7

Readdressing Addiction Stigma: Making Space for Being in the World Differently

Fay Dennis

Introduction

> There was no problem with the drugs. Heroin has done no harm to me. Everything else has, like the lifestyle and whatever has, but not the actual drug. (James [pseudonym], a research participant, heroin user and harm reductionist, 2019)

> By shifting our relations to the characteristics we are being made to see as [the disease problem], we can refigure them as ways of being in the world differently, and as such, as other ways of being human. (Latimer, 2018, 848)

In shifting 'the problem' of drugs from the drug or person who uses them to the environment in which they are consumed, James speaks to an argument made by Joanna Latimer (2018) in her discussion of dementia stigma. Latimer argues that by shifting our relations to the characteristics we see as the disease problem, in her case, dementia, but here, the problem of dependent drug use or addiction, we can refigure them as ways of *being in the world* differently. What is appealing about this approach is its hopefulness for a world where people who use drugs dependently can be more accepted and able to pursue and inhabit identities more easily alongside 'drug user' or 'addict'. This is not to say that frequent, heavy drug use is not a problem for many people. But, by relocating where 'the problem' comes from, we make space for those like James and many in the harm reduction movement who do not automatically see it in these terms. And, if listened to, they may be able

to shed light on alternative, less stigmatising relationships with drugs. For its potential to disrupt disease categories, this argument goes further than mainstream anti-addiction stigma work.

Through the stories of people who use drugs (predominantly heroin and/or crack cocaine) in my research in London, UK, I have come to think about stigma, that is, the 'discrediting' (Goffman, 1963) problem of drug consumption, relationally in terms of how people who use drugs are blocked in their ability to be in the world (quite literally to be alive and well, and to be able to pursue different activities and roles). Like Goffman (1963) argued in his classic sociological work, stigma is not inherent to the person but rather produced and sustained through social relations. I look at how this stigma takes place through three stories of what I call, following Deleuzo-Guattarian (1987) thinking, 'blocked becoming'. These stories account for how people are constrained by their 'association' with drugs and addiction and the narrow understanding of the human that addiction is rooted in (based on autonomy and volition). It is, therefore, not the drug–body interaction but these more complicated socio-material relationships that prevent people who use drugs from living full lives.

If we see being with drugs as different ways of being human, we can ask what more we can do to enable flourishing rather than what more we can do to make people give up. This is what is at the very heart of the harm reduction movement and ethos – an acceptance of different ways of being. This approach is in sharp contrast with the predominance of abstinence-based recovery programmes, where elimination of drug use is considered the only legitimate/successful way to 'treat' drug addiction/dependency. And this is what James' realisation is about. He explains how he spent ten years trying to get off drugs – on a cycle of abstinence and relapse – until, one day, 'the penny dropped':

> Becoming abstinent, getting a job, relapsing … I went around and around on this wheel for about 10 years until, probably four or five years ago, the penny dropped. I don't know why, but it was, 'I'm not doing any harm to anybody. I'm not a thief, what's the problem?' It was like a weight lifted off my chest.

In questioning and dislocating 'the problem' – one that he was told to see in the drugs, in his dependency, and ultimately in himself – a huge weight was lifted: 'It was other people's feelings put onto me and I kind of believed that shit. When I just sat down and actually looked at it, 'What harm am I doing?' When I realised that, it all just went away.' Suddenly, he no longer had to live a life of shame trying to get off drugs and failing. His involvement with harm reduction activism provided him with this acceptance: 'Most of that came about through getting involved in the activism side of things. That's

just really opened my eyes up to so much. I have no issues at all to do with drug use at all now, at all.' James no longer viewed himself as a failed person, but somebody living a different kind of life to one normatively judged as acceptable. The harm and problem he once saw as coming from the drug and himself he now locates within these judging others, and his positioning as an outsider where his practices are outlawed and pushed underground, exposing him to an unregulated drug market, criminal violence, and overdose risk. James now takes a different approach to his drug use, seeing methadone, an opioid used in heroin treatment, as any other medication (that is, to aid living as somebody who uses drugs rather than to 'recover' a former non-addicted self), and heroin as 'a glass of brandy … at the end of the night':

> I don't particularly have any treatment aims. I see the methadone now basically as I take tablets for my stomach, dyspepsia or something. It's just another medication. I don't think I must stop, or I must get off methadone.
>
> [Heroin is] like a glass of brandy, somebody having a cigar at the end of the night or whatever.

