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# The 'blemish of place': Stigma, geography and health inequalities. A commentary on Tabuchi, Fukuhara & Iso

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## **The ‘blemish of place’: Stigma, geography and health inequalities. A commentary on Tabuchi, Fukuhara & Iso**

There has been considerable interest amongst geographers, public health researchers and others in documenting the ways in which place-based processes are important in understanding social and spatial inequalities in health outcomes and related behaviours (Pearce, Barnett, & Moon, 2012). This concern is likely prompted by the substantial, and in many cases rising, geographical inequalities in health that are omnipresent in most high income countries. Over the past 30 years whilst overall health has improved dramatically (e.g. life expectancy has risen) various metrics have been used to show that spatial inequalities have grown by as much as 50 percent (Pearce & Dorling, 2006; Shaw, Davey Smith, & Dorling, 2005). The explanations for why health is becoming increasingly uneven are multifaceted but there is clear evidence that widening discrepancies in a range of social markers including rising income inequality, as well as uneven housing provision, job security and employment opportunities that underpin good health, are pertinent. Inequalities are also related to historical antecedents such as the slave trade, colonial legacies, and recruitment into unpleasant and insecure occupations through encouraged immigration. Further, geographically embedded processes have been implicated including local social norms and practices, the provision of community resources, as well as the formal and informal regulation of neighbourhood resources (e.g. green spaces).

### *Geography, discrimination and health*

There is a long history of work examining the role of discrimination in understanding health and health inequalities. Studies of disability, homelessness, itinerant populations, gender and sexual orientation have all been instructive in understanding the interpersonal and institutional factors that link discrimination and health. Work from the ‘ethnicity and health’ field has been particularly enlightening and has revealed that discrimination is a critical dynamic in understanding ethnic inequalities in health. Ethnic discrimination can vary in type and form and hence has been operationalised in a multitude of ways. These range from the often imperceptible but pervading institutional factors that subtly prejudice ethnic minority groups, to research that considers interpersonal racism whereby personal experiences negatively affect health outcomes (most notably mental health) (Harris, Tobias, Jeffreys, Waldegrave, Karlsen, & Nazroo, 2006). For instance, the effects of macro-stressors

such as economic recessions and ‘natural’ disasters have been shown to disproportionately affect the health of minority populations. Discrimination can also operate to affect health through pathways that destabilise key social determinants such as education, housing, criminal justice and occupational structures. Further, the everyday experiences of perceived discrimination have been shown to act as a psychosocial stressor and result in detrimental health effects including negatively affecting blood pressure, mental health, self-rated physical health, health care utilisation, as well as cigarette and alcohol consumption (Williams & Mohammed, 2009). The social stigma associated with the membership to some minority groups and the spaces that they occupy is significant here. Stigma is articulated as a majority view “emphasizing non-productivity, dangerousness and personal culpability of excluded groups” (Curtis, 2004, p77). Health is negatively affected by social stigma through the exclusion of individuals from gaining access to health and community resources as well as providing barriers to a full participation in society (e.g. employment). Stigma has also been adopted as a deliberate health promotion strategy, most notably in tobacco control where smoking has become a denormalised and highly stigmatised activity (Graham, 2012). Further, it is argued that places can inherit the stigma attached to the groups who occupy these spaces which in turn produces a ‘powerful cognitive map’ that distinguishes between neighbourhoods that are acceptable and unacceptable (Takahashi, 1997). However, a comprehensive conceptualisation of the ways in which place-based stigmatisation can shape population health through the concentration of poverty and ill health, as well as the likely institutional discrimination that leads to inadequate service provision, has not been fully realised.

