‘It's like being in Tattooville’

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Introduction

Explaining place-based health inequalities is a key focus of geographical research (see Bambra, 2016; Curtis and Rees Jones, 1998; Macintyre et al., 2002; Pearce et al., 2015 amongst others). Research has been dominated by studies of the effect of the retail environment (e.g. the density of alcohol, tobacco and fast food outlets [Shortt et al., 2015]); the physical environment (such as green spaces, brownfield land or air pollution [Shortt et al, 2011; Bambra et al., 2014]); the economic environment (e.g. area-level employment rates and income [Diez-Roux et al., 2001]) or the service environment (e.g. health care or housing [Macintyre et al, 2002]) on health inequalities. There has been relatively less focus on collective social functioning and practices – such as the role of social cohesion or history (Bambra, 2016). A particularly under-explored aspect of the influence of collective social functioning and practices on health inequalities, is the role of territorial or place-based stigma (Wutich et al, 2014). This paper uses ethnographic and qualitative methods to examine territorial stigma and health in two socially contrasting areas of a post-industrial town in the North East of England.

Spatial stigma is a social determinant of health in both its potential to directly affect health outcomes as well as its influence on structural conditions that shape health (Keene and Padilla, 2014). Low income neighbourhoods are vulnerable to being easily over associated with criminality, risk and danger; such reputations are often extended to the people who live there (Crossley, 2017). How people internalise and respond to this place-based stigma, and its impact upon health, is an emerging field of interest. This is particularly important during a time of austerity, with socio-spatially concentrated, major reductions in state investment in a range of welfare programmes and local service and infrastructure – potentially further stigmatising certain places (Pearce, 2012: 1922). Several studies have identified clear links between place-based stigma and health (see, for instance, Airey, 2003; Bush et al., 2001; Keene and Padilla, 2010; 2014; Kelaher et al., 2010; Pearce, 2012; Popay et al., 2003; Thomas, 2016; Wutich et al., 2014). Pearce (2012: 3) has described how being 'looked down on' due to being a resident of a highly-stigmatised setting is likely to be detrimental to

a number of life chances, such as education and employment. This, alongside developing interpersonal relationships, are all likely to be harmed due to the baggage of 'moral inferiority' that can be associated with residents of highly stigmatised communities (Bush et al. 2001). Wutich et al. (2014) identify how members of stigmatised groups are more likely to experience psychological distress, anxiety, and depression. For example, the social comparisons that residents of stigmatised communities make with others outside of their own neighbourhood can lead to high levels of psychosocial stress, which in turn can lead to increased rates of hypertension, coronary heart disease, and stroke (Link and Phelan, 2001).

The relationship between territorial stigma and the impact on residents' health and wellbeing, particularly mental health, have been explored by Kelaher et al. (2010) in their mixed methods study of a disadvantaged neighbourhood in Victoria, Australia. They found relationships between place-stigma and the social and self-esteem of residents, which were exacerbated by "postcode discrimination" (Warr, 2005) and highly charged language which was commonly used to describe the area. Wutich et al. (2014: 571) explain how the "experience of living in a stigmatised neighborhood may be so stressful it directly affects mental or physical health". Airey's (2003) research in a low-income neighbourhood in Scotland draws attention to how contextual features of neighbourhoods may exert psychosocial influences upon the well-being of individuals living within them. Airey (2003) suggests that when residents felt stigmatized and tainted by their neighbourhood's reputation, they experienced anger, shame, and other forms of psychosocial distress. It therefore follows that "studying the influence that experiences of place have upon well-being may shed light on the social processes which underpin geographical health inequalities" (Airey, 2003: 130). However, as Wutich et al. (2014: 556) explain: "the relationship between living in impoverished neighborhoods and poor health is well established, but impacts of neighborhood stigma on health are not well understood" – particularly in ethnographic terms.