In shifting the relations to what we normally see as addiction – to the substance, and to the daily need for it – James enters a more harmonious relationship with his drug use and treatment. The daily need for methadone is reframed as like anyone else's need for daily medication, and the desire for heroin is likened to how other people might desire recreational, legal drugs for relaxation. This likening to mainstream, majoritarian societal interests and actors actively resists a positioning of the addict as Other. He explains how he no longer has these 'hang-ups' about being a 'heroin user and a drug addict'. This is because, in many ways, he is no longer (if he ever was) 'an addict' as it has been taught to him – uncontrolled, compulsive, a thief, and harmful to others. In shifting this perspective, he has freed how he sees himself from this stigmatising identity and, crucially, the suffering, anguish, and guilt that has come with it.

In this chapter, I want to further tease out some of the ways that the category of addiction works to block what people can become and explore openings for alternative configurations with drugs. Therefore, this is not simply about the stigma associated with addiction, but the stigmatising which may be inherent to addiction as a disease category. In this sense, the argument is different to anti-stigma work which attempts to disentangle stigma from addiction, and, indeed, even looks to addiction to destigmatise people who use drugs, thereby replacing a moral category with a pathological one. Instead, following Deleuze and Guattari (1987), and as made relevant to the drugs field by Peta Malins (2004), I observe the socio-material ways that

body-persons are stratified as addicts – discussed in what follows as 'junkie', 'thief', and 'prostitute' – and their 'blocking' effect. As James explains, it is not the drug or dependency that has meant he has to live a stigmatised life on 'this wheel' of abstinence and relapse, but these associations and 'other people's feelings put onto [him]'. Rather than judging from the outside, then, I want to ask what can be learned from this insider perspective – turning the gaze inward to ask, where is the stigmatising problem of addiction coming from?

Addiction stigma

Stigma is regularly discussed in the literature on addiction and dependent drug use. These works can be seen to fall into two groups. The first group tends to separate stigma from the category of addiction, which is either left unchecked or endorsed as a mode of destigmatising people who use drugs. The second group takes a more critical approach both to the social and political roots of addiction stigma, and to the category of addiction itself, which is seen to go to the very heart of the stigma facing people who use drugs.

Addressing the first group, scholars have focused on the specificities and experience of stigma rather than its origins as a social process. These studies largely draw on theories of phenomenology and social psychology in exploring the lived experience of addiction stigma (Radcliffe and Stevens, 2008; Simmonds and Coomber, 2009; Kulesza et al, 2013). Scholars have also actively endorsed and engaged with the concept of addiction as a way out of stigma. This follows the disease model of addiction and the idea that seeing heavy, dependent drug use as a brain disease removes blame from the individual and supports a health-based approach. Within this guise, stigma is seen as a by-product of a moral ideology on drugs as *bad* and their users as personally flawed and lacking self-control. Thus, education around addiction as a disease is judged to be what is needed to tackle stigma and improve the lives of people who use drugs. A leading proponent of the disease model of addiction, Nora Volkow (director of the National Institute of Drug Abuse in the United States, the largest funder of drug research globally), explained in 2015:

> If we embrace the concept of addiction as a chronic disease where drugs have disrupted the most fundamental circuits that enable us to do something that we take for granted – make a decision and follow it through – we will be able to decrease the stigma, not just in the lay public, but in the health care system, among providers and insurers. (Fraser et al, 2017, 193)

Such thinking can be seen to inform recent public health campaigns in the UK like the National Health Service (NHS) Addiction Provider Alliance's (2022) campaign, 'Stigma Kills', which aims to 'break down the myths and

misconceptions around addiction demonstrating it is both a mental and physical health condition and not a person's choice'. But, following Suzanne Fraser and colleagues, as sociologists of health and illness, it is hard to believe that disease labelling can lead to less stigma. As these authors note, '[i]t is becoming evident that labelling addiction a brain disease and then attempting to "educate" the public about this disease is not producing any consistent change in stigmatising perspectives' (Fraser et al, 2017, 194). Considering the proliferation of stigma that still exists as depicted in the lived experience of people who use drugs, this emphasis does not seem to be making the promised difference. Indeed, for historian of addiction Nancy Campbell (2023) the brain disease model is simply a reinvention of the moral model.

