

STIGMA, INTOXICATION & ADDICTION

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The main argument

- Social inequality/lower social class is certainly related to adverse consequences of alcohol and drug use
 - though volume of alcohol or drug use may not be
- But there is an extra dimension in the adverse consequences for alcohol and drugs:
- Alcohol and drug use and problems are heavily moralized
 - stigma and marginalization
 - important in adverse outcomes
- Coming to treatment may itself be stigmatizing

Stigma ...

“... means disqualification from social acceptance, derogation, marginalization and ostracism encountered by ... persons who abuse alcohol or other drugs as the result of negative social attitudes, feeling, perceptions, representations and acts of discrimination”

— Wisconsin State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act

- No necessary relation with poverty/social inequality
 - “deserving” vs. “undeserving” poor
- No necessary relation with alcohol or drug use
 - use often associated with high-prestige and positively-valued activities and statuses – e.g. champagne, ecstasy, cocaine

Properties of psychoactive substances relevant to social value and derogation

- Valued physical goods
 - Subject to commodification, globalization
 - Possession/use often a symbol of power/domination
- Use as social behaviour
 - Social meanings attached to use
 - Use often demarcates inclusion/exclusion in group
- Use as intimate behaviour – substance ingested
 - Risk of contamination/poison, as well as nutrition/pleasure/solace – prescriptions & taboos
- As psychoactive substances: affect thinking and feeling, expected to affect behaviour
 - To the extent of “possession” – submerging the true self?
 - (or revealing the true self?)

What's the problem (at the individual level)? 1

- Perceived outcomes
 - * Violence, aggression
 - * Disturbance of peace and order
 - * Accidents, injuries
 - * Needy, neglected children -- family role default
 - Sloth, non-productivity – work role default
 - Physical health problems (cirrhosis, esophageal cancer)
 - Mental illness due to drinking (alcoholic psychosis, dementia)
 - * intrinsically involves harm to others

What's the problem (at the individual level)? 2

- **Constructions of the behaviour**
 - Intoxication – unpredictable, dangerous
 - Focus on event
 - Habitual intoxication
 - Focus on pattern over time
 - Loss of control/addiction/craving
 - Focus on what the pattern over time becomes
- **Gusfield (1967/1996): “moral passage” between eras in the U.S.**
 - Repentant drinker (early, moral-persuasion temperance)
 - Enemy drinker (prohibitionist period)
 - Sick drinker (post-1940s alcoholism movement)

