Chapter 6
A Culture of Stigmatization: The Healthcare of Minoritized Populations

Asia T. McCleary-Gaddy and Drexler James

Introduction

As healthcare and academic professionals examine innovative pathways to improve patient health, research reveals that while medical care (e.g., access to care, quality of care) contributes 10–15% to premature death in the United States, socioeconomic conditions (e.g., income, debt, education) contributes an estimated 60% [1]. The aforementioned "conditions" in which people are born, grow, live, work, and age are known as the social determinants of health (SDOH; [2]). SDOH are broad and include income, education, housing, food security, employment, social support, identity facets, racism, and discrimination. SDOH are shaped by the distribution of money, power, and resources at global, national, and local levels [2].

Prior research has demonstrated that SDOH are major predictors of adverse health outcomes, including infant mortality, diabetes, hypertension, obesity, length, and quality of life [3–6]. Given that these SDOH are oftentimes preventable, healthcare professionals use evidence-based approaches to examine the effects (mediating and moderating) of SDOH on health. In addition, through a SDOH curriculum, health professional students learn more about the pervasiveness of health inequities that are more likely to affect individuals who *systematically* experience greater social or economic obstacles as a result of one or more stigmatized identities.

A. T. McCleary-Gaddy (✉)
Psychiatry and Behavioral Sciences, McGovern Medical School at the University of Texas Health Science Center at Houston, Houston, TX, USA
e-mail: Asia.t.mcclearygadddy@uth.tmc.edu

D. James
Assistant Professor of Psychology, Univeristy of Minnesota, Twin Cities, Minneapolis, MN, USA

R. Scales, A. T. McCleary-Gaddy (eds.), *Cultural Issues in Healthcare*,
https://doi.org/10.1007/978-3-031-20826-3_6

Stigma: A Social Determinant of Health

According to sociologist Erving Goffman [7] "stigma is an attribute that extensively discredits an individual, reducing him or her from a whole and usual person to a tainted, discounted one." (p. 3) Stigmatizing attributes may be visible (e.g., an individual who is obese) or invisible (e.g., an individual who has a mental illness), perceived to be controllable (e.g., HIV/AIDS) or uncontrollable (e.g., sexual orientation), and linked to appearance (e.g., a physical deformity), behavior (e.g., drug use), or group membership (e.g., African American). Crocker, Major, and Steele [8] suggest that stigmatization occurs when a person is "perceived to possess some attribute or characteristic that conveys a social identity that is devalued in a particular social context" (p. 505). Thus, people who are stigmatized are believed to have an attribute that leads to devalued identity(ies).

Stigma exists on three interrelated levels: intrapersonal, interpersonal, and structural [9]. *Intrapersonal stigma* refers to the psychological processes in which individuals engage in response to stigma such as self-stigma: the internalization of negative societal views about your group. In contrast, *interpersonal stigma* refers to interactions that occur between the stigmatized and the non-stigmatized such as attitudes of prejudice and discriminatory behaviors. Last, *structural stigma* refers to stigma at the macrolevel. Structural stigma is defined as the economic and political pressures on a culture that produce social and institutional policies that limit opportunities for the stigmatized group [10]. Structural stigma includes institutional policies that intentionally constrain the opportunities of people with stigmatized identities but also unintentional policies whose consequences impede the options of stigmatized groups. Therefore, in a more comprehensive conceptualization, stigmatization is defined as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised [9].

Overview

Hatzenbuehler and colleagues [11] argue that all stigma-related dynamics have a significant effect on individual and population health comparable to the other social determinants of health. Researchers also estimate that stigma in a healthcare context contributes to more disparity in life expectancy than stigma in the general population [12]. Various models of stigma argue that interpersonal, structural, and intrapersonal levels of stigma individually and interactively contribute to poor health outcomes, especially among minoritized populations (see [13]). For example, the *biopsychosocial model of racism* [14] argues that race stigma (i.e., racism) is a chronic stressor for racial/ethnic minorities that, once experienced, leads to various psychological and physiological stress responses. Similarly, the *Internalized Stigma Model* (IMS) of mental illness suggests that both interpersonal and intrapersonal

forms of stigma of mental illness reduce self-esteem and help-seeking behaviors among those with mental illness [15]. In particular, the IMS suggests that awareness of public stigma can lead to its internalization as self-stigma, which then decreases self-esteem and intentions to seek psychological help [15].

Other models focus on how stigmatization in healthcare settings can lead also contribute to minority-majority health disparities. For example, Knaak and Patten's [16] model suggests that stigma manifests in several different ways in healthcare settings, including a lack of or limited diversity-related healthcare training and healthcare provider-held anti-minority stigmas. As an example, results from a systematic review by Van Boekel et al. [17] found that health professionals generally had negative attitudes toward patients with substance use disorders, which affect their treatment of these patients. In addition, they found that health professionals also lacked adequate education, training, and support structures in working with this patient group, altogether contributing to suboptimal health care for patients with substance use disorders.

