# Oral health-related stigma

Doughty, J.; Macdonald, M. E.; Muirhead, V.; Freeman, R.

*Published in:*
Community Dentistry and Oral Epidemiology

*DOI:*
10.1111/cdoe.12893

*Publication date:*
2023

Received: 21 February 2023 | Revised: 19 June 2023 | Accepted: 7 July 2023

DOI: 10.1111/cdoe.12893

COMMUNITY DENTISTRY AND ORAL EPIDEMIOLOGY WILEY

NARRATIVE REVIEW

# Oral health-related stigma: Describing and defining a ubiquitous phenomenon

J. Doughty[1] | M. E. Macdonald[2] | V. Muirhead[3] | R. Freeman[4]

[1]NIHR Clinical Lecturer, School of Dentistry, University of Liverpool, Liverpool, UK

[2]Clinical Reader and Honorary Consultant in Dental Public Health, Centre for Dental Public Health and Primary Care, Institute of Dentistry, Faculty of Medicine and Dentistry, Queen Mary University of London, London, UK

[3]J&W Murphy Foundation Endowed Chair in Palliative Care Research. Professor, Division of Palliative Medicine. Nova Scotia Health Affiliate Scientist (Research). Faculty of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada

[4]Past co-director Dental Health Services Research Unit, School of Dentistry, University of Dundee, Dundee, UK

**Correspondence**
J.Doughty, NIHR Clinical Lecturer, School of Dentistry, University of Liverpool, Liverpool, United Kingdom.
Email: j.yazdi-doughty@liverpool.ac.uk

## Abstract

This paper is the fourth of a series of narrative reviews to critically rethink underexplored concepts in oral health research. The series commenced with an initial commissioned framework of Inclusion Oral Health, which spawned further exploration into the social forces that undergird social exclusion and othering. The second review challenged unidimensional interpretations of the causes of inequality by bringing intersectionality theory to oral health. The third exposed how language, specifically labels, can perpetuate and (re)produce vulnerability by eclipsing the agency and power of vulnerabilised populations. In this fourth review, we revisit othering, depicted in the concept of stigma. We specifically define and conceptualize oral health-related stigma, bringing together prior work on stigma to advance the robustness and utility of this theory for oral health research.

**KEYWORDS**
dental health, psychosocial aspects of oral health

## 1 | INTRODUCTION

Porter et al (2008) used the phrase 'the face is the window to the soul' to emphasize that facial appearance often dictates people's first impressions and behaviours toward others.[1,2] The lower third of the face, including the lips and teeth, is significantly associated with lay and professional perceptions of attractiveness.[3] Oral health therefore has an important role to play in determining the social value of the face. It is largely impossible (by virtue of its visibility) not to disclose one's oral health status during social interactions. This contrasts with other stigmatized conditions such as HIV infection or mental ill health, which are often invisible unless actively disclosed. An oral health status which differs from the group or social norm can attract stigma through othering (negative stereotypes used to categorize the other leading to the separation of 'us' from 'them'), status loss and discrimination within the context of prevailing social, cultural, political and economic power structures.

This review puts a stake in the ground to recognize the uniqueness of oral health and the lack of discourse and recognition of oral health-related stigma as a distinct entity that causes harm, dehumanizes and therefore requires urgent attention and action.

We present a highly relevant review proposing a working definition of oral health-related stigma which, as yet, has not been fully addressed and make recommendations for critical areas of focus for future research.

The French sociologist Emile Durkheim first explored stigma as a social phenomenon in the late 19th century. He described stigma as deviations from social norms and the propensity of society to judge and punish 'deviant' behaviours (e.g. criminality).[4] American sociologist Erving Goffman focused on stigma as beliefs and attitudes that singled out and devalued the social position of a person or group of people. The result was a 'spoiled identity' whereby a deeply discrediting attribute reduced a person from being whole and usual, to tainted and discounted. As a result, the discredited

person experienced othering and social exclusion; they were 'kept down' through exploitation, 'kept away' by avoidance, rejection or distancing, while others were 'kept in' by complying with the written and unwritten rules of society and being reminded of the high costs of violating the norm.[5,6] Interactions were disrupted between the stigmatized and the 'normal' person, becoming uncomfortable and awkward. The 'normal' person did not know what to expect or how to behave toward the other so distanced themselves from the stigmatized person leading to avoidance.[6] Goffman denoted three types of stigma: abominations of the body, which reflects biomedical concepts of health (e.g. physical deformities, disease), blemishes of individual character (e.g. criminality) and tribal (e.g. culture, race, nationality).

