Chapter 2
The Stigmatization of Drug Use as Mechanism of Legitimation of Exclusion

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Abstract Drug abuse is considered one of the most stigmatizing health conditions. Growing evidence has shown that stigma is associated with the different impairments of stigmatized individuals. The impacts of social stigma include insufficient access to health care, worse indicators of education and employment and, consequently, a negative effect on income. Regarding the availability of services, many people who could benefit from health care do not receive it. In this sense, social stigma becomes a barrier in the search for help and in adherence to treatment. On the other hand, moralizing strategies associated with prohibitionist perspectives, besides being ineffective, restrict the possibilities of access to care for people with problems related to the use of drugs. The lack of trust in treatment services and their efficacy, in addition to stigmatization, has been identified as an important barrier to treatment. This problem requires changes in the screening, detection, and referral of treatment for addiction. Thus, overcoming stigma is necessary to ensure that evidence-based strategies and indicators of effectiveness are used.

2.1 Concept of Social Stigma

Modern conceptualizations of stigma as social injustice can be traced to Erving Goffman (1963), who framed stigma as a mark that leads to "spoiled identity." He believed stigma of all kinds (related to ethnicity, gender, sexual orientation, age, and illness) to be an attribute that is socially discrediting, causing people to being unjustly

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Table 2.1 Matrix describing the stigma of substance use disorders (SUDs)

		Types		
		Public	Self	Label avoidance
Social cognitive structures	Stereotypes and prejudice	*People with SUDs are immoral, to blame for their disorder, and criminal*	*I am dangerous, immoral, and to blame. Leads to lowered self-esteem and self-efficacy*	*I perceive that the public disrespects and discriminates against people with substance use disorders*
	Discrimination	*Employers do not hire them, landlords do not rent to them, and primary care providers offer a worse standard of care*	*Why try? Someone like me is unworthy or unable to work, live independently, or have good health*	*I do not want this. I will avoid the label by not seeking out treatment*

Examples are provided in each of the cells

rejected. Corrigan et al. (2016a, b) developed a matrix useful for understanding the stigma of disease in general, and addictions more specifically. The matrix (see Table 2.1) is defined by two dimensions: social cognitive structures that underlie stigma and types of stigma that meaningfully impact a person with illness.

2.1.1 Stereotypes

Social psychologists distinguish between the largely private experience of stigma in general (stereotyping and prejudice) from the more public, behavioral result that is discrimination (Crocker et al. 1998). Stereotypes are harmful and disrespectful beliefs about a group. What stereotypes might be candidates for the foundation of addiction stigma? Schomerus et al. (2011) began to establish a content-valid measure of alcohol stigma. To identify the stereotypes of alcohol addiction, they conducted focus groups consisting of people with alcohol dependence, providers, and family members. They generated 16 stereotype candidates, including "unreliable," "emotionally unstable," "living at other's expense," and "self-pitying." A similar set of qualitative interviews were conducted to identify candidate stereotypes of "drug users" (Radcliffe and Stevens 2008). Although the resulting analysis from the latter study yielded compelling themes about the form of stigma, specific stereotypes per se did not emerge from their work.

How is a stereotype distinguished from accurate perception? For example, research seems to suggest that violence and crime are associated with drug misuse, although this is a complex relationship with full description requiring additional constructs such as the social determinants of illegal activity (Bennett et al. 2008). Might stereotypes reflect a kernel of truth, that, for example, people who use drugs are in

fact dangerous (Allport 1979)? The kernel of truth rests on assumptions about stereotype accuracy (e.g., research supports the stereotype that "basketball players are tall"). Mostly dated science uses this rationale to argue for accuracy in trait impressions of ethnic groups, such as the Irish are drawn to alcohol or Asians are mathematically strong (Abate and Berrien 1967). Currently, social psychologists are skeptical about the notion of kernel of truth and stereotype accuracy, recognizing that social science is incapable of defining the "traits" of a group in this way (Jost and Banaji 1994). History is replete with assertions that are racist in the guise of kernel of truth. For example, some have asserted that African Americans are intellectually inferior on the basis of population data representing IQ tests (Jensen 1969) when, in fact, better constructed research suggests that any differences in existing scholastic tests represent stereotype threat and concomitant evaluation anxiety (Steele and Aronson 1995). In terms of social policy, any theory that suggests legitimacy of stigma can egregiously be used to further justify discrimination against a group.