To contribute to this literature, this chapter reviews scholarship examining the health consequences of stigma among minoritized populations—populations of people who have less power than their peers. Here we provide evidence of the pervasiveness of stigma within healthcare and the pernicious consequences of stigma on overall health. First, using some examples, we highlight the current research on stigma and health of multiple communities including: (1) racial and ethnic minorities, (2) gender and sexual minorities, (3) individuals living with mental illness, and (4) individuals who are overweight. Following, we discuss areas of future research, methods to cope with and combat stigma, and the implications for health professional education and practice.

Stigma and Minoritized Populations

Weight Stigma

Weight stigma is defined as the social devaluation and denigration of people perceived to carry excess weight and leads to prejudice, negative stereotyping, and discrimination toward those people [18]. Weight stigma is relatively under-studied compared to other forms of stigma (e.g., race, gender), although it is reported to be more common, severe, and socially acceptable [19, 20]. This is especially troubling given that around two-thirds of Americans are either overweight or obese [21]. In the healthcare setting, overweight and obese patients are susceptible to weight stigma from physicians, nurses, medical students, and dental students [22].

For example, Hebl and Xu [23] found that primary care physicians reported that seeing obese patients was a greater waste of their time and that heavier patients were more annoying than patients with lower body weights. Physicians also reported

having less patience and desire to help patients who were overweight/obese. Medical students also express that obese patients are more difficult to work with [24]. In the same way, research shows that nurses also hold largely negative weight-based attitudes toward patients who are overweight/obese, including these patients being lazy, lacking in self-control, and noncompliant [25]. Last, about 30% of dental students report that their obese patients are lazier than non-obese patients and about 17% reported that it was difficult for them to feel empathy for an obese patient [26].

Researchers interested in the obesity epidemic have identified chronic stress as a potential mechanism through which stigma and stigmatizing environments increase the risk for negative health outcomes [27]. Tomiyama [28] outlined the Cyclic Obesity/Weight-based Stigma (COBWEBS) model that depicts weight stigma as a positive feedback loop wherein weight stigma catalyzes weight gain through increased eating and other biobehavioral mechanisms. The COBWEBS model first characterizes weight stigma as a psychological stressor. The stress induced by weight stigma initiates emotional responses such as intense feelings of shame, physiological responses such as an increase in the stress hormone cortisol, and behavioral responses such as "comfort eating." As a result, weight increases weight gain in overweight individuals, which increases their susceptibility to weight stigma.

Much research on weight stigma has focused on the role of the hormone *cortisol.* Cortisol, a stress-related hormone, promotes fat storage and eating behavior [29]. A typical response to a stressor is characterized by a sharp increase in cortisol followed by a slow decline. However, McCleary-Gaddy and colleagues [30] found that overweight individuals who are placed in a weight-stigmatizing situation exhibit a blunted cortisol response. That is, their cortisol response is characterized by relatively small fluctuations following a stressor. Other studies document that people who experience childhood victimization or racial discrimination have blunted cortisol responses to acute stressors [31, 32]. Blunted cortisol responsivity is especially important to individuals who are overweight as cortisol plays an important role in the distribution of adipose tissue, which is implicated in cardiovascular disease and type 2 diabetes [28].

Mental Health Stigma

Mental health stigma refers to the devalued social identity one may possess due to the negative attribute of mental illness [33]. One of the most commonly cited sources of stigma for people with mental illness is the structural stigma within the healthcare system [34]. This is concerning as about one in five US adults lives with a mental illness [35].

Schulze [36] discusses how legislative policies create a low quality of services for people with mental illness, complications for accessing treatment, forceful approaches to care, and inadequate funding of mental health research and services

[34]. In a review of nearly 1000 mental health-related proposed bills in 2002, researchers found 1% were discriminatory (e.g., restricted placement of mental health facilities) and 4% reduced privacy (e.g., permitting disclosure of mental health information in certain circumstances; [37]). Other work also shows that physicians are less likely to accept insurance coverage for some mental health services because of the low monetary reimbursement [38], which exacerbates physician shortage and low quality of services within the mental healthcare domain [39].

