Chapter 4. Discrimination and well-being: role of affective and cognitive identification, solidarity, and collective action tendencies among junior nurses

Introduction

Many social psychologists would agree that the resiliency of discriminated individuals in the face of demeaning treatment is quite a recent finding. In reality, both Allport (1954) and Goffman (1963) not only underlined the challenge of dealing with a negative social identity but also documented, albeit not by way of experimental work, the incredible creativity of stigmatized people. Far from being passive victims of the prejudice of society and members of dominant groups, discriminated individuals display a wide range of cognitions and behaviors that help them navigate through life. It would even seem that targets of discrimination remain unaffected by the aggression directed at their group membership. As a matter of fact, studies aimed at showing differences in distress and well-being between discriminated groups and non-discriminated groups have yielded results that are far from consistent. For example, self-esteem has been found to be high among African Americans (Twenge & Crocker, 2002) but low among most other discriminated groups: women (Kling, Hyde, Showers, & Buswell, 1999), Asians[124] (Twenge & Crocker, 2002) or overweight people (Miller & Downey, 1999). The evidence about psychiatric disorders is also somewhat mixed (Vega & Rumbaut, 1991) even though ethnic minorities seem to be more represented in psychiatric wards (Chakraborty & McEnzie, 2002), homosexuals tend to be more suicidal (Meyer, 2003b) and women have higher prevalence of stress-related disorders (anxiety, depression, somatization) (Klonoff, Landrine, & Campbell, 2000). If discriminated people are not untouched by discrimination, they are far less vulnerable than what was generally thought (see Crocker & Major, 1989).

Discrimination as a diverse experience

As much as this, the rich literature on group differences in mental health points to several other interesting elements. First of all, groups differ. Being a woman, an African American, or a blind person, does not lead to the same experience of discrimination. Both the events in themselves and the coping resources vary depending on the group to which one belongs (Porter & Washington, 1993; Twenge & Crocker, 2002). For example, the Civil

[124] As well as Hispanics and Native Americans.

Rights movement has been widely cited as a source of resiliency for African Americans (Bat-Chava, 1994; Hughes & Demo, 1989) but not for others. Moreover, structural relationships between the discriminated group and the dominant group may vary, as women are more dependent on men than Asians are on Whites (Burn, 1996). Responsibility for the stigmatizing condition has also been shown to influence the experience of discrimination (Crocker, Cornwell, & Major, 1993). In sum, believing that one can account for the reactions of all discriminated groups within a single model seems unrealistic.

Secondly, other factors than discrimination can affect well-being and account for group differences. Regarding ethnic differences in self-esteem and psychiatric disorders, some authors call for an emphasis on cultural differences as occidental constructs sometimes map poorly minority mental health (Chakraborty & McKenzie, 2002; Twenge & Crocker, 2002; Vega & Humbaut, 1991). For example, self-esteem has been pointed out as a culturally biased concept, that does not relate to the collectivist sources of self-regard specific to Asian cultures (Heine, Lehman, Markus, & Kitayama, 1999). As for difference between men and women, distinct roots of self-regard have been underlined, especially the emphasis on an unrealistic physical canon for women (Kling et al., 1999). This can of course be conceptualized as a form of discrimination and some authors include appearance pressure in their scales (e. a. Corning, 2000).

Even when discrimination is posited to be responsible for group differences (for ex. Klonoff et al., 2000), one must disentangle direct discrimination from perceived discrimination. Direct discrimination encompasses all real effects derived from belonging to a disadvantaged group: poorer education, lower income, unemployment or lack of access to health resources, to take a few examples. People who belong to discriminated groups have been shown to encounter more major life events (divorce, aggression, fired from job) than dominant group members (Belle & Doucet, 2003; Kessler, Mickelson, & Williams, 1999; Schulz, Israel, Williams, Parker, Becker, & James, 2000; Taylor & Turner, 2002; Williams, Spencer, & Jackson, 1999). Direct discrimination does not need to be perceived to have an impact upon people's well-being.

The impact of perceived discrimination

Perceived discrimination, in contrast, refers to subjective experiences that are directly linked to group membership and vary among group members (Major, McCoy, Kaiser, & Quinton, 2003). The question remains to be seen whether perceived discrimination has an

effect over and above direct discrimination. Some studies find that perceived discrimination accounts for differences in well-being even when acute life events are controlled for (Landrine, Klonoff, Gibbs, Manning & Lund, 1995; Schulz et al., 2000; Williams et al., 1999) while others do not (Taylor & Turner, 2002). This role of perception lead the researchers to investigate intragroup differences rather than intergroup differences in their study of discrimination.

Like direct discrimination, perceived personal discrimination is often negatively linked to well-being[125] (Branscombe, Schmitt, & Harvey, 1999; Corning, 2000; Schmitt & Branscombe, 2002a; Sellers & Shelton, 2003). However, the link is sometimes very weak or non-existent (Gartska, Schmitt, Branscombe, & Hummert, 2004). Two theories currently try to explain this result. The Rejection – Identification model (Schmitt & Branscombe, 2002a) posits that well-being is protected from the deleterious effects of perceived discrimination through increased identification. A second view, based on stress and coping theory (Lazarus & Folkman, 1984), asserts that different moderators intervene between perceptions of discrimination and well-being, and that those variables can greatly alter the negative effects of demeaning treatment (Allison, 1998; Clark, Anderson, Clark, & Williams, 1999; Major, McCoy et al., 2003 ; Miller & Kaiser, 2001).

The Rejection – Identification model

According to Branscombe, Schmitt and colleagues (Branscombe, Schmitt, & Harvey, 1999; Schmitt & Branscombe, 2002a), perceiving personal discrimination parallels subjective rejection by the dominant group. As belonging and acceptance are fundamental human needs (Baumeister & Leary, 1995; Leary, Tambor, Terdal & Downs, 1995), individuals will suffer from discrimination, hence the negative impact usually found on well-being. In order to counteract this feeling of exclusion, people will identify with their ingroup and, as such, buffer the adverse effects of perceived discrimination.

The positive link between identification with the ingroup and well-being has been documented in numerous studies (Bat-Chava, 1994; Branscombe, Schmitt & Harvey, 1999;

[125] Crocker & Major (1989) posited that stigmatized people could use discrimination as a way to discount their own responsibility when facing failure and thereby protecting their self-esteem. While the data pertaining to this hypothesis is numerous and interesting, it is mainly related to specific lab studies encompassing one single failure at the hands of a prejudiced individual. In our studies, we deal with the more diffuse feeling of being a victim of discrimination, a cognition that has never been shown to protect well-being, and as such, we will not discuss the « discounting » hypothesis any further (for extensive discussions : Major et al., 2003 ; Schmitt & Brancombe, 2002).

