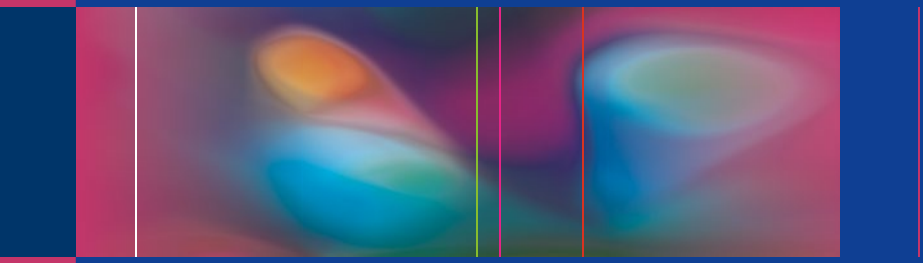
Jonathan D. Avery
Joseph J. Avery *Editors*



The Stigma of Addiction

An Essential Guide

Springer

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Jonathan D. Avery • Joseph J. Avery
Editors

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To Oliver Avery, Alexander Bodini, Zoe Kellner, and Gian Marco Moratti. We love you, and we miss you.

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Contents

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Chapter 1
Introduction

Jonathan D. Avery and Joseph J. Avery

The Stigma of Addiction: An Essential Guide is one of the only books that focuses on stigma directed toward those with substance use disorders (SUDs). This may come as a surprise given addiction's ubiquitous impact and its prominence in the national dialogue. Yet, while scholars have long discussed stigma pertaining to mental illness, addiction, which now is recognized as a disorder and falls within the ambit of mental illness, is just beginning to receive similar scholarly treatment. Our primary goal in this book is to collect leading scholarly thought, providing both the clinician and the nonexpert with a comprehensive understanding of the different aspects of addiction stigma and the different arenas in which it arises.

What is stigma? In the *Journal of Mental Health*, Sonya Lipczynska described how, after a goalkeeper named Andy Goram was diagnosed with mild schizophrenia, English soccer fans would taunt him by yelling, "Two Andy Gorams, there's only two Andy Gorams…" [4]. This is but one of

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countless examples of stigma faced by individuals every day, and it accords with the understanding put forth by the editors of the Oxford English Dictionary, who have stigma as "a mark of disgrace or infamy."

Although the word is widely used and readily understood, there is some variability in how it is defined. The classic definition, by Goffman [2], has stigma referring to an "attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted, discounted one." Link and Phelan [3] embrace Goffman's definition but also add an element of power: "[S]tigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them." For the purposes of this book, we will adopt a definition of stigma that functions as a common denominator of the above three definitions. Addiction stigma refers to negative attitudes toward those suffering from substance use disorders that, one, arise on account of the substance use disorder itself and, two, are likely to impact physical, psychological, social, or professional well-being.

Consider a prototypical example of addiction stigma, one that will be discussed further in Chap. 6. A 25-year-old male named John visits the hospital emergency department multiple times over the course of a year for alcohol abuse. He eventually agrees to inpatient substance use treatment, after which he transitions to outpatient care. He does well. He has a multimonth period of sobriety. However, he relapses and, as he had many times over the prior year, presents himself in the emergency room. While he's waiting to be treated, he overhears a physician remarking to a nurse, "Oh, that's just John. We knew he'd be back again." Here, we see negative attitudes toward an individual that arise on account of the individual's substance use disorder.

But do such attitudes matter? As our authors discuss in this book, such attitudes certainly do matter. Major and O'Brien [5] found that stigma creates unique stressors and psychological distress, not least on account of the fact that stigma involves status loss (see [3]). Moreover, the sheer need to cope with stigma may lead to unintended and unforeseen

consequences, even ones that are unrelated to the stereotype [6]. For instance, the cognitive effort required to defend against self-esteem loss precipitated by stigma could lead to a decrease in cognitive functioning in other areas. Research in social psychology has documented a multitude of adverse outcomes stemming from stigma, including poor academic performance [1]. Over the past decade, stigma has increasingly been linked to adverse mental and physical health outcomes, especially among those who are likely to suffer multiple stigmas, such as African Americans [7].

In 2017, the opioid crisis was declared a Public Health Emergency in the United States, bringing addiction even more into the spotlight. Substance use disorders incur a large toll on individuals and on the collective society. Successful treatment requires astute care by experienced professionals. Unfortunately, stigma against those with SUDs is rampant, permeating multiple professional fields and coloring both social and familial relationships. In service of both scholarly progress and societal welfare, in this book we provide an overview of the different aspects of addiction stigma and the different arenas in which it arises.

Chapter 2 covers self-stigma, the patient's thoughts about his or her own disorder. From there, we cover nine other aspects. Family members of those with SUDs might begin by reading Chaps. 3 and 4, which cover familial addiction stigma, as well as addiction stigma arising in close relationships. Addiction stigma in physicians is covered in Chap. 6, and addiction stigma in the U.S. legal system is covered in Chap. 9. Some researchers have posited that the high rate of incarceration for nonviolent drug offenders in the U.S. is the product of converging drug stigma and racial bias. Thus, in Chap. 8, we consider the nexus of race, stigma, and addiction. We also cover addiction stigma in the workplace (Chap. 10), in the media (Chap. 11), and in the context of addiction treatment (Chap. 7). In a chapter that spans disciplines and provides a framework for thinking about the perpetuation and the reach of addiction stigma, we consider the language of stigma and addiction (Chap. 5). Just as we have, in discussing

the chapters of this book, taken them topically and out of order, the reader should feel free to do the same. The chapters do not depend on one another, and they may be read in any order.

References

1. Crocker J, Major B, Steele C. Social stigma. In: Gilbert D, Fiske ST, Lindzey G, editors. Handbook of social psychology. 4th ed. Boston: McGraw-Hill; 1998.
2. Goffman E. Stigma: notes on the management of spoiled identity. Englewood Cliffs: Prentice Hall; 1963.
3. Link B, Phelan J. Conceptualizing stigma. Annu Rev Sociol. 2001;27:363–85.
4. Lipczynska S. Stigma. J Ment Health. 2005;14(4):423–5.
5. Major B, O'Brien LT. The social psychology of stigma. Annu Rev Psychol. 2005;56:393–421.
6. Smart L, Wegner DM. Covering up what can't be seen: concealable stigma and mental control. J Pers Soc Psychol. 1999;77:474–86.
7. Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. Am J Public Health. 2003;93:200–8.

Chapter 2
Self-Stigma and Addiction

Steve Matthews

Introduction

Neuroscientist Marc Lewis, whose personal history includes misuse of opiates, said that developing self-trust was the reason he gave up drugs.[1] After countless attempts to quit and many years of trying, one day he placed a large handwritten sign inside his house that simply said 'No'. If he could say no to himself for an hour, he thought, then he could say no for another hour and then for a day and then for longer and longer periods, and eventually he realised that he could rely with confidence on his future self to keep that commitment to his earlier self not to backslide. He came to regard himself as a trustworthy person, ably sticking to a principle of abstinence. His newfound self-trust and capacity to resist temptation meant that sources of his shame were now being erased. And ridding himself of this shame – the self-stigma of his addiction – provided an important step to his recovering control. A part of that was an acceptance of who he was. Acceptance and self-trust had led to the removal of self-stigma.

[1] See www.memoirsofanaddictedbrain.com/connect/addiction-recovery-and-self-trust/. For his unique account combining narrative and neuroscience see Lewis [29].

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I have begun at a place where I hope also to finish, but I begin here because in understanding the role of self-stigma in addiction, we can also come to understand how removing the social sources of self-stigma will go some way – perhaps a very long way – to ameliorating the toxic effects ensuing from public stigmatisation of addiction. There is evidence that self-acceptance plays an important role in recovery and that such acceptance goes hand in hand with removal of the marks of disgrace that formerly plagued the affected person. But that fact suggests a possibility: if the social sources of self-stigma can be eliminated, or at least greatly reduced, those who develop substance use disorders will not, in addition to their own internal struggles, also have to face a hostile social world.

In this chapter, I will focus on the process in which stigmatised individuals with substance use disorders (SUDs) take on the labels and stereotypes associated with the stigmatization category. Evidence exists that out of the range of stigmatised groups, individuals with SUDs suffer more marginalisation than those with mental illnesses or those with physical disabilities, especially in relation to the factors of (perceived) blameworthiness and dangerousness [9]. In the light of this, it is not surprising that self-stigma has been thought by some to be partially responsible for the social construction of addiction in a significant range of cases (Matthews et al. [38]: p. 276, Patterson and Keefe [41]: p. 122).[2] But even eschewing this strong conceptually based thesis, there is a plethora of evidence for the claim that public stigma of addiction feeds into the self-conception of those affected leading to deleterious effects on 'life chances' [17, 32].

In what follows, we define self-stigma and explain how the process works in terms of what Hacking [18] has described as the 'looping effects of human kinds' (section "Introduction"). In the section "What Is Self-Stigma and How Does It Work?"

[2] On social construction theory, see Berger and Luckman [4].

we distinguish and describe the two sources that feed into this process – self-recognition (a private source) and the mythological stereotypes in public stigma. Then in the section "The Public Mythology and The Recognitional Reflection of Addiction in Self-Stigma", we explore in greater and more subtle detail what the origins of self-stigma in addiction are, and why it is so severe (relative to comparable other cases such as mental illness). In the section "Where Does Self-Stigma Come from and Why Is It Severe?", we consider the nature of the affective component of self-stigma (shame) and its relation to morality. Finally, in the section "Subjective Themes in Self-Stigma", we describe how the account of self-stigma we offer in terms of looping may lead to recovery; interestingly, the elimination of self-stigma is importantly correlated with a notion of self-acceptance. (For a snapshot of the overall view being defended, see Fig. 2.1.)

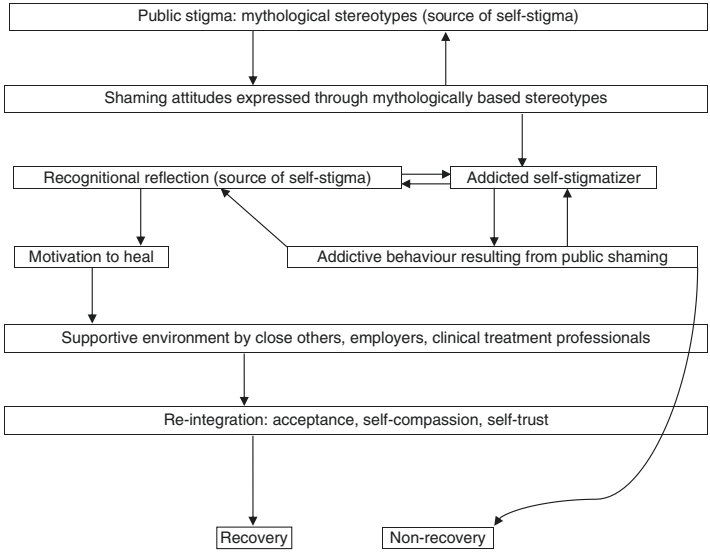

FIGURE 2.1 A model of self-stigma in addiction

What Is Self-Stigma and How Does It Work?

As Mittal et al. [40] point out, the term 'self-stigma' denotes a cluster of closely related ideas such as 'internalized stigma', 'perceived stigma' or 'enacted stigma'. Sometimes the term 'stereotype concurrence' is used when an individual internalises 'negative preconceptions associated with membership in a stigmatized group' (Rodrigues et al. [45]: p. 129). Nevertheless, there are good theoretical reasons for choosing *self-stigma* as the key concept. The subject of the stigmatising attitude is indeed the self, in contrast to (say) some action performed by the self. The stigma felt by an individuals with SUDs extends beyond stigmatising situations, out to significant parts of their whole being. And as we will see, a close cousin of self-stigma – shame – also has the self in its sights. The shame individuals with SUD experience extends beyond the guilt felt over specific actions; it is shamefulness of *who they are*. As Goffman originally had it, stigma's effects go beyond presentations in everyday life situations – temporary discreditations of identity such as embarrassing moments – to the permanent spoliation of whole identities. The identity change in the minds of others means that the stigmatised changes status from being '…a whole and usual person to a tainted and discounted one' (Goffman [16]: 3). This process continues on in self-stigma when the person applies such status loss to himself, coming to agree (if only tacitly) that he bears the marks of the disgraced kind.

Bringing this together, we can say that self-stigmatisation occurs when (1) people react to public stigmatisation of a human kind (based on mythological stereotypes) by coming to see themselves as belonging to that kind, (2) typically as a result of powerlessness they apply the normative categories of the kind to themselves, and (3) the transformation they make in seeing themselves as belonging to the stigmatised group causes harm. This broad account is in line with other definitions found in the literature.[3] But there is a reason when applying the idea of self-stigma within addiction to add a

[3] See, e.g., Livingston ([33]: 39), and Corrigan and Rao [10].

fourth condition: self-stigmatisation can derive from an *accurate recognition* that the affected person has of her own failures to be an effective agent and to live up to her values. This last condition sheds important light on claims about the proper role for self-shaming in leading to recovery. The literature on this question is divided, with some claiming that stigma can motivate recovery and with others claiming that on balance stigma curtails it. In identifying *two* sources of self-stigma, one, the damaging myths that abound in public stigma and, two, the shame arising from genuine self-understanding, we are in a better theoretical position to reconcile these competing positions. I will suggest that private shame need not be damaging to recovery (and may even assist it) so long as the social ambience in which it arises is stripped of the damaging mythologies inherent in the addiction stereotypes.

Self-stigma in addiction can be usefully explained in terms of what Hacking has called the 'looping effects of human kinds'.[4] Individuals with SUDs form a relevant human kind, a kind whose classification imports the public stigmas, and so once the individual with SUD agrees with this classification, he automatically self-attributes some or all of these stigmas. Hacking uses 'human kinds' as,

> …systems of classification … Although I intend human kinds to include kinds of behaviour, act, or temperament, it is kinds of people that concern me. That is, kinds of behaviour, act, or temperament are what I call human kinds if we take them to characterize kinds of people. ([18]: p. 352)

The self-conception of an individual with SUD takes on features from publicly stigmatising beliefs about the human

[4] I thank Robyn Dwyer for originally drawing my attention to Ian Hackings' work, and for connecting the idea of looping to the feedback mechanisms inherent in self-stigma.

kind, which feed back into that very conception.[5] Individuals with SUDs may be viewed, and may view themselves, in terms of a classification constituted by 'generalizations sufficiently strong that they seem like laws about people, their actions, or their sentiments' (Hacking [18]: p. 352). Moreover, the classification 'addict' (and its cognates) contains a quite explicit normative dimension, sometimes a pernicious normativity, based on the public mythology that addicts are bad people, and even the two main international diagnostic manuals (DSM and ICD), as well as twelve-step disease models, carry criteria with negative norms.[6] The more direct effects in addiction of taking up the classifications and internalisation, or cross-situational persistence, of the stereotype include treatment threatening self-esteem, exclusion from public engagement, being seen as appropriate subjects of paternalistic treatment, problems maintaining and applying for work, difficulties finding housing and difficulties securing health (and mental health) treatment. In short, stigma, as experienced by others, as well as by oneself, is one of the social determinants of health [21].

[5] The strong reading of this claim is in terms of social construction theory which is the view about the metaphysical status of social phenomena, and some authors have argued that this would include addiction (Matthews et al.). The theory understands the phenomena as dynamically formed in stages: ideas and concepts are externalised, objectivised, and finally internalized by social actors [4]. So, in this case, the concept of addiction (and related cognates), the discourses, practices, policies, objects and so on associated with it that come into the social space are then made objective. Addiction is then seen as objective (carrying the normative weight of objectivity) when in fact it develops out of perspective-dependent phenomena. And because of this externalisation and normativity it will frame understandings of the actions and behaviour of those it describes whose experience of the world is in fact unique, and which may not neatly fit into the imposed externalising categories.

[6] See Matthews et al. [38]. The diagnostic tools occupy a liminal position between describing and prescribing; they contain morally loaded classifications that simultaneously seek to identify kinds of people in order to help them while at the same time positing social categories that describe norms and frameworks within which individuals with SUDs will grow.

The human kind 'addict' has normativity built into it then, and this includes a measure of self-worth, or rather its lack. The addict stereotype is shameful because the public mythology carries with it a loss of social status. The effects of this normative dimension are pervasive and carry both explicit and implicit biases in the way people interact with individuals with SUDs. This can extend (even) to theorists, as well as to professionals engaged with their clients, to social institutions, corporations, legal frameworks and to mainstream media; ultimately, such classifications cascade throughout and down to the very people they describe. Hacking explains what happens at this stage of the process (p. 368):

> If H is a human kind and A is a person, then calling A H may make us treat A differently … we may reward or jail, instruct or abduct. But it also makes a difference to A to know that A is an H, precisely because there is so often a moral connotation to a human kind … Thinking of me as an H changes how I think of me. Well, perhaps I could do things a little differently from now on. Not just to escape opprobrium … but because I do not want to be that kind of person. Even if it does not make a difference to A it makes a difference to how people feel about A – how they relate to A – so that A's social ambience changes.

I will later argue that attenuation of public stigmatisation of addiction is critical for improving the social ambience in which self-stigma flourishes. Self-stigma is usually at its worst in conditions where public stigma operates unfettered, so it makes sense to improve the social conditions in order to properly address the looping effects of human kinds as they beset addiction.

We have just spoken at a quite general level of the ways in which the addiction classification carries with it the disvalues attaching to the relevant human kind. Consider now one example of a specific effect of looping and self-stigma: addictive consumption in response to shame, where the shame of use turns out to be cyclical and self-perpetuating – individuals with SUDs consume in order to wipe out the shame they are feeling, and in the process they perpetuate the very condition from which they are attempting to free themselves. There is evidence that such practices are not uncommon. For example,

interviewed participants from a recent study on addiction and moral identity explicitly drew the link between negative self-regarding feelings and substance use. In order to cover up how badly they were feeling about what they had done (as a result of their addiction), the affected persons continued to consume, as the following quotes indicate (Matthews et al. [36]: p. 282):

> I know a lot of my heavy using was because I was ashamed of what I was doing and it didn't ... commonsense approach would be to not use. But in my case, it was, use more so I could forget how bad I was feeling about myself. – Brigitte

> I'd stuffed up so many times with things. That's why I drunk as well, it wasn't to self harm myself, it was just to, like I say, get drunk and stop thinking about what I'd done wrong and where I went wrong. – Frank

> I wake up in the morning and go oh what have I done, oh I'll just have another drink. – Simon

> Yeah oh it's just constantly in the back of your head and that's just even more of an excuse to drink and to just eliminate that or just for it to go away for a while but then the next morning or when you wake up sober and it's there ten times as worse and it's just like a revolving circle. – Peter

It turns out that thinking of self-stigma in terms of the internalisation of classifications of human kinds has a positive and hopeful aspect, and that is because these classifications are permanently open to revision. Hacking suggests that feedback loops lead to *changes* in our conceptualising of people and their behaviour, and in turn, as more and more looping occurs, revisions must also occur of the 'classification and theories, the causal connections, and the expectations' surrounding such conceptualising. In consequence, as he puts it, 'Kinds are modified, revised classifications are formed, and the classified change again, loop upon loop' (Hacking [17]: p. 370). This is positive because if classifications can change, then the norms associated with them can also change. There is nothing fixed about human kinds in this story, and so a commitment to weeding out the distorting mythological elements that stoke self-stigma makes for a hopeful overall account.

The Public Mythology and the Recognitional Reflection of Addiction in Self-Stigma

As indicated earlier, it is important to distinguish two sources fuelling the shame constituting self-stigma in addiction: (1) the *mythological stereotypes* that feature in public stigmatisation of addiction, and (2) that which an individual with SUDs might accurately understand about their condition and its negative effects through reflection (call this source *recognitional reflection;* see Fig. 2.1.)

The self-stigma arising from (1) corresponds closely to what Pinel [44] called stigma consciousness, that is, affected people's *expectations* of being stereotyped by others. Both the mythology informing this consciousness and recognitional reflection stoke the shame of addiction, and so if it is thought that such shame may lead to healing and recovery, it is important to separate these. Why? Evidence shows that the push to recover from addiction that might issue from self-stigma will not succeed unless the social conditions (where the mythology potentially abounds) can provide a supportive environment [6]. Indeed, the mythology driving public stigma is on balance highly damaging to recovery systems, and certainly exacerbates addict life chances, which include income, education, housing, physical and mental health, and treatment within public institutions (Link and Phelan [31]: p. 371).

To take one example depicting the mythological dimension to public stigma, consider the belief that addicts are hedonistic pleasure seekers. There are strong reasons to believe that this aspect of the mythology is false. Although pleasure seeking can initially motivate consumption (and even this applies only to some), in general, pleasure seeking ceases to play this role. In a recent study ($n = 69$) (see Kennett et al. [27]), semi-structured interviews were undertaken to determine the effects of substance use on what individuals with SUDs value, and what role pleasure occupied within these values. Three distinct subgroups were identified. Respondents from the first group said that pleasure was the main motivation for using substances, but they realised that

in the long run, the damage their alcohol and drug use caused had the effect of hindering their goal of a hedonistic life. They were disposed to *stop* their consumption for hedonistic reasons. The second group nominated pleasure as *initially* motivating, but after repeated use, pleasure subsided and ceased to motivate.[7] The third group claimed to have never really experienced pleasure from using.

These results provide an important example of the way careful analysis of the publicly generated mythology around addiction is perniciously at odds with the reality for those it purports to describe. It is pernicious because the public misunderstanding built into the stereotype of 'pleasure-seeking wanton' creates an extra burden on individuals with SUDs when they know this stereotype is highly distorting of the history of how they came to be addicted. And indeed, the burden may be so great that over time those affected simply give up trying to explain how their own experiences diverge from the stereotype.[8]

This effect may be particularly egregious in hospital or clinical settings where the power imbalance there means that affected persons will simply pass over opportunities to question their exposure to an imposed stereotype. In these situations even if I am strong enough to resist the imposed stereotype, the fact that others accept it (explicitly or implicitly) leads to a range of behaviours that I adopt in order to protect myself from what I perceive as the false beliefs of those perpetuating the stereotype. These protective measures are destructive when, for example, they disable my capacity to work and/or engage

[7] This is compatible with Kent Berridge's distinction between liking and wanting in which individuals with SUDs stop liking the drug of choice they cannot help continuing to want [5].

[8] This is associated with the phenomenon of the resigned addict in which those affected retain an awareness of their fundamental values, but they estimate that a life according to such values is no longer open to them [25].

with others on an equal footing. They may even lead to avoidance of certain hospitals and clinicians when the individual with SUDs has been treated with suspicion at earlier times as someone who is seeking drugs, not for pain relief but to get high [39].

The mythology around addiction that ultimately fuels self-stigma dominates, yet it is certainly important to acknowledge the private sources of shame that are based on accurate understandings that an affected person might have of addiction. A helpful metaphor for getting this understanding comes from Marc Lewis, the neuroscientist mentioned at the start who wrote of his own addiction. He has described it in terms of the metaphor of the hourglass.[9] At the top where the aperture is widest represents a person pre-addiction: at this point, unaffected by substance use, she has available to her the widest set of possible goals, values, desires, hopes, plans and so on. As she falls into addiction, these goals, values etc. begin to narrow as her focus increasingly moves to her drug of choice. As she approaches this narrow point, more of her time is spent on securing and taking drugs. She becomes single-minded in her pursuit of the drug hit. Friends are lost, relationships trashed, career or study neglected or abandoned and day-to-day responsibilities let go. In the final stages of addiction, she is gripped by a single dominant desire, which is to re-enact over and over the sequence of actions that surround her use. She has reached the narrow point of the hourglass. An inversion has occurred: previously, at the top of the hourglass, her life contained a plurality of options, and *she* determined which of them would be chosen. At the narrow point, now her life has become monochrome: there are never any options, for it is now the *drug* that 'plans' her life for her.

[9] http://www.psychologytoday.com/blog/addicted-brains/201210/the-hourglass-shape-addiction.

This metaphor disguises the nuance of particular cases, but nevertheless Lewis points out that it captures a culture-invariant picture of the individual with SUDs. In serious addiction, the capacity to live according to the values one reflectively endorses is lost, and this stokes the shame that arises privately from recognitional reflection. Self-stigma involves this kind of self-understanding, as well as negative self-assessment. In terms of self-understanding, individuals with SUDs mark themselves out to themselves *as addicts*, only when they understand (or begin to realise) and appreciate the negative effects of their habitual consumption [14]. In leading to feelings of shame, such self-recognition need not be damagingly self-stigmatising (if it can provide an insight that immediately leads to actions to heal), but it would be remarkable if such feelings of shame could neatly separate recognitional reflection from the publicly stigmatising mythology.

Nevertheless, it is worth pressing the point: could (narrow recognitional) self-stigma arise in a social environment in which there is no public stigma? Suppose there were a society that treated individuals with SUDs with understanding and kindness, endeavouring to respect their dignity and to help them get back on track. Is self-stigma possible here? Probably, but it is hard to say, not least because it is hard to neatly cleave off the sources of narrow recognitional self-stigma from the public mythology. How could we gauge the extent to

which removal of the publicly imposed marks of addiction disgrace might reduce private shame? Still, stigma comes in degrees (Link and Phelan [32]: p. 376), and what seems highly plausible is that the removal of public stigma would reduce self-stigma to a very large extent because it would eliminate its central source. Turning off the main tap of public stigma seems very likely to moderate levels of shame that arise in almost all cases we know of.

Where Does Self-Stigma Come From and why Is It Severe?

This section considers an eclectic set of issues in connecting stigma with self-stigmatisation. We note first the highly nuanced relation between self-stigma and public stigma before addressing the important question of the way stigmatising *language* fits with the idea of addicts as human kinds. We note in passing the severity of self-stigma relative to other cases and offer an explanation for this in terms of the nature of addiction itself.

The main sources for self-stigma derive from the distorting and bogus features of addiction falsely spread through the mythological stereotypes within public stigma. But what are the sources of these stereotypes? Public attitudes to addiction stigma might be thought to be strongly influenced by the predominant models adopted in the academy, by clinicians, and in public administration. There is some evidence that this is so, but it is mixed. However, and moreover, the stereotypes encountered in mainstream discourse (typically media) are often enough distortions, oversimplifications or even outright misrepresentations of the careful work of academic and clinical professionals who have devoted significant portions of their careers to highly nuanced understandings of the phenomena [49, 50]. The problems with media translations of the science of addiction are a lack of expertise, institutions that filter scientific information improperly and a corporate media with interests in selling audiences to other corporate

players, and this creates a force for adapting information that can be digested by that audience only if it is in line with the stereotypes.

The determinants of public stigma are inherently complex and include the characteristics of the individual with SUDs (age, gender, social status), the type of addiction (substance, duration) and the person doing the stigmatising [47]. It had been anticipated by supporters of the Brain Disease Model of Addiction (BDMA) that public stigma would decrease, although this has not really happened (as discussed below). In fact, public attitudes to addiction, including the stigma embedded in those attitudes, depend on factors besides these, including harm-minimisation policy and legal changes, such as has happened in Portugal [28]. Decriminalisation seems particularly potent for removing stigma, given the way criminal statutes may be perceived as codification of social norms, and for its effect on the underground economy for drug distribution and consumption.[10]

The BDMA is coming under increasing pressure from two camps, those who advocate a choice model and those who advocate what we might call a developmental (or habit) model in which addiction grows and self-perpetuates after repeated use leading to deep learning.[11] However, there is evidence that the process of self-stigmatisation applies regardless of which model we adopt. In two early studies of attitudes to alcoholism and drug addiction, it was found that although 58% of respondents thought alcoholism a disease, 73% thought alcoholics fit the description of 'skid row habitue'; for drug addiction, 32% thought it a disease and 79% thought drug addicts were 'hippies', where 'hippie' fit the stigma category of the young, unkempt, long-haired and

[10] Nevertheless, the relation between illicit drug taking and the law is complex [36].

[11] On the choice model, see Heyman [23]; on the deep learning account, see Lewis [30]; the disease model has been championed by medicine in general, but particularly in North America by the National Institute on Drug Abuse (NIDA), and its members. See, e.g., Volkow [52]. To get an overall sense of the landscape in theory of addiction, see Snoek and Matthews [48], and Part 1 of Pickard and Ahmed [43].

bearded dirty person with shifty/glassy/bloodshot/dilated eyes wearing jeans [12]. Even more noteworthy is that there is evidence that the disease model – a view partly motivated to reduce stigma – has had less effect in this area than was predicted, and in addition it brings its own unique stigmatising features to bear on labelled patients [7, 22].

Importantly, the language of addiction stigmatisation has the effect of facilitating self-stigma. 'Addict' and related pejoratives such as 'junkie', 'user' and so on are general nouns enabling a fluid memetic transfer of public stigmas within social communication. Those words prime the stereotype automatically and reductively by lumping in the subject with the stigmatised group at a basic linguistic level. By contrast, 'person with substance use issues' is a description that contains the possibility that the individual and her condition are detachable. Moreover, it at least goes some way to preserving the humanity of the subject, whereas 'user' (or worse) reductively emphasises only the disability that the term picks out.[12] The language of stigma is important to our understanding of the way public stigmatisation gets a focus on its targets, considered as human kinds. For the targets themselves, to self-label as the kind *addict* (rather than a person with those issues) prevents dissociation of who *you* are from your conception of what an addict *is*.

Self-stigma in addiction is especially severe, and there appears to be evidence that it is at least as severe as, if not worse than, in other cases of serious mental impairment [9]. First, because of the history of blaming individuals with SUDs, public stigma of addiction is prominent. One speculation for why this is the case is that unlike (say) cases of dementia, in which unusual behaviour is understood to be caused intrinsically and uncontrollably by neuro-cognitive impairment, addiction is regarded as an externalising disor-

[12] See Denver et al. [13] who discuss recent interest in the way linguistic choices (labelling theory) feed into conceptualisations of stigmatising categories in the context of criminal stigma.

der [11]; that is, the maladaptive behaviour depends on features of the environment, and where in virtue of this, conceptual space opens up for thinking individuals with SUDs are able to control their consumption, and since they do not, they are somehow responsible for it. In addition, the moral model of addiction – that addicts not only harm themselves and others through choice but also are morally blameworthy because of it – is inherently antagonistic towards addiction and addicts. This is exacerbated when the blame is codified in the law, as has occurred most damagingly under the war on drugs [19, 20]. In labelling theory, this works in so far as criminalised groups are isolated and alienated from conventional society, leading to subcultural coalescence around the allegedly deviant behaviour and internalisation of group norms [31, 54]. Self-stigmas on this account are counter-productive because they prolong the activity they reject.

There are some other reasons for the severity of self-stigma in addiction. First, in the co-morbidity cases, patients experience a 'double whammy" ' of prejudice, which can further exacerbate those who self-medicate, thereby inducing and prolonging addiction [26]. Second, unlike cases of (say) neuro-cognitive impairment (e.g., late stage Alzheimer's disease), insight into one's situation – and the stigma involved – is not affected on account of the condition itself. On the contrary, self-stigma is arguably internal to the condition of addiction, or at the very least it is an aggravating characteristic [38]. And third, the relation between self-stigma in addiction and injunctive norms suggests the possibility of isolating effects for individuals with SUDs. Injunctive norms are our perceptions of others' responses to us and of how we ought to behave. Different groups respond differently to us, and when a preponderance of such groups make stigmatising judgements, there is a proportionate raising of negative self-imagery. This is further exacerbated by groups perceived to have power or epistemic authority, such as parents, employers, professionals, police, government officials or managers and so on. These are the groups that individuals with SUDs

will encounter in such a way as to lead them to appropriate such attitudes towards themselves.

Subjective Themes in Self-Stigma

We now consider the key affective component of self-stigma – shame – to further bolster the central point of the chapter that it greatly depends on the sources of shame as to whether its possession may become a force for a recovery or a factor that prolongs addiction.

Now although it might be thought that private shame cannot count as self-stigma, it is useful to leave the source of the subjective process open. There are of course strong reasons to believe that individuals with SUDs self-stigmatise largely because they (wittingly or unwittingly) appropriate the labels and stereotypes generated through public discourse and practice and that socially powerful groups generate and exacerbate such talk and practice. Nevertheless, it is sensible that we acknowledge that not all sources of self-stigma arise this way; in the limit case, people may self-stigmatise simply on the basis of *their own* assessment of the way their addiction compromises their capacity to align their motivations with the values they endorse when they rationally reflect on the life they ought to be leading. This self-assessment is aggravated by the repeated disappointment over failures to live up to one's own expectations, and reflection on this personal failure can lead to disgrace in one's own eyes (Flanagan [14]:p. 1).

Such limit cases are something of an idealisation because *in fact* the sources of self-stigma are both public and private. But, nevertheless, it remains more than a mere conceptual possibility for individuals with SUDs to mark themselves out to themselves as failing even when they respond to public stigma with 'righteous anger', as Corrigan and Watson ([8]: p. 36) note, for it may be that the individuals with SUDs believe that the addiction population is unjustly targeted and treated badly, thereby providing a buffer to internalisation of publicly stigmatising attitudes. But that illegitimacy

dissociates from the private disappointment, even shock, at the failure to live up to one's own standards. One sees a version of this expressed in alternative subcultures in which illicit drug taking is the norm where like-minded members can provide support and a kind of scaffolded solidarity required to fight back against public stigma even when they recognise the inherent destructiveness of their practices. The sentiment here is that 'our internal struggles are bad enough – we *know* what they are – without having to put up with a hostile public!' [2].

Consider now the affective dimension of self-stigma, viz., its central emotion, as well as the effects and experiences that it generates. As Luoma and Platt note ([35]: p. 97), '[s]hame is the emotional core of the experience of stigma'.[13] As remarked above, shame takes the self as its object rather than a particular action, and to be ashamed of oneself on account of a substance addiction is to feel compromised, discredited, even tainted in one's social standing, and to be disabled in social agency as a result of these effects. Those who absorb and redirect negative public attitudes inwards feel the shame of it even in the case where they do not regard themselves as particularly blameworthy, though in the typical case they may also blame themselves. The main idea is that shame dissociates from any morally discreditable features: shame does not entail blame.

Shame in self-stigma involves some closely related factors. First, conceptually, shame has a 'swamping' quality. The *aggregated guilt* one might feel for particular actions performed on account of an addiction comes to spill over from act to character [38]. Second, shame gives rise to a fear, even *paranoia*, that others will blame the individual with SUDs in social situations where the addict stereotype might be triggered, e.g., in a social setting where if an item was stolen the (possibly former) addict would fear being blamed. More generally, self-stigma leads to avoidance of situations where stereotyping abounds. Third, addiction shame is associated with

[13] Other writers to have emphasised shame in addiction are Flanagan [14] and Matthews et al. [38].

self-directed anger and despair (Lewis [28]: 191). Fourth, shame leads people to *disguise or erase the shameful identity* (Velleman [51]: p. 44), and for self-stigmatising individuals with SUDs the effect here is to engage in self-censorship, to be socially inhibited, to stay home, in general to adopt the techniques such as anonymity that protect privacy [37]. Fifth, there is the 'John Henryism' effect (Link and Phelan p. 379), in which shame leads to *over-compensation* in order to dispel the stereotype. And sixth, there is evidence of the phenomenon of *self-sabotage* (Matthews et al. [38]: p. 280), in which individuals with SUDs engage in behaviour that damages their capacity for overcoming their addiction.[14]

We spoke above of the importance of separating the phenomenon of self-shame from moral or moralising presuppositions. This bears elaboration. Individuals with SUDs are apt to feel addiction shame independently of genuinely held moral or political stances they take on addiction. Moreover, David Velleman points out that we can feel shame 'without being ashamed of anything in particular'. He gives the example of the shame that teenagers experience in public accompanying their parents. They do not think their own parents are 'especially discreditable as parents' (Velleman [49]; p. 44), rather, their shame stems from efforts at giving birth to an adult social identity, and those efforts entail the need to erase the presence of the childlike social identity. There is an analogue here to self-stigma in addiction in so far as it is dis-

[14] Kathleen Gallo [15] writes movingly about these different aspects in a first-person account of her mental illness. When in private quarters she could 'hide from the cruelty of social stigmatization'. But outside her house she said 'I tortured myself with the persistent and repetitive thought that people I would encounter, even total strangers, did not like me and wished that mentally ill people like me did not exist … I would do things such as standing away from others at bus stops and hiding and cringing in the far corners of subway cars. Thinking of myself as garbage, I would even leave the sidewalk in what I thought of as exhibiting the proper deference to those above me in social class. The latter group, of course, included all other human beings.'

abling of social agency: the self-stigma of addiction motivates those who are affected to hide their addict identity, and that leads to all sorts of self-censorship and disguising of features that reveal addiction. Worse yet, it leads to a form of self-medication where part of the aim is to forget about addiction's woes; and as we saw, this sets up a vicious cycle, a looping effect, that feeds the addiction itself.

But to return to the main point, the effect here has nothing to do (necessarily) with a belief that one's compulsive consumption is morally discreditable and has everything to do with the shame that feeds off others' responses to addictive behaviour.

Self-Stigma and Recovery

That people who self-stigmatise draw on the available human kind of *addict* is suggestive of a way in which some of its negative effects can be dampened, even eliminated. We can think of public stigma as falling within the set of *social determinants of health* [21, 46]. In this connection, the stress of being a stigmatised addict can be understood through a consideration of the negative social ambience created by mythologies in public stigma, discussed earlier. The following quote brings home poignantly the long-lasting sensitivity that this ambience creates:

> I mean there's a time in my life where I'd be paranoid about sitting around other people's possessions you know 'cause if anything went missing generally nine out of ten people in the room would be dismissed and I'd get the blame ... there's a lot of discomfort within yourself after coming out of that lifestyle or existence really. (Quoted in Matthews et al. [38]: p. 278).

In fact, this social ambience can be characterised by five items that form the 'backbone of stigma', as described in one study on mental illness and substance use [42]. These include a lack of trust in intimate settings (cf. the above quote!); risk of contact with the vulnerable, e.g. children; exposure to self-harm; mental illness (disorderliness that threatens authority); and the unease created in having to interact with an affected

person. Socially vulnerable individuals with SUDs – particularly those who cannot disguise the physical marks of their addiction and self-presentation – must negotiate a social world where they feel unwelcome, and, often enough, are positively rejected as well.[15]

One important way in which social vulnerability can be moderated (but of course not the only way) is via the legal system. In the debate over criminalisation, there is some evidence from the Portugal example that a move to decriminalise illicit drug taking tends to increase the willingness of individuals with SUDs to volunteer their consumption, given increased uptake of treatment there [24]. The resulting reduction in public stigma reduces self-stigma, which in turn emboldens those affected to address their condition, or at the very least to open up a conversation about it more willingly. Stigma is well known to increase the barriers to seeking help because those affected are simply too ashamed (that is, self-stigmatised).

It would be an exaggeration to claim that there are two *schools* of thought on self-stigma and recovery: one that claims public stigma is morally permissible in so far as it shames people into changing behaviour and one in which such shame perpetuates it. The latter view is dominant even though some accounts exist for the former. For example, Bayer ([3]: 471) writes that '…there may be circumstances when public health efforts that unavoidably or even intentionally stigmatize are morally defensible'. But Bayer is tentative, claiming that it depends on the case and also that the permissibility depends strictly on evidence-based procedures and utilitarian (public health) ethics. The trouble is that addiction is almost certainly not one of the cases where this may occur. Public stigmatisation of addiction is long-lasting, pervasive and almost always inescapable; over time, it undermines confidence, trust and the capacity to form supportive relationships [53].

[15] For a detailed account of the way the physical marks of addiction compound self-stigmatization see (Matthews et al. [36]: p. 281)

Nevertheless, in support of Flanagan [14], narrowly understood shame, as he puts it, can be a powerful source for healing, so long as this is understood non-moralistically. For that to happen, the social backdrop must be purged of moralistic forces. MacCoun (supporting Braitwaite) [36] comes close to a suitable model, writing (pp. 505–6):

> …an improved labelling theory should indicate the precise conditions under which stigmatization effects will or will not occur. Braithwaite's [6] theory of re-integrative shaming is one such theory; he predicted that the deleterious effects of labelling can be avoided if social disapproval is temporary, occurs in a context of interdependence and communitarianism, and is followed by gestures of forgiveness and reacceptance. Under such conditions, social shaming is predicted to increase subsequent compliance. In the absence of such conditions, shaming is disintegrative and can foster the stigmatization effects predicted by labelling theory.

Even here, a degree of social shaming is condoned, but nevertheless the important point is about *reintegration*. Typically, only if social space is given for recovery will there *be* recovery. Recognitional reflection giving rise to self-stigma (sourced independently of the public mythology) is probably inevitable in addiction – Flanagan goes further saying it's constitutive – and so the question is how to best channel that self-stigma into a force that can rebuild the self. Self-stigma undermines trust; removal of self-stigma is necessary to rebuild that trust, both in oneself and from others. In recovery, self-trust returns: the earlier self can rely on the later self not to pay attention to the temptations that undermined control and led to failures to live up to the values that one reflectively endorses.

Luoma and Platt [35] broaden this, utilising a concept of self-compassion.[16] By this they mean an affective stance

[16] Luoma and Platt [35] discuss this in the context of Acceptance and Commitment Therapy (ACT). See also Luoma et al. [34]. Gallo [15] also identifies acceptance as important to counter stigma. More broadly, Livingston et al. (2012) reviewed thirteen studies concerning interventions reducing stigma in substance use disorders. They concluded that not all are effective but that '…therapeutic interventions, such as group-based ACT and vocational counseling, are likely to produce positive effects [and this] is consistent with the broader research literature regarding self-stigma interventions.' (p. 47)

towards self, which includes care, warmth, interest, sympathetic joy and pride (p. 97). The idea in therapeutic interventions is to instil in clients '…the same sort of caregiving repertoire that one might apply to a friend, loved one, or other beloved person' (p. 97). I have emphasised self-trust as a way of overcoming self-stigma because of the connection that trust has to the idea of being able to rely on one's future self to abstain.[17] The idea of self-compassion fits with self-trust because it creates a space in which the recovering person can be forgiving of himself if he lapses. Self-trust has two components: I need to make *predictions* about my future capacity, and I need to make a *commitment*, and as with trust of others, what is definitive of the concept is a kind of leap of faith: if I genuinely trust you, that means I take you as trust*worthy*, and I do not need to keep checking on you. In the case of self-trust, I (therefore) need to take myself as worthy of my own trust. I need to be a friend to myself, and that is where Luoma and Platt's notion of self-compassion looks exactly right. I need to get to the point where I don't have to keep checking myself. The warmth I may feel towards myself is just the stance in which I see myself as a worthy person, someone I can (largely) rely on, but with a forgiving attitude when I make a mistake. The move to this stance will be greatly held back, even impossible for many people, so long as a hostile stigmatising public feeds the self-doubt that is part of self-stigma.

