



The Stigmatization of Addiction

Surveying Social Shame

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In this literature review essay, Hannah Freeman brings together diverse scholarship detailing the relationship between addiction and social shame. Freeman concludes that only a multipronged strategy accounting for actionable knowledge, education, and public marketing can most effectively destigmatize addiction and allow addicts unfettered access to healthy rehabilitation. This essay was written for *Drugs and Society* with Dr. Chris Garneau.

ABSTRACT

The stigmatization of shame that addicts face is multifaceted. The objective of this literature review is to examine the relationship in all forms. To begin, multiple types of addiction are explored: substance addiction and pornography addiction. The relationship between treatment and shame is examined. Harm reduction as a drug education approach for children is advised. Primary care bias concerning addicts is reviewed. Drugs laws and how they contribute to the stigmatization of addicts are discussed, along with the best way to combat stigmas: social marketing.

Keywords: addiction, stigmas, shame, drug use, treatment

STIGMA AND SHAME WEAVE a tangled web with addiction. It is a classic chicken-and-egg situation; which came first, the shame or the addiction? That is still unknown. What is known is that stigmas about addiction exist and permeate the lives of millions. Shame among addicts exists and is an unnecessary roadblock to have today. There seems to be a cycle of shame that cannot be broken until we as a society have changed. Stigmas concerning addicts refuse to allow addicts to be seen as people. This literature review addresses two types of addictions: drugs and pornography. Treatment focusing on the impacts of shame is addressed. Optimal methods for children's drug education are discussed, along with how drug laws produce stigma. Stigmas concerning primary care providers are also discussed, as well as the best way to publicly combat stigmas.

The word "shame" conjures up many images, all inherently negative. Wiechelt (2007) examined the array of shame in relation to substance misuse. In the United States, being shameful is not something one needs to ever admit. The Western culture of hiding shame only creates a cycle of shame upon shame. Wiechelt (2007) looked at two types of shame: internalized shame and shame as a self-conscious and moral emotion. Internalized shame is something some individuals are born to have as a response. Shame is even considered something that translates across cultures. The psychological effect of shame also produces a cycle of shame. Shame can be a healthy way of realizing when social norms have been broken. However, shame becomes inappropriate when it is integral to one's identity. The second type of shame, self-conscious and moral emotion, evidences that shame and guilt are two separate constructs. Shame stems from feelings towards oneself while guilt stems from a behavior. To explain addiction, Wiechelt (2007) claimed addicts use their substance to relieve their shame. However, using a drug creates more shame. This leads to abusing a substance in order to relieve the cycle of shame. Wiechelt (2007) also said shame from substance

abuse stems from two places: family of origin and trauma. Dysfunctional families and trauma are closely tied into high rates of substance abuse in individuals.

Belief systems also contribute to the shame. Wiens and Walker (2015) analyzed problem drinkers' belief systems for addiction in relation to stigma and shame. The two belief models studied for addiction respectively emphasized disease, psychosocial conceptualization, alongside a control group with no specific belief model. The results did not show that differing beliefs about addiction had any effect on stigmas regarding a past addiction. There was also no correlation between beliefs and stigmas regarding a current addiction. However, Wiens and Walker (2015) found that people who conform to the disease model and psychosocial model do have a stigma level higher than those from a control group. This concludes that belief, in any model, does have a relationship with stigma and shame. The stigmas only applied to current addictions and not ones from the past. Limitations of this study includes the generalizing of stigmas and a small sample size. There are different forms of stigmas, and people's stigmas in relation to the models could differ.

Chisholm and Gall (2015) examined men's addiction to pornography and how shame plays a role. The study noted how 20% of men admitted to watching pornography and did not find their own actions to be appropriate. Chisholm and Gall (2015) suggested that shame is the underlying behavior. Shame creates room for rumination and potentially sparks feelings of lacking responsibility for one's actions. However, it is important to create a clear distinction between shame and guilt. If a person has guilt, they are taking responsibility for what they have done. "Shame is saying 'I am a bad person' while guilt is saying 'I have done something bad'" (Chisholm & Gall, 2015, p. 261). Among men in treatment for a pornography addiction, those with high levels of shame were found to be more hypersexual than those with high levels of guilt. It was also found that men who were willing to modify their behavior had high levels of shame and low levels of guilt. Those who have high levels of

shame seem to be more likely to perform hypersexual behaviors like watching pornography excessively. Self-compassion was found to be a slight reliever of shame. This suggests self-compassion could be a valuable key to rehabilitation for individuals with a pornography addiction.

If an addict seeks treatment, depending on their own view of themselves, stigmas can play a role in the course of recovery. Luoma, Kulesza, Hayes, Kohlenberg, and Larimer (2014) examined three levels of stigmas in relation to time spent in residential treatment for substance abuse disorder. The three levels of stigmas reviewed were self-stigmas, enacted stigmas, and shame. The results found that increased levels of a self-stigma correlate to longer stays in residential treatment. Luoma et al. (2014) argued that what they found suggests that the users receive a type of comfort in the treatment facility. They also suggested users especially find comfort away from the societal judgement or stigma they would receive on the outside. A notable limitation from this study was its small sample size. Luoma et al. (2014) encouraged treatment facilities to devise specialized treatment for people who report a high self-stigma level in the hopes that their stay is decreased, and the cost is not as high.

