WE KNOW THAT THE STIGMA ASSOCIATED WITH ADDICTION, TOWARD PEOPLE WITH ADDICTIONS, AND EVEN TOWARD PEOPLE IN ADDICTION RECOVERY, IS A PRIMARY AND LONG-STANDING BARRIER TO BOTH RECOVERY INITIATION AND RECOVERY SUSTAINABILITY.

RICARES
Report to the Community

PART IV

STIGMA AND ADDICTION IN RHODE ISLAND

We know that the stigma associated with addiction, toward people with addictions, and with people in addiction recovery, is a primary and long-standing barrier to both recovery initiation and recovery sustainability.

Government leaders have recently emphasized the issue by suggesting the intention to address this stigma.

Eric Beane (Secretary of the RI EOHHS) recently stated, "We are taking aggressive action to remove the stigma of addiction. It's the right thing to do."[1] In a subsequent ProJo Commentary, Secretary Beane reiterated, 'There is work ahead to erase the stigma of addiction and to ensure people in recovery have access to jobs, housing, and other needed supports. This is the next chapter in our work as a Task Force and as a community.' [2]

In his national report, the Surgeon General stated, 'for far too long, too many in our country have viewed addiction as a moral failing. This unfortunate stigma has created an added burden of shame that has made people with substance use disorders less likely to come forward and seek help. It has also made it more challenging to marshal the necessary investments in prevention and treatment. We must help everyone see that addiction is not a character flaw…" [3]

Why do we need 'aggressive action to remove the stigma?'
Why for 'far too long' in America?
Why must we 'help everyone see' in America?

The simple answer: it's always been like that.

A 1531 essay by Sebastian Francks, "*On the Horrible Vice of Drunkenness,"* referred to intoxication as a "sin that has become a habit." [4] In 1673, Increase Mather, minister of the Old North Church in Boston, in his sermon, "Woe to Drunkards" declared: "Drink in itself is a good creature of God...and to be received with thankfulness, but the abuse of drink is from Satan; the wine is from God, but the drunkard is from the

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[1] "Raimondo: Overdose deaths in R.I. drop 9%," Providence Journal, December 2017.
[2] RI is disrupting its opioid crisis, Feb, 2018
[3] Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, & Health.
[4] Classics of the Alcohol Literature: A Document of the Reformation Period on Inebriety, Quarterly Journal of Studies on alcohol

Devil." [5] This reflected the Puritan's view of excessive alcohol use as the habitual, but deliberate, engagement in frequent excess. In the 1700's, Benjamin Rush, a RI physician, characterized alcoholism as a 'disease of the will.'[6] An 1870 report of the Commissioners of Charities and Corrections for the city of New York refers to inebriety as a "moral disease" that should be classed with other forms of "licentiousness."

The 1874 Paper of Dr. Robert Harris, Director of the Franklin Reformatory, stated: "As we do not, either in name or management, recognize drunkenness as the effect of a diseased impulse; but regard it as a habit, sin, and crime..." In 1912, a psychological text stated: "Two types of (psychological) organization favor the acquisition of habits of excessive or morbid use of alcohol: the underdeveloped type, and the degenerate, over- sensitive, or otherwise morbid nervous organization." [7]

Well, you get the picture: Horrible vice, a sin, Satan, the Devil, moral disease, licentious, a crime, degenerate. This history is the source of the societal conviction that people with addictions are weak and lack character.

This history is the source of our dominant national attitude today that addiction is intentional behavior, the result of a moral weakness, a lack of character, and hedonistic self-centeredness.

This assumption, or even conviction, is so ingrained and so embedded in our general societal thinking and feeling about addiction; it is as if it has been transmitted, over centuries and through generations, in our societal DNA.

A Disease?

In 1955, the American Medical Association stated that alcoholism is a disease, and in 1989 defined drug addiction as a disease. In a 1955 Gallup poll of the general population, 63% of the respondents agreed that alcoholism is an illness.