We end this section with some further quotes from Matthews et al. [38] indicating both the acceptance and forgiveness aspects of recovery (all quotes p. 284):

> Yeah I think acceptance has got a lot to do with that for me … I had to start a new life 'cause I tried changing my life so many times by stopping … and my new life is an abstinence-based life. I think that's … for me, that's acceptance. And not making grand statements like I'll never use again because I mean that … yeah in my heart I think it's my intention, but I've only got today. – Dan

[17] Some writers on addiction – e.g., George Ainslie ([1], and elsewhere) – make the idea of preference oscillation definitive, so self-trust has to be central to recovery in order to stabilize a preference for abstinence.

> …other times I sort of picked up the pieces and then I failed at a few things and I just went no, stuff it, I lost my place to live again and I was back to that … back to where I started, so that's … the last time I went to rehab I said I'll make sure [that] even if I do have a beer I'm not going to punish myself for it. – Paul

> I've come to a point in my life where I can't say I'm proud of what I've done or anything, but I've accepted it and I'm okay with who I am … It's taken a long time … and a lot of that had to do with the stigma of being homeless and being a drug addict … I wouldn't go so far as proud, but I'm happy with myself … I'm finally starting to do things that are productive – Alice

Conclusion

Self-stigma in addiction is a dynamic process of self-shaming arising mainly (and most perniciously) from public stigma that marks ('spoils' in Goffman's language) identity. An addiction stereotype issues from a mythology around the taking of illicit substances that feeds into the self-conception of those who are already fighting the private shame generated by the recognition of their own inability to control consumption and live according to their values. This has the effect of exacerbating – even further constructing – the addict identity that it is intent on removing. Over time – loop upon loop in Hacking's phrase – the self-stigma of addiction does indeed have the effect of socially situating the individual with SUDs in a place where recovery is made even less likely and more remote. On the other hand, private shame and a re-integrative and accepting social context can provide what is required for self-trust and self-compassion to lead to recovery. The accepting environment needed for development out of addiction is like the bottom half of Lewis's hourglass. If the individual with SUDs survives its narrow neck, it is possible to escape if the conditions allow it. On this point, Lewis remarks:

> …people make whatever attempts they make to get better, to get past it, to 'recover'. And usually, eventually, after ten or a hundred tries, they make it. Then they start to live their own lives once

more, and here's where the hourglass starts to bulge out again, in its bottom half. Now individuality, creativity, and uniqueness get relaunched, without that yoke restricting them, and the hollow tube of mindless repetition fans out to a million possible ways to live one's life.[18]

References

1. Ainslie G. Intertemporal bargaining in habit. Neuroethics. 2017;10:143–53.
2. Andriote J-M. Don't be angry at Spencer Cox; be angry at the stigma that pushes gay men into drugs and unsafe sex. New York: Huffpost; 2016.
3. Bayer R. Stigma and the ethics of public health: not can we but should we. Soc Sci Med. 2008;67:463–72.
4. Berger PL, Luckmann T. The social construction of reality. New York: Anchor Press/Doubleday; 1966.
5. Berridge KC. Wanting and liking: observations from the neuroscience and psychology laboratory. Inquiry (Oslo). 2009;52:378.
6. Braithwaite J. Crime Shame, and reintegration. Cambridge, NY: Cambridge University Press; 1989.
7. Buchman D, Reiner PB. Stigma and addiction: being and becoming. Am J Bioeth Neurosci. 2009;9:18–9.
8. Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. Clin Psychol Sci Pract. 2002;9:35–53.
9. Corrigan PW, Kuwabara SA, O'Shaughnessy J. The public stigma of mental illness and drug addiction. J Soc Work. 2009;9:139–47.
10. Corrigan P, Rao D. On the self-stigma of mental illness: stages, disclosure, and strategies for change. Can J Psychiatr. 2012;57:464–9.
11. Davies W. Externalist psychiatry. Analysis. 2016;76:290–6.
12. Dean JC, Rud F. The drug addict and the stigma of addictions. Int J Addict. 1984;19:859–69.
13. Denver M, Pickett J, Bushway SD. The language of stigmatization and the mark of violence: experimental evidence on the social construction and use of criminal record stigma. Criminology. 2017;55:664–90.

[18] http://www.psychologytoday.com/blog/addicted-brains/201210/the-hourglass-shape-addiction.

14. Flanagan O. The shame of addiction. Front Psych. 2013;5(1.), Article 120):1–11.
15. Gallo KM. First person account: self-stigmatization. Schizophr Bull. 1994;20:407–10.
16. Goffman E. Stigma; notes on the management of spoiled identity. Englewood Cliffs, N.J: Prentice-Hall; 1963.
17. Goldberg DS. Pain, objectivity and history: understanding pain stigma. Med Humanit. 2017;43:238–43.
18. Hacking I. The looping effects of human kinds. In: Dan Sperber DP, Premack AJ, editors. Causal cognition: a multidisciplinary debate. New York: Oxford University Press; 1995. p. 351–94.
19. Hari J. Chasing the scream: the first and last days of the war on drugs. London: Bloomsbury Circus; 2015.
20. Hart C. High price. New York: Harper Collins; 2013.
21. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Public Health. 2013;103:813–21.
22. Heather N. Q: Is addiction a brain disease or a moral failing? A: neither. Neuroethics. 2017;10:115–24.
23. Heyman GM. Addiction: a disorder of choice. Cambridge, MA: Harvard University Press; 2009.
24. Hughes CE, Stevens A. What can we learn from the Portuguese decriminalization of illicit drugs? Br J Criminol. 2010;50: 999–1022.
25. Kennett J. Just say No? Addiction and the elements of self-control. In: Levy N, editor. Addiction and self-control: perspectives from philosophy, psychology, and neuroscience. Oxford: Oxford University Press; 2013. p. 144–64.
26. Kennett J, Matthews S. The moral goal of treatment in cases of dual diagnosis. In: Kleinig J, Einstein S, editors. Ethical challenges for intervening in drug use: policy, research and treatment issues. Huntsville TX: OICJ Press; 2006. p. 409–36.
27. Kennett, Jeanette, Steve Matthews, and Anke Snoek. 2013. Pleasure and addiction. Front Psych 2013; 4: 117–128. doi: https://doi.org/10.3389/fpsyt.2013.00117.
28. Laqueur H. Uses and abuses of drug decriminalization in Portugal. Law Soc Inq. 2014;40:746–81.
29. Lewis M. Memoirs of an addicted brain: a neuroscientist examines his former life on drugs. New York: Public Affairs; 2011.
30. Lewis M. The biology of desire: why addiction is not a disease. Melbourne: Scribe; 2015.

31. Link BG, Cullen FT, Struening E, Shrout PE, Dohrenwend BP. A modified labeling theory approach to mental disorders: an empirical assessment. Am Sociol Rev. 1989;54:400–23.
32. Link BG, Phelan JC. Conceptualizing stigma. Annu Rev Sociol. 2001;27:363–85.
33. Livingston JD, Milne T, Fang ML, Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. Addiction. 2012;107:39–50.
34. Luoma JB, Kohlenberg BS, Hayes SC, Bunting K, Rye AK. Reducing self-stigma in substance abuse through acceptance and commitment therapy: model, manual development, and pilot outcomes. Addict Res Theory. 2008;16:149–65.
35. Luoma JB, Platt MG. Shame, self-criticism, self-stigma, and compassion in acceptance and commitment therapy. Curr Opin Psychol. 2015;2:97–101.
36. MacCoun Robert J. Drugs and the law: a psychological analysis of drug prohibition. Psychol Bull. 1993;113:497–512.
37. Matthews S. Anonymity and the social self. Am Philos Q. 2010;47:351–63.
38. Matthews S, Dwyer R, Snoek A. Stigma and self-stigma in addiction. J Bioeth Inq. 2017;14:275–86.
39. Merrill JO, Rhodes LA, Bradley KA. Mutual mistrust in the medical care of drug users. J Gen Intern Med. 2002;17:327–33.
40. Mittal D, Sullivan G, Chekuri L, Allee E, Corrigan PW. Empirical studies of self-stigma reduction strategies: a critical review of the literature. Psychiatr Serv. 2012;63:974–81.
41. Patterson DL, Keefe RH. Using social construction theory as a foundation for macro-level interventions in communities impacted by HIV and addictions. J Sociol Soc Welf. 2008;35:111–26.
42. Pescosolidio BA, Tait MR, Martin JK, Long SJ. The "backbone" of stigma: identifying the global core of public prejudice associated with mental illness. Am J Public Health. 2013;103:853–60.
43. Pickard H, Ahmed SH, editors. The Routledge handbook of philosophy and science of addiction. London: Routledge; 2019.
44. Pinel EC. Stigma consciousness: the psychological legacy of social stereotypes. J Pers Soc Psychol. 1999;76:114–28.
45. Rodrigues S, Serper M, Novak S, Corrigan P, Hobart M. Self-stigma, self-esteem, and co-occurring disorders. J Dual Diagn. 2013;9:129–33.
46. Room R. Stigma, social inequality and alcohol and drug use. Drug Alcohol Rev. 2005;24:143–55.

47. Sattler S, Escande A, Racine E, Goritz AS. Public stigma toward people with drug addiction: a factorial survey. J Stud Alcohol Drugs. 2017;78:415–25.
48. Snoek A, Matthews S. Introduction: testing and refining Marc Lewis's critique of the brain disease model of addiction. Neuroethics. 2017;10:1–6.
49. Tartakovsky, M. Media's damaging depictions of mental illness. In Psych Central 2017. https://psychcentral.com/lib/medias-damaging-depictions-of-mental-illness/. Accessed 11 July 2018.
50. Taylor S. Outside the outsiders: media representations of drug use. PRO. 2008;55:369–87.
51. Velleman JD. The genesis of shame. Philos Public Aff. 2001;30:27–52.
52. Volkow ND. Preface: how science has revolutionized the understanding of drug addiction. In: Drugs, brains, and behavior: the science of addiction. Washington, DC: NIDA; 2014.
53. Williamson L, Thom B, Stimson GV, Uhl A. Stigma as a public health tool: implications for health promotion and citizen involvement. Int J Drug Policy. 2014;25:333–5.
54. Wright ER, Gronfein WP, Owens TJ. Deinstitutionalization, social rejection, and the self-esteem of former mental patients. J Health Soc Behav. 2000;41:68–90.

Chapter 3
"Bad Parents," "Codependents," and Other Stigmatizing Myths About Substance Use Disorder in the Family

Carrie Wilkens and Jeffrey Foote

A father calls us seeking treatment services for his son. "So sorry to bother you … I'm calling about my twenty-four-year old son. He got out of rehab a week ago. He and his girlfriend OD'd five days ago. He's still in the ICU. Unfortunately, she didn't make it." We could react to many aspects of this description of his situation. We could wonder whether the son left rehab with no medication-assisted treatment plan. We certainly could respond to this father's grief, and we could feel angry at the high toll of overdose deaths mounting in this country, partly as a result of the treatment industry ignoring

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evidence-based treatments. For the purposes of this chapter, however, notice especially: "So sorry to bother you." The apology speaks to the self-blame, shame, and presumed unworthiness of help for his "addict" child.

This father pushed through the stigma of having a family member struggling with substance use. Unfortunately, he represents a fraction of parents, those willing and able to step from isolation and culturally induced shame to get help.

Introduction

Substance use disorders (SUDs) exact emotional and physical tolls on the substance user. A significant part of this pain is attributable to stigma. People with substance problems are labeled ("liars," "losers," "junkies," "addicts"), judged amoral and immoral, and rejected socially. According to the twelve-step doctrine of Alcoholics Anonymous, substance users have flawed characters. Studies have found that substance users are presumed dangerous, blameworthy, infuriating, and repellent [1, 13]. According to various studies, compared with individuals with nonsubstance use mental disorders, individuals with substance use disorders are thought to be weak and incompetent [54], more responsible for their disorder [11], and less pitiable and worthy of help [13]. Insurance, housing, and employment policies that benefit people who are dependent on substances are unpopular [2]. Stigmatized people with substance problems are avoided, insulted, misunderstood, discriminated against, jailed, and abandoned [32].

Family members of those with SUDs face stigma by association. People who care about or are personally linked with a stigmatized person share the stigma [22, 27]. By being in a relationship with a person with a drug or alcohol problem, family members experience loss of respect and status. They are blamed as one cause of the problem or as a reason that the problem is not resolving [10, 34]. They are labeled with the "disease of codependency." They are seen as "contaminated," judged less competent, and are more ashamed of their loved one than are family members of people with other

mental illnesses [13, 27]. They are suspected of being at risk of contagion, and they are more likely to abuse substances themselves or engage in other behaviors that make them socially unappealing [4].

Family members suffer silently as they overhear people talk about substance users—people they love, care for, and identify with—in derogatory ways. A large survey of US health consumers found that 80% had overheard hurtful or offensive comments about mental illness [60]. Family members also see depictions of substance users in the media that are rife with misconceptions and evince little knowledge of effective treatment. Family members themselves are often treated with suspicion or pity. As they try to help their loved ones, they face discrimination in navigating schools, work, the treatment system, and the justice system. Since they are often distracted or managing an urgent crisis or both, they lose jobs and are seen as unreliable. When they do open up about the problem, they face criticism and advice that runs counter to their values and goals ("kick them out," "cut them off," "let them hit rock bottom"). They are "diagnosed" as "codependent" and told that they are powerless to help their loved ones, the thing they most want to do. They are physically stressed and emotionally drained by their experiences and have profound negative feelings about themselves. They agonize, "What will people think? How will our family be treated? Am I a bad parent?" Adding insult to the insult and injury, the strong cultural message of "once an addict, always an addict" can cause a family to be stigmatized long after a problem has resolved.

The outcome for families, as well as for their loved ones using substances, often is isolation, reluctance to seek help [7], and prolonged suffering. This is concerning as research has shown that family members can play a critical role in change by supporting and advocating on behalf of their loved ones [8, 47] and helping facilitate better engagement with treatment [36, 53]. In other words, a key consequence of stigma is the loss of perhaps our most powerful motivating force in a substance user's life: family.

How Stigma Runs in the Family

Approximately 21.5 million people in the United States have substance use disorders, including 1.3 million aged 12–17 [59], and likely live with parents or guardians. Estimates are that for every person with a substance use problem, at least one family member and as many as *five* other individuals are negatively impacted [14, 47, 65]. Other studies indicate that half of American adults have a close family member who has struggled with alcohol dependence [15], a staggering number reaching well above 100 million adults.

Dictionary definitions of *family* refer to a social unit consisting of a father, mother, and their children and other blood relatives including aunts, uncles, cousins, and grandparents. More modern definitions include same-sex couples and their children and single-parent households, and many people consider close friends to be more like "family" than their blood relatives. But in fact, any close other who cares about and identifies with a person struggling with a substance use disorder is likely to experience the effects of stigma. The family is, as the saying goes, in this together. In the succeeding section, we note some primary ways that stigma is understood to be conveyed through family relationships.

Closeness

Theorists have noted multiple pathways leading to the general phenomenon of stigmatization of family members. Goffman [22] observed that stigma tends to "spread from the stigmatized individual to his close connections." This type of stigma is essentially guilt by association, so that even though a family member does not share the behaviors or characteristics of their loved one (e.g., behaviors related to substance abuse), they are close enough to be touched by the stigma and suffer its effects. The social heuristics or automatic processing we use to categorize other people before we get to know them can lead us to stigmatize by association on the basis of physical proximity alone. In a study titled "Known by

the Company We Keep," [26] found that merely being seen talking to a stigmatized coworker was enough for the stigma to rub off, so much the more so for close family members.

Unusualness

Others have focused on the overall "unusualness" of the family [48, 63] as a particular dynamic of association. Families that are outside the norm within a community, such as single parent, minority, or same-sex families, face discrimination and are marginalized in various ways. As social creatures, we tend to see the world through the lens of "us" and "them," judging and rejecting those who don't seem "normal." If a person or family is like "us," we perceive them to be familiar and trustworthy. If they are different, they may be regarded with suspicion; at worst, they are stigmatized, rejected, and sometimes even punished. It is not uncommon for families struggling with substance use disorders to be seen by others as "different," especially since they experience more negative events, including ones that nonfamily members are likely to observe, such as arrests, hospitalizations, and verbal and physical assault [29, 48]. A family that is known to be different, troubled, and unpredictable may become known to members of the community as information passes between groups.

Blame

As well as the stigma that comes from simply being associated through closeness or unusualness with a person abusing substances, family members are often blamed for their loved ones' problems. They are perceived as somehow complicit or culpable [19]. When compared with families who have a loved one with a mental illness like schizophrenia, family members of an individual with SUD are more often deemed responsible for the disorder [13]. They are blamed for causing the problem and held responsible for not fixing it quickly enough.

Stigma and Parenting

While all family members of people with substance use disorders suffer from the effects of stigma, parents of children using substances are perhaps hit the hardest. Since one ubiquitous understanding of substance abuse attributes it to character defects, parents of substance users are assumed to have failed at teaching good morals and instilling proper values in their child. Francis [19] found that parents assume that others blame them for their children's problems, and they are not incorrect in making this assumption. In a survey of public attitudes concerning substance abuse, a quarter of those surveyed blamed parents for not preventing their children's drug dependence [55]. Other studies indicated that parents of children with "invisible" disabilities (like mental illness, including SUDs) feel labelled as "bad parents" [19, 58]. When they ask for help, family members typically receive inculpating if not well-meaning advice, such as "You need to stop enabling him." The message is clear: you are doing something wrong; you are too lax, too strict, too involved, and the list goes on. The burden of blame weighs on mothers in particular as they assume greater responsibility for their children's conditions and behaviors [19].

The Language and Logic of "Codependency"

Directly or indirectly, family members of individuals struggling with substance use are assumed to be part of the problem [30], and in North America this assumption is built into the language. "Codependency," a word that has been used for more than thirty years to explain the behaviors of family members around the substance user (e.g., [3, 44]), represents a Pandora's box of theories unsupported by empirical research. Dr. Timmen Cermak [6] argued in his 1986 book *Diagnosing and Treating Co-Dependence: A Guide for Professionals* that codependency should be included in the DSM-III as a distinct personality disorder. While Cermak's recommendation has not been followed, many people in the

treatment field nonetheless accept the idea of a disease of codependency, and it continues to be common parlance in twelve-step support groups for family members, such as Al-Anon and Nar-Anon.

Family members may not understand what "codependent" means, but they know that it is a stigmata for dysfunction. We reviewed the codependency literature and found that descriptions of a supposed codependent include controlling behavior, perfectionism, excessive caretaking, repressed emotions, mistrust of others, and hypervigilance. "Codependents" are assumed to have "bad boundaries," to live in "denial," and to derive their self-esteem from "rescuing" their loved one.

Within this framework, a stigmatized understanding of substance use disorders and their impact on relationships forms a circular trap. It starts with the idea that substance abuse is a "disease" characterized by permanent, personal flaws that make users "powerless" to control their use. Their resistance to changing is labeled "denial." The "addict" is by definition—genetically, mentally, spiritually, incurably—a liar and a manipulator, such that any attempts by a family member to change the person are taken as both misguided and evidence of their "disease of codependency." The family member is called an "enabler," as if the only explanation for trying to fix the supposedly unfixable is a hidden agenda to help the person to keep using [47]. Anyone in a relationship with a substance user can be "diagnosed" with codependency, but parents of children and female partners of men are more often given the label [47]. The logic of codependency leads to only two recommendations for family members: force compliance from the substance user through an "intervention" [24] or go to a self-help group like Al-Anon/Nar-Anon and learn to "detach with love" and "take care of yourself" while you wait for your loved one to "hit rock bottom."

In fact, many so-called codependent behaviors are normal responses to being in a relationship with someone misusing substances. It's normal to try and be helpful when loved ones are hurting themselves. It's normal to want to protect people we love from the consequences of their behavior, especially when the outcome might be incarceration or death. It's nor-

mal to be anxious and distrustful of others when we are stigmatized and discriminated against for simply being in a relationship with someone using substances. It's normal to hope against hope that things aren't as bad as they look. The language and logic of codependency, however, stigmatizes family members by branding these behaviors as abnormal and sick.

However conferred—implicitly or explicitly through judgment, avoidance, blaming, or the logic of codependency—the stigma of substance abuse stands in the way of true, helpful understanding. We think, "they're not like us," and by extension, "that's *why* they have a substance problem and we don't." We say, "it's bad parenting" and think we know what's really going on in another family's struggle. We call it "codependency" and think that it explains *everything* we see. Unfortunately, such thinking prevents family members and treatment providers from embracing evidence-based approaches to substance use disorders. Stigma also prevents family members from being the powerful resource and support for their loved one that research has shown time and again they can be [8, 37, 47].

Layer Upon Layer of Stigma

Making matters worse, families dealing with substance problems often face multiple sources of stigma. Substance disorders cause (or coexist with) all sorts of other problems for the substance user and the people who care about them, and many of these problems are also stigmatized. Sexually transmitted disease; unemployment; cooccurring psychiatric issues; medical, financial, and housing problems; domestic violence; broken families; and racism compound the stigma of substance abuse.

Many family members also face stigma associated with being involved in the criminal justice system. Of the 2.3 million people incarcerated in the United States, more than 65% met criteria for a substance use disorder [43]. In 2016, the

most recent date for which federal offense data are available, 47% of sentenced federal prisoners were serving time for a drug offense [5], and a study conducted by CASA [43] found that only 11% of inmates receive treatment for their substance use disorder. There is a significant chance that a person with a substance use disorder will interact with the legal system, possibly go to jail, and in the process be stigmatized for their substance use problem and their history of incarceration. Their family will share in all of this stigma.

The Impact of Stigma on Family Members

Shame

Family members of people with substance problems have many experiences, thoughts, and emotions that can lead to feeling shame, all of them caused or exacerbated by stigma. Because of stigma, they feel embarrassed by their loved one's problem and embarrassed about their loved one as a person—in studies of families of people with substance use problems, even those who understand that they are not responsible often feel ashamed and embarrassed anyway [13, 16, 34].

Family members often do feel (and are) blamed, and they are at risk for internalizing the blame. In a survey of over 600 parents who had a child with an emotional or behavioral problem, 72% of parents blamed themselves for causing their child's problem. Interestingly, 97% of these parents felt that they did not deserve the blame of others [16]. Family members frequently feel guilty—and deeply ashamed—for things they have said or done to their loved ones with SUDs. Family members in caretaking roles feel pressure to be strong, rational, calm, and kind. Failing that, they feel ashamed. Unfortunately, it's nearly impossible to be strong, rational, calm, and kind all the time, especially under the prolonged stress attendant to substance use.

Social Isolation

The shame felt by many family members, especially parents, is full of self-judgment and fear that others are judging them just as harshly. While some attribute other people's judgment to lack of knowledge and negative attitudes [34], nonetheless, when faced with the prospect of misunderstanding, blame, and shame, family members understandably pull away and move toward isolation [29, 34]. They may compare themselves to families that seem more "normal" and withdraw to protect themselves. Withdrawal is a self-protective response to the shame that family members feel; it can also guard against opinions and advice that are unhelpful or against their values, such as pressure to ask a child using substances to leave the family home. While the impact varies across groups, family members in studies report strained or distant relationships with extended family and friends because of their loved one's mental health problems [58, 61]. In other words, given the choice between stigma and isolation, many family members choose isolation.

Not Seeking Help

Stigma undermines people's willingness to seek treatment. This is true for both substance users and their family members. The expectation of stigma prolongs and worsens the course of substance use and mental health problems as people who feel stigmatized have a harder time accepting their illness, put off or resist getting treatment, and drop out of treatment sooner than do less stigmatized populations [8]. The same is true for their families. Studies have shown that secrecy prevents family members from seeking and receiving both informal and formal support and increases the burden of helping their loved one with a mental health issue (Gerson et al. [20, 64]). In fact, stigma contributes to delays in seeking help more than structural barriers such as lack of funds [57].

The stigma of substance abuse gives people understandable reasons to do privately whatever it takes to hold their

lives together rather than seek help and be exposed to judgment and concrete life consequences. For example, parents may minimize or hide their child's substance problem if they fear that the child will be treated differently at school. Spouses may try to ignore or even help cover up a problem because the whole household depends on the substance user not losing his or her job. And just as substance users resist treatment because they don't want to be labeled addicts, family members understandably want to avoid the label of codependent. The reality is that family members can be crucial agents of positive change for the substance user: family influence is the most commonly cited reason for treatment entry among help-seeking substance users [33]. Their stigma-induced reluctance to reach out and be involved is doubly unfortunate as stigma makes them less likely to help their loved one get help and less likely to get help for themselves.

Unhelpful Attitudes in Treatment Settings

Moyers and Miller [41] described how the very people trained to help often hold negative attitudes about substance users and their families and contribute to their stigmatization. In one study, surveyed addiction counselors endorsed judgments like "alcoholics are liars and cannot be trusted" [41]. This may impact quality of care [42] as it disrupts trust and rapport building between the professional and the patient. When they do seek help, family members often endure well-intentioned but uninformed advice that implies that they are part of the problem and puts them in a position of having to justify or explain themselves and challenge misconceptions about their loved one and the family [34]. Family members feel judged by unsympathetic health care professionals [34, 47] and regularly report that they are not listened to and are excluded from important treatment decisions by treatment providers [23, 47]. Family members fear gossip and loss of confidentiality and anonymity [34], especially in small rural towns [21]. They deal with treatment providers who make assumptions about their mental health and accuse them of

"enabling." The intrinsically blaming diagnosis of codependency may prevent them from getting assessed and treated for the slew of mental health impacts on families of loved ones struggling with substances—commonly anxiety disorders such as posttraumatic stress disorder or generalized anxiety disorder, or mood disorders that would respond to evidence-based therapies and medications.

Additionally, treatment providers who hold biased views may be unnecessarily pessimistic about the psychological well-being of family members. A study conducted by Burk and Sher [4] found that mental health professionals predicted that teenagers of parents who had a drinking problem would be more likely to have substance problems, mood disorders, and dissatisfaction with life (specifically intimacy problems) as they aged. Family members being treated for codependency are encouraged to "stop enabling," "focus on yourself," and "surrender control," which, as well as being unsupported by evidence, are the opposite of what they want to hear as they try to help a loved one. Many family members report a sense of hopelessness in response to clinical feedback [34, 47].

Stress

For families, the shame, social isolation, and poor treatment or lack of help associated with the stigma of substance abuse adds stress to an already stressful situation. Families may internalize prejudice [10, 12], which has a profound negative impact on self-esteem. Family members of people misusing substances are frequently on the receiving end of arguments, abuse, aggression, and violence [28, 35] and experience marital distress and social and financial problems [52]. At the same time, they are faced with providing financial, practical, and emotional support for their loved ones. The demands of the caretaking role can negatively affect their physical, psychological, social, and financial well-being, and many report that their coping resources are exhausted [45–47]. Stigma further complicates the caretaking role as many family mem-

bers also live with more anger as they have internalized a blaming, shaming, stigmatized view of the problem.

If someone in the family has a non-stigmatized illness like cancer, other people volunteer to help with household chores, bring food, or offer emotional support. The family doesn't get shunned or blamed; judgments are not questioned. But enter substance abuse, and stigma undercuts the reward and joy of parenting that could otherwise serve to offset some of the stress of illness in the family. It is impossible to separately measure stress due to stigma from other stressful aspects of substance abuse (fear for a loved one's safety, for example), but there is no question that living with stigma is stressful, and stress has a substantial independent negative impact. Family members of people with substance use disorders suffer from higher rates of physical illness because of stress, and stress adversely affects their ability to support their loved ones [20].

Stigma and Children

Based on data from the combined 2009–2014 National Surveys on Drug Use and Health, about 1 in 8 children (8.7 million) aged 17 or younger lives in households with at least one parent who has a past-year substance use disorder characterized by recurrent use of alcohol or other drugs (or both) that has resulted in significant impairment [31]. These children suffer: children whose parents abuse alcohol and other drugs are three times more likely to be abused and more than four times more likely to be neglected than children from non-substance-abusing families [50]. These children also tend to have lower socioeconomic status and more difficulties in academic, social, and family functioning when compared with children of parents who do not have a substance use disorder [49]. Many assume caretaking roles for their parent and any other children in the home, and through all this, they experience the effects of stigma. As noted, even when people change their relationship to substances they

often face ongoing stigma for having the problem in the first place. Children continue to suffer when their parents have a harder time finding and keeping jobs, getting licenses, and receiving benefits that help their children, like food stamps and education vouchers.

Children of parents with substance use disorders overhear peers and adults referring to their parents as "addicts" and "losers." They see prejudice in the media. They see how teachers and neighbors look at their parents and experience shame. They are also stigmatized by association and viewed as contaminated [13]. One-third of respondents to a survey on public attitudes toward substance use agreed with the statement: "Parents would be foolish to let their children play in the park with the children of someone who has a history of drug dependency" [55]. These aversive emotional, physical, and material experiences can reach into adult life. A landmark study conducted from 1995 to 1997 with more than 17,000 participants found a dose-response relationship between adverse childhood experiences (physical abuse, divorce or parental separation, or having a parent with a mental and/or substance use disorder) and numerous health, social, and behavioral problems throughout the lifespan, including substance use disorders. Specifically, when compared to people who experienced no adverse childhood events, people who experienced four events or more had a 4- to 12-fold increased risk for alcohol and drug problems, depression, and suicide attempts; a 2- to 4-fold increase in smoking, poor self-rated health; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity [17].

What to Do?

For every person stigmatized for having a substance use disorder, there are typically multiple family members impacted by this stigmatization. Stigma exacerbates the pain of one of the most painful experiences a family can have by adding shame, isolation, and stress, deterring people from getting help, as well as degrading the quality of help received.

Because of the cultural ubiquity of stigma, stigmatized views of addiction are often confused with truth about substance use disorders.

The widespread neglect of life-saving evidence-based treatments points directly to stigma. Much of what is called substance use disorder treatment in the United States is based on a moralizing, stigmatizing ideology of addiction that promotes false beliefs: that addiction is characterized by character defects, [39]; that families must step away and let their loved ones hit rock bottom, and that medications are just another escape from taking responsibility. These beliefs are not supported by empirical evidence. But the following is supported by evidence: what is commonly referred to as addiction is a multidetermined and variably severe disorder, medication-assisted treatment works and is lifesaving, and family members *can* help and do not need to step away. Yet a culture and treatment system that paint vast swaths of people and their problems with one brush and one color tend to resist the evidence for nuanced understanding and individualized care. As long as treatment professionals, legislators, and the media and colleagues, friends, and neighbors substitute stigma for understanding, we are failing people with substance problems and their families

So what to do? The dissemination of evidence-based ideas and strategies related to substance use disorders can play a significant role in unwinding stigmatized understandings and approaches. The more access and exposure people have to non-stigmatizing approaches, the less likely they will be to mistake the myths for real understanding of substance use disorders. Family members, national and state policy makers, health insurers, health care practitioners, the media, and individuals with substance use disorders all need better, evidence-based answers than they’ve been getting.

In the treatment world, we have evidence that can be part of this destigmatizing process for families, but even here, the battle is uphill. For instance, one of the most robust evidence-based approaches to family involvement is virtually unknown in the United States. The Community Reinforcement Approach and Family Training (CRAFT) approach is a behavioral and

motivational treatment for families [56] based on the empirically supported Community Reinforcement Approach (CRA), and has been developed and researched in randomized controlled trials. CRAFT has two goals: engaging the substance user in treatment through behavioral training *for the family members* and enhancing family-member self-care. A primary strategy of CRAFT is to create a relationship environment where abstinence/change behaviors are positively and incrementally reinforced. CRAFT enlists family members as powerful *collaborators* in effecting change without the use of detachment or confrontation.

In several clinical trials CRAFT engaged the substance user into treatment with rates of 74% Meyers et al. [37], 64% Miller, Meyers and Tonigan [40], 67% Meyers et al. [38], 64% Kirby et al. [25], and 71% Waldron et al. [62]. Families reported significant improvements in happiness and sense of family cohesion, as well as reduced anxiety, depression, and anger [53]. The individuals with SUDs significantly reduced substance use, regardless of whether they entered treatment.

The key here is collaboration instead of detachment. The CRAFT approach encourages families to remain engaged, seeing their loved ones as multi-faceted persons who happen to be struggling with substance abuse. CRAFT teaches families to reward positive change and to create respectful, empathic environments that invite change instead of demanding it. Families are considered sources of strength and understanding, and they are valued as key motivators of change. This is the antithesis of a judgmental, stigmatizing stance. By teaching family members functional and behavioral strategies rather than moralistic approaches, CRAFT effectively deconstructs stigma.

Utilizing platforms that go beyond formal treatment systems also offer hope. A recent, grassroots example is instructive. In collaboration with other nonprofit organizations, we have developed a nationwide training program for peer-to-peer dissemination of research-supported, clinically tested approaches at the community level (https://cmcffc.org/). A primary goal is to make concepts and practices from empirically supported treatments (ESTs) available to families outside the formal treatment system. This peer-to-peer coaching

model (in many ways a family “self-help” model) allows families to learn and share new perspectives and effective strategies otherwise unavailable to them.

The coaching program utilizes the Invitation to Change Approach, a composite of several ESTs for substance use problems, including CRAFT, Motivational Interviewing (MI), and Acceptance and Commitment Therapy (ACT), with a particular emphasis on self-empowerment [51], a sense of agency, self-control, and goal directedness [18, 27]. This national network of skilled, volunteer parent coaches providing free evidence-based support to other parents who have children with substance use disorders taps into the largest of all untapped resources for fighting the rising toll of substance use in this country: the families of people using. We are encouraged by the positive changes in family attitudes and practices to date, and we are testing the sustainability and scalability of this peer-to-peer network. We are hopeful that this and other nontreatment, family-based models will provide more keys to eliminating the stigma of substance use disorders.

References

1. Angermeyer MC, Matschinger H, Corrigan PW. Familiarity with mental illness and social distance from people with schizophrenia and major depression. Schizophr Res. 2004;69(2):175–82.
2. Barry C, McGinty EE, Pescosolido BA, et al. Stigma, discrimination, treatment effectiveness, and policy. 2004. https://doiorg/101176/appips201400140.
3. Beattie M. Codependent no more. Center City: Hazelden; 1992.
4. Burk JP, Sher KJ. Labeling the child of an alcoholic. J Studies Alcohol. 1990;51(2):156–63.
5. Carson AE. Prisoners in 2016 Washington, DC. US Dept of justice Bureau of Justice Statistics, NCJ251149, p 13. 2018. https://wwwbjsgov/indexcfm?.
6. Cermak TL. Diagnostic criteria for codependency. J Psychoactive Drugs. 1986;18(1):15–20.
7. Cooper AE, Corrigan PW, Watson AC. Mental illness stigma and care seeking. J Nerv Ment Dis. 2003;191:339–41.

8. Copello A, Templeton L, Powell J. Adult family members and carers of dependent drug users. London: UK Drug Policy Commission; 2009.
9. Corrigan P. Mental health stigma as social attribution. Clin Psych-Sci and Practice. 2000;7:48–67.
10. Corrigan P, Miller F. Shame, blame, and contamination. J of Mental Health. 2004;13(6):537–48.
11. Corrigan PW, River LP, Lundin RK, et al. Predictors of participation in campaigns against mental illness stigma. J Nerv Ment Dis. 1999;187(6):378–80.
12. Corrigan P, Watson A. The paradox of self-stigma and mental illness. Clin Psych-Science and Practice. 2002;9:35–53.
13. Corrigan P, Watson A, Miller F. Blame, shame, and contamination. J Fam Psych. 2006;20(2):239–46.
14. Daley DC, Raskin M. Relapse prevention and treatment effectiveness studies. In: Daley D, Raskin M, editors. Treating the chemically dependent and their families. Newbury Park, CA: Sage; 1991. p. 128–71.
15. Dawson DA, Grant BF. Family history of alcoholism and gender. J Stud Alc. 1998;59:97–106.
16. Eaton K, Ohan J, Stritzke W, et al. Failing to meet the good parent ideal. J Child Fam Stud. 2016;25(10):3109–23.
17. Felitti V, Anda R, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. Amer J Prev Med. 1998;14(4):245–58.
18. Foote J, Wilkens C, Kosanke N, Higgs S. Beyond addiction. New York: Scribner; 2014.
19. Francis A. Stigma in an era of medicalisation and anxious parenting. Soc of Health & Illness. 2012;34(6):927.
20. Gerson R, Davidson L, Booty A, et al. Families' experience with seeking treatment for recent-onset psychosis. Psychiatr Serv. 2009;60(6):812–6.
21. Girma E, Moller-Leimkuhler AM, Muller N, et al. Public stigma against family members of people with mental illness. BMC Int Health & Human Rights. 2014;14:2.
22. Goffman E. Stigma. New York: Simon & Schuster; 1963.
23. Haskell R, Graham K, Bernards S, et al. Service user and family member perspectives on services for mental health, substance use/addiction, and violence. Int J Mental Health. 2016;10:9.
24. Johnson V. Intervention. Minneapolis: Johnson Institute Books; 1986.

25. Kirby KC, Marlowe DB, Festinger DS, et al. Community reinforcement training for family and significant others of drug abusers. Drug Alcohol Depend. 1999;56:85–96.
26. Kulik C, Bainbridge J, Cregan C. Known by the Company we Keep: Stigma-by-Association Effects in the Workplace. Acad Manag Rev. 2008;33(1):216–30.
27. Larson J, Corrigan P. The stigma of families with mental illness. Academic Psych. 2008;32(2):87–91.
28. Laslett AM, Mugavin J, Jiang H, et al. The hidden harm: Alcohol's impact on children and families. Canberra: Foundation for Alcohol Research and Education; 2015.
29. Lefley H. Family burden and family stigma in major mental illness. Am Psychol. 1989;44(3):556–60.
30. Ligon J. Families and significant other. NAADAC News. 2005;15(4):8.
31. Lipari RN, Van Horn S. Children living with parents who have a substance use disorder. The CBHSQ Report: August 24, 2017. Center for Behavioral Health Statistics and Quality. Rockville: Substance Abuse and Mental Health Services Administration; 2017.
32. Link BG, Phelan JC. Conceptualizing stigma. Annual Rev Soc. 2001;27:363–85.
33. Marlowe D, Merikle E, Kirby K, et al. Multidimensional assessment of perceived treatment-entry pressures among substance abusers. Psych Addict Behav. 2001;15(2):97–108.
34. McCann TV, Lubman D. Stigma experience of families supporting an adult member with substance misuse. Int J Mental Health. 2018;27:693–701.
35. McCann TV, Lubman D, Boardman G, Flood M. Affected family members' experience of, and coping with, aggression and violence within the context of problematic substance use. BioMed Central J Psychiatry. 2017;17:209.
36. Meyers R, Wolfe B. Get your loved one sober. Center City, MN: Hazelden; 2004.
37. Meyers R, Miller W, Hill D, Tonigan S. Community reinforcement and family training (CRAFT). J Sub Ab. 1999;10:291–308.
38. Meyers R, Miller W, Smith J, Tonigan S. A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. J Consult Clinical Psych. 2002;70:1182–5.
39. Miller W. Alcoholism Psych Addict Behav. 1993;7(2):129–36.

40. Miller W, Meyers RJ, Tonigan S. Engaging the unmotivated in treatment for alcohol problems. J Consult Clinical Psych. 1999;67:688–97.
41. Moyers TB, Miller WR. Therapists' conceptualizations of alcoholism. Psych Addict Behav. 1993;7:238–45.
42. Mwinituo PP, Mills JE. Stigma associated with Ghanaian caregivers of AIDS patients. Western J Nursing Research. 2006;28(4):369–82.
43. CASAColumbia. Behind bars II. Center on addiction and substance abuse (CASA). 2010. https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america%E2%80%99s-prison-population. Accessed 19 Jul 2018.
44. Norwood R. Women who love too much. New York: Pocket; 1990.
45. Orford J, Velleman R, Copello A, et al. The experiences of affected family members: a summary of two decades of qualitative research. Drugs. 2010a;17(sup1):44–62.
46. Orford J, Copello A, Velleman R, Templeton L. Family members affected by a close relative's addiction. Drugs. 2010b;17(sup1):36–43.
47. Orford J, Velleman R, Natera G, et al. Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. Soc Sci Med. 2013;78:70–7.
48. Park S, Park KS. Family stigma. Asian Nurs Res. 2014;8(2014):165–71.
49. Peleg-Oren N, Teichman M. Young children of parents with substance use disorders (SUD). J Soc Work Pract Addict. 2006;6(1–2):49–61.
50. Reid J, Macchetto P, Foster S. No safe haven. New York: National Center on Addiction and Substance Abuse at Columbia University; 1999.
51. Rogers S, Chamberlin J, Ellison M, Crean T. A Consumer-constructed Scale to Measure Empowerment among Users of Mental Health Services. Psych Services. 1997;48:1042–7.
52. Romijn C, Platt J, Schippers G, Schaap C. Family therapy for Dutch drug users: the relationship between family functioning and stress. Int J Addict. 1992;27:1–14.
53. Roozen HG, De Waart R, Van Der Kroft P. Community reinforcement and family training: an effective option to engage treatment-resistant substance-abusing individuals in treatment. Addiction. 2010;105(10):1729–38.

54. Rüsch N, Angermeyer MC, Corrigan PW. Mental illness stigma. European Psych. 2005;20(8):529–39.
55. Singleton N. Attitudes to drug dependence. London: Drug policy commission; 2010.
56. Smith J, Meyers R. Motivating substance abusers to enter treatment: working with family members: Guilford Press; 2004.
57. Song H, Shin H, Kim Y. Perceived stigma of alcohol dependency: comparative influences on patients and family members. J Subst Use. 2015;20(3):115–61.
58. Struening EL, Perlick DA, Link BG, et al. Stigma as a barrier to recovery. Psychiatr Serv. 2001;52(12):1633–8.
59. Substance Abuse and Mental Health Services Administration (SAMHSA). 2014. https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.
60. Wahl OF. Mental health consumers’ experience of stigma. Schizophr Bull. 1999;25(3):467.
61. Wahl OF, Harman CR. Family views of stigma. Schizophr Bull. 1989;15(1):131.
62. Waldron B, Kern-Jones K, Turner W, et al. Engaging resistant adolescents in drug abuse treatment. J Sub Abuse Treat. 2007;32:133–42.
63. Walker LO, Avant KC. Strategies for theory construction in nursing. 4th ed. Upper Saddle River: Pearson; 2005.
64. Werner P, Mittelman M, Goldstein D, Heinik J. Family stigma and caregiver burden in Alzheimer’s Disease. The Gerontologist. 2012;52(1):89–97.
65. World Health Organization (WHO). Global status report on alcohol and health. 2014. http://apps.who.int/iris/bitstream/handle/10665/112736/9789240692763_eng.pdf;jsessionid=B860C72DA9FF6463A0AF4AE2C60D7128?sequence=1.