The concept of territorial stigmatization forged by Loïc Wacquant (e.g. Wacquant, 2007; 2008; 2009; 2010) is defined as 'not a static condition or a neutral process, but a consequential and injurious form of action through collective representation fastened on place' (Wacquant et al., 2014: 1270). Slater (2015: 5) describes how we are witnessing "a phenomenon of spatial disgrace" distinct from other forms of stigmatization – such as that associated with poverty, race, or unemployment – a phenomenon that is exerting very real and harmful effects. A resulting 'blemish of place' (Wacquant, 2007) can then impact upon residents in several ways, disrupting their sense of identity and social interactions (Keene and Padilla, 2014; McNeil et al., 2015; Wutich et al., 2014). Territorial stigmatization can then aggravate existing inequalities, potentially leading to substantial negative consequences for health and wellbeing.

Graham et al. (2016: 111) emphasised that research should focus on "further describing and characterizing spatial stigma, the processes through which it is construed, and the mechanisms that may link spatial stigma to health outcomes". This is not an easy task, as it is difficult to know to what extent neighborhood stigma shapes negative health outcomes—above and beyond the effects of related and interlocking stigmas associated with poverty and race, ethnicity, or immigration status (Wutich et al., 2014: 558-9). In this paper, we explore how territorial stigma can affect residents' interactions with their physical and social environment; how they negotiate reputational stigma in relation to safety and fear; and the processes of identity formation and 'Othering' in a stigmatised neighbourhood. Specifically, we explore how these aspects of territorial stigma influence the health (including apparent health behaviours) of residents living in two socially contrasting areas of Stockton-on-Tees, a post-industrial town in the North East of England. Rather than aiming to prove a *quantitative* link between territorial stigma, place and health, instead we seek to *ethnographically* uncover what it *feels like* to live in an area tainted by place-based stigma, including how it feels to be a middle-class resident living nearby. Our findings conclude by emphasising a need to critically consider the discourse that surrounds stigmatised places, particularly in light of health concerns and ongoing austerity and cuts to local services.

Study design and methods

This article draws on data from the project 'Health Inequalities in an Age of Austerity: the Stockton-on-Tees study', a five-year, mixed methods project examining localised health inequalities in an era of austerity in the post-industrial town of Stockton-on-Tees, North East England. The borough has some of the highest spatial inequalities in England for both men and women, with life expectancy gaps of 15.1 and 12.7 years respectively between the least and most deprived wards (Public Health England, 2017). The Town Centre ward is the most deprived in the borough and is the 17th most deprived ward in England (Index of Multiple Deprivation, 2015). The ward experiences disproportionate levels of ill health, disability, and unemployment. Stockton-on-Tees and the surrounding areas of Teesside have long been subject to place-based stigmatisation (Bush et al., 2001; Shildrick et al. 2012). For example, in 2016, the second series of the 'poverty porn' television show 'Benefits Street' – a popular terrestrial 'reality' TV series in the UK about benefit recipients - was set in Stockton-on-Tees.

124 qualitative interviews, including eight ethnographic walking interviews, were completed across both areas between 2014 and 2017, alongside detailed participant observation, field notes, documentary research, and photographic data. The inclusion of walking interviews aimed to elicit "more refined theories of place and health that are grounded in the lived experiences of people being studied" (Carpiano 2009: 271). Participants were recruited following ethnographic observation and acted as gatekeepers with snowballing approaches used to recruit others. Fieldwork in the Town Centre ward began in November 2013, with participant observation and interviews carried out in a Trussell Trust foodbank (Garthwaite 2016), Citizen's Advice Bureau, children and family centres, community centres, gardening clubs, cafes, and coffee mornings, alongside engagement with charities, events and services in the area. From March 2014, participant observation began in Hartburn, the third least deprived out of the 26 in the borough, and one of the least deprived wards in England. Observations and interviews here took place at coffee mornings, yoga classes, cafes,

churches, mother and toddler meetings, a credit union, and community centres. Interviews that were arranged to take place in people's homes were recorded and transcribed verbatim. The age range of the overall sample of those interviewed varied from 16 to 78 years old and was almost equally split in terms of men and women. Ethnographic observations captured a wider age range.

