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## **Injecting-related discrimination: a social identity perspective**

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### **Introduction**

Submissions to a NSW State Government enquiry into hepatitis C-related discrimination referred to a cultural norm of discrimination against injecting drug users within the healthcare system (ADB of NSW, 2001). Some doctors and nurses were said to practice punitive measures when they identified patients as being ex or current users. These healthcare workers were reported to view illicit drug use as a criminal rather than a public health issue.

In a study of people with hepatitis C conducted by the National Centre in HIV Social Research (Hopwood and Treloar, 2003), discrimination was found to be particularly salient for ex and current users. Ex and current users were more likely than those who had never injected to report refusal of medical treatment because they were perceived to be currently injecting. Those people who had acquired their infection from injecting were more likely than others to report discrimination from a healthcare worker, and current users were more likely than others to report injecting-related discrimination from a doctor. Finally, current users were more likely than others to report that they had received no information about hep C from a doctor following their diagnosis. Results from a recent study of Sydney heroin users by Day et al., (2003) described the occurrence of injecting-related discrimination in healthcare as a deterrent to users accessing BBV prevention information, hepatitis B vaccination and entry into drug treatment. While it is important to acknowledge that not all healthcare workers discriminate against users, together, these findings may highlight ongoing systemic tensions within healthcare delivery in NSW.

By drawing on data from The 3D Project and the ADB Enquiry, this paper explores the occurrence of injecting-related discrimination within healthcare settings through the theoretical framework of social identity. This perspective explains discrimination between social groups which inhabit distinctive positions in relation to community and social power, and it also proposes strategies by which inter-group bias and conflict may be ameliorated. We conclude by looking briefly at some of these measures, and the barriers to their success.

### **Social Identity Theory (SIT)**

Specifically, Social Identity Theory involves three basic assumptions: (i) people categorise others into in-groups and out-groups; (ii) people are motivated to strive for a positive self-concept and gain a sense of esteem by identifying with a particular in-group; and (iii) people's self-concept partly depends on how they evaluate their in-group compared with other groups (Brown, 2000). This theory describes people's desire to belong to a 'superior' group, and to claim the psychological, social and material benefits obtained from such membership. A review of social identity research by Rupert Brown (2000) has found strong support for the hypothesis that the esteem and cohesion of in-group members increases when discrimination is enacted against an out-group. Discrimination is a means by which powerful community groups defend against overt threats to cultural values. By marginalizing certain groups, societies articulate important community values and define boundaries of accepted behaviours.

The two social groups of principal concern here are healthcare workers and injecting drug users. These are not mutually exclusive personal identity categories however they do exist in distinct social identity positions.

#### *Healthcare workers*

In this analysis healthcare workers comprise the hegemonic in-group. Healthcare is a high status occupation and service industry and its workers are afforded significant prestige. Boundaries are firmly delineated and impermeable with regard to group membership. Doctors,

specialists and nurses often strongly identify with their profession or 'group'. Social Identity Theory (SIT) predicts that the higher the status of an in-group and the stronger members identify with their in-group, the more in-group bias, or favouritism, is observed among members and the stronger their differentiation from out-siders will be. Within this professional world-view, healthy people and behaviour are constructed in very specific terms with little tolerance for accommodating alternative understandings. This bias has implications for lower status social groups.

### *Injecting Drug Users*

On the other hand, injecting drug use is one of the most universally stigmatised behaviours, and users belong to some of the most marginalised populations (Gilmore 1996). Sociologist Rebecca Fulton (1999) writes that because of the way society views illicit drug use and injecting drug users, that is, as a manifestation of deviance and criminality, people are socialised to hold certain beliefs about users and come to question their value as members of society, their ability to find and maintain employment, and their capacity to form relationships with family and others. Injecting drug users are assumed to be addicted and to have close ties with crime in order to finance their addiction. People who use drugs are often stereotyped as a danger to the community because they're likely to spread their negative characteristics to others. This seems especially true if the user comes from a poor socio-economic background and injects heroin (Acker 1993; Jones et al. 1984; Fulton 1999). Most of the current injecting drug users in The 3D Project were on very low incomes and using heroin.

From the perspective of SIT, a heterogeneous collection of individuals become a low-status, unitary social group through out-group homogeneity, that is, the tendency for hegemonic social groups to categorise those who participate in stigmatised activities as being "all the same". While this essentialising discourse belies the diversity of people who inject, it is their shared practice of injecting that is the most salient feature for non-users. In this analysis, healthcare workers achieve a positive differentiation from people who inject through categorising and stereotyping to reinforce a perception that "we are not like them". Brewer (1999) suggests that in large and depersonalised in-groups, like healthcare, ideologies of

moral superiority may give legitimacy to the poor treatment of out-groups. Similarly, Leyens et al (2000) have explored the attribution of emotional states in inter-group relations and tentatively suggest that in extreme cases, dominant groups may perceive their fellow members as more human than out-group members. They speculate that such beliefs could lead to a dehumanisation of out-group members and legitimate discrimination against them.

