Stigma and the Social Safety Net

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200-word summary:

Stigma features prominently in debates about the social safety net, but empirically disentangling its role has left open many questions about whether it is a meaningful—or movable—barrier to take-up. Through four nationally representative studies (N = 11,164) and a new four-dimensional validated scale, we quantify the role that stigma plays in shaping take-up (1) directly, by impacting beneficiary behavior, and (2) indirectly, by influencing program design. We find that a one standard deviation (SD) increase in stigma is associated with a 9-19 percentage point *decrease* in willingness to apply for benefits among low-income respondents. It also predicts a 0.08-0.40 SD increase in society's preferences for policies and program design features that could reduce program access. In both cases, we show that stigma explains more of the variation in policy preferences than any individual respondent characteristic, including political ideology. Notably, program design causally impacts stigma in competing ways: more expansive eligibility criteria reduce stigma, while implementation designs that would simplify access increase stigma. Together, these findings suggest that stigma should be considered both an individual and structural barrier to participation in the social safety net, where it both shapes and is shaped by policy design choices.

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The social safety net in the US provides essential benefits such as food, housing, and healthcare to nearly 100 million people — around 30% of the population (King & Drotning, 2025; Macartney & Ghertner, 2023). These benefits are very effective at lifting households out of poverty and have been shown to have positive long-term impacts on health, economic, and education outcomes (Bailey et al., 2024; Dahl & Lochner, 2012; Schmidt et al., 2016). Yet, as many as half of those who are eligible for government benefits programs do not participate (IRS, 2025; Macartney & Ghertner, 2021). An extensive literature examines the potential drivers of this take-up gap, with more recent studies exploring the role of informational, logistical, and psychological burdens and how they disproportionately impact the lowest-income households (Currie, 2004; Heinrich, 2016; Herd & Moynihan, 2019; Ray et al., 2022; Shepard & Wagner, 2025). But despite this growing literature, many open questions remain: Why have efforts to reduce burdens yielded mixed results and, even when they have been effective, why have they not closed take-up gaps? Why do people fail to participate in programs even when the benefits unambiguously outweigh the hassle and informational costs? If administrative burdens have been shown to impede access to benefits, why does policy support for them remain high? In this paper, we argue that one potential explanation for each of these questions lies in a more comprehensive understanding of the stigma associated with the social safety net.

The pervasive stigma associated with poverty and "welfare" has been well-established in both survey and qualitative research (Barnes et al., 2023; Baumberg, 2016; Celhay et al., 2022; Gilens, 1999; Lauter, 2016; Moffitt, 1983; Stuber & Kronebusch, 2004; Stuber & Schlesinger, 2006; Terhaar et al., 2025). Yet, the relative role of stigma in driving the take-up gap has been surprisingly underexplored. With a few notable exceptions, research aimed at understanding and increasing participation in social safety net programs has mostly targeted informational and compliance hurdles to participation (Finkelstein & Notowidigdo, 2019; Giannella et al., 2024; Herd et al., 2025; Kim et al., 2025; Linos et al., 2022; Linos et al., 2025; Remler & Glied, 2003). The limited number of studies that have tried to isolate the role of stigma have yielded mixed results and conflicting hypotheses about whether stigma is a meaningful — or movable — barrier to take-up (Anders & Rafkin, 2022; Bhargava & Manoli, 2015; Celhay et al., 2022; Lasky-Fink & Linos, 2024; Schanzenbach, 2009).

This apparent contradiction may reflect three features of the existing literature. First, in the absence of a common measurement tool, studies conceptualize and operationalize stigma in different ways, which may contribute to inconsistent empirical findings. Second, most quantitative analyses examine stigma in relation to a single safety-net program or treat the welfare state as a monolithic institution, thereby obscuring potentially consequential variation across programs. Third, the evidence base may underestimate the indirect pathways through which stigma shapes participation, implicitly conceptualizing stigma as an independent barrier rather than as a force that could also operate through informational and compliance channels. This paper addresses each of these issues in turn and further extends the literature by considering the program-level factors that causally drive stigma.

Our data come from four nationally representative survey experiments conducted from August 2024 to May 2025 (Table 1). We first propose and validate a four-dimensional scale to measure the stigma associated with the social safety net. Using this scale in a large-scale survey experiment, we document significant variation in perceived stigma by respondent characteristics, as well as across programs and dimensions. For instance, we show that stigma varies significantly by respondents' political ideology and experience using benefits, among other factors. But we also find even more variation, in some cases, by type of benefits program and by stigma dimension, which warrants further attention as we consider the drivers of persistent take-up gaps. Indeed, we offer evidence that stigma may contribute to take-up gaps both directly, by significantly reducing willingness to apply for benefits among low-income individuals, and indirectly, by shaping broader policy preferences around the design of the social safety net. In fact, we find that stigma is a stronger predictor of willingness to apply for benefits programs than any individual respondent characteristic, including political ideology. Further, through a series of decomposition analyses, we show that stigma also explains a substantial proportion of the variation in policy preferences that is often attributed to political ideology or other mindsets. Finally, in a follow-up conjoint experiment, we isolate the causal effect of program design features on stigma. We find two seemingly conflicting patterns: programs with more expansive eligibility criteria are less stigmatized, yet design features that simplify implementation and, presumably, expand access — such as unrestricted cash benefits or reduced compliance requirements — *increase* stigma. Taken together, these findings point to an urgent need for more scholarly attention to how stigma affects decision-making, as well as the design and implementation of social safety net programs.

Table 1. Study overview

Study	N	Sample	Purpose
Study 1a*	1,528	Nationally representative sample recruited via Prolific	Exploratory Factor Analysis (EFA) to conceptualize and measure the stigma associated with the social safety net.
Study 1b	1,260	Nationally representative sample recruited via Prolific	Confirmatory Factor Analysis (CFA) to conceptualize and measure the stigma associated with the social safety net.
Study 2*	4,376	Nationally representative sample recruited via YouGov, oversampled low-income respondents	Measuring the direct and indirect channels through which stigma may drive the take-up gap.

Study 3*	4,000	Nationally representative sample recruited via YouGov	Measuring what factors causally drive the stigma associated with the social safety net?

*Pre-registered on OSF (see https://osf.io/6fju9/files/4mh7j; https://osf.io/fdjc9/files/mvczx; https://osf.io/b8eqx/files/p4ntm).