Participation was voluntary, confidential, and secured by either verbal or written informed consent where possible. Themes explored during the interviews included: personal and family health; perceptions of the causes of health inequalities; relationship to and opinions of the local area; interests and social networks; employment history; and social security benefits. Participants were not asked directly about stigma but made the connections themselves during interviews and observations. Interviews were transcribed verbatim and the transcripts produced included references to both field notes made and photographs taken. Data were fully anonymised before transcripts were analysed thematically, using open coding to identify initial categories. Data was then further broken down into sub-themes, allowing us to compare and contrast data in a detailed manner. In this way, thematic content analysis was used to analyse the data and extract relevant relationships between study ethnographic observation and interview results. Participants' verbal accounts and non-verbal behaviours could then be analysed and coded in one dataset to give a fuller picture.

Findings

When asked about the life expectancy differences in Stockton, residents in both areas offered a range of explanations (Garthwaite and Bambra 2017) which were often tied to the reputational stigma and place-based disadvantage of living in the borough. Here, three key themes emerged from the data which show how territorial stigma may result in adverse health outcomes, particularly in relation to: (dis)engagement with the physical and social environment; safety and fear in navigating stigmatised locales; and identity formation and 'Othering' in a stigmatised neighbourhood.

(Dis)engagement with the physical and social environment

Residents across both areas identified individual and community characteristics that made (or did not make) their neighbourhood health promoting. Territorial stigma was linked to social and physical aspects of the environment; ethnographic walks enabled us to explore real and perceived boundaries of neighbourhoods for residents.

Following a £38 million regeneration programme unveiled in March 2015, the High Street features independent shops, regular farmer's markets, fountains, and art installations. This has resulted in the High Street winning a 2016 Great British High Street of the Year 'Rising Star' award. Despite this progression, residents from both areas were often critical of the town's rejuvenation and felt efforts to improve the area were "a waste of money, [as it is] still the same people" living in the area (Field notes, 16/4/15). Another key concern related to this is that investment and regeneration may not always benefit residents living in the area. As Slater and Hannigan (2017: 9) have suggested, "it should not be assumed that any investment is uniformly positive". They suggest that the appropriate question to ask, rather, is, "To what extent is any investment in stigmatized territories in the interests of their residents?" This sentiment is evident when speaking to Denise, 49, living in the most deprived area:

> "What they've done with the High Street, it's amazing. That fountain, it's unrecognisable. They're [the empty shops] all coffee shops now, it's nice but it's no good if you can't afford a coffee."

Despite living near the town, Denise felt excluded by her inability to participate in the newly regenerated retail environment. Throughout her interview, Denise spoke of how she had "no friends" and only socialised whilst working on the social care placement she was currently doing as part of her attempts to get back into employment, despite her poor physical and mental health. The

intersecting stigmas of social class and place are important when considering Denise's health. Kallin and Slater (2014: 1353) demonstrate how:

> "When a place becomes tainted by derogatory terms, images and discursive formations, there are not only everyday consequences for people living within it; symbolic defamation provides the groundwork and ideological justification for a thorough class transformation, usually involving demolition, land clearance, and then the construction of housing and services aimed at a more affluent class of resident."

Participants living in the least deprived area also spoke about their feelings of segregation between their neighbourhood and the Town Centre, but for different reasons. Residents living in the most affluent area discussed the importance of familial values and a child-centred lifestyle in explaining the life expectancy gap. An abundance of green space, proximity to a 'good school', and local amenities such as libraries and playgroups were cited as the most important health protecting features of the area. Living in the least deprived area, Jessica, 41, described the importance of the physical environment to the wellbeing of her and her family:

> "…it's ever so green, everyone has their own home and a garden front and back, they planted cherry blossom trees when these were first built and it gives a lovely burst of colour. Our gardens here are really big, that was a huge pulling point. And you can be walking here, everywhere, I feel very much like we're in a village. I think we've got pretty much all that we would ever need just here".

