Stigma in the Addicted Person

El estigma en la persona adicta

Mireia Pascual Mollá*,**, Francisco Pascual Pastor***,****.

*Responsable de prensa de SOCIDROGALCOHOL. **Directora campaña #rompeleestigma.
***Coordinador UCA Alcoi. ****Presidente SOCIDROGALCOHOL.

Sign, mark, brand, blemish, blame, stain, scar, shame, affront or disgrace are some of the synonyms used in English to approach the understanding of the word 'stigma', a word which is further defined by the Oxford English Dictionary "as a mark of disgrace or infamy; a sign of severe censure or condemnation, regarded as impressed on a person or thing; a 'brand'".

Throughout history there have been many diseases, health problems or disorders that have been typecast in this way. The only thing this has achieved has been to remove the person from their social environment and to prevent them from receiving the necessary support and enjoying their human rights. Such people have ended up being despised, marginalised, someone to be avoided. In short, we are dealing with a deeply discrediting label.

We have seen it applied to diseases such as leprosy, plague, schizophrenia and even epilepsy. What's going on here? Aren't these individuals people who deserve to be treated the same as others?

Erving Goffman defined "stigma" as the expectation of a stereotypical and discrediting judgment of oneself by others in a particular context (Goffman, 1968).

In recent decades, in addition to the stigmatization of the mentally ill, we have seen how the same phenomenon has occurred in HIV/AIDS, both in relation to the syndrome itself, and even the personal characteristics of the sufferer. And although not a new phenomenon, people who have a substance use disorder, with all that this entails, are also victims of the same disregard, and this reflects badly on our society.

There was also a time when substance abuse was strongly linked to HIV, which made this prejudice even worse. Society tends to pigeonhole certain people and the media facilitates such representations and beliefs (Rengel, 2005). There is also a tendency to label those who have an addictive disorder negatively, highlighting the negative aspects and identifying their condition as an important part of the story, even when this is not the case.

According to sociologist Javier Rubio, the process of constructing this stigma is *always* arbitrary and cultural, and arises from the need to censor people who deviate from what is or is not recognised as socially and culturally acceptable. It operates as an all-encompassing definition with the capacity to discredit the individual/consumer of toxic substances in social exchanges. The stigmatization process turns the drug addict into a dispossessed person, with his/her social identity being established by comparison with non-consumers, and this comparison serves to fix his/her social position as someone who is different and inferior. What is more, the drug use/addiction itself generates a deterioration in the social environment (with relatives, peers, neighbours, etc.) and in the workplace; by living his/her life through the substance, a psychosocial lifestyle is created in accordance with the new situation and the new role, that of a substance-dependent individual (Rubio, 2001).

The consumption of alcohol and other drugs triggers behaviours that are inappropriate to the social construct; addicts may suffer physical and/or psychological disease that distances them from the context of normality, and may sometimes be involved in criminal acts while also being considered accident prone and associated with intimate partner violence or crime. But it is wrong to label them as junkies, idlers or delinquents, without taking into account that their condition as people who have lost control over

Received: July 2017; Accepted: September 2017.

Send correspondence to:
Mireia Pascual Mollà. Grupo de Alcohólicos Rehabilitados de Alcoi. C/ El Camí, 40. (bajos) 03801. Alcoi.
Mail: mireia.pascual@gmail.com

their actions or the inescapable urge to use the drug has been brought about by the addiction itself. Although in principle the stigma is smaller for users of legal substances, when certain thresholds are crossed and the consequences of consumption become apparent this perception fades, as can be seen with alcohol consumption among the homeless and the risk of social exclusion that these people are subject to (Panadero, Vázquez & Martín 2017).

The determination of certain groups to de-stigmatise issues of gender, mental illness or HIV could serve as an example and guide to try to break the stigma of the addict.

We know that the use of psychoactive substances is surrounded by a dark cloud of symbolism. Psychoactive substances may be prestige products, but there will always be aspects of their use which seem to attract almost universal stigma and marginalization, even going as far as to link substance use to crime (Esbec & Echeburúa, 2016).

