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Structural Stigma and Population Health -- A special issue of Social Science and Medicine

2014-02-13 04:16:20

By Aaron Seaman

The current issue of Social Science and Medicine is a special issue, entitled “Structural Stigma and Population Health.” A wide-ranging issue, spanning disciplines, methodological approaches, bodily conditions, and countries, it is well worth checking out. As editors Mark Hatzenbuehler and Bruce Link write in their introduction, the issue grows out of work done by the Structural Stigma and Population Health Working Group at Columbia University:

> 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.

The issue is organized around four thematic areas presented below, along with articles and abstracts:

Conceptualizing Structural Stigma

Systemic racism and U.S. health care
Joe Feagin and Zinobia Bennefield

> This article draws upon a major social science theoretical approach–systemic racism theory–to assess decades of empirical research on racial dimensions of U.S. health care and public health

institutions. From the 1600s, the oppression of Americans of color has been systemic and rationalized using a white racial framing–with its constituent racist stereotypes, ideologies, images, narratives, and emotions. We review historical literature on racially exploitative medical and public health practices that helped generate and sustain this racial framing and related structural discrimination targeting Americans of color. We examine contemporary research on racial differentials in medical practices, white clinicians' racial framing, and views of patients and physicians of color to demonstrate the continuing reality of systemic racism throughout health care and public health institutions. We conclude from research that institutionalized white socioeconomic resources, discrimination, and racialized framing from centuries of slavery, segregation, and contemporary white oppression severely limit and restrict access of many Americans of color to adequate socioeconomic resources–and to adequate health care and health outcomes. Dealing justly with continuing racial "disparities" in health and health care requires a conceptual paradigm that realistically assesses U.S. society's white-racist roots and contemporary racist realities. We conclude briefly with examples of successful public policies that have brought structural changes in racial and class differentials in health care and public health in the U.S. and other countries.

Stigma, status, and population health

Jo C. Phelan, Jeffrey W. Lucas, Cecilia L. Ridgeway, and Catherine J. Taylor

Stigma and status are the major concepts in two important sociological traditions that describe related processes but that have developed in isolation. Although both approaches have great promise for understanding and improving population health, this promise has not been realized. In this paper, we consider the applicability of status characteristics theory (SCT) to the problem of stigma with the goal of better understanding social systemic aspects of stigma and their health consequences. To this end, we identify common and divergent features of status and stigma processes. In both, labels that are differentially valued produce unequal outcomes in resources via culturally shared expectations associated with the labels; macro-level inequalities are enacted in micro-level interactions, which in turn reinforce macro-level inequalities; and status is a key variable. Status and stigma processes also differ: Higher- and lower-status states (e.g., male and female) are both considered normal, whereas stigmatized characteristics (e.g., mental illness) are not; interactions between

status groups are guided by “social ordering schemas” that provide mutually agreed-upon hierarchies and interaction patterns (e.g., men assert themselves while women defer), whereas interactions between “normals” and stigmatized individuals are not so guided and consequently involve uncertainty and strain; and social rejection is key to stigma but not status processes. Our juxtaposition of status and stigma processes reveals close parallels between stigmatization and status processes that contribute to systematic stratification by major social groupings, such as race, gender, and SES. These parallels make salient that stigma is not only an interpersonal or intrapersonal process but also a macro-level process and raise the possibility of considering stigma as a dimension of social stratification. As such, 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.

Stigma power
Bruce G. Link and Jo Phelan

When people have an interest in keeping other people down, in or away, stigma is a resource that allows them to obtain ends they desire. We call this resource “stigma power” and use the term to refer to instances in which stigma processes achieve the aims of stigmatizers with respect to the exploitation, control or exclusion of others. We draw on Bourdieu, 1987 and Bourdieu, 1990 who notes that power is often most effectively deployed when it is hidden or “misrecognized.” To explore the utility of the stigma-power concept we examine ways in which the goals of stigmatizers are achieved but hidden in the stigma coping efforts of people with mental illnesses. We developed new self-report measures and administered them to a sample of individuals who have experienced mental illness to test whether results are consistent with the possibility that, in response to negative societal conceptions, the attitudes, beliefs and behaviors of people with psychosis lead them to be concerned with staying in, propelled to stay away and induced to feel downwardly placed – precisely the outcomes stigmatizers might desire. Our introduction of the stigma-power concept carries the possibility of seeing stigmatizing circumstances in a new light.

