



The Grand Challenge of Promoting Equality by Addressing Social Stigma

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Grand Challenge 11: Achieve Equal Opportunity and Justice

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The Grand Challenges for Social Work are designed to focus a world of thought and action on the most compelling and critical social issues of our day. Each grand challenge is a broad but discrete concept where social work expertise and leadership can be brought to bear on bold new ideas, scientific exploration and surprising innovations.

We invite you to review the following challenges with the goal of providing greater clarity, utility and meaning to this roadmap for lifting up the lives of individuals, families and communities struggling with the most fundamental requirements for social justice and human existence.

The Grand Challenges for Social Work include the following:

1. Ensure healthy development of all youth
2. Close the health gap
3. Stop family violence
4. Eradicate social isolation
5. End homelessness
6. Promote smart decarceration
7. Reduce extreme economic inequality
8. Build financial capability for all
9. Harness technology for social good
10. Create social responses to a changing environment
11. Achieve equal opportunity and justice
12. Advance long and productive lives

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Working Paper



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Jeremy T. Goldbach, Hortensia Amaro, William Vega, and Michael D. Walter

A common concern of social work is populations that experience significant social disadvantage, inequality, and stigma. Socially disenfranchised groups (e.g., racial or ethnic minorities, sexual minorities, those with psychiatric or physical disabilities, older adults) are associated with poverty, poor health outcomes, and behavioral health disparities. Although these groups face unique challenges, stigma is commonly cited as a driving force that perpetuates disadvantage and social inequality across populations. To date, however, research on stigma has been conducted across diverse populations in parallel but has rarely been the focus of research independent of a specific health outcome of interest (Hatzenbuehler et al., 2013). This single population focus has limited our understanding of stigma as a causal process and led to a lack of large-scale stigma-focused interventions.

In this paper, we argue that significant progress can be made by reconceptualizing stigma as a fundamental cause of social disadvantage (Hatzenbuehler, Phelan, & Link, 2013). Given its ability to conduct clinical, social, and policy intervention research across diverse and interrelated settings, social work has the capacity to address social stigma as a fundamental cause of inequality. Relying upon three theoretical frameworks to understand stigma and guide its recommendations (Goffman, 1963; Phelan, Link, and Tehranifar, 2010; Hatzenbuehler et al., 2013) a fundamental paradigm shift has the power to overcome stigma broadly and provide nation-changing opportunities to improve the lives of stigmatized individuals and groups.

Key words: stigma, grand challenges, social work, equity

BACKGROUND

Social stigma negatively affects members of a wide array of societally marginalized and disenfranchised groups. Negative labeling and inequitable social partitioning of groups, whether by birth or acquisition, results in social disadvantage and a loss of opportunities throughout life. Social stigma involves attribution of such negative aspects to a person or group based on characteristics that others perceive as undesirable and distinguishing them from society. Link and Phelan (2001) defined stigma as the co-occurrence of interrelated components of labeling,

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stereotyping, separating, emotional reaction, status loss and discrimination. Social stigma is not a novel concept. More than 50 years ago, Goffman (1963) identified three universal forms of social stigma: those resulting from “overt, external deformities” (e.g., obesity, health complications), “known deviations in personal traits” (e.g., mental illness, addiction, criminal history, homosexuality, poverty), and “tribal stigma” (e.g., race, ethnicity, gender, religion). Goffman’s conceptualization and labels are outdated and arguably stigmatizing themselves, yet they identify critical social aspects of various stigmatized populations.

Stigmatization is a process that begins with groups being identified and ascribed negative characteristics or stereotypes (Corrigan, 2004) stemming from the exercise of power of a dominant group over less powerful groups (Link & Phelan, 2001). Society forms negative stereotypes about a particular group based on generalizations, misinformation, attitudes, and beliefs. This stigma results in blame, prejudice, and discrimination against the stigmatized group, which is manifested through overt or covert words, actions, or policies, whether conscious or unconscious. This social stigmatization can then be internalized by individuals in the stigmatized group, resulting in self-stigma, whereby an internalized societal view of a group norm adversely influences self-perception (Corrigan & Watson, 2002). Stigma affects the life opportunities of individuals and groups, including health outcomes, housing opportunities, academic achievement, income, and the likelihood of criminal involvement (Link & Phelan, 2001; Major & O’Brien, 2005).

