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"Discredited" Versus "Discreditable": Understanding How Shared and Unique Stigma Mechanisms Affect Psychological and Physical Health Disparities

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Abstract

In his classic treatise, Goffman (1963) delineates between people who are *discredited*—whose stigma is clearly known or visible—and people who are *discreditable*—whose stigma is unknown and can be concealable. To what extent has research in the past 50 years advanced Goffman's original ideas regarding the impact of concealability on stigma management strategies and outcomes? In the current article, we outline a framework that articulates how stigma can "get under the skin" in order to lead to psychological and physical health disparities. Further, we consider when and to what degree concealability moderates these effects, creating divergent outcomes for the *discredited* and *discreditable*.

> Does the stigmatized individual assume his differentness is known about already or is evident on the spot, or does he assume it is neither known about by those present nor immediately perceivable by them? In the first case one deals with the plight of the *discredited*, in the second with that of the *discreditable*. This is an important difference.
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> — Goffman (1963, p. 4)

In his seminal work, the sociologist Erving Goffman (1963) suggested that the experience of stigma differs based on the concealability of the stigmatized attribute. The *discredited* are individuals who have a stigma that is predominantly visible such as race/ethnicity, gender, or physical disability. In contrast, the *discreditable* are individuals who have a stigma that is predominantly concealable such as mental illness, HIV infection, or sexual minority status. Thus, these terms refer to the visual conspicuousness of the stigmatized attribute.[1]

Although Goffman's analysis largely focused on examining differences in the experience of stigma, most psychological research in the past 50 years hasn't adopted a similar approach. Instead, research has largely focused on the causes and consequences of stigmatization

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[1]For purposes of this article, we categorize types of stigmatized identities into discredited or discreditable categories based on whether the attributes are typically visually conspicuous. It is important to note, however, that some identities may be either discredited and visible or discreditable and concealable depending upon specific time or social context. For example, though we conceptualize HIV as a discreditable or concealable stigma, physical symptoms of disease progression may sometimes render the identity as visible (e.g., Stutterheim et al., 2011).

among either visible stigmas (e.g., race: Richeson & Shelton, 2007; gender: Murphy, Steele, & Gross, 2007) or concealable stigmas (e.g., Quinn & Chaudoir, 2009; sexual orientation: Beals, Peplau, & Gable, 2009) alone. Consequently, there exist very few empirical studies (e.g., Frable, Platt, & Hoey, 1998; Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009) or theoretical analyses that directly compare the experiences of visibly and concealably stigmatized individuals.

In the current work, we apply Goffman's (1963) conceptualization of difference in order to understand how concealability contributes to psychological and physical health disparities. Health disparities are differences in health outcomes between groups that reflect social inequalities (Centers for Disease Control and Prevention, 2011a). Psychological and physical health disparities have been shown to occur among groups that occupy a lower social status such as African Americans (Centers for Disease Control and Prevention, 2011a; see also Adler & Rehkopf, 2008; Schnittker & McLeod, 2005) and sexual minorities (Centers for Disease Control and Prevention, 2011b; Marshal et al., 2011; Mayer et al., 2008).

We draw on research and theorizing across social psychology (Adler & Rehkopf, 2008; Earnshaw & Chaudoir, 2009; Hatzenbuehler, 2009; Pascoe & Smart Richman, 2009; Schnittker & McLeod, 2005) and social epidemiology (Berkman, 2000; Krieger, 2000) to present a conceptual framework that captures how stigma "gets under the skin" to affect psychological and physical health disparities. The Stigma Mechanisms in Health Disparities Framework, depicted in Figure 1, describes how public stigma initiates a cascade of processes that ultimately lead to disparate outcomes among stigmatized and nonstigmatized individuals. This cascade of processes begins with *public stigma*, which is the relative degree of devaluation associated with a stigmatized attribute (i.e., cultural stigma; Quinn & Chaudoir, 2009). It encompasses a "community's negative reaction to a stigma"—a reaction that confers lower social status and power to those who possess the stigmatized attribute (Link & Phelan, 2001). Consistent with previous theorizing (Earnshaw & Chaudoir, 2009), public stigma is manifested via a series of stigma mechanisms that can be conceptualized to occur at individual, interpersonal, and sociocultural levels. That is, stigma-related phenomenon can be conceptualized to occur within the individual target, interpersonal interactions among dyads or groups of people, or across societies or cultures. At each of these levels, stigma mechanisms elicit mediating processes—stress, health behaviors, and biological changes—or more proximal processes that enable stigma to "get under the skin" and cause disparities in mental and physical health. Further, at each level, we consider Goffman's (1963) perspective of difference (see Table 2): To what extent does concealability affect the degree to which stigma "gets under the skin" to affect psychological and physical health disparities?

