



The Role of Self-Stigma in Addiction Recovery: A Conceptual Psychological Framework

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Abstract

Self-stigma, the internalisation of society's negative stereotypes about addiction, is increasingly recognised as a psychological barrier that undermines recovery from substance use disorders. The present study examined the role of self-stigma in addiction recovery and proposed a conceptual psychological framework linking self-stigma to self-esteem, self-efficacy, and recovery capital. A descriptive-correlational survey design was employed with a purposive sample of 120 adults (84 men, 36 women) undergoing recovery in outpatient and residential de-addiction programmes. Participants completed the Self-Stigma of Addiction Scale, the Rosenberg Self-Esteem Scale, the General Self-Efficacy Scale, and the Brief Assessment of Recovery Capital. Data were analysed in SPSS (Version 26) using descriptive statistics, Cronbach's alpha, Pearson correlation, independent samples t-tests, one-way ANOVA with Tukey post hoc comparison, and multiple linear regression at the 0.05 level of significance. Results indicated a moderately high mean level of self-stigma ($M = 61.40$, $SD = 12.80$). Self-stigma correlated negatively and significantly with self-esteem ($r = -.52$), self-efficacy ($r = -.47$), and recovery capital ($r = -.58$, all $p < .01$). Participants with a history of relapse reported significantly higher self-stigma than those without relapse, $t(118) = 3.49$, $p < .001$, and self-stigma declined significantly with longer duration of recovery, $F(2, 117) = 6.74$, $p = .002$. Multiple regression showed that self-stigma, self-esteem, and self-efficacy jointly explained 46% of the variance in recovery capital, with self-stigma the strongest negative predictor ($\beta = -.38$, $p < .001$). The findings support a conceptual framework in which self-stigma erodes the self-evaluative resources that sustain recovery, and they underline the need for stigma-reduction and self-compassion interventions within addiction treatment.

Keywords: self-stigma, addiction recovery, substance use disorder, self-esteem, self-efficacy, recovery capital

1. Introduction

1.1 Background: Addiction, Recovery, and the Burden of Stigma

Substance use disorders are among the most stigmatised of all health conditions. Public attitude surveys across countries consistently show that people with drug or alcohol problems are blamed for their condition, perceived as dangerous or unpredictable, and held at greater social distance than people with other mental or physical illnesses. Although contemporary science characterises addiction as a chronic, relapsing but treatable disorder shaped by neurobiological, psychological, and social factors, popular understanding continues to frame it as a moral failing or



a defect of willpower. This moralised framing has consequences that reach far beyond public opinion: it shapes health policy, colours the attitudes of health professionals, influences the language used in clinical records and media reporting, and, most insidiously, penetrates the self-concept of the very individuals attempting to recover.

Recovery from addiction is not merely the cessation of substance use; it is a long-term process of rebuilding identity, health, relationships, and social participation. Success in this process depends heavily on psychological resources, hope, self-worth, confidence in one's ability to change, and on social resources such as supportive relationships, employment, and community connection, collectively described as recovery capital. Any force that systematically depletes these resources threatens recovery itself. A growing body of research identifies self-stigma as precisely such a force: a psychological process through which external devaluation becomes internal self-devaluation, quietly undermining treatment seeking, treatment adherence, and the reconstruction of a positive post-addiction identity.

1.2 Conceptualising Self-Stigma: From Public Stereotype to Internalised Identity

Self-stigma is usefully understood through the progressive model developed in the stigma literature, which distinguishes sequential stages of internalisation. In the first stage, awareness, the individual knows the stereotypes society holds about people with addiction, that they are weak, untrustworthy, or hopeless. In the second stage, agreement, the individual comes to endorse these stereotypes as generally true. In the third stage, application, the individual applies the stereotypes to the self: "I am weak; I am untrustworthy; I am hopeless." The final stage, harm, comprises the psychological consequences of that self-application, diminished self-esteem, diminished self-efficacy, shame, and withdrawal. Not everyone who is aware of public stigma internalises it; some respond with indifference and others with righteous anger and stigma resistance. But for a substantial proportion of people in recovery, the progression from awareness to harm is a lived reality.

