Chapter One: Understanding Stigma

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1. Exploring the Concept of Stigma

Human beings are inherently social creatures who require extensive social acceptance and interaction. However, why do humans sometimes reject members of their own kind? This rejection often stems from the concept of stigma, a social construct with roots tracking back to ancient Greece. The Greeks, known for their proficiency in using visual aids, originated the term 'stigma' to describe bodily marks designed to signify something unusual and negative about a person's moral status. These marks, whether cut or burned into the body, indicated that the bearer was a slave, a criminal, or a traitor—someone tainted and socially shunned, particularly in public spaces (Goffman 1963, p. 3).

Erving Goffman's groundbreaking work, *Stigma: Notes on the Management of Spoiled Identity* (1963), has served as a catalyst for extensive research on stigma throughout the years. Definitions of stigma vary across different studies, a phenomenon Link and Phelan (2001) attribute to two primary factors. First, the concept of stigma has been applied to a wide range of circumstances. Second, the interdisciplinary nature of stigma research has led to different conceptualisations owing to varying frames of reference (Link/Phelan 2001, p. 363).

In this chapter, to delve deeper into the concept of stigma, several key works with distinct frameworks are reviewed, with Goffman's seminal contribution serving as the starting point.

Stigma as an Attribute

Goffman's seminal work in 1963 involved extensive interviews, literature reviews, and other research methods. He defined stigma as 'an attribute that is deeply discrediting', viewing the stigmatised person as 'reduced in our minds from a whole and usual person to a tainted, discounted one' (Goffman 1963, p. 3). Goffman categorised stigma into three types: abominations

of the body, blemishes of individual character, and tribal stigma (Goffman 1963, p. 4).

He described abominations of the body as physical deformities. Blemishes of individual character included traits such as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty, which could be inferred from a history of mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicide attempts, and radical political behaviour. Tribal stigma related to race, nationality, and religion and could be passed down through generations, affecting all members of a family equally (Goffman 1963, p. 4).

Goffman also emphasised the importance of the 'visibility' of a particular stigma (Goffman 1963, p. 48). He argued that the extent to which a stigma is noticeable impacts its ability to communicate the individual's condition. For example, the stigma associated with ex-mental patients is less noticeable compared to that of blind individuals, making blindness a more visible stigma.

In summary, Goffman's work laid a foundation for understanding the complexities of stigma, its various forms, and the role of visibility in shaping social perceptions and interactions.

Stigma as a Mark

In 1984, Jones et al. introduced their perspective on stigma, defining it as a 'mark' that discredits individuals when associated with deviations from societal norms (Jones et al. 1984, p. 9). They framed stigma within cognitive categorisation processes, suggesting that it arises when a mark connects an individual to undesirable traits, leading to discrediting.

Jones et al. identified six dimensions of stigma:

a) Concealability: this concerns the ease with which a stigmatising trait can be hidden or observed (e.g. facial disfigurement vs. homosexuality).
b) Course of the mark: this considers whether the mark becomes more evident or debilitating over time (e.g. multiple sclerosis vs. blindness).
c) Disruptiveness: this refers to how much a stigmatising trait (e.g. stuttering) disrupts social interactions.
d) Aesthetics: this relates to personal perceptions of the unattractiveness of the stigma.

e) Origin of the stigmatising mark: this examines whether the mark is inherited, accidental, or intentional, and includes individual responsibility.
f) Peril: this reflects the perceived risk posed by the stigmatising condition to others (e.g. having a highly contagious, deadly disease vs. being overweight).

Like Goffman, Jones et al. stressed that the visibility of a stigmatising condition amplifies its negative impact on interactions, underscoring the significance of visibility in understanding stigma.

Interrelated Components of Stigma

In their article 'Conceptualizing Stigma', Link and Phelan (2001) explained stigma as a combination of labels, stereotypes, separation, status loss, and discrimination. They emphasised that power plays a role in stigma (Link/Phelan 2001, p. 63). Link and Phelan highlighted two main challenges in understanding stigma. First, many researchers study stigma without directly experiencing it themselves, which can lead to a disconnect between theory and reality. This is akin to criticisms in anthropology, where early anthropologists relied heavily on theories without conducting fieldwork. Second, stigma research has often focused too much on individual experiences.

To address these challenges, Link and Phelan proposed describing stigma through a set of interrelated components, which provides a more comprehensive conceptualisation (Link/Phelan 2001, pp. 367–375):

a) Labelling differences: identifying and labelling human differences.
b) Stereotyping: linking labelled individuals to negative characteristics, creating stereotypes.
c) Separation: categorising labelled individuals to separate 'us' from 'them'. For example, referring to individuals as 'epileptics' or 'schizophrenics' rather than as people with epilepsy or schizophrenia.
d) Status loss and discrimination: this leads to unequal outcomes, seen in both individual and structural discrimination. For instance, treatment facilities for mental illness or substance use disorders are often located in disadvantaged areas.
e) Dependence on power: stigmatisation relies on social, economic, and political power to enforce stereotypes and discrimination.

