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REVIEW

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Poverty stigma, mental health, and well-being: A rapid review and synthesis of quantitative and qualitative research

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Abstract

Poverty is associated with higher rates of mental illness and lower levels of well-being. Poverty affects mental health and well-being through a range of mechanisms, one of which may be experiences of stigma associated with living in poverty or accessing services designed to assist individuals on low incomes (including social security). The aim of this study was to synthesise published research on the relationship between individuals' experiences of poverty stigma and aspects of mental health and well-being. A rapid review was undertaken of quantitative and qualitative research published between January 2005 and February 2021. In total, 22 (5 quantitative and 17 qualitative or mixed methods) studies met the inclusion criteria, the findings of which were extracted and analysed using thematic synthesis. Experiences of poverty stigma were found to be associated with four broad aspects of mental health and well-being: negative self-evaluations, diminished social well-being, negative affect, and mental ill-health. Several forms of poverty stigma, including self, received, perceived, anticipated, and endorsed stigma were implicated in these associations. Poverty stigma may contribute to inequalities in mental illness and well-being, although further quantitative and longitudinal research is required to test its impact on mental health.

KEYWORDS
mental health, mental health inequalities, poverty, stigma, thematic synthesis, well-being

1 | INTRODUCTION

A complete state of mental health is defined as the presence of mental well-being as well as the absence of mental disorder (Iasiello & van Agteren, 2020). Well-being is comprised of hedonic and eudemonic aspects (Ryan & Deci, 2001); hedonic well-being is defined by pleasure and happiness, while eudemonic well-being is based on the view that a life well-lived involves striving to achieve one's full potential (Ryan & Deci, 2001). There is no consensus on how eudemonic well-being should be operationalised, although Ryff's (2014) six-factor model of psychological well-being—comprising purpose in life, environmental mastery, positive relationships, personal growth, autonomy and self-acceptance—is perhaps the most influential model currently.

Poverty is a key determinant of mental health, and people living on low incomes are more likely to experience mental ill-health (Ridley et al., 2020) as well as lower hedonic (Tan et al., 2020) and eudemonic well-being (Kaplan et al., 2008). The relationships between poverty and mental health are complex and can be bidirectional: mental illness can increase the risk of individuals being pushed into poverty, although the experience of poverty can also adversely affect mental health (Ridley et al., 2020).

Stigma is defined as the co-occurrence of labelling, stereotyping, and discrimination, which leads to adverse outcomes among stigmatised groups (Hatzenbuehler et al., 2013). Stigma processes occur at different intrapersonal, interpersonal and structural levels (Pescosolido & Martin, 2015), and researchers distinguish between different forms of stigma, including: internalised negative stereotypes (self-stigma), beliefs about the prevalence of stigma (perceived stigma); the expectation of experiencing stigma (anticipated stigma); experiences of overt discrimination (received stigma); and institutional practices that disadvantage particular groups (structural stigma; Pescosolido & Martin, 2015).

Experiences of stigma are associated with a range of adverse mental health outcomes (Schmitt et al., 2014). Stigma affects health indirectly through several structural, interpersonal, and intrapersonal pathways (Hatzenbuehler et al., 2013). At a structural level, stigma inhibits individuals' access to social and economic resources that support health, including power and social capital (Hatzenbuehler et al., 2013). At an interpersonal level, stigmatised individuals may become socially isolated and withdraw from others to avoid discrimination (Hatzenbuehler et al., 2013; Pachankis, 2007). Intrapersonally, experiences of stigma are associated with negative emotion regulation strategies, which may in turn lead to psychological distress (Hatzenbuehler et al., 2009; Hatzenbuehler et al., 2013). Importantly, it is not only overt forms of discrimination that harm health, as both perceived and anticipated stigma can also affect health through social identity threat processes (Major & Schmader, 2018). For example, anticipated discrimination from others leads to an increase in threat-related cognitions, as well as heightened physiological stress responses (Sawyer et al., 2012).

Poverty stigma can be conceptualised as a broad construct that includes experiences of stigma attributed to living in poverty generally, as well as more specific variants of stigma relating to individuals' use of particular services designed to assist low-income groups (e.g., social security). Several international studies have documented how individuals living on low incomes experience poverty stigma (e.g., Inglis et al., 2019; Reutter et al., 2009), and one study led by individuals who have experience of poverty in the United Kingdom stated that "the impact of stigma and negative judgement is a particularly painful part of poverty" (ATD Fourth World, 2019, p. 39). It is important to note here that these experiences do not occur by chance, and that the underlying processes that generate poverty stigma are instead socially motivated. From a sociological perspective, poverty stigma can be considered a form of social power that allows relatively powerful groups in society to achieve certain aims, including the exploitation and control

of disadvantaged groups (Link & Phelan, 2014; Tyler & Slater, 2018). From a social identity perspective, poverty stigma may also be generated by individuals categorising themselves and others according to income, which in turn leads to greater group-based stereotyping (Jetten et al., 2017).

Experiences of poverty stigma represent a range of psychosocial pathways that may contribute to socioeconomic inequalities in mental health (Inglis et al., 2019). Several studies have explored how experiences of poverty stigma are related to mental health and well-being (e.g., Mickelson & Williams, 2008), although these studies are methodologically diverse and examine different forms of poverty stigma as well as different mental health and well-being outcomes. As a result, it is not clear which types of poverty stigma are most commonly associated with mental health outcomes, or which aspects of mental health or well-being are most commonly associated with experiences of poverty stigma. A structured review of the existing literature would enable researchers to develop a clearer understanding of the association between different types of poverty stigma and specific aspects of mental health and well-being, although to the best of our knowledge, there are no existing reviews of this literature. We address these gaps by undertaking a rapid systematic review and synthesis of the existing research on the relationships between experiences of poverty stigma and mental health and well-being. The review focused on studies that qualitatively explored or quantitatively measured poverty stigma as experienced by individuals themselves, including self-stigma, perceived stigma, anticipated stigma and received stigma (Pescosolido & Martin, 2015). This included personal experiences of stigma originating from structural sources, such as individuals' experiences of interacting with social security services. Mental health outcomes of interest included both aspects of mental illness and distress, as well as aspects of hedonic and eudemonic well-being.

