Conceptualizing Stigma
Author(s): Bruce G. Link and Jo C. Phelan
Source: *Annual Review of Sociology*, Vol. 27 (2001), pp. 363-385
Published by: Annual Reviews
Stable URL: https://www.jstor.org/stable/2678626
Accessed: 11-09-2019 12:08 UTC

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at https://about.jstor.org/terms

Annual Reviews is collaborating with JSTOR to digitize, preserve and extend access to *Annual Review of Sociology*

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

Annu. Rev. Sociol. 2001. 27:363–85
Copyright © 2001 by Annual Reviews. All rights reserved

CONCEPTUALIZING STIGMA

Bruce G. Link[1] and Jo C. Phelan[2]
[1]*Columbia University and New York State Psychiatric Institute, New York, NY 10032; e-mail: BGL1@Columbia.edu*
[2]*Department of Sociology, Columbia University, New York, NY 10021; e-mail: JCP13@Columbia.edu*

Key Words labeling, stereotype, discrimination, exclusion, deviance

■ **Abstract** Social science research on stigma has grown dramatically over the past two decades, particularly in social psychology, where researchers have elucidated the ways in which people construct cognitive categories and link those categories to stereotyped beliefs. In the midst of this growth, the stigma concept has been criticized as being too vaguely defined and individually focused. In response to these criticisms, we define stigma as the co-occurrence of its components–labeling, stereotyping, separation, status loss, and discrimination–and further indicate that for stigmatization to occur, power must be exercised. The stigma concept we construct has implications for understanding several core issues in stigma research, ranging from the definition of the concept to the reasons stigma sometimes represents a very persistent predicament in the lives of persons affected by it. Finally, because there are so many stigmatized circumstances and because stigmatizing processes can affect multiple domains of people's lives, stigmatization probably has a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health, and life itself. It follows that social scientists who are interested in understanding the distribution of such life chances should also be interested in stigma.

INTRODUCTION

Erving Goffman's (1963) book *Stigma: Notes on the Management of Spoiled Identity* inspired a profusion of research on the nature, sources, and consequences of stigma. Both PsychInfo and Medline show dramatic increases in the number of articles mentioning the word stigma in their titles or abstracts from 1980 (PsychInfo 14, Medline 19) to 1990 (PsychInfo 81, Medline 48) to 1999 (PsychInfo 161, Medline 114).

Research since Goffman's seminal essay has been incredibly productive, leading to elaborations, conceptual refinements, and repeated demonstrations of the negative impact of stigma on the lives of the stigmatized. The stigma concept is applied to literally scores of circumstances ranging from urinary incontinence (Sheldon & Caldwell 1994) to exotic dancing (Lewis 1998) to leprosy (Opala &

0360-0572/01/0811-0363$14.00

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

Boillot 1996), cancer (Fife & Wright 2000), and mental illness (Angermeyer & Matschinger 1994, Corrigan & Penn 1999, Phelan et al 2000). It is used to explain some of the social vagaries of being unemployed (Walsgrove 1987), to show how welfare stigma can lead to the perpetuation of welfare use (Page 1984), and to provide an understanding of situations faced by wheelchair users (Cahill & Eggleston 1995), stepparents (Coleman et al 1996), debtors (Davis 1998), and mothers who are lesbian (Causey & Duran-Aydintug 1997).

A substantial portion of the productive research on stigma has been contributed by social psychologists who have used the insights of the social cognitive approach to understand how people construct categories and link these categories to stereotyped beliefs. This line of research represents a major advance in the understanding of stigma processes, and sociologists would do well to attend to it thoroughly (for a comprehensive review, see Crocker et al 1998). Given these advances in the social psychology of stigma and given the accumulated scientific impact of research on stigma more generally, we propose a return to the stigma concept from a distinctly sociological perspective. We engage our sociological perspective by attending to several core criticisms of the stigma concept and its application. The first of these criticisms is directed toward the clarity of the concept and follows from the observation that stigma is defined in different ways by different investigators. The second is a set of criticisms regarding the way in which the stigma concept has been applied by some researchers. We use these criticisms both as a stimulus to return to the stigma concept and as a critical analytic lens in constructing a revised conceptualization. We follow our explication of the stigma concept with a more detailed discussion of each of its component parts. We end by applying our conceptualization to several core issues in the stigma literature with an eye to assessing whether our conceptualization is helpful in understanding those issues. In doing so, we attend more to the nature and consequences of stigma than to its sources. (For a review of some ideas about the origins of stigma see Crocker & Lutsky 1986.)

VARIATIONS IN THE DEFINITION OF STIGMA

One of the curious features of literature concerning stigma is the variability that exists in the definition of the concept (Stafford & Scott 1986). In many circumstances investigators provide no explicit definition and seem to refer to something like the dictionary definition ("a mark of disgrace") or to some related aspect like stereotyping or rejection (e.g., a social distance scale). When stigma is explicitly defined, many authors quote Goffman's definition of stigma as an "attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman 1963, p. 3).

Since Goffman, alternative or elaborated definitions have varied considerably. For example, Stafford & Scott (1986, p. 80) propose that stigma "is a characteristic of persons that is contrary to a norm of a social unit" where a "norm" is defined as

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

a "shared belief that a person ought to behave in a certain way at a certain time" (p. 81). Crocker et al (1998, p. 505) indicate that "stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context." An especially influential definition is that of Jones et al (1984), who use Goffman's (1963, p. 4) observation that stigma can be seen as a relationship between an "attribute and a stereotype" to produce a definition of stigma as a "mark" (attribute) that links a person to undesirable characteristics (stereotypes). In our own reviews of stigma and mental illness (e.g., Link & Phelan 1999), we have added the component of discrimination to the Jones et al (1984) definition.

Of the many reasons that definitions of stigma vary, two seem particularly prominent. First, as indicated above, the stigma concept has been applied to an enormous array of circumstances. Each one of these is unique, and each one is likely to lead investigators to conceptualize stigma in a somewhat different way. Second, research on stigma is clearly multidisciplinary, including contributions by psychologists, sociologists, anthropologists, political scientists, and social geographers. Although there is a great deal of overlap in interests across these disciplines, there are nevertheless some differences in emphasis. Even within disciplines, people approach the stigma concept from different theoretical orientations that produce somewhat different visions of what should be included in the concept. Thus, different frames of reference have led to different conceptualizations.

Because of the complexity of the stigma phenomenon, it seems wise to continue to allow variation in definition so long as investigators are clear as to what is meant by stigma when the term is used. Having said this, we shall also attempt to move matters ahead by specifying a conceptualization of stigma that includes many of the concerns that people working in this area of research share. Before proceeding, however, it is important to note that the use of the stigma concept has been challenged by some social scientists who have focused on the perspective of persons who are stigmatized (Schneider 1988, Fine & Asch 1988, Sayce 1998; Kleinman et al 1995). Understanding these challenges is important for the further development of research on stigma, particularly from a sociological perspective.