They also noted that stigmatised groups might label and stereotype non-stigmatised individuals, but these stereotypes do not have the same impact due to power imbalances. Addressing these power differences is essential to understanding and combating stigma.

Link and Phelan further discussed the consequences of stigma, including status loss, discrimination, and unintended effects of coping mechanisms. They offered principles for combating stigma, emphasising the need for comprehensive approaches that target its root causes. These approaches should aim to change attitudes and beliefs or address power imbalances (Link/Phelan, pp. 379–381).

Evolutionary Views of Stigma

In the same year that Link and Phelan's work was published, Kurzban and Leary (2001) approached the concept from an evolutionary perspective. They argued that the reason why people are stigmatised is 'because they possess a characteristic viewed by society or a subgroup as constituting a basis for avoiding or excluding other people'. Specifically, they proposed that humans have cognitive adaptations geared towards avoiding poor social partners, affiliating with cooperative groups for competitive advantage, and steering clear of those more likely to carry diseases (Kurzban/Leary 2001, pp. 187–188).

The authors identified three evolutionary pressures possibly linked to stigma: dyadic cooperation adaptations, coalition exploitation adaptations, and parasite avoidance adaptations. Dyadic cooperation adaptations involve avoiding unfavourable social partners, influenced by selection pressures tied to potential gains from reciprocal altruism and the impact of others' actions in one's social circle. Coalition exploitation adaptations encompass the exclusion and exploitation of social out-groups. Parasite avoidance adaptations relate to avoiding prolonged contact with individuals more likely to carry diseases (Kurzban/Leary 2001, pp. 192–200).

The evolutionary perspective differs from others by suggesting that stigmatising conditions are not universally addressed. However, criticisms have been raised. Some scholars argue that evolutionary perspectives on stigma overlook the viewpoint of the stigmatised individual and overly focus on internal factors rather than the societal influences shaping social exclusion (Yang et al. 2007, p. 1525).

Moral Dimensions of Stigma

Yang et al. (2007) broadened the scope of stigma to encompass moral experience, viewing it through an anthropological lens. They proposed that stigma's fundamental impact lies in jeopardising or devaluing what individuals hold most dear, or in actually eroding those cherished values. Their definition posits stigma as an 'essentially moral issue in which stigmatized conditions threaten what is at stake for sufferers' (Yang et al. 2007, p. 1524).

The authors extensively explored the Chinese notion of 'face' (*mianzi*), which signifies one's moral standing within the local community. In Chinese society, individuals both possess and bestow 'face' upon others. Losing face is described as deeply humiliating, often manifesting physically as an inability to confront others, a visible deterioration of facial expression, or a sensation of being stripped of identity (Kirmayer/Sartorius 2009; Kleinman et al. 1978; Kleinman/Becker 1998; Yang et al. 2007). This example illustrates how morality shapes stigma and its various dimensions. Yang et al. (2007) introduced the concept of 'moral experience', defining it as the everyday engagements that define individuals' core values. They also introduced the notions of 'moral-somatic', where values are intertwined with physical experiences, and 'moral-emotional', where values intersect with emotional states (Yang et al. 2007, pp. 1528–1532).

This anthropological perspective enriches stigma research by framing it as a socio-somatic process (Yang et al. 2007, pp. 1524–1530), exemplified notably in the Chinese experience of 'face' and its loss. In Chinese culture, mental illness carries stigma, leading individuals to manifest psychiatric issues through somatic symptoms (Kleinman et al. 1978). Somatisation, experiencing distress through physical symptoms, varies in cause and presentation among individuals (Kirmayer/Sartorius 2009). Anxiety and depression can be presented as physical ailments such as hypertension or chronic respiratory diseases in China (Zhou et al. 2017). Sociosomatics, akin to somatisation, explores how social processes shape bodily experiences. When individuals cannot articulate social issues, they may develop emotional and somatic symptoms to cope, often resulting in physical diagnoses to avoid mental illness stigma (Groleau/Kirmayer 2010; Kleinman/Becker 1998).

The authors also utilised Goffman's framework to argue that stigma arises from social interaction, rather than being solely an individual trait (Yang et al. 2007, p. 1527). Goffman's concept of a 'moral career' (Goffman 1963, p. 32) describes how stigmatised individuals internalise societal views and navigate changing social identities. Individuals with mental illness shift

from a 'normal' to a 'discreditable' status, and upon disclosure, to a 'discredited' status, as they manage information about their identity. Thus, stigma emerges as individuals adopt new social identities through interaction with constructed categories.