Phinney & Chavira, 1992; Rowley, Sellers, Chavous & Smith, 1998). However, because the concept seems to derive directly from daily language, identification often lacks precise definition (but see Ellemers, Kortekaas, & Ouwerkerk, 1999). Some authors use it as cognitive categorization of the self (Postmes & Branscombe, 2002); proximity to other group members (Hughes & Demo, 1989); centrality (or importance) of group membership to self-definition (Rowley et al., 1998), exploration of a social identity (Phinney, 1990), affective evaluation of the group ("racial self-esteem") (Hughes & Demo, 1989; Verkuyten & Lay, 1998) or a multi-facetted mixture of ideologies, centrality, and evaluations (Rowley et al., 1998). With each conceptualization come various results, mainly positive, but some studies find no relationship between well-being and identification (Crocker, Luhtanen, Blaine, & Broadnax,, 1994; Verkuyten & Lay, 1998)[126]. Once again, the specific group under scrutiny also seems to be a key factor (Crocker et al., 1994).

The link between perceived personal discrimination and identification has also been documented but the available data are even trickier. First of all, it is not clear whether discrimination causes identification or the reverse. Some authors argue for the former causal link (Branscombe, Schmitt, & Harvey, 1999), others for the latter (Major, Gramzov, McCoy, Levin, Schmader, & Sidanius, 2002), and still others acknowledge a possible circular relationship (Operario & Fiske, 2001; Sellers & Shelton, 2003). Longitudinal data are scarce but indicate that while some facets of identification might predict perceptions of discrimination, others seem to result from it (Sellers & Shelton, 2003). Secondly, as for the link between identification and well-being, both discrimination and identification have been diversely conceptualized, and make some results not directly comparable. Finally, whereas some discriminated groups do not display high levels of identification, whatever their perception of discrimination (e. a. overweight people, Quinn & Crocker, 1999), most data indicates a positive relationship between identification and discrimination (but see Phinney, Madden, & Santos, 1998).

In sum, different facets of identification would seem to play different roles in their relationship to both discrimination and well-being (Cameron & Lalonde, 2001; Ellemers, Kortekaas, & Ouwerkerk, 1999; Postmes & Branscombe, 2002). We wish to investigate this possibility in the present study. The Rejection – Identification model has been tested with numerous groups so far, among them African Americans (Branscombe, Schmitt, & Harvey, 1999), women (Schmitt, Branscombe, Kobrynowicz, & Owen, 2002), international exchange

[126] A thorough examination of this question goes beyond the purpose of this paper, but we devoted more space to

students (Schmitt, Spears, & Branscombe, 2003), people with piercings (Jetten, Branscombe, Spears, & Schmitt, 2001), old people (Gartska et al., 2004). Schmitt, Branscombe and colleagues also showed that members of high status groups do not cope with discrimination in the same way, arguably because their experience of prejudice is rarer and, thus, not as harmful as it is for traditionally stigmatized individuals (Schmitt & Branscombe, 2002a; Schmitt et al., 2002). For members of high status groups, failure due to prejudice is unlikely to repeat itself or have important implications for the future, so it might elicit some anger in a particular context but will not have effects on identification or general well-being (Schmitt & Branscombe, 2002a).

The stress model

In contrast to the Rejection – Identification model, the stress model posits that identification will play the role of a moderator rather than a mediator (Major et al., 2003). According to this perspective, perceiving discrimination constitutes an appraisal of a potentially stressful situation (Allison, 1998; Major et al., 2003; Miller & Kaiser, 2001). Whether it will have an impact upon well-being depends on how people believe it to be stressful and how they then cope with it. Moreover, coping and appraisals partly depend on available resources, among them identification. If people believe that they have enough resources to deal with the situation, they will perceive it as benign, and it will not have important impacts on well-being. At a latter stage, resources can help people to effectively deal with the event and reduce its harmfulness. The role of identification as a moderator has been tested by Sellers and Shelton (2003) who showed that high identifiers are less affected by discrimination than low identifiers. Studies by Ellemers and colleagues (Ellemers, Spears, & Doosje, 1999) also support the idea of identification as a moderator. According to their perspective, high identifiers and low identifiers relate very differently to the group. While high identifiers stand by the group and fight for it when finding themselves under threat, low identifiers tend to dissociate themselves from the group and leave it if possible (Branscombe, Ellemers, Spears, & Doosje, 1999). Even though their studies do not deal with well-being, they indicate that very different effects of discrimination can be expected, depending on the level of identification. However, some authors believe that moderators of the stress phenomenon could become mediators over time (Lepore, Evans, & Schneider, 1991). At the same time, some studies indicate that rather than being characteristic of resiliency,

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it in the second introductory chapter (B. Illégitimité et bien-être).

identification could be a factor of vulnerability, with people who consider a particular identity central to their self-definition being more affected by relevant discrimination (Major, Quinton, & Schmader, 2003).

Our studies

In our studies, we wish to expand and contrast those two models with a different stigmatized group, namely nurses. We will concentrate on the role of identification as a multi-dimensional factor by looking separately at the effect of various components. We believe that the cognitive aspect of identification and a more affective / evaluative should impact differently on well-being. Postmes and Branscombe (2002) showed that when affective identification and cognitive identification were considered together in the Rejection Identification model, only affective identification retained a predictive power. Moreover, Cameron and Lalonde (2001) found that among non-traditional women, affective identification was negatively related to group discrimination while cognitive identification was positively related to group discrimination. It thus seems that there are good reasons to study identification as a multifaceted concept rather than an unitary one.

We also wished to address a number of possible extensions of the model, by considering the role of perceived group discrimination, entitativity, and solidarity. Both the rejection-identification model and the stress model are dealing with perceptions of personal discrimination, striking an isolated individual. If the impact of perceived personal discrimination on well-being is more or less undisputed (but see Crocker & Major, 1989), perceptions of group discrimination (or fraternal deprivation) have a less clear effect. For instance, relative deprivation studies tend to show that fraternal deprivation and psychological well-being are unrelated (Smith & Ortiz, 2002). Also, a number of authors tried to uncover links between general system-blame for the status of discriminated groups and self-esteem but failed to find such a relation (Bat-Chava, 1994 ; Crocker, Luhtanen, Broadnax & Blaine, 1999 ; Hughes & Demo, 1989). Similarly, the public sub-scale of the collective self-esteem scale[127] (Luhtanen & Crocker, 1992) is unrelated to self-esteem, depression, hopelessness or life satisfaction among Asians and Blacks (Crocker et al., 1994; Rowley, Sellers, Chavous, & Smith, 1998). At the same time, group discrimination is usually related to identification

[127] Collective self-esteem is composed of four different dimensions. The identity sub-scale is a measure of identification, referring to the importance of the ingroup in the definition of the self. The membership sub-scale taps the "good member" feeling of the individual. The private sub-scale refers to personal liking of the group, while the public sub-scale is a measure of the outgroup's perceived linking of the ingroup.

