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Relational stigma as a social determinant of health: *“I'm not what you ___see me as”*

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ABSTRACT

Aim: The aim of the paper is to understand how people who use drugs (PWUD) experience stigma. To examine this issue, this paper draws on Bourdieu's *logic of practice* to understand how social harm emerges relationally between people via ‘mechanisms of stigma’.

Methods: This paper draws on 24 qualitative semi-structured interviews with people who use drugs (heroin, crack/cocaine, amphetamine, ecstasy; 11 men/12 women/1 transgender) living in the northeast of England. Thematic analysis of data was undertaken and coded in Nvivo.

Findings: PWUD experienced stigmatisation relationally with family, employers, health workers, Criminal Justice System, and the public for reasons linked to (but not limited to) their drug use, social class position, and their appearance. Stigmatisation shaped how participants saw themselves as a person ‘lacking’ in a valued or worthy identity. Social relations had detrimental effects on mental and physical health, and how participants accessed health services.

Conclusions: Models of Social Determinants of Health (SDoH) currently focus almost entirely on a positivist, material ‘reality’ in which a person lives (housing, employment, food insecurity, healthcare, education, access to services), overlooking the ways in which social relations and a practical ‘mastery’ of social space contribute to health and inequalities. Furthermore, relational stigma shapes our experience of a healthy life; as such, stigma should be regarded as a SDoH as it contributes to a widening of health inequalities and unfairly impacts marginalised people in society.

1. Introduction

The World Health Organisation (WHO) states that the Social Determinants of Health (SDoH) are important factors that shape whether a person, community, or population are able to live in good health (World Health Organization, 2022). SDoH influence health in positive and negative ways through housing, employment, food, healthcare, education, work environment, access to services and not being discriminated against (Marmot, 2010; Wilkinson, 2009; World Health Organization, 2022). The WHO outline the importance of SDoH as they come to constrain, ‘ … the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life’ (World Health Organization, 2022).

Experiences of SDoH are unevenly distributed across the world, meaning that whilst some are able to accrue positive and cumulative effects resulting in greater life expectancy and longer time spent in good health, others experience co-occurring negative impacts of SDoH (Bambra, 2016; Bambra et al., 2021; Wilkinson, 2009). This is variously described as health inequality and inequity – the ‘unfair’ and ‘avoidable’ differences in health between and across populations (Bambra, 2016; Dorling, 2013; Marmot, 2010; Marmot, 2017; Wilkinson, 2009). There is very strong evidence that shows that SDoH lead to unequal and avoidable health outcomes (Bambra, 2018a; Bambra et al., 2021; Marmot, 2010; Wilkinson, 2009). This is exemplified by a social gradient in health whereby those who reside in the 10% most deprived areas in England have a shorter life expectancy (gap of 7 years for women, 9 years for men) than those who live in the 10% least deprived areas (Addison et al., 2022; Bambra, 2016).

Some subpopulations experience deeper health inequality and poorer health outcomes than others because of their marginalised and minoritised status; as such, this paper focuses on experiences of social and

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health inequality amongst people who use drugs (PWUD). Around 1.1 million people (16–59 years) have used a Class A drug (e.g. heroin, powder cocaine, ecstasy) in the UK in the year ending March 2020 (Office for National Statistics, 2020). Notably, ONS report a 22% reduction in Class A drug use in the year ending June 2022, compared to before and during the pandemic (Mar 2020), stating that: 'decreases in the use of Class A drugs may be the result of the coronavirus (COVID-19) pandemic and government restrictions on social contact' (ONS, 2022a); as such, because the effects of the pandemic are still ongoing ONS analysis is inconclusive. In the UK in 2021, there were 4859 deaths related to drug poisoning (3275 male, 1584 female), this is a 6.2% increase from 2020 – half of these were related to opiate usage (ONS, 2022b). Opiate usage is consistently reported as more prevalent in areas of multiple deprivation, with the northeast (NE) of England showing highest prevalence rates (HM Government, 2021). Further, the NE continues to have the highest rates of death related to drug misuse for the past 9 years, and it has some of the most deprived areas overall in the UK (ONS, 2022b; Ministry of Housing Communities and Local Government, 2019). Deaths at a younger age, and increased drug deaths, account for widening health inequalities in life expectancy in the NE (particularly 35–49 year olds men, and 45–49 year olds women) (Public Health, 2019). Furthermore, much research around the multiplicative effects of living in poverty show how stress can feel relentless and damages health (NHS Addictions, 2021; Marmot, 2017; Pemberton et al., 2016; Wilkinson, 2009). We focus on PWUD because they often have multiple complex needs, experience the relentless pressures of poverty, inhabit oppressed intersections of identity, and suffer widening health inequalities (Bambra, 2018b).

However, much research in the area of health inequalities and drug use has tended to be dominated by atheoretical public health perspectives and/or an individualised, biomedical and behaviour model of addiction, rather than a sociological framing, although some exceptions include: Measham et al., 2011, O'Gorman, 2016, Seddon, 2006, Seddon, 2008, Boshears et al., 2011, Maher, 1997, Maher, 2002, Harris and Rhodes, 2018. Furthermore, Scambler (2018a) argues that considerable focus in health inequalities research has been on the material realities of people both positively and negatively affected by SDoH. The dominance of positivist approaches to understanding health inequalities collapses ontology (what is real) into epistemology (what is known) through atheoretical empiricism (what is observable) (Scambler, 2018a). As Scambler states, this assumes a closed system in which causality can be identified and predicted and ignores the 'messiness' of reality.

