



Published in final edited form as:

*Soc Sci Med.* 2008 August ; 67(3): 351–357. doi:10.1016/j.socscimed.2008.03.023.

## Stigma, prejudice, discrimination and health<sup>★</sup>

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### Introduction

There is a great urgency to understand more fully the linkages between stigma, prejudice, discrimination and health to aide in the development of effective public health strategies. A goal of the US Healthy People 2010 programme is to eliminate health disparities among different segments of the population (DHHS, 2002). Prejudice and discrimination are believed to be important contributors to the production of health disparities (IOM, 2002). It is difficult to pick up a consensus report on mental illness or HIV/AIDS without finding numerous references to the ways the stigmatization of these health conditions undercuts prevention and treatment efforts (DHHS, 2003; USAID, 2000).

For this reason, in September 2006, the Health & Society Scholars Working Group on Stigma, Prejudice, Discrimination and Health convened scholars across the social and health sciences who study the social and psychological processes of stigmatization and prejudice. The objective of this conference was to strengthen collaboration across disciplines, discuss challenging conceptual issues, and identify the most pressing research objectives facing this relatively new line of inquiry. Driving discussions was the budding idea for a Special Issue that would attempt to bridge disparate research traditions in stigma, on the one hand, and in prejudice and discrimination on the other. As editors of the Special Issue, we believe the importance of this endeavor lies in missed opportunities for conceptual coherence and for capitalizing on insights generated from each research tradition and possibly, to an underestimation of the impact of stigma and prejudice on health. Several exciting manuscripts emerged from the conference making up the content of this Special Issue.

The Special Issue breaks from existing volumes in fundamental ways. To date, manuscript collections on stigma and those on prejudice and discrimination are organized around a single disciplinary perspective and focus on either stigma or prejudice but never both. Authors included in the Special Issue write from diverse disciplinary perspectives and

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<sup>★</sup>Funding for the Stigma, Prejudice, Discrimination and Health Working Group and for the Conference in support of the development of the Special Issue was provided by the Robert Wood Johnson Health and Society Scholarship Program at Columbia University.

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represent a starting point of cooperation among scholars interested in these two traditions. The articles develop conceptual and empirical research linking stigma and prejudice; identify under-recognized cultural and policy dynamics that contribute to the formation of stigma and prejudice and may mediate their health impacts; describe pathways through which stigma and prejudice affect health outcomes; and explore the implications of these themes for public health practice. In this commentary, we explain why these themes are important and introduce articles in the Special Issue.

## **Bridging stigma and prejudice research traditions**

Stigma and prejudice research traditions stem from the seminal works of sociologist Goffman (1963) and social psychologist Allport (1958). In their works, stigma and prejudice are each complex concepts that encompass individual experience, the interaction between non-marginalized and marginalized groups, and broader structural and social phenomena such as power relations, historical contingencies, community practices and program/policy design. Goffman defines stigma as “an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one (p. 11)”. Allport defines prejudice as, ...” an aversive or hostile attitude toward a person who belongs to a group, simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to the group (p. 7)”. Embodied in both works is similarity in the experiences of stigma and prejudice including: exposure to negative attitudes, structural and interpersonal experiences of discrimination or unfair treatment, and violence perpetrated against persons who belong to disadvantaged social groups.

We believe the differences between the research traditions of stigma as compared to that of prejudice and discrimination have more to do with different subjects of interest rather than any real conceptual difference. Stigma research has traditionally emphasized studying people with “unusual” conditions such as facial disfigurement, HIV/AIDS, short stature and mental illness. By contrast, researchers focused on prejudice and discrimination tend to focus on the far more ordinary, but clearly powerful implications of gender, age, race and class divisions. The article in this Special Issue by Phelan, Link, and Dovidio (2008) supports this contention. The authors conclude that the social processes of stigma and prejudice are quite similar, but that the historical reasons underlying why societies stigmatize or are prejudicial tend to vary. They show how research in the prejudice tradition grew from concerns with social processes driven by exploitation and domination, such as racism, while work in the stigma tradition has been more concerned with processes driven by enforcement of social norms and disease avoidance. This article also deepens our understanding of why the research traditions of stigma and prejudice have evolved along different evolutionary tracks and examines the potential for integration of these theoretical and conceptual schemes.