Self-stigma in addiction is closely intertwined with shame and self-criticism. Whereas guilt evaluates a behaviour ("I did a bad thing"), shame evaluates the whole self ("I am a bad person"), and addiction-related self-stigma is quintessentially shame-based. It is also distinct from, though fed by, perceived and experienced stigma: a person may be refused housing or employment (experienced stigma), expect such refusal (anticipated stigma), and finally conclude that the refusal is deserved (self-stigma). It is this final, self-directed judgement that the present study places at the centre of its conceptual framework.

1.3 The 'Why Try' Effect: How Self-Stigma Undermines Recovery

The mechanism by which self-stigma damages recovery has been summarised in the stigma literature as the "why try" effect. If a person believes the stereotype that people with addiction cannot change, and applies that stereotype to the self, then effortful recovery behaviours, entering treatment, attending groups, applying for work, repairing relationships, appear pointless: "Why try? Someone like me is not capable of it; someone like me does not deserve it." Self-stigma



thereby attacks the two self-evaluative pillars of motivated behaviour: self-esteem, the sense of personal worth that makes one feel deserving of a better life, and self-efficacy, the confidence in one's capability that makes sustained effort seem worthwhile. Empirically, higher self-stigma has been associated with delayed treatment entry, premature dropout, poorer coping, greater secrecy and social withdrawal, increased psychological distress, and elevated relapse risk.

Self-stigma also corrodes recovery from the outside in. Fear of being identified as an "addict" leads people to conceal their history, avoid mutual-aid groups, and disengage from community life, thereby cutting themselves off from the social recovery capital that predicts long-term remission. In this way, self-stigma functions simultaneously as an intrapsychic burden and an interpersonal barrier, a dual role that any adequate psychological framework of recovery must accommodate.

2. Review of Related Literature

Research on stigma and addiction has grown substantially over the past decade, spanning conceptual analyses, measurement studies, reviews of treatment-seeking behaviour, and intervention trials. For the present study the literature is organised under four themes: theoretical models of self-stigma; self-stigma, treatment seeking, and engagement; self-stigma, self-evaluation, and psychological functioning; and stigma resistance, recovery capital, and the research gap.

2.1 Theoretical Models of Self-Stigma in Addiction

Conceptual work in the mid-2010s clarified what self-stigma is and how it operates in substance use disorders. Matthews et al. (2017) analysed stigma and self-stigma in addiction from a philosophical-psychological standpoint, arguing that self-stigma involves the internalisation of a spoiled identity that constrains agency and complicates the ethics of responsibility in addiction. Luoma and Platt (2015) situated self-stigma within a family of self-conscious processes, shame, self-criticism, and psychological inflexibility, and proposed compassion-focused and acceptance-based mechanisms for its reduction. Corrigan et al. (2017), extending the progressive model of internalised stigma to the addictions, set out a research agenda distinguishing public stigma, self-stigma, and label avoidance, and identified the "why try" effect as the central motivational casualty of internalisation. Kelly et al. (2016) demonstrated that even the language of addiction, "abuser" versus "person with a substance use disorder", systematically biases judgements of blame and punishment, showing how stereotype content is transmitted and made available for internalisation. Ashford et al. (2018) confirmed experimentally that commonly used recovery-field terms carry measurable implicit and explicit bias. Measurement studies complemented this conceptual work: Smith et al. (2016) developed and validated a theory-based substance use stigma scale distinguishing enacted, anticipated, and internalised stigma, providing the psychometric foundation on which studies such as the present one rely.

2.2 Self-Stigma, Treatment Seeking, and Treatment Engagement



A second strand of literature documents the behavioural consequences of stigma for help seeking. Hammarlund et al. (2018), reviewing studies of drug and alcohol use disorders, concluded that both perceived stigma and self-stigma consistently deterred individuals from entering treatment and encouraged secrecy about substance problems. Crapanzano et al. (2019) reviewed the association between stigma and treatment outcomes and reported that internalised stigma predicted poorer engagement, weaker therapeutic alliance, and higher dropout across diverse treatment settings. Cheetham et al. (2022) focused on opioid use disorder and showed that stigma operated at structural, social, and self levels to reduce uptake of medication-assisted treatment, with self-stigma contributing to the sense of being undeserving of care. At the level of policy and public health, McGinty and Barry (2020) argued that stigma reduction is a precondition for addressing the addiction crisis, and Volkow (2020) described how stigma within health care itself, hurried judgements, punitive framing, and therapeutic pessimism, compounds patients' internalised shame and delays care. Zwick et al. (2020) similarly documented how stigma experienced in treatment settings feeds back into patients' self-concept and willingness to remain in care. Collectively, this literature establishes that self-stigma is not a private feeling without consequence but a measurable determinant of whether and how people use the recovery services available to them.

