Thomas, & Plaut, 2015). As such, one might expect that a solo identity safety cue will not be enough to signal identity safety within a medical context and that the presence of threatening cues may override the positive effects of identity safety cues, as they have in past research (Purdie-Vaughns et al., 2008; Wout et al., 2014, 2009). Moreover, because it is self-protective to anticipate and prepare for prejudice encounters (Feldman Barrett & Swim, 1998), patients may be more likely to adapt a zero-miss strategy when interpreting conflicting identity safety and threat cues within a medical context.

Implementation. Future research should include fieldwork that examines the presence of identity safety cues within medical spaces to examine how a lack of safety cues may be related to increased anticipation of stereotypes, patient discomfort, and dissatisfaction with medical visits.[2] Moreover, future work should examine preferences for types of identity cues within medical settings among individuals with different stigmatized identities. For instance, certain populations may generally prefer diversity philosophy messages that bring attention to group differences, whereas others might find this approach threatening. For example, although survey respondents who are overweight recommended teaching medical providers about weight stigma as an effective way to reduce stigma encountered by their group (Puhl, Himmelstein, Gorin, & Suh, 2017), it is unknown how this group would feel about highlighting weight stigma within medical offices.

Whereas some literature would suggest that safety cues transfer across identity dimensions (Chaney et al., 2016), other findings have suggested that not all safety cues transfer. Specifically, identity cues may be more likely to transfer between stigmatized groups that share similar stereotypes, when compared to groups that do not share stereotype content (Chaney et al., 2018; Sanchez, Chaney, Manuel, & Remedios, 2018). As such, the transferability of cues within medical settings may rely on the underlying stereotype content or perceived shared fate of the two groups. Moreover, more research needs to be done to expand the transfer of safety cues literature from racial and gender minority groups especially to those with other types of stigmas, for example, sexual minorities or persons with physical disability or who are overweight.

Additional research is needed to examine the effect of individual differences in influencing the receipt of, and preference for, varied identity safety cues. For example, individual differences such as stigma consciousness

[2] See Hall, Schmader, Aday, Inness, and Croft (2018) for a sample field study of identity safety cues in science, technology, engineering, and mathematics settings.

(Pietri et al., 2018; Pinel, 1999), perceived intentionality of racial discrimination (Apfelbaum et al., 2017), and identity centrality (Sellers, Rowley, Chavous, Shelton, & Smith, 1997) may influence receipt of safety cues within medical settings and are a fruitful area for future research. Moreover, those with concealable identities may not be able to pick up on group representation within the medical setting, because, for the most part, their identities are not visible. Therefore, promoting identity safety for those with concealable stigmatized identities may need to come from diversity philosophy messages, policy changes, or transferable cues; however, this has yet to be explored. Lastly, individuals with varied multiple stigmatized identities, such as a Latinx bisexual woman, have reported greater expectations of discrimination and stereotypes than have individuals with one stigmatized identity (Remedios & Snyder, 2018). As such, future research on safety cues within medical contexts should take an intersectional approach when designing interventions to promote identity safety within medical spaces.

Conclusion

Although in other contexts stigmatized group members may be able to disengage or disassociate themselves from the context after experiencing identity threat (Major & Schmader, 1998), disengagement from the health care setting would be difficult for many groups who need long-lasting provider relationships and is detrimental to health outcomes (Byrne, 2008). Identity safety cues can be used as an intervention to improve health outcomes of stigmatized groups, by reducing identity threat experienced within medical visits. We suggest that identity safety cues, including information about the medical provider and staff, the office's diversity philosophy, and inclusive policies in place, have the potential to improve stigmatized group members' quality of health care, utilization, and some consequent health outcomes.

