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Towards greater understanding of addiction stigma: Intersectionality with race/ethnicity and gender

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ABSTRACT

Background: In spite of the significant burden associated with substance use disorders, especially among persons who inject drugs (PWIDs), most affected individuals do not engage with any type of formal or informal treatment. Addiction stigma, which is represented by negative social attitudes toward individuals who use alcohol and/or other drugs, is one of the barriers to care that is poorly understood. The current study: a) assessed implicit (indirect and difficult to consciously control) and explicit (consciously controlled) beliefs about PWIDs among visitors to a public web site; and b) experimentally investigated the effects of ethnicity/race and gender on those implicit and explicit beliefs.
Methods: N = 899 predominantly White (70%) and women (62%) were randomly assigned to one of six target PWIDs conditions: gender (man/woman) x race/ethnicity (White, Black, Latino/a). Participants completed an Implicit Association Test and explicit assessment of addiction stigma.
Results: Participants implicitly associated PWIDs (especially Latino/a vs. White PWIDs) with deserving punishment as opposed to help ($p = 0.003$, $d = 0.31$), indicating presence of addiction stigma-related implicit beliefs. However, this bias was not evident on the explicit measure ($p = 0.89$). Gender did not predict differential implicit or explicit addiction stigma ($p = 0.18$).
Conclusions: Contrary to explicit egalitarian views towards PWIDs, participants' implicit beliefs were more in line with addiction stigma. If replicated and clearer ties to behavior are established, results suggest the potential importance of identifying conditions under which implicit bias might influence behavior (even despite explicit egalitarian views) and increase the likelihood of discrimination towards PWIDs.
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1. Introduction

Most individuals with substance use disorders (SUDs) do not engage with formal treatment (e.g., outpatient or residential specialty care) or informal help services (e.g., peer support groups), making addressing barriers to care for SUDs a healthcare priority (Grant et al., 2016, 2015). The Affordable Care Act (U.S. federal law enacted by President Obama in 2010) is anticipated to improve access to and quality of treatment for SUDs (Humphreys and Frank, 2014). However, unless directly addressed, barriers such as addiction stigma will continue to impede quality of care and utilization of services (Grant et al., 2016, 2015; Volkow, 2008). Critically, a 10-year-long epidemiological survey suggests that addiction stigma has remained stable over time in the U.S. (Chartier et al., 2016; Pescosolido et al., 2010). Simultaneously, addiction stigma continues to be understudied and poorly understood (Kulesza et al., 2013; Livingston et al., 2011). To address this gap, we assessed implicit and explicit addiction stigma and experimentally evaluated the intersection between addiction stigma and other forms of bias (i.e., racial/ethnic and gender).

Addiction stigma is conceptualized as the endorsement of negative stereotypes, by members of the general public, towards individuals coping with SUDs, including persons who inject drugs (PWIDs); thereby increasing marginalization and discriminatory behavior directed at this stigmatized group (Link and Phelan, 2001; Link et al., 1989). Addiction stigma is thought to exacerbate both structural and individual-level barriers to treatment and

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help-seeking (Corrigan, 2004; Hatzenbuehler et al., 2013; Link and Phelan, 2006).

On the structural-level, beliefs that individuals coping with SUDs deserve to be punished rather than helped are related to lower support for public health-oriented drug control policies (funding for SUDs treatment, harm reduction services, etc.), among the general public (Kulesza et al., 2015; Lee and Rasinski, 2006; MacCoun, 2013; Matheson et al., 2013). Thus, moralistic and punitive views towards individuals who use drugs seem to be adversely related to availability of help services for SUDs (Kulesza et al., 2015; MacCoun, 2013). On the individual-level, persons with SUDs might decide against seeking help to avoid anticipated stigma from healthcare providers, employers, and/or neighbors (Link and Phelan, 2001; Link et al., 1989). Longitudinal (Chartier et al., 2016) and cross-sectional data (Keyes et al., 2010; Oleski et al., 2010; Radcliffe and Stevens, 2008) indicate that individuals, who perceive high levels of addiction stigma within society, are less likely to access SUDs help and treatment services.

1.1. Implicit and explicit addiction stigma

Stigma is a multi-faceted construct that is optimally evaluated in multiple ways to provide a more comprehensive understanding of its constituent parts. Traditionally, addiction stigma has been assessed with explicit or self-report measures (Kulesza et al., 2013), which capture beliefs and attitudes that individuals are aware of, have conscious control over, and are willing to report. Stigma may also be assessed with implicit measures, such as reaction time assessments. They capture fast, automatic associations between constructs held in memory and may reflect beliefs or attitudes held outside conscious awareness and volitional control (Dovidio and Fiske, 2012).

