The Field That Was Ashamed (and Proud) of Itself

By William L. White, MA

Exploring the sociological concepts of "courtesy stigma" and "dirty work" affords important insights into how the addiction-related social stigma gets acted out within and between individuals and organizations within the addiction treatment and recovery support arenas. This essay explores how socially-induced shame serves as a catalyst for a number of destructive dynamics within the field while simultaneously spawning strong organizational cultures that assert pride in the work of this specialized profession.

Stigma, as revealed in the classic work of sociologist Irving Goffman (*Stigma,* 1963), refers to a socially discredited status that affects how the discreditors and discredited see themselves and relate to each other. *Courtesy stigma* is the diminished status shared by individuals and organizations closely associated with stigmatized people and issues.

Internalized stigma is the propensity of those who have experienced social and courtesy stigma to self-incorporate devaluing judgments from the dominant culture into their own view of self. Such processes wound self-esteem, lower self-expectations, and, in the extreme, stir acts of self-destruction and aggression against one's own kind.

Dirty work, as outlined by Everett Hughes (*Men and their Work,* 1951), refers to tasks or occupations that, due to their physical, emotional, social, or moral taint, are culturally perceived as repugnant or degrading, even when deemed of value to society. "Dirtiness" is a social construct: it is not inherent in the work itself or the workers, but is instead imputed socially based on subjective and evolving standards of cleanliness and purity (Ashforth & Kreiner, 1999).

Persons experiencing *courtesy stigma* due to their involvement with *dirty work* elicit disparagement, discomfort, and avoidance responses from the general citizenry. As a result, they often isolate themselves professionally and socially to avoid "civilians'" misunderstanding, distaste, or unsolicited and often ill-timed requests for discrete advice. Such discomfort is buffered by the creation of closed ("us versus them") organizational cultures within *stigmatized fields.*

Closed cultures help workers manage the ambivalence toward their chosen work by countering experiences of demoralization with shared expressions of value and pride in the work being done.

Courtesy Stigma & Dirty Work in Addiction Treatment

The field of addiction treatment illustrates the complex dynamics flowing from addiction-related stigma and its accompanying courtesy stigma and dirty work designations. Examples of such dynamics include:

- Inadequate social resourcing of socially designated *dirty organizations* and *dirty workers* on grounds that the *dirty people* served do not morally qualify for greater resource allocation.
- Organizational instability resulting from ineffectual boards, insulated leaders, and oft-changing organizational structures and ownership.
- Inter-organizational competition resulting in exaggerated claims of effectiveness ("Our way is THE way") as a means of status assertion.
- Organizational isolation, inter- and intra-organizational conflict, and isolation from larger professional and social arenas as strategies of taint management (e.g., treatment and mutual aid organizations as *"closed incestuous systems"* [White, 1997]).
- Organizational/workforce hypersensitivity to 1) external attacks on the field, 2) addiction-related casualties of treated patients, and 3) successful recoveries whose sources appear unrelated to professional treatment.
- Workforce instability (problems of recruitment and retention) influenced by social perception of addiction treatment as "dirty work."
- Alternating media portrayals of the addiction treatment workforce as rescuing angels one day and a mix of hustlers, con artists, wanna-be-messiahs, and incompetent or impaired castoffs from other professions on the next day.
- Alternating episodes of recruiting and purging persons with recovery experience as workers within the addiction treatment field.
- Professional taint management strategies that include defensive exaggerations of the value of recovery status as a sole professional credential, professional "passing" (accumulating educational credentials while hiding one's recovery status), or professional distancing (reactive assurances in new social/professional interactions that one's work in the addiction field is not motivated by any past addiction problem).
- Extrusion of impaired counselors as morally unworthy of future work in the addiction treatment field while promoting medical interventions and continued support, rehabilitation, and retention of impaired workers to employers outside the field.
- Continued co-existence of moral (emphasis on personal culpability) and medical models (emphasis on biopsychosocial vulnerability) within treatment and recovery support milieus.
- Incorporation of stigma- and moral-laden language into professional and lay lexicon (e.g., *abuse/abuser, clean/dirty, lapse/relapse*), depersonalization via focus on diagnostic labels, and acts of contempt toward those being served (e.g., sick humor — laughing at versus laughing with).
- Internalizing societal pessimism about recovery and acting out societal stigma via our own anger, frustration, lowered expectations, and apathy, or through frenzied efforts to rescue and save.