Processes of stigmatization include the intimate process of social control between family and friends, social and health-related decisions and government policy decisions. Negative moralising normally sees substance abuse associated with health issues, accidents or social problems, intoxication, addiction or dependency, as well as loss of control. Now we call this Substance Use Disorder, and marginalisation and stigma are commonly added to the mix. Those being treated for alcohol or drug problems are frequently and disproportionately marginalised, resulting in adverse outcomes in the therapeutic process (Room, 2005).

We should try to combat the lack of understanding towards people with addictive disorders since the great majority of people with addiction problems suffer social rejection and are isolated and stigmatised.

It seems paradoxical that we can see the use of certain substances being encouraged, publicised and applauded while the consequences are repudiated.

We see three aspects to this problem:

a. Self-stigma, or concealment of the problem on the part of the sufferer (isolation, non-recognition, etc.), frequently conditioned by shame, which affects health behaviours and generates invisibility, thus negatively affecting socio-political decision making (Dolezal & Lyons, 2017)

   Self-stigma occurs, for example, when people with mental illnesses internalise negative stereotypes and prejudices about their condition, which can reduce help-seeking behaviour and treatment adherence. The problem is that while attempts have been made to combat self-stigma, the effectiveness of interventions is has so far been uncertain, according to a meta-analysis carried out in 2013 (Büchter & Messe, 2017).

   Ultimately, the conception of oneself or self-perception is that of "I am inferior. Therefore, people will dislike me and I cannot be secure with them" (Perry, Gawel & Gibbon, 1956).

b. Social stigma through rejection by the part of the population that does not understand what a person with an addiction is and continues to catalogue addiction to any substance as a vice. Attempts have been made to evaluate different interventions with the mentally ill, and the results highlight the importance of focusing on the behavioural outcomes of the stigmatization process (discrimination and social inequality), which is consistent with models of social justice or rights emphasising social and economic equity for people with disabilities (such as equal access to services, education, work, etc.). However, they also call into question the broad approaches of public education in favour of more specific interventions based on contact (Stuart, 2016); the program proposed by Socidrogalcohol along these lines has been supported from the outset by the affected groups and family members.

c. Finally, the stigma in the public healthcare sector where people like this are seen as a nuisance, and where there is a tendency to label them before even listening to them. It is most likely a lack of sensitivity or even proper training that triggers a certain rejection among these professionals.

   And without needing to go any further, let us not forget that stigma and its consequences are exacerbated when women are involved or when the addict has some physical and especially mental illness, that is to say, when he/she suffers a comorbidity or the coexistence of different sicknesses, diseases or disorders (Foundation Transform Drug Policy, 2010).

This problem was mitigated to a certain extent by the fact that addicts are considered to be sick, according to the WHO's definition of illness as "Alteration or deviation from the physiological state in one or more parts of the body, because of generally known reasons, manifested by characteristic signs and symptoms, and whose evolution is more or less predictable", since for the WHO, health is *a state of complete physical, mental and social well-being, and not only the absence of disease or infirmity* (WHO, 1946) even when considering dependency disorder. As a result such people have the same right to care as any other type of patient. This has made it possible for more people to be provided with care, although this has not yet occurred across the board.

But what is important is perhaps that it is based on the concept of health as the state of complete physical, mental and social well-being, and not just the absence of disease. Therefore, not only does it depend on good physical or physiological condition, but also on the influence of the psychological aspects of one's environment (socioeconomic, family, work, emotional, environmental factors), which in the final analysis is what should be considered when dealing with anybody with a dependency disorder, applying the bio-psycho-social model which governs their care.

We have to take into account that the healthcare resources for attending to these people also frequently reinforce this stigma and that governments in general forget the importance of investing in their recovery; they appear unaware of the fact that the saving that could be achieved when investing in prevention is much greater than the cost, and that all dimensions - social, welfare, prevention, administrative resources, absolutely all of them - are permeated by stigma.

