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The Stigma System: How sociopolitical domination, scapegoating and stigma shape public health

Samuel R Friedman,
Department of Population Health, New York University Grossman School of Medicine

Leslie D Williams,
Division of Community Health Sciences, University of Illinois at Chicago School of Public Health

Honoria Guarino,
Institute for Implementation Science in Population Health, CUNY Graduate School of Public Health & Health Policy

Pedro Mateu-Gelabert,
Institute for Implementation Science in Population Health, CUNY Graduate School of Public Health & Health Policy

Noa Krawczyk,
Department of Population Health, New York University Grossman School of Medicine

Leah Hamilton,
Department of Population Health, New York University Grossman School of Medicine a

Suzan M Walters [Postdoctoral Fellow],
NYU Rory Meyers College of Nursing; University of Southern California, Interdisciplinary Research Training Institute on Hispanic Drug Abuse

Jerel M Ezell,
Department of Sociology, University of Chicago, Chicago, IL b; Department of Medicine, Section on Global Health and Infectious Diseases, University of Chicago, Chicago, IL

Maria Khan,
Department of Population Health, New York University Grossman School of Medicine

Jorgelina Di Iorio [Faculty of Psychology],
CONICET/Buenos Aires University; Intercambios Civil Association

Lawrence H Yang [Adjunct Associate Professor],
Department of Social and Behavioral Sciences, School of Global Public Health, New York University; Department of Epidemiology, Mailman School of Public Health, Columbia University

Valerie A Earnshaw
University of Delaware (Department of Human Development and Family Sciences

[a]Now at Kaiser Permanente Washington Health Research Institute

[b]Now at Africana Studies and Research Center, Cornell University

Corresponding author Samuel R Friedman, 250 Lawrence Avenue (home address), 732 989 9420, samuel.friedman@nyulangone.org.

Abstract

Stigma is a fundamental driver of adverse health outcomes. Although stigma is often studied at the individual level to focus on how stigma influences the mental and physical health of the stigmatized, considerable research has shown that stigma is multilevel and structural. This paper proposes a theoretical approach that synthesizes the literature on stigma with the literature on scapegoating and divide-and-rule as strategies that the wealthy and powerful use to maintain their power and wealth; the literatures on racial, gender, and other subordination; the literature on ideology and organization in sociopolitical systems; and the literature on resistance and rebellion against stigma, oppression and other forms of subordination. we develop a model of the "stigma system" as a dialectic of interacting and conflicting structures and processes. Understanding this system can help public health re-orient stigma interventions to address the sources of stigma as well as the individual problems that stigma creates. On a broader level, this model can help those opposing stigma and its effects to develop alliances and strategies with which to oppose stigma and the processes that create it.

Keywords

stigma; scapegoating; divide and rule; resistance; struggle; domination; subordination

Introduction

This article presents a sociologically-integrated transdisciplinary perspective on stigma as an interactive system, and the relationship of this system to the health of individuals and populations. Although stigma is often viewed as a personal characteristic, as in internalized stigma, or as a social relationship of degradation, as in structural stigma, this paper looks at different aspects of stigma as part of a political economic, interpersonal, and psychological dialectic or system of structures and processes. We frame this dialectic within the Hegelian model of Universal -- Particular – Individual (Hegel & Miller, 1990; Hegel & Wallace, 1975), where the Universal consists of the structures, strategies and actions of international and national centers of power; the Particular is the set of organizations and ideologies that exert their hegemony (in the Gramscian sense) (Brecht De, 2019; Gramsci, 2015; Smet, 2016) and power; and the Individual is the human individual or small group. Stated thus, however, this framing is too simple and one-sided. Following Gamson (*Power and Discontent*),[6] we see the stigma system as a contested power process with two themes: First, a power theme through which the powerful attempt to rule by dividing those they rule through scapegoating some subsets of the population (which requires particularization through ideology and organization and winning a degree of buy-in from non-stigmatized population groups); and second, the discontent theme in which the ruled (and in this case, stigmatized) express, formulate and organize their discontent and sometimes fight back. Figure 1 presents these processes as two totally interactive processes.

Stigma, both structural and individual, is a fundamental driver of adverse population health outcomes (Hatzenbuehler, 2016; McCradden et al., 2019; Stangl et al., 2019). It reduces acceptance of, and success in, many forms of medical treatments (Blair et al., 2011; FitzGerald & Hurst, 2017; Gray, 2002), including those for HIV (Katz et al., 2013; Kerrigan

et al., 2017; Takahashi, 1998) and substance use-related problems (Allen & Harocopos, 2016; Calabrese et al., 2016; Corrigan & American Psychological, 2006; Ford et al., 2008; Gunn & Guarino, 2016; Janulis et al., 2013; Skinner et al., 2007; Spicer et al., 2011; Tsai et al., 2019; van Boekel et al., 2013; Wakeman, 2016). Stigma also is associated with social, economic, and personal harms and disadvantages (Hatzenbuehler, 2016; Hirschfield & Piquero, 2010; Pager, 2009). There is a vast literature on what stigma is (Gilmore & Somerville, 1994; Hatzenbuehler et al., 2013; Pescosolido & Martin, 2015; Pescosolido et al., 2008), how to measure it (Ahorsu et al., 2020; Brown, 2011; Friedman et al., 2020; Palamar et al., 2011; Pouget et al., 2016; van Brakel et al., 2019), and how to reduce it (Cook et al., 2014; Heijnders & Van Der Meij, 2006; Livingston et al., 2012). Importantly, people often occupy more than one stigmatized status (i.e., race/ethnicity, sexual identity, gender, etc.) at once and the stigmas associated with multiple statuses interact with each other (Crenshaw, 1991; Hill Collins, 2015; Turan et al., 2019). For example, systems of oppression and stigma associated with race and gender (i.e., racism and sexism) interact with HIV – and substance use-related stigma to reinforce each other and produce unique experiences for people living at their intersections, oftentimes magnifying health disparities. There has thus been considerable interest in intersectional stigma and its measurement (Earnshaw et al., 2015; L. Rosenthal, 2016; Turan et al., 2019). Recent reviews have also examined it in relation to the opioid/overdose epidemic, including a scoping review of opioid-related stigma and an article on stigma as a fundamental hindrance to the United States opioid overdose crisis response (McCradden et al., 2019; Tsai et al., 2019).

Unfortunately, public health efforts to address stigma focus almost exclusively on internalized and interpersonal stigma without attention to its macro-social and political aspects (Rao et al., 2019). This paper presents a model of what we call the “stigma system” and its interacting components of stigma, the social processes that create, strengthen, or maintain stigma, and the sociopolitical forces that resist, weaken or eliminate stigma. This view of the stigma system as a multilevel system in which individual, organizational, ideological, and macrosocial conflicts interact in a dialectic, as pictured in Figure 1, may help public health and other fields move beyond an individualized model that sees solutions primarily in terms of helping clients or patients cope with the ill effects of stigma on themselves – which might sometimes reduce pressures for social change in the process (Williams et al., 2019, 2020).

As Link and Phelan have noted (pp 364–365), there are many definitions of stigma, which stem from the concerns of different scholarly disciplines and from the application of the term to different subject matters (Link & Phelan, 2001). In this influential review, they propose:

> In our conceptualization, stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of “us” from “them.” In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatization is entirely contingent on

> access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. Thus, we apply the term stigma when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold.

