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## The stigmatisation of alcohol and other drug services

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The Stigmatisation of Alcohol and Other Drug Services

Kim Eaton

A Report Submitted in Partial Fulfilment of the Requirements for the Award of Bachelor of

Arts (Psychology) (Honours), Faculty of Health, Engineering and Science,

Edith Cowan University

Submitted October 2013

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## The Stigmatisation of Alcohol and Other Drug Services

### **Introduction to the Thesis**

This thesis is presented in a multiple part format. The first section consists of a literature review (The Stigmatisation of the Provision of Services for Alcohol and Other Drug Users: A Systematic Literature Review) that has been formatted according to the submission instructions for the journal, *Drugs: Education, Prevention and Policy*. Spelling and grammar for this section conforms to that required by the specified journal (UK English). The instructions to authors for this journal can be found at Appendix A. A flow chart explaining the selection process of appropriate articles for the review can be found at Appendix B. The second section of this thesis consists of a research report (Stigma by Association: Working in the Alcohol and Other Drug Field) that has been formatted according to the submission instructions for the *Journal of Drug Issues*. Spelling and grammar for this section conforms to that required by the specified journal (USA English). The instructions to authors for this journal can be found subsequent to the report at Appendix C. Additional appendices include: Participant Recruitment Flyer (Appendix D), Information Letter (Appendix E), Consent Form (Appendix F), and Interview Protocol (Appendix G). Excerpts from the author's journal are also provided as they provide contextual detail to the conclusions drawn in the research report (Appendix H). A thematic table has been also been included (Appendix I).

The Stigmatisation of the Provision of Services for Alcohol and Other Drug Users:  
A Systematic Literature Review

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The Stigmatisation of the Provision of Services for Alcohol and Other Drug Users: A  
Systematic Literature Review

Abstract

People who are dependent on alcohol and other drugs (AOD) are often stigmatised. Evidence suggests that the people who provide AOD users with health and welfare supports also feel the stigma experienced by users. However, the literature supporting this proposition consists of inadvertent findings and findings generalised from other populations. A systematic review of the limited research into stigma experienced by people working in the AOD field was conducted. This involved a multi-phase database, journal and website search, with additional hand searching of relevant referenced articles. Overall, 146 relevant studies were found, 38 of which were applicable to this review, 10 pertaining to associative stigma in the AOD field, and 3 reporting results related to AOD workers specifically. Findings indicated that although the stigmatisation of AOD workers occurs, there has been no comprehensive investigation into the phenomenon. Consequently, strategies used to manage stigma in the AOD field lack an empirical basis. Research is needed to clarify the origins, manifestations, and impacts of stigma in relation to working in the AOD field.

*Keywords:* Associative Stigma, AOD, Alcohol and Other Drug, Workers, Professionals

## The Stigmatisation of the Provision of Services for Alcohol and Other Drug Users: A Systematic Literature Review

### Introduction

Alcohol and other drug users face a pervasive stigma that has detrimental impacts on their help-seeking (Appel, Ellison, Jonsky & Oldak, 2004; Bennett, 2004; Byrne, 1997; Earnshaw, Smith & Copenhaver, 2013; Motjabai & Brum, 2013). In response to the problems associated with the stigmatisation of AOD users, the Western Australian Drug and Alcohol Office (DAO) formed the Social Inclusion Action Research Group (SIARG) to investigate stigma in the AOD field (Rouwenhorst, 2012). This working party speculated that not only are AOD users stigmatised, but people working in the AOD field also experience stigma (Rouwenhorst, 2012). Rouwenhorst (2012) and Skinner, Freeman, Shoobridge and Roche (2003) have reported that workers are stigmatised because of their occupational association with AOD users, as a result of the negative attitudes held by society of users. Although drawing some criticisms pertaining to methodological issues and problems with generalisability (Duraisingam, Pidd, Roche & O'Connor, 2006), there is epidemiological evidence to support the proposition that AOD workers are experiencing stigma (Skinner et al., 2003).

Stigma compromises a workers ability to provide social and welfare supports to users (Gray, 2010). This outcome impacts on the wellbeing of both worker and AOD user and can affect the safety, prosperity and harmoniousness of local communities (Happell & Taylor, 2001; Treloar & Holt, 2006). Furthermore, future policy change within the AOD field to address stigma requires an informed basis on which to make appropriate and efficacious decisions (Rouwenhorst, 2012).

In this paper I begin with a description of the methods undertaken to comprehensively review the literature into stigma and AOD workers. I then critically examine epidemiological

investigations into AOD workforce issues. I then explain the concept of associative stigma and critically examine research into associative stigma both generally and specific to the AOD field. The paper concludes with my recommendations for future research.

#### Method

I conducted a systematic review of the literature on the stigmatisation of people who work in the AOD field in five phases, using methods modelled on those recommended by Greenhalgh and Peacock (2005) and Doherty and Stavropoulou (2012). Phase one involved a systematic electronic search of online databases (DrugDatabase, Health and Society Database, ProQuest, PsycARTICLES, PsycINFO, and PubMed), using the search term 'stigma' in conjunction with each of the following search terms: association, courtesy, drug, alcohol, AOD, worker, employee, professional. Because of the paucity of articles found, phase two involved broadening search terms to include other stigmatised populations (prostitution, criminal, offender, HIV/AIDS, patients, mental illness). Phase three involved extending the search parameters to other disciplines (i.e. nursing, social health, addictions, organisational psychology). Phase four involved an electronic search of epidemiological papers on institute websites (National Centre for Education and Training on Addiction; National Drug Research Institute). Phase five involved hand searching all reference lists for relevant articles. A process of snowball referencing was also employed where appropriate references were sought from two other AOD stigma researchers.

The search period was set with a commencement date of 1963 (the first documentation of associative stigma) through to 2013. Overall, 146 abstracts of relevant studies were identified (investigations of stigma experienced by people associated with otherwise stigmatised persons), 67 papers were excluded because they were beyond the scope of the review. Exclusion criteria include discussion pieces, reports not directly focussing on the associate of a stigmatised individual, or did not consider the occupation context. Of the

remaining papers, 28 reported relevant studies that investigated the stigmatisation of people associated with otherwise stigmatised individuals and 10 focussed on stigma relating to AOD service provision, three of which contained detail directly related to AOD workers. Because of the limited body of literature in this field it was necessary to make inferences from studies not specifically designed to investigate associative stigma and AOD workers.

## Findings

### Epidemiological Evidence of AOD Work Related Stigma

Results from a number of epidemiological investigations have shown that stigma related to the AOD job role impacts on the wellbeing and retention of workers in the AOD field (Skinner et al., 2003). Pitts (2001) surveyed 43 AOD workers in government and non-government AOD organisations nationally (Australia) and found that stigma contributed to problems with recruiting and retaining AOD specialist staff. Pitts reported that workers felt their job role was stigmatised because they provided treatment and other support services to a stigmatised population. The findings of the Pitts investigation have been criticised in subsequent investigations into AOD workforce issues due to the small sample size used (Roche & Pidd, 2010; Skinner et al., 2003, Wolinski, O'Neill, Roche, Freeman & Donald, 2003). It was suggested that a non-response bias might impact on the generalisability of findings (Roche & Pidd, 2010; Skinner et al., 2003, Wolinski et al., 2003). However, as reported by Pitts the small sample size was due to a low participant response rate that had been difficult to ameliorate.

Wolinski et al. (2003) extended the findings of Pitts (2001) and through the use of a larger sample surveyed 231 AOD treatment agency managers. It was found that 63% of the sample experienced difficulties in filling vacant AOD employment positions. Furthermore, when managers were asked to provide reasons for these difficulties, self-report responses revealed that stigma attached to working in the AOD field was one of the leading

contributing factors amongst others including poor remuneration, lack of qualified and experienced prospective employees and non-metropolitan location of the agency requiring the recruitment.

Similarly, Duraisingam et al. (2006) examined organisational and job factors that impacted on AOD workforce development, worker wellbeing, and retention through a survey of 1345 frontline workers in specialist AOD treatment agencies. Duraisingam et al. found that 73% of respondents were contemplating leaving their jobs or the AOD field entirely. Job role related stigma was reported to be one of the top three barriers to working in the AOD field. More recently Berends (2010) found that AOD job role stigma contributed to difficulties recruiting and retaining AOD staff in rural areas. High turnover rates of community based AOD nursing staff in the United Kingdom and United States have also been found to be related to job role stigma (Eby, Burk & Maher, 2010; Knudsen, Abraham, Roman & Studts, 2011; von Hippel, Brener & von Hippel, 2008).

Self-report measures including questionnaires and surveys, although used extensively in research in the AOD field have drawn criticism regarding the validity and reliability of the instrumentation used (Meyer, Faust, Faust, Baker & Cook, 2012; Zaccai, 2004). Biases, confounding variables and chance have been reported to affect the outcomes of self-report measures (Leung, Yen & Minkler, 2004; Meyer et al., 2013; Zaccai, 2004). Furthermore, questionnaires and surveys are often used without relevant assessment of the psychometric properties of the measure (Leung et al., 2004). However, through targeted selection of the sample population, scale item selection that has been informed by relevant and substantiated evidence, and piloting of measures the conclusions being drawn from epidemiological investigations are more likely to be valid (Zaccai, 2004).

The investigations of Duraisingam et al. (2006) and Wolinski et al. (2003) used at least one of these approaches, validating the methodological rigour of the investigations and

reliability of findings. However, there is insufficient detail regarding validation methods used in the Pitts (2001) investigation and it is therefore difficult to conclude as to the appropriateness of the methods. It is surprising therefore, that even without such validation, Pitts' findings are reiterated in many subsequent epidemiological reports (i.e. Roche & Pidd, 2010; Skinner et al., 2003) and was provided as the main evidence for the presence of AOD worker stigma in the SIARG background paper.

Although drawing attention to the prevalence of stigma in the AOD field and the pervasive impacts stigma has on workforce development and worker wellbeing, the factors contributing to these outcomes were not identified in the epidemiological investigations discussed above (Duraingam et al., 2006; Pitts, 2001; Wolinski et al., 2003). There is some indication however, that AOD workers are indeed stigmatised because of their occupational association with AOD users who are a stigmatised population (Gray, 2010; Lovi & Barr, 2009). There is a paucity of research into the stigmatisation of AOD workers. Therefore, in order to provide an explanation of how AOD workers are stigmatised because of their occupational association with AOD users, it is necessary to first explain stigma transference more broadly. To this extent the subsequent sections of this review are dedicated to this explanation.

#### Associative Stigma Concept Explanation

Courtesy stigma (Goffman, 1963) also known as stigma by association (Goldstein & Johnson, 1997; Neuberg, Smith, Hoffman & Russel, 1994) or associative stigma (Mehta & Farina, 1988) is the stigma a person experiences because of their connection to a stigmatised individual. Associative stigma can be overt, as in avoidance or outward social rejection, or covert, as in subtle expressions of dislike (Bos, Pryor, Reeder & Sutterheim, 2013).

Furthermore, associative stigma may originate from many sources and have a number of

functions including exploitation, domination, enforced conformity and the avoidance of contagious diseases (Phelan, Link & Dovidio, 2008).

#### The Spread of Stigma to an Associate

Stigma can be transferred when the connection between two individuals is purely arbitrary, as in the case of stigma by proximity (Neuberg, et al., 1994; Pryor, Reeder & Monroe, 2012; Walther, 2002). Walther (2002) found that when pairing photos of a neutral person and a stigmatised target person, the previously neutral person became as negatively evaluated as the stigmatised person. Furthermore, Neuberg et al. (1994) found that heterosexual males were devalued when in the presence of homosexual males. Similarly, Pryor et al. (2012) found that being seen in the company of an overweight person resulted in evaluations of unattractiveness for the non-overweight companion. These findings suggest that even simple contact with a devalued, stigmatised person has the propensity to result in the transference of stigma.

Research has also considered the spread of stigma where the relationship between two individuals is more meaningful, such as in familial relationships (Angermeyer, Schulze & Dietrich, 2003; Corrigan & Miller, 2004; Corrigan, Watson & Miller, 2006; Hawkins & Hawkins, 1995; Mak & Kwok, 2010; Norvillitis, Scime & Lee, 2002). Much of the research into associative stigma has focussed on familial relationships, generally related to mental illness (Corrigan & Miller, 2004; Mak & Kwok, 2010; Norvillitis et al., 2002), but has also been extended to consider family members of individuals experiencing AOD dependency (Corrigan, Kuwabara & O'Shaughnessy, 2009; Hawkins & Hawkins, 1995). It has been suggested that associative stigma transfers to family members because of the perceptions of a genetic link or shared environmental causes (Goffman, 1963).