The second group of literature is informed by a more critical take on the category of addiction and the social and political roots of addiction stigma. One way of thinking about the politics and power of addiction stigma that has particularly risen to significance in recent years is through a re/turn to a Marxist lens of political economy and structure, what Imogen Tyler (2018, 2020) calls 'the stigma machine'. This style of thinking is taken up in Addison et al's (2022) edited book, *Drugs, Identity and Stigma*. Quoting Tyler (2018), they argue that stigma constitutes a cacophony of 'mechanisms of inequality' as a 'site of social and political struggle over value' which enables profiteering and deters people from making claims on the State (Addison et al, 2022, 2–3). Such an interest is also taken forward in Liviu Alexandrescu's (forthcoming) book, *Drugscapes: Imaginaries of Intoxication, Dependency, and Control*, in which he explores the ways addiction is 'mobilised in the moral imaginary by the powerful against the powerless to justify the unjust orders of a deeply unequal social world'. In this mode of inquiry, researchers are asked to 'gaze up' (Paton, 2018), including to the very work of the campaigns that seek to challenge stigma (Tyler and Slater, 2018, 727). For example, Alexandrescu (forthcoming) explores the role of pharmaceutical companies in stigmatising pain, which is seen to be at the heart of the US opioid crisis.

Where we have seen scholars 'gaze up' to the stigmatisers – those structures and organisations producing and standing to gain from stigma – and others down to the stigmatised in accounts of lived experience, there are yet some who argue for a third way based on:

> The mutual co-production of power and subjectivity, placing stigma into a performative ontological framework more attentive to the socially constitutive role of such phenomena and, we think, allowing useful insights into stigma's ubiquity and persistence. (Fraser et al, 2017, 194)

Turning the gaze inwards, then, addiction plays an important role in contemporary liberal societies precisely as a mode of Othering. In this register, addiction 'is a means by which contemporary liberal subjects are

schooled and disciplined in the forms of conduct and dispositions required to belong, and to count as fully human' (Fraser et al, 2017, 199). For Jarret Zigon (2019, 53), ' "the addict" has been rendered as the dangerous internal Other from whom the population must be defended'. Addicts are 'those who have lost the characteristics that today are equated with humanness: their freedom, autonomy, self-responsibility, and control' (Zigon, 2019, 60). Taking up this third way, then, I continue to gaze inwards, asking where stigma is coming from and how best to apprehend it.

My approach

The stigma of addiction is a truism that is often left unexplained in the literature on drugs. In their recent review of stigma and hepatitis C, an infectious disease associated with injecting drug use, Harris et al (2021, 2) note: 'While commonly employed as a framing concept, much research lacks explicit theoretical or critical engagement on how stigma is conceptualised'. Moreover, stigma has become somewhat of a catch-all term for the disadvantage and discrimination experienced by people who use drugs, especially in terms of accessing services. It also becomes a convenient way of distracting attention away from underfunding and under-resourcing, what Graham Scambler (2018) refers to as the 'weaponising of stigma' in neoliberal times. For example, in a recent radio interview (BBC Radio 4, 2022) with a government minister for Scotland on the growing use and deaths associated with illicit benzodiazepine, we are relayed a deeply disturbing story from a mother whose son nearly died while suffering psychosis linked to his benzodiazepine use. He was put into an induced coma, only to be discharged from hospital two days later because there were no beds at a neighbouring psychiatric unit. In a sudden and frankly insensitive response to this desperate situation, the minister brings up stigma. Nowhere in this mother's story was there mention of stigma. Her son was not refused help because of stigma. He was refused help because there was no space for him. In this jarring moment, we see how the language and concept of stigma can be employed (even if unknowingly) to cover over and divert attention away from structural inequality and government inaction.

For these reasons, I have tended to avoid the term stigma in my work, especially where it appears relatively stable (as a weapon to be drawn on) and outside of socioeconomic processes. Here, then, I engage with the specificities of where drug events become stigmatising or produce stigmatising effects, and think of stigma as always relational and in process. Speaking to this relationship in her extensive work on Deleuzo-Guattarian approaches, Peta Malins (2004, 88) explains how drug-using bodies become blocked and identities become fixed:

> Most often a drug using body is connected … to the social machines of public health or medicine or morality through which it becomes stratified as a 'drug user' or 'addict' or 'deviant' respectively. Or the machine of law, through which it becomes stratified as a 'criminal' (or now, through diversionary programs: a 'recovering addict'!). Or it might, if we allow it, connect up to a multitude of other machines and become something else entirely (a student, an architect, a mother, a surfer, a masochist, a gardener, a knitter).

