



Stigmatisation in clinical consultations for persistent physical symptoms/functional disorders: A best fit framework synthesis

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ABSTRACT

Introduction: Stigma is a social attribute that links a person to an undesirable characteristic and leads to actions that increase the social distance from that person. This includes different or discriminatory treatment. Stigma is common in healthcare, particularly in people with persistent physical symptoms (PPS) and functional disorders (FD). The aim of this study is to create a new actionable framework to aid understanding of stigmatisation in consultations about PPS/FD and to improve the consultation experiences.

Methods: This framework development used the Best Fit Framework approach to data collected for a scoping review of stigma in functional disorders. The stages included selection of an initial framework from existing conceptual models, mapping quote data from published papers to the framework and an iterative process of revision and re-mapping. The final framework was tested by re-mapping all the quote data to the framework following classification rules.

Results: 253 quotes were obtained from the results sections of qualitative studies from a previous scoping review. The framework comprises of prejudice, stereotypes and actions to increase social distance. Stereotype refers to the focus of stigma: this may be the condition, the patient, or their behaviour. Actions that increase social distance include: othering; denial; non-explanation; minimising, norm-breaking; and psychologising.

By breaking down stigma into recognisable components, the framework provides a way to understand the difficulties that patients and clinicians face during consultations and a way to develop intervention materials.

Conclusions: This new framework for stigma in clinical consultations for PPS/FDs provides a useful tool for the study of stigma in clinical consultations.

1. Introduction

Persistent physical symptoms (PPS) is an umbrella term for symptoms lasting at least three months and which are disproportionate to underlying organ-system disease [1,2]. These symptoms may exist on their own (for example dizziness) or as part of a syndrome. Currently those syndromes are referred to as functional disorders (FDs), the most prevalent being irritable bowel syndrome and fibromyalgia [3,4]. PPS/FDs represent a spectrum of severity, ranging from mild symptoms to severe and chronic disorders [5]. PPS currently cannot be described by any single consistent cause [3] but they can be understood as arising from a complex interaction of biomedical, psychological and social factors [4].

PPS are common; approximately 1 in 6 patients with persistent symptoms had at least 1 symptom diagnosis persistent more than a year

[2,6,7]. In 2010, a Europe-wide review on disability burdens found that the 12-month prevalence rate is estimated to be around 5% (i.e., 20 million individuals in Europe) [8].

Stigma is a social attribute that links a person to an undesirable characteristic [9]. Stigmatisation, in its essence, is the process of increasing social distance between individuals. This is a social process that starts with an identification of a difference that is then connected to a culturally present negative stereotype. Therefore, the labelled persons are placed in distinct categories so as to accomplish some degree of separation of “us” from “them” [9]. This is a process of increasing social distance which then leads to the labelled persons' experiencing differential treatment and discrimination that lead to unequal outcomes.

It is important to note that stigmatisation is contingent on access to social, economic, and political power. This allows the identification of differentness, the construction of stereotypes, the separation of labelled

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persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. Those processes affect stigmatised people's everyday functioning and well-being [9,10].

Stigmatisation related to medical conditions is “a social process or related personal experience characterised by exclusion, rejection, blame, or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person identified with a particular health problem” [11]. Certain medical conditions have been found to carry negative social connotations and therefore can be more stigmatising. There is evidence that PPS/FDs can be experienced as more stigmatising, than medical conditions, which have an established medical diagnosis or cause [12–14]. Moreover, it has been found that patients who have experienced higher levels of stigma, are less likely to adhere to treatment or show improvements in symptoms, depression, or anxiety after treatment [15]. A survey conducted by the functional neurological disorder advocacy organisation [16] found that 85% of FND patients reported feeling disbelieved and disrespected when visiting a medical professional and stigma was believed to be a salient negative influence in clinical interactions [17].

We have recently conducted a scoping review of stigma in medical consultations for PPS/FDs [18]. In this, we found that stigmatisation was present across the spectrum of PPS/FDs in a variety of medical specialties, in different medical settings and across countries and cultures. The findings suggest that there are widespread societal-level conditions, cultural norms, and institutional practices present, which negatively effect the treatment of patients who are affected by PPS/FDs. Together these can be considered as form of structural stigmatisation [10]. We also found that there was no consistent framework or definition of stigma in consultations for PPS/FDs.

