

Stigma through a Systems Lens: Statewide Perspectives

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* Agenda

- * Review stigma concepts and processes
- * Discuss societal messages about mental illness and how these manifest in different systems.
- * Consider best practices for addressing public stigma and examples of stigma interventions in WI
- * Discuss challenges and opportunities for addressing mental health challenges and stigma in youth
- * Review resources available to address mental illness stigma in a variety of contexts

STIGMA



- * *“An attribute that is deeply discrediting” which renders the individual “from a whole and usual person to a tainted, discounted one”.*
- * *“A trait that can obtrude itself upon attention....breaking the claim that other attributes have on us”.*
(Irving Goffman, 1963)
- * *Plainly, it’s when you are associated with something bad, shameful, disgraceful.*
- * *Across the globe, mental illness is a stigma.*

* Stigma exists when the following interrelated components converge:

(Link & Phelan, 2001)

- * 1. Categorizing
- * 2. Stereotyping
- * 3. Dichotomous distinctions
- * 4. Emotional reactions
- * 5. Discrimination
- * 6. Power differentials



* Why do people stigmatize?

* KEEP PEOPLE IN

- * Enforcement of Social Norms

* KEEP PEOPLE DOWN

- * Exploitation and Domination

* KEEP PEOPLE AWAY

- * Avoidance of Disease

(Phelan, Link & Dividio, 2008)

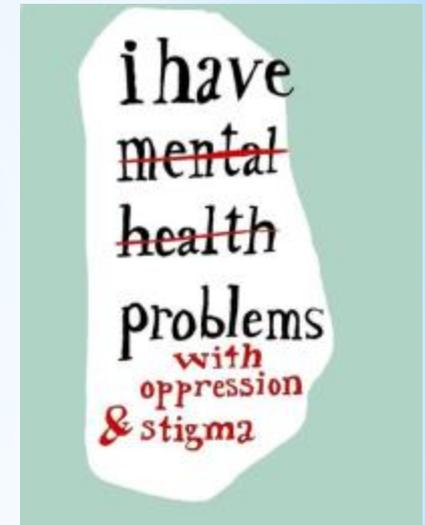
*Types of stigma

*Public-stigma:

- * Interpersonal/social
- * Structural/political

*Self-Stigma (AKA internalized stigma)

*Courtesy Stigma (AKA stigma-by-association)



Public Stigma

* Interpersonal

- * I don't want them to live next door, be a co-worker, marry into my family

* Structural

- * Employers do not hire/support recovery
- * Insurance disputes on type/length of care & parity is not enforced
- * Schools lack resources to provide effective supports and 'safe' spaces
- * Renters with a (noticeable or documented) MH condition receive fewer responses to their rental inquiries, are informed of fewer available units, and are less likely to be invited to apply/contact housing providers.



Maggie



Denise

*Self-stigma

***What is it?** The shame, self-prejudice, and sense of inferiority experienced by the 'marked' individual who has internalized and applied negative stereotypes about their condition to themselves (Corrigan & Watson, 2002).

The (damaging) path of stigmatization

Public Stigma



↓ self esteem
I am not good

↓ sense of efficacy
I am not able



So, why try?

Avoidance, anger and apathy



* Courtesy stigma

- * What is it? Stigma imposed on a labeled individual extends to people with whom that s/he is associated—like a contagion effect.
- * Goffman referred to family members as "**the wise**", by which he meant persons who do not bear a stigmatizing mark themselves, but who by virtue of their relationship to the stigmatized family member "***find themselves accorded a measure of acceptance, of courtesy membership of the clan***" (1963, p. 29), and "***obliged to share some of the discredit of the stigmatized person to whom they are related***" (p. 30).
 - * Other terms: associative stigma, stigma-by-association, affiliative stigma, family stigma

* **Intersectionality: the impact of various (marginalized) identities that interact**

- * People are multi-dimensional (and multi-labeled), and sometimes face stereotypes, prejudices and discrimination from more than one angle.
 - * *Consider for instance that a black woman faces discrimination for **being black**, **being a woman**, and also for being **a black woman**. If this woman also suffers from a mental illness, this intersects with her black womanhood in ways that engender different experiences and reactions from others (relative to women with MI that come from different racial/cultural backgrounds).*
- * **Ignoring the complexity of experiences prevents an accurate representation of the effects of mental illness and stigma.**

* Stigma's Impact on SOCIAL INCLUSION

- * Lost employment
- * Subpar housing
- * Worse health care
- * Diminished education opportunities
- * Alienation from faith community
- * Social withdrawal

* Brainstorm Together



In the last 20 years, what are the broad societal messages about mental health/illness in the public sphere*?

