



ADSCENTER

Resource Center to Address
Discrimination and Stigma

BRIDGING THE GAP BETWEEN WHERE WE ARE AND WHERE WE NEED TO BE

Countering Internalized Stigma among People with Mental Illnesses

September 26, 2007



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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Survey

We value your suggestions. Within 24 hours of this teleconference, you will receive an e-mail request to participate in a short, anonymous online survey about today's training material. Survey results will be used to determine what resources and topic areas need to be addressed by future training events. The survey will take approximately five minutes to complete.

Survey participation requests will be sent to all registered event participants who provided e-mail addresses at the time of their registration. Each request message will contain a Web link to our survey tool. Please call **1-800-540-0320** if you have any difficulties filling out the survey online. Thank you for your feedback and cooperation.

Written comments may be sent to the Substance Abuse and Mental Health Services Administration (SAMHSA) ADS Center via e-mail at stopstigma@samhsa.hhs.gov.



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*The Moderator for this call is **Holly Reynolds**.*



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Questions?

At the end of the speaker presentations, you will be able to ask questions. You may submit your question by pressing **'01'** on your telephone keypad. You will enter a queue and be allowed to ask your question in the order in which it was received. On hearing the conference operator announce your name, you may proceed with your question.



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Speakers

Amy Watson, Ph.D., Assistant Professor at the Jane Addams College of Social Work, University of Illinois at Chicago

Amy Watson is on the faculty of the Jane Addams College of Social Work at the University of Illinois at Chicago, where she teaches in the Mental Health Concentration. She is also an active member and former Project Director of Chicago Consortium for Stigma Research (CCSR), an interdisciplinary group of researchers dedicated to studying mental illness stigma, its consequences, and strategies for attitude change. Her research focuses on stigma as a barrier to accessing mental health services and the influence of mental illness stigma on how people are processed through the criminal justice system. Her current NIMH-funded research studies include one examining the experiences of persons with mental illness who have come in contact with police, and another that seeks to understand how youth with mental health problems who are involved with the juvenile justice system make sense of their dual labels and systems involvement.



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Speakers

Robert Lundin, Director, *The Awakenings Review*

Robert Lundin became ill with psychosis and depression while a student at Vanderbilt University in the 1970s. He showed signs of mania and psychosis for years after that, but eventually responded well to medications. He worked as a freelance journalist for the Chicago Tribune in the early 1990s, then as a research assistant at the University of Chicago in the 1990s and 2000s. Lundin also worked recently as a case manager for Evanston Northwestern Healthcare. Over the years, stigma has weighed heavily on Lundin and he has written about it in a book he co-authored with Patrick Corrigan, and in an article titled, "The Mind Will Follow" published in *Schizophrenia Bulletin*. Lundin is also the founder of the Awakenings Project, an arts group for people with mental illness, and editor of their literary magazine, "The Awakenings Review."





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BRIDGING THE GAP BETWEEN WHERE WE ARE AND WHERE WE NEED TO BE

Speakers

Patricia E. Deegan, Ph.D.

Patricia E. Deegan, Ph.D. is an activist in the disability rights movement, a writer, lecturer and researcher. Pat is also an independent consultant with Pat Deegan & Associates, LLC and an adjunct professor at Sargent College of Health and Rehabilitation Sciences at Boston University. She has many published papers, some of which have been translated into 9 languages. Pat has lectured on the topics of self-directed recovery and empowerment around the world, and has made three films on disability related topics. Pat's current projects include developing software to support shared decision-making in psychiatry, researching a recovery-based approach to using psychiatric medications in collaboration with the University of Kansas, developing recovery-based workforce trainings for mental health practitioners, helping to restore forgotten cemeteries at state hospitals, helping consumers win money for new housing through the sale of state hospitals and developing technical assistance materials for people affected by the U.S. Supreme Court's Olmstead Decision. Pat has lived her own journey of recovery, having first been diagnosed with schizophrenia as a teenager. She received her doctorate in clinical psychology from Duquesne University.



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Self Stigma & Mental Illness

Amy Watson, Ph.D.

The work described in this presentation was funded in part by a grant from the National Institute of Mental Health (MH66059) awarded to Patrick Corrigan.

Overview

- Internalized stigma-a modified labeling theory perspective
- Model of divergent personal responses to mental illness stigma
- Research on internalized/self stigma

“Thinking of myself as garbage, I would even leave the side walk in what I thought of as exhibiting the proper deference to those above me in social class. The latter group, of course, included all other human beings (Gallo, 1994, p 407-408).

How does Stigma Operate?