Many participants in Hartburn described how the appearance and availability of green space – environmental 'goods' (Pearce et al. 2011) - was conducive to leading a healthy lifestyle – there were parks to exercise in, and few takeaway shops selling unhealthy food – which contrasted with the numerous fast food outlets and lack of green space - environmental 'bads' (Pearce et al. 2011) - in the Town Centre. In contrast, the Town Centre was associated with unhealthy behaviours and an

environment that promoted obesity, drug and alcohol addiction, and smoking, all of which were suggested as explanations for health inequalities in the borough. Living in Hartburn, Katie, 41, drew attention to this when discussing the difference between Hartburn and the Town Centre:

> "You don't really see people smoking round here, very rarely even outside the pubs. Further into town you go, everyone's vaping or smoking and obviously if you've got a pound pub in your town like Stockton has then you're not really...you're just fuelling the fire, aren't you really."

Here, Katie refers to a local pub that sold alcohol for £1 for a half pint of beer from 8am, and points to the difficulties in living a healthy lifestyle in this kind of environment. Others in the least deprived area recognised that the differences between the areas could be attributed to wider processes of stigmatisation and inequality. During ethnographic walks, participants were asked to tour what they saw as "their" neighbourhood, as well as particular sites they might associate with good or poor health, and how these were tied to the reputation of the area. In an ethnographic walk around the Hartburn area, Steph, 42, said:

> "I bet you in an area like this if there were any potholes, or litter or vandalism, I bet the council would be out quick sharp because people would complain, this needs doing, they'd nag them until [it got done]. Whereas you go in other areas, poorer areas where there's more…not just litter but disrepair on the roads, on the pavements you know, say graffiti or whatever and it's not so much that's its tolerated by local people because I'd imagine they'd be like me and wouldn't like it but it's…I would say less gets done about it either because there's not as much outcry, or they wouldn't get the same response from the council possibly? I've gone in areas where I'm shocked at the state of the roads and pavements and I think 'Why is it acceptable to leave it like this, why should people have to live like this?'"

Steph is referring to salutogenic aspects of the environment; the resources of communities and neighbourhoods and the associated processes enabling these resources to be accessed for the benefit of the community's health and well-being are more easily accessible to residents of Hartburn than residents in the Town Centre. What Steph's quote also shows is how difficult it can be for residents living in the most deprived areas to feel fully connected to their neighbourhoods when they are subject to structural abandonment. The area can then be easily stigmatised as a "scummy" place to live – all comments attached to the most deprived parts of Stockton regularly throughout the research – which in turns feeds into the reputational taint of the area. As Keene and Padilla (2014: 399) explain, "this spatial stigma may also work to reinforce the disadvantaged conditions that exist in disparaged places by discouraging future investments".

People living in the most deprived parts of Stockton struggled to identify health-promoting features of their neighbourhood. Participants residing in the most deprived area described the many negative ways in which their mental health was affected – in terms of feelings of self-worth, for example – when faced with the inequalities present in their area. Living just outside of the Town Centre, Naomi, 36, recounts the 'felt stigma' she experienced when being present in the more expensive shops in town:

> "You can see certain people looking down their nose at you, just by the way you dress, your accent even cos even though we're from the same town they always seem to have a better accent than you, they pronounce their words properly so straight away you're different, they turn their nose up...even when you're in a shop as well, it's not very often I'll go in Marks and Spencer's but if there's a sale on I will go in cos there are some nice clothes in there, and you can see them looking at you...nah, I don't like it."

For Naomi, the felt stigma of being looked down on when shopping in a well-respected department store by people who are more affluent caused real psychosocial distress, with Naomi admitting that 'sometimes it can take me five changes of clothes before I feel comfortable to go out, and when I am

out I feel everyone's looking at me, paranoid'. Living in the most deprived parts of the area instigated a very real source of psycho-social stress because it engenders feelings of shame and embarrassment (Wilkinson 1996) which can then lead to a 'blemish of place' (Wacquant 2007) extending to - and embodied by - the individual, affecting their identity and psychosocial wellbeing. This was particularly relevant when residents spoke of fear and safety concerns related to the reputation of their communities.