(Operario & Fiske, 2002; Petta & Walker, 1992) and is one of the precursors of collective action[128] (Guimond & Dubé-Simard, 1983; Simon et al., 1998; Smith & Ortiz, 2002). According to the generalization hypothesis developed by Pettigrew (1967) (see also Tougas & Beaton, 2002), people derive the level of perceived group discrimination from their own experience of prejudice. This process links personal experience of discrimination to collective action, through the mediating role of group discrimination.

In one of our recent studies, we examined the differential effects of group and personal perceptions of discrimination on self-esteem with two social categories, namely women and African immigrants living in Belgium (Bourguignon, Seron, Yzerbyt, & Herman, in press and previous chapter). We found that group identification was not related to identification but was positively linked to well-being. We discussed these results in relationship to the Rejection – Identification (Schmitt & Branscombe, 2002a) and the discounting hypothesis (Crocker & Major, 1989). Our belief is that group discrimination can act as a cognition related to 'belongingness', by situating the plight of the individual within the boundaries of group experience. We hope to replicate these results, even though we think that professional groups have characteristics that potentially distinguish them from broad social categories. More precisely, the fact that people choose their career, as opposed to being born as a category member, may undermine the possibility of using group discrimination as a protection.

The concept of solidarity among group members can be linked to social support, a well-documented moderator of stress effects on well-being (Lepore et al., 1991). Indeed, a strong social network is known to buffer the negative consequences of life events. Some authors have argued that social support could be a mediator, negatively influenced by the stressing event (Lepore et al., 1991; Mickelson, 2001). Mickelson (2001) saw that the perceived severity of one's child handicap was linked to lower levels of support from family members. Lepore and colleagues (1991) noted that among crowded students, social support of roommates shifted from moderator to negative mediator as time went by. Given that Branscombe, Schmitt and Harvey (1999) argue that discrimination leads people to identify more with their group, we think that discrimination is likely to increase perceptions of solidarity. Solidarity should mirror inclusion more closely than identification and, thus, could account for identification's positive impact on well-being. In other words, we expect solidarity to partly mediate the positive impact of identification on well-being. However, as identification could be a moderator, so could solidarity.

[128] Even though, its real contribution once structural factors are controlled is somewhat disputed (Kelly &

Finally, entitativity has been defined as the integration of proprieties that make that a number of people is perceived as a group rather than an aggregate (Campbell, 1958). Roughly said, it is "what makes a group, a group". Recent research has shown that entitativity rests on two dimensions. The first one, similarity, is composed of perceptive characteristics, like proximity, similarity, and clear boundaries between the group and other groups. The second dimension, organization, comprised characteristics like common destiny and goals, structure, and organization among group members. Homogeneity per se has long been considered as a negative feature of outgroups. People tend to perceive all others to be the same, to look alike and be interchangeable (Jones, Wood, & Quattrone, 1981; see Brewer & Brown, 1998 for a review). More recently, homogeneity, and its more complex counterpart, entitativity, have been shown to be desirable features of the ingroup (Yzerbyt, Castano, Leyens & Paladino, 2000). The idea is that entitativity of the group can help to fulfill a number of needs that group membership is supposed to account for, such as optimal distinctiveness (Brewer, 1991) and reduction of uncertainty (Abrams & Hogg, 1988). Entitativity is also a cue for power (Dasgupta, Banaji & Abelson, 1999). That is, the specific cohesion that goes with an entitative group should lead group members to feel more social support (Simon & Pettigrew, 1990) as well as a greater ability to change their fate (Doosje, Ellemers & Spears, 1995). The perception of entitativity has been shown to be linked to stronger identification, so that high identifiers perceive their group as more entitative (and are motivated to enforce that perception) and higher entitativity leads to an increase in identification (Yzerbyt et al., 2000). If discrimination boosts identification, it should also increase entitativity. Entitativity could in turn account for the positive impact of identification on well-being. Threats to the group have also been shown to increase perceptions of homogeneity (Doosje et al., 1995; Lee & Ottati, 1995). As discrimination is a form of identity threat, it could well increase entitativity this way too and have a role similar to solidarity and identification.

In sum, we thus propose that the buffering role of identification very much amounts to the effect of solidarity and entitativity as the perception of group efficacy. Moreover, we wish to see whether these group cognitions (solidarity, entitativity) feed into collective action and if this belief in collective action would in the end be protective of well-being.

The decision to work with nurses was made for a number of reasons[129]. We definitely wished to depart from the traditional use of broad social categories and check if the dominant models also apply to unfairly devalued professions. Nurses are often studied in relationship to

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Breinlinger, 1996; Klandermans, 1997)

burn-out[130] (Freudenberger, 1974), which stands for professional fatigue, an incapacity to deal with stressing events related to their jobs. Numerous causes are underlined to explain this stress syndrome, one of them being poor work conditions. In the following study, we will not refer directly to burn-out, in order to stay in line with previous discrimination studies and remain focused on self esteem and life satisfaction. However, as general well-being measures are bound to be related to burn-out, we will take work conditions into consideration in order to examine the specific contribution of discrimination.

Our hypotheses can be summarized as follows:
Hypothesis 1 (exploratory): Different facets of identification will be differently related to group and personal aspects of discrimination.
Hypothesis 2: All aspects of identification will be positively related to well-being.
Hypothesis 3: (exploratory): The Rejection – Identification model will or will not be reproduced depending on the type of discrimination and the facet of identification considered.
Hypothesis 4: Solidarity and entitativity will account for some of identification's buffering effect. They may also have a moderating effect.
Hypothesis 5 a: Entitativity (and maybe solidarity) will predict collective action.
Hypothesis 5 b: Collective action will be positively related to well-being and account for some of identification's buffering effect.
Hypothesis 6: Discrimination will account for negative well-being over and above the impact of work conditions.

Method

Pre-testing phase.

Before we started the proper data collection, an experimenter met with 10 nurses, that she recruited through her social network and conducted with them open interviews in order to check for the existence of perceptions of group injustice and discrimination against nurses. These data were not systematically analyzed because the purpose of this initial contact with the field was mainly to make sure that we were investigating an area that made sense with respect to our hypotheses and concepts. The respondents also filled in our questionnaire in order to check for unsettling questions. We modified some of our questions based on the obtained feedback.

[129] As this study is part of a wider longitudinal framework, we will not discuss them all in this paper.

Participants.

We contacted 941 nurses who had just finished their scholarship through the mail[131]. Of those, we identified 778 females (83%) and 132 males (14%). First names could not inform us of the gender of the remaining 31 people (3%). Our sample was composed of 730 people living in Belgium, 202 people living in France and 9 in other countries (Luxembourg, The Netherlands, Canada), all coming from 12 different French-speaking Belgian nursing schools.

