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ScienceDirect
Addictive Behaviors 32 (2007) 1331–1346
ADDICTIVE BEHAVIORS

An investigation of stigma in individuals receiving treatment for substance abuse

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Abstract

This study examined the impact of stigma on patients in substance abuse treatment. Patients (N=197) from fifteen residential and outpatient substance abuse treatment facilities completed a survey focused on their experiences with stigma as well as other measures of drug use and functioning. Participants reported experiencing fairly high levels of enacted, perceived, and self-stigma. Data supported the idea that the current treatment system may actually stigmatize people in recovery in that people with more prior episodes of treatment reported a greater frequency of stigma-related rejection, even after controlling for current functioning and demographic variables. Intravenous drug users, compared to non-IV users, reported more perceived stigma as well as more often using secrecy as a method of coping. Those who were involved with the legal system reported less stigma than those without legal troubles. Higher levels of secrecy coping were associated with a number of indicators of poor functioning as well as recent employment problems. Finally, the patterns of findings supported the idea that perceived stigma, enacted stigma, and self-stigma are conceptually distinct dimensions.
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Keywords: Stigma; Substance abuse; Substance dependence; Coping

1. The role of stigma in individuals receiving treatment for substance abuse

There can be little doubt that substance abusers in recovery face stigma in its various forms, including enacted, perceived, and self-stigma (Link, Yang, Phelan, & Collins, 2004). Enacted stigma refers to

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0306-4603/$ - see front matter © 2006 Elsevier Ltd. All rights reserved.
doi:10.1016/j.addbeh.2006.09.008

directly experienced social discrimination such as difficulty in obtaining employment, reduced access to housing, poor support for treatment, or interpersonal rejection. Perceived stigma refers to beliefs that members of a stigmatized group have about the prevalence of stigmatizing attitudes and actions in society (cf., Link, Cullen, Streuning, Shrout, & Dohrenwend, 1989). Self-stigma refers to negative thoughts and feelings (e.g., shame, negative self-evaluative thoughts, fear) that emerge from identification with a stigmatized group and their resulting behavioral impact (e.g., avoidance of treatment, failure to seek employment, avoidance of intimate contact with others).

In general mental health areas, enacted stigma is associated with multiple negative outcomes such as unemployment (e.g., Link, 1987; Penn & Martin, 1998), housing problems (Page, 1983, 1993; Penn & Martin, 1998), and difficulty in social adjustment (e.g., Perlick et al., 2001). Self-stigma in the seriously mentally ill, many of whom also have substance use disorders, is associated with delays in treatment seeking (Kushner & Sher, 1991; Scambler, 1998; Starr, Campbell, & Herrick, 2002), diminished self-esteem/self-efficacy (Corrigan & Watson, 2002; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Wright, Gronfrein, & Owens, 2000), and lower quality of life (Rosenfield, 1997). Samples of substance abusing individuals self-report fear of stigma as a reason for not seeking treatment (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Hingson, Mangione, Meyers, & Scotch, 1982; Klingeman, 1991; Sobell, Sobell, & Toneatto, 1992; Tuchfeld, 1981; Tucker, Vuchinich, & Gladsjo, 1994). Because the work on stigma towards mental illness is more advanced (Corrigan, 2004; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Wahl, 1999), we drew on this work as a source of measures to adapt for use with substance abuse stigma, and as a conceptual guide in researching this area.

The present study is an initial attempt to examine the role of stigma toward substance abuse in people in recovery from substance use problems. While a number of studies have documented the existence of various forms of stigma relating to substance use (Fulton, 1999), few studies have examined the relation between stigma and treatment for substance use (Semple, Grant, & Patterson, 2005), or the relationship between substance use stigma and other outcomes of interest such as patient functioning or substance use. Now that stigma is fairly well documented as a phenomenon, it is important that research begin to examine the relationship between stigma and functional outcomes in substance abuse.

Five questions were examined. The first assessed the degree to which persons in recovery experienced stigma in its various forms. Second, we examined evidence for stigma as a multidimensional concept in the substance abuse area (Corrigan, 2004; Link et al., 2004). We assessed whether our conceptually distinct measures of stigma (self-stigma, perceived stigma, and experienced stigma) are in fact empirically distinct and associated in predictable ways with each other and with outcomes of interest. The third question was suggested by Link et al.'s (1989) modified labeling theory of stigmatization, which holds that the stigma process does not primarily begin to impact an individual until the person has entered the treatment system and has received a diagnostic label. Thus, we examined whether experienced stigma would be higher for those with more prior episodes of treatment.

The fourth question examined the impact of secrecy as a method of coping with stigma. Stigma researchers have made a distinction between concealable stigmas, such as substance abuse, and public stigmas, such as race or certain diseases (Goffman, 1963; Smart & Wegner, 1999). Little evidence exists whether it is generally helpful or hurtful to conceal substance abuse as a method of regulating stigma. The issue was examined empirically in the present study. The fifth area we examined was whether intravenous (IV) drug use or involvement with the legal system predicted higher levels of stigma. Researchers have documented that stigma toward substance abuse is usually seen in a benign or even positive light among those working in the criminal justice system (Fulton, 2001; Room, 2004), raising the possibility that drug

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