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Introduction

Introduction to the special issue on structural stigma and health

Introduction

Stimulated by the pioneering work of Goffman (1963), research into the causes and consequences of stigma has proliferated over the past five decades. Progress has been made in the construction of new concepts, measures, and methodological approaches that have illuminated how stigma works to the disadvantage of those targeted by it. The culmination of this intense scrutiny has created the capacity to more deeply understand this powerful human phenomenon, opening the possibility to address its unwanted effects. At the same time, in the midst of this growth and advancement, the stigma concept has been criticized on several fronts. One of the most consistent criticisms has been that stigma research is too individually focused (Link & Phelan, 2001; Parker & Aggleton, 2003). 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, rather than on structural issues underlying stigma.

In part to address this criticism, researchers have recently expanded the stigma construct to consider how broader, macro-social forms of stigma—termed *structural stigma*—may also disadvantage the stigmatized. For instance, Link and Phelan's (2001) influential conceptualization of stigma distinguished between discrimination at individual and structural levels and noted that the concept of structural stigma "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" (p. 382). Despite initial attempts to define (Link & Phelan, 2001) and measure (Corrigan et al., 2005) structural stigma, there has been limited empirical investigation of the extent to which structural stigma represents a risk indicator for adverse health outcomes among stigmatized individuals. This dearth of empirical research on structural stigma has led researchers to conclude that this under-representation represents "a dramatic shortcoming in the literature on stigma, as the processes involved are likely major contributors to unequal outcomes" (Link, Yang, Phelan, & Collins, 2004, pp. 515–16).

Recent research, however, has begun to generate a tantalizing set of findings concerning the role of structural stigma in the production of negative outcomes for members of stigmatized groups, including individuals with mental illness (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012), sexual minorities (Hatzenbuehler, 2011), Blacks (Krieger, 2012), and individuals infected with HIV/AIDS (Miller, Grover, Bunn, & Solomon, 2011). In one example of this work, Hatzenbuehler, Keyes, and Hasin (2009) coded states for levels of structural stigma surrounding lesbian, gay, and bisexual (LGB) individuals, operationalized as the absence of policies that confer protection to gays and lesbians—namely, hate crime statutes and employment nondiscrimination policies that include sexual orientation as a protected class. The researchers linked this policy information to individual-level data on mental health and sexual orientation from a large nationally representative survey of U.S. adults. Sexual orientation disparities in mental health were lower in low-structural stigma states. For instance, sexual orientation disparities in dysthymia (a mood disorder) were eliminated in states with protective policies; however, LGB adults who lived in states with no protective policies were nearly 2.5 times as likely to have dysthymia as were heterosexuals in those same states. Results remained robust after controlling for demographic covariates and perceived discrimination, suggesting that structural stigma contributes to psychiatric disorders independent of individual stigma. These initial findings have shown the impact of structural stigma to be substantial and thereby indicated the need to understand it more thoroughly.

To capitalize on the exciting advancements of this emerging line of research on structural stigma, we founded the Structural Stigma and Population Health Working Group at Columbia University, funded by the Robert Wood Johnson Foundation Health & Society Scholars program. We brought together an interdisciplinary group of psychologists, sociologists, social epidemiologists, and anthropologists to meet twice a month to advance and develop new approaches to theory, methods, and empirical evidence bearing on the role of stigma as a social determinant of population health. After meeting for over a year, our group came to the conclusion that bringing the "social" squarely back into the stigma concept—and examining the impact of these structural forms of stigma on health—required attention to several overlapping foci, including: (1) conceptualizing novel definitions of social/structural dimensions of stigma; (2) measuring and statistically modeling stigma as a structural determinant of health; (3) identifying relationships between structural and individual stigma in predicting health outcomes; and (4) designing interventions to reduce structural forms of stigma that create and perpetuate health inequalities. After pursuing these topics on our own, we invited several experts in the field of stigma, discrimination and health to a conference to discuss these topics further. This special issue "Structural Stigma and Health" emerged out of this larger discussion.

Conceptualizing structural stigma

As we note above, stigma researchers have emphasized the need to conceptualize and measure stigma as a social phenomenon with roots in social structures. This, of course, requires the articulation of

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what is meant by structural stigma. Structures have been defined as "organizing principles on which sets of social relations are systematically patterned" (Bonilla-Silva, 1997, p. 476). Drawing on prior conceptualizations, we define *structural stigma* as societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized. This represents a broad working definition, but our first set of articles was tasked with developing more specific conceptualizations to address important lacunae and to offer further refinements to more clearly articulate core aspects of the construct. Each paper did this by engaging theoretical traditions in sociology that are focused on factors at the macro-level or the intersection of macro and micro levels but which have not been fully integrated into the study of stigma in general or structural stigma in particular.