INDIVIDUAL LEVEL

Stigma Mechanisms and Processes

Most psychological research examining stigma has occurred at an individual level of analysis; it has tended to adopt the perspective of the "target," examining how public stigma manifests itself within stigmatized individuals (Crocker, Major, & Steele, 1998; Major & O'Brien, 2005). Self-stigma is a term that broadly refers to how individuals respond to possessing a stigma (e.g., Pryor & Reeder, 2011). These responses can be manifested as three primary beliefs—anticipated, enacted, and internalized stigma (Earnshaw & Chaudoir, 2009)—regarding how the stigma relates to the broader social context. Anticipated stigma refers to the degree to which individuals anticipate or expect to be the target of discrimination or social rejection because of their stigma. Enacted stigma refers to the degree to which individuals actually have experienced discrimination in the past. Last,

internalized stigma refers to the degree to which individuals feel shame or self-loathing because of their stigma. Anticipated and enacted stigma reflect stigma directed at the self from others, whereas internalized stigma reflects stigma directed at the self from the self. Each of these individual-level stigma mechanisms have been associated with poorer mental and physical health outcomes (e.g., Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Mak, Poon, Pun, & Cheung, 2007; Pascoe & Smart Richman, 2009; Quinn & Chaudoir, 2009).

Expectations and experiences of stigmatization can be stressful. For example, female students who expected to be devalued in a predominantly male math, science, and engineering educational conference experienced greater cardiovascular reactivity (e.g., faster heart rate; Murphy et al., 2007) than women who did not expect to be devalued. Past perceptions of stigmatization can also exacerbate the effect of new stressors. For example, perceived discrimination is related to dysregulation of daily blood pressure trajectories and greater reactivity to new social stressors among adult Black and White participants (Smart Richman, Pek, Pascoe, & Bauer, 2010). In response to stigma-related stressors, individuals may also be more likely to experience negative affective states and utilize maladaptive coping strategies such as alcohol use or rumination (Berkman, 2000; Hatzenbuehler, 2009), thereby facilitating greater overall psychological distress. Over time, chronic exposure to stigma-related stressors and activation of physiologic stress systems (i.e., sympathetic nervous system and hypothalamic-pituitary adrenal axis) can contribute to allostatic load, or the accumulation of physical “costs” or “wear and tear” on the body from stress (for a review, see Ganzel, Morris, & Wethington, 2010). Thus, stigma-related stressors can undermine mental and physical health.

In addition, anticipated, enacted, and internalized stigma may undermine health behaviors that optimize health and well-being (e.g., disease screenings, diet, and exercise) and increase health-compromising behaviors that actively damage health (e.g., tobacco use, sexual risk behavior). For example, people living with chronic illnesses who anticipate stigma from health care workers are less likely to access health care regularly (Earnshaw & Quinn, 2012). Meta-analytic evidence suggests that enacted stigma is associated with increased drug and alcohol use, poor eating behaviors and attitudes, and poor medical treatment adherence (Pascoe & Smart Richman, 2009). Internalized stigma is further associated with decreased adherence to therapy among people living with mental illnesses (Eisenberg, Downs, Golberstein, & Zivin, 2009), as well as drug use and sexual risk (Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008; Weber, 2008). Because these stigma mechanisms undermine the availability of self-regulatory resources (Inzlicht, McKay, & Aronson, 2006; Inzlicht & Kang, 2010) and activate feelings of powerlessness that undermine self-efficacy (Cook, Arrow, & Malle, 2011), they can contribute to poorer health-related behaviors and disparities.

Discredited Versus Discreditable—Because of their visual conspicuousness, the *discredited* are more easily identified as “tainted” relative to the *discreditable*. Consequently, the *discredited* may be more likely to expect and to actually experience individual-level stigmatization relative to the *discreditable*. What evidence exists to support this hypothesis?

Anticipated stigma: To some extent, anticipated stigma appears to affect the *discredited* and the *discreditable* similarly. A large body of research suggests that the stigmatized are subject to a number of detrimental psychological outcomes due to identity threat—situational concern that one will be socially devalued (for a review, see Schmader, Johns, & Forbes, 2008). Although most of this research has focused on visible stigmas such as race and gender, similar effects have been observed for concealable stigmas such as mental illness (Quinn, Kahng, & Crocker, 2004). Similarly, chronic expectations of stigmatization

have been related to greater psychological distress among both visible and concealable stigmas (Chan & Mendoza-Denton, 2008; Quinn & Chaudoir, 2009). For example, women who had a history of abortion reported greater distress at a 2-year follow-up to the extent that they expected stigmatization and felt the need to keep their identity concealed (Major & Gramzow, 1999). There is also evidence that anticipated stigma is related to poorer health outcomes among concealable stigmas (Cole, Kemeny, & Taylor, 1997; Quinn & Chaudoir, 2009), though this possibility has not been examined among visible stigmas. Thus, to the extent that the *discredited* and *discreditable* feel that they are vulnerable to social devaluation, they may experience similar vulnerabilities for psychological and physical health disparities.

Enacted stigma: Some recent evidence suggests that the frequency of enacted stigma is similar for individuals with visible (i.e., African American race) and concealable (i.e., sexual minority status) stigmas (Cook et al., 2011; Hatzenbuehler et al., 2009). In both of these daily diary studies, researchers examined the association between stigma and well-being among African American and sexual minority participants. These studies demonstrate that in the course of about 1 week, there were no differences in how frequently people felt stereotyped in everyday social interactions (Cook et al., 2011) or how frequently they experienced stigma-related stressors (Hatzenbuehler et al., 2009).

