

# Stigma and social welfare

Paul Spicker

## Author's note, 2011

*Stigma and Social Welfare* was my first book, revised and abridged from my original PhD thesis. It went out of print some years ago and the rights to publish have reverted to me. I am making it freely available on the internet, in the hope that some readers may still find something in it to interest them. The book was unusual at the time in the way that it drew on sociological, psychological and anthropological material in order to make a case about social policy. The use of evidence from psychology is still uncommon in social policy, but the references to sociology and anthropology have become part of the mainstream.

The version that is presented here is substantially the same as the 1984 edition, with some very minor edits. There are some proofreading corrections (such as the single word in Greek, which despite my getting specially produced copy to the publisher appeared as a blank space in the original edition). I have also made a concession to changing mores: some of the labels used for stigmatised groups in the 1984 edition were in polite use at the time, but have ceased to be acceptable in the course of the last thirty years, and if I posted them on the Internet now, people would not be happy with me. The pagination is also different from the 1984 edition. I have not otherwise attempted to update the argument or the material. If I was writing the book now, however, I would not write it in the same way.

Paul Spicker

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# Introduction

## THE NATURE OF SOCIAL WELFARE

This book looks at the concept of stigma in the context of social welfare. The idea of 'social welfare' is commonly identified with the 'social services'. Both terms are regrettably unclear. 'Welfare' can be taken to mean 'relief'; a 'welfare recipient' is someone who receives a monetary allowance. Secondly, 'welfare' refers to individual well-being; in economics, 'social welfare' refers to the overall well-being of a society. Thirdly, it signifies a "pattern of organised activities" equivalent to the social services (Butterworth, Holman, 1975, 15). This is the principal use of the term in studies of social administration. Social welfare

is an omnibus term used to cover a wide range of activities in society. These activities are concerned with the maintenance or promotion of social well-being. (Ibid, 14)

This is a very wide concept. 'Social well-being' covers anything that could be argued to be good for society. "All collectively provided services", Titmuss writes, "are deliberately designed to meet socially recognised needs" (1955, 39). ('Need' is used to signify those things which are deemed essential for the well-being of individuals or groups.) But not all services provided on this basis are social services: the army is an obvious example. The needs that are dealt with are of a specific kind. The services which are most commonly accepted in Britain as being social services are health, housing, education, social security and social work. They have in common, not only that they provide for needs, but that people receive directly a good or a service from them and are therefore dependent.

Titmuss refers to "states of dependency" which are recognised as collective responsibilities (1955, 42-3). These include injury, disease, disability, old age, childhood, maternity and unemployment. People in these circumstances rely on socially provided goods and services, and it is this reliance which is the distinguishing characteristic of social welfare and the social services. Eyden writes that

A social service is a social institution that has developed to meet the personal needs of individual members of society not adequately or effectively met by either the individual from his own or his family's resources or by commercial or industrial concerns. (in Byrne, Padfield, 1978, 1)

This definition implies, firstly, that the social services respond to individual need; and secondly, that they do so only when other methods have failed. This is true of some services, but not of others: education, or health, are accepted as social services, but are provided without regard to other resources which could meet the need.

Greve (1971), by contrast, cites a definition of a social service from a UN report: It is an organized activity that aims at helping towards a mutual adjustment of individuals and their social environment. This objective is achieved through the use of techniques and methods which are designed to enable individuals, groups and communities to solve their problems of adjustment to a changing pattern of society, and through co-operative action to improve economic and social conditions. (Greve, 1971, 184-5)

The definition, Greve notes, makes three points. The first is that the provision of social services is not simply a transaction in which a passive person receives bounty (in the form of cash, kind or counselling) from the rest of the community. Nor, as many still think, is a social service concerned to get people to adjust unilaterally to society or to their possibly squalid environment. ... society must also adjust to the individual. (Ibid, p 185)

The second point is that social services help groups and communities, not only individuals. Eyden suggested that social services were individual and residual. But dependency is not necessarily a feature of individuals: a group or community may be collectively dependent.

The third point is that there is a 'positive, developmental function' pursued through 'co-operative action'.

This is a good definition, but it has its weaknesses. Its essential flaw is that it is prescriptive rather than descriptive. It puts great emphasis on self-determination either by enabling people to meet their needs, or by cooperative action - when the relationship may be one of passive dependency. It emphasises mutual adjustment, whereas the reality may be a matter of social control. The concept of dependency does not in itself imply either adjustment or control, or determine a developmental function; but it is consistent with them, as it is consistent with other policies.

A social service can be defined as a social institution which is developed to provide for those conditions of dependency which are recognised as collective responsibilities. This is a restricted definition, but I believe it reflects the actual use of the term. Housing, health, social security, education and social work are social services because they deal with conditions of dependency. Urban planning, road building, libraries and the police force do not. This is the distinction between social and public services. The distinction may seem irrational, and in some ways it is. The study of social policy has moved increasingly towards treating them on an equivalent basis; but 'social policy', which takes in any policy affecting relations in society, is a wider concept than a study of the social services. The distinction is not completely arbitrary; states of dependency do present a distinctive set of problems, and those problems are central to this study.

'Social welfare' is not used quite synonymously with 'social services', although the terms are very close: references to 'social welfare services' can be found (e.g. Reisman, 1977, 50), which seem to mean, not services to promote welfare, but rather services which perform the function called 'social welfare'. Social welfare can be defined as organised activity to improve the condition of people who are dependent.

### **Stigma and social welfare**

Stigma is an important concept in the study of social administration; it has been described as the central issue (Pinker, 1971, 136). A stigma marks the recipient of welfare, damages his reputation, and undermines his dignity. It is a barrier to access to social services, and an experience of degradation and rejection. The imposition of stigma, Pinker writes, "is the commonest form of violence used in democratic societies." (1971, 175).

Although some sociologists have tried to claim it for their own (e.g. Lemert, 1972, 15), 'stigma' is not an academic term; people who are embarrassed or ashamed of their dependency on social services use the word to describe their feelings. An unemployed miner talks about

the stigma of going up to the dole every week, I think it's awful. (cited Gould, Kenyon, 1972, 21)

A tenant of a 'sink' estate says,

It is stigmatised ... You felt ashamed to say you were from Abbeyhills, because of the stigma. (Flessati, 1978)

A person who had been committed to a mental institution for three days in 1935 wrote to a Royal Commission more than twenty years later asking

to get my name off your registers so that I no longer bear the stigma of being a certified person. (Cmnd.169, 1957, 97)

And a recipient of Supplementary Benefit complains,

It's shame, the stigma of it. (Richardson, Naidoo, 1978, 27)

'Stigma' is a part of common speech; and, like many other common words, it has no precise definition, but is used in a way that assumes other people will understand it. Exposition of the concept has been limited, and the idea has been accepted, for the most part, uncritically. References to 'stigma' in studies of social administration tend to be made in passing; they are

asserted, without the benefit of reason or evidence. I have built up an argument, in many places, on the basis of references like these - a short passage from one book, a phrase from another - in order to illustrate both the way the idea is used, and some of the underlying assumptions made about it. The result is, I hope, rather more than a selective review; it is an attempt to clarify the different uses of the word, to establish whether a coherent concept can be constructed, and to see what the implications of the idea of stigma are for social policy.

# Part 1

## Stigma and the social services



## Chapter 1

# STIGMA AND THE POOR LAW

The stigma of the Poor Law is legendary. For over a century, people who claimed poor relief were the objects of a policy intended to deter them from seeking help and mark them off from the normal members of society. When the Poor Law was abolished, there was clearly a belief that the stigma which accompanied it would also be wiped out (see Stevenson, 1973, 1). But in 1966, the Ministry of Pensions and National Insurance published the results of a survey of retirement pensioners (Ministry of Pensions, 1966). This survey showed that large numbers of people still felt a reluctance to claim which, if it was not attributable to stigma, was due to something very much like it. Among couples, for example, 30% had failed to claim because of pride, a dislike of 'charity', or dislike of going to the National Assistance Board; nearly 20% more said that they were 'managing all right', which could mean that they did not need help, but could also mean that they were too determinedly independent to ask (Ibid, 42).

The obvious implication was drawn that, particularly in the minds of old people, the stigma of the Poor Law had not died. In 1966, the name of the Ministry of Pensions and National Insurance was changed to the Ministry of Social Security; National Assistance became Supplementary Benefit; and people were given a right to benefit, instead of receiving it at the discretion of a government agency. Douglas Houghton, the Minister responsible, claimed that this had had "a remarkable success. Some half a million more people applied within a few weeks." This view is disputed by Atkinson (1969), who shows that much of the increase in claims can be accounted for by an increase in the level of benefit that accompanied the administrative changes (pp.62-77).

The stigma of pauperism, which had seemed to be the result of a conscious policy, has proved greatly resistant to abolition. As time has gone on, memories of the Poor Law have dimmed, but stigma is talked about as much as ever. It is difficult to understand why, when deterrent policies have been abandoned, entitlement to benefits established, and the administration of benefits substantially changed, this should be so. A study of the history of the stigma of the Poor Law may help to explain the persistence of the idea.

### **The development of deterrent policies**

In the middle ages, charity was given as a religious duty, intended more for the salvation of the donor than the advantage of the recipient (Fairchild, 1976). This form of charity declined as feudal society developed. War, famine and disease drove itinerant beggars across Europe; men who spread the diseases they were trying to escape, and who were forced to rob if they could not receive charity (see Briod, 1926). Laws were made to restrict the movement of labour - the first in England was made in 1349. A recurrence of the problem in the sixteenth century inspired more draconian measures: mendicancy was punished by flogging and branding (Chambliss, 1964).

At the same time, the growth of the townships and the emergence of a new economic order provided the foundations of the Reformation (Tawney, 1936), a movement which destroyed both the ancient religious basis of charity, and many of the monasteries which dispensed it. The 'protestant ethic' - which was not confined to Protestant communities - emphasized labour as a mark of divine grace (Weber, 1904-5), and led to the treatment of idleness as sin. Calvinism favoured the teaching of St. Paul, that a man who does not work shall not eat. But charity was not abandoned altogether: it was reformed on a new moral basis. The poor were separated into 'deserving' and 'undeserving', with a strong emphasis on the latter. Luther

recommended the creation of a 'common chest' for the 'worthy' poor (Luther, 1536). Zwingli, another of the Protestant reformers, wrote ordinances on poor relief in these terms:

The following types of poor persons and country folk are not to be given alms: any persons, whether men or women, of whom it is known that they spend all their days in luxury and idleness and will not work, but frequent public-houses, drinking places and haunts of ill-repute. ... But to the following folk poor relief shall be distributed, the pious, respectable, poor citizens. (Zwingli, 15Z5, 100-1)

The Elizabethan Poor Law was conceived in less explicitly moralistic terms. An Act of 1576 had made provision for "setting the poor on work and for avoidance of idleness"; 'houses of correction' were established for persistent idlers. The Act of 1601 retained the concern with setting the poor on work; it made an implicit distinction between the able-bodied and impotent poor. The able-bodied became identified as time went on with the 'undeserving' poor, and identification which was strengthened by the growth of puritanism in the seventeenth century. The later development of deterrent workhouses - the first was set up at Bristol in 1697 - was a natural extension of a principle established more than a hundred years before.

The other main deterrent policy in use at this time was badging the poor. Zwingli commended the practice of fixing a badge to the clothing of a pauper to mark him out, in order that the poor who are in receipt of relief may be known, they must have a stamped or engraved badge, and wear it openly. (Zwingli, 1525, 101) This was enacted as law in England in 1697. Unlike the workhouses, badging fell into disuse, probably because it failed to distinguish the able-bodied poor from others. Alcock, writing in 1752, complained:

And tho' Badges by the 8th and 9th of William, seemed rightly ordered to be fix'd as some public Marks of Shame, and to distinguish Parish Paupers from those industrious Poor that live by their own Endeavours: Yet these marks of distinction have had but little effect, and for that Reason, I suppose, have been almost every where neglected. (Alcock, 1752, 17)

The editor of a report by John Locke, reprinted in 1791, gave a more convincing reason for the decline of the practice:

The law which appointed the poor to be badged was, perhaps, meant for the purpose of deterring paupers from unnecessary applications for relief: but, by its universality, was more calculated to produce a contrary effect; and has, therefore, by common consent, gone into total disuse in most parts of the kingdom. Who can bear the idea of affixing a stigma to a child, and of introducing it to the world under a reproach, or at least with a mark of degradation, which it cannot have deserved? (Locke, 1791, 139)

This is the earliest reference to 'stigma' that I have been able to discover in the context of the Poor Law; it seems to be an isolated instance.

### **The movement to reform the poor law**

Over the course of the eighteenth and early nineteenth centuries, the Poor Laws operated in a climate of mistrust of the poor, and a growing concern about the increasing financial burden that pauperism represented. A belief that the poor had been corrupted by the Poor Laws began to be expressed in the mid-eighteenth century, and grew from that time onwards. Alcock (1752) wrote that

When the Statute of Elizabeth relieving the Poor first took place, the Burthen was light and inconsiderable. Few applied for relief. It was a Shame and a Scandal for a person to throw himself on a parish ... but the Sweets of Parish-Pay being once felt, more and more Persons soon put in for a share of it. One cried, he as much wanted, and might as well accept it, as another; the Shame grew less and less, and Numbers encouraged and countenanced one another. (pp.16-17)

Porteous (1783) claimed that

It has been the experience of every country, that a liberal provision for the poor has been followed by sloth, prodigality, and neglect of their families. (p.1)

Gascoigne (1818) stated that only thirty years beforehand,

A general feeling of self-dependence pervaded the labouring class; that parish relief was considered as disgraceful and disgusting; and that to apply for it, even in old age, was to admit either idleness, improvidence, or extreme misfortune. (p.8)

Earl Grey (1834) believed that

It was aforesaid a shame such as no man could bear, to be dependent upon parochial aid - the name of 'pauper' coming next, in the estimation of the peasant, to that of 'felon'. (p.20)

Another writer in 1835 commented,

Poverty will leave its impress upon all men, both as regards habits and manners, but it was left for the pauper system of England to show that it might be rendered available to the destruction of their feelings, and strike out of the machine of man the mainspring of his moral movements, namely - a sense of shame. (Wontner, 1835, 4)

These opinions represent an important strand of a complex debate. (See Poynter, 1969, for other arguments.) It was believed that pauperism had grown because men were no longer ashamed to depend on the parish; it was essential to restore in the poor a proper sense of degradation. The means of doing this were provided by the model of the deterrent workhouse. Joseph Townsend, writing in 1788, commented that

the workhouses operate like the figures which we set to scare the birds, till they have learnt first to despise them then to perch upon the objects of their terror. (Townsend, 1788, 19-20)

It is difficult to know whether this is true, or whether it belongs in a class with the general nostalgia for a bygone age when people were more ashamed to be poor. Becher wrote, in 1828, that

the advantage resulting from a Workhouse must arise, not from keeping the Poor in the House, but from keeping them out of it; by constraining the inferior Classes to know and feel how demoralising and degrading is the compulsory Relief drawn from the Parish to silence the clamour, and to satisfy the cravings, of wilful and woeful indigence. (Becher, 1828, 20)

This passage was marked by George Nicholls, who on the strength of his success as the overseer of a deterrent workhouse was to become a Poor Law Commissioner; and Nicholls gave the text, which is now in the British Library, to Edwin Chadwick, the man principally responsible for the Poor Law Report of 1834.

### **The workhouse test and less eligibility**

The functions of the deterrent workhouse were interpreted in different ways. Some people wished to make it as unpleasant as possible: a letter to Chadwick in 1832 argued that

The workhouse should be a place of hardship, of coarse fare, of degradation and humility; it should be administered with strictness - with severity; it should be as repulsive as is consistent with humanity. (Milman, cited Chadwick, 1833)

However, according to Finer, Chadwick did not share this view.

Chadwick, it must be stressed, never saw in the workhouse, as many of his contemporaries did, 'an object of wholesome horror'. Its food was to be nutritious, its ventilation and accommodation vastly superior to that of the independent labourer.

It would deter by its stigma, its bleakness, its task work. (Finer, 1952, 85)

Chadwick was strongly influenced by Jeremy Bentham, whose secretary he was for a period. From Bentham, Chadwick learned the doctrine of 'less eligibility' (Poynter, 1969, 126). The Poor Law report of 1834 laid it down as 'the first and most essential of all conditions' that the situation of the pauper

on the whole shall not be made really or apparently so eligible as the situation of the independent labourer in the lowest class. (Checkland, Checkland, 1974, 335)

Porteous had written, in 1783, that

where the public maintains them as well as they were maintained by their own industry ... if they are better supplied, it is holding out a temptation almost irresistible

to become poor. It follows, that no person maintained on charity should be raised above that rank which he held in the period of health and industry: - That every person on charity should descend at least one step below the station which he occupied in the season of health and labour ... (Porteous, 1783, 1-2)

This passage is underlined in Bentham's copy of the tract (although it is impossible to say with certainty that the underlining was made by Bentham); the copy was later passed to Chadwick. The argument contains the beginnings of the idea of less eligibility; it would have appealed to Bentham, because it was entirely consistent with his philosophy. Bentham believed that man is motivated by the pursuit of pleasure or the fear of pain, a principle that has been dignified by the name of 'psychological hedonism'. He argued that it is more pleasant not to have to work, and therefore that pauperism could only be reduced if somehow it was made relatively undesirable. Porteous had suggested that this could be done by making a person's condition less desirable than the same person's status in work; Bentham chose to compare the pauper with independent labourers as a class, and concluded that the pauper should be put in a worse situation - one less to be desired - than that of the poorest labourer.

In a fragment on the subject of 'badging', Bentham outlines his position.

The expedient of a badge has experienced violent censure: it is a degradation of the human character; it is stamping infamy upon misfortune: it is confounding innocence with guilt. Answer. - Degrading a man is turning a man down from the class in which you find him, into another class which is below it. The badge marks the class in which it finds him: and there it leaves him. Degradation changes the class; badging indicates it only ... If the mark for a pauper were the same as that for a felon, then indeed the affixing of it would be stamping infamy upon what would oftentimes be mere misfortune; then indeed it would be confounding innocence with guilt. The mark branded upon the body of a felon certifies him to be a delinquent ... The Mark termed a Badge and locked to the garment of a pauper does not certify him to be a delinquent in any shape. What it does certify is that he is poor, and so he is: that he is a burthen upon others; and so he is. (Bentham, 1831-2, 602)<sup>1</sup>

Pauperism, to Bentham, was a degraded status rather than one on which degradation had to be inflicted. At the same time, he was prepared to defend the practice of badging on the principle of less eligibility:

The good ... consists in rendering the condition of the man of industry (in appearance) more eligible than that of the man of no industry: it consequently tends to dispose men to embrace the former condition in preference to the latter. (Ibid, 603)

There is a nice distinction here between putting a pauper to shame and degrading him. A badge did not degrade, but it humiliated, and Bentham did not think that humiliation was undesirable. His conclusion shows this to be a principle of more general application:

By all this, I do not mean to say that under the proposed system I would make a point of affixing a badge ... What I mean to say is that should that same effect follow from that or any other operation, with or without that view, so much the better: that the principle upon which the effect is grounded is a principle not to be censured, but adopted with applause. (Ibid, 603)

It is difficult to assess how far Chadwick was influenced by these or similar arguments. It seems likely that he knew Bentham's opinions, even if he did not know this particular essay. In the event, he did not follow Bentham's reasoning slavishly: it is clear from the report that

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<sup>1</sup> The fragment is undated, and Poynter (1969, 126) has suggested it may date from 1797. In fact, although it has been classified with other fragments of an earlier date, the watermark of the paper reads '1831', and the hand has been identified for me, by Ms. Clare Gobbi of the Bentham Project, as that of Arthur Moore, Bentham's last amanuensis. The piece was presumably written in 1831 or 1832, before his death.

he hoped as much to improve the relative condition of the independent labourer, by ending the depressed wages caused by the 'roundsman' system, as to lower the condition of the pauper. It is noteworthy, and perhaps surprising, that the Report did not really argue for the imposition of a stigma. All it says is that the labourer was tempted to abuse the system

by the absence of a check of shame, owing to the want of a broad line of distinction between the class of independent labourers, and the degradation of the former by confounding them with the latter. (Checkland, Checkland, 1974, 377)

This is framed in the same terms as Bentham's arguments. The workhouse was not intended as an engine of degradation; it would be shameful because it was the mark of a low status. Rather than emphasising the disgrace of the workhouse, the Report stressed its discipline, which would be "intolerable to the indolent and disorderly" (p.338) but relatively a comfort to the old and feeble. The 'workhouse test' would separate the deserving from the undeserving poor.

This opinion was not shared by the Report's critics, who objected that the pauper was to be humiliated. The Times (1834), in a major editorial, commented that

heretofore the employment given to paupers, or the relief extended to them, has not in many cases been attended with circumstances so irksome or humiliating as to mark with a line sufficiently strong the difference between the free labourer and the pauper. - thereby identifying 'less eligibility' with circumstances that were 'irksome' or 'humiliating'. In Parliament, Cobbett opposed the reform vociferously:

Mr.Cobbett said, the whole object of the bill was, to deter the poor from seeking relief. He had heard of an overseer in Sussex who cut off the hair of two women who applied to him for relief, put degrading badges on them, and in this condition marched them through the village to the parish church. (Hansard, 1834a., col.352)

Badging was revived for a period by certain parishes. A Guardian reported, in 1838, that In the Alresford, Andover, Portsea Island and Westhampnett Unions a badge of distinction has been placed on women of immoral character with Bastard children with considerable effect, several left the Houses in consequence ... (W.Hawley, cited Anstruther, 1973, 113-4)

Unlike Chadwick, the administrators of some workhouses evidently did intend to make their institutions 'the objects of wholesome horror'.

'Less eligibility' was difficult to maintain in material terms, largely because the condition of the 'independent labourer' was so bad. Conditions in the workhouse could be better than those outside (Digby, 1978): Taine (1874), on seeing a workhouse, wrote that "this was a palace compared with the kennels in which the poor dwell". He understood the reluctance of the poor to enter the workhouse to be due to the loss of freedom they would experience; but I think it is fair to say that more than this was involved. The sanction of less eligibility, as Pinker (1971) points out, took a necessarily psychological form. It imposed the pain of humiliation and stigma. (p.58) Stigma became essential as a means of preserving the distinction between paupers and labourers, and deterring the poor from dependency.

Abel-Smith (1964) cites, for example, a statement by Longley in 1873:

it was important that ... the stamp of pauperism is plainly marked on all relief given ... the words 'Dispensary' or 'Infirmary' should never be used in forms, advertisements and addresses without the prefix 'Pauper' or 'Poor Law' or 'Workhouse' ... (p.89)

In Birmingham, patients at the infirmary were required to enter and leave by the workhouse grounds to emphasise their dependence on the Poor Law (Ibid, 131). The policy of deterrence came increasingly to rely on measures of this sort. Beatrice Webb (1948) quotes F.H.Bentham, who was with her on the Royal Commission on the Poor Laws, saying in 1906 that

We must mark off for stigma the dependents of the state there must be no blurring of the lines between persons who were supporting themselves and those that were being

supported out of the rates - whether on account of old age, sickness, or unemployment. (p.358)

The Webbs record that, in evidence,

The Chief Inspector and his staff had warned the Commission that medical relief was 'the first step to pauperism', and had insisted that medical treatment at the expense of public funds ought to be rigidly restricted to persons who were actually destitute, and accompanied by the stigma of pauperism through the disenfranchisement of the recipients. (Webb, Webb, 1929, 514-5)

And the Boards of Guardians in 1913 favoured the retention of a stigma on poor children educated as paupers, as a spur to parents to take the full responsibility for them. With what the Webbs call "a curious inconsequence", they also argued that there was no more shame for a young poor parent to get help through the Poor Law than from a Local Education Authority (Webb, Webb, 1929, 748). These people were fighting a rearguard action. The care of the sick ceased to be pauperising in 1885; dependency by the old was widely accepted. Charles Booth wrote, in 1893, that

There are a few parishes where out relief is considered a disgrace, but in most places no stigma attaches to its receipt by the old. It is regarded as a matter of course, and often claimed very much as a right. (in Bruce, 1973, 119)

Old age pensions were eventually to be introduced outside the Poor Law in 1908, by which time they were "largely devoid of controversy in principle" (Fraser, 1973, 139).

### **The stigma of pauperism**

The use of the term 'stigma' in the context of the Poor Law seems to have gained gradual currency over a long period of time. The idea was not associated with the old poor law. In a 'Table of cases calling for relief' drawn up in 1797, Bentham wrote of "stigmatised hands" as paupers who became dependent on the parish through criminal activity - people like robbers, cheats, forgers and thieves (Bentham, 1843, opp. p.360). They were not the only people who Bentham believed were pauperised by virtue of their bad character, but the idea of 'stigma' is confined to them. Stigma to him was specifically the mark of the felon - a mark distinguished clearly from the status of the pauper.

The word was used more at the time of the Poor Law report, but it had not yet developed the particular connotations it was later to have. In 1834, on the subject of bastardy,

Lord Wharncliffe said, that if it were possible to fix any mark of shame on the father, to stigmatize him with any part of the disgrace attendant upon the transaction, he, for one, would gladly impose a penalty of that kind. (Hansard, 1834b, col.782)

The use of the word 'stigmatize' is tentative. In the following year, a pamphleteer expressed the hope that

under the influence of the society, together with the force of example, and the stigma which will then be attached to idleness, that the number of those men who would prefer living upon a fund, to work, will be considerably lessened. (Anon, 1835, 15-16)

A protest against the Poor Laws in 1837 referred to the method of burying paupers as a foul stigma on the ashes of the humble dead (Bowen, 1837, 5)

and complained of the linking of pauperism with crime rates:

This attempt to poison the sources of mercy, by stigmatising the Poor as a band of criminals, and the Poor Laws as the cause of their criminality, has been successful in an alarming degree. (Ibid, 19).

Kay, in 1838, referred to the "taint of pauperism" that might attach to pauper children (cited Henriques, 1979, 51). In 1840, Dr. Alison complained that

There is just sufficient aid given to stamp the person as a pauper, and so to destroy his independence. (Alison, 1840, 20)

The idea of a brand, mark, taint, stain, stamp or stigma seems to have been widely accepted, but the phrase 'the stigma of pauperism' was not yet current.

The idea continued in this form into the 1860's. Wilkie Collins, in 'The Woman in White', published in 1859, has a character say:

No pauper stain - thanks to my firmness and resolution - ever rested on my child.  
(Collins, 1861, 487)

Rawlinson refers to

the dole of charity or the taint of pauperism. (Rawlinson, 1864-5, 160)

The first use I have found of 'the stigma of pauperism' as a set phrase is in W.E.Forster's speech introducing the Education Bill in 1870:

the School Board was to have the power to give free tickets to parents who they think cannot really afford to pay for the education of their children, and we take care that those free tickets shall have no stigma of pauperism attached to them. (Hansard, 1870, col.455)

This has the ring of a cliché; presumably it had become accepted in the years immediately preceding the speech. Certainly, from this time on, 'stigma' becomes a common expression in discussions of the Poor Law.

The Fabian essays of 1889 included, as an object of the Society, the intention to encourage the State

To provide generously, and without stigma, for the aged, the sick and those destitute through temporary want of employment, without relaxing the 'tests' against the endowment of able-bodied idleness. (S.Webb, 1889, 51)

This was written by Sidney Webb, who evidently thought it was possible to preserve the workhouse test without stigma. This reveals a touching faith in the principles of the 1834 report. Although the Fabians made the 'stigma of pauperism' a focal point of their criticism of the Poor Law, it was not completely clear what they meant by it. J.F. Oakeshott wrote, in a Fabian pamphlet of 1894, a call for better laws under which

The worn-out, deserving worker will be maintained in self-respect in his old age; the temporarily disabled will be helped without pauperisation; the children will be started in life without stigma; the professional shirker will be forced to earn his own living; the vicious and criminal will be put under restraint. Pauperism will be blotted out; Poverty will be a social disease; and Idleness will be a social crime. (in Bruce, 1973, 118)

'Stigma', to Oakeshott, seems to mean unfair blame, or possibly disadvantage. Bernard Shaw, writing in 1928, referred to it as the loss of the vote: the *Guardians*, he wrote, must look after the pauper, but they may do it reluctantly and unkindly, they may attach the most unpleasant and degrading conditions they can think of; ... they can attach a social stigma to the relief by taking away a pauper's vote ... (Shaw, 1928, 77)

The Webbs, by contrast, stated that

Whatever may happen to the 'stigma of pauperism', the legal pauper status is indelible and irremovable. (Webb, Webb, 1929, 995)

The Webbs seem rather confused about the use of the term: they do refer to it as a disqualification from the vote (1929, 335-6n) but go on to say that This pauper status, while affording a definite legal basis for the 'stigma of pauperism', is a matter of greater moment than any sentimental feeling or manifestation of disgrace or disapproval (Ibid, 992).

The 1909 Royal Commission on the Poor Laws severely criticised the term, not least because of the emphasis the Minority put on its importance. The minutes of evidence illustrate their attitude. Mr. T.H. Nunn is asking the questions of the Chief Inspector, J.H.Davy.

2230. Does ineligibility consist of these three elements: firstly, of the loss of personal reputation (what is understood by the stigma of pauperism); secondly, the loss of personal freedom which is secured by detention in a workhouse; and thirdly, the loss of political freedom by suffering a disenfranchisement. Are those the main elements of ineligibility, or have I left any out?

- I think those would be the main elements.

2231. Those are almost absent in nearly every form of relief which is now being given by boards of guardians, are they not?

- I should not say so at all.

2232. For instance, take medical relief in infirmaries: no one minds being detained in an infirmary so long as he is ill, and if he does not have to pass through the workhouse he suffers no stigma of pauperism, does he?

- I think only a small proportion of relief is given in infirmaries. ...2234. With regard to most of the out-door relief there is very little personal stigma, there is no detention, and there is, on the part of the women, at any rate, no loss of enfranchisement?

- That is so. (Cd.4625, 1909, 125)

When the Majority report was written, the criticism of the idea of the 'stigma of pauperism' was directed at its relevance to children:

The transference of the children by the Education Authority is sometimes supported by the plea that it is desirable to remove from the children 'the stigma of pauperism'. We wish to protest against the way in which this term is loosely applied by critics of the Poor Law, without consideration of its justice. It can only mean one of three things: (1) That the person to whom it is applied is disenfranchised; (2) that some blame attaches to the person in the mind of the speaker; (3) that the person labours under some disadvantage as compared with others of his class outside the Poor Law. In the first two senses it should be obvious that the term has no possible application to children, and in the last sense it has ceased, as we have seen, in the great majority of cases to be true. (Cd. 4499, 1909, 197)

Although it is possible to disagree with this argument, the criticism of the concept is well founded. The 'stigma of pauperism' was a feature of the political rhetoric of the time; it was unclear exactly what it was meant to be. The recipients of public assistance were not, in later years, deprived of the vote, and 'stigma' came, in consequence, to refer to other elements of the condition of the poor. It was not, however, confined to the loss of reputation a person might incur in claiming benefit. The index of Titmuss's *Problems of Social Policy* (1950) has several references to "Poor Law, stigma of": most of them describe, not the loss of reputation suffered by the poor, but the indignities and humiliations inflicted on them. Titmuss, as Reisman notes, associated stigma "primarily with denial of access and with entry barriers to a service" (Reisman, 1977, 54). The idea of stigma had come to be firmly bound up with less eligibility and the deterrent principles of the Poor Law.

This view has been imbibed by modern writers. When Abel-Smith writes about health care that the services provided for the poor are generally poor services and the process of applying for them is made stigmatising (1976, 42), or a writer in *New Society* asks about food vouchers, "surely, something so entirely stigmatising should by now be abolished?" (Orlik, 1978), they imply that stigma stems from the humiliating practices of the social services. The Members of Parliament believed they could abolish this humiliation with the Poor Law, and it seemed reasonable to suppose that a problem apparently created by a conscious policy could be resolved in the same way.

### **The survival of stigma**

There are three possible explanations as to why this did not happen. The first is that there has not in fact been a change in policy: that stigma is still used to ration scarce resources, and keep people from claiming welfare. This argument is unconvincing; it is difficult to believe that the efforts governments have made to alleviate stigma - notably in 1948 and 1966 - were dishonest, and the differentiation of dependent groups that followed reform of the Poor Law makes it irrational and unnecessary to stigmatise all of them.

A second explanation is that in important ways - the use of old workhouses as institutions (P.Townsend, 1963; Cmnd. 7357, 1978), the legacy of attitudes of a previous generation, and the persistence of selective services for the poor - the Poor Law has not been abolished. The Seebohm Committee, which reviewed the structure of social work departments, wrote that

Historically the aim has been to deter people from seeking ... help and stigma has been attached to those who did. It is not surprising therefore that many are



prejudiced against seeking the help of services they may need and to which they are entitled ... (Cmnd. 3703, 1968, para. 145).

It would follow from this view that, as time goes on, the Poor Law becomes more distant, and services gradually change, stigma will become less important. There is some evidence to support this opinion: the 1966 survey which revealed the effects of stigma was confined to old people, and there is some doubt as to how important stigma is in affecting demand among younger groups - a survey of the takeup of school meals found that mothers were more likely to credit feelings of stigma to other people than to experience it themselves (Reddin, 1977, 67). The Supplementary Benefits Commission (1978) have suggested that the increasing number of applicants shows a reduction in feelings of stigma (p.8). It seems to me to reflect rather an increase in the number of potential dependants, especially pensioners. Ginsburg (1979) argues that the increasing dependence of unemployed people on means-tested benefits suggests that much of the stigma of (and resistance to) means-tested relief has disappeared. (pp.67-68) I should have thought it had more to do with increasing long term unemployment, and the unemployment of school leavers, because people in these categories are not entitled to National Insurance. Meacher comments that Since we did our utmost for more than a century until the 1940's to inculcate feelings of guilt, shame and stigma, their presence among older people is evidence of the success of earlier publicity carried out over a long period. (Meacher, 1972, 41). But there is very little evidence concerning the influence of age on attitudes to services, and it is difficult to say whether old people do feel more ashamed of claiming. Old people are often more secure financially than young people, because their income on social security is higher, because benefits do not meet the cost of a child on an equivalent basis to the cost of an adult (Piachaud, 1979), because their resources are often greater even if their income is not, and because they have lived through periods of greater material hardship than younger people. The statement of old people that they can 'manage' on benefits may be true, rather than a profession of independence and a dislike of charity. On the other hand, an aversion to dependency is not confined to old people. Ritchie and Wilson (1979) found that

people under 25 and over 60 rarely commented on the atmosphere in the office or on the other people there. These feelings were almost entirely confined to the middle age range ... who talked about it in fairly emotional terms.

Research for the SBC found that, of the opinions of 121 male claimants between the ages of 21 and 50, 37% had been reluctant to claim (Richardson, Naidoo, 1978, 25). Few people under the age of 45 can remember the Poor Law at first hand; the War, and evacuation, made it irrelevant to a generation of children, and afterwards it was abolished. However, these people are not immune from shame or embarrassment. It is possible that we have fallen prey to the same illusion as the writers of the eighteenth century: to believe, in the absence of any real evidence, that people are less ashamed of dependency than they used to be. No research has been done to compare the attitudes of people to dependency over an extended period of time.

A third explanation is that stigma is not, in fact, the result of the Poor Law. The problems of degradation, humiliation and reluctance to accept social services are the results of a much deeper process. The Poor Law existed for a long time, and laws punishing the poor preceded it. It was shameful to claim relief before the 1834 Act, despite the common opinion that paupers in England were shameless: the report of 1834 quotes a worker who told the Commissioners,

I know that none but the worst characters would ever think of applying for parish relief; and that the respectable workmen consider it disgraceful. (Checkland, Checkland, 1974, 391).

Poverty was also considered reprehensible in other countries. The Poor Law Commissioners (1834) recorded that,

in Holland, such degradation attaches to the idea of obtaining relief, as is sufficient to stimulate a labourer to the greatest exertion and frugality to avoid it (p.584); and in Norway, it is still considered disgraceful to have recourse to parish relief. (Ibid, 697)

The Poor Law was to influence poor relief in other countries than Britain, notably the US, and evidence that is not tainted directly by contact with the Poor Law or by a similar deterrent system of welfare is hard to find. But there are some indications that the problem did come before the Poor Law. In the Talmud, which was written down at some time about the fourth century A.D., there is the following incident:

When Rabbi Yannai saw somebody giving a zuz to a poor man in public, he said, 'It were better not to have given rather than to have given and shamed him'.

(Encyclopaedica Judaica, 1971, V:342)

Maimonides wrote in the same vein about the virtues of the gift where both recipient and donor were unknown to each other, thereby pre-empting Titmuss by about eight hundred years (Encyclopaedica Judaica, 1971, 342-3). A scheme of poor relief in Ypres, Belgium, ran across familiar problems:

For as moche as we se many so naturally abashed and ferful that they wyl rather hide their nede than disclose and open it ... these secrete and preuy nedions shalbe serched out and such shalbe visyted as ar ashamed to be sene and to them that shalbe gyuen that are abashed to take any thing. (City of Ypres, 1531, 58)

This seems to me to establish the existence of stigma in contexts entirely divorced from the Poor Law, and proof therefore that stigma is not simply the consequence of either the Poor Law or the principle of less eligibility. It helps to explain why stigma was not removed when the Poor Law was abolished: it was, and is, a more fundamental problem than it was believed to be.

### **The effect of stigma on the development of services**

The reaction to the 'stigma of pauperism' was significant in its own right: it became a major factor in the development of social services in Britain. Some people had doubts about the relevance of the idea to present problems. Sir John Simon, the wartime Chancellor of the Exchequer, remarked in a memo:

It is difficult to believe that there are still any very large number of old age pensioners who prefer destitution to the alleged indignity of applying for public assistance.

Enquiries I have made seem to show that, while much is made in the House of the stigma of public assistance, the great majority of industrial workers do not feel very strongly on this point. (cited Bruce, 1973, 234)

But this did not stop him from referring in Parliament a few days later to those people who I feel and I think naturally feel a considerable sense of humiliation because they have to apply weekly for relief from local authorities. (Ibid, 235).

I prefer to see this less as a case of stunning insincerity than as a tribute to the power of stigma as a political myth. Stigma mattered because people believed it mattered; Simon was bowing to the political wisdom of the time.

At the same time as the Poor Law was abolished, the services were reorganised to break their connection with its administration. The National Health Service was formed: social work was separated from social security; social security was redesigned about the principles of national insurance. These changes extended beyond those services which had been governed under the Poor Law. Middleton and Weizman (1976) write:

Although the Poor Law never had control of education, the tenets of the period, influenced by the doctrine of laissez-faire and a mandate of complete parental responsibility for children, ensured that the elementary schools remained in their minds a form of poor relief. This was a stigma that remained, particularly as regards education over the age of eleven, to be largely dispensed only by the 1944 Act. (p.538)

It was in fact one of the principal intentions of the 1944 Act to end this stigma. R.A.Butler, the Minister responsible, recorded:

It was ... possible for the Act to cut right out of the educational vocabulary the word 'elementary', to which the stigma of an inferior kind of schooling for children of the poorer classes had continued to cling ... It was ... equally important to ensure that a stigma of inferiority did not attach itself to these secondary institutions - and they were

bound now to be in the preponderant majority - which lacked the facilities and academic prestige of the grammar schools. (Butler, 1971, 25)

The concept of stigma has broadened as time has gone on, so that now it encompasses almost any case in which a person is likely to be ill-treated, humiliated or degraded; and awareness of the problem has shaped the development of the social services since. The reform of National Assistance in 1966 is the outstanding example, but there are others to note. The reform of the law of mental health in 1959 was made after an active consideration of the stigma relating to committal, and the labels attached to mental illness and handicap (Cmnd. 169, 1957). The development of community-based services was intended to avoid the stigma of individual provision (Cmnd.3703, 1968, 147-8); Pinker (1971) argues that the case for 'positive discrimination' rests primarily on the desire to overcome stigma (ch.5). In education, the debate in the UK on streaming has not been concerned explicitly with stigma, in contrast to the US where

One of the central issues in achieving effective differentiation is how to avoid stigma. The less 'normal', less 'typical' tracks tend to become stigmatised. In turn, stigma leads to degradation and low-quality education ... (Miller, Riessman, 1968, 105)

Inferior education results from low expectations by teachers, damaged self-esteem because of the stigma attached to lower tracks, poor peer models, dull subject matter, and ineffective and uninspired teaching in the lower track. (Schafer, Olexa, 1971, 12) The same argument has been made in Britain in a different terminology:

once allocated, the children tend to take on the characteristics expected of them and the forecasts of ability made at the point of streaming are ... self fulfilling. (J.Douglas, 1964, 114-5)

Stigma has been important in the development of services because people have believed it is important. This belief has affected the form that the services have taken. It is difficult to say whether the effect of this has always been to the good. It is uncertain, for example, whether the abandonment of special classes for slow learners, where it has happened, works to the benefit of the child. Dunn (1968) wrote, in an article that was influential in the US, that we cannot ignore the evidence that removing a handicapped (retarded) child from the regular grades for special education probably contributes significantly to his feelings of inferiority and problems of acceptance. (p.9) The benefit to the child of special education must be weighed against the value of a wider social contact, which is impossible to measure.

A second effect has been the acceptance of a system of insurance as the basis for social security, on the grounds that insurance is more acceptable than means-tested benefits. This choice is made at the expense of comprehensive coverage, because insurance benefits can only go to the people who contribute; alternatively, it can be argued that insurance does not always concentrate resources on those in the greatest need. Insurance may be the best form of social security, or it may not be; the question of stigma is crucial in determining the choice between policies.

Thirdly, and I think most important, the fear of stigma has encouraged a fairly rigid separation of social work and financial assistance, with only fairly limited exceptions (as a result of s.1 of the Children and Young Persons Act 1963). There is a case for separation: Handler (1973) has argued, in the US, that

Separating social services from public assistance not only removes the compulsion thought to be inimical to a sound casework relationship, but also allows for the opening of the door to the nonwelfare poor by removing the welfare stigma. (p.144)

I am not convinced this is true: social work in Britain is still confused with 'welfare', after a separation of more than thirty years. There are, on the other hand, advantages in allowing caseworkers financial powers: it enables them to deal with problems that have a financial basis. Conversely, it would be useful to social security officers to equip themselves with social work skills for those cases where the problem is not solely financial. The reform of certain agencies in the US provides a unique opportunity for comparison of separated and combined services. Piliavin and Gross (1977) found that under the circumstances of separation, recipients tend to reduce requests for services and to perceive social workers as

less helpful. (p.403) This is not altogether surprising; if caseworkers cannot give financial assistance, they are less helpful.

