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NARRATIVE REVIEW

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

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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.

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