As stigmatisation is a social process, the way stigma is communicated and perceived is dependent on prevalent social, cultural and medical contexts [11,19]. In order to be able to improve consultations regarding PPS/FDs we first need to understand what specifically in the communication process causes the stigma that patients experience. For that end, the general models and frameworks about stigma are useful as they help us to understand the wider picture and societal shifts of attitudes and prejudices. Unfortunately, general frameworks are not very useful in a practical sense, particularly in a clinical consultation setting. One of the reasons for the development of a new framework for PPS/FDs, is that for example models for mental health stigma don't always represent PPS/FDs patients' lived experiences, especially considering people's experiences of physical symptoms. In that context the use of mental health stigma models can be stigmatising as those models tend to attribute psychological causes to the patient's physical symptoms. Secondly, social distance models are often not relevant to the context of PPS/FDs as they have focused more on the visible markers of differences and infectious diseases. Moreover, sociological models are overall all-encompassing and describe wider societal and general processes and therefore are abstract. Consequently, those models are not well suited for medical interactions as they are not designed to provide specific guidance on how to evaluate individual experiences or encounters, especially in a medical setting.

Therefore, there is a need for a practical framework with specific examples of what is stigmatising in consultations for PPS/FDs as both patients and clinicians report difficulties and experiences of stigma in those interactions.

This paper aims to address this identified gap in both research and in clinical practice. We describe the development of an actionable framework to aid understanding of how stigmatisation most commonly happens in clinical interactions for PPS/FD.

2. Methods

2.1. Overview

The current study is part of the innovative training network ETUDE

(Encompassing Training in fUNCTIONal Disorders across Europe) [20].

This framework synthesis used the Best Fit Framework (BFF) synthesis approach [21]. The BFF method offers a means to test, reinforce and build on an existing published model. This method is suited for producing context-specific conceptual models for describing or explaining the decision-making and health behaviours of patients and other groups. The BFF can also be used to adopt a model or a framework for a potentially different but relevant population. The process uses several steps: (1) identifying candidate frameworks and choosing an *a priori* framework (2) initial mapping of data to the *a priori* framework (3) identification of new themes to extend the framework if necessary (4) an iterative process of fitting data to the newly formed framework and revising this framework (5) testing of this evolved framework to reach the final conceptual model. The analysis was carried out by HT (PhD student) with regular supervisory input from CB (general practitioner) and additional input and discussion by BMF (PhD student).

2.2. Identifying candidate frameworks and choosing the *a priori* framework

In order to find stigma frameworks and models that describe in the most representative manner the stigma in clinical consultations for PPS/FDs we first looked for current psychological models of stigma. The reason is that stigma is widely researched in the field of psychology and mental health disorders. The search strategy followed the BFF method [21] but as there are no stigma frameworks in PPS/FDs we followed the first stage of the process, which was to combine free text and database searches in the relevant identified fields (psychology, mental health, sociology, stigma, healthcare). We aimed to incorporate key papers for commonly used stigma models in psychology and related mental health fields, therefore we searched Google Scholar and looked for stigma frameworks and models that were considered influential. As stigmatisation is widely recognised as a social process, we also looked for more generic sociological stigma models using the same search strategy. As no single model appeared to be a good fit, therefore we tabulated key components from the identified relevant models and from these derived an *a priori* framework. In this process, existing models of stigma were discussed with three authors (HT, CB and BMF) until those discussions resulted in consensus. At the stage of choosing the *a priori* framework we focused on one with a few high-level and inclusive concepts rather than seeking to produce a more granular *a priori* framework with multiple fields.

2.3. Mapping data to the *a priori* framework

Data for analysis consisted of verbatim quotations from the participants of the qualitative studies included in the previously published scoping review [18]. This analysis included 253 quotations from 32 studies. Those quotes involved both the perspectives of patients with PPS/FDs but also healthcare professionals working with PPS/FDs. The search strategy and selection of these articles are previously described in our scoping review [18]. From the results sections of these articles, we extracted all quotations that were used to illustrate the themes of the individual papers. We used these as the raw data for the mapping process. Mapping refers to a process of applying data to a framework to see what fits (and what does not fit). During this mapping it became apparent that the *a priori* framework, which was aimed to describe high-level structures, provided insufficient detail for the purpose of describing individual experiences. This analysis was carried out by two of the researchers (HT and CB).

2.4. Adding new themes

We thus coded data from the quotations into new conceptual categories, or themes, as described in the BFF [21]. Coding represents a process of generating new concepts (or themes) from the data

(particularly that which did not fit in the mapping exercise). This led to a more detailed framework in which the major conceptual categories were subdivided into meaningful conceptual units. At this stage of initial framework development, we generated a set of descriptors for the conceptual categories being formed.