References

Apfelbaum, E. P., Grunberg, R., Halevy, N., & Kang, S. (2017). From ignorance to intolerance: Perceived intentionality of racial discrimination shapes preferences for colorblindness versus multiculturalism. *Journal of Experimental Social Psychology, 69,* 86–101. http://dx.doi.org/10.1016/j.jesp.2016.08.002

Aronson, J., Burgess, D., Phelan, S. M., & Juarez, L. (2013). Unhealthy interactions: The role of stereotype threat in health disparities. *American Journal of Public Health, 103,* 50–56. http://dx.doi.org/10.2105/AJPH.2012.300828

Balsa, A. I., & McGuire, T. G. (2001). Statistical discrimination in health care. *Journal of Health Economics, 20,* 881–907. http://dx.doi.org/10.1016/S0167-6296(01)00101-1

Berrigan, D., Dodd, K., Troiano, R. P., Krebs-Smith, S. M., & Barbash, R. B. (2003). Patterns of health behavior in U.S. adults. *Preventive Medicine, 36,* 615–623. http://dx.doi.org/10.1016/S0091-7435(02)00067-1

Betancourt, J. R., & King, R. K. (2003). Unequal treatment: The Institute of Medicine report and its public health implications. *Public Health Reports, 118,* 287–292. http://dx.doi.org/10.1016/S0033-3549(04)50252-2

Brandon, D. T., Isaac, L. A., & LaVeist, T. A. (2005). The legacy of Tuskegee and trust in medical care: Is Tuskegee responsible for race differences in mistrust of medical care? *Journal of the National Medical Association, 97,* 951–956.

Burgess, D. J., Ding, Y., Hargreaves, M., van Ryn, M., & Phelan, S. (2008). The association between perceived discrimination and underutilization of needed medical and mental health care in a multiethnic community sample. *Journal of Health Care for the Poor and Underserved, 19,* 894–911. http://dx.doi.org/10.1353/hpu.0.0063

Burgess, D. J., Warren, J., Phelan, S., Dovidio, J., & van Ryn, M. (2010). Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine, 25*(Suppl. 2), 169–177. http://dx.doi.org/10.1007/s11606-009-1221-4

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J., . . . Kane, R. L. (2016). *Improving cultural competence to reduce health disparities* (Comparative Effectiveness Reviews No. 170, Report No. 16-EHC006-EF). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK361126/

Byrne, S. K. (2008). Healthcare avoidance: A critical review. *Holistic Nursing Practice, 22,* 280–292. http://dx.doi.org/10.1097/01.HNP.0000334921.31433.c6

Chaney, K. E., & Sanchez, D. T. (2018). Gender-inclusive bathrooms signal fairness across identity dimensions. *Social Psychological and Personality Science, 9,* 245–253. http://dx.doi.org/10.1177/1948550617737601

Chaney, K. E., Sanchez, D. T., & Remedios, J. D. (2016). Organizational identity safety cue transfers. *Personality and Social Psychology Bulletin, 42,* 1564–1576. http://dx.doi.org/10.1177/0146167216665096

Chaney, K. E., Sanchez, D. T., & Remedios, J. D. (2018). We are in this together: How the presence of similarly stereotyped allies buffer against identity threats. *Journal of Experimental Social Psychology, 79,* 410–422. http://dx.doi.org/10.1016/j.jesp.2018.09.005

Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities. *Journal of General Internal Medicine, 28,* 1504–1510. http://dx.doi.org/10.1007/s11606-013-2441-1

Chaudoir, S. R., Earnshaw, V. A., & Andel, S. (2013). "Discredited" versus "discreditable": Understanding how shared and unique stigma mechanisms affect psychological and physical health disparities. *Basic and Applied Social Psychology, 35,* 75–87. http://dx.doi.org/10.1080/01973533.2012.746612

Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine, 139,* 907–915. http://dx.doi.org/10.7326/0003-4819-139-11-200312020-00009

Crosby, J. R., King, M., & Savitsky, K. (2014). The minority spotlight effect. *Social Psychological and Personality Science, 5,* 743–750. http://dx.doi.org/10.1177/1948550614527625