Let us give a couple of examples of why bridging these research traditions is an important endeavor. The first reason is that greater collaboration between stigma and prejudice researchers could enhance existing models that conceptualize stigma and prejudice as psychosocial stress in the lives of marginalized groups. Researchers interested in the health

impact of prejudice tend to focus on the stress induced by discrimination that occurs in the context of interpersonal interactions where a non-marginalized person treats a marginalized person unfairly. There is no shortage of studies documenting the relationship between this form of discrimination and compromised psychological wellbeing, psychosomatic symptoms and cardiovascular and psychological reactivity (Williams & Williams-Morris, 2000). The majority of these studies examine the health impact of discrimination in a US context among African Americans, although sexual orientation, social class, and gender are social categories also linked to instances of interpersonal discrimination (Karlsen & Nazroo, 2002; Laveist, Rolley, & Diala, 2003; Meyer, 2003a).

Stigma researchers generally have two different ways of conceptualizing stigma as a psychosocial stressor, which are distinct from the types of stress induced by interpersonal discrimination. Sometimes when researchers refer to stigma as a stressor they are referring to the anticipation of negative treatment by members of dominant groups (Meyer, 2003b). Goffman (1963: 13) describes how individuals with mental illness approach interactions in society with anxiety. In this case, the anticipation of negative treatment and the accompanying chronic stress involved in reactivating and maintaining a vigilant state is the psychosocial stress involved in producing morbidity. This is different from interpersonal discrimination because this form of stress can persist even when discriminatory treatment is not experienced.

Stigma has also been conceptualized as a stressor in another way. The stress induced by stigma has been described as the direction of negative societal attitudes towards the self or the so-called “internalization” of stigma. For example, Link describes a process among individuals who become labeled as mental patients and notes that societal negative attitudes that “once seemed to be an innocuous array of beliefs... now become applicable personally and [are] no longer innocuous” (1987: 97). Stuber and Schlesinger (2006) write about one form of welfare stigma as the internalization of negative stereotypes associated with users of means-tested programs by welfare participants. This form of stress is also distinct from interpersonal discrimination. A few prejudice researchers have considered internalized forms of oppression as a source of stress contributing to poor health outcomes (Clark, Anderson, Clark, & Williams, 1999; Meyer, 2003b), but generally this is not a main focus of inquiry.

The point is, when prejudice researchers focus on forms of discrimination to the exclusion of stigma-related stress processes they are missing important dimensions of the stress process likely contributing to poor health outcomes. When stigma researchers focus on internalizing or vigilance behavior to the exclusion of interpersonal and structural forms of prejudice and discrimination, they too are missing important dimensions of the stress process. We argue that health researchers from each tradition should incorporate the dimensions of stress processed emphasized in the other’s approach. Because such a rich conceptual scheme is rarely deployed, we suspect, the health impacts of discrimination and stigma have been ill-defined and minimized. Furthermore, without such a rich conceptual scheme, the ability to examine interactions among the various forms of stress is compromised.

A second reason why it would behoove stigma and prejudice researchers to cooperate pertains to innovations by prejudice researchers investigating unconscious or what has come to be known as “aversive” racism (Dovidio & Gaertner, 2004). Prejudice researchers currently explore implicit (unconscious) forms of bias as overt forms of race prejudice and discrimination have been declining in the US over the past 50 years due to the civil rights movement and the public’s general endorsement of the principles of racial equality and integration (Bobo, 2001). This body of work has obvious implications for researchers interested in stigmatized social statuses such as obesity or mental illness. Here too, researchers are beginning to find evidence that unconscious forms of bias exist even in the absence of overt expressions of prejudicial attitudes as it is becoming less politically correct to frown upon obese or mentally ill persons publically (Teachman & Brownell, 2001; Teachman, Wilson, & Komoravoskaya, 2006). Advancing conceptual understanding and methodologies to measure unconscious biases is a pressing agenda for researchers interested in stigma and prejudice as it relates to health.

