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Destigmatization and health: Cultural constructions and the long-term reduction of stigma

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ABSTRACT

Research on the societal-level causes and consequences of stigma has rarely considered the social conditions that account for destigmatization, the process by which a group's worth and status improve. Destigmatization has important implications for the health of stigmatized groups. Building on a robust line of stigma reduction literature in psychology, we develop a sociological framework for understanding how new cultural constructions that draw equivalences and remove blame shape public and structural stigma over time. We examine historical transformations of cultural constructions surrounding three stigmatized groups in the United States: people living with HIV/AIDS, African Americans, and people labeled as obese. By tracing this process across cases, we find that the conditions that account for destigmatization include the credibility of new constructions, the status and visibility of actors carrying these constructions, the conclusiveness of expert knowledge about stigmatized groups, the interaction between new constructions and existing cultural ideologies, and the perceived linked fate of the stigmatized and dominant groups. We also find that the reduction of structural and public forms of stigma often depend on distinct processes and constructions. To conclude, we propose a framework for the comparative study of destigmatization as an essential component of promoting a culture of health.

1. Introduction

Stigma—the negative stereotyping and separation from groups who are labeled as different—limits access to material, social, and cultural resources for members of stigmatized groups (Link and Phelan, 2001). As Hatzenbuehler et al. (2013) argue, stigma is a fundamental cause of health inequalities because it contributes to the unequal distribution of resources and power through multiple pathways. Consequently, understanding how groups become less stigmatized can improve the wellbeing of individuals and populations.

This article examines how changing cultural constructions of groups may facilitate the reduction of societal-level stigma over time, which we call the social process of destigmatization. Widespread understandings of stigmatized groups—including negative associations and attributions—are integral to stigma (Goffman, 1963; Link and Phelan, 2001; Lamont et al., 2014). Through various mechanisms, these cultural constructions legitimate and reproduce the lower status of marked groups (Link and Phelan, 2001). Although scholars increasingly interrogate the social causes of stigma (Hatzenbuehler and Link, 2014; Pescosolido and Martin, 2015; Pescosolido et al., 2008; Yang et al., 2007), significantly less research has explored the broader social conditions that enable destigmatization (Cook et al., 2014: 106).

Many stigma-reduction interventions aim to change potential stigmatizers' beliefs and attitudes, often by seeking to refute stereotypes, shift causal attributions, and/or diminish feelings of difference (Cook et al., 2014; Corrigan and Kosyluk, 2013; Paluck and Green, 2009). With the goal of designing effective interventions, psychological research on stigma reduction often analyzes which aspects of interventions effectively alter how participants think and feel (Cook et al., 2014; Corrigan and Kosyluk, 2013; Parker and Aggleton, 2003). This aim is vital, given that stigma-reduction efforts need practical information about what creates individual-level change. However, by focusing on modifying the beliefs and attitudes of individual stigmatizers, this research attends less to

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how the broader societal meanings about stigmatized groups change.

Because most attempts to destigmatize groups occur outside deliberate interventions, it is essential to examine how various social actors alter dominant constructions of groups in real-world contexts. This goal entails considering both the constructions that are advanced and the actors who create, diffuse, legitimate, and employ them. Past studies have shown how changing constructions of stigmatized conditions have influenced public attitudes over time, revealing some of the promises and perils of potentially destigmatizing constructions (e.g., Phelan, 2005). These studies typically focus on a single condition. Comparative studies, by contrast, tend to examine multiple stigmas but at a single point in time (e.g., Mak et al., 2006). However, comparative historical studies can highlight how changing cultural constructions of various groups may facilitate destigmatization, while also revealing the barriers to such social change over time. Gaining a better understanding of this process is crucial to fostering social resilience (Hall and Lamont, 2013; Panter-Brick, 2014).

To examine how cultural constructions of stigmatized groups shift over time, we compare how social actors have attempted to destigmatize three groups that have experienced varying levels of destigmatization in the United States: people living with HIV/AIDS (PLHAs), African Americans, and people labeled as obese (PLOs). Given space constraints, we limit our analysis to two meanings: constructions that *remove blame* and those that *draw equivalences* between the out-group and in-group. We find that similar constructions may shape public attitudes (public stigma) or be institutionalized in structural policies (structural stigma) in different ways. Moreover, because stigma is a multidimensional construct (Link and Phelan, 2001; Pescosolido and Martin, 2015), destigmatizing constructions may reduce stigma on one dimension while leaving other dimensions untouched.

We conclude with a framework for the comparative study of destigmatization across both stigmatized conditions and social contexts, and we highlight implications for research on disparities in health. Because cultural constructions are used by particular actors in particular contexts, this framework also incorporates the experts and activists who are involved, as well as the broader social and cultural conditions that allow new constructions to be institutionalized at the level of public and structural stigma. We close with policy implications to complement existing stigma-reduction efforts.

2. Background

2.1. Stigma and health

Stigma can affect health through multiple pathways (Schnittker and McLeod, 2005). The downstream, micro-level psychological mechanism of perceived stigmatization and discrimination bears on health in several ways. Perceived discrimination can affect mental health directly and indirectly through stress responses, including chronic stress that alters individuals' allostatic load (Brondolo et al., 2009; Dressler, 2012). Additionally, individuals who experience devaluation and discrimination may cope with such experiences by engaging in risky behaviors, such as substance abuse, with negative health effects (Pascoe and Smart Richman, 2009).

