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Abstract	`Stereotypes and judgments about people with substance misuse problems are extremely prevalent and negative. These negative evaluations are made not only by those who abstain from substance use, termed public stigma, but also by those who themselves use and abuse substances, termed self-stigma. While the exact form of discrimination may vary across different substances and social groups, research indicates that substance misuse appears to be at least as stigmatized as psychological disorders such as depression, schizophrenia, or borderline personality disorder. As used conventionally, stigma refers to an attribute or characteristic of an individual that identifies him or her as different in some manner from a normative standard and marks that individual to be socially sanctioned and devalued. This chapter outlines theories of stigma in relation to addiction. Types and levels of stigma are described, including structural versus individual stigma and public versus self-stigma. It is argued that stigma is a complex phenomenon that needs to be studied in context as its effects may vary across levels of analysis and across populations. Also outlined is the existing scientific literature on the impact of self-stigma, the role of stigma in the social networks of those with addiction, and the impact of stigma in treatment settings. Finally, interventions to reduce stigma are described and data on effectiveness are reviewed. Research on stigma in addiction is sparse, and much more research is needed to improve the effectiveness of these interventions.

Keywords (separated by '-')	Stigma - Shame - Addiction - Substance use disorder

Substance Use Stigma as a Barrier to Treatment and Recovery

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Contents

Introduction . . . . . .
What Is Stigma? . . . . . .
Stigma Depends on Basic Verbal/Cognitive Processes . . . . . .
Stigmatizing Thoughts are Resistant to Change
Stigma Is Sustained Through Cultural Practices
Types and Levels of Stigma Toward Substance Abuse . . . . . .
The Need to Study Stigma in Context . . . . . .
The Impact of Stigma on Individuals with Substance Abuse Problems . . . . . .
Self-Stigma . . . . . .
Stigmatizing Attitudes and Behavior of Friends and Family . . . . . .
Stigma in Treatment Settings . . . . . .
Stigma as a Barrier to Initial Treatment Engagement . . . . . .
Stigma and Treatment Retention and Outcome .
Stigmatizing Attitudes and Behavior of Professional Staff . . . . . .
Interventions to Reduce Stigma . . . . . .
Reducing Public Stigma . . . . . .
Reducing Stigma in the Health Care System . .
Empowering Those in Recovery . . . . . .
Stigma and the Emotion of Shame . . . . . .
Conclusions . . . . . .
References . . . . . .

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Introduction

Stereotypes and judgments about people with substance misuse problems are extremely prevalent and negative [15, 18, 22, 74]. The content of these stereotypes varies, with examples including "people who use drugs are immoral," "alcoholics are unreliable," or "addicts are dangerous." These negative evaluations are held not only by those who abstain from substance use, but also by those who themselves use and abuse substances. As the criminalization of drug use has increased over recent decades in the United States, the level of negative attitudes toward drug use has also increased [10].

While the exact form of these stereotypes and judgments may vary across different substances and social groups, substance misuse appears to be at least as stigmatized as psychological disorders such as depression, schizophrenia, or borderline personality disorder, if not more so [15, 18, 22, 74]. While the data are quite clear about the prevalence and negativity of stigmatizing attitudes, research to date on the links between these attitudes and subsequent negative outcomes for those with substance addiction is relatively sparse. As the body of data on stigma toward the mentally ill is much broader and deeper, especially for psychotic disorders, this chapter depends somewhat on extrapolation from mental illness stigma, to substance abuse stigma.

A review of sociological and historical analyses of factors that have contributed to the stigma

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of substance abuse is beyond the scope of this chapter. Other authors (e.g., [106]) have provided excellent narratives on such topics as the history of legal policy toward substance use and how larger values systems such as Puritanism contribute to stigmatization. Instead, this chapter will focus on the nature of stigma and its impact on those with substance abuse problems through review of scientific research and theory. We also will discuss implications for interventions regarding stigma, particularly in the context of the substance abuse treatment system. The chapter begins with a short review on the nature of stigma in general, followed by a focus on stigma as directed toward those using or abusing substances.

What Is Stigma?

As with most other common language terms that have been adopted by the social sciences, the concept of stigma has been difficult to narrow to a single definition. As used conventionally, stigma refers to an attribute or characteristic of an individual that identifies him or her as different in some manner from a normative standard and marks that individual to be socially sanctioned and devalued. One of the most widely cited definitions of stigma comes from Goffman [39], who saw stigma as an "attribute that is deeply discrediting". This attribute impacts the perceiver's global evaluation of the person, reducing him or her "from a whole and usual person to a tainted, discounted one" (p. 3). Another influential definition comes from Jones et al. [57] who suggested that a stigmatized person is "marked" as having a condition considered deviant by a society. Through an attributional process, this mark is linked to undesirable characteristics that discredit the person in the minds of others. Perhaps one of the most comprehensive definitions of stigma comes from the work of Link and Phelan [73], who define stigma as occurring when the following processes converge: (1) people distinguish and label human differences; (2) dominant cultural beliefs link labeled persons to undesirable characteristics that form a stereotype; (3) labeled persons are seen as an outgroup, as "them" and not "us"; (4) labeled persons experience status loss and discrimination that lead to unequal outcomes; and (5) this process occurs in a context of unequal power distribution, where one group has access to resources that the other group desires.

Stigma Depends on Basic Verbal/Cognitive Processes

Stigma is always in the eye of the beholder. At a psychological level of analysis, all the above definitions hinge on the role of the cognitive and emotional responses of the perceiver in determining who is stigmatized. Stigma emerges from some of the most basic functions of language and cognition, such as categorical, evaluative, and attributive processes [42]. As verbally able humans, a common cognitive activity is evaluating and classifying the people in our social world. This is particularly common when a lack of extensive personal experience with someone leads us to rely on cues for assigning that person to a social category, whether accurately or inaccurately. Our ability to classify according to socially defined categories is universal among language-able humans and also unique to us as a species. Just try it out for yourself. Read the following sentences and fill in the blank:

Men are _____.
Women are _____.
Alcoholics are _____.
Gays are _____.
Addicts are _____.

Were you able to fill in those blanks? Even if doing so felt uncomfortable, most people are able to provide responses that *seem* to describe the group in question. Answers may readily appear even when they are unwanted or disagreeable. Anyone who participates in a cultural/verbal system learns common stereotypes for the groups that have been defined in that culture [26] whether they agree with them or not.