- Pejorative labeling of those served who have the most severe, chronic, and complex problems, (e.g., "retreads," "frequent flyers").
- Aggression towards those served, e.g., acts of emotional, sexual, or financial exploitation; invasive therapies; profane confrontations; ridicule and humiliation; clinical abandonment (i.e., physical/emotional distancing, throwing clients out of treatment for confirming their diagnosis via AOD use); and blaming poor treatment outcome on the service recipient's lack of motivation rather than on flawed design or execution of treatment protocols.
- Expiating problems of collective self-esteem via scapegoating of organizational leaders or persons within the field who challenge prevailing ideologies.

It is my contention as a historian of addiction treatment that the above conditions are influenced by courtesy stigma and the social definition of addiction treatment as emotionally dirty work. They differ in prevalence and intensity across geographical, cultural, and organizational settings, and across individual workers. They also ebb and flow over time in response to changes in social attitudes toward addiction, addiction treatment, and addiction recovery, and to changes in the quality of care within the addiction treatment and mutual aid arenas.

Stigma also feeds periodic public and professional attacks on our organizations and our workers, with such attacks serving the role of status enforcement — reminding the field and those it serves of their place in the social order. This is not to say that some of the criticisms of the field during such backlash periods lack factual merit. It does, however, raise questions about such criticisms related to their timing (Why now?), intent (Is the purpose of criticism reform or restraint?), and intensity (Why is part of the field so adamantly portrayed as the whole?).

Effective Taint Management

The suggestion that the history of addiction treatment has been profoundly influenced by the collective wounds inflicted by courtesy stigma and the dirty work designation may on the surface seem ridiculous to those, like the author, who so value this field and worked so long to elevate its status. But that is precisely the conclusion that I have drawn from my studies of this history. Addiction treatment and addiction counselors stand with many similarly affected fields and roles. From the hospice nurse to the police officer, from the AIDS outreach worker to the child protection worker, from the psychiatrist to the prison guard, from the nursing home attendant to the grief counselor, and on and on, people are confronted with the question/comment: "How do you handle it? It must take a SPECIAL person to do that kind of work. I don't think I could do it."

In making this suggestion, it is equally important to acknowledge the strides made to date in altering these dynamics. The resistance and resilience of the addiction treatment field in the face of such marginalization is itself an important story.

Addressing occupational stigma has required three overlapping strategies. The first has been to build a strong infrastructure upon which the field's continued maturation can be based. That has come in the form of numerous professional associations. I anticipate a period of consolidation of these organizations that will allow the field to speak with one voice on issues of emerging consensus. The professional development of the field, including the growth in science-based treatments, improved professional training, refined credentialing/licensing mechanisms, and improved models of clinical supervision — have all been critical to elevating the quality and perception of addiction treatment. These developments have provided a backdrop for the emergence of ennobling ideologies that extol the legitimacy, meaningfulness, and importance of work within the field.

A second taint management strategy has been to move out of professional isolation and enter into collaboration with professionals from allied fields. These collaborations have increased our own sense of professionalism and have afforded important learning opportunities that have affected how we see ourselves and are seen by other health and human service disciplines and the larger culture.

A third, and recently emerging, taint management strategy involves not just improved methods of personally and organizationally managing the social taint, but actually working to change the taint at broad social levels. We must protest, educate, advocate, legislate, and create forums that bring the public into contact with addiction professionals and individuals and families in long-term recovery. We must, through our own stories of lives transformed, become part of the living proof that recovery is a reality, is achieved through diverse pathways, and flourishes in supportive communities. It is this strategy that I think has the most long-term potential. It involves solidifying those working in the field as an advocacy force not just to advocate for their own personal and institutional interests, but to work actively to change the public understanding of addiction, addiction recovery, and the value of specialized treatment in enhancing long-term recovery outcomes. There is a new recovery advocacy movement closely aligned with those goals, and it is time addiction professionals entered into full partnership with that movement. If we are ever to expect people in recovery and their families to publicly tell their stories, we must pave the way by telling the stories of the meaning and value we have found in this unique service ministry. We must share with the civilian world what we have learned about addiction, its treatment, and the fruits long-term recovery extends to individuals, families, and communities.

We need public stories, not of addiction, but of healing, recovery, and recovery giving back what addiction has taken from individuals, families, and communities. We will know that stigma is a thing of the past when the concepts of courtesy stigma and dirty work applied to addiction treatment and recovery lie deep within the dustbin of our professional history.

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