Addiction Treatment
Science and Policy for the Twenty-first Century

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In Praise of Stigma

SALLY SATEL, M.D.

A few years ago, a journalist asked me whether I was concerned about the stigma associated with addiction. I replied that I could imagine few behaviors more deserving of stigmatization. The National Association of Alcohol and Drug Abuse Counselors greeted my comment with a press release stating, "Dr. Satel's nonsensical statement that divorces brain functioning from human behavior further erodes her credibility as an addiction expert."[1] Some months later, I repeated my prostigma comment at a debate at the annual meeting of the College on Problems of Drug Dependence and elicited a collective gasp from the audience.

Clearly, I committed heresy.

Fighting stigma is all the rage nowadays. But the stigma abolitionists rarely say what exactly it is they wish to strip of shame: addictive behavior, seeking help, or addiction treatment itself? I vigorously applaud help-seeking; encourage attendance at a twelve-step group; and believe treatment should be accessible, respectful, and competent. But we don't have to neutralize the moral valence of addiction-fueled behavior to destigmatize the treatment process. We approve of bad parents and abusive spouses when they try to improve themselves through therapy without ever condoning their abusiveness. Indeed, I think it is bad policy to try to cleanse the addict's image. Why try to destigmatize irresponsibility that leads to ruptured families, ruined careers, and crime? Besides, it is unlikely the public would go along; just look at the justifiably scornful attitudes toward drunk drivers.

Let us consider some of the alleged benefits of eliminating stigma, as set forth by the National Institute on Drug Abuse.[2]

Eliminating stigma will get more addicts into treatment. Consider the employee with a drug problem who wants time off to enter treatment. He is reluctant to ask his boss, lest he feel embarrassed or suffer some kind of reprisal. In the end, the worker does not ask for leave, he does not get treatment, and his drug problem worsens. If he had a bad hip, instead of drug problem, the employee would not have hesitated to ask for leave to undergo surgery.

Yet for every employee who is ashamed to tell his boss or fears some kind of reprisal, another may decide to stop on his own or get help precisely because he wants to avoid the embarrassment of failing at the job or of revealing the problem to his boss. Shame, or the prospect of experiencing it, can be an effective deterrent. "Eliminating stigma" may backfire by making more addicts comfortable continuing drug use and avoiding treatment.

Eliminating stigma will improve the availability of treatment. Another rationale for promoting the idea that addiction is simply a medical condition—comparable to, say, hypertension or asthma—is to increase public and political will to fund drug treatment. Greater availability of treatment is a worthy goal, indeed, though I am skeptical that antistigma campaigns of the "have-you-hugged-an-addict-today?" variety will help. Surely, patients must not be discharged from treatment prematurely, but whether a revolving door should be kept open for those who relapse repeatedly—a behavior almost always under one's control—is highly debatable. (The same is true of noncompliant patients with diabetes, for example. Perhaps, they too, should come under more scrutiny for poor self-care.) Softening the moral dimension of addiction is not why we divert petty drug criminals to treatment instead of jail. The reason drug courts have exploded since the early 1990s is because their architects were hardheaded enough to predict that supervised treatment is more effective and less expensive than incarceration—not because treatment is kinder and gentler than jail—and subsequent outcome analyses vindicated their hypothesis.

Eliminating stigma will speed the development of medications. Unlikely. Potential for commercialization will eventually trump bad press—cynical perhaps, but true. After all, consider the innovation in HIV/AIDS drugs. Although male-on-male sex and intravenous drug

use—the main vehicles for transmission of HIV—have negative moral connotations, that has not stopped companies from undertaking robust research and development programs on antiviral medications. If there are few antiaddiction medications in the pipeline, it is because few show clinical promise. If a blockbuster drug for addiction comes along, the me-toos will soon come roaring down the pipeline.

Eliminating stigma will help addicts' "self-esteem." Is this necessarily a good thing? In my clinic, many patients say they came for help only because they "couldn't stand" themselves any longer. Why insulate individuals from the adverse consequences of their behavior when those consequences (a) motivate them to seek help and (b) serve as a lesson to others about socially acceptable conduct?[3] And what would substance prevention counselors do if they couldn't warn youth about the consequences of alcohol and drug abuse? Consequences are meant to strike teens as aversive precisely because they signify a moral lapse or portend humiliation.