At its core, stigma concerns how one is seen and judged by others, whether present, possible, or imagined flaws or defects. Link and Phelan proposed stigma as a composite of labelling, stereotyping, othering, status loss and discrimination.[7] The awareness of how others view the self can give rise to the deeply self-conscious experience of shame.[8] Shame encompasses a range of feelings, from embarrassment through to mortification.[9] It is linked to one's core identity and can threaten one's sense of interpersonal belonging and social acceptance.[10]

Goffman's deviance model is of critical importance in the historical context of the conceptualisation of stigma. However, critics have suggested that Goffman failed to address social structures such as power, class, gender and ethnicity.[11] Scholars have since recognized the central role of power in the stigmatization process, concerned that earlier models reinforced victim-blaming of stigmatized individuals.[12] Stigma can be theorized as a manifestation of symbolic power; a highly sophisticated and insidious form of violence.[13] In scholarly research there has been a radical expansion of the notion of power. Power has been characterized as the interrelationships between people and groups: the power of actors to make, receive and resist change. Social theorist, Stephen Lukes, describes three forms of power:[14,15] At its most intuitive, power, in its concentrated form, is the ability of one actor to influence another to do something that they do not want to do. The second form of power involves concealment and conscious exclusion of people and issues from the political agenda. Lastly, power, in its diffuse and invisible form, is leveraged by such deeply ingrained political socialization that actors unwittingly comply with the dictates of power, even against their best interests.[16] Implicit meanings and understandings in a given cultural context have power, whether overtly, covertly or invisibly communicated.

Stigma-power, a term coined by Link and Phelan, is used to exploit, control, or exclude through the communication of disgust, mistrust and reinforcement of the social hierarchy.[5,16] There are myriad ways to slight, discredit, exclude and exercise stigma-power to achieve desired ends. Lala and colleagues have described in detail the relevance of power in dentistry and in this article, we dive deeper to explain specifically the importance of stigma-power over oral health.[17]

The effects of stigma may be enacted and experienced through collective negative attitudes toward stigmatized characteristics (known as public stigma), anticipation of prejudice and discrimination toward a stigmatized characteristic (anticipatory stigma), perceptions of being judged or stereotyped for a flaw or defect (perceived stigma), association with a member of a stigmatized group including caring responsibilities (secondary and family stigma).[18] When people who are disadvantaged by stigma unconsciously accept the cultural valuation of their diminished place in the social order and adopt negative self-judgements, this is internalized or self-stigma.[5,19,20] Stigma encompasses and gives rise to 'isms:' e.g. racism, ableism, ageism. These "isms" can give rise to discrimination.[21] Discrimination becomes the outcome of stigma; it is the unequal treatment and societal conditions that constrain opportunities, resources, and well-being at individual and structural levels.[22]

## 2 | STIGMA AND HEALTH

Recent health research has focused on the social, cultural, political and economic power structures that drive and facilitate stigma.[23] Both stigma and shame are detrimental to health outcomes through acute avoidance behaviours and maladaptive health behaviours, thereby undermining diagnosis, treatment and long-term mental and physical health outcomes.[24] Further, stigma is anchored in and perpetuates exclusion and poverty.