- * Q: What questions ARE being asked in relation to mental illness and mental health? What questions ARE NOT being asked?
- * Q: What are the PRIORITIES for public spending on mental health/illness? Where is the money NOT going?

* **Public sphere: media, political establishment, academia, medical community, non-medical service sector, clients and advocates**

* Small group discussion & share-out



* Q: In your small group, discuss: How have these messages infiltrated 'your' system or institution? [10 minutes]

* Please share 1-2 discussion points from your group [10 minutes]

* Select a group member to share out.

What Changes Stigma?

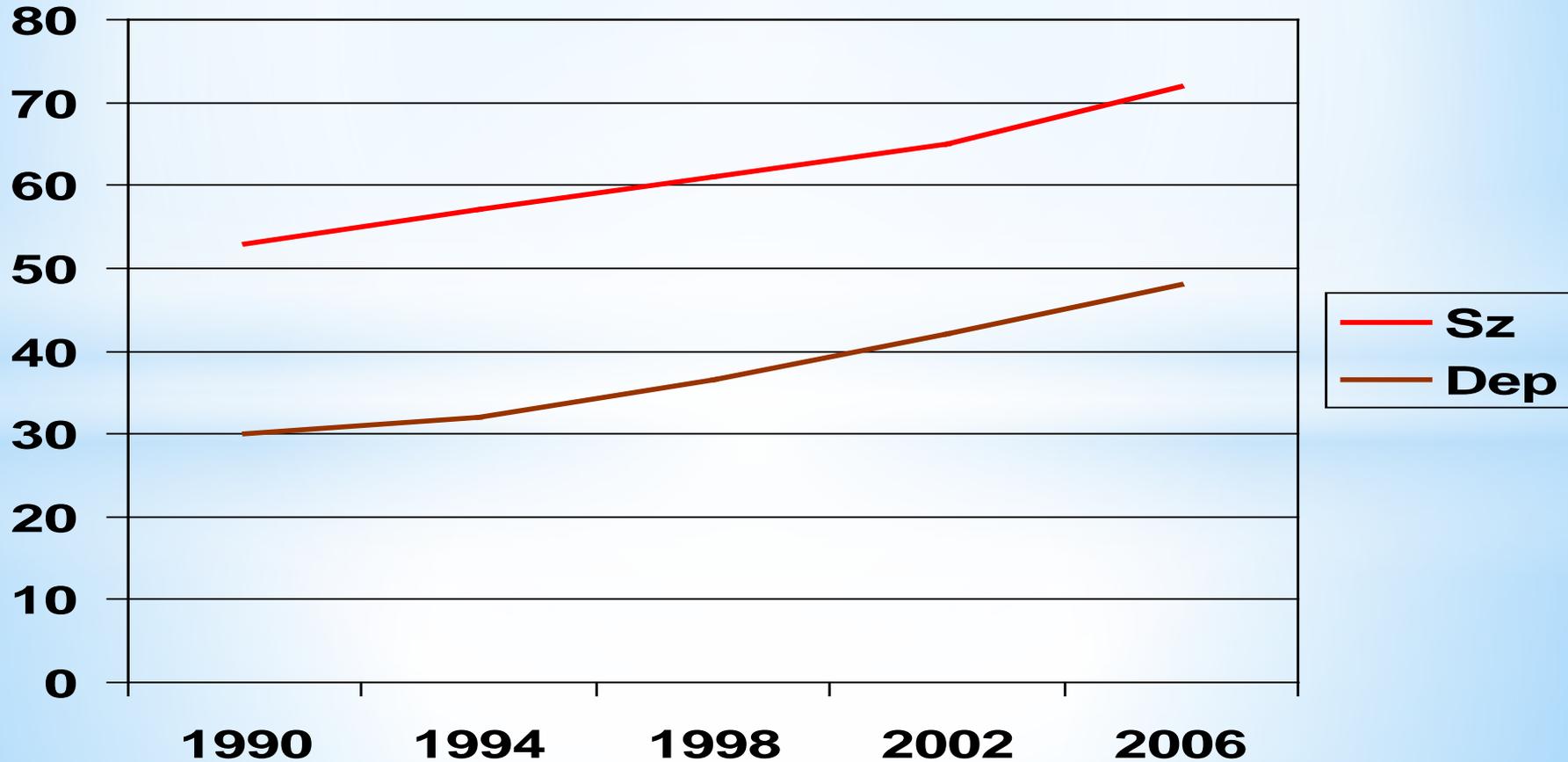
DOES STIGMA DECREASE AS KNOWLEDGE INCREASES?

