Healing the Stigma of Addiction

A Guide for Treatment Professionals

Second Edition, Revised 2005

GREAT LAKES ADDICTION TECHNOLOGY TRANSFER CENTER

Written by Pamela Woll, MA, CADP

Foreword by William L. White, MA

CHICAGO, ILLINOIS
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great lakes addiction technology transfer center
FUNDED BY CENTER FOR SUBSTANCE ABUSE TREATMENT, SAMHSA

RECOVERY COMMUNITIES UNITED, INC.
AN AFFILIATE OF NCADD
NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC

southeast addiction technology transfer center
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Great Lakes Addiction Technology Transfer Center
(written by Pamela Woll, MA, CADP, with a Foreword by William L. White, MA)

Collaborative Partners:
Recovery Communities United, Inc.
Southeast Addiction Technology Transfer Center

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Jane Addams College of Social Work
1640 W. Roosevelt Rd., Suite 511 (M/C 779)
Chicago, Illinois 60608-1316

At the time of this publication, Charles G. Curie, MA, ACSW served as SAMHSA Administrator. H. Westley Clark, MD, JD, MPH served as CSAT Director, and Karl D. White, EdD served as CSAT Project Officer. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of DHHS, SAMHSA, or CSAT. No official support or endorsement of DHHS, SAMHSA, or CSAT for the opinions described in this document is intended or should be inferred.

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FOREWORD BY WILLIAM L. WHITE[1]

Two celebrities marked a milestone today: One celebrated his 14th year of continuous sobriety; The other was arrested for the third time in three years for possession of heroin. The lack of coverage for the former was lost in the frenzy of media coverage of the latter. Such selective coverage is a story about stigma.

Maria C. was admitted to the hospital for treatment of alcoholism just before her 46th birthday. She never took another drink following this first treatment but died nine months later from advanced alcohol-related liver disease. She died of stigma—a stigma that had incubated her alcoholism into its lethal stages within the cloistered secrecy of her family status and wealth.

John B., a recovering addict with more than 10 years of sobriety and responsible citizenship, could not vote in the last election because of his prior drug-related criminal offenses. His political disenfranchisement is a story of stigma.

Rodney's company informed him today that he was being transferred from his safety-sensitive position because of his addiction background. In spite of more than 15 years of uninterrupted sobriety and performance commendations, the company's new "never-ever" policy requires his removal from this position. His displacement is a story of stigma.

A local alcoholism council flounders because its recovering members spend most of their time dealing with internal personality conflicts and dissension. Their story is one of internalized stigma.

An addiction counselor who once proclaimed his recovery to all who would listen later withdrew the visibility of this status behind a cloak of increasing academic and professional credentials. His silence is a story, not of professionalism, but of "passing"—an escape from stigma.

[1]William L. White is a Senior Research Consultant at Chestnut Health Systems in Bloomington, IL and the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.*

Jeremy faces a dilemma today. During a physical for a new life insurance policy, his doctor tells him that they can either lie about Jeremy's long-past history of addiction (and gain low rates because of his current excellent health status) or tell the truth (and risk either rejection of his policy application or higher rates). His dilemma is a story of stigma.

Sharise is a poor African-American mother of three seeking admission into addiction treatment. The programs in her community do not provide specialized women's treatment, nor do they provide the transportation and day care services that would allow her to participate in the treatment that is available. These multiple obstacles mirror multiple stigmas.

On April 1, 1944 Marty Mann founded the National Committee for Education on Alcoholism (NCEA). NCEA, the forerunner of today's National Council on Alcoholism and Drug Dependence (NCADD), was birthed in the belief that social progress in the treatment of alcoholism was being held back primarily because of the stereotypes and stigma that pervaded public perceptions of alcoholism and the alcoholic. Mann believed that policy advocacy and public and professional education could remove these stereotypes and stigma and lead to more enlightened treatment of the alcoholic. She was right.

The slow and unrelenting education and advocacy work of NCEA and the other organizations within the "modern alcoholism movement" culminated in the passage of federal legislation in 1970. Sponsored by Senator Harold Hughes, who was himself in personal recovery from alcoholism, this Act set the stage for the explosive growth in addiction treatment and recovery mutual-aid societies between 1970 and the late 1980s. The achievements of the modern alcoholism movement are truly stunning. Public opinion shifted toward the view that alcoholism was a disease and that the alcoholic was suffering from a sickness that could and should be treated.

As the stereotype of the alcoholic as a "skid row wino" broke down, changes in law and social policy paved the way for a Camelot period in which hundreds of thousands of people embarked on personal recovery from alcoholism and other addictions. In the late 1970s, celebrities from all walks of life brought the subject of addiction out of the shadows in the public proclamations of their own recoveries. The modern alcoholism movement was successful because it was able to carry its advocacy and educational efforts into the very heart of the American culture: into the arenas of business and industry, medicine, law, religion, and virtually every public media outlet.

This decades-long advocacy movement dissipated in the 1980s as it lost much of its founding leadership and became professionalized and absorbed into the growing network of treatment programs. In the wake of this loss, there was an ideological and financial backlash against a treatment system that by the early 1990s was being criticized and perceived by many as ineffective and exploitive. The optimism about recovery in the 1970s gave way to therapeutic pessimism in the 1990s. As a result of these forces of professionalization, dissipation, and backlash, the functions of policy advocacy and public and professional education fell by the wayside. The seeds of stigma, once dormant, began to re-germinate.

Three trends have been evident since 1990. The first is the restigmatization of severe and persistent alcohol and other drug problems. The images of first ladies, next-door neighbors, and our own family members are being replaced with more demonized images that elicit public fear and anger rather than compassion. The second trend is the demedicalization of alcohol and other drug problems. This is evident in attacks on medical models of addiction treatment and the mass transfer of those with alcohol and other drug problems out of medical care arenas. The third trend is the recriminalization of the status of addiction in the United States—a trend that has fueled the explosive growth of the criminal justice system in general, and the American prison system in particular. Theses changes are anchored in a belief system that portrays the source of addiction in personal character, portrays the addict as an infectious agent of evil, and portrays recovery as a rare anomaly—the exception to the rule. Such emotion-laden beliefs provide the justification for disregard, disenfranchisement, and punishment.

These shameful regressions have triggered a resurgence in grassroots recovery advocacy activities. Renewed and new local advocacy organizations are springing up across the United States to again pursue the functions of policy advocacy and public and professional education. The battle cry of this New Recovery Movement is not that addiction is a disease or that treatment works, but that recovery is a reality in the lives of hundreds of thousands of individuals and families all across America. This new movement is calling on a vanguard of recovering people to step forward to offer themselves as **living proof** of the hope for sustained recovery from addiction. This movement is attacking stigma by challenging portrayals that misrepresent, dehumanize, and stigmatize addicted and recovering people.

It is time that those concerned about alcohol and other drug problems again became students of stigma. We need to understand the forces that initiate and sustain stigma. We need to learn how stigma operates at cultural, institutional, interpersonal, and personal levels. And we need to learn the antidotes to stigma—antidotes that can work at these same levels.

The Great Lakes Addiction Technology Transfer Center, Recovery Communities United, Inc., and the Southeast Addiction Technology Transfer Center have provided a great service by developing *Healing the Stigma of Addiction*. Pam Woll has added another fine contribution to the addictions field in her preparation of this manual. What this product should do is give treatment professionals an opportunity to explore the nature and impact of stigma and the potential range of public education activities in which they and their clients could be involved.

Addiction is a potentially lethal disorder, but that lethality is dramatically amplified by the social stigma attached to the disorder. Stigma's greatest enemy is knowledge. Understanding and Healing the Stigma of Addiction will help open the doorway to such knowledge. It is time we all walked through that doorway.

ACKNOWLEDGMENTS

Funding and Sponsorship

The Great Lakes Addiction Technology Transfer Center (GLATTC), Recovery Communities United, Inc. (RCU), and the Southeast Addiction Technology Transfer Center (SATTC) wish first and foremost to thank our funding source, the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (CSAT, SAMHSA), without whose support none of our work would be possible. Thanks to CSAT Director H. Westley Clark, MD, JD, MPH, CAS, FASAM; and SAMHSA Acting Administrator Joseph H. Autry III, MD, for their ongoing commitment and support.

In addition, the Great Lakes and Southeast ATTCs wish to acknowledge the vision, guidance, and support of our National ATTC Network, whose work truly does unify research, education, and practice to transform lives. Special thanks to Karl White, EdD, CSAT Project Officer for the ATTC Network, and Susanne Rohrer, RN, MBA, former Project Officer. We also wish to thank our sponsoring educational institutions, the University of Illinois at Chicago, Jane Addams College of Social Work (GLATTC); and the Morehouse School of Medicine, Department of Psychiatry and Behavioral Sciences (SATTC).

Recovery Communities United extends special thanks to Rick Sampson, Director of State and Community Assistance for CSAT; Catherine D. Nugent, MS and W. Barry Blandford, CSAT Project Officers for the Recovery Community Support Program (RCSP); and June Gertig, JD, Project Director of the RCSP Technical Assistance Project for their hard work and tireless efforts in making the Recovery Community Support Program a great success. RCU would also like to express gratitude for the help and leadership of its parent organization, the National Council on Alcoholism and Drug Dependence, a leading force in public education for the understanding and treatment of people with addictions.

Continuing Education Credit

Our thanks to the Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA) for supporting this project through continuing education credit. Special thanks to IAODAPCA Executive Director Bill Johnson, CSADC, CADP; and Senior Operations Assistant Debra K. Trott for help in this process, and for all their efforts on behalf of the education and professionalization of the field.

Information Sources

The easiest way to say it is that this manual is truly a synthesis of the knowledge, ideas, experience, conviction, and enthusiasm of many people. The author's only job was to capture this information, structure it, and spill it out on paper.

Since so much of the information came from more than one source, and since this is a self-study manual rather than a research piece, citations haven't been included for the individual points made in the manual. Only quoted material, and sections that rely heavily on one source, are documented. However, the bibliography includes all the publications used in researching the manual, as well as a few more that were recommended by our contributors.

Now all that remains is to try to describe the contributions of the people who will be mentioned on the next few pages. In phone interviews, on the GLATTC/SATTC Stigma Reduction Consensus Panel, and in an informal focus group hosted by Recovery Communities United, these folks made the process of researching and writing this manual come alive. The names and affiliations that follow may tell a little about their credentials, but they don't come close to describing their dedication, their expertise, or their vision.

Inspiration

We could fill an entire manual with a description of the inspiration received from all the people who have lent their passion and conviction to this cause. Many of them are acknowledged as consensus panel members, interviewees, reviewers, and so on. But here are a few whose special contributions can't be captured in those terms.

With the publication of *Slaying the Dragon: A History of Addiction Treatment and Recovery in America*, Bill White opened our eyes to the urgency of our need for public education on behalf of people with addictions. In that book, and in his work in general, Bill has raised our standards through his scholarship, his vision, his skill, his willingness to speak the truth, and his willingness to examine and question all the things we think we know as a field. As a mentor to so many of us, he has given us his patience and enthusiasm and helped us find our own voices and the courage to use them.

SAMSHA, CSAT, and the CSAT National Advisory Council officially established stigma reduction as a national priority by devoting an entire section of *Changing the Conversation: The National Treatment Plan Initiative* to stigma reduction. The careful and painstaking preparation of that work is testament to its developers' vision and dedication to this cause. The Plan will provide much-needed help and direction to our efforts as change agents in the years to come. Special thanks to National Treatment Plan Coordinator Donna M. Cotter for her dedication, and for her encouragement of our efforts toward this self-study manual.

Peg Rider, PhD, a Chicago-based writer and consultant in the treatment field, added early information and inspiration to the process that eventually resulted in the creation of this manual, when she researched and wrote a comprehensive paper for Recovery Communities United called "Understanding Addiction," covering the history and current state of stigma-reduction advocacy efforts. Her dedication and thoroughness set high standards for the work that was to follow.

In her work with the DC/Delaware ATTC, including her pivotal role in *The Stigma Reduction Forum: Breaking the Stigma, Freeing Our Community's Voices*, Val Robinson provided both spiritual inspiration and a wonderful forum for the experience and conviction of many people.

And in the many presentations that are part of his work, Rick Sampson has given us a stellar example of the eloquence and conviction with which public education for stigma reduction can be infused into our everyday work and communication with the world.

All this said, though, the fundamental inspiration for this work has come from the lives, the stories, the hard work, and the courage of countless people who have suffered addiction, struggled to understand, struggled to be understood, struggled to tell the truth, done the hard work of treatment and/or recovery, and allowed their lives to be transformed in ways they didn't always understand. They have given every potential change agent undeniable proof that people with addictions are human beings capable of great things, and that recovery is a reality. And those who have been less fortunate and have not survived this disease also deserve our gratitude. They have "carried the message" through their suffering, and strengthened our determination to overcome the stigma that helped keep them trapped in the addictive process.

Consensus Panel on Stigma Reduction

The initial vision for this manual came from the work of a consensus panel convened by the Great Lakes ATTC early in 2000. That panel's work contributed a great deal of information and inspiration to the process. Its members were:

Chair: Joseph D. Rosenfeld, PsyD
Director of Curriculum Development
GLATTC

Daphne Baille
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Flo Hilliard, MSH
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Silvia Wilber
Assistant to the President
College of Menominee Nation
Keshena, WI

Reviewers

Four reviewers deserve special recognition and gratitude for their tireless support and guidance of this process from its early days. They are:

Lonnetta Albright
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Great Lakes ATTC
Chicago, IL

Donald E. Malec, MS, CADC
Director
Recovery Communities United, Inc.
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Joseph D. Rosenfeld, PsyD
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Senior Research Consultant
Lighthouse Institute
Chestnut Health Systems
Bloomington, IL

Great appreciation also goes out to the rest of the reviewers, both for their patience in reading through a long draft and for their insightful recommendations. They were:

Donna M. Cotter
National Treatment Plan Coordinator
CSAT, SAMHSA
Rockville, MD

Jackie Langetieg
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Coordinator, Consumer Initiative
Bureau of Substance Abuse Services
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Director of Training
and Deputy Director
DC/Delaware ATTC

David Whiters
Program Coordinator
Southeast ATTC
Atlanta, GA

Interviewees

From the author's perspective, these folks have been the lifeline of the manual-development process. Their words have energized and expanded this process and given it the passion and conviction that characterize their own efforts. They are:

Jeff Blodgett
Coordinator
The Alliance Project
St. Paul, MN

Angela Bowman
Chief Executive Officer
Illinois Alcohol and Drug Dependence Association
Springfield, IL

Antonio Delgado, PhD
President
Information Technologies Across Cultures
Espanola, NM

Troy Harden, MSW
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Ernest Kurtz, PhD
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Rick Sampson
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Chicago, IL

William L. White, MA
Senior Research Consultant
Lighthouse Institute/Chestnut Health Systems
Bloomington, IL

Silvia Wilber
Assistant to the President
College of Menominee Nation
Keshena, WI

Focus group

Early in the manual development process, Recovery Communities United hosted a focus group of front-line counselors and recovering people, to gather questions and information for this process. Thanks to RCU, and to the focus group members:

Dawn Cribari
Forest Park, IL

Tony Harris
Chicago, IL

Tina Kingery
Administrative Assistant
Recovery Communities United, Inc.
Oak Park

Donald E. Malec, MS, CADC
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Oak Park, IL

Robert Reese, BA, CADC
Counselor
BRASS Foundation
Chicago, IL

Field-Testers

Two professionals from the field also volunteered to field-test and time-test the manual, by reading its content and completing the workbook exercises. Their help in trying out the material, and in documenting the effort required to complete it, was invaluable. They are:

Claudia Krempp, PsyD, CRADC
Clinical Psychologist
Professionals at Risk Treatment Services
Elmhurst, IL

Mary K. Kelts
Provisional A Counselor
Ripper and Associates
East Peoria, IL

How to Use This Manual

Healing the Stigma of Addiction has been written in a workbook format, with each page or two of text followed by a workbook exercise. These exercises are not designed to measure your knowledge or memory of the text you've just read. Instead, they ask you to:

- Describe your own observations and experience of the subject at hand
- Think about how you might use some of these ideas in your work

Healing the Stigma of Addiction as a Technology Transfer Tool

This is an example, not of training, but of *technology transfer*. Simply put, technology transfer is the process of taking new knowledge and skills and applying them to your ongoing work, to bring about positive change. This requires a blend of the new technology (the new information and skills) with the knowledge, skills, experience, and insight you already have.

This process prepares you to be a *technology transfer agent*, someone who can pass along the new technology to your clients, clients' families, the public, and any others you would help or inform. There the new technology will be blended with their existing knowledge, skills, experience, and insight. At each level, the whole becomes greater than the sum of its parts.

Points of Caution

Some of the workbook exercises ask that you interview "a stable client" or another person in stable recovery, to get his or her experience and insights. For these purposes, the word "stable" describes someone who is mentally healthy enough, and far enough along in the treatment/recovery process, to be able to answer the questions given without experiencing an emotional setback that will interfere with treatment/recovery effectiveness or with the person's safety. It would be far better to skip an exercise—or to skip the whole manual—than it would be to complete it at the cost of someone's safety and/or recovery.

When you work through these exercises, you'll also be asked to describe some clients' lives and circumstances, or ways in which you would apply these concepts in your treatment of specific clients. When you do this, please keep foremost in your mind the anonymity of the people you describe and the confidentiality of any information they disclose to you. If you mention a client's name, don't use the real name. And if you describe circumstances, please do it in a way that will not allow others to connect these circumstances with any particular person.

Some of the exercises will be photocopied and turned in for CEUs, and others will not. In choosing the exercises required for CEUs, we have avoided those that ask you to describe details of clients' lives. But even the exercises that aren't turned in can present some risk for clients, if someone else happens to find your book. If you write anything here that's confidential, please keep the manual in a private place.

Applying for Continuing Education Credit

At the end of this manual (Page 149) you will find a form that you can use to apply for Continuing Education Units from the Illinois Alcohol and Other Drug Abuse Professional Certification Association. You will need to send photocopies of some completed workbook exercises, the completed Manual Evaluation form, and a check or money order for $5 made payable to GLATTC/UIC, with your application. Instructions are included on Page 147.

OBJECTIVES AND EXERCISES

The purpose of *Healing the Stigma of Addiction* is to prepare you to help heal the stigma of addiction in the lives of your clients, and in our society as a whole. This preparation process can be broken down into several objectives, reflected in the workbook exercises in this manual:

Pre-Manual Exercise: Assess your own beliefs and feelings about addiction, treatment, recovery, and people with addictions *(Page 14)*

PART I: UNDERSTANDING STIGMA

Chapter One: Understanding Stigma

1a. Describe the experience of one client whose life has been negatively affected by this stigma *(Page 23)*

1b. Identify personally meaningful incentives for getting involved in public education for stigma reduction *(Page 26)*

1c. Describe the possible effects on your work, your clients, your community, and society as a whole if addiction weren't stigmatized *(Page 28)*

Chapter Two: Stigma Exists

2a. Describe some of the effects of the stigma of addiction that you have seen *(Page 30)*

2b. Describe some of the ways in which people with addictions have been portrayed on TV and in the movies *(Page 32)*

2c. Identify some stigmatizing terms used in society *(Page 34)*

2d. Identify some of the common stigmatizing myths about addiction and people with addictions *(Page 35)*

2e. Identify some common myths about relapse *(Page 36)*

2f. Answer a brief quiz about addiction, to identify some myths that that may have been conveyed to you *(Page 37)*

Chapter Three: Stigma in the Individual

3a. Identify some emotional reactions that people have in response to some of the behavioral symptoms of addiction *(Page 41)*

3b. Describe some of the symptoms of stigma *(Page 44)*

3c. Describe the effects of isolation, shame, denial, and hopelessness on the progression of substance use and addiction, and on people's willingness and ability to seek help and stay in treatment *(Page 46)*

3d. Identify some steps you are taking or might take to understand the effects of multiple stigmas and stereotypes on your clients *(Page 47)*

3e. Identify some of the effects of stigma on your job satisfaction *(Page 49)*

Chapter Four: Healing Stigma in Treatment

4a. Identify ways in which you might use resiliency theory to help clients heal the effects of stigma *(Page 53)*

4b. Identify ways of helping clients heal the effects of stigma *(Page 54)*

PART II: HEALING STIGMA THROUGH PUBLIC EDUCATION

Chapter Five: Why Public Education Now?

5a. Describe the historical momentum behind the stigma of addiction *(Page 64)*

5b. Describe some effects of the history of stigma-reduction efforts *(Page 67)*

Chapter Six: Building Commitment

6a. Identify some possible benefits of, and obstacles to, your involvement in a variety of public education activities, and how you might approach those activities *(Page 72)*

6b. Identify your own stage of change in stigma-reduction efforts, and address your primary tasks at that stage of change *(Page 77)*

6c. Draft a mission statement for involvement in public education for stigma reduction *(Page 83)*

Chapter Seven: Being an Effective Change Agent

7a. Identify key needs and characteristics of specific audiences for your public education efforts *(Page 87)*

7b. Identify key elements in the effectiveness of specific public education messages *(Page 88)*

7c. Rate your knowledge on a variety of research topics *(Page 89)*

7d. Identify stigma-reduction issues in which you might want to get involved *(Page 91)*

Chapter Eight: Change Agents in Recovery

8a. Describe what you would say to a person in stable 12-Step recovery about self-disclosing his/her recovery status in public education efforts *(Page 94)*

8b. Describe how you would assess the appropriateness of self-disclosure for a newly recovering person and respond to his or her questions about the possibility *(Page 95)*

8c. Identify factors that increase or decrease people's risk of experiencing discrimination if they publicly self-disclose as being in recovery from addiction *(Page 96)*

8d. Rate a number of public education activities for their level of risk for people in early and/or unstable recovery *(Page 98)*

8e. Identify ways in which people can balance involvement in public education for stigma reduction with a focus on personal and spiritual growth *(Page 99)*

Chapter Nine: Making a Plan

9a. Define your personal goals in stigma reduction *(Page 102)*

9b. Write a first draft of a personal plan for involvement in stigma reduction *(Page 104)*

Post-Manual Exercise: Assess how you may have changed in the course of completing this self-study manual *(Page 106)*

Manual Evaluation Form: Assess how well the manual has helped you meet these objectives *(Page 107)*

Pre-Manual Exercise:

STIGMA SELF-ASSESSMENT

This exercise is meant only as an inventory of your own experience with the stigma of addiction and your own attitudes toward addiction and people with addictions. You won't be asked to send this exercise in for CEUs, so please don't try to give the "right" answers. The only right answers to these questions are the ones that are true for you.

Pre-Manual Exercise: Stigma Self-Assessment

1. When you first became aware of addiction, how did the people around you seem to view it? What were people's attitudes toward people with addictions?

   _____

   _____

2. When you were a child, how did you feel about addiction to alcohol or other drugs—and about people with addictions—and why do you think you felt that way?

   _____

   _____

3. At that time, what did you believe about addiction—and about people with addictions?

   _____

   _____

4. As you've grown into the person you are now, what factors have most affected your beliefs about addiction and your attitudes toward people with addictions?

   _____

   _____

5. What do you personally believe is the true nature of addiction?

   _____

   _____

6. How does that affect your work with people who are addicted?

   _____

   _____

7. What effects would you like this manual to have on you?

   _____

   _____

PART I:

UNDERSTANDING STIGMA

CHAPTER ONE:

PUBLIC EDUCATION FOR STIGMA REDUCTION

Here's a riddle for you:

What figment of the human imagination has the power to:

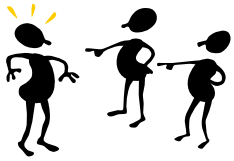
- isolate individuals and families;
- encourage people to deny a fatal illness and ignore its symptoms;
- keep desperately ill people from seeking help;
- block funding for treatment for all but a small fraction of those who need it; and
- persuade society to choose far more expensive alternatives—alternatives like imprisonment; the human and financial cost of accidents and secondary illnesses; and the wholesale loss of human lives, productivity, and potential?

