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The Conceptualizations, Causes, and Consequences of Stigma

Background for a Model of Migration-Generated Stigma

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Abstract

To provide a foundation for understanding migration-generated stigma, existing theoretical and research accounts of general stigma processes are reviewed. Existing frameworks of stigma are discussed, including those that have organized stigma according to its social functions, evolutionary functions, and associated stereotype contents, and structural, interpersonal, and intrapersonal manifestations of stigma are reviewed. These manifestations impact numerous health outcomes through replaceable intervening mechanisms and make stigma a fundamental cause of poor health. Postulated causes and dimensional features of stigma are considered that highlight similarities and distinctions across diverse stigmatized characteristics. The application of existing theory and research is explored for the specific case of migration-generated stigma and several future research directions highlighted. By providing a broad overview of several decades' worth of theory and research into stigma, this chapter positions the field of migration-generated stigma to understand the nature and function of this particular form of stigma and pursue the most promising paths toward its reduction.

Organizational and Functional Frameworks of Stigma

As a sociopsychological process, stigma refers to the negative stereotyping, discrimination, and social, emotional, and physical separation that is directed toward individuals who possess a socially devalued mark (Crocker et al. 1998). Goffman, who initiated the formal study of stigma, noted that the stigmatized individual "is reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman 1963:3). Yet, lest the concept become overly

encompassing of any trait deemed disagreeable or distasteful by any individual in any context, the sociological definition of stigma also requires that such stereotyping, labeling, and separation occur in societal systems of unequal power in which individuals possessing the devalued trait are deemed less worthy of, and given less access to, power than individuals who do not possess the trait. As a result of this power inequity between the stigmatized and nonstigmatized, stigma necessarily elicits material disadvantage, including lower access to the resources necessary for equal health, well-being, and life chances available to the nonstigmatized (Hatzenbuehler et al. 2013). When defined as such, it can be argued that stigma affects numerous populations, if not most individuals, at some point in the life course. Reflecting this possibility, Goffman (1963:129) noted: "The issue becomes not whether a person has experience with a stigma of his own, because he has, but rather how many varieties he has had his own experience with." Indeed, stigma encompasses numerous highly prevalent attributes, impactful identities, and health conditions, such as old age, obesity, mental illness, and migration status (Pachankis et al. 2018).

Given the magnitude and complexity of stigma's influence on societies and populations, various frameworks have been utilized to characterize and organize the forms and functions of stigma. For instance, Goffman (1963) organized manifestations of stigma into three categories: moral failings (e.g., mental illness), tribal blemishes (e.g., immigrant status), and body abominations (e.g., physical disabilities). He categorized stigma more broadly according to whether it can be considered to be automatically discredited in daily life (because it is visible) or discreditable (because it is concealable and would only become discredited if known). As reviewed below, later empirical research has validated the utility of these general categorizations for highlighting distinct social and evolutionary functions of various stigmas and distinct impacts on psychosocial well-being.

Various types of stigma have also been categorized in terms of their social functions (Phelan et al. 2008). For instance, some stigmas serve the social function of allowing the powerful to exploit and dominate a socially subordinated group for material gain. Stigma directed to race and ethnicity represents a clear example. Other stigmas serve the social function of allowing the dominant, power group to enforce the social norms that reflect and preserve their social positions and culture. Stigmas such as sexual and gender minority identities, polyamory, and nonmainstream political beliefs serve as examples. Still other stigmas serve to motivate avoidance of the threat of perceived disease. Research finds that this avoidance can be relatively nonspecific and even extend to nontransmissible conditions, including physical disabilities and overweight status. These three social function categories highlight what is at stake for the perpetrators of stigma; namely, loss of power, purpose, and health, respectively (Phelan et al. 2008).

The categorizations of stigma reviewed above overlap somewhat with the evolutionary functions that have been argued to underlie stigma (Kurzban and

Leary 2001; Schaller and Neuberg 2012). Specifically, the evolutionary argument suggests that stigma evolved to help us avoid high-risk social investments that could end with a high probability of being cheated out of resources, to strengthen the fitness of one's own group through the exploitation of other groups, and to avoid parasitic infection. These evolutionary functions correspond to Goffman's categorization of moral failings, tribal blemishes, and body abominations, respectively. According to the evolutionary view, these stigmas evolved to solve problems inherent to humans' sociality and operate through cognitive processes that facilitate social decision making.