These are two examples of how researchers interested in stigma and prejudice could benefit from greater collaboration. Another area of cooperation that receives too little attention in the stigma and prejudice literatures is the intersection of multiple sources of stigma and prejudice where research is typically conducted with a focus on singular forms. For example, researchers focus on racism or mental illness stigma or stigma related to HIV/AIDS, but rarely do they attend to the social reality that marginalized persons often experience stigma and prejudice for more than one reason (Kessler, Mickelson, & Williams, 1999). For example, people with mental illness in the US may also experience stigmatization stemming from high utilization of means-tested programs. People with HIV/AIDS may also experience racism. This unitary focus comes at a cost to understanding how the intersections of multiple disadvantaged social statuses impact health. Here we will elaborate on these costs and describe how two articles in the Special Issue begin to address these concerns.

The use of a singular focus in stigma and prejudice research misses how the meaning and experiences of stigma and prejudice are transmuted by other important identities and statuses. In investigations of stigma and prejudice focused on a particular population there is a powerful drive to identify commonalities in this experience (Crenshaw, 1996). The paper by Collins, von Unger, and Armbrister (2008) analyzes Latina women’s experience of mental illness stigma within the context of their sexuality, gender and ethnicity. They find that mentally ill women describe a range of negative experiences, such as sexual health risks, that cannot be reduced to their mental illness per se, but to the intersection of these multiple stigmatized identities. Their findings highlight that efforts to combat stigma and prejudice will be ineffective if they do not account for multiple and interlocking identities (Crenshaw, 1996). The paper by Padilla et al. (2008) is also illustrative of why attention to multiple disadvantaged statuses is important to identifying the root causes of health disparities. In their work on bisexual Dominican male sex workers they find multiple disadvantaged statuses have important consequences for HIV risk. Cultural notions of “sexual silence” and masculinity shape the decisions of these men to disclose to their female partners their involvement in commercial sex work and homosexual behaviors. Thus, attention to multiple disadvantaged social statuses is important to designing effective interventions. While these articles do not provide a prescription for how to study every form

of intersection, they underscore the need to further elucidate the nature of multiple disadvantaged statuses and their implications for health and health disparities.

## The formation of stigma and prejudice

At the conference, there was a call for greater attention to the reasons why and methods used by societies to promulgate stigma and prejudice. Stigma researchers in particular are criticized for not paying enough attention to these issues (Corrigan, Markowitz, & Watson, 2004; Link & Phelan, 2001; Parker & Aggleton, 2003). The critique is that stigma researchers tend to describe the adverse effects of stigma on persons labeled with a stigmatized attribute, explaining stigma by examining the social cognitive elements of the stigmatizer, who perceives a stigmatizing mark, endorses the negative stereotypes about people with the perceived mark, and behaves toward the marked group in a discriminatory manner. Thus, stigma has come to be understood as a negative attribute that is mapped onto people who, by virtue of being different, are understood to be negatively valued in society. As a result, much of the research on stigma as a social process has focused on negative stereotyping and on public opinion surveys of those who are perceived to stigmatize others.

As Parker and Aggleton (2003) argue, this focus has led to interventions targeted either at increasing empathy and altruism in the general population or at enhancing the coping strategies of stigmatized individuals, which are interventions that ultimately have small effects. They advocate for a shift in emphasis towards an understanding of stigma as something that is strategically deployed by persons in power. They call upon stigma researchers to put greater emphasis on patterns of stratification, dominance and oppression, and struggles of power and privilege, which tend to be the focus of sociological accounts of prejudice and discrimination. Their critique is also applicable to some research on prejudice, where many studies have focused on individual and interpersonal experiences of discrimination, neglecting more structural manifestations of prejudice (Adams, 1990; Clark et al., 1999; Jones, 2000).

Conference participants agreed that more work must be done to fully understand stigma and prejudice as social processes linked to the reproduction of inequality and exclusion. Collectively work on the health implications of stigma and prejudice makes clear that the effects of prejudice and stigma are powerful. From this vantage point, it behooves us to think more as a field about the inputs into these social processes. In this Special Issue, several articles focus on either unrecognized or under-studied structural, cultural and policy factors that underlie stigma and prejudice.

