

(The Gender Centre advise that this article may not be current and as such certain content, including but not limited to persons, contact details and dates may not apply. Where legal authority or medical related matters are cited, responsibility lies with the reader to obtain the most current relevant legal authority and/or medical publication.)

# Stigma and Health

## An Overview

Paper presented by Dr. Max Hopwood at N.C.H.S.R. Consortium Workshop 19, 30th May 2007, Cockle Bay, Sydney  
Article appeared in Polare magazine: October 2007 Last Update: October 2013 Last Reviewed: September 2015



Dr. Max Hopwood

**T**he term "stigma" comes from ancient Greek and was used to describe the signs which were cut or burnt into a human body to mark a person as someone of unusual or bad moral status. The bearers of these stigma-signs were slaves, criminals and traitors; people to be avoided particularly in public places (Goffman, 1968). Two and a half thousand years later the term stigma has come to describe the disgrace or social disqualification which arises from possession of an attribute, visible or unseen, that is considered deeply discrediting. Sociologist Erving Goffman, since publication of his 1963 treatise, *Stigma: Notes on the Management of Spoiled Identity* is considered the founder of modern stigma theory. By the early 1960 sociology was deeply concerned with the notions of conformity and deviance and Goffman used this framework to study interactions between individuals that led to stigma. He noted that it is the social meanings which are ascribed to particular attributes in a given context, rather than an attribute per se, that stigmatise an individual or a group.

***Stigma can lead to people experiencing chronic stress which gives rise to maladaptive approaches to coping such as withdrawal and isolation.***

Take an attribute such as the love of reading; many people would feel no compunction in being seen walking into a library, on the other hand, a professional criminal would probably not feel comfortable being seen by his peers entering a library (Goffman, 1968). Goffman redefined a stigmatized individual as someone who possesses an undesired characteristic and who is therefore "disqualified from full social acceptance".

He described three differing types of stigma as: that associated with abominations of the body like physical deformities and including diseases such as leprosy; stigma associated with blemishes of individual character (e.g., weak-will, dishonesty, mental disorders and addictions); and stigma associated with "tribal" identity such as ethnicity and religion.

In the past forty-five years, social scientists have refined Goffman's theory, particularly by highlighting the social processes which underpin interactions between individuals.

Today stigma is increasingly understood as both a social process perpetrated by non-marginalised groups to achieve goals of exclusion and conformity, and a psychosocial process that marginalised groups must navigate and contend with (Ahern *et al.*, 2007). Indeed, powerful social groups stigmatise individuals or groups of people who display difference from social norms and who identify with or enact unsanctioned behaviours. Stigmatisation is a means by which societies defend themselves against overt or perceived threats to cultural values, and stigma is manifested through rules and sanctions directed towards "offenders" (Malcolm *et al.*, 1998). For example, most gay men, lesbians, bisexuals and transgender people are familiar with stigma; non-heterosexual people challenge previously cherished notions of the "naturalness of heterosexual gender roles. Same-sex attracted people are perceived by powerful social structures, like the military, as undermining the authority of patriarchy. Similar is the concern of religion - testament to the power of heterosexual men to define and control what is moral, ethical and acceptable in life - which has historically and persistently opposed recognition of gay rights. Indeed, God's love is not boundless, there are limits and theological exclusion of gay, lesbian, bisexual and transgender people help to define "acceptable" morality.

Here, the stigmatising trait or value is one that conflicts with an important cultural value upheld by the majority (Malcolm *et al.* 1998; Gilmore *et al.* 1994); that is, compulsory heterosexuality where straight men rule! Ultimately, stigmatisation and its corollary, discrimination, are means by which societies deter unwanted behaviours (Ahern *et al.*, 2007). The kind of behaviours that come to be stigmatised, however, can vary widely between cultures and can change over time (Fulton 1999; Pittam 2000).

Over recent decades, stigma has entered popular discourse thanks largely to Goffman's work and the concept is becoming increasingly common and important within health discourses today. However, in the context of health research and policy, Goffman's formulation of stigma has limited application as today the language of abominations, blemishes and tribal identities is antiquated.

