

EDITORIAL

Inaugural Editorial

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This February 2026 issue of *Stigma and Health* marks the journal's transition to a new editorial team. Patrick Corrigan founded *Stigma and Health* in 2015 as a venue for research on the impacts of stigma on people living with mental and physical illness. The establishment of the journal reflected the increased popularity of scholarship in this area and the accompanying need for an intellectual home for this research. *Stigma and Health* has thrived since its founding due to Corrigan's leadership as editor-in-chief and the generous efforts of its associate editors, all of whom have been luminaries in the field of stigma and health research. Thanks to this team, the journal has become a premier outlet for our field's scholarship on associations between stigma on health, interventions to address stigma and improve health, theoretical advancements in understanding stigma and health, and methodological innovations in studying stigma and health. *Stigma and Health* has additionally become the "town square" for stigma and health researchers. We come from a wide range of disciplinary backgrounds (e.g., psychology, sociology, anthropology, public health, medicine) and study many different health conditions (e.g., depression, schizophrenia, weight, HIV, cardiovascular disease, cancer). *Stigma and Health* is our place to connect and share our most innovative findings and ideas for advancing our field. Finally, *Stigma and Health* has established itself as a partner in social justice work to promote health equity.

By partnering in social justice work, *Stigma and Health* has followed a long and robust tradition of psychologists and other social scientists who have pursued the goal of social justice through the means of science. In their review of the history of social psychology's contributions to the understanding and practice of social justice, Jost and Kay (2010) noted that psychologists' commitment to social justice research was a reaction to rising fascism in the early and mid-20th century. For example, Kurt Lewin, who was born Jewish in 1890 and lived in Germany from 1905 until Hitler was appointed Chancellor in 1933, studied intergroup relations and social action against a backdrop of rising anti-Semitism (Jost & Kay, 2010; Lewin, 1946). In 1954, Gordon Allport noted that psychologists of the time

asked "how is it possible to preserve the values of freedom and individual rights under conditions of mounting social strain and regimentation? Can science help provide an answer?" (Allport, 1954a, p. 4). Seminal texts laying the foundation for stigma research were published during this time, including *the Nature of Prejudice* by Allport (1954b) and *Stigma: Notes on the Management of Spoiled Identity* by Goffman (1963). Over half a century later, *Stigma and Health* was founded within this tradition. In an editorial published in the first volume of the journal, Corrigan positioned "the stigma of health" as "a matter of social injustice," and echoed the fundamental questions posed by our field's founders by asking "what role does research have for social justice?" (Corrigan, 2016, p. 1). In the decade since this first volume, *Stigma and Health* has answered this question by publishing high-quality scholarship that is unwavering in its response to current events.

In the years ahead, we plan to carry on in this tradition established by the founders of stigma research and committed to by Corrigan and his editorial team during *Stigma and Health*'s first decade. As I write this editorial in the summer of 2025, I wonder if we have found ourselves in a historical moment this is, or could become, not unlike that experienced by Lewin, Allport, and Goffman. In 1946, Lewin observed that people were ready to face the social issues of their time head-on; however, they felt like they were in a fog. He noted that "they feel in the fog on three counts: 1. What is the present situation? 2. What are the dangers? 3. And most important of all, what shall we do?" (Lewin, 1946, p. 34). Stigma and health researchers are ideally positioned to help people move through today's fog and understand the present situation as it relates to stigma, characterize the ways that this stigma may endanger health, and, perhaps most importantly, identify steps to take to address stigma and promote health. To achieve these goals at *Stigma and Health* in the coming years, our top two priorities will be to publish high-quality, use-inspired research and respond to current events. These priorities were established during the first decade of the journal, and Corrigan and I re-committed to them following the 2024 presidential election in the United States (Earnshaw & Corrigan, 2025). We will additionally undertake efforts to clarify and fortify our scientific vocabulary.