Chapter 4
The Stigma of Addiction in Romantic Relationships

Lindsey M. Rodriguez and Lauren Prestwood

Love is the absence of judgement.
–Dalai Lama

Substance abuse can substantially disrupt the harmony associated with positive social relationships. When someone struggles with addiction, all types of relationships can be placed under tremendous strain. In this chapter, we will focus on the dynamics surrounding substance use disorders (SUDs) and a particularly critical relationship: the romantic relationship. Given how addiction can cause feelings of betrayal, perceived lack of dependability, and, most acutely, breaches of trust, it is unsurprising that substance abuse is among the top causes of divorce [1].

There are substantial consequences of addiction for long-term romantic partnerships. Economically, funds can be redirected from savings accounts toward fueling the habit. Psychologically, one person's SUD can result in the presence of mood swings, reduced sexual interest and functioning, less

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quality time with the other partner, general social isolation, and an increased likelihood of physical and emotional abuse. Common partner responses to SUDs in a loved one include leaving the relationship, responding in ways that potentially increase conflict, or even complicity, such that one partner covers for the other and may even provide him or her with substances, often with the ostensible goal of helping.

Although much work has focused on the bidirectional link between SUDs and relationships, [2, 3], relatively little attention has been devoted to understanding addiction stigma as it occurs within romantic relationships [4]. Intimate partners play a significant role in treatment and relapse processes, [5–9], and their influence can be harnessed to combat stigma from outside sources and help in the rehabilitation and recovery processes, but it is important to consider how they may communicate and maintain stigma as well. This chapter focuses on precisely this duality.

Before beginning, let us consider "Jake" and "Ashley," a couple who have been together since they were both 18 years old, a period of seven years. For the first few years, they enjoyed outdoor activities and traveling, as well as evenings at home watching movies, eating take out, and occasionally drinking a beer or two together. They maintained a healthy and happy, physically and sexually active relationship during this time. However, everything changed when Jake's father passed away. Jake spent the first two weeks drinking much more than usual as a way to cope with his recent loss. He went from drinking two to three beers a week to an entire bottle of whiskey. At first, Ashley tried to be understanding of his loss. However, about four months later, she noticed that the problem had gotten worse. Jake was now drinking a bottle of whiskey every other night, and had recently started doing cocaine as well. When she confronted Jake about it, he responded, "You don't understand what it's like to lose your dad, I'm just trying to cope." Ashley knew she did not know what that felt like, so she tried again to be understanding and not overbearing but told herself to remain watchful. When they went out with their friends, Ashley noticed Jake going to the bathroom frequently but figured it was merely due to his

drinking. When they would come home, Jake was unable to engage in sexual activities with her. Ashley internalized this and began to think that perhaps Jake was being unfaithful or that she had done something wrong. Jake would get angry at her for accusing him of infidelity, and Ashley did not know what else to think. She sought out answers from the Internet. She found that frequent alcohol and drug usage can cause sexual dysfunction and thought that this might be the answer to her problems. When Ashley spoke to him about this, Jake got very defensive and upset. Jake was internally distressed because he knew his substance use was the source of his issues. He knew his problem was getting out of control and that he wanted to please Ashley but he also wanted to gratify his substance cravings. He realized his reliance on alcohol and drugs had affected not only him but also his partner and his ability to be a partner.

We will be returning to this hypothetical scenario in the sections that follow. Specifically, we will explore addiction stigma from both sides of the romantic partnership: from the perspective of the concerned partner and also from the perspective of the individual with a SUD. We conclude by discussing effective therapeutic approaches, including ways that the influence of partners can be harnessed to reduce stigma related to addiction.

Through the Lens of the Person Struggling with SUD

Individuals exhibit a range of feelings and emotions toward their partner. In a healthy relationship, these feelings might stem from love, passion, care, compassion, honesty, and trust. On the other hand, partners also have attitudes toward themselves. They may evaluate their adequacy as a partner, including how pleasing they think they are toward their partner and how much they perceive themselves to provide to their partner in physical, emotional, and tangible domains.

Research has identified some differences in how individuals struggling with addiction perceive themselves as a person

and a partner. As the "addicted" companion, one might feel insecure, anxious, guilty, or burdensome. In a 2004 study, individuals with SUDs reported experiencing enacted, perceived, and self-stigmas [10]. Moreover, individuals with SUDs report being perceived as untrustworthy, blameworthy, and dangerous [11], which have the downstream effect of hindering help-seeking behaviors [12, 13]. "Enacted" stigma refers to social repercussions, such as difficulties acquiring employment or receiving little support for treatment. These types of issues are particularly acute for those with substance abuse issues, who face even worse social attitudes than do those with schizophrenia [14, 15].

Stigma contributes to relationship distress in many ways. For example, if a partner cannot find work, he or she may feel as if he/she cannot provide or contribute to the relationship and therefore may not seem to be a "good fit" as a romantic companion. In addition, the fact that many substances of abuse are illegal complicates nonusing partners' displays of empathy. The nonuser might see his/her loved one as a criminal rather than an individual with a medical disorder who needs treatment.

Perceived stigma refers to the "beliefs that members of a stigmatized group (such as drug addicts) have about the prevalence of stigmatizing attitudes and action in society." [16] If an individual already believes that he or she is being branded as an addict, especially by his/her partner, this may influence how he/she feels about himself/herself. Fixation on feelings that one is being labeled or judged by one's partner can deter efforts to get help. This type of stigma might prevent our hypothetical Jake from seeking treatment, or even admitting that he has an issue, simply to avoid being judged by his partner or others.

Self-stigma refers to the negative thoughts and opinions of oneself that can develop from being a part of a stigmatized group and the impact that these behaviors have: failure to seek or obtain employment, treatment avoidance, avoidance of intimate contact or relations with others. Consequences of self-stigma include lower quality of life and diminished self-

efficacy [17–19]. Self-stigma also can influence self-evaluations, especially those pertaining to intimate relationships. An individual with SUDs might feel less present, less able to give his or her partner attention and love.

Even more, he or she might feel like a burden, an added weight to the nonpartner, an unnecessary and unwanted source of stress.

Indeed, most people struggling with SUDs are aware of the fact that the disorder is creating genuine difficulties in their partners' lives as well. Because of their addiction, they might have an inability to keep a job, resulting in little to no income. SUDs can lead to job loss, resulting in a partnership that suddenly has less income. The partnership also might suffer from a sudden dearth of emotional responsiveness or a decrease in sexual interest. For example, in Jake and Ashley's relationship, Ashley was under the impression that perhaps her boyfriend had been unfaithful or was becoming disinterested in her, when in reality his substance abuse issues had begun to affect his libido and stamina. Patterns of substance abuse might offer understanding to the problems and instability experienced in young adult marriages [20]. One recurring theme is that, on average, people struggling with substance abuse issues do not care any less about their relationship and partner. Individuals want and expect their romantic relationships to endure, similar to relationships in which neither partner is abusing substances [21].

Through the Lens of the Partner

Existing literature on stigma is primarily concerned with the individual who is misusing substances. Relatively less attention has been given to those who are closely connected to that individual, even though their outcomes are intimately tied to those of the individual. Romantic partnerships are impactful on mental and physical health, and romantic partners are in a unique position of being both directly impacted by the substance use and able to facilitate positive change.

Because the vast majority of individuals with SUDs refuse to enter treatment [22–24], the lives of family members are directly and negatively impacted by the consequences of the SUD.

In an intimate partnership, addiction can place a strain on the very foundation of the relationship. Addiction has the potential to spread to every aspect of shared life: leisure and quality time, social and sexual functioning, work and professional life. It also has the potential to create financial, medical, psychological, and legal problems. Furthermore, there is the possibility of cognitive biases (e.g., confirmation bias, availability heuristic) to mutate mundane daily stressors into addiction-related problems. For example, imagine that Jake is late to work one day. Ashley might assume that he was late because he was up the night before drinking. Or she might think that it is on account of the extra stress he has created by spending too much money on alcohol and cocaine. Such theories, true or not, create the possibility of increased conflict, which in turn may precipitate additional substance abuse by Jake. In this way, such theories are self-fulfilling prophecies, ones that initiate a cycle of accusation and subsequent use.

Romantic partners experience a number of emotions upon realizing that their partner has an SUD. Interviews with wives of husbands with alcohol use disorders found that the most common reactions were anger, hostility, and resentment, followed by feelings of abandonment, betrayal, helplessness, and frustration [25]. Fear was also present, especially if the substance is one that is known to cause aggression, and fear is especially present when the relationship deteriorates and both parties become frustrated and despondent. Interviews with spouses also indicate feelings of guilt and shame based on their partner's addiction, demonstrating that partners also experience stigma from outside sources. For example, one partner of an individual with SUDs said, "I will start by saying that living with an alcohol addicted husband or family member is extremely difficult. First of all there is the wish to hide, the shame. You go out and people see, and sometimes ask what's wrong with him" [26]. Other women in interviews

expressed desire to eradicate the sense of feeling different on account of the substance-using partner.

Despite the negative emotions associated with the discovery and daily experience of the consequences of the SUD, partners frequently distinguish between their attitudes toward the substance use and their feelings for the person. One third of the sample in one study expressed love, sympathy, and compassion for their spouse while still being upset about the SUD: "I loved him, but hated and detested what he was doing in his life with his life"; "I love him dearly for the man he is when he is sober and I see him struggling with the disease. When he is drunk I dislike being around him as a person. He is two completely different people sober and drunk" [25]. Spouses may also experience a degree of responsibility for their situation and for that of their partner. Common patterns include inner dialogue with various critical voices: their own (e.g., inability to prevent the addiction may be perceived as a personal failure), their spouse (e.g., who may place blame on them for the addiction), and society (e.g., who may place blame for not leaving their drunken and sometimes abusive partner and also for failing to take care of him or her) [26].

Moreover, viewing the struggle and consequences of the addiction might lead concerned partners to question (a) if their partner is really sick, (b) if they really require further attention, (c) if they have the capacity to be a contributing member of society, and (d) if they can change. Ashley may wonder if Jake will eventually want to change his behavior or if her relationship with him will ever go back to the way it was before the SUD began. She may wonder what she can do to help him get his life back on track, especially if he does not recognize that he has a problem. Stigma is more likely to emerge to the extent that the SUD is attributed to poor willpower, a character disorder, or a spiritual deficit rather than the result of extenuating circumstances or simply a short-term problem. As elaborated below, whether couples choose to work together to overcome the problem (the couple vs. the SUD) versus the problem being one person's problem and

the two partners against each other (the 'addict' vs. the partner) is an important distinction for the couple's capacity to prevail.

The Importance of Concordance

Three overall patterns may characterize different ways that drugs and alcohol present themselves within a relationship: two abstaining or light-drinking/using partners (i.e., concordant abstinent/light partners), a single user with a nonusing partner (i.e., discrepant partners), and two equally heavy-drinking/using partners (i.e., concordant heavy partners). In a discrepant partnership, the partner may have difficulty relating to issues associated with fear around quitting and relapsing. Thus, partners in discrepant partnerships may display higher levels of stigma compared to concordant partnerships, at least within the relationship. However, partners in discrepant partnerships may have a more objective perspective with regard to the SUD and may have unique opportunities to help their partner into treatment. For example, if Ashley also misused substances, she may have a more difficult time recognizing her own problem and Jake may not see as much need to change his behavior. However, in concordant partnerships, there is also the possibility of conflict around one person's entering treatment.

Ways That Partners Can Reduce Stigma and Help Their Partner Overcome Addiction

Partners are placed in a unique position to respond to their partner's use patterns. Just as partner influence can cause further distress and substance misuse, it can also be harnessed to help the person struggling with addiction get into treatment. Partners have the opportunity to respond anywhere along a spectrum, with anger, resentment, and distress on one end—each of which might elicit guilt and/or shame in the partner. On the other end of the spectrum are compassion, under-

standing, and support—which might potentially enable the partner's use but might also help him/her find strength to seek treatment. Indeed, romantic relationships should not be painted in broad strokes as supportive or unsupportive—they are often both [4]. Partners may struggle to find the right balance of constructive yet thoughtful concern, and this balance differs across individuals and couples. A successful path for one person or one couple may not work for another. They may also be experiencing negative emotions themselves relating to the SUD, so remaining optimistic, patient, and supportive may be difficult. Regardless, reappropriating stigma by reframing the way both individuals think about the SUD—particularly in cases where one person has made strides toward recovery and partners can celebrate how far they have come—is likely going to be helpful for both partners moving forward.

Therapeutic Approaches for Concerned Partners and Couples Struggling with SUDs

Sometimes partners may not know where to look when they discover their partner's SUD. Professional support can facilitate the partner's journey to both take care of him or herself, as well as help his or her partner get into treatment. Of course, the partner may or may not want to enter treatment, and the ways in which partners communicate, behave, and take care of themselves are focal points of therapeutic techniques for substance use disorders among those in relationships. A few—community reinforcement and family therapy (CRAFT), alcohol behavioral couples therapy (ABCT), and Al-Anon—are briefly discussed here.

CRAFT [27] leverages the cultivation of awareness, compassion, and understanding with self-care for the concerned partner to create an environment where abstinence is positively reinforced for the individual struggling with SUDs. CRAFT also emphasizes the importance of boundaries and self-care for the concerned partners. The framework underlying CRAFT is that contextual contingencies are an important

factor in promoting the individual into treatment and in reducing the concerned partner's emotional distress. Moreover, it is worth considering that sometimes the best course of action for a partner who has put in a substantial amount of effort over an extensive period of time may be for the partner to leave the relationship. CRAFT has been found more effective for engaging unmotivated problem drinkers into treatment compared with Al-Anon, [27–29], a pattern replicated with drug-abusing populations [25]. CRAFT has also been shown to improve concerned partners' depression, family conflict and cohesion, and relationship satisfaction [27, 30]. Finally, CRAFT was successfully disseminated from tightly controlled research laboratories to a community treatment center [31].

Another highly efficacious approach for those with alcohol use disorders is alcohol behavioral couple therapy (ABCT) [32–34]. ABCT recognizes that families play a large role in the beneficial and detrimental effects of alcohol use. The approach focuses on familial/partner antecedents (e.g., daily habits or celebrations) and consequences (e.g., missed work or social obligations) of drinking as well as improving communication and problem-solving skills. Spouses are taught skills to effectively manage alcohol-related situations, including reinforcing abstinence or light drinking, eliminating or reducing situations that trigger drinking, and assertively discussing their concerns over alcohol use. Behavioral couples therapy is more effective in increasing abstinence and improving relationship quality compared with individual treatment [28, 35, 36], primarily through increasing reinforcing components of the relationship, enhancing greater support for partner change, and improving couple-level problem solving. Recently, ABCT has been efficacious for females with alcohol use disorders, [35, 37, 38], men and women in same-sex relationships, [39], and nonspousal family members [40].

Al-Anon and the the twelve-step approach [41] are a common resource of support for concerned partners. In maintaining that alcoholism and other addictions are diseases, Al-Anon helps alleviate partners' guilt over being responsible for the addiction. Assigning responsibility to the disease rather than

to themselves facilitates forgiveness and acceptance. Like CRAFT, Al-Anon focuses on the concerned other and emphasizes working toward personal peace and serenity rather than controlling the other person. The fellowship provided by the Al-Anon community can also be a helpful support system. A review of family-based alcohol use disorder interventions found that Al-Anon increases adaptive coping for family members with life stressors both related and unrelated to the person's drinking [28, 36, 42]. Family members also report lower depression, anger, and family conflict and greater family cohesion and relationship quality [27, 43]. Al-Anon and Nar-Anon have largely been shown to be ineffective as approaches for bringing users into treatment [5, 27, 44, 45], which is understandable given the programs' foci on improving the well-being of concerned others.

Conclusion

Within the context of romantic relationships, use and misuse of substances have significant consequences, as do moderating and quitting substance use. Relationship partners inhabit close proximal and psychological space. The thoughts, feelings, and behaviors of one partner often become woven into the fabric of the other partners' existence. For this reason, spouses and romantic partners are among the first to experience the repercussions of an SUD, and the presence of an emergence of an SUD in a relationship can make many aspects of life challenging, especially to the extent that SUDs often jeopardize the fulfillment of primary relationship needs, including those for stability, security, connection, and tranquility. At the same time, spouses and romantic partners have tremendous potential to influence decisions related to seeking and completing treatment and are key allies in comprehensive treatment programs. In this chapter, we highlighted that partners have a unique and important perspective when intimately involved with a partner struggling with an SUD. Learning more about addiction-related stigma as it affects one's partner, speaking out and challenging inaccura-

cies related to the addiction, keeping hope alive, thinking about the partner holistically, and treating him or her with respect are all ways to challenge and overcome stigma.

References

1. Amato PR, Previti D. People's reasons for divorcing: gender, social class, the life course, and adjustment. J Fam Issues. 2003;24(5):602–26.
2. Marshal MP. For better or for worse? The effects of alcohol use on marital functioning. Clin Psychol Rev. 2003;23(7):959–97.
3. Rodriguez LM, Neighbors C, Knee CR. Problematic alcohol use and marital distress: an interdependence theory perspective. Addict Res Theory. 2014;22(4):294–312.
4. Gunn AJ, Sacks TK, Jemal A. "That's not me anymore": resistance strategies for managing intersectional stigmas for women with substance use and incarceration histories. Qual Soc Work. 2016:1473325016680282.
5. Barber JG, Gilbertson R. An experimental study of brief unilateral intervention for the partners of heavy drinkers. Res Soc Work Pract. 1996;6(3):325–36.
6. De Civita M, Dobkin PL, Robertson E. A study of barriers to the engagement of significant others in adult addiction treatment. J Subst Abus Treat. 2000;19(2):135–44.
7. Miller WR, Benefield RG, Tonigan JS. Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. J Consult Clin Psychol. 1993;61(3):455.
8. Shaffer HJ, Simoneau G. Reducing resistance and denial by exercising ambivalence during the treatment of addiction. J Subst Abus Treat. 2001;20(1):99–105.
9. Simpson DD, Sells SB, editors. Opioid addiction and treatment: a 12-year follow-up. Malabor: Krieger Publishing Company; 1990.
10. Link BG, Yang LH, Phelan JC, Collins PY. Measuring mental illness stigma. Schizophr Bull. 2004;30(3):511.
11. Room R. Stigma, social inequality and alcohol and drug use. Drug Alcohol Rev. 2005;24(2):143–55.
12. Fitzgerald T, Purington T, Davis K, Ferguson F, Lundgren L. Utilization of needle exchange programs and substance abuse treatment services by injection drug users: social work practice implications of a harm reduction model. Practice Issues in HIV/

AIDS Services: Empowerment-based Models and Program Applications 2004;10.
13. Hartwell S. Triple stigma: persons with mental illness and substance abuse in the criminal justice system. Crim Justice Policy Rev. 2004;15(1):84–99.
14. Corrigan PW, River LP, Lundin RK, Wasowski KU, Campion J, Mathisen J, Goldstein H, Bergman M, Gagnon C, Kubiak MA. Stigmatizing attributions about mental illness. J Community Psychol. 2000;28(1):91–102.
15. Crisp AH, Gelder MG, Rix S, Meltzer HI, Rowlands OJ. Stigmatisation of people with mental illnesses. Br J Psychiatry. 2000;177(1):4–7.
16. Link BG, Cullen FT, Struening E, Shrout PE, Dohrenwend BP. A modified labeling theory approach to mental disorders: an empirical assessment. Am Sociol Rev. 1989;54:400–23.
17. Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. Clin Psychol Sci Pract. 2002;9(1):35–53.
18. Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. Stigma as a barrier to recovery: the consequences of stigma for the self-esteem of people with mental illnesses. Psychiatr Serv. 2001;52(12):1621–6.
19. Wright ER, Gronfein WP, Owens TJ. Deinstitutionalization, social rejection, and the self-esteem of former mental patients. J Health Soc Behav. 2000;41(1):68–90.
20. Collins RL, Ellickson PL, Klein DJ. The role of substance use in young adult divorce. Addiction. 2007;102(5):786–94.
21. Simmons J. Singer M. I love you... And heroin: care and collusion among drug-using couples. Subst Abuse Treat Prev Policy. 2006;1(1):7.
22. Marlatt GA, Tucker JA, Donovan DM, Vuchinich RE. Help-seeking by substance abusers: the role of harm reduction and behavioral-economic approaches to facilitate treatment entry and retention. NIDA Res Monogr. 1997;165:44–84.
23. Stinson FS, Grant BF, Dawson DA, Ruan WJ, Huang B, Saha T. Comorbidity between DSM-IV alcohol and specific drug use disorders in the United States: results from the National Epidemiologic Survey on alcohol and related conditions. Drug & Alcohol Dependence. 2005;80(1):105–16.
24. Wang PS, Berglund P, Olfson M, Pincus HA, Wells KB, Kessler RC. Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62(6):603–13.

25. Weinberg TS, Vogler CC. Wives of alcoholics: stigma management and adjustments to husband-wife interaction. Deviant Behavior. 1990;11(4):331–43.
26. Peled E, Sacks I. The self-perception of women who live with an alcoholic partner: dialoging with deviance, strength, and self-fulfillment. Fam Relat. 2008;57(3):390–403.
27. Miller WR, Meyers RJ, Tonigan JS. Engaging the unmotivated in treatment for alcohol problems: a comparison of three strategies for intervention through family members. J Consult Clin Psychol. 1999;67(5):688.
28. O'Farrell TJ, Clements K. Review of outcome research on marital and family therapy in treatment for alcoholism. J Marital Fam Ther. 2012;38(1):122–44.
29. Roozen HG, De Waart R, Van Der Kroft P. Community reinforcement and family training: an effective option to engage treatment-resistant substance-abusing individuals in treatment. Addiction. 2010;105(10):1729–38.
30. Meyers RJ, Roozen HG, Smith JE. The community reinforcement approach: an update of the evidence. Alcohol Res Health. 2011;33(4):380.
31. Dutcher LW, Anderson R, Moore M, Luna-Anderson C, Meyers RJ, Delaney HD, Smith JE. Community reinforcement and family training (CRAFT): an effectiveness study. Journal of Behavior Analysis in Health, Sports, Fitness and Medicine. 2009;2(1):80.
32. McCrady BS, Epstein EE. Overcoming alcohol problems: a couples-focused program workbook. Ann Arbor: Oxford University Press; 2008.
33. Hallgren KA, BS MC. We-language and sustained reductions in drinking in couple-based treatment for alcohol use disorders. Fam Process. 2016;55(1):62–78.
34. Noel NE, McCrady BS. Alcohol-focused spouse involvement with behavioral marital therapy. In: O'Farrell TJ, editor. The Guilford substance abuse series. Treating alcohol problems: marital and family interventions. New York: Guilford Press; 1993. p. 210–35.
35. McCrady BS, Epstein EE, Cook S, Jensen N, Hildebrandt T. A randomized trial of individual and couple behavioral alcohol treatment for women. J Consult Clin Psychol. 2009;77(2):243.
36. O'farrell TJ, Fals-Stewart W, Murphy M, Murphy CM. Partner violence before and after individually based alcoholism treatment for male alcoholic patients. J Consult Clin Psychol. 2003;71(1):92.

37. Fals-Stewart S, Birchler GR, Kelley ML. Learning sobriety together: a randomized clinical trial examining behavioral couples therapy with alcoholic female patients. J Consult Clin Psychol. 2006;74:579–91.
38. Schumm JA, O'Farrell TJ, Muchowski P. A randomized clinical trial of behavioral couples therapy for women with alcohol dependence. Paper presented at annual meeting of the Association for the Advancement of behavioral and cognitive therapies: Orlando; 2008.
39. Fals-Stewart W, O'Farrell TJ, Lam WKK. Behavioral couple therapy for gay and lesbian couples with alcohol use disorders. J Subst Abus Treat. 2009;37:379–87.
40. O'Farrell TJ, Murphy M, Alter J, Fals-Stewart W. Behavioral family counseling for substance abuse: a treatment development pilot study. Addict Behav. 2010;35:1)1–6.
41. Al-Anon Family Groups. This is Al-anon. New York: Al-Anon Family Groups; 1981.
42. Nowinski JK. Family recovery and substance abuse: a twelve-step guide for treatment. Thousand Oaks: Sage Publications; 1999.
43. Timko C, Young LB, Moos RH. Al-anon family groups: origins, conceptual basis, outcomes, and research opportunities. J Groups Addict Recover. 2012;7(2–4):279–96.
44. Meyers RJ, Miller WR, Smith JE, Tonigan JS. A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. J Consult Clin Psychol. 2002;70(5):1182.
45. Sisson RW, Azrin NH. Family-member involvement to initiate and promote treatment of problem drinkers. J Behav Ther Exp Psychiatry. 1986;17(1):15–21.

Chapter 5
The Language of Stigma and Addiction

Sarah E. Wakeman

Introduction

Language has always played an important role in the generation of stigma, as well as in combating it. Language can be used intentionally or unintentionally to communicate a message about a person or group of people as being "other" and to perpetuate stigma. Historical examples exist, such as with HIV or many psychiatric illnesses, where language was used to ostracize and demonize affected populations. Diminishing stigma for these medical conditions required a shift in the words used to describe them. This is also true for addiction, where much of the attendant language bears little resemblance to the terminology used for other medical conditions. These words are not just emotionally damaging, but in fact they influence clinical decision making and public perceptions. In this chapter I explore the range of stigmatizing terms

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used to refer to addiction, why language matters, and how our terminology is gradually beginning to change.

Throughout history, language has played an important role in perpetuating and dispelling stigma. While stigmatizing language and messages are used inadvertently, they also are used intentionally. In both cases, the outcome is the same. Stigmatizing messages share certain attributes and provide cues to distinguish groups of people, to categorize those individuals as separate, to imply personal responsibility for being in the identified group, and to link the group to physical and social peril [17]. Examples in medicine abound. Reporting in the early years of the global HIV epidemic was deeply influenced by negative attitudes toward lesbian, gay, bisexual, and transgender (LGBT) people, particularly men who have sex with men. Headlines referring to the "gay plague" stoked homophobia, fear, and blame toward men who have sex with men as responsible for HIV transmission [1]. Language commonly used to refer to people with psychiatric illness previously included a range of pejorative terms, including "maniac," "lunatic," "hysteric," and "psycho." These terms served to perpetuate false notions that people with psychiatric illness were volatile, violent, and dangerous [3].

For HIV and psychiatric illness, there has been an explicit and dedicated effort to change the language used to reduce stigma. Using medically precise and person-first language has been central for both. For example, we no longer refer to a person as "a schizophrenic" but rather as a person with schizophrenia. Similarly, people are not HIV infected but rather described as a person living with HIV. These historical examples of both stigma and strategies for change offer important lessons for how we think about language and stigma related to people with substance use disorder too.

Drug and alcohol use disorder are the number one and four most stigmatized conditions on earth, according to an international survey conducted by the World Health Organization [15]. Stigma has broad, negative impact on people with substance use disorder. It is one of the main reasons that people with substance use disorder don't access

treatment, which contributes to the tremendous gap between the number of people affected by substance use disorder and those who get treatment [19]. The experience or perception of stigma among people who use drugs has been associated with a lower likelihood of accessing health care services [12, 21]. People who inject drugs who report greater internalized stigma are also less likely to utilize crucial harm reduction services such as syringe exchange, thus increasing the risk of acquisition and transmission of infectious diseases [14].

Stigma toward people with substance use disorder is communicated through and perpetuated by language. Similar to harmful language used in the past to refer to HIV or psychiatric illness, damaging words relating to substance use disorder spread misinformation and heighten societal disapproval. Stigma is enhanced when an individual is perceived to be responsible for a condition and when the condition is thought to be controllable. Terminology such as "substance abuser" or "drug abuser" heightens stigma by implying that the affected individual is the perpetrator of his illness. The term abuse has been used for shameful and willful commissions since the fourteenth century, with its roots in the word *abusion* meaning a "wicked act or practice, a shameful thing, a violation of decency" [22]. Abuse or abuser is also not a term we use for any other medical condition. Consider, for example, the difference between referring to a person with an eating disorder and calling someone a "food abuser."

This is not just an issue of semantics; language choices have very real implications on clinicians' decision making as well. Researchers demonstrated this in a study where they asked masters or doctoral-level therapists to make treatment recommendations after reading a patient vignette. The clinicians were randomly assigned a description of the patient either as a "substance abuser" or a "person with a substance use disorder"; those who received the "substance abuser" vignette were more likely to recommend punitive interventions [9]. These findings illustrate the clinical importance of person-centered language.

Words also shape how the public perceives people with a substance use disorder. A recent nationwide survey randomly assigned U.S. respondents to read a vignette of an individual described as a "drug addict" versus having an "opioid use disorder" and found that participants reported more stigmatizing views for the person labeled as an "addict" [6]. In addition, people in the general public who report the greatest stigma toward individuals with opioid use disorder are significantly more likely to support punitive policies rather than public-health-oriented policies [11]. These findings highlight the negative ramifications that language may have on much-needed support for public health interventions, particularly in the midst of the current overdose crisis.

Words such as "abuse," "abuser," and "addict" have been empirically demonstrated to increase stigma. However, there are many more negative terms frequently used to describe people affected by substance use disorder. An extreme example, still in use in the lay press and by public officials, is the term "junkie" to refer to a person with drug use disorder. In 2017, a Massachusetts town official posted on social media: "I think hypodermic needles are routinely in that area. It's greasy. The junkies are out of control" (http://boston.cbslocal.com/2017/10/27/wilmington-official-drug-addicts-opioid-detox-center/). Other problematic terms include referring to a person's toxicology testing as "dirty" or even describing a person in recovery as clean. While the latter may sound like a positive term, it implies that someone who is still actively using drugs is "dirty."

Specific word choices are the most obvious example of the stigmatizing impact of language and addiction. However, the way the language is used to frame issues related to drug use and addiction can also negatively influence readers and listeners. A recent example was an article in *The New York Times* about reoperation for people who inject drugs with recurrent endocarditis. The title of the article was "Injecting Drugs Can Ruin a Heart. How Many Second Chances Should a User Get?" [5]. The article caused an uproar in the addiction treatment community in large part because of how the

title and the thesis of the article were framed around the fundamental question of whether people who use drugs are worthy of saving. This question is not raised about the futility of medical interventions when a person has multiple heart attacks because of diet, tobacco use, or lack of medication adherence, yet when it comes to people who use drugs this question is posed as a legitimate discussion.

Language can also contribute to stigma through the use of inaccurate terminology. The most obvious example of this is the frequent misuse of the terms dependence and addiction. Physiological dependence is among the eleven criteria to diagnose a substance use disorder. However, it is neither necessary nor sufficient to make the diagnosis. For example, a person with a severe cocaine use disorder will not have physiological dependence, yet a person appropriately treated with opioid therapy for chronic pain will. However, these two terms are frequently conflated by journalists, policy makers, and even some clinicians. This has important clinical ramifications. First, it perpetuates a negative misperception about the most effective treatments we have for opioid use disorder. Long-term treatment with methadone or buprenorphine is the only treatment shown to reduce the risk of overdose death and relapse by more than 50%, and both of these medications work by maintaining physiological dependence while successfully treating addiction [4, 18]. A person taking buprenorphine daily is able to function normally, achieve remission from opioid use disorder, and stay healthy. Unfortunately, stigma persists about this type of treatment, and we continue to hear people erroneously state that people successfully treated with methadone or buprenorphine are "addicted" to their medication. Even our former secretary of health and human services publicly said that these medications are "substituting one opioid for another" [8]. These two terms are also often misused with reference to infants born with opioid withdrawal syndrome. A baby born to a woman who is physiologically dependent on opioids, whether because of addiction, chronic opioid therapy, or successful treatment with methadone or buprenorphine, may experience with-

drawal symptoms at birth, which can be treated. These infants do not meet criteria for addiction, defined as compulsively using a substance despite harm. Yet headlines commonly refer to infants as "born addicted." This inaccurate labeling perpetuates misunderstanding and stigma toward pregnant and parenting women with substance use disorder.

Another subtle example of the impact of language includes the way harm reduction services are frequently framed. Harm reduction is a philosophy and practice of reducing the negative consequences of drug use. Examples include syringe exchange programs, hepatitis vaccinations, naloxone distribution, or safer injection education. Harm reduction has been made to be unnecessarily controversial, and critics often create a false dichotomy as if a choice has to be made between harm reduction on one hand and treatment and recovery on the other. In fact, harm reduction is congruent with other general medical principles, including nonmaleficence and respect for patient autonomy. It is also complementary to the goals of treatment and recovery. It is an approach that is widely embraced in other areas of public health. Examples include safer sex education, condom distribution, the use of seatbelts and helmets. The role of language is particularly interesting in debates around harm reduction. Those opposed to the concept frequently describe it as "enabling" drug use. Those within the harm reduction movement have launched a campaign around this concept called "Enabling Health." In describing this effort, the director of policy at the harm reduction coalition commented: "I got into harm reduction to enable people who use drugs. I enable them to protect themselves and their communities from HIV and hepatitis C and overdose. I enable them to feel like they have someone to talk to, someone who cares, someone who respects them and their humanity. If that makes me an enabler, I'm proud to claim that term" (http://harmreduction.org/enablinghealth/) [7].

Another way that writing and discussions about harm reduction can communicate stigma actually comes from supporters trying to make a case for this approach. Too often the sole reason that harm reduction is argued for is because

"dead people don't recover." This argument is an important reminder of the lifesaving importance of harm reduction interventions. However, the sole focus on the goal of recovery sends a strong message that the only purpose is to help those who will ultimately stop using drugs. This undermines the importance of harm reduction for harm reduction's sake, that is, to keep people who use drugs safer. A broader understanding of harm reduction recognizes that people who continue to use drugs have not forfeited their human rights, including the right to health.

Examples of how language can perpetuate stigma toward people who use drugs and people with addiction are common. However, increasingly, there have been important efforts to change language to impact stigma and care. Beginning in 2013, academic medical journals began featuring articles arguing for the importance of language when referring to substance use [10, 16, 22]. Several national organizations made similar pleas, including the American Society of Addiction Medicine.

In 2017, attention toward this issue moved to the federal level. The White House Office of National Drug Control Policy under then President Obama and Director Michael Botticelli issued an important memorandum entitled "Changing the Language of Addiction" [13]. This memorandum was sent to all heads of executive agencies and departments and included a broad overview of the importance of terminology related to substance use and guidelines for language choices in internal and public facing communications. The official release of this memorandum was preluded by a piece in the *Journal of the American Medical Association* by Director Botticelli, with the same title sharing these insights broadly with the medical community [2].

In the subsequent years attention to this issue has continued to grow. The Associated Press took a huge step by changing its guidelines for journalists reporting on addiction. The 2017 edition of the AP Stylebook declares that "addict" should no longer be used as a noun and instead recommends using person-first language such as "people with addiction"

[20]. In addition, the National Press Foundation has incorporated education around language and stigma into its annual fellowship program for the past two years.

The language used in reporting or by clinicians will take time. These ongoing efforts by leading journalism organizations coupled with similar attention from the federal government and from medical societies have laid the groundwork for significant change.

Conclusion

Language matters, and the words we use to describe people who use drugs, people with addiction, and people with substance-related issues more broadly have substantial impact. Negative terminology has been associated with more punitive treatment recommendations by clinicians and more stigmatizing perceptions among the public. In turn, greater stigma is associated with increased support for punitive public policies. One of the greatest barriers we must surmount to truly address the ongoing crisis of overdose deaths in this country is stigma, which keeps people away from the health care system and at continued risk for death. Changing our language is a crucial component of reducing stigma and improving the lives and health of people who are affected.

References

1. AVERT. Homophobia and HIV. https://www.avert.org/professionals/hiv-social-issues/homophobia. Accessed on 4 Apr 2018.
2. Botticelli M, Koh H. Changing the language of addiction. JAMA. 2016;316(13):1361–2.
3. Byrne P. Psychiatric stigma: past, passing and to come. J R Soc Med. 1997;90:618–21.
4. Clark RE, Baxter JD, Aweh G, O'Connell E, Fisher WH, Barton BA. Risk factors for relapse and higher costs among Medicaid members with opioid dependence or abuse: opioid agonists, comorbidities, and treatment history. J Subst Abus Treat. 2015;57:75–80.

5. Goodnough A. Injecting Drugs can ruin a heart how many second chances should a user get?. The New York Times. 2018. Available online at https://www.nytimes.com/2018/04/29/health/drugs-opioids-addiction-heart-endocarditis.html. Accessed on 7 May 2018.
6. Goodyear K, Haass-Koffler CL, Chavanne D. Opioid use and stigma: the role of gender, language and precipitating events. Drug Alcohol Depend. 2018;185:339–46.
7. Harm Reduction Coalition. Enabling health. http://harmreduction.org/enablinghealth/
8. Harper J. Price's remarks on opioid treatment were unscientific And damaging, Experts Say. 2017. NPR. Available online at https://www.npr.org/sections/health-shots/2017/05/16/528614422/prices-remarks-on-opioid-treatment-were-unscientific-and-damaging-experts-say. Accessed on 7 May 2018.
9. Kelly JF, Westerhoff CM. Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. Int J Drug Policy. 2010;21:202–7.
10. Kelly JF, Wakeman SE, Saitz R. Stop talking 'dirty': clinicians, language, and quality of care for the leading cause of preventable death in the United States. Am J Med. 2015;128(1):8–9.
11. Kennedy-Hendriks A, Barry CL, Gollust SE, Ensminger ME, Chisolm MS, McGinty EE. Social stigma toward persons with prescription opioid use disorder: associations with public support for punitive and public health-oriented policies. Psychiatr Serv. 2017;68(5):462–9.
12. Lan CW, Lin C, Thanh DC, Li L. Drug-related stigma and access to care among people who inject drugs in Vietnam. Drug Alcohol Rev. 2018;37(3):333–9.
13. Office of National Drug Control Policy (ONDCP). Changing federal terminology regarding substance use and substance use disorders. 2017. Available online at https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Memo%20-%20Changing%20Federal%20Terminology%20Regrading%20Substance%20Use%20and%20Substance%20Use%20Disorders.pdf. Accessed on 7 May 2018.
14. Rivera AV, DeCuir J, Crawford ND, Amesty S, Lewis CF. Internalized stigma and sterile syringe use among people who inject drugs in new York City, 2010-2012. Drug Alcohol Depend. 2014 Nov 1;144:259–64.
15. Room R, Rehm J, Trotter RT II, Paglia A, Üstün TB. Cross-cultural views on stigma valuation parity and societal attitudes

towards disability. In: Üstün TB, Chatterji S, Bickenbach JE, Trotter II RT, Room R, Rehm J, et al., editors. Disability and culture: Universalism and diversity. Seattle: Hofgrebe & Huber; 2001. p. 247–91.
16. Saitz R. International statement recommending against the use of terminology that can stigmatize people. J Addict Med. 2016;10(1):1–2.
17. Smith R. Language of the lost: an explication of stigma communication. Commun Theory. 2007;17(4):462–85.
18. Sordo L, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017;357:j1550.
19. Stringer K, Baker EH. Stigma as a barrier to substance abuse treatment among those with unmet need: an analysis of parenthood and marital status. J Fam Issues. 2018;39(1):3–27.
20. Szalavitz M. Why we should say someone is a 'Person With An Addiction,' Not An Addict. NPR. 2017. https://www.npr.org/sections/health-shots/2017/06/11/531931490/change-from-addict-to-person-with-an-addiction-is-long-overdue. Accessed on 7 May 2018.
21. von Hippel C, Brener L, Horwitz R. Implicit and explicit internalized stigma: relationship with risky behaviors, psychosocial functioning and healthcare access among people who inject drugs. Addict Behav. 2018;76:305–11.
22. Wakeman. Language and addiction: choosing words wisely. Am J Public Health. 2013;103(4):e1–2.

Chapter 6
The Stigma of Addiction in the Medical Community

Jonathan D. Avery

Introduction

Those in the medical community — and physicians in particular — are often thought to be immune to negative attitudes toward individuals with conditions such as substance use disorders (SUDs). However, this has repeatedly been shown to not be the case. In fact, there is evidence that the attitudes of clinicians toward individuals diagnosed with SUDs may be worse than attitudes toward individuals with different medical and mental health diagnoses [3–6, 13, 14, 21]. It appears that these attitudes may be even worse among more seasoned clinicians [4, 14, 21].

These attitudes are concerning, as regardless of specialty, clinicians are frequently called upon to take care of individuals diagnosed with SUDs. After all, in 2015, an estimated 20.8

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million Americans, or 6.5% of the population, met the criteria for an SUD in the past year, including 15.7 million people who had an alcohol use disorder and 7.7 million people who had an illicit drug use disorder [10]. SUDs contribute to numerous medical and psychiatric illnesses, increase and prolong hospital stays, and cost our health care system millions of dollars [16]. Overdose deaths, especially from prescription and illicit opioids, have increased dramatically in the last 20 years; in the United States alone, more than 530,000 people died from drug overdoses between 2001 and 2015 [18]. It is important, therefore, that clinicians take an active role in caring for individuals with SUDs.

When clinicians have negative attitudes toward these patients, quality of care declines substantially. Providers have been shown to view patients with SUDs as persons of lower importance than other patients, poorly motivated, manipulative, and even violent [7, 9]. These negative attitudes result in reductions in empathy, provider involvement, personalization of patient care, and treatment outcomes [9, 25].

Here I explore the stigma of addiction among those in the medical community and discuss ways to potentially improve these negative attitudes.