Developing a Comprehensive Measure of Stigma

To develop a comprehensive measure of stigma, we began with 49 potential items adapted from related literature, each measured on a seven-point Likert scale. We then constructed a scale in two steps. First, we conducted an exploratory factor analysis (EFA) using all 49 items to identify the latent constructs underlying the correlations between measures and to reduce the number of items per construct for ease of use (Study 1a). Second, we conducted a confirmatory factor analysis (CFA) to evaluate the factor structure identified through the EFA (Study 1b). Each study used a separate nationally representative sample recruited through Prolific. Additional details on sampling, survey implementation, exclusions, and analytical decisions are provided in the Supplement (see Section III.C). This process yielded a four-dimensional stigma scale, with the following items and conceptualization:

1. **Societal stigma:** The negative beliefs, attitudes, and stereotypes about beneficiaries or prospective beneficiaries of means-tested programs.
    a. Most people who receive [program name] are poor because of the choices they make.
    b. Most people who receive [program name] waste money when they have it.
    c. Most people who receive [program name] expect someone else to solve their problems.
    d. Most people who receive [program name] do not contribute their fair share to society.
2. **Internalized stigma:** The shame, poor self-efficacy, or low self-worth associated with being a beneficiary or labeled as a beneficiary of means-tested programs.
    a. I would think less of myself if I received [program name].
    b. I would be ashamed if I received [program name].
    c. I would feel inadequate if I received [program name].
    d. My self-confidence would remain the same if I received [program name] (reverse-coded).
3. **General anticipated stigma:** Expectations of being the target of prejudice or discrimination because of an association or perceived association with means-tested programs.
    a. Other people would look down on me if they knew I received [program name].
    b. Other people would think I lack a work ethic if they knew I received [program name].

c. Other people would think I was inferior if they knew I received [program name].

d. If people knew I received [program name], they would see me as weak.

4. **Anticipated treatment stigma:** Expectations of being the target of prejudice or discrimination specifically in the process of accessing or using means-tested benefits.

a. I would be treated fairly when using [program name] (reverse-coded).

b. When applying for [program name], I would be treated respectfully (reverse-coded).

c. I would be treated poorly when applying for [program name].

Summary statistics for each dimension are reported in the Supplement (Table S7). We use this scale as our primary outcome in Study 2.

Individual and program-level predictors of stigma

In Study 2, respondents were shown brief descriptions of one of six means-tested programs or Social Security — a universal entitlement program that is not means-tested. We then examined the individual-level correlates of each stigma dimension, as well as the variation in stigma by program, controlling for individual characteristics.

Variation by individual respondent characteristics

In absolute terms, reported internalized, general anticipated, and anticipated treatment stigma are all higher than reported societal stigma. This may be due to demand effects or a more deep-rooted difference between how a respondent would view their own experience if they were a program participant compared to how they view other program participants. But we also find variation in the predictors of each dimension.

As shown in Figure 1, both societal and internalized stigma vary significantly by individual respondent characteristics. For instance, societal stigma is 0.21 standard deviations (SD) lower among Black respondents than White respondents; 0.15 SD lower among college-educated respondents; 0.16 SD lower among low-income respondents; and 0.31 SD lower among respondents who currently receive government assistance[1] (all means regression-adjusted; see Supplement Table S12). We see some similar patterns for internalized stigma, which is 0.40 SD lower among Black respondents than White respondents; 0.18 SD lower among low-income respondents; and 0.37 SD lower among respondents who currently receive government assistance. Yet, there are also some notable differences in predictors of each dimension. For example, internalized stigma is 0.11 SD *higher* among college-educated respondents than non-college-educated respondents — the opposite pattern as what we see for societal stigma. And despite these large differences in societal and internalized stigma, we see less variation in general

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[1] Based on self-reported answer to the question "Do you or someone in your household currently receive government assistance?"

anticipated stigma and anticipated treatment stigma: race, current benefits use, and trust in government significantly predict both dimensions of anticipated stigma, but we see little variation by education, ideology, or income. This suggests that conceptualizing stigma as a single construct obscures meaningful variation in levels of stigma, as well as its predictors.

By far, the strongest predictor of both societal and internalized stigma is political ideology. Societal stigma among liberals is almost a full standard deviation lower than among conservatives (0.91 SD, $p < .001$), while the ideological gap in internalized stigma is smaller, but still significant (0.42 SD, $p < .001$). If we instead examine differences by party affiliation, we see a similar pattern: societal stigma is 0.72 SD lower among Democrats than Republicans, and internalized stigma is 0.30 SD lower (both ps $< .001$). Below, we explore whether these large ideological differences in stigma also explain differences in behavior and policy preferences.

Variation by program

Much of the literature documenting the stigma associated with the social safety net focuses on "welfare" as a single, all-encompassing construct, or on individual programs, such as the Earned Income Tax Credit (EITC) or the Supplemental Nutrition Assistance Program (SNAP) (Bhargava & Manoli, 2015; Celhay et al., 2022; Gilens, 1999; Moffitt, 1983). In Study 2, we examine stigma across programs, as well as between means-tested and non-means-tested programs. We find that the stigma associated with means-tested programs is 0.31 to 0.74 SD higher than the stigma associated with Social Security — a universal entitlement program (all ps $< .001$). This offers additional empirical evidence that people view the social safety net and its participants as fundamentally different from other types of government benefits and programs.

However, we also document significant variation in stigma across different means-tested programs (Figure 2). Even after controlling for respondent characteristics, the societal stigma associated with rental assistance and Temporary Assistance for Needy Families (TANF), the most highly stigmatized programs, is 0.26 SD higher than for Medicaid, the least stigmatized program ($p < .001$). This is nearly one-third of the overall 0.91 SD gap in societal stigma between conservatives and liberals. Variation in internalized stigma is even larger. The gap in internalized stigma between TANF and Medicaid is 0.47 SD, which is *larger* than the gap in internalized stigma between conservatives and liberals. Although there is less variation by program in general anticipated stigma and anticipated treatment stigma, TANF and rental assistance are still significantly more stigmatized than Medicaid and the EITC along these dimensions. Notably, both the patterns and magnitudes of these differences are similar among liberal and conservative respondents — despite the fact that the overall stigma associated with means-tested programs is much higher among conservatives than liberals.

Taken together, this underscores the need to not only differentiate the dimensions of stigma, but also to disaggregate "welfare" into its specific programs. Just as conceptualizing "stigma" as a single construct may obfuscate variation across dimensions and individual characteristics, so too does conceptualizing "welfare" as a single construct. Uncovering and

quantifying this variation could help inform interventions aimed at shifting stigma and improving outcomes. In fact, our findings suggest that studying — and shifting — stigma in the context of the EITC may be fundamentally different than in the context of TANF. This could help explain some of the mixed results from existing experimental studies.

