

‘It is surprising how much nonsense you hear’: How residents experience and react to living in a stigmatised place. A narrative synthesis of the qualitative evidence

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Abstract

There are significant geographical inequalities in health. Spatial stigma - negative representations of particular localities - could be an important mechanism through which place influences population health. To explore this, we undertook a narrative synthesis of studies reporting residents' perspectives of living in stigmatised localities. Qualitative research (38 studies) was reviewed to identify how spatial stigma manifested in residents' lives, their strategies to cope with stigma and the health consequences. The review found residents internalised stigma, but also resisted it differently. Although relatively few studies purposefully investigated health, living somewhere stigmatised had psychological effects and constrained life opportunities that have implications for health.

Key words

Social stigma, neighbourhoods, health inequalities, qualitative synthesis

Introduction

There are significant geographical inequalities in health. In England, for example, the average gap in life expectancy at birth between the most and least deprived neighbourhoods is nine years for men and seven years for women (Bambra, 2016). Research has suggested various mechanisms for explaining how features of local places might influence these inequalities (Bambra et al., 2019); a growing body of which has focused on the influence of spatial stigma (e.g. Thomas, 2016; Tran et al., 2020).

Conceptualising spatial stigma

Since *Stigma: Notes on the Management of Spoiled Identity* was published in the 1960s (Goffman, 1963), researchers have investigated the experiences of individuals and groups affected by stigma in a wide range of contexts (Tyler and Slater, 2018) including its relevance to health (Birbeck et al., 2019). While concepts of stigma are still debated (Pescosolido and Martin, 2015), Link and Phelan's (2001) work has sought to emphasise the underlying social processes and power dynamics that perpetrate stigma. In this definition, stigma is, arguably, evident where particular groups or individuals become negatively marked out on the basis of particular differences. In turn, individuals or groups may experience stereotyping or labelling, which can result in discrimination, social exclusion or other forms of disadvantage (Link and Phelan, 2006).

Following this definition, spatial (or territorial) stigma may be evident where a locality (e.g. a town, neighbourhood or housing estate/project) becomes marked out negatively on the basis of characteristics associated with the locality. Through labelling and stereotyping, this may lead a locale to gain a notorious reputation for being dangerous or a no-go area within public, media or political discourses (Wacquant, 2014). This may have psychological and material impacts for residents living in the area (Keene and Padilla, 2014) and even affect residents' life chances after they leave and move elsewhere (McCormick et al., 2012).

Spatial stigma is argued to be located in structural causes, meaning what leads an area to become stigmatised is closely aligned with its history as well as its socio-economic and political context (Keene and Padilla, 2014; Pearce, 2012). There is no single aspect that results in spatial stigma although it is almost exclusively associated with localities characterised by disadvantage and social exclusion. In the United States, spatial stigma is

often associated with the historical legacy of racial segregation linked to urban neighbourhoods experiencing high poverty (Felner et al., 2018; Keene and Padilla, 2010). In comparison, UK research has highlighted how spatial stigma is evident in low-income areas or post-industrial areas, (Garthwaite and Bambra, 2018; Thomas, 2016), as well as neighbourhoods with predominantly white working class populations or ethnic minority populations (Rhodes, 2012). Beyond this, spatial stigma has also been associated with other place characteristics including the concentration of public (social) housing (Hastings, 2004), an area's perceived crime rate (Kearns et al., 2013) or poor physical environment conditions (Bush et al., 2001).

Like stigma more generally, spatial stigma is a complex and multi-layered construct (Pescosolido and Martin, 2015). In referring to spatial stigma, we recognise that this term encompasses several dimensions. A key focus of this paper relates to stigma manifestations – namely how residents experience stigma in their daily lives as well as the actions and behaviours of others that perpetrate stigma (termed stigma practices). While the latter includes 'public stigma' such as derogatory attitudes in the general population (Pescosolido and Martin, 2015), perpetrators of spatial stigma may involve a wide range of actors. While the media is often implicated (Kearns et al., 2013), family members and acquaintances have been found to display stereotypical attitudes, for example, avoiding visiting friends or relatives because of unfounded concerns about an area's safety (Ponsford et al., 2018). Professionals may also make stereotypical assumptions about residents who are clients of their services on the basis of where they live (Stevenson et al., 2014). Structural dimensions include policies and institutional practices that can act as drivers of stigma. For example, urban regeneration programmes have been criticised for perpetuating negative area portrayals as a means of justifying gentrification of neighbourhoods and the displacement of existing residents (Paton et al., 2017). Such an example illustrates how those with greater power might utilise stigmatising processes in order to maintain the status quo or achieve their interests (Link and Phelan, 2001).

Wacquant's work on advanced marginality has also contributed towards understanding of how residents cope with spatial stigma in their daily lives (Wacquant, 2008; Wacquant et al., 2014). A central focus of his original thesis concerned the ways in which residents assume damaging internalised responses to stigma, affecting their self-worth and social relationships in communities (Wacquant, 2008). As research has amassed, researchers have questioned if

this argument applies in all contexts, leading Wacquant to update his original thesis to recognise the possible ways that residents resist stigma as well as submit to it (Wacquant et al., 2014). For example, studies have reported several instances of residents challenging spatial stigma with little evidence of internalisation (Jensen and Christensen, 2012; Kirkness, 2014; Slater and Anderson, 2012) as well as mixed responses that include submission and resistance within the same community (Thomas, 2016).

Spatial stigma and geographical inequalities in health

Research into how the context of places leads to geographical health inequalities has focused largely on physical environment pathways (such as green spaces, brownfield land or air pollution (Bambra et al., 2014; Shortt et al., 2011); economic environment pathways (e.g. area-level employment rates and income (Roux et al., 2001) political economy factors (e.g. (Bambra et al., 2019) or the influence of the service environment (e.g. health care or housing (Macintyre et al., 2002) and the retail environment such as the density of alcohol, tobacco and fast food outlets (Shortt et al., 2015). A less explored aspect of how place impacts on population health is the ‘collective social functioning and practices’ pathway (Macintyre et al., 2002) – which includes spatial stigma (Bambra, 2016).

Earlier research on stigma among groups particularly with health conditions has demonstrated clear impacts on mental health outcomes as well as health consequences that stem from people’s life opportunities being constrained (Hatzenbuehler et al., 2013; Link and Phelan, 2006; Stangl et al., 2019). While public health attention to spatial stigma has only emerged in recent years, theory and evidence suggest that the experience of stigma similarly presents serious risks for the health and wellbeing of residents of stigmatised places (Keene and Padilla, 2014). There are various pathways through which spatial stigma could impact on health outcomes: stigma has been found to act as a deterrent to accessing services or result in discrimination that constrains opportunities for social interaction or job seeking (Link and Phelan, 2006). Being ‘looked down on’ due to being a resident of a highly-stigmatised setting has also been associated with detrimental life chances, such as education and employment (Pearce, 2012). Another pathway is the psychosocial impact of ‘moral inferiority’ that can be associated with residents of highly stigmatised communities (Bush et al., 2001) leading to higher levels of psychosocial stress, which in turn can lead to increased rates of hypertension, coronary heart disease, and stroke (Link and Phelan, 2006). Spatial stigma may also affect health by causing psychological distress such as poorer self-esteem,

anger, or shame (Airey, 2003; Kelaher et al., 2010; Wutich et al., 2014) as well as adversely affecting mental health outcomes (Tabuchi et al., 2014, 2012).

Although spatial stigma is now recognised as a health inequalities issue, no systematic review has been undertaken of the existing body of evidence to inform future public health research and practice directions. Nor have the lay perspectives of residents been privileged in the debates so far. Therefore, a synthesis of published qualitative evidence was conducted to explore residents' own accounts of living in areas experiencing spatial stigma. The review sought to address (i) the ways in which this stigma manifested in people's lives (ii) the coping strategies used to manage stigma including submission and resistance (iii) and any consequences of the stigma for their health.