Stigma produces inequality through broad mechanisms. Link and colleagues (2014) identified four: (1) direct person-to-person discrimination; (2) discrimination that operates through the internalization of negative ascriptions among stigmatized individuals (i.e., self-stigma); (3) interactional discrimination involving the perceptions of stigmatized individuals; and (4) structural discrimination. These four mechanisms map closely to traditional social work research, education, and practice paradigms, including ecological systems theory (Bronfenbrenner, 1979) and risk and resilience (Hawkins, Catalano, & Miller, 1992). However, despite significant evidence of a relationship between social stigma and inequality across numerous populations common in social work (described in the following section), research has tended to move forward with these disparate groups in discrete silos. Historical misconceptualizations of the role of stigma have confounded cause and effect and led to an underestimation of stigma; stigma is too often viewed as simply a proximal contributor to health outcomes rather than as a fundamental or root cause of inequities and disparate social outcomes (Hatzenbuehler et al., 2013).

Separately from work on social stigma, some scholars have examined what are known as fundamental causes of health outcomes (Link & Phelan, 1995; Phelan et al., 2010). This approach suggests that poor health conditions persist in some populations despite prevention and treatment efforts because of underlying social and structural conditions. Fundamental causes have four key characteristics: (1) they influence multiple disease outcomes; (2) they affect disease outcomes through multiple risk factors; (3) they involve access to resources that can be used to avoid risk or minimize the consequences of disease once they occur; and (4) the association between the fundamental cause and health is reproduced over time (Phelan et al.,

2010). Most commonly, the persistent influence of low socioeconomic status on health across numerous populations has led thought leaders to categorize it as a fundamental cause of health inequality (Phelan et al., 2010). Like those of lower socioeconomic status, individuals who belong to a socially stigmatized group are granted fewer opportunities and thus experience inequality across numerous domains (Sernau, 2014). In rethinking stigma as a fundamental cause of health inequality, and promoting research on stigma *as a unique contributor that warrants both etiological and intervention research*, the next generation of social workers can be aligned more effectively to employ strategies that broadly address stigma—creating a dramatic impact on the health of many groups.

STIGMA AS A COMPELLING CASE FOR FOCUSING SOCIAL WORK

As noted, social inequality occurs when resources are distributed across a society or among specific classes of people inequitably, through norms of allocation based on socially defined categories. Membership in these categories based on negative socially ascribed characteristics conveys an implicit *status stigma* of inferiority. Marrying this general construct to Goffman's (1963) universal forms of social stigma clearly highlights populations of critical public interest because they are unable to benefit from otherwise available opportunities. Although we recognize that social inequality and stigma are not a uniquely American experience, given the importance of social status and position in allocation of resources, we focus the present grand challenge on the United States. Furthermore, there are dozens of populations that experience social stigma, inequality, and marginalization in the United States. Thus the social categories described here are not meant to be exhaustive but rather illustrative of the detrimental effects of social inequality and associated stigma on vulnerable populations that are of central interest to social work research and intervention. We believe that nearly any social work academic or practitioner will readily see how changing this power dynamic in a fundamental way would have significant implications for their own population of focus.

Race and Ethnicity

When compared to their non-Hispanic White peers, Hispanic and Black youth are at substantially higher risk of a host of health problems including unplanned pregnancy, HIV, substance use, alcoholism, and mental health concerns including depression, distress, and suicide. Researchers have commonly attributed these poor outcomes to lower socioeconomic opportunity and stigma-related stressors such as discrimination and racist victimization, commonly referred to as culturally based, acculturative, or race-based stress (e.g., Cervantes, Padilla, Napper, & Goldbach, 2013). The history of race relations in the United States is defined by a pattern of social and structural discrimination resulting from the stigmatization of populations of color, leading to slavery; Jim Crow laws; the targeted restriction of immigration from Latin American countries; systematic deportation that disparately affects undocumented immigrants of color; revocation of citizenship for U.S.-born Latinos; racialized discrimination in housing such as racial zoning, redlining, and racially restrictive deed covenants; and a criminal justice system that has created a system of mass incarceration disproportionately affecting people of color—to name just a few of the most salient examples (Omi & Winant, 2014).

Gender

A clear example of gender stigma is the persistent wage gap in the United States, where women working full time earn an average of only 78% of what men earn as recently as 2013 (Fisher, 2015). Women of color experience a larger wage deficit than White women, with Latinas earning as little as 56% compared to their White male counterparts (Fisher, 2015). Although factors such as occupation, hours worked and time spent in the labor force contribute to gender wage gaps, these differences reflect “significant structural and economic realities that limit women’s abilities to compete with men in the labor force, resulting in lower pay” (Fisher, 2015, p. 1). Furthermore, race and ethnicity also interact to affect the gender wage gap. A second example is gender-based violence, recognized worldwide as an outcome of women’s inequality (U.S. Agency for International Development, 2012; World Health Organization, 2009). Gender-based violence, particularly intimate partner violence, results in a significant social cost and negative mental health and health outcomes among women and their children, families, and communities (Tjaden & Thoennes, 2000; Ulibarri, Sumner, Cyriac, & Amaro, 2010; U.S. Agency for International Development, 2012; World Health Organization, 2009). Gender inequity stemming from lower status ascribed to women, whether at the level of society, family, community, or culture, is recognized as the root cause of violence toward women.