The review was designed to address the following specific research questions (RQ):

RQ1. *Which types of poverty stigma are associated with mental health and well-being?*

RQ2. *Which aspects of mental health and well-being are associated with experiences of poverty stigma?*

2 | METHODS

2.1 | Design

A rapid restricted systematic review of quantitative and qualitative evidence was conducted, whereby the methodology was streamlined to expedite the review process (Plüddemann et al., 2018). This involved restricting the time frame of the literature search to studies published since 2005, and largely relying on single reviewers for screening and quality assessment (Plüddemann et al., 2018). This approach was taken to ensure that the review could be completed with the resources that were available to the research team (Plüddemann et al., 2018). We decided to review both quantitative and qualitative evidence to generate a more comprehensive account of the research questions, and to gain a contextual understanding of how poverty stigma is experienced by individuals (Hong et al., 2020). The review was conducted by a multidisciplinary team of researchers with experience of working in psychology, education, mental health, and poverty research and advocacy work.

2.2 | Inclusion criteria

Several inclusion criteria were applied. First, studies had to be primary research reported in peer-reviewed journals and published in English between the January 2005 and February 2021. Second, study participants had to be living on low incomes or accessing services designed to assist individuals living in poverty. Studies that reported findings from large general population samples were also eligible if they conducted sub-group analyses by socioeconomic

position. Third, studies had to report on individuals' experiences of stigma attributed to their financial situation or use of services designed to assist individuals living in poverty. Fifth, studies had to report on how these experiences of poverty stigma are related to some aspect of mental health or well-being.

2.3 | Search strategy

Literature searches were performed in February 2021 using the following databases: Web of Science Core Collection, PubMed, SocINDEX and PsychInfo. The searches were limited to peer-reviewed evidence published between January 2005 to February 2021.

The following search terms were used in each database: (Poverty OR poor OR financ* OR depriv* OR hardship OR "low income" OR "social class" OR welfare OR "social security" OR "food insecur*") AND (Stigma* OR self-stigma OR discrimin* OR stereotyp* OR prejud* OR classis*) AND ("Mental health" OR "mental illness" OR wellbeing OR well-being OR anxiety OR depression OR stress OR "negative affect" OR shame OR self-esteem OR "positive affect" OR "life satisfaction" OR "quality of life").

The reference lists of the reports included in the review were also searched to identify additional eligible studies (Figure 1).

2.4 | Screening

A random 10% of titles and abstracts were initially screened independently by two reviewers, and inter-rater reliability was assessed by calculating the prevalence-adjusted and bias-adjusted kappa (PABAK = 0.93; Byrt et al., 1993). Disagreements between the reviewers were resolved through discussion, and the remaining 90% of titles and abstracts were screened independently by a single reviewer.

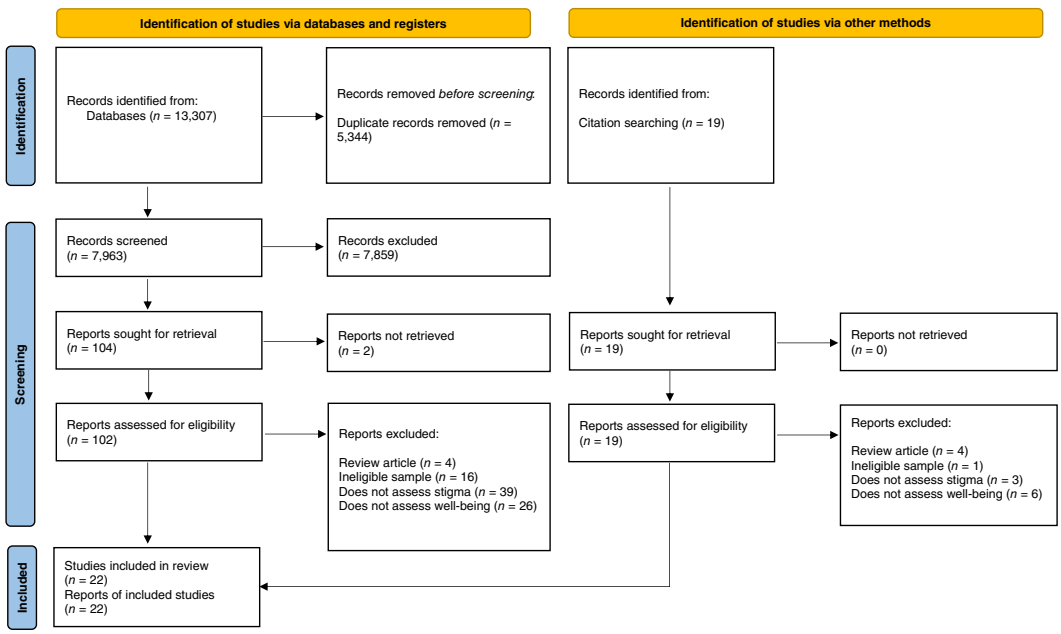

FIGURE 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram

Full-text screening was completed by a group of five reviewers. First, a pilot sample of five articles were screened by all five reviewers who then met to resolve any disagreements and clarify any questions regarding the inclusion and exclusion criteria. Second, the remaining articles were then divided, and each was screened by one of the five reviewers. Any uncertainties over whether an article met the inclusion criteria was resolved through discussion with a second reviewer until a decision was made.

The literature search returned a total of 13,307 records, from which 5,344 duplicates were removed. Titles and abstracts of the remaining 7,963 records were then screened against the inclusion and exclusion criteria, at which point 7,859 reports were excluded. We then attempted to retrieve the remaining 104 reports, although 2 of these could not be accessed. This left 102 reports that were read in full and assessed against the inclusion and exclusion criteria, of which 17 were included in the review. The reference lists of these studies were then screened and an additional 19 potentially relevant reports were identified and accessed for full-text screening. Five of these reports were included, which brought the total number of studies that were included in the analysis to 22. This process is summarised in Figure 1.

2.5 | Quality appraisal

One reviewer assessed each of the studies with the Mixed Methods Appraisal Tool Version 2018 (Hong et al., 2018), and each study received a quality score ranging from 0 to 5.

