PILLARS OF STIGMA AND RECOVERY STORYTELLING (BILL WHITE, BILL STAUFFER, AND DANIELLE TARINO)

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A central goal of public recovery self-disclosure is to challenge myths and misconceptions about addiction and recovery through the elements of our personal stories. Recovery advocates must avoid contributing to false narratives by having selective parts of our stories appropriated while ignoring the central recovery message.

Addiction/treatment/recovery-related social stigma and its untoward consequences rests on old and new misconceptions regarding the sources and solutions to alcohol and other drug problems. Such key pillars of belief about the nature of addiction, addiction treatment, and addiction recovery constitute the structural supports of addiction-related social stigma. Below are examples of such pillars (in the stigmatized language in which they have been historically conveyed) and how our stories can be hijacked to support these false narratives

Addiction is a product of moral turpitude (badness) that is best prevented and discouraged by public shaming and other forms of punishment. Acts flowing from this premise began with American colonies forcing those convicted of public intoxication to wear the letter D (for "Drunkard") on their clothing or to be set in stock in the town square under a sign reading "Drunkard." The moral turpitude pillar continues to feed social shunning, serves as grounds for divorce, and provides a rationale for political disenfranchisement and discrimination in housing, employment, education, and medical benefits. Overemphasizing or exaggerating the "bad people" we were in the addiction portion of our stories inadvertently feeds this view.

Addicts pass on their degeneracy ("bad seed") to their children. This pillar of belief has resulted in the inclusion of addicted people in mandatory sterilization laws, surgical sterilization without consent during institutionalization, and loss of parental custody and related legal rights. It also feeds false narratives that paint the children of addicted parents with the same brush, e.g., false narratives of "crack babies" as a "biological underclass."

The addict is an infectious agent who must be closely surveilled and isolated from the community. This pillar of belief provided the rationale for inebriate penal colonies, prolonged institutionalization in psychiatric asylums, prolonged surveillance (addict registries, prolonged probation/parole), and fed the modern era of mass incarceration.

Addicts pose the greatest threat to the community when they associate with each other. This belief undergirded laws banning addict fraternization and probation or parole violations for associating with other addicts. "Loitering addict" laws provided for the arrest of known addicts for simply being in the presence of other individuals identified as addicts. Policies that dissuade recovery networking and the inclusion of recovery voices in matters that affect us may well be rooted in earlier biases against addicts being with each other.

Addiction does not discriminate. Actually, it does! It was with the purest of intentions that the tagline of "addiction does not discriminate" became one of the public education mantras in the wake of the "opioid epidemic." It was a way of saying, "See…it could happen to anyone… and now you should care." This narrative sought to normalize (AKA Whiten) addiction by projecting the image of "innocent," (AKA White), middle-class children and their parents deserving of public resources to support their care. Such care was advocated as an alternative to arrest and incarceration for the "deserving" (AKA White people of means), while addiction in communities of color continued to be stigmatized, de-medicalized, and criminalized.

Stating that alcohol and other drug problems cross boundaries of race and class in the United States obscures the inordinate toll addiction and drug policies have long taken and continues to take on communities of color and other historically marginalized populations. The addiction vulnerability of these communities stems from historical trauma; social, economic, and political marginalization; and related disparities in access to prevention, harm reduction, early intervention, treatment, and recovery support services. An ethical framework of public messaging and education would call for equity of policy application and resource allocation across all affected communities. Ideally, recovery storytelling would include the stories of people from diverse backgrounds and living circumstances. It is important that through our stories we convey the reality of recovery, the varieties of recovery experience, and the challenges of recovery across cultural contexts.

Addiction is untreatable ("Once a junkie, always a junkie.") This pillar of belief feeds personal, public, and professional pessimism about addiction and provides the rational for prolonged institutionalization /incarceration as well as justification for harmful and potentially lethal treatment experiments. In the U.S., the latter have included brain surgeries, indiscriminate use of chemo- and electroconvulsive therapies, toxic drug withdrawal procedures, and other harmful treatment methods. Portraying the role treatment played within our recovery stories and the nature and positive effects of modern treatment challenges this misconception.

