Transcript:

Preventing and Reducing Stigma; Evidence-Based Practice

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Recorded on November 5th, 2020

CHUCK KLEVGAARD: Welcome to today's recorded webinar. We're glad you're here to learn more about preventing and reducing stigma and evidence-based practices.

This recorded webinar today is brought to you by the Great Lakes Prevention Technology Transfer Center, PTTC, just located at the University of Wisconsin-Madison Center for Health Enhancement System Studies, or CHESS. We're funded by the Substance Abuse and Mental Health Services Administration, or SAMHSA, to provide training, technical assistance, and services to the substance abuse prevention field, including professionals, pre-professionals, organizations, and others in the prevention community.

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The PTTC Network uses affirming language to promote the application of evidence-based practice. You'll learn much more today in this recorded webinar about the importance of language to inspire hope and put people first.

OK. Let's get started. As a result of listening to this recorded webinar today, you'll be able to describe common components and three levels of stigma. You'll also be able to describe the importance of non-stigmatizing language. You'll be able to list cross-cutting practices for preventing or reducing stigma, along with some evidence-based strategies for stigma prevention and reduction.

It's important to clarify what we're talking about, and we encourage everybody to take the time to introduce a basic definition. This can stimulate conversation, provide a foundation for common language, and increase community-wide literacy on the topic of stigma. This particular definition comes from John Kelly and Cassandra Westerhoff, two important researchers

in the field, major contributors to our current understanding of the importance of language. You'll hear more about that later in this recording.

So basic definition states that stigma can be understood as an attribute, behavior, or reputation that is socially discrediting. And substance abuse problems appear to be particularly susceptible to stigma. Now take a minute to assess how this definition squares with your own beliefs.

Now let's break it down a bit. Stigma is often described in terms of components starting with stereotypes, which are ideas and attitudes assigned to label social entities. Prejudice is then the endorsement of those negative beliefs and attitudes within those stereotypes. Finally, discrimination then is behaviors that act to endorse and reinforce, thus creating the disadvantage of those that are originally labeled.

Stigma's frequently conferred through these labels, which sometimes are officially sanctioned and then encoded by official agents. For example, the medical profession using the term mentally ill or the criminal justice system referring to individuals as criminals. Intentional or not, this perpetuates negative beliefs.

It also happens informally. Anyone referring to an entire race of individuals as lazy, for example, sets up the negative belief leading to prejudice, creating discrimination. To be clear, labels produce stereotypes with variable levels of negative social consequences of prejudice leading to discrimination.

A last word about stigma and definitions. The word stigma itself is sometimes debated. Some see it as a victim word and prefer discrimination as a better word for framing the issue. While I would agree it's important that all of us play a role in shaping perceptions, I think it's also important to bring people together on this issue, meaning don't get hung up about political correctness.

Instead, focus on where you and a colleague can agree. Be gentle with folks who use stigmatizing language. It's almost always unintentional. A gentle reminder about language in private is always more productive than a public reprimand.

Stigma happens on various levels or is sometimes described as layers in somewhat of an ecological model. So starting on the outside, working our way in, structural stigma is about the prejudice and discrimination by policies, laws, constitutional practice, often referred to as institutionalized stigma that occurs at the societal level or community level.

Public stigma then, the next layer in, has to do with the stereotypes, prejudice, and discrimination endorsed by the general population in a community. A set of negative attitudes and beliefs that motivate individuals to fear and reject, avoid, and discriminate against folks with mental illness or substance use disorders.

Unchecked public stigma almost always leads to discrimination. For example, public stigma can lead to differential public and political support for treatment, differential public and political support for criminal justice, create barriers to employment, education, or training. Results in reduced housing and social support, increased social distance.

There in the center is personal or self-stigma. This is the internalization of that public stigma that can lead to shame and guilt, lowered self-esteem. And for some, self-stigma can lead to a lack of problem acknowledgment, meaning that I'm a bad person rather than an individual with a disorder that needs treatment.

This can result in delays in help-seeking behavior, less treatment engagement, and then the creation of barriers for recovery. So to be clear, all three levels have an impact on how successful we can be at the community level with treatment outcomes and the support for individuals in recovery.

It's sometimes helpful to provide colleagues with a few examples at each level. So again, working our way in, structural stigma exists in public and private institutions, includes businesses, courts, government at all levels, professional groups, school systems, social service agencies, universities. Talk about stigma at the structural level and its power to endorse discrimination, which contributes both to public and self-stigma.