Mental illness stigma also has inward-facing impacts on health professionals' own willingness to seek help or disclose mental health problems [40]. Research has found that dentists experience greater levels of anxiety and depressive disorders as a result of the stress of their occupation, but are less likely to seek help because of self-stigma [41]. Nurses who suffer from mental illness often felt that they were targets for exclusionary behaviors including shunning reactions from supervisors and expulsion from the workplace [42]. However, Arvaniti and colleagues [43] found that nurses report the least favorable attitude toward people with mental illness when compared to doctors, medical students, and other healthcare personnel. For medical students and physicians, mental illness stigma elicits perceptions of incompetence and creates stagnation in career trajectory in the competitive medical setting. For example, Hampton [44] found that the most frequently cited barriers to treatment were lack of confidentiality (37%), stigma (30%), and fear of documentation on academic record (24%). Since mental illness is a concealable stigma, an identity people can choose to make known to others, many healthcare professionals may never reveal the status of their mental health, which may increase the risk of suicidal behaviors, depression, anxiety, and exacerbate the mental illness [44].

Racial/Ethnic Minority Stigma

US racial minorities have a shorter life expectancy and poorer physical and mental health than their US non-Hispanic White counterparts [45]. Previous and extensive work shows that race-related stigma, that is racism, is a significant cause of these health disparities [46, 47]. Models of racism (e.g., biopsychosocial model of racism; [14]; multidimensional conceptualization of racism-related stress; [48]) suggest that racism is a stressor that can result in psychological/physiological damage among racial/ethnic minorities (also see [49]). For example, among racial/ethnic minorities experiences with racial discrimination increases the body's physiological stress responses, including increased blood pressure and heart rate [50] and increased cortisol production (for meta-analysis see [51]).

Within the healthcare domain, race stigma influences healthcare providers' attitudes and interactions with racial/ethnic minority patients. For example, Van Ryn and Burke [52] found that physicians were more likely to rate their Black/African American as less intelligent and less likely to adhere to treatment regimens. Van

Ryn and Burke [52] suggest that these negative racial attitudes might account for racial/ethnic disparities in the quality of healthcare [53], treatment recommendations [54], patient–physician relationships [55], and treatment recovery [56], where racial/ethnic minorities experience oftentimes experience poorer outcomes than their White counterparts. Indeed, racial/ethnic minorities are less likely to seek professional healthcare for fear of experiencing racial discrimination by their healthcare provider [57]. Other work suggests that this perceived racial bias also increases racial/ethnic minority patients' mistrust of their healthcare provider, which can lead to poor medication adherence [58].

Experiences with racial/ethnic discrimination can also lead racial/ethnic minorities to internalize race-related stigma, that is, *internalized racism*. Internalized racism (IR) is a form of racism that leads people to internalize beliefs and stereotypes about their race/ethnicity [59]. Internalized racism is associated with poor physical (e.g., systolic blood pressure; [60]) and mental (e.g., depression; [61]) health outcomes. Indeed, a recent meta-analysis found that internalized racism (IR) was associated with poorer mental and physical health outcomes among RE minorities [62]. This increased risk of poorer health might also result from a decreased willingness to seek healthcare resulting from increased internalized racism [63]. Other work shows that internalized racism exacerbates the negative health effects of experiencing discrimination. For example, Chae et al. [64] found that among Black/African American men with high levels of internalized racism, experiencing discrimination was associated with shorter leukocyte telomere length (LTL) while for those with low internalized racism, experiencing discrimination was associated with lower LTL.

LGBTQ+ Stigma

Sexual minorities (i.e., those who identify as non-heterosexual) report poorer health relative to heterosexuals including higher rates of substance use and abuse [65], cardiovascular disease [66], and suicidality [67]. In a national sample of American adults, Rice and colleagues (2019) found that sexual minority participants reported higher rates of general discrimination, victimization, and healthcare discrimination than heterosexual adults. Indeed, Meyer [68] posited the "sexual minority stress" model to explain how experienced sexual minority stigma (e.g., discrimination, internalized homophobia) increases sexual minorities' risks of poor health outcomes. Previous research shows that experienced stigma is positively associated with poor mental [69], physical [70], and sexual health [71] outcomes among sexual minorities.

Other research has focused specifically on the ways in which stigma affects sexual minorities within the healthcare context. For example, in a sample of African American sexual minority women, Li et al. [72] found that 46.2% of participants reported negative healthcare experience within the past 5 years due to their sexual orientation. Li et al. [72] also found that increased experiences with healthcare

discrimination predicted reduced healthcare service utilization. In the same way, Steele et al. [73] found that bisexual women were likely to report an unmet need for mental healthcare as cisgender heterosexual women. Here the authors argue that in addition to interpersonal stigma experienced by healthcare professionals the systemic exclusion of sexual minorities from healthcare systems also contributes to sexual minority health disparities.

In fact, in a sample of 180 physicians Jabson et al. [74] found that 171 (95%) of physicians reported that they were aware, and 9 (5%) were unaware, that patients in their practice identified as gay, lesbian, or bisexual, and 171 (95%) reported that they were aware, and 9 (5%) were unaware, that patients in their practice identified as transgender. However, despite this awareness, the sample of physicians still held overall negative attitudes about sexual minority patients. Citing the importance of structural-level policies at hospitals, Jabson et al. [74] found that physicians at a hospital with Healthcare Equality Index (HEI) training/policies held less negative attitudes toward sexual minorities than those at a hospital without HEI training/policies. These physician-held biases have consequences for patient treatment. For example, Calabrese et al. [75] found that greater explicit bias against gay men is linked to provider decisions among medical students, such as less willingness to prescribe Pre-Exposure Prophylaxis (PrEP), a drug that reduces HIV risk.