Stigma may be a myth; but, if it is, it is a powerful one, with important implications for social welfare. The measures taken to avoid it have had important consequences, and may conceivably have acted to the detriment of services.

### **Chapter 1: Summary**

'Stigma' has not been clearly defined. The word became a cliché in describing the effects of the Poor Law in Britain. Critics of the old Poor Law, who wanted to impose deterrent policies on the poor, argued that paupers had lost the sense of humiliation they had felt in previous years. The workhouse was not designed to maltreat paupers, but only to be austere; it was to deter by restoring a sense of shame. In practice, stigma became the principal method by which deterrence was maintained.

However, when the Poor Law was abolished, the stigma of welfare remained. Stigma is not simply a survival of the Poor Law, but a more basic problem underlying the working of the social services. Although its precise meaning is still unclear, it has been influential in the determination of policies, and it is important to understand its nature in order to establish whether these have been appropriate.

## Chapter 2

# THE EFFECT OF STIGMA ON SERVICES

Stigma is associated with two problems fundamental to social welfare. The first is the quality of service provided. The second, closely related to this, is its effect on the demand for services. Stigma has been represented as a form of rationing; under the Poor Law, it was used explicitly to hold down demand to a manageable level, and reduce the burden on the ratepayer. But this does not imply the best or most efficient use of resources to achieve the aims of the social services (if these aims are not merely to hold the cost of a service to a minimum), and the effect stigma is supposed to have on demand nullifies the efforts of the services to reach people in need.

### The quality of services

'Whatever the individual's needs and capacities', Holman argues, once defined as 'undeserving' or 'unworthy' they are awarded services inferior to others. (1973, 414)

This does not have to happen - people with venereal disease are not necessarily treated less well than others - but where it does, it arises in two main ways. Firstly, the attitudes of staff towards them are likely to be condemnatory, in part because the staff share the opinions of the rest of society, but also as a reflection of unpleasant experiences. Willis (1978), reviewing the literature, finds that

helpers' perceptions of a given target are considerably less favourable than lay persons' perceptions. (p.981)

He gives several reasons for this. The attitudes of helpers are coloured by practical problems; a person who makes their job more difficult is not likely to be appreciated. Helpers (like other people) prefer clients whose attitudes and characteristics are most like their own. This is not true of many stigmatised people. It is easier to remember cases where a client has done something unusual, which is often something bad. This is no less true because nuisances are time-consuming. Helpers tend to dislike clients who resist their influence. Lastly, helpers are inclined, like others, to look for faults in people's characters rather than their circumstances. Goffman (1961) adds a further reason. An institution runs by a logic of its own; the staff treat people, not as individuals, but in a way that is determined by their formal and informal roles. The stereotypes that staff members express are as much a justification of the situation as a cause of it (p.84).

Secondly, because stigmatised people are 'undeserving', they tend to lack the political influence that is needed to divert resources towards them. In cases where their stigma is morally reprehensible, as it may be, for example, in the case of unemployment, they may have resources diverted away from them; it is more likely, though, that they will simply be ignored.

Thirdly, within the context of the service, stigmatised people may be treated as inferior individuals. One of the most degrading features of the old people's homes described by Townsend (1963) was the lack of privacy the inmates were allowed - few personal possessions, inadequate places to put them in, and large, impersonal dormitories (chs. 13, 14). Morris (1969) found, in a survey of hospitals for mentally handicapped people, not only a lack of personal possessions and storage space, but lack of anywhere that was private - a proportion had toilets without doors, and others had them without partitions (pp.89ff). Institutions affect the behaviour and character of the residents. Goffman suggests, in Asylums, that much of the behaviour of people in mental institutions can be understood as a reaction to a situation where sanity seems to have been abandoned, rather than pathological madness (Goffman, 1961). And Barton (1959) describes one effect of institutional life as a

clinical syndrome, which he terms 'institutional neurosis'. Many residential institutions are insufficiently protected from these problems. The buildings are physically isolated, the staff - especially untrained staff, who are substantially in the majority - tend, for their own convenience, and because they are severely overburdened, to favour methods that facilitate the control of residents rather than their care, and the residents are not in a position to protest (see K.Jones et al, 1976).

The provision of services reflects an underlying attitude to the people who use social services. They are supposed not to care about the quality of service they receive. Privacy, personal possessions and consideration for personal needs are thought of as dispensable luxuries. The recipient is treated as something less than human, and this treatment both implies and encourages his degradation.

### **The demand for services**

The reactions of people to ill-treatment are complex. Masserman (1943), in an interesting if distasteful experiment, subjected cats to blasts of air in their faces, or electric shocks, while they were feeding (ch.4). The cats reacted very much as individuals. Some cats preferred to starve. Some waited until they were driven to feed by hunger. One cat paced up and down, refusing to eat. Two became passive and immobile at the time for feeding. One snarled when the signal for food was given. It is possible to recognise in the cats' behaviour some analogy with the beneficiaries of social services. But people are more complicated than cats. They can express their feelings; they are able to rationalise their behaviour; they can communicate their attitudes to each other. People cannot be expected to react in a simple or uniform way. Demand, as Parker notes (1967) depends on what people think about a service. This is affected by the experience of the previous generation, and whether or not they feel the service carries the stigma of social inadequacy, failure, or charity. (p.206)

This section tries to assess the implications of these feelings for demand.

#### *The failure of demand.*

The recipients of certain services do show a marked reluctance to claim. The Ministry of Pensions survey (1966) gave strong indications of unwillingness to claim benefit because of the shame or embarrassment that people felt. These feelings are evident in many subsequent studies. A survey in Coventry of over a thousand people found 281 eligible non-applicants for Supplementary Benefit (Coventry Social Services, 1973). Common reasons for not claiming were dislike of charity, humiliation, resentment of the means test, and the reinforcement of negative opinions by the attitudes of staff.

This reluctance is not confined to old people. Moss (1970), questioning 184 people in Liverpool, found that people were reluctant to apply because they preferred to be independent, they were afraid, in the case of education benefits, that their children would be jeered at by other children, they felt that there was too much 'red tape', or they had applied before and weren't prepared to be 'humiliated' again. In Ireland, Clifford (1975) found that 42% of his sample of 110 people confessed to shame or embarrassment when approaching Home Assistance, a state agency which gives residual income maintenance, or St. Vincent de Paul, a charitable institution (p.46). In the US, Stuart (1971) found between one and two thirds of a small sample of welfare recipients felt uncomfortable about making their application. This depended crucially on the type of benefit claimed (p.167). In another small survey, Horan and Austin (1974) found only 18 out of 48 people prepared to say that they never felt ashamed or bothered to be on welfare (p.652). Podell (1968), in a survey of 2179 mothers on Aid to Families with Dependent Children (AFDC), a form of residual income maintenance given to female single parents, found that 58% were bothered by being on welfare; 56% agreed that people on welfare feel ashamed (pp.31-33). Handler and Hollingsworth (1971) found that nearly half their sample of AFDC recipients were sometimes or often embarrassed to be with people not on AFDC (p.167).

The takeup of many benefits has been low. Official estimates suggest, for example, that one quarter of people eligible for Supplementary Benefit, and one half of those eligible for Family Income Supplement, fail to take them up (DHSS, 1981, 253). A number of explanations have been given for the failure of demand which this represents. In a survey in Islington, Meacher found both a marked ignorance about benefits, and a certain diffidence when it came to claiming; for example,

**Table 2.1: Knowledge of non-recipients about means-tested benefits (from Meacher, 1972, 22).**

	<b>% unaware of benefit</b>	<b>%unaware if eligible</b>	<b>% aware eligible but not claiming</b>
Free milk	45	10	13
Free prescriptions	67	5	12
Rate rebates	39	25	17
Free school meals	6	11	15

It is clear from these figures that ignorance has an important effect on demand; but it is not clear how far, if at all, the residual failure of demand is due to stigma rather than to other factors. There are a large number of other factors to consider. The Supplementary Benefits Commission (1978) attributed reluctance to

some mixture of pride, ignorance, a sense of stigma, reluctance to make the efforts which a claim calls for, a desire for self-sufficiency on the part of an individual or family, an unwillingness to become involved with a government agency and a feeling that the whole business is not worthwhile. (pp.7-8)

Klein (1975) suggests that stigma is an excuse for an explanation. It is the phlogiston of social theory: a label attached to an imperfectly understood phenomenon - when low take-up of means-tested benefits can be explained just as well, perhaps better, by the information costs involved, by the fact that expense in time, trouble and travel may outweigh the value of small benefits, and by the ability of some people to manage on a given amount of money better than others. (p.5)

Some impressive evidence for this contention comes from a study of the takeup of free school meals made in 1968, written up by Davies some years later (Davies, 1978). Davies' book is difficult to decipher; it fails to clarify the basis of its analysis, or to specify the numbers of people replying to particular questions. I have been fortunate to be given access to some of the results by Mike Reddin, who collaborated with Davies on the original survey, and it is on my analysis of those results that the following argument is largely based.

### *Stigma as myth*

There was little direct evidence in the school meals survey to show that stigma was important in affecting people's decisions to apply. "The major reasons for non-uptake in the English free school meals systems", Reddin writes,

were more evidently related to information than stigma. Stigmatising factors were identified extensively by survey respondents (mothers) as accounting for the lack of uptake of benefit by 'other people'. It was, however, only referred to by a small minority as affecting their own decisions. Thus stigma may be a piece of folklore: part of that popular mythology which avows work ethics that are not manifest, moralities that are not observed, hostilities that are not felt - and explanations of Their behaviour but never Ours. (1977, 67)

The same conclusion is reached by Davies (1978, ch.5), and on the face of it the figures certainly support this argument. Davies defined 'stigma' to include the attitudes of other

children and of teachers, a feeling of charity, a dislike of stating income, and a dislike of telling an employed that one was applying - a wide definition of the term (p.256). Of 226 people who did not receive free school meals, only 15 felt that 'stigma' affected their decision. 15 felt that there was no stigma at all. The remaining 196 said that stigma was felt by other people, not by themselves.

However, there are grounds on which to question this interpretation. Firstly, it is possible that an admission of stigma is itself stigmatising. People may be eager to deny that they feel any stigma. The parent of a mentally handicapped child claims,

I let everyone know we've got a daughter like it and that there is no stigma (Cooper, Henderson, 1973, 119) ;

the assertion seems to contradict itself. Tucker (1966) asked a man who lived on a council estate whether he felt any stigma, and received the reply:

Certainly not. Why should you say that? Do you think we've all got some terrible disease here? (p.35)

The same person continued to express the fear - irrationally, in view of his denial - that if there was any stigma, it might harm his daughter. The reason for denial is not difficult to establish: a person who complains of stigma is admitting to degradation, the contempt of others, a loss of social standing; it may be a truth he would rather avoid.

Secondly, it is widely accepted that statements about what 'other people' think are indications of the respondent's own opinions. For example, one technique for measuring attitudes, 'facet analysis', rests in part on a distinction between a person's behaviour ('personal interaction'), his beliefs about his behaviour ('hypothetical interaction'), and his perceptions of group attitudes (the 'norm') (Guttman, 1959). The perception of a group norm may be 'projection', which is simply a reflection of the subject's own values. Richardson and Naidoo (1978) interpret their results in this way. 83% of their sample thought that other people felt bad about being unemployed and on Supplementary Benefit, and 61% felt bad themselves. They suggest that the discrepancy (which is much smaller than in the school meals survey) probably conceals some true feelings.

Davies' figures show that people who pay for school meals, in particular, are more likely to attribute stigma to others than recipients are:

**Table 2.2: Attribution of stigma to others by users of school meals  
(from Davies, 1978, 82)**

	Payers agreeing	Recipients of free meals agreeing
Eligible families don't claim because of stigma	86	56
Other reasons	72	90

(Chi-square = 4.3, p<.05)

In the US, by contrast, Wyers found that users of different benefits consistently ascribe more stigma to other people than non-users do, although this is statistically significant only in the case of public assistance.



**Table 2.3: Attribution of stigma to others by users and non-users of public assistance, food stamps and free school meals (US) (from Wyers, 1975, 135)**

Those who agree that others feel stigma about:	Users (N=72)	Non-users (N=72)
Public assistance	49	34 (p<.05)
Food Stamps	52	41
Free school meals	41	29

The difference in results is, I think, explained by the difference in the questions. Davies is asking about claiming; Wyers, about shame and embarrassment in relation to the benefits. The people who have claimed may be embarrassed, but they have not been deterred. The results are consistent with the view that opinions about other people reflect the subject's own feelings; the claimants attribute embarrassment to others because they feel it themselves, but do not necessarily expect others to be deterred by it, because they were not. Conversely, it may be true that some payers have been deterred, and therefore more likely to attribute the same behaviour to others.

Thirdly, it can be argued that school meals are not typical of other benefits. The person who receives school meals is not the claimant, but the child, and this may mean that the claimant is less sensitive to the potential embarrassments of receiving benefits. Like Davies and Reddin, Wyers found a marked discrepancy in the numbers of people who said they felt stigma in relation to school meals and those who thought others felt stigma:

**Table 2.4 Stigma and school meals in the US. (from Wyers, 1975, 135)**

	Users (N=72)	Non-users (N=72)
Feel stigma	12	3
Others feel stigma	41	29

However, analysis of his figures shows a significant difference between the attitudes of non-users to school meals, food stamps and public assistance:

**Table 2.5: Feelings of stigma by non-users of certain benefits in the US. (from Wyers, 1975, 135)**

	Feel stigma	Feel no stigma
Public assistance	20	52
Food Stamps	16	56
Free school meals	3	69

Chi-square = 14.83, 2 d.f., p<.001. Chi-square is used as a test of goodness of fit, not of independence)

The attitudes of users are not significantly differentiated, although there still seems to be a tendency to attribute less stigma to free school meals:

**Table 2.6: Feelings of stigma by users of certain benefits in the US.**  
(from Wyers, 1975, 135)

	Feel stigma	Feel no stigma
Public assistance	18	54
Food Stamps	13	59
Free school meals	12	60
Chi-square = 1.8, 2 d.f., n.s.		

It is not possible to be certain that these results apply to conditions in Britain, but they do give some indication that it would be unwise to accept the apparent unimportance of stigma in the British survey on school meals as representative of attitudes to other benefits and services.

*Stigma, low take-up, and lack of information*

Davies found no shortage of evidence to suggest that the absence of information, taken together with mothers' inability to devote time and energy to coping with a complex system, was probably the most important factor causing the shortfall in uptake. (1978, 129) This does not exclude the possibility that stigma plays a part. A person who feels that benefits are stigmatising is not likely to make an effort to find out about them; it is possible that the ignorance of those who are eligible and not claiming is a consequence of their feelings about benefits. This argument cannot, without further research, be much more than a speculation, but there is some evidence to reinforce the idea. In an unpublished paper, Pinker (1973) recorded that people who were disabled seemed to know less often about registers than people of the same social class who were not disabled. The paper offers the tentative suggestion that illness leads to a denial process and avoidance of services suspected of being stigmatising. (p.36) Similar questions arise from a survey of disabled people which showed substantial confusion about registration of blindness. 2% of the sample believed they were registered as blind, and half of these actually were. 5% were registered (CCETSW, 1974, 48). So, 4% - four-fifths of the people on the register - said that they were not on it. Is this only confusion, or is there an element of denial in the answers?

These studies give at least some reason to look again at the evidence that ignorance causes low take-up. The survey of pensioners by the Ministry of Pensions and National Insurance found, even after people were told they were entitled to benefit, that a number still refused to claim (1966, 49). Moss (1970) found a small number of people who would not apply for benefits even if they were eligible: 22 people of 184 would not apply for school uniform, and 4 would not apply for Family Allowances (the former name for Child Benefit) (p.10). Age Concern (1974) found 341 old people out of 2700 who had not claimed Supplementary Benefit when they thought they were eligible or didn't know if they were (p.63). 23% of these did not want to claim because they considered the benefit to be charity; 11% were reluctant to reveal personal details; 30% more were vague about their reasons. Of the fifteen eligible people in Davies' and Reddin's survey who did not know about free school meals, it may have been that some would not have claimed even if they had known. The survey into school meals was done at a time when there was extensive publicity, and a 'personal' letter had been circulated from the Department of Education to every parent. The circular led to a substantial increase in take-up (Davies, 1978, 128-9). Illiteracy, mentioned as a problem by Davies, may account for the failure of some parents to respond. But the number of people who said they had not received information is high - a fifth of the whole sample and it seems quite possible that people were ignoring information they didn't want to know about.

*Attitudes and demand.*

There is no doubt that some people are reluctant to claim benefits and services, and that some feel embarrassed or ashamed on making an application for help. This is influenced by the attitudes of other people. The Ministry of Pensions survey, covering several thousand respondents, found large numbers unwilling to claim because of pride or dislike of charity; but proportions ranged from 19.7% of single males to 29.8% of couples (Ministry of Pensions, 1966, 42). The higher proportion of couples is an indication of the effect of one person's negative attitude on the spouse.

Bellin and Kriesberg (1967) examined why some people on low incomes applied for public housing in the US when others did not. Their sample was small - 75 out of 80 young families responded but it is possible to rearrange their figures to get some interesting results. The approval of relatives or friends was an important factor in deciding to apply.

**Table 2.7: The relationship of the approval of relatives and friends to application for public housing in the US (Bellin, Kreisberg, 1967).**

	Applied	Didn't apply
Relatives and friends:		
Approve	22	12
Disapprove	9	32
(Yates chi-square = 12.3, p<.001)		

Further analysis shows a relation between the interest that a person has in applying for rehousing and the decision to apply:

**Table 2.8: The relationship of interest in applying for public housing to application (Bellin, Kreisberg, 1967).**

	Interested	Not interested
Applied	26	5
Didn't	16	28
(Yates chi-square = 14.66, p<.001)		

This is hardly surprising. But what is most intriguing is the relation of a person's interest in applying with the attitudes of relatives and friends:

**Table 2.9: The relationship of the approval of relatives and friends to application for public housing in the US (Bellin, Kreisberg, 1967).**

	Interested	Not interested
Relatives and friends:		
Approve	30	4
Disapprove	12	29
(Yates chi-square = 23.893, p<.001)		

The expression of 'interest' itself seems to depend on the respondent's view of other people's opinions - which may be accurate, or may in turn depend on his own views. Whichever is true, it is clear that attitudes and opinions are important factors in the demand for public housing.

*The effect of stigma on demand.*

The pensioners in the 1966 survey were far more likely to explain their reluctance to claim as pride or dislike of charity than as dislike of the service: only 6.8% said they didn't want to claim because of their feelings about the National Assistance Board, compared with 29.8% who were too proud to claim or did not want to ask for charity (Ministry of Pensions, 1966, 42). However, once a claim has been made, it appears that the claimant's experience of the service becomes the crucial factor, and colours his memory of the initial application. For example, people who receive free school meals are more likely than non-recipients to agree that children don't receive free school meals because parents don't like to state their income:

**Table 2.10: Persons agreeing that people are reluctant to claim free school meals because they dislike stating their income.**

	Recipients	Non-recipients.
Agree	112	183
Disagree	37	120
(Yates chi-square = 8.97, p<.01)		

This implies both that recipients did not like to state their income, and that they did so. On the other hand, non-recipients are far more likely to agree that people were put off because the application was too complicated - a view which recipients, if they ever shared it, seem to have forgotten.

**Table 2.11: Persons agreeing that people are reluctant to claim school meals because the application is too complicated.**

	Recipients	Non-recipients
Children not receiving because:		
Application too complicated	43	153
Not for this reason	106	149
(Yates chi-square = 18.43, p<.001)		

Klein seems to be justified in saying that the trouble it takes to apply is an important reasons for not claiming. But it is less important than dislike of the means test:

**Table 2.12: Non-recipient's reactions to statements that children don't receive free school meals because of either a dislike of stating income, or because the application is too complicated.**

	Dislike of stating income	Application too complicated
Agree	183	153
Disagree	120	149

(Yates chi-square = 5.42,  $p < .05$ . Chi-square is again used as a test of goodness of fit.)

I have already reviewed some of the evidence which suggests that shame, embarrassment and dislike of benefits are felt by many welfare recipients. These results do not contradict that evidence, but they emphasise that people who feel embarrassed are not necessarily deterred from claiming. For the most part, these studies concentrate on people who are in receipt of benefit. One old woman told Glennerster that, when she claimed,

I felt awful going to post it, and when I put it in the letterbox I felt as if I had signed my death-warrant (1962, 7).

Another recipient was

afraid of someone coming in and seeing me that I knew. Degrading. (Stevenson, 1973, 29)

But they still applied. Richardson and Naidoo (1978) found that, of the 61% of claimants who 'felt bad', 31% were more ashamed to be unemployed than they were to be in receipt of benefit. The 37% who had been reluctant to claim had, of course, claimed anyway; they would not otherwise have been included in the survey (p.26).

Weisbrod (1970) argues that the decision to claim a service balances the benefit of receiving help against the costs of claiming a service, which include the stigma associated with it. If a person is already stigmatised, a little more matters less than it would to someone who is not stigmatised at all:

the marginal stigma costs associated with accepting welfare or other aid may be negligible even if the total stigma costs of being poor and accepting other types of poverty aid are substantial. (p.7)

By this model, stigma is not so much a barrier to access as a price one has to pay. The price may be acceptable to some and not to others. This implies that stigma may be a problem for applicants, and yet have only a limited effect on the demand for services. Stigma may, then, be a more widespread problem than it appears at first. Firstly, even if stigma does not deter claims, it can have an effect on the claimant's attitude to services. Pomeroy et al (1970) found, in research in New York, that people who were less willing to ask for help also had more negative attitudes to the services, and were less willing to talk about their circumstances with their caseworker (pp.21-2). Secondly, the cost in stigma which recipients are forced to pay may be inconsistent with the functions of a service, if these are intended to produce a benefit for the people they serve. Although stigma seems to deter only a minority of claimants from applying, its implications extend far beyond that.

## Chapter 2: Summary

Stigma affects both the quality of services, by affecting the attitudes of providers and the provision made, and the demand for services, which has been an area on which much research has been concentrated. It has been argued that stigma is a myth, that low take-up is due to other factors, but the evidence for this is open to differing interpretations. There is some reason to believe that embarrassment is felt by more people than are deterred from

claiming, and that stigma should be taken into account as a cost imposed on people who use services.

## Chapter 3

### STIGMA AND THE SOCIAL SERVICES

'Stigma' refers to many things. A service is stigmatising when it degrades the recipient, or undermines his dignity; when it embarrasses or humiliates him, and makes him feel guilty or ashamed; when it deters him, or makes him hesitate to seek help; when it deprives him of rights, or treats him with contempt; when it marks him out from others, or identifies him as someone who is socially rejected.

At the same time, the social services are also described as 'stigmatised', as if it was the service itself which was tainted. It is possible to talk, for example, about a council estate with a "bad reputation" (Griffiths, 1975, 10); Supplementary Benefits, Denistone writes, are in danger of becoming "a stigmatised second-class service for stigmatised second class citizens. (1976, 358) " It is fairly common to talk about a stigma in a way that makes it uncertain whether the stigma is a part of the service, or something the service inflicts on its beneficiaries. It has been said that stigma "surrounds the occupation of a council house" (NALGO, undated, 10). Council estates (Griffiths, 1975, 10), the personal social services (Jordan, 1974, 179), or public wards in US hospitals (Duff, Hollings head, 1968, 155) have all been said to "carry" a stigma. In schools, stigma is "attached to the lower tracks" (Schafer, Olexa, 1971, 12). In practice, 'stigma' and 'stigmatising' are used interchangeably. It is difficult to imagine a service that could be one without the other; Armstrong (1975) comments, for example, that the reputation of an estate "undoubtedly results in the population itself feeling stigmatised" (p.21), a pattern which is reflected in other services.

There are many reasons why a service can be described as stigmatised. It is impossible to discuss these problems without referring to specific programmes; I intend, as a basis for analysis, to outline the contexts in which stigma is attributable to different services, and subsequently to look at some of the explanations that are commonly given for stigmatization.

#### Stigmatised services

As a general proposition, housing, social work and social security are stigmatised, and health and education are not. But the services are diffuse, performing different functions in many cases; generalisations like this are difficult to maintain. The division breaks down when it is examined in more detail; reactions to individual services are not uniform.

#### *Housing*

"All council estates", according to Griffiths (1975, 10), "carry a social stigma". Stigma is not confined to council estates. Spencer (1964) describes the same process in a private estate, and Schifferes (1978) writes that in Ireland, private rented housing is stigmatising - but it is often associated with them (p.179). Stigmatised estates are distinguished by a reputation which attaches to the people who live in them, sometimes (though not by any means always) coinciding with poor physical conditions and high indices of social deprivation. But, as one Social Services officer commented to Griffiths (1975), "It's mainly the stigma that comes through, not the actual problems." (p.36) Corina (1976) comments,

It seems that some residents are acutely conscious (one tenant used the word 'ashamed') of being given a tenancy which is tantamount to a housing 'caste mark'.  
(p.44)

On the other hand, some council estates are highly desirable and much sought after. I worked in a housing department where many owner-occupiers applied for council housing because it was superior to their own. Huttman (1969) argues that, if council housing was really stigmatised, there would be a lowering of the social class of occupants, more reluctance to apply, shorter waiting lists, a high turnover of tenants, people wouldn't go out of their way

to get a council house, and adult children would try to move away from the estates. It would be more difficult to find sites for council housing, particularly in the outlying suburbs; property developers would not mix their private buildings with council estates; and there would be more consideration of the alternatives to council housing. She suggests that these things are not, in general, true of Britain in the way they are in the US, and this leads her to believe that there is not a severe stigma on council housing (ch.9). However, there are certain estates which do have a high turnover of tenants, which are not accepted willingly by applicants for council housing, which are regarded with suspicion by owners and other council tenants alike. These are the 'ghetto' or 'sink' estates which are the worst kind of council housing (see Corina, 1976); they are clearly stigmatised.

There are also specific provisions which are stigmatised. Cox (1971) refers to the 'stigma of homelessness' attached to large units intended to provide for homeless families (p.19); Huttman (1969) refers to the closure of units in Lewisham "because of the workhouse image and stigma that they created" (pp.310-311). A report by BASW in Kent complains of the "stigma-inducing treatment" to which homeless families are subjected, "even if this amounts to no more than being dealt with by a social worker" - which says something about the reputation of social work - "but which usually includes admission to temporary accommodation of some kind" (BASW, 1974, 57-8).

Provision for housing may be made in cash rather than in kind, a distinction which the French refer to as 'aide à la personne' rather than 'aide à la pierre'. Rent rebates and allowances, which are payments to tenants on low incomes, may be stigmatising (Taylor-Gooby, 1976); on the other hand, there is no evidence to suggest that this is true of other financial assistance with housing - tax relief to owner-occupiers, option mortgages (in which the government subsidises the interest payments), the purchase of council houses at a discount, improvement grants or assistance to first-time buyers.

In housing, therefore, some services are stigmatising, and others are not. The type of service provided - whether financial or material - does not seem to make the difference. It is not immediately clear what does.

### *Personal social services*

In the personal social services, the position is just as confusing. Like housing, these services are generally assumed to be stigmatising: "the personal social services", Jordan writes, "always carry a stigma" (1974, 179). Holman (1974) argues that intensive casework treatment publicly marks 'inadequate' clients as 'problem families' (p.610). Shenton (1976) comments that Agencies such as social services ... add to the stigma of an area by their very presence. (p.31).

Glastonbury et al (1973) found that 302 of their sample believed social work departments to be for the 'lazy and feckless' (p.194). And Rees (1975) reports that, in a survey he conducted, the only respondents who denied feeling some sense of shame or guilt at being referred to a social worker were either those few who had been in contact with social security officials for years and had resigned themselves to the situation, or those who had sought advice and help with difficulties - such as applications to become adoptive parents, or aids to the disabled - which did not reflect on their position in the social structure. (pp.65-6)

The functions of local authority social services departments are complex, and it is difficult to draw dividing lines between a social worker's fields of activity. Having said that, it seems fair to say, in the absence of statements to the contrary, that aids for the disabled, fostering and adoption do not seem to be stigmatised. There are, conversely, other provisions which are stigmatising. The reception of children into care, with its attendant implications of neglect, abuse or criminality, can be seen as a stigmatising function, primarily but not exclusively of parents. Social workers are still in part responsible for the compulsory detention of mentally ill people, an action which labels a person formally, deprives him of certain rights, and discredits him socially. Local authority social services administer old people's homes, which



I have already commented on. And lastly, the department is responsible for maintaining a register of disabled people, which is not well regarded. As one writer put it,

However much the caring services deny it, there is a stigma - or a special look in the visitor's eye - when your name is on file. At least one local authority runs a register of disabled people who don't want to be included on a register of the disabled. (New Society, 1978, 3)

Again, the pattern is diverse, and there is no evident rationale in the attribution of stigma to services. In part, this is the result of a collection of tenuously related responsibilities into one administrative department; but it also reflects the subtle distinctions made between different provisions in different groups.

### *Social security*

In the study of social security, the problems of stigma have been more thoroughly discussed and analysed than in other fields. Traditionally, a distinction is made between benefits which are means-tested and those which are not. Meacher (1972), for example, describes among old people "A proud sense of self-respect which saw the receipt of means tested benefits ... as a stigma." (p.40) The means test is believed to be, and often is, demeaning. But there are exceptions: Pinker (1971) points out that grants for educational purposes are not stigmatising (pp.170-1), and Blaxter (1974) found that, where means tested benefits were used for the purpose of providing health care, they were accepted by the recipients without embarrassment. They felt quite differently about 'welfare'. By contrast, benefits which are not means tested may still be stigmatising. Lynes (1979) suggests that

One explanation of the low takeup of the child benefits premium (which is paid to single parents in addition to the basic, universal allowance) may be that a benefit payable only to lone parents carries a stigma even if it is not means tested.

The current take-up of this benefit is about 60% (personal communication from the DHSS, 1980). It is difficult to evaluate this figure, for three reasons: single mothers on Supplementary Benefit have nothing to gain by claiming it; being a fairly recent introduction, some ignorance can be expected; and it is paid nominally as part of Child Benefit, which has relatively little stigma attached to it.

Attitudes to National Insurance benefits are also difficult to assess. I wrote to the DHSS to ask for figures about take-up, only to be told that there weren't any, because there was no reason to suppose that there was any problem. The extent of ignorance alone makes this arguable; but I also feel that the assumption there is no stigma is open to question. In Denmark, according to Kai Westergaard (who was Director-General of the Ministry of Labour there), people on unemployment benefit are well provided for in comparison to their British counterparts - they receive more than three-quarters of the average wage in benefit but there is a strong social sanction attached to unemployment, and people are ashamed to admit it (Westergaard, 1979). In the UK in May 1980, some three hundred thousand people were unemployed but not registered as unemployed, and therefore not claiming benefit (Employment Gazette, 1980). Many of these were looking for part time work, and others would be married women who believe (rightly or wrongly) that they were not entitled to benefit, but it would be surprising to discover that no-one had failed to register because of pride or embarrassment. One man told Townsend his reason for not registering:

Always being at work I've had a fear of these places. It seems as if you're trying to beg for something. (Townsend, 1979, 598)

The analysis of these problems has been hampered by the uncritical acceptance of a received wisdom, which has caused administrators and researchers to ignore the stigmatising potential of benefits that are not means tested. In reality, the stigmatising effects of social security provision are no less complex than those of other services.

### *Health services*

Certain functions of the health services are stigmatised because of the reaction to the conditions they treat. VD has been argued to be morally stigmatised, with the effect that the provision made for VD patients is below standard:

With few exceptions, the clinics' premises are physically unattractive, congested and uncongenial (Singha, Donnan, 1980, 151)

This criticism, which I think is an isolated one, may be interpreting the quality of provision in the light of attitudes to V.D.. The same complaint could be made of many other forms of health care, for conditions which are not morally reprehensible. More important is the possible effect of stigma on the use of services. Alcoholism is another disease with negative connotations.

While more people with drink problems were coming forward to seek help ... many suffered in solitude, either because they did not know where to go for help or because they were afraid of the stigma. (Shore, 1981)

Mental illness has powerful implications for the patient. "You mention St. Elizabeth's", one woman said about a mental institution, "and they throw up their hands in holy terror." (Yarrow et al, 1955, 34) The institution itself has the power to stigmatise: an article by Phillips (1963) shows how the rejection of mentally ill people tends to be greater when medical help is sought, or a person goes to mental hospital. The effect may be to deter people from seeking help.

Within these limitations, it is commonly accepted that the British health service is not stigmatising - a view which is supported by the attitude to financial provisions for 'health' described by Blaxter. Mechanic (1974) asserts that health care

can foster dependency or encourage self-reliance. It can respect and enhance the dignity of persons or contribute towards stigmatizing and humiliating them. (p.12)

The National Health Service appears to have avoided the problems which occur in other countries. It has sought to provide equal standards of care for all - in contrast to the US, where public wards (Duff, Hollings head, 1968) and clinics (Stoeckle, 1975) represent a different standard of treatment for the poor. Duff and Hollings head describe the aversion of patients to the ward:

Admission to the wards was not easy and it was not accepted willingly by those who could avoid it. (p.117)

In some (admittedly limited) circumstances, the provision for poor people in Britain is different in kind from the service received by others. NHS spectacle frames, Simpson (1978) records,

were frequently rejected as carrying with them a social stigma. 'I may be poor but I don't want to look poor'. (p.42)

(The range of NHS spectacles is not extended for fear of discouraging opticians from providing NHS treatment: Simpson, 1978, 55) In another case, the Campaign for the Homeless and Rootless comments that single homeless people find it difficult to get medical care:

The mobility and stigmatisation of the homeless poor reduce their chances of registering with a general practitioner. (cited Beacock, 1979, 130)

It is surprising that the Health Service appears to have none of the taint of other services. Unlike housing, the health service was administered under the Poor Law, but it seems to be altogether dissociated from it - in contrast to the position in Ireland, where the removal of the health services from the control of the county councils in 1970 was intended, among other things, "to take away the stigma of the poor-law system." (Stephen, 1979, 97) In Britain, the infirmaries were administered under the Poor Law until 1930. A disabled person, writing in 1926, complained about the degrading practices of these institutions:

A man who goes into the Infirmary has all his clothes searched to start with; he is cross-questioned as to his past ... His relatives, if he has any, are written to and asked to contribute for his maintenance. In an ordinary hospital they are content with just your medical history, and if you cannot pay anything no steps are taken. That is the difference between the two. (Cripples' Journal, 1926, 291)

The aversion to this form of health care is assumed to have disappeared without trace. Cartwright, in a survey published in 1964, found a possible exception: a private patient told her,

I thought, of course, it's a terrific amount of money for working people, but if it's the last halfpenny I have I'm not going into the Infirmary. (p.199)

His reluctance to go there may have been because of its associations with pauperism; on the other hand, it may be that he thought the Infirmary in question was just a bad hospital. The same ambiguity exists in the behaviour of many private patients: do they believe they will get better treatment?<sup>9</sup> or do they think that it is wrong to accept a free service?

These instances, although they are limited, do give some reason to question the general assumption that health care is not stigmatising. Cartwright (1964) found, for example, that delays in seeking medical care were often caused by the reluctance of patients to approach the doctor. "We're not a family for bothering the doctor." (p.14) Research for the Royal Commission on the NHS remarks on a similar reaction. One patient said, "... I don't like to go unless it's something bad." (Simpson, 1978, 19) An old person commented,

I don't like bothering the doctor with simple things. My wife has rheumatism, but doesn't bother the doctor about it. (Ibid, 19-20)

These statements can be taken in many ways: they are generally regarded as deference to busy doctors, but they might conceivably be taken as an assertion of independence, of the sort made by pensioners in the 1966 study of National Assistance. If people said this sort of thing about social security - 'I don't really need it', 'I don't like to bother them' - it would be interpreted as a feeling of stigma.

There are other reasons for reluctance to visit the doctor besides deference. A patient has been put off by the doctor on his last visit; "the receptionists are off-putting ... they think you make things up, you exaggerate"; "there's always a problem and I just can't put up with a fight every time I go there" (Simpson, 1978, 22). This, again, can be compared with a feature of the social security system - the reluctance of people to claim benefit after they have been refused once. There seems to be an active deterrence of 'malingering'; many doctors consider that consultations are made for trivial, inappropriate or unnecessary reasons. Papper (1970), writing in the US, describes the features of the 'undesirable' patient in a way that seems to be equally applicable in Britain. The undesirable patient is alcoholic, aged, dirty, uneducated, or very poor; he is ungrateful, wants to know too much, or already knows too much; he is not ill, or has an illness which the doctor thought he didn't have, or he does not respond to the correct treatment; and he comes late to appointments. A patient with these features is unlikely to be well received anywhere.

In health care, as in other fields, the social services have a potential to stigmatise which seems to have been underestimated. I do not want to say that health care in Britain is stigmatising to the same extent or in the same way as social security; I think that would be unfair. But there does seem to be a process similar to what is called 'stigmatisation' in other services. The fact that it has not been described in these terms says something about the received wisdom of social administration in Britain.

### *Education*

Education is another service which is not apparently stigmatised. Schools are institutions which are acceptable to the community, in contrast to other social agencies which may be stigmatised. (Smith, Smith, 1974, 189)

But here, as in the health service, there are exceptions to be made. In the US, it has been argued that 'streaming' in schools is stigmatising, because it degrades certain pupils in the lower streams (Pink, Sweeney, 1978, 374). Jensen criticises minimum competency tests for high school graduation:

It appears to me to be an unnecessary stigmatising practice with absolutely no redeeming benefits to individual pupils or to society. (cited Cookson, 1980)

Lynn (1969), writing in Britain, talks about "the stigma of having failed the eleven plus" (p.295). These uses seem to be founded in the view that a person is stigmatised if he is treated as an inferior, which is a weak interpretation of the idea.

There is more force in the argument that special classes for the mentally retarded are stigmatised. Jones asked teachers about the reactions of pupils to the classes: more than four-fifths were aware of pupils being ashamed of being in a class for 'slow learners' in junior or senior high schools (RL Jones, 1972, 562). I have already mentioned the dilemma this creates for policy. Similarly, boarding schools for disadvantaged children may be stigmatising, because in their attempt to provide special facilities they also mark the children out from others.

'Residential care' is the posh word for a situation of stigma and shame. (M.Miles, cited St.John-Brooks, 1980)

A further source of stigma in education lies in the links of certain schools with deprived areas. "No education authority", Freeman argues (1979),

however inspired or resourceful, could have escaped from some of the stigma which inner city dereliction imparts to the public services.

Berg (1968) describes how parents from a 'respectable' school objected to a move to a disreputable one:

It was a bad district, and they did not want their children to inherit the stigma. (p.196)

The Plowden report (Central Advisory Council for Education (England), 1967) called for 'positive discrimination' in favour of schools suffering from the conditions of greatest deprivation. This led to the creation of 'Educational Priority Areas' (EPA's). The reaction to this provision was not universally favourable. Anne Corbett (1968) wrote that

There is wide support for the view that to be classified as an EPA is a slur. 'It sounds more like Poor Law charity than an opportunity for innovation', said one teacher.

Many (local education authorities) seem to agree. There is at least one which is going all out not to get designated. (p.787)

Acland (1971), similarly, suggests that the classification of EPA's is based on a distinction between 'good' and 'bad' schools.

'Good' and 'bad' schools are distinguished by their reputations rather than their educational merits. A 'bad' school may be an excellent teaching establishment with a bad image: Berg (1968) argues that Rivington, in Islington, was a school of this sort. There are schools to which parents are reluctant to send their children, which teachers are reluctant to work in, and which give the child a bad name in the local community. A teacher in a priority school described to me the problems the school had in recruiting teachers, and the reactions of other people who assumed that no competent teacher would choose to work in such a school. Berg, in her case study, shows that parents can be deterred from putting their children in a secondary school by administrators, teachers and the head of a child's primary school (1968, 162-3). It does not seem unduly forced to call these schools 'stigmatised'.

### **The reasons for stigmatisation**

In every branch of the social services, some provisions are stigmatising and others are not; but the reasons for the pattern of stigmatisation are not immediately clear. Council estates, means-tested benefits, mental institutions, registers for the disabled and priority schools have little in common that would explain why they should be thought of as stigmatising. A number of arguments have been put forward to identify the factors in the services which lead to stigma.

#### *Degrading treatment*

One of the principal explanations is the ill-treatment which is a continuing feature of contact with the social services. Hilary Rose (1975) remarks, acidly, that

The 'gift relationship' which exists in Supplementary Benefit is one of an exchange of public cash for personal humiliation ... (p.152) and that to succeed in a Supplementary Benefit Appeal Tribunal, the applicant must adopt a suppliant role, like a medieval leper exhibiting his sores. (Ibid, p152)

As a representative at these tribunals, I have watched people in these tribunals hold out articles of clothing for examination, interrogated as to their moral worthiness, or faced with queries about their sex life. Rose calls them "rituals of degradation"; the term seems to me entirely appropriate. (The law governing these tribunals has recently been reformed. It remains to be seen what effect the reform will have.)

A common reason for not claiming benefits is the reaction of people who refuse to be 'humiliated' again. It may be that they are being oversensitive to an impersonal process which, in times of stress, they see as hostile. But their comments tend to be a little stronger.

They make you feel like dirt. (Wyers, 1975, 138)

If I could be treated like something other than an animal. (Ibid, 139)

They treat you as though you were muck. (Richardson, Naidoo, 1978, 28)

Stuart (1975) found significant correlations between feelings of stigma, the opinions that a service was inadequate, and perceptions of favouritism in the operation of a service: which, he thinks, suggests that feelings of stigma are associated with negative perceptions of how one is treated. (p.85)

The relationship is unsurprising: inferior treatment implies a loss of esteem, or contempt, which is bound up with the idea of stigma.

One example of the process of degradation is the treatment of people in residential institutions. Another is the treatment of people on 'welfare' - residual income maintenance. Briggs and Rees (1980) comment that

In most respects, the evidence we collected did not support the view that transactions with supplementary benefit officers would be felt to be unpleasant or stigmatising.