2.5. Iterative fitting of data and revising of framework

We then repeated the mapping of all data to the revised initial framework. HT and CB carried this out independently and disagreements were resolved by discussion. A further step was that a third reviewer BMF (PhD candidate) independently mapped all text data to the revised framework. Any differences were again resolved by discussion.

2.6. Testing of the final conceptual framework

As a final step, we identified the themes in the quote data that did not fit the revised initial framework. These themes and the data supporting them were then considered and discussed by the entire review team. A final consolidated list of modified conceptual categories and definitions led to the slight revision of the new conceptual framework. At this stage, we finalised the new conceptual framework definitions.

3. Results

3.1. Identifying candidate frameworks and choosing the a priori framework

We identified five potentially relevant models of stigma in mental health: (1) Measuring Mental Illness Stigma [22]; (2) Mental Illness Stigma Framework [14]; (3) The Health Stigma and Discrimination Framework [23]; (4) Social Categories and Stereotypes Communication Framework [24]; (5) A Framework for Assessing Structural Stigma in Health-Care Contexts for People with Mental Health and Substance Use Issues [25]. We also identified four more generic stigma models: (1) Sociological model of stigma [9]; (2) Psychological mechanisms of stigmatisation [26]; (3) Health related stigma model [11]; and (4) Model for attitude and behaviour in stigma [27]. From these models we derived five components of stigma that could be observed in each. This is summarised in Table 1. While power differences are explicit in stigma, we accepted that these are implicitly present in clinical encounters and did not expand on them further. The remaining three components (Prejudice, stereotype and actions) are described below. (See Fig. 1.)

Table 1
Derivation of the priori framework from candidate models.

	Aim of the model	Power differences	Prejudice	Stereotypes	Actions	Outcomes
Link & Phelan (2001) [9]	Sociological model of stigma	Stigma as a way of exercising power	Dominant belief about undesirable characteristics	Used to construct categories of difference	Reduce status; produce unequal outcomes	Separation, status loss, and discrimination
Fiske (2000) [27]	Model for attitude and behaviour in stigma	Interpersonal level of one person responding to another\ based on that person's perceived social category	Present	Present	Present	Prejudice predicts behaviour more strongly than stereotypes
Major & O'Brien (2005) [26]	Psychological mechanisms of social stigmatisation	Members of high-status and low-status groups are likely to respond in dramatically different ways to being the target of stigma, even though the immediate situation seems the same	Present	Present and automatically activated	Negative treatment; Expectancy of same; Act to threaten identity	Situational cues, collective representations of one's stigma status, and personal beliefs and motives impact on well-being
Weiss et al. (2006) [11]	Health related stigma model	Present; social disqualification	Present	Discriminatory/ adverse social judgment	Cultural epidemiology of stigma and practical actions to implement to counter undesirable effects of stigma	Stigma as disqualification from full social acceptance

3.1.1. Preconceived judgements or prejudices

Prejudice reflects an evaluative or emotional component of social bias [28]. In *The Nature of Prejudice*, Allport [29] argued that an adequate definition of prejudice must include two essential elements. Firstly, there must be an attitude of favour or disfavour. Secondly, there must be an overgeneralised, erroneous belief [30]. These can be characterised as preconceived judgements that are culturally relevant, widespread, and often invisible, as it is in the case of implicit bias. The quote data evidenced the prejudiced beliefs, which perceived the objectively measurable “organic” disorders to be categorically different from other disorders. Therefore, this prejudice carries the implicit belief that objective organic disorders are more “real” and carry less implications of moral responsibility. It is then perceived that disorders not fitting this rigid definition may be either mental (in the mind) or not actually medical disorders at all. Prejudices are typically hidden from cognitive processes, are more of an emotional response and are more difficult to access but set the stage for the activation of negative stereotypes.

3.1.2. Activation of a negative stereotype

Link and Phelan [9] described two components: labelling and stereotyping, however we found it difficult, particularly considering the nature of the quote data, to differentiate between them. Therefore, we chose to use the terminology of ‘negative stereotype’, which aims to include in itself the activated negative labels. The reason for this decision was that at this stage we had no access to the cognitive and emotive processes that differentiate the labelling between stereotype activation.