A well-researched example of health stigma is illustrated by social responses to HIV. HIV stigma is defined as 'negative attitudes and beliefs about people with HIV'.[25] Globally, HIV-related stigma is driven by misconceptions about high levels of HIV infectivity, outdated assumptions about health outcomes for people with HIV (PWH) and pejorative beliefs about moral transgressions linked to HIV acquisition (i.e. social practices related to sexuality and perceived promiscuity).[26] HIV-related stigma remains pervasive and persistent; despite markedly improved outcomes for PWH, HIV-related stigma is considered a critical public health problem impacting health outcomes. For example, PWH who report HIV-related stigma experience higher rates of depression, lower social support, lower adherence to antiretroviral therapy and poorer access to and usage of health services.[27]

HIV-related stigma is (re)produced in the following ways: PWH are labelled based on their HIV infection or behaviours associated with HIV infection risk. Dominant sociocultural beliefs associate negative stereotypes to PWH which leads to othering and separation. As a result, PWH may self-impose discrimination, for example by failing to present to health services because of the expectation of refusal of treatment.[28] PWH may experience individual discrimination such as being treated differently by health professionals or sexual rejection in relationships. Structural or institutional discrimination may lead to health professionals making unnecessary referral to specialized care services or disclosing the HIV status of PWH without their permission.[24,29] These stigmatizing processes occur when stigmatisers possess social, political, or economic power with respect to the stigmatized group; for example, in systems where structural discrimination and violence (e.g. heterosexism, racism,

poverty) and pre-existing stigmas (e.g. homosexuality, intravenous drug use) contribute to perceptions of the legitimacy of stigma and discrimination.[30]

## 3 | ORAL HEALTH-RELATED STIGMA: A WORKING DEFINITION

To this point, we have exposed the various guises through which stigma is enacted and experienced, discussed the connection between stigma, shame, discrimination, and detrimental health outcomes. Next, we consider the need for a working definition of stigma as applied to oral health.

To date, the literature on oral health-related stigma has conceptualized it in disparate and individualistic terms related to downstream drivers (e.g. dental status or appearance) and extrinsic (e.g. teasing, social attractiveness, access to services) or intrinsic (e.g. shame, embarrassment, self-esteem, diminished quality of life) manifestations. Though this approach succeeds in revealing the individual cause and effects of stigma, it does not present a full conceptualisation of stigma specific to oral health, nor does it unpack the structural origins of the stigma manifest. Therefore, building on the work of Link and Phelan, we have drafted a working definition of oral health-related stigma.[7] For this definition, we appeal to FDI's broad definition of oral health; that is, related to 'the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex'.[31]

We define oral health-related stigma as:

> *a unique health stigma characterised by both externally applied and internalised processes. These processes include labelling, stereotyping, social exclusion, and discrimination enacted by society at large on individuals or groups with marked deviations from dominant oral health norms. Oral health-related stigma is amplified by the unequal distribution of social, political and economic power, structural violence and pre-existing intersecting stigmatised identities. It reflects and perpetuates disadvantage and causes harm to stigmatised individuals and groups across the life-course.*

The following sections draw on published literature underpinning our working definition of oral health-related stigma, pausing to theorize each component part. We then conclude with a worked example of the production of oral health-related stigma.

### 3.1 | Labelling, stereotyping and social exclusion

Our definition of oral health-related stigma draws on the ways in which stigma is imposed by people with power on those who have less power, overgeneralising individuals and groups by labelling and stereotyping. People with straight, white teeth, (a social prerogative in Western societies), are perceived as healthy and wealthy, coincident with perceptions of the ideals of the elite or dominant class.[32] Deviations in oral health away from the expected social and valued norms are associated with lower intelligence, older age, poverty and ill health.[33] Sociocultural norms and ideals position oral health and the appearance of the orofacial region as a visual manifestation of overall health, attractiveness and as a marker of acceptable identity.[32,34]

Labels and stereotypes are often experienced by the stigmatized as at odds with their sense of self and identity. Prevention, concealment or correction, are tools used by individuals to protect themselves from the threat of deviant oral health to their known self.[35] For example, 'hanging on' to natural teeth is motivated by desires to preserve sense of self and deteriorating oral health can reflect the loss of self, socioeconomic rules, and social capital.[36,37] Oral health is so profoundly enmeshed within social identities that desires to begin taking care of one's teeth emerge alongside plans for rehabilitation, detox and intentions to reclaim life.[37] As a result, visible (social) oral health is commonly prioritized over invisible (biomedical) oral health.[33]

