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Fostering Awareness, Inclusivity, and Self-Efficacy: Facing Social and Internalized Recovery Stigma

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Fostering Awareness, Inclusivity, and Self-Efficacy:
Facing Social and Internalized Recovery Stigma
by

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MSW Clinical Research Paper

Presented to the Faculty of the
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

A dynamic interplay takes place between social, public, and internalized addiction and recovery stigma. This systematic literature review sought to further understand the pervasive relationship between social stigma and internalized stigma around addiction, as well as clinical implications for alleviating the effects of shame and empowering those in recovery. A total of 14 studies were included in the final sample. The results of this review depict three main themes which explore the nature of social and internalized stigma as well as implications for responding to the effects of internalized stigma: Individual Identity Transformation, Group Belonging and Social Support, and Public Education and Awareness. Each theme identified within this review further delves into the interconnected nature of social and internalized stigma while also identifying pathways for fostering awareness, inclusivity, and self-efficacy. Furthermore, the results of this review indicate the need for an integrative and collaborative approach to understanding and addressing addiction and recovery stigma on a micro, mezzo, and macro level. This research proposes the effects of internalized stigma can be alleviated by raising awareness, building belonging and inclusivity, and fostering self-efficacy.

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Table of Contents

Substance use disorders can have a devastating effect on countless individuals, families, and communities across the nation, yet the impact of addiction does not have to be lifelong. In fact, recovery from substance use disorders and a shift toward holistic and healthy living is possible through timely interventions, access to necessary services, and a conducive environment to recovery and self-transformation (Columbia University, 2012). Today, an estimated 23 million individuals are experiencing recovery from a substance use disorder (Columbia University, 2012; Laudet, 2013). Despite addiction being a treatable disorder, roughly 90 percent of people living with a substance use disorder will not have access to care (Columbia University, 2012). Without access to care, individuals, families, and communities are impacted by the effects of addiction on numerous levels (Columbia University, 2012; Laudet, 2013). A wide variety of barriers have been found to hinder treatment accessibility and authenticity, yet research identifies stigma as one of the most prominent barriers to recovery (Janulis et al., 2013; McGinty et al., 2015). Social stigma around addiction has serious implications for accessing mental health services, fully engaging in treatment services, and maintaining long term, holistic recovery (Conner & Rosen, 2008; Dearing et al., 2008; Gray, 2010; Livingston & Boyd, 2010, Luoma et al., 2007; McGaffin et al., 2013).

Social stigma around addiction does not solely impact individuals who are actively struggling with a substance use disorder but also negatively impacts members of the recovery community. Internalized stigma can remain a serious indicator of individual wellbeing in recovery (Conner & Rosen, 2008; Corrigan et al., 2015; Luoma et al., 2008). According to Livingston and Boyd, "a higher level of internalized stigma is associated with lower levels of hope, empowerment, self-esteem, self-efficacy, quality of life, and social support" (p. 2157). Research asserts both individual and group interventions can be utilized to empower individuals

with self-stigma and enhance acceptance and resilience among individuals, who have experienced public stigma and discrimination (Corrigan et al., 2015; Crabtree et al., 2010; Kelly et al., 2014; Luoma et al., 2008; Woodward et al., 2014).

Due to the dynamic and deeply relational roots of social stigma, practitioners must be informed and intentional while working alongside clients with internalized stigma and shame. By further understanding where internalized stigma stems from, concrete efforts can be made to challenge social stigma, promote individual self-efficacy, and in turn enhance interpersonal recovery (Gray, 2010; Janulis et al., 2013; Livingston & Boyd, 2010). Issues relating to discrimination, interpersonal empowerment and self-efficacy, as well as internalized shame and inauthenticity are each critical components to understanding and responding to the internalization of addiction stigma throughout recovery (Barry et al., 2014; Dearing et al., 2005; Gray, 2010; Luoma et al., 2007).

A substantial amount of qualitative and quantitative research has been devoted to examining the overarching implications of social stigma on mental health; yet, fewer studies specifically focus on the internalization of social stigma on individuals who are in recovery from a substance use disorder (Barry et al., 2014; Conner & Rosen, 2008; Corrigan et al., 2009; Livingston & Boyd, 2010). For the purpose of clarity, the background section of this research paper will be devoted to explaining social stigma, the internalization of social stigma, and potential pathways for addressing the negative consequences of social stigma. Therefore, this systematic literature review will attempt to the explore the dynamic interplay between social stigma, public stigma, and internalized stigma, as well as clinical implications for empowerment and self-forgiveness among those in recovery.

Background

Substance Use Disorders as a Treatable Mental Health Diagnosis

According to the National Center on Addiction and Substance Abuse, roughly one in every seven individuals living within the United States has a substance use disorder; however, research estimates only 10 percent of these individuals receive treatment (2012). Due to the intimate, yet relational impact of a substance use disorder, mental health professionals must be intentional about the outreach, assessment, and intervention methods used when working with clients who may be directly or indirectly impacted by substance-related and addictive disorders (Barry et al., 2014; Conner & Rosen, 2008; Gray, 2010; McGinty et al., 2015; van Boekel et al., 2013). Substance-related and addictive symptoms and behaviors can be exhibited across numerous aspects of a person's life; in fact, a formal diagnosis of a substance use disorder takes into account the ways in which context and change vary from person to person (American Psychiatric Association, 2013; Columbia University, 2012). The DSM 5 affirms the complexity of substance-related disorders by presenting the following criteria:

A problematic pattern of […] use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. [Substance] is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control […] use.
3. A great deal of time is spent in activities necessary to obtain […] use […], or recover from its effects.
4. Craving, or a strong desire or urge to use [substance].
5. Recurrent [substance] use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued [substance] use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of [substance] use.
8. Recurrent [substance] use in situations in which it is physically hazardous.
9. Use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by [substance].
10. Tolerance, as defined by either of the following:

a. A need for markedly increased amounts of [substance] to achieve […] desired effect.
b. A markedly diminished effect with continued use of the same amount of [substance].
11. Withdrawal, as manifested by either of the following:
a. The characteristic withdrawal syndrome for [substance]
b. [Substance] is taken to relieve or avoid withdrawal symptoms.

As illustrated by the DSM 5, practitioners must be responsive to the multiple areas of a person's life which may be affected by a substance use disorder. Further, because substance use disorders can impact individuals, families, and communities on a variety of different levels, mental health professionals are responsible for attending to the unique factors and characteristics associated with substance-related disorders on an individual as well as collective basis (Conner & Rosen, 2008; Gray, 2010; Luoma et al., 2014; van Boekel et al., 2013). When left untreated, substance use disorders can create tremendous physical, psychological, occupational, social and interpersonal strain on an individual's life (American Psychiatric Association, 2013; Columbia University, 2012; Laudet, 2013).

Effective treatment methods are both person-centered and clinically-informed (Alvanzo et al., 2014; Gray, 2010; van Boekel et al., 2013). Alvanzo and colleagues affirm, "Research has demonstrated that specialty alcohol treatment, 12-Step facilitation, and non-specialty alcohol-related community services are all effective in achieving long-term abstinence or reductions in alcohol consumption" (2014, p. 48). Despite only 10 percent of individuals with a substance use disorder ever receiving treatment, an estimated 23 million people living within the United States report being in recovery from alcohol and other drugs (Laudet, 2013). Although recovery is not easily, nor commonly defined, the addiction and recovery field does agree recovery is a self-determined, ongoing process aimed to *maintain* a positive lifestyle transformation (American Psychiatric Association, 2013; McGaffin et al., 2013).

Understanding Social Stigma Around Substance Use Disorders

To begin, stigma is broadly defined as a social *mark* which symbolizes personal deviance, insufficiency or lack of value (as cited in Janulis et al., 2013; Livingston & Boyd, 2015). To develop an understanding of the pervasive nature of stigma around addiction and its effect on those with substance use disorders, it is useful to define three main concepts: social stigma, public stigma, internalized stigma. Social stigma can be further categorized into two main concepts: public and internalized stigma (Janulis et al., 2013). As discussed by Janulis and colleagues (2013), "Stigma is dependent on the relationship between the specific discrediting attribute and the specific social context; in other words, a stigmatized characteristic may not be discrediting in all situations, it is therefore a product of the social situation rather than any specific individual" (p.1065).