3.1.3. Actions to stigmatise

In the stigmatisation process, Link and Phelan [9] described components of exclusion: separation and status loss. In this framework we have regarded it as the things that clinicians do or say to create or increase the social distance between ‘them’ and ‘us’, or between ‘deserving’ and ‘undeserving’ patients. This process can be seen as the exercise of unequal power in the consultation by attributing a lower status to the patient and enforcing epistemic injustice. The notion of epistemic injustice describes an unfair treatment that takes place in the context of giving, sharing and receiving knowledge, as in this case, it is in the context of medical interaction [31].

3.1.4. Discriminatory outcomes

Stigmatisation results in discrimination, a way of unfair treatment that is based on negative stereotyping and results in a person not getting the medical treatment that they need and otherwise would receive. Discriminatory actions have been evidences to have negative effects for

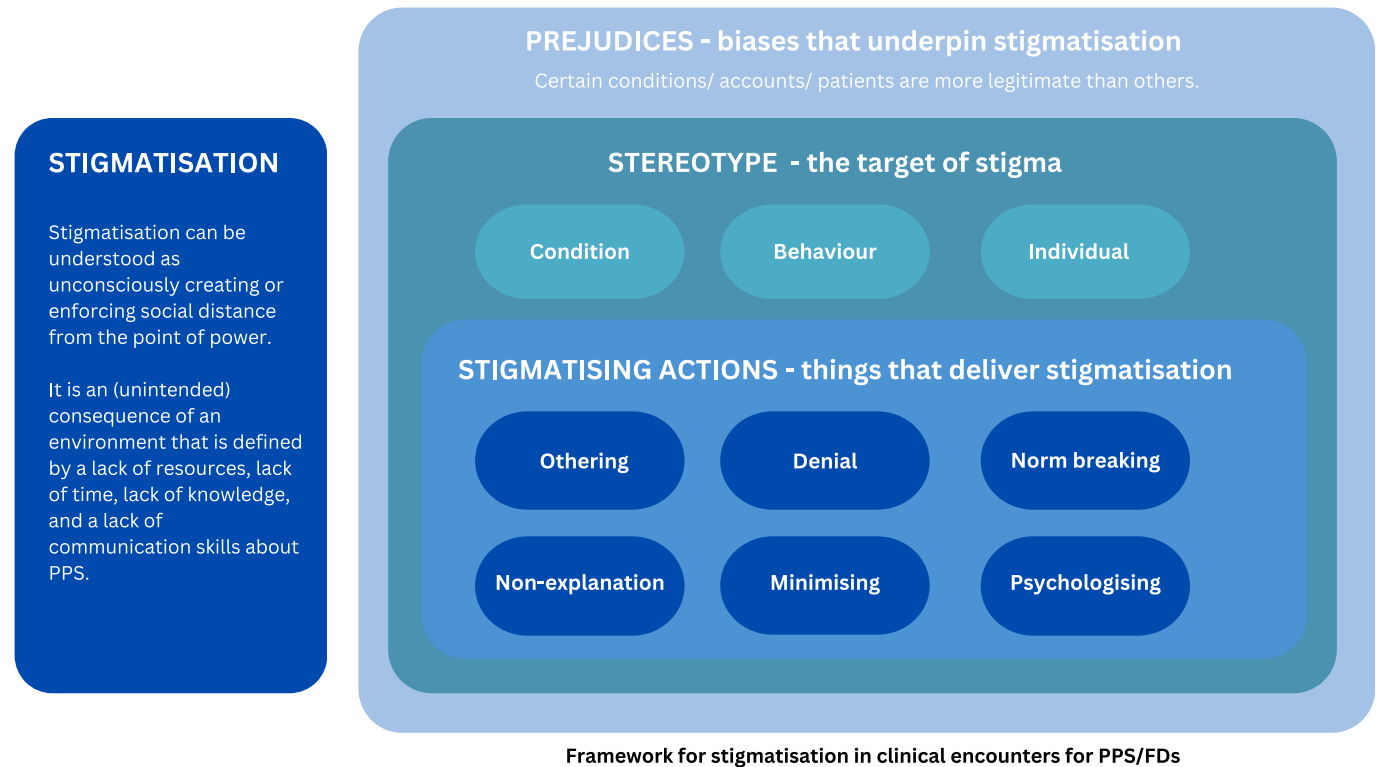


Fig. 1. Framework for stigmatisation in clinical encounters for PPS/FDs.

Table 2
Classifications of Stereotype / focus of the stigma.