Public Stigma

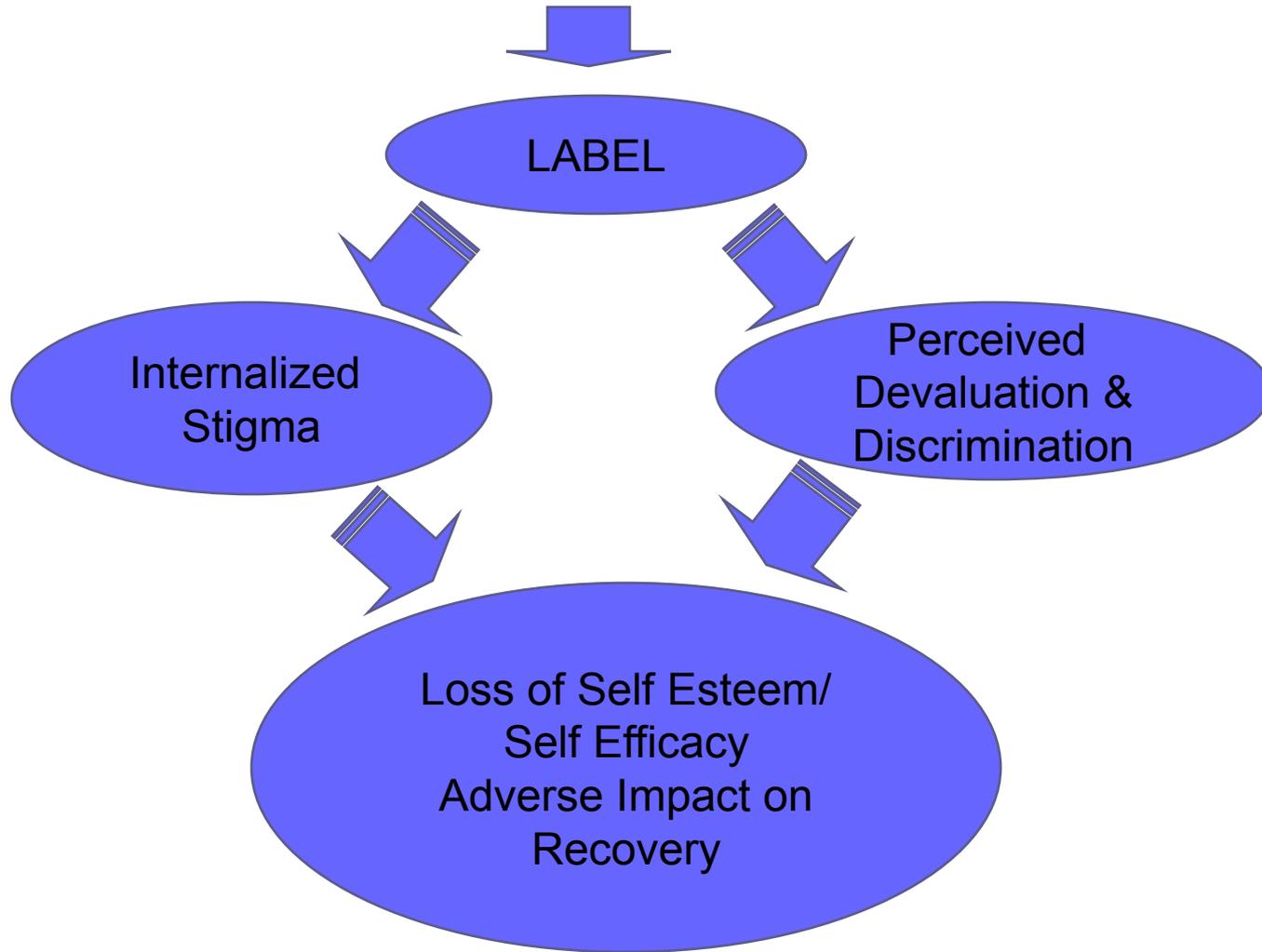
- **Stereotype:**
Negative belief about a group
e.g., dangerousness
incompetence
character weakness
- **Prejudice:**
Agreement with belief and/or
negative emotional reaction
e.g., anger
fear
- **Discrimination:**
Behavior response to prejudice
e.g., avoidance of work and
housing opportunities
without help

Self-Stigma

- **Stereotype:**
Negative belief about the self
e.g., character weakness
incompetence
- **Prejudice:**
Agreement with belief
Negative emotional reaction
e.g., low self-esteem
low self-efficacy
- **Discrimination:**
Behavior response to prejudice
e.g., fails to pursue work
and housing
opportunities

Labeling Theory & Self Stigma

Culturally shared conceptions of mental illness



Labeling Theory & Self Stigma

Internalized stigma and perceived devaluation & discrimination have been linked to:

- Diminished self esteem & self efficacy (even once) symptoms have remitted
- Diminished adherence to treatment
- Diminished pursuit of rehabilitation goals (employment, housing, social networks)

Alternative Responses to Stigma

- Indifference
- Empowerment/righteous anger

What accounts for these varied responses to mental illness stigma?