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[5] White, *The Combined Addiction Disease Chronologies of William White, Ernest Kurtz, and Caroline Acker*, www.williamwhitepapers.com, 2001

[6] (*An Enquiry into the Effects of Spirituous Liquors upon the Human Body, and Their Influence upon the Happiness of Society,* 1784)

[7] Partridge, G.E., *Studies on the Psychology of Intemperance,* 1912

In a 1963 survey, 66% of the respondents agreed that alcoholism is an illness. [8] These were somewhat encouraging percentages that seemed to leave room for growth.

However, a 2014 (50 years later!) survey[9] that compared attitudes about people with addictions v. people with mental illness revealed little movement:

- 64% of the respondents said that companies should be able to deny employment to persons with a drug addiction – 25% said people with mental illness should be denied employment
- 43% said people with a drug addiction should be denied health insurance benefits v. 21% for people with mental illness
- Only 22% said they would be willing to work closely on a job with person with drug addiction v. 62% with someone who had a mental illness
- 30% of the respondents said that recovery from either drug addiction or mental illness is not possible.

The 2014 survey reinforces a 1999 study that affirmed that drug addiction is one of the most socially stigmatized conditions, e.g., viewed as more blameworthy and more dangerous than mental illness.[10] A 2014 survey found that 80% of the respondents described individuals suffering from addiction as weak or lacking will power.[11]

The deeply held attitude and belief remains constant.
This is what we are fighting against.
This is why we need aggressive and collective action in the form of a targeted and comprehensive anti-stigma campaign.

We must understand that we are fighting a complexity of long-standing and deep-seated mutually reinforcing mechanisms. We must understand that we are attempting to change deeply held attitudes and beliefs.

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[8] Johnson, *The Alcoholism Movement in America: A Study in Cultural Innovation,* University of Illinois, Ph.D. Dissertation, 1973

[9] *Discrimination, Treatment Effectiveness and Policy: Public Views About Drug Addiction and Mental Illness,* Oct 2014, Psychiatric Service

[10] Corrigan, et al, *The public stigma of mental illness and drug addiction: Findings from a stratified random sample., Journal of Social Work,* 1999

[11] http://www.drugrehab.org/is-drug-addiction-hereditary/

Any campaign to counter addiction/treatment/recovery-related stigma must ask two related questions:

- "What is the source of stigma?"
- "Who profits from stigma?"

Stigma— the Source

"All the people like us are we, and everyone else is they." (Kipling)

Stigma is a complicated subject. It is multi-dimensional, there are different types, and there are functional theories. Stigma is powerfully linked to oppression. There are four broad types of addiction-related stigma, and at least a half dozen different dimensions of stigma that can relate to people with substance use disorders. An exploration of types, dimensions, and the power implications goes beyond the scope of this report. This report will attempt to give a brief overview of stigma as it relates to Rhode Islanders with addictions, and suggest some ways to combat that stigma.

The word 'stigma' originates from an ancient Greek word meaning tattoo or puncture mark made with a sharp object. This stems from a practice in ancient Greece of branding slaves with a pointed stick to ensure universal recognition of their status and to prevent them from absconding. The classic definition of stigma comes from Erving Goffman…'an attribute that is deeply discrediting' and that reduces the bearer 'from a whole and usual person to a tainted, discounted one.'[12]

On one level, stigma is a universal phenomenon. Many of us have experienced a side of the stigmatizing relationship, experiencing negative responses to our acne, nationality, weight, glasses, baldness, etc. These examples may, or may not, have had serious consequences for us. But it is when the stigma overrides all other aspects of our identity and when it looms over and affects our interactions with others that the impact can be damaging - when our membership of a particular group becomes the defining feature of our identity: what Coffman calls our 'master status.' The reasoning goes: "A blind person ... can never just be a college student or a lawyer, at best he or she will be 'the blind college student' or 'the blind lawyer." [13]

Stigma is different from disapproval of particular behaviors – it's not necessarily linked to the actions of an individual, but rather to what is assumed about 'someone like that.'

[12] Stigma; Notes on the Management of Spoiled Identity, 1963
[13] Jones, et al, *Social Stigma: The Psychology of Marked Relationships,* 1984

Stigma Associated with Addictions

Here is a quick look at the research.