2.6 | Analysis

A data-based convergent synthesis design was adopted, whereby the results from the quantitative and qualitative studies were pooled and analysed using the same synthesis method (Hong et al., 2017). This approach is recommended when the research questions can be addressed by both quantitative and qualitative evidence (Stern et al., 2020). To do so, information on the aims, methods, results and conclusions of the quantitative studies was extracted and written up as summaries which were then entered into NVivo for analysis. This process of "qualitizing" is considered to be less error-prone than attempting to "quantitize" qualitative data (Stern et al., 2020). Data were extracted from the qualitative studies by copying all the text reported under the results sections of the study reports and transferring this into NVivo (Thomas & Harden, 2008). The extracted data from all studies were then analysed using thematic synthesis (Thomas & Harden, 2008). Data were initially coded line by line, and these codes were subsequently grouped into an initial set of themes. The codes and themes were developed inductively though the analysis, without any a priori framework. These themes were then reviewed and organised into a smaller number of higher-order themes that addressed the research questions.

3 | RESULTS

3.1 | Study characteristics

A summary of the included studies is provided in Table 1.

Five studies used quantitative methods, 16 used qualitative methods, and one used mixed methods. Most studies recruited samples of participants who were experiencing poverty or socioeconomic disadvantage, except Simons et al. (2017) who report findings from a study on "perceived classism" (individuals' experiences of stigma attributed to their "financial situation, education or occupation") among a nationally representative sample of adults in the

Netherlands. This study was included as the authors tested whether the associations between perceived classism and mental health variables were moderated by socioeconomic position, although no such sub-group differences were found.

Most studies examined stigma relating to poverty generally (Chase & Walker, 2013; Heberle & Carter, 2020; Hirsch et al., 2019; Inglis et al., 2019; Kelly, 2016; Mickelson & Williams, 2008; Pemberton et al., 2016; Reid & Herbert, 2005; Reutter et al., 2009; Walker et al., 2013; Whittle et al., 2017, 2020), or receiving welfare benefits (Chan et al., 2022; Jun, 2022; Mendes et al., 2020; Patrick, 2016; Peterie et al., 2019; Saffer et al., 2018; Sherman, 2013). Other forms of stigma examined include stigma associated with mortgage strain (Keene et al., 2015) or using foodbanks (Garthwaite, 2016).

The studies were conducted in the United States (8), the United Kingdom (7), Australia (3), Canada (1), the Netherlands (1), and China (1), and one study recruited an international sample across seven countries including Uganda, India, and Korea.

3.2 | Types of poverty stigma investigated

We first sought to identify the main types of stigma that were examined across the studies. Three of the five quantitative studies measured specific forms of poverty stigma. Mickelson and Williams (2008) and Hirsch et al. (2019) used separate scales to assess adults' experiences of *self-stigma* (e.g., "I feel that I am odd or abnormal because of my financial situation") and *received stigma* from others (e.g., "people treat me differently because of my financial situation"). Stigma scores in these studies ranged from 1 to 5. The mean levels of self-stigma reported were 3.43 (Mickelson & Williams, 2008) and 3.59 (Hirsch et al., 2019), indicative of medium to high levels of stigma, while the mean levels of received stigma were 2.91 (Mickelson & Williams, 2008) and 2.87 (Hirsch et al., 2019), indicative of low to medium levels of stigma.

Heberle and Carter (2020) assessed children's endorsement of poverty stereotypes (*endorsed stigma*) through interviews with dolls. One doll was introduced as having a poor family and the other doll was introduced as having a non-poor family. Children were told stories about the dolls and were asked to select which doll they thought the story applied to. For example: "one of the children is very smart. [He or she] is one of the smartest children in [his or her] school. The other child is not as smart. Which child do you think is smart?" The children were then asked to explain their reasoning and their responses were quantified to create stereotype endorsement scores. The authors did not report mean levels of stigma endorsement.

The remaining two quantitative studies used more generalised measures, where items relating to multiple types of stigma were combined in a single scale. Simons et al. (2017) modified Mickelson and Williams's (2008) poverty stigma scales to assess experiences of stigma due to income, education, or occupation. A single scale was created with four items reflecting *received stigma* and two items reflecting *self-stigma*. Scores were dichotomised, whereby participants who scored any of the items 4 or above on a 5-point Likert scale were classified as "perceiving classism" (18.2% of the total sample).

Chan et al. (2022) report data from two samples collected in Mainland China and Hong Kong. In the Mainland China sample, *welfare stigma* was measured with a two-item scale that reflected perceived welfare stigma ("Whether you agree receiving Dibao [means tested welfare] hurt personal dignity and privacy") and a general sense of perceived inferiority ("How often do you feel inferior when interact with others?"). Stigma scores ranged from 1 to 5, and the mean score was 2.41 among Dibao recipients and 2.27 among non-Dibao recipients, indicative of low to medium levels of stigma. In the Hong Kong sample, stigma was measured with three items concerning how participants felt they were treated by others generally (e.g., the extent to which they were "treated with respect by other people"), although these items did not specifically relate to participants' income or receipt of welfare. For this reason, only the data from the Mainland China sample were included in the review.

TABLE 1 Summary of studies included in the review

Authors	Country	Method	Sample	Stigma investigated	Aims	Key findings	Quality appraisal score
Chase and Walker et al. (2013)	United Kingdom	Qualitative. Interviews.	Forty-two adults with experience of claiming benefits.	Poverty stigma.	To explore how people living in poverty experience shame in different settings.	Participants expressed a sense of failure over their inability to meet social expectations and experienced disapproval from others which led to feelings of shame. Interactions with welfare institutions were dehumanising and contributed to feelings of shame.	4
Garthwaite (2016)	United Kingdom	Qualitative. Ethnographic observation and interviews.	Over 100 interviews with residents from the most and least deprived neighbourhoods in the area, including 60 interviews with foodbank users.	Foodbank stigma.	To explore lived experiences of health inequalities in the North East of England.	Participants experienced stigma and shame due to how others would think of them for using a foodbank or how they thought of themselves. The media was also identified as a source of embarrassment.	4
Inglis et al. (2019)	United Kingdom	Qualitative. Focus groups.	Thirty-nine adults living on low incomes.	Poverty stigma.	To explore how individuals living on low incomes experience poverty stigma.	Participants reported stigma relating to the media, social security services and public attitudes. Participants described the negative emotional impact of stigma, and how stigma can become	5

(Continues)

TABLE 1 (Continued)