Methods

Search strategy and screening

The search strategy used a range of keywords/phrases such as 'territorial stigma' or 'reputation' (see supplementary file – Table A). Electronic searches were carried out in five databases (Medline, PsychINFO, Academic Search Ultimate, SocINDEX, Web of Science). The final search was run in October 2019, applying a qualitative filter. Additionally, reference lists of positional papers (Keene and Padilla, 2014; Larsen and Delica, 2019; Pearce, 2012) as well as a review of lay perspectives of socio-economic inequalities (Smith and Anderson, 2018) were screened.

We defined 'spatial stigma' to mean a locality of any geography perceived as having a poor reputation/image among those external to the area (e.g. in the media). Studies were only included where residents perceived this to be the case. Participants included adults and children all ages, those resident in the locality or accessing services there, as well as former residents who had moved away. We excluded perspectives of those without personal connection with the area (e.g. healthcare workers). A focus on high-income country contexts was also stipulated.

Table 1 sets out the study's inclusion and exclusion criteria. Searches were filtered to return texts in the English language. Grey literature and theses/dissertations were excluded. The

review covered a twenty-year timeframe (2000-2019), reflecting a growing interest in place research in this period – particularly in the United States and UK.

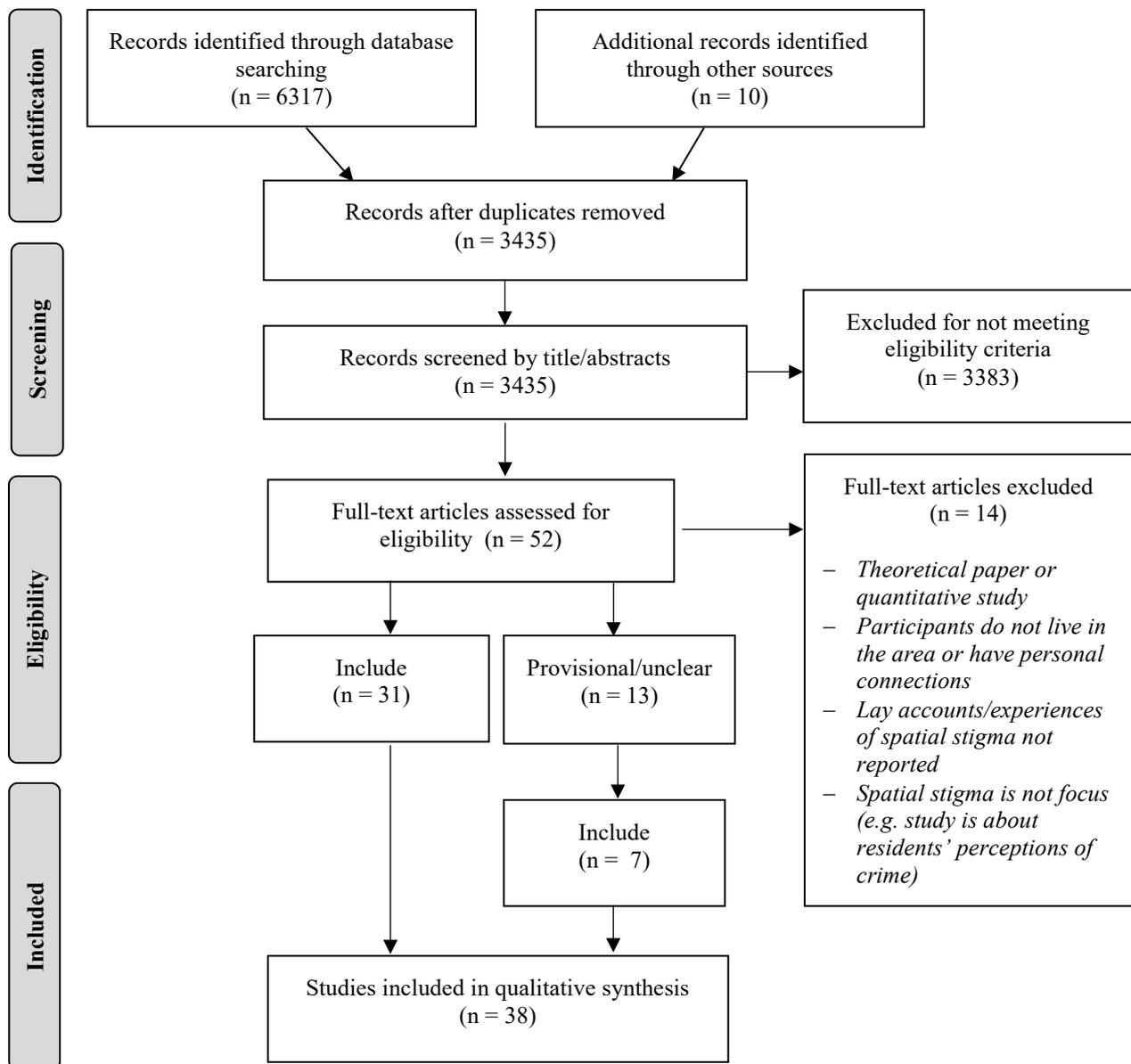
Table 1 Inclusion and exclusion criteria

Inclusion
<ul style="list-style-type: none">• Qualitative (e.g. interviews, ethnography, participatory methods) or mixed methods studies with a qualitative component• Published in English language• Studies conducted in high income country settings (defined by World Bank/OECD)• Studies reporting findings on lay accounts of living in an area which is stigmatised
Exclusion
<ul style="list-style-type: none">• Commentaries or predominantly theoretical papers• Quantitative studies or quantitative findings from mixed method studies• Grey literature, theses/dissertations• Papers not published in the English language or without translation• Perspectives of those without a personal connection to the area (e.g. social workers or healthcare workers)

Search results and screening

All search results were downloaded into Endnote X9 and screened for inclusion after duplicates were removed. This resulted in a total of 3435 records. Titles/abstracts were initially screened by EH. Due to capacity issues it was not feasible to double screen records at this stage, however, a second author (LB) reviewed the results and agreed the records for full text screening (n=52). Full text screening was completed by two authors (EH and LB) who double screened any articles identified as provisional (study partially meets criteria) or unclear (further discussion between reviewers required). The final set of papers (n=38) was then imported into NVIVO 12 for coding and synthesis. A flow diagram of the screening process and results is provided in Figure 1.