Give up? It's the stigma that we as a society attach to alcohol and other drug addiction—the deep and sometimes hidden belief that addiction is something shameful and that people with addictions are somehow weak willed or morally inferior.

We "learn" the stigma of addiction early in life. We hear its echoes in our families, our schools, our communities, the language we use when we talk about people with addictions, our public policy, and the popular and professional media. And many of us continue to hold it in some forgotten pocket of our belief systems long after we encounter undeniable scientific proof—and flesh-and-blood human evidence—that addiction is a medical condition, and that people with addictions have the full range of human qualities.

What is Stigma?

Erving Goffman, traditionally the best-respected authority on the subject of stigma, defined stigma as "an attribute that is deeply discrediting" and described the stigmatized individual as "a discredited person facing an unaccepting world" (Goffman, 1963). Stigma is sometimes described as an imaginary "stain" that we see on a human being.



We as a species have long used stigma to separate out those whose symptoms or characteristics we fear—in some cases because those characteristics are destructive, and in other cases just because they're different from the norm. Whole bodies of myths and mistaken beliefs have grown up around stigma, to support and justify it.

Central to the stigmatization of one characteristic—like addiction—is the illusion that people who don't have that characteristic are superior, or without significant flaws. "We live in a culture that doesn't accept limitation of any kind,"[1] says Ernest Kurtz, author of *Not God: A History of Alcoholics Anonymous* and *The Spirituality of Imperfection: Storytelling and the Journey to Wholeness.*

Kurtz cautions that the stigma will never really be removed from addiction, and that society's overstigmatization of addiction is a reflection of its fear of the ordinary limitations that all human beings have. However, Kurtz says, "We are all limited beings. Healing means wholeness, and we can find wholeness only by accepting the reality that we are limited."

If the stigmatized characteristics are matters of choice, stigma can sometimes be an effective way of discouraging inappropriate behavior, like the stigma attached to extramarital affairs. But where the ability to choose has been compromised—as in the chronic brain disease of addiction—stigma merely shames and isolates its victims and their families.

As society matures and our expanding knowledge crowds out the myths and mistaken beliefs about addiction, the stigma doesn't always disappear. For many people, it simply goes underground. We may deny the stigma, but it still remains in our subconscious, and it guides many of our choices and emotions.

Stigma and Addiction

As an object of shame, stigma feeds into the forces of isolation and denial that push people deeper into the addictive process and farther away from the hope of recovery. As a social justification for giving up on people, stigma pushes public policy away from a medical response to addiction—and toward what might seem like an easy answer: simply punishing its symptoms.

All this adds up to one thing: Many people who need help are not getting it, even though we have both the technology to treat addiction and a full range of mutual-help networks to support ongoing recovery.

Exercise 1a: One Client's Story

Describe one client who has put off getting professional help out of a sense of shame or guilt about the addiction, or has been denied help because funding or reimbursement was not available. How has stigma affected this person's life and recovery?

_____

_____

_____

_____

_____

_____

_____

_____

Healing the Stigma

If good, scientific information isn't enough to heal the stigma in society, what is?

Think about a client who has long-held negative beliefs that are getting in the way of recovery. It's not enough just to hear from you, or to read in a couple of books, that those beliefs aren't rooted in reality. The client needs to hear the new, positive messages over and over again, from many different people, before the new information can even begin to "tape over" the old messages. The client also needs, not just to hear about hope, but to **see** hope, in face after face, life after life.

It's the same with stigma. Many stigmatized groups—people with mental illness, cancer, diabetes, and disabilities, to name a few—have made good progress in changing the way society sees and relates to them. But in most cases it has taken great and visible effort on the part of both the professional and non-professional communities. It has taken strong change agents, people who are willing to speak out. Professionals, people who have these conditions, and family members have stepped forward to explode the myths and show the real human lives that they hide. Healing the stigma of alcohol and other drug addiction will take the same level of effort.

In simple terms, "public education" is any effort to increase the public's awareness or understanding. Public education for stigma reduction might be thought of as any activity that seeks to:

- Provide accurate information about addiction in place of stigmatizing myths
- Lift some of the social "taboos" against talking about addiction, treatment, and recovery
- Help people understand people with addictions as human beings
- Help people understand that limitation is a normal and ordinary part of being human
- Help people recognize the reality and value of recovery
- Speak out against stigmatizing language, statements, images, or humor
- Help people heal the effects of stigma in their own lives

At one end of the spectrum, public education might be something as simple as mentioning to an acquaintance that you work in a treatment facility, or showing up at a Recovery Month event. At the other end, it might be something as committed as researching and writing a rebuttal to a stigmatizing article in your local newspaper, or getting up in front of a community group to talk about the value of recovery. (We'll look a lot closer at what's involved in public education for stigma reduction in Chapter Six, "Building Commitment.")

This manual is designed to help you find:

- A clearer awareness of the stigma of addiction and a deeper understanding of how it keeps people from getting well
- A public education role that works for you—for the person you are, with the time, talent, and energy you have

The Role of the Change Agent in Social Policy

People who become involved in public education on social issues are often described as "change agents," because they work to help society improve the way it responds to its problems. That's the term that will be used to refer to them in this manual.

When we're fighting something as deeply embedded in the social fabric as stigma is, we need to help people change their attitudes, perceptions, beliefs, feelings, and behaviors. But because people's responses are so often influenced by the social structures around them, this change process sometimes requires that the structures themselves change.

There are many hearts and minds that we won't be able to reach until some of the informal and formal policies that surround them send a clear message that addiction is a medical condition, that it should be treated rather than punished, and that people with addictions are human beings worthy of respect. Informal policies include families', institutions', and communities' values, standards, and norms around responses to people with addictions. Formal policies include local, state, and federal laws, and the many licensing and other regulatory functions they cover.

Change agents who work in treatment and related fields play two separate roles, both very important: 1) as employees of agencies, many of which receive federal funds; and 2) as private citizens. This is an important distinction to make, because the law says that federal funds cannot be used for "lobbying," which might be described as any attempt to 1) directly influence lawmakers or their employees on specific legislation or appropriations, or 2) appeal to the public to contact their elected representatives to voice their support for or opposition to specific measures or otherwise influence their votes.[2]

1. In the first role, if you're "on the clock" working for (and/or using expense money paid by) an organization that uses federal funds, you can educate the public—which includes lawmakers and policy makers—on the general issues, but you can't speak out in favor of (or against) specific legislation. For example, as part of your agency role, you could write an article or make a speech about the need for and effectiveness of treatment and the importance of making treatment available to more people, but you couldn't name a specific law on treatment availability and ask people to support it.
2. In your "before-and-after-hours" role, you can address specific legislative issues, if you choose to do so. As long as you are clearly not representing your federally funded agency, and you don't charge your agency for any of the time or money you put into these activities, you're free speak or write about these issues. But you need to keep the boundary between those two roles clear and uncompromised at all times.

Why Become a Change Agent?

Most people in the addiction treatment field understand that the stigma of addiction causes problems. But why do some people take it a step farther and get involved in public education? Why do they go beyond the scope of their everyday jobs and lives—and in some cases step outside their comfort zones—to say things that others might find it hard to hear or understand?

For many people, compassion for the suffering client or family member is a strong enough incentive to fight the stigma that keeps many people from getting the help they need. But there are other, more personal and professional incentives as well. Here are just a few:

1. Reductions in funding and drastic loss of insurance reimbursement have kept people out of treatment and wiped out treatment jobs and entire treatment organizations.
2. Some of the stigma associated with addiction has attached itself to the treatment field itself, and to the treatment professional's role.
3. Many public education efforts have a strong positive emphasis and bring new people and activities into your life. They can breathe new life and optimism into your career and help fight burnout.
4. As stigma-reduction efforts succeed, people will be less afraid to seek treatment. Some clients will have better access to treatment, and to the levels of treatment they need to succeed. Greater success can bring a greater sense of purpose and satisfaction.
5. If the treatment field doesn't define addiction and recovery for society, others who have less knowledge and compassion will do it instead, as they have been doing for centuries.

6. Taking responsibility for stigma reduction is an important part of taking professional responsibility for the success of the field and the well being of the client population.

In the end, the difference between a change agent and one who chooses to remain silent might be just a matter of motivation, willingness, confidence, courage, or the help of other people who can inspire and encourage us.

Exercise 1b: Incentives for Stigma-Reduction

Pick three of the six incentives listed above (or others that aren't listed) that seem important or meaningful to you, and tell why you find them important.

____ Why?_____

_____

_____

____ Why?_____

_____

_____

____ Why?_____

_____

_____

Why Now?

In *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, William L. White (1998) has traced the long, slow path of the political pendulum back and forth between medical and criminal justice responses to people with addictions. History makes it clear that the pendulum's path is a wide one. The current trend toward moralization and criminalization of addiction is not likely to end soon without strong involvement by treatment professionals, people in recovery, and family members who understand addiction.

But many of the arguments for getting involved in public education **now** are positive ones:

- New structure and recommendations for effective public education are now available in the Stigma Reduction section of *Changing the Conversation*, CSAT, SAMHSA's newly released National Treatment Plan (summarized in Appendix C, Page 133). Among other measures, the Plan recommends applying social marketing principles to the challenge of changing society's attitude toward addiction. Social marketing is the science that uses commercial advertising and marketing techniques to bring about social change.

- We have better information to offer, including a wealth of hard evidence that addiction is a medical condition. Research into the neurochemistry of addiction is providing scientific data to back up the traditional wisdom of the field, and technological advances have given us visual proof of the effects of addiction on the brain. "Translated" research that's easy for non-researchers to use is also becoming available on a wider scale from a number of organizations, including the National Addiction Technology Transfer Center Network, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism.

- Nineteen regional centers have been set up to organize and empower recovering people and their families in public education efforts. These centers are funded by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (CSAT, SAMHSA) under the Recovery Community Support Program.
- The 13 regional ATTCs and the National ATTC are producing and providing more and more resources to support change agents, conducting training programs on this and related issues, and becoming involved in a number of stigma-reduction initiatives[3]
- The momentum is building. According to White (2000), we're witnessing the birth and rapid growth of a new and diverse recovery movement nationwide. "Collectively, these communities without boundaries are expanding local recovery support services, advocating for the needs of addicted and recovering people, and finding creative ways to make amends and carry hope to others."

The Opposite of Stigma

If you're being asked to help reduce stigma, what are you being asked to promote? What is the opposite of stigma? Some possibilities:

- Widespread acceptance of the truth about addiction
- Acceptance of the fact that human beings all have limitations
- Self-respect, self-esteem, dignity, and humanity
- Honest compassion for people with addictions and their families
- A human face applied to addiction and recovery, instead of the old caricatures of addiction
- Recognition of the courage it takes to make the transition into recovery
- A sense of wonder at the reality of recovery in so many people's lives
- A recognition that people in recovery are normal, everyday people who live, love, work, play, pay taxes, and vote

If stigma is so often born out of pain and negative experience, perhaps its opposite is best born out of hope and confidence. This manual is meant, not to stigmatize stigma or to point the finger at those who hold it, but to offer something more accurate and useful to put in its place. Please join in this effort. Whatever you're willing to contribute will move us farther away from stigma, and closer to an honest understanding of addiction.

Exercise 1c: Life Without Stigma

1. What do you believe is the opposite of the stigma of addiction?

   _____

   _____

   _____

2. Remember the client you described on Page 23? Describe how that client's pre-treatment, treatment, and recovery experience might have been different if addiction weren't stigmatized in our society.

   _____

   _____

   _____

3. How might your job be different without the stigma attached to addiction?

   _____

   _____

   _____

4. How might the community you serve be different without the stigma attached to addiction?

   _____

   _____

   _____

Notes for Chapter One

[1] Interview with Ernest Kurtz.

[2] CSAT/SAMHSA's March, 2001 *Recovery Community Organization Development and Community Organization Program (Guidance for Applicants)* defines the federal boundaries for "lobbying" as follows: "Federal law prohibits grantees from using Federal funds or lobbying activities to influence legislation or appropriations pending before Congress or any State legislature. This prohibition includes directly lobbying Congress or State legislators on such matters, or 'grassroots' lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate support for or opposition to pending legislation or to urge those representatives to vote in a particular way."

[3] See the reprint of the National *ATTC Networker* article on stigma reduction in Appendix D, Page 135.

CHAPTER TWO:

STIGMA EXISTS

Much of the power of addiction comes from its ability to convince the sufferer—and often the surrounding family and social structures—that it's not there. *This is normal adult behavior,* it says, or *the real problem is something else. If only **that** problem would go away, the drinking and drugging would stop.*

Stigma is equally clever. In its more obvious forms, it feels like an honest recognition of bad behavior that has to be controlled or punished. In its more subtle forms, it tells us it's gone: We know the facts now; We no longer attach any stigma to the medical condition we call addiction. But many of us in the field still assume that people who aren't familiar with treatment or recovery will feel awkward or judgmental if we talk about our connection with alcohol and other drug addiction, and sometimes we're more comfortable if we can avoid the subject.

It's true that client and family denial systems are organized to protect the alcohol and other drug use. But stigma often serves as fuel for denial: *I **can't** be an alcoholic or an addict, because I can't be anything that horrible.*

It's also true that the policy decisions that criminalize addiction often come out of a belief that these are fiscally responsible choices. So do the healthcare management measures that restrict access to treatment. But it's often the stigma of addiction that helps people feel justified in making these choices—and makes it all seem reasonable to the voting public.

Stigma has deep roots in our society and profound effects on our ability to help people find and hold onto recovery. The beginning of our journey toward stigma reduction might be similar to the first step in many people's recovery from addiction—a deeper knowledge that the problem exists, and a broader awareness of all the ways in which it shows itself.

Stigma in a Complex Society

In a society that stigmatizes many circumstances, people often link the stigma of addiction with the stigma they attach to race, culture, socioeconomic status, educational history, criminal history, mental health history, and family history. Whole patterns of mythology have grown out of these often-imaginary connections. Some cultures also hold higher levels of stigma and shame around addiction, making it harder for members of these cultures to accept the reality of addiction and get help.

Stigma also attaches itself more effectively to some substances-of-choice than to others. In many circles, the word "alcoholic" conjures up milder images and emotions than does the term "drug addict," in spite of the similarities in the way the brain becomes addicted to these substances. People who are addicted to illegal drugs are subject to more shaming and discrimination than are people who are addicted only to alcohol.

Even among the illegal drugs, there are often strong differences in stigma depending on the damage they do, and on the racial and socioeconomic images that are associated with them in the public eye. For example, think of the most common images of a "cocaine addict," and then think of the most common images of a "crack addict." How would you describe some of the differences between those two sets of images, and people's attitudes toward them?

_____

_____

_____

_____

Like addiction, stigma is slippery: It can't be captured in a simple formula.[1] The next chapter will address the complexities of stigma in the individual, but first the current chapter sets the stage by looking at some of the ways in which stigma shows its face, including:

- Images in the popular media
- Stigmatizing language
- The mythology of addiction

Exercise 2a: Examples of Stigma's Effects

Give five examples of the effects of stigma that you've seen in the past month.

1. _____
2. _____
3. _____
4. _____
5. _____

Stigma in the Media

A television host is interviewing a long-famous and much-revered actor on the craft of acting. Talking about an early film in which he played an alcoholic, the actor says a few words on what his character was facing as an alcoholic, and adds, "which I am, by the way."

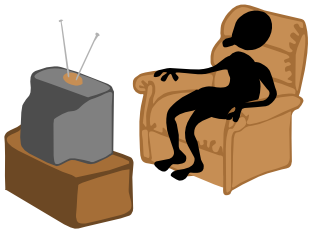
The host does a quick double-take and says, "You mean [your character] is an alcoholic." The actor clarifies it, simply and directly: "**I'm** an alcoholic." After a second's silence, the host changes the subject.

Stigma in the popular media isn't limited to the more blatant images and information we've grown used to over the years, including:

- One-dimensional dramatic portrayals of people with addictions as "skid-row bums" or "crazed druggies"
- The large-scale writing and casting of people of color as low-income, criminally involved people with drug addictions
- Caricatures of drunk or drugged behavior used to make fun of people with addictions
- The news media "feeding frenzies" that often take place when a public figure is found to suffer from addiction or to have used drugs in the past
- Popular books and web sites that declare that there's no such thing as addiction, and that all that's needed is a better way to develop will-power
- The media's eagerness to adopt highly stigmatizing terms like "crack babies," and to sensationalize these kinds of conditions

One example of a more subtle image not intended to do harm might be the cover of a 1997 *Time* magazine article on addiction. The article itself was well researched and informative, but the cover showed a grotesque cartoon of a giant fish head, its mouth caught on a giant hook (Nash, 1997). The cartoon illustrated the headline ("How We Get Hooked"). But indirectly, it also associated the person who has an addiction with a great big ugly fish.

The fact that it's more subtle doesn't make an image or stereotype any less powerful. In fact, it may be more powerful because we're less aware of its presence. How can we filter out something we don't notice? How can we use our knowledge and logic to analyze thoughts that we don't know we're having?



Like it or not, many people consciously or unconsciously let the popular media influence their images and opinions. The media depend on sales for their livelihood, and sales depend on the level of attention that an article or program draws. And few things grab our attention as effectively as drama, accusations, and exaggerated stereotypes.

If the stigmatizing images and information were balanced out with accurate and multi-dimensional material, it would help. But well thought-out books, articles, and dramatic roles have been slow in coming to the popular media. As change agents, we can't keep the media from publishing stigmatizing material, unless it violates specific laws. But we can challenge the stigmatizing material in public, and we can educate the media in the need for:

- The publication of complete, accurate information
- Calm, thoughtful, and balanced responses to public situations that involve addiction
- Sensitive and multi-dimensional portrayal of people with addictions
- More widespread and more accurate portrayal of people in successful recovery

Exercise 2b: Stigma and TV/Movie Characters

1. Name six TV or movie characters you've seen who show people with addictions in ways that are shallow, stereotypical, exaggerated, and/or one-dimensional:

   _____ _____

   _____ _____

   _____ _____

2. Name six TV or movie characters you've seen who show people in active addiction in multi-dimensional ways, showing (for example):

   - The humanity of the character (generosity, intelligence, love, dignity, etc.)
   - The complexity of the character's relationships
   - Some of the character's inner struggles around values, conscience, etc.

   _____ _____

   _____ _____

   _____ _____

3. Name six TV or movie characters you've seen who show people in successful recovery, including:

   - Successful coping with life problems without returning to use of alcohol/drugs
   - Healthy use of support systems (groups, friends, and/or faith communities)
   - Healthy functioning in work, family, social, and community life

   _____ _____

   _____ _____

   _____ _____

4. Compare how easy it was to answer these 3 questions. What does that tell you?

   _____

   _____

   _____

Stigmatizing Language

What do we call something that destroys people's lives? How do we talk about people who are compelled to betray social values—and their own deepest values—again and again? The temptation is to use the strongest words we can find, to somehow capture the tragedy and the absurdity of the situation.

The problem is that we're so impressionable: The words we use to describe someone or something often have profound effects on our images, attitudes, and beliefs. As we know from labeling theory—and from watching the world around us—words are very powerful. Get enough of them together, and they can make the difference between hatred and forgiveness, between alienation and belonging, between giving up and trying again.

First let's get some of the openly stigmatizing terms out of the way: Drunk, souse, junkie, rummy, boozer, lush, dope fiend, pot-head, crack baby, wino, speed freak, and so on. History has provided a long list of these and other colorful terms (like "rum-sucker"). These terms often carry society's anger and disgust toward people with addictions—and the anger and disgust that many people with addictions direct toward themselves. These terms may not be "politically correct" in some circles, but they haven't fallen out of use.

However, when we talk about stigma, we're always talking about two layers—the obvious and the subtle. Subtle stigmatization can be just as effective in language as it is in images and stereotypes.[2]

Most of the people interviewed for this manual identified the term "substance abuse" as a stigmatizing term when it's used as a substitute for "addiction" or "chemical dependency." Clearly there is such a thing as substance abuse, but many people who aren't addicted also abuse alcohol and other drugs, and addiction isn't just an extreme form of substance abuse. As a matter of fact, in order to meet the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, 1994) diagnosis for a substance abuse disorder, a client's symptoms must never have met the criteria for a diagnosis of Substance Dependence. So according to DSM-IV, people with substance abuse disorders aren't addicted.

It's important to clarify the difference between abuse and addiction:

- **Abuse** is use of alcohol or other drugs that leads to negative social consequences, and to negative consequences at work, at school, at home, or in the legal system.
- **Addiction** also has negative consequences, but in addiction the use has become compulsive. It is often marked by increased tolerance to the drug and withdrawal symptoms when the drug isn't present.

Some interviewees also pointed out that people with addictions aren't actually abusing the alcohol or other drugs, but rather being abused by these substances. The neurochemical effects of addiction have taken away their ability to "just say no," and the chemicals they feel compelled to use are damaging their bodies and intensifying their compulsion to use.

Here's another complication: Words are absorbent. They tend to take on the emotions and connotations of the situations associated with them, as an apple wrapped up with an onion will start to smell like an onion. When words are linked with toxic situations, they grow toxic. The word "abuse" is a good example of this, because that word is so often linked with acts of violence or destruction against others who are weaker or more vulnerable.

Addiction creates painful situations that raise intense shame, fear, anger, and guilt. How many of the words linked with addiction might have grown toxic from their association with it? Each person's experience is also different, so a word that might feel harmless or even healing to one person might feel humiliating to another. When we're speaking to someone we don't know well, how can we know the impact our words will have? One way is to ask.

Exercise 2c: Stigmatizing Language

Interview a stable client* or recovering person about the language used to refer to addiction and people with addictions. For each term, ask the person to describe:

- The situations in which he or she heard it used, as a child and later in life
- The people who used it, the emotions in their voices, and how it feels to hear it now
- The people that term was used to describe, and their feelings toward those people

1. Which terms raise the most negative feelings and images for this person, and why?
   - _____
     _____
   - _____
     _____
   - _____
     _____

2. Which terms are most comfortable for this person, and why?
   - _____
     _____
   - _____
     _____
   - _____
     _____

3. What was the most important thing you learned in doing this interview?

   _____
   _____

*"Stable client" here refers to someone who is able to answer these kinds of questions without experiencing an emotional setback that will interfere with treatment or sobriety.

The Mythology of Addiction

For all we know about it—even now that we understand the way it changes the brain—addiction still holds a lot of mystery. And one thing we humans tend to do when we run into something mysterious is to develop myths to explain it. These myths form a framework to hold all the words, images, and feelings that carry stigma from person to person.

As mentioned earlier, a central myth about addiction is that it doesn't exist, that it's just a moral weakness or a failure of will power. But many other myths cluster around that larger myth, and many of them can exist even among people who understand addiction as a chronic medical condition.

Exercise 2d: Common Stigmatizing Myths

What are some myths you've heard that are related to addiction or people with addictions?

- _____
- _____
- _____
- _____
- _____

Myths About Relapse

Some of the most common myths have attached more than a little stigma and shame to relapse. These myths are often widely accepted, even in many recovery circles, and in some treatment organizations. Another problem is that the term "relapse" is often applied to return to use among people who may have been abstinent, but haven't really achieved sobriety.

One central myth here is the belief that people with addictions should be ready, willing, and able to do whatever it takes to get sober as soon as they get into treatment or recovery groups. This ignores all we've learned about the effects of addiction on the brain, and about the slow development of human motivation in change processes.