As this discussion of stigma and health highlights, whilst there is a voluminous literature evaluating the role of various forms of discrimination in understanding health and inequalities, *geographical* accounts of discrimination have been thin on the ground. A geographical perspective is likely to be valuable in explicating the role of discrimination in explaining social and spatial inequalities in health; in particular discrimination that is rooted in ‘place’. For instance there is an extensive literature exploring the role of residential segregation in affecting health. The premise of this concern is that ethnic segregation deepens inequalities, with negative connotations for health and well-being. It is argued that segregation (in the US at least) bolsters institutional discrimination resulting in restricted access to education and employment opportunities. Public and private disinvestment in segregated neighbourhoods produces inadequate urban infrastructure which in turn

undermines community health (Acevedo-Garcia & Lochner, 2003; Acevedo-Garcia & Osypuk, 2008). Other work has drawn on theories of environmental justice to reveal systematic variations in the distribution of environmental characteristics across communities differentiated in terms of socio-demographic characteristics (e.g. income and ethnicity). Environmental injustices that have been documented include environmental ‘bads’ (e.g. air pollution, climate change and environmental disasters) and environmental ‘goods’ (e.g. green space and features of the urban infrastructure such as shops, public transport and schools) (Pearce, Richardson, Mitchell, & Shortt, 2011; Walker, 2011). Recent work has sought to establish the extent to which the socio-spatial distribution of environmental goods and bads is pertinent in understanding the health gradient across ethnic groups (Evans & Kantrowitz, 2002) as well as the institutional structures that account for the socio-spatial arrangement in the first place (Schlosberg, 2007).

#### *Place-based discrimination and health in Japan*

Whilst work from the fields of ethnicity, minority populations and health on interpersonal and institutional discrimination has been instructive in developing an understanding of health inequalities, there are other important pathways through which discrimination can affect health which have received limited attention. In particular, few studies have considered the consequences for population health of the forms of discrimination that can arise from residing in a highly stigmatised community. Further, there is relatively little work examining broader concerns relating to how local residents become ‘contaminated’ by their area of residence and how they attempt to resist this spatial stigma. These omissions are perhaps surprising given the detailed sociological accounts that have documented the pervasiveness of the stigma associated with a number of urban neighbourhoods. Few health researchers have engaged with these literatures. The paper in the current edition of *Social Science and Medicine* by Tabuchi and colleagues is a welcome contribution to the underexplored themes of discrimination, place, and health (Tabuchi, Fukuhara, & Iso, 2012). In this Japanese study, the authors consider the notion of ‘geographically-based discrimination’. The premise of the work is that residing in a neighbourhood with a negative reputation has an impact on health that is independent of the multitude of other social correlates that are also causally related. The focus is Buraku district of the Nishinari ward in the city of Osaka, an area with the lowest life expectancy in Japan. The authors note that historically, this neighbourhood has been highly stigmatised due to a tradition of high poverty and a multitude of associated social

problems including poor quality housing and high levels of crime. Using data collected from a sample of the population of Buraku district, the authors investigated whether personal experiences of discrimination in this geographical setting were associated with increased likelihood of depressive symptoms and a diagnosis with mental health. They distinguished between two types of discrimination based on the district and ward in which the respondents resided. The findings suggest that perceived geographically-based discrimination was independently associated with both indicators of poorer mental health.

Given the lack of attention afforded to place-based stigmatisation, as well as the limited geographical work on the spatial dimensions of discrimination and health outside the United States, the contribution by Tabuchi and colleagues is timely. The Japanese work builds on a long tradition of scholarship concerned with the detrimental health effects associated with residing in socially and economically disadvantaged, highly (socially and/or racially) segregated, and marginalised neighbourhood. The particular concern explored in the Japanese paper is with the effect of residing in a highly stigmatised community, the personal experience of discrimination, and the implications for health. Despite the well established link between stigma and health, few empirical studies have considered the salience of *spatial* stigma in affecting population health and wellbeing. Among the small number of studies that have attended to this concern, Popay *et al.* (2003) use data collected in the northwest of England to identify a set of 'guidelines' that provide the shared social meanings which produce 'proper' and 'improper' places. The authors suggest that these place-based connotations affect the everyday (health-related) practices of individuals residing there. Place-based identity construction in the face of 'normative dissonance' explains (in some cases) individual strategies that are disadvantageous for health as well as the heightened social fragmentation that undermines collective action to improve neighbourhood health. In part, these processes account for rising inequalities in health across neighbourhoods. Other work in Christchurch, New Zealand drew on interview data collected from residents of a socially deprived neighbourhood in this city to argue that the dual stigmatisation of being a smoker (a stigmatised activity) and residing in a disadvantaged neighbourhood (a stigmatised place) produces 'smoking islands' that can serve to reinforce smoking as a normalised activity (Thompson, Pearce, & Barnett, 2007). Similarly, a study undertaken in low income communities in Glasgow, Scotland demonstrated that collective smoking behaviours is used by residents as a coping strategy to deal with residing in a stigmatised neighbourhood (Stead, MacAskill, MacKintosh, Reece, & Eadie, 2001).

