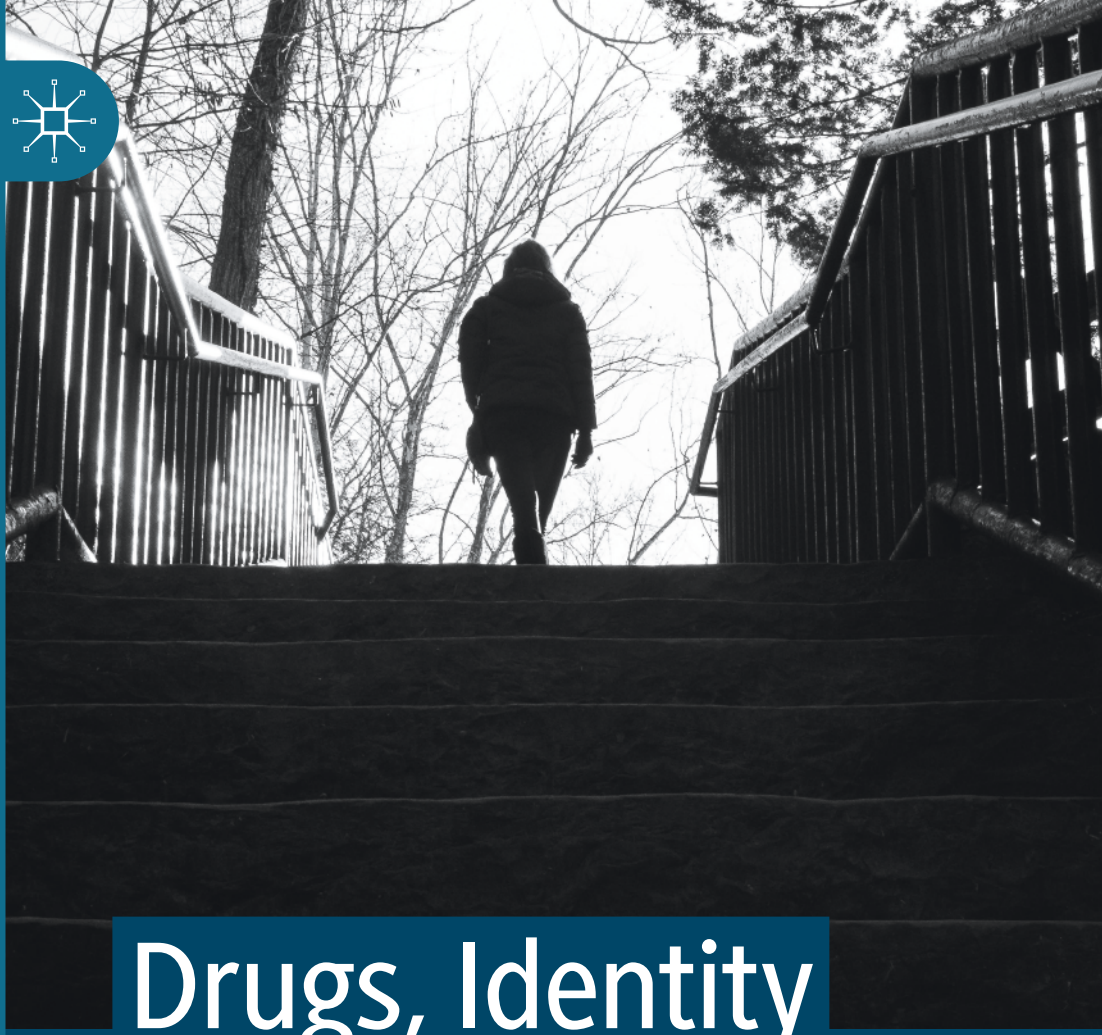

Drugs, Identity and Stigma

Edited by
Michelle Addison
William McGovern
Ruth McGovern

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Stigma 'Under the Skin'

Michelle Addison, William McGovern, and Ruth McGovern

Introduction

Stigma is powerful: it can do untold harm to a person and place with long-standing effects (Ahern et al. 2006; Baumberg Geiger 2016; Chang et al. 2016; Hatzenbuehler 2013; Pemberton et al. 2016; Room 2005;

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Scambler 2018). Stigma can regulate and reproduce what, and who, is and is not valued in any given time or space, and it can be weaponised to justify vast, pernicious, and entrenched inequalities (McKenzie 2012; Scambler 2018; Devine et al. 2005). For us, stigma is not a noun but a verb—something that is done in the everyday interactions between people. Stigma is also structural, woven into the fabric of society, government policies and legislation, and practice. As such, what we come to recognise as stigma is social, cultural, *and* political. Stigma constitutes a cacophony of 'mechanisms of inequality', as Tyler (2020) puts it, intended to inscribe some as people of *value* (Goffman 1990; Pemberton et al. 2016; Scambler 2018; Tyler 2018a; Skeggs 2011; Bambra 2018a; Marmot 2017, 2018; O'Gorman et al. 2016; PHE 2017, Public Health England 2019; Tyler 2018b, 2020; Tyler and Slater 2018) and others as 'wasted humans' (Tyler 2013b) through a series of intersecting classificatory schemas from gender to class, race to disability, age, sexuality, and more (Tyler 2020). Inhabiting the supposed 'wrong' kind of personhood can easily attract 'stigma'—a sticky and contagious way of being marked as valueless, worthless or insignificant by those more powerful in society, as others have identified (Tyler 2013a, 2015, 2020; Pemberton et al. 2016; Scambler 2018).

In this collection we unpick why it is that stigmatisation happens to people who use drugs (PWUD). Having power to name, shame, and blame through stigma produces advantages for individuals and organisations who wish to retain and protect their accrued privileges and capital (economic, social, cultural) as symbolic and legitimate (Bourdieu, 1984/2010). This process has been described as a 'site of social and political struggle over value' (Tyler 2020: 180). Elsewhere, Braithwaite writes that, 'Stigmatising other human beings is a common human frailty because stigmatising the debased identity of others is a way of shoring up our own identity' (1989: 4). In doing so, the boundary of valued/valueless personhood is continually affirmed.

The history of stigma exemplifies multiple complex mechanisms of inequality and power, and is associated with the marking and denouncing of certain groups and people. For example, Tyler's research explores the historical legacy of stigma through practices such as branding, marking and denouncing certain people and communities

(2020). Tyler discusses how the stigmatisation of people of colour through heinous practices operated as a mechanism of inequality that functioned to legitimate slavery, allowing people and organisations in positions of power to unfairly and unjustly extract economic capital. Tyler also sheds light on the stigmatisation of women via conduits of disgust, blame, and shame that control and prevent access to public speech and arenas of power (Tyler 2020). She writes that stigma is a political and economic vehicle that operates to justify the dispossession of certain people and legitimate extensive capital accumulation across time (2020). As such, stigma works to devalue people in order to create the right conditions to enable 'profiteering'—all in spite of the devastating effects on a person and community (Tyler 2020: 27). Furthermore, stigma is a 'dehumanising practice of subjugation', writes Tyler (2020: 270), that deters people and communities from making claims on the state. Studying stigma and its effects on PWUD matters because, as we will discuss, it operates as a powerful way to 'police' and regulate often the most marginalised and vulnerable in society (Braithwaite 1989, 2000).

The study of stigma has been of interest to scholars because it is a lens through which structures of inclusion and exclusion come into focus across different social contexts. Stigma is a marker—a form of 'distinction making' that can tell us a lot about the society we live in and how a society perceives and values certain kinds of people. Brathwaite's theory of reintegrative shaming has been influential in studies of stigma, particularly in criminology, where stigmatisation is discussed as the process of shaming certain individuals as a 'bad person' so that they constitute the sum of their deviant actions (Braithwaite 1989). Stigmatising individuals in this way can be humiliating, disrespectful, and a degradation of their humanity (Braithwaite 1989). This form of disintegrative shaming leads directly to further marginalisation and deeper social exclusion, serving to label certain persons with a pathologically 'deviant' identity, and increase feelings of alienation and disadvantage. Stigmatisation inscribed on persons in this way through shame can become part of a 'deviant' cycle that is difficult to escape and, as Braithwaite notes, as marginalisation increases so the pressure to survive intensifies.

Our embodiment, as well as our way of *being* and *doing* in the world, is seen through a lens of 'value' depending on where we are located in social space (Bourdieu 1990, 2015; Skeggs 2011). How we act in certain spaces and around certain people can be recognised and interpreted by more privileged and powerful others to signal identities of value/valuelessness. Being perceived as being without value draws stigma like a lightning pole, culminating in everyday acts of symbolic violence and social harm (Bourdieu 1979, 1990, 2016; Skeggs 2011). However, this makes stigma as 'practice' sound very straightforward and simple, which it is not. Time and place matter, as does the 'kind' of person and 'practice' in question (Bourdieu 1990, 2008, 2015). For instance, taking drugs is variously stigmatised (Chang et al. 2016; Hatzenbuehler 2013; Room 2005) but all people who use drugs are not subject to the same mechanisms of stigma (Room 2005)—so, in this collection we ask how are some people able to resist and negotiate stigmatisation whilst others are subsumed by stigma? Drugs have historically and culturally traversed licit and illicit boundaries (Bambra 2018a; Best et al. 2012; Best and Lubman 2012; Boshears et al. 2011; Carbone-Lopez 2015; Ettore 2007; Seddon 2011), and can be located in a moral and political economy (McCarthy 2011; Wakeman 2016) meaning that *what* you use matters when it comes to understanding how stigma operates in society (Sayer 2002; Seddon 2006, 2008; Tavakoli 2014; Tuchman 2010; Wakeman 2016; William Best and Ian Lubman 2017; Zawilska and Andrzejczak 2015). *Who* takes *what* drugs, *when*, *how*, and *why*, all influence appraisals and inscriptions of stigma (Room 2005; Scambler 2018) and its power to worm its way *under the skin* (Kuhn 1995; Devine 2004) and do social harm (Bambra 2018a; Pemberton et al. 2016).

In this book we frame and understand stigma and stigmatisation as elaborate, knotty, and sophisticated structures of power that come into focus through social relations between people. This edited collection studies stigma and how it operates as a complex mechanism of exclusion and inequality by exploring the everyday lives of people who take drugs. We bring together new interdisciplinary analyses to assess and understand painful impacts of stigma and stigmatising practices attached to people who use (or have used) licit and illicit drugs, through an exploration of inequalities, power, and sensations of feeling 'out of place' in

neoliberal times. In doing so, we look at how stigma is variously navigated, managed, and resisted by people who use drugs at festivals, in the local 'pub', to get through the day, and those in recovery. The focus here is on how stigma is experienced, negotiated and differently impacts on people who use diverse drugs and are located in disparate social backgrounds and geographies. What is more, we are centrally concerned with the complexity of how stigma and illicit drug use links to persistent social and health inequalities (Room 2005; Scambler 2018; Seddon 2006; Tyler 2013a).

This opening chapter begins by introducing the concept of stigma and how it is understood across different disciplines, and how language can act to reinforce stigma. It asks questions about the lasting effects of stigma on PWUD (Room 2005). Across the collection, contributors shed new light on the lasting impacts of stigma on a person's health, pathways in and out of crime and interactions with the criminal justice system, as well as building on new debates about how stigma is reproduced through complex mechanisms structuring groups and organisations. The volume draws attention to current neoliberal drug policies that focus on individualised behaviour change subject to performance measures for interventions, treatment completion and non-returns (Black 2020a, b; Home Office 2017; HM Government 2021; O'Gorman et al. 2016; Pemberton et al. 2016; Scambler 2018). Taken together, this book challenges individualised narratives of 'problematic' drug use by demonstrating how structures and practices of stigmatisation around drug use become normalised and expected and serve the interests of more privileged individuals and organisations in power. The reader is encouraged to consider wider complex social systems, mechanisms of stigma, and structural inequalities impacting on the lives of PWUD. Finally, we also bring together an overview of the contributions offered in this collection which begin to address these important issues. We wish to introduce themes, which are explored across the collection, of inequality, power, and social injustice, and how these can potentially coalesce to impact on a person's sense of value and inclusion in society.

Navigating Stigma

Stigma can get 'under the skin' of a person (Kuhn 1995), particularly a person who uses drugs. We want to encourage you, our reader, to reflect on what this can tell us about how intersections of identities and drug practices are shaped through the reproduction of stigma.

Goffman wrote extensively about stigma across his oeuvre—he variously identified stigma as 'abominations of the body', 'blemishes of the character' and 'marks of race, nation and religion' (Goffman 1990: 4–5) and described it as 'an attribute that is deeply discrediting' (1990: 2; Addison 2016). For him, stigma was produced in social interactions between people when a person fails to recognise a social norm (cf. Tyler 2020). In Goffman's *Presentation of Self in Everyday Life* (1959) he examined action observable in body language, facial expressions, gestures, and props. Further, exploring the roles that people adopt in certain spaces and around certain people and provided in-depth analysis of 'dramatic realisations' and how people manage impressions and 'stigma' held by others about oneself (1959). Goffman (1959) presented the theory that in order to do 'impression management' convincingly this required putting knowledge of valued social attributes into practice (Addison 2016)—not only that, this performance requires knowledge of how to 'play the game' and get ahead (Addison 2016).

Knowing what looks good or sounds right can be challenging, especially if one's embodied identity is already knowingly under-valued. Inhabiting the 'wrong', or a stigmatised, identity means encountering mechanisms and structures of exclusion (Addison 2016), the result here is that we come to recognise that a stigmatised identity is equal to a 'spoiled' identity that is to be *avoided* at all costs unless we too are to survive exclusion at the margins (Goffman 1990). Addison also writes how having knowledge about which aspects of identity are stigmatised, and which have use or exchange value, is central to 'identity formations and refusals' (2016: 54). However, resistance and refusals of a 'spoiled identity' are not actions available to everyone; having a stigmatised identity thrust upon oneself is often beyond the control of already vulnerable people. As Lawler puts it, stigma can be 'something imposed on us irrespective of how we feel about ourselves' (Lawler 2005: 802).

Having knowledge capital of what stigma is attached to, inscribed on and inferred upon is essential to knowing how to 'play the game' (Bourdieu 1990, 2015) and avoiding pitfalls (Addison 2016). As Savage et al. write, this also means having knowledge of how people are marked 'as lacking in appropriate tastes and demeanour' (Savage et al. 2001: 108), and as Skeggs (1997, 2011) notes—how value is carried on the body. Mobilising knowledge capital to navigate mechanisms of inequality is vital to maintaining inclusion; as Addison describes, some people are able to 'use this knowledge of dominant classifications to propertise their personhood (cf. Adkins, 2005)' (2016: 54) and work on the 'self'. However, as Skeggs and Loveday attest, there are people and communities who are not able to do this work on the self to mitigate stigma convincingly, or willingly: they do not, cannot, embody the 'good citizen' (Skeggs and Loveday 2012: 473).

Goffman is recognised as a key theorist in the area of stigma, but his work is variously criticised (Addison 2016; Hochschild 1983; Scambler 2018; Tyler 2020): for instance, Tyler argues that whilst Goffman describes how and what stigma comes to look like in social relations, he problematically overlooks power relations that enable stigma and stigmatisation to function. Power relations operate at both a macro and micro level structuring interactions in society (Tyler 2020) and serve the interests of dominant and privileged individuals and organisations. Goffman focused on individual level forms of stigma between people, so much so, that he overlooked, according to Tyler, the structures of violence that perpetuate stigma and inequality. As such, Tyler (2020: 101) argues that Goffman's conceptualisation of stigma is uncritically passive and 'emptied of power', only serving to divert attention away from the causes and arbiters of stigma. Tyler calls attention to 'stigma craft' engaged by powerful elites: that is, the mechanisms through which stigma is produced by dominant factions to 'silence, constrain and misrepresent' (Tyler 2020: 104). From this, she seeks to highlight the oppression and symbolic violence enacted on vulnerable and marginalised communities through stigma and structures of inequality (2020). Likewise, Scambler (2018) also seeks to go beyond Goffman's conceptualisation of stigma and instead writes how it comes to be weaponised in neoliberal times. Scambler linked stigma to deeply felt emotions of shame, and acts of

shaming defined by cultural norms (2018). He argued that 'deviance' has come to be conflated with stigma so as to justify blaming individuals for their position. This weaponising of stigma then legitimates a raft of neoliberal austerity measures intent on reducing state involvement and support of vulnerable and marginalised communities, and a rationale for increased policing and regulation of victims of stigmatisation (Scambler 2018). Elsewhere, Braithwaite also wrote about the pernicious aspects of shaming as a means to stigmatise and pathologise individuals in his research around restorative justice (1989). For him, shaming and blaming served to increase marginalisation and criminal activity, rather than counter it—and as a consequence, provided justification for more ardent attempts at crime control through constraint, punishment and regulation by the state, police, and its dominant factions.

In other theorisations of stigma, Wacquant wrote about *territorial* stigma in his research looking at individuals who were marginalised in certain urban spaces in Chicago and Paris (2008). Wacquant was interested in how stigma was inscribed in struggles over space and place, or what he termed 'bounded stigma' (2008: 169) where certain people are trapped in a 'branded' and 'blemished' space (2008: 171). People living in these areas of urban deprivation were variously pathologised as depraved, deviant, and deficient by 'outsiders'. Wacquant noted how economic inequality in these areas gave rise to intense feelings of psychological stress and demoralisation; unrest in these areas was labelled as dangerous and deviant thus justifying symbolic violence exercised via the state through greater policing and criminalisation of poverty (Wacquant 2008). And yet, Wacquant argues that these mechanisms of stigmatisation and policing act to occlude the 'causal mechanisms feeding the new urban poverty' (2008: 7), mask 'state policies or abandonment and punitive containment' (2008: 175) and serve the interests of those in positions of power.

Wacquant (2008) noted how some residents living in deprived urban areas of Paris were able to undergo 'impression management' to mitigate the effects of stigma and how they were perceived by others. This concept of managing one's impression in the eyes of others is discussed by contributors in this volume and is located as a key theme within the book. Wacquant explains how individuals would 'hang out' in upmarket

areas of Paris, like the Champs-Elysees, to navigate and resist feelings of stigma and mitigate negative self-worth. However, as Wacquant highlights in his work, certain people are not able to do this—and find themselves contained and constrained by perceptions others hold of their body. He describes how certain areas of Chicago are marked out and differentiated by a classificatory schema based on race and aligned with problematic stigmatised categories; this makes it nearly impossible for a person of colour to traverse spatially bounded stigma and manage impressions of how they are perceived by others in his research, given that race, poverty, and stigma are deeply attached to space and place in the city.

In comparing residents who lived in Chicago and Paris, Wacquant argued that the pervasive ideology of moral individualism was very influential in the USA—this idea of an 'agentic and choosing individual' (Giddens 1994) operating in a market driven meritocracy negated any recourse to state accountability or other social determinants—the individual was regarded as culpable for their position in life. Rather than looking up and out at regimes of inequality, Wacquant noted that feelings of shame and blame explicating poverty and marginalisation were turned inwards amongst the communities living in deprived areas of Chicago. This internalisation of stigma 'under the skin' ostensibly negated state inflicted symbolic violence, social harm, and legitimated structures of inequality disguised by neoliberalism.

The deeply felt effects of stigma are unevenly distributed throughout society and amount to an erosion of social solidarity, trust and an intensification of social differentiation in and amongst already marginalised communities (Bourdieu and Wacquant 2013; Wacquant 2008). The result is extreme—for instance, individuals who have drug use issues, serious mental health challenges, or who need to claim welfare to survive, are subjected to an intensification of stigma practices in order to shore up differences between 'morally respectable' individuals in poverty, and those who evoke disgust and anger due to a 'waste of public resources' (Wacquant 2008: 184). These 'wasted humans' (Tyler 2013a, b) are, as Wacquant describes '[the] faceless and demonised other – the downstairs neighbours, the immigrant family dwelling in an adjacent building, the youths from across the street who "do drugs"' (Wacquant 2008: 240)—a

toxic narrative then that serves to further justify and reproduce negative perceptions of marginalised groups whilst maintaining power structures.

We know that illicit drug use is unequally socio-spatially distributed: heroin use is the most recognisably stigmatised drug in the UK (Wakeman 2016), with new evidence also pointing to similar issues around novel-psychoactive drugs e.g. Spice (Addison et al. 2017); whereas stimulants are used by a broader range of people occupying upper/middle/working class positions: ranging from students, professionals, mothers, clubbers, and people who are homeless (Measham et al. 2011; Minozzi et al. 2016; Home Office 2017; Wakeman 2016). Within drug literature it is documented that illicit drugs are perceived as part of a cultural hierarchy of meaning, distinction, and value (Room 2005; Wakeman 2016; Measham et al. 2011; Pennay and Measham 2016), with certain kinds of licit and illicit drug use, methods and people considered normalised unlike others who experience the social harm of stigmatisation. Room noted how the stigmatisation of people who used drugs operated through social relations and state structures: this was frequently generated via family and friends, social and health agencies, and through government policy (Room 2005). Room described this heavy moralisation of drug use as 'problematic' due to: 'illness, violence, casualities, and failures in major social roles, particularly at work and in the family' (2005: 149). Stigmatisation is legitimated because the person is perceived as lacking somehow—they are dehumanised and made culpable for their position, subsuming and making invisible wider structural factors. Similarly, Seddon also observed the marginalisation of PWUD via the criminal justice system and repeat experiences of police and prison custody (Seddon 2006). These people were subjected to further controls and regulation intent on deterring further acts of deviance, and we argue, stigmatised in order to justify exclusion from society.

Negotiating stigma involves mobilising valued capital and resisting the negative inscriptions from others in society (Skeggs 1997, 2011; Goffman 1990). This is fraught with difficulty (Tyler 2013a, b) and can be an impossible refusal for many of the most vulnerable people in society who use drugs (Chang et al. 2016; Addison et al. 2017). As Room writes, 'Alcohol and drug use can serve as a demonstration to the

user and to others about highly valued personal qualities such as self-control' (2005: 152). Some people who use drugs might have greater social capital, status, social credit, or use drugs recreationally, and are in a position to mitigate and offset the effects of stigma (Measham et al. 2011; Pennay and Measham 2016), whereas there are others who find themselves experiencing greater disadvantage and pressures to survive.

Criminalisation of Drug Use

Drug use is criminalised in many areas of the world because of the associated costs to society, harms to individuals and communities, links to vulnerability, and connections to violent networks (Abdul-Khabir et al. 2014; Ahern et al. 2006; Bradley 2009; Braithwaite 1989, 2000; Darke et al. 2008; Seddon 2006, 2011; William Best and Ian Lubman 2017; Woolley 2021). By bringing people who use drugs into contact with the criminal justice system through legislation and policy focussed on punishment, deterrence, and shaming, this further compounds multiple disadvantage and exacerbates social harm amongst already marginalised and vulnerable individuals and communities (Woolley 2021). Contributors in this volume connect with these debates and highlight how the criminalisation of a person who uses drugs can lead to greater vulnerabilities that are also amplified through axes of social inequality impacting on their lives.

Whilst the use of illicit drugs is evident across social strata in society, and motivations to use vary (Addison et al. 2021; Carbone-Lopez et al. 2012; O'Donnell et al. 2019) research shows that illicit drug use is more common in unequal societies, and can be linked to the painful everyday experiences of low social status amongst marginalised groups (Wilkisnon and Pickett 2009; Bambra 2018a; Marmot 2017, 2018; O'Gorman et al. 2016; PHE 2017; Public Health England 2019). However, this research often overlooks the everyday experiences of people who use drugs and the damaging effects of stigma in particular. The social, personal, and health costs of drug use are stark for those living at the margins of society (Chang et al. 2016; Marmot 2017, 2018), although it is important to acknowledge that middle-class drug use can often be less visible. In order

to tackle illicit drug use, the UK drug strategy 2021 (HM Government 2021, 2017) focuses on reducing demand and supply, building recovery, and global action. This strategy engenders neoliberal policies that focus on individualised behavior change subject to performance measures for interventions, treatment completion, and non-returns, whilst remaining disconnected from complex social systems, contexts (Rutter et al. 2017), mechanisms of stigma, and social inequalities (Scambler 2018).

This 2021 UK Drug Strategy arises out of legislation mandated 50 years ago—the UK Misuse of Drugs Act, 1971 (HM Government, 2021). Whilst there are notable disparities across Europe (e.g. Portugal, Switzerland—both adopt a public health approach to drug use as a primary resolution), as well as across the devolved administrations in the UK, this particular legislation criminalises possession and consumption of illicit drugs, as well as production and supply—making drugs a problem to be tackled by the criminal justice system (CJS) through control of substances and punitive charges that go on a person's permanent record. Whilst out of court disposals such as penalty notice for disorder (PND) or conditional cautions can divert people for minor drug offences (e.g. related to cannabis) (National Police Chiefs' Council [NPCC] 2017), it is still the CJS that are expected to enact the UK Misuse of Drugs Act, 1971. Woolley (2021) argues that the UK Misuse of Drugs Act (HM Government 1971) is not fit for purpose if the intention is to reduce drug use, and with it, wider social harms related to crime, health, and social cohesion. This legislation is failing people who use drugs: drug related deaths in the UK remain the highest in Europe, and despite a global pandemic the availability of illicit drugs remained constant (Woolley 2021). Bambra highlights the damage caused through policy-related harms around drug use and addiction adding to widening health inequalities (Bambra 2018a, b). Furthermore, this legislation exacerbates policy related harms through structural and systemic stigmatisation of certain individuals and communities—particularly amongst people of colour and those from working-class backgrounds; as Woolley comments, the evidence shows how this legislation is used to legitimate 'stop and search' sanctions of black people at a rate six times higher than white counterparts (Woolley 2021).

Effect of Stigma on Health and Social Capital

The effects of stigma on the health of PWUD is an emerging field (Ahern et al. 2006; Chang et al. 2016; Hatzenbuehler 2013; Marmot 2017, 2018). However, many studies utilised in policy formation around drug use are dominated by atheoretical public health perspectives and/or an individualised, behaviour model of addiction, although some exceptions include Measham et al. (2011), O'Gorman et al. (2016), Seddon (2006, 2008), and Boshears et al. (2011). We argue that the 'rational agent' figures centrally in these studies—that is to say that a person who uses drugs is framed as someone who makes 'bad choices' (across both addiction as disease literature and harm reduction literature) and is held culpable, to various degrees, and accountable in health and criminal justice settings either through punitive measures or individualised health interventions focused on changing behaviour (Ahern et al. 2006; Beck 1992; Best and Lubman 2012; Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017; Scambler 2015; Seddon 2006). This individualisation of the 'problem of drugs' through mechanisms of stigma succeeds in diverting attention away from structures of inequality as outlined by (Tyler 2020).

Yet, there is reason to be hopeful as recent evidence strongly makes the connection between dependent drug use and the impact of poverty which is difficult for the government to ignore. Dame Carol Black's Review (Black 2020a) reports how long-term drug use is linked to everyday experiences of poverty. There has been much important research to show that high rates of relative poverty lead to widening of health inequalities between affluent and marginalised communities (Marmot 2010, 2017, 2018; Wilkisnon and Pickett 2009; Bambra 2018a; Whitehead et al. 2014). Black's review shows how dependent drug use, poverty and marginalisation is exacerbated as people become caught in a cycle of moving in and out the criminal justice system with little scope for success in recovery or achieving meaningful employment (Black 2020a). Here, we encourage you to pause and consider the idea that dependent drug use is not a pathological problem of the person, which is a convenient and yet stigmatising narrative, but often an outcome of extreme social harms perpetuated through complex structures of inequality. According

to Black, the 'cost to society of illegal drugs is around £20 billion per year, but only £600 million is spent on treatment and prevention' (Black 2020a, b: 3; HM Government 2021), and yet the current legislation and criminalisation of drug use is *not* working as intended—to deter illicit drug use. Instead, legislation and policies intended to wage a 'war on drugs', with drug users ostensibly portrayed as victim and violator, perpetuate damaging structures of inequality by stigmatising people who use drugs simplistically as free agents making 'bad choices'. As mentioned earlier, these already vulnerable people become framed as 'wasted humans' (Tyler 2013a, 2020), legitimating discriminatory and exclusionary practices embedded in social relations, public perception, access to services and full participation in society. Stigma corrodes a person's social capital (Panebianco 2016; Scambler 2015; Tyler 2013b), which has enormous health implications (Ahern et al. 2006; Chang et al. 2016; Hatzenbuehler 2013; Room 2005), and reproduces systemic social harm against those who are most vulnerable, underheard and marginalised (Pemberton et al. 2016; Room 2005; Woolley 2021). This pervasive social harm towards the most vulnerable in society cannot and must not continue.

Layout of the Collection

We take up this social justice agenda and explore the themes and consequences of stigma and structures of inequality amongst people who use drugs throughout this collection. The book is organised as follows:

Mechanisms of Stigma and Identity Formation

In this section, we look at how stigma is reproduced through structures of inequality structuring groups and organisations, as well as in practices and social relations within and between people in different settings. We begin with Karenza Moore's chapter *Intersectional Identities, Stigma and MDMA/Ecstasy Use* in which she discusses how Ecstasy/MDMA is subject to persistent public and mediated stigma producing potential

self-stigma, which must be negotiated, managed, and at times resisted by its users. We then move on to explore *Guilt, Shame, & Getting Passed the Blame: Resisting Stigma Through the Good Mothering Ideal* written by Tracy R. Nichols, Amy Lee, Meredith R. Gringle, and Amber Welborn who tell us more about mothers who use drugs (MWUDs) and their experiences of stigmatisation through social interaction. They discuss in-depth how these women internalise the stigma that labels them as 'bad mothers' and they draw attention to power dynamics that make resistance and negotiation of stigma challenging. Finally in this section, we include Carole Murphy's chapter which explores mechanisms of stigma and identity formation within a framework of recovery from drug use in *Identity Construction and Stigma in Recovery*.

Social Inequality, Health and Crime

In this section we explore how stigma and stigmatisation can have lasting impacts on a person's health, pathways in and out of crime and interactions with the criminal justice system, and crucially widen social inequalities. Sam P. Burton, Keegan C. Shepard, and Sergio A. Silverio bring to the collection their insights and discussion regarding stigma as it comes to impact on healthcare professionals in *What's Your Poison? On the Identity Crises Faced by Healthcare Professionals Who (Ab)Use Drugs and Alcohol.* In this chapter, they present a critical review of the literature in which they discuss the resultant identity crisis of a population of interest (HCPs) experiencing drug and/or alcohol (ab)use. Next is Jim McVeigh and Geoff Bates where they explore the stigmatisation of different kinds of drug use by focusing on anabolic androgenic steroid use amongst men: *Stigma and the Use of Anabolic Androgenic Steroids by Men in the United Kingdom.* Following this, Kelly J. Stockdale, Michelle Addison, and Georgia Ramm discuss the challenges of stigma and stigmatising practices within a police and prison custody setting in *Navigating Custodial Environments: Novel Psychoactive Substance Users Experiences of Stigma.* Lastly, we include Cassey Muir, Ruth McGovern & Eileen Kaner's chapter which critically engages with existing literature

and empirical studies to explore the impact of stigma within families: *Stigma and Young People Whose Parents Use Substances*.

Normalisation, Negotiations, and Refusals

Our last section explores how structures of inequality and practices of stigmatisation around drug use become normalised and expected. These chapters look at how people who use drugs are able to navigate and negotiate stigma and impacts with varying levels of 'success' and 'failure'. Are people who use drugs ever in a position to *refuse* stigma? Are people who use drugs able to disidentify with stigmatisation mechanisms and practices? Or, is this an impossible refusal for many? Tammy Ayres and Stuart Taylor write about *Cultural Competence to Cultural Obsolescence: Drug Use, Stigma and Consumerism* in their chapter—they argue that the contemporary remit and nature of stigma is increasingly shaped by consumerism and its polarisation of proficient and flawed consumption practices. Craig Ancrum, Steph Scott, and Louise Wattis discuss the normalisation of cocaine use amongst certain subsets of the population in their chapter '*It's What Happens Now When People Go for a Drink': Normalising Non-dependent Recreational Cocaine Use Amongst Over-35s in the UK*'. We add our own contribution here, in which we discuss negotiations and resistances to stigma and structures of inequality, as we return to recovery settings in *Negotiating "Self-Stigma" and an "Addicted Identity" in Traditional 12 Step Self-Help Groups.* We explore how people in recovery recognise stigma, negotiate their place within a self-help group through stigma, and variously resist stigmatising mechanisms advocated within and outside the group.

Key Questions to Consider and Reflect on as You Read This Collection

- How do we understand everyday experiences of people who use drugs?
- What lens do we use to understand and make sense of social status, identity, affect and personhood amongst people who use drugs?

- How does stigma get 'under the skin' and what this can tell us about the lasting effects of stigma on a person who uses drugs?
- How is stigma variously experienced by people who use drugs from within the criminal justice system, social work, health organisations, and services?
- How do stigmatising processes persist in positioning people who use drugs as certain 'kinds of people'?
- What impact does stigmatisation have on social mobility and identity formation?
- How is stigma identified, negotiated, refused, and resisted by people who use drugs?
- How does stigma and drug use impact on a person's sense of inclusion in society?

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Intersectional Identities, Stigma and MDMA/Ecstasy Use

Karenza Moore

Introduction

MDMA/Ecstasy is a popular illegal drug predominately consumed globally by those who attend raves, nightclubs, festivals and parties, typically in conjunction with music consumption in the leisure spaces of youth (sub)cultures. MDMA/Ecstasy and its users may not immediately spring to mind when considering drugs, identities, and stigma. MDMA/Ecstasy, in comparison to say alcohol or heroin, is a *relatively* benign substance (Nutt et al. 2010). As highlighted in this edited collection, people who use drugs (PWUDs) and develop dependencies struggle to negotiate, manage and resist perceived public stigma and self-stigma, as 'problem drug user' (PDU) becomes their master status (Goffman 1963; Anderson and Kessing 2019). Indeed, we might ask whether MDMA/Ecstasy and its users are really *that* stigmatised?

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I argue in this chapter that MDMA/Ecstasy, its use and its users *are* subject to sometimes subtle and not so subtle processes of stigmatisation. My argument is supported by recent sociological work on the concepts of stigma, deviance, shame and blame (Scheff 2014a, b; Scambler 2018; Tyler 2018, 2020; Tyler and Slater 2018), and a historical contextualisation of MDMA's uses, diverse user groups, and variable meanings (Moore et al. 2019). Further, I present two 'security stories' or ethnographic vignettes of the sort told and retold amongst club and festival-goers. These vignettes or 'evocative little stories' (Schöneich 2021: 116) demonstrate the importance of intersectional identities and sociocultural relations in contemporary considerations of drug-related stigma. These include intersections of age, social class, gender/sexuality, disability, and race/ethnicity relations, alongside State-based control and oppression, notably through legal powers (Greene 2020; Scambler 2018), and the proactive policing of global drug prohibition (Measham and Moore 2008; Moore and Measham 2012).

The history of MDMA and its stigmatisation may be read through its deployment as a boundary marker between the burgeoning professional psychiatric profession and those 'counter-cultural' therapists exploring alternatives to dominant medical theories and practices in the 1960s and 1970s (Passie 2018). The potential of MDMA-assisted therapy has again been buoyed up by successes in recent Phase 3 clinical trials in the US and support from the US Food and Drug Administration (FDA) (Mitchell et al. 2021; MAPS 2020). In a consideration of its variable positioning, MDMA has long slipped between meanings. The drug is at once a health-giver to those suffering from recalcitrant PTSD and depression (MAPS 2020), a 'dance drug' consumed by ecstatic hedonists (Reynolds 1998), and a grim heralder of agonising effects amongst its young users (Burgess et al. 2000). Processes of public stigmatisation differentially position psychoactive substances such as MDMA/Ecstasy as (somewhat) legitimate or otherwise according to whether use occurs in a medical/therapeutic *or* recreational setting, and whether it is situated within the legal medico-pharma complex, or illegal/criminal market (Moore et al. 2019; Quintero 2012).

Over the past decade or so there has been considerable upheaval in global illicit drugs markets. From 2009, we saw the emergence of

Novel Psychoactive Substances (NPS) and the arrival of the stimulant Mephedrone or M-Cat onto UK drug scenes (Measham et al. 2011), with dance music clubbers and gay men being two early-adopter groups (Wood et al. 2012), reflecting the emergence of MDMA/Ecstasy use in gay scenes in the US and the UK decades earlier (Silcott 1999; Reynolds 1998). The rapid rise of NPS took many drug researchers by surprise given the relative stability of (Western) illegal drug markets comprising of the big four: Cannabis, Cocaine, Amphetamine-type substances (ATS) including MDMA/Ecstasy, and Heroin. Yet on reflection the emergence of NPS made sense as drug prohibition endured (Stevens and Measham 2014). Through the 2000s prohibition proponents continued to attempt to disrupt supply of MDMA/Ecstasy with varying degrees of success. By 2010, MDMA users were becoming increasingly frustrated by poor quality (low strength and purity) MDMA/Ecstasy, with some turning to Mephedrone (Measham et al. 2010, 2011). At this point, MDMA/Ecstasy pills were positioned as 'inferior' 'Chav' drugs, invoking a derogatory British term denoting 'underclass' (Tyler 2013). In contrast, MDMA crystal was positioned as a premium product despite little corroborating evidence from drug analyses at the time (Smith et al. 2009). From around 2012, MDMA/Ecstasy purity started to improve and demand was once again fulfilled, even in countries in which the drug is considered difficult to procure such as Australia (Sindicich and Burns 2012).

Considering the positioning of GHB/GBL or 'G' and applying it to MDMA/Ecstasy, a psychoactive substance may be variably positioned according to the regulatory regime it is under (Seddon 2016, 2020), as well as perceived dominant user groups, and the uses it is put to (Moore and Measham 2012). In part, G's meanings rest on the heightened visibility of gay people, notably gay men visiting saunas, nightclubs, afterparties and 'chemsex' parties (Hakim 2019). These historically stigmatised minority groups frequenting (liminal) leisure-pleasure spaces/times are already widely problematised. This has relevance to a consideration of MDMA/Ecstasy given its aforementioned association with similar marginalised and stigmatised groups (Silcott 1999; Reynolds 1998). It is worth reflecting on the history of MDMA to further highlight its multiple, complex and changing meanings. MDMA was originally

synthesized in 1912 but first came to the attention of the authorities due to its use as a therapeutic adjunct in the 1960s and early 1970s (Freudenmann et al. 2006). When MDMA was brought under the 1961 and 1971 UN Conventions, there was little evidence of its widespread use in the recreational settings we firmly associate the substance with today. However, MDMA use became popular in US gay discos and nascent house clubs of the 1980s, often frequented by black gay men and women pioneering novel musical sounds and genres (Thomas 1995).

These associations between MDMA/Ecstasy and other ATS with already stigmatised communities, not least black gay disco, house and techno music scenes in the USA and Europe, have led to the substance's categorisation as a marker of deviant subcultures, disrupting dominant cultures with a kind of dangerous 'alternativity' (Holland and Spracklen 2018). Nightclubs remain key spaces of illicit drug use and have long associated with various 'queer' subcultures of social dancing (Buckland 2002; Hae 2012). Globally, nightclub and nightlife districts are subject to processes of criminalisation, stigmatisation, but also sanitisation, involving the 'clean-up' of 'undesirable' people and practices. From the remaking of New York's Times Square (Hae 2012) to Roppongi nightclub district in Tokyo (Cybriwsky 2011), gentrification and resistance to processes of stigmatisation from owners, staff and customers plays out. Yet despite its relative 'mainstreaming', dancing on drugs remains taboo. MDMA/Ecstasy users rarely speak openly about their experiences, not even (or especially) academic researchers deemed to be 'respectable' (Ross et al. 2020). As one of the 'big four' in the global illegal drug market, this is perhaps not surprising. However, a question mark remains as to how MDMA/Ecstasy continues to be such a stigmatised substance, despite its relatively low harm threshold, notably as compared to the socially acceptable drug, alcohol (Nutt et al. 2010; Moore et al. 2019). A partial answer to the conundrum of MDMA's enduring stigmatisation rests on the drug's long-standing positioning as counter-cultural product associated with non-dominant cultures.

Negotiating the Specificities of Stigmatised Drug Use

People who use drugs (PWUDs) must negotiate stigma, yet this negotiation is not a uniform experience. Instead, it is differentiated by drug(s) of choice, polydrug repertoires, user identities, and the spaces/times in which substances are consumed (Chatterton and Hollands 2003). This highlights the importance for drug researchers and PWUDs of understanding the specificities of stigma and processes of stigmatisation around drug use/users, as it relates to power relations in our profoundly unequal society. Exploring how drug users and dealers frame their own and others drug use has proved fruitful for social researchers (Askew and Salinas 2019), notably in terms of how stigma and the norms of shame, and deviance and 'norms of blame' are negotiated, managed and even promulgated (Scambler 2018: 771). Drug users (and others) draw on and create hierarchies of drugs that typically reflect class relations (the ageing post-industrial worker, the undeserving poor), and cultural norms of deviance and stigma about drugs more generally, and 'other' PWUDs specifically. People who inject heroin are named 'addicts' and 'junkies' and wrongly positioned as 'out of control' and 'feckless' by state, media, health professionals, and other PWUDs alike (eg. Muncan et al. 2020). Here, dependent drug users are *abjects* who are to be both shamed and blamed for their (assumed to be) individual failing (Tyler 2013). We might contrast the terrible and indeed life-threatening stigma enacted against and felt by PWUDs deemed to use them 'problematically' with that felt by those who take drugs in recreational settings (EMCDDA 2018). MDMA/Ecstasy use is typically occasional, rarely develops into dependency, and is not associated with the profoundly stigmatised practice of injecting as a route of administration (Moore et al. 2019). Instead, a particularly subtle process of stigmatisation is at work, whereby the substance is represented as a 'lifestyle' drug of choice of middle-class (perhaps even rich) students and young professionals who can afford relatively high cost of MDMA/Ecstasy prices and leisure event tickets.

However, this partial picture dismisses mediated, enacted and felt stigma towards 'recreational drug users', and risks assuming that those consuming MDMA/Ecstasy are a homogenous (ie. white, middle-class)

group, with the same 'strong' sociocultural and economic resources to resist stigma, deviant labels, and norms of shame and blame (Scambler 2018). This is simply not the case. Instead, to better understand the processes of stigmatisation at work, we might examine several specific aspects of MDMA/Ecstasy representations and experiences. These include tracing the emergence of MDMA/Ecstasy use, including its shifting meanings and association with marginalised populations and liminal leisure spaces/times; highlighting how the relatively young age profile of regular MDMA users is deployed in processes of stigmatisation through discourses of risk, vulnerability, protection and safety; relatedly considering how the securitised and liminal spaces/times of MDMA/Ecstasy use are experienced by those subject to heightened scrutiny (such as young black and Asian men) due to their intersectional identities (Release 2013); and finally, considering how MDMA/Ecstasy-related deaths are represented in the media twenty years after Alasdair Forsyth's (2001) seminal work on the issue. The backdrop to any such examination is a questioning of prohibitionist law enforcement approaches to drug use, support for a legal regulated market in MDMA and other ATS products (Transform 2020), and the establishment of MDMA-friendly spaces to counteract current harms, notably of concurrent MDMA and alcohol use (Moore et al. 2019). We start then with the relationships between the legal status of a substance, assumptions about related risks, and stigma associated with its use.