Future Research Considerations for Stigma and Health

Intersectional Stigma

Oftentimes, stigma is examined along one identity dimension (e.g., race) rather than along multiple identity dimensions (e.g., race and gender). To address the limitations of such investigations, especially in relation to health and well-being, Turan et al. [76] reintroduced "intersectional stigma": a concept that characterizes the convergence of multiple stigmatized identities within a person or group. An intersectional perspective allows health professionals to think holistically about how living with multiple stigmatized identities affects behaviors, as well as individual and population health. For example, socioeconomic status (SES), whether measured by income, education, or occupational status, is among the most robust determinants of variations in health outcomes throughout the world [77]. Understanding the complex ways in which stigmatized identities such as race/ethnicity, gender, sexual orientation, and SES uniquely and in combination, influence health outcomes is a critical task in addressing disparities across the socioeconomic spectrum [78].

Intersectional stigma has been repeatedly associated with worse health behaviors and outcomes. For example, Eisner and researchers [79] found that African Americans were associated with greater disease severity and greater risk of acute COPD, but these differences no longer persisted after controlling for SES variables. In another study investigating transgender individuals, researchers found higher

levels of violence was reported for transgender youth who were low income [80]. Collectively, this suggests that lower SES exacerbates the health outcomes for individuals who already possess one stigmatized identity.

Future research should aim to understand the ways in which childhood SES and other stigmatized identities contribute to adult health inequities, including the psychosocial and physiological pathways [76]. Research that investigates a single health-related stigma without including the co-experience of other stigmas is likely to have limited success in reducing health inequities because it does not accurately reflect the lived experiences of our society [76].

Racial Stigma and White American Health

Research examining racial stigma and its relationship to health and mortality overwhelmingly examine these relationships among racial/ethnic minority populations. However, recent scholarly works suggest that racial stigma (structural, interpersonal, and internalized) can lead to poor health among non-Hispanic White Americans in the US, that is, the racial majority. Recently, Williams et al. [81] highlighted a need for research that examines how racism effects the health of non-Hispanic whites in the US. Indeed, similar to the negative health effects of racism on minority health, research shows that self-reported experiences of discrimination are also associated with poorer health outcomes among US whites. For example, Mustillo et al. [82] found that self-reported experiences of racial discrimination were associated with higher rates of both preterm births and low birth weight babies in a sample of 352 African American and White American women. Similarly, Tomfohr et al. [83] found that higher endorsement of everyday discrimination was associated with less diastolic blood pressure (DBP) and systolic blood pressure (SBP) dipping among Black and White American men and women.

In the same way, scholars (e.g., [59]) argue that White Americans' internalization of racism—the internalization, among members of a dominant, privileged, or powerful racial/ethnic groups, of attitudes, beliefs or ideologies about the inferiority of other racial/ethnic groups and/or the superiority of their own racial/ethnic group—can also have negative health consequences for them. Internalization of such beliefs can lead White Americans to espouse beliefs that can, directly and indirectly, affect their health. As an example, Tesler [84] found that anti-Black racial resentment was associated with increased opposition to the Affordable Care Act (ACA) by White Americans. Replicating these findings, Metzl [85] found, in interviews, that lower income White men report that even to risk to their own health that they would not vote for policies that would give racial/ethnic minority groups or immigrants more access to healthcare (e.g., the ACA). Here, we see that some racial majority members will risk their own life and health to maintain the racial hierarchy. This is particularly telling as Metzl [85] shows that states that introduced the ACA saw a reduction in overall mortality of 6.1% from 2011 to 2015.

Conclusion

Despite a growing understanding of the importance of SDH, the inclusion of this material into standard training curricula remains sporadic, and when it is included, it is often considered optional [86]. As the field of healthcare transitions into a physician advocacy model, it is important that we embed research on the pervasiveness of stigma into the curriculum. Health professionals would benefit from a social science curriculum that details how the thoughts, feelings, and behaviors of individuals are influenced by the actual, imagined, and implied presence of others (e.g., social psychology; [87]).