Figure 1. Variation in stigma by respondent characteristics
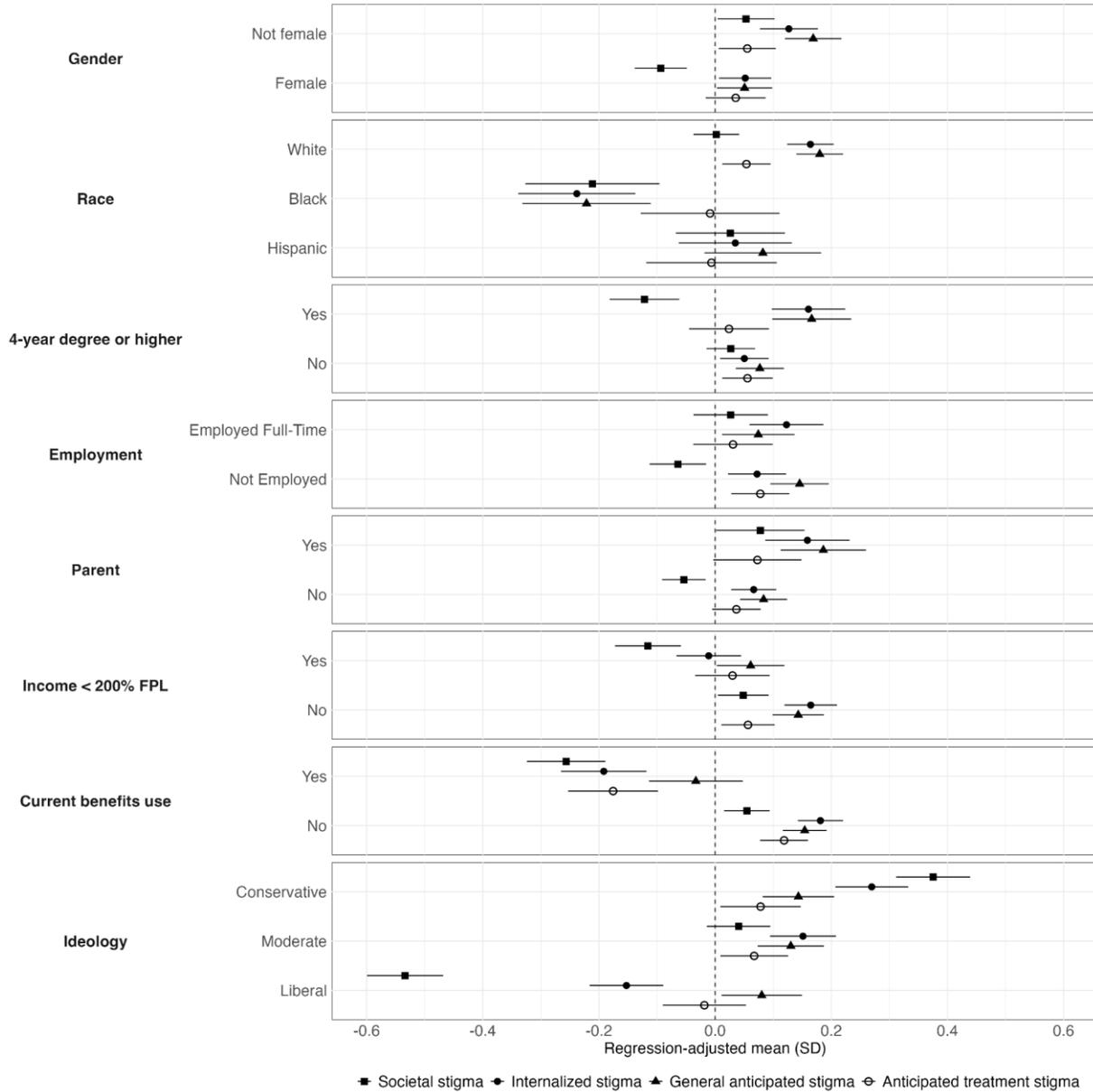
Notes: Regression-adjusted means from equation (1) showing the level of stigma (standardized) associated with key respondent characteristics. Bars indicate 95% confidence intervals. Categories comprising less than 10% of respondents are not shown. N = 3,741.

Figure 2. Variation in stigma by benefits program
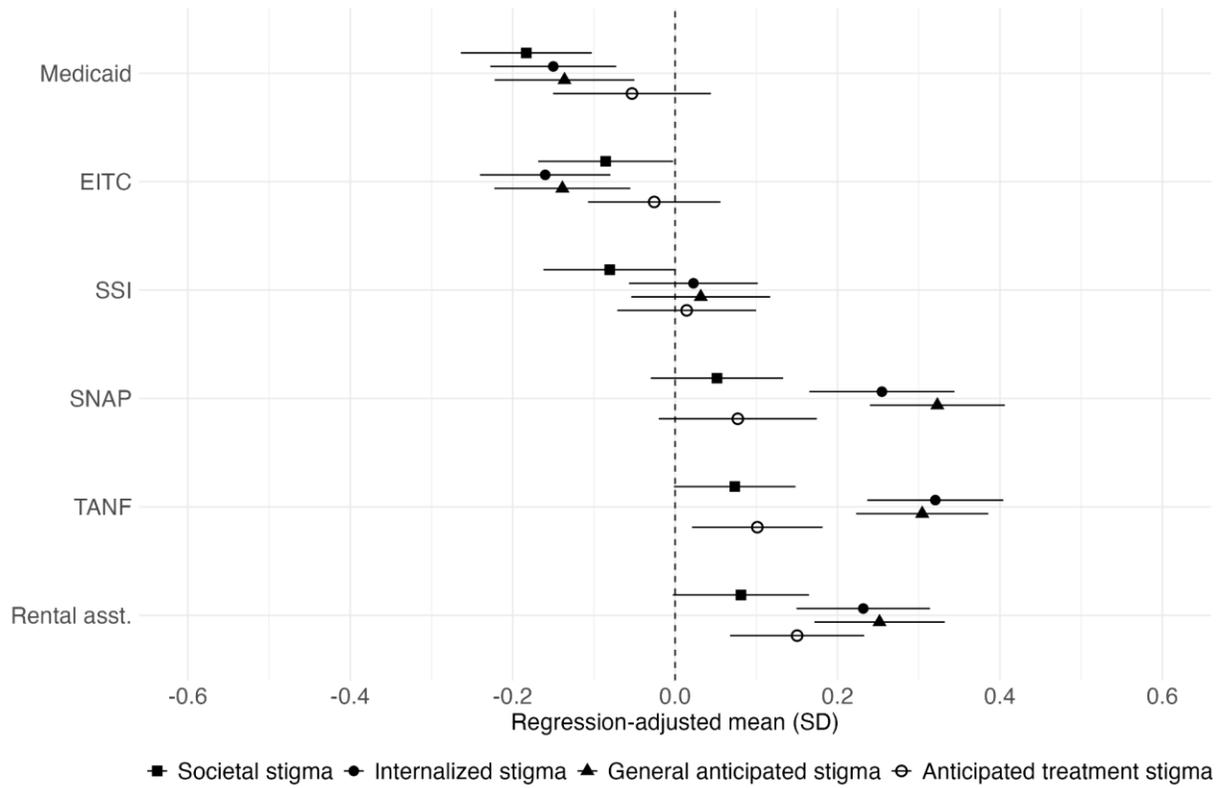
Notes: Regression-adjusted means from equation (1) showing the level of stigma (standardized) associated with each means-tested program. EITC = Earned Income Tax Credit; SNAP = Supplemental Nutrition Assistance Program; SSI = Supplemental Security Income; TANF = Temporary Assistance for Needy Families. Bars indicate 95% confidence intervals. N = 3,741.

Stigma affects take-up directly and indirectly

Extant literature focuses primarily on examining the direct relationship between specific burdens (informational, compliance, or psychological) and beneficiaries' willingness to participate in a given program. We posit that stigma could affect participation in the social safety net through two channels: directly, by influencing beneficiary behavior; and indirectly, by influencing the design of and support for safety net programs. On the one hand, eligible potential beneficiaries may forgo program participation because of feelings of shame or reduced self-worth, or out of fear of being judged, mistreated, or discriminated against by others. Put differently, we hypothesize that internalized and general anticipated stigma are stronger predictors of willingness to apply for benefits programs than societal stigma. On the other hand, stigma may also indirectly affect participation by influencing voter and policymaker preferences for the design and generosity of benefits programs. For instance, program design features, such as additional work requirements or more frequent recertification, have been shown to impede access to programs, especially for the most vulnerable (Fox et al., 2022; Herd & Moynihan,

2025; Shepard & Wagner, 2025). To the extent that stigma affects support for these types of hurdles, it may indirectly impact take-up by making participation harder for target beneficiaries. We hypothesize that societal stigma is the most predictive of policy preferences that could influence program take-up in this way. To examine this empirically, in Study 2, we measure three categories of critical policy-relevant outcomes: (1) willingness to apply for benefits programs; (2) burden tolerance; and (3) support for the social safety net. We then evaluate the relationship between these outcomes and stigma.