CHALLENGES TO THE STIGMA CONCEPT

There are two main challenges to the stigma concept. The first is that many social scientists who do not belong to stigmatized groups, and who study stigma, do so from the vantage point of theories that are uninformed by the lived experience of the people they study (Kleinman et al 1995, Schneider 1988). For example, in writing about the experience of disability, Schneider (1988) asserts that "most able-bodied experts" give priority "to their scientific theories and research techniques rather than to the words and perceptions of the people they study." The result is a misunderstanding of the experience of the people who are stigmatized and the perpetuation of unsubstantiated assumptions. Writing about disability, Fine & Asch

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

(1988) identify five assumptions: (*a*) that disability is located solely in biology, (*b*) that the problems of the disabled are due to disability-produced impairment, (*c*) that the disabled person is a "victim," (*d*) that disability is central to the disabled person's self-concept, self-definition, social comparisons, and reference groups, and (*e*) that having a disability is synonymous with needing help and social support.

The second challenge is that research on stigma has had a decidedly individualistic focus. For example, according to Oliver (1992), the central thrust of stigma research has been focused on the perceptions of individuals and the consequences of such perceptions for micro-level interactions. According to Oliver (1992), research examining the sources and consequences of pervasive, socially shaped exclusion from social and economic life are far less common. Interestingly, this criticism is echoed by at least one renowned student of stereotyping, prejudice, and discrimination. In her review of these topics, Susan Fiske (1998) concludes that (at least within social psychology) the literature on discrimination is far less extensive than that on stereotyping and that more attention needs to be addressed to structural issues. In another vein, even though Goffman (1963, p. 3) initially advised that we really needed "a language of relationships, not attributes," subsequent practice has often transformed stigmas or marks into attributes of persons (Fine & Asch 1988). The stigma or mark is seen as something *in the person* rather than a designation or tag that others affix to the person. In this respect the term stigma directs our attention differently than a term like "discrimination." In contrast to "stigma," "discrimination" focuses the attention of research on the producers of rejection and exclusion—those who do the discriminating—rather than on the people who are the recipients of these behaviors (Sayce 1998). Thus, the terms we use could lead to "different understandings of where responsibility lies for the 'problem' and as a consequence to different prescriptions for action" (Sayce 1998).

Researchers on stigma could respond to these challenges by disputing their validity or pointing to exceptions in the now voluminous literature on stigma. We find these critiques to provide a useful stimulus for a reassessment of the conceptualization of stigma and related concepts. One way in which some of the issues raised by the critiques can be addressed is to propose that stigma be described with reference to the relationships between a set of interrelated concepts.

DEFINING STIGMA IN THE RELATIONSHIP OF INTERRELATED COMPONENTS

An important precedent to locating the meaning of stigma in the relation between concepts is available in Goffman's observation that stigma can be seen as the relationship between an "attribute and a stereotype." We expand the nexus of relationships somewhat with the intent of capturing a fuller set of meanings for

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

the term by doing so. We state our conceptualization as concisely as we can and then elaborate the components it contains.

In our conceptualization, stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them." In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. Thus, we apply the term stigma when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold. With this brief explication of the stigma concept as background, we turn to a more detailed examination of each component we identified.

COMPONENT 1—ON DISTINGUISHING AND LABELING DIFFERENCES

The vast majority of human differences are ignored and are therefore socially irrelevant. Some of these—such as the color of one's car, the last three digits of one's social security number, or whether one has hairy ears—are routinely (but not always) overlooked. Many others such as one's food preferences or eye color are relevant in relatively few situations and are therefore typically inconsequential in the large scheme of things. But other differences, such as one's skin color, IQ, sexual preferences, or gender are highly salient in the United States at this time. The point is that there is a social selection of human differences when it comes to identifying differences that will matter socially.

The full weight of this observation is often overlooked because once differences are identified and labeled, they are typically taken for granted as being just the way things are—there are black people and white people, blind people and sighted people, people who are handicapped and people who are not. The taken-for-granted nature of these categorizations is one of the reasons that designations like these carry such weight. There are, however, some observations we can make that bring to light just how social this social selection of human differences is.

First, substantial oversimplification is required to create groups. One example is the assignment of individuals to categories of "black" or "white" when there is enormous variability within the resulting categories and no clear demarcation between categories on almost any criterion one can think of, even attributes like skin color, parentage, or facial characteristics that are believed to define the categories

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

(Fullilove 1998). The same can be said for other categorizations like gay or straight, blind or sighted, handicapped or not.

Second, the central role of the social selection of human differences is revealed by noting that the attributes deemed salient differ dramatically according to time and place. For example, in the late nineteenth century, human physical characteristics such as small foreheads and large faces were particularly salient—these characteristics were thought to be ape-like—and were believed to reveal the criminal nature of the people possessing them (Gould 1981). And, of course, cultures vary extensively in characteristics deemed socially significant. For example, ancient Mayan culture gave unusual significance to being cross-eyed and sought to create this desirable characteristic in children through devices that encouraged babies to focus on objects in ways that forced their eyes to cross. Sociological studies of social construction and medicalization are also good examples (Conrad 1992). Hyperactivity is much more salient now, as an indicator of a disorder, than it used to be, and the medical term ADHD (attention deficit hyperactivity disorder) is part of common parlance.

Because human differences are socially selected for salience, we have chosen to use the word "label" rather than "attribute," "condition" or "mark." Each of these latter terms locates the thing that is being referred to in the stigmatized person and risks obscuring that its identification and election for social significance is the product of social processes. In contrast, a label is something that is affixed. Moreover in the absence of qualifications, terms like "attribute," "condition," or "mark" imply that the designation has validity. In contrast the word "label" leaves the validity of the designation an open question—an option that has great utility as, for example, when one wishes to discuss the stigma some women experienced as a consequence of being labeled witches.

With regard to this aspect of the stigma process, the critical sociological issue is to determine how culturally created categories arise and how they are sustained. Why is it that some human differences are singled out and deemed salient by human groups while others are ignored? What are the social, economic, and cultural forces that maintain the focus on a particular human difference?

COMPONENT 2—ON ASSOCIATING HUMAN DIFFERENCES WITH NEGATIVE ATTRIBUTES

The second component of stigma occurs when labeled differences are linked to stereotypes. This aspect of stigma was highlighted in Goffman's (1963) work and has been central to the conceptualization of stigma ever since. It is the aspect of stigma that has been most salient in the psychological literature about stigma, perhaps because it poses critical questions of a psychological nature about the thought processes that facilitate connections between labels and stereotypes. Consistent with this emphasis in psychology is the centrality of this dimension in psychologists' definitions of stigma. For example, Crocker and colleagues (1998)

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

define stigma, as noted above, as an "attribute or characteristic that conveys a social identity that is devalued in a particular context."

In our terms, this aspect of stigma involves a label and a stereotype, with the label linking a person to a set of undesirable characteristics that form the stereotype. An example of this component is evident in a vignette experiment conducted by Link et al (1987). The study experimentally manipulated labeling, tagging a random half of the vignettes "former mental patients" and the other half "former back-pain patients." It also included a measure of the extent to which respondents believed that mental patients *in general* were "dangerous." When the vignette described a former back-pain patient, beliefs about the dangerousness of people with mental illness played no part in rejecting responses toward the vignette subject. When the vignette described a former mental patient, however, these beliefs were potent predictors of rejecting responses: Respondents who believed mental patients were dangerous reacted negatively to the person described as a former mental patient in the vignette. Apparently, for many people, the "mental patient" label linked the described person to stereotyped beliefs about the dangerousness of people with mental illness, which in turn led them to desire for social distance from the person.