Treatment Works! is a counter misconception in that it suggests the presence of a uniform protocol of addiction treatment in the U.S. that achieves consistently positive clinical outcomes. It also ignores widespread addiction treatments that lack empirical evidence of their effectiveness as well as the presence of treatments more focused on financial profit than long-term recovery outcomes. This central marketing slogan of the treatment industry misrepresents the highly variable outcomes of addiction treatment, which span minimal, moderate, and optimal effects, as well as harmful effects. Addiction is a treatable condition, but recovery outcomes depend upon numerous personal, clinical, and environmental factors. Great care must be taken in how our stories are used by the addiction treatment industry. What we are offering as advocates is living proof of long-term recovery, not an advertisement for a particular proprietary approach to addiction treatment. (See HERE for full critique of this slogan.)

Recovery is not possible until an addicted individual "hits bottom." Actually, most people recover from addiction long before "hitting bottom" (losing everything). Addiction-related loss and pain in the absence of hope is an invitation for continued self-destruction. Recovery initiation is the fruit of addiction-related consequences interacting with sources of hope for a healthier and more meaningful life. The "hit bottom" premise suggests that recovery responsibility rests solely with the individual—that there is little family or community can do until that point of individual awakening arrives. This constitutes an invitation for family and community abandonment of those suffering from addiction. This premise is untrue, is not applied to other medical conditions, and should be forever discarded within the addictions arena. We must not let our story be twisted to support this supposition even if we were one of those who did hit bottom and lost everything.

Addiction recovery is the exception to the rule. Actually, recovery is the norm; individuals who do not achieve sustainable recovery are the exceptions. Those who struggle with recovery stability are distinguished by higher problem severity, co-occurring problems that make recovery initiation and recovery more difficult, and fewer natural recovery supports in the community. Even people with the most severe addiction problems can and do

recover with more intense and prolonged recovery support resources. We must repel any effort to cast our recovery as the heroic "exception to the rule" and convey the consistent message that no one need die of addiction. Recovery is far more than possible; it is the probable long-term outcome for those who experience alcohol- and other drug-related problems.

Addiction recovery is a brief episode that allows one to then get on with their life. For people with mild to moderate levels of addiction severity who possess substantial recovery capital, recovery may be just that. However, for those escaping addictions marked by severity, complexity, and chronicity, recovery is a prolonged process comparable to the assertive and sustained management needed for other chronic medical conditions. It is important in our stories to acknowledge variability of addiction severity and recovery support resources. Our recovery story is just that—our personal story; it is not the whole addiction/recovery story.

Media channels frequently tell the story of addiction recovery only as a personal story rather than a larger story of the role of family and community in addiction and recovery. The prevalence and severity of addiction are profoundly influenced by social, economic, and political contexts. The recovery tipping point has as much to do with family and community resources and capacity for resource mobilization as it does what is going on inside the addicted person. We serve best when we present our journey from addiction to recovery within these larger contexts and extoll the role of family and community in the recovery process.

Addiction recovery is only achieved through a particular type of professional treatment, lifelong affiliation with a recovery mutual aid society, and lifelong abstinence from alcohol and illicit drugs. Actually, people recover from substance use disorders with, and without, treatment, and through diverse approaches to treatment and recovery support. People achieve recovery with and without involvement in recovery mutual aid groups. Professional- and peer-supported pathways of recovery constitute particular styles of recovery, not the only pathways to recovery. Those involved in treatment and recovery mutual aid represent more severe and prolonged patterns of addiction. There are secular, spiritual, and religious pathways to alcohol and other drug (AOD) problem resolution, and AOD problems can be resolved through styles of sustained abstinence or through decelerated patterns of drug use (the latter most viable for individuals with less severe AOD problems and greater social supports). Our personal story illustrates one within many pathways and styles through which people resolve AOD problems. We preface our stories with "In my experience…" and "What I have observed is…" We are sharing our experiential knowledge, not universal truths that have stood the tests of science or application across diverse cultural contexts.

The above pillars of belief (and the degrading caricatures that often accompany them) serve the interests of multiple parties. They aim to socially stigmatize and discourage drug use. They disparage groups with whom the drug is, correctly or incorrectly, associated. They justify surveillance and over-policing of marginalized communities. And they feed institutional profit. Collectively, these pillars define us as a people as outsiders–outcasts for whom doors of entry into the human community should remain closed.

Our goals run counter to these interests. Our intent is to elicit what Isabel Wilkerson has christened "radical empathy"—the ability of listeners to emotionally project themselves into our experience to the point that they move beyond tolerance and compassion to actions that include us within the human community. This requires framing our stories to elicit conscious awareness that addiction is only one of many forms of woundedness that can and do touch all of our lives, and that recovery mirrors the promise of healing that can follow. The challenge we face is to assure that our recovery stories serve this higher purpose and not feed false narratives that are part of the problem.

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