Authors	Country	Method	Sample	Stigma investigated	Aims	Key findings	Quality appraisal score
						internalised, thereby lowering individuals' self-esteem.	
Jun (2022)	United Kingdom	Qualitative. Interviews.	Lone mothers who had recently stopped claiming benefits.	Welfare stigma.	To explore lone mothers' well-being as they transition from welfare to work.	Participants experienced subtle and direct stigma from others because they claimed benefits, which caused emotional distress. Participants were also concerned about what others thought of them, which led some to withdraw socially.	4
Keene et al. (2015)	United States	Qualitative. Interviews.	Twenty-eight individuals experiencing mortgage strain.	Mortgage strain stigma.	To explore experiences of stigmatisation among African American homeowners experiencing mortgage strain.	Participants were concerned that they would be judged negatively by others, and some attempted to hide their financial situation which contributed to social isolation. Stigma affected participants' mental health and caused emotional distress.	5
Mendes et al. (2020)	Australia	Qualitative. Interviews.	Eighteen welfare recipients, and 24 community stakeholders.	Welfare stigma.	To explore the impact of compulsory income management.	Participants felt stigmatised by compulsory income management and described how others	5

TABLE 1 (Continued)

Authors	Country	Method	Sample	Stigma investigated	Aims	Key findings	Quality appraisal score
						held negative attitudes toward welfare claimants. Stigma affected participants' well-being and contributed to feelings of worthlessness.	
Patrick (2016)	United Kingdom	Qualitative. Longitudinal interviews.	Fifteen benefits claimants.	Welfare stigma.	To explore lived experiences of welfare reform.	Participants felt stigmatised while claiming benefits and described negative public attitudes toward claimants, which was internalised by some. Stigma negatively affected participants' self-esteem.	3
Pemberton et al. (2016)	United Kingdom	Qualitative. Interviews.	Sixty-two individuals experiencing poverty.	Poverty stigma.	To explore individuals' responses to stigmatising public discourses regarding poverty.	Participants were aware of negative public attitudes toward people living in poverty, which they partly attributed to negative media coverage. Perceived public stigma negatively affected individuals' self-esteem.	3
Peterie et al. (2019)	Australia	Qualitative. Interviews.	Eighty unemployed welfare recipients.	Welfare stigma.	To explore unemployed person's experiences of	Unemployment services were bureaucratic and treated individuals	5

(Continues)

TABLE 1 (Continued)

Authors	Country	Method	Sample	Stigma investigated	Aims	Key findings	Quality appraisal score
					unemployment policies.	disrespectfully. Participants felt ashamed of being unemployed which led to feelings of failure.	
Reid and Herbert (2005)	United States	Qualitative. Interviews and group meetings.	Twenty women living on low incomes.	Poverty stigma.	To explore how women living on low incomes perceive the relationship between poverty and health.	Participants described negative public stereotypes around poverty, which lowered their self-esteem and led to feelings of shame and humiliation.	5
Reutter et al. (2009)	Canada	Qualitative. Individual and group interviews.	Ninety-three adults living on low incomes.	Poverty stigma.	To explore how people living in poverty experience poverty stigma.	Participants encountered stigma from a variety of sources, including family and government agencies. Stigma affected individuals' self-esteem and provoked feelings of shame, which led some to isolate themselves from others.	5
Saffer et al. (2018)	United Kingdom	Qualitative. Interviews.	Fifteen adults with experience of claiming disability benefits.	Welfare stigma.	To investigate the experiences of people with physical health conditions who have experienced welfare reform in the United Kingdom.	Participants described how benefit claimants were judged and treated unfairly by the benefits system and the wider public, which increased feelings of distress, diminished	5

TABLE 1 (Continued)

Authors	Country	Method	Sample	Stigma investigated	Aims	Key findings	Quality appraisal score
						participants' confidence and led to internalised stigma.	
Sherman (2013)	United States	Qualitative. Ethnographic field work and interviews.	Fifty-five adults from a low-income population.	Welfare stigma.	To investigate the impact of the 2007–2009 economic downturn on low-income families in Washington State, United States.	Participants felt that welfare was stigmatised, and accepting welfare was therefore associated with feelings of shame and emotional distress as well as a loss of identity.	4
Walker et al. (2013)	Uganda, India, China, Pakistan, Korea, United Kingdom, Norway	Qualitative. Interviews.	Two hundred twenty-two adults and 95 children.	Poverty stigma	To explore lived experiences of poverty and shame.	Participants thought of themselves as failures for not meeting social expectations, and experienced stigma from others through social interactions and public services. Stigma led to feelings of shame, social withdrawal, and distress.	2
Whittle et al. (2017)	United States	Qualitative. Interviews.	Sixty-four adults from a community-based food assistance programme for individuals with low incomes and living with HIV or type 2 diabetes mellitus.	Poverty and welfare stigma	To explore how changes in government policy shape experiences of disability and stigma among individuals living with HIV and type 2 diabetes mellitus.	Participants felt that others judged them for relying on government assistance, which could be internalised as feelings of inadequacy. Stigma was also generated by	5

(Continues)

TABLE 1 (Continued)

Authors	Country	Method	Sample	Stigma investigated	Aims	Key findings	Quality appraisal score
						government institutions, which were described as penalising and uncompassionate.	
Whittle et al. (2020)	United States	Qualitative. Interviews.	Thirty-eight women experiencing food insecurity.	Material-need insecurity stigma.	To explore the experience of multiple material-need insecurities among women in the US.	Participants described the social safety net as bureaucratic and hostile which communicated to them that they were inferior for relying on assistance. Stigma was detrimental to mental health.	5
Chan et al. (2022)	China	Quantitative. Cross-sectional survey.	Four thousand two hundred forty-two participants who had applied for welfare.	Perceived welfare stigma.	To examine the relationships between poverty stigma and well-being among welfare and non-welfare recipients in Mainland China and Hong Kong Special Administrative Region.	Welfare stigma associated with negative affect ($\beta = .48$) and social interaction ($\beta = -.05$).	3
Heberle and Carter (2020)	United States	Quantitative. Cross-sectional design.	Ninety-four children aged between 48 and 108 months.	Poverty negative stereotype endorsement.	To assess whether poverty stereotype endorsement is associated with attention problems and anxiety/depression among children from	Stereotype endorsement positively associated with attention problems among children from socioeconomically disadvantaged families, but not among children	3

TABLE 1 (Continued)