This paper attempts to address this theoretical gap in health inequalities research by drawing on a social harm lens. Pemberton (2016) outlines social harm as the compromising of 'human flourishing', which can take form as: psychological/emotional, physical, sexual, and financial harms. This conceptual lens, anchored in Zemiology as a field of study, shares important overlaps with the health inequalities oeuvre. By adopting a social harm lens, it allows for a holistic understanding of health and social inequality amongst marginalised groups, extending our knowledge to include not only how social harms happen and why they happen, but also advances understandings of power and oppressive systems (see also Addison, 2023). This is important because, as Pemberton writes, 'Depending on the resources and social capital we are able to draw on, our ability to respond to specific social harms can differ significantly, which in turn means that harms can have contrasting impacts on a person's life chances' (2016: 3): this inequity is unfair and socially unjust.

To explore this further, we are interested in the relationality of health and how this is made worse through the 'messiness' of social interactions between PWUD, the wider public, and health providers. In particular, we are interested in how stigma is mobilised in social relations in certain spaces and around certain people, and how this *harms* the health of PWUD. Stigma has interested academics because of its conceptual power to understand permutations of social and health inequality amid a diversity of experiences at both an individual and population level (Goffman, 1990, Hatzenbuehler et al., 2013, Pemberton, 2016, Room, 2005, Scambler, 2018a, Tyler, 2013b).

Stigma has been conceptualised in various ways. The idea of 'intersectional stigma' has been developed and utilised by a range of scholars (Adley et al., 2022; Ghasemi et al., 2022; Turan et al., 2019) to mean the 'convergence of multiple stigmatised identities' (Turan et al., 2019: 1) and the impact this has on a person and a group. However, this conceptual tool is imprecise because it oscillates between stigma as an 'identity' that is inhabited and a 'practice' that impacts a person. Intersectionality, discussed in detail by Crenshaw (1989), is used as a lens to convey axes of oppression and privilege that are mapped onto, and arise out of, axes of identity that a person inhabits in a given society. The concept of 'intersectional stigma' then does not seem to work as it is intended because its utility depends on stigma being mapped onto intersecting identity characteristics - this over complicates understandings of stigma and identity and how they operate, whilst also making invisible the practice of *doing* stigma. For this reason, we do not use intersectional stigma in this paper. Elsewhere, Ghasemi et al. have conceptualised stigma as a phenomena that is internalised, anticipated, perceived, and experienced by people (2022). Stigma is also variously described as being generated at a micro/meso/macro level which adds to the complexity. For us, stigma has *meaning* and becomes apparent through its effect on and between people (Addison et, al. 2022). We frame stigma as a relational practice which generates social harm, particularly towards marginalised groups like PWUD who may inhabit axes of identity that are already oppressed. Scambler writes, 'attributes are neither creditable nor discreditable *in* themselves' (2018b: 767) but are inscribed with stigma relationally (Goffman, 1990). Aligning with Tyler and Scambler, we understand stigma as a praxis that functions within a symbolic system. Stigma is something which is *operationalised* between people via mechanisms that attach value (or not) to intersecting identity attributes and (so-called deviant) practices (Scambler, 2018a; Tyler, 2020) according to the prevailing dominant classificatory schema.

Stigma can be linked to negative health outcomes for those who are deemed most vulnerable and marginalised in society (e.g. sex workers, PWUD, immigrants, justice-involved). This link is particularly evident in relation to mental health, stress, high blood pressure, and increased cortisol levels (NHS Addictions Alliance, 2021; Thornicroft et al., 2022). Combined with other material determinants of health, stigma has a 'corrosive impact' on health outcomes and widens inequalities amongst marginalised communities (Hatzenbuehler et, al. 2013, 2017). Research shows that stigma negatively impacts help-seeking behaviours, reducing engagement with health care providers and services that are focused on harm reduction (NHS Addictions, 2021; Thornicroft, 2022). This is exacerbated by negative experiences and interactions on an inter-personal level with staff, where marginalised individuals (like PWUD) feel stigmatised and are sensitive to judgments (Chang et, al. 2016; Myers et al., 2016; Goodman et al., 2017).

Stigmatising judgements can be grounded in a dominant moralising and medicalised rhetoric that deems PWUD as individually responsible for their drug use and for changing their behaviours (Ezell et at. 2021; Myers et al., 2016). Navigating stigmatising interactions is not easy and requires an understanding of how to *be* in health settings. Chang et al. (2016) discuss how the role of cultural health capital as a means to mitigate the effects of stigma in interactions with health care providers is unevenly distributed amongst PWUD, and this is similarly echoed in Hatzenbhueler's et al.'s discussion of unequal access to health resources and treatment (2013). There is also limited research which examines resistance and resilience to the negative effects of stigma amongst PWUD (although exceptions include Fast et al., 2014; Wakeman, 2016).