The stigma associated with professional women taking time off from work to care for children or other family members negatively affects their career opportunities; such women encounter barriers to resuming their careers after family leave (Hewlett & Luce, 2005). Similarly, men who request family leave to engage in child care often suffer from a femininity stigma—being viewed as less masculine and, possibly, passed over for promotions and raises (Rudman & Mescher, 2013).

Lesbian, Gay, Bisexual, and Transgender

Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals report higher rates of internalizing psychopathology including depression, anxiety, and self-harm and externalizing behaviors such as substance use, HIV risk behavior, suicidal ideation, and suicide attempts than their heterosexual peers. Heterosexism and other forms of sexual stigma have numerous negative consequences for LGBT individuals, including negative stereotypes and societal prejudice against gay rights (e.g., marriage and adoption), family abandonment, violence, and internalized homophobia and self-hatred (Herek, 2004). Gender-based discrimination against transgender individuals has also been found to result in alarmingly high rates of physical (36%) and verbal (83%) gender victimization, rape (59%), and attempted suicide (32%) in the transgender community (Clements-Nolle, Marx, & Katz, 2006).

In 2011, an Institute of Medicine report on the health of LGBT individuals noted that “clinicians and researchers are faced with incomplete information about their health status” (p. 1). In part, the report acknowledged that discrimination and marginalization has contributed to a lack of knowledge about LGBT individuals, resulting in a need for (a) demographic markers; (b) research on the social influences of poor health among LGBT individuals; (c) research on

numerous health care inequalities; (d) intervention research; and (e) transgender-specific health needs research.

Immigration

Although the United States is a nation of immigrants, throughout history new immigrant groups have faced significant stigma and structural barriers to equality (McGouldrick & Tannen, 1977; Sowell, 1981). For example, early Irish and Italian immigrants faced significant discrimination and lack of access to jobs, housing, and social integration. Chinese immigrants, whose labor was responsible for building the early railroad system in our country, were denied equal status (Lyman, 1974). In contemporary society, this trend has manifested in negative attitudes and stigma toward new waves of immigrant groups, particularly those of lower socioeconomic status and racial and ethnic minority groups (Mayda, 2004). Such stigma has manifested in the misperception that immigrants overly rely on government goods and services, resulting in high costs to society. For example, contrary to the public perception that immigrants' use of health care is a driver of increasing health care costs, immigrant populations tend to be healthier than their native-born counterparts and underuse health care services (Ortega et al., 2007). Stigmatization of immigrants has led to decreased access to health care, in part because of a misplaced societal perception that immigrants create a strain on local resources and because many immigrants are reluctant to seek care because of worries that they will receive poorer treatment than nonimmigrant groups (Derose, Escarce, & Lurie, 2007).

Aging

The World Health Organization (2012) has declared “good health adds life to years” (p. 1). It is widely recognized that adverse life experiences including economic deprivation, social marginality, and poor living conditions are predictive of both chronic disease risk and lower levels of functioning in later life (Deary & Gow, 2008; Shonkoff, Boyce, & McEwen, 2009). Evidence has suggested that aging well begins in childhood, because the living conditions of early life are associated with positive development and the odds of aging well or experiencing embedded effects on health across the life course (Brandt, Deindl, & Hank, 2012). Factors related to socioeconomic, including work circumstances and incarceration history, are also predictive of aging outcomes across adulthood (Britton, Shipley, Singh-Mannoux, & Marmot, 2008). Although staying cognitively and physically active is predictive of healthy aging, ageism and age-related stigma have deleterious effects on social behaviors, functioning and mobility, self-concept, and mental health of many older people (Reynolds & Lim, 2013).

Disability

Researchers have long contended that disabilities among individuals are more than their physical or cognitive attributes, representing instead a set of experiences with social marginalization that further exacerbate the impact of a physical disability (Bickenbach, Chatterji, Badley, & Üstun, 1999; Oliver, 1990). Whether as children or adults, individuals with a physical disability are commonly stigmatized by their peers (Green, 1997; Harper, 1999). Individuals with a disability are commonly devalued and their peers without disabilities commonly expect their capacity to be

less (Green, 2007; Louvet, 2007; Weiserbs & Gottlieb, 2000). This stigma can be attached to an individual during childhood and dramatically affect life domains including psychological well-being and likelihood of transitioning successfully into adulthood social roles (Westervelt & Turnbull, 1980).

