[Is it time to re-visit stigma? A critical review of Goffman 50 years on](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)

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It has become a truism that the subject of mental health and in particular, those who suffer from mental health conditions, are subject to social stigma. Indeed [Bates and Stickley (2013)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) demonstrate how mental health nurses and the law combine to reinforce stigma through systems-fostered defensive and risk-averse practice. This article explores further how the law on unintended consequences can predispose well-meant practice to be, in some cases, counter-productive and contrary to the principles of recovery. It also illustrates how stigma is understood to be a far more complex and subtly corrosive phenomenon than Goffman foresaw.

Sociologist Erving Goffman is well known for his seminal work regarding stigma, *Stigma: Notes On The Management Of Spoiled Identity* ([Goffman, 1963](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). Goffman defines stigma as:

**‘[An] attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted and discounted one’**

([Goffman, 1963: 3](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

Goffman's definition of stigma is regularly quoted by authors when explicitly defining stigma ([Link and Phelan, 2001](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)) and still remains highly respected and dominant ([Carnevale, 2007](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). However, his work has been criticised for implying that individuals with stigmatic qualities are helpless, although [Link and Phelan (2001)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) claim that the stigmatised are less likely to directly challenge the discrimination experienced and will accept their lower status.

Alternative definitions

Since Goffman's definition, there have been a variety of alternative definitions of stigma. [Link and Phelan (2001)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) produced their own conceptual definition of stigma that considers many different factors that can be seen to effect or define the stigmatised. Thus, ‘stigma exists when elements of labelling, stereotyping, separation, status loss and discrimination occur together in a power situation’ ([Link and Phelan, 2001: 337](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). Therefore, it could be argued that Link and Phelan's definition of stigma is more applicable to modern society and current nursing practice, as there are key words within the definition that aptly illustrate that the use of the word stigma to describe every situation is not necessary. Additionally, [Link and Phelan (2001)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) argue that the incorporation of terms such as ‘discrimination’ and ‘power’ reflect their understanding of what a stigmatised group endures and consequently allows them to fully understand the crucial issues related to stigma.

For Goffman the stigmatised can either be discreditable or discredited. If the individual is described as discredited, there is a potential risk of tension between the stigmatised and the ‘normals’ (Goffman's word). Goffman apparently believed that the important element of the management of stigma is whether or not the source of stigma is visible to others. If the stigmatising attribute is visible the individual is then referred to as the ‘discredited’ (an example of having a discredited attribute would be an amputee). The second essential term, ‘discreditable’, refers to when the stigmatising attribute is not seen by others and subsequently can be concealed—thus, mental illness would be classed as a discreditable stigma.

To better understand discredited stigma, [Carnevale (2007)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) conducted a study that investigated the social experience of families with children requiring mechanical ventilation at home. Carnevale concluded that the mechanical ventilation meant that the children would be open to discrediting stigma. [Carnevale (2007)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) found that the families of the disabled children felt that their child's life was regularly devalued by friends, family and even healthcare professionals. For example, parents of such children were asked regularly whether or not they should continue to sustain the child's life — a choice they felt was not a ‘real choice’. In addition to this, a sister reports that she felt uncomfortable talking about her disabled brother to her friends, due to the fear of how they may react. This suggests that even though the disabled child is classed as having a discrediting attribute, which led to a stigma, the family suffer also. The only option the family felt would alleviate the discrediting stigma associated to the family is by letting their child die, something which parents report they are pressured into often ([Carnevale, 2007](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

These narratives are fitting to Goffman's discrediting and discreditable stigma theory and more importantly highlights that his theory can be used in current society. However, Carnevale's findings highlight that as professionals, it is vital to see past the medical diagnosis—the families’ distress only partially related to the medical diagnosis. The predominant distress was the reactions of others and the feeling of rejection. This is something that mental health professionals may need to take in to consideration when working alongside service users and their families to try and ensure that they are not reinforcing distress or stigma.

The second essential term is the discreditable. This is when the stigma is hidden and cannot be seen to others. [Goffman (1963)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) states that this sort of stigma can cause anxiety if the proposed stigma is revealed and consequently the individual is termed as discreditable ([Goffman, 1963](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). An example of a discreditable stigma would be an individual who can predominantly conceal their condition such as HIV or mental illness. It is claimed that the life chances of the stigmatised for having a discreditable stigma, such as being HIV positive, are significantly reduced. However, this is only relevant if the stigma becomes known.