Figure 1 Screening process and results



Methods for synthesis

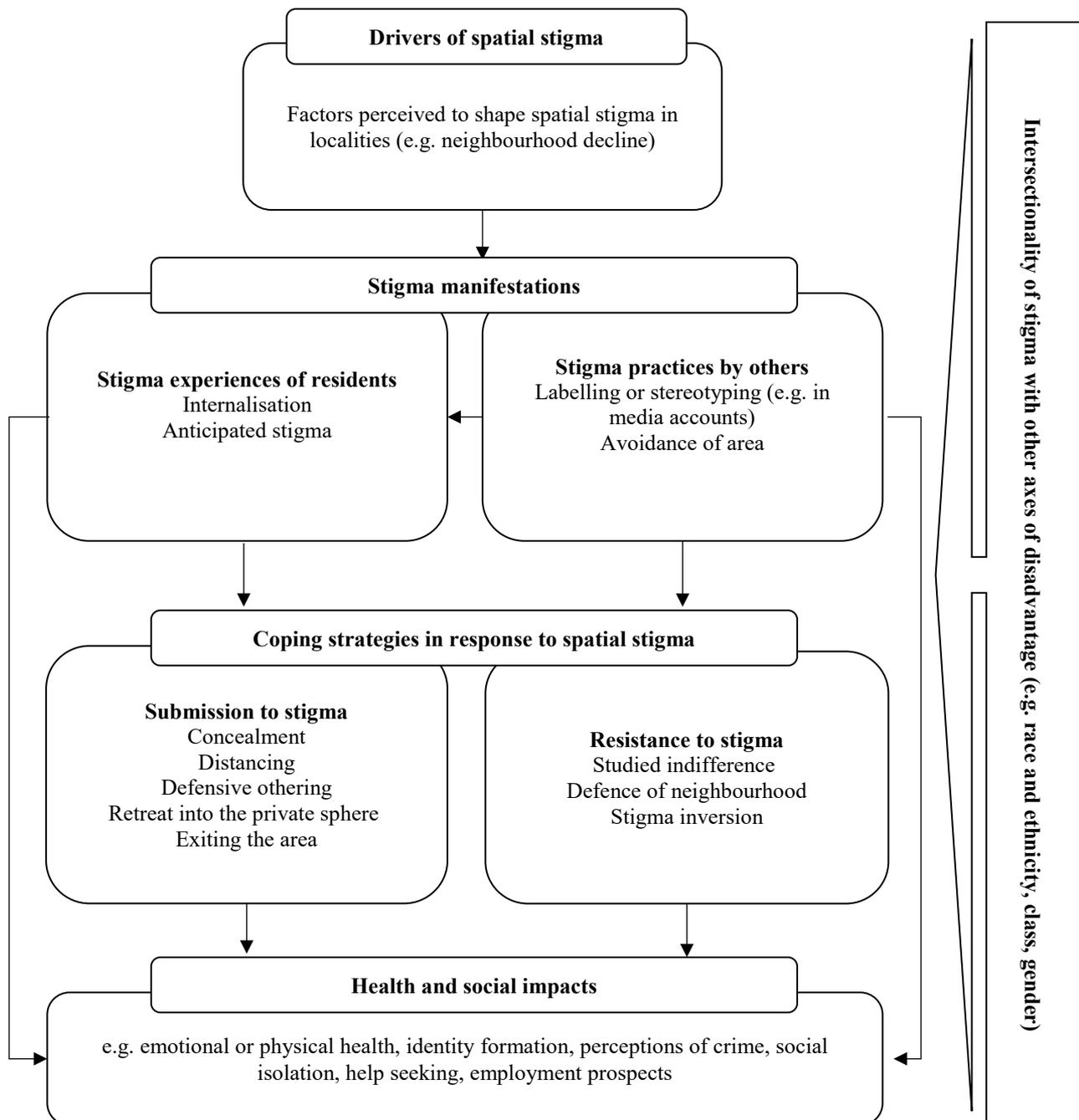
Narrative synthesis is appropriate when studies are insufficiently similar to allow for a specialist synthesis method such as meta-ethnography (Popay et al., 2006). The approach does not subscribe to one particular method but selects the tools and techniques most appropriate to the nature of the data (Popay et al., 2006). A framework was developed to guide coding and support interpretation (see Figure 2). The starting point for this was a 'health stigma' framework developed by Stangl and colleagues (2019). This framework was selected because it is designed to be generalisable to researching health related stigma across different topic areas. Intersectionality is also integral to the framework making explicit how health-related stigma(s) intersect with other social identities (e.g. race/ethnicity, class, gender). This may result in some groups being exposed to multiple forms of disadvantage and discrimination. We also adapted the framework to take account of theories of spatial stigma, particularly Wacquant's (2014) thesis, which proposes a set of coping strategies used by residents in response to stigma, summarised below.

The first domain in Figure 2 relates to the drivers perceived to influence the formation of spatial stigma, such as economic decline in a neighbourhood. The second domain 'stigma manifestations' concerns the ways in which stigma is experienced by residents as well as the stigma behaviours and practices perpetuated by others. The third domain outlines strategies related to how residents cope with living in a stigmatised neighbourhood. Wacquant's framework (2014) lists four submission strategies used to cope with spatial stigma: (i) concealment of address (ii) distancing from fellow residents (iii) defensive othering and (iv) wishing to exit the area. The framework also outlines three strategies of resistance: (v) studied indifference (vi) defence of the area and (vii) inversion of stigma. The final domain refers to pathways to health impacts that may arise both from manifestations of stigma and/or the ways in which residents enact coping strategies.

During the full text screening, the reviewers (LB and EH) used Excel as a tool to record pre-agreed information from each study. This extracted data informed a preliminary synthesis of study findings. During the full synthesis stage, study findings were coded in NVIVO12. Narrative synthesis techniques included charting and conceptual mapping and supported a systematic comparison across the studies and against the domains of the framework. The review also applied an intersectional lens to consider how spatial stigma interlocked with key

social categories (Kapilashrami et al., 2015). Finally, our preliminary synthesis of data found relatively little health data in studies meaning that evidence related to this domain of the framework was limited and it was not possible to consider differential impacts.

Figure 2 Framework guiding coding and synthesis (adapted from Stangl et al., 2019)



The following approaches were adopted for the appraisal of studies. Firstly, peer review was considered an initial indicator of quality. The CASP tool was then used to guide an appraisal of all included studies. However, similar to Smith and Anderson (2018), we became aware that some studies which we deemed as relevant because they reported detailed findings about residents' experiences scored poorly due to a lack of methodological detail in reporting. Therefore, we did not exclude studies on the basis of methodological quality. Instead, a study's CASP score was used to reflect more generally on the quality of the reporting. Alongside the CASP, we adopted an approach used in another narrative synthesis (Arai et al., 2005) to categorise studies which provided 'thicker' or 'thinner' descriptions of spatial stigma. Studies offering thicker descriptions were those that moved beyond descriptive accounts to offer explanations of underlying meanings and motivations in these accounts (Ponterotto, 2006). The results of the appraisal is contained in a supplementary file (Table B). The ENTREQ framework (Tong et al., 2012) guided overall reporting of the review and its synthesis.

RESULTS

Characteristics of studies

Table 2 summarises key features of the studies including their geographical spread, the participant sample and qualitative research method. A more detailed overview of study characteristics is contained as a supplementary file (Table C). Studies were conducted across localities of diverse scale including neighbourhoods undergoing redevelopment, areas with high density of social (public) housing, towns and city districts/neighbourhoods. Localities typically were defined as having socio-economic disadvantage, concentrated poverty, or experiencing post-industrial economic decline. Studies also considered spatial stigma across other contexts ranging from its interrelationship with air quality to its impact on accessing services. Findings from the preliminary synthesis are available in the supplementary files (Tables D and E).

Table 2: Key features of studies

Geographical location						
United States	Canada	UK	Europe (other)	Australia		
6	5	12	9	6		
Main qualitative method						
Ethnographic	Interviews	Focus groups	Participatory methods	Interviews & focus groups	Case study	
7	15	4	6	5	1	
Participant sample						
Residents - general	Children and young people*	Black & other (non- white) ethnic groups*	Former residents*	Public housing tenants	LGBTQ community*	Service users*
20	10	9	2	2	2	2

*Includes studies listed in more than one category

Note - In categorising studies in this table, this refers to studies where these categories were the primary sampling criteria. Studies referred to as 'residents – general' also included a mix of participants from across these groups.

In the following sections we report on drivers and manifestations of stigma; the coping strategies enacted by residents; and the consequences for health and life opportunities where reported. In the interest of readability, the study ID found in the supplementary file (Table C) is used to refer to underpinning evidence within these sections, and is contained within square brackets [] within the text.

Drivers and manifestations of stigma

In this section, we report on residents' perceptions of how stigma manifested in their daily lives and perceptions of the factors underpinning spatial stigma in neighbourhoods. While the findings are grouped in relation to the domains of Figure 2, it should be noted that

residents' accounts of stigma experiences, practices and drivers were overlapping. For example, it was not always possible to distinguish whether residents' accounts were based on events that had taken place, or if residents perceived negative external attitudes to exist, and anticipated stigma as a result. Similarly stigma practices such as discriminatory police actions were also located in structural causes and could be viewed as a driver of stigma.

Stigma experiences

Residents across all studies spoke of anticipating or encountering derogatory attitudes towards their place of residence among those living or working outside the area. This included friends and family, new acquaintances, work colleagues, service providers as well as the media (see mapping of actors in Table D – supplementary files). In half of the studies reviewed, spatial stigma led residents to feel shame or embarrassment connected to living in the area, with internalisation evident from a young age. This mother described the effect of the area's reputation on her children: *'They say 'Mama, don't mention that we are living in RP, people look down on us' ... and so they feel low'* [4]. Internalisation was also present in the subtext of how residents talked about their areas, with statements made by residents such as *'why would you want to move [here]?'* [9]. In these contexts, some participants described feeling overtly conscious about how they were viewed in shops or when using services outside of the area [13,22].