First, Stuber, Galea, and Link (2008) examine the role of tobacco control policies, power differences between those who smoke and those who do not smoke, and social norms in the formation of smoker-related stigma in the USA. They find evidence that certain tobacco control policies may lead to the stigmatization of smokers. While smoker-related stigma may have the potential benefit of reducing the prevalence of smoking, this article finds that smoker-related stigma is not perceived equally. Whites and persons with more education perceive more smoker-related stigma than Blacks and Hispanics and persons with less education raising the possibility that smoker-related stigma contributes to disparities in

tobacco use in the US. Second, Yang and Kleinman in their paper seek to more fully capture stigma as a social process through an examination of the cultural dynamics of “face” in China (Yang & Kleinman, 2008). They argue that an understanding of face, or of one’s moral status in his/her local world, is essential to understanding the stigmatization of schizophrenia and HIV/AIDS in China and its consequences, jeopardizing the ability of stigmatized persons to mobilize social capital and to attain essential social statuses. These authors draw lessons from their study of face to increase our understanding of the role of moral experiences embedded within local contexts in stigma formation processes.

Third, Link, Castille and Stuber (2008) turn our attention to the policies and institutional practices that have critical relevance to the production of mental illness stigma. In an evaluation of New York State’s outpatient commitment law for people with mental illness, they find evidence that such coercive approaches, widely used in mental health care delivery systems throughout the US, are in part, counterproductive because of the negative consequences of stigma brought forth by the commitment process. Finally, Pescosolido, Martin, Lang, and Olafsdottir (2008) present a new model of stigma formation; an ambitious attempt to combine individual and structural models of stigma formation. Their model is situated at the individual–community interface where reactions to persons with mental illness are shaped. Drawing from various social science theories, their model brings together insights from labeling theory, social network theory and the limited capacity model of media influence.

### **Linking stigma, prejudice and health**

Progress has been made in explicating the pathways through which stigma and prejudice impact health in this young field of inquiry. However, conference participants agreed, much more work is needed to deepen our understanding of the many ways that stigma and prejudice affect marginalized persons leading to psychological, social and biological consequences. In general, stigma and prejudice are believed to adversely impact health through five pathways.

First, studies have documented that interactions between marginalized and non-marginalized individuals that are perceived to be discriminatory are health harming because of the stress processes they activate (Krieger, 1990). Discriminatory interactions also have negative implications for health and well being as they can lead to mistreatment in educational settings, in finding jobs, housing and health care (Wahl, 1999). Second, many of the health disadvantages experienced by marginalized persons occur outside a model in which one person consciously does something unfair to another. There are numerous examples of how structural forms of stigma and prejudice such as segregation lead to poor health outcomes for marginalized individuals because they are denied access to basic health and life resources (LaVeist, 2003). Third, unconscious forms of prejudice perpetrated by non-marginalized individuals are being shown to occur spontaneously, automatically and without the full awareness of the persons perpetrating this form of prejudice (Dovidio & Gaertner, 1998). There is growing evidence that these unconscious biases are not only perceived by marginalized persons (Richeson & Shelton, 2005), but may lead to discriminatory behavior among persons who hold these unconscious biases (Dovidio & Gaertner, 2004). Fourth, is



the internalization of stigma and prejudice by marginalized individuals, which has been linked to serious health harming consequences ranging from constricted social networks (Link et al., 1989), compromised quality of life (Rosenfield, 1997), low self-esteem (Wright, Gronfein, & Owens, 2000), depressive symptoms (Link, Streuening, Rahav, Phelan, & Nuttbrok, 1997), and to unemployment and income loss (Link, 1987). Finally, stigma and prejudice researchers write about vigilance in the anticipation of negative treatment chronically activating psychological stress responses and leading to impaired social interactions between marginalized and non-marginalized persons (Meyer, 2003b).