In contrast, other evidence suggests that individuals with visible stigmas may experience greater enacted stigma than those with concealable stigmas. Rather than compare two separate groups of visible or concealable stigmatized individuals, Stutterheim and colleagues (2011) focused on examining a single stigmatized identity that can be *either* visible or concealable: HIV-positive status. As HIV infection progresses, side effects of antiretroviral medications—such as lipodystrophy, or abnormal distribution of fat—can cause HIV status to become visible. In this sample, visibility of HIV status does appear to affect stigma-related outcomes. People living with visible symptoms of HIV report greater enacted stigma and psychological distress but lower self-esteem and social support, compared to people living without visible symptoms of HIV (Stutterheim et al., 2011).

What might explain this conflicting pattern of results? One possibility is that this pattern may be attributable to the types of samples utilized across these studies, which likely differ in the degree of cultural stigma associated with them. The studies demonstrating that there were no differences in rates of enacted stigma involved African American and sexual minority participants (Cook et al., 2011; Hatzenbuehler et al., 2009), whereas the study demonstrating differences involved only HIV-positive participants (Stutterheim et al., 2011). One advantage of utilizing the same stigmatized identity and measuring its visibility is that it rules out cultural stigma—or severity of social devaluation associated with the identity—as a potential confounding variable. Thus, the association between visibility and enacted stigma in the HIV sample is attributable only to visibility and not to differing levels of cultural stigma that maybe associated with different types of identities. In this way, it's unclear whether the null results found in the former studies (Cook et al., 2011; Hatzenbuehler et al., 2009) are attributable to concealability per se, or differing levels of cultural stigma associated with African American ethnicity and sexual minority status.

Regardless of whether there are differences in the frequency of enacted stigma, research does suggest that the psychological consequences of enacted stigma on people with visible and concealable stigmas is different. Feeling stereotyped was related to greater behavioral inhibition—feeling less able to express oneself freely—among individuals with concealable stigmas relative to individuals with visible stigmas, and this association was mediated by identity centrality (Cook et al., 2011). Similarly, Hatzenbuehler and colleagues (2009) found that after experiencing stigma-related stressors, individuals with concealable stigmas

reported greater social isolation and less social support than individuals with visible stigmas. The association between stigma-related stress and psychological distress was mediated by social isolation/social support. Together, this research suggests that concealability may not necessarily affect the *frequency* of stigma-related events but rather the *effectiveness* of coping strategies utilized to address the demands of these stressors.

Internalized stigma: Goffman (1963) theorized that stigmatization would lead to internalized stigma: "The stigmatized individual tends to hold the same beliefs about the identity that we do. [This may cause him] to agree that he does indeed fall short of what he really ought to be. Shame becomes a central possibility" (p. 7). Since Goffman's original writings, researchers have demonstrated that internalized stigma can lead to negative psychological outcomes for some, but not all, stigmatized individuals. Because group-based comparisons and attributions for discrimination can provide self-protective benefits (Crocker & Major, 1989), individuals with visible stigmas such as race, gender, and physical disability are less likely to experience psychological detriments because of their stigmatized status. Yet research examining concealable stigmas such as HIV/AIDS (Earnshaw & Chaudoir, 2009) or sexual minorities (Hatzenbuehler, McLaughlin, et al., 2008; Meyer, 2003) continues to demonstrate that internalized stigma is a reliable predictor of important outcomes such as greater psychological distress, greater participation in health-compromising behaviors, and lower physical well-being. Further, some research findings offers direct evidence to suggest that the *discreditable* do, in fact, demonstrate lower self-esteem (Frable et al., 1998) and greater internalized stigma than the *discredited* (cf. Cook et al., 2011; Hatzenbuehler et al., 2009). Together, these findings suggest that internalized stigma negatively affects psychological outcomes, though this is most likely to occur among concealable stigmas.

INTERPERSONAL LEVEL

Stigma Mechanisms and Processes

Public stigma further shapes the way in which stigmatized individuals experience their social lives via mixed dyadic social interactions, social support, and social network features. Goffman's writings paid significant attention to how public stigma affects the nature of mixed dyadic social interactions (i.e., interactions between stigmatized and "normal" individuals). For example, he wrote that when stigmatized and "normal" individuals interact, social interactions "can become tense, uncertain, and ambiguous for all participants, especially the stigmatized one" (Goffman, 1963, p. 41). Indeed, research in the past 50 years has demonstrated that mixed interpersonal interactions between the stigmatized and nonstigmatized can be awkward and strained (for a review, see Hebl, Tickle, & Heatherton, 2003). These mixed dyadic social interactions may act as situational stressors that undermine health (Trawalter, Richeson, & Shelton, 2009). For example, interracial interactions between Black and White Americans are often anxiety-provoking experiences that elicit cardiovascular reactivity and other markers of physiological stress (e.g., Lepore et al., 2006). In addition, mixed dyadic social interactions characterized by stigma may undermine health behaviors. In the context of interracial patient–provider interactions, expectations or actual occurrence of stigmatization can lead to a host of deleterious outcomes that have direct effects on health disparities, including lower rates of adherence to treatment protocols, lower rates of access to and maintenance of care, and increased mistrust of the medical field, in general (for reviews, see Dovidio et al., 2008; Smedley, Stith, & Nelson, 2003).