In this chapter, I focus on three striking accounts of where participants discuss their stratifications as a 'junkie', 'thief', and 'prostitute', and the ways that they are blocked, respectively, from becoming a patient, a guest at a party, and an employee. As will become clear, it is in these stratifying connections – of imagery, legislation, knowledge, and objects – that body-persons are blocked (from becoming *other than* an addict). Thought of in this way, stigma is a relational activity that keeps people trapped in the addict identity, plugged into these webs of control.

This is different from Goffman's relational approach, in which he focuses too much on the affected individuals and how they cope and relate to others, and not enough on 'why particular features or issues come to be stigmatised' and what is achieved politically by this stigmatisation (Fraser et al, 2017, 194), or the 'bigger picture', as Tyler (2018, 2020) puts it (see also Parker and Aggleton, 2003; Hannem and Brucket, 2012; Addison et al, 2022). But so too is the approach taken here different from a solely top-down approach of the powerful over the powerless where people who use drugs can easily be rendered passive. What draws me, then, to understanding stigma through Deleuze and Guattari's ontology of becoming is its inherent hopefulness, to 'become something else' (and hold multiple identities), as Malins (2004) phrases it.

Blocked becomings: stratified as a 'junkie', 'thief', and 'prostitute'

Beckie (B): [My partner] died on my lap … He came back up from the toilets. I wasn't using then. I was clean then, came back and he said, 'Oh babe, can I have a seat? I feel a bit funny'. I said, 'Alright, sit here'. I've got my one-year-old son with me at the time, our son. I'm sitting talking to him and I'm getting no response. His head is on my lap. The next time I look, he's just blue. No one would help. It was in the middle of Newcastle city centre. No one would help him. There was a doctor in the crowd. When I was screaming for help, obviously

a crowd came fucking running. There was a doctor, and he wouldn't touch him.

FD: Why not?

B: He's a junkie.

FD: What did he say?

B: 'I can't treat him. I can't do anything'. I had to revive him, not forgetting that I've got my son in the pram. Give him CPR. Luckily, I was a first aider, and I knew what I was doing. I had him breathing by the time the ambulance came. He was physically dead on my lap.

In this distressing account, Beckie's partner nearly died in her lap. She experiences this stigmatising event as deadly, as (almost) killing him. She is clear that 'no one would help him', not even a doctor, because he was a 'junkie'. Stratified by this identity, all his other identities ceased to matter. He was not seen as a father or partner, even with Beckie and their baby by his side. He could not even be a patient. Beckie notes that the doctor 'wouldn't touch him'. She is pointing here to the way the 'junkie' figure is connected to notions of disease and contagion. It was the skin-to-skin intimacy that the doctor and crowd were refusing. They would look – 'obviously a crowd came fucking running' – but they would not touch him. Due to this stratification, he was constrained in the most extreme way: almost dying.

In the next account, a participant called Lucy is forced to leave a party due to an 'addict' or 'junkie' identity that puts her under suspicion of criminality. Unlike other party guests under the same circumstance of a missing purse, this stratification as an 'addict' – 'because of the association', as she puts it – immediately turned her into a thief, to the point that she felt unable to stay:

> The stigma can actually be horrible, because, let me give you an example. There was a party and me and my boyfriend were *known*, and somebody couldn't find their purse and they went in my bag three times, ranting and raving, and then they found it in their car. So that part of it is really insulting. Because they presume you're a thief all the time. And it really made me upset, and I was really angry. I wouldn't steal off people. And it was a big family event on my boyfriend's side and his mum was stressed and there was loads of politics going on. But because of the association, because they know of our lifestyle, they … there was this panic and I remember just being so angry, I thought for fuck's sake, you've already been through my bag once, the accusation is such an insult … Then this person just rang up and said 'oh, I found my purse', and I just thought where's your bloody apology. And I just remember storming out and I remember just feeling so angry. I was so angry and so humiliated. Because there was this person ranting and

> raving around this place, and the image of … everyone was asked, but me and my boyfriend were asked too much, too intently, to the point that I just wanted to go, and I felt really tearful and … God, the insults I've had to take.