Results from a meta-analysis study:

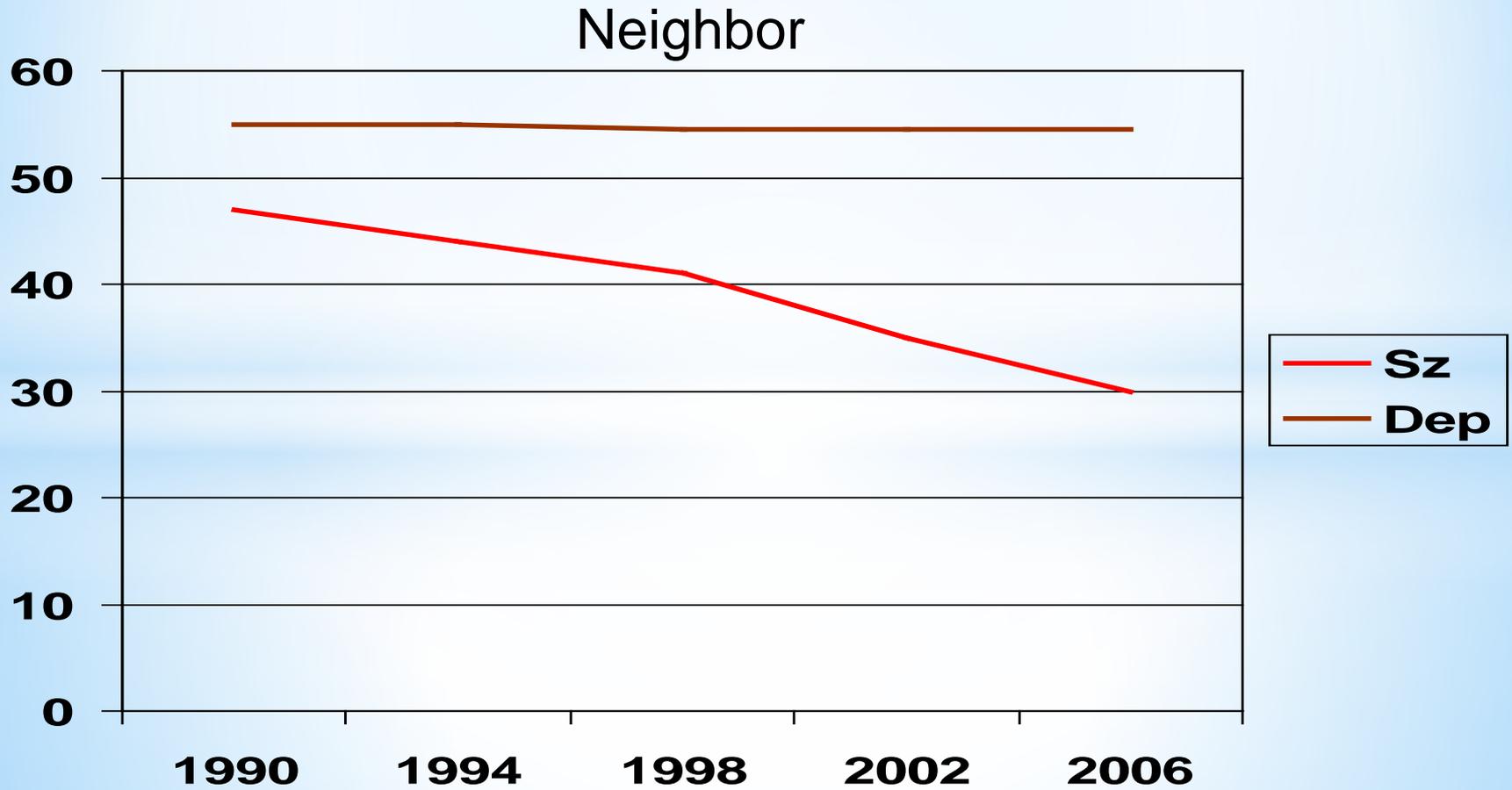
- ▶ Knowledge: Causes of Mental Illness
- ▶ Stigma: Acceptance

