Stigma & LAIs

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Brief overview of roles & responsibilities

- Lead for Obesity, Canadian Psychiatric Association
- · CPSO Assessor , College of Physicians and Surgeons Ontario
- · Board of Director, Association of General Hospital Psychiatric Services AGHPS Ontario
- · Medical Director In patient Psychiatry
- · Clinical Director Assertive Community Treatment Team
- · Clinical Lead Director ECT Service
- · Adjunct Assistant Professor Psychiatry, University of Toronto
- · LMCC Examiner, Medical Council of Canada since 2018
- · Member, Canada Society of Addiction Medicine, Education Committee 2017 till date
- · Co- Chair, Diabetes Canada Mental Health Special Interest Group 2016 till date
- · Co-Chair, North Indian Medical Dentists Association Of Canada CME Committee 2017 t-2019
- · Diabetes Canada program planning committee 2018
- · Regional Delegate GTA Diabetes Canada (2016-2017)
- · Diabetes Education Centre SRHC planning committee 2015 till date
- · Quality & Patient Safety & Physician Quality Council SRHC 2018
- · Physician panel member of the Research Board and Ethics Committee 2016
- · Physician panel member of the Medication Safety Committee 2014 -15

Disclosure

- **Faculty:** Dr. Gaurav Mehta
- **Relationships with commercial interests:**
  - Grants/Research Support: **Janssen**
  - Speakers Bureau/Honoraria: Lundbeck, Janssen, Purdue Pharma, HLS Therapeutics, Otsuka
  - Consulting Fees: Addiction Services York Region. York Social Support Network
  - Advisory Board: Novartis, Lundbeck, Otsuka

Learning Objectives

- To understand the concept of stigma
- To review the typology of stigma
- To recognise the stigma around LAI and discuss about its management