Upstream, structural-level mechanisms involve the unequal distribution of resources. Stigmatizing ideas motivate and justify discriminatory treatment, with both direct and indirect health consequences (Hatzenbuehler et al., 2013). Upstream mechanisms operate in a range of organizational settings. For example, when healthcare professionals hold stigmatizing beliefs, they are more likely to provide unequal medical treatment (Williams, 1999: 184). Discrimination in housing disproportionately exposes stigmatized individuals to toxic environments (Krieger, 2014; Williams, 1999). In education and employment, discriminatory treatment can create unequal access to resources such as knowledge and wealth, which contributes to health disparities (Hatzenbuehler et al., 2013).

2.2. Culture and destigmatization

Existing research outlines several pathways through which new cultural constructions of stigmatized groups are likely to shape public and structural stigmas that, in turn, bear on health. First, redefining the stigmatized group can improve beliefs and attitudes among potential stigmatizers. This shift enables more positive interactions between stigmatized and non-stigmatized groups, which can, in turn, decrease devaluation and discrimination. This mechanism can operate both in informal interaction and in institutions that allocate resources and opportunities, including medical settings where stigma can lead to differential treatment (Puhl and Heuer, 2009; Saguy, 2013).

Second, changing constructions of groups can convey norms about appropriate beliefs, attitudes, and behaviors, such that potential stigmatizers may avoid acting in devaluing ways (Crandall and Stangor, 2005; Cialdini, 2007). Norms structure behaviors even as individuals harbor bias and prejudice. In the case of injunctive norms, individuals tend to avoid social sanctioning by acting in accordance with what they think others believe is proper, even if they do not endorse those beliefs themselves (Cialdini, 2007). Additionally, although destigmatizing cultural constructions may not have a direct and immediate impact on implicit bias, positive constructions are likely to strengthen positive implicit associations over time, thus reducing discrimination in the long run (Gawronski and Bodenhausen, 2006).

Third, stigmatizing constructions legitimate laws and policies that intentionally or unintentionally exclude stigmatized groups (Corrigan et al., 2005). Support for laws and policies that incorporate and protect stigmatized groups often requires a belief in a group's blamelessness (see Bobo et al., 2012). Similarly, when the dominant public lacks empathy and a sense of connectedness with a stigmatized group, they are less likely to see its plight as problematic—and when people fail to see another group's circumstances as problematic, they are unlikely to seek out or support social change (Loury, 2002). While laws cannot protect against perceived stigmatization in everyday interpersonal interactions, they nevertheless define what is normally appropriate, while providing citizens recourse to defend their rights and dignity.

While extant literature outlines various pathways through which cultural constructions bear on stigma, scholars have paid relatively little attention to how new meanings shift over time in ways that reduce stigma (Parker and Aggleton, 2003). To our knowledge, no framework considers the interrelationships between groups of actors, sets of meanings, and the pathways through which less stigmatizing understandings become publicly available. This article considers the conditions under which potentially destigmatizing constructions of a stigmatized group improve public attitudes (public stigma) and increase inclusionary organizational, governmental, and societal policies and practices (structural stigma). We thus examine destigmatization at the intersection of research on stigma reduction and on the social causes of stigma by considering how the meanings of groups change at the broad societal level over time.

3. Methodological approach

In order to identify how cultural constructions of stigmatized

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groups shift, we selected three cases of stigmatized groups in the United States to maximize variation on several dimensions. First, we varied the type of "mark" to include two medicalized cases (HIV/AIDS and obesity) and one case that is primarily understood as a social status (African Americans). Second, we sought cases that have reached different levels of destigmatization over time and in different domains. More specifically, while PLHAs have experienced a gradual reduction in both public and structural stigma, African Americans have undergone contradictory movements, both in public stigma (e.g., persistent implicit bias) and in structural stigma (e.g., school desegregation enforcement). For their part, PLOs face new forms of public and structural stigma.

Social actors use various cultural constructions to reduce stigma. We focus on two such constructions: *removing blame* and *drawing equivalences*. These constructions are the antithesis of two central components of Link and Phelan (2001)'s model of stigmatization, namely the attribution of negative characteristics and the separation between the stigmatized and dominant group. Constructions that remove blame aim to contradict stereotypes and devaluing explanations of the group's condition. Drawing equivalences underscores commonalities between the out-group and the in-group, as a reversal of separation, or what cultural sociologists call bridging group boundaries.

To understand how these new constructions have shaped public and structural stigma, we first reviewed influential historical and sociological accounts of the stigmatization of each group to identify the trajectory of constructions surrounding each group. Then, we revisited each case, focusing on the social actors who created and disseminated these constructions, including social scientists, legal professionals, public health officials, and social movement actors, who often convey and institutionalize new constructions in society (Eyal and Buchholz, 2010). Drawing on Hall (2006)'s method of systematic process analysis, we traced the process by which new constructions did or did not shape public and structural stigma. We consulted academic experts on each stigmatized group to confirm our understandings of the role of new constructions, actors, and processes involved in the destigmatization of each group. Finally, in order to identify both common and unique social conditions of destigmatization, we compared our cases with one another, ultimately generating a framework that details the possible social pathways of destigmatization.

4. Three cases of destigmatization

Table 1 summarizes and compares the actors who advanced constructions of blamelessness and equivalence across the cases. The following sections detail when and why these two constructions influenced public and structural stigma.

4.1. People living with HIV/AIDS

In 1981, the Center for Disease Control (CDC) published a report that five gay men in the United States had been treated for a rare pneumonia, which seemed to be associated with a "homosexual lifestyle." This pneumonia was later identified as a late manifestation of AIDS. Living with AIDS immediately became associated with gay men (Epstein, 1996) and, later, drug users and sex workers (Brown et al., 2003; Deacon, 2006)—groups stigmatized for engaging in risky and immoral behaviors. Perceived to be communicable, AIDS has been stigmatized for instrumental reasons as well, given the fear of and misconceptions surrounding contagion (Herek, 1999).