Throughout a typical day we classify people into groups based on some identifying characteristic or behavior, make judgments about what this means about them, and respond based on this judgment. Much of this process of stereotyping and responding occurs outside of our normal awareness and is harmless, even adaptive. For example, we identify the person at the checkout counter in the grocery store as a clerk and proceed to have them scan our groceries. Research has shown that stereotypes help to reduce the burden of problem solving in complex social environments (e.g., [81]). We are able to quickly develop evaluations and expectations of individuals based on their perceived membership in a group about which we have some social knowledge (i.e., stereotypes [41]). These stereotypes allow us to predict that person's behavior and act accordingly. Sometimes this is quite useful, such as when purchasing items in a grocery store. Sometimes it is less so, for example, when seeing a bumper sticker on a person's car endorsing a disliked political candidate, we may make unsavory assumptions about the driver and may be more inclined to engage in discourteous behavior on the road. Sometimes this process is clearly harmful, for example where culturally sanctioned stereotypes devalue certain individuals and this same process results in stigmatizing, rejecting, and even discriminatory interactions. Through this process of objectification and dehumanization, we fail to appreciate the complex, historical human being and respond to the person solely in terms of their participation in verbal categories [44, 78].

Stigmatizing Thoughts are Resistant to Change

Stigmatizing thoughts and attributions have been shown to be difficult to change through direct intervention [44]. One reason for this may be that judgment and stereotyping are massively useful for the individual in many social situations and thus are highly prevalent and automatic, often happening without awareness. Additionally, verbal/cognitive networks, once formed, tend to maintain themselves [44]. Stereotype disconfirming information that occurs during social interactions tends to be forgotten if the new material conflicts with older stereotypes [50]. People tend to infer stereotype-congruent behaviors to dispositional causes, while stereotype-incongruent behaviors are inferred to situational causes [47], thus further supporting their already existing stereotypes. Even people who exhibit low levels of prejudice know the common stereotypes of stigmatized groups, and once learned, these stereotypes don't go away [27]. If a person learns new ways of thinking, the old ways of thinking don't disappear, but rather are available to re-emerge if the new ways of thinking are frustrated or punished (e.g., [145]). Thus, if new stereotypes are learned about a group, these generally do not replace the old stereotypes; rather the new learning is metaphorically "layered over" the old learning. The old stereotypes are still available to reemerge under situations in which the newer learning is put under strain.

Stigma Is Sustained Through Cultural Practices

While stigmatization is a universal human phenomenon, *what* is stigmatized has been shown to vary over time and across cultures [67]. This suggests that stigma results from cultural practices that exist on the basis of their past ability to facilitate the survival of that culture [5, 144], much in the same way that genes are selected based on their contribution to the survival of a species. Cultural practices which support categorization and stereotyping facilitate membership in and favoritism toward a perceived in-group (e.g., [48, 128]), as well as the resulting mistreatment of those in a perceived out-group [132]. These distinctions preserve and sustain a variety of cultural practices when they generate advantages for the in-group, even when the groups are based on arbitrary characteristics bearing no direct adaptive value. Though stigmatization is defined as the behavior of an individual, it is

always generated and sustained by cultural practices which reinforce and support stigmatizing attitudes, stereotypes, and actions. Thus, in order to change stigma, it is important to change both the behavior of individuals and the cultural practices which support stigma among individuals of that culture.

Types and Levels of Stigma Toward Substance Abuse

The above section was only a brief overview of the vast literatures on stigma, stereotyping, and prejudice. In contrast, the rest of this chapter focuses specifically on stigma toward addiction and begins with a review of types and levels of stigma in relation to substance abuse. Stigma can be subdivided into various types and levels. One distinction can be made between structural and individual stigma. Structural or institutional stigma refers to macroscopic patterns of discrimination toward those with substance misuse that cannot be explained at the individual psychological level alone. This kind of stigma can be either intentional or unintentional [16]. Intentional stigma refers to the rules, policies, and procedures of private and public organizations and structures with power that consciously and purposely restrict rights and opportunities of the stigmatized group. Intentional structural stigma toward addiction would include laws and tax codes that provide inadequate levels of funding for addictions treatment compared to other health conditions or harsher sentencing laws for crack cocaine versus powder cocaine. In contrast, unintentional stigma refers to instances where rules, policies, or procedures result in discrimination, seemingly without the conscious prejudicial efforts of a powerful few [49]. Examples of unintentional structural stigma might include the lower wages and poorer benefits paid to substance abuse treatment professionals compared to other health care or mental health care workers, thus potentially resulting in poorer quality care. Another potential example of unintentional structural stigma would be the exclusion of substance abuse treatment benefits from the Mental Health Parity Act of 1997, resulting in less accessibility of addiction treatment services. This exclusion continued until 2008, when the Mental Health Parity Act of 2008 included substance use disorders.

It is conceivable that prevalent negative attitudes toward substance abuse might contribute to institutional practices that typify structural stigma. For example, prevalent attitudes that people who are addicted to substances are blameworthy and not likely to recover from addiction might make it less likely that the public would be supportive of spending a portion of their tax dollars on treatment. This phenomenon has been witnessed in a German sample who reported that during periods of economic difficulty, they would be prefer to cut funding for mental illness and addiction treatment before cutting funding for physical problems [120].

At the individual level, stigma can be broken down into two types [21, 79], public stigma and self-stigma. The most obvious form of stigma is public stigma, which refers to the reaction the general public has toward the stigmatized group. This includes stereotypes and attitudes toward the stigmatized group, as well as acts of discrimination, termed enacted stigma. For example, rejection by a friend following discovery of a person's substance abuse history, denial of a job opportunity because an employer suspects an applicant is in recovery, or disparaging remarks about people with addictive disorders would all be examples of enacted stigma. People abusing substances and those in recovery frequently encounter enacted stigma [1, 79]. Enacted stigma has been clearly associated with a number of adverse outcomes in mentally ill populations [69, 95, 98, 99, 101]. Though data demonstrating direct links between encounters with enacted stigma and negative outcomes are less available in substance-misusing populations, data showing more negative social attitudes toward substance abusers than those diagnosed with schizophrenia [15, 18, 22, 74] suggest that enacted stigma is even more severe toward those abusing substances.