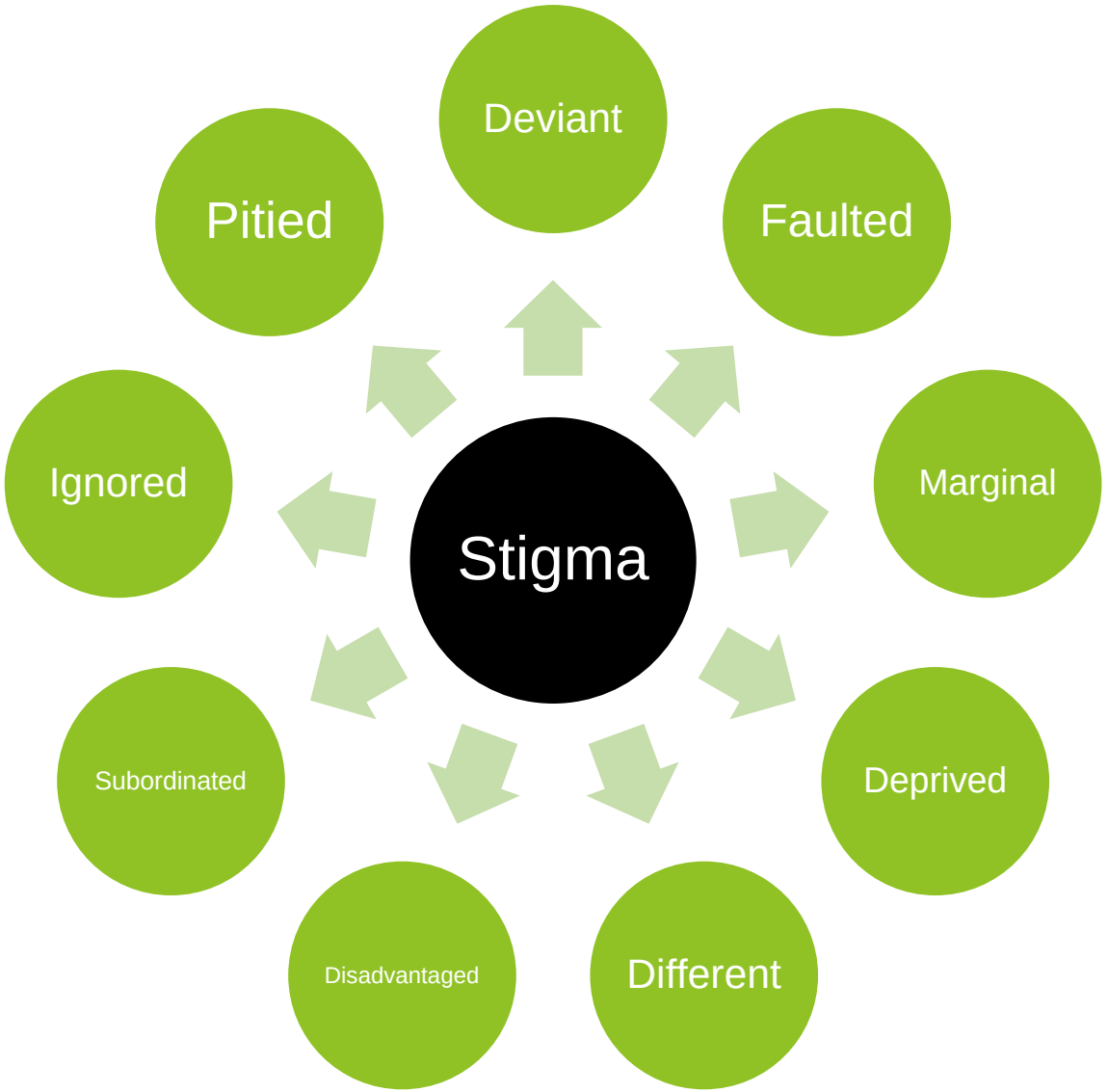
Stigma –Meaning

- Ref- Oxford Dictionary of English-2nd Edition

- A mark of disgrace associated with a particular circumstance, quality or person.

- Originated in late 16th Century
- Denoting a mark made by pricking or branding
- Via Latin from Greek stigma – a mark made by a pointed instrument
- A dot related to stick

Words that resonate with ‘Stigma’



- Goffman 1963
- Stigma word originated with the ancient Greeks
- Refer to body marks or brands that were designed to expose infamy or disgrace
- For eg slave or criminal

- Now a days, it is more applicable to the disgrace itself, rather than bodily evidence of it.

- Stigma denotes an attribute that is deeply discrediting -that reduces the possessor in our minds from a whole and usual person to a tainted and discounted one

Categories or Groups

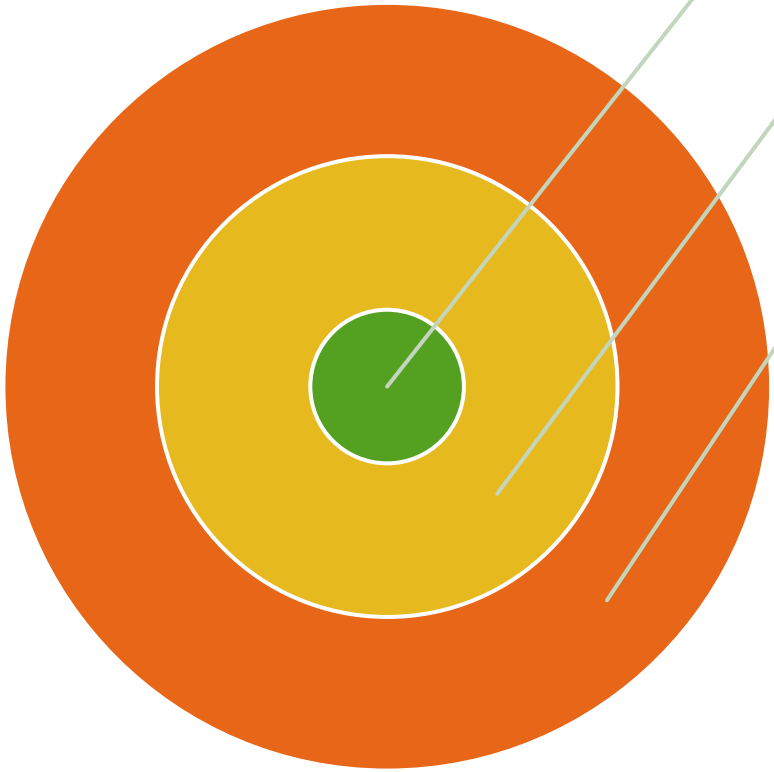
- Race
- Mental Health
- Elderly
- Physical disability
- Deformities
- Chronic disease
- Behavioural deviants – Law offenders, Substance users. Alcohol use, Sex workers

Attitude

Criticize and avoid

- openly
- For e.g. Law offenders
- Covertly and unconsciously
- innocent victim of misfortune
- For e.g. paraplegic person

Types of Stigma



Abominations of the body- various physical deformities, disabilities and chronic diseases .