As indicated above, this connection between labels and stereotypes has been a major aspect of the psychological study of stigma in recent years, following the social cognitive approach (Fiske 1998). This intriguing and very fruitful body of research seeks to elucidate the cognitive processes underlying the use of categories and the linking of those categories to stereotypes (Crocker et al 1998). We focus briefly on some selected aspects of this extensive body of research.

According to this literature, categories and stereotypes are often "automatic" and facilitate "cognitive efficiency." The automatic nature is revealed in experiments that indicate that categories and stereotypes are used in making split-second judgments and thus appear to be operating preconsciously. For example, Gaertner & McLaughlin (1983) conducted an experiment in which one group of white subjects was primed by the word "whites" and another by the word "blacks," and then both groups were tested as to the speed with which they were able to identify whether two strings of letters were both words. Both high- and low-prejudiced subjects responded more rapidly to positive words like "smart," "ambitious," and "clean" when primed by the word "whites" than when primed by the word "blacks." In addition to operating in a preconcious, automatic way, some studies suggest that category use preserves cognitive resources. Thus, for example, if subjects are provided with labels like doctor, artist, skinhead, or real estate agent when asked to form an impression of a vignette, they are better able to simultaneously perform another task like turning off a beeping computer than are subjects who are not provided these labels (Macrae et al 1994). Thus, from a psychological standpoint, culturally given categories are present even at a preconcious level and provide people with a means of making shorthand decisions that free them to attend to other matters. At the same time, other research in social psychology reveals considerable latitude in the cognitive processes that transpire such that very different

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

outcomes may occur depending on the nature of the cognitions people employ and the contexts in which people are embedded (Crocker et al 1998).

COMPONENT 3—ON SEPARATING "US" FROM "THEM"

A third feature of the stigma process occurs when social labels connote a separation of "us" from "them" (Morone 1997, Devine et al 1999). United States history and politics offer many examples as established old-order Americans defined African-American slaves, American Indians, and successive waves of immigrants as outgroups—the "them" who were very different from "us." Few groups were entirely spared. For example, Morone (1997) provides quotes from Benjamin Franklin's observations of the impact of Dutch immigrants ("them") on the English colonists ("us"). "Already the English begin to quit particular neighborhoods, surrounded by the Dutch, being made uneasy by the disagreeableness of dissonant manners . . . Besides, the Dutch under-live, and are thereby enabled to under-work and under-sell the English who are thereby extremely incommoded and consequently disgusted" (Franklin 1752). And of course, while the groups representing "us" and "them" have changed, this separation is still prominent today. "They" are a menace to "us" because they are immoral, lazy, and predatory (Morone 1997). Thus, other components of the stigma process—the linking of labels to undesirable attributes—become the rationale for believing that negatively labeled persons are fundamentally different from those who don't share the label–different types of people. At the same time, when labeled persons are believed to be distinctly different, stereotyping can be smoothly accomplished because there is little harm in attributing all manner of bad characteristics to "them." In the extreme, the stigmatized person is thought to be so different from "us" as to be not really human. And again, in the extreme, all manner of horrific treatment of "them" becomes possible.

Evidence of efforts to separate us from them are sometimes directly available in the very nature of the labels conferred. Incumbents are thought to "be" the thing they are labeled (Estroff 1989). For example, some people speak of persons as being "epileptics" or "schizophrenics" rather than describing them as having epilepsy or schizophrenia. This practice is revealing regarding this component of stigma because it is different for other diseases. A person *has* cancer, heart disease, or the flu—such a person is one of "us," a person who just happens to be beset by a serious illness. But a person *is* a "schizophrenic."

COMPONENT 4—STATUS LOSS AND DISCRIMINATION

In this component of the stigma process, the labeled person experiences status loss and discrimination. Most definitions of stigma do not include this component, but as we shall see, the term stigma cannot hold the meaning we commonly assign to it when this aspect is left out. In our reasoning, when people are labeled, set apart,

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting, and excluding them. Thus, people are stigmatized when the fact that they are labeled, set apart, and linked to undesirable characteristics leads them to experience status loss and discrimination.

Consistent with this, stigmatized groups are disadvantaged when it comes to a general profile of life chances like income, education, psychological well-being, housing status, medical treatment, and health (e.g. Druss et al 2000, Link 1987). While some groups escape the experience of some disadvantaged outcomes sometimes (e.g., African Americans regarding self-esteem—see Crocker 1999), when one considers the profile of all possible outcomes, the general principle clearly holds for most stigmatized groups. How does this happen?

Status Loss

An almost immediate consequence of successful negative labeling and stereotyping is a general downward placement of a person in a status hierarchy. The person is connected to undesirable characteristics that reduce his or her status in the eyes of the stigmatizer. The fact that human beings create hierarchies is, of course, evident in organizational charts, who sits where in meetings, who defers to whom in conversational turn-taking, and so on. One strand of sociological research on social hierarchies, the so-called expectation-states tradition, is particularly relevant to the study of stigma and status loss (Cohen 1982, Driskell & Mullen 1990). Based on finding a reliable tendency of even unacquainted indivdiuals to form fairly stable status hierarchies when placed in group situations, researchers set out to understand the processes that produced this state of affairs. What they have found is relevant to research on stigma in many ways, two of which we shall emphasize here. First, this research shows that external statuses, like race and gender, shape status hierarchies within small groups of unacquainted persons even though the external status has no bearing on proficiency at a task the group is asked to perform. Men and whites are more likely than women and blacks to attain positions of power and prestige—they talk more frequently, have their ideas more readily accepted by others, and are more likely to be voted group leader (Mullen et al 1989). These findings are important to research on stigma because they show how having a status that is devalued in the wider society can lead to very concrete forms of inequality in the context of social interactions within small groups. Second, although inequalities in status-related outcomes definitely occur in the groups, they do not result from forms of discrimination that would be readily apparent to a casual observer. Instead group members use external statuses (like race and gender) to create performance expectations that then lead to a labyrinth of details that involve taking the floor, keeping the floor, referring to the contributions of others, head nodding, interrupting, and the like. This is important to research on stigma because it shows that substantial differences in outcome can occur even when it is difficult for participants to specify a single event that produced the unequal outcome.