The second type of individual level stigma is that of self-stigma, which refers to difficult thoughts and feelings (e.g., shame, negative self-evaluative thoughts, fear of enacted stigma) that emerge from identification with a stigmatized group and their resulting behavioral impact [79]. For example, a person with substance abuse problems or a person in recovery might avoid treatment, not apply for jobs, or avoid intimate social relationships because, as a result of self-stigma, they no longer trust themselves to fulfill these roles or fear rejection based on their substance-using identity. Among populations with serious mental illness and dual diagnoses, self-stigma has been associated with delays in treatment seeking [65, 118, 130], diminished self-esteem and self-efficacy [20, 75, 146], and lower quality of life [113].

Perceived stigma is a component of self-stigma and refers to beliefs among members of a stigmatized group about the level of public stigma in society (cf. [69]). A result of perceived stigma may be that people may limit their actions (e.g., seeking treatment or acknowledging their own struggles with recovery) in an attempt to avoid stigmatization. Some data are available showing that perceived stigma may serve as a barrier to treatment adherence, at least in some groups [127]. At least one cross-sectional study of stigma in addiction [79] has generated empirical support for the conceptual distinctions between public, perceived, and self-stigma.

The Need to Study Stigma in Context

Despite the volume of available research on stereotyping, prejudice, discrimination, scapegoating, social categorization, and social deviance, the amount of stigma literature relating these processes specifically to substance abuse is quite sparse. Ahern [1] has suggested that this hole in the literature may result from the common perception that stigma and discrimination against drug users serves to deter drug use and that the possible negative effects of stigma are relatively minor compared to the deterrent value of stigmatization. A substantial body of literature from a law enforcement and criminal justice perspective views stigma as a positive form of social control which discourages illegal activity [11]. This literature largely ignores the potential negative effects of stigma. In contrast, most of the professional literature from mental health and recovery perspectives views stigma as negative and in need of reduction [112]. This literature seems largely to ignore of the possibility that stigma might have beneficial effects in some contexts. Each of these perspectives seems to minimize the importance of context and neither seems to acknowledge the possibility that stigma may have both beneficial and harmful effects depending upon the context in which it is found.

A comprehensive scientific approach to stigma would involve examination of the phenomenon across the myriad of situations in which it occurs. Stigma is a complex phenomenon with many forms and widely varying impacts on the individual. Prior to initial drug use and throughout the developmental trajectory for addition and recovery, stigma may have various possible functions. For example, stigma may affect some who are currently not using drugs by dissuading them from initial use. On the other hand, those who identify with marginalized populations may actually be attracted to drug use because of its marginalized status. Once a person has bypassed barriers to initial drug use, stigma could serve to further reinforce and isolate drug-using subcultures, further supporting consumption. For many, stigma serves as a barrier to entering treatment because of fear of being labeled and stigmatized by others. For others, experiences of being stigmatized and judged by others once drug use is discovered or labeled as problematic might serve as a motivator for treatment entry. The effects of stigma might change again after a person enters treatment. Those experiencing more self-stigma or who are more fearful of enacted stigma may stay in treatment for longer periods of time, perhaps benefiting more from treatment. On the other hand,

the impact of self-stigma may impede recovery by reducing substance abusers' motivation and creating negative beliefs about their ability to recover, resulting in earlier relapse. Some people may be relatively unaffected by stigma, perhaps because of personal conditions which help guard against its impact (e.g., financial resources), or because they do not identify with a stigmatized group. Finally, ongoing experiences of stigma-related rejection may serve as a barrier to reengagement with healthy, non-drug-using social relationships, returning to work, or obtaining a reasonable living arrangement. This array of possibilities suggest that simple judgments about the goodness or badness of stigma may be insufficient in understanding the role of stigma in initial drug use, the development of addiction, and recovery from substance abuse. Given the potential complexities, we need a contextually situated approach to examining the effects of stigma on drug use and related outcomes in order to maximally benefit all involved.

Straying from the hypothetical scenarios described in the above paragraph, a study by Farrimond [33] nicely demonstrates the contextual nature of stigma's impact. Qualitative analyses of reports from tobacco smokers in the United Kingdom showed that smokers from lower socio-economic status groups were more likely to internalize smoking related stigma and feel bad about themselves for smoking, rather than change their behavior to avoid it. In contrast, smokers from higher socio-economic status groups were less likely to internalize smoking related stigma and were more likely to have the resources to change their behavior to avoid being stigmatized. The authors suggested that this finding was a partial explanation for the much higher rates of smoking found in lower socio-economic status groups. They hypothesized that broad-scale campaigns to stigmatize smokers might reduce smoking in higher socio-economic status brackets who would work to avoid it, whereas those in lower socio-economic status may not be responsive, and furthermore, that such campaigns may even impede efforts to stop smoking because of increased internalized stigma. They argued that intervention efforts promoting stigma could actually exacerbate disparities already present between higher and lower status groups.

Thus far, this chapter has outlined the nature of stigma in general, including its types and levels. It has outlined how stigma is a complex phenomenon, the effects of which vary by context. The remainder of this text is more focused specifically on what is known about the stigma of substance abuse specifically, describing its importance for those individuals with substance abuse problems, information about stigma in families and social networks of those with addiction, stigma in the treatment system, and interventions to change stigma.

The Impact of Stigma on Individuals with Substance Abuse Problems

Self-Stigma

The psychological impact of stigma on the individual can be described under the term self-stigma. Self-stigma can be defined as shame, evaluative thoughts, and fear of enacted stigma that results from an individual's identification with a stigmatized group and serves as a barrier to the pursuit of valued life goals [78]. The dominant stereotypes about stigmatized groups are widely known in a given culture. Self-stigma comes about when a person first sees himself or herself as a member of a stigmatized group; now the negative stereotypes and biases of society that used to be about someone else apply to the self. For example, at the point when the person who misuses substances identifies himself or herself with the category "addict," relevant stereotypes (e.g., "addicts are irresponsible") that once applied to another now apply to himself or herself. To the extent that the person believes this stereotype, they are likely to impede their own chances for success, for example, by not applying to jobs that would require someone to be responsible. As the dominant stereotypes of marginalized groups are largely negative and

devaluing, self-stigma may further increase the shame that often comes with addictive behavior that violates important societal and personal values and norms.

