February 2020

# Mothers' Experiences of Stigma: Multi-Level Ideas for Action

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## KEY MESSAGES

Women who use substances in pregnancy and/or have children with Fetal Alcohol Spectrum Disorder (FASD) are highly stigmatized by the media, public, and health and social service providers. Social isolation, non-disclosure of alcohol and/or substance use, and not seeking or receiving the necessary support can be the result.

## Issue:

***Stigma*** refers to the prejudicial attitudes, stereotypes, and discriminatory behaviours [1] toward a person or group. The impact of stigma on an individual or group usually results in failure to acknowledge their strengths [2]. For mothers who use(d) substances during pregnancy or whose children have FASD, stigmatization can result in service providers or institutions taking a judgemental or punitive approach that often includes increased surveillance, child apprehension, and limited care options [2-4].

Many women may feel unsafe disclosing their alcohol use because of stigma, fear of judgement from health and social service providers, and fear of child protection involvement [5-8]. Health and social service providers who are judgemental, who adopt punitive approaches, or who insist on complete abstinence from substances, can limit women from accessing necessary harm reduction and support services, such as housing, nutritional supports, or substance use treatment programs [9]. This is particularly true for women of colour, women from lower socioeconomic brackets, or those who experience other inequities [10, 11].

Moreover, when providers hold a belief that only certain 'types' of women can have a child with FASD, women from other groups who may need help to reduce their drinking may be deterred from asking for it, or may be incorrectly reassured that their drinking is not problematic [12].

**The purpose of this issue paper is to explore the stigma experienced by pregnant and parenting women who use(d) substances during pregnancy. It will identify opportunities and resources to mitigate stigmatization and better support women who are accessing substance-related and other support services for themselves and their children.**

## Background:

Substance use and addiction are highly stigmatized in social, political, and legal spheres, more so than other health conditions [13]. Women who use substances or have substance use problems experience dual stigma because they are seen as infringing on socially constructed ideas of what a "good woman" or "good mother" is [4]. The dual stigma, and the negative labels, placed on mothers can perpetuate the belief that women are, or will be, a "bad" or "unfit" mother [14, 15] and add to the internalized stigma women experience. This stigma may contribute to the belief that substance use during pregnancy is an uncaring choice [16].

The lack of understanding from health and social service providers and the public, as to the contributing factors to substance use such as trauma, interpersonal violence, stress, poverty, and isolation, can reinforce the belief that women deserve the stigma and discrimination that they receive [5]. The responsibilities placed on mothers to uphold the notions of a "good mother" ultimately influences the attitudes and reactions to mothers who drink while pregnant or who have children with an FASD diagnosis [6].

In our companion paper, we described the experiences of stigma faced by individuals with FASD, their families, and their support networks [17]. This paper follows the four levels of stigma outlined in the action framework of Canada's Chief Public Health Officer [18], to explore the stigma experienced by pregnant and parenting women who use(d) substances during pregnancy or whose children have FASD, and what we can do about it. It specifically examines:

- internalized stigma experienced by mothers;
- interpersonal stigma and its impact on access to prenatal care and substance use treatment;
- institutional stigma and its impact on women's access to trauma-informed and harm reduction oriented services; and,
- population level stigma experienced by women who use(d) substances in pregnancy, that is influenced by media messaging and public discourse.

### 1. Internalized Stigma and its Impact on Women's Self-Efficacy

The attitudes of health and social service providers, as well as media representations of mothers who use substances, can influence mothers' self-efficacy and perceptions of themselves [6, 19]. Women may come to believe the negative stereotypes that they are "unfit" to mother [18, 20], and these beliefs may be compounded by feelings of guilt or fear as to how their alcohol use has impacted their child's health. These internalized perceptions ultimately negatively affect a mother's feelings about herself, lowering her self-esteem and confidence in being able to mother her child. Moreover, they can limit her capacity or comfort to seek

additional supports, such as substance use counselling, or other services that could support her in reducing her alcohol or substance use [9, 20].

## 2. Interpersonal Stigma and its Impact on Access to Prenatal Care and Substance Use Treatment

Stigma is considered one of the biggest barriers to women accessing, and practitioners providing, care for pregnant women who use substances [21]. Discrimination directed to women who have substance use problems and become pregnant, and inconsistent messaging around substance use in pregnancy by health care providers, deters women from seeking the help they and their children need, and undermines access to proper medical care [6, 18]. Moreover, for women who are pregnant and aware of the risks of alcohol use in pregnancy but are struggling to abstain because of a multitude of factors (including social pressure, life circumstance, violence, trauma, or addiction), judgemental or abstinence-only responses from practitioners may perpetuate shame. Women may avoid accessing preconception and prenatal care out of fear of being judged by their health care providers, or out of fear of child apprehension or criminalization [6, 9, 21, 22].