Examples might include limits on exercising one's civil rights to serving on a jury or holding political office, discriminatory hiring practices, or even admissions policies based on stereotypes. People with mental and substance use disorders are overrepresented in the criminal justice system, which is both a consequence and a source of stigma. Example from the slide is a state health agency board who makes decisions about populations and strategies without representation of individuals with lived experience.

Public stigma is operationalized through the behaviors of individuals and groups of all kinds as well. Relevant groups did provide examples. Educators, employers, health care providers, journalists, police, judges, legislators.

With a broad reach, the media can play a strong influence on stigma at all three levels. Despite ongoing and successful efforts to educate media professionals about behavior disorders, stereotypes about violently mentally ill individuals are perpetuated.

Social media can also play a source of stigma as a means of promoting and affirming attitudes. The example I think of is one of a local news article I recently saw showing a GIS map of neighborhood hotspots for overdose and a corresponding heat map of reported crime. Sort of unintentional on the part of this journalist, but without any more context, that article could certainly perpetuate fear or even create or strengthen existing stereotypes that individuals with opioid use disorders are dangerous.

Spend some time with folks talking about self-stigma. Self-stigma reduces self-efficacy, can discourage people from disclosing their conditions for fear of being labeled and subjected to discrimination. Take time to talk with colleagues about the damage that self-stigma can do, providing them with some examples about how label avoidance in turn discourages help.

As we mentioned a moment ago, it reduces treatment seeking on the part of people with mental and substance use disorders and their families. This avoidance creates barriers to early diagnosis and treatment, adding to the heavy burden of untreated mental and substance use disorders at the community level, costs for victimization, crime, incarceration, lower productivity, and even premature death.

Now let's move into a discussion about the impact that the three levels of stigma can have on recovery. Stigma can reduce willingness to seek professional help. It can cause reluctance to even attend treatment. And for some, resulting in the non-completion of treatment. It can also limit access to health care, housing, and employment, all important factors for recovery.

In addition to impacts on recovery, research indicates that stigma contributes to a host of adverse outcomes for stigmatized populations, including people with mental, health, and substance use disorders. The impact of stigma both disadvantages the stigmatized individual and is a major source of stress in their lives. In fact, many argue that stigma is in fact a central driver of morbidity and mortality at a population level. And emerging evidence indicates that stigma can be discussed as a fundamental cause of health inequalities.

So here's how to talk about that. Let people know that stigma does this through a couple mechanisms. So first, stigma influences several physical and mental health outcomes that affect millions of people in the United States. Further, it disrupts or inhibits access to multiple resources-- structural, interpersonal, psychological-- that could otherwise be used to avoid or minimize poor health.

In addition to health inequities, I think it's important to talk about what else we know. Stigma can diminish self-esteem and affect personal relationships at a time when they're needed most, and increase involvement in risky behavior.

Finally, these inequities and health outcomes for stigmatized and non-stigmatized groups are by no means inevitable. And we'll talk more in this recording about what you can do about it.

Now let's take a moment and clarify what we mean by person-first language and offer some illustrative examples about how important language really is. First of all, the language we use to discuss mental health and substance use disorders can either increase or decrease stigma. Now that happens through formal messaging from our organization or our professions. It also happens informally through conversations with colleagues and stakeholders.

Now in the context of the growing opioid crisis, the language we use becomes particularly important as many of us now find ourselves working in partnership with people who actively misuse substances who are, in fact, many folks with opioid use disorders.

Remembering that public stigma is driven by stereotypes about people-- in this case, people with opioid use disorders, such as their perceived dangerousness, perceived moral failings, which can translate into negative attitudes towards people with opioid use disorders. Now unchecked, these stereotypes can become encoded in cultural norms, local laws, and discriminatory policy.

Here's how this can happen. One community I worked with recently provides a great example. In this small town, local leaders came up with what I think is discriminatory policy solution in response to both compassion fatigue and real resource fatigue.

So after years of dedicating resources through first responders administering Naloxone as a large part of their day realized that they were doing overdose reversals with some of the same individuals again and again. The local solution was to set a limit on how many times and under what conditions or circumstances local first responders would administer Naloxone.

One aspect of this proposed policy was to require individuals to give back, perform community service if they had a second or third overdose reversal. I don't think we would treat other individuals this way. This policy seemed to me grounded in a negative, inaccurate belief or stereotype about individuals with opioid use disorders. It implies that they have control and that it's somehow their fault, two of the most pervasive conditions that we must work against in the perpetuation of stigma.