Finally, the stereotype content model (Cuddy et al. 2007; Fiske et al. 2002) categorizes stereotypes—a key component of stigma—according to dimensions of warmth and competence. These dimensions stem from perceptions of a group's status and competitiveness; namely, perceptions of whether the group's goals pose harm or benefit and whether the group can achieve those goals. These combined perceptions predict distinct emotional and behavioral reactions toward the target group. For instance, groups perceived as warm and competent (e.g., the in-group, a society's reference group) elicit admiration and helping tendencies. Groups perceived as cold and incompetent (e.g., the homeless) elicit contempt and harm tendencies. Groups perceived as cold and competent (e.g., Asian Americans) elicit envy, passive helping (e.g., tolerance) tendencies, as well as active harm (e.g., exclusion) tendencies. Finally, groups perceived as warm and incompetent (e.g., the elderly) elicit pity, active helping tendencies (e.g., inclusion), and passive harm tendencies (e.g., neglect). These two dimensions—warmth and competence—are also likely functional in that the ability to discern these traits has been argued to facilitate social success and even survival (Major and O'Brien 2005). While various stigmatized populations can be categorized according to these two dimensions, with predictable emotional and behavioral reactions among the stigmatizers, all the above categorization systems can also predict the characteristic psychosocial experiences of individuals within various categories of stigma, as reviewed later in this chapter.

Structural, Interpersonal, and Intrapersonal Manifestations of Stigma

A common framework used to understand the nature and impact of stigma on the health and well-being of the stigmatized organizes stigma in terms of the socioecological levels in which it manifests. Here we summarize the socioecological model of stigma by focusing on three such levels: the structural, interpersonal, and intrapersonal.

Given that stigma ultimately relies on power inequities (Link and Phelan 2001), stigma can be argued to manifest most broadly in the form of laws, policies, and other levers of a society's allocation of rights and resources. This

broadest form of stigma is known as structural stigma (Hatzenbuehler 2016). Taking advantage of geographic variability in laws, policies, and other indicators of structural inequality, researchers have sought to quantify the impact of that variability on the health and well-being of the stigmatized who live in those geographic areas. For instance, greater country-level structural stigma, in the form of aggregated anti-immigrant attitudes in one's current country of residence, is associated with lower access to health services among sexual minority male migrants who had moved to one of 38 European countries (Pachankis et al. 2017b). Among sexual minority individuals in general, greater structural stigma, in the form of country-level anti-sexual-minority laws, policies, and national attitudes across 44 countries, is associated with higher odds of depression and suicidality (Pachankis et al. 2021). Additional research establishing an association between structural stigma and health and well-being has relied on natural experiments showing that changes in structural stigma are associated with hypothesized changes in health and that this effect is specific to the target stigmatized group and operates through hypothesized mechanisms, such as social isolation, internalized stigma, and identity concealment (Hatzenbuehler 2016). Together, this research establishes the validity of the nature and impact of structural stigma.

On the interpersonal level, stigma is enacted through discriminatory behaviors indicative of unfair treatment based on one's membership in a socially disadvantaged group. In some contexts, these discriminatory behaviors manifest as blatant acts of hostility, such as police violence that disproportionately impacts African Americans (Hetey and Eberhardt 2018) and elevated levels of bullying and peer victimization facing sexual minority youths (Clark et al. 2020). In other contexts, discrimination manifests in more subtle forms, such as sitting farther away from the stigmatized person, making less eye contact, and terminating interactions prematurely (Hebl et al. 2002; Trawalter et al. 2009). Notably, interpersonal forms of stigma can also be perpetuated through seemingly positive behaviors, such as unsolicited, excessive offers of assistance often directed toward members of stigmatized groups stereotyped as warm and incompetent (e.g., people with physical disabilities; Wang et al. 2015) and compliments based on racial stereotypes (e.g., Blacks are good athletes; Czopp 2008). According to two meta-analyses encompassing individuals with a wide range of stigmatized identities, interpersonal forms of stigma have been linked to myriad physical and mental health outcomes, including a number of chronic health conditions (e.g., obesity, hypertension), depression, anxiety, sleep disturbance, and overall health-related quality of life (Pascoe and Smart Richman 2009; Schmitt et al. 2014).