Narratives of spatial stigma in north America particularly reflected experiences of marginalisation linked to racial segregation [7,9,11,18,21]. Participants described the ways in which this affected residents from particular cities: *'I feel like because I am from Chicago, I'm already labelled'* [18]. Similar accounts were evident in other countries among those who had immigrated to a new country. Residents in France [12,19] and Canada [38] described how spatial stigma compounded processes of exclusion.

Some French people live here, it's true. ... But basically, it's just Arabs and blacks and when we go to Nîmes, they look at us bizarrely because they know we're from the ZUP. ... The ZUP sticks to your skin. You can't be properly French when you're from here [19]

While not always possible to disentangle in studies, in some cases, residents did articulate how spatial stigma was layered onto racial discrimination [16,18]. In focus groups with young people living in London [16], several participants asserted that being black in one part of the city was worse than being black from elsewhere:

Caroline: So, do you think that black people who come from Brixton – is it worse than being black from Croydon [a nearby area] or . . .

Many [shouting]: Yeah! yeah, it is.

Cliff: Yeah, cos you're born in Brixton

Stigma practices

Media coverage was frequently reported as a perpetrator of spatial stigma [2,16]; sensationalising the scale of an area's problems such as drugs, violence or crime [4,7,17,20,38] or the physical decline [31] for the sake of boosting sales [12]. News stories could also amplify others' negative views of a locality. When young people living in a stigmatised locality confronted other children about their views, their classmates cited newspaper reports as confirmatory evidence of the '*rumours*' about the area [33].

Negative attitudes were also referenced in relation to the police. This was reported in studies conducted in Australia [2-3], France [12,19], and north America [11,18,28,38]. For example, Ghanaian immigrants in Canada linked their address with the frequency of being stopped and questioned: '*...when they saw the name of the neighbourhood they [police] started asking us questions upon questions*' [38]. In contrast, residents living in another locality referred to police unwillingness to meet with residents in the area despite invitations to community meetings. By apparently avoiding the area, police were seen to endorse the widely accepted image of the neighbourhood as a no-go area. As this resident explained: a lack of police presence, therefore, perpetuated '*this [negative] image for the outside world that they [the police] have helped create*' [19]. Further accounts of stigma practices among service providers or among employers and work colleagues are referenced in the later section on health consequences, highlighting how this respectively affected experiences of help seeking as well as life opportunities.

Drivers of stigma

Residents associated their area's poor reputation with perceived decay in the neighbourhood's material and social fabric [5,14] or features such as social (public) housing [2-3] and the association of the area with concentrated industry [6-7]. In some instances, decline was seen to stem from a lack of external investment into the area [7,13]. These markers of the physical landscape, as well as permeating residents' daily lives, were also believed to amplify negative outside views:

You see, like, trash everywhere, so when people do come out from other states and come see Detroit, they're just like, you know, you see all these, the trash, the burnt houses and stuff. So ... the first impression, you know, means everything [14]

Where regeneration was planned or had happened, some residents expressed concerns that neighbourhood renewal exacerbated stigma or did little to mitigate its effects. Residents were sceptical about the extent that regeneration could change a poor reputation. For example, changing the area's name was reported in one study as ineffectual in shifting external attitudes towards the locality and was described as '*a Band-Aid cover*' [24]. Others expressed concern that new mixed tenure developments within their neighbourhood served to intensify difference and the stigma of public versus private housing: '*It's still segregated. Ours is black brick, theirs is red brick*' [4]. Yet for others, regeneration was viewed positively. Another perspective was that mixed tenure developments helped to improve reputation by deconcentrating social housing in a neighbourhood [2]. For some, moving to a revitalised area meant moving somewhere that they felt more proud of compared with their former surroundings [21].

Strategies to cope with spatial stigma: submission or resistance

We mapped findings to identify the extent of these coping strategies across the studies. The synthesis sought to identify decisions (rationales) informing the adoption of these strategies and allowed for the emergence of alternative strategies in residents' accounts. In the following sections, Tables 3 and 4 provide an overview of identified submission and resistance strategies, including illustrative examples from the original studies.

Strategies of submission

We found the findings from studies mapped onto Wacquant's four submission strategies. However, residents enacted these strategies in different ways and for different reasons.

Concealment of address

Information management through concealment of address was evident in several studies. Specific strategies included residents being vague about where they lived [2,26,30] or citing a different location (e.g. a neighbouring suburb which was more desirable) [2,9,16,24,33,34,38]. Concealment has been understood as a way of protecting oneself against the shame of living in a 'defamed' locality (Wacquant et al., 2014). While studies provided evidence to support this theory (see Table 3), concealment was equally routed in concerns about the consequences of stigma. This included not wanting to spoil social opportunities (e.g. meeting a prospective partner) [9,21,36] or perceived discrimination when job seeking [9,16,21,26,28,38]. Residents who had moved away spoke of formerly concealing their old address but now being happier to reveal their place of residence [21]. Yet these resident still concealed their *former* place of residence in certain situations (for example, meeting more affluent neighbours) as a strategy to protect their new identity.

Table 3 Submission Strategies

Strategy	Description	Rationales	Illustrative quotes/examples	Citing authors
Concealment	Information management in an attempt to conceal one's address (e.g. being vague, giving out false information or denial)	Shame or embarrassment associated with place of residence	<i>'I don't usually say Redcrest. I say a nearby street or something, because you don't want people thinking that you live in a ghetto or bad area'</i> (van Ingen et al., 2018)	(Airey, 2003; Arthurson et al., 2014; Browne-Yung et al., 2016; Contreras, 2017; Howarth, 2002; McCormick et al., 2012; Pereira and Queirós, 2014; Slater and Anderson, 2012; van Ingen et al., 2018)
		Perceived stigma in social situations (e.g. meeting new people)	<i>'Damn, I don't want to tell you I live in Compton, 'cause I know right there it's done.' And it's happened before'</i> (Contreras, 2017)	(Contreras, 2017; McCormick et al., 2012; Warr, 2005)
		Concern about economic consequences (e.g. discrimination when applying for jobs)	<i>'I would never tell no one. I do, yeah, I come from Brixton, there is nothing I can do about it, but if I was going to a job interview, I would have to tell a little lie. Say I was from somewhere different'</i> (Howarth, 2002)	(Contreras, 2017; Howarth, 2002; McCormick et al., 2012; Pereira and Queirós, 2014; Purdy, 2003; Zaami, 2015)
		Protecting new identity after relocating	<i>'And the lady [homeowner] was sitting up there saying, "I'm telling everything. The people from the projects, they ain't no good." I'm from the projects but I didn't, you know, I didn't say nothing. I'm getting heated and my blood getting heated'</i> (McCormick et al., 2012)	(Keene and Padilla, 2010; McCormick et al., 2012)
Retreat into private space	Withdrawal into the security of personal space or withdrawal into neighbourhood	Avoidance of perceived threats such as fear of crime	<i>'I will show you what I do, I put the key in and lock it, shut that down and then pull that door'</i> (Popay et al., 2003)	(Airey, 2003; August, 2014; Browne-Yung et al., 2016; Pereira and Queirós, 2014; Popay et al., 2003)
		Remaining in secure and familiar places	Helen, a sole parent of two children, spends most of her time in the local area where she is less likely to be confronted by the stigma (Warr, 2005)	(Arthurson et al., 2014; Garthwaite and Bamba, 2018; McKenzie, 2013; Warr, 2005)
Distancing	Geographic or social (symbolic) distance from other residents or the avoidance of particular localities within the area	Avoidance of specific localities due to perceived threats	<i>'I don't particularly like Penketh. There are loads of stories about it. I never go there. They jump people, someone was stabbed there or something. I was like, nope, not going there'</i> (Thomas et al., 2018)	(Arthurson, 2013; Browne-Yung et al., 2016; Garthwaite and Bamba, 2018; Jensen and Christensen, 2012; Osborne et al., 2011; Palmer et al., 2004; Pereira and Queirós, 2014; Purdy, 2003; Rhodes, 2012; Thomas et al., 2018; Thomas, 2016).