Obesity

There is little doubt that obese individuals experience social stigma and isolation (Puhl & Brownell, 2001). Furthermore, the health and behavioral health consequences of obesity are evident (Flegal, Carroll, Ogden, & Curtin, 2010). Weight stigma (against those who are overweight or obese) affects self-esteem, and the internalized negative self-perception of individuals who are overweight can result in them falsely attributing any negative feedback to their weight (Crocker, Cornwell, & Major, 1993). For overweight children, social stigma from peers, parents, and educators can lead to negative physical and emotional consequences, including decreased physical activity, depression, body dissatisfaction, disturbance in peer relationships, and suicidal behaviors (Puhl & Latner, 2007). Obesity also disproportionately affects minorities and individuals with lower education and environmental factors such as access to healthy and affordable foods, parks, and recreational facilities have a clear impact on the prevalence of obesity in a community (Flegal et al., 2010).

HIV/AIDS

Poverty, income inequality, and a lack of social capital and social connectedness have been associated with transmission of HIV/AIDS (Holtgrave & Crosby, 2003; Parker & Aggleton, 2003). People living with HIV/AIDS experience social, psychological, and cultural stigma related to their HIV status and this affects the course and trajectory of their disease, including getting tested for HIV, starting treatment, and staying connected to care. According to Alonzo and Reynolds (1995), stigma against this group “substantially reduces life chances by reducing the humanizing benefits of free and unfettered social intercourse” (p. 313). Furthermore, marginalization and discrimination are associated with higher risk of HIV transmission through misinformation (Herek, Capitano, & Widaman, 2002), the belief that one deserves to be infected with HIV (Goldin, 1994; Herek et al., 2002), and a *felt or fear of stigma* that discourages an individual from experiencing stigma such as through disclosure (Corrigan, Watson, & Barr, 2006; Herek, 2009).

Mental Illness and Addiction

Individuals with mental illness and substance abuse disorders are socially stigmatized (Hinshaw & Stier, 2008; Link & Phelan, 2001; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). Scholars have found that common stigmatizing beliefs exist for those with mental illness, including the belief that these individuals are dangerous, unable to achieve most life goals, and the cause of their own illness (Angermeyer & Dietrich, 2006; Rüsçh, Angermeyer, & Corrigan, 2005). Individuals with mental illness who are stigmatized experience decreased life satisfaction and higher levels of depression and anxiety (Markowitz, 1998), as well as lowered self-esteem and fewer social opportunities (Corrigan, 2004).

Stigma attached to mental illness and thus, to seeking mental health services contributes to avoidance of seeking needed mental health services (Stuck-Girard, 2014) because the very act of receiving mental health care is self-stigmatizing (Corrigan, Druss, & Perlick, 2014). The internalization of this stigma may represent a fundamental barrier to recovery (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001).

Homelessness

During the course of a year, nearly 1.49 million people, or approximately one of every 200 Americans, will experience homelessness for at least one night (U.S. Department of Housing and Urban Development, 2013). However, homelessness has a disproportionate impact on historically marginalized or stigmatized groups, including Blacks and individuals with mental illnesses and other disabilities (Culhane, Metraux, & Hadley, 2002), and has been correlated with social stigma (Kidd, 2007; Phelan, Link, Moore, & Stueve, 1997; Roschelle & Kaufman, 2004; Takahashi, 1997).

The aforementioned forms of stigma are not exhaustive; rather, they are illustrative of populations to which social scientists may have unique access in addressing the problem of social stigma. This is reason the challenge is so compelling for the profession to address. The effects of stigma manifest at all levels, from micro (e.g., self-stigma), to meso (e.g., families, communities, institutions, service providers), and to macro (e.g., on structural and cultural levels). Work to be done to reduce stigmatization is needed on every scale and in nearly every component of civic discourse.