In the following decades, PLHAs have continued to experience stigmatization in the workplace (Fesko, 2001), in certain state laws and state-mandated healthcare surveillance (Gostin and Webber, 1998; Lehman et al., 2014), and in interpersonal and family life (Deacon and Stephney, 2007); yet, structural and public stigmas have declined since the 1980s in the United States. Negative public attitudes of blame and discomfort toward PLHAs have declined (Kaiser Family Foundation, 2011), while institutions and local governments have shifted from blaming PLHAs to recognizing and accommodating them, and to improving their quality of life (Burris and Gostin, 2002).

Much of the initial stigma surrounding PLHAs emerged from public hysteria surrounding the lack of knowledge about the causes of AIDS (Burris and Gostin, 2002). Journalists—emboldened by disagreements among public health experts and the CDC's emphasis on the demographic group seemingly most affected by AIDS (i.e., gay men)—constructed cultural meanings that associated AIDS with gay sexual deviance (Albert, 1986). Meanwhile, alarmed politicians proposed coercive measures, such as quarantining PLHAs and restricting their freedom to marry, ostensibly out of fear about the unknown nature of the syndrome's transmission (Burris and Gostin, 2002). Some even debated whether children living with HIV/AIDS could attend public schools (Kirp, 1989). Consequently, clearing up misconceptions about the etiology of the condition significantly stemmed hysteria and allowed for alternative meanings to take hold.

Scientific knowledge about the etiology of AIDS, as caused by a virus (HIV) transmitted through specific types of contact with infected blood or other bodily fluids, reached a general (though still debated) consensus by 1985 (Epstein, 1996). In their

Table 1
Comparison of social actors in the (De)stigmatization of three groups.

	People living with HIV/AIDS	People Labeled as obese	African Americans
Public Health & Medical Experts	Contributed initially to public and structural stigma, but later enabled destigmatizing meanings	Largely contributed to public stigma	Low involvement
Legal Experts	Contributed to structural destigmatization	Low involvement	Contributed to structural destigmatization, but restricted claims to reduce inequality
Social Science & Policy Experts	Contributed to hysteria and stigmatizing proposals initially, but later contributed to structural destigmatization	Low involvement, but contributed both stigmatizing and destigmatizing meanings	Contributed both stigmatizing and destigmatizing meanings, and critical to structural destigmatization
Media & Journalists	Contributed to stigma initially, but later disseminated destigmatizing meanings	Contributed to crisis narrative & stigmatizing representations, but also disseminated destigmatizing meanings	Contributed both stigmatizing and destigmatizing meanings
Social Movement Activists	Disseminated destigmatizing meanings and contributed to structural destigmatization	Low involvement, but disseminated destigmatizing meanings	Disseminated destigmatizing meanings and contributed to structural destigmatization
Firms & Workplaces	Disseminated stigmatizing and destigmatizing meanings, site of structural destigmatization	Contributed stigmatizing meanings	Disseminated stigmatizing and destigmatizing meanings, site of structural destigmatization

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communication with the general public, medical experts progressively shifted blame from the acts of gay sex and substance abuse toward the mechanism of viral transmission (Epstein, 1996: 96). Indeed, McAllister (1992; also Epstein, 1996) argues that the media's construction of HIV/AIDS depended heavily on scientific knowledge, given health experts' relative authority during the height of hysteria. Therefore, the clarification that HIV was not transmitted by casual contact—articulated by public health officials and primary care physicians—coincided not only with the media's new focus on testing and prevention but also with a shift in public opinion about everyday interaction with PLHAs (Kaiser Family Foundation, 2011).

Understanding the cause of AIDS was an important, but insufficient, condition in the gradual and modest destigmatization of HIV/AIDS. While scientific knowledge about the syndrome eased fears and therefore opened up space for alternative cultural constructions, constructing PLHAs as blameless and "just like us" also depended on broader cultural beliefs about sex, drug use, and, especially, homosexuality. Cultural mores around queer sexuality were challenged by increasingly politicized and nationwide social activism in the 1960s, which evolved into significant legal challenges to statutes banning homosexual relations in the 1990s and 2000s. Indeed, many LGBTQ social activists feared that the AIDS epidemic would derail the increasing acceptance of non-normative sexual behaviors, which led them to advocate for safer-sex practices as opposed to abstinence in their framing of prevention (Epstein, 1996: 97). The contemporary trend toward greater acceptance of queer sexuality has likely provided the backdrop against which PLHAs have increasingly become understood as blameless. Acceptance varies by region, however. Indeed, in every state in the United States where sex education laws condemn homosexuality ("no-promo-homo" laws), a statute allows the criminal prosecution of PLHAs who do not disclose their HIV-positive serostatus (see Lehman et al., 2014).