As dental techniques advance, so too do public expectations. For example, gingival depigmentation processes are becoming popular; they can eliminate physiological racial pigmentations, perpetuating ideals of beauty as related to Whiteness.[38] Adult orthodontics is increasing in popularity even for minor irregularities.[39] The boundaries of normal are ever-narrowing and thus reinforcing our moral obligation to perform oral bodywork to meet expected standards and thereby avoid the labelling and stereotyping that give rise to social exclusion, discrimination and ultimately comprise oral health-related stigma.

Societal norms have created a narrative that leads people with power to exclude individuals and groups with deviations in oral health and victim-blame those with oral disease.[33,40] While cancer, diabetes and depression are perceived as conditions that could affect anybody, oral health specifically triggers associations as a condition of the poor and reinforces social class differences.[41]

### 3.2 | Intersectionality

For people whose lived reality embodies a distinct stigmatized identity, the intersection of their identity and oral health status may amplify stigma, discrimination and rejection in social interactions and the dental setting. As a result, people with stigmatized identities may have low self-esteem and fear further humiliation when going to the dentist.[42] To illustrate this point, people who identify as transgender experience up to five-fold greater shame related to oral health compared with cis-gender controls.[43] Homeless populations experience significantly more embarrassment or shame related to their oral health compared with the general population and feel acutely stigmatized by both their homelessness and their visibly unhealthy mouths.[42,44] Poor oral health coupled with addiction and mental

illness can lead to experiences of dentists blaming and criticizing patients and people who are Black are more likely to be provided with extractions compared with restorative care.[45,46] Further, stigma and discrimination may present an advantageous tool for dental professionals to keep at bay patients whose stigmatized identities are 'bad for business'. The result of these intersecting stigmas and their impact on the experience of oral health-related stigma is complex and unique to the individual, their intersecting identities and the socio-environmental context in which they live.

### 3.3 | The harms of oral health-related stigma

Stigma can create a vicious cycle that has direct implications for oral health and access, and which begins with patients' expectations that the dentist will blame them for neglecting themselves.[40,47] Feelings of shame, guilt and inferiority related to deviances in oral health status can perpetuate fear and avoidance of dental care[48]. Additionally, stigma and discrimination in healthcare practice undermines diagnosis, treatment and successful health outcomes.[49] Implicit biases held by healthcare professionals can result in poor interpersonal communication and micro-aggressions.[50]

Health system structures and funding mechanisms designed in a way that excludes those with the greatest need, perpetuates the stigmatization of oral health and contributes to a social hierarchy of oral health. Oral health inequalities are driven by structural, intermediate, and proximal determinants of health including issues of access to dental services.[51] Underfunded health systems have the power to disproportionately affect people living with low-income for example, by encouraging extraction rather than restoration of teeth. Thereby long-lasting bodily differences are cemented, impacting individuals' and groups' prospects for the future.[52]

As with poor oral health generally, oral health-related stigma impacts across the life course.[53] In childhood, oral health-related stigma may present as bullying or teasing, which in turn can lead to depression, low self-esteem, poor academic performance and impaired socialization with far-reaching effects that persist into adulthood.[54] At working-age, visible dental conditions can negatively impact appraisal of employability and relational competence.[55,56] In older age, poorer oral health and tooth loss may lead to limited social interaction and lowered self-esteem, perpetuating loneliness and isolation.[57,58] As a result of longstanding exposure to the social stress of stigma, individuals can become vulnerable to chronic ill health arising from systemic inflammation and compounded by avoidant health-seeking behaviours.[59,60]