A FRAMEWORK FOR RESEARCH, POLICY & PRACTICE IN THE NEXT 10 YEARS

Historical examples have suggested that addressing social stigma and inequality can occur through intervention. Women’s suffrage, the civil rights movement, voting acts, fair housing acts, the end of Don’t Ask, Don’t Tell, and marriage rights for LGBT individuals are examples of civic action strategies that arguably have pushed forward policies that promote equality and redistribution of resources to the benefit of marginalized populations. These approaches also have been somewhat successful in reducing social stigma. For example, after the passage of the Civil Rights Act of 1964, Black infant mortality rates dropped significantly (Almond, Chay, & Greenstone, 2006). Likewise, research preceding the repeal of Don’t Ask, Don’t Tell clearly indicated the policy’s impact on stigmatization, victimization, depression, anxiety, substance use, and feelings of isolation among LGBT service members (Burks, 2011; Estrada, Probst, Brown, & Graso, 2011; Moradi, 2009), and although related stigma is still evident (Mount, Steelman, & Hertlein, 2015), it may be slowly diminishing (Ramirez et al., 2013).

Scientific evidence foretells significant progress regarding reducing stigma. History demonstrates that some types of stigma—against divorced people, people becoming parents outside of marriage, and people with tattoos—have been markedly reduced (see Akerlof, Yellen, & Katz, 1996; Amato, 2010; Emery, 2011; Gerstel, 1987; Jones, 2000; Wegar, 2000). Lessons learned from these changes, social psychological research, and specifically constructed stigma reduction strategies all favor a positive outcome for tackling this challenge. Social movements are one way that the stigmatization process has been reversed in the past. The gay rights movement, for example, has been quite effective at transforming shame and guilt into righteous indignation and pride (Britt & Heise, 2000). Although stigmatization as a social process is unlikely to be fully eradicated, there is strong evidence to suggest that many specific forms can be eliminated or significantly reduced. Although a degree of stigma reduction may occur naturally over time for some groups without outside intervention, we discuss here currently available tools and the creation of new strategies that will help the accelerate the process of destigmatization for marginalized groups in the United States.

With regard to setting a research agenda toward overcoming stigma, several directions are promising. First, “big data” studies are necessary to understand how stigma manifests in the developmental sequence, presaging early pathways leading to health problems. Large-scale comparative studies are also needed to understand how stigma affects the onset of distinctive health, behavioral, and functional conditions (Weiss & Ramakrishna, 2006). Additionally, Link and colleagues (2014) described four mechanisms of social stigma that guide additional recommendations for research over the next 10 years on social stigma as a fundamental cause of health inequity.

Direct Discrimination and Discrimination that Operates through Individuals

Direct discrimination is the most commonly recognized form of discrimination, in which an individual chooses to provide or impede access to services because of another individual's socially ascribed stigmatized status. Research has indicated that stigma may be motivated by fear of contagion, moral judgment, an effort to exploit, or other factors (Phelan, Link, & Dovidio, 2008; Weiss & Ramakrishna, 2006), yet more research is needed to understand the effects of stigma as a direct predictor of opportunity inequality. For example, only one study has examined the relationship between obesity stigma and inequality (i.e., housing discrimination; Karris, 1977). More research is needed to elucidate the role of stigma in inequity and health, both in unique populations and across conditions.

Oftentimes, however, stigma operates through more subtle experiences such as expectations of rejection by others based on commonly held stereotypes (e.g., Black men are aggressive, lesbian women are butch) and fear of seeking help because of self-stigmatizing beliefs. These implicit biases (unconscious and unintentional) are insidious and pose a pervasive challenge to stigma reduction efforts. Perpetrators of stigmatization are often unaware of how they stigmatize others or themselves, with their implicit attitudes and actions often conflicting with their stated beliefs (Kirwan Institute for the Study of Race and Ethnicity, 2013). Individuals who know they belong to a group that faces prejudice may worry they will be judged stereotypically (i.e., stereotype threat; Steele & Aronson, 1995; Steele, Spencer, & Aronson, 2002). These stereotype expectations are correlated with increased stress, poor mental health and coping, and lower performance and career aspirations (Davies, Spencer, Quinn, & Gerhardtstein, 2002; Schmader, Johns, & Forbes, 2008; Steele et al., 2002). Implicit biases and their internalizing impacts have clear implications for educational, economic, and career opportunities (Cohen, Purdie-Vaughns, & Garcia, 2012), and research that focuses on reducing implicit bias and internalized stigma is necessary. Furthermore, this area of research may also elucidate the mechanisms by which individuals who are part of a stigmatized group choose to seek, engage, and remain in treatment (Link et al., 2001), thus affecting access to care.