Da Silveira et al. (2018) examined the self-stigma concerning addicts who were seeking treatment. Individuals who were alcohol or crack cocaine addicts were used for this study. Three models were compared to help gain a clear understanding of self-stigmas: socio-demographic, psychological, and psychosocial models. The results concluded that the psychosocial model has a clearer explanation for self-stigma than the other two models. Building from this result, da Silveira et al. (2018) suggested that those with higher self-stigmas are afraid of the outside world. They are afraid of rejection and the stigmas from others they would have to endure. A limitation in this study is that only correlation, not causation, can only be found. Da Silveira et al. (2018) suggested a longitudinal study for more conclusive results.

Meehan (2017) reviewed drug education for schools in relation to stigmas in Ireland. Since 1992, a policy has been in place that requires drug education. However, the information approach is used there. An information approach implies adolescents will try drugs because they are blind to the dangers of the drugs. To combat this, educators try to make the drugs as unappealing as possible. They do this through fear with shocking images or stories. It is well known that this approach does not work. Meehan (2017) documented the teachers' own biases towards drugs. These could make students feel like they cannot ask questions in fear of alienation or judgement. Meehan (2017) also suggested a harm-reduction approach to drug education in schools. This type of approach would provide actual, not fear-based, knowledge of drugs and encourage a safe environment for questions.

Seear, Lancaster, and Ritter (2017) reviewed drugs laws in Australia and how they produce stigmas. Seear et al. (2017) began by stating that an important first step is working out how drug laws produce stigmas. Stigmas result from the ways the laws are written and enforced. Those in power often have people they want to send a message to, whether it is addicts, criminals, etc. Burris (as cited in Seear et al., 2017, p. 599) said it best concerning power and stigmas: "Sensitivity to the way stigma operates, particularly through self-lacerating shame and self-discrimination, invites reflection on whether it is morally acceptable to use stigma as a means of social control, even for public-health purposes." Before studying future laws, stigmas must be reevaluated under performative theory. This means stigma must be seen as something that is made, not natural.

Flanagan et al. (2016) investigated primary care stigmas towards individuals with a mental illness or addiction. To do this, participants were taught how to create a Recovery Speaks Performance. A Recovery Speaks Performance involves a retelling of a person's recovery, in detail, with pictures. Twenty-seven primary care providers were split up into two groups: a control and a performance

group. The primary care providers in the performance group reported on average liking the performance, a slight change in their perception, and a slight change in their practice. One primary care provider said, “I was impressed that people stood up and shared their stories. I found it very moving. I learned a lot about how people feel about stigma and how they are perceived and how that affects how they perceive themselves” (Flanagan et al., 2016, p.567). Comparing the two groups, the primary care providers who viewed the Recovery Speaks Performance reported a general better understanding of people who suffer from mental illnesses and addiction.

Lavack (2007) analyzed current stigmas for addictions and the best way to combat them. Lavack (2007) suggested in order to help individuals who are addicted to substances or abuse substances, the stigma needs to be removed. Looking at the attribution-emotional model of stigmatization, two responses are elicited: anger and pity. Anger is produced when it seems an individual is at fault for their own predicament. Pity is produced when it seems like the individual is not at fault. Addiction, in the eyes of most, produces anger. People who fall under the pitied category are better liked and are given more leeway. Lavack (2007) suggests social marketing as a way to correct society’s stigmatization of addiction. First, advocates would market a better understanding of the relationship between addiction and stigmas. The second task would be to convince people to give up their stigmas to ensure addicts receive help is a worthwhile cause. The third task would be to introduce this message to the media. The final step would continue promoting the message and idea.

The stigmatization or shame that addicts face is multifaceted. There exists plentiful research on stigmas and addiction, all of it confirming a relationship between the two. However, an all-encompassing view seems to be lacking, and rectifying that was a goal in this paper. This issue is important because the world is currently in an opioid epidemic, and prosocial behavior is key. People cannot fall suspect to incorrect fears or views of addicts. Addicts need to receive

compassion from society, and then maybe they can start turning that compassion in on themselves.

Harm reduction is a crucial way to start the process of prosocial behavior. It is also an effective educational approach. Empathy for addicts needs to be introduced. An effective way to implement this would be in schools across the United States. Individuals out of school already should follow Meehan's (2017) guidelines for the social marketing of de-stigmatization. The evidence that empathy for addicts exists is already known due to the study by Flanagan et al (2016); the primary care provider, after exposed to the reality of trouble addicts face, had empathy. Following Seear et al.'s (2017) example, politicians could review the current drugs laws to see if the language and the execution of the laws are reinforcing stigmas. The most important step to take is the reintroduction of empathy which calls for the ending of stigmas and the cycle of shame concerning addicts. ►►

►► REFERENCES

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