

Stigma and Discrimination in Substance Use: Impact and Intervention

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Abstract

Stigma and discrimination are two phenomena found commonly throughout the world. Mental illnesses and substance use are common targets of stigmatized beliefs and discriminatory behavior. Individuals with substance use disorders are especially stigmatized, when compared to many other commonly stigmatized groups. Stigma is commonly categorized in a number of ways, most notably in this context, public and internalized stigma. Public stigma involves the application of negative stereotypes and beliefs to an individual, group, or trait; internalized stigma is the adoption of negative stereotypes and beliefs about oneself or a group to which one belongs. As stigma and discrimination have an impact on a number of populations and can result in significant distress and negative outcomes, the development and identification of interventions to successfully address both public and internalized stigma are both important steps to addressing the damage that stigma can do.

Keywords: stigma, discrimination, substance use, mental illness, internalized stigma, public stigma

Stigma and Discrimination

Both stigma and discrimination can be found in many parts of the world (Kite & Whitley Jr., 2016; Koschorke et al., 2017). The effects of these two phenomena are as far reaching, universal, and consequential as the concepts themselves. Worldwide, stigma and discrimination are often expressed towards individuals who differ from societal norms based on their identity (Casey et al., 2019) or other factors that cause them to deviate from normal expectations, such as those experiencing mental illness and substance use disorders (Michaels et al., 2012; Yang et al., 2017).

One eloquent definition of stigma characterizes it as “the dehumanization of the individual based on their social identity or participation in a negative or an undesirable social category” (Goffman, 1963). More broadly, stigma can be described as a negative (and often inaccurate) belief or view held by a group or individual about a specific trait, behavior, belief, or other characteristic of an individual (Corrigan & Watson, 2002). Discrimination, by contrast, is unjust or prejudicial behavior directed at a stigmatized group (e.g., refusal to work with a person with a mental illness or substance use disorder) (McGinty et al., 2015). Often, the two concepts function in tandem; stigma gives rise to discriminatory behavior which leads to further widespread reinforcement of negative beliefs.

Stigma has been constructed in a number of ways, most notably as public and internalized stigma (Kulesza et al., 2015). Public stigma is the “endorsement by the public of negative attitudes against a specific stigmatized group, which manifests in discrimination toward individuals belonging to that group” (Kulesza et al., 2015). Victims of public stigma may experience it as direct actions or statements, or may simply believe they are targets (Birtel et al., 2017). Internalized (or “self-”) stigma is the same concept, turned inward. Internalized stigma is

the cognitive or emotional adoption of stigmatizing stereotypes and assumptions about oneself or a group to which one belongs (Drapalski, et al., 2013). While stigma and discrimination in relation to both mental illness and substance use have been found, at times, to be more detrimental than the conditions themselves (Thornicraft, et al., 2016), individuals who engage in drug and alcohol misuse are frequently the subjects of especially virulent stigma (Kulesza et al., 2015). In a group already facing challenges like co-occurring mental illness at a rate of 50% (Kronenberg et al., 2014), and an increased risk of infection with HIV/AIDS, hepatitis C virus (HCV), tuberculosis (TB), and other communicable illnesses (Volkow & Li, 2005; Khalsa et al., 2008), the impact of stigma stands only to worsen outcomes and interfere with any long-term recovery in anyone suffering from a substance use disorder.

Recipients and Consequences of Stigma and Discrimination

The consequences of stigma and discriminatory behavior impact health outcomes in many ways (Stangl, et al., 2019). Public stigma, for example, has the capacity to endanger opportunities for employment, housing, education, and healthcare, cause social isolation, impairment, or withdrawal, and is thought to influence suicidality in already vulnerable populations (Rüsch et al., 2014). Stigma also plays a role in how and whether policy-makers may extend aid, such that solutions for more highly-stigmatized conditions (such as substance use disorders) often receive very little in the way of legislative support (Yang et al., 2017). Stigma informs one U.S. policy, for example, that states that a family can be evicted from public housing if any member of it becomes associated with drug dealing. Such policies, while ostensibly well-meant, serve only to further the perpetuation of stigma and discrimination (Room, 2005). When taken to the extreme, stigma against individuals with substance use disorders can be used as a reason to perpetuate extreme injustice upon them. A notable example of the power of stigma

when adopted by lawmakers, which also used the stigmatization of the African American community, is Nixon's war on drugs. This campaign consisted of years of institutionalized stigma and racism that disproportionately affected African Americans using the stigma surrounding substance use as a motivator. The war on drugs solidified many of the inaccurate and discriminatory views of both the African American community and of any individual who engages in substance use (Provine, 2011), and its effects are still felt to this day.