When perceived as largely blameless and fairly non-threatening given the syndrome's etiology, PLHAs could contest legal and political efforts to restrict their liberties beginning in the mid-1980s. For example, legal challenges were brought against health care providers who refused to treat PLHAs, and the Supreme Court case *Bragdon v. Abbott* (1998) broadened the interpretation of the Americans with Disabilities Act to include, under certain circumstances, those with AIDS. In *Bragdon*, the Court rejected the notion that PLHAs should be protected on the grounds of their stigmatization alone, and instead framed HIV/AIDS as a disability (Larson, 2014). The Court's interpretation underscores one positive implication of drawing equivalences to other stigmatized groups—rather than the general population—in gaining access to important legal protections. Moreover, lawyers pressured the government and hospitals, as well as individual courts, to side in favor of privacy rights with respect to the disclosure of an individual's HIV-status (Gostin and Webber, 1998). Such claims to privacy, initially rejected by many courts, eventually gained traction as advocates likened PLHAs to other protected groups. Although punitive laws remain on the books in some states, successful legal challenges relied on claiming protective rights enshrined in American laws, not just on the framing of PLHAs as blameless and harmless.

During the 1980s and '90s, media campaigns attempted to draw equivalences between PLHAs and other Americans. In addition to disseminating accurate information about the etiology of the syndrome, public service announcements and television advertisements included explicit messages about the harms of stigma, such as a lack of open discussion about safe sex (Kaiser Family Foundation, 2006). While increased knowledge about the etiology of AIDS has been shown to have few long-term effects on individual attitudes in intervention studies (Brown et al., 2003), persistent societal-level cultural framings of equivalence can shift public attitudes and norms. Central to constructions of equivalence were the announcements of high-profile celebrities, especially American basketball star Magic Johnson (Kalichman, 1994). Constructions of equivalence were also enabled by the increasing familiarity with PLHAs in everyday interactions, particularly in high-status domains such as the arts and professional workplaces, where gay men living with HIV/AIDS held prominent positions (Epstein, 1996). Scientific knowledge around the etiology of the condition proved that anyone could contract HIV, and the status of prominent PLHAs revealed that people "like us" were also susceptible to the condition.

4.2. African Americans

The exploitation of African Americans, buoyed by stigmatizing anti-black ideologies and stereotypes, has marked American society from its beginning (Feagin, 2010). We delimit our discussion of the stigmatization of blacks to 1950-present. This period has witnessed a complicated evolution of anti-black attitudes, stereotypes, and structural policies in the United States. Despite signs of progress, stark black-white racial inequality persists (Clair and Denis, 2015). The socially isolated black poor in particular continue to face discrimination in myriad social contexts such as the criminal justice system, schools, neighborhoods, and labor markets (Reskin, 2012; Wilson, 1978). And compared to successive waves of racialized immigrant groups, African Americans remain at the bottom of the symbolic racial order (Waters et al., 2014).

Yet, public and structural stigmas toward African Americans have fluctuated since the 1950s. Changes in nonblack attitudes toward racial intermarriage, the decline of blatant racism, the presence of blacks in positions of power, and numerous other indicators of change in intergroup relations paint a portrait of progress in public stigma (Bobo et al., 2012). With respect to structural stigma, civil rights legislation resulted in numerous protections against discrimination and—to a nominal degree—the recognition of historical discrimination against blacks in the initial framings of certain policies, such as affirmative action (Graham, 1990). Despite these positive changes in public and structural stigma, implicit bias, concealed bias, and "colorblind" ideologies that stereotype blacks as lazy, undeserving, and criminally inclined suggest that other forms of stigma persist (Bobo et al., 2012; Krysan, 2012), contributing to continued perceived discrimination (Lamont et al., 2016). Moreover, the gradual dismantling of Civil Rights-era legislation, such as voting rights laws, school desegregation enforcement, and affirmative action (Reskin, 2012), underscore the fragility of improvements in structural stigma.

The cultural constructions of blamelessness and equivalence were involved in the initial improvement, gradual transformation, and contemporary regression of the destigmatization of African Americans. Here social scientists as well as legal and policy experts played a crucial role in the dissemination of such constructions. The conditions that enabled or constrained their intended effect on public and structural stigma are detailed below.

The stigmatization of African Americans is reproduced in large part by dominant explanations of perceived and real black-white inequality in multiple domains, including wealth, employment status, and educational attainment (Anderson, 2010). Since the mid-twentieth century, the dominant attributions of black-white inequalities have transformed from explicitly racist ideologies of biological inferiority to subtle and often implicit perceptions of cultural inferiority (Clair and Denis, 2015). Both biological and cultural attributions place blame on blacks; however, structural attributions of black-white inequality attempt to remove blame by emphasizing the role of historical and contemporary racial discrimination in creating inequality (Bobo et al., 2012). Since the

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1950s, efforts to reduce black-white inequality have relied in part on either cultural or structural attributions.

While cultural attributions have become dominant, as reflected in contemporary public attitudes and anemic support for anti-discrimination policies (Bobo et al., 2012), structural attributions—those that seek to remove blame—have resonated at particular moments and, ultimately, contributed to certain declines in structural stigma. *Brown v. Board of Education* (1954) exemplifies the centrality of structural attributions. In *Brown*, the Supreme Court relied on psychological research on the negative effects of segregation on black psyches. The Court framed research by Kenneth and Mamie Clark, in particular, as "modern authority" on the effects of racial segregation on black-white inequality (Graham, 1990: 367). In addition to school desegregation, other legal battles during the Civil Rights Movement attempted to shift blame from blacks in order to pass policies that equalized treatment. Initial Congressional hearings and debates around affirmative action and job quotas in the 1960s were justified by the recognition of racial discrimination in hiring, coupled with economists' testimony to the economic harms of such discrimination (Graham, 1990: 100–121). This latter justification framed anti-discrimination as beneficial to everyone, not just the stigmatized.