#### Associative Stigma Through Occupational Contact

As the spread of stigma through heredity and proximity conduits cannot entirely explain the spread of stigma where there is no kin relationship, research focus has been applied to associations that are continued through deliberate choice. When people choose to work with stigmatised populations associative stigma takes on a different propensity to that of familial or proximity associative stigma (Haber, Roby & High-George, 2011; Phillips, Benoit, Hallgrimsdottir & Vallance, 2012; Verhaeghe & Bracke, 2012).

For example, Haber et al. (2011) investigated the effects of stigma on workers providing care to people living with HIV/AIDS. As no quantitative measure of associative stigma yet exists, Haber et al. created a 17-item Likert type response scale using a combination of stigma index items drawn from a scale used by Holzemer et al. (2007) and the theoretical propositions of Goffman (1963) and Link and Phelan (2001). The questionnaire addressed factors such as labelling, neglect, gossip, avoidance, support and remuneration. The reliability and validity of the questionnaire employed by Haber et al. (2011) is questionable as only face validity checks were conducted with no statistical analysis employed to assess its structure or psychometric properties. However, in an attempt to validate questionnaire responses, Haber et al. conducted twelve focus groups discussing key elements of the questionnaire. Of the sample, 74% of respondents reported that they experienced job role related stigma. Qualitative exploration of this finding revealed that workers believed they were stigmatised because of their contact with people living with HIV/AIDS on the basis of fear of the contagion of disease (Haber et al., 2011).

In a further study, investigating the impacts of job role stigma, Dwyer, Snyder and Omoto (2013) found that continued exposure to job role stigma resulted in attrition from the volunteer role. Volunteers who continued to work in the field reported less client contact over time. An important finding of the Dwyer et al. investigation was the moderating effect of self-esteem on stigma over time. Volunteers high in self-esteem (as measured by

Rosenberg's (1965) self-esteem scale) were less likely to be affected by stigma and more likely to retain client contact when assessed three months after the initial testing. The findings of Dwyer et al. need to be considered with some caution. Anticipated associative stigma was measured with a three item Likert type response scale. Statistical analysis of the scale revealed a low reliability ( $\alpha = .36$ ) yet the scale was retained. Therefore it is difficult to conclude with certainty the degree to which associative stigma impacted on the reductions in client contact and job role attrition. However the findings of similar investigations into associative stigma in this population lend support to the propositions of Dwyer et al. (Boyes, Mason & Cluver, 2013; Mason, Berger, Ferrons, Sultzman & Fendrich, 2010).

The findings of Haber et al. (2011) and Dwyer et al. (2013) clearly indicate that people who work with stigmatised populations can experience stigma as a result of their occupational association. However, the evidence of associative stigma found by Haber et al. and Dwyer et al. were more indicative of stigma based on the fear of contagious diseases and cannot entirely explain how stigma is spread when the health condition is not physically contagious (i.e. mental illness, AOD dependency).

A tendency to associate nurses with the pathologies they treat has revealed a devaluation of psychiatric nursing in comparison to other nursing specialties (Halter, 2002, 2008). The mentally ill are often portrayed in derogatory ways, which emphasise dangerousness, and unpredictability (Brener & von Hippel, 2008; Ditchman et al., 2013; Stuart, 2006). Halter (2002, 2008) has suggested that mental health workers receive similar personalisations to that of their clients and have been portrayed as neurotic and mentally ill themselves. Halter (2008) surveyed 30 registered and licensed practicing nurses regarding their perceptions of various specialist nursing job roles. Mental health nursing was ranked as the least preferred area of nursing. Furthermore mental health nurses were ranked as being the least skilled, autonomous and respected. Halter reported that these findings were due to

the occupational association mental health nurses had with people experiencing mental illness. However, although providing empirical evidence of the stigmatisation of the mental health nursing role, how Halter reached the conclusions regarding associative stigma were not made entirely clear. Furthermore, Halter has received some criticism pertaining to the small sample used and generalisability of findings (Gouthro, 2009).

Through an extension of the findings of Halter (2002, 2008), Verhaeghe and Bracke (2012) investigated associative stigma among mental health professionals as a result of their connection to mentally ill patients. A battery of test measures was employed to measure associative stigma, burnout, job satisfaction, job autonomy, collegiality, and mental health status. Once again, as no standardised measure exists as yet for the measurement of associative stigma, Verhaeghe and Bracke (2012) created a brief index measuring number and type of stigma experiences. Statistical assessment of the measure found an alpha reliability coefficient of only .51, therefore the use of the measure was changed from scale to index. It was found that associative stigma was positively associated with depersonalisation ( $\beta = .151, p < .001$ ) and emotional exhaustion ( $\beta = .136, p < .01$ ). Associative stigma was negatively associated with job satisfaction ( $\beta = -.161, p < .001$ ) and with service user satisfaction ( $\beta = -.120, p < .05$ ).

There is clear evidence once again to support the notion that people who work with stigmatised populations are also stigmatised. However, although people experiencing mental illness and substance use problems are often afforded similar negative attributions, there are differences between the two in terms of the controllability of and responsibility for the health problem (Corrigan, Watson & Miller, 2006). The causation and controllability of mental illness usually lies outside the individual experiencing the illness (Pryor, Reeder, Yeadon & Hesson-McInnis, 2004). However, AOD users have also been thought to be culpable for their ill health and welfare circumstances because of their substance use (Lloyd,

2010; Pryor et al., 2004; Room, 2005). Because of this culpability, AOD users are deemed undeserving of supports and therefore the stigma that is applied to mental health workers could differ to that of AOD workers because AOD workers assist clients that are determined to be blameworthy for their conditions.

#### Stigma by Association with Clients Rejected on Moral Grounds

Contagion, contamination and corruption are suggested to be drivers for associative stigma when applied to professionals working in moralistically denounced service industries (Phillips et al., 2012). Phillips et al. used a mixed methods study design incorporating participant observation, semi structured interviews and a short questionnaire to investigate associative stigma amongst front line service providers assisting adult sex workers. A lack of social support, funding disparities, inadequate resources, and a lack of professional respect for the workers' knowledge and authority were found. Phillips et al. reported that workers were stigmatised because of their occupational association with sex workers, as a result of the negative attitudes held by society of sex workers. These findings indicate that associative stigma can be experienced as a result of occupational contact with clients who are derogated on moralistic grounds. Society views the sex worker as morally discordant and as such they are deemed undeserving of supports. Service providers who work with populations stigmatised on moral grounds also experience stigma because they provide services to such people (Skinner, Roche, Freeman & McKinnon, 2009).

It has been suggested that people draw similar attributional conclusions regarding sex workers and substance users (Goffman, 1963; Móró, Katalin & Sárosi, 2013; Phillips et al., 2012). Both behaviours are determined to be illegal, unnecessary, unsafe, and morally unacceptable (Goffman, 1963; Móró et al., 2013; Phillips et al., 2012). Given the similarities in the moralistic stance against sex work and substance use, a connection between the two in terms of stigma could be drawn. Just as those who provide health and support services to sex

workers are stigmatised because of their association with a marginalised population, so too could service providers working with substance users who are also a marginalised population (Lloyd, 2010; Livingston, Milne, Fong & Amari, 2011).

Working with AOD users and sex workers involves providing services that are in direct contention with societal health justice values (Corrigan et al., 2009; Gray, 2010; Olsen, Richardson, Dolan & Menzel, 2003; Skinner et al., 2009). Also, by coming into physical contact with AOD users and sex workers, service providers are deemed to be at risk of contracting various illnesses stereotypically linked to the health compromising behaviours of their clients (i.e. hepatitis, HIV/AIDS) (Brenner & von Hippel, 2008). However, more unique to the provision of AOD services, the provision of harm reduction measures such as needle exchange can be seen to be supporting drug use (Brenner & von Hippel, 2008). Therefore, although similarities exist, there are still unique ways in which AOD service providers experience associative stigma.

#### Associative Stigma in the AOD Field

In an ethnographic study, Smith (2010) conducted interviews with community members and business owners who contested the establishment of a methadone clinic in their local community. Smith found many stigmatising references regarding the clients of the clinic. When discussing the difficulties experienced during data collection, Smith noted the rejection he had experienced in the community. Community members were suspicious of him and ostracised him on the basis of a perception that he was acting in representation of the methadone clinic. Although an inadvertent finding, and not directly addressed by Smith, it could be concluded that the researcher had experienced associative stigma. As indicated by Smith's findings, stigma is perpetrated because there is a perception held that a meaningful connection exists between an individual and an otherwise stigmatised associate (Anstice,

Strike & Brands, 2009; Rance, Newland, Hopwood & Treloar, 2012; Strike, Meyers & Millson, 2004).

The vicarious nature of stigma when an individual is occupationally connected to a stigmatised population has also been evidenced within the nursing field (Lovi & Barr, 2009). Lovi and Barr initially aimed to explore the daily working experiences of registered nurses working with AOD users. However, thematic analysis of interview transcripts revealed a repetition of themes surrounding interdepartmental discord with a particular focus on the stigmatisation of the provision of supports for AOD related patients. Redirecting the investigatory aims of the study to focus on these stigma experiences, Lovi and Barr found that AOD nurses felt that non-AOD nurses held a moralistic view of substance users. This moralistic view echoes that initially discussed by Goffman (1963), Treloar and Holt (2006) and Skinner et al. (2009). Users are deemed undeserving of health and welfare supports because substance use is seen to be self-indulgent, reckless and contradictory to moral order (Corrigan et al., 2006; Goffman, 1963; Treloar & Holt, 2006).

There was evidence to suggest that the AOD nurses in the Lovi and Barr (2009) study were experiencing associative stigma. The AOD nurses reported being criticised for supporting AOD users and often felt they needed to defend themselves and their clients against these criticisms. Furthermore, the AOD nurses reported that non-AOD nurses often refused to provide assistance in the AOD department. If they did assist, they presented with a disgruntled attitude. It is important to note however that the AOD nurses experienced stigma vicariously when the stigma, although not targeted at them personally but impacting them directly, became an impediment to functioning in the job role. Therefore, even when the target of the stigma is the client and not the worker, the worker still experiences an extension of that stigma (Crocker & Major, 1989).

Stemming from the findings of the Lovi and Barr (2009) study, Gray (2010) investigated stigma in the therapeutic relationship between AOD user and AOD service provider. Although the investigatory aims of Gray did not include a direct assessment of associative stigma, Gray revealed an inextricable link between the stigmatisation of AOD users, AOD treatment settings and AOD workers. In depth, semi-structured interviews were conducted with 17 AOD workers in New South Wales, Australia. It was found that workers employed in AOD specific health care settings (e.g., outreach supports, residential care, community health) were stigmatised because of their association with AOD users. Stigma even originated from within the AOD field and was reported to act as a barrier to effective provision of service. It was also found that workers actively avoided working for agencies that attracted greater stigma (Gray, 2010). Once again, although no investigative attention was drawn to the associative stigma evident in Gray's findings, there is evidence to indicate that AOD workers are stigmatised because of their occupational association with AOD users.

The associative stigma evidenced in the Gray (2010) and Lovi and Barr (2009) studies has gone largely ignored in subsequent research. Instead, subsequent investigations have focussed primarily on the negative perceptions held by medical health professionals of AOD related patients (i.e., de Maeyer et al., 2011; Ford, 2010; Li, Comulada, Wu, Ding & Zhu, 2011; Morgan, 2012; Timko, Bonn-Miller, McKellar & Ilgen, 2013). Although these studies have provided valuable insight, the importance of inter-professional origins of associative stigma remains to be explored. Future studies may wish to focus empirical attentions on expanding the Lovi and Barr findings, particularly on the way in which stigma is experienced by AOD workers.

Overall Gray (2010), Lovi and Barr (2009) and Smith (2010) have, mainly through inadvertent findings, confirmed that associative stigma exists within the AOD field.

Regardless of whether the stigma is directed at the AOD user or the AOD worker, the worker still experiences impacts from the stigma.