Clinicians' Attitudes Toward Individuals with Substance Use Disorders

One of the largest studies on clinicians' attitudes toward individuals with SUDs was a European study that found that many different clinicians (physicians, psychiatrists, psychologists, nurses, and social workers) had lower regard for individuals using substances than for patients diagnosed with depression or diabetes [14]. These negative attitudes appeared to start early in training too. Several studies among physicians in training found that attitudes toward individuals diagnosed with SUDs were more negative than those toward individuals diagnosed with other disorders [4, 6, 13, 21]. Figure one illustrates how psychia-

try residents' attitudes were worse toward individuals with SUDs, compared to individuals with other diagnoses.

One might expect that clinicians' attitudes toward individuals with SUDs at first might be negative because they are similar to general societal attitudes and that they would improve over time as clinicians became more skilled in taking care of these individuals; however, the opposite has been found. In a survey of medical students and house staff at the Johns Hopkins Medical School and Hospital, there was a trend toward more negative attitudes among more senior house staff than beginning medical students toward individuals diagnosed with alcoholism [13]. A similar study at the University of Connecticut School of Medicine was even more striking. Despite medical students and residents feeling that their training was adequate to care for patients diagnosed with SUDs, satisfaction achieved in caring for these patients consistently diminished over years in training, and the belief that these patients overutilize health care resources increased [21]. In the study of psychiatry residents referenced above (see Fig. 6.1), it was also found that attitudes toward patients with SUDs steadily decline during training [4]. More senior residents—postgraduate year (PGY) 3 or 4—had worse attitudes toward patients with SUDs than junior residents (PGY

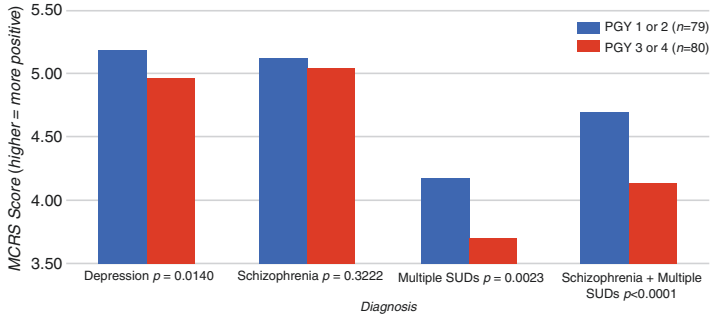

Figure 6.1 Changes in psychiatry residents' attitudes by first for second half of training [4]

1 or 2) [4]. It appears that these attitudes may even continue to worsen after training. The large European multicenter study mentioned above, for example, found that staff with fewer than 10 years of experience reported higher regard for individuals who used drugs when compared to their more experienced colleagues [14].

It should be noted that not all clinicians, though, have negative attitudes toward individuals with SUDs. A small but significant number of health care professionals decide to take care of individuals with SUDs. Not surprisingly, data show that these clinicians do not have the same negative attitudes toward individuals with SUDs as their colleagues [3, 14]. More work is needed to understand the differences between health care professionals who choose to work with individuals with SUDs and those who choose not to work with them.

The Impact of Knowledge and Skills on Clinicians' Attitudes

It is often assumed that a lack of knowledge and skills in the diagnosis and treatment of SUDs may primarily drive clinicians' negative attitudes toward these individuals [24]. There has been a robust effort to improve the education of clinicians after numerous studies documented how clinicians often miss the diagnosis of an SUD and fail to address the substance use even if they do identify it as a problem [8, 12, 23]. Numerous training programs now have curricula that provide addiction training in multiple treatment settings [15, 19, 24].

While these efforts have been important and likely have improved attitudes toward individuals with SUDs, there is more work to be done in this area. Even if clinicians are familiar with specific treatments, that does not mean that they will prescribe them or recommend them to patients. They may simply say "go to Alcoholics Anonymous" or "you need help" and not take an active role in the treatment

process. The stigma of addiction treatments is especially concerning and is discussed in Chap. 7.

Further Understanding Clinicians' Negative Attitudes

In addition to potentially not feeling well-enough trained to take care of individuals with SUDs, there are several other factors that contribute to clinicians' negative attitudes toward these patients.

Most clinicians learn that addiction is a brain disease and that an individuals' ability to make rational, healthy choices greatly diminishes when he or she has an SUD. We are learning more about the neurobiology and neurocircuitry of addiction every day. It is complex and somewhat different for each substance of use and for each individual based on his or her genetics and other factors, including epigenetics and past trauma. At the simplest level, substances increase dopamine in specific areas of the brain, such as the nucleus accumbens, which results in alterations in an individual's reward circuitry [20]. We are learning that many other neurotransmitters and areas of the brain play a role and are altered in SUDs as well [20]. Despite this knowledge, there is still the belief among clinicians that substance misuse is a moral failing and that individuals should just "shape up" or "quit already." This is in line with the attitudes of the public in general, discussed in other chapters of this book.

Individuals with SUDs often have other stigmatized medical and mental health diagnoses as well, which may further contribute to clinicians' negative attitudes toward these individuals. In one study, for example, comparing the attitudes of addiction psychiatrists to community psychiatrists, it was found that both groups had more negative attitudes toward individuals with a mental illness and an SUD than toward individuals with only one diagnosis [3]. The reality is that people with SUDs typically have at least one cooccurring psychiatric and medical disorder, while people with a primary psychiatric disorder often have at least one cooccurring SUD [2].

There are numerous other factors that impact clinicians' baseline attitudes toward individuals with SUDs. As discussed above, it is often imagined that doctors are different than other people, but they are just as prone to the impact of the media, views about race and culture, the legal system, and other social, structural, and cultural influences. In addition, many clinicians have personal and family experiences with the consequences of substance use, which may impact how they view these individuals.

The Impact of Clinical Experiences on Attitudes

One of the more difficult aspects of clinicians' attitudes toward individuals with SUDs to understand is why attitudes worsen over time. As discussed above, one might expect that clinicians' attitudes toward individuals with SUDs would improve over time as clinicians become more skilled in taking care of these individuals; however, the opposite has been found.

Clinicians often describe repeated negative experiences in caring for individuals diagnosed with SUDs as a large reason why attitudes toward these individuals decline over time. The hypothesized reasons for the negative impact of these clinical experiences are many. They are outlined in Table 6.1 and discussed below.

Table 6.1 Factors that worsen clinicians' attitudes toward individuals with substance use disorders

Clinical experiences primarily with individuals with severe substance use disorders
Lack of exposure to individuals in recovery
Lack of time and resources
Poor role models and mentorship
Perception of substance misuse as a moral failing

Clinicians' interactions with individuals with SUDs are often with individuals who are actively using and require acute medical or psychiatric attention because of the consequences of their use. Or these are the interactions that clinicians remember more than their interactions with individuals who are in recovery. After all, if an individual is not actively using or doesn't endorse that they are using, substance use may not come up at all in a routine clinical encounter. As a result of this, clinicians can falsely assume that individuals with SUDs rarely improve and aren't worth their time and effort.

Further, if the clinician does not view an SUD as a disease in which there are relapses and also hope for recovery, then he or she is likely to blame the individual who relapses and may even conclude that he or she doesn't have the time or energy to keep working with the patient. If the diagnosis was cancer, on the other hand, the clinician may be much more understanding of relapses and crisis moments, and even if that clinician was not an expert in cancer treatments, he or she would likely take the time to help that individual find treatment without viewing it as a burden.

The negative attitudes of senior, respected clinicians and mentors toward individuals diagnosed with SUDs may play an especially large role in the development of these attitudes in young clinicians [6]. This "hidden curriculum" has been offered as an explanation for the failed attempts to make fundamental changes to medical training [1, 6, 17]. This "hidden" training is passed down via small details and interactions, such as the attitudes of supervising physicians [6].

Consider this case example. A well-known male patient with severe alcohol use disorder had been to the hospital emergency department 5 times over the course of 2 years for alcohol intoxication or withdrawal. He eventually agreed to inpatient substance use treatment, and subsequently transitioned to outpatient care with an 8-month period of sobriety. He relapsed and appeared back in the emergency room, at which time an emergency physician remarked: "Oh, that's just John. We knew he'd be back again."

This comment was made during morning rounds to a group of senior clinicians, residents, and medical students, and the patient overheard it. The callous remarks of the emergency room staff did not convey the pride and hopefulness of his outpatient providers after such a significant period of sobriety [6]. Furthermore, it conveyed to the other physicians and the trainees that he was not deserving of the respect normally shown to patients [6]. This disrespect was evident with the use of John's first name, the negative remark itself, and the lack of concern for the fact that the patient was within earshot [6].

Current Strategies to Improve Clinicians' Attitudes

There are currently very few interventions aimed at improving clinicians' attitudes toward individuals with SUDs. Certainly, efforts to improve knowledge about SUDs are taking place, especially given the current opioid epidemic and the amount of deaths from opioids, but few efforts are focused on the negative attitudes of clinicians. During training to become a doctor or another clinician, it is rare to have dedicated educational time to learn about such attitudes. While seldom employed in most training programs, there have been several studies that have looked at brief interventions to improve attitudes [6]. These interventions range from short educational conferences to skill-based didactics [6, 11, 22]. While these interventions may improve attitudes temporarily, the duration of these improvements is unclear [6, 11, 22].

Potential Future Strategies to Improve Clinicians' Attitudes

There are many options to improve clinicians' attitudes, but the ideal intervention will likely vary according to the clinical setting and the culture/nature of the clinicians and their

patients in each setting. Also, as attitudes improve in other aspects of the culture toward individuals with SUDs (as discussed in other chapters), this will likely impact clinicians' attitudes as well. Table 6.2 discusses some of the options to improve attitudes, and these interventions are discussed below.

To start, clinicians simply need to be made aware of the often negative and stigmatizing attitudes that can be held toward individuals with SUDs [6]. Ideally, they would be given time to reflect on their experiences taking care of these individuals throughout their professional career [6]. A good place to start may be in training programs [6]. Didactic time should be set aside for this purpose early in the training of clinicians, and the topic should be revisited periodically [6]. Ballon and Skinner provided a good model for this when they utilized reflection discussion times, reflection journaling, and mandatory end-of-rotation reflection papers during a 4-week addiction psychiatry rotation to improve attitudes [7]. If employed over the course of a training program, these exercises may help stop the deterioration of attitudes that seems to take place over time [6]. Trainees should also be given increased exposure to individuals in recovery and their stories of hope.

The importance of the "hidden curriculum" and the role of senior clinicians could also guide interventions [6]. Interventions should be targeted at even these senior clinicians as they are critical in shaping the attitudes of students and younger clinicians and the attitudes of institutions [6].

Table 6.2 Strategies to improve clinicians' attitudes toward individuals with SUDs

Increase awareness of negative attitudes
Provide forums to discuss common attitudes
Continue to increase and improve addiction treatment options
Intervene at all levels of professional development

Training programs could also identify the many clinicians who do enjoy working with patients with SUDs and put them in charge of teaching trainees [6]. If trainees see their supervisors treating individuals diagnosed with SUDs skillfully, and with kindness and respect, they will likely learn to do the same [6].

Conclusion

Increased attention needs to be paid to the attitudes of clinicians toward individuals diagnosed with SUDs. These attitudes seem to worsen over time, and they adversely affect the care of many patients [6]. More work needs to be done in order to better understand the formation of these attitudes and the types of interventions that may best improve these attitudes [6]. As a first step, it may be helpful to start basic educational didactics and reflection exercises on attitudes toward individuals diagnosed with SUDs and to try to form a positive "hidden curriculum" in the medical community [6].

References

1. Anderson DJ. The hidden curriculum. Am J Roent. 1992;159:21–2.
2. Avery J, Barnhill J. Co-occurring mental illness and substance use disorders: a guide to diagnosis and treatment. Arlington, VA: American Psychiatric Publishing; 2017.
3. Avery J, Dixon L, Adler D, et al. Psychiatrists' attitudes toward individuals with substance use disorders and serious mental illness. J Dual Diagn. 2013;9(4):322–6.
4. Avery J, Han BH, Zerbo E, et al. Changes in psychiatry residents' attitudes towards individuals with substance use disorders over the course of residency training. Am J Addict. 2017;26(1):75–9.
5. Avery J, Zerbo E, Ross S. Improving psychiatrists' attitudes towards individuals with psychotic disorders and co-occurring substance use disorders. Acad Psychiatry. 2016;40(3):520–2.
6. Avery J, Zerbo E. Improving psychiatry residents' attitudes toward individuals diagnosed with substance use disorders. Harv Rev Psychiatry. 2015;23(4):296–300.

7. Ballon BC, Skinner W. "Attitude is a little thing that makes a big difference": reflection techniques for addiction psychiatry training. Acad Psychiatry. 2008;32(3):218–24.
8. Buchsbaum DG, Buchanan RG, Poses RM, et al. Physician detection of drinking problems in patients attending a general medicine practice. J Gen Intern Med. 1992;7:517–21.
9. Capurso NA, Shorter DI. Changing attitudes in graduate medical education: a commentary on attitudes towards substance use and Schizophrenia by Avery et al. Am J Addict. 2017;26(1):83–6.
10. Center for Behavioral Health Statistics and Quality. Key substance use and mental health indicators in the United States: Results from the 2015 national survey on drug use and health. No. SMA 16-4984, NSDUH Ser H-51. 2016;7(1):877–726.
11. D'Onofrio GD, Nadel E, Degutis L, et al. Improving emergency medicine residents' approach to patients with alcohol problems: a controlled educational trial. Annals of Emergency Medicine. 2002;40(1):50–62.
12. Friedman PD, McCullough D, Saitz R. Screening and intervention for illicit drug abuse: a national survey of primary care physicians and psychiatrists. Arch Intern Med. 2001;161:248–51.
13. Geller G, Levine DM, Mamon JA, et al. Knowledge, attitudes, and reported practices of medical students and house staff regarding the diagnosis and treatment of alcoholism. JAMA. 1989;262(21):3115–20.
14. Gilchrist G, Moskalewicz J, Slezakova S, et al. Staff regard towards working with substance users: a European multi-centre study. Addiction. 2011;106:1114–25.
15. Gopalan R, Santora P, Stokes E, et al. Evaluation of a model curriculum on substance abuse at the Johns Hopkins University School of Medicine. Acad Med. 1992;67(4):260–6.
16. Gryczynski J, Schwartz RP, O'Grady KE, et al. Understanding patterns of high-cost health care use across different substance user groups. Health Aff (Millwood). 2016;35(1):12–9.
17. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. Academic Medicine. 1998;73(4):403–7.
18. Humphreys K. Avoiding globalisation of the prescription opioid epidemic. Lancet. 2017;390:437–9.
19. Ianucci R, Sanders K, Greenfield S. A 4-year curriculum on substance use disorders for psychiatry residents. Academic Psychiatry. 2009;33(1):60–6.
20. Koob GF, Vokow ND. Neurocircuitry of addiction. Neuropsychopharmacology. 2010;35:217–38.

21. Lindberg M, Vergara C, Wild-Wesley R, et al. Physicians-in-training attitudes toward caring for and working with patients with alcohol and drug abuse diagnoses. Southern Medical Journal. 2006;99(1):28–35.
22. Maher KH, Nereberg L, Bower KJ. Modifying residents' professional attitudes about substance abuse treatment and training. The American Journal on Addictions. 2001;10(1):40–5.
23. Miller NS, Sheppard LM, Colenda CC, et al. Why physicians are unprepared to treat patients who have alcohol- and drug-related disorders. Acad Med. 2001;76:410–8.
24. Polydorou S, Gunderson EW, Levin FR. Training physicians to treat substance use disorders. Curr Psychiatry Rep. 2008;10(5):399–404.
25. Van Boekel LC, Brouwers EPM, Van Weeghel J, et al. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug Alcohol Depend. 2013;131(1-3):23–35.

Chapter 7
Stigma and Addiction Treatment

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Introduction

Substance use disorders (SUDs) are one of the most stigmatized conditions in the United States, making it exceedingly difficult to adopt solutions rooted in science and human compassion. SUDs are not rare—more than one in six people in the United States meet the clinical criteria for a SUD, and another one in three use addictive substances in a way that threatens their own or others' health and safety. In fact, the number of people with SUDs far surpasses the number suffering from heart disease, cancer, or diabetes [19]. There are numerous government-funded institutes and organizations tasked with researching, preventing, and treating addiction

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and countless nonprofit and grass roots organizations dedicated to doing the same. Stories of addiction and its effects regularly appear in the headlines of news media and in popular songs, books, television shows, and movies. Public officials regularly acknowledge addiction's enormous social, physical, and economic toll. Given its broad reach and obvious public interest, why has it remained so difficult to implement an effective, health-promoting, and compassionate response to this disease?

In one word, the answer is stigma.

Stigma is a social phenomenon whereby individuals who deviate from the accepted norm are perceived by society as less desirable and are judged or punished accordingly [39]. Stigma operates in a manner that exemplifies the exercise of power: labeling a group as different, attaching stereotypes to that group, and separating the labeled group by distinguishing "them" from "us." This process establishes a rationale for those with power to devalue, reject, and exclude those who do not conform to a certain social ideal, leading to loss of status and discrimination for the stigmatized group [52].

Stigma operates on three levels, each of which influences the other. Social (or public) stigma occurs when the public endorses stereotypes about and acts against a stigmatized group. Institutional (or structural) stigma occurs when rules and policies intentionally or unintentionally disempower that socially stigmatized group. Finally, internalized (or self) stigma occurs when people in the stigmatized group anticipate social rejection, endorse the stereotypes, and perceive themselves to be of low value in society [26].

Public Perceptions of Addiction and its Treatment

Although stigmatized attributes vary across contexts and time, substance use and addiction consistently have been at odds with social convention [39], and people with addiction

historically have been perceived as dangerous and blameworthy [53]. The dangerousness stereotype stems from the illicit status of drugs and the loss of self-control and inhibition that results from their intoxicating effects. The blameworthiness stereotype stems from the belief that individuals have a choice in their use of drugs [53]. These stereotypes form the basis for seeing addiction as a marker of personal irresponsibility and for believing that people with addiction are morally weak [33]. Other research on stigma posits that individuals whose distress seems to derive from an uncontrollable cause receive sympathy and assistance while those whose distress seems to derive from a controllable cause are met with hostility [45]. The latter is reflected in the view, deeply entrenched in our society, that addiction is a choice, a moral failing, and an indicator of weakness. These stereotypes around addiction endure despite a significant body of research attesting to a very different picture of how addiction develops, why it persists, and how it can best be managed.

Over the past few centuries, two general models have dominated society's understanding of addiction: the moral model and the disease model [50]. The model that predominates at any given time influences how individuals with SUDs are perceived and treated across the three levels of stigma: social/public, institutional/structural, and internalized/self.

The moral model frames addiction primarily as a failure of morality or personal responsibility [68]. This model attaches blame, creates shame and embarrassment, increases the likelihood of discrimination, and decreases the chances that an individual with SUDs will seek or receive effective treatment. It implies that addiction should be addressed in ways that hold people accountable for their "immoral" behavior, which usually translates into restricting needed social services or inflicting some sort of penalty within the criminal justice system (see Fig. 7.1).

The disease model of addiction, in contrast, emphasizes the role of biology in the development and persistence of addiction, drawing on advances in genetic and neuroscience research [51]. Although this approach tends to be less judg-

mental of people with SUDs, it runs the risk of being reductionistic and of discounting personal responsibility when it comes to substance-related decisions and behaviors. It also can engender feelings of hopelessness regarding the chances of achieving a sustained recovery through treatment.

In contrast to these two models, the biopsychosocial model (see Fig. 7.1) recognizes addiction as a disease, but one that originates from and exists within a larger ecological context in which many interrelated determinants influence substance use initiation and its progression to addiction [77]. This model is the one most deeply steeped in the research evidence and most widely accepted by researchers and public health experts today. Unfortunately, despite its strong empirical support, it is not widely accepted by the public, which largely continues to adhere to the moral model of addiction.

The longstanding stigma associated with addiction pervades not only public attitudes but also the government and health care and justice systems' responses to it.

In addition to the stigma around addiction itself, there also are many misconceptions deeply held by the public, policy makers, health professionals, and criminal justice professionals about its treatment. These are exemplified by prevailing views such as the following: (1) addiction treatment does not fall within the purview of the medical system, (2) an adequate qualification to treat addiction is to have experienced addic-

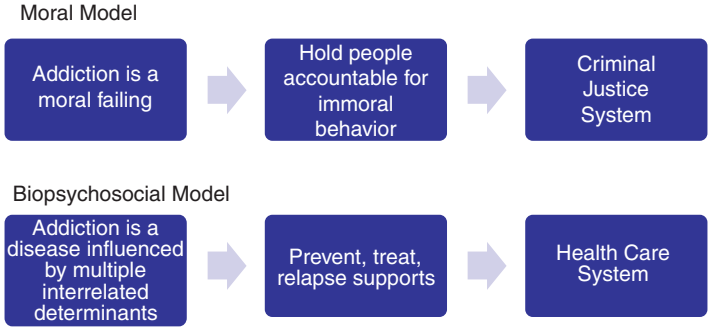

Figure 7.1 Model of Addiction Dictates the Approach to Addiction

tion oneself, (3) complete abstinence is the primary goal of treatment, (4) addiction treatment medications should be avoided because they merely "substitute one addiction for another," (5) if medication to treat addiction is used, the patient should be weaned off it as quickly as possible, and (6) a person needs to "hit rock bottom" for treatment to be successful. Each of these assumptions is patently contradicted by the research evidence, and each reinforces the stigma around the disease.

There also is widespread misunderstanding of what exactly constitutes addiction treatment. For example, detoxification alone is not treatment; rather it is, in some instances, a necessary precursor to treatment. A 28-day stay in a rehabilitation facility is not the optimal treatment model; rather, most cases of addiction can best be treated on an outpatient basis, and most require more than 28 days of treatment to be effective. Finally, the 12-step, mutual support model (e.g., Alcoholics Anonymous, Narcotics Anonymous) is not, on its own, an evidence-based treatment for addiction; rather it is, for many people, a helpful supplement to treatment and relapse reduction efforts.

Despite these misunderstandings, there is hope. Recent history shows us that when a health condition is thought to derive from bad behavior, a character flaw, or a moral deficit, it produces a markedly different public response than when it is thought to derive from a genetic predisposition, a neurological disorder, or a biological impairment. There also is evidence that when a condition is seen as treatable, the stigma surrounding it tends to decrease. Take, for example, our country's shifting perceptions of depression. Until it was understood that many cases of depression could be attributed, at least in part, to neurochemistry rather than a character flaw and until antidepressant medications gained widespread acceptance, depression was highly stigmatized. Once it was shown to be amenable to treatment by medical professionals, the stigma surrounding it declined [12]. This is also exemplified in how the public response to HIV/AIDS—one of the mostly highly stigmatized conditions in recent history—has evolved toward a more tolerant and health-based approach

as evidence accumulated regarding its cause, nature, progression, and responsiveness to medication. Policy changes were made, and payment programs were expanded to increase access to these medications, ultimately resulting in a steep drop in AIDS-related morbidity and mortality [99].

When it comes to addiction, however, 37 percent of adults in the United States still believe that people with opioid use disorder, for example, have a personal weakness rather than an illness, and the majority either think that there is no effective long-term treatment for it (30 percent) or do not know whether such a treatment exists (35 percent) [69]. Because of the lingering view that addiction results from personal weakness, stigma associated with addiction and its treatment is difficult to eradicate. Nevertheless, as new treatments for addiction emerge and as its care increasingly becomes integrated into mainstream medical practice, we can expect a decline in the stigma surrounding addiction, people with SUDs, and treatment for SUDs.

Self-Perceptions of Individuals with Addiction

The widespread misunderstanding about the disease of addiction and its treatment contributes not only to public disapproval and to institutional discrimination against those with addiction but also to how individuals with SUDs perceive themselves. Self-stigma is reflected in the language they use (e.g., referring to themselves as "addicts"), in their sense of failure when they experience relapse, and in some of the basic tenets of the addiction recovery community.

The language used in reference to substance misuse and addiction is fraught with stigma and has been adopted by many who themselves have the disease. Stigmatizing language commonly is used in both popular and clinical parlance in reference to unhealthy substance use—substance or drug "abuse"—and in reference to those who engage in that behavior—"addict" or "drug abuser." Terms such as "abuse" are powerful and villainize those who use addictive substances,

casting them as aggressive or immoral and connoting a deliberate and malevolent action. Likewise, terms such as "getting clean" or having a "dirty" toxicology screen impute derogatory value judgments on normal clinical manifestations of the disease of addiction but nevertheless commonly are used by those who have the disease [72].

The shame and self-recrimination that are so prevalent among those with addiction have very real consequences: they reduce the chances that someone will seek and receive needed support and treatment, jeopardize recovery efforts, and increase the risk of relapse [21]. A national survey found that 29 percent of adults in the US believe that the main reason people with addiction do not get the help they need is a fear of social embarrassment or shame [19]. The fear of disapproval can derive from an individual's own sense of shame, or it can derive from a realistic fear of abandonment by friends or family because of the substance use or the decision to pursue treatment [70, 76]. More than half of those who do manage to begin treatment do not complete their program [81]. Reasons for dropout vary, but it is clear that stigma plays a large role in driving high attrition rates [16].

Self-stigma also occurs on a structural level within the addiction recovery community. A primary intervention recommended for people with SUDs is the 12-step, mutual support model. Three key characteristics of that model are as follows: (1) care is essentially delivered by peers who have addiction and are themselves in recovery; (2) the desired outcome is complete abstinence, and any substance use, even in the form of addiction medication, generally is frowned upon; and (3) the goal of anonymity is paramount. Although mutual support programs undoubtedly help countless people with addiction, these features run counter to a science-based understanding of the disease of addiction and perpetuate the stigma associated with it.

First, best practice for addiction care calls for treatment to be delivered by a qualified health care professional, not a peer (although peer support is extremely valuable to ensure a sustained recovery). The mutual support model does not

embody the goal of treating addiction within the mainstream medical system where all other diseases are treated. This separation of treatment is one of the main driving forces behind the stigmatization of addiction, which has been perpetuated by a system that does not rely on medical facilities or professionals to deliver care for it. Second, holding abstinence up as a primary goal of treatment is an obstacle to one of the most effective forms of treatment for opioid use disorder and, in some cases, alcohol use disorder: addiction treatment medications. These medications save countless lives and give many more a second chance at a productive and rewarding life. Yet stigma has contributed to a misperception that medications to treat addiction are a poor way to manage one's disease, a misperception that does not extend to other medication use, such as insulin for those with diabetes, beta-blockers for those with heart disease, or inhalers for those with asthma. This perspective is held not only by people within the recovery community but also by many treatment providers [71]. Finally, a cornerstone of most mutual support programs is the preservation of participants' anonymity. Clearly, revealing a person's medical condition without consent is unethical within the context of any disease. However, prohibiting public scrutiny and valuing anonymity above all sends a clear message that needing to be in a mutual support program is embarrassing or shameful. In reality, the more people are made aware of individuals in their lives who have SUDs, the better the odds of defeating the stigma that so strongly clings to this disease [49].

How Did We Get Here? The History of Stigma Around Addiction and Its Treatment

The current state of the addiction treatment system is the result of a long and ongoing history of stigmatizing people with addiction, as well as the medical professionals who treat them.

Perceptions of drug use have fluctuated from periods of tolerance to antidrug zealousness [28]. From the mid-nineteenth century through the early twentieth century, there was widespread acceptance of the use of addictive substances, including opium, to treat common ailments [61]. Pure morphine injections became one of the most frequently utilized pain relievers; its fast-acting relief made it seem like a "wonder drug." While some doctors certainly were aware of the potentially addictive properties of these medications, their medicinal properties were believed to outweigh their risks [62]. Prescribers were almost entirely unregulated during this time, and medications were not required to reveal their opioid content, leading to reckless distribution and misuse [62]. Easy accessibility, combined with an influx of Civil War veterans suffering from injuries and trauma, fueled drug consumption during the latter half of the nineteenth century [28, 29].

Most pertinently, people suffering from opioid addiction often were prescribed opioids to ease their withdrawal symptoms, a practice referred to as "maintenance"—a predecessor to the more recent use of medications like methadone to treat addiction [29, 62].

In a series of events reminiscent of the current opioid epidemic, concerns about the use of opioids to treat medical disorders—and, in particular, SUDs—began to take hold by the late 1800s as addiction rates climbed at an alarming rate [27, 62]. The risk of addiction began to be seen as outweighing the medical benefits of opioid medications [62]. Naturally, this led to reduced faith in the prescribing physicians. When it became clear that a significant addiction problem existed, the public swiftly turned against medical professionals for their reckless prescribing habits. The medical community generally suffered from an astoundingly poor reputation during this time; many doctors themselves had addiction and freely prescribed drugs in the absence of training or practice standards [61]. As a result, addiction treatment began its century-long shift away from the field of medicine.

Negative attitudes toward physicians and their patients with addiction contributed to the passage of the Harrison Narcotics Tax Act of 1914. The Act, which regulated and taxed the production, importation, and distribution of opioids and coca products, made it nearly impossible to prescribe opioid medications to patients with addiction [96]. Initially, the Supreme Court treated the Harrison Act with some trepidation as it was wary of the power that the government was attempting to exert over the field of medicine. However, the Court eventually ruled that while physicians could prescribe narcotics to patients for medical treatment, they could not do so for the treatment of addiction since the latter did not constitute a legitimate medical practice [92, 95]. This effectively prohibited the provision of opioid-based medication to treat individuals with addiction [62, 98].

The stringent regulation of opioid-based treatments for addiction propelled the separation of addiction treatment from the mainstream health care system, the trend for medical professionals to distance themselves from caring for people with SUDs, and the shift toward punitive measures to address addiction and its consequences. With the medical community effectively removed from addiction treatment, the Federal Bureau of Narcotics was created in 1930 to handle drug-related issues. People who violated the country's strict narcotic laws were imprisoned, leading to overcrowded jails and high relapse rates [62]. Around this time, "narcotic farms" were established via the 1929 Narcotic Farms Act in place of medical clinics to address addiction. They were based on a withdrawal model, essentially a precursor to today's abstinence-based rehabilitation facilities. Any substances used to ease a patient's withdrawal symptoms were given only on a temporary basis. The farms essentially functioned as barely more than overflow rooms for overcrowded prisons and were largely ineffective, since the vast majority of the participants relapsed post-departure [98].

Stigma's Effect on Addiction Treatment Today

The stigma against doctors and patients with addiction established during the early twentieth century is evident in our current approach to addiction and its treatment. Tragically, this has resulted in the well-documented statistic that only about one in ten individuals in need of addiction treatment receive it, and even fewer receive evidence-based care [83].

Preference for Punitive Approaches

Coupled with the illicit status of drugs, stigma around addiction has contributed to the public and institutional view that the most appropriate means of addressing addiction is through punitive measures rather than through medical interventions. This perspective endures despite evidence that punitive approaches are ineffective and that the criminal justice system is ill-equipped to provide addiction treatment. Policy makers have embraced our nation's aggressive "war on drugs" for more than 50 years, with funding for punitive approaches outpacing efforts to expand treatment [33, 54].

Aside from failing to help those with SUDs and their families, punitive efforts have proven ineffective in reducing drug availability and demand. People with SUDs continue to flood jails and prisons, but the prison system is incapable of accommodating their needs. As of 2015, half of the individuals incarcerated in federal prisons had drug-related offenses [18]. Based on a recent analysis of more than one million arrests for drug law violations in the United States in 2016, most arrests (85 percent) were for possession of a controlled substance; only 15 percent of arrests were for the sale or manufacture of a drug [32].

Drug use and addiction are associated with an increased risk of recidivism [34], and the criminal justice costs associated with drug use and addiction account for a very large portion of total government spending ([88]). Although the justice system is constitutionally mandated to provide inmates with "adequate" medical care [35], only 11 percent of incarcerated

individuals with addiction receive treatment and very few of those receive evidence-based care [89]. The criminal justice system has largely shunned the adoption of evidence-based treatment, including medications to treat addiction. As of August 2018, only Rhode Island offers all three forms of opioid addiction medication to those who are incarcerated; 28 states do not offer any medication to prisoners with opioid use disorders [55]. Failing to provide evidence-based treatment in prison is unethical, contradicts medical guidelines, reduces the chances that an individual will seek treatment postrelease, and increases the odds of postrelease relapse and overdose [37].

The criminalization of addiction only exacerbates its stigma. When individuals with SUDs are incarcerated rather than treated, the perception of addiction as a crime as opposed to a disease is reinforced and public support for improved treatment opportunities is eroded. The failure of the criminal justice system to connect individuals with SUDs to effective treatment is a tremendous missed opportunity.

In recent years, the criminal justice system has attempted to rectify this situation by implementing diversion or "alternative to incarceration" programs, which provide opportunities for individuals in the criminal justice system who have substance use disorders to engage in treatment. These programs have demonstrated promise in reducing recidivism and saving costs [56]. However, they do not always provide effective or evidence-based care. Participants may be jailed for failed drug tests and relapses, outcomes that could have been averted with proper treatment. Historically, drug courts have been reluctant to allow the use of medications for addiction treatment, although they now are required to do so as a condition for federal funding [17].

Poor Access to Quality Addiction Treatment

Stigma against addiction in the health care system is rooted in a historical belief that addiction is not worthy of the attention of medical professionals. This has had a profound impact on creating generations of providers who are unable to identify, treat, or manage a preventable and treatable disease that

is prevalent in their patient population. It also affects the quality of care that patients with addiction do receive since a shadow treatment system has filled the void left by the health care system. This system is not subject to the same rigorous standards as the health care system, does not adhere to evidence-based practices, offers substandard care to patients with a serious medical condition, and increases the risk of avoidable relapse, morbidity, and mortality.

The separation of addiction care from mainstream medicine is evident in the minimal education and training that health care providers receive in relation to addiction. Medical schools and other health professional training programs barely address addiction [19]. As a result, many health care providers do not feel confident in their abilities to treat a patient with a SUD [59] and tend to share many of the same stereotypes and misconceptions about such individuals as those held by the general public [53]. These biases significantly affect the type and quality of care that a patient with addiction receives [58, 67]. As the opioid epidemic has worsened in recent years, professional health care education and training programs have begun to incorporate some addiction training into their curricula [22, 23, 57].

Physicians comprise a small proportion of the addiction treatment workforce. There are few physician role models within the addiction field to mentor and inspire younger physicians [59], and their preparation in medical school and residency training to treat patients with SUD and complex cooccurring conditions is severely limited. Treatment must be comprehensive, and the medications used to treat addiction require close monitoring and follow-up. Addiction treatment providers tend to be paid less than other types of health care providers. The siloed nature of the treatment system means that doctors do not have access to necessary outpatient services such as counseling and support systems to help patients navigate their treatment and recovery [93]. For all these reasons, many doctors consider treating patients with SUDs a disheartening, costly, and futile practice [53].

Given the longstanding absence of an adequate workforce of health care providers to treat people with SUDs, others

have filled the gap. These providers, while typically very well intentioned, are largely unqualified to provide the level of evidence-based clinical treatment needed by most people with a complex disorder like addiction. Those delivering care to people with addiction often are armed primarily with their own lived experience with addiction rather than advanced professional training. Addiction counselors, who comprise the vast majority of the workforce, typically are not required to have an advanced degree, and some states require only a high school degree and practical training [19]. One would be hard-pressed to think of another disease—especially one that overlaps with as many mental and physical health conditions—where the primary qualification for treating it is having experienced the disease itself rather than having medical training. Although there is little doubt that individuals in recovery from addiction are essential for providing treatment supports, clinical treatment involving the provision of medications and psychotherapy is best delivered by trained health care professionals.

States are in charge of licensing and certification requirements for addiction treatment providers and facilities, but the degree of oversight is meager. The requirements typically are set by state agencies that are charged with overseeing addiction services rather than the agencies responsible for regulating health care facilities [19]. Private organizations comprise the majority of treatment facilities in the United States, and a lack of regulation allows many to operate on a profit motive rather than in the best interests of patients with SUDs [98]. As our understanding of addiction has evolved, the treatment system has not kept pace, and many of the current approaches do not reflect the scientific evidence regarding what works best to treat this disease. The lack of medical professionals, practice standards, and oversight in the addiction treatment system not only highlights the continued stigma around addiction and the wide scale misunderstanding of the disease but also makes it exceedingly difficult for patients and their families to find quality, effective, lifesaving care.

Medications for Addiction Treatment

Although there are many ways in which the current addiction treatment system does not adequately meet patients' needs, perhaps the most glaring example of how stigma creates a barrier to effective, evidence-based care is the extreme underutilization of medications to treat opioid addiction. Medications are commonly used to treat other chronic diseases, including HIV/AIDS, heart disease, and diabetes. When medications were developed to alleviate suffering and extend the lives of patients with these diseases, they were heralded as wonder drugs. But medications for addiction, particularly opioid addiction, are viewed very differently.

The use of U.S. Food and Drug Administration (FDA)-approved medications in combination with psychosocial therapy is commonly referred to as medication-assisted treatment (MAT), but even the term "assisted" in this context is stigmatizing as it suggests, contrary to evidence, that these medications on their own are inadequate for alleviating addiction symptoms [36]. There are FDA-approved medications to treat nicotine, alcohol, and opioid use disorders. The medications help control cravings and withdrawal symptoms and allow individuals with addiction to avoid substance use and improve life functioning. FDA-approved medications to treat opioid addiction include methadone, buprenorphine, and naltrexone. Methadone and buprenorphine are opioids but, when taken as prescribed, do not produce the same euphoric rush characteristic of misused opioids. Naltrexone, which is not an opioid, blocks the effects of opioids, helping to prevent opioid misuse and overdose.

The stigma against medications for opioid addiction treatment is rooted in a general misunderstanding that these medications cannot treat addiction because, being opioids themselves, they merely "replace" or "substi-

tute" one addiction for another [75]. Underlying this belief is a conflation of physical dependence and addiction. Physical dependence occurs when the brain adapts to a drug's effects and develops tolerance so that more of the drug is required to achieve the initial positive effect, and continued use may be required to prevent painful and uncomfortable withdrawal. In contrast, addiction is characterized by the compulsion to use substances despite negative consequences, including loss of employment, damage to personal relationships, and even overdose. Many types of medication produce physical dependence without the psychological characteristics of addiction. Medications for treating opioid addiction have proven successful in reducing withdrawal symptoms and cravings and decreasing the risk of overdose, disease transmission, and substance-related crime [24, 80]. The fact that patients are able to regain normal functioning in their lives while on these medications is evidence that their addiction is being effectively managed.

The stigma around these medications is so strong that public opinion has been slow to change despite the growing body of evidence demonstrating their effectiveness. A 2018 poll found that only 33 percent of respondents would consider a friend to have been effectively treated for opioid addiction if the person no longer misused opioids but did use a medication on a long-term basis to control cravings [69]. Even addiction treatment providers view abstinence-based interventions as more appropriate than pharmaceutical treatments [19]. Less than half of addiction treatment facilities provide medications such as buprenorphine to treat opioid addiction [74]. Because of the stigma around these medications, patients often are unwilling to admit that they take them and face pressure from family members to discontinue their use.

Stigma is also reflected in the requirements around how these medications are delivered. While the addiction treatment system is largely unregulated, medications for opioid addiction treatment are subject to a legal and regulatory regime that is wholly unique to these medications and not applicable to any other type of medical treatment. Methadone is the oldest medication for opioid addiction, and despite decades of demonstrated success in alleviating cravings and reducing relapse, it has long been treated with apprehension by the public and policy makers because of the incorrect belief that it perpetuates addiction [31, 98]. As a result, federal law requires that methadone for opioid addiction be prescribed and dispensed in separate, specially-licensed facilities known as opioid treatment programs (OTPs) (unless a patient has been hospitalized for another medical condition), and regulations dictate patient eligibility requirements, initial dosing, counseling requirements, and criteria for take-home medication [3]. States are permitted to impose additional regulations on methadone. The medication is only covered by Medicaid in about one in three states in the United States [43].

Most patients must travel to an OTP daily to receive a supervised dose of the medication. There is a deep shame associated with attending an OTP [94]. Patients in treatment are routinely drug tested and monitored for illicit substance use, making them feel as though they are under surveillance and cannot be trusted with their own medications [67]. OTPs are highly stigmatized, as is reflected in the "not in my backyard" phenomenon, where local residents typically resist having them in their neighborhoods based largely on an unfounded fear of criminal behavior among persons with opioid addiction [14, 38], which further limits patients' access to methadone treatment.

Unlike methadone, buprenorphine can be prescribed in an office-based setting for at-home use. Buprenorphine was intended to free patients from the restrictions and stigma surrounding OTPs and increase access to treatment by allowing patients to receive care more quickly and easily from their primary care or other office-based provider. Nevertheless, buprenorphine is also subject to unique regulatory restrictions that only allow doctors to prescribe the medication under a limited set of conditions [46]. The Drug Addiction Treatment Act (DATA) allows qualified providers to prescribe buprenorphine to a limited number of patients under a "waiver" from the U.S. Drug Enforcement Administration. The number of patients who can be prescribed buprenorphine at a time depends on the prescriber's qualifications and prescribing experience [84]. The maximum number of patients that a single provider can treat is 275, but most providers are permitted to treat only 30 or 100 patients at a time (21 U.S.C § 823; 42 C.F.R. Part 8, Subpart F) [1, 2]. In practice, fewer than five percent of physicians have received the DATA waiver, and of those who have, only about half have ever even prescribed buprenorphine and most prescribe well below the allowed limits [47]. Sixty percent of rural counties and one in four urban counties in the U.S. have no physicians with the DATA waiver [9]. Initially, only physicians were allowed to prescribe buprenorphine, but in recent years, in light of the opioid epidemic, other health professionals have been granted prescribing authority.

Concerns about misuse and diversion serve as the justification for these tight regulations. However, these risks are not unique to or particularly elevated for addiction treatment medications. Methadone and buprenorphine, like any opioid, do have the potential for misuse and diversion, but they rarely are the primary drugs of choice for illicit opioid use. Notably, when

they are diverted or responsible for overdoses, they generally are one of several drugs taken, or they are misused to control opioid cravings and withdrawal symptoms that have not been adequately managed clinically [64]. Indeed, many participants in one study reported self-treating because of the lack of availability and "hassle" of OTPs. None of the individuals surveyed had ever used buprenorphine in an attempt to get high [60]. It also is important to note that the same restrictions do not apply to the prescribing of other opioid medications where there are legitimate concerns about misuse and diversion, such as oxycodone and other opioid pain relievers. Even when methadone is prescribed for the treatment of pain, it is not subject to supervised dosing in an OTP but is dispensed in a pharmacy upon presentation of a prescription. The only difference between these medications and other medications with risks for misuse and diversion is that methadone and buprenorphine are prescribed to patients known to have a SUD. Restrictions, therefore, are based not on the type of medication being prescribed but rather on the type of patient receiving it.

