Implicit & Internalized Stigma of Mental Illness among Providers & Veterans: Measurement & Impact

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Learning Objectives

Participants will be able to:

– Define “implicit stigma” and “internalized stigma”.
– Describe how implicit stigma and/or internalized stigma affect psychologists’ work with Veterans.
Stigma Defined

✓ A scar or brand left by a hot iron
(Merriam Webster Dictionary)

✓ Comes from Greek word for “mark”

✓ A cluster of negative attitudes & beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses

(Achieving the Promise: transforming Mental Health Care in America)
Stigma: Creation and Maintenance

Cultural Views ➔ Learning ➔ Expectations

Learned Perspectives ➔ Implicit ➔

Thinking heuristics (short cuts) ➔

Selective attention ➔

Changes in Behaviors ➔

Effects on person ➔

Self-fulfilling prophecy
Biased Associations Are Learned and Perpetuated Through:

1. The Media
2. Our Peers and Colleagues
3. Jokes/Tales/Myths

(video: “The Stigma of Mental Illness: Markers of Societal Prejudice and Discrimination against Individuals Who Have Psychiatric Illnesses”, Massachusetts Mental Health Center, Harvard Medical School)
Implicit and heuristic

Over time learned attitudes and behaviors become automatic – to help us make quick and multiple decisions (heuristic)

And – we do not realize how it is affecting us or our behaviors (implicit)
How Our Behaviors Maintain Beliefs

Further maintenance of stigma comes when changes in behavior – for example, when we keep social distance from, avoid looking at or interacting with, persons with mental disorders.

Do you have social interactions with people who have serious mental illnesses?
Development of IAT-SMI:
Thanks to …

The Veterans who participated in the focus group on stigma to identify the stereotypes and nomenclature used in the task
And
To the PSR Fellowship at the VA Palo Alto Health Care System for the support and time to develop the task used in this module
Implicit Associations Task

Implicit social cognition
Overview article by Greenwald & Banaji, *Psychological Review*, 1995;

First published IAT

Automatic Stereotypes
Implicit Associations

- Our ability to associate words reflects how often and strongly we have learned to pair them.
- They can be “over-learned” and we may not be aware of them: when one is triggered, the other comes to mind.
- These associations can guide our thoughts and actions in subtle ways we may not be aware of.
Institute of Medicine

Health disparities: based on race
apparent throughout U.S./VA cited also
ex: blacks 3x more likely than whites to receive
amputation for diabetes

Conclusion: Health providers biases leading cause of
disparities – biases may be implicit and not explicit
## Word Categorization

<table>
<thead>
<tr>
<th>Insects</th>
<th>Flowers</th>
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<tbody>
<tr>
<td>Bad</td>
<td>Good</td>
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<tr>
<td>O</td>
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<td>✓</td>
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<td>O</td>
<td>Tulip</td>
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<tr>
<td>O</td>
<td>terrible</td>
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Guidelines for Taking the Implicit Associations Task (IAT)

• Go fast
• Try not to make mistakes
• Don’t correct errors
• Go down left column before right
• Don’t skip any items
• Quick check through circle
## Category Switch

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15
Implicit Attitudes And Beliefs

Normal People
- Rational
- Sane
- Sound-minded

High Functioning
- Employed
- Well-groomed
- Independent

Mentally ill People
- Schizophrenic
- Manic
- Psychotic

Low Functioning
- Unemployed
- Disheveled
- Dependent
# Implicit Attitudes And Beliefs

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<td>Psychotic</td>
</tr>
<tr>
<td><strong>Growth</strong></td>
<td><strong>Deterioration</strong></td>
</tr>
<tr>
<td>Succeeding</td>
<td>Declining</td>
</tr>
<tr>
<td>Developing</td>
<td>Relapsing</td>
</tr>
<tr>
<td>Achieving</td>
<td>Failing</td>
</tr>
</tbody>
</table>

- Manic
- Schizophrenic
- Psychotic
- Sane
- Sound-minded
Implicit Attitudes And Beliefs

Normal People
- Rational
- Sane
- Sound-minded
- Compliant
- Cooperative
- Easy
- Compliant

Mentally ill People
- Schizophrenic
- Manic
- Psychotic
- Noncompliant
- Difficult
- Noncompliant
- Challenging
Discussion

How was the experience?