#### Social Identity Theory and 'Dirty Work'

The studies investigated in this review have predominantly used a descriptive approach to the reporting of findings or have merely aimed to provide support for the existence of associative stigma in certain populations. Therefore there is an absence of a theoretical explanation of the experience of job role related stigma and the resulting psychological impacts for AOD workers. However, from a theoretical perspective the principles of social identity theory have successfully been applied to the explanation of the psychological impacts of stigma more generally (Ashforth & Mael, 1989; Corrigan & Watson, 2002; Crocker, Major & Steele, 1998; Kreiner, Ashforth & Sluss, 2006; Major & O'Brien, 2005; Yang et al., 2007).

It has been suggested that an individual's occupational identity contributes to the formation of social identity (Kreiner et al., 2006). An individual's sense of self and belonging are derived from connections to groups (or workplaces) that the individual identifies with and values (Tajfel & Turner, 1979; Turner, Wetherell & Hogg, 1989). The positive qualities of the group are internalised and this determines the individual's self-concept. When the occupational interests of the individual are stigmatised the resulting devaluation impinges on an individual's self-concept and therefore their social identity (Baran et al., 2012). The 'dirty work' stigma attributions applied to working in the AOD field could impact on an AOD worker's occupational identity and therefore their social identity.

People who work in occupations considered to be 'dirty work' are often stigmatised for their occupational undertakings (Ashforth & Kreiner, 1999; Baran et al., 2012). 'Dirty work' is work that is deemed to be degrading or disgusting because of the physical, moral or

social taint that is ascribed to the work (Ashforth & Kreiner, 1999). As evidenced in the findings of Lovi and Barr (2009) described above, working in the AOD field is perceived as morally reprehensible because of the moral taint ascribed to AOD users. Therefore working in the AOD field could be determined as 'dirty work' and as such stigmatised because of the negative social conceptualisation of the job role.

Research that has investigated the response to the threat to social identity that stigma poses has presented mixed findings. Increased vigilance (Pratto & John, 1991), externalising blame (Crocker & Major, 1989), disengagement (Keller & Dauenheimer, 2003), and increased dedication (Corrigan & Watson, 2002) have all been found to result from stigma based threats to identity. However, none of these findings have been validated in a sample with AOD related attributes. Furthermore, an individual's identity is derived from more than just their understanding of how others perceive them (Corrigan & Watson, 2002). There are also a number of complex social systems that an individual interacts with that contribute to the formation of identity (Corrigan & Watson, 2002; Crocker et al., 1998; Yang et al., 2007). An individual's occupational identity is just one of those social systems. As such, the response to stigma can vary because of many moderating and mediating factors unique to the individual and their social worlds (Major & O'Brien, 2005). It is this variation in responses that requires future research attentions to understand how AOD workers respond to the stigma they experience.

Because of the paucity of research into the stigmatisation of AOD workers and the lack of theoretical explanation of associative stigma more generally, there exists a need for future research to evaluate the impacts of stigma on the social identity of AOD workers using a structured theoretical basis on which to form empirical conclusions. Without doing so, it is difficult to move beyond mere description of the impacts of stigma and into the formation of sound remedies.

### Summary and Directions for Future Research

The empirical and epidemiological investigations reviewed in this paper have, mainly through inadvertent findings, confirmed that people working within the AOD field experience associative stigma from working with AOD users. However, there have been no comprehensive investigations into the phenomenon and researchers have not drawn on theory to contextualise findings and conclusions or guide research design. Therefore uncertainty remains regarding the true nature of the phenomenon: its causes, perpetrators, manifestations, and impacts on the social identity of AOD workers. As a result, tackling stigma in the AOD field is problematic because responses to stigma are more likely to be efficacious when targeted interventions are based on evidence rather than conjecture (Lloyd, 2010; Rouwenhorst, 2012).

Therefore, an exploratory investigation into stigma in the AOD field is required. This should focus on how workers within this field experience stigma, where the stigma originates from, and what impacts the stigma has on the workers personally (in terms of their social identity) and also in their professional identity. The findings of such investigations will better equip researchers to develop a quantitative measure of associative stigma suitable to assess the degree to which stigma is impacting on workers in the AOD field. Researchers are then better able to find ways to address the causes and impacts of associative stigma, reducing the stress on workers and increasing the quality and quantity of services available to AOD users.

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Stigma by Association:

Working in the Alcohol and Other Drug Field

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## Stigma by Association: Working in the Alcohol and Other Drug Field

### Abstract

An exploratory interpretive phenomenological study was conducted in which Western Australian AOD workers were interviewed regarding their experiences of associative stigma. Thematic analysis of interview transcripts revealed five themes; the use of language; public perceptions of AOD work; the role of advocacy; driving forces behind structural stigma; breaking the stigma silence. Findings indicated that workers do indeed feel stigmatized because of their occupational association with AOD users. The workers in this study reacted to the stigma associated with their role with defiance and a strong sense of client advocacy. Resiliency to stigma determined the way the six themes found in this study were experienced by workers. Recommendation is made for the provision of means by which AOD workers can report stigma and receive counselling for stigma experienced as a result of working in the AOD field.

*Keywords:* Associative Stigma, AOD, Alcohol and Other Drug, Workers, Professionals

## Stigma by Association: Working in the Alcohol and Other Drug Field

### INTRODUCTION

The concept of courtesy stigma (Goffman, 1963), also known as stigma by association (Neuberg, Smith, Hoffman & Russel, 1994) or associative stigma (Mehta & Farina, 1988), includes processes by which individuals are stigmatized because of their association with an otherwise stigmatized individual. Associative stigma can be overt as in obvious displays of discrimination and rejection, or covert, as in subtle expressions of dislike or unaccommodating social systems (Bos, Pryor, Reeder & Sutterheim, 2013).

Associative stigma can stem from being seen in the company of a stigmatized individual (Neuberg et al., 1994). It can also occur when there is a meaningful connection between the stigmatized individual and his or her associate, as in the stigma experienced by family members of individuals with mental illness, physical disability or substance misuse problems (Angermeyer, Schulze & Dietrich, 2003; Corrigan, Watson & Miller, 2006; Mak & Kwok, 2010; Norvillitis, Scime & Lee, 2002).

Where a person's relationship with a stigmatized individual is continued by deliberate choice rather than familial duty, then the associative stigma is more severe (Haber, Roby & High-George, 2011; Phillips, Benoit, Hallgrimsdottir & Vallance, 2012; Verhaeghe & Bracke, 2012). People who work with stigmatized populations are often thought to do so out of deliberate choice (Goffman, 1963). As a result, these workers are marginalized because they choose to be occupationally associated with people whom society discriminates against (Gray, 2010; Lovi & Barr, 2009; Smith, 2010). The maintenance of this association is deemed to transgress the prescribed values of the referent society (Goffman, 1963).

Workers in the alcohol and other drug (AOD) field can be seen to validate the attributes and behaviours that inform the stigmatization (Phillips et al., 2012). For example, harm-reduction strategies such as needle exchange services might be seen to promote drug use (Smith, 2010). In an ethnographic investigation, Smith (2010) interviewed local community members and business owners to explore public perceptions of a recently opened methadone clinic. An overt rejection of the methadone centre and its clients was evident. Furthermore, local community members rejected and

ostracised the researcher on the basis that the researcher was perceived to be acting in support of the methadone clinic and its clients. The stigma, although aimed directly at the methadone clinic's clientele, was equally applied to the researcher (Smith, 2010).

Workers can also be stigmatized when others assume the worker has a similar history to that of the stigmatized associate (Phillips et al., 2012). Using a mixed methods design incorporating participant observation, semi structured interviews and a short questionnaire, Phillips et al. found that service providers supporting sex workers were stigmatized against because it was believed that the service provider themselves had a history of working in the sex trade. In the case of people working in the AOD field, society might assume workers have their own AOD abuse history and are therefore stigmatized on the basis of that perceived history.

Workers who support people who have communicable diseases are stigmatized against on the basis of a fear of contagion of the disease (Dwyer, Snyder & Omoto, 2013; Haber et al., 2011). Workers associated with people living with HIV/AIDS have reported experiencing stigma in a similar fashion to that of their clients (Haber et al., 2011). Workers in the HIV/AIDS treatment field felt that society held a strong belief of the contagiousness of HIV/AIDS and assumed that workers, through constant contact with their clients could transfer the virus (Dwyer et al., 2013; Haber et al., 2011). Substance use, particularly injecting drug use, is often stereotypically associated with health problems such as hepatitis and HIV/AIDS (Brenner & von Hippel, 2008). Therefore, AOD workers could be stigmatized because of a fear of contagion of the diseases stereotypically associated with AOD use.

Society views work that carries a physical, social or moral taint as 'dirty work' (Ashforth & Kreiner, 1999; Baran et al., 2012). The provision of services to AOD users is deemed to be morally discordant and as a result job roles in the AOD field are stigmatized because society devalues the provision of supports to AOD users (Lovi & Barr, 2009; Olsen, Richardson, Dolan & Menzel, 2003). This devaluation impacts on a workers occupational identity and has been reported to result in high workforce turnover and compromised worker wellbeing (Baran et al., 2012; Duraisingam, Pidd, Roche & O'Connor, 2006). Occupational identity and social identity are inter-related and contribute collectively to an individual's sense of self. As such, defining who one is socially, is contingent on defining who one is occupationally (Ashforth & Kreiner, 1999; Baran et al., 2013). The

stigmatization of a worker's occupational identity compromises the workers sense of self, social connectedness, and belonging (Baran et al., 2001).

However, the threat to identity that stigma poses, might not always result in the internalization of stigma (Miller & Kaiser, 2001). Workers may not necessarily be the direct targets of the stigma (Gray, 2010; Lovi & Barr, 2009) and therefore the attributes that are being stigmatized are not attributes that are intrinsic to the worker (Crocker & Major, 1989). Furthermore, research has shown that where workers value the work they do and the clients they support, the response to stigma is more likely to be one of indignation and an increased determination to help their clients (Corrigan & Watson, 2002; Phillips et al., 2012). Workers are able to refute societal perceptions of their work being 'dirty work' because they see value in the work they do and recognize the untruth in the stigma (Corrigan & Watson, 2002; Dwyer et al., 2013; Kreiner, Ashforth & Sluss, 2006). As such this fortifies the workers belief in their social identity and also their ability to disregard the stigma.

Overall, research has indicated that workers in the AOD field are indeed stigmatized. However, to date there has been no comprehensive investigation into how stigma is experienced by AOD workers, particularly a lack of focus on the psychological impacts of experiencing stigma (Eaton, 2013). Therefore, there is a need to understand how workers in the AOD field experience stigma and respond to the threat to identity that stigma poses.

As no quantitative measure of associative stigma yet exists (Haber et al., 2011; Verhaeghe & Bracke, 2012) it is necessary to investigate the phenomenon with a qualitative approach that will provide the detail that may inform the development of future quantitative measures. There is also a paucity of research into this field, rendering the process of drawing suitable items for the construction of a quantitative assessment difficult and likely to yield an insufficient measure of associative stigma in this particular population (Corrigan & Watson, 2002; Yang et al., 2007). To understand how workers in the AOD field conceptualise and experience stigma it is necessary to explore the meaning of those experiences from the situated perspective of the worker (Gray, 2010; Yang et al., 2007). This way the true meaning of what it means to be stigmatised as an AOD worker can be uncovered. This may lead to the development of informed strategies to manage stigma in the AOD field, resulting in better outcomes for both workers and clients.

Therefore in the present I examined how AOD workers experienced stigma and what meanings they ascribe to those experiences, addressing three broad research questions: (1) How do workers in the AOD field conceptualize stigma? (2) How do workers in the AOD field experience stigma? (3) What impacts do these stigma experiences have on the worker personally and professionally?

## **RESEARCH DESIGN**

### **METHODOLOGY**

Crotty (1996, p. 38) has stated, “that which is known is in the knower”; therefore to understand the experience of being stigmatized as a worker in the AOD field, the meanings of such a lived experience are best derived from the situated perspective of the worker (Biggerstaff & Thompson, 2008). To this extent interpretive phenomenology informed the methodology of the present study. This method aims to explore how people make sense of their social world and is an approach that allows participants to reveal in detail that which they feel is most meaningful to them, providing insight into unique personal experiences (Smith, 1996). Furthermore, the epistemological basis of interpretive phenomenology is social constructionism, so there is an appreciation for the role that social context and social interaction play in an individual’s understanding of concepts such as stigma (Gergen, 1985; Smith, 1996).