We will use this definition of "stigma," with two caveats. First, the phrasing Link and Phelan use ("first", "second" etc.) might seem to imply a time or causal ordering of events. As we discuss below in relation to historical examples, such a time-ordering may not always occurs so we define stigma simply in terms of the co-occurrence of the phenomena. Second, we point out (following Goffman[50] but fully consistent with Link and Phelan) that our definition includes individual, interpersonal, mid-range and macrosocial characteristics and relationships, and a variety of processes that connect them. In particular, this definition of stigma draws upon concepts of "self" and "other" as developed by Hegel and Meade (Hegel & Baillie, 1967; Hegel & Miller, 1990; Hegel & Wallace, 1975; Mead et al., 2015); and also upon concepts of power and opposition (the discontent theme referred to in Figure 1) similar to those in Gamson, *Power and Discontent*, Fanon, *The Wretched of the Earth*, and Memmi, *The Colonizer and the Colonized* (Albert; Fanon, 2021; Gamson, 1976). Implicit in this, then, is a dialectics of stigma-related processes as a Hegelian or Marxist dialectical system in which the *Individual* (the stigmatized) presupposes the *Universal* (power and interests as organized in a given social system) and the *Particular* (the structures through which this power and discrimination is organized); and in which discontent with the system manifests itself through the *Individual, Particular and Universal* as shown in Figure 1. Such a system is characterized by conflict and by varying efforts of the dominated/stigmatized to resist, to organize, to end the stigmatization, and perhaps to transform the social system that dominates them.

Prior research on stigma and health has studied the systemic nature of stigma. Corrigan, Pescosolido, Martin (Corrigan et al., 2004; Pescosolido & Martin, 2015), Link, Phelan, Hatzenbuehler, and their collaborators have written a number of articles on structural stigma,[1] how stigma can benefit powerful groups, and the moral/cultural dimensions of stigma (Hatzenbuehler, 2016; Hatzenbuehler et al., 2013; Link & Phelan, 2014; Link & Phelan, 2001; Phelan et al., 2008; Yang et al., 2014; Yang et al., 2007). HIV/AIDS researchers have considered stigma in its interlocking social and personal dimensions, including setting-level variation in stigmatizing ideologies and intrapersonal normative processes (Williams et al., 2019, 2020), and the ways in which such prevailing ideologies are used by the powerful to maintain inequality and, to some degree, how the disempowered resist this (Lichtenstein, 2014; Parker & Aggleton, 2003). The literature on structural violence has also covered these themes (Farmer, 2010; Farmer et al., 2011; Yang et al., 2014). Other anthropologists such as Eric Wolf and James Scott have dealt with similar themes in terms of domination, oppression and resistance (Scott, 2009; Wolf, 1969). From this literature and our own studies of racial subordination, it is clear that all relationships

[1]As is discussed below, structural stigma has been defined as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized."[56, 57, 96]

of oppression, such as racism, class oppression and gender oppression, necessarily involve stigma and dignity denial, although stigma can also arise out of fears in cultures where value, self-worth and blame are major ideological components (Friedman et al., 2015; Samuel R. Friedman, 1998; Friedman et al., 2020; Pouget et al., 2016; Singer, 1998). Thus, stigma is a necessary part of the process of oppression, but other forms of stigma can also exist (and, if widespread, potentially be used by the powerful in scapegoating strategies to increase division among those they rule.)

None of these authors, however, has integrated these concepts into the kind of dialectical and structural multilevel model that we discuss in this paper. Our focus includes not only intra- and interpersonal processes and norms but also includes (1) the sociopolitical production of stigma and scapegoating as a way to defend the interests of the powerful and the wealthy and (2) patterns of resistance to, defiance of, and social support in the face of stigma. This is the topic of this article: Stigma, social processes such as scapegoating that maintain or create stigma (Samuel R. Friedman, 1998), social processes of resistance to stigma, and how they fit into, interact and engage in conflict in what we will call the "**stigma system**." Our discussion focuses more than does prior work on dialectical interaction in the production of stigma, stigma as acted upon and as internalized, and resistance to stigma, along with discussing the organizational forms that mediate these interactions. In writing this, we bring in insights from studies of a wide range of forms of stigma and oppression, and draw on both historical and more contemporary examples to illustrate various aspects and processes of the "stigma system" (Hegel & Wallace, 1975). Although one focus of this article is on how these issues relate to health, health is deeply embedded in these wider social processes, so parts of our presentation focus on these wider processes rather than on health itself. Within the health field, and related to the authors' areas of expertise, the article tends to focus on infectious diseases and on issues of substance use and mental health.

Stigma as a social psychological and small group phenomenon

In analyzing this system, we will first describe it piece-by-piece then address the dynamic and relationships between pieces later in the paper. Stigma is a social process and a system of demeaning cultural distinctions that often originates at higher levels of the social system but which is also manifested, experienced, maintained, and reproduced within individuals and small groups. (See Figure 2; see also Figures 1 and 4 for how the parts of this paper fit together.) Stigma works through several mechanisms at the individual level (Earnshaw & Chaudoir, 2009; Earnshaw et al., 2013): *Internalized* stigma is when a person with a stigmatized identity endorses social discreditation and considers themselves to be devalued (Livingston & Boyd, 2010). *Enacted stigma* refers to past stigma that has been experienced and interpreted as unfair treatment (Scambler, 2009). *Anticipated stigma* refers to the belief that negative treatment will occur in the future due to stigmatized characteristics. These mechanisms are not discrete (Turan et al., 2017). For example, if someone experiences enacted stigma, they may internalize stigma, and greater internalized and enacted stigma may lead to greater anticipated stigma (Earnshaw & Quinn, 2012; Turan et al., 2017). Therefore, stigma at an individual level may not only include a lowered sense of self-worth (the core of what is usually seen as internalized stigma) but also the anticipation of being stigmatized by others and of having others see one as unworthy or undesirable – which

can and does influence individuals' decisions to try to avoid stigmatizing situations (e.g., whether people engage with social and medical services, take part in political activities, and much else) (Barney et al., 2006; Brookmeyer et al., 2019; Latkin et al., 2010; Rivera et al., 2014; Rüsch et al., 2009; van Boekel et al., 2013).

These aspects of internalized stigma are also part of the culture and interaction patterns of small groups that create, reinforce and/or maintain stigma at the individual level (Pescosolido & Martin, 2015). The stigma system thus includes normative processes (in the Parsonian sense of norms being a pattern of interactions between individuals and small groups) (Parsons, 1951, 1966, 1968). Some of a person's internalized stigma, anticipated stigma, and enacted stigma is caused, reinforced and/or maintained by group beliefs that certain characteristics are shameful and/or by experiences of dignity denial or micro-aggressions by individuals or subgroups of groups (Gramsci, 2015).[2] Data on dignity denial as experienced by people who inject drugs (PWID), men who have sex with men (MSM), and high-HIV-risk heterosexuals are presented in Friedman et al (2017), based on a theorization of dignity denial presented by Friedman, Rossi & Ralon (2015) (Forrest-Bank & Jenson, 2015; Friedman et al., 2015; Samuel R. Friedman et al., 2017).

Fear can be one cause of stigma at the individual and small group level (Gilmore & Somerville, 1994; Person et al., 2004). This is well-exemplified by the COVID-19 epidemic in the United States. Fears of getting infected led in many cases to verbal or physical attacks on people of Asian descent whom some people came to fear as spreaders of the coronavirus (Ahorsu et al., 2020; Earnshaw & Katz, 2020; Turnbull, 2020). It should be added, as a precursor to later discussion of how political elites exacerbate stigma, that this fear and stigmatization was stoked by the language of former U.S. President Trump (Earnshaw & Katz, 2020; Somvichian-Clausen, 2020). Also, although COVID-19 or HIV stigma may seem to arise spontaneously among individuals or small groups of stigmatizers, there is a systemic character to it when it is part of a "culture of individual blame" that is produced by capitalism and its individualistic ideologies and by a culture in which scapegoating has become normalized (S. R. Friedman, 1998; Samuel R. Friedman, 1998). More specifically, a culture that accepts the ideology that success or failure are reflections of individual effort and worth, and thus that defects are matters of personal blame and inadequacy, creates a popular predisposition to create stigmas and to stigmatize on the part of the population. In this context, an initial fear can lead to seemingly autonomous stigma, but this is not independent of the overall dominance of stigmatizing predilections of the system.