Symptoms of post-acute withdrawal syndrome can seriously impair the client's cognitive ability to do the hard work of treatment and recovery. For the first six months to two years of abstinence from mood-altering substances, many people have trouble with problem solving, memory, understanding, concentration, stress management, depression, and unpredictable emotional states. This can make it hard to make a firm commitment to sobriety and stick to it.

We also know from motivational theory that even people whose brains are functioning well can't always make major life changes simply because it makes sense to change. The decision to change, and the ability to change, develop slowly and progress through a number of stages. Many clients are introduced to treatment in the early stages of change (precontemplation and contemplation), and haven't yet gone through the developmental processes that will eventually prepare them to accept treatment and recovery.[3]

Another common myth is the belief that recovery is an unbroken line that doesn't start until the person has had his or her last drink or drug. For some people, it has been an unbroken line. But for others, recovery seems to come in waves, with each period of recovery building a little more skill and conviction, and each period of return to use bringing more negative consequences. The problem is, of course, that many people die during these return-to-use periods and never get another chance at recovery.

Attaching stigma to relapse may have started in society as a way to discourage it—and in some cases fear of that stigma may motivate people to get more help to stay sober. But sometimes the stigma only makes it harder for people to ask for help again after they've been "out there."[4]

Exercise 2e: Relapse Myths and Stigma

1. What are some of your thoughts and feelings about relapse myths and stigma?

   _____

   _____

   _____

2. Describe one client who returned to use after receiving treatment, but in your opinion hadn't really achieved recovery.

   _____

   _____

   _____

3. What would you say to this person if he or she told you he or she was afraid to return to treatment because of the "relapse"?

   _____

   _____

   _____

Facts are often the best tools for dispelling myths—if we have the patience to seek out the information. The addiction quiz shown below is one way to test your own knowledge of some of the facts about addiction. The answers will be given later in the manual.

Exercise 2f: Addiction Quiz

1. What is the rate of recovery for people who have both treatment and recovery group attendance? _____%
2. What percentage of children of addicted families become addicted? _____%
3. What percentage of people with heroin addiction are employed? _____%
4. Does addiction treatment have the same rate of success as treatment of other chronic illnesses? Yes No
5. Which has most successful treatment: Hypertension Addiction Asthma
6. Cocaine addiction has a lower rate of recovery than other addictions: True False
7. People won't get into recovery until they're ready: True False
8. Coerced treatment doesn't work: True False
9. Drug abuse rates are higher in African-American communities than they are in Caucasian communities: True False

Now that you've taken a quick inventory of some of the ways in which stigma shows up in society, it's time to look at how it operates in human hearts and minds. The next chapter focuses on stigma in the individual.

Notes for Chapter Two

[1] Some change agents in the fight against stigma use the acronym "SPAM" as code for "stigma, prejudice, and misinformation."

[2] For in-depth discussions of the language used to refer to addiction and people with addictions, see some of the articles by William L. White listed in the Bibliography, most notably "The Lessons of Language: Historical Perspectives on the Rhetoric of Addiction."

[3] More information on the stages of change (as they relate to the decision to get involved in public education) is included in Chapter Six, "Building Commitment." Some excellent resources on motivation and change are also listed in the Bilbliography. These include *The Change Book*, published by the National ATTC Network; *Motivational Interviewing: Preparing People to Change Addictive Behavior*, by William Miller and Stephen Rollnick; and the *Technology Transfer Journal* and *Implementation Journal* being developed for GLATTC by The Change Companies.

[4] Many excellent tools are available to help clients address their relapse-prevention issues in practical and non-shaming ways. Some (by Terence T. Gorski) are listed in Appendix A.

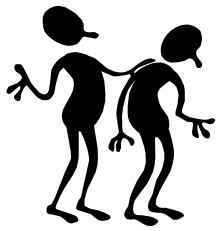
CHAPTER THREE:

STIGMA IN THE INDIVIDUAL

It's hard to deny the presence of stigma in our society, but easier to deny or overlook it in ourselves. However, its effects range from troubling to tragic. Take for example:

- The woman who struggles unsuccessfully with addiction instead of seeking treatment, fearful of asking for help for something that feels so shameful and bad
- The family member whose senses of hope and compassion have dried up, lost in the flurry of conflicting thoughts and emotions that his loved one's addiction has inspired
- The front-line clinician burned out by daily exposure to the painful effects of addiction
- The policy maker grappling with choices about funding and services for a condition that she was raised to believe is little more than a moral lapse

Stigma is not just a political problem, to be addressed through public education efforts. It's also a psychological problem, to be understood and addressed in treatment, recovery, and family and community healing processes. This chapter is about all of us as individuals—clients, clinicians, family members, community members, policy makers—human beings. It looks at stigma from five perspectives: the psychological seeds of stigma, stigma as a defense structure, the impact of stigma, factors that can compound the stigma of addiction, and stigma's effects on treatment professionals.



The Seeds of Stigma

Stigma clearly includes learned beliefs, images, and words, but it's not just something we learn. It's also a psychological reaction to an experience, the experience of someone else's addiction. Stigma meets some psychological needs that arise when we're exposed to the effects of addiction. It's unlikely that even the best-taught stigma would grow such strong roots in people's hearts and minds if it didn't resonate with our own needs and experience.

The experience of being exposed to someone else's active addiction is a complex one that deserves a manual all its own. But we can start to talk about that experience in terms of three conditions: pain, ambivalence, and fear.

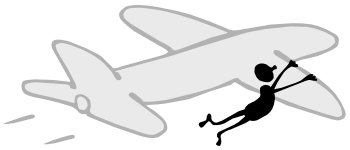
Pain

When people are active in addiction, they're being driven by powerful urges deep within their brains, and their higher thinking centers are being impaired by the addictive substances and the damage those substances have caused (Leshner, 1997). Sometimes people do things that violate their own values and the values of their families, cultures, and communities. The words and actions of people in active addiction sometimes bring pain to themselves and the people around them. For example, people might:

- Fail to fulfill important responsibilities or show up for important events
- Take money or valued possessions from people they love
- Overreact to minor mistakes with extreme anger or coldness
- Withhold signs or expressions of love or respect
- Neglect or abuse people who are important to them, including their children
- Drive recklessly, endangering their own lives and the lives of others

Ambivalence

For concerned friends, colleagues, and loved ones, the behavior of people in active addiction often doesn't make sense. What's worse, it produces quite a few conflicting emotions. On the receiving end of the symptoms of addiction, we may feel many ways at once, including:



- Loving
- Concerned
- Sympathetic
- Fearful for the person with the addiction
- Fearful for ourselves or others we love
- Helpless in the face of something we can neither control nor understand
- Sad, grieving the relationship we could have had
- Angry at the person with the addiction
- Angry with ourselves for being angry
- Angry with ourselves for putting up with the effects of the addiction

Fear

Most people don't like pain and ambivalence. We fear those conditions, and we tend to associate that fear with the people and experiences that inspired them. We may feel a need to create distance, to construct defenses that will protect us from pain and ambivalence.

Most of us also fear the limitations that we all have as human beings. When we see someone whose limitation is so pronounced—in this case, the inability to drink normally or stay away from other drugs—it might remind us of our own limitations, even if those limitations are different. This creates discomfort. If we can make this person a symbol of limitation and create some distance between us, we might be able to forget that we, too, are limited human beings.

Exercise 3a: The Experience of Someone Else's Addiction

Think about a client (or former client) who is (or was) in active addiction, showing some of the behavioral symptoms of that condition.

- How did this person's words or actions cause pain for you or other people in his or her life?

  _____

  _____

- What conflicting emotions did you or others in the client's life experience in response to his or her words or actions?

  _____

  _____

- What fears did you or others experience as a result of relationships with this client?

  _____

  _____

Stigma as a Defense Structure

Stigma might be thought of as an elaborate defense structure against pain, ambivalence, and fear. Four major components of stigma—myths, stereotypes, disapproval, and discrimination—might be thought of as logical forms of defense against pain, ambivalence, and fear.

Myths and Stereotypes

Both developmental psychology and the history of mythology teach us that people tend to make sense of a complex and confusing world by designing simple and often symbolic explanations of the way things are. If we can adopt and believe a simple explanation, it can go a long way toward reducing the anxiety and ambivalence associated with a complex experience. Myths and stereotypes also reduce their objects to a set of simple (and often negative) characteristics, thus giving us a sense of psychological distance and manageability.

Perhaps the central myth about addiction is that people engage in addictive behavior because they're weak willed or morally inferior. On the surface, it makes sense: People with addictions sometimes violate their moral codes and lose their will to quit or cut down on addictive substances. Addiction must have some connection with will and morality. The oversimplification here is the decision to attribute the **cause** of the addictive behavior to a lack of will power or morality.

From that central myth fan out a host of other myths, things like:

- Once a junkie, always a junkie
- They could quit if they wanted to
- Treatment doesn't work, and nobody really recovers

Disapproval

Like myths and stereotypes, disapproval also serves to separate the person holding the stigma from the object of that stigma. The very act of making the judgment separates the one perceiving from the one being perceived, and so gives the perceiver a feeling of greater emotional distance and psychological safety. The fact that the judgment is negative makes the distance even wider. There's also the element that, when we've been hurt, it often feels satisfying to disapprove of the people who have hurt us.

For the concerned friend, family member, employer, or community member, disapproval of the person in active addiction may also feel like an act of service to that person, undertaken for his or her own good. After all, disapproval is a common way of discouraging unwanted behaviors in our society. If the addictive behavior were voluntary, disapproval might be an effective way of correcting it. There's only one problem: When addiction has damaged people's ability to control their behavior, disapproval isn't going to restore that ability. No matter how "right" it feels to act disapproving, it simply doesn't help the situation.

Discrimination

Whatever else discrimination might be—a political move, a convenient way of redirecting scarce resources—it can also serve as a defense against the need to face complex and difficult issues. For example:

- If the community keeps the recovery home out of the neighborhood, community members might feel safe from their confusion and ambivalence, safe from the stereotyped images that frighten them.
- If policy makers withhold needed funding from addiction treatment, they don't need to justify increased spending to voters who tend to think in terms of substance abuse rather than addiction—and consider it all a criminal justice issue.
- If addiction treatment and mental health providers stay in their own separate worlds and avoid the difficult and messy process of collaboration and cross-training, they don't have to face the cross-stigma that each field still holds toward the other's clients.
- If a residential treatment center or a recovery home sticks to its policies against allowing residents to be on methadone treatment, staff members don't have to look at their own tendency to stigmatize methadone and methadone patients, or their need to learn more about medical interventions in addiction treatment.
- If an addiction treatment program continues to kick out clients who are having trouble staying abstinent, staff members don't have to face their own discomfort with the difficulties that some clients experience in the struggle to recover.

In these examples, discrimination is another agent of separation, creating more distance from people whose circumstances are challenging and disturbing.

Exercise 3b: Symptoms of Stigma

Think of someone you know who stigmatizes people with addictions, on conscious or unconscious levels. This might be you, a client, a family member, or anyone else.

- What myths or stereotypes does that person believe?

  _____

  _____

  _____

- How does that person show disapproval of people with addictions?

  _____

  _____

  _____

- How does that person discriminate against people with addictions?

  _____

  _____

  _____

The Impact of Stigma

For the person with an addiction who becomes the object of stigma, its impact is very real and very tangible. Four of its strongest effects are isolation, shame, denial, and hopelessness.

Isolation

If stigma is designed to create distance, it often succeeds at this task. Propelled by myths, stereotypes, disapproval, and discrimination, many people with addictions are pushed into isolation. Faced with disapproval and discrimination by non-addicted society, many seek out the company of the only people who seem to understand them—others who share their addiction.

This isolation from the non-addicted world may be emotional, rather than physical. In either case, isolation often becomes a breeding ground for addictive patterns of thought, emotion, and behavior. The force of society's disapproval pushes people farther into their own shrinking world. They're caught in a vice between society's rejection and the chaos, fear, and compulsion that await them in the addictive process.

Shame

In some ways the word "stigma" is almost synonymous with shame. Shame is the loudest message that the myths, stereotypes, disapproval, and discrimination carry. It's both a natural consequence of isolation and a force that propels people deeper and deeper into isolation.

If addiction were simply a collection of purely voluntary behaviors, shame might be an effective clinical tool, a sort of social behavior-modification technique. But instead, addiction is a chronic condition of the brain whose symptoms include an overwhelming urge to use alcohol or other drugs (Leshner, 1997). Shame isn't strong enough to defeat that urge, but it is strong enough to destroy people's:

- Sense of hope in their ability to recover
- Knowledge of their own value as human beings
- Belief in their own dignity

In a 2001 survey of people in recovery, 40 percent of the survey respondents identified shame as a significant obstacle to recovery (Hart, 2001).

Remember: People with addictions were raised in the same world as everyone else. Before they became addicted, they probably stigmatized addiction just as strongly as the rest of society. If they were raised in addicted families—and genetic factors make this a good possibility—they may have stigmatized addiction even more strongly than most people. The experience of being addicted didn't eliminate the stigma, but instead turned it inward—one more weapon to use against themselves.

Denial

For the person who's on the receiving end of the myths and stereotypes associated with addiction, those myths often set up a simple logical argument:

> Addicts are bad people ➔ I'm not a bad person ➔ I must not be an addict ➔ If I'm not an addict, I don't need help

This argument forms the skeleton of what the addiction field and the recovery community most often call "denial."[1] In the 2001 Hart & Associates survey, 60 percent of respondents identified denial as a significant obstacle to recovery (Hart, 2001). Stigma may not be the only contributor to denial, but it's often a significant contributor. Many people avoid admitting their need for help—even to themselves—because they desperately don't want to be linked with anything as shameful as they believe addiction to be.

The argument can twist the other way, too:

> I'm an addict, and addicts are bad people ➔ I must be a bad person ➔ If I'm a bad person, I don't deserve any help

Trapped in the addictive process, some people can bounce back and forth between these two arguments for years.

Hopelessness

As mentioned earlier, stigma, shame, and limiting negative stereotypes are tailor-made to destroy people's hope in their ability to recover. For many people, the effects of discrimination further compound the experience of hopelessness.

When people do find the courage to face the truth and seek help, the kind of help they need may not be available. The forces of stigma have been working on the other side too, to limit the availability of treatment and the funds available to pay for it. Consider the examples of discrimination given in the last chapter, and think of their effects on people's ability to hope, including:

- The newly recovering woman who needs a recovery home but can find homes only in run-down, drug-filled, unsafe neighborhoods
- The uninsured man who's struggling to get into publicly funded treatment, finds out he isn't among the prioritized populations, so he'll have to join the end of a long waiting list—and learns that his highest chance of gaining access to (limited) treatment would be through the criminal justice system
- The pregnant woman who needs residential treatment but finds that there are nowhere near enough treatment slots for pregnant women
- The man who needs long-term treatment, but whose health insurance policy covers only detoxification or short-term treatment services
- The woman who has been treated for addiction by providers who didn't know how to address her other mental disorders effectively, and has been turned away from mental health treatment because she isn't abstinent from alcohol and other drugs
- The methadone patient who needs residential treatment or a placement in a recovery home, but who can't find a facility that will take methadone patients
- The man with multiple problems and deeply entrenched addictive patterns who's been kicked out of treatment because he hasn't yet been able to achieve abstinence
- The woman with HIV/AIDS who needs a recovery home or residential treatment, but who fears being stigmatized by other clients and providers for her HIV/AIDS, because she must keep her medications refrigerated, and the facility has only one central refrigerator

In each of these cases, the systems that were meant to provide hope and help have failed due to the effects of stigma and discrimination. To the person who has finally summoned up the courage to ask for help, this might feel like a significant betrayal of trust.

People in active addiction have well established patterns when it comes to coping with isolation, shame, hopelessness, and betrayal: Self-medication with alcohol or other drugs.

So the disapproval and discrimination that are meant to discourage addictive behavior have quite the opposite effect: They push people farther and farther into their addictive patterns.

Exercise 3c: Isolation, Shame, Denial, and Hopelessness

Think of a client (past or present) who is or was experiencing isolation, shame, denial (or lack of insight), and hopelessness.

- Describe the effects of isolation on this client's ability to seek and accept the amount of help needed.

  _____

  _____

  _____

- Describe the effects of shame on this client's ability to seek and accept the amount of help needed.

  _____

  _____

  _____

- Describe the effects of denial this on client's ability to seek and accept the amount of help needed.

  _____

  _____

  _____

- Describe the effects of hopelessness on this client's ability to seek and accept the amount of help needed.

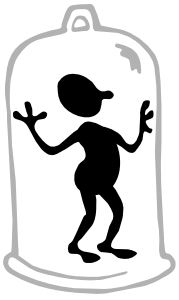
  _____

  _____

  _____

Factors That Can Compound the Stigma of Addiction

The stigma of addiction may be a symbol of shame and failure, but it lives in a society that has laid out many symbols of pride and shame, success and failure, high and low status. People are often looked down on for ethnic or racial characteristics; for physical or psychiatric illnesses or disabilities; for their religion; for their gender or sexual orientation; for their family circumstances; for being too old or too young; for their educational levels; for involvement with criminal justice, welfare, or child custody systems; for their experiences as victims of violence or abuse; and for their occupational or financial status.



With all the stigmas and stereotypes and hierarchies that crisscross our society, many people with addictions carry the burden of more than one stigma. Some cultural images—those of Native Americans or Irish, for example—also include a higher physical vulnerability to alcoholism. Sometimes multiple stigmas can lock society even further into its judgment and preconceived notions—and lock people with addictions even further into feelings of worthlessness and hopelessness.

Stigma's effect is compounded when racial and economic stereotypes and discrimination change the circumstances of people's lives. When some police officers, judges, and jury members tend to associate addiction, substance abuse, and crime with low-income and impoverished people of color—particularly young African-American men—the result is the arrest, conviction, and imprisonment of disproportionately high numbers of people of color. For example, according to Mauer and Huling (1997), "While African Americans constitute 13% of all monthly drug users, they represent 35% of arrests for drug possession, 55% of convictions and 74% of prison sentences." Here addiction is clearly not being addressed as a medical condition in need of treatment, but rather as a crime in need of punishment. [2]

It would take another entire manual to map out the interweaving effects of the many forms of stigma, and even that wouldn't tell you what the experience is like for an individual client. For example, for one person the intersection of racial or ethnic stigmas and stereotypes with the stigma of addiction might create a sense of shame and hopelessness that's greater than the sum of its parts. For another person, the same profile might breed a determination to succeed in spite of others' expectations, and cultural strengths might prove more powerful than the effects of prejudice.

We also need to know how deeply the stigma of addiction is rooted in the cultures in which the individual has developed. For example, in many Latino cultures addiction in one family member is considered a mark of deep shame that is shared by the entire extended family. How much more intense might the shame and denial run in someone who has been raised with that belief—and in the surrounding family system?

The best way to grasp an individual's experience of multiple stigmas is to listen as deeply and as openly as possible. Only when we learn about one person's experiences of shaming and discrimination—as well as the sources of strength and resiliency in his or her life—can we begin to see that person's experience clearly.

Exercise 3d: Understanding the Effects of Multiple Stigmas

1. If you had to guess, what percentage of the people you serve are:

____% women or girls	____% African American
____% youth	____% Native American
____% elders	____% Latino
____% gay, lesbian, or bisexual	____% offenders or ex-offenders
____% people who are HIV positive	____% survivors of abuse

____% people with other psychiatric disorders
____% people with physical, cognitive, or learning disabilities
____% people raised in addicted families
____% people in low socioeconomic groups, and/or on welfare
____% parents of children in child custody systems

Exercise 3d (Continued)

2. Pick three groups that you've given high percentages in question 1, groups that you've also never been a member of. What steps have you taken to understand better the effects of stigma on the experience of being in each of these groups?

   Group: _____ Steps you've taken: _____

   _____

   Group: _____ Steps you've taken: _____

   _____

   Group: _____ Steps you've taken: _____

   _____

3. What's another step you can take to understand the depth and complexity of these experiences, or the experience of living with multiple stigmas?

   _____

   _____

Stigma's Effects on Addiction Professionals

If addiction somehow lowers the social status of the person who has it, what does it do to the status of the person who works with it? If the stigma of addiction can damage people's ability to believe in their own recovery, what effects can it have on addiction professionals' ability to believe in their work and experience it as worthwhile? The answer will be different for each addiction professional—as it is for each client—but there are certain patterns.

In many people's minds, addiction treatment has a lower status than the treatment of other chronic diseases that are no more life threatening. Is this primarily because those other diseases are treated by physicians, or because those diseases lack the stigma that has attached itself to addiction? Salary ranges in the addictions field are also lower than those of physical and mental health professionals. How much of this is due to the stigma of addiction?

The fact that the field has long attracted recovering staff has strengthened the base of first-hand knowledge and insight in the field, but it's also helped transfer the stigma of addiction onto addiction professionals. The public misperception may be that most addiction counselors are recovering people who have only their experience to draw on, and have not been trained or educated appropriately.

The work you do is probably very hard at times, full of demands on your time, attention, and emotional reserves. It's hard to sustain work like that without a strong belief that you're doing something worthwhile, doing it well, and making a positive difference. Stigma can attack that belief.

Exercise 3e: Effects of Stigma on Job Satisfaction

1. Describe some of the reactions that people outside the field have had when you've told them what you do for a living.
   - _____
   - _____
   - _____
2. On a stress-scale of 1 to 10—with 1 being "energetic and enthusiastic" and 10 being "burned out"—where would you place yourself in the past few weeks?

   1 2 3 4 5 6 7 8 9 10
3. Describe what you believe—and what you've been feeling lately—about your ability to do something worthwhile and make a positive difference through your work.

   _____

   _____

   _____

Note for Chapter Three

[1] Some advocates and treatment professionals consider the word "denial" a stigmatizing term, because it implies that the person with the addiction is purposely and consciously denying the addiction, which is not the case. They suggest using the term "lack of insight" instead.

[2] For more information on sentencing discrepancies by race, see "Young Black Americans and the Criminal Justice System: Five Years Later" (Maur and Huling, 1995) and "Intended and Unitended Consequences: State Racial Disparities in Imprisonment (Maur, 1997). These and other articles can be found on the web site of The Sentencing Project, www.sentencingproject.org.

CHAPTER FOUR:

HEALING STIGMA IN TREATMENT

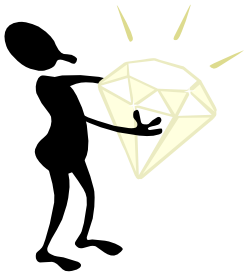
If the stigma of addiction makes it harder for many people to:

- admit they need help,
- believe they're worthy of help,
- seek out the help they need, and
- keep getting help for as long as they need it,

then it makes sense to address stigma openly and assertively in the treatment process. A comprehensive approach toward addressing stigma in treatment would take a whole manual to describe, but in the next few pages we'll look at ways of using resiliency theory, storytelling, and other activities to help patients heal from the stigma of addiction.

The Role of Resiliency in Treatment and Recovery

Stigma wants us to believe that people with addictions are not only bad, but also weak willed—failures at life. It focuses our attention on all the mistakes people have made, and on everything cruel, selfish, dishonest, manipulative, or self-defeating they've done. It ignores the strengths and resiliencies that live in even the most troubled human being. This kind of negative focus is likely to feed people's negative behaviors and destroy their ability to believe they'll ever get well.



One of our tasks as treatment professionals is to help shift clients away from their self-stigmatizing focus on their imagined worthlessness, and to open their perceptions to the sources of strength and hope that already live inside them. This can be tricky, especially with clients who deny their part in their problems or hide their self-hatred under a crust of arrogance. We need to introduce clients to their strengths and resiliencies, without denying the behaviors that are causing problems in their lives.

