Chapter 13
Stigma and Medicine

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> *Archbishop Tutu*: I think, I mean, that we have very gravely underestimated the damage that apartheid inflicted on all of us. You know, the damage to our psyches, the damage that has made—I mean, it shocked me. I went to Nigeria when I was working for the World Council of Churches, and I was due to fly to Jos. And so I go to Lagos airport and I get onto the plane and the two pilots in the cockpit are both black. And whee, I just grew inches. You know, it was fantastic because we had been told that blacks can't do this.
> *Ms. Tippett*: Right.
> *Archbishop Tutu*: And we have a smooth takeoff and then we hit the mother and father of turbulence. I mean, it was quite awful, scary. Do you know, I can't believe it but the first thought that came to my mind was, "Hey, there's no white men in that cockpit. Are those blacks going to be able to make it?" And of course, they obviously made it—here I am. But the thing is, I had not known that I was damaged to the extent of thinking that somehow actually what those white people who had kept drumming into us in South Africa about our being inferior, about our being incapable, it had lodged somewhere in me.
> From On Being, with Krista Tippett (www.onbeing.org)

13.1 Introduction

As illustrated in the above quotation, human beings can have very clear values which are inconsistent with other thoughts and feelings that may arise. As noted, Desmond Tutu, while clearly standing for the equality of black people in South Africa, describes, during a turbulent airplane flight, having the thought "Hey, there's no white men in that cockpit. Are those blacks going to be able to make it?" He discusses a sense of almost being infected with the social norms that gave rise to that thought, despite his values and hard work promoting the equality of black people. Tutu describes a very normal human phenomenon, in which consciously held values may have very little to do with thoughts that feel automatic, and may not be subject to conscious control. He also demonstrates that he holds these troubling

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thoughts lightly, with a sense of playfulness, in his public telling of the story. He is clearly not hiding these thoughts, suppressing them, or avoiding them.

Turning to medicine, it is clear that the values embedded in the Hippocratic Oath involve practicing medicine with honor, competency, and respect. Yet, despite these core values, medical students and physicians still may have thoughts and feelings that are the opposite of these cherished values. These thoughts and feelings may emerge with respect to patient care, and notably, may also involve the care provided for themselves and for their colleagues. For example, with respect to patient care, one may feel that people who are obese are entitled to excellent care and can live a life of worth and integrity, while at the same time, also struggle with thoughts and feelings about that person being a "a slob, weak willed…they did this to themselves…," and thus, back away from providing effective, compassionate medical care. With respect to physician and medical student self care, one may truly believe that physicians are human and can experience depression and that professional help may be useful, while at the same time, one may also have thoughts about weakness and shame and thus avoid seeking or recommending care.

No one likes having thoughts and feelings that are not consistent with who we want to be or who we believe ourselves to be. And a natural, human, understandable response to being in this predicament would be to try to not feel that way. However, efforts to not feel undesired feelings, as we shall see, can result in actually intensifying those very feelings (Wegner 1994). One normal solution to intensely troubling thoughts and feelings would be to distance oneself from the people or circumstances that provoke such feelings. But this, as we shall see, can be set up for dehumanization and stigma.

Stigma in medicine is important because, when acted upon, believing or avoiding one's stigmatizing thoughts can result in restricted opportunities and thus poor outcomes when applied to oneself or to the patient's under one's care.

This chapter will explore the kinds of stigma relevant for health-care providers and for patients. This chapter will also focus, specifically, on stigma surrounding obesity as well as on some of the unique features of depression and suicidality in physicians and medical students. Methods of reducing the adverse impact that stigma of all kinds can have on the provision of health care will also be discussed.

In this chapter, a slightly different approach will be applied to problem-based learning (PBL). Cases will be presented that target personal, emotional, and cognitive responses from the reader, and the reader is invited to consider those responses as the cases unfold. In addition, the PBL tables have a different format from most chapters in this book. The tables invite further exploration of the reader's thoughts, feelings, and behaviors.

Objectives By the end of this chapter, the reader will be able to:

1. Define enacted stigma and describe how this may impact the provision of heath care.
2. Discuss the effects of self stigma, or "shame," on seeking and receiving health care.
3. Describe specific aspects of obesity-related stigma.
4. Describe specific aspects of medical student and physician self stigma as it relates to depression and suicidality.
5. Discuss how physicians and medical students might reduce the effects of stigma in health care.