Interactional Discrimination

This mechanism involves how individuals behave with those who are ascribed a stigmatized identity and how stigmatized identities affect social exchanges. An individual may act differently around others with a stigmatized identity, including manifestations of excessive kindness or subconscious superiority. Likewise, stigmatized individuals may act with less confidence or be less likely to speak or offer their opinion in the workplace, feeling silenced by their stigmatized identity (Amaro & Raj, 2000). For example, although Whites now commonly report more favorable opinions of Blacks (e.g., Dovidio, Brigham, Johnson, & Gaertner, 1996), they may still act in subtle, discriminatory ways. In the literature on racism, this has become known as aversive racism (Dovidio & Gaertner, 1991). In broader terms, this is known as unconscious bias (Haider et al., 2011). Unconscious bias has been explored as a correlate of poor physical (Ravenell & Ogedegbe, 2014; van Ryn & Saha, 2011) and behavioral (Stuber, Meyer, & Link, 2008; van Ryn & Fu, 2003) health outcomes and of inequality more widely in targets (Banks & Ford, 2008;

Rhode, 1988; Ridgeway, 1997), but insufficient effort has been expended to better understand and respond to this problem at the individual and policy level.

Currently, the main direction of social stigma reduction interventions is focused on interactional experiences, including disputing (organized interventions against false information, stigmatizing advertisements, media reports, and public statements), educating (to improve mental health literacy among the general population and specific groups), and increasing contact (to create an atmosphere of equal status through cooperative interaction) (e.g., Rüsçh et al., 2005). For example, knowledge-contact interventions both provide information to increase literacy and also promote intergroup contact so program recipients can meet and get to know people with mental illness; initial evidence suggests that such interventions may be effective at increasing mental health literacy (Pinto-Foltz, Logsdon, & Myers, 2011) and perhaps can be applied to broader stigma reduction approaches. Michaels and colleagues (2014) found that knowledge-contact interventions for mental health providers could raise stigma awareness and recognition, thereby improving service delivery. Knowledge-contact interventions need to be carefully designed and implemented, however. If these programs are poorly implemented, they may reinforce stigmatizing behavior. Short-term small group interventions have also been found to be effective with HIV service providers, leading to increased protection of HIV patients' confidentiality and right to testing, decreased prejudice against people living with HIV and AIDS, and better understanding and use of universal precautions (Wu et al., 2008).

These interventions should also be supplemented with professional training programs. For example, programs for professionals on trauma-informed care can help to prevent the revictimization of rape and sexual assault victims through false assumptions about their role in such assaults (Ullman, 2010). Interventions to help formerly incarcerated individuals obtain employment and other measures of equal status have found success when involving the target group in the planning and running of programs, using their life experience to help provide practical approaches to reduce discrimination against ex-convicts (Malek, 2014). Such professional training programs and interactional experience interventions could be tested for reduction of stigma and unconscious bias toward LGBT populations. Studies have found lower satisfaction and engagement in services among LGBT individuals due to both expected and real experiences of prejudice by treatment staff compared to their heterosexual peers (Colcher, 1982; Zigrang, 1982); Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Simpson & Helfrich, 2007), lack of provider training on LGBT issues, ambivalent or negative attitudes toward working with the population (Eliason, 2000; Eliason & Hughes, 2004; Hellman et al., 1989), and failure of treatment programs to provide tailored services for LGBT clients and recommended clinician-level training programs (Cochran et al., 2007).

Structural Discrimination

Structural discrimination includes laws, social policies, and other practices that exist in the social infrastructure that promote marginalization or direct resources toward or away from certain groups. These include historical issues of voting rights for Blacks and women, marriage and family rights for LGBT couples, hate crimes, and laws that restrict the civil rights of those with mental illness. Emerging literature has supported the relationship among stigma, policies, and health. For example, Hatzenbuehler and colleagues (e.g., Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009) explored institutional and state-level stigma and discrimination as predictors of psychiatric outcomes among lesbian, gay, and bisexual adults. However, scholars have noted a lack of research focused on structural changes (Hatzenbuehler et al., 2013; Weiss & Ramakrishna, 2006).

Strategic policy approaches

Social work must identify key strategic policy approaches to address structural aspects of stigma that contribute to inequality. Examples include policies that remove barriers to housing and employment among individuals with histories of incarceration, promote a living wage, and reduce gentrification and displacement that often accompany economic development in poor communities. Weiss, Ramakrishna, and Somma (2006) discussed several intervention strategies to challenge stigma toward individuals with chronic health conditions and physical disabilities. Advocacy, lobbying, and legislation, as well as research to support those activities, can help generate more effective evidence-based health and social policies to better treat health conditions and reduce the likelihood of stigmatization across populations.