Concepts and social definitions of use and misuse

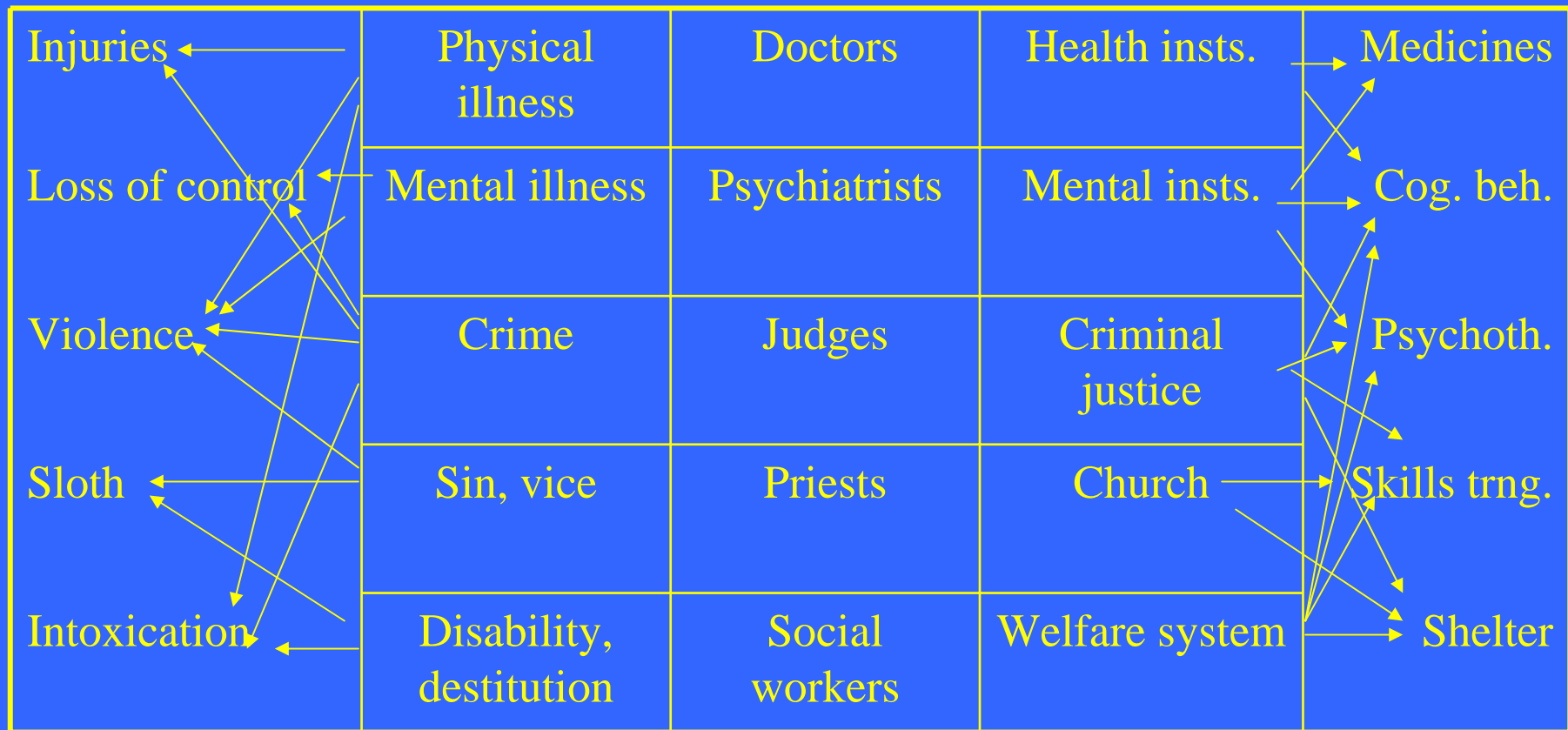
- “In drunkenness of all degrees of every variety, the Church sees only the sin; the World the vice; the State the crime. On the other hand the medical profession uncovers a state of disease.”
 - Norman Kerr, *Inebriety or Narcomania* (1888)

Components of the conceptualizations

- What's the defining problem, and under which social rubric does it fall?
- Which social institutions should deal with it?
- Which professions should deal with it?
- What is the action model to counter the problem?

Responding to problems: rubrics, professions, institutions: 1

(the arrows are not exhaustive)



Responding to problems of alcohol/drug use: rubrics, professions, institutions: 2

- Drug and alcohol problems fall between the jurisdictions
- Often fall in areas of shared jurisdiction
- Not obvious which system should have primary jurisdiction
- Historical shifts in governing image and primary institution
 - Badness to sickness
 - But also the other direction
- Apparently alternative images can be combined
- Old governing images don't disappear completely

Social movements to remove stigma

- “alcoholism movement”: replace the “old moral model” with the disease model
- assumptive frame: disease rubric less stigmatized than crime/sin rubrics
- But:
 - rubrics are not mutually exclusive – adopting one does not mean abandoning the other
 - a disease can still be heavily moralized
- in 14 countries, expert rankings on degree of social disapproval or stigma for 18 conditions:

Degree of social disapproval/stigma: Relative ordering from lowest to highest mean rating within each country

(Room et al., 2001:276)

Condition (& Ordering in Total Sample)	Country													
	Canada	China	Egypt	Greece	India	Japan	Luxembourg	Netherlands	Nigeria	Romania	Spain	Tunisia	Turkey	UK
Wheelchair bound (1)	2	3	1	5	2	5	2	2	1	3	2	1	1	2
Blind (2)	1	5	2	2	4	9	1	1	3	1	1	2	3	1
Inability to read (3)	6	6	3	3	1	2	5	3	2	5	4	5	2	6
Borderline Intelligence (4)	3	4	4	7	5	7	3	4	5	7	5	7	6	4
Obese (5)	9	1	5	1	3	1	4	7	4	4	6	3	14	11
Depression (6)	5	2	10	4	6	15	6	6	9	2	3	12	5	3
Dementia (7)	4	8	7	6	9	10	9	8	7	8	7	4	9	5
Facial disfigurement (8)	7	7	8	8	8	3	7	10	6	6	8	9	8	7
Cannot hold down a job (9)	10	11	12	10	10	4	8	9	11	10	11	11	7	10
Homeless (10)	16	9	6	9	7	12	13	15	8	16	10	8	12	8
Chronic mental disorder (11)	12	13	11	12	14	17	10	8	15	9	9	10	10	12
Leprosy (12)	11	16	9	15	13	11	11	11	18	13	14	6	13	9
Dirty & unkempt (13)	15	14	13	11	12	8	12	12	12	12	13	13	11	14
Does not take care of their children (14)	18	10	16	14	11	6	16	14	10	11	15	17	4	17
Alcoholism (15)	8	12	15	13	15	14	15	16	13	14	12	14	17	15
Criminal record for burglary (16)	13	17	17	16	16	13	17	17	17	18	16	15	15	16
HIV positive (17)	14	18	14	18	17	16	14	13	14	15	18	16	16	13
Drug addiction (18)	17	15	18	17	18	18	18	18	16	17	17	18	18	18
N	15	15	16	15	47	18	16	13	15	15	18	15	15	12