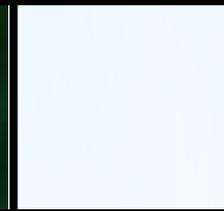
META-ANALYSIS FINDINGS: CAUSE

Brain Disease



META-ANALYSIS FINDINGS: **ACCEPTANCE**





* Contact

“I’d like you to meet Simone,
Rosa, Linda, Nneka, Paul,
Charles, Val, Sumi, Denise,
Mark and Dori”

A Recovery Story

My name is _____ and **I have** faced mental health and/or addiction challenges...

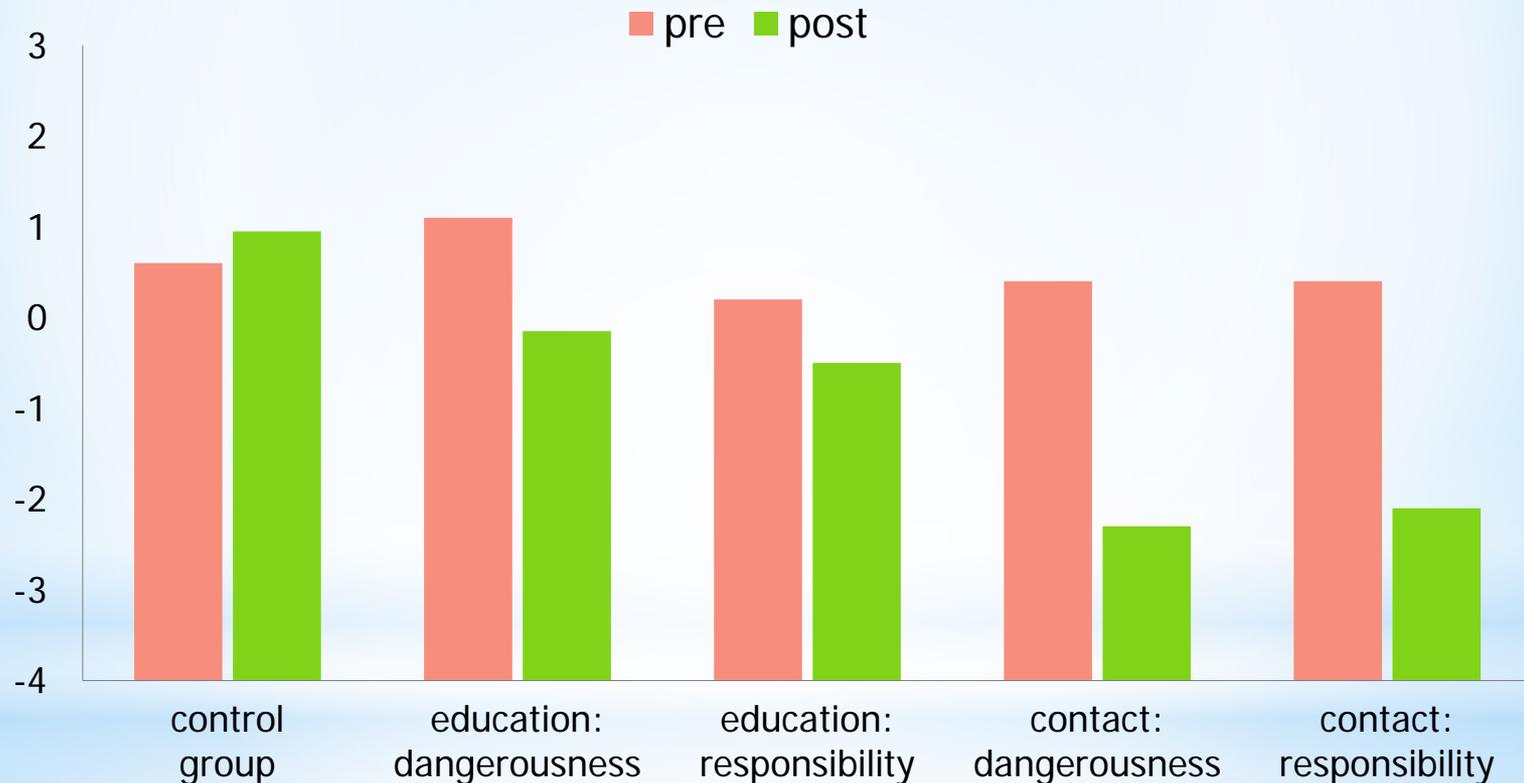
My **childhood** was...