Self Stigma

- Typically, what is measured and loosely referred to as “self stigma” is perceived devaluation and discrimination.
- This is the first component of our model of self stigma that attempts to account for varied responses.

Components of Self Stigma

1. Stereotype awareness (perceived discrimination & devaluation)
2. Stereotype agreement
3. Stereotype self-concurrence
4. Self esteem decrement

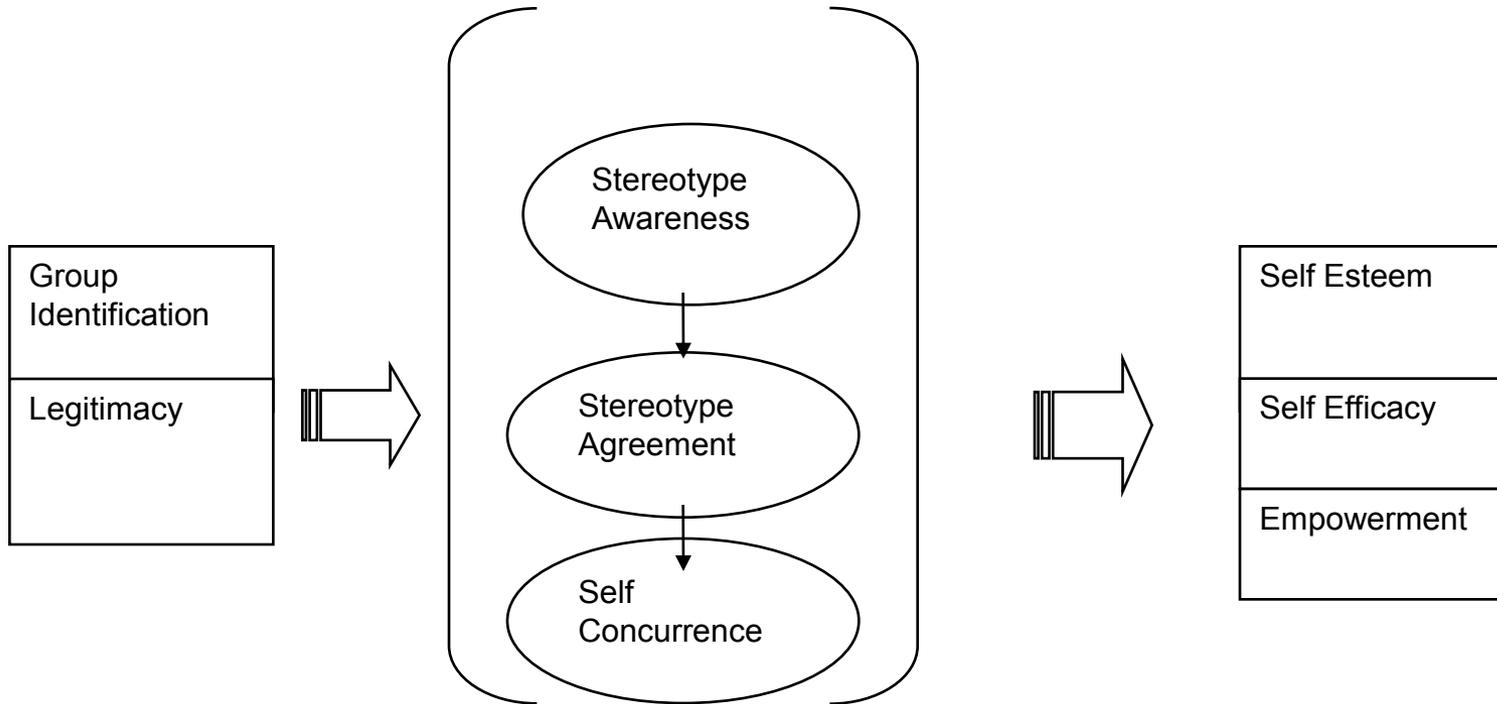
Factors That Influence the Process

Further development of our model of self stigma...factors that influence the process

- Group identification
- Perceived legitimacy of stigma
- Awareness/illness insight