As a socially constructed occurrence, social stigma serves to justify overt and covert discrimination against a particular group of people (Barry et al., 2014). When analyzed as a social construct, stigma can be recognized as an intimate yet collectively dynamic process. While social stigma toward those who are actively using alcohol and other drugs, mirrors public stigma, social stigma can continue to affect individuals who are in recovery through both experienced and internalized stigma (Luoma, et al., 2008; McGinty et al., 2015; Woodward et al., 2014). When compared alongside physical disabilities and other forms of mental illness, substance-related disorders are socially stigmatized at a much more alarming degree (Corrigan et al., 2009; Lutman et al., 2015; McGinty et al., 2015; van Boekel et al., 2013). Past research has shown that social labeling significantly contributes to the stigmatization of and discrimination against people with substance-related disorders (Barry et al., 2014; Conner & Rosen, 2008; Corrigan et al., 2009; Gray, 2010; Janulis et al., 2013; McGinty et al., 2015).

In a study, conducted by Corrigan and colleagues, researchers sought to understand how social stigma towards persons with a mental illness, substance use disorder, or physical handicapped influence an individual's perception, bias, or discrimination toward a particular group of people (2009). Corrigan and colleagues conclude, "Americans hold significantly more negative attitudes toward persons with drug addiction than toward those with [other] mental illness" (2009, p. 1270). Although research does identify a collective trend that agrees substance use disorders are treatable, the general public tends to assign blame and criminality to those with active and recovered substance-related disorders (Corrigan et al., 2009; Lutman et al., 2015; McGinty et al., 2015).

Public Stigma

Due to the stigmatization and criminalization of people with substance use disorders, the general public is found to express a desire for social distance from those with active and recovered substance use disorders (Corrigan et al., 2009; McGinty et al., 2015). Apart from stigma contributing to the marginalization of people with a substance use disorder, social stigma also reinforces and solidifies negative public attitudes, perceptions, and behaviors through social messages and expectations for compliance (Barry et al., 2014; Janulis et al., 2013; Luoma et al., 2007; Lutman et al., 2015; McGinty et al., 2015; Van Vliet, 2008; van Boekel et al., 2013).

Public stigma does not impact all groups of people in the same way; however, the stigmatization of mental health disorders have been found to have serious ramifications for people across the country (Conner & Rosen, 2008; Corrigan et al., 2009; Gray, 2010; Livingston & Boyd, 2010; Luoma et al., 2014; Lutman et al., 2015). In fact, research has found that public stigma around addiction and recovery can have direct implications for the social, emotional, and occupational wellbeing of those with a substance use disorder (Columbia University, 2012;

Conner & Rosen, 2008; Livingston & Boyd, 2010; Luoma et al., 2007 van Boekel et al., 2013). When enacted, public stigma has been found to negatively impact treatment accessibility and outcomes, reinforce discriminatory housing and employment policies and practices, and create dissonance or marginalization among individuals with a substance use disorder (Bowen & Walton, 2015; Corrigan et al., 2009; Gray, 2010; Lutman et al., 2015 van Boekel et al., 2013).

Internalized Stigma

As discussed prior, social stigma can be found at two main levels: public and internalized (Corrigan et al., 2009; Janulis et al., 2013; Livingston & Boyd, 2010). Whereas public stigma around addiction involves commonly held negative attitudes, beliefs, and behaviors toward individuals with substance use disorders, internalized stigma involves an insidious attack on self through shame, self-devaluation, isolation, and stagnation (Livingston & Boyd, 2010; McGinty et al., 2015). Due to the relational nature of social stigma, public stigma can have serious psychological implications on an individual who has experienced or perceived stigma around addiction (Conner & Rosen, 2008; Corrigan et al., 2015; Crabtree et al., 2010). Shame and guilt have been seen as emotional responses to the internalization of social stigma (Dearing et al., 2015; Gray, 2010; McGaffin et al., 2013). Whereas stigma initially is enacted and perpetuated on a relational level, shame is personal in nature (Gray, 2010). As discussed by Gray, "shame tends to be described as a deeply personal and individual experience, the result of innate attributions (internal shame) and the internal processing of external and social cues (external shame). In contrast, stigma is characterized as being discredited by a social group" (2010, p. 687). When social stigma is internalized, shame can be exasperated, further hindering an individual's sense of self-concept and potential for recovery (Gray, 2010; Livingston & Boyd, 2010; McGaffin et al., 2013).

Shame and guilt as a response to internalized stigma. Furthermore, shame and guilt cannot be synonyms. Research indicates a distinct difference between shame and guilt (Dearing et al., 2015; McGaffin et al., 2013; Woodward et al., 2014). Historically, shame has taken on a significant role in maintaining social control and decreasing socially deviant behavior; however, recent research has found that shame may negatively reinforce a perpetual state of being (McGaffin et al., 2013; Van Vliet, 2008; Woodward et al., 2014). In a quantitative study conducted by McGaffin, Lyons, and Deane, data indicated guilt-proneness may enhance recovery outcomes while shame-proneness tends to promote stagnation in recovery from alcohol and other drugs (2013). Dearing and colleagues conducted a similar study which found, guilt-proneness could be seen as a protective factor when reviewing the course of substance use; whereas a positive correlation between shame-proneness and problematic substance use was identified (2005). Both studies speculated shame-proneness may be a maladaptive coping mechanism to the internalization of stigma (Dearing et al., 2005; McGaffin et al., 2013). When shame is distinguished from guilt, a more complex understanding of internalized stigma can be identified.

Because shame can be such a disinhibiting emotional response, the internalization of stigma can take on many characteristics (Dearing et al., 2005; Livingston & Boyd, 2010; Luoma et al., 2007; McGaffin et al., 2013; Van Vliet, 2008; Woodward et al., 2014). Research seems to agree that internalized stigma not only exasperates shame in general but internalized stigma also supports emotional as well as behavioral disturbances (McGaffin et al., 2013; Van Vliet, 2008). In fact, a variety of maladaptive emotional responses and coping mechanisms develop in response to internalized stigma; some of which include, inauthenticity, decreased self-esteem, lack of empathy toward self and others, avoidance, denial, self-isolation, and disruptive

emotional regulation such as internalized or externalized anger (Dearing et al., 2005; Gray, 2010; Livingston & Boyd, 2010; McGaffin et al., 2013). The internalization of addiction stigma is not only dependent on social context but is also intrinsically related to the extent in which a person identifies with a particular social stigma (Conner & Rosen, 2008; Corrigan et al., 2015; Gray, 2010; Livingston & Boyd, 2010).

Addressing Stigma: Collective Consciousness and Individual Transformation

To decrease the widespread impact of stigma around addiction, and stigma's disastrous effect on those with a substance use disorder, stigma must be addressed using a multifaceted approach (Barry et al., 2014; Corrigan et al., 2015; Janulis et al., 2013; Lutman et al., 2015). Researchers have identified a variety of potential pathways for addressing social stigma through both public and individual initiatives (Crabtree et al., 2010; Janulis et al., 2013; Luoma et al., 2008; Pescosolido et al., 2013). First, recent research asserts collective conscious raising and societal awareness of substance use disorders and recovery may help alleviate negative and hostile perceptions toward those with a substance use disorder (Barry et al., 2014; Conner & Rosen, 2008; McGinty et al., 2015). Next, the enhancement of prosocial behavior and group identification has been found to address stigma on a collective level while also reducing the impact of internalized stigma and shame (Corrigan et al., 2015; Crabtree et al., 2010; Woodward et al., 2014). Van Vliet discusses the importance of strengthening individual resilience to decrease shame through empowerment and acceptance (2008). Finally, research examines the extent in which self-forgiveness and self-compassion may promote a positive sense of self further decreasing the effects of internalized stigma (Kelly et al., 2014; Luoma et al., 2008; McGaffin et al., 2013).