2.1.2 Prejudice and Discrimination

Stereotypes are unavoidable; they are learned as part of growing up in a culture; for example, American children learn at a young age that "addicts" are dangerous (Corrigan and Watson 2002). Being prejudiced is agreeing with the stereotype, leading to emotional and evaluative consequences: "That's right! All those addicts are violent and I fear them." In path models, affective responses to stereotypes (another element of prejudice) are often mediators between stereotypes and its behavioral result, discrimination: "And because I *fear* addicts, I will not hire them, rent to them, give them the same opportunities at school, or let them worship with my congregation."

Three emotional responses mediate stereotyping and subsequent discriminatory behavior (Corrigan et al. 2003; Pingani et al. 2012): (1) fear, causing unfair discrimination that undermines personal goals related to work, independent living, relationships, and health; (2) blame (believing people caused their addiction), leading to anger and subsequently to discrimination, often in the guise of unnecessarily coercive treatments; and (3) internalized blame (I caused my addiction because I am weak), leading to shame (decreased sense of self-esteem and self-efficacy).

2.1.3 Stigma Types

Discrimination's impact becomes clear when realizing it varies by type (Corrigan and Kosyluk 2014; Phelan et al. 2008). Three types are summarized in Table 2.1: public stigma, label avoidance, and self-stigma.

Public stigma occurs when the general population endorses stereotypes and decides to discriminate against people labeled as "addicts." Research shows that employers are less likely to hire and landlords are less likely to rent to people with

substance use disorders (SUDs) (van Olphen et al. 2009; Spencer et al. 2008). There is also discrimination when seeking public office or pursuing work in child care (van Boekel et al. 2013). Research shows that health care providers admit to the stigma of addiction (Henderson et al. 2008), which leads to withholding primary care (Weiss et al. 2004) and pharmacy services to people with addictions that are in need (Anstice et al. 2009).

Stigma is likely to undermine support for harm reduction strategies such as safe injection facilities and needle exchange programs (Rivera et al. 2014). However, this is a complex relationship, with the impact of addiction stigma conflated with criminalization. For example, research shows that people who endorse the depth of legal penalties for substance use agree with greater discrimination against people with SUDs (West et al. 2014). Future research needs to unpack the relative impact of addiction and criminalization stigma as well as the ways they interact.

Public stigma impacts care seeking for people with SUD when it leads to *label avoidance*. Epidemiological research shows that only 25% of people with SUDs ever participate in any care program (Dawson et al. 2005). People who perceive higher stigma toward peers with SUDs are less likely to use treatment programs for alcoholism (Keyes et al. 2010) and less likely to participate in sterile syringe programs (Rivera et al. 2014). These are mostly small and compartmentalized studies; however, future research needs to tackle these questions more broadly and rigorously.

Self-stigma occurs when people with mental illness internalize the corresponding prejudice (Link 1987; Link et al. 2001). A regressive model of self-stigma has four stages (Corrigan and Watson 2002), in which people are (1) aware of the stigma of mental illness (also called perceived stigma: "The public thinks people with substance use disorders are dangerous" [Phelan et al. 2000]), which might lead to (2) agreeing with the stigma ("Yep; that's right. Addicts are dangerous!"), followed by (3) self-application ("I'm an addict so I must be dangerous"), which (4) negatively impacts self-esteem ("I am less of a person because I am an addict and dangerous") and self-efficacy ("I am less able to accomplish my goals because I am mentally ill and dangerous"). Self-discrimination causes the "why try effect" (Corrigan et al. 2016): "Why try to seek a job; someone like me is not worthy." "Why try to live independently; someone like me is not able."

Self-stigma seems to have an equally egregious effect on the well-being of people with addictions (Luoma et al. 2013). Research by Schomerus et al. (2011) partially validated the regressive model of self-stigma for people with alcohol dependence. Namely, people who apply stereotypes to themselves report greater harm to self-esteem, which, in turn, seems to undermine drink-refusal self-efficacy. Other studies showed self-stigma of addictions to be associated with greater depression and anxiety, as well as diminished psychological well-being (Brown et al. 2015; Luoma et al. 2013). Interestingly, some research suggests that self-stigma does not always lead to harmful effects. One study showed that people with higher self-stigma were more likely to stay in treatment longer, leading to higher abstinence (Luoma et al. 2014). This finding shows the complexity of stigma in addiction, calling for research that looks at the varied directions of, in this case, self-stigma on the person who internalizes stereotypes.

2.2 Moralization of Drug Use and Consequences of Stigmatization

2.2.1 Stigma and Substance Use Disorders

Drug abuse is one of the most serious public health problems in the world, and the prevalence of users has been growing over the years. These problems, although largely avoidable, represent a significant social and health burden globally (WHO 2016). Drug abuse is also one of the most stigmatized conditions, even compared with stigmatized mental illnesses. There is a consensus among specialists, advocates, and stakeholders that the stigma of addiction has a negative effect on clinical outcomes and the well-being of people with SUDs or those who are users but do not have a disorder (Corrigan et al. 2016a, b).