Location of stereotype	Description	Example
Medical condition	The stereotype location is in the condition itself, with emphasis on the nature of the condition itself (rather than a particular patient or patient group). Typically separates the condition from other conditions, and places negative values on the condition: it is substantively different and less legitimate than other medical conditions. Labelling could be used as a way to stigmatise the condition, but applying a label is part of the stigmatisation of the condition. Language use: quotes here will typically take the perspective of the condition, using pronouns: 'it', 'this condition', 'it'.	"I have been discouraged from even mentioning this issue with most doctors and nurses that I deal with, being told that if it's not epileptic it's not a "real" seizure and should not be even brought up ever. And yet, when I find myself on the floor, it sure feels real to me! This is not in any way something that I would want to invent, fake or choose to have if there were an option" [Table 4, source 10] (<i>Patient with non-epileptic seizures - current acceptable terminology Functional (dissociative) seizures</i>)
The behaviour	The stereotype location is in the behaviour of a person with the condition. The emphasis is on the behaviour of the person during interaction with healthcare professionals or when seeking help (e.g. during a consultation, or receiving a diagnosis). Typically , generalises about the behaviour and actions of people, in a negative way. This emphasises that the behaviour and actions of people is different from how other people behave or are expected to behave. Language use: the comment is typically focussed on actions of people (using verbs).	"A lot of them give the impression that they are steering the diagnosis towards this end, when they find out what the disease entails. It's as if they want their symptoms to fit –and if they fit into something that's already been done, defined, even better– because that's easy. All these diagnoses that don't have a precise definition are clung to like a life vest, a salvation." [Table 4, source 8] (<i>Physiotherapist perspective on patients with Fibromyalgia</i>)
The person	The stereotype location is in the people with the condition, with emphasis on the attributes and motivations of an individual person. Typically , generalises about the person (they are grouped with other people) and places negative values onto the person. This creates the impression that they are inherently different to other patients (in terms of characteristics and attributes, motivations for health-seeking, and aspirations). Language use: quotes here will typically focus on the individual person: 'you', 'me', 'them'.	"I'm reluctant as far as this sort of thing is concerned, but I have to admit that it comes down to my own prejudice. I hold it against this sort of patient to a certain degree, they're soft, you have to put pressure on them so that they will live up their act/.../I think that in cases of women with fibromyalgia you're conditioned to think twice about granting them work leave." [Table 4, source 8] (<i>General Practitioner perspective on patients with Fibromyalgia</i>)

multiple levels of micro-, meso- and macro- social interactions [23]. Not all quotes described the discriminatory outcomes and where it was reported it appeared to be highly context dependent.

3.2. Mapping data to the a priori framework and adding new themes

During the mapping we found that while prejudice was apparent in

the data, it was not well differentiated. Rather it could be summed up by a common prejudice that PPS/FDs did not have the same status as "organic" disorders. While there may have been different prejudices that are relevant, these were not readily apparent in the qualitative quote data.

We also found that discriminatory actions or outcomes that followed from stigmatisation were not easily classified and often left implied. This

left us with a three-part model of stigmatisation in clinical encounters. The three parts were (1) prejudice, (2) stereotype and (3) action to stigmatise. The themes developed were then used to create meaningful categories within the stereotype and action components as described below.

3.2.1. Prejudice

Hidden or implicit beliefs regarding the inferior status of PPS/FDs compared to “organic disorders” that is prevalent in the wider context of the society. By “organic disorders” we mean the cluster of symptoms with a clearer or more structural explanation or being able to apply a medically established diagnosis.

3.2.2. Negative stereotypes

These represented the focus of stigmatisation. There are three sub-categories of this: (1) Condition (stereotypes referring to the nature of the symptom or condition itself); (2) Person (perceived personal characteristics of the individual with PPS/FDs, or people with PPS/FDs in general);(3) Behaviour (the perceived actions of a person or group of people with PPS/FDs during the clinical consultation, or referring to the general behaviour of people with PPS/FDs). These are described further in Table 2.

3.2.3. Actions used to stigmatise

These represent the behaviour by the clinician within the consultation. We identified six categories: (1) Othering – the person is not perceived as a legitimate patient and therefore it is perceived to be justifiable to treat the patient in a way that in other circumstances would be socially completely unacceptable; (2) Denial- the person's complaints are perceived not to be medically valid and therefore it is perceived to be justifiable to refuse to engage with the patient further; (3) Non-explanation – It is communicated that there are no medically valid ways of understanding and explaining the person's complaints and

therefore blocking the person the access to further care and leaving the person isolated; (4) Minimising - It is communicated that the person's complaints or symptoms are not at a severity that warrants clinical interventions, therefore putting the disproportionate amount responsibility for managing their symptoms on the patient; (5) Norm-breaking – the clinical practitioner acts in a way which typically is perceived as inappropriate; (6) Psychologising – The clinical practitioner explicitly or implicitly communicates that the person's bodily symptoms or their cause is purely psychological and therefore the physical symptoms are not addressed. These are described in more detail in Table 3.

