reducing the absolute level of bad enacted stigma (“presumably” because there are few data on how effectively law does this). Even if enacted stigma is reduced, however, people do not make decisions based on what happens, but on their perceptions of what happens. Hence the important questions include: Can law promote resistance by reducing the perceived risks of resistance and by changing self-conception? Can law facilitate activism by acting against discrimination and providing a script to guide social interactions? Can it mobilise collective action? Clearly, resistance to stigma needs to become more prominent in any thinking about how law can address the problem.

Some insights may be forthcoming from studies of the Americans with Disabilities Act. Researchers are looking at how people with disabilities integrate a new protective law into their long-term coping strategies. The “disabled” label may make things worse in some ways—e.g., reinforcing separate status or victimhood. Prohibition is also permission; the Act forbids discrimination against a person with a disability who can do a job with no more than minimal changes in procedures or job environment, but therefore authorises discrimination against those who need more.

Stigma exemplifies the fact that law is more than just words on paper. “Laws on the books” are transformed in the course of implementation into social practices and attitudes that must be accounted for in any consideration of law’s relation, good and bad, to stigma. The stigma research agenda thus demands greater integration of health, science, and law.

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References

Stigma, race, and disease in 20th century America

Keith Wailoo

Historically, people of African descent in the USA have experienced a stigmatisation based on presumptions about their racial character and identity, and (in the case of African-Americans with disease) a second taint when particular high-profile, stigmatised disorders have been involved. This interplay of race, stigma, and disease has been reflected in professional writings and in popular images throughout the 20th century, and the interrelation between group-associated stigma and disease-associated stigma presents a compelling current medical, cultural, and public policy dilemma. A few examples will illustrate this complex, historically evolving web of stigmatisation.

A drawing in William D Postell’s book, Health of Slaves on Southern Plantations, published in 1951, illustrates how notions of race and disease stigma from one historical era could be revised in later eras (figure). In the drawing, a modest home in the country is shown. Sunlit against a landscape of cleared land on the left, a physician approaches the front door. A panel underneath illustrates the typical tools of his trade—chemical compounds like calomel and opium. At the back door, another scene unfolds. A black woman stands there, framed by a background of dense vegetation, darkness, and heavy shadows, with nefarious figures dancing mystically in the distance around a fire. The panel beneath suggests that the tools of her trade are a chicken’s head, frog and snake parts, roots, and herbs. Such illustrations of racial beliefs and racial behaviours continue to provide potent imagery—framing ideas about illness beliefs within the group—even as society’s medicine, its maladies, its scientific models of disease, and its race relations have changed.

The tainted group as disease carrier

The early 20th century saw one kind of convergence between disease stigma and racial stigma. In an era when infectious disease predominated, African-Americans were often portrayed as a key disease vector, capable of infecting other parts of the American population. Hookworm, for example, was a disorder prevalent in the South and designated as the “germ of laziness” among white and black Americans, because of the lethargy associated with the anaemia caused by the infection. But in a 1911 article medical researcher Charles Wardell Smith noted the incidence of the disease “possibly indicates that the negro has brought [it] with him from Africa . . . and spread it broadcast through the south . . . we must frankly face the fact that the negro . . . because of his unsanitary habit of polluting the soil . . . is a menace to others.”

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Here was an example of what Erwin Goffman later commented upon—the interplay of a notion of a “tribal stigma of race . . . transmitted through lineage” (“the negro”) with a stigmatised disease, to doubly stigmatise African-American character as, itself, a polluting disease vector.’

This web of stigmatisation had far reaching implications in a society defined by racial segregation, but in which some degree of racial interaction was also inevitable. In the case of tuberculosis, a southern physician wrote, in 1932, that the:

> “safeguarding of the health of the Negro [was not a] fight against disease, but against physical, mental, and moral inferiority, against ignorance and superstition, against poverty and filth”.

The image of disease carriers suggested a social menace whose collective superstitions, ignorance, and carefree demeanour stood as a stubborn affront to modern notions of hygiene and scientific understanding.’ In the context of an economy where black people worked as cooks, gardeners, servants, and caregivers in white homes (and where “Typhoid Mary”, the asymptomatic carrier, had become a household name), such images of the African-American as “disease vector” highlighted a prevalent, pervasive and long-lasting anxiety that persists in contemporary global health discussions—particularly where economies continue to necessitate movement across borders and among peoples.

**Shining a light on stigma, group identity, and disease**

Such assumptions about disease transmission and group identity continued to inform ideas about medical practices and discriminatory social policies into the middle of the 20th century, but at this time the processes of group and disease stigmatisation also came under increased scrutiny. During World War II, for example, the American Red Cross practised racial segregation of blood plasma. However, the war also spurred technical innovations, new ideas about disease, and new roles for women and ethnic minorities in wartime industries, and fomented debates about these policies. If blood was equated with race, then the war era led to a broad criticism of assumptions about blood as a source of racial identity, stigma, and group identity—especially in the face of Nazism and Aryan racial ideology.