400 people answered this first questionnaire (42.5 % of the sample). 352 (87%) were female, 47 (12%) were male and 1 did not mention his/her gender. The mean age was 22.91 years old. The distribution of school and place of residence remained roughly similar to the one observed in the contacted sample. As we wanted an relatively homogeneous sample, four people who reported having worked as nurses for more than five years were dropped from the analyses. The remaining 396 participants had worked for an average of 4 months at the time of the data collection.

Procedure.

Participants received the four-page questionnaire through the mail along with a letter of introduction presenting the study in rough lines and another sheet that described in detail the method to respond to the items. Participants also received a prepaid pre-addressed envelope in order to return the questionnaire.

Material.

The four-page questionnaire comprised several scales. All answers had to be given by indicating personal agreement with the items, using 7-point Likert-type scales ranging from 1 (: I do not agree at all with the statement) to 7 (: I totally agree with the statement). Only scales used in this study will be described.

We measured four types of **discrimination:** general group discrimination (3 items, items: "Prejudice and discrimination against nurses really exist", "Nurses suffer as a group because of their profession" and "Nurses as a group are regularly confronted with

[130] Composed of emotional fatigue, loss of empathy and feelings of worthlessness (Maslach, 1975).

devaluation"), personal discrimination (3 items: "I have personally been victim of discrimination because of my profession", "I have personally been victim of devaluation because of my profession", "I am regularly confronted with prejudice against my professional group"), devaluation by the medical staff (3 items: "I am happy with the relationship I have with the doctors I meet in my workplace", "I think that the era is long gone when doctors gave orders to the nursing staff with contempt", "There is a real wish of the doctors to work hand in hand with the nursing staff" (all items were reversed)) and societal devaluation (4 items: “People believe that nursing is an easy job”, "Few people realize all the responsibilities that befall on nursing staff", "Too little budget is allocated to improve the working conditions of nurses", "As a nurse, I think that the fact of rapidly training chiropractors and care assistants to basic nursing acts to compensate the lack of nursing staff is a way of devaluing the profession[132]").

We also assessed **structural variables** from social identity theory: legitimacy (4 items like "The social status of nurses is legitimate" and "It is legitimate that a doctor is entitled to more respect than a nurse"), permeability (4 items: "It is not difficult for a member of the nursing staff to be treated like a member of the medical staff" ; "If a nurse wants it, he/she can easily climb up in the hierarchy of an hospital") and stability (4 items: "Society will never appreciate nurses at their true value" ; "Whatever we do, doctors will always have a higher status in society than nurses").

Twelve items assessed **group identification**, a priori divided in three dimensions, following Ellemers, Kortekaas and Ouwerkerk (1999) conceptualization. The dimension of cognitive identification comprised four items, such as “To describe myself, I would certainly refer to the fact that I am a nurse” or “I have a lot of common points with other nurses”. The dimension of behavioral identification comprised four items as well, such as “It is important for me to claim I am a nurse in my daily life” or “Whatever happens, I will stick to the nursing staff.” The evaluative dimension comprised four items, e. a. “I feel good about being a nurse” or “I feel nurses can be satisfied of who they are”.

Two items assessed **reciprocal pride**: “I feel proud as a nurse” and “I think other nurses respect me”.

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[131] We obtained their names and addresses through letter and phone contacts with nursing high schools in Wallonia and Brussels. The choice of « starting professional » was due to the longitudinal aim of the study and will be explained in a further chapter.

Six items evaluated **work conditions**: "I am paid enough for the work I do" (reverse coded) or "There is an overload of work in my team". One item about opportunities reduced the reliability of the scale and thus was deleted. The other five items were collapsed into one single index of work conditions (α = .73).

Eight items tapped **burn-out**: e. a. "I feel exhausted after a day at work" or "Work generates so much stress in me that I become aggressive with my colleagues, patients and family" (α = .78). The difference between work conditions and burn-out items is that in the burn-out items, there are explicit references to frustration, stress and fatigue. Work conditions items remain more or less objective statements.

The ten items from the Rosenberg's scale measured **trait self-esteem** (α = .86).

Six items measured **life satisfaction**. Examples of items are "In general, I am satisfied of my life as it is today" and "Everything that I have achieved so far in my life has proved satisfactory" (α = .81).

Six items measured **ingroup solidarity**. Examples are "Nurses can count on each other" or "I have the feeling that among nurses, we understand each other" (α = .95).

Three items measured **collective action tendencies** ("I think it is important that we act together to obtain a re-evaluation of our profession"). These items were collapsed into one index (α = .66).

Finally, nine items measured **entitativity**. Examples are. "Nurses share a common nature", "Nurses live similar experiences in the course of their career." Those will be described in the results section.

People had also to write down their gender, age and the length of time they had worked so far.

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[132] This was a specific situation in the Belgian setting at the time.

Results.

Exploratory analyses

Some of the scales were new and specifically designed for our study. We first analyzed their factorial structure.

The *discrimination* items were submitted to a principal component analysis with varimax rotation. This generally yielded the expected pattern of results, dividing our items into four different types of discrimination (variance explained : 61 %). Unexpectedly, one item of personal discrimination ("I regularly come across prejudice against my professional group") loaded on the group discrimination factor. It appears that this item can be understood as a group situation because the encountered prejudice may be directed at the group in general rather than at the specific person. We thus decided to use it as an indicator of group discrimination. On the basis of these results, we computed four indexes, namely perceived group discrimination (4 items) (α= .76) (M = 3.98), perceived personal discrimination (α= .82) (M = 2.43), negative relationship with the doctors (α= .76) (M = 3.84) and perceived societal devaluation (α= .54). Given the questionable reliability of this last index, and the impossibility to correct for it, societal devaluation will not be used in further analyses.

Unfortunately, our structural variables items did not correlate properly. Therefore, we decided to keep one item from each concept, choosing the one that approached most closely the meaning of the variable. For (il)legitimacy, we retained " I think that the way nurses are considered in society is unfair" (M = 3.14). For stability, we retained "The societal position of nurses will never change" (M = 2.69). For permeability, we retained "A nurse, if he/she wants it really, can change jobs and rise in society" (M = 5.38).

The *identification* items were submitted to a principal component analysis with varimax rotation, along with the two reciprocal pride items. We obtained three factors but not exactly the ones that were expected (see Table 1). The first factor, that we called "affective identification", was composed of 6 items (the 4 expected ones, one item of pride, one item of behavioral identification) (alpha = .80) (mean = 5.99). Four items loaded on the second factor, bringing together similarity to other members of the group and willingness to get involved in group defense (alpha = .68) (mean = .5.48). Three items loaded on the last factor (alpha = .73) and referred to the idea of self-definition as a nurse (mean = 5.13). The second item of reciprocal pride did not load well on any of the factors and was thus omitted from the index of

identification. Because this item taps ingroup acceptance, we will use it as a separate predictor.

Table 1. Factor loadings of identification items.

