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Reducing Addiction-related Social Stigma

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There is no physical or psychiatric condition more associated with social disapproval and discrimination than alcohol and/or other drug dependence (Corrigan, Watson, & Miller, 2006). Addiction-related social stigma constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the cultural resources allocated to alcohol- and other drug-related problems. Efforts to forge "recovery-oriented systems of care" inevitably confront social stigma as a barrier to shaping community attitudes and policies supportive of long-term addiction recovery. The purpose of this article is to highlight some of the modern research on addiction-related social stigma and outline actions addiction professionals can personally take to reduce such stigma within their communities.

Stigma 101

Stigma Defined: Stigma is the experience of being held in contempt (shunned or rendered socially invisible) because of a socially disapproved status

(Sayce, 1998). It involves processes of labeling, stereotyping, social ostracism, exclusion, and extrusion—the essential ingredients of discrimination. There are three types of personal stigma: 1) *enacted stigma* (direct experience of ostracism and discrimination, e.g., social rejection; professional disrespect; difficulty acquiring employment, housing or services; denial of governmental benefits—student loans, public housing, small business loans), 2) *perceived stigma* (perception of stigmatized attitudes held by others toward oneself), and *self-stigma* (personal feelings of shame) (Luoma, Twohig, Waltz et al., 2007).

Stigma and Recovery: Addiction-related social stigma extends to people who have achieved stable recovery from addiction (Tootle, 1987).

Courtesy Stigma: The social stigma attached to addiction can be experienced by families, organizations (e.g., addiction treatment programs), neighborhoods, and whole communities. Goffman (1963) referred to this stigma by association as "courtesy stigma." The social stigma attached to families affected by addiction carries the implication that the family

somehow failed to prevent this problem, contributed to its onset, and/or played a role in failing to prevent or inciting relapse episodes. Children may be socially shunned due to the perception that they have been contaminated by the addiction of their parents or siblings (Corrigan, Watson, & Miller, 2006).

Multidimensional Stigma: The weight of addiction-related social stigma is not equally applied. Its burdens fall heaviest on those with the least resources to resist it, e.g., those for whom stigma is layered across multiple conditions (addiction, mental illness, HIV/AIDS, incarceration, minority status, poverty, homelessness) (Yannessa, Reece, & Basta, 2008). Persons experiencing such layered, multidimensional stigma are less likely to seek addiction treatment than persons experiencing a single discredited condition (Conner & Rosen, 2008). The most intense social stigma attached to addiction begins at the point of admission to treatment (a social signal of problem severity) and intensifies with multiple treatment episodes (a social signal of treatment failure) (Luoma, Twohig, Waltz et al., 2007). The social stigma attached to illicit drug use varies by drug and method of ingestion in the U.S., with use of heroin and crack cocaine being the most stigmatized substances and injection the most stigmatized method of ingestion (Surlis & Hyde, 2001).

Greater addiction-related stigma may also be extended to people in particular treatment modalities. Stigma is particularly severe for persons whose treatment and recovery is supported by methadone, in spite of the well-established scientific legitimacy and effectiveness of methadone treatment (Joseph, 1995; Murphy & Irwin, 1992; Woods, 2001). Methadone-related stigma generates a wide span of discrimination—spanning employment, child custody, access to other forms of addiction treatment, and even denial of the privilege to speak at some recovery fellowship meetings (Hettema & Sorenson, 2009; Joseph, Stancliff, & Langrod, 2000).

Stigma and Long-term Health: Stigma can elicit social isolation, reduce help-seeking, and compromise long-term physical and mental health (Ahern, Stuber, & Galea, 2007). Social stigma is a major factor in preventing individuals from seeking and completing addiction treatment (Luoma et al., 2007). Social stigma increases the service needs of persons with substance use disorders, but that same stigma decreases access to such services by fostering social rejection and discrimination (van Olphen, Eliason, Freudenberg, & Barnes, 2009).

Personal Responses to Stigma: Individual strategies to deal with stigma include:

- secrecy/concealment
- social withdrawal
- preventative disclosure
- compensation (using personal strengths in another area to counter the imposed stigma)
- strategic interpretation (comparing oneself to others within the stigmatized group rather than to those in the larger community), and
- political activism (Shih, 2004).

Stigma and Cultures of Addiction: Individuals who share the "spoiled identity" of addiction have historically organized their own countercultures marked by distinct language, values, roles, rules (behavioral codes), relationships, and rituals (White, 1996). These subcultures provide shelter from stigma; access to drug supplies; social support for sustained drug use; meaningful roles, activities, and relationships; and mutual protection. Within these cultures, drug users protect their own identities by stigmatizing other drug users viewed as less in control of their drug use (Boeri, 2004; Simmonds & Coomber, 2009). Such attitudes can get played out within the social pecking order of drug treatment milieus. "Street cultures" are also imbedded with myths designed to inhibit treatment-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement, e.g., street myths about methadone—"it rots your teeth and bones" (Rosenblum, Magura, & Joseph, 1991).