We can get some help from the resiliency concepts that have been prominent in the prevention field for several years.[1] These concepts are aimed at helping people see the strengths that already exist within them, have existed since they were children, and have sustained them even in their most turbulent times. The fact that people have become addicted doesn't mean they don't have significant strengths and resiliencies.

When clients find in their own histories examples of the resiliencies that have helped them have positive effects on their own lives and the lives of others, it becomes easier for them to believe that they have what it takes to get sober and stay sober—and that they are worth saving.

One of the many resiliency models you might consult is Steven and Sybil Wolin's work, developed through their clinical experience and interviews with adults who had been raised in difficult circumstances. The Wolins have identified seven resiliencies that often help children and adults survive:

1. Insight: "…the mental habit of asking searching questions and giving honest answers."

2. Independence: "…the best possible bargain you can drive among competing needs: Your right to safe boundaries between you and your troubled parents, the dictates of your conscience, and your longing for family ties."

3. Relationships: "…intimate and fulfilling ties to other people…Early on, resilient children search out love by *connecting* or attracting the attention of available adults."

4. Initiative: "…the determination to assert yourself and master your environment. Resilient survivors prevail by carving out a part of life they can control amid the swirling confusion and upheavals of the troubled family."

5. Creativity: "…safe harbor of the imagination where you can take refuge and rearrange the details of your life to your own pleasing."

6. Humor: "…mixing the absurd and the awful and *laughing* at the combination."

7. Morality: "…your wish for a good personal life grown large and inclusive. The seeds of morality are sown early when strong children in troubled families feel hurt, want to know why, and begin judging the rights and wrongs of their daily lot."[2]

Exercise 4a: Resiliency and Stigma Reduction

For each of the following resiliencies, describe the evidence of this quality in the present actions and/or past history of one client you have known, and how you might use this information to help that client.

1. Insight: _____

   _____

2. Independence: _____

   _____

3. Relationships: _____

   _____

4. Initiative: _____

   _____

5. Creativity: _____

   _____

6. Humor: _____

   _____

7. Morality: _____

   _____

Storytelling to Heal Stigma

When people are in patterns of self-blame, self-criticism, or self-hatred, it can be helpful for them to step back and take a more objective look at themselves—to tell the story of the people they've been, the people they are now, and the people they're working toward becoming. In his book, *Pathways From the Culture of Addiction to the Culture of Recovery*, William L. White suggests a series of questions that can help clients overcome the effects of stigma by redefining their identities in recovery. These questions can be used in storytelling exercises, in individual or group sessions:

1. Who was I before I began using alcohol/drugs?
2. Who and what did I become as a result of my use?
3. Why me? How do I explain what happened?
4. What happened to break this pattern? (How do I explain why and how I stopped?)
5. Who and what am I now?
6. Where am I going, and what do I need to do to get there?[3]

Exercise 4b: Strategies for Healing Stigma in Treatment

The following are some strategies that might be useful in your efforts to help clients heal from the stigma of addiction. For each one, describe how you might begin to incorporate it into your work—or how you're already doing it.

- Examining and healing any stigma that you might attach to addiction or its symptoms

  _____

  _____

- Listening to clients and seeking to understand their experience of stigma

  _____

  _____

- Listening to family members, to find out what they need in order to let go of stigma

  _____

  _____

- Bringing a patient and consistent message of hope and respect; Focusing on recovery

  _____

  _____

- Helping clients recognize and appreciate the importance of their personal strengths and resiliencies, both in their own histories and in their recovery

  _____

  _____

- Helping clients and families accept the many wounds and limitations that all people have, and helping them see imperfection as normal; Encouraging them to use their spiritual and psychological resources to come to terms with their "humanness"

  _____

  _____

- Using non-stigmatizing language and helping clients find non-stigmatizing language

  _____

  _____

- Teaching about the brain's role in addiction, so that clients can understand and believe that addiction isn't a form of weak will or moral inferiority

  _____

  _____

- Teaching clients about the ways in which stigma contributes to the addictive process

  _____

  _____

- Counseling clients on the emotions raised by stigma, and training them in ways of coping with those emotions

  _____

  _____

- Relating the healing of stigma to other models that clients are familiar with, like the 12 steps, relapse-prevention models, or cultural healing traditions

  _____

  _____

- Avoiding judgmental, moralistic, or confrontational methods, language, and approaches

  _____

  _____

- Using culturally competent (race, age, gender, ethnicity, etc.) materials and approaches

  _____

  _____

- Bringing in recovering speakers who convey a positive image of recovery, particularly speakers who come from the same community as clients

  _____

  _____

- Using recovering counselors effectively as examples of success in recovery

  _____

  _____

- Talking to clients about safe vs. unsafe self-disclosure about their addiction (for example, the negative effects of self-disclosure on hiring or acceptance for health insurance)

  _____

  _____

- Examining your organizational culture for any signs and effects of stigma, and addressing these in organizational development processes

  _____

  _____

- Treating relapse and return to use as symptoms of the chronic medical condition of addiction, rather than as bad behavior or an infraction of rules

  _____

  _____

- Identifying any hierarchies that exist in staff perceptions of clients—or in clients' perceptions of one another—and helping to promote a greater sense of equality

  _____

  _____

- For managers and administrators, reviewing the salary structures in your organization, and their implications for staff morale and the value that staff members place upon their work

  _____

  _____

On to Part II

Part I of this self-study manual has taken a look at some of the evidence of stigma in our society, and at some of the more personal aspects of stigma. Now it's time to look outward, toward the role that treatment practitioners can play in helping to heal stigma in society as a whole. The best treatment services will go only so far, as long as the larger human environment keeps shoveling more and more shame and misunderstanding on top of the burden of addiction. The next few chapters will give you some preparation for working to heal that external environment. But first, the answers to the Addiction Quiz are listed on the next page.

Answers to the Addiction Quiz (Page 37)*

1. What is the rate of recovery for people who have both treatment and recovery group attendance?

   Answer: Some studies place that figure as high as 85 percent, when people complete treatment and participate in recovery groups on an ongoing basis.

2. What percentage of COAs become addicted?

   Answer: 17 percent.

3. What percentage of people with heroin addiction are employed?

   Answer: 80 percent.

4. Does addiction treatment have the same rate of success as treatment of other chronic illnesses? Yes No

   Answer: Treatment of addiction meets or exceeds success rates for treatment of other chronic illnesses.

5. Which has most successful treatment: Hypertension Addiction Asthma

   Answer: Addiction

6. Cocaine addiction has a lower rate of recovery than other addictions: True False

   Answer: False

7. People won't get into recovery until they're ready: True False

   Answer: False

8. Coerced treatment doesn't work: True False

   Answer: False

9. Drug abuse rates are higher in African-American communities than they are in Caucasian communities: True False

   Answer: False. The rate of drug abuse among Caucasians is about eight times as high as the rate among African Americans.

*This quiz, and its answers, were compiled by the Stigma Consensus Panel from a number of sources, including the DATOS study; the National Household Survey conducted by the US Department of Health and Human Service; *Principles of Drug Addiction Treatment*; the Center for Therapeutic Change; the National Institute on Drug Abuse; and "Drug Dependence, a Chronic Medical Illness" (McLellan et. al., 2000). For more information on the work of the consensus panel, contact Dr. Joseph Rosenfeld.

Notes for Chapter Four

[1] Although most of the resiliency work has been done in the context of prevention rather than treatment, the concepts themselves do hold some valuable information for treatment professionals, if you're willing to apply them across these disciplines. An Internet search on the word "resiliency" can yield a number of good web sites for this information.

[2] From *The Resilient Self: How Survivors of Troubled Families Rise Above Adversity* (Wolin & Wolin, 1993).

[3] From *Pathways From the Culture of Addiction to the Culture of Recovery* (White, 1996, p. 422).

PART II:

HEALING STIGMA THROUGH PUBLIC EDUCATION

CHAPTER FIVE:

WHY PUBLIC EDUCATION NOW?

A majority of the tax dollars used to support the United States Office of National Drug Control Policy do not go for treatment, but for law enforcement, border interdiction, and source country elimination programs. This policy is contrary to the findings of the Rand Corporation's Drug Policy Research Center that for every dollar invested in drug treatment, to get comparable results we would have to spend seven dollars in domestic law enforcement, ten dollars in border patrol interdiction programs, and twenty-three dollars in source country elimination programs.

Don't our legislators and policy makers know all this? Why don't they do something about it? The historical fact is that the actions of legislators and policy makers at all levels of government are driven not by education, or by research, or even by common sense. Their actions are driven primarily by constituencies.[1]

— Alex Brumbaugh

Together, as a field, we need to communicate our purpose. We need to sell the value of what we do. We have to speak up, not only for ourselves and for our field, but for those who struggle with addiction and haven't found their voices yet, but still need someone advocating for them. Why is this important? Because if we don't speak up, someone else is framing the issue for us. Someone else is defining addiction for us. We can choose to be silent. But silence won't take away the stigma.[2]

—Daphne Baille

We envision a society where people who are addicted to alcohol or other drugs, people in recovery from addiction, and people at risk for addiction are valued and treated with dignity; and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. We envision a society where addiction is recognized as a public health issue—a treatable disease for which individuals should seek and receive treatment; and where treatment is recognized as a specialized field of expertise.[3]

—CSAT, SAMHSA National Treatment Plan

If we don't get involved, will the work get done? If we put off getting involved, how many more people will die who could have lived?

This chapter uses a little bit of history and a glimpse of the current situation to show that:

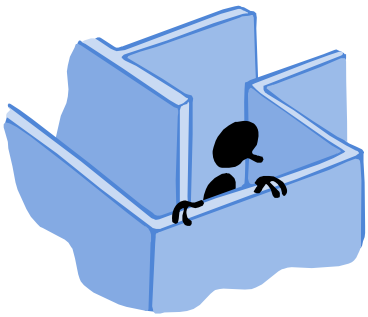
- Stigma has proved itself to be a powerful and resilient force.
- All of the stigma-reduction efforts that have taken place so far have been necessary to get us where we are today.
- Where we are today is not far enough. Stigma still has a strong influence on formal and informal social policy, and on the way society treats people with addictions. And it can get worse.

This chapter owes virtually all of its historical information to William L. White's (1998) fascinating and definitive text, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.* For anyone who hasn't yet read that book, the hope is that this chapter will inspire you to read it. Special thanks also go to Peg Rider (2000), who provided an impressive summary of key historical events in *Understanding Stigma*.

The Force of Stigma in History

In Chapter Two, we looked at some of the ways in which stigma shows up in society, but now it's time to look at the momentum behind it. The historical points listed below represent a few examples of stigma at work in American society. You won't be asked to remember any of these facts. But as you read them, please pay attention to your "gut" feelings and the thoughts they raise in you. This is a big part of our legacy as a field.

- Although early temperance movements attracted many "reformed" alcoholics as members and speakers, as these movements evolved throughout the 1800s, many of their other members grew to regard alcoholics with contempt.
- By the late 1800s and early 1900s, alcoholics were regularly described as moral inferiors, as in T.D. Crothers' 1902 text: "Often the higher moral faculties of the person are undeveloped, and the children of alcoholized people are born criminals without consciousness of right and wrong, and with a feeble sense of duty and obligation" (White, 1998, p. 88).



- Although other mood-altering drugs were legal in the 19th century, more and more stigma was attached to addiction, and many people failed to seek treatment for fear of public exposure.
- Although many early opiate addicts were middle- or upper-class women addicted to tonics and elixirs, the press characterized addicts almost exclusively as people of color, from stereotypes of African-American addicts to the "yellow peril" myths that predicted the country would be overrun with opium-smoking Chinese immigrants.

- With the passage of the Harrison Anti-Narcotic Act in 1914, aggressive enforcement of that law—along with the criminalization of most existing treatment methods—resulted in a wholesale loss of needed services for people with cocaine and opiate addictions, as well as the indictment of more than 25,000 doctors.
- In the early 1920s, the narcotics clinics that had been established to cope with the nation's drug problem were closed. Dr. Dana Hubbard of the New York City Department of Public Health declared that "…drug adddiction is not a mysterious disease…drug addiction is simply a degrading, debasing habit, and it is not necessary to consider this indulgence in any other light than an antisocial one" (White, 1998, p. 119).
- In the 1920s, prohibition added criminality to the moral stigma attached to alcoholism.
- The eugenics movement of the early 20th century advocated mandatory sterilization for alcoholics, among others. Some state laws also mandated voluntary or involuntary sterilization of alcoholics and/or addicts. And in the 1930s, '40s, and '50s, electroconvulsive ("shock") therapy was used widely on people with addictive disorders.
- In the 1940s and '50s, an unknown number of people with alcoholism and drug addiction were lobotomized in misguided attempts to treat their condition.
- The Boggs Act (passed in 1951) and the Narcotic Control Act of 1956 dealt out tougher and tougher sentences for drug violations and laid the groundwork for harsh and invasive treatment techniques.

- In many early therapeutic communities established to treat addiction (in the late 1950s and early '60s), applicants for treatment were required to sit quietly for hours before their intake interviews, and in those interviews were required to admit that they were "stupid."
- During the Reagan era, the federal "zero-tolerance" drug-control policy began to shift the public focus from treatment and research to criminal justice "solutions" to addiction.
- In the 1980s, the concept of alcoholism as a medical condition came under heavy fire in the popular culture, with articles and books like Herbert Fingarette's *The Myth of Alcoholism* and Stanton Peele's *The Diseasing of America*, both published in 1989.
- In the late '80s and early '90s, the effects of managed care gutted the private treatment industry, shortening lengths of stay, consuming staff time in paperwork, and forcing many programs to shut down or reduce their services.
- The criminalization of addiction that began in the 1980s accelerated dramatically during the '90s. In effect, the primary responsibility for treating people with addictions has been shifted onto the criminal justice system.
- In spite of the neuroscientific evidence in favor of a chronic disease model of addiction, this concept continues to fall under attack in the current moralistic climate.

- Media attention continues to focus on sensationalized images of addiction, particularly on return to drinking or drug use by public figures who have self-identified or been identified as recovering from alcoholism and addiction. A strong media focus on the treatment struggles of high-profile African-American athletes continues to promote the myth that most people with addictions are people of color.

Exercise 5a: Historical Momentum Behind Stigma

1. Describe your feelings in reading the examples of stigma on the last two pages:

   _____

   _____

2. Which point(s) affected you most strongly, and why?

   _____

   _____

   _____

3. Which of these influences do you see most clearly in our society today, and in what ways?

   _____

   _____

   _____

   _____

4. Which of these influences do you believe has been most effectively addressed in our society, and why do you think so?

   _____

   _____

   _____

   _____

The Historical Benefits of Public Education

You can well imagine the frustration that these stigmatizing influences brought out in the people throughout history who knew—first in their gut and later through scientific evidence—that addiction was not the moral failing it was believed to be. Many of these people dedicated time and energy to healing public perceptions. Some did it as part of their work, and some as part of their non-working lives. A few of their contributions are described on the next two pages.

- Benjamin Rush (1746-1813) was the first American authority on alcoholism and the first to characterize it as a progressive medical condition. This highly esteemed physician, author, and professor proposed abstinence for people with chronic drunkenness. His influence "laid the groundwork for the medical treatment of drunkenness and marked the birth of the American temperance movement" (White, 1998, p. 2).
- In the 1800s, alcoholics formed fraternal temperance societies, reform clubs, and other organizations for mutual support in sobriety. Although these organizations had problems surviving, they did send examples of recovery into the public eye, including one US Representative who showed up in the House wearing a reform club symbol.
- Founded in 1935, Alcoholics Anonymous soon began quietly healing the stigma by producing more and more sober members with visibly changed lives, and through the 1939 publication of the book *Alcoholics Anonymous*. Beginning in the early 1940s, a series of articles about the organization in the popular press widely expanded the organization's influence and membership, and a few popular films began to show the public, not only a more realistic picture of alcoholism, but also the hope of recovery.

- In the late 1930s and '40s, under the leadership of Dr. Norman Jolliffe, the Research Council on Problems of Alcohol (RCPA) broke ground by focusing, not on the consequences of excessive drinking, but on the factors that led to alcoholism. Its research findings found their voice in the newly established *Quarterly Journal of Studies on Alcohol*. RCPA consultant Dwight Anderson led the organization further into public education and stigma-reduction efforts with the publication of four "kinetic ideas." These statements affirmed that alcoholics were ill, could be helped, and were worth helping, and that the healing professions and the public were responsible for solving the problem.
- In 1943, a Center of Alcohol Studies was established at Yale University, under the leadership of Drs. Howard Haggard and E.M. Jellinek. Its activities included research; publications; the Summer School of Alcohol Studies (later affiliated with Rutgers), which drew its faculty from a number of related fields and from members of Alcoholics Anonymous and has trained thousands of clergy and social service, treatment, and criminal justice workers; the innovative Yale Plan Clinics; and the birth of the National Committee for Education on Alcoholism (NCEA).
- As founder and leader of the NCEA (later to become the National Council on Alcoholism and the National Council on Alcoholism and Drug Dependence), Marty Mann devoted 35 years' worth of time, talent, energy, and dedication to helping the public understand alcoholism as a disease and a significant public health problem and accept the alcoholic as someone worthy of help who can recover successfully.
- Public education inspired by the work of the NCEA and the Yale Center began to convince many business leaders that workplace alcoholism programs would be cost-effective, and the numbers of these programs began to rise.
- Organizations like the National Clergy Council on Alcohol and Related Drug Problems and the North Conway Institute educated clergy about alcoholism. Their work led to a 1985 National Council of Churches' proclamation calling for ministry, education, and planned legal control of alcohol.

- Led by a recovering alcoholic, the Christopher D. Smithers foundation funded a wide variety of education, research, and public education efforts.
- The NCEA and the Yale Center contributed significantly to the public education that shaped state responses to the need for publicly funded community-based treatment. In 1961, the Cooperative Commission on the Study of Alcoholism came out with a series of recommendations that set the stage for the progressive legislative measures that followed. Change agents were needed every step of the way to inspire and inform these legislative responses. Most notable and dedicated among these was Iowa Senator Harold Hughes, a recovering alcoholic who tirelessly sponsored and supported legislation to build effective treatment systems during the 1970s and 1980s.
- Many other recovering alcoholics, addicts, and concerned family members have also taken on significant public education roles, some disclosing their recovery status, and others not. Although this constituency has not yet reached the level of consumer or family involvement or organization found in many other disability fields, these efforts have been necessary and important in the struggle for effective and humane responses to this condition.
- Beginning in the early 1970s, developing research on the neuroscience of addiction has helped us understand the roots of addiction in the brain, giving change agents solid scientific evidence that this is a medical condition, rather than a moral failing.
- In 1998, Chestnut Health Systems/Lighthouse Institute published *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, written by William L. White. Readers of that history have found new insight into the struggles for understanding and effective treatment that have been necessary in the past, and the crucial lessons that history has to offer.
- White now documents the birth of a widespread and largely spontaneous "recovery movement," defined as "an organized effort to: 1) remove barriers to recovery for those still suffering from AOD problems, and 2) improve the quality of life of those recovering from AOD problems" (White, 2000). Organizations like the Alliance Project and Join Together have also been established to help organize and support public education efforts on a large scale.

- Realistic media treatment of addiction, like Bill Moyers' acclaimed PBS series on addiction aired in March of 1998, has brought accurate information to wider audiences.
- In 1998, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) established the Recovery Community Support Program, with 19 sites nationwide dedicated to public education and stigma reduction. These sites work to foster links among recovery communities and treatment organizations, and to help recovering people and their families get involved in public education and become more effective change agents.[4]

- In the past few years, the National ATTC Network has stepped up its efforts to collect and distribute research-based information that will help change agents fight the stigma of addiction. The ATTCs have also initiated and joined a number of stigma-reduction efforts in collaboration with a variety of organizations.
- In November of 2000, SAMHSA published a detailed set of recommendations for public education efforts in the stigma-reduction section of *Changing the Conversation*, the report of its National Treatment Plan Initiative.[5] That report proposes a four-point approach to changing public perceptions of addiction and recovery:
  1. Science-based marketing research, including a language audit
  2. A social marketing plan, based on the results of the research
  3. Support for grassroots efforts at public education in the recovery community
  4. Promotion for people in treatment and recovery of the same rights and dignity due to people who have experienced other illnesses

Exercise 5b: Effects of Stigma-Reduction Efforts

1. Which efforts described in the last two pages affected you most strongly, and why?

   _____

   _____

   _____

2. Which of these efforts do you think have been most important, and why?

   _____

   _____

   _____

3. Which of these efforts would you have something to contribute to, if they were (or are) going on in your lifetime, and if you had the time to devote to them?

   _____

   _____

   _____

Where We Are Now

As impressive and dedicated as all these public education efforts have been, we still live in the stigma-burdened society described in Chapter Two ("Stigma Exists"). A few things have improved, though: We now have the scientific evidence we need to fight stigma, and organizing structures are in place that can coordinate, support, and inform public education efforts.

The well being of many clients and potential clients will depend on the survival and the competence of the addiction treatment field. Stigma has damaged the field in many ways, in terms of funding, morale, and ideology. But with our knowledge, experience, and conviction, we are still in the best position to educate the public about the need for improved access to appropriate services.

In the last chapter of *Slaying the Dragon*, White (1998) draws a number of thought-provoking lessons from the history of treatment and recovery. Some of these have to do with the survival and quality of the field itself:

> *The modern system of addiction treatment grew out of the broader medicalization of personal and social problems, and might fall victim to the current de-medicalization of such problems. The reframing of personal problems in moral and characterological terms—along with a restructuring of responses to social problems that focuses more on managing their economic costs than on their personal outcomes—poses a significant threat to the future of the addiction treatment field, in terms of both the field's existence and its essential character.*[6]

White's assessment of responses to addiction in the broader social and political arena is equally troubling:

> *As this book goes to press, America is caught in a transition between two addiction paradigms: one that views addiction as a diseased condition emanating from biopsychosocial vulnerability, and the other that views addiction as willful and criminal behavior emanating from flaws of personal character. In a shift that began in the early 1980s, America is moving addiction once again from the arena of public health to the arena of public morality.*
>
> *If this trend continues, it is likely that addiction will be de-medicalized and increasingly criminalized for all but the most affluent of our citizens. During the next decade more addiction programs will close, and many more will be integrated into larger behavioral-health organizations and networks. The field will continue to be buffeted in a highly turbulent operating environment, and many programs will risk losing their focus on personal recovery. There is considerable danger that much of the core technology of addiction treatment will be lost in the coming decade, eroding the field's ability to further develop that technology. In many communities, waiting lists for inadequate doses of specialized addiction treatment will—where they already have not—lengthen to the ridiculous. Alcoholics and addicts will once again drift to or be captured by other institutions: the jail cell, the prison cell, the hospital emergency room, the local psychiatric unit, the state psychiatric hospital, the urban mission, or the domestic-violence shelter.*[7]

The bad news is that more than a century's worth of public education efforts haven't been enough. So what's the good news? The good news fills the remainder of this manual. It tells us:

- Even if we're not sure whether or not to get involved in public education, we can work slowly and carefully toward that decision.
- We now have clear guidelines that can help us build effective public education efforts.
- There are public education roles for all kinds of people, even those who don't have much time to spare and those who aren't comfortable with public speaking.
- People recovering in 12-Step programs can do public education without violating any traditions of their programs, as long as they follow a few guidelines.
- All of our public education efforts **will** make a difference.