A second component of self-stigma is the fear of enacted stigma. Out of this fear of being the target of stigma a person might avoid treatment in the first place or might not get needed social support that could come from disclosing their concerns to trustworthy others. People with substance abuse widely report fear of stigma as a reason for avoiding treatment [23, 51, 63, 137, 138]. Less evidence is available for other effects of self-stigma in addiction, but self-stigma in mental illness has been associated with delays in treatment seeking [65, 118, 130], diminished self-esteem/self-efficacy [20, 76, 146], lower quality of life [113], early dropout from treatment [127], poorer social functioning over time [100], and increased depression at follow-up [110].

Coping and Self-Stigma

Much of the harm of self-stigma comes not only from the presence of shame, painful self-evaluations, or fear of stigmatization, but also from understandable yet costly attempts to cope with these difficult thoughts and feelings. For example, when people who identify with a stigmatized group enter situations where they perceive the potential for devaluation based on this identity [131], they often expend energy searching for and defending against this perceived threat. The effort is taxing and distracts the individual in ways which might hinder social or intellectual performance. In a recent test of this idea, Quinn et al. [105] found that individuals with a history of mental illness who revealed this history prior to taking an intelligence test had poorer performance compared to a control group who did not relate their history of mental illness. These results are in line with more general findings on stereotype threat, that is, that people perform more poorly in situations where a specific stereotype about the group of which they are a member applies [131]. Specifically in relation to substance abuse stigma, these findings suggest that when people with a history of substance abuse problems are in a situation in which addiction-related stereotypes might apply, they may perform more poorly than they would in situations unrelated to addiction-related stigma.

People also cope with stigma by withdrawing their efforts from or disengaging their self-esteem from domains in which one's in-group is negatively stereotyped or in which they fear being a target of discrimination. In an attempt to cope with the potential judgment, failure, or shame that might result from "confirming" a stereotype, a person may exert less effort in domains of living that relate to relevant stereotypes [82]. For example, a person who identifies with the stereotype that alcoholics are immoral might not engage with spiritual or religious groups out of fear that they might be judged by others for their "moral weakness." Unfortunately, when a domain is one that might be part of living well (e.g., a steady job) and is likely to elicit thoughts of common stereotypes (e.g., "they won't hire an addict"), then disengagement from that domain (e.g., not looking for work) is likely to interfere with recovery.

Whether a stigmatizing mark can be concealed is also a relevant variable to how people cope. For example, some stigmas may be relatively concealable, such as a past felony conviction or a history of depression, while others may be quite difficult to conceal, such as obesity or diseases with obvious physical characteristics. For many people with substance abuse problems, their condition is concealable, while for others it is less so. Another way to think about concealable stigma is the distinction between "discredited" versus "discreditable" individuals [39]. For individuals with a concealable stigma, a common occurrence is deciding with whom, where, and when to disclose the stigmatizing identity. Whether disclosing a stigmatizing identity is helpful or harmful is likely to be highly dependent on context [30]. In some cases, through disclosing a stigma a person may be able to obtain social support or direct assistance from treatment agencies or health care professionals. Revealing a secret to a trusted confidant has

also been shown to be related to a number of psychological benefits, including improved psychological and physical health [60, 111]. On the other hand, disclosure of a stigma could result in social rejection and isolation, the loss of a job, rejection by family members, judgment from treatment professionals, or disappointment that others were not more helpful. Research on secrecy as a method for coping with the stigma of addiction is relatively scarce and what exists is somewhat crude, typically examining secrecy as a generalized tendency in response to the fear of stigma, rather than examining the patterns of disclosure and how they might interact with social context. As a general rule, the use of secrecy and withdrawal from others as a coping mechanism has been associated with negative psychosocial outcomes [1, 72, 79, 115]. However, this general pattern should not be overgeneralized as a recent large study of mostly minority drug users [1] found that talking with friends and family about being stigmatized and judged was associated with poorer health outcomes. One difference between the Ahern study and other studies of stigma was that Ahern specifically focused on discussions of being stigmatized, whereas most other studies examined the tendency to keep substance use a secret. This suggests that the content of what is disclosed may also affect the likelihood of a positive outcome from disclosure.

All of the coping processes described above (i.e., searching for potential threats, withdrawing efforts from valued domains, and secrecy) could be seen as forms of a broader process termed experiential avoidance. Experiential avoidance refers to the attempt to avoid, control, or reduce the frequency of difficult or painful emotions, thoughts, memories, or other private experiences [45]. Experiential avoidance overlaps with several closely related concepts, including lack of distress tolerance [9], cognitive and emotional suppression [141], and emotion/avoidance-focused coping [12]. As a broader pattern, experiential avoidance has been shown to contribute to a wide range of psychological and behavioral problems, including substance abuse, depression, anxiety, psychosis, and burnout among others [45]. Since experiential avoidance has been shown to be modifiable through mindfulness and acceptance based interventions [36, 46, 139], this suggests that teaching mindfulness and acceptance may be helpful in coping with stigma.

Multiple Stigmatized Identities

For a person with substance abuse problems, the stigma of substance abuse is often only one of several stigmatized identities. Each stigmatized identity is layered on top of the other, creating a dense web of ideas about the self that must be managed and responded to depending upon the social and personal context. For example, substance abuse disorders are highly comorbid with other psychiatric disorders, meaning that the majority of people in treatment for drug abuse also have to contend with the stigma of mental illness [31, 61]. Many people in addiction treatment are also sexual or racial minorities. They may have a stigmatized medical condition such as hepatitis or HIV. They are frequently poor or homeless, both situations which carry their own stigma. Women who abuse substances are often assumed to be promiscuous [119]. Many people with substance abuse histories also have had problems with the legal system or have been incarcerated. In addition to the stigmatization that people may experience directly from the legal system, they now have the added stigma of a prior conviction. Each additional stigmatized identity increases the chance of stigmatization. Each layer of stigmatized identity carries its own challenges that make it even harder to cope with the stigma of drug addiction.