Strategies to Address Social Stigma: Three broad social strategies have been used to address stigma related to behavioral health disorders: 1) protest, 2) education, and 3) contact (Corrigan & Penn, 1999). One major strategy, seeking to inculcate the belief that alcohol and drug addiction is a disease, has not been consistently shown to produce sympathetic attitudes toward those with severe alcohol and other drug problems (Cunningham, Sobell, & Chow, 1993). One of the most effective strategies to reduce social stigma is to increase interpersonal contact between mainstream citizens and people in recovery (Corrigan, 2002). Contact between stigmatized and nonstigmatized groups as a vehicle of stigma reduction is most effective when this contact is: between people of equal status (mutual identification), personal, voluntary, cooperative, and mutually judged to be a positive experience (Couture & Penn, 2003). Social stigma is particularly influenced by social proximity and distance. For example, community attitudes toward Oxford Houses are most positive among neighbors who live closest to these houses (Jason, Roberts, & Olson, 2005). Reducing social distance and increasing interpersonal contact are important goals of any anti-stigma campaign.

Historical/Sociological Perspectives

Before exploring personal strategies that addiction professionals may use to address addiction/treatment/recovery-related social stigma in their own communities, it may be helpful to set this issue within a larger perspective.

Social stigma toward alcohol and other drug (AOD) addiction may be defined as an obstacle to problem resolution or as a strategy of problem resolution. The stigmatization and criminalization of alcohol and other drug problems in the United States has grown over more than two centuries as an outcome of a series of "drug panics" and resulting social reform campaigns (Jonnes, 1996; Musto, 1973). These campaigns have generated policies of isolation, control, and punishment of drug users (White, 1979).

Stigmatization is not an accidental by-product of these campaigns. It is a reflection of policies that "unashamedly aim to make the predicament of the addict as dreadful as possible in order to discourage others from engaging in drug experimentation" (Husak, 2004). An outcome of this complex social history is that many addiction professionals and recovery advocates see the stigma produced by "zero tolerance" policies as a problem to be alleviated, whereas preventionists see the stigma produced by such policies as a valuable community asset. A key question thus remains, "How do addiction treatment professionals, recovery advocates, and preventionists avoid working at cross-purposes in their educational efforts in local communities?"

Efforts to increase or reduce stigma attached to illicit drug use may have intended or unintended side-effects (Room, 2005). Two examples illustrate this point. First, efforts to decrease illicit drug use by portraying the drug user as physically diseased, morally depraved, and criminally dangerous may inadvertently decrease help-seeking behavior by creating caricatured images of addiction with which few people experiencing AOD problems identify. Such strategies may also promote patterns of social exclusion and discrimination within local communities that block the ability of drug-dependent individuals to re-enter mainstream community life. Second, an anti-stigma campaign could inadvertently increase drug use if it normalized illicit drug use, increased non-user curiosity about drug effects, conveyed the impression that addiction treatment is an assured safety net (available and affordable) and that recovery is easily attainable, and glamorized the recovering addict as a heroic figure within cultural contexts in which few heroic models are available.

Any campaign to counter addiction/treatment/recovery-related stigma must ask the question, "Who profits from stigma?" Efforts by one group to define another group as deviant can serve psychological, political, and economic interests.

Put simply, stigmatizing others often serves to increase the self-esteem of the stigmatizer (Tajfel & Turner, 1979). It elevates oneself as more worthy than the demeaned "other" and defines oneself as an upholder of community health and morality. Social scapegoating of others increases during periods in which personal esteem, security, safety, and social value are threatened. Participation in or support of campaigns to define others as outsiders serves to confirm one's own insider status. Addiction professionals seeking to reduce social stigma attached to addiction/treatment/recovery must address such issues of esteem, security, safety, and social value. Stigma has political utility. Anti-drug campaigns often mask and reflect deeper conflicts of gender, race, social class, and generational conflict. Such issues have long been manipulated for political gain. Stigma is often the delayed fruit of anti-drug campaigns waged for the benefit of those seeking to build or retain political power. Anti-stigma campaigns must address the question of how the community and its political leaders can benefit from changes in attitudes toward addiction/treatment/recovery. Social stigma can be fed by individuals and institutions whose economic interests are served by such attitudes. Changes in attitudes can trigger shifts in cultural ownership of alcohol and other drug problems and, in that process, shift millions of dollars in ways that affect the destinies of individuals, organizations, and whole communities. For example, past changes in community attitudes have shifted millions of dollars between community-based addiction treatment and the criminal justice system. Such shifts influence the fate of professional careers, organizations, and in some cases, entire community economies. Similarly, what may be viewed as a problem of "not in my back yard" (NIMBY) prejudice by citizens of a particular neighborhood may actually reflect opinion being manipulated by hidden financial interests, e.g., developers who would profit from future gentrification of a neighborhood targeted for a new addiction treatment facility.