Notes for Chapter Five

[1] From "Investing in Community Recovery."
[2] From "Stigma Reduction," a presentation by Daphne Baille at the Illinois Alcohol and Other Drug Abuse Professional Certification Association conference, March 29, 2000.
[3] From *Changing the Conversation: The National Treatment Plan Initiative*, released by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Administration (CSAT, SAMHSA) in November, 2000.
[4] Addresses, phone numbers, and web sites of all Recovery Community Support Program grantees are listed in Appendix B, beginning on Page 122.
[5] For a brief summary of the stigma-reduction portion of the Plan, see Appendix C, Page 133. The Plan as a whole is available on the CSAT web site, www.samhsa.gov/centers/csat/csat.html.
[6] From *Slaying the Dragon*, p. 337.
[7] From *Slaying the Dragon*, p. 341.

CHAPTER SIX:

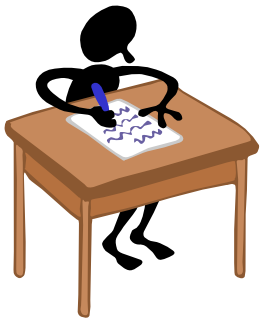
BUILDING COMMITMENT

Have you ever really known you should do something, but found yourself not doing it anyway? Then at some point your reasons for doing it all came together. You felt the commitment happening in you, and you started doing it.

This chapter will help you work toward making a commitment to try public education for stigma reduction. But it doesn't make sense to commit to something if you don't know what that really means. So let's look at what makes someone get involved in the first place.

In the list that follows, check off all the activities that qualify as public education against stigma and in favor of effective responses to addiction.

- Speaking to a community group about addiction and treatment
- Writing a letter to the editor of your local newspaper in response to a stigmatizing article or letter published in the newspaper
- Explaining what you do for a living to someone you meet at a party
- Explaining to a managed care company employee why an applicant for treatment should be covered for a particular service or length of stay
- Gathering cost-effectiveness data in your treatment center
- Showing up at a public meeting or a rally
- Giving your own doctor a fact sheet on addiction, treatment, and recovery
- Wearing a purple scarf to the theater



If you checked all but the last entry (just there to keep you honest), you were correct. Public education isn't always a big commitment, and it isn't something we can put off "until we have time"—because we'll never find the time until we make the commitment. **Public education is something we can do every day, in one way or another.**

For many people, becoming a change agent isn't about throwing ourselves heart and soul into the struggle. It's about always being aware of opportunities to set the record straight—and being ready to rise to those opportunities when we see them.

Public education isn't a talent that you're born with or born without. It's a large set of skills. Some of those skills fit your personality and your values, so you develop and use them. Other skills don't fit, so you leave them alone and let other people use them. If enough people get involved, enough work will get done. Things will change for the better.

Exercise 6a: What Public Education Might Mean to You

The first step is to see if you can picture yourself doing any of the many things that qualify as public education. As you read each activity description, see what your gut reaction is. Can you picture anything about it that you'd enjoy, or any benefits to doing it? What do you think the obstacles might be if you tried to get involved? Who do you know who does this already, who could help you overcome those obstacles? If you don't know, just leave it blank.

- **Examining, working through, and healing any stigma you still attach to addiction:** This is an essential activity in preparing for a stigma-reduction role. Without it, you won't be as effective in the other efforts, no matter how dedicated you are.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Someone you know who does it: _____

- **Studying the research that affects the field.** Learning about the neuroscience of addiction, treatment outcomes, the cost-effectiveness of treatment, and other research topics is an important step in preparation for effective public education. Any time you add to your knowledge base, you're increasing your value as a change agent.

  Possible benefits of doing this: _____

  _____

  _____

  Obstacles to doing this: _____

  Someone you know who does it: _____

- **Public education in everyday conversation:** Ordinary conversations with friends, neighbors, teachers, clergy, doctors, and other people you know hold opportunities for carrying the message. People value the information they get from people they know and respect.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Responses to published material:** When you read or see stigmatizing material in the popular or professional press, it's worth the time it takes to write a short letter to the editor that will straighten out the facts and give voice to others who may be offended or hurt by the stigma, but can't respond to it.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Calling in to talk shows:** When people on TV or radio call-in talk shows say stigmatizing things, they should be challenged. Who better to do it than someone who works in the field and has a solid knowledge base?

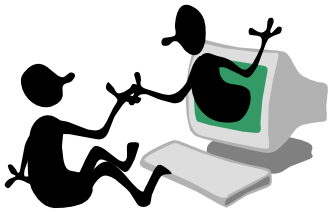
  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Communicating in chat rooms:** In computer chat rooms on a variety of sites, people talk about almost any subject imaginable. Why not bring up the subject of addiction, respond to people's questions about it, or correct stigmatizing comments?

  Possible benefits of doing this:_____

  _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Voting for candidates who support treatment and recovery:** It's important to find out where the candidates stand and—as a private citizen, on your own time and expenses—support those who are willing to respond effectively to addiction.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Supporting events like Recovery Month:** If you don't know about the activities in your area, contact the nearest Recovery Community Support Program grantee (see the list in Appendix B, beginning on Page 122). This doesn't take much time, but it's a chance to stand up and be counted.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Public education with managed care and insurance companies:** Every time you work to help someone understand why a particular client needs a particular service or length of stay, you're planting the seeds of understanding and adequate services.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Collaborating with people in related fields:** People in other helping professions—like child welfare, domestic violence, criminal justice, public aid, law enforcement, medicine, mental health, education, and prevention—sometimes hold onto stigmatizing attitudes even if they have frequent contact with people with addictions. Through collaboration and cross-training, you can affect many key areas of clients' and their families' lives.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Organizational development and training on the job:** Addressing stigma in the treatment organization is another good investment of time and energy. Done carefully, it can improve working conditions and client outcomes.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Joining and/or supporting the stigma-reduction efforts of public education organizations:** Appendix B (Page 119) lists a number of organizations. They need members, committee and work group members, money, ideas, and enthusiasm.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Supporting local issues and policies:** When you get involved as a private citizen in local policy groups and public education networks, you'll learn about a number of issues that need your voice.

  Possible benefits of doing this:_____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Gathering meaningful cost-offset data to support the need for treatment:** Treatment funding is directly affected by public perceptions of the cost-effectiveness of treatment. Treatment centers need to manage costs carefully, and to gather accurate outcome data in terms that will be meaningful to funding sources. Researchers need to use real data from a number of sources—like the databases of medical, criminal justice, and social service agencies—to compare the cost of treatment to the social costs of untreated addiction.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Providing information relevant to state- or federal-level issues and policies:** You can do this—on your own time and paying for your own expenses—by becoming informed, writing to policy makers, or visiting policy makers as part of your public education efforts. You have information that is important to the well being of their constituency. (**One caution:** Remember that federal funds can't be used for lobbying. If you're going to advocate specific legislative changes, you'll have to do it on your personal time, and without using any federal monies.)

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Writing articles and op-ed pieces:** These don't have to be long, just accurate and well thought out. You can even collaborate with others on these projects.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Public education through the arts:** Stories, songs, plays, poetry, films, and visual artwork can also help heal stigma, by presenting positive views of recovery and recovering people.

  Possible benefits of doing this:_____

  Obstacles to doing this: _____

  Where you might start: _____

- **Public education through research:** Practitioners are needed to get involved in research projects, bring research projects into treatment centers, and generally influence the direction of the research that affects this field.

  Possible benefits of doing this: _____

  _____

  Obstacles to doing this: _____

  Where you might start: _____

- **Can you think of another activity?**_____

  Possible benefits of doing this: _____

  _____

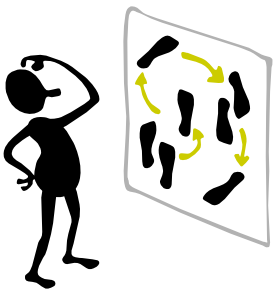
  Obstacles to doing this: _____

  Where you might start: _____

No matter how little time or how much doubt you have, you probably found something in these activities that you'd be willing to do, or that you're already doing. As time goes on you might want to fill in some of the spaces you've left blank. You'll also be using this worksheet to help fill in later worksheets.

Exercise 6b: Mapping Your Change Process

At this point it's a good idea to see where you are in the stages of change outlined in the Transtheoretical Model of Change, adapted for the field by Miller and Rollnick (1991). You may have used this model with clients, to map their readiness for change. It works with all kinds of change processes, including the movement toward public education for stigma reduction. (Three ATTC publications were particularly helpful in designing these exercises. One was *The Change Book: A Blueprint for Technology Transfer*, published by the National ATTC Office,[1] and the others were *Technology Transfer Journal* and *Implementation Journal*, under development for the Great Lakes ATTC by The Change Companies.[1])



The five stages of change are:

Precontemplation—Not even considering change
Contemplation—Looking into the possibility of change, with mixed feelings
Preparation—Already made a decision; getting ready for change
Action—Actively changing; doing new things
Maintenance—Working to maintain and improve the change

In the list shown above, check the one that sounds most like your current stage in the process of moving toward a public education role in stigma-reduction efforts. (You can always change your mind later, if you realize you're at a different stage of change.) Now in the next few pages, read and answer the questions in the box for your current stage of change.

If you don't feel like you're in any stage of change—public education for stigma reduction just isn't something you're interested in doing—then fill in the box for the Precontemplation stage.

Stage One: Precontemplation

When you're in the precontemplation stage for this or any other change process, you probably don't think of yourself as being in precontemplation. You're just not interested in getting involved in public education for stigma reduction, or you've ruled it out for reasons that are important to you.

If that's how you feel and you've gotten this far into the manual, congratulations! It says a lot about your self-discipline and your determination to get those CEUs. As long as you're here, though, please answer the following questions:

1. What would you like to see changed in the way society looks at addiction?

   _____
   _____
   _____
   _____
   _____

2. What are the main reasons you aren't considering taking on any public education roles in stigma reduction?

   _____
   _____
   _____
   _____
   _____

3. Name two people you know and respect who are involved in public education for stigma reduction, or are considering getting involved. Write their phone numbers down, too.

   Name: _____ Phone: (_____)_____

   Name: _____ Phone: (_____)_____

   Name: _____ Phone: (_____)_____

4. Please make a commitment to call at least one of those people and ask them to talk about the doubts and reservations they might have had before they decided to get involved.

Stage Two: Contemplation

In this stage your main task is to look at all the pros and cons of getting involved—and not to rush yourself in that process or overload yourself with information.

1. Turn back to Pages 23 and 28. Look at your description of a client whose life and/or recovery have been affected by stigma, and your description of how that life might have been different without stigma. What are some of your reactions (thoughts and feelings) in reading those two stories?

   _____

   _____

   _____

   _____

   _____

2. Read through your responses to the public education activities listed on Pages 72 through 77, and note the three most significant obstacles you listed there. For each one, write the name and phone number of someone you know and respect who might give you help or advice in overcoming that obstacle.

   Obstacle: _____

   Name: _____ Phone: (_____)_____

   Obstacle: _____

   Name: _____ Phone: (_____)_____

   Obstacle: _____

   Name: _____ Phone: (_____)_____

3. Now list all the possible benefits you wrote on Pages 72 through 77, and any others you can think of. These can be benefits to you (like enjoyment or feelings of success), benefits to clients, or benefits to society or to people with addictions.

   _____

   _____

   _____

   _____

   _____

   _____

   _____

Stage Three: Preparation

In this stage you've made a decision to get involved, but you're not ready to start. Your job now is to gather information, start making contact with others who are involved in public education, and make a plan for involvement.

1. Name two people you know and respect who are involved in public education for stigma reduction. Write their phone numbers down, too.

   Name: _____ Phone: (_____)_____

   Name: _____ Phone: (_____)_____

   Choose one of those people, and make a commitment to call him or her this week and ask about his or her experience with public education. Circle the person's name and number, and make a note of it somewhere where it will remind you to make the call.

2. Read over the activities listed on Pages 72 through 77, and choose one activity that you'd really like to do. Write a specific description of that activity, the setting in which you might do it, the skills and talents you have to contribute, the obstacles you might encounter, possible resources for overcoming those obstacles, and the kinds of information you still need before you start doing it.

   Activity: _____

   Setting: _____

   Skills/Talents: _____

   _____

   Obstacles: _____

   Resources for Overcoming: _____

   _____

   More Information Needed: _____

   _____

3. Write an imaginary description of yourself doing the activity described above. Include any feelings you might have, before, during, and after the activity. Write about how that activity (and others like it) might change you, as a person and/or as a professional.

   _____

   _____

   _____

   _____

Stage Four: Action

In this stage, you've already started doing public education for stigma reduction and started experiencing some of the benefits and challenges that go with it. Right now you're just looking for new information and problem-solving skills to help you keep improving your efforts.

1. What do you like best about the public education you're doing?

   _____

   _____

   _____

   _____

2. What challenges have you encountered, and what (or who) are some possible resources for helping you overcome those challenges?

   Challenge: _____

   _____

   Resources: _____

   _____

   Challenge: _____

   _____

   Resources: _____

   _____

   Challenge: _____

   _____

   Resources: _____

   _____

3. What new skills or information do you want or need?

   _____

   _____

   _____

   _____

   _____

Stage Five: Maintenance

In this stage, you've been doing public education for stigma reduction for a while. You've grown comfortable with it, but you want to avoid getting stale or burned out on it.

1. What do you use—or might you use in the future—to reward yourself for the public education work you do?

   _____

   _____

   _____

   _____

2. Who are some of the people in your professional and personal life who are most supportive of the public education you do? In what ways do they support your efforts (encouragement, information, hands-on help, faith in you, etc.)? If you don't feel like you have enough support, name people whom you might ask to fulfill that role.

   Name: _____ Current Possible Source of Support

   Kinds of Support: _____

   _____

   _____

   Name: _____ Current Possible Source of Support

   Kinds of Support: _____

   _____

   _____

   Name: _____ Current Possible Source of Support

   Kinds of Support: _____

   _____

   _____

   Name: _____ Current Possible Source of Support

   Kinds of Support: _____

   _____

   _____

Exercise 6c: Building a Mission

Whatever stage of change you're in, you can at least start to build a personal mission statement around stigma reduction. A mission statement is useful because it keeps your focus on the highest goal of your efforts. It's sometimes described as the "eyes on the prize" vision. A good mission can keep you from losing conviction and getting bogged down in all the frustrations that tend to arise in human efforts.

Your personal mission statement is your central reason for living, the purpose of your life. So your stigma-reduction mission statement would be your central reason for getting involved in this work. Jonathan and Susan Clark (1992) name three qualifications of a good mission statement:

- It should be distinct, yours and no one else's.
- It should be stimulating, stirring you to action.
- It should motivate, inspire, and excite you.

Your mission statement should be short, including only your ultimate vision and how you'll work toward it. What do we mean by that?

- **Your vision:** This is the "prize," the center point on the horizon that you aim for in your journey. In this kind of mission statement, it might be a vision of the way people's lives can be without the burden of stigma. In a few words, how would you describe your vision? (For example, one vision might be "a society where stigma doesn't keep people from getting help," and another might be "my clients healed of the effects of stigma.") If you're not sure about your vision, you might look back at your answers to the questions on Page 28, and think about how your vision might have grown and changed in working through the rest of the manual. Write your vision below.

  _____

- **How you'll work toward it:** This is what you will do to reach that vision. In a few words, describe what you will, can, or might do to work toward that vision. (You might also include something about the quality of the work you'll do.) For example, one statement might include the words "exploring and using all appropriate opportunities for effective public education." If you're in an early stage of change, you might just describe the work you'll do to decide whether or not to get involved. For example, one statement in an early stage of change might include "learning all I can about stigma reduction." Write below how you'll work toward your vision.

  _____

  _____

  _____

There's no one right format or structure for a mission statement. Some statements read something like this: "To [promote your vision] by [how you'll work toward it]." (For example, "To reduce stigma in our society by exploring and using all appropriate opportunities for effective public education.") Others might read something like this: "My stigma-reduction mission is to [how you'll work toward your vision] so that [your vision will come about]. (For example, "My stigma-reduction mission is to use all the effective stigma-reduction tools I can find to help my clients heal from the effects of stigma." Again, you don't have to use any particular format for yours. Do it in a way that feels right and inspiring to you.

Your mission statement should be clear enough and central enough to guide difficult decisions that you may face in the future. For example, if your mission statement says you're going to explore and use all appropriate opportunities for effective public education for stigma reduction, that will help guide your decision if someone calls you and invites you to a meeting to discuss a new stigma-reduction project.

Now write a rough draft of your stigma-reduction mission statement below.

Stigma-Reduction Mission:

_____

_____

_____

_____

_____

Missions and mission statements often change over time, but this will get you started, and perhaps give you a reason to keep working on it. It's a good idea to review your mission statement every three months, to keep it current with your changing vision and opportunities.

No matter how well motivated or committed you are, the quality and appropriateness of your public education efforts will also make a big difference in their effects. The next chapter will give you some very specific guidelines for effective public education for stigma reduction.

CHAPTER SEVEN:

BEING AN EFFECTIVE CHANGE AGENT

Like the young violinist whose teacher described him as having "more passion than pitch," many change agents fall short of their mark simply because they haven't yet learned how to do it effectively. Change agents interviewed for this manual have identified a number of guidelines for effectiveness, including:

1. Plan and carry out strategic moves
2. Approach audiences effectively
3. Use effective messages
4. Use research to heal stigma
5. Define the issues carefully

These guidelines, and tips on using them, are outlined in this chapter. But remember: The young violinist mentioned above is the same one who, wandering lost in New York City with his violin case, approached a passer-by and asked her how to get to Carnegie Hall. The answer, of course, was "Practice, practice, practice."

Guideline #1: Plan and Carry Out Strategic Moves

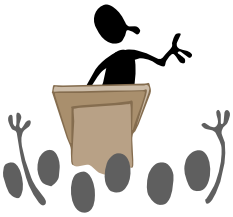
Here are some tips from seasoned change agents:

- **Start out small.** Start with the simplest, easiest, least-intimidating, and least time-consuming activities, then move outward.
- **Look for opportunities.** Stay aware, listen, and use your imagination.
- **Find and use mentors.** These can be people you know, people in public education organizations, or experts who are willing to talk—and listen. Don't try to do it alone.
- **Make a personal action plan.** This is something you can start in the Contemplation stage and keep refining as you get more involved. It will help keep you on track. (A worksheet for this plan is shown on Page 104.)
- **Make a long-term plan.** You'll probably want to do this in a group setting, when you've formed some alliances for public education efforts. A long-term plan is essential.

- **Use social marketing techniques.** Audiences these days are used to being wooed in sophisticated ways, thanks to marketers and advertisers. Now there's a whole branch of social science that has studied the most effective ways of approaching audiences about social policy. As you get more involved in public education activities and networks, you might want to study social marketing principles—for example, understanding the needs of the people you're trying to persuade, making your messages available to people, and taking steps to help people understand and accept your messages[1] Your public education organization might also want to involve a social marketing expert in its efforts.

Guideline #2: Approach Audiences Effectively

An "audience" here is defined as anyone who receives your stigma-reduction message. This might be an old friend you bump into in the grocery store, a family group you facilitate, a policy maker, or an auditorium full of people. Often the truth and urgency of your message will be less important to your audience members than the way you approach them, the way you treat them, and the way they feel about you—and about themselves—when you speak to them. Here are some general guidelines for approaching audiences:



- **Be aware of your own attitudes and biases.** If you're still being influenced by stigma, you might be trying to convince your audience of something you don't completely believe yourself. Awareness of this might help you take steps to avoid giving mixed messages. Or if you find your audience's attitudes frustrating, awareness of your own frustration can help you decide to use coping skills before and during your contact with the audience.
- **Understand the psychological roots of stigma.** Approach your audience with a knowledge that the stigma of addiction is probably serving some purpose for them right now—like helping them detach from the effects of addiction, or helping them feel justified in their anger at people whose addictions have hurt them. Depending on the situation, you may or may not be able to help them find healthier ways of meeting their needs. But at least you can be aware of the power that stigma may have in their lives.
- **Know your audience as well as possible.** If you know and respect what people already know on the subject, you have less danger of sounding condescending. If you know what they don't know, there's more chance that you'll address the gaps in their knowledge. If you're aware of their feelings and attitudes, you won't jump in with the wrong approach. If you know their stages of change and understand the principles of technology transfer,[2] you'll be in a better position to help them integrate and apply the new information you offer. If you know what they fear, you'll be able to address their fears. If you know what they want and value, you'll know how to appeal to those desires and values. These things can make all the difference.

- **Keep respect at the forefront.** Everybody needs and deserves respect, whether or not their thoughts and feelings seem to make sense right now. Think about what respect means to you, and about what it might mean to your audience. Your attitude of consistent respect may win people over even if they aren't yet convinced by your words.
- **Listen, and respond to what you hear.** Hear their concerns, their needs, their fears, their feelings, their hopes. Try to tailor your message to what they're really saying. Don't minimize their concerns or their anger. Acknowledge them, then address them.[3]

For planned public education activities, the Audience Profile form can help you find out what you need to know about your audience. You may want to interview someone who's familiar with the audience to get answers to these questions. Feel free to make photocopies and use one each time you plan a presentation, a written work, or an important approach.

Exercise 7a: Audience Profile

1. Describe the range of knowledge about addiction in your audience:
   _____ to _____
2. Describe the range of attitudes toward addiction in your audience:
   _____ to _____
3. What information on this subject do you believe your audience needs most?
   _____
4. What do you perceive as your audience's main fears or concerns about addiction?
   _____
   _____
5. What purposes might the stigma of addiction be serving for them now?
   _____
6. At what stage of change do you believe your audience is on stigma reduction?
   Precontemplation Contemplation Preparation Action Maintenance
7. How receptive to stigma-reduction efforts do you believe your audience will be?
   Not at all receptive Skeptical but polite Interested Open and receptive
8. What values and needs are most important to your audience?
   _____
9. How do the audience members themselves stand to benefit from stigma reduction, and/or from the steps you're asking them to take?
   _____
10. What can you say to communicate those benefits in terms of their values/needs?
    _____
    _____

Guideline #3: Use Effective Messages

The most effective public education messages are simple, powerful, positive, well researched, well timed, and relevant to the self-interest of their audiences. A few key points to remember:

- To heal the stigma of addiction, we need a positive focus on the reality of recovery, rather than "scare tactics" about addiction.
- It's important to speak of people with addictions as people first.
- If you make reference to the experiences of treatment clients, be careful to avoid violating clients' privacy or anonymity.
- To counter moralistic views of addiction, we can speak of addiction as a chronic medical condition and compare treatment success, not with success in treating acute diseases, but with success in treating other chronic diseases. Addiction has average or slightly-higher-than-average treatment success in this category.
- Every field has its internal debates, and ours is no exception. We often disagree on important issues—the use of methadone, for example—and debate within the field is a healthy thing. However, the public and policy makers will find our public education messages most credible and persuasive if we present a unified front. One solution might be to rely on science-based research to guide our arguments.

You'll find more specific guidelines in the following checklist. You can photocopy it and use it to assess messages you're planning to communicate to your audiences.

Exercise 7b: Effective Message Checklist

This public education message:

Uses no stigmatizing language (except to explain why the language is stigmatizing)
Stays away from jargon and other terms the audience might not know
Uses clear and straightforward language; keeps it simple
Focuses on hope and solutions
Presents people with addictions as human beings first, with human qualities
Emphasizes the reality of successful recovery for many people
Paints a positive picture of recovery
Avoids scary images of addicts and the consequences of lack of treatment
Doesn't say anything that would violate clients' anonymity or privacy
Stays honest and respectful
Appeals to the audience's self-interest
Appeals to the audience's values
Is culturally competent for the audience it addresses
Communicates its message at the right strategic time
Compares addiction to other chronic diseases, rather than to acute diseases
Doesn't bring up debates that should be settled within the field instead

Guideline #4: Use Research to Heal Stigma

Because stigma is so deeply rooted in the emotions, knowledge of the facts isn't enough to heal the stigma. But it helps. It starts the healing process in motion and makes it harder and harder to hold stigmatizing thoughts and say stigmatizing things.

