



Implicit and explicit internalized stigma: Relationship with risky behaviors, psychosocial functioning and healthcare access among people who inject drugs



Courtney von Hippel^{a,*}, Loren Brener^b, Robyn Horwitz^a

^a School of Psychology, University of Queensland, St Lucia, QLD 4072, Australia

^b Centre for Social Research in Health, University of New South Wales, Sydney, NSW 2052, Australia

HIGHLIGHTS

- Implicit and explicit internalized stigma among people who inject drugs is assessed.
- Explicit internalized stigma is associated with poorer psychosocial functioning.
- Explicit internalized stigma is associated with less comfort attending NSPs.
- Implicit positivity is associated with needle sharing and treatment avoidance.

ARTICLE INFO

Keywords:

Internalized stigma
Implicit associations
IAT
Injecting drug use
Risk behaviors

ABSTRACT

Introduction: People who inject drugs (PWID) are stigmatized by society. Over time people may begin to internalize the stigma about their group. This research examines how implicit and explicit internalized stigma among PWID relates to health care and treatment access, psychosocial functioning, and engagement in risky behaviors.

Methods: PWID were recruited from a needle and syringe program (NSP) located in Sydney, Australia. Participants completed a survey examining explicit and implicit internalized stigma, risky behaviors (e.g., sharing injecting equipment, unprotected sex), health care and treatment access (e.g., comfort attending NSPs), and psychosocial functioning (e.g., mental health). Detailed demographic variables were also collected.

Results: A total of 115 clients completed the measures. To the degree that participants had internalized the stigma about their group (measured explicitly), they felt less comfortable attending NSPs, had greater severity of dependence, and experienced more depressive symptoms. The implicit measure of internalized stigma was related to treatment engagement and needle sharing, although the direction of these effects was unexpected.

Conclusions: This research highlights the importance of ongoing research into the implications of internalized stigma for PWID. Assessing both explicit and implicit internalized stigma appears to be beneficial as these are related to different health and behavioral outcomes.

A long research tradition demonstrates that being stigmatized negatively impacts psychological health (e.g., self-esteem and emotional well-being; Bourguignon, Seron, Yzerbyt, & Herman, 2006; Major, Quinton, & McCoy, 2002; Major, Kaiser, O'Brien, & McCoy, 2007) and physical health (Ahern, Stuber, & Galea, 2007; Hopwood, Treloar, & Bryant, 2006; Schuster et al., 2005). Injecting drug use is a highly stigmatized behavior and people who inject drugs (PWID) receive harsh condemnation (Capitanio & Herek, 1999; Frable, 1993). PWID are stereotyped as dangerous, irresponsible, and weak (Conrad, Garrett, Cooksley, Dunne, & MacDonald, 2006; Herek,

Capitanio, & Widaman, 2003; Tindal, Cook, & Foster, 2010). They are often perceived as people who steal to support their habit and pollute mainstream society with their chaotic behavior and drug related illnesses (Elliott & Chapman, 2000). These negative views of PWID are not limited to the general public, as it is well documented that PWID also experience stigma and discrimination from health care workers (Day, Ross, & Dolan, 2003; Hopwood et al., 2006; von Hippel, Brener, & Von Hippel, 2008; Wilson, Brener, Mao, & Treloar, 2014).

Over time, people from stigmatized groups can come to internalize the stigmatizing attitudes that others hold about them

* Corresponding author.

E-mail address: c.vonhippel@psy.uq.edu.au (C. von Hippel).

(Gilmore & Somerville, 1994). This self-stigma occurs when people internalize the stereotypes about their group and blame themselves for their illness (Corrigan, Watson, & Barr, 2006). Most research on internalized stigma and health related outcomes has come from the mental health field where internalized stigma is related to lower self esteem, reduced confidence and hope, decreased likelihood of adhering to or completing treatment, and an increased severity of psychiatric symptoms (Corrigan et al., 2006; Corrigan & Watson, 2002; Livingston & Boyd, 2010; Watson, Corrigan, Larson, & Sells, 2007). Similarly, for those living with HIV/AIDs greater internalized stigma is associated with poorer mental health (Lawless, Kippax, & Crawford, 1996; Logie & Gadalla, 2009; Simbayi et al., 2007), less disclosure of their HIV status (Overstreet, Earnshaw, Kalichman, & Quinn, 2013), and less social support (Lawless et al., 1996; Lee, Kochman, & Sikkema, 2002).

Research on *addiction* self-stigma is growing, with outcomes mostly consistent with those found in the mental health field (for a notable exception see Luoma et al. (2013) where higher self-stigma was associated with longer stays in residential rehabilitation). Limited research has examined internalized stigma among PWID specifically, but the studies that do exist are consistent with research on other stigmatized groups. For example, internalized stigma was related to increased depression and lower self-esteem (Cama, Brener, Wilson, & von Hippel, 2016) and was associated with suboptimal use of pharmacies and needle exchange programs for access to sterile injecting equipment (Rivera, DeCuir, Crawford, Amesty, & Lewis, 2014). It seems feeling negative about your self is associated with less concern about health or causing themselves harm (Fraser & Treloar, 2006).