In Lucy's 'association' with drugs and addiction, she is connected and stratified by images of deviance and criminality. Under a situation of pressure, these often-invisible structures are voiced and publicly made known in a most explosive and humiliating way. Unlike others at the party, Lucy and her partner are accused and questioned 'too much, too intently', signalling them out as Other. Feeling humiliated, angry, tearful, and ultimately unwelcome, they leave.

Trying to explain further about how this stratification works, this time, in relation to the 'addict' as 'diseased' (like Beckie's example), Lucy recounts another pressurised incident in which her boyfriend 'was wacked around the face by his step-mum and we were told that we should have labels put on us saying that we are dirty junkies':

> There was a lot of politics going on because, basically, we were using [drugs] and we were in a stage of moving house, and there was a lot of our stuff kept in their garden. But this box, where our needles were, were in this bag, really deep, and his father must have really gone in his cupboard and really gone to find them. So, he made this big deal about finding these pins in this box and then, they'd had a kid, and the boy wasn't very well, and I just remember the woman came storming through this kitchen and just wacked him. And she was American. And she was just screaming at us, saying you 'fucking junkies, you should wear a label, you don't bring that shit [into our house]'.

The syringes ('pins') here are key to this story and how this stratification works. As Nicole Vitellone (2010) explains in her work on the 'sociology of the syringe', syringes are already 'designated disgusting'; they are connected to images of disease and contamination. The pins become the catalyst of this outburst. Speaking directly to the invisibility of how this disease imagery and stratification works, the stepmother says that Lucy and her partner should wear a label, marking them out as 'junkies'. With this, we are reminded of the original meaning of the word stigma rooted in Ancient Greek to denote a bodily sign: '[T]he term stigma … refer[s] to bodily signs designed to expose something unusual and bad about the moral status of the signifier' (Goffman, 1963, 1). In her recent book, Tyler (2020) traces examples of stigma as derived from the root 'stig-', meaning to prick or to puncture, from ancient penal tattooing, to the marking of slaves, to the ways Jewish people were exhibited with cardboard signs saying 'I have been excluded

from the national community' during anti-Jewish pogroms, and to the modern-day use of shaming techniques in the US where convicted petty criminals are forced to hold placards or wear billboards outside shopping malls stating 'I am a thief' (Tyler, 2020, 145). In her rage, then, the stepmother is drawing on a long and violent history of the use of physical signs and markers to denote body-persons as bad and otherwise subhuman. In these two accounts, Lucy and her partner lose their identities as guests, as family members, as they become stratified and blocked by this 'junkie' identity as criminal and diseased.

The third account of stigma I want to share is from Tina. Tina tells me about a horrific experience in which she is stratified as an 'addict' and prostitute, and shamed and blocked from being able to work – even though she had done all the training. She explains how she calls the recruitment agency about her criminal record and is invited into their offices to show them her Disclosure and Barring Service (DBS) check. Her DBS shows multiple old charges – 'these are all years ago' – for soliciting sex and drug possession:

> Me, like an idiot, phoned her up [the recruiter] and said, 'I don't know if you'll take me on with my record'. She said, 'bring it [the DBS check] in, you'll be alright'. I took it in, she went downstairs, said she'd gone to see the manager, and whilst she was downstairs, women kept on coming up and looking at me. There was a room downstairs with women all on computers and they kept coming up and pretending, asking questions to the girl, then the two managers came up, called me into the back room, she said we're sorry but even if we send this to head office, they'll say no. So, I said okay and just walked out. I was angry, but I didn't show it. I should have got them done for the way I was treated. And I'd done all the training and everything. I had to go all the way to bloody East London, you know, borrow money to get the bus fare up there every day. And then they told me no. And that put me off trying again … All I wanted was a job. And it's not good work care work. It's only £6 an hour. I just wanted to do something, you know, to feel good inside, instead of feeling dirty all the time. It just fucking makes you feel like, fuck it.

The DBS check continues to mark Tina out – stratifying her as an addict and prostitute even though she no longer uses drugs or solicits sex. It is an identity that continues to follow her, to define and restrict her. We are alerted again to this feeling of shame and dirtiness that is often felt in these processes of stratification, what Zigon (2019, 53) discusses as 'the addict' as akin to shit. She is left feeling dirty by this experience and questions the point of giving up drugs if she continues to be stratified by them in these most life-constraining ways.