Note: Ranking of 1 indicates least stigma, ranking of 18 indicates most stigma.

Further evidence of social devaluation of substance users

- Public opinion on setting health priorities (Britain, U.S., Australia): less priority for --
 - tobacco smokers
 - “high” alcohol users
 - illegal drug users (Olsen et al., 2003)
- In “disadvantaged” categories of people in deprived districts in Portugal:
 - alcoholics had bad health, but
 - least likely to have used health services
 - most likely to have “bad” or “very bad” opinion of services (Santana, 2002)

Utilization of and attitudes to the health system
among categories of the disadvantaged living in poor
districts in Portugal (Santana, 2002)

	Alcohol addicts	Hard drug users	Home- less	Ex- prisoners	Single mothers	Poor elderly
Health < good	100	96	100	90	87	99
Used health services	15	35	12	20	35	58
Bad opinion of health services	42	31	50	29	28	26

Sources of substance-related stigmatization

- Intimate processes of social control and censure in the family and among friends
 - Often effective
 - But may result in extrusion &/or pushing into treatment
- Decisions by social agents and agencies
 - Attending often to the most problematic cases
 - Decision often amplify the marginalization and stigma (if “tough love” does not “succeed”)
- Policy decisions by local or national governments
 - criminalization
 - regulatory actions; e.g., eviction of family from public housing if a member mixed up in dealing drugs
 - public information campaigns, etc., can also stigmatize

Objects of substance-related stigmatization: what is problematic?

1. **Occurrence of problems ascribed to use:** illness, violence, casualties, failure in work/family roles
 - Those with problems stigmatized by other heavy users
 - “Getting caught” is the problem; the ideal of the “competent drinker”, **controlling** the risks
- Three other areas of stigmatization arising from this:
2. **Intoxication *per se***
 - Other than in “time out”?
 - Unpredictable, disinhibiting, causing bad behaviour
 - Defended only in literary and artistic cultural space
 - Reprehensible or at least questionable in most other public discourse
 - “wrong to appear in public”: the 14-country study again:

Percentage of informants responding “People would think it was wrong” for a person to appear in public, by country

(Room et al., 2001:281)

Condition	Total %	Country													
		Canada	China	Egypt	Greece	India	Japan	Luxem- bourg	Nether- lands	Nigeria	Romania	Spain	Tunisia	Turkey	UK
A woman in her 8 th month of pregnancy	2	0	0	0	0	4	0	0	0	7	0	0	0	7	0
Someone who is blind	3	7	0	0	0	6	0	0	0	7	13	0	0	0	0
A person in a wheelchair	2	0	0	0	13	7	0	0	0	0	0	0	0	0	0
An obese person	12	20	7	13	7	6	19	31	8	13	0	17	0	20	8
A person who is intellectually “slow”	7	7	0	0	0	4	23	0	0	13	0	0	14	33	8
Someone with a face disfigured from burns	6	0	33	6	0	0	0	12	0	20	0	0	13	7	0
Someone with a chronic mental disorder who “acts out”	15	0	33	0	20	17	12	19	17	13	27	22	0	0	17
Someone who is dirty and unkempt	25	20	27	69	20	17	0	44	8	47	40	17	43	0	33
Someone who is visibly drunk	46	13	27	88	27	46	6	81	8	80	73	50	79	14	50
Someone who is visibly under the influence of drugs	58	20	57	100	40	67	M	56	17	64	67	56	79	M	M
N	245	15	15	16	15	47	18	16	13	15	15	18	15	15	12

Objects of substance-related stigmatization: what is problematic? (continued)

3. **Addiction or dependence**

- “diseases of the will” -- loss of control
 - “One of the most vivid and isolating distinctions which can be made in a culture which attributes morality, success, and respectability to the power of a disciplined will” (Lemert, 1957)