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

Discrimination

INDIVIDUAL DISCRIMINATION The standard way of conceptualizing the connection between labeling, stereotyping, and discrimination in the stigma literature follows a relatively simplistic formulation. In this approach, the importance of attitudes and beliefs are thought to lie in whether person A's labeling and stereotyping of person B leads person A to engage in some obvious forms of overt discrimination directed at person B, such as rejecting a job application, refusing to rent an apartment, and so on. There is no doubt that this rather straightforward process occurs with considerable regularity, although some social psychologists with interests in stigma have recently bemoaned the fact that documenting discriminatory behavior has not been their strong suit (Fiske 1998). Connecting attitudes to behaviors is, therefore, conceptualized as something the area of research on stigma and stereotyping needs (Fiske 1998). In this regard Ajzen & Fishbein's (1980) "theory of reasoned action" has been successfully applied to the prediction of many behaviors and might also be useful in predicting discriminatory behaviors. The approach they propose is effective because it asks us to narrow our focus to a very specific behavior and to be attentive to the intricacies of the beliefs and attitudes toward performing the specific act in question. But the area of stigma research needs to expand its conception of the processes through which labeling and stereotyping lead to social inequalities in life circumstances. By itself the standard model that asks "what-makes-person-A-discriminate-against-person-B" is inadequate for explaining the full consequences of stigma processes. In fact, getting tangled up in the narrow intricacies of explaining a specific act from knowledge of a specific set of attitudes and beliefs could cloud rather than illuminate our understanding of why stigmatized groups experience so many disadvantages.

STRUCTURAL DISCRIMINATION The concept of institutional racism sensitizes us to the fact that all manner of disadvantage can result outside of a model in which one person does something bad to another. Institutional racism refers to accumulated institutional practices that work to the disadvantage of racial minority groups even in the absence of individual prejudice or discrimination (Hamilton & Carmichael 1967). For example, employers (more often white) rely on the personal recommendations of colleagues or acquaintances (more often white and more likely to know and recommend white job candidates) for hiring decisions. The same kind of structural discrimination is, of course, present for other stigmatized groups. For example, disabled persons may be limited in their ability to work not so much because of their inherent limitations but because they are exposed to what Hahn (1983) calls "a disabling environment" created by the barriers to participation that reside in architecture we humans have constructed (Fine & Asch 1988). Consider some possible examples of structural discrimination for a mental illness like schizophrenia. Suppose that because the illness is stigmatized, less funding is dedicated to research about it than for other illnesses and less money is allocated to adequate care and management. Moreover, consider that, because of historical

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

processes influenced by stigma, treatment facilities tend to be either isolated in settings away from other people (Rothman 1971) or confined to some of the most disadvantaged neighborhoods in urban settings in communities that do not have enough clout to exclude this stigmatized group from their midst (Dear & Lewis 1986). At the same time, the most successful and accomplished mental health personnel tend to accrue more status and money by treating less serious illnesses in private offices in affluent areas, leaving the care of people with schizophrenia to a generally less accomplished group (Link 1983). To the extent that the stigma of schizophrenia has created such a situation, a person who develops this disorder will be the recipient of structural discrimination whether or not anyone happens to treat him or her in a discriminatory way because of some stereotype about schizophrenia. Stigma has affected the structure around the person, leading the person to be exposed to a host of untoward circumstances.

STATUS LOSS AS A SOURCE OF DISCRIMINATION In keeping with observations about the role of stigma in the loss of status, it is important to note that lower placement in a status hierarchy can begin to have effects of its own on a person's life chances. It is not necessary to revisit the labeling and stereotyping that initially led to the lower status, because the lower status itself becomes the basis of discrimination. For example, low status might make a person less attractive to socialize with, to involve in community activities, or to include in a business venture that requires partners who have political influence with local politicians. In this way, a lower position in the status hierarchy can have a cascade of negative effects on all manner of opportunities. Because the discrimination that occurs is one step removed from the labeling and stereotyping, it is easy to miss the more distal effects of these factors in any accounting of the effects of these stigma components.

SOCIAL PSYCHOLOGICAL PROCESSES OPERATING THROUGH THE STIGMATIZED PERSON Once the cultural stereotype is in place, it can affect labeled persons in important ways that do not involve obvious forms of discriminatory behavior on the part of people in the immediate presence of the stigmatized person. For example , according to a modified labeling theory about the effects of stigma on people with mental illnesses (Link 1982, Link et al 1989), people develop conceptions of mental illness early in life as part of socialization into our culture (Angermeyer & Matschinger 1996, Scheff 1966, Wahl 1995). Once in place, people's conceptions become a lay theory about what it means to have a mental illness (Angermeyer & Matschinger 1994, Furnham & Bower 1992). People form expectations as to whether most people will reject an individual with mental illness as a friend, employee, neighbor, or intimate partner and whether most people will devalue a person with mental illness as less trustworthy, intelligent, and competent. These beliefs have an especially poignant relevance for a person who develops a serious mental illness, because the possibility of devaluation and discrimination becomes personally relevant. If one believes that others will devalue and reject people with mental illnesses, one must now fear that this rejection applies personally. The person may

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

wonder, "Will others look down on me, reject me, simply because I have been identified as having a mental illness?" Then to the extent that it becomes a part of a person's world view, that perception can have serious negative consequences. Expecting and fearing rejection, people who have been hospitalized for mental illnesses may act less confidently and more defensively, or they may simply avoid a potentially threatening contact altogether. The result may be strained and uncomfortable social interactions with potential stigmatizers (Farina et al 1968), more constricted social networks (Link et al 1989), a compromised quality of life (Rosenfield 1997), low self-esteem (Wright et al 2000), depressive symptoms (Link et al 1997), unemployment and income loss (Link 1982, 1987). While this theory has been most thoroughly examined with respect to mental illnesses, the process is probably much more general. In keeping with this possibility, Pinel (1999) has recently called the expectation of stereotyping "stigma consciousness" and has proposed its application to other stigmatized statuses.

A related but slightly different approach to understanding the effect of stereotypes is Steele & Aronson's (1995) concept of "stereotype threat." According to this idea, people know about the stereotypes that might be applied to them—African Americans know they are tagged with attributes of violence and intellectual inferiority, gay men know they are seen as flamboyant and promiscuous, and people with mental illnesses know that they are believed to be unpredictable and dangerous. The insight that Steele & Aronson provide is that the stereotype becomes a threat or challenge either because one might be evaluated in accordance with the stereotype or because one might confirm the stereotype through one's behavior. In keeping with this idea, Steele & Aronson have shown that, controlling for initial differences on SAT scores, African-American students perform worse than white students on a test when study participants are led to believe that the test measures intellectual ability. In contrast, when the same test is not labeled as being diagnostic of ability, African Americans score as well as whites. This research tells us that the existence of a stereotype and the administration of a test of "ability" can lead to an invalid assessment of the academic potential of African-American students and thereby to discrimination against such students on the basis of a seemingly "objective" test.

Note that in both the modified labeling theory and theory about stereotype threat, no one in the immediate context of the person needs to have engaged in obvious forms of discrimination. Rather, the discrimination lies anterior to the immediate situation and rests instead in the formation and sustenance of stereotypes and lay theories. Still the consequences are sometimes severe and undoubtedly contribute greatly to differences in the life chances of people in stigmatized groups.

