Associative stigma among mental health providers: Converging results from three studies in the US

Joseph S. DeLuca, M.A.
Ph.D. Student, Clinical Psychology
September 20, 2017
Overview

- Universities and researchers involved:
  
  - **John Jay College/CUNY Graduate Center (New York, USA)**
    - Mental Health Recovery Research Lab: Lauren O’Connor, Beth Vayshenker, and Phil Yanos
  
  - **Indiana University-Purdue University Indianapolis (Indiana, USA)**
    - Kim Dreison, Sadaaki Fukui, Jennifer Garabrant, Nancy Henry, Gary Morse, Angie Rollins, Kelley Rounds, Mike Sliter, Michelle Salyers, and Julie Szempruch
Overview (cont.)

1. Brief review of associative stigma
2. Purpose of the current research
3. The three studies we conducted
4. Limitations, conclusions, and future directions
**Associative Stigma (AS)** (also known as “courtesy stigma” or “affiliate stigma”)

- Refers to the process by which people associated with a stigmatized group in society become discredited themselves.
  - In his landmark description of the stigma process, Erving Goffman (1963) asserted that it is typical for persons who are “related through the social structure to a stigmatized individual” to “share some of the discredit of the stigmatized person to whom they are related.” He added that, “The problems faced by stigmatized persons spread out in waves, but of diminishing intensity” (p. 30).
Assessing Stigma (AS) (continued)

• Most commonly reported by (and researched with) family members of individuals diagnosed with mental illness
  • e.g., relatives report reduced status, demeaning social interactions, social avoidance from others (e.g., Angermeyer et al., 2003)
  • genetic “contamination” (Koschade & Lynd-Stevenson, 2011) and “...suspicion of having played a role in cause or the lack of ability to help” (Pescosolido & Martin, 2015, p. 94)

• Increasingly being studied among MH providers (MHPs):
  • e.g., “psychiatry has low prestige” and students seen as having “...personal problems,” among a sample of medical faculty (Stuart et al., 2015); public belief that MHPs are more eccentric and unpredictable than GPs, and that mental health problems may cause or result from mental health employment (Ebsworth & Foster, 2013)
Associative Stigma (AS) (continued)

“...we conclude that associative stigma deserves more research attention. Future studies should start with the development of a more sophisticated instrument for measuring associative stigma” (p. 29)
Purpose of research

• (1) elucidate nuances of AS experiences (no qualitative studies ever done in this area), (2) determine valid instruments to assess AS, and (3) learn more about the relationship between AS and other key variables (e.g., burnout, quality of care) in diverse samples

![Figure 1. Conceptual Model](image-url)
Timeline

- **Study 1 (Spring 2016)**
  - “As Soon As People Hear That Word…”: Associative Stigma Among Clinicians Working with People with Serious Mental Illness (Vayshenker, DeLuca, Bustle, & Yanos, under review)

- **Study 2 (Summer 2016)**

- **Study 3 (Fall 2016/Winter 2017)**
  - Associative Stigma among Mental Health Workers at a Community Mental Health Center in Indiana (Salyers et al., studies ongoing)
Study 1 (Vayshenker et al.)

- **Method:** Online qualitative study, $N = 47$, three coders for consensus | Snowball sampling to recruit MHPs who had direct experience working with individuals diagnosed with SMI | Nine questions about experiences of AS and ways of managing it

- **Exploratory hypotheses:** MHPs would report frequent AS experiences and would endorse avoiding discussing their work as their primary management strategy

- **Findings/Major themes:**
  - a reluctance to discuss one’s work with others | negative portrayal of mental health professionals (e.g., unethical, personal psychological problems) | the view that work with people with serious mental illnesses could be done by anyone, but that no one would want to do it if they had the choice | coping via educating others, using humor
Study 1 (Vayshenker et al.)

- **Themes, %’s, and representative quotes:**

  - **Describing profession to others (15%):** “It becomes even harder when talking about my research and experiences working with schizophrenia, because as soon as people hear that word, they conjure up whatever stereotype they've been exposed to...and immediately think I'm working with dangerous, crazy individuals.”

  - **Job devaluation (26%):** “I had family members once tell me that I had the job that others didn't want, like a garbage collector. They all laughed about it. I did not think it was funny...”

  - **Coping with AS via education (32%):** “(hearing jokes about MH) empowers me to educate those outside the profession about what we actually do, as opposed to what movies and media portray about us.”
Study 2 (Yanos et al.)

- **Method:** online survey with MHPs ($N = 472$) who completed the Clinician Associative Stigma Scale (CASS) and measures of burnout and quality of care | CASS was developed with an initial pool of 26 items on the basis of prior research, including our qualitative study, and expert opinion (seven MHPs with SMI work experience)

- **Hypotheses:** CASS would show statistically significant relationships with measures of burnout and quality of care (convergent validity) and no statistically significant relationships with a measure of general self-efficacy or provider expectations of recovery (discriminant validity).
**Study 2** (Yanos et al.)