Stigmatization also occurs when members of stigmatized groups internalize one or more forms of stigma and interact with each other. This can have severe negative consequences on health. For example, Jessell et. al reported sexual violence, including sexual assault, as occurring within contexts characterized by victimization of women who use drugs by men who use drugs both as a result of stigmatizing negative sexual perceptions the men ascribed to women drug users, and to the internalized stigma of both men and women who use drugs (Jessell et al., 2017). As another example, people who use drugs often stigmatize people

[2]"Dignity" and "thus "dignity denial" are complex concepts and thus hard to define. A full discussion of these concepts appears in Friedman, Rossi & Ralon (2015).[66]

who use substances that are more stigmatized (e.g., crack (Social networks, drug injectors' lives, and HIV/AIDS, 2011)) or who use substances in ways that are more stigmatized (e.g., injecting drugs). Often drugs or behaviors that carry more stigma, such as crack smoking, are embedded in racist ideas of drug use (Reinarman & Levine, 1997). Racialized stigmatization can be complex, as shown by research that members of racialized groups sometimes stigmatize others with a different skin tone (Monk, 2015).

In contrast, at the small group level of analysis, group members often offer each other support when their dignity is attacked (S. R. Friedman et al., 2017), which sometimes takes the form of intravention against stigmatizing beliefs and norms that may result in improved health outcomes (Brecht De, 2019). As Turan et al. have discussed (Turan et al., 2019):

People in stigmatized groups may find solidarity within their community, which can offer protection against some of stigma's negative effects. Among Black American women with HIV in Chicago, awareness of systemic oppression and a desire to join others to enact social change ('critical consciousness') was associated with a higher likelihood of a CD4 count greater than 350 and a lower likelihood of detectable HIV viral load when perceived racial discrimination was high (Kelso et al., 2014).

Creation of stigma:

There is a wide social science literature on the historical, political, and community roots of, and creation of, gender subordination, racism, and other forms of oppression including discrimination toward persons who use drugs. This literature has not often been systematically presented as part of stigma research, although it forms part of the system that creates and maintains what has been called "structural stigma," which has been defined as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized" (Corrigan et al., 2004; Corrigan et al., 2005; Hatzenbuehler & Link, 2014; Link & Phelan, 2014; Phelan et al., 2008). One distinction between the concept of structural stigma and the discussion of the creation of stigma in this section of the paper is that structural stigma refers primarily to existing sociocultural structures whereas here we discuss social processes and strategic actions and projects that originate and/or greatly increase a particular stigma (see Figure 1). For example, Friedman presented an analysis of scapegoating that discussed how scapegoating, a form of divide and rule politics (Smet, 2016), stigmatized key populations such as PWID and MSM and helped create and sustain the HIV/AIDS epidemic (S. R. Friedman, 1998; Samuel R. Friedman, 1998).

This analysis of stigma as stemming at least in part from the scapegoating activities of the wealthy and powerful does not contradict, but rather supplements, arguments like those presented by Tsai et al. who see stigma primarily as a set of processes and structures in a given population (Tsai et al., 2019). In presenting a typology of kinds of stigma, they present public stigma towards opioid users as "driven by stereotypes about people with opioid use disorders, such as their perceived dangerousness or perceived moral failings, which translate into negative attitudes toward people with opioid use disorders." (p. 1) Importantly, for Tsai et al., enacted stigma is the "behavioral manifestations of public

stigma, including discrimination and social distancing." They then go on to say that "Public and enacted stigma can become structural stigma when they become encoded in cultural norms, laws, and institutional policies." (p. 4) Our analysis of the maintenance of stigma has many similarities with this model. Where it differs is that Tsai et al do not provide a framework to understand the genesis of stigmas. In addition, their model does not capture the entrepreneurial political aspect of events like U.S. presidents Nixon's or Reagan's drug wars and how they served political functions for them (and for the wealthy and powerful as a class) while causing much harm to people who use drugs and their families. Tsai et al also do not discuss the organizations and roles through which stigma and scapegoating become specified as institutionalized parts of society, which we present in Figure 3 (which is discussed in the section below on "Structures and Processes that Create and Maintain Stigma").

Before discussing these structures, however, we first provide examples of historical events or processes whereby threats to the rule of the wealthy and powerful led them to engage in "divide and rule" scapegoating that led to long-term stigmatization of scapegoated populations. These examples include 1) witch-hunting in the 14th century; 2) subordination by race in the 17th century; and 3) criminalization of people who use drugs in the 20th century. We recognize that historical interpretation is often contested, and that this is a limitation of these examples.

Witch hunting: the scapegoating of oppositional and non-conforming women.

Sylvia Federici has written extensively on the use of witch hunting (the scapegoating of oppositional women as witches) as a way to divide and to forestall peasant and worker opposition to nobility and the Church for scores of years in the period after the Black Death epidemic in the mid-1300's in Europe (Federici, 2021). This period was marked by considerable decline in the power of the nobility and the higher levels of the church since the great loss of life meant that peasants could leave their villages and find land to grow crops in areas of abandoned cultivation. The nobility, the upper levels of Christian churches (at first only the Catholic Church, but some Protestant churches as well, during and after the Reformation), and master craftsmen in the towns took action against losing peasants and workers, and the associated decline in their living standards and political power. In many cases, they used heresy or witchcraft charges to punish peasants or town plebeians who tried to obtain a greater voice or better conditions. These punishments were meant to divide and intimidate their potential opposition. For example, to weaken the unity of the lower classes in the towns and cities, they encouraged young men to have contempt for lower class women and to use gang rapes and beatings of women both as a way to amuse themselves and as a way to engage in feuds between families or neighborhoods. Such attacks on women were not prosecuted in either the secular or the religious courts during this time. They also stoked fears of witchcraft, and condemned to death many thousands of women rebels, as well as women who did not bear children, as witches. They did this both to suppress women rebels and as part of a long-term strategy to increase population (and decrease the independence of the poorer classes) by forcing women to have many children.

This strategy worked, and it reshaped gender relationships and institutionalized the further oppression and stigmatization of women for centuries. This institutionalization became self-reinforcing because along with it came stigmatizing beliefs, shared by many women as well as men, that women's place was primarily defined as raising children, that women had few or no rights inside or outside of domestic contexts, and that women were naturally unfit for most public activities and many forms of work.

Race/ethnicity: The "Invention of the white race" and the stigmatization and subordination of Black people.

"Racial" scapegoating and stigmatization are readily visible parts of modern life, including the racialization of what might appear to be religious or national differences. The use of such scapegoating as a divide and rule strategy is currently visible in the political fortunes of so-called "nationalist" leaders in many countries (e.g., the United States, India, Israel/Palestine, and many other places). An early, and perhaps foundational, example of such scapegoating, subordination and stigmatization is the way in which the division between whites and Blacks was established early in the history of Britain's American colonies (Allen, 2014; Allen, 2012). In the Virginia Colony, the 1620s saw many tenants' and wage laborers' legal status reduced to that of bond servants to their masters. Resistance mounted, and often involved a degree of unity among slaves, bond servants and indentured laborers of different race/ethnicities. The resistance reached a crescendo in 1676, culminating in the interracial Bacon's Rebellion, which seriously threatened the power of the rich and wealthy before it was suppressed.

Following this suppression, the ruling classes engaged in a long-lasting systematic policy of divide and rule. They granted "privileges" to white laborers while passing laws to establish racialized slavery on Black people. By 1735, the legislature took the vote away from free Blacks in order to:

> "fix a perpetual Brand [that is, a stigma] upon Free Negros and Mulattos by excluding them from that great Priviledge of a Freeman, well knowing they always did, and ever will, adhere to and favour the Slaves. And 'tis likewise said to have been done with design, which I must think a good one, to make the free-Negros sensible that a distinction ought to be made between their offspring and the Descendants of an Englishman, with whom they never were to be Accounted Equal (Gooch, 1736).