Upholding Journal Priorities

Publishing High-Quality, Use-Inspired Research

What type of research is needed to help people understand stigma and its role in health, and intervene in stigma to improve health? Certainly, we need applied research. We have learned a great deal about the nature of stigma, the pathways whereby stigma impacts health, and moderators of associations between stigma and health

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over the past several decades. At a time when stigma toward many vulnerable groups is surging (Underhill et al., 2024), we need to apply what we have learned to prevent stigma from widening existing health inequities and arrest the surges in stigma that we are witnessing at the structural, interpersonal, and individual levels. Corrigan affirmed the importance of applied stigma research in an editorial published following Trump's first election, noting "our work is worthy when findings inform real-world efforts to right social injustice" (Corrigan, 2017, p. 1). Yet, we also need basic research. Results of meta-analyses suggest that our current interventions have, on average, small effects on reductions in stigma-related outcomes (Can Gür & Yılmaz, 2023; Mak et al., 2017; Moore et al., 2022; Morgan et al., 2018). We need to do better. Basic research continues to be needed to develop stronger understandings of why and how stigma manifests, how stigma impacts health, and what reduces stigma in order to eliminate it.

Taken together, our very best scholarship on stigma and health both, (a) advances our fundamental understanding of stigma and health and (b) can ultimately be applied to address stigma and improve health. In his critique of the linear model of basic to applied research, Stokes (1997) reenvisioned the relationship between basic and applied research as a two-by-two table with research inspired by the quest for fundamental understanding along one axis and considerations of use along the other. He labeled the quadrant of research that both advances fundamental understanding and has potential for application as "Pasteur's Quadrant" in honor of Louis Pasteur, who both advanced fundamental understanding by developing germ theory and considered use by inventing pasteurization processes for safe food consumption. Our best scholarship is additionally theoretically and methodologically rigorous, drawing on a diverse range of strong research designs and analytic approaches to answer our key questions. There are many examples of theoretically and methodologically rigorous use-inspired research in *Stigma and Health*. As examples, the scholarship featured in the August 2023 special issue on *Intersectionality in Stigma and Health*, led by Nicole Else-Quest, advanced our understanding of the concept of intersectionality, expanded our toolkit to study intersectionality, and introduced innovative strategies for interventions to address intersectional stigma (Else-Quest, 2023). In the years ahead, we remain committed to publishing high-quality, use-inspired research.

Responding to Current Events

The founders of stigma research engaged in scholarship that was highly responsive to the needs of their time. As examples, Lewin and Allport engaged in research on antisemitism, racism, and classism amidst the backdrops of the Holocaust in Europe and the Civil Rights Movement in the United States (Allport, 1954b; Jost & Kay, 2010; Lewin, 1946). Importantly, needs of the time evolve given that stigma waxes and wanes across historical contexts (Earnshaw et al., 2022), as highlighted in the journal's November 2024 special section on *Time in Stigma and Health Research*. Since its founding, *Stigma and Health* has been highly responsive to these shifts in stigma. During the COVID-19 pandemic in 2020–2021, the journal featured a running special section that documented experiences (Amir, 2021; Lee & Waters, 2021; Zolnikov & Furio, 2020), drivers (Grivel et al., 2021; Hossain et al., 2021), and public health impacts (Earnshaw et al., 2020) of COVID-19 stigma. The journal published research documenting structural stigma in mental-health related bills during the first Trump

administration (Conley, 2021). And, in the wake of surging transgender stigma, the journal published research identifying intervention strategies for mitigating the impact of stigma on the health of transgender and gender diverse populations (Wall et al., 2022).