Davies, P. G., Spencer, S. J., & Steele, C. M. (2005). Clearing the air: Identity safety moderates the effects of stereotype threat on women's leadership aspirations. *Journal of Personality and Social Psychology, 88,* 276–287. http://dx.doi.org/10.1037/0022-3514.88.2.276

Dovidio, J. F., Penner, L. A., Albrecht, T. L., Norton, W. E., Gaertner, S. L., & Shelton, J. N. (2008). Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care. *Social Science & Medicine, 67,* 478–486. http://dx.doi.org/10.1016/j.socscimed.2008.03.019

Dovidio, J. F., Penner, L. A., Calabrese, S. K., & Pearl, R. L. (2017). Physical health disparities and stigma: Race, sexual orientation, and body weight. In B. Major, J. F. Dovidio, & B. G. Link (Eds.), *The Oxford handbook of stigma, discrimination, and health* (pp. 29–51). New York, NY: Oxford University Press.

Downey, S. N., van der Werff, L., Thomas, K. M., & Plaut, V. C. (2015). The role of diversity practices and inclusion in promoting trust and employee engagement. *Journal of Applied Social Psychology, 45,* 35–44. http://dx.doi.org/10.1111/jasp.12273

Farley, T. A., Dalal, M. A., Mostashari, F., & Frieden, T. R. (2010). Deaths preventable in the U.S. by improvements in use of clinical preventive services. *American Journal of Preventive Medicine, 38,* 600–609. http://dx.doi.org/10.1016/j.amepre.2010.02.016

Feldman Barrett, L., & Swim, J. K. (1998). Appraisals of prejudice and discrimination. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 11–36). http://dx.doi.org/10.1016/B978-012679130-3/50036-3

Fujisawa, D., & Hagiwara, N. (2015). Cancer stigma and its health consequences. *Current Breast Cancer Reports, 7,* 143–150. http://dx.doi.org/10.1007/s12609-015-0185-0

Gee, G. C. (2008). A multilevel analysis of the relationship between institutional and individual racial discrimination and health status. *American Journal of Public Health, 98*(9, Suppl. 1), S48–S56. http://dx.doi.org/10.2105/AJPH.98.Supplement_1.S48

Ghavami, N., & Peplau, L. A. (2013). An intersectional analysis of gender and ethnic stereotypes: Testing three hypotheses. *Psychology of Women Quarterly, 37,* 113–127. http://dx.doi.org/10.1177/0361684312464203

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

Good, C., & Inzlicht, M. (2006). How environments can threaten academic performance, self-knowledge, and sense of belonging. In S. Levin & C. van Laar (Eds.), *Stigma and group inequality: Social psychological perspectives* (pp. 143–164). New York, NY: Psychology Press.

Good, J. J., Woodzicka, J. A., & Wingfield, L. C. (2010). The effects of gender stereotypic and counter-stereotypic textbook images on science performance. *Journal of Social Psychology, 150,* 132–147. http://dx.doi.org/10.1080/00224540903366552

Gudzune, K. A., Bennett, W. L., Cooper, L. A., & Bleich, S. N. (2014). Perceived judgment about weight can negatively influence weight loss: A cross-sectional study of overweight and obese patients. *Preventive Medicine, 62,* 103–107. http://dx.doi.org/10.1016/j.ypmed.2014.02.001

Hall, W., Schmader, T., Aday, A., Inness, M., & Croft, E. (2018). Climate control: The relationship between social identity threat and cues to an identity-safe culture. *Journal of Personality and Social Psychology, 115,* 446.

Hatzenbuehler, M. L. (2017). Structural stigma and health. In B. Major, J. F. Dovidio, & B. G. Link (Eds.), *The handbook of stigma, discrimination and health* (pp. 105–121). New York, NY: Oxford University Press.