Despite initial reductions in structural stigma, many hard-fought legal protections have subsequently eroded. Affirmative action has been slowly dismantled, and desegregation efforts have all but ceased (Anderson, 2010). This erosion, in part, results from the failure of blamelessness (i.e., structural attributions) to resonate over time. Even during the Civil Rights Movement, efforts to reduce black-white inequality relied on cultural attributions as much as they did on structural attributions. For example, instead of removing blame from African Americans, the infamous Moynihan Report was interpreted by the Johnson administration and the American public—filtered through the media—as placing blame on the black family (Coates, 2015). Many sought to encourage job programs for inner city black men—including Moynihan, who partly framed the problem of black-white inequality as a problem of pathological black families. Yet, such efforts were limited because large segments of the American population refused to interpret the conditions of African Americans as a function of persistent racism (see Steinberg, 2015; Wilson, 2011: 6–7).

Ironically, attempts to draw equivalences between blacks and other Americans have at once reduced certain forms of public stigma, particularly norms around race and race talk, while also legitimating attempts to remove race-conscious policies such as affirmative action. Recent arguments against affirmative action have relied on the legal doctrine of equal protection to argue that racial preferences for historically marginalized groups both stereotype them as "less than" and violate equal protection for dominant groups (Anderson, 2010: 155). Thus, one unintended consequence of framing blacks as "like us" is the erasure of historical and contemporary disadvantages that disparately hamper blacks' life chances.

Grassroots efforts to reduce public stigma have, most notably, produced alternative representations of blacks that counter stigmatizing stereotypes. In the 1960s, black nationalist movements were influential in efforts to strengthen in-group pride (Dawson, 2001; Nelson, 2011). Such movements ushered in a broader culture of diversity and multiculturalism in higher education, business, and other middle-class and elite domains (Dobbin, 2009; Berrey, 2015). Resonant with the American notion of individualism and individual (as opposed to group) equality, multiculturalism is now a mainstream norm, in direct opposition to America's white supremacist past (Bobo et al., 2012). A slim black elite and upper-middle class have been able to take advantage of such changes; yet, large portions of the black middle class and poor remain disadvantaged and viewed as undeserving in a purportedly post-racial, multicultural America (Berrey, 2015).

Compared with PLHAs, African Americans present a contradictory case of destigmatization. While explicit racist attitudes have declined and diversity is celebrated through the institutionalization of *de jure* equal opportunity hiring practices in firms, stereotypes remain and some legal protections—a hallmark of racial progress during the Civil Rights Movement—have been weakly enforced and gradually dismantled. Moreover, unlike the case of PLHAs, some legal experts have relied on the construction of equivalence to dismantle rather than advocate for redistributive policies.

4.3. People labeled as obese

Although obesity has been associated with adverse health outcomes, stigma, beyond body size itself, compromises the health and life chances of PLOs, who face discrimination and devaluation in employment, education, interpersonal relationships, health care, and other domains (Puhl and Heuer, 2009). Anti-fat bias in the United States appears to have grown, as adults' reports of weight-based discrimination rose 66% between 1995–1996 and 2004–2006 (Andreyeva et al., 2008). Aside from statutes in a few cities and the state of Michigan, the United States offers no legal protection against weight-based discrimination (Puhl and Heuer, 2009).

Public understandings of obesity are significant barriers to destigmatization (Saguy, 2013). Generally, Americans see body weight as resulting from individuals' own actions, especially overeating and physical inactivity. This causal attribution rests on the belief that individuals can control their weight and that they are responsible for doing so (Puhl and Heuer, 2009). This construction of corpulence resonates with longstanding American values of self-reliance and self-control (Saguy, 2013: 70–71), while concording further with earlier constructions that trace obesity to gluttony and sloth, while framing slim, fit bodies as evidence of virtue (Greenhalgh, 2015). Various influential actors attribute body weight to individuals' own actions, including food companies skirting blame for rising obesity rates; pharmaceutical firms and diet companies that market weight-loss products; national and international health organizations; the media; and physicians, thus contributing to the salience and credibility of this perspective (Puhl and Heuer, 2009; Saguy, 2013).

Attributing obesity to individuals' poor choices enables blame and devaluation. Because the apparent inability to lose weight suggests a lack of willpower and restraint, large individuals are often stereotyped as unintelligent, unmotivated, incompetent, and even cavalier (Puhl and Heuer, 2009). These stereotypes persist even as many obese people worry about their weight and make great efforts to slim down (Greenhalgh, 2015). Whereas previous generations thought that body fat evinced poor character, today's public also sees personal failings as the cause of a medical crisis that harms both fat individuals and society (Saguy, 2013: 72). This construction risks casting fat people as bad citizens who contravene society's need for members who produce and contribute rather than detract from the common good (Greenhalgh, 2015).

Fat acceptance advocates and some obesity experts have attempted to remove blame by tracing body size to biology. Citing medical research that has demonstrated genetic links to obesity, these actors see corpulence as an ascribed trait, not the result of individual behaviors (Saguy, 2013). Actors who remove blame in this way aim to refute stereotypes and to attenuate negative emotions associated with believing that individuals have brought on their own misfortune. To the extent that the public takes obesity as evidence that individuals burden society and reject common values, removing blame may attenuate the sense that PLOs are bad

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citizens. Experimental studies show that framing fatness as biological can indeed reduce anti-fat prejudice (Crandall, 1994). The potential of genetic framings is mixed, however. As long as the public views fatness as a problem, the notion that large people are different by virtue of their genes can contribute to a sense that they are also "less than" (Saguy, 2013).