The present study aimed to go beyond mere description of the phenomenon and through the use of the interpretive phenomenological approach explore in detail the experiential world of the participant. From a Gadamerian perspective to describe the phenomenon in its most explicit form is to recognise that the researcher has an active role in the interpretation of the informant’s inner understandings of the phenomenon (Biggerstaff & Thompson, 2008; Gadamer, 1975). Therefore the interpretation of the ‘story’ is co-constructed between the participant and the researcher, with the participant remaining as the ‘expert’ regarding their experience (Gadamer, 1975).

As suggested by Lovi and Barr (2009), phenomenological investigation provides insight into the understanding of the term stigma and the meanings attributed to the experience of being stigmatised. The interpretive phenomenological method has previously been used to explore the socially constructed and contextually driven nature of stigma within the AOD field (Lovi & Barr,

2009). Furthermore, the interpretive phenomenological method has been successfully applied to investigate the lived experiences of clinicians and other health field professionals regarding sensitive issues (Dollarhide, Shavers, Baker, Dagg & Taylor, 2012; Hung, Huang & Lin, 2009). This methodological approach is well suited to the exploration of sensitive topics and to achieve this studies objectives of investigating the lived experience of stigma of AOD workers. As such Gadamerian interpretive phenomenological analysis informed the following methods.

#### SAMPLE

A stakeholder sample of 11 informants (Male  $n = 6$ , Female  $n = 5$ ; Non-indigenous  $n = 8$ , Indigenous  $n = 3$ ), with an age range of 29 to 58 years ( $M = 44$ ) and an average length of service in the AOD field of nine years was recruited from the Western Australian AOD service provision field. Given the exploratory nature of this investigation, diversity within the sample was considered essential. Participants were employed in a variety of AOD specific services including counselling, needle exchange, outreach, health and other critical support services. Participants worked in volunteer and paid capacities, for government and nongovernment organisations, metropolitan, regional, and remote based.

#### DATA COLLECTION PROCEDURES

It has been reported that the AOD field is particularly workload burdened and time poor (Eby, Burk & Maher, 2010). Therefore, a pragmatic approach to sampling was undertaken to enhance response rates within a participant cohort that was likely to be disinclined to respond on the basis of time constraint (Iqbal, Haroon, Jabbar, Babor & Qureshi, 2012; Patel, Doku & Tennakoon, 2003). A targeted recruitment drive was conducted with the assistance of two peak Western Australian AOD governing bodies, the Western Australian Drug and Alcohol Office (DAO) and the Western Australian Network of Alcohol and Other Drug Agencies (WANADA). Details of the study were forwarded by electronic mail and newsletter release to agencies registered on the DAO and WANADA services database. A secondary participant recruitment drive was conducted through direct contact with agencies. I also presented at an AOD industry seminar (Corrigan, 2013) providing information on the research and participant recruitment process. To ensure procedural rigour, advertising media, information letter, consent form and interview protocol were reviewed by the

projects supervisor and two individual stakeholders at DAO and WANADA. Any recommended changes were made in consultation with these industry experts.

Upon expression of interest by a participant, consent form and participant information letter were forwarded prior to the interview to facilitate the extended opportunity for consideration and question asking. Interviews were scheduled at a time and location that suited the participant to ensure confidentiality, as it was recognised that participants could be conversing about events and people from within the industry and in some cases their own workplaces (Toffoli & Rudge, 2006). Consent forms were signed at the time of interview for face-to-face interviews. For telephone interviews, consent was audio recorded and later transcribed.

Interviews of approximately 90 minutes duration were conducted either face to face or by telephone for regional and remote workers. In a partial replication of the methods of Lovi and Barr (2009) and conforming to the prescribed methods of interpretive phenomenology, interviews were informal and semi structured, with the use of broad open questions. As recommended by Gill, Stewart, Treasure and Chadwick (2008) the use of such a format prevents leading the participant. Furthermore, participants reveal that which they perceive to be most salient to them, drawing the true meanings ascribed to the experience, the core assumption of interpretive phenomenology (Gill et al., 2008; Smith, 2007).

The interview protocol supported a rapport building stage and the coverage of three key domains: the conceptualization of stigma; the description of experiences of stigma; the personal and professional impacts of those experiences. Questioning began broad, for example: "stigma means different things to different people, how do you conceptualize stigma?" with prompts used to draw richer explanations of concepts or experiences for example: "could you tell me more about that". Towards the close of questioning, participants were asked if there was anything more they would like to add and were provided with time to allow those thoughts to come forward (Biggerstaff & Thompson, 2008).

No definition of stigma was provided to participants, as it was believed that doing so would result in the participant's conceptualization of stigma being created within the parameters of the

description provided. This would limit the ability to draw from the participant a description of stigma as they saw it, untainted by a social construction of the term predefined by the researcher.

Participants were able to freely contact the researcher at any later stage to provide further comment. To ensure procedural rigour these conversations were documented. The advantage of offering open contact was that it permitted participants who were time constrained the opportunity to provide further detail. Ethics approval was granted by the Edith Cowan University ethics committee. Transcripts are stored at Edith Cowan University and may be accessed for future use by parties with legitimate research purposes.

#### DATA ANALYSIS PROCEDURES

Interviews were audio recorded and transcribed verbatim. To protect the identity of participants and organisations, each participant was provided with a code name at time of transcription and used when referring to the participant in this report (Giordano, Taylor & Dogra, 2007). All transcripts were de-identified and the original recordings deleted. Field notes were taken by the researcher throughout the interviews as per the recommendation of Giorgi (1997). To achieve interpretive rigour reflexive journaling took place after each interview and subsequently throughout analysis. Reflexive journaling maintains contextually specific information (i.e. tone of voice, long pauses, humour) that is integral to the interpretation of meaning (Giorgi, 1997; Morrow, 2005). Furthermore, reflexive journaling acts as a method of examining the influence the researchers own beliefs and thoughts have on the interpretation (Morrow, 2005). These notations also served as a method of triangulation whereby constant comparison was made between thematic constructions, transcripts, field notes, and journal (Giorgi, 1997; Morrow, 2005).

Transcribed data were analysed using the Biggerstaff and Thompson (2008) extension of the Giorgi (1997) method of interpretive phenomenological analysis. The original Giorgi (1997) method used a descriptive approach to data analysis that chiefly aimed to seek data excerpts that were confirmatory to initial research questions. Biggerstaff and Thompson (2008) extended the Giorgi (1997) method and used a more comprehensive interpretive search for text examples of both convergence and divergence. This fluid approach to analysis breaks from the rigidity of solely

seeking to confirm research questions and enables a richer interpretation of the phenomenon under investigation (Smith, 1996).

Transcripts were read and re-read to gain a holistic view of their contents. Gaining familiarity with the data through constant re-reading helped to develop an intimacy with the data that enhanced interpretation (Smith, 1996; Giorgi, 1997). Through a process that was both inductive and recursive, the initial stages of data reduction enabled the clustering of similarly coded data. Divergent explanations were included to provide a more balanced understanding (Biggerstaff & Thompson, 2008). More in depth and comparative coding of data was then conducted from which themes that best captured the ideas proffered in the interviews were collated. This process being dynamic and continual progressed from being descriptive to more interpretive around the meaning of a theme (Biggerstaff & Thompson, 2008). An audit trail process promoted interpretive and procedural rigour whereby progressive changes in thematic structures were documented to provide substantiation to the resulting conclusions (Barusch, Gingeri & George, 2011).

Review continued until thematic saturation was reached. Saturation became apparent after the ninth interview, with two more interviews conducted to confirm this. Thematic saturation has been thought to be achieved when further interviews yield no additional constructs, only example variations on existing themes (Malterud, 2012). As discussed by Malterud (2012) the seeking of thematic saturation is particularly problematic for investigations of an exploratory nature and suggested that saturation is achieved when the data provides a rich explanation of the phenomenon. Should the initial thematic assessment not yield sufficient richness then the researcher is to return to the interviewing stage (Malterud, 2012). The present study being exploratory in nature sought thematic saturation in line with the propositions of Malterud (2012).

To ensure interpretive rigour through a process of triangulation and member checking, a number of participants were contacted to discuss the thematic conclusions drawn by the researcher (Malterud, 2012). Clarification was sought where inconsistencies were found and the thematic structure was modified (Creswell & Miller, 2000). This form of member checking has been suggested to be the most crucial in the interpretive process to establish the credibility of the conclusions being drawn (Creswell & Miller, 2000). Themes, subthemes and transcript extracts were

discussed with the projects supervisor. Additionally, three research colleagues investigating stigma within the AOD area reviewed the final thematic construction, adding to the methodological and interpretive rigour of the study.

## FINDINGS AND INTERPRETATIONS

Five major themes were identified: the use of language; public perceptions of AOD work; role of advocacy; driving forces behind structural stigma; breaking the stigma silence. Each of these five themes and their component subthemes are discussed below, with relevant quotes drawn from interview transcripts included to support findings and interpretations.

### THE USE OF LANGUAGE

Workers, when reflecting on what stigma meant to them identified words such as *discrimination, stereotyping, demoralizing, judgments, and marginalization*. These terms represented processes whereby language was used to describe AOD users in derogatory ways. For example:

*It's labeling isn't it, of people, through a set of characteristics. So for example if you are talking about drug and alcohol you are saying that people see people as druggies, oh as losers, that kind of thing... So it's those labels that have negative connotations* (Betty).

Betty used the term 'connotation' in her statement to imply that there was greater meaning behind the words being used to describe her clients. A single term like 'druggie' constitutes multiple meanings around societies views of AOD users (Treloar & Holt, 2006). Words like this convey the disregard, contempt, rejection, and fear society has of AOD users (Treloar & Holt, 2006). Crystal referred to this process as "*verbal shorthand*".

Because language was such a strong conduit for stigma, changing the way language was used could moderate the stigma clients were exposed to. Some workers felt they had an obligation to model more appropriate use of language. By describing their clients only as "needy" and avoiding using terminology related to substance use, workers could protect their clients from stigma. By manipulating the terms they used, workers were manipulating the connotations attached to those terms, a process known as impression management (Goffman, 1963). According to the workers, society determined "need" as being 'in need of help', "druggie", as being 'undeserving of help'. By using 'needy' workers could achieve better outcomes for their clients and to some extent reduce the

stigma applied to their role by enhancing the profile of the clients they worked with. The inappropriate use of language and processes of labeling have previously been shown to result in poor treatment of people when they were described in derogatory ways (Angermeyer & Matschinger, 2003).

#### PUBLIC PERCEPTIONS (OF AOD WORK)

The theme of public perceptions incorporates the meaning that workers derive from the subtle and not so subtle ways in which working in the AOD field was stigmatised. Workers were acutely aware of the judgments society, family, friends and colleagues made of their choice to work with AOD users. Those judgments made workers feel as though they had to justify to others their desire to work in the AOD field. To this extent the subthemes of dirty work; hierarchy; stigma anticipation; disclosing occupational identity explain the theme of public perceptions of AOD work.

#### DIRTY WORK

The term “*dirty work*” was used by workers to describe the way they felt society viewed their occupations. In the following example it was the exposure to specific drugs or methods of drug taking that made AOD work ‘dirty work’:

*I kind of get this feeling that something, like that people think my work is the dirty work. You know when people talk about heroin or talk about specific drugs and people get all queasy about it and that sort of thing (Marcus).*

However, in the next example, ‘dirty work’ was expressed in terms of the contact the worker had with AOD users:

*And I think that people think that my work is really dirty and it’s messy, and it’s not like that at all! As far as I can see my clients are all normal, they have just gotten a little bit lost along the way (Cindy).*

It was interesting that workers, unprompted, described their job roles as ‘dirty work’. The organizational psychology literature in this area has indicated that people employed in occupations that carry a social, physical or moral taint are aware of this taint (Ashforth & Kreiner, 1999; Baran et al., 2012). One of the concerns regarding stigma is the propensity for stigma to become internalized and result in negative impacts on an individual’s wellbeing (Major & O’Brien, 2005; Vogel, Bitman,

Hammer & Wade, 2013). Stigma acts as a threat to social identity as it compromises belonging and connectedness and therefore impinges on self-concept (Crocker & Major, 1998; Major & O'Brien, 2005). However, in the case of 'dirty work' the stigma is not applied to any personal attribute possessed by the worker, rather to the job itself (Ashforth & Kreiner, 1999). Therefore, because the worker is not the target of stigma, there should be no internalization of stigma. Through statements such as "*people just don't get what it's all about*" (Daniel), "*they're ignorant*" (Betty), "*it's about the client*" (Samson), and "*it's not true*" (Petra), workers indicated awareness that although they experienced stigma they were not the targets of that stigma. Workers also acknowledged that the stigma pertaining to their job role was due to the ignorance of others.