Specifically, discussing stigma as a social determinant of health addresses three levels of how an individual is affected. It also promotes greater self-reflection of our healthcare professionals with the goal of better healthcare for all. These discussions may also act as a catalyst for a greater conversation about inclusive coping mechanisms. For example, coping mechanisms associated with weight stigma can range from harmful (e.g., maladaptive eating behaviors) to beneficial (e.g., healthy lifestyle change; [88]). Greater knowledge of culturally sensitive coping mechanisms as a response to stigma can also increase healthcare for all. Last, while this chapter was not intended to be comprehensive of all stigma faced by the various minoritized communities, it provides a broad overview of how stigma contributes to ill-health among minoritized populations. In particular, this chapter serves to demonstrate, briefly, how stigma (structural, interpersonal, and internalized) affects healthcare service, particularly for patients who are members of minoritized populations in the US.

References

1. Schroeder, S. A. (2007). We can do better—improving the health of the American people. *The New England Journal of Medicine, 357*(12), 1221–1228.
2. WHO (World Health Organization). What are the social determinants of health? 2020. Available from: http://www.who.int/social_determinants/sdh_definition/en/. Accessed 8 Oct 2020
3. Chetty, R., Stepner, M., Abraham, S., Lin, S., Scuderi, B., Turner, N., Cutler, D., et al. (2016). The association between income and life expectancy in the United States, 2001-2014. *JAMA, 315*(16), 1750–1766.
4. Kim, D., & Saada, A. (2013). The social determinants of infant mortality and birth outcomes in Western developed nations: A cross-country systematic review. *International Journal of Environmental Research and Public Health, 10*(6), 2296–2335.
5. Kreatsoulas, C., & Anand, S. S. (2010). The impact of social determinants on cardiovascular disease. *The Canadian Journal of Cardiology, 26*, 8C–13C.
6. Reidpath, D. D., Burns, C., Garrard, J., Mahoney, M., & Townsend, M. (2002). An ecological study of the relationship between social and environmental determinants of obesity. *Health & Place, 8*(2), 141–145.
7. Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice Hall.
8. Crocker, J., Major, B., & Steele, C. M. (1998). Social stigma. In D. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *Handbook of social psychology* (Vol. 2, 4th ed., pp. 504–553). McGraw-Hill.

9. Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of. Social Forces, 27*(1), 363–385.
10. Hatzenbuehler, M. L. (2016). Structural stigma: Research evidence and implications for psychological science. *The American Psychologist, 71*(8), 742–751. https://doi.org/10.1037/amp0000068
11. Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813–821. https://doi.org/10.2105/AJPH.2012.301069
12. Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Thornicroft, G., et al. (2014). Mental health-related stigma in health care and mental health-care settings. *Lancet Psychiatry, 1*(6), 467–482.
13. Eccleston, C. P. (2008). The psychological and physical health effects of stigma: The role of self-threats. *Social and Personality Psychology Compass, 2*(3), 1345–1361.
14. Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (2013). *Racism as a stressor for African Americans: A biopsychosocial model* (pp. 79–103). Jossey-Bass/Wiley.
15. Lannin, D. G., Vogel, D. L., Brenner, R. E., & Tucker, J. R. (2015). Predicting self-esteem and intentions to seek counseling: The internalized stigma model. *The Counseling Psychologist, 43*(1), 64–93.
16. Knaak, S., & Patten, S. (2016). A grounded theory model for reducing stigma in health professionals in Canada. *Acta Psychiatrica Scandinavica, 134*, 53–62.
17. Van Boekel, L. C., Brouwers, E. P., Van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*(1–2), 23–35.
18. Tomiyama, A. J. (2014). Weight stigma is stressful. A review of evidence for the cyclic obesity/weight-based stigma model. *Appetite, 82*, 8–15.
19. Brochu, P. M., & Esses, V. M. (2011). What's in a name? The effects of the labels "fat" versus "overweight" on weight bias 1. *Journal of Applied Social Psychology, 41*(8), 1981–2008.
20. Puhl, R. M., & Heuer, C. A. (2009). The stigma of obesity: A review and update. *Obesity, 17*(5), 941.
21. Ogden, C. L., Carroll, M. D., Kit, B. K., & Flegal, K. M. (2014). Prevalence of childhood and adult obesity in the United States, 2011-2012. *JAMA, 311*(8), 806–814.
22. Puhl, R., & Brownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research, 9*(12), 788–805.
23. Hebl, M. R., & Xu, J. (2001). Weighing the care: Physicians' reactions to the size of a patient. *International Journal of Obesity, 25*(8), 1246–1252.
24. Wear, D., Aultman, J. M., Varley, J. D., & Zarconi, J. (2006). Making fun of patients: Medical students' perceptions and use of derogatory and cynical humor in clinical settings. *Academic Medicine, 81*(5), 454–462.
25. Brown, I. (2006). Nurses' attitudes towards adult patients who are obese: Literature review. *Journal of Advanced Nursing, 53*(2), 221–232.
26. Magliocca, K. R., Jabero, M. F., Alto, D. L., & Magliocca, J. F. (2005). Knowledge, beliefs, and attitudes of dental and dental hygiene students toward obesity. *Journal of Dental Education, 69*(12), 1332–1339.
27. McCleary-Gaddy, A. T., Miller, C. T., Grover, K. W., Hodge, J. J., & Major, B. (2019). Weight stigma and hypothalamic-pituitary-adrenocortical Axis reactivity in individuals who are overweight. *Annals of Behavioral Medicine, 53*(4), 392–398. https://doi.org/10.1093/abm/kay042
28. Tomiyama, A. J., Epel, E. S., McClatchey, T. M., Poelke, G., Kemeny, M. E., McCoy, S. K., & Daubenmier, J. (2014). Associations of weight stigma with cortisol and oxidative stress independent of adiposity. *Health Psychology, 33*(8), 862.
29. Himmelstein, M. S., Incollingo Belsky, A. C., & Tomiyama, A. J. (2015). The weight of stigma: Cortisol reactivity to manipulated weight stigma. *Obesity, 23*(2), 368–374.