Illegality, Stigma and Identity

Legal, medical and public health discourses and practices shape social and moral norms and influence drug-takers' understandings of acute and chronic risks and harms, risk-management techniques and self-regulatory practices, as they are located in space and time. Pennay (2015) in her ethnographic study of young 'mainstream' alcohol and drug users in Australia, explored attempts to manage tensions between public health messages and the pursuit of pleasurable intoxication in *pre/in and post-club settings* (see also Moore and Miles 2004). Her participants practised techniques of containment and restriction in visible

public and semi-public settings (the street, the nightclub), reserving their most 'carnivalesque' of pleasures for private 'post-club' domestic spaces. Here we see the situated management of permissible 'respectable' pleasures and impermissible pleasures framed as carnal, volatile, risky and potentially disordered (Pennay 2015; Pennay and Moore 2010; Moore and Measham 2012; O'Malley and Valverde 2004). Some drug users are able to marshal their greater social and economic capital to mitigate against the worse exigences of drug-related stigma and norms of shame, for example, older middle-class professionals taking cocaine powder in another private domestic setting, that of the dinner party. The UK government (and others) have sought to 'scapegoat' 'middle-class drug users' by appealing to their supposedly heightened ethical sensibilities (Wincup and Stevens 2021). Middle-class drug users are presented as contributing to an 'explosion' of county-lines dealing, where vulnerable young people are enlisted in drug distribution networks by organised crime groups (OCGs) (Spicer 2021a). This assertion has been criticised by those who point out that blaming any drug user for drug market violence ignores how global prohibition fuels such violence (Spicer 2021a; Transform 2020) and leaves vulnerable young people to fend for themselves in a failed system of drug 'control' (Spicer 2021b). This leads us on to a consideration of stigma, global drug prohibition, and the Class A status of MDMA/Ecstasy, which prohibits its possession and criminalises users.

MDMA is classified as a Class A substance under the UK Misuse of Drugs Act 1971, as a Schedule 1 substance under the UK Misuse of Drugs Regulations 2001, and as a Schedule 1 substance in the US under the Controlled Substances Act. MDMA/Ecstasy use remains so demonised that even discussion of its re-classification under the now 50-year old UK Misuse of Drugs Act 1971 from Class A to Class B (ACMD 2008), let alone decriminalisation or legal regulation (Moore et al. 2019; Donelly 2015), is considered highly controversial and 'radical' (Moore et al. 2019). Successive UK governments have been enthusiastic supporters of prohibition, with both Labour and Conservative governments taking a 'proactive prohibition' approach to the emergence of 'new' drugs such as ketamine and GHB/GBL over the last two decades (Measham and Moore 2008; Moore and Measham 2012). As Stevens

and Measham (2014) note in relation to SCRAs, the 'drug policy rachet' means that drug laws tend towards 'net-widening' in attempts to control both existing and emergent drugs and drug markets. MDMA/Ecstasy was classified as a Class A substance in the Misuse of Drugs Act 1971 *before* its use in leisure spaces/times was widespread. Indeed, as previously mentioned, the first consumers of MDMA are widely thought to be what we might call 'therapeutic users' (Passie 2018).

A change in the perceived purpose of MDMA (from therapeutic to recreational) and its user groups—from those in therapy to those attending gay discos and all-night raves—greatly contributed to the stigmatisation of MDMA/Ecstasy seen today (Moore et al. 2019). Crucially, processes of stigmatisation associate already 'deviant' intersectional identities of user groups (young, gay, Black, urban dwelling) to the spaces/times of dancing, drug use and debauchery. The illegality of a psychoactive substance produces seemingly illogical concerns about use—particularly among young people in leisure-pleasure settings—in comparison to legal drugs such as alcohol. The illegality of MDMA/Ecstasy ensures it continues to be associated with risks and potential harms, and groups who consume it are assumed to be both/either 'risky' and/or 'at risk'. In festival spaces/times, for example, the 'dangers' of MDMA/Ecstasy are foregrounded, whilst the easy availability, heavy marketing and associated harms of alcohol use in festival spaces are largely ignored, or framed as only problematic when combined with illegal drugs in the form of polysubstance use (alcohol plus at least one other drug). In stark contrast, there is considerable localised law enforcement activity around MDMA/Ecstasy. Alongside National Crime Agency and Border Force work against importation and production, this activity is focused on the highly visible policing of the UK's Night-time Economy (NTE) and broader youth leisure spaces/times, such as commercial music festivals, illegal raves, and parties. The proactive policing of drug prohibition within and around such spaces has become 'normalised'. It is for example hard to imagine festival drug detection dogs and strip searches at other kinds of cultural events (such as a day at the races, or on the football terraces), despite the likelihood that drug use also takes place there (EMCDDA 2018). It is to

this more localised drug law enforcement activity we now turn, understood through the lenses of securitisation, deliberate stigma strategies, and enacted and felt experiences of stigma.

'It's Not Worth the Risk': Stigmatising MDMA/Ecstasy Use and Shaming Users in Securitised Leisure Spaces/Times

In the context of drugs and drug policy, securitisation can be thought of as the security narrative which enables the prohibitionist regime to continue. With drugs posing an 'existential threat' under this regime, this security narrative presents itself as the sole solution to that 'threat' (Crick 2012). We know that youth leisure is often understood to involve the leisure-pleasure spaces of the risky and at risk (such as young working-class people). These spaces are subject to heightened securitisation in the context of broader neoliberal ideologies and polices (Tyler 2013). This means that attendees must successfully negotiate 'the door'—the physical and metaphorical boundary of such spaces—and specifically the stigma of being explicitly labelled as a drug user, or 'worse', a dealer (as below) at 'the door'. Hall (2015) in her work on the aesthetics of transparency in the movement of Foucauldian docile consumers through airport security, notes that those without the privilege to 'perform innocence', as a result of their race or immigration status for example, are considered to be opaque, a threat, and most likely to be subjected to searches and potential detention. Similarly, dance drug users with intersectional identities fall 'victim' to the problematising dynamic of perceived drug-related deviance and stigma, especially at 'the door' as a securitised border. In the UK, some amongst those who frequent leisure-pleasure spaces are treated differently depending on 'who they are'. The specificities of enacted and felt stigma and deviance coalesce around the drug in question, those who are understood to use it, and the purposes and settings of its use, then and now (black gay men in discotheques, or 'naïve' teenagers at commercial festivals). So, processes of stigmatisation around MDMA/Ecstasy users and 'their' spaces incorporate securitisation and

demands to 'perform innocence', that is to 'look innocent' and therefore attempt to disrupt security agents' stigma-informed assumptions.

Link and Phelan's (2001, 2014) conceptualisation of stigma, drawing as it does on Goffman's (1963) seminal work, when combined with Tyler's (2018, 2020) more 'politicised' version of stigma, helps us engage with what I call 'deliberate stigma strategies', such as those used by government drug prevention campaigns. In the Summer of 2019, festival-goers were, for example, invited by Cheshire Constabulary—the police force tasked with securitising a large UK commercial dance music festival—to contemplate being caught with drugs in this leisure space. A double-sided flyer aimed at the festival's largely youthful clientele and distributed both prior to and during the festival, lists on one side the risks of attempting to cross 'the door' with drugs in a classed manner: 'You risk losing your university place, career & freedom'. Under the straplines 'Advice from Cheshire Police' and 'It's not worth the risk', youthful festival-goers are told 'Do not give in to peer pressure – you will be held personally responsible'. Here individuals within friendship groups of peers are responsibilised through the manifestation of the potentiality of shame. The festival-goer is cast as at once naïve but also knowingly 'deviant'. The constrained complexity of young people's 'journeys' in and out of drug-taking (Williams 2013) are obscured, whilst prohibition and drug law enforcement remain unchallenged. Deliberate stigma strategies emerge then as an important aspect of processes of stigmatisation at work around MDMA/Ecstasy use. Further, the 'flip-side' of the festival flyer is emblematic of the tensions between a law-and-order response to 'dance drug' use and more harm reduction orientated approaches, here as in other cases promulgated by the festival organisers (Measham 2019). Under the heading 'Mudfields Cares',[1] alcohol and drug harm reduction advice is offered under six headings 'Too hot?' 'Heat Stroke?' 'Dehydrated?' 'Bad Trip' 'Overdose' and 'Remember…'. The caring flip-side flyer invites festival-goers to shrug off potential stigma (of immoderate intoxication) and negative policing and security experiences (in self-identifying as a drug user) in order to seek help.

[1] The name of the festival has been changed.

In debates around stigma, one suggestion is that shame should be foregrounded in any discussion, as Nichols, Gringle and Welborn's contribution to this edited collection notes in relation to the shaming of women who use drugs while pregnant, and the 'good mothering ideal' some mothers deploy to resist this specific form of stigma. Indeed Scheff (2014a) argues that stigma *is* shame, noting stigma can be defined as shame, and that also this usage might allow shame researchers to know of each other's work' (p. 725). Whilst Link (2014) disagrees that stigma is 'only' shame and should be researched as such, he does acknowledge that Goffman (1963) mentioned shame on multiple occasions, and hence that shame might fruitfully be drawn into the complex multifaceted interdisciplinary concept that is stigma. This alerts us to the relationship between mediated and enacted stigma around 'risk-taking', the felt shame of (the possibility of) 'getting caught with drugs', and the drug prohibition-securitisation of liminal leisure-pleasure spaces/times. The ongoing prohibitionist war on MDMA/Ecstasy users and the criminalisation of the counter-cultural and commercial forms of rave/dance music cultures is implicated in the dynamics of intersectional identities and the re-production of inequalities, stigmatisation and marginalisation. Stigmatising encounters and their relationship to broader power relations are central to this re-production (Link and Phelan 2014). These stigmatising encounters might include those between the human and non-human, such as between a metal detector arch or a drug detection dog (and handlers). In their study of the deployment of drug dogs at Australian festivals, Grigg et al. (2018) found dogs to have little to no deterrent effect on surveyed festival-goers' decisions to smuggle in and use drugs (4% chose not to). Instead, festival-goers adopted a range of strategies to avoid detection, including 10% who concealed drugs internally. Grigg et al. (2018) conclude that 'in the face of mounting evidence of both ineffectiveness and iatrogenic effects, the use of drug detection dogs at Australian music festivals should be urgently reconsidered' (Grigg et al. 2018: 89). Age is relevant here, as is its intersection with gender. Youthful and intoxicated bodies experience disproportionate security at (legal, licensed) music events including dance music festivals, resulting in over-policing and under-protection through stigmatising encounters. Young racially minoritised men are framed as 'naturally' problematic, whilst

young (white) women are assumed to be vulnerable. These encounters might be defined as the coalescence of enacted and felt stigma and deviance, where shame, blame, but also resistance emerge as key themes. I present two ethnographic vignettes from (pre-pandemic) observations at two large dance music events which took place weeks apart in the Summer of 2019 to explore these themes.

Vignette 1: 'He Even Felt Between My Toes!': Negotiating Leisure Boundaries as a Young Asian Man

We are standing in a long queue outside the warehouse style venue, waiting to get into a trance music night run by a well-known and well-respected promoter (at least amongst trance fans in the North of England!). Security is 'tight'. Usually, this promoter's events run in a medium-sized local nightclub where the bouncers are pretty relaxed about the obvious 'dance drug' use (mainly MDMA and powder cocaine, as well as ubiquitous alcohol) amongst its customers. This warehouse event is different. We are funnelled past two private security 'drug dog' handlers between the familiar metal security 'festival fences'. As always, I go before my partner. From our experiences during the past three years of clubbing together, we know that a smiling middle-aged white woman is deemed less 'problematic' to security than a serious-looking British Asian man in his 20s with a shaved head. We have also (rather hilariously) worked out that if Z stands on his own for any more than 5 minutes, fellow revellers are likely to ask 'You selling pills mate?' on the assumption that he must be the resident drug dealer, presumably because he is Asian and looks by his own admission 'a bit dodgy sometimes, especially with my hood up'. So tonight, I go first, and the drug dog I walk past is suddenly *very* interested in me. It wags its tail and makes towards my feet, apparently ready to 'indicate'. As I tentatively stop about 4 metres apart from Z, the dog's (male) handler has other ideas. The poor mutt is yanked backwards, and told to sit next to Z, who looks bemused. I am relieved, and walk slowly forward before turning round to see Z being taken aside by another (female) bouncer, who says 'Tell me what

drugs you have on you?' After some thought, Z (rather cheekily) says 'Er, tobacco?'. This does not go down too well. A male bouncer steps over to start the search of Z's person. I watch this unfold, as do around 20 other people waiting in the queue or in the space between the security and the warehouse's main entrance. Z is seemingly relaxed, mainly (I presume) because he does not have any illegal drugs on his person. The female bouncer is getting annoyed, perhaps riled by Z's sanguine expression. 'Just tell us what you got on you!' she shouts in his face. The male bouncers asks (very politely) if Z can remove his shoes and socks. Z obliges, still smiling. The male bouncer bends down and places a digit between Z's big toe. Myself and others look on. The male bouncer straightens up, and says 'You're good mate', and steps aside. We had a great night, and Z spent most of the afterparty telling anyone who would listen how he nearly didn't get into the main event, and how the bouncer 'even felt between my toes!'.

Vignette 2: 'Get the Fucking Medics': Dealing with Drug-Related Risks in the Face of Festival Securitisation

We are both still tired and emotional from yesterday at the festival. We checked the local newspapers today. No news of any drug-related deaths. What a strange and awful thing to need to do. But it's all good. If anything had happened to that lass it would be reported, so we presume she is okay. 'God knows what she said to her folks' Z says. We'd come across a young girl, mid-twenties, white, on the floor, or rather grass, outside one of the dance tents. A slightly older, mixed race lad was kneeling beside her, in obvious bits. 'She took the whole fucking bag of MD into the portaloo' he says to Z, 'She came out and just collapsed'. Z is a first aider. He's straight down by their side, offering reassurance to the lad and checking her breathing. 'She's okay' he says, but flicks a glance at me. Her hands are tightly clenched and her body rigid. Serotonin syndrome maybe? I'm feeling sick. A security guard appears, large middle-aged white guy, angry face 'WTF, who gave her what?' He directs this at the lad (a family member we are later told), before he gestures to

start a body search on him. That's it. I'm on my feet and calmly (at first) I say, 'Get the medics please Sir. Get the medics Sir. Get the fucking medics NOW'. He does.

These two vignettes highlight key points about securitisation of leisure spaces in which MDMA/Ecstasy use takes place. Firstly, from both we can see the importance of intersectional identities in the negotiation of, and resistance to, processes of stigmatisation of drug use. Z, a young, public-school educated Asian man, 'successfully' negotiated processes of stigmatisation emergent in the assumptions of private security in a liminal leisure space/time. Microaggressions meant to shame the recipient failed to do so, whilst the afterparty 'dining-out story' might be thought of as an act of resistance to shame through humour. Secondly, the capacities and (harm reduction) potentialities of medical help-seeking at highly-securitised spaces of contemporary leisure-pleasure landscapes relate intimately to intersectional identities. In the second vignette, stigma around MDMA/Ecstasy use was negotiated through aspects of the author's intersectional identity, as a white, middle-aged female drug researcher, by challenging risk-producing securitisation practices through appeals to 'superior' situational knowledge. Both examples specify how processes of stigmatisation of drugs and their users, here of MDMA/Ecstasy, relate uniquely to the leisure spaces/times in which they emerge. In the remaining sections of this chapter, I argue that despite the commercialisation of dance music cultures and marketisation of 'the Ecstasy experience', the stigmatisation of MDMA/Ecstasy through the tropes of risk and vulnerability continues. The question of *why* this may be so is also tackled.

Stigma, Subcultures and Commercial Dance Music Cultures

Leisure spaces may be *physical* spaces, from the local 'hangout' for a handful of teenagers to commercial festivals attended by thousands. As Thornton (1995) observed in her seminal work on subcultural capital in dance music and club cultures, the music played and those frequenting spaces/times synonymous with 'dance drugs' take on the

monikers afforded to these spaces, so Paradise Garage in NYC spawned US Garage, whilst thousands of young people in the UK became 'ravers' as the Second Summer of Love unfolded. For some, especially young women in early 1990s Britain, house music spaces became more of a 'home' than their own domestic spaces (Pini 2001). The history of MDMA/Ecstasy use amounts to the criminalisation of a counter-cultural form, starting with the roots of house music from gay black club cultures and acid house/rave and later dance music cultures. MDMA/Ecstasy users have to negotiate these fluid intersections of criminalisation and commercialisation of the spaces/times in which the drug is consumed, at illegal raves, licensed nightclubs, the superclubs of the late 1990s and early 2000s, commercial warehouse raves, and 'pandemic parties' of Covid times. Deviant and liminal leisure spaces/times and practices are produced through human and non-human action and interactions, regulatory and material environments, and the discourses which produce them as 'problematic', but also *desirable*. We might say the commercialisation of dance music cultures means MDMA/Ecstasy users occupy a *less* deviant and liminal space(s) than positioning them as counter-cultural deviants allows for. We have seen the marketisation of 'the Ecstasy experience' at festivals**,** alongside work on differentiated normalisation (Shildrick 2002) and on diverse drug experiences in the context of a multiplicity of leisure-pleasure spaces/times (Measham et al. 2001; Turner and Measham 2019).

This may at first glance undermine arguments about the drug's stigmatised status and its users' deviant positioning. Yet, MDMA/Ecstasy users now simply have to work harder to negotiate *both* negative and (questionably) positive assumptions about clubber or festival-goer 'lifestyles' and attendant drug use. MDMA/Ecstasy pills, powder and crystal are (variably) desirable consumer products, with their use framed as an enviable pursuit that remains the preserve of those who can afford the expense of a 'big night out' or a festival abroad. Yet such drug-fuelled hedonism is situated as at best meaningless, with users positioned as largely naïve to their status as promulgators and victims of neoliberal consumer capitalism—the assertion that market exchange does and should guide all human action—which has commodified and commercialised 'the Ecstasy experience'. The ultimate price to pay for this

experience is drug-related death. Yet these tragic consumers are chiefly 'victims' of the ongoing pursuit of the *War on Drugs*, not of the individualised nor *necessarily* harmful pursuit of hedonic pleasures. Press coverage frames young drug users—especially young women—as vulnerable to 'naïve' drug use and to the 'evil' dealers to whom they fall prey. In turn, MDMA/Ecstasy is framed as an *inherently* dangerous 'drug'. MDMA/Ecstasy use emerges as a set of stigmatised practices, with the focus being on preventing young people taking the drug altogether and/or on more 'responsible use'. These narratives individualise the MDMA user/'victim' and stigmatise 'irresponsible' MDMA users, whilst obscuring the structural aspects of MDMA-related deaths, such as how the emergence of 'super strength' pills rests on their status as illegal and hence unregulated products (Moore et al. 2019). Instead, the stigmatisation of MDMA/Ecstasy through the individualising tropes of risk and vulnerability continues, from Forsyth's (2001) study of the 1:1 press coverage ratio (toxicology report: press article) of MDMA-related death in newspapers, to the present day.

Prosocial Pleasures and Processes of Stigmatisation

The sensationalised reporting of MDMA-related fatalities amongst young people 'at play' and the enforcement practices of the police and private security—targeting the 'usual suspects'—works to reproduce stigma. The risks and (largely preventable potential) harms of MDMA/Ecstasy use are exacerbated by prohibition and related law enforcement practices, as captured by festival-goers who consume all their drugs at once as soon as Police sniffer dogs come into view (Grigg et al. 2018). Shame, or rather the avoidance of stigmatising processes which (aim to) produce shame amongst drug users through both soft and hard/formal strategies of social control—such as police/council leaflets, private security, heavy police presences, drug detection dogs and strip searches—is key to the 'successful' negotiation of stigma by MDMA/Ecstasy users. However, prohibition and resultant unregulated illegal markets are rarely if ever foregrounded as the problem, even in

methodological critiques of drug-checking services (Palamar et al. 2021). The need to test substances lies in their procurement from unregulated illegal markets. Securitisation practices and the global drug prohibition system from which they emerge are almost always left unquestioned, to the extent that Taylor et al. (2016) warn we should carefully evaluate interventions to ensure we are not simply promulgating prohibition. This is no easy task. Rather than question drug prohibition and the stigmatising processes it involves, the 'drug problem' is assumed to somehow rest *within* the illegal substance *itself*, that is as an *inherently* dangerous product therefore worthy of continued criminalisation. This is most apparent in the 'one pill can kill' message associated with 'Just say no' drug prevention interventions. It follows then that 'naive' and vulnerable' users must be 'kept safe' from themselves, the drug, and the 'evil dealer'. Indeed, the latter is to be decisively repelled, whilst oddly encouraged, as party-goers perceive it to be safer to purchase once past the securitised leisure space threshold, than run the gauntlet of dogs and bouncers at 'the door' with drugs on their person (Grigg et al. 2018).

However perhaps focusing solely on how *risks and harms* are produced and put in the service of stigmatisation *reproduces* dominant views of MDMA/Ecstasy as a dangerous drug used by at risk and risky people. In 30 years of 'partial insider' involvement in dance music scenes in the UK, the dominant narrative of 'committed clubbers' around their consumption of MDMA/Ecstasy in leisure spaces/times remains almost unswervingly positive. Nearly half a million young people in the UK tried it in the past year (Stripe 2020). Whilst MDMA/Ecstasy's illegality and related securitisation practices are central to understanding its stigmatisation, we also need to consider the *pleasures* of intoxication in leisure spaces/times and the social control function of drug law policing to really get at processes of stigmatisation which produce emotions of fear and shame amongst users. In sum, as those in power continue to position MDMA/Ecstasy users as anti-social—especially when located in liminal leisure spaces such as illegal raves—those involved typically emphasise the positive and *pro-social* aspects of the drugs and attendant practices (mainly dancing, chatting and hugging). As one young woman describing her experience at a 'quarantine rave' which was raided by the

police recently said: '*It was beautiful until the dog attacked me*' (Busby 2020).

Perhaps ironically, an explicit focus on the pleasures of MDMA/Ecstasy use helps us not only better understand the drug's appeal to its users, but also respond to the question of *why* the State might be quite so exercised by a relatively safe psychoactive substance (Moore et al. 2019). Why so much scientific literature on MDMA/Ecstasy risks and harms, much of which has been challenged, yet so little on the benefits of its use (even in therapeutic settings)? Why such comprehensive coverage of MDMA-related deaths, when most MDMA/Ecstasy users come to little or no acute harm? Why enduring and often intense police attention when MDMA/Ecstasy does not correlate with interpersonal violence as alcohol does? Once MDMA/Ecstasy use and attendant pleasures are situated within capitalist consumer cultures, it becomes apparent that (albeit idealised) MDMA/Ecstasy experiences may go *against* the grain of consumer culture individualism, and the related cultural denigration of 'the other' which works so well to obscure inequalities and apportion blame to the 'failed consumers' of neoliberal ideologies and policies (Tyler 2013: 211). The nature of MDMA/Ecstasy use experiences may be characterised as empathetic and prosocial (Hysek et al. 2014), tending towards the collective rather than the individualistic, notably within youth and music subcultures (Moore and Miles 2004). MDMA/Ecstasy use typically occurs in social public and private settings where friends (and strangers) mingle, and where a kind of easy sociability is encouraged, even expected (Pennay 2015). Regular MDMA/Ecstasy users speak of life-long friendships formed in such settings (see http://peopleanddancefloors.com/ for examples). The thread running through countless accounts of rave/dance culture involvement and MDMA/Ecstasy experiences is that of 'togetherness'. This togetherness challenges neoliberal ideologies and policies, leading to illiberal 'counter-reactions' from State agencies, private often rich entities, and 'concerned' moral entrepreneurs (Tyler 2013; Tyler and Slater 2018).

Conclusion

In this chapter, I have explored how stigma is (re)produced and experienced among diverse MDMA/Ecstasy users in recreational settings. Processes of stigmatisation 'work' through the demonisation of MDMA as an inherently dangerous substance; the intersectional identities of (some of) those who consume it; and the framing of young MDMA/Ecstasy users as 'at risk' (from 'evil dealers'), but also 'risky' (as 'dealers/users'). The spaces/times of MDMA/Ecstasy use are simultaneously criminalised and commercialised. These highly visible and securitised leisure spaces/times are stigmatised through drug prevention campaigns and police and private security practices aimed at 'controlling' the flow of illegal substances into a specific setting. Combining work on intersectional identities with how historic and contemporary processes of stigmatisation (re)produce existing power relations speaks to the complexities of how mediated, enacted and felt stigma around illicit drug use perpetuates the inequalities with which this edited collection is concerned. Relatedly, we looked to the drug's prosocial capacities enabled in the spaces/times of its consumption to better understand its persistent stigmatisation.

The intersections between the historical counter-cultural use of MDMA—whether as therapeutic adjunct, or recreational drug of choice in black gay discos in the late-1980s—alongside its contemporary association with youthful hedonism, perpetuates prohibition and attracts moralistic media crusades denouncing its use and its users. These processes include negative depictions of youthful drug users within political rhetoric, policy documents and news media. Further, they incorporate the self-stigma and shaming of those whose bodies, intersectional identities and consumption practices are deemed 'deviant' and 'dangerous', such as young black and Asian male party-goers. What is certain is that processes of stigmatisation 'work' to perpetuate prohibition, making MDMA/Ecstasy users vulnerable to localised overpolicing, shaming securitisation, and the vagaries of products procured from unregulated global drug markets. What is less certain is how (or even whether) MDMA/Ecstasy users can and will 'successfully'

negotiate, manage and resist stigma in much-changed post-pandemic leisure-pleasure landscapes.

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Guilt, Shame, and Getting Passed the Blame: Resisting Stigma Through the Good Mothering Ideal

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Introduction

Stigma associated with perinatal substance use centres around norms of motherhood, which prescribes maternal sacrifice and idealises heteronormative, white, middle-class mothers. Mothers who use drugs (MWUDs) are stigmatised for both their drug use and their mothering (Stone 2015). When drugs are used during pregnancy, the stigma is intensified (Syvertsen et al. 2021). Ingesting drugs while pregnant, even in the case of prescribed medications, can result in being labelled a 'bad mother;' custody loss; and even criminal prosecution (Terplan et al.

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2015). MWUDs often resist the 'bad mother' label by identifying how their parenting fits the good mothering ideal. Using the published literature on maternal experiences, we describe stigma resistance strategies expressed by mothers as they navigate treatment and recovery. Our analyses included identification of instances of maternal identity, stigma resistance, and expressions of the good mothering ideal within original quotes we identified across studies. We then applied research poetics to centre mothers in their own words. Our findings highlight tensions between internalising and resisting stigma through embracing, struggling against, and transforming the 'good mother' ideal. Power dynamics inherent within the construction of MWUDs' stories also surfaced as a potential influence on maternal identity and stigma resistance. In this chapter, we illuminate critical nuances in the relationship between social and self-stigma by centring the construction of maternal identity through MWUDs accounts and recognising the power dynamics inherent in the stories MWUDs are required to tell. We argue that understanding the role of hegemonic motherhood in bidirectional exchanges between social and self-stigma associated with perinatal substance use is critical for developing systems of compassionate care and increasing access to critical healthcare and social services.

The Process of Stigma

Stigma represents the process of devaluing people based on attributes, characteristics, and/or behaviours (Goffman 1963). This process is culturally bound, context-specific, and exists within social interactions and relationships (Sheehan et al. 2017). It is not limited to one devalued attribute, characteristic, or behaviour. Instead, stigmas may overlap and intersect. Intersectional stigma, as an extension of intersectionality (Bowleg 2012), centralises issues of social location and oppression. The devaluing of people through a stigmatising process leads to social and health inequities for both individuals and populations (Link and Hatzenbuehler 2016). These inequities are produced through direct

(person-to-person) discrimination, structural (laws, policies, and institutional practices) discrimination, and the internalisation of societal devaluing practices (Link and Phelan 2014).

While direct discrimination is defined as the intentional expression of prejudice or stereotypes, interactional discrimination is a form of social stigma that occurs without intent and is similar to the concept of racial micro-aggressions (Sheehan et al. 2017). Interactional discrimination describes the behavioural patterns of a person interacting with someone carrying a stigmatised status. These behavioural patterns can include 'hesitance, uncertainty, superiority, or even excessive kindness' (Link and Phelan 2014: 25). Interactional discrimination is likely more prevalent than direct discrimination and can create feelings of shame and self-loathing in the stigmatised (Hatzenbuehler 2017). These behavioural patterns can cause reactions from the stigmatised person that further affects the relationship and creates even more social distance between the stigmatised and stigmatiser(s) (Link and Phelan 2014). It is also likely that repeated interactions with the person, or people who occupy a similar role (such as a healthcare provider), can result in avoidance or defensive behaviour on the part of the stigmatised (Fraser et al. 2017). It is important to understand bidirectional relationships between forms of social stigma and self-stigma to improve access to a variety of healthcare and social services for MWUDs.

Stigma and fear of custody loss associated with perinatal substance use can keep women from accessing critical healthcare and social services and/or keep them from revealing their drug use to their care providers (Stone 2015). While the stigma experiences of MWUDs have been well-documented (Martin 2019), less is known about how these experiences are internalised and/or resisted. This chapter uses an intersectional lens (Bowleg 2012) to examine the unique stigmatising experiences of MWUD in their interactions with social service and healthcare providers and potential relationships to both their identity as a mother and their degree to which they internalise stigma.

Stigma and Perinatal Substance Use

Societal valuing surrounding stigma associated with perinatal substance use includes an intersection of gendered norms of motherhood as well as societal norms of substance use and beliefs about addiction. Both the definition of addiction and the stigma surrounding it are complex and controversial. While current attempts to re-label addiction (or substance use disorders) as a chronic and relapsing brain disease have been proposed as stigma-reducing (Volkow 2015), others argue that it merely trades one type of stigma for another as diseases are already stigmatised (Fraser et al. 2017). Fraser et al. (2017) argue for a definition that acknowledges how illegitimacy is bestowed upon people who use drugs based on the degree to which they prescribe to norms of sobriety, autonomy, and rationality. Dominant societal beliefs around mothering, or hegemonic motherhood, prescribe norms of maternal sacrifice and idealise heteronormative, white, upper and middle-class mothers as 'good mothers' (Arendall 2000; Hays 1996). In the Global North, what it means to be a mother encompasses the politics of maternal care as well as of race, ethnicity, and class (Valencia 2015). In this way, motherhood is an institution, embedded in expectations of autonomy, discipline, and the raising of model citizens (Rich 1995). When combined, belief systems surrounding motherhood and drug use condemn MWUDs as illegitimate and unfit mothers who live at the lowest rung of drug-using hierarchies (Ettorre 2015).

In the Global North, both public sentiment and the state hold child-centric positions that force mothers to prove their maternal worthiness when substance use is present (Terplan et al. 2015). Although best practices in perinatal substance use services require treating the mother and foetus as a dyad (Jones and Kaltenbach 2013), this is not usually enacted in either practice or policy. Services for mothers often depend upon the presence of the foetus or child. Court-ordered removal of a child is associated with increased marginalisation, loss of benefits and services, decreased social support, trauma, and overdose (Broadhurst and Mason 2017; Kenny and Barrington 2018; Thumath et al. 2021). It can also contribute to a continuing cycle of pregnancy and removal (Broadhurst and Mason 2013). Centring of children through the sacrificing of mothers can also be seen in the US where punitive

policies have increased. Currently, 25 states require mandated reporting of suspected prenatal substance use and 23 states consider the use and/or misuse of substances prenatally to be a form of child abuse (Guttmacher Institute 2020). In addition to the loss of custody, pregnant women can be forced into treatment and/or imprisoned for using substances (Amnesty International 2017; Paltrow and Flavin 2013). The criminalisation of substance use during pregnancy, although often supported by public sentiment, connects with larger issues of personhood, reproductive rights, and bodily autonomy (Lupton 2012; Paltow and Flavin 2013).

Laws, policies, and societal norms represent ways in which structural stigma (Hatzenbuehler 2017) oppresses women's rights and their access to services. Structural stigma can also influence social stigma through the enactment of these policies and practices within institutions through service delivery. Interactional discrimination, a form of social stigma, is well-documented in studies examining experiences of MWUDs as they access services (Stone 2015). However, stigmatising beliefs are tied to norms of hegemonic motherhood, a form of structural stigma, which have been found in reports from healthcare and social service providers—even among those who advocate for MWUDs (Nichols et al. 2020). While a growing literature on provider experiences with MWUDs details these stigmatising practices it also hints at tensions providers experience between empathy and condemnation (Benoit et al. 2014; Geraghty et al. 2019). The bidirectional nature of interactional discrimination may exacerbate feelings of condemnation if internalised stigma keeps MWUDs from accessing care and/or disclosing drug use.

Maternal practices within hegemonic motherhood are reinforced and disseminated through systems of social services and are embedded in expert knowledge, referred to as 'psy-knowledge' (Valencia 2015). These practices change over time and more recent explications of expert-approved practices include ways mothers engage with and develop lifelong relationships with their children (Martin 2019). Much of the current intensification of parenting practices can be traced to attachment theory. Kanieski (2010) argues a shift in focus on secure attachment as a protective factor for children, rather than a risk for a medical disorder, is responsible for increasing dominant ideals of motherhood

to include high levels of sensitivity and responsiveness. 'Psy-knowledge' advice has transformed attachment theory to fit neuroscientific models that support the importance of emotional bonding between mother and child by evoking a 'back-to-basics' approach to early childrearing (Thornton 2011). These changes have significantly increased both the amount and range of tasks for mothers (Lee et al. 2010). Thornton (2011) argues it is not just the expectation of maternal practices that has increased but also expectations of maternal attitudes to view these practices as liberating and empowering.

This emphasis on bonding and relationships has raised additional questions on the legitimacy of maternal practices and attitudes by MWUDs that further distances them from the 'good mothering' ideal (Lamb 2019). Forslund et al. (2021) describe both the increased importance of attachment theory in child custody and child protection cases as well as how it is often misapplied. Of particular concern is the use of isolated behaviours to assess the quality of attachment and confusing the quality of attachment with relationship quality. Sharon Lamb's (2019) personal account of her work as an expert witness in child protection cases highlights these concerns. Lamb describes examining and rating women's maternal fitness through observations of mother–child interactions. She acknowledges these observations become a performance of 'good enough mothering' and that the dyad is trying to 'act natural in an unnatural context.' Through critical reflection, she argues that not only is the evaluation of mothering highly subjective but that the identifiers of good and bad mothering are deeply enmeshed with issues of class and culture.

The discovery of drug use among pregnant and/or parenting mothers immediately calls their maternal practices (or anticipated practices) into question. There is a robust literature on the experiences of MWUDs that describe how the 'good mothering' ideology serves multiple purposes, including a motivation for behavioural change, a source of internalised stigma, and a way to resist stigma (Martin 2019). This chapter re-examines the literature on experiences of MWUDs by employing a method of research poetics (Nichols et al. 2015) that centres maternal identity. This methodology allows us to examine how maternal identity is formed, in part, through internalised stigma at the intersection of

hegemonic motherhood and drug use but also through resistance to that stigma.

Research Poetics as Method

Research poetics were used to examine issues of self-stigma as well as stigma resistance among MWUDs. Research poetics, part of a larger field of arts-based qualitative methodology, can be used as both an analytic tool and as a way to re/present data. The method includes a variety of applications, such as poetic transcription (condensing and re-writing verbatim transcripts), found poetry (condensing and re-writing literary texts and public documents), as well as poetry that captures researchers' experiences and perceptions (Nichols et al. 2015). For these analyses, we applied research poetics to quotes from published qualitative studies on MWUDs experiences. A search of the published literature on the lived experiences of MWUDs was conducted and yielded 60 articles. The full group of studies were reviewed for quotes explicit to maternal identity and mothering practices. Articles that focussed solely on interactions with healthcare and social service systems and/or providers were excluded. We examined the findings from identified studies (Banwell and Bammer 2006; Baker and Carson 1999; Benoit et al. 2014; Bjonness 2015; Chandler et al. 2013; Chandler et al. 2014; Couverette et al. 2016; Grundetjern 2018; Gubrium 2008; Gunn et al. 2018; Hardesty and Black 1999; Harvey et al. 2015; McClelland and Newell 2008; Radcliffe 2009; Radcliffe 2011; Reid et al. 2008; Rhodes et al. 2010; Richter and Bammer 2000; Smirnova and Gatewood Owens 2019; Sliva et al. 2012; valentine et al. 2019; Virokannas 2011) for quotes that addressed issues of parenting practices and maternal identity. Collected articles spanned 20 years and eight countries. Participants were recruited from a variety of venues, including reproductive healthcare facilities, inpatient and outpatient substance use treatment facilities, as well as through posting announcements at community centres. Studies varied on whether mothers were engaged in active drug use or were in recovery as well as whether mothers were also engaged in sex work and/or whether they regained or lost custody of their child(ren).

The first author created a series of research poems from the identified quotes. A specific poetic format was chosen that expands the 'I Poem' technique, designed to capture issues of identity (Gilligan et al. 2006), to also capture narrative themes. 'I Poems' were created by identifying and isolating all 'I' statements within the previously identified quotes. By starting each line of a poem with 'I,' the mother's identity is centred in the account of their experience. Poems were first created within the original article. All quotes that discussed issues of maternal practice and/or identity were used to create one poetic narrative per article. Within the article, poems were compared with each other to identify potential emergent themes. Stanzas from within—article poems were used to create thematic poems that spanned across articles. The final step consisted of editing out the redundancy of words and phrases that occur in natural speech and making minor edits for readability. Poems were titled by their thematic content and included: *Pregnancy and Drug Use*, *Shielding Children*, *Being Normal*, *Mothering While Using Drugs*, *Bad Mothering*, *Custody*, and *Identifying Against the System*.

Thematic poems were independently read by two of the authors. Each author wrote analytic memos from the readings by asking themselves a series of interpretive questions including: What stands out in terms of maternal identity? What is missing? What do the poems suggest about how mothers resist stigma? How do they internalise it? What can the poems say about stories mothers tell about their mothering? These memos were then shared and comparison memos, detailing where the authors' interpretations converged and diverged were conducted. Throughout the process, each author also included reflexive comments based on their reactions to the poems. This reflexive practice was embedded in their comparative memos as well.

Poetry as an analytic technique offers two advantages for this work. The first is that poetry provides a rich opportunity to both access and (re)present lived experiences and embodiment (Nichols et al. 2015) by 'touch[ing] us where we live' (Richardson 1997: 143). This (re)presentation of lived experience acknowledges the co-construction of that experience between participants and authors (Richardson 1997). Using poetry underscores the way this study represents co-constructions of maternal narratives between two of the authors and a variety of

maternal voices across countries, situations, and time. The second is that poetry, unlike prose, is based on invitation instead of exposition. This means that poetry is less overly instructional but instead readers of poetry are invited into the analytic space. Reader interpretation is both acknowledged and welcomed by poetic forms. In this way poetry narratively eases the stigma around maternal substance use, inviting the reader to not only touch but be touched by mothers' lives through poetry's welcoming stance.

Poems on Maternal Identity

An analytic reading of the research poems showed maternal identity was primarily expressed through everyday practices of care. The poems highlighted positive practices, such as creating a 'normal' life, providing for and nurturing children, and protecting children from harm as evidence to refute stigmatising beliefs that drug use negated maternal fitness. MWUD described their efforts and struggles with the 'good mother' identity and expressed how this identity co-existed with drug use. MWUDs resisted stigma by both embracing and transforming the good mother ideal.

Embracing the 'Good Mother' Ideal

MWUD's efforts to embody 'good mothering' began during pregnancy. Upon learning of a pregnancy, most women became acutely aware of the reality of their child. The experience of finding yourself the responsible half of a maternal–fetal dyad can, literally, be sobering. MWUD described learning as much as they could about substance use during pregnancy and complying with the advice of healthcare professionals as positive maternal practices. The *Pregnancy and Drug Use* poem includes multiple stanzas centering mothers' agency as they responded to the news, such as the stanza below:

> I wanted to start coming down, detoxing myself

I didn't want him to have a habit. They said
I couldn't do it, so
I done it myself.

Even when MWUDs were unable to completely stop using, mothers across studies described their efforts to care for their unborn child and give them the best chance they could. In this way, mothering can be seen as an identity that develops before the child is born. The question of whether one is a 'good mother' develops as part of maternal identity, as evidenced by the following stanza:

I used drugs when
I knew
I was pregnant. Sometimes
I relapsed
I couldn't stop taking drugs,
I felt very scared and guilty. How could
I be a good mother?

Efforts to identify as a 'good mother' in the face of drug use continued throughout the poems describing maternal practices. Everyday practices of caring, providing, and protecting children were described as positive aspects of their parenting. A primary aim of mothers across studies was to create a 'normal' world for their child(ren). Descriptions of normalcy often included ordinary domestic moments but were positioned in relation to their drug use, as seen in the stanza below.

I made dinner every day, so that
I could eat with my daughter, so that we could have a meal together
I've been able to put food on the table for my kids
I don't want to look like a user either.

The poem, *Being Normal*, also describes other care practices like getting children to school on time and paying the bills. For example, one mother positioned 'normal things' as providing 'food and gas, and electric.' The poem also captures aspirational (saving for a house; going to Disneyland) and reputational (making certain children are

'dressed right') aspects of being normal. The stanza below highlights the importance of achieving a normal life, even while actively using.

> I have a nice house, now
> I have a nice partner
> I'm working towards stabilising my life so
> I can have a normal life in the community.
> I know we're still on meth but we feel like normal people, our neighbours talk to us now.

It became clear that mothers were presenting examples of these daily practices as evidence of maternal fitness. The poems focussed on observable proof of good mothering, such as cleanliness and financial security. MWUDs made declarations of maternal fitness by not just stating they kept a clean house or nurtured their child(ren) but by emphasising the diligence and constancy with which they engaged in care practices and as noted below, by their ability to carry out maternal tasks while using drugs. Notably absent are references to emotions or their relationships with their children.

> I was functional
> I was still cooking my daughter meals on time
> I was getting my kids to school on time
> I was keeping my house clean
> I was there for the kids.
> I made sure my bills were paid, my rent was paid
> I knew that they were dressed right
> I always took care of them. No matter how high
> I got, my kids were always tended to, *always*.

Across studies, MWUDs also described the ways they protected their child(ren) from potential negative consequences of their drug use or other illicit behaviours. These practices are described in the poem *Shielding Children*. Mothers provided details on how they arranged their lives so that their child(ren) were not around them when they used drugs. They also described keeping evidence of their use out of children's sight, as described in the following stanza:

I don't involve them in any way. If they're watching television,
I'll do it. If they're in the shower
I'll go to my room.
I keep it in a private place.
I would do it when they were not around.

The tactics mothers used to shield their drug use from their children cannot be separated from issues of social support and resources. Mothers described their efforts to partition their drug life from their children's home life using the resources and strategies available to them. Examples ranged from using at home while children were occupied or sleeping to coordinating drug use with childcare arrangements.

Struggling with the 'Good Mother' Ideal

The concept of being a 'good mother' can only exist in contradiction to 'bad mothering.' While all mothers struggle with the internalisation of these idealised parameters, MWUDs 'failings' are always related to their drug use. Throughout the data, mothers made references to the ways they failed at obtaining the ideal. As with 'good mothering,' these examples of failures started in pregnancy.