This pattern of racial subordination, racial division to weaken the unity of the laboring classes, and stigmatization spread from Virginia throughout the other colonies and thence throughout the United States after the Revolution. It established a lasting ideological effect of stigmatizing minority races and weakening possibilities of unity among workers and others against the rule of the rich and powerful. The history of racism and racial stigma in the United States has been marked by discord among workers and in poor communities between whites, Blacks, American Indians, Latinos/as and others and, to some extent, within these groups on the basis of skin color as well as on how to respond to racism; and by deliberate use of these divisions to maintain the power of capital at workplaces (including

hospitals (Sacks, 1988)), in local governments, and in the nation as a whole (Esch & Roediger, 2009; Goldfield, 1997; Monk, 2015; Moody, 2014; Omi & Winant, 2013).

The "War on Drugs" as divide and rule scapegoating and stigmatization of Blacks, protesters and people who use drugs:

The War on Drugs was developed explicitly by U.S. President Richard Nixon and his allies in the late 1960s to stigmatize blacks and student anti-war protesters and to divide them from workers and others. (This was a period of considerable unrest by workers that saw a wave of union organizing by public employees and by large-scale wildcat strikes and rank-and-file movement organizing among workers of various racial/ethnic groups and industries) (Brenner et al., 2010; Friedman, 2013; Weir, 1972). It is an example of the way they operationalized Kevin Philips' (1969) recommendation to President Nixon and his allies that they use "social issues" by emphasizing crime as a strategy to divide Black and other communities.[107] This effort built upon centuries of U.S. history in which racism and its institutionalization in Southern Jim Crow institutions and in Northern racial segregation became a key part of the structures and ideologies of the United States. The escalation of the "war on drugs" at this time was an explicit form of social control. John Ehrlichman, the domestic policy chief to US President Richard Nixon, explained this, many years later (Baum, 2016):

> The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.

Given the influence of the United States in international politics, the U.S. War on Drugs has contributed to the stigmatization and criminalization of people who use and handle drugs (and their incarceration, most notably in the U.S. itself) in many parts of the world (Drucker, 2014). This stigmatization has made it much harder to get political and economic support for HIV prevention and care for PWID (including slowness in getting syringe exchange legalized and/or funded in the United States and Russia, among other places) and for establishing treatment services for people whose drug use becomes problematic (S. R. Friedman, 1998; Samuel R. Friedman, 1998).

Choosing targets to be scapegoated

These three case studies of the scapegoating and stigmatization of women, Blacks, and people who use drugs exemplify how subordination and stigmatization create structural and cultural divides that make it easy to create or perpetuate disunity and subordination. There is a bit of a chicken and egg issue here. Scapegoating is most easily done on pre-existing cultural lines of stigmatization—which are often the product of previous scapegoating projects that created or strengthened the stigma and subordination (Gilmore & Somerville,

1994; Goldfield, 1997; Parker & Aggleton, 2003; Phelan et al., 2008; Yang et al., 2007). One way to think of this is as an opportunity for "political aspirants" to gain office or other advantage through scapegoating of already-stigmatized groups. Omi and Winant generalized this in the concept of "racial projects" in which political and economic elites mobilize potential allies to subordinate Blacks, Latinos/as, American Indians, and indeed, historically, many of what are now known as "white ethnic groups" before they became "white" (Omi & Winant, 2013).

As Friedman (1998a, 1998b) argued, politicians, the media, and governments often have some leeway over which culturally-stigmatizable groups to scapegoat (S. R. Friedman, 1998; Samuel R. Friedman, 1998). Thus, confronted with the need or opportunity to implement divide-and-rule politics, sometimes it is useful to scapegoat racial/ethnic minorities, at other times "sinful women," sometimes people who use drugs, sometimes the poor—and as we have noted, such scapegoating can lead to imprisonment, physical violence or death for the scapegoated. In addition, national or local contexts in which people who are LGBTQ+, who use drugs, or who engage in sex work are heavily scapegoated have created many difficulties for HIV prevention and care.

Structures and processes that create and maintain stigma

Figure 3 schematically ties the global and national levels together with primarily-local level structures and processes and how they affect the stigmatization at the small group and individual level that was the focus of Figure 2, and with the earlier section on individual and small group stigma. At the highest levels, the problems of, and threats to, continued rule by the wealthy and powerful and/or the dominance of capitalism as a system often generate a sense among the powerful that they have to reinforce their rule. One way they do this is via divide-and-rule politics—usually taking the form of scapegoating. (Another way to reinforce their rule is hyper-militarization of police and/or armies, which can be effective so long as they can keep these bodies loyal.)

As mentioned above, scapegoating is most effective along the lines of pre-existing structures of subordination and (usually highly correlated) ideologies of stigmatization and inferiority (or dangerousness) of some sets of the population. In highly individualistic societies and cultures, such as those encouraged by neoliberalism, subordination (and its resulting differences in income, life styles and the like) tends to reinforce stigma—that is, the culture of neoliberalism posits that people's life situations are the result of their own personal characters and decisions, and thus that those who are poor or uneducated "deserve it" (Harvey, 2007). Scapegoating is usually reinforced and embodied in laws and in patterns of repression. The laws and policing associated with witchcraft in the late Middle Ages and thereafter, with the creation (or re-organization) of racism in what became the United States in the 1600s (and since—for example, the hyper-militarized policing of racial protest in Ferguson, MO), and with the War on Drugs exemplify this pattern. This scapegoating is often implemented, or reinforced through national (and often international) media, social media, and political campaigns (by "political aspirants," perhaps) that directly or indirectly frame the scapegoated group as inferior or dangerous (McCradden et al., 2019).

The effectiveness of scapegoating as a political strategy and as a force shaping the beliefs, norms and actions of populations depends upon the extent to which its targeting of groups seems credible to people in their everyday lives. Such credibility depends both on pre-existing belief systems in the culture (such as pre-existing beliefs in women as inferior or in drug users as depraved or the normalization of beliefs that the group to which one belongs(such as men or whites) as being superior or morally better, as occurs during white racial framing) (Elias & Feagin, 2016; Thompson-Miller et al., 2015; Wingfield & Feagin, 2012) which shape how daily experience and the media messages are interpreted, and the actualities of daily experience. If the scapegoated group is experientially distant from a group of observers, it is probably easier to gain acceptance for demonizing messages about them. Similarly, if in daily experience the only people who use drugs that you recognize as such fit negative stereotypes (e.g., aggressive, homeless), it is easy to view them as inferior or depraved. Link and Phelan summarize some aspects of this by saying that the stigma process involves classification as different, as well as stereotyping and status loss for the stigmatized, all of which encourage unfamiliarity and thus separates the groups by making the stigmatized group experientially distant from the favored groups (Link & Phelan, 2001).

We argue here that stigma is created and/or maintained and intensified, in part, by the actions of political strategists who use scapegoating to disrupt the potential or existing unity of groups that challenge (or may challenge) their interests. The argument that stigma often arises as a divide-and-rule scapegoating strategy of the wealthy and powerful to divide potential challengers against each other may seem to some to be a “conspiracy theory” and thus as something to be dismissed out of hand. Political strategies, however, do get formulated, and powerful people do act on the basis of these strategies, as exemplified in the three historical cases presented; and the extent to which a strategy and its goals are stated publicly or not depends on the details of the strategy and the intentions of those implementing it. This suggests that the more fruitful issue to be addressed is not “is it a conspiracy?” but rather the extent to which those who initiate and carry forward a scapegoating project themselves believe the stigma it embodies. Clearly, for any given instance, this demands careful empirical investigation. Based on what the authors know of history, for example, we consider it highly likely that most of those who developed the Jim Crow segregation strategy in the post-Civil War U.S. South were themselves overt racists who believed that Black people were inferior and that “race-mixing” threatened the purity of the “white race”—and also believed that dividing the white and Black poor was essential to maintaining the rule of the owners of Southern agriculture and industry (Allen, 1992; Allen, 2014; Allen, 2012; Bloom & Hatcher, 2019; Cash, 1991; Woodward & McFeely, 2002). On the other hand, as the Ehrlichman quote above suggests, Nixon and his associates were probably much less convinced about the inferiority of (or other stereotypes associated with) the student protestors and Black—or even of the “drug users”—against whom they called forth a War on Drugs.