In his influential 1942 study, *An American Dilemma*, sociologist Gunnar Myrdal would write that among many white Americans:

> “the one who has got the smallest drop of ‘Negro blood’ is as one who is smitten by a hideous disease . . . Inside him are hidden some unknown and dangerous potentialities, something which will sooner or later crop up.”

And in a cartoon of the same year, entitled “An American Tragedy”, similar insights could be harnessed to the criticism of American Red Cross and military policy of blood plasma segregation. In one panel a wounded white soldier is told by the Red Cross attendant, “You might as well wait here, bud—we ain’t got nothin’ but Negro blood left”. A second panel shows a scientist scratching his head because the labels have fallen off bottles of white and black blood. “What a dilemma,” he says, “now how can we tell the white from the negro plasma?” And a fourth panel shows a wounded black soldier saying to his white doctor “if I need a transfusion, gimme anybody’s blood, so long as I get back to the front”.

In such popular venues and in scholarly circles too, it seemed increasingly obvious that these assumptions about group inferiority interacted with ideas about disease (dangerous entities hidden in “negro blood”) in service of a larger goal: maintaining a segregated social order. At mid-century, a new light was being shone on these processes of stigma formation.

**Sickle cell: new carriers, old concerns**

The rise of social activism around both disease and race relations in the 1960s and 1970s dramatically altered the relation of stigma to issues of race and health, as stigmatised and marginalised groups themselves came together to challenge many of these mainstream assumptions and processes. The case of sickle cell anaemia provides a case in point. Where some had long seen the disease as a hereditary taint or stigmatising mark originating in “Negro blood”, African-Americans and their advocates portrayed it as a painful disease and as a poignant symbol of the African-American struggles for justice in the health-care system, in biomedical research, and in mainstream society.
Yet, this trend of activism, increasing attention to the disease, and new scientific understandings of disease carriers (heterozygotes) did not negate the interplay of racial stigma and disease stigma. Rather, new forms of double stigmatisation emerged, for example, as scientists, and policymakers debated the question of testing for sickle cell trait and counselling carriers on matters of reproduction. Linus Pauling, the very scientist who discovered the molecular basis of the disease, went so far as to suggest that

“there should be tattooed on the forehead of every person a symbol showing possession of the sickle-cell gene . . . [so that] two young people carrying the same seriously defective gene in a single dose would recognize the situation at first sight, and refrain from falling in love with one another.”

Debates about carrier status also led the US air force to ban carriers from high altitude missions, and to other practices of using the trait as a screening and selecting test to fit employees to jobs. Over time, stigmas associated with group identity have accentuated, and been accentuated by, disease-associated stigma—even in the midst of dramatic changes in disease, social relations, and medical science. Indeed, medical science, from bacteriology to genetics, has fed into the process of stigmatising individuals, by designating hidden invisible taints (whether bacteriological or genetic), and thereby reinforcing broader prejudices and policies. If we are to understand and reduce stigma in relation to global health in the developed and developing world today, we must pay increased attention to these complex historical and sociological processes by which stigmatised categories are formed and deconstructed and examining their influence on societies and individuals today.

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I declare that I have no conflict of interest.

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References
1 Postell WD. Health of slaves on southern plantations. Baton Rouge: Louisiana State University, 1951.

The many stigmas of mental illness
Kay Redfield Jamison

Much of the stigma of mental illness is engrained in deep and ancient attitudes held by virtually every society on earth. These attitudes govern the decisions societies make and the behaviours they tolerate. Newspapers and television stations can print or broadcast statements about those with mental illness that simply would not be tolerated if they were said about any other minority group. Stigma also insinuates itself into policy decisions, access to care, health insurance, employment discrimination, and in research allocations and priorities. Unfortunately, people who have mental illness also stigmatise themselves. They make few demands and their expectations are frighteningly low—with grave consequences. Stigma can kill.

The inability to discuss mental illness in an informed and straightforward way, to deal with it as the major public health concern that it is, is unjustifiable. There is a very large group that I think of as the silent successful—people who get well from psychiatric illness but who are afraid to speak out. This reluctance is very understandable, very human, but it is unfortunate because it perpetuates the misperception that mental illness cannot be treated. What remains visible in the public eye are the newspaper accounts of violence, the homeless mentally ill, the untreated illness in friends, family, and colleagues. What is not seen are all the truck drivers, secretaries, teachers, lawyers, physicians, and government officials who have been successfully treated, who work, compete, and succeed.

My own perspective on stigma is shaped not only by being a professional who studies mental illness but as someone who has suffered from manic depression since I was 16 years old. I strongly believe that we need to better understand why stigma exists, and not just from a sociological or anthropological point of view. Studies of animal behaviour make it very clear that animals discriminate not only against those who are markedly odd, but also against those who are different in more subtle ways. I believe that the expression of stigma or discrimination is deep-wired into the brain. There are good reasons for fear, which have to do with the unknown, the unpredictable, and the potentially violent. We have to acknowledge upfront that untreated