### **The 3D Project Results**

The 3D Project found that ex and current users were significantly more likely to report having being refused medical treatment because it was assumed they were currently injecting. Refusal of medical treatment exemplifies the creation of boundaries that social identity theory predicts will occur when specific groups or practices are deemed incompatible or threaten hegemonic group values. As Gilmore (1996) states, healthcare workers who do not use illicit drugs and who come into contact with users may view those that do use as morally, personally and biologically inadequate. Significantly, prohibition positions drug users as criminals flouting the rules of society. If participation in an illegal activity is also synonymous with the transmission of disease as well as other negative health outcomes, SIT predicts that those whom eschew these activities will act to distance themselves from people involved in order to preserve in-group safety and uphold in-group values. Boundaries are created to delineate the in-group containing rational, healthy, law-abiding citizens and those deviant 'others' who compromise their mental and physical health by choosing to use illicit drugs. Boundaries reaffirm hegemonic social values (ie. observation of the law and the prioritising of one's health) by excluding deviant ones (Gilmore and Sommerville, 1994). Boundaries satisfy the in-group's need for security, and bolster a collective self-concept and sense of esteem. Denying ex and current users access to healthcare illustrates medicine's status to designate out-groups and articulate impermeable boundaries.

Our study found that ex users were more likely than others to report that a healthcare worker had discriminated against them because they were assumed to be currently injecting. Current users were more likely to report injecting-related discrimination from their doctor. And participants who reported receiving no information, advice or referral from their doctor at

diagnosis regarding their infection, were more likely to be current users. These findings may be explained by recent research by Hebl et al (2000) into varied forms of discrimination against people in stigmatised roles in naturalistic settings. Their work demonstrates that out-groups are responded to significantly more negatively in interpersonal ways. Some of these ways include shorter interpersonal interactions, less words spoken during interactions and less adherence to common courtesies. Our qualitative data highlights some participants' concerns regarding the quality of verbal communication with doctors when receiving their hepatitis C diagnosis and during subsequent consultations. In our study, some current users may have received no explanation or information about their infection because of a tendency for some doctors to shorten consultation times and engage less with these patients. This behaviour may be enacted to communicate a doctor's disapproval regarding a patient's source of hepatitis C infection and in some cases to discourage patients from returning for further treatment.

### **Improving inter-group relations**

Given this perspective, how can SIT contribute to ameliorating injecting-related discrimination in the context of healthcare? What practical solutions can it offer? As far back as the 1950s, Allport's (1958) Contact Hypothesis was touted as an effective strategy for minimising inter-group conflict when certain conditions prevailed. In the last two decades, theorists have built upon Allport's work with regards to two strategies for improving inter-group relations. Efforts to de-categorise group perceptions, that is, to challenge negative stereotypes and negative affect through ongoing positive group interaction, have been successful in reducing in-group bias and discrimination against out-groups. Another significant strategy has been to develop and nurture a common-group identity so that former rivals become subsumed into a superordinate social grouping (Brown, 2000).

However, it is questionable whether either of these approaches can be helpful in the context of injecting-related discrimination by healthcare workers without significant structural change to the field in which social relations occur. Processes that work well to dissolve impermeable group boundaries and improve inter-group relations that exist within the law may be stymied by criminalisation of drug use. Challenging healthcare workers' negative

perceptions and affectations about users, creating conditions for ongoing close and positive contact between users and healthcare workers, and the formation of a common-group identity are strategies that are difficult to implement under current conditions. The illegal status of drug use represents one of the most significant barriers to blurring the group boundaries between users and healthcare workers.

## **Conclusion**

Our data identifies ex and current users as being at increased risk of discrimination from healthcare workers. Social Identity Theory indicates that discrimination against people who inject illicit drugs may serve a socially adaptive function for certain groups by reinforcing cultural norms and values. Discriminatory responses from healthcare workers reflect attempts to establish and maintain distance from users and to uphold what are seen as important community and health profession values. However, continued discrimination and stigmatisation of people who inject will obstruct efforts to encourage people into treatment and undermine prevention of the further spread of blood-borne viruses like hepatitis C. Significant legal reform could pave the way for broader changes in the attitudes and social norms that currently inform discriminatory practice, leading to opportunities to improve relations between what are currently polarised social identities of injecting drug user and healthcare worker.

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