Now before we leave this conversation, take a moment to consider the real challenges in rural America in relation to our current opioid crisis. Limited resources, access to specific opioid treatment, geography itself creating distance between individuals. Are there other solutions we could offer these local leaders? We'll talk about how to address public stigma later in this recording.

So back up on the screen is that position statement we talked about at the beginning of this recorded webinar. This, again, is the PTTC Network position on the use of affirming language. The serves as a great example of some simple steps you can take. Consider developing such a position for your coalition, your agency, your organization. And then disseminate that message through all the channels already in place. That can easily include your agency brochures and all your training materials.

We talked a couple of times already in this recording about what we know from research about stigma, so I want to highlight a couple of areas where

there's a lot of research that's happened in recent years. First of all, there's a whole collection of research, a whole body of research looking at the issue of blame. Are individuals in control or at fault, and what's the impact of those beliefs on individuals? There's also a body of research that looks at social distance-related issues, asking participants in studies, for example, would I have them marry into my family?

And finally, there's a body of research looking at issues around dangerousness. Are individuals with mental health or substance use disorders unexpectedly volatile or a threat to my safety? And looking at the impact of those kinds of beliefs.

Here's what we're learning from that research. First of all, individuals with mental health or substance use disorders are more stigmatized than other populations. People with substance use disorders are perceived as more to blame for their disorder. And the patients themselves who hold more stigmatizing beliefs about substance use disorders are less likely to seek treatment. And describing substance use disorders as treatable helps.

In this section, we'll take a look at some of that research so that we can better understand and articulate what it means to folks. You're looking at a picture of John F. Kelly, who is the founder and director of the Recovery Research Institute at Massachusetts General Hospital.

Kelly has helped us understand the impact of the word abuse, and in particular how it has led to the use of the term abuser, and that the word abuser implies volitional acts of willful misconduct. And it's associated with things like child abuse. And the importance of substance use disorder as an alternative conveys something very different, a medical disorder.

Kelly further often articulates that substance use is the only thing we talk about this way. He often cites the example that people with eating-related conditions are almost always referred to as having an eating disorder and never referred to as food abusers.

Now let's take a look at what Kelly found. In this study, he surveyed more than 500 mental health care providers. Each clinician read one of two vignettes about a character with a substance use problem who was in a court-mandated treatment program, but had relapsed and had positive urine results.

The vignettes themselves were identical in that one, the character was described as a substance abuser, and in the other vignette as someone with a substance use disorder. He found that clinicians who read the vignette about the substance abuser were significantly more likely to say that the character was personally responsible for his actions and should be punished for them.

Further, the participants in this study also felt that the substance abuser as compared to the individual with a disorder was less likely to benefit from

treatment, more likely to benefit from punishment, more likely to be socially threatening, more likely to be blamed, and more able to control their use without help. Now take a minute to think about all the implications if those beliefs and how they can contribute to all three levels of stigma we talked about earlier.

So Kelly suggests that in addition to the use of substance use disorder using other non-stigmatizing words as preventionists, words like misuse rather than abuse, hazardous use, harmful use, or unhealthy use. All better alternatives than talking about the word abuse as that, we know, leads to the use of the term abuser.

So here's a graph showing some of what we just talked about. Take a moment and see what you notice with regard to the differences between substance abuser and substance use disorder.

I noticed the significant differences where participants landed on punishment versus exoneration. I think as equally important, the notion of self-regulation, that folks who read vignettes about substance abusers were twice as likely to believe that that person could self-regulate as opposed to an individual with a disorder.

So this image presents us with a way of thinking about conditions at the community level. Starting on the right, if people in a community believe that individuals with substance use disorders are at fault and could stop if they wanted to were likely to see lots of public stigma, prejudice, and discrimination.

On the left, if we can increase community members' understanding of addiction, thereby reducing perceived fault and control, we can expect to see less stigma and reduced discrimination. We also believe that increasing use of person-first language along with addiction literacy can play a significant role in shifting community conditions in the right direction.

All right. This slide presents us with a way of starting the conversation about the importance of language and what language is stigmatizing versus language that's not stigmatizing. Take a look at the list and think about for a moment, which of the stigmatizing words have you heard use where you live or work?

Remember, we talked earlier that often the use of stigmatizing language is not intentional. It bears repeating that we don't want to put ourselves in the position of enforcers of political correctness. At the same time, we all need to take a role in reframing the conversations in the language that perpetuates stigma. Again, as we talked about, pulling someone aside discreetly, privately to remind them about the importance of language is often more productive than embarrassing somebody in a group.