[Judgeo and Moalusi (2014)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) found that many HIV-positive individuals' chances of a promotion or development within their company were significantly reduced. Yet, this is only applicable to when the HIV or stigmatising attribute becomes visible, for instance, a deterioration in an individual's mental state with a diagnosis of schizophrenia may cause the individual to isolate themselves from others. This isolation may contribute to a further worsening mental state—delaying the inevitable. Thus, concealment of a stigmatising attribute could reduce the detrimental effects of stigmatisation, but if the stigmatising attribute becomes visible the effects of stigmatisation reoccur.

[Chaudoir et al (2013)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) elaborated Goffman's idea further and incorporated three forms of stigma: anticipated, enacted and internalised. This demonstrates how each of the above types of stigma relate to Goffman's notion of discrediting and discreditable. It is claimed that anticipated stigma is likely to be experienced by both the discrediting and discreditable. This is because anticipated stigma requires the individual to expect to be the target of discrimination or rejection from society due to the stigmatising attribute. As a consequence, the individuals believe that they are exposed to social devaluation and may experience vulnerability in the terms of psychological and physical health needs. The findings of [Chaudoir et al (2013)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) are seen to support [Judgeo and Moalusi's (2014)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) notions of reduced life chances for the stigmatised.

Enacted stigma refers to previous discrimination the individual may have experienced. It is argued that enacted stigma is most likely to be experienced with a discrediting stigma. However, [Chaudoir et al (2013)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) assert that both the discrediting and discreditable will experience enacted stigma, but will have different experiences. Something which Goffman did not explore. For instance, they found that individuals with concealable stigmas experience greater social isolation and less support compared to individuals with visible stigmas. [Goffman (1963)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) argues that this is due to the anxiety of others becoming aware of their stigma as well as maintaining their hidden identity. However, there is a lack of studies comparing consequences and disparities between visible and concealed stigmas ([Chaudoir et al, 2013](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

[Goffman (1963)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) hypothesised that stigmatisation would lead the individual to internalising the stigma. [Chaudoir et al (2013)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) internalised stigma theory is in support of this view nearly 50 years later. Internalised stigma is consistently demonstrated for concealable stigmas. Unfortunately, it is believed that this forecasts lower physical health wellbeing, greater psychological stress and increased chance of participating in activities that compromise the individual's health ([Chaudoir et al, 2013](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). However, [Goffman (1963)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) asserts that the person enduring stigma should be sensitive to what others think, and then further internalise that which does not confirm to certain social norms. If the individual is not aware or is resilient towards the stigma, then according to Goffman, the consequences of stigma may not be experienced.

The concept of anticipated, enacted and internalised stigma, is an elaboration and slight variation of Goffman's classic stigma theory. However, the core elements of Goffman's treatise are incorporated. On the contrary, Goffman's work alleged that stigma management experiences of the discredited and discreditable differ in essential ways.

Implications for nursing practice

Goffman's seminal work regarding stigma is still cited frequently throughout the literature. Whether it is his definition which is quoted or his theoretical approach that has provided a foundation for others to elaborate or incorporate his work. What is explicit from the literature, specifically [Chaudoir et al (2013)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) and [Carnevale (2007)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185), is that stigma that can be discrediting or discreditable, and has detrimental effects for the individual and others ([Link and Phelan, 2001](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). This has vital implications for mental health nursing practice—particularly, as mental illness is classed as a concealable stigma. The literature illustrates that individuals who have a concealable illness endure more consequences. It is vital that all mental health nurses have an in-depth understanding of stigma to try and challenge the stigma mental illness patients endure. By raising awareness and education for the healthcare professional and mental health service users could significantly reduce the effects of stigmatisation ([Bates and Stickley, 2013](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

In addition to this healthcare professionals can provide vital support for families if they are aware of the inclusion and exclusion process. Healthcare professionals could provide families with techniques to manage information control which subsequently, can help reduce the level of stigmatisation. As well as this introducing the family to carers groups or other families who are suffering from a similar stigmatisation ([Carnevale, 2007](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)) could help create a stigma-free community ([Corrigan et al, 2009](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). Goffman identified three ways that the stigmatised could manage the social deviance. Creating their own social norms, isolating themselves from the perpetrators or engaging in techniques that prevent information leakage about a discrediting stigma, which subsequently will allow the individual to be accepted in society, these were all techniques used in [Carnevale's 2007](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) study to a good effect for the families enduring stigma associated to children requiring mechanical ventilation.