	Avoiding contact with others in the area as a form of self protection	<i>'I really don't do much socialising with people in the building. I've seen how ignorant they act, you know amongst each other. So I try not to involve myself in that'</i> (Keene and Padilla, 2010)	(Graham et al., 2016; Keene and Padilla, 2010; McCormick et al., 2012)	
	Emphasis on how own lives or situation differs from other residents	<i>'It's just the people—I mean ... Most of the people in, in my neighborhood are just, they don't care. They just—I don't know, just stealing. They, they, they burn houses. There's—I don't know. They're just out of control over there'</i> (Graham et al., 2016)	(Airey, 2003; August, 2014; Bush et al., 2001; Keene and Padilla, 2010; Palmer et al., 2004; Popay et al., 2003; Purdy, 2003; Van Der Burgt, 2008; Warr, 2005)	
	Disassociation with neighbourhood identity	Some respondents absolutely do not want to identify with the neighborhood. They describe their neighborhood as being “dirty,” “unsafe,” “unpleasant,” (Waerniers, 2017)	(Graham et al., 2016; Howarth, 2002; Keene and Padilla, 2010; McCormick et al., 2012; Waerniers, 2017)	
	Avoidance of area in attempt to avoid situations that pose risks in effort to ‘clean up’ identity	According to many participants, the street-based drug scene was the defining characteristic of the Downtown Eastside, and its inhabitants were “drug addicts” with bad mental health issues (Collins et al., 2016)	(Collins et al., 2016; Felner et al., 2018)	
Othering	Deflection of stigma by denigrating sub-localities (microspatial level) on basis of perceived disorder/danger	<i>'[I] don't like to stereotype or whatever but there are some bad areas, streets I don't like to walk down at night [name of street] being one of them.'</i> (Arthurson, 2013)	(Airey, 2003; Arthurson, 2013; August, 2014; Browne-Yung et al., 2016; Bush et al., 2001; Garthwaite and Bambra, 2018; Jensen and Christensen, 2012; Osborne et al., 2011; Palmer et al., 2004; Pereira and Queirós, 2014; Popay et al., 2003; Purdy, 2003; Rhodes, 2012; Thomas, 2016; Van Der Burgt, 2008)	
	Denigrating particular localities or groups of residents within the area	Deflection by amplifying stereotypes and prejudices based on race/ethnicity	<i>'I will accuse Asians of not looking after their property ... it's the old ghetto situation ... more Asians come in and they get in that area and they don't look after the property, so very quickly it becomes slums'</i> (Rhodes, 2012)	(Airey, 2003; Contreras, 2017; Felner et al., 2018; Garbin and Millington, 2012; Garthwaite and Bambra, 2018; Gruner, 2010; Jensen and Christensen, 2012; Keene and Padilla, 2010; Popay et al., 2003; Purdy, 2003; Rhodes, 2012)
		Deflection by amplifying stereotypes and prejudices based on age or gender	<i>'I live in Compton and I ain't seen girls from Compton that weren't like dirty, you know what I mean?'</i> (Contreras, 2017)	(Contreras, 2017; Jensen and Christensen, 2012; Osborne et al., 2011; Thomas, 2016)
		Deflection by amplifying stereotypes and prejudices based on class	People on the north side are often considered “trash” by those on the south side, while north siders often consider south siders “posh” (Jensen and Christensen, 2012)	(Collins et al., 2016; Garbin and Millington, 2012; Garthwaite and Bambra, 2018; Jensen and Christensen, 2012; Purdy, 2003; Rhodes, 2012)
		Deflection by amplifying stereotypes and prejudices based	<i>'This is a pretty good area, but you go behind the schools and it's really like feral ... there's [Housing Trust] half-houses'</i>	(Arthurson, 2013; Arthurson et al., 2014; Browne-Yung et al., 2016; Kullberg et al., 2010; McCormick et al., 2012;

	on housing (tenants in social housing or private renters)	<i>everywhere ... people just really don't give a shit about their yards ... or their kids for that matter'</i> (Osborne et al., 2011)	Osborne et al., 2011; Palmer et al., 2004; Popay et al., 2003; Warr, 2005)
	Explaining area's negative reputation with reference to issues such as drug taking or gang violence or 'problem' residents	<i>'[T]he people that live in the bad bits are the people that are more into domestic violence, more into child abuse, more into drugs'</i> (Palmer et al., 2004)	(Airey, 2003; August, 2014; Browne-Yung et al., 2016; Collins et al., 2016; Contreras, 2017; Garthwaite and Bambra, 2018; Graham et al., 2016; Jensen and Christensen, 2012; Keene and Padilla, 2010; McCormick et al., 2012; Palmer et al., 2004; Popay et al., 2003; Rhodes, 2012; Thomas, 2016; Zaami, 2015)
	Demarcating particular localities based on poor health	<i>'...there is a high preponderance of asthma sufferers etc., especially in Grangetown, South Bank sort of the east Cleveland area and they are living under British Steel, they are living under ICI and one wonders'</i> (Bush et al., 2001)	(Bush et al., 2001; Collins et al., 2016; Garthwaite and Bambra, 2018)
Exiting the area	Neighbourhood conditions or decline	<i>'[T]he ghetto is not where I want to stay for the rest of my life. I say that not because of the area you know, 'oh, St Paul's', but because . . . St Paul's is situated in a big dip and it collects all the city's crap . . . In my previous [rented] house [in more affluent Kingsdown] I was on a hill and it was light and you had a view, it was less polluted and I didn't feel as depressed'</i> (McKenzie, 2013)	(Graham et al., 2016; Keene and Padilla, 2010; Purdy, 2003; Slater and Anderson, 2012)
Express wish or plan to leave, or have already left	Economic factors or educational opportunities	<i>'I wished I relocated to other areas in the city because there is certainly a huge price that I pay simply by living in this area'</i> (Zaami, 2015)	(Cairns, 2018; Jensen and Christensen, 2012; Thomas, 2016; Zaami, 2015)
	Temporary exit	Both Alena and Uwe consider themselves 'captives' of the estate. For this reason, I interpret their strategy [of exit] as a way of escaping from the stigma imposed on Marzahn (Cuny, 2019)	(Cuny, 2019)

Retreat into private space

Around a quarter of studies described residents retreating into the private space. At one level, this involved withdrawal into the security of their home. Residents described not wanting to go out (or go out alone), or remaining in at night because of perceived neighbourhood threats such as crime [1,4,5,26,27]. Additionally, retreat was associated with withdrawal into the neighbourhood as a whole. This was evident through residents avoiding situations that brought them into contact with people external to the neighbourhood's boundaries (e.g. when socialising or shopping) or preferring to remain in their neighbourhood where this felt secure and familiar [2,13,22,36].

Social and physical distancing

Distancing concerned maintaining social distance from fellow residents or the avoidance of particular localities within the neighbourhood. Studies identified a number of rationales for why residents distanced in this way. Firstly, physical distancing was linked to perceived risks associated with a particular location in the area such as a park or street deemed to be unsafe [2,5,13,17,23,24,26,28,29,31,32]. The next two rationales were both related to distancing from fellow residents but were enacted for different reasons. For the first rationale, residents created a demarcation between their own lives and those of other residents, emphasising how their values or lifestyles differed from others [4,18,24,27,28,33,36]. Geographical distance was sometimes used in this way to emphasise the distance between where residents lived and other localities perceived to have problems [1,27] or to identify their pocket of the neighbourhood as '*safer*' [4], '*cleaner*' [6] or '*more desirable*' [24] in comparison. Additionally, residents who had moved to a new neighbourhood participated in distancing from former neighbours for another reason. Here, distancing served as self-protection to avoid situations which might risk trouble or lead to complaints being made against them in their new surroundings [18,21].

Distancing also included residents' disassociation from the neighbourhood as a whole. In these situations, participants denied they were from the area all together or repeated stereotypes about their place of residence but distanced themselves from connection. This strategy was again evident where people had moved away from an area [18,21] but was also found in accounts of those still resident in an area [14,16,35]. Some evidence of disassociation was also evident among individuals accessing services [8,11]. This could

mean people avoiding help seeking if the service was located in a stigmatised neighbourhood [8].