I used,
I think three times while
I was pregnant, knowing it was wrong,
[I] thought maybe one or two won't hurt.
I was being very selfish

In the stanza above, we see guilt expressed for any use during pregnancy as opposed to pride in reducing use significantly. Other confessions of 'bad mothering' behaviour revolved around absence. If the ideal of the 'good mother' includes being there for your child(ren) and paying attention to them and their needs, then bad mothering is being either physically, emotionally, and/or mentally absent. In some cases, this meant being permissive and/or inconsistent with discipline. In the majority of examples, however, mothers described 'choosing' drugs over

time spent with their child(ren). Some examples involved leaving them in an irresponsible manner, while others described children being left with a responsible and caring adult.

> I was not there for them. Staying out all night, leaving kids with my mom.
> I would just skip on.
> I could leave my kids with my grandma, take off for three days or four days.
> I left my children at the babysitter
> I left for the weekend
> I just
> I left the house
> I forgot about my kids

Even when children were left with a responsible adult, leaving was not perceived as shielding or protecting them from witnessing their drug use, but rather as abandoning them. The major difference seemed to be in the absence of concern for their child(ren). Descriptions of 'bad mothering' often used language, such as putting 'addiction first' and 'being selfish,' that demonstrates an internalisation of stigmatising beliefs about drug use being a rational and moral choice. The underlying assumption is that 'good mothers' will sacrifice their desire to use drugs for the sake of their children.

Transforming the 'Good Mother' Ideal

Some of the MWUDs described their mothering practices in ways that transformed what it means to be a 'good mother' and refused to accept dominant narratives of either motherhood or drug use. In the poem *Mothering While Using Drugs* we can see mothers resisting the stigmatising belief that all maternal drug use is bad, immoral, and harmful to children. This poem describes the ways in which drug use has helped their maternal practices. Mothers described how substance use, by altering emotional states, can improve their interactions with their child(ren).

I smoke weed,
I will take better care of her
I will take more time,
I will be more gentle
I'm high.
I will start an activity,
[I] will be more into it.
I don't smoke weed,
I'm so nervous
I can't concentrate

Other examples in the poem described drug use as helpful in reducing tension and anxiety, as a form of relaxation after a long day of caring for children, and as a motivation and stimulant to engage in the mundane and repetitive aspects of motherhood and household chores. As described in the stanza below, these poems acknowledge that maternal practice can be isolating and soul-crushing.

I would just wake up and think 'oh, God, what a drag.'
I've got [to] and get up and change nappies all day
I know it sounds terrible, but it gave me something to spring out of bed for,
'I've got a shot this morning!'.
I'd spring out of bed
I'd have it and then get into the housework and do everything!

Drug Use, Motherhood, and 'The System'

Understanding how MWUDs both internalise and resist the good mothering ideal cannot be separated from their interactions with systems developed to judge their mothering ability and that threaten their right to mother their child(ren). The reactions of MWUDs to the systems of healthcare and social services are detailed in the poem *Identifying Against the System*. This poem describes the shock, disbelief, anger, and bitterness experienced by mothers when they realised the system was not working with them but rather against them. Stigma resistance appears in their refusal to accept this treatment.

I didn't feel I received the help
I was entitled to.
I was bitter on the system; first they promise family treatment, then they take it away
I wanted to be clean
I was sympathetic to receive help, then they lied to me

Similar to the poems that detailed MWUD's 'good mothering' practices, this poem describes actions taken by mothers' to keep or regain custody. However, the actions described here are presented by mothers as proof of complying with structural demands but still being mistreated.

I didn't understand why the child protection service took my children
I was four years clean,
I could give you all the clean specimen that you wanted,
I am under [getting an] education,
I have a decent home,
I have a decent boyfriend, what else can you demand from me?

The tone in this poem conveys anger and resolution to continue fighting for their child(ren) and their right to be a mother. However, both the threat and the experience of custody loss were also described in terms of distress and grief. The poem, *Custody,* illustrates these emotions as well as feelings of both resignation and resistance. Similar to the *Bad Mothering* poem, there are instances where MWUDs use language demonstrating the internalisation of stigmatising beliefs around drug use and mothering.

I was just so drunk
I had problems with alcohol
I knew I was being watched
I gave up
I gave up that responsibility to other people.
I wanted to die
I took every penny
I had and bought every hubba
I could find.

The descriptions of strong emotions in the poems that detail interactions with the system along with both the threat and experience of losing custody highlight the absence of emotional language and imagery in the other poems. MWUDs did not use their emotional attachment to their child(ren) as evidence of being a 'good mother.' There were very few descriptions of their intimate relationships with their child(ren) outside of the experience of losing that relationship. That the emotions and relationships exist is evident from these later poems and requires us to question why they are not highlighted in any other accounts of their maternal experiences.

Discussion

The poetic analysis highlighted MWUD's' descriptions of their practices and strategies while caring for their children and using drugs. These practices were constructed as ways they protected their children from their substance use, along with the ways they nurtured, cared, and provided for their children while using substances. Mothers described their strategies for creating a 'normal' home for their children through their maternal practices. Taken together, these findings detail expressions of the 'good mother' ideology that are a significant part of the women's maternal identity. At the same time, descriptions of 'bad mothering' were found across studies. MWUDs lived with the internalisation of the good/bad mother dichotomy on a daily basis. Martin (2019) suggests their embracing of these 'good mothering' ideals provides a way for them to fulfil gender norms that are often questioned by their substance use. Good mothering was described by MWUDs as providing a stable home life by cooking and caring for children as well as ensuring financial support and a sense of normalcy. Protecting children from any potential harm related to substance use was paramount. Since MWUDs are stigmatised as unfit and uncaring mothers (Terplan et al. 2015), embracing hegemonic ideals of motherhood can become a means to resist that stigma.

Intensive mothering demands children are not only centred but that mothers are willing to sacrifice all for them (Hays 1996). The increasing

focus on attachment and emotional bonding requires mothers' presence—both physically and emotionally—to be considered 'good enough mothers.' These hegemonic mothering norms make it common for mothers (regardless of whether or not they use drugs) to report feeling guilt when they put their own needs first. Guilt appears in the mothers' description of their daily parenting through examples of 'putting addiction first,' and not providing 'time to think about my child.' It also includes descriptions of inattention while they were with their children, which resulted in inconsistent discipline and communication. MWUDs internalisation of the stigma of 'bad' mothering from substance use was apparent when they discussed instances of their maternal absence. Ruddick (1989) posits maternal practice consists of preservative love, nurturance, and training. She describes preservative love as responding to the vulnerability of a child with care rather than 'abuse, indifference, or flight' (19). Our findings suggest that when drug use results in a mother's physical or emotional absence, mothers respond with a sense of guilt and the perception that they are 'fleeing' their maternal responsibilities even when others are there to respond to the child's needs. Likewise, MWUDs struggled with the good mother identity in pregnancy when efforts to achieve sobriety failed. Even in cases where drug use was significantly reduced and other health behaviours were adopted, some mothers internalised 'failures' as moving them away from the 'good mother' ideal.

In their study of parents who use substances, valentine et al. (2019) noted that while parents articulated specific experiences of guilt around substance use and parenting, they did not endorse feelings of shame. Similarly, our poetic analysis revealed only minimal 'I' statements that suggested mothers felt shame from their behaviours, although there were a number of statements around guilt and remorse. Research on provider perspectives reports providers describing mothers as being plagued with both guilt and shame and often conflate the two (Nichols et al. 2020). As valentine et al. (2019) point out, shame resides within identity (I am bad) while guilt resides within the act (I did a bad thing). The extent to which providers convey expectations of shame can be viewed as a form of interactional discrimination while MWUDs ability to focus on their parenting acts can be seen as a form of stigma (or shame) resistance.

Some MWUDs provided narratives that presented positive aspects of combining drug use with mothering. This demonstrates a form of stigma resistance through the transformation of the 'good mother' ideal to fit their own realities. Mothers' descriptions of drug use as a positive parenting experience disrupts the traditional recovery journey narrative (Anderson 2015) and begins to create a space between the dichotomous portrayal that all drug use is bad and out of control and that abstinence is the only alternative (Lee and O'Malley 2018). Similar to Sibley et al. (2020), assertion that people who use drugs need to determine their own understanding of addiction rather than consuming the definitions of experts, MWUDs need safe spaces to engage with meaning-making around motherhood and drug use.

Neither descriptions of mother–child relationships nor expressions of maternal love was paramount in MWUDs descriptions of their mothering. The exception to this was the strong emotions expressed at the loss (or threatened loss) of their children. It is likely that the focus and methods of the original studies did not lend itself to meaning-making around mother–child(ren) relationships. Martin (2019) notes that although the literature on MWUDs experiences is robust, the absence of an exploration of mothers' experiences and meaning-making of their relationship with their children is notable and problematic. This is especially true given the increased importance attachment, bonding and relationships play in determining custody.

MWUDs consume expert definitions of substance use and recovery models as well as effective parenting practices, or 'psy-knowledge' (Valencia 2015). More than just a model of 'how to' parent, these normative models become the criteria on which their parenting is judged by those who have (or are perceived to have) the authority to separate mothers from their children. These criteria, which are grounded in expert opinion, may not fit the lives of women who are marginalised (Broadhurst and Mason 2013). Threats to revoke or deny custody unless a woman meets certain standards of maternal practice are likely to create a need to constantly speak to the ways they can meet it. Therefore, it is not surprising that mothers' descriptions of their maternal practices are linked to the criteria used to evaluate their maternal fitness. While stigma resistance is one interpretation of why MWUDs embrace

the 'good mothering' narrative, another interpretation is pragmatism. MWUDs understand their maternal fitness is always under surveillance and, when questioned by providers, may choose to highlight the criteria by which they are evaluated.

MWUDs representations of their maternal experiences cannot be separated from issues of setting and audience embedded in the sharing of those experiences. The traditional recovery journey narrative frequently needs to be evoked and presented to professionals to gain both resources and acceptance. This process can include presenting oneself as a 'good addict' (Sibley et al. 2020). For MWUDs, the narrative of good mothering is tied to both the recovery journey and the 'good addict' identity. It is likely that participants in research studies, such as the ones from which this data is drawn, will evoke these narratives in response to questions about their parenting experiences. When the voices of MWUDs are centred around their sense of self, we see a tension between the internalisation of and resistance to both the good mother ideal and the stigma surrounding maternal drug use. However, we need to remain cognisant that these stories were told in a very particular instance: a research study where there were huge power differentials between MWUDs and researchers.

For the current analysis, it is important to keep in mind how poems were constructed. While all 'I statements' from the original quotes were used to create the full poems, the decision on which stanzas represent specific interpretations were made by the authors. This is also true of the original quotes used to create the poems. They were selected as re/presentations of maternal experiences by the original authors of the identified articles. The full interviews were not available for poetic transcription. In this way, our analysis, while a construction of the mothers' experiences and perceptions, is doubly layered with co-constructions of multiple researchers. Research poetics allows for greater fluidity of interpretation and brings the co-construction inherent in any qualitative analysis to the forefront. Since MWUDS are likely telling select versions of their full experiences to researchers and providers, any understanding of these experiences needs to keep in mind how power, distance, and reader perception (all of which can be influenced by stigma and bias) may be applied.

Conclusion

Social stigma and fear of punitive policies keep MWUDs from accessing treatment that's critical for the health and well-being of mother and child (Stone 2015). Likewise, internalised stigma reinforces feelings of maternal unfitness, which can interrupt maternal-child bonding (Lamb 2019). Internalised stigma, interactional discrimination by providers, and structural level policies are all fuelled by social norms around drug use and motherhood. The poems allow us to reconceptualise maternal quotes, which are often presented in research articles as the 'performance of good motherhood,' as representations of the struggle between MWUDs' resistance to and internalisation of stigma. Deepening our understanding of how the levels of stigma interact in perinatal substance use provision and the critical role of hegemonic motherhood norms throughout the levels represents an important first step in reducing stigmatising interactions and increasing both the accessibility and utilisation of services by MWUDs.

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Identity Construction and Stigma in Recovery

Carole Murphy

Introduction

Based on analysis of data from twenty-seven semi-structured interviews, this chapter critically explores identity construction and the process of negotiating a new or reconfigured identity in recovery from addiction. Labelling and stigmatising practices in broader society have been associated with the marginalisation of individuals living with addiction. Official definitions of 'addiction' and taken for granted assumptions about 'addicts' underpin much of these stigmatising discourses. The chapter begins with a discussion of the concept of stigma to provide insight into how stigma operates and is used by diverse actors to discriminate against and exclude people in recovery. Narratives and the re-storying of the self are important elements of this identity project. To overcome stigma, construction of a 'new' or reconfigured identity in

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recovery is fundamental and debates about individual versus the social nature of identity construction are outlined. These are used as a theoretical backdrop for understanding how narratives encountered in recovery communities, illustrated in this study, can help to overcome negative labelling and enable the construction of a new 'normal' identity.

Stigma and Identity Construction

The term stigma was originally defined and explained as 'bodily signs designed to expose something unusual and bad about the *moral status* of the signifier' (Goffman 1986: 1, original emphasis). According to Goffman, historically, signs to indicate stigma were purposely inflicted on people and included burns or scars from cutting as a way of marking someone out as a thief, a slave, or a traitor. Stigmatised persons were therefore easily identifiable and could be avoided in public. This understanding of stigma changed over time and later became the term used to refer to the 'disgrace itself than to the bodily evidence of it' (Goffman 1986: 1). In the more specific context of substance use, the 'user' is regarded as lacking in moral standing and consequently experiences reduced status in the public sphere (Goffman 1986: 1).

The relationship of stigma to identity construction is also perceptible in theories of self-identity which suggest that interactions with others play a role in the formation and reformation of identity by individuals, resulting in the internalisation of 'the attitudes which others hold towards them' (McIntosh and McKeganey 2001: 49). The messages received from others are not automatically incorporated into one's identity but are processed through the capacity in which the individual is able to interpret these attitudes and to 'accept, reject or modify them' (McIntosh and McKeganey 2001: 49). The extent of one's personal ability to filter attitudes is therefore crucial to identity construction and is complicated by stigma. For people who have experienced addiction, encountering stigma has been a part of their everyday lives they may internalise labels and compare themselves against what is considered normal, resulting in an incorporation of the stigmatised attitudes.

Recently, Tyler's (2020: 7) discussion of stigma has extended our understanding to take account of how personal stigma intersects with relations of power. She argues that stigma is 'propagated as a governmental technique of division and dehumanisation'. On a personal level, how this 'divisive politics gets under the skin of those it subjugates' demonstrates the power of 'state-cultivated stigma' to influence people's self-perception (Tyler 2020: 7). This reinforces the argument about the ability to 'accept, reject or modify' the attitudes of others (McIntosh and McKeganey 2001: 9). There are several key concerns in relation to how these issues are constituted and understood in the wider population. First, misunderstandings of addiction contribute to the stigmatisation and discrimination of those who are substance dependent. Second, stigma and discrimination persist in the public sphere, fuelled by erroneous information (McKeganey 2001; Hunt and Derricot 2001; Matheson, 2002). Finally, stigma actively plays a part in obstructing attempts at recovery (Lloyd 2010).

Surveys in the UK demonstrate the negative attitudes held by the public towards those who are substance dependent (Lloyd 2010; Room et al. 2001). Responses reveal that drugs were more negatively perceived than alcohol, despite the global burden associated with alcohol and the social and economic costs of alcohol use (Institute of Alcohol Studies (IAS) 2020) and the additional stigma associated with the status of illegal substances. This is despite millions of people in the UK in receipt of prescription drugs that can lead to dependence and withdrawal (Marsden et al. 2019). Room's survey (2001: 276) conducted in fourteen countries including the UK shows the degree of social disapproval or stigma across a broad spectrum of 'conditions', including depression, alcoholism and drug addiction. In most cases, drug use scored highest, with alcohol use not far behind (Room 2005: 146). Room's definition of stigma, in the context of alcohol and drug dependence usefully sums this up: 'Stigma' means disqualification from social acceptance, derogation, marginalisation and ostracism encountered by […] persons who abuse alcohol or other drugs as the result of societal negative attitudes, feelings, perceptions, representations and acts of discrimination (Room 2005: 144).

People who use substances face stigma when attempting to get help, even from those whose role it is to assist. Unchallenged, stigma in these 'helping' contexts contributes to an environment of discrimination and 'dehumanisation' (Tyler 2020: 7), in which it is deemed acceptable to denigrate people who are substance dependent. Although some of these attitudes may be based on actual interactions with someone who is actively using substances, the media, society and some drug treatment programmes continue to stigmatise drug users.

Other frameworks for understanding stigma specifically related to substance use examined the degree to which those in recovery are affected by stigma (Luoma et al. 2007). Three forms of stigma were identified: enacted, perceived and self-stigma. The first of these, 'enacted stigma', reflects Room's definition (2005, above), as it refers to direct forms of structural and cultural discrimination, which may occur in different settings, such as employment, housing or interpersonal relationships. Second, perceived stigma refers to the beliefs held by members of the stigmatised group about the prevalence of attitudes and beliefs in wider society, and third, self-stigma refers to negative thoughts and feelings that are internalised by the individual. Scarscelli (2006: 239) captures this latter development with reference to the role of social interaction in the process of constructing the identity of 'drug addict': 'the definition that the subject gives of himself and his situation is influenced by the perception that others have of the subject himself'. Merton's (1948) concept of 'self-fulfilling prophecy' is also useful here as it illustrates how the person accepts the image held by others, leading to a redefinition of their own identity.

Self-stigma is also addressed by Buchanan and Young (2000: 414) who state that 'Discrimination has led many problem drug users to internalise and blame themselves for their position. This loss of confidence and self-esteem is a serious debilitating factor'. Internalisation of stigma can present a significant obstacle to recovery and can lead to social isolation, obstructing the construction or reconstruction of identity. Concepts such as these are familiar from other contexts. In her discussion of identity and the loss of self for the chronically ill, Charmaz (1983: 1) identifies four forms of suffering: 'leading restricted lives; experiencing social isolation, being discredited and burdening others'.

Substance users living outside of conventional society are also subject to leading restricted lives, being discredited, a burden and experience social isolation. The inability to maintain a 'normal' life that is, according to Charmaz (1983: 2), the 'symbol of a valued self', further reduces opportunities for recovery. Thus, the concept of normal can be considered key to recovery.

Perceptions of norms and normality are critical themes when discussing stigmatised identities. Evidence of labelling particularly in terms of normal/abnormal can be found in media reports, societal discourses and in drug treatment programmes. Definitions of addiction have been operationalised by addiction professionals and defined by World Health Organisation (WHO) and the American Psychiatric Association (APA) in terms of 'problems of social functioning' and as a series of symptoms (Taieb et al. 2008: 990). 'Normal' includes other 'binary divides', for example, right/wrong and insider/outsider (Waterhouse 2004: 69), binaries which are frequently related to groups in society who are, or have been, identified as 'abnormal', deviant, or outsiders.

People who do not comply with the 'taken for granted' social world are often constructed as 'other', and inferences can be made about their core identity as 'either normal' or 'deviant'. Labelling such as this has repercussions for the individuals that are labelled (Waterhouse 2004: 72), and could have the detrimental effect of stigmatisation in the long term (McNulty and Roseboro 2009). Waterhouse (2004) demonstrates how labelling contributes to the social construction of deviance. That is, 'as a negotiable phenomenon relative to time, place, situation, and the definitions of participant actors … [in which] emphasis in the Labelling perspective is on deviance not as an "official" or given category of rule transgression, but as a socially constructed product of the *"responses of other people"*' (Becker 1963 in Waterhouse 2004: 71, my emphasis).

The reactions of others as 'onlookers' may be more important in understanding deviance than the acts themselves. Becker's (1963) sequential deviance model is useful here to comprehend both the changes that take place over time in the consumption of psychoactive substances and the processes of social interaction that influence these changes. The social interaction leads to a series of questions the person may ask of

themselves in this process, such as whether they have been able to hide their behaviour, and if not, how the image held by others has changed and may affect how the person defines themselves (Scarscelli 2006). This awareness of the self in relation to the opinions of others is a key theme that emerged in this study and is explored further below, following an overview of the research design and methods.

Research Design

Twenty-seven interviews were conducted with sixteen men and nine women, ranging in age from twenty-five to fifty-five. The majority were poly-drug users. They had engaged with between 1 and 8 treatment programmes and were in recovery from 4 weeks up to 14 years. Access was arranged via selected gatekeepers using purposive sampling (Matthews and Ross 2010: 162). The research was explained and participants were reassured of anonymity, confidentiality and the right to withdraw from the study at any point (Vanclay et al. 2013). Individual face-to-face interviews were conducted with participants and interview recordings were transcribed, assigned pseudonyms by the researcher and coded using a thematic analytical framework. Interviews were analysed using thematic analysis (Braun and Clarke 2006: 5). The key themes identified using this analytical approach include self-stigma, self-storying, self-discovery and 'doing normal'.

Several key conceptual frameworks useful for understanding identity provide useful context for interview extracts: identity construction (e.g., Giddens 1991); narratives as a tool for identity construction and as central to understanding the potential for change (e.g., Taieb et al. 2008); and the application of Riceour's definition of hermeneutics as a tool to further understand identity construction in recovery (Kerns-Zucco 1998).

One of the main reasons for interest in the use of narratives in recovery was 'the potential use of narrative as a vehicle for change' (Taieb et al. 2008: 991) and developing the capacity *to keep a particular narrative going* (Giddens 1991: 54). Also noted as critical for recovery, Ricoeur's

(1984, 1986, 1988) narrative theory draws on the concept of the 'narrative dimension of the self' (in Taieb et al. 2008: 991) in which a hermeneutic process is viewed as inherently part of the recovery process: '[…] there occurs an operation of understanding in relation to the interpretation of texts which includes two key dynamics: the first is the realization of discourse as a text, and the second is the elaboration of the categories of the text as the concern of a subsequent study' (Ricoeur 1988: 43 cited in Kerns-Zucco 1998: 40).

The importance of these concepts to debates surrounding identity construction and overcoming stigma are revealed in respondents accounts under four main themes: Self-stigma, Self-Discovery, Self-Storying, and 'Doing Normal'. The penultimate of these refers to the narrative dimension of identity construction and that analysis concludes with accounts highlighting how these stories contribute to a 'normal' identity.

Self-Stigma: 'We Are the Anti-Christ'

The way in which substance abuse and dependence have been operationalised by addiction professionals and reinforced via assessment, care planning and outcome measurements (see for example Deady 2009) is problematic and may contribute to stigma. Definitions from WHO and the APA based on 'problems of social functioning' and identification with a range of symptoms are inadequate for a 'phenomenon for which there is no single truth' (Taieb et al. 2008: 990). Despite Taieb et al.'s argument, an individualistic, medical model persists, which is 'at odds with the 'sociological imagination' (Larkin and Griffiths 2002: 284). This construction also disregards the interactive, 'social nature of addiction recovery' (Larkin and Griffiths 2002: 284) and contributes to isolation, acts as a barrier to accessing support and promotes self-stigmatising behaviours and beliefs. The internalisation of a stigmatised identity is evident in the following extract:

> When we are in full-blown active addiction; we turn into the Anti-Christ. We're not a normal, sane person anymore. (Angela, 47years old, Recovery6yrs)

Angela's self-perception reveals how she associates being 'not normal' with 'full-blown active addiction', evidence of the internalisation of stigmatising attitudes and beliefs. Perceptions of broader social stigma are also co-opted by people who are substance dependent and may contribute to delaying access to professional support as in Kira's case:

> And the reason I was buying it on the street was, I stupidly, looking back, I thought that I didn't want anyone to know my business. There were only a few people that knew I was on it; my family never knew. So, I just thought, if I get onto a clinic, my name would be registered as a drug addict and all that sort of stuff. So, it ended up I got in contact with a girl that lives up near me and she runs a clinic and I was telling her what was happening to me and she was saying, "K, don't be buying it. Jesus, I can get you onto a clinic, and I was like "I don't want to be associated with drug addicts. I don't want to be seen going in or out of it. (Kira, 35years old, Recovery2wks)

The avoidance of being associated with drug addicts and the related stigma was a key factor in Kira's reluctance to engage with services and therefore a barrier to recovery, resulting in social isolation. She was, in the words of Scarscelli (2006: 239) attempting 'to hide this particular behavior from non-consumers so as to avoid being stigmatized'. Others in this study were at a different stage in their recovery process and were involved in grappling with overcoming a stigmatised identity through reflecting more deeply on their identity.

Self-Discovery: 'Find the Me'

Reflection mostly occurred in recovery groups and communities who provided resources to support making choices about 're-storying' a new identity. In some cases, this was a safe place to meet others in recovery; in others, more structured activities such as therapy groups, support

networks and counselling were on offer, all of which could be drawn upon, using 'stories', to assist with the construction of a non-stigmatised identity (Taieb et al. 2008; McIntosh and McKeganey 2000, McKeganey et al. 2002). Telling stories about oneself is regarded as one of the ways of reconfiguring/(re)-constructing identity in recovery. For some individuals, the process involves recovering an old identity, whereas for others, their 'true' identity is perceived as unknown even to themselves. Thus, the process involves attempting to recover 'a sense of who they were' (Gibson et al. 2004: 604). When discussing what recovery means to her, one respondent referred to her self-development through reflection on her recovery process:

> It's something for me to enhance and for me to have something to empower me, to be able to develop me, and to find the me who I was in the beginning of my substance use, the me who's a different person after that substance misuse. (Tina, 42yo, R2.5yrs)

As part of this process of self-discovery, a level of flexibility in terms of self-identification within the process of recovery is crucial. In the context of Gidden's argument that '[T]he self is not a passive identity, determined by external influences' (1991: 2), involvement in the reflexive making of the self, especially for those attending recovery organisations in which therapy, group work and counselling are commonplace, is evident.

> I mean, in recovery I've seen [names bands], I like live music, I've done a sky dive, I've been Thorpe Park. Recovery had given me a life. It hasn't given me a life; it's given me a life I never had. It hasn't given me my old life back, because I wouldn't want that back, but it's given me a life. You know when I fail, I don't see it as a failure anymore. I just see it as experience. What can I learn from that experience? Just dust myself down, just keep getting on with life. (Philip, 38yo, R3yrs)

Although Philip speaks of external influences, his use of narratives of popular culture and everyday activities to illustrate his sense of self-discovery demonstrates the reflexive making of the self, and the importance of new experiences as a central aspect of recovery.

Bourdieu's (1990) concept of 'imaginary experience' and 'folk tales' is also useful for understanding the power of stories for change. On the one hand he argues that 'the habitus tends to ensure its own constancy and its defence against change'. However, he also recognises that 'folk tales' can neutralise the 'sense of social realities' […] so that the social world 'takes the form of a universe of possibles equally possible for any possible subject' (Bourdieu (1990: 60). Likewise, Ricouer (1992: 162 in Taieb et al. 2008: 994) refers to 'folk tales' and discourses that may also include 'fiction and other professional literature [which] is used to help those in recovery to organise their lives, and to attempt to become 'coauthor as to its meaning'. In Philip's case, the 'folk tales' were popular cultural texts, used to develop his own unique narrative of identity. These narratives of self-discovery were more obvious in discussions of earlier stages of recovery, transitioning to stories focussed on the making of the self in later stages, as discussed below.

Self-Storying: 'How Far I've Come'

Hughes (2007) discusses the 'entangled identity' that is formed through engagement in substance using practices and maintains the case for narratives to assist in positive identity formation. In the process of recovery, the identity is disentangled from the everyday practices in which it has become enmeshed (Gibson et al. 2004: 597). This process of untangling the identity in the practice of a non-substance using lifestyle contributes to a rejection of the 'street addict role' (Stevens 1991) and most often comes about through life narratives through which individuals could claim to be recovered. Addiction specialists in recovery communities have used these stories and their markers/turning points to 'render addictive careers intelligible' as well as to construct their own professional identities (Taieb et al. 2008: 994). Indeed, the use of stories drawn from 'specialists' is evident in research, in which individuals in recovery had access to 'the interpretive support of therapists [which] had helped them to formulate their own interpretation of their lives' (Hanninen and Koski-Jannes 1999: 1847). For example, Nancy recounts

her journey from feeling alienated to experience life as pleasureful in recovery:

> Life is a gift. And I never saw it like that from a little kid. I felt like a bit of an alien. What was the point of this life stuff? Kind of liked the idea that I probably wouldn't live to an old age. And now I'm thinking "God, I've, hopefully I've still got all these years left". It's incredible. I get pleasure…I was given all of this stuff for free, and now I get pleasure in giving that back for free. Cos I want other people to have what I've been given. (Nancy, 41yo, R2yrs)

Nancy refers to being 'given stuff for free', referring to what she's received from staff and others in recovery. The concept of narrative is central to this transformation and/or reconstruction process. It is not just defined in terms of theorising one's life (Hanninen and Koski-Jannes 1999: 1838) or understanding the self but also in the role it plays in constructing the self; the idea of *writing one's life* (my emphasis). Castel et al. argue that the story or narrative is not just '*about* recovering from addiction; it can also be a *component of* recovery' (1998: 60). McIntosh and McKeganey (2000, McKeganey et al. 2002) provide evidence of this occurrence in their study, which identified how the narrative of recovery may also be one of the mechanisms by which individuals achieve recovery. Peter reflects on the skills he learned in recovery: structure, employment and building confidence, that enabled him to live an 'everyday' life and shows this through 'writing a new story' about his life:

> Recovery well … at the start it was getting clean and trying to stay clean… looking back now what it had done for me, it was coming in, and it was to build up my confidence and, I couldn't see it at the time, but I was building up life learning skills. Like working in, when I was going through treatment, working in an office, having a structure, and to look back, these structures that you were working in, in treatment were what you do in everyday life and how you cope in a position in your own job and everyday life. (Peter, 35yo, R11yrs)

This process of 'telling' creates an environment in which the person can develop as an individual 'because s/he is part of a community, and

this involves sharing common attitudes to the group, as the individual takes on the institutions of the group into 'his own conduct' (Kerns-Zucco 1998: 41). Booth Davies (2009) maintains that people who have substance dependence problems use the discourses available to them to conceptualise and verbalise their addiction. Likewise, this analysis suggests that recovery communities provide an alternative narrative that affords an opportunity to take on 'the institutions of the group' not just as a discourse but incorporated into their 'own conduct' (Kerns-Zucco 1998: 41), that is, their attitudes, behaviour and characteristics. Thus, the group discourse 'results in the creation of two texts: a personal biographical text and a text of social history' (Kerns-Zucco 1998: 41). In the telling, interpretation and reflection of their 'personal biography', the person is also creating a social history (Kern-Zucco 1998: 41–42). Taylor (1989) suggests that 'In order to have a sense of who we are, we have to have a notion of how we have become, and of where we are going' (in Giddens 1991: 54). In this way, the individual can become 'theorists of their own life' (Hanninen and Koski-Jannes 1999: 1838).

Moreover, the social history 'is an organised text that emerges through verbal interchanges of recovering addicts' (Kerns-Zucco 1998: 41). Although the suggestion is that this social history transpires purely from the discussion, the organised nature of this 'text' implies something that is structured, prepared and planned. Recovery programmes such as NA, AA, therapeutic communities and others are often constructed around a particular philosophical ethos, with specific rules, regulations, obligations and expectations that structure the experience of recovery. Furthermore, even though in these contexts the narratives are composed as individual biography, within the context of the group and 'the organized responses of all the members of the group', eventually the individual is guided towards the 'realization of a common history' (Kerns-Zucco 1998: 41) and the possibility of overcoming stigma and labelling through the construction of a different identity. The 'realization of a common history' is exemplified in this quote:

> But when I actually realised that there's a hell of a lot of people out there that felt exactly the way that I did, and that now, are free, completely

> free, and live a normal happy, healthy life and are content with themselves. Once I kind of, once that sunk in that actually "I want what you've got" then I was off and you know, it was great yeah. (Nancy, 41yo, R2yrs)

The second key dynamic noted above: 'the elaboration of the categories of the text as the concern of a subsequent study' (Ricoeur 1988: 43 in Kerns-Zucco 1998: 40) is evident here. The person in recovery will tell and retell the story in self-help (or indeed other types of therapeutic group processes), continually interpreting and reinterpreting their biographical and social history texts. Within these groups the process of identification with others is encouraged. Although usually regarded as a psychological process, this process of identification with others involves listening to the verbalised accounts that they present, and connecting these to personal experience, which then becomes a comparative process.

Stories heard in self-help meetings can be 'related to' and, through conscious reflection, the relevance of the story to the listener's life can involve a reworking not only of personal biography but of social history (Kerns-Zucco 1998: 43–43). In this way, the interaction experienced through the telling, listening and reflection contributes to identity construction, in which respondents can distinguish themselves as the same but different (Brewer 1991). One respondent reflects on how he views himself now in relation to his past and in relation to others, illustrating the process of rewriting his story:

> Personally, I look at myself and especially when I see an addict walking down the street, and I always look at myself and say Jesus, that was me back then. And I look at myself now, having a job, having a great family life and doing things, going on family holidays every year, something I never did in my life and I'm really happy with myself about how far I've come and how confident I am about staying off drugs. (Peter, 35yo, R11yrs)

Peter's narrative draws from concepts of what it is to be 'normal', which were verbalised in many of the interviews and included references to stable relationships, jobs, holidays and children. Other features of 'normal' are discussed below.

'Doing' Normal

As noted, the process of recovery demands interaction with others to facilitate the hermeneutic process, initially in recovery communities, and then later in 'normal' society, the subject of the following discussion. Primarily, through dialogue and interaction in group discussions, individuals 'call out' similar stories in other individuals, contributing to the notion of shared experience (Mead 1956: 158). This highlights the importance of verbalising accounts to others in recovery so that the 'truth of past experiences', as constructed by the speaker, can be acknowledged (Kerns-Zucco 1998: 44). Subsequently, these shared experiences discussed in a nurturing environment can also contribute to improved psychological and emotional well-being. Finally, recognising the many interrelated forces at play that contribute to, or obstruct, a person's recovery, including how substance use is understood, talked about, and defined, not just in specialist environments where support is offered, but in the everyday world (Kerns-Zucco's 1998) is critical. It is in this everyday world when re-engaging with 'normal' society that opportunities for encountering new stocks of stories occur. Anthony elucidates how he moved on from the treatment context and began to develop a new narrative, both in the literal and figurative sense:

> When I went onto this psychology course, and maybe there was 2 people I knew from the rooms out of what, maybe 40 people? And everyone else had their own stuff going on, like mortgages and holidays and kids, and there was no mention of what meeting are you going to, and what treatment centre are you going to, who's your sponsor and it was yeah, I enjoyed that. (Anthony, 32yo, 4yrs)

As in Peter's and Anthony's accounts, mortgages, holidays and kids all represent recovery and thus normality. Doing the psychology course enabled Anthony to move beyond his usual discursive domain that consisted of treatment centre, rooms, meetings and sponsors. Brent's struggle to construct a new narrative of normality illustrates how this is a component of his recovery process as he reflects on his everyday life:

> I'm abstinent. And living life on life's terms; got a partner, child, just what people call normal I think, and that's about it really. I do AA; I go out of town, because I can't do the normal thing; I've tried it. I've tried washing the car on Sunday. It doesn't work for me. Stuff like that; just getting on day by day. Everything's okay. (Brent, 40yo, R5yrs)

Evidently, the concept of normal is an important aspect of identity construction for those with stigmatised identities. Goffman (1986: 7) claims that despite being subject to stigma, the individual believes at a deep level that they are also normal, 'a human being like anyone else'. Nancy, three years into her recovery journey, had started to acknowledge her humanity:

> I'm a human being I think above everything. I've got to remember that, and I'm going to get human instincts, and everything's natural isn't it. You feel the same as I do. We just sometimes deal with things differently but thank God I'm starting to come over to the winning side. […] So it's yeah amazing. And I don't believe that normal people, most of them probably don't feel like that. (Nancy, 41yo, R2yrs)

In contrast to Nancy's previous quote in which she stated that she has *always* 'felt like a bit of an alien', recovery narratives have given her the language of belonging; 'we are all human and feel the same way'.

These new stories then are crucial for achievement of a sense of normality, even if they 'can't wash the car on Sunday' as illustrated by Brent above. Engaging with these everyday activities counteracts the earlier discredited identity, restricted life and social isolation discussed by Charmaz (1983). Respondents feel less of a burden, experience less shame, have opportunities to emerge from the social isolation, to contribute to society and relationships in a constructive way, and can begin to regain the lost self, and dare to plan for the future. Ricouer (Taieb et al. 2008: 992) notes 'The story of a life continues to be refigured by all the truthful or fictive stories a subject tells about himself or herself. This refiguration makes this life itself a cloth woven of stories told'. Stories heard in self-help meetings have relevance to identity construction (Kerns-Zucco 1998: 43). These stories can be recognised and related to by members of recovery communities, and thus contribute

to a rich tapestry woven with stories that have resonance for group members.

Discussion

The effects of stigma and labelling in broader society have serious consequences for those in recovery. First, stigmatised groups internalise the discrimination targeted at them. Second, external parties including policymakers, the media, medical and other helping professionals play a part in actively promoting the exclusion of the 'other'. The former can also be recognised as those who have the power and resources to label and exclude others; the 'machinery of inequality' identified by Tyler (2020) dehumanises and crushes hope for those at the bottom of the social ladder, including substance users. These external factors impinge on the successful construction of a new identity.

To counteract these negative impacts and outcomes, positive personal narratives, based on interactive discourses in recovery communities and beyond, are essential for successful recovery. Drawing from a broad range of stocks of stories provided respondents with opportunities to re-story their lives and use narratives to construct a new, non-stigmatised identity. Yet, despite the obvious benefits of narratives to recovery, scholars note that experts/researchers are often concerned with scientific theories and research techniques at the expense of understanding the words and perceptions of the people they study (Link and Phelan 2001: 365). In biomedicine, in particular, historically, there has been scepticism about the value of the words of patients, who tended to be overwhelmingly viewed through their bodily functions (Hydén 1997). Disregarding the narratives of patients leads to a misunderstanding of the people and their experiences, which can perpetuate unsubstantiated assumptions. A focus on the words and stories of those researched is therefore crucial.

Focussing on the words and stories of respondents here provided insight into the often circular and complex journey of recovery, in which change was an incremental process and identity changed over time. As outsiders from 'normal' society, social isolation had compounded a sense of a loss of self, promoted self-stigma and obstructed the ability to

imagine a different life. When taking steps towards recovery, individuals relayed the complex reasons for this decision including arrest, detention, loss of children, death of loved ones, incarceration and ill health, which also contributed to self- and societal-stigma. Prior attempts to recover though, whilst seemingly fruitless, had exposed respondents to a range of recovery narratives, which enabled an assessment of what recovery intervention might work for them at some point in the future.

All respondents were able to use new knowledge to construct new responses to stigma, to effectively process the attitudes held by others towards them, and to learn how to reject or modify these attitudes (McIntosh and McKeganey 2001: 49). Evidence from the narratives illustrates how respondents developed skills in the rejection or modification of the attitudes of others and were able to reconfigure self-stigma towards an appreciation of the essential value of humanity that can also contribute to a rejection of societal stigma.

Some respondents constructed a recovery identity based on 12-step programmes and the notion of a 'saved' life. Others rejected the 12-step philosophy and engaged instead with community-based or residential, therapeutic programmes, constructing a different narrative of recovery. Whatever the programme philosophy, respondent's engagement in a recovery process, involving an interaction with others in recovery, confirmed that despite possessing a status of 'not normal', and as a member of a stigmatised and discredited category, the opportunity to 'write one's life' and construct a new, non-stigmatised identity was a distinct and realistic possibility. The ability to become 'theorists of their own life' is a powerful and empowering tool of recovery narratives (Hanninen and Koski-Jannes 1999: 1838). The centrality of producing a coherent, ongoing recovery narrative utilising stocks of stories drawn from a range of sources was elucidated here as essential to positive identity construction. These narratives included well-known accounts of recovery embedded in various programmes, such as NA, AA, therapeutic communities and other recovery communities. Educational texts and experiences, and popular cultural texts, were also highlighted as important sources of alternative narratives surrounding 'normal' life.

The benefits of narratives for recovery were illustrated as a vehicle for making sense of one's life throughout the recovery journey. That a narrative approach could be used to help with understanding identity, the way changes occur during the recovery period, and the contribution to an improved conceptual framework for understanding such a complex issue is evident. The narrative provides a bridging mechanism between the 'addict' and the 'normal' world, an opportunity to move from the liminal space of being an 'Ex-' (addict, junkie and alcoholic), which stigmatises those in recovery (Radcliffe and Stevens 2008). To support the construction of a recovery identity, opportunities to access stocks of positive stories is critical to understand that the social world, in the words of Bourdieu, 'takes the form of a universe of possibles equally possible for any possible subject' (1990: 60).

Undoubtedly, the need to address the self- and societal stigma, and the stigmatising effect of language is crucial, as shown in interview extracts. Recovery communities are spaces where people who use substances can explore and try out a new identity, one that conforms to notions of normality. But normality is a complex concept and so it is important to understand societal norms alongside the values proscribed by recovery communities for people in recovery and how these impact on successful recovery journeys. This is especially imperative in the early stages of recovery following what for many in this study was an extended period of chaos, involving the criminal justice system, mental health services, social services and in some cases involving loss—of partners, friends, children, family, employment, homes and dignity.

There are many interrelated forces at play that contribute to, or obstruct, a person's recovery including how addiction is understood, talked about and defined, not just in specialist environments where support is offered but in the everyday world (Kerns-Zucco 1998). Especially important is the challenging of notions of identity as fixed or core constructs. Findings from this study demonstrate the fluidity of identity in recovery as individuals consistently build on stories encountered in various contexts to construct or re-construct a different identity, one that is suitable for new life circumstances away from the 'street addict role' (Stevens 1991). People in recovery need to gain access to alternative

narratives and experiences that enable them to produce an identity that moves beyond the stigma of the 'addict'.

Conclusion

The recovery process is complex, involving a transition from a stigmatised to a 'normal' identity. In this process, knowledge and skills are needed to negotiate 'normal' society until such a time as new social practices are enmeshed in this new/reconstructed identity. This research has shown the centrality of narratives and stories to constructing and maintaining a 'recovered' identity. Broader recognition of recovery as an interactive and transitional process is needed in the public domain to move beyond binaries of 'addict-as-abnormal' and 'others-as-normal' and to counteract the narrative of 'once an addict, always an addict'. Acknowledging the fluidity of identity and the potential for *all* individuals to generate change, and to narrate a new identity, would provide a new narrative that moves beyond the current frame of stigma. Improved services with trained staff who understand stigmatising discourses and how they impact on recovery journeys, as well as recognising the role of alternative narratives in identity construction would support substance users in their recovery journey. As Lutman et al. (2015) assert, it is time to 'De-Demonise the 'monstrous' drug addict'.