### HIERARCHY

Closely related to 'dirty work' was the subtheme of 'hierarchy'. Both themes encompassed the views others held of the AOD job role, however, 'hierarchy' was related to inter-professional stigma as opposed to societal perceptions. Workers used the term "*hierarchy*" to explain how AOD work was considered to be less important than services that helped other clinical populations such as mental health. For example:

*And maybe from a professional point of view, counseling services or mental health professionals might perceive drug and alcohol as being, well ... they might see it as somehow being a lesser role. Like for example, see AOD workers as desperate for work, or that they don't have the experience in these kinds of roles because they're not that sought after (Les).*

In this example it is the worker who is stigmatised. The worker, being 'desperate for work' and willing to take on a 'lesser role' was perceived to be unskilled and unworthy of working with clients who were not as tainted as AOD users. The stigma, however, was contingent on the worker's relationship with the client.

Link and Phelan (2001) have suggested there are negative impacts from being downward placed on a social status hierarchy. However, for the workers in the present study, although feeling that the stigmatization of their occupations was unacceptable and the "*height of rudeness and disrespect*" (Betty), they generally ignored the sense of being occupationally stigmatized. Workers accepted the forced placement of their profession on the social services hierarchy and simply moved

on. Rumination over something that was determined to be unchangeable was seen to be unproductive and took the focus off the provision of supports to users. As Betty explained: *“You’re obsessed with your own feelings and you are not doing the work. You’re not there for you, you’re there for them, and I guess it takes your focus off work a bit”*.

#### STIGMA ANTICIPATION

As evidenced in the previous subtheme, occupational stigma experienced by workers was inextricably linked to the clients they supported. Workers made many mentions of other people questioning their choice to work in the AOD field, and to work with *“those people”*. Comments, that at face value, seemed to show respect and admiration for the occupational choices of AOD workers, were actually perceived to be implicitly discriminating. Seemingly polite comments needed to be read into to derive the true meaning behind the comment. For example:

*But I think that some of the compliments you get can be quite telling in that they will say things like ‘oh I really admire what you do, I think it’s really hard, but I don’t think I could do that’. And I’m not sure if they couldn’t do it because it’s so hard or because they don’t like the idea of working with people who struggle with addictions (Les).*

What this meant for workers was an increased vigilance for and sensitivity to stigma cues. Stigma anticipation could serve a protective purpose, enabling the detection of people to be avoided, but could also contribute to hyper-vigilance, where workers would look for stigma where there was none to be found. This finding supports that of previous investigations that have reported that ongoing exposure to stigma contributes to stigma sensitivity and stigma vigilance (Major & O’Brien, 2005).

Patrick spoke in jest of an occasion where he was purchasing equipment for his agency and was suspicious of the salespersons interest in his needs for the equipment. Patrick reacted with tactics he often employed to avoid stigma only to find later that the salesperson was actually very supportive of his agency and the particular support services they offered to users:

*And I kind of had one of those moments, oh here’s me making my judgements about him and really he’s looking for an opportunity to open his mind a bit and put back and take a role in the community... (Patrick)*

Because workers are aware their roles were stigmatized, this had the propensity to promote skepticism and reactivity in the face of perceived or real stigma threats. This defensiveness acted to protect workers from the assault that stigma related to their occupation had on their social identity. Therefore, anticipating stigma could ready the worker to take appropriate action to avoid a prospective stigma threat.

#### DISCLOSING OCCUPATIONAL IDENTITY

As a result of stigma anticipation, workers chose in many circumstances not to disclose their occupational identity to others. To disclose their occupational identity would be to invite open comment as to the moralistic worth of providing services to AOD users. The discussion of this notion during interviews resulted in much eye rolling and sighing by participants which may indicate the tiresome, pointless and burdensome way this kind of judgment can be experienced. For example:

*But yeah I mean I wouldn't be likely to tell people what my job was unless they really asked me. Just because it takes too much time to explain. Then you get all these misconceptions and they all come out in the form of 'don't they this, don't they that, aren't they this, aren't they that, aren't they horrible people', so yeah well like really they're just people! (Betty).*

Previous research has found that where workers were occupationally associated with a stigmatized population or worked in a job that was socially denigrated (like 'dirty work'), there was often a non-disclosure of occupational identity (Haber et al., 2011). This has been reported to be a protective measure to prevent a loss of social supports that can result when others become aware of whom the worker is associated with (Baran et al., 2012). However for workers in the present study, non-disclosure of occupational identity was as a result of the avoidance of moral judgments pertaining to their work. Perhaps because of the frequency of stigma exposure workers were weary of needing to justify their decision to work in the AOD field. Therefore non-disclosure of occupational identity was more about autonomy of choice, without having society judge that choice, than it was about loss of social connection.

#### ROLE OF ADVOCACY

A pervasive theme amongst the workers responses was the role of client advocate that workers assumed in order to protect their clients from stigma.

## JOB VALUE

Previous investigations have reported that in response to the threat to identity that stigma contributes to, people compensate for the stigma by becoming more determined to overcome the stigma (Miller & Kaiser, 2001). Contrary to the finding that stigma is internalized. This determination is derived from identifying the stigma as being untrue and in contention with the value placed on the aspect being stigmatized. In the present study workers expressed with absolute conviction that they were proud of working in the AOD sector and that they received great personal reward from helping their clients. For Marcus this was evident in his commitment to the job:

*...in another way I almost feel that my work is more important because people don't understand it. Because drug and alcohol work is not very well understood by people, it's almost like I kind of need to and want to keep going, keep doing what I do... So the stigma makes me more determined, I feel more committed to what I do.*

For Samson, advocacy was about instilling power in clients: “*and that's what I love about my job, it's about breaking down that stigma and empowering people and helping people to feel like they do have that power*”. For Patrick, it was the responsibility that rested with the AOD industry as a whole:

*Well it makes me want to dig my heels in more and makes me just kind of go well we all pat ourselves on the back and go to conferences and say what a wonderful job we are doing but we have so much more to do.*

A strong sense of client advocacy has been found in previous investigations into worker populations who support stigmatized clients (Dwyer et al., 2013; Phillips et al., 2011). The role of advocacy has been reported to be one of the most critical components of comprehensive service delivery in the health services field, promoting good prospects for recovery, enhancing equality, and ameliorating the negative impacts of stigma (Stylianios & Kehyayan, 2012). The belief in the role of client advocate is testament to the value that workers placed on their occupations. This sense of job value in turn served to protect the worker from internalizing stigma because they saw the stigma as being based on false beliefs (Corrigan & Watson, 2002; Miller & Kaiser, 2001).

## DISPELLING STIGMA MYTHS

The role of advocacy also involved tackling stigma directly, choosing the right time and place

to dispel stigma myths and confront people on their false beliefs about AOD users. However, workers were quick to express that their contributions to stigma management were not intended to change stigma in a global sense but to proactively address it more locally. As Cindy explained:

*I just want to change the footpath in front of our building, because that goal is a little more realistic and I put my energy where I think I can move it and make the changes, address the stigma. You pick your time and place, because otherwise you would feel like you are constantly banging your head against the wall... You say well this is going to be my conversation where I do actually address this.*

Samson indicated that addressing stigma globally might require the distribution of “*a truth drug or a lobotomy*” to those who stigmatize. The application of those solutions was seen to be as unrealistic as managing stigma in a global sense. However, Samson was contented with applying “*measured and balanced*” tutelage to select individuals whom he felt he could address the stigma issue with, thus reducing the impacts of stigma on both worker and client. It has previously been found that defense tactics such as the direct confrontation of the stigma perpetrator aims to lessen stigma taint and render it less psychologically salient for the individual (Ashforth, Kreiner, Clark & Fugate, 2007).

#### DRIVING FORCES BEHIND STRUCTURAL STIGMA

The theme of driving forces is comprised of the meanings workers ascribe to structural stigma experiences, particularly the frustration that resulted from feeling powerless to control or change systems that stigmatize. Workers referred to inadequacies and disparities in the provision of financial and structural supports that were needed to maintain the functional integrity of AOD agencies. Structural stigma is stigma that occurs within a broader systemic spectrum (Yang et al., 2007) and has previously been reported to be a leading contributor to status loss and discrimination (Link & Phelan, 2001; Yang et al., 2007). To this extent the subthemes of financial constraints; service philosophy; abstinence; and stigma from within the field explain the theme of driving forces.

#### FINANCIAL CONSTRAINTS

Workers reported several experiences in which stigma had impacted on their ability to provide services to AOD users. These experiences shared a common factor of financial constraint and

were manifested in many ways including inadequate remuneration, substandard facilities, and funding disparities. Workers expressed that because AOD users were seen as undeserving of support, service provision to AOD users would receive less financial resources. For Les this was evident in the paucity of financial support his agency received: “...if drug and alcohol were considered to be more important, then I think we would see more funding to work with people who are affected by drugs and alcohol”.

For Marcus structural stigma was evident in the insufficient wages he received: “You know one of the frustrating things is that I feel, like, well I do work really hard... and just compared to other organisations, you know... the pay is just really crap” (Marcus). As described previously, AOD work was not perceived to require high levels of training. Workers felt that their pay conditions were reflective of that opinion and as a result wages were not representative of the amount or complexity of work they undertook or the stress they were exposed to.

For Petra structural stigma was evident in the substandard buildings she had been required to work in, because her agency was inadequately funded to afford better professional surroundings:

*I remember years ago when I was working for (service provider) ... you know the roof used to leak, I mean we put bins in there it was leaking in there so much, really run down and we used to freeze in there! (Petra).*

For Crystal structural stigma was evident in the inadequacies of service infrastructure because of a lack of vested financial interest in the AOD field and was usually perpetrated by the Government and other state run or affiliated agencies:

*Yes well, if you look at the hospitals, say for example Charles Gardiner, and you look at the mental health unit and AOD supports there, it's disgraceful... Its poor, so the mentally ill including AOD will get the worst building, the worst premises, you know second or third best if you like. And that's not good enough! ... And what does this say to the client, if you are being put into emergency services that are substandard. That's saying, well what does society think of your problem, well we don't think very much of your problem.*

What this meant for workers was that the provision of supports for AOD users was reliant on funding which in turn was reliant on the perceptions of worth attributed to those services. Structural

stigma was therefore believed to originate from the disinterest society and the Government held for the needs of AOD users. Yang et al., (2007) have reported that funding issues are often the fate of agencies providing supports that do not match with the modern zeitgeist of popular causes.

#### SERVICE PHILOSOPHY

Workers revealed that the degree of stigma perpetrated against a worker or agency was dependent on the “*working philosophy*” that guided an agency’s service provision methods. Workers employed by harm reduction focused agencies reported feeling a keen sense that their agencies were more stigmatized than prevention or treatment focused agencies because they felt they were seen to be “*promoting or sustaining drug use*”. As a result workers felt they were coming into contention with the expectation of abstinence that society held for AOD users. Abstinence from substance use has been reported to be a common expectation held by society of AOD users (Treloar & Holt, 2006)

Workers reported that they felt society did not understand the purposes behind harm reduction and this contributed to the perpetuation of stigma. This finding supports that of previous investigations into public perceptions on harm reduction approaches that have evidenced a general rejection of those approaches (Buchanan, Shaw, Ford & Singer, 2003; Heller & Paone, 2011). It was also indicated by workers that it was difficult to measure the success of harm reduction and that this could also contribute to ongoing stigma. For example Patrick stated:

*And I think, for those coming from a service provider’s point of view, stigma is about what kind of philosophy you work under. For instance, I often see that people who work within a recovery role are seen as doing something good for their community. However I have always worked within a harm reduction role and we have often been seen as facilitating drug use.*

Patrick further explained that because the agency he worked for promoted harm reduction they were bypassed for funding and supportive donations:

*...they work for residential treatment and they got a free building ... And I was sitting there thinking that well I’ve worked for (harm reduction agency) for a number of years now and I don’t think we’ve got anything for free at all. And then I kind of thought well oh yeah well people don’t want to be aligned with what we’re doing. People want to be aligned with recovery and seen as doing moral good.*

In this example, Patrick reiterated the role that financial disparity played in the structural stigmatization of the AOD field mentioned previously by Les (p. 18).

