

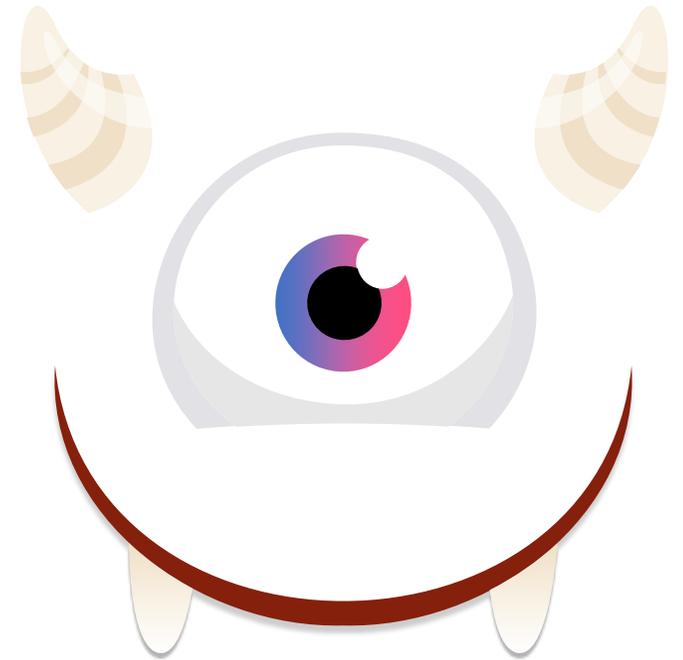
Addiction, Culture, and Implicit Biases

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Vignette 1

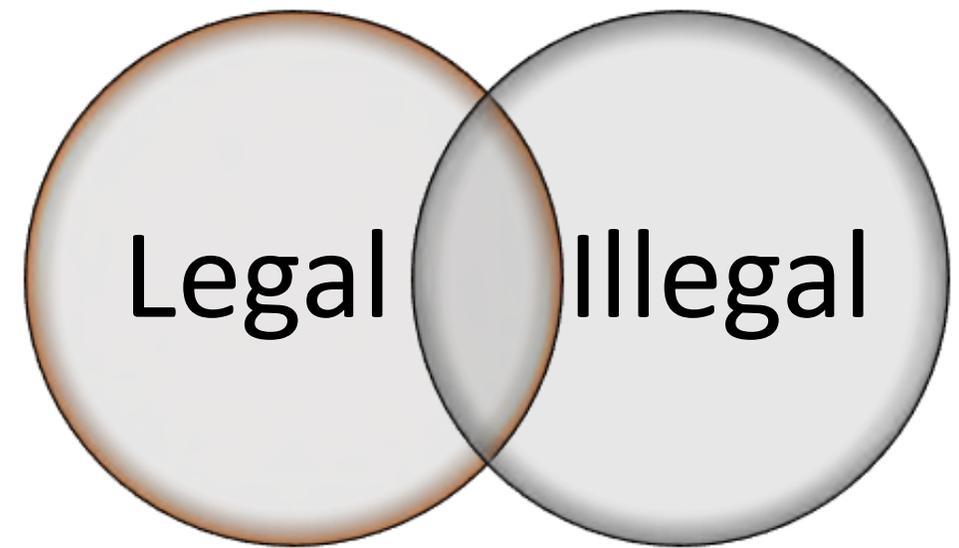
Outline

- Addiction History
- Culture of Addiction
- Stigma and discrimination
- What can we do?



What Makes a Drug Legal or Illegal?

- Dual drug industry
 - Aboveground
 - Belowground
- The distinction we sometimes make is between
 - Drugs that give pleasure directly (recreational use)
 - Drugs that give people the ability to function in society (which can indirectly lead to pleasure) (medicine use)



History of Drugs

- Psychoactive substances have always been closely associated with religion

A drug evolves			
<i>Drug</i>	<i>Material</i>	<i>Type</i>	<i>Date discovered</i>
Opium poppy	whole plant	herb	~ 10000 BC
Poppy bulb	plant part	herb	~ 4000 BC
Bulb sap	part extract	herb	~ 3000 BC
Gum opium	dried extract	herb	~ 1000 BC
Laudanum	tincture of dried extract	pharmaceutical	1524
Morphine	chemical from tincture	pharmaceutical	1803
Heroin (diacetyl-morphine)	modified chemical	pharmaceutical	1874
Fentanyl	synthesized opioid	pharmaceutical	1953
3-methyl-fentanyl ("China White")	fentanyl analogue	designer drug	1979

History of Drugs

- Psychoactive substances have always been closely associated with religion
- The first drug problem in the USA

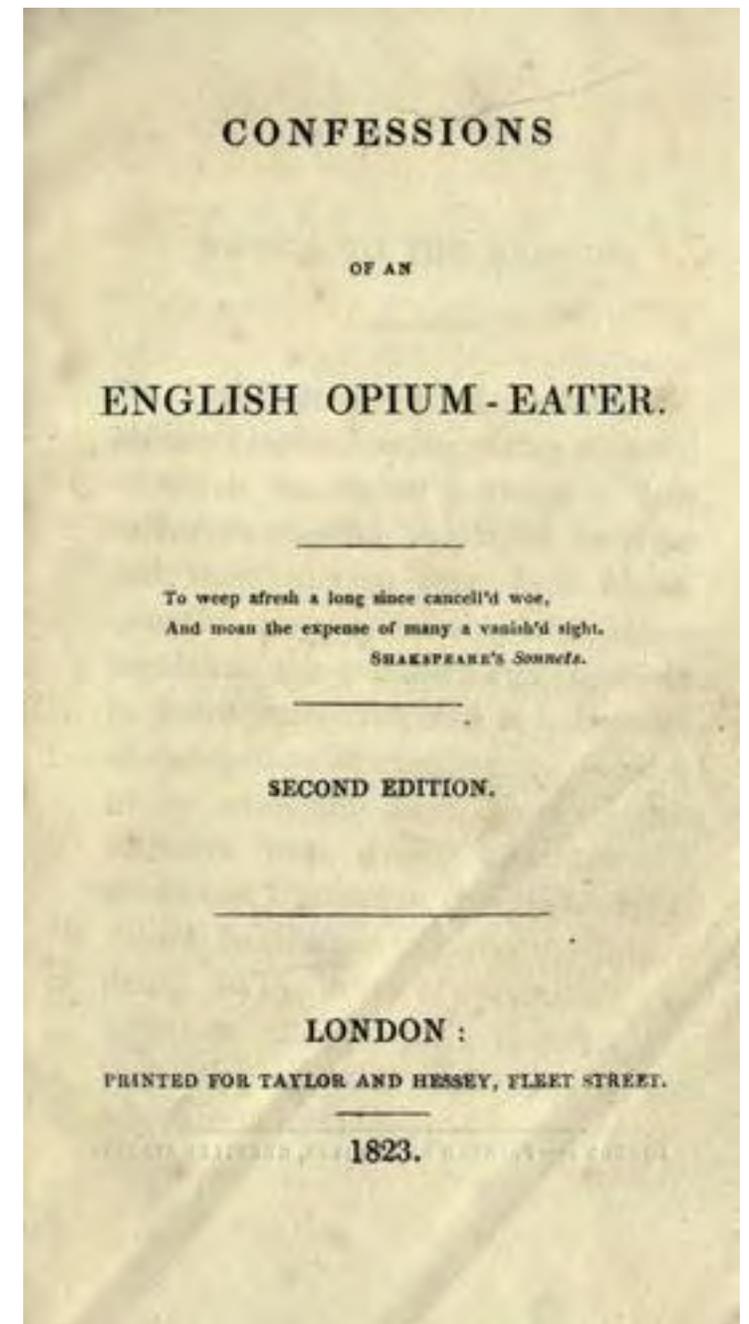
is a much adulterated article. No. 8D420 Price, per 1-pound box.....10c

Laudanum.
(Tinct. Opium.)
U. S. P. Strength. Directions on each bottle for young and old.
No. 8D424 Price
1-ounce bottle..... 8c
2-ounce bottle.....15c
4-ounce bottle.....25c
Unmailable.

Paregoric.
Always useful, both for children and adults. One of the best known and most extensively used house remedies. Full directions.
No. 8D426 Price, 2-ounce bottle..10c
Price, 4-oz. bottle.....15c

If by mail, postage and tube extra, small, 12 cents; large, 16 cents.

Tasteless Castor Oil.



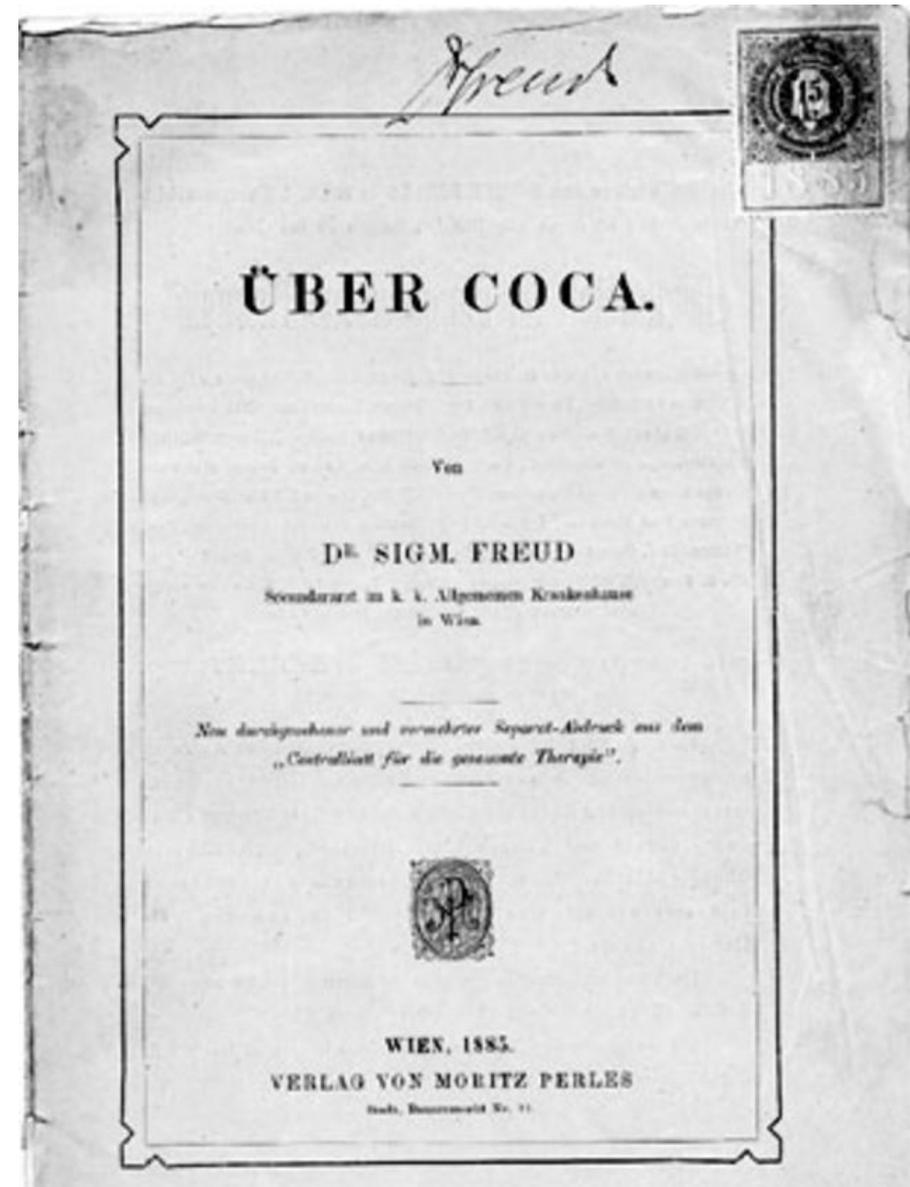
History of Drugs

- Psychoactive substances have always been closely associated with religion
- The first drug problem in the USA
- Hypodermic syringe invented (1853)
- The First Opium War (1839 – 1842)
- The Second Opium War (1856 – 1860)
- Chinese immigrants to USA 1850s
- Smoking opium came to be “on the hip”
- Cocaine isolated (1859) – used as stimulant and antidepressant