Information prevention

When the individual has a discrediting or discreditable attribute, there is a possibility that others are not aware of the discrediting or discreditable attribute and subsequently, will not give the attribute any recognition. However, Goffman claimed that the situation and social interactions can become tense, uncertain and ambiguous for all involved—particularly for the stigmatised individual. For individuals who have a discreditable stigma the onus is with controlling the visibility of the stigmatic quality and this will consequently moderate the effects of the stigma during social interactions ([Goffman, 1963](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

The situation exacerbates for those with a discreditable stigma. According to Goffman, the greatest worry is the risk of the discreditable stigma becoming apparent. Therefore, the primary intention is no longer tension management; instead the main goal for the discreditable becomes information management—to display or not to display; to tell or not to tell; to lie or not to lie. An example of this would be someone with a mental health problem who would have to face prejudice against themselves as, well as an unwitting acceptance of themselves, by others who are prejudice to the stigmatised group. Wherever the individual goes, they will attempt to falsely conform ([Goffman, 1963](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). This may be completed by withholding information about themselves and consequently living with the anxiety of concealment.

Goffman argues that managing discreditable information can lead to a double life as the individual must always be alert to prevent information leakage. This demonstrates how important it is for mental health nurses to be aware of this notion as living in fear of information leakage and living a double life could cause added stress and in turn may affect their care seeking behaviour ([Corrigan et al, 2014](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

‘Passing’ is a central concept to Goffman, which he developed to help describe information control. The term is used to describe when an individual with a stigmatic quality manages information to appear ‘as others’ and will do so if they can. Moreover, the individual has to be alert to who does know and who does not know about their secret, consequently, leading to a double life ([Goffman, 1963](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). Goffman describes these people as ‘passers’. Passers use many different information management techniques such as concealment or covering up and removing certain devices. An example of a dis-identifier would be a gay man attending a function with a woman. These techniques are use to try and minimise the obtrusiveness of the stigmatic quality ([Goffman, 1963](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

Mental health nurses could attempt to equip the individuals they work with, with the stated skills and subsequently will be empowering the individual and possibly reducing the stigma they receive. [Carnevale (2007)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) states that it is slightly easier for children to pass as ‘normal’ due to the parents help. For instance a child who is paraplegic but sat in a pushchair would unwittingly pass as able-bodied. Carnevale further claims that the parents can create a protective capsule in the home environment where the child would feel accepted and normal. This allows the child to live in ignorance to the difficult challenges to come. This transpires into a dilemma of when to disclose the problem to the child ([Goffman, 1963](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). If parents disclose too early, the child may not be psychologically ready, and if they wait too long the child may not have enough preparation to handle the unnerving social situations they will likely have to encounter. This can be transferred across to mental health nursing as it is a potential dilemma nurses will face—as well as doctors—particularly in terms of giving someone a severe mental health diagnosis such as bipolar disorder, schizophrenia or Alzheimer's disease. There is also the dilemma of when to tell the person, so that it does not affect them accessing the appropriate services ([Corrigan et al, 2014](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

In Goffman's historical writings he focused on how information management would affect the dyadic social interactions. He postulated that interactions between the ‘normals’ and stigmatised would be strained, awkward and uncomfortable. [Judgeo and Maoalusi (2014)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) found that today stigma has the same effects on social interactions as Goffman forecast 50 years ago. They additionally found that stigma is more likely to redefine the stigmatised individual's social life.

Research in the past 50 years has focused on mixed social interactions between visible stigmas, racial minorities, individuals' with physical disabilities, concealable stigmas and sexuality ([Chaudoir et al, 2013](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). The research is still in favour of Goffman's notion of passing. However, recent research has found that it is a useful adaptive quality but it comes at a psychological price for those with concealable stigmas. [Chaudoir et al (2013)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) found that individuals with concealable stigmas are more likely to be doing greater cognitive work during social interactions to keep their true identities concealed. Therefore, it appears that the social interactions are going well for those with a discreditable stigma, which they have opted to conceal. In contrast, It is likely that they will be more preoccupied with maintaining their identity and the others perspective than the actual interaction ([Chaudoir et al, 2013](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). Notably, concealing a discrediting stigma appears to have greater outcomes when interacting with others and lowers the threat of being stigmatised, but the individual must have the cognitive ability to be able to do so. The findings of Chaudoir et al illustrate that Goffman's passing theory is still relevant in today's society.