The social stigma attached to addiction exists at cultural, institutional, interpersonal, and intrapersonal levels.[14] There is no physical or psychiatric condition more associated with social disapproval and discrimination than alcohol and/or other drug dependence.[15] Addiction-related social stigma constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the cultural resources allocated to alcohol and other drug-related problems.[16] Addiction-related social stigma extends to people who have achieved stable recovery from addiction.[17] The social stigma attached to illicit drug use varies by drug and method of ingestion: heroin and crack cocaine are the most stigmatized substances and injection the most stigmatized method of ingestion.[18] An especially troubling effect is that social stigma is a major factor in preventing individuals from seeking and completing addiction treatment.[19]

Our Master Status

Goffman characterized a 'master status.' It seems clear to us that 'drug addict' is a master status. This master status affects how the public understands and responds to drug users and blinds them to other attributes and other aspects of personality and lifestyle. It is self-evident to us that a significant percent of the general public perceives people with addictions as dangerous, deceitful, unreliable, unpredictable, and to blame for their predicament.

While these are seen as characteristics of people with active addictions, they redound upon people in addiction recovery. We believe that *blame* and *responsibility* lie at the heart of the stigmatization of people with addictions, especially drug users. It is this

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[14] Woll, *Healing the stigma of addiction: A guide for treatment professionals,* Great Lakes Addiction Technology Transfer Center, 2005
[15] Corrigan, et al, Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members, Journal of Family Psychology, 2006
[16] White, et al, *Stigma: The Addictions Professional as Activist,* 2009
[17] Tootle, Social acceptance of the recovering alcoholic in the workplace: A research note, Journal of Drug Issues, 1987
[18] Surlis & Hyde, *HIV-positive patients' experiences of stigma during hospitalization,* Journal of the Association of Nurses in AIDS Care, 2001
[19] Luoma, et al, *An investigation of stigma in individuals receiving treatment for substance abuse,* Addictive Behaviors, 2007

blame that makes it difficult for problem drug users to be adopted as an unfairly treated group, alongside clearly blameless groups such as the mentally ill and the disabled.[20] When the historical perception that defines us as blameworthy is combined with our status as criminals (meaning that we are also to be feared), it easily makes us subject to exclusion and discrimination in many areas.[21]

"Our national drug is alcohol. We tend to regard the use of any other drug with special horror."
(William Burroughs)

Stigma is also powerfully associated with the fear of illicit drugs. This linkage to the stigma of drugs further reinforces the stigma of individuals who use prohibited drugs.

Stigma: Who Profits?

It is a bit remarkable that the social stigma attached to people with alcohol and other drug problems has been able to remain so prevalent. It seems self-evident to us that there are other forces in play in addition to lack of information/education and the existence of generationally transmitted attitudes. The obvious question is: Who benefits? And the obvious starting point is: Follow the Money.

William White identifies five social institutions that directly or indirectly benefit from the stigma attached to addiction and addiction recovery:

(1) The Media: For a couple of centuries now, illicit drugs, illicit drug users and illicit drug sellers have been demonized by the media, while at the same time the media is the primary advertising vehicle for licit drugs. The alcohol and other drug (AOD) problems of celebrities are sensationalized. Drugs are identified as being primarily responsible for many societal problems, such as crime and violence. The media uses emotionally alarming language and lurid and fear-evoking images, not to inform, but to promote and sell products.

(2) The Criminal Justice Industrial Complex: How AOD problems are defined dictates problem ownership and the recipients of the resources allocated to address the problems. The twentieth century stigmatization and intensified criminalization of

[20] *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users,* UK Drug Policy Commission, 2010
[21] *Getting Serious about Stigma: the problem with stigmatizing drug users,* UK Drug Policy Commission, 2010

drug problems created the largest expansion of the criminal justice system in American and world history. Suggestions that drug users deserve compassion and care rather than punishment and control threatens the transfer of billions of dollars to other social institutions.

(3) The Child Welfare System: The moral panic that surrounded pre-natal cocaine exposure ('crack babies'), and all the misinformation on which it was based, led to the largest expansion of the child welfare system in the history of the United States. The vested interests have prevented the dismantling of the beliefs upon which the institutional expansion was based.