Quantifying the relationship between stigma and willingness to take up benefits

Self-reported willingness to apply for benefits programs varies significantly by type of program, ranging from 59.2% (TANF) to 74.7% (Medicaid), even after controlling for individual respondent characteristics. These rates are loosely aligned with the real-world estimated take-up gap for each program, although TANF is a notable outlier (Supplement Table S1). Surprisingly, willingness to take up a given benefit does not vary meaningfully by race, education, employment, or parental status, but we do see small differences by age and gender, as well as large differences by political ideology and current benefits participation. On average, liberals are nearly 20 pp more likely to say they would participate in a given program than conservatives (77.3% vs. 57.7%, regression-adjusted). This difference is almost as large as the gap between those currently on (any) benefits and those who are not: 84.7% versus 60.8%, respectively.

If stigma influences willingness to apply for benefits programs, it could directly contribute to observed take-up gaps. Indeed, as shown in Figure 2, we find a significant relationship between each dimension of stigma and take-up: a one standard deviation *increase* in stigma is associated with an 8.3 pp to 18.3 pp *decrease* in willingness to apply for benefits programs (all ps < .001). While this relationship is remarkably consistent across all income levels, from a policy perspective, we may be most interested in low-income respondents who are the most likely to be eligible for means-tested programs. Among low-income respondents, all four dimensions of stigma have a large and significant relationship with willingness to apply for benefits programs, but internalized stigma is, by far, the strongest predictor: a one SD increase in internalized stigma is associated with a 18.8 pp decrease in willingness to take up benefits (p < .001). In comparison, a one SD increase in societal stigma is associated with a 12.3 pp decrease in willingness to apply for benefits among low-income respondents (p < .001). While both relationships are highly significant, the *difference* between these coefficients is also significant (p < .001). Meanwhile, the relationships between general anticipated stigma and anticipated treatment stigma and willingness to participate in benefits programs are smaller, but still highly significant (all ps < .001). This points to one potential pathway for targeted take-up interventions: shifting internalized stigma may be more feasible than shifting societal stigma, especially in the short-term, and may also have a larger impact on take-up behavior (e.g., Lasky-Fink & Linos, 2024). Moreover, reducing real or perceived judgment by others may not shift take-up gaps as much as directly targeting internalized stigma.

*Quantifying the relationship between stigma and policy preferences*

A second pathway through which stigma could affect take-up is by indirectly influencing burden tolerance: society's willingness to accept government imposed compliance hurdles — such as work and documentation requirements — which have been shown to have broad support, but also a large negative impact on access to programs (Baekgaard et al., 2025; Haeder & Moynihan, 2024; Haeder & Moynihan, 2023; Halling et al., 2023). We examine this relationship by using a four-item scale developed by Baekgaard et al. (2025) to measure burden tolerance. In line with existing literature, we find that burden tolerance varies significantly by political ideology, trust in government, current benefit use, and education level. Again, we see the largest differences by political ideology, with a 0.86 SD gap in burden tolerance between liberals and conservatives (Table S22). Importantly, all dimensions of stigma significantly predict burden tolerance, although in this case it is societal stigma — not internalized stigma — that is the most predictive. A one standard deviation increase in societal stigma predicts a 0.40 SD increase in burden tolerance ($p < 0.001$; Table S23).

We see a similar pattern for more traditional policy preference questions around government priorities and spending. Specifically we examine the following additional outcomes: (a) three measures of support for programs intended to help the poor (Alesina et al., 2023); (b) beliefs about welfare spending (NORC, 2024); (d) beliefs about the government's role in reducing poverty (Pew, 2014); and (e) beliefs about the government's role in reducing inequality (Pew, 2014). While there is significant variation in whether people think the government should spend more or less on helping the poor or to reduce inequality, there is a large and robust relationship between all four dimensions of stigma — but especially societal stigma — and policy preferences (Figure 3). A one standard deviation increase in societal stigma is associated with 0.27-0.35 SD less support for increasing spending on programs to help the poor (all ps < .001). The relationship between internalized, general anticipated, and anticipated treatment stigma and support for spending on programs to help the poor is smaller, but still significant: a one standard deviation increase in internalized stigma is associated with 0.21-0.26 less support for such programs, while a one standard deviation in general anticipated stigma is associated with 0.09-0.12 SD less support. We see similar patterns for other policy-relevant outcomes: societal stigma strongly and positively predicts beliefs that the government is spending too much on welfare ($\beta = 0.46$, $p < .001$), as well as beliefs about the government's responsibility for reducing poverty ($\beta = -0.29$, $p < .001$) and inequality ($\beta = -0.23$, $p < .001$). Again, the magnitudes of the relationships between internalized, general anticipated, and anticipated treatment stigma and these outcomes are smaller, but still significant.

Of note, the relationship between policy preferences and stigma looks remarkably similar for liberals and conservatives across most measures, despite very large differences in baseline level of support (see Supplement Table S27): on average, support for increasing funding for programs aimed at helping the poor is 1.02 - 1.14 SD higher among liberals than conservatives, but among both groups, a one standard deviation increase in societal stigma is associated with

0.29 SD less support for spending on income support programs, 0.24-0.25 SD less support for funding for schools in poor neighborhoods, and 0.30-0.31 SD less support for spending on housing for the poor (all $ps < .001$).