In addition to the problem of multiple stigmas, the impact of substance abuse stigma can also compound existing social inequalities. For example, the stigma of substance abuse has disproportionately impacted the African–American community in the United States, whose drug-related incarceration rate far outstrips their comparative prevalence as drug users [142]. As many in treatment for addiction are relatively poorer, the stigma of drug abuse that tends to fall on those in treatment will also tend to further reduce

the life chances available to those who are experiencing poverty [33]. Again, in addition to the direct effects of the stigma of addiction, stigma also tends to exacerbate the effects of already existing prejudice, marginalization, and disadvantage based on other identities.

Stigmatizing Attitudes and Behavior of Friends and Family

Supportive, cohesive, and non-critical social networks predict good outcomes in addictions treatment [32, 90, 94], while conflict with several members of a social support network, interpersonal conflict, and isolation predict poor treatment outcomes [90, 91]. People entering treatment for addictive disorders are often marginalized, with few connections to family, friends, or coworkers. Entering treatment may be a marker for having exhausted their "moral credit" with employers and families [112]. Stigma may contribute to poorer outcomes by further contributing to the disruption of social ties and increasing isolation beyond the problems created through the direct impact of addictive behavior. Some data are available that bear directly on this point. A recent study of primarily minority drug users [1] found that discrimination and stigmatizing interactions from family and friends was common and independently associated with poorer mental and physical health.

Stigma appears to degrade social networks over time. In one longitudinal study of people with mental illness, many of whom also abused substances [71], perceptions of stigma were associated with reduction in support from non-household relatives over time. Stigmatizing attitudes and behavior of friends and family may also reduce treatment adherence. A recent study of individuals taking antidepressants for depression [122] found that stigmatizing caregiver attitudes predicted premature discontinuation of treatment.

Family members of substance abusers may also suffer from "courtesy stigma." Courtesy stigma refers to the tendency to devalue and stigmatize people who maintain or enter relationships with those in the stigmatized group [39]. For example, in a study by Barton [3], parents of adolescents who abused drugs reported that neighborhood children were told to stay away from their child, resulting not only in isolation for the child but also feelings of shame for the parents. Parents of substance-abusing adolescents also experienced shaming interactions when dealing with institutions such as schools, police, and the legal system. Courtesy stigma may disrupt social cohesion through contributing to struggles inside families that have a member who abuses substances. Family members may attempt to distance themselves from a substance-abusing family member in order to distance themselves from courtesy stigma and the shame that can accompany it. It may be the case that much of the behavior described in the literature as "enabling" or "co-dependent" may result from the family's attempt to avoid the shame of stigma [35] and maintain its identity as a "normal" family.

Stigma in Treatment Settings

Stigma as a Barrier to Initial Treatment Engagement

The public health implications of untreated substance abuse and dependence are enormous. Despite the proven benefits of substance abuse treatment, only a small fraction of those who could benefit ever enter treatment. In 2005, only about 2.3 million of an estimated 23.2 million Americans with substance abuse problems received some form of treatment [116]. Barriers to treatment entry are structural (e.g., location of facilities, lack of qualified personnel, lack of funding), and social (e.g., fear of stigma among those with substance misuse). Stigma contributes to structural barriers when people resist having substance abuse treatment facilities placed in their neighborhoods [6], thus limiting access to treatment. This is important since a having to travel a longer distance to obtain addictions treatment has been associated with poorer

retention [4]. The public is less interested in funding substance abuse treatment compared to other health or mental health problems [120], contributing to long waiting lists and prohibitive cost for treatment. Stressful job conditions result in high rates of burnout and job turnover in addictions professionals [62], resulting in less experienced counselors and less integrated, cohesive treatment centers.

Among the social barriers to treatment entry for addiction, probably the most common barrier cited in the literature is stigma [2, 23, 51, 63, 119, 137]. Across numerous studies, substance-abusing individuals report fear of stigma as a reason for not seeking treatment [23, 51, 63, 137, 138]. For example, Cunningham et al. [23] examined reasons for delaying or not seeking treatment among people with alcohol abuse problems who either self-changed and were in sustained recovery, were still actively abusing, or were currently in treatment. They found that people who were either actively using or self-changed saw treatment as stigmatizing, wanted to avoid the stigma of the label "alcoholic," and reported that embarrassment and pride were barriers to seeking treatment. All three groups reported relatively similar reasons for avoiding treatment, leaving the authors to conclude that "current treatment is stigmatizing and that some alcohol abusers believe that seeking treatment would reflect negatively on them" (p. 352). A study of depressed individuals in Australia found it common to fear that others would think less of them for seeking help and that professionals would respond to them in a condescending manner [2].

Stigma and Treatment Retention and Outcome

For those who are able to overcome barriers and enter treatment, the most stable predictor of positive outcome is length of time in treatment, with studies commonly finding rates of dropout in the first month of outpatient and residential treatment exceeding 50% [54, 55, 125, 126]. Early treatment retention is critical, as data show that early dropouts have equivalent outcomes to those who are untreated [129], and that more time in treatment is related to better outcomes [24, 56, 124]. Unfortunately, stigma doesn't only serve as a barrier to treatment entry; stigma also appears to increase when individuals enter treatment, possibly contributing to poorer retention and thus poorer outcomes [54, 123, 129]. Link and colleagues' [71] modified labeling theory of stigma in mental illness holds that stigma begins to impact people once they have officially received a label from the treatment establishment. A relatively large body of data on seriously mentally ill and dually diagnosed populations supports the hypothesis that entering treatment for a stigmatized condition can result in a labeling process that negatively impacts people's engagement with treatment, psychosocial functioning, and self-concept [20, 75, 146].

The data on such a stigma-labeling process are less developed in the area of addiction, but some direct data are available to support this view. For example, Semple et al. [121] found that methamphetamine abusers who had previously been in treatment reported higher levels of stigma-related rejection than those who had never been in treatment. Another survey of people in treatment for substance abuse [79] found that people with higher levels of current stigma-related rejection had more previous episodes of treatment and that this relationship remained stable even after controlling for other explanatory variables, such as current severity of addiction, demographics, secrecy coping, and current mental health. While this evidence suggests that the impact of stigma and the rate of contact with stigmatizing experiences may increase with treatment entry, we know little about how this happens. For example, we know little about whether stigmatizing messages and rejecting experiences primarily come from non-family social relationships, close family, employers, media, or treatment staff. Moreover, we do not know if certain sources have greater impacts than others, or whether the impact is different for those new to treatment versus those returning to treatment.