(4) The Alcohol, Tobacco and Pharmaceutical (ATP) Industries: The portrayal of America's drug problem in terms of illicit drugs and illicit drug markets draws attention from the harmfulness of ATP products and the exploitive marketing practices of the ATP industries. The foundation of the inordinate profits of the ATP industries rests on the stigma attached to illicit drugs, the legal prohibition of these substances, and the resulting inflated industry prices and profits.

(5) Specialty Sector Addiction Treatment: Mainstream health and human service agencies have historically viewed people with AOD problems with contempt and as not morally worthy of compassion and care. The inadequate response of these systems became the rationale for a specialized field of addiction treatment. There is presently a movement toward the integration of addiction treatment, mental health treatment, and primary health care in the U.S. The resistance of addiction treatment leaders to this service integration could be based on legitimate concerns about the capacities of other systems to effectively treat addiction. It could also be based on the threats to personal, professional and institutional interest. If substance use disorders were to be fully destigmatized, one of the outcomes could be the dissipation of specialty sector addiction treatment and the resulting effects on institutional profits.[22]

(6) One More - Others: That is to say, Us. Stigmatizing others often serves to increase the self-esteem of the stigmatizer.[23] It elevates oneself as more worthy than the demeaned 'other' and defines oneself as an upholder of community health and morality. It's a powerfully self-righteous thing.

HOW DO WE START TO COMBAT STIGMA?

[22] Blog and New Postings, March 4, 2016, www.williamwhitepapers.org
[23] Tajfel & Turner, *An intergrative theory of intergroup conflict*, The social psychology of intergroup relations, 1979

Three broad social strategies have been used to address stigma related to behavioral health disorders: (1) Protest or advocacy (2) Education around the disease model of addiction and (3) Increased interpersonal contact between stigmatized and non-stigmatized groups.

What WE Can Do

"We" refers to the Rhode Island recovery communities: people in recovery, our families, our friends, and our allies. As stigma recipients, we must to be involved in any anti-stigma campaign planning. Our lived experience will inform the process. However, our involvement is hypocritical and uninformed if we, as communities of treatment and recovery, do not resolve our own internal stigmatizing attitudes and behaviors.

Our first task is to self-assess, to identify the ways in which we perpetuate and reinforce the stigma and stop our stigmatizing of each other.
An obvious starting point is to stop insisting that there is only one effective and superior approach to recovery. There are many pathways to recovery.

We can stop insisting that there is only one effective and superior approach to treatment. The 'abstention-ists' can stop attacking the 'medication-ists.'
There are simple personal strategies that each of us can take to help create a Rhode Island in which people with a history of alcohol or drug problems, and people in recovery, are valued and treated with dignity, and where stigma, discrimination, and other barriers to recovery are eliminated. They include, but are not limited to:

- Stay recovery focused (on our own recovery)
- Be a recovery carrier/witness – tell stories of individual and family recovery at every opportunity. The most important thing that we have to offer individuals, families and our community is Hope
- Walk the walk – conduct ourselves as an ambassador of recovery and do our best to convey core recovery values such as humility, honesty, gratitude, respect, tolerance, responsibility and service
- Embrace and promote diverse recovery pathways – avoid controversies about <u>the</u> way to treat addiction or <u>the</u> way to recover. Our best message is, 'There are many pathways to addiction recovery, and all are cause for celebration.'[24]

I. Advocacy

[24] White, et al, *Stigma: The Addictions Professional as Activist,* 2009

The simplest, and most effective, advocacy tool is the public faces and voices of people in successful, long-term recovery. When we speak up, we shatter stereotypes; we diminish that 'master status' effect by enabling people to see us as an individual. We can advocate by speaking out against stigma-related discrimination, e.g., in housing, employment, access to health and human services, and stigma shaped policies and practices within addiction treatment.
We can advocate by changing our language. For example, the terms 'substance abuse' and 'substance abuser' are especially problematic. Three reasons why:

- Abuse is the willful commission of an abhorrent act. There are crimes called child abuse, domestic abuse, sexual abuse, elder abuse, and animal abuse. These are heinous acts committed by bad people. The terms 'abuse' and 'abuser' can evoke automatic negative thoughts about people with substance related problems.
- The term substance abuse comes from prior editions of the DSM, the diagnostic and statistical manual for behavioral healthcare professionals. The most recent edition of the DSM has discontinued the diagnostic term substance abuse. The operative diagnosis is now Substance Use Disorder (Mild, Moderate or Severe).
- Those of us that believe addiction is a medical condition should use medical terminology. There is no other medical condition that is described as 'abuse.'