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103,* 813–821. http://dx.doi.org/10.2105/AJPH.2012.301069

Hausmann, L. R. M., Hannon, M. J., Kresevic, D. M., Hanusa, B. H., Kwoh, C. K., & Ibrahim, S. A. (2011). Impact of perceived discrimination in healthcare on patient-provider communication. *Medical Care, 49,* 626–633. http://dx.doi.org/10.1097/MLR.0b013e318215d93c

Hausmann, L. R., Jeong, K., Bost, J. E., & Ibrahim, S. A. (2008). Perceived discrimination in health care and use of preventive health services. *Journal of General Internal Medicine, 23,* 1679–1684. http://dx.doi.org/10.1007/s11606-008-0730-x

Iezzoni, L. I., & O'Day, B. (2006). *More than ramps: A guide to improving health care quality and access for people with disabilities*. http://dx.doi.org/10.1093/acprof:oso/9780195172768.001.0001

Kaiser, C. R., Vick, S. B., & Major, B. (2006). Prejudice expectations moderate preconscious attention to cues that are threatening to social identity. *Psychological Science, 17,* 332–338. http://dx.doi.org/10.1111/j.1467-9280.2006.01707.x

Kirby, T. A., Kaiser, C. R., & Major, B. (2015). Insidious procedures: Diversity awards legitimize unfair organizational practices. *Social Justice Research, 28,* 169–186. http://dx.doi.org/10.1007/s11211-015-0240-z

LaVeist, T. A., Nuru-Jeter, A., & Jones, K. E. (2003). The association of doctor-patient race concordance with health services utilization. *Journal of Public Health Policy, 24,* 312–323. http://dx.doi.org/10.2307/3343378

Lee, C., Ayers, S. L., & Kronenfeld, J. J. (2009). The association between perceived provider discrimination, healthcare utilization and health status in racial and ethnic minorities. *Ethnicity & Disease, 19,* 330–337.

Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science, 8,* 521–548. http://dx.doi.org/10.1177/1745691613497965

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27,* 363–385. http://dx.doi.org/10.1146/annurev.soc.27.1.363

Love, K. (2015). Voices from the past: Understanding the impact of historical discrimination on today's healthcare system. In A. Madlock Gatison (Ed.), *Communicating women's health: Social and cultural norms that influence health decisions* (pp. 15–25). New York, NY: Routledge.

Major, B., & Schmader, T. (1998). Coping with stigma through psychological disengagement. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 219–241). http://dx.doi.org/10.1016/B978-012679130-3/50045-4

Mak, W. W. S., Poon, C. Y. M., Pun, L. Y. K., & Cheung, S. F. (2007). Meta-analysis of stigma and mental health. *Social Science & Medicine, 65,* 245–261. http://dx.doi.org/10.1016/j.socscimed.2007.03.015

Marx, D. M., Ko, S. J., & Friedman, R. A. (2009). The "Obama effect": How a salient role model reduces race-based performance differences. *Journal of Experimental Social Psychology, 45,* 953–956. http://dx.doi.org/10.1016/j.jesp.2009.03.012

McCabe, S. E., Hughes, T. L., Bostwick, W. B., West, B. T., & Boyd, C. J. (2009). Sexual orientation, substance use behaviors and substance dependence in the United States. *Addiction, 104,* 1333–1345. http://dx.doi.org/10.1111/j.1360-0443.2009.02596.x

Miller, C. T., & Kaiser, C. R. (2001). A theoretical perspective on coping with stigma. *Journal of Social Issues, 57,* 73–92. http://dx.doi.org/10.1111/0022-4537.00202

Muehrer, P. (2002). Research on co-morbidity, contextual barriers, and stigma: An introduction to the special issue. *Journal of Psychosomatic Research, 53,* 843–845. http://dx.doi.org/10.1016/S0022-3999(02)00519-6

Murphy, M. C., Steele, C. M., & Gross, J. J. (2007). Signaling threat: How situational cues affect women in math, science, and engineering settings. *Psychological Science, 18,* 879–885. http://dx.doi.org/10.1111/j.1467-9280.2007.01995.x

Nguyen, H.-H. D., & Ryan, A. M. (2008). Does stereotype threat affect test performance of minorities and women? A meta-analysis of experimental evidence. *Journal of Applied Psychology, 93,* 1314–1334. http://dx.doi.org/10.1037/a0012702