In addition, public stigma may shape characteristics of social networks that surround stigmatized individuals. Social networks are simply the collection of friends, family, coworkers, and others with whom a given person typically interacts (Scott, 1988). Public

stigma affects the composition of social networks by facilitating greater homogeneity of the types of people within the network. Namely, fear of stigma-by-association—or the tendency for social devaluation to transfer from a stigmatized target to persons who are associated with the target—may limit the number of nonstigmatized individuals within the social network (McLaughlin-Volpe, 2006). Greater homogeneity of social networks may involve trade-offs for stigmatized individuals. On one hand, stigmatized individuals can derive a number of self-esteem benefits from their group membership to the extent that they feel that they are part of a larger group (Tajfel & Turner, 2004). On the other hand, belonging to a larger disadvantaged group may block individuals' access to information, social opportunities, and resources that benefit their health (Berkman, 2000).

Further, public stigma affects the degree to which stigmatized individuals experience social support. Social support is typically conceptualized and measured in two primary ways: perceived social support, and received social support (for a review, see Uchino, 2009). Perceived social support refers to the degree to which individuals feel that they can access interpersonal support from others (Sarason, Sarason, Shearin, & Pierce, 1987), whereas received social support refers to the degree to which individuals utilize or exchange support in specific situations of need (Bolger & Amarel, 2007; Cobb, 1976). Thus, whereas perceived support is typically conceptualized and measured as an individual difference variable, received support is typically conceptualized and measured as a state or situation-specific process. Social support is a strong predictor of optimal adaptation to stress and better health behaviors (for a review, see Uchino, 2009) and can therefore lead to improved health among stigmatized individuals.

Discredited Versus Discreditable

Dyadic social interactions: In his original writings, Goffman emphasized that dyadic social interactions between the stigmatized and nonstigmatized could be strained, awkward, and uncomfortable, especially for those whose stigma is visible. In the past 50 years, most psychological research has examined mixed social interactions among visible stigmas such as racial minorities (Richeson & Shelton, 2007) or individuals with physical disabilities or deformities (Kleck & Strenta, 1980), with limited examination of mixed social interactions among concealable stigmas such as sexual orientation or mental illness (for reviews, see Hebl et al., 2003; Quinn, 2006). How does concealability affect experiences of dyadic social interactions? Although the ability to "pass" appears to be adaptive for the quality of social interactions, it does appear to come at some psychological cost for individuals with concealable stigmas. As Quinn (2006) reviewed, individuals with concealable stigmas are likely to be doing extra "cognitive work" during mixed social interactions to keep their identities concealed. Thus, although the social interactions may go more smoothly for individuals with concealable stigmas, they are likely to be more preoccupied with thoughts about their identities (Smart & Wegner, 1999) and their partner's perspective (Frable, Blackstone, & Scherbaum, 1990). Thus, concealability appears to afford a relative trade-off: Better social interactions and lower social evaluative threat come at the expense of greater cognitive detriments.

In therapeutic or clinical contexts, this trade-off may have more serious consequences for well-being. Although concealability is likely to create better social rapport in the social interaction, it may compromise the quality of treatment provided. For example, an individual who conceals her mental illness from her medical provider may develop better rapport with her provider because she doesn't have to worry that she is being socially devalued by her provider, and her provider's behavior won't be affected by this knowledge of her stigmatized attribute. However, because she hasn't disclosed this information to her provider, the provider doesn't have access to the full range of information that is needed to

build an effective treatment protocol. Given that antidepressants prescribed to treat mental illness can create adverse reactions when coadministered with many painkillers (Sansone & Sansone, 2009) and other pharmacological treatments, omission of this important information could limit the efficacy of her treatment. Thus, concealability can pose a serious and direct threat to mental and physical health by affecting the social information available for use (Chaudoir & Fisher, 2010). In addition, concealing may hurt the development of social rapport in therapeutic or treatment contexts under certain circumstances. Concordance between patient and provider can lead to improved treatment for patients with both visible (Smedley et al., 2003) and concealable (Davidson et al., 1999) stigmas. If patients or providers conceal their stigma, however, such rapport cannot be achieved. In this way, concealability may further threaten health by limiting opportunities for connecting over shared experiences.

Social network homogeneity: Fundamentally, concealability means that the *discreditable* have a much harder time identifying and interacting with people who share their stigmatized attribute. For example, in a survey study of perceptions of psychological marginality, individuals with concealable stigmas reported feeling more unique and perceiving less similarity with other people relative to individuals with visible stigmas (Frable, 1993). Thus, to the extent that psychological marginality is a proxy for the composition of larger social networks, these data might suggest that individuals with concealable stigmas are less likely than individuals with concealable stigmas to have homogenous social networks that include other similarly stigmatized individuals.