Othering

Researchers have interpreted strategies of defensive othering as evidence of how residents manage their identities living in challenging circumstances (Popay et al., 2003). Like distancing, othering was apparent in the majority of studies. As Table 3 shows, othering occurred at the micro-spatial level (e.g. a street, park or residential area), or on the basis of social categories such as race/ethnicity, class, housing type, gender or age. Residents also referred to perceived personal failings of fellow residents or attributed the area's reputation to issues such as drug taking. A further approach identified in a small number of studies was a spatial demarcation based on poor health such as associating a locality with high rates of illness or health damaging behaviours.

An intersectional lens helped to show how othering manifested in different contexts. Within European studies, deflecting stigma was associated with anti-immigrant rhetoric and racist prejudices [1,12,13,15,17,27,29]. Yet a study of far-right supporters in an English town also showed that othering was enacted towards white residents on the basis of class, as well as in relation to Asian communities [29]. Within the United States, deflection linked to racist stereotypes was evident [9,11,18]. In Los Angeles, for example, native-born residents blamed immigrants for the area's decline, yet othering also occurred between and within black and Mexican communities, and males utilised gendered reflections against female residents [9]. Othering on the basis of housing tenure was evident across several studies, as Table 3 shows. However, this pattern of othering was not clear cut with one study showing this directed towards younger more transient residents, but that some tenants engaged in strategies of blame towards fellow tenants as well [23]. Finally, there were only few instances of young people being at the receiving end of othering [23,31]; but young people were found to engage in othering from a young age [31,33].

Exiting the area

Residents spoke of a desire to move away from area [7,28,30,38] or that they were definitely planning to do this [17,36]. Yet the stigma was largely not cited as the primary reason for leaving. Alternatively, residents articulated issues concerning neighbourhood decline or violence, drugs and crime as informing their desire to leave. For a potential house buyer,

purchasing property in another part of town was an economic decision to '*protect that investment*' [17]. For younger residents, a desire to leave was sometimes associated with a negative view of the neighbourhood [38] but was also linked to the pursuit of future aspirations [7,31]. Being unable to move could result in a '*feeling of entrapment*' [38], with one study identifying the use of temporary exiting (visiting places that had meaning outside the area) as a means of escape [10].

Strategies of resistance

Wacquant's framework (2014) incorporates three strategies of resistance: studied indifference, defence of the area and stigma inversion. In mapping findings, we identified some evidence of strategies of indifference and inversion. During full text screening, we also allowed for the possibility of resistance being implicit as well as intentional within residents' accounts (Garbin and Millington, 2012; Kirkness, 2014). This led us to identify six types of defence expanding on Wacquant's thesis. Table 4 outlines each strategy with illustrative examples.

Studied indifference

Indifference to spatial stigma appeared least frequently in studies. In one study, ambivalence among a small number of participants was suggested (in that they neither overtly challenged nor internalised the stigma) but the majority of respondents were reported to be '*sad, frustrated or angry*' in response to the stigma [17]. As the quote in Table 4 illustrates, while one resident had initially internalised the stigma, she now displayed ambivalence towards negative attitudes by laughing them off [36]. Although explicit examples of studied indifference were not common, the strategies outlined below indicate that residents were not indifferent to the potential damage that spatial stigma caused. As such they attempted to challenge this in multiple ways

Table 4. Resistance Strategies

Strategy	Description	Rationales	Illustrative quote/example	Citing authors
Studied indifference	Ambivalence about the area's reputation - not resigning or internalising the stigma, nor showing a defiant or emotional response	Not stated explicitly – potential mechanism to deflect stigmatising attitudes	<i>'For a long time I had this stigma about being in Corio ... and I was embarrassed to say I was in Corio because it had such a bad name, but now I just think, look, that's your problem. My sister, she's very funny, like they're in Lovely Banks because they didn't want to be associated with being in Corio, and we just laugh at them now because they're just across the road'</i> (Warr, 2005)	(Jensen and Christensen, 2012; Warr, 2005)
Revealing address	Intentionally stating address and place of residence to outsiders	Desire to challenge outsiders' attitudes or display defiance in response to these attitudes	<i>'I tell people I'm proud to live in Regent Park, I'm not ashamed.. It's a great place. I'm not embarrassed'</i> (August, 2014)	(Arthurson et al., 2014; August, 2014; Contreras, 2017; Jensen and Christensen, 2012).
Claiming public spaces	Not retreating into the private space	A statement of appropriation, as a form of resistance or reclaiming of public spaces	Younger residents that I encountered seemed to thrive off the image of being the 'Other' and, in so doing, positioned themselves in visible spaces where they could be recast as central occupiers and 'owners' of the cité' (Kirkness, 2014)	(Cuny, 2019; Kirkness, 2014; Thomas et al., 2018)
Contesting legitimacy of reputation	Not accepting how area is portrayed or questioning accuracy of reputation based on lived experience	Belief that negative portrayal of area is unjustified, exaggerated or wrong	<i>'Samuel: Everything they say about Backhagen is just not true, you shouldn't believe it. Danielle: Who is saying things, then? Samuel: It's in the papers, rumours simply start circulating'</i> (Van Der Burgt, 2008)	(Airey, 2003; August, 2014; Bush et al., 2001; Cairns, 2018; Howarth, 2002; Jensen and Christensen, 2012; Kullberg et al., 2010; Osborne et al., 2011; Purdy, 2003; Slater and Anderson, 2012; Van Der Burgt, 2008; Whitley and Prince, 2005)
		Belief that area is no worse compared to other areas or compares more favourably	<i>'Kirkhead is a good place to live in— certainly better than some of the other neighbourhoods in the city'</i> (Airey, 2003)	(Airey, 2003; Arthurson et al., 2014; Browne-Yung et al., 2016; Osborne et al., 2011; Thomas, 2016)
Constructing positive narratives of place	Drawing attention to the area's assets such as its sense of community	Personal positive experiences or memories of living in the area	<i>'A lot of people just get the sense that Camden is a bad city, and it's not. It's a very good place. Like, kids grow up here. This is home to many, many people. And that's the way I'll always see it'</i> (Cairns, 2018)	(August, 2014; Cairns, 2018; Jensen and Christensen, 2012; Kirkness, 2014; Kullberg et al., 2010; McKenzie, 2013; Palmer et al., 2004; Popay et al., 2003; Purdy, 2003; Slater and Anderson, 2012; Thomas, 2016; van Ingen et al., 2018; Whitley and Prince, 2005)
Actions that directly challenge spatial stigma	Activities intended to challenge spatial stigma by individual residents or through collective action	Desire to actively fight against defamatory representations or persuade outsiders to change their views	A report on the initiative quoted a local resident as saying she had organised the meeting: <i>'because I was irate at having Matchville always being called a bad place to live and to tell bureaucrats that we did have community spirit'</i> (Palmer et al., 2004)	(Arthurson et al., 2014; August, 2014; Contreras, 2017; Jensen and Christensen, 2012; McCormick et al., 2012; Palmer et al., 2004; Purdy, 2003; Thomas et al., 2018)

Actions that indirectly challenge spatial stigma	Activities with a positive effect on area's image indirectly (e.g. community projects that promote good news stories)	Recognition of area's positive attributes as a source of agency to contest spatial stigma	<i>'We take part in international dahlia contests. We won a first prize in Tours. So we are trying to get out of La Courneuve, we are trying to give another image of La Courneuve'</i> (Garbin and Millington, 2012)	(Cairns, 2018; Garbin and Millington, 2012)
		Implicit challenge (e.g. opening a business in the area contests the reputation as a 'no-go area')	<i>'It is surprising how much nonsense you hear about Valdegour. And when I set up Le Coin Ecolo [the company], people were really surprised. The truth, to be honest, it is that I wouldn't have set it up anywhere else'</i> (Kirkness, 2014)	(Jensen and Christensen, 2012; Kirkness, 2014; Palmer et al., 2004)
Inversion of stigma	Turning the stigma to advantage	Inversion of label attached to area is means of strengthening the collective identity	<i>'We've been called lots of things over the years, but if they're going to call us a ghetto, they're spot on, love'</i> (Slater and Anderson, 2012)	(Garbin and Millington, 2012; Slater and Anderson, 2012)
		Spatial stigma is a badge of honour or status	<i>'Some young people anyway, they identify with this tough guy image that 'we are the rulers of the roost' sort of thing'</i> (Arthurson et al., 2014)	(Arthurson et al., 2014; Kirkness, 2014)
		Evidence of ability to survive or do well in difficult circumstances	<i>'Territorial stigma is an interesting term, but I have to say I've used that to my advantage. If I look at my daughter, for example, when we were fundraising for her expensive New York education, it was all done on the premise of, here is this poor, single-parent child, raised in the notorious Northcott So in some ways it's actually to our advantage to have that'</i>	(Arthurson et al., 2014; Cairns, 2018; Kirkness, 2014; McKenzie, 2013; Zaami, 2015)

Not concealing address

Not hiding one's address contrasted directly with the aforementioned submission strategy of concealment. Residents referred to deliberately saying where they lived when meeting others [3,4,9], showing how residents rallied against internalisation by refusing to feel shame or embarrassment. This form of resistance also reflected an expression of connection to the neighbourhood. For women living on a council estate in the UK, researchers observed them always beginning conversations by describing their connections to the area [22]. Similarly, another study identified young men dedicated to revealing their 'hood' in conversations with others [9].