So where can I find information about non-stigmatizing language? What's on your screen now is the addicion-ary advice. This comes from the Recovery Research Institute's glossary of addiction-related terms which are flagged as stigma alert based on research that suggests that they potentially induce bias. Our friend John Kelly helped to create this dictionary, again, which is a glossary of addiction-related terminology, to help medical professionals and the general public modify their language about addiction.

OK. As we move into the homestretch, before we talk about evidence-based practice, we want to take a minute and cover some of what we think of as cross-cutting practices to address stigma. Now, these are things that we can all do as community members regardless of where we live or work.

So first, increasing awareness and knowledge about mental and substance use disorders is key. We can all play a role in doing that with colleagues and conversations and community presentations. We can also educate about stigmatizing language and its impact on population health.

Further, we can enhance the support and resources to entities who are working with individuals with substance use disorders and mental health populations. It can also engage community partners and stakeholders in group conversations about substance use disorders and mental health.

All right. Just a few more cross-cutting practices. The first one involves providing opportunities for interaction with individuals with substance use or mental health disorders. Often called contact-based education, uses social contact as a way to improve relations or dispel stereotypes among groups that are experiencing stigma and discrimination. Stigma is reduced in this way through providing an opportunity for interpersonal contact between people who have a mental or substance use disorder and audiences themselves who may be stigmatizing towards them, or simply who need to work with them in culturally relevant, non-stigmatizing ways.

The second approach involves promoting peer programs in which people who have disclosed their conditions offer their experience and expertise. Quick but important caveat on this strategy. Involving individuals this way needs to be preceded by opportunities to guide those participants who are considering disclosure to make informed decisions, considering the risks and benefits of that kind of disclosure.

OK. Ready to look at strategies? We'll do that by looking at strategies on all three levels, starting with structural and moving on to public, and then finally self-stigma. You might recall earlier that we talked about structural stigma as prejudice and discrimination by policies, laws, and practices. We referred to it sometimes as institutionalized stigma. It occurs at the societal or community level.

Targets of structural stigma would include legislators, institutions, policymakers, or systems, organizations that fund and regulate places and situations where discrimination happens. Interventions that would be appropriate at this level would be considered legal, policy, advocacy, or professional education strategies. Again, or strategies that would be aimed at changing decision making processes, policies, or regulations that support discrimination against people with mental and substance use disorders.

Now let's turn to public stigma. We've talked about this as stereotypes, prejudice, and discrimination that's endorsed by the general population, a set of negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with mental and substance use disorders.

Targets for interventions to reduce public stigma might include the general population, general public, landlords, employers, health care providers, and groups within criminal justice, for example. The corresponding interventions would be aimed at changing behaviors and interactions from discrimination and fear and neglect or even abuse into extending support, high-quality treatment, equal opportunities for housing, employment, and personal success.

Examples of interventions would include the use of media for mass messaging to dispel myths regarding behavioral health disorders and treatment to education strategies that counter the lack of knowledge about disorders and treatment, and contact with people with behavioral disorders, and actual protest strategies against discrimination.

Now let's take a look at the last area, and that would be self-stigma. And we described earlier a personal or self-stigma as the internalization of public stigma can lead to shame and guilt, lowered self-esteem. For some, self-stigma can lead to a lack of problem acknowledgment. Remember, we talked about, if I'm a bad person rather than an individual with a disorder that needs treatment. This can result in delays in help-seeking behavior, less treatment engagement, and significant barriers to recovery.

The general effects of this sort of self-stigma and what we might call why try effect can be diminished by interventions that target individuals with behavioral disorders. Interventions would focus on promoting self-esteem and self-efficacy, empowerment through peer support, mentoring, and education to dispel myths, increase social and coping skills, and education to encourage treatment engagement. So for many individuals, disclosure may be another additional step that they could take in the process of reducing self-stigma when it can be done in a safe and strategic manner.

All right. That concludes this recorded webinar today. I want to take one more moment and remind you that these slide decks are part of the Great Lakes PTTC slide deck series, and you can download and customize this presentation, along with several others. So as you can see on this title slide,

you can put in your own name, the date, the organization you're speaking with, and where this presentation is, along with a whole bunch of other features that would allow you to customize this for your community.

One final reminder. Stigma's not limited to one setting or condition. Rather, it's cross-cutting in all communities and populations. Consider working in partnership with existing groups, task forces, or coalitions, and strive to include as many community segments as you can. The PTTC website has slide decks on 10 community segments, each emphasizing the importance for that segment, the impact on stigmatized population, and programs, practices, and policies shown to be effective for preventing or reducing stigma within that segment.

[MUSIC PLAYING]