In the steadily growing body of research on addiction, we have some wonderful arguments against stigma. If you haven't yet found much time to study this research, it's highly recommended. It will enrich your practice and make you a better change agent.

Many kinds of research can help you in these efforts, and some articles are being written in "translated" form, so you don't have to be a researcher to understand them.

Exercise 7c: Rating Your Research Knowledge

The following are some areas of research that are particularly important to public education for stigma reduction. Please rate your knowledge in each area:

- **The neuroscience of addiction:** Information on the neurological roots of addiction clearly takes addiction out of the realm of the bad habit or the moral failing, and into the scientific realm where it belongs. The new technology is proving what recovering people and practitioners in the field have known intuitively for a long time.

  How would you rate your knowledge of the neuroscience of addiction?

  Circle a number (1 is low; 10 is high): 1 2 3 4 5 6 7 8 9 10

- **Genetic factors in addiction:** There is clear and indisputable evidence that vulnerability to addiction can be passed from parents to children. This also makes it clear that addiction isn't just a series of bad choices.

  How would you rate your knowledge of genetic factors in addiction?

  1 2 3 4 5 6 7 8 9 10

- **Demographics on people with addictions:** Research that shows demographic factors (including race, economic levels, etc.) can be used to disprove many of the common myths and racial stereotypes connected with addiction.

  How would you rate your knowledge of the demographics of addiction?

  1 2 3 4 5 6 7 8 9 10

- **Research on outcomes and cost-offset factors:** This research proves that it really does make good fiscal sense to treat addiction, rather than wait until its symptoms lead to loss of employment, broken marriages, illness, injury, criminal activities, and death. But when you're using cost-offset arguments, make sure they're relevant to the self-interest of your audience. For example, a health insurance provider might not particularly care that successful treatment reduces unemployment, but might be interested in the fact that it can reduce other medical costs in the years to come.

How would you rate your knowledge of cost-offset research?

1 2 3 4 5 6 7 8 9 10

- **Research on treatment of other chronic diseases:** A look at the research on treatment of conditions like heart disease, cancer, and diabetes shows that their treatment compliance and success rates are similar to those of addiction. Changing lifestyle behavior is very hard, even in diseases that don't pack the neurological wallop that addiction does. The shame associated with treatment difficulties, relapse, and return to use can be both a product of stigma and a contributor to it.

  How would you rate your knowledge of treatment effectiveness for other chronic diseases?

  1 2 3 4 5 6 7 8 9 10

- **Research on the history of stigma-reduction efforts, in this field and in others:** People in our field and others—like those serving people with mental illness and other disabilities—have traveled this road before. We can learn from their successes.

  How would you rate your knowledge of the history of stigma-reduction efforts?

  1 2 3 4 5 6 7 8 9 10

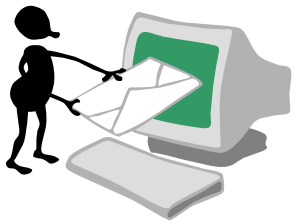
If you have access to the Internet, research is a lot easier to find now than it used to be. Appendix B (Page 119) lists a few places to start looking for the research you want. If you don't have access to the web—or if you do have access but need more information to make it meet your organization's needs—the National ATTC has a booklet called *Untangling the Web: A Guide for Treatment Programs*, which you can download from its web site.[4]

Another important aspect of research was mentioned in Chapter Six: the need for change agents to help shape the field's research agenda. If research is going to be one of our most important tools, it's important that we have input into its design. If you'd like to find out more about research-to-practice efforts, you might start by looking on the GLATTC web site (www.glattc.org) or that of the National ATTC (www.nattc.org).

Guideline #5: Define the Issues Carefully

Another important part of being an effective change agent is knowing what the issues are, knowing their complexities, and knowing which ones you'll be most effective at addressing.

A first step is to get hooked up with one or more of the public education organizations that exist and start receiving information from them, reading it, and thinking of ways you might help. If you live or work near a Recovery Community Support Program grantee, you can learn through direct contact with their work. You can also contact national organizations like The Alliance Project, Join Together, and the National Association of Alcohol and Drug Abuse Counselors and receive their newsletters, magazines, and e-mail alerts.



Many of these groups are listed in Appendix B, and they can lead you to still more groups and efforts. These organizations often collaborate on a variety of projects.

In light of national estimates that only 34-40 percent of people who need treatment have access to it,[5] it makes sense that a number of issues would center on funding for treatment, either through health insurance or through public funding. You'll hear a lot about "parity" legislation, laws that would require private insurors to cover addiction treatment to the same extent that they cover other chronic, recurring diseases like diabetes and hypertension. Many change agents say that parity legislation hasn't succeeded because there haven't been enough people educating the public and policy makers about the need for treatment. [6]

Many other budgetary issues center on the amounts of public money budgeted for treatment, the administration of treatment funds, and the kinds of programs that will receive them. According to an article published in NAADAC's *Counselor*, of the federal funds earmarked to address the nation's drug problem in 2000, only 19 percent went to treatment, as opposed to 68 percent spent on law enforcement and interdiction (McColl, 2000).

Compelling as the funding issues might be, change agents warn against focusing just on those issues and ignoring the full range of issues in need of our attention:

- There are issues of public perception (like media treatment of addiction or community attitudes toward addiction, treatment, and recovery), issues of discrimination (like the effects of addiction on eligibility for various licenses or the effects of employers' "never-ever" policies[7]), and issues of funding (for treatment and other services).
- There are local issues (like zoning issues or controversy over the placement of halfway houses in the community), statewide issues (like state policy or licensing requirements), and national issues (like national policy).
- There are a number of campaigns to get involved in (like CSAT's National Treatment Plan or Join Together's "Demand Treatment" initiative).
- There are time-limited issues (like a particular initiative) and ongoing issues (like a whole area of need or discrimination that must be addressed over time).

Exercise 7d: Public Education Issues

Of the issues and issue areas described above, which ones seem most interesting to you, and/or seem like you might have the most to offer in a public education role?

_____

_____

_____

_____

_____

_____

The next chapter looks at the benefits that people in recovery can bring to public education for stigma reduction, and a few important considerations for people in recovery who want to get involved.

Notes for Chapter Seven

[1] A few web sites for social marketing resources are included in Appendix B, on Page 131.
[2] For more information about technology transfer, you can get copies of *The Change Book* from the National ATTC office, address and phone information on Page 119. To download a copy, go to www.nattc.org. Click on the *Change Book* icon at the bottom of the home page, and navigate to the place where you can click for a PDF version of the booklet. When you get the PDF version, you can print it from the Internet.
[3] Thanks to Daphne Baille's Stigma Reduction presentation at the March 29, 2000 IAODAPCA Conference for information on many of the points raised in this Guideline.
[4] You can get copies of *Untangling the Web* from the National ATTC office, address and phone information on Page 119. To download a copy, go to www.nattc.org. Click on the *Untangling the Web* icon at the bottom of the home page, and navigate to the place where you can click for a PDF version of the booklet. When you get the PDF version, you can print it from the Internet.
[5] From "Research-to-Practice: The Federal Perspective," a presentation by Rick Sampson, Director of State and Community Assistance for the Center for Substance Abuse Treatment, at the May 1, 2000 "Bridging the Gap" Symposium in Madison, Wisconsin (published in *Wisconsin's Research-to-Practice Initiative: Proceedings from the May 1, 2000 Symposium.* Chicago: GLATTC and Wisconsin Bureau of Substance Abuse Services).
[6] NAADAC published a helpful summary of parity and other issues and public education needs, called "The Politics of Drug Issues: What Congress is Doing—How Advocacy Helps," in its December, 2000 edition of *Counselor*.
[7] "Never-ever" policies are hiring and placement policies that limit employees' opportunities for promotion or placement based on any past history of substance abuse, addiction, or treatment, no matter when that history took place, or whether or not it affected job performance.

CHAPTER EIGHT:

CHANGE AGENTS IN RECOVERY

As it stands in our society now, people see alcoholics and addicts all the time . . . in ERs, courts, spread all over the highway, killing people, saying rude things. The addicted person gets into recovery, and is invisible.[1]

—Paul Wood

We in recovery have been part of the problem. We have both accepted and perpetuated the stigma that kept us from getting help and that has killed millions of addiction disease victims.

By hiding our recovery, we have sustained the most harmful myth about addiction disease: that it is hopeless. And without the examples of recovering people, it's easy for the public to continue thinking that victims of addiction disease are moral degenerates—and that those who recover are the morally enlightened exceptions.

We are the lucky ones—the ones who got well. And it is our responsibility to change the terms of the debate, for the sake of those who still suffer.[2]

—Senator Harold Hughes

Should people in recovery become involved in public education for stigma reduction? And if they do, should they say that they're in recovery? The experience of other disability fields tells us that the myths and stereotypes about people with addictions can be healed more effectively if recovering people and their families talk openly about being in recovery. Helping professionals can help make this possible, but first we have to face some puzzling questions:

- What about the 12-Step traditions that emphasize anonymity? Although these traditions refer only to people's anonymity as members of specific programs—and only to anonymity in the media—many members believe they're not supposed to talk at all about being in recovery. What do we tell them?

- Can public education efforts harm the change agent or put his or her recovery in danger? Can public education work get in the way of recovery progress? Is public education itself a recovery activity?

Self-Disclosure for 12-Step Group Members

Most of us are familiar with this media scenario: Movie star gets in trouble with alcohol and other drugs, goes into rehab, comes out clean, talks to the media being in recovery or in AA/NA, stays clean for a while, returns to alcohol and drug use, gets in more trouble, gets into the papers again, goes into rehab again, etc. The general public is given one more excuse to say that treatment and recovery don't work, and many people in 12-Step groups feel betrayed by both the media and the movie star.

AA's 11th tradition protects the safety of its members—and of the organization itself—by requiring "personal anonymity" for group members "at the level of press, radio and films." The *Twelve Steps and Twelve Traditions* (1952) of Alcoholics Anonymous makes it clear that this tradition refers to anonymity as members of the organization itself, and only in the media. Still, many recovering people think it means they're not supposed to talk at all about being addicted, being in recovery, being in a 12-Step group, or being in a recovery group.

In their pamphlet "Advocacy With Anonymity," NCADD and Join Together confirm that "this language does not preclude you from speaking out about your own recovery or from advocating for the rights of other alcoholics and addicts as long as you do not involve the twelve-step group by name."[3] The pamphlet cites the fact that AA founders Bill W. and Dr. Bob were on the founding board of NCADD, an organization formed for public education.

"Advocacy With Anonymity" recommends that people speak out about their recovery. If members of 12-Step groups mention their recovery in the media, they can say "I found my recovery through a twelve-step group, but our traditions don't permit me to name it in the media."[4] Also, a change agent may speak publicly as a person in recovery, but never as a representative of AA, NA, or any other 12-Step group.

Exercise 8a: Talking About Recovery

If a former client or a friend in stable 12-Step recovery told you she'd like to be on a panel of recovering people speaking to an audience of doctors, but that the 11th Tradition of AA says she can't talk about being in recovery, how would you respond?

_____

_____

_____

_____

But what about our movie star, who publicly self-discloses in the first blush of recovery, then gets caught with a hangover in the camera's eye, freshly bailed out of jail, a few months later? Two thoughts on that one:

- Part of our general work as change agents is to teach the public about the nature and complexity of addiction. Just because someone completed a treatment program, that doesn't mean he was solidly in recovery. What seems like a relapse may just be a return to use by someone who isn't yet sober. Just because he returned to use, that doesn't mean that he failed in recovery, or that treatment doesn't work. He might simply need more services before recovery can take hold. And the fact that one person relapses or returns to use doesn't mean that another will have the same experience. These are important distinctions to make clear in our public education efforts.
- It's the responsibility of each potential change agent to get an accurate assessment of his or her stability in recovery before self-disclosing in public, and to wait until the risk of relapse has been lowered. In the relief of early recovery, some people have intense feelings of enthusiasm and dedication to sobriety. It's easy to mistake those feelings for stability in recovery and jump into public education too soon. It's up to treatment professionals, sponsors, fellow change agents, program friends, and other support people to help newcomers 1) understand the difference between enthusiasm and stability and 2) find safer ways of getting involved. Many change agents recommend waiting for two years' continuous sobriety before getting involved in public education efforts.

Exercise 8b: Questions About Self-Disclosure

1. If a newly sober former client (or a client in a continuing-care group) asked you if he should disclose his recovery status in a public education activity, what questions would you ask?

   _____

   _____

   _____

   _____

2. What other kinds of circumstances would you take into account in deciding how to respond?

   _____

   _____

   _____

   _____

   _____

Safe Public Education for People in Recovery

People in recovery who are thinking of getting involved in public education need to know this going in: Change agents who self-identify as part of a stigmatized population can become targets of the discrimination they're fighting to eliminate. Discrimination can also be magnified for people of color, women, youth, elders, people living in poverty, people with low incomes, people who are HIV positive, people with multiple diagnoses, etc. Areas of discrimination can include:

- Social networks (formal and informal)
- Employment (including hiring, job assignment, and promotion)
- Housing
- Criminal justice
- Insurance (particularly health and life insurance)
- Health care (including appropriate pain medication)
- Human services
- Licensing
- Politics

Jeff Blodgett, Coordinator of The Alliance Project, speaks of the "courageous few" who come forward in the early days of any anti-stigma movement. "Look at other issues like AIDS and HIV in the early 80s," says Blodgett. "A very courageous few did step out, and a lot of hard work by a lot of courageous people really dragged AIDS and HIV out into public awareness."[5]

Exercise 8c: Discrimination Risks

How much should the danger of discrimination affect an individual's decision to self-disclose? Here are a few things to think about:

- **The level of exposure on which the self-identification takes place:** For example, the woman who casually mentions to a few friends that she's been in recovery for several years may be at low risk, compared to the woman who mentions her recovery status at a town meeting or in an interview for a newspaper article.

  Another level-of-exposure example: _____

  _____

  _____

- **The level of disclosure:** For example, a man who mentions in public that he's a recovering alcoholic is at lower risk than a man who reveals intimate details of the personal, financial, marital, and legal problems that came out of that addiction.

  Another level-of-disclosure example: _____

  _____

  _____

- **The level of financial vulnerability:** For example, a woman who works in the addictions field is less likely to suffer job discrimination after she self-discloses about being in recovery than is her friend who works in an unrelated industry. Someone who has a firmly established career and finances may be less vulnerable than someone who is still struggling for financial security. Someone who already has stable health insurance is in a better position to self-disclose in public than someone who's about to start a new job or look for new health coverage.

  Another financial vulnerability example: _____

  _____

  _____

- **The level of emotional vulnerability:** For example, a woman with a strong network of friends and support people would have an easier time handling discrimination than a woman who is just starting to build her support network. A man with strong coping skills and emotional resiliency would be less vulnerable than a man who's struggling with anxiety or depression.

  Another emotional vulnerability example: _____

  _____

  _____

- **The length and stability of sobriety:** For example, a man in recovery might make an informed decision to self-disclose even though it might put him at some risk of discrimination. If he's stable in his recovery and his support network, and the discrimination wouldn't endanger his sobriety, then he's making a courageous decision. But if he's new or unstable in his recovery, and there's a danger that discrimination might increase his stress and raise his risk of relapse, then he's making a foolish decision. His fellow change agents, his support network, and the helping professionals in his life have a responsibility to help him find safer ways of getting involved.

  Another stability-in-recovery example: _____

  _____

  _____

- **Other Stigmatized Factors:** As mentioned in Chapter Three, people with addictions can experience extra discrimination related to their ethnic or racial characteristics; physical or psychiatric illnesses or disabilities (including HIV status); religion; gender or sexual orientation; family circumstances; age; educational level; involvement with criminal justice, welfare, or child custody systems; experiences as victims of violence or abuse; and occupational or financial status. For example, a Caucasian woman might suffer less discrimination as a result of her public education efforts than would an African-American woman—even if their economic and educational circumstances were the same. Potential change agents need to be aware of how society might react to all their characteristics, and take that into account in their decisions about self-disclosure.

Another multiple-stigma example: _____

_____

_____

There are many different kinds of public education activities, with different levels of exposure and intensity of involvement. Someone in earlier recovery might do fine participating in a rally or another group activity, but wait quite a while before doing anything that would raise greater risk or stress.

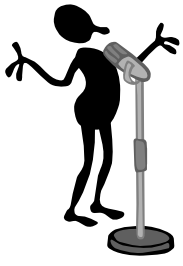
Exercise 8d: Rating Public Education Activity Risk Levels

Look through the list of public education activities on Pages 72 through 77. List some specific activities on the numbered lines below. Arrange them starting with the one that seems safest for people in early and/or unstable recovery, and gradually move toward the one that seems most risky, and best left for later and more stable recovery.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Keeping Recovery First

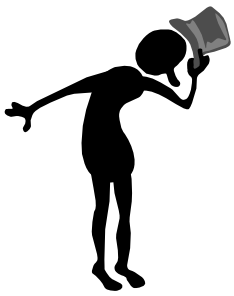
For any recovering person who wants to get involved, the most important thing to remember is to keep recovery first. Public education "should never take precedence over going to meetings, doing meditations, or talking to other recovering people,"[6] says William Cope Moyers, President of the Johnson Institute Foundation and one of our country's most dedicated and visible change agents in recovery.



Although public education work can be a powerful way of "carrying the message," public education activities are **not** appropriate substitutes for recovery activities, and pursuing public education as a way of life is not a viable recovery strategy, according to White (2000): "The history of addiction in America is strewn with the bodies of those who believed otherwise. When helping, educating, and advocating for others is used as or replaces a personal program of recovery, there is a considerable risk of relapse. People involved in these activities must find a way to sustain themselves (and their personal recovery)."

And relapse (or return to use) isn't the only risk. The spiritual and psychological growth that recovery programs promote are important, not only for relapse prevention, but also for basic happiness, coping with life's problems, and appropriate social functioning. Public education activities may be enriching, but they're no substitutes for careful self-examination, reflection, reality-checking, intimate communication, and spiritual discipline.

When the early AA members crafted their Traditions, they wanted to protect, not only the safety of their members, but also their humility. Humility is an important component of spiritual and psychological growth in many recovery philosophies. Sometimes described as "teachability," and sometimes as "being right-sized" (neither minimizing or exaggerating one's worth or importance), humility is very different from denying one's value or good qualities. In the popular wisdom, "humility isn't thinking less of yourself; It's thinking of yourself less." It's an honest recognition of the limited nature of all human beings.



What happens to humility when we spend a lot of time in the limelight, and our mission requires that we show our expertise and put on our best face for the public? What happens when our own personal stories gather a lot of attention, and we're admired for our strength and courage in telling those stories? Humility can be overshadowed by a sense of our own importance. We can get pulled in by our own drama and lose sight of the fact that we still have just as much to learn from the people who are out there admiring us as they have to learn from us.

Recovering people who choose to get into high-profile activities would do well to make sure they also follow conscious and deliberate strategies for developing and maintaining their personal humility—whatever that means to them. It will help them stay out of the ego trap, and help them continue to grow as social and spiritual beings.[7]

Exercise 8e: Personal and Spiritual Growth

1. Based on your own experience and/or that of your clients, what are some of the biggest challenges to balancing personal ambitions and personal growth?

   _____

   _____

   _____

2. What ways of meeting those challenges have you and/or your clients found most successful?

   _____

   _____

   _____

   _____

Now that you've had a chance to think about specific public education activities, effective ways of getting involved, and special considerations for change agents in recovery, it's time to start making a plan. But the plan you'll start in the next chapter won't be limited to public education activities. It can cover all stigma-reduction activities you plan to engage in, formally or informally. It should be tailored to your own convictions and your current stage of change. This should be a working document, one that can grow along with your own awareness and skills.

Notes for Chapter Eight

[1] Quoted from Paul Wood, former president of the National Council on Alcoholism and Drug Dependence (NCADD). In McAleavy, T (1998). Speaking Up About Addictions. *The Record Online*, November 23, 1998. www.bergenrecord.com/cope/cope112319981123.htm

[2] From "Coming out of the Closet to Fight Abuse" (1994-1995). *SOAR USA Bulletin* Fall/Winter. Posted at http://www.aaw.com/library/soar1.html

[3] The text of *Advocacy With Anonymity* is presented in full in Appendix E, Page 139. You can also get copies of this pamphlet from a number of sources. Recovery Communities United can supply copies (their phone and address are listed on Page 125). You can get copies of this pamphlet in bulk by calling Join Together, or you can download it from the organization's web page (phone, address, and web address are listed on Page 127).

[4] Also quoted from *Advocacy With Anonymity*.

[5] Interview with Jeff Blodgett.

[6] Interview with William Cope Moyers.

[7] Considerable wisdom on this subject can be found in Ernest Kurtz and Katherine Ketcham's (1992) book *The Spirituality of Imperfection: Storytelling and the Journey to Wholeness.*

CHAPTER NINE:

MAKING A PLAN

You've done a lot of work on this manual. You've read and written about:

- How stigma shows up in individuals, in the media, in our language, and in societal beliefs about addiction and people with addictions
- Stigma's effects on the addictive process, on the lives of people with addictions, and even on our own job satisfaction
- Ways of helping clients heal the effects of stigma
- The historical momentum behind stigma and the history of stigma-reduction efforts
- Public education activities for stigma reduction, and the possible benefits and obstacles you might encounter if you were to become involved in some of these activities
- The stages of change, where you are in the process of moving toward a public education role, and your personal mission for stigma-reduction efforts
- Ways of understanding your audiences and crafting effective messages
- Roles you might play in helping recovering people and their families become safely involved in public education efforts

There's just one more thing to do as part of this manual: to use the work you've done to pull together a plan for your own involvement in stigma-reduction efforts. This plan should not be limited to things that we think of as public education activities. It can also include:

- Efforts to study and learn more about the subjects covered in this manual
- Studying the research on addiction, the history of the field, and the history of stigma reduction in this field and others
- Helping clients and families heal the stigma of addiction
- Responding as an individual to stigmatizing language, concepts, myths, and images in society

There are many forms that a plan might take, and the following is a fairly simple one.

Stigma-Reduction Mission (Exercise 5c Revisited)

Before you start, it's important to keep your mission in front of you. Find the mission statement you drafted on Page 83, and write it below. (Of course, you can change it if you think of a better way to say it.)

_____

_____

_____

_____

_____

Exercise 9a: Choosing Your Goals

Now it's time to choose goals that will take you toward that mission, and action steps toward those goals. The goals are specific, measurable achievements. Some examples might be:

- "Find out how much stigma has affected my own attitudes and beliefs"
- "Get a better understanding of the brain chemistry of addiction"
- "Get better at responding to stigmatizing statements by friends and family members"
- "Incorporate some stigma-healing activities into my work with clients"
- "Get actively involved in an organization or initiative that works toward stigma reduction"
- "Add a stigma-reduction page to my agency's web site"

The goals that you choose should be consistent with your own values and convictions, with the realities of your life and work, and with your skills and interests. They should also be appropriate for your stage of change. In other words, please don't take on anything that you know you're just going to put off or feel conflicted about doing.

The easiest way to find appropriate goals might be to look back through this workbook, at your answers to the exercises on Pages 72 through 77, and on Page 91. After you've done that, use the spaces that follow (on this page and the next) to list as many goals as you think might be right for you. (Leave the "#" space blank at first.)