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin, 133,* 328–345. http://dx.doi.org/10.1037/0033-2909.133.2.328

Petroll, A. E., & Mosack, K. E. (2011). Physician awareness of sexual orientation and preventive health recommendations to men who have sex with men. *Sexually Transmitted Diseases, 38,* 63–67. http://dx.doi.org/10.1097/OLQ.0b013e3181ebd50f

Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews, 16,* 319–326. http://dx.doi.org/10.1111/obr.12266

Pietri, E. S., Johnson, I. R., & Ozgumus, E. (2018). One size may not fit all: Exploring how the intersection of race and gender and stigma consciousness predict effective identity-safe cues for Black women. *Journal of Experimental Social Psychol-*

ogy, 74, 291–306. http://dx.doi.org/10.1016/j.jesp.2017.06.021

Pinel, E. C. (1999). Stigma consciousness: The psychological legacy of social stereotypes. *Journal of Personality and Social Psychology, 76,* 114–128. http://dx.doi.org/10.1037/0022-3514.76.1.114

Plaut, V. C., Thomas, K. M., & Goren, M. J. (2009). Is multiculturalism or color blindness better for minorities? *Psychological Science, 20,* 444–446. http://dx.doi.org/10.1111/j.1467-9280.2009.02318.x

Puhl, R. M., & Heuer, C. A. (2009). The stigma of obesity: A review and update. *Obesity, 17,* 941–964. http://dx.doi.org/10.1038/oby.2008.636

Puhl, R. M., Himmelstein, M. S., Gorin, A. A., & Suh, Y. J. (2017). Missing the target: Including perspectives of women with overweight and obesity to inform stigma-reduction strategies. *Obesity Science & Practice, 3,* 25–35. http://dx.doi.org/10.1002/osp4.101

Purdie-Vaughns, V., Steele, C. M., Davies, P. G., Ditlmann, R., & Crosby, J. R. (2008). Social identity contingencies: How diversity cues signal threat or safety for African Americans in mainstream institutions. *Journal of Personality and Social Psychology, 94,* 615–630. http://dx.doi.org/10.1037/0022-3514.94.4.615

Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97,* 634–651. http://dx.doi.org/10.1037/a0015815

Remedios, J. D., & Snyder, S. H. (2018). Intersectional oppression: Multiple stigmatized identities and perceptions of invisibility, discrimination, and stereotyping. *Journal of Social Issues, 74,* 265–281. http://dx.doi.org/10.1111/josi.12268

Roediger, D. (2005). What's wrong with these pictures? Race, narratives of admission, and the liberal self-representations of historically White colleges and universities. *Washington University Journal of Law & Policy, 18,* 203–222.

Ruben, M. A., & Fullerton, M. (2018). Proportion of patients who disclose their sexual orientation to healthcare providers and its relationship to patient outcomes: A meta-analysis and review. *Patient Education and Counseling, 101,* 1549–1560. http://dx.doi.org/10.1016/j.pec.2018.05.001

Ryan, C. S., Hunt, J. S., Weible, J. A., Peterson, C. R., & Casas, J. F. (2007). Multicultural and colorblind ideology, stereotypes, and ethnocentrism among Black and White Americans. *Group Processes & Intergroup Relations, 10,* 617–637. http://dx.doi.org/10.1177/1368430207084105

Sabin, J. A., Riskind, R. G., & Nosek, B. A. (2015). Health care providers' implicit and explicit attitudes toward lesbian women and gay men. *American Journal of Public Health, 105,* 1831–1841. http://dx.doi.org/10.2105/AJPH.2015.302631

Sanchez, D. T., Chaney, K. E., Manuel, S. K., & Remedios, J. D. (2018). Theory of prejudice and American identity threat transfer for Latino and Asian Americans. *Personality and Social Psychology Bulletin, 44,* 972–983. http://dx.doi.org/10.1177/0146167218759288