A 2010 study clearly delineates the effect of the 'abuse' term. 314 people, half of whom were healthcare professionals, responded to questions related to how they perceived or felt about two people actively using drugs and alcohol. One person was referred to as a 'substance abuser' and the other was referred to as 'having a substance use disorder.' The result was that participants felt overall that the 'substance abuser' was:

- Less likely to benefit from treatment
- More likely to benefit from punishment
- More likely to be socially threatening
- More likely to be blamed for their substance related difficulties
- More able to control their substance use without help

The result differences were described as "large in magnitude." The conclusion was that the term 'substance abuser' elicits a more punitive implicit cognitive bias whereas the term 'substance use disorder' elicits a more therapeutic attitude. Thus, the "abuser" label may perpetuate stigmatizing attitudes and serve as a barrier to help

seeking.[25] The terms 'abuse' and 'abuser' continue to be commonly used by clinicians, scientists, policy makers, and the general public. This may be one of the reasons that individuals are reluctant to seek treatment. We recommend that the condition formerly known as 'Substance Abuse' be called 'Substance Use Disorder, and that the action formerly known as 'substance abuse' be called 'substance misuse,' 'hazardous substance use,' or 'harmful substance use.'

II. Education

As noted, the American Medical Association designated alcohol and drug addictions as diseases decades ago.
The American Society of Addictive Medicine recently characterized addiction as a 'primary, chronic disease of brain reward, motivation, memory and related circuitry.'[26]
The National Institute on Drug Abuse defines addiction as a chronic, relapsing brain disease that changes the structure and functionality of the brain.
Medical science has spoken.
The field's standard solution and approach to the stigma surrounding substance use disorders and addiction is Education – that SUD's are a disease of the brain, a chronic and reoccurring medical condition. This education typically consists of slides and explanations about brain neurochemistry, genetic predispositions, and compromised executive functions in the pre-frontal cortex of the brain.

This education is necessary; the only problem is – It has not worked.
We don't have to keep saying that cancer is a disease or schizophrenia is a disease, but for decades we have been insisting that addiction is a brain disease - people haven't bought it and still don't buy it.

Scientific validation that addiction has its origin in neurochemistry or the nexus of neurochemistry, genetics and environment has not meant acceptance by policymakers, healthcare professionals, or the public. The frozen attitudes and beliefs about all things related to addiction have not thawed to any meaningful degree.

WHY NOT? Some speculation…
Historically, stigma trumps science. For example, the genetic differences between races and ethnicities are demonstrably miniscule if any, but continue to serve as the basis for stigma that has led to conflict, oppression, and wars. Facts don't necessarily

[25] Kelly & Westerhoff, *Does our choice of substance-related terms influence our perceptions of treatment need? An empirical investigation with two commonly used terms,* Journal of Drug Issues, 2010
[26] ASAM Public Policy Statement: Definition of Addiction, April 2011

change beliefs – facts get 'interpreted' to fit those beliefs. And actually, think critically about it: Why would we think that portraying people as having a chronic brain disease will decrease stigma? Seriously? The characterization as a chronic brain disease might inadvertently risk further contributing to social stigma from a public that interprets 'chronic' in terms of 'forever and hopeless" (once an addict always an addict). Further, the disease understanding may make a person's behavior more understandable, but they do not make the person more desirable as a friend, spouse, neighbor, or employee.

What is missing from the education approach?

We believe that complete information about the brain disease paradigm is necessary but not sufficient. Is it possible that communicating the neuroscience of addiction without simultaneously communicating the neuroscience of recovery and the prevalence of long-term recovery will increase the stigma facing individuals and families? Is it possible that the longer the neurobiology of addiction is communicated to the public without conveying the corresponding recovery science, the greater the burden of stigma will be?
We believe that there are at least two crucial communications that must be included as education companions in order to attain sufficiency:

- With abstinence and proper care, addiction induced brain impairments rapidly reverse themselves
- Millions of individuals have achieved complete long-term recovery from addiction and gone on to experience healthy, meaningful, happy and productive lives.[27]

III. Increase Interpersonal Contact

We believe that the greatest reduction in the stigma related to addiction comes not from the belief that addiction is a brain disease, but through identification with a beloved figure in recovery or persons in recovery from one's family, social, or occupational network.