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What's Your Poison? On the Identity Crises Faced by Healthcare Professionals Who (Ab)use Drugs and Alcohol

Sam P. Burton, Keegan C. Shepard, and Sergio A. Silverio

Introduction

Despite the advancements in modern medicine, it is evident healthcare organisations and their staff are under an enormous amount of pressure. Various factors, including a growing and ageing population, as well as increased numbers of patients presenting with chronic and complex conditions, means heightened levels of patient demand. As a result, healthcare professionals [HCPs] in the UK National Health

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Service [NHS] are working in increasingly understaffed and underfunded systems which makes it challenging to meet adequate standards of medical care. Research demonstrates working in these inadequately resourced and poorly equipped environments significantly impacts patient safety, as HCPs are not operating as safely or as effectively as they would be with an adequate level of resource. This can result in higher prevalence of psychiatric morbidity among HCPs than the general population, with increased risk of emotional exhaustion or burn-out, which is rising across the health and caring professions. Generally, HCPs report equivalent or lower levels of alcohol consumption than the general public, yet report higher rates of binging and (ab)use of prescription drugs, indicative of maladaptive coping towards psychological distress. This chapter is a critical review of the identity crises faced by healthcare professionals who (ab)use drugs and alcohol. Critical reviews aim to synthesise materials after extensive, though not usually systematic, literature searching to provide a narrative around the issue being discussed with literature being drawn upon for their contribution to the field of study rather than assessed or evaluated quality (Grant and Booth 2009). A critical review 'typically manifest in a hypothesis or a model, not an answer' (Grant and Booth 2009: 93) and therefore often poses more questions or new ways of thinking. In the case of this chapter, we synthesise and present literature on the topic of healthcare professionals and the pressures which may lead to them developing habits relating to drug and alcohol (ab)use and the resultant identity crises which often follow.

Due to a variety of factors, including a growing and ageing population, as well as an increase in the number of patients presenting with chronic and complex conditions, the NHS in the United Kingdom is experiencing a heightened level of patient demand, where 'winter pressures' are now being felt year-round, thereby presenting significant risks to patient safety (Oliver et al. 2014; Lafond et al. 2016). This is especially true following the outbreak of COVID-19 at the beginning of 2020, which continues to place an overwhelming strain on the NHS and its staff, as well as highlighting its vulnerabilities, including an inadequate number of available beds, lack of personal protective equipment [PPE] and overworked employees. Furthermore, healthcare professionals are working in an understaffed and underfunded healthcare system which has made

it challenging to provide a high standard of medical care (Sizmur and Raleigh 2018; Wilkinson 2015). This unprecedented and dramatic rise in demand has impacted almost all services offered by the NHS, including mental health clinics, GP surgeries, ambulance callouts, and A&E departments. For instance, according to the British Medical Association (2020), there was an increase of 3.77 million GP appointments in England from the previous year. This demand on GPs has led to a rise in waiting times for appointments, where the average time for patients waiting for a GP appointment is now over two weeks, for the first time on record. A wait for primary care services ultimately leads to an increase in demand for secondary care and ambulance services (Department of Health 2016; Freeman and Hughes 2010; NHS Improvement 2020). There is an expectation this demand will continue to increase as the country's population ages, and unless there is an infusion of monetary resource and additional personnel, it is up to the current level of staff and infrastructural resource to pick up the pace. This strategy presents disastrous outcomes for patient safety (Charlesworth and Johnson 2018), including increased wait-times, prioritisation of certain patient groups above others, increased virtual care provision—all things we have seen occur during the COVID-19 pandemic, and which may continue long after as services are built back again in preparation for future health system shocks.

A rising workload inevitably means an increase in working hours and a decrease in time allocated for leave, further training, and professional development. Over time, these pressures can breed unpleasant working environments filled with inter-professional conflict (Apesoa-Varano 2013; Varcoe et al. 2003), and intra-professional incivility (Farrell 1997; Thomas et al. 2015). These experiences can result in HCPs experiencing burn-out, and ultimately, workforce attrition (Banovcinova and Baskova 2014; Davies et al. 2022; Sharma et al. 2008; Yoshida and Sandall 2013). Evidence, from cross-sectional and longitudinal surveys of HCPs, suggests that in response to these experiences, HCPs may adopt and even rely on harmful and maladaptive coping behaviours such as (ab)use of alcohol and prescription and/or illicit drugs (i.e. prescription opioids and benzodiazepines, cocaine, LSD) and a substantial body of evidence is building, both in the UK and internationally, which suggests

HCPs have higher rates of hazardous alcohol use (a pattern of drinking that places an individual at risk of adverse health events based on the AUDIT screening tool) or harmful alcohol use (a pattern of drinking associated with known alcohol harms) in comparison to the general population, increasing over the years spent working (Aalto et al. 2006; Bazargan et al. 2009; Kenna and Wood 2004; Medisauskaite and Kamau 2019; O'Cathail and O'Callaghan 2013; Raistrick et al. 2008; Rosta and Aasland 2013; Schluter et al. 2012). Despite high rates of alcohol use among HCPs in the UK, the prevalence of alcohol dependence (characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences) in this subset of the population is equivalent, if not lower, than the general population (Medisauskaite and Kamau 2019). Nevertheless, binge drinking (six or more units in a single session) and daily alcohol use, is problematic (NHS England and NHS Improvement 2019, NHS Digital 2019) and has been associated with psychological (Mäkelä et al. 2015) and occupational distress (Medisauskaite and Kamau 2019).

The question now must be asked: What happens when those in charge of health and healthcare, themselves, turn to harmful drug and/or alcohol (ab)use? In responding to this question, we address how HCPs enact a double-voiced identity (Bakhtin 1963/1984; Baxter 2014) whereby they provide care and yet, do harm to themselves, in a form of cognitive dissonance (Festinger 1957).

This chapter, therefore, proceeds as follows: We begin with an explanation of the pressure faced by the National Health Service [NHS] in the UK as an example of a healthcare system in distress. To provide a sufficiently analysed example, we will focus on just this one healthcare system to ensure our theorisation is not marred by differences across countries, especially where private medical care might be more common. Next, we explain the harmful morbidities associated with HCPs who succumb to the pressures of a broken healthcare system. And finally, we address the fragility of the HCP identity by exploring themes of shame, stigmatisation, and the private identity crises experienced by HCPs who may turn to drug and/or alcohol (ab)use as a maladaptive coping mechanism.

Stretched, Strapped, and Stressed: The Healthcare System Under Pressure

According to The King's Fund (2020b), between 2009 and 2020, the budget for the NHS rose annually at a rate of 1.4%, despite the average yearly increase since its inception being roughly 3.7%. These substantial funding cuts are hitting the NHS at a precarious time when patient demand is spiking, resulting in an unavailability of staff and necessary equipment, an overreliance on medically unqualified staff, such as healthcare assistants [HCAs], and the missing of key performance targets (Sizmur and Raleigh 2018; Buchan et al. 2019). The King's Fund (2020a) reported the four-hour timeline for treating patients presenting at Accident & Emergency [A&E] services has not been achieved since 2013/2014, a deeply concerning statistic. Beyond emergency A&E visits, the standard target for referral to treatment for elective care has not been reached since February of 2016 (Charlesworth et al. 2020). It is no longer uncommon to see patients waiting for beds on trolleys in hallways of busy hospitals, or a long queue of ambulances at A&E waiting hours to drop off patients and unable to attend to 999 calls until they do (Fisher and Dorning 2016). As the demand for health and social care services continues to increase, the corresponding strain on healthcare systems is evident: financial instability and a reduction in the availability of qualified clinical staff to deal with the increasing number of patients culminating in dire operating circumstances.

NHS organisations and staff have not been able to tackle this problem by hiring additional qualified HCPs to pick up the increased patient demand; instead, this has fallen on the shoulders of the existing staff, who are in short supply. In 2020, there were around 100,000 vacancies reported in the NHS, with nursing staff representing the majority with 41,000 vacant registered nursing posts in England alone (Buchan et al. 2019). While the current staffing shortage appears to be at a critical level, it is only projected to worsen as the expectation is of a shortfall of staff of 250,000 by the year 2030, just short of a decade away (The Health Foundation, The King's Fund, and Nuffield Trust 2018). A recent report by The Health Foundation (Buchan et al. 2019) has highlighted that work must be done immediately to improve retention of staff

and to reduce existing staff's workloads; however, the rate of turnover of staff who enter the NHS, but choose or feel they have no choice, but to leave, has gradually worsened since 2011 (up to between 10 and 20% in 2017/2018 depending on profession, region, and workplace environment), signifying not enough has been done over the previous decade.

Against the backdrop of this staffing shortfall in the NHS, existing staff are grossly overworked, which has had a significant negative impact, affecting their morale, the rates of attrition, sick days taken, as well rationing of care and quality for patients (Buchan et al. 2019; Sizmur and Raleigh 2018). In the late 1990s, a total of 26.8% staff in the NHS reported 'damaging levels of stress' (Wall et al. 1997), and this figure has not improved since as NHS staff continue to report the worst rates of stress and anxiety when compared to the rest of the British workforce. This feeling of stress and anxiety has had a negative impact on the physical health of NHS staff, as a recent NHS Staff Survey (National NHS Staff Survey Co-ordination Centre 2019) found that 40.3% of respondents reported they have experienced a feeling of being unwell due to work-related stress over the prior twelve months when completing the survey. Somewhat unsurprising, this figure has steadily increased over the previous years, as 36.8% of NHS staff who responded to the NHS Staff Survey (National NHS Staff Survey Co-ordination Centre 2016) reported the same back in 2016. Despite a high proportion of NHS staff reporting feeling unwell, a majority of them (56.6%), in NHS Staff Surveys from 2017 to 2019, have also reported they come into work while not feeling well enough, putting vulnerable patients and colleagues at risk (National NHS Staff Survey Co-ordination Centre 2019).

The implications of the nursing shortage alone, are extensive, and well documented in the literature, where it has been demonstrated to have adverse outcomes on remaining staff, the patients in their care, as well as the broader healthcare system in which they operate. The quality of the working environment that NHS staff face has been further eroded as demand increases, and the negative impact on the health and well-being of staff is doubly concerning as overworked HCPs can have real-life effects on the care that patients receive (Aiken et al. 2002; Carayon and Gurses 2008; Fagerström et al. 2018; Griffiths et al. 2019; Welp et al.

2015). The outcome of this is a reliance of HCAs to 'plug the gap', whereby healthcare organisations increase hiring and reliance on unqualified, medically uneducated, untrained, and unskilled staff to fulfil the roles and duties historically undertaken by HCPs, exposing patients to high levels of risk (Buchan et al. 2019; Griffiths et al. 2019).

Beyond the overreliance on unqualified and untrained staff to fill the roles of nurses, there is also an increase of workarounds or shortcuts, as well as care rationing, to manage the care of patients during periods of high demand (Debono et al. 2013; Papastavrou et al. 2014). As mentioned previously, another obvious consequence of the shortage of nurses is that as they are routinely short-staffed within hospitals, the remaining nurses are left to pick up the workload while being expected to maintain the same standard of care and patient safety. Ultimately, HCPs adopt workarounds, or adaptations, which operate outside of the standard protocol to address the real pressures faced by demand and staffing shortages, and these adaptations can both facilitate the safe treatment of patients, as well as put them in harm's way; therefore, while some are necessary to achieve a high standard of care, others can place patients at severe risk (Debono et al. 2013). Research has shown that as a result of the higher workload, HCPs are more likely to commit violations and practice unsafe care, as they may not have adequate time to adhere to the highest standards of care, or even practice routine hygiene, such as washing their hands regularly (Carayon and Gurses 2008). While working practices are compromised when a healthcare system is under immense strain, so too is the health and wellbeing of the healthcare staff who are attempting to deliver within these circumstances. The outcomes, can not only be harmful to the individual themselves, but may actually exacerbate issues of patient safety, if HCP drug and/or alcohol (ab)use becomes commonplace.

Broken, Bewildered, and Burnt-Out: Healthcare Professionals and Substance (Ab)use

Where adverse working conditions within a healthcare system exceed individual HCPs' ability to cope, the effect across the whole systems' workforce is one of being unable to perform safely and capably in-line with regulations and training. Healthcare professionals may then turn to maladaptive sources of relief in order to de-stress *from*, cope *with*, or perform *through* the workplace situation which is causing them to burn-out. While alcohol is a common substance to draw upon, it has also been reported that HCPs have shown high uses of prescription and illicit drug use, as outlined below.

Healthcare professionals demonstrate different patterns of drug and alcohol (ab)use, dependent on profession and also demographics such as gender. For example, among medical doctors, men consume alcohol more frequently than women; and dentists are known to engage in more minor opiate use, compared to GPs and medical physicians who report higher rates of alcohol and anxiolytic use (Kenna and Wood 2005a, b). This of course may be under-reported due to the often self-report nature of the survey-style data collection from which these findings are drawn. Medical Doctors have also been found to drink a larger volume of alcohol, and at a greater frequency of hazardous and harmful drinking (Frank and Segura 2009; Juntunen et al. 1988; Montali et al. 2016; Voigt et al. 2009). Indeed, across other lifestyle factors there is considerable variance in prevalence rates internationally such as smoking (Smith and Leggat 2007) and exercise (McGrady et al. 2007; Tan et al. 2014). In terms of alcohol use, doctors have comparable levels of alcohol misuse to the general populous (Sørensen et al. 2015), yet hazardous consumption levels have been reported to be higher in doctors (Sebo e al. 2007) and lower levels of binge drinking (O' Keeffe et al. 2019). Disparities make it hard to draw conclusions on prevalence of alcohol use in HCPs, with cultural differences influencing attitudes towards the benefits and negative effects of alcohol consumption.

Explanations for these higher levels of substance use compared to the general population have been proposed to be the result of work-related pressures (such as work-related stress and burn-out; Nash et al. 2010; Romero-Rodríguez et al. 2019). Occupational distress described as encompassing burn-out, depression, and maladaptive coping strategies, such as alcohol (ab)use are common (Medisauskaite and Kamau 2017). Such distress can stem from emotional exhaustion, negative response to job aspects, and a sense of lack of achievement (Maslach et al. 2001), and is deemed particularly relevant to HCPs who face frequent exposure to emotionally demanding and interpersonal stressors (Koinis et al. 2015), more so than other professions (Skogstad et al. 2013). Theoretical models of occupational distress, such as job demand-control model (JDC; Karasek 1979; Karasek and Theorell 1990) and job demand-resource model (JDR; Demerouti et al. 2001), suggest high demand in isolation does not lead to excess stress, but lack of control or reduced resources interact with demand leading to occupational distress. Occupational distress is associated with poor mental health and negative health-related behaviours (Alexandrova-Karamanova et al. 2016; Demerouti and Bakker 2011; Hollon et al. 2015; Shirom 2010). Evidence suggests increased levels of occupational distress can be associated with poorer patient care, such as medical errors and service losses (Dewa et al. 2014; Hall et al. 2016), leading to poorer patient satisfaction and increased incident risk (Panagioti et al. 2018).

Healthcare professionals' own health and wellbeing are proposed to have a downstream effect on their ability to provide effective patient care (Taub et al. 2006), and counselling of patients (Frank et al. 2010). That is to say, HCPs in better health are more likely to provide better care for patients than those who are suffering poor health. Doctors who regularly engage in a given health-related activity are more likely to provide counsel to a patient surrounding said activity (Lobelo and de Quevedo 2016), and has been shown to improve patient adherence to such health-related activity (Elley et al. 2003). Healthcare professionals play a key role in the implementation of health promotion behaviours and preventative practices to hazardous substance use behaviours (Raistrick et al. 2008; Rosta 2002). In this respect, our front-line HCPs' behaviours, experiences, and attitudes towards drug and alcohol (ab)use may potentially

have a protective effect in terms of improving patient uptake of health benefit behaviour.

There is potential for HCPs own behaviour to influence patients' attitudes and motivation to change their lifestyle (Saeys and Cammu 2014). Healthcare professionals' own behaviour and lifestyle choices have been shown to influence a patient's perception of health risks (Sebo et al. 2007). Predictors of health promotion behaviours are an individual health care professional's own alcohol use. Several studies have observed significant associations between clinical management of a given substance and their own use of said substance, where individuals with healthy lifestyles are more likely to advise on preventative measures to alcohol use (Bakhshi and While 2014; Rosta 2005). However, interactions between care giver and patients, particularly the level of care received, is the result of a variety of factors including HCPs' personal beliefs, attitudes, and experiences with alcohol (Crothers and Dorrian 2011; Rosta and Aasland 2013; Voigt et al. 2009). Particularly HCPs' personal experience with alcohol can have a significant effect on the interaction with the patient (Aalto et al. 2006). For example, in a cohort of nurses, those who consumed alcohol were more likely to believe the danger is in alcohol rather than the patient, and therefore would build a positive rapport with the patient (Crothers and Dorrian 2011).

Healthcare professionals are ideally positioned to promote and improve the health of individuals and their wider community (Bakhshi and While 2014). The expectation is such that, HCPs 'practice what they preach', and therefore are viewed as role models, which in turn leads to the expectation they must behave in a certain manner (Frank and Segura 2009; Voigt et al. 2009). Personal attitude, health beliefs, and the importance attributed to them have all been shown to affect the perception of patients who (ab)use substances, from unrewarding to unpleasant, depending on their professional background (Gilchrist et al. 2011). Healthcare professionals' own experience and beliefs surrounding drugs and alcohol, may therefore influence patient care.

Dissonant, Dissenting, and Double-Voiced: Healthcare Professionals Who (Ab)use Drugs and Alcohol

It is clear that in distressed, understaffed, and underfunded healthcare systems, HCPs are under ever-increasing pressure to deliver an ever-expanding workload, which ultimately can take a toll on their mental and physical wellbeing. Though not all HCPs will experience burn-out, many may turn to excessive alcohol use and/or may (ab)use prescription or illicit drugs. The outcomes of this response to workplace stressors are indicative of maladaptive, negative, coping mechanisms in response to severe and unrelenting psychological distress (Aguglia et al. 2020; Alexandrova-Karamanova et al. 2016; Baldwin-White 2016; Lathrop 2017; O'Driscoll and Cooper 2002; Zeidenstein 1995). This then positions HCPs as both responsible professionals and as individuals who may end up requiring medical or psychological interventions, delivered by fellow HCPs. What this causes—we suggest—is a double-voiced identity (Bakhtin 1963/1984; Baxter 2014) where they are—at once—both powerful and powerless (Fairclough 2014). Here, the HCP powerfully asserts themselves as someone who may counsel against self-abuse (i.e. by relying on substances to cope and/or perform) in their professional role. However, they themselves may be powerless and only function in said role, when (ab)using the very same substances their patients are being counselled against, or even reprimanded for utilising (see Kelleher 2007). This double-voicing of professional-private, HCP-substance (ab)user status (or powerful-powerless; Fairclough 2014), is in itself a portrayal of cognitive dissonance (where one's actions are in direct contravention to one's held beliefs; Festinger 1957), and the associated identity which is constructed as a result is multifaceted and difficult to unpack.

Identity itself, is a complex phenomenon, often displayed in-line with societal norms and desires in what some have called a 'performative' act whereby our social roles—especially in the Western world are so clearly defined that people rarely stray from the norm for fear of their transgression being negatively evaluated (Butler 1988; Goffman 1959; Silverio 2019). Healthcare professional identity is further complicated

by being synonymous with responsibility within the community and also for the fact that they are authoritatively powerful in the relationship they maintain with their patients. Their role is not only as someone who can help the patient to heal, but as a role model for both how to maintain one's health and how to be an effective and productive member of society. Healthcare professionals will often have people who (ab)use alcohol and drugs under their care in all settings of a healthcare system, and when they themselves are facing the same struggles with drug and/or alcohol dependency or (ab)use, this positions any criticism of their patients' behaviours as an automatic critique of their own personal lifestyle choices. To maintain the identity as an HCP (publicly) and therefore virtuously against damaging health behaviours such as drug and alcohol (ab)use, but as a drug and/or alcohol (ab)user (privately) and therefore warranting of their own damning criticism; may foster feelings of shame and stigma, ultimately resulting in a private identity crisis.

HCPs may fall foul of the very same predispositions to drug and/or alcohol (ab)use as members of the population who are not trained HCPs. For instance, via a family history (Kenna and Wood 2005a), or previous association with substance (ab)users in their childhood or early adulthood (Kenna and Lewis 2008). However, as trained professionals, HCPs are positioned as role models making healthy lifestyle choices, and therefore are expected to not engage in such behaviours. The trigger for drug and/or alcohol (ab)use by HCPs, we argue in this chapter, is not that of a predilection towards alcohol, prescription drugs, or illicit substances, but rather the working environment in which they are expected to repeatedly perform to ensure the safety and lives of the general population who are sick or injured, and in need of medical care. When these environments are stretched beyond capacity, the workforce can equally bear the cracks associated with the pressures of responsibility, duty, and expected performance. It has been argued that *'given the increasingly stressful environment due to manpower shortages in the healthcare system in general, substance induced impairment among some healthcare professions is anticipated to grow'* (Kenna and Lewis 2008: 1), should these workplace environments and workforce pressures, continue to go unaddressed.

HCPs may continue to enact professional counsel, while they themselves engage in alcohol and/or drug (ab)use, in order to cope with these

work-based pressures, no matter how maladaptive a coping mechanism it may be, or they know it to be, which may in turn, ultimately result in irreparable damage to the HCP workforce, while also endangering patient safety.

Conclusion

In this chapter, we have described how the healthcare system (the NHS) in the United Kingdom has endured extreme pressures since being founded more than seven decades ago, which appear to have increased in incidence and severity in more recent years as the population increases and ages. More recently, the COVID-19 pandemic placed an additional strain on an already over-burdened health service and exacerbated its existing pressures, thereby placing patient safety at a heightened risk. We have also detailed how well-documented the evidence is that HCPs often turn to harmful, maladaptive, and negative coping mechanisms such as the (ab)use of drugs and/or alcohol. In response to these maladaptive ways of coping with the demands and pressures of the healthcare professions and working environments, we suggest there is evidence for HCPs enacting a double-voiced identity whereby they maintain a professional persona which may well have to counsel against drug and alcohol (ab)use, while privately assuming a substance (ab)user identity. This dual persona leads to cognitive dissonance which is wrestled with regularly, and provides a constant point of tension between the HCP's personal and professional lives. Not only does this personal identity crisis provoke feelings of shame and stigma, it more fundamentally endangers the health and wellbeing of the HCP who themselves is responsible for the health and care of the population of patients in their care. And with sub-optimal performance resulting from HCP intoxication, and a reliance on, or (ab)use of these harmful substances, the end result is—worryingly—an endangerment of patient safety.

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Stigma and the Use of Anabolic Androgenic Steroids by Men in the United Kingdom

Jim McVeigh and Geoff Bates

Introduction

This chapter will draw on empirical research conducted by the authors and the wider literature in which people who use anabolic androgenic steroids (AAS) describe negative experiences of engagement with services, in particular, primary health care and their lack of confidence in receiving non-judgemental support. For many, this has resulted in a distrust of health professionals and reluctance to engage with health care, and the self-management, diagnosis and treatment of health issues. Research has identified that issues of stigma play a significant role in this, complicated further by the common assertion that people who use AAS are not drug

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users per se and their negative attitudes towards people who use other drugs. Many who use AAS fear being identified with or labelled as drug users, with this acting as a further barrier to service engagement. Negativity towards the use of AAS may stem from its misuse within sport and reputation as a form of cheating, however, in recent years AAS has also been blamed for both mindless acts of violence in the form of "roid rage" (Pope et al. 2021) and in premeditated atrocities and acts of terror (BBC News 2018). The chapter will consider the role of social identity and of the subcultures that AAS use operates in and how stigma develops and is experienced.

AAS are synthetic hormones based on the male hormone testosterone. Once the domain of elite sport, the twenty-first century has seen AAS become commonplace within the general population (McVeigh and Begley 2017). During the last 20 years, advances in pharmacology, technology and the expansion of the Internet, have facilitated the availability of low-cost drugs to meet the increasing demand for AAS. These drugs attend self-administered in supra-therapeutic dosages in both oral and injectable form, often combined with other drugs (known as "stack") for a specific period, followed by a period of abstinence (a cycle). However, there is a growing trend for the "off-cycle" to be replaced by a maintenance dose of AAS, referred to as "blast and cruise" (Chandler and McVeigh 2013). While there is no "average" stack that is used by people who use AAS, a novice level of use could cost as little as £25 per week, although many people will consume many times this amount, including a wide variety of other substances at extremely high dosages (Llewellyn 2017).

Estimates of the prevalence of AAS use are notoriously difficult, however, a meta-analysis of available data indicates a global lifetime prevalence of 3.3% (men: 6.4%, women: 1.6%) (Sagoe et al. 2014). All studies indicate that this is predominantly a male pursuit and while most commonly identified in men aged between 20 and 40, some start using at an earlier age and there is increasing use in older men (Begley et al. 2017; Ip et al. 2015; Havnes et al. 2019; McVeigh and Begley 2017).

While numbers of women who use AAS are relatively small, they face additional levels of stigma within a society that is less tolerant of highly muscular women, particularly those perceived as having an

AAS enhanced physique. This stigma can even be observed within bodybuilding, as new categories attempt to reduce the muscularity of women competitors to provide a more stereotypical "feminine" appearance (McLean and Germain 2021). Physical changes due to AAS use in women are often pronounced, and potentially permanent, including masculinisation which may impact self-esteem, social life and sexual function (Havnes, Jorstad, Innerdal, et al. 2020). While men who use AAS may find sanctuary and acceptance within the gym environment, this is not always the case for women (McLean and Germain 2021), with even women's forums falling prey to "cultural manspreading", encroaching on women's forum space and causing the women's voices to shrink in response (Henning and Andreasson 2019). The complex multi-layered issues related to women who use AAS require detailed exploration, beyond the constraints of this current chapter.

In many countries including the USA (Collins 2019), Australia (Van de Ven and Zahnow 2017) and much of Europe (European Commission 2014), personal possession of AAS is illegal. However, the UK has taken a different approach, with the legislation, (The Misuse of Drugs (Amendment) Regulations 1996 SI No. 1597) controlling trafficking and supply offences but not personal possession. The rationale being, that criminalising significant numbers of otherwise law-abiding individuals would force AAS to use further underground creating barriers to health service engagement and ultimately resulting in more harm (ACMD 2010). The UK context provides the opportunity to examine barriers to service engagement, secrecy and stigma amongst people who use AAS, in an environment that is not influenced by criminal sanctions. However, despite their legal status, we will see how mistrust of those outside of the AAS community is commonplace, acting as a barrier to meaningful engagement with support services. So, while AAS use is a global phenomenon, the focus of this chapter is on the UK, drawing on research from other countries, in particular Australia, across Europe and the USA, as needed.

In reality, AAS is an abbreviation for AAS and a range of associated drugs, collectively known as image and performance enhancing drugs (IPEDs). Polydrug use has long been the norm (Korkia and Stimson 1993; Lenehan et al. 1996), with a vast pharmacopoeia reported:

anabolic agents (e.g. human growth hormone); other enhancement drugs (e.g. weight loss products); substances to treat or prevent the common side effects of AAS (e.g. tamoxifen), (Sagoe et al. 2015); and a range of new untested substances with unknown risks (Kimergard et al. 2014).

There is an established and growing evidence base of harms associated with many of the body's organs and systems including: cardiovascular; haematological; psychiatric and neuropsychologic; and hormonal and metabolic effects (Pope et al. 2014). Of growing concern is the evidence of cardiovascular harm (Baggish et al. 2017), anabolic steroid induced hypogonadism (ASIH), resulting in the absence of testosterone production (Underwood et al. 2020; Kanayama et al. 2015) and a range of mental health problems, including dependence (Kanayama et al. 2018; Havnes et al. 2019), associated with damage to structure and function of the brain (Bjørnebekk et al. 2021; Bjornebekk et al. 2019). In addition to these life-changing adverse effects there are a range of other side effects, often due to a hormonal imbalance of excess testosterone (e.g. acne, acceleration of male-patterned baldness, gynaecomastia) or low testosterone (ASIH) resulting by in low libido and depressio (Pope et al. 2014).

This chapter is based on a comprehensive review of evidence relating to stigma and AAS, incorporating the authors' recent reviews of the AAS literature focusing on factors influencing AAS decision-making, (Bates et al. 2018) treatment interventions and support services (Bates et al. 2019), and the review and synthesis of UK-based research studies (McVeigh et al. 2021). Studies within were identified that included experiences of stigma amongst people who use AAS, relating to their substance use, its causes or impacts. We considered attitudes about AAS and those who use them, representations and perceptions of AAS use, and behaviours and actions towards the individuals and communities who use AAS. We considered all sources of stigma either experienced by, or generated by the AAS communities and those who they interact with across the sociological spectrum. These studies were supplemented with a targeted search for studies exploring stigma and AAS use carried out in November 2020. We extracted relevant data into themes represented by the subheadings throughout the chapter. The findings were complimented by the authors' recent qualitative research exploring the

experiences of men who use AAS when accessing healthcare and support services (Bates 2019).

Access to Primary Health Care and Treatment

Stigma, as experienced by people who use AAS has been most commonly discussed in the literature relating to their interactions with health care providers, in particular GPs within primary care settings, and their decisions whether to access support and treatment. Not all people who use AAS will experience severe harm or damaging side effects, but many will experience some negative health outcomes likely to be attributable to, or exacerbated by, AAS use (Korkia and Stimson 1993; Bates and McVeigh 2016). It is difficult to estimate how frequently people who use AAS experience stigma or negative responses from health care providers but many share these expectations, resulting in decisions not to engage with health care (Kimergard and McVeigh 2014; Zahnow et al. 2017; Hanley Santos and Coomber 2017; Maycock and Howat 2005); or not to disclose their AAS use when seeking treatment (Dunn, Henshaw, and McKay 2016; Richardson and Antonopoulos 2019; Harvey et al. 2019).

These findings are not new, evidence from nearly 30 years ago indicated that only a minority of those using AAS told their GP that they were doing so, despite experiencing adverse effects (Korkia and Stimson 1993). This reluctance to divulge AAS use or seek help is somewhat understandable, as 6% of those who did request healthcare associated with AAS were met with refusal (Korkia and Stimson 1993). This barrier to engagement with primary healthcare continues, with more recent studies highlighting a reluctance to seek medical support (Zahnow et al. 2017; Pope et al. 2004; Bates and McVeigh 2016; Hope et al. 2013b).

Barriers and reluctance to engage with GPs and associated primary healthcare services is predominantly related to the perceptions of those using AAS, however, a small study from the USA (Yu et al. 2015) tested the extent that health professionals hold stigmatising attitudes about AAS by examining their responses to a series of vignettes. The study identified that in comparison to vignettes presenting cocaine use, bulimia nervosa

and a control condition; health professionals rated AAS use more negatively. As attitudes towards AAS amongst health professionals has rarely been studied in any depth, it is largely unclear why this situation has developed. One explanation suggested by Dunn and colleagues (Dunn, Henshaw, and McKay 2014) is the health professionals' belief that AAS use is ultimately an unhealthy *choice* and it is therefore their job to try to prevent use. Attempts to dissuade AAS use may be perceived by the recipient as a judgemental attitude and a lecture that they wish to avoid (Hope, Leavey et al. 2020a).

Research indicates that when asked how they responded to a side effect or problem associated with AAS use, 72% had simply waited for the effects to go away, compared to 5.5% who engaged with a GP or 4.5% with another health professional (Begley et al. 2017). Similarly, the Global Drug Survey indicated that the majority of people who used AAS (65%) did not seek health care in response to drug-related adverse effects (Zahnow et al. 2017). In reality, this may be the extent to which a GP may intervene in response to many of the most commonly reported side effects of AAS; however, of additional concern is this lack of trust as a barrier to engagement and its wider health and healthcare implications. Research recently conducted in Wales provides stark evidence of these barriers not just to health care in relation to AAS and associated drug use but wider health and wellbeing.

> Perceived negative attitudes of GPs, A&E staff and pharmacists inhibited participants using AAS from disclosing their AAS use or attending services for AAS related symptoms. This stigma/shame even prevented one or two participants seeking treatment for non-AAS related symptoms since they felt that staff would blame all afflictions on their AAS use and wanted to avoid a lecture. (Hope, Leavey et al. 2020a)

People who use AAS went on to describe concerns about being judged and looked down upon. They expressed the perceived unfairness that:

> …abusers like heroin addicts, are treated where the addiction is considered an illness. Steroid users ... I think are treated like it's self-inflicted, like they've brought it on themselves and they've only got themselves to blame. (Hope, Leavey et al. 2020a)

Importantly, the idea that AAS use is an unhealthy lifestyle choice or somehow morally bad, and therefore is something to be stopped, is likely to clash with the perceptions of many users that they are choosing to undertake a training and dietary regime that includes AAS use to improve their physique and feelings of wellbeing. These two extracts from the authors' interviews with men who use AAS illustrate the difficulties that some experience seeking help from their GP:

> Using steroids doesn't make you healthy but if you're eating well and training well, and using steroids wisely, then it can be a good thing. But [my GP] just said it's bad for me, you need to stop. It was really frustrating, all they could see were the steroids as the cause and like the solution too, as in stop taking them and that will solve everything. (Bates 2019)
>
> She didn't want to know about it. It wound me up if I'm honest with you 'cos I was there trying to say I've got this problem, but as soon as she heard steroids it was like, nope, can't help you, you just need to get off it and you'll be ok. (Bates 2019)

Some scholars have theorised that health professionals' poor understanding of AAS stems from the (lack of) training and guidance on how to respond to AAS and provide treatment (Yu et al. 2015). Studies have highlighted that people who use AAS frequently identify poor knowledge and understanding about AAS amongst GPs as a barrier to engaging with health care (Hope, Leavey, et al. 2020a; Zahnow et al. 2017). For example, while attempts to dissuade AAS use might be well-intended, it may be perceived as demonstrating a lack of understanding that the decision to use can be deeply ingrained or that stopping use can lead to users experiencing significant adverse effects. The reluctance of GPs to intervene or provide a referral to an endocrinologist on cessation of AAS is a further area of conflict and mistrust. ASIH can result in marked adverse effects including depressive illness and while for many this is a transient effect, returning to normal testicular function, spermatogenesis and good mental health, for some this is a prolonged or indefinite process (Tan and Scally 2009).

The belief that 'He knows more than his doctor' (Grogan et al. 2006) summarises the pervasive view of a lack of faith in health care professionals amongst this population. This lack of knowledge on behalf of the professional is sometimes due to the simple lack of available scientific evidence. Recently published reviews in relation to health management, harm reduction, treatment of adverse effects or support for the cessation of use have identified the dearth of high-quality evidence (Bates et al. 2019; Mullen et al. 2020; Harvey et al. 2019). Progress has been made in the UK with the inclusion of AAS and associated IPEDs within the clinical guidelines for substance use management (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017), however, the reasonable suggestion that practitioners provide an "explanation of some limitations in the evidence base" (Op. Cit., p. 231) will undoubtedly contribute to the common feeling that medical practitioners have little knowledge or understanding of AAS. For some, there are additional concerns associated with divulging information about AAS use due to the fear of this information being held on their medical records and potentially impacting on insurance or occupation (Hope, Leavey et al. 2020a).

Engagement with Harm Reduction Services

As with people who use other drugs in the UK, health care for people who use AAS is not only provided through interactions with primary healthcare or the treatment of adverse effects, but also through harm reduction services. These harm reduction services for people who inject drugs have been established since the 1980s, with an aim of engaging people who use drugs in treatment and needle and syringe programmes (NSPs).

Some of these services have been targeting users of AAS, with varying levels of success for over thirty years (McVeigh et al. 2003; Lenehan and McVeigh 1997; McVeigh and Begley 2017). With the vast majority of people who use AAS injecting at least some of their drugs (Begley et al. 2017), these services have been the mainstay of UK harm reduction. Most of these services are limited to the provision of sterile injecting

equipment and basic harm reduction advice regarding injection, but some NSPs have developed specialist services with a range of interventions regarding health monitoring advice together with outreach and community engagement (Henning and Andreasson 2020; PHE 2014). UK policy is clear regarding the key role that NSP should play in reducing the potential harms associated with AAS and associated IPEDs (NICE 2014; Bates et al. 2013; ACMD 2010), with NICE providing the overarching message that NSPs

> …are provided at times and in places that meet the needs of people who inject image- and performance-enhancing drugs. (For example, offer services outside normal working hours, or provide outreach or detached services in gyms.) (NICE, 2014: P15)

People who use AAS in the UK have accessed NSPs in increasing numbers over the past twenty years and now constitute the largest client group in many areas (Kimergard and McVeigh 2014; ACMD 2010; McVeigh and Begley 2017). However, the proportion of this population who access services is unknown and there is evidence that many rely on others to collect their injecting equipment rather than attend a service themselves (Glass et al. 2018). Furthermore, with a readily available and affordable supply of injecting equipment available via the internet or provided by their AAS supplier the reliance on NSPs for sterile injecting equipment has diminished over the last 30 years.

For those people who use AAS that do attend NSPs there is often a reluctance to engage with staff (Harvey et al. 2019; Hope, Leavey et al. 2020b). Echoing criticisms of GPs and primary healthcare, people who use AAS have raised concerns regarding a lack of understanding of AAS use amongst NSP staff (Hope, Leavey et al. 2020b; Harvey et al. 2019). These findings are not unique to the UK, in Australia a key concern for NSP staff is their limited knowledge on this specialism (Dunn, McKay, and Iversen 2014), with this variability in knowledge, competence and confidence also being common in the UK (Kimergard and McVeigh 2014). An additional factor originating in Australia is the view that within a resource scarce environment, people who inject psychoactive drugs should be prioritised for NSP services before those who inject AAS

(Van Beek and Chronister 2015). This has been countered in the UK on the grounds of the identified prevalence of blood borne viruses within this population, supported by national policies and guidance from the National Institute for Health and Care Excellence (NICE 2014), Department of Health (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017) and Advisory Council on the Misuse of Drugs (ACMD 2010). However, it is unknown to what extent that the message "NSPs are not really being for people who use AAS" has been picked up by a well-informed, networked population. It is also plausible that the view regarding NSPs being for people who inject psychoactive drugs is present amongst at least some services within the UK. These feelings of not being the primary target population for NSPs may have contributed to feelings of being unwelcome.

The Stigma of Psychoactive Drug Use

Since the first comprehensive research in the UK in the 1990s people who use AAS have raised concerns regarding engagement with services designed for people who use other drugs (Korkia and Stimson 1993; Lenehan et al. 1996). There are obvious differences between those attending NSPs who use AAS and those seeking equipment for the injection of psychoactive drugs, including the specific drugs of use, the mode of injection (intramuscular rather than intravenous) and the motivations for use (Begley et al. 2017; Public Health England 2020). Beyond this people who use AAS are more likely to be employed, have stable accommodation and overall, better physical and mental health (Whitfield et al. 2019). Studies have shown that people who use AAS distinguish themselves from people who use other drugs and do not want to be associated with those who they consider to be stereotypical "*drug addicts*" (Hanley Santos and Coomber 2017; Harvey et al. 2019). Some do not want to be perceived as having a drug "problem" or addiction, and find it stigmatising to be seen as a "drug user", themselves, a theme we shall return to. The following extract demonstrates how one man who used AAS interviewed by the authors felt stigmatised attending drug services and the stigmatising attitude held towards people who use opioids:

> It's not people I really want to be seen with, it's (the service) not exactly hidden away so people can see you go in and out. They can see me in there with, you know, junkies and whatever. You'd want to wear a sign that says "I'm not like that", you know? 'Cos I'm not. You just don't want to go there and have that label on you. (Bates 2019)

The antipathy of many who use AAS towards people who use psychoactive drugs may have implications on service engagement amongst clients (or potential clients) who themselves use psychoactive drugs and is currently an under researched area. It is further complicated by the crossover between the two forms of substance use. Research in the UK has indicated that levels as high as 46% of people using AAS had also taken cocaine in the previous year (Hope et al. 2013a). Concomitant use of psychoactive drugs, in particular stimulant use, is by no means limited to the UK (Zahnow et al. 2020). In The Netherlands 23% had used cocaine in the previous 3 months (Smit et al. 2019), while in Australia more than half had recently used a psychoactive drug, with cocaine being the most popular (Van de Ven et al. 2018). In Norway, this crossover between substances of use has been further identified with 36% of men receiving treatment for psychoactive drug use, also reporting lifetime AAS use (Havnes, Jorstad, McVeigh et al. 2020). However, this subgroup of people who use AAS is in stark contrast to those who perceive their AAS use as a natural progression from nutritional supplement use to enhance physique (Boardley 2019).

Stigma from Within the AAS Population

For some, another source of stigma may be other people who use AAS. In recent UK studies, participants referred to a "new generation" of users as being different to themselves (Richardson and Antonopoulos 2019; Bates et al. 2021). These younger users were believed to use AAS out of a desire to cut corners to achieve their ideal physique quickly without working hard for it. It is ironic that AAS research published in the mid-1990s identified the same theme (McVeigh 1996). Gym owners across the North West of England identified the increasing use of AAS by young

people who lacked even the basic knowledge related to appropriate use and potential harms as being a major concern. It is unknown as to the proportion of young people who discontinued use or who continued into maturity and are now middle-aged, experienced users with concerns about young people.

The Demonisation of People Who Use AAS

Griffiths and colleagues (2016) theorise that public stigmatisation relates to how some people find it difficult to empathise with individuals who experience body image or appearance issues. They are unlikely to see body issues as serious concerns that justify the use of AAS. Some scholars have suggested that negative portrayals of AAS in the media may contribute towards stigmatising attitudes towards those who choose to use them by reinforcing unfavourable stereotypes and misinformation (Maycock and Howat 2005; Richardson and Antonopoulos 2019). The belief that AAS use causes violence has been pervasive since the 1990s, despite the relatively weak statistical association between these drugs and aggression (Chegeni et al. 2019). While the potential link between AAS dependence and aggression linked to structural changes to the brain has been hypothesised, it is accepted that antisocial personality traits are an important mediator. The AAS causation of violence is far from clear, however, recent journal papers such as *Anabolic–Androgenic Steroids, Violence, and Crime* (Pope et al. 2021) and *Anabolic steroids and extreme violence: a case of murder after chronic intake and under acute influence of metandienone and trenbolone* (Aknouche et al. 2021) do not necessarily portray these uncertainties and media reports of spontaneous steroid-related violence, termed "roid rage" continue to be published (Roberts 2010). The last decade has seen attempts to attribute some of the most heinous premeditated acts of terror with the use of AAS: "*London Bridge terror attackers 'took steroids' before incident*" (BBC News 2018), was subsequently dismissed by the leading toxicologist as inconsequential in relation to the violence (ITV News 2019). While the media reported the AAS use that presaged the atrocities committed by Anders Breivik in 2012 (Associated Press 2012), a more measured assessment

stated that AAS "*did not directly cause, mental symptoms*" (Melle 2013), went largely unreported. The impact of this AAS demonisation on public opinion is unknown. However, these reports contribute to the perceived stigmatisation of people who choose to use AAS.

The Perceived Stigmatising Effect of Research

There have been concerns raised from academics and those within the AAS using communities that the mainstream scientific and health research approach to the use of AAS has contributed to misrepresentation and stigma (Underwood 2019; Van de Ven and Mulrooney 2019; Mulrooney et al. 2019). A belief that the harms associated with this form of drug use have been exaggerated while the non-problematic use associated with benefits such as pleasure, increased self-esteem enhanced feelings of wellbeing have been largely ignored. Furthermore, research has contributed to this stigma by depicting people who use AAS as either deviant, dysfunctional or damaged. The "anti-doping" agenda that aims to eliminate AAS use in competitive sport may have influenced public opinion and has certainly influenced research, focusing on AAS prevention amongst young athletes and in school settings. Research has drawn on anti-doping efforts and promoted ideas about AAS use as immoral, undesirable or unethical (Brand and Elbe 2012; Mulcahey et al. 2010; Barkoukis et al. 2016). However, anti-doping morals and ethics have little in common with public health approaches and may misrepresent the nature of decision-making that people who use AAS make, contributing to negative assumptions about their choices as something that needs to be corrected. Additionally, researchers have used the potential for health harms to justify the need to take action, but in highlighting the excesses of the most extreme users (e.g. the quantity and variety of drugs, injection risk behaviours), and encouraging the attitude that AAS use is somehow "bad"(Underwood 2019), they may have alienated those who do not associate their AAS use with these high risk behaviours (McVeigh 2019; de Ronde 2018) undermining the public health response.