Addressing Public Stigma

Public perceptions and attitudes toward addiction have a tremendous impact on the way social stigma is perpetuated (Barry et al., 2014; Conner & Rosen, 2008; Janulis et al,. 2013). Research has found that although the general public typically maintains a high desire for social distance from those with a substance use disorder, exposure and education can shift negative perceptions (McGinty et al., 2015). Because fear is so closely aligned with perceived dangerousness and a desire for social distance, portraying recovery in a positive light has been found to alleviate the influence of fear (McGinty et al., 2015). McGinty, Goldman, Pescosolido, and Barry suggest, "the type of material about mental illness and drug addiction presented to the American public – through the news media, popular media, and other sources – has important influence on public attitudes about these conditions" (2015, p. 79). Due to the significant role healthcare providers play in the treatment continuum, social stigma has been identified as a barrier to care; the language and labels healthcare providers use to explain patients with a substance use disorder not only reinforce bias but also serve to rationalize discriminatory practices (Gray, 2010; van Boekel et al., 2013). Furthermore, combating public stigma around addiction through education and positive media portrayal is speculated to support policy and program development around insurance parity, employment and education opportunity, as well as the social reintegration of individuals in recovery (Barry et al., 2014; Lutman et al., 2015; McGinty et al., 2015; Pescosolido et al., 2013; van Boekel et al., 2013).

Addressing Internalized Stigma

Through the reduction of self-isolation and the enhancement of adaptive coping mechanisms, the effects of internalized stigma can be mitigated through social connection, forgiveness, and change (Corrigan et al., 2015; Crabtree et al,. 2010; Kelly et al,. 2014; Luoma et

al., 2008; McGaffin et al., 2013; Van Vliet, 2008). Research seems to agree maladaptive emotional responses to internalized stigma can be addressed through group and individual interventions (Corrigan et al., 2015; Luoma et al., 2008; McGaffin et al., 2013; Woodward et al., 2014) Collective coping has been described as a group's ability to withstand the effects of public and internalized stigma through social belonging (Crabtree et al., 2010). Group identification serves to strengthen recovery and reduce internalized shame as it promotes an environment for authenticity, supportive attachment, other-oriented empathy, as well as reintegrative shame (Crabtree et al., 2010; Livingston et al., 2010; McGaffin et al., 2013; Van Vliet, 2008; Woodward et al., 2014). Just as shame-proneness differs from guilt-proneness, internalized shame also varies from reintegrative shame (McGaffin et al., 2013; Woodward et al., 2014). Reintegrative shame can be explained as one's ability to recover from destructive patterns of behavior through secure attachments and individual transformation (Woodward et al., 2014). In the same way internalized stigma must be addressed on a macro and mezzo level, individual efforts must also be made to increase self-forgiveness and self-efficacy (Dearing et al., 2005; McGaffin et al., 2013; Van Vliet, 2008). Therefore, this systematic literature review aims to further understand the pervasive relationship between social stigma and internalized stigma around addiction as well as clinical implications for alleviating the effects of shame and empowering those in recovery.

Data Collection Methods

To thoroughly understand the relationship between social and internalized stigma around addiction and recovery, it is useful to develop a review protocol to help guide the data collection process. In the same way, quantitative and qualitative interviews gather data from its' participants, systematic literature reviews complete an interview with literature (Bidwell, 2016).

This project plan is detailed as it provides an in-depth overview of inclusion criteria as well as the research strategy used for gathering data. By identifying key terms, research design, time frame, search engines, and any exclusion criteria prior to gathering literature, the data collection process can be both clear and specific.

Inclusion Criteria

As discussed, social stigma is both pervasive and relational. Because of the interconnected nature of social stigma and internalized stigma it was important to gather data relating to all three forms of addiction stigma (i.e. *social, public, internalized*). Research included in the systematic literature review must examine at least one of the following three topics: social addiction stigma, consequences of internalized stigma and shame, treatment and recovery from shame relating to addiction. Further, search terms included social stigma, public stigma, and internalized stigma to assess the steadfast nature of stigma as well as the manifestations of stigma on multiple levels (i.e. macro, mezzo, micro). To be included in the final literature review, research must have been conducted within the last 10 years, research must be peer reviewed, and research must have a section devoted to professional implications.

Search Strategy

This literature review utilized the following electronic databases: *Social Work Abstracts, SocIndex with Full Text, Criminal Justice Abstracts Full-text,* and *Summon.* Search terms such as *addiction, substance use disorder, chemical dependency,* and *substance abuse* was included to identify the broad language used when describing a substance use disorder. However, for the purpose of this systematic literature review, nicotine use disorder was excluded from the inclusion criteria as this substance use disorder holds a different degree of social stigma.

Similarly, compulsive addictive disorders as well as generalized mental health disorders were excluded from the final sample size as different mental health disorders often carry stigmas and stereotypes that are socially constructed. Next, to develop an understanding of the emotional implications of internalized stigma, *shame*, *guilt,* and *self-stigma* were incorporated terms. Finally, to assess individual recovery outcomes in relation to internalized stigma and self-efficacy, *treatment, therapy, group support,* and *recovery* were terms incorporated to best capture the range of recovery modalities. The key terms identified as inclusion criteria were chosen as they helped distinguish where internalized stigma comes from, the impact of internalized stigma, as well as implications for recovery. Below, figure 1 illustrates the search criteria used throughout the data collection process.

Databases	Inclusion Criteria	Exclusion Criteria	Search Terms
-Social Work Abstracts -SocIndex with Full Text -Criminal Justice Abstracts -Summon	-Published within 10 yrs -Peer Reviewed -Must have an abstract	-Nicotine Use Disorder -Sex addiction -International studies -Gambling Disorder -Generalized Mental Health Stigma	-Addiction(s) -Substance Abuse -Substance Use Disorder -Chemical Dependency -Stigma -Shame -Recovery -Guilt -Self Stigma -Therapy -Group Support -Treatment -Recovery

Figure 1

A total of six search combinations were used to identify the number or articles meeting basic search term criteria. Next, each article as screened by title to better assess its' relevance to the topic. After articles were screened by title, the researcher reviewed each article by abstract to further evaluate quality. Finally, articles compiled by abstract were read more thoroughly to be

included or excluded from the final research sample. Table 1 helps depict the process of including and excluding data, following the data collection criteria outlined above.

Table 1 - Search Strategy: Data Inclusion Process		
Search Term Combinations	Research Included By	Number of Articles
Six Searches	Search Terms	650 Articles
Six Searches	Title	55 Articles
Six Searches	Abstract	25 Articles
Six Searches	Content	14 Articles

Data Abstraction

The final sample size consisted of 14 articles which best met the criteria described above; this data was then analyzed using a pre-determined strategy. A data abstraction grid (see Appendix A) was utilized to abstract and organize data as it relates to the article's title and author, concern or topic of research, population or sample, key concepts and terms identified across literature, as well as findings and implications for the future.

Findings

A total of 14 studies met the selection criteria outlined in the methods section of this paper; after analyzing the content of these 14 studies, three distinct themes emerged. Within these main themes, several strategies for alleviating the effects of shame and empowering those in the recovery process have been identified as an integrative approach to addressing internalized stigma. The three main themes and nine subthemes identified below seem to best describe the dynamic nature of internalized stigma as well as an integrated approach for responding to social, public, and internalized stigma throughout the recovery process:

1. Individual Identity Transformation
   - Self-Forgiveness
   - Acceptance and Commitment
   - Empowerment: Identity Negotiation
2. Group Belonging and Social Support

- Group Belonging
- Support Systems
- Social Reintegration
3. Public Education and Awareness
    - Social Constructionism: Policy Reform
    - Portrayal: Language and Labels
    - Integrative Health Care Practices

Individual Identity Transformation

When left unaddressed, internalized addiction stigma can have serious ramifications for an individual's recovery. Internalized stigma has been correlated with an increase in isolation, avoidance, maladaptive coping, self-shame, negative identity distortions and a decrease in self-efficacy (del Pino et al., 2016; Gueta & Addad, 2013; Hernandez & Mendoza, 2011; Luoma et al., 2007; Luoma et al., 2008). Due to the direct and intimate nature of internalized addiction stigma, interventions for counteracting the effects of internalized stigma and promoting individual recovery must be tailored to the needs of those who have internalized social stigma (del Pino et al., 2016; Gueta & Addad, 2013; Hernandez & Mendoza, 2011; Heslin et al., 2012; Luoma et al., 2008). Several studies express the importance of undergoing a personal identity transformation to redefine negative self-perceptions in a way that promotes self-forgiveness, acceptance and commitment, self-efficacy, and resilience in recovery (del Pino et al., 2016; Gueta & Addad, 2013; Hernandez & Mendoza, 2011; Heslin et al., 2012; Luoma et al., 2008; Luoma et al., 2006; Woodward et al., 2014). According to Hernandez and Mendoza (2011),

> Shame resilience theory (SRT) proposes that a [person] who experiences shame can reduce the sense of feeling trapped, isolated, and powerless by implementing specific strategies and processes that increase awareness and understanding about shame and the sociocultural expectations that trigger it. (p. 375)

Gueta and Addad conducted a qualitative study involving women in various stages of recovery; the themes found within this study were similar to other findings as it suggests a crucial part of supporting long-term recovery is building resilience and allowing those in recovery to negotiate a *new identity* (2013). To address internalized stigma and shame in a way that enhances self-efficacy and resilience, those seeking recovery from a substance use disorder must be supported in the process of identity transformation (Gueta & Addad, 2013; Hernandez & Mendoza, 2011).