INTERCHANGEABLE MECHANISMS The problem of stigma has been described as a predicament or a dilemma by Goffman and others (Ainlay et al 1986, Crocker et al 1998). One reason for this is brought to light by the sociological observation that mechanisms like the ones we have described are both interchangeable and mutually reinforcing in achieving ends that discrimnate against stigmatized

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

groups (Lieberson 1985). If powerful groups are motivated to discriminate against a stigmatized "them," there are many ways in which such discrimination can be achieved. If stigmatized persons cannot be persuaded to voluntarily accept their lower status and inferior rewards, direct discrimination can be used to accomplish the same outcome. If direct discrimination becomes ideologically difficult, sophisticated forms of structural discrimination—such as tests that induce stereotype threat—can achieve some of the same ends. The mechanisms are mutually reinforcing as well. To the extent that stigmatized groups accept the dominant view of their lower status, they are less likely to challenge structural forms of discrimination that block opportunities they desire. Further, direct discrimination reinforces the belief among stigmatized groups that they will be treated in accordance with stereotypes and therefore reinforces processes like those explicated in the context of modified labeling theory and the stereotype-threat concept. From this vantage point, stigma is a predicament in the following sense—as long as dominant groups sustain their view of stigmatized persons, decreasing the use of one mechanism through which disadvantage can be accomplished simultaneously creates the impetus to increase the use of another. This latter observation brings us to the final aspect of our stigma concept—its dependence on power differences.

THE DEPENDENCE OF STIGMA ON POWER

Stigma is entirely dependent on social, economic, and political power—it takes power to stigmatize. In some instances the role of power is obvious. However, the role of power in stigma is frequently overlooked because in many instances power differences are so taken for granted as to seem unproblematic. When people think of mental illness, obesity, deafness, and having one leg instead of two, there is a tendency to focus on the attributes associated with these conditions rather than on power differences between people who have them and people who do not. But power, even in these circumstances, is essential to the social production of stigma.

In order to reason about the role of power in stigma, first consider instances in which it is clear that social power is important. To begin, take the example provided earlier in which eighteenth century English colonists tagged the Dutch with attributes of disagreeableness and low-living. Along the same lines, people of Irish background were stereotyped as "temperamental, dangerous, quarrelsome, idle and reckless" by old-order Americans in the nineteenth century. The Irish at the time were likened to apes and were portrayed as such in cartoons of the day (Feagin & Feagin 1996). In the light of current circumstances, it is clear that English colonists of the eighteenth century and the old-order Americans of the nineteenth century were able to stigmatize the Dutch and Irish because of their positions of power over these groups at the time. And, of course, it was the power of the Nazis that allowed their thorough and devastating stigmatization of Jewish people.

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

But how can we think of the role of power in circumstances like mental illness, obesity, deafness, and one leggedness? One way is to recognize that stigmatized groups often engage in the same kinds of stigma-related processes in their thinking about individuals who are not in their stigmatized group. Consider for example patients in a treatment program for people with serious mental illness. Patients in such a setting are likely to identify and label human differences in staff members. For instance, they might tag some clinicians with the label "pill pusher" and apply stereotypes connected with the labels they create such as that pill pushers are cold, paternalistic, and arrogant. Finally they might treat the people they identify as pill pushers differently in accordance with the conclusions they have drawn about them by avoiding or minimizing communication with them, exchanging derogatory comments and jokes about them, and so on. Thus although the patients might engage in every component of stigma we identified, the staff would not end up being a stigmatized group. The patients simply do not possess the social, cultural, economic, and political power to imbue their cognitions about staff with serious discriminatory consequences.

Consider further that scenarios similar to the one just described exist for all sorts of other circumstances in which relatively powerless groups create labels and stereotypes about more powerful groups and treat members of the more powerful group in accordance with those stereotypes. Such a realization clarifies why the definition of stigma must involve reference to power differences. Without such a reference, stigma becomes a very different and much broader concept that might be applied to lawyers, politicians, Wall Street investors, and white people. Stigma is dependent on power.

Because of the importance of power in stigmatization, it is critical to ask the following set of questions: Do the people who might stigmatize have the power to ensure that the human difference they recognize and label is broadly identified in the culture? Do the people who might confer stigma have the power to ensure that the culture recognizes and deeply accepts the stereotypes they connect to the labeled differences? Do the people who might stigmatize have the power to separate "us" from "them" and to have the designation stick? And do those who might confer stigma control access to major life domains like educational institutions, jobs, housing, and health care in order to put really consequential teeth into the distinctions they draw? To the extent that we can answer yes to these questions, we can expect stigma to result. To the extent that we answer no, some of the cognitive components of stigma might be in place, but what we generally mean by stigma would not exist.

IMPLICATIONS OF THE STIGMA CONCEPT

The stigma concept we have articulated has implications for how one might reason about several persistent questions including: (*a*) the definition of stigma, (*b*) stigma as a matter of degree, (*c*) the origins of stigma, (*d*) the image of the stigmatized

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

person as a passive victim versus an active challenger, (*e*) the consequences of stigma, (*f*) stigma as a persistent dilemma, (*g*) what we should do to change stigma processes, and (*h*) the importance of stigma in understanding the distribution of life chances.

The Definition of Stigma

Our explication of the stigma concept is revealing with regard to why so many definitions of stigma are extant in the literature—there are several components, each one of which has been described as stigma. We chose to define stigma in the convergence of interrelated components. Thus, stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them. This is a definition that we derived, not one that exists in some independent existential way. As such, its value rests in its utility. One reason it is helpful is that the term stigma is in very wide use, and some degree of clarity will help us communicate about the concept. Second, there are words that aptly describe each of the components like label (or mark or status), stereotyping, exclusion, status loss, and discrimination so that the use of the word stigma to describe any particular aspect is not necessary. Third, the definition coheres with the current usage of the term as it is applied to groups that are commonly referred to as stigmatized groups. Recall that if we only used the cognitive components of labeling and stereotyping to define stigma, groups like lawyers, politicians, and white people would have to be considered stigmatized groups. Our incorporation of power, status loss, and discrimination allows the formal definition we derived to cohere with current understandings of what a stigmatized group is. Fourth, we believe that the definition helps us envision and thereby more fully understand several important issues in the stigma literature as described below.

Stigma as a Matter of Degree

Our conceptualization leads to the conclusion that stigma exists as a matter of degree. The labeling of human differences can be more or less prominent. A label can connect a person to many stereotypes, to just a few or to none at all. Moreover, the strength of the connection between labels and undesirable attributes can be relatively strong or relatively weak. The degree of separation into groups of "us" and "them" can be more or less complete, and finally the extent of status loss and discrimination can vary. This means that some groups are more stigmatized than others and that some of the components we have described can be used analytically to think about why differences in the extent of stigma experienced vary from group to group.

The Origins of Stigma

Our paper has been focused on the nature and consequences of stigma rather than its sources. Nevertheless our conceptualization provides some ideas about how

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

to think about the origins of stigma. As we indicated at the outset of this paper, a great deal of attention in the literature on stigma has been directed toward the cognitive processing of stigma-relevant information. As crucial as the knowledge gained from this literature is, it is not a sufficient basis for understanding the origins of stigma. As we have pointed out, groups both with and without power label and form stereotypes about the other group—members of each group engage in the kinds of cognitive processes that are studied in the now voluminous social psychological literature. But what matters is whose cognitions prevail—whose cognitions carry sufficient clout in social, cultural, economic, and political spheres to lead to important consequences for the group that has been labeled as different. Here is where the sociological study of stigma is badly needed—for while cognitive processes may be necessary causes for the production of stigma, they are not sufficient causes. We need to further understand the social processes that allow one group's views to dominate so as to produce real and important consequences for the other group.

