Stigma: Practitioner Attitudes
Examples from Qualitative Interviews in the VA

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I do care about social justice and factors that influence it (e.g., stigma).
1. Stigma
   – definitions, expressions, harms

2. Expressions of stigma observed in a qualitative study with primary care providers from the U.S. VA Healthcare System

3. Implications
What is Stigma?

• **Stigma is a process of distinguishing and labeling differences, stereotyping, separation (e.g., “us” from “them”), status loss, and discrimination within a social, economic, and political context.** –Link and Phelan 2001

• **Stigma can be understood as an attribute, behavior, or reputation that is socially discrediting.** –Kelly 2010

• **Deeply embedded in social and cultural norms, stigma includes prejudicial attitudes that discredit individuals, marking them as tainted and devalued.** –Pescosolido 2010

Pescosolido 2010; Link and Phelan, 2001; Kelly Int J Drug Policy, 2010
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Multiple Levels of Stigma

Structural / Institutional stigma

Social / Enacted stigma

Felt stigma
(Perceived or Internalized)
Multiple Ways to Enact or Express Alcohol-Related Stigma

- Assumptions regarding **choice** of and **culpability** for disease
- Beliefs regarding the extent to which an individual has **volitional control** over disease
- Expectations of **character flaws** (e.g., untrustworthiness, irresponsibility, aggressiveness)
- **Social distancing** (e.g., this problem should be cared for by someone else)
- **Labelling language** (e.g., abuser versus individual with an alcohol use disorder)
What does Stigma have to do with Healthcare Providers?

- Providers exist within structures and social forums in which community-based attitudes, beliefs, and predispositions may (often subconsciously) shape responses to patients.

“The stigma of substance use is based on broad social inequalities but also developed or reinforced through interpersonal experiences, like the provider-patient interaction.”

–Chang, 2015
Stigma may be a Barrier to Provision of High-Quality Care for Alcohol Use Disorders

728 Mental Health Providers Randomly Assigned 1 of 2 vignettes

Those assigned to “substance abuser” versus “substance use disorder” were more likely to agree with the notion that the patient was personally culpable for his condition and to suggest punitive (as opposed to treatment) measures be taken.

Kelly et al, Int J Drug Policy, 2010
Stigma may be a Barrier to Treatment Receipt for Patients

In a nationally representative sample, only 14.6% of people meeting criteria for lifetime alcohol use disorders reported receiving any treatment. Stigma was a big barrier:

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should be strong enough to handle it alone</td>
<td>44.4</td>
</tr>
<tr>
<td>Thought problem would get better by itself</td>
<td>31.5</td>
</tr>
<tr>
<td>Stopped drinking on my own</td>
<td>24.4</td>
</tr>
<tr>
<td>Did not think drinking problem was serious enough</td>
<td>21.1</td>
</tr>
<tr>
<td>Was too embarrassed to discuss it with anyone</td>
<td>18.0</td>
</tr>
<tr>
<td>Could not afford to pay the bills</td>
<td>12.7</td>
</tr>
<tr>
<td>Did not want to go to treatment</td>
<td>11.2</td>
</tr>
<tr>
<td>Hated answering personal questions</td>
<td>10.3</td>
</tr>
<tr>
<td>Did not think anyone could help</td>
<td>8.4</td>
</tr>
<tr>
<td>Did not know anyplace to go</td>
<td>8.4</td>
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</tbody>
</table>

Includes only individuals with an alcohol use disorder who thought about, but did not utilize, alcohol treatment.

• Cohen et al, Drug and Alc Depend, 2007
Stigma may be a Barrier to Treatment Receipt for Patients

- In another national survey, the top 6 reasons people aged 12 or older who felt they needed but did not receive substance use treatment were:
  - no health coverage and could not afford cost
  - not ready to stop using
  - concern that getting treatment might cause neighbors/community to have negative opinion
  - not knowing where to go for treatment
  - being able to handle the problem without treatment
  - possible negative effect on job

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Do Primary Care Providers Express Alcohol-Related Stigma?
The purpose of the study was to understand barriers and facilitators to provision of pharmacotherapy for alcohol use disorders in primary care.

We conducted secondary analyses to identify expressions of stigma in the data, which are the focus of today’s presentation.
Study Setting:
Veterans Health Administration (VA)

• **Veterans Health Administration (VA)**
  – Largest integrated healthcare system in the United States
  – Over 900 clinics nationwide, divided into 21 networks, serving 5 million patients

• **Present Qualitative Study:**
  – 5 geographically dispersed and independently managed primary care clinics associated with a single large medical center in the Pacific Northwest

• **Key Contacts and Snowball Sampling:** started with clinical or administrative leaders and identified primary care provider (GP equivalent) participants via snowball sampling

• **Semi-structured interviews:** 20-30 minutes; digitally recorded and transcribed.
Parent study data were analyzed with template analysis to identify *a priori* and emergent themes.