My mental health challenges were **difficult for me and others**. They did not go away quickly...

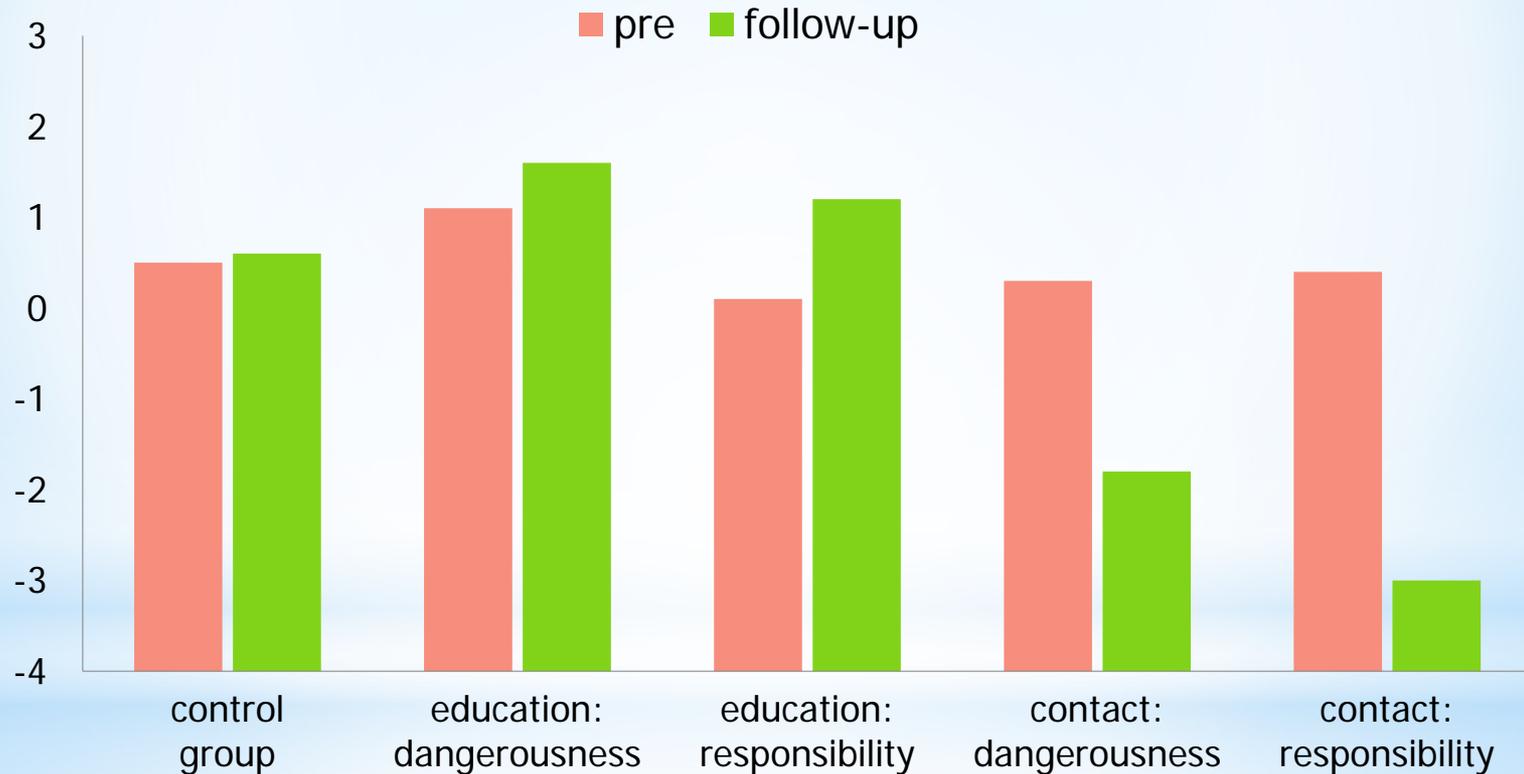
Combining my internal resources with external resources, I found my unique path to recovery...