History of Drugs

- Cocaine isolated (1859)
- Sigmund Freud: “Über Coca” (About Coke) (1884)
 - Cocaine was a “magical drug” and effective for morphine addiction
 - Addiction poorly understood
 - Morphine used for alcohol addiction
 - Cocaine used for morphine addiction
- Coca-Cola (1886)



History of Drugs

- Cocaine isolated (1859)
- Sigmund Freud: “Über Coca” (About Coke) (1884)
- Coca-Cola (1886)

“A large proportion of the wholesale killings in the South during recent years have been the direct result of cocaine, and frequently the perpetrators of these crimes have been hitherto inoffensive, law-abiding Negroes.”—American Medical Association Report, 1913

“Most of the attacks upon white women of the South are the direct result of a cocaine-crazed Negro brain.”—Dr. Koch, Pennsylvania Board of Pharmacy, testifying to Congress on federal antinarcotic laws, 1914



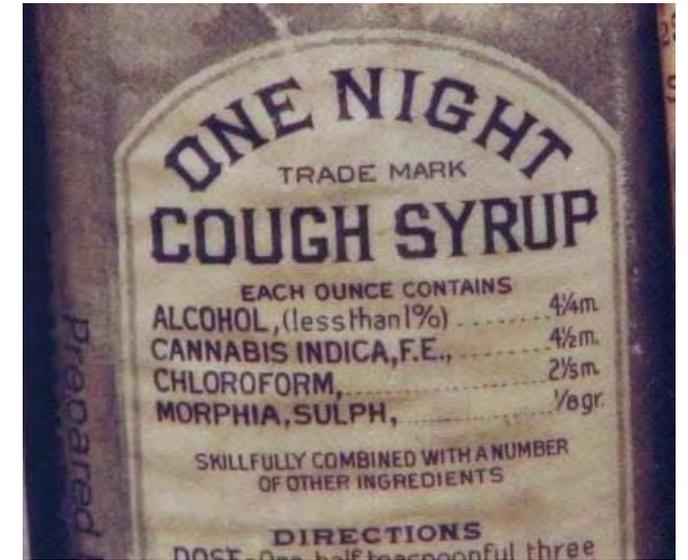
History of Drugs

- 1898 – 1910: Heroin was market has a cough suppressant
- Pure Food and Drug Act (1906)
- Smoking Opium Exclusion Act (1909)
 - First Federal law to ban the use of non-medical substances
- Harrison Act (1914)
 - Regulated and taxed opiates
- Prohibition Era (1919-1933)
- Anti-Heroin Act of 1924
- Narcotic Farms Act of 1929: Kentucky & Texas infirmary



History of Drugs

- Marihuana Tax Act of 1937
- 1950s: Hallucinogens popular
- 1950s: Chloroform used to relieve asthma symptoms
- Boggs Act of 1951: mandatory sentences for drug convictions.
- 1966 Narcotic Addiction Rehabilitation Act: civil commitment for narcotic addiction
- Comprehensive Drug Abuse and Control Act of 1970
- Nixon declares “War on Drugs” (1971)
 - Drug Enforcement Administration (DEA) in 1973
- Anti-Drug Abuse Act (1986)



Classification	Description	Drug Examples
Schedule I	No current legal medical use High potential for physical and/or psychological dependence High risk for addiction/abuse	<ul style="list-style-type: none"> • Heroin • GHB • LSD • Marijuana • MDMA/Ecstasy • Mescaline • Methaqualone • Peyote • Psilocybin
Schedule II	Restrictive legal medical use High potential for physical and/or psychological dependence High risk for addiction/abuse	<ul style="list-style-type: none"> • Adderall • Cocaine • Codeine • Crystal Meth • Demerol • Morphine • Opium • OxyContin • PCP • Percocet
Schedule III	Accepted legal medical use Low/Moderate potential for physical dependence Moderate/High potential for psychological dependence Moderate risk for addiction/abuse	<ul style="list-style-type: none"> • Anabolic Steroids • Ketamine • Lorcet • Aspirin (w/codeine) • Testosterone • Vicodin
Schedule IV	Accepted legal medical use Low potential for physical and/or psychological dependence Low risk for addiction/abuse	<ul style="list-style-type: none"> • Ambien • Atvian • Equanil • Rohypnol • Talwin • Xanax • Valium
Schedule V	Accepted legal medical use Limited potential for physical and/or psychological dependence Low risk for addiction/abuse	<ul style="list-style-type: none"> • Codeine-based cough medicines (Robitussin)
Schedule VI (Unscheduled)	Over-the-counter availability Legal without a prescription	<ul style="list-style-type: none"> • Alcohol • Aspirin • Caffeine • Nitrous Oxide • Nyquil • Tobacco

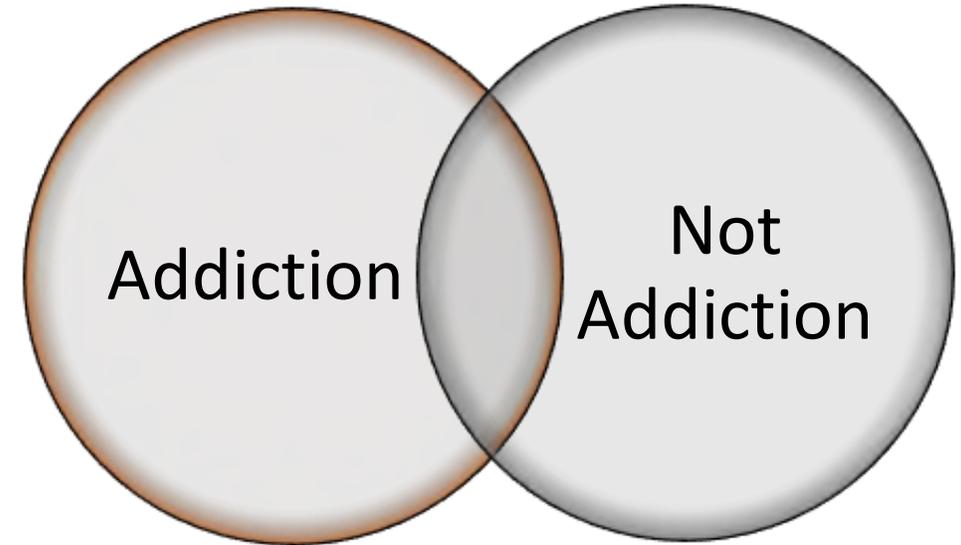
Table 2.1. Trends in drug enforcement, 1981–96

	1980	1985	1990	1994	1996
Drug arrests	581,000	811,000	1,090,000	1,350,000	1,506,000
Heroin and cocaine only	70,000 (12%)	240,000 (30%)	590,000 (54%)	635,000 (47%)	602,400 (40%)
Distribution only	104,000 (18%)	192,000 (30%)	345,000 (31%)	370,000 (27%)	376,500 (25%)
Currently incarcerated for drug offenses (one day count)					
(Total)	31,000	68,000	291,000	392,000	401,000
Local jails	7,000	19,000	111,000	137,000	112,000
State prisons	19,000	39,000	149,000	202,000	234,000
Federal prisons	4,900	9,500	30,500	51,800	55,200

Sources: FBI (annual); BJS (biannual); 1980–94 jail figures are authors' estimates, 1996 from BJS.

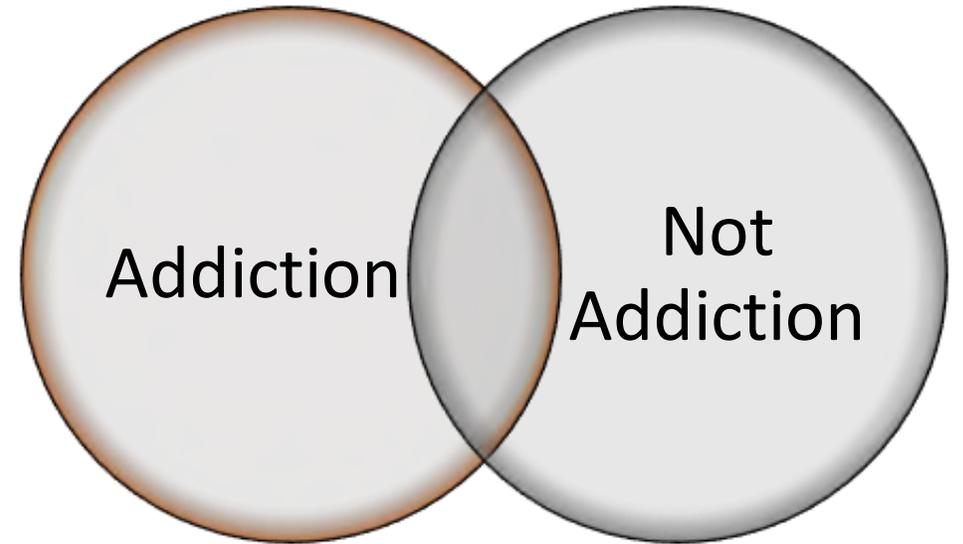
Why some do and some don't

- Risk factors
 - Genetic
 - Socioeconomic status
 - Psychosocial
 - Deviant subcultures
 - Approval/disapproval of friends and parents
 - Availability
 - Judgment of risks involved
 - Inclination toward other drug use or delinquent behavior



Why some do and some don't (cont.)