Despite growing clarity about the linkages between stigma, prejudice and health, much more research is needed to understand these pathways fully. Several articles in the Special Issue shed more light. Meyer, Schwartz, and Frost (2008) measure multiple types of stress including: common forms of stress (e.g., stressful life events), and those uniquely experienced by persons of marginalized social statuses (in this case among persons of minority sexual orientation, race/ethnicity and gender). They examine whether types of stress are patterned in a predictable fashion, consistent with social stress theory, whereby marginalized subgroups are burdened by additional types of stressors that non-marginalized subgroups are not burdened by such as internalized oppression, and whether the stress experienced by marginalized subgroups is additive depending upon how many marginalized social statuses one experiences. They are also able to compare the distribution of available coping resources across marginalized and non-marginalized subgroups. It is rare that a study has a sample powered adequately to study the intersections of multiple marginalized social statuses. The results are surprising and suggestive of a need to revise social stress theory.

Williams et al.'s contribution to the Special Issue is based on a national probability sample of 4351 South Africans (Williams et al., 2008). Their main contribution lies in the exploration of the deleterious health consequences of race discrimination in an underexplored, but highly relevant, national context and the diversity of Blacks (African, Coloured and Indian) within the sample. They model the association between chronic and acute forms of racial discrimination adjusting for conditions that might diminish this relationship including non-racial forms of discrimination, common forms of stress, multiple indicators of socioeconomic status and psychological factors (social desirability, self-esteem and personal mastery). They find that even after adjustment for these additional factors, levels of chronic racial discrimination persist in being adversely associated with self-reported mental health.

Garcia and Crocker's focus is on "motivational systems" of the self and how one's psychological orientation in this regard can modify or shape the very experience of stigmatization and one's psychological well-being (Garcia & Crocker's, 2008). In their US-based study of people who identified as gay, lesbian, bisexual or depressed, they measure so-called "ego" and "eco" system motivations of the self and find that persons of the ecosystem type are more likely to disclose depression and to experience greater psychological well-being for having done so. Their findings shed light on the paradox that marginalized people are sometimes found to function as well as other people despite experiences of stigma and prejudice (Clark et al., 1999; Crocker & Major, 1989). This

paradox calls for a richer understanding of how self appraisals and coping styles shape the health consequences of stigma and prejudice.

The manuscript by Dovidio et al. (2008) explores the ways in which unconscious forms of racial prejudice seep into the clinical encounter. They focus on the ways in which White physicians' unconscious stereotypes of and prejudice towards Blacks generates patient distrust and detracts from the effectiveness of health care delivery for Blacks in the US. Their article emphasizes the importance of studying the provider-patient interaction and the ways in which unconscious forms of prejudice may alter these dynamics with ramifications for the production of health disparities. The diversity and depth of these articles underscore the complexity of the linkages between stigma, prejudice and health. The development of practical interventions and policy to reduce and attenuate the impacts of stigma and prejudice on health for marginalized populations depends on more fully understanding these linkages.

### **Implications of these themes for public health practice**

Nearly all the articles in the Special Issue are suggestive of innovative approaches and points of intervention to either reduce the impact of prejudice and stigma for health or to redress stigmatization and prejudice and their root causes. For example, returning to Dovidio et al.'s contribution, they describe that just because some forms of prejudice can be unconsciously or automatically activated, does not mean that they cannot be changed (Dovidio et al., 2008). He and others have found that with extensive practice, it is possible to change unconscious beliefs. For example, extended practice in associating counter-stereotypic characteristics with a group can inhibit or suppress the "automatic" activation of cultural stereotypes (Kawakami, Dovidio, Moll, Hermsen, & Russin, 2000). There are important implications of this work for adapting such intervention strategies in clinical settings. Stuber, Galea and Link's contribution suggests that, if we can identify tobacco control policies and broader cultural sources that contribute to the formation of smoker-related stigma, we may identify one factor contributing to disparities in tobacco use (Stuber et al., 2008). Of course, health promotion strategies, counter-marketing strategies to blunt the targeted marketing of the tobacco industry at disadvantaged social groups, and other interventions are also warranted, but we should also ensure that the policies we create, actually remediate, as opposed to contribute, to the production of health disparities.