Since the publication of research that identified HIV amongst users of AAS in the UK (Hope et al. 2013a), there have been a number of subsequent investigations and publications focused on HIV infection (Hope et al. 2016), hepatitis C (Hope, McVeigh et al. 2020) and injecting risks (Hope et al. 2015). While authors stated that it remained unclear how HIV had been contracted and that sexual contact and prior psychoactive drug injection played a probable role, there were some vocal members of the AAS community who felt that the findings misrepresented the risks associated with the use of AAS and contributed to the stigma felt by this population (Underwood 2019). While the research was both rigorous and significant, the diverse populations of people who use AAS, as identified in recent work developing a related typology (Zahnow et al. 2018; Christiansen et al. 2016), means that for some, the findings are an unimportant, negative distraction and just the latest "*scare story*" that drove the use of AAS further underground (Underwood 2019). The issue of HIV followed other unwanted research such as the muscle dysmorphia work originating in the 1990s (Pope et al. 1997), in which those with a distressing preoccupation turn to AAS to self-medicate their disorder. While sections of the AAS using communities do not recognise this model, it is relatively recently that the research community have looked to challenge it (Settanni et al. 2017; Sandgren and Lavallee 2018; Mulrooney et al. 2019).

These disputed foci of research should be viewed within a historical context. For many years the scientific and medical community dismissed the effectiveness of AAS as an enhancement drug. Despite clear indications to the contrary both the British Association of Sports Medicine (BASM) and the American College of Sports Medicine (ACSM) position statements of the 1970s had denied the potential benefits of AAS (Taylor 2001) describing it as a "fool's gold" (Pampel 2007) with no aid to athletic performance (Goldman 1984). While these statements engendered mistrust of the scientific community, the unfounded links made between AAS and Nazi Germany were far more insidious and potentially stigmatising. These unfounded rumours appeared in the scientific literature in the 1970s (Wade 1972) and were repeated by various academics (Taylor 1991; Houlihan 1999) despite a lack of evidence. This demonisation through association with the dictatorship of Nazi Germany has

contributed to the negative reputation of AAS and those who use these drugs (Baker 2012; Reinold and Hoberman 2014).

Recent typology work (Christiansen et al. 2016; Christiansen 2020; Zahnow et al. 2018) may have unwittingly supported the notion that amongst the AAS using population there is a sub- group that is ill informed, risk-takers, responsible for the majority of harm associated with AAS use and are therefore stigmatised. While the data supports the typology structure, it may be convenient to scapegoat the sub-group of young risk-takers: The YOLO type (You Only Live Once) attributing the excesses and harms to one section of the community who are young, inexperienced and ill informed. While there may be some elements of truth in this, it is an over-simplification that cannot incorporate many additional factors such as the relatively short AAS careers of many within the "YOLO" category. The key evidence-based harms in relation to cardiovascular disease, cognitive function, ASIH and dependence are, after all, linked to long-term use of the committed members of the community rather than the haphazard hedonistic use of the ill informed.

Stigma from the Public

Evidence of stigma from the public is mainly based on interviews with people who use AAS, with some recounting negative experiences or judgemental attitudes of the public (Hope, Leavey et al. 2020b; Maycock and Howat 2005). There is little evidence on how the general population perceives AAS or those that use these substances, however, one study with university students in Australia (Griffiths et al. 2016) levels of stigma towards AAS at a greater level than cannabis, and comparable to cocaine and heroin.

It has been reported that other weight trainers can consider AAS use to be a form of cheating (Richardson and Antonopoulos 2019; Hope, Leavey et al. 2020b) and therefore something to be looked down upon, perhaps the further influence of the anti-doping agenda. Studies have highlighted that people who use AAS feel that their practice is poorly understood by non-users who do not appreciate the dedication and hard work that is part of their fitness regimes, instead the public is encouraged

to adopt the stigmatising vocabulary of "*clean*" and "*dirty*" athletes used within discourses on doping control (UKAD 2021). The public may hold negative stereotypes about AAS, possibly fuelled by media portrayals that contrasts greatly with how someone who uses AAS views themselves. The perception that using AAS is unhealthy may be at odds with how many consider their AAS use or their own self-image as someone who is interested in and trying to improve their health and fitness:

> I wouldn't say I'm at risk. I'd like to think that I'm doing good for my health by doing this, that's what it's all about. I know what I'm doing and I know how to do it well. (Bates 2019)

To avoid experiencing stigma from others, some people who use AAS may resort to strategies such as changing their friendship networks to hiding their AAS use from friends and family (Maycock and Howat 2005). We can only speculate on the impact on social and mental well-being from adopting such approaches and feeling judged or stereotyped by others, particularly amongst individuals who may already have low self-esteem, body image issues and mental health conditions.

Conclusion

The issue of stigma and AAS is complex, with evidence indicating that people who use AAS are highly stigmatised. Moreover, people who use AAS may stigmatise people who use other drugs (despite high levels of their own illicit drug use) and even sections of their own communities. Public opinion is clearly influenced by an often judgemental media and the anti-doping rhetoric of cheating and the regular headlines relating to AAS and violence.

There are tensions within the AAS using communities. For many, there is a wish to engage with supportive health-related services. This may be to address a wide range of issues, from transient adverse effects that are reasonably straight forward to treat through to complex and chronic issues such as ASIH or mental health issues including dependence. However, there remains an enduring stigma in engaging with

these services which address these problems. While some of the negative perception of this population that is directed towards health professional may be justified, the lack of available scientific evidence to support the treatment of people who use AAS is perhaps the greatest barrier to effective engagement. Clearly, research will play its part in improving the current situation, however, this research must effectively engage with the target population at all stages of studies and be sensitive to the needs of all people who use AAS.

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Navigating Custodial Environments: Novel Psychoactive Substance Users Experiences of Stigma

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Introduction

There are over 700 varieties of Novel Psychoactive Substances (NPS) in circulation globally that are being tracked by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2021). These NPS are monitored for levels of harm through 'event-based data, toxicovigilance, signal management, and open-source information' and, depending on results, varieties of NPS can be subject to intense monitoring and public health alerts (EMCDDA 2021). NPS are synthetic,

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plant-based substances that mimic the drug-induced effects of traditional illicit substances categorised as depressants, stimulants, cannabinoids, and hallucinogenics (Evans-Brown and Sedefov 2017; Zawilska and Andrzejczak 2015; Winstock and Wilkins 2011). They are usually mass produced and can quickly be adapted by altering the chemical formula slightly to circumnavigate drug control laws and crime prevention strategies—so much so that as soon as a variant is identified by law enforcement organisations there are usually already several other variants prepared ready for distribution (Zawilska and Andrzejczak 2015). This amoeba like characteristic to NPS is further compounded through aggressive modern marketing techniques that utilise branding, imagery, and colourful packaging, to further complicate the tracking of derivative versions of NPS (Addison et al. 2018). Names such as Pandora's Box, Pandora Returns, Pandora's Explosion (in the UK) imply an association to the original 'Pandora' stimulant but certainty about the 'type' and toxicology of substance acquired is ambiguous to say the least (Winstock and Wilkins 2011; White et al. 2019); with some varieties been found to have traces of heroin, rat poison, or bulking agents (White et al. 2019; Addison et al. 2017).

NPS can be ingested by injecting, smoking and via liquids; they are particularly problematic because of the fluctuating levels of potency, quantity, and frequency of use (Addison et al. 2017; White et al. 2019). In light of the complexity surrounding NPS and the people who use these drugs, managing and controlling NPS presents a complex set of challenges to health and social care providers, emergency services, and staff working in custody settings. Arising out of this context, the aim of this chapter is to discuss the everyday experiences of people who use NPS as they try to navigate different custodial settings: a busy city centre police custody suite and a Category C prison both based in England. In particular, we focus on how staff construct understandings of NPS users through mechanisms of stigma, and how this creates a barrier to healthcare for these individuals.

In England and Wales until May 2016, NPS were legitimately available to purchase in 'headshops' found on local highstreets, as well as in petrol stations and takeaway shops (Addison et al. 2017; Irving et al. 2015). People who used NPS crossed the social spectrum, attracting

individuals who were curious and were first time users, as well as more experienced people who were looking to try, or switch, to the latest psychoactive substance. The social and health-related problems surrounding NPS have been well documented: they tend to be much stronger (White et al. 2019) cheaper, easier to access, and linked to low-status volume crime (Home Office 2016). Reports from Accident and Emergency Units, as well as police and prison custody, highlighted unpredictability and violent behaviour as presenting factors of individuals who had consumed NPS (White et al. 2019; Home Office 2016). As such, the Novel Psychoactive Drugs Act came into force in 2016 making it illegal to produce, sell or distribute NPS to others, or possess NPS in custodial settings (HM Government 2015). NPS are now controlled as Class B substances and can lead to a maximum sentence of 5 years for possession, 14 years for possession with intent to supply, or a maximum 14 years for supply and/or production (HM Government 2016). This has generally been enough to deter a large swathe of the population who might have been tempted to try NPS out of curiosity and perceived 'legitimacy' (Addison et al. 2017) as a 'legal high.'

However, a vulnerable subset of the population who were already established users (for example amongst: street homeless, prisoners, and those in temporary accommodation), in particular, continue to use NPS despite changes in legislation in England and Wales, precisely because NPS are cheaper and stronger than more traditional illicit substances like cannabis, heroin, and ecstasy (Addison et al. 2018). Dame Carol Black's most recent independent review of drug use in England and Wales (2020) shows that drug-related deaths amongst 'rough sleepers' are now at the highest since records began. DrugWise (2021) highlights that NPS can now be acquired illegally through shops and the internet (i.e., *Dark Web*) more so than any other illicit substance. Black (2020) also reports how long-term drug use is highly correlated to poverty, and that dependent drug users move in and out of prison settings with little scope for success in recovery or achieving meaningful employment.

In the current social climate, the Office for National Statistics (ONS 2020) report on Drug Use in England and Wales year ending 2020 that around 115,000 adults had used NPS in the last year, with 71% of these people aged between 16–24 years old. ONS go on to report that this is

a far greater percentage of young people who use NPS compared with other drug types: cannabis: 45%; powder cocaine: 38%; ecstasy: 54%. With the loss of many protective factors (such as stable employment, social capital, and investment in health and social care services), Black reports that the current social context in England and Wales, where the 'cost to society of illegal drugs is around £20 billion per year, but only £600 million is spent on treatment and prevention' (2020: 3), and to which we would also add the parallel pandemic of COVID-19 and existing health inequalities (Bambra et al. 2021), culminates in the 'perfect storm' impacting on the most vulnerable and marginalised in society.

In this chapter we focus on mechanisms of stigma inflicted on users located in custody settings, which we frame as part of the dynamism that keeps this 'storm' increasing in volatility, to show how stigma can have harmful and painful outcomes for vulnerable individuals and can translate into barriers to health and social care services in these settings. Custody environments are highly pressured and controlled spaces, depending on regimen, structure, and adequate resourcing to function properly (Addison et al. 2017, 2018; McGovern et al. 2020). Our research shows that NPS had a striking effect on both police custody and prison environments, which we discuss in our findings. The Chief Inspector of Prisons warned 'Synthetic cannabis is "destabilising" some UK prisons and the situation amongst inmates is getting worse, not better' (BBC News, 2016). We discuss the stigma associated with substance use, in particular, the way in which NPS use is recognised, understood, and managed by staff working in the criminal justice system. To do this we draw on research findings from two qualitative studies from 2016 and 2018 which included interviews with staff from a busy city centre police custody suite and a Category C men's prison. We focus on the custody environment in particular because of a high density of NPS users, and propensity to try to use, as well as the opportunities and failures to act upon 'teachable moments' (Addison et al. 2017) to intervene with NPS usage.

Theorising Stigma in the Context of NPS Use

In this section we discuss mechanisms of stigma that situate people who use NPS as 'revolting subjects' (Tyler, 2013), and how these operate within and through distinctions made to other kinds of substances and the people who use them, for example heroin and alcohol. Stigma attached to NPS use is particularly wounding in the current social context because (i) people who use NPS tend to be already highly vulnerable, experiencing marginalisation and multiple co-occurring stressors (Winstock and Wilkins 2011; Chang et al. 2016), and (ii) NPS is perceived as a low-status drug, located at the bottom of a moral economy of drug use (Wakeman 2016; Addison et al. 2018).

Goffman (1963) sets out the structural preconditions of stigma; of particular interest to our research is the stigma directed towards those inferred as having *'weak will'* due to their use of drug use and/or addiction: for Goffman this person is viewed as 'less' by others, they are tainted, or discounted. Stigma can be seen as a negative social response to a perceived flaw and involves mechanisms such as labelling, stereotyping, separation, and discrimination (Stuber et al. 2008; Link and Phelan 2001). These mechanisms can be deployed by those of higher social position to create and maintain a downward comparison to stigmatised individuals/groups. This legitimates and perpetuates social control and a need for separation between 'us' and 'them.' In Goffman's work, stigmatised populations include those with mental health challenges, people who have offended, and drug users; notably, the degree of social disapproval towards drug addiction is high. Using data from across 11 countries, Room (2005: 4) highlights that the attitude amongst the general population towards perceived drug addicts shows more disapproval and stigmatisation than towards those who have a criminal record for burglary. Furthermore, both drug addiction and criminal record for burglary were met with greater social disapproval than chronic mental health disorders, homelessness, and unemployment (Room 2005: 145).

This social disapproval goes further—Goffman argues that once a person is reduced in the mind of another they are dehumanised and discriminated against: 'the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which

we effectively, if often un-thinkingly, reduce his (sic) life chances' (1963: 14). There is a relationship between the person who is stigmatised and the one doing the stigmatising in that attributes are defined as 'undesirable' depending on the other person, and also in relation to place, and space. Stigma is repeatedly directed towards people who use drugs or have committed a crime because these are seen by the general public (and also within the criminal justice system in England and Wales) as having made a 'rational *choice*' to do so; the person has either weighed up the perceived benefits and risks or is too 'weak willed' to stop themselves from doing so. This rhetoric of the agentic, choosing individual is dominant in neoliberal society, despite evidence to show that other social determinants such as employment, housing, education, and access to healthcare are influential in the everyday lives of people—widening social inequality and actually constraining 'choice' (Bambra 2016; Garthwaite et al. 2016; Addison et al. 2019). Dame Carol Black's recent review of drugs reports (2020, 2021) specifically highlights a link between poverty, drug use, and subsequent criminal behaviour demonstrating that the pervasive and stigmatising construction of drug users as people who make 'bad choices' is problematic, misleading, and harmful.

Alongside the continued increased level of drug use, there is also the problem of stigmatisation from wider society. Goffman's (1963: n.p.) notion of a 'spoiled identity' i.e. disapproval from society, can be used to understand the stigma people face when entering the criminal justice system and gaining the label of a 'criminal.' This can go one of two ways; it can deter people who have offended from facing further stigmatisation by avoiding the temptation of taking drugs, with some frequently taking an oppositional stance against using NPS, such as 'spice' (Addison et al. 2017). Goffman (1963: 19) argues that stigmatised people strive to adjust their perceived spoiled identity to gain a new social identity, which offers normal 'acceptance.' The other option is accepting that their identity is already 'spoiled' and consuming drugs as a result of this, or alternatively, giving into the intense pressures of being incarcerated for which the drugs offer some relief: 'spice' is often referred to by prisoners as 'bird killer' ('bird lime' is Cockney rhyming slang for 'prison time') in that they believe it helps their sentences go faster by relieving

the boredom of prison life and inducing relaxation (Baker 2015; User Voice 2016).

Unsurprisingly, there is a significant level of stigma towards people who use drugs from the wider public. This stigma takes a variety of different forms; to begin with there is a large amount of opposition to public policies aimed towards helping people who are addicted to drugs, compared with policies aimed towards helping people with mental illnesses, reflecting the negative attitudes towards drug addicts (Barry et al. 2014). Sympathetic views may result at least in part form societal ambivalence about whether to regard substance abuse problems as medical conditions to be treated or personal failings to be overcome. Addiction is often viewed as a moral shortcoming with the illegality of drug use reinforcing this. It is likely that socially unacceptable behaviour accompanying drug addiction (for example, reckless behaviours and crime) heightens society's condemnation. For instance, upon entering the prison setting, prisoners are subjected to negative social evaluation from the wider public (Room 2005) due to the 'criminal' label being condemned by the rest of society for being outside of societal norms and values. This marginalises and excludes prisoners from the rest of society and, arguably, leads to people who use drugs seeking out similar others to form a supportive counterculture and consolidate social capital. For Room (2005), this counterculture is a form of 'secondary deviance' which further marginalises people who use drugs.

The level of social disapproval experienced by people who use drugs is also dependent on the type of drugs taken, for instance—heroin use is more stigmatised more than cannabis use (Wakeman 2016). NPS use appears to rank 'lower' than other types of drug use and attract more social disapproval—including amongst other drug users (Addison et al. 2017; Ahern and Galea 2006; Chang et al. 2016). Press portrayals of 'spice zombies' as 'threatening' or 'disgusting' presences both dehumanise and ignore the complexities of the user's life: equating 'drugs' with personal failure whilst simultaneously ignoring any structural inequalities, such as poverty, material deprivations, and social injustice (Stockdale 2017). This, in turn, desensitises the public's opinion towards the systemic, symbolic, and sometimes physical violence

directed at them. Olsen et al. (in Room 2005) reported that respondents from their survey felt that illegal drug users, tobacco smokers, and 'high' alcohol users should all receive less priority in health care; often believing that users behaviour contributed to their own illnesses. Barry et al. (2014) concluded that people were more likely to view discrimination against persons with drug addiction as 'not a serious problem,' compared with discrimination against persons with mental illness (63% vs. 38%). Research suggests that when substance users do seek care, they often experience discrimination in health care settings and the quality of care received is less than a non-substance user would receive (Miller et al. 2001; Chang et al. 2016). This idea is perpetuated through society and often this marginalisation can affect NPS users' health status by preventing them from accessing the healthcare they are entitled to: this can lead to the exclusion of substance users from public service provision (Room 2005).

Imprisoned persons are frequently stigmatised by the criminal justice system and the wider public, but they are often subjected to stigma from fellow prisoners and detainees too. This can include those inmates who use and do not use drugs. As users often experience stigma from one another, due to different drugs having their own level of social acceptance, creating a hierarchy between users (Palamar et al. 2012). For example, steroid users have been noted to stigmatise the use of psychoactive illegal drugs because such substances are used to get 'high' instead of a means to improve health and physical fitness (Simmonds & Coomber 2009; Monaghan 2002, as cited in Palamar et al. 2012). In 2015, The Ministry of Justice introduced a 'crackdown' on NPS supply and use in prisons, involving new penalties for prisoners who use these substances. This compounded the ideology that drug addiction is a *choice* and that users merely 'lack self-control' (Room 2005: 8); creating a wider societal symbolism of deviation, which is seen as a sign of character weakness to the wider public. This, combined with the criminalisation of drug use in England and Wales, reinforces the assumption that prisoners and detainees make rational choices through calculating the increased risk of punishment. These problem representations perpetuated by government bodies, reinforces the stigma and shame around drug addiction, with the government historically implementing 'just say no' policies

on drugs, rendering drug use socially unacceptable and reinforcing the idea that addiction is rooted in 'bad choices' rather than structural and systemic inequality. These ideas are propagated despite drug addiction being classified as a health disorder, similar to various other chronic diseases (Room 2005). It can be said that the state 'weaponises' stigma (aided by political and media voices) to point at the supposed 'moral deficits' of those deemed culpable for their own 'troubled and troubling' condition (extreme poverty, lack of shelter, disability, work incapacity, migration status etc.) (Tyler 2013, 2020; Crossley 2018) and deflect collective responsibility towards the individual.

Methodology

This chapter builds on research findings from two qualitative projects within one police force with a busy city centre and suburban custody suite, and one prison identified as having 'very serious issues' in relation to NPS which impact on the health of prisoners, the safety of the prison, and are framed as a drain to local resources e.g. the ambulance service (HMP Inspectorate Report, December 2015). Whilst the findings might not be generalisable across custody this is an opportunity to discuss emerging themes in relation to the impact of NPS on custody staff and mechanisms of stigma.

Both project's data collection took place after the Psychoactive Substances Act was enacted in May 2016. The police custody project took place June–September 2016 and involved qualitative, in-depth, face-to-face semi-structured interviews with 25 NPS users & 15 police staff. Police custody staff were invited to take part via email and recruitment leaflets, interviews took place in the police custody suite and their time to take part in the research was supported by senior officers. The prison project took place from April–August 2018 and involved semi-structured interviews with 10 NPS users & 13 prison staff. Prison staff were recruited through the Head of Reducing Reoffending and the Head of Drug Strategy and Healthcare Provision and were drawn from a range of roles: six were prison officers, five had supervisory/managerial roles, and two were strategic head of functions.

The interview process was structured via topic guides, with any emergent issues explored further in subsequent interviews. All participants were provided with detailed information about the study and gave informed consent. Participants had the right to withdraw from the study for 28 days after the interview took place. Anonymisation took place at the transcription stage and all names removed. It is important to note that for both studies the police and prison staff are describing interactions with people who they *believed* to have taken NPS. All interviews were audio-recorded and fully transcribed and the narrative accounts were used to enable a thematic analysis of key issues for participants.

Findings

Custody Staff Perceptions of NPS Users

In our studies prison and police custody staff often demonstrated experience and familiarity with how to manage and interact with people who used more traditional illicit substances like heroin and cocaine, as well as licit substances like alcohol. When asked about their perceptions of people who use NPS custody staff highlighted a particular gap in their knowledge and experience which impacted their confidence to interact with NPS users—they were unsure what substance had been consumed or what the effects would be. There did not appear to be a distinct 'type' of user: 'there doesn't seem to be any sort of like rhyme nor reason nor age' [Prison Officer 02].

Whilst it was noted that some users might not be 'typical' or dependent drug users, the majority were described as engaging in long-term alcohol and drug use (typically polysubstance use).

> They're generally not people that we haven't seen before. There's very few, in my experience [detainees new to custody]. Because of legal highs, I would think it tends to be those who are more prone to offend while on drink or drugs anyway. [Police Custody Sergeant 02]

Custody staff felt that prisoners and detainees were motivated to use NPS because they were cheaper or more easily available. Staff did not perceive NPS to be a primary drug of choice *per se*, rather, users were viewed to consume NPS out of desperation to alleviate withdrawal, boredom, and mental health issues:

> they're just generally using everything … everything they can get their hands on. Well, any street drug. [Police Custody Detention Officer 07]

Prison officers noted a difference between people on their wing who took NPS and those who did not take substances or took substances other than NPS. Interestingly this officer describes the difference when a prolific user of NPS stopped using the substance, noting the difference after they have been 'clean' for four weeks:

> Prison Officer Head of Function 06: he's a bit of a success at the moment … it's real good to see, and even he thinks that he's in a lot better place, yeah, he looks like a person should look, he's not all dishevelled, unshaven, unwashed, clothes dirty, he's a proper human being, so to speak. You know, he gets up in the mornings, he has a wash, he has a shave, he puts clean clothes on, and he takes pride in the fact that he's cleaned his cell, and you know that he's nicely turned out.
>
> Researcher: are [you saying] people who are using NPS, they don't take that care about their appearance, or their cell ...
>
> Prison Officer Head of Function 06: No [they don't], not in any way, they're completely unshaven, they lose weight, they don't care about how crumpled and dirty their clothes are, um a majority, because of the fact they've been found to have been under the influence, they haven't really worked so all they do is lay in their bed all day, and when you try to get them interacting with the drugs workers, doing an awareness course, but if they are so far down, they just are not interested … and it's trying to get through to those people, that we have to, we get through to some, but you'll never get through to them all.

In the conversation above it is noteworthy how the prison officer describes the change in the person since stopping using drugs, that they were more like a 'proper human being' when 'clean' of the substance. On

clarifying this the prison officer describes users as being 'so far down' and describes both their 'dirty' physical appearance as well as a 'lazy' attitude and being uninterested in interaction with support workers as evidence of this.

Pressure Cooker: Resentment from Staff

The environment within police and prison custody was highly pressurised. Staff were dealing with prisoners and detainees who presented multiple complex needs as well as unpredictable and volatile behaviour. The staff had a duty of care to keep all inmates and detainees safe and secure by following protocols and procedures which staff recognised, however, both police custody and prison staff described resentment towards the impact that NPS use had on their daily routines; the additional stress and strain it placed on an already difficult role operating in conditions where resources were already overstretched:

> They've no concept quite often of where they are, who they are, no matter about where they are, or what they're doing or why, and they don't understand the process and they are constantly wanting or needing something if they're not self-harming or tying things round they're neck, things that need urgent attention … there seems to be a cycle of questions and cycle of neediness, they don't want to be left they want someone to be there to talk to all the time. Unfortunately we don't have the time to sit with them all day, in some ways it would be pointless because you having the same old conversation, it's a loop, they ask the same old questions you give the same old answers, goes round and round and round and that's just the state there in at the time, they just can't get out of the cycle of what there thinking, and that's obviously the effect, they're not coherent … they do take up a lot of time. [Police Custody Detention Officer 15]

Prison staff discussed dealing with prisoners who had used NPS and needed attention drew attention to how NPS created disruption to prison life and routines. Staff describe being stretched and fatigued from what was a time-consuming interaction, frequently impacting on their scheduled breaks, and adding to their daily duties:

> Yeah, umm ... as a damned nuisance – it's usually when I'm on ground patrol, and I'm just enjoying a cup of tea, and a break, and it's Code Blue [difficulties breathing] … we go down to workshop … and this was the one that was being awkward, we thought, we're gonna have to summon some more staff in a minute if we want to get him back to his [cell] … and they [the other prisoners] were all laughing at him, and he was playing the goon … then he came 'round enough, to see a bit of sense and we were actually able to walk him back to the wing so umm … I find … when I see them like that, I don't fear they are going to come to any harm uhh, they may be a nuisance, but we're gonna get him back to the wing, put him in his cell, somebody else will do the paperwork, job done. Umm, but when it gets a bit of a nuisance … I don't exactly lose patience with them [but I have the thought] "oh it's another blessed one of these things, I'm sick of these things". [Prison Officer 04]

NPS use, unlike other drugs that may be used in prison and police custody, produces unpredictable reactions amongst individuals. When prisoners or detainees had consumed NPS any adverse reactions had to be prioritised by custody staff to prevent them coming to serious harm—the importance then of managing reactions to NPS outstripped that of other drugs. This is demonstrated in a discussion with a prison officer who noted that even though they might get a 'whiff of cannabis' as they walked the landings, they knew that the user was unlikely to have a reaction or need help. In contrast, NPS users' reactions could be unpredictable, and they typically needed an urgent response due to difficulties in breathing (code blue), as highlighted here:

> yes, I think, the only real noticeable difference is, with NPS, you can't ignore it ... if there's a Code Blue … then everything stops, sometimes it's very disruptive to the normal regime. [Prison Officer 04]

Similarly for police custody staff, NPS use is seen as more labour intensive due to the behaviour of the person who had taken them:

> I mean, we've got a duty of care to make sure they're safe, and that's the real problem. If they are being violent, we can just shut the door and leave them in there to monitor them on CCTV; that's not a problem. We get

> that quite common with drugs. The problem comes if they start harming themselves; if they tie things around their neck, or bang their heads on the wall, or even fall over by accident, then we have to enter the cell and stop it – untie whatever's round their neck, or stop them banging their head – that's when it becomes a problem, because it puts officers and staff at risk. It's also resource intensive; we might have to handcuff them, we might have to leave an officer with them on close proximity supervision, and it's just very resource intensive. And it's possibly dangerous for us, and dangerous for the individual that we're trying to restrain'. [Police Custody Detention Officer 02]

For many staff, both across police and prison custody, watching the way a person behaved when taking NPS—and noting a transformation from a 'placid and polite' person to someone different when they used substances. This prison officer notes the consequences when there was a medical emergency with the person in their care often had a long-lasting impact on staff:

> I've seen people here, a prisoner who has been normally quite placid and polite to staff, swearing, fighting staff, even when there might be four or five staff there with them, for their own safety, um, that they still want to fight. I've had one instance [I attended] and they were just about to get the de-fib [defibrator] machines, because they thought he had gone into cardiac arrest ... there were hardly any pulse. It was, it was very serious at that point, thankfully he started then to, sort of, recover a bit … but he came so close to death that day and I think it's one of those things that I'll never forget about it. [Prison Officer Head of Function 06]

Mechanisms of Stigmatisation: The Agentic, Rational Actor

Staff from police and prison custody were under mounting pressure to do more with less and saw NPS users as a serious drain on their time and already overstretched resources. Staff felt unhappy, angry, and at times resentful, towards NPS users as a result. Many prison and detention officers saw NPS use as a rational and free choice made by the individual, and thus felt justified blaming and stigmatising people who did use NPS

that could potentially have serious health side effects. Staff rarely understood motivations for drug use generally, and NPS use was considered baffling. Many of the staff framed their stigmatisation and resentment towards NPS users via a logic that predicated that if people did not use NPS then the circumstances within the custody settings would not be so fraught and this would alleviate pressure.

Some detainees were described as 'addicted' to NPS; however, a number of custody staff were dubious about its addictive potential and drew upon a rhetoric of 'rational choice' instead:

> We've got a couple of lads that come through who are addicted to legal highs, or that they tell us they're addicted to legal highs. Whether you can be addicted to whatever is in these, I don't know. I guess you probably could if you're taking them as frequently as that. [Police Custody Detention Officer 01]

At the time healthcare advice was that these substances were not addictive and so there was little support for the rehabilitation of users. However, this information was conflicting with real life experience from staff dealing with users who were witnessing what looked to be signs of withdrawal. This detention officer describes the complexity around this—they are witnessing someone in pain, unable to help with the physical symptoms of withdrawal. Whilst feeling sorry for the person, the officer also discloses that they think the NPS user has brought it upon themself:

> from the drug rehabilitation side of it, they don't see legal high as an actual drug to be addicted to but that's serious cos you see the rattling signs, the sweats, the shakes, the pains they go through … the ones who are genuinely serious you can see the pain they're in, and as much as they say we're not human, we are human and you do feel really quite sorry for them, even though they've brought it on themselves. [Police Custody Detention Officer 14]

Within a prison environment it was also seen as a choice, although some staff thought there was a possibility that there may be a physical addiction, those who used NPS were still seen to have *chosen* to take it:

> They're choosing to take it you know, there is a choice element there, you know, yes they're addicted but, sometimes, you know, I mean I've, when I have had the chance to be able to put prisoners down in the seg, [segregation unit] on it, and within you know a week or so, you can see a complete change in them, you know, when they come off it … they start to look healthier, I mean, we had a lad down there who was always under the influence, um and … it's taken him a long time, but he, I mean he's transferred now, but he, he just looked so healthy, and I did his last seg review before he was transferred and I said 'you're just a completely different character' and he says 'Miss, my head is my own … for the first time in a long time'… umm, but if we put him back on the unit, he'd have gone straight back to it. [Prison Officer, Head of Function, 05]

Again, staff describe this transformation and change—whereby the user is seen as a human at times, especially when they are not using the substance, but then dehumanised at others. This is reflected in the management of NPS in both prison and police custody which is typically short-term in relation to controlling the immediate situation presented—not necessarily in relation to long-term care or treatment or support of the person. Longer-term solutions in prison were predominately around physically removing a user from the wing where the source was available or placing in segregation (which will be discussed in more detail later in this section). However, some of the officers did see the issues that users faced were part of broader social issues, including deprivation, homelessness, and cuts to services:

> the problem is NPS is it's not a symptom it's the solution in their eyes, the symptoms are things like homelessness, poor upbringing, deprived backgrounds. [Police Custody Detention Officer, 14]

Vulnerability of NPS Users

Prison staff also noted that vulnerable prisoners were sometimes spiked with the drug/given it to either test its potency for entertainment or to cause disruption in the prison.

> I think, very early on … people were getting spiked, because they … they wanted to see other people's reactions, and they wanted to mock them... or make them look stupid … which they often do when they've … 'cause they do, they do act like goons, I know their reactions in workshop is uh, you know they have a good laugh over it all … [Prison Officer 04]

Here we see staff show sympathy towards some users of NPS and a recognition towards the vulnerability of these people within a prison environment. However, these feelings are held in conjunction with feelings of disdain whereby there was a transference of contempt towards the other prisoners who exploit them. There is also the recurring sense of weariness and frustration from staff that there are limited options available to deal with the problem, again we see a response limited to the restriction of the vulnerable person routine or moving the person to a different wing as a means to protect them.

> One of the, the worst things I think for prisoners is they've been using the more vulnerable prisoners, and they've actually been testing it out on them. And these prisoners are addicted, to, to the [N]PS so they'll gladly take it for free … and some of them have reacted really badly. One particular case I remember is a lad, and they were just, well they would have died, if we hadn't done what we did with him … we put him into [NAME] Wing, and he had a restricted regime, where he was restricted from anywhere else, umm, and it eventually worked for him … but uhh, he would have died. [Prison Officer Head of Function 05]

Segregation and Violence

It was noted that the segregation unit is not the best place for prisoners to be, but there is a lack of other options when their behaviours are posing a risk to themselves and to others

> I mean, in the extreme cases, I mean...it's not ideal, but both of those individuals [who used NPS] were actually located on the segregation unit because of the risk that they posed to themselves … but [also] the risk that they posed to staff and other prisoners as well … the segregation unit isn't the right place for them, you know, from a mental health point

> of view but the overriding thing is the risk that they pose to themselves and others. [Prison Officer, Head of Function, 05]

There are also other issues observed by staff within the prison setting. One of these being in relation to the violence that can occur in order to obtain drugs. It is interesting that the sexual violation and violence staff describe here is attributed to the drug use—it is what NPS does to a person.

> I actually dealt with a nasty incident one weekend, on one of our wings, where they'd actually, they thought a prisoner had some drugs secreted [in his rectum] and all the member of staff on that wing saw was a prisoner dragging another prisoner, lifeless across the landing … they'd actually forced him to have spice. They then, what they call spooned him to get what they thought he had. So, it is sexual assault. And they'd left him with like, stuff all around his head, coloured all over his face, with his pants round his feet, and the spoon still stuck out of his anal area on the landing….and that's you know, what it does. [Prison Officer, Head of Function, 05]

There is a further issue in relation to a prisoner being vulnerable to violent attacks or retribution due to the disruption they cause by their drug use. If a user has 'gone under' and a Code B emergency is called, then this disrupts movement around the prison. When prison staff leave to attend to the user then activities may be cancelled, equally if health-care staff attend then other prisoners may be delayed in receiving their prescribed medication (which may include drugs to help manage their drug addictions). As this prison officer describes:

> [if a prisoner is taken by ambulance] we need to send two staff with them, if they become violent, we have to look at the safety and security of the ambulance, so we might need to send a third person, if that then person stays out, that's four staff every 24 hours, sat there, looking after him. It has a big impact on the rest of the regime, because you can't run the regime and the prisoners end up being locked behind their cells, in their cells, which then leads on to effectively them getting bored, and causing trouble, it just has a complete knock-on effect of the whole way down

> the line. Um, and you know, staff don't want to be sat out, just because someone has taken a drug of their own accord, you know, it's work that we could be doing with them in here, that will help, a lot more. [Prison Officer, Head of Function, 06]

Whilst the disruption to prison routine may result in revenge violence towards the user from other prisoners who had their routine altered or their own medication delayed. The same disruption to service provision was felt by police custody staff. NPS users often required more intensive care and supervision than other people in the custody suite due to the impact of the substance on their behaviour. This often meant less support available to other people (who may by vulnerable or have other health care needs) in the custody suite at that time:

> '[its] very, very labour intensive in how we would deal with that person all the way through. But you've got to remember that I've also got to deal with everybody else as well.' [Police Custody Detention Officer 03]

Tougher Measures

Within the prison estate tougher punitive measures were enacted for prisoners who used NPS. For this prison anyone who had used a substance (it was not possible to identify what that substance was/if it was NPS) and had a reaction whereby they were unconscious, and staff were called then, in addition to a referral to the drug and alcohol recovery team, they would be returned to their cell and all personal items (including pictures/photos and drawing) would be removed, privileges would be withdrawn, and they would face additional time added to their sentence. This prison officer explains what the prisoner is faced with when they come round from taking NPS:

> I think that they're blinkered … they [SIGH] what inmates seem to go for is somethings that they want in the here and now… they'll go for, they'll do it, regardless of any consequences … and they don't think, like you and I would, 'oh I better not do that because'. So what happens is, they have their hit, they get taken back, they get seen by healthcare, they

> get taken back to their cell eventually, and then when they come around … and come to their senses, if they do, well as much as they can and "ooh hang on, me tele's gone"; they've had their tv removed from their cell, "oh I had a magazine there, all of the magazines have gone"; any paper in the cell, would have been removed in case it's been impregnated. So, they've got nothing to read, they've got no tv, but it doesn't stop there - they could well end up in front of a judge, get extra time. In the meantime, they've lost a lot of their spending ability on canteen … they'll have lost a lot of … they get all sorts of things knocked back on … instead of having a two-hour visit, they've got a one-hour visit and so it goes on. So, for that one hit, it's been very expensive for what it is, to them, so, you can't tell me they don't enjoy all of these other things. So, they've gone into taking that, stuff without thinking they were going to lose all of that. [Prison Officer 04]

Again, the emphasis is on the person making a choice to use or not to use NPS or other illicit substances within the prison, if they chose to use then they would face certain consequences. At the time of the research project further measures were being trialled which involved contacting the prisoner's family if they were found either as a code blue from using NPS or if they failed a mandatory drug test. This went further for prisoners who had children at home:

> If that person uses multiple times and has children, then I will notify social services because I don't want them to be a danger to children, their own children or any other children, when they're released … so I make social services aware, what they do with that, that information, is up to them. And the prisoner is told that social services were informed, they're told that their family will be informed ... so it's made quite clear from the outset from when they come in here, that these are the actions that will happen if you fall into one of these areas. [Prison Officer, Head of Function, 06]

Reflections

Custody staff and other people who use drugs discuss NPS use in derogatory ways, reproducing mechanisms of stigma that pathologise NPS users

as repellent 'kinds of people.' What is more concerning to us is that our research found that this differentiation of NPS users can affect how people who use NPS access and experience treatment within custodial settings, for example: in their healthcare plans and provisions when withdrawing from NPS; the administration of harsher punishments for NPS use in prisons; and the ways in which NPS users are treated by other substance and non-substance using prisoners. As such, mechanisms of stigma within custodial settings had a demonstrably negative impact on the health and wellbeing of people who use NPS. What is more, additional work created by managing the care of NPS users generated greater pressure on already overstretched staff within custody environments.

Furthermore, NPS users were frequently transferred to A&E thus creating further resourcing challenges. Both police and prison staff perceived NPS users to be extremely volatile and reported that managing risk to themselves and users was increasingly challenging. In such a pressurised context, custody staff held the NPS users accountable for the strain they felt and utilised the rhetoric of drugs users making 'bad choices,' rather than an alternative explanation being rooted in chronically under-funded infrastructure within custody and wider social and health inequalities impacting on continued use of NPS amongst these individuals.

Conclusion

Returning to Dame Carol Black's Review of Drugs in the UK, with a focus towards prevention, treatment and recovery, she writes that the 'Government faces an unavoidable choice: invest in tackling the problem or keep paying for the consequences' (HM Government 2021). This means adopting a 'whole-system' approach which starts with proper investment in treatment and recovery services. To facilitate the success of these care pathways for people who use drugs, the social determinants of health need to be tackled and invested in. For Black, this means the Ministry of Justice and the Home Office, as well as the Department of Health and Social Care, Department for Work and Pensions, and the Ministry of Housing, Communities and Local Government all working

together to provide better housing, better employment opportunities, better outcomes from the criminal justice system, and opportunities for education and training.

We would add that social relations that inscribe stigma onto people who use drugs need to be recognised as harmful; mechanisms of stigma lower self-esteem, impact on mental health, and obstruct access to health care services. This cannot continue—this is a call to action to health and social care providers, as well as those in the provision and management of custody settings, to reflect on and stop practices within their organisations that perpetuate the stigmatisation of people who use drugs. This begins with proper investment in the infrastructure of these settings to alleviate pressure on custody staff and adopt a 'whole-systems' approach to offender management and recovery from substance use. Only then can we hope to see people who use drugs weather the storm.

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Stigma and Young People Whose Parents Use Substances

Cassey Muir, Ruth McGovern, and Eileen Kaner

Introduction

Substance use, including the use of alcohol and/or illicit drugs, can be highly stigmatised, particularly for the person who uses drugs (Yang et al. 2017) depending on a number of factors like type, strength, volume, as well as intersections of identity. Conceptualising stigma is complex: in this chapter it is framed as an association of disgrace or public disapproval with something, such as an action or condition, and can be experienced by association due to family member behaviour. Through association, stigma can be experienced by children and young people whose parents use substances. In this chapter, we will draw on published qualitative studies to explore painful feelings connected to the stigma experienced by young people in their everyday lives, like shame and

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embarrassment, which they may feel about their parents' substance use. We will analyse instances of direct stigmatisation and discrimination that these young people experience from those around them, and we will signal wider social injustices and structural inequalities they face, including stigmatising policies and funding cuts for support services. This chapter will also begin to explore how stigma may play a role in the outcomes of young people whose parents use substances, and how wider socio-economic and political factors can exacerbate differences amongst young people. We argue that some young people move beyond experiencing 'associated stigma' to experiencing direct stigma and discrimination connected to their own substance use or offending behaviours.

Parental Substance Use

In this chapter, we are focused on parental substance use that has the potential to cause harm to a child (Advisory Council on the Misuse of Drugs 2003; McGovern et al. 2018). We focus upon high-risk patterns of substance use ranging from frequent or heavy alcohol use to any use of illicit drugs, including the misuse of legally prescribed drugs. Parental substance use is prevalent worldwide, and presents major child safeguarding and public health concerns (Canfield et al. 2017). However, the prevalence of parental substance use is difficult to estimate due mainly to the hidden nature of the problem—figures range between 5 and 37% of children who live with at least one parent who uses substances (European Monitoring Centre for Drugs and Drug Addiction 2010; Manning et al. 2009; Galligan and Comiskey 2019). A considerable amount of research has also focused on the impact that parental substance use has upon a young person, including upon physical, emotional, social and behavioural development. Such impacts include, poor school attendance and concentration (Díaz et al. 2008), low academic performance (Hogan and Higgins 2001), antisocial problems (Molina, Donovan, and Belendiuk 2010), anxiety and depression (Gorin 2004), as well as their own substance using and offending behaviours (Velleman and Templeton

2016). Most existing research states that young people are either vulnerable or resilient to the impacts of parental substance use, depending on a number of risk and protective factors. Protective factors may be individual (e.g. having high-esteem); parental (e.g. positive and consistent parenting); familial (e.g. no other comorbid psychopathology in parents); as well as social and contextual (e.g. positive social support) (Park and Schepp 2015). This research has been crucial in the understanding of how to support young people and to promote their resilience. However, there has been limited research on the role of stigma within this relationship of vulnerability-resilience and how stigma may also play a fundamental role in the outcomes of young people whose parents use substances. We address this gap here in this chapter.