Studies have shown that alcohol and drug addiction are one of most stigmatized condition (Silveira et al. 2015), being judged as much more responsible for their condition. In addition, substance addicts cause more social rejection and more negative emotions in the general population and are at particular risk of social and structural discrimination (Schomerus et al. 2011).

The intense rejection of drug dependence is closely related to the way society has been dealing with the issues that are associated with it, ranging from explanatory models to social practices guided by them. Throughout history, conceptual definitions related to drug addiction have characteristics that tend to moralize behaviors and problems that occur as a result of substance abuse. The moderate consensus among the theoretical models that try to explain it makes this condition capable of producing several negative reactions. Among them, shame, rejection, and guilt stand out; these reactions end up ignoring the social and biological context of addicts (Frank and Nagel 2017).

The reasons why drug users are subject to stigma are diverse and complex, involving historical, sociopolitical, and economic factors. However, it is necessary to recognize how current attitudes and public policies reflect the dominant moral model of addiction in the first half of the twentieth century. This model understands that the use of drugs is a personal choice and adopts a critical moral position against this choice. Drug addicts, in this model, are considered weak, antisocial, selfish, lazy, and as people who value pleasure (Pickard 2017).

The medical or disease model makes different assumptions from the moral model, although also widely diffused, and considers dependence a compulsion, a chronic neurobiological disease in which the individual has no rational control or judgment (Frank and Nagel 2017; Pickard 2017). Based on genetic, neurophysiological, neuroscience, and animal models, the medical model has spread the understanding of dependence as a type of "kidnapping of the brain" (Frank and Nagel 2017). To prevent drug addicts from being seen as bad people, and therefore to avoid stigmatization, it is proposed that they should be seen as victims of a chronic and recurrent brain disease and treated with an individual and often decontextualized approach (Heather 2017). However, considering drug addiction as a disease

through the adoption of medical terms does not necessarily result in a discourse free of moralization (Frank and Nagel 2017).

Studies have pointed out that substance abuse is also stigmatized by health professionals (Silveira et al. 2015; Ronzani et al. 2009). According to Room et al. (2001), social disapproval of addiction is greater than social disapproval of a range of highly stigmatized conditions, including leprosy, HIV-positive status, homelessness, dirtiness, neglect of children, and a criminal record for burglary. Pickard (2017) emphasizes that stigmatization can be a mark of social disgrace. It carries condemnation and ostracization by society and, typically, creates corresponding shame and isolation on the part of the stigmatized person.

2.2.2 Consequences of Stigmatization among People with Substance Use Disorders

The impacts of social stigma include insufficient access to mental health care (Corrigan et al. 2014), reduction in life expectancy, low education levels, unemployment (Silveira et al. 2016), increased risk of connections with criminal justice systems, and poverty (Gronholm et al. 2017). Despite the availability of evidence-based services, epidemiological research suggests that many people who could benefit from health care do not receive it. Thus, social stigma becomes a significant barrier in the search for help (Corrigan et al. 2014).

Substance users might choose to hide their habit or even isolate themselves from social interactions, which could exacerbate the effects of stigma and discrimination (Luoma et al. 2013). Furthermore, substance users may internalize the negative views of society about their health condition, which, in addition to affecting their willingness to seek help and adhere to treatment, can generate negative emotions such as a perception of self-discredit and feelings of worthlessness and devaluation (Li et al. 2009).

The effects of stigma internalization are related to several factors, from the restriction of good life opportunities to difficulty in accessing health services, thereby enhancing the social exclusion of individuals (Li et al. 2009). Studies show that internalized stigma is associated with global impacts on the life of the bearer of a stigmatizing condition, including loss of self-esteem and self-efficacy, which reduce their already limited prospects of recovery. Similarly, individuals who internalize stigma may not adhere to psychiatric treatment in an effort to minimize the chance of being labeled or prevent their condition from being discovered. Some feel hopeless and believe that treatment no longer has an effect on them (Fung et al. 2007; Silveira et al. 2016).

In addition, the negative way that health professionals perceive the user creates obstacles for those seeking treatment, which contributes to their exclusion (Ssebunnya et al. 2009). This leads to poor adherence to treatment, aggravation of symptoms, decrease in quality of life, low self-esteem, and low self-efficacy (Li et al. 2009; Ssebunnya et al. 2009).