#### THE EXPECTANCE OF ABSTINENCE

As evidenced in the previous subtheme, the stigmatization of the AOD field can partly be explained by the expectance of abstinence to which AOD users are deemed to be noncompliant. However, workers also revealed that society expected abstinence from AOD workers as well. Workers reported that they felt society believed it was irrelevant whether they were promoting harm reduction, prevention or treatment, they were expected to be completely abstinent from all substance use. As Daisy described: *“I mean I smoke cigarettes and people always comment that I have an addiction so then what am I doing in my job... Its double standards, just because of what we do!”*

Workers reported that not only were these sorts of attitudes preposterous but that they also limited them socially. Workers were less inclined to attend social events or to be seen to be consuming alcohol because of the judgements from others regarding the expectance of abstinence. As Daisy continued to explain: *“I just don’t go to the pub and things like that... oh yeah, it would be nice to have a good night out every now and then... but people have got this whole thing about you being a drug and alcohol counselor”*.

This finding provides an indication that workers experienced stigma on a basis that was more complex than just because of their occupation contact with a stigmatized person. This type of stigma is not about personal attributions; it is about social conformity and the expectance that the worker should abide by the rules society applies to the AOD user. To avoid being stigmatized for non-compliance to these rules, workers must modify their social behaviors according to the expectance of abstinence, as Daisy (this page, above) indicated she had.

#### STIGMA FROM WITHIN THE AOD FIELD

Previous research has indicated that a proportion of people working in the AOD field hold stigmatizing opinions of and perpetrate stigma against AOD users (Lovi & Barr, 2009; Morgan, 2012). The following statement made by Samson lends support to those propositions: *“Clients, I’ve had people in other agencies refer to clients as junkies, as whores, as wastes of space”*. Furthermore, in an extension of the findings of Lovi and Barr (2009), and Morgan (2012), workers in the present

investigation reported that stigma perpetrated from within the field was pervasive, with senior AOD workers implicated in the perpetuation of stigma. Patrick revealed a stigmatizing experience perpetrated against him by a senior AOD manager and stated: *“I was kind of surprised where it came from and it was a sense of well those people should have known better. Of anyone in our community, these people should know better...”*

Furthermore, as reported by Marcus there were workers within the AOD field who held *“old fashioned views”*, usually related to the expectance of abstinence. It was reported that these senior workers stigmatized clients who were perceived to be unworthy of supports because they were non-compliant with the expectance of abstinence.

The workers interviewed explained that stigma within the field had a direct impact on help seeking by AOD users. Furthermore stigma from within the field acted to undermine the integrity of the field and could result in AOD users developing a negative perception of AOD service providers as a whole on the basis of interactions with an unrepresentative minority. For Samson this meant that clients might see him as: *“part of the system, part of the evil empire, part of the society that doesn’t work for them”*. This is something that workers wanted to avoid.

#### BREAKING THE STIGMA SILENCE

Workers felt that stigma was not talked about enough in the workplace, but they wanted to be able to do so:

*One of the reasons why I wanted to come and talk to you about it (stigma) is because you know we just don’t talk about it at work. You know we do our thing and stuff comes up, but we don’t talk about it, about stigma... (Marcus).*

Therefore, there are AOD workers in the field who are prepared to speak about stigma if afforded the opportunity, for the benefit of the workers themselves and their clients. This in turn would indicate the likelihood of support for future stigma management strategies employed in the field. However as discussed by Halter (2002), workers are often not afforded means by which to express their stigma experiences.

There is a lack of supportive and confidential processes through which workers are able to report and seek counsel on stigmatizing experiences. For workers who had experienced stigma

perpetrated by a colleague within the AOD field itself, this was particularly pertinent:

*And I have to weigh up how much harm has been done to me personally and if I did write some kind of complaint and want some kind of resolution about it, compared to what kind of damage might be done to me in the future. So right at the moment I'm choosing to keep myself quiet. The question is whether you are willing to take this stigma, because this job means a lot to me and the people I help do as well (Patrick).*

From this excerpt it can be seen that speaking up about stigma can impact on the future employment prospects of workers and as a result they face a dissonance regarding the desire to be heard versus the fear of repercussion. As discussed by Bjorkelo and Macko (2012) reporting workplace wrongdoings can cause significant emotional distress for workers as they face the possibility that by reporting they are likely to be further stigmatized or otherwise punished. By not providing means by which workers can express their feelings regarding stigma experiences or have the issue rectified, workers are left not only dealing with the stigma experience but also the knowledge that there is nothing that can be done about it. This adds to the stress that the stigma causes, reducing worker wellbeing and having negative flow on effects to the provision of services for users (Halter, 2002).

For workers already experiencing job role stress or personal difficulties, having no means to express their stigma experiences and their emotions around that experience, compounded existing burdens. Petra, who had been experiencing difficulties at work as a result of constant exposure to stigma targeted at both herself and her clients, reported:

*It gets to me, it wears me down for sure. There's no way I don't get affected by things like that, because I definitely do, it definitely builds up. It makes it more difficult when life isn't travelling so well, it adds another layer.*

The unfortunate outcome is that without adequate defenses, stigma becomes internalized and has the effect of reducing the sense of connectedness and belonging that sustains an individual's self-concept (Holmes & River, 1998). Workers who are already experiencing strain in their lives experience a lower resiliency to stigma, therefore their faith in the job can no longer outweigh the pressures of the stigma (Dwyer et al., 2013).

However workers also reported that having strong family and social support networks helped to sustain them emotionally, cushioning the more immediate psychological impacts of ongoing stigma. As David stated “*well my wife she is working in mental health, so she understands what it’s like, we support each other*”. Supportive familial and collegial relationships that foster a psychologically safe space in which to discuss stigma experiences has been found to promote wellbeing in workers, reduce turnover rates, job role related stress and burnout (Jack, Canavan, Ofori-Atta, Taylor & Bradley, 2013).

## DISCUSSION AND CONCLUSION

The purpose of this paper was to explore the stigma experiences of AOD workers, with a particular focus on the psychological and professional impacts of those experiences. A recurrent aspect of ‘stigma resilience’ was evident throughout the themes presented in this paper. Many of the issues raised in the themes and subthemes were contingent on the value that workers placed on their occupation. Workers were aware that their occupations were stigmatized by society because they supported a marginalized population. However, workers were able to deflect the stigma because they did not agree with the views that were driving the stigma. This finding supports previous research that has found that in response to the threat to identity that stigma contributes to, people compensate and strive harder to overcome the stigma where they value the domain being threatened (Miller & Kaiser, 2001). The strong sense of client advocacy evident in the present paper has shown the ways that AOD workers compensate for and manage the stigma attributed to their job roles.

The participant sample constituted workers who made a choice to come forward to speak of their stigma experiences. Indeed Marcus (p. 21) mentioned that he thought stigma was not talked about enough, but felt it should be. This is not to ignore however, that there could be people working in the field who, like Petra (p. 22) are experiencing negative impacts from the stigmatization of their role and their clients. It has been suggested that in order to manage the stigma threat, people employ strategies to distance themselves from the stigma (Dwyer et al., 2013; Goffman, 1963). In the case of people working in the AOD field, in order to distance themselves from the stigma, workers might distance themselves from users by terminating their employment within the AOD sector. Given the high turnover of the AOD workforce, evidenced by Duraisingam et al. (2006), avoidance of AOD

users to manage stigma threat may be contributing to this turnover. Future research is needed to address this issue with a particular focus on the ways to best identify workers who are at imminent risk of or are currently experiencing negative impacts from stigma that are beyond their ability to cope. The unusual finding of the expectance of abstinence of AOD workers requires further empirical attention. Because of this stigma, workers reported actively modifying their lifestyle and became socially restricted as a result. Social isolation resulting from this practice has the effect of compounding psychological stress (Major & O'Brien, 2005), impacting on wellbeing.

The present study is the first to undertake a comprehensive investigation into the stigma experiences of people working in the AOD field. However it is important to acknowledge the low response rate, which could be seen to be a limitation of the study. It is difficult to determine the reasons behind this. Workers may have just been too busy, or because of the stigma silence were unprepared or not permitted to talk about their stigma experiences. It may be that there simply were not enough stigma experiences to speak of. However, given the conviction with which workers expressed a myriad of different stigma experiences, this seems unlikely. Future research may choose to consider assessing stigma in a larger sample

Having revealed areas in which stigma is manifesting in the AOD field, future research is better positioned to create a quantitative measure to assess the degree to which stigma is present within the field. Although there are workers who show resiliency to stigma, there are workers who might already be experiencing difficulties that stigma will only compound further and as such are at risk of internalizing stigma. By identifying a number of structural and interpersonal ways that stigma occurs and impacts on worker wellbeing and service, the present study has raised areas that could constitute such a measure. Furthermore, these same issues could be readily addressed by policy makers, funding agencies and organizational managers to reduce stigma in the AOD field. The first and most obvious being the provision of appropriate means for workers to report and seek counsel regarding their work related stigma experiences. The second is the provision of additional supports for workers experiencing difficulties to reduce the compounding effect of stigma.

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Appendix A  
**Guidelines for Contributions by Authors (Literature Review)**

Drugs: Education, Prevention and Policy

**Manuscripts:** Manuscripts should be between 3000-5000 words. Shorter papers of approximately 1,500 words are also acceptable and may be published more rapidly. Papers should be typed, double spaced (including the references), with margins of at least 2.5 cm (1 inch). All pages must be numbered.

All submissions should be made online at Drugs: Education, Prevention and Policy's Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

Authors should prepare and upload two versions of their manuscript. One should be a complete text, while in the second all document information identifying the author should be removed from files to allow them to be sent anonymously to referees. When uploading files authors will then be able to define the non-anonymous version as "File not for review".

The first page should include the title of the paper, name(s) of the author(s), and for each author a full institutional address, and an abbreviated title (for running headlines within the article). At the bottom of the page give the full name and address (including telephone and fax number and email address if possible) of the author to whom all correspondence (including proofs) should be sent. The second page should repeat the title and contain an abstract of not more than 200 words. The third page should repeat the title as a heading to the main body of the text. Within the text section headings and subheadings should be typed on a separate line without numbering, indentation or bold or italic typeface.

**Abstracts:** The abstract for an empirical research study should be structured into: aims, methods, findings, conclusions. Abstracts for other submissions (e.g., policy commentaries) need not follow this structure.

Please also include a minimum of three keywords, which you can either provide yourself or select from our list on Manuscript Central.

You may, if you wish, suggest preferred or non-preferred reviewers for your paper. You may also suggest an Editor to whom you think your paper could be assigned.

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All submissions will be sent anonymously to independent referees.

Acknowledgement of funding and conflict of interest: Authors are requested to acknowledge sources of funding for research projects and to declare any conflict of interest.

Acknowledgements should be placed after the text and before the reference section.

References: All publications cited in the text should be listed following the text; similarly all references listed must be mentioned in the text. Style, statistical reporting, and reference citations should conform to the American Psychological Association's guidelines, from the APA Publication Manual, sixth edition.

Endnotes: Please note that endnotes are preferred to footnotes.

Illustrations: All illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Fig. 3). Each should be submitted separately to the main text document and numbered with Figure number (Arabic numerals). The captions of all figures should be submitted when prompted in Manuscript Central at the upload stage, should include keys to symbols, and should make interpretation possible without reference to the text.