What are the consequences of having a social network that doesn't readily include people who share the stigmatized attribute? Given that people rely on visible social cues to infer belongingness (Murphy et al., 2007; Walton & Cohen, 2007), the *discredited* may chronically experience lower sense of belonging, lower self-worth, and greater internalized stigma because they are less likely to see similar others in their day-to-day lives. Indeed, a daily diary study found that individuals with concealable stigmas reported greater negative affect, greater social isolation, and lower self-esteem than those with visible stigmas (Frable et al., 1998). Although they felt more socially isolated, when individuals with concealable stigmas did have the opportunity to be around "similar" others, they experienced a temporary boost to their well-being. Individuals with visible stigmas did not experience a similar "boost," possibly because they are more accustomed to interacting with "similar" others in their day-to-day lives.

Further, as other scholars have noted (Pachankis, 2007; Quinn, 2006), concealability acts as a barrier to forming a group identity with similar others and prevents the use of group-based coping responses. Although individuals with visible stigmas can utilize group-based coping resources in the face of stigma-related stressors (Crocker & Major, 1989), these processes are largely unavailable to the *discreditable*. For example, a daily diary study revealed that individuals with a visible stigma (i.e., African Americans) reported greater identity centrality than individuals with a concealable stigma (i.e., sexual minorities; Cook et al., 2011). Further, when made to feel stereotyped in their everyday interactions, sexual minorities felt lower in power than African Americans, a pattern of effects that was mediated by identity centrality. Thus, this evidence would suggest that because individuals living with concealable stigmas may be less able to cultivate a strong sense of identity centrality relative to individuals living with visible stigmas, they might be more vulnerable to deleterious effects of stigmatization.

If the *discreditable* cannot rely on group-based coping resources such as identity centrality, social support, or collective self-esteem, what can they rely upon in times of stigma-related stress? Converging evidence suggests that the *discredited* may be more likely to utilize

avoidant or otherwise ineffective coping strategies—such as substance abuse, rumination, and social isolation—in order to cope with stigma-related stressors (Hatzenbuehler et al., 2009). Indeed, in a daily diary study, individuals with concealable stigmas reported greater social isolation and less social support than individuals with visible stigmas after experiencing stigma-related stressors (Hatzenbuehler et al., 2009). The tendency for individuals with concealable stigmas to socially isolate themselves and feel less social support mediated the association between stigma-related stress and psychological distress. Thus, these data suggest that when individuals with concealable stigmas engage in socially isolating coping responses, they risk exacerbating their levels of distress. Thus, whereas visible stigmas can utilize a wide array of approach and avoidance-focused coping resources (e.g., Major & O'Brien, 2005; Miller, 2006), our review suggests that the *discreditable* are less able to utilize approach-focused coping resources and processes that visible group membership affords. Given that stress is one of the primary mediating processes by which stigma "gets under the skin," the *discreditable* are at a distinct disadvantage in coping with stigma related stressors.

Social support: How does concealability affect the social support that is available to and utilized by stigmatized individuals? Although there is no direct evidence examining this question among perceived social support, there is some evidence to suggest that concealability affects whether social support is actually utilized in response to stigma-related stressors. In a daily diary study conducted by Hatzenbuehler and colleagues (2009), individuals with either a visible stigma (i.e., African American race) or a concealable stigma (i.e., sexual minority status) tracked their exposure to stigma-related stressors and their utilization of social support and feelings of psychological distress. They found that sexual minority participants reported greater social isolation and less utilization of social support than African Americans after experiencing stigma-related stressors. In fact, African Americans actually utilized more social support on days that they experienced stigmatization, relative to days without these stressors. Further, the greater tendency for sexual minorities to socially isolate themselves and utilize less social support mediated the association between stigma-related stress and psychological distress. These data suggest that when individuals with concealable stigmas actively engage in socially isolating coping responses and fail to utilize social support, they risk exacerbating their levels of distress.

Overall, these findings echo the aforementioned conclusions regarding the impact of concealability on well-being. In times of stress, individuals with concealable stigmas are simply less able to identify others who can provide essential social support. This represents a key difference in the experience of stigma—one that has significant consequences for well-being.

SOCIOCULTURAL LEVEL

Stigma Mechanisms and Processes

Individual beliefs and interpersonal processes are both nested within broader sociocultural phenomena. We focus on three ways in which sociocultural-level phenomena, or characteristics of social contexts, influence the health of people living with stigmatized identities: hazardous environmental conditions, health care access and quality, and public policy.

Members of stigmatized groups are differentially exposed to hazardous environmental conditions that threaten their health. Neighborhoods, schools, and workplaces remain largely segregated based on race and socioeconomic status within the United States and elsewhere. Within these segregated environments, racial minorities and individuals of low socioeconomic status and are regularly exposed to greater amounts of toxic substances and

pollutants (Krieger, 2003; Schnittker & McLeod, 2005), greater violence (Krieger, Waterman, Chen, Soobader, & Subramanian, 2003), and greater exposure to infectious diseases including syphilis, gonorrhea, chlamydia, and tuberculosis (Krieger et al., 2003). These hazardous environmental conditions result in biological changes that undermine the health of stigmatized individuals. The greater amounts of toxic substances and pollutants that racial and ethnic minorities are exposed to within segregated living and working environments put them at greater risk of cancer and other chronic health conditions (Krieger, 2003; Schnittker & McLeod, 2005). The greater violence that occurs in disadvantaged neighborhoods puts people of low socioeconomic status at increased risk of experiencing bodily harm and death (Krieger et al., 2003). Unsafe working conditions further threaten bodily injury and death among people of low socioeconomic status (Adler & Rehkopf, 2008).