	Factor 1	**Factor 2**	**Factor 3**
I feel good about the group of nurses.	.61		
I think that nurses have numerous things they can feel proud about.	.66		
Whatever happens, I will stay on nurses' side.		.67	
I would be willing to mobilise for the nurses' cause.		.55	
I have a lot of common points with other nurses.		.78	
The fact that I am a nurse is an important reflection of what I am.			.56
To describe myself, I would certainly refer to the fact that I am a nurse.			.80
I feel fundamentally different from other nurses. (reverse coded)		-.64	
It is important for me to claim I am a nurse in my daily life.			.84
I think that nurses can be satisfied of what they are.	.59		
Considering reality, I would have rather had another profession than nurse.	-.72		
I have a lot of respect for nurses.	.61		
I am proud to be a nurse.	.59		

The principal component analysis on the entitativity items revealed three factors. The first one comprises most of the aspects of entitativity (but for essentialism and homogeneity) (alpha = .73). The second one taps essentialism (common nature) (alpha = .65) and the last one homogeneity (alpha = .56). As the reliability of the whole scale was better, we will thus use it as a composite rather than separate scales (α = .76).

Means and correlations.

Table 2 presents the means and standard deviations of our variables.

Table 2. Descriptive statistics for all variables.

	Mean	Std. Deviation
Personal discrimination	2.43	1.85
Group discrimination	3.98	1.36
Negative attitudes of the medical staff	3.84	1.41
Legitimacy	3.14	1.79
Permeability	5.37	1.65
Stability	2.67	1.68
Solidarity	4.97	1.42
Evaluative identification	5.99	0.95
Similarity and involvement identification	5.48	1.07
Self-definition	5.13	1.36
Entitativity	4.37	0.92
Acceptance by the ingroup	5.24	1.43
Support for collective action	6.05	1.01
Work conditions	5.50	1.04
Burn-Out	3.36	1.18
Self Esteem	5.62	1.00
Life satisfaction	5.61	1.08

Structural variables, discrimination and identification.

Correlation coefficients between the discrimination, structural variables, and identification indexes are presented in Table 3. Despite the high levels of inter-correlation, the different facets of identification seem to be distinctively related to discrimination. Whereas affective identification is unrelated to legitimacy and negatively linked to all three forms of discrimination, both similarity and self-definition are negatively related to legitimacy. Moreover, self-definition is positively linked to discrimination, as would be expected from the Rejection – Identification model. Stability and permeability are linked to affective identification, with less stability and more permeability linked to higher levels of identification.

Table 3. Correlation coefficients for discrimination indexes, structural variables and identification facets.

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
1. Personal discrimination	/							
2. Group discrimination	.43***	/						
3. Medical staff discrimination	.12*	.21***	/					
4. Legitimacy	-.26***	-.41***	-.09†	/				
5. Permeability	-.08	-.06	-.11*	-.05	/			
6. Stability	-.01	.06	.08†	-.12*	-.07	/		
7. Evaluative identification	-.13*	-.18***	-.22***	-.03	.13**	-.14**	/	
8. Similarity identification	.09†	.03	-.15*	-.21***	-.03	-.04	.55***	/
9. Self-definition	.13**	.19***	-.06	-.21***	-.04	-.06	.40***	.37***

Note: †: $p < .1$ *: $p < .05$ **: $p < .01$ ***: $p < .001$

We conducted a series of regression analyses in order to see which structural variables predict discrimination and identification. In line with the pattern of correlations, legitimacy was the sole significant predictor of group discrimination (β = -.42, $p < .0001$). Both legitimacy (β = -.27, $p < .0001$) and permeability (β = -.10, $p < .05$) predicted personal discrimination. The negative attitudes of the medical staff were predicted by permeability only (β = -.11, $p < .05$).

Legitimacy predicted self-definition (β = -.22, $p < .0001$) and similarity (β = -.22, $p < .0001$). In contrast, evaluative identification was predicted by permeability (β = .12, $p < .02$) and stability (β = -.14, $p < .01$). These results seem to indicate that whereas affective identification reflects a positive structural relation (unstable and permeable), self-definition and similarity are more the identification of the underdogs. The link between permeability and some of the discrimination variables support the idea that permeability in itself seems to lead to perceptions of injustice (even though illegitimacy and permeability are not related, in this data).

Discrimination, entitativity, and solidarity.

Correlation coefficients are presented in Table 4. If all the perception scores are highly correlated, none of them seems to be linked to the perception of discrimination, with the exception of negative medical staff attitudes. Surprisingly, respondents who perceive the medical staff to be arrogant and superior also believe that their group is less entitative and less supportive and feel less respected by other ingroup members.

Table 4. Correlation coefficients for discrimination indexes, entitativity and solidarity.

	Entitativity	**Solidarity**	**Ingroup Acceptance**
Personal discrimination	.07	..02	-.04
Group discrimination	.09†	-.03	-.01
Medical staff attitudes	-.12*	-.19***	-.19***
Entitativity	/	.52***	.44***
Solidarity		/	.58***
Ingroup Acceptance			/

Note: †: $p < .1$ *: $p < .05$ **: $p < .01$ ***: $p < .001$

Identification, entitativity, and solidarity.

As can be seen in Table 5, all indexes are highly correlated. As expected, identification is positively related to entitativity and solidarity as well as ingroup acceptance. All three indexes of identification were found to be related to the same extent to the perceptive variables.

Table 5. Correlation coefficients for identification facets, solidarity and entitativity.

	Self definition	**Similarity**	**Affective identification**
Entitativity	.37***	.42***	.34***
Solidarity	.25***	.45***	.46***
Ingroup Acceptance	.29***	.41***	.47***

Note: *: $p < .05$ **: $p < .01$ ***: $p < .001$

Well-being and discrimination.

Correlations are presented in Table 6. Whereas discrimination is negatively related to all three measures of well-being, work conditions only predict burn-out, an index more closely related to the work setting. We also observed a correlation between work conditions and group discrimination, suggesting that the perception of discrimination may indeed come from work conditions (or the reverse).

Table 6. Correlation coefficients for discrimination indexes and well-being measures.

	Work Conditions	**Burn Out**	**Self Esteem**	**Life satisfaction**
Personal discrimination	.08†	.17***	-.14**	-.17***
Group discrimination	.21***	.28***	-.16**	-.13*
Medical staff attitudes	.03	.17***	-.23***	-.22***
Work Conditions	/	.38***	.08	.02
Burn Out		/	-.27***	-.23***
Self Esteem			/	.48***
Life satisfaction				/

Note: †: $p < .1$ *: $p < .05$ **: $p < .01$ ***: $p < .001$

Well-being and identification

Correlation coefficients are presented in Table 7. Affective identification seems to be the strongest predictor of well-being, as it is highly related to self esteem and life satisfaction, and the only index of identification to be linked to lower burn-out. On the other hand, harsh work conditions go hand in hand with similarity and self-definition.