Figure 3 discusses some of the structures through which these ideological scapegoating campaigns become “structural stigma” – that is, social structures of discrimination, dignity denial, degradation, disempowerment and deprivation (Link & Phelan, 2014; Phelan et al., 2008; Tsai et al., 2019). These include laws, repression and the institutionalization of belief systems (as, for example, in educational programs about the inferiority or depravity of racial

"minorities," women, sexual "minorities", or people who use drugs.) At a local level, these have been analyzed in terms of roles and organizations that enact stigma. One important such role-type is that of "dirty workers" (i.e., people doing the dirty work) involved in American racism as analyzed by Hughes (1962), Friedman (1969), and Rainwater (1967) (Friedman, 1969; Hughes, 1962; Rainwater, 1967). As Friedman defined "dirty workers" at that time:

> They are the front-line troops—they conduct those tasks in which the dominant racial group deprives and exploits the subordinates. In the American context, these include the following roles and organizations: personnel managers, teachers, admissions officers, police, courts, loan sharks, slumlords, ghetto retail stores, tax-assessors, welfare case workers, and real estate agents. (p. 19)

This statement, written in the 1960s, needs to be updated and indeed corrected. Not all of those who fill these roles acted, then or now, to stigmatize minorities. Many indeed have been active fighters against such stigmatization at the individual, group, workplace, and societal level. Unfortunately, as a huge literature has demonstrated, racism and other stigmatization by frontline role-holders of these organizations continues, often in the absence of personal racism on the part of the worker (Bakan & Dua, 2014; Bonilla-Silva, 2010; Elias & Feagin, 2016; Feagin & Bennefield, 2014; Massey et al., 1975; Moody, 2018; Omi & Winant, 2013). This is often referred to as "institutionalized racism" or "institutionalized stigma."

This description should also include institutionalized stigmatization and dignity denial as core parts of "dirty-working." Tsai et al., in their discussion of structural stigma as "encoded in cultural norms, laws, and institutional policies," discusses this institutionalization in daily routines, the work of the media, and the stigmatizing policies of medical financing institutions, in order to delineate how these processes work in terms of the opioid epidemic in the United States (Tsai et al., 2019). Such institutionalization includes the "school to prison pipeline" that shunts many minority and lower class children into lives of incarceration and the bureaucratization and often unpleasant physical environments that exude lack of respect for welfare and drug treatment clients (and the employees in these fields) (Cooper & Fullilove, 2020; Drucker, 2014; Friedman et al., 2015).

Many holders of "dirty-worker" roles are public employees who, on occasion, may rebel against aspects of their jobs (as is discussed in Rainwater 1967). Public employees and private employees who function as dirty-workers need to be paid and in other ways to be funded, and the funding of such roles is also part of the stigma system. This is based on the continuing legitimacy and salience of the stigmatizing ideologies that justify such funding, and thus on those media, clergy and educators who support and reinforce the stigma in their daily work.

Local organizations are also an important part of the stigma system which oftentimes participate in and perform various times dirty-working, funding, and legitimating roles and, in some cases, take active part in political scapegoating strategies. Such organizations include elite citizens committees that enforce stigmas (like the White Citizens Councils in the 1950s, the Council for a Drug-Free America during the crack epidemic, and professional

associations or unions that ban one or another stigmatized group from employment or membership), as well as vigilante groups like the Ku Klux Klan or those who physically attack the homeless or drug users in the streets. An important aspect of the stigma system is the “Not in My Back Yard” (NIMBY) phenomenon wherein neighborhood organizations take it upon themselves to keep social or medical services that aid stigmatized groups from being located in their community. Tempalski et al studied this in relationship to opposition to syringe exchange; and Takahashi has written widely on NIMBY and related issues as they embody and reflect widespread stigma against people living with AIDS (Takahashi, 1998; Tempalski et al., 2007). Related to this, structural stigma against people who use drugs has limited their access to medications for opioid use disorder (Andraka-Christou, 2016). This literature is reviewed in McCradden et al (2019) (McCradden et al., 2019).

Despite the difficulties created by stigmatization and the power of their enemies, stigmatized persons and groups do find ways to resist their oppression. On occasion, they make major gains to reverse it as with the successes of sexual minorities in many countries in recent decades (Drucker, 2015) .These efforts form the “discontent theme” discussed in Figure 1. They draw on bonds of solidarity, the development of cultures of interpretation and belief, and their ability to learn and think as individuals and together about how and why they are oppressed and stigmatized and about how to fight this (Friedman et al., 2015; Samuel R. Friedman, 1998; Friedman et al., 2009; Gamson, 1976, 1990). We describe these processes below.

Resistance to stigma: The Discontent Theme

As is clear from the above discussion, the stigma system is very much comprised, in part, of political processes that both affect the stigmatized (and their friends and allies) and also can stabilize or de-stabilize nations or other political units. Like all structures of political power, scapegoating and stigmatization provoke both unorganized and organized resistance and opposition (Gamson, 1976, 1990). Previous work on informal resistance to stigma has shown that stigmatized individuals engage in various forms of resistance to stigma (Thoits, 2011). Although this research shares with our model an understanding of stigmatized people as active agents resisting stigma, much of this work has focused on how individuals resist within the micro-level context of one-on-one interpersonal relationships (Thoits, 2011). We focus more on resistance strategies that leverage the solidarity of communities of stigmatized people, although we have also discussed ways in which people who inject drugs, men who have sex with men, and high-risk heterosexuals act when confronted with interpersonal stigma (S. R. Friedman et al., 2017). Informal resistance among stigmatized people and the communities of the stigmatized draws upon latent or explicit solidarities and includes health intraventions to protect each other and also includes people giving each other social support when they are actively stigmatized or when their internalized stigma becomes problematic for them (Friedman et al., 2009; Friedman et al., 2007; Friedman et al., 2020). This was discussed in the section on small group aspects of stigma. Figure 4 presents a model that concretizes the Discontent Theme and shows how the stigmatized and subordinated resist and oppose their oppression.

One example of **informal** strategies to resist public stigmatization comes from a study of young people who use opioids in New York City and who are immigrants from the former Soviet Union. Because these young people faced a double layer of drug use stigma, emanating from both the United States culture at large and their own primarily Russian-speaking community, becoming publicly known as a drug user within their immigrant community was perceived as tantamount to social death. To preserve respectable social identities, young opioid users strove to conceal their drug use or anything that might get them suspected of being drug users. This made them reluctant to use a mobile syringe exchange service in or near their neighborhood of residence. These young PWID instead organized secondary syringe distribution within their peer networks so that most of them did not have to visit the syringe exchange. This was a form of resistance to the dominant system of stigmatization, as it served to limit their public visibility and the stigma they believed would accrue to them if they were to be seen patronizing the syringe exchange service. By designating a specific member of their peer network, particularly one with an automobile, to be the one to discreetly pick up a large number of syringes for others to use, these young immigrants were enacting a form of intravention that simultaneously served to protect the health of the group and manage their collective potential for public stigmatization.

Quantitative data are available from interviews conducted in New York City with PWID, MSM, and high-risk heterosexuals in 2012–2015. Respondents were asked how often they saw someone attack someone else in a way that attacked their dignity or demeaned them (for example, for being jobless, or using drugs, or their appearance). More than half of each group reported that they saw such dignity attacks on a weekly basis or more often. Approximately two-thirds of each group reported that they told the attacker to stop attacking the other person at least “sometimes,” indicating that informal resistance to stigmatization is widespread. Many also said they consoled the person who was attacked, a form of group support against stigmatization (sometimes or more: PWID 62%; HRH 54%; MSM 48%). (See Friedman et al 2017 for methods (Samuel R. Friedman et al., 2017). These data on how they responded to such attacks have not previously been published.) Another paper from this study reported widespread efforts on the part of members of drug using communities to support other people who use drugs in various health-related domains including drug use management, injection-related risk reduction, and overdose prevention and response (Mateu-Gelabert et al., 2018).

