Crisis and Emergency Risk Communications: Countering Stigmatization

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Hello. I'm Dr. Barbara Reynolds, a CDC crisis and emergency risk communication specialist. The CDC's Crisis and Emergency Risk Communication framework encourages best practices for communicating with the public, media, and stakeholders during emerging health threats, such as the ongoing novel Influenza Type A H1N1 outbreak. In this podcast, I'll define stigmatization, describe how stigmatization can occur in a community, and discuss activities that response officials and communication professionals can do right now to prevent or confront stigmatization.

Throughout time, infectious diseases have been a menace. Only since the late 1800s and the advent of the germ theory have people had to face the anxiety of a threat that they can't see, smell, or hear. When every object around an individual, including the very air they breathe, could carry the threat of death, there is ample opportunity for strong emotional reactions to infectious diseases.

When new infectious disease illnesses emerge, the potential exists to stigmatize people, places, animals, or products. If a particular parasite, virus, bacteria, or toxin evokes an instant negative association with a particular ethnic, racial, age, or gender group—stigmatization is already occurring.

Early in an outbreak, such as the novel H1N1 flu outbreak, groups of people, places, and animals can be singled out and are at risk of being stigmatized by association with the threat the virus poses. Groups are stigmatized by an infectious disease when the risk of infection to others is not present or remote but the association of the risk is magnified by others for that population group or animal.

Stigmatization is a psychological short-cut, or stereotype, used by people who are concerned about their wellbeing. People naturally want to protect themselves and when a situation is evolving or uncertain, they may revert to visible markers to infer risk. Stigmatization occurs when the people associated with the risk, based on outward appearance, are shunned or excluded from societal benefits.

Communication professionals must work to communicate the *real* risks that exist, without needlessly associating an identifiable group of people with that risk. For example, state clearly that the risk is associated with travel, or exposure through close contact with people who travel to affected locations. It's not merely because one shares a racial or ethnic heritage from the affected area.

Stigmatization takes a toll. Other than obvious societal reasons, stigmatizing groups during an outbreak can be harmful in many ways. Members of that stigmatized group may literally hide their illness to avoid the stigma, which could hamper response and community mitigation measures. Also, stigmatized individuals may experience emotional pain from the stress and

anxiety of social avoidance and rejection. This stress may make them more susceptible to illness. In rare, but documented, instances, group conflict may arise and important community resources will be withheld from those stigmatized.

There are steps response officials and communication professionals should take to reduce the potential for stigmatization or counter stigmatization when it occurs. Here are 12 steps to take before or during an outbreak and two steps to take after an outbreak subsides. Remember: products, animals, places, and people can be stigmatized.

1. Avoid constant use of visuals that portray only one ethnic group in briefing, education, and outreach materials. Media reports are different because they are a record of a news event and, therefore, set in time.
2. Avoid geographic mentions of past infectious disease outbreaks; instead substitute dates. For example, instead of saying the "Toronto SARS outbreak," one could say the "2003 SARS outbreak." Also, instead of saying the "Spanish Influenza Pandemic," one could say the "1918 Influenza Pandemic."
3. Ask staff who share the ethnic background of persons experiencing the earliest outbreaks whether the proposed materials are offensive, and if no staff share the ethnic background, reach out to trusted partners.
4. If a particular parasite, virus, bacteria, or toxin evokes an instant association with a particular ethnic, racial, age, or gender group, stigmatization is already occurring.
5. Teach response officials and communication staff, as broadly as possible, about the harm that results from stigmatization. Remember, people may literally hide their illness to avoid the stigma, which could hamper infection control and community mitigation measures.
6. Share with media the concern about stigmatization and work together to create visuals that tell the story without targeting one group.
7. Address the issue in preplanning community checklists and guides. The more people are aware that this could occur, the more people can help guard against it.
8. Have a mechanism in place that allows people to seek the help of public health experts in determining *real* risks versus imaginary or theoretical risks.
9. Have a mechanism in place to allow people who are feeling stigmatized to express their concern and ask for help.
10. Ensure the environmental scanning process being used is able to discern and alert communication staff to stigmatizing visuals, statements, or behaviors. This should include monitoring misperceptions in the community regarding real risks, versus imagined or theoretical risks, in relationship to products, animals, places, and people.
11. When stigmatization occurs in the community, counter it immediately with emotional appeals for fairness, justice, and sound scientific facts. For example, when Vietnamese nail salon owners appealed for help from the health department during the SARS outbreak because women feared they would get SARS at the salons, the health department was able to allay public concern about increased risks and shorten the negative emotional and fiscal impact of the stigmatization.
12. Engage respected political and civic leaders in countering stigmatization. For example, the governor of Hawaii visited Honolulu's Chinatown during the SARS outbreak.

After an outbreak subsides, there are some additional steps that should be taken.

1. Ensure that historical accounts of the event do not unfairly show any one ethnic group. The potential is high for historical accounts that cover the early part of the outbreak to unintentionally perpetuate the stigmatization.

2. If stigmatization does occur in the community, reach out to the stigmatized community to learn, and believe me, they will know when stigmatizing behavior started. Ask them what led to it, how it was manifested, and how they coped or countered it themselves. Learn the lessons and engage them in the future for help.

As an infectious disease outbreak becomes much more widespread in the general population and people cannot distinguish themselves from others who are becoming sick, meaning everyone is sharing the risk equally, stigmatization will decline. However, it can erupt as new developments occur or new data emerge.

If you'd like more information or free materials about this and other Crisis and Emergency Risk Communication best practices, send an email to CERCrequest@cdc.gov or visit emergency.cdc.gov/cerc. Scroll down from there to course books and select the "Crisis and Emergency Risk Communication Pandemic Influenza" book. Thank you.

For the most accurate health information, visit www.cdc.gov or call 1-800-CDC-INFO, 24/7.