Some experiences regarded by claimants as humiliating were recounted to us, but they were not very common. Spontaneous favourable comments about the last interview and the manners and helpfulness of officers greatly outnumbered unfavourable ones. (p.73)

At the same time, there is a striking difference in their figures between the expression of general difficulties by pensioners and those of other groups. For example, only seven pensioners out of 285 complained about officials, in contrast to 61 unemployed people out of 395. This may reflect preferential treatment, a reluctance to complain by pensioners, a willingness to complain among unemployed people, or simply a reaction to the differences in the operation of the scheme for pensioners and unemployed people; it is difficult to know which. Whatever the explanation, their impression of attitudes is not easily reconciled with the views expressed by others quoted above.

Coser (1965), writing in the US, identifies three types of treatment which he considers particularly degrading: the denial of privacy, intrusion into their home, and the limits on freedom to choose how to spend their money (p.145). The intrusion on privacy may be substantial: a welfare recipient does not have the right to keep personal information to himself. Obviously, the agency must have some information to work on. A number of welfare recipients told Handler and Hollingsworth (1971) that their financial affairs were none of the agency's business, which is a surprising view to take about a means-tested benefit (p.83). But other resentments seem legitimate; a similar proportion said they were bothered 'much' or 'moderately' by caseworkers discussing their social life (p.113). Some social services - in particular, social work and medicine - put a strong emphasis on confidentiality. It is a widely held principle, but not a universal one. The Jenner Amendment in the US, passed in 1951, opened welfare rolls to public scrutiny in the hope of checking welfare abuse (Cohen, Berman, 1952); but it is something of an exception. It is more common to find a lack of care taken with confidential information. I have heard receptionists in social security and housing offices broadcast details about a person's claim across a crowded waiting room. This shows a certain insensitivity to a recipient's feelings, rather than a specific loss of esteem - although of course, insensitivity could be taken as an indication of the recipient's loss of status.

Intrusion on the home is, similarly, a mark of lowered status. Handicapped people complained, during a CCETSW survey, that they were visited without notice by helpers who did not identify themselves or their purposes in calling on them. (CCETSW, 1974, 15)

Their resentment is a reaction to a practice which is demeaning, rather than degrading; the behaviour of the officials is a mark of the same insensitivity to a person's feelings. In the local authority where I worked, the housing investigators refused to make appointments to visit people. They reasoned, firstly, that people would clean up before they arrived, which would make it difficult to assess their standard of housekeeping; and secondly, that it was essential not to make appointments so that they could catch people out who were not living where they said. This indicates an attitude towards clients, which, although it is not hostile towards them, does not recognise a need for civility.

Handler and Hollingsworth (1971) remark that it is disturbing how few people are bothered by unannounced visits from welfare investigators (p.172). The practice has been challenged in the US courts; the Constitution offers protection to citizens against searches, and a group of mothers on AFDC complained of "unreasonable searches, harassing surveillance, eavesdropping and interrogation concerning their sexual activities". The court held that a welfare recipient had a perfect right to refuse entry to an investigator - but she could hardly complain if, when she did, she was cut off the welfare rolls (Piven, Cloward, 1971, 166-7). Offensive intrusions have also been known in Britain: the work of social security investigators chasing cohabitation has gained a certain notoriety. Julian Fulbrook has told me of the time he questioned a visiting officer at a tribunal how he could make with such confidence the assertion that a couple were sleeping together. The officer replied that he had climbed a gable below their bedroom and looked in. It is worth noting that intrusion into a person's home is nevertheless less degrading than removal from it - a point which Goffman shows is particularly important for people who become mental patients (1961, 130ff), but which is clearly just as important for old people forced to go into a 'home'. It is an additional problem in relation to institutional care.

The third factor Coser remarked on was the lack of freedom people had to choose how to spend their money. In certain cantons of Switzerland, for example, a person in receipt of assistance is not allowed to enter a bar (Sales, in ICSW, 1969, 150). Sarbin (1970) writes that to degrade an individual's social identity, one need only remove from him the opportunity to enact roles that have elements of choice. (p.41)

A person who is not free to spend is not a full member of society. This is the substance of the reaction against relief in kind, or against payment tied to particular purposes, like food vouchers (see Orlik, 1978). Stuart (1971), however, found on the basis of a small sample that marginally less stigma was attached to food stamps in the US than to public assistance (p.183). This is perhaps because food stamps are less significant in limiting a person's total range of activities than public assistance is. A person who is stigmatised also finds it more difficult to take part in normal economic transactions. Griffiths (1975) describes how people living on a stigmatised council estate were unable to get goods on credit, get newspapers delivered, or get a taxi to come to the area (p.37).

The limitations on a person's freedom of choice may go beyond economic matters, not least because the social services themselves, which work on criteria outside the economic market, are not always geared to give someone a choice. Preferences are, nominally, taken into account in the allocation of council housing; but mobility between areas is not provided for, and if someone is deemed to be 'adequately' housed, he has little hope of a transfer. It is probably putting it too strongly to say that these things are stigmatising in themselves. Denial of privacy, intrusion into one's home, or a lack of choice are important, as they imply a lack of status; but this is not necessarily the same thing as stigma. They complement the process of stigmatisation, and probably form a part of it, but they do not account for it.

### *Loss of rights*

A second explanation is based in the loss of rights which a person experiences by claiming social services. Julia Parker (1975) refers to stigma as a "denial of citizenship" (p.146).

Citizenship is composed, not only of formal rights, but of informal ones

the notion of citizenship postulates that similar respect be accorded to those who are dependent and poor. (Ibid, 146)

Rights and respect are bound up with each other. A loss of formal rights is a mark of disrespect; the person who loses them ceases to be regarded as a proper person. The most obvious case of legal disability in the social services is the treatment of people committed to mental hospitals. Goffman (1961) refers to the process as "civil death" (p.25). A recent British government document suggests that the removal of legal disabilities

would be a significant step towards removing any stigma associated with admission to a mental illness or mental handicap hospital. (Cmnd. 7320, 1978, 2)

The establishment of rights has been a major element in the protection of vulnerable and dependent groups. In the US, old people have a decalogue of rights (Bergman, in ICSW, 1969, 430). In a legal case in the same country, Wyatt v. Stickney, it was decided that a psychiatric patient has a constitutional right to, amongst other things, a comfortable bed, adequate meals, and a television set in the day room (cited Sutherland, 1976, 225). In England and Wales, disabled people have been given rights - by virtue of duties placed on others - to certain facilities, like telephones, under the 1970 Chronically Sick and Disabled Persons Act. These duties are subject to administrative discretion, and are not perhaps to be taken as real obligations. Homeless families have a right to temporary accommodation, and perhaps permanent accommodation (which the local authority has a duty to 'secure the provision of') under the Housing (Homeless Persons) Act 1977. The rights under this Act are residual; they do not apply to all citizens, but only to people who find themselves without an alternative. They do not imply a right to a home.

These things go beyond the rights of a normal citizen; but they cannot be taken as evidence that mental patients, old people, disabled people or homeless families have been fully restored to citizenship. They seem, rather, to respond to the disadvantages of these groups. There is no reason to suppose that these laws have overcome any stigma attached to these people; legal reform may be a necessary step, but it is not a sufficient one.

### *Entitlement and charity*

There are services to which a person is entitled, and others which are given on a discretionary basis, comparable to 'charity'. Blaxter (1974) suggests that this distinguishes 'health' and 'welfare' services, at least in the public mind:

'Health' was a basic universal entitlement: medical services were seen as a 'right'. (pp.47-8)

Welfare, on the other hand, is paid not by right but by need. It is, in consequence, less acceptable.

'Dislike of charity' is a recurring theme in surveys which identify feelings of stigma. The 1966 survey of pensioners classified 'pride' and 'dislike of charity' together (Ministry of Pensions, 1966, 4Z, 44-6); so does Taylor-Gooby (1976), in a study of the take-up of rent benefits (p.44-5). But Clifford (1975), in his survey in Ireland, separated the factors, and found an interesting variation in people's reasons for reluctance to claim from Unemployment Assistance (a means-tested benefit for unemployed people), Home Assistance (a means-tested residual benefit), and St.Vincent de Paul (a charity). Pride and independence featured strongly in reasons for not taking the state benefits, but less strongly in reaction to the charity. Shame and embarrassment were less pronounced in reaction to Home Assistance than they were to either the charity or Unemployment Assistance. Similar attitudes can be found elsewhere. Stuart (1975), testing people's feelings about various means-tested benefits in the US, found no discernible relationship between the opinion that a benefit was 'charity' and the stigma that a respondent felt was attached to it (p.86). One unemployed man told Briggs and Rees (1980) that

there is a certain stigma attached to crawling to the state for money that is a right (p.151)

- which indicates both that he considered it a right, and that he thought it stigmatising. A similar conclusion is indicated by the failure of the 1966 Ministry of Social Security Act to eradicate the stigma attaching to Supplementary Benefit (Atkinson, 1969, 58ff). Entitlement is not enough.

### *Labelling*

Further explanations rest in the way a service affects the relations of the individual to society. One example of this is the problem of labelling. The recipient of social services is identified as a different kind of person through his contact with the services. The services have a tendency, in common with any bureaucratic structure, to rationalise their activities by the classification of their clients. A label, in this sense, can be seen as a stigma - a mark of shame that the recipient is forced to bear.

Proponents of 'labelling theory' - better described as the 'labelling perspective' - argue that labelling is the critical act in the process distinguishing a person from the rest of society. The definitions imposed by social agencies become a part of that person's social identity. Holman (1974) argues, for example, that Problem families are not separate from the rest of society ... What most distinguishes them is to have been designated a problem family by a social agency. (p.609) According to Szasz (1971),

Individuals categorised as mentally ill labour under the handicap of a stigma imposed on them by the State through Institutional Psychiatry. (p.207)

Shoham (1970) writes that "name-calling, defining, tagging is not stimulating reality; it is reality itself." (p.130)

This is true in so far as the label defines the situation of the labelled person, and changes the opinions and actions of other people towards him; but it is only a half-truth at best. Many people are labelled as a result of receiving benefits - like 'pensioners' - who do not seem to be stigmatised because of it. And, even in those cases where the recipient is stigmatised, labelling does not account for all the rejection he experiences. Phillips (1966) found that the fact a normal individual had been in mental hospital would cause substantial rejection by other people, which can be seen as evidence of the importance of categorisation in forming people's opinions; but he also found that rejection increased with disturbing behaviour (p.761). Blizard (1971) disputes the finding that the source of help makes a difference to attitudes, and attributes rejection entirely to behaviour. This is probably too extreme: Nunally (1961) shows that the label conveys an expectation of certain types of behaviour, and the knowledge that someone has been in mental hospital creates uncertainty about his behaviour. Pollack et al (1976) found that the application of the label to a videotape of a person's behaviour made no difference to their subjects' response to the tape. Kirk (1974) found the same thing using short verbal descriptions rather than a visual image. Segal (1978), in a review of the literature on attitudes towards mental illness, concludes that

The behaviour itself, or the pattern of behaviour, is the major determinant of the positive or negative character of the public's attitudes towards mental illness. (p.213)

Nunally (1961), putting the case a little more strongly, says that

People would be no less afraid of a lion if we hung a sign around its neck saying 'pussycat'. (p. 148)

The label can have a detrimental effect. Denzin and Spitzer (1966) note that the formal legal status of a mental patient makes the attitudes of staff towards him more negative, and this can act to his disadvantage. Equally, the label can have advantages, because it encourages people to make allowances. Budoff and Siperstein (1978) found that children were less likely to express dislike for a child who couldn't spell if that child was labelled mentally retarded. The label causes people to make assumptions about the person who is labelled. It is, therefore, potentially but not necessarily stigmatising. It does not explain the reactions associated with rejection, and it is not adequate as an explanation of the process.



### *Differentiation and selectivity*

More fundamentally, the roots of stigmatisation can be seen in the way in which social services set people apart from the rest of society. The tradition that health and education services in Britain are not stigmatising rests in the belief that they do not differentiate between different sectors of society. Holman (1970), for example, writes that

No stigma is attached to receipt, as they are experienced by the majority of the population. (p.191)

The main exceptions - mental health and special education - are exceptions precisely because they do separate their recipients from other people.

The stigma of public housing, and in particular of depressed estates, is founded in this process. In Paisley, Armstrong (1975) writes,

The allocation policy of the Housing Department seems to have been effectively and consciously controlled in a way that segregates Paisley's 'bad elements'. In other words, social stigma has become an administrative device ... (p.20)

Minns (1972) describes a similar process with homeless families:

one of the norms of good housing management demanded that homeless families, because they exhibited objectionable traits, should be 'insulated' from settled housing estates. (p.7)

From my own experience, I can say that it is not always true that homeless families are allocated the worst properties because they are not considered to deserve better, although this may happen. They are likely to get these places because no-one else will have them, and the houses have to be let. From the families' point of view, of course, the effect is the same.

Social security has similar problems. Selective benefits, Jordan (1974) writes,

have contributed to the worsening situation of the poor by creating an enormous class of people whose circumstances have, by stigma and rationing, to be made less eligible than those of another group who do not qualify for allowances. (p.14)

In other words, differentiation and inferior treatment are combined to the disadvantage of the recipients. Other people have argued that the residual nature of social assistance is in itself sufficient to cause stigma. Beck (1967) writes that

Residual welfare makes possible the separation of populations of persons who do and who do not use the programmes, thus bringing the stigma of welfare use directly onto some people. (p.267)

But the problem is not so simple. Jones et al (1978) suggest that

the selective benefits for the disabled do not appear to be associated with stigma and the universal health service in many instances stigmatizes the way people are treated. (p.46)

These points are open to argument, but they are not untenable, and similar points can be made about other selective benefits. Widow's Benefit, or Child's Special Allowance, are selective, in the sense of aiming at a particular category of people in need, but there is no indication that they are stigmatised. The problem is not that there is a selection, but that certain selective benefits carry a stigma while others do not.

### *Conclusion*

None of the reasons looked at so far - degrading treatment, loss of rights, feelings about 'charity', labelling, or selectivity explains in itself why a service should be stigmatised. There are services which are stigmatising, but which do not use degrading treatment (like social casework); which do not cause a loss of rights (like special education); which do not label the claimant (like rent allowance); and to which there is an entitlement (Supplementary Benefit). The only exception is a service which is not selective; it seems to follow from the concept of stigma as something that distinguishes and discredits people that a service which is not selective cannot be stigmatising. Conversely, some services do treat people badly (the regime of some hospitals is oppressive); cause a loss of rights (like student grants, which make an adult dependent on his parents); label people (as doctors do); are selective (like medical benefits), and offer services that are not entitlements (no-one is entitled to adopt a child) and yet they are not stigmatising.

It is probably true that the more of these features a service has, the more likely it is to be stigmatised. The Poor Law had them all, and its stigma was vicious; Child Benefit has none, and it is not, I believe, generally stigmatised. Most services, however, fall somewhere between these two extremes, and there are curious anomalies. Wolins (1967) gives the example of Old Age Security and AFDC in the US, which have the same non-contributory base, the same eligibility and financing provisions, and which were enacted in the same statute, but are looked on quite differently - AFDC is stigmatised and OAS is not (p.10). Wolins gives four reasons for this distinction. Firstly, he argues that OAS has more clearly defined aims and intentions than AFDC. This is questionable; the objective of AFDC, to enable unsupported mothers to look after their children without having to go out to work, is at least as clear as that of OAS. Secondly, he says, OAS accepts large numbers of people; AFDC deals with a scattered, isolated population. I am not convinced that this matters; Widowed Mothers' Allowances are given to a scattered population, and Unemployment Benefit to a much larger number of people, but Unemployment Benefit is more stigmatising. Thirdly, OAS conforms to existing values; AFDC does not. Fourth, the recipients of OAS are seen to be acting as upright, law-abiding citizens, unlike AFDC recipients. Both of these points beg the question: why should different services cause such different reactions? If AFDC does not conform to existing values, and its recipients are not seen as good citizens, this is an indication of the stigma attached to it, not an explanation.

The obvious conclusion - one which Wolins somehow manages to avoid - is that the reasons for stigma may lie with the nature of the users of the service, rather than with the service itself. The reaction of people to a VD clinic, a leprosarium or a tuberculosis sanatorium is a direct result of their reaction to stigmatising disorders. There is no intrinsic reason why a residential institution, set apart from the city, should be stigmatised; public schools seem none the worse for their physical isolation. It is not possible to explain the stigma of these institutions by looking at the institutions designed to deal with them. The social reaction to mental illness explains both why mental institutions were built in isolated locations, and why the institutions are stigmatised. At the same time, it is true that confinement in a mental institution is profoundly stigmatising; the asylum sets apart people who are mentally ill, both physically and socially, and this exacerbates a reaction which is already negative. But the explanation of stigma cannot be given simply as a rejection of recipients. There are services which are stigmatised, which deal with people who are not stigmatised - more than 60% of the claimants of Supplementary Benefit are pensioners, and although pensioners do not altogether escape from social rejection, they are not stigmatised in the way that the stigma attached to Supplementary benefit might suggest. Stigmatised people may receive unstigmatised services - disabled people receive non-contributory benefits like Attendance and Mobility Allowance. The relationship may be clarified only by examining the nature of the stigma which affects the people involved.

### **Chapter 3: Summary**

Social services are often described as stigmatised. As a general proposition, housing, social work and social security are stigmatised, and health and education are not; but this distinction breaks down when it is examined in more detail. In every service, some provisions are stigmatising and others are not.

A number of reasons have been put forward for this: degrading treatment, loss of rights, dislike of 'charity', labelling, and selectivity. None of these is altogether satisfactory. The stigma associated with the social services seems to have more to do with the characteristics and problems of the stigmatised people who use them.

## **Part 1: a conclusion**

The idea of 'stigma' has been traced from its origins in the Poor Law to its current uses in the context of different social services. Stigma affects both the quality of services and the demand for services. The uses of the term reflect to some degree a number of related problems, but its meaning is often inconsistent and unclear. This suggests that stigma cannot be understood in terms of the services alone. In Parts 2 and 3, the idea of stigma is looked at from the point of view of the people it affects - both as individuals and groups - in an attempt to clarify the concept.

## Part 2

### The stigmatised person

## INTRODUCTION TO PART 2

### THE NATURE OF STIGMA

Stigma has been identified with loss of dignity, ill-treatment, deterrence, degradation, the denial of citizenship, shame, embarrassment, disadvantage, an imputation of failure or inadequacy, the reluctance to claim benefits, labelling, and feelings of inferiority. I have, up to this point, avoided specific definitions of stigma. Although the concept was born out of the social services, it cannot be understood in terms of the services alone. It is only when it is related to people - groups and individuals - that it begins to make sense.

It can be argued that a stigma is essentially an attribute of the stigmatised person. A stigma is a mark of disgrace. The mark may be a physical one, or it may be something which attaches to the person, like a stain or taint. Goffman (1963) at first refers to stigma as

a failing, a shortcoming, a handicap (p.12);  
an attribute that is deeply discrediting (p.13);  
an attribute that makes him different from others ... and of a less desirable kind (p.12); and  
a shameful differentness. (p.21)

These definitions present stigma as a personal flaw. There is an implication, when we talk about someone who is stigmatised through homelessness and unemployment, that his condition somehow defines his character. George Orwell wrote about unemployed men in the following terms:

In their circumstances, it was inevitable, at first, that they should be haunted by a sense of personal degradation. That was the attitude to unemployment in those days: it was a disaster which happened to you as an individual and for which you were to blame. (Orwell, 1937, 86-7)

An unemployed teacher writes to the Guardian:

One visit to get benefit is usually sufficient to make you feel stigmatised, a burden, a failure. (Vellender, 1980)

A failure, a shortcoming or a handicap are features which reflect on the person who has them. The idea that stigma is a personal characteristic implies a pathological view of social problems. This use is unsatisfactory. A mark cannot be inherently discrediting; the marked individual is discredited by the interpretation that is put on it. A stigma is socially defined. Reddin (1977) quotes the definition of 'stigma' in the OED: it is an "imputation attaching to a person's reputation; stain on one's good name." (p.64) A reputation exists in the minds of others, not in the character of the person; and the attitudes of other people are clearly important to the stigmatised person. A stigmatised person loses respectability, and the shame he feels is a natural consequence of that.

People suffer a loss of esteem through the receipt of social services. Clifford found that two-thirds of his sample thought they would lose self-respect if they claimed benefit (1975, 45) - which is equivalent to saying they do not respect the people who do claim. People may become aware of this loss of reputation in various ways. The taunts of children can be extremely wounding: Moss (1970), researching in Liverpool, found it was a major reason for not claiming education benefits (p.9). And Land (1966) records a pathetic request from an eleven year old child to his mother : "Please pay ... 'cos if you're a free school meal child you're marked for life." (p.795)

The stigmatised person may experience discrimination. Mentally ill people, epileptics and coloured people may experience discrimination in the job market; in a survey of ex-mental patients, Miller and Dawson (1965) found that a third of those who felt stigma felt it only because of the discrimination they had experienced in this field (p.285). The link between

stigma and discrimination is a close one; Cumming and Cumming (1965) actually call discrimination, or the expectation of it, "situation stigma" (p.140). Thirdly, there is the debilitating experience of being an object of pity. Scott argues that it is demoralising and humiliating to be pitied, because this implies that the object of pity is inferior to the other person.

The blind person comes to feel that he is not completely accepted as a mature, responsible person. As a second-class citizen, he must deal with the sense of inadequacy that inevitably accompanies that status. (Scott, 1969, 37)

It is clear that these attitudes are not formed without reference to the characteristics of the stigmatised person. Goffman tries to explain the position by saying that

a stigma ... is really a special kind of relationship between attribute and stereotype. (Goffman, 1963, 14)

I think this places a little too much emphasis on the characteristics of the stigmatised person; it would be more accurate to say that the stigma consists of a negative social reaction to a characteristic that a person is supposed to have. However, the main failing of this definition is that it fails to take into account the feelings of the stigmatised person, which are an important part of the concept of stigma. People feel embarrassed to use the social services; they are ashamed to be in that position. These feelings are commonly described as 'feelings of stigma'.

Some of this can be attributed to a sense of failure; Singer actually identifies a sense of failure as an internalised form of shame (in Piers, Singer, 1953, 52). A welfare recipient, talking to Gould and Kenyon, complained:

There's always a stigma, there's always a comeback, there's always an innuendo that you've been a failure. (Gould, Kenyon, 1972, 35)

Landy and Singer note that mentally ill people feel

the very fact of mental illness marks them apart with the stigma, not only of being different, but of not being up to the demands of a competitive, status- and achievement conscious society. (Landy, Singer, 1968, 457)

This interpretation is important for an understanding of stigma because, in the way the words are used, failure itself is a stigma. The idea of 'perception of stigma' is, in this case, equivalent to a perception of failure, and an acceptance that failure is discrediting.

However, a sense of shame does not have to be related to anything so specific as failure. Clifford (1975) records that

loss of face before neighbours, the feeling of being gossiped about, and the feeling of being misclassified with low status recipients, seems to be what hurt the recipients most and accounts, it seems, for much of their shame and embarrassment. (p.46)

These seem to be the effects of stigma, rather than the stigma itself. In practice, when we say that people feel stigma, we mean that people feel the effects of a stigma which itself remains elusive and undefined. The important element in 'feeling stigma' is not the stigma but the feeling. Something is assumed to exist to account for the feelings and reactions which people experience, and that something is called 'a stigma'. But 'stigma' in this sense is inseparable from those feelings. It is possible to have a stigma, in the sense of a mark of disgrace, or to 'feel stigma'; but it does not make sense to talk of someone as if he 'had stigma' or 'felt a stigma'. The 'perceptions of stigma' which figure so prominently in the debates about take-up refer to something quite different from the pathological view of social problems implied by the view of stigma as a shortcoming or handicap.

In practice, the characteristics of the stigmatised person, his feelings, and the attitudes of other people are bound together in the idea of stigma. This complexity is anticipated by the concept of 'facet analysis' (Guttman, 1959) referred to before. This takes into account a person's behaviour, his beliefs about his behaviour and about group attitudes as composite aspects of his state of mind. Although it is possible, and sometimes necessary, to distinguish these elements, there are some cases in which they are too closely intertwined to be separated. The 'stigma of poverty', in its various uses, implies that the person is poor, which

is a characteristic (a handicap, possibly a failing); that because he is poor, he is socially rejected; and, to some extent, that he feels his poverty to be shameful.

Stigma must, then, be seen as a complex concept, which is formed from certain discrete but interrelated elements. It is not wholly possible to treat attributes, attitudes and feelings in distinct sections, but I propose in the following part to postpone consideration of attitudes and feelings, and focus on the attributes which bring about social rejection, to discuss some explanations for these attributes, and their implications for social policy.

### **Stigmatising attributes**

Goffman divides the forms of stigma into three "grossly different" types: physical deformities, defects of individual character (like mental illness and unemployment) and tribal stigmas, including low classes and statuses (1963, 14). The classification is based on his work in the *Presentation of Self in Ordinary Life* (1959). In that book, he looks at the effect of social roles - 'performances' - for the individual, for teams (small groups that have to cooperate with each other) and for regions (different groups that share space with each other). Physical deformities correspond to the problems of an individual performance; defects of character, to a position in a team; and tribal stigmas, to relations between groups, which is equivalent to the 'regional' aspect. The purpose of this classification is to relate stigma to the context of an individual's roles. It seems to follow from the analysis that lies behind the classification that any discrediting attribute may be taken as a deformity, personal defect or tribal stigma depending on the social context in which it is viewed. The classification is, I think, intended to emphasise the similarities between stigmas rather than to distinguish them, and this limits its usefulness as a guide to policy. It is at times uncertain which group a stigmatising feature belongs to: skin colour, for example, can be treated as both a physical stigma and a tribal stigma. Defects of character are difficult to distinguish from the stigma of status or class: single parents, unemployed people, or welfare recipients in general can be stigmatised as defective individuals or as members of wider sectors of society. People with physical defects may be attributed defects of character. And any kind of 'tribal stigma' implies some kind of personal defect, or it would not be stigmatising.

Pardo (1974) uses only a twofold classification, between 'physical' and 'moral' stigmas (p.1). This distinction, for reasons which are in part implied by Goffman's analysis, is not as clear as Pardo makes it seem. Physical stigmas, like disfigurement or chronic disease, are socially defined: I have already given the example of the Kumba, who regard a certain skin disease as normal (Bloom, 1963, 99). Physical stigmas are governed by social norms - generalised expectations about health and appearance. Moral stigmas are also governed by social norms, but they are of a different kind. Moral norms are distinguished from others in three ways. Firstly, moral conduct is deemed to be responsible. It is possible to breach expectations in ways for which one is not deemed to be responsible - for example, by being crippled - and this is not generally considered immoral. Secondly, moral norms carry a sanction. A generalised expectation that a person will behave in a certain way, coupled with a sanction if he does not, is a rule: it creates an obligation, and conveys rights to others. There are certain types of behaviour which breach expectations, but which do not carry social sanctions - to take again the example of a high court judge who rents a council house, it may be surprising, but there is no obligation on him to live elsewhere, and no right for others to make him. Thirdly, moral norms are valued more than other expectations; there is some rationale for them, either religious, or to do with their effect on other people. Rules for which there is no such reason are demoted to matters of etiquette.

The distinction between physical and moral stigmas is useful, but insufficient. Both terms are too specific to cover all the circumstances. 'Physical' stigmas do not really include cases of mental illness, addiction and learning disability, which are as likely to be seen as aberrations of behaviour as they are to be attributed to organic disorders. Secondly, people who are poor welfare recipients, unemployed people, beggars, homeless people or slum tenants - may

be in breach of social norms, but it would be wrong to suppose that poverty is necessarily seen as immoral. The attribution of responsibility is unnecessary, and this means the norms are of a different order.

It is possible to refine the classification to allow for these points. Physical stigmas need to be distinguished from mental stigmas. Physical stigmas include physical illness, disability, old age, and race. They take in people discredited by loss of function, disfigurement, or infectious disease. Clearly, the implications of these problems are diverse. Illness has little that is evidently held in common with the problems of race; it is perhaps surprising to see old age included in the same category. However, it has been argued that

Advanced age carries its own particular stigma. In a society marked by its concerns for consumption, money, work and youth, old people represent a special branch of deviance ... (Sussman, 1969, 392)

The reasons for this are complex, and they extend beyond the physical features of old age - as the reasons for rejection of racial minorities extend beyond their physical features. I have described them as 'physical stigmas' because the physical features are the immediate cause of rejection, around which other problems are gathered. A physical stigma is simply a physical characteristic which leads to social rejection. Mental stigmas are found in the behaviour and mental capacity of the stigmatised person; they include learning disability and retardation, mental illness and addiction. It is not possible to describe a mental stigma in exactly the same terms as a physical stigma, because mental stigmas are associated with patterns of behaviour, rather than personal characteristics. However, the stigmatised behaviour is usually attributed to a mental state, rather than immoral conduct, and the mental state may be regarded as a discrediting personal characteristic. Physical and mental stigmas are discussed in Chapter 4.

A distinction must also be made between the stigmas of poverty and moral stigmas. The stigmas of poverty run the gamut of deprivation: unemployment, low pay, financial dependency, homelessness, and living in slums. These problems are linked, simply, by a lack of resources which is socially discrediting. At the same time, poverty may cause dependency on others, and in particular dependency on social services. This leads to rejection that is greater than the stigma of poverty alone. A degree of rejection is attributable to dependency in its own right, and it follows from this that the stigma of dependency can be considered as a problem discrete from the stigma of poverty. It is impossible to separate them completely, but it is easier, for the purposes of analysis, to make an artificial distinction between them. The stigma of poverty is considered in Chapter 5; dependency, in Chapter 6.

Finally, there are moral stigmas. The problems these present are of a different kind to the problems of poverty or dependency, although there are connections between them, as there are connections between mental and moral stigmas. Generally speaking, a person is stigmatised morally when he does something that is seriously unacceptable and is believed to be responsible for it. Disability, illness, learning disability or epilepsy are not ordinarily thought of as the result of a conscious decision or act of the stigmatised person. Mental illness, and the stigmas of poverty, may be looked at differently; some people argue that no responsibility attaches to them, while others say that it does. A stigma is the result of a moral principle in so far as responsibility is attached to it. It becomes distinctively a 'moral stigma' when it is primarily the consequence of the breach of a moral rule. This includes sexual stigma, the stigma of criminality, illegitimacy and divorce. Moral stigmas are the subject of Chapter 7.

The classification of stigmas I have outlined - physical stigmas, mental stigmas, the stigmas of poverty and dependency, and moral stigmas - is imperfect. There are substantial overlaps between the different groups. A person with a physical stigma may also be stigmatised mentally - 'Does he take sugar?' (Ford, 1966, 41) - and morally:

'Get out of my house!' she shouted. 'Only bad, dirty people would have a child like that!' (Killelea 1952, cited Romano, 1968, 2)



as well as being poor and dependent. Poor people and mentally ill people may be stigmatised morally, because they are blamed for their condition. Poor people are 'lazy idle loafers on the dole'; mentally ill people are regarded as relatively worthless, dirty, dangerous, cold, unpredictable, insincere and so on. (Nunally, 1961, 45-6) The classification is, as a result, arbitrary to a degree; but it is necessary to provide a framework for analysis of the problems the stigmas present.

## Chapter 4

# PHYSICAL AND MENTAL STIGMAS

The rejection of people with physical and mental stigmas follows a pattern which is clear and fairly consistent, but difficult to analyse. In a study in the US, Tringo (1970) asked several different groups how acceptable these stigmas were to them. Rejection was measured by a modified form of the 'social distance' scale devised by Bogardus (1925). Bogardus had asked people whether they would marry a person with certain characteristics, accept them as kin by marriage, as a neighbour, a casual friend, and so on, using the answers to gauge the extent to which one person would reject or accept another. Tringo changed the items slightly, and weighted them according to their relative importance. He describes a 'hierarchy of preference' in their answers. There was a limited degree of rejection of people with arthritis, an ulcer, diabetes or asthma; greater rejection of those affected by heart disease, amputation, blindness or a stroke; still more rejection of cancer sufferers, old people, paraplegics, epileptics, dwarves, hunchbacks and people with cerebral palsy; and the strongest rejection of tuberculosis, mental retardation, alcoholism and mental illness. The only major discrepancy between the order of preferences of his different sample groups was in the attitude to epilepsy, which was much more strongly rejected by high-school students than by those with more education.

It is difficult to find any coherent explanation for this ordering. Tuberculosis is infectious, which may explain its rejection, but it is the only category which is. Some personal responsibility for the condition may be attributed to people with mental illness, but the same is true of people with heart disease or ulcers. Some attributes are more disfiguring than others, but cancer sufferers are rejected more than amputees, mentally retarded people more than hunchbacks. Some diseases are more disabling than others, but dwarfism is less acceptable than arthritis. Some characteristics make it difficult to maintain normal social interaction with a person, but epileptics are rejected more than deaf people. Some diseases lead to dependency, but a hunchback is rejected more than someone with a stroke. Some conditions cause fear and superstition, but alcoholism is rejected more than epilepsy. It is not sufficient, then, to explain the pattern of rejection solely in the terms that a disease or handicap is infectious, possibly self-inflicted, disfiguring, particularly disabling, intrusive on social contact, that it creates dependency, or that it engenders fear. The problem is that different handicaps and diseases have a variety of features that may lead to rejection. Rather than attempting to consider these conditions individually, it seems best to try to distinguish the different causes of rejection, and consider the implications of these factors for policy.

### Physical stigmas

There are many different types of physical stigma, and Tringo's results show that reactions to them differ. Siller et al (1967) note that different disabilities conjure up different images in people's minds. Deafness seems to imply impaired communication, cerebral palsy suggests lack of control, paralysis is believed to lead to dependency, blindness to problems of mobility and cognition, and muscular dystrophy to helplessness (p.iii). These are all disabilities, but they are diverse, both in their nature and their effects.

The reasons for rejection are equally diverse. One is that a loss of function leads to poverty. A disabled person's capacity to earn is diminished. A recent analysis of the causes of poverty in Britain (Layard et al, 1978) found that nearly one-third of disabled single men, and nearly two-thirds of disabled single women, are living at or below the level of Supplementary Benefit. Many of these people are old (p.29). Their age is a sufficient reason for their poverty: because they are unable to work, they are financially dependent, and because pensions are low, they are poor. Nearly two thirds of elderly people live on an income below

140% of the Supplementary Benefit level (p.29) (140% being a measure of poverty taken by Townsend and Abel-Smith, 1965). More than half the poor are elderly (Layard et al, 1978, 114). But among other families, too, disabled people were likely to be poor: more than half of all families in which the man was disabled received less than 140% of the Supplementary Benefit level.

Physical stigmas are also closely linked with dependency. When a limitation is severe enough, the handicapped person is forced to accept a dependent role. It is a role that takes different forms in different societies. Hanks and Hanks (1948) described various treatments of disabled people. In India or Arabia, they were outcasts; to the Eskimoes, an undesirable liability; the Northern Blackfeet, or the Kiwai of Melanesia, tolerated them and occasionally used their services; the Trobriand Islanders, and the Maori, allowed limited participation; and the Bathanga allowed them to behave as normal members of society. In the developed countries, the writers suggest, there is not usually more than limited participation; handicapped people cannot always take on a full economic role.

It has been argued that dependency is a major factor in physical illness. Parsons (1951) describes physical illness as a socially defined role (pp.312-313). A role can be seen as a set of rights and obligations, or, more accurately, as "a typified response to typified expectations" (Berger, 1963, 112). In Parsons' model, the sick role is characterised by four principal features. Firstly, the sick person is discharged from ordinary social obligations. He is not expected to do the same as someone who is healthy. Kassebaum and Baumann (1965) emphasise not only the extent to which other people make allowances for illness, but also the way in which sick people demand special treatment from others. They note that men, older people, and those with low education are more likely to deny that they are ill; they see the sick role as demanding a dependence that they are not ready to accept. Women and those who are not employed are more likely to accept the role, to make allowances for others and to ask others to make the same allowances for them. Secondly, the sick person must not be sick by choice. A malingerer or a hypochondriac is someone who tries to manipulate the sick role, rather than someone who is genuinely of it; the fact that the illness is voluntarily assumed breaks expectations and alters the obligations of others towards the sick person.

Third, though the sick role is an undesirable status, it is accepted as a legitimate one; and fourth, the sick person must seek help in an attempt to get better. "The stigmatising of illness as undesirable", Parsons writes,

and the mobilisation of considerable resources of the community to combat illness, is a reaffirmation of the valuation of health and a countervailing influence against the temptation for illness. (1958, 117)

These arguments are clearly intended to apply to acute illness. Acute illness, however, appears to carry little stigma; it leaves open the possibility that health will be re-established. The illnesses that lead to rejection - like heart disease, cancer, or tuberculosis - are all chronic. The 'sick role' does not really apply in the same way. Although there is an obligation to seek help at first, this becomes pointless over a longer period of time. Although allowances will be made for a chronically sick person, there is a limit to the tolerance of other people, and a prolonged state of dependence is likely to cause a rift between the sick person and others who are healthy. Further, the dependence of a sick person extends beyond physical or psychological demands of other people; it is also a financial problem.

Temporary illness, Howe (1978) suggests,

is less stigmatising than a long-term handicap since it does not reduce potential earning power. (p.185)

Parsons emphasises dependency as the outstanding feature of the sick role; but chronic dependence is qualitatively different from the short term release from social responsibilities that he is concerned with. The undesirable features of illness no longer serve the function of persuading the sick person to return to normality; instead, they work against him, and lead to rejection and isolation.

A third reason for rejection is disfigurement. Disfigurement is not the same as 'visible handicap' - a visible handicap may be a visible loss of function. Goffman (1963) argues that they are similar in effect - a wheelchair, or a white cane, is a 'stigma symbol' that marks someone off for special treatment (p.589). But disfigurement can cause a number of reactions, ranging from strained conversations to repulsion and hostility. Skin disease, which is disfiguring but not disabling, provoked the strongest rejection by Siller et al's subjects - stronger than the rejection of blindness, deafness, cerebral palsy or muscular dystrophy (Siller et al, 1967, 59-60). Disfigurement is not an objective quality; it is socially defined. Skin colour can be a discrediting physical attribute in a society where black is not beautiful. Conversely, disorders which seem 'objectively' to be disfiguring are not always seen in the same way: the reaction of the Kumba to skin disorders again comes to mind (Bloom, 1963, 99). Ugliness, and beauty, are social constructs. They convey more than aesthetic properties. People believe that 'what is beautiful is good': those who are good-looking are expected to be of a higher status, and more pleasant, than others who are not (Dion et al, 1977). Conversely, people who are ugly - disfigured people - are thought to be base and evil. The attitude is a stereotype, a prejudice, and all the things I have said about prejudice apply to it. The problem runs deeper, though, than the repetition of stereotyped comments. Rejection is couched in terms of repulsion. One person remarked to Siller et al that lack of muscular coordination is rather repulsive. (1967, 53) Someone else commented that cerebral palsy was "sort of disgusting" (p.53). One woman described her reaction to skin disorders as "repulsion, shock, fright" (p.59). Another woman said, "it just nauseates me" (p.59). These statements go much further than a naive association of the beautiful and the good. They suggest an element of personal threat.

Some illnesses are genuinely threatening. Tuberculosis, leprosy and syphilis are all chronic, infectious and potentially fatal. Understandably, they engender fear. The reaction to leprosy is compounded by the physical disfigurement the sufferer may experience; syphilis is rejected as much for moral reasons as it is for infectiousness. But fear is undoubtedly a major element in the reaction to these diseases. Having said this, epilepsy is also believed, in parts of Africa, to be infectious. Orley (1970) records that this belief has been found in Uganda, Tanzania, Ethiopia and Nigeria. Among the Baganda, the epileptic is rejected:

Even after death the stigma remains and no-one will inherit from him for fear of also inheriting the illness. (pp.35-36)

This belief may be false, but it illustrates an important point. It does not follow that, because a disease is infectious, the rejection of it is rational. Leprosy was not even recognised as infectious until the 17th century; lepers were rejected because they were unclean or contaminated, not because they spread disease (Richards, 1977, ch.6). The fear of leprosy is almost certainly exaggerated - it is an unpleasant and distressing disease, but it seems not to afflict everyone who is exposed to infection. (Gussow and Tracy (1968, 320) say that it is not debilitating and probably not even mildly contagious.) This testifies to the strength of feeling against disfigured people, but it also illustrates the irrational element in rejection. Siller et al found, from extended interviews with 65 people, that 22 expressed fears that a disability could happen to themselves, 19 feared ostracism by association with disabled people, and 12 were afraid they would somehow 'catch' the disability (1967, ch.5). There is some overlap between the answers, but they give a clear indication of the anxiety and fear generated by physical stigmas.

Safilios-Rothschild (1970) explains this prejudice in terms of 'body image'. A person has his own image of the 'normal' body, which is associated with the image of his own body. If someone does not conform to the norm, the observer feels threatened (pp.99-100). This theory also explains something of the reaction of the person who is physically disabled, who finds it difficult to reconcile himself, to the difference between his body as it is and the image he has of what a body is supposed to be. This can be more difficult for someone with a slight deformity than another with a major handicap, because his body image is closer to other people's. Barker (1948) describes greater problems of adjustment for the 'marginally' disabled person than for people who are more severely handicapped (pp.32-34).

## Mental stigmas

Like physical stigmas, the different mental stigmas provoke some very different reactions. 'Mental illness', in particular, is complex. It is conventionally classified into psychoses and neuroses. A psychosis is an abnormal or pathological mental state, of which schizophrenia and manic depression are the main examples. Schizophrenia is likely to be seen as odd or confused behaviour; depression may be seen as 'giving up'. A neurosis is a functional disorder, which does not imply any organic change, but only a change in behaviour. Hysteria and anxiety states are the main types; they are likely to be treated as weakness of character. There are other types of mental illness: psychopathy, which falls outside this classification, is a personality disorder which may not be recognised as an 'illness' at all. People do, to a surprising extent, recognise the diverse nature of mental illness (Crocetti, 1973). This fact has led Page and Page (1974) to repudiate the idea of a 'stigma of mental illness'. "Mental illness, they argue,

is only conceptually stigmatising. It is a semantic albatross.