Authors	Country	Method	Sample	Stigma investigated	Aims	Key findings	Quality appraisal score
					socioeconomically disadvantaged families.	from advantaged families. Stereotype endorsement not associated with anxious/depressive symptoms.	
Hirsch et al. (2019)	United States	Quantitative. Cross-sectional survey.	One hundred uninsured primary care patients.	Received poverty stigma. Poverty self-stigma.	To test how perceptions of self and received poverty stigma relate to health related quality of life (HRQL) and belongingness.	Received stigma negatively associated with mental HRQL ($r = -.45$) and belongingness ($r = -.43$). Self-stigma negatively associated with mental HRQL ($r = -.50$) and belongingness ($r = -.35$). Self and received stigma were both indirectly related to mental HRQL through belongingness.	3
Mickelson and Williams (2008)	United States	Quantitative. Cross-sectional survey.	Two hundred twenty women living on low incomes.	Received poverty stigma. Poverty self-stigma.	To test the indirect effects of self and received poverty stigma on depression, through perceived support availability, fear of rejection and self-esteem.	Self-stigma associated with depression ($r = .48$), self-esteem ($r = -.51$), perceived support availability ($r = -.14$) and fear of support rejection ($r = .30$). Received stigma associated with depression ($r = .37$),	3

(Continues)

TABLE 1 (Continued)

Authors	Country	Method	Sample	Stigma investigated	Aims	Key findings	Quality appraisal score
						self-esteem ($r = -.34$), perceived support availability ($r = -.17$) and fear of support rejection ($r = .31$). Self-stigma was indirectly associated with depression through self-esteem and fear of support rejection. Received stigma indirectly associated with depression through fear of support rejection only.	
Simons et al. (2017)	Netherlands	Quantitative. Cross-sectional survey.	One thousand five hundred forty participants from the Longitudinal Internet Studies for the Social Sciences panel.	Perceived classism.	To test how perceived classism relates to socioeconomic status, health outcomes, perceptions of inferiority and health behaviours.	Perceived classism associated with negative emotions (OR = 2.97), shame (OR = 4.64), social anxiety (OR = 1.69) and low self-esteem (OR = 1.65).	5
Kelly (2016)	Australia	Mixed methods. Survey and focus groups.	Fifty-two participants experiencing poverty took part in focus groups or completed a survey.	Poverty stigma.	To explore public perceptions of poverty and how these affect people living on low incomes.	Participants felt unfairly judged by others in their community because of their financial situation, which led to feelings of disempowerment, low self-esteem, and distress.	1

Three quantitative studies (Heberle & Carter, 2020; Hirsch et al., 2019; Simons et al., 2017) included income as a covariate when examining the association between stigma and mental health and well-being, although two studies did not (Chan et al., 2022; Mickelson & Williams, 2008).

The qualitative studies provided rich accounts of poverty stigma that were classified into two main types of stigma through the thematic synthesis. These are summarised below.

3.2.1 | Perceived public stigma from communities and the media

Participants described how others in society held negative attitudes toward individuals experiencing poverty (Chase & Walker, 2013; Inglis et al., 2019; Kelly, 2016; Patrick, 2016; Pemberton et al., 2016; Peterie et al., 2019; Reid & Herbert, 2005; Reutter et al., 2009; Saffer et al., 2018; Walker et al., 2013; Whittle et al., 2017). Participants believed that others view poverty as an issue of personal failure, such as the view that poverty is caused by laziness. The *public stigma* associated with unemployment and welfare benefits was highlighted, with participants describing how individuals are stereotyped as "welfare bums" in the United States (Reid & Herbert, 2005), "dole bludgers" in Australia (Peterie et al., 2019) and "benefit scum" in the United Kingdom (Saffer et al., 2018). Participants also described how *public stigma* could also be attached to particular communities or neighbourhoods (Chase & Walker, 2013; Inglis et al., 2019; Kelly, 2016; Walker et al., 2013).

> They class these as benefits estates you know? … full of down and outs. And I'm like, "I'm no down and out and I'm living there. (Chase & Walker, 2013, p. 745).

Participants also reported being aware of *public stigma* even when they had not directly encountered stigma from others (Keene et al., 2015; Reutter et al., 2009). In these cases, individuals could "just tell" that they were stigmatised by others (Jun, 2022), which could be described as a form of *anticipated* or *felt stigma* (Reutter et al., 2009)

> Well, no one's ever said anything like I'm wasting the taxpayers' dollars although I know they're thinking it. (Reutter et al., 2009, p. 302).

The media was identified as a source of *public stigma*, and participants across several studies described how negative representations of low-income communities promoted negative stereotypes (Chase & Walker, 2013; Garthwaite, 2016; Inglis et al., 2019; Pemberton et al., 2016; Reutter et al., 2009; Saffer et al., 2018; Walker et al., 2013). The media was also seen to contribute to negative public attitudes and stereotypes of people living in poverty (Inglis et al., 2019; Pemberton et al., 2016; Saffer et al., 2018).

3.2.2 | Received stigma from communities and institutions

Participants reported being devalued, rejected, or treated unfairly by others because of their financial situation. These forms of *received stigma* (Pescosolido & Martin, 2015) were most often described in relation to participants' experiences of interacting with social security agencies, which were described as overly bureaucratic, punitive, and stigmatising (Chase & Walker, 2013; Inglis et al., 2019; Mendes et al., 2020; Patrick, 2016; Peterie et al., 2019; Whittle et al., 2017; Whittle et al., 2020). Some studies further highlighted the dehumanising nature of social security, and how individuals are treated with indifference:

> You're just another number, you're not a person. That's how I feel about it [being on benefits]. (Patrick, 2016, p. 249).

Participants also described encountering derogatory attitudes and behaviour from social security staff members, where they felt unfairly treated, disrespected, and looked down on (Chase & Walker, 2013; Inglis et al., 2019; Patrick, 2016; Peterie et al., 2019; Reid & Hubert, 2005; Reutter et al., 2009; Saffer et al., 2018).

> I think the way the Job Centres treat people who are on benefits is absolutely shocking. I mean, these are the people that are employed to help people to get back to work, but they're the most likely to judge you…. (Inglis et al., 2019, p. 45)

Participants further provided examples of being disrespected by others in their community (Chase & Walker, 2013; Kelly, 2016; Mendes et al., 2020; Patrick, 2016; Pemberton et al., 2016; Reid & Herbert, 2005; Reutter et al., 2009), including encountering negative comments and stereotypes from members of the public, and family and friends:

> [My brother-in-law said], "I'm tired of supporting welfare people like you. Tired of supporting your kids. You had your kids, you raise your kids. Why should I go out to work to pay for welfare to look after you and your kids? I have to work for a living. Why can't you work? (Reutter et al., 2009, p. 301).