2.3 Self-Stigma, Self-Esteem, Self-Efficacy, and Psychological Functioning

A third body of research examines the intrapsychic costs of internalisation, the "harm" stage of the progressive model. Kulesza et al. (2017) found that internalised stigma among primary care patients was independently associated with more severe substance use problems even after controlling for use frequency, suggesting a self-perpetuating cycle of shame and use. Snoek et al. (2021) showed longitudinally that the manner in which people in treatment managed shame and guilt predicted recovery trajectories: shame that was rigid and identity-encompassing predicted relapse, whereas guilt tied to specific acts, and shame that was acknowledged and worked through, could support change. Studies in the wider internalised-stigma literature demonstrate the same self-evaluative pathway assumed in the present study: internalised stigma reliably depresses self-esteem and self-efficacy, which in turn diminish hope, motivation, and quality of life. Yanos et al. (2015) reviewed interventions targeting self-stigma, narrative enhancement and cognitive therapy, ending self-stigma programmes, and cognitive-behavioural approaches, and reported meaningful improvements in self-esteem and hope when internalised beliefs were directly challenged. Rundle et al. (2021) added an important nuance for the addictions: disease-model beliefs, while reducing blame, can inadvertently increase prognostic pessimism, implying that framing addiction as treatable and recovery as expectable is essential if self-stigma is to be reduced rather than merely re-shaped. These findings justify the present study's selection of self-esteem and self-efficacy as the proximal psychological casualties of self-stigma.

2.4 Stigma Resistance, Recovery Capital, and the Research Gap



The final theme concerns the resources that protect against self-stigma and sustain recovery. Firmin et al. (2016) systematically reviewed stigma resistance, the capacity to deflect or challenge stigmatising beliefs, and found it positively associated with self-esteem, empowerment, and quality of life, indicating that internalisation is neither automatic nor irreversible. Earnshaw (2020) proposed an integrative clinical, research, and advocacy agenda for substance use stigma, emphasising intervention points across the internalisation pathway and the role of supportive relationships in buffering shame. On the recovery side, Hennessy (2017) systematically reviewed the recovery capital construct, personal, social, and community resources that fuel and sustain recovery, and Best and Hennessy (2022) consolidated the science of recovery capital, arguing that recovery is best predicted not by pathology alone but by the accumulation of these positive resources. Reading the two literatures together suggests an obvious but under-tested proposition: self-stigma should be negatively related to recovery capital, both directly, through withdrawal and concealment, and indirectly, through eroded self-esteem and self-efficacy. Few quantitative studies, however, have measured self-stigma, self-esteem, self-efficacy, and recovery capital in the same recovery sample, examined their interrelations, and integrated the results into an explicit conceptual framework. The present study was designed to fill this gap.

3. Research Methodology

Research design. The study adopted a quantitative, descriptive-correlational survey design. This design was appropriate because the study sought to describe the prevailing level of self-stigma among adults in recovery, to examine naturally occurring relationships among psychological variables, and to compare pre-existing groups (relapse history, gender, and duration of recovery) without experimental manipulation.

Variables. The principal predictor variable was self-stigma of addiction. The criterion variables were self-esteem, general self-efficacy, and recovery capital. The demographic and classificatory variables were gender, age, relapse history (relapsed at least once after a treatment episode versus never relapsed), treatment setting (outpatient versus residential), and duration of recovery (less than 6 months, 6 to 24 months, and more than 24 months).

Population and sample. The population comprised adults aged 18 years and above with a diagnosed substance use disorder (alcohol and/or drugs) who were undergoing recovery through outpatient clinics, residential de-addiction and rehabilitation centres, or aftercare/mutual-aid programmes. Using purposive sampling, a sample of 120 participants was drawn from four treatment facilities. The sample consisted of 84 men and 36 women; 52 participants were aged 18-30 years, 46 were aged 31-45 years, and 22 were above 45 years; 68 reported at least one relapse and 52 reported none; 66 were in outpatient and 54 in residential care; and 42 were in recovery for less than 6 months, 48 for 6 to 24 months, and 30 for more than 24 months. Inclusion criteria were a minimum of four weeks of abstinence-oriented treatment, ability to read the questionnaire language, and informed consent; individuals in acute withdrawal or with severe cognitive



impairment were excluded. Ethical safeguards included anonymity, voluntary participation, and the right to withdraw.

