The elephant in the room? Why spatial stigma doesn't receive the public health attention it deserves.

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Abstract

In the context of health inequalities, spatial stigma refers to the ways that areas experiencing socio-economic inequalities become negatively portrayed and labelled in public, official and policy discourses. With respect to the body of research on social determinants of health and health inequalities, and attention accorded to this issue in policy or practice, spatial stigma remains significantly underrepresented compared with other possible causal factors. We suggest three explanations contributing to this neglect. First, the lack of research into spatial stigma originates from a more limited public health focus on the symbolic meanings of places for health, compared to their physical and social dimensions. Second, lay involvement and evidence of lived experiences of health inequalities continues to be under-represented in public health decision-making. Finally, it is the case that public health organisations may also be contributing to negative area portrayals in their communications of health inequalities. There are growing examples of social action being taken by groups of residents to resist this stigma through the promotion of more positive portrayals of areas and communities. Greater public health attention to this issue as well is likely to result in health gains and aid the development of more effective health inequalities strategies.

Introduction

Reporting in 1893, one of London's Medical Officers of Health (MOH) drew attention to newspaper coverage concerning the scale of poverty in one of his districts. Municipal officials, including the MOH, were quick to counteract an accusation levied at the authority that they had done little to improve conditions. Quoting a letter by the Chairman of the Sanitary Committee to the *Daily News*, the MOH highlighted an '*erroneous*' claim that the authorities were '*indifferent to the state of the poor*.' Missing the point, perhaps, the MOH suggested the area's problems were more to do with the moral character of the residents than the poor quality of the environment: *'I will only observe here, with reference to the houses, that if it were possible to clear them of their present inhabitants, and to substitute a better class— artisans, labourers, etc., there would be little cause for complaint.*'[1]

Although this is an example drawn from the archives, similarly denigrating accounts of entire neighbourhoods and their inhabitants are manifest today. Spatial stigma refers to the ways that particular localities (e.g. towns, wards, estates) and their residents are negatively portrayed and stereotyped (e.g. in media coverage). In particular, Wacquant's thesis of 'territorial stigma'[2] has been adopted in investigations of geographically-related discrimination in neighbourhoods worldwide.[3-6] Territorial (spatial) stigma is argued to represent a feature of 'advanced marginality' where global economic systems and neoliberal politics have resulted in the spatial separation of local populations – often along racial or class lines - to certain areas, marked out by socioeconomic inequalities. These areas, in turn, become increasingly 'vilified' in public, official and political discourses.[7]

Debates on spatial stigma have also extended to housing and regeneration in the context of major urban redevelopment initiatives. Such programmes have been criticised for gentrifying neighbourhoods to attract private investment and more affluent incomers,[8] justifying the displacement of existing residents by implying: '*there must be something wrong with an area* [and its residents]'.[9] In the context of austerity policies, others have forewarned that state withdrawal and disinvestment could exacerbate spatial stigma,[10] with labelling of welfare recipients or the working classes in political and public discourses seen to smooth the path to more stringent policy directions.[11-13]

Within public health studies in the UK context, the concept of area reputation rather than spatial stigma has often been adopted,[14, 15] with Macintyre and colleagues first using the construct within a framework of place effects and health.[15] Unlike spatial stigma, area reputation is viewed in the model (like other neighbourhood features) as having the potential to be positive or negative and therefore protective of, or damaging to, health. Researchers have also examined different types of reputation (how residents view the area and perceive those external to the area to view it) to investigate the potential for different health impacts, of internal as opposed to external reputation.[16]

While the purpose here is not to go into depth about these conceptual differences (see Kearns, 2013 for a discussion of this[17]), we clarify our own terms before going further. The primary focus of the paper concerns spatial stigma, which is almost exclusively a geographical discrimination experienced or anticipated by residents of socio-economically deprived areas. Within this context, however, we will also outline how residents resist this stigma, through promoting more positive area narratives (reputations) as a means of challenging dominant stigmatising discourses.

The paper has three aims. Firstly, we will set out why addressing spatial stigma is a priority for public health, drawing attention to the available evidence. Secondly, we offer three explanations as to why this issue remains seriously under-represented in public health research, policy and practice. Finally, we provide examples from our own research and more widely, to demonstrate how communities are resisting spatial stigma associated with their neighbourhoods.

Why spatial stigma matters for health inequalities

It is only in the last decade that researchers have given more explicit attention to the importance of spatial stigma for health inequalities (e.g., Keene and Padilla 2014, Pearce 2012),[10, 18] with Keene and Padilla's conceptual framework (2014) in particular, outlining how health is affected, including the consequences for residents' psychological stress.[18] In this section, we draw on these papers and other evidence published subsequently to outline why spatial stigma should undeniably be considered a public health issue.