Stigma also affects health and well-being via intrapersonal mechanisms such the impact that stigma has on the thoughts (e.g., self-evaluation), emotions (e.g., anxiety), and behavioral reactions (e.g., avoidance) of the stigmatized. For instance, through social learning, a stigmatized person comes to predict how they will be treated in any given situation because of their

stigmatized identity. Of course, various characteristics of the stigma (e.g., its concealability or visibility) determine this treatment and the resulting intrapersonal consequences (e.g., Smart and Wegner 1999). These expectancies shape the stigmatized individual's thoughts, emotions, and behaviors in any given social interaction and can lead the stigmatized individual to confirm these expectancies through nonconscious self-fulfilling mechanisms. For instance, experimental research into stereotype threat (Steele 1997) demonstrates that activation of common societal stereotypes can undermine the performance of stigmatized individuals in ways that confirm negative stereotypes about their group (Shih et al. 2002). Possessing a stigma can also undermine self-esteem or lead an individual to disengage their self-esteem from domains in which their group is expected to underperform (e.g., academic success; Crocker and Wolfe 2001). Another way in which stigma can undermine health and well-being is through yielding chronic, anxious expectations of stigma-based rejection (e.g., Mendoza-Denton et al. 2002). For instance, sexual minority individuals who experience parental and peer rejection report more expectations of future rejection toward their stigmatized identities (Pachankis et al. 2008). Ultimately, possessing a stigma can lead the individual to perceive that the threat in their environments outweighs their resources for coping with this threat, thereby generating excess stress and poorer health and well-being (Meyer 2003). As a result, stigma-related stress compounds the effects of general life stress to jeopardize disproportionately the health and well-being of the stigmatized compared to the nonstigmatized. In this way, stigma serves as a fundamental cause of poor health.

Stigma as a Fundamental Cause of Health Inequities

As we have illustrated thus far, stigma represents a major source of stress for a wide range of marginalized populations and disadvantages them through structural-, interpersonal-, and intrapersonal-level processes. To this end, it is not surprising that stigma has been increasingly recognized as a key driver of physical and mental health inequities along with other known social determinants of health (e.g., socioeconomic status). Drawing upon the fundamental cause theory (Link and Phelan 1995), Hatzenbuehler et al. (2013) posited stigma as a social factor that is persistently associated with multiple disease outcomes over time and across geographic locations, even though the intervening mechanisms underlying these associations might vary across contexts. Below, we highlight several pathways that link stigma to myriad adverse physical, mental, and behavioral health outcomes.

By definition, stigma undermines health via status loss and discrimination, thus hindering access to opportunities in important life domains. Specifically, substantial disparities in employment, housing, and health-care access have been documented among members from various stigmatized groups, including

racial/ethnic minorities (Williams and Collins 2001), sexual and gender minorities (Downing and Rosenthal 2020), people with mental illnesses (Corrigan et al. 2012), and people with disabilities (Krahn et al. 2015). Ample evidence suggests that stigmatized individuals, especially those with disabilities and chronic physical/mental illnesses, are disproportionately impacted by social isolation (Chou and Chronister 2011; Tough et al. 2017). Taken together, these inequalities restrict stigmatized individuals' access to flexible resources (i.e., knowledge, money, power, prestige, and beneficial social connections) that can be deployed to avoid health threats and maximize health benefits. For instance, poverty and residential segregation may limit stigmatized individuals' access to healthy food, preventative care, and transportation and put them at greater risk to develop chronic medical conditions, such as cardiovascular disease, cancer, and diabetes (Dovidio et al. 2018) as well as infectious diseases, such as HIV and COVID-19 (Pareek et al. 2020).