Further, members of stigmatized groups often have less access to quality health care than members of non-stigmatized groups. There are a variety of reasons for this. For example, rates of uninsurance are higher among racial and ethnic minorities (Lurie & Dubowitz, 2007). In addition, racial minorities are more likely to live in neighborhoods where there are fewer physicians and where physicians are less likely to be board certified (Williams & Jackson, 2005). The hospitals in these neighborhoods also provide poorer emergency care, including greater transportation time to the hospital and low-quality care (Williams & Jackson, 2005). Further, racial minorities presenting with disease symptoms or characteristics are often treated less aggressively by providers (Smedley et al., 2003). Decreased health care access and quality prevents stigmatized individuals from adopting positive health behaviors and therefore leads to poor health.

Finally, public policies often disadvantage members of stigmatized groups and may ultimately shape their mental and physical health. Examples include policies that restrict people living with HIV/AIDS from accessing medical and dental care, attending schools, entering countries, and joining certain employment sectors (Earnshaw & Kalichman, 2013). Other policies designed to fight the “war on drugs” stereotype current drug users as “criminals” and “junkies” in an attempt to prevent people from using drugs (Tempalski et al., 2007). Further, policies that ban same-sex marriage and the adoption of children by sexual minorities delegitimize or discredit same-sex relationships (Weber, 2008). These policies may undermine health by preventing stigmatized individuals from adopting positive health behaviors (e.g., regular medical and dental care, use of clean injection equipment) and increasing their psychological distress (Hatzenbuehler, 2011; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010).

Discredited Versus Discreditable

Health care access and quality: In response to striking evidence of racial and socioeconomic disparities, a great deal of attention and ameliorative efforts have been focused on increasing quality and diversity of health care providers and resources in order to reduce these gaps (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). To what extent does concealability affect these gaps in health care and access and efforts to reduce them? At present, it seems that these gaps disproportionately affect visible stigmas such as race. However, emerging evidence is beginning to document gaps in care among some concealable stigmas. Many areas of the country provide limited access to health providers who are trained to provide effective care services to treat mental illness and mental health issues that are unique to individuals with concealable stigmas such as homosexuality, sexual assault, and drug or alcohol addiction (e.g., Mayer et al., 2008). At the same time, evidence pointing to inferior health outcomes among sexual minorities (Wolitski, Stall, & Valdiserri, 2008) and people living with mental illness (Atdjian & Vega, 2005) continue to accumulate.

Concealability affects health care access and quality to the extent that it focuses greater attention on visible relative to concealable stigmas. The gaps in health care access and quality may that are distributed on the basis of race and socioeconomic status may, in fact, be substantially greater than those distributed based on sexual orientation, mental illness, chronic illness, or any other number of concealable stigmas. But, the available data do not provide clear evidence to fully understand the extent to which stigma affects health care access and quality in these domains. Thus, although the largest gaps and efforts to reduce these gaps focus on race and socioeconomic status, it remains unclear whether this is because gaps in health care access and quality do not occur or whether there are too few data to adequately examine this possibility.

Hazardous environmental conditions: To date, most research suggests that differential exposure to hazardous environmental conditions (e.g., pollution, carcinogens, violence, health-compromising commodities) is contingent upon race and socioeconomic status (Adler & Rehkopf, 2008; Krieger, 2003; Schnittker & McLeod, 2005). The current evidence, therefore, appears to suggest that these stigma mechanisms disproportionately affect individuals with visible stigmas. However, to date, little research has directly examined whether these hazardous environmental conditions might also disproportionately affect outcomes for individuals with concealable stigmas.

One possibility is that many of the same social and governmental influences that contribute to segregation among race and socioeconomic status might also contribute to segregation among concealable stigmas. For example, sexual minorities may be more densely populated in regions of the country or cities that are more accepting of sexual diversity. Certain government policies and social services also contribute to greater segregation. Policies such as those that provide affordable housing for individuals with severe mental illness, chronic illness, or HIV can also contribute to greater density of concealable stigmas in particular areas. Although this segregation may enable individuals with concealable stigmas to find greater social support from similar others, it can also lead to greater marginalization. To the extent that hazardous environmental conditions disproportionately affect these areas, concealable stigmas may be subject to similar detriments.

Public policy: Public policies, guidelines, and laws serve to formalize the values and expectations of a given society. As such, public policies play an important role in promoting values and behaviors that express acceptance and prohibiting values and behaviors that express bigotry. Although some federal policies such as the Americans with Disabilities Act provide equal protection for visible (e.g., physical) and concealable (e.g., mental illness) disabilities (U.S. Department of Justice, 2011), most federal policies such as Title VII of the Civil Rights Act, the Equal Pay Act, and other laws enforced by the U.S. Equal Employment Opportunity Commission primarily afford protection against discrimination and prejudice for the *discredited* (e.g., prejudice based upon race, gender, age; U.S. Equal Employment Opportunity Commission, 2011).