Measuring and Modeling Structural Stigma as a Risk Indicator for Poor Health

Structural stigma and all-cause mortality in sexual minority populations
Mark L. Hatzenbuehler, Anna Bellatorre, Yeonjin Lee, Brian K. Finch, Peter Muennig, and Kevin Fiscella

Stigma operates at multiple levels, including intrapersonal appraisals (e.g., self-stigma), interpersonal events (e.g., hate crimes), and structural conditions (e.g., community norms, institutional policies). Although prior research has indicated that intrapersonal and interpersonal forms of stigma negatively affect the health of the stigmatized, few studies have addressed the health consequences of exposure to structural forms of stigma. To address this gap, we investigated whether structural stigma—operationalized as living in communities with high levels of anti-gay prejudice—increases risk of premature mortality for sexual minorities. We constructed a measure capturing the average level of anti-gay prejudice at the community level, using data from the General Social Survey, which was then prospectively linked to all-cause mortality data via the National Death Index. Sexual minorities living in communities with high levels of anti-gay prejudice experienced a higher hazard of mortality than those living in low-prejudice communities (Hazard Ratio [HR] = 3.03, 95% Confidence Interval [CI] = 1.50, 6.13), controlling for individual and community-level covariates. This result translates into a shorter life expectancy of approximately 12 years (95% C.I.: 4–20 years) for sexual minorities living in high-prejudice communities. Analysis of specific causes of death revealed that suicide, homicide/violence, and cardiovascular diseases were substantially elevated among sexual minorities in high-prejudice communities. Strikingly, there was an 18-year difference in average age of completed suicide between sexual minorities in the high-prejudice (age 37.5) and low-prejudice (age 55.7) communities. These results highlight the importance of examining structural forms of stigma and prejudice as social determinants of health and longevity among minority populations.

Structural racism and myocardial infarction in the United States
Alicia Lukachko, Mark L. Hatzenbuehler, and Katherine M. Keyes

There is a growing research literature suggesting that racism is an important risk factor undermining the health of Blacks in the United States. Racism can take many forms, ranging from interpersonal interactions to institutional/structural conditions and practices. Existing research, however, tends to focus on individual forms of racial discrimination using self-report measures. Far less attention has been paid to whether structural racism may disadvantage the

health of Blacks in the United States. The current study addresses gaps in the existing research by using novel measures of structural racism and by explicitly testing the hypothesis that structural racism is a risk factor for myocardial infarction among Blacks in the United States. State-level indicators of structural racism included four domains: (1) political participation; (2) employment and job status; (3) educational attainment; and (4) judicial treatment. State-level racial disparities across these domains were proposed to represent the systematic exclusion of Blacks from resources and mobility in society. Data on past-year myocardial infarction were obtained from the National Epidemiologic Survey on Alcohol and Related Conditions (non-Hispanic Black: N = 8245; non-Hispanic White: N = 24,507), a nationally representative survey of the U.S. civilian, non-institutionalized population aged 18 and older. Models were adjusted for individual-level confounders (age, sex, education, household income, medical insurance) as well as for state-level disparities in poverty. Results indicated that Blacks living in states with high levels of structural racism were generally more likely to report past-year myocardial infarction than Blacks living in low-structural racism states. Conversely, Whites living in high structural racism states experienced null or lower odds of myocardial infarction compared to Whites living in low-structural racism states. These results raise the provocative possibility that structural racism may not only harm the targets of stigma but also benefit those who wield the power to enact stigma and discrimination.

[Physiological stress response to loss of social influence and threats to masculinity]
Catherine J. Taylor

Social influence is an important component of contemporary conceptualizations of masculinity in the U.S. Men who fail to achieve masculinity by maintaining social influence in the presence of other men may be at risk of stigmatization. As such, men should be especially likely to exhibit a stress response to loss of social influence in the presence of other men. This study assesses whether men who lose social influence exhibit more of a stress response than men who gain social influence, using data collected in a laboratory setting where participants were randomly assigned into four-person groups of varying sex compositions. The groups were videotaped working on two problem-solving tasks. Independent raters assessed change in social influence using a well-validated measure borrowed from experimental work in the Status Characteristics Theory tradition. Cortisol is used as a

measure of stress response because it is known to increase in response to loss of social esteem. Results show that young men who lose social influence while working with other young men exhibit cortisol response. In contrast women do not exhibit cortisol response to loss of social influence, nor do men working with women. Results are consistent with the hypothesis that loss of social influence in men may be associated with a physiological stress response because maintaining social influence is very important to men while in the presence of other men. This physiological response to loss of social influence underscores the importance to men of achieving masculinity through gaining and maintaining social influence, and avoiding the stigma associated with the failure to do so.