In addition to thwarting access to flexible resources, stigma also compromises health by exposing individuals to elevated levels of stress. Both minority stress theory (Meyer 2003) and identity threat models of stigma (Steele et al. 2002) posit that possessing a stigmatized identity increases exposure to stressful situations, including external events (i.e., experiences of discrimination) and internal events (e.g., fear of being stereotyped or rejected). Experimental studies have shown that the stress associated with experiencing enacted and anticipated stigma can trigger a host of cognitive, affective, and physiological responses, including hypervigilance, negative emotions (e.g., anger, anxiety), and increases in blood pressure and cortisol (Guyll et al. 2001; Townsend et al. 2011). When chronically activated, these stress responses can undermine both physical and mental health, exacerbating cardiovascular disease risk and driving symptoms of depression and anxiety (Major et al. 2013).

Given the myriad challenges associated with stigma, it is not surprising that the act of contending with stigma-related experiences can also compromise health by hindering adaptive psychological responses to stress, such as self-regulation. As noted by Inzlicht et al. (2006), stigmatized individuals use and deplete executive resources to manage their socially devalued identities, leaving them less able than their nonstigmatized counterparts to monitor and regulate their emotions effectively. A daily diary study, for example, showed that both sexual and racial/ethnic minority participants were more inclined to engage in maladaptive emotion regulation strategies, such as rumination (i.e., passively and repetitively focusing on one's problems and their causes) and suppression (i.e., inhibiting emotion-expressive behaviors), on those days when they experienced stigma-related stressors (Hatzenbuehler et al. 2009b). In other studies, encompassing individuals with a wide range of stigmatized identities, chronic exposure to stigma has been linked to deficits in emotion regulation abilities (e.g., ability to understand and accept one's emotions), which were in turn associated with adverse mental and behavioral health

outcomes such as depression, anxiety, and substance use (Burton et al. 2018; Pachankis et al. 2015; Rendina et al. 2017; Wang et al. 2018).

In sum, a straightforward evidence base supports the role of stigma as a fundamental cause of health inequities. Specifically, stigma has been shown to influence multiple physical and mental health outcomes by disrupting access to flexible resources, increasing stress exposure, and hindering adaptive coping responses such as self-regulation. This theoretical framework highlights the pervasive impact of stigma on population health. To capture the full impact of a given stigmatized identity, such as migration, on health, it is important to consider the impact of migration-related stigma across multiple mechanisms and outcomes, as well as how other intersecting identities (e.g., race/ethnicity, sexual orientation) might shape the experience of migration stigma. Since stigma, by definition, entails power differentials between socially dominant versus marginalized groups, the reduction of health inequities can be particularly challenging, given that stigma operates through varying intervening mechanisms and outcomes that are seemingly designed to evade progress toward health equity. As such, the theoretical framework summarized here underscores the importance of attending to stigma, along with other social determinants of health, in the development and implementation of effective public health interventions.

Causes of Stigma

While the nature of stigma can be discerned through its multilevel manifestations and impacts, it can also be understood by examining its underlying causes. Although stigma is ultimately a social process, the search for the causes of stigma tends to focus on processes within the individual, including personality traits, cognitive processing, fears of one's own mortality, evolutionary adaptive threat detection, or psychological preferences to maintain a predictable social order. Thus, the question, "Why do humans stigmatize?" has been answered in several ways:

1. Some humans possess a prejudiced personality (Adorno et al. 1950; Altemeyer 1981; Sidanius and Pratto 1999).
2. Stigma facilitates cognitive efficiency (Macrae et al. 1994).
3. Stigma helps stave off the specter of human mortality (Rosenblatt et al. 1989).
4. Stigma represents an evolved functional means to avoid disease (Schaller and Neuberg 2012).
5. Stigma is motivated by desire to maintain beliefs in a just, predictable world (Jost and Banaji 1994).

Below we review the theory and evidence for each of these possibilities.