In all three examples, then, it is not the person's addiction that is causing these restrictions to life, but their connection to these stratifying identities. It is not the drug or addiction that nearly kills Beckie's partner, but its association with contagion that means a doctor will not treat him. It is not Lucy's drug use that drives her to leave a party, but the fact that she is labelled and accused of being a thief. The same goes for Tina. It is not her past dependency that means she cannot work, but her DBS record that continues to mark her out in this way as Other, turning her into an object of ridicule and entertainment for a sniggering recruitment agency.

Having seen the way stigma operates through these networks and always in process as a means of blocking life chances and what people can become, I want to return to this idea that, where bad connections are happening, good ones are also possible. Key to this is what Peta Malins (2004) wrote (see previous section): *if we allow it*. Therefore, opening up space for people who use drugs to exist differently, outside of the confines of addiction, involves us all.

Making space for being otherwise: in solidarity with people who use drugs

Our role, then, as sociological researchers of health and illness, if we want to act in solidarity with people who use drugs and try to reduce these stigmatising events, is to see these lives as worthy lives. In Latimer's (2018, 833) essay on dementia stigma, she explores the ageing body, which much like the addicted body, 'can be experienced as disgusting and repulsive because it represents deviation from what is most cherished in modernity and contemporary preoccupations with specific forms of personhood'. Latimer argues that, by researching closely with stigmatised groups, or 'dwelling alongside', as she puts it, we can see worlds differently together. Latimer emphasises the livingness in those otherwise stigmatised lives and says that they can instead be seen as 'a possible way to resist the dominant forms of personhood mobilized in late modern capitalism and which "others" those no longer willing or able to be response-able and fold themselves into its demands' (Latimer, 2018, 849). For example, in my research over the last fifteen years or so, I have been struck by the complex, generative ways people make their lives *with* drugs. In a recent essay, a colleague and I reflect on the life of Kim, a fifty-something Black British woman who is adamant that she will continue smoking crack cocaine until the day she dies:

> If I went into old age and I was still smoking cocaine, I'd be a soldier … I'd be a toughie, I'd be a real toughie. I'd be really proud of myself that I hadn't bowed to social pressure – treatment and this and that and

> police … Personally, I'd like to use until the day I die and that would be my choice. (Dennis and Pienaar, 2023, 796).

Kim refuses treatment narratives that erase the life-affirming aspects of her drug use and seek her 'recovery'. Even though her drug use may be judged as dependent and therefore problematic by outsiders, she tells us how she cares for herself and others. Like many other people I have met who use drugs in ways that attract the label of dependency and addiction, she refuses a narrative that she is ill. Instead, if listened to, she is changing the terms of what it means to live a worthwhile life.

To drive home what is at stake here, if this is not already clear from these harrowing accounts of blocked, constrained lives, every year for a decade now, more people in the UK are dying of 'drug-related' causes. In an article published in 2021, I argued that we are failing to respond to the needs of people who use drugs, particularly through our abstinence-driven treatment system, where, as we see in James' testimony, this does not work for everyone. Rather than doubling down on drugs as 'the problem' and therefore the solution being abstinence, James is encouraging us to see the problem as coming from elsewhere. Here, I have located this 'problem' in a process of stratification that is dramatised in the three accounts of blocked becoming, with the first example showing explicitly how life can be ended by these processes. As we have seen, it is not the drug that is responsible for these constraints, but its connections to those images, knowledges, and objects (such as the 'pins' in Lucy's story) that depict these person-bodies as 'addicts' – diseased, devoid, less-than-human, or, in Latimer's (2018) terms, a living death. To intervene and undo these 'blockages', we must learn to dwell alongside these body-persons differently, work to become more response-able to them, and in essence, value these lives as worthy lives.

Let me now give an example of what I mean. After publishing the article saying that rising drug-related deaths were linked to our limited response-ability to these lives, particularly when it comes to prescribing diamorphine, I received several desperate emails from people who use drugs, their family members, and a prescriber. They all spoke of how their lives or the lives of their loved ones or people they worked with had been made on substances such as diamorphine (not despite them) – a family, career, home-life, their health and wellbeing – and these were now under threat as they had been told their prescription would be stopped or had already been.

