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CHAPTER 11

Acceptance and Mindfulness for Undermining Stigma

Jason B. Luoma, Ph.D.

Portland Psychotherapy Clinic, Research, and Training Center

The term "stigma" originally referred to a practice among the ancient Greeks of literally marking or branding people who were slaves, criminals, or traitors. It has since come to refer to a mark or indicator that a person is devalued or has a lower social status. The content of stigma varies across time and cultures, but the stigmatization process occurs across all human societies.

For those who are stigmatized, stigma results in many negative social and health consequences. Among those labeled as mentally ill, stigma is associated with unemployment, lower quality of life (QOL), poorer treatment adherence, higher symptom severity, and constricted social networks (Livingston & Boyd, 2010). Stigma toward those with addictions results in interpersonal rejection, discrimination, and barriers to employment (Luoma & Kohlenberg, 2012). Stigma toward obesity is associated with depression, isolation, and reduced QOL (Puhl & Heuer, 2009). Similar findings have been documented for HIV stigma (Gonzalez, Solomon, Zvolensky, & Miller, 2009), sexual minority stigma (Yadavaia & Hayes, 2012), and many other conditions. Cross-sectional studies suggest that stigma may also harm the mental health of the stigmatizer (Masuda & Latzman, 2011).

Stigma can occur at structural or individual levels. At the structural level stigma takes the form of laws, physical structures, or institutional practices that systematically disenfranchise or devalue certain groups of individuals. At the individual level, stigma takes two forms: public stigma and self-stigma. Public stigma refers to the reaction that out-group members have toward the stigmatized group (Corrigan, 2007). Self-stigma reflects difficult thoughts and feelings (e.g., shame, negative self-evaluative thoughts, fear of being stigmatized) that emerge from identification with a stigmatized group, resulting in negative behavioral effects (Luoma, Kohlenberg, Hayes, & Fletcher, 2012).

In this chapter, we focus mostly on the individual level of analysis, though these ideas can be scaled to influence stigma at a structural level. Specifically, we outline an account of stigma that is based on a psychological flexibility model of healthy personal and interpersonal functioning. Emerging from work on acceptance and commitment therapy (ACT) and a modern behavior analytic theory of language

and cognition called relational frame theory (Hayes, Niccolls, Masuda, & Rye, 2002), a central tenant of this model of stigma is that the objectification of human beings occurs because of a pervasive tendency to behave toward people in terms of their participation in verbal categories. This behavior dominates over other ways of responding, resulting in insensitivity to other aspects of the context, including the situationally variable human beings.

The chapter begins with a brief conceptual overview of public and self-stigma, followed by a review of mainstream models of stigma intervention. An alternative psychological flexibility model of stigma as a way to target stigma reduction is proposed. Finally, data from ACT interventions for stigma reduction are reviewed.

Stigma Models

Models of stigma span different levels of analysis and disciplines. Attempts have been made to specify overarching, general models of stigma (Pescosolido, Martin, Lang, & Olafsdottir, 2008). Still other models have focused on stigma at the individual level of analysis or one part of the stigmatization process, such as stereotyping (Macrae, Milne, & Bodenhausen, 1994), implicit attitudes (Greenwald & Banaji, 1995), or perspective taking (Galinsky & Moskowitz, 2000). Common to these models is the idea that stigmatization is fundamentally social and language based. Through our interactions with others, we are taught the common stereotypes associated with significant social groups (Devine, 1989). We automatically classify people into social group categories and use these labels to predict the behaviors of those around us and to provide guidance about how to respond to them. This stereotyping process is a normal part of human behavior, as it reduces the cognitive burden of responding to complex social situations (Macrae et al., 1994). Public stigma occurs when we assign a devalued or constricted social category to others.

Likewise, we also learn to place ourselves in various social categories. This process of conceptualizing the self reflects everyday learning processes in which the individual learns to generate coherent stories

that seem to describe who they are as an individual and explain one's actions (Luoma & Kohlenberg, 2012). The nature of the conceptualized self is fluid with various aspects of self-content triggered contextually. Some of these identities may be more central and have consistent effects across many situations, while others are more situationally bounded. Self-stigma occurs when a person is attached to a conceptualized self that includes the identification with a marginalized and devalued group, and the person may come to devalue herself, experiencing shame, self-doubt, and feelings of helplessness and powerlessness. Additionally, people may come to fear being a target of stigma, and then avoid seeking treatment, employment, or relationships.

Mainstream Models of Stigma Intervention

Mainstream methods for changing public stigma can be categorized into one or more of the following: education, contact, or protest (Corrigan et al., 2001). In educational approaches, new information is provided in an attempt to dispel negative stereotypes. Some educational interventions show short-term improvements (Corrigan et al., 2001; Penn, Kommana, Mansfield, & Link, 1999), but gains are generally not maintained (Corrigan et al., 2002) or limited to those with lower levels of prejudice to begin with. Other educational interventions may have paradoxical effects. For example, an increasingly promoted educational strategy to reduce stigma at the highest levels of mental health care is to refer to mental disorders as "brain diseases" with biological or genetic causes. However, this strategy has been shown to be ineffective at best, and in some cases may actually increase both public and self-stigma (Rüsch, Todd, Bodenhausen, & Corrigan, 2010; Walker & Read, 2002).

Protest interventions generally attempt to suppress stigmatizing attitudes through disputing the morality of holding and expressing such views. This strategy, while extremely common, is found to be largely ineffective (Corrigan et al., 2001) with notable paradoxical

effects. For example, demanding correct behaviors can increase physical avoidance of stigmatized persons (Langer, Fiske, Taylor, & Chanowitz, 1976) and increase implicit prejudice (Legault, Gutsell, & Inzlicht, 2011).

The final group of stigma-reduction strategies involves arranging positive social contact between members of the stigmatized group and the public. Contact-based interventions are the most consistently successful strategies in reducing stigma in the short term, with some studies showing change maintained over time and changes in overt behavior (Corrigan et al., 2001, 2002). Unfortunately, this method can be hard to implement because of numerous variables that need to be managed in real-world applications (Corrigan, 2007).

Acceptance and Mindfulness Models of Stigma Reduction

While research exists on interventions for reducing stigma, little of this research is translational (i.e., emerges from basic experimental research). The present psychological flexibility model is informed by basic research on complex human behavior, including cognitive rigidity, stereotyping, and perspective taking, and the intervention model involves helping people to approach stigma-relevant situations in a more conscious and aware manner. Rather than making efforts to change the form, frequency, or content of stereotypes and attitudes, the model largely focuses on secondary change with regard to cognitive content. On the other hand, first-order change is applied to overt behavior, wherein people are helped to behave in a way that is more flexible and values-consistent in the presence of stereotype-eliciting situations. Psychological flexibility is composed of six psychological processes. The first four processes directly target mindfulness and acceptance, while the last two provide a guide for more flexible behaviors that emerge from mindfulness and acceptance.

Mindfulness and automaticity. Stigma-related biases emerge very rapidly in response to stigma-related stimuli, and they often go

unnoticed (Greenwald, Poehlman, Uhlmann, & Banaji, 2009). These biases, even when denied overtly, can be measured implicitly and predict negative social interactions with members of target groups (e.g., McConnell & Leibold, 2001). While evidence is still limited, some data suggest that conscious and mindful awareness of the present moment may mitigate some of the influence of these biases. For example, a brief mindfulness intervention has been shown to reduce the effects of priming age-related stereotypes on subsequent stereotype-activated behavior (Djikic, Langer, & Stapleton, 2008). The preliminary data suggest that greater mindfulness may attenuate effects of implicit biases on action.

The psychological flexibility model teaches mindfulness in the presence of stigma in a variety of ways. Individuals may build awareness of biases and the automatic process of stereotyping through meditative exercises and daily self-monitoring. Mindfulness may be further increased by voluntary contact with stigma-eliciting situations. For example, as a homework assignment, the participant might be asked to interact with a stranger and notice the stereotypes his or her mind generates as he or she spends time getting to know that person. The goal of these mindfulness exercises is to increase participants' ongoing present-moment awareness of events as they unfold in stigma-relevant contexts.

Acceptance, suppression, and avoidance. Suppression and avoidance of stigmatizing attitudes may lead to negative effects among both in- and out-group members. When people fear being devalued in a given social context based on a certain identity, they often expend energy searching for and defending against the perceived threat. This behavioral effort results in reduced performance, which can persist even after they leave the stereotype-relevant situation (Inzlicht & Kang, 2010). People with HIV/AIDS who cope with stigma through disengagement have higher levels of anxiety and depression than those who less frequently disengage (Gonzalez et al., 2009). Among overweight individuals, experiential avoidance has been shown to partially mediate the relationship between body-mass index (an indicator of obesity) and quality of life (Lillis, Levin, & Hayes, 2011).

Together, the promotion of acceptance may be helpful to ameliorate the problematic effects of suppression and avoidance in the context of self-stigma.

The effects of suppressing stereotypes related to public stigma are still less clear. However, newer research suggests that the effects of stereotype suppression may have more to do with the motivation behind suppression. That is, people who are motivated to suppress stereotypes because they value reducing their prejudice may be more successful than those who are told by others to do so (Legault et al., 2011).

The psychological flexibility model teaches experiential acceptance in the context of stigma in a variety of ways. Typically, a safe intervention context is created at first so that unhealthy efforts to suppress evaluative thoughts and stereotypes are less likely to occur. Common ACT exercises (e.g., the polygraph metaphor or the quicksand metaphor; Hayes, Strosahl, & Wilson, 1999) build awareness of the paradoxical processes involved in avoiding cognitive content, including stigma and stereotypes. Additionally, participants might engage in expressive writing about stigma-related content without trying to suppress or control their emotional reactions. During the course of intervention, individuals are instructed that what is important is not necessarily whether one has stigmatizing beliefs or not, but how one acts when they occur. Given the paradoxical effects of suppressing stigmatizing beliefs, the goal is to develop a more open and compassionate stance toward these psychological experiences without acting on them.

Cognitive change versus defusion. The process of "us" and "them" is an inextricable feature of social interaction. The process of putting others and self into social groups is massively useful for the individual and highly reinforced. Stereotypes, once formed, tend to maintain themselves (Hayes et al., 2002), while stereotype-disconforming information tends to be forgotten (Hilton & von Hippel, 1996). Stereotype-congruent behaviors of self and others are inferred to dispositional causes, while stereotype-incongruent behaviors are inferred to situational causes (Hewstone, 1990), thus supporting stereotypes.

Cognitive defusion is a more effective path to decreasing the *influence* of rigid and inflexible stereotypes, rather than attempting to directly change their form or frequency. In cognitive defusion exercises, people are taught to notice the ongoing process of thinking, to see thoughts as thoughts rather than what they seem to be (e.g., a truth about self or others). One study found that defusion from stigmatizing attitudes mediated the effects of an acceptance- and mindfulness-based intervention on public stigma (Hayes et al., 2004).

In cognitive defusion, people are taught to notice stigmatizing thoughts as they arise so that behavior is less tied to or controlled by these thoughts. Such awareness permits one's action to come under other sources of influence, such as *direct experience* (with others) or *personal values* such as compassion, openness, or fairness. Classic ACT techniques may be used to help people to notice the tendency of the mind to construct the world while being unaware of this process. The technique of word repetition might be applied to a stigmatizing thought. In such an exercise, the word "loser" might be repeated out loud for thirty to sixty seconds while participants are coached to notice what happens. Typically the word loses its meaning and gains additional psychological functions beyond its literal meaning. "Physicalizing" exercises where stigma-related thoughts or feelings are imagined to have a physical form can also be used to aide in cognitive defusion. For example, participants may act out a tug-of-war with the group leader who plays the "shame monster" in which the participant is encouraged to notice the workability (or unworkability) of his or her struggle with trying to get rid of shame (Luoma et al., 2012). Highlighting the distinction between thoughts/feelings and behaviors, participants may also be encouraged to carry a card on which stigma-related judgments they have about themselves or others are written while noticing that having those thoughts does not need to interfere with or dictate one's actions (LeJeune, Luoma, Terry, & Glaser, 2012).

Flexible perspective-taking versus rigid self- (and other) processes. Through language and social training, we learn to tell coherent stories about ourselves and others (i.e., conceptualized self/other). When we observe people behaving, we learn to explain this behavior in terms of

dispositional causes (e.g., "He did that because he's lazy") and in terms of group membership (e.g., "That's because he's schizophrenic"). In addition, these basic processes of social classification that underlie stigma are maintained because they favor one's in-group and justify mistreatment of out-groups (Tajfel, 1982). These in- and out-group effects may be reduced through fostering identification with an overarching category that places both individuals in "the same in-group." Examples of this strategy are compassion-focused interventions designed to foster the sense of commonality in suffering as fellow human beings. These methods have been shown to increase feelings of connectedness with others and better interpersonal functioning (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008). Compassion-focused interventions seem to work, at least partially, by increasing self–other overlap, whereby the other is seen as more similar on a salient dimension (Galinsky, Ku, & Wang, 2005).

Mimicking the movements of another is an additional perspective-taking exercise that appears to reduce prejudice toward a perceived out-group (e.g., Inzlicht, Gutsell, & Legault, 2012). Other perspective-taking exercises involve imagining being in someone else's place—for example, through writing a first-person narrative, or meditative exercises that promote contact with a sense of self as a conscious, transcendent observer of experience. These exercises are theorized to loosen the attachment to a sense of self as being separate and distinct from others and to build a more interconnected and interdependent sense of self.

Helping individuals gain a sense of "common humanity" may compete with an "us-them" perspective, a defining feature of stigma. The "cross-cutting categories exercise" is an exercise in a group-based ACT stigma-reduction intervention used for this purpose (Luoma et al., 2012). This exercise involves volunteers responding to a series of personal questions in front of other members; when done effectively, it elicits a sense of vulnerability in the volunteers and a sense of empathy and compassion in the observers. Concurrently, the audience members notice how quickly their minds generate assumptions about the volunteers based on very little information; they also observe how these judgments tend to disappear as the sense of a shared human

experience is gained. Other exercises might utilize visualization techniques with which a person imagines that a loved one has developed a stigmatizing condition or the participant writes a story in which she lives a day in another person's life while experiencing the stigma of the target group (LeJeune et al., 2012). These exercises are designed to promote a positive sense of connection and empathy in relation to the target group (e.g., the "mentally ill"). Taken together, the goal of these exercises is to lead people through a variety of psychological perspectives so that they may relate to the stories about self and other from a more distanced and compassionate perspective.

Values and intrinsic motivation. Finally, the psychological flexibility model focuses on values. Values are defined as "freely chosen, verbally constructed consequences of ongoing, dynamic, evolving patterns of activity, which are intrinsic in nature" (Dahl, Plumb, Stewart, & Lundgren, 2009). The freely chosen and intrinsic nature of value is the most relevant to the topic of stigma, as interventions aimed at helping people to contact their own motivations to reduce prejudice tend to result in lower levels of prejudice (Phills, Kawakami, Tabi, Nadolny, & Inzlicht 2011; Legault et al., 2011). In ACT for stigma reduction, people are guided through expressing their own chosen valued directions in relation to out-groups or stigma-related domains of living. While acceptance and mindfulness processes reduce the dominance of more habitual stereotype-based responses to self and other, values provide an alternative compass that guides how to interact with the self and other.

Furthermore, for public stigma, stigma-focused values exercises also highlight how individuals would choose to behave toward those in the stigmatized group. For self-stigma, a variety of exercises might help those individuals contact longer-term goals and life aspirations that relate to the areas of their life in which they experience stigma, commonly focusing on self-care, treatment engagement, and self-compassion.

Effective prosocial action versus avoidance and inflexibility. Ultimately, reductions in prejudice and stigma depend upon overt

actions. As reviewed above, positive intergroup contact promotes reductions in stigma (Corrigan et al., 2001), and behavior aimed at approaching out-group members has been shown to increase self–other overlap (Phills et al., 2011), a sign of greater empathy and compassion toward self and others. Intervention protocols that focus on public stigma have typically asked participants to identify their intentions for responding to out-group members and sometimes have encouraged public statements of intentions for future action.

In terms of self-stigma, effective action may involve taking more compassionate and caring actions toward a self that is perceived as devalued or damaged. This may involve actions such as effective self-care behavior, obtaining help for problems, treatment engagement, or advocacy for other in-group members. Protocols often encourage participants to identify concrete actions that are tied to values as well as plans about how to respond to internal barriers that arise in the process of acting on these intentions.

Review of Data

To date, a psychological flexibility model has been applied to a number of types of stigma. These include weight self-stigma, self-stigma in addiction, public stigma toward mental illness, self-stigma relating to same-sex attraction, and addiction counselor stigma toward clients.

Self-Stigma

Lillis, Hayes, Bunting, and Masuda (2009) randomly assigned 84 patients who had completed a weight-loss program to receive either a one-day ACT-based workshop or a wait-list control condition. At the three-month follow-up, greater improvements in quality of life, psychological distress, weight-related stigma, and body mass were found in the ACT condition than were found in controls. Reduced self-stigma in the ACT group was mediated by improved acceptance

and mindfulness. An open trial showed that an ACT intervention targeting self-stigma and shame among those struggling with substance misuse resulted in gains across a range of measures at post-treatment, including internalized shame (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008). In a larger pilot study (Luoma et al., 2012), 133 addiction treatment patients were randomized to receive the six-hour ACT protocol developed in the open trial or to treatment as usual. The difference between conditions was small, in terms of treatment received, with the ACT intervention replacing six hours of regular programming during a 28-day residential program. The ACT condition resulted in smaller gains in shame at post-treatment but larger gains at the four-month follow-up. Those in the ACT condition also reported fewer days of substance use and more treatment attendance at follow-up. Finally, a multiple-baseline study by Yadavaia & Hayes (2012) evaluated a six to ten session intervention based on ACT for self-stigma related to same-sex attraction, showing promising findings.

Public Stigma

In a study aimed at reducing public stigma toward mental illness, Masuda et al. (2007) assigned 95 undergraduates to either a two and a half hour ACT workshop or an educational model of the same length. Both interventions were successful in reducing mental health stigma at the one-month follow-up in those who were psychologically flexible. However, the ACT group, but not the education group, was effective for those low in psychological flexibility. A second open trial (Masuda et al., 2009) of the same intervention with 22 undergraduates showed that change in psychological flexibility was correlated with change in stigmatizing attitudes at a one-month follow-up. In a third study of public stigma (Hayes et al., 2004), 90 addiction counselors were randomly assigned to attend one-day workshops based on ACT training, multicultural training, or a control lecture focused on a biological basis for methamphetamine addiction. Stigmatizing

attitudes were reduced post-training in both active treatment groups, but only the ACT condition had lower scores through the three-month follow-up. The ACT intervention also decreased burnout at the three-month follow-up, suggesting that interventions targeting stigma in providers may improve their psychological well-being.

Conclusion

The burden of stigma is huge and the number of proven interventions to help those living under its weight is small. More traditional methods focusing on first-order cognitive change have generally shown limited effectiveness and have not led to robust programs of implementation in the real world. Recent developments based on acceptance and mindfulness approaches focus on second-order cognitive strategies and have the benefit of closer connections to basic research on the nature of stigma and stereotyping. While data are still preliminary, early intervention trials suggest that this approach might hold promise.

More research is needed. Of particular importance are studies that dismantle larger stigma-reduction packages and focus on theoretically defined processes of change. Longitudinal studies exploring how acceptance and mindfulness processes interact with stigma-related thinking will serve to refine intervention targets and our understanding of these processes (Livingston & Boyd, 2010). Improved measurement of stigma-related behavior is needed, rather than a sole reliance on self-report. Finally, larger trials are needed to better establish the generalizability and size of these effects.

A comprehensive approach to reducing stigma will need to cut across levels of analysis, discipline, and society. While there is an abundance of research on what stigma "is," there is limited data on how to effectively change it, and most research on stigma reduction comes from pilot studies. With time, hopefully psychological flexibility–based interventions will mature into evidence-based, organizational strategies that achieve long-lasting stigma reduction.

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