- Protective factors
 - Genetic
 - Positive home environment
 - Education
 - Peer relationships
 - Positive attitudes and beliefs



	ADDICTION	HYPERTENSION	DIABETES
Insidious- at least at the beginning	YES	YES	YES
Cuts across all racial, ethnic, intellectual and socioeconomic backgrounds	YES	YES	YES
Family suffers	YES	POSSIBLE	POSSIBLE
Craving	YES	YES	YES
Use of defined substance not allowed	YES	YES	YES
Can be out of control	YES	YES	YES
Relapse is possible	YES	YES	YES
Patient compliance with treatment (medications)	50%	50%	50%
Use despite negative consequences	YES	YES	YES
Life-long chronic disease	YES	YES	YES
Life style changes needed	YES	YES	YES
Behavioral therapy of benefit	YES	YES	YES

*Junk is not just a habit. It is a way of life.
When you give up junk, you give up a way of life.*

—WILLIAM BURROUGHS
Junkie

Culture of Addiction

Role of Culture

- Socialization starts early
- Conflict of norms
 - Ideal norms vs behavioral norms
- May play a role in sustaining use over time
- Subcultures exist
 - Celebrated drugs: “blessed for social consumption”
 - Tolerated drugs
 - Instrumental drugs
 - Prohibited drugs

- Culture of recovery

The culture of recovery is an informal social network in which group norms (prescribed patterns of perceiving, thinking, feeling, and behaving) reinforce sobriety and long-term recovery from addiction.

- Reconstructing social networks
- Engage in activities that do not involve the use of psychoactive substances

Biopsychosocial Systems Model of Addiction

Drugs...

affect

are affected by

are part of

...the BPS environment.

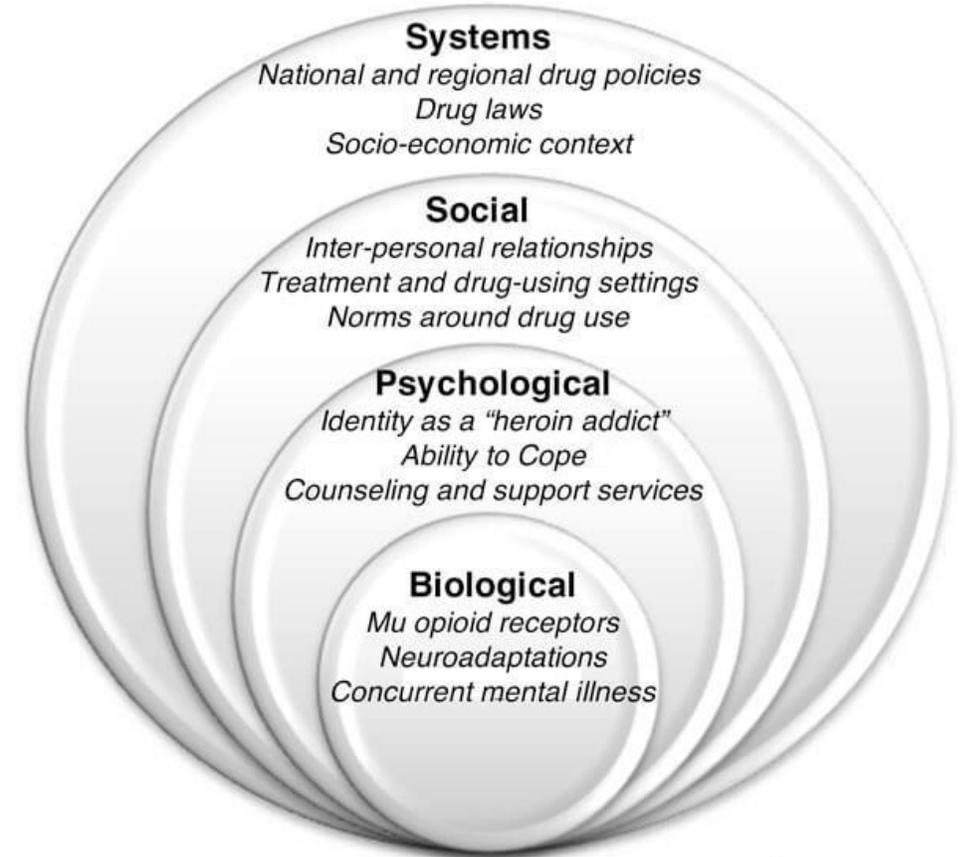
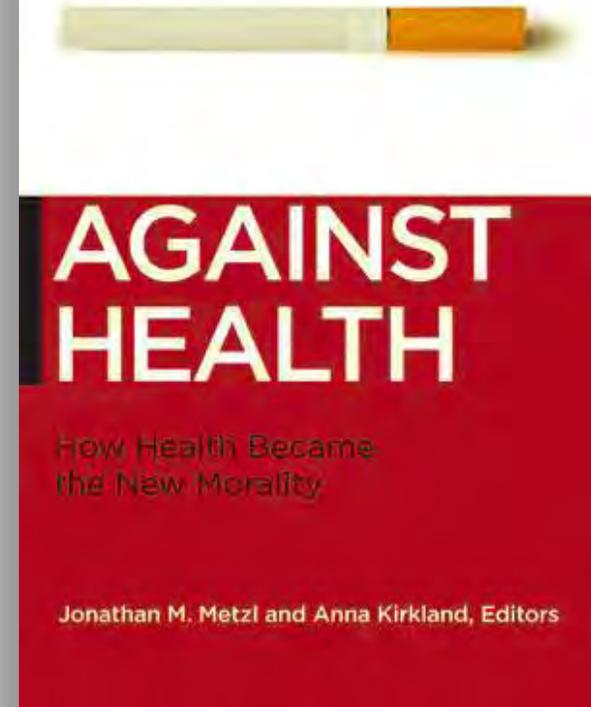
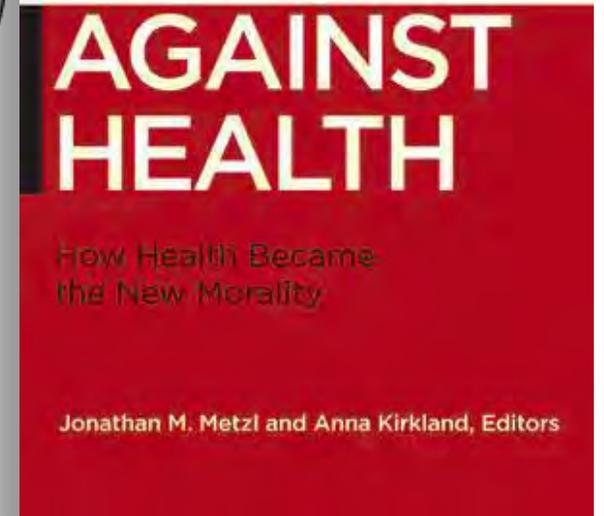
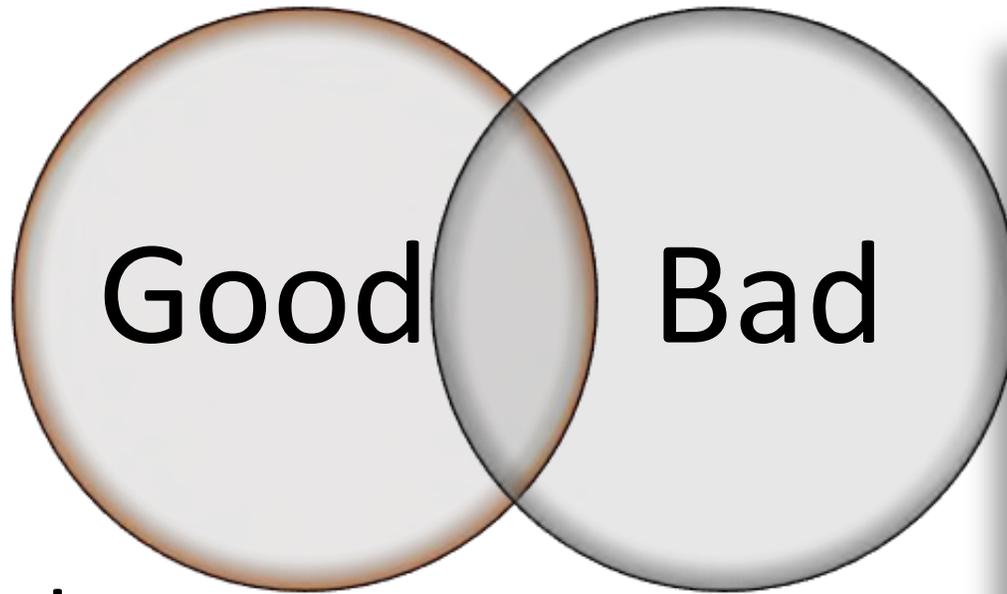


Figure 1: The Biopsychosocial Systems Model of Addiction. Primary features of the model are shown in boldface; variables exemplifying heroin-assisted treatment are shown in italics.

How can anyone take a stand against health?

- We believe in the germ theory of infectious illness.
- We believe in penicillin.
- We believe that physicians should wash their hands between patient visits.