30. McCleary-Gaddy, A. T., & Miller, C. T. (2019). Negative religious coping as a mediator between perceived prejudice and psychological distress among African Americans: A structural equation modeling approach. *Psychology of Religion and Spirituality, 11*(3), 257–265. https://doi.org/10.1037/rel0000228
31. Bevans, K., Cerbone, A., & Overstreet, S. (2008). Relations between recurrent trauma exposure and recent life stress and salivary cortisol among children. *Development and Psychopathology, 20*(1), 257–272.
32. Richman, L. S., & Jonassaint, C. (2008). The effects of race-related stress on cortisol reactivity in the laboratory: Implications of the Duke lacrosse scandal. *Annals of Behavioral Medicine, 35*(1), 105–110.
33. Corrigan, P. (2004). How stigma interferes with mental health care. *The American Psychologist, 59*, 614–625. https://doi.org/10.1037/0003-066X.59.7.614
34. Pugh T, Hatzenbuehler M., Link B. Structural stigma and mental illness. Commissioned Paper for Committee on the Science of Changing Behavioral Health Social Norms, Mailman School of Public, Columbia University. Aug 2015.
35. Mental Illness. 2019. Retrieved 20 Oct 2020, from: https://www.nimh.nih.gov/health/statistics/mental-illness.shtml.
36. Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry, 19*(2), 137–155.
37. Corrigan, P. W., Watson, A. C., Heyrman, M. L., Warpinski, A., Gracia, G., Slopen, N., & Hall, L. L. (2005). Structural stigma in state legislation. *Psychiatric Services, 56*(5), 557–563.
38. Bishop, T. F., Press, M. J., Keyhani, S., & Pincus, H. A. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry, 71*(2), 176–181.
39. Cummings, J. R., Wen, H., Ko, M., & Druss, B. G. (2013). Geography and the Medicaid mental health care infrastructure: Implications for health care reform. *JAMA Psychiatry, 70*(10), 1084–1090.
40. McCleary-Gaddy, A. T., & Scales, R. (2019). Addressing mental illness stigma, implicit bias, and stereotypes in medical school. *Academic Psychiatry, 43*(5), 512–515.
41. Rada, R. E., & Johnson-Leong, C. (2004). Stress, burnout, anxiety and depression among dentists. *Journal of the American Dental Association (1939), 135*(6), 788–794.
42. Farrell, G. A. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing, 35*, 26–33.
43. Arvaniti, A., Samakouri, M., Kalamara, E., Bochtsou, V., Bikos, C., & Livaditis, M. (2009). Health service staff's attitudes towards patients with mental illness. *Social Psychiatry and Psychiatric Epidemiology, 44*(8), 658–665.
44. Hampton, T. (2005). Experts address risk of physician suicide. *JAMA, 294*(10), 1189–1191.
45. Substance Abuse and Mental Health Services Administration. (2015). *Racial/ethnic Differences in mental health service use among adults. HHS publication no. SMA-15-4906*. Substance Abuse and Mental Health Services Administration. Retrieved from: http://www.integration.samhsa.gov/MHServicesUseAmongAdults.pdf
46. Alegria, M., Woo, M., Takeuchi, D., & Jackson, J. (2009). Ethnic and racial group-specific considerations. In P. Ruiz & A. Primm (Eds.), *Disparities in psychiatric care: Clinical and cross-cultural perspectives* (pp. 306–318). Lippincott Williams and Wilkins.
47. Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gee, G., et al. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLoS ONE, 10*, e0138511. https://doi.org/10.1371/journal.pone.0138511
48. Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the Well-being of people of color. *The American Journal of Orthopsychiatry, 70*(1), 42–57.
49. Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *The American Behavioral Scientist, 57*(8), 1152–1173.