[Corrigan et al (2009)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) completed a study that investigated whether or not the disclosure-based strategies employed by gay or lesbian people can relate to people stigmatised by mental illness. They acknowledged that some individuals are unable to hide their mental illness due to association with mental health hospitals, but feel strongly that there are similarities between the stigma associated with sexuality and mental illness. Therefore, they postulate that the coming out model is a relevant model for both parties, as according to Goffman, sexuality and mental illness are both discrediting stigmas.

It is claimed that coming out is an uncomfortable experience but very prominent for personal development. [Corrigan et al (2009)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) found no apparent patterns for coming out, but instead found that coming out is a very complex process that can be manipulated to yield the best outcomes for the individual. The most significant finding within the study was the importance of communities. They found that the feeling of belonging to a community is crucial for the gay or lesbian individual as it is how they later define themselves ([Corrigan et al, 2009](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

There are communities in the USA that are created and maintained by people with serious mental illness for people with mental illness. However, evidence states that most people with mental illness want to escape the community, as they want to feel empowered and achieve their own personal goals ([Corrigan, 2004](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). The findings of [Corrigan et al (2009)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) make a contribution to the plethora of literature on gay and lesbian people. However, not all the findings are applicable to mental illness. This is due to the small sample size and the use of a convenience sample strategy. Moreover, the participants within the sample were already open about their sexuality, meaning the study is not representative to those who conceal a stigma.

What is apparent from their study is that elements of Goffman's passing and withholding information were evident. For instance, the idea that gay and lesbian people have to weigh up the pros and cons of coming out to others—if they chose to come out they can then manipulate the situation slightly to achieve a better outcome and less stigmatisation. This is something, which is transferable to mental health nursing.

Most of the collated evidence is supportive of the idea of concealment of stigmas. However, in the clinical context, concealment of a stigma has serious consequences. Concealment of a stigma may initially aid building a good rapport with professionals, but may compromise the quality of treatment ([Chaudoir et al, 2013](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). For example, a person who conceals their mental illness is more likely to develop a better rapport with the provider as they feel they do not have to worry that they are being devalued. However, because they have not disclosed the true nature and degree of their illness, the provider does not have full access to a range of information which would generate an effective treatment plan. Additionally, using concealment or withholding information could limit the efficacy of the treatment if the individual was not to report any adverse side effects of medication ([Chaudoir et al, 2013](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

Conclusion

There are pros and cons with using Goffman's theories regarding information control in today's society. It is evident that there are many pros for the individual to want to control certain information, as it can enhance life opportunities as well as making social interactions more comfortable. However, in a clinical setting concealment could be detrimental to the individuals care. It is vital for mental health nurses to gain and maintain a therapeutic relationship with the individual so they feel they do not have to withhold any information that could affect the care outcomes and not to reinforce or perpetuate the stigma. Advocates and nurses should learn from the complex research literature on stigma management to facilitate them in implementing programmes that can improve care seeking behaviour but does not add any more discrimination ([Corrigan et al, 2014](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)).

In refute of Goffman's idea that mental health nurses will not stigmatise, [Bates and Stickley (2013)](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185) argue that mental health nurses do stigmatise, but unknowingly do so. They claim that this is due to the nurses having a duty of care to not only protect their patients, but also the public from harm, signifying that this leads nurses to emphasize risk management over promoting patient choice. Through focusing on risk management, professionals remove the responsibility from the patients and hand it back to the mental health service providers. This consequently reinforces stigma as it reduces empowerment, increases the chance of social exclusion, and affects care-seeking behaviour. Thus, unwittingly, mental health nurses reinforce and perpetuate stigma as they are pressured by a combination of legislation, and their own fear of litigation ([Bates and Stickley, 2013](http://www.magonlinelibrary.com.ezproxy.staffs.ac.uk/doi/10.12968/bjmh.2016.5.4.185)). This suggests that the failure of professionals to actively challenge stigma is not explicitly the nurses' fault but rather the policies that shape their practice.

To a certain extent Bates and Stickley's argument counters Goffman's theory that nurses will not stigmatise yet—evidence states that they do. However, this is done either unknowingly or through the policies advocated in practice. This counter-argument portrays how mental health practice has progressed since Goffman produced his writings during the medical model era. Subsequently, mental health nursing has evolved and the recovery model is currently favoured. It is hoped that the systems which regulate mental health care—both formally and informally—can adapt to allow for a more client-centred approach and therefore true therapeutic risk-taking to help reduce stigma in all its forms.

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