Self-forgiveness. When internalized, stigma can create a felt sense of shame, rejection, and self-hate (Gueta & Addad, 2013; Hernandez & Mendoza, 2011; Luoma et al., 2008; Woodward et al., 2014). Repeatedly, research affirms addressing the interpersonal effects of shame within treatment and support settings assists in the recovery process as it enhances self-awareness and empathy toward self and others (Chou et al., 2013; del Pino et al,. 2016; Gueta & Addad, 2013; Hernandez & Mendoza, 2011; Woodward et al., 2014). Self-forgiveness and self-love have been identified to counteract internalized stigma and shame in a way that supports recovery and wellbeing (del Pino et al., 2016; Gueta & Addad, 2013; Hernandez & Mendoza, 2011). Gueta and Addad explain, part of identity transformation for some means taking a stand against treating the body as a means for promoting punishment, and in turn, adopting a perspective of self-love (2013). As social stigma perpetuates shame and internalized stigma, self-acceptance and love toward oneself helps enhance overall wellbeing and recovery maintenance (del Pino et al., 2016; Gueta & Addad, 2013; Hernandez & Mendoza, 2011). Through specialized groups and interventions, an internal sense of self-acceptance and understanding can be cultivated (del Pino et al., 2016; Hernandez & Mendoza, 2011; Luoma et al., 2008; Woodward et al., 2014).

Acceptance and commitment. Avoidance, resistance, secrecy and decreased self-efficacy can take place in response to internalized stigma (Lloyd, 2013; Luoma et al., 2008; Luoma et al., 2014; Luoma et al., 2007). Due to the disinhibiting characteristics of internalized stigma and shame, individuals in recovery have been found to benefit from interventions that build self-efficacy and self-esteem (Luoma et al., 2008; Luoma et al., 2014). As identified by Luoma and colleagues, heightened internalized stigma may contribute to lower levels of self-efficacy and a lengthened treatment duration (2014). On the other hand, interventions and treatment modalities that strengthen acceptance and commitment to one's recovery has been found to reduce the harmful effects of internalized stigma and increase self-efficacy (Luoma et al., 2008; Luoma et al., 2014; Luoma et al., 2007). Luoma, Kohlenber, Hayes, Bunting, and Rye conducted a study in a residential treatment facility to assess the effectiveness of Acceptance and Commitment Therapy (ACT) for reducing self-stigma (2008). Luoma and colleagues affirm, " the target of the intervention was not the reduction of shame per se, but rather increasing participant's acceptance of the feeling of shame and mindfulness of stigmatizing thoughts and evaluations" (2008, p. 162). Acceptance and Commitment Therapy for self-stigma can enhance self-efficacy and self-esteem through cognitive diffusion techniques, mindfulness, and value exploration (Luoma et al., 2008). Interventions and groups that aim to enhance individual skill sets for tolerating public stigma and building upon internal resilience strengthen recovery outcomes by working to alleviate the effects of internalized stigma and shame (Lloyd, 2013; Luoma et al., 2008; Luoma et al., 2014).

Empowerment: Identity negotiation. A critical component to addressing internalized stigma is identity negotiation and transformation (Gueta & Addad, 2013; Hernandez & Mendoza, 2011; Heslin et al., 2012; Sanders, 2012). Just as internalized stigma decreases self-efficacy, the

internalization of social stigma can also negatively alter one's perception of self (Gueta & Addad, 2013; Sanders, 2012). As a social construct, stigma can take a serious toll on identity when it has been internalized; therefore, identity negotiation and construction becomes a part of building a recovery discourse (Gueta & Addad, 2013). As found in Gueta and Addad's research, a recovery discourse is seen as the transformative process which enables an individual in recovery to negotiate and voice their new-found identity as someone who is recovered from a substance use disorder (2013). From the perspective of building resilience through empowerment, identity negotiation can be viewed as a form of self-advocacy (Gueta & Addad, 2013; Hernandez & Mendoza, 2011). By counteracting stigmatizing distortions of self and negative shame self-talk through shame resilience strategies, those in recovery can practice reality-testing and self-expression skills (Hernandez & Mendoza, 2011; Sanders, 2012). Gueta and Addad found those in long-term recovery often adopted an integrated identity of "recovering addict" (2013). As speculated by Gueta and Addad, "The ability to simultaneously construct an identity endowed with agency and a victim identity indicates a unique combination of rejecting responsibility for past behavior but accepting responsibility for the present" (2013, p. 39). Empowering individuals to negotiate and voice a recovery identity may promote self-esteem in recovery through the rejection of social constructs and the acceptance and commitment to current action (Gueta & Addad, 2013; Luoma et al., 2007; Hernandez & Mendoza, 2011; Heslin et al., 2012; Sanders, 2012; Woodward et al., 2014).

Group Belonging and Social Support

As discussed before, stigma is a dynamic social construct; the internalization of addiction and recovery stigma does not take place outside the context of social and public stigma (Luoma et al., 2007). Just as internalized stigma and shame must be addressed on an individual level,

interpersonal insight and interventions must also occur to promote wellbeing in recovery from alcohol and other drugs (del Pino et al., 2016; Gunn & Canada, 2015; Hernandez & Mendoza, 2011; Heslin et al., 2012; Sanders, 2012; Woodward et al., 2014). Group identification, strengthened peer and family support systems, as well as social participation and reintegration have been found to nullify the effects of internalized stigma (Chou et al., 2013; del Pino et al., 2016; Gunn & Canada, 2015; Heslin et al., 2012; Lloyd, 2013; Sanders, 2012; Woodward et al., 2014). Unlike individualized interventions, interpersonal approaches must strive to promote social inclusivity and reintegration on a mezzo level through group awareness, exposure, and participation (Chou et al., 2013; Gunn & Canada, 2015; Heslin et al; 2012). Chou and colleagues explain, "social support mediates the negative impact of internalized stigma by facilitating the use of adaptive coping behaviors" (2013, p. 106). Furthermore, group identification and social inclusivity for those in recovery may mitigate marginalization, shame, and exclusion and in turn, promote holistic recovery (Chou et al., 2013; del Pino et al., 2016; Gueta & Addad, 2013; Gunn & Canada, 2015; Hernandez & Mendoza, 2011; Heslin et al., 2012; Sanders, 2012; Woodward et al., 2014).

Group belonging. Oftentimes members of stigmatized groups experience exclusion and marginalization from the larger community; individuals with substance use disorders as well as those in recovery often face public stigma and exclusion (Chou et al., 2013; Conner & Rosen, 2008; Gunn & Canada, 2015; Heslin et al., 2012; Lloyd, 2013; Luoma et al., 2008; Sanders, 2012; Woodward et al., 2014). Part of the reason social stigma can have such devastating effects on individuals is due to the isolating characteristics of public stigma and internalized stigma (Gunn & Canada, 2015; Heslin et al., 2013; Loyd, 2013). Through group identification and belonging, individuals experiencing public stigma from the larger community can establish a

sense of identity and belonging as part of the recovery community or mutual support groups (Chou et al, 2013; Gunn & Canada, 2015; Heslin et al., 2012; Sanders, 2012; Woodward et al., 2014). Unfortunately, social stigma has been found to play a role within mutual support groups; although peer support has identified as a protective factor to recovery, intragroup stigma continues to create division treatment and recovery settings (Conner & Rosen, 2008; Gunn & Canada, 2015; Heslin et al., 2012; Luoma et al, 2007). In a study conducted by Gunn and Canada, participants indicated the need to build upon commonality to support cohesion in the recovery process (2015). Research agrees group identification and belonging has been found to promote identity negotiation, accountability, commitment to action, and resistance to the internalization of stigma and shame (Gunn & Canada, 2015; Hernandez & Mendoza, 2011; Sanders, 2012; Woodward et al., 2014). Utilizing an online quantitative research survey, Chou and colleagues found, "for every unit of social support that increased, the reported level of internalized stigma decreased by .85 units, whereas reported adaptive coping behaviors increased by .31 units" (2013, p. 106). Interventions and curriculums that have a group focus simultaneously build individual and group resilience through increasing peer support and self-efficacy (Hernandez & Mendoza, 2011; Luoma et al,. 2008; Luoma et al., 2007; Sanders, 2012).