Blemishes of individual character- socially deviant behaviour

Tribal stigma of race, nation and religion

Reactions in the non-stigmatised observer

- Be aware of a particular stigma
- Feel threatened by it
- Feel sympathy and/or pity for its possessor
- Hold the possessor responsible for having it

Awareness of Stigma

- Visibility of stigma
- Not just the visual perceptibility but the general evidentness of a stimulus

- This can be confused with the following 3 notions
- 1 Know-aboutness of the attribute – previous knowledge or contact or gossip

- 2 Obtrusiveness – the extent to which a stigma interferes with the flow of interaction
- For eg the cane of a person with visual impairment – a very visible symbol but it can be disattended .
- However the person's failure to direct his/her face to the eyes of conversational co-participants repeatedly disrupts the feedback mechanics of spoken interaction

- 3 Perceived focus of stigma- observer's perception of the sphere of the life activity for which the particular attribute disqualifies the possessor
- For eg ' Ugliness' is a stigma that is focused in social situations.
- It ought to have no effect on the person's competency in solitary tasks
- On the other hand , in DM – may have no effect on the person's qualifications for face to face interaction, but may lead to discrimination in employment

Visibility of stigma

- Know-aboutness of the attribute
- Obtrusiveness
- Perceived focus of stigma

Why is this important ?

- All of these factors determine the people’s level of awareness of a particular stigma in various interaction situations, hence the extent to which they will treat the possessors as deviant

Threat of a Stigma

- Different stigma – variation in the degree and severity
- For eg Behavioural deviants – law offenders/delinquents – may elicit fears of physical harm

- <u>Reaction in people</u>
- Interaction with sick and injured – may arouse apprehensiveness in observers
- The contact may cast doubt on the widely held belief that ‘world is a just place where innocent do not suffer’ Lerner 1970
- Karma theory

- It may remind the observer of their own vulnerability to sudden misfortune , or raise the prospect of becoming enmeshed in another person’s dependency.

- Moreover , to the extent that these factors lead to avoidance of someone who is disabled, it can lead to lowering of self-esteem in the observer.

Threat of stigma is greater in

- Severe > Mild
- Permanent> Curable
- Mysterious , relatively uncontrollable (cancer)> equally dangerous but more understood medically (heart disease)
- Neurotic anxiety sufferers with behavioural manifestations > depressed people who are more subdued and non- disruptive

Sympathy arousal

- Observer's reactions are NOT always negative
- Feelings of sympathy for the underdog
- Distress over suffering of others
- Respect for striving and overcoming severe handicaps

- Social norm – physically and mentally disabled should be treated well
- However , specific types of deprivation are not apparent to others
- For eg Job discrimination
- Perception Race > SMI
- It may not be true
- SMI – may actually be subjected to as much or more negative bias

- Perception of being intrinsically disabling
- For eg Physical handicap> prison record

- Visibility of disability plays an important role in perception
- It can be determined by the observer’s ability to decode disability cues.

- Variation in reactions
- The more evident the disability/handicap is, more likely the others are likely to help them and feel sympathy

- However , deprivation is often taken as sign of badness and guilt Heider 1958
- For eg Poverty and weakness evoke negative evaluations , even contempt.

Perceived Responsibility

- How likely the possessor is likely to be held responsible or judged by others ?
- For eg Moral norm violation (voluntary)< tribal or bodily stigma (involuntary)
- Hence less sympathy for Law Offenders

- Physical health issues caused by negligence, self-indulgence or immorality – negative attitudes
- For eg Obesity, ‘ They could control their weight if they really wanted to’

- In handicap/disability, more sympathy for accidental causes > genetic causes
- In depression, more sympathy for loss of loved ones> victims of inexplicable ,endogenous depression

Why is this important ?