The dichotomy

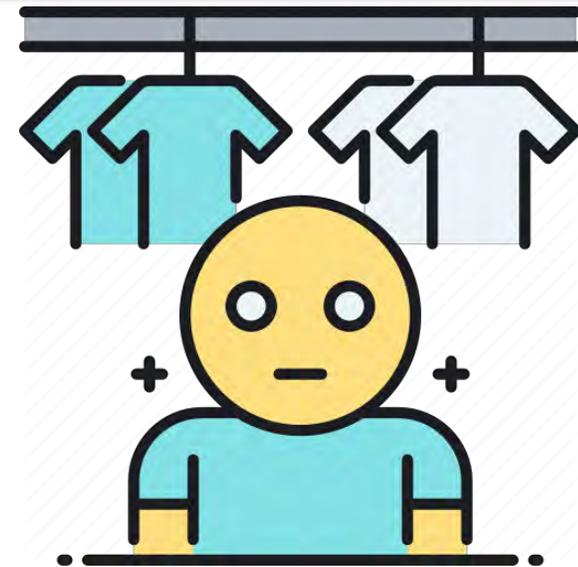
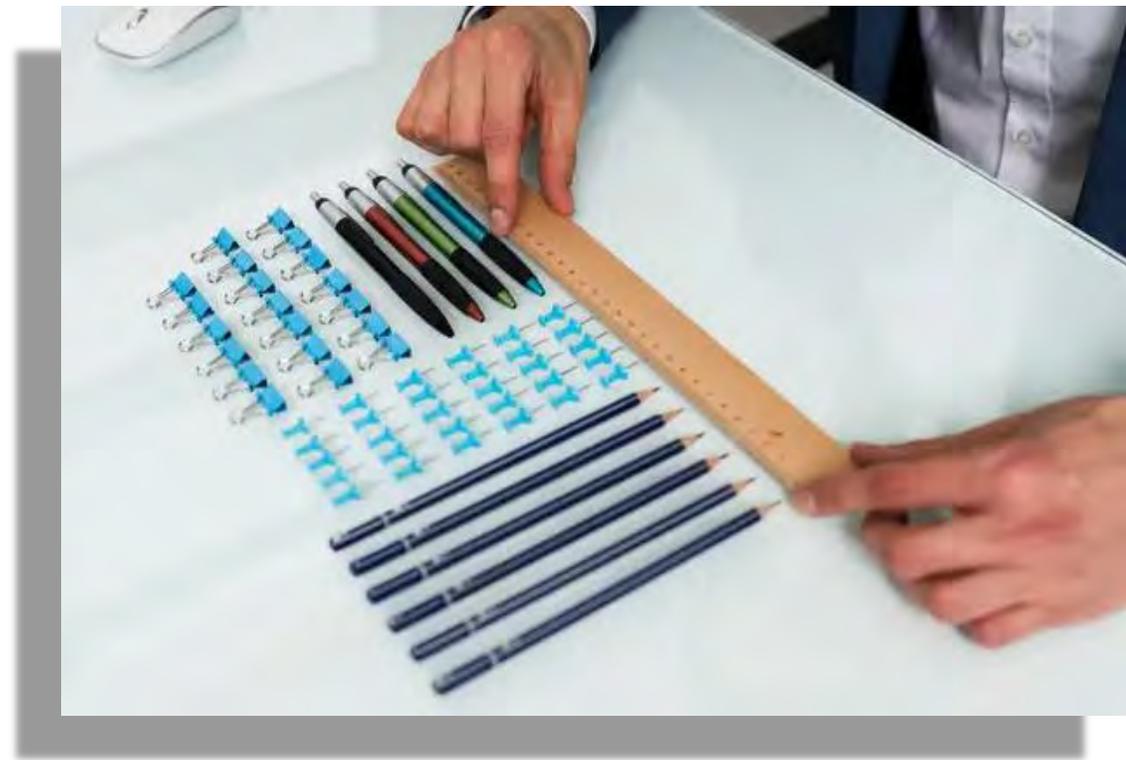
- Smoke is bad for your health
- Obesity is bad for your health
- The definition of our own health depends in part on our value judgments about others

Obsessive-compulsive disorder (OCD)

→ 1970s:

- Prevalence 0.05% to 0.005%
- So rare!
- If you “were alone, odd, and certainly crazy”

→ Now: 2%



Rationale for the use and avoidance of certain terms

- Burden of disease due to substance use is growing!

PAST YEAR, 2019 NSDUH, 18+

Among those with a substance use disorder:
2 IN 5 (38.5% or 7.4M) struggled with illicit drugs
3 IN 4 (73.1% or 14.1M) struggled with alcohol use
1 IN 9 (11.5% or 2.2M) struggled with illicit drugs and alcohol

Among those with a mental illness:
1 IN 4 (25.5% or 13.1M) had a serious mental illness

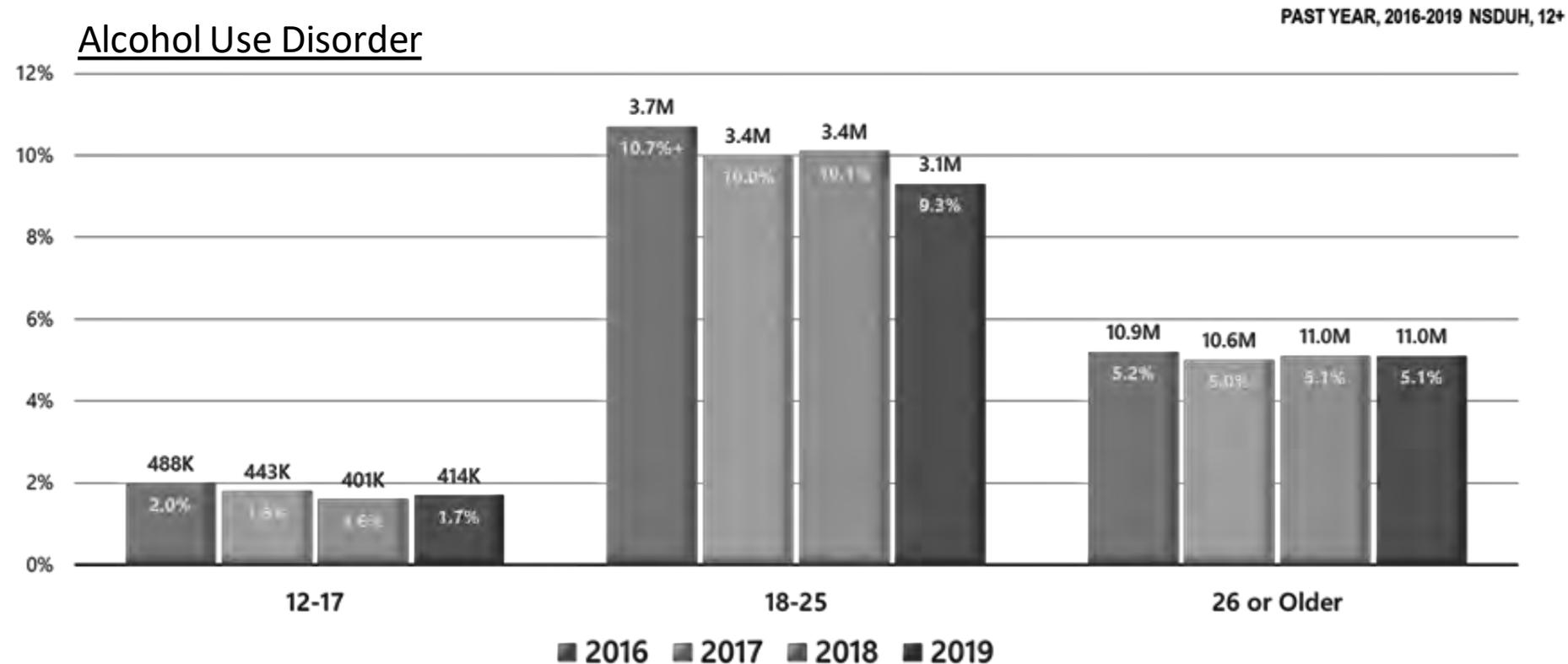
7.7%
(19.3 MILLION)
People aged 18 or older had a substance use disorder (SUD)

3.8%
(9.5 MILLION)
People 18 or older had BOTH an SUD and a mental illness

20.6%
(51.5 MILLION)
People aged 18 or older had a mental illness

Rationale for the use and avoidance of certain terms

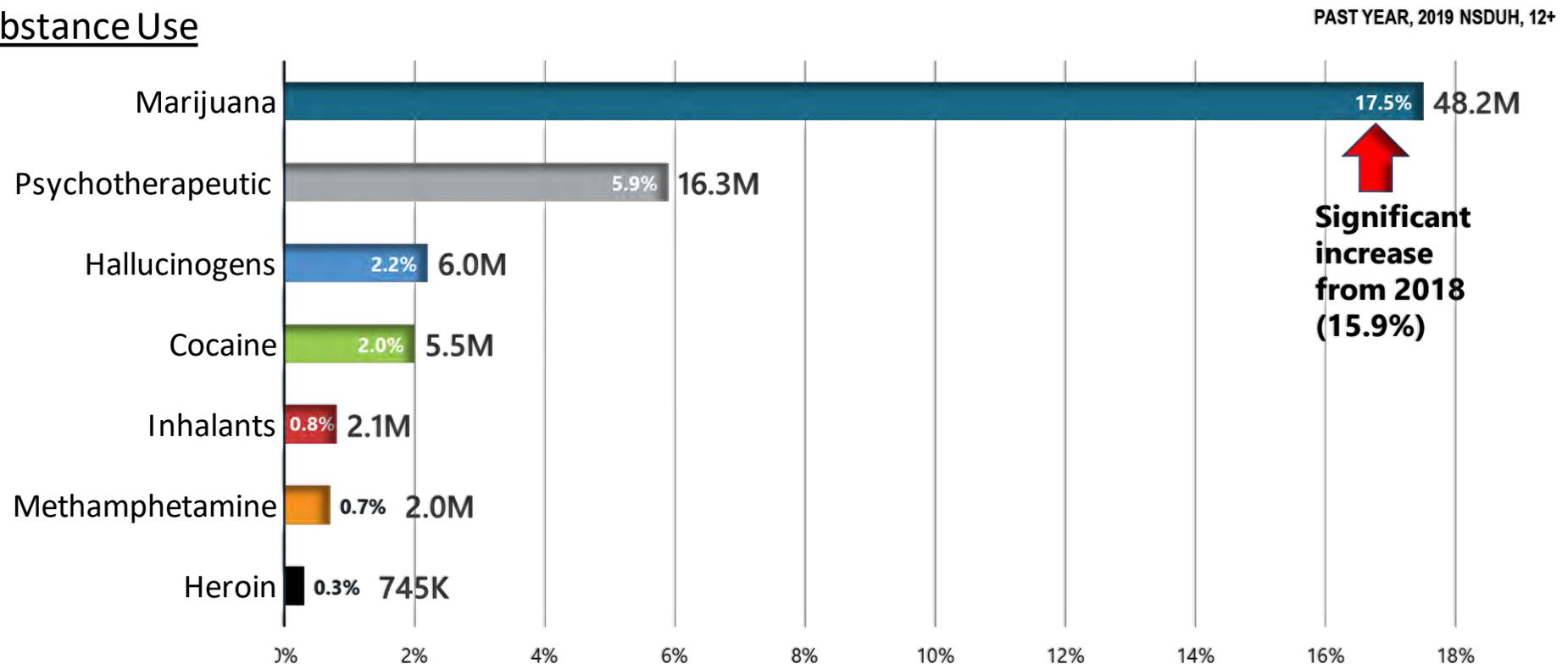
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Rationale for the use and avoidance of certain terms

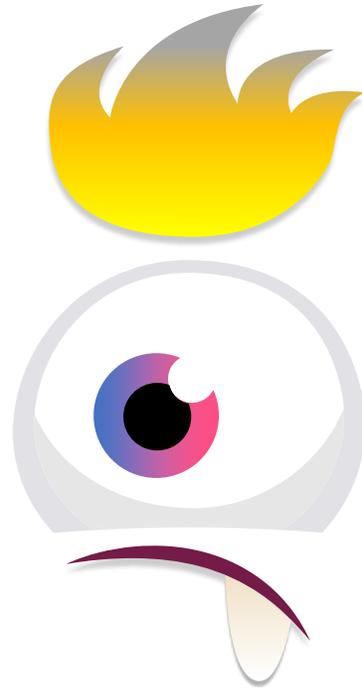
- Burden of disease due to substance use is growing!