The concept he developed is so broad that it fails to address health-related interests of social and health policy, and the central notion in his thesis of "normality" and "deviance" has less currency in a multi-cultural context like modern Australia where what is considered normal in one culture might be stigmatised in another. The core concern here is that while Goffman effectively focused on shifting the

discourse of stigma from symbols to social processes by studying social interactions, he did not spend much time discussing the social structures and discourses, like gender and class that inform all personal interactions.

Although he alluded to social structure often, he failed to elaborate on the impact of how power differences, for example based on income, were played out during interpersonal interactions. It is for these reasons that a revised adaptation of stigma theory is necessary for health research, disease control and community action. A revision needs to identify and highlight the structural and organisational factors which underpin health-related stigma.

## Health related stigma

Research into health-related stigma has increased over recent years as the impacts of stigma on health have become more evident.

Stigma is increasingly seen as an added burden on the health of affected individuals who are often already dealing with stigma associated with poverty, and/or minority-group status. Stigma influences the health-seeking behaviour of many health consumers; it can delay appropriate help-seeking, interfere with access to treatment for treatable problems, and impede the effectiveness of case finding and treatment, which are key interests of public health.

Stigma can lead to people experiencing chronic stress which gives rise to maladaptive approaches to coping such as withdrawal and isolation. In certain contexts, the impact of the meaning of a disease or condition may create more problems for an individual than the symptoms of the disease itself.

## H.I.V./AIDS related stigma

The two major global viral epidemics of recent decades - H.I.V. / AIDS and Hepatitis C have both been accompanied by epidemics of stigma and discrimination.

The quote below from the United States Advisory Committee on H.I.V. / AIDS highlights how infectious diseases, such as viral hepatitis and H.I.V./AIDS, have a history of eliciting stigma and affected people are often labelled and excluded from a range of social contexts.

"The panic and uncertainty that accompany epidemic disease may lead to a desperate search for explanations ... Stigmatisation seems to provide a partial (although spurious) answer ... the convenience of having an already despised or suspect group in the vicinity allows for quick attribution of causality and blame." (Turner *et al.* 1989, page 391)

H.I.V./AIDS has become one of the most stigmatised diseases of recent times and is often perceived as a threat to the self or one's community. Social disqualification that is, stigmatisation - is viewed as a method of preserving the physical and moral health of the community against the problems represented by the disease (Gilmore *et al.* 1994). Often, a disease comes to represent all the "suffering and evil" in society and people with the disease are positioned as an out-group representing "societal shortcomings, inadequacies, unmet needs or unrealised expectations" (Gilmore *et al.* 1994 page 1346).

The burden of stigma often weighs heaviest on the poorest and most marginalised people in our community and this point reveals the political dimension of stigma, that is, powerful groups can enforce rules onto less powerful groups (Fulton 1999). The early days of the H.I.V. epidemic saw calls from both individuals and social institutions for people living with H.I.V. / AIDS to be quarantined, to be excluded from participating in the workforce and other social contexts, and to be identified as carriers of death and disease (Sontag 1989; Crimp 1987). While gay community political mobilisation helped prevent the worst of these actions from occurring, AIDS-related stigma cost many lives, and still survives. In 2007 Australia's immigration laws preclude most H.I.V. positive applicants from obtaining permanent residency in Australia (Komer, 2007). Stigmatisation aims to simultaneously identify and disempower those affected by H.I.V./ AIDS in order to define the "model citizen", and to protect and preserve social values.

## Hepatitis C related stigma

The stigma and discrimination familiar to many people living with H.I.V. / AIDS is, in some ways, being replayed, this time in the context of Hepatitis C where the villains are injecting drug users. Stigmatisation of illicit drug users has been a central tenet of global drug prohibition for almost a century (Levine, 2003). The stigma of illicit drug use taints all people affected by Hepatitis C.