It is important to recognise that while some of these actions are likely to always be stigmatising (e.g. othering and denial); others are only stigmatising in some contexts. For instance, breaking the norms of a consultation can be a positive disruption in a situation of mutual trust. Similarly, explaining the role of psychological factors when the patient wishes to know about them is not stigmatising.

4. Discussion

4.1. Summary of main findings

We used an established BFF method to create a new actionable framework which can be used to characterise the stigmatisation which commonly occurs in medical consultations about PPS/FDs. It comprises of an underlying prejudice about PPS/FDs, the negative stereotypes regarding the condition or the behaviour the or the person with PPS/FDs and lastly the actions used by the clinicians to stigmatise.

4.2. Strengths and limitations

The main strength of this work is the use of a structured approach to developing the framework. The BFF method has been recognised as

Table 3
Characteristics of actions used to stigmatise.

Action to stigmatise	Description	Example
Othering	The person is not perceived as a 'proper' patient. There is something about this person that separates them from a typical legitimate patient. They do not warrant normal engagement	"If you have ever had an alcohol or drug issue no matter how far in the past it was and how much you dealt with it, if you mention that to any doctor that is dealing with your chronic pain, and your painkillers, they will forever brand you an addict or an alcoholic and in doing so, will completely change the way they approach you with the medicine and their whole attitude and outlook." [Table 4, source 14] (Patient with Chronic pain)
Denial	Saying or implying that the underlying condition is not valid, that there is no medically valid reason for their complaints. Or outright denying that there is a condition that matches the patient's account	"...doctor in the hospital said that because there were no abnormalities in my brain waves that it could be nothing else but voluntary"[2] [Table 4, source 10] (Patient with non-epileptic seizures - current acceptable terminology Functional (dissociative) seizures)
Non-explanation	Implying or saying that the condition is not understood and therefore not appropriate for a medical consultation. Requests for explanation are blocked	"My GP does not seem to understand what is going on and every time I go and ask for help or advice I get nothing from her" [Table 4, source 2] (Patient with Multiple Chemical Sensitivity)
Minimising	It is implied that this person's symptoms are not of a severity which needs medical solutions. Minimal or no solutions or explanations are offered. Therefore, putting the disproportionate amount responsibility for managing their symptoms on the patient	"The neurologist was more interested in my migraines than what was troubling me. He dismissed my concerns and just said they were "funny turns" and would go away eventually by themselves" [Table 4, source 10] (Patient with non-epileptic seizures - current acceptable terminology Functional (dissociative) seizures)
Norm-breaking	Practitioner speaks or acts in ways which would typically be perceived as inappropriate.	"Three women noted that their physician told them to get drunk before having intercourse, as this would aid in their relaxation. As Maya (34 years old) recalled, "I did go to my gynaecologist, and I said, you know, 'I'm having a really hard time having sex.' And she was just saying, "You're just nervous. You're tensing up. Get drunk." [Table 4, source 9] (Patients with Psychosomatic attribution to experiencing sexual pain)
Psychologising	Practitioner explicitly or implicitly implies that this person's symptoms are of psychological origin. There is no evidence provided to explain the psychological causes or the reasoning for attributing this cause. It is implied that the way to deal with their physical symptoms is using psychological treatments.	"The neurologist did not give me a diagnosis. Instead, he suggested that my mother organize an appointment to see Dr. X. When we rang to make the appointment, we realized that Dr. X was a psychologist. It was then that I realized that the neurologist thought that it was all in my head" [Table 4, source 10] (Patient with non-epileptic seizures - current acceptable terminology Functional (dissociative) seizures)

valuable for qualitative evidence synthesis to address “policy-urgent” questions [21,32]. We considered an extensive range of potential models in the first stage and in the later fitting stages, and the mapping of data to frameworks was carried out independently by three researchers at different stages.

This framework has several limitations. Firstly, the quotes were extracted from already published studies which may have had a selection bias towards more polarised quotes. Secondly the quotes from the studies were very varied and studies used may have used different levels of rigour in selecting the quotes. On the other hand it could be considered a strength that despite the different qualitative approaches and the array of study methods used, types of PPS/FD and different countries where the studies were set, we found that the conceptual model remained relevant in all those contexts. However, further validation is needed to know if the framework still applies in other cultural and healthcare contexts, other than the populations identified in the scoping review.