Stigmatization of families supporting an adult with substance abuse disorder is widespread and undermines their ability to support the individual and maintain their own well-being. In a recent study, "keeping it secret and minimising contact with others" and "lack of knowledge and empathy" are shown to exacerbate the problem. It also speaks of the useful role of nursing and, in general, professionals working with addictions, who could help reduce stigma through a special approach, thereby challenging the attitudes of some clinicians, and improving ways of communicating with families (McCann & Lubman, 2017).

At the scientific society Socidrogalcohol, we are aware of these issues and propose an awareness raising scheme with the goal of reducing the stigmatization of people with addictive disorders through a programme which aims to:

- Promote an approach which is integrated, public and free, involving coordination with non-governmental organisations, patient organisations and the private sector, in which physical, psychological and social aspects are equally important in achieving the total recovery of the person.
- Demand care structures appropriate to the needs of patients and their families: outpatient treatments, hospital resources for detoxification, day centres, therapeutic communities, specific programs for dual disorders, sheltered housing, reinsertion programs and support and coordination with mutual support groups.
- Standardise services and care resources: standardisation of integrated resources within public health networks.
- Provide each centre with a small team of professionals, in accordance with their characteristics, working in a multidisciplinary way with a bio-psycho-social approach.
- Demand that the rights of these patients to receive treatment and care under the same conditions as anyone suffering other pathologies are upheld and consolidated.
- Demand governmental support for patient and family organisations.
- Increase social awareness of the fact that addiction is a disease.
- Raise social awareness of the need to reintegrate addiction sufferers, and that stigma does not contribute to this but complicates it.

To this end, a program of action has been developed which takes into account the three agents involved in the problem, i.e. the person him/herself (by involving addict groups and their relatives), society in general, and public healthcare professionals, with the contents and materials being created accordingly. On the one hand, we have drawn up a document containing the points of equity, homogeneity and entitlement to healthcare set out above. Furthermore, endorsements have been requested in order to raise awareness, but above all to give the whole programme maximum publicity and to let others feel that they are also part of the process. We also have the support of patient associations, professional groups, foundations, etc., both in Spain and in different parts of Europe.

At the same time, we have produced written material, such as diptychs and leaflets, which has been complemented by a series of specific posters which show the addict as equal to anybody else requiring public healthcare, all accompanied by gifs, testimonial videos for social networks, TV and radio spots. The aim is to get the message across to the greatest possible audience. And finally, materials are being developed to raise awareness also among all professionals, counting on the help of nursing staff, professional colleges, doctors, psychologists and social workers. We are using the media and also organising debates in the autonomous communities and at the national level to generate the maximum possible resonance.

In addition, the social networks could not be ignored. The campaign uses the hashtag #RompeElEstigma both on Facebook and Twitter to spread and highlight the message, and on many occasions we use a second hashtag #CombateLaAdiccion. The choice of name for the campaign and the hashtag, which is the same, was made for a simple reason: stigma, as outlined at the beginning of this article, is something that accompanies a multitude of diseases, and by using the same message we can join forces with other groups also fighting for the same cause. Sometimes, however, we are interested in focusing on the message that stigma is present in addiction, and for this reason the word 'addiction' is always present.

The materials that have been produced transmit two main messages. 1. That addiction is a disease. 2. That anyone can suffer it and that its appearance, age, sex, condition, etc. cannot be used to label the person. To this end, the materials are produced as an interrelated series of items, that is, the radio ads, the TV spot, the posters and the diptychs use the same characters, the same messages and the same scenarios.

To make the campaign identifiable, we have come up with a mascot in the form of a bird which, caged in its stigma, manages to liberate itself and gain its freedom. A friendly and fun image that reaches out to its target and provides a focal point of unity and understanding for all involved in this obstacle to the proper care of addiction.

The bird itself develops as the campaign progresses, facing up to its own 'self-stigma'; its logo initially features a capital 'E' for 'Estigma' but this ends up being torn off as the bird finds freedom and replaced by the 'L' of 'Libertad'.