Defining Stigma

Beyond lay understanding, the classic theorisation of stigma is provided by Goffman (1963: 3) in his seminal work on the 'spoiled identity', in which he states stigma is a social process where certain groups or individuals possess 'an attribute that is deeply discrediting' reducing them 'from a whole and usual person to a tainted, discounted one'. He also referred to non-stigmatised people as 'normals' and goes on to say that when an individual realises they have failed to conform to or adopt the society's norms and standards, they will be induced to feel shame and out of this stigma will arise. Whilst Goffman's work has been hugely influential to the study of how individuals experience living with stigma and stigmatised identities, this research has been critiqued as being too individualistically focused and failing to account for structures of power that inscribe some people with stigma and some as 'normal' (Link and Phelan 2001).

Link and Phelan's work on conceptualising stigma and 'stigma power' has been significant in attempting to focus on the socio-cultural structures of stigma, as well as linking them to individual experiences and interactions (Link and Phelan 2001, 2014). They conceptualised stigma as a social process involving labelling, stereotyping, separation, status loss, and discrimination, where unequal power is a necessity for stigma

to occur (Link and Phelan 2001). In this regard, discrimination can be individual, through interactions, as well as structural, occurring within institutional practices or government policies that disadvantage certain groups of people. Thinking about why people stigmatise, three functions have been proposed: (1) to keep people subservient or 'down' through exploitation and domination; (2) to keep people conforming or 'in' through enforcement of social norms; and (3) to keep people 'away' through avoidance (Phelan et al. 2008). The role stigma plays in achieving the aims of those who stigmatise and the functions of stigma regarding 'exploitation, management, control and exclusion of others' are called 'stigma power' (Link and Phelan 2014: 24). This concept has been further extended to understand stigma as a cultural and political economy that leads to social inequality and injustice, especially in thinking about the history of race and class (Tyler and Slater 2018; Tyler 2020).

Goffman (1963) also referred to associated others as being stigmatised, called 'courtesy stigma', otherwise known as 'associative stigma' (Mehta and Farina 1988). Family members are particularly susceptible to associative stigma, due to close physical and/or relational proximity (Larson and Corrigan 2008). Park and Park (2014) identified 'family stigma' as one key type of associative stigma, which arises from the 'unusualness' of the family, including factors such as parental substance use. Family stigma can be defined by three common attributes: negative attitudes towards a family and avoidance of them, the belief that association with the family could be harmful, and the belief that the entire family is contaminated by association with the stigmatised individual. Stigmatisation by others can have emotional, social, and interpersonal impacts on family members leading to a poorer quality of life (Park and Park 2014).

Stigma can also operate from self to self, termed self-stigma (Goffman 1963). Self-stigma essentially turns public stigma inwards on the self. Public stigma reflects the beliefs and attitudes that the public holds about a particular group of individuals or conditions (Corrigan et al. 2010). This can then become internalised self-stigma, where individuals come to make sense of themselves through public stigma and align themselves with the negative stereotypes and societal attitudes that may be ascribed to them, resulting in low self-esteem, shame, and fear (Corrigan

et al. 2006, 2010). This awareness of public stigma may also result in stereotype threat or social identity threat, where people believe and fear they will be stigmatised if labelled as different in the eyes of others (Steele and Aronson 1995). Research into these concepts as well as other similar concepts highlights that the existence and knowledge of public stereotypes can harm stigmatised groups, even in the absence of direct stigma and discrimination from another person or institute (Aronson et al. 2013). However, for some individuals, living with a stigmatised identity can be an empowering experience (Shih 2004). This model of thinking views stigmatised individuals as active participants in society who can create positive outcomes for themselves or others. The strength of overcoming and confronting such adversities of stigma lead to individuals perceiving that a situation has made them stronger or more resilient. However, this model places the management of stigma onto the individual and makes structures of inequality invisible.

In order to highlight and unravel these structures of inequality, it can be useful to consider the holistic environment surrounding an individual. Bronfenbrenner (1979) ecological systems theory divides an individual's environment into five interrelated 'systems', which can all impact development. When thinking about a child whose parents use substances as the individual, the first system is the *microsystem*, which incorporates the immediate environments surrounding the child, for example, family members and peers. The second level is the *mesosystem*, where interactions occur within the child's microsystem, for example, the relationship between their parents and school. The third level is the *exosystem*, those systems that do not directly affect the child but can impact the child's life, such as neighborhoods. Next is the *macrosystem*, which is the larger sociocultural environment, for example, policies and social norms. Finally, the *chronosystem*, which includes environmental changes or transitions over the child's life course. When thinking about children's health and disparities, Kramer et al. (2017) proposed a framework based on the ecological model whereby social class gradients create variation in children's mesosystems and microsystems that manifest in a number of ways to impact children's health. The ecological model can also be applied to the experience of stigma. Kotova (2020) proposed a multi-faceted and cumulative model of stigmatisation that considers 'associative stigma'

as well as stigma associated with class, race, and poverty for families of people in prison. They argued that not only do families experience stigma from their connection with a stigmatised individual, and their socially excluded backgrounds, but the stigma is amplified by current neoliberal political, legal and social views about value and worth. Thus, microsystem and macrosystem level factors become linked through social injustices and societal stereotypes, and it is through this model of stigma that we can better understand the experience of stigma for individuals and affected family members.

Stigma and Young People Whose Parents Use Substances

The remaining sections of this chapter will draw on published qualitative studies to explore the lived experience of stigma amongst young people whose parents use substance, with discussion of the wider socio-cultural factors that may shape their stigma experience.

Labelling and Stereotypes

Negative stereotypes about people who use substances are prevalent and are key to their experiences of stigmatisation (Yang et al. 2017). Public and media framing of the issues tend to focus on a lack of self-control (Tindal et al. 2010), as well as blame regarding potentially adverse or legal consequences (Corrigan et al.2009; Obot et al. 2004). Media-led discourse often perpetuates negative stereotypes of substance use via the use of derogatory language (Taylor 2008). Furthermore, government policies, programmes, and discourse can exacerbate the stigma experienced by families and young people (Crossley and Lambert 2017). Current austerity, welfare cuts and a neoliberal political economy increase stigmatisation of those who use substances and those associated with them (Alexandrescu 2020). In recent qualitative studies, Bancroft et al. (2004), Barnard and Barlow (2003), and McGuire (2002), explored young people's perception of parental substance use and found that

parental drug use was seen as more stigmatising and shameful than parental alcohol use, with mother's drug use perceived as worse than father's drug use for some young people. Additionally, Houmøller et al. (2011) and Park and Schepp (2018) found that young people whose parents used alcohol identified more open use in front of them but when parents were confronted, denied their use was problematic. These differences for young people are partially due to the illegal status of classified drug use and societal perceptions of those whose use is seen as problematic within society (Room 2005).

Children of parents who use substances are likely to go on to use substances themselves (Sheridan 1995). Within the United Kingdom, the construction and labelling of some families and young people as 'troubled' due, in part, to substance use has been driven by government policies, national programmes, and media depictions, many of which have propagated stigma (Goldson and Muncie 2015; Cameron 2011). For example, the Troubled Families Programme, launched in 2011 by the Coalition Government, claimed to support the most disadvantaged families. In his speech, the then prime minister, David Cameron clarified what he meant by the term *'troubled families'*: 'Officialdom might call them 'families with multiple disadvantages'. Some in the press might call them 'neighbours from hell'. Whatever you call them, we've known for years that a relatively small number of families are the source of a large proportion of the problems in society. Drug addiction. Alcohol abuse. Crime. A culture of disruption and irresponsibility that cascades through generations' (Cameron 2011: 3). Whilst this programme has seen some success, it has also been criticised because this labelling led to problematic stigmatisation and subsequent discrimination of families and young people (Crossley and Lambert 2017). Similar policies have also been found across Europe, which label and exclude certain families and young people, resulting in the reproduction of stigma and a reduction in opportunities for young people (Deakin et al. 2020). For instance, McGuire (2002) explored young people's experiences of living with parental drug use and found that some young people are labelled with derogatory terms and are perceived to use drugs like their parents, even if they do not. Additionally, Tamutienė and Jogaitė (2019) explored young people's experiences of living with parental alcohol use and found some young

people are discriminated against due to other people's perception that the young person will turn out like their parents. Stigma can therefore be viewed as a political 'weapon' that can lead to widening social inequalities and injustices for families labelled as *'troubled'* (Tyler 2020).

Awareness of Parental Substance Use: Not Feeling 'Normal'

Society has embedded structures which marginalise some families and individuals who are unable to conform to societal norms and expectations. This awareness of difference is painful and induces shame amongst young people whose parents use substances. In recent qualitative research, Barnard and Barlow (2003), Backett-Milburn et al. (2008), and Houmøller et al. (2011) all found that young people, whose parents use substances, reported feeling great shame when they realised that their family was unlike other families, and their parent's behaviour was not perceived as 'normal'. This awareness and induced shame led to a fear of being discriminated against. Such a belief that their families are not 'normal', and by association they are not 'normal', has been found amongst other young person populations who experience parental mental illness (Haug Fjone et al. 2009), domestic violence, and abuse (Arai et al. 2019), as well as childhood sexual abuse (Kennedy and Prock 2018). The concept of what is 'normal' has been criticised because it glosses over differences amongst individuals that have been structured and reproduced through histories of societal power and privilege, grounded in colonialism, patriarchy, ableism, and so on, making those who use substances and associated others to feel inferior and suppressed because of who they *are* as well as what they do (Tyler 2018).

Within families, communication around parental substance use may also play an important role in how young people experience stigma and shame. Young people's awareness and realisation of parental substance use is often coupled with the continued efforts of their parents to hide, disguise or deny their substance use even if their children confront them (Barnard and Barlow 2003; Houmøller et al. 2011; Backett-Milburn et al. 2008). Where there is concealment and secrecy from family

members, this may establish the topic as taboo within the family, reinforcing the perception that substance use is embarrassing, shameful and something to be hidden from others (Roloff and Ifert 2000). Therefore, young people may be at risk of internalising feelings of stigma and shame, as well as feeling unable to reach out for support (Haverfield and Theiss 2016). Conversely, where families are open, honest and acknowledge the substance use, young people may feel less internalised shame and stigma around seeking support for themselves (Tinnfält et al. 2011). However, in a recent qualitative study by Nattala et al. (2020) exploring adolescent experiences of paternal alcohol use, a young female reported that her mother openly discussed her father's alcohol use, but in a way that could be perceived as harmful. The young female's mother wanted her family to commit suicide so that they did not have to live with the stigma of being associated with substance use. This young person internalised the shame, which impacted her self-worth and well-being. Experiencing such shame and stigma within the family, especially from a parent who may be seen as the protective non-using parent, could have damaging lasting impacts on young people.

Fear of Being Stigmatised and Experiencing Associative Stigma

Children and young people often report feeling stigmatised for their parents use. Whilst some research suggests that children and young people were not blamed for their parents substance use (Corrigan et al. 2006), they were often seen as needing to be avoided (Corrigan et al. 2006). Qualitative studies by McGuire (2002), Houmøller et al. (2011) and Holmila et al. (2011) found that young people, whose parents use substances, reported feeling judged by others regardless of enacted discrimination. Additionally, Bancroft et al. (2004) and Barnard and Barlow (2003) found that some young people feared other people's reactions to their parent's substance use and worried about being stigmatised or bullied. Furthermore, evidence suggests that fear of stigma and being different impacts on some young people's ability to develop social relationships, leaving them feeling alone and isolated (Moore et al.

2010; Nattala et al. 2020), and occasionally ostracised (Yusay and Canoy 2019). What is more, in an online survey, Haverfield and Theiss (2016) found that adult children of parents who drink alcohol has increased depressive symptoms, and decreased self-esteem and resilience if they felt stigmatised by others regardless of actual stigmatisation. Fear of being stigmatised can be a powerful experience for young people; this fear signals how these young people demonstrate a greater sensitivity to how they think they are perceived by others and society more broadly, regardless of any concrete discrimination.

Moreover, stigma, bullying, discrimination, or embarrassment were likely to occur when young people's parents were seen drunk or using drugs by other people—either within the community (Bancroft et al. 2004; Barnard and Barlow 2003), at school (Hagström and Forinder 2019; Nattala et al. 2020), or if the young person invited friends to their home (Backett-Milburn et al. 2008). Interactions between young people's family and others that led to discrimination reinforced young people's internalised stigma and low self-esteem (Moore et al. 2010). Evidence suggests that experiencing stigma and discrimination due to parental substance use can perpetuate isolation amongst young people (Nattala et al. 2020; Reupert et al. 2012). However, Lee (2006) found that supportive interactions between young people's family, peer, or school environments have been associated with positive youth development. Positive interactions for young people included, receiving empathy and support from those who have witnessed their parent's substance use (Houmøller et al. 2011; McGuire 2002), or their parents acknowledging the substance use and seeking professional support for their children (Tinnfält et al. 2011).

Stigma can also affect the health and well-being of individuals through the barriers it creates in interactions with professionals, adding to social stress and increased discrimination (Link and Phelan 2006). Recent qualitative research by Wangensteen et al. (2020) explored young people's lived experiences of parental substance use and found that some young people experienced stigma and prejudice from lots of different practitioners in the health, care and education system. Bancroft et al. (2004) also found that some young people reported being made to feel different, or that they were *'picked on'* by teachers because of their families and

home life. Other researchers found that some young people may experience prejudice within social services (McGuire 2002; Wangensteen et al. 2020), or the healthcare profession (Hagström and Forinder 2019). Furthermore, discrimination can also be felt and feared throughout a young person's life, impacting on future job prospects and relationships (Bancroft et al. 2004; Nattala et al. 2020).

Intersectionality, Poverty, and Class

Individuals can experience stigma due to many different overlapping and intersecting factors, including their gender, race, class, sexual orientation, and physical ability. Discrimination is often located and exacerbated at these intersections of identity and axes of power and oppression, generating new and old stigmatisation (Cornish 2006). Children and young people who grow up experiencing poverty and deprivation are more likely to be exposed to a number of other adverse childhood experiences, such as parental substance use, compared with their more socially and economically advantaged peers (Marmot et al. 2020). There is a clear social gradient in the experience of parental substance use, as well as other adverse childhood experiences related to deprivation (Allen and Donkin 2015). Furthermore, across most societies, there is a long history of stigmatising individuals and communities who are working class or claiming benefits, exacerbating vulnerabilities and widening inequalities (Geremek 1997). Tyler (2020) frames these structures as the 'machinery of inequality', maintained through stigma practices and processes of discrimination, either directly or systemically, keeping people and families in disadvantaged positions. Young people and families who experience stigma because of numerous disadvantages, or social injustices, are likely to be socially isolated, and experience decreased well-being and health outcomes (Reupert et al. 2020). Furthermore, as has been argued by Scambler (2018), modern neoliberal states and those who enforce such ideologies have 'weaponised' stigma, whereby factors such as poverty are not only stigmatised characteristics but also those who are living in poverty are seen as deviant people and to blame.

Qualitative studies by Bancroft et al. (2004), McGuire (2002), and Yusay and Canoy (2019) found factors such as poverty, claiming welfare benefits, and being perceived as a lower social class compounded young peoples' experiences of stigma. The financial impact of parental substance use, for example, most of the family's money being spent on alcohol or drugs, can leave little money for things such as food, clean clothes, or school fees. These experiences led to some young people feeling shame as well as being bullied by those who exploited this difference (Houmøller et al. 2011). However, some young people may experience a socio-economic advantage due to being from a higher social class (Bancroft et al. 2004). Within these families, parents could afford to buy the best clothes or make sure their children had what they needed for school. Where this was the case, young people did not feel discriminated against or stigmatised for their parent's alcohol or drug use, as they could more easily hide it from others. Therefore, the evidence available to us suggests that there is an unequal distribution of stigma for young people dependent on the class or wealth of their family. It can also be reasonable to expect such unequal distribution of stigma due to a young person's race and ethnicity, but to our knowledge this is currently missing in the literature for young people whose parents use substances. However, such distribution has been found across other similar populations (Kotova 2020). In addition to poverty and class, there are other interrelating factors that compound young people's experience of stigma and deserve greater exploration than space in our chapter will permit, these include: parental mental health problems (Bancroft et al. 2004), inter-parental conflict (Houmøller et al. 2011), as well as a family member(s) in prison (Bancroft et al. 2004).

Moving to a Position of Direct Stigmatisation

Bancroft and Wilson (2007), argued that there is a constructed 'risk gradient' within the United Kingdom's policy and practice for children whose parent's use substances. This gradient means that within policy and practice it is assumed that responsibility for harm to the young person lies with the parents or the young person. For example,

when children are young, parents are identified as responsible for any harm children and young people might experience, including injury or neglect. However, as young people grow into their late teens they are framed as increasingly agentic individuals who can be held accountable, both legally and socially, for any harm they experience or inflict, including participating in substance use or offending behaviours. At this critical stage in adolescence, we argue that young people also move from a position where they are stigmatised due to association with their parent's behaviour to being directly stigmatised for their own behaviours. However, what policy and practice then fail to address is the systemic harm, stigmatisation and marginalisation young people experience, and instead focus on individualised accountability which heaps more blame and shame on already marginalised families and individuals.

Bancroft et al. (2004) and Houmøller et al. (2011) found that some young people's substance use or offending behaviour were seen as the problem in society. However, these behaviours were signs that they were trying to cope with and resist the emotional and physical impacts of parental substance use (Backett-Milburn et al. 2008; Turning-Point 2006). Not all young people have equal choice or resources to access support, and their 'agency' and ways of coping can be impeded by their social position as well as discriminatory policies and practices. Moreover, as some young people have constrained choice, their behaviours indicate attempts to find ways to navigate an unequal society. Such perceptions within the health, social, educational, or criminal system that young people and their indivdiualised behaviours, taken out of social context, are the problem may lead to a lack of adequate support and young people to feel let down and excluded. Labelling such young people as 'risky' and responsible for their own harm, in addition to the social exclusion that may occur, especially within the education system, elicits a social process of stigmatising the young person and their behaviour whilst also diminishing the risk from their family circumstances and wider systemic marginalisation. This stigmatisation and systemic inequality can lead to reduced life chances and limited opportunities for some young people, leading to further toxic stigmatisation in later life (Deakin et al. 2020).

Coping with Stigma

One of the main strategies to manage stigma is to keep family substance use private or 'hidden'. Hiding parental substance use can be linked to the concept of a concealable stigmatised identity, where an individual believes their identity should be hidden from others because it may incur social devaluation (Crocker et al. 1998). Concealing an identity from others by not disclosing parental substance use can have both benefits and costs to an individual's health outcomes (Quinn 2017). Quinn (2017) proposed that those who reveal their stigmatised identities within supportive environments have greater health benefits, whereas those within hostile and discriminatory environments may benefit from concealment, but only if the concealment does not lead to greater internalised stigma, shame, and further isolation. Researchers have found that the fear of rejection, being bullied or made to feel different from others prevented young people from seeking support when they needed it (Bancroft et al. 2004; McGuire 2002; Hagström and Forinder 2019). Some young people also set boundaries and kept their family life and wider social networks separate (Barnard and Barlow 2003; Houmøller et al. 2011). This separation served as an important step in promoting self-identity and well-being for some young people, but also perpetuated their self-stigma and shame. When young people do receive support, professionals who provided space and time to open up without singling them out were considered invaluable (Bancroft et al. 2004; McGuire 2002). Talking to other young people whose parents use substances was also reported to be helpful (McGuire 2002; Hagström and Forinder 2019). As Haug Fjone et al. (2009) argued, being able to talk to other people in similar situations can help young people to develop a shared identity, to feel less alone, and to feel less stigmatised. Alternatively, experiencing a breach in trust (Bancroft et al. 2004), not being believed (Houmøller et al. 2011), or experiencing a lack of support when parental substance use was known (Hagström and Forinder 2019), were all seen as damaging interactions. Such interactions which make the young person feel stigmatised and discriminated against regardless of the individual's intent, can impact on the young person's help seeking behaviour,

reducing their opportunities for positive support, thus impacting on their health, well-being and opportunities in the future.

Children and young people are encouraged to strive for a version of success in a neoliberal society that platforms achievement at school, full employment, and a stable family. However, this pathway to success is incredibly problematic for those who are having to navigate stigma in a system intent on reproducing structures of inequality. Whilst some young people do have the resources to navigate this system successfully, others are reprimanded and stigmatised (Bancroft et al. 2004; Hagström and Forinder 2019; Houmøller et al. 2011). Those young people who are seen as doing well in school and living a life different to their parents are commonly referred to as resilient e.g. experiencing positive outcomes despite their parent's substance use. However, reliance on viewing resilience as achievement in these aforementioned areas, could lead to reduced support for such young people who may need social or emotional support. Moreover, such well-intended labelling could further lead to stigmatisation of individuals who do not meet such criteria, as well as placing the burden of 'stigma management' on the individual. As discussed earlier, those young people who are seen in practice and policy as 'risky' due to their own substance use or offending, may be trying to cope with the impacts of parental substance use and a flawed support system, but because their form of coping is stigmatised they are more likely to experience discriminatory interactions and further negative outcomes. It is whether young peoples' forms of coping are deemed socially acceptable and resilient, e.g. doing well at school, or deemed socially unacceptable and risky, e.g. use of substances that mitigates whether they are further stigmatised, excluded, and experience worse outcomes.

Awareness of Harms Caused Through Stigma

Using the ecological systems theory to think about the stigma experience of young people whose parents use substances and to link the micro-level experiences with the macro-level systems helps us to understand that we need to be attentive to stigma and how it operates within structures,

policy and practice to work against the best interests of young people and families. As Ungar et al. (2013: 357) have argued, in relation to promoting resilience, 'changing the odds stacked against the individual contributes far more to changes in outcomes than the capacity of individuals themselves to change'. The same reasoning can be applied to the understanding of initiatives to reduce stigma. Services which provide a safe space for young people to talk, with opportunity to meet others with similar experiences may be useful in helping decrease the stigma and shame experienced by young people. Furthermore, there needs to be training for all professionals who work with children and young people around the stigma and fear experienced in seeking support and talking about parental substance use, as well as useful communication techniques to decrease stigma and discrimination. In addition, services that support positive communication between family members, as well as encouraging parents to acknowledge their use to their children, may help young people to feel less stigma and feel supported to seek help for themselves. There also needs to be wider understanding of stigma via public information that helps to reduce or counter the stereotype and labelling around those who use substances.

If the goal of such initiatives would be to reduce stigma so that young people can reach out for support, then we also need to look at access to and quality of the support available to young people, now and in the future. Taking the United Kingdom as an example, mental health and social care services have been historically underfunded during a time when the need for these services are increasing (Stuckler and Basu 2013; Cooper and Whyte 2017). For children and young people's services between 2010/2011 and 2017/2018, there was a 29% reduction in funding, equating to a decrease of £3 billion spent on supporting families in need (Britton et al. 2019). These support services, when they thrived, generally benefitted disadvantaged children the most—but with cuts to funding, there is a disparate impact on young people from different socio-economic backgrounds. Spending on children and young people's services in the most deprived local authorities has fallen almost five times faster than in the least deprived local authorities (OECD Family Database 2019). Additionally, there have been funding cuts to primary, secondary, and tertiary education, further impacting young

people's access to support (Britton et al. 2019). For parents who use substances, the same picture is presented, with regional disparity in funding cuts to addiction treatment services, set against an increased need for such services (The Centre for Social Justice 2019). Lack of support for parent's substance use further impacts on young people. If these funding cuts continue, quality of and access to support for families and children in the future will continue to decrease, with less opportunities for those from socially and economically disadvantaged backgrounds. As Tyler (2020: 18) argued, stigma can disproportionately affect those individuals who are in need, as it amplifies these existing inequalities and is 'deliberately designed into systems of social provision in ways that make help-seeking a desperate task'. And as we have discussed, those young people who live in poverty and whose parents use substances experience compounded stigma and discrimination. If anti-stigma initiatives around parental substance use are to work at removing the barriers to help seeking by young people, then learning can be taken from research exploring anti-stigma initiatives for mental health, whereby governments need to simultaneously address the funding for public service provision and the deeper, systemic roots of stigmatisation.

Conclusion

Not every young person whose parents use substances experience the same outcomes. A complex system of personal, social, political, and economic resources also shape the life circumstances of a young person. We have demonstrated that stigma can play a key role in the lived experiences and outcomes of young people whose parent's use substances, and that intersectionality, wider socio-cultural and political factors can exacerbate such differences amongst young people. Stigma is compounded for those young people who also experience poverty or financial hardship alongside their parent's substance use, whilst others may experience a socio-economic advantage, creating an unequal distribution of stigma across families and young people. In addition, we have argued that some young people move from a position of acquiring 'associative stigma' due to their association with parental substance to 'direct stigma' due to their

own 'risky' behaviours and ascribed level of agency and accountability. Children and young people are encouraged to strive for a version of success in a neoliberal society that platforms achievement at school, full employment, and a stable family. However, this pathway to success is incredibly problematic for those who are having to navigate stigma in a system intent on reproducing structures of inequality. There is a need to develop initiatives across many different levels, encouraging greater levels of awareness of the harms inflicted through the stigma that is embedded in systems of support and care for young people whose parents use substances, whilst also tackling the stigma faced by individuals who use substances themselves.

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Cultural Competence to Cultural Obsolescence: Drug Use, Stigma and Consumerism

Tammy Ayres and Stuart Taylor

Introduction

This chapter considers the stigmatisation of drug users within the context of consumer capitalism, arguing that the contemporary remit and nature of stigma is increasingly shaped by consumerism and its polarisation of proficient and flawed consumption practices. Its point of departure sees the socio-political positioning of substance use as a drug apartheid (Taylor et al. 2016) with the legal status of different drugs aligning with the evolution of capitalist markets, their subjectivities, drives and needs (Ayres 2019, 2020). The ensuing outcome, in a society where *everyone* is a drug consumer, is that the substances we consume interact with our

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real/imagined social status and in the construction of our unique and individualised identity(s); a process governed by both the type of drug and its consumer.

Stigmatisation, therefore, is seen as being determined—in both form and application—by a neoliberal era of consumer capitalism, which sees engagement with consumer markets and the consumption of goods mediating all aspects of social life, including citizenship. Neoliberalism, according to Harvey (2007: 2) is 'a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade'. It is in this context that the drug apartheid—a concept defined by Taylor and colleagues (2016: 459) as an arbitrary division of drugs 'that has privileged the use of certain substances and outlawed the use of other substances, a corrupt system that has much to do with who uses the drugs and little to do with the risks posed by the drugs'—has flourished. Hence, whilst certain legal drug markets prosper within the neoliberal context with, for example, a loosening of regulatory restrictions, other substances and their users are simultaneously posited as detrimental to the functioning of the dominant order.

Resultantly, a range of negative stereotypes surrounding some drugs and their users exists, but not others, which over time have been shown to result in stigmatisation and spoiled identities (Goffman 1963). Here, the consumption of certain drugs 'spoil' individuals as they are seen as deviating from social norms (UKDPC 2010a, b). As the ensuing discussion will show, however, these social norms are contradictory, discriminatory and harmful due to the drug apartheid. Importantly, whilst substances can represent the *attribute* which Goffman (1963) refers as being *deeply discrediting*, they can conversely, depending on what substance and how/by whom it is used, be an indicator of social competence and status. Hence, on the one hand righteous consumption of licit drugs infers cultural competence, indicating effective citizenship within set parameters, serving crucial social functions, and even acting as a signifier of success. Whilst on the other hand inappropriate drug use infers cultural obsolescence, indicating the failure of users to make the right consumption choices, abide by neoliberal notions of responsible

consumption, and play an active and productive role in society (Reith 2004). This juxtaposition means that those who consume drugs such as heroin, crack cocaine and spice are jettisoned into the cultural abyss. They are stigmatised as 'addicts' but also as flawed consumers (Bauman 2000), unable to engage with the virtuous consumptive practices of the majority. It is in this context that the drug apartheid operates and thrives, as stigma—a public form of branding—is used to demarcate those who deviate from societal norms, acting as a mechanism of social control (Szasz 2003).

Crucially, at a time when capitalist markets in relation to substance use are rapidly evolving, there exists a liminal space between these two extremes, which sees the boundaries between acceptable and unacceptable consumption based on notions of the licit and illicit blurring. On one side market forces are demanding we make healthier, less risky consumer choices, meaning that those who use legal drugs inappropriately are increasingly framed as social pariahs. While the liberalisation of laws around cannabis in certain jurisdictions means that the once stigmatised (see Young 1971) are being repositioned. As such, it is only through a consideration of the position and outcomes of all drug consumption within the ever-evolving context of consumerism, that we can fully locate the historical and contemporary existence, application and consequences of stigmatisation—and, as this chapter argues, illustrate the purposeful role this serves in ensuring the smooth order of the (harmful) socio-economic status quo.

To explore these competing and indeed contradictory facets, we utilise and attempt to build upon Goffman's seminal work on stigma, employing his straightforward definition of stigmatisation as a status or 'attribute that is deeply discrediting' that reduces a 'whole and usual' person 'to a tainted, discounted one' (Goffman 1963: 12), particularly when it becomes their master status, as is often the case with those labelled problematic substance users. For Goffman (1963), the new identity ascribed is internalised, so they take on the new role/identity being assigned to them (master status), which influences the way they see themselves (see also Becker 1963). It is also important to acknowledge that 'shifts have occurred in the kinds of disgrace that arouse concern' (Goffman 1963: 11), which can be seen in the consumption of (some)

drugs by some users throughout history, yet stigmatisation has mostly been reserved for those obvious/visible problematic illegal drug users (UKDPC 2010a). Here, we consider issues of stigma within a framework which locates drug consumption on a spectrum of social acceptability. This provides insight into the differential positioning of substances within the current drug apartheid, the drug's social status, framing, function and outcomes, illustrating how a hierarchy of substance use exists within the context of neoliberal consumer capitalism.

The theoretical spine of this discussion draws attention to two key processes. Firstly, that the drug apartheid provides a vehicle to mobilise society against what Bauman (2007) refers to as the collateral casualties of consumerism, whereby those addicted to illegal drugs are framed as failures in terms of their consumption choices and de facto their civic existence as morality is now relative and determined by the ability to be an efficient and ethical consumer. Secondly, that the drug apartheid distances certain substances from the 'drugs' label allowing their consumption to be understood as an indicator of social competence/functionality, attracting commendation rather than condemnation. This is a process which ironically demonstrates the essentialism of drug consumption, and even addiction, to the economic and social fabric of modern society and the construction of individual identities (Ayres 2019, 2020).

We argue that there is a need to reconceptualise our understanding of drugs to contest the ongoing drug apartheid and to reposition attention onto the wider sphere of substance use with the intention of developing a single regulatory system which encompasses all currently legal and illegal substances. In doing so, we recognise the full spectrum of social harms and benefits that arise not only from substance use, but from society's reaction, stigmatisation and criminalisation of certain substance use/users; and its juxtaposed accommodation and celebration of others, despite them being as/more harmful.

Cultural Obsolescence

Whilst the prohibition of certain substances is justified as 'evidence based' (Taylor 2016) a body of writers contend that the legal/illegal drug dichotomy is grounded in political, economic, and moral bias (Szasz 2003; Pryce 2012). Instead of being rooted in science, this framework is legitimised through a fallacious interlinking of problematic populations, using problematic substances, and engaging in problematic behaviours (Taylor 2008). In essence, therefore, prohibition represents a system of control premised on capital rather than scientific harm (Ayres 2020)—a system more accurately described as the drug apartheid, which privileges certain drugs and their users whilst criminalising others (Taylor et al. 2016). So whilst certain intoxication practices are deemed socially acceptable and desirable, the practices of others are framed as social ills that require punishment and/or treatment (Ayres and Taylor 2020). Instead, unprivileged substances (i.e. illicit drugs) are blamed for many of society's ills (e.g., crime, disease, promiscuity, violence and abuse), whilst the wider systemic causes of societies objective violence is disavowed (Žižek 2008). It is in this context that certain substances, particularly illegal ones, act as a scapegoat, which sees their users ritually persecuted (Szasz 2003) and in some instances stigmatised (Goffman 1963). This is a malaise underpinned by illegal drugs being framed as inherently harmful, uncivilized, and resulting in a key outcome—addiction. Addiction is associated with a 'junkie scumbag' narrative (Radcliffe and Stevens 2008) that infers its prevalence amongst certain types of people, who use certain substances and consume outside the boundaries of acceptability. Here, addiction is used as a cypher for concerns about a lack of control (Reith 2004), to illustrate the inevitable consequences of inappropriate drug/lifestyle choices, as the fairy-tale villain through which we persuade people to 'just say no' to avoid becoming not only addicted but also an 'addict'.

Indeed, the 'addict' is stereotypically portrayed in society as a spectacle, which acts as a warning to us all to stay away from drugs (Ayres and Jewkes 2012). The power of some drugs is emphasised/portrayed as a demon possessing and haunting individuals, destroying them both morally but also physically (Ayres and Jewkes 2012) reducing them 'from

a whole person to a tainted, discounted one' (Goffman 1963: 3). While a dependency on other more privileged drugs (e.g. caffeine) is not only ignored/glossed-over, but is actively solicited (e.g. via the new coffee shop culture) and encouraged (e.g. sugary rewards for children). Such incongruences are not only indicative of the dichotomies inherent in drug policy and the wider political economy, but they also illustrate capitalism's dynamics of (planned) obsolescence (Burlow 1986). In this sense capitalism constantly seeks to revolutionise itself via new products, services, substances, lifestyles and experiences, which also perpetuates the illusion of freedom and choice (Winlow and Hall 2016), as every aspect of life is constantly revolutionised and commodified (Bauman 2000). This ethical and moral framing influences the social and cultural processes that arise from the spectacle as the 'boundary lines between conformist and deviant, good and bad, healthy and sick' are continually drawn and reasserted (Cohen 1971: 10). Those lacking the fortitude to 'say no' are ultimately held responsible for their morally reprehensible decision to use such substances, which simultaneously acts as a symbolic indicator of their morally repugnant lifestyles, creating a 'twofold stigma' which questions the utility of such populations within the neoliberal social-economic order (Atkinson and Sumnall 2020: 2).

Consequently, addiction to illegal drugs has become a metaphor for failure, with the 'addict' exemplifying Bauman's (2007) collateral casualties of consumerism. Here, addiction represents flawed consumption (and therefore citizenship) as it 'turns the sovereign consumer on its head, transforming freedom into determinism and desire into need' hence 'rather than consuming to realize the self, in the state of addiction, the individual is consumed *by* consumption; the self destroyed' (Reith 2004: 286 emphasis in original). Addiction, therefore, whether seen as a disease or value driven choice (Pickard 2020), is portrayed as a moral failure as 'addicts' constitute flawed consumers—yet in reality these consumers are merely heeding the calls/demands of the market (Žižek 2014; Ayres 2019, 2020). Resultantly, moralistic notions of self-responsibility permeate understandings and responses to consumerism generally and addiction more specifically. Consequently, state intervention is perceived as both necessary and benevolent (Brown and Wincup 2020), as competition between individuals is sublimated (Winlow and

Hall 2013). Hence, the category of the 'junkie' through its association with uncontrolled substance use, specifically heroin use, and criminality (Radcliffe and Stevens 2008), threatens the social order and thus warrants condemnation, which as Bauman (2000), drawing on the work of Levi-Strauss observes, manifests as stigmatisation and results in either their exclusion (anthropoemic) or assimilation (anthropophagic).

The stigmatisation of these casualties of consumerism therefore presents a warning to us all. It is a warning that many heed, aware of the ever present threat of apparent harm and stigmatisation. According to official statistics, the majority of the public do not use illegal drugs (ONS 2020), a key reason being that they associate such use with problematic outcomes (Fountain et al. 1999) and/or being contrary to personal values/self-image (Rosenberg et al. 2008). Meanwhile the significant minority that do use illegal drugs actively engage in processes to avoid stigmatisation in both their personal and professional lives through carefully managing disclosures of use, not engaging with drug services, etc. (UKDPC 2010a; Askew and Salinas 2019). Here, we see those whose wider lifestyles indicate an allegiance to the wider norms and demands of a successful neoliberal consumerist existence—a group who Askew and Salinas (2019) refer to as the *law-abiding criminal*—camouflage their second lives to maintain a position of social credibility. Nonetheless, their activities do receive denunciation from authorities but rather than proactively policing these, there is an attempt to shame those involved as unethical consumers who should modify their irresponsible marketplace behaviours (Siddique 2018; Elliot 2021). This is a process with lineage in the UK whereby free market access to products such as alcohol and on-line betting is accompanied by the contradictory messages to drink and gamble responsibly. Whilst there is some apparent public compassion for those who fail to assert control and progress towards addiction then (Roberts 2009), there is a strong belief that such an outcome is explained by personal (moral) failings (UKDPC 2010b) as drug use is consistently linked to morality.

Drug addiction has a long history of being posited, understood and responded to on moral grounds (Berridge 2013; Szasz 2003). Whilst this can take the form of 'addicts' being perceived as victims of circumstance (or indeed diseased) and considered with a degree of public sympathy,

the dominant narrative of drug scares (Reinarman 1994) associates drug users with an outsider status, concurrently constructed as vulnerable, peripheral, damaged and dangerous. In fact, addiction is a convenient term to describe disapproved consumption patterns, in this instance for substance use. Historically, 'addicts' have been labelled as evil, amoral and passive individuals controlled by the substance and who would do anything for their next fix as they are demonised, scapegoated and othered (Szasz 2003; Berridge 2013). Drug users and 'addicts' are something we should not be. In an epoch of fear, the addicted have been framed as a threat that needs to be exposed and/or managed—a belief that has seen an extension of prohibitive drug laws and the implementation of ever more punitive responses to such individuals (Ayres 2019). Instead, the dominant perception is that 'addicts' contaminate communities and in any 'decent' society they constitute 'matter out of place' (Douglas 1966: 36). Resultantly, we see addiction as a threat—a threat which arises due to poor individual consumption choices (Bauman 2001). Hence those who choose to use illegal drugs who consequently become enslaved through an inability (for biological, psychological or sociological reasons) to control this, become a fundamentally different entity (Taylor 2016). Whilst constructions of this threat show a proclivity towards racial, sexist and class-based bias, they fit into a broader theme of concern around the monstrous, immoral consumer.

Whilst addiction is therefore a failing, it is the wider connotations attached to the stereotypical 'addict' that cement their position as a social failure—an inability to work, ill-health, unacceptable parenting, reliance on welfare, committal of economic-impulsive property crime (Taylor et al. 2016). 'Addicts" erroneous consumption of drugs becomes the defining factor in their lives and identities. Their addiction is blamed for everything that is wrong as they are held individually responsible for consuming outside the boundaries of acceptable and legitimate consumption. Hence the addicted are 'portrayed as lax, sinful and devoid of moral standards' (Bauman 2007: 34). Their spoiled identities are deeply discrediting as it distinguishes them—the drug user—from other members of society. Those who encounter addiction, or more precisely those who encounter addiction who are drawn from certain populations, are framed as a menace to the status quo—an already marginalised

population, who despite the illusory freedom offered by contemporary consumer society are unable to engage with, or contribute to it 'properly', and who therefore endanger our way of life (Douglas 1966). Resultantly, they are posited as a problem to be managed, legitimising continued adherence to policies of drug prohibition and the bifurcated criminal justice system's coercive/punitive responses to those deemed problematic drug users (Brown and Wincup 2020). Here stigma is used by communities, individuals, the state and its agents to strengthen, produce and reproduce social inequality (Parker and Aggleton 2003)——with drug 'addicts' exemplifying how the ritual persecution of scapegoats pervades society (Szasz 2003), invoking stigma (Goffman 1963). Not only are certain forms of consumption vilified (e.g. excessive), but as Szasz (2003) shows, policies scapegoat certain drugs and their users illustrating the drug apartheid.

Yet the scale and scope of the 'monster hypothesis' is both fluid and related to the evolution of the consumer marketplace, which manipulates and shapes our desires (Baudrillard 1998). Monaghan and Yeomans (2016: 126) have emphasised the need to consider the convergence of drug and alcohol policy in the UK around the central facet of the 'problematic behaviours of problematic populations' noting that '…problem drinking and drug use are located within groups who exist somewhere outside of the societal mainstream'. While untrue, this argument draws attention to how the use of alcohol (and indeed tobacco) in certain ways has begun to blur with the characteristics of the illegal drug consumer we identify above. In relation to alcohol, recent decades have seen UK government funded marketing campaigns with taglines such as 'know your limits', 'fewer units more happy hours', 'you wouldn't start your night like this so why end it that way?' all emphasising the need for personal accountability in relation to alcohol consumption. Such thinking reinforces the message to consume and engage in risk, just not too much or they only have themselves to blame (Bauman 2001; Žižek 2008, 2014). It is also reinforced by partnerships between UK government and industry which frame engagement with these liberalised markets as an individual responsibility (e.g. Drinkaware). So, whilst the majority engage with multi-buy offers on alcohol in supermarkets and happy hours in local bars in a sensible manner—therefore legitimising

the legality and freedom of the market—a minority are unable to show such restraint (e.g. street drinkers; binge drinkers). Consequently, the latter group of flawed consumers become the target of policy advancements which seek to control and change or failing that exclude their behaviour as individuals seen as responsible for their own stigma are more heavily stigmatised (UKDPC 2010a). Resultantly, whilst heroin and crack cocaine users have consistently maintained a position as fallen and flawed individuals, there is a blurring of such unacceptability with those who use licit substances yet in unacceptable ways (e.g. pregnant women who smoke) (Ayres and Taylor 2020).

As Goodwin and Griffin (2017: 21) note 'in exercising consumer-based lifestyle choices, the individual is recast as an entrepreneur of the self who becomes responsible for their own fate'. Hence, those who lack the ability to consume (Bauman 1995) or those who consume beyond the boundaries of acceptable and civilised consumption (Ayres 2019, 2020), are marked out as beyond the boundaries of social order (Douglas 1966). Those that stray are criminalised, stigmatised and excluded as they become 'wasted humans' potentially infecting and polluting the rest of society and its normal functioning (Bauman 1995, 2004; Douglas 1966). It is here that the politics of exclusion (anthropoemic) implemented by the state operates, which, according to Bauman (2001: 96), has a tribal element that leads to a 'balkanisation of human coexistence', imposed through society's objective violence (Žižek 2008). This justifies the conjoined strategies implemented by society aimed at eradicating otherness as well as the unwanted 'Other', which applies to the stigmatised drug user:

> All over the urban spaces of the lands conducting the civilizing crusade. Fighting the 'ethnic cleansers', we exorcize our own 'inner demons', which prompt us to ghettoize the unwanted 'foreigners'…to demand the removal of obnoxious strangers from the city streets and to pay any price for the shelters surrounded by surveillance cameras and armed guards. (Bauman 2000: 199)

Instead, society has created public spaces designed to nullify otherness or exclude others via a bricolage of enclaves where we only encounter

people just '*like us*' (Bauman 2000: 176, emphasis in the original) to create 'a pathology of public space resulting in a pathology of politics' (Bauman 2000: 109). Thus, the flawed consumers—the outcasts—either warrant assimilation via treatment and therapy—or exclusion that operates as a form of social control (Szasz 2003). Public (and structural) stigma allows drug 'addicts' and vagrants (many of whom are also substance users), to be physically excluded from public spaces (Ayres 2019), employment (Singleton and Lynam 2009) and clinical interactions (Chang et al. 2016) to be treated and cured of their malaise (Ayres and Taylor 2020); they become a problem to be resolved or concealed (Bauman 2004, 2007), which is ideologically justified. It is in this context that the moral relativism that pervades contemporary society channels/sublimates competition, whilst also facilitating feelings of moral superiority over others (Winlow and Hall 2013). What we, and you as the reader of the chapter, fail or are unwilling to recognise, is that we are *all* drug users and many of us are also 'addicts', it is just that we are dependent on socially acceptable and sanctioned substances like sugar and caffeine that for the majority of us, does not impact on our productivity or ability to be a productive and consuming citizen, since citizenship is reserved for the good (not the unruly) consumers.