Stigmatizing Attitudes and Behavior of Professional Staff

The therapeutic alliance early in counseling has been shown to be a predictor of engagement and retention in substance abuse treatment [89]. Other data show that negative therapeutic alliances predict deterioration in substance abuse treatment [44]. Thus, any actions on the part of substance abuse treatment practitioners that harm the therapeutic alliance are likely to negatively impact retention and treatment outcome among their clients. Health professionals, including addiction counselors, nurses, physicians, and support staff, have been exposed to the same cultural environment that instills stereotyped beliefs in other people. Thus, whether they are aware of it or not, providers likely have internalized many of the same stigmatizing beliefs about substance abuse as others in society. Research shows that health professionals often have moralistic, negative, and stigmatizing attitudes toward substance misuse and believe that substance-abusing individuals are unlikely to recover [87, 90, 109]. For example, one study of mental health support workers in the UK found that alcohol and drug addiction produced more negative responses to an attitude questionnaire than did other problems or mental illness and that those with alcohol and drug problems were mostly likely to be seen as unable to improve if treated [135].

To the extent that stigmatizing attitudes are expressed by providers, they could negatively impact the alliance, thereby reducing retention and creating poorer outcomes. Similarly, support and non-treatment staff could potentially create a hostile atmosphere for clients, further contributing to reduced retention. Because stigmatizing attitudes tend to have a greater impact in situations in which one group has power over another [73], stigmatizing beliefs among healthcare providers may be particularly likely to negatively affect the recovery of those they are trying to help [8]. Some evidence suggests that stigmatizing interactions with providers may be more frequent than expected: one study of methamphetamine abusers found clients' inability to get along with treatment staff was a major reason for dropout [121], while two surveys of consumers of mental health services found that 19% [28] and 25% [140] of consumers had experienced stigmatizing provider behavior. Data from a qualitative study of alcohol and drug abuse counselors found that counselors largely saw illicit drug use as a failing of the individual that needed to be "fixed" with drug treatment rather than seeing the larger context which includes such factors as stigma. In this study, while counselors were generally aware that stigma serves as a barrier to drug treatment, they "did not perceive they as individuals and as treatment workers could perpetuate the same barriers and prejudices" [136] (p. 378).

Interventions to Reduce Stigma

While a large literature on the nature of stigma exists, research on how to change stigma or how to help people with stigma is much more limited [11]. Interventions can target either public or self-stigma and can vary from large-scale interventions targeting the general public to focused interventions targeting high risk or identified target populations.

Reducing Public Stigma

A number of kinds of interventions for reducing stigma in the general public have been proposed and researched. Corrigan et al. [17] proposed three strategies derived from social psychology theory for changing public mental illness stigma that could also be applied to substance abuse stigma: education, contact, and protest. Each of these approaches is reviewed below.

Educational approaches aim to provide new information about a stigmatized group and dispel negative stereotypes. Nearly all the research on education as a stigma reduction method involves mental illness rather than substance abuse

stigma. Cross-sectional research has shown that those who are more knowledgeable about mental illness are less likely to exhibit stigmatizing attitudes [69, 70]. Whether this indicates that people who are less stigmatizing are more open to learning about mental illness, or whether education reduced stigma is unclear. A number of studies have shown short-term improvements in attitudes toward stigmatized groups as a result of educational interventions [17, 19, 59, 93, 97], though results are sometimes inconsistent [53], and studies have generally lacked follow-up assessments. One study that did have a follow-up showed that initial positive results were not maintained [19]. Haghighat [40] has suggested that these positive results might be a product of social desirability rather than true attitude changes. Other data suggest that education may serve to increase positive attitudes among those who already exhibit positive attitudes but may not impact those with negative attitudes or may even reinforce preexisting negative biases [7].

Recently, researchers have also begun to pay attention to the content of educational interventions for stigma reduction, especially the effects of characterizing psychiatric symptoms as caused by psychosocial events versus a disease of the brain with biological, genetic, or structural abnormalities. In general, data are not very supportive for the effectiveness of a biological/genetic message as a method for reducing stigma, and some data suggest that it may actually increase stigma. The one exception is that a biological/genetic message has sometimes been shown to reduce blame toward those with mental illness for causing their own problems, which was found in two studies [68, 88] but not in a third [103]. One of these same studies showed that while a disease explanation reduced blame, it actually provoked *harsher* behavior toward a person described as mentally ill versus a psychosocial explanation [88]. Another experimental study showed that a biological explanation resulted in a less hopeful expectation of improvement [68]. Extensive correlational research shows that genetic or biological explanations for mental illness and diagnostic labeling are related to greater perceptions of dangerousness, desire for distance, and prediction of poor prognosis [103, 107, 108]. For example, surveys in the United States from 1950 and 1996 showed both an increased likelihood to view mental illness as having a biological cause and also to believe that those with mental illness are dangerous [104]. In contrast, data are more reliably supportive of interventions presenting psychiatric symptoms as understandable reactions to life events (i.e., psychosocial explanations). Psychosocial explanations of mental illness have also been related to more positive attitudes toward mental illness in correlational studies [108]. Interventions promoting a psychosocial explanation have resulted in a reduction in fear of dangerousness, desire for social distance, and other negative attitudes [68, 83, 92, 93], though the impact has sometimes been found to vary by target group [68], and these results have not been assessed for their long-term effects. In sum, while a small sample of data suggests that a brain disease message may reduce blame, the preponderance of existing data supports that idea that describing mental illness as a brain disease is not likely to improve stigma on a broad scale and may even lead to increased stigma of some kinds. At the current time, promoting a brain disease message as a stigma reduction method could not be considered an evidence-based practice, while promoting psychosocial explanations for mental illness appears to be promising, at least in these preliminary studies.

While the data indicate that educational interventions based on efforts to characterize mental illness as a brain disease are not likely to reduce stigma, these results do not mean that more complex and nuanced approaches to stigma education that emphasize both biological and psychosocial causes, such as diathesis-stress models, might not be effective. In addition, it remains unknown whether current findings will reliably generalize to the stigma of addiction. It may also be the case that there has been an overemphasis on educational approaches predicated on the idea of information provision as a primary method for stigma reduction and that information provision is simply not a very effective way to change

entrenched attitudes. Other types of interventions based on models other than information provision may be more effective in reducing stigma. Some of these models are explored in more detail below.