Clinical Vignette 13.1.1 Presenting Situation: Betty
Betty is a 32-year-old, morbidly obese woman who is pregnant with her first child. She presents to the emergency department at approximately 27-week gestation, weighing 425 pounds. She is unsure about her last menstrual period; therefore, the gestational age of the fetus is estimated by an ultrasound performed at her last visit to the emergency department. Betty is dressed in sweatpants and a t-shirt. She is carrying a large purse, and you see soda and candy wrappers sticking out. She has a bad odor about her, resulting perhaps from poor hygiene.

Betty has been experiencing lower back pain for approximately 2 days. The pain comes and goes. She reports good fetal movement. There is no vaginal bleeding or discharge.

You are the emergency room (ER) physician assigned to Betty you have been working long hours and you are halfway through a 14-h shift.

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Visualize this patient and notice what emotional reactions come up in you. Be honest and write down what first comes to mind without censoring your responses. Please proceed with the problem-based approach. In this case, your thoughts, feelings, and behavior will be explored. The following table is modified from Chiles and Strohsahl (2004; Fig. 13.1)

	My response	How I feel about my own response?
What is your primary *positive* emotional response?		
What is your primary *negative* emotional response?		
What aspects of this person's situation and behavior elicit the most *negative* or *judgmental* response from you?		
What aspects of this person's situation and behavior elicit the most *positive* or *compassionate* response from you?		
What is the biggest barrier you would encounter continuing to interact with this person?		

Fig. 13.1 Betty

Case Vignette 13.1.2: Continuation
During her previous visits to the county hospital, ER employees became frustrated with Betty. She missed follow-up prenatal appointments and continued to use the emergency department for routine care. She reported concern that the pregnancy clinic staff "won't take me seriously."

Betty approaches the admission staff, who know her by name from her visit 3 weeks prior. You hear the staff say reprovingly: "You will have to wait your turn, Betty. Did you even see your obstetrician at the clinic, are you even concerned about your baby?"

While you are experiencing emotional negative, judgmental feelings about Betty, you are also aware that people with obesity are stigmatized in a very severe way, as the stigma of being overweight cannot be concealed and is seen as a controllable condition (Crocker et al. 1993).

13.2 Learning Issue: Stigma

The general term "stigma" refers to a process that has both high social/political and personal implications. Stigma refers to a process of judging a particular category of people based upon group membership. So a blond woman might be viewed as *flakey* or *fun*, an obese person might be viewed as *lazy* or *weak willed*, an addict might be viewed as *hopeless* and to *be feared*, a depressed medical student might be viewed as *incapable* and *weak*. Physical disability, mental illness, medical status, addiction, race, ethnicity, religion, and gender are a few examples of stigmatized groups.

While stigma takes many forms, the *process of stigma* may be understood as a process of attempting to avoid or suppress people, thoughts, or situations that give rise to discomfort. This process would be the same whether one is stigmatizing or avoiding another person or group (enacted stigma), or whether one is avoiding a feeling or cognition about oneself (self stigma).

Enacted Stigma Enacted stigma, or how we stigmatize others, is part of a process that, throughout history and continuing today, has given rise to the extermination of large groups of people defined ethnically, geographically, and religiously. With respect to this case, enacted stigma refers to judging and dehumanizing Betty, the obese pregnant patient, because of her obesity.

Self Stigma Self stigma refers to feelings of shame and negative thoughts about oneself because of one's membership in a particular stigmatized group. Feelings such as "why try, I'm such a loser…I'm obese, I'll never get that job…Doctor's never take me seriously, because I am so slovenly…" are all examples of statements reflecting self stigma.

13.3 Learning Issue: Weight Stigma

Overweight and obese people are pervasively stigmatized, including in employment settings, health-care settings, and romantic relationships. It is thought to be one of the last socially acceptable forms of discrimination (Vartanian et al. 2014). Literature suggests that while other conditions such as physical disability or being a member of a disadvantaged ethnic group can elicit empathy and sympathy, obese people do not receive that advantage (Chen and Brown 2005). Obesity is a dangerous epidemic, associated with many chronic disease conditions (e.g., US Department of Health and Human Services 2001). Medical professionals are known to have negative feelings about obese patients (Puhl and Heuer 2009). In fact, the Social Security Administration (http://www.disability-benefits-help.org/disabling-conditions/obesity-and-social-security-disability) does not list morbid obesity as a disabling condition. Furthermore, it is typical for insurance plans to exclude obesity treatment from coverage (Puhl and Brownell 2001). Such negative and judgmental feelings can lead to enacted stigma, that is, behavior that minimizes, marginalizes, and restricts opportunities to those with the stigmatized condition.