Table 7. Correlation coefficients for identification facets and well-being measures.

	Self definition	Similarity	Affective identification
Work conditions	.18***	.18***	.08
Burn out	.00	.03	-.28***
Self esteem	.14**	.18***	.37***
Life satisfaction	.16**	.21***	.45***

Note: *: $p < .05$ **: $p < .01$ ***: $p < .001$

Well-being and perceptions of the ingroup.

Correlations are presented in Table 8. Work conditions and burn-out are weakly related to group perception variables. In contrast, self esteem and life satisfaction are positively related to all ingroup variables: entitativity, solidarity, and ingroup acceptance.

Table 8. Correlation coefficients for entitativity, solidarity and well-being measures.

	Entitativity	Solidarity	Ing. Acceptance
Work Conditions	.10*	.01	.10†
Burn Out	.08	-.11*	-.07
Self Esteem	.19***	.28***	.31***
Life satisfaction	.19***	.41***	.38***

Note: †: $p < .1$ *: $p < .05$ **: $p < .01$ ***: $p < .001$

As the pattern for life satisfaction and self-esteem was similar across all variables, and their correlation coefficient was high ($r = .48$), we decided to collapse these measures into a single index of well-being in our remaining analyses.

Collective action tendencies

We correlated the collective action item with the three discrimination indexes (see Table 9), the ingroup variables (Table 10) and the well being measures (Table 11). We will not describe all results here, as strategies will be examined elsewhere in this section.

Table 9. Correlation coefficients for discrimination indexes and collective action.

	Personal discrimination	Group discrimination	Medical staff	Legitimacy	Permeability	Stability
Collective action	.08	.13*	-.04	-.21***	.10*	-.20***

Note: *: $p < .05$ **: $p < .01$ ***: $p < .001$

Table 10. Correlation coefficients for ingroup variables and collective action.

	Affective ident.	Self definition	Similarity	Entitati-vity	Solidarity	Ingroup Hom.	Outgroup Hom.	Ingroup acceptance
Collective action	.41***	.29***	.44***	.29***	.25***	.17***	.10†	.20***

Note: †: $p < .1$ *: $p < .05$ **: $p < .01$ ***: $p < .001$

Table 11. Correlation coefficients for well-being measures and collective action.

	Well Being	Work conditions	Burn Out
Collective action	.25***	.23***	-.03

Note: *: $p < .05$ **: $p < .01$ ***: $p < .001$

Main results

Identification facets and perceptions of discrimination at different levels (*hypothesis 1)*

We computed a regression to see if the different aspects of discrimination as well as the work conditions could predict the various facets of identification. The regression analysis for self-definition was significant ($F(4,389) = 7.24$, $p < .0001$, *adj. R2*= .06). Personal discrimination was not related to self-definition. Poor work conditions (β= .15, $p < .01$) and group discrimination (β= .15, $p < .01$) increase self-definition as a nurse while bad relationships with the medical staff decrease it (β= -.10, $p < .05$).

Similarity could also be predicted with the set of variables used above ($F(4,389) = 7.15$, $p < .0001$, *adj. R2*= .06). In contrast to what happened for self-definition, similarity could not be related to group discrimination. Personal discrimination marginally predicted similarity (β= .10, $p < .06$) while both bad relationships with the medical staff (β= -.17, $p < .001$) and poor work conditions (β= .18, $p < .001$) were also significantly related to it.

Finally, affective identification was predicted by group discrimination (β= -.14, p < .05), bad relationships with the medical staff (β= -.19, p < .001) and work conditions (β= .11, p < .05) (F(4,389) = 8.58, p < .0001, *adj. R2*= .07).

To sum up and confirming the analysis of the pattern of correlations, group discrimination is related positively to self-definition but negatively to affective identification. In contrast, bad relationships with the medical staff always predict poorer identification. As for poor work conditions, this variable always predicts higher identification. Personal discrimination is only marginally related to similarity.

The "pure" rejection identification model.

We decided to test the pure rejection-identification (Schmitt & Branscombe, 2002a) model by using only personal discrimination, well-being, and self-definition in the regression equation[133]. In so doing, we relied on the procedure outlined by Baron and Kenny (1986). The link between personal discrimination and well-being is negative and significant (F(1,393) = 13.58, p < .001, *adj. R2*= .03) (β= -.18). Personal discrimination is also positively related to self-definition (F(1,393) = 6.88, p < .01, *adj. R2*= .01) (β= .13). When we put both discrimination and self- definition in the equation in order to predict well-being, both predictors remain significant (F(2,393) = 16.11, p < .0001, *adj. R2*= .07)(R^2 *change* = .04, p < .0001) . Self-definition is positively related to well-being (β= .21, p < .0001) and personal discrimination is negatively related to it (β= -.21, p < .0001). To test whether the link between personal discrimination and well-being is significantly greater when self-definition is added to the equation, we computed a Sobel Test, which is significant (z = 2.231, p < .03). As such, we can safely say that self-definition buffers the relationship between personal discrimination and well-being, even though the relationship remains significantly negative when self-definition is not controlled for.

One of our aims was to check for the role of entitativity and solidarity within the equation (hypothesis 4). Regression analyses are presented in Table 12. The inclusion of either entitativity (Alternative 1) or solidarity (Alternative 2) in the regression model significantly increases the fit of the model. Both entitativity and solidarity mediate the relationship between identification and well-being (Sobel tests are respectively z = 3.37, p < .001 and z = 4.33, p < .0001). However, when both predictors are present simultaneously in

the model, only solidarity remains significant and entitativity as such is not necessary. The link between discrimination and well-being is unchanged by the presence of solidarity (or entitativity) in the equation. We can thus conclude that the buffering effect of identification is partly explained by perceptions of solidarity.

Table 12. Regression analysis: prediction of well-being.

	Main model	**Alternative 1**	**Alternative 2**	**Alternative 3**
Personal discrimination	-.21***	-.21***	-.20***	-.20***
Self Definition	.21***	.14**	.11*	.11*
Entitativity		.19***		.00
Solidarity			.38***	.38***
F	16.11	15.80	35.49	26.55
adj. R2	.07***	.10***	.21***	.21***
R^2 change		.03***	.14*** a	.00 ns b

a: Compared to main model

b: Compared to alternative 2.

Note: *: $p < .05$ **: $p < .01$ ***: $p < .001$

We also tested for the presence of moderator effects of both solidarity and self-definition with discrimination. Whereas the interaction between personal discrimination and self-definition failed to reach significance, the interaction between solidarity and personal discrimination was significant (table 13). To understand better this interaction, we broke it down by looking at the effect of personal discrimination at one standard deviation above the mean and one standard deviation beneath the mean of the solidarity index. This allowed us to look at people perceiving high and low levels of solidarity without dividing the sample. People perceiving low levels of solidarity are strongly affected by personal discrimination (β = -.31, $p < .0001$) whereas people perceiving high levels of solidarity are only marginally affected by it (β = -.11, $p < .08$). It would thus seem that the positive effect of self-definition can be partly accounted for by solidarity, but solidarity also plays a moderating role.