Sekaquaptewa, D., & Thompson, M. (2003). Solo status, stereotype threat, and performance expectancies: Their effects on women's performance. *Journal of Experimental Social Psychology, 39,* 68–74. http://dx.doi.org/10.1016/S0022-1031(02)00508-5

Sellers, R. M., Rowley, S. A., Chavous, T. M., Shelton, J. N., & Smith, M. A. (1997). Multidimensional inventory of Black identity: A preliminary investigation of reliability and construct validity. *Journal of Personality and Social Psychology, 73,* 805–815. http://dx.doi.org/10.1037/0022-3514.73.4.805

Smart, L., & Wegner, D. M. (1999). Covering up what can't be seen: Concealable stigma and mental control. *Journal of Personality and Social Psychology, 77,* 474.

Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist, 52,* 613–629. http://dx.doi.org/10.1037/0003-066X.52.6.613

Steele, C. M., Spencer, S. J., & Aronson, J. (2002). Contending with group image: The psychology of stereotype and social identity threat. In *Advances in experimental social psychology* (Vol. 34, pp. 379–440). http://dx.doi.org/10.1016/S0065-2601(02)80009-0

Stevens, F. G., Plaut, V. C., & Sanchez-Burks, J. (2008). Unlocking the benefits of diversity: All-inclusive multiculturalism and positive organizational change. *Journal of Applied Behavioral Science, 44,* 116–133. http://dx.doi.org/10.1177/0021886308314460

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: A review. *Canadian Medical Association Journal, 152,* 1423–1433.

Trawalter, S., & Richeson, J. A. (2008). Let's talk about race, baby! When Whites' and Blacks' interracial contact experiences diverge. *Journal of Experimental Social Psychology, 44,* 1214–1217.

Trippet, S. E., & Bain, J. (1992). Reasons American lesbians fail to seek traditional health care. *Health Care Women International, 13,* 145–153. http://dx.doi.org/10.1080/07399339209515987

Van Houtven, C. H., Voils, C. I., Oddone, E. Z., Weinfurt, K. P., Friedman, J. Y., Schulman, K. A., & Bosworth, H. B. (2005). Perceived discrimination and reported delay of pharmacy prescriptions and medical tests. *Journal of General Internal*

Medicine, 20, 578–583. http://dx.doi.org/10.1007/s11606-005-0104-6

van Ryn, M., Burgess, D., Malat, J., & Griffin, J. (2006). Physicians' perceptions of patients' social and behavioral characteristics and race disparities in treatment recommendations for men with coronary artery disease. *American Journal of Public Health, 96,* 351–357. http://dx.doi.org/10.2105/AJPH.2004.041806

West, T. V., & Schoenthaler, A. (2017). Color-blind and multicultural strategies in medical settings. *Social Issues and Policy Review, 11,* 124–158. http://dx.doi.org/10.1111/sipr.12029

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health, 93,* 200–208. http://dx.doi.org/10.2105/AJPH.93.2.200

Wout, D. A., Murphy, M. C., & Barnett, S. (2014). When having Black friends isn't enough: How threat cues undermine safety cues in friendship formation. *Social Psychological and Personality Science, 5,* 844–851. http://dx.doi.org/10.1177/1948550614535820

Wout, D. A., Murphy, M. C., & Steele, C. M. (2010). When your friends matter: The effect of White students' racial friendship networks on meta-perceptions and perceived identity contingencies. *Journal of Experimental Social Psychology, 46,* 1035–1041. http://dx.doi.org/10.1016/j.jesp.2010.06.003

Wout, D. A., Shih, M. J., Jackson, J. S., & Sellers, R. M. (2009). Targets as perceivers: How people determine when they will be negatively stereotyped. *Journal of Personality and Social Psychology, 96,* 349–362. http://dx.doi.org/10.1037/a0012880

Received October 31, 2018
Revision received March 19, 2019
Accepted September 30, 2019 ■