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Now, imagine how Betty may feel and experience her interaction with health-care providers. Imagine *her* responses when filling out the table below (Fig. 13.2):

	Betty's response	**How Betty feels about her response?**
What is your primary *positive* emotional response to your health care providers?		
What is your primary *negative* emotional response to your health care providers?		
What is the biggest barrier you would encounter continuing to receive health care from these providers?		

Fig. 13.2 Betty's responses. (Adapted from Chiles and Stohsahl 2004)

13.4 Case 13.1.3 Continued

Betty leaves the ER in tears. You, as her health-care provider, are full of mixed feelings. Your peers share your feelings of discouragement and support your tendency to blame Betty for this difficult interaction. You feel justified and also feel worried about her likelihood of returning for the needed follow-up. You are worried about her unborn baby and also wish that the interaction had gone better. You are very glad to be off work after your shift, and you hope that if she returns, she will not be your patient.

Betty likely felt shamed and stigmatized as a result of her interactions with the health-care system (Puhl and Heuer 2009). Like many other patients with obesity, she may avoid health care, in order to avoid feeling so shamed and stigmatized (Vartanian et al. 2014). This kind of stigma, stigma that is internalized, is called felt stigma, and results in avoidance of situations that would bring about such feelings. How can this situation be improved, that is, how can the providers reduce enacted stigma and the patients reduce self stigma?

13.5 Learning Issue: Reducing the Impact of Enacted and Self Stigma

In every patient encounter, the physician brings biases about certain groups or categories of people based on their own experience. For example, a physician might negatively stigmatize a patient seeking pain medication if the physician him or herself has a history of a substance use disorder. In such an example, the patient might be inappropriately categorized as an addict, user, or drug seeker and denied treatment for pain. At the other end of the continuum, physicians may have a positive feeling about a patient, who may then not receive the care appropriate for their illness. For example, physicians are likely to assume adherence to medical regimens in patients with whom they are well acquainted, an assumption that may be false (Wailoo 2006).They may think, "I know this patient really well, and I'm sure they are taking their medications." The provider may not fully engage with the evaluation of the patient. Often, clinical judgments are based on outward features of a patient, previous actions, or membership in a certain group. This bias may result in suboptimal care because the details of the patient's medical problems are not assessed. At both ends of the continuum, enacted and self stigmatization describe how a physician judges a person and how that person responds, all leading to a distance between the patient's needs and their treatment.

Betty is a person who is among the most stigmatized in our society, due to her obesity. Her condition can give rise to enacted and self stigma, a process resulting in social isolation and rejection (Lazare 1997) and clearly impacting health care. In Betty's case, the physician might engage in negative enacted stigma, which might result in the following behaviors:

1. Failure to elicit Betty's concerns.
2. Inadequate time spent educating and treating her because of her past failure and her predicted failure to follow through in the future.
3. Blame toward Betty for her poor health.
4. Rationalization for not optimally engaging with this patient, followed by feelings of guilt, defeat, and burnout.

Betty may feel a great deal of shame about her present situation. She may, in fact, have avoided health care just because of her own shame around her condition (Lazare 1997). She may be afraid about pregnancy and being morbidly obese, and her avoidance of health care may be related to her attempts to not think about her own precarious health. After all, if she does not see a doctor, perhaps she can forget that she is, in fact, so overweight. Perhaps she can ignore her pregnancy and the addition of new responsibilities. In addition, she may be accurately afraid of coming in for help from past experiences of being stigmatized by health-care providers. In this situation, both enacted stigma and felt stigma are interacting to produce a very poor health-care outcome.

13.6 Learning Issue: How Might the Physician Improve This Situation?

First, it is important to note that it is not possible to completely eliminate judgmental thoughts and feelings from one's mind. Indeed, we are trained on many levels to make judgments of our patients in an attempt to evaluate and help them. These judgments include features of personality and risk factors for poor compliance and prognosis. When these judgments cause us to under-evaluate a patient, to treat them condescendingly or harshly, or to withhold our best intentions, then we begin the downward spiral of stigma. It is not possible to be without judgment but it is possible to decide not to allow one's actions toward patients to reflect these judgments. Physicians may strive to provide excellent health care even when their thoughts and feelings are inviting them to take short cuts that do not serve the patient's health-care needs.