[133] We computed the same regression analysis controlling for gender, age and work length, but since it did not alter the results, we present here the analysis without controlling demographic variables.

Table 13. Regression analysis: prediction of well-being.

Personal discrimination	-.22***	-.21***
Self Definition	.12*	.11*
Solidarity	.38***	.39***
Interaction discrimination * self definition	.07	
Interaction discrimination * solidarity		.10*
F	27.33	28.10
adj. R2	.21***	.22***
R^2 change (compared to alternative 2, T. 13)	.00 ns	.01*

Note: *: $p < .05$ **: $p < .01$ ***: $p < .001$

Alternative Rejection – identification models (hypothesis 3)

Group discrimination

To the extent that our correlation analyses reveal that perceived group discrimination is negatively related to well-being, there is no reason to suspect that group discrimination would protect people from the ill-effects of personal discrimination, as we observed in previous studies (see previous chapter). The test of the Rejection – Identification model with group discrimination rather than personal discrimination delivers almost identical results to the model with personal discrimination[134]. When we used both group and personal discrimination in the model, only perceived group discrimination retained a significant impact on self-definition ($F(2,393) = 7.94$, $p < .0005$, $\beta = .16$) whereas personal discrimination was not linked to it ($\beta = .06$, *n. s.*). Both types discrimination retained separate links to well-being ($F(2,393)=8.61$, $p < .0003$) even though the impact of personal discrimination was greater ($\beta = -.14$, $p < .02$) than the marginal effect of group discrimination ($\beta = -.10$, $p < .07$).

The inclusion of self-definition into the model yielded a significant analysis ($F(3,393) = 13.15$, $p < .0001$, $\beta = .23$). Personal discrimination retained a similar effect on well-being ($\beta = -.15$, $p < .005$) whereas group discrimination became significantly related to well-being ($\beta = -.14$, $p < .01$). A Sobel test indicated that self-definition did indeed buffer the link between group discrimination and well-being ($z = 2.50$, $p < .02$).

[134] Group discrimination predicted self-definition : $F(1,393) = 14.71$, $p < .0001$, $\beta = .19$.
Group discrimination was also related to well-being : $F(1,393) = 10.74$, $p < .002$, $\beta = -.16$.
When taken together, the negative relationship between group discrimination and well-being increased ($F(2,393) = 15.44$, $p < .0001$, $\beta = -.21$, and the Sobel test appeared highly significant ($z = 2899$, $p < .005$).

Evaluative identification.

Rather than self-definition, one could be tempted to use evaluative identification as the buffering cognition. The regression of the two discrimination indexes on evaluative identification is significant ($F(2,393) = 7.06$, $p < .005$) even though only group discrimination is related to evaluative identification ($\beta = -.15$, $p < .005$) (for personal discrimination, $\beta = -.06$, *n. s.*). It is noteworthy that group discrimination is negatively linked to identification, rather than positively, as the Rejection – Identification model would have it.

As we observed in the correlation analyses, evaluative identification is a strong predictor of well-being ($F(1,395) = 116.17$, $p < .0001$, $\beta = .48$).

When the discrimination indexes are considered together with evaluative identification ($F(3,393) = 41.63$, $p < .0001$), personal discrimination retains its predictive power ($\beta = -.11$, $p < .05$) but group discrimination impact upon well-being disappears ($\beta = -.04$, *n. s.*). It thus appears that whereas personal discrimination has a direct and negative impact on well-being, the effect of group discrimination derives from its negative effect on evaluative identification. The Sobel test indicates that this is indeed the case ($z = -2.56$, $p < .01$).

Finally, we included self-definition to this last equation. The analysis reveals that self-definition does not modify the relationships ($F(4,393) = 31.22$, $p < .0001$) and has no effect on well-being when evaluative identification is simultaneously considered ($\beta = .02$, *n. s.*).

Regression analysis of collective action tendencies (*hypothesis 5a)*

We computed a regression analysis on the collective action score (see Table 14). First, we entered the discrimination indexes as well as work conditions. Work conditions is the sole predictor of collective action tendencies ($\beta = .21$). In a second step, we included the three identification indexes ($F(9,388) = 16.41$, $p < .001$, *adj. R2*= .27) . This analysis revealed the presence of a positive link between affective identification and similarity, and collective action tendencies. Finally, we added solidarity and entitativity ratings, but neither one of these variables impacted on collective action.

Table 14. Regression analysis: prediction of collective action tendencies

	Step 1	Step 2	Step 3
Personal discrimination	.03	-.00	.00
Group discrimination	.07	.13*	.12*
Attitudes of the medical staff	-.08	.03	.03
Work conditions	.21***	.13**	.13**
Self-definition		.03	.01
Similarity		.24***	.23***
Affective identification		.31***	.31***
Solidarity			.07
Entitativity			-.03
F	4.00	16.41	13.58
adj. R2	.05***	.27***	.27***
R^2 change		.22***	*n. s.*

Note: *: $p < .05$ **: $p < .01$ ***: $p < .001$

Regression analysis of general well-being (*hypothesis 2, 5b and 6)*

Finally, we computed a regression analysis with well-being as the criterion and the three discrimination indexes, work conditions, the three identification indexes, solidarity, entitativity and collective action tendencies as predictors (see Table 15). We first entered the three discrimination indexes as well as work conditions[135]. All four scores significantly predicted well-being ($F(6,367) = 7.14$, $p < .001$, *adj. R2*= .09). The four relationships were negative.

At step 2, we added the three identification indexes. This yielded a significantly better equation ($F(9,367) = 15.75$, $p < .001$, *adj. R2*= .27). However, only affective identification appeared to be positively related to well-being. Both group discrimination and work conditions lost their impact on well-being.

At step 3, we added entitativity and solidarity, again increasing the explanatory power of our regression model ($F(11,367) = 15.54$, $p < .0001$, *adj. R2*= .30). Only solidarity appeared to be positively related to well-being. Even though affective identification retained most of its predictive power, a Sobel analysis indicates that solidarity does mediate part of its effect ($z = 3.36$, $p < .001$).

[135] Controlling for age and gender.

Finally, we included collective action tendencies. The predictive power of the model was improved ($F(12,367) = 14.67$, $p < .0001$, *adj. R2*= .31) and collective action appeared marginally related to well-being (β= .10, $p < .06$). Collective action marginally accounts for some of the affective identification effect but the Sobel test failed to reach statistical significance ($z = 1.82$, $p < .07$).