Stigmatization and scapegoating, then, can spur organization among those who are the targets of these attacks. Forms of organization and resistance include both informal forms like syringe distribution among peer networks to formal activist organizations of members of stigmatized groups. Sex workers in India, for example, have organized many formal organizations to fight for their rights and health and to reduce police violence against them (Gamson, 1976; Jana et al., 2004; Lakkimsetti, 2014; Vijayakumar et al., 2015).

Organizing against stigma and scapegoating can be an important sociopolitical process and a way to defend or re-create community cohesion against forces that tend to disrupt it. Such resistance strategies themselves help create power and establish visible roles for stigmatized people and groups among themselves and in larger communities. They have individual, microsocial and macrosocial outcomes. Not only do groups become more effective, their

members learn and develop leadership skills that transfer to other spheres of life, renegotiate social identities and find ways to support others community members in these settings (Riemer et al., 2020).

The stigmatized form many groups and formal organizations in their efforts to improve their lives. They often frame this in terms of defending civil liberties or human rights. Examples of such formal groups include a host of LGBT rights organizations; the Black Lives Matter movement in the United States; the wide variety of feminist and radical women's organizations (e.g., Feministas Antiprohibicionistas in Brasil); the International Network of People Who Use Drugs (INPUD); Stop Stigma Now (an organization primarily of methadone patients); international and national groups of people living with HIV; the National Alliance on Mental Illness in the United States; and sex workers' groups (e.g., Red Thread in the Netherlands, the International Union of Sex Workers in the United Kingdom, Durbar Mahila Samanya Committee in India, and the Association of Women Sex Workers (AMMAR) in Argentina.

Relatively little research has been conducted on the extent to which and conditions under which these groups work together as allies versus competing or being in conflict (Lisa Rosenthal, 2016). Questions that should be researched in this regard include understanding how and when severe scapegoating of given groups leads others to abandon or even to attack them. Many civil liberties groups and worker activists in the United States refused to defend groups brought to trial under the red-baiting Smith Act during the 1840s and 1950s, for example. And many United States trade unions refused to represent women and/or Blacks during the 19th and much of the 20th Centuries.

Finally, Figure 4 also includes (potential) mass movements. As has been seen in the years since the 1930s, mass movements among industrial workers, public employees, minority groups, women and gays greatly weakened the stigmas against these groups. (When these movements weakened, on the other hand, political aspirants found ways to attack them and reverse the gains.) When these movements are strong, they greatly increase the power of the organizations that try to represent them and also potentially change the goals of these anti-stigma organizations to aspire to much more radical reductions in stigma and oppression.

Discussion

The stigma system is multilevel, complex, and interactive. This paper builds upon prior writings regarding structural stigma and how stigma can serve the purpose of powerful groups while damaging the health of stigmatized groups (Hatzenbuehler et al., 2013; Link & Phelan, 2014; Link & Phelan, 2001; Rao et al., 2019; Yang et al., 2014). In particular, our model incorporates and expands upon prior writings describing ideologies and organizational forms used by the powerful to maintain their power and wealth and to reduce opportunities for those subject to their rule to challenge their power successfully. Our model further clarifies pathways regarding how stigmatized individuals resist subordination, stigmatization and scapegoating (Samuel R. Friedman, 1998; Goldfield, 1997; Hughes, 1962; Lichtenstein, 2014; Parker & Aggleton, 2003; Rainwater, 1967). It also discusses

how resistance and opposition to scapegoating and stigmatization both result from the stigmatization process and interact with it as the powerful attempt to weaken or destroy such resistance (Samuel R. Friedman, 1998; Gamson, 1976, 1990; Gramsci, 2015; Smet, 2016). Our model's novel contributions lie in the identification and interrelation of the different major "layers" of the stigma system in their interaction with the efforts of the stigmatized and their allies to resist or destroy stigma and sometimes to destroy the system that creates it.

We see this paper as extending and complementing the groundbreaking work of analysts such as Link, Phelan and their collaborators, and Pescolido and her collaborators, who have also proposed perspectives that attempt to synthesize the social and the psychological and to conceptualize the social in fairly specific terms (Pescosolido & Martin, 2015; Pescosolido et al., 2008). This paper attempts to extend their insights in several ways: 1. We focus on how stigma and discrimination are part of an active system of domination and response; 2. Although we recognize that stigmas become important aspects of culture and as such also become internalized and part of psychological processes, we see such culture and internalization not only in terms of small group interactions, but also as imbedded in dynamic political and economic forces and changes; 3. We examine long-term processes that established certain stigmas in their current form; and 4. We look at specific roles and organizational forms that are central in both creating/maintaining and challenging stigmas.

As discussed above, Figure 4 presents a different view of the dialectical model than Figure 1 presented. It concretizes Figure 1 and expresses how it takes specific organizational and political form. Scapegoating projects conducted to maintain the power of the rich and powerful are operationalized downwards in this diagram, representing ways in which the power of international and national capital and state forms take root and are concretized and enacted in a somewhat hierarchical fashion. Their actions are assisted and perhaps reshaped to an unknown degree as pre-existing stigmatizing norms and attitudes and beliefs in the underlying population influence the views, norms, and actions of those with more power. (This is represented in the arrows originating in the box on stigmatization among the population.) Little research has been conducted on the relative extent (under varying conditions) to which stigma at the bottom influences stigma at higher reaches of power or the extent to which it influences the targets at which elites' scapegoating projects are directed or the ways in which they are conducted (Stangl et al., 2019). The system is further complicated by the existence of both informal resistance among the stigmatized and formal organizations that attempt to defend the rights, dignity, and lives of the scapegoated and stigmatized. Again, it is likely that these forms of resistance and opposition interact with both scapegoating projects and with the diffusion of stigma from the population to elites. Little research has been done on this complex pattern of dialectical interaction among divide-and-rule scapegoating, diffusion from bottom to top, and opposition. Nonetheless, the model we have presented should help the stigmatized and their allies, as well as public health actors more generally, to understand the stigma system and either to resist (or destroy) it or to reduce its negative impacts on health by developing more systematic, multilevel interventions.

More fundamentally, there is a dialectical interaction between the threat of potential mass movements (or the actuality of real mass movements when they exist) and the scapegoating/stigmatizing projects of the rich and powerful. In many ways, they are mutually constitutive: Elites conduct scapegoating campaigns to protect their wealth and power, and to some extent their stigmatizing values and beliefs, from challenge by mass movements. And as was discussed in Friedman, Rossi & Ralon (2015), outrage at attacks on peoples' dignity (an important aspect of stigma and scapegoating) is a powerful motivator of mass movements (Friedman et al., 2015). One way to look at the intermediary layers of Figure 4 is that local and national role-holders and organizations act as mediators between the (potential) mass movements and the scapegoating projects of the wealthy and powerful, although in this interpretation we would probably want to include specific discussion of the role of organic intellectuals among both the elites and the stigmatized in the analysis (Hatzenbuehler et al., 2013).