Although federal laws do offer some degree of protection against prejudice, the discredited are also more likely to be subject to additional policies that may compromise this protection. For example, the U.S. Department of Defense's enforcement of "Don't Ask, Don't Tell" policies encourage a military culture that views and treats sexual minorities as inferior and may, therefore, contribute to greater victimization of sexual minorities in the military (Burks, 2011). Similarly, sexual minority students who attend schools that have not incorporated sexual diversity curriculum and antibullying training into their curriculum are 20% more likely to have attempted suicide relative to students who attend schools with these policies and programs (Hatzenbuehler, 2011). Similar policies are also related to greater stigmatization and mental and physical health risks among people living with HIV/AIDS.

Until 2010, U.S. laws prohibited HIV-positive foreigners from traveling within the U.S. ("Medical Examination of Aliens," 2009). Furthermore, state laws that prohibit individuals from engaging in sexual acts without disclosing their HIV status serve to legitimize stigmatization of HIV and undermine public health efforts aimed at reducing the transmission of HIV (Galletly & Pinkerton, 2006). Thus, to the extent that policies encourage or fail to discourage prejudicial behaviors, they facilitate environments that may further stigmatize the *discreditable*. In these ways, the discreditable frequently experience less federal protection against prejudice and discrimination relative to the discredited.

CONCLUSION

Goffman's (1963) original treatise assumed that the stigma management experiences of the *discredited* and *discreditable* diverge in fundamental ways. Yet, over the past 50 years, social psychological and epidemiological research has focused the vast majority of its attention on understanding stigma mechanisms (for reviews, see Crocker et al., 1998; Major & O'Brien, 2005; Pascoe & Smart Richman, 2009) and health disparities (Adler & Rehkopf, 2008; Berkman, 2000) among visible stigmas such as race, gender, and physical disability. Comparatively less attention has focused on understanding stigma mechanisms (for reviews, see Pachankis, 2007; Quinn, 2006; Quinn & Earnshaw, 2011), and almost no attention has focused on understanding health disparities among concealable stigmas such as sexual orientation, HIV/AIDS, and mental illness. And, as outlined in Table 1, very few studies have directly compared stigma mechanisms among visible and concealable stigmas to examine how concealability affects outcomes. Thus, 50 years later, a relative paucity of research exists that allows researchers to directly examine whether and to what degree concealability creates divergent experiences and outcomes for stigmatized individuals.

The framework proposed herein provides a conceptual "roadmap" that can guide the next generation of stigma researchers to understand two critical elements: (a) how stigma "gets under the skin" to affect mental and physical health disparities, and (b) when and to what degree concealability moderates these effects. The current framework marries social psychological approaches that have traditionally focused on individual and interpersonal mechanisms with social epidemiological approaches that have traditionally focused on sociocultural mechanisms. It is, therefore, a unified framework that crosscuts disciplinary boundaries and explicitly positions the study of stigma mechanisms and processes within a broader socio-cultural milieu that is consistent with Goffman's original theoretical approach. Work from Brondolo, Love, Pencille, Schoenthaler, and Ogedegbe (2011) on the association between racism and hypertension underscores the importance of adopting such a multilevel approach to the study of stigma and health disparities. Our framework positions public stigma as the most distal causal agent of health disparities. Whereas existing conceptual approaches to studying health disparities give little or no consideration to the role of stigma (e.g., Adler & Rehkopf, 2008; Berkman, 2000; cf. Krieger, 2000), our framework calls attention to public stigma as a vital social determinant of health and health disparities.

The current work is also the first to directly consider how concealability might moderate the effect of stigma on mental and physical health disparities. Does stigma affect visible and concealable stigmas in fundamentally different ways? Our framework outlines areas of both similarity and difference (see Table 2). In examining the potential moderating effect of concealability, our analysis reveals areas where gaps in research knowledge are most severe. Given that much of the comparative work has focused on only a few types of visible identities (e.g., African American ethnicity, obesity) and only a few types of concealable identities (e.g., sexual minority status, HIV), it remains unclear to what extent our conclusions generalize to the heterogeneous range of visible (e.g., physical disability, age) versus concealable identities (e.g., mental illness, addiction, sexual traumas). Thus, future

research that examines elements of the framework among a wider range of identities will help to establish the generalizability of the current hypotheses.

A number of additional future research directions will also help to expand upon the current framework. For example, future research could examine the extent to which other stigma-related dimensions such as controllability or peril (Jones et al., 1984), identity-related dimensions such as centrality or salience (Quinn & Chaudoir, 2009), or the presence of multiple stigmatized attributes (e.g., Berger, 2004) might further modify the processes outlined in the current framework. In addition, future research could also consider how individual stigma mechanisms (anticipated, enacted, internalized stigma; Earnshaw & Chaudoir, 2009) develop and change over time and whether concealability moderates these developmental trajectories.

Although the *discreditable* have received significantly less empirical attention relative to the *discredited*, we see that this gap is most pronounced at the sociocultural level where very few studies have examined how hazardous environmental exposure, health care access and quality, or public policies affect the *discreditable*. Although this gap reflects the fact that psychologists' research tends to examine stigma from individual or interpersonal rather than social or ecological perspectives, future work that directly examines whether or to what degree concealability affects disparities via individual, interpersonal, and sociocultural phenomena can close these gaps in research knowledge.