## 3. Institutional Stigma and its Impact on Women's Access to Trauma-Informed and Harm Reduction Oriented Services

Institutional stigma impacts women's access to a multitude of services that can support their and their children's needs. Organizational policies that require women to be abstinent from substances can limit women's access to necessary prenatal care, substance use, mental health and harm reduction services, and anti-violence and housing programs [23, 24]. A lack of training in substance use counselling for health practitioners limits understanding of why a woman may drink in pregnancy and instead perpetuates the unfounded and harmful notion that women are intentionally harming their children [19]. Moreover, it can result in punitive approaches and concerns about child removal, which perpetuates women's distrust and fear of service provision and can result in additional drinking to cope, exacerbation of trauma histories, and avoidance of accessing support services [4, 6, 25, 26]. Recent changes in some Canadian provinces to child protection policies are prioritizing keeping families together. This shift in practice may bring about promising changes whereby women feel safer to access financial and other supports available from child welfare agencies both when pregnant and parenting [27, 28].

## 4. Population Level Stigma Arising from Public Health Messaging and Media Representations

The public discourse around women who drink alcohol in pregnancy is characterized by both misinformation concerning 'safe' levels of alcohol consumption in pregnancy and stigma towards women who drink in pregnancy. The media's portrayal of women's alcohol use in pregnancy often perpetuates narratives of victimhood or shame, whereby mothers are seen as irresponsible, immoral, or villainous [29, 30]. These narratives do not consider the many

influences on women's substance use and perpetuate misconceptions of which groups of women use alcohol in pregnancy. The result of these narratives can cause providers to not ask *all* women and girls of childbearing age about their substance use, and to ask only subpopulations who have been falsely stereotyped [27, 28]. In this context, many women may feel unsafe or reluctant to have discussions about alcohol use, and may be afraid to accurately report their alcohol use [28].

## Implications and Recommendations:

- Women need to feel comfortable seeking support and treatment. Our health messaging must not be stigmatizing, and instead should be compassionate, strengths-based, trauma-informed, and harm reduction oriented to better encourage and support women in seeking the services that they may need [28].
- Health care and social service providers must increase their competence in providing appropriate support for women with substance use concerns and in using harm reduction oriented, FASD-informed, and trauma-informed approaches that recognize the many factors influencing women's substance use [31-33] and the services available to support women's and children's growth and change.
- Providers must collaborate across sectors to support mothers in a safe and supportive way on a range of health and social concerns [27, 34]. Policy and practice approaches where practitioners in child welfare and substance use services are working collaboratively to keep families together, to wrap care around mothers and children, and to support attachment, resilience, and recovery that can inspire others in this destigmatizing, respectful, cross sectoral work, are evidence-based strategies to support women and their families [27, 34-37].
- Governments must fund health messaging and media campaigns around women's substance use and FASD prevention that are evidence-based, challenge stereotypes, and work to address discrimination [18, 28]. Language guides, such as *Language Matters: Talking about Alcohol and Pregnancy*, should be followed. Similar guides can also be used by program providers and policy makers when developing awareness campaigns as to invite, rather than deter, women from seeking help.

## Conclusion:

Women who drink alcohol in pregnancy or who have children with FASD experience stigma from the media, health and social service providers, and their friends and family, which can limit women's access to necessary health and social services. FASD-informed, trauma-informed, and harm reduction oriented health messaging and health education should be adopted to better support women in accessing these needed services. By reducing the stigma and discrimination that women who use alcohol and other substances face while pregnant or mothering, we will improve women's access to necessary support and services and prevent FASD going forth.

## Recommended Resources:

The following resources are examples that can be referred to in supporting women and girls who have substance use concerns.

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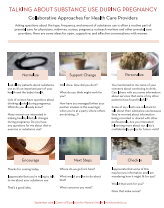
|  | **Language Matters: Talking about Alcohol and Pregnancy**<br>(includes other guides on FASD, building awareness campaigns, and using images when talking about alcohol, pregnancy, and FASD)<br>https://canfasd.ca/wp-content/uploads/2019/11/3-LanguageImages-Matter-5.pdf |
|  | **Doorways to Conversation: Brief Intervention on Substance Use with Girls and Women**<br>http://bccewh.bc.ca/wp-content/uploads/2018/06/Doorways_ENGLISH_July-18-2018_online-version.pdf |
| CanFASD<br>CANADA FASD RESEARCH NETWORK | **Prevention Conversation (Online Training Course)**<br>https://estore.canfasd.ca/prevention-conversation |
|  | **Talking about Substance Use During Pregnancy: Collaborative Approaches for Health Care Providers**<br>http://bccewh.bc.ca/wp-content/uploads/2018/10/Collaborative-Conversation-Ideas_Sept-19-2018.pdf |
|  | **Mothering and Opioids: Addressing Stigma – Acting Collaboratively**<br>http://bccewh.bc.ca/2019/11/mothering-and-opioids-addressing-stigma-acting-collaboratively/ |
|  | **Overcoming Stigma through Language: A Primer**<br>https://www.ccsa.ca/sites/default/files/2019-09/CCSA-Language-and-Stigma-in-Substance-Use-Addiction-Guide-2019-en.pdf |
|  | **Addressing Stigma: Towards a More Inclusive Health System**<br>https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf |

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