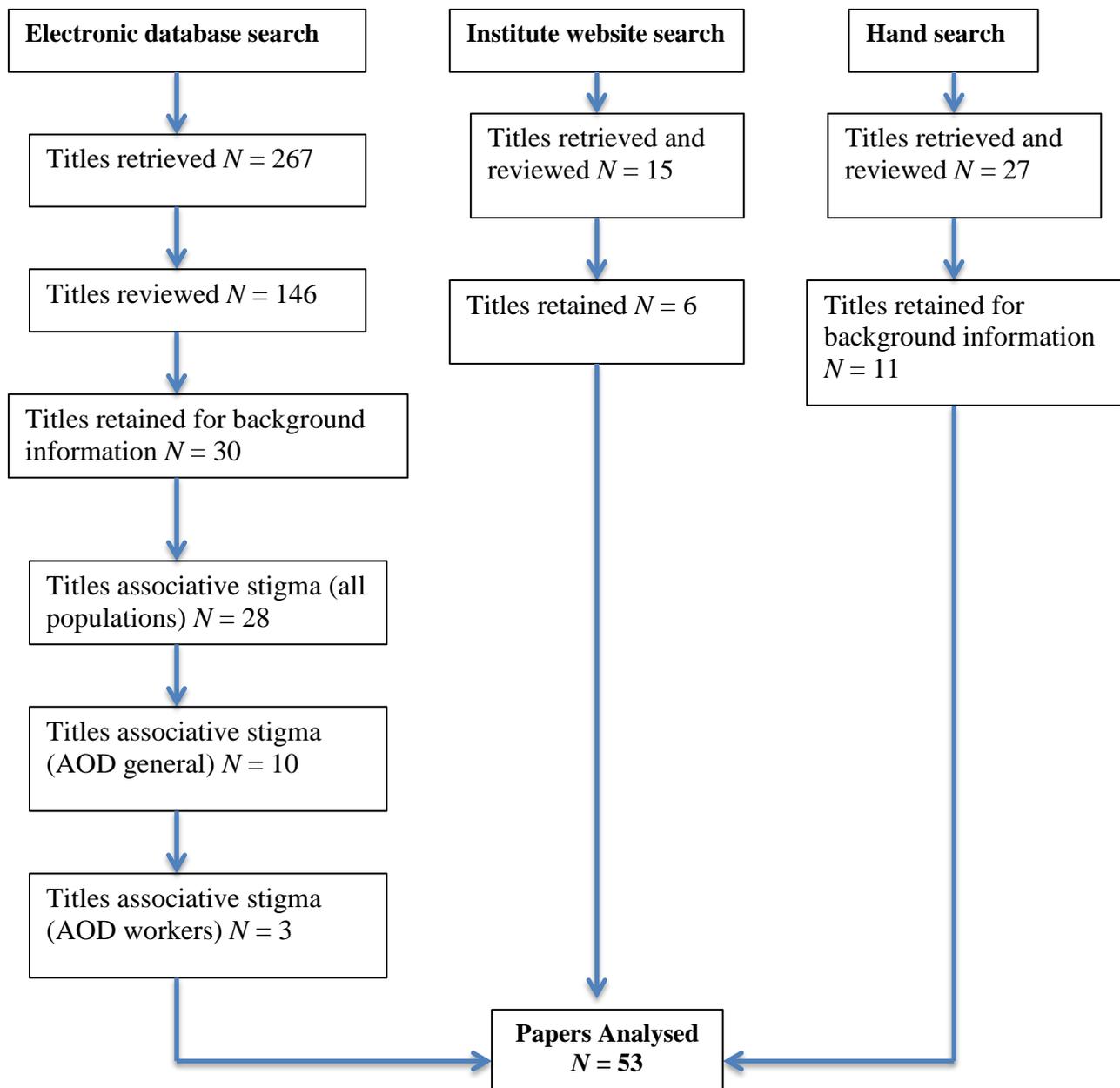
Figures should ideally be professionally drawn and designed with the format of the journal (135x210 mm) in mind and should be capable of reduction.

Tables: Tables should be submitted separately, numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

Proofs: Proofs will be sent by email to the author nominated for correspondence. Proofs are supplied for checking and making essential typographical corrections, not for general revision or alteration. Proofs must be returned (by email or fax) within 48 hours of receipt. Offprints and Reprints: Free access to a pdf which can be sent or printed up to 50 times.

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## Appendix B

**Flow Chart: Literature Review Article Selection Process**

*Figure 1.* Flow chart of article selection through the process of systematic review of the literature into associative stigma

## Appendix C

**Guidelines for Contributions by Authors (Research Report)**Journal of Drug Issues

## MANUSCRIPT

Manuscripts should be submitted electronically to <http://mc.manuscriptcentral.com/jodi>

## PREPARATION

Manuscripts should not exceed 30 pages of text. Prepare text in Times New Roman 11 point type. Manuscripts should be double spaced, including references. Do not use automatic endnote function in your word processing program. Endnote marks in the text should simply be superscripted numbers, and notes should be typed separately at the end of the text. For reference on style, see the Publication Manual of the American Psychological Association, 6th ed. Sample articles formatted according to JDI's style guidelines may be viewed here. Manuscripts will not be accepted until they are formatted correctly.

FOR INTERNATIONAL AUTHORS: ENGLISH LANGUAGE REFINEMENT  
AND EDITING

JDI receives many submissions from authors that are non native English speakers. Unfortunately, many of these manuscripts must be rejected outright because they are difficult for reviewers to understand. We strongly encourage authors for whom English is a second language to seek help from professional editing services before submitting their manuscripts, which will greatly increase chances of acceptance. For useful resources and information, please see <<http://www.sagepub.com/journalgateway/engLang.htm>>.

## ABSTRACTS AND BIOGRAPHICAL SKETCHES

An abstract not to exceed 150 words and biographical sketches not to exceed 50 words for each author should be provided.

## RUNNING HEAD

Submit a short running title of no more than 55 characters, including spaces.

## HEADINGS

First level headings should be bold and aligned left. Second-level headings should be italicized and aligned left. Third-level headings should be italicized and indented:

**FIRST-LEVEL HEADING***SECOND-LEVEL HEADING**THIRD-LEVEL HEADING*

## REFERENCE LIST

The reference list should be formatted according to American Psychological Association (APA) and JDI style guidelines. All references should be complete. JDI's style requires

including the names of all authors, full titles of periodicals and books, and volume and page numbers.

#### TABLES AND FIGURES

Tables should be prepared in Times New Roman 10 point type. Table notes should be prepared in Times New Roman 9 point type. A location in the text for each table and figure should be indicated (e.g., “Table 1 about here”), and tables should appear after the reference list.

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To facilitate anonymous review, only the title of the article should appear on the front page. Names, affiliations, complete mailing addresses, e-mail addresses, phone numbers, and fax numbers of all authors should be included on a separate cover page. Authors should keep a copy of their manuscripts.

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## Appendix D

## Participant Recruitment Flyer



# What has been YOUR experience?

Research on service  
provision in the AOD field

This research project is being conducted by Edith Cowan University. It aims to explore the concept of stigma as it relates to AOD service providers professionally and personally.

If you are interested in participating or require any further information, please contact Kim to arrange an interview.

[kime@our.ecu.edu.au](mailto:kime@our.ecu.edu.au)

040 318 3228



## Appendix E

**Participant Information Letter****INFORMATION LETTER TO PARTICIPANTS****Stigma in the Alcohol and Other Drug Field**

My name is Kim Eaton and I am a Psychology Honours student at Edith Cowan University (ECU), Perth WA. I am inviting you to take part in the research project I am conducting as part of the requirements of my Honours degree. This research project has ethics approval from the ECU Ethics Committee.

This project aims to investigate the concept and role of stigma as it relates to Alcohol and Other Drug (AOD) service providers in both a personal and professional sense. If you choose to take part in the project you will be asked to participate in an interview of approximately one hour duration. You may also be asked to assist with follow up questions during a second contact.

The interviews will be audio recorded. All information collected during the research project will be treated confidentially and will be coded so that you and your organisation remain anonymous. All de-identified data collected will be stored securely on ECU premises after the project has concluded. The information will be presented in a written report in which your identity will not be revealed. You may be sent a summary of the final report on request.

I do not anticipate any risks associated with participating in this research project, however I do understand that some issues raised may be sensitive in nature and as such I have provided contact details should you wish to seek assistance with any discomfort you may feel as a result of this study (*Lifeline, 13 11 14; Crisis Care 13 16 11*).

Participation in this project is voluntary and you are free to withdraw at any time and there will be no penalty for doing so. If you would like to take part in the project, please contact me at **kime@our.ecu.edu.au (040 318 3228)**.

If you have any questions about the research project or require further information you may contact me directly or alternatively my supervisor, **Dr Greg Dear (08 6304 5834, g.dear@ecu.edu.au)**.

If you have any concerns or complaints and wish to contact an independent person about this research project, you may contact **Associate Professor Andrew Guilfoyle (08 6304 5192, a.guilfoyle@ecu.edu.au)**, School of Psychology and Social Science.

Thank you for your time,

Yours sincerely,

Kim Eaton  
Honours in Psychology  
Edith Cowan University

## Appendix F

**Participant Consent Form****CONSENT FORM****Stigma in the Alcohol and Other Drug Field**

- I have been provided with a letter explaining the research project and I understand the letter.
- I have been given the opportunity to ask questions and all my questions have been answered satisfactorily.
- I am aware that I can contact Dr Greg Dear or Associate Professor Andrew Guilfoyle if I have any further queries, concerns or complaints.
- I have been given their contact details in the information letter.
- I understand that participating in this project will involve an interview of approximately one hour.
- I consent to having my voice recorded during the interview.
- I understand that the researcher will be able to identify me but that all the information I give will be coded and kept confidential.
- I am aware that the information collected during this research will be stored in a locked cabinet at ECU after the completion of the project.
- I understand that I will not be identified in any report, thesis or presentation of the result of this research.
- I understand that I can withdraw from the research at any time without penalty.
- I agree to further contact should the researcher require clarification of any aspects I raise.

I freely agree to participate in this project:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix G

### Interview Protocol

The interview is to be administered in a semi structured, open ended format, permitting use of prompts. Interviews are to be conducted one to one. Initial introductions to the broad area of research are to be made, no definition of ‘stigma’ to be provided, moving into the first domain and content question. Participant to be permitted to digress into related topics they feel are salient to the richness of the interview. Closed questions may be used for more concrete answers and to manage overly divergent discussion. Interviews are to be closed by asking participant if there is anything further they would like to add. Participants are to be thanked for their time and debriefed regarding counselling and support services.

The following form the key research domains and broad opening questions that are intended to commence discussion in the area:

#### **Domain A: Conceptualisation of stigma**

What does the term stigma mean to you?

What are your thoughts on stigma in the AOD field?

Could you describe how you feel other people see your role in the AOD field?

#### **Domain B: Experiences of stigma (Direct/Indirect, Short Term/Long Term)**

Have you ever experience stigma whilst working in the AOD field?

Could you describe that experience for me? How did that experience make you feel? Why do you think that happened?

#### **Domain C: Impacts of stigma**

*Using specific examples of stigma described by the participant*

What impacts has this experience had on you professionally/personally?

Do you think that people treat you differently because you work in the AOD field? If yes, how so?

What do you think is going on when that happens?

**Should the participant report NO STIGMA – question why this is**

## Appendix H

**Excerpts from Researcher's Journal Notes****Interview with Participant 1**

This participant was an AOD specific nurse. Much of the conversation was around training to become a nurse and the minimal role that AOD related education played in that training. The participant seemed to think that it was failing in the training that was the problem. Throughout this interview I kept getting the feeling that the participant was not telling me everything, or that there was something they wanted to say but felt it was not appropriate. When she steered the conversation away from talking about specific agencies I had the feeling that she had a bad experience with a particular agency or group of agencies that involved stigma and her directly. However, I was unable to pursue this with her. The participant at one stage went into what I feel was an irrelevant conversation about training nurses to give injections. At that time I thought the participant was overly focused on nursing and not on AOD, so I did not pursue that line of thought and took her back to a previous point. This participant has recently left her job after her contract expired with her provider. She has found it difficult to find work again, which is surprising to me because much of the literature suggests vacant positions are hard to fill because there is a shortage of workers. This might be given the specific nature of her work.

**Interview with Participant 2**

This participant phoned me and wanted to have his interview immediately. I was unsure of what his eagerness was about, and thought I would wait and see if that revealed itself in the interview. It did reveal itself. This participant revealed very early on in the interview a stigmatising experience that had originated from someone who works in upper management of the AOD field. This conversation I have had to speak with my supervisor about as I felt that the meanings behind it underpinned the whole interview. It will be difficult to discuss this conversation in the report without identifying the individual and will take some work to express the importance of this experience in a cautious way. This participant continues to be a substance user whilst in the employ of an AOD associated occupation. He identified that this resulted in multiple stigmatisations. I found his story about purchasing a part for the needle exchange van very interesting, because he suggests that he expects to experience stigma as a result of what he does, and that he was surprised when he did not experience it on this occasion. The participant also explained a very painful experience of feeling conflicted in providing help to a psychotic partner because when he called the police for assistance he was arrested for drug cultivation and possession. This was an outcome that he foresaw but in

order to help his partner he had to make a self-sacrifice. Once again, this is a story that would likely identify the participant and as a result will need a keen sense of confidentiality when in the write up stage.