### 3.4 | Oral health-related stigma-power

The power of the medical gaze and the subjectification of the body has expanded beyond clinically defined need to become a social force for self-diagnosing, self-scrutinizing and self-analysing the body, including the mouth. Medical and dental knowledge (readily available through social media, television, posters and other sources) informs our perceptions of who is healthy and who is the other, identifying and separating 'us' from 'them'. In the case of oral health, the dental gaze legitimizes disciplining and subjectivising of the other through discourses, practices and institutions.[61] In a sociocultural context where the understanding is that oral hygiene practices and healthfulness are prerequisites for the successful social self, people with a lived reality of conventional oral health possess power with respect to people with deviant oral health and feel entitled to discipline them through judgement and victim-blaming.[34,40] In contrast, the stigmatized other experiences a lack of control over their oral health and perceives dental care as inaccessible.

Oral health-related stigma-power can be used to exploit, control and exclude.[5,16] People with deviant oral health are 'kept down' by denial of employment opportunities for example. People are 'kept in' by the stiff social costs of deviant oral health including ostracisation and status loss. People are 'kept away' because deviant dental appearance or other signs of oral disease (e.g. bad breath) could signal infection and provoke disgust, a dehumanizing disease-avoidance emotion that occurs even in the absence of objective proof of a threat to self.[62]

Hatzenbueler, Phelan and Link argue that stigma is a fundamental social determinant of poor health outcomes and compound disadvantage.[22] Three key characteristics support this assertion for oral health-related stigma. Firstly, it can impact multiple health risk factors across a substantial number of people. Secondly, it can impair access to resources by affecting status, material wealth, interpersonal influence, status, power and prestige. Lastly, oral health-related stigma can be robustly related to health inequalities that persist across time and place. Therefore, oral health-related stigma can be operationalized in relation to the production and sustainment of inequalities.

### 3.5 | Oral health-related stigma: A worked example

Oral health-related stigma is driven by public perceptions of what constitutes oral health and disease, beliefs about moral transgressions linked to deviations in oral health status (i.e. self-neglect, lower social standing) and sociocultural practices (i.e. regular tooth brushing and concerns for hygiene).[26]

Using our working definition, oral health-related stigma is (re) produced in the following ways: People are labelled based on their oral health status or behaviours associated with maintaining oral health. Dominant sociocultural beliefs perpetuated by the media and society associate negative stereotypes to people with deviations from oral health norms which leads to social exclusion through othering and status loss. As a result, people with deviant oral health may internalize these social cues, anticipating embarrassment, shame and discrimination; this may lead to loss of self-esteem or avoidance behaviours toward social situations and dental services.[28] People with deviant oral health may experience being treated differently and discriminated against; for example, being blamed for their oral health status, being bullied about their appearance, or encountering

structural or institutional discrimination.[29] Unequal distribution of power, structural violence and pre-existing stigmas may impact perceptions of the legitimacy of stigmatizing and discriminating against certain populations pre-disposed to poorer oral health outcomes (e.g. inclusion health groups).[63,64]

### 3.6 | Future directions

This review recommends further research that deepens the understanding of how and to what extent internalized and externally applied oral health-related stigmas are driven by social groups, society at large, the media and the dental profession. Applying an intersectionality framework to oral health-related stigma could explore how internalized and externally applied oral health-related stigmas interact to create intersecting disadvantage for those with already stigmatized identities. Understanding oral health-related stigma and othering perpetuated by dental professionals' attitudes and behaviours toward patients could lead to strategies underpinned by empathy that combat disgust, pity, blame, and shaming. Finally, we need to understand the lived experience of people who are stigmatized to further inform the definition of oral health-related stigma and to encourage positive patient oral health behaviours and relationships with dental professionals.

Research critically reflecting on how the dental profession can reduce the drivers of oral health-related stigma and empower individuals is a crucial next step in the oral health-related stigma agenda. HIV is an example in which people with lived experience have had a central role in advocating for improved health outcomes and have rallied against HIV-related stigma. There are no notable examples of similar patient-led groups advocating for approaches to reduce oral health-related stigma. Stigma-reduction interventions should be evidence-based and targeted at multiple levels from the individual, through to professional education and media campaigns.