Contact between stigmatized and non-stigmatized groups as a vehicle of stigma reduction is most effective when this contact is: between people of equal status (mutual identification), personal, voluntary, cooperative, and mutually judged to be a

[27] William White blog: Hijacked brains and the question of social Stigma, 2013

positive experience.[28] Social stigma is particularly influenced by social proximity and distance.[29] For example, community attitudes toward Oxford Houses (a model of recovery housing) are most positive among neighbors who live closest to the houses.

Stigma research suggests that a focus on the abilities, competencies, and community integration of persons with substance use disorders may offer a promising direction to address public stigma.[30]
In other words, and to reiterate, people in successful long-term recovery speaking about their recovery is crucial to combat stigma. We believe that stigma can start to be overcome in Rhode Island when thousands of our faces and voices come forward and announce our recovery.

Some Barriers to the Elimination of Stigma:

- There is the continued cultural dissension about whether the cultural ownership of AOD problems should reside with medicine, religion, or the law - Is the addicted person best viewed as a patient, a sinner, or a criminal?
- The media depiction that demonizes and sensationalizes us is killing us. (Even stories that are produced by sympathetic people tend to stigmatize us – to a degree, this is our fault; we have not educated the media sufficiently)
- While the government purports to view addiction as a disease, it works in opposition to that position through the War on Drugs that declares most drug users criminals. Our society is hardwired to prolong stigmatization, and stigma contributes to addiction's lethality.[31]
- Social reform campaigns are generally the response to the series of 'drug panics' over centuries. These include the response to Chinese railroad workers bringing in opium in the 1800's, the demonization of marijuana and the legal Prohibition of alcohol (also demonized) in the last century, the more recent responses to crack cocaine and then to methamphetamine, and the present response to the opioid overdose epidemic (e.g., the move to charge drug dealers with homicide). These campaigns have done little to affect our nation's drug use problems, but have successfully generated policies of isolation, control and punishment of drug users

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[28] Couture & Penn, *Interpersonal contact and the stigma of mental illness: A review of the literature,* Journal of Mental Health, 2003
[29] Jason, et al, *Attitudes toward recovery homes and residents: Does proximity make a difference?* Journal of Community Psychology, 2005
[30] American Journal of Psychiatry, 2010
[31] www.TheFix.com, 2012

- Some preventionists, and others, believe that the stigma is a valuable community asset. The policies that stigmatize, "unashamedly aim to make the predicament of the addict as dreadful as possible in order to discourage others from engaging in drug experimentation."[32]

It seems clear to us that these barriers have resulted in a situation where addiction treatment professionals, recovery advocates, preventionists, law enforcement, public policy makers, and healthcare professionals are presently working at cross-purposes – all with the goal of mitigating our nation's addiction epidemic and ongoing crises; and none succeeding.

~ A CAVEAT ~

William White cautions us: An anti-stigma campaign could inadvertently increase drug use if it normalized illicit drug use, increased non-user curiosity about drug effects, conveyed the impression that addiction treatment is an assured safety net (available and affordable), that recovery is easily attainable, and that glamorized the recovering addict as a heroic figure within cultural contexts in which few heroic models are available.[33]

We once again derive inspiration from the work and writing of Arthur Evans:
The guiding vision of our work must be to create a city and a world in which "people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated."[34]

NOTE: As always, we have relied heavily on the work and writings of William White in this report. We are grateful to him for his leadership and genius and also for allowing everyone to use his work.
NOTE: Footnotes at the end of paragraphs are intended to apply to all paragraph content; content is often taken verbatim or close to verbatim from the source.

[32] Husak, *The moral relevance of addiction,* Substance Use and Misuse, 2004
[33] White, 2009
[34] Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia, 2013