Attentive to this concern, some actors highlight parallels between large individuals and other groups. While some fat acceptance activists draw attention to their difference, sometimes as acts of resistance, many also highlight similarities to those who are not as large—such as liking healthy food, exercising, and simply wanting to enjoy life (Saguy and Ward, 2011). This strategy combines questioning stereotypes, highlighting common humanity, and claiming a right to "normalcy." Additionally, fat acceptance activists have analogized large individuals to other devalued groups such as racial and sexual minorities, whose difference is increasingly recognized as an asset in corporations and other institutions (Saguy, 2013: 65). It is unclear if attempts to draw equivalences between obese people and other groups have influenced public stigma, in large part because of the overwhelming presence of stigmatizing representations of overweight people as social burdens. Additionally, framing fatness as an asset remains tied to the desire for efficiency and innovation. Creativity and productivity are key in some settings, but claims about what fat people contribute to society in domains outside of intellectual labor are uncommon.

As scientific knowledge changes, opportunities for reframing and destigmatizing obesity arise. Recently, the argument that obesity stems from the fundamental malfunctioning of the endocrine system, rather than from overeating or inactivity, has gained visibility. According to this perspective, excessive carbohydrates dysregulate endocrine functioning, leading the body to store carbohydrates as fat instead of delivering them to cells for energy (Taubes, 2011). This process not only leads to weight gain, but also makes individuals hungry again, locking them in a cycle of eating and fat storage.

The "metabolic dysregulation" hypothesis has suggestive destigmatizing potential. First, it attributes obesity to human biology rather than to insufficient motivation and restraint. Advocates of this perspective explicitly reject that gluttonous overeating and laziness cause obesity, asserting instead that obesity itself leads to hunger and further intake. Thus, this perspective frames fat people as responding reasonably to the exigencies of the body rather than succumbing to hedonism (Taubes, 2011). Second, this attribution draws equivalences between overweight individuals and their slimmer peers. Unlike genetic attributions, which suggest that large individuals are intrinsically different, this perspective traces weight gain to universal biological features. But the metabolic dysregulation framing has potential pitfalls, as well. While it is destigmatizing on the dimensions of blame, separateness, and stereotypes, it casts fatness as injurious to individual and public health. In other framings of fatness, highlighting the health consequences of obesity can magnify anti-fat bias (Saguy, 2013).

While the metabolic dysregulation perspective has detractors, it is advanced by medical experts and journalists with legitimacy derived from academic credentials and positions at prestigious universities. Further, the argument is based in science, which remains a central criterion of legitimacy in arguments about body size because fatness is seen as a medical issue, and biomedicine derives its legitimacy from scientific knowledge (Saguy, 2013). Additionally, advocates of metabolic framings of obesity have appeared in mainstream media venues. However, this framing is likely to face barriers to institutionalization due to competing interests of powerful actors. Historically, food companies and food-industry lobbying groups have denied that their products uniquely influence dietary health when individuals have a "balanced" diet and sufficient exercise (Nestle, 2013).

Of our three cases, PLOs have experienced the most limited destigmatization relative to their own previous levels of stigma. The lack of scientific consensus about the etiology of obesity allows multiple constructions of the group to proliferate, including entrenched notions that body weight stems from individual failings. Despite the existence of alternate framings, pharmaceutical firms, food companies, health organizations, and the media continually frame obesity as a medical problem that can be addressed through individual actions (Saguy, 2013). Although individuals at all weights can benefit from diet and exercise, framing obesity as the result of individuals' own failings continues to enable stigma that taxes the health of large people.

5. Conditions of destigmatization

Our comparison of PLHAs, African Americans, and PLOs suggests three social conditions associated with the reduction of public and structural stigma: 1) the credibility of new constructions, which depends on their conclusiveness and the status of actors advocating for them; 2) the interaction of new constructions with existing ideologies; and 3) the perceived linked fate between the stigmatized group and the dominant group.

First, the public must come to see new cultural constructions as *credible*. The credibility of constructions often relies on the degree to which expert knowledge supporting such constructions is *perceived to be conclusive*. Increasingly conclusive medical knowledge demystified stereotypes about PLHAs, especially that only gays get AIDS. The case of African Americans reveals how social scientists developed new and conflicting views of the causes of black-white inequality (e.g., structural causes and culture of poverty arguments), while the case of PLOs shows how medical experts provided more complex, yet contested, understandings of the causes of obesity.

The credibility of destigmatizing constructions is affected by the *status and visibility* of social actors who disseminate them. For instance, Magic Johnson's openness about his HIV-status helped to shift public understandings that HIV could affect successful and respectable individuals as well as members of devalued groups. Johnson's public statements as a celebrity consequently helped to establish equivalence between PLHAs and respectable citizens. The mobilization and political impact of gay social activists who had high levels of cultural and social capital also lent credibility to the view that AIDS was not limited to "deviant" groups. In contrast, the case of African Americans reveals the stickiness of cultural stereotypes of inferiority despite the presence of highly visible and high-status individuals who contest them. Given the long and persistent history of black-white inequality in the United States and the disproportionate concentration of blacks in low-income categories, the public often views high-status blacks as exceptions to the rule (Loury, 2002) and attaches less importance to their claims. Moreover, the persistence of relationships of domination and exploitation that depend on racial status hierarchies (Gaertner and Dovidio, 1986) and a concomitant sense of group positioning (Blumer, 1958) also feed resistance to equivalence constructions. The case of African Americans suggests real-world limitations of stigma-reduction interventions that would rely primarily on high-status people to promote positive meanings (see Paluck and Green, 2009).