Substance Use



Rationale for the use and avoidance of certain terms

- Burden of disease due to substance use is growing!
- High priority public health concern in the United States
- Unintentional overdose is the leading cause of accidental death
- A main barrier to seeking and receiving help is stigma.



Opioid Misuse

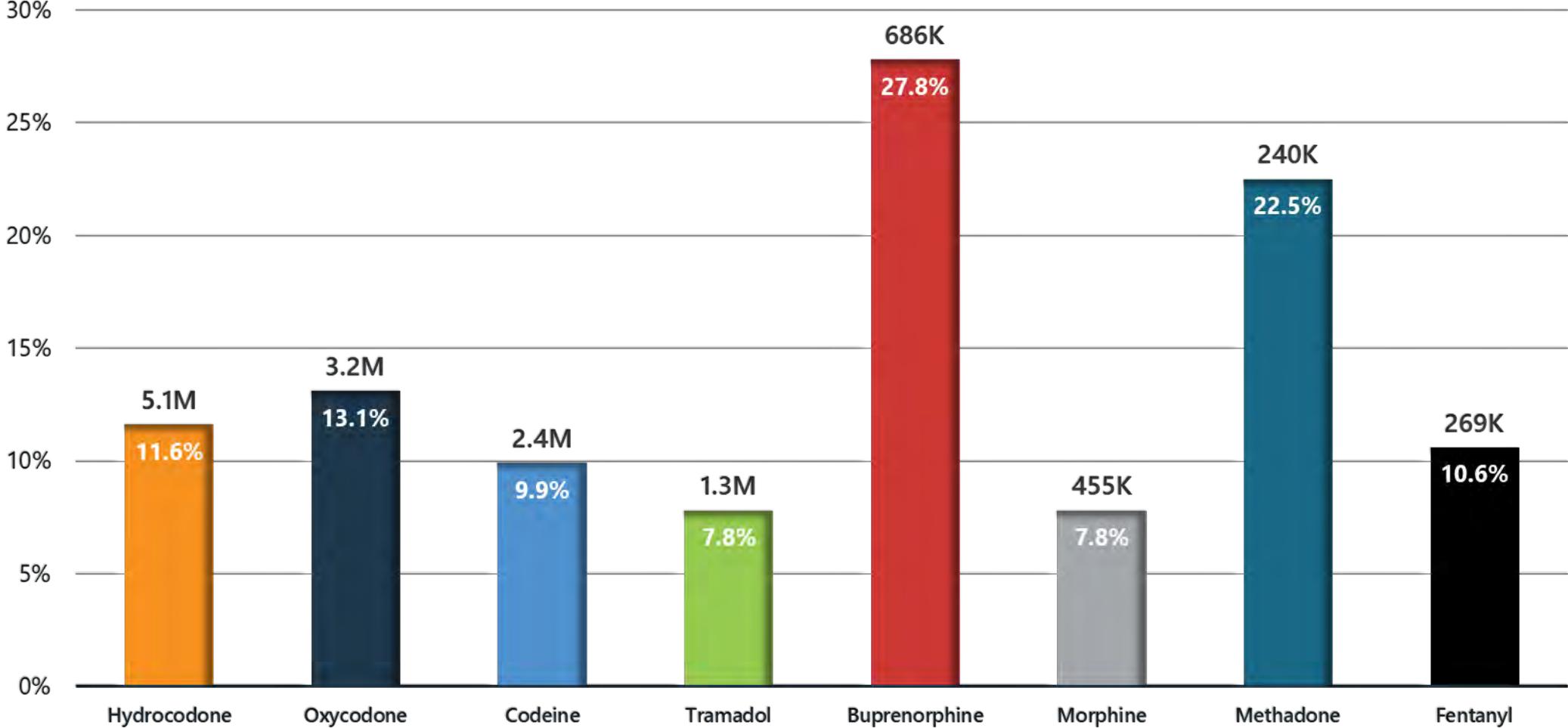
PAST YEAR, 2016-2019 NSDUH, 12+



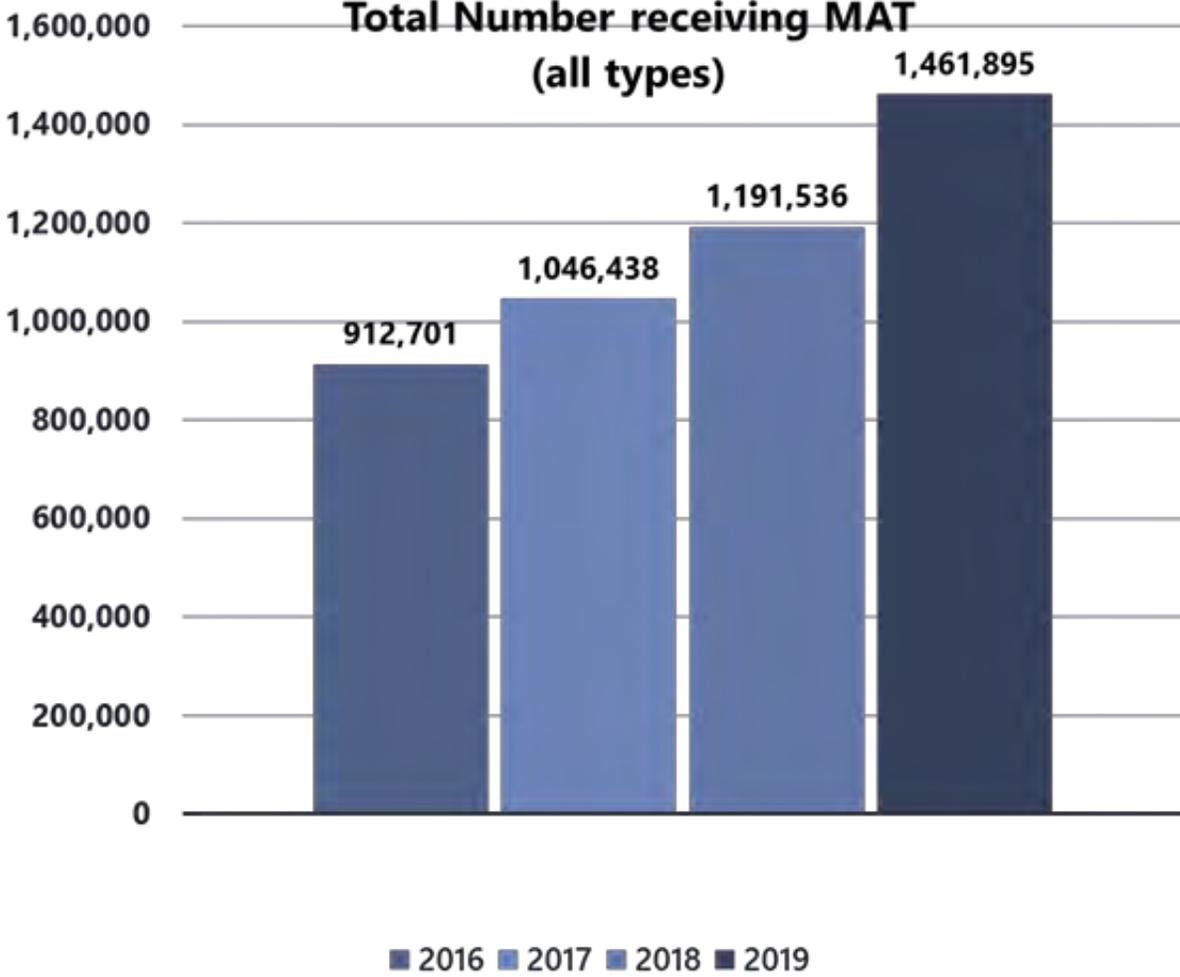
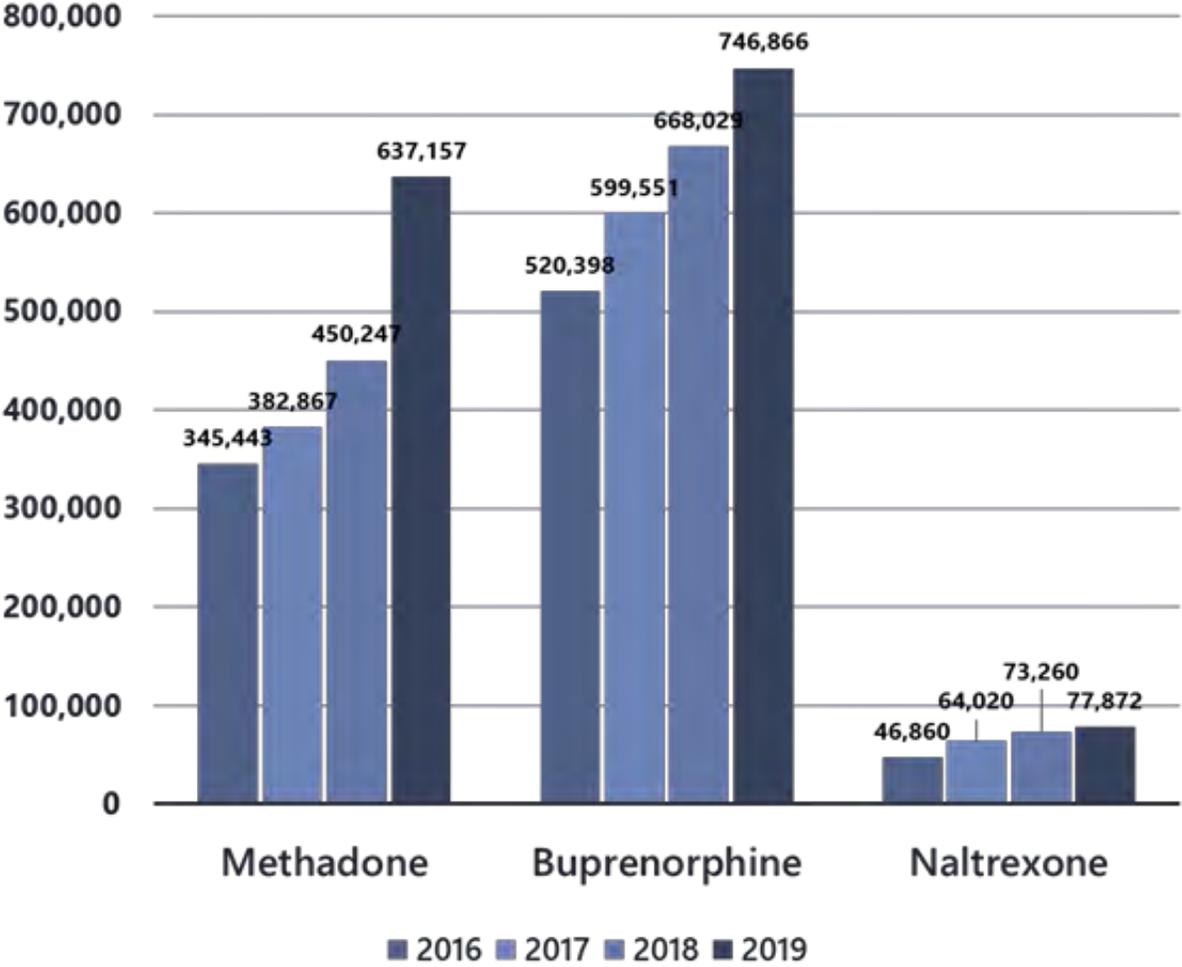
+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Opioid Misuse: Types