Perhaps the earliest of the proposed causes of why people stigmatize each other—the prejudiced personality—was pursued in the postwar environment by European social scientists and intellectuals from the Frankfurt School who were motivated to explain anti-Semitism and fascism. Relying on psychoanalytic understandings of human development, Theodor Adorno and colleagues (1950) hypothesized the "authoritarian personality," posited to reflect deference toward authority figures resulting from overly punitive parental punishment and the subsequent displaced anger toward one's parents and suppressed homosexuality. Adorno developed a multi-item scale to capture the nine traits proposed to underlie authoritarian leanings, such as submission to authority and perception of the world as dangerous. Reflecting the popularity of personality-driven conceptualizations of stigma, Gordon Allport (1954) noted in his classic text on prejudice: "prejudice is basically a trait of personality" (Altemeyer 1981:73). Yet around the same time, the validity of Adorno's scale was found to be psychometrically lacking and was further called into question by its biased participant sampling and item wording. Nevertheless, this early work inspired subsequent studies that examined two of the traits proposed by Adorno—right-wing authoritarianism (Altemeyer 1981) and social dominance orientation (Sidanius and Pratto 1999)—measured with psychometrically reliable instruments predictive of a range of intergroup phenomena (as reviewed in Sibley and Duckitt 2008). More recent research, however, has suggested that because these factors are not strongly predictive of behavior, they represent something closer to social attitudes rather than personality traits and are themselves predicted by personality traits and socialization experiences (Sibley and Duckitt 2008).

The next purported cause of stigma is its functional role in cognitive processing. Specifically, research shows that stereotypes operate as mental "energy-saving" devices by freeing up cognitive resources for optimal navigation of complex, information-heavy worlds (Macrae et al. 1994). Indeed, perceiving others by attending to their specific, individuating attributes requires more mental energy and time than relying on their simple category membership (Fiske and Neuberg 1990; Fiske and Pavelchak 1986). Research suggests that stereotypes are more accessible under mentally demanding conditions and that people become more efficient at completing a cognitive task (e.g., reading) when presented with stereotypic information during a simultaneous impression formation task (Macrae et al. 1994). Notably, this type of reliance on stereotyping is unintentional and occurs subconsciously (Bargh 1989). However, reliance on stereotypes is not a universal, or even necessarily automatic, process. Indeed, a person's motivation, goals, values, and social accountability pressures can steer them toward engaging in more resource-intensive attentional processes, such as attribute-based impression formation instead of simple reliance on category membership (e.g., Neuberg and Fiske 1987).

A third hypothesized cause of stigma is offered by terror management theory (Ernest 1973; Solomon et al. 1991). Terror management theory relies

on the proposition that humans are unique in being cognizant of their own mortality, of the fact that they are nothing more than "an ambulatory assemblage of blood, tissue, and guts, inherently no more significant or enduring than a barnacle, a beetle, or a bell pepper" (Solomon et al. 2000:200). As a result of this terrifying awareness, humans rely on cultural systems to provide collective meaning and purpose and ultimately the promise of immortality. Religious institutions often communicate a promise of immortality directly. At the same time, terror management theory argues that all culturally imbued practices, including formal (e.g., the arts) and daily (e.g., work) enactments of culture, serve to keep humans removed from the specter of their mortality. Humans collectively and personally defend their specific cultural systems from attack, especially from distinct systems that might call into question the validity of one's own culture. These defenses can manifest in war and other forms of extreme collective sacrifice, argued to match the extremeness of the psychological threat to one's immortality. Evidence supporting terror management theory comes from experiments in which mortality primes greater liking for people who possess similar worldviews as oneself and threat and hostility toward people who possess alternate worldviews (e.g., Greenberg et al. 1997; McGregor et al. 1998).

Stigma has also been argued to have evolutionary origins (Schaller and Neuberg 2012). Evolutionary arguments specifically suggest that distinct prejudices and their associated affective (e.g., fear, disgust) and behavioral (e.g., avoidance, poor treatment) action tendencies have a genetic basis that emerged from ancestral environments in which such tendencies were adaptive. These tendencies are argued to have increased reproductive fitness in the ancestral environment even if today they might often lead to more social harm than good. Perhaps the clearest evidence for the evolutionary cause of stigma comes from studies which show that distinct types of threats give rise to distinct types of prejudicial responses (e.g., Cottrell and Neuberg 2005) and the existence of discrimination-like behavior among nonhuman primates (e.g., Goodall 1986). Ancestral threats mostly involved interpersonal hostility, infectious disease, and being cheated out of resources. Therefore, natural selection produced psychological mechanisms that allow for quick detection and avoidance of these threats that thereby confer evolutionary advantage (Neuberg et al. 2011). These threat-detection mechanisms persist today and, depending on the environment, can err on the side of caution and produce overgeneralized threat perceptions and associated responses. For instance, the "behavioral immune system," argued to have originally evolved to help humans avoid infectious disease, often yields overgeneralized false positives, including extension to avoidance of immigrants and people who are overweight (Schaller and Park 2011). The evolutionary argument for stigma extends and refines the personality argument by suggesting that, although associations exist between personality traits such as social dominance orientation (a general type of threat tendency associated with preference for traditional hierarchies) and prejudice, this association can be

better explained by the association between more specific types of threat (e.g., possible infection) that give rise to distinct types of prejudice (e.g., avoidance of certain physical traits).