The second category of interventions, protest, involves attempting to suppress negative attitudes and representations of a stigmatized group through disputing the morality of holding and expressing such views or through threatening a boycott of a company's products. Research on thought suppression suggests that attempting to suppress or avoid unwanted thoughts can result in paradoxical increases in those very thoughts [141]. People who are asked to suppress thoughts about stereotyped groups can actually become more sensitized to them, resulting in unwanted intrusions of thoughts about that group and more behavioral avoidance of the stigmatized group [80]. Creating conditions that demand correct behaviors (e.g., "do not stare at the physically disabled") can also increase the physical avoidance of stigmatized persons [66]. As suggested by this basic research, most studies of protest strategies targeting attitude and behavior change in individuals have shown it to be inert [17]. In contrast, some anecdotal reports of the use of protest strategies, such as letter writing campaigns or product boycotts to get companies to remove or correct stigmatizing portrayals of mentally ill individuals in the media, have reported some success [13]. In sum, systematic confrontation and protest targeting the stigmatizing behavior of individual persons seems to be largely ineffective and may even exacerbate stigma. On the other hand, the effects of targeting corporations or organizations with organized protest campaigns have not been systematically evaluated.

Finally, contact strategies attempt to change attitudes toward stigmatized groups by creating positive social contact between members of the stigmatized group and the public. Research has shown that people who have more contact with mentally ill individuals endorse less stigma [70, 96, 97], though it is unclear whether contact with mentally ill individuals decreases stigma or whether those with lower levels of stigma are more likely to seek contact. Contact as a strategy for reducing prejudice has long been known to be successful in research on racial prejudice [102]. Interventions based on contact have been the most consistently successful at reducing negative attitudes toward the mentally ill [17, 19], generating at least some maintenance of attitude change over time and impact on related overt behavior. The limits and exportability of this approach are still somewhat unknown as past research has shown that there are number of situational constraints that can make this approach difficult to implement in real world settings [14]. Specifically, as this approach does not appear to have been tested in stigma reduction with those with substance abuse or in recovery, its putative efficacy in that area remains hypothetical.

The lack of research on stigma reduction strategies in addiction may have to do with conflicting societal views about the usefulness and moral correctness of stigma toward substance use and substance users. In contrast with mental illness where few would argue in support of stigma, there are vocal proponents of actively stigmatizing drug use and drug users [117]. Some large-scale drug prevention programs, such as the Montana Meth Project, which uses advertisements featuring dramatic and often violent depictions of problem drug use, appear actively designed to stigmatize drug users. The Montana program appears to be focused largely on preventing initial drug use and some evidence suggests that this program may be effective in that aim [58]. However, as is common in the criminal justice literature, the potential impact of this campaign on those who are currently using illicit drugs or attempting to recover appears unexamined. Thus, while these types of approaches may reduce initial drug use through increasing stigma, they may have the unintended effect of compounding stigma toward and among those who do become addicted, though further research is needed to examine this question. Thus, the overall public health impact of campaigns such as the Montana Meth Project may be negative, despite the possible reduction in rates of initial drug use that may result from these stigmatization-focused programs.

Reducing Stigma in the Health Care System

Since stigma appears to increase after the person has entered the treatment system and has been labeled as a substance abuser, then it would make sense that interventions targeting the health care system and the process of entry into treatment might be particularly important in reducing the impact of stigma on those attempting to recover from drug addiction. Thus, interventions targeting the prevalent stigmatizing attitudes and behaviors of health care providers and professional staff or focusing on changing organizational structures or admissions procedures might have promise in improving treatment engagement or retention. In targeting stigma in addictions specialty providers, programs designed to provide direct education about stigmatized groups or to promote contact with those in the stigmatized group do not seem very relevant since addictions professionals already know vastly more about these topics than do average persons and have also had a great deal of contact. As protest has not shown much promise, other interventions are needed.

One alternative intervention that has been studied is the use of mindfulness, acceptance, and values processes derived from Acceptance and Commitment Therapy [43]. Acceptance and Commitment Therapy as applied to stigma in addictions professionals focuses on promoting psychological acceptance of difficult thoughts and feelings that come with working with difficult clients (i.e., those most likely to be stigmatized), reducing the behavior regulating impact of the literal content of stigmatizing and evaluative thoughts (e.g., "This client is hopeless"), and helping clinicians to contact the values they bring to their work so that these values can better guide their behavior. In one pilot study of this approach [43], 90 licensed or certified alcohol and drug abuse counselors were randomly assigned to 1-day workshops based on Acceptance and Commitment Training ($N = 30$), Multicultural Training ($N = 30$), or a control lecture about methamphetamine and 3,4-methylenedioxymethamphetamine interventions. Stigmatizing attitudes were reduced post-training in both active treatment groups, but only the Acceptance and Commitment Therapy condition generated lower stigmatizing attitudes at the 3-month follow-up. An additional benefit of the Acceptance and Commitment Therapy intervention is that it decreased burnout at the 3-month follow-up, suggesting that interventions targeting stigma in providers may also have the effect of reducing burnout.

Organizational interventions might also be useful in identifying and remediating stigmatizing policies and procedures. For example, an admission process walk-through [34] might be used to examine whether stigmatizing messages or behaviors occur during initial treatment engagement. These stigmatizing messages might range from the more overt (e.g., telling a client they are hopeless) to more subtle (e.g., therapists telling jokes about "addicts"). Admission walk-throughs could identify potentially stigmatizing interactions that happen during potential client's first contacts with the treatment system and options for remediating these problematic interactions. The overall goal of a walk-through exercise is to identify problematic processes and improve service delivery by allowing providers and those in charge of the system of care to understand what it is like to enter the treatment system [34]. Other organizational and quality improvement interventions might also be adapted to target organizational change relating to stigma.

Empowering Those in Recovery

Another way to help participants in the addictions treatment system is to empower them to overcome the negative evaluative thoughts, shame, and fear of enacted stigma that are part of self-stigma. For substance abuse related stigma, an uncontrolled pilot study targeting self-stigma with Acceptance and Commitment Therapy [79] showed promising outcomes with medium to large effects across a number of variables at

post-treatment. However, the intervention was delivered along with concurrent treatment, making it difficult to rule out the possibility the observed effects were not simply the result of concurrent treatment. Other studies that have examined interventions for self-stigma in mental illness might provide some guidance for developing interventions for self-stigma in addiction.