Figure 3. Relationship between stigma and policy-relevant outcomes
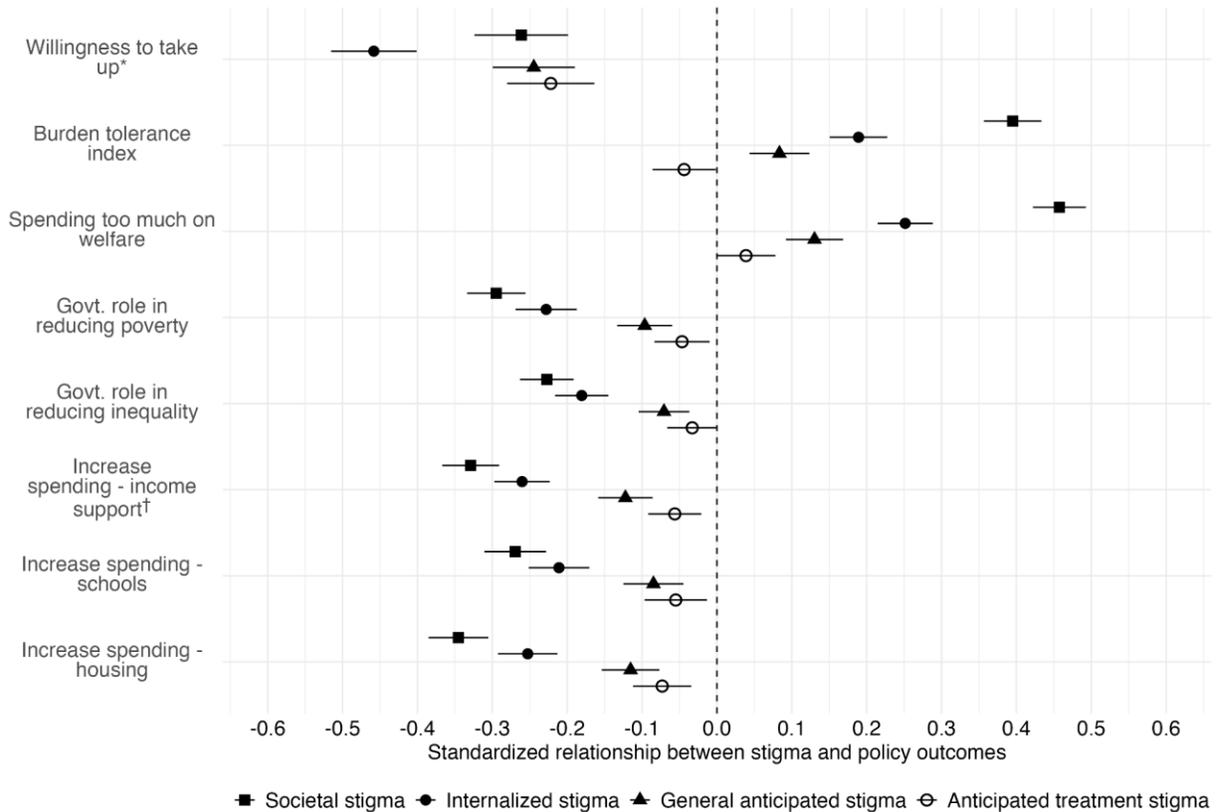
Notes: Estimates from equation (2) showing the standardized relationship between each stigma dimension and policy preferences (N = 3,741). *Sample is restricted to low-income respondents only (N = 1,636). † N = 2,739 due to missingness in the outcome.

Estimating the relative importance of stigma compared to other predictive factors

Although we find a robust and significant relationship between stigma and a wide range of policy-relevant outcomes, existing evidence documents many factors that are strongly correlated with support for and willingness to participate in means-tested programs, including demographic characteristics like race and gender, political ideology, familiarity and experience with benefits, and other mindsets such as racial animus, poverty attributions, and zero sum thinking (Bullock et al., 2003; Chinoy et al., forthcoming; Halling et al., 2023; Yeung & Glasgow, 2025). To understand the relative importance of stigma — compared to these other well-documented factors — in explaining policy preferences and behavior, we conduct two additional analyses. First, we conduct a dominance analysis to examine how much of the variation in take-up and burden tolerance can be explained by stigma versus respondent

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characteristics. This approach quantifies the marginal contribution of stigma to overall model fit while accounting for intercorrelations among covariates (Budescu, 1993). Second, we conduct an Oaxaca-Blinder decomposition to examine the extent to which observed differences in policy preferences or program participation across groups can be explained by differences in stigma versus differences in other observable or measured characteristics.

First, we consider willingness to apply for benefits programs. In a model that regresses take-up on a traditional set of individual-level controls, the three strongest predictors are whether the respondent currently participates in a benefits program, political ideology, and the type of benefits program. However, societal, internalized, and general anticipated stigma are each stronger predictors of willingness to apply for benefits than the program itself or any individual respondent characteristic, including political ideology (Supplement Tables S28-S30). Quantifying this in separate models, societal stigma explains half (49.8%) of the model's explained variance in willingness to apply for benefits; internalized stigma explains 66.5%; and general anticipated stigma and anticipated treatment stigma explain about 34.9% and 28.7% of the overall variation, respectively. These patterns hold even when including other mindsets and beliefs in the model, such as poverty attributions or zero-sum thinking. Put differently, societal, internalized, and general anticipated stigma are each the most dominant explanatory factor of variation in respondents' willingness to apply for benefits programs, over and above personal beliefs, mindsets, and demographic characteristics. Meanwhile, anticipated treatment stigma explains a large proportion of the variation in willingness to apply for benefits, but less than respondents' experience using benefits — though the latter also likely implicitly captures respondents' beliefs about the treatment they will receive applying for benefits.

Using a threefold Oaxaca-Blinder decomposition, we also consider the relative importance of each stigma dimension in explaining the gap between conservatives and liberals in their willingness to participate in benefits programs. Because this method is scale-dependent, our main continuous predictors — stigma and other mindsets — were standardized to allow for direct comparison of the relative contribution of different constructs. Following Yun (2005), we also compute the analysis based on normalized effects for all categorical variables. Overall, liberals are 0.46 SD more likely to say they will apply for benefits programs than conservatives. Across separate specifications, we find that approximately 58-61% of this gap is explained by societal stigma and 50% of this gap is explained by internalized stigma, while other survey-based measures of mindsets, such as zero-sum thinking, racial animus, and poverty attributions account for about 9-14% of this gap collectively (Supplement Table S32). To be sure, it is still possible that stigma is rooted in historical and institutional structural racism or other attitudes. However, our findings suggest stigma can and should be measured as a distinct and highly policy relevant mindset in and of itself.

Second, we consider predictors of burden tolerance. Following the same methodology described above, we find that societal stigma plays a critical role in explaining variation in burden tolerance. Regressing burden tolerance on individual-level covariates and program controls yields an overall fit of 15.2%, and political ideology is the most predictive factor,

explaining 66.9% of the model's explained variance. In models including societal stigma, overall fit jumps to 27.4%, and societal stigma explains 59.7% of the variance, while political ideology explains just 23.9%. In a separate model, we find that internalized stigma explains about 20.3% of the explained variation in burden tolerance, but it comes in second to political ideology. Both general anticipated and anticipated treatment stigma have even weaker explanatory power.

We again decompose the gap in burden tolerance between conservatives and liberals to quantify the relative importance of stigma. Across specifications, we find that 38-52% of the 0.83 SD gap between liberals and conservatives can be explained by societal stigma, while zero-sum thinking, racial animus, and poverty attributions explain about 15-25% of the gap collectively (Supplement Table S37).[2]

Taken together, these analyses highlight stigma as a critical — and potentially understudied — determinant of policy preferences, with substantial predictive power across multiple pathways that can influence program take-up. Stigma shapes individuals' willingness to participate in benefits programs directly, their tolerance for compliance burdens that may deter participation, and their broader preferences for government spending that could influence program access. It exerts a stronger influence than individual-level factors such as political ideology or personal experience with benefits programs and accounts for a larger share of the ideological divide on this issue than other attitudinal constructs examined in prior research.

How does the design of benefits programs causally impact stigma?

Given the outsized influence stigma has on take-up, the logical next question is to ask what could reduce stigma, and thereby increase take-up? We could consider both individual-level and structural-level determinants of stigma. Existing research focuses primarily on the former, testing behavioral approaches that aim to directly shift decision-making among potential beneficiaries (Bhargava & Manoli, 2015; De La Rosa et al., 2021; Finkelstein & Notowidigdo, 2019; Linos et al., 2022; Linos et al., 2025). In this paper, we focus instead on the latter by examining how the design of benefits programs causally affects stigma.