50. Sawyer, P. J., Major, B., Casad, B. J., Townsend, S. S., & Mendes, W. B. (2012). Discrimination and the stress response: Psychological and physiological consequences of anticipating prejudice in interethnic interactions. *American Journal of Public Health, 102*(5), 1020–1026.
51. Korous, K. M., Causadias, J. M., & Casper, D. M. (2017). Racial discrimination and cortisol output: A meta-analysis. *Social Science & Medicine, 193*, 90–100.
52. Van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science & Medicine, 50*(6), 813–828.
53. Egede, L. E. (2006). Race, ethnicity, culture, and disparities in health care. *Journal of General Internal Medicine, 21*(6), 667.
54. Berz, J. P., Johnston, K., Backus, B., Doros, G., Rose, A. J., Pierre, S., & Battaglia, T. A. (2009). The influence of black race on treatment and mortality for early-stage breast cancer. *Medical Care, 47*(9), 986–992.
55. Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *JAMA, 282*(6), 583–589.
56. Silber, J. H., Rosenbaum, P. R., Romano, P. S., Rosen, A. K., Wang, Y., Teng, Y., Volpp, K. G., et al. (2009). Hospital teaching intensity, patient race, and surgical outcomes. *Archives of Surgery, 144*(2), 113–120.
57. Lee, C., Ayers, S. L., & Kronenfeld, J. J. (2009). The association between perceived provider discrimination, health care utilization, and health status in racial and ethnic minorities. *Ethnicity & Disease, 19*(3), 330.
58. Greer, T. M., Brondolo, E., & Brown, P. (2014). Systemic racism moderates effects of provider racial biases on adherence to hypertension treatment for African Americans. *Health Psychology, 33*(1), 35.
59. James. (2020b). Health and health-related correlates of internalized racism among racial/ethnic minorities: A review of the literature. *Journal of Racial and Ethnic Health Disparities, 7*(4), 785–806. https://doi.org/10.1007/s40615-020-00726-6
60. Hatter-Fisher, D., & Harper, W. (2017). The relevance of depression, alexithymia, and internalized racism to blood pressure in African Americans. *International Journal of Health and Social Sciences, 7*(1), 49–60.
61. James, D. (2020a). Self- and group-focused internalized racism, anxiety, and depression symptoms among African American adults: A core self-evaluation mediation pathway. *Group Processes & Intergroup Relations, 24*(8), 1335–1354. https://doi.org/10.1177/1368430220942849
62. Gale, M. M., Pieterse, A. L., Lee, D. L., Huynh, K., Powell, S., & Kirkinis, K. (2020). A meta-analysis of the relationship between internalized racial oppression and health-related outcomes. *The Counseling Psychologist, 48*(4), 498–525.
63. Gupta, A., Szymanski, D. M., & Leong, F. T. (2011). The "model minority myth": Internalized racialism of positive stereotypes as correlates of psychological distress, and attitudes toward help-seeking. *Asian American Journal of Psychology, 2*(2), 101–114.
64. Chae, D. H., Nuru-Jeter, A. M., Adler, N. E., Brody, G. H., Lin, J., Blackburn, E. H., & Epel, E. S. (2014). Discrimination, racial bias, and telomere length in African-American men. *American Journal of Preventive Medicine, 46*(2), 103–111.
65. McCabe, S. E., Hughes, T. L., Bostwick, W. B., West, B. T., & Boyd, C. J. (2009). Sexual orientation, substance use behaviors and substance dependence in the United States. *Addiction, 104*(8), 1333–1345. https://doi.org/10.1111/j.1360-0443.2009.02596.x
66. Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science, 8*(5), 521–548. https://doi.org/10.1177/1745691613497965
67. King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8*, 70. https://doi.org/10.1186/1471-244X-8-70

68. Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674
69. Mustanski, B., Andrews, R., & Puckett, J. A. (2016). The effects of cumulative victimization on mental health among lesbian, gay, bisexual, and transgender adolescents and young adults. *American Journal of Public Health, 106*(3), 527–533. https://doi.org/10.2105/AJPH.2015.302976
70. Evans-Polce, R. J., Veliz, P. T., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2020). Associations between sexual orientation discrimination and substance use disorders: Differences by age in US adults. *Social Psychiatry and Psychiatric Epidemiology, 55*(1), 101–110. https://doi.org/10.1007/s00127-019-01694-x
71. Yoshikawa, H., Alan-David Wilson, P., Chae, D. H., & Cheng, J. F. (2004). Do family and friendship networks protect against the influence of discrimination on mental health and HIV risk among Asian and Pacific islander gay men? *AIDS Education and Prevention, 16*(1), 84–100.
72. Li, C. C., Matthews, A. K., Aranda, F., Patel, C., & Patel, M. (2015). Predictors and consequences of negative patient-provider interactions among a sample of African American sexual minority women. *LGBT Health, 2*(2), 140–146.
73. Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., Williams, C. C., & Ross, L. E. (2017). LGBT identity, untreated depression, and unmet need for mental health services by sexual minority women and trans-identified people. *Journal of Womens Health, 26*(2), 116–127.
74. Jabson, J. M., Mitchell, J. W., & Doty, S. B. (2016). Associations between non-discrimination and training policies and physicians' attitudes and knowledge about sexual and gender minority patients: A comparison of physicians from two hospitals. *BMC Public Health, 16*(1), 256.
75. Calabrese, S. K., Earnshaw, V. A., Krakower, D. S., Underhill, K., Vincent, W., Magnus, M., Dovidio, J. F., et al. (2018). A closer look at racism and heterosexism in medical students' clinical decision-making related to HIV pre-exposure prophylaxis (PrEP): Implications for PrEP education. *AIDS and Behavior, 22*(4), 1122–1138.
76. Turan, J. M., Elafros, M. A., Logie, C. H., Banik, S., Turan, B., Crockett, K. B., Murray, S. M., et al. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Medicine, 17*(1), 7.
77. WHO Health Commission. (2008). *Final report of the CSDH*. World Health Organization.
78. Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status and health: Complexities, ongoing challenges and research opportunities. *Annals of the New York Academy of Sciences, 1186*, 69.
79. Eisner, M. D., Blanc, P. D., Omachi, T. A., Yelin, E. H., Sidney, S., Katz, P. P., Iribarren, C., et al. (2011). Socioeconomic status, race and COPD health outcomes. *Journal of Epidemiology and Community Health, 65*(1), 26–34.
80. Stotzer, R. L. (2009). Violence against transgender people: A review of United States data. *Aggression and Violent Behavior, 14*(3), 170–179.
81. Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and health: Evidence and needed research. *Annual Review of Public Health, 40*, 105–125.
82. Mustillo, S., Krieger, N., Gunderson, E. P., Sidney, S., McCreath, H., & Kiefe, C. I. (2004). Self-reported experiences of racial discrimination and black–white differences in preterm and low-birthweight deliveries: The CARDIA study. *American Journal of Public Health, 94*(12), 2125–2131.
83. Tomfohr, L., Cooper, D. C., Mills, P. J., Nelesen, R. A., & Dimsdale, J. E. (2010). Everyday discrimination and nocturnal blood pressure dipping in black and white Americans. *Psychosomatic Medicine, 72*(3), 266.
84. Tesler, M. (2012). The spillover of racialization into health care: How President Obama polarized public opinion by racial attitudes and race. *American Journal of Political Science, 56*(3), 690–704.

85. Metzl, J. M. (2019). *Dying of whiteness: How the politics of racial resentment is killing America's heartland*. Hachette UK.
86. Siegel, J., Coleman, D. L., & James, T. (2018). Integrating social determinants of health into graduate medical education: A call for action. *Academic Medicine, 93*(2), 159–162.
87. Eisenberg, L., & Kleinman, A. (Eds.). (2012). *The relevance of social science for medicine* (Vol. 1). Springer Science & Business Media.
88. Himmelstein, M. S., Puhl, R. M., & Quinn, D. M. (2018). Weight stigma and health: The mediating role of coping responses. *Health Psychology, 37*(2), 139.

Asia T. McCleary-Gaddy, Ph.D. serves as the Director of Diversity and Inclusion for UTHealth and Assistant Professor of Psychiatry and Behavioral Sciences for McGovern Medical School. Asia serves the UTHealth community through design and implementation of policies and procedures that support diversity and inclusion, recruitment, and retention of URM faculty and students, program evaluation, and data analysis for students, residents, and faculty members. Dedicated to furthering the empirical research published on diversity and health, she has published in leading journals including Annals of Behavioral Medicine, Journal of Health Psychology, and Equality, Diversity, and Inclusion.

Previously, Dr. McCleary-Gaddy served as the inaugural Director of Diversity and Equity for Hackensack Meridian School of Medicine and helped launch the institution's high school pipeline/pathway programs. Prior to that role, she served as a Data Analyst for the Vermont Department of Health in Burlington, VT where she analyzed data for the Healthy People 2020 initiative. Dr. McCleary-Gaddy earned a PhD in Experimental Social Psychology. She also holds a Bachelor of Arts in Psychology with a distinction in Research and Creative Works from Rice University.

Drexler James, Ph.D. joined the faculty at Univeristy of Minnesota, Twin Cities in 2022. He completed his doctorate in Social Psychology from the University of Illinois at Chicago. Dr. James aims to advance theories of social stigma in ways that will help reduce persistent health disparities. Namely, rather than approaching stigmas as fixed "traits" that individuals possess, he examines stigma as a dynamic and relational social psychological process to reveal how it reinforces and reproduces health-relevant social inequality