There are a myriad of factors that might influence the stigma perception in a consultation. As stigma is a very complex social phenomenon, it is likely that there are aspects of stigmatisation that the framework does not and cannot capture. The framework aims to describe and categorise common experiences of patients that they have reported to be stigmatising. With this work we aim to draw attention to the finding that there are certain patterns that emerge from the experiences of patients that can have a very negative impact on those patients. Moreover, in the scoping study [18] only two studies directly observed the consultations, the remainder relied on recalled accounts by patients or professionals. This might be a limitation as there might be a recall bias. However, since stigma is also a subjective ongoing or a cumulative process, a third objective party might not be in tune to understand that this interaction was stigmatising, as the meaning communicated could be understood by the stigmatised or marginalised party.

In developing this framework, patient advocacy groups were not directly involved during the developmental stages. We consulted a patient advocacy group, Pain Alliance Europe, to understand if such a framework would be useful for patients. Moreover, we have conducted focus groups and have collaborated with a patient advocacy group in the further development and the validation of the framework.

Lastly, for future research it would be useful to have a wider perspective on cultural and other healthcare contexts.

4.3. Implications for practice, policy, and research

Stigma is mistakenly often thought of as most prevalently occurring between individuals. Although the setting for stigmatisation is often on the level of an individual interaction, we all are affected by the dominant societal norms, beliefs, and prejudices. Therefore, when designing communication interventions for PPS/FDs in order to reduce stigmatisation in the clinical consultation settings, we should also address the underlying social processes and structures. If we are failing to adequately consider the established societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatised, we mistakenly put the burden of responsibility and change on the most affected and vulnerable groups. This risks further stigmatising and constraining the opportunities and wellbeing of the affected persons.

This framework is currently being tested in a focus group study of patients. That study is the first step in validating the framework in different contexts and to gauge the potential usefulness for the framework to act as a tool in better understanding the experiences of patients.

There are several more implications for future research and practice development. Firstly, the future research is needed to better understand the effects of stigmatisation in PPS/FDs on the individual. That includes both the psychological and social processes and also the consequences of stigmatisation on self-perception and social perception of self.

Future research could also explore the relation of this developed framework of stigma in PPS/FDs to other stigma frameworks. Currently we know that stigma is a very complex social process, which can depend on several aspects whether the person perceives themselves to be stigmatised or not. For example, the prior experience of stigmatisation has been found to perpetuate stigma in addiction services [33].

There have been, to our knowledge, few studies focusing on frameworks of stigma in healthcare settings. One recent study applied the Health Stigma Discrimination Framework to the clinicians working with HIV patients. They found that stigma manifested highest through the endorsement of stereotypes and in the use of unnecessary precautions when treating people with HIV [34]. This finding is a testament to the idea that while stigmatisation has some common denominators, the way stigma is being acted out or communicated varies from the setting and the medical condition at hand. Future research would benefit by understanding stigma as not just an isolated process, but to address the wider and underlying sociological processes that perpetuate stigmatisation in medical settings.

4.4. Implications for the use of the framework

The framework should make it easier and more accessible to recognise stigma when it is present by identifying specific actions and ways of communicating therefore making it a useful tool for understanding the reasons that certain patterns of communication are stigmatising. Secondly, it shows that potentially well-intentioned clinical approaches, such as exploring psychological factors, might carry the unintended connotation of stigma, so that clinicians can be aware and potentially modify their approaches to avoid that happening. Third, it provides a framework which can be used to develop and train focused interventions to reduce stigma. For instance, by finding appropriate language or by introducing psychological factors in a way that is not stigmatising.

This framework provides practical and specific examples of how stigmatisation is being communicated in the clinical consultations for PPS/FDs. This can then be used to design specific communication and intervention strategies to address each identified action for stigmatisation. It is important to note that the stigma in PPS/FDs can be described as structural in nature – that it is embedded in the way care is structured and delivered [18]. Strategies that might be successful in the medical communication for other healthcare conditions may carry increased potential for stigmatisation in PPS/FDs. But these social distance strategies are only stigmatising depending on the individual context. For example, when done in a collaboration with the patient, exploring psychosocial factors carries a huge benefit for the continuous management of a chronic condition and might contribute to the increased quality of life for the patient.