PAST YEAR, 2019 NSDUH, 12+ SUBTYPE USERS



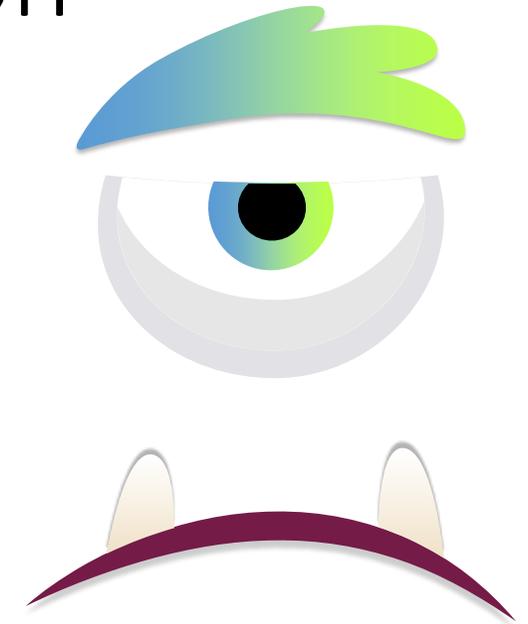
Getting Treatment for Opioid Use Disorder



Both race-specific medicine and genetic selection technologies stem from a medical model that attributes problems caused by social inequities to individuals' genetic makeup and holds individuals, rather than the public, responsible for fixing these inequities.

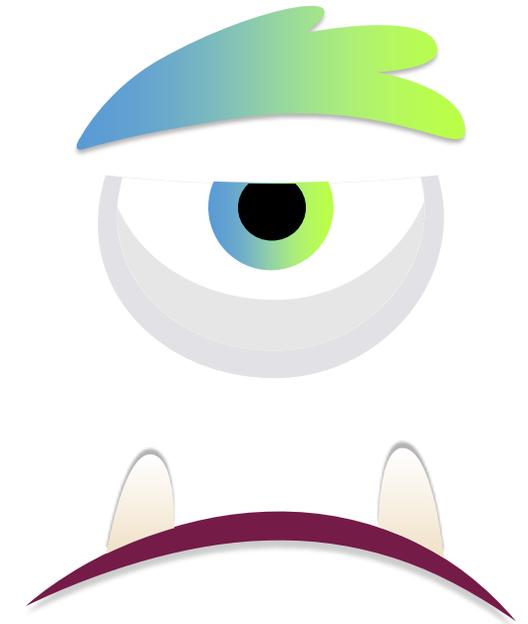
Stigma and discrimination: No other conditions are more stigmatized than addiction

- Stigma: an attribute, behavior, or condition that is socially discrediting.
- Stigma is influenced by two main factors:
 - Cause
 - “It’s not their fault” → stigma is diminished.
 - Controllability
 - “they can’t help it” → stigma is diminished.
- Many people still perceive addiction as a “choice” and that addicted individuals really can control it



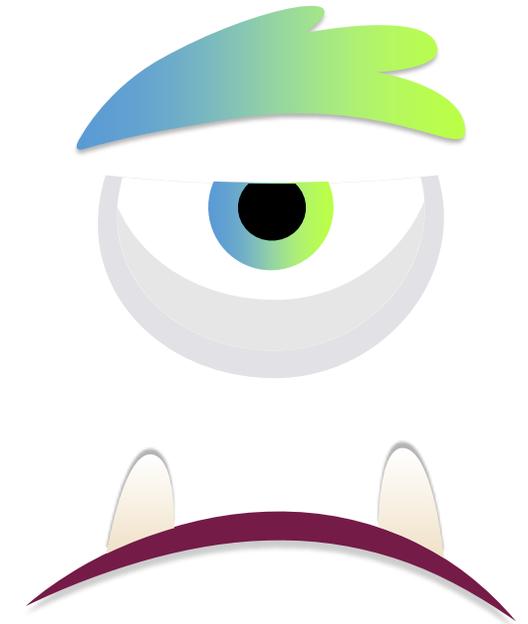
Stigma

- Self-stigma: negative feelings (about self)
 - Due to that individual's experiences, perceptions, or anticipation of negative social reactions
- The “why try” effect
 - Self-devaluation “three A’s” of self-stigma:
 - Awareness
 - *People with mental illness are to blame for their disorder*
 - Agreement
 - *That’s right, people with mental illness are actually to blame for their disorder*
 - Application
 - *I am mentally ill so I must be to blame for my disorder*



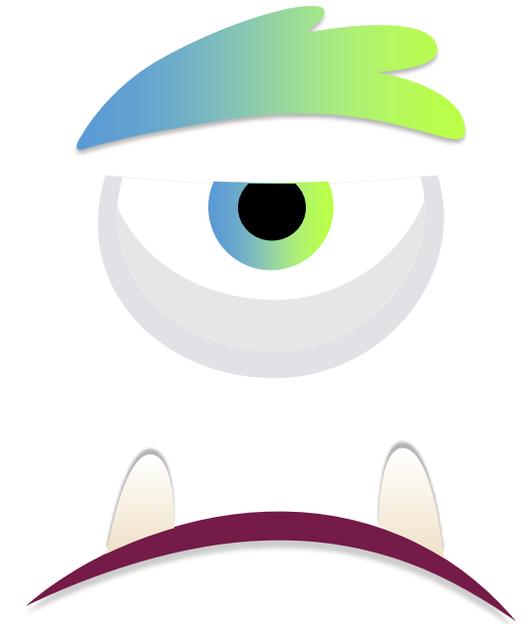
Stigma

- Self-stigma: negative feelings (about self)
 - Due to that individual's experiences, perceptions, or anticipation of negative social reactions
- Structural stigma: rules, policies and procedures of institutions that restrict the rights and opportunities for members of stigmatized groups



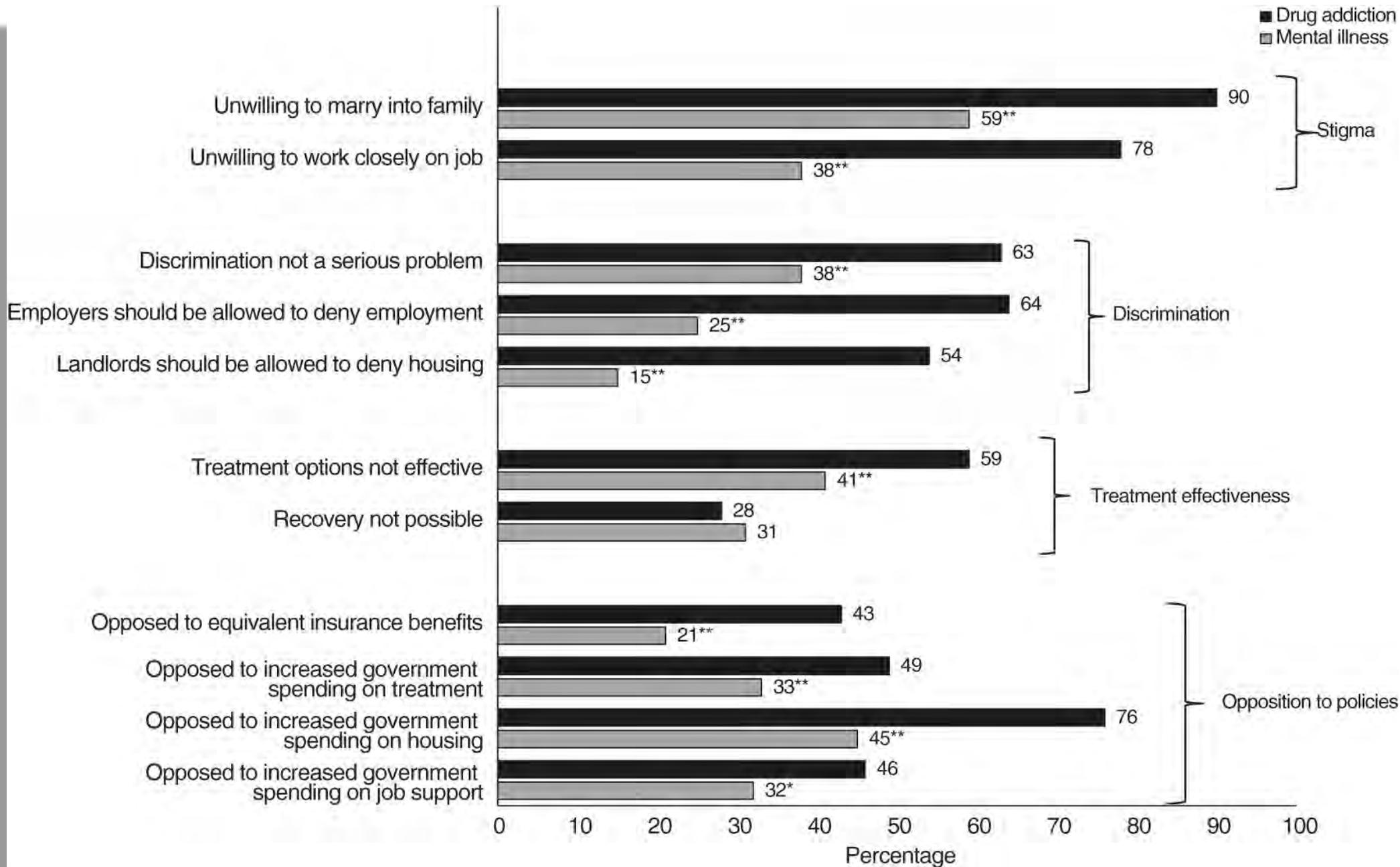
Stigma

- Social stigma: phenomenon of large social groups endorsing stereotypes about and acting against a stigmatized group
- Pervasive and persistent negative attitudes among persons with mental illness
 - Social distance
 - Dangerousness of persons with serious mental illness