In Study 3, we conduct a conjoint experiment with a nationally representative sample (N = 4000) to examine whether stigma is causally driven by (a) the policy domain of the benefit, such as health, nutrition, or general income; (b) design features of the benefit — such as whether the transfer is provided in cash or in kind, whether benefits are temporary or ongoing, or income eligibility thresholds; and (c) characteristics of the beneficiary population, such as the percentage that are Black, unemployed, or immigrants. We note that program design decisions could affect both (b) and (c) directly by determining eligibility requirements, and indirectly by influencing who chooses, and is able, to access benefits, which thereby affects the overall composition of the beneficiary population.

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[2] Note that dispositional attributions for poverty is a notable outlier, explaining about 29-40% of ideological gap across model specifications. However, it still explains less than societal stigma when both are included in the same model.

Respondents saw four tasks in total. Each task presented two side-by-side descriptions of different government programs, which varied along ten attributes. After each task, respondents were asked to choose which program was more stigmatized, measured via four questions capturing each stigma dimension and adapted from the scale developed in Studies 1a and 1b. Figure 4 shows the average marginal component effects (AMCEs) of each attribute level on each dimension of stigma. First, we find that policy domain directly impacts all dimensions of stigma. Stigma is significantly lower among programs that provide assistance with healthcare and housing than programs that provide assistance for "general expenses," although the differences between the latter and food assistance programs is smaller and not significant for our internalized stigma outcome.

Second, certain design features of the benefit itself have a strong influence on stigma. For instance, internalized and general anticipated stigma are both significantly lower for programs that provide in-kind or restricted cash benefits, as well as programs that provide benefits for shorter periods of time. Respondents were 1.9 pp and 1.3 pp less likely to say they would feel ashamed participating in programs with in-kind or restricted cash benefits (relative to unrestricted cash), respectively. Similarly, respondents were 1.9 pp and 1.6 pp less likely to say they would be looked down upon if they participated in programs with in-kind or restricted cash benefits (relative to unrestricted cash), respectively. We see similar effects for programs that provide short-term benefits for up to 6 months, compared to up to 5 years. At the same time, we find that the effect of compliance burdens on internalized, general anticipated, and anticipated treatment stigma differs significantly by political ideology. For instance, conservative respondents were 3.7 pp *less* likely to say they would be ashamed to participate in programs with high compliance burdens (relative to low burdens), while liberal respondents were 3.2 pp *more* likely to say they would be ashamed to participate in high burden programs. Meanwhile, compliance burdens do not appear to significantly impact societal stigma among liberals, while programs with higher burdens are significantly less stigmatized among conservatives. Overall, this may shed light on why support for program design features that seem to add economic and targeting inefficiencies remains strong: programs that would provide unrestricted cash and lower compliance hurdles are both more stigmatized — at least among conservatives — than more burdensome or complex program designs.

Income eligibility thresholds, on the other hand, also make a large difference but in the opposite direction: across all four stigma dimensions, programs that target the poorest of the poor — those that have an income eligibility threshold of $10,000 or less for a family of three — are significantly more stigmatized than programs with a higher income eligibility threshold of $58,000 or less, with effects ranging from 3.9 pp to 4.9 pp. This may reflect broader stigmatization against the poor, but nonetheless may have large consequences for how programs are designed.

Third, we consider how the composition of program participants impacts stigma. While some program eligibility requirements directly dictate who can participate (e.g., TANF is only for families with children), other program design features, such as compliance burdens, may

indirectly affect the composition of the beneficiary population by influencing who chooses and is able to access benefits. This may, in turn, affect stigma if the resulting beneficiary population is more heavily skewed toward populations that are already the subject of pervasive negative stereotypes and discrimination. Indeed, in line with stereotypes about "welfare queens" from the 1980s and beyond (Foster et al., 2008; Hancock, 2004), we find that programs that serve higher proportions of women, immigrants, Black, and unemployed beneficiaries are more highly stigmatized across most dimensions. These relationships are largely consistent among both liberal and conservative respondents, although the magnitude of the effects are larger among conservatives.

These findings suggest that programs with more expansive eligibility criteria would be less stigmatized, assuming such criteria also shifts the composition of the beneficiary population. As an illustrative example, extrapolating from our results, a program for which all low-income families, including the working poor, are eligible would be about 10% less likely to be stigmatized than a program that is only for very low-income families with children. Indeed, we see some evidence of this in Study 2: societal stigma associated with TANF, a program specifically for families with children, is 11.8% higher than with Medicaid, a program with much more expansive eligibility criteria, although this is confounded by policy domain.

Taken together, the results of Study 3 point toward seemingly conflicting causal relationships: on the one hand, program design features that would expand access to benefits are *more* stigmatized, while on the other hand, programs that serve broader beneficiary populations are *less* stigmatized.

Figure 4. Effect of program design factors and beneficiary characteristics on stigma
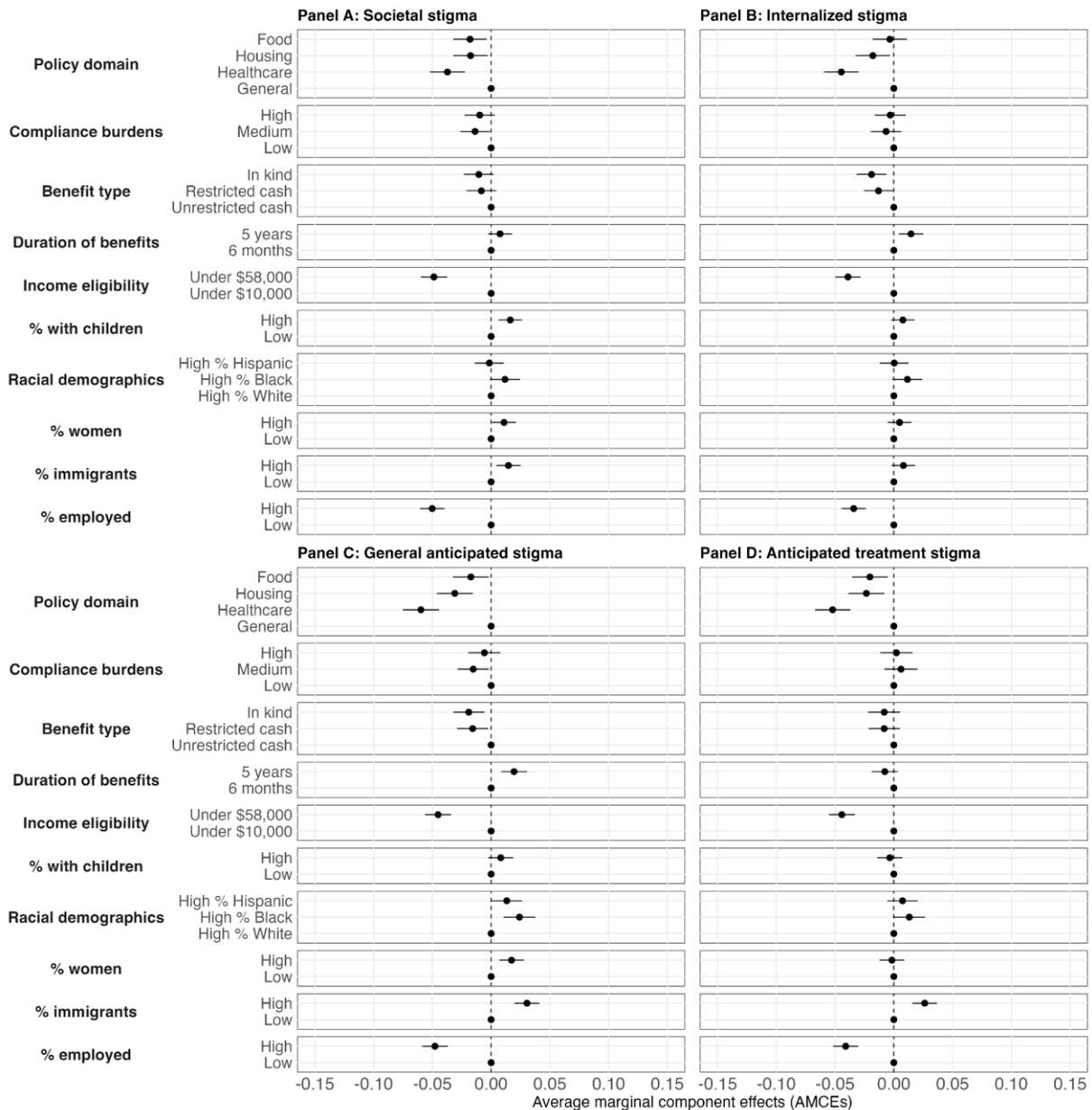
Notes: Estimates from equation (3) showing the effect of each attribute level on stigma. Each outcome is an indicator variable, adapted from the stigma scale developed in Studies 1a and 1b, that equals 1 for the more highly stigmatized profile. N = 4,000 respondents. Specific language used for each attribute level is available in the Supplement.