The many restrictions on medications to treat opioid addiction make these medications highly inaccessible to the growing population of people who desperately need effective treatment. The result is that more than one million patients with opioid addiction are unable to access evidence-based care [47]. In light of the current opioid epidemic, it is difficult to argue that the societal risks associated with these medications still outweigh the societal benefits. Stigma and a persistent misunderstanding of these medications and the disease of addiction sustain the current regulatory structure intended to limit access to effective medication treatments because of distrust of the patients who need them and of their doctors.

Room for Improvement

Stigma and misunderstanding of addiction are evident in many of the ways we currently address the disease. First, the addiction treatment system, in its current form, is not designed to treat addiction as a chronic disease. While the high rates of relapse for addiction are comparable to other chronic diseases, inadequate or ineffective treatment interventions may be a contributing factor to many instances of relapse [58]. The usual approach to addiction treatment involves brief, episodic interventions rather than long-term disease management, which is indisputably needed to treat chronic health conditions effectively.

Second, the addiction treatment system largely does not take into account that addiction affects parts of the brain associated with motivation, decision-making, judgment, risk/reward assessment, and impulse control. Lapses in these cognitive abilities are symptoms of the disease itself rather than signs of a moral failing or that an individual with addiction is not interested in treatment or recovery. Still, because of these cognitive and emotional effects, the motivation and energy to seek treatment can be fleeting and unpredictable. Therefore, a "no wrong door approach" is needed to ensure that patients can be engaged in appropriate treatment regardless of the setting or time in which they demonstrate a willingness to pursue and receive care. In the current system, in contrast, patients and their families must find treatment on their own, make countless phone calls, spend months on a waiting list, tolerate the ubiquitous stigma, and, if they do enter treatment, endure the constant threat of involuntary discharge if there is a relapse episode. Likewise, if a person experiences a drug overdose, he or she increasingly will be revived with an overdose reversal drug like naloxone, but it is unlikely that he or she will be connected to treatment despite the obvious indications that the person has a potentially fatal disease. A lack of motivation to get treatment is often cited as an excuse simply to discharge the patient once he or she is stabilized postoverdose, even though the evi-

dence of extreme impairment from the disease could not be starker than in the event of an overdose. None of these practices aligns with how we treat any other chronic, impairing, life-threatening disease.

Third, the addiction treatment system does not adequately address the high rate of cooccurrence of mental health and SUDs. Although best practices call for integrated, simultaneous treatment of cooccurring conditions, the separation of the health care and addiction treatment systems means that they typically are not treated together [66]. A 2016 survey revealed that only half of existing treatment facilities had a special program for patients with cooccurring conditions [82]. Failing to treat a cooccurring mental health disorder increases the risk of relapse and reduces the likelihood of a successful and sustained recovery.

Finally, the addiction treatment system largely takes a "one-size-fits-all" approach, in which the care that a patient receives is largely determined by whatever type of intervention is most readily available. Yet treatment is most effective when it is tailored to the individual needs and characteristics of the patient.

Stigma and Addiction Treatment for Women

Special consideration must be given to the stigma that women face when seeking addiction treatment. Women face gender-specific obstacles that compound the already existing barriers to accessing and attaining addiction treatment [41, 78]. Women often are cast into specific roles that carry restrictive social and cultural expectations, which makes it more difficult for them to acknowledge their addiction and seek help [15, 41, 42]. The punitive approach to addiction is especially pronounced for pregnant or parenting women with SUDs; they are derided as unfit mothers and can face imprisonment on charges of child abuse or neglect and risk losing custody of their children if they admit to using

addictive substances [44, 85]. The stigma surrounding pregnant women with SUDs is especially damaging because it can dissuade them from seeking prenatal care and addiction treatment during a time when women are typically highly motivated to receive help because of concerns about their baby's health [73]. Even women who do seek treatment may not get the most effective care if they are pregnant. The general stigma surrounding the use of medications to treat opioid use disorder is compounded for pregnant women. Most do not receive these medications despite evidence that they are safe and effective and despite the risks to the fetus of long-term exposure to addictive drugs or to the stress associated with unmanaged detoxification and withdrawal [48, 86]. Practical considerations that typically affect women more than men, such as lack of childcare services, are additional obstacles for women who might require long-term treatment [15]. And although the causes, manifestations, course, and consequences of addiction in women differ in many respects from men (e.g., prevalence of cooccurring disorders, history of trauma), most treatment programs do not adequately take into account these gender differences [40, 87].

Lack of Coverage and Funding

In the United States, addiction treatment historically has not been covered by health insurance. While insurers are now expected and, in many cases, legally obligated to cover addiction treatment, vestiges of discriminatory insurance practices persist, making it difficult for patients to receive affordable care. Lack of insurance coverage and high cost frequently are cited as key obstacles to care [79].

Relative to other health care services, addiction treatment is excluded more frequently, covered less adequately, and subjected to more restrictive limits and requirements by insurers. Patients face greater difficulty accessing in-network addiction treatment than other types of medical treatment, leading to higher out-of-pocket costs [20]. Further, insurance determinations often dictate the type and duration of treatment a patient receives, which may not align with best practices for treating addiction [7, 8, 10, 90]. Common insurance practices, such as requiring prior authorization and "fail-first" policies, can be very detrimental to patients with SUDs because they delay access to care, increasing the risks of relapse and overdose [90].

Stigma is evident not only in the way insurers cover or fail to cover addiction treatment but also in how requirements to improve insurance coverage have not been prioritized or enforced. The Mental Health Parity and Addiction Equity Act of 2008 [6] requires coverage for mental health and SUD benefits to be equal to the coverage of other medical conditions. The Patient Protection and Affordable Care Act (ACA) of 2010 required covered plans to offer SUD benefits as an Essential Health Benefit [4, 5]. Together, the parity law and the ACA provide the strongest protections available for patients seeking treatment paid for by their insurance.

While both laws hold great promise, they are not realizing their full potential. Although the ACA's reforms have helped to increase access to mental health treatment, there does not appear to have been a comparable increase in the rate of addiction treatment [30]. The current parity enforcement framework, which relies primarily on traditional regulatory tools and consumer complaints, is insufficient [97]. Stigma is at the root of this lack of enforcement. Patients are often unaware of their rights under the laws, lack the expectation that insurers should cover addiction treatment, and are reluctant to assert their rights in a time of personal crisis. Federal and state governments have not prioritized enforcement of

insurance protections despite recognizing that increasing access to treatment is an important priority in the midst of an unrelenting opioid epidemic.

Federal, state, and local governments have long borne the cost associated with addiction treatment [88, 91]. However, spending on addiction treatment only accounts for a small fraction of the exorbitant costs associated with addiction [88]. Despite the fact that the opioid epidemic has received significant attention from Congress, recent increases in funding have failed to invest adequately in treatment. Federal funding for addiction treatment is not centralized and, therefore, is largely short term and grants based. In 2016, the 21st Century Cures Act provided only $1 billion over two years, and in 2018, Congress allocated $6 billion for fiscal years 2018 and 2019 in its omnibus spending bill [25]. While the increased funding and attention from the federal government are encouraging, these are inadequate and short-term solutions for a large-scale and systemic problem—the commitment of funding for only two years is insufficient to implement programs with the potential to catalyze real change.

How to Reduce the Impact of Stigma on Addiction Treatment

Because of addiction's effects on countless health and social conditions, its reach is broad and wide. Despite its widespread prevalence, addiction and its treatment are stigmatized in a manner unmatched by most other diseases, regardless of their magnitude. It is nearly impossible to imagine a condition other than addiction that has as much scientific proof of a physiological and health basis, and as strong evidence of effective clinical treatments, that continues to be addressed outside the scope of mainstream medical practice. The only real hope for reining in its damage is to prevent its occurrence whenever possible and offer effective and lasting treatment to those for whom it was not successfully prevented.

Unfortunately, our nation has not chosen to take this sensible approach. Instead, we offer blame, shame, and humiliation to those who have the disease; discriminate against them so that they are deprived of the social, emotional, and economic capital and support needed to seek care and achieve a sustained recovery. The farms essentially functioned as barely more than overflow rooms for overcrowded prisons and were largely ineffective, since the vast majority of the participants relapsed post-departure [99] (see Fig. 7.2).

If its pervasiveness, reams of scientific evidence, and well-documented adverse effects are not enough to catalyze an effective repudiation of the stigma associated with the disease of addiction, then what can be done? The only logical response is to remove the stigma itself. Doing so would require a widespread public education campaign aimed at undoing centuries of misunderstanding and bias against individuals whose use of addictive substances has led to pain and suffering. While necessary, this is a costly and time-consuming endeavor, and our current addiction crisis cannot wait until the hearts and minds of millions of people are redirected from bias and disparagement toward science and compassion.

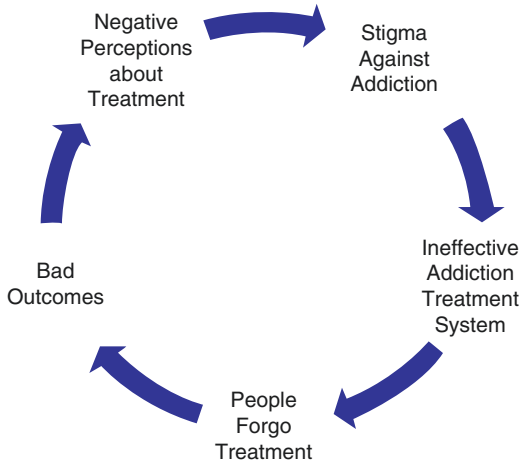

Figure 7.2 Stigma Feedback Loop

In the absence of (or preferably alongside) efforts to eradicate stigma, those with the power to ensure that individuals with addiction receive the treatment they need must be convinced, incentivized, or, if necessary, compelled to do so. It is important to make a clean break with the past, base policy and practice on current science, and stop allowing stigma to dictate our approach to addiction treatment.

Treat Addiction Within the Health Care System

To ensure that people with addiction receive the treatment they need, health care professionals must be trained and remunerated to treat it as they do any other complex disease and should no longer be allowed to dismiss addiction care as being outside of their profession's purview.

This change will not happen overnight. Many seasoned medical professionals who have not been involved in addiction treatment will likely have entrenched views about addiction and their responsibility to treat it. The greatest shift in care will most likely occur once emerging and future health professionals receive the proper education and training to address addiction as the treatable disease that it is. This change will require a commitment on the part of medical training institutions to better integrate addiction care into their curricula, enforceable standards by policy makers, financial incentives from payers, and a paradigm shift in best practices for treatment delivery and in standards of evidence-based care. One thing that perpetuates stigma and the sense of failure around those with addiction is that, when treated improperly as it frequently is, addiction can seem intractable. However, once health care providers routinely render evidence-based services for addiction, there will be higher rates of recovery, lower rates of relapse, and a reduction in the prevailing sense of hopelessness summed up by the popular stigmatizing phrase "once an addict, always an addict."

For too long, our nation has allowed just about anyone to render ill-defined addiction care services, often to the detri-

ment of people struggling with a very real and life-threatening disease. To truly transform how addiction is addressed in the United States and eradicate the effects of stigma on treatment delivery and quality, professional health care training programs must provide comprehensive and ongoing training about addiction prevention and treatment, just as they train health professionals to prevent and treat other complex chronic diseases that affect a significant proportion of the patient population. Policy makers should provide additional resources and incentives as needed to increase substantially the training and availability of addiction medicine specialists to meet the need nationwide. Non-health care professionals, such as educators, law enforcement, and criminal justice personnel, who interact regularly with people at risk for or who have addiction should also be educated about substance use and addiction and trained to respond to it effectively [19].

Policy makers and professional associations must exercise their leverage to ensure that addiction treatment programs and providers are offering evidence-based clinical care. Professional conduct should be monitored and regulated, as it is in relation to the treatment of any other health condition. Standards of care should be developed and adhered to, and there must be consequences for failure to comply with these standards. Health care accrediting organizations should stipulate requirements for all facilities and programs providing addiction treatment with regard to professional staffing, intervention and treatment services, quality assurance, and outcome monitoring. All addiction treatment facilities and programs should be subject to the same mandatory licensing processes as other health care facilities and should be required to have a certified addiction physician specialist on staff to serve as medical director, oversee patient care, and be responsible for treatment services. Providers should be required to collect and report comprehensive quality assessment data, including process and outcome measurements, related to all aspects of addiction care.

The way that the government regulates addiction treatment bears little resemblance to its regulation of other forms

of health care practice. Despite its lax oversight of treatment providers and programs in general, its stringent restrictions on the delivery of FDA-approved medications for opioid use disorder have no parallel in mainstream medical practice. The fact that any person with a medical license can prescribe addictive opioids to treat pain but those who wish to treat people addicted to those opioids with proven medication therapies require extensive government scrutiny is the clearest sign that stigma is deeply entrenched in how addiction treatment is delivered in the United States.

Employer Involvement Is Critical for Reducing Stigma and Expanding Addiction Services

The annual economic toll of substance misuse in the United States exceeds $700 billion, a significant proportion of which is due to lost productivity [63]. Employees with SUDs miss an estimated 50 percent more workdays than their peers, have significantly higher turnover, and incur higher health care costs [65]. Still, addressing addiction barely registers as an important goal for employers. Traditionally, stigma has stood in the way of addressing addiction in the workplace. But employers no longer can afford—morally or financially—to turn a blind eye to the benefits of supporting treatment to allay the tremendous costs of untreated addiction among employees and their families.

Employers should raise awareness and provide support for workers and their family members struggling with addiction, ensure that employee insurance plans offer comprehensive addiction treatment benefits, and have naloxone on site and train employees in overdose reversal. To help reduce stigma, health promoting rather than punitive policies should be implemented, such as offering assistance if an employee fails a drug test or hiring workers in recovery. Investing in employees' addiction treatment is not only the right thing to do; it also increases worker productivity and reduces turnover and health care costs [65].

Change the Way We Talk about About Addiction and Its Treatment

Language strongly influences how addiction is perceived and addressed by the public, health professionals, and policy makers. Words like addict, junkie, abuse, and dirty demean patients who have a real medical disease, deter them from seeking needed care, and dissuade qualified providers from offering treatment. Eliminating imprecise and pejorative terms from our language and instead adopting terms that reflect a health perspective and are consistent with those used to describe other health conditions is necessary to reduce stigma and transform delivery of addiction care [13, 72]. As we face the deadliest addiction crisis in U.S. history, we no longer can afford to debase, ignore, and marginalize individuals with a legitimate and treatable medical condition.

Conclusion

The stigma surrounding addiction and its treatment is its own public health crisis, deterring people with a treatable disease from getting the care they need and deserve to live a healthy and rewarding life [11]. Given what we now know about addiction and how to treat it, it is unethical and cost prohibitive to continue to deny effective care to the millions of Americans with the disease of addiction or to fail to intervene to help the millions more who are at risk.

Unfortunately, because of stigma, too many people do not seek or receive the help they need. Many have a legitimate fear that disclosing their SUD can jeopardize their parental rights, job, housing, personal relationships, or educational prospects. The behaviors most closely associated with addiction in the public's eye—criminality, irresponsibility, unreliability, negligent parenting—and that contribute most to stigma and discrimination rarely are indicative of a person's true nature; rather, they generally are symptoms or behavioral manifestations of the disease itself. Addiction alters the

brain in ways that make obtaining and using the addictive substance rise in importance above all other needs and desires [51]. Rejecting or marginalizing people with addiction will only exacerbate the disease. Instead, we must treat the disease so that healthier and more natural rewards take precedence over drugs in driving behavior.

This can be done, if only we can manage to turn away from a treatment paradigm steeped in stigma and toward one driven by health promotion. A person with addiction should not have to "hit rock bottom" or "submit to a higher power" to get treatment. A person with addiction should not have to travel miles, wait months, or spend his or her family's life savings to get treatment. A person with addiction should not be sent to facilities that lack basic medical, psychiatric, and therapeutic services. A person with addiction should not have to forgo effective treatment because federal requirements have made medications for addiction treatment largely unavailable where they live. A person with addiction should not have to stop using a medication that controls addiction symptoms just because of an unfounded belief that complete abstinence from any type of drug is superior to medication management. A person with addiction should not be arrested for having a disease, nor should a person with addiction feel compelled to get arrested as the only hope of obtaining treatment for that disease. A person with addiction should not be considered a failure if it takes longer than 28 days to recover. And parents in the United States in the twenty-first century should not have to watch their teenage children die because treatment for addiction—recognized for over 60 years as a medical disease—simply is not available.

We do not ask these things of people with diabetes, asthma, heart disease, or cancer. We should not tolerate them for people with the disease of addiction.

References

1. 21 U.S.C § 823 (2011). Registration requirements. Available at: https://www.gpo.gov/fdsys/pkg/USCODE-2011-title21/html/USCODE-2011-title21-chap13-subchapI-partC-sec823.htm.

2. 42 C.F.R. Part 8, Subpart F (2016). Authorization to increase patient limit to 275 patients. Available at: http://federalregister.gov/a/2016-16120.
3. 42 C.F.R. § 8.12 (2016). Federal opioid treatment standards. Available at: https://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol1/pdf/CFR-2002-title42-vol1-sec8-12.pdf.
4. 42 U.S.C. § 300gg-6(a) (2010). Coverage for essential health benefits package. Available at: https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapXXV-partA-subpart1-sec300gg-6.pdf.
5. 45 C.F.R. § 156.115(a)(3) (2015). Health insurance issuer standards under the Affordable Care Act, including standards relating to exchanges, essential health benefits. Provision of EHB. Available at: https://www.gpo.gov/fdsys/pkg/CFR-2013-title45-vol1/pdf/CFR-2013-title45-vol1-sec156-115.pdf.
6. 78 Fed. Reg. 68,240, 68,254 (2013). Final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Available at: https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf.
7. American Psychiatric Association. Practice guideline for the treatment of patients with substance use disorders (2nd Ed.). 2010. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf.
8. American Society of Addiction Medicine. Public policy statement on office-based opioid agonist treatment (OBOT). Chevy Chase, MD: Author; 2010.
9. Andrilla CHA, Coulthard C, & Larson EH. Changes in the supply of physicians with a DEA data waiver to prescribe buprenorphine for opioid use disorder. Data Brief #162. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; 2017.
10. Ashford RD, Brown AM, Curtis B. Systemic barriers in substance use disorder treatment: a prospective qualitative study of professionals in the field. Drug Alcohol Depend. 2018;189:62–9.
11. Bayer R. Stigma and the ethics of public health: not can we but should we. Soc Sci Med. 2008;67(3):463–72.
12. Blummer KH, Marcus SC. Changing perceptions of depression: ten-year trends from the general social survey. Psychiatr Serv. 2009;60(3):306–12.
13. Botticelli MP, Koh HK. Changing the language of addiction. JAMA. 2016;316(13):1361–2.
14. Boyd SJ, Fang LJ, Medoff DR, Dixon LB, Gorelick DA. Use of a 'microecological technique' to study crime incidents

around methadone maintenance treatment centers. Addiction. 2012;107(9):1632–8.
15. Brady TM, Ashley OS. Women in substance abuse treatment: Results from the alcohol and drug services study (ADSS). Substance Abuse and Mental Health Services Administration. Rockville: Substance Abuse and Mental Health Services Administration; 2005.
16. Brener L, Von Hippel W, Von Hippel C, Resnick I, Treloar C. Perceptions of discriminatory treatment by staff as predictors of drug treatment completion: utility of a mixed methods approach. Drug Alcohol Rev. 2010;29(5):491–7.
17. Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. Adult drug court discretionary grant program FY 2015 competitive grant announcement. 2015. Available at: https://www.bja.gov/Funding/15DrugCourtSol.pdf.
18. Carson EA, Anderson E. Prisoners in 2015. Washington, D.C.: Bureau of Justice Statistics, Office of Justice Programs, United States Department of Justice; 2016. Available at: https://www.bjs.gov/content/pub/pdf/p15.pdf
19. CASAColumbia. Addiction medicine: closing the gap between science and practice. New York: Author; 2012.
20. Claxton G, Rae M, Cox C, & Levitt, L. An analysis of out-of-network claims in large employer health plans. Petersen-Kaiser Health System Tracker. 2018. Available at https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/?post_types=brief#item-start.
21. Clement S, Schauman O, Graham T, Maggioni F, Evans-Lacko S, Bezborodovs N, Morgan C, Rüsch N, Brown J, Thornicroft G. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med. 2015;45(1):11–27.
22. Commonwealth of Massachusetts. 2015. Baker-Polito administration announces groundbreaking medical school program to curb opioid crisis. Available at: https://core.ac.uk/download/pdf/146529648.pdf.
23. Commonwealth of Massachusetts. 2016. Baker-Polito administration, advanced practice nurses, physician assistants and community health centers expand on core competencies to combat opioid epidemic. Available at: https://www.mass.gov/news/baker-polito-administration-advanced-practice-nurses-physician-assistants-and-community-health.

24. Connery HS. Medication-assisted treatment of opioid use disorder: review of the evidence and future directions. Harv Rev Psychiatry. 2015;23(2):63–75.
25. Consolidated Appropriations Act. 2018 Pub. L. No. 115–141. Available at: https://www.congress.gov/115/bills/hr1625/BILLS-115hr1625enr.pdf.
26. Corrigan PW, Kerr A, Knudsen L. The stigma of mental illness: explanatory models and methods for change. Appl Prev Psychol. 2005;11(3):179–90.
27. Courtwright DT. A century of American narcotic policy. In: Gerstein DR, Harwood HJ, editors. Treating drug problems, vol. 2. Washington, D.C.: National Academy Press; 1971.
28. Courtwright DT. Dark paradise: a history of opiate addiction in America. 2nd ed. Cambridge, MA: Harvard University Press; 2001.
29. Courtwright DT. Preventing and treating narcotic addiction: a century of federal drug control. N Engl J Med. 2015;373(22):2095–7.
30. Creedon TB, Lê Cook B. Access to mental health care increased but not for substance use, while disparities remain. Health Aff. 2016;35(6):1017–21.
31. Dole VP, Nyswander M. A medical treatment for diacetylmorphine (heroin) addiction: a clinical trial with methadone hydrochloride. J Am Med Assoc. 1965;193(8):80–4.
32. Drug War Facts. 2017. Total annual drug arrests in the United States by offense type. Available at: http://drugwarfacts.org/node/234#.
33. Duncan D, Nicholson T, White JB, Ellis-Griffith G. A brief history of prohibition and treatment solutions for substance abusers. Int J Criminol Soc. 2014;3:186–99.
34. Durose MR, Cooper AD, Snyder HN. Recidivism of prisoners released in 30 states in 2005: Patterns from 2005 to 2010 (NCJ 244205). Washington, DC: U.S. Department of Justice; 2014.
35. Estelle v. Gamble, 429 US. 97, 103. (1976).
36. Friedmann PD, Schwartz RP. Just call it treatment. Addict Sci Clin Pract. 2012;7:10.
37. Fu JJ, Zaller ND, Yokell MA, Bazazi AR, Rich JD. Forced withdrawal from methadone maintenance therapy in criminal justice settings: a critical treatment barrier in the United States. J Subst Abuse Treat. 2012;44(5):502–5.
38. Furr-Holden CD, Milam A, Nesoff ED, Johnson RM, Fakunle DO, Jennings JM, Thorpe RJ. Not in my Back yard: a compara-

tive analysis of crime around publicly funded treatment centers, liquor stores, convenience stores, and corner stores in one mid-Atlantic city. J Stud Alcohol Drugs. 2016;77(1):17–24.
39. Goffman E. 2009. Original work published in 1963. Stigma: Notes on the management of spoiled identity. Available at: https://books.google.com/books?id=zuMFXuTMAqAC.
40. Gopman S. Prenatal and postpartum care of women with substance use disorders. Obstet Gynecol Clin N Am. 2014;41(2):213–28.
41. Green CA. Gender and use of substance abuse treatment services. Alcohol Res Health. 2006;29(1):55–62.
42. Greenfield SF, Brooks AJ, Gordon SM, Green CA, Kropp F, McHugh RK, Lincoln M, Hien D, Miele GM. Substance abuse treatment entry, retention, and outcome in women: a review of the literature. Drug Alcohol Depend. 2007;86(1):1–21.
43. Grogan CM, Andrews C, Abraham A, Humphreys K, Pollack HA, Smith BT, Friedmann PD. Survey highlights differences in Medicaid coverage for substance use treatment and opioid use disorder medications. Health Aff. 2016;35(12):2289–96.
44. Guttmacher Institute. Substance use during pregnancy. Guttmacher Institute: State Laws and Policies. 2018. Available at: https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy.
45. Hegarty P, Golden A. Attributional beliefs about the controllability of stigmatized traits: antecedents or justifications of prejudice? J Appl Soc Psychol. 2008;38(4):1023–44.
46. Jaffe JH, O'Keeffe C. From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States. Drug Alcohol Depend. 2003;70:S3–S11.
47. Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication-assisted treatment. Am J Public Health. 2015;105(8):e55–63.
48. Jones HE, Heil SH, Baewert A, Arria AM, Kaltenbach K, Martin PR, Coyle MG, Selby P, Stine SM, Fischer G. Buprenorphine treatment of opioid-dependent pregnant women: a comprehensive review. Addiction. 2012;107(1):5–27.
49. Keyes KM, Hatzenbuehler ML, McLaughlin KA, Link B, Olfson M, Grant BF, Hasin D. Stigma and treatment for alcohol disorders in the United States. Am J Epidemiol. 2010;172(12):1364–72.
50. Lee PR, Lee DR, Lee P, Arch M. 2010: U.S. drug and alcohol policy, looking back and moving forward. J Psychoactive Drugs. 2010;42(2):99–114.

51. Leshner A. Addiction is a brain disease, and it matters. Science. 1997;278(5335):45–7.
52. Link BG, Phelan JC. Conceptualizing stigma. Annu Rev Sociol. 2001;27(1):363–85.
53. Lloyd C. The stigmatization of problem drug users: a narrative literature review. Drugs: Educ Prev Policy. 2013;20(2):85–95.
54. Lopez G. How Obama quietly reshaped America's war on drugs. 2017. Available at: https://www.vox.com/identities/2016/12/19/13903532/obama-war-on-drugs-legacy.
55. Lopez G. How America's prisons are fueling the opioid epidemic. 2018. Available at: https://www.vox.com/policy-and-politics/2018/3/13/17020002/prison-opioid-epidemic-medications-addiction.
56. Marlowe DB & National Association of Drug Court Professionals. Research update on adult drug courts. 2010. Available at: http://www.antoniocasella.eu.
57. McCance-Katz EF, George P, Scott NA, Dollase R, Tunkel AR, McDonald J. Access to treatment for opioid use disorders: medical student preparation. Am J Addict. 2017;26(4):316–8.
58. McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. J Am Med Assoc. 2000;284(13):1689–95.
59. Miller NS, Sheppard LM, Colenda CC, Magen J. Why physicians are unprepared to treat patients who have alcohol- and drug-related disorders. Acad Med. 2001;76(5):410–8.
60. Mitchell SG, Kelly SM, Brown BS, Schacht Reisinger H, Peterson JA, Ruhf A, Agar MH, O'Grady KE, Schwartz RP. Uses of diverted methadone and buprenorphine by opioid-addicted individuals in Baltimore, Maryland. Am J Addict. 2009;18(5):346–55.
61. Musto DF. Iatrogenic addiction: the problem, its definition and history. In: Proceedings from the conference on developing guidelines for the use of sedatives and analgesics. New Haven, CT: Yale Child Study Center; 1984.
62. Musto DF. The American disease: origins of narcotic control. 3rd ed. New York: Oxford University Press; 1999.
63. National Institute on Drug Abuse. Trends and statistics. 2017. Available at: https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs.
64. National Institute on Drug Abuse. What is the treatment need versus the diversion risk for opioid use disorder treatment?. 2018. Available at: https://www.drugabuse.gov/publications/med-

ications-to-treat-opioid-addiction/what-treatment-need-versus-diversion-risk-opioid-use-disorder-treatment.
65. National Safety Council. Drugs at work: What employers need to know. 2018. Available at: https://www.nsc.org/work-safety/safety-topics/drugs-at-work.
66. Padwa H, Guerrero EG, Braslow JT, Fenwick KM. Barriers to serving clients with co-occurring disorders in a transformed mental health system. Psychiatr Serv. 2015;66(5):547–50.
67. Pauly BB, McCall J, Browne AJ, Parker J, Mollison A. Toward cultural safety: nurse and patient perceptions of illicit substance use in a hospitalized setting. Adv Nurs Sci. 2015;38(2):121–35.
68. Peele S. A moral vision of addiction: how people's values determine whether they become and remain addicts. J Drug Issues. 1987;17(2):187–215.
69. POLITICO-Harvard T. H. Chan School of Public Health. Americans' views on policies to address prescription drug prices, the opioid crisis, and other current domestic issues. 2018. Available at: https://cdn1.sph.harvard.edu/wp-content/uploads/sites/94/2018/07/Politico-Harvard-Poll-July-2018-Rx-Drug-Prices-Opioids-Farm-Bill.pdf.
70. Rapp RC, Xu J, Carr CA, Lane DT, Wang J, Carlson R. Treatment barriers identified by substance abusers assessed at a centralized intake unit. J Subst Abus Treat. 2006;30(3):227–35.
71. Rieckmann T, Kovas AE, Rutkowski BA. Adoption of medications in substance abuse treatment: priorities and strategies of single state authorities. J Psychoactive Drugs. 2010;6:227–38.
72. Richter L, Foster SE. Effectively addressing addiction requires changing the language of addiction. J Public Health Policy. 2014;35(1):60–4.
73. Roberts SCM, Pies C. Complex calculations: how drug use during pregnancy becomes a barrier to prenatal care. Matern Child Health J. 2010;15(3):333–41.
74. Roman PM, Abraham AJ, Knudsen HK. Using medication-assisted treatment for substance use disorders: evidence of barriers and facilitators of implementation. Addict Behav. 2011;36(6):584–9.
75. Salsitz E, Wiegand T. Pharmacotherapy of opioid addiction: putting a real face on a false demon. J Med Toxicol. 2016;12(1):58–63.
76. Saunders SM, Zygowicz KM, D'Angelo BR. Person-related and treatment-related barriers to alcohol treatment. J Subst Abus Treat. 2006;30(3):261–70.
77. Skewes MC, Gonzalez VM. The biopsychosocial model of addiction. In: Miller PM, editor. Principles of addiction: com-

prehensive addictive behaviors and disorders, vol. 1. San Diego: Academic Press; 2013. p. 61–70.
78. Stringer, KL. Stigma as a barrier to formal treatment for substance use: A gendered analysis. (Master's thesis, University of Alabama at Birmingham). 2012. Available at: http://www.mhsl.uab.edu/dt/2012m/stringer.pdf.
79. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2012 National Survey on Drug Use and Health: Summary of national findings (NSDUH Series H-46, HHS Publication No. (SMA) 13–4795). Rockville, MD: Author; 2013.
80. Substance Abuse and Mental Health Services Administration. Medication and counseling treatment. 2015a. Available at: https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat.
81. Substance Abuse and Mental Health Services Administration. Treatment episode data set (TEDS): 2012. Discharges from substance abuse treatment services. BHSIS Series S-81, HHS Publication No. (SMA) 16–4976. Rockville, MD: Author; 2015b.
82. Substance Abuse and Mental Health Services Administration. National Survey of Substance Abuse Treatment Services (N-SSATS): 2016. Data on Substance Abuse Treatment Facilities (BHSIS Series S-93, HHS Publication No. (SMA) 17–5039). Rockville, MD: Author; 2016.
83. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Author; 2017.
84. Substance Abuse and Mental Health Services Administration. Buprenorphine waiver management. 2018. Available at: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver.
85. Terplan M, Kennedy-Hendricks A, Chisolm MS. Prenatal substance use: exploring assumptions of maternal unfitness. Subst Abuse Res Treat. 2015;9(S2):1–4.
86. The American College of Obstetricians and Gynecologists. Medication-assisted treatment remains the recommended therapy for pregnant women. The American College of Obstetricians and Gynecologists. 2017. Available at: https://www.acog.org/About-ACOG/News-Room/News-Releases/2017/

Medication-assisted-Treatment-Remains-the-Recommended-Therapy%2D%2Dfor-Pregnant-Women.
87. The National Center on Addiction and Substance Abuse at Columbia University. Women under the influence. Baltimore: Johns Hopkins University Press; 2006.
88. The National Center on Addiction and Substance Abuse at Columbia University. Shoveling up II: the impact of substance abuse on federal, state and local budgets. New York: Author; 2009.
89. The National Center on Addiction and Substance Abuse at Columbia University. Behind bars II: substance abuse and America's prison population. New York: Author; 2010.
90. The National Center on Addiction and Substance Abuse. Uncovering coverage gaps: A review of addiction benefits in ACA plans. New York: Author; 2016.
91. The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation. Substance use disorders and the role of the states. 2015. Available at: http://www.pewtrusts.org/-/media/assets/2015/03/substanceusedisordersandtheroleofthestates.pdf.
92. United States v. Doremus, 249 U.S. 86. (1919).
93. Vestal C. In fighting an opioid epidemic, medication-assisted treatment is effective but underused. Health Aff. 2016;35(6):1052–7.
94. Vigilant LG. The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. Humanit Soc. 2004;28(4):403–18.
95. Webb v. United States, 249 U.S. 96. (1919).
96. Weber EM. Failure of physicians to prescribe pharmacotherapies for addiction: regulatory restrictions and physician resistance. J Health Care Law Policy. 2010;13(49):49–76.
97. Weber E, Woodworth A, Vuolo L, Feinstein E, & Tabit M. Parity tracking project: making parity a reality. 2017. Available at: https://lac.org/wpcontent/uploads/2017/06/ES_ParityTrackingReport_ASC.pdf.
98. White WL. Slaying the dragon: the history of addiction treatment and recovery in America. 2nd ed. Bloomington: Chestnut Health Systems; 2014.
99. Williams AR, Nunes E, & Olfson M. To battle the opioid overdose epidemic, deploy the 'cascade of care' model. Health Affairs Blog. 2017. Available at: https://www.healthaffairs.org/do/10.1377/hblog20170313.059163/full/.

Chapter 8
Race, Stigma, and Addiction

Sonia Mendoza, Alexandrea E. Hatcher, and Helena Hansen

In the United States, racialized images of those who are substance dependent have long reinforced stigmatizing political, social, and clinical responses to addiction. With the recent rise in opioid abuse and dependence among whites in the United States, policy makers and clinicians have made unprecedented efforts in reducing treatment stigma for opioid use dependence (OUD). One such effort is to provide opioid maintenance treatment in primary care settings, like buprenorphine maintenance treatment (BMT), with the intent of increasing treatment accessibility and reducing treatment stigma. This chapter argues that popular images of OUD

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among rural and suburban whites in America shaped approaches to and accessibility of treatment that are problematic for people of color and Native Americans, despite that Natives have similar rates of opioid overdose mortality as whites [8] and despite that black middle-aged men appear to demonstrate the fastest increase of OUD rates [9].

Treatment and policy innovations like office-based BMT target primarily white communities [38], under the assumption that medicalization of addiction treatment will reduce stigma in treatment. As this chapter will explore, current literature points to raced-based differences in experience of stigma, as treatment and legal consequences vary along racial and ethnic lines. Our aim is to highlight how stratified medicalization of treatment furthers racial inequalities in addiction treatment while falling short of reducing treatment stigma even among white Americans. We explore how the process of racialization of OUD has led to different policy and clinical responses, leading to criminalization of addiction among nonwhites and medicalization of addiction among whites in the United States, therefore deeply influencing and differentiating the experiences of stigma among these groups.

In order to make these claims, we first must operationalize how we are defining stigma, medicalization, criminalization, and racialization for the purposes of this chapter. We will be employing Link & Phelan's adaptation of Erving Goffman's definition of stigma, which explains that *stigma* "exists when elements of labeling, negative stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold" ([31], p. 382). *Medicalization,* as employed here, has the standard definition of the process of rendering human conditions and problems as medical conditions, which then become subject to diagnosis and medical treatment. Similarly, *criminalization* of addiction refers to the process of rendering human behavior as criminal and subject to punitive consequences by the law. Finally, *racialization* is used in this chapter to capture the racial ideology that signifies the extension of racial meaning to a social practice or group [39], especially in the context of medical, political, and criminal institutions.

Throughout this chapter, we argue that the relationship between the concepts of criminalization and medicalization in association with OUD leads to differential experiences of stigma based on race, through the process of racialization of OUD as white or nonwhite (Fig. 8.1). To accomplish this, we will first provide a brief historical overview of how substances, OUD, and those who are substance dependent have been racialized and stigmatized in the United States through sociopolitical and clinical responses. We describe how clinical and policy responses have differed throughout the decades based on popular perceptions of user ethnicity/race and how these responses, in turn, are associated with stigmatization of addiction and its treatment. Second, we explore current efforts to destigmatize addiction treatment through medicalization, specifically pharmaceutical treatments, and how these have been influenced by the racialized and stigmatized history of drug dependence and treatment. Third, we offer a brief study report of opiate maintenance treatment programs in NYC that describes how patients in primary care and out-

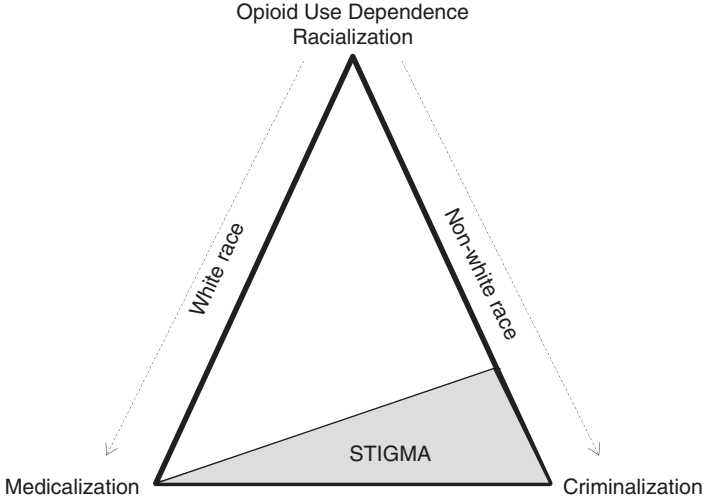

Figure 8.1 Model of criminalization and medicalization processes on stigma in the context of opioid use dependence and racialization

patient treatment programs (OTPs) experience stigma. Lastly, we conclude with an overview of medicalization of addiction as being necessary but insufficient in the reduction of OUD stigma in the context of racialized sociopolitical and clinical approaches to OUD and its treatment.

Race and Addiction: A Brief Historical Overview

Racialization and stigmatization of substance use have been persistent attributes of addiction in the United States throughout the nineteenth and twentieth centuries. Racialized approaches to addiction have shaped medical and institutional responses, but they were first made possible through popular imagery regarding substances and their relationship to racial and ethnic minorities. Stigmatizing images of "cocaine crazed Negros," "Chinese opium dens," and "reefer madness" among Mexicans have permeated the popular imagery of who a substance user is and what they look like. Despite these pervasive and concurrent racialized narratives, during this same time, narcotic use and overdose were at record levels among whites. From World War II through the 1960s, narcotic use among whites was largely due to legally prescribed non-opioid narcotics such as barbiturates and, later, benzodiazepines such as meprobamate (Miltown) and diazepam (Valium), which was also colloquially known as "Mother's Little Helper." Further, stimulants that were heavily marketed to white, largely middle-class patients with private doctors also tended to be used by women during this time [25].

After the initial opioid epidemic of the late nineteenth and early twentieth centuries, two subsequent opioid epidemics emerged in the twentieth century—the first following World War II and the second beginning in the 1960s with lasting effects into the 1980s and 1990s. After World War II, heroin use increased among blacks and Puerto Ricans but was largely confined to a "bohemian" subculture in major U.S. port cities and among Mexican communities in the Southwest

[5]. Policy responses began to sharply distinguish between illegal and prescribed narcotics, thereby protecting white drug consumers despite their high level of narcotic use and overdose [25]. Public officials and popular media coverage amplified racial stereotypes about the identity and moral irresponsibility of heroin users. Harry Anslinger, who ran the Federal Bureau of Narcotics from 1930 to 1962, stated that the majority of drug users were "Negroes, Hispanics, Filipinos, and entertainers." Few public health or educational measures were taken to curb the epidemic, and no evidence-based treatments were available at the time [27].

Racialized drug policies fueled by stigmatizing imagery paved the way for political figures to criminalize substance dependence by leveraging punitive drug policy measures that shaped the longstanding treatment of people of color and Native Americans in the United States. The Nixon administration declared the first War on Drugs in light of popular images of heroin use in black and Latino city neighborhoods in the era of civil rights protests and urban riots. The War on Drugs was later reinvented by the Reagan administration in an era of divestment from public benefits and media coverage of crack-cocaine-related violence in black and Latino neighborhoods, culminating in the 1986 Anti-Drug Abuse Act, which mandated minimum prison sentences for possession of one one-hundredth the weight of crack cocaine (seen as a black drug) as powder cocaine (seen as a white drug). After its passage, narcotics searches and arrests were geographically targeted to communities of color and led to sharp increases in mass incarceration [1], with disproportionate public spending on incarceration among residents of low-income black and Latino neighborhoods, made visible in maps of "million dollar blocks" defined as a block where more than a million dollars per year was spent on sending residents to jails and prisons (Sentencing Project).

Today's opioid epidemic has largely been portrayed as demographically distinct from previous epidemics, in that those new to heroin use in the past decade are 90% white, and where a dramatic increase in heroin and nonmedical pre-

scription opioid use has been observed in suburban and rural areas [10]. Yet, Native Americans have the highest rates of opioid-related mortality in the context of persistent disparities in rates of depression, post-traumatic stress disorder, violence, and suicide, along with limited treatment resources in tribal and Indian Health Service facilities [17]. Although there is limited data as to whether there has been a disproportionate amount of opioid prescribing among Native Americans, some tribes are suing companies that are alleged to have flooded their communities with opioid medications or turned a blind eye to suspicious opioid prescribing and dispensing practices [26].

Nevertheless, the current opioid epidemic, which was fueled by pharmaceutical industry giants, has used media to its advantage to garner sympathy for the new face of addiction, the young white suburbanite. The utility of such imagery used old racialized pretext to shift the conversation in both science and media, from criminalization to a medicalized approach of treatment [21].