One woman wrote to me explaining how she had been on a daily pickup prescription of diamorphine since 1992, 'working, feeling fine, healthy, exercising, et cetera' until her prescription was recently and abruptly ended. She felt forced back to the illicit market and now has non-healing wounds from her injecting sites. She has begged to be restarted on diamorphine, but was told this is not possible. One daughter who writes to me on behalf of

her father struggles to understand how medical professionals are failing to see the good that diamorphine has done in her father's life – allowing him to work, care for his children, grandchildren, and manage back pain and other chronic health issues – and cannot 'fathom how any medical professional would hold themselves accountable to make a decision to stop it!'

To challenge stigma as a relational process of becoming blocked and act in solidarity with people who use drugs, we must open ourselves up to these different ways of being and question where harm or the problem of drug use is actually coming from. As Latimer (2018, 846) puts it in relation to people with dementia who are often described as 'away' and elsewhere, 'we have to consider that it may be "us" that are elsewhere. Us, with our projects and our futures who are really "away"'. By seeing stigma as relational in the processes of blocked becoming – nearly dying, unable to socialise, unemployed – rather than the consequences of the drug or addiction, we can shift an image of addiction as inevitable decline and harm. To reiterate from the epigraph: 'By shifting our relations to the characteristics we are being made to see as [the disease problem/addiction], we can refigure them as ways of being in the world differently, and as such, as other ways of being human' (Latimer, 2018, 848).

As researchers, we must tell such counter-stories and spotlight grassroots movements where alternative ways of living with drugs are taking place, like in James' experience of harm reduction activism. As Zigon (2019, 111) explains, 'to practice harm reduction is to let-users-be and to build worlds that are open to this letting-be'. This is an alternative form of care that refuses the 'negative imagery of the addict' that 'result[s] in the fact that the only kind of care available for the "addict", when any care is available at all, is that biopolitical care that demands that the "addict" becomes "clean"' (Zigon, 2019, 141). I would add that this is different, too, from the biomedical care predicated on the 'addicted subject' accepting their status as 'sick', a logic that anti-stigma work frequently relies on. Therefore, in these alternative acts of care and solidarity, we make space for the kinds of being-with drugs that James and Kim call for in questioning where 'the problem' is coming from and our role in this problem-making. In other words, it is through these acts of care that we can foster acceptance and dismantle stigma.

Conclusion

In this chapter, I have presented three accounts of stigma as 'blocked becomings', where people who use drugs have been prevented from becoming a patient, guest, and employee, as well as many other identities such as partner, son, and father. Rather than thinking of stigma as something that happens prior to these events – as a belief system 'out there' and already stigmatised individuals entering the event – I have examined the ways in

which stigma materialises in these events as constricting peoples' capacities to act and be outside of the addict identity. The blocking effects often attributed to the drug, addiction, or the failed person – depicted here through accounts of near-fatal overdose, social and familial exclusion, and unemployment – are coming from these processes. In this sense, more so than in Goffman's (1963) classic account of stigma as relational, attention is steered away from the individual or aggregates of individuals to that of the relation. In doing so, this also does something else. Instead of looking to anti-stigma work that claims to tackle stigmatising beliefs, this approach invites a closer look at where the problem is coming from.

By attuning to the complex interplays between 'the social' and 'the individual', this is not about seeing the human behind the illness as anti-addiction stigma campaigns proclaim: '[Stigmatising beliefs and attitudes] create stereotypes, judgements and biases, stopping us from seeing the human being behind the illness' (NHS Addiction Provider Alliance, 2022). But rather, this is precisely about seeing the human in the illness or, even more precisely, seeing the human because these practices are no longer seen as illness. But there is more. By becoming response-able to people's lives with drugs as alternative modes of living or being human, we can ask more productive questions to the effect of what more we can do to enable flourishing with drugs, rather than simply how we make people end and recover from them. It is this socio-material care work that I think of as anti-stigma work.

Could things be different?

- It is rarely helpful to understand frequent drug use as addiction. Stigma could be reduced by developing greater acceptance of different ways of living with drugs.
- If frequent, heavy drug use was not always seen as a problem of addiction that needs to be reversed, people might be enabled (and resources allocated) to live with drugs in more positive ways.
- If this is going to be achieved, then people working in these fields need to collaborate with affected communities and particularly activists who are already involved in this work of reconceptualising and putting into practice alternative care structures.
- More training and research informed by the harm reduction movement and ethos will be needed to undo dominant thinking about regular drug use and promote more creative thinking about the diverse role of drugs in peoples' lives.