In sum, the goals of destigmatization listed above are noble (except, perhaps, the desire to protect addicts' "self-esteem," which is just naive). But no matter how many times we hear that "addiction is a brain disease" or are shown illuminated positron emission tomography scans of addicts' craving brains, it will not change the fact that the *behavior* of addicted people is what the public condemns. Indeed, as one of my colleagues put it, you can examine brains all day, but you would never call anyone an addict unless he acted like one.

But can he control how he acts? Yes. The phrase "brain disease" implies otherwise, yet there is much that is indeed voluntary in addiction.

Contingency management experiments in the lab and in the clinic show that rewards and sanctions typically exert a significant effect on drug use. This is the very essence of voluntariness: the course of a behavior can be intentionally altered in response to consequences. No amount of reinforcement or punishment can alter the course of a truly autonomous biological condition. Imagine bribing a cancer patient—one who adhered faithfully to the treatment regimen prescribed by her physician—to keep her tumor from metastasizing or threatening her with jail if her tumor spread.

In the midst of intense craving, granted, it is very hard to govern oneself. Addicts, however, do not spend all of their time in such a state. In the days between binges, for example, cocaine addicts make many deliberate choices, and one of those choices could be the choice to stop

using the drug. Heroin-dependent individuals, by comparison, use the drug several times a day but can often function quite well as long as they have stable access to some form of opiate drug to prevent withdrawal symptoms. What's more, addicts have episodes of clean time that last for weeks, months, or years. During these periods, it is their responsibility to reduce vulnerability to drug craving and relapse.

Motivation and self-control are acts of the brain as well. Psychologist Gene Heyman, at McLean Hospital, in Massachusetts, makes a subtle but powerful point when he reminds us that voluntary behavior is also mediated by the brain (Heyman, 2003). If we somehow removed stigma we would effectively decrease opportunities to treat the brain insofar as decisions to change depend on a cognitive calculus that often includes the desire to minimize shame. The question is not whether the brain is involved in addiction or whether compulsive drug use changes brains, but whether addicts' behavior can be influenced by its consequences (i.e., is voluntary). The answer is that it can.

When antistigma champions bemoan the fact that "substance abuse is seen as a personal failing or lack of willpower," they don't seem to realize that recovery itself depends on willpower—and thank goodness it does.[4] Acknowledging as much does not "blame the victim," but rather it endorses an optimistic truth that people have the capacity to transform themselves. Alcoholics Anonymous leverages this logic when it says one is not responsible for being an alcoholic (that is, for inheriting or developing a disorder of control) but one is responsible for not drinking.

In the end, the destigmatization campaign—whose practical aims are to encourage people with substance problems to get care and to ensure that treatment is available to them—has its heart in the right place. But its goals will come about, I believe, only when the effectiveness of treatment itself improves. This will boost the public's perception of its value and increase demand, and for this to happen we need good quality care with better treatment outcomes. Former addicts themselves—the treatment beneficiaries—must become visible symbols of hard work and responsibility. In a sense, they must destigmatize themselves; it is not something a slogan can achieve. All of this is difficult.

Promulgating antistigma rhetoric is easy, not to mention a feel-good waste of time. Keith Humphries, a psychologist at Stanford University, offers a good analogy in the form of Americans' initial attitudes toward

immigrant groups, like the Irish, Italian, Jews and Koreans. Contempt for them did abate after time—not because of ads and posters but because they succeed in America, and success destigmatizes.

Finally, even if we could somehow untaint addiction, what would be the price? Stigmatization is a normal part of human interaction, has a civilizing effect on social life, and is often the basis of the antidrug messages we give to children. Censure and disapproval can help define deviancy upward (to play on Daniel Patrick Moynihan's famous phrase), causing drug users to hit their moral bottom sooner so that, finally, they stop using or go into treatment. There is nothing unethical—and everything natural and socially adaptive—about condemning the reckless and harmful behaviors that addicts commit. This need not negate our sympathy for them or our duty to provide care.

NOTES

1. Letter dated May 1, 2003, www.weird-harolds.com/print.php?sid=44.

2. www.drugabuse.gov/about/welcome/aboutdrugabuse/stigma/

3. I do not consider harm reduction techniques (e.g., needle exchange, methadone) to be at odds with this notion. By the time individuals require/want these services, they are already exhibiting behaviors that are socially distasteful.

4. National Governors Association, www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF/vD_4407,00.html.

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