Instead, these ideologically biased perspectives serve as 'both an enabling condition and a pervasive ideological outcome of our systemically violent liberal democracies' (Taylor 2010: 147) perpetuating capitalism via its system of divide and rule as 'fantasy constructs the scene in which the Other [the 'addict', the 'junkie']' wants to steal or has already stolen our enjoyment, partly by threatening to ruin our way of life (Žižek 1997). Rather than acknowledge that capitalism has no 'genuine grounding in morality' (Winlow and Hall 2013: 57), 'addicts serve as a warning to us all; the "memento mori" sandwich men walking the streets to alert or frighten the bona fida consumers. They are the yarn from which nightmares are woven' (Bauman 2007: 32) and the only way to redeem themselves is via consumption; the consumption of products and services available from the legitimate marketplace (Ayres 2020).

It is only by consuming such products and services (e.g. drug treatment) that the flawed consumer with their spoiled identity can redeem their citizenship and be assimilated (anthropophagic) back into society as

'getting rid of that stigma… now conditions happiness; and happiness, as everybody would agree, needs to be paid for' (Bauman 2007: 37). Nowhere is this more evident than around illicit drugs, where we have a responsibility to consume ourselves out of addiction via the products and services proffered on the contemporary marketplace as drug use and addiction is individualised and pathologized. People are seen as either weak willed or sick, whilst the external, social and political economic factors are disavowed (Žižek 2008). As Bauman (2004: 118) contends:

> The state washes its hands of the vulnerability and uncertainty arising from the logic (or illogicality) of the free market, now redefined as a private affair, a matter for the individuals to deal and cope with by the resources in their private possession.

Illegal drugs use, addiction and stigma are therefore entwined within the content of neoliberal consumer capitalism, yet it is important not to view these phenomena in a substance use vacuum. Whilst some have recognised this by unveiling how not only dependent but also recreational drug users and dealers negotiate processes of stigmatisation (Askew and Salinas 2019), there is a need to move beyond a focus on solely illegal drug markets (Ayres and Taylor 2022). We must, therefore, expand our horizons into the wider drug apartheid to explore the social position and indeed negation of stigma in relation to legally accommodated drug consumption—as it only through an acknowledgement that other drug users gain social credence and identity from their use, that we develop a fuller understanding of the stigmatisation of illegal drug users as failed consumers.

Cultural Competence

Whilst considering issues of stigmatisation in relation to illegal drug users is therefore insightful, to recognise that such a process of stigmatisation is purposeful rather than an unfortunate by-product of the drug apartheid, there is a need to consider the wider malaise of drug use within consumer society, and indeed the differential social reaction it receives.

For whilst a spoiled identity may ensue from illegal drug use, most drug use affords a socially competent identity free from stigmatisation. The key reason being that in the context of consumerism there sits a hierarchy of substance use—one built not on the premises of reason, science, harm or danger but on the expediency of respectability, popularity, class of user and profit.

Resultantly, this is a house built on sand, which lacks a logical underpinning foundation and therefore has no structural integrity. Yet it uses the stigmatisation of the drug using others to camouflage these weaknesses: cloaking the systematic processes of corporate harm and structural inequalities inherent in contemporary capitalism, serving to control those deemed uncivilized, problematic and dysfunctional yet rewarding those who engage in practices, which although equally harmful (on an individual, social, environmental level) are deemed acceptable (Buchanan 2015). Whilst critical drug scholars have therefore focussed on the stigmatisation of a minority of drug users, to fully expose the contradictory practices of the drug apartheid and the harms faced by this group, there is a need to 'destabilize the boundaries' (Ivsins and Yake 2020: 34) of drug prohibition by considering the social stature of, and harms experienced by, the majority (Ayres and Taylor 2022) as processes of stigmatisation represent a purposeful tool for the perpetuation and evolution of the capitalist status quo. It is therefore imperative to expose how those licit drugs, which promote harm on an equal, if not greater scale than illegal drugs (Taylor et al. 2016) are socially accommodated and embedded, demonstrating how the differential social positioning of a drug and its users enables the continuation of the two central motivations of the drug apartheid—ongoing profitability and control.

Taylor and colleagues (2016) argue that the legal/illegal positioning of substances is arbitrary as the claim that such categorisations are governed by notions of harm is untenable. Within these frameworks, however, the utility of different substances is far from arbitrary as they provide intentional outcomes. Take for example our incentive system with young children whereby good behaviour is positively reinforced through treats such as ice creams, sweets, fizzy drinks and chocolate. Here we provide sugar (and caffeine) as a reward for social success with conformist behaviour positively reinforced with the supply of a drug over

which children crave due to its deserving and pleasurable characteristics (McCafferty et al. 2019). While most people see nothing inherently wrong with rewarding children in this way, the reality is we are encouraging them to eat what is scientifically posited as a poison, that they will become addicted to, and which has the potential to cause many of the same harms we attribute to alcohol—and yet there are not many who would reward a child with a glug of whiskey or a bottle of gin (Lustig et al. 2012) after they have put their toys away, but why?

The answer is that our understanding and accommodation of drugs are governed by engrained understandings of dominant social practices (Bancroft 2009)—which are themselves engineered by the consumer marketplace and contemporary ideology (Ayres 2020). The substances used by the majority result in sought after social reactions and labels (Becker 1963) because they are used by the majority. The stigmatisation of the minority occurs because they are just that—the minority—a tangential group, on the periphery, the other. Let alone when the drug use of this minority is combined with other stigmatised traits/backgrounds including class, race/ethnicity and sexuality. Whilst the question of why illegal drug use is stigmatised is therefore a relevant one, it is insignificant in relation to the more imposing question of why the majority of drug use—which prompts a much wider scale and scope of harm—is constructed as socially acceptable/competent.

It is essential to therefore realise that the consumption of the 'right' substances does not invoke stigma unless you exceed the constantly changing and contradictory limits of acceptability outlined/proffered by postmodernity's imaginary ideals and moral relativism. This means that most drug use, despite resulting in greater harm than that associated with illegal drug use, fails to attract condemnation. Instead, it is indicative of cultural competence and conspicuous, often wasteful, consumption (Ayres 2020; Veblen 1969). In fact, luxurious substances like Krug champagne, diamond encrusted Royal Courtesan Gurkha Cigars or Henri IV Dudognon Heritage Cognac have shaped the spirit of capitalism (Veblen 1969; Baudrillard 1998; Ayres 2020). Quite aside from whether consumers enjoy the taste of these products, their consumption is associated with celebrations of wealth, status and achievement alongside the formation of identities as people consume themselves into being

(Baudrillard 1998). Indeed, 'champagne wars' amongst the rich and famous see oligarchs attempting to outspend each other to become the ultimate embodiment of success (see Binns 2013) as everyone attempts to stand out from the crowd but also fit in as they conform to the imaginary ideals and symbolic frames of reference promoted by neoliberal capitalism (Baudrillard 1998; Hall et al. 2008). In fact, consumerist performances/behaviours determine their inclusionary or exclusionary status. Even when used to excess, rich and famous 'addicts' are not stigmatised and excluded, instead the celebrity 'addict' living the high life makes money from their addictions, as addiction sells, and moral relativism dominates. Look at Russell Brand who has made a career from his addictions or Kate Moss who increased her market value after being dubbed 'Cocaine Kate' (Ward 2005; Vernon 2006). However, it is not just the consumption of luxury substances by the rich and famous that warrant such a reaction, we also see it with more mundane and everyday privileged non-drugs like caffeine and sugar, which an addiction to is neither mentioned nor acknowledged, and may in fact be actively encouraged.

The social positioning of substances and their consumption therefore relates to socially reinforced norms and patterns of behaviour, but also to how we construct our social identities and leisure time, our lifestyles. A good example here is the way people organise social interactions around (non) drug consumption (e.g. meeting for coffee or going for afternoon tea). Whilst such a rendezvous may not immediately appear drug focussed, the social position of a drug, caffeine (and sugar) in this instance, is crucial to the whole meaning, experience and existence of such behaviour. Here, we can draw on an exchange from the film Good Will Hunting.

Skylar: Maybe we could go out for coffee sometime?
Will: Great, or maybe we could get together and just eat a bunch of caramels.
Skylar: What?
Will: When you think about it, it's just as arbitrary as drinking coffee.

Will's comments are astute, but he is wrong to assume that meeting for coffee is arbitrary. Instead, it represents a lifestyle choice, one in which the competent consumption of caffeine is a key factor in a wider cultural experience which espouses sophistication. It also allows consumers to implement their freedom and partake in ethical consumption, as everyone seems to have bought into the new coffee ethic; an ethic that legitimises the non-drug coffee and promises its drinkers redemption (Žižek 2008). Meeting for caramels simply does not carry the same social significance. Instead, going for a coffee in chains like Starbucks are imbued with ideology (Žižek 2014) as are other substances which includes drugs and non-drugs (see Ayres 2020). In fact, although you may pay more for coffee in Starbucks (as well as other 'good' coffee houses/chains) you are buying more than just a coffee, you are buying into a lifestyle choice—'a coffee ethic'—that constitutes ethical consumption, which means you are partaking in 'good coffee karma' that offers you redemption for being nothing more than a consumer (Žižek 2008, 2014).

The centrality of substance use to such cultural experiences and lifestyles epitomises the wider role it plays within our consumerist existences and the exigencies of capitalism more widely (Ayres 2019, 2020). Indeed, substance use increasingly plays a pivotal role in our attempts to redress the substantive lack whilst acting as a medium through which we may avoid disparaging social labels which demarcate us as flawed (Ayres and Taylor 2020). Consumption of these substances put us ahead of the competition (Ayres 2019, 2020) as everyone strives for perfection (Bauman 2007; Hall et al. 2008). Here we see people consume an array of legal substances (which are increasingly procured through illicit marketplaces—see Hall and Antonopoulos 2016) to achieve a desirable social identity/image/status—e.g. Viagra and masculinity (Loe 2001); steroids and an enhanced body image (Begley et al. 2017); cosmetics and beauty; pharmaceuticals and health (Ayres 2020). These (non)drug users, rather than warrant condemnation and stigmatisation, actually elicit envy and desire, despite consuming sham objects that are potentially harmful—more harmful than many illicit and prohibited drugs (Ayres 2020; Winlow and Hall 2016). These are (non)drugs around which users project an image of themselves and their accomplishments,

indicating their eminence (Hayward and Turner 2019). For at a time when a demand for ethical consumption interweaves with a middle-class desire for authentic, artisan products that detach users from the gullible crowds who lack the ingenuity and independence to break free from mass produced goods (Thurnell-Read 2019), drug use has become a key defining feature around which we both inwardly and outwardly centre our lives and lifestyles around. We have therefore seen the reinvention of established alcohol products which boast their craft credentials, one only has to look at the 'embourgeoisement of beer' (Thurnell-Read 2018) whereby it has moved from being 'bitter' to 'real ale' to 'craft ale' with an explosion in the markets surrounding the product allowing those involved to centre their leisure pursuits around this (through attending beer festivals, brewery tours or micro-pubs). Simultaneously a beer's craft credentials mean its consumers distance themselves from the crass orange, pink and blue flavoured products imbibed by the stigmatised binge drinking neanderthal (Thurnell-Read 2017).

Engel et al. (2020) have argued the need for more positive drug stories relating to illegal substances to enable users to move beyond a stigmatised identity to one which demonstrates a degree of pride. Just as the brand of beer one drinks can reflect on one's self-image, so could the type of ecstasy tablet. Yet this is not the case. But when considering this we must recognise that this demarcation is not grounded in any rational scientific basis. Legal drugs are equally, if not more dangerous than illegal drugs, despite the former being illicitly produced. The stigmatisation of drug use and users therefore is only achieved through society attributing stigma to the use of certain substances and not others. In an alternative universe, a daily dose of amphetamine in a morning might be acceptable, a night-cap of heroin equally so; whilst a double shot of coffee with sugar to wake us up and a large whiskey to send us off to sleep might attract condemnation. The position of a drug in the hierarchy of the drug apartheid—and the ensuing stigmatisation that it does or does not receive, is not an accident and is certainly not governed by the inherent danger that it apparently represents—instead, it is determined by its social positioning, which is guided by the capitalist markets that produce, distribute and sell it—and the markets inherent need to polarise and pillory those on the periphery. Hence, this positioning demarcates

between acceptable/unacceptable, and healthy/unhealthy substance use, drawing attention to certain unwelcome consumption practices whilst celebrating others, highlighting what harms are constructed as drug related and which are not, determining the gaze through which we apply notions of stigma and success, of cultural obsolescence and cultural competence. Thus, it establishes that it is only possible to understand the stigmatisation of certain drug use and drug users through locating such use/users within the ideology of neoliberal capitalism and its erroneous hierarchy of substances determined by the drug apartheid; a context increasingly moulded by the market forces of consumerism, its moral relativism and the omnipresent lack felt by its consumers.

Conclusion

When considering substance use, in its widest sense, through the lens of stigma, amidst the context of consumerism, things are undoubtedly complex. This chapter, however, utilises the concept of the drug apartheid to illustrate how these facets interact to present an apparent justification for the differential positioning of drugs and their consumers within contemporary society—a situation we regard as untenable. In doing so, we argue that this complexity is indicative of an economic system built upon contradictory principles, which ensures the dominant status quo is maintained and indeed perpetuated; and a set of laws surrounding such markets which are inconsistent, arbitrary and grounded in fallacious reasoning. Hence, whilst certain drug use signals cultural competence, embedding the functional citizen into the circuits of consumerist society, other drug use is pilloried with users jettisoned into cultural obsolescence; casualties of their flawed consumption choices.

It is in this context that the drug apartheid operates and thrives, as stigma, operating as a public form of branding, vilifies those who deviate from societal norms, acting as tacit form of social control (Szasz 2003). Resultantly, those branded warrant either exclusion (anthropoemic) or assimilation (anthropophagic) (Bauman 2000) as stigma is used to perpetuate social inequality (Parker and Aggleton 2003), whilst the

hypocrisy underpinning the erroneous distinction between drugs and non-drugs is disavowed. Despite *everyone* being a drug user and many demonstrating characteristics of drug dependency—albeit to legal non-drugs—the focus remains on certain substances and certain users in certain contexts. Meanwhile, the harms arising from these non-drugs, the frameworks which govern their use and the wider structural social inequalities are fetishistically disavowed (Žižek 1997). Instead, certain drugs become the scapegoat—blamed for the breakdown of society, families and communities, a cause of crime, disease and even death—as this process of demonization conveniently detracts from the more complex personal, social and structural drivers of addiction and the innate harms of neoliberal capitalism and its objective violence (Žižek 2008; Taylor et al. 2016; Ayres 2020).

Erroneously, certain drug use brings cultural competence and some cultural obsolescence whilst others still occupy a liminal position somewhere in between these (Taylor et al. 2018). Within this malaise the contrasting processes of social stigmatisation and significance are applied (and in some cases sought after) and experienced in a discriminatory fashion formulated around wider notions of a (un)successful, normative neoliberal existence that largely revolves around consumption. Such processes will continue unabated until we reconceptualise what we understand to be drugs (Seddon 2016), contest the dominant drug apartheid, and revise the damaging processes of consumer capitalism. It is not until all drugs become recognised as drugs, and all people become recognised as drug users that this can occur—and until we breakdown the arbitrary dichotomy between drugs and non-drugs this cannot happen. Within the consumerist context people self-identify as tea or coffee drinkers, as craft ale enthusiasts, as artisan gin lovers, as having a sweet-tooth, as cigar aficionados, with a degree of pride—illegal drug users should also be able (if they so wish) to do the same, and enjoy such emotions, and whilst the stigmatising processes of drug prohibition currently mean that the label 'drug user' is more stigmatising that it is beneficial, it should be something that we have an ambition to readdress as long as it is redressed along scientific evidence-based lines than stand up to scrutiny, rather than a political, economic and morally biased system that is shot through with contradictions and paradoxes. There is

therefore a need to move beyond contemporary constructions of drugs and stigma, which merely exacerbate many present harms through their legitimisation of the drug apartheid. Until then, drug related harm, of which stigma constitutes a singular yet crucial element, will continue unabated as a tool of condemnation to indicate an individual's failure to abide by the barometers of a successful neoliberal existence, which merely perpetuates and prioritises the exigencies of capitalism.

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‘It’s What Happens Now When People Go for a Drink’: Normalising Non-dependent Recreational Cocaine Use Amongst Over-35s in the UK

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Introduction

This chapter explores lived experience of non-dependent recreational drug use (NDRDU) amongst ‘older’ people who use drugs (PWUD) in North East England, categorised by extant literature to be those over 35-years-old. We examine the role that NDRDU plays in the lives of this population group and, to a lesser degree, extent and patterns of use. Here, we define NDRDU as occasional or sporadic use that occurs for pleasure in the company of others in recreational settings (Fletcher et al.

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2010). Recent literature reviews have examined problematic, dependent or treatment seeking illicit drug use in older populations (Carew and Comiskey 2018; Larney et al. 2017). However, we found little available research and no reviews focusing solely on NDRDU amongst adults aged 35years+ , as well as a particular lack of qualitative literature in this area. A recent qualitative systematic review exploring polysubstance use across all age ranges (where amphetamine-type stimulants were the primary substance) identified just two studies that focused only upon older adults, and both did not explore NDRDU only (O'Donnell et al. 2019). Moreover, we argue here that binary distinctions between dependent and recreational drug use can be unhelpful. In reality, lines between recreational and dependent drug consumption can be blurred, with shared definitions of recreational use lacking, particularly in relation to drug type, length of use and patterns of consumption (Caiata-Zufferey 2012). For example, dependent PWUD may take drugs for recreational reasons, albeit with a high level of dependency, quantity and frequency (O'Donnell et al. 2019; Addison et al. 2020).

Drawing on rich ethnographic data (collected by CA), our findings highlight the dominance of cocaine powder (Cocaine hydrochloride) as the drug of choice for over-35s. Polydrug use featured alcohol, cannabis and MDMA tablets and powder as part of consumption practices. Further, the routine and regular nature of consumption was noted, and—as the title of this chapter suggests—cocaine powder had become a normalised, recreational element of social life, particularly alongside alcohol consumption. In our analysis, we draw on interlinked theoretical understandings of normalisation and stigma to interpret NDRDU amongst older people. We assert that older people in this study did not appear to internalise stigma, in relation to their own recreational drug use, despite external stigma levelled at cocaine use in wider society, and despite their own disapproval of 'harder' drugs such as crack cocaine. In resisting the stigma associated with their drug use, older consumers subverted or renegotiated Goffman's (1968) description of the 'spoiled identity', a concept central to his seminal definition of stigma. A lack of self-stigma about powder cocaine led to continued, routinised or normalised recreational use. Reasons for continued use mirrored why people drink and take drugs recreationally in general terms—because

it relieves boredom and because of the sociability and hedonism traditionally associated with recreational drug use. In other words, they took cocaine with other people taking cocaine to enjoy themselves, and subverted stigma by keeping within peer groups who they take drugs with, also avoiding condemnation and disapproval.

The remainder of this chapter is organised as follows. First, we outline relevant literature which foregrounds a discussion of NDRDU amongst older adults. We then examine theoretical literature focusing both on normalisation and interpretations of stigma, particularly the categorization of self (internal) and public (external) stigma. Second, we briefly discuss methods and methodological assumptions, moving on to explore key findings of the research. Finally, we outline the implications of our findings, concluding with a prompt for further research into lived experience of NDRDU amongst older people.

Background

The Rise in Powder Cocaine Use

Powder Cocaine is the drug of choice for many millennials (aged 25–40) and older, rising in both purity and availability in recent years (European Monitoring Centre for Drugs and Drug Addiction 2018; González-Mariño et al. 2020; Miller et al. 2019) Once regarded as the drug of the rich and famous, between 2013/2014 and 2018/2019, the number of powder cocaine users rose by approximately 24% (Home Office 2020). Moreover, 22% of current recreational users are aged 35–59 (with significant increases for those 50+ years old); and 23.8% earn over £50,000 per year, with those in higher managerial, administrative and professional occupations driving much of this increase. Recent data also show a statistically significant increase in the number of women reporting recreational powder cocaine use (Home Office 2020). Nevertheless, whilst a very small, burgeoning field of literature has begun to focus on older, recreational drug consumption (Askew 2016; Moxon and Waters 2019), most of this work explores long-term cannabis use with very little work focusing on powder cocaine.

Recreational Drug Use Amongst Older Adults

In seeking to understand patterns and experiences of illicit drug use following the upsurge in consumption as part of 1980s and 1990s rave/club culture, the normalisation thesis is probably one of the most well-known and widely used concepts within the literature on illicit drug use (Measham et al. 1994; Parker and Measham 1994). Based on research with young people aged 14–15 in the North West of England in the early 1990s, Measham et al. (2011) suggest that normalisation relates to 'the social and cultural acceptance of drugs in everyday lives' (p. 421). This framework has inspired a raft of studies which build upon, and reassess, the concept to explore the extent to which normalisation holds up in more recent work and beyond the UK context (O'Gorman 2016; Patton 2018; Pennay and Measham 2016; Shildrick 2016; Williams 2016). Further, though it has been argued by some that normalisation overstates and oversimplifies the level of broad acceptance of illicit drug use, Shildrick's (2002) notion of 'differentiated normalisation' perhaps captures the nuances of contemporary recreational drug use, by suggesting that different types of drugs and different types of drug/or use may be normalised for different groups of people; whilst O'Gorman (2016) asserts that such differences are shaped by different intentions, avowed identities and diverse structural, temporal and socio-spatial settings.

Studies conducted in the wake of normalisation have traditionally focused on young people's experiences, with some broader work including the experiences of young adults in their twenties (Cristiano and Sharif-Razi 2019; Patton 2018; van der Poel et al. 2009). As set out in our introduction, there is a dearth of literature focusing on older people's NDRDU, beyond the presentation of statistics and work focusing on dependent consumption, predominantly of substances like heroin and crack cocaine (Latkin et al. 2013; Muncan et al. 2020; Boeri et al. 2008), and which focus on harm reduction and the stigma associated with intravenous drug use. Notable exceptions include Boeri et al.'s (2006) study of baby boomers which includes some exploration of non-dependent use; and Pearson's (2001) seven-year (1990–1997) ethnography of older PWUD, based on observation and interactions in several traditional

neighbourhood pubs in inner London. The latter revealed similar themes to our later observations relating to how, within networks of friends and acquaintances, drugs had undergone a process of 'cultural normalisation' as a typical leisure practice, with cocaine use increasingly evident within jokes and exchanges, and via the communal rituals associated with cocaine use, such as leaving a line of cocaine powder in the toilet for friends. As Pearson (2001) states:

> …they did not think of themselves as "drug users"—it is merely something that they do, or do not do, as an ancillary to other aspects of their lives, whether work or leisure—and who only rarely, if ever, gather together for the purpose of consuming drugs. (p.173)

Pearson's early contribution also points towards the use of cocaine powder alongside alcohol. Physiologically, cocaine powder facilitates the consumption of alcohol far beyond regular limits (Gossop et al. 2006), and the two substances interact to produce a longer, more euphoric high (Pagano et al. 2005). From a critical criminological perspective, Ayres and Treadwell (2011) describe this as embracing 'pharmacological oblivion' and an opportunity to purchase a period of 'time out' from societal control and the banality of everyday life. Indeed, concurrent or simultaneous use is considered to be an integral and functional component of mainstream leisure pursuits within the Night-Time Economy (NTE) (Brache et al. 2012; Boys et al. 2001; Ayres and Treadwell 2011).

More recently, Williams (2016) has reflected upon the contemporaneous relevance of the normalisation framework, cautiously observing that, whilst we may be witnessing the 'denormalization' of recreational drug use amongst younger people—as evidenced in decreased consumption of illicit substances—this is juxtaposed against recent increases in drug use amongst older people which resonate with trends we explore in this chapter. Williams (2016) contends increased prevalence of drug use amongst the current older generation may be attributed, in part, to the legacy of 1980s and 1990s rave/club culture, arguing that young adults who lived through this period and participated in the drug and club culture took more illicit drugs—predominantly ecstasy and

amphetamines—than any other generation before and after. Consequently, the increases we now see are merely a continuation of drug use for this generation into middle-age and a delay in 'ageing out'. Alternatively, other work suggests that what we are seeing represents 'lifetime use' or use across the life course, amongst specific subgroups. For example, Van der Poel et al. (2009) note increases in 'lifetime' Dutch cocaine users (aged 16–64) between 1997 and 2005. Further, whilst not focusing on cocaine use, Addison et al. (2020) found increased use of Amphetamine-Type Stimulants (ATS) at critical turning points (unemployment, physical/mental health problems, involvement with social workers) amongst users aged 19–62. Meanwhile, some studies suggest a greater degree of risk management or 'responsible use' amongst older, recreational drug users, with 'calculated' or 'enlightened' hedonism reported in much the same way as alcohol use (Ayres 2019; Szmigin et al. 2008). Nevertheless, vulnerable drug users are likely to have very different experiences. Conceptually, such differential experiences align to stigma associated with certain types of drug use, to which we will now turn.

Defining Stigma and Hierarchies of Drug Stigma

'Stigma' is a contested concept (Hicks and Lewis 2020; Tyler 2020), the roots of which are well covered in other chapters of this edited collection. The seminal understanding of stigma, which underpins most sociological research, originates from the work of Goffman, who described stigma as 'an attribute that is deeply discrediting' (1968: 13). Rather than a fixed or immutable trait, he suggested stigma to be a 'relational concept'—we create it via interaction and, therefore, can contest it in the same manner (Goffman 1968). Indeed, Hicks and Lewis (2020) have argued that stigma is *negotiated, resisted and apportioned* in everyday life, with those stigmatised often also performing the role of 'stigmatiser'. Scambler (2009) and Tyler (2020) have argued for a re-conceptualisation of stigma, by outlining how Goffman's original work excluded questions of how social relations are embedded within capitalism and structured through power and governmentality (Tyler and Slater 2018). Meanwhile,

within applied health research, stigma has been operationally defined as 'the ways that particular localities (e.g., towns, wards, estates) and their residents are negatively portrayed and stereotyped' (Halliday et al. 2020). This reflects a traditional public health focus on geographical areas marked out by socio-economic inequalities, and has led to a more recent focus upon place-based, spatial or territorial stigma (Halliday et al. 2020). This disconnects with sociological interpretations of individual-level or 'identity' stigma, which do not tend to examine health impacts (Garthwaite and Bambra 2018).

In this chapter, we draw on Bowen and Bungay (2016) who define stigma as:

> A socially constructed, context-specific experience of Othering that devalues one's identity, social contributions and potentially in ways that limit how one can interact within one's world of socio-structural relationships. (p. 187)

We also draw on Corrigan and Watson (2002) who focus on differential stigma, namely how stigma can be categorised conceptually as public stigma and self-stigma. Public (or social) stigma refers to discrimination, public fear and negative social construction. Meanwhile, self-stigma can be defined as internalisation of negative public stereotypes, characterised by shame, secrecy, discrimination and social withdrawal (Boyd Ritsher et al. 2003; Corrigan 1998) Others have articulated this as different 'levels' of stigma—structural, public and individual (Inglis et al. 2019; Kulesza et al. 2013) or enacted, perceived and self-stigma (Buchanan 2004), highlighting that multiple stigmas can co-exist and have a compounding effect in people's lives (Hammarlund et al. 2018; Kulesza et al. 2013). Nevertheless, as alluded to earlier in this chapter, much extant literature exploring drug use and stigma focuses on intravenous drug use and/or dependency. Like others, we therefore acknowledge the possibility of 'hierarchical' drug stigma, where some forms of drug use, often equated to drug type and social status of user, become more heavily stigmatised than others, both within drug-using circles and wider society (Briggs 2012, 2013; Bancroft 2009). For example, Sznitman (2008) illustrated the micro-politics that drug users engage in to resist or subvert

the stigma attached to them. Meanwhile, Pennay and Moore (2010) identified a range of ways in which those within a friendship network negotiated stigma associated with drug use. Added to this, are new and intensified forms of stigma, such as the portrayal of drug users as a form of entertainment (see Alexandrescu's 2019 work on spice zombies). Like Shildrick (2002), we contend that there is no singular experience of drug use, leading to the core question in this chapter: what if NDRDU in certain circles is routine, accepted and largely mundane, rather than stigmatised?

Methods

Drawing on the role of CA as a 'peer' or 'insider', data presented here is a secondary analysis of data originally derived from a larger, established ethnographic study, which began in 2004 as a study into the impact of deindustrialisation in disadvantaged locales (Ancrum and Treadwell 2016; Hall et al. 2005, 2008); the methodological and ethical implications of which have been discussed elsewhere (Ancrum 2013; Hall et al. 2008). Data stems from overt observation, biographical narrative interviews, conversations and interactions with residents from two Council Estates in North East England. Recent years have seen increasing recognition of biography, relationships and emotion in criminological and sociological research (Newbold et al. 2014; Wattis 2019; Wakeman 2014). Whilst this is not an auto-ethnographical account, like others, we contend that familiarity with a particular culture, in this case drug use, allowed the researcher (CA) to provide insights beyond abstract theories (O'Neill 2017; Ross et al. 2020). Here, access was enabled by close personal relationships with key stakeholders in the local drug market economy.

Our interpretation in this chapter is based upon one theme—the 'normalisation' of non-dependent recreational cocaine use amongst older adults. Data were then framed within sociological and criminological literature about normalisation, NDRDU and stigma (or lack of). The findings below are presented as a series of narrative case studies exploring the widespread acceptability of non-dependent recreational use

of powder cocaine in this sample of over-35s, and the relative disapproval of other types of drug use such as crack cocaine.

Findings

Overall, our findings suggest that, within peer groups, recreational drug use amongst older people, specifically the consumption of cocaine powder, now carries a degree of acceptability and 'normalisation' within said peer groups and networks, and carries little individual or self-stigma. This is supported by the sociability of cocaine use amongst friendship and acquaintance groups. Indeed, it would appear that cocaine use was a central element in social lives, often alongside alcohol consumption. Although usage varied across the findings—for instance, regular weekly usage as opposed to cocaine as a treat for special occasions—degree of acceptance and lack of stigma did not. It is important to state however, that cocaine use may well be condemned beyond the peer group. The following accounts illustrate this, centring on the following themes: the expert/key informant on drug use; the habitual but unproblematic user and the discerning consumer.

'Billy'

Billy (aged 52) is a local cocaine dealer who has been involved in drug supply in the area for a number of years, elevating his authority status to expert/key informant. In other words, he was able to act as a barometer for activity in this particular local area. In his accounts, Billy emphasised the normality and lack of stigma attached to cocaine use—from speaking to his retail level contacts he is aware that powder cocaine is popular across the age and gender spectrum and that many otherwise law-abiding adults are using cocaine regularly. Billy's perspective is borne out in research evidence on cocaine use. For instance, Troiano et al. (2017) found that the percentage of circulating banknotes' positivity to cocaine ranged from 2.5 to 100%; whilst it is estimated that 23 kg of cocaine is consumed every day in London (González-Mariño

et al. 2020). Increases were also highlighted in reports from the Forensic Science Service from 2010 which indicated that every banknote in Britain becomes contaminated with cocaine within two weeks of issue.

Looking at the extract from Billy below, the normality of drug use is reinforced by references to space and place. The physical spaces in which drug use occurs are often a key aspect of the 'risk environment' for PWUD (Hunter et al. 2018). Traditionally, such spaces were seen on the margins of inner-city urban space, associated with risk and disturbance, and characterised by some form of enclosure and separation from street-level activity, but still public in character (Linas et al. 2015). Instead, Billy describes people snorting cocaine in the social club, the hub of the traditional working-class community:

> Billy: *there are so many people on it now it's unreal. People that used to look down their noses on drug users are suddenly hammering the beak [cocaine]. Blokes that had never touched drugs in their lives, my age, they're snorting in the bogs on an afternoon sesh in the [social] club. Then they stop on it with their lasses later on…it's just spread. It's a drug that lets you drink and stay out. You don't feel pissed with it really so you can keep going.*

Moreover, the use of mobile phones and social media such as WhatsApp have made the sale and purchase of drugs more convenient and 'risk-free'. Insights into the widespread nature of supply and demand, increasing normalisation and availability of powder cocaine, were also offered by Dean, aged 47, a small-scale cocaine dealer, and George, aged 54, long-time user and ex-career criminal:

> Dean: *You can see people on it everywhere. It's not just young 'uns either, it's all sorts. A lot of older people like it coz it keeps them going on the drink. I sell more to lasses than lads a lot of the time, they can't seem to get enough of it, they seem to have stopped wanting speed and buying 'beak' instead.*
>
> George: *Everyone wants it now and everyone can get it. I remember when it was a real mission to find it. We used to trek all over, the West End, the coast, across the river everywhere and sometimes still not score. Now, the fucker's everywhere, it's just become normal for people to use it. It was much less known about back then, the only people I knew who used it were other grafters [criminals, especially commercial burglars], lads with a bit cash on the hip, it was 50 quid a G (gram) back in them days (late 80s) but like*

I say wasn't easy to always find. There's any amount of it now right on ya doorstep or even fucking delivered, happy days (laughs).

Some participants, including Billy, referred to a drug hierarchy. In other words, weed and cocaine were acceptable, whereas crack and 'smack' were subject to vilification and public stigma. Further, he describes two different types of PWUD—continuation of younger drug-taking (for example ex-ravers), but also people who were not into that scene, and had started taking cocaine later in life.

Billy: *It's only really cocaine and maybe weed they see as ok. And even cocaine, if it's crack, lowest of the low crack and smack heads…Nobody is bothered about it [cocaine], it's just become a part of going out for a lot of people. I think a lot of them are the same crowd that used to go raving in the early nineties. Can't handle the whole weekend off their faces on E and stuff but still like to party so they use that.*

'Yvette and Andy'

Yvette and Andy are a married couple in their mid-40s. Andy owns a small building firm and Yvette is a care assistant. They have two children both in their teens. They began using cocaine approximately five years ago and describe their pattern of use as occasional. Yvette and Andy typify older NDRDU, those who do not overdo it, and who are described in various theories of intoxication as controlled or calculated hedonism (Szmigin et al. 2008; Taylor, Ayres, and Jones 2020):

Yvette: *It's just on the odd weekend really. If we're out and having a good time we'll get a bag or sometimes you get a line off someone else and then you want some of your own*

CA: *So how much would you use between you on a good night out?*

Yvette: *We never buy more than a gram, so half a gram each and maybe a couple of lines from somebody else…. but then you might give away a couple of lines as well, the odd time at a party or something you might take a bit more.*

For Yvette and Andy, powder cocaine use was an extension to their alcohol use, for much the same reasons as those highlighted earlier in

the chapter—it was seen as fun, social and accepted amongst friendship groups; Yvette's narrative also confirmed that it would be very unusual for people not to drink alcohol in this social group ('*just coke and alcohol … obviously*'). Yvette and Andy represent older people who, although they had dabbled with recreational drugs when younger, drug use was not a huge part of their lives; they had started to use cocaine later in life, in similar ways to the pub goers in Pearson's seminal study:

Andy: *I only drank until about five or six years ago. I've tried weed and took acid a few times when I was a bairn but I've always loved me drink.*

Importantly, Andy describes how powder cocaine is consumed in the kitchen whilst chatting. What he describes here is a very casual, domestic and normal tableau, which in common with the social club, is far removed from the stigmatised and marginalised lives of dependent drug users. Like Billy, Andy describes a higher prevalence in powder cocaine use ('*every fucker is on it now*'), leading to normalisation and subversion of personal-stigma or stigma within social networks:

Andy: *I just like the feeling. It's a good buzz and that. Makes everyone nice to each other and you have a good craic with it. You end up in the kitchen at stupid o'clock talking shite and that but it's good.*
CA: *And do think there is any stigma attached to cocaine use? Do people look down on you for using it?*
Andy: *Naw, not at all. Every fucker is on it now. It's nowt really just a good laugh. Obviously you don't want to be on it all the time, would send you loopy but for most people it's just fun on the weekend sesh.*

Titch

Participants in this study reported a marked increase in the purity and quality of cocaine which they perceived as altering the market in two key ways: (1) the price of new, purer products has increased at wholesale and retail level; (2) a secondary market in heavily adulterated cocaine has developed known as 'bosh' or 'bash', diluted with lactose, or caffeine powder. This weaker cocaine is popular amongst those who merely want a drug that will keep them awake and allow them to drink heavily without getting too drunk. Nevertheless, we noted a distinct preference

for a 'purer' product. Drawing on Edland-Grvt et al. (2017), whilst user perceptions may not necessarily reflect pharmacological 'fact', they are nonetheless important because PWUD act according to these perceptions when deciding if and what drugs to use, thus providing a barometer of market preferences. Informants linked higher purity preference to the emergence of a different user—the discerning consumer who demands a higher quality product, and who will go to dealers who will provide them with this. That said, some users, albeit not many, preferred heavily diluted 'boshed' cocaine, finding high purity powder to be 'too much'. 'Titch', a 47-year-old regular user stated:

> Titch: *The proper stuff, the pure gear, fucking too strong mate. You start off having a laugh, talking shite and that but then after a couple of lines you are off ya fucking nut. Wired to fuck staring at the floor. Makes me go dead quiet, proper in me shell. With the boshed gear you don't get that.*

In other words, recreational powder cocaine users demonstrated agency and choice, in much the same way as consumers of alcohol or tobacco. In itself, the ability to do so highlights an absence of stigma and, for this group of older people, cocaine use was a routine element of leisure activities.

'Pauline'

Pauline is 56 years old and a pub landlady. Again, Pauline represents a key informant—she revealed that she is well aware of cocaine use in her pub but turns a blind eye, mainly for financial reasons. She articulated widespread, normalised use ('*a badly kept secret*'), often found evidence of cocaine use in the pub and commented that the pub would be empty if she barred people:

> Pauline: *Of course I know what goes on, you'd be daft not to. The lads especially, they are in and out of the toilets like a fiddler's elbow. It's not really a problem as long as they don't go stupid. Try and be a bit discreet like. If I was to bar them for using it there would be nobody left in the bar some nights…To be honest they usually behave themselves anyway, makes them nicer, all smiles and politeness buying you a drink for yourself when you get*

served. Never seems to be any fighting or anything but mebbe that happens later. You go in the toilets to clean in the morning and there will often be a line still left on the cistern, too bloody dear to waste so shows you how off it they must be (laughs) or those little plastic bags on the floor, see it all the time. The disabled stall in the gents is the favourite.

Like George and other informants, Pauline discussed older, female cocaine use:

Pauline: *Oh aye, the lasses do it as well but not so much. Saturday when it's mainly couples you see them more, not just the young uns either, women in their thirties and forties but they tend to be more discreet than the lads are. There are a few lasses who come in regular and you know they are doing it but again there's no bother so I don't see any point in making a fuss about it.*

George: *I sell more to lasses than lads a lot of the time, they can't seem to get enough of it.*

Pauline's relaxed approach and acceptance of cocaine use on the premises was not shared by everyone as Neil, a 44-year-old regular drinker and cocaine user explains:

Neil: *The bloke who runs (name of another local pub), he doesn't stand for it like. He's a right miserable twat. He comes in the bogs snooping, especially on a Saturday afternoon when us lot are in (laughs) he's even barred a couple of the young uns, he says it's the brewery on his back about it, tosser.*

Such attitudinal differences are not borne out in research literature. Thus, despite increased recreational drug consumption occurring in licensed premises (Measham 2004; Turner 2018; Measham and Moore 2009; Ayres 2019), literature is limited to alcohol policy; we identified no qualitative literature focusing on attitudes of licensees towards recreational drug use/policy in these spaces.

Discussion

Our findings reveal mixed biographies of drug use. Some participants had been part of prior club and drug cultures and continued to consume drugs into adulthood and middle-age. Others came to drug use in their 30s and 40s, without a previous 'drug career', arguably due to the increasing prevalence and popularity of cocaine powder. Indeed, whilst under 30s may account for 61% of all last-year users of recreational drugs, the use of powder cocaine is more likely to persist in over 30s (Home Office 2020). Taken together, our data reveals the routine nature of recreational drug use amongst particular groups of older people (over 35s) in North East England. We suggest that a number of relational practices (the user, peer group, supplier, accessibility and availability, weak surveillance from business owners) come together, culminating in a culture of normalisation, and in turn leading to the resistance or subversion of stigma, particularly self-stigma, amongst certain groups of older adults. Drug use (and co-occurring alcohol use) is identified in previous literature as a social activity in much the same way as drinking alcohol exclusively (Ayres and Treadwell 2011). A number of theoretical perspectives could conceivably be used as explanatory tools here. For example, harnessing a deviant leisure perspective would suggest that drug consumption (licit or otherwise) offers an escape or 'release' from the pressures of 'moral responsibility' and from our contemporary consumer society (Ayres 2019) whilst being an integral component of it. Alternatively, adopting Lyng's (1990) seminal concept of edgework, which has previously been applied to both recreational and heavy-end drug use (McGovern and McGovern 2011; Reith 2005), recognises that cocaine use may offer PWUD an opportunity to control the 'uncontrollable' and 'create meaning within an otherwise meaningless existence'.

Most significantly, older people in this study do not represent the marginalised or stigmatised high-dependency drug users often associated with older drug use. UK Drug policy, including the 2017 Drug Strategy, tends to target marginalised communities, overlooking higher socio-economic groupings (Brown and Wincup 2020). Instead, for people in this study, consumption of recreational drugs was a routine element of leisure activities. Some illicit drugs (including cocaine) were 'not a big

deal' and have become part and parcel of a night down the pub. This mode of use/user been described by Askew and Salinas (2018) as a 'silent majority'—where drug taking goes largely unnoticed and where those involved are considered 'law-abiding' criminals insofar as their regular criminal transgressions are not reflected in the ways broader society, their immediate networks, nor they, view themselves. Above all else, our analysis suggests a lack of, or resistance to, stigma and/or disapproval of NDRDU within this demographic of older people. This begs the question of how and why those in our study were able to successfully subvert stigma. We argue that this is irrevocably linked to status and privilege—in other words, they subverted stigmatisation because they were able to lead conventional lives and socialised with others doing the same thing, allowing them to carry on as normal, in a way that you cannot if you use crack cocaine or heroin. Cocaine use took place in the pub with a pint, in the social club and in the kitchen, normalised places and spaces which also served to subvert stigma. However, this is not to say that these people would not suffer stigma if they ventured outside of their peer group or extended their 'repertoire' to unacceptable drug types. There is much to unpack here—our findings highlight the complexity of stigma and challenge traditional notions of stigma often attached to drug use and certain populations. We found acceptance and accommodation in recreational use of a variety of illegal and legal drugs. Like MDMA and ecstasy users in Edland-Gryt et al.'s (2017) study, our participants drew symbolic boundaries between their own drug use and other drugs/users. We argue that drawing such boundaries allowed participants in our study to subvert stigma—by distancing themselves from stigmatised behaviour, differentiating themselves from 'others' and thus defining their own status.