Passive Victim Versus Active Challenger

One of the most troublesome issues in the study of stigma emerges when social scientists seek to articulate the real constraints that stigma creates in people's lives, and in doing so they end up portraying members of the stigmatized group as helpless victims (Fine & Asch 1988). Ironically, this produces more lines in the list of undesirable attributes that form the stereotype about the stigmatized group—they are additionally "passive," "helpless," or "acquiescent." Because of this, there are from time to time articles that remind us that people artfully dodge or constructively challenge stigmatizing processes (e.g. Reissman 2000). These are very important reminders, and the message they deliver needs to be incorporated into our understanding of stigma. At the same time, the simple fact that these forms of resistance exist suggests there *is* something out there to avoid and that there *are* powerful constraining forces at work. How can we reason about these contrasting images and portray constraint and resistance in research about stigma? Here, our emphasis on the importance of power differences in stigma and our observation that stigma is a matter of degree are helpful. Specifically, these allow us to see issues of constraint and resistance in the context of a power struggle. We can see that people in stigmatized groups actively use available resources to resist the stigmatizing tendencies of the more powerful group and that, to the extent that they do, it is inappropriate to portray them as passive recipients of stigma. At the same time, to the extent that power differences exist, resistence cannot fully overcome constraint. The amount of stigma that people experience will be profoundly shaped by the relative power of the stigmatized and the stigmatizer.

The Outcomes of Stigma

Our conceptualization of stigma demands the assessment of multiple outcomes, not just one or two. We cannot assess the extent of stigmatization when we assess

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

just one outcome, whether that single outcome be self-esteem, housing status, or access to medical care. From one vantage point, this is an odd stricture to impose on the study of stigma. If we adopt a narrow conceptualization of stigma, for example as a label linked to a stereotype, we might expect specificity in the outcomes. We might identify the elements of the stereotype and then, based on what the stereotype entails, predict which outcomes might be affected. If the stereotype is math incompetence, then we might expect the person to be excluded from endeavors where math competence is required. As important as this kind of theorizing might be for understanding some aspects of stigma, it will cloud our vision of the full consequences if it is the only approach we employ.

Among the reasons our conceptualization of stigma calls for the scrutiny of many outcomes are three we consider here. First, stigma involves status loss—a downward placement in the status hierarchy. To the extent that this occurs, we can expect members of stigmatized groups to accrue all manner of untoward outcomes associated with lower placement in a status hierarchy, ranging from the selection of sexual partners to longevity. Second, structural discrimination can produce negative outcomes that have little to do with the stereotyped beliefs that initially motivated the structural discrimination. For example, the Not In My Back Yard (NIMBY) phenomenon resulted in treatment facilities for people with mental illness being located in relatively poor and powerless areas of the city that were also crime ridden and dangerous (Dear & Lewis 1986). As a consequence, people with mental illness are much more likely to be victimized than other people. Third, people's efforts to cope with stigma may have untoward consequences that are seemingly unrelated to the stereotype (James et al 1984, Smart & Wegner 1999). For example, social epidemiologist Sherman James puts forward the concept of what he calls "John Henryism"—the tendency for some African Americans to work extremely hard and with great pressure to disprove the stereotype of laziness and inability. According to James et al (1984), under some conditions this coping effort bears costs in the form of hypertension. In short, a comprehensive exploration of the stigma concept makes it clear that stigma can involve many outcomes and that any full assessment must look to a broad range of such outcomes.

Stigma as a Persistent Predicament

As previously mentioned, the literature makes reference to stigma as a predicament or dilemma. Our conceptualization draws attention to one way in which stigma is a persistent predicament—why the negative consequences of stigma are so difficult to eradicate. When powerful groups forcefully label and extensively stereotype a less powerful group, the range of mechanisms for achieving discriminatory outcomes is both flexible and extensive. We mentioned three generic types of mechanisms—individual discrimination, structural discrimination, and discrimination that operates through the stigmatized person's beliefs and behaviors. But lying below these broad-band designations are a whole multitude of specific mechanisms—there are many ways to achieve structural discrimination,

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

many ways to directly discriminate, and many ways in which stigmatized persons can be encouraged to believe that they should not enjoy full and equal participation in social and economic life. Moreover, if the mechanisms that are currently in place are blocked or become embarrassing to use, new ones can always be created. This is the main reason that stigma is such a persistent predicament. When people in a stigmatized group take action to avoid a negative consequence, they frequently do so by counteracting (e.g. confronting or avoiding) the specific mechanism that leads to the undesirable outcome they seek to escape. But when the range of possible mechanisms is broad, the benefit is only temporary because the mechanism that has been blocked or avoided can be easily replaced by another.

A second and related reason that stigma is a persistent predicament is that there are a multitude of associated outcomes. One can exert great effort to avoid one stigma-related outcome, like discrimination in medical insurance or injury to self-esteem, but doing so can carry costs. For instance, the coping effort can be stressful, as in the case of John Henryism and hypertension levels among African Americans (James et al 1984). In that example, the effort to eliminate one bad outcome ironically produces strain that leads to another. Also, focusing particular attention on one outcome means that less attention is available to deal with other aspects of life. As a result, while benefits may accrue in one domain, concomitant harms may result in others. It is the existence of multiple stigma mechanisms and multiple stigma outcomes that helps explain why stigma is a persistent predicament—why, on average, members of stigmatized groups are disadvantaged in a broad range of life domains (e.g. employment, social relationships, housing, and psychological well-being).

We end our discussion of stigma as a persistent predicament with a point of clarification. First, to say that stigma is a persistent predicament is not to say that every individual in a group suffers the same outcome. Individual differences in personal, social, and economic resources also shape the life circumstances of persons in stigmatized groups, thereby producing substantial variation within stigmatized groups in any outcome one might consider. Thus, no one is fully trapped in a uniform disadvantaged position. All of the other characteristics of persons influence an outcome in the same way they influence outcomes for persons who are not members of the stigmatized group in question. The persistent predicament refers to a general pattern of disadvantage that is connected to stigma processes of labeling, stereotyping, status loss, and discrimination.

Changing Stigma

If stigma is a persistent predicament, how can it be changed? One approach is to focus on a particular behavior in a particular group. For example, one might target hiring practices with the aim of increasing the employment chances for a stigmatized group such as people with mental illnesses. One could then try to change employers' beliefs about and attitudes toward hiring persons with such illnesses. This approach is very appealing because it breaks down the morass of interconnecting stigma-facets into a more tractable problem. If one were to develop

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

an intervention, one could target the intervention to the specific beliefs, attitudes, and behaviors of employers, thereby increasing the likelihood of an apparently successful outcome for the intervention research study. But what is appealing about this approach is also what makes it such an inadequate response to the broader problem of stigma. The intense focus on one specific behavior in one specific group leaves the broader context untouched and as a consequence even the very positive outcomes of an unusually successful program will erode with time. This will occur for reasons we have stated: There exists a flexible package of mutually reinforcing mechanisms linking the attitudes and beliefs of dominant groups to an array of untoward outcomes for stigmatized persons.