Tabuchi and colleagues therefore begin to draw attention to a body of work that has hitherto received scant recognition in the public health literature. This work on spatial stigma highlights the disabling effect of place of residence that denies local inhabitants complete acceptance by other members of society or what has been termed a ‘blemish of place’ (Wacquant, 2007). While Tabuchi and colleagues are to be applauded for highlighting the role of place in understanding stigma, as well as the subsequent health implications, the conceptual basis linking spatial stigma and health is not fully explicated. The authors’ conceptualisation of ‘place based discrimination’ is likely to provide only a partial account for why spatial stigma affects physical and mental health. The current study lacks a comprehensive assessment of the pathways linking place, discrimination, stigma and health. As will be argued below, the framework adopted by the authors to operationalise place-based discrimination is unlikely to capture much of the complexity associated geographically-based stigmatisation. The remainder of this commentary draws on nascent work in urban sociology and urban geography to draw out a wider set of concerns linking spatial stigmas and health, and includes some discussion of the utility of this literature for future work on place, stigma and health.

### *Territorial stigmatisation and health: a conceptual model*

The concept of place-based stigma has been developed by researchers in the fields of urban sociology and urban geography. Loïc Wacquant in particular has been a proponent of the concept of ‘territorial stigmatisation’ which is a powerful discourse firmly associated with a number of traditionally working class urban neighbourhoods (Wacquant, 2008). Areas such as South Central in Los Angeles, Toxteth in Liverpool or the *banlieue* of France maintain infamous recognition as in the public discourse as ‘hellholes’ or ‘sink estates’. These are ‘notorious’ neighbourhoods at the very bottom of the hierarchy of places that are often constructed as no-go zones requiring continuous policing. This prejudicial and geographically-rooted stigmatisation double jeopardises places already stigmatised by high levels of poverty and crime, various other social concerns, as well as a sizable recent immigrant or ethnic minority population.

So why does territorial stigmatisation matter for health? With a few notable exceptions, health researchers have been slow to engage with the territorial stigmatisation literature and

at the same time urban scholars have failed to fully explicate the potentially causal relationships between place-based stigma and health. Nonetheless, an assessment of these conjoint literatures suggests that health might be impinged on by territorial stigmatisation and its antecedents through five (non-mutually exclusive) individualised and institutionalised pathways.

The first potential pathway relates to the tendency of local populations to internalise the stigma that relates to their place of residence. It has been argued that territorial stigma is a 'badge of dishonour' that spoils, manipulates and mediates individual identities and social relations (Wacquant, 2007). Residents of these areas have been shown to demonstrate their shame through adopting strategies such as concealing their address, avoiding having family and friends visit their home, feeling compelled to provide excuses for living where they do, and propelling their stigma onto faceless others (Wacquant, 2007). Territorial stigma is also enduring and likely to be highly mobile. Spatial stigma is not exclusive to residents of stigmatised places but rather can be transported with residents when they move into different geographical settings (Keene & Padilla, 2010). These are pertinent concerns for health researchers because sociological constructs such as identity and social relations have well established aetiological links particularly with health related behaviours (e.g. smoking and alcohol consumption) and mental health (e.g. depression and suicide). Second, being 'looked down on' due to being resident of a highly stigmatised setting is likely to be detrimental to a number of life chances. Educational and training opportunities, employment prospects as well as developing interpersonal relationships are all likely to be harmed due to the baggage of 'moral inferiority' that is associated with residents of highly stigmatised communities. It is well established in the social epidemiology literature that these factors are causally related to health. Education, employment and interpersonal relations over the lifecourse are extremely important for explaining current and future health status. Further, the social comparisons that residents of stigmatised communities make with proximal others (e.g. outside of their own neighbourhood) can lead to highly levels of stress and or 'status anxiety'. There is ample evidence demonstrating a close correlation between societal-level income inequalities and a range of social ills. More unequal affluent societies have greater social dysfunction and poorer health outcomes than more equitable nations. Although the precise mechanism linking income inequality and health is contested, Wilkinson and Pickett (2010) argue that relative inequality across society can harm health due to the psychosocial harm of individuals comparing their material and other resources to those of others.