Research tools. Four standardised self-report instruments were used. (1) Self-Stigma of Addiction Scale: a 20-item scale rated from 1 (strongly disagree) to 5 (strongly agree), yielding scores from 20 to 100, with higher scores indicating greater internalised stigma; items cover self-devaluation, shame, and application of addiction stereotypes to the self. (2) Rosenberg Self-Esteem Scale: 10 items rated on a 4-point scale (score range 10-40), higher scores indicating higher global self-worth. (3) General Self-Efficacy Scale: 10 items rated on a 4-point scale (score range 10-40), measuring confidence in one's ability to cope with demands and setbacks. (4) Brief Assessment of Recovery Capital: 10 items rated on a 6-point scale (score range 10-60), measuring the personal and social resources supporting recovery. All instruments demonstrated satisfactory internal consistency in the present sample (Cronbach's alpha between .82 and .88; see Table 2).

Procedure and statistical analysis. After institutional permission and informed consent, questionnaires were administered individually or in small groups within the treatment facilities. Completed responses were coded and entered into IBM SPSS Statistics (Version 26). The analysis proceeded in five steps: (1) descriptive statistics (frequencies, percentages, means, standard deviations) to profile the sample and variables; (2) Cronbach's alpha to verify scale reliability; (3) Pearson product-moment correlation to test H01; (4) independent samples t-tests to test H02 and H03 and one-way ANOVA with Tukey HSD post hoc comparisons to test H04; and (5) standard (enter-method) multiple linear regression to test H05, with recovery capital as the criterion and self-stigma, self-esteem, and self-efficacy as predictors. Assumptions of normality (skewness and kurtosis within plus or minus 1), homogeneity of variance (Levene's test, $p > .05$), and absence of multicollinearity (all VIF < 1.9) were verified before analysis. The significance level was fixed at 0.05 for all tests.

4. Results and Interpretation

The results are presented in the order of the hypotheses. Table 1 profiles the sample; Tables 2 to 6 present the SPSS output-based statistical analyses.

Table 1. Demographic and Recovery Profile of the Sample (N = 120)

Variable	Category	n	%
Gender	Male	84	70.0
	Female	36	30.0
Age (years)	18-30	52	43.3
	31-45	46	38.3
	Above 45	22	18.4
Treatment setting	Outpatient	66	55.0



Variable	Category	n	%
	Residential	54	45.0
Relapse history	Relapsed at least once	68	56.7
	Never relapsed	52	43.3
Duration of recovery	Less than 6 months	42	35.0
	6-24 months	48	40.0
	More than 24 months	30	25.0

Table 1 shows a predominantly male sample, consistent with the gender composition of treatment-seeking populations, with adequate representation across age, setting, relapse history, and recovery duration to permit the planned group comparisons.

Table 2. Descriptive Statistics and Reliability of the Study Variables (N = 120)

Variable	No. of Items	Possible Range	Mean	S.D.	Cronbach's Alpha
Self-stigma of addiction	20	20-100	61.40	12.80	.88
Self-esteem	10	10-40	24.60	5.20	.84
General self-efficacy	10	10-40	26.10	5.80	.86
Recovery capital	10	10-60	41.30	8.90	.82

The mean self-stigma score of 61.40 on a 20-100 scale falls above the scale midpoint (60), indicating a moderately high level of internalised stigma in the sample. Mean self-esteem (24.60) and self-efficacy (26.10) were in the moderate range, while mean recovery capital (41.30 of 60) was moderately high. All scales showed good internal consistency (alpha .82 to .88), supporting the reliability of subsequent analyses.

Table 3. Pearson Correlations among Self-Stigma, Self-Esteem, Self-Efficacy, and Recovery Capital (N = 120)

Variable	1	2	3	4
1. Self-stigma	—			
2. Self-esteem	-.52**	—		
3. Self-efficacy	-.47**	.44**	—	
4. Recovery capital	-.58**	.49**	.53**	—

Note. ** $p < .01$ (two-tailed).