While relatively few in number, empirical studies have now firmly established a link between spatial stigma/reputation and health outcomes, finding that the experience of

living in an area with a negative reputation may result in poorer mental and physical health.[19] Spatial stigma has also been associated with poorer self-reported health and life satisfaction,[20] lower levels of residential wellbeing and social trust[21] and having a mental health diagnosis.[22] Place-based stigma can act as a barrier to service use if residents feel looked down on by providers.[23] The potential for differential patterning of inequalities is likely. For example, residents already encountering the negative effects of poverty related[24] or racial prejudice,[25] or groups at risk of discrimination due to their health status,[26] could have their health further compromised by the associated stigma of place of residence.

Researchers have highlighted the potential for stigma to reduce access to social and economic resources.[18] This includes potential weakening of social networks and cohesion, if coping mechanisms to deflect stigma involve residents blaming particular localities or other residents for bringing the overall reputation down.[27, 28] There are also risks to social isolation, if residents distance themselves from neighbours or family, undermining social support and collective identity.[29] In contrast, other studies point to residents demonstrating solidarity, strong social ties and a sense of belonging to their area in spite of (or potentially because of) the externalised stigma.[3, 4]

Economic impacts have also been observed although fewer studies have tested the association. At an area level, it has been posited that spatial stigma can result in public or private disinvestment into an area leading to the physical fabric deteriorating and the area being further 'blemished'.[10] Tunstall and colleagues identified no evidence that employers treated applicants differently based on where they lived, at least at the initial application stage.[30] In a different study, however, residents trying to leave behind an area with a negative reputation found that stigma inhibited attempts to find employment even after they had moved out.[25]

The under-representation of spatial stigma in public health

While the public health evidence base is accumulating, spatial stigma remains significantly under-represented with respect to the body of research on determinants of health inequalities and attention accorded to it in policy or practice, when compared with the volume of research literature and workforce guidance exploring other possible determinants. Recent public health guidance on psychological pathways, for example, while

drawing attention to the importance of 'community belonging' (the extent that people feel connected to their place/community), does not include area reputation or spatial stigma within its conceptual framework.[31]

We suggest there are three main factors directly contributing to the neglect of this issue, outlined in turn below. These are: (i) a limited public health focus on symbolic place meanings and their importance for health; (ii) the persisting failure to give weight to residents' experiential knowledge of health inequalities in public health decision making; and (iii) the possibility that the public health system is also contributing to the formation of spatial stigma.

Symbolic place meanings

First, we suggest the lack of research and policy/practice attention to spatial stigma and area reputation originates from a more limited focus on the symbolic importance of places, compared to their physical and social dimensions. The meanings that people attribute to where they live has been described previously as a *'missing link'* in understanding the causes of inequalities in health.[32] Such accounts can be traced back over several decades. Writing into a London newspaper in 1880, R.H. Haddon, a local pastor commented of the area's negative portrayal: *'we EastEnders owe many a grudge to the journalist, and novelists, and conversationalists, who have written and talked about us without really knowing us.'*[33] Such accounts highlight people's emotional attachment to places despite an area's poverty and negative external representations. Robert Roberts's account of Salford life in the early twentieth century illuminates the ways that material and symbolic dimensions coalesce in narratives of 'what it's like to live round here'.[32] *'"They're knocking our life and times away!"* said a Salford resident in response to the mass housing clearances in the area.[34]

In more recent years, rich qualitative investigations have drawn attention to people's lived realities of their neighbourhoods, highlighting that experiences are not homogeneous across a local population and may shift over a life course. In the UK context, young people living in a post-industrial community in Wales were found to deal with the area's stigma in a range of ways that included strategies of resistance and distancing.[6] Garnham's study of deindustrialisation in Clydebank also identified that while younger people sought to

distance themselves from the negative image (by seeking to leave the area), older adults, while recognising the negative representations, retained pride in the town's positive reputation connected to its industrial history.[35] In a region in the north east of England, the legacy of heavy industry, poor health and air pollution was found to shape public and official discourses of the area and in turn, the representations of people living there.[36] Studies such as these, embedded in people's experiences of where they live, provide a more nuanced understanding of place and health inequalities than epidemiological studies.[32] Yet as we argue next, this body of evidence, arguably, remains to be fully embedded in policy and practice efforts to alleviate health inequalities.

Lay knowledge of health inequalities

The second factor relates to the continued underrepresentation of lay voices and experience in policy and practice decision making. If understandings about health inequalities are shaped without authentic involvement of those most affected, then it is unsurprising if more holistic understandings do not emerge. Public Health England acknowledge that '*the invaluable contributions and experiences of citizens actively involved in their own communities are rarely considered as part of the evidence base'*,[37] and have invested in guidance aiming to strengthen how communities are involved in public health endeavours.[38]

Yet achieving authentic involvement also requires a focus on the accountability of systems including public agencies and private interests, redressing power imbalances that constrain the ability of people to influence decisions. Where negative portrayals of a neighbourhood prevail, this increases the likelihood that residents' voices are not heard, their concerns not taken seriously, and compounds their inability to contest vested interests affecting their living environments.[39] The opening historical quote becomes less distant on the realisation that the neighbourhood described, is located in the municipality where residents of Grenfell Tower repeatedly expressed safety concerns about their homes, which were largely ignored.