Negotiating reputational stigma: safety and fear

Kelaher et al. (2010: 385) have described how problems of stigma are woven together with other difficulties in the neighbourhood, such as the crime rate, alcohol consumption, and street safety – all of which were offered by residents in this study as potential explanations of the large life expectancy gap in the area. This in turn can have an effect on psychosocial distress and engagement with the environment, as the previous section identified. Perceptions of safety and fear of the most deprived area were associated with pre-existing health inequalities, including how this could impact upon mental and physical health. Residents in both the most and least deprived areas regularly associated safety concerns with living in the Town Centre, whilst Hartburn was seen as "a different world" (Field Notes 16/4/15) where people have a "better sort of job, you're out on the golf course, you have nice holidays, a house with plenty of toilets, nice bathrooms" (Dennis, walking interview). Stockton Town Centre was regularly described in highly loaded, stigmatising terms such as "Tattooville", "a ghetto", "Dickensian", "a dump", "scummy" and "grotty". In contrast, Hartburn was labelled as "idyllic", "beautiful", "ideal", "classy", and "a dream". Tim, 69, living in Hartburn, the least deprived area, discussed what he believed was the presence of anti-social behaviour which led to him and his wife avoiding the town:

> "The people you see when you go in, the drunkenness if you go in later in the day, probably the drugs as well playing a part, the language as you're walking around...it's not a pleasant experience to go because you've got to go to the bank or whatever".

Structural inequalities resulting from declining investment and deindustrialisation can "be embodied by residents and incorporated into their identities and reputations", as we see in Tim's quote above, "particularly when residents themselves are perceived to be responsible for creating these conditions" (Murphy 2012, cited in Keene and Padilla 2014: 394). These practices can then lead to a continuation of place-based stigma and impact upon pre-existing health inequalities.

Living in Hartburn with her husband and two children for over nine years, Jessica agreed, and commented:

> "I don't like going in [to town] because it makes me sad. I feel as though I look different and I feel very, very conscious of that. My bag I hold that extra bit tightly without actually even meaning to do it. And then I'm thinking 'Why is it there are so many young people in town with babies and pushchairs, and other groups of young people who obviously aren't at work or at college?' And it makes me think about their lives, and why aren't they doing that? There's almost this air of sadness. There's this whole kind of underclass of people I guess, who are there, who exist but who almost people can go past without ever really seeing them. And you do, you know there is this big change and big disparity in people, but you don't have to see it if you don't want to. Yet they're so near us, it's miles away, if that."

Jessica identified how she looks physically "different" from people who she sees in the Town Centre, resulting in feelings of fear, sadness and disbelief at the vast health and wellbeing inequalities in the borough. This ties into findings from Davidson et al. (2008) who note how premature ageing due to deprivation is "written on the body". In this sense, spatial stigma becomes attached to individuals living in the neighbourhood by those in the more affluent areas. Such a perspective was not limited to those living in the more affluent parts of town. Peter, the manager of a drug and alcohol treatment service in the Town Centre, emphasised the existence of "no-go areas" in the town, which were perceived as too risky and unsafe to enter due to high levels of drug dealing, drug taking and poor quality, transient housing:

> "I mean if you talk to anyone in the area and say, 'Do you go down Harley Road?' they don't. They keep away from the area, in effect it's causing...I suppose you could say a ghetto".

Considering the impact of territorial stigma on residents of Chicago public housing projects, Wacquant (2008) has described how spatial defamation contributed to pervasive fear of its residents. He also found that this defamation was often applied to residents by their neighbours, in a process of lateral denigration that contributed to social isolation – as we have seen clearly in the quotes selected above.

Fears over safety were also linked to the presence of sex workers in the area. Melinda, 44, lived in what she termed "Stockton's red-light district", a street just outside of the Town Centre, with her two young children. She said:

> "You don't feel safe letting your children out, not even in the daylight really. I spent years paying for them to go to theatre school after school just so they weren't on the streets. When they were younger and were just playing on the street [that was ok], but when they got older and wanted to go to the next street, where I couldn't see them that was the period when I said 'No, you've got to do activities somewhere safer' and that was a big overdraft for me. I was quite concerned it was bringing predatory threats into my neighbourhood".