Medicalization: Antidote to Stigma?

As a product of this novel moment, political pressures have emerged to end the criminalization of opioids and replace this response with medicalization. One such approach has been the promotion of office-based buprenorphine maintenance treatment (BMT), which is most commonly prescribed as a buprenorphine-naloxone formulation. BMT, as a pharmaceutical approach, is characterized by many benefits, such as enhanced accessibility due to multiple venues for treatment and the potential to lessen the stigma of drug dependency among low-income patients and ethnic minorities who already experience other forms of social stigmatization. Reducing stigma has been an oft-cited rationale for moving BMT into the general medical office setting, a setting that enables patients to receive addiction treatment undetected, alongside patients treated for physical ailments [15].

The benefits of BMT have been unevenly distributed, however. An early nationally representative study of BMT patients found that 91% were white and the majority had some college education, were employed at baseline, and sought treatment primarily for prescription opioid dependence [32, 42], and more recent regional studies have found similar patterns [22]. Most BMT patients are treated in private physician practices [4, 16, 32, 41, 42] and pay out of pocket [29] or are privately insured [2]. Studies mapping buprenorphine prescriptions in New York City, the U.S. city with the largest opiate-dependent population, demonstrate higher prescription rates in high-income residential areas with low percentages of black and Latino/Latina residents [20, 22]. In the brief study report presented later in this chapter, we further explore the association among patient sociodemographic characteristics (i.e. race, employment, housing status), BMT settings, and stigma experiences.

Treatment rate disparities are fueled by buprenorphine marketing that focuses on the private sector, as well as regulations and certification requirements that impede its implementation in the public sector [38]. Clinical studies have suggested—and influenced clinicians' perceptions—that office-based BMT is most appropriate for employed, "stable" patients [7, 30]. Like clinicians, congressional lawmakers, in passing legislation that legalized office-based buprenorphine [the DATA 2000 bill], responded to testimony that office-based buprenorphine treatment is more suitable for "suburban youth" (implicitly white patients) than methadone treatment. They also affirmed that the setting of general medicine clinics is more appropriate for privately insured patients, who presumably do not need the social services and mental health interventions provided in the public sector or the social control that is provided in highly regimented methadone programs [21]. In these contexts, terminologies such as "stable" and "suburban" are racially coded to stand in for white.

This differs from the portrayal of a "typical" methadone maintenance treatment patient.

Although black patients report a preference for BMT given that methadone treatment carries substantial stigma [18], methadone clinics are frequently located in poor, urban, racial/ethnic minority communities. There is evidence that the racial distribution of methadone treatment is in part due to the geographic location of general substance use dependence programs, methadone clinics, and buprenorphine providers. Substance abuse programs accepting Medicaid (which may not offer methadone treatment) exist in 60% of all U.S. counties but are less likely to be found in counties with a higher proportion of black and/or uninsured residents [12]. Between 2002 and 2011, buprenorphine provider availability has expanded particularly in nonmetropolitan areas; otherwise, little is known about the location of buprenorphine providers with respect to neighborhood demographics [14]. Further, racial and ethnic disparities in pharmaceutical marketing and regulation of buprenorphine likely contributed to disparities in methadone maintenance use [38].

Due to the disparities in BMT availability and OUD program geographic distribution, we begin to see that medicalization does not function as an antidote to OUD treatment stigma across all patient demographics. However, despite the processes that complicate the reduction of stigmatization on OUD through medicalization, efforts to decrease stigma should still be championed. Due to its insidiousness, stigma complicates health outcomes, especially for socially marginalized patients of taboo diseases such as mental illness, HIV, and substance dependence [3, 11, 40]. Stigma, as a social disadvantage, not only has health consequences, but is also associated with limiting other resources with similar implications as socioeconomic factors and discrimination. Hatzenbuehler, Phelan, and Link [24], for example, note that structural conditions of stigma are generally ignored, and that the health inequalities generated by stigma are so pervasive that stigma should be analyzed as a fundamental cause of these health disparities. Still, compared to other health issues, clinical analysis of stigma in relation to OUD and its treatment is limited. Nevertheless, the limited research regarding stigma, mental health, and substance dependence that does exist has

shed light on approaches that may mitigate the negative effects of stigma, such as improving communication between healthcare providers and OUD patients [33, 34].

BMT Racial Disparities: NYC-Based Study Brief Report

In this section, we offer a brief overview of quantitative and qualitative findings from our multi-sited study of BMT, race, and class in the context of public clinics. Through this brief study report, we aim to highlight how the macro-social and political structures manifest on the individual level and how race and class are differently implicated in stigma experiences among racial/ethnic minority and white patients.

To better understand the effects of addiction stigma, especially as it relates to racial disparities in treatment, we conducted semi-structured interviews as part of a larger ongoing mixed methods study examining the mainstreaming of BMT into primary care clinics as opposed to outpatient treatment programs (OTPs). The interviews examined patient experiences with the stigma of addiction and addiction treatment, as well as how these intersect with other sociodemographic factors, such as race, ethnicity, education level, and housing status.

Buprenorphine patients who were enrolled in primary care differed demographically and clinically from those enrolled in OTPs (Fig. 8.2). Compared with the patients in the substance abuse OTP, primary care patients were more likely to be white, employed, stably housed, to hold at least a bachelor's degree, and to be new to addiction treatment (Fig. 8.2).

Three groupings of Likert scale answers that had a variance of less than 0.03 were labeled as "Addiction Secrecy and Stigma," "Behavioral Withdrawal & Micro-Aggressions," and "Educate and Correct." The *Addiction Secrecy and Stigma* factor captured questions regarding how often participants concealed their addiction or kept it from others. The *Behavioral Withdrawal* factor captured questions regarding how often participants felt more comfortable around others who had substance use disorders (SUDs) and

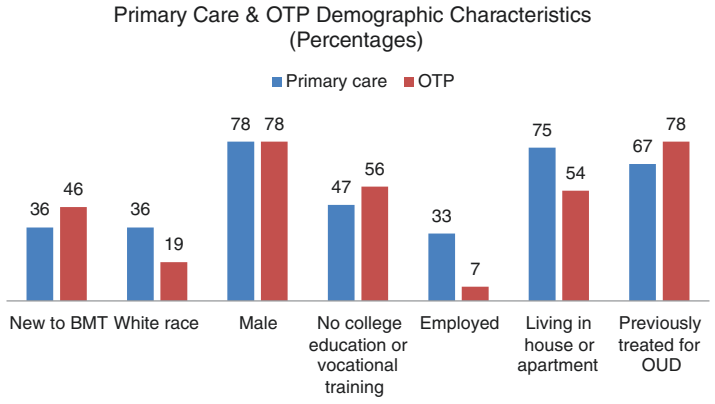

FIGURE 8.2 Clinic descriptive statistics and demographics

how often they avoided social situations involving people who had never had SUDs. Grouped with Behavioral Withdrawal, the *Micro-Aggressions* factor captured questions regarding how often participants had negative social and interpersonal interactions due to their addiction. Finally, the *Educate and Correct* factor captured questions regarding participant willingness to correct negative assumptions about addiction, treatment, and substance use. Patients who were enrolled in a primary care setting reported greater addiction secrecy compared with patients who were treated in an outpatient treatment program (OTP) setting ($p = 0.015$). Being housed was correlated with fewer instances of experiencing behavioral withdrawal and micro-aggressions ($p = 0.012$) compared with those who were in transitional housing or homeless. Finally, those who had more years of education, including vocational and college education, reported less on micro-aggressions than those who had only primary school education or less ($p = 0.025$). Those who had previous treatment were more likely to report instances of educating and correcting negative stereotypes about addiction than those who had no previous OUD treatment experience ($p = 0.028$).

Overall, our quantitative analysis pointed to disparate demographic characteristics of primary care and OTP patients who were associated with differential experiences of stigma and responses to stigmatization in their social settings. The demographic differentiation in our sample is reflective of the treatment setting disparities seen throughout the United States, where a large percentage of white OUD patients are seen in primary care settings and patients of color are treated in outpatient substance abuse treatment programs. Given these baseline characteristic differences, we sought to further analyze the experiences of stigma given demographic and treatment setting differences.

Social Positions and Situational Context

Race and socioeconomic resources were tightly linked in our study sample as they are in populations across the country. Analysis of the narrative data from the qualitative sections of the interviews revealed major differences between white primary care based patients and black and Latino OTP patients. Black and Latino patients in our sample were less likely to be housed or to have more than a high school education. While housed patients reported that they were more likely to hide their addiction from others, patients with only a high school education or less, and patients who were homeless, reported that they experienced more negative social and interpersonal interactions because of their addiction. Overall, the pattern was that white, educated, and housed patients kept their addiction secret given that their employment and housing opportunities were at stake. Further, white patients reported less stigma in their everyday lives than black and Latino patients for whom addiction stigma combined with race- and class- based stigma and discrimination.

Black or Latino patients enrolled in OTP (rather than primary care) reported more instances than whites of interactions with social service agencies, homeless shelters, or the criminal justice system. These patients often blurred distinctions

between the social stigma associated with race, criminality, and the stigma associated with addiction alone. A Latino patient enrolled in OTP interrupted the questionnaire to clarify his answers regarding addiction stigma in the following way: "You keep saying addiction, but people treat me negatively based on racism, because of *who I am*. They look at me as a fiend, they'll turn me down for a job" [emphasis added].

Additionally, black and Latino OTP patients described in-group addiction stigma, stating that they often felt friends or family did not trust them. The following quote exemplifies such an experience: "People think I might steal. My mother-in-law would tell people to put the gold and watches away … it was offensive." OTP patients also mentioned the stigmatized nature of opiate use and its correlation with the image of the "desperate addict" who steals and who is not to be trusted, especially if his or her use of heroin is public: "If someone said someone used heroin, anytime something comes up missing, like a wallet, you're going to automatically look at the person using heroin. Who else?"

White patients enrolled in primary care, on the other hand, described fewer barriers to socialization, social integration, or what they considered "normal" social functioning while in addiction treatment. They were also more likely to describe supportive relationships with their physicians. One patient with a professional job who relocated to New York City received a 9-month supply of buprenorphine from her initial prescriber to ease her transition, and years later, when she relapsed, she contacted the same prescribing physician for help in locating a new buprenorphine physician close to her home. Another educated, white primary-care-based buprenorphine patient stated that she valued being treated in a general clinic like non-SUD patients, "not being treated like a criminal or separated from the general population."

Given that most of the primary care patients had received higher education and were employed, they often felt a need to keep their addiction a secret in order to prevent status loss.

For example, one college-educated professional described the following reason for keeping her addiction a secret:

> I usually like to keep my addiction a very private thing. I don't really talk about it with people. I'm not proud of it. I keep it private. Professionally speaking I have to be careful, you can lose grants, respect; it's a stigma to be opiate dependent, obviously.

White primary care patients who were employed and had more years of education described keeping their addiction a secret in order to prevent negative social and economic consequences. For example, one such patient said, "I don't have to tell my employer that I'm a recovering addict. I didn't tell my parents that I relapsed. I don't know what benefit that would have." The same participant went on to say, "I integrate in society, and I integrate very well. Ask my students. They love me, and I love them." On the other hand, patients of minority background who were unemployed and economically unstable tended to describe their secrecy as stemming from a moral obligation to prevent interpersonal complications with friends or family: "The wife has always been anti-drugs and I knew that if she ever finds out I'm using it'll break her heart and I'll lose control. Who am I to say 'no' to this, say 'no' to that to my kids? I'd be hypocrite number one. It's a secret."

Addiction secrecy was often described as something that was meant to protect what was valuable to patients; for patients of disparate backgrounds, addiction secrecy revealed daily context, worldview, and what was at stake for each. Employed white participants revealed that they had jobs and other social ties that they wanted to maintain and avoid compromising. On the other hand, black and Latino OTP participants valued being role models for their families and close others, setting examples for children. Similarly, OTP participants also mentioned concealment of their addiction, treatment, or relapse from maternal figures or partners in order to avoid disappointing them or to avoid feelings of shame or failure.

Stigma of Addiction Treatment

Stigma of addiction treatment varied by patient experiences. For example, patients treated in the OTP who had previously been on methadone maintenance described BMT as less stigmatizing, primarily because of the illicit activity and diversion that was often associated with methadone maintenance clinics. Additionally, participants described a greater sense of freedom on BMT compared to methadone:

> In methadone you feel like you're in prison, and it's embarrassing and you worry about who you see going in and out. The whole stigma of it, and it's years before you get any freedom. You're treated like a child.

> [Buprenorphine] makes a difference, it's less embarrassing [than methadone]. Less humiliating. When I don't want to use, I base it on that [buprenorphine is] more private. I see a line and I see automatically what it is, it's methadone! That's my experience.

Further, primary care participants often differentiated themselves from others who were being treated for OUD. When asked if he felt more comfortable around others in OUD treatment, one white participant who was new to BMT said, "No, they're unpredictable, so I don't feel at ease or safe. You have to be careful and watch your back." Other primary care white patients tended to describe instances where they observed and disagreed with morally undesirable behavior by "typical" individuals with SUDs. These white patients preferred the individualized, anonymous treatment offered in primary care over the group therapies and collective style of substance abuse treatment programs.

Our findings point to racialized differences in vulnerability to stigmatized and stigmatizing social and clinical settings. Patients were funneled into treatment arms based on this racialization, either into medicalization or criminalization even within clinical settings where there was differential perceptions of "freedom" and surveillance (Fig. 8.1). Demographically, white patients were less likely

to have had previous treatment experiences, had more years of education, and were more likely to be employed and housed. OTP patients were more likely than primary care patients to see their OUD in the context of other factors in their lives such as their race and the association of OUD with criminalization.

Contextualizing Care

Patients in primary care and OTP settings were divided socioeconomically and racially and experienced stigma and negative social consequences to addiction and treatment differently. Social settings outside of clinic have a powerful impact on addiction stigma and perceptions of treatment. The intersectionality of multiple oppressions experienced by patients of color enrolled in OTP emerged as contributors to feelings of stigma in addition to stigma regarding OUD and its treatment. Medicalization of addiction and the increased accessibility of treatment for OUD offered by office-based BMT were predicted to decrease stigmatization, but as we have described, access to this treatment is not evenly distributed or experienced the same way across race, ethnicity, and social class.

A number of studies of addiction treatment in clinical spaces have found that clinics and clinicians often reinforce stigma. Ethnographers of individuals with SUDs and their doctors have found that their relationships are often laden with mutual mistrust, feeding patients' fears of stigmatization and mistreatment [37] and that a narrow medical concept of addiction that ignores the social processes and power relations that underlie addiction stigma can paradoxically enhance stigma [19, 28]. Nevertheless, other ethnographies have found that individuals on buprenorphine maintenance treatment experience greater autonomy and a heightened sense of ability to lead "normal" lives—lives closer to those of individuals without OUD [23]. Class, race, and geography are important factors that ethnographers have shown to shape perceptions of OUD.

Lack of racial/ethnic representation in clinical settings may contribute to stigmatization in clinical settings and the negative effects associated with stigmatization, such as a lack of compliance, secrecy, and internalized stigma among patients. For example, between 70% and 86% of the workers in publically funded drug treatment settings are white, 8–10% are black, and 3% are Latino [43]. Increasing the rates of patient and provider racial/ethnic concordance may be one way to attenuate feelings of stigma and increase empathy for patients of color, which in turn may increase patient treatment adherence and treatment success [43]. Patient-provider racial/ethnic concordance may also be one avenue to foster supportive alliances between providers and patients similar to those described by white primary care based patients in our sample. Nevertheless, it is important to reiterate that availability of OUD treatment choices is important to consider; black and Latino patients are significantly less likely to complete treatment for OUD than whites, and limited treatment options may contribute to this disparity [36].

BMT was developed and marketed for the white middle class market, with the implicit assumption that they would be less likely to divert buprenorphine and more likely to adhere to treatment. In order to distance OUD from its criminalized and racialized connotations, and in an effort to mainstream buprenorphine treatment into general medical practice, advocates asserted that addiction was a chronic physiological disease analogous to diabetes, asthma, and hypertension [35], without taking into account the sociopolitical differences among white, black, or Latino people with OUD. Instead, they fostered assumptions about whites as the universal standard and "ordinary" patient [13]. As a consequence, patients experienced medical institutions and BMT differentially based on race, which resulted in patients of color being left without the social services they needed and receiving less individualized care than their white counterparts. One way to combat these racialized disparities is to increase, at the policy level, attention on structurally vulnerable communities that have less access to

resources at baseline, especially in areas of the United States in which treatment options are limited.

Conclusion

> What American publics and institutions define as worthy cures for drug addiction depends on who is perceived to be addicted, on what drugs addicts depend, on the meanings attributed to addiction, and on patterns of social status. (p. 12) –*Discovering Addiction*, Nancy Campbell [6]

While effective and less stigmatizing than criminalization or methadone maintenance treatment, current efforts to medicalize OUD through the promotion of BMT have nonetheless been racialized and have further deepened treatment disparities in the United States. Racial disparities in addiction stigma affect patient treatment initiative, retention rates, and therefore treatment effectiveness. Targeted efforts are necessary to alleviate and prevent further deepening of these disparities.

Although preferable to criminalization for individuals with SUDs, we are not convinced that office-based BMT reduces stigma and increases treatment equity in the ways that were predicted. Instead, it reveals the hazards of ignoring the U.S. context of race and class segregation in housing, employment, criminal justice and in healthcare itself in pursuit of a biologized, and purportedly "color blind," approach to addiction treatment. The intersectional stigma described by our black and Latino study participants, in which addiction stigma is intertwined with racial stigma and the stigma of unemployment and homelessness, not only requires reversal through pharmaceutical treatment offered in mainstream primary care clinics, but also requires addressing social and economic needs of people with OUD through education, housing, and income supports. Thus far, primary-care-based buprenorphine treatment has represented a move further away from providing such supports, in that primary care clinics are less likely than substance abuse programs to offer social work and psychosocial treatments such as individual

and group therapy. In order for medication-assisted treatment such as buprenorphine to reduce stigma and narrow inequalities in treatment access and treatment outcomes, a reimagined biomedical approach that acknowledges and addresses the social determinants of health, along with its physiological determinants, is needed.

References

1. Alexander M. The new Jim Crow: mass incarceration in the age of colorblindness. New York: The New Press; 2010.
2. Andrews CM, D'Aunno TA, Pollack HA, Friedmann PD. Adoption of evidence-based clinical innovations: the case of buprenorphine use by opioid treatment programs. Med Care Res Rev. 2014;71(1):43–60. https://doi.org/10.1177/1077558713503188. Epub 18 Sep 2013.
3. Barnett AI, Hall W, Fry CL, Dilkes-Frayne E, Carter A. Drug and alcohol treatment providers' views about the disease model of addiction and its impact on clinical practice: a systematic review. Drug Alcohol Rev. 2018;37(6):697–720. https://doi.org/10.1111/dar.12632. Epub 2017 Dec 14.
4. Barry DT, Irwin KS, Jones ES, Becker WC, Tetrault JM, Sullivan LE, Hansen H, O'Connor PG, Schottenfeld RS, Fiellin DA. Opioids, chronic pain, and addiction in primary care. J Pain. 2010;11(12):1442–50. https://doi.org/10.1016/j.jpain.2010.04.002. Epub 2 Jun 2010.
5. Broz D, Ouellet LJ. Racial and ethnic changes in heroin injection in the United States: implications for the HIV/AIDS epidemic. Drug Alcohol Depend. 2008;94(1–3):221–33. https://doi.org/10.1016/j.drugalcdep.2007.11.020.
6. Campbell ND. Discovering addiction. : The science and politics of substance abuse research. Michigan: University of Michigan Press; 2007. https://doi.org/10.3998/mpub.269246.
7. Casadonte PP, Kolodner GF, Horton T, McMurphy SM. Community treatment programs take up buprenorphine. Sci Pract Perspect. 2004;2(2):24–9.
8. Centers for Disease Control (CDC). Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. Morb Mortal Wkly Rep. 2011;60:1487–92.

9. Centers for Disease Control (CDC). Overdose deaths involving opioids, cocaine, and psychostimulants — United States, 2015–2016. Morb Mortal Wkly Rep. 2018;67(12):349–58. https://doi.org/10.15585/mmwr.mm6712a1.
10. Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. JAMA Psychiat. 2014;71(7):821–6. https://doi.org/10.1001/jamapsychiatry.2014.366.
11. Corrigan PW, Shapiro JR. Measuring the impact of programs that challenge the public stigma of mental illness. Clin Psychol Rev. 2010;30(8):907–22.
12. Cummings JR, Wen H, Ko M, Druss BG. Race/ethnicity and geographic access to medicaid substance use disorder treatment facilities in the United States. JAMA Psychiat. 2014;71(2):190–6. https://doi.org/10.1001/jamapsychiatry.2013.3575.
13. Delgado R, Stefancic J. Critical race theory: an introduction. New York: NYU Press; 2017.
14. Dick AW, Pacula RL, Gordon AJ, Sorbero M, Burns RM, Leslie D, Stein BD. Growth in buprenorphine waivers for physicians increased potential access to opioid agonist treatment, 2002-11. Health Aff (Millwood). 2015;34(6):1028–34. https://doi.org/10.1377/hlthaff.2014.1205.
15. Duncan LG, Mendoza S, Hansen H. Buprenorphine maintenance for opioid dependence in public sector healthcare: benefits and barriers. J Addict Med Ther Sci. 2015;1(1):031–6.
16. Fiellin DA. The first three years of buprenorphine in the United States: experience to date and future directions. J Addict Med. 2007;1(2):62–7. https://doi.org/10.1097/ADM.0b013e3180473c11.
17. Gone JP, Trimble JE. American Indian and Alaska native mental health: diverse perspectives on enduring disparities. Annu Rev Clin Psychol. 2012;8:131–60. https://doi.org/10.1146/annurev-clinpsy-032511-143127.
18. Gryczynski J, Jaffe JH, Schwartz RP, Dusek KA, Gugsa N, Monroe CL, et al. Patient perspectives on choosing buprenorphine over methadone in an urban, equal-access system. Am J Addict. 2013;22(3):285–91. https://doi.org/10.1111/j.1521-0391.2012.12004.x.
19. Hansen HB, Skinner ME. From white bullets to black markets and greened medicine: the neuroeconomics and neuroracial politics of opioid pharmaceuticals. Ann Anthropol Pract. 2012;36:167–87.

20. Hansen HB, Siegel CE, Case BG, Bertollo DN, DiRocco D, Galanter M. Variation in use of buprenorphine and methadone treatment by racial, ethnic, and income characteristics of residential social areas in New York City. J Behav Health Serv Res. 2013;40(3):367–77. https://doi.org/10.1007/s11414-013-9341-3.
21. Hansen H, Netherland J. Is the prescription opioid epidemic a white problem? Am J Public Health. 2016;106(12):2127–9.
22. Hansen H, Siegel C, Wanderling J, DiRocco D. Buprenorphine and methadone treatment for opioid dependence by income, ethnicity and race of neighborhoods in New York City. Drug Alcohol Depend. 2016;164:14–21.
23. Harris S. To be free and normal: addiction, governance, and the therapeutics of buprenorphine. Med Anthropol Q. 2015;29:512–30.
24. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Public Health. 2013;103(5):813–21. https://doi.org/10.2105/AJPH.2012.301069. Epub 14 Mar 2013.
25. Herzberg D. Happy pills in America: from Miltown to Prozac. Baltimore: Johns Hopkins University Press; 2009.
26. Heygi, N. (2017). Cherokee Nation Sues Wal-Mart, CVS, Walgreens over tribal opioid crisis. Retrieved from https://www.npr.org/sections/codeswitch/2017/04/25/485887058/cherokee-nation-sues-wal-mart-cvs-walgreens-over-tribal-opioid-crisis.
27. Hughes PH, Barker NW, Crawford GA, Jaffe JH. The natural history of a heroin epidemic. Am J Public Health. 1972;62(7):995–1001.
28. Kaye K. De-medicalizing addiction: toward biocultural understandings. Crit Perspect Addict. 2012;14:27–51.
29. Kissin W, McLeod C, Sonnefeld J, Stanton A. Experiences of a national sample of qualified addiction specialists who have and have not prescribed buprenorphine for opioid dependence. J Addict Dis. 2006;25(4):91–103.
30. Larance B, Carragher N, Mattick RP, Lintzeris N, Ali R, Degenhardt L. A latent class analysis of self-reported clinical indicators of psychosocial stability and adherence among opioid substitution therapy patients: do stable patients receive more unsupervised doses? Drug Alcohol Depend. 2014;142:46–55. https://doi.org/10.1016/j.drugalcdep.2014.05.018. Epub 2 Jun 2014.
31. Link BG, Phelan J. Conceptualizing stigma. Annu Rev Sociol. 2001;27:363–85. https://doi.org/10.1146/annurev.soc.27.1.363.

32. Magura S, Lee SJ, Salsitz EA, Kolodny A, Whitley SD, Taubes T, Seewald R, Joseph H, Kayman DJ, Fong C, Marsch LA, Rosenblum A. Outcomes of buprenorphine maintenance in office-based practice. J Addict Dis. 2007;26(2):13–23.
33. McGinty EE, Goldman HH, Pescosolido B, Barry CL. Portraying mental illness and drug addiction as treatable health conditions: effects of a randomized experiment on stigma and discrimination. Soc Sci Med. 2015;126:73–85. https://doi.org/10.1016/j.socscimed.2014.12.010. Epub 5 Dec 2014.
34. McGinty E, Pescosolido B, Kennedy-Hendricks A, Barry CL. Communication strategies to counter stigma and improve mental illness and substance use disorder policy. Psychiatr Serv. 2018;69(2):136–46. https://doi.org/10.1176/appi.ps.201700076. Epub 2 Oct 2017.
35. McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 2000;284(13):1689–95.
36. Mennis J, Stahler GJ. Racial and ethnic disparities in outpatient substance use disorder treatment episode completion for different substances. J Subst Abus Treat. 2016;63:25–33.
37. Merrill JO, Rhodes LA, Deyo RA, Marlatt GA, Bradley KA. Mutual mistrust in the medical care of drug users. J Gen Intern Med. 2002;17:327–33.
38. Netherland J, Hansen H. White opioids: pharmaceutical race and the war on drugs that wasn't. BioSocieties. 2017; 12(2):217–38.
39. Omi M, Winant H, editors. Racial formation in the United States: from the 1960s to the 1990s. 2nd ed. New York: Routledge; 1994.
40. Rice WS, Logie CH, Napoles TM, Walcott M, Batchelder AW, Kempf MC, Wingood GM, Konkle-Parker DJ, Turan B, Wilson TE, Johnson MO, Weiser SD, Turan JM. Perceptions of intersectional stigma among diverse women living with HIV in the United States. Soc Sci Med. 2018;208:9–17. https://doi.org/10.1016/j.socscimed.2018.05.001.
41. Roman PM, Ducharme LJ, Knudsen HK. Patterns of organization and management in private and public substance abuse treatment programs. J Subst Abus Treat. 2006;31(3):235–43. Epub 14 Aug 2006.
42. Stanton A, McLeod C, Luckey B, Kissin WB, Sonnefeld LJ. Presentation: SAMHSA/CSAT evaluation of the buprenorphine waiver program: expanding treatment of opioid

dependence: initial physician and patient experiences with the adoption of buprenorphine. Substance Abuse Mental Health Ser Admin. 2006.
43. Williams IL. The intersection of structurally traumatized communities and substance use treatment: dominant discourses and hidden themes. J Ethn Subst Abuse. 2016; 15(2):95–126.

Chapter 9
Addiction Stigma in the US Legal System

Joseph J. Avery

Introduction

The US judiciary has a long history of thinking about substance use, with prominent case law even touching on such matters as the medical model of addiction. The treatment of addiction by US courts is nuanced, if not always consistent. In some limited contexts, active substance use, especially alcohol intoxication, can be used as a defense to avoid civil or criminal liability. At the same time, addiction is generally not an affirmative defense and generally not a viable basis for legal insanity. Moreover, substance use disorders (SUDs), as recognized mental disorders, cannot be criminalized, but active behavior stemming from such disorders, especially acute intoxication, may be. Amidst this formal treatment, we can identify three areas within the law in which addiction stigma arises and has impact. First, there are stigmatizing attitudes held by prominent legal actors, such as criminal defense attor-

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neys, and this stigma may compound with racial bias. Second, there is the issue of stigma attaching to individuals who, while no longer incarcerated, have records that contain drug convictions. Third, stigma attaches to attorneys who struggle with and seek treatment for SUDs.

The Legal System and Drug Offenses

Conceptualization of Substance Use

In 1962, the US Supreme Court held that, while criminalizing drug use was valid pursuant to the police power, a statute criminalizing addiction itself violated the Eight Amendment's prohibition of cruel and unusual punishment and was unconstitutional [64]. In a concurrence to the court's opinion, Justice Douglas wrote, "If addicts can be punished for their addiction, then the insane can also be punished for their insanity. Each has a disease and each must be treated as a sick person" (370 U.S. at 674). A few years later, in *Powell v. Texas* [59], the court concluded that while a statute prohibiting alcoholism itself would have been unconstitutional, one that prohibited public intoxication was valid. As Morse [46] wrote, these two cases "continue to be robustly emblematic of the criminal law's response to addiction" (p. 265).

Other behaviors besides substance use can, of course, lead to long-term brain changes and related criminal acts. In *Entertainment Software Assn. v. Blagojevich* [25], the Seventh Circuit considered whether exposure to violent video games increased aggressive thinking and behavior in adolescents. In *Brown v. Entertainment Merchants Assn.* [11], Justice Breyer's dissent supported the argument that violent video games are linked to similar behavior (564 U.S. at 854). In addition, the Supreme Court has carved out protections for young people (in a triumvirate of cases: [26, 43, 65]) and for the intellectually disabled [4, 29] on the grounds that there is a common denominator for such groups: as Richard Posner bluntly put it, "[T]hey have problems with their brains" [58].

Similar to injury, illness, and trauma, addiction is characterized by significant and long-term alterations in neurological functioning (see [16, 30, 35]). Yet, in spite of the fact that addiction is recognized in DSM-V as a mental disorder, it almost never is accepted as a sufficient basis for asserting an insanity defense and is explicitly barred from such use in some jurisdictions [34]. In essence, the claim is that, while those suffering from a traumatic brain injury or from posttraumatic stress disorder are innocent in the legal sense, individuals with SUDs are responsible for their illegal behavior since they are responsible for the development of the brain states that precipitated such behavior ([6]; see also [5]).

Criminal Justice Treatment

While only 5% of the US population meets the criteria for a drug use disorder, greater than half of state prisoners and sentenced jail inmates meet the same criteria [10]. More than a million individuals with substance use disorders (SUDs) pass through the criminal justice system each year [63]. This is impactful, as incarceration of individuals with SUDs is associated with increased rates of violence, victimization, suicide while in custody, mortality after release, and recidivism [7, 17, 36, 60, 73]. Moreover, in the carceral system, there is a large treatment gap for those with substance use disorders [51]. For example, a majority of US prisons forbid inmates from receiving the accepted proper treatment for individuals with opioid use disorder [50]. Even when care is provided, it is largely subpar and ineffective [63]. Referral of clients who show signs of SUDs to mental health experts is especially important given that 75% of all individuals diagnosed with drug use disorders have also been diagnosed with a psychiatric disorder [9, 67].

States have experimented with noncarceral and minimally carceral approaches. There are nearly 3,000 drug treatment courts—collaborative programs of judicially supervised treatment—around the United States, each of which is as "varied in form and format as the diverse legal and treatment cultures from which they spring" [31].

Racialized Drug Stigma

Racially unequal rates of incarceration are a durative attribute of the US criminal justice system [48]. In 2015, the US population was 13% black [75], while the US state prison population was 38% black [14]. This disparity is especially acute in the context of drug offenses [1, 61]. In some US states, black men have been convicted on drug charges at rates dozens of times greater than white men [32]. In 2016, there were more than 81,000 individuals in federal prisons for drug offenses, and 37.9% of them were black, while 21.6% were white [15]. Moreover, a number of reports have shown that the percentage of blacks imprisoned for drug crimes is not proportional to arrest rates [18]. In other words, once arrested for a drug crime, blacks are more likely to go to prison.

These disparities in drug convictions exist in spite of two facts (see Fig. 9.1). First, whites vastly outnumber blacks: in 2016, 61.3% of the US population was white, while a mere 13.3% was black [75]. Second, rates of using and selling drugs are similar for whites and blacks [33, 42, 72, 79].

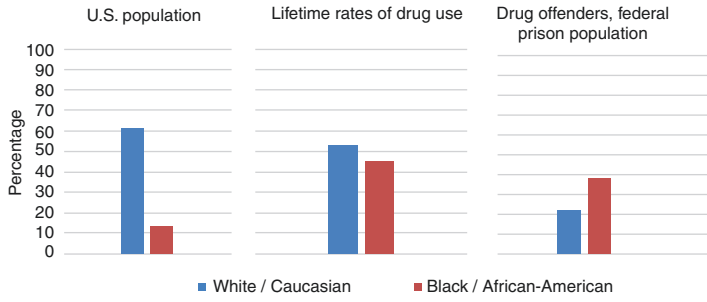

Figure 9.1 Population [75], lifetime rates of illicit drug use among persons aged 12 or older ([72], p. 224, Table 1.29B), and individuals in federal prisons whose primary offense was a drug charge ([15], p. 20, Table 15). All results represent percentages and are for the year 2016 and for persons in the United States

Racial bias, especially in the criminal context, has been well documented. Studies have found evidence of cultural stereotypes linking African-Americans with violence [28, 55], dangerousness [74], and criminality [2, 20, 27].

Stigma against drug users also has been well documented (see [21, 40, 69]). Substance use disorders are viewed more harshly than other forms of mental illness [62], and those who use drugs are "typically perceived as low in both warmth and competence, leading to contempt and social avoidance" ([52], p. 452). Disproportionately negative attitudes toward drug users, including attitudes that worsen over time, have been found even in physicians [6]. The effects of substance use stigma, which include shame [77], persist longer than the effects of stigma related to other mental illnesses [41]. Michael Botticelli, former director of the White House Office of National Drug Control Policy, said, "I almost found it easier to come out as being a gay man than a person in recovery" [70].

Compounding discrimination is best understood in the light of intersectionality, an analytical framework for identifying and understanding the power differentials that enable discrimination when multiple factors, such as race and gender, are involved. Crenshaw [22, 23] argued that any analysis of crime that looks at disparities must take into account intersecting identities (see also [54]). Drug stigma and racial bias may be considered one such intersection. Given their dual identities, African-American drug offenders face a confluence of bias and stigma (see [1]). Rush [66] found that participants assigned greater blame to black individuals who developed drug dependence, as compared to white individuals who did the same. In a qualitative study of 10 African-American substance users, Scott and Wahl [71] found that black participants perceived that their substance use problems were viewed less favorably than the substance use problems of whites. Still others have identified differential treatment in public policy, arguing that, during the most recent opioid epidemic, minority substance users were treated as irresponsible and criminal while white substance users were treated as mentally ill and in need of treatment [49].

How to improve criminal justice attitudes toward individuals with SUDs is an important consideration. It also represents a difficult task. In myriad realms, interventions aimed at addressing both implicit and explicit bias have shown little or, at best, short-term efficacy [24, 39]. "After a few hours to days, average levels of bias tend to snap stubbornly back to their baseline levels" ([56], p. 236). Perhaps the best route forward is the one taken by police departments around the world, which have been and are adopting crisis intervention trainings (CIT), which are programs focused on, *inter alia*, improving recognition of mental illness and increasing knowledge of referral services [12]. Even with CIT programs, though, it is hard to know which specific interventions are best. A variety of programs are in use, and while it appears that those which make use of immersive and relatively durative training environments are the most successful, it is not at all clear that any CIT programs help with implicit bias [47]. This is concerning since, as discussed above, intersectional stigmas, ones arising from a confluence of implicit and explicit attitudes toward multiple identities, may be of paramount importance when it comes to the health of individuals with SUDs.

The Social Stigma of Drug Crime

As this present volume attests, stigma against persons with SUDs has been well documented. At the same time, a criminal record, on its own, brings significant social stigma [44]. Stigma relating to criminal offender status often is compounded by formal and informal marginalization, including voting rights restrictions, employment difficulties, and hardship in other important aspects of daily life [57]. Not least on account of psychological responses to stigma, criminal offenders' reintegration remains challenging [45, 78]. This is especially true for those convicted of drug crimes. A study of over 30,000 individuals released from Washington State prisons found that the risk of death was 12.7 greater than normal during the first 2 weeks after release, and 75% of these deaths were the result of drug overdose [8].

There are formal protections in place for those with SUDs, including the Americans with Disabilities Act (ADA) of 1990 and the ADA Amendment Act of 2008, and these protections are broad, requiring that employers allow for modified schedules so that treatment can be received, rehabilitation without negative impact on job security, and reassignment to less stressful posts [3]. However, it seems certain that, just as there is well-documented stigma toward individuals with criminal records and individuals with SUDs, those with dual identities face significant, if not compounding, stigmatization. More research is needed in this area.

Stigmatizing Attorneys with Substance Use Disorders

Attorneys experience substance use disorders at a high rate [19], and attorney rates of alcohol use disorder are higher than in the general population [68]. According to a 2016 study conducted by the Hazelden Betty Ford Foundation and the American Bar Association, 21% of lawyers qualify as problem drinkers [37]. Even though the survey was confidential, a full 75% of attorneys surveyed refused to answer questions related to drug use, suggesting to some the effects of both fear of professional loss and stigma (see [81]). It is believed that substance use is especially pernicious in the legal realm given "high levels of stigma" [13], stigma that pertains to substance use and also to seeking help for the disorder [76]. In recent years, there have been repeated calls for law firms and legal organizations to devise interventions for addiction stigma [80]. Largely in response to these calls, the American Bar Association is set to begin sharing testimonials of attorneys' struggles with substance use and their paths to recovery [38]. Also, in South Carolina, there has been a concerted effort to help attorneys by combating addiction stigma [53]. Yet there remains a significant need for greater resources to assist attorneys with substance use disorders [37].

Conclusion

The legal community has a complex relationship with individuals with substance use disorders. The law punishes much substance use, but it also simultaneously protects individuals with SUDs (through partial recognition of addiction as a mental disorder) and disadvantages them (through restrictions on when such a conception can be used as a legal defense). What is clear is that when it comes to treatment of individuals with substance-related charges, race matters. Within the law, there is racialized drug stigma. Beyond the criminal justice system, addiction stigma and the law collide in two important areas: one, societal treatment of individuals who were formerly incarcerated for drug offenses and, two, stigma against attorneys who struggle with SUDs. It is clear that addiction stigma impacts individuals with drug crime records, but more research is needed to better understand these attitudes and how they impact formerly incarcerated individuals. Lastly, when it comes to attorneys with substance use disorders, law firms and legal organizations are just beginning to raise awareness and to intervene to improve attitudes and increase the number of attorneys receiving proper treatment. As a next step in studying addiction stigma in the law, greater understanding of intersectional stigmas, such as those arising from the combination of criminal behavior and substance use, or from minority status and drug use, is necessary. In the law, drug use seldom occurs in isolation, and the full complexity of stigmatizing reactions to use warrants closer inspection.

References

1. Alexander M. The new Jim Crow: mass incarceration in the age of colorblindness. New York: The New Press; 2010.
2. Allport GW, Postman L. The psychology of rumor. New York: Henry Holt; 1947.
3. Aoun EG, Bazzi L. Addiction and the law. Am J Addict. 2018;27:56–7.

4. Atkins v. Virginia, 536 U.S. 304 (2002).
5. Avery J. Picking and choosing: inconsistent use of neuroscientific legal evidence. Albany Law Rev. 2018;81(3):101–34.
6. Avery JD, Han BH, Zerbo E, et al. Changes in psychiatry residents' attitudes towards individuals with substance use disorders over the course of residency training. Am J Addict. 2017;26:75–9.
7. Baillargeon J, Binswanger IA, Penn JV, Williams BA, Murray OJ. Psychiatric disorders and repeat incarcerations: the revolving prison door. Am J Psychiatry. 2009;166:103–9.
8. Biswanger IA, Stern MF, Deyo RA, et al. Release from prison: a high risk of death for former inmates. N Engl J Med. 2007;356(2):157–65.
9. Brady KT, Sinha R. Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. Am J Psychiatry. 2005;162:1483–93.
10. Bronson J, Stroop J, Zimmer S, Berzofsky M. Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009. U.S. Department of Justice, Bureau of Justice Statistics. 2017:1–27.
11. Brown v. Entertainment Merchants Association, 564 U.S. 786 (2011).
12. Browning SL, Van Hasselt VB, Tucker AS, Vecchi GM. Dealing with individuals who have mental illness: the crisis intervention team (CIT) in law enforcement. Br J Forensic Pract. 2011;13(4):235–43.
13. Butler Center for Research. Addiction recovery poses special challenges for legal professionals. Hazelden Betty Ford Foundation. 16 Mar 2017. https://www.hazeldenbettyford.org/education/bcr/addiction-research/substance-abuse-legal-professionals-ru-317. Accessed 19 June 2018.
14. Carson EA. Prisoners in 2014. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. 2016. https://www.bjs.gov/content/pub/pdf/p14.pdf. Accessed 20 June 2018.
15. Carson EA. Prisoners in 2016. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. 2018. https://www.bjs.gov/content/pub/pdf/p16.pdf. Accessed 19 June 2018.
16. Chang L, Alicata D, Ernst T, Volkow N. Structural and metabolic brain changes in the striatum associated with methamphetamine abuse. Addiction. 2007;102:16–32.
17. Chang Z, Larsson H, Lichtenstein P, Fazel S. Psychiatric disorders and violent reoffending: a national cohort study of convicted prisoners in Sweden. Lancet Psychiatry. 2015;2:891–900.