Building on this wider body of work, we explore how stigma within social relations is harmful to health amongst PWUD. To do this, we will now outline our Bourdieusian theoretical framework which we use to understand how stigma is experienced by PWUD.

2. Theoretical framework

Using Bourdieusian insights we explore examples of stigma across this dataset and the 'messiness' of the 'real' in an open system (cf. Scambler, 2018a). We draw on Bourdieu's logic of practice to understand how social harm can emerge relationally between PWUD and others via generative mechanisms of stigma, and negatively harm health (Pemberton, 2016; Pemberton et al., 2017; Tyler, 2020). We outline some of the specific Bourdieusian theoretical concepts we draw upon below.

2.1. Relationality

Bourdieu provides a way of making sense of the world through a 'logic of practice' that takes into account how the social and the personal, the subjective and objective, are inter-related and reproduce power dynamics as *doxa* – unquestioned truths (Addison, 2016; Bourdieu, 1990). Health inequalities research has largely been concerned with what is observable and measurable, whereas social relations require a different way of thinking about the 'real'. Bourdieu frames social relations as governing social space as akin to an *invisible reality*: 'that cannot be shown but which organizes agents' practices and representations' (Bourdieu, 1998:10). These relations are structured through norms, rules, and conventions within a particular society and so are structuring of social interaction between people (Bourdieu, 1990, 2015) and are relevant for making sense of the everyday experiences of PWUD. As such, the way PWUD interact depends on how each individual is positioned in social space, as well as how interactions are governed in society (Bourdieu, 1990; Skeggs, 2011; Skeggs & Loveday, 2012; Tyler, 2020). This means that we act differently around certain kinds of people (e.g. PWUD, health providers, family, friends), and in certain spaces and places (e.g. health settings, school, work, home) depending on the logic of practice in play (i.e. principles guiding action) (Addison, 2016, 2017). This is important to explore because, as this paper will advance, social relations impact on a PWUD and their health.

Bourdieu uses game-playing as a metaphor to help explain how we are located and act in the world: he writes how we are all 'born into the game' that is already taking place. We learn how to act by acquiring knowledge of the 'rules of the game' (i.e. logic), and we use this knowledge to help navigate social interaction (Addison, 2016; Bourdieu, 1990). Social relations between PWUD and other individuals are structured via this logic – meaning that some people are positioned as inhabiting a valued and 'worthy' identity, compared to others positioned as 'lacking in value', stigmatised and inscribed as 'wasted humans'' (Tyler, 2013, 2020). The way we interact with each other generally serves to reproduce the dominant 'game' underway – we abide by the rules and norms governing how we should act with each other. However, social relations are profoundly unequal, shaped by structures of power that inscribe value, prestige and status (Addison, 2016; Lawler & Payne, 2018; Reynolds, 2021; Skeggs & Loveday, 2012). Unequal social relations can often be felt 'under the skin' (Kuhn, 1995) as painful or ugly feelings (Ngai, 2007), a sense of being 'out of place' (Bourdieu, 1990, 2015), or not belonging (Ahmed, 1998) and, we argue, this may come at a cost to health. What is more, Reynolds (2021) has shown how power relations and health resources interact to have negative impacts on population health; she writes 'power relations matter for life chances' (2021: 496). She notes how power distribution affects health inequalities through stratification, commodification, discrimination and devitalisation. Some people are more exposed to harm depending on whether they have access to health resources that are vital for life.

2.2. Playing the game: habitus, capital and field

To understand how advantage is accrued through 'playing the game' it is useful to briefly turn to Bourdieu's concept of *habitus* – an embodied history that shapes how a person might act, think and feel in certain spaces and around certain people in ways that are constrained by 'conditions of existence' (Bourdieu, 1990, p. 5).

> … habitus are also classificatory schemes, principles of classification, principles of vision and division, different tastes. They make distinctions between what is good and what is bad, between what is right and what is wrong, between what is distinguished and what is vulgar, and so forth, but the distinctions are not identical. Thus, for instance, the same behaviour or even the same good can appear distinguished to one person, pretentious to someone else, and cheap or showy to yet another. (Bourdieu, 1998: 8)

Bourdieu writes how *habitus* are 'generative principles of distinct and distinctive practices – what the worker eats, and especially the way he eats it' (1998: 8). What these practices mean is understood through an individual's grasp of social categories - the symbolic differences which constitute a logic to the game. An individual uses a practical logic, with no conscious intent, to navigate these conditions that they are born into to try and gain mastery of the game. When a person then reproduces schemes of perception, this *performative magic* ensures that these structures, which are always advantageous to some, continue to be remade over time (Addison, 2016).

From the outset, some individuals are already at an advantage because they embody intersections of identity that are imbued with privilege in the society that they live in (e.g. white skin, male, heterosexual). Others find themselves at a disadvantage because their embodied subjectivity is marked as distinct and read as value*less* in certain social spaces. This is important because the (re)production of distinction between ways of being and objects in the world generates symbolic value. Distinction making is undertaken between people and is a *relational property* considered as a 'socially pertinent difference' (Bourdieu, 1998:9); these differences are always perceived through the hegemonic classificatory schema dominant at the time. Distinction does not exist in and of itself – it is something to be done in *practice* between people. Therefore, the supposed value of material objects that come to signify value (socio-economic position for example) have meaning when understood as a matter of distinction which is always in the act of being reproduced between people drawing on an understanding of the logic of the game.