Section Conclusion

The exploration of stigma reveals its multifaceted nature and profound impact on individuals and societies. From Goffman's seminal framework to Jones et al.'s dimensions and Link and Phelan's interrelated components, each perspective offers valuable insights into the complexities of stigma and its impact on individuals and society. Additionally, evolutionary and cultural perspectives further enrich our understanding by shedding light on the adaptive explanation and moral dimensions of stigma.

By synthesising these perspectives, we gain a comprehensive understanding of stigma as a social construct deeply intertwined with perceptions, stereotypes, power dynamics, and moral values. This holistic approach underscores the importance of addressing stigma through comprehensive strategies that target its root causes and promote social inclusion and acceptance.

2. Stigma Versus Prejudice

While stigma and prejudice are often used interchangeably, they represent distinct yet interconnected concepts. Both terms involve negative attitudes and beliefs towards individuals or groups, but they operate in different contexts and have unique implications. Understanding the nuances between stigma and prejudice is essential for unravelling the complexities of social interactions and identity formation. By delineating these concepts, we aim to foster a deeper appreciation of their intricacies.

The term 'prejudice', originating from the Latin noun *praejudicium*, has undergone semantic evolution over time. Its transformation unfolds in three stages. Initially, to the ancients, *praejudicium* denotes a judgment based on prior decisions and experiences. Subsequently, in English, it evolved to signify a judgment formed hastily or prematurely, without due examination of the facts. Finally, the term acquired its contemporary emotional connotation of favourability or unfavourability that accompanies

such premature judgments (Allport 1954, p. 6). In its simplest form, prejudice can be defined as thinking ill of others without sufficient warrant. Allport (1954) specifically defined ethnic prejudice as 'an antipathy based upon a faulty and inflexible generalization. It may be felt or expressed. It may be directed toward a group as a whole, or toward an individual because they are a member of that group' (p. 9).

Building on this understanding of prejudice, Phelan et al. (2008) compared stigma and prejudice, drawing two conclusions regarding their differences: the one-animal conclusion and the two-animal conclusion. The one-animal conclusion suggests that models of stigma and prejudice are either parallel (describing the same phenomena in different terms) or complementary (describing different parts of one overarching process). The two-animal conclusion proposes that these concepts may be contradictory (describing conflicting phenomena) or disconnected (describing distinct and unrelated processes) (Phelan et al. 2008, p. 359).

Phelan et al. (2008) argued that prejudice is primarily related to one's attitudes and thus has attitudinal components, while stigma is a broader process. Stigma models place more emphasis on targets, particularly in terms of stereotypes, identity, and emotions, whereas prejudice models focus more on the perpetrators, including individual discriminatory behaviour outside interactions (Phelan et al. 2008, p. 360). These differences reflect the contrasting foci in the two seminal works on prejudice and stigma: Allport (1954) clearly focused on the perpetrator, while Goffman (1963) focused more on the target.

Furthermore, Phelan et al. (2008) identified a distinction between 'group' characteristics (those shared by family members) and 'individual' characteristics (occurring more sporadically within families), which is significant in understanding models of prejudice and stigma. This distinction, uncovered by their examination of models of prejudice and stigma, led them to review 162 articles with the word 'stigma' in the title and 139 articles with the word 'prejudice' in the title, revealing that in most cases (62%), prejudice was connected with race or ethnicity, while stigma dealt with illness, disability, or behavioural or identity deviance (these articles are based on a search of PsycInfo from 1955–2005, see Table 1).

Table 1: Types of human characteristics associated with 'prejudice' and 'stigma' in journal articles, based on a search of PsycInfo from 1955 to 2005 (Phelan et al. 2008, p. 362).

	Prejudice (N = 139)(%)	Stigma (N = 162)(%)
Race or ethnicity	62	4
Gender	7	2
Behavioral/identity deviance		
Sexual orientation	3	4
Other deviance	4	8
Illness/disability		
Mental illness	0	38
Substance use	0	4
HIV/AIDS	1	16
Other illness/disability	6	22
Other characteristic	6	0
Unspecified characteristic	11	2

They then proposed three functions of stigma and prejudice: exploitation/domination, enforcement of social norms, and avoidance of disease. These functions respectively maintain power dynamics, societal norms, and health preservation (Phelan et al. 2008, p. 362).