Table 15. Regression analysis: prediction of well-being

	Step 1	**Step 2**	**Step 3**	**Step 4**
Personal discrimination	-.11*	-.10*	-.11*	-.11*
Group discrimination	-.12*	-.05	-.06	-.07
Attitudes of the medical staff	-.22***	-.13*	-.12*	-.12*
Work conditions	-.11*	.07	.08†	.07
Self-definition		-.02	-.03	-.03
Similarity		.00	-.06	-.09
Affective identification		.45***	.38***	.35***
Solidarity			.24***	.24***
Entitativity			.00	-.01
Collective action				.10†
F	7.14	15.75	15.54	14.67
adj. R2	.09***	.27***	.30***	.31***
R^2 change		.18***	.03***	.01†

Note: †: $p < .1$ *: $p < .05$ **: $p < .01$ ***: $p < .001$

Discussion.

In this study, we intended to clarify the roles of identification and discrimination on well-being, using a professional group, nurses. We also wanted to see if solidarity, entitativity, and collective action tendencies could account for part of the buffering role of identification, as it has been proposed by the Rejection – Identification model.

The analysis of our identification scale indicated the existence of three distinct facets, namely an affective/evaluative component, a self-definition component and a similarity to other group members component. We decided to use those three factors separately in our analyses.

Although both perceived group and personal discrimination indexes similarly correlate with affective and cognitive identification, regression analyses show that when both discrimination indexes are considered together, only group discrimination remains related to identification dimensions. Moreover, it is positively related to cognitive identification, but negatively related to affective identification. This pattern is similar to what Cameron and Lalonde (2001) found among non-traditional women. The negative link between others' perceptions of the ingroup and personal evaluation of the group is also reminiscent of the pattern Crocker and colleagues (1994) encountered with Asian students, who mirrored public regard in their own evaluation of the ingroup. However, Asian students also reflected public regard in their cognitive identification. One reason why we observe a distinctive pattern might be that nurses, like women or Asians, have an identity partially based on other people's appraisals (see Kling et al, 1999 for women; Twenge & Crocker, 2002 for Asians). Because nurses interact with doctors and, more importantly, with patients, their social contacts are central to their daily tasks. When they perceive that others believe their profession to be low status, this impacts upon the view that they have of their profession as well, hence the negative relationship between group discrimination and affective identification. This might be increased because our participants are young nurses that just started their working career. Their motivation and implication for their new job might be exceptionally high (mean of affective identification = 5.99) and as such, more likely to be affected by perceptions of group discrimination, especially since they will not quit their job in a long time. At the same time, group discrimination is also positively related to cognitive identification, a finding that is replicated elsewhere (Operario & Fiske, 2001; Petta & Walker, 1992). However, as our data is correlational in nature, it is difficult to assert that discrimination impacts upon identification rather than the reverse; only longitudinal or experimental data will be able to answer this fully.

When we considered only the variables usually addressed in the Rejection – Identification model, we were able to replicate the model. Cognitive identification (here called self-definition) partially buffered the negative link between perceived personal discrimination and well-being. However, neither group discrimination nor affective identification played similar roles in the equation. Affective identification appeared to be the strongest predictor of well-being but was always negatively related to discrimination, whether we examined group or personal perceptions. Group discrimination on the other hand appeared to be related to well-being only through its negative effect on affective identification. When

all four predictors are considered together, the Rejection – Identification model simply disappears because the effect of affective identification reduces the impact of self-definition to nothing. So, it seems that whereas perceived personal discrimination has a direct impact on well-being but is unrelated to identification, group discrimination is related to identification, both positively to cognitive aspects and negatively to affective aspects.

These results contrast with our previous findings on broad social categories (Bourguignon et al., in press (and previous chapter)). In that study, we found that among women and African immigrants, group discrimination was unrelated to identification[136] and positively related to well-being. It seems possible that some strategies, like the protective power of group discrimination, are developed over time and through contact with older professionals. As our nurses just started working, the belief that they are just beginning a long career in a poorly thought of profession seems hardly protective. Moreover, as people chose their careers, they might feel responsible for the stigma that goes with it, and as such, can not blame the outgroup for their negative standing. This would be a similar process to that observed with overweight people (Crocker et al., 1993) that prevents them to use other people's prejudice as a discounting cognition.

We also hypothesized that the positive effect of identification on well-being would be partly due to a feeling of inclusion within the group, partly due to a belief in strength and possible change. As a matter of fact, we observed some impact of solidarity on well-being. The positive impact of identification (whether it was affective or cognitive) on well-being was partially mediated by solidarity. Solidarity also acted as a moderator, so that people perceiving high levels of solidarity were less affected by discrimination than people perceiving low levels of solidarity. In contrast, entitativity, with its numerous dimensions, did not impact upon well-being, when solidarity was controlled for. It might be that the different facets of the concept play different roles in their relationship to discrimination, well-being, and identification. This should be investigated in further studies.

Collective action was mainly predicted by work conditions and group discrimination and two of the three facets of identification. All those links are in line with expectations, especially considering the literature on relative deprivation (e. a. Dion, 1986; Smith & Ortiz, 2002), social identity (e. a. Ellemers, Spears & Doosje, 1999; Tajfel, 1981) and social movements (e. a. Kelly & Breinlinger, 1996; Klandermans, 1997; Simon et al., 1998). We had

hoped that solidarity and entitativity would play a role here but we were unable to find supportive evidence. It is worth noting however that our index of collective action measured the belief in the need for collective action. A belief in the possibility of collective action (or the chance to succeed) might have been more related to entitativity or solidarity perceptions.

Interestingly, collective action was also positively related to well-being and marginally mediated the impact of affective identification. It thus seems that whereas part of the positive link between identification and well-being is due to perceptions of solidarity and belief in collective action, identification in itself retains most of its predictive power. As it concerns affective identification, this result shows that liking your career has a direct and positive impact on well-being, which is hardly surprising.

Some of the results that we obtained lead us to question the direction of the relationships we wished to investigate. It could well be that identification predicts perception of discrimination rather than the reverse. It seems quite possible that high affective identifiers minimize the discrimination that their group faces in order to keep a positive social identity. At the same time, people who affirm their membership might be more willing to acknowledge the problems that their group encounters. To investigate more fully those results, we wish to proceed to a longitudinal study with the same population. This study will be the focus of our next chapter.

Conclusion

Even though poor work conditions are often underlined as the main nuisance for nurses, we observed that perceptions of discrimination had a distinct impact on well-being. If we were able to replicate the Rejection – Identification model while focusing on its usual components, the evidence for the model disappeared when we looked at the wider picture. Rather than being positively related to discrimination, affective identification, the strongest predictor of well-being, was negatively related to it. As such, it seems that perceiving discrimination does not give weapons to its victims in any straightforward way. Our results should encourage us to look beyond the material rewards of any profession and to take into account the specific perceptions that go with it.

[136] The fact that we did not divide our identification score into its two components (affective and cognitive) might explain why.