Because of the way our society views - and criminalises - specific types of drug use, people are socialised into holding certain beliefs about illicit drug users - and by association people with hepatitis C - and many come to question their value as members of society (Fulton 1999). People with Hepatitis C are stereotyped as lacking social worth and as a danger to the community because they are likely to spread their negative characteristics to others.

Understanding of social phenomena are reflected in government policy. It has been observed by author Gary Hulse that in Australia Hepatitis C policy was slow to develop (Hulse 1997). One reason for this is the view that the virus is largely confined within injecting drug user populations and it was regarded as unlikely that hepatitis C would cross over into mainstream Australian society. Hulse argues that injecting drug users were perceived by the health bureaucracy as disorganised and that they did not constitute a "community" in the same sense as the gay community which had facilitated a rapid and efficient response during the early years of the H.I.V. epidemic. Hulse points out that power for making and informing public health policy concerning Hepatitis C shifted back to senior health bureaucrats and away from giving a role to affected communities (Hulse 1997). Since Hulse wrote his analysis in the mid 1990s, several things have changed; the national and state-based Hepatitis councils and drug user organisations have worked hard to reclaim the right of affected communities to represent their interests and to combat structural stigmatisation which endangers the development of relevant policy sensitive to the needs of a diverse population. As well, state government funding of initiatives has increased. Nonetheless, bureaucratic apathy concerning this epidemic remains at the federal level and this has contributed indirectly to Hepatitis C related stigma (Hulse 1997). A history of denial by Federal governments of the existence of this epidemic and those most affected by it

has contributed to increasing isolation and stigmatisation, and blame.

## Health has become more important than freedom

Increasingly, wealthy societies are making a distinction between "guilty" and "innocent" victims of some diseases and epidemics (Herek & Glunt 1988). Graham Scambler (2006), a British sociologist suggests that a series of well documented changes which has occurred since the early 1970s have had significant impact on how health-related stigma is seen and how notions of blame for personal health problems have been increasing. Scambler describes the significant changes imposed by globalisation of the world economies and the rise of a "new" regime of capital accumulation and its class relations; changes which profoundly altered nation - states:

... abilities to regulate their economies. These changes have delivered a culture ideology of consumerism, and neo-liberal policies of privatisation have been pursued by governments of both the left and the right during this period, particularly in the domain of health. State responsibility for the health and welfare of its citizens is being divested to the individual and it is not uncommon to hear health ministers today adopt discourses which emphasise the virtue and significance of personal responsibility in the maintenance of health. A consumer movement of healthism has emerged in the West during this period whereby individuals are implored to be personally responsible for their health, for example by exercising, attending to diet and ceasing smoking - (Crawford, 1980).

The upshot of these changes is that blame is attached to the shame which defines health-related stigma. Individuals or groups of people whose lifestyle practices are perceived as constituting a personal or community health risk are at best understood as a drain on resources and at worst a threat to civilisation, and often both. If a condition is understood to be the result of an individual's own actions, then those affected are likely to be viewed adversely and discriminated against (Jones et al. 1984). Because injecting and unprotected sex are seen as voluntary behaviours, the community often positions people with Hepatitis C and H.I.V. as responsible for their own illness, justifying their exclusion from society's concerns.

## Conclusion

To conclude this brief overview, stigma is an important factor in consideration of social and health policy and for clinical practice. To address the impacts of stigma on health, research, policy and practice need to take account of both the disease and the culture-specific aspects of stigma, that is, whose interest's does stigma serve?

Stigmatisation is a socially adaptive process whereby certain groups can assert power by reinforcing specific cultural norms and values. Therefore, efforts to reduce stigma need to be cognizant of the power effects of - shaming and blaming - and work within this understanding in order to secure improvements in the health and quality of life of affected people.