Support systems. Aside from strengthening support within treatment and recovery settings, peer and family support has been identified as another protective factor in recovery maintenance (de Pino et al., 2016; Heslin et al., 2012). As members of a marginalized group, individuals in recovery may continue experiencing discrimination, exclusion, and rejection in multiple arenas of life (Chou et al., 2013; Guetta & Addad, 2013; Heslin et al., 2012; Kelly & Westerhoff, 2010; Lloyd, 2012). From substandard health care and exclusion from the community, to employment and housing discrimination, enacted stigma can have serious

personal ramifications (del Pino et al., 2016; Heslin et al., 2012; Lloyd, 2012; Luoma et al., 2014). Luoma and colleagues (2014) aimed to understand the extent in which enacted stigma influenced individual participants in outpatient and inpatient treatment facilities. The study found enacted stigma was moderately to significantly correlated with perceived stigma related rejection; roughly 60 percent of participants indicated stigma at an above average level (Luoma et al., 2014). del Pino and colleagues studied the correlation between enacted stigma by family members and recovery outcomes among gay men; the internalization of stigma relating to sexual orientation and recovery from a substance use disorder was seen as a dynamic interaction which hindered recovery and perpetuated isolation and self-shame (2016). This concept can be explained by incorporating a statement from one of del Pino and colleague's participants, *"I think our relationships with our family, they're very important…. A lot of time when we feel isolated or we feel shunned, that contributes to our alcoholism and the drug abuse"* (2016, p. 12). By recognizing the need for external support and strengthening external support systems (i.e. family, friends, employers, neighbors) individuals in recovery exhibit increased self-expression, self-efficacy, and self-esteem (del Pino et al., 2016; Hernandez & Mendoza, 2011; Heslin et al., 2011; Woodward et al., 2014).

Social reintegration. Research seems to assert that social reintegration is a pivotal component to alleviating the internalized effects of stigma and shame (Heslin et al., 2012; Lloyd, 2013; Woodward et al., 2014). Because social stigma enforces a divide between the stigmatized and the collective public, social reintegration creates a bridge for members of stigmatized people groups to reintegrate back into society (Heslin et al., 2012; Lloyd, 2013). Individuals in recovery from substance use disorders can find themselves cut off from the larger community; social reintegration calls for those in the recovery community and those in the general public to take

steps toward inclusivity and participation (Heslin et al., 2012; Lloyd, 2013; Woodward et al., 2014). In a study conducted by Heslin and colleagues, 10 focus groups were created which included 68 residents or operators from local sober living houses (2012). Heslin and colleagues identified *community inclusion and stigma reduction* was one of the main themes present for residents and operators of sober living houses; residents and operators discussed the need for creating positive relationships with neighbors, businesses, and community officials (2012). Sober living houses were found to continuously invest in the community in order to enhance the public's perception of those living and working in recovery communities; this ongoing process seemed to serve as a bridge for those in recovery to reintegrate into the community while maintaining positive group identification with those in sober living houses (2012). Inclusion and participation are characteristics of social reintegration (Heslin et al., 2012; Lloyd, 2013). Acceptance and action must occur by individuals in recovery as well as members of the community in order to promote community inclusivity and reduce public stigma (Heslin et al., 2012; Lloyd, 2013; Luoma et al., 2008; Woodward et al., 2014).

Public Education and Awareness

Finally, addressing the internalization of addiction stigma demands simultaneous micro, mezzo, and macro level attention (Conner & Rosen, 2008; Heslin et al., 2011; Kelly & Westerhoff, 2010; Lloyd, 2012; Luoma et al., 2007). While enhancing individual and collective coping skills and strategies are useful for alleviating the personal effects of internalized addiction or recovery stigma, awareness, education, exposure, as well as program and policy reform are crucial components of addressing the social and public stigma that is internalized (Chou et al., 2013; Conner & Rosen, 2008; Heslin et al., 2012; Kelly & Westerhoff, 2010; Lloyd, 2012; Luoma et al., 2007). Heslin and colleagues further depict the need for integrative reform by

writing, " indeed, efforts to educate others about [substance use disorders and recovery] have been conceptualized largely as personal coping strategies rather than constructive action aimed at broader social change" (2012, p. 392). Research asserts addiction and recovery stigma must undergo a form of social reconstruction to address the internalization of addiction and recovery stigma (Heslin et al., 2012; Kelly & Westerhoff, 2010; Lloyd, 2012). Through policy reform, a human-centered portrayal of substance use disorders and recovery, as well as a shift toward integrative health care practices, individuals in recovery can be better supported as they seek mental health care services, negotiate a recovery-identity, and establish a sense of community or belonging (Conner & Rosen, 2008; Gueta & Addad, 2010; Heslin et al., 2012; Kelly & Westerhoff, 2010; Lloyd, 2012).

Social constructionism: Policy reform. As a socially constructed phenomenon, social stigma must be addressed on a macro level to truly alleviate the internalization of addiction and recovery stigma (Conner & Rosen, 2008; Heslin et al., 2012; Kelly & Westerhoff, 2010; Lloyd, 2013; Luoma et al., 2007). Policy reform allows for the reconstruction of the way substance use disorders and recovery is perceived and responded to on a large-scale level (Kelly & Westerhoff, 2010; Lloyd, 2013; Luoma et al., 2007). In fact, policies ultimately dictate the general public's perception of those in recovery as it implies deservingness and undeservingness of services and blame (Kelly & Westerhoff, 2010; Lloyd, 2013). In turn, through intentional policy reform, social constructionism around recovery can take root which may promote access to care, enhance group belonging, and reduce public and internalized stigma (Heslin et al., 2012; Kelly & Westerhoff, 2010; Lloyd, 2013; Luoma et al., 2007). In a systematic literature review conducted by Lloyd, protest and advocacy were identified as mediums for promoting awareness, increasing exposure and contact of those in recovery, and implementing strategies for supporting recovery

and reintegration (2013). Whereas social reintegration and group belonging falls primarily on the shoulders of those in recovery, social reconstructionism and policy reform recognizes the need for collaborative efforts to promote awareness, inclusivity, and reform (Heslin et al., 2012; Kelly & Westerhoff, 2010; Lloyd, 2013).

  Portrayal: Language and labels. Portrayal is a powerful tool for maintaining and perpetuating social stigma; through stigmatizing or criminalizing language and labels, individuals with substance use disorders as well as those in recovery can be portrayed as dangerous or undeserving and face marginalization from the larger society (Conner & Rosen, 2008; Gueta & Addad, 2013; Gunn & Canada, 2015; Heslin et al., 2012; Kelly & Westerhoff, 2010). Lloyd depicts, "Two central issues that have been identified in the general stigma literature and which seem particularly relevant […] danger and blame. The greater the extent to which [individuals] are seen as dangerous and to blame for their situation, the greater will be their stigmatization" (2013, p. 93). Kelly and Westerhoff aimed to understand the way language and labels used to describe individuals with a substance use disorder may influence beliefs about *behavioral self-regulation, social threat, and treatment vs. punishment* (2010). Similar to other research, Kelly and Westerhoff found language does have a tremendous influence on the way individuals with substance use disorders are portrayed and perceived by the larger public, health care providers, mental health care providers, as well as those in recovery (2010). As explained by Kelly and Westerhoff, "One simple and inexpensive way to achieve this might be to refer instead to affected individuals as having a substance use disorder, as is done with eating disorders, or as individuals with a substance-related problem or condition" (2010, p. 205). By adopting more person-centered language and putting an end to labels that classify a person (ie. Substance-

abuser), blame and undeservingnesss of support can be replaced with awareness, understanding, and access to care (Gueta & Addad, 2013; Kelly & Westerhoff, 2010).