It is important to be mindful that *habitus* is a system of *principles,* not rules or laws, and this disposes a person to act in a certain way, in particular social spaces and people. However, there are times when a person may feel out of place and not know *how* to act (a fish out of water), or other times where a person's habitus does not align with the practical logic of a given field (social space) they have moved into (e.g. a health service setting). What occurs in these moments is a disruption that can often be painful (Addison, 2016) as a person either attempts to converge with the new logic of practice or maintains behaviours synonymous with their habitus and more familiar fields (home). Bourdieu conceptualizes this mismatch between habitus and field as hysteresis (see Hardy, 2008).

It is important to acknowledge that the 'game' is always shifting – the symbolic value of certain embodied capitals is 'characterized relationally' and always in negotiation depending on the logic of the game, a person's habitus, and historical location (Bourdieu, 1999: 5). Social relations between people generate symbolic value through distinction and the mobilisation of capital (economic, social and cultural) (Bourdieu, 2015). Distinction making constrains ways of being in the world and whether a person will accrue symbolic value or experience symbolic violence and social harm. Problems can arise out of an imbalance of power between different people in certain social spaces – those who do not, or cannot, follow legitimate ways of being in the world that are endorsed by dominant groups are exposed to *symbolic violence* through everyday acts of discrimination and stigmatisation. Symbolic violence is a form of weaponisation of socially situated meaning attached to embodied identity and practice which has the effect of a social sanction that is normalised and harmful.

Tyler and Scambler have both discussed the weaponisation of stigma against marginalised people as a way of securing power and privilege for more dominant groups (see also Reynolds, 2021). Stigma functions as symbolic violence through generative mechanisms that devalue aspects of class, gender and race, and fundamentally do harm to the individual. Scambler has written how the combination of stigma and deviant practices has a doubling down impact on the person rendering them 'unhuman' and abject: 'If collectivities can be successfully reconstructed as abject, after all, they can be ignored, sidelined, sanctioned and even punished' (Scambler, 2018b, p. 142). Tyler furthers this conceptualisation of stigma as a 'form of governance which legitimizes the reproduction and entrenchment of inequalities and injustices' (2013: 8), (see also Hatzenbuehler et al., 2013).

Going forward, understanding an 'invisible reality' (Bourdieu, 1998) in transition is ontologically and epistemologically challenging; it is reasonable to say that public health, and as Scambler observes - the dominance of epidemiology in this field, is uneasy with these ontological parameters. Public health generally favours a realist and causal approach to understanding the world as a 'closed system' (Marmot, 2017; Marmot, 2018; Scambler, 2018a; Wilkinson, 2009). More broadly, epidemiology is cautious of critical insights, 'which might seem abstract and obscure' to examine the '"choices" made by social agents in the most diverse domains of practice' (Bourdieu, 1998: 6). To begin to address this, we have outlined a Bourdieusian theoretical approach to explore a different ontological understanding of health inequalities and emerging social harms, and to set out a way to broaden the scope of SDoH. By thinking about the 'invisible reality' of social relations we explore if *how* we interact with each other can be harmful, impacting on health and wellbeing - particularly for those who are marginalised.

3. Research design

This study is qualitative in design and explores the everyday lived experiences of ordinary people who are marginalised (Allen, 2007; Back, 2007). We undertook semi-structured in-depth interviews with 24 people (12 men, 11 women, 1 transgender; aged between 20 and 50 years old; the majority of White British ethnicity). Fieldwork occurred before and during the global Covid-19 pandemic (2020–2021) meaning that a combination of face to face and online/telephone interviews were conducted to mitigate the risk of contagion.

Inclusion criteria focused on people who used heroin, crack or crack cocaine, Spice (Novel Psychoactive Substance), or Amphetamine as their primary drug of choice, although a range of frequency of drug use was acceptable (self-reported). A diverse set of identity characteristics were sought, although participants had to be 18 years+. Participants were recruited into the study using a combination of snowball and purposive sampling, and via social media, leaflets, posters, using a range of established contacts within voluntary and 3rd sector organisations who acted as gatekeepers and helped to establish contact with potential participants.

Participation in the study was voluntary and all interested persons were given the opportunity to read and keep an information leaflet about the study and ask questions. Participants were advised that all discussions would be anonymised and identifiers removed, and that taking part would be treated as confidential unless immediate harm to self or others was disclosed in the interview. Interviews were between approximately 30 min - 1 h, with some lasting over 2 h. Interviews were conducted at a safe and convenient time for the participant, and they were debriefed with information of how and where to access support from relevant services if required. All participants were provided with a £10 shopping voucher. The study received ethical approval from [Northumbria University] university ethics board - submission ref: 17,304.

Data was organised using Nvivo, and initial coding was undertaken to establish categories; these were then organised into themes and a Bourdieusian theoretical framework was overlayed to support interpretations of the data. This process was reflexive and iterative, and inferences were reviewed by the research team to strengthen credibility (Lester, Cho and Lochmillier, 2020; see also Addison, 2023).