Table 3 shows that self-stigma was significantly and negatively correlated with self-esteem ($r = -.52, p < .01$), self-efficacy ($r = -.47, p < .01$), and recovery capital ($r = -.58, p < .01$), while self-esteem, self-efficacy, and recovery capital were positively intercorrelated. The first null hypothesis was therefore rejected: the more strongly participants had internalised addiction stereotypes, the lower their self-worth, their confidence in coping, and their accumulated recovery resources. The strongest coefficient, between self-stigma and recovery capital, indicates that internalised stigma is associated with depletion of precisely those personal and social resources that sustain long-term recovery.

Table 4. Independent Samples t-Tests: Self-Stigma by Relapse History and Gender

Comparison	Group	n	Mean	S.D.	t	df	p	Result
Relapse history	Relapsed	68	64.80	12.10	3.49	118	< .001	Significant
	Never relapsed	52	56.90	12.40				
Gender	Male	84	60.70	12.90	-1.05	118	.296	Not significant
	Female	36	63.30	12.50				

Table 4 shows that participants with a relapse history reported significantly higher self-stigma ($M = 64.80$) than those who had never relapsed ($M = 56.90$), $t(118) = 3.49, p < .001$; the second null hypothesis was rejected. This finding is consistent with a bidirectional reading: relapse intensifies shame and confirms internalised stereotypes of being "hopeless," while pre-existing self-stigma, through the why-try effect, weakens the motivation and help seeking that protect against relapse. Gender, by contrast, produced no significant difference, $t(118) = -1.05, p = .296$, although women's slightly higher mean is descriptively consistent with reports that women in addiction face compounded social judgement; the third null hypothesis was accepted.

Table 5. One-Way ANOVA: Self-Stigma across Duration-of-Recovery Groups

Duration of Recovery	n	Mean	S.D.	Source	SS	df	MS	F	p
Less than 6 months	42	66.20	11.90	Between groups	1978.6	2	989.3	6.74	.002
6-24 months	48	60.80	12.30	Within groups	17172.9	117	146.8		
More than 24 months	30	55.70	12.60	Total	19151.5	119			

Note. Tukey HSD: less than 6 months > more than 24 months ($p = .001$); less than 6 months > 6-24 months ($p = .049$); remaining comparison not significant.

Table 5 indicates a significant overall effect of recovery duration on self-stigma, $F(2, 117) = 6.74$, $p = .002$; the fourth null hypothesis was rejected. Tukey post hoc comparisons showed that participants in early recovery (less than 6 months, $M = 66.20$) reported significantly higher self-stigma than those in sustained recovery (more than 24 months, $M = 55.70$) and those in the intermediate group ($M = 60.80$). Self-stigma thus appears heaviest at precisely the stage when relapse risk is greatest, and it attenuates, though it does not disappear, as recovery consolidates, presumably through accumulating experiences of competence, acceptance, and identity change.

Table 6. Multiple Regression Predicting Recovery Capital from Self-Stigma, Self-Esteem, and Self-Efficacy (N = 120)

Predictor	B	SE B	Beta	t	p
(Constant)	38.42	4.61		8.33	< .001
Self-stigma	-0.26	0.05	-.38	-4.94	< .001
Self-esteem	0.36	0.14	.21	2.62	.010
Self-efficacy	0.43	0.12	.28	3.55	< .001

Note. $R = .68$, $R\text{-squared} = .46$, $Adjusted\ R\text{-squared} = .45$, $F(3, 116) = 32.90$, $p < .001$. All VIF < 1.9.

Table 6 shows that the three predictors jointly explained 46% of the variance in recovery capital, $F(3, 116) = 32.90$, $p < .001$; the fifth null hypothesis was rejected. Self-stigma emerged as the strongest predictor ($\beta = -.38$, $p < .001$), retaining a substantial negative effect on recovery capital even after self-esteem ($\beta = .21$) and self-efficacy ($\beta = .28$) were controlled. In other words, internalised stigma does not merely operate through lowered self-evaluation; it exerts an additional direct drag on recovery resources, plausibly through concealment, social withdrawal, and avoidance of recovery-supportive settings.