Social stigma attached to addiction/treatment/recovery involves complex issues, but each of us may find simple steps we can take to help create a world in which "people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated" (SAMHSA, 2002).

Twelve Personal Strategies

Addiction professionals and recovery advocates in the City of Philadelphia are engaged in a sustained conversation about addiction-related stigma. We are exploring how to best shape community attitudes and policies to transform the city into a true community of recovery. Some of the ideas we are hearing about how addiction professionals and recovery advocates can contribute to this effort include the following.

1. <u>Assess Yourself</u>. Explore (self-inventory) how addiction-related stigma may have inadvertently influenced your personal (and your program's) attitudes, beliefs, and practices.

2. <u>Stay Recovery Focused</u>. Keep your own batteries charged by staying in touch with individuals and families in long-term recovery, e.g., attending open meetings of local recovery fellowships and/or recovery celebration events.

3. <u>Build Respectful Partnerships</u>. Cultivate service relationships marked by respect, choice, and continuity of support.

4. <u>Make Amends</u>. Acknowledge and correct mistakes and shortcomings in your relationships with people who are seeking or in recovery.

5. <u>Be a Recovery Carrier/Witness</u>. Tell stories of individual and family recovery at every opportunity. The most singularly important thing you have to offer individuals, families, and your community is *hope*.

6. Walk the Walk. Conduct yourself in the community as an ambassador of the recovery movement, conveying as best you can such core recovery values as humility, honesty, gratitude, respect, tolerance, responsibility, and service. Never forget that people will judge those you serve, your organization, and your profession by how you conduct yourself in the community.

7. Model Non-stigmatizing Language. Use language that is medically descriptive rather than moralistic, e.g., "addiction," "drug dependence," or "substance use disorder" rather than "drug abuse." Refrain from language that equates methadone with heroin, e.g., avoid references to methadone treatment as a "substitution therapy" or "replacement therapy" (Maremmani & Pacini, 2006). Use "person first" language in inter-professional and community-level communications, e.g., "person with a substance use disorder" or "person experiencing drug-related problems" rather than "substance abuser" or "addict." Confront language in the treatment milieu that demeans and objectifies, e.g., references to persons re-admitted for treatment as "frequent flyers" or "retreads."

8. Educate Yourself. Seek educational opportunities to increase your knowledge about addiction, treatment, and recovery—particularly on subjects about which you have great passion but little education. Passionate opinion in the absence of knowledge is not an admirable trait of the addictions professional or recovery support specialist.

9. Be an Educator. Seek out opportunities to educate allied professionals, other community service workers, and the larger community about addiction, treatment, and recovery. Use encounters with addiction/treatment/recovery stereotypes in the community as educational opportunities, but be careful to speak only within the boundaries of your education, training, and

experience. It is far better to declare, "I don't know" than to convey an ill-informed opinion.

10. Extol the Honor of Service Work. When talking about your work with other professionals and members of the community, emphasize points that will enhance optimism about long-term recovery and the importance of, and personal satisfaction that can be drawn from, professional/personal support of long-term recovery efforts.

11. Be an Advocate. Speak out against stigma-related discrimination, e.g., in housing, employment, government benefits, access to health and human services, *and* in stigma-shaped policies/practices within addiction treatment.

12. Embrace and Promote Diverse Pathways for Recovery. Avoid polarized "either/or" debates about *the* way to treat addiction or *the* way to recover. Our best message is: *There are many pathways to addiction recovery, and all are cause for celebration*. Help people see that there are others like themselves in recovery who share their world view, whether that view reflects a secular, spiritual or religious orientation.

13. Challenge Institutions. Don't assume that institutions in the treatment field or that should otherwise "know better" don't stigmatize people in the same way that the broader society does. Stigma is pervasive and the attitudes of even well-meaning individuals and institutions may unconsciously reflect such stigma.

14. Join the Movement. Participate in local recovery advocacy organizations and grassroots anti-stigma campaigns. Contribute your time, talent, and money to support such efforts. (See www.facesandvoicesofrecovery.org)

Closing Reflection

The social stigma attached to addiction exists at cultural, institutional,

interpersonal, and intrapersonal levels; potential antidotes to such stigma must work at these same levels (Woll, 2005).

Too many of us hide within our own professionally and socially cloistered worlds while boldly challenging our clients to re-enter the life of communities from which we have long been disengaged. We need to reenter those communities and stand in partnership with those we serve to confront the social stigma attached to addiction/treatment/recovery. It is not enough to personally help each client initiate a recovery process. We need to assure a community/world that welcomes and nourishes such recoveries. As part of our larger recovery-focused systems transformation process, the City of Philadelphia is exploring development of a long-term strategy to reduce the stigma attached to addiction/treatment/recovery. Other communities across the country are involved in similar efforts. We hope this opening discussion will stimulate your own thinking about how you can contribute to this movement.

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