Crisp has suggested that the diseases, and the reactions they provoke, are sufficiently unlike for it to be possible to speak of different stigmas of mental illness (London Medical Group, 1979).

This argument can be extended to other mental stigmas. Retardation is a matter of degree, ranging from 'slow learners' to people with substantial organic disorders. The problems of the most severely mentally handicapped people may include a number of physical handicaps, incontinence, epilepsy, problems with speech, and behaviour disorders (Bone et al, 1972, ch.4), which attract a variety of different reactions. Epilepsy may be minor, with no loss of consciousness; amnesic, causing confusion without convulsions; or major convulsions, of which grand mal is the best known form (see Linford Rees, 1976, 158-160). It may not be recognised as epilepsy at all, dismissed as a twitch or a lack of concentration; or it may be a major handicap, causing fear and revulsion. Alcoholism takes a variety of forms: it may involve sustained, regular drinking, a neurotic compulsion to drink, or drinking in sporadic bouts (Kessel and Walton, 1965, 81). Again, it may not be recognised as a problem, and the range or reactions it can produce is considerable; in some social circles, excessive drinking is even a mark of status.

The reasons why mentally stigmatised people are rejected are diverse. Firstly, they are likely to be poor. People with mental problems may be actively discriminated against in employment. Ex-mental patients are regarded with suspicion and hostility, based in the belief that they can never be quite normal again. Epilepsy is still a reason for dismissal: examples from my own experience include a nursery teacher dismissed because she could not be left to look after young children on her own, which I think is a reasonable objection, and a filing clerk dismissed from government service for having fits, which is not. In France, epileptics are barred from going into public service or becoming priests (Bastin et al, 1977, 652). Mental stigmas can also be disabling, and disability leads to poverty. Mental retardation makes a person less competent to earn a wage: mental illness tends to incapacitate a person from maintaining social contact, which makes it difficult to work in a job. Alcoholism, Kessel and Walton note, leads to absenteeism and unemployment, debt ... (and) social decline ... (1965, 21) Of course, not all people with mental stigmas are poor. Hollingshead and Redlich (1953) found that neurotic disorders, in contrast to psychotic disorders like schizophrenia, were associated with higher social classes (pp.108-109). Epilepsy, too, seems not to be related to lower class. It might have been expected that, because epileptics are handicapped in finding jobs, and because epilepsy is associated with learning disability, that there would be a tendency for epileptics to be poorer than other people. Gudmundsson (1966) however found a greater incidence of epilepsy in the middle class in Iceland than in the lower class (pp.112-113). This is perhaps because of under-reporting by lower class people, but that is only a speculation, and the figures as they stand are intriguing.

Secondly, mentally ill people are likely to be dependent. Financial dependency follows from the same root as poverty, but there are other sorts of dependency. Severe learning disability leads to profound physical dependency on other people; some forms of mental illness, implying an inability to cope, may also lead to physical dependency. Psychological dependency may be associated with certain neuroses. The concept of the sick role again gives some indication of the implications of this dependency. A person with an acute mental illness is expected to seek help, he is condemned if he does not, and allowances will be made for him until he gets better - although this reaction is mixed with rejection if he does seek help, because of the fear that mental illness generates. A lingering implication remains, after this, that he cannot recover completely, and the effect is similar to someone with a chronic disability; he is forced into a dependent, and inferior, social role.

Thirdly, mentally ill people are rejected because of their behaviour. "What psychiatrists see as mental illness", Goffman points out, the lay public usually sees as offensive behaviour - behaviour worthy of scorn, hostility and other negative social sanctions. (1967, 137)

There have been criticisms that the term 'mental illness' is too often used as a rationalisation of antisocial behaviour (Cohen, 1966, 66 ff.; Wooton, 1959). There is a moral implication attaching to certain mental stigmas. Mentally ill people may see themselves as 'sinners'. Alcoholism is seen as a defect of character. This is because individual responsibility is attached to the actions of the people concerned.

Medical practitioners distinguish behaviour that is offensive or unusual from 'mental illness' by their diagnoses. They can take away moral responsibility by certifying that a person is ill. But the name of mental illness itself is a cause of rejection. Mental patients, and ex-mental patients, are more likely to be rejected than those whose behaviour is simply odd (Cumming, Cumming, 1957; Phillips, 1963). Criticisms have been made - with some justification - of the importance attached to diagnoses which are imprecise and too firmly founded in organic medicine. But the labelling perspective is not altogether satisfactory; all the indications are that it is the behaviour of mentally ill people which is the main cause of rejection.

Mental stigmas are disruptive of social relationships. Mentally ill people fail to observe the rules of normal conversation (Goffman, 1967, 137-148). Mental retardation, or an epileptic fit, can be very intrusive in a conversation. They prompt uncertainty and consternation; people don't like it when they don't know what to expect. The feeling is well expressed by the parent of an epileptic child:

For the most part people are startled and flabbergasted and for some reason horrified because they've never seen it and they don't know what it's all about ... (Cooper, Henderson, 1973, 111)

Novak and Lerner (1968) found that people were less keen to interact with someone who had had a nervous breakdown if he was like themselves. The trend was clear, if not statistically significant. Lehtinen and Vaisanen (1978) found, in a survey of a thousand Finns, that attitudes to mental illness were less favourable when the person who held them showed signs of psychological disturbance himself (pp.65-66). These results, though obviously open to argument, suggest that the reaction caused is not solely the result of a dislike of the unfamiliar. There seems, again, to be a sense of personal threat.

Mental stigmas, like physical stigmas, provoke anxiety and fear; and Lyketsos and Panayotakopoulos (1970) found that prejudice against mental illness was associated directly with the fear of it. Mental stigmas have been the object of superstition. Mentally handicapped children were believed to be 'changelings' children exchanged by fairies or demons for real children. 'Changelings' were recognised not only by their ugliness, but by their inability to speak or laugh. Martin Luther wrote that

The Devil sits in such changelings where their soul should have been. (cited by Wolfensberger, 1969, 71)

This belief survived for centuries. Haffter (1968) notes eight recorded cases, in Germany, Scotland and Ireland, between 1880 and 1895, when 'changelings' were seriously maltreated or killed perhaps burned alive - by their parents (p.60). Epilepsy has also been the object of superstition. The word itself derives from a root meaning 'to lay hold on' - implying possession by spirits or devils (Hudzinski, 1975, 27). And madness was also linked with possession. Lyketos and Panayotakopoulos (1970) found that superstitious people in Greece were less likely than other prejudiced people openly to avoid, condemn, or show aggression to the mentally ill, but they were also much more likely to put off the time when mentally ill people would get help (p.181). This may be a reflection of a rural culture; or it may be that their fear causes them to prolong a period of uncertainty so that they will not have to know the worst. It seems to me that this superstition reflects the apprehension feel about mental stigmas, rather than being a cause of it. Superstition is a rationalisation of an experience that is not understood. The rejection of these stigmas is best explained in terms of the fear they cause.

Foucault (1961) suggests that madness filled a void when leprosy ceased to be important in Europe; madmen became the new lepers. The idea of 'mental illness' probably increased the rejection of madness, because the idea of illness conveys a further threat.

All those forms of unreason which had replaced leprosy in the geography of evil, and which had been banished into the remotest social distance, now became a visible leprosy ... Unreason was once more present, but marked now by an imaginary stigma of disease, which added to its powers of terror. (Foucault, 1961, 205)

Madness is beyond the bounds of normality. This is true in other societies besides our own. Jaques (1960) describes how, in Vietnam, mad people would be chained in one room and left there, even years after their madness had apparently subsided (p.12). Orley (1970) gives a fascinating account of the attitudes of the Baganda:

In the old days mad people were put into the stocks until they got better or died, but in these days there can be few Baganda who have not heard of Butabika, the Mental Hospital at Kampala, even though it was only opened ten years ago. It is now regarded as a natural replacement for the stocks of old. (P.30-)

This gives some support to Szasz's apparently extravagant claim that the function of experts in psychiatry is "to justify the majority in rejecting and persecuting the minority." (1971, 240) I do not think this is true - Szasz seems to me to confuse effect and intention - but it would be wrong to pretend that there is no case to answer.

## **Rehabilitation**

Certain problems are distinctive to physical and mental stigmas - the problems of disfigurement, and the sense of threat that physical and mental stigmas produce in others. Both physical and mental stigmas disturb social interaction; they lead to problems of tension and information management. The main problem is one of social adjustment: how to make these people acceptable to themselves and to society. This process is called rehabilitation. It is an ambiguous concept. It implies three things: first, that a person's physical or mental capacities should be restored, or at least developed to their full potential; second, that his competence to fill social roles should be established; and thirdly, that he should be integrated into society, which implies not only that he should be integrated into society.

Physical and mental stigmas spoil social roles by limiting a person's capacity to fulfil them, or by opening a distance between the stigmatised person and others. Rehabilitation is a means of overcoming these problems, and the stigma which accompanies them. Conversely, a sense of stigma could be argued to improve the possibility of rehabilitation. A person who recognises his condition as an undesirable one will make an effort to get out of it. Chaiklin and Warfield (1973) found that amputees who denied feeling stigma made slower progress towards rehabilitation (p.164). This is analogous to the position of the sick role, which makes temporary dependency legitimate while encouraging a person to regain his health.

The essential problem is to restore the dignity of the stigmatised person. Safilios-Rothschild (1970) writes that

Often serious psychological problems became accentuated after the completion of rehabilitation. (p.250)

It is a strange concept of 'rehabilitation' that leaves people with serious problems. This comes of seeing rehabilitation as a development of physical capacity. Rehabilitation which improves the psychological state of the stigmatised person asks for rather more. Payne (1980) argues:

It is undoubtedly true that the individual social worker can do nothing in everyday work to affect the general position whereby the client groups and the services of his agency are stigmatised. In individual cases, however, it may be possible to manage some of the personal effects of stigma felt by clients, and this is worthwhile for three reasons. First, stigma management may reduce feelings of distress felt by clients. Second, it may enhance the effect of interventions designed to help clients by reducing the damage caused by stigma. Third, it may have a cumulative effect on perceptions of the social services and their clients. (p.44)

I must confess to some scepticism about this. Although what Payne says may be true of some individuals, it is questionable whether it can be generally applied to people who are physically or mentally stigmatised. The problems of stigmatised people stem from a complex series of social relationships. Casework can help some individuals to adjust to their social circumstances, and perhaps revive the spirits through a kind of faith healing; but where the problem rests in those circumstances, it cannot deal effectively with the problems that stigmatised people experience.

Another way of trying to deal with the problem is to encourage participation in a self-help group. This may have the effect of changing a person's social circle, and establishing sympathetic people as 'significant others'. Self-help groups are of two kinds. One is the type which, like Alcoholics Anonymous, uses the knowledge and experience of reformed alcoholics to redirect others (Trice, Raman, 1970). The other is the group which seeks to establish mutual respect and support, and perhaps to establish a common identity in reaction to a common experience of rejection. The problem with either approach is that it rests in participation, and participation may, for a stigmatised person, be difficult to achieve. Firstly, it is necessary for him to avoid withdrawal from society. It may be easier when the people he will associate with are like himself, but it is never easy. Secondly, he must admit he is like others who are stigmatised, which it may also be difficult to do - or unreasonable to ask of him, because he may have nothing in common with the group apart from his stigma. Thirdly, there are often financial and physical obstacles to participation in groups for which assistance may be required.

A further method is to attempt to change the attitudes of stigmatised people through a process of education. This may be done by the education of individuals about their problem, so that in turn they will seek to change the opinions of the people they meet. Gussow and Tracy (1968) describe how certain sufferers from leprosy have become militant in correcting misapprehensions about the disease (pp.322-323). However, this requires a certain temperament which not everyone possesses.

#### **Chapter 4: Summary**

Different handicaps and diseases have a variety of features that may lead to rejection. Physical stigmas may be rejected because they lead to poverty, or dependency, and because they cause disfigurement, which leads to stereotyping, repulsion and fear. Mental stigmas similarly may be related to poverty or dependency, but other grounds for rejection include the perception of behaviour as immoral or disruptive, and the ability of mental illness to provoke anxiety or fear.



Policies for mentally and physically stigmatised people may be directed to reintegrate them into the community by restoring their capacity to function in society, by changing their perceptions of their role, or by attempting to change the attitudes of society towards them.

## Chapter 5

### THE REJECTION OF POVERTY

Although attitudes to the poor are often negative, a major survey undertaken in the nine countries of the European Community found substantial differences in the attitudes to poverty of people in different nations. People in Britain were far more likely than others to attribute poverty to laziness or lack of willpower - 43% of Britons said so, compared with 23% in West Germany, 16% in France, and 12% in the Netherlands (Riffault, Rabier, 1977, 72). There is no distinction in this between the deserving and the undeserving poor. Poverty is a sign that the person is not deserving, and it is therefore a cause of social rejection.

"There is absolutely no evidence", Handler (1972) writes,

to support the notion that the working poor have deserving poor status. (p.152)

He argues that it is not acceptable to earn only a part of what one needs to live. Matza (1967) writes of the 'disreputable poor'

the people who remain unemployed, or casually or irregularly employed, even during periods approaching full employment. (p.289)

This recognises in part that the working poor, as well as the unemployed, may be stigmatised. In a later version of this paper, he develops this idea into the concept of 'sub-employment'. Subemployed people may be working, but their work is not adequate to bring them the full respect and status accorded to other people in society. They are consequently stigmatised (Matza, Miller, 1976, 661-662). Support for this view can be found in Newby's study of agricultural workers (1977), or Walsh's description of dustmen in the US (1974). Those who are working may be less disreputable than those who are not, but they are disreputable nevertheless.

The idea of poverty itself is stigmatising; people resist the very word. Marsden (1973) notes how

Mothers found the word insulting ... the words obviously carried a stigma, and the mothers preferred to talk of being 'hard up'. (pp.59-60)

Harvey (1970) gives the example of Potter Addition, a community in the mid-west US, which is the object of 'stigmatic labelling'. The community consists of the working poor and marginally employed. But they resist the imputation that they are poor:

To be poor in their minds is to be useless, to be a relief cheater, and to be despicable ... To finally admit that they are indeed poor is to give up the last line of self-defence against degradation. (p.140)

Blaxter (1974) found, by contrast, that

People gave no impression of wishing to conceal, or being ashamed of, lack of money (p.50);

and it is perhaps possible to distinguish lack of money from poverty. As Bosanquet argued (1902),

To have classified a man as belonging to the poor, or the residuum, or the submerged, means that we no longer expect from him the qualities of independence and responsibility which we assume as a matter of course in all others.

The rejection of poverty has important implications for the social services. Social services exist, in large part, to offer support to people in need. But need is often defined by poverty, and a resort to the social services - a request for help - is an admission that one is poor. "I wouldn't go within a mile of the Home Assistance, one person told Clifford (1974). "It has the brand of poverty on it." (p.494)

#### **Class, poverty and power**

People who are poor belong to inferior classes in society. Classes, by Weber's definition,

are groups of people who, from the standpoint of specific interests, have the same economic position... (1967, 31-2)

This idea is closely linked with status. Class has been described as an aggregation of persons in a society who stand together in a similar position with respect to some form of power, privilege or prestige. (Lanski, 1966, 74-75)

Lanski identifies classes with status groups. Weber argues that they are not the same, but that Social honour can adhere directly to a class situation, and it is also, indeed most of the time, determined by the average class situation of the status-group members. (1967, 31-32)

Runciman, similarly, suggests that "Status is a lagged function of class" (1963, 138); by which he means that a change in class, or economic circumstances, is eventually reflected in a change in status, or social context. Status adheres to class, as it does to status. If status is a form of social honour, and low class implies low status, then poverty is associated with a lack of social honour. But this cannot be taken for granted; the association of social roles, social honour and economic circumstances is a process which needs to be explained.

Poor people, in general, lack power. It is not possible to talk meaningfully about power as a monolithic concept. Power is diffuse, taking a different shape in economic, social and political affairs. It is made up of different elements: notably, control, authority, and influence. A person has a degree of control over another when he has an effective sanction against him. He has authority when his commands are accepted as legitimate. He has influence when his opinions or desires are likely to be accepted by another. There is, of course, a great deal of overlap between these sorts of power, but they are not the same. Poor people lack power in every sense. They have no resources to command; they have no economic sanction, and little influence or authority. Their social power is restricted. They have no effective social sanction - rejection or condemnation by the poor distresses no-one but other poor people. They have no social authority, because poverty is not a legitimate status in society. They have little social influence, because they are less able than others to summon the resources needed to gain it. Similarly, their political power is limited. Their only authority, and their only effective sanction, is found in so far as they constitute a part of the electorate; there are few people to speak for them, and with neither sanction nor authority to support their arguments, they are able to exercise little influence.

Powerlessness is treated with contempt. Adorno et al (1950) found, in the authoritarian personality,

a desperate clinging to what appears to be strong and a disdainful rejection of whatever is relegated to the bottom. (p.971)

Fromm (1942) follows a similar line of argument, and comes to the conclusion that some people like to be in a hierarchy. Put crudely, the great advantage of looking up to some people is that you can look down on others. This type of explanation is attractive, but it begs the question. There may be an element of authoritarianism in everyone, but different societies manifest these views in different ways - there are enormous differences in attitudes to poverty, even between countries as similar as the members of the European Community. The psychology of contempt reflects these social differences, rather than explaining them. Sociological explanations may seem tame by comparison, but they are also much sounder. Shils (1968) argues that social honour - 'deference' - is a function of power. We defer to those who are stronger than ourselves, and we condemn poverty because it has no power (1968, 104-108). But the process is more complex than this suggests. Power and deference are associated through a person's status. A status is 'a collection of rights and duties', and people without power have few rights because few people have obligations towards them. A person with low status has little power. Status has elements, though, not only of power, rights and obligations, but also of expectations, honour, economic position, and life style. The question remains why these things should be associated.

The simplest explanation is one that bases status in economic circumstances. Money implies power, to the extent that it gives control; in a society where status is deemed to be achieved, it

calls for honour; it determines life-style; and, taken together, these things set social expectations. Poverty in turn implies lack of power, dishonour (because poverty is seen as a result of personal inadequacy) and a limited life style. But it is not possible to be crudely deterministic. Education and occupation affect life style and expectations; a degree of status may be determined by birth. The getting of money is facilitated by power, social honour, the appropriate life-style, or by expectations. There is a constant interaction between the different factors.

Power tends to be associated with high status; but, although stigmatised people tend to have low status, not all stigmatised groups are powerless. Pensioners, who are poor, have considerable power as a lobby. They have legitimate authority, both because they form a substantial proportion of the electorate, and because respect for the aged is a demand of our moral code. Groups of disabled people, like the National Federation for the Blind, have been influential although they possess neither authority nor control. Racial minorities, especially in the US, have gained substantially in influence because of riots in the ghettos - a material sanction. However, although many of the people affected are poor, these groups are not primarily distinguished by their poverty. They are all physically stigmatised. Other types of stigmatised groups - people with mental stigmas, moral stigmas, or the poor - have failed to gain power. Their lack of influence is founded in a belief that they are socially inadequate. In cases where the assumption of inadequacy has broken down, stigmatised people are able to gain power. If this is correct, powerlessness is not so much a cause of stigmatisation as a consequence of it.

### **Social control**

One part of the function of social services is to control behaviour that is socially unacceptable. The prevention of child abuse, the restriction of benefit to people who have become unemployed through 'industrial misconduct', or the treatment of truancy as a social problem, are all cases in which the idea of welfare is strapped to a big stick. Stigmatisation has been represented as another form of social control, a deliberate policy to make people behave themselves. This is closely related to the question of power. It has been argued that power is concentrated in the hands of those who own the means of production, and poor people are controlled because the people who have the power wish to preserve it. But I do not think it is necessary to posit the existence of a conspiratorial ruling class to explain social control. Some behaviour cannot be reconciled with certain types of social organisation, whether because it breaches social norms, it hurts others, or it imposes a burden on others which they are not prepared to accept. Stigmatisation is, in part, a response to behaviour of this sort. It controls behaviour by punishing the offender and by acting as a warning to others.

"The stigma of being a claimant", Ginsburg (1979) suggests,  
is an essential ingredient in a system designed to discipline claimants and to promote the values of insurance and individual and family self-help. (p.104)

This discipline is seen most strongly in the attempt to make the able-bodied poor work. The Poor Law did this by means of a work test, administered at first in the workhouse, and then more commonly in special centres for people receiving out-relief (see Cmd. 3585, 1930). Those who received benefits outside the scope of the Poor Law were examined to make sure they were 'genuinely seeking work' (Deacon, 1976). More recently, the 'four week rule' limited the benefit to which a person was entitled if work was believed to be available (Meacher, 1974). Even now, it is generally a condition of receiving benefit that an able-bodied person is registered for work, and someone who becomes unemployed voluntarily or through 'misconduct' has benefit restricted for up to six weeks.

The object of these policies may be seen either as an attempt to force people to work, or to dissuade others from giving up work, in the belief that people will not choose to work if they have the opportunity to avoid it. This belief is highly questionable. Ideally, the person who

is unemployed should return to stable work at the first opportunity. In practice, however, the intermittent employment which results from being pushed into marginal work is taken as evidence, when the person becomes unemployed again, that he doesn't want to work - and, because he may not like to admit that he has no control over his own affairs, the unemployed man may reinforce this impression. This disguises powerful social factors which cause people to work. Marsden and Duff (1975) give an excellent example of the results of this process:

'I'm not bothered. I never bother going for a job now. Aw, if you can keep your dole and make £10 per week on top of that, who's going to work?' Within four months this man had found a job and was back in full-time work. (p.189)

Piven and Cloward (1971) argue that

to buttress weak market controls and ensure the availability of marginal labour, an outcast class - the dependent poor is created by the relief system. ... Its degradation at the hands of relief officials serves to celebrate the value of all work ... (p.165)

I suppose this is a tenable interpretation of the problems of unemployment, but I think it goes too far. It may be true that the relief system serves the interests of employers, but it does not follow that this is its intention. Jordan (1974) writes in the same vein:

In order to retain the exaggerated respect for work (at any wage) which is considered an essential element in the market economy, the authorities devise procedures which stigmatise, ration and harass both those who are not working and those who cannot afford to live on what they earn. (p.59)

This is inconsistent. He cannot hold both that there is an exaggerated respect for work at any wage and that poor working people are stigmatised. But there are more important objections. Firstly, like Piven and Cloward, Jordan sees the problem as one of the market economy. But work is vital to any economy. Even in the Soviet Union, there is an Act to curb the activities of

able bodied adult citizens who lead an anti-social, parasitic mode of life, maliciously avoiding socially useful work, and likewise living on an income not earned by labour. (Beerman, 1958 et seq)

Secondly, it is unwise to attribute all the undesirable features of a service to the deliberate actions of the authorities. Certainly, they have to ration - that is true of any service that is in short supply where the price mechanism is not in use. (It is probably more true, in consequence, of non-market economies.) But the harassment, ill-treatment and degradation of claimants by officials are as much attributable to the attitudes which the officials share with the rest of society as they are to the policies of the agencies. It is simply not true that all the consequences of a policy are intentional.

It requires some explanation that people who are not expected to work - pensioners, single parents, or disabled people - are still affected to some degree by the stigma of not working. Marris (1958) records that widows would still go out to work, because

they seemed less afraid of their children suffering from lack of their mother's company, than from the stigma of poverty. (p.110)

Spitzer (1975) relates the rejection of stigmatised groups to the needs of the capitalist system. Using the specific example of mental retardation, he argues that the meritocratic ideologies of capitalism sanction the stratification of society, that the destruction of the extended family weakens the traditional methods of assimilation of such people, and that the use of unskilled labour by capitalist production is threatened by the existence of mentally retarded people who could do the job just as well (p.640). Along with other 'social junk' - the aged, the handicapped, and the mentally ill - these people are therefore excluded from the process of production, where they become

a costly but relatively harmless burden. (p.645)

He argues that deterrent policies are used because

The social expenses and threat to social harmony created by a large and economically stagnant surplus-population could jeopardise the preconditions for accumulation. (p.643)

It should be noted that old, handicapped, mentally ill or mentally retarded people are rejected in societies that are not capitalist. Societies that are not capitalist are also stratified; the 'traditional methods of assimilation' include burning mentally handicapped children (Haffter, 1968, 60), chaining up mentally ill people (Jaques, 1960, 12), and killing handicapped people who are a burden (ibid, 10). Mentally handicapped people are generally less able than others to participate in production in any society (Jackson, 1977); they are not excluded only in 'capitalist' societies. Spitzer's argument is tendentious nonsense.

It can still reasonably be argued that the rejection of people not expected to work is a result of the work ethic. Walker writes:

The generally accepted assumption that those who are out of work will be worse off than those who are in work follows directly from the overriding value that industrial society places on work. ... The same individualistic value also underlies the definition of the elderly and other groups which are in poverty as dependent on the rest of society, and it assigns the stigma that is part of this dependent status. (1980, 59)

The problem comes down to a matter of social values - not of the policy of the welfare agencies. At the same time, while acknowledging the importance of the work ethic, there are other factors in the rejection of stigmatised people - particularly the moral rejection of single parents - which seem to me to be stronger. I think it is a mistake to overemphasise the importance of work as a source of stigma; it is only one element out of many.

### **Policies for poverty**

Poverty itself is a stigmatised condition. Rainwater (1967) argues that the only problem the poor have is lack of money (p.124). It has been assumed too often that they can be helped while they are poor, which is a treatment of the symptoms of poverty, not the causes. He believes that an attack on inequality is the only way out. But redistribution is not an answer in itself; it implies dependency, which is also a stigmatised condition. Moreover, the stigma of poverty is itself an obstacle to redistribution. "If the distribution was to be changed significantly", Howe argues, "the stigmatising values which supported it would have to be changed first" (1978, 186). This is Catch-22. People are stigmatised by lack of money; the stigma of poverty makes society reluctant to give them more money; and if they did give them more money, it would only lead to more stigma.

There are two possible approaches to take. One is to 'rehabilitate' individual poor people. By giving the individual the opportunity to escape from poverty, that individual can be redeemed. Pinker (1979) argues that

In a society in which the consensus of popular opinion favours the enhancement of welfare in the economic market and equates citizenship with economic independence, social welfare becomes intrinsically stigmatising to its recipients. In this kind of society it may be a genuinely equal right to compete in the economic market rather than an equal right to share in the social market which is most conducive to social consensus. (p.210)

This was the approach of the Victorian reformers who favoured 'scientific charity' for the deserving poor. Octavia Hill, for example, wrote:

As soon as I entered into possession, each family had an opportunity of doing better; those who would not pay, or who had clearly led immoral lives, were ejected. (cited Gauldie, 1974, 86)

The problems of this approach are considerable. Many poor people are incapable of 'lifting themselves' out of poverty; they are often old, disabled, sick, or educationally disadvantaged. Pinker accepts that

When rehabilitative agencies identify 'success' with return to work an self-supporting status, they will be reinforcing the expectations and attitudes of their clientele. The

consequences of using this criterion of 'success' will be to elevate the morale of those who respond to treatment and lower still further the morale of those who do not recover. (1971, 210)

One effect of this is to discourage the provision of services that are unlikely to be 'successful'.

Wherever the criteria of the economic market prevail, those states of dependency with the worst prognosis will receive the poorest social services. (p.50)

Scott (1967), for example, notes that services for the blind are disproportionately concerned with young people when a substantial majority of those affected by blindness are old.

Rehabilitative services can only be an answer for a limited number of people. In any unequal or competitive society, which includes virtually every society known to man, someone has to come at the bottom. 'The poor ye have always with you'. A policy of rehabilitation strengthens the divisions between the deserving and the undeserving poor. It might be argued that this distinction, like the work ethic, is desirable as a motive force in society: if poverty is not made unpleasant, then people will not attempt to avoid it. The answer to this, I think, is that poverty is bad enough without having to support the contempt of other people at the same time.

An alternative to this approach is to attempt to improve the position of the poor collectively. 'Positive discrimination' has been seen as a way of overcoming the stigma of poverty by diverting resources to poor people. But redistribution of money is not enough, because it increases the sense of dependency. The improvement of the condition of the poor involves a redistribution of power. The poor need to establish a collective identity - a rational step, Haggstrom (1964) argues, when they cannot succeed as individuals (p.218) - to overcome their social disadvantages. In the field of social welfare, this implies that poor people must take collective action in respect of the policies which affect them. This has been the thrust of the 'War on Poverty' in the US, community action, and the trend towards participation in the administration of services.

There are a number of difficulties inherent in these approaches. It does not always help to have a collective identity if the image of the group is negative and the group relies on persuasion to gain influence. There is, as Griffiths (1975) argues, a double bind: a group that says nothing will get nothing done, but a group that forces itself on public attention risks an identification that may aggravate a stigma (p.31). Another difficulty is that since stigmatisation implies isolation and a lack of participation, those people most in need of assistance will not be touched by collective action. This is true in part, but it is not a strong argument. In the first place, I have argued that 'stigmatisation' affects more people than those who 'feel stigma'. This means that many people affected by stigma will not be isolated or prevented from acting because of it. Besides, the actions of certain people - community or group leaders - on behalf of others may still be to the advantage of all. The Disablement Income Group, for example, has exercised pressure on behalf of many disabled people for income support. On the other hand, this can work against a stigmatised group: the work of the Claimants Unions (*pace* Jordan (1973) and H.Rose (1973)) has not unquestionably improved the lot of claimants, and I believe that in certain respects, notably by generating antagonisms within a service, may be said to have made it worse.

Formal participation suffers from the further disadvantage that it depends upon on administrative machinery. Arnstein (1971) describes a 'ladder' of citizen participation, ranging from manipulation and 'therapy' to citizen control. This model draws attention to another basic problem, which is the relationship of the community to the administration. It does not follow that, because there is a collective organisation, it will gain the influence necessary to redress disadvantages or change social attitudes. A further problem is that 'collective action' means something only if there is a community of interest - a problem which Arnstein's model fails to recognise. In real life, there may be a conflict of interests, or even numerous conflicts. 'The poor' are not a homogenous whole. The 'undeserving poor' gain status at the expense of the deserving poor. The unemployed in one area may get jobs at the expense of unemployed people in another area. There may be a conflict between slum

tenants who want to be rehoused, and those who want the area improved and community preserved. Some single parents may want a guaranteed income; others would benefit more from the right to be maintained.

Despite all these reservations, there are some advantages in participation. It allows opinions to be heard which otherwise would not be. It creates social organisations which can support individual members, like Goffman's 'huddle-together self-help groups'. It can assist in establishing the influence of a client group, and helps them to put the case in their favour. Because I do not attribute stigma to a lack of power, I am sceptical about the potential of an increase in power to reduce stigma. But the influence gained can be used to change some of the conditions which lead to stigma.

An example of this is the effect of tenant participation in the management of public housing estates. Griffiths (1975) advocates this as a method of improving depressed estates, and illustrates this with a case study. Power (1979) gives a similar example. By co-operative action, the tenants were able to make a physical improvement in their area, reversing the cycle of decline and establishing a shared pride in their achievement. But this achievement, real as it is, must be seen in context. Co-operative effort has succeeded by diverting resources towards itself - which implies that they are being diverted from somewhere else - and often, Power's work suggests, by establishing itself as a form of deserving poverty, and excluding difficult tenants and problem families from admission to the community. There is reason to be cautious about the claims made for the process.

### **Chapter 5: Summary**

It may be argued that the rejection of poor people reflects their lack of power, and that policies towards the poor are oppressive mechanisms reinforcing the 'work ethic'. The work ethic is important as a set of social values, but the attribution of a specific intent to oppress the poor is difficult to maintain, and other values besides the work ethic are also significant. Policies dealing with the stigma of poverty have taken three main approaches. First, there is financial redistribution; but redistribution is resisted because of negative attitudes. Second, there is 'rehabilitation' - which may lead to a distinction between the deserving and the undeserving poor. Third, there are collective policies - positive discrimination and collective action - which seem to have limited scope.



## Chapter 6

### THE STIGMA OF DEPENDENCY

Poor people are rejected, but people who are poor and dependent are rejected more. The distaste for dependent poverty is evident in the dislike people feel for 'charity', or social services which they see as a form of charity. This feeling is not, I have suggested, a major element in the failure of demand; nor is it a strong factor distinguishing types of service, because the reason for disliking a service, its association with dependent poverty, is the same for any sort of residual welfare. The emphasis people put on independence is almost certainly made for the same reason. The survey of pensioners in 1966 found, in addition to those who were too proud to claim or who disliked the National Assistance Board, a substantial proportion who said they were 'managing alright' nearly 20% of couples, 30% of single men, and 37.7% of single women (Ministry of Pensions, 1966, 42). It is possible that many of these were not ready to become dependent, although the precise proportion is a matter for speculation.

The public rejection of dependent poverty is strong. Unemployment is one of the most disreputable forms, and one which is prominent in the public mind: in the European study, 'laziness' and 'chronic unemployment' were the most common reasons given by those in the UK who had seen people in poverty (Riffault, Rabier, 1977, 69). The two are closely linked: there was a time when unemployment was called 'idleness', which has pronounced moral overtones. In its consideration of social security, the popular press devotes a disproportionate amount of space to unemployment benefit disproportionate both in terms of its cost and the numbers of people who claim it. Stubbs (1980) found, in a sample taken from the national popular dailies, that out of 457.5 column inches on social security, 226.5 were given to unemployment benefit. (63.75 more went on Supplementary Benefit, of which a proportion goes to unemployed people) Most of the stories were judged to be unfavourable.

The other main groups dependent on welfare benefits are people who are old, sick, disabled, widows or single parents. In the US, programmes for income maintenance are often related to specific groups in need - unlike Supplementary Benefit in the UK, which covers all these groups. The American practice gives us some indication of the extent to which groups of welfare recipients are rejected, and how that affects the services that deal with them. Williamson (1974c) asked people to rank several programmes according to how much stigma they inflicted. General relief was felt to cause the most, probably because this benefit goes to the rump of the poor, like tramps, who are not covered in other ways. It was followed by AFDC, which is specifically given to unsupported mothers with children; Unemployment Compensation; Aid to the Disabled; and Old Age Assistance (pp.217-220). All of these groups are, to some degree, rejected in their own right, and it can be argued that the order in which benefits are placed reflects feelings about the recipients. At the same time, it should be emphasised that the receipt of welfare carries with it a stigma of its own. As one old man told Walsma (1970),

I am a welfare case. I have humbled myself. (p.148)

#### The dependent person

There are three kinds of dependency. The first is physical. Ill, disabled, old and mentally handicapped people may rely on the services of others for their basic physical needs, such as mobility, food and hygiene. The second is material dependency, which is associated most strongly with the financial dependency of social security programmes, but which includes those cases where a person receives goods in kind. Thirdly, there is psychological dependency - a dependent state of mind. It is marked by resignation, helplessness, hostile

pessimism, physical sickness for which doctors can find no organic base, passivity, and inability to mobilise the self to take necessary action or responsibilities. (Perlman, 1951, 327) Psychological dependency implies more than the fact of dependence; it is a need to rely on another person because of an inability to act for oneself. It is an aspect, for example, of depression (Sutherland, 1976). It manifests itself in a dependent role which may be clinging, demanding, manipulative, pleading, or any number of these things by turns.

There is some overlap between these forms. Physical dependency often implies financial dependency - many of these people are poor as a result of their physical limitations - and it may be bound up with psychological dependence, although this is not a necessary consequence. Physically stigmatised people are often expected to fit into the sick role, to be dependent, and it may be necessary for a disabled person continually to assert his physical independence in order to keep himself out of the role. Traditionally, financial dependency has been believed to lead to psychological dependency. Franklin wrote in 1753:

I have sometimes doubted whether the laws peculiar to England, which compel the rich to maintain the poor, have not given to the latter a dependence that very much lessens the care of providing against the wants of old age. (cited Williams, 1944, 77)

Gladstone (1889) expressed a similar concern for the moral welfare of the pauper:

If he loses his self-reliance, if he learns to live in a craven dependence on wealthier people rather than upon himself, you may depend upon it he incurs mischiefs for which no compensation can be made.

Financial dependency is believed to be a result of personal inadequacy as well as a cause of it. Social work clients, Marcus wrote in 1928,

have fallen into the limbo of the dependent and are exposed to the social stigma which even professional case workers still attach to dependency, the stigma of suspected inferiorities - mental, moral and physical. (p.136)

It is still true that professional workers may take this view. Problem families, according to Soyer (1961),

seek quick and tangible help. Over and over again one senses beneath a hostile veneer, an oral character; a client who never stops demanding, a mother who cannot give emotionally to her children but can only drain those around her of emotional sustenance. The dependency is pervasive ... (p.36)

It is not altogether surprising to hear that same people who are dependent on social services are also psychologically dependent. Poverty is debilitating, and poor people can hardly be blamed if they try to get help from others; psychological dependency is an understandable response to an oppressive situation. At the same time, it would be absurd to suggest that everyone who is financially dependent is helpless, or that dependency inevitably leads to a degraded character. Perlman (1951) protests the confusion of psychological and financial dependency, which are logically distinct. A widow is not inadequate; an unemployed person need not be resigned to dependency; a pensioner is not a defective person. They are "sound citizens with empty purses" (p.328).

### **The norm of reciprocity**

There is a general obligation to make some return for things received. This is the norm of reciprocity. The norm of reciprocity was identified by Aristotle as an important element in social relationships (Thomson, 1953); Levi-Strauss (1958) has written,

In anthropology, this theory continues to stand, as soundly based as the gravity theory in astronomy. (p.162)

Gergen (1969) has suggested a simple psychological basis for reciprocity. Reinforcement leads to repetition, and so we reinforce behaviour which gives us pleasure and try to deter behaviour which does not. Exchange is a method of mutual reinforcement. Exchange, we learn from the theory of 'comparative advantage', has general benefits: by exchange, we can expand our potential both for production and for consumption (Kindleberger, Lindert, 1978, 16-23).

This is enough in itself to explain the recurrence of the phenomenon in different societies. But exchange also has specific sociological functions. Exchange, Levi-Strauss (1949) writes, "provides the means of binding men together." (p.480) The act of exchange is important in ritual: the Kula ring, the formal exchange of essentially worthless articles by the Trobriand islanders, is a classic example (see Mauss, 1925, ch.2).

Exchange is useful and desirable, and it has therefore in the course of time acquired, by the process Burke called 'prescription', the status of an obligation. Because prescription - the process by which a practice is tried, found good and accepted as a moral imperative - is determined by the nature of the society in which it takes place, exchange takes many forms. The workings of the principle are seen most clearly in the most extreme cases. Mauss, in his book on *The Gift* (1925), describes the potlach, which is a form of aggressive giving. By potlach, one person can gain dominance over another by pressing on him a gift that he cannot match. This is not generally practised, but it is an example of a process common to many, if not all, societies. Gouldner (1960) has argued that reciprocity is a fundamental principle of social organisation. "The norm of reciprocity is a concrete and special mechanism involved in the maintenance of any social system." (p.174)

Reciprocity is not the only norm governing gifts. The receipt of goods may be a mark of high status, rather than a state of dependency. In some societies, there have been tributes, which may be regarded as the opposite of the potlach: the aggressive demanding of 'gifts', sanctioned by war. The legend of Theseus and the Minotaur centres around a tribute: Theseus was sent with others as a tribute to Crete. The Romans took tributes from conquered countries. It could be argued that German 'reparations', or the 'protection' money paid to gangsters, are a kind of tribute, although they have the form of reciprocity. Another example in modern society is the making of presents for a royal wedding. Secondly, there are norms of altruism. We are told it is more blessed to give than to receive (Acts 20:35). In *The Gift Relationship* (1970), Titmuss argued that blood donation was an example of a 'pure gift' - a gift made by an anonymous donor to an anonymous recipient, without penalties for not giving or rewards for doing so, and without obligation or expectation that a gift would be made in return (pp.84-85).

There is a conflict between reciprocity and altruism. Where reciprocity is the norm, there can be no such thing as a pure gift: some return is demanded or expected. The expectations of people who believe in a 'just' world are one example of the influence of reciprocity: gifts which appear to be altruistic may be motivated by an irrational hope of reward. Titmuss argued that the Gift could become a guiding principle of social organisation. Exchange theory stands in opposition to this.

This explains something of the destructive aspect of charity. Engels (1845) inveighed against the principle: Charity - when he who gives is more degraded than he who receives.

Charity - when those who dispense alms also insist that those who receive them must first be cast out of society as pariahs ... (pp.313-314)

Frenkel-Brunswick argues that

From a social point of view, charity often has the function of keeping the underprivileged in their place, kindness acting in effect as a humiliating factor. (Adorno et al, 1950, 307)

She explains this in terms of the aggression which underlies charitable motives. Exchange theory provides a model which I find more convincing. In the first place, it is morally improper, under the norm of reciprocity, to break off relations or to launch hostilities against those to whom you are still indebted. (Gouldner, 1960, 175) Secondly, dependency implies a relationship in which the giver is more powerful than the receiver, because he can control aspects of the receiver's fate. If an exchange is conceived in a negative way, the imbalance of power inherent in dependency may be used to the disadvantage of the dependent person. Charity may be humiliating, as well as being degrading in itself.

All social services, Pinker (1971) argues, are systems of exchange (p.153). People are expected to give something in return for what they get. Dependency is only acceptable if same contribution has been made, or is likely to be made, to society, and a service is not respectable unless same element of reciprocity can be established. Steiner (1971) complains that

... it has become an important part of the veterans' pensions mythology to deny that a pension is relief and to insist that it represents deferred compensation for wartime service. In agriculture there is a myth that the food relief programmes are not really welfare programmes but are designed to benefit the farmer by removing surpluses from the free market. Public housers like to play down the idea of a decent shelter for the poor ... (pp.3-4)

But veterans' pensions are deferred compensation for wartime service; that is why their pension is accepted as a legitimate form of dependency when others are not. Food relief programmes do help the farmer - the destruction of food by the Common Agricultural Policy is proof of that. And a decent shelter for the poor is not accepted as an adequate reason for dependency.

