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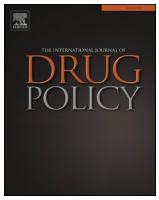

Short Report

'I don't really want to speak up because they're on a different level to me': The stigma of not engaging in trauma talk

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ABSTRACT

Background: The stigma attached to substance use disorder (SUD) can prevent entry into, and engagement with, treatment services. This paper provides an initial exploration into what could be an emerging trend using a case study approach.

Methods: Semi-structured interviews were conducted with 15 women who have used, or were currently using, residential or community-based addiction services in Cork (Ireland).

Results: Some participants reported the well documented stigma attached to SUD as a barrier for entry into, and engaging with, the recovery process. Two participants reported feeling ashamed of being unable to identify specific traumas that could account for their substance use. They felt the stereotype of 'the addict' having had a traumatic life did not map onto their experiences, and felt stigmatised by others within recovery for this. Consequently, they questioned whether they had a SUD and should access treatment, and this initially prevented them from engaging in therapy.

Conclusion: This paper does not refute the association between trauma and SUD. Rather it argues that common misunderstandings of trauma and substance use, and increased use of trauma talk, may have contributed to a new form of stereotype that some with SUDs must navigate.

Introduction

Trauma is increasingly being identified as a contributing factor in problematic substance use and there is a growing acknowledgement of the need for trauma-informed care. More generally, Haslam and McGrath (2020:523) found trauma's 'cultural salience' increased steeply during the 2000s to become the 'dominant idiom for understanding the effects of the social environment on the person'. This trend revolves around trauma talk, defined by Marecek (1999:158) as a 'system of terms, metaphors, and modes of representation for talking about' physical and sexual abuse, including 'a particular vocabulary of distress' and provision of 'a diagnostic category'. Trauma talk emerged when feminist psychologists sought a language to counter conventional diagnosis and therapeutic modalities, which they felt were stigmatising and pathologizing. They believed this could empower women by allowing them to position themselves as 'victims' of events 'beyond their control' and reframe behaviour as 'normal rather than abnormal' responses to trauma (Marecek, 1999:163).

Early clinical definitions of trauma focused on discrete traumatic events (Courtois & Ford, 2016). By the early 2000s, researchers and practitioners begun identifying trauma as 'a defining and organising experience that forms the core of an individual's identity', whether from one discrete event or the culmination of smaller events (Harris and Fallot, 2001:12). Larger traumas are easier to identify and process than culminative relational traumas (Courtois & Ford, 2016). Recent studies have found that age, ethnicity and political orientation influence how individuals conceptualise trauma (O'Connor et al., 2026). That is, different people hold different ideas of what constitutes trauma.

While this short article accepts that trauma is often part of the aetiology of substance use disorder (SUD) it reports the experience of two participants in a larger study who identified a form of stigma that has, to the best of our knowledge, yet to be recorded in the literature: they felt stigmatised by some within their group and ashamed because they had *not* identified childhood or adult trauma. The stereotype of 'the addict' having had a traumatic life did not map onto how they framed their past experiences, causing them to question whether their substance use was problematic or whether they should access treatment, and preventing them from speaking in therapy. This article provides an

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initial exploration into what could be an emerging trend using a case study.

Method

Semi-structured interviews were conducted with 15 women who have used, or were currently using, residential or community-based addiction services in Cork (Ireland). The aim of the wider project was to understand women's experiences of drug treatment services. All participants were female, aged over 18 years and English speakers. Employing purposive sampling, posters were first placed in a residential addiction service asking for participants. Service staff then sent an invitation email to those fitting the involvement criteria. Interviews were organised around general themes designed to elicit in-depth and contextualised experiences of addiction treatment services. Interviews lasted between 45 and 90 minutes, and participants were offered a €20 voucher. Participants were told that we were interested in their experiences and would talk about what was meaningful to them. That several participants spoke, unprompted, about stigma suggests that feeling stigmatised was a meaningful theme in their recovery process.

Interviews were digitally recorded, transcribed and thematically analysed using Braun and Clarke's (2021) six-phase process. We employed this version of thematic analysis because its interpretive reflexive process fitted the research aims, and we acknowledge that our lived experiences can influence data collection and analysis. The analysis began deductively, using themes drawn from the existing research literature, but then became more inductive as we emersed ourselves in the interview data. During coding, we identified the stigma of SUD as a theme engaged by most participants. This theme employed Link and Phelan's (2001) definition of stigma as the convergence of labelling, stereotyping, othering and discrimination within power imbalances. We coded for reported incidences of Adverse Childhood Experiences (ACE) (Anda et al., 2002) which became part of the theme of trauma. The current article focuses upon one theme we developed: feeling stigmatised for not disclosing trauma.