In these ways, we argue that research that advances the study of concealability will play a critical role in developing both theory and practical strategies designed to lessen the burden of stigmatization. Understanding the extent to which the processes by which stigma "gets under the skin" differ for people with visible and concealable stigmatized identities is critical for adapting treatments, interventions, and policies to improve the health of stigmatized individuals and ultimately eliminate health disparities—a significant and persistent national priority (U.S. Department of Health and Human Services, 2000, 2010). Thus, research that advances the study of concealability will examine Goffman's original proposition of "difference" and utilize it—50 years later and beyond—to improve the lives of those who are socially devalued.

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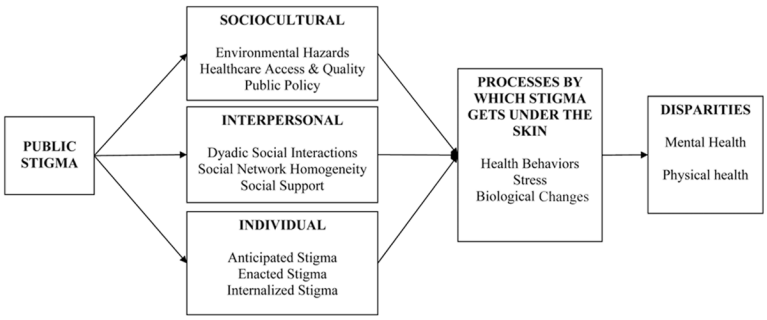

FIGURE 1.
Stigma mechanisms in health disparities model.

TABLE 1

Quantitative Studies That Directly Compare Visible and Concealable Stigmas

Article	Study Design Features	Type of VS and CS Examined	Major Findings
Boarts, Bogart, Tabak, Armelie, & Delahanty, 2008	*N* = 57 Longitudinal study (baseline, 3 months)	VS: African American race CS: HIV status, sexual minority	Lifetime enacted stigma reported at Time 1 was related to lower adherence to antiretroviral medications at Time 2 for VS, but not for CS.
Cook et al., 2011	*N* = 64 Experience-sampling study (7 days)	VS: African American race CS: Sexual minority	Feeling stereotyped was associated with lower feelings of power and greater behavioral inhibition among both VS and CS. Feeling stereotyped was related to greater inhibition among CS relative to VS, and this effect was mediated by greater identity centrality among VS.
Frable, 1990	*N* = 88 Cross-sectional study	VS: African American race, overweight, acne CS: Sexual minority, rape victims, incest victims	CS were more likely to adopt a partner's perspective and remember features of a social interaction than were VS.
Frable, 1993	*N* = 142 Cross-sectional study	VS: Obese, facial scars CS: Sexual minority, epileptic, juvenile delinquents, incest victims	CS felt more unique and marginal than people with VS.
Frable et al., 1998	*N* = 86 Experience-sampling study (11 days)	VS: African American race, overweight, stuttering CS: Sexual minority, eating disorder, low socioeconomic status	Overall, CS reported greater negative affect and lower self-esteem than VS. CS had greater social isolation than VS. CS felt better when they were around "similar" others relative to dissimilar others and nonsocial situations.
Hatzenbuehler et al., 2009	*N* = 50 Experience-sampling study (10 days)	VS: African American race CS: Sexual minority	After experiencing stigma-related stressors, CS reported greater social isolation and less social support than VS. Greater social isolation/less social support mediated the association between stigma-related stress and psychological distress.
Stutterheim et al., 2011	*N* = 667 Cross-sectional study	VS: People living with visible symptoms of HIV CS: People living without visible symptoms of HIV	People living with visible symptoms of HIV report greater enacted stigma and psychological distress, but lower self-esteem and social support, compared to people living without visible symptoms of HIV.

Note. VS = visible stigma; CS = concealable stigma.

TABLE 2

Comparison of Stigma Mechanisms Between Visible and Concealable Stigmas

Stigma Mechanism	VS vs. CS
Individual	
Anticipated stigma	• Situational and chronic expectations of stigmatization affect outcomes similarly for VS and CS
Enacted stigma	• Mixed results regarding whether concealability affects the frequency of stigma-related events • Concealability does appear to affect the effectiveness of coping strategies utilized (i.e., CS are less able to utilize social support resources to cope with stressors)
Internalized stigma	• CS are more likely than VS to experience negative psychological outcomes due to internalized stigma
Interpersonal	
Dyadic social interaction	• Social interactions more likely to be smoother among CS relative to VS • However, this may incur psychological and health costs
Social network homogeneity	• CS less likely than VS to be surrounded by similar others and are, therefore, less likely to utilize group-based support • VS may have more social network-based resource limitations than CS
Social support	• CS have less social support than VS
Sociocultural	
Hazardous environmental exposure	• VS more likely to incur greater exposure than CS • However, it remains unclear whether CS are segregated in similar ways that may increase exposure
Health care access and quality	• Relative inattention to CS may render poorer health care quality
Public policy	• CS more likely to be target of laws that marginalize them

Note. VS = visible stigma; CS = concealable stigma.