The final hypothesized cause of stigma is guided by system justification theory (Jost and Banaji 1994; Jost et al. 2004), which posits that people's need for predictable social order often supersedes their own and their group's self-interest. Support for system justification theory comes from numerous experimental and observational studies finding that people do, in fact, seek to uphold the existing social order, even if that order actively disadvantages or oppresses one's own stigmatized group (e.g., Jost et al. 2003; Newman 2002). This desire is reflected most strongly in implicit, compared to explicit, attitudes, which among the stigmatized manifests as implicit internalized stigma such as implicit favoritism of heterosexuals among sexual minorities or Whites among African Americans (Nosek et al. 2002). Paradoxically, justification of the status quo is often stronger among those who are most oppressed by it; namely, the stigmatized (Jost et al. 2004). In this way, rather than explaining stigma solely as a matter of a dominant group imposing its will on subordinated stigmatized group, system justification theory highlights the role of the stigmatized in maintaining the social order. Indeed, it has been argued that across human history, individuals and societies have sought to maintain the status quo more than they have sought to revolt and rise up even in the face of extreme oppression (Zinn 1968). At the same time, system justification theory proposes that individuals will advocate for social change when their needs for self- and group esteem override their needs to maintain the existing social order. Given the strength of needs for self- and group esteem, such advocacy is argued to be relatively rare.

Variations among Stigmatized Attributes

In addition to the overarching antecedents and consequences of stigma across various socially devalued groups discussed above, it is important to acknowledge that each stigmatized attribute is associated with a distinct set of perceptions and experiences. Indeed, since the field's inception, stigma researchers have been developing systematic frameworks to organize myriad stigmatized identities, conditions, and attributes along shared dimensions. Such dimensional conceptualizations of stigma serve two important goals. First, they help elucidate the diverse social and health implications of stigma across different stigmatized groups by identifying the most relevant dimensional correlates with negative interpersonal and health outcomes. Second, they allow researchers to determine the generalizability of findings from one stigma to another based on their similarities and differences in dimensional ratings, thereby maximizing scarce research resources and facilitating information exchange among stigma researchers. In this section, we highlight one of the most

prominent dimensional taxonomies in the stigma literature and describe its utility in quantifying the variations among stigmatized attributes.

In their pioneering book, *Social Stigma: The Psychology of Marked Relationships*, Jones et al. (1984) outlined six dimensions along which all stigmas are expected to vary:

1. Concealability (the extent to which a stigma is visible to others),
2. Course (the extent to which a stigma persists over time),
3. Disruptiveness (the extent to which a stigma interferes with smooth social interactions),
4. Aesthetics (the potential for a stigma to evoke a disgust reaction),
5. Origin (the extent to which the onset of a stigma is believed to be controllable), and
6. Peril (the extent to which a stigma poses a personal threat or potential for contagion).

Using this theoretical framework, previous research has examined how each of these six dimensions relates to the perceptions and experiences of stigmatized individuals, with concealability and origin having received the most empirical attention.

Regarding concealability, individuals with concealable stigmas have been shown to utilize less social support to cope with stigma-related stressors, feel greater social isolation, and experience more adverse psychological outcomes, such as greater negative affect and lower self-esteem (for a review, see Chaudoir et al. 2013; Frable et al. 1998; Hatzenbuehler et al. 2009b). At the same time, however, concealability can be beneficial as it may enable individuals to pass as "normal," thus avoiding prejudice and discrimination in less supportive environments. Among HIV-positive individuals, for example, those with visible symptoms reported more stigmatizing experiences and greater psychological distress than those without visible symptoms (Stutterheim et al. 2011). Relatedly, children with congenital heart disease were better adjusted than children with facial scars, even though the former group actually experienced greater functional limitations than the latter (Goldberg 1974).