This interpretation also offers useful insight into how public health has historically viewed stigma: One fundamental goal and result of the hegemony of capitalist social relations and its associated oppressions and stigmatization processes is to *individualize* the way people think about their lives and to make people think that most problems in their lives are their own fault (Arat-Koç, 2014; Decoteau, 2014; Du Bois et al., 2021; Samuel R. Friedman, 1998; Viscelli, 2016). This is visible in the way many public health and popular discussions and interventions treat stigma as an individual problem that involves interactions between people with "spoiled identities" (in Goffman's terms in his canonical work on *Stigma*) and people who are themselves "racists" or "sexists" or "homophobes" or "addictophobes" (Goffman, 2014). The solution for such individual ills is then seen primarily as being a matter for education, individual counseling or perhaps (for the stigmatizers) individual punishment. On the other hand, as discussed above, the most effective ways to weaken or eliminate stigma and scapegoating are mass movements—that is, a political solution that is the opposite of individualized analysis and intervention.

What does this imply for public health research and action?

Research agendas to understand stigma systems should embrace a wealth of different methodologies, disciplines, and, indeed, ontological frameworks. On the one hand, the issues raised in this paper can be addressed using standard positivistic, quantitative multilevel statistical models in which stigma in different geographic units are studied (Williams et al., 2019, 2020). Longitudinal models that assess variation over both place and time could capture potential causal pathways. Ethnographic studies can study the details of stigmatizing and scapegoating processes; ideally, such studies will include studies of elites and their actions and discussions around issues of scapegoating, structured inequality, and stigma. Historical, sociological, and political science studies can also study these processes (and perhaps antidiscrimination and anti-stigmatization interventions) as dialectical conflicts. These different forms of studies will produce a wealth of information and interpretations that can then be synthesized to get a fuller understanding of stigma and how it can be fought and reduced.

Most important, this paper has practical implications (L. Rosenthal, 2016). Given the extent to which stigma is an obstacle to public health interventions like treating people with HIV or hepatitis C or other STIs (Takahashi, 1998), scaling up evidence-based treatment for drug-related problems (which can also reduce overdose mortality) (Des Jarlais et al., 2006; Hadland et al., 2018; Olsen & Sharfstein, 2014; Tempalski et al., 2007), or addressing mental health care (Cerit et al., 2012; Cooper et al., 2003; Corrigan & Watson, 2002; Henderson et al., 2013), as just a few examples, it is important to find ways to address and reverse stigma. Similarly, given the enormous importance of racism, sexism and other forms of oppression and marginalization as negative factors in the mortality and health of populations (Clark et al., 1999; Risman, 2004; Williams & Mohammed, 2009; Wingood et al., 2000), it is important to find ways to end these mechanisms of stigmatization. As discussed above, most such efforts in public health have been guided by concepts of stigma based on reducing internalized stigma at the individual level, using interventions that target small groups or individuals' personal social networks to reduce interpersonal stigma (see Figure 1), or in some cases to use educational approaches to reducing stigmatizing behavior by medical personnel (Jenkins et al., 2021; Nyblade et al., 2019; Rao et al., 2019; Stangl et al., 2013; van Boekel et al., 2013). This paper implies that such approaches are not adequate on their own since they are based on partial theories. *Stigma and scapegoating are political processes as well as public health menaces*. Powerful people and institutions use them for their own benefit and defense. This means that public health efforts around stigma reduction need to take this into account and have to recognize that effective stigma interventions cannot be "value neutral" but instead have to be framed in terms of supporting the interests and needs of the scapegoated and stigmatized. One example of pressure on governments and on powerful people and institutions that has led to useful effects on public health is the effort to create civil rights laws of various types for sexual minorities (Hatzenbuehler et al., 2020; Rao et al., 2019).

This means that research that is open about its political goals is needed.

This is not new to medical or public health fields: Modern medicine routinely takes the side of patients to kill other living things (like bacteria) that are hurting the patients. Furthermore, public health has historically intervened in terms of building codes (e.g., to reduce the spread of tuberculosis and other diseases), sewers, and many other sanitation measures, even when these have been resisted by real estate interests or others who stood to lose money as a result. Similarly, the field of occupational health has often taken sides in favor of workers and against employers.

It is important, of course, that research on stigma be honest and accurate. This is entirely feasible in research that opposes stigma and the stigma system. Such a full program of research on stigma may run into political obstacles to getting funded, but this also is nothing new. Powerful political actors in the United States have stopped research projects on HIV/AIDS and gun violence, and at the current time, research on climate change and its health effects is a political battlefield.

In conclusion, the stigma system is a complex pattern of social and interpersonal power and conflict, and thus is a thoroughly political system that is highly deleterious to individual and

public health. Research on this system has far to go, but action needs to be taken as further research is conducted. Indeed, we would anticipate that the research and the action can learn from each other to the benefit of both.

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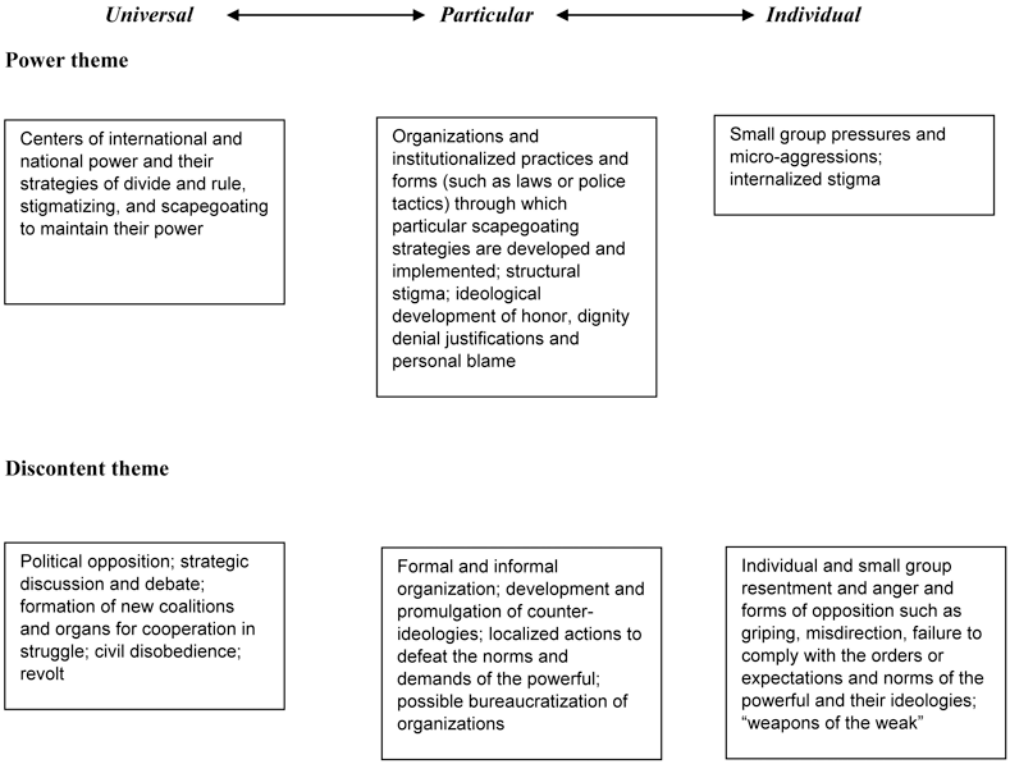