Acknowledgements

Thank you to the editors for producing such a warm and generative space for collaboration on this project. I am especially thankful to Oli Williams

and Amy Chandler for their insightful and constructive comments on the chapter, and to Andy Guise for his thoughts on an earlier draft.

References

Addison, M., McGovern, W. and McGovern, R. (2022) *Drugs, Identity and Stigma*, Basingstoke: Palgrave Macmillan.

Alexandrescu, L. (forthcoming) *Drugscapes: Imaginaries of Intoxication, Dependency, and Control*, London: Routledge.

BBC Radio 4 (2022) 'High anxiety: The deadly trade in street Valium', *BBC*, [online] 6 November 2022, Available from: https://www.bbc.co.uk/programmes/m001dnbr [Accessed 7 June 2024].

Campbell, N. (2023) 'Confronting the drug war session 5: Deconstructing the brain disease model of addiction', *YouTube*, [online] 3 August, Available from: https://www.youtube.com/watch?v=qvovM4eF7d8 [Accessed 7 June 2024].

Deleuze, G. and Guattari, F. (1987) *A Thousand Plateaus: Capitalism and Schizophrenia*, Minneapolis, MN: University of Minnesota Press.

Dennis, F. (2021) 'Advocating for diamorphine: Cosmopolitical care and collective action in the ruins of the "old British system"', *Critical Public Health*, 31(2): 144–55.

Dennis, F. and Pienaar, K. (2023) 'Refusing recovery, living a "wayward life": A feminist analysis of women's drug use', *The Sociological Review* 71(4): 781–800.

Fraser, S., Pienaar, K., Dilkes-Frayne, E., Moore, D., Kokanovic, R., Treloar, C. and Dunlop, A. (2017) 'Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis', *International Journal of Drug Policy* 44: 192–201.

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*, Harmondsworth and Ringwood: Penguin.

Hannem, S. and Brucket, C. (2012) *Stigma Revisited: Implications of the Mark*, Ottawa: University of Ottawa Press.

Harris, M., Guy, D., Picchio, C.A., White, T.M., Rhodes, T. and Lazarus, J.V. (2021) 'Conceptualising hepatitis C stigma: A thematic synthesis of qualitative research', *International Journal of Drug Policy*, 96: 103320.

Kulesza, M., Larimer, M. and Rao, D. (2013) 'Substance use related stigma: What we know and the way forward', *Journal of Addictive Behaviours, Therapy and Rehabilitation*, 2(2): 782.

Latimer, J. (2018) 'Repelling neoliberal world-making? How the ageing–dementia relation is reassembling the social', *The Sociological Review*, 66(4): 832–56.

Malins, P. (2004) 'Machinic assemblages: Deleuze, Guattari and an ethico-aesthetics of drug use', *Janus Head*, 7(1): 84–104.

NHS Addiction Provider Alliance (2022) 'Stigma kills campaign', *NHS*, [online], Available from: https://www.nhsapa.org/stigma [Accessed 7 June 2024].

Parker, R. and Aggleton, P. (2003) 'HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action', *Social Science and Medicine*, 57(1): 13–24.

Paton, K. (2018) 'Beyond legacy: Backstage stigmatisation and "trickle-up" politics of urban regeneration', *The Sociological Review*, 66(4): 919–34.

Radcliffe, P. and Stevens, A. (2008) 'Are drug treatment services only for "thieving junkie scumbags"? Drug users and the management of stigmatised identities', *Social Science and Medicine*, 67(7): 1065–73.

Scambler, G. (2018) 'Heaping blame on shame: "Weaponising stigma" for neoliberal times', *The Sociological Review*, 66(4): 766–82.

Simmonds, L. and Coomber, R. (2009) 'Injecting drug users: A stigmatised and stigmatising population', *International Journal of Drug Policy*, 20(2): 121–30.

Tyler, I. (2018) 'Resituating Erving Goffman: From stigma power to Black power', *The Sociological Review*, 66(4): 744–65.

Tyler, I. (2020) *Stigma: The Machinery of Inequality*, London: Bloomsbury Publishing.

Tyler, I. and Slater, T. (2018) *The Sociology of Stigma*, London: SAGE/ Sociological Review Monograph.

Vitellone, N. (2010) 'Just another night in the shooting gallery? The syringe, space, and affect', *Environment and Planning D: Society and Space*, 28(5): 867–80.

Zigon, J. (2019) *A War on People: Drug User Politics and a New Ethics of Community*, Oakland: University of California Press.