Did you notice anything?

How did you feel?

Were you surprised at what you experienced?
Pilot Study IAT Findings: Number of words categorized

All differences between stereotypical & counter-stereotypical pairs significant, p<.05

STEREOTYPICAL PAIRS

26 flowers/good & insects/bad
20 mentally ill / lo functioning
21 mentally ill / deterioration
21 mentally ill / non-compliant

COUNTER-STEREOTYPICAL

15 flowers/bad & insects/good
11 mentally ill / hi functioning
12 mentally ill / growth
14 mentally ill / compliant
Additional domains and groups:

Association biases have been found for other groups and domains, reflecting stereotypes:

– black and bad; white and good
– men and math quicker than women and math
– gay and AIDS

Why care?

• Associational biases may:
  – reflect internalized attitudes
  – bias our decisions about others
  – affect provision of and access to services
  – impact our actions and beliefs about ourselves and others and, ultimately, the recovery process and outcome
Evidence: We see what we expect

• Educational studies: teacher expectations

*When given portfolios of students claiming “bad” behaviors – teacher’s reported more such behavior*

• Stanford study (Rosenhan): psychiatric diagnoses - *Staff observations/reports based on diagnostic label and not actual behaviors*
Biases and Behavior

• Hidden biases = Behaviors when stressed, distracted, relaxed or competitive

• Unconscious beliefs & attitudes associated with language, eye contact, blinking, and smiles

• Greater implicit prejudice = more unfriendly behavior toward black and gay people
More Bias ➔ Behavior

Hidden biases have been found to be related to discriminatory behavior in:
- Employment: hiring and promotion
- Choice of housing and schools
- Jury deliberations and other daily tasks requiring judgments of human character
- Split-second, life-or-death decisions (i.e., police shootings)
And our practices show it …

- < 10% of persons with psychiatric disabilities receive diagnostically indicated services (SAMHSA national survey, Willis, Willis, Male, Henderson, & Manderschield, 1998)
- > 90% of persons with schizophrenia received neuroleptic treatment but < 50% participated in appropriate psychotherapies (Schizophrenia Patient Outcome Research Team national survey, Lehman et al., 1998)
Even in health care …

- Persons with MI label receive fewer medical services than those not labeled as such (Desai, Rosenhack, Druss, & Perlin, 2002; Druss & Rosenheck, 1997)
- In large sample (113,653), those identified with psychiatric label were significantly less likely to undergo coronary angioplasty after myocardial infarction (Druss, Bradford, Rosenheck, Radford, & Krumholz, 2000)
Disparities

Health disparities are differences …

- in the quantity and quality of healthcare provision
- in the prevalence, mortality, and burden of disease and other adverse health conditions
- not due to access related factors, clinical need, preferences, or appropriateness of the intervention (IOM)

(S. Randal Henry, DPH, MPH QUERI HIV/HEP-C)
Disparities

• IOM (2003) report: nation-wide health care
• HSR&D report (2007): diagnosing/treating black veterans with MI as having psychotic disorders (schizophrenia) & white veterans as having affective disorders (bipolar, depression)
• NAMI: disparities for persons from ethnic and racial minorities where they were “less likely to receive high quality evidence-based care” (2004, p. 30)
Questions

Persons with SMI die earlier than those without (20 years or more)

*Could some of this be due to provider implicit biases?*

- Referrals for more intensive services, preventive or ancillary services (e.g., pain management, andrology, sleep management, cardiac, surgery)
- Acceptance into programs & services
- Misdiagnosis and treatment
Biases Are More than Implicit

VA Staff perceptions of persons with severe mental illness:

– Majority will not ever recover (72% believe)
– The mental illness is the main thing that defines persons in recovery (40% believe)
– Coping with mental illness is the main focus of their lives (57% believe)