I am achieving a satisfying life with several accomplishments.

The effects of contact versus education were greater when measuring attitudes of avoidance.



The effects of contact on attitudes of avoidance were sustained at the one month follow-up.



**Many education and misguided contact efforts
have helped us to understand the pain of mental
health crises.**





Yet, there exists a curtain of ignorance
about resilience and recovery.

Our opportunity to engage
emotions to support
inclusion and self-directed support.

The TLC4 Model

- Targeted
- Local
- Credible
- Continuous
- Change-focused
- **Contact**

Goal?

Create environments where everyone
can speak up

Carefully

Honest, Open & Proud

strategic disclosure

Safe Person Decal & 7 Promises

supportive listening

Compassion Resilience

caregivers and providers

Reversing Self and Public Stigma

Inclusion and Self-Directed Support



Components of a “WISE” Approach:

Internalized/self and associative stigma

1. Support for strategic disclosure (i.e. HOP) –

Public, institutionalized, courtesy stigma

1. Organizations use TLC4 as they design, implement and evaluate efforts - Public stigma
2. Address compassion fatigue from a systemic perspective in all sectors - Public stigma
3. Share learnings statewide
4. Train people to be effective supporters (i.e. SP7P)

Safe Person & Seven Promises

By displaying this decal, I promise to:

1. Acknowledge that reaching out for support is a strength.
2. Listen and react non-judgmentally.
3. Respond in a calm and reassuring manner.
4. Reflect back the feelings, strengths, and ideas I hear when listening.
5. Ask how I can be helpful and respond as I am able.
6. Do what I can to connect to other supports if asked.
7. Maintain confidentiality and communicate if exceptions exist.



Specific examples of stigma interventions that impact stigma across all levels

- Emergency Departments (structural-public stigma)
- Upstage Stigma: Staging a community art event to address self- and public-stigma



* Discussion

*** Challenges &
opportunities with
youth who struggle
with MH issues**

* Developmental Considerations

Q: What unique developmental issues of adolescence must be considered when trying to understand and address mental illness stigma in this age group?

* Strengths (examples):

- * Changing attitudes toward common mental illnesses (magnitude and spread not clear)
- * Respond well to peer-to-peer/role-model interactions
- * Creative—can find outlets for feelings in multiple media/activities
- * Often demonstrate social resilience
- * Receptive to a variety of models of support/treatment: phone, web-based, email, text-based

* Vulnerabilities (examples):

- * MH condition(s) still unfolding—much ambiguity
- * Heightening of self-consciousness and exquisite sensitivity to being different and judgment
 - * Imaginary audience
- * Under a magnifying glass
- * Critical role of peers in amplifying (or reducing) the impact of high-risk experiences
 - * Social media
 - * Bullying and/or social ostracism
- * Coping skills are still under development
 - * More categorical thinking
- * Prefer autonomy/reluctance to engage in treatment
- * Risk-taking

* Context is critical for youth

- * Youth are HIGHLY context-dependent
- * Opportunities to work with families and schools to:
 - * Ensure and nurture positive and warm relationships
 - * Develop awareness of the messages sent with different behaviors and policies
 - * Develop solutions in collaboration with youth
 - * Get creative--develop alternatives that align with youths' interests and needs
 - * Expand narrow notions of "normality" and success
 - * Challenge tendency to see problems as fixed
 - * Look for and celebrate expressions of resilience and positive change
 - * ...

* Examples of some school programs that are working in Wisconsin and beyond

- * Proactive SEL programming for students and teachers; developing a culture of emotional risk taking
- * Integrated models for MH services in schools
- * Re-entry plans for students who have been hospitalized

Resources to address/eliminate stigma