In addition to the actions described above, in order to disseminate the campaign the structure and organisation of Socidrogalcohol's delegations in the autonomous communities was used. After the material was printed, it was delivered to each community, with each local delegation being in charge of distributing to the different resources. In addition, they were encouraged to use the endorsements of the primary document, and to be actively involved in the distribution, for example, with the option of adding a tagline at the end of the advertisements, such as "With the collaboration of ...", adding the name of the association or entity. The intention is to reach out as far as possible; we understand that the task of destigmatising involves each and every one of the social agents concerned, and without this it will be difficult to reach society in general.

The campaign is not closed. On the contrary, it is alive and programmed for continuous change that adapts itself to society and moments in time, as well as to the observations of those who can put it into practice. New materials in multiple forms, videos, publications, etc. will be published. At the very least we should be able to plant the word 'stigma' firmly within the field of addictive disorders so that at least reflection and debate are encouraged, because without this we cannot contribute to or encourage change, nor develop an approach of how best to deal with it.

The importance of the implementing this program against stigma can be found in the words of UN Secretary-General Ban Ki-moon in 2008 (Ki-moon, 2008).

"*No one should be stigmatised or discriminated against because of their dependence on drugs. I urge Asian governments to amend antiquated penal legislation laws that criminalises the most vulnerable sectors of society, and to take all necessary measures to ensure that these people can live in dignity.*"

Conflict of interests

The authors state that there is no conflict of interest.

Bibliography

Büchter, R.B. & Messe, M. (2017). Interventions for reducing self-stigma in people with mental illnesses: a systematic review of randomized controlled trials. *German Medical Science, 15,* Doc07. doi:10.3205/000248.

Dolezal, L. & Lyons, B. (2017). Health-related shame: an affective determinant of health? *Medical Humanities,* pii: medhum-2017-011186. doi:10.1136/medhum-2017-011186.

Esbec, E. & Echeburúa, E. (2016). Substance abuse and crime: considerations for a comprehensive forensic assessment. *Adicciones, 28,* 48-56. doi:10.20882/adicciones.790.

Goffman, E. (1968). Stigma: Notes on the Management of Spoiled Identity. New York: Simon and Schuster.

Foundation Transform Drug Policy, (2010). Retrieved at http://www.countthecosts.org/sites/default/files/Stigma_Spanish.pdf.

Ki-moon, B. (2008). Message of June 26, 2008. On the 60th anniversary of the Universal Declaration of Human Rights. Retrieved at http://www.un.org/es/sections/universal-declaration/60th-anniversary-universal-declaration-human-rights-1948-2008/index.html.

McCann, T.V. & Lubman, D.I. (2017). Stigma experience of families supporting an adult member with substance misuse. *International Journal of Mental Health Nursing.* Advance publication online. doi:10.1111/inm.12355.

Panadero, S., Vázquez, J.J. & Martín, R.M. (2017). Alcohol, poverty and social exclusion: Alcohol consumption among the homeless and those at risk of social exclusion in Madrid. *Adicciones, 29,* 33-36. doi:10.20882/adicciones.830.

Perry, H. S., Gawel M. L. & Gibbon, M. (1956). *Clinical Studies in Psychiatry.* Nueva York: W. W. Norton & Company.

Rengel Morales, D. (2005). La construcción social del 'otro'. Estigma, prejuicio e identidad en drogodependientes y enfermos de sida. *Gazeta de Antropología, 21,* artículo 25.

Room R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24,* 143–155.

Rubio Arribas, J. (2001). Proceso de la construcción social de un enigma: La exclusión social e drogodependiente. *Nómadas, 4.* Retrieved at http://www.redalyc.org/articulo.oa?id=18100414.

Sturat, H. (2016). Reducing the stigma of mental illness. *Global Mental* Health (Cambridge), 3, e17. doi:10.1017/gmh.2016.11.

World Health Organization. (1946). World Health Organization Constitutive Act. Retrieved at http://www.who.int/suggestions/faq/es/