Like Airey's (2003) study, here Melinda related her negative perceptions of the perceived 'riskiness' of the neighbourhood to the wellbeing and safety of her family. A designated 'Other' was often formed in participants' narratives when discussing Stockton and their neighbourhood, a process of lateral denigration (Wacquant 2008) that will be explored further in the third theme.

Identity formation and 'Othering' in a stigmatised neighbourhood

In our study, participants attempted to avoid further stigmatisation by distancing themselves from a problematic 'Other', a concept of lateral denigration that applies to neighbours rather than to themselves (Keene and Padilla 2018; Thomas 2016; Wacquant 2008; Garthwaite 2015). Identity

formation was linked to this characterisation of a perceived 'Other', particularly when reflecting tensions over incoming immigration in and around the Town Centre. Denise, 49, did not engage with the Town Centre very frequently, as she believed it had "changed beyond words" since she recently moved back into the area after living outside of the borough for five years:

> "Hell of a change really, I can't say for better or for worse. It's gone from druggies and drunks to Africans, it scared the life out of me when I come back here."

In 2016 Stockton-on-Tees had the 5th highest population of asylum seekers per head of population in the UK (Millar 2016), many of whom are housed in and around the Town Centre. Headlines such as 'Poor North dumping ground for migrants: Many towns are SWAMPED' (Young, 2016, original emphasis) reminded residents of this. Immigration was a topic discussed across both research sites, and ethnographic observation witnessed a steady increase of people seeking asylum in the Town Centre, particularly in the foodbank and when spending time in the High Street.

An interview with husband and wife Glen and Tracey following an initial meeting at the local foodbank showed neighbourhood tensions clearly linked to race. Disassociating himself from Stockton as a place, Glen, living on an estate in the Town Centre ward, readily distanced himself from the 'Others' he believed were living there:

Interviewer:	And do you like Stockton as a place to live?
Glen:	Naw...naw wouldn't want to live in Stockton
Tracey:	Well this is classed as Stockton, Glen! (laughs)
Glen:	I like round this area where we are, there's too many different colours and types of people in Town Centre, if you see what I mean

When asked about the life expectancy gap in the area, for Glen, the ethnic diversity in the Town Centre offered an explanation. It also meant that he was keen to detach himself from a place which

he labelled as “dirty” and “not for us” in the rest of the interview. In this way, Glen was ‘‘thrusting the stigma onto a faceless, diabolized Other’’ (Wacquant 1996, cited in Keene and Padilla 2010: 1219). Participants actively dissociated themselves from social problems that they identified in the area by emphasising the ‘‘Otherness’’ of the people deemed to give the area a bad name. People therefore distanced themselves from problems and health behaviours that fed into negative representations of Stockton as a place. This theme of disidentification was also found in Airey’s (2003) work, who argues that “engaging in distancing strategies may represent a potentially important way in which the respondents exert their agency in order to resist psycho-social stressors associated with the social environment.”

A further example of this can be identified in the many discussions about the newly installed fountains on the High Street; they became a symbolic space for situating territorial stigma. The following extracts from ethnographic walking interviews show the tensions the fountain evoked. Dennis, 64, living in the least deprived area, said:

> “See this is one of the nicer features of Stockton I think, this water fountain. We’ll go and have a look… [we go and sit by the fountain] I’ve heard this called the biggest changing room, allegedly this is where immigrants come to have a shower and get changed. Now there’s nobody in the shower at all, I’m looking round here and I’d say the four lads we just walked past there weren’t British people but they’re not doing any harm, sat eating a bag of chips”.