3.3 | Relationships between poverty stigma and well-being

We next sought to identify how experiences of poverty stigma were related to mental health and well-being and found that poverty stigma is associated with four broad outcomes: negative self-evaluations, diminished social well-being, negative affect and mental ill-health. These are discussed below.

3.3.1 | Negative self-evaluations

There was evidence that experiences of poverty stigma are associated with negative self-evaluations and low self-esteem. Simons et al. (2017) reported a negative association between a generalised measure of perceived classism and self-esteem, while other studies reported more nuanced findings regarding specific forms of stigma. In one quantitative study, Mickelson and Williams (2008) found that reports of *received stigma* were negatively associated with self-esteem and several qualitative studies highlighted how perceived *public stigma*, or individuals' perceptions of how they are viewed by others, negatively affects self-esteem (Inglis et al., 2019; Kelly, 2016; Mendes et al., 2020; Patrick, 2016; Reid & Herbert, 2005; Reutter et al., 2009):

> …If you feel like all your neighbors think you're a loser welfare bum it's going to impact you. I think the biggest for me with being on welfare is self-esteem. It's hard on you, it's really hard on you. (Reid & Herbert, 2005, p. 169)

There was also quantitative evidence that *self-stigma* is associated with low self-esteem (Mickelson & Williams, 2008). Several qualitative studies similarly highlighted how individuals can come to accept perceived *public stigma* and apply negative stereotypes to themselves, which in turn affects self-esteem and self-worth (Inglis et al., 2019; Patrick, 2016; Pemberton et al., 2016; Reutter et al., 2009; Whittle et al., 2017). In one study, for example, participants felt that there must be "something wrong with them" because they were unable to find employment (Peterie et al., 2019). While *self-stigma* and self-esteem were measured as separable constructs in the quantitative studies (Mickelson & Williams, 2008), it was at times difficult to distinguish between the two in the qualitative studies:

> And people like me have no worth because I'm not producing right now in terms of making anything. (Saffer et al., 2018, p. 1568).

3.3.2 | Diminished social well-being

Stigma was found to be associated with a range of social outcomes. Chan et al. (2022) reported that perceived welfare stigma was associated with less social interaction with others, while Simons et al. (2017) found that perceived classism was positively associated with social anxiety. Regarding more specific forms of stigma, measures of both *self-stigma* and *received stigma* were found to be associated with lower levels of perceived social support availability and greater fear of rejection of support requests (Mickelson & Williams, 2008), as well as lower levels of belongingness (Hirsch et al., 2019).

The qualitative studies similarly highlighted how individuals experiencing poverty could be socially excluded by others (Chase & Walker, 2013; Walker et al., 2013):

> They never say anything but it's the way they stop asking you out and the way they do not visit you like they used to (Chase & Walker, 2013, p. 745).

The qualitative studies also showed how *anticipated stigma* could also lead individuals to withdraw and reduce social contact, in order to avoid disapproval from others (Jun, 2022; Reutter et al., 2009; Sherman, 2013). One woman whose husband was unemployed, for example, avoided situations where she might be asked what she did for a living (Reutter et al., 2009), while another woman described how she had reduced contact with her family because she was concerned that they would think she was looking for money:

> The first thing that comes out of [my dad's] mouth when I call is, how much do you need? That hurt, that was kind of painful to hear. So I think for a couple of months, I didn't call him, if there was any contact, then he called me… (Jun, 2022, p. 208)

Some individuals also withdrew from social situations to avoid feelings of stigma, which may reflect *self-stigma* or *perceived public stigma* (Chase & Walker, 2013; Sherman, 2013; Walker et al., 2013; Whittle et al., 2017). In one study of mortgage strain stigma, for example, a woman described how,

> I actually even stopped talking to people that I considered my friends… [W]hen you're in a crisis like that, you don't want people to know." (Keene et al., 2015, p. 1010).

Similarly, participants described concealing information about their current situation in order to prevent others from knowing about their financial struggles (Chase & Walker, 2013; Garthwaite, 2016; Jun, 2022; Keene et al., 2015; Patrick, 2016; Reutter et al., 2009; Sherman, 2013; Walker et al., 2013). This desire to conceal information was in part motivated by a desire to avoid feelings of shame and embarrassment as well as *anticipated stigma* of how others would react (Chase & Walker, 2013; Garthwaite, 2016; Jun, 2022; Keene et al., 2015; Patrick, 2016; Reutter et al., 2009). This concealment contributed to individuals' isolation and created barriers to receiving support from others (Reutter et al., 2009).

3.3.3 | Negative affect

Both quantitative and qualitative studies highlighted an association between stigma and negative affect. Simons et al. (2017), for example, found that perceived classism is positively associated with negative affect.

Chan et al. (2022) also found that perceived welfare stigma is positively associated with negative affect, and that this relationship is mediated by lower levels of social interaction. These results are supported by qualitative evidence, which also provide insight into the specific stigma processes that are associated with negative affect. For example, participants described experiencing distress as a result of being treated unfairly by others in the community (*received stigma*; Kelly, 2016; Mendes et al., 2020), including being "dehumanised" by debt collectors (Keene et al., 2015). Some studies also described how negative emotions could result from stigmatising or disrespectful interactions with social security services (Chase & Walker, 2013; Patrick, 2016):

> When I went to the job centre the person there who I saw was really rude to me and I ended up in absolute tears … (Saffer et al., 2018, p. 1566).

Participants also described the negative emotional effects of being stereotyped and judged by others (Inglis et al., 2019; Jun, 2022; Kelly, 2016; Pemberton et al., 2016; Reid & Herbert, 2005). Kelly (2016), for example, reports that negative public attitudes caused individuals living on low incomes to "… feel insecure, unstable, anxious, unhappy, and fearful," "miserable and sad," and "distressed".