Feagin and Bennefield (2014) leverage theory and concepts from work in the area of "systemic racism" (Feagin, 2006, 2010) within sociology bringing insights from that tradition to bear to understand racial inequality in health and health care in the United States. The dimensions of racism that are of use in this endeavor, such as racial hierarchy, social reproductions of racial-material inequalities, and collective discriminatory practices, illuminate structural processes that powerfully affect racial disparities as experienced in the health domain. And as the article makes very clear, current manifestations of these phenomena are deeply embedded in historical processes, thereby sensitizing us to the importance of incorporating historical dimensions, which have largely been lacking in the study of structural stigma and health. This approach is consistent with recent empirical evidence showing that the highest mortality rates among Whites and Blacks in states with and without Jim Crow legislation in the decade between 1960 and 1970 occurred in Black populations within Jim Crow states; conversely, the lowest mortality rates occurred among Whites in these same states, suggesting that systemic racism benefits Whites while compromising the health of Blacks (Krieger, 2012).

Phelan, Lucas, Ridgeway, and Taylor (2014) direct attention to another area of sociology, the so called "status characteristics tradition" (Berger, Rosenholz, & Zelditch, 1980; Ridgeway & Erickson, 2000) that is particularly well-known for its capacity to link macro and micro processes. In particular, Phelan and colleagues suggest that "status" as conceived in this tradition is an important, but overlooked, dimension of structural stigma, and they demonstrate how linking stigma to status characteristics theory can help embed the study of stigma in a social-structural framework. The authors discuss several parallels between status and stigma (e.g., in both, macro-level inequalities are enacted in micro-level interactions, which in turn reinforce macro-level inequalities), which reveals close parallels between stigmatization and status processes that contribute to systematic stratification by major social groupings. These conceptual intersections highlight the fact that stigma is not only an interpersonal or intrapersonal process, but also a macro-level process. The authors' contribution underscores a central theme of this special issue: that stigma's impact on health "should be scrutinized with the same intensity as that of other more status-based bases of stratification such as SES, race and gender, whose health impacts have been firmly established" (p. 15).

Finally, Link and Phelan (2014) travel to the sociological theories of Bourdieu (1987, 1990) playing off his ideas about "symbolic power" and the utility of hidden, "misrecognized" processes in deploying power to achieve desired ends. Using these ideas, Link and Phelan introduce a new concept of "stigma power" to identify the macro-level factors that create social structures in which stigmatized individuals are exploited, controlled, or excluded. This concept points to the ways in which stigmatizers achieve their goals of keeping stigmatized individuals "down, in, or away" (Phelan, Link, & Dovidio, 2008). The authors demonstrate that individuals with mental illness exhibit concerns with staying in, feel propelled to withdraw and "stay away," and are induced to feel downwardly placed. In this way, the stigmatized ensure that the outcomes that the stigmatizers might desire are enacted, but without the stigmatizers ever being involved in direct person-to-person discrimination. The concept of power has been central to sociological concepts of stigma (Link & Phelan, 2001; Parker & Aggleton, 2003), but this article provides new insights into how stigmatizers are able to ensure the outcomes they desire in insidious and under-recognized pathways that reinforce social structures in which stigmatized individuals are embedded.

The articles in this section accomplish two central aims. First, they collectively highlight important gaps in current conceptualizations of stigma, which are almost exclusively individually focused. Second, these articles significantly advance this literature by offering several key concepts (both new concepts, as well as existing concepts that may be fruitfully applied to understanding the stigma process) that are absent from current conceptualizations of structural stigma—including stigma power, status, and systemic racism.

Measuring and modeling structural stigma as a risk indicator for poor health

Having defined and elaborated important components of structural stigma, we next turn to a series of articles that demonstrate novel ways of measuring this construct as it relates to health. Theoreticians of institutional racism (Ture & Hamilton, 1967) have noted that this form of racism is less overt and more difficult to identify than other forms (i.e., individual- and interpersonal-level racism). Similarly, structural stigma can be hard to capture, ensuring that it frequently remains hidden or "misrecognized" (Bourdieu, 1987, 1990). Part of the role of social scientists is therefore to develop measures of structural stigma to make the processes that underlie it less invisible and more manifest.

Accomplishing this task, the papers in this special issue highlight a range of different measures of structural stigma that can be used in order to study the role of structural stigma as a social determinant of population health. In the first article, Hatzenbuehler et al. (2014) constructed a measure capturing the average level of anti-gay prejudice in the community (defined at the primary sampling unit level, which included metropolitan statistical areas and rural counties), using data from the General Social Survey. This information was prospectively linked to mortality data via the National Death Index. Sexual minorities who lived in high-structural stigma communities—operationalized as communities with high levels of anti-gay prejudice—had increased mortality risk compared to those living in low-structural stigma communities, controlling for individual and community-level covariates. This effect translates into a life expectancy difference of 12 years on average (range: 4–20 years), which is greater than life expectancy differences between individuals who do and do not complete a high school education (Muennig, Fiscella, Tancredi, & Franks, 2010). There was no association between geographic mobility since age 16 and mortality among sexual minorities, demonstrating that the results were robust to selection effects (i.e., they cannot be explained by healthier respondents moving to low-stigma communities).

In the second article, Lukachko, Hatzenbuehler, and Keyes (2014) adopt a different approach to examining structural measures of racism, including political participation, employment and earning, economic autonomy, judicial parity, and disparities in incarceration. Data on structural racism at the state level was linked to individual-level data on myocardial infarction from the National Epidemiologic Survey on Alcohol and Related Conditions, a