4. **Use *per se***

- Justified in terms of risk of harm, addiction
- Selective stigmatization
 - Not for alcohol in mainstream of industrial societies
 - Increasingly for tobacco
 - For illicit drugs, at least officially

Studying stigma

- Two different traditions:
 - Oriented around illness/mental illness/disability:
 - Stigma taken for granted as a social evil
 - Studying effects of stigma, methods of neutralizing
 - Oriented around crime:
 - Stigma taken for granted as an instrument of social control
 - as formal punishment or as an adjunct or alternative
 - Often viewed positively, e.g. re corporate crime
 - “Stigma saturation”: recognition of perverse effects

Alcohol and drugs in studies of stigma

- Not many studies, most analysis in the clinical tradition
 - Stigma as barrier to treatment
 - Managing stigma post-treatment
 - Documenting and decrying public attitudes
- Some parts of field (e.g., drinking-driving) easily fit in the stigma-as-social-control tradition
- As a matter of cultural politics, difficult to extend either frame to cover the whole alcohol and drug field

Marginalization, stigma, and the “two worlds” of alcohol & drug problems

- General population studies
 - Varying distribution by social class of use and level of use of substances
 - Adverse consequences tend to be greater for poorer people (less social and resource margin?)
 - Modest relations with indicators of marginality
- Treated populations
 - Highly marginalized
 - US alcoholism treatment: 1/2 not in families, 60% unemployed
 - Swedish alcohol/drug treatment: only 1/4 married/partnered, 1/2 live alone, 30% homeless, 30% unemployed
- Marginalization and stigma as the salient differences?
Stockholm study of who comes to alcohol treatment ...

(Storbjörk & Room, The two worlds of alcohol problems, *Addiction Research & Theory* 16:676-84, 2008.)

Predicting entry to treatment: Odds Ratios

Variables	Model 1	Model 2	Model 3	Model 4	Model 5
Sex [ref: female]	2.49***	2.49***	1.62	2.10(*)	3.05***
Age [ref: 65+]					
18-34	1.09	2.59*	1.06	1.16	3.05
35-49	2.77***	11.74***	8.07***	7.62*	9.59*
50-64	3.47***	9.61***	7.90***	7.20**	6.38*
Education					
[ref: university]					
Elementary	4.42***	3.15***	1.01	1.01	2.65*
High-school	2.51***	1.63*	1.25	1.35	1.32
Living situation					
[ref: highly stable]					
Fairly stable		2.92***	1.47	.62	.33*
Unstable		30.68***	41.20***	15.94***	6.00**
Work status [ref: work]					
Retired/sick-leave		13.73***	17.77***	22.00***	25.67***
Unempl./Instituted		20.98***	15.57***	12.49***	18.63***
Alcohol: high volume			5.92***	4.02*	2.15
Alcohol: 5+ weekly			8.07***	6.15***	6.90***
Alcohol dep'ce: 3+			19.03***	7.39***	5.13**
Formal response				9.49***	6.47***
Informal response				1.36	1.33
Treatment last year					18.28***
Pseudo R ²	0.0543	0.2849	0.6404	0.7341	0.7679

*** p < 0.001; ** p < 0.01; * p < 0.05; (*) p < 0.10.

Some research directions

- Relation between social inequality and marginalization & stigma in substance use context needs study
- How and when does marginalization & stigmatization happen in the path to treatment?
- Studying effects of stigmatization in a balanced frame
 - are there preventive effects and when?
 - what and how big are the negative/perverse effects?
 - nonstigmatizing alternatives for social control?
- Give priority to studies (individual or aggregate level) of what happens when some aspect of social inequality or of marginalization changes

The ambiguous role of treatment entry

- “doing something about my problem”
- the vouching function of treatment
 - “s/he’s better now”

BUT

- a signal of difference, of incompetence
- when incentives fail, difference is reinforced

Can a “hidden addict” be better off left hidden?

How to construct a treatment service, and a treatment system, so:

- it is no stigma to enter?
- increasing stigma is not a possible outcome?

Clinical, treatment system directions

- Implementing assessment and brief intervention in general practice and other unstigmatized clinical environments
 - Roche AM & Freeman T “Brief interventions: good in theory but weak in practice” *Drug & Alcohol Rev.* 23:11-18, 2004.
- Destigmatizing addiction-specific services: a challenge
 - Often issues in internal attitudes & functioning
 - Still doesn't solve issues in the outside society
 - Some changes over time, but still an uphill climb