STEREOTYPE

FIGURE 1: Theoretical Model of Self Stigma



Factors Influencing the Self Stigma Process: Findings

- The more aware of MI stigma  the less it is perceived as legitimate. Awareness also reduces self concurrence****
- Stereotype agreement is positively associated with self concurrence.
- Self concurrence negatively associated with self esteem and self efficacy

Factors Influencing the Self Stigma Process: Findings

- The more identified with the group, the less likely to agree and self concur with stereotypes and have higher self efficacy
- The more stigma is perceived as legitimate, the more likely to agree & self concur and have lower self efficacy
- Illness insight associated with greater stereotype agreement and lower self esteem, self efficacy, self esteem and empowerment. ****

Other Recent Studies

- Lysaker, Roe & Yanos (2006) Illness Insight & Internalized Stigma

Group 1: Low Insight/ Mild stigma	Group 2: High Insight/ Minimal Stigma	Group 3: High Insight/ Moderate stigma
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- Group 3: insight paired with internalized stigma > poorer self esteem and less hope than other two groups, Group 2 fared the best, group 3 in the middle

.. "it is as important to assist in developing a sense of mastery as it is to help enhance insight."

- Ritsher & Phelan (2004) Internalized Stigma & Morale
 - Stereotype Endorsement, Social Withdrawal & **Alienation**** dimensions predicted depression and lowered self esteem

"What is needed is an antidote for alienation."

Discussion

- Protective factors
 - stereotype awareness
 - group identification (this may reduce alienation)
- Harmful factors
 - perceived legitimacy of stigma
 - alienation
 - disease awareness absent positive group identification

Implications

- Identify and evaluate mechanisms that
 - promote positive group identification
 - support interpersonal engagement and fellowship
 - enhance stigma awareness
 - challenge the legitimacy of stigma
 - support role recovery and mastery
 - instill hope

Self-Stigma A Fall From Grace?

Robert Lundin



Can you call self-stigma “disgrace?”

- We are unable to achieve other people's or society's goals or meet their expectations
- Many of us fail in reaching our own life's plan (which is dictated in large part by other people's expectations)
- Where there are shortcomings there are often feelings of disgrace, e.g. failure and negative self-image

My fall from grace

- Having to quit graduate school in 1979
- Being fired from a university admissions department in 1980
- A ruinous psychosis in 2007
- Leaving my last job 2007

How do you cope with disgrace?

- Realign one's values
- Keep trying
- Understand that disgrace is put upon you, you need not accept it

Healing From Self-Stigma

Patricia E. Deegan, PhD

<http://www.patdeegan.com>

Macro-aggression

- Examples
 - Take-downs and physical restraint
 - Macing by police and attendants
 - Solitary confinement
 - Homelessness in an affluent country
 - Lack of access to healthcare resulting in premature mortality
 - Illegal locked units in nursing homes such as in New York State
 - Involuntary shock treatment