Figure 1.
The Stigma System as an Interactive Dialectic of Multilevel Processes

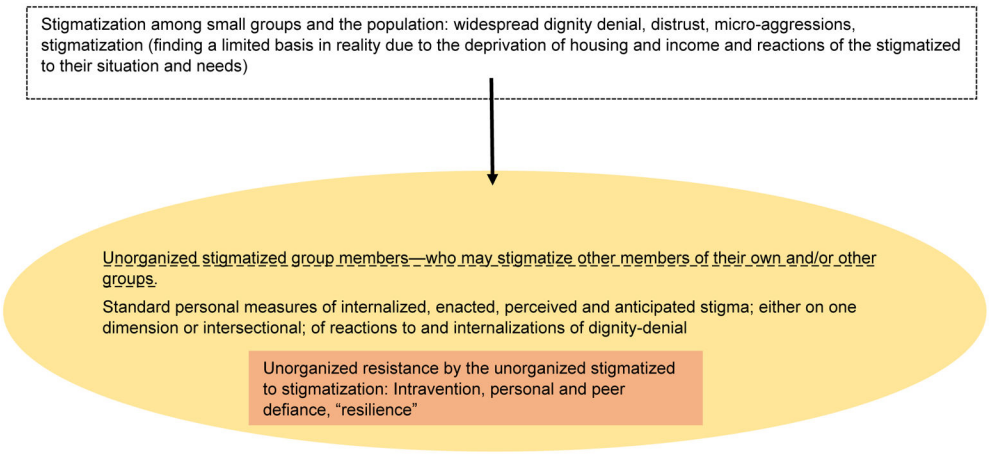

Figure 2.
A social psychological or small group perspective on stigma

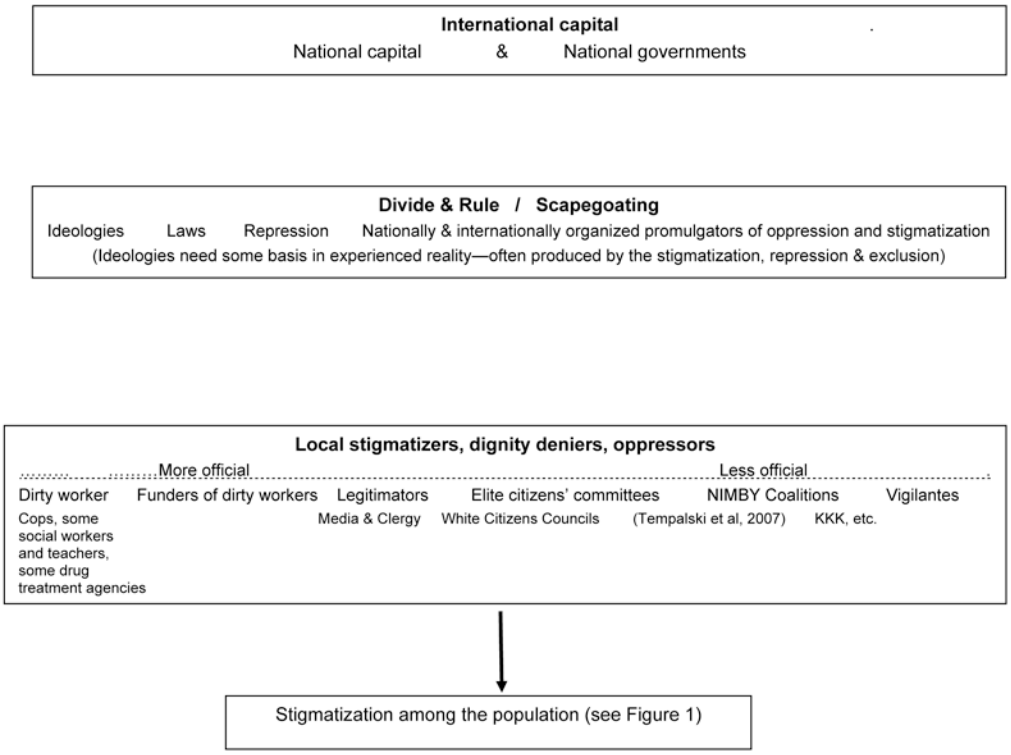

Figure 3. Stigma production/scapegoating: A concretization of how the Power Theme discussed in Figure 1 works

Note: The term "capital" may be unfamiliar to some readers. There are many definitions. In this paper, "capital" refers to institutions and organizations of whatever kind that invest in order to make profits.

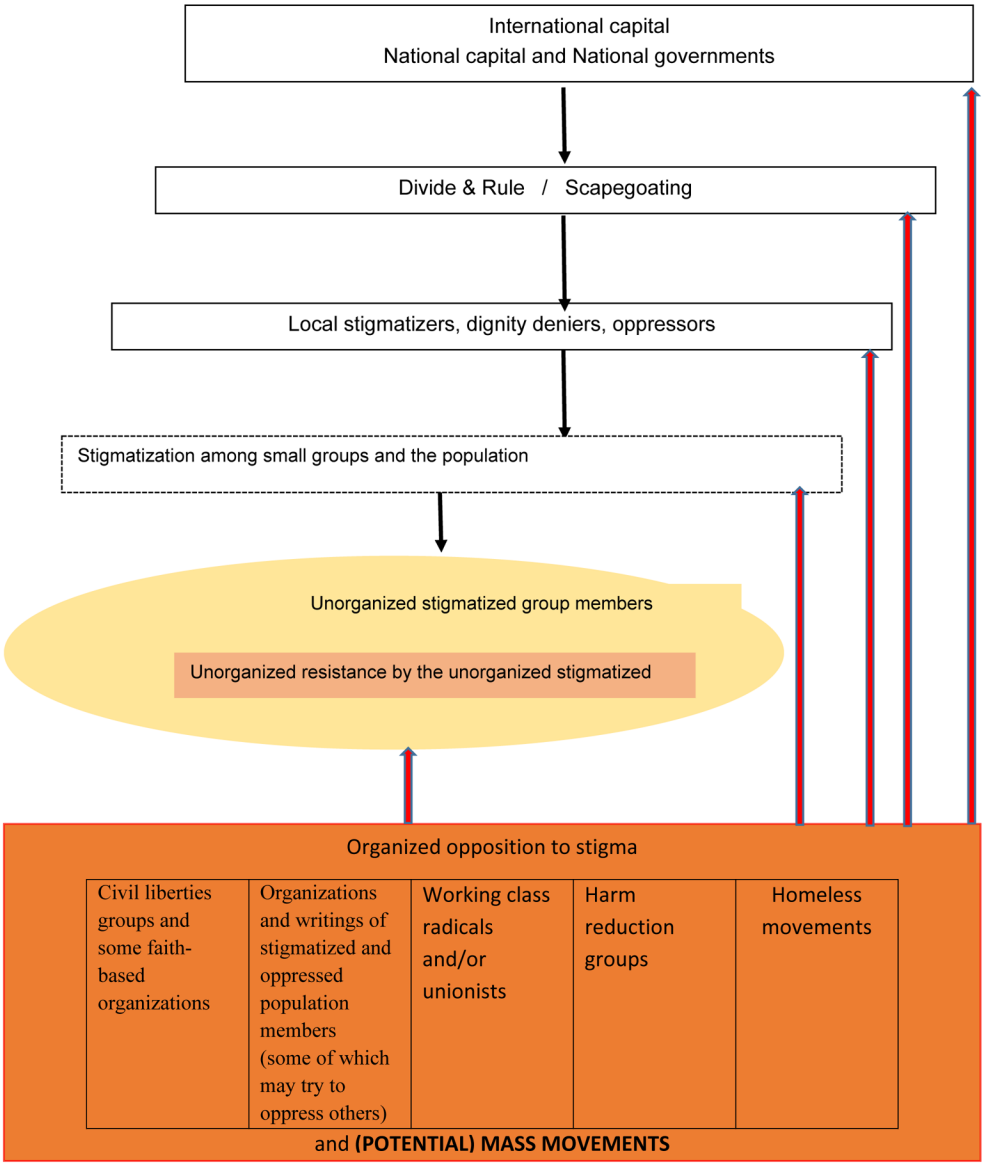

Figure 4. The Stigma System as a Concrete Whole

Downward-facing arrows represent ways in which powerful actors create and institutionalize scapegoating and thereby divide populations in order to rule them. Upward-facing arrows represent various ways in which the resistance and opposition of the oppressed and stigmatized manifest themselves in creating the Discontent Theme referred to in Figure 1. This Figure does not illustrate two other important parts of this dialectic: 1. That pre-existing stigmatization of part of the population by another part of the population creates lines of division that can be used by local, national or international power-holders or aspiring power-holders to win support via scapegoating; nor 2. That ideologies of individual blame and meritocracy facilitate "blaming the victim" and thus scapegoating.[155]