Claiming public spaces

How residents were present in the area's public space was viewed in one ethnographic study as an implicit but conscious strategy to resist spatial stigma. Here, researchers observed how young people '*positioned themselves in visible spaces*' presenting themselves as '*occupiers*' and '*owners*' [19]. We did not find direct evidence of this strategy elsewhere although work in Berlin shows how photography encouraged residents to articulate their own place narratives, with the researcher taking photographs of them within neighbourhood spaces that residents felt most represented the area [10]. Similarly, a participatory project in Wales involved young people working with researchers to improve neighbourhood lighting. This, in turn, enabled young people to reclaim and use spaces perceived as dangerous as well as challenge outsider perceptions [32].

Constructing positive place narratives

Several studies pointed to the ways in which residents had a positive association with their neighbourhood. Participants expressed considerable affection for where they lived and a sense of belonging [4,7,19,22,30]. Sometimes this perspective was linked to having lived in the area for a long time [24,28] or a strong sense of neighbourhood identity [30]. Several participants also referred to being happy where they lived and/or cited evidence of the area's social and physical assets sometimes seen to go unnoticed [7,17,20,27,31,34,37].

Contesting the reputation's legitimacy

Where residents expressed a positive internal view, this sometimes was used to contest the legitimacy of the area's reputation. Residents challenged the scale of the reputation, indicating that the perceived social and economic challenges were out of proportion [1,23,33] or misrepresented reality [6,20,30,37]. Legitimacy was also challenged in relative terms, with residents suggesting the area had improved compared to the past [14], was favourable as a place to live in contrast to other areas they knew [1,3,37] or 'no worse' than other places [5,31]. Lastly, media reporting was criticised specifically, with residents questioning the accuracy and fairness of news reports [4,7,16,28,31].

Actions that challenge spatial stigma

Individual and collective actions included efforts to change an area's negative reputation both directly (e.g. challenging how the area was portrayed externally) and indirectly (e.g. via improvements to neighbourhood conditions). At the individual level, residents contested spatial stigma in conversations within their networks (e.g. among work colleagues), offering a more accurate picture of the neighbourhood based on their lived experience [4,9,24]. Other actions by individuals included residents stating they would remain in the area despite having a choice to move [17] or moving back into an area to start a new business [9], although studies acknowledged that such decisions were likely to be informed by other factors as well.

Where communities had a history of social organising, this was reported to support resistance to stigma [30], with the suggestion that communities gained collective strength from resisting the stigma 'together' [4]. Direct action included organising community meetings with the media and public officials to challenge external portrayals [24]. By tackling social determinants such as residents' efforts to improve education [28] or address neighbourhood concerns [32], such actions could also challenge external attitudes. One resident involved in an international flower competition highlighted the success of growers from the area and how this supported a more positive view, particularly because the flowers had been produced locally [12]. Young people involved in a food project similarly pointed to the 'good work' of local organisations and felt that this required greater recognition [7].

Inversion of stigma

Finally, Wacquant's (2014) framework describes residents using stigma inversion as a strategy of resistance. Some evidence was found in studies often involving young people. Firstly, this involved inverting the negativity of the 'label' attached to the area as a means of strengthening the neighbourhood's identity, as the following quote illustrates '*... if they're going to call us a ghetto, they're spot on, love*' [30]. Secondly, living somewhere with a poor reputation was cited as evidence of people's ability to survive in difficult circumstances [19,22]; in this respect stigma was a sign of '*inner worth and adaptability*' [19]. In two further studies, examples were provided of how this was used materially to residents' advantage; in one case resulting in a job offer (where employers were impressed by applicants' achievements in spite of living where they did) [38] and in another situation, in making the case for educational scholarships and grants [3]. Lastly for young people particularly, the notoriety of the neighbourhood offered status; leading them to claim others were afraid of them and the area [3,19].

Consequences for health and life opportunities

Although studies largely did not report on health impacts, there was some evidence of spatial stigma having a direct impact on psychological wellbeing as well as having potential to affect health indirectly through social and economic pathways. In a few studies, spatial stigma was linked with psychosocial stress [13,21], poorer levels of self-esteem, self-belief and confidence [16,24,36,38] and poorer wellbeing [1,4,13,20]. Among residents who had relocated as part of a regeneration programme, stress, anxiety and depression was observed, however, this appeared to be associated with residents' changed circumstances and the new forms of social stigma encountered in their new address [18,21]. In some studies, coping strategies involving distancing from residents were found or theorised by study authors to have consequences for health, as a result of isolation or loneliness [13,14,18,38].

Supporting earlier research on stigma, it is also possible to theorise the possibility of health consequences arising from constraints to residents' life chances. Within the workplace, employed residents described colleagues making disparaging remarks about their address which created potential for shame or embarrassment [5,6,12,17,30,36]. For those looking for work, there was a concern that their address could affect their chance of being offered a

position, although it was not clear whether this always affected opportunities [12,16,18,28,38]. Nevertheless, as reported earlier, a fear of discrimination when job seeking was a factor leading people to conceal their address. Examples were also given of residents anticipating or experiencing stereotyping when they accessed health or other services (e.g. welfare support). Such accounts were sometimes found to intersect with race and class. A young woman in the UK relayed feeling judged for being a single mother with mixed race children and because of where she lived: *'I know what they're thinking ... 'oh it's one of them from there'* [22]. In the United States, young people criticised LGBTQ organisations for not addressing racism and stigma experienced by service users from particular areas of Chicago [11]. Negative experiences were also evident in accounts of residents who had relocated under renewal programmes [18,21]. While residents reported service providers previously avoiding their former address, the same residents were now subject to intrusive housekeeping checks in their new properties [21].

Discussion

Contribution to spatial stigma research

The findings from this synthesis highlight the importance of examining the complex relationship between spatial stigma and other axes of disadvantage. Findings confirm that spatial stigma may cause internalisation but that residents also responded with a wide range of reactions including frustration and resistance. The review provided limited evidence on the direct health consequences of spatial stigma because many studies did not set out to research this relationship. This gap is most likely to be explained by the fairly recent interest of health researchers in spatial stigma, with several studies in the review located in disciplines where health pathways were not theorised. However, given the established body of evidence on stigma and health more generally (Hatzenbuehler et al., 2013; Link and Phelan, 2006), it is plausible to suggest that spatial stigma presents a risk to the health and wellbeing of residents living in a stigmatised area. This is also supported by a growing body of observational studies that have found an association between spatial stigma and particularly mental health outcomes (Tabuchi et al., 2014, 2012; Tran et al., 2020). Our review has therefore highlighted the importance of spatial stigma for health inequalities and

added significantly to the emerging literature on the role of ‘collective social functioning and practices’ as a pathway linking health and place (Macintyre et al., 2002).

In summary, we suggest that the review adds to the evidence base for this topic in the following ways. Firstly, submission strategies were more prevalent compared to resistance strategies across the studies, with othering and distancing most commonly cited. However, most studies showed communities adopting strategies across the spectrum of submission and resistance rather than adopting only one or the other. We did not identify any new submission strategies that did not fit into Wacquant’s (2014) framework. However, the review does provide detailed insights as to how rationales for adopting strategies varied between groups of residents. For example, while concealment of address was in some cases connected to feelings of shame or internalisation, this strategy was also commonly grounded in residents’ concerns about the material and social consequences of disclosure such as the implications for job seeking. Such responses arguably reflect the ways in which people living in difficult circumstances manage situations that put them at risk of further discrimination and disadvantage (Elliott et al., 2015).