(* Audience responses from Recovery Conference, Palo Alto, 2002, Ritscher)
Dispelling Myths About Persons in Recovery

• We can engage in behaviors to counter these myths and beliefs –

PERSONAL CONTACT

The Actor-Observer effect (Nesbitt): The more we know/identify with someone, the more we attribute their negative actions to environmental causes. The more different we perceive them as different from us, the more we attribute negative actions to internal causes – e.g., personality, diagnosis
Research has shown …

CONTACT is key to attitude change

BUT

Not all contact is equally effective
Two things to remember …

**WHO** that contact is with
And
**TYPE/PURPOSE** of contact
Both
Impact how effective it will be in changing attitudes and stereotypes
Who ....

Find SIMILARITIES between person & oneself:

- when we think of someone as similar to ourselves, we attribute negative behaviors to environment

- when think of someone as different, we attribute negative behaviors to internal causes (e.g., personality, constant)
What Type of Contact

Contact that has been most effective in overcoming prejudice involves:

• Working towards **mutual goals**
• Cooperative problem solving
• **Interdependent activity:** outcome dependent on everyone
Stigma → Poor Outcomes for Persons in Recovery

- Stigma has been associated with:
  - Loss of social status, social networks, self-esteem
  - Unemployment and Isolation
  - Delayed treatment seeking
  - Prolonged course, treatment refractory symptoms & avoidable hospitalizations
Effects of Stigma

(Link & Phelan, 2001; Perlick, Rosenheck, Clarkin, Sirey, Salahi, Struening, & Link, 2001)

- Societal Stigma
  - Prejudice/Discrimination
    - Unemployment
    - Erosion of Social Status
  - Internalized Discrimination
    - Erosion of Self Esteem
    - Delayed treatment Seeking
    - Treatment Refractory Symptoms
    - Prolonged Course
    - Avoidable Hospitalizations
Stigma and Military Culture

- Concern about effect on career for seeking help
- PTSD – controversy about Purple Heart
- Recent DoD campaigns to reduce stigma, enhance resilience, increase access.
- Generals revealing struggles with PTSD.
Internalized Stigma

- Inner psychological harm caused by stigma.
- Stigma in society may cause external harm.
  - Reduced access to housing, employment etc.
- Internalized stigma makes objective obstacles even more difficult to overcome.
Internalized Stigma / Self-Stigma

- Easier for us to work on the stigma that is inside the person’s head than the stigma that is out in society
Internalized Stigma

- Self-devaluation based on stereotypes about mental illness.
- People with mental illness have grown up with the same stereotypes as the rest of us.
- Several Components
Internalized Stigma of Mental Illness (ISMI) scale

- Developed with substantial consumer input
- Well-validated
- Widely used (60+ languages)
- Other versions
  - 10-item, used by NEPEC in PRRC evaluation
  - Mental Health Assistant version on CPRS
  - Leprosy, epilepsy, smoking, irritable bowel syndrome
- Likert format: strongly agree – strongly disagree
- Total score and 5 subscales

Internalized Stigma of Mental Illness (ISMI) scale

- Subscales:
  - Stereotype endorsement
  - Alienation
  - Social withdrawal
  - Discrimination experience
  - Stigma resistance
Stereotype Endorsement

• Believing stereotypes about mental illness
Stereotype endorsement

- Mentally ill people tend to be violent
- Mentally ill people shouldn’t get married
- People with mental illness cannot live a good, rewarding life
- People can tell that I have a mental illness by the way I look
- Because I have a mental illness, I need others to make most decisions for me
- I can’t contribute anything to society because I have a mental illness
- Stereotypes about the mentally ill apply to me
Alienation

• Feeling set apart from others
Alienation

• I feel out of place in the world because I have a mental illness
• I am embarrassed or ashamed that I have a mental illness
• I feel inferior to others who don’t have a mental illness
• I am disappointed in myself for having a mental illness
• Having a mental illness has spoiled my life
• People without mental illness could not possibly understand me
Social Withdrawal