Discussion

Despite extensive evidence documenting the stigma associated with the social safety net in the US, there is wide variation in how "stigma" is conceptualized and measured in existing literature. Perhaps as a direct result of this, studies that have attempted to identify and quantify the relative role of stigma in driving take-up gaps have yielded mixed results. This paper

contributes to and extends extant literature in three ways. First, we offer a validated scale for measuring the stigma associated with the social safety net. Importantly, we show that stigma can be conceptualized as four distinct constructs. While these constructs are, naturally, correlated, they also vary independently and meaningfully by respondent characteristics and by specific programs. Second, we document that stigma is a critical factor in explaining variation in policy-relevant outcomes including willingness to apply for benefits (take-up), burden tolerance, beliefs about the role of government in reducing poverty, and support for policies aimed and supporting the poor. This points to both direct and indirect channels through which stigma might affect program participation. Underscoring the importance of conceptualizing stigma as different dimensions, we show that societal stigma is the strongest predictor of burden tolerance, while internalized stigma is the strongest predictor of willingness to apply for benefits. In each case, we find that stigma accounts for a large proportion of the variation in policy outcomes that is often attributed to political ideology or other differences in mindsets. Third, we demonstrate that specific program design features — such as eligibility rules and compliance requirements — causally influence stigma. This suggests that the design of benefits programs both reflects and causally reinforces stigma.

More broadly, these findings suggest that the role of stigma in shaping participation in the social safety net may have been underappreciated or misspecified in previous work. We show that stigma is both a measurable and consequential factor in explaining the persistence of take-up gaps, pointing toward a number of promising areas for further research. Additional studies are needed to fully disentangle causality in the relationships explored in this paper, as well as to explore whether the multidimensional conceptualization of stigma allows for more effective and targeted stigma reduction interventions. Overall, incorporating stigma more centrally into analyses of participation, policy implementation, and public support can improve both empirical precision and theoretical understanding of the design of the social safety net.

METHODS

Ethics. All studies were approved by the Harvard University Committee on the Use of Human Subjects (IRB22-1397), and all respondents consented to participate.

Studies 1a and 1b

Sample. Studies 1a (N = 1,528) and 1b (N = 1,260) were conducted via Prolific in August 2024 with nationally representative samples. Supplement Table S3 shows the characteristics of the final sample compared to the US population.

Data quality. Each survey included three attention checks; all participants who failed one or more attention checks or that were flagged by Qualtrics as potential bots are excluded from the final analytic sample. Additionally, we exclude participants who completed the survey more than once based on Prolific ID or IP address. In Study 1a, the median completion time was 9.8

minutes ($SD = 11.7$), balanced across experimental conditions ($F(3, 1524) = 0.47$, $p = .70$). In Study 1b, the median completion time was 8.3 minutes ($SD = 5.3$), balanced across experimental conditions ($F(3, 1256) = 0.77$, $p = .51$). All questions in both studies were forced response; thus there is no missingness in any measure.

Survey structure. The structure of Study 1a and Study 1b was identical: all respondents were randomly assigned with equal probability to one of four conditions corresponding with different means-tested programs: (1) SNAP; (2) rental assistance; (3) Medicaid; or (4) EITC. In each condition, participants saw a short description of the program, such as:

> *The US government runs many programs to help low-income individuals and households. One of these programs is the Earned Income Tax Credit (EITC), which provides eligible workers with a tax break by reducing the tax they owe or increasing their refund.*

In both studies, participants were then asked a series of questions to measure stigma, presented in a random order. Individual measures were adapted from relevant literature (Baumberg, 2016; Brown et al., 2010; Fox et al., 2018; Gabbidon et al., 2013; Vogel et al., 2006).We also measured racial prejudice and poverty attributions (ANES, 2013; Feagin, 1972; Piff et al., 2020), and respondent demographic characteristics including race, age, gender, education level, party affiliation, political ideology, state of residence, parental status, employment status, income, and experience using benefits.

Study 2

Sample. Study 2 ($N = 4,376$) was conducted via YouGov in December 2024 with a nationally representative sample that oversampled from low-income populations, defined as respondents with a household income at or below 200% of the 2024 Federal Poverty Level. All respondents were asked initial screening questions, including zip code and household income, to facilitate the sampling approach. Supplement Table S4 shows the characteristics of the final sample compared to the US population.

Data quality. The survey included three attention checks, and respondents who failed more than one are excluded. In the final analytic sample, 37.7% of respondents passed two attention checks and 62.2% passed all three. The median time to completion was 17.2 minutes ($SD = 517.9$ minutes), balanced across treatment conditions ($F(6, 4369) = .32$, $p = .93$).

All questions were voluntary, but respondents were prompted to respond if they attempted to skip a question and overall missingness is low: no question is missing for more than two (0.05%) respondents.

Survey structure. All respondents were randomly assigned with equal probability to one of seven conditions: (1) SNAP; (2) rental assistance; (3) Medicaid; (4) EITC; (5) SSI; (6) TANF; and (7) social security.[3] In each condition, participants saw a short description of the program, such as:

> *The US government runs many programs to help low-income individuals and households. One of these programs is the Supplemental Nutrition Assistance Program (SNAP), which provides funds to eligible individuals to help them purchase food and necessities.*

After seeing the prompt associated with their experimental condition, we measured stigma using the scale developed in Studies 1a and 1b, as well as willingness to apply for benefits and beliefs about program beneficiaries. Additionally, we measured burden tolerance, beliefs about inequality, poverty, and the role of government, preferences for anti-poverty policies, poverty attributions, racial prejudice, and zero-sum thinking (Alesina et al., 2023; ANES, 2013; Baekgaard et al., 2025; Chinoy et al., forthcoming; Feagin, 1972; Piff et al., 2020). Where applicable, all blocks and questions within blocks were presented in a random order. Finally, we asked about respondent political ideology, party affiliation, trust in government, experience using government benefits, and perceived socioeconomic status. We also collected respondent demographics including age, gender, race, zip code, household income, and prior voting history.