Our conceptualization leads us to focus on two principles in considering how to really change stigma. The first is that any approach must be multifaceted and multilevel. It needs to be multifaceted to address the many mechanisms that can lead to disadvantaged outcomes, and it needs to be multilevel to address issues of both individual and structural discrimination. But second, and most important, an approach to change must ultimately address the fundamental cause of stigma—it must either change the deeply held attitudes and beliefs of powerful groups that lead to labeling, stereotyping, setting apart, devaluing, and discriminating, or it must change circumstances so as to limit the power of such groups to make their cognitions the dominant ones. In the absence of fundamental changes, interventions targeted at only one mechanism at a time will ultimately fail, because their effectiveness will be undermined by contextual factors that are left untouched by such a narrowly conceived intervention. Thus, in considering a multifaceted multilevel response to stigma, one should choose interventions that either produce fundamental changes in attitudes and beliefs or change the power relations that underlie the ability of dominant groups to act on their attitudes and beliefs.

Understanding the Influence of Stigma Processes on the Distribution of Life Chances

A core concern of sociology is to understand the distribution of life chances, whether those refer to careers, earnings, social ties, housing, criminal involvement, health, or life itself. We believe that stigma processes have a dramatic and probably a highly underestimated impact on such life chances. Most research proceeds by examining the stigma associated with one circumstance at a time (e.g. AIDS, obesity, mental illness, minority racial status, female gender, homosexuality, etc), and most also assesses only one outcome at a time (e.g. earnings, self-esteem, housing, social interactions, etc.). When this occurs, researchers often find some level of effect for a particular stigmatized group on a particular outcome. However, it is also usually true that many factors other than the stigma processes in question influence the outcome, leaving stigma as just one factor among many. This can lead to the conclusion that stigma matters but that its effect is relatively modest compared to other factors. This accounting is misguided for two reasons. First, in seeking to understand the impact of stigma for a particular circumstance, one must keep in mind that it can affect many life chances, not just one. Thus, a full

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

accounting must consider the overall effect on a multitude of outcomes. Second, there are a host of stigmatizing circumstances that need to be considered in studying a particular outcome. A full assessment of the impact of stigma on such an outcome must recognize that many stigmatizing circumstances contribute to that outcome and not just the one selected for the particular study in question. When viewed broadly, stigma processes likely play a major role in life chances and deserve scrutiny not just by investigators who happen to be interested in stigma but by a variety of social scientists who are interested in the distribution of life chances more generally.

CONCLUSION

Almost forty years after the publication of Goffman's book on stigma, we revisited the concept in light of research that has been undertaken in the interim. Attending to criticisms of the concept and its application by researchers from Goffman to the present, we constructed a revised conceptualization of the term. In our definition, stigma exists when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold. After developing this definition and explicating its component parts, we found it useful in providing a substantially different perspective on several crucial issues in the literature on stigma. Moreover, our conceptualization suggests that stigma is likely to be a key determinant of many of the life chances that sociologists study, from psychological well-being to employment, housing, and life itself. A propitious avenue for future research would involve the incorporation of stigma concepts and measures in community-based survey research that seeks to understand the social determinants of a broad array of life chances. Such an undertaking would greatly advance research on stigma because it would assess the linkage between stigma and outcomes that clearly matter in people's lives, thereby overcoming the criticism we alluded to earlier regarding the overemphasis on microlevel interactions in stigma research. At the same time, the incorporation of stigma concepts and measures in research focused on life chances would provide investigators in many areas of sociological research with additional possibilities for understanding the social distributions of the particular outcomes that are the focus of their attention. Most importantly, however, such an endeavor would tell us much more than we already know about the conditions under which stigma is related to untoward outcomes in real life situations. Knowledge of this sort should form the basis for the kinds of multifaceted multilevel interventions that represent our best hope for producing real change in stigma-related processes.

ACKNOWLEDGMENTS

We thank Patrick Corrigan, Bruce Dohrenwend, David Penn, and Elmer Struening for valuable comments on an earlier version of this paper.

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

Visit the Annual Reviews home page at www.AnnualReviews.org

LITERATURE CITED

Ainlay SC, Becker G, Colman LM. 1986. *The Dilemma of Difference: A Multidisciplinary View of Stigma*. New York: Plenum

Ajzen I, Fishbein M. 1980. *Understanding Attitudes and Predicting Social Behavior*. Englewood Cliffs, NJ: Prentice Hall

Angermeyer M, Matschinger H. 1994. Lay beliefs about schizophrenic disorder: the results of a population study in Germany. *Acta Psychiatr. Scand.* 89:39–45

Angermeyer MC, Matschinger H. 1996. The effect of violent attacks by schizophrenia persons on the attitude of the public towards the mentally ill. *Soc. Sci. Med.* 43:1721–28

Cahill S, Eggleston R. 1995. Reconsidering the stigma of physical disability. *Sociol. Q.* 36:681–98

Causey KA, Duran-Aydintug C. 1997. Tendency to stigmatize lesbian mothers in custody cases. *J. Divorce Remarriage* 28:171–82

Cohen EG. 1982. Expectations states and interracial interaction in school settings. *Annu. Rev. Sociol.* 8:209–235

Coleman M, Ganong L, Cable S. 1996. Perceptions of stepparents: an examination of the incomplete institutionalization and social stigma hypotheses. *J. Divorce Remarriage* 26:25–48

Conrad P. 1992. *Deviance and Medicalization: From Badness to Sickness*. Philadelphia: Temple Univ. Press

Corrigan PW, Penn Dl. 1999. Lessons from social psychology on discrediting psychiatric stigma. *Am. Psychol.* 54:765–76

Crocker J, Lutskey N. 1986. Stigma and the dynamics of social cognition. In *The Dilemma of Difference*, ed. SC Ainlay, G. Becker, LM Coleman. New York: Plenum

Crocker J. 1999. Social stigma and self-esteem: situational construction of self-worth. *J. Exp. Soc. Psychol.* 35:89–107

Crocker J, Major B, Steele C. 1998. Social stigma. In *The Handbook of Social Psychology*, ed. DT Gilbert, ST Fiske, 2:504–53. Boston, MA: McGraw-Hill

Davis KR. 1998. Bankruptcy: a moral dilemma for women debtors. *Law Psychol. Rev.* 22:235–49

Dear ML, Lewis G. 1986. Anatomy of a decision: recent land use zoning appeals and their effect on group home locations in Ontario. *Can. J. Commun. Mental Health* 5:5–17

Devine PG, Plant EA, Harrison K. 1999. The problem of us versus them and aids stigma. *Am. Behav. Sci.* 42:1212–28

Driskell JE, Mullen B. 1990. Status, expectations, and behavior: a meta-analytic review and test of the theory. *Personality Soc. Psychol. Bull.* 16:541–53

Druss BG, Bradford DW, Rosenheck RA, Radford MJ, Krumholz HM. 2000. Mental disorders and the use of cardiovascular procedures after myocardial infarction. *J. Am. Med. Assoc.* 283:506–11