To be more effective, think about how you might engage less with the judgmental thoughts and feelings you identified with this case, and focus on how to provide respectful, effective health care. In daily life, there are many examples where we behave effectively even when our thoughts and feelings dictate otherwise, such as going to work even when tired or depressed. It is possible to provide effective health care even when you feel discouraged and defeated by the patients themselves. These sensibilities are aspects of Acceptance and Commitment Therapy (Hayes et al. 1999).

13.7 Learning Issue: Avoiding Stigmatization

Here is an example of how one doctor might avoid stigmatizing Betty or another patient:

> Physician: "It is great you came in. I am glad you are here. You look really tired. Was it hard to get here?"
> Patient: "I'm so tired. The buses were all late and I had to borrow money for the fare. I'm not feeling good at all and I am worried about my baby…"
> Physician: "I'm glad you care so much. We want to help. I notice this is your fourth visit to the ER. It must be hard, but did you have chance to make it to your obstetrician appointment since we last saw you? Is there something that can be done to help make it easier for you to attend your outpatient appointments? I wonder if there is a way to get you some bus passes … would that help?"

In caring for a patient with felt stigma and shame, it could help to be empathic and to invite the patient to share what she may feel and to discuss how important it is to seek health care anyway. Much the way you have to learn to behave as a competent physician in spite of judgmental feelings, the patient must also take care of her body even when she is feeling ashamed (Fig. 13.3). For example:

> Physician: "Betty, I know how hard it must be to come in here. I know that many times, people who have had problems like this feel embarrassed and feel some shame. I am so glad that you are in here today; even though it is hard, and I am going to try really hard to have this visit go well for you."

How might you, as her physician, elicit the most *positive* and cooperative responses from Betty?	

How might you, as her physician, feel positive and engaged with Betty and proud of your medical care for her and her unborn child?	

Fig. 13.3 Strategies to improve physician and patient responses in Vignette 13.1

Vignette 13.1.4: Conclusion
Betty returns to the ER a few weeks later, just as a follow-up. You, her physician, notice your negative reactions, and also greet her warmly and thank her for returning. You notice that Betty is teary, and you ask her to tell you about what is wrong. She tells you that she is worried that her overweight might negatively impact her baby, and also tells you (while seeming very embarrassed) that she is trying to diet while pregnant. You lean toward her and discuss candidly her concerns, focusing on her commitment to her unborn child and on her desire to do what recommended for the duration of the pregnancy. You both leave that interaction feeling that effective, compassionate, care has been provided and has been received. You feel that you have done good work in this case, and are quite open to seeing Betty again.

Vignette 13.2.1 Presenting Situation: Mary
Mary is a 25-year-old medical student who is currently a clerk on your internal medicine service. You have worked with her for a few weeks, and saw her as bright and engaged. Of late, you notice that she seems tearful and withdrawn. She has been late, distracted, unprepared, and seems very fatigued. You notice bandages on her wrists. You ask her into your office to see if you can give her feedback about her sudden drop in performance.

Mary begins to cry, she notes she is not sleeping, has lost about 10 pounds in the last few weeks, her boyfriend broke up with her, and she feels totally unprepared for boards. She confides that her brother was recently diagnosed with cancer. She states she has been using alcohol for sleep, unsuccessfully. You ask her if she is receiving support from her peers or if she is in counseling or taking any psychiatric medication. She states "yeah, right, who has time for that…." You want to help her further, but she gets up and thanks you for your attention, assures you she is doing just fine, promises to do better, and rushes out of your office.

Please think about your reactions to Mary as her attending physician and work through the table below (Fig. 13.4):

	Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

You are uncomfortable about Mary's behavior, as you want to believe in this talented medical student, and you do not want to negatively impact her training. You remember being a medical student, and you remember struggling with depression, and even using alcohol inappropriately, and how important it felt to hide it in order

	My response	**How I feel about my own response. Include both positive and negative feelings.**
What is your primary *positive* emotional response?		
What is your primary *negative* emotional response?		
What aspects of this person's situation and behavior elicit the most *negative* or *judgmental* response from you?		
What aspects of this person's situation and behavior elicit the most *positive* or *compassionate* response from you?		
What is the biggest barrier you would encounter continuing to interact with this person?		

Fig. 13.4 Responses to Mary

to not lose the confidence of your peers and teachers. The bandages on her wrists are very troubling to you, you want to ask her about them but do not want to embarrass her and also are unsure of what to do if she, in fact, has been engaging in suicidal behavior.