This process identified expressions of stigma.

Second pass at qualitative data to more comprehensively code expressions of stigma.
  * Prototypical examples were extracted for presentation.
Results

• 24 primary care providers participated
  – 19 Medical Doctors (MDs)
  – 1 Doctor of Osteopathy (DO)
  – 4 Nurse Practitioners (NPs)
Results

• Multiple expressions of stigma were identified, including:
  – Perceptions of character flaws (e.g., untrustworthiness, aggression)
  – Social Distancing (e.g., someone else should treat this condition)
  – Perceptions of control of and culpability for disease
  – Labelling language (e.g., alcoholics)
“You know they can sit there and say, ‘sure I’ll try to change’ and give you lip service but in reality most of them never do.”
“I don’t want those people coming in here saying that. Then it will be ‘you didn’t give me enough’. Or ‘you didn’t give me the right dose . . .’ So I think I have limited optimism on naltrexone.”
“It’s almost useless. It’s very difficult, very sad in some ways. . . . anything short of [a near death experience], you can lose your job, you can lose your family and everything else and a lot of that sometimes never matters to these people.”
“Many alcoholics are not particularly interested in it anyway, but if they are interested in it and there isn’t any excuse not to do it, there’s a lot of easy ways for them to say, ‘oh just I can’t do it.’”
“Give us an in house counselor a couple days a week to work with the patients. Let them identify who’s really going to do it and who has just been pushed in there by an employer or judge or something like that.”
You know, in my mind, you [people with AUD] need special kind of help. You know, to me, actually the mental health clinic is the place to go.”
“I wouldn’t want to take on the yoke of like, ‘I am treating your alcoholism’.
“If they’re really serious they’ll hop over this barrier and we’ll work with them.”
“Some of those recalcitrant cases. . . I think we all get frustrated with them. And I generally, I mean I don’t have an answer there. I mean when somebody’s not willing to get help and won’t change their habits and continues to abuse. I mean until they get to a point where legally they’re forced to do it, you know, um. Yeah. I don’t have a way of forcing people to get treatment.”
“telling someone that you may have a genetic predisposition to this issue is, what’s the world, kind of. . .it doesn’t excuse them from their choices and their behavior. . .”
“I definitely put it on them [patient] to make the call [to specialty addictions treatment]. I feel like that is, that shows a patient who is ready to do the work of dealing with their addiction.”
“You can’t spoon feed someone addiction treatment, they have to be ready... they have to be the ones to make the change. So it’s a little bit different maybe than some mental health conditions like depression and things.”
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We observed expressions of stigma during qualitative interviews with primary care providers focused on understanding barriers and facilitators to provision of an evidence-based treatment for alcohol use disorders.

Expressions of stigma included perceived character flaws, social distancing, perceptions of control of and culpability, and labelling language.
Implications

• Stigmatized attitudes toward patients with alcohol use disorders may influence:
  – provision or quality of care for alcohol use disorders
  – patients’ response or openness to care

• Stigma-reduction interventions aimed toward primary care providers may be needed
Thank you!
Public Perceptions of Alcohol Dependence
1996 - 2006

N=630 members of U.S. general public randomly assigned a vignette describing alcohol dependence*

<table>
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</tr>
<tr>
<td>Unwilling to work closely with</td>
<td>72%</td>
<td>74%</td>
</tr>
<tr>
<td>Perceived dangerousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent to self</td>
<td>78%</td>
<td>79%</td>
</tr>
<tr>
<td>Violent to others</td>
<td>65%</td>
<td>67%</td>
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*Now termed Alcohol Use Disorders, DSM 5

Pescosolido, Am J Psych, 2010
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*Now termed Alcohol Use Disorders, DSM 5
N=723 general public, general practitioners, healthcare professionals, and clients in the Netherlands: comparisons across groups in stereotypical attitudes

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Interventions Should Be Informed by Evidence
N=630 members of U.S. general public randomly assigned a vignette describing alcohol dependence*

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<th>Disease Attribution</th>
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<td>Neurobiological Attribution of Disease</td>
<td>44%</td>
<td>50%</td>
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• Holding a neurobiological conception of alcohol use disorders increased the likelihood of support for treatment but was generally unrelated to stigma.
• Where associated, the effect was to increase, not decrease, community rejection.

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