Linking Macro and Micro

Public attitudes regarding individual and structural discrimination: Two sides of the same coin?
Matthias C. Angermeyer, Herbert Matschinger, Bruce G. Link, and Georg Schomerus

Public attitudes and beliefs are relevant to both individual and structural discrimination. They are a reflection of cultural conceptions of mental illness that form a reality that people must take into account when they enact behavior and policy makers must confront when making decisions. Understanding and keeping track of these attitudes is critical to understanding individual and structural discrimination. Theories of stigma posit that both forms of discrimination are distinct phenomena. Practically nothing is known about how attitudes regarding individual and structural discrimination relate. Our study addresses this gap by examining how attitudes toward allocating financial resources to the care of people with depression (structural discrimination) have developed over the last decade in Germany, compared to the public's desire for social distance from these people (individual discrimination). Previous studies have shown the public being more ready to accept cutbacks for the care for mentally ill persons than for medically ill persons. These preferences could have changed with regard to depression, since there is a growing awareness among the German public of an "epidemic of depression". The idea of a high prevalence of depression may have led to a heightened perception of personal susceptibility for this disorder, making the public become more reluctant to accept cutbacks for the care of people with depression. On the other hand, there is reason to assume that the growing awareness of high prevalence of

depression among the general public has not affected individual discrimination of persons suffering from this disorder. The two assumptions were tested comparing data from population surveys conducted in Germany in 2001 and 2011. Within ten years, the proportion of respondents who opposed cutting money from depression treatment tripled from 6% to 21%. In contrast, the public's desire for social distance from persons with depression remained unchanged. Moreover, both trends proved to be independent from each other. Our findings suggest that attitudes relevant to structural and individual discrimination are not necessarily linked together and may lead to divergent results. This means that a comprehensive understanding of stigma must consider both forms of discriminating attitudes together. Studying both simultaneously may deepen our understanding of each and point to novel ways to produce change.

[The influence of structural stigma and rejection sensitivity on young sexual minority men's daily tobacco and alcohol use]
John E. Pachankis, Mark L. Hatzenbuehler, and Tyrel J. Starks

Stigma occurs at both individual and structural levels, but existing research tends to examine the effect of individual and structural forms of stigma in isolation, rather than considering potential synergistic effects. To address this gap, our study examined whether stigma at the individual level, namely gay-related rejection sensitivity, interacts with structural stigma to predict substance use among young sexual minority men. Sexual minority (n = 119) participants completed online measures of our constructs (e.g., rejection sensitivity). Participants currently resided across a broad array of geographic areas (i.e., 24 U.S. states), and had attended high school in 28 states, allowing us to capture sufficient variance in current and past forms of structural stigma, defined as (1) a lack of state-level policies providing equal opportunities for heterosexual and sexual minority individuals and (2) negative state-aggregated attitudes toward sexual minorities. To measure daily substance use, we utilized a daily diary approach, whereby all participants were asked to indicate whether they used tobacco or alcohol on nine consecutive days. Results indicated that structural stigma interacted with rejection sensitivity to predict tobacco and alcohol use, and that this relationship depended on the developmental timing of exposure to structural stigma. In contrast, rejection sensitivity did not mediate the relationship between structural stigma and substance use. These results suggest that psychological predispositions, such as rejection sensitivity, interact with features of the social environment, such as structural stigma,

to predict important health behaviors among young sexual minority men. These results add to a growing body of research documenting the multiple levels through which stigma interacts to produce negative health outcomes among sexual minority individuals.

[Pathologizing poverty: New forms of diagnosis, disability, and structural stigma under welfare reform]
Helena Hansen, Philippe Bourgois, and Ernest Drucker

In 1996 the U.S. severely restricted public support for low income people, ending “welfare as we know it.” This led to dramatic increases in medicalized forms of support for indigent people, who increasingly rely on disability benefits justified by psychiatric diagnoses of chronic mental illness. We present case studies drawn from ethnographic data involving daily participant-observation between 2005 and 2012 in public clinics and impoverished neighborhoods in New York City, to describe the subjective experience of structural stigma imposed by the increasing medicalization of public support for the poor through a diagnosis of permanent mental disability. In some cases, disability benefits enable recipients to fulfill important social roles (sustaining a vulnerable household and promoting stable parenting). The status of family members who receive a monthly disability check improves within their kin and neighborhood-based networks, counterbalancing the felt stigma of being identified by doctors as “crazy”. When a diagnosis of mental pathology becomes a valuable survival strategy constituting the basis for fulfillment of household responsibilities, stigmatizing processes are structurally altered. Through the decades, the stigmatized labels applied to the poor have shifted: from being a symptom of racial weakness, to the culture of poverty, and now to permanent medical pathology. The neoliberal bureaucratic requirement that the poor must repeatedly prove their “disabled” status through therapy and psychotropic medication appears to be generating a national and policy-maker discourse condemning SSI malingerers, resurrecting the 16th century specter of the “unworthy poor”.