4. Findings

This section is organised around the three key themes of: participants' perceived positionality in society, their perception of stigma as social harm and how this impacted their health and engagement with services.

4.1. *'Feeling looked down on' through social relations*

Several participants described feeling judged in interactions with other people because of aspects of their embodied identity and practices, and how this impacted the way that they felt about themselves.

> I always thought there was something wrong with me just culturally like you're looked down upon and seen as less than [Andy, 29]

Jack described how this made him feel excluded from wider society because his identity is marginalised by others:

> I'm locked out from society and they've made us like that, and them in power look down on people like me … The upper classes and middle classes and the working classes. Do you know what I mean? [Jack, 43]

A similar trope about social class is captured in conversation with Jasmine, who shows her awareness and fear of stigma that is attached to certain aspects of 'failed' identity (which is juxtaposed against 'success') – like being a single parent claiming welfare support. As a child in a single parent family growing up, Jasmine experienced directly the harm arising from stigmatisation and had intended to avoid this in her own life.

> I used to fear about being a single parent on benefits, because my mam was a single parent on benefits with two kids. I don't know, it was just built into my mind that I would be a bigger success. [Jasmine, 38]

Karla describes a sensitivity to being stigmatised by others in society and the impact this has on her mental health:

> Addict just addict, or alcoholic, or … yes, I think society is quick to label people. […] It just disheartens you. […] I think you internalise and beat yourself up about it. [Karla, 39]

Tony describes an awareness of how social relations are structured: he describes that how he looks and acts in certain places and around certain people impacts on how he is perceived, and the treatment he is likely to receive. He claims his position as 'common' and attempts to inscribe this with value despite knowing that he can be misrecognised by others:

> If I walk past someone in the street and they look at me, even if I look well and feel clean and well, they think bad about me, "Oh, he looks scruffy …" [Tony, 26]

Other participants, like Kev, note that how they are seen by others constrains their freedom to legitimately be in a place:

> Like people don't want you about, you walk in a shop they automatically think you're a shoplifter just because of the way you look or whatever. Yeah, there's definitely a fine line between what's acceptable in people's eyes and what's not. A lot's to do with your presentation I suppose. [Kev, 41]

Karla recognises the disparity in how she is treated by others when using drugs: despite a powerful desire to be treated equally she shares feelings of being positioned as 'less than' and 'frowned upon'.

> I think everybody should be tret [treated] the same. But because I have been tret 'less than' especially when I was using drugs, you're frowned upon; you're definitely not treated as equal when you're using. [Karla, 49]

Participants described feeling judged and excluded from society on the grounds of their appearance and drug using practices, but also in relation to their reliance on benefits. This highlights the signifiers that reinforce their marginalised identities.

4.2. Stigma as social harm

This section builds on the previous one by focusing on stigma as one particular aspect of society's treatment of PWUD. Participants experienced stigma for a number of reasons related to combined axes of their identity and drug using practices. Tony recognises how stigma has inscribed him with what Goffman referred to as a 'spoiled identity' (Goffman, 1990):

> … It's like you're tarnished with something [Tony, 26]

Hannah describes what it is like to be a pregnant woman who uses drugs:

> I just felt stigmatised that I was an addict and that I'd fallen pregnant do you know what I mean, I just feel like there's so much more on women […] men come and go, they're in prison, and it's not seen as a big difference, but then … you're sitting in them [social care] meetings […] and then to sit and have to read through what you've done and just feel like everybody … because they're haven't been through it so why would they understand? I don't know, I just … you just feel ashamed, that sort of, "Well how can you do that when you're pregnant?" "How can you do that?" [Hannah, 35]

Hannah conveys here how judgements over her drug taking practices are being reinforced in social care, multi-agency meetings because of the harm she may be causing to the baby. Because of her identity as a mother and a PWUD, she experiences a double burden of stigma that is distinctly gendered. Hannah did not receive any help with her situation but instead highlighted the shame that was invoked in these interactions by the male chair of proceedings. These feelings were not resolved for Hannah and she internalised this sense of stigma and shame for not embodying social expectations of 'motherhood'. This feeling of guilt and shame in parenting was shared by others:

> I was the most horrible, disgusting parent. Even though he was able to look after himself, but I wasn't there for him, do you know what I mean? [Nancy]

Nancy is visceral in her self-stigmatisation of parenting. She shares how she was unable to reconcile being the 'good' parent constructed by societal expectations with her drug practices that were highly stigmatised. Using drugs tarnished her identity as a mother and meant that she too experienced a distinctly gendered double burden of stigma.