18. Chin G. Race and the disappointing right to counsel. Yale Law J. 2013;122:2236–59.
19. Chung R. In a punishing profession, too many lawyers are paying the ultimate price. Above Law 21 July 2017. https://abovethelaw.com/2017/07/in-a-punishing-profession-lawyers-need-to. Accessed 19 June 2018.
20. Correll J, Park B, Judd CM, Wittenbrink B, Sadler MS, Keesee T. Across the thin blue line: police officers and racial bias in the decision to shoot. J Pers Soc Psychol. 2007;92:1006–9.
21. Corrigan PW, Kuwabara SA, O'Shaughnessy J. The public stigma of mental illness and drug addiction: findings from a stratified random sample. J Soc Work. 2009;9:139–47.
22. Crenshaw K. Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. Univ Chic Leg Forum. 1989;1989:139–67.
23. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. Stanford Law Rev. 1991;43:1241–99.
24. Devine PG, Forscher PS, Austin AJ, Cox WTL. Long-term reduction in implicit race bias: a prejudice habit-breaking intervention. J Exp Soc Psychol. 2012;48:1267–78.
25. Entertainment Software Assn. v. Blagojevich, 469 F.3d 641 (7th Cir. 2006).
26. Graham v. Florida, 560 U.S. 48 (2010).
27. Graham S, Lowery BS. Priming unconscious racial stereotypes about adolescent offenders. Law Hum Behav. 2004;28(5):483–504.
28. Greenwald AG, Oakes MA, Hoffman HG. Targets of discrimination: effects of race on responses to weapons holders. J Exp Soc Psychol. 2003;39(4):399–405.
29. Hall v. Florida 572 U.S. (2014).
30. Herman MA, Roberto M. The addicted brain: understanding the neurophysiological mechanisms of addictive disorders. Front Integr Neurosci. 2015;9(18):1–4.
31. Hora PF. Drug treatment courts and the treatment of persons in the criminal justice system. In: Ries RK, Fiellin DA, Miller SC, Saitz R, editors. The ASAM principles of addiction medicine. 5th ed. New York: LWW; 2014.
32. Human Rights Watch. Punishment and prejudice: racial disparities in the war on drugs. HRW Rep. 2000;12(2). https://www.hrw.org/reports/2000/usa/. Accessed 20 June 2018.

33. Human Rights Watch. Targeting African-Americans: Drug law enforcement and race in the United States. 2008. https://www.hrw.org/report/2008/05/04/targeting-blacks/drug-law-enforcement-and-race-united-states. Accessed 20 June 2018.
34. Jones OD, Schall JD, Shen FX. Law and neuroscience. New York: Wolters Kluwer Law & Business; 2014.
35. Kalivas PW, Volkow ND. The neural basis of addiction: a pathology of motivation and choice. Am J Psychiatry. 2005;162:1403–13.
36. Kinner SA, Forsyth S, Williams G. Systematic review of record linkage studies of mortality in ex-prisoners: why (good) methods matter. Addiction. 2013;108:38–49.
37. Krill PR, Johnson R, Albert L. The prevalence of substance use and other mental health concerns among American attorneys. J Addict Med. 2016;10(1):46–52.
38. Krill P. Lawyer testimonials aim to stamp out mental health stigma. Law.com. 27 Mar 2018. https://www.law.com/2018/03/27/lawyer-testimonials-aim-to-stamp-out-mental-health-stigma. Accessed 19 June 2018.
39. Lai CK, Skinner AL, Cooley E, Murrar S, Brauer M, Devos T, Nosek BA. Reducing implicit racial preferences: II. Intervention effectiveness across time. J Exp Psychol Gen. 2016;145:1001–16.
40. Link B, Phelan J, Bresnahan M, Stueve A, Pescosolido B. Public conceptions of mental illness: labels, causes, dangerousness, and social distance. Am J Public Health. 1999;89(9):1328–33.
41. Link B, Struening E, Rahav M, Phelan J, Nuttbrock L. On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. J Health Soc Behav. 1997;38(2):177–90.
42. Miech RA, Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE. Monitoring the future: national survey results on drug use, 1975–2014. Ann Arbor: Institute for Social Research, The University of Michigan; 2014. http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2014.pdf. Accessed June 20, 2018
43. Miller v. Alabama, 567 U.S. 460 (2012).
44. Moore KE, Stuewig JB, Tangney JP. The effect of stigma on criminal offenders' functioning: a longitudinal mediational model. Deviant Behavior. 2015;37(2):196–218.
45. Morani NM, Wikoff N, Linhorst DM, Bratton S. A description of the self-identified needs, service expenditures, and social outcomes of participants of a prison-reentry program. Prison J. 2011;91:347–65.

46. Morse SJ. The science of addiction and criminal law. Harv Rev Psychiatry. 2017;25:261–9.
47. Mulay AL, Vayshenker B, West ML, Kelly E. Crisis intervention training and implicit stigma toward mental illness: reducing bias among criminal justice personnel. Int J Forensic Ment Health. 2016;15(4):369–81.
48. Munger FW, Seron C. Race, law, and inequality: fifty years after the civil rights era. Annual Review of Law and Social Science. 2017;13:10.1–10.20.
49. Netherland J, Hansen HB. The war on drugs that wasn't: wasted whiteness, "dirty doctors," and race in media coverage of prescription opioid misuse. Cult Med Psychiatry. 2016;40:664–86.
50. The New York Times Editorial Staff. If addiction is a disease, why is relapsing a crime? The New York Times. 29 May 2018. http://www.nytimes.com. Accessed 11 June 2018.
51. Oser CB, Knudsen HK, Staton-Tindall M, Taxman F, Leukefeld C. Organizational-level correlates of the provision of detoxification services and medication-based treatments for substance abuse in correctional institutions. Drug Alcohol Depend. 2009;103:S73–81.
52. Pachankis JE, Hatzenbuehler ML, Wang K, et al. The burden of stigma on health and well-being: a taxonomy of concealment, course, disruptiveness, aesthetics, origin, and peril across 93 stigmas. Personal Soc Psychol Bull. 2017;44(4):451–74.
53. Padgett B. Stigma hurts. South Carolina Lawyer. 28 Jan 2017;9.
54. Paik L. Critical perspectives on intersectionality and criminology: introduction. Theor Criminol. 2017;21(1):4–10.
55. Payne BK. Prejudice and perception: the role of automatic and controlled processes in misperceiving a weapon. J Pers Soc Psychol. 2001;81:181–92.
56. Payne BK, Vuletich HA, Lundberg KB. The bias of crowds: how implicit bias bridges personal and systemic prejudice. Psychol Inq. 2017;28(4):233–48.
57. Pogorzelski W, Wolff N, Pan KY, Blitz CL. Behavioral health problems, ex-offender reentry policies, and the "second chance act". Am J Public Health. 2005;95:1718–24.
58. Posner R. Justices should use more than their gut and "brain science" to decide a case. Slate. 26 June 2012. http://www.slate.com/articles/news_and_politics/the_breakfast_table/features/2012/_supreme_court_year_in_review/supreme_court_year_in_review_the_justices_should_use_more_than_

their_emotions_to_decide_how_to_rule_. Accessed 20 June 2018.
59. Powell v. Texas, 392 U.S. 514 (1968).
60. Pratt D, Appleby L, Piper N, Webb R, Shaw J. Suicide in recently released prisoners: a case–control study. Psychol Med. 2010;40:827–35.
61. Quigley W. Racism: the crime in criminal justice. Loyola Journal of Public Interest Law. 2012;13:417–26.
62. Rasinski K, Woll P, Cooke A. Stigma and substance use disorders. In: Corrigan PW, editor. On the stigma of mental illness: practical strategies for research and social change. Washington, DC: American Psychological Association; 2005.
63. Rich JD, Wakeman SE, Dickman SL. Medicine and the epidemic of incarceration in the United States. N Engl J Med. 2011;364:2081–3.
64. Robinson v. California, 370 U.S. 660 (1962).
65. Roper v. Simmons, 543 U.S. 551 (2005).
66. Rush L. Affective reactions to multiple social stigmas. J Soc Psychol. 1998;138(4):421–30.
67. Rush B, Koegl CJ. Prevalence and profile of people with co-occurring mental and substance use disorders within a comprehensive mental health system. Can J Psychiatr. 2008;53:810–21.
68. Schiltz PJ. On being a happy, healthy, and ethical member of an unhappy, unhealthy and unethical profession. Vanderbilt Law Review. 1999;52:871–951.
69. Schomerus G, Lucht M, Holzinger A, Matschinger H, Carta MG, Angermeyer MC. The stigma of alcohol dependence compared with other mental disorders: a review of population studies. Alcohol & Alcoholism. 2011;46:105–12.
70. Schwarz A. Michael Botticelli is a drug czar who knows addiction firsthand. The New York Times. 26 Apr 2015. https://www.nytimes.com/2015/04/26/us/michael-botticelli-is-a-drug-czar-who-knows-addiction-firsthand.html. Accessed 20 June 2018.
71. Scott MC, Wahl OF. Substance abuse stigma and discrimination among African-American male substance users. Stigma Research and Action. 2011;1(1):60–6.
72. Substance Abuse and Mental Health Services Administration. Results from the 2016 national survey on drug use and health: detailed tables. 2017. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf. Accessed 19 June 2018.

73. Teasdale B, Daigle LE, Hawk SR, Daquin JC. Violent victimization in the prison context: an examination of the gendered contexts of prison. Int J Offender Ther Comp Criminol. 2016;60:995–1015.
74. Trawalter S, Todd AR, Baird AA, Richeson JA. Attending to threat: race-based patterns of selective attention. J Exp Soc Psychol. 2008;44(5):1322–7.
75. United States Census Bureau. Population estimates program. 2017. https://www.census.gov/quickfacts/fact/table/US/PST045216. Accessed 19 June 2018.
76. Vincent T. To be a good lawyer, one has to be a healthy lawyer. Michigan Bar J. 2018;97:53.
77. Wiechelt S. The specter of shame in substance misuse. Subst Use Misuse. 2007;42:399–409.
78. Winnick TA, Bodkin M. Anticipated stigma and stigma management among those to be labeled "ex-con". Deviant Behavior. 2008;29:295–333.
79. Wu LT, Woody GE, Yang C, Pan JJ, Blazer DG. Racial/ethnic variations in substance-related disorders among adolescents in the United States. Arch Gen Psychiatry. 2011;68:1176–85.
80. Zaretsky S. Some law firms try to 'eliminate stigma' from attorneys struggling with mental-health issues. Above Law. 22 May 2017. https://abovethelaw.com/2017/05/some-law-firms-try-to-eliminate-stigma-from-attorneys-struggling-with-mental-health-issues. Accessed 19 June 2018.
81. Zimmerman E. The lawyer, the addict. The New York Times. 15 July 2017. https://www.nytimes.com/2017/07/15/business/lawyers-addiction-mental-health. Accessed 19 June 2018.

Chapter 10
The Stigma of Addiction in the Workplace

Ann Roche, Victoria Kostadinov, and Ken Pidd

As other chapters in this volume have demonstrated, stigma related to alcohol and other drug (AOD) use[1] is apparent in many facets of society. This is in turn associated with considerable threats to the health and wellbeing of people who use AOD. The current chapter focuses on AOD-related stigma at work, including its origins and impact on finding, maintaining, and participating in employment opportunities, as well as strategies for minimizing it.

[1] In this chapter, the term "AOD use" is taken to mean alcohol and/or drug use that is harmful, has adverse effects in the workplace, or is unsanctioned/problematic/otherwise contrary to societal norms or expectations in a given context. This generic term is preferred over "addiction" as it is broader and encompasses a wider range of issues and concerns. For instance, some AOD use can be extremely problematic, especially in the workplace, and heavily stigmatized but may not necessarily involve addiction.

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Stigma, AOD, and the Workplace[2]

Stigma is ubiquitous in a wide variety of settings and contexts but is not always recognized or understood. In part, this is because there is no single, universally accepted definition of stigma. Goffman's seminal work defined stigma as "an attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted, discounted one" [3]. This stigmatizing attribute can be any characteristic that "conveys a social identity that is devalued in a particular social context" [4], for example illness, religion, sexual orientation, ethnicity, or—as is the focus here—AOD use and addiction.

Stigma may be perceived (real or imagined fear of discrimination), enacted (experiences of discrimination), and/or internalized (negative thoughts/feelings about oneself due to due to identifying as part of a stigmatized group) [5]. It can also operate on a subconscious level, influencing perception, memory, emotions, and behavior [6, 7].

Stigma can in turn lead to prejudice, stereotyping, and discrimination, which can play out with profoundly detrimental effect in settings such as workplaces. As has been highlighted throughout this volume, being a member of a stigmatized group can have serious and tangible implications for health and wellbeing [8]. Targets of stigma may experience feelings of shame, anger, worthlessness and hopelessness, as well as social exclusion and marginalization [5, 8]. These effects can also be observed in the workplace.

[2] The language used to discuss AOD, individuals who use AOD, and AOD-related problems can shape public perceptions about these issues [1]. In order to ameliorate the stigmatization and associated negative outcomes that can arise from poor word choice, this chapter follows SAMHSA's guidelines on non-stigmatizing language [2]. Therefore, we use "person first" language (e.g., "a person who uses drugs" instead of "a drug user"). In addition, we have made every effort to avoid colloquialisms and non-scientifically/inconsistently defined terms, and to avoid conflating AOD use (which occurs on a spectrum and may not necessarily be problematic) with clinically-diagnosed substance use disorders. Therefore, terms such as "addict" and "abuse(r)" are not used.

AOD use is one of society's most stigmatized behaviors [9]. Reasons for such extreme opprobrium are complex. In part, it derives from the voluntary engagement in illegal and/or criminal activities (in the case of illicit drugs) where, by definition, a social contract has been broken. Concomitantly, AOD use is often seen as a moral deficit or failing rather than a health issue [10], with those individuals who use AOD deemed "at fault" and flawed [2].

AOD use can also become the subject of censure if it is believed to be a causal or contributory factor in problems such as violence, unsafe behaviors (e.g., impaired driving), illness (e.g., HIV/AIDS), social problems (e.g., poverty, criminality), or failure to perform a major prescribed social role (e.g., as an employee or family member) or if it breaches a social/community value (e.g., abstinence among some groups and religions) [10, 11].

Further, the underpinning motivation for drug use is often believed to be the pursuit of pleasure. The combination of hedonism and perceived selfishness intensifies the associated stigma. AOD use also involves a quest to alter one's consciousness and as such can generate suspicion and disapproval. Moreover, any loss of control associated with intoxication and/or addiction is regarded by many as a base human condition that justifies severe sanctions.

The extent of AOD stigmatization varies according to the substance (e.g., illicit drugs are usually more stigmatized than alcohol; heroin is more stigmatized than cannabis); frequency and method of use (e.g., injecting vs occasional smoking/ingesting); context and consequences of use (e.g., at parties vs in professional settings, degree of intoxication or impairment); and characteristics of the individual, with stigmatization intensified when a person also belongs to another stigmatized group (e.g., people of color, those with lower socioeconomic status, LGBTI individuals, and women) [5, 12]. The stigma associated with psychoactive substances is also fluid: for example, tobacco smoking was once lauded but is now heavily stigmatized, and cannabis use is becoming less stigmatized as it is increasingly considered a medicinal or benign recreational substance.

Such variations notwithstanding, there is widespread cultural acceptance and endorsement of stigmatizing attitudes toward and sanctions against people who use AOD.[3] In some cases, this may be operationalized at a structural level in policies and laws [10, 13, 14]. It can also be apparent in healthcare settings where healthcare professionals may view patients who use AOD as less "deserving" of care, which in turn can result in poorer treatment and health outcomes [15–17].

Employee AOD Use

The ubiquity of AOD-related stigma notwithstanding, AOD use is highly prevalent among employed people. Establishing exact prevalence rates of AOD use among workers can, however, be difficult. Research has typically focused on treatment-seeking, prison-based, or general populations, with limited attention specifically directed to those in the paid workforce. Furthermore, workplace-based research has characteristically targeted discrete industries or occupations [18], thereby curtailing its generalizability.

Available data indicate that the majority of people who use AOD are employed, in contrast to prevailing stereotypes of use occurring predominately among the poor, unemployed, and marginalized. A 2016 nationally representative survey of Americans found that 8008 employees had used an illicit drug in the past year, compared to 4202 people who were unemployed or not in the labor force [19]. Similarly, an

[3] This chapter refers throughout to stigma that can effect "people who use AOD." However, as noted, the extent to which people who use AOD experience stigmatization depends heavily on personal characteristics and the type and context of use. Not everyone who uses AOD will experience stigma; indeed, in certain situations stigma can arise from *not* using AOD (e.g., social events). Our intention in using such broad terminology is to recognise that the experience of stigma is context dependent, and that while it may most commonly effect certain sub-groups (e.g., those who use illicit drugs at heavy/problematic levels; those who also belong to other stigmatized groups) it is not possible to definitively predict if and when a person who uses AOD will experience stigma as a result.

Australian survey identified that 2042 employed people had used illicit drugs in the past year compared to only 1033 unemployed people [20].

While it is difficult to compare rates of employee AOD use in different countries due to measurement and sample variations, available data highlight high rates of risky alcohol (and to a lesser extent drug) use among workers in America, Australia, Great Britain, Norway, and Belgium [19–24]. For example, among American workers, 15% reported using illicit drugs,[4] 34% reported binge drinking,[5] and 9% reported heavy alcohol use[6] in the past month [19]. It is likely that other Western countries also have similar patterns of risky AOD use among employed people.

Given the pervasive nature of AOD use among employees in many countries around the world, workplace AOD stigma is an issue of considerable relevance and import for a large number of people. The following sections of this chapter outline how and why stigma can manifest at work, its consequences, and how organizations can prevent and address it.

AOD Stigma in the Workplace

The precise mechanisms underlying the stigmatization of AOD use can be obscure, particularly given that the use of some substances (even when taken to excess) can in certain contexts be normative and acceptable (see section "Stigma, AOD, and the Workplace"). One of the key factors underpinning AOD-related stigmatization in the workplace is negative assumptions about AOD and the attributes of people who use them. These assumptions can stem from false understandings or misperceptions about the nature and potential effects of AOD, value judgments about those who use AOD (includ-

[4] Cocaine, hallucinogens, heroin, inhalants, methamphetamine, cannabis, sedatives, pain relievers, stimulants, tranquilizers.
[5] Five/four or more drinks on the same occasion for males/females.
[6] Five/four or more drinks on the same occasion for males/females on each of five or more days in the past 30 days.

ing their abilities and attributes), and subsequent consequences for the workplace.

In particular, individuals who use AOD may be assumed to not have the necessary skills, attributes, and competencies to be good employees and/or to be dangerous, criminals, or untrustworthy. Because these assumptions are implicit, elicit strong negative emotional responses, and are not typically subjected to open and critical dialogue, they can be difficult to address [25]. The ways in which these assumptions can give rise to stigmatization and discrimination in the workplace setting are described below.

How Stigma Manifests at Work

Individuals who use AOD, particularly if they experience problems or dependence, may encounter stigma in the workplace in a variety of ways. Stigma may result in discrimination in hiring, promotion, and accessing full employment benefits, as well as inequity in workplace policies and workplace social interactions [25]. As a result, people who use or have a history of using AOD may be at elevated risk of unemployment, underemployment, and precarious employment (i.e., work with little security, employer protections, and opportunities for advancement) [25].

Individuals who use AOD may be less likely to obtain paid employment for several reasons. In some cases, people with a history of problematic AOD use may experience multiple forms of social disadvantage, which interact with personal factors to create significant barriers to entering or reentering the workforce. These disadvantages or challenges may include a lack of education, work experience, and/or job skills, mental or physical health problems, and logistical issues (e.g., insecure housing, needing to attend medical appointments) [26–28].

However, the majority of people who use AOD do so infrequently and nonproblematically, and many are highly educated, skilled, and experienced workers. Nevertheless,

current or past AOD use can constitute a formidable barrier to gaining or maintaining employment. Biased or discriminatory hiring practices may result in individuals who use AOD not being offered positions despite possessing all necessary skills and attributes [29, 30] or the withdrawal of job offers after an applicant's history of AOD use is discovered [31].

Individuals who have internalized stigmatizing attitudes toward their own AOD use (sometimes described as "self-stigma") may also face additional self-imposed barriers to gaining employment. Self-stigma can result in a diminished sense of value and self-worth, which can at times lead to individuals (often inaccurately) perceiving themselves as incapable of productive employment and therefore refraining from actively seeking work [5, 32].

Despite this, research investigating the relationship between AOD use and employment has found mixed results. While some studies have found that individuals who use AOD are less likely to be employed, other studies have failed to find a significant association between AOD use and employment [28, 32–36]. The different results may be due to the level and impact of AOD consumption or other factors such as overall unemployment levels and economic climate [28].

Among individuals who use AOD who are already employed, stigma can negatively impact their workplace experiences, performance, mental health, and career progression. This includes reduced ability to participate in supportive social interactions, being passed over for promotion, or being forced to take lower pay rates [25, 37]. In some areas with fewer legal protections for workers, they may even be fired [38]. It is therefore unsurprising that individuals who have AOD-related problems often attempt to conceal them [39]. However, this can have the unintended consequence of preventing individuals who use AOD from demonstrating their skills and capabilities, supporting others who use AOD, or advocating for their working rights [25].

The characteristics of the workplace may also influence the extent and ways in which stigma can manifest. For example, workplaces that emphasize profit and efficiency may be more likely to stigmatize individuals who are perceived to be less competent workers [25] or fail to conform to prescribed social and behavioral norms. The culture of a particular workplace (and whether it promotes tolerance and diversity vs conformity and discipline) can also have an important impact on stigmatization. This is discussed in more detail in section "Public Perception".

Compound Stigma

As noted earlier, many personal characteristics or attributes can be stigmatized, including gender, race, religion, sexual orientation, and health status, among others. Individuals who belong to several stigmatized groups (e.g., women of color, LGBTI individuals who have disabilities) can encounter especially severe stigmatization and discrimination [40–42].

The relationship between different forms of stigmatization, AOD use, and workplace outcomes can be multifarious. Individuals with mental health problems, physical illnesses/disabilities or criminal records often face similar difficulties to those who use AOD in obtaining or maintaining employment [25, 29, 43]. Moreover, this constellation of characteristics frequently cooccurs with problematic AOD use [44–46], resulting in a large number of people who both use AOD and belong to at least one other stigmatized group. For these individuals, employer bias can be particularly strong [47], potentially making it extremely difficult to find and retain paid employment.

Compound stigma can also manifest in more complex scenarios. For instance, people of color are disproportionately incarcerated and receive harsher sentences for drug offenses [48–50]. This can lead to the loss of current employment and also limit future work opportunities due to criminal records becoming apparent in preemployment screening (even if the offense is unrelated to the position for which they have applied) [29].

Stigma by Association

Individuals who use AOD are not the only targets of stigmatization in the workplace. "Stigma by association" refers to the process whereby stigma can be "transferred" to people who do not necessarily possess the stigmatizing attribute or engage in the stigmatized behavior (e.g., who do not use AOD) but who interact with those who do [51]. For example, alcohol and other drug workers and other health professionals may face stigmatization as a result of their professional relationship with individuals who use AOD.

Although the exact mechanisms underlying the process of vicarious stigmatization are not completely understood, it has been theorized that workers who support or provide care to people who use AOD may be stigmatized due to an assumption that they also have histories of AOD use or out of fear that they may be exposed to conditions stereotypically associated with people who use AOD (e.g., HIV/AIDS) [52]. Alternatively, the stigma may be in response to workers providing support and assistance (and thus validation) to a group seen as morally deviant and less deserving [15, 52].

Associative stigma can also affect the friends and family members of people who use AOD (known as "family stigma") [53]. Parents, siblings, and spouses of individuals who use AOD may be seen as responsible for their family member's AOD use and therefore deficient or blameworthy themselves. Similarly, the children of people who use AOD may be seen as "contaminated" by their parent's AOD use [54]. Consequently, the stigmatization described in section "How Stigma Manifests at Work" may also be experienced by the close friends, family, and work colleagues of individuals who use AOD in the form of a halo effect.

Wider Influences on Workplace Stigma

The attitudes and opinions of individual employees are not the only factors that shape AOD-related stigma at work. Social and structural systems can also act to reinforce and

perpetuate the stigma experienced by workers who use AOD. It is vital that these broader influences on workplace stigma are understood as efforts to reduce stigmatization that focus solely on the individual and fail to address underlying structural drivers are unlikely to be successful.

Public Perception

The way in which individuals who use AOD are represented and perceived in society has profound implications for AOD-related stigma at work. The workplace does not exist in a vacuum, and workers bring preexisting attitudes, opinions, and assumptions with them to their work roles and to the work setting. Inevitably, personal belief frameworks influence how employees perceive and treat colleagues who use AOD. These frameworks are the product of one's life experience and may be formed and shaped by interrelated factors such as the following:

- Previous exposure to people who use AOD (including any personal use)
- Attitudes of friends and family and social and religious relationships/exposure
- Media portrayals of people who use AOD
- Social systems and structures (e.g., government legislation and rhetoric)
- Prevailing social and cultural milieu (e.g. "moral panics" over illicit drug use) [55]

The manifestation of stigma in the workplace context is therefore an expansion of broader values and norms within society, and the latter must be taken into consideration if the former is to be effectively addressed.

Healthcare System

As problematic AOD use is most appropriately seen as a health issue, it is important to consider the relationships between the employment and health sectors. In the United

States, employment and AOD use are especially intertwined due to the structure of the healthcare and health insurance systems. While most developed countries provide access to publically funded healthcare, in the US employer-provided health insurance is central to accessing healthcare (including AOD treatment)[7] [57]. Those without health insurance are subject to high and often unexpected out-of-pocket costs for medical care, which can lead to reluctance to seek medical treatment (for fear of incurring unmanageable debt) and in turn poorer health outcomes [57].

Paid employment is therefore of particular importance to individuals who use AOD and who reside in the United States or are subject to US employment conditions. In addition to the general benefits of work (outlined below in section "Reducing AOD-Related Stigma at Work"), employment in the United States bestows the means by which to obtain assistance and treatment not only for AOD dependence but also for the health problems that can occur as a consequence of AOD use. Consequently, AOD-related stigma can have devastating effects if it results in individuals not being hired or losing their position as it substantially impedes their ability to access healthcare. Ironically, in this situation, the stigmatization of AOD use can directly worsen the behavior and consequences it ostensibly denigrates.

Since the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) in 2010, the financial requirements and treatment limitations imposed by health plans and insurers for substance use disorders can be no more restrictive than those imposed for medical/surgical conditions [58]. However, MHPAEA does not explicitly require that health insurance plans offer benefits for AOD-related issues (and is not applicable to all workplaces) [59]; as such, coverage for these

[7] Although provisions exist for the elderly, those with low incomes, and Veterans, health care coverage remains incomplete; in the fourth quarter of 2017, 12% of Americans (39 million people) were uninsured. This is expected to further increase as the Affordable Care Act's requirement that most people have some form of health insurance is effectively repealed starting in 2019 [56].

issues is not guaranteed even for those who have health insurance.

It is feasible that the stigma associated with AOD use may in some cases manifest in organizations choosing not to provide coverage for AOD-related issues (e.g., if they believe benefits should not be provided for "voluntary" or "deviant" behaviors). Again, this demonstrates how stigma in the workplace can have tangible and deeply damaging effects on employees who use AOD, both by denying healthcare to a population in particular need of it and by reinforcing the message that their problems and choices are not legitimate.

Workplace Culture

The culture of a workplace can have an important influence on employee behavior. Workplace culture refers to the shared values, beliefs, expectations, and norms held by employees of a particular organization (or within a particular team/department); it influences the way workers think about and respond to tasks, events, and challenges [60].

The culture of an organization has been shown to influence employees' AOD consumption patterns [61]. Workers who perceive their organization to condone AOD use are more likely to use alcohol or drugs [62–65]. Certain working conditions are also conducive to higher rates of AOD use, including stressful or isolated environments, low levels of supervision and work visibility, high mobility, and psychosocial factors (e.g., job satisfaction) [66–70].

The influence of workplace culture on AOD use has important implications for organizations seeking to minimize employee AOD consumption without resorting to stigmatizing strategies. Namely, shaping a workplace culture that promotes healthy behaviors can discourage employee AOD use without utilizing discriminatory policies and procedures [68] (see section "Workplace Responses to AOD Use" for more details about addressing AOD at work).

In addition to influencing patterns of AOD consumption, workplace culture can also shape responses to AOD use,

including how employees who use AOD are perceived and treated (both in social interactions and in terms of the nature and frequency of work and career opportunities they are afforded) [71]. That is, culture can impact the extent to which AOD-related stigma is endorsed and enacted in the workplace. Employees who use AOD may therefore use their knowledge of the workplace culture (including psychological and social aspects of the work environment, relationships with colleagues and managers, and perceived level of acceptance and understanding) to determine whether it is safe to disclose their use and/or ask for accommodations and support at work [71].

A number of different factors can combine to shape the culture of a workplace in regard to AOD-related stigma. These include the presence (or absence) of operational structures for dealing with discrimination and employees with health concerns, the degree of acceptance and valuing of diversity, as well as unspoken norms (either positive or negative) that become routine behavior patterns [71]. Importantly, these factors are amenable to change. When implemented appropriately, workplace initiatives (e.g., see those described in section "Workplace Responses to AOD Use") can assist in creating workplace cultures that are supportive of individual differences and discourage AOD-related stigma.

Workplace Responses to AOD Use

Organizations are increasingly exhorted to implement formal policies and procedures to address employee AOD use. Unfortunately, many workplace responses to AOD can often arise from and perpetuate the stigmatization of AOD use and can increase the associated harm, distress, and discrimination experienced by workers.

The intent here is not to suggest that workplace AOD policies, procedures, or initiatives are unnecessary. Quite the contrary, employers have a duty of care toward workers and are obliged to provide a safe work environment and to

ensure that employees are fit for work. In some safety-sensitive roles (e.g., aviation) strict no-tolerance policies regarding AOD use are both appropriate and necessary [5]. However, it is possible to meet workplace health and safety obligations without compromising employee privacy, autonomy, and dignity and without stigmatizing personal behaviors.

The following sections provide an overview of the commonly cited rationale for stigmatizing workplace policies, what these policies can look like, and alternative (nonstigmatizing) approaches to addressing employee AOD use.

Rationale for Stigmatizing Workplace AOD Policies

Stigmatizing workplace policies are frequently justified by the need to "protect" businesses from the productivity losses and safety risks associated with AOD use [72]. There is a long history of maligning employees who use AOD. For instance, President Ronald Regan in his 1986 Executive Order creating a drug-free federal workplace stated: "*Federal employees who use illegal drugs, on or off duty, tend to be less productive, less reliable, and prone to greater absenteeism than their fellow employees who do not use illegal drugs*" [73].

AOD use by workers can have detrimental effects on occupational health and safety [62, 74–76]. Studies have found employee AOD use to be associated with workplace injuries [75], missing work, poor quality work, arriving late/leaving early, doing less work, arguing with colleagues [77], withdrawal behaviors [78], absenteeism [79, 80] and presenteeism [81]. Furthermore, productivity losses associated with AOD-related illness/injury, premature mortality, and absenteeism/presenteeism can place a substantial fiscal burden on businesses and the economy [82–87].

However, a number of other conditions or circumstances may also result in threats to productivity or occupational safety. These can include the following:

- Having young children (and the associated fatigue and carer's leave)
- Being overweight (more common than AOD dependence and associated with similar health concerns)
- Chronic health conditions (which may result in cognitive/physical impairments and substantial time off)
- Being older (associated with physical and cognitive health problems)
- Being young (lacking experience and judgment, increased risk taking, and corresponding potential for error) [88]

While some of these groups may experience stigmatization in the workplace and other settings [89–91], they are rarely the targets of formal, systemic discrimination embedded in policy. Indeed, in many countries or regions, legislation exists to protect the rights of such groups at work (e.g., [92, 93]). The degree of institutionalized workplace prejudice against individuals who use AOD or experience addiction therefore does not (solely) stem from potential productivity and safety risks. Rather, it reflects moral judgments about the behavior itself and the person/s engaging in those behaviors.

Organizations may also justify stigmatizing policies related to AOD use as an attempt to discourage employees from engaging in unhealthy/undesirable behaviors. This position is in line with "deterrence theory," which seeks to dissuade prohibited activities by making the cost of participating in them too high via "certain, swift, and severe" punishment [94]. It also draws on social control theory, which argues that "delinquent" behaviors can be prevented by strong bonds with aspects of traditional society (e.g., friends, family, religion, work) including monitoring, supervision, and directing behavior toward acceptable goals [95].

However, the vast majority of individuals who use AOD do so infrequently and do not experience significant AOD-related health problems, nor do the majority become addicted [96]. Indeed, it has been argued that most harms stem not from the drug use but from its illegal status and associated stigma. Stigmatizing policies can contribute to the exclusion of already vulnerable and marginalized individuals and

worsen health and social outcomes [10, 97]. Any potential health gains due to the deterrent effect of stigmatization may therefore be outweighed by the significant negative outcomes experienced by members of stigmatized groups [98]. Hence, organizational policies can actually cause further harm to the very employees to whom there is a duty to protect.

Addressing Workplace AOD Use

Workplace Policies

Most workplace responses to employee AOD use are underpinned by a formal policy. The way in which these policies are developed and implemented can influence the level of AOD use [99, 100] and also the extent of AOD-related stigmatization. If the focus of the policy is on the identification and punitive treatment of "problem AOD users," then stigmatization is likely to occur. By contrast, policies that emphasize methods for sensitively and appropriately approaching and dealing with employees affected by AOD use, as well as providing information on treatment or counseling services, are less likely to engender stigmatization.

Education and Training

The provision of regular and ongoing employee education plays a crucial role in changing attitudes and behaviors relating to AOD use. Good practice education programs extend beyond providing details of policy content and procedural awareness and include information about (1) AOD-related harm to health and safety in general and (2) how to gain access to counseling and treatment. Providing training for employees builds their capacity to appropriately identify and respond to workplace AOD use. Quality training has also been demonstrated to enhance supervision and management capability and skills in communicating with employees who may be experiencing AOD-related issues [101]. By placing

the focus of education and training initiatives on health, well-being, and nonpunitive approaches to AOD (rather than policy content and procedural awareness only), the potential for stigmatization is minimized.

Access to Counseling and Treatment

An important strategy for addressing employee AOD use is access to counseling and treatment services. This approach is less punitive than instant dismissal for policy breaches and therefore more likely to be accepted by employees; it is also less likely to result in stigmatization of AOD use.

Some employers provide counseling/treatment services via an employee assistance program (EAP) or pay for private services; others use community-based not-for-profit services. Regardless of service type utilized, it is important to ensure the service provider has appropriate and relevant skills and knowledge. While access to counseling and treatment may be compulsory when employees breach conditions of the policy, good practice necessitates that employees should also be able to access these services voluntarily. Employees should be assisted to locate and access these services and provided with paid or unpaid leave to attend. Confidentiality must also be assured.

Drug Testing

Workplace drug testing is increasingly commonplace. However, despite its growing prevalence, research consistently finds that few conclusions can be definitively drawn regarding the efficacy of testing due to the poor quality of the evidence base [102, 103]. Furthermore, research indicates that testing may result in unintended negative consequences for workplace safety and productivity [103]. If not implemented and managed correctly, workplace testing may also contribute to the stigmatization of AOD use, especially where a positive test for drug use results in punitive outcomes such as dismissal or the refusal of a job offer. In the case of false posi-

tive results, this stigmatization may also extend to employees who do not use AOD. Drug testing may also result in a displacement effect, whereby more dangerous and harmful drugs are consumed because they are less detectable.

A "Whole-of-Workplace" Approach

Traditional responses to AOD-related harm in the workplace have generally focused on the identification and treatment of employees with a perceived alcohol or drug "problem." This approach is inherently limited and likely to contribute to the stigmatization of AOD use as it focuses on the small number of "problem users," without acknowledging the much larger numbers of employees who engage in AOD use only occasionally [68].

A more constructive response that is likely to minimize stigmatization is a broader primary prevention "whole of workplace" approach [104]. The whole of workplace approach recognizes AOD use as a wider workforce wellbeing issue that can affect any employee rather than a "problem" that resides within a minority of individual employees. As this approach to workplace AOD use focuses on all employees, it is not only likely to be more effective than the traditional individualistic approach; it is also likely to minimize stigmatization by discouraging the "othering" of employees who use AOD and promoting inclusive (rather than discriminatory and punitive) methods of addressing AOD use.

Key elements of a whole of workplace approach to addressing AOD use include the following:

- *Education and training programs* include AOD policy content and procedure awareness, as well as information on the individual, social, and workplace factors that contribute to AOD use and related harms. In addition, policy breaches should result in access to counseling and treatment services in the first instance, with disciplinary action as a last resort.
- *Workplace health promotion programs* have a long history and have generally been effective in improving employee wellbeing and productivity [105]. Embedding responses to

workplace AOD use within a wider health promotion program has demonstrated effectiveness [106] and minimizes stigmatization by treating AOD use as a health issue (rather than as a personal failing). As health promotion programs are framed in terms of general wellbeing, they also avoid AOD-related stigma, which may otherwise result in employees not attending AOD-specific programs [107].

- *Peer intervention* involves use of peers as agents of change. Its effectiveness has been demonstrated in addressing a wide range of social and health-related behaviors [108]. Applied to the workplace, peer interventions are based on the premise that suitably trained coworkers are best placed to recognize and respond to employees with alcohol or drug problems. This approach is also likely to minimize stigma as it involves colleagues with preexisting relationships assisting each other as equals, which can circumvent categorizing people who use AOD as "other" and "flawed."
- *Psychosocial skills training* involves a range of techniques including motivational interviewing, cognitive behavior therapy, problem solving, goal setting, social skills training, contingency management, and coping strategies. Evaluations of workplace psychosocial skills training indicate that it can reduce AOD use and related problems [109]. It is also likely to reduce stigmatization as it educates workers about the underlying causes of AOD use, which can help to counter negative assumptions about people who use AOD.

Reducing AOD-Related Stigma at Work

Benefits of Reducing Stigma

There are a number of practical strategies that can be undertaken to prevent and reduce the stigmatization of individuals who use AOD at work. The workplace is an ideal setting in

which to implement antistigma initiatives as it offers opportunities for close interpersonal contact and team situations requiring cooperation, both of which can promote the deconstruction of stigmatizing attitudes [25]. Interventions implemented within the workplace can also have cumulative effects: as AOD-related stigma decreases, individuals who use AOD become more willing and likely to disclose their use in the workplace. This can encourage coworkers and managers to revisit and revise assumptions they may hold about people who use AOD, further reducing stigma.

An obvious benefit of antistigma strategies is decreased workplace discrimination against individuals who use AOD. Such initiatives therefore have the potential to improve employment rates among this population. This is important for a number of reasons.

Employment bestows a number of practical benefits, many of which have particular importance for individuals who have, or are recovering from, AOD-related problems. Foremost among these is economic security, which is central to protecting individuals against AOD-related harms (i.e., by ensuring adequacy housing, nutrition, healthcare, etc.) [5]. It also reduces unstructured leisure time; provides meaning, routine, and opportunities for socialization; builds skills (and consequently self-worth); and is integral in defining social identity and social class [35, 97, 110]. Gaining employment is often cited as a priority by individuals in treatment for substance use and has been associated with positive treatment outcomes [28, 97, 111–113].

Reducing AOD-related stigma at work can also have positive consequences for other facets of life. For example, increased employment opportunities improve financial security, which in turn enables fuller social participation and access to other valued social roles such as parenting. It can also help break the nexus between AOD use and poverty and/or criminality and allows more people to participate in the workforce and contribute to society and the economy [25]. Reducing AOD-related stigma in the context of the workplace can thus have wide-reaching positive outcomes at both the micro and the macro levels.

Despite their potential, relatively little research has examined workplace-based programs to reduce AOD-related stigma. However, mental health stigma has been more widely studied, with several workplace programs showing positive results [114]. Elements of these programs have potential for adaption and application to AOD-related stigma. The following sections summarize the available literature in this area.

Strategies to Reduce Stigma

Information and Education

As noted above, some stigmatizing attitudes about people who use AOD are predicated on misunderstandings and incorrect beliefs about AOD and the attributes of those who use AOD. The provision of factual information can assist in breaking down the negative assumptions underpinning stigma. Similarly, educating employers and employees regarding AOD, discrimination, and how to appropriately and sensitively work with people who use AOD is an important step in combating stigma [5, 29]. Employees who use AOD also need to be aware of their rights and how to access support if required [5].

However, while important, educational initiatives alone are unlikely to effectively reduce AOD-related stigma. Rather, such efforts need to be undertaken in concert with systemic strategies at the organizational and societal level [5]. Furthermore, some individuals hold deep-seated and entrenched negative beliefs about people who use AOD; education efforts alone are unlikely to be effective in reducing stigma in these cases.

Workplace Policies and Supports

The way in which AOD use is discussed, understood, and addressed at work can impact the attitudes and assumptions endorsed by employees. Therefore, it is important for workplaces to ensure that policies and procedures do not implic-

itly or explicitly condone stigmatizing or discriminatory behaviors. By contrast, documentation formalizing the organization's commitment to diversity and tolerance can be important and meaningful (as long as it is supported by concrete actions).

Individuals who use AOD are often reluctant to make formal complaints about experiencing discrimination. To combat this, robust safeguards are required that enable and support employees to make complaints (and ensure that such complaints are handled promptly and appropriately). Official policies are also required regarding (1) the need to keep discussions about staff members' AOD use (and any related issues such as treatment) strictly confidential and (2) the use of factual (rather than emotive/discriminatory) language in conversation and personnel files. Furthermore, where AOD use is apparent in preemployment screening, employers should consider whether or not it is relevant to the position in question (rather than automatically discounting the application) [5].

In addition, AOD-related issues can be legitimized by making the same allowances and provisions for workers with AOD-related problems as for staff with health conditions or challenging personal circumstances. For example:

- Providing flexible working arrangements to allow employees to seek treatment/attend medical appointments, etc.
- Allowing for reasonable adjustment of duties to accommodate the specific needs of individuals with AOD-related problems
- Instituting return-to-work programs for employees who have been out of work for a period of time due to AOD-related issues
- Providing a range of readily available and appropriate support options for dealing with AOD use (e.g., via employee assistance programs) and ensuring they are well-publicized and understood by employees [5]

However, care is required when implementing these strategies in order to avoid unintended consequences. For exam-

ple, providing additional support or alternative working arrangements for people who have AOD-related problems may provoke hostility if they are perceived as reducing the capacity of the work group or as preferential treatment [25].

Societal Strategies

As noted above, AOD-related stigma at work is inextricably intertwined with the stigmatizing attitudes, behaviors, and policies present in society at large. As such, wider strategies are required (in concert with workplace initiatives) to comprehensively address and eliminate AOD stigma at work.