**On later reflection:** This story may be more relevant as a discussion about user populations as I feel that the core theme around this story is regarding continued substance use and the effects this has on the family, relationships and its legal implications.

### **Interview with Participant 3**

This participant was a regional worker and originally expressed that stigma limited her socially. More specifically that her ability to go out socially was restricted because she might bump into clients or that others would judge her for having a drink. From this interview I drew the idea that AOD workers are meant to be abstinent as abstinence is what they are required to promote. This is interesting, because the literature suggests that it is this moralistic expectation of abstinence that drives stigma against the user. This participant also revealed that stigma can be alleviated by having a strong working relationship, good collegiality and good communication between agencies. Although I had originally thought I would like to conduct all my interviews face to face to garner the nuances of body language and such, I have taken three requests for interviews from regional workers. It is unlikely that I will be able to travel to the far reaches of the state, so telephone interviews will need to be conducted. This interview was a telephone interview and I felt that I was still able to understand the participant's point of view. There are perhaps very long pauses while I wait for the participant to finish and I think this might have made her reluctant to go on. I did not want to interrupt her too much, however I felt that she wanted more talking and direction from me. I will bear this in mind for future telephone interviews.

### **Interview with Participant 4**

This interview was a telephone interview with a regional participant who had moved to Australia from an overseas country where he had worked as a counsellor. His description of counsellors being known as 'head doctors' in his birth country was really interesting. The 'head doctor' is held in similarly high esteem to that of the 'body doctor', who we know as the GP. Throughout the interview he described not experiencing stigma as a result of his role. Which was interesting, and I wonder if any other participants will suggest the same. His reasons for feeling that stigma does not exist is that although he lives and works in a major country town, his clients come from very remote areas and he feels that the work that he and his colleague do is well regarded and much appreciated. His partner also works in mental health and he feels that there is support in the home, and understanding, which means

stigma is not perpetuated at home. He feels that close working relationships, and collegial support prevent stigma. This is the second participant to mention this and both were regional workers.

### **Interview with Participant 5**

This interview was a telephone interview with a participant that refused to meet in person. I became aware that this participant was extremely distracted throughout the interview. I wanted to question him about his distraction but thought it was inappropriate. He also 'Google' searched the term stigma because he was unhappy with not being provided a definition. The intention of not providing a definition is that I wanted participants to explore their understanding of stigma, particularly from how it sits in the raw with them, not how it sits in comparison to someone else's description. During this interview, the participant announced that he thought my study was not going to go anywhere and that I should be focussing on 'caring for carers', which he did not want to elaborate on. However, there was detail revealed about ignoring stigma because focussing on stigma was unproductive. And there was reiteration of this perception of the need for abstinence. The participant also revealed a story about helping a man with a more intense problem and that this story was the reason he worked in the field. He suggests that when people question him about why he does his job, he tells them this story. There was also some indication that AOD and mental health had made progress recently to taking better care of clients.

### **Interview with Participant 6**

This participant has an expansive working history in AOD, in other countries and throughout Australia. The interview was face to face. She began speaking before I had even commenced the formal introductions to the research or covered the participant information letter or consent form. Part of her original discussion was not recorded, however I returned to this conversation later in the interview. The context of this discussion was that stigma is systemic and can begin in the early stages of training if a student is not adequately exposed to patients who are mentally ill or have AOD histories. Particularly within nursing training. This participant was the first to reveal stigma as a result of a professional hierarchy where working with AOD clients was considered to be the lowest. This participant revealed a desire to work in the AOD field and felt some pressure from her contemporaries because of that choice. She also revealed that experience and faith in one's own professional ability acted as a protective factor against stigma. Inadequate training was also discussed by this participant in a similar fashion to that discussed by the first participant. Specifically that insufficient exposure to AOD during training contributed to stigma. Collegiality was also

mentioned in this interview. The participant also referred to 'knowing your place' which I took to mean that people just accept the stigma, even if they do not believe the stigma opinions are validated. This is because of the choice people make to work in the AOD field and that you take the stigma with the role because that is how it is. That is their place in the world. Which I find an incredibly sad but also strong thing to believe, because it means these workers have fortitude in their beliefs about working with AOD clients. There was also mention of Government mandating of the sector to change attitudes and beliefs. The mandating of training and services in Western Australia should reflect practices that are used in other parts of Australia and the United Kingdom which exclude stigma and promote proactive supports.

**Note:**

This participant made reference to a skit performed by John Cleese and the Two Ronnie's. This skit has three different people from three different eras explaining how they are different and superior to each other. The relevance of this skit is that people believe that they have places in society that they are born to and that social power depends on the level of status this position holds. This is reflective of social identity theory, which explains the process of social inclusion and exclusion based on social hierarchy. The participant made repeated references to 'hierarchy' within the AOD and mental health field and this was reminiscent of such references made by other participants.

**Interview with Participant 7**

This interview was also conducted with a regional participant over the telephone. This participant was insightful and articulate in his presentation of his thoughts. He appeared to have prepared for the interview and had a plan about what he wanted me to know. This was very surprising for me; however it made for a really easy and free flowing interview. I did not feel as though I had to actively draw information from him as I have felt in previous interviews. He covered many different aspects of stigma including hierarchy in services, job related stigma, stigma from other professionals, links to mental health, funding, waiting lists for services and location of services. Interestingly he raised the issue of strong collegiality acting as a buffer to stigma. He also raised the valuable point that stigma acts as a barrier to treatment, something that is strongly reiterated in the literature. He was the first participant to directly raise the idea of associative stigma, which I take to be the underlying factor of stigma related to the AOD sector for workers. This is my major idea relating to this project. The associative stigma experienced by workers is much the same as that experienced by users because it is an extension of the user stigma. This participant also mentioned not telling

people where he worked because of the response he gets. This is interesting because this is evidence of direct and overt stigma regarding the job role and the association with users.

**Note:**

It has started to become difficult to recruit participants. The original participant pool has been exhausted with all contacts and leads followed up from the preliminary participant drive. I updated the information flyer and contacted agencies directly via email and telephone call. I received two more participants from this process. I am starting to become worried about the lack of interest and this primarily because I do not feel as though thematic saturation has been reached yet. This lack of interest also raises questions for me regarding the reasons why this is occurring. Are there no participants because the request for participation is not being passed on? Is the collaborative agency not supporting the research? Are people too busy? Is there no stigma to be reported anyway? Are they reluctant or ashamed to talk to me, or not being permitted to do so? I raised these issues with my supervisor and we have put further plans into action to recruit more participants.

**Interview with Participant 8**

This participant was extremely supportive of the study. She went to a great effort to make me feel comfortable and welcome. This was a nice feeling as I have felt that for some participants the interview has been more of a chore than something they really wanted to do. This participant raised again the idea of associative stigma, and this was raised within the first few minutes of the interview, without questions or prompting. The notion of not telling people where you work was also raised. There seems to be an underlying factor of not wanting to have to get into a discussion about moral worth. This participant also discussed stigma relating to funding and that it was hard to gain funding from agencies that held stigmatising views of AOD users. The hierarchy of how clients view themselves compared to other users was raised; therefore there is the perpetuation of stigma even amongst clients. This participant suggested that reducing stigma should start with a focus on delivering appropriate educations about AOD in high school. A number of participants have mentioned education as being at fault in the manifestation of stigma and also the remedy for stigma. This participant spoke of the need for self-care to manage ongoing stigma.

**Notes from follow up contact:** This participant was recontacted regarding the need for self-care to manage ongoing stigma because of the adverse effects noted after the interview with participant 11. It appears that there is a real risk of experiencing stigma in the AOD field and this is likely to compound existing problems experienced by the worker. Self-care in the

form of removing oneself from the front line of service provision helps to manage the emotional strain of stigma.

### **Interview with Participant 9**

This participant was a young man, who works mainly with juveniles with AOD related issues, particularly those who are court mandated. His experience of stigma is interesting because his clients often do not make the choice to attend counselling, they are required to as part of their court mandate. The participant discussed how being mandated for counselling results in a negative conceptualisation that juveniles have of counselling. He also raised the notion that mandated clients often stigmatise the counsellor or his agency because the client sees the agency as being an extension of the criminal justice system.

This participant also had difficulty telling people where he worked or being able to discuss his work because people might think he was an ex-substance user or a know it all. He discussed stigma originating from ignorance about users or their experiences, which has been mentioned by other participants. The participant expressed strongly that stigma makes him more determined to do his job, because clients needed more help as a result. Stigma was viewed by this client as acting as a barrier to treatment provision and treatment seeking.

### **Interview with Participant 10**

This interview was conducted face to face. This participant was adamant about his need for confidentiality, where previous participants have not been as overly concerned. Although his concern was well warranted and part of my ethical obligations, his secrecy interested me. Partaking in this research was not under the approval of his workplace. This was not an issue that I was able to broach with him 'on the record'. However, this in itself is interesting because I asked myself why he would not be permitted to speak to me and given the generally low response rate from workers I wondered if stigma was seen as taboo or likely to incriminate workplaces or workers. This participant also seemed to answer my questions with stating his answers in question format. He was very direct in his response and I felt he had an agenda of what he wanted me to know, regardless of my questions. The participant mentioned similarly to others that he does not tell people where he works, that there is a hierarchy between user groups, and that when addressing stigmatising attitudes one must 'pick their battles'. Interestingly this participant revealed that stigma could not be entirely 'cured'. The recurrent theme that stigma makes the workers job harder was reiterated by this participant.

**Follow up note:** I have often felt that participants who have chosen to take part in the interview have done so because they have experienced a particularly severe or unique case of

stigma relating to their job role. When asked about their reason for participating that experience was often revealed and was very telling of inter-professional stigma. Because of this participants secrecy I believed quite strongly that he had a particular reason that he chose to be a participant when recontacted about this. He expressed however, that he likes to participate in research as he has previously conducted research himself and finds the process fascinating. Interestingly the participant responded that he only participated in my research as it was being conducted qualitatively and that this method was the only real way to explore stigma. I felt validated in my choice of methodology after speaking with this participant.

### **Interview with Participant 11**

This interview was a very short face to face interview, with an Indigenous AOD worker. It was very difficult to illicit responses from this participant and I was in danger of leading her with my questioning in order to open discussion. She revealed 'off the record' that she was feeling unwell, suffering emotional stress and burnout. She had been experiencing a great deal of job related stress and had to advocate on behalf of some very difficult and high need clients recently, which had worn her down. She had some negative experiences in the emergency departments of our major hospitals whereby clients were not provided immediate care. The reasons for this she implied were because of the view the nurses held of her clients. She also reported stigma towards her clients and herself from prison workers when she visited clients who were detained. The participant stated that she does not tell people where she works but provided no further explanation for why, other than the perception that this was just part of being an AOD worker. Interestingly the participant expressed that stigma was not just one thing, but constituted lots of little things. Furthermore she implied that the little things probably go unnoticed because they are exactly that, little things. However she seemed to experience a revelation when she stated that the little things are actually big things. I left this participant feeling immensely sad for her and her situation. I thought that for all the help and support that she obviously gives others she deserves some kindness in return and probably a break away from it all for a while.

## Appendix G

**Thematic Table (Thesis Report)**

Table 1

*Themes and Subthemes of the Experiences of Associative Stigma by Workers in the Alcohol and Other Drug Field*

| Theme                                   | Subtheme                         |
|---|----------------------------------|
| The Use of Language                     | No Subtheme                      |
| Public Perceptions (of AOD work)        | Dirty Work                       |
|   | Hierarchy                        |
|   | Stigma Anticipation              |
|   | Disclosing Occupational Identity |
| Role of Advocacy                        | Job Value                        |
|   | Dispelling Stigma Myths          |
| Driving Forces Behind Structural Stigma | Financial Constraint             |
|   | Service Philosophy               |
|   | The Expectance of Abstinence     |
|   | Stigma from Within the AOD Field |
| Breaking the Stigma Silence             | No Subtheme                      |