Public health area portrayals

Thirdly, there is the possibility that public health organisations may be exacerbating spatial stigma,[40] including in the ways that health inequalities are publicly communicated.[41] Take, for example, the Royal Society for Public Health's (RSPH) reimagining of Hogarth's *Gin Lane*

in 2016. Aiming to raise awareness of the '*public health challenges'* of British society during the RSPH 160th anniversary, the commissioned image was intended as *'representative of a typical street scene in London, or indeed anywhere in the UK today.'*[42] The scene, among other characters, depicted an overweight female [wearing leopard skin leggings] deemed to be '*preoccupied with eating junk food, which she has also fed to her child.*' The launch of the artwork achieved national media coverage: '*Obese mothers, payday lenders and chicken shops'* exclaimed the Daily Mail,[43] with BBC online coverage referring to '*a mother salivating over junk food...*'[44] Such coverage favoured individual behavioural explanations rather than the constraints of low income and time as factors shaping food related decisions,[45] or the concentration of fast food outlets in localities.[46] As Smith and Anderson conclude from a review of evidence of lay perspectives of health inequalities, those with a public health role need to think carefully about their choice of language (and image selection) when writing or talking about inequalities, and ensure that the public engagement activities they undertake do not compound stigmatisation of communities and places.[41]

Strategies of community 'resistance'

Finally, accounts of residents have shown that they often not only have more positive perceptions of their areas than those externally, but display pride and attachment.[3, 4] This has led some residents to reject the label of stigma, as well as take collective action to resist negative portrayals. Palmer and colleagues describe how residents living on a housing estate in Australia reacted against the estate's negative reputation and collectively organised a large public meeting to challenge media's reporting and the official agency portrayals of the area.[28] Similar examples are also located within neighbourhood contexts in the UK. "Grenfell Speaks", a social media news channel set up by a resident has sought to enable local people to gain more 'control' over the ways that the area and residents are represented in the public domain, with the community's narrative central to this.[47] In a project involving a public campaign by young people to install lights in an unlit area, the authors of the study argued the campaign was an interconnected response to the community' sense of abandonment that had resulted in the area's degradation (including the poor lighting) and was a means of challenging stigmatising external narratives.[48] Not unlike this example, the Communities in Control study, an independent evaluation of the Lottery funded Big Local place-based initiative, identified several instances of resident-led

partnerships across England prioritising the issue of 'reputation', 'image' or 'stigma' in their neighbourhood plans; and delivering projects such as public art instillations and community festivals, as well as publicity work to promote more positive portrayals in the media.[49] Examples can also be found in other place-based funding programmes, where resident knowledge is more centrally placed within local efforts to tackle health inequalities.[50]

Such approaches, underpinned by social action instigated by residents or undertaken collaboratively with researchers and practitioners, place emphasis upon the positive attributes of residents and the area, as well as challenging negative portrayals. By drawing attention to the civic roles through which residents contribute to their local areas, this helps to resist narratives of communities as being 'uninvolved' or lacking 'connectedness'.[28, 49] Where local people are able to construct alternative narratives of where they live privileging their perspectives and knowledge, this contributes to empowerment but also enables people to challenge the negative representations that permeate the mainstream.[51]

This should not, however, be considered a solution for tackling reputational issues nor should residents have to take responsibility for countering stigma, given that its source stems from structural causes of inequalities, shaped in turn, by institutional and policy processes.[10, 18] We would argue, however, that the community prioritisation of this issue and the social action being taken, emphasises the point that these perspectives are not sufficiently prioritised in public health decision making, reflecting the gulf between top down priorities and residents' experiential knowledge of inequalities.

Conclusion

To conclude, we would echo Pearce's observation that the continued lack of attention to spatial stigma as a public health concern is 'surprising' given the research evidence, albeit modest, that is accumulating on this topic.[10] Future research should pay attention to the causal drivers of spatial stigma as well as ways of preventing and mitigating its negative effects. In the current climate, austerity and welfare policies urgently need to be monitored for their contribution to the stigmatisation of areas and their residents.[13] There is also sufficient evidence from the wider literature to recognise that the consequences of health-related stigma are profound if action is not taken.[52, 53] Stigma and discrimination are not inevitable but if ignored like the elephant in the room, they are more likely to thrive. Not

acknowledging spatial stigma as a public health concern and acting on the accruing body of evidence available, only serves to make public health complicit.

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