____ Goal: _____

_____

____ Goal: _____

_____

____ Goal: _____

_____

____ Goal: _____

_____

____ Goal: _____

_____

____ Goal: _____

_____

____ Goal: _____

_____

Now look through the goals you've listed, and use the "#" spaces to put them in numerical order. You might want to start with the goals that make you feel best when you think about doing them, sound least intimidating, and/or sound most important to you. Now pick the top three goals, and make three copies of the Action Plan form on the next page. Write the name of each goal on a copy of the form.

Choosing Action Steps

The action steps are the small actions that lead toward a goal. You write them in the left-hand column of the Action Plan form. No matter how ambitious the goal is, the action steps should be little and easy to accomplish—making a phone call, looking something up, making a decision, etc. For example, if you came up with the goal, "get actively involved in an organization or initiative that works toward stigma reduction," some action steps might be:

1. "Talk to someone I know and respect who's involved in public education for stigma reduction; Ask how they did it"
2. "Choose public education activities I'd like to get involved in"
3. "Call one or two of the organizations listed in Appendix B, and/or look on their web sites"
4. "Choose an organization or initiative I'd like to know more about"
5. "Attend a meeting or another activity of the organization or initiative"

Choosing Resources and Setting Timelines

Public education and other stigma-reduction efforts are often best if we do them in collaboration with other people, or at least take advantage of others' knowledge and experience. For every action step, list some resources you might use. These might be people you know or don't yet know, web sites, organizations, or materials. You can use Appendices A and B for ideas.

It's also important to give yourself a realistic deadline or "due date" for each action step—something that's comfortable within the scope of your life. Write these dates on the form. Then, when you've completed an action step, check it off in the "Done?" column.

Exercise 9b: Action Plan

Goal: _____

Action Step	Resources	Due Date	Done?

After You Make Your Plan

Here's a paraphrase of the old frog story: Three frogs are sitting on a log. One frog draws up an action plan for getting off the log. Now how many frogs are on the log? Three, of course.

You can just submit your action plan and the required exercises to get CEUs for this course, then bury the plan under that mound of paper that's trying to eat your desk. But you also have the option to tack it up somewhere very visible, look at it once in a while, and do the action steps one by one.

Who knows? You might bring about some lasting changes in your own life, the lives of your clients, the lives of friends and family, your community, or the society we live in. In the language of technology transfer, this would be called adoption or implementation—using what you've learned.

Your vision of a stigma-free society, with stigma-free lives, is important and valid. The fact that most of the momentum of history would rather roll right over that vision doesn't make it any less important or any less valid. A century ago, the large number of people who are living clean and sober now must have sounded like a pipe dream, but it wasn't. It just took a lot of people working together to get this far.

The stigma of addiction isn't the only factor that keeps people isolated and ashamed, keeps people out of treatment, makes denial seem like the best alternative, talks people into abandoning their recovery programs, and talks society into abandoning people who need help. But it is a significant factor, and when we're dealing with an often-fatal condition, every significant factor counts.

You might look at this as a struggle against stigma, or a celebration of recovery, or a push for scientific truth over myth and prejudice. But however you see it, your vision—combined with your knowledge and your willingness to take action—is exactly what's needed right now.

And getting involved might turn out to be exactly what **you** need right now—to wake up your sense of hope, to breathe new life into your work, and to help shape a society where people are free to get well and live in dignity.

Post-Manual Exercise:

SELF-ASSESSMENT OF CHANGE

This exercise is an inventory of the ways in which your feelings, beliefs, and practices might have changed as a result of your completing this manual. Like the Stigma Self-Assessment exercise you completed before you started the manual, this exercise is meant for your own reflection. You don't have to turn it in or show it to anyone.

Post-Manual Exercise: Self-Assessment of Change

1. Look at the Stigma Self-Assessment exercise on Page 18. How did you describe your personal beliefs about the true nature of addiction?

   _____

   _____

2. In what ways have your beliefs about addiction grown stronger during the process of completing this manual?

   _____

   _____

3. In what ways have your beliefs about addiction changed?

   _____

   _____

4. How has your understanding of people with addictions changed?

   _____

   _____

5. How has your understanding of people who stigmatize addiction changed?

   _____

   _____

6. How have your feelings about public education changed during this process?

   _____

   _____

7. What are you now prepared to do differently, or already doing differently?

   _____

   _____

   _____

   _____

MANUAL EVALUATION FORM

This form will help us evaluate how well *Healing the Stigma of Addiction* meets its objectives (listed on Pages 15 through 17), so we can continue to work on improving our products. Please take a few minutes to circle the appropriate numbers, then submit it with your application for CEUs. If you're not applying for CEUs, please photocopy or remove these pages and mail them to:

Stigma Manual Evaluations
GLATTC/UIC
808 S. Wood (MC 779)
Chicago, IL 60612

How well prepared do you believe you are to do each of the following:	**1=Poorly 3=Average 5=Very Well (Please circle one)**				
1a. Understand the experience of clients whose lives have been negatively affected by the stigma attached to addiction	1	2	3	4	5
1b. Continue to identify incentives for getting involved in stigma-reduction efforts	1	2	3	4	5
1c. Envision the possible effects on your work, your clients, your community, and society as a whole if addiction weren't stigmatized	1	2	3	4	5
2a. Understand some of the effects of the stigma of addiction that you have seen	1	2	3	4	5
2b. Describe some of the ways in which people with addictions have been portrayed on TV and in the movies	1	2	3	4	5
2c. Be aware of stigmatizing terms used in our society	1	2	3	4	5
2d. – 2f. Be aware of some of the common stigmatizing myths about addiction, about people with addictions, and about relapse	1	2	3	4	5
3a. Identify some emotional reactions that people have in response to some of the behavioral symptoms of addiction	1	2	3	4	5
3b. Describe some of the symptoms of stigma	1	2	3	4	5

How well prepared do you believe you are to do each of the following:	1=Poorly 3=Average 5=Very Well (Please circle one)				
3c. Describe the effects of isolation, shame, denial, and hopelessness on the progression of substance use and addiction, and on people's willingness and ability to seek help and stay in treatment	1	2	3	4	5
3d. Understand the effects of multiple stigmas and stereotypes on your clients	1	2	3	4	5
3e. Identify some of the effects of stigma on your job satisfaction	1	2	3	4	5
4a. Use resiliency theory to help clients heal the effects of stigma	1	2	3	4	5
4b. Identify and introduce ways of helping clients heal the effects of stigma	1	2	3	4	5
5a. Understand the historical momentum behind the stigma of addiction	1	2	3	4	5
5b. Describe some effects of the history of stigma-reduction efforts	1	2	3	4	5
6a. Assess your potential for involvement in public education for stigma reduction, and how you might approach this involvement	1	2	3	4	5
6b. Monitor your own stage of change moving toward a public education role, and identify your primary tasks at that stage of change	1	2	3	4	5
6c. Follow and continue to revise (as appropriate) your mission statement for involvement in stigma reduction	1	2	3	4	5
7a. Understand the needs and characteristics of the audiences for your stigma-reduction efforts	1	2	3	4	5
7b. Assess the effectiveness of specific messages	1	2	3	4	5
7c. Identify research topics on which you might want to gain more knowledge	1	2	3	4	5
7d. Identify stigma-reduction issues in which you might want to get involved	1	2	3	4	5
8a. Respond to a person in stable 12-Step recovery about self-disclosing his/her recovery status in public education efforts	1	2	3	4	5

How well prepared do you believe you are to do each of the following:	**1=Poorly 3=Average 5=Very Well (Please circle one)**
8b. Assess the appropriateness of self-disclosure for a newly recovering person and respond to questions about that possibility	1 2 3 4 5
8c. Identify factors that might put people at risk of experiencing discrimination if they publicly self-disclose as being in recovery from addiction	1 2 3 4 5
8d. Assess the level of risk that people in early and/or unstable recovery might experience if they are involved in various public education activities	1 2 3 4 5
8e. Balance involvement in public education efforts with a focus on personal and spiritual growth	1 2 3 4 5
9a. Follow and continue to revise (as appropriate) your personal goals in public education for stigma reduction	1 2 3 4 5
9b. Follow and continue to revise (as appropriate) your personal plan for involvement in stigma reduction	1 2 3 4 5
Overall: Continue to assess your own change process where stigma-reduction efforts are concerned	1 2 3 4 5

When you decided to work through this manual, what effect(s) did you want it to have on you and/or your work? (See question 7 on Page 18)

_____

_____

_____

How well has it done in having those effects? 1 2 3 4 5

Please explain: _____

_____

_____

What could we do to improve this manual and/or future products? _____

_____

_____

_____

APPENDICES

APPENDIX A:

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APPENDIX B:

ORGANIZATIONS AND WEB SITES

Addiction Technology Transfer Centers

ATTC National Office
University of Missouri–Kansas City
5100 Rockhill Road
Kansas City, MO 64110
(816) 482-1146
www.nattc.org

Delivery address:
2700 E. 18th St., Suite 208
Kansas City, MO 64127

DC/Delaware ATTC
(Washington DC, Delaware)
DANYA International
8737 Colesville Rd.–12th Floor
Silver Spring, MD 20910
(301) 565-2142
www.dcde-attc.net/

Center for Excellence for HIV, Hepatitis, and Addiction Technology Transfer (CHHATT)

Great Lakes Addiction Technology Transfer Center (GLATTC)
(Illinois, Ohio, Wisconsin; auxiliary services to Indiana and Michigan; expansion plans)
Jane Addams College of Social Work
University of Illinois–Chicago
1640 W. Roosevelt Rd., Suite 511 (M/C 779)
Chicago, IL 60608-1316
(312) 996-1373
www.glattc.org

Center for Excellence in Criminal Justice

Mid-America ATTC
(Missouri, Kansas, Minnesota)
University of Missouri–Kansas City
5100 Rockhill Rd.
Kansas City, MO 64110
(816) 482-1100
email: atc@mattc.org
www.mattc.org

Delivery Address:
2700 E. 18th St., Suite 208
Kansas City, MO 64127

Mid-Atlantic ATTC
(Virginia, West Virginia, Maryland, North Carolina)
Virginia Commonwealth University
PO Box 980205
Richmond, VA 23298
(804) 828-9910
email: mid-attc@mindspring.com
www.mid-attc.org

Delivery Address:
1112 E. Clay St., Room B08
Richmond, VA 23219

Mountain West ATTC
(Nevada, Montana, Wyoming, Utah)
Mountain West ATTC/mailstop 279
University of Nevada
Reno, NV 89557
(775) 784-6265
www.unr.edu/mwattc/

Delivery Address:
1664 N. Virginia St.
Reno, NV 89503

ATTC of New England
(Vermont, New Hampshire, Maine, Rhode Island, Massachusetts, Connecticut)
Center for Alcohol and Addiction Studies
Brown University, Box G-BH
Providence, RI 02912
(401) 444-1808
www.caas.brown.edu/ATTC-NE

Delivery Address:
ATTC–NE
Brown University
800 Butler Drive
The Potter Building
Room 108
Providence, RI 02906

Northeastern States ATTC
(New York, New Jersey, Pennsylvania)
Professional Development Program
Rockefeller College, University at Albany
135 Western Avenue Draper 314
Albany, NY 12222
(518) 442-5702
www.pdp.albany.edu/nsattc

Northwest Frontier ATTC
(Alaska, Idaho, Oregon, Washington)
Northwest Frontier ATTC
3414 Cherry Ave. NE, Suite 100
Salem, OR 97303
(503) 373-1322
email: nfatc@open.org
www.open.org/nfatc

Pacific Southwest ATTC
(California, Arizona, New Mexico)
University of California, San Diego
Department of Psychiatry
School of Medicine
565 Pearl Street, Suite 306
La Jolla, CA 92037
(858) 551-2944
www:attc.ucsd.edu

Prairielands ATTC
(Iowa, Nebraska, South Dakota, North Dakota)
782 Van Allen Hall
University of Iowa
Iowa City, IA 52242
(319) 335-5368
www.uiowa.edu/~attc

Center of Excellence for Dually Diagnosed Persons
Center of Excellence for Substance Abuse and Lesbian, Gay, Bisexual, and Transgendered Persons (LGBT)
Center of Excellence Native Americans and Substance Abuse
Center of Excellence for Women and Substance Abuse

Puerto Rico ATTC
(Puerto Rico, Virgin Islands)
Centro de Estudios en Adiccion
Universidad Central del Caribe
Call Box 60-327
Bayamon, PR 00960
(787) 785-4211
email: prattc@uccaribe.edu
www.uccaribe.edu/prattc/

Southeast ATTC
(Georgia, Alabama, South Carolina, Florida)
Morehouse School of Medicine
Cork Institute
720 Westview Drive, SW
Atlanta, GA 30310
(404) 756-5742
www.mattc-cork.org

Texas ATTC
(Texas)
University of Texas
School of Social Work
Center for Social Work Research
1925 San Jacinto Blvd.
Austin, TX 78712
(512) 471-3538
www.utattc.net

Recovery Community Support Program Grantees

Association of Persons Affected by Addictions (APAA)
(Texas)
Dallas Helps, Inc.
2200 Main St.
Dallas, TX 75201
(214) 954-0090
email: LoisOlson1@aol.com
www.APAArc.org
www.DallasHelps.org

AWARE Program
Always Working Towards Advancing Recovery Environments
(California)
California Association of Alcohol and Drug Program Executives
1127 11th St., Suite 208
Sacramento, CA 95814
(916) 329-7409
(800) 288-1222 (message center, California only)
Email: info@caadpe-aware.org
www.caadpe-aware.org

Circles of Recovery Support Program
(Colorado)
White Bison, Inc.
6145 Lehman Drive, Suite 200
Colorado Springs, CO 80918
Email: info@whitebison.org
www.whitebison.org/

Connecticut Community for Addiction Recovery (CCAR)
(Connecticut)
465 Silas Deane Highway
Wethersfield, CT 06109
Email: CCAR2005@aol.com
www.ccar-recovery.org

El Paso Alliance/Recovery Community Organization
(Texas)
Aliviane NO-AD, Inc.
7722 North Loop
El Paso, TX 79915
(915) 782-4000
email: ysims-epa@email.msn.com

Missouri Recovery Network
(Missouri)
Missouri Department of Public Health
1648 E. Elm St.
Jefferson City, MO 65101
(573) 635-6669
Email: mzcoutm@mail.dmh.state.mo.us (M. Couty)

National Council on Alcoholism and Drug Dependence of Michigan
(Michigan)
913 West Holmes Road, Suite 111
Lansing, MI 48910
(517) 394-1252
email: advocacy@ncaddm.org
www.ncaddm.org/

New England Alliance for Addiction Recovery (NEAAR)
(Maine)
New England Institute of Addiction Studies
99 Western Ave., Suite 12
Augusta, ME 04330
(207) 621-2549 (N. Miner)
email: miner@ueias.org (N. Miner)
or
1492 Elm St.
Manchester, NH 03101
(603) 668-4115 (D. Devlin)
email: neias@mva.net (D. Devlin)
www.neaar.org

Partners in Recovery Alliance (PIRA)
(California)
Contra Costa County Health Services Department
597 Center Avenue, Suite 320
Martinez, CA 94553
(925) 313-6389
email: cdeutschman@hsd.co.contra-costa.ca.us
delvalle@hsd.co.contra-costa.ca.us
www.cccpira.org

Pennsylvania Recovery Organizations Alliance (PRO-A)
(Pennsylvania)
500 N. Progress Ave.
Harrisburg, PA 17109
(717) 541-9313 (D. Dmitrovic)
or
Gaudenzia Foundation
106 W. Main St.
Norristown, PA 19401
(610) 239-9600 (M. Harle)
email: recovery@ezonline.com

People With Recovery & Disabilities (PWRD)
(Arizona)
Pima Prevention Partnership
345 E. Toole Ave., Suite 104
Tucson, AZ 85701
(520) 791-2711 (H. Kressler)
(520) 884-1300 (I. Baker)
email: ibaker@pimaprevention.org

PRO-ACT: Promoting Recovery Organizations – Achieving Community Togetherness
(Pennsylvania)
Bucks County Council on Alcoholism and Drug Dependence, Inc.
Bailiwick Office Campus, Suite 12
252 W. Swamp Rd.
Doylestown, PA 18901-2444
(215) 345-6644
email: PROACT6644@aol.com

Recovery Association Project (RAP)
(Oregon)
Central City Concern
2 NW Second Ave.
Portland, OR 97209
(503) 294-1681
(503) 973-9655 (Voice Mail)
email: tleckron@transport.com
www.recoveryassociation.org

Recovery Communities United/NCADD Illinois
(Illinois)
1010 Lake Street, Suite 210
Oak Park, IL 60301
(708) 383-2885
Email: donmalec@aol.com
www.inrecovery.org/
www.ncaddillinois.org/

Sacred Circle Project
(Iowa)
Native Family Resource Center, Inc.
809 W. 7th St.
(PO Box 3704)
Sioux City, IA 51102
Email: deb.scholten@nativefrc.org
Maynard.needham@nativefrc.org
Info@nativefrc.org

Santa Barbara Recovery Community Network
(California)
Santa Barbara Council on Alcoholism and Drug Abuse
226 E. Canon Perdido St., Suite H
Santa Barbara, CA 93101
(805) 899-2933
Email: alexb@recoverycommunity.org
recovery@silicom.com
www.communityrecovery.org/

Speak Out: LGBT Voices for Recovery
(New York)
Lesbian and Gay Community Service Center
One Little West 12th Street
New York, NY 10014
(212) 620-7310
email: speakout@gaycenter.org
tom@gaycenter.org
www.gaycenter.org

STAR Project
(Wisconsin)
University of Wisconsin
523 Lowell Hall
610 Langdon Street
Madison, WI 53703
(608) 263-6557 (R. Kessel)
(608) 265-2679 (F. Hilliard)
email: fth@mail.DCS.wisc.edu (F. Hilliard)
www.starofmadison.com

Substance Abuse and Addiction Recovery Alliance (SAARA)
(Virginia)
100 N. Washington St., Suite 239
Falls Church, VA 22046
(703) 237-6141
email: director@saara.org
www.saara.org

Organizations With Public Education Resources and Activities

Alcohol Policies Project
Center for Science in the Public Interest
1875 Connecticut Avenue, NW, Suite 300
Washington, DC 20009
(202) 332-9110, Ext. 385

The Alliance Project
1954 University Avenue, Suite 12
St. Paul, MN 55104
(651) 645-1618
www.defeataddiction.com (or)
www.defeataddiction.org

Center on Alcohol Advertising
San Francisco General Hospital
1001 Montero Avenue
Building 1, Room 300
San Francisco, CA 94110
(415) 821-8209
www.traumafdn.org/alcohol/ads/index.html (under construction)

Center for Substance Abuse Treatment (CSAT)
1 Choke Cherry Road
Rockville, MD 20857
(301) 443-5700
www.samhsa.gov/centers/csat/csat.html

Community Behavioral Healthcare Association
3085 Stevenson Drive, Suite 308
Springfield, IL 62703
(217) 585-1600
www.cbha.net

Hazelden Center for Public Policy
Hazelden Foundation
PO Box 11
Center City, MN 55012
www.hazelden.org

Johnson Institute Foundation
2314 University Avenue, Suite 24
St. Paul, MN 55114
(651) 659-9100
www.johnsoninstitute.org

Join Together
441 Stuart Street, 7th Floor
Boston, MA 02116
(617) 437-1500
www.jointogether.org
(to get *JTO Direct* newsletter, click the JTO box on the left side of page)

Legal Action Center
236 Massachusetts Avenue, NE, Suite 505
Washington, DC 20002
(202) 544-5478

National Association of Alcohol and Drug Abuse Counselors (NAADAC)
1911 N. Fort Meyer Drive, Suite 900
Arlington, VA 22209
(800) 548-0497
www.naadac.org

National Council on Alcoholism and Drug Dependence, Inc. (NCADD)
12 W. 21st Street
New York, NY 10010
(212) 269-7797
www.ncadd.org

Physician Leadership for National Drug Policy
Center for Alcohol and Addiction Studies
Box G-BH
Brown University
Providence, RI 02912
(401) 444-1818

Stigma Busters
National Alliance for the Mentally Ill (NAMI)
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201
(800) 950-NAMI
www.nami.org/campaign/stigmabust.html

Stigma of Addiction Project
Centre for Addiction and Mental Health
Ontario, Canada
(416) 535-8501
http://sano.arf.org/stigma.htm

Community Partners in the Demand Treatment Project (as of 2/01)

Boise, Idaho
Mayor's Advisory Committee on Substance Abuse

Chicago/Cook County, Illinois
Recovery Communities United
Consortium of Radio Stations Against Drugs

Denver, Colorado
City of Denver

Des Moines, Iowa
Employee and Family Resources, Inc.

Houston, Texas
Mayor Lee Brown's Houston Crackdown

Indianapolis, Indiana
Drug Free Marion County

Kansas City, Missouri
COMBAT, Jackson County Prosecuting Attorney's Office

Knoxville, Tennessee
Metropolitan Drug Commission

Manchester, New Hampshire
Friends of Recovery, New Hampshire

Mobile, Alabama
Drug Education Council

Nashville, Tennessee
Music City Demands Treatment

Pittsburgh, Pennsylvania
The Coalition for Leadership, Education and Advocacy for Recovery

San Antonio, Texas
Southwest Texas Addiction Research and Technology Center

San Francisco, California
Community Substance Abuse Services

Trenton, New Jersey
City of Trenton
Concerned Pastors of Trenton

Tucson, Arizona
Pima Prevention Partnership

Organizations With General Information and Research on Addictions

Addiction Technology Transfer Center (ATTC) National Office
University of Missouri – Kansas City
5100 Rockhill Road
Kansas City, MO 64110
(816) 482-1146
www.nattc.org

Center for Substance Abuse Treatment (CSAT)
Rockwall #2
5515 Security Lane
Rockville, MD 20857
(301) 443-5700
www.samhsa.gov/centers/csat/csat.html

National Institute on Drug Abuse (NIDA)
6001 Executive Boulevard
Bethesda, MD 20892
(301) 443-1124
www.nida.nih.gov

Prevention First, Inc.
2800 Montvale Drive
Springfield, IL 62704
(800) 252-8951
www.preventionfirst.org (under construction)
720 N. Franklin, Suite 500
Chicago, IL 60610
(800) 572-5385

Other Web Sites for Addiction Information

Addiction Abstracts
(Scans journals and offers access to literature)
www.carfax.co.uk/

Addiction Research Foundation
(In Ontario, offers program information, bibliographies, and other resources)
www.arf.org

Addictions and Life Organization
(Links to other web sites on addiction-related issues)
www.addictions.com

Alcoholics Anonymous
(The organization's central web site)
www.alcoholics-anonymous.org
(Many related links and downloadable information)
www.recovery.org/

Anti-Drug Coalitions of America
(Includes public education information)
www.cadca.org

Close to Home (Public Broadcasting System)
www.pbs.org/wnet/closetohome/home.html

The DATOS Study
(Excellent source of information on current federal research on outcomes and retention)
www.datos.org

Drug Policy Research Center
(Research, policy analysis, and outreach)
www.rand.org/centers/dprc/

Journal of Psychoactive Drugs
www.mind.net/cns/jpd.htm

Journal of Substance Abuse Treatment
www.elsevier.nl/inca/publications/store/5/2/5/4/7/5/525475.pub.shtml

Narcotics Anonymous
(The organization's central web site)
http:/www.na.org

National Clearinghouse for Drug and Alcohol Information
(Many government publications on addiction)
www.health.org

National Treatment Improvement Evaluation Study
(A five-year study funded by CSAT)
www.calib.com/nedtac/nties/index.htm

Web of Addictions
(Information about addictions)
www.well.com/user/woa/

Web Sites With Information on Social Marketing

Novartis Foundation for Sustainable Development
www.foundation.novartis.com

The Social Marketing Institute, Weinrich Communications
www.social-marketing.com

The Social Marketing Network, Education Development Center
www.edc.org

Search Engines

These web sites allow you to search on keywords for web pages on-line materials.

www.altavista.com

www.askjeeves.com

www.dogpile.com (calls up other search engines too)

www.excite.com

www.google.com (starts with the pages that have been accessed most often)

www.hotbot.com

www.lycos.com

www.northernlight.com (arranges results in folders)

www.snap.com

www.webcrawler.com

www.yahoo.com

Note: If you want to search on multiple keywords (for example, "addiction," "treatment," and "retention"), many search engines require that you type the word "AND" between the keywords (but don't use quotation marks). So you'd type in *addiction AND treatment AND retention* and click the search key. (Some sites (like google.com) don't require the "AND.")