On the topic of smoker-related stigma, this subject is of broader theoretical and practical interest to stigma researchers because of the possibility raised by the smoking case that stigmatization may serve a beneficial purpose in public health. Ron Bayer's article sparks a lively debate with Scott Burris on whether there is ever justification for deploying stigma as an instrument of social control to discourage unhealthy behaviors (Bayer, 2008; Burris, 2008). A little context is in order to introduce the controversy. In recent years, research on stigma has received a great deal of attention in public health. The prevailing wisdom is that stigma is damaging to health and should be combated by policy makers and public health institutions. Such arguments, for example, have been persuasive in our thinking about stigmatization of persons with HIV/AIDS. Against the backdrop of the HIV/AIDS epidemic, public health officials and advocates began to recognize the profoundly negative



consequences of stigmatization for public health namely, that the stigmatization of gay men, drug users, and commercial sex workers only serves to make them more vulnerable to HIV infection, driving them further from the reach of those who sought to affect the behaviors that placed them and others at risk (Parker & Aggleton, 2003). However, there is an alternative perspective on stigma that muddies the conceptual definition of stigma and raises ethical dilemmas for public health.

An alternative perspective on stigma in public health focuses on its potential benefits that is, in some cases, stigma may improve the health of stigmatized individuals and may be a useful tool of social control discouraging unhealthy behaviors. Historically, in the US there has been a strong tradition within public health and medicine that morally constituted norms emphasizing the role of individual responsibility shape behaviors in the interest of public health (Brandt & Rozin, 1997). This belief has informed a variety of public health responses to public health problems including: tuberculosis, HIV/AIDS, alcohol consumption during prohibition, and reckless behavior associated with alcohol abuse now. Stigmatization is believed to be part of the dynamic underlying these approaches even though such efforts are sometimes couched in a language of social disapproval (Brandt & Rozin, 1997; Gusfield, 1986). The central idea is that individuals because they do not want to be out of step with social norms and any resulting stigmatization will act to change their behavior bringing direct benefits to individuals and indirect benefits to society because of a resulting reduction in illness or socially disruptive behavior (Gibbs, 1965).

These varied conceptions are suggestive that the definition of what constitutes stigmatization is currently unclear. Can we consider potentially modifiable social statuses such as being a smoker or a person who is overweight stigmatized? Alternatively, are they simply behaviors that the majority in society disapproves of and, this disapproval is justified because there are potential benefits for the individuals who partake in these behaviors and for society? Ron Bayer's article takes up the question of how public health ought to balance the burdens imposed by stigmatization against the public health benefits it might produce (Bayer, 2008). Bayer proposes a framework for thinking about stigma and the ethics of public health focusing on the complex interaction between the utilitarian moral underpinnings of public health, respect for rights and distributive justice. The editorial response to Bayer's work was so enlightening that a commentary by Scott Burris is included in this Special Issue as well as a response from Bayer (Bayer, 2008; Burris, 2008).

Bayer and Burris's debate helps return us to the main motivation for the Special Issue, to begin a new era of cooperation between researchers interested in the health implications of stigma and prejudice. In their debate, if we were to substitute the term prejudice in lieu of stigma imagine the offensiveness of the idea that there is something "useful" to the perpetuation of prejudice in contemporary US society. So, while we argued at the outset of this commentary that stigma and prejudice are conceptually more alike than dissimilar, we further highlight that there are differences in the root causes of these social processes maintaining the conceptual distinction. As Phelan, Link, and Dovidio (2008) conclude, the functions of stigma and prejudice in society have varied throughout history. While the root causes of stigma and prejudice stem from exploitation and dominance, the rationales used to

stigmatize further extend to norm enforcement and to disease avoidance (Phelan et al., 2008). Perhaps there are some justifications to stigmatize, but not to justify prejudice?

We hope reading articles in the Special Issue stimulates new ways to think about the links between stigma, prejudice, discrimination and health. Its triumph, however, does not lie solely in what it accomplishes within its pages, but also in its conception and introduction of a concrete set of strategies intended to breathe life into this pressing research agenda going forward.

## Acknowledgments

We wish to thank Fred Markowitz and Suzanne Ouellette for their thoughtful reviews of manuscript proposals for the Special Issue.

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