## 4 | CONCLUSIONS

Deviances in oral health from the sociocultural norm invoke value judgements about health behaviours and social status. Western societies penalize and reward based on oral health status. Those with the least power, agency and resources to maintain or address their oral health are likely to suffer most acutely. Therefore, it is the moral imperative of the dental profession to recognize the drivers of oral health-related stigma and to understand its manifestations, adverse outcomes, and impacts across the life course. This understanding will enable us to address stigma meaningfully through an intersectional lens that considers the human-whole and intersecting identities therein.

### ACKNOWLEDGEMENTS

We would like to acknowledge Dr Martha Paisi, Dr Andrea Rodriguez, and Dr Helena Mendes Constante for their sage advice and critical feedback on the content of the review.

### FUNDING INFORMATION

The authors received no funding for the research and authorship of this article.

### DATA AVAILABILITY STATEMENT

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

### ORCID

*J. Doughty* https://orcid.org/0000-0003-1445-9376
*V. Muirhead* https://orcid.org/0000-0003-1632-773X
*R. Freeman* https://orcid.org/0000-0002-8733-1253

### REFERENCES

1. Zebrowitz L. *Reading Faces. Window To The Soul?* . Taylor & Fran; 1997.
2. Porter S, England L, Juodis M, ten Brinke L, Wilson K. Is the face a window to the soul? Investigation of the accuracy of intuitive judgments of the trustworthiness of human faces. *Canadian J Behav Sci*. 2008;40:171-177.
3. Ren H, Chen X, Zhang Y. Correlation between facial attractiveness and facial components assessed by laypersons and orthodontists. *J Dent Sci*. 2021;16:431-436.
4. Durkheim E. *The Rules of Sociological Metho*. The Free Press; 1982.
5. Link BG, Phelan J. Stigma power. *Soc Sci Med*. 2014;103:24-32.
6. Goffman E. *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall; 1963.
7. Link BG, Phelan JC. Conceptualizing stigma. *Annu Rev Sociol*. 2001;27:363-385.
8. Dolezal L, Lyons B. Health-related shame: an affective determinant of health? *Med Humanit*. 2017;43:257-263.
9. Garfinkle ELY. Shame: the hidden resistance. *Canadian J Psycho*. 2012;20:44-69.
10. Scheff TJ. Shame and the social bond: a sociological theory. *Sociological Theory*. 2000;18:84-99.
11. Scambler G. Health-related stigma. *Sociol Health Illn*. 2009;31:441-455.
12. Birbeck GL, Bond V, Earnshaw V, El-Nasoor ML. Advancing health equity through cross-cutting approaches to health-related stigma. *BMC Med*. 2019;17:40.
13. Pinker R. Stigma and Social Welfare. *Social Work*. 1970;27:13-17.
14. Lukes S. *Power: a Radical View*. Macmillian; 1974.
15. Barasa EW, Cleary S, English M, Molyneux S. The influence of power and actor relations on priority setting and resource allocation practices at the hospital level in Kenya: a case study. *BMC Health Serv Res*. 2016;16:536.
16. Foucault M. The subject and power. *Critical Enquiry*. 1982;8:777-795.
17. Lala R, Gibson BJ, Jamieson LM. The relevance of power in dentistry. *JDR Clinical & Translational Research*. 2021;6:458-459.
18. Larson JE, Corrigan P. The stigma of families with mental illness. *Acad Psychiatry*. 2008;32:87-91.
19. Quinn DM, Williams MK, Quintana F, et al. Examining effects of anticipated stigma, centrality, salience, internalization, and Outness on psychological distress for people with concealable stigmatized identities. *PloS One*. 2014;9:e96977.
20. Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. *World Psychiatry*. 2002;1:16-20.
21. Branco C, Ramos MR, Hewstone M. The association of group-based discrimination with health and well-being: a comparison of ableism with other "isms". *J Soc Issue*. 2019;75:814-846.
22. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. *Am J Public Health*. 2013;103:813-821.