- Pulling away from contact with others because of concerns about the status of having a mental illness (not directly due to symptoms)
Social Withdrawal

• I avoid getting close to people who don’t have a mental illness to avoid rejection
• I don’t socialize as much as I used to because my mental illness might make me look or behave “weird”
• I don’t talk about myself much because I don’t want to burden others with my mental illness
• Negative stereotypes about mental illness keep me isolated from the “normal” world
• Being around people who don’t have a mental illness makes me feel out of place or inadequate
• I stay away from social situations in order to protect my family or friends from embarrassment
Discrimination Experience

- Perceived exposure to discrimination
Discrimination Experience

• People discriminate against me because I have a mental illness
• People often patronize me, or treat me like a child, just because I have a mental illness
• People ignore me or take me less seriously just because I have a mental illness
• Nobody would be interested in getting close to me because I have a mental illness
• Others think that I can’t achieve much in life because I have a mental illness
Stigma resistance

Lack of stigma, ability to resist stigma
Stigma resistance

• People with mental illness make important contributions to society
• I feel comfortable being seen in public with an obviously mentally ill person
• Living with mental illness has made me a tough survivor
• In general, I am able to live my life the way I want to
• I can have a good, fulfilling life, despite my mental illness
Summary of research

- Research shows internalized stigma is harmful.
  - Self-esteem
  - Depression and other symptoms
  - Recovery orientation, empowerment, hope
Internalized Stigma References


What can we do about our biases?
FIRST

Becoming aware of what we take for truth and that affects our practice –
- questioning assumptions
- challenging assumptions

Through gathering of CORRECT information – seeking out training and education – look at evidence
MYTH

Persons experiencing severe mental illness do not recover
Recovery

1. Over half of persons with SMI recover
   Harding studies
   WHO studies

2. Recovery involves more than sx reduction:
   - quality of life as defined by consumer across all domains of life

3. Recovery can be from care provision
   (i.e., institutionalization, provider’s low expectations and imposed limitations)
DUAL MYTHS

There is no effective treatment for persons experiencing SMI

&

Persons with SMI can not benefit from treatment
Plenty of effective treatments

- Persons with SMI have been shown to benefit from evidence based treatments targeting:
  - preoccupation with sx & symptom reduction
  - social and living skills
  - med adherence
  - social withdrawal, anxiety, self esteem
  - employment
MYTH

Treatment can not begin in an acute phase – while the person is hospitalized, or until they are stabilized
PUTTING IT INTO PRACTICE

1. Look at own biases and behaviors and challenge them.
2. Are you addressing all life goals and domains or putting limits on expectations? (seeing the whole person)
3. Bring up discrimination & experiences that could limit person’s expectations for self.
4. Help person address these and set higher expectations for self (i.e., overcome their own internalized stigma).
Dispelling Myths Through Your Practice

MODEL:
Accurate knowledge and skills ➔
Our practices ➔ Beliefs/attitudes ➔
Persons we work with ➔ Outcomes ➔
Reduce biases (e.g., recovery is possible)

Noticing and seeing success reinforces our use of EBP and PSR
Multifaceted Model of Person in Recovery

- education
- work
- leisure
- INDIVIDUAL in Recovery
- hopes
- goals
- dreams
- son
- partner
- friend
Techniques for Reducing Bias

• Working collaboratively
• Look for positive, anti-stereotypical models of persons in recovery
• Make implicit biases explicit
• Stop and think before acting
• Ask self if seeing/interacting with person and not label
• Working towards mutually agreed upon goals
• Working with strengths and skills
More Techniques for Reducing Stigma

• Ask about goals, interests, abilities, strengths and what hope for in life
• Get to know others as persons
• Hear what they have to say
• Give opportunity for persons to talk about experience with discrimination
• Examine your environment for barriers
Resources to Assist You in Combating Stigma and Bias

Websites to:

- Raise your consciousness of biases (tolerance.org)
- Challenge stereotypes/provide role models
- Challenge stigma
- Provide techniques (e.g., language)
- Empower ourselves and others