Micro-aggression

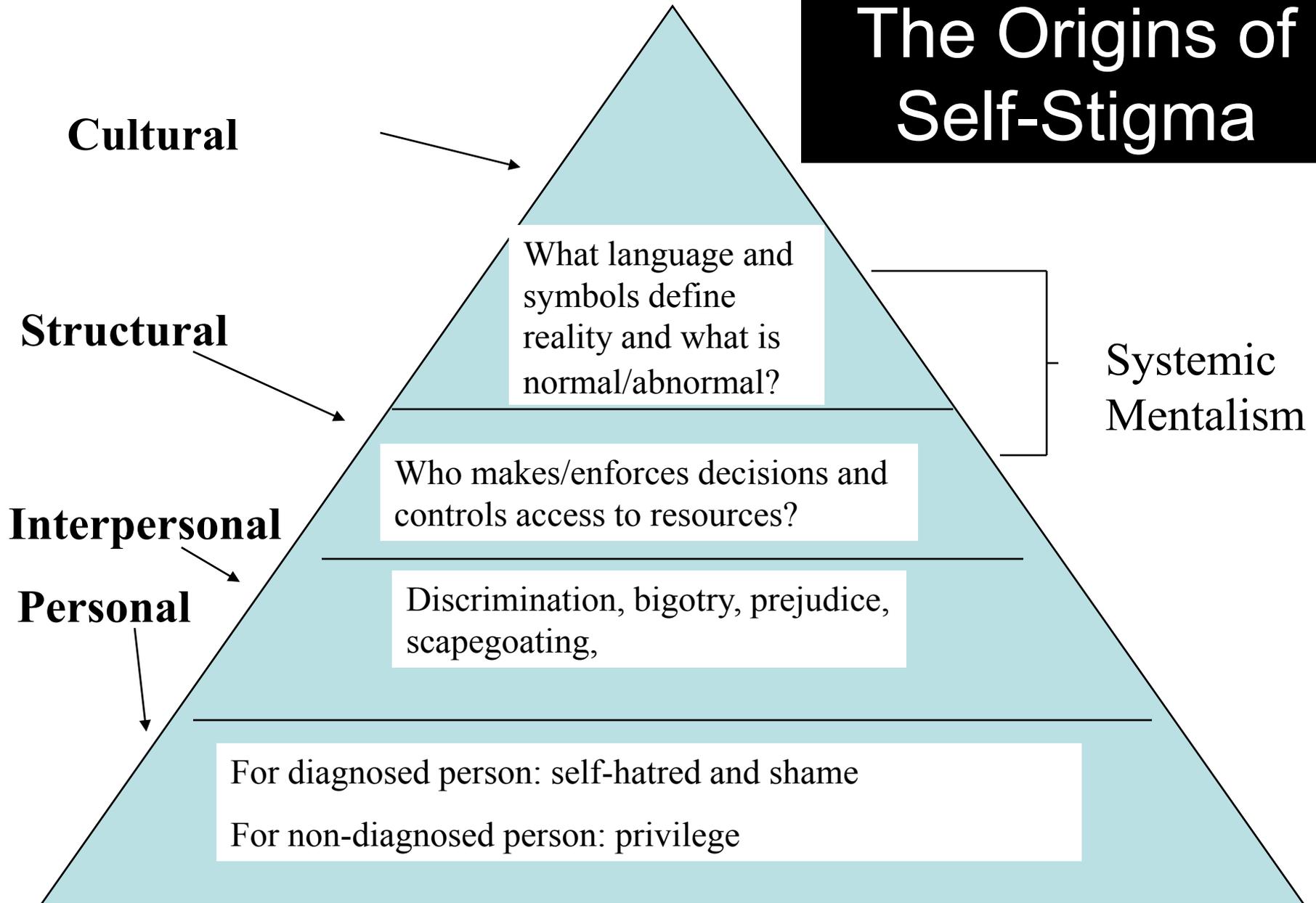
- More subtle and stunning
- More consistent and difficult to “prove”
- Less like a club striking you down and more like sandpaper wearing you down

Micro-Aggression

- “Brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative racial slights to the target person or group.”

Sue, Capodilupo, Torino, et al. 2007, “Racial Microaggressions in Everyday Life: Implications for everyday practice, American Psychologist.

The Origins of Self-Stigma



Survey

- 16 adult residential, supported housing and MH/substance abuse residential treatment programs

Questions for Clients

1. Has a staff person in a mental health program or hospital ever said something disrespectful to you or someone you know? If so, will you give me an example of that? 94 examples were generated
2. How do staff show you respect? 123 responses were generated

Questions to Staff

- What are the words, phrases or slurs you have heard used by staff in mental health settings that are stigmatizing, disrespectful or that devalue clients? 85 examples were given

Communicating Disrespect: Survey Results

- Categories of disrespectful communication
 - Slurs
 - Insults
 - Pet Names
 - Demoralizing Messages
 - Clinical Language
 - Verbal Abuse
 - Behavior
 - Silence

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Healing

- Stop minimizing and validate the harmful impact of macro-aggression and micro-aggression: It's real!
 - “I deserved to put in restraints”
 - “He called me low functioning but it didn't bother me
- Peer support – discovering our self-worth and rejecting internalized self-hatred
 - “I don't go to that program because I don't want to hang out with low-functioning people”
- Prevention: Changing MH practice



More Information

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Questions for discussion are generated by emails sent to the ADS Center. If your question does not appear below, please feel free to contact the ADS Center or the presenters directly.

Questions for Discussion

- 1.) What strategies can we use to change the negative values we hold about ourselves?
- 2.) How do the labels, often assessment and program admission categories, like SMI (serious mental illness); moderate mental illness; and, mild mental illness contribute to internalized stigma?
- 3.) What does research show regarding internalized stigma within mental health professionals who have a mental illness? For example, what is the prevalence of self-reported mental illness in this profession? What policies exist in mental health workplaces to support symptomatic or non-symptomatic employees?
- 4.) How does our own internal stigma cause us to stigmatize our peers? What can we do when we notice that we are judging our peers because they appear different or "less functional?"

Please note: Questions may have been edited for content and clarity.



Resources

The views expressed within these resources do not necessarily represent the views, policies, and positions of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.

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