Racialised tensions and stereotypes when discussing the centre of Stockton were heard frequently through fieldwork and were related to wider discussions of who the physical and social environment of the town centre was ‘for’. Macintyre et al. (1993) have identified neighbourhood reputation as a central socio-environmental influence upon the self-esteem and morale of residents. Their work suggests that neighbourhood reputation may be understood to be a psycho-social influence upon

well-being. The following extract from the walking interview with Lauren shows how self-esteem and identity can inhibit people's ability to take care of their health and wellbeing:

> "I think you do need the drive to think "I'm important and I will take care of myself". Round here it's really difficult to get on. People who do get on seem to do it outside the area, they may come back but…come back to what? Cos the jobs aren't here.

Macintyre et al. (1993) show how identity formation was closely linked to the way in which respondents described the negative reputation of their area, resulting in them struggling to personally identify with their neighbourhood and seeking to distance themselves from it – a process described by Lauren above. These distancing strategies in turn contributed to social isolation, suggesting territorial stigma can permeate residents' lives in disadvantaged neighbourhoods. These processes can then lead to a widening of pre-existing health inequalities.

Discussion

Territorial stigma and the stigma ascribed to people living within those places – by residents and non-residents alike - had clear links to psychosocial strain in the everyday lives of people living in the most deprived neighbourhoods. The perceived, or felt, stigma and its consequences were seen clearly in the participant narratives. Graham et al. (2016: 111) have found that retreating from social networks or avoiding particular places may reflect 'identity work' that participants employ as they attempt to distinguish themselves as being different or distinct from others, but it may also reflect some internalisation of stereotypes about the neighbourhood and its residents who are perceived to be dangerous influences. This reflects two of the strategies identified by Wacquant (2011, cited in Wacquant et al. 2014: 1276) as being useful in coping with territorial stigma: retreating into the private sphere; and lateral denigration, whereby residents accept a dominant stigmatising discourse, but insisting that it applies to their neighbours and not themselves (Wacquant 2008). Wutich et al.'s (2014: 561-2) 'neighbourhood stigma scale' designed to capture both "enacted stigma" (actual

experience of discrimination) and "perceived stigma" (internalized or felt stigma) that includes shame, secrecy or withdrawal, and fear of discrimination provides a further important distinction when considering our findings. For participants in this study, perceived stigma was a powerful and pervasive experience that was felt across the socio-economic spectrum, whether people experienced stigma or attached stigma to particular locales. Participants identified various health-related effects of this stigma – particularly in terms of mental wellbeing, and also the psychosocial pathways connecting stigma to ill health including fear, stress and isolation.

When looking at perspectives of residents from the least deprived area, the Town Centre is consistently presented as a risk-laden, unattractive place – people are drunk on the High Street, they use bad language, and people "look different" to their affluent neighbours. Unhealthy lifestyles are considered to be the norm, facilitated by numerous fast-food outlets and pubs selling cheap alcohol. Birdsall-Jones distinguishes stigmatisation, where "areas of deprivation are created in the mind" from ghettoisation, where they are created in space (2013: 316): "there exists in people's minds…those dark spaces where the good people ought not to go" (2013: 324). This is helpful in understanding perspectives of the Town Centre, as we can see how both stigmatisation and ghettoisation fused together to create the descriptions of the area as "Dickensian", "scummy" and "a dump". Living in an area tarnished by such a 'blemish of place' can then impact upon your mental health and wellbeing, as it can lead people to retreat into the private sphere to avoid such stigmatisation. Keene and Padilla (2014: 400) explain how spatial stigma can lead to "health demoting stress when individuals… are exposed to negative interpersonal dynamics as a result of their association with a vilified locale". A resultant 'blemish of place' can add an additional layer of disadvantage to any existing stigma that is associated with people's poverty, culture, or ethnicity (Rogers et al. 2017: 179).

As community bonds fragment and residents withdraw from public spaces, a "dissolution of place" (Wacquant 2008:241) can occur. This can lead to a "diversion of public opprobrium onto scapegoats

such as notorious ‘problem families’ and foreigners, or drug-dealers and single mothers” (Wacquant, 2008: 183). For instance, stigma created through ‘‘defensive othering’’ in Stockton-on-Tees was not only associated with class or with the local area, but also with ethnicity (Keene and Padilla 2010), particularly when participants discussed the Town Centre. This resulted in ‘symbolic and material boundaries’ (Parker and Karner, 2010: 1452) being formed, which can then lead to social isolation and a withdraw from collective life that has a negative effect upon health and wellbeing (Keene and Padilla 2014).