Secondly, the findings expand upon Wacquant’s theories of resistance identifying a range of implicit and explicit tactics. Where a wider range of resistance strategies was reported these tended to be studies providing thicker descriptions of spatial stigma. This may in part be due to the research design itself, for example, in-depth longitudinal research enabling observations of resistance in daily lives (Kirkness, 2014). Yet, similarly designed studies also found residents enacting predominantly submission strategies (Contreras, 2017), indicating that the social context of places has a bearing on how residents respond. In studies describing resistance, there was some indication that residents were already active in local community associations (Cairns, 2018; Kirkness, 2014) or long term residents were more likely to defend their area against negative stereotypes (Palmer et al., 2004). Other studies evidencing resistance included areas with a history of social action (August, 2014; Purdy, 2003). Research by Thomas and colleagues in Wales also showed how research processes enabled resistance, by supporting people to reclaim the narratives of their places within media discourses (Thomas et al., 2018).

Thirdly, an unanticipated finding was the large number of studies (a quarter of those reviewed) which focused specifically on children and young adults. It has been argued that

spatial stigma may be additionally detrimental to younger people as they spend more time in their homes and neighbourhoods (van Ingen et al., 2018). The review found mixed findings in this respect. On the one hand young people were conscious of stigma from a young age (Van Der Burgt, 2008); leading to poor self-esteem or concerns about future prospects (Howarth, 2002). In contrast, other young people reported positive experiences of where they lived and did not appear to internalise stigma (Cairns, 2018; Thomas, 2016). While these experiences largely reflect the pattern among adult residents, one notable difference was the way in which young people resisted stigma. Strategies of inversion were more likely to be found among young people. In this respect, strategies of resistance may differ in the extent to which they reinforce potentially negative social or health consequences. While some resistance strategies may protect against the negative effects of stigma or may theoretically contribute to positive impacts for self-identity where resistance actions are empowering, stigma as a ‘badge of honour’ may risk reinforcing the negative social and economic impacts of disadvantage on young people’s lives.

Finally, where intersectionality informed study designs, these were largely based in the United States (Contreras, 2017; Felner et al., 2018; Graham et al., 2016; Keene and Padilla, 2014), potentially reflecting the origins of intersectionality theory in this country (Heard et al., 2020). In a few other studies, the relationship of race/ethnicity and class to spatial stigma was considered (McKenzie, 2013; Rhodes, 2012; Slater and Anderson, 2012) although these did not explicitly adopt an intersectional lens. Our review found some evidence of intersection with particularly race or ethnicity in several studies although this varied in depth. Many studies referred to othering associated with racial prejudice or anti-immigrant views in communities but only studies with an intersectional focus considered more than one social category: othering being experienced by black women but not black men, for example (Contreras, 2017). We also noted some interchangeability in the use of the terms ‘race’ and ‘ethnicity’ suggesting the need for conceptual clarity. While north American studies usually referred to race, other studies utilised ‘ethnicity’ or referred to ‘race and ethnicity’ without distinguishing why they selected to use one or other term.

Limitations

The review involved comprehensive searches; however, not all relevant research may have been identified, as grey literature and doctoral theses were excluded. Additionally, included studies were weighted towards north American and UK research and other English-speaking

countries and were only included if they were in the English language. This may reflect where the majority of this research is located but could also be a limitation of our search strategy. Secondly, the appraisal process identified some variation in the quality of reporting across the studies. Approximately two third of studies were categorised as higher quality reporting (in that they reported on the majority of CASP criteria) with the remaining studies categorised as lower or medium quality of reporting (in that they lacked detail about the methods such as an in-depth description of the analysis process). However, reflecting other reviewers' experiences, it is also feasible that gaps in information did not constitute methodological flaws (Dixon-Woods et al., 2006; Smith and Anderson, 2018). While not necessarily a limitation, some difference between studies reporting thicker or thinner descriptions of spatial stigma was also evident. Notably studies with thicker descriptions were more likely to provide evidence of resistance strategies, with these strategies less evident in studies with thinner descriptions of spatial stigma.

Thirdly and related to the above, the evidence underpinning resistance strategies appeared to be less well established compared to the evidence on submission strategies. On the one hand, it is possible that this may reflect researchers being more attuned to negative experiences of stigma, which may have led to more attention to submission strategies in their research. Alternatively it may also reflect a need for future research which uses methods to elicit observations of resistance where these strategies are not explicit in residents' narrated accounts.

Next, the heterogeneity of the studies was an advantage in that we were able to explore how spatial stigma manifested in different contexts. However, synthesising such diverse studies (for example, views of far-right political supporters in a post-industrial English town, youth of colour accessing LGBTQ services in north America or public housing tenants in Australia) presented a not inconsiderable challenge and is likely to have rendered less visible the nuances embedded within these experiences.

Lastly, disentangling spatial stigma from other interlocking stigmas was challenging. For example, several studies were located in areas of concentrated public housing and identified public housing tenants experiencing stigma. However, it was not always feasible to distinguish whether stigma was linked to public housing or was spatially driven (or both), reflecting the need for future research that further investigates the interaction of these different forms of stigma (Horgan, 2020).

Implications for future research and practice

Within the past two decades, the research on spatial stigma has grown considerably, offering an important theoretical and empirical contribution to understandings of the relationship between place and health. In looking ahead however, we suggest that a predominant inward gaze on places and the residents who encounter spatial stigma may in itself be problematic, risking further stigmatisation of these places (Popay et al., 2020). Four future directions for research and practice are proposed. Firstly, this needs to be attuned to the collective agency within communities and focus on ways of mitigating stigma. Participatory research methods can enable communities to resist negative external depictions by offering spaces for residents to create their own counternarratives that privilege their experiences and perceptions of an area (Elliott et al., 2015; Thomas et al., 2018). Place based programmes involving a degree of resident control have also been found to support resistance to negative media representations when communities are provided with resources to do so (Halliday et al., 2020).

Secondly, Smith and Anderson (2018) have drawn attention to researchers' responsibilities to be sensitive to the choice of language and labels used when framing health inequalities. In the context of communicating geographical inequalities in health, public health organisations including researchers could also be exacerbating stigma. This may occur when narratives of areas experiencing significant socio-economic disadvantage are continually narrated with respect to their negative characteristics such as their poor health profiles. In this regard, involving groups who experience disadvantage and exclusion should be key to informing how inequalities are discussed and framed.

Thirdly, Whittaker and colleagues (2020) have recently called for research to focus on understanding macro level policies and programmes that may amplify spatial stigma. This upstream focus also reflects wider stigma debates that encourage a shift in emphasis onto the drivers and contexts where stigma is produced rather than only on the receivers (Tyler and Slater, 2018). Lastly, there is potential for researchers with interests in spatial stigma to consider how this can be more centrally located in research and practice on health stigma. While recent health stigma frameworks have rightly acknowledged the need for a cross cutting approach to stigma research and practice, such frameworks have typically conceptualised stigma related to health conditions (e.g. obesity, mental health) with little or no reference to stigma associated with living environments (Stangl et al., 2019).

Conclusion

Our review has shown how people living in stigmatised areas perceive and respond to spatial stigma. It has also provided some, albeit limited evidence about the associated health impacts of living somewhere stigmatised. While research on lay perspectives offers important insights into lived experiences of inequalities, there is a need to balance this with an upstream research focus on the social, economic and political drivers shaping spatial stigma (Whittaker et al., 2020) and the construction of disadvantaged places (Bambra et al., 2019). Our review has emphasised the importance of applying an intersectionality lens, which can help shift attention to the ways in which processes of exclusion interact to reproduce stigma and discrimination (Heard et al., 2020). Future research should consider the ways in which spatial stigma can be alleviated as part of upstream interventions that address common manifestations and drivers across multiple forms of stigma (Turan et al., 2019).

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