The effects of stigma regarding other factors such as race, profession, or socioeconomic status may also be increased when combined with the stigma around substance use. Members of traditionally stigmatized groups who also engage in substance use may therefore be the victims of increased discriminatory behavior. Racism and institutionalized racial disparities are largely foundational in America's origin—and history has only proven to perpetuate these injustices. Racial minorities are often inaccurately portrayed as impoverished, dependent on state assistance, and violent (Room, 2005). African Americans, for example, are frequently the recipients of stigma and stereotypes that are disproportionately negative (Raley, 2011). Again, the Nixon-era war on drugs is an excellent example of the ways in which a minority status (i.e., African American) can play a role in the reinforcement of negative stereotypes and the dangerous use to which substance use stigma can be put (Provine, 2011).

Another example of a marginalized population that seems to be the recipient of significant stigma both separately from and in relation to their drug use is that of sex workers (Sallmann, 2010). While some sex workers report that their use of drugs and their profession are separate, there is a not-insignificant number for whom their work and their use of substances are inherently connected (Ditmore, 2013). As participation in the sex industry is widely condemned throughout the United States, the receipt of stigma for such participation likely comes as no

surprise (Sallmann, 2010). The perceived stigma of being both a sex worker and an individual who uses substances, however, appears to be compounded when compared to other, non-sex-industry professions (Benoit et al., 2015). One study examined the association between sex work and the use of socially more acceptable (e.g., cannabis and alcohol) and socially less acceptable (e.g., heroin and cocaine) drugs by both sex workers and non-sex workers. This study found a greater association between the use of less socially acceptable substances in individuals engaging in sex-work than in individuals engaging in other professions. Additionally, stigma appeared to play a mediating role in the link between sex work and the use of less socially acceptable drugs (Benoit et al., 2015). Overall, any stigma faced by sex workers for being sex workers appears to be intensified by the stigma associated with substance use. The influence of stigma surrounding substance use and sex work shapes the lives of those whom it is applied to—such individuals routinely face “labeling, violence, and discrimination . . . because of their involvement in prostitution and substance use” (Sallmann, 2010).

In the general public, individuals with substance use disorders are seen by many to be dangerous, unstable, irresponsible, and to be blamed for their own condition—despite a general view that, following initiation of use, sufferers of a substance use disorder had any control over their addiction or behaviors (Yang et al., 2017). Stigma is also a major barrier that prevents many people from even seeking, let alone accepting, treatment for their use disorder, leading only to increased struggles with addiction and any associated mental illness (Janulis et al., 2013). Even among health professionals, evidence suggests that stigma against those with mental illness and substance use disorders may be as severe, if not more, than among the general population (Ye et al., 2016)—with individuals suffering from substance use disorders again taking a much harder hit than those with just mental illness alone.

Often associated with inadequate education, training, experience, and poor infrastructure, health professionals have been found to frequently express negative attitudes toward individuals suffering from a substance use disorder (van Boekel et al., 2013). As health professionals play an essential role in recognizing and treating some of the problems that can co-occur with substance use, a pattern of negative beliefs about those with an addiction is undoubtedly problematic. Like other members of the public, healthcare workers and even some mental health professional have been found to think of individuals with substance use disorders as volatile, violent, and manipulative (van Boekel et al., 2013), a view that undoubtedly interferes with many aspects of the profession which are essential to providing effective care. This has been demonstrated in reduced time spent with, lack of empathy for, and general avoidance of individuals with substance use disorders by healthcare workers (Peckover & Chidlaw, 2007).

The negative attitudes and avoidant approach with which some healthcare providers treat individuals suffering with a substance use disorder is thought to reduce the amount of collaboration that takes place between healthcare providers and individuals suffering with a substance use disorder (van Boekel et al., 2013). For such individuals, this tendency of healthcare providers to withdraw may lead to a loss of the feeling of empowerment, lowered self-esteem, and may interfere with the eventual outcome of the patient (Curtis & Harrison, 2001). As with patients in the HIV epidemic, the perception of individuals with a substance use disorder as ‘dangerous’ or ‘responsible for their own misfortune’ may be ameliorated simply by familiarizing healthcare professionals with the reality of what substance use is and who individuals with a substance use disorder actually are (Peckover & Chidlaw, 2007).

Aside from the potential effects it has in a healthcare setting, stigma is also associated with differences in the general health of individuals suffering from substance use disorders

following recovery. In one study, perceived stigma centering around substance use was associated with lower self-esteem, more anxiety and depression, and poorer sleep (Birtel et al., 2017). Socially, stigma related to substance misuse serves only to isolate individuals with a substance use disorder, to damaging effect. One study found that, when compared to people who are smoking and who are obese, individuals with a substance use disorder were the most highly stigmatized. Additionally, participants of this study had a higher intention to remain “socially distant” from an individual who was actively using substances (Phillips & Shaw, 2015).