Regarding origin, stigmas perceived to be uncontrollable at onset (e.g., physical disabilities, cancer) tend to elicit pity and helping behaviors, whereas stigmas perceived to be controllable (e.g., obesity, HIV) tend to elicit hostility and behavioral avoidance (Weiner et al. 1988). Onset controllability was also identified as a key dimension in predicting social rejection toward individuals with various physical and mental illnesses (e.g., Crandall and Moriarty 1995; Feldman and Crandall 2007; Hebl and Kleck 2002). Recent research on mental illness stigma, however, has demonstrated that attributing mental illnesses to biological causes, such as neurochemical imbalances and genetic abnormalities, can be problematic. Specifically, although these explanations might reduce personal blame, they can exacerbate other aspects of stigma by enhancing the public perceptions of mental illnesses as severe and persistent (Phelan

2005) and contributing to pessimism about one's prognosis among individuals affected by mental illnesses (Lebowitz 2014).

Integrating prior research, Pachankis et al. (2018) developed and validated a taxonomy that organized 93 stigmatized attributes along all six dimensions, with the goal of better understanding the individual and joint impact of stigma dimensions on social perceptions and health. Among both stigma experts and members of the general public, greater desired social distance was associated with those stigmas that were perceived to be more disruptive, perilous, aesthetically unappealing, and onset controllable. Relatedly, among individuals who endorsed a wide range of stigmas, disruptiveness was most strongly associated with poor mental health and overall well-being. Pachankis et al. proposed that each stigmatized attribute can be located within one of five clusters characterized by a unique dimensional fingerprint with distinct relationships to social perceptions and health. Notably, stigmas that are highly visible, highly disruptive, and persistent in course (e.g., physical disabilities; the "awkward" cluster), as well as stigmas that are highly perilous, onset controllable, and aesthetically unappealing (i.e., HIV, substance use; the "threatening" cluster), were associated with more frequent experiences of discrimination and higher levels of health impairment compared with other stigmatized attributes.

Taken together, the research reviewed here provides compelling evidence for the utility of applying a dimensional framework to the study of migration-generated stigma. Given that migrants represent diverse racial/ethnic groups, nations of origin, and cultural backgrounds, a dimensional framework would help quantify these heterogeneous experiences and elucidate health discrepancies across different migrant groups. Additionally, noting that migration often intersects with other marginalized identities (e.g., membership in racial/ethnic minority groups, low socioeconomic status), a dimensional framework can advance the understanding of these intersectional experiences, both by enabling researchers to compare the health-compromising effects of individual stigmas with one another and by fostering innovative quantitative solutions for capturing intersectionality when predicting health (e.g., aggregating dimensional ratings across all stigmas endorsed by an individual, weighting more heavily those stigmas that are considered to be more personally impactful).

Application of Stigma Concepts to Migration-Generated Stigma

The conceptual models and categorical frameworks reviewed above can be usefully applied to increase our understanding of stigma directed toward migrants, including its nature, function, and impact on the health of migrant populations. Indeed, in applying predictions of these models and frameworks to migration-generated stigma, existing research has identified theoretically derived predictors of migration-generated stigma and located migration-generated stigma across socioecological levels. It also suggests that migration-generated stigma

fundamentally causes adverse health for migrants, serves specific social and perhaps evolutionary functions, and locates this stigma within dimensional classifications.

In the framework by Goffman (1963), stigma toward migrants would be classified as a tribal blemish, given that migrant status is commonly attached to a particular race, ethnicity, religion, and/or ideology. According to the evolutionary framework, research finds that stigma toward migrants is related to fears of infectious disease threat and the behavioral immune system (Faulkner et al. 2004). However, when considering the social function of migration-related stigma, it is possible that stigma toward migrants emanates not only from a hyperactive disease avoidance mechanism but also serves to reinforce in-group dominance, exploiting and enforcing its cultural norms onto migrants.

Research that applies the stereotype content model to stigma suggests that the type of stigma directed toward migrants might depend on the perceived traits of particular migrant groups. This research recognizes that not all migrant groups are stigmatized equally. For instance, migrant groups perceived as high competence and low warmth elicit envy whereas those perceived as low competence and high warmth elicit pity (Caprariello et al. 2009). Of course, how migrants are perceived and categorized in these frameworks is ultimately a function of the social structures to which they arrive.