Some studies highlighted how experiences of stigma were associated with more specific negative emotions, such as shame and embarrassment. Simons et al. (2017), for example, reported that perceived classism is positively associated with shame. Walker et al. (2013) conducted interviews with adults and children living in poverty across seven countries, including the United Kingdom, China and Uganda, and reported that participants described similar feelings of poverty-related shame as a result of their own internalised feelings of failure as well as others' attitudes and behaviour. Jun (2022) similarly reported how participants' feelings of shame were tied to their perception of how others in their community viewed them, while other studies suggested that individuals experienced embarrassment in social situations where there was a risk of being judged negatively by others (Inglis et al., 2019; Patrick, 2016). This is illustrated in the following extract, where two individuals describe their experience of going to a foodbank for the first time and their concerns about being seen by others (Garthwaite, 2016, p. 280):

> Tracey: I said to Glen "Get inside, don't let no one see us" cos obviously we'd never had to go anywhere like that before.
>
> Glen: Ashamed, just felt ashamed.
>
> Tracey: We were just so ashamed we had to go in.

3.3.4 | Poverty stigma and mental ill-health

Poverty stigma was found to be associated with several measures of mental ill-health. In one quantitative study, Mickelson and Williams (2008) found that reports of *self-stigma* and *received stigma* from others were positively associated with symptoms of depression. Hirsch et al. (2019) similarly report how *self-stigma* and *received stigma* from others are negatively associated with mental-health-related quality of life. Heberle and Carter (2020) also found that the degree to which children from socioeconomically disadvantaged families endorsed negative stereotypes about poverty (*endorsed stigma*) was positively associated with parental reports of attention problems. On the other hand, there was no association between *endorsed stigma* and parental reports of anxious-depressive symptoms.

There was also some evidence from qualitative studies that stigma contributes to mental ill-health. Keene et al. (2015), for example, describe how experiences of stigma relating to mortgage strain contributed to one participant's suicidal thoughts, and Whittle et al. (2020) similarly report that stigma associated with reliance on social security contributed to one participant's suicidal ideation.

Some studies investigated the mechanisms through which stigma may be related to mental ill-health. For example, Mickelson and Williams (2008) found that the association between *self-stigma* and depression was mediated by low self-esteem. There was also evidence that the relationships between poverty stigma and mental ill-health are mediated by social processes. Specifically, Mickelson and Williams (2008) found that fears of support rejection mediated the associations between *self-stigma* and *received stigma* and depressive symptoms, while Hirsch et al. (2019) reported that the relationships between *self-stigma* and *received stigma* and mental-health-related quality of life were mediated by lower levels of belongingness.

3.4 | Summary of findings

The overall findings are summarised in Figure 2 and are discussed in relation to the research questions below.

RQ1. Which types of poverty stigma are associated with mental health and well-being?

The studies included in the review highlighted five broad forms of poverty stigma that were associated with mental health and well-being outcomes. Two of the most cited forms of stigma were *received* and *perceived public* stigma. *Received stigma* relates to individuals' experiences of unfair treatment from others, which included encountering disrespect from members of the community as well as being treated unfairly by social security agencies. *Perceived public stigma* relates to individuals' perceptions of how others in society view people living in poverty or receiving welfare benefits. Closely related to this is *anticipated stigma*, where individuals expect others to stigmatise them, independent of whether they had direct experience of received stigma from others. *Self-stigma*, whereby individuals accept and apply negative stereotypes to themselves, was also found to relate to mental health and well-being in several studies. Finally, one study reported on the relationships between *endorsed stigma*, defined as agreement with negative stereotypes, and mental health.

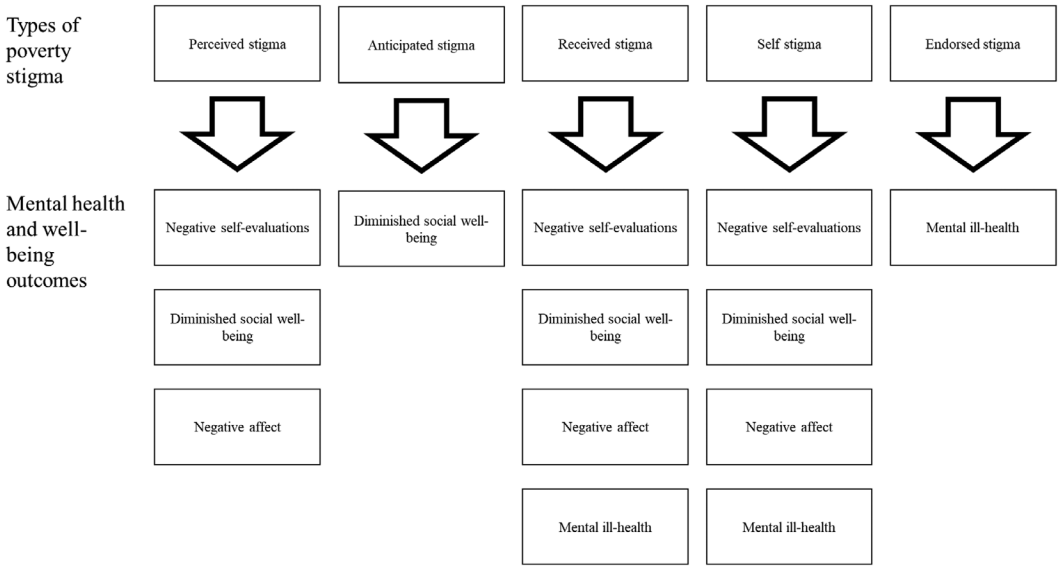

FIGURE 2 Summary of key findings

RQ2. Which aspects of mental health and well-being are associated with experiences of poverty stigma?

Experiences of poverty stigma were associated with four broad mental health and well-being outcomes. First, experiences of received, perceived and self-stigma were found to be associated with negative self-evaluations and low self-esteem. Received, perceived, anticipated, and self-stigma were also found to be associated with diminished social well-being, which was marked by lower levels of perceived social support and withdrawal. Received, perceived, and self-stigma were further found to be associated with negative affect and shame. Finally, there was evidence that received, endorsed, and self-stigma were associated with mental ill-health, such as depressive symptoms.

4 | DISCUSSION

The findings from 22 international studies provide evidence that poverty stigma is associated with several aspects of mental health and well-being. These findings relate to multiple forms of poverty stigma, including self-stigma, perceived stigma, received stigma, anticipated stigma, and endorsed stigma.