Ethics

The study was granted ethical approval from our Social Research Ethics Committee. Participants were provided with an information sheet and informed consent form. Both were reviewed by a clinical psychologist to ensure those with lower reading ages could comprehend all information. We emphasised that interviewers were independent of any addiction service and participation was completely voluntary. All names and identifying information were anonymised.

Findings

Participants were aged between early-20s and late-50s. Around half could be considered middle-class based on educational attainment and career. Nine reported polydrug use, the remaining six reported using alcohol only. Roughly in-line with comparable Irish studies (i.e. Morton et al., 2022), half reported having experienced more than one ACE. As participants were not specifically asked questions about childhood trauma, some may have experienced traumas but not disclosed them. Several participants also reported traumatic events in adulthood, including the death of family members and, sexual and physical assault.

Most participants identified feeling stigmatised, including by medical professionals, and felt the stigma attached to their substance use was a barrier to accessing treatment. Some participants expressed self-stigma. Both Ms. P and Ms. K said they would be 'a junkie all my life', and several participants reported being unable to initially engage with 12-step meetings because they were not like 'them'. Several participants had internalised stereotypes of 'the addict' – i.e. older working-class male alcoholics or homeless heroin users – which their self-image did not conform to. Ms. D identified this self-stigma as a barrier to opening up during recovery, because she did not want people:

> to think less of me … I thought if I was an alcoholic and an addict, I was scum on the floor you know. I was the man or woman down the side-alley shooting up heroin (Ms. D).

While these forms of stigma have been extensively covered by research (Lloyd, 2013), two participants reported a stigmatised identity un-acknowledged in the research literature. The subsequent analysis is focused on the experiences of Ms. J and Ms. Y, who reported not having experienced trauma as children or adults but felt that popular psychological books and podcasts frame *all* addiction as founded in trauma. They identified trauma talk, at a societal level and within therapy, as a barrier to entering into and engaging with recovery. This included the common narrative that all individuals with SUD use substances to sooth trauma. They initially felt that they could not be 'addicted' because they did not have identifiable traumas and later, as they went through the recovery process, felt ashamed of their lack of childhood and/or adult trauma, and initially felt stigmatised by others within recovery.

Ms. Y almost immediately sought to distance herself from trauma by telling us during the interview that she:

> Grew up in a very normal household, very loving parents, one brother, no trauma or anything growing up (Ms. Y).

Ms. Y had begun heavy alcohol use to calm intrusive thoughts after a close family member had been diagnosed with a life altering disease and a romantic relationship had ended. While some might define these experiences as traumatic, Ms. Y felt shame at her lack of childhood trauma when speaking in group therapy:

> … a lot of people you know would have terrible stories. You know they'd have suicides early in their life or they had you know an alcoholic parent … I don't have that story … I didn't really want to speak up because they're on a different level to me, like I had nothing. I had a great childhood, and I always felt guilty saying like I had a really good childhood, like I had great fun, we went on holiday you know. We had a really good time. I don't think I actually ever said that out loud. I said I had a normal childhood growing up but that's the reality (Ms. Y).

Ms. Y continued with alcoholics anonymous (AA) meetings regardless of the felt stigma attached to her lack of trauma, and eventually found common ground with others:

> [In AA] meetings there's nearly always something … linking back to like an abusive father or you know a parent you know not loving them … it was very hard to find why I started drinking because there was, there was no defining act or moment that I could link it back to and everyone could so I did find that a little bit difficult … but then they spoke about how they felt and I'd relate to that completely. I just don't relate to a moment [of trauma] so you know I would think about that a little bit but it didn't stop me from you know doing the program (Ms. Y).

Ms. J reported feeling pressured in therapy to find the trauma which could explain her SUD, and:

> There is a stigma around it … If I was to tell someone that I was struggling with drink I've seen them. Like I have, had, a great job, I'm single, I travelled, and I've seen them [think] "like why would you be drinking, what have you to be worried about, like you don't have kids". So there's a lot of single ladies out there that won't come forward because they feel like they're supposed to be carrying kid baggage and husband and divorce baggage (Ms. J).

Ms. J had internalised two sets of shame which acted as a barrier to entering and engaging in treatment. The more traditional stigma of being a women with SUD generated feelings of having 'disappointed' her family *and* the absence of identifiable trauma, or even hardships, resulted in judgement from others in recovery and guilt of having 'no

right' to be distressed:

> I think we [women] can be quite judgy towards ourselves … women are carrying how they've disappointed their partner, plus for my example and I do get it on a low day I'll say "well I don't have three kids and I'm not in debt with a mortgage and I'm not going through a divorce so what the fuck am I crying about like". So then that becomes a judgement on myself, not alone someone else judging me turning around and saying "sure what the fuck do you have to be worrying about" (Ms. J).