There remains very little qualitative, in-depth research focusing on the experiences of older, female recreational drug users. Extant literature tends to focus on dependant and/or welfare-involved use, sex work, crack cocaine use and younger/juvenile female drug users (Jeal et al. 2017; Perrin et al. 2020). Our work demonstrates a need for additional research in this population group. Furthermore, despite broader use and the widespread availability of illicit drugs, we still know very little about

socio-economic groupings and NDRDU. Again, there remains a particular lack of research focusing on the experiences of older, middle class drug users, with no research exploring powder cocaine use in this demographic. Whilst we know (and know of) middle class cocaine users, our data focuses on participants in one geographical area, largely of lower socio-economic status. Further work could broaden this sample in order to explore recreational drug use in middle-class communities, for which we hold anecdotal evidence only, despite positive cultural portrayals in popular media. For example, the recent BBC drama *Industry* portrayed normalised and routine use of cocaine powder amongst young interns working at a fictional investment bank. Likewise, another BBC drama *I May Destroy You*, featured polydrug use as a key constituent of night-time leisure practices. Indeed, both shows reflect themes of hedonism, escape and hyper normalisation in their depictions of recreational drug use. In contrast, this can be juxtaposed with tabloid shaming and stigmatisation of celebrities who are 'caught' taking drugs (see the treatment of Nigella Lawson for example). Interestingly, all of these examples are based in London, illustrating a strong metropolitan trope in coverage/representations of drug use.

Finally, our findings expand the notion of drug using spaces—in our study, these spaces were hyper-normal (kitchens, pubs, social clubs), aligning with previous research conducted by O'Neill (2017) who highlighted that private residences were a common and desirable setting for drug use amongst recreational users aged 21–49 in Northern Ireland, largely due to reduced risk of detection, convenience, lack of boundaries and reduced cost. Our findings also link to work conducted by O'Gorman (2016) who found that, for young people, different drug intentions required different settings. Literature exploring drug spaces and places remains dominated by dependency, with a particular focus on people who inject drugs. Further work should expand this area by examining the specific meaning of place and space within older recreational drug use, aligning with burgeoning work within sensory criminologies.

Conclusion

By way of conclusion, we return to the concept of 'normalisation'. Like Parker (2005), we suggest that normalisation may be used as a barometer of social change. For example, increasing prevalence in non-dependent recreational powder cocaine use amongst over 35s may contrast with changes in young people's drug use e.g., increasing use of ketamine and NPS. However, research focusing on recreational drug use continues to be pre-occupied with the experiences of 'young people'—it is vital that this is broadened to include those over the age of 35. Our work identifies key omissions in the field of NDRDU as a whole and, more specifically, in the study of powder cocaine use. Future work should explore NDRDU (and drug use spaces) across gender, age and socio-economic boundaries, and there remains a need for in-depth, qualitative work drawing together these fields of study.

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Negotiating "Self-Stigma" and an "Addicted Identity" in Traditional 12-Step Self-Help Groups

William McGovern, Michelle Addison, and Ruth McGovern

Introduction

In empirical accounts of self-help processes, it is often argued that individuals "self-stigmatise" (Corrigan and Rao 2012), wherein they self-identify as "diseased", label themselves "addict" then fashion a new "in recovery" addicted identity. This identity formation is located in social interactions with addicted others as they mutually seek to resolve their drug related concerns. Using the social identity approach to recovery as a framework this chapter theoretically explores self-help processes and

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the ways in which self-help users negotiate the concepts of "stigma" and an "addicted identity" in traditional types of 12 step self-help groups. This detailed discussion builds upon McGovern's empirical study of 36 long-term self-help users (6 months—10 years) who had experience of sponsoring others in recovery in the North of England (McGovern et al. 2021). Based on data from this study, we propose the following typology of self-help users in order to highlight variations of "The Addicted Identity" and complex experiences captured in self-help groups: Defender of the Legacy, Partial Appropriator and Repudiator.

Making sense of the structural, social and cultural mechanisms of public stigma in which people are negatively categorised, labelled and treated in society because they use substances (Corrigan and Roe 2012) is important for understanding the ways in which interpersonal and intrapersonal processes reproduce self-stigma in self-help groups. We critically engage with the idea that addiction is a disease and/or social pathology and recognise that this idea permeates society, government strategies, treatment systems and scholarly interpretations of use, self-help and recovery (Martin and Waring 2018; Smith 1997; Yeung 2007). We also understand that in traditional types of self-help groups like Narcotics Anonymous and Alcoholics Anonymous, members are actively encouraged to "self-stigmatise", take individual responsibility for their use and accept they "suffer the disease of addiction" (Smith 1997; Yeung 2007). However, in this chapter we argue that the focus of scholarly and empirical work in this area has tended to moralise the process of identity formation in the context of drug use and disease, and in so doing fails to consider the ways in which individuals negotiate "self-stigma" or the multiple identities they may hold in their group and/or the wider social context of other groups they may belong to (Best 2016).

Public Stigma and Disease

People who use drugs are among some of the most stigmatised groups in society and the dominance of the addiction as a disease model has led some to commentate that many practitioners working in treatment

services adopt this medicalised model of addiction unquestionably (Reinarman 2005). This can also be said for many people who use substances, and nearly all individuals who understand themselves to be in recovery (Reinarman 2005). In a wider societal context, avoiding "addiction" and therefore having the ability to exercise self-control, self-regulation and to self-govern are seen as technologies of "modern citizenship" within western cultures (Rose 1999).

Modern citizenship is not attainable to everyone; Foucault's concept of "governmentality" applied here is a useful lens to show how the state can exercise power but also produce knowledge and certain discourses that can be internalised and guide the behaviour of certain populations (Martin and Waring 2018). In society those who are unable or perceived as unwilling to adhere to their societal commitments or role obligation are at risk of being labelled deviant, disloyal, dysfunctional and open to normative sanctions, or in extreme circumstances, exclusion (Allan 2007). Those individuals in society who are identified as being unable to be like this, such as drug and alcohol users, can find themselves "lumped together as social problems, diagnosed as lacking self-esteem and charged with antisocial behaviour" (Cruikshanks, 1999: 330). In particular, it is those subgroups of corresponding low social status, such as so-called problematic alcohol and heroin users, who find themselves subject to public stigmatising and negative evaluative judgements about their character, motivations and individual abilities (Tyler 2020). Drawing on the concept of stigma theorists like Tyler have illustrated the many ways in which it is reproduced and used by government and institutions as a way of securing the interests of powerful elites in society (Tyler, 2020). People who use drugs are portrayed as being either trapped at the margins of society as victims of their own pathological values and beliefs and in need of control and regulation, or as having little ability to articulate or act upon their own needs (cf Seddon 2006; Measham and Shiner, 2009).

During the last two decades there has been an increasing shift in UK government policy and by traditional welfare agencies to target and engage with particular types and subgroups of people who use substances (Elliot 2013). For instance, in the UK 2017 drug strategy specifically outlined targeting an ageing cohort of people who use substances: opiate

users, entrenched drug users and those with significant health and mental health-related problems (National Drugs Strategy, 2017).

Furthermore, whilst it is apparent that some welfare agencies and self-help groups have been able to gain access to users, it is also true that many of those who use substances also find themselves coerced, referred to or mandated by the criminal justice system in the UK, Europe and the US to attend formal treatment (Moos and Tinko 2008). In a somewhat critical context of the social processes involved in formal drug and alcohol treatment, power, discourse and micro politics are often played out by addiction therapists in organisations that are often normally represented and perceived as humane interventions for substance users (Callero 2003; Cruikshanks 1999). In these types of situations and circumstances, the role of providing treatment is to motivate change in the individual, from the inside out to create a self-regulating subject (Callero, 2003: 118). The wider structural issues that individuals often face in relation to poverty, inequality and social exclusion are ignored and priority areas for change in individuals are reframed against a series of measurable outcomes or improvements (Marmot et al. 2020; Anderson et al. 2016). This individualising of responsibility for substance use means that the service user is tasked with managing as far as possible by themselves (Anderson et al. 2016). This approach to treatment focusses the person's attention back upon themselves, and has been shown to be punitive in orientation, exacerbating structurally embedded health inequalities and the widening of socioeconomic disparities (Charmaz 1983; Anderson et al. 2016; Addison et al. 2019; Bambra 2016; Marmot 2020).

To understand the concept of "public stigma" it is also important to recognise the dominance of the "addiction as a disease" discourse in theoretical and empirical accounts of substance use (Reinarman 2005). The idea that addiction is a disease has been described as one of the most dated and historical, yet central and durable concepts in society, as well as grounding scholarly interpretations of substance use and self-help groups (Stolberg 2006). Tracing an aetiology of the different "addiction as a disease" models is difficult as there is striking differentiation in the ways in which academic scholars have engaged with the concept (Thombs and Osborn 2013). Substance addiction has been variously

framed as a disease due to a consequence of an individual's predisposed physical vulnerability (Kimura and Higuchi 2011); as an expression of biographical events such as emotional psychology (Shields 2011); and, as an embodied biological concept that constrains individual agency and social action (Elliot 2013).

Many "addiction as a disease" models rely heavily on the idea that exposure to, or indeed the single use of a substance, can result in significant changes to both the structure and functioning of the brain (Reinarman 2005). According to theorists like, Angre and Angre (2008) these changes in structure and function of the brain can result in a form of pathological learning; specifically, learning to crave drugs. As the processes of craving progress and becomes established in practice, an addiction is believed to manifest. This addiction is also linked to a range of deficits which occur concurrently in areas such as motivation, memory and decision making, all which are believed to accompany the addiction process (Angres and Angres 2008). In these types of models, individuals are often stigmatised as a result of their practices and dehumanised as "pathological" (Tyler 2020). Furthermore, social action is constructed as bounded and structured physical predispositions and biological compulsions to repeat in order to replicate the original and pleasurable drug experience, whilst avoiding withdrawal (Angres and Angres 2008). Issues such as individual motivations and the social context in which use occurs are either ignored, overlooked or deemed unimportant in comparison to the other processes which are believed to be occuring (Marmot et al. 2020; Peele 1985).

In moving the conceptual framework from biological to a psychological form of pathology it is recognised that the shift from non-user to addict or addiction is a more gradual movement (Johnson 1980). Initial and ongoing substance use is still deemed important here, but addiction is also understood to be driven by the dualistic discourses of individual susceptibility and culpability (Milan and Ketchman 1983). More specifically, it is argued that the continued and repeated use of substances erode the cognitive functioning of the brain and so in turn individuals become less amenable or able to exercise choice about using (Baler and Volkow 2006). Further, rather than being driven only by physical and/or

biological processes to consume substances it is recognised that individuals do have a level of self-awareness and reflexivity when it comes to choosing to use or engage with substances (Elliott 2013). However, it is also often thought by theorists in this area that these attributes and abilities are objectively overridden, either by the individual's pathological loss of reasoning or a lack of individual self-will (May 2001). Here the use of substances is deemed to result from the fact that individuals are unable to control and regulate themselves and their own desires. It is the on-going compulsion to use substances or avoid withdrawal which erodes the ability of the individual to engage an internal locus of self-control and appropriate decision making (Baler and Volkow 2006). It is also argued that the use of substances simply exacerbates already pre-existing socially pathological conditions in the individual and any ability they may have had to act in a rational way (Piazza and Moal 1998).

In the next section of this chapter, we will explore the ways in which the structural, social and cultural processes reproduce "public stigma" as "self-stigma" in self-help groups. However, before we shift to this particular aspect of "stigma" it is important to recognise that there have been numerous empirical and theoretical concerns raised around the disease concept of addiction and the physical and pathological concepts associated with its use. In the first instance, the disease model fails to reconcile both the site and mechanisms of addiction and are only partially successful in identifying the physical pathology of both the addict and addiction. Secondly, it has also been noted, in a more generalised context, that addiction is an ill-defined and rudimentary concept (Baler and Volkow 2006). It has also been recognised by social and cultural theorists that concepts like disease and addiction are socially constructed concerns (Peele 1985); and that social action cannot simply be organised in relation to a hierarchy of medical entities (Thombs and Combs 2013).

The Social World of Self-Help and Self-Stigmatisation Processes

Self-help groups can be framed as micro social worlds, where each have their own language, practices, technologies, criteria for memberships and processes for self-transformation (Smith 1997; Kelly 2003; Yenug 2007; Humphreys 2011). Understanding the objective influence of these types of "social world" processes is fundamental to explaining how the "self-stigmatisation" process is experienced and replicated in traditional types of self-help groups.

The philosophy and language of 12 step groups and organisations in the present day actively encourages and underpins the self-labelling and self-stigmatisation process. In AA and NA readings, slogans and literature actively encourage members to "pray to have serenity to accept the things they cannot change about themselves" (Sered and Norton-Halk 2011: 313). The negative labels and stigmatising processes that people who use substances experiences in wider society and drug treatment are personalised in self-help groups and individuals are encouraged in step work to "admit they are powerless over [substance] alcohol (our emphasis)" and "that their lives have become unmanageable" (AA, 2020). Here, users are also encouraged to admit they have lost self-control and addiction can be understood as a process in which self-will has depreciated caused in part by an excess of the self, self-pity, self-satisfaction, self-gratification and self-importance (Wilcox 1998).

The practice of open self-help groups is designed to expose users to the philosophy and 12 step approach but within them newer members are also encouraged to "self-stigmatise" further and adopt an addicted identity because it is endorsed and validated by more experienced members as being key/or the only way to recovery by others. In self-help groups the types of support/services (open and closed meetings) that self-help groups are able to offer their members will differ from group to group and depend on the actual and virtual resources that each group has available to them (Humphreys 2011). In AA and NA, open meetings occur monthly and are designed for newer members, those considering membership of AA/NA and for professionals or family members of users who are interested in understanding more about the 12 step philosophy

and approach. These meetings are standardised across the AA and NA network and are highly structured: a typical meeting would involve readings around the group philosophy, a "share" and testimonial statements from existing group members about their involvement and the benefits of membership. During the "share" or life-story as it is sometimes called a more senior group member will give a detailed account of their life, their experiences with substances and illustrate some of the problems and concerns that they experienced as people who use substances. They then present a case or illustrate how they engaged with the groups' programme of change and ideology as an individual endeavouring to resolve their substance related concerns. During this "share" they may also discuss their own early experiences of groups and self-help processes and how they initially rejected the idea that they were an addict. The "share" is concluded with a discussion led by the individual whose story is being shared in which they relate the group's philosophy, the 12 steps and the principles of the group to the resolution of their substance related problems and concerns.

In open meetings existing members who wish to contribute to the group discussion or pass comment to another user will start making their feedback by making the declaration "I am [name] and I am an addict" (NA World Services 1997). These meetings are primarily used by groups like AA and NA to familiarise users and potential new members with the philosophy and approach but also to reinforce the strict code of ethics and confidentiality that all 12 step groups adhere to (Yeung 2007). Closed meetings are provided for those users who wish to follow the teachings of AA/NA, often those who are also working through the 12 steps and the groups' "programme of change". These groups are themed and can include, but are not limited to, participation meetings, study meetings, question and answer meetings and topic meetings. Admission to closed groups is restricted to those who identify with the idea that they have a disease and the ideological premise that they are "addicts". In these type of meetings individuals will not have to declare their diseased status, however, a statement is read out by the individual leading the group which outlines the criteria for involvement and directions for non-addicts to more open types of meeting (NA World Services 1997).

The process of self-transformation in groups like AA and NA is wholly underpinned with self-stigma and the self-identification that the individual is an addict, in which the individual must surrender themselves, via the 12 steps and then make a radical shift or move towards transcendent and spiritual awakening (Kurtz 1997). This transcendence, it is believed, can only be achieved with the help of others and involves replacing one's own omnipotent self "with the belief that there is a power greater than the self" (Kurtz 1997: 37). More specifically, in this context it is also argued that individuals are largely able to resolve their substance related concerns by reinventing or reclaiming as "an addict" and by following their groups mandate or programme of change (Banonis 1989). All self-help groups have their own technologies and ways of working which enable their users to come together, share and exchange practical knowledge, with a view to resolve their substance related concerns. Across all groups and meetings there is standardisation in the format and process for sharing and exchanging practical knowledge and understanding with others. There is also significant differentiation in the actual formatting and structuring of groups and variations in the ways that knowledge about avoiding use, situations and relapse is exchanged and accrued between members. In smaller types of groups individuals are afforded time and the opportunity to speak as an individual and receive highly personalised feedback about their needs, aspirations and plans from others. In larger groups individuals are not always afforded the opportunities described prior, but they are still able to accrue different forms of knowledge and understanding by listening who have had similar experiences or concerns and by observing the exchanges that occur between different group members (Humphreys 2011). Sometimes in these contexts individuals report that they learn what to do by observing and discussing the mistakes others make in their recovery.

Contextually, it is important to recognise that "cross talk" is not permitted in 12 step groups and that individuals do not give advice to others or exchange information in self-help as they would in a conventional way. If an individual is seeking to provide guidance or advice to someone in a meeting they first must be able to understand the issue or point the individual is trying to make, then have a similar experience

they can draw upon. Secondly, they must also be able to understand how their own subjective experiences are similar and relevant and then be able to share their story in a way that provides a level of understanding, makes sense to the other person and helps them progress. In turn the person being helped must be able to understand the point being made by the other and the relevance the other person's story has to them. All of which occurs and is shared under the premise that everyone, in-group, also shares the same ideological perspective, self-concept and/or identity (Brewer 1991).

The idea that addiction is a disease is significantly important and appealing to self-help users/those seeking recovery. It forms the basis for an internal dialogue, elicited from illness, which enables users to develop an understanding of their previous experiences; it allows users to come together to collaborate and to explain their behaviours in a rational, albeit diseased way (MacIntosh and McKegany 2000 2002). Those who use substances problematically are more likely to be receptive to these labels because of their experiences and endorse them as labels and stereotypes associated with disease and engage in self-stigma as they enter and engage with self-help groups and processes (Corrigan and Rao 2012).

More critically, organisations like AA and NA also condemn as denial, the efforts of individuals to explain their addictions and other problems in terms of social structures or outside forces (Sered and Norton-Halk 2011). Here, individuals may also be motivated to accept the idea of an addicted identity because it makes sense for them to do so (Davies 1998), however, they will also be particularly keen to avoid any risks associated with being socially embarrassed, excluded or isolated from the social and cultural context they find themselves in (Gauntlett 2007). Alcoholism or drug dependency from the AA and NA perspective is seen as an individual, personal responsibility and as a consequence the users of AA and NA are required to adopt a set of principles and practices in the form of the 12 steps. Central to this is a very particular and subjective way of understanding the nature of their addiction, how they should resolve their substance related concern and a long lasting if not permanent "addicted identity" (Yeung 2007). Social world theorists such as Smith (1997) have argued that members come to redefine themselves within their new life situation, take up a new self-concept, a new

role definition, new values and norms about drinking and other social behaviours.

Research into self-stigma in self-help groups has been largely concerned with exploring the concept to prove its existence and the consequences for the group and individual group member. Each theorist (see below) has had their own focus and perspective to explore self-stigma, yet each have also reached the same conclusion: the adoption by the individual of a highly subjective state in relation to their own self-concept and (addicted) identity, which then affects the way the individual thinks about their "self" and behaves towards others (Brewer 1991). For example, in groups like AA and NA, it has been argued that users are vulnerable to the biases of labelling, stereotyping and self-stigma associated with disease and addiction and subject to evaluating themselves in a criteria set out for them by others in the group (Rose 1999). Over time, it is argued, that these labels are internalised by the individual and incorporated into their own self-concept and identity (McIntosh and McKeagany 2000). Others have focussed (using narrative analysis) on the ways in which the group story becomes incorporated in the life and experiences of the individual who then adopts it as a way of practicing and living (Kurtz 1997) In a wider and more critical context, social theorists like Brewer have argued that individuals in closed or semi-closed social and cultural contexts can be victimised by their new social environment and left to choose from an ever-diminishing set of self-concepts available to them (Brewer 1991). These individuals can then go on to become more committed to feeling and thinking about themselves in particular ways and acting and behaving in a manner which is congruent with their reframed "identity" (Brewer 1991).

The idea that individuals can become victims of their own social environment and self-identity is dealt with in a largely unproblematic manner (Brewer 1991). Within these types of models, it is often argued that particular types of social (self-help) and subcultural contexts can act as "total institutions" to individual social actors (Goffman 1968: 162–163). Individuals relinquish their agency to the group and go on to accept their current situation or make the best of it once their subjective identity is reformed (Allan 2007). Their position, identity and vulnerability to subcultural labelling and stereotyping is also believed to be

compounded here because there is little danger in them being confronted by any existential crisis or vulnerable moments that may require a more reflexive response and evaluation (cf Shildrick and MacDonald 2008).

The next section of this chapter focuses on the intersubjective experiences of self-help users in self-help. It will explore the more innovative, reflexive and creative ways in which individuals can engage with concepts like self-stigma and the idea of an "addicted identity" as they seek to mutually aid others in resolving their own substance related concerns and issues.

Variations of "The Addicted Identity" Found in Self-Help Groups

In this section we continue to utilise Brewers' (1991) idea of the "social self" and the idea that individuals in semi open/closed social and subcultural contexts will be forced to choose from an ever-diminishing set of self-concepts and identities available to them. However, in taking other aspects of his work further, alongside our own empirical work in the field of self-help (McGovern et al. 2021), we explore the idea that individuals can also function in self-help groups whilst rejecting the self-concepts or identities on offer if the characteristics, behaviours, personality requirements associated with them are too restricted and narrow. To differentiate among users', we present a typology we have developed to capture the experiences of individuals: Defender of the Legacy, Partial Appropriator and Repudiator to capture the experiences of individuals and ways in which users themselves report how they engage with self-stigma, their groups' philosophical standpoint, ideological principles and the idea of an "addicted Identity". These discussions are based on McGovern's qualitative study of 36 long-term self-help users (6 months—10 years) attending self-help groups in the North of England (for further discussion see McGovern et al. 2021).

Defenders of the Legacy

Defenders of the Legacy (DOL) are individuals in self-help who positively embrace the stigmatised identity in a way that benefits their recovery. They are individuals who come to self-help having experienced the most problematic forms of substance use and the most significant types (mental health, social isolation, homelessness) of substance use related concerns and issues (Humphreys et al. 1999). They often find it the most difficult to get a foothold in their respective groups, however, they also benefit the most from the initial support offered by others and the democratising functions of their groups (Humphreys et al. 1999). These DOL find meaning in their self-stigmatising identity and show the least amount of resistance to the concept and self-stigmatising processes. They attend their group frequently, engage with the groups' programme of change and immerse themselves in the group participation. More often than not, they will have spent a significant amount of time, particularly during their early involvement, immersing themselves in different types of open and closed groups. As a result of their participation and beliefs they feel a strong and fundamental sense of the identification with the 12-step philosophy and the idea that they suffer from the disease of addiction. Characteristically these individuals use the concept of disease to explain their previous experiences of substance use. They also apply these concepts to explain other behaviours, such as relationships, sex, shopping and gambling if they feel these have been problem areas in the past. DOL discuss self-help as a way of life and they believe that without AA or NA they will be vulnerable to relapse and further addiction.

DOL are established group members and will attend and participate in open and closed meetings regularly, they describe their role as being key to both their groups functioning and continuation (Smith 1997). They are also recognised by others as being skilled in self-help and self-help processes and may take up a formal role helping others "sponsorship" or providing service "facilitating meetings" to the group. Their role in providing sponsorship is to support less experienced members, provide support to those doing step work and to school and instruct them in the philosophy and practices of the group. A key part of the DOL role is to encourage others who are less experienced to "self-stigmatise", relate to

the labels used to explain use and understand what the concept of being an addict means to them. Outside the group DOL will organise and arrange AA and NA social events for others and they are more likely to have less access to conventional social worlds and networks in the form of non-using peer groups.

Partial Appropriators

Partial Appropriators (PA) are individuals who only partially self-stigmatise. This is functional to them in order to enable their access to the group. They are individuals who have experienced problematic substance use and significant substance related concerns, however, they may also have accessed/are accessing formal drug or alcohol services/treatment and have been the recipient of a structured/unstructured psychosocial intervention as they enter self-help (cf DoH 2017). These individuals often enter self-help with the support of family and non-using peers and self-stigmatise to an extent; but they will reject the concepts and labels used in groups which they do not identify with and will not apply the concepts of addiction and/or disease wholeheartedly to explain their substance use. PA's will often engage with step work and the groups programme of change but they may also not take the opportunity to engage with more knowledgeable or senior members as they do so. They will use the concepts of disease and addiction to explain specific periods of substance use/events and will be committed to living an abstinent life. But they will also reject the notion that they are never able to self-govern and also identify that not all concerns or problems they experience are brought about by their individual vulnerability to addiction. PA will attend meetings regularly, if and when they can and will be committed to the groups functioning and continuation. PA's are not openly critical to the idea or others who identify with the concept of disease or who self-stigmatise more than they do. PA's are respectful of others who do self-stigmatise and will tend to refrain from in-depth conversations about ideology and philosophy, they will often claim to be more concerned with the practical steps that can be taken to

avoid use/relapse. They do derive a sense of belonging and connectedness to others from their involvement and will only play a more formal role such as "service" and/or "sponsorship" if asked directly to do so. PA's will also normally have access to social networks of non-using peers and family, they will also be participating in conventional social worlds of work in a paid or voluntary capacity. They will only attend AA or NA organised social events outside the group if asked to and will not see their long-term participation in self-help as being key to their ongoing abstinence.

Repudiators

Repudiators will opt out of self-stigmatisation, labelling and the concept of the addicted identity. Like DOL and PA's, repudiators are individuals who have experienced significant substance related use and concerns prior to their involvement in self-help. They may also have attended formal treatment and been a recipient of a structured/unstructured psychosocial interventions (Doh 2017). These individuals do not have a strong sense of identification with the philosophy of 12 step groups and largely reject self-stigmatising and the idea that addiction can be classified as a disease. Characteristically, these individuals may be attending a number of different types of self-help groups (SMART or Rational Recovery) and will not be following or applying any particular approach to tackle their use. Repudiators are generally not concerned with the ongoing continuation and functioning of their groups and will typically attend meetings during periods where they are experiencing a personal crisis.

Like other established members, repudiators are knowledgeable about self-help, self-help processes and understand the legitimate culture of self-help groups. They generally do not complete or engage in the group's programme of change: step work. They are however, able to attend and participate in open and closed meetings. Repudiators may occasionally be openly critical of others, self-stigma, labelling or the concept of an "addicted identity", but will not be hostile to the group philosophical ideology or those who use it to explain their use. Established users often

describe Repudiators as being in denial or lacking self-awareness and self-understanding and will tend not to engage with them and claim that they are in the process of identification: developing understanding about themselves in relation to the groups. Repudiators tend to use different and less negative types of labels to rationalise their substance use such as: "not being myself" or "only being an addict when in active addiction". They tend not to engage with AA or NA specific social events or other users outside the group; they may also associate with current users but will also have access to conventional social worlds, opportunities and non-using peer/social/sports/community groups.

Discussion: Reproducing and Resisting Self-Stigma in Self-Help Groups

It can be seen from the sections and discussions above that those members who are Partial Appropriators and Repudiators, and who are not prepared to self-stigmatise, need to have a particular level of self-application, practical mastery and competence when exchanging knowledge and interacting with others in their groups (cf Bourdieu 1977). Individuals in these positions cannot simply attend the group, avoid stigmatising processes and take from others. These individuals are expected to embrace the concept of fellowship and contribute, to give back, to be involved and to participate to be accepted and become an established member (Smith 1997). Simply attending whilst neither participating nor criticising the group's ideological premise or philosophy will not enable these types of members to stay in the group and act as a member. All self-help groups have functions and processes for excluding members and signposting them to alternative meetings they can attend, if they do not accept or identify with the groups ideological premise or the idea that they are not an addict. As such, Repudiators and Partial Appropriators need to have a particular level of expertise, knowledge and understanding about self-help and the self-help process, to function as established group members: sometimes referred to as a "self-help specialist" (Yeung 2007) or "self-help experts" (Smith 2007).

Repudiators, in particular, are able to avoid self-stigma and engage with the concept of disease by only using the concept as a metaphor to describe and convey particular problems they face in terms of their use (Thombs and Osborn 2013). Alternatively, these individuals de-stigmatise the concept by developing their own socially acceptable and shared definitions, such as being "allergic to alcohol" or "only being an addict when in active addiction" as alternatives as they engage in self-help groups (Strauss 1978). In doing so Repudiators are also able to focus more on the practical aspects of substance use and refrain from offering reflections of the more philosophically or ideologically driven concepts. In self-help groups the process of self-stigmatisation is seen as part of a larger and more positive process that enables individuals to come together with others in similar situations and address their substance related concerns and problems (Smith 1997; Yeung 2007).

There is significant variation in the ways social theorists have explored the self-identities of users (Denzin 1993; Becker 1967) and the ways they are formed/reformed, as individuals move in and out of different types of settings (Reismann and Carroll 1995; Allan 2007). There are very few points of unification in the ways that these theorists explain the factors that influence the process and the ways in which identity is formed/reformed, role adherence (Smith 1997) normative communities (Kurtz 1997), internalising labels (Trice and Roman 1970), narratives and story-telling (Rapport 1993). However, two key points prevail here: firstly that the identity is important in relation to an individual's use/motivation not to use and that individuals choose their self-identity from those available to them in different subcultural contexts. As is the case with *Defenders of the Legacy*, who enter self-help and draw on past and present social experience and cultural meanings to develop an identity elicited from times of crisis or illness (Charmaz 1983)—these individuals are able to utilise and benefit in the shorter term from developing new-identities as a way to reinterpret aspects of their needs, reconstruct the self and for the future (McIntosh and McKeganey 2000). Theoretically however, it is important to recognise that individuals, like Repudiators, will avoid self-concepts, labels, categories and self-identities in self-help groups that are too personalised or too inclusive (Brewer 1991). They are able to partly manage this process practically by limiting

their participation in non-essential social activities inside and outside their group. These individuals are also more likely to attend self-help whilst either retaining significant links to conventional self-concepts, identities and social worlds outside their group, or are able to manage how they "perform" (Heir 2005) their addict role in-group in a way which they benefit and are able to participate without compromising their own position or the recovery of others.

Conclusions

Arising out of McGovern's qualitative study of 36 self-help users based in the North of England we have identified that the process of self-stigmatisation occurs in self-help groups and is seen by the majority of self-help users as a useful way of understanding their previous use and for moving forward in their recovery. This is despite the wider recognition that self-stigma is a progressive concern which can diminish self-worth, self-efficacy, and result in self-discrimination which has been shown, in turn, to decrease healthcare service use, lead to poor health outcomes and a poorer quality of life (Marmot et al. 2020). Over the longer term, negative self-stigma is also associated with diminished self-worth and self-esteem, which limits the extent to which individuals feel able to take advantage of opportunities of employment or independent living (Corrigan and Rao 2012).

Engaging with self-help groups and self-stigmatising processes is important in helping individuals understand how they are perceived, in society, outside their groups, but it does play an important part in how the individual engages with the technologies, self-concepts and identities that are available to them in self-help groups (Brewer 1991). Our theoretical discussion of self-help groups and the self-stigmatisation process has highlighted how there are benefits to the individual achieved via self-stigmatisation in the short term as it offers users the opportunity to engage in critical self-assessment, thus providing a way of understanding addiction and the basis of a plan for living in the future (McIntosh and

McKeganey 2002). However, over the longer term it leads to continuous self-discrimination and can have detrimental individual, social and economic consequences for users (Bourdieu 1994).

It is important that academic scholars and those working with users recognise that individuals respond differently to what can be intense structural and cultural constraints within self-help groups and are differentially able to exercise agency, reflexivity and choice as they have been shown to do in other situations (Macdonald and Marsh 2002; Shiner and Newburn 1997; Seddon 2006). It needs to be recognised that whilst some individuals are able to negotiate self-stigma, reject it and develop different ways of understanding and labelling behaviours whilst actively engaging with others in self-help and attempting to resolve their substance related concerns, others in these groups may find they are misrecognised and inscribed with a label they do not identify with. It is also important to recognise that many individuals do not passively accept self-concepts that are presented to them in different sub-cultures or the semi-closed social world of self-help. Instead, there is an active engagement with these concepts. We have shown that the orthodox model of "addiction as disease" which prevails in self-help groups is grounded in specific concepts and ideas of the "self" as a person pathologically and physiologically addicted to using drugs. However, what we hope is clear from our own discussions in this chapter is that these concepts are not rigid and passively absorbed by people attending self-help groups like AA and NA. Instead, these concepts are in flux—being remade, negotiated and resisted within and between interactions inside and outside these self-help groups. It is our intention that our typology illustrates how different kinds of self-help attendees contribute to the remaking and undoing of the "addiction as disease" model of substance use in these spaces. We suggest that further research in this area of "self-help" and recovery would help to provide insights into how axes of power and oppression intersect with a drug using identity, and how some individuals may find it more challenging than others to navigate health and social care services anchored in an "addiction as disease" model.

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Final Reflections on Stigma and Implications for Research, Policy, and Practice

William McGovern, Michelle Addison, and Ruth McGovern

In Whose Interests?

At the beginning of this collection, we wrote about the power and the pain of stigma when it gets 'under the skin' (Hatzenbuehler 2013; Finch 2001; Kuhn 1995; Devine 2005). By bringing these chapters together here we wanted to provide an evidence base from which to draw attention to the (in)visible harm enacted on a person who uses drugs via mechanisms of stigma (Ahern 2006, Baumberg Geiger 2016, Chang 2016, Hatzenbuehler 2013, Pemberton 2016, Room 2005, Scambler

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2018, Tyler 2020), and how stigma is repeatedly weaponised to justify entrenched inequalities impacting people who use drugs (Scambler 2018; Schram 1995). Our discussions have conceptualised stigma as something that is done in the everyday interactions between people, *and* as structurally embedded in our histories, in the places we grew up, in how we form our identity, in how we access welfare, services, in politics and policymaking, culture, the criminal justice system and our access to health and education provision. This is clearly not an exhaustive list; stigma permeates our ways of being and doing in the world (Addison 2012 2016) constraining who is knower and who is known through this lens of value. Stigma *is* power as praxis to identify us—calling into question whether we are a person of value, or not, and according to whom.

The core of this collection has been to highlight how power is wielded through stigmatisation to inscribe some as people of value (Pemberton 2016, Scambler 2018, Tyler 2018a, Skeggs 2011, Marmot 2018, O'Gorman 2016, Tyler 2018b, 2020, Tyler and Slater 2018) and others, for instance many who use drugs, as 'wasted humans' (Tyler 2013) through a series of intersecting classificatory schemas from gender to class, race to disability, age, sexuality and more (Tyler 2020). The key collective reflection we ponder throughout is *why?* Why is power as stigma wielded in this way? You have been with us through this journey—we encourage you to join us and to think over—*in whose interests* does this serve to stigmatise people who use drugs in this way*?* The golden thread in this book has brought us back time and again to how stigmatisation is *legitimated* through a neoliberal, individualisation thesis which blames and shames people who use drugs for making (simplified) 'bad choices'—when of course, the context for using drugs is never simple. This rationale, we have argued, neatly side-steps the violence done through socially and politically entrenched inequalities and traps already marginalised people in a maze of mirrors intended to reflect social determinants of health and causes of crime back on the self. But in *whose interests* does this serve?

If you have read a chapter, a few chapters, or even the whole of this collection you will have or will be moving towards developing a greater understanding of the concept of stigma, its mechanisms, drug

use and how identity formation/reformation is perceived and experienced as people who use drugs move in and out of the range of different social and cultural contexts explored in this collection. It is clear from the empirical and theoretical work, and the discussions contained in this collection, that many people who use drugs are some of the most stigmatised individuals and groups in society. Stigma is a complex concern which is perpetuated by a number of factors, including the socio-political positioning of the drug, its legal status, societal views and perceptions, the media and media outlets (see Ayres and Taylor's example of this as 'Cultural Competence to Cultural Obscolence'), institutional and professional practices (see Nichols et al. discussion in 'Motherhood, Guilt, Shame and Getting Passed the Blame'), cultural and social norms, the perceived competence and status of the user and the extent to which the individual themselves choose to self-stigmatise (see Carole Murphy's: 'Identity Construction and Stigma in Recovery'). Each of the contributing authors in this collection has chosen to discuss and explain stigma and the process of stigma from their own theoretical perspective, however, within the work contained here there are a number of clear and collective ideas about stigma and processes associated with stigma.

There is certainly consensus that stigma can lead to the exclusion, dehumanising and the unfair devaluing of particular individuals and groups in society, the perpetuation and promotion of negative stereotypes and labels and the manifestation and continuation of different forms of inequality, prejudice and discrimination. Discrimination in turn can be direct, indirect, intentional, unintentional and can have an interactional context (person to person) as Muir, McGovern and Kaner discuss in relation to 'family stigma' and the ways in which those who use substances (alcohol) refrain from asking for help (official) and accessing services as a way of seeking to avoid institutional stigma and the highly subjective shame associated with their status in society. As we have also seen, and as we have written ourselves in our own contribution (McGovern, Addison and McGovern), it is often those subgroups of corresponding low social status, such as so-called 'problematic' alcohol and heroin users, and those with the least access to social and economic resources who find themselves subject to the most damaging and harmful forms of public

stigmatising and negative evaluative judgements about their character, motivations and individual abilities.

Illustrating how stigma is perpetuated and the implications of stigma for individuals and groups in different social and cultural settings is an important and fundamental social justice concern. It is also important contextually in this collection for exploring and illustrating the ways in which stigma relates to identity formation/reformation and, in particular, the ways in which individuals and groups engage with and/or reject stigma in its different (public/private) forms. As we can see from the expansive range of social and cultural contexts and settings explored in this collection, identity, identity formation and identity reformation are important concepts that need to be considered in relation to stigma and drug use. There are a number of important themes which have emerged from the individual chapters presented here, that need to be considered and illustrated. The first theme relates to the idea that some individuals and groups are largely aware of societal stigma about their particular substance and its use, the negative perceptions about their character and their overall status in society. The second relates to the notion that structural and cultural processes can affect subjective self-perception, self-concept, behaviours and the identity of people who use substances in different social contexts and settings. The third and more theoretically driven point relates to the widely shared idea in this collection that individuals and individuals within groups do not simply accept or adopt behaviour, characteristics and a corresponding identity from what is traditionally thought of as an ever-diminishing set of identities which are believed to be available to them in different social and cultural sub contexts. As we have seen from the methodologically innovative work of (Muir et al. chapter) 'systematic qualitative literature review' (Nichols et al. chapter) 'poetics' and (Moore, K, Chapter) 'ethnographic vingettes'—*identity* is not a rigid concept. By continuing to engage with people who use drugs in an innovative and creative way it is clear that the contributions in this collection have been able to deepen and develop our understanding of the concept of stigma, and how individuals interact with it and others as they negotiate the liminal space between identities of value in different social and cultural contexts.

Because of our belief in equity, fairness and social justice we continue to reflect on the impact of stigma, and in whose interests' stigmatisation operates. Stigma is a form of symbolic and physical violence (Bourdieu 2016, Tyler 2020) inflicted upon people who use drugs, and as such is a *public* problem worthy of urgent attention (Ahern 2006; Bambra 2018; Black 2020a, 2020b; Hatzenbuehler, 2013; Marmot 2017, 2018). We know that having power to name, shame and blame through stigma produces advantages for some individuals and organisations who wish to retain and protect their accrued privileges and capital (economic, social, cultural) framed as symbolic and *legitimate,* or indeed, side-step accountability for systemic inequalities (Bourdieu 2016, Tyler 2020, Atkinson, 2012). In continuing to do so, and ignore the problems perpetuated through stigma, the boundary of valued/valueless personhood continues to be affirmed and reproduced (Atkinson 2012; Skeggs 2011) in ways that are harmful to already disadvantaged people who use drugs. This is a thorny problem of social injustice that needs attention from policymakers, practitioners, scholars, us and wider publics if we are to prevent stigma from getting 'under the skin' and continuing to harm people.

In bringing this chapter and edited collection to a close, it is important to consider some of the key themes in relation to implications that this collection raises for those who research, commission, work with or even use illicit drugs. Firstly, by building on some of the methodologically innovative work here (and that which is occurring elsewhere) empirical researchers, can and should where possible, aim to be more collaborative in their approach to understanding the mechanisms of stigma, the impact of stigma and the outcomes of it in relation to the experiences of underserved groups who use illicit drugs. This will require the relinquishment of power in decision-making to some extent, planning, commitment and the bringing together of key players from academic communities, policy makers, commissioners, practice providers and different community groups. Policy makers and those who commission services can and need to start to recognise and challenge the ways in which their organisation produce and reproduce processes which dehumanise individuals, devalue their perspectives and lead to further discrimination (be this immediate or at a later point), exclusion and

inequality. Practice partners, no matter how well intended or formulated, can also start to challenge stigma and stigmatising processes by recognising the interactional context of discrimination, be this direct, indirect, intentional, unintentional and how this manifests in operational and practice-based contexts. These processes can and will only occur, however, if commissioning bodies and senior leaders recognise the pressure neoliberalist approaches in relation to focus, measurement, accountability and performance management, place on the operational practices of organisations they commission as well as individual practitioners.

Practitioners and those who engage with underserved groups have the most difficult job when it comes to challenging and addressing stigma, but they also have the most important when it comes to affecting positive change and reducing the impact of stigma at an individual and local level. Practitioners can start to reduce the impact of stigma by engaging in critical self-reflection about their own practice, the language they use and the ways in which their conscious/unconscious bias affects their perceptions and practice. As an important first step, practitioners can also help individuals navigate their understanding of public stigma and the ways this has potentially detrimentally affected their own self-concepts, self-awareness, values and beliefs. We know from this collection that individuals and groups are largely aware of societal stigma about their particular drug type and its use, the negative perceptions about their character and their overall status in society. We also know, however, that individuals within groups do not simply accept or adopt behaviour, characteristics and a corresponding identity from what is traditionally thought of as an ever-diminishing set of identities which are believed to be available to them in different social and cultural sub contexts. Here practitioners need to engage with the concept of private or self-stigma and help support a person's understanding of the impact this can have on their self-perceptions, their own needs, their own character but also their own motivations, behaviours and identity. Challenging the factors that perpetuate stigma in society, the socio-political status of drugs, their legal status, wider society views, the media and media outlets may very well be beyond the scope of practice at an organisational and individual practitioner level. However, those groups with the power to affect change in the ways described can and need to act! The fundamental point being made

here that we leave you with is that stigma and the mechanisms associated with its production, reproduction and the perpetuation of exclusion, social harm and inequality are not inevitable, they are *preventable*.

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