One aspect of self-stigma is the way that fear of enacted stigma can impede recovery. One study tested an intervention that consisted of education about stigma, discussion of methods to combat and cope with stigma, and discussion about personal experiences of stigma that focused more on coping with enacted stigma than on other aspects of self-stigma. In this study, rehabilitation clubhouse members ($N = 88$) were randomly assigned to either 16 group sessions of the stigma intervention or no treatment. At a 6-month follow-up the intervention group was not significantly different from controls on any measure.

Knight et al. [64] compared a six-session group intervention based on cognitive behavioral therapy to a waitlist. The cognitive behavioral therapy intervention was developed primarily from existing manuals on the group treatment of auditory hallucinations and the group treatment of poor self-esteem. At post-treatment, effects were seen for measures of psychopathology and self-esteem, with these effects mostly maintained through follow-up. However, no effects were seen on stigma coping or empowerment measures, making it less clear whether the effects were more general therapeutic effects or had any specific impact on self-stigma.

Another group intervention for mental illness examined the impact of a 12-session group intervention (1.5 h per group) that focused on helping individuals with first-episode psychosis to maintain an identity distinct from mental illness, promote hopefulness, minimize the impact of stigma, and help them to embrace a healthy sense of self [85]. Results of this randomized trial, comparing treatment as usual to treatment as usual plus the stigma intervention, showed that at post-treatment, the group that received the experimental intervention had improved scores on a measure of self-stigma, hopefulness, and quality of life, but not on several other scales [86]. A previous pilot study of the same intervention also showed an impact on a measure of self-stigma that the investigators termed engulfment, which refers to the tendency to allow illness and its associated stigma to entirely define the self-concept [85].

In summary, there exist a number of promising interventions for self-stigma, with some mixed findings regarding the specificity of their effects. Now that some interventions have begun to show promising effects on stigma and related variables, future research needs to focus more on testing of specific models of change.

Stigma and the Emotion of Shame

Both of the definitions of stigma and most of the research on stigma ignore the emotional responses that are entailed in this phenomenon [77] such as guilt, disgust, anger, and, most prominently, shame. Recently, several prominent stigma researchers called for more research into the relationship between stigma and shame [114]. Much of what has been described as characteristic of the personal experience of being stigmatized has also been described in the literature on the emotion of shame. For example, shame has been defined as an experience of "self as flawed and undesirable in the eyes of others" [38, 134], which is similar to Goffman's [39], idea of stigma as an "attribute that is deeply discrediting" that reduces a person "from a whole and usual person to a tainted, discounted one" (p. 3). Shame is often elicited in social contexts and is associated with thoughts that one is seen as inferior or that others are condemning the self [38]. Similarly, in self-stigma people are fearful of being condemned, stigmatized, or judged by others because of their member in the stigmatized group. Shame is also associated with cultural values, meaning that what is shameful varies according to the standards and ideals of a particular culture [67] as is what is stigmatized varies across cultures.

Shame has been called a "moral emotion" [133], in that it is seen as relating to transgressions of the norms and values of a society. While most authors agree that shame is a highly socially based emotion, substantial disagreement exists as to the usefulness of shame in regulating human behavior. Some authors see shame as a largely maladaptive, negative emotion, with little useful function [134]. Following similar reasoning, some therapy developers have suggested that shame should be directly targeted using shame reduction strategies [25, 143]. Other authors have suggested that shame may serve a valuable function in regulating people's behavior through limiting deviations from accepted norms [29]. As shame can also arise when people violate their own standards and values, shame may have a role in alerting people to important deviations from their own values or self-standards [84] so that they can self-correct their behavior. Seen through this lens, attempts to directly reduce shame during treatment may actually feed the addictive cycle [78] by allowing people to continue deviant behavior or violate self-standards and values [37] without feeling the shame that would ordinarily attend those actions. At least one study [79] specifically targeted the experience of shame in addiction and showed that it could be reduced through treatment. However, in this study, while shame was reduced at post-treatment, the target of the intervention was not the reduction of shame, but rather increasing acceptance of the feeling of shame and mindfulness of stigmatizing thoughts and evaluations. Thus, it may not be as helpful to try to reduce shame directly, but rather to help people change their psychological relationship to shame, so that they are more mindful and accepting of the experience.

As discussed above in reference to stigma, the context in which shame is experienced is probably extremely important in understanding its function and usefulness. In some contexts, shame may be an adaptive, though painful, emotion that highlights deviations from important values or self-standards, whereas in other contexts, shame may simply be excessive and serve no useful function. The debate over whether shame is a maladaptive or adaptive emotion will likely be resolved when more attention is paid to the specific social and psychological contexts in which shame is experienced and how people cope with and respond to shame.

Conclusions

Stigma operates at many levels. Self-stigma works within the individual to impede recovery. Structural stigma operates through the formal and informal policies and procedures of the health care and legal systems. Enacted stigma is expressed in the negative attitudes and behavior of the public. Courtesy stigma extends the impact of stigma to families and to addictions treatment professionals who are paid more poorly than those in other health care fields [52]. Furthermore, the stigma of substance abuse falls disproportionately on those who already experience greater societal injustice, such as racial and sexual minorities and those living in poverty, and who, as a result, have been denied many life opportunities. Stigma is such a broad, pervasive process that it is difficult to characterize its full impact, with any one study only able to document a small portion of its effects. Only by taking an expansive view and appreciating the effects of stigma across many contexts can we begin to see the tremendous cost of this process to the people struggling with drug and alcohol addiction and to society in general.

A broad and pervasive problem like stigma merits a comprehensive and systematic solution. Currently, research and theorizing about the impact of stigma in addiction is in its infancy. We know even less about how to reduce the burden of stigma on those who are attempting to recover from a life damaged by addiction. Anyone who has ever worked with addiction has seen its devastating effects on the lives of individuals and the immense struggle involved in living even a single day clean and sober. People attempting to climb the mountain of recovery do not need the additional burden of stigma, as their road is hard enough.

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Chapter 59

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