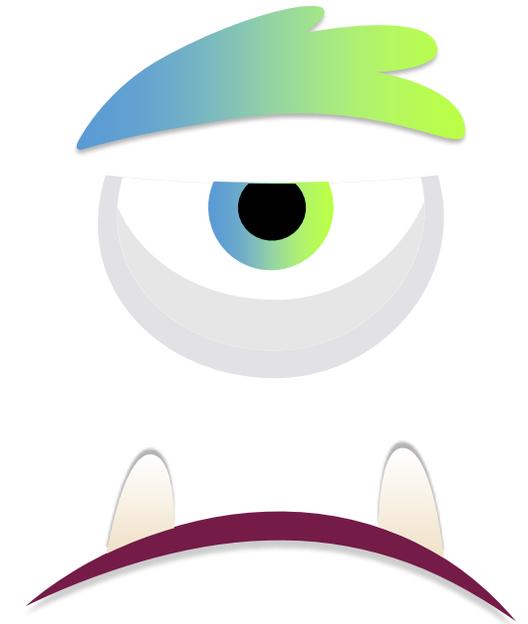
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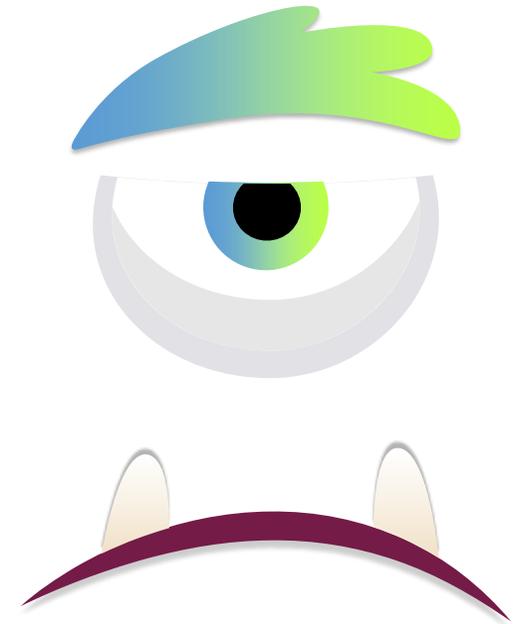
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Stigma

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Stigma

- Structural stigma: rules, policies and procedures of institutions that restrict the rights and opportunities for members of stigmatized groups
 - Assumption that people who are labeled as being mentally ill are not competent to use guns

State	Term used to describe the bill's target			
	"Mental illness"		"Incompetence" or "disability"	
	N	%	N	%
Alabama	2	15	0	—
Alaska	0	—	0	—
Arizona	4	14	9	31
California	4	5	5	6
Colorado	5	17	0	—
Connecticut	2	6	4	12
Delaware	0	—	0	—
Florida	0	—	8	20
Georgia	0	—	2	22
Hawaii	3	17	2	12
Idaho	0	4	58	—
Illinois	2	5	11	26
Indiana	4	21	0	—
Iowa	5	24	0	—
Kansas	2	15	2	15
Kentucky	0	—	6	26
Louisiana	0	—	0	—
Maine	4	57	0	—
Maryland	4	7	2	4
Massachusetts	7	30	1	4
Michigan	6	18	4	12
Minnesota	10	48	5	24
Mississippi	3	18	2	12
Missouri	10	23	9	21
Nebraska	1	11	1	11
Nevada	2	67	2	67
New Hampshire	2	25	1	13
New Jersey	8	16	6	12
New Mexico	0	—	0	—
New York	11	17	10	16
North Carolina	2	17	0	—
Ohio	3	27	1	9
Oklahoma	2	11	1	6
Pennsylvania	2	8	3	12
Rhode Island	5	11	4	9
South Carolina	0	—	0	—
South Dakota	0	—	0	—
Tennessee	2	11	0	—
Utah	2	12	4	24
Virginia	1	3	6	17
Vermont	2	15	1	8
Washington	2	18	3	27
West Virginia	5	26	3	16
Wisconsin	0	—	0	—
Wyoming	1	14	1	14
Total	130	13	123	12

Stigma

→ Structural stigma: rules, policies and procedures of institutions that restrict the rights and opportunities for members of stigmatized groups



Drug and Alcohol Dependence

Available online 18 March 2021, 108664

In Press, Corrected Proof 



“I felt like I had a scarlet letter”: Recurring experiences of structural stigma surrounding opioid tapers among patients with chronic, non-cancer pain

Allyn Benintendi ^a, Sarah Kosakowski ^a, Pooja Lagisetty ^{b, c}, Marc Larochelle ^a, Amy S.B. Bohnert ^{c, d}, Angela R. Bazzi



→ Patients with chronic, non-cancer pain who had undergone a reduction in opioid daily dosage

→ 3 elements:

- Overlooked by of the opioid crisis
- Invalidated and stereotypes of acting disingenuously
- Marginalized surveillance

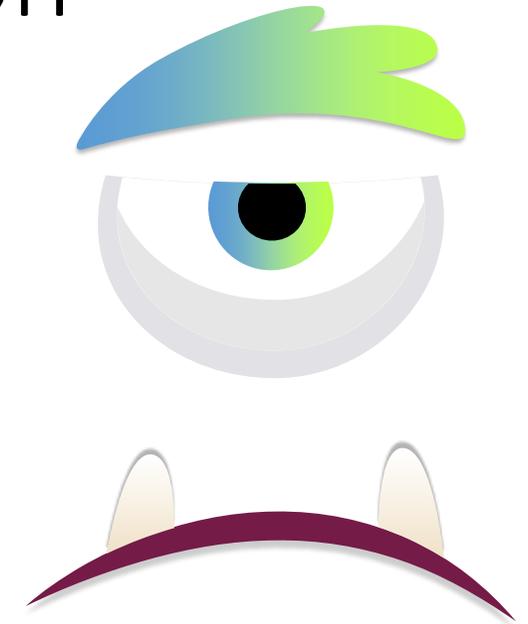
Stigma and discrimination: No other conditions are more stigmatized than addiction

→ Stigma: complex construct

- A label
 - “Addict”
- A stereotype
 - Beliefs held about a group of people with SUD
- Discrimination

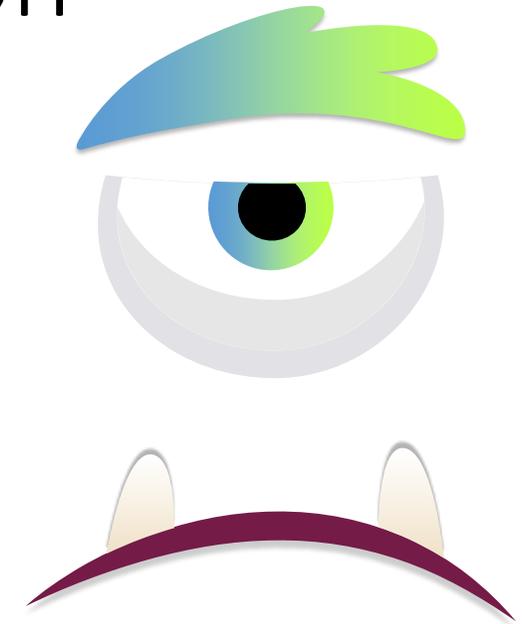
→ Common labels:

- Opioid addict vs. substance abuser
- “Person with a substance use disorder”
- “Person with an opioid use disorder”
- “clean”, “dirty”, “medication-assisted treatment”, “medication-assisted recovery”, “untreated”, “alcoholic”



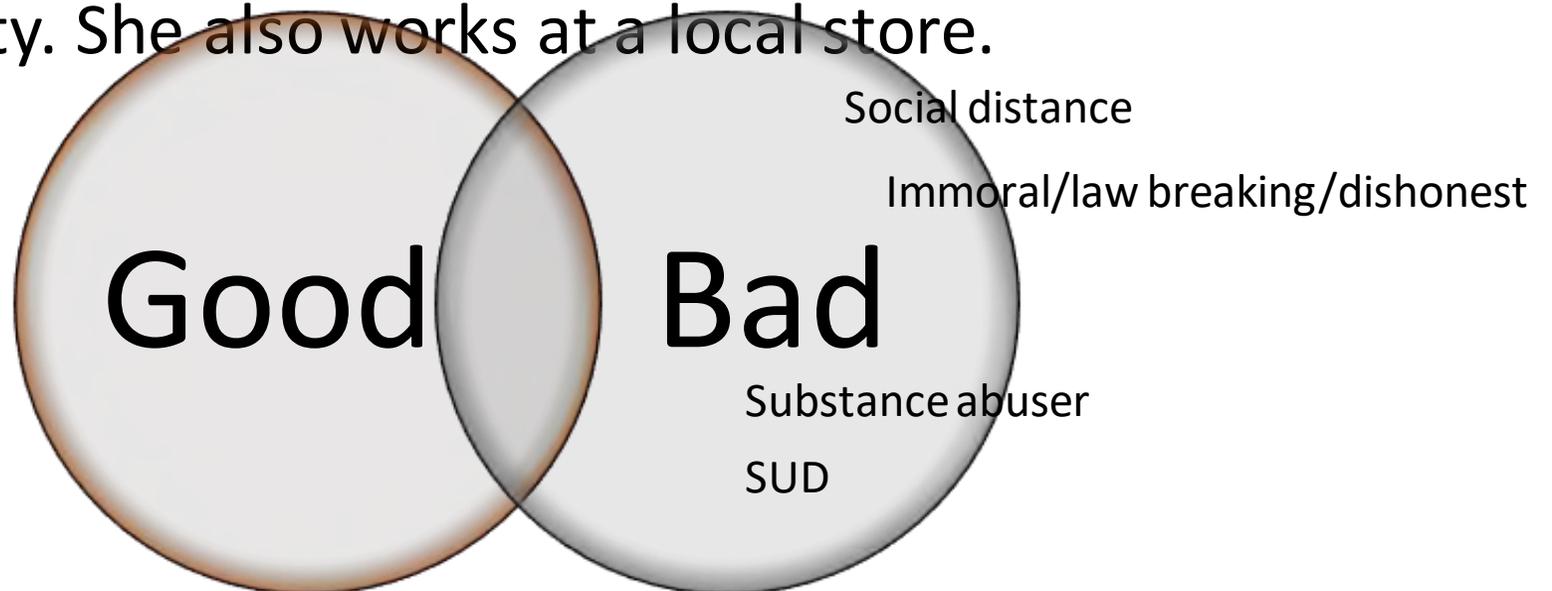
Stigma and discrimination: No other conditions are more stigmatized than addiction