Several participants, like Jack, shared the impact that stigma had on how they felt about themselves as valueless or worthless, or that they were denied subjectivity as a human being: 'They don't even look at me and class me as a human being' [Jack, 43]. He goes on to say:

> They always put us down, put us down and put us down and put us down. […] They say it to put you down, so you then … it ruins your day, or you get to feel shit about yourself or judged [Jack, 43]

Ultimately, this becomes a self-fulfilling and harmful cycle, as Jack and other participants attempt to cope with this constant erosion of their self-worth by perpetuating drug using behaviour. Furthermore, Sam describes how weary she feels being stigmatised for using drugs and the emotional harm this causes her:

> Because everybody judges, everybody judges, and I walk down the street the other night and a couple of lads called me a smack head because I didn't have a lighter on me to give them a light for a fag. […] So, like they call you that to put you down. So, when the more people do that, the more starts getting to me here. And the more you start thinking right, well *that's what I am.* [emphasis from participant - Sam, 36]

Being stigmatised through social relations also had violent consequences for some PWUD. Some participants discussed being attacked, intimidated, having things thrown at them and stolen from them because they were seen as 'less than' human. Kev shares how he was victim of a knife attack because of how he looked and his drug use:

> You get them people walking down the street shouting "Smack head", whatever else, you just put up with it don't you, it's one of them things. I mean you get … I've been stabbed in the neck, I've been jumped on by groups of lads just because I do what I do, not because I've done anything to them in particular but they just feel they're better. [Kev, 41]

Participants described feeling stigmatised around different aspects of their identities, and how this perpetuated their marginalised position in society. The following theme explores in more depth how that impacted on their health.

4.3. Stigma as social harm impacting on health

4.3.1. Mental & physical health

The deleterious effects of stigma as social harm on a person's mental and physical health were clear across the majority of interviews. The internalisation of stigma meant that people like Karla described how self-loathing impacted their lives:

> You self-loathe yourself and that's not a nice place to be for years and years. [Karla, 49]

Karla elaborates on how stigma impacts on people's psychological wellbeing:

> … It makes you mentally and emotionally and spiritually not well. It just deadens anything that's healthy really, any healthy thoughts, feeling anything, emotionally well about yourself and I think that's what it strips away from you. [Karla, 39]

Haven describes the force of responsibilising and individualising rhetorics around drug use. Blaming the individual for drug use and for occupying a 'devalued' identity status was normalised and this added to feelings of shame which were particularly harmful to a person's mental health and wellbeing.

> Shame is a huge driving force behind addiction. Guilt you can process, but shame is a lot deeper and it's about what you think of your value, and I think when you live in a system where some people are seen as having more value than others, that's going to feed into shame for anyone who's not at the top of the pile. [Haven, 30]

Jack shares how stigmatisation exacerbates his mental state to such a great extent that he uses drugs as a way of coping with the stressors he experiences and to manage feelings of suicidal ideation. His sense of exhaustion from navigating stigmatising social relations is palpable in this excerpt:

> I am really poorly. I suffer with mental health – with voices, with psychosis, with depression – every day and it's a fucking fight to get me through a day. It really is. But people's comments and all the rest of it … and I'm just fucking sick of it. I don't want to be on drugs for the rest of my life. But if I wasn't on drugs or I didn't take anything, I wouldn't be here. They make us feel that fucking bad. Do you know what I mean? [Jack, 43]

The difficulty of navigating stigma as social harm in social relations through drug use is highlighted by Tony; in trying to manage his mental health and feelings of being 'less than' Tony notes the toll this takes on his body as the cycle of stigmatisation continues:

> The more drugs you take, the worse you look, the thinner you look, the worse you look, the worse you look after yourselves, the worse people are going to judge you. It's going to be worse. The more you do it, the worse it's going to get. So the drugs don't really help, no. They might for that split second, but you know it's not doing you any good. [Tony, 26]

Making claims to a valued personhood was complex and often temporal; Haven is aware that PWUD are able to navigate stigma in social relations, and mitigate social harm, by taking up a 'recovering addict' status. Haven is extremely ambivalent about this, and how it is inscribed by others. They share their sensitivity to this 'acceptance' as a person of value being contingent on the performance of 'good abstinence', and how this could be withdrawn should a relapse occur.

> … When I was in active addiction, it was a huge barrier, absolutely massive and I think the acceptance I get now is very conditional on me being in recovery and being in recovery the right way, you know? I need to be inspiring and have wise thoughts and if I'm even just a messy human being who happens not to do drugs anymore, that's not good enough. So, it does feel like a very conditional acceptance [Haven, 30]

Thus society's view on addiction tends represent people as having a singular, drug related, deviant identity, which can only be redeemed on, and be contingent on, remission. These stigmatising practices had far broader consequences for people.

4.3.2. Isolation and loneliness

A number of participants, although not all, expressed feeling powerless to resist stigmatisation and so instead coped by isolating themselves. Kev describes shutting himself away and staying out of the public eye because of the toxic harm of internalising stigma, which was grounded in being a perceived economic 'burden' to society (see also Charmaz, 1983):

> It's just the way it goes. I mean you can't help but feel a bit low. The amount of money it costs just to treat us I suppose and stuff like that, could go elsewhere sort of thing, I do feel really low sometimes. No, I tend to stay at home these days anyway, I don't go out, I don't do anything, so I stay out of the public eye […] I've just shut myself away [Kev, 41]

Tony is also mindful of how he is perceived by others and positioned in social relations because of how he acts and looks. This increases his feelings of self-consciousness leading to reduced engagement with others.