Moreover, it is important to recognise that the way of improving the consultations for PPS/FDs is to address the structural stigma patients affected by those conditions face. Therefore, clinicians need to learn not simply how not to stigmatise, but how to actively destigmatise. This framework aims to provide a starting point for that.

5. Conclusion

We have developed a new actionable framework to categorise stigma in clinical healthcare consultations for PPS/FDs. In contrast with previous, more broad conceptual approaches, this new framework can be used to understand individual consultations and experiences.

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CRediT authorship contribution statement

Höbe Treufeldt: Writing – review & editing, Writing – original draft, Validation, Software, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Chris Burton:** Writing – review & editing, Validation, Supervision, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Brodie McGhie-**

Fraser: Writing – review & editing, Validation, Formal analysis.

Declaration of competing interest

This research has not been submitted elsewhere for publication. The authors declare we have no conflicts of interest.

Appendix

Table 4
Scoping review included studies overview (Treufeldt, Burton, 2024).

	AUTHOR	COUNTRY	CONDITION	STUDY POPULATION (N)
1	Kozłowska et al. (2021)	Multiple countries	FND	Multidisciplinary team of experts; paediatric patients and their families
2	Briones-Vozmediano and Espinar-Ruiz (2021)-	Spain	Multiple Chemical Sensitivity	Female patients (n = 22)
3	Canna and Seligman (2020)	USA	PNES	–
4	Diniz et al. (2020)	Portugal	Chronic pain	Female nurses (n = 50)
5	Tolchin et al. (2020)	USA	PNES	Patients (n = 60)
6	Fouché et al. (2019)	South Africa	PNES	Clinicians (n = 13)
7	Naushad et al. (2018)	USA	Chronic pain	Four groups of patients (N = 236): depression only, chronic pain only, comorbid depression and chronic pain, and healthy controls.
8	Briones-Vozmediano et al. (2018)	Spain	Fibromyalgia	Clinicians (n = 12)
9	Braksmajer (2018)	USA	Vulvodynia	Female patients (n = 32)
10	Robson and Lian (2017)	Across countries	NES	Patients (n = 135)
11	Houwen et al. (2017)	Netherlands	MUS	Patients (n = 43)
12	Lehti et al. (2017)	Sweden	Chronic pain	GPs(n = 8); Patients(n = 10); Clinicians (n = 7)
13	Colmenares-Roa et al. (2016)	Mexico	Fibromyalgia	Physicians (n = 4); Patients with Fibromyalgia (n = 8)
14	Buchman et al. (2016)	Canada	Chronic pain	Patients (n = 27); re-contact interview patient-participants (n = 4); physicians (n = 6)
15	Homma et al. (2016)	Japan	Fibromyalgia	Physicians (n = 233)
16	Maatz et al. (2016)	England	MUS	Physicians (n = 17)
17	Burbaum et al. (2010)	Germany	MUS	Patients (n = 49); a control group (n = 42)
18	Jones et al. (2009)	USA	IBS	Patients (n = 148)
19	White and Seibold (2008)	Australia	Chronic pain	Female patients (n = 5)
20	Undeland and Malterud (2008)	Norway	MUS	Female patients (n = 2)
21	Gilje et al. (2008)	Norway	CFS	Patients (women n = 10; men n = 2); follow up meeting (women n = 5)
22	Werner and Malterud (2005)	Norway/ Denmark	Chronic pain	Female patients (n = 10)
23	Åsbring and Närvänen (2003)	Sweden	Fibromyalgia/CFS	Physicians (n = 26)
24	Åsbring and Närvänen (2002)	Sweden	Fibromyalgia/CFS	Female patients with CFS (n = 12) and fibromyalgia (n = 13)
25	Dixon-Woods and Critchley (2000)	UK	IBS	Female patients with IBS (n = 14) Physicians (GPs n = 6; gastroentologists (n = 6)
26	Lennon et al. (1989)	USA	TMPDS	Patients (n = 151)
27	Nishikawara et al. (2023)	Canada	Fibromyalgia	Patients (n = 14)
28	Stortenbeker et al. (2022)	Netherlands	MUS	BOTH We compared 41 MUS and 41 MES transcribed video-recorded general practice consultations.
29	S Battin et al. (2022)	Norway	Chronic pain	BOTH 19 professionals and 26 patients
30	Bellman and Zolnikov (2022)	USA	MUS	Patients (n = 42)
31	Yon et al. (2015)	UK	MUS	Physicians (n = 22)
32	Dickson (2009)	New Zealand	Somatoform disorder	Multidisciplinary team of health care professionals (n = 6)

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