Discussion

Haslam and McGrath (2020:21) argued that 'trauma now often confers political legitimacy and moral virtue on the traumatized'. Two participants felt that, initially, their lack of identified trauma reduced their legitimacy within the recovery process and within recovery networks. The legitimacy conferred to those who can engage in trauma talk may create a hierarchy within therapy which establishes the power imbalance required for stigma to unfold (Link & Phelan, 2001). Indeed, research shows that people who use drugs can be both 'stigmatised and stigmatising' (Simmonds & Coomber, 2009:121). They can internalise stereotypes (Radcliffe & Stevens, 2008) and/or use stigma to frame the 'other' as 'worse in definable ways' (Simmonds & Coomber, 2009:127).

Studies have found stigma to be influenced by media representations of people who use substances (Lloyd, 2013). It's possible that the trauma turn, within both media and policy domains, has established a 'dominant cultural belief' (Haslam & McGrath, 2020:22) which emphasises desirable characteristics (i.e. engaging in trauma talk) against less desirable characteristics (i.e. not engaging in trauma talk). Participants in this study did eventually navigate this and found common ground with others in treatment, but this stigma was an initial barrier to entering and engaging in the recovery process.

The stigmatisation of those without disclosed trauma may be an unintended consequence of well-meaning and positive actions. Trauma talk emerged from feminist psychologists attempting to counter stigmatising and dehumanising therapy modalities (Marecek, 1999) and it likely does help counter traditional forms of stigma (see Sumnall et al., 2021). There is also substantial evidence showing that people who use substances problematically are more likely than the general population to have experienced trauma, including ACEs (Anda et al., 2002; Hughes et al., 2017; Leza et al., 2021). These quantitative studies are supported by qualitative studies showing how people use licit and illicit substances to soothe trauma (Cambridge et al., 2022; Morton et al., 2022). The research literature tends to suggest that cumulative trauma, especially ACEs, can increase the *risk* of problematic substance use, and a relatively high percentage of those with multiple ACEs may develop a SUD. For example, Hughes and colleagues (2017, italics added) meta-analysis of 37 studies found individuals with over four ACEs had an 'increased *risk* of all health outcomes compared with individuals with no ACEs'. Such studies do not suggest all individuals with multiple ACEs will develop a SUD nor that those without multiple ACEs will avoid problematic substance use. Risk simply means that 'the likelihood of such an outcome is higher' (ACMD, 2018:8) and, the mechanisms between ACEs and SUD are complex (Leza et al., 2021).

Conclusion

While the findings of this paper are limited by a small sample size, the key proposition needs further investigation as the adverse impacts of stigma are well documented (see Lloyd, 2013; Radcliffe & Stevens, 2008). Lloyd (2013) has suggested that we can counter the stigmatisation of people who use drugs by training practitioners, 'challenging media language and stereotypes' and 'encouraging public figures to speak out about their personal experiences'. In Ireland, several public figures have spoken about their experiences, and media language and stereotypes are being challenged, often by people with lived experience. This has included popular podcasts, autobiographies and, presentations to the Oireachtas (parliament) and Citizens Assembly. Many have emphasised trauma as a means of de-stigmatising and humanising those who use substances problematically. This activism is needed but may have inadvertently contributed to a new form of stigma. This observation does not attribute blame: the first authors own research often points towards the influence of trauma on SUD (i.e. Cambridge et al., 2022) and the second author facilitated a trauma studies programme. Rather we argue that more space may be needed for those with SUD who do not, cannot, *or do not wish to* engage in trauma talk. Providing such space fits within trauma-informed care models which seek to avoid causing harm and, ensure individuals have maximum choice and control (Harris & Fallot, 2001). That is, all should have autonomy of when, and if, they disclose their trauma. Awareness training can help practitioners avoid the stigmatisation of those who not disclose trauma, although this can be challenging in environments with insufficient funding for trauma-informed care (Emsley et al., 2022).

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CRediT authorship contribution statement

James Windle: Writing – review & editing, Writing – original draft, Project administration, Methodology, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Joan Cronin:** Writing – review & editing, Formal analysis, Data curation.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

James Windle reports financial support was provided by Taighde Éireann - Research Ireland. Tabor Group (an addiction service) are project partners in the wider research project, but had no input into the current paper. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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