[“What matters most:” A cultural mechanism moderating structural vulnerability and moral experience of mental illness stigma]
Lawrence H. Yang, Fang-pei Chen, Kathleen Janel Sia, Jonathan Lam, Katherine Lam, Hong Ngo, Sing Lee, Arthur Kleinman, and Byron Good

To understand Chinese immigrants’ experiences with mental

illness stigma and mental health disparities, we integrate frameworks of ‘structural vulnerability’ and ‘moral experience’ to identify how interaction between structural discrimination and cultural engagements might shape stigma. Fifty Chinese immigrants, including 64% Fuzhounese immigrants who experienced particularly harsh socio-economical deprivation, from two Chinese bilingual psychiatric inpatient units in New York City were interviewed from 2006 to 2010 about their experiences of mental illness stigma. Interview questions were derived from 4 stigma measures, covering various life domains. Participants were asked to elaborate their rating of measure items, and thus provided open-ended, narrative data. Analysis of the narrative data followed a deductive approach, guided by frameworks of structural discrimination and “what matters most” – a cultural mechanism signifying meaningful participation in the community. After identifying initial coding classifications, analysis focused on the interface between the two main concepts. Results indicated that experiences with mental illness stigma were contingent on the degree to which immigrants were able to participate in work to achieve “what mattered most” in their cultural context, i.e., accumulation of financial resources. Structural vulnerability – being situated in an inferior position when facing structural discrimination – made access to affordable mental health services challenging. As such, structural discrimination increased healthcare spending and interfered with financial accumulation, often resulting in future treatment nonadherence and enforcing mental health disparities. Study participants’ internalizing their structurally-vulnerable position further led to a depreciated sense of self, resulting in a reduced capacity to advocate for healthcare system changes. Paradoxically, the multi-layered structural marginalization experienced by Chinese immigrants with mental illness allowed those who maintained capacity to work to retain social status even while holding a mental illness status. Mental health providers may prioritize work participation to shift service users’ positions within the hierarchy of structural vulnerability.

Self-regulatory processes underlying structural stigma and health
Laura Smart Richman and Micah R. Lattanner

In this article, we examine self-regulatory processes that are initiated by structural stigma. To date, the literature on self-regulation as a mechanism that underlies stigma and health outcomes has focused primarily on harmful health-related behaviors that are associated with perceived discrimination. Numerous studies find that when people experience discrimination,

they are more likely to engage in behaviors that pose risks for health, such as overeating and substance use. However, a large body of literature also finds that low power – which is also a chronic, though often more subtle, experience for stigmatized groups – is associated with a heightened activation of inhibitory processes. This inhibition system has wide-ranging influences on cognition, behavior, and affect. We provide an overview of these two literatures, examine synergies, and propose potential implications for measurement and research design.

Reducing Structural Stigma

Intervening within and across levels: A multilevel approach to stigma and public health
Jonathan E. Cook, Valerie Purdie-Vaughns, Ilan H. Meyer, Justin T.A. Busch

This article uses a multilevel approach to review the literature on interventions with promise to reduce social stigma and its consequences for population health. Three levels of an ecological system are discussed. The intrapersonal level describes interventions directed at individuals, to either enhance coping strategies of people who belong to stigmatized groups or change attitudes and behaviors of the non-stigmatized. The interpersonal level describes interventions that target dyadic or small group interactions. The structural level describes interventions directed at the social-political environment, such as laws and policies. These intervention levels are related and they reciprocally affect one another. In this article we review the literature within each level. We suggest that interventions at any level have the potential to affect other levels of an ecological system through a process of mutually reinforcing reciprocal processes. We discuss research priorities, in particular longitudinal research that incorporates multiple outcomes across a system.