In seeking to tackle place-based stigma and its capacity to both negatively impact on health and reinforce social inequalities (Keene and Padilla, 2014) the importance of challenging popular discourses around stigmatized places promoted in political rhetoric (Hancock and Mooney 2013) and mass media representation is key. They note how “the contrasts drawn between “problem” places and populations and supposedly “normal” places and people reflect classed assumptions about deprived working-class communities” (Hancock and Mooney 2013: 54) which become important when we think about consumption, taste, lifestyle and health – all of which were drawn on by residents in both areas when discussing the prevalence of health inequalities in Stockton-on-Tees. In Stockton-on-Tees territorial stigma has “become nationalised and democratised” with the second series of Benefit Street being filmed there in 2014. Set amidst a backdrop of an estate which showed litter, empty beer cans, and horses freely roaming the streets, the show depicted frequent criminal activity and a lack of education amongst the residents. Beneath the exterior presented to viewers, though, clear social networks were present, but also obvious were physical and mental health issues such as depression, substance abuse, and disabilities. Now, the area is “renowned and reviled across class and space as redoubts of self-inflicted and self-perpetuating destitution and depravity” (Wacquant et al 2014: 1273) are increasingly associated with it. Crossley and Slater (2014, unpaginated) have argued that:

> "Benefits Street, in both title and content, is a pure exemplar of territorial stigmatization, both in terms of its (re)production and in the way it serves to counterpose "problem" places and populations against supposedly "normal" places and people."

In an Australian context, Warr (2005) identifies the salience of television and other media whose 'negative … attention amplifies and cements the quotidian prejudices that are experienced by people living in 'discredited' neighbourhoods'. The resultant impact upon health and wellbeing is likely to be a detrimental one, causing further psychosocial stress and exacerbating health inequalities.

Conclusion

This paper has drawn on extensive ethnographic and qualitative field work to explore territorial stigma and its association with health inequalities in a post-industrial town. We found that the stigma ascribed to particular places can move beyond the place and become attached to the people living there – and impact on their health - through three key psychosocial pathways: (dis)engagement with the physical and social environment; safety and fear in navigating stigmatised locales; and identity formation and 'Othering' in a stigmatised neighbourhood. Our findings highlight a need to critically consider the discourse that surrounds stigmatised places, as such a 'taint of place' can often extend to the stigmatisation of people living there, leading to widening structural inequalities.

At a time of ongoing cuts to local services, further reducing the availability of support in places such as Stockton will mean there is a real danger of further spatial stigmatisation which is likely to be detrimental to the health of residents. Link and Phelan (2001) argue that the construction and maintenance of stigma is entirely dependent on social, economic, and political power. An imbalance of power favours and privileges some groups over others and creates injustice and disadvantage that influences life experiences and subsequent health outcomes. The story we need to tell about health

inequalities is that it is bad not just for those who are most directly affected, but also for society as a whole (see Wilkinson and Pickett 2009). Inequality also affects those living in the least deprived neighbourhoods, as our findings suggest. Furthermore, as Tyler has observed (2013: 212) "stigmatization operates as a form of governance which legitimises the reproduction and entrenchment of inequalities and injustices which impact upon us all."

Finally, the approach we take as researchers, community organisers, policy makers, and decision makers should be informed by people who are living in areas with deep inequalities. Smith and Anderson (2018) have warned that how health inequalities and their causes are discussed can have a further (unintentional) negative effect upon feelings of stigma. They suggest that "alternative approaches to engaging communities in health inequalities discussions are required" (2018: 146). Taking an ethnographic approach such as the one outlined here is a first step in beginning to do this. However, future research and policy development should ensure co-production in the research process from design to dissemination, involving local residents from all socio-economic backgrounds in decision making.

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