Internalized stigma, which is related to increased shame, has been shown to be mediated by higher perceived social support (Birtel et al., 2017), though both public and internalized stigma around individuals with substance use disorders often interferes. Generally speaking, perception of social support and internalized stigma have been shown to be predictive of mental health and this relationship seems (yet again) to be intensified in cases of substance use. Internalized stigma has also been shown to interfere with social functioning in individuals who have substance use disorders, such that higher levels of self-stigma were associated with lower levels of social functioning (Can & Tanriverdi, 2015).

The impact of self-stigma on individuals with substance use disorders also has implications for the efficacy and length of stay in residential treatment. One study by Luoma et al. (2014) examined the relation between levels of internalized stigma and the length of stay in residential treatment. They found that individuals with high levels of self-stigma had longer average stays in residential treatment—a finding that bore out even after controlling for other relevant predictors (Luoma et al., 2014). Another study found that internalized stigma was not only significantly associated with greater substance use problems, it was also the strongest predictor of future substance use problems (Kulesza et al., 2017). These relations are thought to

function at least partly as a result of a sense of reduced self-efficacy and that identification with negative stereotypes may impair an individual's ability to cope with the negative outcomes of substance use (Kulesza et al., 2017; Luoma et al., 2014).

The above factors represent only a few aspects of what makes stigma around substance use so threatening. Unless the barriers to care that both public and internalized stigma cause are somehow circumvented, individuals with substance use disorders are likely only to continue to be negatively impacted—socially, mentally, emotionally, and physically. Additionally, stigma around substance use has been used to dangerous effect as a justification for the poor treatment of already marginalized and vulnerable populations. Not only does this stigma damage its targets, it impacts individuals who are otherwise unconnected to it. Only by breaking down the negative views that others have of individuals with substance use disorders, as well as the views many of these individuals have of themselves, can this damage be reversed and prevented.

Interventions to Reduce Internalized and Public Stigma

Given the severity and pervasive nature of stigma and discrimination that individuals with substance use disorders face, it is imperative to identify interventions to help reduce both public and self-stigma regarding substance use (Drapalski, et al., 2013). Some research has been done to this effect and identifying both the successful and unsuccessful interventions is paramount to introducing systemic change to reduce the negative stereotypes and beliefs that surround substances and their users. Additionally, it may be helpful to examine efforts to reduce stigma related to mental illness generally to develop new strategies for combatting both the public and internalized stigma endured by individuals with a substance use disorder.

One effort to address internalized stigma around individuals with substance use disorders through use of acceptance and commitment therapy (ACT) shows particular promise. Luoma and colleagues (2008) recruited 88 adults divided into nine cohorts to participate in an ACT group in place of their regularly scheduled therapy sessions. Prior to the commencement of their treatment, participants were given a preliminary evaluation that measured levels of a number of traits which included (but was not limited to) shame, internalized stigma, self-esteem, perceived stigma, stigmatizing attitudes and beliefs, and stigma-related rejection. The treatment sessions centered on teaching participants to respond to their stigmatizing thoughts with acceptance, defusing the volatility of their thoughts, and exploring their goals and values as opposed to their automatic thoughts. Following the treatment, participants showed a significant decrease in shame and significant reductions in their levels of internalized stigma when compared to their preliminary evaluations (Luoma et al., 2008).

As internalized stigma is connected to a number of negative effects (Drapalski, et al., 2013), any therapy that helps individuals with substance use disorders cope more functionally with their own negative thoughts and beliefs could serve to reduce the impact that self-stigma has (Luoma et al., 2008). Though this study was primarily a preliminary exploration of the potential benefits of ACT for the reduction of both shame and internalized stigma. Further research is indicated to determine whether this effect can be replicated. In a review conducted by Livingston et al., (2011), several research articles were examined to determine which described modalities showed promise in reducing stigma. Of the three mentioned in reference to reducing self-stigma, the examination of ACT and self-stigma was of particular note (Livingston et al., 2011).

Another study which shows some promise for addressing the stigma surrounding substance use focused on reducing the negative attitudes medical students held toward individuals with substance use disorders. In a study conducted by Silins et al. (2007), first-year medical students were surveyed prior to and following their attendance at a three-week drug and alcohol education course. Fourth-year medical students were given similar surveys both before and after a nine-week drug and alcohol education program. The survey measured the students' general attitude, motivation to intervene with individuals with a substance use disorder, confidence in managing cases of substance use, and the perceived "role legitimacy" of practitioners handling patients with substance use disorders (Silins et al., 2007). In both the first-year students and fourth-year students, a small but significant effect was found, such that students' dislike of problem drinkers was reduced. For fourth-year students a significant reduction in the dislike of heroin users, a moderate reduction in the anticipated level of discomfort in working with people who have alcohol use disorders, and a significant increase in the students' sense of responsibility toward individuals with substance use disorders (Silins et al., 2007).