Competing perspectives on erasing the stigma of illness: What says the dodo bird?
Patrick W. Corrigan and Mandy W.M. Fong

The dodo bird is an Alice in Wonderland character who, at the end of a race, concludes “Everybody has won and all must have prizes”. The dodo bird effect has been used to describe a conundrum resulting from behavior change research that fails to distinguish superiority among discrete strategies for

psychotherapeutic change. Research on stigma change may find itself at this point. Advocates have developed and implemented multiple approaches to changing stigma; some of these might be shown to have more beneficial impact than others. The mental health community has been especially active in tackling stigma, so many of the examples herein come from the corresponding body of research. We divide the multiple approaches to stigma change into sets of competing or complementary perspectives and examine both the benefits and the negative unintended consequences of examples. We consider the effects of education versus contact on stigmatizers (public stigma), the stigmatized (self-stigma), and the social sphere in which the two groups engage (structural stigma). Stigma impact varies by targets and outcomes so we examine impact on knowledge versus attitudes at the population versus grassroots levels. Overall, we found that effects of contact seem greater than education for stigmatizers. For the stigmatized, approaches that target eliminating self-stigma may be less beneficial than interventions designed to promote disclosure. Targeting grassroots may yield greater impact than population-based approaches. Increasing knowledge and pity may yield unintended consequences which may undermine life opportunities of people with the illness. Our review highlighted the benefits of competing perspectives in advancing our understanding of stigma change and crafting of more effective anti-stigma interventions.

[HIV prevention interventions to reduce sexual risk for African Americans: The influence of community-level stigma and psychological processes]
Allecia E. Reid, John F. Dovidio, Estrellita Ballester, and Blair T. Johnson

Interventions to improve public health may benefit from consideration of how environmental contexts can facilitate or hinder their success. We examined the extent to which efficacy of interventions to improve African Americans' condom use practices was moderated by two indicators of structural stigma—Whites' attitudes toward African Americans and residential segregation in the communities where interventions occurred. A previously published meta-analytic database was re-analyzed to examine the interplay of community-level stigma with the psychological processes implied by intervention content in influencing intervention efficacy. All studies were conducted in the United States and included samples that were at least 50% African American. Whites' attitudes were drawn from the American National Election Studies, which collects data from nationally representative samples. Residential segregation was drawn from

published reports. Results showed independent effects of Whites' attitudes and residential segregation on condom use effect sizes. Interventions were most successful when Whites' attitudes were more positive or when residential segregation was low. These two structural factors interacted: Interventions improved condom use only when communities had both relatively positive attitudes toward African Americans and lower levels of segregation. The effect of Whites' attitudes was more pronounced at longer follow-up intervals and for younger samples and those samples with more African Americans. Tailoring content to participants' values and needs, which may reduce African Americans' mistrust of intervention providers, buffered against the negative influence of Whites' attitudes on condom use. The structural factors uniquely accounted for variance in condom use effect sizes over and above intervention-level features and community-level education and poverty. Results highlight the interplay of social identity and environment in perpetuating intergroup disparities. Potential mechanisms for these effects are discussed along with public health implications.

Structural competency: Theorizing a new medical engagement with stigma and inequality
Jonathan M. Metzl and Helena Hansen

This paper describes a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. It reviews existing structural approaches to stigma and health inequalities developed outside of medicine, and proposes changes to U.S. medical education that will infuse clinical training with a structural focus. The approach, termed "structural competency," consists of training in five core competencies: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating "cultural" formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility. Examples are provided of structural health scholarship that should be adopted into medical didactic curricula, and of structural interventions that can provide participant-observation opportunities for clinical trainees. The paper ultimately argues that increasing recognition of the ways in which social and economic forces produce symptoms or methylate genes then needs to be better coupled with medical models for structural change.

AMA citation
Seaman A. Structural Stigma and Population Health -- A special issue of Social Science and Medicine. *Somatosphere*. 2014. Available at: http://somatosphere.net/?p=7161. Accessed February 13, 2014.

APA citation
Seaman, Aaron. (2014). *Structural Stigma and Population Health -- A special issue of Social Science and Medicine*. Retrieved February 13, 2014, from Somatosphere Web site: http://somatosphere.net/?p=7161

Chicago citation
Seaman, Aaron. 2014. Structural Stigma and Population Health -- A special issue of Social Science and Medicine. Somatosphere. http://somatosphere.net/?p=7161 (accessed February 13, 2014).

Harvard citation
Seaman, A 2014, *Structural Stigma and Population Health -- A special issue of Social Science and Medicine*, Somatosphere. Retrieved February 13, 2014, from <http://somatosphere.net/?p=7161>

MLA citation
Seaman, Aaron. "Structural Stigma and Population Health -- A special issue of Social Science and Medicine." 13 Feb. 2014. Somatosphere. Accessed 13 Feb. 2014.<http://somatosphere.net/?p=7161>