You are also aware that medical students have higher rates of depression, burnout, and mental illness than the general population, and that these issues tend to get worse as training continues (Schwenk et al. 2010). You are also aware that physicians commit suicide more than twice as often as nonphysicians, and that female physicians are particularly vulnerable. And you know that rates of suicidal thoughts occur in just under 10% of fourth-year medical students and residents (Goebert et al. 2009).

Now imagine how it might feel to be Mary, experiencing emotional struggles, and then being called in to her attending physician's office (Fig. 13.5).

Medical students experience significant enacted and felt stigma around their emotional struggles, depression, and suicidal ideation (Schwenk et al. 2010). That is, they are not only subject to significant stress and emotional struggle, but also feel that seeking help and revealing their struggles will negatively impact their careers. They also experience significant felt stigma, that is, they feel shame around admitting their vulnerability in a culture where appearing strong, independent, and competent is so highly valued (Fig. 13.6).

Mary is falling into the category of possibly having depression and may be abusing alcohol. You are not sure. She is also possibly cutting her wrists. These problems are very difficult for anyone, including physicians, to deal with. These

	Mary's response	Positive and negative effects on Mary
What might she have felt in her attending physicians office that felt positive to her? What might she have felt felt negative to her? What is her primary *positive* emotional response?		
What is her primary *negative* emotional response?		
What aspects of this situation and staff behavior elicit the most *negative* or *judgmental* response from her?		
What aspects of this situation and staff behavior elicit the most *positive* or *compassionate* response from her?		
What is the biggest barrier she would encounter in continuing to try to receive help?		

Fig. 13.5 Mary's feelings in Vignette 13.2

How might you encourage Mary to talk about her struggles and to be open to getting help and support?	

Fig. 13.6 Strategies to elicit the most positive and cooperative responses in Vignette 13.2

types of mental health issues are highly stigmatized in our culture. People with mental illness are often severely judged, feared, and given suboptimal health care (Corrigan 2005). Mary's dysfunctional behavior may be particularly difficult to accept because she is a medical student and may evoke particular responses on the part of the physician. In the area of substance abuse, enacted stigma is particularly severe, as it tends to evoke even greater negative social attitudes (Crisp et al. 2000).

Vignette 13.2.2 Conclusion
Mary is distraught during rounds later that day. You approach her again and offer to talk. She does not want to tell the attending physician that she is feeling hopeless because her boyfriend broke up with her and is feeling suicidal.

She fears he will not take her seriously as a student. The attending's pager beeps.

"I have some really acute patients to take care of Mary. What do you need right now?"

Mary cannot pinpoint what she needs. She does know that she feels intense anxiety about her relationship and her studies. She is suddenly unsure that she can trust the attending to maintain confidentiality.

"Nothing! I have nothing. I need nothing! I'll go home deal with it"

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

When physician judgments result in enacted stigma, the following may occur:

1. Referral to psychiatry immediately, without any discussion with Mary.
2. Minimization of the problems because of her medical student status, for example, "You will feel better after finals…"
3. Blame toward the patient for their poor health. "You didn't take your meds…"
4. Temporary feelings of justification in not having engaged with this patient; followed by feelings of defeat and burnout.

When physician judgments do not lead to enacted stigma, the following might occur:

1. Quality time spent with the student; genuine engagement with her and understanding of her problems; development of a thoughtful, collaborative referral if indicated.
2. Connection with her medical student status; empathy, and encouragement to take care of herself.
3. Assessment of her problems with adherence to medications, including an assessment of side effects, costs and benefits, and alternative treatment regimens.
4. Consultation from trusted colleagues about your own feelings about treating someone who is so distressed and yet may share a profession with you.

In this case, it is likely that Mary feels tremendous felt stigma or shame. Seeking treatment from the same people who teach and evaluate her is likely very difficult. She may, in fact, have avoided seeking help earlier due to her own shame about her condition. In addition, statistically, her suicide risk is high.

To be more effective with Mary, think about how you might engage less with your judgmental thoughts and feelings and focus more on the provision of respectful, effective health care. It is possible to provide effective health care even when you feel judgmental and defeated. Learning these skills will help you teach them to

Mary. Empathize with how she may be feeling under these conditions and reinforce her willingness to seek help when needed. Connect with Mary's value of taking care of herself and thus succeeding in her medical career.