> … really, like, more paranoid about the way I look and think more about it and think, "Oh, god, I feel rough today," and it'll be even harder to talk to people [Tony, 26]

Ravi describes feeling powerless to do anything about stigma practices and how this adds to feelings of isolation:

> I've just been a loner, just I felt isolated, on my own, unable to do anything about things, it's been difficult. [Ravi, 42]

Isolation, especially because of the harmful impact of stigma, has important ramifications for how marginalised people are able to access health care support. Those who are excluded and marginalised from society are at greater risk from multiple social harms and being unknown to services exacerbates this further. This is contrasted by Hannah's experience, who highlights the importance of her social networks to access support:

> I was quite lucky to have people push to get me things where not many people's got that strength. Like I say, I was quite lucky to have my mum and people to fight my corner to make sure I got certain things whereas if I didn't have that I'd still be out there and I'd still be using drugs even more so. [Hannah, 35]

The harmful effects of stigma in society are particularly damaging for those who have low social capital and are isolated. Positive social bonds between PWUD and family/friends can serve as a buffer to stigma related harms because the person is known and valued in ways that extend beyond a reductive 'drug-user' identity.

4.3.3. Disengagement with health care providers

Sensitivity to stigmatising practices meant that some participants did not feel able to engage with services. Stigma as social harm was painful and participants were often using drugs to avoid further suffering and retraumatisation; as such sensitivity to stigma impacted help-seeking behaviour. Several participants across the study described with anger, frustration, and shame how they experienced stigma in social relations with health care providers:

> It's when you put the power of gatekeeping behind it and say, "People with this stigma attached to them can't have this". That's when it becomes a problem. If someone wants to look at me in the street and go, "Ugh, dirty junkie", that doesn't affect me. If that person is my GP and they won't let me get any medical treatment then it becomes my problem. So, I have experienced stigma, I have experienced judgement … It's when they are able to use that to cut me off from things that I need that it becomes my problem. [Haven, 30]

Whilst Haven describes their frustration at stigma practices that prevent access to healthcare, Kev shares how his experience of health and social care to be imbued with stigma, judgement and unequal treatment. This stigma permeates statutory services in a way that is damaging people's health.

> … The way you're treated, I mean for a lot of years I couldn't get proper treatment for my legs because they just look at you, "*You're just a heroin user but that's your own fault",* sort of. And you do get very negative things, I mean I got took into hospital because I'd OD'd and the nurses had stripped me off and things … and as soon as, *"It's a heroin overdose*" you just see their faces change and the way they sort of are working … But not everybody's the same, but in general – yes, definitely! I mean a lot of the chemists you go and get your methadone each day and depending on what chemist you go is depending on what looks you get … some places that are just very negative. I mean I'm pretty lucky, I mean the chemist that … they don't care, they just want their money … but it doesn't make you feel good. [Kev, 41]

Hannah and Karla also share how healthcare provider's stigmatising practices impact their mood and sense of worth as a human being:

> I think probably the doctor's is the main one. Yes, you've just got that stigma. […] It's like you're walking around with a sign on your head. It doesn't feel nice. [Karla, 38]

> Some people even just say that they've got you written off. And when you're feeling that shit about yourself it's a bit like … if the one person that you're meant to be working with hasn't got that belief in you or gets sick of you, then what chance do you really have? [Hannah, 35]

Not everyone experienced stigma in this way. The health benefits from positive, judgement free social relations were evident in conversation with Ravi, who discussed how he was able to be honest and open with his keyworker without fear of judgement:

> Barbara is my key worker, she's a good key worker she knows … I don't hide nothing from her and she goes out of her way to do everything that she can to help and support me. [Ravi, 42]

These positive interactions were not widespread across the sample; however, when participants did report feeling seen and valued in interactions with health providers the benefits for them included an increase in sense of self-worth, self-belief and allyship.

Haven notes how structural inequalities are built into the healthcare system meaning that whilst some people were able to navigate social relations and 'play the game', becoming advantaged and able to access the care they need, others who felt stigmatised, described social harms and feelings of exclusion.

> I feel there's a lot of people with good intentions but I think the structures that are in place are very firmly rooted in that some people are meant to get ahead and some people are not, and we're a long way off really dismantling those, even if a lot of individual people want things to get better. [Haven, 30]

The impacts of stigma to health were unevenly experienced depending on degrees of marginalization. Certainly, stigma caused harm to mental and physical health arising out of low self-worth and unequal treatment by some healthcare providers. Participants discussed coping with the harms arising from external and internalised stigma through isolation – this eroded social bonds and damaged social capital, which for some was a buffer to stigma incurred harms. Increased loneliness negatively impacted mental health. Participants also reported disengaging from healthcare providers where stigmatising practices occurred, although the benefits of positive social relations with health providers helped to improve self-worth for some individuals.

5. Discussion

At present SDoH, as defined by the WHO (2022), focus predominantly on a positivist, materialist experience of the world; a relational understanding of SDoH is missing, which this study has sought to address. Our findings show that stigmatising social relations should be considered an important SDoH because they structure an 'invisible reality' that operates in synergy with psychosocial and material determinants of health (Bambra et al., 2021), informing how people are seen and valued in society for *who* they are and *what* they do. These social relations can do social harm to a person and community when there is a power imbalance and, as Tyler notes, where stigma mechanisms are weaponised (Reynolds, 2021; Tyler, 2020).