The present research examines internalized stigma among PWID in Australia. Although Australia has a more progressive approach to illicit drug use than many countries, PWID continue to face stigma and discrimination (Treloar, Hopwood, Yates, & Mao, 2015; Wilson et al., 2014). As a consequence, they may internalize societal stigma about themselves. This study extends previous research on internalized stigma and risky behaviors by examining risky behaviors beyond needle sharing, including multiple/binge drug use and sexual risk taking. We also examine the relationship between internalized stigma and psychosocial functioning (severity of dependence; mental health), and health care and treatment access (treatment engagement; comfort in attending needle and syringe programs [NSPs]).

This research also examines *implicit* internalized stigma. Attitudes and beliefs have traditionally been measured via explicit measures, in which people are directly asked about their feelings. There has been an explosion of research on implicit measures, which allow for the assessment of attitudes and beliefs without the person being directly asked about them. A major advantage of implicit measures is they can reveal attitudes and beliefs of which people are unaware (Fazio & Olson, 2003), which is particularly relevant in this context because the link between addiction-related internalized stigma and identity may not be consciously accessible (i.e., the stigma is automatically activated and without introspection). Implicit measures may also predict important behaviors that are not accounted for by people's explicit self-reports. For example, implicit measures have been shown to predict reduction in panic symptoms among panic disorder clients in psychological treatment (Teachman, Marker, & Smith-Janik, 2008), relationship break-up among romantic couples (Lee, Rogge, & Reis, 2010), and retention in residential rehabilitation (Wolff, von Hippel, Brener, & von Hippel, 2015) beyond the impact of explicit measures. Thus, in important real-world circumstances, implicit measures sometimes predict current and future behavior better than consciously expressed beliefs and attitudes do.

The present research examines how implicit and explicit internalized stigma relates to health care and treatment access, psychosocial functioning, and risk behaviors among a sample of PWID. Based on previous research, it is predicted that PWID who have internalized the stigma will engage in more risk behaviors, have poorer mental health

and psychosocial functioning, and be less engaged in treatment. We also explore whether differences emerge between implicit and explicit measures of internalized stigma.

1. Method

1.1. Sample and procedure

Participants (who were currently injecting drugs and over 18 years) were recruited from a NSP located in Sydney from May 9th to June 7th 2016. Staff informed eligible clients about the study on the three days per week that a research assistant was present. One hundred and fifteen clients (69 men; 45 women; 1 non-response) participated. The study took approximately 20 min to complete, and consisted of a self-administered computer-based questionnaire and two single category implicit association tests (SC-IATs). Participants were reimbursed \$20 for their time. Data were collected over a one-month period. The study received ethics approval from the Human Research Ethics Committee at the University of New South Wales, the University of Queensland, and the relevant local health district.

1.2. Measures

The survey was pre-tested with three volunteers from a peer drug user organization who had a history of injecting. After pre-testing, slight wording changes were made to remove ambiguities and better reflect the vocabulary of PWID.

1.2.1. Demographics

Participants answered questions assessing their age, gender, sexuality, drug treatment experiences, living arrangements, education, and income (See Table 1).

1.2.2. Injecting drug use

The survey assessed age at first injecting, injecting frequency over the past two weeks, drug of choice, and how many friends inject.

1.2.3. Risk behavior

A range of risk behaviors was examined. Sharing was assessed by asking participants how often they used a needle and syringe after someone else. Participants were also asked whether they had binged on two or more drugs for an extended period of time, as the synergistic and additive effects of combining drugs increases the harms associated with drug use (Lee, Freeburn, Ella, Perry, & Conigrave, 2012; Smit, Monshouwer, & Verdurmen, 2002). Sexual risk practices were assessed with the question *Have you engaged in unprotected penetrative (anal or vaginal) sex within the last 6 months?*

1.2.4. Health care and treatment access

Two areas of health care and treatment access were explored: treatment engagement and comfort in attending NSPs. Treatment engagement was assessed with the question "When were you last in drug treatment?" using 5-point scale ranging from *currently on treatment* to *more than five years ago*. Comfort in attending NSPs was assessed with the question "How comfortable are you in attending a NSP or other service to obtain needles and syringes?" using a 5-point scale ranging from *very uncomfortable* to *very comfortable*.

1.2.5. Psychosocial functioning

Mental health was assessed with the Kessler Psychological Distress Scale (K10; Kessler & Mroczek, 1994), a ten-item scale measuring anxiety and depressive symptoms experienced in the last week (for example, *During the last week, how often did you feel nervous?*). Items were scored on a 5-point scale ranging from *none of the time* to *all of the time* with higher scores representing greater distress, depression, and anxiety. Internal reliability in this study was found to be good ($\alpha = 0.92$).

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات