Appendix 5
Suggested Reading for
Chapter 5: Meeting Women's Basic Needs

MEETING BASIC NEEDS:
ADDRESSING ECONOMIC ADVERSITY IN WOMEN'S LIVES*

One of the most consistent findings in community studies of people with mental and addictive disorders is that those at the lowest economic rung of the ladder typically have the highest rates of mental health and substance use problems. In our study of women who use publicly funded mental health and substance abuse services in Dane County, the vast majority of whom report a current mental health or substance use problem, or both, economic adversity and its consequences are major problems with which women need and want help.

Several findings reveal the extent of economic adversity with which women use alcohol, drug, or mental health (ADM) services in the publicly funded system in Dane County grapple with on a daily basis.. First, when we compare these women, whom I will refer to subsequently as "consumers," with other women in Dane County, we find:

- Consumers are less likely to continue their educations beyond high school than other women in Dane County
- Consumers are more likely than other women in Dane County to be unemployed (50% versus 22.5%)
- Among those consumers who are employed, only 35% are employed fulltime compared to 49% of other women in Dane County
- The average monthly income of consumers is $1000, less than a third of that of other women in Dane County ($3,299)
- 77% of the consumers we interviewed reported having had serious money problems, including not enough money for a place to live or food, at some point in their lives

In short, women who receive services in the publicly funded ADM system in Dane County are **significantly disadvantaged compared to other women in Dane County in terms of their access to material resources.**

How can economic adversity affect a woman's life?

It is difficult to convey the grinding, demoralizing impact that chronic economic difficulties can have on a person's life. We asked the women we interviewed, "During the past three months, did you generally have enough money each month to cover ...?" Their "no" responses to this query are listed below:

- housing (16% said no)

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* Joy Newmann (2002), Principal Investigator, Women and Mental Health Study Site of Dane County. Written for the *NPW Consumer Curriculum*. Please contact the author for permission to reprint, jnewmann@facstaff.wisc.edu.

- food (26% said no)
- clothing (40% said no)
- transportation (20% said no)
- social activities, like movies or eating out in a restaurant (51%)
- medical care (32%)

Indeed, our findings show that not only are insufficient material resources a major life problem for women, it is also a major barrier that undermines a woman's ability to seek and find appropriate services to address her mental health and substance use problems. For example, although many women told us they felt they needed such services, close to half (42.3%) reported that they did not seek care because they did not have the money to pay for services; twenty-seven percent did not have transportation to get to needed services.

What are some solutions to this problem?

(1) Make mental health and substance abuse services more affordable and available to poor women.

As part of our efforts to learn how to improve services for women, we asked: "If you were able to change one thing about the mental health or substance use service system in Dane County, what is the first thing you would do?" Interestingly, the most common response, given by 46% of the women, was to *increase access to care*. For many, this involved reducing financial barriers or making services more accessible for working women:

> *"I would have services in evenings so people who work and don't have insurance can go to them and not miss work..."*
>
> *"So many people now days don't have insurance and (agency) have such extensive waiting lists I think more facilities are needed."*
>
> *"I think there should be more structured groups available to the working poor, scheduled at times that they can attend."*
>
> *"I got bounced around for six years before I found (agency), because I didn't have the right insurance. Nobody would take my insurance, so I guess there should be places that people can go that don't have any money."*
>
> *"Its not cheap...the cost is a barrier...more people would use it if it were cheaper."*
>
> *"Make it more affordable."*

(2) Insure that mental health and substance abuse services are more "recovery-oriented" in the sense of addressing women's economic adversity directly.

Although many women are satisfied with their care providers in the publicly funded ADM system in Dane County, our findings suggest that much more can and

should be done to address women's economic problems directly as part of ADM services. Although many caregivers do this, 25% of the women we interviewed stated that their caregivers had not asked them about their current work situation and/or interest in finding a job during the prior six-month period. Moreover, 37% of the women did not feel the services they had received had helped them "do better in school or work."

This is a surprising finding given that many women who are unemployed are eager to find a job, if they can. In fact, we asked women: "What does recovery mean to you?" The most frequent response related in some way to what we conceptualized as: "leading a normal and productive life." Some version of this idea, which was mentioned by 29% of the women we interviewed, typically involved getting more education or getting a job:

> *"I guess the idea of recovery is different for everybody. I am as recovered as much as I am going to be. It is being able to participate in life to the best degree that you can. Just to try and live as normal of a life as I can."*
>
> *"To be able to live my life in a productive manner. Being able to go to work and take care of myself."*
>
> *"It means going back to work and being able to function in normal society without my mental illness limiting my ability to perform. It means getting through the days without being haunted. It means being productive and satisfied with my work. It means pursuing hobbies cheerfully and happily. It means regaining my independence."*
>
> *"Getting back to a normal life and leading a normal life. Not living in Hell. That's what it means to me."*

These statements, which reflect an attitude about one's place in the world as a productive citizen, were frequently linked with "getting out of the system" and becoming economically independent:

> *"Being free from all the programs and everything and not having to deal with the system."*
>
> *"Being off disability and off medication and working full-time again. Taking care of myself monetarily."*
>
> *"Getting off social security, getting a job in (work sector) and moving. I have absolutely nothing in (city) because everyone knows everything about me here...there is no way I could get a job in (work sector). I would like to own a house and have a car...be able to play the stock market and go on trips."*
>
> *"Not needing services from a mental health provider...being able to hold a job...do the functions of life without questioning myself and being free of flashbacks."*

Finally, toward the end of the interview, we asked women: "In looking ahead to the next six months, what do you see as the areas of your life that you would most like to change?" The most frequent response women gave had something to do with what we called ***increasing their material resources***. This group of responses included material resources beyond money and reiterated a theme we heard throughout the interview--a desire to improve one's socioeconomic standing and material well being more generally. Areas of change mentioned, which were coded in this category, included wanting a better job, job training, a bigger home, an education, transportation, or health insurance:

> *"My money situation, I would like more money. I would like to live at the poverty level, not below it."*
>
> *"Housing- I would like to have a home or something that is much bigger than this because it stresses me out that this apartment is so small and I don't have the money to get something more decent."*
>
> *"A better job. A decent job that would take care of me and my kids and I wouldn't have to worry about the bills. That is really important to me...being a single parent."*
>
> *"Get a medical assistance card...I'd be happy if I could just get a medical assistance card. It would pay for the drugs. Now I pay for them myself. There are some drugs, a few of the drugs, that I do get straight from the companies, but I still pay quite a bit for drugs. I could go to the dentist too, get my eyes checked...I just wish I could get a medical assistance card and get my eyes checked...I just wish I could get a medical assistance card...it would make it so much easier for me."*

(3) Help women singly and collectively address their own needs to improve their work skills, motivation, and access to educational and job training opportunities.

One of the most heartening experiences during the two years that the Women and Mental Health Study Site was funded was the opportunity to work with many women who have been long-time consumers of mental health and/or substance use services in Dane County. We shared common goals, and some that were different, but we worked long and hard together to make Dane County a better place for women to seek and receive good care for their mental health and substance use problems. Some of this work has continued under the New Partnerships for Women Project. Moreover, it promises to continue into the future through other endeavors. Important questions for the future are: What can be done to insure that you, and other women like you, have an opportunity to continue growing and learning? How can we convert these experiences into viable employment opportunities that recognize your strengths and creativity? Finally, for those of you who are unable to work, what can we do collectively to insure that you have sufficient material resources, including adequate health care, so that you can purchase services that fit your needs?

DISCUSSING TRAUMA AND PTSD WITH YOUR DOCTOR*

The experiencing or witnessing of traumatic events can lead to psychological (emotional) problems and to physical problems (in addition to any that occurred at the time of the trauma). These symptoms can last for a relatively short time after the event, can last for months or years, or can "surface" months or even years later.

Not everyone who experiences trauma will go on to develop full PTSD. You may suffer from only some problems. Even so, treatments are available for these problems.

You may find it helpful to talk with your primary care physician about your experience(s) and any symptoms you have --- even if he or she does not ask first. Keep in mind that your doctor may not know about the emotional or psychological after effects of trauma or the many-associated medical problems. You can help your doctor understand you better and plan your treatment by sharing this crucial information about yourself. Please note that not everyone who experiences trauma will go on to develop full PTSD. You may suffer from only some PTSD symptoms or problems. Even so, it is important to discuss symptoms or problems with your health care providers, and treatment may be helpful.

At first, individuals may find it hard to discuss their experience(s). Because it may be difficult for you to discuss what happened to you, and the symptoms that you suffer, there is a quick checklist below that you can use to show to your doctor. It may help you to begin to talk about your trauma experience and the symptoms you are experiencing.

Quick Checklist of Trauma Symptoms

Check those symptoms below that you experience (that may or may not be related to a traumatic event) and make some notes as needed:

I experienced or witnessed a traumatic event during which I felt extreme fear, helplessness, or horror.

The event happened in (day/month/year)_____.
What happened?_____.

1) I have symptoms of reexperiencing or "reliving" the traumatic event:

☐ Having bad dreams or nightmares about the event or something similar

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* Pamela Swales, Ph.D. and Joe Ruzek, Ph.D. A National Center for PTSD Fact Sheet. Available at: http://www.ncptsd.org/facts/specific/fs_doctor.html. This information is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a mental health problem without consulting a qualified health or mental health care provider. This article is in the public domain and may be copied and distributed without restriction. For more information telephone (802) 296-5132 or send email to ncptsd@ncptsd.org.

- ☐ Behaving or feeling as if the event were actually happening all over again ("these are known as "flashbacks")
- ☐ Having a lot of emotional feelings when I am reminded of the event
- ☐ Having a lot of physical sensations when I am reminded of the event (e.g. heart races, pounds, or "misses a beat"; sweating, hard to breathe, feel faint, feel like I'm "going to lose control")

2) I have symptoms of avoiding reminders of the traumatic event:

- ☐ Avoiding thoughts, conversations, or feelings that remind me about the event
- ☐ Avoiding people, places, or activities that remind me of the event
- ☐ Having difficulty remembering some important part of the event

3) I have noticed that since the event happened:

- ☐ I have lost interest in, or just don't do things that used to be important to me
- ☐ I feel "detached" from people-I find it hard to trust people
- ☐ I feel emotionally "numb" and I find it hard to have loving feelings even toward those who are emotionally close to me
- ☐ I have a hard time falling or staying asleep
- ☐ I am irritable and have problems with my anger
- ☐ I have a hard time concentrating
- ☐ I think I may not live very long-so why plan for the future?
- ☐ I am "jumpy" and get startled easily
- ☐ I am always "on guard"

4) I experience these medical or emotional problems:

- ☐ Stomach problems
- ☐ Intestinal problems
- ☐ Gynecological problems
- ☐ Weight gain or loss
- ☐ Chronic pain (e.g. back, neck, in women-pelvic area)

- ☐ Problems getting to sleep
- ☐ Problems staying asleep
- ☐ Headaches
- ☐ Skin rashes and other problems
- ☐ Irritability, "short fuse", "quick temper", other anger problems
- ☐ Nightmares
- ☐ Depression
- ☐ Lack of energy, chronic fatigue
- ☐ Alcoholism and other substance use problems
- ☐ General anxiety
- ☐ Anxiety (panic) attacks
- ☐ Other symptoms I have are: _____

Here is a list of possible questions that may help you identify what you might like to ask your doctor or counselor:

- "What do people have to do to recover from PTSD?"
- "Why do I have PTSD and other people don't?"
- "Does having PTSD mean that I'm crazy or mentally ill?"
- "What will happen if I go for treatment?"
- "How long will treatment last?"
- "What will be the likely effects of treatment?"
- "What should I tell my wife/partner/other family members about PTSD?"

If medication treatment is being discussed, you might like to ask some of these questions:

- "How is this medication supposed to help me?"
- "How will it affect my symptoms?"
- "How long will I have to take it?"
- "Can I stop it if I don't like it?"
- "How will we know if it is working or not?"
- "What will happen if it doesn't work?"
- "What are the side effects of the medication?"
- "How will it affect my other medications that I'm taking?"

- "Why do I need to go for counseling if I'm receiving medication treatment?"
- "How will medication treatment fit in with my PTSD counseling?"
- "How will medication affect my substance abuse recovery?"

Again, if you think you have PTSD, or even just some of the symptoms, it is important for you to let your primary care physician know. This information is invaluable in planning your medical treatment. It can also help your doctor in providing you with appropriate referrals for other services you may need (e.g., psychologist, social worker, child abuse protective services, lab tests, etc.).

You may find it helpful to bring this and other fact sheets available from the National Center for PTSD to show to your doctor. Fact sheets from the National Center for PTSD can be found on the Internet at http://www.ncptsd.org.

INFORMATION ON PTSD FOR WOMEN'S MEDICAL PROVIDERS*

How common is sexual trauma among women?

Estimates vary, but studies suggest that about 13% of women have experienced a sexual assault at some time during their life.[1] Estimates for child sexual abuse are higher, with 27% of women reporting this experience.[2] In some samples (e.g., veterans and current military), these rates tend to be higher).

Consequences of Sexual Assault

Although many women who have been sexually assaulted function quite well, others have considerable difficulties. Many of the problems experienced by these women are those that may present themselves in the primary care setting. These difficulties include interpersonal, social, physical, and psychological problems that may last for many years. Women who have experienced sexual trauma are also more likely to be high utilizers of healthcare.

Physical Consequences. Numerous physical problems have been reported to occur with greater frequency among women with sexual assault histories. These problems include: diabetes, obesity, arthritis, asthma, recurrent surgeries, chronic pelvic pain, irritable bowel syndrome, back pain, headache, eating disorders, poor reproductive outcomes, digestive problems, and hypertension.

Women reporting a history of childhood sexual abuse also report higher rates of numerous problems including venereal disease, pelvic inflammatory disease, surgical evaluation of pelvic pain, respiratory problems, gastrointestinal problems, and neurological problems.

Sexual trauma and healthcare utilization. Given the increased reports of health problems, its not surprising that the experiences of childhood and adult sexual trauma are associated with increased healthcare utilization and costs.

A recent study examining HMO health care utilization found that women who reported a history of childhood sexual abuse were more likely to visit the emergency room and had annual total health care costs that were significantly higher than those without abuse histories.[3] These differences held even after excluding the costs of mental health care.

Adult sexual trauma victims also appear to utilize high levels of health care (increased physician visits and outpatient costs), even in comparison to women who have been victims of other types of crime.[4]

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* Erica Sharkansky, Ph.D. A National Center for PTSD Fact Sheet. Available at http://www.ncptsd.org/facts/specific/fs_female_primary.html. This article is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a mental health problem without consulting a qualified health or mental health care provider. This article is in the public domain and may be copied and distributed without restriction. For more information telephone (802) 296-5132 or send email to ncptsd@ncptsd.org.

Although, women who have experienced sexual assaults may have considerable mental health symptoms, they are significantly more likely to present in medical than in mental health settings.[5]

Psychological Consequences. The most widely studied psychological consequence of sexual assault is posttraumatic stress disorder (PTSD). Data from a large scale study comparing the effects of different types of traumatic events suggests that the experience of a sexual assault may be more likely to lead to PTSD than other types of traumatic events.[6]

45% of women in the study who reported having experienced a rape met criteria for PTSD. This was significantly higher than the 38.8% rate of PTSD among men who had experienced combat.

Sexual assault appeared to be extremely difficult for men as well (65% of men who had been raped met criteria for PTSD), but the proportion of men in the study who experienced a rape (0.7%) was significantly smaller than the proportion of women who did so (9.2%).

The experience of childhood sexual trauma was also associated with high rates of PTSD. 26.5% of the women who reported experiencing molestation as their most traumatic experience met criteria for PTSD. This percentage was significantly higher than the percentage of men meeting criteria for PTSD who reported having been molested.

Symptoms of PTSD include reexperiencing the trauma, avoidance of situations associated with the trauma, emotional numbing, and hyperarousal any of these symptoms can present in and around the medical setting. Perhaps the most dramatic trauma related symptom that may be seen is dissociation. Dissociation can involve a range a phenomena from altered awareness or attention to flashbacks and out of body experiences. Dissociation is usually triggered by a strong emotional reaction such as feelings of terror, surprise, or feeling trapped, helpless, shame, or exposed.

There are several aspects of the medical setting that may increase the likelihood that PTSD symptoms may occur. The types of procedures that are performed in the medical office (particularly those performed in primary, GYN and GI clinics) can potentially trigger a posttraumatic reaction in patients who have experienced sexual trauma. In particular, pelvic exams, colonoscopies, endoscopies, and other procedures that involve placing an instrument into a bodily orifice may be sufficiently reminiscent of sexual trauma to evoke a posttraumatic reaction.

Although invasive procedures are the most dramatic examples of triggering events occurring in the medical setting, a number of other features of this setting may also evoke trauma reminders. These include being touched (even in a usually nonthreatening place), the power differential between patient and provider, the removal or absence of clothing, and the focus on bodily pain or disorder.

In one study a large portion of sexual trauma survivors reported unpleasant experiences during a gynecological exam.[7] These included overwhelming emotions, unwanted or intrusive thoughts, having traumatic memories triggered, body

memories, and feelings of detachment from the body. Many of these experiences were not reported to the providers.

In this same study, both women who had and had not experienced childhood sexual trauma reported anxiety during a pelvic exam. However, the women who had been sexually traumatized reported that having their sexual organs examined was the primary reason for discomfort, whereas women who had not been sexually traumatized reported that physical discomfort was their most common reason for discomfort.

Because sexual trauma survivors may anticipate these difficulties they may be likely to repeatedly cancel appointments for exams or avoid telling their providers about symptoms (e.g. blood in the stool) that would cause an invasive test to be ordered.

What you can do

It's generally a good idea to find out whether a female patient has been sexually traumatized. Although most women have never been asked by their gynecological provider about a history of sexual trauma, the overwhelming majority of women indicate that they would like to be asked this question.[7] Few survivors are likely to spontaneously offer this information.

In addition to knowing about your patient's history, there are a number of things you can do to make it more likely to have the patient successfully complete the examination with as little emotional distress as possible, and not increase the likelihood that she will avoid care in the future.

- Reduce the power differential between you and your patient
- Greet the patient in your office (not exam room) while she is still fully dressed
- Give the patient as much control as possible
- Provide health education materials
- View the patient as an expert about herself. Ask her what would be most likely to help her reduce her stress during the exam
- Ask her to predict what will be the most difficult parts of a procedure
- Take a break if necessary
- Provide the patient with as much choice as possible
- Engage in dialogue throughout exam
- Explain everything you do in advance and as you're doing it
- Listen carefully to any concerns
- Check in regularly about the patient's level of anxiety
- Remind the patient why you're doing this exam
- Plan ahead
- Allow extra time: schedule these patients for slower days or late appointments

- Be prepared and willing to reschedule the exam if necessary
- Use distraction
- Consider using relaxation techniques (though for some trauma survivors this is contraindicated) and involve a mental health provider in planning care

If symptoms do occur

Despite your best efforts to avoid it, posttraumatic symptoms may occur during an exam. If this happens, don't panic and try to use grounding techniques with the patient.

- Speak in a calm, matter of fact voice and avoid sudden movements
- Reassure your patient that everything is okay
- Continue to explain what you're doing
- If at all possible, stop the procedure
- Ask (or remind) the patient where she is
- Offer her a drink of water, an extra gown, or a warm or cold wash cloth for her face
- Provide a change of environment.

References:

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[2] Finklehor, D., Hotaling, G., Lewis, I.A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse and Neglect*, 14, 19-28.

[3] Walker, E.A., Unutzer, J., Rutter, C., Gelfand, A., Saunders, K., VonKorff, M., Koss, M.P., & Katon, W. (1999). Costs of health care use by women HMO members with a history of childhood abuse and neglect. *Archives of General Psychiatry*, 56, 609-613.

[4] Koss, M.P., Koss, P.G., & Woodruff, M.S. (1991). Deleterious effects of criminal victimization on women's health and medical utilization. *Archives of Internal Medicine*, 151, 342-347.

[5] Kimerling, R., & Calhoun, K.S. (1994). Somatic symptoms, social support, and treatment seeking among sexual assault victims. *Journal of Consulting and Clinical Psychology*, 62, 333-340.

[6] Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52, 1048-1060.

[7] Robohm, J.S., & Buttenheim, M. (1996). The gynecological care experience of adult survivors of childhood sexual abuse: A preliminary investigation. *Women and Health*, 24, 59-75.

AFRAID OF THE DENTIST?*

If you are like most Americans, going to the dentist is not your idea of having fun. However, for many of us who are psychiatric survivors and/or survivors of physical/sexual/emotional abuse, going to the dentist can be more than just scary or uncomfortable. It can be re-traumatizing. In order to avoid retraumatization many of us avoid the dentist completely and eventually find our teeth in various state of decay or disease.

Two researchers from New Hampshire have pulled together a brochure entitled, "Dental Tips for Individuals Sexually Abused as Children."[1] These women suggest three major strategies. The first is doing anything that increases your sense of control, such as asking your dentist to explain all procedures before beginning them, or developing an agreed-upon "signal" that indicates to your dentist that you want to stop. The second suggestion is using "mental techniques that you can practice ahead and while at the dentist." One such technique is deep breathing through your nose to relax yourself. The third suggestion involves a list of "other things to do" such as bringing a friend to be with you during the dental procedure, wearing pants rather than a skirt to the dental appointment, educating your dentist, bringing a soothing audiotape to listen to, etc.

Although this brochure is intended for survivors of sexual abuse, the techniques suggested will help anyone with high levels of fear of the dentist. For those of us who have been abused in mental institutions, who have been tied up in restraint and seclusion with staff hovering over us, or who have been force fed or medicated against our will, the dental experience can have similar symbolic/triggering aspects. These include having to lay in the dental chair with the dentist hovering over us; being in a relatively helpless position while alone in a room with a professional/doctor; having intrusive procedures without warning; etc. Thus, even though this brochure is advertised as helpful to survivors of sexual abuse, I think it is also quite applicable to psychiatric survivors.

One final note. In my long struggle to feel more skilled and safe in using dental services, I have found out an important point that is not mentioned in the brochure but that may help you. When children/people are abused, our bodies react with a heightened sense of vigilance, fear, or what is called "hyper-arousal". One of the long-term effects of abuse is that our bodies did not develop the capacity to modulate levels of affective arousal. We seem to jump from 1 to a 10 if a car backfires and startles us. And we tend to stay at "10" or a high level of arousal long after the car had backfired. Our bodies can't "settle down" as quickly as people who do not have trauma histories.

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[1] NPW editorial comment: The "Dental Tips for Individuals Sexually Abused as Children" brochure is available on two internet sites, http://www.sidran.org/dental.html or http://www.stardrift.net/survivor/bwdentist.html.

For years when I would go to the dentist and get Novocain, my heart would start racing. I was filled with feelings of panic, and I felt like I was going to die. I wasn't afraid of the needle. It was only once the Novocain drug was in my body that I had trouble. Finally I discovered that drugs such as Novocain, which are used by dentists to block pain signals from the nerve, also contain another drug called epinephrine. Epinephrine causes the blood vessels to constrict and can simulate a startle response or "fight/flight" response in the body. In effect Novocain was simulating the human bodies reaction to trauma by triggering a state of hyperarousal.

Once I understood this I talked it over with my dentist. We tried using Novocain-type drugs with no epinephrine in it. This definitely helped to eliminate my hyperarousal and the feeling of panic. However, the numbing effect only lasted a short time and this was bad news when I was halfway into a root canal procedure. So then we tried a numbing drug that had some epinephrine in it, but the dentist injected in very, very slowly so my body could accommodate slowly. We made sure to tip the dentist chair way back so I didn't feel dizzy. The dental assistant kept her hand on my shoulder while the dentist reminded me to breathe deeply. To my joy I avoided the hyperarousal effect and could continue with my treatment without being re-traumatized. Maybe it will work for you!

THE CAUSE AND EFFECT OF STIGMA AND SHAME*

More often than NOT, people become accustom to accepting the majority point-of-view rather than the minority point-of-view. More often than NOT, women who struggle with a trauma history and mental health or substance use problems tend to accept the overwhelming negative images and stereotypes related to their problems, rather than finding the positive images, (unfortunately the negative images are in the majority, rather than in the minority). Shame then usually follows as a direct result from internalizing these negative messages.

So as we think about this, we can see the interlocking oppressions that women with mental health and/or substance abuse (MH/AODA) problems must face: 1) The negative images of stigma and shame (which, again, is the thinking of the majority) and 2) Then personalizing it (which is also the majority of women's personal experiences with MH/AODA and trauma histories). The end result of these interlocking oppressions oftentimes results in women not getting their basic needs met, mostly due to the impacts of stigma and shame. So as one can see, one of the deadliest killers coming from stigma and shame is personal destruction caused by the societal effect of the negative images of MH/AODA and trauma survivors.

What is Stigma?

- *It is misplaced blame and fear from ignorance.*
- *It is the use of cruel jokes and stereotypes that serve to isolate people.*
- *It is the careless use of words like yuppie, loony, nuts, batty, wacko, mental case, alcky, druggy, wimp, dike, and a number of others that ridicule individuals.*
- *Stigma causes discrimination in society, employment, health insurance, health treatment, services, housing, and many more.*
- *Exposure to this kind of stigma for anyone, has unfortunate consequences, and may result in personal degradation, causing many people no matter what the label is, life-debilitating hardships as a result of STIGMA.*[1]

Stigma isn't just the use of the wrong word or action. More than that, it is about socialized disrespect, disrespect that often then becomes so internalized it becomes a personal "norm." This level of stigma tends to create a feeling of "demoralized comfort" (an OK unhealthy comfortable feeling within oneself) that unfortunately keeps women from getting their basic needs met. The outcome of this internal shame will then often determine which path women will choose in extremely important decision-making situations.

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* Jessica Barton (2002). New Partnerships for Women. Written for the *NPW Consumer Curriculum*. The author grants permission to reprint. Citation of the source is appreciated.

[1] This definition of stigma was developed by consumers involved in the Women and Mental Health Study Site of Dane County.

Stigma is a barrier that discourages people and their families from getting the help they need due to the fear of being further stigmatized and discriminated against. Furthermore, stigma may even result in women (and their families) feeling they don't deserve to get help. Consumers or survivors will even go as far as to sacrifice their own personal needs to protect themselves, once again, from further being shamed or to protect their identity as having a mental health problem and/or substance abuse problem.

Sacrifices of such basic needs continues a cycle of shame that often contributes to consumers not feeling worthy of having these basic needs met. Some sacrifices that will marginalize consumers into deeper emotional shame are sacrifices of: health, safety, food, shelter, and general well-being. All-in-all, the avoidance of these needs will only hurt the consumer and not change the attitudes of the general public.

Some Facts About Stigma

- **Do you know that** an estimated 50 million Americans experience a mental disorder in any given year? So in turn you can only imagine how many of that 50 million don't get their basic needs met.[1]
- **Do you know that** stigma is not just the use of the wrong word or action?
- **Do you know that** stigma is about socialized disrespect, and that stigma is about the use of negative labels for, and attitudes towards, people living with mental illness and substance abuse?
- **Do you know that** stigma is a barrier and discourages individuals and their families from getting the help they need due to the fear of being further stigmatized and discriminated against?
- **Do you know that** many people would rather tell employers they have committed a petty crime and were in jail, than admit to being in a psychiatric hospital or having a drinking or drug problem?
- **Do you know that** stigma has allowed companies to provide inadequate insurance coverage for mental health services as well as services at all?
- **Do you know that** stigma results in fear, mistrust, and violence against people living with MH/AODA and any other type of character we find so called different?
- **Do you know that** stigma results in families and friends turning their backs on people with MH/AODA and any other type of character we find so called different?
- **Do you know that** stigma keeps people from getting everyday basic needs met?

[1] This information was taken from the link/article on shame found on the web site, http://www.mentalhealth.org.

Steps To Help Create Positive Changes

Below are some suggested **DO'S** that may help bring hope to many women struggling with the stigma and shame associated with MH/AODA and trauma histories and break the barriers of not getting basic needs met. These suggestions can be shared with and used by anyone, we all have internalized negative messages about ourselves and others.

- **Do use** respectful language such as:
    - Person with a psychiatric disability or a person who is recovering from some difficult alcohol or other drug addictive struggles.
- **Do respect** persons who have been challenged with the limitations that stigma has presented.
- **Do respect** the ability and strength that one must have to overcome the stigma and shame that has been placed upon them by their label (MH/AODA/trauma) in order to meet their basic needs.
- **Do emphasize** abilities, not limitations.
- **Do tell** someone if they express a stigmatizing attitude.

Here are some suggestions for things to NOT do that can also help to end the stigma and shame experienced by survivors and consumers. Again, each one of us can practice these principles:

- **Don't use** generic labels such as retarded, or the mentally ill or terms like crazy, lunatic, manic-depressive, slow functioning, or normal.
- **Don't pre-label**, make assumptions about, or re-stigmatize someone before you even meet them.
- **Don't assume** all consumers are alike.

By avoiding some of these, you may help bring hope to many women struggling with the stigma and shame associated with MH/AODA and trauma histories and help break barriers that have prevented basic needs from being met.

Labels such as these will only hinder, not help. It is hard enough that women with MH/AODA must struggle with society's stigma, why add to their hardship? So take a moment to think during the course of a day, how many times you yourself must show identification or label who you are just to get some simple basic needs met?