If the payments are connected to the operation of the production system ... or to the future production of workers ... or to previous work status, then stigma does not attach to the support. (Miller, Roby, 1968, 75)

This is most of the truth. Contribution is measured largely by work status. Pensioners are respectable; they have paid their dues, by working most of their lives. Students are accepted, perhaps with some reservations, because they are going to contribute in the future. Disabled people are not generally accepted, although their dependency may be made temporarily legitimate through the sick role, which assumes that they will eventually be able to work again. People disabled through industrial injury have a special status. But it is not all the truth, because contribution can be measured in other ways - as the status of war pensioners, or widows, testifies. Pinker, in a small and unpublished survey (1973), found that most people saw the different social services either as exchange or as residual systems to be used only if an individual was unable to help himself - more than half as an exchange system. Very few saw the main function of the social services as an altruistic one involving a transfer to help people in need.

Titmuss himself recognised the importance of the norm of reciprocity. In *The Gift Relationship*, he found that the apparently altruistic gift of blood was usually governed by other considerations. There is in all these transactions, he wrote,

an unspoken assumption of some form of gift-reciprocity: that those who give as members of society to strangers will themselves (or their families) eventually benefit as members of that society. (Titmuss, 1970, 248)

But he saw this as evidence that altruism could work; a moral society could be developed on the basis of enlightened self-interest. Pinker argued, by contrast, that the norm of reciprocity undermined the principle of altruism, and Titmuss, who believed passionately in the altruistic society, criticised Pinker's arguments for their vagueness, and the conception of stigma in them as a parochial view based on the experience of one or two countries. He claimed that there was a great deal of evidence to show that the experience of being a claimant was different in different countries (Titmuss, 1974, 45). Unfortunately, he did not say where this evidence could be found, and being limited in my linguistic capacity, I have not come across it. There is, however, evidence to suggest that the problem of stigma is not confined to Britain and the United States. It appears in France (Stevens, 1973), Denmark (Westergaard, 1979), Ireland (Clifford, 1974), and Canada (Wadel, 1973). In Australia, welfare departments tend to be highly stigmatised, with a negative 'welfare' image. (Rodgers et al, 1979, 176) In Israel,

the right to assistance ... is seen as carrying strong elements of stigma and shame. (Rodgers et al, 1979, 124)

Even in the Soviet Union,

public assistance, financed from local funds, keeps its clients substantially below the poverty line; by requiring them to prove destitution, as well as age or disability, it also humiliates them. (Madison, 1968, 207)

The sole exception I have found is a statement by Dorothy Wilson that there are no problems with the take-up of benefits in Sweden (Wilson, 1979, 546). If this observation is correct, it could be taken to support the view that the rejection of financial dependency is based in the norm of reciprocity. Gergen (1969) reports a survey examining attitudes to gifts in Sweden, Japan and the US. Only in Sweden was a gift accepted with an attitude more favourable than to someone who had offered an exchange (pp.77-80) The different attitude to reciprocity implies a different attitude to the social services.

Titmuss was inconsistent in recognising the importance of reciprocity and denying its relevance to the problems of stigma. I suspect he realised that, if Pinker was right, his own ideal would be impossible of achievement; and the accusation of 'parochialism' was a reaction to a theory which excluded his conception of the Good Society.

### **Exchange and stigma**

A lack of reciprocity, of which dependent poverty is a clear example, has important implications for the status of the dependent person. Simmel (1908) argued that what makes a person poor is not the lack of means.

The poor person, sociologically speaking, is the individual who receives assistance because of the lack of means. (p.140)

Simmel's description of the process by which this happens relied on the idea of 'gratitude'. When a person was unable to reciprocate, he was bound to feel grateful for what he had received - a feeling which put him at a disadvantage in relation to the giver. Gratitude is difficult to redeem; it has 'a taste of bondage' (Simmel, 1950, 393). The esteem the recipient is required to feel for others is a form of homage; they gain in status, and he loses. This form of argument was taken further by Homans (1961). Esteem was given to people as a reward for the things they have done that are of value to others (p.149). As the value of the person to the group increases, so does the esteem he gets from them. This leaves less esteem for other people (p.163). Esteem is the basis of status. Because an esteemed person has a higher standing than other people, they defer to him, and he gains 'authority' (which I would call 'influence') over them (p.288). So, in cases where exchange is unequal, the donor gains both status and power, and, conversely, the recipient loses them. Homans seems to suggest that there is a limited stock of esteem; and Blau (1964), who develops Homans' work further, argues that status, like capital, can be drawn on, accumulated, or invested (pp.132ff). This is an unusual concept of status, but it is not untenable; status is a form of relationship, but it is also a social fact.

There are two main flaws in these arguments. Firstly, status is seen, especially by Homans, as something which is achieved by contribution. This is not true: much status is ascribed, by heredity, occupational status, or economic circumstances. It can be argued that there is an assumption of some contribution, but this is not a necessary feature of ascribed status. Secondly, as Ekeh (1974) points out, they tend to concentrate on social exchange as an extension of a dyadic interaction. The pattern of exchange in a whole society is different from that in a small group.

Levi-Strauss (1949) contrasts restricted exchange, which is directly reciprocal, with generalised exchange, by which he seems to mean any condition in which a circle of exchange could be completed (p.146). That much is true of any transaction which is not a direct exchange; it seems that any exchange or gift which is not restricted is generalised. The point of the idea of generalised exchange is that it entails generalised obligations toward society. Once a circle of exchange is complete, things come into balance, and there are no outstanding obligations. But while it is incomplete, it acts to create obligations and bind a

society together. Generalised exchange establishes a system of operations conducted 'on credit'. (Levi-Strauss, 1949, 265)

Social relations in a whole society are not equivalent to those of a small group. It is possible to ignore in a large society people who cannot be ignored when contact with them is more immediate, and people who are unable to reciprocate, Gouldner (1960) suggests, are likely to be neglected because they cannot fully participate in society (p.178). Furthermore, social rejection tends to be stronger when dependency is impersonal. Berkowitz and Daniels (1963) found, in a psychological experiment, that someone who was told that his effort was being made known to a dependent person was less likely to blame him than he was when the efforts were not known. (This casts even stronger doubts on Titmuss's hopes for anonymous altruism.) It seems that exchange binds more strongly in a small group, which might have been expected, and that one effect of generalised exchange, because it is more remote, is to increase the rejection of dependent people.

The relationship between exchange and status can be described directly in terms of the norm of reciprocity. Linton (1936) defines a status as 'a collection of rights and duties' (p.113). A person who receives something has a duty to reciprocate. If he fails to do so, an obligation is outstanding - which, by definition, implies a relative loss of status. Someone who is absolutely dependent on others, and unable to contribute anything in return, has in consequence a very low status. I have argued before that Linton's definition is a limited interpretation of the idea of status, which extends beyond rights and duties into social honour, life-style, economic circumstances and social expectations. The relationship described between exchange and status can still be made out if a wider definition of status is used; a person whose behaviour or life style does not correspond to the expectations attached to his role is degraded.

There is an apparent contradiction in the assimilation of reciprocity with stigma. Stigma divides people; reciprocity binds them together. A person who is dependent is not rejected; he is bound up with the social organisation. If exchange theory is correct, this should bring him closer to society, not drive him away from it. In a brilliant essay, Marshall Sahlins (1972) resolves the paradox. He distinguishes three kinds of reciprocity: generalised, balanced and negative. Generalised exchange occurs when people give without expecting something directly in return, in the belief that the others would, or will, do the same for them. It is most often found in intimate relationships or families. Balanced exchange is strictly reciprocal: it is the reciprocity of more distant friends or business partners. negative exchange is self-seeking: the harshly competitive relationship of commercial trade. Almost by definition, generalised exchange implies a closer relationship than balanced exchange, which is in turn closer than negative exchange. If our exchange is generalised, we assume - or conclude - that we are close. Exchange is, therefore, the main determinant of social distance. (Sahlins, 1972, ch.5) If this is taken to its logical conclusion, a gulf opens between those people who are engaged in exchange, and those who cannot be involved because they have little or nothing to offer. Some redistribution is necessary to bring the poor into society, and to hold society together.

The greater the wealth gap ... the greater the demonstrable assistance that is necessary to maintain a given degree of sociability. (p.211)

The rich must give to the poor; and, Sahlins shows in an appendix that is a tour de force, the obligations of high status are common to a wide variety of cultures and societies. However, the governing principle is not the altruism that Titmuss hoped would emerge, but negative exchange. The collectivity, of which the poor person is a part, enters into a relationship with him, confronting him, treating him as an object. (Simmel, 1908, 31) 'Noblesse oblige' is a duty that the donors would gladly avoid but which they nevertheless recognise. As a result, people continue to support others who they despise.

Sahlins' argument provides an explanation for stigmatisation which is elegant, orderly and persuasive. But some reservations should be made. Dependency is not always dishonourable; and some conditions, including poverty itself, are rejected although they are

not dependent. The argument is not a comprehensive explanation of social rejection; it is at best a contribution, albeit an important one, to a complex and difficult problem.

## Implications for policy

### *The reduction of dependency*

I have argued, in the introduction, that dependency is the defining characteristic distinguishing social services from other forms of public provision. If dependency is stigmatising, the association of stigma with the social services is unavoidable; dependency is inherent in their nature. At the same time, it becomes desirable to limit the degree of dependency as far as possible. The degree of stigmatisation varies with dependency, because greater dependency implies an increased limitation of roles, and limited roles lead to stigma through lowered status, the imputation of failure, or lack of reciprocity. Secondly, dependency leads to restrictions on individual freedom; a person who is dependent on others to do things for him loses autonomy, because he can only act with the aid or acquiescence of others, and because their actions may limit the choices available to him. Dependency limits an individual's power of self-determination - a power which, Downie and Telfer (1969) argue, is fundamental to respect for persons.

The administration of social services has sometimes failed to take these problems into account. Lipman and Slater (1978) cite a White Paper issued by the Ministry of Health in 1950, shortly after the abolition of the Poor Law:

'The workhouse is doomed. Instead, local authorities are busy planning and opening small, comfortable homes where old people ... can live pleasantly and with dignity. The old "master and inmate" relationship is being replaced by one more nearly that of an hotel manager and his guests.'

They argue against this that the idea of a hotel forces inmates to rely unnecessarily on staff: dependency is inherent in the notion. (p.199)

The guest in a hotel does not choose the decoration or furniture in his room, cannot use the room as he wishes, and cannot decide when to have meals. He is relieved of certain responsibilities. Although this does imply a loss of independence, I do not think it is so great as altogether to invalidate the concept of a Home as a Hotel, which some people may find desirable. A far greater loss of independence has resulted from the confusion of residential care with medical treatment. The sick role is, I have argued, an inappropriate model for chronic incapacity, because it rests on the assumption that the object of treatment is a return to normality. Treatment in hospital is regimented in a way which facilitates physical repair, but is rather less desirable as a way of living. The training of nurses has been inadequate for positions in residential care - and there is some doubt as to whether nursing is appropriate at all for many of the people they deal with. They are taught to do everything for their patients, and the lives of patients are shaped around the organisation of the ward. Institutional neurosis flourishes.

'We do treat them like children,' the nurse admits. 'That's what they are really, isn't it?' (Harrison, 1978, 122)

If dependency is to be avoided, however, it requires more than the reduction of physical dependency. Payne (1980) suggests that social workers can help their clients to reduce their sense of dependency by emphasising, wherever possible, the contribution they have made to society, and by limiting the period for which they are dependent. This approach is essentially negative; ideally, we should be trying to create opportunities for the recipient of social services to contribute. One way of enabling more responsibility for recipients is to allow for some form of participation, a policy which I have already discussed. The Seebohm committee suggested that participation should reduce the rigid distinction between the givers and takers of social services, and the stigma which being a client has often involved in the past (Cmnd.3703, 1968, 151) but it was magnificently vague as to how this could be achieved. The norm of reciprocity implies that a recipient must be able to contribute something to society in return for a service. The emphasis in programmes of rehabilitation for disabled people has been on the reduction of dependency by filling a job. In some cases, this

approach is entirely appropriate. Olshansky (1970) describes one experiment in which mentally retarded people were given work driving fork lift trucks. He reports that this was wholly successful: "Work enfranchises them as human beings." (p.45) But there are problems in taking this for general policy. The first is that it assumes that stigmatised people are capable of work, which is not always true. Many are old and retired; others are simply incapacitated. A policy concentrating on rehabilitation through work simply does not touch them. Secondly, those who can work are often given jobs which are boring and petty. Baldwin (1979) objects to the idea that this is worse than not working: the pious hope that they should be exempted from the need to work singles out a stigmatised group to spearhead the assault on one of the central values of a society which already assigns them low status. Work, even petty work, brings with it a certain self-respect - not a lot, but it is better than unemployment and dependency. The third objection is that the emphasis on work gives to some disabled people the status of the deserving poor. The idea of 'self-determination' is a strong theme in social work, and Soyer (1975) argues that there is a 'right to fail'. This is all very well for the people who succeed; but, necessarily, it must leave others behind who do not. This objection applies equally to any attempt to make it possible to contribute to society.

*The principle of insurance.*

By contributions, a person can acquire a right to benefit. It is received wisdom that People do not want to be @ e rights to pensions and benefit; they want to earn them by their contributions. (Cmnd. 3883, 1969, 12) This is the main justification of the principle of insurance.

While there is something humiliating in receiving assistance without giving something in return, insurance, which requires an effort on the part of the insured, gives him a feeling of dignity. (Laroque, in ICSW, 1969, 86)

The claims made for insurance are considerable. Mauss (1925), reflecting a contemporary debate in France, saw the introduction of insurance as a return to 'group morality', and a foundation of 'social solidarity' (pp.65-66). This is a strange argument; should have thought that the principle of insurance was more closely linked with ideas of individual responsibility. And yet the rhetoric of the Beveridge report (Cmd. 6404, 1942) reflects this euphoric opinion. Insurance would be given, "not as a charity but as a right" (para.296). It would be comprehensive (para.303) and social (para.303), redistributive (paras. 445-7), and would ensure a "national minimum" (para.66). In practice, insurance has fallen far short of these ideals. This is not because it has not been properly applied; the failings are part of any scheme of insurance. Stevenson (1973) records how

We cling to the idea of individual insurance against poverty and related problems, thus, by implication, stigmatising those who have not been able to make such provision. (p.19)

National insurance does not help those who have not worked - groups such as the congenitally sick and disabled, school-leavers who are unemployed, young unmarried mothers, and married women who have kept house or left the labour market to raise children. Provision can be made for some of these groups, but, as Abel-Smith (1976) argues,

If some categories are not excluded from the rights purchased by paying the insurance contributions, it ceases to be insurance in any normal use of the term. ... Normally separate provision for these groups is made through a public assistance scheme. And usually this creates a stigma of some kind. The credibility of social insurance is normally secured by penalising in some way those outside the scheme. (p.43)

This is the first objection to the idea that insurance creates 'social solidarity'. It is not comprehensive; it does not ensure a national minimum. On the contrary, it makes it necessary for some other provision to be made which does not carry the same 'rights'. A second, even more basic objection is that people do not necessarily look on insurance as a right. Social security in the US is less stigmatised than other benefits (Williamson, 1974c, 220), but the bald statement that unemployment insurance is not stigmatised (e.g. Stein, 1971, 67) is questionable. Schiltz (1970) reports that in the US



archival survey evidence neither confirms nor denies the assumption that social insurance is more acceptable as a remedy for the ravages of unemployment than are need-based programmes. (p.118)

This can be put more strongly. The attitude to Unemployment Benefit in the UK is negative despite its being an insurance programme. This does not mean that insurance is no better than relief; the contributory element helps, by reducing the feeling of degradation associated with a lack of reciprocity. But this is only a part of the problem associated with dependency on welfare benefits. There is a stigma attached to the conditions, like poverty, disability, or unemployment, which cause people to become dependent in the first place. If the norm of reciprocity was all that mattered, an unemployed person should be more 'entitled' to unemployment benefit than a disabled person to non-contributory invalidity pension. But it is unemployment which carries a greater stigma. Health services are generally seen as more acceptable than welfare. This has been taken to be because there is a right to health. Liebman (1976) writes that Whether one is 'disabled' or 'on welfare', previously only a technical distinction between categorical aid programmes, is now a matter of the greatest practical, moral and emotional significance. This is because our social welfare programmes fall along a continuum that may be crudely described as running from legitimacy to stigma, from entitlement to gratuity. (p.857) There are two reasons for this. Firstly, the reason for dependency is important. Dependency because of illness is legitimated through the sick role; dependency through unemployment is not. This is a substantial qualification to the application of a general theory of reciprocity. Secondly, health services are, perhaps perversely, seen as reciprocal. Many people still believe, mistakenly, that the NHS is paid for largely from Insurance contributions. Pinker (1973) found that the NHS is often thought of as a system of exchange (p.67).

In a similar vein, Briggs and Rees (1980) found a number of recipients of Supplementary Benefit justifying their dependency by asserting they had paid for their benefit through taxation or even (remarkably) through insurance contributions (p.147). This is less a tribute to the power of insurance to legitimate dependency than an attempt to establish reciprocity by any convenient means. It suggests that the norm of reciprocity can be, if not overcome, at least circumvented by a convenient myth. But it still falls a long way short of the model of an altruistic society favoured by Titmuss.

#### *Means-testing.*

The main alternative to insurance is means-testing; but means tests are commonly believed to be more stigmatising than insurance payments. In the past, means tests were a part of the Poor Law. The practice of means testing was oppressive and much resented (see Orwell, 1937); a legacy has been left of mistrust and hostility. TenBroek and Matson (1966) point out the continued opportunities for harassment, the denial of choice, bureaucratic control and the abuse of administrative discretion (p.499).

A part of the problem has been that means tests are of their very nature intrusive. It can be argued against this that assessments for income tax are also intrusive, but there are important differences in practice. Means tests are not an automatic process applying to all, as the payment of tax is; Briggs and Rees (1980) found a number of claimants who suggested that the reason Supplementary Benefit seemed like charity was that one had to claim it (p.148). (This attitude does not extend to claims for tax allowances - perhaps because this is seen as reclaiming one's own money, rather than as a form of dependency) Tax forms are generally dealt with in correspondence; many means tests - notably Supplementary Benefit - require a person to appear at the office and be interviewed. Tax forms require only income to be declared, whereas means tests may also require information about wealth, expenditure on housing, personal spending, special needs and, most important, personal relationships. A second difficulty is that means tests identify the claimant as a poor person; qualification for benefit is proof of poverty. This is fundamental to any system of residual welfare. The reluctance of people to state their income may simply be a reluctance to admit they are poor

- a problem which does not occur with tax forms, because poverty is not an essential prerequisite of paying tax.

I think however that Handler (1972) identifies the real problem when he points out that there is, in the practical administration of means tests, a presupposition that the claimant is likely to be dishonest (p.29). Harvey (1979) describes the case of a couple who, in order to qualify for a rent allowance, were asked to produce evidence of their receipt of sickness benefit, documentation of the payment of rent, bank statements, details of their debts, their previous address, their reasons for moving and an outline of their daily budget. "They had not, she notes drily, "thought to be so mistrusted" (p.29). The reaction of claimants to this treatment is probably made worse by a feeling that there is something dishonest about claiming - a consequence of their own attitudes towards dependency.

It seems desirable that if we must have means tests, they should not be unnecessarily offensive. A system begun in Alabama reformed the method of verifying entitlement to benefit (Alabama Social Welfare, 1965). Instead of asking people to produce documents, verification of statements and signatures from all concerned, an experimental group of people were asked simply to state their position in a 'declaration'. Out of 228 cases, only 4 were discovered, on a later check, to be in error. Encouraged by this result, the administrators extended the procedure of declaration across the state. In the first year, 9677 cases were checked by a more thorough examination. 156 errors were discovered. 55 of these did not involve any change of payment, and in 21 of the remaining 101 cases, the payment was increased. The administrators concluded that the extensive documentation required in the past has been unnecessary. Other states subsequently took up the procedure. Requirements such as proof of age, registration for work, verification of residence, documentation of employment record, and the signature of every adult in the household were dropped. Phillips (1972) reports that these states found no difference in the validity of declarations for benefit when compared to the previous tests, and faster administration of claims. Not only this, but the attitudes of claimants to the service, and to the benefits, changed very favourably.

Means tests in Britain usually require less information than used to be required in these states, but possibly more than is necessary. The evidence suggests strongly that people who are treated as honest do behave honestly; too many current procedures assume they will not. As the administrators in Alabama stated,

the public assistance programme must plead guilty to charges of creating and preserving a climate that is more conducive to the harassment of clients than to the preservation of human values. (Alabama Social Welfare, 1965, 14)

### *Rights and discretion*

The rejection of dependency also reflects on the attempt to overcome stigma by giving stigmatised people a right to welfare. Donative rights are not compatible with the idea of reciprocity. Entitlements cannot be given, because there will always be a residual obligation which comes from the failure to make a return. There is a curious optimism about the importance of legal rights which it is difficult to justify rationally. Raynsford (1979) writes about

the prejudices and stigma attaching to the homeless which the 1977 Act is overcoming. (p.133)

The 1977 Act may have changed the practice of the responsible authorities, but that is not the same as overcoming prejudice.

Rights are important for three reasons. Firstly, they are a means of protection against the disadvantages which follow stigmatisation. Rights for mental patients in the US have helped to curb abuses. Rights for unemployed people under the National Insurance scheme have at least mitigated the harshness of the treatment of the unemployed between the wars (see Deacon, 1976). Secondly, rights help to guarantee minimum standards of material welfare.

Rights for homeless people have helped in cases where local authorities would have turned families away. Rights are not a complete protection in themselves, but they certainly contribute towards a standard. Thirdly, rights are important because they are a mark of a universal system of social welfare. Julia Parker (1975) argues that a person's rights are the proof of his status as a citizen; where social welfare is determined by right, there is no stigma (pp.146-147). Marsden (1973) sees this as the way to overcome the traditional aversion to social welfare:

Only by giving the families as far as possible benefits as of right, can they be allowed to escape from the stigma of the Poor Laws. (p.308)

However, as I have already argued, the creation of rights does not in fact remove stigma. Stigmatised people lack rights because they lack status and power; legal rights can help to improve status and power, but there is a limit to their scope. Jones (1980) argues that the creation of rights may even have the effect of increasing stigma. Rights are clearly distinguished from charity; the creation of rights only emphasises the distinction, and therefore the lack of entitlement felt in other ways (p.142). This seems to me correct in theory, and in practice it has this effect in the cases of rehabilitation and insurance. The alternative to the establishment of rights in the provision of services is a reliance on administrative discretion. Discretion is not an 'anonymous gift'. The person who wants a service must ask for it, and must ask an official who has the power to admit or refuse the request. To some extent, this is true of all services: the staff decide which claims fall into which categories. Hall (1974) found that the reception staff who did this rarely even recognised it as discretion; they thought of it as 'common sense'. The same may be true of the feelings of claimants about it. But the fact of having to ask in itself brings home an acute sense of dependency; it can make a claimant feel like a beggar. In addition, discretion gives scope for individual prejudice, and discretionary procedures therefore put at a disadvantage a person who is stigmatised.

On the other hand, discretion is necessary to guarantee flexibility. Jordan (1974) states that in the case of social security,

flexibility and responsiveness to need have been sacrificed in an attempt to reduce stigma and make the administration of benefits more impersonal. (p.181)

But, he argues, the necessity of some flexibility has led to demands being placed on the financial powers of local authority Social Services departments, who are not always equipped to deal with problems of this sort adequately. This is representative of a constant dilemma. There is always an element of discretion in the administration of social services; the question is not whether it should happen, but how much there should be. Benefits established by 'right' are still stigmatised for dependency; discretionary benefits may be more stigmatising, but it is a matter of degree. Responsiveness to need is not inconsistent with personal dignity. And although the use of discretion may involve a humiliating dependency, the consequences of not being provided for may be worse.

## Chapter 6: Summary

Dependency may be physical, psychological or financial. Each form is stigmatised and confused with the others. People who are dependent are in breach of a general norm of reciprocity. A lack of reciprocity implies lowered status, and social isolation or rejection. Dependency is inherent in the nature of the social services. A reduction of dependency is important if stigmatisation is to be reduced. This has been attempted through insurance, but the argument that insurance is not stigmatising, and that means tests, which imply dependency and poverty, are stigmatising, is questionable as a generalisation. The attempt to give 'rights' to claimants may assist as a protection against disadvantage, but rights do not remove the stigma of dependency.

## Chapter 7

# MORAL STIGMAS

### Morality and deviance

Morality is uncompromising. Where there are social norms, there is a social division; those groups which are within the moral code are distinguished strictly from those which are not. The distinction is made between normal groups and deviant ones. Deviance is not simply abnormality; nor is a person deviant simply because he is discredited (Cohen, 1966, 36; Goffman, 1963, ch.5). It involves a breaking of the rules which govern civil society. Simmons (1965) asked people who they thought of as deviant. The answers included homosexuals, criminals and communists; but the only group identifiable as recipients of social welfare were mentally ill people (p.224). The imputation of deviance is, in this case, an accusation of immorality.

There is a substantial literature on deviance, which has grown out of criminology. It attempts to identify the process by which deviants are marked off from the rest of society. There are many different explanations for this process. One rests on the assumption that people are pathologically immoral. Another depends on the rejection of social values, either as an individual or jointly with others. Thirdly, there is the concept of 'drift' described by Matza (1964) in relation to juvenile delinquency; people become deviant, he suggests, because there is no reason not to. Fourthly, there is the view that deviants are forced into deviance by society. The object of this section is not to give a comprehensive review of the sociology of deviance, but rather to look at the relevance of these ideas to social welfare.

#### *Pathological immorality*

The idea of pathological immorality involves the assumption that immoral conduct requires explanation; it presumes that a state of observance to morality is the natural condition of humanity. It has been regarded at certain times to be evidence of a personality disorder if an unmarried girl became pregnant. At the turn of the century, social problems - like crime, social immorality and drunkenness - were considered to be the consequence of intellectual disability. These characteristics were called the 'degeneracies'. Boies (1893), writing in the US, proclaimed:

We believe it is established beyond controversy that criminals and paupers both, are degenerate; the imperfect, knotty, knurly, worm-eaten, half-rotten fruit of the race. (p.266)

According to Cooley (1902), better known for his concept of the 'looking glass self', A degenerate might be defined as one whose personality - personality, note, and not behaviour falls distinctly short of a standard set by the dominant moral thought of the whole. (p.372)

He wrote:

This truth that all forms of deficient humanity have a common philosophical aspect is one reason for giving them some common name, like degeneracy. Another is that the detailed study of fact more and more forces the conclusion that such things as crime, pauperism, idiocy, insanity and drunkenness have, in great measure, a common causation, and so form, practically, parts of a whole. (p.375)

Cooley advocated social isolation for degenerates. The school of thought which this represents led eventually to the advocacy of eugenics as a longer-term policy to deal with social problems. Promiscuity was evidence of mental disorder, and unmarried mothers were committed to institutions and sometimes sterilised.

The modern descendant of the degenerate is the 'problem family'. 'Problem families' are not the same thing as 'families with problems' - the term 'multi-problem family' tends to confuse

the issue. They are families that are problems for social agencies. The definitions of the term tend to vary. Spencer (1963) notes some of their features: they are often large, mobile, socially isolated, and organised around the mother. There are likely to be chronically dependent on social services, exploitative, and fail to respond to the help they receive - by definition, as they would not be a problem if they did respond to help. Their social relations are inadequate or destructive (p.12).

Blacker (1952), an advocate of eugenics, remarks on five 'commonly recognised' features: mental subnormality, temperamental instability, ineducability, a squalid home, and the presence of numerous children (p.16-28). This is more the language of genteel insult than informed observation. Philp and Timms (1957), reviewing the literature, pick out some of the most persistent characteristics. The emphasis tends to fall on the family's way of life, neglect of their children, and their personal defects, in health, mental capacity, or sanity. Holman (1974), it may be remembered, argued by contrast that problem families were distinguished by being designated a problem family by a social agency (pp.609-610). This is too simplistic a view. Learning disability, criminality, chronic dependency, ill health and mental illness all have a profound capacity to stigmatise. The combination of several of these characteristics may be rare - as Rutter and Madge (1976) believe it is (ch.9) - but it can only be devastating when it occurs.

It would be going too far to say that there was no substance in the pathological view. At the same time, it is difficult to see how, when moral codes are socially defined, immorality can be defined in personal terms. It is necessarily the result of a relationship between the individual and society. It is this relationship which needs to be explained.

#### *Deviant attitudes*

A second view of deviance attributes it to the attitudes of deviant people to society. Merton (1968) classifies the forms of deviation according to the acceptance or rejection of social values and the structure of society. If a person accepts both structure and values, he conforms. If he accepts structure and rejects values, he involves himself in ritual - the form, but not the spirit, of morality. If he accepts social values and rejects structure, he acts as an innovator in society. If he rejects both values and structure, he 'retreats'. Retreatists include psychotics, autists, pariahs, outcasts, vagrants, vagabonds, tramps, chronic drunkards and drug addicts. (p.194) They call values into question by ignoring them. Finally, there are rebels - people who reject both values and structure, but accept others which they wish to substitute. The combinations can be represented in a table, as follows: '+' signifies agreement, and '-' disagreement.

**Table 7.1: Attitudes to society. (Merton, 1968, 207)**

	Social values	Social structure
Conformity	✓	✓
Ritualism	✗	✓
Innovation	✓	✗
Retreatism	✗	✗
Rebellion	±	±

The category which is most relevant to stigmatised people is the 'retreatist' group. The classification has two main weaknesses. Firstly, it is difficult to attribute any uniform attitudes to pariahs or outcasts. An outcast is defined by what is done to him, not by his

attitudes; and a stigmatised person can share the values and opinions of others in society. Secondly, a person's attitudes are not to be assumed from one aspect of his behaviour. It does not follow that, because a person is a drunkard or a vagrant, that he rejects social values in their entirety, even if he rejects them in respect of his own condition.

Shoham (1970) uses a similar method to classify deviant behaviour and attitudes. He takes three essential factors - value deviation, deviant behaviour, and stigma - and examines each of the possible combinations. In a table, the classification looks like this:

**Table 7.2: Forms of deviance, (Shoham, 1970, ch.4)**

Description of condition:	Value deviation	Deviant behaviour	Stigma
Solidarist (non-deviant)	No	No	No
Levantine (Ritualism)	Yes	No	No
Privileged	No	Yes	No
Successful sanction orientation (primary deviant)	Yes	Yes	No
Victimised	No	No	Yes
Defiant	Yes	No	Yes
Inner conflict	No	Yes	Yes
True deviant	Yes	Yes	Yes

These categories are related, in his argument, to the deviance of criminals rather than the particular problems of the stigmatised people who rely on social services. These can be very different. Not all stigmatised people are deviant, either in values or behaviour. A person who is not deviant may be stigmatised because he has discrediting personal characteristics. His values may or may not correspond with society's. A person whose behaviour is deviant - who breaches moral norms - may have deviant values, but he may not if he is not responsible for his behaviour (for example because of mental illness), if the deviant act is not representative of all that person's values (like becoming an unmarried mother), or if society itself is ambivalent towards the behaviour (as in the case of claiming welfare benefits).

This last point highlights the common flaw of Merton's and Shoham's approaches. They assume that social values are consistent; they are not. Attitudes to old people, for example, include contempt, pity, the expectation of dependency, affection, and exaggerated respect. Mentally ill people are seen as being in need of help at the same time as they are condemned if they seek it. Everyone - or almost everyone - agrees on the necessity of some form of social security, but people are rejected if they actually take it. So it is difficult to establish whether behaviour really is deviant, or attitudes are in opposition to social norms. These classifications are useful in so far as they create a set of ideal types of deviation, but in practice they may be difficult to apply.

### *Drift*

Another weakness of this approach is that there is no sense of process in it; the opinions of the deviant sprung ready formed into being. In real life, people do not begin as deviants or

conformists; their attitudes and behaviour develop in accordance with their social circumstances. The theory of drift - sometimes called the 'anomie theory of deviance' - suggests that people become deviant, not through a deliberate choice of deviant values, but through a process of gradual separation from the main culture. It is related to anomie, because there is an absence of social norms to guide the individual and prevent him from becoming deviant; he is under-regulated. "Being pushed around", Matza (1964) writes, puts the delinquent in a mood of fatalism. He experiences himself as effect. In that condition, he is rendered irresponsible. The sense of irresponsibility puts him into drift. Drift makes him available for delinquent acts. (p.89)

This theory is, once more, formed primarily in respect of criminal activity. It is tempting to extend it to the recipients of social services. They also are 'pushed around', and a mentally ill person, or a person who has to claim social security, may be 'channelled' into a degraded status. The difference is, I think, that although a decision to claim a service may be the result of a process, the recipient does not wander into dependency. There is no primary deviation, no gradual stage of initiation into deviance. The act of claiming benefit is, in itself, a major step defining a social role. As Marshall (1963) wrote of the Poor Law, The stigma which clung to poor relief expressed the deep feelings of people who understood that those who accepted relief must cross the road that separated the community of citizens from the outcast company of the destitute. (p.83)

The theory of drift relies on the effect of a lack of regulation on responsible behaviour. The moral careers of stigmatised people are diverse, but there are no indications that, where moral issues are at stake, the conditions of the anomie theory are relevant to the problems of the people who use social welfare.

#### *Labelling theory*

A different account of the process of becoming deviant is given by labelling theory, which concentrates on the attitudes of society to the deviant individual, rather than on his views of society. Lemert's (1951) distinction between primary and secondary deviation is an attempt to explain this process. The primary deviant - the person who has done something bad - becomes a secondary deviant, a 'bad person', because of labelling. This separates him from the community, reinforces his deviant conduct, and pushes him to adjust to a deviant status (ch.4).

Lemert's emphasis on labelling has been followed by many writers, in an attempt to explain the effect that the social definition of an individual's condition has on that individual. This has led to the perspective known as 'labelling theory'. Labelling theory argues, essentially, that people are deviant because they are labelled as deviants. Becker (1963) has written that  
Social groups create deviance by making the rules whose infraction constitutes deviance. (p.9)

This view has been strongly criticised. Fisher (1972) retorts:

With equal relevance and accuracy one could say that lovers create deviants by conceiving the persons who make the rules whose infraction constitutes deviance. (pp.82-83)

Becker is arguing that the label which society puts on the deviant person is more important as a feature of deviance than the behaviour of the deviant person. I have already looked at evidence about the rejection of people who are mentally ill; all the indications are that people are labelled because they are deviant, not deviant because they are labelled.

Labelling theory is not without value. Its scope in the field of social welfare is limited, because so much of it is concerned with formal processes of stigmatisation - particularly by the courts which have limited relevance to most of the forms of stigma discussed in this study. But the labelling perspective has led to a healthy scepticism of many of the labels we do use, particularly in the field of psychiatry. It has led to an appreciation of the role that social agencies play in marking off deviants from the rest of society. It also helps to explain the reluctance of many people to put themselves in a position where they will be identified as deviant.

The conditions under which a label is accepted depend, however, on the nature of the stigma. Gove (1976) argues that a formal label makes little difference to disabled people, but in some cases it may have a positive advantage, because of the services which follow labelling (pp.68-69). This is true to some extent although it is worth remembering that there is substantial resistance among physically disabled people to registration as disabled (New Society, 1978, 3). The balance which has to be struck is the choice between costs and benefits described by Weisbrod (1970). It is true that in certain cases the benefits may outweigh the costs, but there is a cost attached to the acceptance of a label which should not be denied.

## **Implications for policy**

### *Labelling and welfare*

The history of social administration is littered with futile attempts to achieve overnight reform by changing the names of services. 'Public assistance' was introduced in 1930 as a reform to dissociate welfare from the stigma of out-relief under the Poor Law; it soon acquired a stigma of its own. 'Transitional payments' were introduced for the unemployed, later renamed, in 1934, 'Unemployment Assistance'. As part of the abolition of the Poor Law, in 1948, Unemployment Assistance became the basis of National Assistance. (A similar change was made in France in 1954, when public assistance was renamed as 'social aid': Stevens, 1973, 10) And when National Assistance was discovered to be disliked, after Richard Crossman had announced "I will change the name only when I have changed the system" (cited Kincaid, 1973, 36), the name was changed to Supplementary Benefit. It is not that, throughout this time, the services did not change; but in practice, the most significant changes, like the abolition of the household means test in 1941, had little or nothing to do with the new beginnings trumpeted abroad by a change of name.

It is not only the services that go under different names. Mentally handicapped people in the UK are called 'subnormal' or 'severely subnormal'; in the US, they are 'mentally retarded'; in Australia, they are 'intellectually handicapped'. 'Degenerates' have become the undeserving poor, multi problem families, hard to reach, or problem families (a term which, Matza (1967, 290) points out, conveys the point that they are a pain in the neck). Poor people have been called the poor, the lumpenproletariat, the submerged tenth, the abyss. Unemployed people used to be 'idle'. A recent letter to the Guardian suggested,

Sir, - The word 'unemployed' has developed unfortunate connotations. Would not the use of the description 'unproductive' be preferable in present circumstances?  
(Kirk, 1980)

I was charmed by the silliness of this proposal; it is not only that 'unproductive' means something quite different from 'unemployed', but that besides it seems to me to have no advantage in the images it evokes.

Disreputable poverty, Matza (1967) writes, has gone under many names in the past two centuries. The major thrust and purpose of word substitution has been to reduce and remove the stigma, and perhaps one reason for its obsessiveness is that the effort is fruitless. The stigma adheres in the referent and not the concept. (p.289) This is, I think, the crucial point. The services acquire a bad reputation because of the people they deal with, the way they deal with them, and the dependency they entail; the change in name makes little difference.

At the same time, names are important. They serve to identify a stigmatised group. Blaxter (1975) distinguishes the stigma of the general label from the specific label. She notes that disabled people choose the label with less negative connotations. They may, for example, say that they are 'diabetic' rather than 'disabled', but prefer the term 'disabled' to 'epileptic'. (I have noticed a tendency among some people I have worked with to prefer the term 'registered disabled' to 'disabled', but I do not know whether this is representative of a wider feeling.) Similarly, it could be argued that it is better to be thought of as a 'widow' than a 'single parent', and 'single parent' is better than 'unmarried mother'.



Names also convey ideas about people. Nunally (1961) found that the words describing mentally ill people - words like 'mad' or 'insane' - were not only misleading, but had strong negative connotations. Mentally handicapped people used to be called idiots, morons, imbeciles or feeble-minded, under the 1913 Mental Deficiency Act. These words are still insulting now, in a way that 'subnormal' is not. The Royal Commission on Mental Illness and Mental Deficiency (Cmnd. 169, 1957) remarked:

We consider that the public attitude towards mental disorder has outgrown the terms 'idiot', 'imbecile', and 'person of unsound mind', and that new terminology is needed to make a step forward from ancient prejudices and fears and to be an outward sign of real advance in public sympathy. (p.59)

There is some justice in this. 'Subnormality' was a step forward from 'idiocy' - it could hardly have been worse.

There are two things which distinguish the importance of names in the fields of public assistance and learning disability. Firstly, public assistance is a system; learning disability is a problem. If systems are stigmatised largely through the people they serve, it does not help to change their name without at the same time changing references to the people they serve. Changes of this kind have been made, in the history of the Poor Law, with large groups of people ceasing to be 'paupers': in 1885, when an exception was made for hospital treatment; in 1908, for those who received old age pensions; in 1930, for people on 'public assistance'; and in 1948, when pauperism was abolished. It seems, in general, to have helped - although avoidance of the workhouse and the material disadvantages of pauperism may be enough to explain the improvement in status. Secondly, the names imply different things about the people involved. There is, in the sense of 'handicap', no sense of blameworthiness or responsibility. The idea of 'assistance', on the other hand, conveys only dependency, and 'Supplementary Benefit' is a piece of gobbledegook that conveys nothing at all. Nunally (1961) offers a technique, the 'semantic differential', which makes it possible to assess the impact on attitudes of different names. It is important that, before any further change is made, some investigation is undertaken to see whether it would help.

### *Morality and social control*

The social services are sometimes organised in a way that will penalise moral turpitude. Elman (1966), for example, records how applicants for public housing in New York could be evicted if they had illegitimate children (a similar policy was declared illegal in Arkansas in 1967: Mandelker, 1973, 64); if the husband and wife had been separated twice in the past five years; if their work history was irregular; if they had ever been evicted from public housing; and, strangely, if they were mentally retarded (p.22). The Cullingworth report on the allocation of council housing in England expressed surprise to find some housing authorities who took up a moralistic attitudes towards applicants:

the underlying philosophy seemed to be that council tenancies were to be given only to those who 'deserved' them and the 'most deserving' should get the best houses. Thus unmarried mothers, cohabitees, 'dirty' families, and 'transients' tended to be grouped together as 'undesirable'. (Central Housing Advisory Committee, 1969, 32-33)

The suspension of unemployment benefit for industrial misconduct, the loss of rights by people who are judged to be 'intentionally' homeless, or the steps taken to curb 'abuse', are symptomatic of the prevailing moral framework. "Where morality is at issue", Handler argues, "welfare is conditioned, regardless of any notional entitlement" (1972, 24). Moral stigmas, and the policies based on them, serve a purpose. They control the undesirable behaviour of individuals, in cases where that behaviour is itself detrimental to other people (as it may be, for example, in the case of some mental illnesses) or where the behaviour is inconsistent with the maintenance of the social structure, which it could be argued to be where work or family relationships are abnormal. Mary Douglas (1966) argues that morality itself serves a function by defining a society within common boundaries. So is it desirable that moral stigmas should be overcome?

I believe it is. Social welfare should seek to benefit individuals as well as society as a whole; it emphasises the need to integrate people into society. It is true that a moral norm can itself be an integrative force for the people who are not cast out, but this can only work at the expense of those who are. The material effects of moral stigmas on illegitimate children are difficult to defend. The stigma of mental illness, which is in part a moral stigma, may cause people to deny their problem and avoid seeking treatment. The stigma of venereal disease, which is largely moral, may have a similar effect, as well as causing people to conceal the sources of contagion. The moral condemnation of welfare recipients leads to harassment and humiliation. It is not to say that moral stigmas are not, in some cases, justified on other grounds. But, from the point of view of welfare, censure and confinement are not constructive. The object of the social services must be to improve the condition of the recipient, rather than to control his behaviour.

### **Chapter 7: Summary**

Moral stigmas are occasioned by the breach of a moral rule. They imply a separation between normal and deviant groups. Deviance has been attributed to pathological immorality, the rejection of social values, 'drift', or because deviants are forced into deviance by society through the process of labelling. Each of these has limited relevance to social welfare. Moral stigmas may be used in social policy for the purpose of social control; this approach may be inconsistent with an intention to improve the condition of the recipient of social services.

## Part 2: a conclusion

This part has covered a wide range of material, and because it has dealt with diffuse and different problems, it has perhaps not seemed to form a cohesive whole. This is more a reflection on the concept of 'stigma' than on the construction of the argument. In practical terms, there are important distinctions to draw between people who are epileptic, old, alcoholic, unemployed, slum dwellers, or single parents. No one policy is appropriate to deal with all these forms of stigmatisation. Physical and mental stigmas call for enablement and normalisation; poverty needs rights, power or the redistribution of resources; dependency requires the opportunity to contribute to society; moral stigmas should lead to the re-integration of the offender. There are conflicts between these different kinds of policy, and contradiction in the policies that are followed for any particular stigmatised group. Many of the policies advocated at present are inappropriate; they may work for some groups of stigmatised people, but not for others. Participation is useless for people who have no interest in it. Donative rights are not very helpful to people who are stigmatised for dependency, although they may be valuable as a protection against disadvantage and a guarantee against deprivation. Collective action may have advantages for poor people which it does not have for those who need individual rehabilitation; rehabilitation, conversely, may not be satisfactory for poor people.

A further problem is that a policy aimed at reducing stigma in one way may increase it in others. Increased redistribution entails increased dependency. The establishment of rights, self-help or participation by a group fosters the idea that they are respectable, which may be a deviant attitude; it may serve only to make them more identifiable. An emphasis on individual rehabilitation may lead to a distinction between deserving and undeserving people. Different solutions may conflict with each other. It is contradictory to encourage participation and attempt to conceal a stigmatised group. It is contradictory to assert that both a minimum standard of living and a 'right to fail' are necessary for respect. And, although it happens throughout the social services, it is contradictory to give a person rights and status and then tell him that his condition is not legitimate and that he must be rehabilitated.

To what extent, then, can stigma be considered a unified concept? Goffman argues that, despite the apparent differences between stigmas, stigmatised people do have enough in common to merit classification together for the purposes of analysis (1963, 174). This argument is examined in the subsequent part.

## Part 3

# The social relationships of the stigmatised person

## Introduction to part 3

At the beginning of the second part, I argued that stigma cannot be seen solely in terms of the characteristics of the stigmatised person, but must also take into account the feelings of stigmatised people and others. In this part, I intend to discuss whether these feelings can be said to create a common experience of stigma. Firstly, the attitudes of other people may be influenced by factors which have little to do with the stigmatised person. In Chapter 8, I consider whether prejudice towards stigmatised people is directed in the same way towards different kinds of stigma. Secondly, Goffman argues that there are fundamental similarities between the attitudes and reactions of stigmatised people in a variety of circumstances. These arguments are considered in Chapter 9.

## Chapter 8

# STIGMA AND PREJUDICE

### The nature of prejudice

There are many types of negative attitude. They include disapproval, dislike, contempt, aversion, repulsion, fear and mistrust; and they occasion discomfort, strain, pity, censure, hostility, isolation and superstition. This is commonly summed up as 'prejudice'. Prejudice is a portmanteau term, which covers not only the attitudes and feelings of one person towards another, but also his behaviour. Lyketsos and Panayotakopoulos (1970), for example, include in 'prejudice' against the mentally ill the likelihood that a person will avoid, deprecate, disfavour, deny employment to, delay the treatment of or physically attack someone who is mentally ill. This collection of attitudes and actions is sometimes taken as directly equivalent to 'stigma' (e.g. by Mulford, 1968). Allport (1954) defines prejudice as

an aversive or hostile attitude toward a person who belongs to ... (a) group, and is therefore assumed to have the objectionable qualities ascribed to the group. (p.7)

Prejudiced attitudes are stereotyped; they are based on the group, not the individual. Katz and Braly (1961) show that people respond to certain words with irrational preconceptions: people were prepared to say things about Turks, for example, although they had never met one (p.43).

Berger and Luckman (1967) argue that stereotypes - "typifications of social action" - are essential means of organising our knowledge of the world (p.31). Without them, the information we receive would be unmanageable. Stereotypes lose definition when their objects are distant. The difference between generalisation and prejudice is, they argue, a matter of degree. Allport, by contrast, believes that stereotyping is a distortion of the natural process of categorisation. "Prejudgments", he writes,

become prejudices only if they are not reversible when exposed to new knowledge. (1954, 9)

The distinction is an important one. In a European study of poverty, 45% of those in the UK who had seen people in poverty thought that the cause of poverty was laziness, compared with 43% of the total (Riffault, Rabier, 1977, pp.69, 71). In other words, the experience of seeing poverty makes little difference to expressed opinions. This is almost certainly the result of stereotypes, formed without reference to experience and maintained

It does not follow, from the fact that a negative attitude is held about a group, that we know what a person's reaction will be. It could, for example, be fearful, contemptuous, or hostile. Moreover, stigmatised people are not regarded as an undifferentiated mass; different stigmas evoke different reactions. Although there are similarities, which I hope to elaborate, the stereotypes of mental illness are not the same as the reactions to physical disability, or to dependence on social security. Stereotypes are created by an interaction between the people who come to form prejudices and others who are the objects of them. At this stage, I intend to examine the development of stereotypes only from the point of view of the prejudiced person, and to deal later with the bases of particular prejudices later, in the context of specific categories of stigma.

The origins of prejudice are complex. Allport (1954) identifies six different categories of causation. These are historical, socio-cultural, situational (that is, deriving from a social environment), psychodynamic, phenomenological (deriving from contact between people), and an emphasis on a reputation which a person or group may have earned (ch.13). The point comes, however, when it is difficult to distinguish these factors from each other; historical factors merge into socio-cultural ones, socio-cultural into situational, and so on. Although the first two categories apparently describe continuities in prejudice rather than its origins, this distinction cannot be reinforced in practice. I have tried, in consequence, to

merge the categories into a broad classification, distinguishing only the social roots of prejudice - the bases of commonly held prejudices- from the influence of individual characteristics which may help to explain why some people accept stereotyped views when others do not.

*Blaming the victim.*

"It is a principle of human nature", Tacitus wrote, "to hate those whom you have injured". Katz et al (1977) argue that there is a concealed hostility towards the physically disabled, because they are not normal; there is guilt, because the hostility is unfair; and the combination of the two creates a tension (or 'dissonance') which is lessened by denigrating the person. This lessens the feeling of guilt (pp.419-420). I have doubts about the general validity of Katz et al's study; the findings do not substantiate the view that people feel guilty about their hostility, although they do not contradict them either; and I am not sure that the supposed expression of hostility - inflicting a painful noise on a stigmatised person - is not simply a sign of insensitivity, which would follow from a rejection of the person. Glass (1964) came to a similar conclusion in a more convincing style. He found that people who agreed, despite their expressed principles, to administer electric shocks to others, would either blame themselves if they had low self-esteem, or come to dislike the victim. He also explains this in terms of 'dissonance'.

The theory of dissonance posits that people need to reconcile inconsistencies in their behaviour or their view of the world. Festinger and Carlsmith (1959) found, for example, that people who were paid \$1 for doing a monotonous task liked it more than those who were paid \$20. They explain this as a result of 'dissonance': the people who said they liked the work were reconciling themselves to the fact that they had spent time doing something that was boring for little reward. Dissonance theory has been substantially criticised, because the experiments on which it is based can be interpreted in different ways (see Chapanis, Chapanis, 1964). Bem (1967) argues that Festinger's experiments can be better explained as the consequence of self-judgments. We judge ourselves, he argues, in just the same way that other people judge us. The people who did the boring work said they enjoyed it because anyone else doing it for little reward would be assumed to enjoy it. Either of these explanations is compatible with Glass's experimental results. The subjects saw themselves as good, principled people; the only way to reconcile their action with their self-concept was to blame the victim.

It is questionable, though, whether people really see stigmatised persons as their victims. Frenkel-Brunswick argues that charity is motivated by aggression. Charity is a possible manifestation of atonement which, in turn, is known to be a reaction to aggression. (in Adorno et al, 1950 307)

Charity is, in consequence, marked by a peculiar ambivalence to its objects. Adorno argues that prejudiced people have been raised in an environment where compassion is forbidden and emotional displays lead to punishment. Their reaction, when faced with people who provoke compassion, is to punish them as they were punished (in Adorno et al, 1950, 700). This theory is intriguing, but I do not find it convincing. Factors such as 'compassion' are not measurable and the theory is, I suspect, impossible to falsify.

An idea I find more persuasive, because of the empirical work that has been done to verify it, is the concept of the 'just world'. Lerner (1970) argues that people want to believe that the world is fair, and that people get what they deserve (p.203). The theory explains why people of high status should be looked up to; they are supposed to deserve their advantages. On the other hand, the misfortunes of respectable people may precipitate condemnation of their actions. Jones and Aronson (1973) found that a married woman or a virgin who were victims of rape were more likely to be condemned than a divorcee. The injustice in their case was thought to be greater, and this could only be reconciled with a belief in a just world if they were found to be more at fault.

Conversely, people with low status are believed to deserve their disadvantages. If they suffer, they are blamed not for their actions, but their character (Lerner, Miller, 1978, 1041). The theory explains why, for example, people should be blamed for unemployment at a time when it is obvious that unemployment is caused principally by economic factors. It also explains why people should feel ashamed of their problems; they feel, in part, responsible for them. This sort of reasoning is pervasive. Herrick (1976) remarks on the survival of the primitive belief that people become ill because they have done something wrong. Their belief causes them stress, guilt, fear and anxiety, and creates a further possibility of illness (p.331). Bulman and Wortman (1977) interviewed twenty-nine people paralysed in accidents. All but one of them had asked themselves, 'Why me?'; and all of these had found some reason. Ten, for example, said that 'God had a reason'; two, that they had deserved it (pp.358ff).

The idea of the 'just world' has noble antecedents. In the Hindu idea of Kharma, there is the belief that everyone's station in life has been the result of their previous conduct, and that anyone not receiving his present deserts will have them in a future incarnation. Gore (1958) uses this to explain the condemnation of beggars in India.

Begging itself is a misfortune ... But then - in the context of the Kharma philosophy - no person can disclaim total responsibility even for his misfortunes. And therefore, there is a sense of shame attached to begging. The beggar experiences a loss of social status even if his begging is due to factors entirely beyond his control. (p.29)

There is something of the same reasoning in the traditional Christian concept of Heaven and Hell. People gave charity for their own salvation, while despising those they gave it to.

Zuckerman (1975), in a fascinating experiment, found that people who believed in a just world were more likely at a time of personal stress to help others. Students were asked to read to a blind student. Those who believed in a just world volunteered more help as their own exams got nearer. This reaction was not, however, purely altruistic. They behaved as though they stood to gain something by becoming more deserving. Those who believe in a just world are also more likely to condemn those who have bad luck. So, paradoxically,

both rejection of victims and compassionate reactions toward them derive from the same underlying psychological processes. (Lerner, 1970, 207)

Because a stigma represents a conflict with belief in a just world, its presence leads to anxiety, and sometimes, as a defence against the discomfort it causes, it may occasion hostility. The theory helps to explain many of the problems associated with stigma - the relationship of stigmatising attributes to the attitudes of others, to their feelings, and the feelings of stigmatised people. Above all, it offers an explanation for the curious linking of low status and misfortune with immorality, and this is important to an understanding of the problem.

### **The prejudiced personality**

Negative attitudes to different kinds of stigma tend to be associated with each other. The coincidence of prejudices suggests that the origins of prejudice lie, not in the objects of the prejudices - stigmatised groups - but in the people who hold them. Yuker et al (1966) found correlations of attitudes to disabled people with attitudes to mental illness  $r = .19$  to  $.34$  and attitudes to old people  $r = .26$  to  $.44$  (pp.146-7). Szuhay (1961) discovered that a moderate association in the attitudes of young children to disabled people and African Americans ( $r = .25$ ) became much stronger in older children ( $r = .52$ ) (p.56-7) - suggesting that a process of socialisation is at work which either leads to generalised prejudice, or which reduces prejudices in cases where they are not part of a general framework. And Katz et al (1977) found a similar rejection of African Americans and physically disabled people:

the successful replication suggests that despite obvious differences in the status of blacks and the orthopaedically disabled in American society, the assumption that they are both regarded ambivalently is useful for predicting certain types of behaviour towards them. (p.427)

Kogan (1961) found striking correlations of attitudes to old people with attitudes to mental illness ( $r = .46$ ), African Americans (.46), minorities (.43), blindness (.52), deafness (.48) and



cripples (.53). The association was, however, substantially lower when, instead of agreeing with an unfavourable opinion about old people, the subjects would have had to disagree with a favourable one (p.50). This could be interpreted in two ways. One is that the association is a mark, not of generalised prejudice, but of a willingness to take suggestion. This would not mean that the attitudes are unimportant, because unthinking cliches can still be hurtful to stigmatised people; but there is no reason to suppose that these opinions are likely to be reflected in any adverse behaviour. The second possibility is that it is simply more difficult, given the ambivalence that we feel towards old people, to disagree with favourable statements made about them than it is to agree when they are denigrated. The indications of an association between different negative attitudes are, I think, too consistent to be ignored.

It is not possible to maintain that all prejudice is the outcome of a prejudiced personality. But certain personal characteristics may dispose people to prejudiced reactions. Siller (1962) found no distinctive pattern related to the acceptance or rejection of disabled people, but suggested that "a negative self-image and disturbed object relationships are conducive to an aversive reaction." Eisenman (1970) also found that people with low self-esteem were likely to rate disabled people as inferior, and concluded that low self-esteem may be associated with prejudice. (p.153)

This research is mainly related to physical stigmas, and it may be that this is the only area in which psychological factors are relevant. There is one major study which goes further: *The Authoritarian Personality*, written in 1950. The study was intended to discover the causes of anti-semitism. The authors rapidly discovered that anti-semitism was not an isolated problem; a person who was anti-semitic was also likely to oppose other minority groups, and to condemn outsiders. This led to a theory of ethnocentrism, which is based on a pervasive and rigid ingroup-outgroup distinction; it involves stereotyped negative imagery and hostile attitudes regarding outgroups, stereotyped positive imagery, and submissive attitudes regarding ingroups, and a hierarchical, authoritarian view of group interaction in which ingroups are rightly dominant, outgroups subordinate. (Adorno et al, 1950, 150)

These attitudes form the kernel of the prejudiced personality. The individuals with the strongest prejudices were examined in detail, and a composite picture of the 'authoritarian personality' was formed. In this personality, a basically hierarchical, authoritarian, exploitive parent child relationship is apt to carry over into a power oriented, exploitively dependent attitude toward one's sex partner and one's God and may well culminate in a political philosophy and social outlook which has no room for anything but a desperate clinging to what appears to be strong and a disdainful rejection of whatever is relegated to the bottom. (Adorno et al, 1950, 971)

The signs of this attitude are prevalent in status distinctions. Williams (1956), in a study of an English village, found a remarkably clear division made in people's attitudes to other status groups in relation to their own. The attitudes of the different 'classes' to the lower class are a graphic example. To the 'upper upper' class, the lower class were the immoral element in the village ... the worst of the lower orders. (p.107) To the 'lower upper' and 'intermediate' classes, they were "dirty people". The 'upper medial' class said they were People who don't try to lift themselves. (p.108)

The 'medial' and 'lower medial' groups thought they were Folk who don't care what they look like. (p.108) To the lower classes themselves, they were "decent folks", and everyone else was a snob of some degree (p.109).

The study generally shows a rigid, hierarchical division of a small rural society, a strong identification with the ingroup, and antipathy towards the outgroups (which in attitudes to higher classes seems to be stronger than deference).

*The Authoritarian Personality* is a study of a psychological as well as a social phenomenon. The strict divisions that are drawn between groups are an indication of deeper distinctions.

The inherent dramatisation ... extends from the parent-child dichotomy to the dichotomous conception of sex-roles and of moral values, as well as to a dichotomous handling of social relations as manifested especially in the formation of stereotypes and of ingroup-outgroup cleavages. (Adorno et al, 1950, 971)

In other words, there is a psychological basis for the division between what is good and bad, acceptable and unacceptable, stigmatised and unstigmatised. The lines of battle are drawn up by a society, but the strength of the rejection and its divisiveness is the result of the prejudiced personality. Attitudes to the poor are an example of this.

Abolition of the dole ... the spirit of the adage, 'who does not work, shall not eat', belong to the traditional wisdom of economic rugged individualism ... the ideas involved have a tinge of punitiveness and authoritarian aggression which makes them ideal receptacles of some typical psychological urges of the prejudiced character. (p.699)

There are other feelings involved: the cynicism of the authoritarian, in believing that people respond only to material incentives; his projectivity, blaming the poor for his own passivity and greed; and his adverse reaction to feelings of compassion, which are apparently linked to the punishments he received as a child.

*The Authoritarian Personality* has been heavily criticised on methodological grounds. Hyman and Shatsley (1954) have accused it of over-generalisation and discarding contradictory evidence. The selection of the sample by membership of groups, rather than randomly, implied that the subjects had a previous commitment to group values; certain topics in the scales have been duplicated, and correlations between the scales are then taken as supporting evidence. These points are well taken. Adorno et al set out to prove a hypothesis rather than to disprove it - which is, from the point of view of scientific inquiry, a cardinal sin. But criticisms of methodology do not necessarily invalidate the findings. There is much in the work that remains challenging and important.

The 'F-scale', the measure of authoritarianism which is used in the study, correlates well with negative attitudes to stigmatised people. Rosenberg (1974) found a correlation of .86 between the F-scale and authoritarian attitudes to the mentally ill (pp.3031). Mayo and Havelock (1970) found that it accounted for 13% of the variance in the rejection of mentally ill people by staff in institutions (p.292). Canter (1963) found a correlation of .43 with the attitudes of student nurses to mental patients. This affected their behaviour: there was an inverse correlation of .57 between the F-scale and an assessment of their relationships with their patients. Mulford and Murphy (1968) record a correlation of -.48 between the F-scale and acceptance of mentally ill people (p.106), and Mulford (1968) found -.50 (p.109). Jabin (1965) measured various factors against attitudes to the physically disabled. He found that authoritarianism - including authoritarian aggression and submission - was associated with feelings of pity, hostility and repulsion, but most strongly with feelings of pity (p.55). Noonan et al (1970) found the F-scale was inversely related to favourable opinions about disabled people  $r = -.33$  (p.6). And Cowen et al (1958) found that there was a low but reliable relationship between prejudice against minorities, authoritarianism, and negative attitudes to the blind (pp.302-3). The blind are not strongly stigmatised in comparison to other groups, and a more pronounced relationship could not really be looked for.

Kogan (1961) found that the correlation of authoritarianism with attitudes to old people was positive when the sentiments were negative - but negative when people were asked to agree with positive statements (p.49). One explanation for this is that authoritarianism leads to conformity in responses; Triandis and Triandis (1965) suggest that the F-scale in fact measures conformity to dominant social values, and certainly it contains a ferocious response bias. This would reinforce the idea that stereotyping and socialisation are at the root of prejudice. Another view is that authoritarians have, more than other people, a peculiar ambivalence - an exaggerated respect for old age coupled with an exaggerated contempt for its weaknesses. This would be consistent with the analysis in *The Authoritarian Personality*.

Old people may be low in a hierarchy of physical appearance and financial status, but they are high in a structure that demands respect for seniority.

The F-scale is also associated with a belief in a just world: Lerner found a correlation of .20, Zuckerman of .35, and Rubin and Peplau .56 (cited Rubin and Peplau, 1975, 76-77). The reason for the connection is uncertain; it may be that authoritarianism disposes people to an outlook which facilitates the rejection of others, or simply that both reflect dominant social values. It is clear, though, that authoritarianism is related both to negative attitudes to stigmatised people, and to a general outlook that favours stereotyping and prejudice. The evidence, is, however, limited to physical and mental stigmas, and the hypothesis that it can be extended further has yet to be substantiated.

### **The social determinants of prejudice**

Stereotypes are fostered by a process of socialisation. People learn their attitudes from others - from their families, from social contacts, from written and spoken information; the absorption of generalisations is a part of this process. The formal instruments of socialisation - such as the Press - can have only a limited effect. The Press has been blamed for creating an atmosphere around the claiming of social security benefits which deters or humiliates respectable claimants (Golding, Middleton, 1978). But the image of claimants as social parasites was evident long before the Press became a major factor influencing opinions; the rejection of the dependent poor goes much deeper. Socialisation involves a gathering of views from a variety of sources, of which the Press is only one.

Social factors, such as class or culture, are not primary instruments of socialisation, but there is an association of these factors with the formation of stereotypes, because they stand for the environment within which socialisation takes place. There is, notably, a relation of prejudice with social class - that is, 'socioeconomic status'. Some writers present the lower classes as tolerant, permissive and forgiving of other people's misfortunes. Goldthorpe and Lockwood (1963), for example, suggest that a typical 'working class' attitude to the poor is that poverty is the result of bad luck :

'They have been unlucky'  
'They never had a chance', or  
'It could happen to any of us'. (p.317)

The middle classes, by contrast, supposedly believe that the poor are idle and could be as rich as anybody else if only they worked.

'Many of them had the same opportunities as others who have managed well enough.'

'They are a burden on those who are trying to help themselves' (Ibid, 317)

This view is questionable. Williamson (1974b) shows that 'many of the poor share the view of the rest of the population' about social security (p.645). Ransford (1972) found that 74% of lower class workers in the US agreed

There's more concern today for the 'welfare bum' who doesn't want to work than for the hard working person struggling to make a living. (p.338)

Davidson and Gaitz (1974) found no significant difference in the attitudes to work of the lower class: if there is any difference, the poor are possibly more committed to 'dominant' values than the middle class are. This conclusion is borne out by Cohen and Hedges' study of 'lower-lower class' males. These men valued, " more than anybody else, the routine, the familiar, the predictable." (1963, 316) Their way of thinking is entirely compatible with a strict and conventional morality - as well as stereotyped responses to social problems. It is true that this class is less likely to 'blame the victim' for his poverty, and that they are less likely to demand that welfare recipients should sell their home or car; but the emphasis on dominant values about work and social security means that, in practice, attitudes are less than sympathetic. People in the lowest class are also likely to think that a person's morals should be taken into account in determining whether they should get poor relief (Northcutt, 1959, 52ff).

The lower classes also tend to reject people who are physically different more than the middle class do. Westie and Westie (1957) found, in an important review of evidence about racial prejudice, that there was more social distance between whites and blacks of low status than there was between the races at higher statuses. Negative attitudes to physically disabled people are also more common in the lower social classes (English, 1977, 165). Attitudes to mental defects are more complex. Rootman (1972) found people in social class IV - mainly semi-skilled manual workers - were most likely to favour the isolation of mentally ill people (pp.26-7). Bord (1971) distinguished types of mental illness, and found that people in low-status jobs were more likely to reject someone who was paranoid or a depressed neurotic, but less likely to reject someone suffering from a phobia or simple schizophrenia (pp.504-5). Hudzinski (1975) discovered that people in the highest social class were most likely to reject epileptics (pp.97-102). The differences in reaction to different stigmas argue for quite specific differences in socialisation between the social classes.

This may be because the education of the classes is different largely because education determines, in part, a person's occupational status. Education has the general effect of increasing tolerance, and people with higher education tend to be more accepting. English (1977), in a review of studies of attitudes towards the physically disabled, noted that six out of eight studies found a significant relationship in this direction (p.166). Tringo (1968), in an impressive study, found that females tended to be less accepting than males; but

An increase in educational level was invariably associated with a decrease in social distance for males. The direct relationship was reversed on eight disability variables for females. (p.33)

This is difficult to explain. Sex has been a significant factor in many studies - English (1977) found seven which showed a significant relationship (pp.164-5) - but it is difficult to see why education should have opposite effects on the different sexes.

One explanation is that educated people are less likely to attach importance to physical characteristics, and more to other standards of achievement. This explanation has certain disadvantages. One might suppose that someone who puts more emphasis on mental ability would feel a greater threat, and so a stronger aversion, than others, when faced with mental defects; this is not the case. Further, the attitude of females should, one might have thought, reflect their socialisation into an exaggerated emphasis on physical appearance. But females are generally more accepting of physical disability, not less; and females who are more educated, and might therefore be expected to put less emphasis on physical attributes than other females, are less accepting than other females. A second view is that education encourages patterns of thought that are less rigid and stereotyped than uneducated views. This is not, however, consistent with the fact that educated females reject disabled people more than other females.

A third explanation is that the culture of the social classes differ, and their responses reflect their culture. There are clear differences in attitudes to stigmas between countries and (where they can be identified as such) between cultures. Jenkins (1966) found, for example, that African Americans were more likely to stigmatise tuberculosis patients than American whites or Hispanics were (pp.420-1). Sanua (1970) found a wide range of attitudes to cerebral palsy in seven countries, and different determinants of attitudes. Triandis and Triandis (1965) note substantial differences in social distance from physically disabled people in different countries. Tseng (1972) compared the attitudes of US and Asian students to disabled people, and found not only that US students were more favourable, but that those Asians who had been in the US longest were more favourable than other Asian students. Jacques et al (1970) compared the reactions to disability of males and females in different countries. In the US, there was no significant difference between the attitudes of the sexes; in Denmark, the males were more favourable to the disabled, but in Greece, the females were. This is a strong indication that these attitudes are subject to socialisation.

However, there are also similarities of attitude between countries. Richardson et al (1961) argue that, although there are differences in the strength of reaction, the ranking of physical

disability is constant between cultures (p.244). This implies that there is either a common psychological basis, or a functional one, for the rejection of physical disability. There are exceptions to Richardson et al's proposition - the Kumba regard a certain skin disease as the norm (Bloom, 1963, 99) - which make reference to a fixed psychological reaction unconvincing. An argument based on the effect of disability on social functioning is stronger. Jackson (1977), for example, makes out a case to look at learning disability in this way; in any society, he argues, there is a minimum standard of competence below which a person cannot fall. This case can be extended: every society demands standards of appearance, physical capacity, mental capacity and behaviour. In the case of physical disability, the disability itself is the most significant determinant of capacity, and although incapacity may have different implications in the context of different societies, the hierarchy of disabilities remains fairly constant.

The question remains whether there is an equivalent process at work between social classes. Most work suggests that the classes share the same basic culture, but it could be argued that the lower social classes reject physical disability more because physical disability is a greater handicap to people who rely on manual skills or physical appearance. The stigmas rejected by middle-class people - notably epilepsy - are, in turn, the characteristics which might threaten their livelihood if they were found to possess them. Females in general are socialised to put less emphasis on a career in employment, so that they are less threatened by people who are incapacitated; but educated females emphasise work and career more, and consequently reject stigmatised people more.

This interpretation puts a great stress on economic factors, expressed through general social norms which are related to the capacity to work and contribute to society. If it is correct, then the association of prejudice with factors such as class, sex, education and culture reflects the relation of these factors to the norms.

#### *Implications for policy: the effects of familiarity and education*

It would seem to follow, from the fact that stereotypes are unjustified generalisations about people, that a process which contradicted those generalisations, through education and familiarity with the objects of the stereotype, would break down the prejudice. Moseley (1973), for example, found that children who had contact with disabled children in their classes at school became more favourable to disabled people in general - suggesting that a positive stereotype had replaced a negative one. But this can cut both ways. Gottlieb and Budoff (1973) made a study in an experimental school built without internal walls, and discovered that retarded children were rejected more there than in other schools. Increased contact seems to have led to a negative reaction.

The same problem occurs with educational programmes. Safilios-Rothschild (1970) writes, Educational campaigns informing a population about the nature of an illness or a disability and describing specific symptoms may unintentionally bring about a greater intolerance of mildly disabled persons who might have 'passed' as normal. (p. 10)

Cumming and Cumming (1957) found that a project to reform the attitudes of the public towards mental illness because the public's view was more permissive than professional attitudes. This is not to be interpreted as a liberal attitude. It is rather that ignorance allows mentally ill people to pass. If a person is discovered to be mentally ill, rejection follows.

Phillips (1967) found that

the ability to correctly identify ... behaviours as mental illness is not associated with acceptance, but rather with rejection. (p.266)

This finding was not confirmed in a later study by Bentz and Edgerton (1971) who showed people the behaviour instead of asking them about a written vignette, but I feel Phillips has established an important point. There is a danger that information about a problem can lead to increased rejection. Physical and mental stigmas are not particularly attractive. People who come into contact with them may feel threatened; the knowledge that, for example, mental illness can happen to anyone may increase the sense of threat. Sorensen (1972) found that attempts to familiarise people with the nature of epilepsy, by showing a film of an

epileptic having a fit, increased their rejection of the condition (pp.19-20). Familiarity or education do not necessarily lead to sympathy or understanding.

It may seem strange, in the circumstances, to talk about 'stereotypy' as the root of the problem. The term seems to suggest that stigmatisation is based in ignorance, and this is not necessarily the case. But the term is appropriate, because there is a process of generalisation about stigmatised people. It does not follow, because a person has an unattractive disability, that he is an unattractive person. The stigma obliterates the other features of an individual personality, and this is a reaction based on stereotype rather than mature observation.

Education which concentrates on the stigmatising characteristic must fail. It only increases the tendency of the stigma to obscure the characteristics of the person who has it. It is necessary to encourage people to look at the person, not at the category he belongs to. Familiarity can contribute to education only if it is more than superficial; education is meaningless if it teaches only recognition. But familiarity and education together can achieve an effect that neither can have independently, by making people aware of the stigmatised person as an individual. But the conditioning of reactions by material circumstances suggests that stereotypes may prove resistant to change if there is no change in the circumstances which fostered them.

### **Conclusion**

The concept of prejudice adds a further dimension to the understanding of stigma. It helps to explain the tenacity of common misconceptions, and something of the basis of social rejection. But it is not, I think, helpful to argue that stigmatisation is directly the result of prejudice, because the idea of "prejudice" is itself so vague. The attitudes and reactions the term refers to, and the reasons for them, are diverse; none of the accounts given can be considered a full explanation of the problems, and none excludes others. In the next chapter, I hope to broaden the scope of the argument by considering the feelings of the stigmatised person, his relationship to others, and the consequent effects on his social identity.

### **Chapter 8: Summary**

Negative attitudes are categorised as 'prejudice'. Some people tend to "blame the victim"; this may be attributable to a belief that the world is just, or to certain traits of personality,. But the effect of socialisation in the creation of stereotypes suggests that material circumstances may condition the response of social groups to people with certain attributes, and this may vitiate attempts to alter stereotypes through educational programmes.

## Chapter 9

# THE SOCIAL POSITION OF THE STIGMATISED PERSON

### The moral career

Goffman (1963) describes the process by which a person comes to be stigmatised as a 'moral career'. His life style is changed by a series of events, both formal and informal, which channel him into a new status (pp.45ff). A stigmatised person has to adjust, to learn to live with his stigma. The moral career takes into account the process of stigmatisation - the things which are done to him - and the experience of stigma, which depends on his reaction to the process.

Pinker (1971) defines the dimensions of the moral career as depth, time, and distance. Depth refers to the extent to which a person is made aware of his stigma, and accepts stigmatisation as legitimate. Stigma has a tendency to obliterate any other characteristics a person has; the deeper a stigma is, the more it becomes the outstanding feature of his social identity. Time is the duration of the stigma; a stigma that is permanent and inescapable, such as a deformity, creates problems of adjustment that are different from one that is temporary, like unemployment. The longer a stigma lasts, the more likely it is that the person who has it will come "to redefine his total social life in terms of the stigma" (p.170). Distance may be social or spatial; it is the distance between a person who is stigmatised and another who holds a negative attitude towards him. As distance increases, it becomes more difficult to distinguish individuals; their characteristics recede and grey until they are no different from the mass of others. A stigma is usually more noticeable than other features, and it tends to be the last thing that fades from view.

These are general dimensions, but they have a personal and individualistic flavour. Depth, in particular, is a source of differentiation, not only between stigmatised groups, but within them; there is no reason why any two people who are ill, or poor, or unmarried mothers, should feel rejected and accept a stigma all to the same extent. The classification describes differences rather than similarities between stigmatised people.

It is possible to argue that the moral career of stigmatised people is basically similar. Kardiner and Ovesey (1951) claim that the experience of discrimination has led to a common personality structure among African Americans. All their twenty-five subjects, on a Rorschach test, showed anxiety, aggression, suspiciousness, emotional isolation, a deficient rapport with other people, apathy, passivity and compliance. It is a psychology, they argue, which results from oppression (ch.10). But this generalisation is questionable; it was a small sample which I suspect may have reacted in this way because of the circumstances of the interviews rather than any deep-seated psychological characteristics.

Stigmatised people do not share a common experience. The rejection of disfigurement is not the same as the social reaction to poverty. Goffman argues, though, that stigmatised people have enough of their situations in common to warrant classifying them together for the purposes of analysis. (Goffman, 1963, 174) He describes patterns of behaviour which he thinks are common to all stigmatised people in some degree. The stigmatised person has difficulties with his self-concept, in interaction with others, his personal relationships, and his social identity. These elements define the social situation of the stigmatised person.

## The effects on the person

### *The prejudices of stigmatised people.*

"The stigmatised individual", Goffman writes, "tends to hold the same beliefs about identity that we do" (1963, 17). Stigmatised people are not necessarily 'wise'; they judge themselves in much the same way, and by much the same standards, as other people do. Orwell (1937) describes how,

When I first saw unemployed men at close quarters, the thing that horrified and amazed me was to find that many of them were ashamed of being unemployed. ...The middle classes were still talking about 'lazy idle loafers on the dole' and saying that 'these men could all find work if they wanted to', and naturally these opinions percolated through to the working classes themselves. I remember the shock of astonishment it gave me, when I first mingled with tramps and beggars, to find that a fair proportion, perhaps a quarter, of these beings whom I had been taught to regard as cynical parasites, were decent young miners and cotton workers gazing at their destiny with the same sort of amazement as an animal in a trap. (Orwell, 1937, 86)

Dixon (1973) reviewed evidence on the prejudices of disabled people, and concluded that By and large, these studies tend to report that disabled persons bear a large amount of prejudice toward disabled people. (pp. 53-54)

But this does not follow a regular pattern. Deaf adolescents were found by Blanton and Nunally (1964) to rate others who were deaf and blind lower than normal people did. Brookfield (1969) found (in a sample that was possibly unrepresentative) that, although the attitudes of disabled people to other disabled people were negative, they were more favourable than the attitudes of those who were not disabled. Dixon (1973) found the same, with the exceptions of amputees and persons suffering from stroke - both groups which had become disabled after a period without disability - but noted that they were more favourable to others with the same handicaps as themselves. With that difference, they ranked disabilities in roughly the same order as those who were not handicapped did (pp.98-117). Lastly, Bell (1967), working with a small sample, produced the understandable result that disabled people who accepted their own handicaps were also less likely to think of disabled people in general as different from others.

These results suggest that some people may be sympathetic to their own, but they are not conclusive. In other areas, the reverse is probably true. Crumpton et al (1967) found that normal people tended to see mental patients as 'sick' or 'dangerous'; the patients themselves were more likely to think of a mental patient as a 'criminal' or 'sinner'. The mental patient seems to judge himself in moral terms, and not in the most favourable way. Similarly, social security claimants, and potential claimants, are likely to condemn other welfare recipients. Wyers (1975), for example, found little difference between the attitudes of users and non-users, to statements that claimants were "lazy", "chisellers" or that they should be made to work (p.158). And a similar view emerges from other studies:

'I felt very bad; I understood it was for people who don't want to work or are lazy. I'd worked all my life.'

'I felt like a social parasite.'

'I felt as if I was scrounging.' (Richardson, Naidoo, 1978, 25)

Kerbo (1976) mentions a study he took part in, in which a third of the claimants interviewed agreed with two out of three propositions: that people are poor because they are lazy; that poverty is self-induced; and that people in the suburbs work harder, and if everyone did the same there would be no poverty (pp.173-4).

The condemnation is perhaps more than agreement with common prejudice. As Velho (1978) points out,

When people accuse others of deviance they are classifying themselves as normal, nice, good people ... Stigmatised by the place they live in, they develop a militantly moralistic attitude, emphasising their position as good and decent people. (p.530)

This explains in part why African Americans reject mental illness more:



blacks already feel stigmatised as a minority and cannot tolerate the additional stigmatisation of mental illness. (Jalali et al, 1978, 699)

This intolerance serves to separate them from the deviant group. Ritchie and Wilson (1979) found that Supplementary Benefit claimants aged between 25 and 60 disliked calling at the office or felt degraded or embarrassed, partly because of the procedure they had to go through, but also because they disapproved of the other people with whom they felt forced to associate. (p.7) Cooper (1965), in much the same terms, remarks that those who are unhappy living (in public housing) are generally far more concerned about the types of people with whom they have to associate, than they are about being 'charity cases' living in Housing. (p.181)

Stigmatised people may share common beliefs about stigmas, but they do not necessarily have the same degree of prejudice. Victimisation, Allport wrote (1954), can scarcely leave an individual with a merely normal amount of prejudice. (p.155) A person can react by sympathy for his own group, as a defence of his condition; prejudice against the out-group, as a way of devaluing their opinions; or aggression towards his own group, in an attempt to separate himself from it. Any of these is likely to distort his views in comparison to other stigmatised people, and consequently to affect his opinion of himself.

#### *The self-concept of stigmatised people.*

The concept a person has of himself is a complex thing. It is important, not only what he believes himself to be, but how he evaluates his position, and whether he accepts it. The ideas of self-concept, self-esteem, and self-acceptance (or 'adjustment') are difficult to separate; self concept has elements of self evaluation, and self-evaluation tends to determine adjustment.

It is easy to make the broad assumption that stigma leads to low self-esteem. A person who is rejected by other people can be expected to feel inferior. Edgerton (1968), for example, argues that

The label of mental retardation ... not only serves as a humiliating, frustrating and discrediting stigma in the conduct of their life, it also threatens to lower their self esteem to such a nadir of worthlessness that the life of a person so labelled is scarcely worth living. (p.80)

Ziller et al (1964) found that neuropsychiatric patients had a lower social construct of themselves than normal people did - a form of low self-esteem (pp.61-62) - although it could also be seen as a realistic assessment of their social position. Cohn (1977) found that unemployment caused a loss of self-esteem. And Ward (1974) discovered that those people who identified themselves as old were more likely to accept negative images of old age - a problem of self-concept, esteem, and adjustment. Their self esteem was strongly associated with their attitudes to old age and their satisfaction in life (pp.144-146), but attitudes were not directly related to satisfaction (Ward, 1977, 172).

On the other hand, there is some evidence that is difficult to reconcile with this assumption. The association between low self-esteem and perception of stigma in welfare benefits is apparently low - Goodman et al (1969), in a survey of several thousand recipients, calculate the correlation at -.06 (pp.60-61). And the incidence of low self-esteem in stigmatised people is uncertain. Blind adolescents did not have a significantly different self-concept from normal adolescents (Cowen et al, 1961). Poor blacks did not have a lower self-concept than those who were not poor (Coward et al, 1974, 626). Disabled people did not have a lower self-concept than non-disabled people (Brookfield, 1969), and disabled people who were labelled as disabled did not have lower self-esteem than those who were not (Christensen, 1977, 108). A number of studies have shown, on the contrary, that stigmatised people have a higher self concept than others. Soares and Soares (1969) discovered that culturally disadvantaged children have higher self-perceptions than others (pp.39-40). Arluck (1941) found that epileptics had a higher self-concept than others, although they believed that their behaviour was inferior and they fell further short of their ideal (pp.50-57). And Epstein

(1955) found that schizophrenics were likely to rate themselves lowly when a conscious evaluation was made, but a test of unconscious evaluation - what they really thought - indicated that they had a higher view of themselves than others. This could be dismissed as a quirk of schizophrenia, but for the fact that the same higher self-concepts can be found elsewhere. The confusion which exists in this field is well summed up by Wright (1960). Reviewing studies of the adjustment of disabled people, she noted that three showed they had adjusted badly to disability, three more showed no relation, and two actually showed a better adjustment than people who were not disabled. "Psychological processes", she notes, "do not add up in a simple way" (p.53). Dixon (1973) found that different types of disability would lead to different self-evaluations (ch 5), but it is not clear from the study why this should be.

The high self-concept of certain stigmatised people needs to be explained. One possible reason is that people are not telling the truth - that they are overcompensating for their damage to their self-esteem. This is difficult to falsify, but Epstein's study apparently contradicts it. Another view is that the self-concept depends on a comparison with a reference group. Culturally disadvantaged children do not have culturally advantaged people to compare themselves with. This is not borne out by Arluck's findings: epileptics were prepared to accept that other people's behaviour was better, but this did not lead to a low self-concept. A third view is that the prejudiced person who is stigmatised will not admit to a lower self-concept. According to Adorno et al (1950),  
the prejudiced tend towards self-glorification, conventionality of ego-ideal, and lack of insight; and at the same time, they exhibit self-contempt which is not faced as such and which they try to deny. (p.443)

This, again, is difficult to apply; there is no clear reason why the effect should be different for different stigmas.

Goffman (1963) presents the problem as a paradox.

The stigmatised individual defines himself as being no different from any other human being, while at the same time he and those around him define him as someone set apart. (pp.132-3)

The stigmatised person sees himself, at one and the same time, as someone who is inferior and a normal person, as something bad and something good. The image which is most important to him depends on the nature of his stigma, the reactions of other people, and his own attitudes.

## **Interaction**

### *Strained interaction.*

Blaxter (1976) records that the perception of stigma by disabled people is strongest in all those conditions which threatened the taken-for granted world of everyday interaction ... (e.g.) ataxias, spasticity, severe multiple sclerosis, deafness, blindness to a lesser extent, and epilepsy. (p.198)

Physical stigmas intrude on contact with other people, making conversation awkward, tense and constrained. Goffman (1963) extends this to all forms of stigma. He distinguishes four features of stigma which affect the pattern of interaction. One is visibility. The second is given the clumsy title of 'known-about-ness', which describes the extent to which other people might know about a stigma beforehand. Thirdly, there is obtrusiveness: a wheelchair, he points out, is less obtrusive than a stammer, because a stammer continually gets in the way during a conversation. Lastly, there is 'perceived focus' - the opinions other people already have about a stigma (pp.64-68).

Although Goffman's essays on 'Stigma' are concerned with wider issues, the focus is very much on the interaction between stigmatised people and others. Goffman's work has been influential, and many of the studies which have been made of the effect of stigma have looked specifically at its effects on the mechanics of interaction. A stigma may affect

personal distance, the time of an interaction, or the behaviour of the parties during their contact.