Integrative healthcare practices. Finally, substance use disorders and addiction recovery must become part of an integrative health care system (Hernandez & Mendoza, 2011; Kelly & Westerhoff, 2010; Lloyd, 2013; Luoma et al., 2014; Luoma et al., 2007). As a barrier to care, social stigma influences treatment accessibility, mental health and health care bias and insight, as well as quality of care and treatment outcomes (Chou et al., 2013; Conner & Rosen, 2008; Kelly & Westerhoff, 2010; Lloyd, 2013; Luoma et al., 2014). One particular finding which asserts the need for an integrative healthcare system was the lack of awareness and increased bias toward patients with substance use disorders among mental health and health care providers (Conner & Rosen, 2008; Kelly & Westerhoff, 2010; Lloyd, 2013; Luoma et al., 2007). Disheartenly, mental healthcare providers are not exempt from stigmatizing perceptions and practices; because of the lack of specialization and awareness of substance use disorders as a mental health diagnosis, the mental health care system often reinforces social stigma toward those with a substance use disorder (Kelly & Westerhoff, 2010; Lloyd, 2013; Luoma et al., 2007). Treatment was also found to routinely contribute to the felt stigma of those seeking mental health services for a substance use disorder (Lloyd, 2013). While it is important to make the distinction that not all providers hold stigmatizing attitudes toward patients with a substance use disorder, moving toward an integrative health care system enhances education around treatment and recovery, promotes treatment accessibility, and bridges the gap between inpatient and long-term care and recovery (Chou et al., 2013; Conner & Rosen, 2008; Hernandez & Mendoza, 2011; Kelly & Westerhoff, 2010; Lloyd, 2013). As concluded by Kelly and Westerhoff, "the less stigma that affected individuals perceive, the more likely they will be to

seek help and to seek it earlier. In turn, this is likely to diminish the prodigious personal and social harms" (2010, p. 206).

Discussion

This systematic literature review aimed to further understand the pervasive relationship between social stigma and internalized stigma around addiction as well as clinical implications for alleviating the effects of shame and empowering those in recovery. The 14 research studies meeting the inclusion criteria for this review support previous findings regarding the interconnected relationship of social stigma, public stigma, and internalized stigma around substance use disorders and recovery. Similarly, previous research regarding the topic of social stigma around addiction and recovery has also asserted the need for a multidimensional approach to addressing the internalization of addiction and recovery stigma. While previous research has focused more specifically on the need to dismantle social stigma as a whole, this review had the intention of exploring the interrelated nature between social stigma and internalized stigma as well as pathways for alleviating the internalization of stigma and shame. Overall, this research demonstrates the internalization of addiction and recovery stigma is complex and calls for a radical and integrative approach to promote self-efficacy, inclusivity, healing, and recovery.

This systematic review is compiled of 14 research articles that met the full inclusion criteria outlined in the methods section of this review. To focus more specifically on stigma regarding substance use disorders and recovery, the final sample was relatively small. Further, the 14 articles compiled were incorporated due to their ability to address the two main objectives of this research paper: (1) Explore the pervasive relationship between social stigma and internalized stigma (2) Examine implications for alleviating the effects of internalized stigma and empowering those in recovery from a substance use disorder. Overall, three distinct themes

seemed to surface: *Individual Identity Transformation*, *Group Belonging and Social Support*, *Public Education and Awareness*. Together, these three themes generated nine principles that seem to fuel a micro, mezzo, and macro level approach to address internalized, public, and social stigma addiction and recovery.

On a micro level, *Individual Identity Transformation* can be pursued through three objectives: (1) *Self Forgiveness* (2) *Acceptance and Commitment* (3) *Empowerment: Identity Negotiation.* Research suggests each of these objectives are useful in the process of healing shame, building resilience, and empowering individuals toward adopting a positive identity discourse. Next, research emphasizes the need for a mezzo level intervention aimed toward mitigating the interpersonal effects of internalized stigma. The second theme, *Group Belonging and Social Support* directs the following three goals aimed to enhance positive group identification and community inclusivity: (1) *Group Belonging* (2) *Support Systems* (3) *Social Reintegration.* Finally, several studies affirm the need for simultaneously addressing social stigma on a macro level. The third theme, *Public Education and Awareness* can be broken down into three distinct concepts: (1) *Social Constructionism: Policy Reform* (2) *Portrayal: Language and Labels* (3) *Integrative Health Care Practices.*

Theory and Thought

Aligned with the initial theory that public stigma influences the internalization of addiction and recovery stigma, all of the articles analyzed spoke to the triadic relationship between social, public, and internalized stigma. More noticeable, was the extent to which each study sought to better understand stigma as a whole and identify ways to alleviate or address the individual and collective effects of social stigma on different levels of intervention. The articles compiled throughout this review further illustrate the intimate, yet widespread, repercussions of

internalized stigma and shame which have been interpreted and experienced across research and practice. Sanders (2009) conducted a study regarding felt stigma among women in a mutual support group (Narcotics Anonymous); roughly two thirds of the 92 participants involved reported difficulty overcoming the internalization of social stigma around their personal addiction and recovery. More specifically, 60-75 percent of participants indicated enacted and felt stigma from family members, members of the community, media portrayal, and/or the general public has constituted significant challenges in the way they view themselves in regard to their substance use disorder and recovery (Sanders, 2009). Across the literature, researchers have captured the insidious nature of internalized addiction and recovery stigma, a nature that is deeply rooted in socially constructed expectations, beliefs, and practices.

Disheartenly, the consequences of internalized addiction stigma can be so immobilizing that individuals striving to recover from alcohol and other drugs find themselves taking on the stigma of their mental health disorder, further jeopardizing their sense of worth and future recovery. As summarized by Chou and colleagues (2013) when internalized, stigma has been found to drastically decrease self-efficacy and self-esteem (two characteristics that promote recovery), while increasing resistance to change, isolation, and shame. Repeatedly best practice corroborates internalized stigma and shame can be barriers to individual recovery and reintegration back into the community. Yet an array of research speaks to the usefulness of integrative advancement for promoting enhanced self-efficacy in recovery and strengthened collective efforts for inclusivity, belonging, and participation of individuals recovering from substance use disorders.

Strengths and Limitations: A Direction for Future Research

It is useful to consider the strengths and limitations of this current study in order to recognize unique characteristics of the data as well as areas for further expansion and consideration. One strength that can be identified in this study is the variety of research methods found within the collected articles. Quantitative, qualitative, and systematic literature reviews were incorporated in the final sample to depict different types of data; similarly, a broad inclusion in sample or population also offered diversity as it allowed for a greater analysis of individual experiences with addiction and recovery stigma. Bias is an inherent component of human nature and cannot be completely eradicated in exploratory research.

Despite the rigor of the method selected for identifying and analyzing research in a systematic and predetermined way, the researcher's preference toward theories embedded in social constructionism, social justice, symbolic interactionism, and conflict/contingency may have influenced the researcher's exploration and analysis of addiction and recovery stigma. Still, this data adds to recent findings as it further explores and examines the interconnected nature of social stigma and internalized stigma as well as implications for addressing internalized stigma and shame on multiple levels of practice. Furthermore, the findings in this study seem to offer consistency which is seen across the literature; this consistency may be an indicator of accuracy in data analysis.

With these findings in mind, future research should further explore the interpersonal nature of stigma among those in recovery and members of the general community and examine how awareness, exposure, and reintegration impact public and internalized attitudes toward individuals with a substance use disorders as well as those in recovery. Researchers must also be intentional about studying the way stigma around substance use disorders may differ or relate to other mental health diagnoses and the influence of practitioner bias on clients with comorbid

substance use disorders. Finally, more expansive research must be done around the effectiveness and implementation of stigma reduction strategies; a great debate still exists regarding the extent to which social stigma *can* be addressed as well as the most useful strategies for responding to the interconnected relationship between social, public, and internalized addiction and recovery stigma.