Poverty stigma appears to be related to negative self-evaluations and diminished self-esteem. In some cases, public stigma may also become internalised, resulting in self-stigma. It was often difficult to distinguish between accounts of self-stigma and self-esteem in the qualitative studies, although these are distinct constructs where self-stigma theoretically precedes diminished self-esteem (Mickelson & Williams, 2008).

Poverty stigma was also found to be associated with diminished social well-being. This could be a consequence of being explicitly devalued by others, although the qualitative data also suggested that anticipated stigma leads individuals to reduce social contact and conceal their financial difficulties from others. The latter finding is consistent with the broader stigma literature, which has explored how individuals attempt to conceal stigmatised identities order to avoid rejection from others (Pachankis, 2007; Quinn et al., 2017). Whilst these identity management strategies may protect individuals from stigma in some contexts, active concealment of a stigmatised identity may also adversely affect well-being by reducing the social support available to individuals (Camacho et al., 2020).

Poverty stigma was found to be associated with negative affect, as well as more specific feelings of shame. Shame is a self-conscious emotion that is specifically triggered by experiences of social devaluation (Sznycer et al., 2016) and is therefore likely to be a particularly salient affective consequence of poverty stigma. The importance of shame in this context is further underscored by international research which identifies shame as a ubiquitous psychosocial consequence of poverty across diverse cultures (Walker et al., 2013). This is significant as shame can be detrimental to health, particularly when individuals are unable to directly address the source of shame and repair their social identity (Cibich et al., 2016).

Finally, there was evidence that poverty stigma is associated with indicators of mental ill-health, such as measures of depression, and that poverty stigma may affect mental ill-health through social processes. Interventions designed to bolster social support may, therefore, help to lessen the negative impacts of stigma.

The current findings demonstrate that experiences of poverty stigma are associated with adverse mental health and well-being outcomes and, therefore, suggest that anti-stigma interventions may be effective in lessening socioeconomic inequalities in health. Regarding psychology specifically, the American Psychological Association recommend that psychologists working with individuals from low-income backgrounds engage with continuing education and training to enhance service providers' understanding of poverty and reduce biases toward low-income groups (Juntunen et al., 2022). Similar guidelines should be adopted among other professionals working in services designed to assist low-income communities, and future research is required to identify the most effective means of challenging stigmatising attitudes and behaviours among service providers. One approach of doing so could be the use of poverty simulations in staff training programmes. Poverty simulations are experiential learning activities that ask participants to work through scenarios faced by people living on low incomes to gain insight into the lived reality of

poverty. Several positive outcomes have been attributed to these exercises, including increased empathy toward people living on low incomes and greater understanding of the wider societal issues that cause poverty (Piff et al., 2020; Turk & Colbert, 2018).

Future social marketing campaigns could also draw on psychological research to challenge negative attitudes within communities and stereotyping in the media. For example, research on the cognitive effects of scarcity and how poverty itself harms individuals' decision making could be effective counterargument to negative stereotypes (e.g., irresponsibility) and individualistic explanations of poverty (Davis & Williams, 2020).

It is important to acknowledge, however, that interventions designed to address individuals' attitudes will be insufficient without also addressing the upstream, structural forces that generate stigma (Tyler & Slater, 2018). Psychologists should, therefore, advocate for wider social change and policies to reduce poverty directly as well as challenge structural forms of stigma. An example of such advocacy work can be found in the British Psychological Society's recent campaign to make social class a protected characteristic within the UK Equality Act, which would make class-based discrimination illegal (Rickett et al., 2022).

5 | LIMITATIONS AND FUTURE RESEARCH

Our findings are limited in several ways. First, we only identified five quantitative studies that met our inclusion criteria, each of which used cross-sectional methods which prevent any causal interpretations. Furthermore, only three of the quantitative studies included income as a covariate in the analyses. Additional quantitative research using longitudinal data is, therefore, needed to estimate the prevalence of different aspects of poverty stigma, and to compare how these experiences are related to mental health over time whilst also controlling for the effect of income. Future research should also examine whether experiences of stigma differ across demographic groups, such as by gender or ethnicity, as well as how other aspects of disadvantage may act as effect modifiers to amplify the adverse impacts of stigma on mental health. Future quantitative studies should also develop more comprehensive measures to better capture different forms of poverty stigma. For example, we did not identify any quantitative studies that included measures of perceived public stigma or anticipated stigma, although these appeared to be important concerns for the individuals who took part in qualitative studies.

In addition, we did not conduct a full systematic review of the literature, which means that some relevant studies may not have been identified. Our findings should, therefore, be treated with a degree of caution (Plüddemann et al., 2018). The review was also limited to studies that examined individuals' experiences of poverty stigma, and we did not consider structural forms of stigma, such as institutional policies that disadvantage stigmatised populations (Hatzenbuehler, 2016). Similarly, the present review does not take account of the "political economy" of stigma, including the social processes through which stigma is produced as well as the social functions that poverty stigma serves (Tyler & Slater, 2018). As such, there is a need to contextualise the individual and interpersonal stigma processes that we report here within the broader socio-political contexts within which they occur.

It is also important to reflect on our definition of poverty stigma and how this informed our inclusion criteria. Poverty stigma is complex due to the heterogeneous risk factors associated with poverty and the varied consequences of living on a low income, which may in themselves contribute to intersecting forms of stigma. We attempted to define poverty stigma in relatively narrow terms, as experiences of stigma associated with living on a low income or use of services designed to assist individuals living in poverty. Although there are advantages to this approach, it did mean that we chose to exclude studies examining more specific forms of stigma that are associated with poverty, such as homelessness stigma (e.g., Weisz & Quinn, 2018). Similarly, our inclusion criteria meant that we focussed on studies of stigma associated with receiving out of work benefits specifically, while studies of more general experiences of unemployment stigma were excluded. This brief discussion highlights the challenges of operationalising and drawing boundaries around the construct of poverty stigma, and future reviews should seek to synthesise the evidence regarding these other related forms of stigma and well-being.

In summary, the findings of this review demonstrate that several aspects of poverty stigma are associated with mental health and well-being. Poverty stigma, therefore, represents a range of psychosocial mechanisms through which low income may affect mental health, although further quantitative studies utilising more comprehensive assessments of stigma are required to fully test this.

CONFLICT OF INTEREST

The authors declare no potential conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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