Third, place-based stigma is destined to undermine progressive social policy by encouraging state institutions to adopt strategies that counter efforts to challenge the marginalisation of residents and are hence highly likely to negatively affect population health. The social construction of places plays a vital role in pattern of investment and disinvestment into communities which in turn shapes the opportunities available (including for a healthful life) to its residents (Macintyre, Ellaway, & Cummins, 2002). As Slater and Anderson argue, territorial stigmatisation can be such a potent force that it “not only leads even residents of such territories to look upon them with shame and disgust – it also has serious effects on how they are managed” (Slater & Anderson, 2012; px). Highly stigmatised communities suffer from disinvestment in housing, local infrastructure and services which destabilise efforts to sustain the social determinants of health. Fourth, the entrapment and displacement of residents is likely to disrupt the social networks in communities which often develop over many years. Similarly, community social bonds and collective efficacy are likely to be further undermined as highly marginalised communities retreat from the public realm into the private sphere in response to perceived threats related to territorial stigmatisation. There is a large body of evidence that the breakdown of strong community ties is likely to detrimentally affect physical and psychosocial health. Finally, the urban sociology and urban geography literatures also challenges the notion that neighbourhood processes are static. Rather neighbourhoods are a historical and political construction that represent multi-scalar social and economic processes which accumulate over long periods of time (Wacquant, 2008). This assertion suggests that the contrasting trajectories that affect the positioning of places in the urban hierarchy provide at least partial accounts for the observed spatial inequalities in health.

### *The ‘blemish of place’*

In summary, the literature from urban sociology, urban geography and beyond is suggestive of the role of place-based stigmatisation in affecting various social outcomes. As work in the de-industrialising *banlieue* of Paris and elsewhere has shown, it is unfeasible that local residents can disregard the scorn to which they are subjected because of the ‘branded space’ in which they live and its close association with poverty, crime and disorder that is in the public imagination. It is highly likely (but largely untested) that these processes are also important for understanding the close link between neighbourhood disadvantage and

multitude of health outcomes that have been noted in a number of epidemiological investigations. The findings of the work by Tabuchi and colleagues support this notion.

The Japanese study also draws attention to the demand for further geographical work that examines the role of place-based discrimination in explaining spatial inequalities in health. As previous work has shown, the effects of place-based stigmatisation are likely to be far-reaching and extend beyond the conceptualisation that is detailed by the authors. The direct effects of interpersonal discrimination are likely to provide only a partial account. This commentary draws attention to a number of the public health challenges that are associated with place-based stigma. Territorial discrimination can affect health in a multitude of subtle ways including affecting individual identities and social relations, undermining some key social determinants of health, entrapment and displacement, as well as influencing institutional responses to addressing deep rooted social concerns. Given the multiple pathways that potentially link place-based stigma to health, and the range of health outcomes that may be implicated, further work could usefully enhance the specification of the ways in which place-based stigmatisation operates in this area of Osaka and elsewhere. Drawing on the literature from urban sociology and urban geography offers an opportunity for health researchers to enhance the conceptual understanding of the pathways through which place-based stigmatisation gets under the skin to affect health.

Further work on stigma, place and health would be timely. Many European countries are currently entering a period of significant 'austerity' with major reductions in state investment in a range of social programs and infrastructure. There is significant concern that retrenchment in various aspects of social policy could further marginalise and disenfranchise already stigmatised communities (the riots in the summer of 2011 across some English cities is one possible expression of this). Therefore, one of the likely implications of reducing investment into communities with a multitude of social problems is that such places will become increasingly stigmatised which is likely to be detrimental to the health of local residents.

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