Analysis. We conduct three distinct analyses. First, we examined the individual-level correlates of each stigma dimension, as well as the variation in stigma by program, controlling for individual characteristics. using the following specification:

$$(1)\ Y_i = \propto + \beta_{1-5}program_i + \beta_6 order_i + \delta_i + \varepsilon_i$$

where Y_i is a standardized measure of stigma; $program_i$ is a categorical indicator for assignment to one of the six conditions corresponding with a means-tested program;[4] $order_i$ is a binary indicator reflecting the order in which the stigma questions were shown; δ_i is a vector of respondent-level characteristics including a continuous measure of age, categorical indicators for race (non-Hispanic White, non-Hispanic Asian, non-Hispanic Black, Hispanic, non-Hispanic multi-racial, and Other race), employment status (full-time, part-time, or not employed), and political ideology (Liberal, Conservative, Moderate, Not sure), and binary indicators for gender, college education (4-year degree or more), low-income (at or below 200% FPL), current participation in a benefits program, parental status, high trust in government, and passing all three attention checks. Each stigma dimension is evaluated in a separate model and all analyses also include survey weights.

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[3] There was an eighth condition that is excluded from this paper (N = 624).
[4] Respondents assigned to the Social Security condition (N = 635) are excluded from all analyses except the analysis of the stigma associated with means-tested programs versus Social Security.

Second, we evaluate the relationship between policy-relevant outcomes including take-up, burden tolerance, and policy preferences, and stigma using the following specification:

$$(2)\ Y_i = \propto + \beta_1 stigma_i + \beta_{2-6} program_i + \beta_7 order_i + \delta_i + \varepsilon_i$$

where Y_i is our outcome of interest; $stigma_i$ is a standardized measure of stigma; $program_i$ is a categorical indicator for assignment to one of the six conditions corresponding with a means-tested program; $order_i$ is a binary indicator reflecting the order in which the stigma questions were shown; δ_i is a vector of respondent-level characteristics, as described above. For every outcome, we evaluate equation (2) separately for each dimension of stigma due to collinearity between the four dimensions. All analyses also include survey weights.

Third, we conduct two types of decomposition analyses: (a) dominance analysis, following Budescu (1993); and (b) Oaxaca-Blinder decomposition analysis. Both are conducted in Stata 18 using the *domin* and *oaxaca* commands, respectively. The dominance analysis relies on equation (2) and determines the relative importance of each independent variable based on its contribution to overall model fit. We examine every outcome and stigma dimension in separate models and, for each, report the general dominance statistics of each predictor, standardized to be out of 100%.

Next, for each outcome of interest — take-up and burden tolerance — we also conduct a series of Oaxaca-Blinder decompositions to quantify the proportion of the ideological gap that can be explained by societal stigma and internalized stigma. We examine the relative role of stigma in six separate models. All models take a similar functional form as equation (2), but vary the right-hand side variables as follows: model 1 includes stigma and our standard set of respondent-level covariates; model 2 adds to model 1 a standardized measure of situational attributions for poverty; model 3 adds to model 1 a standardized measure of dispositional attributions for poverty; model 4 adds to model 1 a standardized measure of zero sum thinking; model 5 adds to model 1 a standardized measure of anti-Black racial prejudice; and model 6 adds to model 1 the full set of other mindsets: situational attributions, zero sum thinking, and anti-Black racial prejudice. We run all six models separately for societal stigma and internalized stigma.

Study 3

Sample. Study 3 (N = 4,000) was conducted via YouGov in February 2025 with a nationally representative sample. Supplement Table S4 shows the characteristics of the final sample compared to the US population.

Data quality. The survey included three attention checks, and respondents who failed more than one are excluded. In the final analytic sample, 19.0% passed two attention checks and 81.1% passed all three. The median time to completion was 12 minutes (*SD* = 311.5 minutes).

Survey structure. In a conjoint design, all participants saw six tasks: four presented profiles of two government benefits programs, while two presented profiles of two beneficiaries of government benefits programs.[5] All tasks were presented in a random order. Attributes in both the program and beneficiary profiles included type of program; program requirements; type of benefits; length of benefits; income; parental status; race; gender; immigration status; and employment status. The full survey instrument, available in the Supplement, shows the levels associated with each attribute, which were defined based on data from real benefits programs, as well as pilot studies in which we measured beliefs about beneficiary characteristics.

As is typical for conjoint studies, the levels shown in each profile were randomly assigned, but the randomization was constrained such that no task could include two identical profiles. All attributes were presented in the same order across tasks and respondents. All levels were displayed at roughly equal rates.

In each task, respondents were asked to choose the profile associated with higher stigma, or a third "no difference between profiles" option. Specifically, for the beneficiary profiles, respondents were asked which person (profile) is (a) more likely to be poor because of their own choices; and (b) more likely to waste money when they have it — measures that are adapted from our societal stigma scale. For the program profiles, our outcomes are similarly adapted from each dimension of our stigma scale: respondents were asked to choose the program (profile) in which (a) participants are more likely to be poor because of their own choices (societal stigma); (b) they would be more ashamed to participate (internalized stigma); (c) they would be more likely to be looked down upon for participating (general anticipated stigma); and (d) they would be more likely to be treated respectfully (anticipated treatment stigma). As shown in the Supplement (Supplement Table S39), missingness was 0.1% or less for each of our primary outcomes.

Analysis. Unlike traditional conjoint experiments, our dependent variables were not a forced binary choice between profiles; they included a third option of "no difference between profiles." We thus construct binary outcomes such that a 1 reflects choice of a specific profile (program) in a specific task, and 0 reflects choice of the other profile or of the third "no difference" option. Outcomes (a)-(c) were phrased such that the profile chosen is the program with higher stigma; outcome (d) — anticipated treatment stigma — was reverse coded so that the indicator can also be interpreted as the profile with higher stigma. Then, in line with Hainmueller et al. (2014), we estimate the average marginal component effects (AMCEs) of each attribute level on each outcome using the following specification:

(3) $Y_{ijk} = \alpha + \sum_{a=1}^{A} \sum_{l=2}^{L_a} \beta_{al} * \mathbf{1}(X_{ajk} = l) + \varepsilon_{ijk}$

where Y_{ijk} is a binary indicator for respondent i's choice of profile j in task k; β is the AMCE of attribute a's level l, relative to baseline level $l = 1$; and X is a dummy variable that equals 1 if

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[5] Results from the two beneficiary-oriented tasks are excluded from this paper.

attribute *a* of profile *j* in task *k* = level *l*. We run separate models for each outcome. In each model, the AMCEs can be interpreted as the effect of a given attribute level on stigma, compared to the reference category for that attribute. All models include survey weights.

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