Given the important role that healthcare providers play in recognizing and treating both substance use disorders and the consequences of those disorders (e.g., overdoses, substance-induced illnesses, etc.), any intervention that demonstrates the capacity to change attitudes regarding individuals with a substance use disorder cannot be overlooked. As stated above, much of what contributes to the public stigma, particularly in healthcare settings, is lack of education or experience with substance use disorders and the individuals who have them (van Boekel et al., 2013). Deprivation or decreased quality of care in emergency or general health care for individuals with a substance use disorder often spells disaster.

A review of the available literature regarding the effectiveness of stigma-reducing interventions in medical settings by Pinto-Foltz and Logsdon (2009) identified several other developing strategies to reduce stigma in relation to mental illness and substance use. For example, two simple interventions shown repeatedly to produce favorable results are those of education and contact (Pinto-Foltz & Logsdon, 2009).

Education reduces stigma simply by providing information that contradicts it. This education can come in various formats (e.g., books, videos, structured programs, etc.) and work to reduce stigma among different groups of people, such as police officers (Pinfold, et al., 2003), government and private workers (Goro et al., 2003), and college students (Kosyluk, et al., 2016). The downside of such educational programs, however, is that they often only reach audiences already in sympathy with the message, are of unknown effect size, and it is unknown whether any significant changes of behavior follow their use (Rüsch et al., 2005). Contact reduces stigma in much the same way by introducing members who hold a stigmatized view with member of the populations to whom the stigma is assigned. The effect of doing so is such that the majority members are less likely to continue to stigmatize members of the stigmatized group in question (Rüsch et al., 2005).

An example of the effectiveness of both education and contact for reducing stigma regarding mental illness was demonstrated in a study conducted by Kosyluk, et al. (2016). Participants in this study were divided into one of two anti-stigma presentation groups and a control group. The treatment conditions consisted of a contact-based anti-stigma group and an education-based anti-stigma group. In the contact-based condition, a currently enrolled student who both suffered from and took medication for was invited to share details of their mental illness (e.g., experience of symptoms, challenges due to their mental illness, and successes, etc.)

and to inform participants what they could do to help reduce stigma. The education-based consisted of a power point presentation given by a graduate student which defined stigma and mental illness, went on to list some common myths about mental illness (such as the belief that mental illness is uncommon among college students), and provided corrective statistics to contradict this myth. Results of this study show that both interventions succeeded in reducing the participants' desired social distance from individuals with mental illness, increasing positive beliefs about individuals with mental illness (e.g., that individuals with mental illness should be empowered), increasing intention to seek treatment, and generally reducing participants' stigmatize beliefs about mental illness (Kosyluk, et al., 2016).

Challenges and Future Directions

While many of the above interventions do show some promise to help reduce public and/or self-stigma and provide excellent places to start, the literature does present a number of problems. First, the age of much of the data and articles specific to reducing the stigma around substance use call into question the validity of these findings in the present day. Any attempt at replication or expansion upon these findings is either missing in the literature or does not exist. The lack of depth and specificity also provides another set of problems. Many of the above studies fall into the categories of preliminary research or pilot studies and need further investigation in order to be considered fully as successful interventions. That many of these studies are geared toward correcting the stigma around mental illness alone, and not the stigma surrounding substance use, also may present a problem. Research has shown that stigma directed toward individuals with substance use disorders is both more severe and more critical than stigma surrounding mental illness alone (Kulesza et al., 2015). Further research must be conducted to determine whether the interventions that function well in reducing stigma around

mental illness will provide the same effect when applied to substance use disorders alone. Currently, the breadth of research is not meet for the problem it seeks to address. Additionally, while the literature in question was reviewed systematically, it is possible that some relevant content or analysis of the topic may have been missed. Still, this researcher is hopeful that, with further investigation, there may yet be a solution suitable to tackle this problem to be discovered.

Conclusion

Though much of the above research in this area is preliminary and requires expansion, hopeful trends can be found, regardless . Overall, stigma and discrimination each play a serious role in the outcomes of the lives of many people with mental illnesses, and especially in the lives of individuals with substance use disorders (Kulesza et al., 2015). It not only impacts the lives of substance-users, it also has the potential to negatively affect populations only tangentially related to it (Ditmore, 2013; Provine, 2011). Though research does exist that has the potential to address substance-use-related stigma, some of which has been reviewed here (Kosyluk, et al., 2016; Luoma et al., 2008; Silins et al., 2007), more work may be needed to identify which interventions are best used to address such stigma.

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