Second, even when new constructions are credible, their destigmatizing potential depends on their *interaction with preexisting understandings and ideologies* (see Skrentny, 2002). The cultural-legal script of privacy rights was central to legal claims made by PLHAs petitioning against statutes that restricted their liberties. Claiming equal protection often required drawing equivalences between PLHAs and other marginalized groups, such as people

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with disabilities in *Bragdon v. Abbott*. Similarly, fat rights advocates often draw on rights-based claims developed by other disability groups (Saguy, 2013). In the case of African Americans, drawing equivalences between blacks and other Americans often legitimated policy perspectives that favored colorblindness over redistribution. In the late twentieth century, colorblindness resonates more with American notions of equality and individualism than do redistributive policies that compensate for historical harms.

Third, destigmatization is more likely when *non-stigmatized individuals* find their own fate *linked to the stigmatized group*. When AIDS became understood as viral, not bound to a "homosexual lifestyle," the general public could see HIV/AIDS as relevant to their own lives. While this construction contributed to the instrumental fear of contracting the virus, it also moved the media and public health officials to educate about safer sex practices and the harms of stigma, in order to promote testing and disclosure. It has proved more difficult for whites to view their fate as linked to that of African Americans. Segregation in neighborhoods, the workplace, and everyday interactions hardens social boundaries along racial lines, further feeding stereotypes (Anderson, 2010: 44–66). Finally, given the widespread belief that obesity results from individual actions, "normal" weight individuals may not imagine themselves joining this stigmatized category, as occurred with HIV/AIDS. At the collective level, the public generally views its fate as compromised by overweight and obese individuals, who are framed as social burdens.

Public and structural stigmas sometimes attenuate through distinct processes. Common to both is the resonance, and ultimate cultural power (Schudson, 1989), of new cultural constructions among some sets of actors. By definition, reducing public stigma requires the broad resonance of new constructions in the general population, which is typically slow and may transform into hidden forms of bias, as in the case of African Americans. For its part, the reduction of structural stigma requires the transformation of beliefs and behaviors among key political, policy, and legal experts, which may result in policy and legal changes without the support of the general population, as occurred in *Brown v. Board of Education*.

6. Framework for the comparative analysis of destigmatization processes

Based on the foregoing analysis, we provide a framework for the examination of the actors who create, diffuse, legitimate, and deploy meanings of stigmatized groups that, in turn, enable destigmatizing actions. Fig. 1 depicts this framework, which could be applied to, and extended through, other cases.

This framework focuses on two general types of meanings attributed to stigmatized groups: *constructions of stigmatized conditions* and *constructions of cultural membership* (or *belonging* for short). Our case analysis shows that expert knowledge often provides the basis for constructions of the stigmatized condition. In turn, various social actors draw on these constructions of the stigmatized group and on the expert knowledge itself. Actors also engage in various *destigmatizing actions* that can contribute to destigmatizing outcomes. The arrow flowing from *constructions of belonging* indicates that existing understandings of the group can moderate the efficacy of *destigmatizing actions*. These constructions of belonging often interact with *existing ideologies* fundamental to the society—ideologies which enable and constrain the claims that actors can make in seeking social change.

Applied to other cases of stigmatized groups, this framework could accommodate different meanings, actors, actions, and outcomes. Future research could also examine other framings and claims, such as positive stereotyping, cultivating in-group pride or confronting aggression in order to assert dignity (Lamont et al., 2016). Another important construction to examine further is framing destigmatization as a broader social and economic good that benefits everyone, even the non-stigmatized. In the case of obesity, for example, those who contend that fat individuals burden society with medical costs may find compelling the argument that anti-fat stigma itself creates medical expenses in the form of stigma-related health issues—and that anti-fat bias also harms "normal" weight individuals who develop disordered eating to avoid weight gain (Greenhalgh, 2015).

This framework also enables cross-national research on destigmatization. Future cross-national research could consider the salience of various types of social actors across countries. While research has considered the importance of the law in the United States (Lamont et al., 2016), future research could employ our framework to consider whether legal experts intervene more in the United States while public intellectuals do so more in Europe. Similarly, researchers could consider how varying national institutions—from strong anti-poverty policies to neoliberal policy regimes (Mijs et al., 2016)—may enable the inclusion of specific stigmatized groups.

A final path for future development involves comparing how various destigmatization processes relate to boundary change processes documented by social scientists studying group boundaries and groupness, including boundary extension, bridging, and retraction (Lamont and Molnar, 2002; Brubaker, 2006; Wimmer, 2013). Despite their affinities, literature on stigma and boundary work have, regrettably, evolved largely in parallel. Much can be expected from a sustained comparison of findings and dialogue between research traditions. For instance, researchers could compare the social processes of stigma reduction with those that lead to a weakening of boundaries against ethnic groups (Wimmer, 2013).

7. Conclusion

This article provides a framework for identifying the social conditions that contribute to destigmatization over time and across stigmatized groups. This framework centers on the changing cultural constructions surrounding stigmatized groups and the efficacy of these constructions in shaping public and structural stigma. In particular, we examined the role of actors in producing, disseminating, and institutionalizing two cultural constructions—removing blame and drawing equivalences—in the case of PLHAs, African Americans, and PLOs. These constructions shaped public and structural stigma through distinct pathways and with varying degrees of success. While research on stigma-reduction interventions aims to challenge stigma at the level of the individual, our framework highlights the need to shift constructions of stigmatized groups at the level of collective representations that are instantiated in institutions, norms, and interpersonal interaction (Pescosolido et al., 2008: 437).