In the years ahead, we will continue to publish scholarship that is responsive to the needs of our time. We appear to be in a moment of dramatic social change, with stigma associated with many social statuses changing rapidly and often regressively. In the United States, this change is readily observable at the structural level where laws targeting racial minorities, sexual and gender minorities, women, and others have passed at an accelerated rate in recent years (Underhill et al., 2024). Research on structural stigma will therefore continue to be critically important in the coming years. Studies are needed that document associations between structural stigma and health outcomes, identify pathways whereby structural stigma impacts health, test intervention strategies to reduce structural stigma and/or disrupt its associations with health, and introduce new methods to advance structural stigma research. Many of these recent laws target multiple marginalized groups simultaneously, including sexual and gender minorities, people of color, and women (Underhill et al., 2024). This demonstrates the synergistic nature of stigma and highlights the importance of adopting an intersectional lens in stigma and health research. Studies are needed that continue to investigate the experience of intersectional stigma, ways in which intersectional stigma may uniquely impact health, and interventions to address intersectional stigma.

Clarifying Our Scientific Vocabulary

In my year as incoming editor-in-chief of *Stigma and Health*, I have been impressed by how many different ways that authors submitting articles to the journal define stigma. I would argue that our scholarly definition of stigma has been evolving. Erving Goffman introduced our most well-known and cited scholarly definition of stigma in his 1963 book titled *Stigma: Notes on the Management of Spoiled Identity* (Goffman, 1963). Goffman attributed the term stigma to Ancient Greek. The Greeks used the term $\sigma\tau\acute{\iota}\gamma\mu\alpha$ as a noun to describe cuts, burns, tattoos, or other marks on the body meant to signify that an individual was a slave, criminal, traitor, or otherwise morally "polluted" person (Goffman, 1963; Liddell & Scott, 1901). Goffman went on to introduce a two-part scholarly definition of stigma. The first part remains the most well-cited, which is that stigma is "an attribute that is deeply discrediting" (Goffman, 1963, p. 3). Perhaps because Goffman used this language of "attributes," scholars today often use the term stigma to refer to attributes, marks, and/or characteristics that are socially devalued and discredited. This conceptualization, along with Goffman's focus in his book on individuals with stigmatized statuses, has led activists and scholars to critique the concept of stigma as overly focusing on individuals with stigmatized statuses (Sayce, 1998). Critics argue that this focus ultimately insinuates that the "problem" lies within these targeted individuals rather than those who are perpetrating stigma, institutions and organizations that maintain stigma, or the societal conditions giving rise to stigma.

Yet the second part of Goffman's definition, which is far less cited than the first, advises readers that stigma is a social phenomenon. Goffman, who was a sociologist, went on to qualify his definition by stating "but it should be seen that a language of relationships, not attributes is really needed" (Goffman, 1963, p. 3). This second half

of Goffman's definition is consistent with the Ancient Greek term στίζω, a verb derived from the noun στίγμα, which meant "to carve, to mark as a sign of shame, punishment, or disgrace" (Economou et al., 2020, p. 36; Liddell & Scott, 1901). Although the noun version of the term suggests that stigma is something that stigmatized individuals *are* or *have*, the verb version suggests that stigma is something that individuals and societies *do* (Earnshaw et al., 2025). Link and Phelan, who are also sociologists, introduced what is arguably our second most well-known and cited scholarly definition of stigma in the *Annual Review of Sociology* in 2001. They describe stigma as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination within a power context (Link & Phelan, 2001). Phelan, Link, and Dovidio further considered the definition of stigma following their analysis of scholarship on stigma and prejudice, recommending that scholars use "the term 'stigma' when referring to a broader social process including many components" (Phelan et al., 2008, p. 365). More recently, in their introduction to *The Oxford Handbook of Stigma, Discrimination and Health*, Major, Dovidio, Link, and Calabrese described stigma as a social construction, or a phenomenon that society creates, maintains, and enforces. Taken together, our contemporary definitions arguably position stigma as a social process or phenomenon that impacts individuals rather than a characteristic of individuals themselves (Major et al., 2018).