Stigma toward migrants has been shown to manifest across structural, interpersonal, and intrapersonal levels. For instance, the implementation of anti-immigrant laws and policies have been shown to influence health outcomes such as missed primary care appointments and increased emergency department visits (e.g., Samuels et al. 2021) as well as anxiety (Frost 2020). Further, experiences of interpersonal discrimination have been linked to poorer self-rated physical health, psychological well-being, and health risk behaviors, such as substance use (Chen 2013; Jasinskaja-Lahti et al. 2006; Lin et al. 2011). Although less research has directly examined the intrapersonal manifestations of migration-related stigma, perceived pressure to assimilate into the culture of one's destination country, which can be conceptualized as one facet of anticipated stigma, was negatively associated with life satisfaction among migrants who valued conformity (Roccas et al. 2000). Consistent with the fundamental cause theory discussed above, stigma toward migrants has been shown to influence a wide range of physical and mental health outcomes by disrupting access to flexible resources (e.g., social capital; Chen et al. 2011), thereby making migration-generated stigma a fundamental cause of health inequities facing this population.

Research has found support for the applicability of various causal models of stigma to stigma toward migrants specifically. For instance, drawing upon the notion of the prejudiced personality, research has found that various personality traits (e.g., narcissism, psychopathy, low openness) predict right-wing authoritarianisms and social dominance orientation, which in turn predict anti-immigrant stigma (Hodson et al. 2009). Some of the predictions of

terror management theory, as applied to migrant-generated stigma, also find empirical support. For instance, mortality salience has been shown to generate more negative evaluations of immigrants among people high in right-wing authoritarianism, but more positive evaluations for people low in right-wing authoritarianism (Weise et al. 2012). Further, mortality salience has been shown to affect evaluations of undocumented immigrants depending on whether the immigrant is from a culturally familiar versus less familiar country (Bassett and Connelly 2011). In support of disease avoidance mechanisms being generally applied to migrants, research has found that perceived vulnerability to disease predicts negative reactions only to subjectively "foreign" people, but not subjectively to familiar people (Faulkner et al. 2004). In further support of this notion, COVID-19 pandemic threat exposure in 105 European regions was shown to be associated with more negative attitudes toward immigrants (Freitag and Hofstetter 2022).

Finally, in terms of locating migrant-generated stigma along the various dimensional features of stigma, research has shown that how migrants are perceived varies depending on the specific group to which they belong. For instance, in the United States, people who are Latinx, South Asian, and Middle Eastern are perceived to possess a highly visible status with a persistent course but low disruptiveness, peril, and onset controllability. By contrast, Muslims are perceived to possess a relatively perilous, concealed, and onset-controllable status (Pachankis et al. 2018). Similarly, research applying the stereotype content model to migrant-generated stigma finds variation across migrant groups: Arabic populations in the United States are perceived as low in competence and warmth; British, Jewish, and Asian populations are perceived as being high in competence but low in warmth; and Irish people are perceived as being high in competence and warmth (e.g., Cuddy et al. 2007).

Conclusion

The study of migration-related stigma can be enhanced by applying several decades' worth of theory and research into stigma, including its conceptual frameworks, multilevel manifestations, mechanisms, causes, and variations. To the extent that future scholarship draws upon this existing foundation, remaining questions about the specific form and function of migration-related stigma can be formulated and informed solutions posed to speed its reduction. To this end, the following topics are highlighted for future study:

- Determine the societal and personal characteristics, and their interactions that predict migration-related stigma.
- Establish the temporal and spatial conditions under which migration-related stigma is strongest.

- Ascertain the extent to which migration-related stigma is similar to or distinct from other stigmatized conditions in terms of its multilevel determinants.
- Identify variations within and across migrant populations, including along established dimensional features of stigma, that predict different manifestations of migration-related stigma.
- Determine the specific causes of migration-related stigma that can be addressed through mechanistically informed interventions.

The existing body of stigma theory and research reviewed here, even if not always specifically referencing migration-related stigma, lays a solid foundation for scholars to advance understandings and solutions of stigma as it directly affects migrant populations.

Acknowledgments