Several studies have shown that people stand further away from a disabled person than they do from a normal person (Kleck et al, 1968; Kleck, 1968; Worthing, 1974; Comer, Piliavin, 1972). Kleck et al (1968) tried to assess relative acceptance or rejection by measuring this distance. The results are a little eccentric: the subjects placed themselves nearest to a professor they liked, furthest from a professor they disliked, nearer to an African American than to a stranger, and nearer to a stranger than to an amputee (p.114). But it does seem that there is some relationship in this between acceptance and physical distance. Kleck (1968a) found that people had more eye-contact when they were listening to a disabled person than they would in conversation with someone who was normal. He suggests that, because disabled people move less, people who talk to them are unable to rely on the visual cues that they would normally take in conversation, and find it necessary to concentrate harder on what the disabled person is doing (pp.23-26). Langer et al (1976) take a less charitable view of the process. People want to stare at the disabled, they argue, because they are different. Unfortunately, it is rude to stare. This could be a reason for the distance they keep from stigmatised people. The amount of eye-contact a person is permitted is a function of the distance he is placed from someone he is talking to (Argyle, 1967, 88). Standing at a further distance makes it easier to stare; it also makes interaction more formal and uncomfortable.

A second possible effect on interaction is the effect on the time that someone takes with a stigmatised person. Kleck et al (1966) argue that a disabled person was given more time; Worthing (1974) that there was no significant difference. Thirdly, the behaviour of others towards stigmatised people is often different to their behaviour towards those who are not disabled. Kleck (1968a) judged that conversation with disabled people tended to be stereotyped and lacking in variety, and that people would distort their opinions into something they supposed was more acceptable to the disabled (pp.25-26). Katz et al (1978) found that people were less likely to offer help to a disabled person who was thought pleasant than to someone who was pleasant and not disabled - but more likely to offer help to an unpleasant disabled person than to someone who was unpleasant and not disabled. It seems that people are prepared to make allowances when a disabled person is unpleasant, but are not prepared to treat a disabled person on the same basis as others.

The importance of this material lies in the effect that small indignities can have on stigmatised people. A stigmatised person, especially one who is ashamed of his stigma, is likely to be sensitive to the subtle differences with which he is treated. The ways people act in conversation towards him are likely to reinforce his feelings of stigma, and the effect a stigma has on him.

### *Tension management*

When a person's stigma is known about, he has to learn how to take the tension it causes out of a conversation. This is the problem Goffman (1963) calls 'tension management' (ch.2). There is no reason to expect that people will be equally able to do this, or, for that matter, that they will be very good at it. Comer and Piliavin (1972) found that disabled people tended to feel more inhibited, smile more, and have less eye-contact with normals than they did with other disabled people. Farina et al (1971) suggest that ex-mental patients did not adjust their behaviour, but they felt some tension because they believed that other people were unfavourably inclined towards them.

Sullivan (1971) attempted to test the relevance of this concept to social security claimants. He asked a welfare rights group what problems the claimants - mothers on AFDC - experienced, and then asked the mothers about them. There is some confusion, in his study, between tension management and acceptance of stigma, but there were items which were directly relevant to tension management. These included questions whether recipients were self-conscious and concerned about the impression they made; if they suspected other people of being two-faced; if they avoided people who were not on welfare; and if they

'alternated between cringing and bravado'. In each case the welfare rights group had said that the recipients did. The means of answers given by the mothers, on a five-point scale where 1 indicates the most negative answer and 5 the most positive, ranged from 1.62 to 2.64 (pp.108-111). So, although some individuals may have agreed, the overall picture suggests that tension management was not important. It may be, of course, that the welfare rights group simply had a romantic but wrong idea of what people did and how they felt; but the results suggest a stronger conclusion - that the idea of tension management may have little scope in cases where a stigma does not affect the appearance or behaviour of the stigmatised person. The validity of Goffman's statements may be limited to physical and mental stigmas.

### *Information management*

People whose stigmas are not known about are in a different position. They are, in Goffman's words, 'discreditable' but not 'discredited' (Goffman, 1963, 57). They have to decide whether they should let other people know about their stigma, and, if they do, how it should be done. This problem is called 'information management'. It is, for the stigmatised person, a crucial decision. If he is open about his stigma, he risks rejection; if he hides it and is then discovered, or if his stigma is already known about, he may be rejected more (Jones, Archer, 1976). Even if he does not reveal it, he may be inhibited by his own knowledge:

Concealing the disability does not eradicate it; it still remains in the eyes of the person as the barrier to his acceptance by the sought-for group. The stigma of disability that prompts his efforts to cover up at the same time negates his effort. (Wright, 1960, 40)

Fishbein and Laird (1979) argue that concealment may lead a person to think of an attribute negatively, and disclosure, conversely, to think of it positively - which would imply that disclosure is to be encouraged as a form of stigma management. A person may prefer to disclose his stigma for other reasons. It may be a way of looking for sympathy, or a means of forestalling criticism. Handler and Hollingsworth (1969) found that AFDC recipients who are more embarrassed about being on AFDC than others are more likely to discuss it with their friends or relatives (pp.6-7). It may be a way of asserting that there is nothing really wrong. Wadel (1973) writes that

for many unemployed, their 'aggressive' arguing is an effort to maintain their dignity. (p.112)

The disclosure may be done defensively. It may be accompanied by some mitigating factor: Clark and Anderson (1967) give the example of mentally ill old people who compensate for their loss of status by emphasising their supposedly noble descent (p.182). It may be done persistently. Erikson (1973) remarks on a pattern of behaviour by mental patients:

All children are taught in this culture that it is impolite to stare at or make reference to the infirmities of cripples . . .

(this is an important point; if a person wants to avoid embarrassing references to his stigma, it is likely the other person will assist);

... So it is interesting to note that the generous impulse of outsiders to overlook a patient's less visible infirmities is likely to put the patient in an instant state of alarm, and to bring urgent assurances that he is severely sick and in serious need of treatment. Patients often bring this topic into conversation on scant provocation and continue to talk about it even when fairly vigorous attempts are made by visitors to change the subject. (p.388)

Erikson suggests that this may be an attempt to justify their condition to the world; a person who is sick is not responsible for his state. But it could be many other things: a form of self-abasement, made to expiate guilt (Turner, 1972); an attempt to elicit sympathy; a type of covering up, claiming sickness to avoid the accusation of madness; or a consequence of self-absorption that convinces people that their disorder is of enormous interest to others. The alternative to disclosure is concealment. Concealment takes three main forms, for which Goffman (1963) uses the general term 'passing'. Firstly, people may not tell others about their stigma, and hope it never emerges. This is passive concealment. Walsma (1970) quotes claimants of Old Age Security in the US:

'...I don't advertise it. I came down in status.'

'I wouldn't tell about being on OAS. I would rather work.' (p.149).

'I don't like to tell anyone as I don't want them to know my age.' (p.147)

Secondly, some people will go out of their way to cover up their stigma. This is active concealment. Concealment shades into misrepresentation. 'I never say I live in Knowle West', one person told Tucker (1966). 'I always tell people it's Novers Park or Knowle. That clears you of stigma.' (p.64)

Misrepresentation shades into falsehood. Naturally enough, not everyone who lies will admit to it, and this makes it difficult to tell how widespread it is; but Jones (1972) found, in a small study of boys in special classes for slow learners, that most said they lied about what they did at school (p.560).

Petty subterfuge is possible. Schafer and Olexa (1971) give one example. (Translations from the American are in brackets.)

A non-college prep girl (a girl who was not being given an academic education in preparation for entry to college) told one of the authors that she always carried her general-track books (the books used for the lower stream) upside-down to make them less identifiable, because of the humiliation she felt when other students saw them ... (Schafer, Olexa, 1971,

Many subterfuges are more elaborate. Westergaard (1979) gives an example of unemployed people in Denmark who may go out during the day so that people will not know they are working; I have come across a similar case in Newcastle. Fabrega (1971) writes about beggars in San Cristobal, Mexico: Most limosneros beg only away from their home town or city for fear of being seen by people they know. (p.284) And Scarfe (1974) describes the embarrassment of someone who was illiterate:

on occasions he's walked off the job without being paid rather than admit it. (p. 65)

A third form of concealment can be described as masking: a stigmatised person tries to disguise his stigma as something else. Cole and Lejeune (1972) discovered that, among welfare recipients, women who accept the dominant view of welfare are more likely to view their health as poor than those who reject that view. (p.351) This may be because they have to be more ill to claim welfare in the first place; but it may also be that sickness is a more acceptable reason for dependency than unemployment. (This leads to the intriguing possibility that the stigma of welfare may increase the demand for health services: Lejeune (1968, 201) found that people who accepted their dependency less were likely to see their doctor more.) Goffman (1963), similarly, gives the example of mentally retarded people in a mental institution who pretended that they were mentally ill, because it was less stigmatising than learning disability (p.117).

The reaction of stigmatised people to their stigma varies, and it is difficult to generalise about concealment and disclosure. The reaction does not seem to be determined by the form the stigma takes: Kleck (1968b), for example, found that epileptics made different decisions about disclosure. There is some evidence, though, that the importance of 'passing' has been overestimated. Sullivan (1971) tested several assumptions made about welfare recipients: that they delayed making essential payments with their welfare cheques; they avoided other welfare recipients; and they hesitated to mention at job interviews that they were on welfare. He claims that there was evidence of this in 38% of cases (p.108), but there is no evidence in the data he presents to indicate that these assumptions were justified.

## **Personal relationships**

### *The attitudes of significant others.*

The social environment of the stigmatised person is crucially determined by 'significant others', the people who are closest to the stigmatised person. The most significant others tend to be the family, and they are affected by the stigma as much as they help to create it. Scott suggests (1969) that

high social status is in part contingent upon the ability of children to improve, or at least maintain, the social status of their parents. (p.127)

Romano (1968) elaborates this view: the parent regards the child, in many ways, as an extension of himself. Parents see in the child a means of transcending death; they derive a vicarious satisfaction from his achievements. When people have a child who is mentally handicapped, it reflects on them. The child is difficult and demanding to bring up: they may be able to derive a feeling of worth from meeting the child's needs, but their reaction cannot be the same as it would be to a 'normal' child (p.59). It is significant, I think, that deaf children who have deaf parents have higher self-concepts than those with parents who can hear (Meadow, 1969, 432-4). This may be because children judge themselves against their parents, but I suspect it has more to do with the reactions of the parents to the child. Watson and Midlarsky (1979) found that mothers of retarded children had in general a more favourable attitude to retarded children than other mothers did, and that they were more inclined to think that other people's views were unfavourable. This may be true; their experience of prejudice may lead them to the overprotectiveness that is common with parents of handicapped children. On the other hand, it may be that the mothers project their own negative feelings onto other people. Redner (1980) tried to assess from reactions to taped interviews with mothers of mentally handicapped children something of the stigma they experienced by association. He found that there were differences in his subjects' reactions to these mothers and reactions to mothers of children who were not handicapped, but that these differences did not depend on the information that a mother had a handicapped child. The difference is probably, then, rooted in differences in the mothers' behaviour - although this will not always be recognised by the mothers themselves. Dow (1965) found 8 out of 97 adults, in 58 families, who would not take their disabled child out to shop, to the beach, or on a visit in the neighbourhood (p.49). (11 families failed to respond - which may conceal further embarrassment.) Pehrsson (1972) asked similar questions about blind children, and found that 60% of his sample (86 couples) were embarrassed by their children. This correlated perfectly with their willingness to allow their child to do household chores, go shopping, or visit friends with them (p.87).

Schmid (1977), taking this line further, found that the decision to place a mentally handicapped child in a residential institution was associated, amongst other things, with their embarrassment about the child (p.125), their reluctance to reveal that he was handicapped (p.128), the visibility of the handicap (p.165), and the sorrow, disappointment and depression they felt (pp.238-240) but not with the severity of the handicap. This represents another way in which stigma can affect the demand for services. Alivisatos and Lyketsos (1968) found, in Greece, that a large proportion - 255 out of 291 relatives - did not want a mental patient to come home. Nine said that they considered the patient dead. Four, out of the 36 who wanted the patient to return, wanted it because they were ashamed to have a relative in a mental institution (p.363). This could represent rejection of the undesirable behaviour of a person who is mentally ill, but it seems to owe more to his social position. In general, rejection leads to the separation of the stigmatised person from the community. Moroney (1976) notes that Families who did seek institutionalisation were not stigmatised. In fact, the evidence seems to suggest the opposite. Families who decided to care for the mentally handicapped felt isolated from the rest of the community. (pp.71-2) This helps to explain something of the social isolation of residential institutions. Families are encouraged to remove handicapped children from their lives; it is unsurprising that, once they do, so many fail to visit.

Parents are unusually important, because they control and shape the social position of the child. Husbands and wives also have a special relationship: the husband's status tends to determine the wife's. A wife who is in a stigmatised position is therefore less affected than a husband would be; the stigma does not obliterate her personality as much as her husband does. Edgerton (1967) remarks on how some husbands enjoy dominating their mentally retarded wives: it is a 'benevolent conspiracy' in which the handicap becomes irrelevant (p.204). On the other hand, when the husband is affected, problems are likely. Some of these difficulties, like the fear of financial insecurity recorded by Cappeller (1972), follow from the handicap rather than the stigma it carries; but he also found that the wives of mental

patients were concerned about identification with their husbands (p.105). Schwartz (1956) found wives afraid they would be demoted to a lower 'caste' because of their husband's mental illness.

This sort of fear is not so true of other relatives, although there is still a fear of stigma by association. Stigma is treated as though it were infectious. Nearly a quarter of the relatives of ex-mental patients interviewed by Freeman and Simmons (1961) took this view - mainly on the grounds that they thought they would lose the respect of their fellow workers, or suffer embarrassment when inviting people to the house (p.315). Gove and Fain (1973) found no support for this view, because relationships seemed if anything better than they were before hospitalisation (p.498). But this does not mean that they felt no stigma; it is rather, I suspect, that a person who has been discharged from mental hospital is easier to live with than someone who ought to go into one, and this outweighs the disadvantages of stigma by association.

### *Isolation*

Friends can be expected to react in a similar fashion. A friend is not linked as intimately to a stigmatised person as a member of the family is, and friendship does not convey the same stigma of association; but, by the same token, it does not imply the same commitment to a relationship. The stigmatised person is likely to become isolated. There is, as Scheff (1966) remarks,

a vicious circle begun by stigmatisation, withdrawal to avoid more stigma, stigmatisation because of withdrawal or its effects, and so on around the circle. (Scheff, 1966, 98)

Stigmatisation leads initially to rejection. Bogardus's social distance scale (1925) gives an indication of this problem: if, for example, a person says we will not work with someone who is stigmatised, some coldness can be expected if they are employed together, even if the threat of rejection is not carried out. Whatley (1959) argues, on this basis, that

the pattern of avoidance ... suggest(s) that the ex-mental patient risks a certain amount of social isolation through curtailed interaction opportunities. (p.319)

But rejection is not the only reason why someone should become isolated. Firstly, a stigmatised person may be oversensitive to any slight, and feel rejection where none was intended. Zara (1970) showed paraplegics a stereogram, with a picture of a scowling face to one eye and a smiling face to the other; they were more likely to remember seeing the scowl. Cappeller (1972) notes that mental patients

expressed overtly the over-sensitivity to stigma that made it difficult for them, in many instances, to differentiate between ordinary behaviour and prejudicial reactions. (p.103)

This affects, in turn, their attitudes to the services; a mentally ill person, Parker (1967) suggests, who receives a slight rebuff at the employment exchange is more likely than others to be deterred from further applications (p.206). The same problems are apparent among young West Indians, who turn down low-status jobs:

Anything which has the slightest stigma attached, they avoid. (E.Murray, cited Geddes, 1980, 1)

Secondly, if stigma leads to a lowered self-esteem, a person may be less likely to make contact with others. Rosenberg (1965) found, in a study of adolescents,

a striking relationship between self-esteem and club membership. (pp .192ff)

On the other hand, I have already noted that stigma does not necessarily imply lowered self-esteem. Moriarty (1974) records that stigma (by which he means the knowledge that one is different)

decreases the attractiveness of the fellow minority member. (p 854)

This is probably because the high self-concept of many stigmatised people is a compensation for their stigma. The stigmatised person does not want to be reminded of his disadvantage; an association with others who have similar problems would be inconsistent with his self-concept. At the same time, it cuts him off from others who might best understand his position.

Isolation is not necessarily the result of stigma. Many stigmatised people are in a low social class, and members of the lower social classes are less likely than others to participate as the administrators of the American 'War on Poverty' discovered (Curtis, Zurcher, 1971, 347ff). This may be the result of cultural differences, of education, or simply of low income. The last is most likely. Social activities are expensive; people on Supplementary Benefit are less likely than others to take part in them for that reason (Clark, 1978, 401). And there are other reasons why stigmatised people may be isolated. Old people may find that their circle of friends narrows as they grow older. Disabled people may have problems getting out and about.

It is difficult to know which factors are most important. Chaiklin and Warfield (1973) interviewed amputees, who were isolated to a disturbing degree.

'I guess ... I can't do anything. I don't participate.'

'I have trouble getting around. I don't see them so often.'

'I haven't seen my old friends. One is all I've seen since I had my leg off. I just stay home. I never go out.' (pp.165-166)

These statements are richly ambiguous. It is not clear whether the people are rejected by friends, isolated by their disability, or have simply withdrawn from the world. Rogler and Hollingshead (1965) write, of the mentally ill person in Puerto Rico:

He withdraws from society out of fear that he will be stigmatised as a *loco*; in turn, the rejection of his friends and associates pushes him to withdraw. The stigma attached to this role is so strong that the withdrawal of the sick person from participation in all types of social groups appears to be a natural sequel to the condemnation he suffers. (p.245)

Withdrawal can be a reaction to rejection, or an anticipation of it.

## **Social relationships**

### *The attitudes of stigmatised people to society*

The stigmatised person is rejected by society, and this could be expected to colour his attitude to society in turn. Handler and Hollingsworth (1969) found that the people who felt embarrassed by receiving benefits were more likely to be those who had experienced difficulties, and were more likely to feel that the community was hostile (p.5). Theorists of deviance have argued that the experience of becoming an outcast encourages the stigmatised person to behave like one. Lemert (1951) distinguishes 'primary' and 'secondary' deviation. A person is a primary deviant when he does something in breach of social norms; he becomes a secondary deviant when he or other people define him as someone likely to breach norms (pp.75-76). It is the difference between committing a crime and being a criminal. The theory is developed largely, but not exclusively, in relation to criminology: once a person comes to think of himself as a 'thief', for example, he is more likely to steal things. Becker (1963) writes:

Treating a person as though he was generally rather than specifically deviant produces a self-fulfilling prophecy. (p.34)

The secondary deviant explores his role, and takes full advantage of it. This can be extended to people stigmatised for reasons other than crime. Blind people, Lemert argues, are forced to make a profession of dependency - they are expected to be dependent, and consequently exploit their situation (1951, ch.5).

However, this is only one possible reaction. Levinson (1964) classifies the attitudes of the stigmatised person to society in three categories: moral, calculative, and alienative reactions. Moral reactions are those which accept the dominant social norms and therefore stigmas - as legitimate. Calculative reactions are exploitative; the stigmatised person tries to make the best of his position. This corresponds to the position of the secondary deviant. Alienative reactions are of three kinds: feelings of powerlessness, normlessness and meaninglessness. A person feels powerless when there is a probability or expectation that he cannot control his own fate. Meaninglessness is suffered when he cannot make sense of what is happening, or



predict what will happen in any way. Normlessness occurs when he believes that he can only gain control by a breach of norms.

This classification is taken from Seeman's (1959) description of alienation, which includes two further categories omitted by Levinson: isolation and self-estrangement. Isolation is a feeling of distance from society: a low value is placed on social goals and values. Self-estrangement is distance from one's self, experienced when a person's actions are not rewarding in themselves. This concept of 'alienation' is not the same as the Marxist idea. Marx's concept of alienation is most closely linked to powerlessness and, to a certain extent, self-estrangement. Meaninglessness has more to do with the classic conception of 'anomie'. The alienated person rejects conventional values; the anomic person wants to conform, but has nothing to conform to. "Social constraint", Lukes (1977) writes,  
is for Marx a denial and for Durkheim a condition of human freedom and self-realisation. (Lukes, 1977, 81)

I do not think these views are really exclusive, because the person who is alienated may find he has no values to put in the place of the ones he has rejected; but they are not alike. Are stigmatised people alienated? It is a difficult question to answer. Sommer and Hall (1958) found, using a scale which measured conformity to common values and aspirations, that newly admitted mental patients were not alienated, but long-term patients were. This is hardly surprising: a long spell in a closed institution causes people to lose the aspirations that are common in the world outside, like the wish to have a car. Rodgers (1977) found, in a sample of welfare recipients, that they were more alienated and felt more powerless and helpless than the group of welfare officials, teachers and students with whom they were compared (ch.4). And Handler and Hollingsworth (1971) found that welfare recipients who felt stigma were also more likely to complain about the services - a reaction which the researchers thought healthy. "The more worrisome cases", they comment,  
... are the recipients who do not feel stigma. They seem to be passive, accepting, satisfied and unable to take advantage of the few things that the AFDC programme has to offer. (p.177)

By contrast, Sullivan (1971), who took his measure directly from Levinson's work, found a very low correlation of the attitudes to society with a perception of stigma (p.199); Goodman et al (1969), in a large study, record a correlation of only .01 of alienation with the perception of stigma (pp.60-61); Joyce (1973) found no significant relationship between feelings of powerlessness and the extent of dependency on social services (p.194); and @erbo (1976) found that those people with a high sense of stigma were less likely to blame the system (p.178) which suggests they were less alienated than others. It is possible that the relationship of alienation to stigma would be clearer if 'alienation' were assessed by other criteria - in particular, isolation or self-estrangement - but this must wait for further research.

The relation of stigma to anomie is also difficult to assess. An individual scale of 'anomia' has been devised (Srole, 1956), and Rodgers (1977) found using this that welfare recipients were more likely to be 'anomic' (ch.4); Sullivan (1971), on the other hand, found no real association of 'meaninglessness' and stigma (p.199). There is some indication that anomie, in the traditional sense, is not related to stigma. Durkheim (1952) found that poor people were less likely than others to commit suicide. Suicide, he argues, is an indicator of anomie; it follows that poor people are less likely to be anomic, possibly because they are more constrained by society (ch.5). Sainsbury (1955), similarly, found that  
in distribution, poverty and suicide are mutually exclusive. (p.251)

But poverty is a stigmatised condition. It could be argued, therefore, that stigma is not related to anomie. This is probably untrue. Firstly, suicide is higher in 'degraded' areas (HL Smith 1955, cited Sainsbury, 1955, p.50), where stigmatised people live. Secondly, Sainsbury (1955) found that

among the suicides were many who had lost status, either through unemployment, illness, business failure or the poverty of old age. (p.72)

This was not statistically significant, but it squares with the view that stigma can lead to anomie. A person who loses status has, for a certain time, a spoiled identity; a discrepancy

between status and self-concept is forced on him. At the same time, he loses his place, and his role, in society; he loses the security that his acceptance of social values had given him. Stigmatisation and anomie, in this event, are results of the same process.

Clifford (1975) argues, after Goffman, that a stigmatised person accepts the values of society. He feels stigmatised precisely because his acceptance of those values leads him to condemn himself, and makes him aware of how others feel - or makes him feel that they are condemning him (p.53). This would suggest that stigma is the reverse of alienation and anomie: that it stems, not from the rejection of social values, nor from the lack of them, but from their acceptance. It is unwise, I think, to assume that one explanation excludes the others. Stigmatisation is complex, and the careers of stigmatised people differ. Some may be alienated, some anomic, while others accept the norms that condemn them. Those who accept dominant values are the most likely to feel stigma; but they are not the only people affected by it.

### *Spoiled identity*

Goffman (1963) describes stigmatisation as the spoiling of social identity. Stigma, he writes, constitutes a special discrepancy between virtual and actual social identity (pp.12-13); that is, between those characteristics attributed to the stigmatised person, and those which he can be proved to possess. This formulation is unsatisfactory. Firstly, social identity is defined by society, and it is unclear how someone can be 'proved' to be different from that definition. Secondly, there is no reason why a person who is discredited because of an attribute or characteristic he actually possesses should not be said to be stigmatised. Watson (1980) argues that people who are responsible for their condition should be stigmatised - they deserve it. (p.56)

It should be clear, he writes, that

an individual responsible for his dependence on social services to provide what would otherwise be found through his fulfilment of the work role or maintenance of supportive family relationships, on the principle of respect for person, is unduly reliant, and the individual is justly a victim of stigma. (pp.56-57)

Goffman's conception of stigma does not leave room for this interpretation. As Lemert writes (1972),

The definition of stigmatisation as a collective process which necessarily misrepresents what (the stigmatised person) has done and attacks his integrity permits the deduction that it 'naturally' arouses feelings of injustice. (Lemert, 1972, 67)

The idea that someone is only stigmatised when there is a discrepancy implies that he is being dealt with unfairly. This is not necessarily true.

Thirdly, as Goffman himself says, it is important to understand what a man believes himself to be, rather than what he actually is. The feelings of a stigmatised person are inseparable from the idea of stigma. It is true that in some cases, there is a discrepancy between self-concept and social identity, and if the idea of spoiled identity has any meaning, it must be within this context. Blaxter (1976) gives an example from her study of physically disabled people.

They defined themselves as normal except for a handicap that was purely physical, but it seemed to them that they were being defined as abnormal in character, or intelligence, or mental condition. They were being labelled in ways which they felt to be entirely wrong and unfair. (p.203)

Spoiled identity is a form of maladjustment - Lemert (1951) calls a person in this position a 'maladjusted deviant' (p.91) - because a person does not accept a social definition of himself.

If a person has a high self-concept and low status, he is going to feel resentful if he is treated in a way that is less than he thinks it should be. Goffman's proposition seems too obvious to disagree with. But the dimension of time changes this simple pattern. Bem (1967) argues that people's opinions of themselves are determined by other people's opinions:

Self-perception ... is a product of social interaction. (p.75)

This suggests that there should be a reformulation of a person's self-concept as time goes on, leading him to accept the social definition of his identity. This does not always happen. Carson (1967), for example, found in a survey of welfare recipients and others using Vocational Rehabilitation Offices that

The group that scored highest on self-concept and self acceptance was the group that had received welfare for three years or more. (p.427)

This is paradoxical. Brehm and Cohen (1962) try to explain a similar problem in terms of cognitive dissonance:

where the behaviour cannot be changed or misinterpreted, that is, where the cognition of behaviour is also highly resistant to change, then the dissonance may well be reduced by a reaffirmation of that aspect of the self-concept with which the behaviour is discrepant. In other words, the discrepant behaviour may only strengthen the dissonant aspects of the self-concept. (p.59)

A stigmatised person compensates for the discrepancy between ego- and social- identity by shoring up his self-concept. A simpler way of putting it might be that he denies there is anything wrong with him, and therefore he does not have to feel uncomfortable about it. An illustration of this process is the way in which unemployed people deny that other people's opinions are important to them. Cohn (1977) asked both employed and unemployed people whether it mattered to the unemployed what other people thought. Unemployed people were more likely to say it did not. In effect, a person with spoiled identity tries to preserve an image of himself which is only defended by ignoring the opinions of others. If he fails to do this, his self-esteem will plummet.

The idea of 'spoiled identity' introduced by Goffman can be presented in another way: as a discrepancy between features of a social identity. A stigma is a characteristic which forces someone into a position that is lower than the one he would otherwise occupy. In this form, the idea of 'spoiled identity' bears a striking resemblance to that of status inconsistency. Lenski (1954) introduced the concept as 'status crystallisation'. A person's social position was determined by his position in a number of hierarchies - in particular, hierarchies of income, education, occupation and ethnic group (p.406). A person who is high in all the hierarchies, or low in all of them, has a high degree of status crystallization. People who were high in some and low in others - like a black doctor, or an unemployed graduate - had a low status crystallization. The person with low crystallization was in a position similar to Stonequist's idea of the 'marginal man' (1935). Placed between two cultures, the marginal man is a part of neither. The result, Lenski suggests, is that the person with incongruent statuses has problems in dealing with others that cause him to avoid contact and limit his participation in society. Lenski's findings can be explained as an example of spoiled identity. A person may formulate an image of himself by referring to a higher status; but there is then a discrepancy between this image and his lower statuses. The unemployed graduate is an instance of this. His education leads him to think highly of himself; his unemployment causes others to look down on him.

However, the idea of status inconsistency has been knocked firmly on the head by empirical research. Bauman (1968) found that status inconsistency had no significant effect on the behaviour of working-class people, and an opposite effect to that predicted on middle-class people. Segal et al (1970) found that inconsistency didn't matter; people simply averaged their statuses. Blocker and Riedesel (1978) comment on a near-total absence of positive findings ... (pp.285-6) and find that, even when an attempt is made to use a subjective test of inconsistency, there is no effect:

In day-to-day life, the average person is not really bothered by the inconsistencies in status which somehow do bother sociologists. (p.287)

Where does this leave the idea of 'spoiled identity'? The adjustment of people to their incongruent statuses is, I think, to be expected; discrepancies in social identities become irrelevant. Spoiled identity may be a part of the moral career, but it is not a permanent feature of it.

## Stigma as a social relationship

The moral career has a dimension of structured social relationships as well as the personal problems which arise from immediate contact. The process of stigmatisation is determined by the behaviour of others toward the stigmatised person, and it is possible to represent this process in terms of its effect on social relationships. Three main aspects may be distinguished. The first is the lowering of the status of the stigmatised person; the second is the denial of status; and the third is the denial of humanity.

Status is directly related to esteem. Weber called status "a quality of social honour or a lack of it ... " and asserted that status groups are

determined by a specific, positive or negative, social estimation of honour. (Gerth, Mills, 1948, 186-187)

There are, clearly, close connections between status and stigma: Watson (1980) suggests that they are two sides of the same coin (p.48). People who are stigmatised may lose position, either because a stigmatising characteristic may limit their capacity to adopt certain social roles, or because some stigmas - like unemployment, or financial dependency - define inferior roles for them. Stigmatised people are also likely to be poor, because they are unable to earn or are in a position where they are not earning; their life style is therefore restricted. Brown (1966) writes:

There must be few situations more degrading to the dignity of man than the realisation that his disability, which has already deprived him of his independence, will eventually demote him to a socially inferior class. (p.135)

Most important, stigma is a quality of social dishonour: a mark of degradation, loss of esteem, or loss of reputation. Low status implies inferiority, and the imputation of inferiority is an aspect of stigmatisation. People with low status may have problems which are similar to those of stigmatised people: Newby (1977), for example, records a comment from an agricultural labourer who told him, "I hide it I'm a farm worker if I go out - I won't tell anybody." (p.346) And it can be argued that it is stigmatising to treat somebody as a social inferior. Fabrega (1971) describes how

Residents of San Cristobal usually refer to limosneros (beggars) regardless of their age, sex or background by means of the informal personal pronoun 'tu' and overtly describe their status as a socially inferior and reprehensible one. (p.284)

Stigma and low status become difficult to distinguish. Titmuss (1974) wrote,

If men and women come to think of (and feel) themselves as inferior persons, subordinated persons, then in part they stigmatise themselves, and in part they are reflecting what other people say about them. (p.44)

This is not completely adequate as a description of stigma, which goes beyond a sense of inferiority. When Griffiths (1975) writes that

the system of providing accommodation for the majority of lower income people carries a stigma of inferiority (p.9),

or Goffman argues that "we are all stigmatised to some degree" (1963, 154), I think they understate the force of the idea, and to some extent devalue it. A person who has an inferior status is expected to defer to others; his life style is restricted; he is held in low esteem. The implications of 'stigma' are complementary, but they are not the same. Stigma is a more extreme and, I think a more restricted, idea than low status; it contains elements, not only of degradation, but of rejection and humiliation.

The second form is the destruction of social identity - the denial of status, of rights, of a social existence. Goffman remarks, at the beginning of his study, that the origin of the word 'stigma' lies in the brand that was put on a criminal in ancient Greece (1963, 11). But the Greeks also had another concept - *ατιμια*, literally 'dishonour' - which meant both social disgrace and the loss of civil rights. (Aristotle uses this word in relation to suicide :1871, 105) The Romans also denied social rights to stigmatised people: the codes of Justinian, formed in 530 A.D., denied legal status to persons who were deaf and dumb from birth. They had no rights, could not marry, and had guardians appointed for them (Meadow, 1969, 430). In

more modern societies, legal status has been denied to mentally ill people, epileptics (Gudmundsson, 1966, 100), and paupers. The loss of citizenship is a mark of their social as well as their legal standing; they are less than other people. There is a sense, then, in which the loss of rights is a stigma.

Thirdly, the stigmatised person loses his claim to common humanity. Goffman (1963) writes that

we believe that the person with a stigma is not quite human. (p.15)

Stigmatised people are held in contempt. They are often compared with animals, for example, by the public health inspector who told Damer (1974), "Animals, that's what they are ..." (p.227) or the clerk of the hostel for homeless men, who complained about bedwetters,

they're worse than animals, some of them. You can't do anything for them. (cited Turner, 1960, 34)

A television programme about Rampton, a special hospital for mentally handicapped offenders, asked a former inmate:

- What was the most frightening thing to you about it?

- Being treated like an animal. (Cutler, Willis, 1979)

Fabrega (1971) notes that beggars in Mexico who are offered a place for the night are put in the kitchen, corridor or patio, like dogs (p.284).

Much of the problem of stigma arises from the fact that people who are thought of as animals are treated like them. Wolfensberger (1969) argues that the provision made in institutions for mentally handicapped people reflects the assumptions we make about them. We believe that their behaviour is likely to be primitive and uncontrolled, and so institutions are designed to be 'abuse resistant' - things are not left around which they might break. Because mentally handicapped people are supposed to be destructive and violent, they are given what is euphemistically called 'custodial care' rather than help. They are supposed to be incapable of choice, and so there are no light switches or thermostats accessible to them. They are dirty, and so there are mass cleaning facilities. They are like animals, so they have to be 'kept' in asylums designed for supervision. They have no aesthetic sense, so the institutions are drab. Their inability to learn means that they are given no stimulation. And because 'animals have no rights', they are not allowed privacy, property, communication, relationships with each other, or individuality (pp.70-77).

Each of these aspects of stigma - the loss of status, of society, and of humanity - is a description of the social position of the stigmatised person. They define his social identity, his roles, his relationships with others. But these relationships are determined principally by the feelings and reactions of other people besides himself. The stigmatised person is treated as an object; and his own feelings are reactions to a situation which is largely outside his control. If stigma is seen as a social relationship, these feelings may best be understood as a reaction to stigma rather than a part of the stigma in themselves.

## **Chapter 9: Summary**

The stigmatised person has difficulties with his self-concept, in interaction with others, his personal relationships, and his social identity. This reflects his position in the social structure, which may mean lowered status, a denial of social status, or even a denial of humanity.

## Part 3: conclusion

The diversity of the experience of stigma seems to emerge from this study more strongly than any unifying factors. Goffman's belief that stigmatised people share a common experience in their interaction with others is at best questionable. "Stigmatisation" refers to a variety of experiences, attitudes and feelings, which depend on a wide range of personal circumstances. But this lack of cohesion does not imply that the use of the term is irrational, or that the idea is inappropriate. The underlying coherence of a concept rests, not in an attempt to confine its use to a specific or unambiguous use, but in a pattern of "family resemblance" which defines similarities between related clusters or factors. The idea of "family resemblance" recognises that two members of the same family may be quite unlike, but they are linked by the similarity to other members. The experiences of a person with a physical handicap and a low paid worker may be fundamentally dissimilar, but there are elements which connect them with other people stigmatised in different ways. If there is a unifying thread, it rests, not in the moral careers of individuals, but in the pattern of structured social relationships which mark stigmatised people out from the other members of society. In the final part, I intend to examine these relationships in more detail and consider their implications for social welfare.

## Part 4

### Stigma, society and social welfare

## Chapter 10

# THE MORAL DIVISION OF SOCIETY

### Morality and prejudice

Edmund Burke argued that prejudice was equivalent to morality. It reflected the wisdom and experience of previous generations. Prejudice, he wrote,

is of ready application in the emergency; it previously engages the mind in a steady course of wisdom and virtue, and does not leave the man hesitating of decision, sceptical, puzzled and unresolved. Prejudice renders a man's virtue his habit; and not a series of unconnected acts. Through just prejudice, his duty becomes a part of his nature. (1790, 105-106)

The meaning of prejudice has changed since Burke's time, but its identification with morality deserves emphasis. Both prejudice and morality are based on social norms. People are condemned for a breach of a moral principle; a prejudice is itself a condemnation. In this, they are clearly comparable.

Gibbs (1972) distinguishes social expectations from evaluations. It is a logical distinction, but in practice, it is difficult to maintain; people value their concept of normality, and a person who falls outside the boundaries of that conception will be valued negatively. As Goffman says,

We lean on those anticipations that we have, transforming them into normative expectations, into righteously presented demands. (1963, 12)

Moral norms are not essentially different from other expectations, although they are distinguished by the elements I have described before - responsibility, gravity, and a social sanction. A moral norm is an idealised standard of approved behaviour; a prejudice is a generalisation which assumes a set of negative characteristics. The connection between them is strong enough to mean that a person who breaches a moral rule may become the object of prejudice; the breach invites, not only contempt and rejection, but a generalisation based on stereotype. Conversely, the person who is the object of prejudice is likely to be condemned morally.

This depends, of course, on the attitudes of the prejudiced person. Although many expectations are shared, it is not by any means true that everyone in society thinks in the same way. Zavalloni (1973) criticises Goffman for presenting a set of middle-class values as a social consensus (pp.72-74). I think the epithet 'middle-class' is unfair, because working-class people are just as likely to be prejudiced against stigmatised people; but the substance of the criticism is reasonable. There is not a consensus about these values. However, there is enough agreement about them to make it a problem when someone falls foul of the norms. A person who has breached a moral rule, or who is the object of prejudice, becomes the object of a stigma.

A stigmatised person is someone whose characteristics or behaviour go so far beyond the norm as to be unacceptable. "The general principle at work", Lemert (1972) asserts, is a simple one: when others decide that a person is *persona non grata*, dangerous, untrustworthy, or morally repugnant, they do something to him, often unpleasant, which is not done to other people. This may take shape in hurtful rejections and humiliations in personal contacts, or it may be formal action to bring him under controls which curtail his freedom. (p.68)

But it is not quite so simple. A social division may be caused by extreme social distance rather than positive rejection; it may reflect a relationship between a dependent person and the community, rather than a rule breaker and those who create the rules. There is, nevertheless, an ultimate division between those who are accepted and those who are not.



The division is dichotomous, because the norms which bring it about are dichotomous. Stigma involves categorical societal definitions which depict polarized moral opposites (Lemert, 1972, 63), and the stigmatised person is an outcast.

### **Division and caste**

In this respect, the stigmatised person is directly comparable to the deviant. Scott (1972) argues that the function of deviance is to preserve the social order. The separation of deviants from the rest of society is to enforce standards within society. The deviant is demarcated off from the rest of society, and moved to its margins. (p.30)

The deviant is excluded, not so that he will be reformed - little emphasis is put on this - but in order to impress a code on the rest of society. This extends beyond the moral issues, although the deviant is generally seen as someone who is morally inferior. It includes abnormalities of behaviour, appearance and social circumstances. The deviant, or the stigmatised person, is cast out to uphold the values of a society.

Nadel (1953) suggests that the outcast is a feature of the advanced society. In primitive societies,

there is no intentional discrimination against the offenders; nor is there any thought of a stigma imposed on them. Rather ... stigmatisation is on the whole alien to primitive society. (pp.269-270)

I find it difficult to accept this as it stands. The accusation of witchcraft, which makes outcasts of the accused and may lead to their deaths, is an extreme form of stigmatisation (see M.Douglas, 1970, ch.8). What is true is that those who break lesser rules in small-scale societies may be reintegrated rather than cut off from the normal social structure.

In principle, the deviant act is not considered immoral. ... The social attitude to the deviant person or group corresponds to the attitude to the deviant act. The deviant is not stigmatised, and there is no secondary deviance. Instead of alienating the deviant, he is reintegrated and rehabilitated. (Seibel, 1972, 255)

This does not mean that these societies have no position analogous to stigmatisation. In traditional Indian society, there are no outcasts, but there are pariahs. It is a feature of the caste system that, at all levels, it carries traditional privileges as well as disadvantages. The untouchables have exclusive rights to occupations which only they can do.

In a class society the 'people at the bottom' are those who have been forced there by the ruthless forces of economic competition; their counterparts in a caste society are members of some closely organised kinship group who regard it as their privileged right to carry out a task from which all other members of society are rigorously excluded. (Leach, 1976, 183)

At the same time, the integration of untouchables into Indian society is not 'integration' as it is understood in the West. Niesewand (1980) cites a survey of 141 villages in Madhya Pradesh, where there had been a series of unpleasant physical attacks on Harijans, the untouchable caste. Only one washerman in 82 washermen themselves belonging to an inferior caste (Barth, 1960, 140) - was prepared to wash for a Harijan; 107 out of 124 barbers, also in low castes, would not cut a Harijan's hair; 56 temples refused them access; 29 village councils made them squat on the floor as a sign of their low status. This shows a degree of hostility and rejection far in excess of the reaction that I have described to stigmatised people. The Harijans are treated in a way that is if anything worse than an 'outcast' would be treated in the West.

The system of caste has no direct equivalent in Western society. Barth describes it as a pattern of social stratification - that is, a conceptual scheme for ordering the individuals of a community, each occupying multiple statuses, in terms of a limited set of hierarchical categories. (1960, p.129)

But hierarchical organisation is only one aspect of a distinctive social structure. A further aspect is hereditary specialisation. Caste is more accurately defined as

a hereditary, endogamous, usually localised group, having a traditional association with an occupation and a particular position in the local hierarchy of castes. (Srinivas, 1962, 3)

It is this feature which sets caste apart from other forms of social stratification. Thirdly, caste depends for the maintenance of social distinctions on the idea of pollution. Relations between castes are governed, among other things, by the concepts of pollution and purity, and generally, maximum commensality occurs within the caste. (Ibid, 3)

Castes are separated by social boundaries, and pollution occurs when boundaries are crossed. Dirt is matter out of place; when there is a confusion between those things which ought to be kept separate, there is disorder, and where there is disorder, there is pollution.