Articles submitted to *Stigma and Health* include definitions of stigma that range from individual-focused conceptualizations inspired by Goffman (1963), defining stigma as a something that individuals are or have, to social process-oriented conceptualizations inspired by Link and Phelan (2001) and Major et al. (2018), defining stigma as something that societies do. Why does it matter if stigma is defined as something that individuals have or as something that societies do? The way that we define stigma has broad implications for our field as well as specific implications for the journal. Regarding our field, these definitions shape how we study and attempt to intervene in stigma. An individual-focused definition focuses our attention on individuals, their characteristics, and their interactions with other individuals. A social process-oriented definition focuses our attention on societies, their processes, and how individuals think, feel, act, and interact within their contexts. Regarding our journal, these conceptualizations shape what authors think "counts" as stigma research and therefore what they do or do not submit to *Stigma and Health*. Scientists operating under an individual-focused definition of stigma may not submit their scholarship on stigma at the interpersonal level (e.g., perhaps conceptualized as discrimination research) or structural level (e.g., perhaps conceptualized as research on oppression or structural discrimination) to the journal. Yet scholarship on stigma as a multilevel phenomenon is both critically important for advancing our field and enthusiastically welcomed at the journal.

A related vocabulary issue is the proliferation of synonyms within publications on stigma and health. Different researchers use different terms to refer to the same phenomenon (e.g., self-stigma vs. internalized stigma, enacted stigma vs. experienced stigma vs. perceived discrimination). I myself have switched terminology with time or based on the health context that I am studying. Although stigma researchers can translate these terms, the lack of shared terminology can make it difficult for nonstigma researchers to understand our scholarship. As examples, researchers without formal training in stigma may struggle to determine whether internalized stigma and self-stigma scales measure the same or different constructs.

Government leaders and community advocates who want to learn about evidence-based stigma interventions may be unsure whether interventions that enhance resilience to enacted stigma and perceived discrimination are targeting the same or different experiences. Conflicting terminology may ultimately be a barrier to *Stigma and Health* fulfilling its potential to impact research as well as partner on social justice work.

A shared and agreed-upon common vocabulary could accelerate stigma research as well as promote the accessibility of our articles to nonstigma scientists and leaders in social justice work. Clarity surrounding our scientific vocabulary is particularly important now, given that words that are central to our field (e.g., discrimination, prejudice, stereotypes, implicit bias, intersectionality) are being flagged by federal funders and removed from public health agency websites. As the town square for stigma researchers, *Stigma and Health* is uniquely positioned to resolve these issues with our vocabulary. During our term, my editorial team and I plan to invite stigma scientists to partner with us to collectively clarify our scientific vocabulary.

Concluding Remarks

In this time of social change, we are committed to following in the footsteps of the founders of stigma research and upholding the foundational priorities set by Corrigan and his editorial team during the first 10 years at *Stigma and Health*. We will continue to publish scholarship that aims to right social injustice. High-quality, use-inspired research is needed to achieve this goal. We will also continue to publish scholarship that is responsive to current events. Research on structural stigma and that considers intersectionality is needed to understand and respond to current events, helping scholars, government leaders, and community advocates move through our current fog. We will additionally work on clarifying our scientific vocabulary in the years ahead to accelerate our field, promote the accessibility of our work, and push back against efforts to censor our scholarship.

I am very grateful to our incoming associate editors, including Annie Fox, Victoria Frye, Jelani Kerr, Bryan Kutner, Carmen Logie, Mark Manning, Kelly Moore, Rebecca Pearl, and Philip Yanos, for their partnership and dedication to the success of *Stigma and Health*. In my year as incoming editor-in-chief, I have come to appreciate the many ways in which our associate editors are the backbone of the journal. I am also grateful to our consulting editors and ad hoc peer reviewers, who volunteer their time to ensuring the scientific integrity of the articles that we publish. I thank the publishing team at the American Psychological Association for their tireless support and hard work on behalf of the journal. Finally, I am humbled by the authors who trust us with their scholarship. I thank them for considering *Stigma and Health* as a home for their work. And to you, the readers—thank you for joining us, discovering with us, and seeking to right social injustice with us.

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