Social relations shape the world that we live in through a logic of practice (how we act in the world) across certain fields (spaces and places); the complexity of these relations and how they operate day to day is difficult to untangle; however, the utility of Bourdieu's framework allowed us to theorise aspects of these social relations by drawing on key concepts such as *habitus*, capital, field, *doxa,* and *hysteresis*. This theoretical framework partnered well with our mobilisation of Tyler's 'stigma mechanisms' and Scambler's notion of 'weaponisation' (2018b) to make visible how and why social harm (Pemberton, 2016) occurs both as a product and process of 'stigma craft' (Tyler, 2020) (for further discussion please see Addison, 2023).

This study has provided qualitative insights into how stigma operates as a key mechanism in *social relations* that harm PWUD. Stigma is harmful and should be regarded as a SDoH: we have shown that stigma is deleterious to health in two key ways: [i] stigma has detrimental effects on mental and physical health; and [ii] stigma impacts how participants engaged with health services.

Stigma as social harm was present in social relations between people through dominant connotations of undesirable and intersecting identity characteristics (e.g. gender and class positioning) and so-called deviant practices (drug use) to do social harm (see also Addison, 2023). This stigmatisation had detrimental effects on participants' mental and physical health by exacerbating feelings of loneliness and isolation which research shows lowers a person's quality of life and amplifies existing health complications (Kung et al., 2022; Patulny & Bower, 2022). Further, harms to mental health occurred for participants through stigma mechanisms in social relations that positioned their habitus (embodied history) as *abject* by other more dominant groups (see Scambler, 2018b) – that is, they felt that they were a person without value to society, worthless or *un*human. Many of these PWUD felt reduced to a singular all-encompassing identity of a 'drug-user'; this was undoubtedly pathologising and harmful. This kind of symbolic violence done to PWUD and denial of intersecting subjectivities in social relations also meant that more dominant groups felt legitimated in treating participants with contempt.

Furthermore, individuals discussed feelings of shame based on their actions, identity and how they felt perceived by others in society. These 'ugly feelings' (Ngai, 2007) added to a hegemonic individualising rhetoric of responsibilisation and self-governance, which PWUD internalised as blame and stigma directed at themselves (Addison, 2023; Addison et al., 2022). What was clear in discussions was how blame and shame corroded a person's sense of self-worth further and, for many participants, lowered mood and reduced interest in self-care practices.

Stigma influenced attendance, engagement with, and perceptions of health services. Sensitivity to stigma and stigmatisation meant that PWUD felt vulnerable and marginalised, and some were quite reticent when it came to seeking help. This is a particularly pernicious issue when it comes to individuals who are unknown to services. For others who had accessed health services, experiences of stigmatising gatekeepers meant that some people felt that they could not access the help that they needed unless they could navigate these stigmatising social relations and *play the game*. Doing this involved mobilising 'health capital' (Chang et al., 2016) and an understanding of *how* to navigate the field to authentically perform the role of the 'deserving patient'. Not all individuals were able to navigate social relations in this way and felt underserved by health services because of the harmful effects of stigma; this adds to the problematic widening of health inequalities amongst this sub-population.

Finally, stigma done by others, and internalised by participants, meant that PWUD experienced harms to mental and physical health daily – this harm was normalised and led to short-term horizon scanning (Reynolds, 2021); in our study participants reported a sense of '*what's the point?'* to changing their drug use behaviour and did not like to think too far into the future, preferring to focus on day-to-day survival. Many of these participants were not 'future-orientated' individuals, instead preferring to continue with drug use to alleviate some of the daily harms that they were experiencing.

6. Strengths and limitations

The main strength of this study lies in the inclusion of marginalised voices that would otherwise be unseen and unheard – it gives prominence to what makes a 'liveable life' possible (Back, 2007). A diversity of characteristics, drug use, and consumption patterns were sought, however the main limitation of this sample is that it is largely white British; whilst this is congruent with the population composition in the NE of England, the authors acknowledge that the themes discussed here are not necessarily reflective of experiences held by minoritised communities based on, for example, race. The authors were reflexive that the subject matter could be highly sensitive and emotionally activating for participants so measures were taken to provide signposting to support, and the researcher took steps to be neutral and non-judgemental throughout.

7. Conclusions

This paper has argued that stigmatising social relations should be considered a social determinant of health because they structure an 'invisible reality' experienced by marginalised individuals (see also Bourdieu, 1990). Stigma mechanisms organise social interactions between people and can be particularly harmful to marginalised people (like PWUD) based on intersections of identity and deviant practices, whilst maintaining power structures (see also Scambler, 2018b; Tyler 20, 230; Reynolds, 2021; Link and Phelan 1995). This social harm, done through stigma, impacts a person's physical and mental health and is a pernicious invisible problem that exacerbates health inequalities. Social relations, and how they act in synergy with psycho-social and material SDoH (Bambra et al., 2021), is an under-researched area and as such, justifies the use of Bourdieu's theoretical framework further in partnership with a social harm lens to advance understanding in this area.

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Ethics

This research acquired ethical approval from Northumbria University during the time that the author (MA) was employed by this institution, Aug 16 2019, (Submission REF: 17304).

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper

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