23. Phelan JC, Link BG, Dovidio JF. Stigma and prejudice: one animal or two? *Soc Sci Med*. 2008;67:358-367.
24. Nyblade L, Stockton MA, Giger K, et al. Stigma in health facilities: why it matters and how we can change it. *BMC Med*. 2019;17:25.
25. Centre for Disease Control and Prevention. Facts about HIV Stigma | HIV Basics | HIV/AIDS | CDC. https://www.cdc.gov/hiv/basics/hiv-stigma/index.html 2020.
26. Chao L-W, Szrek H, Leite R, Ramlagan S, Peltzer K. Do customers flee from HIV? A survey of HIV stigma and its potential economic consequences on small businesses in Tshwane (Pretoria), South Africa. *AIDS Behavior*. 2017;21:217-226.
27. Rueda S, Mitra S, Chen S, et al. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. *BMJ Open*. 2016;6:e011453.
28. Okala S, Doughty J, Watt RG, et al. The people living with HIV STIGMASurvey UK 2015: Stigmatising experiences and dental care. *Br Dent J*. 2018;225:143-150.
29. Brondani MA, Phillips JC, Kerston RP, Moniri NR. Stigma around HIV IN dental care: PATIENTS' experiences. *J Can Dent Assoc*. 2016;82:g1.
30. Mahajan AP, Sayles JN, Patel VA, et al. Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. *Aids*. 2008;22:S67-S79.
31. FDI World Dental Federation. *FDI's definition of oral health*. https://www.fdiworlddental.org/fdis-definition-oral-health 2016.
32. Khalid A, Quiñonez C. Straight, white teeth as a social prerogative. *Sociol Health Illn*. 2015;37:782-796.
33. Bedos C, Levine A, Brodeur J-M. How people on social assistance perceive, experience, and improve Oral health. *J Dent Res*. 2009;88:653-657.
34. Exley C. Bridging a gap: the (lack of a) sociology of oral health and healthcare. *Sociol Health Illn*. 2009;31:1093-1108.
35. McCabe J. Subjectivity and embodiment: acknowledging abjection in nursing. *Abjectly Boundless*. Routledge; 2010.
36. Warren L, Kettle JE, Gibson BJ, Walls A, Robinson PG. 'I've got lots of gaps, but I want to hang on to the ones that I have': the ageing body, oral health and stories of the mouth. *Ageing and Society*. 2020;40:1244-1266.
37. Coles E, Freeman R. Exploring the oral health experiences of homeless people: a deconstruction–reconstruction formulation. *Community Dent Oral Epidemiol*. 2016;44:53-63.
38. Patil KP, Joshi V, Waghmode V, Kanakdande V. Gingival depigmentation: a split mouth comparative study between scalpel and cryosurgery. *Contemp Clin Dent*. 2015;6:S97-S101.
39. Increase in adults seeking orthodontic treatment. *Br Dent J*. 2020;228:908-908.
40. Gregory J, Gibson B, Robinson PG. The relevance of oral health for attenders and non-attenders: a qualitative study. *Br Dent J*. 2007;202:E18; discussion 406-407.
41. Moeller J, Singhal S, Al-Dajani M, Gomaa N, Quiñonez C. Assessing the relationship between dental appearance and the potential for discrimination in Ontario, Canada. *SSM Populat Health*. 2015;1:26-31.
42. Mago A, MacEntee MI, Brondani M, Frankish J. Anxiety and anger of homeless people coping with dental care. *Community Dent Oral Epidemiol*. 2018;46:225-230.
43. Prates SG, Jesuino RD, Paranhos LR, Herval AM, Tannus Gontijo LP. Oral health self-perception for transgender people: a controlled cross-sectional study. *Biosci J*. 2021;37:e37003.
44. Yokota K, Yu SW, Tan T, Anderson J, Stormon N. The extent and nature of dental anxiety in Australians experiencing homelessness. *Health Soc Care Community*. 2020;28:2352-2361.
45. Brondani MA, Alan R, Donnelly L. Stigma of addiction and mental illness in healthcare: the case of patients' experiences in dental settings. *PloS One*. 2017;12:e0177388.