The object of the code of pollution, like the object of the exclusion of deviants, is to preserve social order. Pollution disturbs the social order, and disrupts social norms. It is therefore a fundamental sign of immorality - 'therefore' not in the sense of a logical progression, but because immorality and disruption are taken to be synonymous. The borders of society are maintained by 'pollution powers', which are designed to preserve order. Pollution powers, Douglas (1966) writes,

punish a symbolic breaking of that which should be joined or joining of that which should be separate. (p.113)

A person who tries to cross a boundary is a polluting agent. he is a disruptive force; a source of fear as well as contempt because he threatens to disturb the natural order of things. Douglas argues that "a polluting person is always in the wrong" (p.113); but the polluting person can be a symbol of power as well as an object of rejection, because only a person of power can join things which should be separate.

A disabled person is a pollutant; he does not conform to the norms of the body image. So it is that the disabled person is treated, in some societies, as a person with mystical powers: blind people can be taken for seers, handicapped people for sorcerers (Jaques et al, 1960, 10-12).

Paradoxically, the pariah is considered to be a polluting person. It is paradoxical because it is the position of the pariah to be in a fixed place in the lowest caste, which is in keeping with order rather than disorder. But the pariah is also at the bottom of society; he is expected to do the dirtiest jobs, and to work with polluted articles, which do not affect him because he is already polluted. As pollutants, pariahs are also treated as immoral people. They are considered

innately polluted, manifestly or latently, first by some form of inherited intellectual inferiority resulting in potentially defective mental processes; second, by irremovable forms of ugliness, uncleanness, or communicable disease; and third, by forms of innate moral depravity which lead pariahs to commit reprehensible, forbidden acts ... Whereas individual members of a pariah group may be overtly free of any of these stigmata, by nature of their genetic identity they are inescapably carriers ... (de Vos, 1967, 297)

This is strongly reminiscent of the position of stigmatised people in general, and of the 'degeneracies' in particular, which suggests that there is at least a parallel to be drawn between stigma and low caste. Stigma is not the same thing as low caste; there is no element of endogamy, or of hereditary specialisation. But it shares with caste a concept of a divided society, and the importance of repulsion in maintaining social boundaries. Stigma is a form of pollution, a mark of disorder, and the stigmatised person is a polluting person.

### **Stigma and immorality**

As polluting people, stigmatised people are treated as immoral. This may be fair in some cases. As Watson (1980) says,

Those who neglect their capacity and opportunity for self-help ... fail to display those abilities which make a human being worthy of respect ... Stigmatisation in such cases is a demand of our social morality. (p.57)

This may explain, in part, why poverty is considered as an immoral state. A poor person has neglected his capacity for self-help. The Poor Law Commissioners in 1834 considered that the failure to maintain one's family was against the "ordinary laws of nature" (Checkland, Checkland, 1974, 135) and that it meant "moral debasement" (p.179). Poverty was the result of "indolence, improvidence, or vice" (p.378). This is still a strong element in British and American thought. The stigma of welfare, as Lemert (1951) comments, carries with it well-defined ideas of improvidence, laziness, sexual immorality, and proneness to fraud in obtaining relief and charity. (pp.89-90)

A substantial proportion of British people are ready to attribute poverty to laziness, drink or having too many children (Riffault, Rabier, 1977, 69); people in the US are likely to blame it on loose morals and drunkenness (Feagin found 48% who agreed this was the case: 1975, 97). At a time when poverty is demonstrably mainly the result of old age, this opinion indicates an irrational concern with a limited section of the poor. In general, welfare recipients are viewed as being more idle, more dissolute, more dishonest and more fertile than they actually are. (Williamson, 1974a, 172)

Free and Cantril (1967) found that two thirds of their sample agreed the relief rolls are loaded with chiselers and people who don't want to work (p.27) at a time when few of the claimants could be considered employable.

Poverty and dependency are believed to be inherently immoral. An example of this is the attitude to begging. Begging, in Britain, is a criminal act. A beggar is, under the Vagrancy Act of 1824, classed as a person with a 'disreputable mode of life'. An ordinary beggar would, when the Act was introduced, be charged as an 'idle and disorderly person' - an interesting use of the word 'disorderly'; one who exposed wounds and deformities, as a 'rogue and vagabond', and on a second offence as an 'incorrigible rogue'. The offence beggars commit, vagrancy, was the same offence committed by people who abused the Poor Law, or who possessed implements for housebreaking (Cd. 2852, 1906, 8). The classification is revealing. Beggars and thieves were clearly linked in the minds of the legislators. (It is, incidentally, a combination which occurs in literature, in 'The Beggar's Opera', or the Court of Miracles in 'The Hunchback of Notre Dame'.) In the USSR, beggars are treated under the same law as black marketeers (Beerman, 1958 et seq.).

Dependency is linked with dishonesty. 'Scrounging' - 'chiseling' in the US, 'bludging' in Australia - is a dishonest activity, although its precise meaning is unclear: it sometimes means that people take advantage of the services available, and at other times implies that they are cheating the system. However, as Deacon (1978) says,

whilst scrounging exists, the degree of popular concern is out of all proportion to its extent. (p.122)

Smigel (1953) points out that 'chiseling' is a criminal offence, but that it does not have the stigma of criminality (p.60) perhaps because of the ambiguity in the term I have noted. Even so, a large minority of people believe that welfare recipients are dishonest. A Gallup poll in 1964 in the US found 75% agreeing that most recipients were on relief for dishonest reasons, and 61% who said some were (cited Anderson, 1978, 62). Kallen and Miller (1971) found, out of 300 black and 300 white subjects, that 20% and 28% respectively of their samples disagreed that most claimants are honest (pp.86-87). By contrast, Feagin (1972) found 71% agreeing that most claimants are not honest (p.926) - which says something about the importance of framing the question. Williamson (1974a), asking people what proportion of claimants they thought were dishonest, found an average of 41% (p.165). Recently, in the UK, 30% of respondents to a survey estimated that over a quarter of claimants were scroungers (Golding, Middleton, 1982, 172) - which is perhaps evidence of a more liberal attitude. The belief that claimants are dishonest is associated with the view that poverty is the result of lack of effort (Alston, Dean, 1972) 'Dishonesty' which takes the form of working while claiming benefit does not suggest 'lack of effort', and it is strange to see them confused. Marsden and Duff (1975) suggest that people 'fiddle' by working because it is more acceptable than doing nothing (p.249), although clearly it is also affected by a desire to supplement a limited income.

The East London Claimants' Union (1974) attributes accusations of abuse to a deliberate attempt to control or deter the recipients of welfare; they argue that the members of the Fisher Committee, a body set up to investigate the problem of abuse, failed to see that its prime function was that of stigmatising claimants and reducing their self-esteem in the community. (p.88)

This is, I think, a misinterpretation; the concern of successive governments with abuse reflects a deep public suspicion rather than a specific policy of repression. The effect, however, has been to create attitudes and an atmosphere in the offices which is detrimental to a service intended to help the individual. The success of the 'declaration' reflects on present methods of dealing with the abuse of services. The current policy of the Department of Health and Social Security is to clamp down on abuse as a way of improving the position of claimants.

'If we can clean up the image of the unemployed there will be less stigma about people on the dole being scroungers' (a spokesman said). And perhaps the people who DON'T claim the £300m a year they are entitled to will come forward without feeling they are being branded with the scrounger stigma. (Blair, 1980)

It is difficult to see how the reputation of a service could be improved by a clampdown on abuse. If the clampdown fails, it leaves a service with a tarnished reputation; if it succeeds, the reputation is tarnished just as badly because of the adverse publicity which accompanies the clampdown. Poverty and dependency become associated with abuse in the minds of the claimants and of the public. This may not actually deter people from claiming, but it may be a source of humiliation, and it runs a risk of creating a self-fulfilling prophecy, by making people feel they are doing something dishonest when they claim. Moreover, the measures which are necessary to deal with abuse involve a rigorous investigation of circumstances which is likely in itself to be the cause of resentment and distress. The concern with abuse is excessive, the steps taken to deal with it offensive, and, from the evidence of the declaration procedure, wasteful and unnecessary.

Poverty and dependency are associated, not only with dishonesty, but with sexual immorality. It is true, as Day (1977) remarks, that part of the stigma toward welfare recipients arises from the fact that they are sex-role deviants. (p.872)

A limited proportion of recipients are female single parents about twelve per cent of Supplementary Benefit claimants. Large families, the other main dependent group which is blamed for lack of sexual restraint, may contribute to the numbers of those in poverty - 98% of families with five or more children have an income less than 140% of the Supplementary Benefit level (Layard et al, 1978, 15) - but only 8% of the households in poverty in the UK are families with three or more children, where the man is not disabled (p.30). The emphasis on having 'too many children' in the European study of attitudes to poverty is not justified.

Nevertheless, accusations of sexual misconduct are frequent. Velho (1978) remarks of a building in Copacabana that it was "notorious as a place of sexual encounters" (p.527) - apparently on the basis that it was overcrowded, and that overcrowding was an indication of promiscuity. Benington (1972) describes in Hillfields, Coventry, how the process of stigmatisation had begun to label the area as a source of vice, drugs and crime. (p.5)

Berg (1968) describes how a school's reputation was tarnished by sexual innuendo about the libertarian headmaster (pp.126-127). Cook and Braithwaite (1979) give the example of attitudes to vagrants:

the intensity and frequency with which allegations of sexual misconduct are made against vagrants is always alarming and invariably at considerable variance from the knowledge and experience of workers in the field. (p.8)

I have already remarked on attitudes to divorced women. Fecundity is one of the 'problems' of problem families. And it is interesting to note that criticisms based on sexual morality may

be raised against other stigmatised people, as in the association of learning disability (Romano, 1968) or leprosy (Richards, 1977, xvi) with venereal disease.

### **Poverty, immorality and dirt**

Stigmatised people are not only believed to be immoral. Orwell once wrote,

It may not greatly matter if the average middle class person is brought up to believe that the working classes are ignorant, lazy, drunken, boorish and dishonest; it is when he is brought up to believe he is dirty that the harm is done. (1937, 130)

And it is the case that the lower classes are believed to be dirty as well as immoral. An assistant overseer at Windsor told the Poor Law Commissioners,

The wives of paupers are dirty and nasty and indolent; and the children generally neglected and dirty and vagrants, and immoral. (Checkland, Checkland, 1974, 169)

Well, perhaps they were. It is difficult to be clean and upstanding in a hovel without water. But the language is not the language of considered complaint. In 1837, the US Supreme Court, upholding a law which prohibited the immigration of poor people into New York, referred to paupers as a "moral pestilence" (*City of New York v. Miln*, cited Bendich, 1966, 92) - a concept which seems to combine immorality with dirt and disease. (It took the court more than a hundred years to recognise that "poverty and immorality are not synonymous": *Edwards v. California*, cited Bendich, 1966, 93)

The association of poverty with dirt still occurs. Rodman (1965) notes that

Members of the lower class are often thought to be 'immoral', 'uncivilised', 'promiscuous', 'lazy', 'dirty' and 'loud'. (p.220)

Williams' study of Gosforth, with its descriptions of the lowest class as "the immoral element of the village", "dirty people who have no self respect", or "folk who don't care what they look like", bears this out (1956, 107-108). And poor people are still accused, partly in jest, of keeping coals in the bath because they don't know what baths are for (Damer, 1974, 227). Of course, some poor people are dirty. Vagrants may have nowhere to wash, and no clothes to change into. Beggars in Ireland, Gmelch and Gmelch (1978) suggest, choose to be dirty because of the prejudice that someone who is not dirty cannot be in need (pp.444-6). But as a generalisation, the accusation of dirtiness is difficult to maintain. Rokeach and Parker (1970) asked people to rank the values they considered important to their daily life. Poor people were more likely to think cleanliness important than richer people did (pp.102-103); low-educated people ranked it higher than the higher-educated; African Americans ranked it higher than Whites (p.109). Their explanation is, simply, that these are the people who have to worry more about cleanliness; it is more difficult to keep clean when there is a shortage of hot water, amenities, or washing facilities, and it therefore takes more attention. But this does not square with the view that the poor are dirty. On the contrary, although there may be practical difficulties in keeping clean, the emphasis on cleanliness compensates for this. The idea that the poor are dirty is just not true.

Similarly, the idea that the poor are immoral is very questionable. There is some indication, from Rodman's theory of the 'culture of poverty', that some poor people do not share a conventional moral attitude to the family. But tests of moral values have indicated that there is a more rigid adherence to traditional moral standards among the lowest classes (Cohen, Hedges, 1963, 316). The association of poverty and dependency with immorality and dirt seems to be ill-founded.

Stigma, and the stigma of poverty in particular, seems to be linked irrationally with these ideas. The same association can be found in the idea of pollution. A stigmatised person is, I have said, a polluting person. Dirt is matter in the wrong place; disorder is the root of immorality. Poverty, immorality and dirt are bound up together in an image of society based on a primitive and powerful conception. This reinforces the identification of stigma with caste. Like the pariah, the stigmatised person is held at a distance; he is assumed to be immoral and dirty. He is kept outside the boundaries of society. This gives the impression

of a group of outcasts, of deviant groups; but the process is more complex than many theories of deviance suggest. The creation of pariahs is a basic mechanism of social organisation, and stigmatised people are the pariahs of our society.

### **The idea of stigma**

Despite the confusion, despite the differences between the various types of stigma, I have come to feel that there is an underlying coherence in the idea of stigma. Stigmatised people do have enough of their circumstances in common to justify classifying them together for the purposes of analysis. But it is not the sort of relation described by Goffman. Goffman is concerned principally with small groups. There are some similarities in the conditions of stigmatised people in small groups, but the differences outweigh them. In small groups, the things which are important are the effects of distinguishing characteristics on interaction. In this context, physical and mental stigmas may have certain features in common, but it is difficult to extend this to the stigmas of poverty or immorality.

Stigmatised people do not have an identical social position; like The members of low castes, there are important distinctions made between them, not least the distinctions they make themselves. Old and disabled people have in general a higher status than unemployed men or unmarried mothers. At the same time, they share an inferior position in relation to the rest of society. A boundary separates them from other people. This boundary can be represented as a division, a barrier, or as a social distance - a gulf - between stigmatised people and others. They have a place in society - which is, in relation to the social services, a dependent one - but their very dependency only serves to remove them from the normal pattern of social relationships. The distance between us makes it difficult to see them as individuals; and, because we like to believe that people are responsible for their fates, they tend to be rejected and isolated further, and, in the lowest castes, stereotyped as dishonest, dirty and immoral.

The status of stigmatised people is determined by a number of factors - by their dependency, their poverty, and their lack of power. We reject them because they have low status, but we also reject them for other reasons - because of our prejudices against them, or because they have violated our expectations, our ordered view of society. And this degrades their status further, because rejection limits a person's roles in society, and social honour also depends on the roles he plays. Stigma perpetuates itself. It denies people access to roles, status or influence; it increases social distance; it isolates people from the main body of society. By doing this, it bars access to the advantages offered by normal social contact.

Figure 10.1: The causes of social rejection.

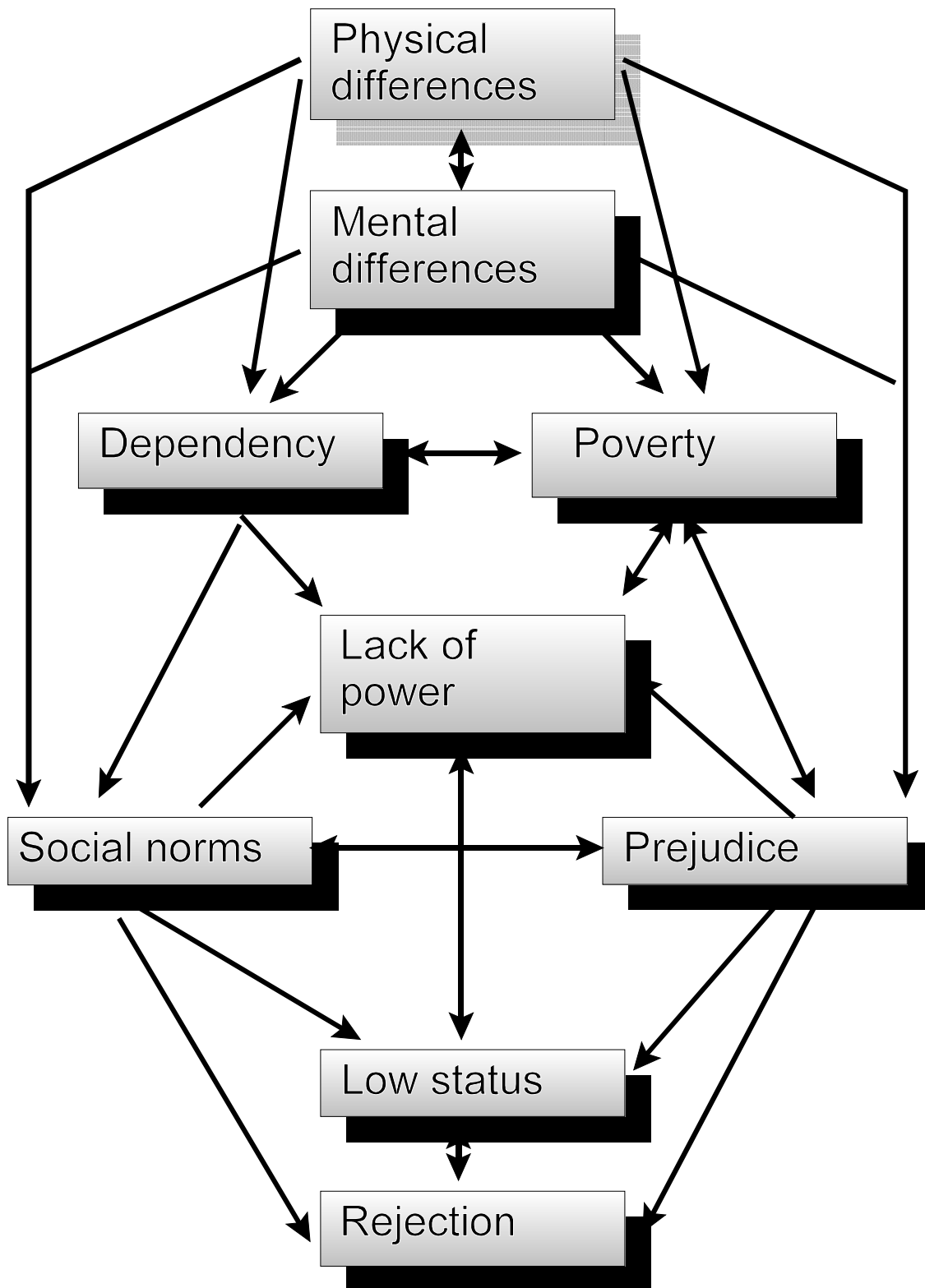


Figure 10.1 is a representation of the principal relationships. The arrows in the diagram represent sequential links rather than direct causation. Physical and mental stigmas, which are related, and dependency and poverty, which are also related, imply breaches of social norms - norms of behaviour and appearance - and prejudice, which is founded in the same process of socialisation which structures social norms. The symmetrical pattern is determined by the affinity of poverty and dependency, and of prejudice and social norms. The interpretation of the diagram depends on the weight that is given to the different factors. It should be clear, for example, that I do not think that power is a major determinant of these relationships; but a different interpretation, which put more emphasis on power, would not be inconsistent with the basic model.

### **Chapter 10: Summary**

The roots of morality lie in the same social norms as the origins of prejudice. These norms are dichotomous; stigma consequently involves polarised social categories. Stigmatised people are outcasts. Their position is analogous to that of people of low caste, or pariahs. A pariah is a polluting person, simultaneously immoral, disruptive, and at the lowest rung of society. Like pariahs, stigmatised people are believed to be dishonest and sexually immoral, and dirty.

Stigmatised people have a common social position, separated by a boundary from other members of society. Through an interaction of factors, stigmatised people become dependent, poor, powerless, low in status and socially rejected.



# Chapter 11

## STIGMA AND SOCIAL POLICY

Stigma and social welfare are both complex concepts, and the relationship between them is multi-faceted. In the first part, I discussed some of the common explanations for stigmatisation in the social services - degrading treatment, loss of rights, attitudes to 'charity', labelling and selectivity. None of these is a sufficient explanation of stigmatisation, but each helps to explain some of the dynamics of the process by which the recipients of social services become stigmatised. The rejection of social welfare as 'charity', for example, is a rejection of the dependency inherent in the nature of the social services. The services may also stigmatise recipients through labelling, which is a mark of status; by denying rights, which is a way of defining an inferior status; or through selectivity, which sets apart a status group. However, the role of the services in creating stigma is only a part of the whole picture. The possession of other stigmatising characteristics - poverty, immorality and physical and mental stigmas - often means that people are stigmatised before they come to the services. The services are not only stigmatising in themselves, but tainted with the reputation of the people they serve.

At the conclusion of part II, I argued that the varied nature of different stigmas implied policies which are fundamentally inconsistent with each other - rehabilitation and individual rights, redistribution and the pursuit of independence, collective action and individual reform. The conception of stigma as a division in society casts a different light on these conflicts. The focus is changed: the issue is not whether a policy is appropriate to a particular stigma, but whether a coherent policy can be followed to deal with the essential problems stigma presents.

### **Residual and institutional welfare**

The concept of stigma as a social category poses a conflict between policies, which extends beyond a distinction between universal and selective provision. There is a choice to be made between normalisation and the acceptance of differences, gifts and exchanges, dependency and self-determination, social control and the redistribution of power, discretion and rights, and selectivity and universality. The choice is often represented as a choice between the residual and institutional forms of welfare. Butterworth and Holman (1975) write:

Whereas the residual view of social welfare implies that those in need are relatively discrete groups which require a concentration of resources upon them as the main priority of policy, the institutional view implies that most people are likely in their lives to need help to meet various crises and eventualities for which it is difficult to plan adequately and that responsibility for help rests with the state. (pp.14-15)

The model of residual welfare, according to this interpretation, is characterised by its response to problems as the problems of individuals. It seeks to provide for those people who are most in need. It is selective; it uses means tests, or tests of need, to establish who should receive social welfare. It retains discretion to guarantee responsiveness to individual problems. It works as a safety net in society, as a supplement to the economic system protecting those unable to compete in it. Institutional welfare, by contrast, is collective. It provides comprehensive categorical benefits to people as a mark of citizenship, and establishes formal rights to services. It replaces the economic market with the social market, and the exchange with the gift. These models stand in opposition to each other. Selectivity is opposed to universality, tests of means or needs to comprehensive categorical benefits, discretion to rights, individual to collective provision, the economic market to the social market.

The focus of the debate on policy has fallen on a discussion of 'universality' and 'selectivity'. It has been argued that selective systems of welfare, which attempt to give aid to

the people who are most in need, necessarily stigmatise the recipients. Wilensky and Lebeaux (1958), for example, state that

Because of its residual, temporary, substitute characteristic, social welfare ... often carries the stigma of 'dole' or 'charity'. (p.139)

Equally, it is claimed that stigma can only be overcome by means of an universal system of welfare. Titmuss (1968) wrote of universality:

One fundamental historical reason for the adoption of this principle was the aim of making services available and accessible to the whole population in such ways as would not involve users in any humiliating loss of status, dignity or self-respect.

There should be no shame of inferiority, pauperism, shame or stigma in the use of a publicly provided service: no attribution that one was being or was becoming a 'public burden'. Hence the emphasis on the social rights of all citizens to use or not to use as responsible people the services made available by the community in respect of certain needs which the private market and the family were unable or unwilling to provide universally. If these services were not provided by everybody for everybody they would either not be available at all, or only for those who could afford them, and for others on such terms as would involve the infliction of a sense of inferiority and stigma. (p.129)

These arguments are examined in the following sections.

### *Selectivity*

The first objection to selectivity is that it creates an underclass - a pariah group. Titmuss argued that

the greatest source of stigma is likely, in a competitive society, to derive from the continuous process of selection and rejection that the individual experiences in the private sector. (Reisman, 1977, 51-52)

He identified this process with selectivity in the social services. Residual welfare is intended to help people who are least able to cope in the market society, and selectivity is the mechanism by which this is done. Selectivity therefore defines those who have failed in a competitive society. Dependency on social services becomes stigmatising because it identifies the lowest class - people who are not only dependent, but dirty and immoral. Selectivity, Townsend (1976) argues,

fosters hierarchical relationships of superiority and inferiority in society, diminishes rather than enhances the status of the poor, and has the effect of widening rather than reducing social inequalities. Far from sensitively discriminating different kinds of need it lumps the unemployed, sick, widowed, aged and others into one undifferentiated and inevitably stigmatised category. (p.126)

The second objection is that selectivity acts, in itself, as a form of labelling. It announces that a person is poor and in need, and indicates what that need is by marking the benefit as one for the unemployed, the disabled, the sick, and so on. To claim a service, a person must accept the label attached to it. But residual welfare also affects the identity of these groups in ways other than labelling. Much concern has been expressed that groups should not be marked out as undeserving; this emerges in many debates on policy. The Seebohm report commented as follows on the idea of giving Social Services departments responsibility for difficult tenants:

To relieve (housing departments) of responsibility for dependent or unreliable tenants would discourage them from looking at the housing needs of their area as a whole and create or reinforce degrading stigmas and social distinctions. (Cmnd. 3703, 1968, 126)

The transfer of responsibilities for homeless families to housing departments from Social Services departments (Department of the Environment Circular 18/74) was made for much the same reason. The rationale was not that housing departments are less stigmatising than social work departments, but rather that homelessness should be treated as a housing problem rather than a personal one. The change in policy is a response to the belief that clients were being misidentified.

It is more frequent, though, that the objection is made not to misclassification but to a more precise distinction of stigmatised groups. This is the third, and possibly the most important, element in policy. The Review of the Mental Health Acts (Cmnd. 7320, 1978) considered the criteria for compulsory admission to mental institutions, and noted:

some people have pointed out that making dangerousness a criterion for admission might increase the stigma often attaching to those detained under compulsory powers. (p.23)

The objection to the sale of council houses is that sales

take out of the council stock houses in popular areas. their loss increases the stigmatisation of the rest. (Karn, 1979, 738)

The effect of this policy, according to its critics, will be to identify council housing as housing for the poor rather than housing for the people. It is noteworthy that many of the critics of council house sales on this ground (including myself) would nevertheless favour the allocation of housing according to need, which implies a certain inconsistency; it arises because of the belief that those in need should receive the best service possible.

The problem is not rejection alone, but a question of whether the stigma is brought to other people's attention. The salience of a stigma leads, collectively, to a problem equivalent to the individual's concern with information management. It is important enough that a person feels he acknowledges a stigma by using a social service; this creates reluctance to seek help and embarrassment when he does. It is doubly important whether other people know about it, because then the fear of rejection is translated into reality; and whether they know about it depends on the salience of the stigma. The provision of a service may increase salience.

English (1978) remarks how

the unpopularity and stigma which are suffered by many slum clearance estates were exacerbated in the case of Ferguslie Park by an enclave of 45 'supervised' houses dating from 1942 (p.4);

and Higgins (1978) argues that

An already stigmatised area may become even more stigmatised by being chosen to take part in a poverty programme. (p.112)

Retarded people are rejected more when they have been in special classes; mentally ill people when they are in, or have been in, residential institutions; public tenants, when developments are architecturally distinctive and physically isolated (Newman, 1972). These are all examples of physical salience. But there are also cases where it is the stigmatised person's social identity, rather than material circumstances, which is salient. Stigmatised people with common problems - like 'the disabled', 'the mentally ill', 'the poor' - become identified as a group. Unemployed people are marked out socially by the fact that they register for work. They are not generally identifiable as individuals, but the group itself is a subject of scorn - 'lazy idle loafers on the dole' - which affects both the attitudes of the individual to his condition, and the attitudes of others towards him when he is discovered.

The acceptability of a service is largely influenced by the reputation of the people it serves. In those circumstances where a service deals with several categories of recipient, the relative salience of stigmatised groups is crucial to the image of the service as a whole. The majority of Supplementary Benefit claimants are pensioners, but the image of Supplementary Benefit seems far worse than their reputation would suggest (see e.g. Stubbs, 1980). This is because unemployed people and single parents, who represent only about a third of all claimants, attract substantially more attention. The propensity of selective provision to stigmatise seems to depend both on the degree of discrimination that is exercised, and the characteristics of the group selected. It is not a simple question of which group is in a majority, but how far the image of that group becomes prominent in relation to the service. In some cases, the reputation of a service may be enhanced by the inclusion of 'respectable' recipients. In other cases the stigma attaching to some recipients becomes identified with the entire service, and the service passes on the stigma to other recipients like an infection.

### *Universality*

The principle of universality is the distinguishing feature of such services as the National Health Service, Child Benefit, and comprehensive education. Properly speaking, these services are not available to all: they are available to everyone in a specified category, defined by age or need, but not by means. Reddin (1977) argues that universal benefits are distinguished from selective ones by a test of means; Seldon, on the other hand, advocates selective benefits on the basis that they include a test of means or need (Seldon, Gray, 1967, 3). This makes for a rather pointless and sterile debate; the two sides never really come to grips with each other.

Clearly, there must be some selection for treatment on the basis of needs; not everyone wants or needs chest surgery or psychiatric care. Titmuss thought that the real challenge resides in the question: what particular infrastructure of universalist services is needed in order to provide a framework of values and opportunity bases within and around which can be developed acceptable selective services provided, as social rights, on criteria of the needs of specific categories, groups and territorial areas and not dependent on individual tests of means? (1968, 122)

This would be nonsense if 'selective' was taken to mean 'means tested'; Titmuss evidently thinks, like Seldon, that services based on needs are selective. (This seems to include the NHS.)

It seems to me that Titmuss, even allowing for confusions in terminology, mistakes the issue. The main problem caused by selectivity is that it identifies a dependent group. This can be avoided by a universal service, like Child Benefit, which is intended to benefit the poor, but which does not distinguish them from other people in its treatment of them. Tax forms are a means test, but most wage earners have to fill them in; again, they do not distinguish the poor, even though the tax office does treat people on an individual basis after the form has been filled in. The problem with selection is that it separates the poor from the rest of society and makes them aware of the separation, not that it asks for a statement of income. If selective services are based on need but not on means, then the problem remains - whether or not they are given as a right. Because the group is stigmatised before it becomes dependent, the main determinant of rejection is not whether they have rights, but whether the service draws attention to them. Unemployment Benefit, which does establish rights, is stigmatised. The 'universal' health service supposedly offers a right to medical care, but mentally ill people are rejected when they take it up.

This emphasises the importance of one of Titmuss's strongest principles, the anonymous gift, where neither donor nor recipient are known to each other. He saw this as the foundation stone of social integration. But his ideal is difficult, perhaps impossible, to achieve. There is no hope of providing a service which is responsive to need without in some way identifying the recipients as a group. The best result that can be looked for is that their dependency should be accepted as legitimate - as it is in the NHS. This leads to a second problem: that in general, dependency is only legitimate where there has been a contribution, either past (as in the case of pensioners) or future (as with students, or, in the case of the sick role, dependency is accepted as a temporary aberration. This is arguably as true of the NHS as it is of other services.

Rights are still important in the context of universalist services. The effect of selectivity is to emphasise the division of society; where someone is stigmatised morally, an outcast or a pariah, a universal system - one which can offer benefits and services as of right - ideally can aid the process of integration by bringing them into a relationship of gift and exchange which binds society together, and by asserting the status of the stigmatised person as a citizen. However, although they are helpful to pariah groups, their potential for social change should not be overestimated.

### *Residual and institutional models of welfare*

In theory, at least, residual and institutional welfare are antithetical. I have argued that neither individual nor collective functions implies a coherent set of principles, and I presented the distinction between them as a difference of aims. Both residual and institutional models of welfare have individual and collective functions. Residual welfare is associated with curative, preventive, minimalist, and protective functions, a handmaiden function, and elements of social control. Institutional welfare involves curative, protective, and developmental functions, as well as a handmaiden function. Either could be argued to be integrative. The two models are partly distinguished by aims, but it is not a clear distinction; residual welfare, like rent rebates, need not be minimalist, preventive or involve social control, and universal welfare, like Child Benefit, need not have a developmental function. In these cases, their essential functions are indistinguishable. The health service, which is supposedly universal, is concerned primarily for the individual; its essential function is curative, and it has important protective and handmaiden functions. It acts as a safety net for those who fall sick; it has, as a result, a great deal in common with a residual service. However, because it is believed to be based on rights, and because it accepts dependency as a normal condition, it is thought of as an institutional system.

The models of residual and institutional welfare are effectively distinguished, not by their methods or aims, but by their intentions towards the people they serve. Residual welfare sees dependency as an exception; institutional welfare treats it as an accepted feature of social life. If stigma is seen as a division of society, its identification with residual welfare is virtually tautologous. The difference between residual and institutional welfare is in part defined by stigma, and selectivity, which is the main distinguishing characteristic of a residual system, creates the conditions necessary for an identification of stigmatised groups. However, institutional welfare is not sufficient in itself to avoid stigma, because the problem is not confined within the field of social welfare. Comprehensiveness and rights do not in themselves get around the problems of stigmatisation. In so far as dependency itself is stigmatising, universal provision is preferable to selectivity only because it conceals or encourages the acceptance of certain states of dependency, and sets aside policies which are degrading because they foster a structured form of inequality.

The distinction between institutional and residual welfare is not entirely satisfactory. A distinction based on intentions implies a greater concern with the moral virtues of the services than with their effects, and this merely obscures the issues. It is quite true that a general acceptance of the principles of universal welfare would largely dispose of stigma, but this says no more than the fact that stigma would not be a great problem for the social services if there was no social division and everyone was prepared to accept responsibility for those who were poor and dependent. The assurance that institutional welfare is morally superior to residual welfare is unenlightening as a guide to practical action.

### **The social context of welfare**

There is a fundamental incompatibility between two of the approaches to stigma which I have examined. One, represented by policies of rehabilitation and individual insurance, argues that the only way to avoid stigma is to allow a person to adopt an independent role in society. This approach emphasises the importance of individual self-determination as the source of personal dignity - the element of choice which Downie and Telfer (1969) argue is essential to any conception of social respect (pp.20-21). The second, which encourages participation and the creation of social rights as a mark of citizenship, is based in the belief that stigma may be reduced by a change in the structure of society, a reorientation of collective status. These approaches are incompatible, not because the policies cannot coexist - they already do - but because they lead to an incongruous position. A person whose status is legitimate has no need for rehabilitation; a person who can acquire rights by an individual contribution achieves a legitimacy that is greater than he would have as a member of a dependent group.

The conflict between these two approaches reflects not only a difference in attitudes, but also different assumptions about the social context of welfare. The first approach is essentially individualistic: it aims to help the individual adjust to society, and makes it possible for him to avoid stigma by re-establishing his dignity. Its disadvantage is that some people who are unable to assume a normal role will continue to be stigmatised. The second is collectivist: it tries to change the status of dependent groups by changing their social, economic and political relationships. The disadvantage of this approach is that it institutionalises dependency in a society which does not accept it.

The social context of the policy is a vital consideration; this context determines the reaction to the policy and its beneficiaries, and therefore the potential of the policy to stigmatise. Scott (1970) argues that attributions of stigma by experts vary between cultures: in a 'capitalist' society, people are stigmatised for a lack of self-reliance, and in a 'communist' society, they are stigmatised for their failure to contribute to the community (p.272). An individualistic approach to welfare is most compatible with a view of society as a competitive structure, which recognises the virtues of independence and individual achievement. The collectivist view is more appropriate to a socialist conception of society, which emphasises the interdependence of its members and the values of collective action.

These views of society have tended to dominate the contemporary debate, but they offer only a limited appreciation of the social context. A third view is implied by the argument of chapter 10: that status divisions in society are effectively stratified, and that each person receives the treatment that is considered appropriate to his social position. Stigmatisation, under these conditions, may be an integral mechanism of the social structure, serving to define social boundaries and at the same time to bind society together.

Each of these views represents a dimension of a complex social structure. In his book on 'Social Justice', David Miller (1976) presents these three dimensions in the form of three ideal models of society, to which reality may conform in greater or lesser degree. He argues that our idea of justice depends on its social context, and identifies a different theory of justice with each of these models. A stratified or hierarchical society fosters a concept of justice based on "rights", or privilege. An individualistic or competitive society, the market society, bases its idea of justice in the idea of desert. Finally, a collectivist society (which Miller typifies as a primitive society, because he maintains its conditions could only exist in a primitive community) bases justice on need. Miller presents these as discrete theories of justice; I prefer to think of them as different applications of a principle of justice. "The just", as Aristotle wrote, "is the proportionate" (Thomson, 1953, 147). An action is considered just when it is appropriate to certain defined criteria. In a hierarchical society, it is 'just' to give someone an amount that is proportionate to his status; in a market society, to his desert; and in a 'primitive' society, to his need. The plea for 'social justice' is often an emotive appeal based on a moral judgement as to which kind of society is most desirable.

These models of society also correspond to different concepts of exchange. Utlley (1980) classifies three types of gift/exchange associated with the social services. The first is the seeming 'unilateral transfer', an exchange based on beneficence, made as 'gifts' or benefits to meet personal needs. This is the dominant form of exchange in a hierarchical society; it is typified in the concept of 'noblesse oblige'. The second is reciprocal exchange, which leads, in a market society, to the demand for a contribution to be made in return for the benefit received. Thirdly, there is exchange based on the rights of citizenship, which is the distinguishing feature of the collectivist or socialist society. This is the Universal Gift advocated by Titmuss, a transfer that is not a pure gift, but which helps to bind society together by the recognition of common interests.

Heath (1976) interprets Titmuss's arguments against stigma in the light of his views of society. If 'charity wounds', it is because we live in a society that emphasises ... desert, not need. (p.154)

A society that emphasises desert distinguishes the deserving from the undeserving, and rewards people accordingly. The idea of the 'just world', it should be noted, is strongly rooted in this conception of justice; it reasons that people deserve their fate, and regards them as responsible for their condition. In other societies, the rationale for blaming the victim differs. In a society that emphasises privilege, the condition of the lowest group is accepted fatalistically. The world can be seen as just only if fate is just - a view which is supported by a religious interpretation of status like the doctrine of Karma. Kerbo (1976) found that "those who believed their poverty is the plan of heaven feel less stigma" (p.181) - presumably because they have faith in the justice of their situation. If need is stressed, the idea of a just world becomes untenable, unless the existence of need is denied altogether. Titmuss was committed to a concept of justice based on need, a concept which precluded the possibility of blaming the victim, which would make irrelevant the distinction of the deserving and the undeserving poor, and which he believed could therefore end the problems of stigma. "On this view", Heath (1976) writes,

stigma is not a cultural universal to be found wherever there is unequal exchange but a phenomenon that flourishes above all in the capitalist societies of the west. (p.154)

This argument is tenable only in so far as modern society is thought of in terms of ideal types. In practice, society is complex, and has elements of each model; Titmuss's desire to eliminate stigma by moving towards a socialist society is itself an ideal, dependent on a form of society which does not and which has not existed. The objections I have raised so far to Titmuss's arguments have been based on the evidence of existing societies, societies which correspond better to the models of a hierarchical or market society than to a socialist one. It is unclear whether the concept of a generalised exchange made in respect of social rights is feasible.

Modern industrial society is often described as 'capitalist', inviting identification of our social structure with the values of individualism, competition and the economic market. It would be consistent with this argument to settle on an individualistic model of welfare as a response to stigma - a model which, despite its deficiencies, at least offers an opportunity to minimise stigma within the constraints of a market society and reciprocal exchange. However, social reality does not correspond to this simple model. The social services have to work in diffuse and complex circumstances; they cannot expect to have simple, consistent effects. On the one hand, it is possible for people to make a contribution through social insurance, which legitimates dependency when they become old, sick, disabled or unemployed; but these people are still rejected to a degree, partly because of the continued acceptance of social divisions which define these groups as lower castes, or treat them as pariahs. On the other, services like health care and Child Benefit may be widely accepted even though they are not based on individual contributions; with reservations, they indicate that collectivist principles are also accepted in part.

It is difficult to derive any clear prescription for policy from a theoretical analysis. Our aims, the principles on which we work, and the social context of the policies, are neither uniform nor consistent. It may be possible to represent stigma as a single, if complex, problem, but it does not follow that it is susceptible to a single solution. The theory defines principles, offers some explanation of the causes of stigma, and may suggest possible measures, but it can do little more. In the end, we are driven to an incremental, pragmatic approach to social policy. I could recommend no better method of proceeding than Edmund Burke's precept of sound government:

By a slow but well-sustained progress, the effect of each step is watched; the good or ill success of the first, gives light to us in the second; and so, from light to light, we are conducted with safety through the whole series. We see, that the parts of the system do not clash. The evils latent in the most promising contrivances are provided for as they arise. One advantage is as little possible sacrificed to another. We compensate, we reconcile, we balance. We are enabled to unite into a consistent whole the various anomalies and contending principles that are found in the minds and affairs

of men. From hence arises, not an excellence in simplicity, but one far superior, an excellence in composition. (1790, 209)

### **Chapter 11: Summary**

The social services may create or reinforce the stigmas which attach to recipients. Different stigmas imply different policies to deal with the problems that result. In certain cases, however, the policies which may be followed are contradictory. In order to establish a coherent policy, it is necessary to examine the aims of social welfare, and these must be seen in their social context. The debate about 'universality' and 'selectivity' reflects a concern with different forms of social organisation, but the related distinction between 'institutional' and 'residual' welfare is inadequate, because it gives no guide to practical action.

An attempt is made to relate different approaches to welfare to certain social contexts. An individualist approach to welfare is most compatible with a competitive view of society, a collectivist approach with a socialist one, and both may lead to stigma in different circumstances. Social structures may also be stratified or hierarchical, and in these circumstances stigma may act as an integrative force. These dimensions of social organisation correspond to Miller's classification of societies with different conceptions of social justice, based on rights, desert or need, and to different concepts of exchange. It is difficult to draw concrete conclusions for policy from this analysis. The models represent different attitudes in modern industrial society, and the success of a policy in any particular context depends on their relative importance.



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