Implications for Social Work Practice and Policy

As previously mentioned, too often inaccurate or fear-based portrayals of individuals with substance use disorders are used to perpetuate the social and interpersonal stigmatization of those in recovery. Kelly and Westerhoff, along with other researchers have come to understand the way in which society depicts individuals with mental health disorders widely influences the healthcare they will receive as well as individual recovery outcomes (2010). Taking this thought a step further, researchers, health care providers, and policy makers have started to examine the way public policy and the healthcare system interact and ultimately some of the ways policy and practice helps and hinders individuals with substance use disorders and members of the recovery community. On November 17th, 2016, a new *Surgeon General's Report on Alcohol, Drugs, and Health* was released which indicated the United States continues to recognize and experience the dire need for the ongoing reconstruction of the way we view and respond to our fellow brothers and sisters with substance misuse, substance use disorders, as well as members of the recovering community (U.S. Department of Health and Human Services). With nearly 21 million individuals experiencing the direct effects of a substance use disorder, not to mention the countless families and communities facing the aftermath of untreated substance use disorders as well as victory in recovery, we as a people must strive to create and implement policies that promote individual recovery, collective inclusivity, and national reform.

This review proposes, social workers and policy makers alike must strive to implement an integrated healthcare system aimed to dismantle the dysfunctional relationship between social, public, and internalized addiction and recovery stigma. Interventions designed to enhance self-efficacy and decrease self-stigma, strengthen support-networks and group-belonging, and develop evidence-based and person-centered policy reform can strengthen recovery outcomes among individuals, groups, and communities (Heslin et al., 2012). As a nation, we cannot stay complacent with the current notion that individuals with substance use disorders and members of the recovery community are responsible for changing their immoral behavior. Rather, I suggest we shift our beliefs and behaviors away from a *them* problem toward an *us* opportunity. We must continue to construct an integrative and responsive healthcare system while undergoing major upheavals in the way we perceive and respond to individuals with substance misuse, substance use disorders, and members of the recovery community on an individual and collective level.

This study's findings offer an in-depth exploration of internalized addiction and recovery stigma as well as clinical implications for alleviating the effects of shame. Due to the dynamic relationship between social, public, and internalized stigma, it is crucial that practitioners and policy makers are mindful of the interplay between discrimination or disenfranchisement among individuals with substance use disorders as well as those in recovery. It is the responsibility of social workers and other health care providers to empower the marginalized while striving to promote social awareness, education, and change. The NASW Code of Ethics reminds social workers...

> *Relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore,*

> *maintain, and enhance the well-being of individuals, families, social groups,*
>
> *organizations, and communities* (2008).

The internalization of addiction and recovery stigma has tremendous implications for the overall well-being of our nation, communities, and households. Not only does social stigma around addiction create a substantial barrier to adequate healthcare but it also reinforces a divide between individuals with substance use disorders and the general public. Today, roughly 25 million adults are in remission and/or recovery from a past substance use disorder (as cited by U.S. Department of Health and Human Services, 2016). Social workers must empower individuals with internalized stigma and shame, restore ruptured relationships, and promote inclusivity, reintegration, and participation throughout and among members of the recovery community. By adopting an *us* frame of mind, we can transition away from stigma, blame, and shame, and toward awareness, compassion, and inclusivity.

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Appendix A

Pre-Determined Analysis of Previous Research Regarding Addiction and Recovery Stigma

Articles/ Authors	Topic Area	Population	Concepts And Key Terms	Areas Measured, Assessed	Findings	Implications
Social Support as a Mediator Between Internalized Stigma and Coping Behaviors of Individuals With Substance Abuse Issues. **Author: Chih-Chin Chou et al.**	Impact of internalized stigma on social support and coping Clinical Implications for supporting individuals with internalized stigma through recovery	Adults Online Recovery Support Group	Internalized Stigma = problematic coping Social Support = positive coping Adaptive and Maladaptive Coping	Demographics Internalized Stigma Scale Social Support Scale Coping Scale	-Moderate Internalized Stigma among participants -High Social Support Moderately high adaptive coping -Moderately low maladaptive coping -Greater internalized stigma = < social support, < positive coping mechanisms	-Assess for quality of support -Strengthen Support Systems to help alleviate internalized stigma and increase adaptive coping -Address professional bias to reduce societal stigma
"You're Nothing But a Junkie": Multiple Experiences of Stigma in an Aging Methadone Maintenance Population **Author: Conner & Rosen**	Multiple forms of stigma and personal experience	Older Adults Methadone Maint.	-Multiple Stigmas -Barriers to Care -Type of use or SUD	Themes Identified: Types of Stigma: 1.Drug Addiction – primary 2.Aging - secondary 3.Psychotropic Rx 4.Depression 5.M.M. 6.Poverty 7.Race 8.HIV Status	Stigma > fear of seeking treatment 23/24 participants experience stigma (each experiencing multiple stigmas) -Stigma > w/ certain drugs -Bias and lack of insight around MM/SUD/ Recovery in the health fields	Clinicians should: -Identify multiple stigmas within population -Address ct. experience w/ stigma enhance coping mechanisms -Enhance public awareness to decrease shame/blame Research -Multiple forms of stigma -Tx interventions
Stigma and Family Relationships of **Middle-aged Gay Men** **del Pino et al.**	Individual's experiences with ongoing and multiple forms of stigma; coping strategies in recovery	Gay Adult Men in Recovery	-Gay Men -Minority Stress -Aging -Family Support -Community identification	Demographic Questionnaire Themes: -Internalization of stigma -Changes in coping strategies	- SU was a way to alleviate guilt, shame, emotional pain relating to sexual orientation -Stigma around using identity -Internalized stigma = isolation, breaking	-Addressing the role of family attachment -"Family" Involvement in recovery -Individual and group level interventions

					-Ongoing stigma Theoretical Frameworks: -Minority Stress Theory	family ties, shame/guilt -Recovery offered the space to address negative emotions around sexual orientation and develop new coping mechanisms (rejection v. stigma)	-Increase resilience and coping strategies for each population
Moulding an emancipatory discourse: How mothers recovering from addiction build their own discourse. **Gueta & Addad**	The transformation of identity negotiation throughout the recovery process	Mothers in different stages of Recovery	-Stages in Recovery -Mothers -Therapeutic Community - Social Construction and expectation -Language, relationships, cultural attributes -Recovery Discourse -Shame, self-hate, guilt -Punishment to self-love -Connection, self-efficacy	-Recovering Addict Identity -Victim Identity -Monster Identity Narrating the past Identity Construction in Recovery	-Those in early stages of recovery align w/ social labels or constructs "monstrous mothers" -Those in long-term recovery developed a recovering-addict identify which counteracts social constructs -Development of self-respect and positive social connections -rejecting past responsibility for behavior and being accountable to present actions -deconstruction and reconstruction of self -Self Advocacy and Identity Construction -Social Stigma to enacted stigma to internalized stigma	-Social and public discourse as well as individual agency supports identity transformation -individuals must be supported emotionally and socially to create their own interpretation of self -The Recovery Discourse offers hope, and political resistance to social stigma -Identity construction can be a form of advocacy
Intra-group stigma: Examining peer relationships among women in recovery for addictions	Factors that may further marginalize women in recovery as well as clinical implications for treatment	Women Residential Treatment	-Peer Support -Intragroup stigma -Hierarchy of SU and SUD -socially constructed	Themes Identified: *-Promoting Drug Use Differences, Perceiving Stigma Hierarchies* and	-Intra-group stigma among those in treatment -Division between "Hard Drug" and "Soft Drug" SUDs -Positive recovery outcomes = peer	-Peer support groups must address intra-group stigma as a tool for recovery -Enhance empowerment and stigma management tools