At a broad level, governmental policy that promotes stringent drug-control policies in pursuit of prohibition is likely to engender serious harms, including (but not limited to) severe stigmatization [115]. A public health (rather than criminal justice) approach centered on harm minimization is likely to result in better outcomes for all facets of society, including in the workplace.

Related to this, antistigmatization strategies that focus on changing public perceptions of individuals who use AOD are vital. This includes challenging commonly held assumptions about AOD and people who use AOD, as well as promoting nonstigmatizing language (e.g., using "person-first language" and avoiding terms such as drug "abuse(r)," "addict," etc.) Such strategies will have direct flow-on effects for the workplace (e.g., if managers do not hold stigmatizing attitudes, they will be more likely to hire people with a history of AOD use) [25].

Given the difficulties that people who have AOD-related problems can face when attempting to find employment and the importance of paid work for these individuals, better pathways to support individuals who use AOD to find employment are also an imperative. People who are in treatment for AOD-related problems should be offered access to education, training, and employment services as part of standard discharge planning and posttreatment support [5].

Conclusion

AOD use is highly prevalent in the workforce in many countries and can in some contexts be associated with risks to productivity and safety. However, in contrast to widely held beliefs, most people who use AOD do so infrequently, do not experience significant problems as a result of their use, and are not addicted. The extent to which employees who use AOD are subject to stigmatization and discrimination varies according to many complex and interrelated factors, including personal characteristics, type and context of use, and wider attitudes toward AOD (and people who use them) in the workplace and society at large. Nevertheless, AOD-related stigma at work is ubiquitous, disproportionate, and profoundly harmful on many levels. Its effects range from overt discrimination in hiring practices to marginalization and exclusion from full participation in work life, and it represents a significant threat to wellbeing.

Polices to prevent, reduce, and manage AOD use at work are often necessary and important but if implemented poorly can facilitate and perpetuate AOD-related stigmatization. However, the "whole-of-workplace" approach holds potential for addressing workplace AOD use in an appropriate and nonstigmatizing manner. Dedicated strategies for reducing AOD-related stigma at work are also required and may include information and education, workplace policies and supports, and broader structural strategies. Effort should be directed toward applying such strategies as they will benefit not only individuals who use AOD but also their families, colleagues, and community, with wide-scale positive impacts on many levels.

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References

1. Broyles LM, Binswanger IA, Jenkins JA, et al. Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response. Subst Abus. 2014;35(3):217–21.
2. Substance Abuse and Mental Health Services Administration. Words matter: how language choice can reduce stigma. Rockville: Substance Abuse and Mental Health Services Administration; 2017.
3. Goffman E. Stigma: notes on the management of spoiled identity. Englewood Cliffs: Prentice Hall; 1963.
4. Crocker J, Major B, Steele C. Social stigma. In: Gilbert DT, Fiske ST, editors. The handbook of social psychology. Boston: McGraw-Hill; 1998.
5. Queensland Mental Health Commission. Changing attitudes, changing lives: options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use. Brisbane: Queensland Mental Health Commission; 2018.
6. Blair IV, Steiner JF, Havranek EP. Unconscious (implicit) bias and health disparities: where do we go from here? Perm J. 2011;15(2):71–8.
7. Kapur N. Unconscious bias harms patients and staff. Br Med J. 2015;351:h6347.
8. Alcohol and Drug Foundation. Stigma and vulnerability to AOD 2017. Available from: https://adf.org.au/insights/stigma-and-vulnerability/.
9. Room R, Rehm J, Trotter RT, et al. Cross-cultural views on stigma, valuation, parity and societal values towards disability. In: Ustun TB, Chatterji S, Bickenbach JE, Trotter RT, Room R, Rehm J, et al., editors. Disability and culture: universalism and diversity. Seattle: Hogrefe & Huber; 2001. p. 247–91.
10. Livingston JD, Milne T, Fang ML, Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. Addiction. 2012;107(1):39–50.
11. Room R. Stigma, social inequality and alcohol and drug use. Drug Alcohol Rev. 2005;24(2):143–55.
12. Thomas N, Bull M. Representations of women and drug use in policy: a critical policy analysis. Int J Drug Policy. 2018;56:30–9.

13. Government of Western Australia Department of Health. Stigma, discrimination, and mental illness. Perth: Government of Western Australia Department of Health; 2009.
14. Earnshaw V, Smith L, Copenhaver M. Drug addiction stigma in the context of methadone maintenance therapy: an investigation into understudied sources of stigma. Int J Ment Heal Addict. 2013;11(1):110–22.
15. Skinner N, Feather NT, Freeman T, Roche AM. Stigma and discrimination in health-care provision to drug users: the role of values, affect and deservingness judgments. J Appl Soc Psychol. 2007;37(1):163–86.
16. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics. 2017;18(1):19.
17. Gilchrist G, Moskalewicz J, Slezakova S, et al. Staff regard towards working with substance users: a European multi-centre study. Addiction. 2011;106(6):1114–25.
18. Roche AM, Lee NK, Battams S, et al. Alcohol use among workers in male-dominated industries: a systematic review of risk factors. Saf Sci. 2015;78:124–41.
19. Substance Abuse and Mental Health Services Administration. 2016 National survey on drug use and health dataset. Secondary analyses conducted by National Centre for Education and Training on Addiction (NCETA) Flinders University. 2018.
20. Australian Institute of Health and Welfare. 2016 National drug strategy household survey dataset. Secondary analyses conducted by National Centre for Education and Training on Addiction (NCETA) Flinders University. 2017.
21. Office for National Statistics. Adult drinking habits in Great Britain. London: Office for National Statistics; 2018.
22. Nielsen MB, Gjerstad J, Frone MR. Alcohol use and psychosocial stressors in the Norwegian workforce. Subst Use Misuse. 2018;53(4):574–84.
23. Lambrechts M-C, Vandersmissen L, Godderis L. Alcohol and other drugs among workers: prevalence and job related consequences. Occup Environ Med. 2017;74(Suppl 1):A58–A9.
24. Pidd K, Roche AM, Buisman-Pijlman F. Intoxicated workers: findings from a national Australian survey. Addiction. 2011;106(9):1623–33.
25. Krupa T, Kirsh B, Cockburn L, Gewurtz R. Understanding the stigma of mental illness in employment. Work. 2009;33(4):413–25.
26. Bowden K, Goodman D. Barriers to employment for drug dependent postpartum women. Work. 2015;50(3):425–31.

27. Sutton L, Cebulla A, Heaver C, Smith N. Drug and alcohol use as barriers to employment: a review of the literature. Loughborough: Loughborough University; 2004.
28. Bauld L, Templeton L, Silver K, et al. Pathways back to work for problem alcohol users. Policy Stud. 2013;34(3):360–76.
29. Batastini AB, Bolanos AD, Morgan RD, Mitchell SM. Bias in hiring applicants with mental illness and criminal justice involvement: a follow-up study with employers. Crim Justice Behav. 2017;44(6):777–95.
30. Corrigan PW, Tsang HWH, Shi K, et al. Chinese and American employers' perspectives regarding hiring people with behaviorally driven health conditions: the role of stigma. Soc Sci Med. 2010;71(12):2162–9.
31. UK Drug Policy Commission. Getting serious about stigma: the problem with stigmatising drug users. London: UK DPC; 2010.
32. Biegel DE, Stevenson LD, Beimers D, et al. Predictors of competitive employment among consumers with co-occurring mental and substance use disorders. Res Soc Work Pract. 2009;20(2):191–201.
33. Paljärvi T, Martikainen P, Pensola T, et al. Life course trajectories of labour market participation among young adults who experienced severe alcohol-related health outcomes: a retrospective cohort study. PLoS One. 2015;10(5):e0126215.
34. Tiikkaja S, Sandin S, Hultman CM, et al. Psychiatric disorder and work life: a longitudinal study of intra-generational social mobility. Int J Soc Psychiatry. 2015;62(2):156–66.
35. Laudet A. Rate and predictors of employment among formerly polysubstance dependent urban individuals in recovery. J Addict Dis. 2012;31(3):288–302.
36. Bray JW, Zarkin GA, Dennis ML, French MT. Symptoms of dependence, multiple substance use, and labor market outcomes. Am J Drug Alcohol Abuse. 2000;26(1):77–95.
37. Lancaster K, Seear K, Ritter A. Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use. Brisbane: Queensland Mental Health Commission; 2017.
38. Pokrajac T, Nolimal D, Leskovsek E. Stigma, drug addiction and treatment utilisation: PWUD perspective. J Drug Abuse. 2016;2(4):1–5.
39. Luoma JB, Twohig MP, Waltz T, et al. An investigation of stigma in individuals receiving treatment for substance abuse. Addict Behav. 2007;32(7):1331–46.

40. Gary FA. Stigma: barrier to mental health care among ethnic minorities. Issues Ment Health Nurs. 2005;26(10):979–99.
41. Hartwell S. Triple stigma: persons with mental illness and substance abuse problems in the criminal justice system. Crim Justice Policy Rev. 2004;15(1):84–99.
42. Mizock L. The double stigma of obesity and serious mental illnesses: promoting health and recovery. Psychiatr Rehabil J. 2012;35(6):466–9.
43. Fevre R, Robinson A, Lewis D, Jones T. The ill-treatment of employees with disabilities in British workplaces. Work Employ Soc. 2013;27(2):288–307.
44. McNiel DE, Binder RL, Robinson JC. Incarceration associated with homelessness, mental disorder, and co-occurring substance abuse. Psychiatr Serv. 2005;56(7):840–6.
45. Swartz JA, Lurigio AJ. Serious mental illness and arrest: the generalized mediating effect of substance use. Crime Delinq. 2007;53(4):581–604.
46. Stanley S, Cleland CM, Gerald M, et al. Violent offenses associated with co-occurring substance use and mental health problems: evidence from CJDATS. Behav Sci Law. 2009;27(1):51–69.
47. Tindal C, Cook K, Foster N. Theorising stigma and the experiences of injecting drug users in Australia. Aust J Prim Health. 2010;16(2):119–25.
48. Traci B. Skin color and the criminal justice system: beyond black-white disparities in sentencing. J Empir Leg Stud. 2015;12(3):395–420.
49. Brewer RM, Heitzeg NA. The racialization of crime and punishment: criminal justice, color-blind racism, and the political economy of the prison industrial complex. Am Behav Sci. 2008;51(5):625–44.
50. Hart CL. Viewing addiction as a brain disease promotes social injustice. Nat Hum Behav. 2017;1:0055.
51. Kulik CT, Bainbridge HTJ, Cregan C. Known by the company we keep: stigma-by-association effects in the workplace. Acad Manag Rev. 2008;33(1):216–30.
52. Eaton K, Ohan JL, Dear G. The stigmatisation of the provision of services for alcohol and other drug users: a systematic literature review. Drugs Educ Prev Policy. 2015;22(1):19–25.
53. Song H, Shin H, Kim Y. Perceived stigma of alcohol dependency: comparative influence on patients and family members. J Subst Abus. 2015;20(3):155–61.

54. Corrigan PW, Watson AC, Miller FE. Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. J Fam Psychol. 2006;20(2):239–46.
55. Buchanan J. Understanding problematic drug use: a medical matter or a social issue? Br J Community Just. 2006;4(2):387–97.
56. Auter Z. U.S. uninsured rate steady at 12.2% in fourth quarter of 2017. Washington, DC: Gallup; 2018.
57. Hoffman C, Paradise J. Health insurance and access to health care in the United States. Ann N Y Acad Sci. 2008;1136:149–60.
58. U.S. Department of Health and Human Services (HHS) Office of the Surgeon General. Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health. Washington, DC: HHS; 2016.
59. Frank RG, Beronio K, Glied SA. Behavioral health parity and the affordable care act. J Soc Work Disabil Rehabil. 2014;13(0):31–43.
60. Anya J, Helena N, Markus G, et al. Time to change: a review of organisational culture change in health care organisations. J Organ Effect People Perform. 2016;3(3):265–88.
61. Pidd K. Workplace culture and alcohol use. Of Subst. 2005;3(1):18–21.
62. Frone MR. Does a permissive workplace substance use climate affect employees who do not use alcohol and drugs at work? A U.S. national study. Psychol Addict Behav. 2009;23(2):386–90.
63. Bacharach SB, Bamberger P, Sonnenstuhl WJ. Driven to drink: managerial control, work-related risk factors, and employee problem drinking. Acad Manag J. 2002;45(4):637–58.
64. Biron M, Bamberger PA, Noyman T. Work-related risk factors and employee substance use: insights from a sample of Israeli blue-collar workers. J Occup Health Psychol. 2011;16(2):247–63.
65. Frone MR. Workplace substance use climate: prevalence and distribution in the U.S. workforce. J Subst Abus. 2012;71(1):72–83.
66. Frone MR. Work stress and alcohol use: developing and testing a biphasic self-medication model. Work Stress. 2016;30(4):374–94.
67. Frone MR. Predictors of overall and on-the-job substance use among young workers. J Occup Health Psychol. 2003;8(1):39–54.
68. Pidd K, Roche AM. Changing workplace cultures: an integrated model for the prevention and treatment of alcohol-related problems. In: Moore D, Dietze P, editors. Drugs and public health. Melbourne: Oxford; 2008. p. 49–59.

69. Macdonald S, Wells S, Wild TC. Occupational risk factors associated with alcohol and drug problems. Am J Drug Alcohol Abuse. 1999;25(2):351–69.
70. Ames GM, Grube JW, Moore RS. Social control and workplace drinking norms: a comparison of two organizational cultures. J Stud Alcohol. 2000;61(2):203–19.
71. Kirsh B, Gewurtz R. Organizational culture and work issues for individuals with mental health disabilities. In: Schultz IZ, Rogers ES, editors. Work accommodation and retention in mental health. New York: Springer New York; 2011. p. 393–408.
72. Foster WH, Vaughan RD. Absenteeism and business costs: does substance abuse matter? J Subst Abus Treat. 2005;28(1):27–33.
73. Executive Order No. 12,564 Drug-free Federal Workplace, 3 CFR 224 (1986).
74. Dong XS, Wang X, Largay JA. Occupational and non-occupational factors associated with work-related injuries among construction workers in the USA. Int J Occup Environ Health. 2015;21(2):142–50.
75. Spicer RS, Miller TR, Smith GS. Worker substance use, workplace problems and the risk of occupational injury: a matched case-control study. J Stud Alcohol. 2003;64(4):570–8.
76. Drugs and Crime Prevention Committee. Inquiry into strategies to reduce harmful alcohol consumption: final report. Melbourne: Drugs and Crime Prevention Committee; 2006.
77. Amick B, Bell N, Cote J, et al. Employee drinking practices and work performance. J Stud Alcohol. 1999;60:261–70.
78. Lehman WEK, Simpson DD. Employee substance use and on-the-job behaviors. J Appl Psychol. 1992;77(3):309–21.
79. Bass AR, Bharucha-Reid R, Delaplane-Harris K, et al. Employee drug use, demographic characteristics, work reactions, and absenteeism. J Occup Health Psychol. 1996;1(1):92–9.
80. Pidd KJ, Berry JG, Roche AM, Harrison JE. Estimating the cost of alcohol-related absenteeism in the Australian workforce: the importance of consumption patterns. Med J Aust. 2006;185(11–12):637–41.
81. de Graff R, Tuithof M, van Dorsselaer S, ten Have M. Comparing the effects on work performance of mental and physical disorders. Soc Psychiatry Psychiatr Epidemiol. 2012;47:1873–83.
82. Roche A, Pidd K, Kostadinov V. Alcohol- and drug-related absenteeism: a costly problem. Aust N Z J Public Health. 2015;40(3):236–8.

83. Schou L, Moan IS. Alcohol use–sickness absence association and the moderating role of gender and socioeconomic status: a literature review. Drug Alcohol Rev. 2016;35(2):158–69.
84. Bouchery EE, Harwood HJ, Sacks JJ, et al. Economic costs of excessive alcohol consumption in the U.S. Am J Prev Med. 2011;41(5):516–24.
85. Pidd K, Roche A, Kostadinov V. Workplace costs. In: Tait RJ, Allsop S, editors. The social costs of methamphetamine in Australia 2013/14. Perth: National Drug Research Institute, Curtin University; 2016.
86. Creating Preferred Futures. Social costs of smoking in Victoria 2015–16. Hobart: Creating Preferred Futures; 2018.
87. Nash R, Featherstone H. Cough up: balancing tobacco income and costs in society. London: Policy Exchange; 2010.
88. Moore AD. Drug testing and privacy in the workplace. J Comput Inf Law. 2012;29:463–92.
89. Ren LR, Paetzold RL, Colella A. A meta-analysis of experimental studies on the effects of disability on human resource judgments. Hum Resour Manag Rev. 2008;18(3):191–203.
90. Chou RJ-A, Choi NG. Prevalence and correlates of perceived workplace discrimination among older workers in the United States of America. Ageing Soc. 2011;31(6):1051–70.
91. Rudolph CW, Wells CL, Weller MD, Baltes BB. A meta-analysis of empirical studies of weight-based bias in the workplace. J Vocat Behav. 2009;74(1):1–10.
92. Employment Equity Act 1995 (CA), c 44.
93. Equality Act 2010 (UK), c 15.
94. Piquero AR, Paternoster R, Pogarsky G, Loughran T. Elaborating the individual difference component in deterrence theory. Annu Rev Law Soc Sci. 2011;7(1):335–60.
95. Moos RH. Active ingredients of substance use-focused self-help groups. Addiction. 2008;103(3):387–96.
96. Degenhardt L, Hall W. Extent of illicit drug use and dependence, and their contribution to the global burden of disease. Lancet. 2012;379(9810):55–70.
97. Laudet A, Magura S, Vogel H, Knight E. Interest in and obstacles to pursuing work among unemployed dually diagnosed individuals. Subst Use Misuse. 2002;37(2):145.
98. Ahern J, Stuber J, Galea S. Stigma, discrimination and the health of illicit drug users. Drug Alcohol Depend. 2007;88(2–3):188–96.

99. Pidd K, Kostadinov V, Roche AM. Do workplace policies work? An examination of the relationship between AOD policies and workers' substance use. Int J Drug Policy. 2016;28:48–54.
100. Pidd K, Roche AM. Workplace alcohol and other drug programs: what is good practice? Melbourne: Australian Drug Foundation; 2013.
101. Cameron J, Pidd K, Roche AM, et al. A co-produced cultural approach to workplace alcohol interventions: barriers and facilitators. Drugs Educ Prev Policy. 2018;2018:1–11.
102. Macdonald S, Hall W, Roman P, et al. Testing for cannabis in the work-place: a review of the evidence. Addiction. 2010;105(3):408–16.
103. Pidd K, Roche AM. How effective is drug testing as a workplace safety strategy? A systematic review of the evidence. Accid Anal Prev. 2014;71:154–65.
104. Pidd K, Roche AM, Cameron J, et al. Workplace alcohol harm reduction intervention in Australia: cluster non-randomised controlled trial. Drug Alcohol Rev. 2018;37(4):502–13.
105. Bergstrom G, Bjorklund C, Fried I, et al. A comprehensive workplace intervention and its outcome with regard to lifestyle, health and sick leave: the AHA study. Work. 2008;31(2):167–80.
106. Richmond R, Kehoe L, Heather N, Wodak A. Evaluation of a workplace brief intervention for excessive alcohol consumption: the workscreen project. Prev Med. 2000;30(1):51–63.
107. Cook R, Schlenger W. Prevention of substance abuse in the workplace: review of research on the delivery of services. J Prim Prev. 2002;23(1):115–42.
108. Rivera MS, Nangle DW. Peer intervention. In: Hersen M, Gross AM, editors. Handbook of clinical psychology. Hoboken: John Wiley & Sons, Inc.; 2008.
109. Bennett JB, Patterson CR, Reynolds GS, et al. Team awareness, problem drinking, and drinking climate: workplace social health promotion in a policy context. Am J Health Promot. 2004;19(2):103–13.
110. Batastini AB, Bolanos AD, Morgan RD. Attitudes toward hiring applicants with mental illness and criminal justice involvement: the impact of education and experience. Int J Law Psychiatry. 2014;37(5):524–33.
111. Sinakhone JK, Hunter BA, Jason LA. Good job, bad job: the employment experiences of women in recovery from substance abuse. Work. 2017;57(2):289–95.

112. Poremski D, Woodhall-Melnik J, Lemieux AJ, Stergiopoulos V. Persisting barriers to employment for recently housed adults with mental illness who were homeless. J Urban Health. 2016;93(1):96–108.
113. Walton MT, Hall MT. The effects of employment interventions on addiction treatment outcomes: a review of the literature. J Soc Work Pract Addict. 2016;16(4):358–84.
114. Hanisch SE, Twomey CD, Szeto ACH, et al. The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. BMC Psychiatry. 2016;16(1):1.
115. Csete J, Kamarulzaman A, Kazatchkine M, et al. Public health and international drug policy. Lancet. 2016;387(10026):1427–80.

Chapter 11
Stigma of Addiction in the Media

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Introduction

Most Americans get information about health issues from the news media [3], and large bodies of communication, social psychology, and political science research have shown that news media coverage can influence audiences' attitudes toward the individuals experiencing those issues [5, 20, 38]. While the majority of research to date has focused on the news media, content disseminated to audiences through other types of media, such as entertainment media, social media, and public information campaigns, can also influence public attitudes about health issues. In this chapter, we first discuss the media's role in shaping stigmatizing attitudes toward populations experiencing health problems like addiction. We then summarize what is known about depictions of addiction in the media and draw upon communication

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research and theory to consider how such coverage may influence the public's pervasive stigmatizing attitudes toward people experiencing addiction.

Media Effects on Stigma

The two primary ways in which media content influences public attitudes about health issues like addiction are agenda setting and framing [38]. The evidence surrounding these media effects and the implications for addiction stigma are discussed below.

Agenda Setting

Agenda setting is the idea that topics receiving high levels of attention in the media are likely to be perceived by the public as priorities for intervention [38]. Research shows that in the USA, illicit drugs have typically received more news media coverage than alcohol and tobacco, which parallels the public's perception that illicit drug use is a pressing societal problem [11, 14]. It also parallels the US public's stigmatizing attitudes, which are greater toward people who use illicit drugs than those who use alcohol and tobacco [25, 35].

Agenda setting can influence stigma by focusing audiences' attention on topics likely to generate—or mitigate—stigma toward certain populations. For example, an analysis of US newspaper coverage from 2001 to 2011, a period encompassing the early years of the ongoing opioid epidemic, found that newspapers predominantly covered opioid issues in white, rural, and suburban communities [30]. Given that this population—unlike the urban minority populations that were the subject of news media coverage in prior drug epidemics [17, 21]—has historically been positively constructed and viewed as deserving by the US public [39], the authors posited that the opioid epidemic entered the public agenda as a white nonurban opioid epidemic, which might

have limited or reduced audiences' stigmatizing attitudes toward opioid users [30].

Framing

Framing is the idea that emphasizing certain aspects of an issue over others can influence how the public views that issue [5, 38]. While very limited research has examined framing effects in the context of addiction, a broader body of framing research on other health and social issues points to key types of media frames that are likely relevant for addiction stigma (Table 11.1). Only two studies have examined how framing influences audiences' stigmatizing attitudes toward people with addiction specifically [23, 27]. Experimental work testing how different types of message frames affect addiction stigma, with particular focus on identifying stigma-reducing frames, should be a priority for future research.

Table 11.1 Types of media frames shown to influence stigma

Media frame	**Examples in the addiction context**
Individual depiction: a description of a specific individual experiencing a health or social issue	Examples include but are not limited to media depictions of people experiencing addiction as criminals, racial/ethnic minorities, glamorous, violent, engaging in treatment, or in recovery
Causal frame: a media message that directly states or implies the cause of the problem of interest	People who become addicted to drugs have made poor choices. Addiction is a disease
Consequence frame: a media message that emphasizes a certain consequence of the problem of interest over others	The drug epidemic fueled a wave of violent crime. The drug epidemic left a generation of children without their parents, who were incarcerated for drug crimes

Media depictions of individuals with a given health issue, in this case addiction, can have powerful effects on audiences' stigma toward these individuals. To help engage audiences, news stories about health issues frequently include one or more "individual depictions," or descriptions of specific individuals experiencing the health issue of interest. Individual depictions are also the primary way in which health issues are broached in entertainment media, i.e., through portrayal of a character experiencing a given issue. While shown to increase audience engagement and emotional response to media content [12, 29], these individual depictions can also increase stigma. Research shows that relative to broad, general descriptions of health issues (e.g., of the type provided in documentaries or long-format, investigative print journalism), individual depictions can increase stigma by leading audiences to blame the affected individuals—as opposed to societal factors—for the problem they are experiencing [19, 20].

This individual-attribution issue can potentially be overcome by use of narratives, which can blend individual depictions with contextual information about the structural factors influencing the problem at hand [12, 32, 33]. One experimental study found that a short text narrative that included both an individual depiction of a pregnant woman with opioid use disorder and a description of the external barriers to treatment that she faced, such as a long waiting list for methadone treatment, increased audiences' feelings of sympathy and pity for the woman relative to a control arm and a narrative describing the same woman without discussing barriers to treatment [23]. Importantly, the ability of narratives to reduce addiction stigma likely depends heavily on the contextual content's ability to lead audiences to attribute blame for addiction to factors outside of the depicted individual's control and beyond the individual's personal characteristics. In the same study referenced above, the authors tested versions of the narrative depicting the pregnant woman as having high versus low socioeconomic status. Relative to those who read the version portraying a woman with low socioeconomic sta-

tus, respondents who read the high socioeconomic status narrative reported lower stigmatizing attitudes toward people with opioid use disorder and were less likely to blame people with prescription opioid use disorders for their condition [23].

The characteristics of an individual depicted as experiencing a health issue in media content can have powerful effects on public attitudes: research shows that audiences exposed to a depiction of a specific individual experiencing a health or social issue tend to generalize that individual's traits to the entire population affected by the issue, even if the individual depicted is atypical [45]. In a seminal experiment demonstrating this phenomenon, Ruth Hamill and colleagues found that relative to a control group, respondents who read a description of an irresponsible welfare recipient were more likely to believe that all welfare recipients are likely to be irresponsible, even when given corrective factual information noting that most welfare recipients use the resources provided in a responsible manner [15]. This body of research suggests that media depictions of people with addiction emphasizing negative traits, such as weak moral character or propensity for violence, may increase stigma; media depictions emphasizing positive traits, such as perseverance and determination in the face of adversity and/or successful recovery, may decrease stigma. One experimental study found that relative to portrayals of individuals with untreated, symptomatic prescription opioid and heroin use disorder, depictions of the same individuals as engaged in treatment and having well-controlled symptoms reduced stigmatizing attitudes toward people with drug addiction among a nationally representative sample of Americans [27].

Media messages framing the causes of health issues like addiction can increase stigma by attributing responsibility for the problem to factors under an individual's control, like morality or individual choices; messages attributing responsibility for the problem to factors outside of affected individuals' control, like neurobiology or an injury resulting in treatment with prescribed opioids, can decrease stigma [7, 43, 44]. Media messages about the consequences of health

issues can also influence public attitudes. One experimental study tested messages framing the consequences of childhood obesity and found that relative to a control arm, messages emphasizing obesity's detrimental effects on military readiness made conservatives less likely to blame parents and children for the problem and more likely to attribute responsibility to societal actors like the government and the food industry [13]. To our knowledge, no experimental studies have tested how media content emphasizing different causes or consequences of addiction influence stigma.

Addiction Stigma in the Media

In this section, we consider how the three types of media frames discussed above—individual depiction, causal, and consequence frames—manifest in media content about addiction that has implications for stigma. As noted previously, the majority of research discussed in this chapter has focused on the news media, though we discuss several studies of entertainment media. To the best of our knowledge, no studies have examined addiction stigma in social media content. We discuss research on both US and international media.

Media Depictions of People with Addiction

Research suggests that news media depictions of people with addiction, particularly drug addiction, are predominantly negative. A study of US print and television news media coverage of opioid analgesic misuse during 1998–2012 found that over 80% of the news stories sampled depicted a specific individual and that 66% of those depictions showed an individual engaged in criminal activity [28]. In contrast, only 36% of the individual depictions showed a person receiving any type of treatment for opioid use disorder. Studies of US news media coverage of cocaine in the 1980s and 1990s found that people using cocaine were disproportionately depicted as

urban and African American [17, 21]. Racial bias has also been documented in more recent news media coverage of the ongoing US opioid epidemic. An analysis of 100 US popular press articles from 2000 and 2001 describing heroin and prescription opioid users found that the news media tended to depict urban black and Latino heroin injectors as criminals while portraying suburban white prescription opioid users as blameless victims [30]. Similar negative depictions were documented in a study of Australian print news media coverage of heroin during 1992–1997, which found that heroin users were often framed as criminals and threats to society [10].

Fewer studies have examined media depictions of individuals with alcohol or tobacco addiction. Studies of US and Australian news media content have documented negative media portrayals of mothers with alcohol dependence who give birth to babies with fetal alcohol syndrome [6, 9], though the Australian study found a mix of sympathetic and stigmatizing depictions of such mothers [9]. A study of Australian television news content found that nonsmokers with lung cancer were portrayed as deserving of audiences' sympathy, while smokers with lung cancer were depicted as responsible for their disease [26].

News media depictions of celebrities with addiction issues have been shown to be more positive than depictions of noncelebrities, raising concerns about the glamorization of substance use [8, 40]; similar concerns have been raised about glamorous depictions of substance use in entertainment media, which research suggests can increase substance use initiation among the youth [16, 37]. Overall, entertainment media depictions of substance use are less negative than the majority of individual depictions in the news media. A review of such depictions in 57 US and international films produced between 1906 and 2001 identified four common stereotypes of alcohol and drug users: the tragic hero, the demonized user, the rebellious free spirit, and the comedic user [4]. Of these, only the demonized user depiction framed people who use substances in an explicitly negative light, emphasizing their unpredictability and violence.

Media Framing of the Causes of Addiction

The study of US news media coverage of opioid analgesic misuse during 1998–2012, referenced previously, found that illicit drug dealing by doctors, patients, or others was the most frequently mentioned cause—mentioned in 57% of news stories—of increasing rates of prescription opioid misuse and addiction [28]. The implications of this causal frame for stigma are unclear, though it is possible that it may increase stigma by implying to audiences that individuals are at fault for making the decision to buy or sell prescription opioids illegally. The second most frequently mentioned cause of opioid analgesic misuse (in 45% of news stories) was overprescribing of opioids by physicians, a potentially stigma-reducing frame that shifts the onus of addiction from affected individuals to physicians. In the study of Australian print news coverage of heroin during 1992–1997, heroin use was framed as an individual choice requiring punishment [10]. In the study of Australian television news portrayals of people with lung cancer, those who smoked tobacco were framed as responsible for their own disease [26]. Therefore, to date, research suggests that most causal frames in the media have emphasized individual culpability in explaining addiction.

Media Framing of the Consequences of Addiction

In the study of US news media coverage of opioid analgesic misuse during 1998–2012, health-related consequences of misuse, including addiction and overdose, were mentioned in 94% percent of news stories [28]. Trouble with the law was the second most frequently mentioned consequence, though it appeared in far fewer (35%) news stories. No experimental research has tested these frames on stigmatizing attitudes, but communication theory suggests that "trouble with the law" consequence framing, which implicitly frames people with addiction as criminals, is more likely to elevate stigma than health consequence framing. Studies have also shown that

news coverage of the US War on Drugs emphasize punishment through the criminal justice system as the logical consequence of drug addiction [17, 21]. Similarly, a study of Australian newspaper coverage of illicit drug issues during 2003–2008 found that coverage predominantly depicted law enforcement or criminal justice action [18]. An analysis of coverage of alcohol-related issues in British newspapers and television news programs during 2009 found that news reporting emphasized negative consequences of alcohol use, predominantly drunk-driving and long-term health impacts, specifically liver disease [31]. Analysis of the reality television show *Intervention* found an emphasis on negative consequences of addiction, including debt and failed social relationships [24]. These studies demonstrate that the media has presented addiction using a variety of consequence frames, with some highlighting the criminal justice consequences of drug consumption in societies in which certain drugs have been criminalized, while other media have focused on the consequences for the health and well-being of the affected population.

Reducing Addiction Stigma in the Media

Stigmatizing media frames of addiction are common, particularly in the news media. This suggests an urgent need for reporting guidelines and training for reporters covering substance use and addiction. Several promising efforts are underway. The Associated Press (AP) created guidance on reporting about drug issues in the 2017 AP Stylebook [2]. The US Office of National Drug Control Policy provided guidance on destigmatizing the language of addiction, e.g., avoiding stigmatizing terms like "substance abuser" and "addict" and instead using person-centered language, e.g., "person with a drug use disorder" [34]. Experimental studies have shown that the terms "substance abuser," "alcoholic," and "addict" elicit stigmatizing attitudes from audiences [1, 22]. While no studies have systematically examined the use of stigmatizing

language about addiction in media content, based on our team's experience analyzing news media coverage of addiction issues, such language is very common. Training for journalists, editors, and producers on strategies for avoiding stigmatizing language and media frames, as well as education on addiction more generally, is also critical. The Carter Center and the Poynter Institute both deliver training and disseminate educational materials related to addiction reporting [36, 41, 42].

Critically, more research is also needed. As noted previously, only two experimental studies have tested the effects of media frames on addiction stigma [23, 27]. More research is needed to fully understand the effects of commonly used media frames on public attitudes toward people with addiction issues and, perhaps more importantly, to develop destigmatizing frames. Such frames could be disseminated to journalists through media training, as well as used in public-stigma-reduction communication campaigns.

Conclusion

The limited available research suggests that the news media often depicts individuals experiencing addiction, especially drug addiction, in a negative light. Given that the news media is a key source of information about health issues for many Americans, such depictions likely contribute to widespread stigmatizing attitudes toward this population. The relatively small body of research on media depictions of addiction suggests that the entertainment media has portrayed people with addiction on balance more positively and with greater nuance than has the news media, though stigmatizing depictions, particularly depictions of people with addiction as violent, are also evident in films. Very limited experimental research suggests that narratives that combine sympathetic individual depictions of people with addiction issues with messages about societal barriers to treatment, such as provider shortages, may reduce stigmatiz-

ing attitudes. Media depictions of individuals who have undergone successful addiction treatment and are in recovery may also reduce stigma. More experimental research is needed to better understand how common media frames of addiction influence stigma, and research is needed to identify destigmatizing frames. To reduce addiction stigma in the media, journalists and other media producers should receive education regarding the various facets of their work that impact addiction stigma, including how media frames influence public perception and the importance of using nonstigmatizing language.

References

1. Ashford RD, Brown AM, Curtis B. Substance use, recovery, and linguistics: the impact of word choice on explicit and implicit bias. Drug Alcohol Depend. 2018;189:131.
2. Associated Press. The Associated Press stylebook. 2017. https://store.stylebooks.com/apstylebookonline.html. Accessed 26 Jan 2018.
3. Brodie M, Hamel EC, Altman DE, Blendon RJ, Benson JM. Health News and the American Public, 1996–2002. J Health Polit Policy Law. 2003;28(5):927–50.
4. Cape GS. Addiction, stigma and movies. Acta Psychiatr Scand. 2003;107(3):163–9.
5. Chong D, Druckman JN. Framing theory. Annu Rev Polit Sci. 2007;10(1):103–26.
6. Connolly-Ahern C, Broadway SC. "To booze or not to booze?" newspaper coverage of fetal alcohol spectrum disorders. Sci Commun. 2008;29(3):362–85.
7. Corrigan P, Markowitz FE, Watson A, Rowan D, Kubiak MA. An attribution model of public discrimination towards persons with mental illness. J Health Soc Behav. 2003;44:162–79.
8. Denham BE. Folk devils, news icons and the construction of moral panics: heroin chic and the amplification of drug threats in contemporary society. Journal Stud. 2008;9(6):945–61.
9. Eguiagaray I, Scholz B, Giorgi C. Sympathy, shame, and few solutions: news media portrayals of fetal alcohol spectrum disorders. Midwifery. 2016;40:49–54.

10. Elliott AJ, Chapman S. 'Heroin hell their own making': construction of heroin users in the Australian press 1992–97. Drug Alcohol Rev. 2000;19(2):191–201.
11. Fan DP. News media framing sets public opinion that drugs is the country's most important problem. Subst Use Misuse. 1996;31(10):1413–21.
12. Frank LB, Murphy ST, Chatterjee JS, Moran MB, Baezconde-Garbanati L. Telling stories, saving lives: creating narrative health messages. Health Commun. 2015;30(2):154–63.
13. Gollust SE, Niederdeppe J, Barry CL. Framing the consequences of childhood obesity to increase public support for obesity prevention policy. Am J Public Health. 2013;103(11):e96–e102.
14. Gonzenbach W. A time-series analysis of the drug issue, 1985-1990: the press, the president, and Public Opinion. Int J Public Opin Res. 1992;4(2):126–47.
15. Hamill R, Wilson T, Nisbett R. Insensitivity to sample bias: generalizing from atypical cases. J Pers Soc Psychol. 1980;39:578–89.
16. Hanewinkel R, Sargent JD. Longitudinal study of exposure to entertainment media and alcohol use among German adolescents. Pediatrics. 2009;123(3):989–95.
17. Hartman DM, Golub A. The social construction of the crack epidemic in the print media. J Psychoactive Drugs. 1999;31(4):423–33.
18. Hughes CE, Lancaster K, Spicer B. How do Australian news media depict illicit drug issues? An analysis of print media reporting across and between illicit drugs, 2003–2008. Int J Drug Policy. 2011;22(4):285–91.
19. Iyengar S. Framing responsibility for political issues: the case of poverty. Polit Behav. 1990;12(1):19–40.
20. Iyengar S. Framing responsibility for political issues. Ann Am Acad Pol Soc Sci. 1996;546:59–70.
21. Jernigan D, Dorfman L. Visualizing America's drug problems: an ethnographic content analysis of illegal drug stories on the nightly news. Contemp Drug Probl. 1996;23(2):169–96.
22. Kelly JF, Westerhoff CM. Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. Int J Drug Policy. 2010;21(3):202–7.
23. Kennedy-Hendricks A, McGinty EE, Barry CL. Effects of competing narratives on public perceptions of opioid pain reliever addiction during pregnancy. J Health Polit Policy Law. 2016; https://doi.org/10.1215/03616878-3632230.
24. Kosovski JR, Smith DC. Everybody hurts: addiction, drama, and the family in the reality television show intervention. Subst Use Misuse. 2011;46(7):852–8.

25. Link B, Phelan JC, Bresnaham M, Stueve A, Pescosolido BA. Public conceptions of mental illness: labels, causes, dangerousness, and social distance. Am J Public Health. 1999;89(9):1328–33.
26. MacKenzie R, Chapman S, Holding S. Framing responsibility: coverage of lung cancer among smokers and non-smokers in Australian television news. Aust N Z J Public Health. 2011;35(1):66–70.
27. McGinty E, Goldman H, Pescosolido B, Barry C. Portraying mental illness and drug addiction as treatable health conditions: effects of a randomized experiment on stigma and discrimination. Soc Sci Med. 2015;126:73–85.
28. McGinty EE, Kennedy-Hendricks A, Baller J, Niederdeppe J, Gollust S, Barry CL. Criminal activity or treatable health condition? News media framing of opioid analgesic abuse in the United States, 1998–2012. Psychiatr Serv. 2015;67(4):405–11.
29. Murphy ST, Frank LB, Chatterjee JS, Baezconde-Garbanati L. Narrative versus nonnarrative: the role of identification, transportation, and emotion in reducing health disparities. J Commun. 2013;63(1):116–37.
30. Netherland J, Hansen HB. The war on drugs that wasn't: wasted whiteness,"Dirty Doctors," and race in media coverage of prescription opioid misuse. Cult Med Psychiatry. 2016;40(4):664–86.
31. Nicholls J. UK news reporting of alcohol: an analysis of television and newspaper coverage. Drugs Edu Prev Policy. 2011;18(3):200–6.
32. Niederdeppe J, Heley K, Barry CL. Inoculation and narrative strategies in competitive framing of three health policy issues. J Commun. 2015;65(5):838–62.
33. Niederdeppe J, Shapiro MA, Kim HK, Bartolo D, Porticella N. Narrative persuasion, causality, complex integration, and support for obesity policy. Health Commun. 2014;29(5):431–44.
34. Office of National Drug Control Policy. Changing the language of addiction. 2017. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Memo%20-%20Changing%20Federal%20Terminology%20Regrading%20Substance%20Use%20and%20Substance%20Use%20Disorders.pdf. Accessed 26 Jan 2018.
35. Phillips LA, Shaw A. Substance use more stigmatized than smoking and obesity. J Subst Abus. 2013;18(4):247–53.
36. Poynter Institute. Covering the opioid crisis. 2017. https://www.poynter.org/news/how-address-challenges-covering-opioid-epidemic. Accessed 11 July 2018.

37. Sargent JD, Beach ML, Adachi-Mejia AM, Gibson JJ, Titus-Ernstoff LT, Carusi CP, Swain SD, Heatherton TF, Dalton MA. Exposure to movie smoking: its relation to smoking initiation among US adolescents. Pediatrics. 2005;116(5):1183–91.
38. Scheufele DA, Tewksbury D. Framing, agenda setting, and priming: the evolution of three media effects models. J Commun. 2007;57(1):9–20.
39. Schneider A, Ingram H. Social construction of target populations: implications for politics and policy. Am Polit Sci Rev. 1993;87(2):334.
40. Smith KC, Twum D, Gielen AC. Media coverage of celebrity DUIs: teachable moments or problematic social modeling? Alcohol & alcoholism. 2009;44(3):256–60.
41. The Carter Center. Carter Center releases national journalism guide for reporting on behavioral health. 2015. https://www.cartercenter.org/news/pr/journalism-guide-behavioral-health-reporting.html. Accessed 18 Mar 2017.
42. The Carter Center (2017). The Rosalynn Carter Fellowships for Mental Health Journalism. https://www.cartercenter.org/health/mental_health/fellowships/, Accessed March 18, 2017.
43. Weiner B. On sin versus sickness: a theory of perceived responsibility and social motivation. Am Psychol. 1993;48(9):957.
44. Weiner B, Perry RP, Magnusson J. An attributional analysis of reactions to stigmas. J Pers Soc Psychol. 1988;55(5):738.
45. Zillman D, Brosius H. Exemplification in communication: the influence of case reports on the perception of issues. London: Lawrence Earlbaum Associates; 2000.

Index

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