As discussed earlier, the impacts of stigma relating to drug use suggest that many people decide not to look for health services or abandon treatment prematurely. Despite the advances in mental health care, studies show that professionals sometimes perform treatment using what could be perceived as coercive means, including hospitalization and reducing an individual's personal control (Corrigan et al. 2014), which is particularly frequent when it comes to users of alcohol and other drugs.

2.3 Stigma, Social Exclusion, and Public Policies: How Stigmatization Becomes Official Exclusion Actions

In the health field, healthcare is inextricably related to public policies, guidelines, and social norms. Accordingly, some questions may be raised, taking into account that health can be conceived as the total or partial realization of separate well-being projects. Going further, the environment in which individuals live influences them, according to their gender, social class, ethnicity, sexuality, and others factors (Gulliford et al. 2013). However, stigma directed at some minority groups and related to certain health conditions is one of the most significant barriers to achieving health (Hatzenbuehler et al. 2013).

Some of the inequalities represented by barriers at the system level are attributed to structural stigma, a macrosocial process that reflects public policies and private institution initiatives that intentionally or unintentionally restrict the opportunities of people with mental disorders (Corrigan et al. 2004). Intentional actions include those that restrict civil rights, occurring in part because of the stigmatizing belief that people with mental disorders are not capable. The unintended manifestations of stigma are related to distribution of resources. As a result of the moralization of substance abuse, for example, the idea that people are responsible for their condition makes it less likely that the government makes the distribution of resources a priority. At the macro-level, structural stigma is related to unequal distribution of resources for mental health. Similarly, not only the provision of services is affected but also the resources for research. Despite the great impact of mental disorders, resources are not available at levels comparable to those distributed for many physical illnesses (Link 1987; Link et al. 2001; Corrigan et al. 2014).

Social stigma has several implications for substance abuse treatment, once professionals are more willing to give poor and coercive treatment. Attached to this, the process of stigmatization reinforces the exclusion model that secures another aspect of discrimination, compulsory treatment. Compulsory treatment is becoming popular in relation to drug use and involves the exercise of power by placing labeled individuals in separate circumstances and treating them differently. This has several implications regarding social relationships and integration impairment, and may also compromise chances for recovery (Schomerus et al. 2011).

As described above, when considering the use of drugs as a choice, the moral model of addiction gives addicts the responsibility of being in their situation and makes them worthy of stigma and the austere treatment that they receive. Hence, as long as the moral model continues to influence conceptions of drug use, implicitly or explicitly, the prejudice and injustices to which drug users are subject may seem justifiable (Pickard 2017). In this context, there is a strong public appeal that considers the brain disease model of addiction as the only way in which the general population, the creators of opinion, and public policy makers can be persuaded not to blame or punish dependent users for their problematic behavior. In other words, rejecting the medical model means believing and spreading the idea that dependency is a moral failure of people with this diagnosis. The main consequence of this argument is the direct opposition: dependence is either a brain disease or a moral failure, which limits understanding the problem in alternative ways (Heather 2017).

Stigmatizing views about drug users legitimize ineffective approaches that not only attribute to users the responsibility for the problems they face, but also blame them for social problems such as violence. Consequently, these stigmatizing views are barriers to the search for treatment and employment, which are important aspects in the recovery and social reintegration of individuals. Overcoming this social stigma is necessary to ensure strategies for prevention, treatment, and social reintegration that focus on the evidence of effectiveness. Furthermore, the involvement of patients in the treatment decision-making process is important, as is considering other requirements of the individual, rather than exclusive focus on abstinence from drug use (Silveira et al. 2016).

2.4 Final Considerations

Corrigan et al. (2016a, b) suggest that studies on stigma related to drug dependence are still limited, predominantly descriptive, and require greater conceptual and empirical sophistication, especially compared with literature on stigma related to mental disorders. However, existing evidence on this topic indicates, according to Grant (1997), that substance dependence brings several negative consequences to individuals, ranging from health consequences to social disabilities. Users are prevented from performing many social roles and are limited to the condition of addiction.

Negative social reactions, based on erroneous or distorted perceptions, may also be harmful. Evidence in the literature indicates that lack of confidence in treatment services and in their effectiveness, as well as stigmatization, are important barriers to the pursuit of treatment. Therefore, changes in the screening and detection methods and in the referral patterns of addiction treatment services are necessary (Grant 1997). As a consequence, many patients who might benefit from treatment do not seek it, as a strategy to avoid stigmatization.

A key duty for all those who are involved in this field is to consolidate countries' abilities to face drug-related public health challenges and offer technical support.

Public health measures must be adequately prioritized, otherwise drug-related mortality, disability, morbidity, and impact on people's well-being will remain a huge global public health problem (WHO 2016).

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