Our analysis does not exhaust the potential components of societal-level destigmatization processes. First, it is beyond the scope of our analysis to examine whether boundaries between stigmatized and dominant groups attenuate as social networks become more diverse through intermarriage, demographic shifts, or changing patterns in residential and workplace segregation. Second, we do not discuss all of the social actors in each case, such as politicians, ordinary citizens, and others who often play pivotal roles in advancing new cultural constructions. However, our framework points to areas for further study and suggests how and under what conditions cultural constructions may influence stigma. Third, future research should examine other stigma outcomes, such as self-stigma, which also contributes to health disparities and health inequities. Finally, while we

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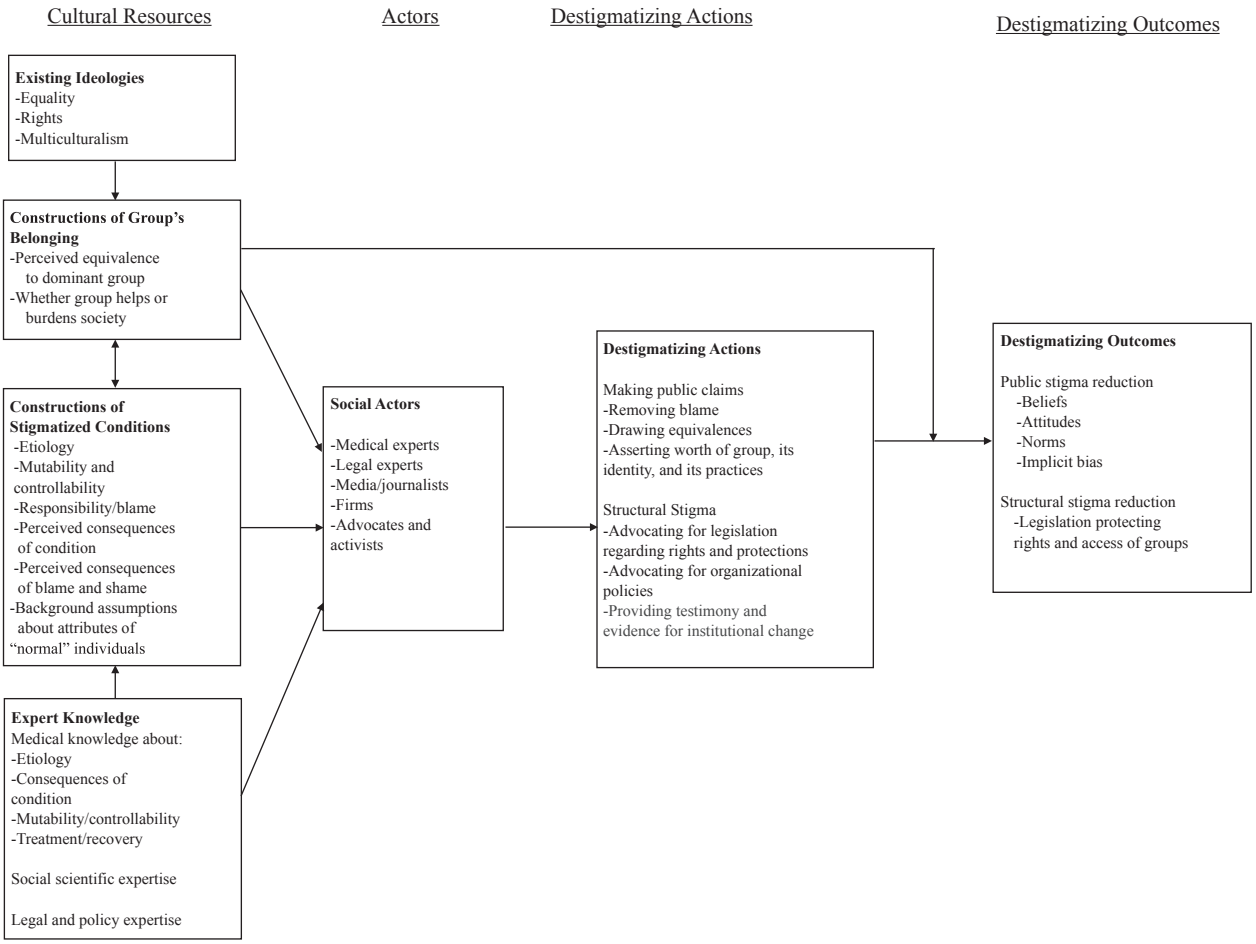

Fig. 1. Cultural resources and actors contributing to destigmatization.

motivate our analysis with research on health and stigma, we do not observe the direct health benefits of destigmatization in each case. Future research should consider linking changes in structural and public stigma to changes in health disparities over time.

These limitations aside, this article broadens our understanding of how societal-level cultural constructions shape individuals' health and of how to foster cultures of health more broadly. Our findings and framework highlight that governments need to systematically consider how policies may reinforce or weaken blamelessness, the creation of equivalence, and other cultural constructions that contribute to destigmatization (see Sykes et al., 2015). Organizations could consider how inclusive, non-stigmatizing policies benefit not only devalued groups, but also dominant group members. We identify the central actors—including legal experts, social scientists, and media professionals—who could be employed to disseminate and institutionalize new constructions. To contribute to destigmatization, these actors could foster the social conditions we identify as central to the destigmatization process: using their credentials and capitals to legitimate destigmatizing constructions and knowledge about stigmatized groups; challenging existing cultural ideologies that inhibit claims for inclusion and redistribution; and advocating for integration in public, social, and residential life in order to increase a sense of linked fate between dominant and stigmatized groups.

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