13.8 Learning Issue: Avoiding Stigmatization

Please consider the following as one possible way to avoid stigmatizing Mary or another patient:

> Physician: "Mary, I understand you may feel uncomfortable because we know each other and I am your teacher. You have opened up to me a little, which I know is awkward, and I feel strongly that your courage is very admirable and a good step in taking care of yourself. I will do my best to keep what we discuss here between the two of us."
> Mary: "Thank you. I'm so upset. My boyfriend just broke up with me. I'm scared. I'm scared to be alone. And exams are coming. I can't focus or concentrate. I can't do what I need to do."
> Physician: "It's hard to focus when you are trying to sort out feelings. I am wondering if you are having feelings about harming yourself."
> Mary: "I've had those thoughts. That's probably what scares me the most. I have been cutting … see my wrists? It takes away the pain for a while and then it becomes unbearable all over again."
> Physician: "It must be hard for you to share this with me. You sound worried about your thoughts and feelings. I am concerned about you and want to make sure that you get the help you need. What is important is that you get help when you need it so that you can pursue your goals and stay healthy."

13.9 Conclusion

Avoiding the effects of stigma may well be the most difficult aspect of providing equal health care to all people. This may be the case because doing so requires the disciplined efforts of all health-care personnel to monitor their feelings and thoughts and to control their actions. Within groups, one person has the power to promote a culture of tolerance and compassion. Consider an internal medicine resident asking the staff psychiatrist to help him understand a patient with borderline personality disorder: "She has brought me to my wit's end … I can't stand her … I feel terrible." For a minute, the psychiatrist sits with the resident, validates his feelings, commends him for recognizing the problem in himself, and then states simply that this patient's emotional progress became retarded ever since she was raped at home as a teenager. "And so she still sees the world as a young teenager in many ways, even though she is well educated and physically very capable." The resident and the patient will benefit because the resident sought help to manage his feelings of frustration and burn out, and a senior colleague took time to think the problem through.

13.10 Discussion Questions

1. Why do you think enacted stigma causes others to feel shame? What kind of verbal and nonverbal signals have you seen people use to send this demeaning signal to others?
2. Why should a patient's self-imposed stigma burden a physician who is adequately treating the patient otherwise?
3. What specific personal goals can you make to reduce the demoralizing and debilitating effects of stigma of your working environment?
4. When is shame a positive emotion? When is shame a negative emotion? When have you felt stigma in your life? How can you ward off the ill effects of this stigma?

References

Chen, E. Y., & Brown, M. (2005). Obesity stigma in sexual relationships. *Obesity, 13*(8), 1393–1397.

Chiles, J., & Strosahl, K. (2004). *Clinical manual for assessment and treatment of suicidal behavior*. Washington D.C.: American Psychiatric Publishing.

Corrigan, P. W. (2005). *On the stigma of mental illness: Practical strategies for research and social change*. Washington, D.C.: APA. http://dx.doi.org/10.1037/10887–000.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177*, 4–7.

Crocker, J., Cornwell, B., & Major, B. (1993). The stigma of overweight: Affective consequences of attributional ambiguity. *Journal of Personality and Social Psychology, 64*(1), 60–70.

Goebert, D., Thompson, D., Takeshita, J., Beach, C., Bryson, P., Ephgrave, K., et al. (2009). Depressive symptoms in medical students and residents: A multischool study. *Academic Medicine, I*, 236–241. doi:10.1097/ACM.0b013e31819391bb.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Lazare, A. (1997). Shame, humiliation, and stigma in the medical interview. In M. Lansky & A. Morrison (Ed.), *The widening scope of shame* (pp. 383–396). NJ: Analytic Press.

Puhl, R. M., & Brownell, K. D. (2001). Bias, discrimination and obesity. *Obesity Research, 9*(12), 788–805.

Puel, R., & Heuer, C. A. (2009). The stigma of obesity: A review and update. *Obesity, 17*, 941–964.

Schwenk, T., Davis, L., & Wimsatt, L. (2010Depression, stigma, and suicidal ideation in medical students. I, Sep 15;304(11):1181–90. doi: 10.1001/jama.2010.1300. Washington, DC, APA, http://dx.doi.org.

US Dept of Health and Human Services. (2001). *The surgeon general's call to action to prevent and decrease overweight and obesity*. Rockville: U.S. Department of Health and Human Services.

Vartanian, L. R., Pinkus, R. T., & Smyth, J. M. (2014). The phenomenology of weight stigma in everyday life. *Journal of Contextual Behavioral Science, 3*(3), 196–202.

Wegner, D. M. (1994). Ironic processes of mental control. *Psychological Review, 101*, 34–52.

Wailoo, K. (2006). Stigma, race, and disease in 20th century America. *Lancet, 367*, 531–533.