While the addiction stigma literature has been dominated by the use of explicit stigma assessments (Kulesza et al., 2013), including both forms of assessment has advantages (Rusch et al., 2010; Van Boekel et al., 2014). First, implicit and explicit measures predict unique variance in behaviors across many domains (Greenwald et al., 2009), including substance use (Reich et al., 2010), suggesting that these measures are not redundant. Second, notwithstanding valuable contributions from explicit methods, some biases may be unconscious and/or uncontrollable, and therefore may be best assessed by implicit measures (Dovidio and Fiske, 2012). Third, explicit stigma measures might suffer from underreporting due to social desirability bias (Greenwald et al., 2009), while implicit measures are less vulnerable to self-presentation concerns (Nosek et al., 2007) and may be especially valuable for socially sensitive constructs like addiction stigma, gender and racial/ethnic bias (Greenwald et al., 2009; Nosek et al., 2007).

Two studies, which evaluated implicit and explicit addiction stigma, illustrate the utility of these multimodal assessments. In both studies, addiction treatment providers reported high implicit, but low explicit, addiction stigma, highlighting potentially meaningful discrepancies between the two types of assessments (Brener et al., 2007; Von Hippel et al., 2008). Also, implicit, but not explicit, addiction stigma fully mediated the relationship between job-related stress and intentions to quit among providers (Von Hippel et al., 2008). Thus, the current study will evaluate explicit and implicit addiction stigma, and extend prior research by assessing the intersection of race/ethnicity and gender of PWIDs on addiction stigma among general U.S. adult population, rather than focusing exclusively on healthcare providers.

1.2. Intersection of race/ethnicity, gender and addiction stigma

Recent theoretical work emphasizes the importance of adapting an intersectionality framework to achieve better public health-related outcomes, such as increased access to healthcare among underserved populations (Earnshaw et al., 2013; Hatzenbuehler et al., 2013; Rosenthal, 2016). Specifically, the causes of disparities may be better understood by describing how the intersection between multiple social identities (racial/ethnic minority, women) and structural inequalities linked to these identities (racism, sexism) may adversely impact one's life experience (access to healthcare), thereby perpetuating disparity within marginalized groups (Cole, 2009; Crenshaw, 1995). To illustrate, racial bias among healthcare providers has been linked to poorer quality of care and health disparities among racial minority populations (Dovidio and Fiske, 2012; Dovidio et al., 2008; Hall et al., 2015). In addition, gender differences in life experiences (e.g., work choices, family life) are an important contributor to differential health outcomes, such as higher mortality among men but higher morbidity among women (Bird and Rieker, 2008).

When applied to addiction, an intersectionality framework suggests that addiction stigma may also intersect with other forms of bias, such as racism and sexism. Consequently, individuals with SUDs may be treated less favorably if they also hold other status characteristics that are marginalized. For instance, the greater proportion of individuals with SUDs, who are within the criminal justice versus healthcare system, is often cited as an example of discrimination following from addiction stigma (Bohnert et al., 2011; Degenhardt et al., 2014, 2011; Strathdee et al., 2015). Moreover, although rates of drug use and selling are comparable between racial/ethnic groups, minorities (compared to Whites) are significantly more likely to be arrested and receive harsher sentences for drug-related offenses (Curry and Corral-Camacho, 2008; Fielding-Miller et al., 2016; Mitchell and Caudy, 2015). Also, compared to women, men are more likely to be sentenced and receive harsher sentences for drug-related crimes (Cano and Spohn, 2012; Davidson and Rosky, 2015). However, criminal justice-involved women, as compared to men, are more likely to have mental health problems (Kim et al., 2015).

Two evaluations of the relationship between race/ethnicity bias and addiction stigma had conflicting results (Garland and Bumphus, 2012; Lee and Rasinski, 2006). In both studies, participants' perceptions about the involvement of racial/ethnic minorities in drug use and sales were used as a proxy for racial bias. In one study (Garland and Bumphus, 2012), researchers found a positive relationship between endorsements of "minority involvement" and addiction stigma (i.e., endorsement of punitive vs. help-oriented drug policies). However, data from the other study did not support a direct relationship between these two constructs (Lee and Rasinski, 2006). The use of a self-report bias measure could explain the mixed findings (i.e., participants may have desired to appear egalitarian). Thus, the current study will examine implicit and explicit addiction stigma, and consider how race/ethnicity of stigmatized individuals influences them.

Gender of PWIDs, and others with SUDs, may also moderate the expression of addiction stigma. As with race/ethnicity bias, results are mixed. On the one hand, a previous study found participants reported more concern, sympathy, and interest in helping behavior towards women (vs. men) with SUDs (Wirth and Bodenhausen, 2009). However, three qualitative reports suggested that women felt they would be looked down upon by others, more than their male counterparts would be, if their identity of a "drug user" was known to others (Copeland, 1997; Schober and Annis, 1996; Spooner et al., 2015). These accounts are consistent with reports of gender-based, denigrating attitudes towards women with SUDs (i.e., promiscuous, unfit mothers) (Schroedel and Fiber, 2001; Terplan et al., 2015). Akin to the discussion for race/ethnicity, the current study will assess how gender of PWIDs influences both implicit and explicit addiction stigma.

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