- **CASS** (18 items, alpha = .85, $M = 42.3$ [range 21-72], $SD = 8.5$):  
  - **Four-factor structure:** (1) neg. stereotypes about professional effectiveness, (2) discomfort with disclosure, (3) neg. stereotypes about people with MI, (4) stereotypes about professionals’ MH

- **Sample items:**  
  - “When I tell them about the work that I do, people outside of the mental health field express that it must be sad because people with serious mental illness don’t improve in treatment” (58% agreed)  
  - “When I tell them about the work that I do, people outside of the mental health field remark that the work must be ‘scary’” (64%)  
  - “I have heard people state or joke that mental health professionals help others because they do not want to confront their own psychological problems” (55%)  
  - “I have heard people outside of the mental health field express the view that mental health professionals don’t know what they are doing/can’t really help” (42%)
### Study 2 (Yanos et al.)

**Findings:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinician Associated Stigma Scale</td>
<td>—</td>
</tr>
<tr>
<td>2. Oldenburg Burnout Inventory (OBI) total score</td>
<td>.27*</td>
</tr>
<tr>
<td>3. OBI disengagement subscale</td>
<td>.18*</td>
</tr>
<tr>
<td>4. OBI emotional exhaustion subscale</td>
<td>.30*</td>
</tr>
<tr>
<td>5. Quality of Care Scale (QoCS) total score</td>
<td>-.01</td>
</tr>
<tr>
<td>6. QoCS client-centered care subscale</td>
<td>.08</td>
</tr>
<tr>
<td>7. QoCS general work</td>
<td>-.13*</td>
</tr>
<tr>
<td>conscientiousness subscale</td>
<td></td>
</tr>
<tr>
<td>8. QoCS low-errors subscale</td>
<td>-.15*</td>
</tr>
<tr>
<td>9. Provider Expectations for Recovery Scale</td>
<td>-.04</td>
</tr>
<tr>
<td>10. General Self-Efficacy Scale</td>
<td>-.01</td>
</tr>
</tbody>
</table>

*p<.01 (two-tailed)*
Study 2  (Yanos et al.)

- “Thank you for including me in this survey, but most poignantly, thank you for giving our field a voice. I felt solidarity when reading questions, knowing I was not the only one who had felt one way or another”
  - (emailed to us from a social worker who completed the survey)
Study 3 (Salyers et al.)

- **Method:** online survey (part of a larger study to intervene and reduce burnout) with MHPs at a large community mental health center in Indiana ($n = 71$, study ongoing)
- **Hypotheses:** CASS would show statistically significant relationships with additional measures of professional life, including burnout, job satisfaction, and emotional dissonance when working with clients
Study 3 (Salyers et al.)

- **Example items:**
  - **EE**: “I feel emotionally drained from my work”
  - **PA**: “I can easily understand how my clients feel about things.”
  - **SE**: “I am confident that I can perform effectively on many different work tasks.”
  - **Surface**: “I put on an act in order to deal with clients in an appropriate way.”
  - **Deep**: “I work hard to feel the emotions that I need to show to clients.”

<table>
<thead>
<tr>
<th>Measure</th>
<th>Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CASS</td>
<td>(.88)</td>
</tr>
<tr>
<td>2. EE</td>
<td>.27*</td>
</tr>
<tr>
<td>3. Depersonalization</td>
<td>.23</td>
</tr>
<tr>
<td>4. PA</td>
<td>-.32*</td>
</tr>
<tr>
<td>5. Job Satisfaction</td>
<td>-.29*</td>
</tr>
<tr>
<td>6. CTxS</td>
<td>-.25</td>
</tr>
<tr>
<td>7. Self-Efficacy</td>
<td>-.28*</td>
</tr>
<tr>
<td>8. Work Well Being</td>
<td>-.19</td>
</tr>
<tr>
<td>9. Surface_Client</td>
<td>.36**</td>
</tr>
<tr>
<td>10. Deep_Client</td>
<td>.25*</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01. (Two-tailed)
Limitations

• Sample characteristics, selection bias, generalizability, longitudinal data and causal pathways

• Other variables at play?
  • Personal, public MH stigma endorsement and perceptions of stigma
  • Personal connection to MH (e.g., self, family, friend)
  • Institutional/organizational climate and colleague relationships (e.g., some people might report more AS because they see all work-related issues in a negative way)
  • Others?
Conclusions & Future Directions

• **Takeaway message:** associative stigma exists among MHPs and can have detrimental impacts on MHPs well-being and clients’/patients’ well-being. More research is needed to determine pathways, assess other contributing variables, and generalize findings to other countries and regions.

• **Future work:**
  - Future Indiana results: longitudinal data (second round of surveys being analyzed)
  - Policy implications: considering AS as a specific job stressor? and seeing MHPs as both potential targets of MH stigma and contributors
Thank you

• Email: jdeluca@gradcenter.cuny.edu