- Implicit bias: subconscious associations
 - Race
 - Body type
 - Gender
 - Sexual orientation
- Strongly associated with the negative implicit bias
 - “substance abuser” and “addict”
 - Can lead to social exile and self-stigmatization
- Less associated with the negative implicit bias
 - “person with a substance use disorder”



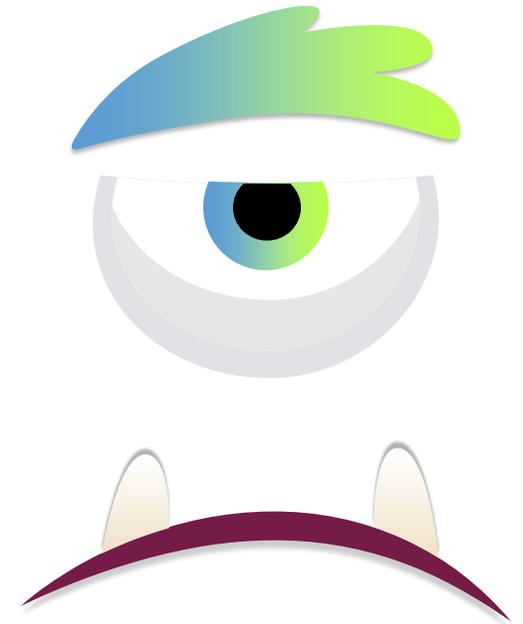
Mary 3

- Mary is a White woman who has completed college. She also has a substance use disorder but has managed to get through the challenges she has faced. As a woman in recovery, she lives with her family and enjoys spending time outdoors and taking part in various activities in her community. She also works at a local store.



Stigma and discrimination

- Some SUD treatment centers are against using any medications
- Many SUD treatment programs do not employ clinicians who can prescribe, dispense, and monitor medications
- Rates of substance use disorders among those on probation or parole are significantly and consistently higher than those of the general population
- The risk of opioid overdose is considerably higher for persons on probation or parole than for the general population.
- Many individuals who would benefit from treatment are in the criminal justice system
 - 45% of individuals in state and local prisons and jails have a co-occurring diagnosis
 - MOUD are underutilized in treatment courts



...using race as a shortcut. It's a crude but convenient proxy for more important factors, like muscle mass, enzyme level, genetic traits they just don't have time to look for. But race is a bad proxy. In many cases, race adds no relevant information at all. It's just a distraction.

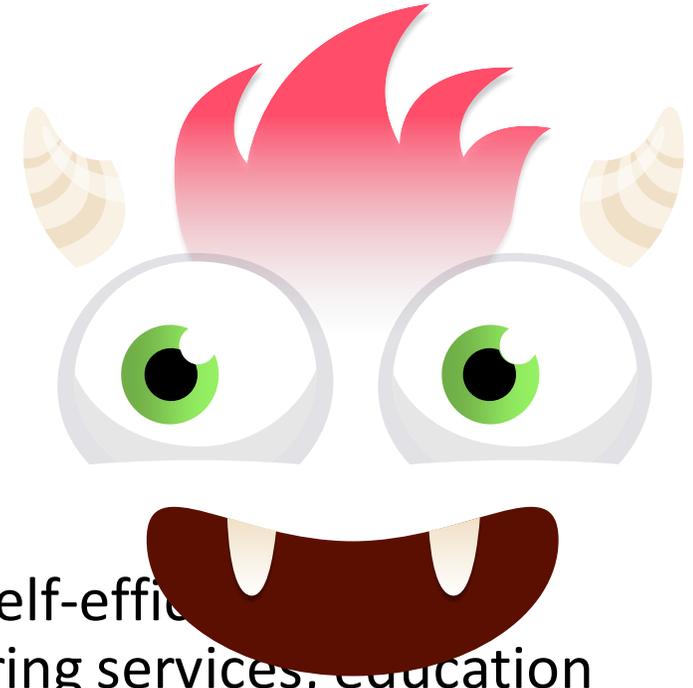


...It blinds doctors to patients' symptoms, family illnesses, their history, their own illnesses they might have –all more evidence-based than the patient's race. Race can't substitute for these important clinical measures without sacrificing patient well-being.



Empowerment and self-stigma are opposite

- Some stigmatized groups show increased self-esteem
 - Some show decreased self-esteem
- Some react with anger to stigma
 - Some are indifferent to stigma
- Challenging self-stigma
 - Empower goal attainment
 - Peers vs. Helpers →→ improves self-esteem and self-efficacy
 - Services: drop-in centers, peer support and mentoring services, education
 - Group identity
 - Coming out



What can we do?

- Protest → suppression
 - Resource-demanding
 - Rebound effect
- Education: content is important
 - Biological vs. inherently flawed??
 - Depicting individuals with an opioid use disorder or alcohol use disorder in positive ways
 - Decreased social stigma among the general public
 - Successful treatment may be a powerful anti-discrimination tool
- Contact



Culture-Relevant questions:

- What was your families use the alcohol or drugs while you were growing up?
- How and when did you first start using drugs or alcohol?
- When did you first encounter problems associated with your substance use? What were the problems?
- How has your substance of choice help you function in your life?
- How has your substance of choice help you function in your life?
- What has been your use of substances in the past 24 hours? Week? Month? Year? Over

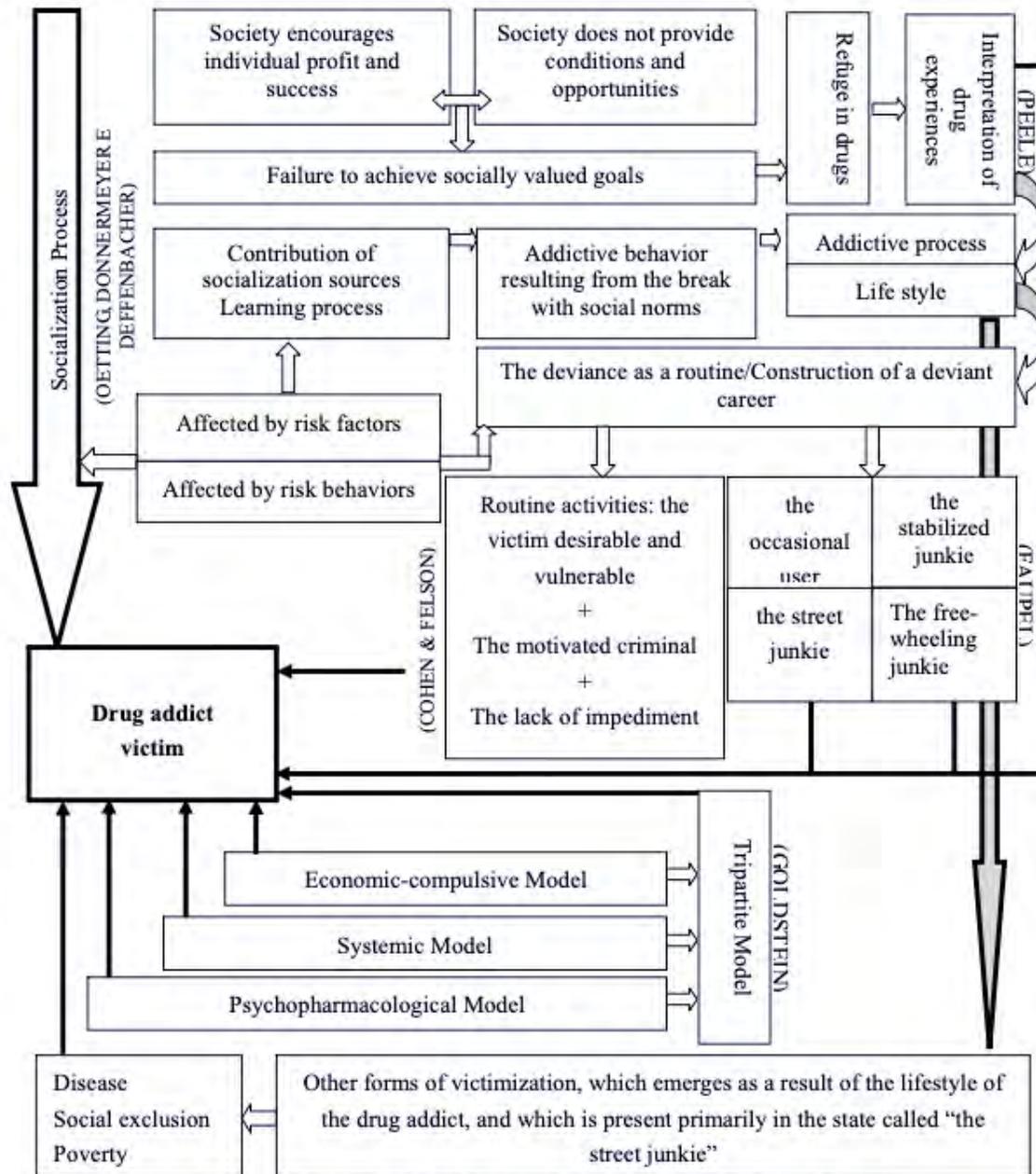
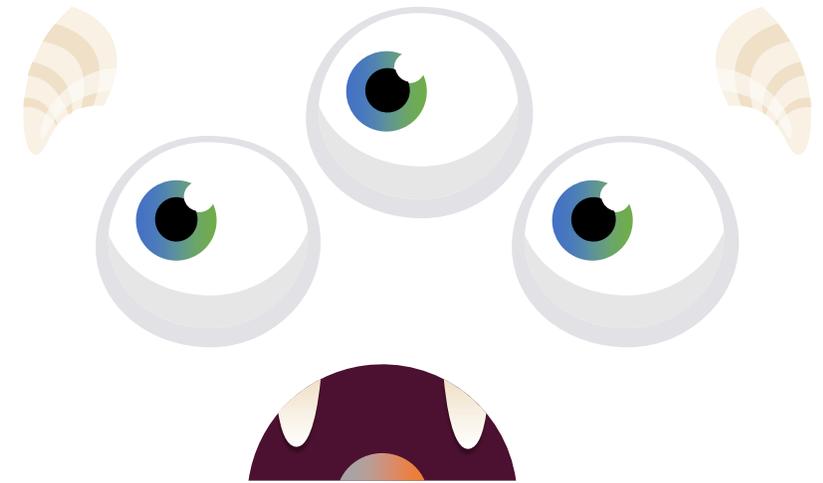


Figure 1 Integration of Models About the Victimization of the Drug Addict



THANK YOU!