Estroff SE. 1989. Self, identity and subjective experiences of schizophrenia: in search of the subject. *Schizophrenia Bull.* 15:189–96

Farina A, Allen JG, Saul B. 1968. The role of the stigmatized in affecting social relationships. *J. Personality* 36:169–82

Feagin JR, Feagin CB. 1996. *Racial and Ethic Relations*. Upper Saddle River, NJ: Prentice Hall

Fife BL, Wright ER. 2000. The demensionality of stigma: a comparison of its impact on the self of persons with HIV/AIDS and cancer. *J. Health Soc. Behav.* 41:50–67

Fine M, Asch A. 1988. Disability beyond stigma: social interaction, discrimination, and activism. *J. Soc. Issues* 44:3–22

Fiske ST. 1998. Stereotyping, prejudice, and discrimination. In *The Handbook of Social Psychology*, ed. DT Gilbert, ST Fiske, 2:357–411. Boston, MA: McGraw Hill

Franklin B. 1752. Letter to James Parker. In *The Importance of Gaining and Preserving the*

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

Friendship of the Indians to the British Interest Considered, ed. A Kennedy. London: E Cave

Fullilove MT. 1998. Abandoning race as a variable in public health research: an idea whose time has come. *Am. J. Pub. Health* 88:1297–98

Furnham A, Bower P. 1992. A comparison of academic and lay theories of schizophrenia. *Br. J. Psychiatr.* 161:201–10

Gaertner SL, McLaughlin JP. 1983. Racial stereotypes: associations and ascriptions of positive and negative characteristics. *Soc. Psychol. Q.* 46:23–30

Goffman E. 1963. *Stigma: Notes on the Management of Spoiled Identity.* Englewood Cliffs, NJ: Prentice Hall

Gould SJ. 1981. *The Mismeasure of Man.* New York: Norton

Hahn H. 1983. Paternalism and public policy. *Society* XX:36–46

Hamilton C, Carmichael S. 1967. *Black Power.* New York: Random House

James SA, LaCroix AZ, Kleinbaum DG, Strogatz DS. 1984. John Henryism and blood pressure differences among black men: II. The role of occupational stressors. *J. Behav. Med.* 7:259–75

Jones E, Farina A, Hastorf A, Markus H, Miller DT, Scott R. 1984. *Social Stigma: The Psychology of Marked Relationships.* New York: Freeman

Kleinman A, Wang W-Z, Li S-C, Cheng X-M, Dai X-Y, Li K-T, Kleinman J. 1995. The social course of epilepsy: chronic illness as social experience in interior China. *Soc. Sci. Med.* 40:1319–30

Lewis J. 1998. Learning to strip; the socialization experiences of exotic dancers. *Can. J. Hum. Sexuality* 7:51–66

Lieberson S. 1985. *Making It Count: The Improvement of Social Research and Theory.* Berkeley: Univ. Calif. Press

Link B. 1982. Mental patient status, work, and income: an examination of the effects of a psychiatric label. *Am. Sociol. Rev.* 47:202–15

Link B. 1987. Understanding labeling effects in the area of mental disorders: an assessment of the effects of expectations of rejection. *Am. Sociol. Rev.* 52:96–112

Link BG. 1983. Reward system of psychotherapy: implications for inequities in service delivery. *J. Health Soc. Behav.* 24:61–69

Link BG, Cullen FT, Frank J, Wozniak J. 1987. The social rejection of ex-mental patients: understanding why labels matter. *Am. J. Sociol.* 92:1461–1500

Link BG, Cullen FT, Struening E, Shrout P, Dohrenwend BP. 1989. A modified labeling theory approach in the area of mental disorders: an empirical assessment. *Am. Sociol. Rev.* 54:100–23

Link BG, Phelan JC. 1999. Labeling and stigma. In *The Handbook of the Sociology of Mental Health*, ed. CS Aneshensel, JC Phelan. New York: Plenum

Link BG, Struening EL, Rahav M, Phelan JC, Nuttbrock L. 1997. On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *J. Health Soc. Behav.* 38:177–90

Macrae CN, Milne AB, Bodenhausen GV. 1994. Stereotypes as energy saving devices: a peek inside the cognitive toolbox. *J. Personality Soc. Psychol.* 66:37–47

Morone JA. 1997. Enemies of the people: the moral dimension to public health. *J. Health Polit., Policy Law* 22:993–1020

Mullen B, Salas E, Driskell JE. 1989. Salience, motivation, and artifact as contributions to the relation between participation rate and leadership. *J. Exp. Soc. Psychol.* 25:545–59

Oliver M. 1992. *The Politics of Disablement.* Basingstoke: Macmillan

Opala J, Boillot F. 1996. Leprosy among the limba: illness and healing in the context of world view. *Soc. Sci. Med.* 42:3–19

Page RM. 1984. *Stigma.* London: Routledge & Keegan Paul

Phelan JC, Link BG, Stueve A, Pescosolido B. 2000. Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared. *J. Health Soc. Behav.* 41:188–207

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms

Pinel EC. 1999. Stigma consciousness: the psychological legacy of social stereotypes. *J. Personality Soc. Psychol.* 76:114–128

Reissman CK. 2000. Stigma and everyday resistance: childless women in South India. *Gender Soc.* 14:111–35

Rosenfield S. 1997. Labeling mental illness: the effects of received services and perceived stigma on life satisfaction. *Am. Sociol. Rev.* 62:660–72

Rothman D. 1971. *The Discovery of the Asylum.* Boston: Little Brown & Coompany

Sayce L. 1998. Stigma, discrimination and social exclusion: what's in a word *J. Mental Health* 7:331–43

Scheff TJ. 1966. *Being Mentally Ill: A Sociological Theory.* Chicago, IL: Aldine de Gruyter

Schneider JW. 1988. Disability as moral experience: epilepsy and self in routine relationships. *J. Soc. Issues* 44:63–78

Sheldon K, Caldwell L. 1994. Urinary incontinence in women: implications for therapeutic recreation. *Ther. Recreation J.* 28:203–12

Smart L, Wegner DM. 1999. Covering up what can't be seen: concealable stigma and mental control. *J. Personality Soc. Psychol.* 77:474–86

Stafford MC, Scott RR. 1986. Stigma deviance and social control: some conceptual issues. In *The Dilemma of Difference*, ed. SC Ainlay, G Becker, LM Coleman. New York: Plenum

Steele CM, Aronson J. 1995. Stereotype vulnerability and the intellectual test performance of African Americans. *J. Personality Soc. Psychol.* 69:797–811

Wahl OF. 1995. *Media Madness: Public Images of Mental Illness.* New Brunswick N J: Rutgers Univ. Press

Walsgrove D. 1987. Policing yourself: social closure and the internalization of stigma. In *The Manufacture of Disadvantage*, ed. G Lee, R Loveridge. Philadelphia: Open Univ. Press

Wright ER, Gonfrein WP, Owens TJ. 2000. Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *J. Health Soc. Behav.* 41:68–90

This content downloaded from 157.193.51.61 on Wed, 11 Sep 2019 12:08:27 UTC
All use subject to https://about.jstor.org/terms