Gunn & Canada	and social integration		stereotypes and expectations -Race -Motherhood	*Imposing Bad Mother Label*	support yet stigma is expressed toward peers -Constructivism Deservingness and undeservingness -Group identification, belonging or exclusion, isolation -Despite division women in tx affirmed the need for unity among the community	for individuals/groups -Tx centers must foster dialogue to address intragroup stigma and reduce marginalization -Intragroup stigma mirrors social stigma and must be examined and acted upon
Shame Resilience: A Strategy for Empowering Women in Treatment for Substance Abuse. **Hernandez & Mendoza**	Shame resilience theory as a way to empower women in Tx	Women Residential Treatment	-Shame - resilience, - empowerment- women, - psychoed -Emotional expression -Connection -"Connections Curriculum" -Social Expectations	-Acculturation Risk -Health -Depression -Internalized Shame -Perceived Stigma of Addiction -Test of Self Conscious Affect -Shame Proneness and Guilt Proneness -Shame Resilience Model	-After completion of intervention = higher levels of health, wellbeing. Decreased Depression and levels of internalized shame -Increased self-esteem, decreased negative self-talk (shame, blame) -Guilt separate from shame results -Increased ability to recognize shame and triggers -Increased emotional/experiential expression and positive connection	-Addressing shame in treatment allows room to develop skills for self-efficacy -Gender-responsive and early interventions to support care -Group work and psychoeducation to increase knowledge and commonality -Shame must be addressed across individual, familial, and sociocultural levels
From personal tragedy to personal challenge: responses to stigma among sober living home residents and operators. **Heslin et al.**	The influence of public stigma and acceptance on those living within SLH	Residents and Staff SLH	-Community -Identity -Social Support -Modified Labeling Theory -Intra-group stigma -Enacted/ Public Stigma	-Demography -Views about SLH and Recovery Outcomes -Advantages/ Disadvantages to SLH -Perceptions neighborhood Themes: -Enacted Stigma -Intragroup stigma	-Residents/operators encountered enacted stigma -Felt stigma (awareness of stereotypes) -High Internalized stigma (women and gay men) -Intragroup stigma and accountability (Severe MI)	-Stigma may be a form of social control yet it is damaging when internalized -SLH may help reintegrate those in recovery back into society (bridging the gap) -Recovery micro, mezzo, macro

				-Felt Stigma -Project Identity -Community Inclusion and Stigma Reduction	-Identity transformation among those in recovery -Residents connections w/ community helped reduce negative stereotypes -High community participation, inclusion to reduce public stigma/ desire for social distance	-Organization's responsibility to promote education, awareness and social belonging -Individual's task to recreate identity and have prosocial behaviors
Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms **Kelly and Westerhoff**	Social and individual implications of language around substance use disorders and its' relationship with stigma	Mental Health Care Providers	-Policy -Language -Labels -Access to care -MH Providers –Perception	-Social Survey (social support/ social threat) -Self Regulation Subscales: -Perpetrator/ punishment -Social Threat - Victim/ Treatment	-34% of MH Providers focus on SUD/Recovery -Label of "substance abuser" associated w/ choice and Perpetrator/ Punishment Scale -Moral versus medical solution may lie in language -Deserving vs Undeserving of support/ resource	-Language as a way to reduce stigma -Policy address stigma as a barrier to care (internal/ external) -Decrease perceived stigma to increase access to care (reducing social and personal costs of untreated SUD)
The stigmatization of problem drug users: A narrative literature review. **Lloyd**	Social stigma around addiction has a widespread effect on the livelihood of those with SUDs as well as the recovery process	Literature	-Policy -Public Stigma -Enacted "felt" stigma -Intragroup stigma -Discrimination -Shame -Acceptance -Language -Identity -Inclusion/ Isolation	Systematic Review Themes: -Public Stigma -Exposure/ felt stigma -Methadone Maint. -Criminalization/ identity -Intragroup stigma -"Lifetime" stigma and recovery	-Stigmatizing attitudes towards SUD = common among public & MHCP -Enacted/internalized stigma = significant impact on access to care -Public/ Prof stigma (bias, rejection, neg. Attitudes) -Stigma enacted, experienced, internalized	-Awareness (education, media, policy reform, exposure) -MHC and HC Education -Reduce public stigma to reintegrate (inclusion/ involvement) -Individual and group advocacy (social support) -Changes in Language -"Coming out" in Recovery

					(pharmacy, Tx) -Identity transformation in recovery -Stigma has a holistic effect on those with SUD/ Recovery (self-concept, emotional and social expression, discrimination)	
Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development, and pilot outcomes. **Luoma et al.**	The usefulness of ACT for addressing internalized stigma for those in Tx for a SUD	Adults Residential Treatment	-Internalized Stigma (self) -Shame -Mindfulness -Acceptance -Social Support -Avoidance -ACT Model -Residential	Standardized: -Demographics -Internalized Shame -Internalized Stigma -Acceptance and Action -Stigmatizing attitude believability -Overall MH -Quality of Life -Perceived social support -Self esteem -Perceived Stigma -Stigma related rejection -Believability for drug use -Working alliance -Self concealment - satisfaction	-Significant decrease in shame post intervention (internalized stigma) -Increase in overall MH -No change in perceived stigma -Increased Self-esteem, social support (peers)	-Directly targeting shame in Tx -Increase people's tolerance to shame/stigma through acceptance of feelings and responsive mindfulness -Reducing feelings of shame may not be useful in recovery -Defusion, mindfulness, commitment, value work -Enhancing recovery support system (peers, family, etc)
Stigma predicts residential treatment length for substance use disorder. **Luoma et al.**	Interplay between perceived and internalized stigma and Tx duration	Adults Res Tx	-Rejection -Social Support -Shame -Accessibility -Tx retention and duration – ACT Model -Residential	-Demographics -Overall MH -Social Support -Internalized Shame -Stigma related rejection -Self Stigma	-Significant correlation internalized shame and self-stigma - stigma variables accounted for 10.6% of the variance after controlling - higher self-stigma was found to predict a	-Address stigma and shame on a group and individual level -HC system responsibility to address social stigma -Enhancing self-efficacy

					-longer length of stay in the residential unit -higher self-stigma = lower self-efficacy -Report higher self-stigma, lower social support (does not = Tx duration) -Longer residential stay is not solely impacted by lack of social support	-Promoting group identification and inclusivity/ belonging -Supporting the recovery community outside of Tx -Invest in outpatient/ community interventions to reduce the need for Long-term inpatient care
An investigation of stigma in individuals receiving treatment for substance abuse **Luoma et al.**	Impact of stigma on those receiving services for SUD	Adults Res and OP Tx	-Residential -Outpatient -Coping -Enacted Stigma -Perceived Stigma -Self Stigma -Type of use	-Demographics -Quality of life -Overall MH -Perceived stigma -Secrecy Coping -Stigma related rejection -Internalized Shame -Acceptance/ Action	-Current tx system may further stigmatize those seeking services -Increase tx episodes = more stigma related rejection -Differences between IV and non-IV drug users' felt stigma -Maladaptive coping (secrecy) poor emotional, social, occupational functioning -Those w/ legal problems reported less internalized shame and stigma	-Attend to individual experience w/ stigma and shame -Analyze and refine organizational policies which may add to stigma w/in Tx -Reduce MHCP bias and stigmatizing practices -ACT Training for MHCP to reduce stigma toward ct -Increase adaptive coping skills -Address discriminatory practices through policy
Use of Mutual Support to Counteract the Effects of Socially Constructed Stigma: Gender and Drug Addiction.	Perceived stigma among women in recovery and strategies for overcoming stigma through mutual support groups	Women, NA	-Mutual Support Groups -Social Constructs/ expectations -Women, motherhood -Gender Specific Recovery	-Demographics Areas Assessed: -stigmata to overcome -multiple forms of stigma -Treatment by others	-2/3 participants reported difficulty in positive identity transformation -Sensed lack of understanding among public, community, media, loved ones	-Enhancing support, solidarity, inclusivity to enhance group identification -Support positive regard/ identity transformation of self

			-Labels -Types of Use -Multiple forms of stigma	-Others Understanding of SUD/ Recovery	-Experience multiple forms of stigma -Felt negative treatment from general public and family -Constructs/ standards may be reinforced within support groups	-Openness in mutual support groups to reduce shame/ intragroup stigma "telling all" -Addressing patriarchal confides of mutual support groups
Sanders						
Examining the Effects of Social Bonds and Shame on Drug Recovery within an On-Line Support Community. Woodward et al.	The effects of social bonds/ and shame on recovery from a SUD	Adults On-line Recovery Support Group	-Control, Reintegrative Shaming Theory -Shame -Attachment -In Recovery -In use -Belief -Commitment -Involvement	Identified Themes: -Attachment -Detachment -Commitment -Disinterest -Involvement –Disengagement -Belief -Reintegrative Shame -Disintegrative Shame	-Attachment as a positive component to recovery -Commitment and belief enhanced among those in recovery -Disintegrative shame among those still active in SUD -Development of positive coping and regulation among those in recovery -Rejection of labels, stigma among those in recovery	-Increase resilience and tolerance around stigma -Reduce isolation and increase inclusivity -Radical acceptance and commitment to change on one's behalf -Promoting self-forgiveness as a way to change -Understanding reintegrative shame or guilt as a way to create movement