Through their work, the authors concluded that although models of prejudice and stigma essentially describe the same phenomena using different terminology, the discernible differences in their functions prompted them to identify three subtypes of the functions of stigma and prejudice. They propose that prejudice can be seen as attitudinal components, focusing specifically on the attitudes of perpetrators, while stigma encompasses a broader process rooted in common individual experiences (Phelan et al. 2008, pp. 360–361).

3. Examining the Different Types of Stigma

As previously mentioned, scholars have various interpretations of the concept of stigma. Goffman viewed stigma as an attribute, identifying three types of it. Jones and colleagues considered stigma a mark, listing six components. Link and Phelan conceptualised stigma through five interconnected components. Kurzban and Leary explored it from an evolutionary perspective, while Yang and colleagues added moral and cultural dimensions (Goffman 1963; Jones et al. 1984; Kurzban/Leary 2001; Link/Phelan 2001; Link/Phelan 2006; Yang et al. 2007). These diverse approaches lead to multiple ways of categorising stigma.

Despite these differing approaches, scholars generally agree that stigma is a social construct. This section explores stigma across three societal levels: structural (involving laws, regulations, and policies), public (encompassing attitudes and behaviours of individuals and groups), and self-stigma (internalised negative stereotypes) (National Academies of Sciences, Engineering, and Medicine 2016, p. 4).

Structural stigma, as defined by Hatzenbuehler and Link (2014), involves 'societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and well-being for stigmatized populations' (p. 2). This type of stigma exists in both public and private institutions, including businesses, courts, government entities, professional groups, school systems, social service agencies, and universities. Structural stigma can perpetuate discrimination, influencing public and self-stigma. Examples include restrictions on civil rights, such as serving on a jury or holding political office, and discriminatory hiring or admissions policies based on stereotypes (National Academies of Sciences, Engineering, and Medicine 2016, p. 5).

Public stigma manifests through the behaviours of individuals and groups in society, including educators, employers, healthcare providers, journalists, police, judges, policymakers, and legislators. The media, with its broad reach, significantly impacts stigma at all levels. Despite efforts to educate media professionals about various social issues, stereotypes often persist in reports and public discourse. Social media can either perpetuate stigma or promote inclusive attitudes. Public stigma encompasses negative attitudes, beliefs, and behaviours within a community or cultural context, collectively referred to as negative social norms. Intersecting stigmas, such as those related to race or poverty, can exacerbate discrimination and injustice. Public stigma predisposes communities or social groups to fear,

reject, avoid, and discriminate against stigmatised individuals (Parcesepe and Cabassa 2013; Corrigan et al. 2009, p. 140; National Academies of Sciences, Engineering, and Medicine 2016).

Transitioning from structural and public stigma, we now explore self-stigma and its internal effects on individuals.

Self-stigma occurs when individuals internalise the negative attitudes and beliefs held by society. This internalisation lowers their self-confidence and may deter them from disclosing their conditions due to fear of being labelled and discriminated against. As a result, they might avoid seeking help or treatment, hindering early diagnosis and intervention. This avoidance exacerbates the social burden of untreated conditions, leading to issues like chronic disease, victimisation, crime, incarceration, lost productivity, and premature death (National Academies of Sciences, Engineering, and Medicine 2016, pp. 4–5).

Self-stigma, which does not stem from a lack of insight or a deliberate embrace of negative social norms, is defined by the impact on individuals who internalise societal stigma. It often emerges from previous experiences of discrimination or rejection. This internalisation can cause individuals to deny their symptoms and reject treatment, further isolating them from essential social supports. Like low self-efficacy, self-stigma poses a significant barrier to recovery for those affected (Corrigan et al. 2014; Corrigan et al. 2009, p. 140; National Academies of Sciences, Engineering, and Medicine 2016, pp. 21–22).

In summary, stigma operates on different levels: structural (laws and policies), public (societal attitudes), and self-stigma (internalised beliefs). These contribute to discrimination and hinder individuals from seeking help. Addressing stigma comprehensively is crucial for fostering a more inclusive and supportive society.

4. Conclusion

In conclusion, the exploration of stigma in this chapter has unveiled its multifaceted nature and significant impact on individuals and society. From Goffman's foundational framework to Jones et al.'s dimensions and Link and Phelan's interrelated components, we gain a comprehensive understanding of stigma's complexity. Evolutionary and cultural perspectives further enrich this understanding, highlighting how adaptive explanations and moral dimensions shape stigmatisation processes.

Understanding stigma as a social construct deeply embedded in perceptions, stereotypes, power dynamics, and moral values is crucial. This holistic approach emphasises the need for comprehensive strategies to address stigma, aiming to dismantle its root causes and foster a more inclusive and supportive society. By recognising and addressing the structural, public, and self-stigma, we can mitigate the adverse effects of stigma on individuals with substance use disorders, thereby promoting recovery and social integration.

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