Regardless of the type of intervention, programs that seek to reduce stigmatization should include a focus on institutions and groups that wield power and influence in society. Examples include schools, hospitals, religions, mental health workers, law enforcement, politicians, government agencies, and employers, to name just a few. These groups control resources, help socialize cultural views toward *out-groups*, and often maintain and promote the stereotypes that drive the stigmatization process. They are therefore important targets for stigma reduction interventions, particularly those seeking to address structural forms of social stigmatization. Generating change in these areas can be accomplished through information, education, communication, and social marketing campaigns to generate compassion for and reduce blame placed on stigmatized groups (Weiss et al., 2006).

Practice and Self-Assessment

Efforts to overcome stigma in the general population can begin with understanding implicit biases individuals hold that are built into institutions. Amaro and Raj (2000) noted that “the framework of oppression invites us to consider the role of social institutions” and “their participation in oppression” and how “the social sciences and public health system . . . might be misused in the interests of oppression” (p. 730). Individuals can object to stigma and the everyday discrimination it fosters, yet beliefs and behaviors undergirding stigma are deeply held and often insidious in their manifestation until formal corrective actions are taken. Examples

abound regarding the participation of science and various disciplines in promoting inequality and engaging in unethical practices such as the eugenics movement, Tuskegee experiment, sterilization campaigns targeting minority and other socially stigmatized groups, unethical research conducted among individuals with mental illness and institutionalized populations, and unethical research on racial and ethnic groups (see Amaro & Raj, 2000).

Self-analysis

First and foremost, this work must start with the challenge of self-analysis as a profession. The narrative of social work has long been one of equity and social justice. However, the field must recognize the inherent vulnerabilities in a society between discrepant formal egalitarian ideology versus actual social and organizational behaviors regarding inequality. In such a society, it is likely that some of social work's function has likewise contradicted its stated principles. Thought leaders in inequality have recognized the role of institutions as agents of social control; for example, feminist scholars have long acknowledged that gender, race, and class are “an integral part of our social structures and institutions” (Koss et al., 1994, p. 4; also see Reid, 1993).

The perception of social work

Social work must also examine how socially stigmatized groups perceive the profession. Social work cannot call for self-examination of other institutions, groups, and students without doing the same. Concern about the potential role of social work as an agent of social control has been noted in the literature. For example, Asquith, Clark, and Waterhouse (2005, p. 12) noted that

. . . far from addressing the inequalities with which we live, [social work] may well play an important role in sustaining or perpetuating the very social and economic system which promotes such inequalities. Rather than liberating, it can be viewed as oppressive and for that reason not true to the core values on which it claims to be based. (Jordan and Parkinson, 2001; Jordan, 2004).

Although some studies have been conducted on public opinion and perceptions of social workers, they have been limited (LeCroy & Stinson, 2004). Particularly missing are studies of populations that have received services from social workers, especially international comparative studies; previous research have largely focused on population surveys.

In this realm, critical analysis is needed to investigate the historical and contemporary role of social workers as agents of social control. Similarly, studies such as those conducted among medical students and physicians are needed to help the field understand how the marginalized populations social work serves perceive the roles of social workers in relation to inequality, social justice, and social control (LeCroy & Stinson, 2004), and how implicit bias affects service delivery among social workers. These studies should examine the following questions: How has the field of social work served as an agent of social control and supported inequities? What are potential areas of future misuse of social work related to promoting inequities? What interventions are efficacious in reducing unconscious bias among social workers?

Practice innovation

There is significant room for innovation in the practice of stigma reduction. Because of stigma's widespread effects on numerous groups at all levels, there is no dearth of options for innovative programs to address stigma reduction. Because stigmatization is the status quo across so many populations and communities, any approach that aims to bring about significant change in the stigmatization of marginalized groups will necessarily have to be new, different, and innovative—in essence an antistigma culture. Effective approaches will be multipronged, span all levels of society, involve interdisciplinary collaboration, and address the structural aspects of society and culture to create an environment in which stigma can be progressively mitigated and eliminated.

Workforce Training*Reducing bias in training*

Social work must examine the presence and role of stigma in training of students. To be a transformative profession that provides leadership in reducing inequality, social work will need to take an honest and close look at how its history and role as a social institution may inadvertently contribute to inequities and how it emphasizes modes of training students. Studies are needed to inform our pedagogy regarding the nature and extent of implicit bias among social work students that should be expected or even fostered unintentionally by the embedded assumptions of our interventions. Such studies of students and clinicians in other health professions (e.g., Haider et al., 2011; Paradies, Truong, & Priest, 2014; van Ryn & Fu, 2003) have been conducted and can provide a model and approach for similar studies with social work students.