46. Patel N, Patel S, Cotti E, Bardini G, Mannocci F. Unconscious racial bias may affect Dentists' Clinical decisions on tooth restorability: a randomized Clinical trial. *JDR Clinical & Translational Research*. 2019;4:19-28.
47. Gregory J, Gibson B, Robinson PG. Variation and change in the meaning of oral health related quality of life: a 'grounded' systems approach. *Soc Sci Med*. 2005;60:1859-1868.
48. Berggren, U, Meynert, G. Dental fear and avoidance: causes, symptoms, and consequences. *J Am Dent Assoc*. 1984;109:247-251. doi:10.14219/jada.archive.1984.0328
49. Stutterheim SE, Sicking L, Brands R, et al. Patient and provider perspectives on HIV and HIV-related stigma in Dutch health care settings. *AIDS Patient Care STDS*. 2014;28:652-665.
50. Morris M, Cooper RL, Ramesh A, et al. Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review. *BMC Med Educ*. 2019;19:325.
51. Watt RG, Venturelli R, Daly B. Understanding and tackling oral health inequalities in vulnerable adult populations: from the margins to the mainstream. *Br Dent J*. 2019;227:49-54.
52. Horton S, Barker JC. Stigmatized Biologies: examining the cumulative effects of Oral health disparities for Mexican American farmworker children. *Med Anthropol Q*. 2010;24:199-219.
53. Sheiham A, Alexander D, Cohen L, et al. Global oral health inequalities: task group—implementation and delivery of oral health strategies. *Adv Dent Res*. 2011;23:259-267.
54. Seehra J, Newton JT, DiBiase AT. Bullying in schoolchildren – its relationship to dental appearance and psychosocial implications: an update for GDPs. *Br Dent J*. 2011;210:411-415.
55. Hyde S, Satariano WA, Weintraub JA. Welfare dental intervention improves employment and quality of life. *J Dent Res*. 2006;85:79-84.
56. Moore D, Keat R. Does dental appearance impact on employability in adults? A scoping review of quantitative and qualitative evidence. *Br Dent J*. 2020. doi:10.1038/s41415-020-2025-5
57. Smith JM, Sheiham A. How dental conditions handicap the elderly. *Community Dent Oral Epidemiol*. 1979;7:305-310.
58. Rouxel P, Heilmann A, Demakakos P, Aida J, Tsakos G, Watt RG. Oral health-related quality of life and loneliness among older adults. *Eur J Ageing*. 2016;14:101-109.
59. Geronimus AT, Hicken M, Keene D, Bound J. 'Weathering' and age patterns of allostatic load scores among blacks and whites in the United States. *Am J Public Health*. 2006;96:826-833.
60. Wakeel F, Njoku A. Application of the weathering framework: intersection of racism, stigma, and COVID-19 as a stressful life event among African Americans. *Healthcare (Basel)*. 2021;9:145.
61. Hancock BH. Michel Foucault and the problematics of power: theorizing DTCA and medicalized subjectivity. *J Med Philos*. 2018;43:439-468.
62. Azlan HA, Overton PG, Simpson J, Powell PA. Disgust propensity has a causal link to the stigmatization of people with cancer. *J Behav Med*. 2020;43:377-390.
63. Paisi M, Kay E, Plessas A, et al. Barriers and enablers to accessing dental services for people experiencing homelessness: a systematic review. *Community Dent Oral Epidemiol*. 2019;47:103-111.
64. Paisi M, Baines R, Wheat H, et al. Factors affecting oral health care for asylum seekers and refugees in England: a qualitative study of key stakeholders' perspectives and experiences. *Br Dent J*. 2022;1–7:1-7. doi:10.1038/s41415-022-4340-5


**How to cite this article:** Doughty J, Macdonald ME, Muirhead V, Freeman R. Oral health-related stigma: Describing and defining a ubiquitous phenomenon. *Community Dent Oral Epidemiol*. 2023;00:1-6. doi:10.1111/cdoe.12893