Whether the individual is blamed or not, is likely to have important consequences for how they participate in the treatment plan

Attitudes about sick

- Both positive and negative elements
- Kind treatment of the sick is socially approved
- Religious basis-Worldwide
- Sick have a preferential position
- It is a privilege for the healthy to care for them

Cancer

- Cancer(20th Century) replaced Leprosy (Middle ages) as an illness with moral significance
- Not just a lethal illness (Sontag 1978)
- Shameful
- A symbol of corruption and decay
- Arousal of disproportionate sense of horror
- An irrational dread of contamination

- Severo 1977
- Friends / Family of cancer patients – frequently brittle and ugly

- Initial- sympathy  give way to anger and resentment

Social Psychological aspects of Cancer

- Ambivalence
- Confusion
- Discomfort
- Avoidance
- Discourage open communication
- Conflicting verbal cues in presence of the sick
- Myth is even prevalent in health care professionals
- Refusal to handshake
- Fear of contagiousness

Wortman and Dunkel- Schetter (1979)
Kleiman,Mantell and Alexander 1977-

Psychoanalytical perspective of linkage between abnormality and wrongdoing

- 3 Primitive, often unconscious reactions to disease or injury

- The belief that physical disorders are a punishment for wrongdoing
- The belief that a sick person has been unjustly punished and therefore is under pressure to do an evil act in order to balance the injustice
- Projection of one's own unacceptable desires over the unfortunate other.

- All three reactions involve a perception of the afflicted person as dangerous.

- Physical health is a desirable attribute .
- Safilos- Rothschild 1970 – very strict standards for physical integrity and perfection and beauty in Anglo-Saxon Countries , middle class
- Any deviation from this could lead to social stigmatization
- Not only physical deformities/ chronic invalidating illness
- But also obesity, acne ,oily hair, bad breath, sweating odour

- Degree of aversion is more in skin disorders, amputation, body deformation, cerebral palsy > deafness, blindness or paralysis (Siller &Chapman 1964)

- Out of all types of visual disabilities, facial disfigurements – greatest amount of aversion in children and adults (Richardson,Hastorf, Goodman, Dornbusch 1961)

- Facial anomalies > Blindness
- Although blindness – most feared disability and considered to be most severe (Whiteman & Lukoff,1965)

Cognitive -perceptual disposition in Stigmatization Process

- Heider 1944 – Notion of fundamental tendency to see things of like quality as belonging together and as causally related
- Thus Negative states (sickness, deformity) are perceived as having negative causes (wrongdoing)
- A person who displays a strongly negative attribute (physical defect) will tend to be seen as having other negative attributes as well.

  (Spread phenomenon of perceptual association)
- Non -disabled individuals tend to create consistently negative impressions of the disabled individuals, who are then viewed as inferior across a broad range of non visible characteristics simply on the basis of visible or known disability

Stigma in the context of LAI

- A qualitative study of perceptions and attitudes toward LAIs among psychiatrists in Canada.
- Focus groups were conducted with 24 psychiatrists in 4 Canadian provinces.
- Psychiatrists in the study prescribed the oral formulation of APs most of the time and had limited experience with LAIs.

Reference: CanJPsychiatry2013;58(5 Suppl 1):23S–29S Iyer et al

Themes in the study

- Limited Knowledge & Experience
- Attitude towards LAI
- Prescribing Practices
- Pragmatic Barriers

Key points for discussion –Myths/Facts

- The predominant use of LAIs as an end-of-the-road option, in a context of either coercion or a fragile therapeutic relationship owing to a history of treatment nonadherence, may continue to reinforce a negative image of LAIs.

- A major theme that emerged was psychiatrists' lack of knowledge about LAIs (for example, available options, side effects, and outcome literature) and lack of confidence in extant knowledge. In this context, participants discussed their limited prior exposure to LAIs

Attitudes toward LAIs

- Beliefs about patient perceptions
- Personal bias
- Advantages and Risks

- Patients feel controlled or perceive LAIs as more intrusive or coercive.
- It is hard to convince patients to start an LAI.
- Patients will refuse LAIs.
- Patients fear LAIs as they could hurt or be painful.
- Patients have strong feelings about the needle factor.
- Patients see LAIs as a message from treatment providers that the patient cannot manage on his own or cope.

