Overcoming Stigma: Exploring Effective Directions for Clinical Psychology Training and Wider Healthcare Systems

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Agenda

Exploring Stigma
• Evidence
• Sources
• Contexts

How should Clinical Psychology training approach the issue?
• Clinical conceptualisations
• Disclosure
• Interventions
Is stigma towards mental ill health changing?

Systematic review and meta-analytic evidence
Analysis of ‘national time trends’ regarding mental illness-related beliefs and attitudes with minimum follow up of two years (Schomerus, Schwahn, Holzinger et al., 2012). 16 studies representing data from eight countries.

Findings
A coherent trend to greater mental health literacy, particularly towards a biological model of mental illness (inherited, genetic, brain disease); a greater acceptance of professional help.

No changes or change for worse regarding attitudes towards people with mental ill health.

Conclusions
Bio-medical / genetic explanations do not reduce stigma.
Bio-psychosocial explanations likely to be more helpful.
Health related stigma

Evidence of stigma / discrimination towards individuals / families with:

- Amputations (Stuts, Bills, Erwin & Good, 2015)
- Appearance impairment (Lebel, Castonguay, Mackness et al., 2013)
- Attention Deficit Hyperactivity Disorder (Mikami, Chong, Saporito et al. 2015).
- Autism (Kinnear, Link, Ballan et al., 2016).
- Epilepsy (Benson, O’Toole, Lambert et al., 2015*)
- Intellectual Disabilities (Ali, Hassiotis, Strydom et al., 2012*)
- Obesity (Puhl & Hueur, 2009*)

* systematic review / review
Sources of Stigma

‘Weeble’

Definitions:

1. Egg shaped plastic toy person with a weight in the bottom [made by Hasbro in 1970’s]

2. Derogatory slang for a fat or bottom heavy person, based on the toys of the same name
Emerging treatments for severe obesity in children
Stigma is fluid and unpredictable

- Stigma hotspots might include...
  - Admission to Hospital
  - Sectioning under Mental Health Act
  - Diagnosis (+ / -)
  - Family perspectives / expressed emotion
  - Issues of disclosure
  - Appointments with staff
  - Double stigma – e.g. culture plus ill health
  - Language used (are / have; ‘PD’, ‘obese’)
  - The meaning of taking medication
  - Attending health / social / council services (‘toxic’ buildings)
  - Applying for a job / at interview
  - Self-harm
  - When protective factors reduce
  - Attendance or absence from school / college
  - Police involvement (awareness / understanding)
  - When parents ask where their child is / has been
  - Key events – weddings, funerals, religious festivals
How do people cope with Stigma?

Attempts to cope
- Coping orientations (Link et al., 1991).
  - Secrecy
  - Avoidance / withdrawal
  - Education

“Consistent effects in the direction of producing more harm than good” (Link et al., 1991, p. 302).

So how should clinical psychology training respond to this issue?
How should training approach Stigma?

1. Target trainee* knowledge / opinion

- Protest  Evidence: Rebound effect
- Education  Theory, Evidence, Ramifications
  Onward Dissemination / Teaching
- Contact  Working with the ‘individual’

*Trainee identities: clinician, student, member of public, expert by experience, carer...
How should training approach Stigma?

2. Focus on aiding our clients

Awareness
• Consideration of oneself: Social Contexts (Burnham, 2013)
  [Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual Orientation, Spirituality].

• Language: stigma, self-stigma, public stigma, courtesy stigma

Therapy and Intervention
• As part of a general therapy / treatment plan (e.g. identify strengths, formulation)

• Tackling a specific issue (e.g. disclosure)

• Stigma-focused therapy (e.g. issues of self-esteem, empowerment)
  (see Knight, Wykes, & Hayward, 2006; Knight & Mir, 2014).
Developing a clinical conceptualisation that incorporates
issues of stigma and disclosure

Example Exercise:
Think about a client / family / family system you have been working with in your recent placement. Choose someone who the issues discussed today appear relevant for.

Consider:
1. Their sense of self, personal identity, views on their experience / condition / diagnosis.
3. The process of disclosure from others to them (informally or formally through diagnosis / treatment).
4. How they have undergone the process of disclosure to others, including yourself and those that surround them (friends, family, health, educational, occupational).
5. How the models of disclosure might relate to them, and their potential stage of disclosure.
6. What might help them with the above.
Levels of disclosure

Consideration of options / stages

1. Social avoidance - associating only with others with similar experiences
2. Secrecy - not revealing
3. Selective disclosure - revealing to chosen individuals
4. Indiscriminant disclosure - no active efforts to conceal
5. Broadcasting - includes educating others

See Corrigan & Lundin (2001), Herman (1993)

Learning

• Reflection on personal disclosures
• Understanding that disclosure can take many forms (voluntary / involuntary)
• Learning from other minority group experiences, e.g. LGBTQIA+ (See Corrigan & Matthews, 2003)
The effectiveness of interventions

Stigma and mental ill health
Thornicroft, Mehta, Clement et al. (2016). Narrative review of interventions to reduce stigma. 80 papers and eight systematic reviews.

Findings
A pattern of short-term benefit, with certain group level interventions showing promise. Social-contact-based interventions improved attitudes but less so knowledge. Little behaviour change focus. Caution in generalising results. Need to focus on service-user goals more.

Self-stigma and mental ill health

Findings
Two core methods of intervention,
1. Alter stigmatising beliefs and attitudes of the individual,
2. Focus on coping though self-esteem, empowerment and help-seeking behaviour.

Second approach has ‘gained traction’, p. 974.
Group therapy for stigma and self-esteem

Therapy
Evidence based psychological therapy intervention to challenge the effects and legitimacy of stigma (Knight, Wykes, & Hayward, 2006).

Focus on stigma, prejudice, discrimination and challenging myths, alongside coping techniques and self-esteem work.

Results - increased self-esteem, and reduced depression and psychosis ‘symptoms’ in participants.

Update
Development of the intervention (Knight & Mir, 2014).

Therapy with Expert by Experience co-facilitation, focus on participants’ goals in and beyond therapy, ‘our journey’ including ill/poor health and good health, and greater detail regarding disclosure and coping.

Results – certain individuals have re-engaged with work / studies. Inspiration from Expert by Experience role.
Challenge through contemporary culture

Dave – Psycho – Psychodrama Album

‘I'm here with David, This is our first session, We're just gonna talk about your background Where you're from, any issues you've been dealing with
... How do you stop all the pain, huh? ... But if I'm a psycho, then I don't wanna be sane
... My teacher used to say I need counselling, Couldn't stop asking me, "What do you feel?"
There's so many old scars that they wanna reveal ... But if you're looking for a psycho, you got one
... Bro, I shed so many tears on a pillow ... Blame my environment, it made me a sicko
... People tell me I'm a little bit barmy, ... probably battlin' with manic depression
Man, I think I'm going mad again, Man, I need some therapy
I used to cry about my dad until my f*cking eyes burnt
Suicide doesn't stop the pain, you're only moving it, Lives that you're ruining
Thoughts of a world without you in it, hiding. I ain't psycho but my life is.’

Stormzy – First Things First – Gang Signs & Prayer Album

Like, alright, first things first, I've been putting in the work
... I've been gone for a while but I saw you n****s smile, When I cancelled all my tours
... You was fighting with your girl when I was fighting my depression, wait
... Mad, mad demons in my thoughts
... Took a little break from the game, started praying, Man, I had to get my mind right (started praying)