## References

- Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug & Alcohol Dependence*, 88, 188-196.
- Crawford, R. (1980). Healthism and the medicalisation of everyday life. *International Journal of Health Services*, 10, 365-388.
- Crimp, D. (1987). *AIDS: Cultural analysis, cultural activism*. (Ed.) D. Crimp, Cambridge, Massachusetts: M.I.T. Press: 3-16.
- Fulton, R. (1999). [The stigma of substance use: a review of the literature](#). Centre for Addiction and Mental Health, Toronto, Canada. [accessed online 8th February 2003].
- Gilmore, N. & Somerville, M.A. (1994). Stigmatisation, scapegoating and discrimination in sexually transmitted diseases: overcoming "them" and "us". *Social Science and Medicine*, 39, 1339-1358.
- Goffman, E. (1968). *Stigma. Notes on the management of spoiled identity*. Harmondsworth, England: Penguin.
- Herek, G.M. & Glunt, E.K. (1988). An epidemic of stigma: public reactions to AIDS. *American Psychologist*, 43, 886-891.
- Hulse, G.K. (1997). Australia's public health response to H.I.V. and H.C.V.: a role for "affected" communities. *Drug and Alcohol Review*, 16, 171-176.
- Jones, E.E. (1984). *Social stigma: the psychology of marked relationships*. New York: W.H. Freeman.
- Komer, H. (2007). "If I had my residency I wouldn't worry": Negotiating migration and H.I.V. in Sydney, Australia. *Ethnicity and Health*, 12, 205-225.
- Levine, H.G. (2003). Global drug prohibition: Its uses and crises. *The International Journal of Drug Policy*, 14, 145-153.
- Malcolm, A., Aggleton, P., Bronfman, M., Galvao, J., Mane, P. & Verrall, J. (1998). H.I.V.-related stigmatization and discrimination: its forms and contexts, *Critical Public Health*, 8, 347-370.
- Pittam, J. & Gallois, C. (2000). Malevolence, stigma, and social distance: Maximizing intergroup differences in H.I.V. / AIDS discourse. *Journal of Applied Communication Research*, 28(1),24-43.
- Scambler, G. (2006). Sociology, social structure and health-related stigma. *Psychology, Health and Medicine*, 11, 288-295.
- Sontag, S. (1989). *AIDS and its metaphors*. New York: Farrar, Straus and Giroux.
- Turner, C.F., Miller, H.G. & Moses, L.E. (Eds.) (1989). *AIDS: Sexual behaviour and intravenous drug use*. Committee on AIDS Research and the behavioural, Social and Statistical Sciences, Commission on behavioural and Social Sciences and Education, National Research Council. Washington D.C.: National Academy Press.

## Dr. Max Hopwood

From the University of New South Wales website:  Dr. Max Hopwood B.A. (Hons) PhD. is a Research Fellow at the National Centre in H.I.V. Social Research at the University of New South Wales. He is a social psychologist with an interest in hepatitis C, H.I.V., chronic illness, illicit drug use, harm reduction and international and national drug policy. His work includes mixed-method research designs which he has used to explore phenomena related to quality of life for people living with blood borne viral infections, including the impact of stigma and discrimination on health and identity.



Polare Magazine is published quarterly in Australia by The Gender Centre I<sub>nc.</sub>, which is funded by the Department of Family & Community Services under the S.A.A.P. program and supported by the N.S.W. Health Department through the AIDS and Infectious Diseases Branch. Polare provides a forum for discussion and debate on gender issues. Unsolicited contributions are welcome, the editor reserves the right to edit such contributions without notification. Any submission which appears in Polare may be published on our internet site. Opinions expressed in this publication do not necessarily reflect those of the Editor, The Gender Centre I<sub>nc.</sub>, the Department of Family & Community Services or the N.S.W. Department of Health.

The Gender Centre is committed to developing and providing services and activities, which enhance the ability of people with gender issues to make informed choices. We offer a wide range of services to people with gender issues, their partners, family members and friends in New South Wales. We are an accommodation service and also act as an education, support, training and referral resource centre to other organisations and service providers. The Gender Centre is committed to educating the public and service providers about the needs of people with gender issues. We specifically aim to provide a high quality service, which acknowledges human rights and ensures respect and confidentiality.