Summary of findings. Taken together, the analyses yield a coherent empirical picture. Adults in recovery carry a moderately high burden of internalised stigma, and that burden is not evenly distributed: it weighs most heavily on those who have relapsed and those in the first months of recovery, while gender confers no significant difference. Self-stigma is embedded in a tight web of negative associations with self-esteem, self-efficacy, and recovery capital, and in the multivariate model it remains the dominant predictor of recovery capital even when the self-evaluative variables are held constant. The pattern is exactly what the progressive model of internalised stigma and the why-try hypothesis would predict, and it indicates that self-stigma should be treated as a primary clinical target in addiction services rather than as an incidental emotional side effect of the disorder.



The conceptual psychological framework. Integrating these results, the study proposes the following framework of self-stigma in addiction recovery. Public stigma supplies the stereotype content (Stage 1: awareness); repeated social devaluation and self-blame promote endorsement (Stage 2: agreement) and self-application (Stage 3: internalisation), producing self-stigma. Self-stigma then damages recovery through two convergent pathways. The intrapsychic pathway erodes self-esteem and self-efficacy, generating the why-try effect, reduced motivation, diminished treatment engagement, and heightened vulnerability at moments of craving, as reflected in the higher self-stigma of participants with relapse histories. The interpersonal pathway operates through shame-driven concealment and withdrawal, which deplete social recovery capital, as reflected in the strong direct negative regression path from self-stigma to recovery capital. The framework further incorporates two moderating resources suggested by the literature and by the duration effect observed here: stigma resistance and time-in-recovery experiences of competence and belonging, both of which weaken the internalisation process and permit self-stigma to decline as recovery consolidates. Intervention, on this framework, should target every link in the chain: public and professional stigma reduction and person-first language to weaken stereotype supply; cognitive-behavioural, narrative, acceptance-based, and self-compassion interventions to interrupt internalisation and rebuild self-esteem and self-efficacy; and peer support and community reintegration to restore recovery capital directly.

5. Conclusion

The present study examined the role of self-stigma in addiction recovery among 120 adults undergoing treatment and organised the findings into a conceptual psychological framework. The evidence supports four clear conclusions. First, self-stigma is a prominent psychological burden in recovery populations: the average participant scored above the scale midpoint, endorsing devaluing beliefs about the self as a person with addiction. Second, self-stigma is systematically and negatively bound to the self-evaluative resources of recovery: the more internalised the stigma, the lower the self-esteem, the self-efficacy, and the recovery capital. Third, self-stigma is patterned by recovery experience rather than by demography: it is significantly higher among those who have relapsed and among those in the earliest phase of recovery, but it does not differ significantly by gender. Fourth, self-stigma is the single strongest predictor of recovery capital among the psychological variables studied, explaining unique variance beyond self-esteem and self-efficacy.

These conclusions carry direct implications for practice and policy. Addiction treatment should routinely screen for self-stigma, particularly in early recovery and after relapse, and should embed stigma-focused components, psychoeducation reframing addiction as a treatable condition, cognitive restructuring of internalised stereotypes, self-compassion and acceptance-based exercises for shame, and structured peer support that supplies live counter-evidence to the stereotype of hopelessness. Health professionals should audit their own language and attitudes, since clinical encounters are a major conduit through which public stigma becomes self-stigma. At the policy level, campaigns that portray recovery as expectable and people in recovery as



contributing citizens attack the stereotype supply on which internalisation depends. Relapse, in particular, should be reframed clinically and publicly as a common event in a chronic condition rather than as proof of personal failure, since the present data suggest that relapse and self-stigma feed each other.

The study's limitations bound its claims. The design was cross-sectional, so causal direction, particularly between self-stigma and relapse, cannot be established; the sample was purposive, drawn from treatment settings in one region, and relied on self-report instruments; and unmeasured variables such as depression, social support, and substance type may condition the observed relationships. Future research should test the proposed framework longitudinally, examine stigma resistance and self-compassion as moderators, and evaluate stigma-reduction interventions using randomised designs. Within these limits, the study demonstrates that self-stigma is not a peripheral discomfort but a central psychological mechanism in addiction recovery, one that erodes the very resources recovery requires, and that reducing it is therefore not merely a matter of kindness but a clinical and public health necessity.

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