APPENDIX C:

THE CSAT, SAMHSA NATIONAL TREATMENT PLAN

A BRIEF SUMMARY OF STIGMA-REDUCTION INFORMATION FROM *CHANGING THE CONVERSATION: THE NATIONAL TREATMENT PLAN INITIATIVE*

November, 2000
Center for Substance Abuse Treatment

In November of 2000, the Center for Substance Abuse Treatment (CSAT) released *Changing the Conversation: The National Treatment Plan Initiative*. That report was the product of a long study process by a number of panels on key topics related to addiction, treatment, and recovery.

Panel II of the Initiative focused on Reducing Stigma and Changing Attitudes. That Panel defined its vision statement as follows:

> *We envision a society where people who are addicted to alcohol or other drugs, people in recovery from addiction, and people at-risk for addiction are valued and treated with dignity; and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. We envision a society where addiction is recognized as a public health issue—a treatable disease for which individuals should seek and receive treatment; and where treatment is recognized as a specialized field of expertise.*

The Panel proposed a four-point approach for reducing stigma:

1. **Conduct science-based marketing research (e.g., polling, surveys, focus groups) to provide the basis for a social marketing plan.** This effort should begin with a language audit to determine problems or opportunities inherent in the language currently used in the field and in public discussions.

2. **Based on the results of the marketing research and language audit, develop and implement a social marketing plan designed to change the knowledge, attitudes, beliefs, and behavior of individuals and institutions to reduce stigma and its negative consequences.** One goal of the plan should be to develop a commonly accepted, clearly worded taxonomy to describe alcoholism and drug addiction and the treatment services available.
3. **Facilitate and support grassroot efforts to build the capacity of the recovery community to participate in the public dialogue about addiction, treatment, and recovery.**
4. **Promote the dignity of and reduction of stigma and discrimination against people in treatment or in recovery from alcohol or other drugs by encouraging the respect for their rights in a manner similar to people who have suffered from and overcome other illnesses.**

The Panel noted particular concern about the effects of "overlapping and compounding stigmas associated with alcoholism and drug addiction," including stigmas associated with substances used or treatment providers providing services; and associated with demographic factors such as race, ethnicity, gender, age, religion, employment status, geography, disability, sexual orientation, education, position/profession, lineage, and criminal justice status.

The panel next identified populations who tend to be stigmatized more than others, specifically, women, people of color, youth, elders, people living in poverty, and people with multiple diagnoses. The panel also defined a number of areas in which stigma often leads to discrimination, including criminal/juvenile justice, education, employment, housing, health, insurance, and human services.

The report also reviewed national efforts to reduce or prevent stigma, public opinion research, formal approaches to reducing stigma and changing attitudes, and previous recommendations addressing the reduction of stigma and change in attitudes.

How to Display the Plan

Changing the Conversation can be found on the CSAT web site. Instructions for bringing up a display of the Plan are as follows:

1. Go to the CSAT web site, at www.samhsa.gov/centers/csat/csat.html
2. In the upper central portion of that page is a heading "CSAT Related Topics," and under that, "CSAT Program Resources." Click on the first entry so the drop-down list appears. Click on "National Treatment Plan."
3. Click the **Go Now** button. The Treatment Plan will appear. Find the Reducing Stigma and Changing Attitudes section. You can print all of part of the Plan from this display.

APPENDIX D:

STIGMA NEWS FROM THE ATTC NETWORKER

The following article was published in two parts in the Spring and Summer, 2000 editions of the *ATTC Networker*, the newsletter of the ATTC Network, published by the National ATTC.

FIELD COMBATS STIGMA, ATTITUDES & BELIEFS

The Center for Substance Abuse Treatment (CSAT) has identified stigma as an important factor to consider when looking at the future of the treatment field. CSAT is addressing this topic in the national initiative, "Changing the Conversation: A National Plan to Improve Substance Abuse Treatment."

In addition to four other topic panels, a "Reducing Stigma and Changing Attitudes" expert panel is charged with defining the debate surrounding stigma, developing a national plan to reduce stigma, promoting national understanding that substance abuse is a public health problem and that treatment is a specialized field of expertise.

Camille Barry, deputy director for CSAT, stated, "In addition to the other themes addressed by the Treatment Plan, we identified stigma and changing attitudes as an important overarching theme. This panel is reviewing all aspects of stigma, and will make recommendations for CSAT and the field to follow." The final report will be completed this spring.

The current focus on stigma is being driven by a number of grassroots efforts. William Cope Moyers, vice-president of public affairs at the Hazelden Foundation, is leading the field in addressing this topic. "We must build public understanding of recovery and treatment," explained Moyers. "Recovery happens all over the world every day. It is time for the public to embrace this fact."

Moyers believes the key to reducing stigma is to “put a face on recovery.” He encourages those in recovery to responsibly stand up and speak out in their own communities about recovery. While some feel this violates the anonymity of many 12-step programs, Moyers believes that a person can speak about their own recovery as long as they don’t involve the recovery program in which they participate.

Hazelden is a non-profit organization that provides rehabilitation and education in chemical dependency.

The ATTCs are addressing stigma in a number of ways. The Mountain West ATTC (MWATTC) is directly addressing stigma in undergraduate and graduate course work at the University of Nevada-Reno. Nancy Roget, co-director of the MWATTC, explains, “We require students to give up one behavior for nine to fourteen weeks. Students are asked to pick the one thing that seems too difficult to give up in order to make the experience impactful. They are then asked to sign a contract and must write about their experience including how others react to them, their ‘cravings’ and any ‘relapses’ they face.”

What Is Stigma?

A 1997 edition of Webster’s Dictionary defines stigma as, “a brand; mark of disgrace; stain on character.”

Stigma in Our Work, in Our Lives, a 1998 video package developed by the Anti-Stigma Project of On Our Own of Maryland, Inc., states the following about stigma: “Assumption. Prejudgment. Discrimination. Painful. These are all words used to describe the phenomenon of stigma. When applied to the field of mental health and substance abuse, stigma is a pervasive and damaging influence on the quality of services, treatment outcomes, and therapeutic, professional and personal relationships.”

This experience helps students identify with others who are trying to stop the addictive cycle. “Some of the best teaching happens during this course because students realize how hard it is to get support and how hard it is to change behaviors,” says Roget. “They often feel stigmatized by the people they expect to receive support from. It is a powerful learning experience.”

The Great Lakes ATTC (GLATTC) is also addressing stigma in their region. They have conducted surveys, panel discussions, consensus panels, presentations and are collaborating with the Southeast ATTC (SATTC) and to develop a workshop platform for counselors. The workshop is designed to empower counselors to combat stigma through their daily interactions with others.

A second collaboration is underway between GLATTC, SATTC, and Recovery Communities United (the Recovery Community Support Program grantee in Illinois) to develop a stigma reduction self-study course. This course will provide examples, workshop exercises and job aids to help clients and the community overcome stigma. Students who complete this course will receive CEUs from the state’s certification board.

Another organization working to reduce stigma is the National Council on Alcoholism and Drug Dependence (NCADD), a nationwide network of affiliates which advocates for substance abuse prevention, intervention, research and treatment.

Stacia Murphy, NCADD's President, believes stigma must be looked at in the broadest context if it is to be appropriately addressed. "Stigma prevents people from becoming mainstream members of society. It prevents them from coming to treatment earlier, and prevents them from talking about the power of recovery."

NCADD is focusing on addressing stigma through its 109 community affiliates. "We are working to organize the recovering community and their families to help them become more vocal," states Murphy. "But reducing stigma must be an all-inclusive process. Stigma also affects counselors and prevents them from recognizing the extraordinary role they play in the recovery process. We must all be prepared to deal with our own uses of language and attitudes before we can alleviate stigma."

Through community education programs, media campaigns and resource centers, NCADD is playing an active role in reducing stigma. For information about ATTC products, call 877-652-ATTC. To learn about NCADD, call (212) 206 6770.

Stigma Reduction Forum

Breaking The Stigma,
Freeing Our Community's Voice
Sponsored by DC/Delaware ATTC
September 28, 2000 • Washington, DC
Contact: Valerie Robinson at 301-565-2142
or vrobinson@danya.com for more information.

Anti Stigma Tool Kit

From the Center for Mental Health Services, this kit is designed to eliminate negative images associated with mental illness. Includes a poster, fact sheet and brochures.
Contact: CMHS Knowledge Exchange Network at 1-800-789-2647.

APPENDIX E:
ADVOCACY WITH ANONYMITY (PAMPHLET)

The following is a text-only version of the pamphlet "Advocacy With Anonymity," developed by NCADD and produced and distributed by Join Together. You can get copies of this pamphlet from a number of sources. Recovery Communities United can supply copies (their phone and address are listed on Page 125). You can also get copies of this pamphlet in bulk by calling Join Together, or you can download it from the organization's web page (phone, address, and web address are listed on Page 127).

"Hello. I'm a recovering alcoholic/addict working a twelve-step program. I am feeling better in my sobriety and more and more grateful for the blessings that it has brought me. I want to reach out and help others who are still suffering from drug and alcohol addiction. I hear the terms advocacy and anonymity all the time, but I'm not sure what they mean or how they apply to me. What can I do to help other alcoholics and addicts who are still suffering? And how can I increase the public's understanding of these diseases?"

This person is one of many men and women in recovery across the nation who want to speak out and share their experiences with others still in the throes of alcohol and drug addiction. If you, too, are in recovery and want to speak out for the greater good and to talk about the obstacles you have overcome, this pamphlet will help you feel more comfortable with the concept. You can speak out publicly without compromising the principles of the recovery program in which you participate. By doing so, you will be reaching out to alcoholics, addicts, their families and their communities and providing them with new hope.

Anonymity at the level of the media is the cornerstone principle of many twelve-step groups and other recovery programs. It is an essential element of success because it gives the newly recovering person the protection he or she needs from scrutiny. Anonymity also plays a crucial role in establishing personal humility, which is a cornerstone of the spiritual foundation of recovery. The principle of anonymity also was established to keep groups from becoming enmeshed in any public controversy that would divert them from their primary purpose of helping alcoholics and addicts to get sober. The traditions that follow lay out the principle of anonymity as it applies to many twelve-step groups.

> Tradition 6: "[A twelve-step group] ought never endorse, finance or lend the [twelve-step group] name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose."
>
> Tradition 10: "[The twelve-step group] has no opinion on outside issues; hence, the [twelve-step group] ought never to be drawn into any public controversy."
>
> Tradition 11: "Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films."

Clearly, this language does not preclude you from speaking out about your own recovery or from advocating for the rights of other alcoholics and addicts as long as you do not involve the twelve-step group by name. But while the idea of speaking out may interest you, you may be grappling with a number of concerns. Here are some of the questions people typically ask, as well as information to make you feel more comfortable with this new idea.

Questions and Answers

Q: Even if the traditions do not specifically preclude advocacy that does not associate itself specifically with any twelve-step group, isn't it still harmful?

> A: Absolutely not. There is a long and extensive tradition of people in recovery speaking out as advocates for the individual rights of others. In fact, Bill Wilson and Dr. Bob were on the founding board of the National Council on Alcoholism and Drug Dependence (NCADD), the nation's oldest advocacy group. The passage below, taken from a 1958 *Grapevine* article, details Bill Wilson's memory of this important event.
>
> "Then came Marty Mann (NCADD founder). As a recovered alcoholic, she knew that public attitudes had to be changed, that alcoholism was a disease and that alcoholics could be helped. She developed a plan for an organization to conduct a vigorous plan of public education and to organize citizens' committees all over the country. She brought the plan to me. I was enthusiastic . . . ."

Q: Why does the recovering community need to develop an active and enthusiastic public policy?

> A: Because we are all losing the war. Never has there been less funding and access to treatment for the alcoholic and the addict. The alcoholics' and addicts' share of the research pool continues to drop dramatically. There is no political or financial downside to removing alcoholics' and addicts legal, social and financial rights. We are an invisible population, hiding behind a mask of stigma and shame. We must become visible again.

Q: How should I speak out?

A: Start by telling your story. Talk about recovery and how you achieved it. Describe the situation in your community and the kinds of barriers that prevent many people from getting treatment. People rarely see the faces of recovering alcoholics and addicts. They need to see firsthand that treatment really does work. The question which has been posed to me the most about this whole issue is "If I recovered through Alcoholics Anonymous, how do I talk about my recovery in the media without referring to AA?" I believe we must answer this question definitively if we are to become successful in this effort.

Q: What do I say about my membership in a twelve-step group if it was the means of my recovery?

A: Simply say, "I found my recovery through a twelve-step group but our traditions do not permit me to name it in the media."

Q: Where should I speak out?

A: Start by talking with one other person or a small group. As you become more comfortable talking about your disease and recovery, expand your audience. You may want to speak at meetings of civic or religious organizations. As your comfort grows you may want to speak publicly or privately with your city council, state legislators or other public officials.

Q: How can I advocate if I am uncomfortable speaking publicly?

A: Write letters to your local newspaper responding to a published article on the subject. Submit an op-ed piece on a relevant topic such as expanding insurance coverage for the treatment of addiction and alcoholism. Write to your elected officials supporting the rights of alcoholics and addicts.

Q: How do I start?

A: As in most new roles, you will need to get comfortable by seeking support and guidance from people you trust. Join together with others in the community to give a speech. If you are new to public speaking, practice among friends. No matter how tentative your first steps may seem, the most important thing is to start small. The common sense steps below are a good set of guidelines for participation:

- No recovering person should advocate publicly if their sobriety, job or financial well-being will be put into jeopardy.
- No recovering person should advocate at the level of public media unless they have two years of recovery.
- No one who is advocating in the media should identify themselves as a member of any specific twelve-step group.

Here is another thought from Bill Wilson to keep in mind as you proceed:

> "So let us hasten to work alongside those projects of promise to hasten the recovery of millions who have not yet found their way out. These varied labors do not need our special endorsement; they need only a helping hand, when, as individuals, we can possibly give it."

The following organizations can help you get started:

- National Council on Alcoholism and Drug Dependence, Inc. (NCADD)

  NCADD sponsors the Registry of Addiction Recovery (ROAR), a national volunteer campaign to fight the stigma of alcoholism and other addictions. Members of ROAR help put a human face on recovery by agreeing to be interviewed by the media. Application forms are available on NCADD's website or from the address above.

- Alcohol Policies Project
  Center for Science in the Public Interest

  The Alcohol Policies Project is a watchdog group that offers advocacy and information on federal and state alcohol policy.

- Center on Alcohol Advertising

  The Center on Alcohol Advertising monitors alcohol product promotion and advertising and offers assistance with media advocacy.

- Join Together

  Join Together is a national resource helping communities fight substance abuse and gun violence. Its website, Join Together Online, connects people across the country electronically to share their stories. It also provides access to the latest news and research on substance abuse and gun violence.

- Legal Action Center

  The Legal Action Center provides advocacy for expanding addiction treatment and prevention, and fighting discrimination against people who are in recovery from alcoholism, drug dependence and HIV/AIDS.

- Mothers Against Drunk Driving (MADD)

  Mothers Against Drunk Driving is a nonprofit grassroots organization with more than 600 chapters nationwide. Its focus is to look for effective solutions to drunk driving and underage drinking problems, while supporting the victims of these crimes.

APPENDIX F:

AUTHORSHIP AND SPONSORSHIP OF THIS MANUAL

This manual was researched and written by Pamela Woll, MA, CADP, a Chicago-based consultant in writing, editing, and instructional design, serving as Product Development Consultant for GLATTC. Pam has been researching and writing a variety of materials in addiction treatment, prevention, and other human service fields for the past 14 years, on topics including addiction, cultural competence, technology transfer, research-to-practice, violence, child development, addicted families, resiliency, and mentorship. In addition to her instructional materials, Pam is primary author of *Worth Protecting: Women, Men, and Freedom From Sexual Aggression* (with Terence T. Gorski), and second author of *The Call to Write: An Invitation to Aspiring Writers* (with William L. White).

Sponsorship/direction of this manual was a collaborative effort of the Great Lakes ATTC, Lonnetta Albright, Director; Recovery Communities United, Inc., Donald E. Malec, MS, CADC, Director; and the Southeast ATTC, Onaje Salim, MA, NCACII, CCS, Director. Project direction was provided by Joseph D. Rosenfeld, PsyD, Curriculum Development Director for the Great Lakes ATTC.

The following paragraphs describe the two sponsoring networks, the National ATTC Network and the Recovery Community Support Program.

The National ATTC Network

In 1998, members of the ATTC Network came together to define their collective vision, "Unifying research, education, and practice to transform lives." More than a tagline, this vision statement encompasses the underlying goals and principles of the entire ATTC Network.

Thirteen ATTCs now serve 39 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. A national coordinating center (the ATTC National Office) facilitates communication among the 13 Centers and works to improve national awareness of the Network. The ATTC Network is funded by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Uniting to define common Network objectives and principles has allowed the ATTC to greatly expand its reach. By forming a coordination center and combining the capabilities of the 13 regional Centers, the ATTC is having a profound impact on the substance abuse treatment field, both nationally and regionally. Although the size and areas of emphasis of the individual Centers may vary, each is charged, as is the Network collectively, with three key objectives:

- To increase the knowledge and skills of addiction treatment practitioners from multiple disciplines by facilitating access to state-of-the-art research and education;
- To heighten the awareness, knowledge, and skills of all professionals who have the opportunity to intervene in the lives of people with substance use disorders.
- To foster regional and national alliances among practitioners, researchers, policy makers, funders, and consumers to support and implement the best treatment practices.

ATTC work is focused in seven areas of emphasis: *cultivating systems change, advancing addiction education, addressing workforce development, communicating recommended approaches, fostering culturally competent practice, harnessing technologies, and evaluating the impact.* Ultimately, the purpose of our work is to improve substance abuse treatment for all people suffering from addiction.

As part of the ATTC Network, GLATTC currently serves Illinois, Ohio, and Wisconsin, with auxiliary services to Indiana and Michigan, and plans to expand in the next grant period.

The Recovery Community Support Program

In 1998, the US Department of Health and Human Services Substance Abuse and Mental Health Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) launched a $3.9-million initiative known as the Recovery Community Support Program (RSCP).

It was CSAT's expectation that projects funded under this program would become models for recovery community involvement in the planning, design, delivery, evaluation, and continuous quality improvement of substance abuse treatment services at the local, state, regional, and national levels.

The goals of the RSCP grantees are to:

- Empower recovery organizations to participate in the planning, delivery, and evaluation of addiction policies, systems, and services so that they become more responsive to the needs of recovering people and their families;
- Promote linkages among people in recovery and their family members and allies, and facilitate linkages between the recovery community and formal delivery systems;
- Reduce stigma associated with addiction, treatment, and recovery;
- Foster financial self-sufficiency and independence of the projects; and
- Document organizational structures and processes used by RSCP grantees in their organizing and advocacy efforts.

Projects funded under this program have become models for recovery community involvement in the planning, design, delivery, evaluation, and continuous quality improvement of substance abuse treatment services at the local, state, regional, and national levels. In a few short years, they have worked hard to put a face on recovery and become the voice for people suffering from the disease of addiction to alcohol and other drugs.

As a Recovery Community Support Program grantee, Recovery Communities United directly serves individuals and organizations in Illinois.

APPENDIX G:

INSTRUCTIONS FOR CEUS

IAODAPCA CEUs

This manual has been approved for 8 CEUs from the Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA). To apply for those CEUs from GLATTC, please:

1. Complete at least the top half of the IAODAPCA CEU Application Form on Page 149 (the questions on the bottom half are optional, intended only to help us in our analysis of the audience reached by this manual).

2. Photocopy all of the following completed exercises from the manual:

   - 1b (Page 26)
   - 1c (Page 28)
   - 2a (Page 30)
   - 2b (Page 32)
   - 3a (Page 41)
   - 3c (Page 46)
   - 4b (Page 54)
   - 5a (Page 64)
   - 5b (Page 67)
   - 6a (Page 72)
   - 6c (Page 83)
   - 7c (Page 89)
   - 7d (Page 91)
   - 8c (Page 96)
   - 8d (Page 98)
   - 9a (Page 102)
   - 9b (Page 104)
   - Manual Evaluation Form (Page 107)

   Although you're expected to complete all the exercises in the manual, we've limited the number you're required to submit, to cut down on the time required for photocopying. We've eliminated any exercises that might ask for personal information about you or a client, and we've limited it to two exercises per chapter.

3. Send the **IAODAPCA CEU Application Form,** the **exercise photocopies,** and a **check or money order for $5 made payable to GLATTC/UIC**, to:

   Stigma CEUs
   GLATTC/UIC
   808 South Wood St. (MC 779)
   Chicago, Illinois 60612

4. A certificate will be mailed to you after your work has been evaluated.

If you have any questions about this process, please call GLATTC at (312) 996-1373.

CEUs From Other States

At the time of this printing, CEUs for this manual are available only from the IAODAPCA, but other states' certification bodies may also be interested in awarding CEUs for its completion. Here is the process that GLATTC followed in order to arrange for IAODAPCA CEUs.

GLATTC approached IAODAPCA for permission to award CEUs for the completion of this manual. In doing so, we had two professionals in the field time-test a draft of the manual, to see how long it took to complete all the exercises. IAODAPCA had a number of forms that had to be submitted for CEU approval. Their staff reviewed the manual and used the time-tests to determine how many CEUs to award.

Other states' credentialing bodies might be approached as well, to see if they would award CEUs for the completion of this self-study manual. If you would like to approach your state's professional certification association and would like technical assistance to help you get started, please feel free to contact GLATTC at (312) 996-1373.

IAODAPCA CEU Application Form

Certification Information

Name: _____ IAODAPCA Cert #: _____

Title: _____

Organization: _____

Address to Mail CEUs: _____

This is a: work _____
home _____
address.
(Check one.) _____

Demographic Information (optional)

We are asking this information to help us gather data on the use of this manual in the field. We would appreciate your taking a moment to check all the boxes that apply to you.

Discipline:
- Addiction/Substance Abuse Treatment
- Mental Health
- Social Work
- Criminal Justice
- Medical/Health Care
- Prevention
- Other: _____

Service Modality:
- Outpatient
- Intensive Outpatient
- Residential
- Recovery Home
- Methadone Program
- Hospital Based
- Other: _____

Length of Time in Field:
- Less than 3 months
- 3 months to 1 year
- 1 to 2 years
- 2 to 5 years
- 5 to 10 years
- More than 10 years

Race/Ethnicity:
- African American (non-Hispanic)
- Latino/Hispanic
- Asian/Pacific Islander
- Caucasian
- Other: _____

Gender:
- Male
- Female

Previous Experience With Public Education for Stigma Reduction:

None Minimal Substantial

Send this form, with photocopies of the completed exercises listed on Page 147, and a check or money order for $5 made payable to GLATTC/UIC, to Stigma CEUs, GLATTC/UIC, 808 South Wood St. (MC 779), Chicago, Illinois 60612.