Prescribing Practices Around LAIs

- The length of time for reaching a steady state with LAIs making them less suitable for the acute phase or in inpatient units.
- LAIs were generally seen as a more suitable option for patients in an involuntary context of either a CTO or a forced hospitalization or a threat of a CTO; patients with a clear history of nonadherence; and seriously ill patients, with risk factors for nonadherence, for example, “if the patient is using substances.”
- LAIs were also generally considered unsuitable during the early treatment course of psychotic disorders.
- Own bias that injectables are painful or that the therapeutic alliance will be damaged.

Pragmatic Barriers to Using LAIs

- Problems with storage and lack of personnel to administer injections in small towns and (or) small centres
- Difficulties finding trained and available nursing staff to give injections
- Cost considerations (even when patients were covered for the cost of the LAI, sometimes physicians perceived LAIs as expensive and as costing the Canadian health care system)
- Concerns about arranging injections when patients went on vacation
- Difficulty transferring care to general practitioners who may not be comfortable with LAIs

Where do we stand now at SRHC ?

- YTD 2019
-
- Clopixol Depot 100
- Haldol LA 40
- Fluanxol Depot 20
-
- Risperdal Consta 30 (vs 50 in 2018 full year)
- Paliperidone LAI 125 (vs 110 in 2018 full year)
- Aripiprazole LAI 30 (vs 15 in 2018 full year)

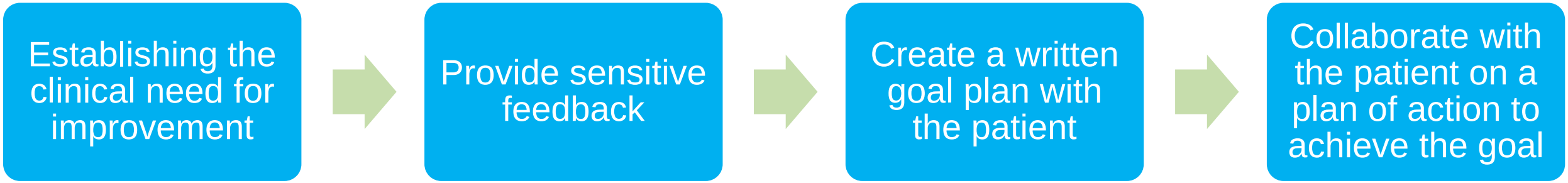
- The above #'s (345 total YTD) would translate into approximately 415 doses of LAI's for full year 2019, of which just over 50% are supplied by Centric Health Rx (53%),

GAIN –A Psychosocial tool

- Goal setting
- Action planning
- Initiating treatment
- Nurturing motivation

Reference: Psychiatry (Edgemont) 2009;6(4):22–27 LASSER et al

Goal Setting



Action Planning

Show the patient, that you as a clinician believe that treatment with LAI may be an overall positive step

Review the potential benefits and risks of LAI and explain how it works

Re-link the specific goals potentially achievable with the help of LAI

Initiate Treatment

Manage patient perceptions and experience

Nurturing Motivation

Engage the patient in dialogue and listen carefully

After a few months of therapy, discuss the long term treatment plan.

Seven ways you can reduce stigma

- Know the facts. Educate yourself about the illness
- Be aware of your attitudes and behaviour. Examine your own judgmental thinking, reinforced by upbringing and society.
- Choose your words carefully. The way we speak can affect the attitudes of others.
- Educate others. Pass on facts and positive attitudes; challenge myths and stereotypes.
- Focus on the positive. illness is only part of anyone's larger picture.
- Support people. Treat everyone with dignity and respect; offer support and encouragement.
- Include everyone. It's against the law to deny jobs or services to anyone with these health issues.

Reference- https://www.camh.ca/en/driving-change/addressing-stigma

Thanks Folks!

Job done!

- Thanks a lot

- References are available on request

Disclaimer

All of the work in this presentation is directly available in the resources quoted – I have not contributed to it ,in any shape or form