

Stigma and its public health implications

Bruce G Link, Jo C Phelan

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Department of Epidemiology
(Prof B G Link PhD) and
Department of Sociomedical
Sciences (J C Phelan PhD),
Mailman School of Public
Health, New York, NY 10032,
USA

Correspondence to:
Prof Bruce G Link
bgl1@columbia.edu

The publication of Erving Goffman's *Stigma: Notes on the Management of Spoiled Identity* in 1963 generated a profusion of research on the nature, sources, and consequences of stigma—albeit with considerable variation on how stigma was defined. In our conceptualisation, stigma is the result of a process in which a series of five interrelated components combine to generate stigma. In the first component, people identify and label human differences. Although most human differences are socially irrelevant, differences such as skin colour, IQ, and sexual preferences are highly salient in many social contexts. The point is that there is a social selection process determining which differences are deemed relevant and consequential, and which are not. Medical conditions vary dramatically in the extent to which they are socially significant. Compare hypertension, bone fractures, and melanoma, for example, with incontinence, AIDS, and schizophrenia.

The second component of stigma involves the process of stereotyping in which the labelled person is linked to undesirable characteristics. In a third component the group doing the labelling separates “them”—the stigmatised group—from “us”. In the fourth component, stigmatised people experience discrimination and loss of status. We reason that when people are labelled, set apart, and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting, and excluding them.

Finally, there can be no stigmatisation without the fifth component of stigma, the exercise of power. The essential role of power is clear in situations where low-power groups attempt a reverse stigmatisation. For example, patients being treated for mental illness may label their clinicians as pill pushers—a cold, paternalistic, and arrogant “them” to be despised and avoided. Nevertheless, the patients lack the social, cultural, economic, and political power to translate their negativity into any significant consequences for the staff. The staff, in such circumstances, are hardly a stigmatised group.

Major forms of discrimination

We characterise three major forms of discrimination, which can have varying degrees of severity. Direct discrimination occurs when A engages in overt rejection of B's job application, refuses to rent B an apartment, and so on. Structural discrimination is more subtle. An example would be white employers who rely on job recommendations from their white colleagues, who in turn are more likely to recommend white candidates. There is no direct denial of a job to a person of colour, yet discrimination has clearly

occurred. Another example of structural discrimination is evident when treatment facilities for stigmatised diseases like schizophrenia are located in isolated settings or poor or dangerous neighbourhoods.

An insidious form of discrimination occurs when stigmatised individuals realise that a negative label has been applied to them and that other people are likely to view them as less trustworthy and intelligent, and more dangerous and incompetent.^{1,2} According to this modified labelling theory, people who have been hospitalised for mental illnesses may act less confidently and more defensively with others, or may simply avoid a threatening contact altogether. The result may be strained and uncomfortable social interactions,³ more constricted social networks,¹ a compromised quality of life,⁴ low self-esteem,⁵ depressive symptoms,⁶ unemployment, and loss of income.^{7,8}

Stigma processes and life chances

Stigma processes have a dramatic and probably under-recognised effect on the distribution of life chances such as employment opportunities, housing, and access to medical care. We believe that under-recognition occurs because attempts to measure the impact of stigma have generally restricted analysis to one circumstance (eg, AIDS, obesity, race, or mental illness) and examined only one outcome (eg, earnings, self esteem, housing, or social interactions). If all stigmatised conditions were considered together and all outcomes examined we believe that stigma would be shown to have an enormous impact on people's lives. To exemplify one part of this point we analysed nationally representative data from the USA, in which multiple stigmatising factors were taken into consideration in relation to self-esteem, and found that stigma could explain a full 20% of the variance beyond the effects of age, sex, and years of education.

Stigma and stress

The extent to which a stigmatised person is denied the good things in life and suffers more of the bad things has been posited as a source of chronic stress, with consequent negative effects on mental and physical health.⁹ Stress is also associated with the constant threat of being stigmatised. The social epidemiologist Sherman James suggests that such fear sometimes generates harmful health outcomes.¹⁰ An example would be the career woman who works extremely hard and under great pressure to show that she is as good as any man at the top. Such coping efforts can come at the cost of hypertension and other health problems.

The stress associated with stigma can be particularly difficult for those with disease-associated stigma. Not only are they at risk to develop other stress-related illnesses, but the clinical course of the stigmatised illness itself may be worsened and other outcomes affected, such as the ability to work or lead a normal social life. Indeed, the fear of being labelled with the disease may cause individuals to delay or avoid seeking treatment altogether, while those already labelled may decide to distance themselves from the label, forgoing treatment or becoming noncompliant. When either of these processes operate, people suffer the consequences—tragically, including death. Even when patients are willing, stigma can discourage care-seeking. The presence of barbed wires, guards, locked wards, and body searches in treatment facilities for the mentally ill could understandably discourage a would-be patient. More broadly, if a stigmatised illness has received less attention and fewer research and treatment dollars, the effectiveness of treatments may lag behind treatments for other less stigmatised diseases.

Stress is by no means the only factor exacerbating the health problems that stigmatised individuals face. We have proposed¹¹ that some social conditions are intrinsically related to health because they affect an individual's exposure to disease risks and protective factors. Thus, throughout history, socioeconomic status has had a robust association with disease and death: people with greater resources of knowledge, money, power, prestige, and social connections are generally better able to avoid risks and to adopt protective strategies. As stigma places people at a substantial social disadvantage with respect to these resources, it increases their exposure to risks and limits access to

protective factors, potentially adding to their burden of disease or disability.

Conflict of interest statement

We declare that we have no conflict of interest.

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Stigma and the law

Scott Burris

There are three broad areas where law affects the operation of stigma in society. Law can be a means of preventing or remedying the enactment of stigma as violence, discrimination, or other harm; it can be a medium through which stigma is created, enforced, or disputed; and it can play a role in structuring individual resistance to stigma. For the individual with a stigmatised health condition, acceptance of society's views and self-stigmatisation may lead to concealment to avoid discrimination. But an anti-stigma activism is also possible. For many stigmatised diseases (epilepsy, for example¹), the consequences of concealment may often be more severe than those of resistance. In both cases the individual faces status loss and discrimination, but, depending on the nature and incidence of enacted stigma, people who adopt resistance strategies may actually face

less stigma, experience less social harm, and be better able to cope with any discrimination. At the same time they avoid the life-long hidden distress and unhappiness experienced by people who conceal.

Legal protection against the enactment of stigma

Law is most commonly seen as a tool for blunting the effects of stigma by protecting health information and prohibiting discrimination based on a health condition. Legal protection can deter harmful conduct and can provide recompense when harm has been done. But law is limited. It addresses behaviour, but does not necessarily change the attitudes that produce the behaviour. Moreover, most enacted stigma is not forbidden by law, and many of the effects of stigma will

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 Temple University Beasley
 School of Law, Philadelphia,
 PA 19122, USA (Prof S Burris JD)
 scott.burris@temple.edu