Raising awareness of contributions to inequity

Although health care professionals, including social workers devoted to justice and equity, may find it challenging to acknowledge that they contribute to systemic inequities in health, significant evidence supports this notion (van Ryn & Fu, 2003). Van Ryn and Fu (2003) argued that “resistance to exploring the ways in which providers may contribute to health disparities reflects a lack of understanding of the automatic, unconscious, and ubiquitous nature of fundamental social cognition processes” (p. 252). Foremost is a need for personal awareness of culturally embedded paternalistic attitudes about individuals and subgroups that struggle to overcome the challenges besetting them, because poverty or impaired functioning too often are perceived as the consequences of personal disorganization and defective problem solving. Case study models are needed for systematic examination of creative ways to identify situations and individual outcomes in which stigma was a potential factor and made it necessary to reevaluate a course of action.

INNOVATION THROUGH COLLABORATION TO ADDRESS STIGMA

One of the challenges of stigma reduction is that much of the literature on stigma has focused on specific groups that are marginalized and researchers use terms and measures that are not aligned with one another. For example, researchers studying mental illness stigma typically do not use findings from researchers studying stigma related to racial stereotyping, homelessness, HIV/AIDS, or medical conditions like epilepsy. This results in a wide range of different theoretical and conceptual models to assess, measure, and interpret stigma for different marginalized groups. Thus there is much room for interdisciplinary, cross-sector collaboration to be fostered and improved in the area of stigma measurement and reduction. Stigma prevention is one area that has been understudied and will also require significant cross-sector collaboration.

Addressing the problem of stigma, particularly as a fundamental cause of health disparities, will require extensive interdisciplinary collaboration and evidence-based advocacy in the social work profession. Taking an approach that cuts across intrapersonal, interpersonal, social, and societal systems will require the contribution of psychology, law, political science, public health and epidemiology, sociology, and criminal justice. For example, interventions to reduce stigma against individuals living with HIV/AIDS need to focus on health-care workers (e.g., doctors, nurses, pharmacists, other medical professionals including social workers); the stigmatized individuals, families and other support systems; and the general population (L. Brown, Macintyre, & Trujillo, 2003).

However, we assert that social work is uniquely positioned to lead an effort to address stigma as a fundamental contributor to health inequalities. Social work has a long narrative and history of social justice, an understanding of stigma, and a nearly exclusive focus on populations that experience high rates of stigma and poor health outcomes. Social work also has a long tradition of working across systems and must reinvigorate its history and scholarship in community organizing and structural change. In this section, we discuss the domains in which social work can provide transformative leadership in reducing inequality by addressing social stigma.

To address more structural forms of stigma (e.g., institutional racism or age bias in the workplace), the political system, legal system, news media, and other advocacy groups must be involved. One example of this is the recent push for an amendment to the Voting Rights Act to help stop voting discrimination based on race (Khan, 2014). In India, the stigmatization of women resulting in and exacerbated by acid attacks has prompted discussions about the need for legal approaches that provide special provisions for this type of crime and extra legal protections for women (Ahmad, 2012). To counter age stigma in the workplace and ensure fair treatment of older workers, organizational ageism policies and expansions of legal protections such as the Age Discrimination in Employment Act are needed (Finkelstein & Farrell, 2007). Reducing structural and social stigma also requires the involvement of the educational system, targeting educational professionals with training designed to promote awareness and skills for intervening with early childhood programs (Baratz & Baratz, 1970; Payne & Smith, 2011). School programs such as Roots of Empathy, which teaches children how to cultivate empathy and consider other people's feelings, can help to prevent stigmatizing behavior before it begins (E. Brown, 2014).

CONCLUSION

Grand Challenges for Social Work Initiative

Working Paper



Addressing stigma enables society to resolve the dissonance between ideals and facts about inequality in the United States. Social status and the roles assigned to groups based on certain characteristics (e.g., gender, race, class, sexual orientation) are integrated into the fabric of inequality. As long as stigma exists and is not systematically addressed as a fundamental cause of inequality, society is susceptible to blaming the victim, thereby obscuring a more effective analysis of the conditions that affect the most vulnerable communities and delaying the resolution of critical issues. With an organized effort to address stigma at multiple levels, however, American society can reverse the adverse effects of oppression through stigmatization and produce greater equity for all.

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ABOUT GRAND CHALLENGE 11

Achieve equal opportunity and justice. In the United States, some groups of people have long been consigned to society's margins. Historic and current prejudice and injustice bars access to success in education and employment. Addressing racial and social injustices, deconstructing stereotypes, dismantling inequality, exposing unfair practices and accepting the super diversity of the population will advance this challenge. All of this work is critical to fostering a successful society.

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