Examining Attitudes towards Addiction in Irish Society

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Abstract

In this current study, attitudes towards addiction were examined within Irish society to discover firstly the relationship between alcohol use and attitudes towards addiction. Whether education level achieved would influence attitudes towards addiction. Also, investigating if age and gender variables would have an effect on attitudes towards addiction. Research has shown that negative attitudes towards addiction can cause self-stigma and cause an impact on individuals seeking treatment and attending treatment. When investigating alcohol use and attitudes, the aim was to discover if there was any relationship between the variables. The current study aims to examine variables such as education level, age range and gender and to determine if these variables that had the most and least negative attitudes towards addiction, asking questions such as 'would you trust a person with addiction to teach your child in primary school?'. A total of 180 participants completed questionnaires measuring their attitudes towards addiction, demographical comparison such as gender, males 79 (43.9%) females 101 (56.1%), age, level of education, salary bracket and place of residence . Findings from a correlation analysis revealed that the mean showed extremely high alcohol use with a mean score of 16.9, the scale determined 15 or more had a likelihood to have alcohol dependence and the mean for overall attitudes showed a medial score of 18.7 out of max 32, this was a surprising result as, it could be assumed that higher alcohol use would result in a lower score for negative attitudes. In between groups Anova, statistical test was conducted to measure education levels achieved and attitudes towards addiction, results showed no statistical significance, there was no difference whether individuals were more or less educated in attitudes towards addiction. However, when measuring attitudes towards addiction there was a statistical significance with employment status. Implications for this study was the sample used has a societal norm of higher alcohol intake as part of the culture.

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Introduction

Stigma of addiction is dehumanizing and the problem needs to be addressed within society, the importance of reducing stigma within society especially in professionals such as healthcare workers, psychratrists, GP's, garda are crucial for people to be treated with empathy instead of judgement, there is a need to humanize the condition of addiction so that people can be treated with respect and dignity and not like criminals (Crapanzano et al. 2014). In a study by the World Health Organisation WHO, they found that out of 18 Health conditions including mental health and drug addiction; drug addiction stigma ranked 1st and 2nd out of 12 in 14 countries, alcoholism stigma ranked between 2nd and 7th in 13 countries (World Health Organisation, 2018).

According to the most recent Healthy-Ireland-Survey by the HSE for 2018 within a 12 month time frame, 37% of the Irish population reported weekly problem drinking (in accordance to weekly low-risk alcohol HSE guidelines, 11 standard drinks for women and 17 standard drinks for men spread out, no more than 6 on any one occasion, also recommended 2-3 days alcohol free days a week (HSE, 2019), 39% of the Irish population reported problem drinking at least every month. Men were more likely to binge drink at 54% compared to women at 19%. The highest effected age range was 15-24yrs at 67%, then 25-34yrs at 64%. Out of the total population that reported problem drinking, 15% reported feeling guilty or remorseful about their drinking, 14% had suffered memory loss, not remembering something they'd said or did, 8% reported not being able to continue with plans the next day and 3% needed another alcoholic drink after a night of heavy drinking (HSE Healthy Ireland Survey 2017).

The reality of drug and alcohol abuse issues in Irish society is that it is costing the healthcare system approx. 1.9 billion annually/36.8 million per week for the cost of alcohol related inpatient healthcare, which account for 11% of all public healthcare expenses –

(Alcohol Action, 2020). Other impacts of alcohol abuse include child neglect from parents with alcohol dependence; this has been identified as the biggest child welfare issue (Hope, 2020). It is responsible for two fifths of fatal collisions on the roads, there is also a link between alcohol misuse and assaults, sexual assault, rape, domestic violence, and manslaughter. The majority of public order offenses are also caused when under the influence of alcohol (Dr Hope, A, Department of public and primary care, Trinity college, Dublin, 2020).

There are two main types of stigma, social and self stigma (Corrigan, 2002). Social or public stigma are negative views in society of individuals or groups of individuals that belong to a stigmatised group (Corrigan & Watson, 2002). Societal stigma demoralises a individual's characteristics because they don't conform to societies norms (Yangs et al, 2007). Self stigma is when an individual that belongs to a stigmatised group, begins to internalise the stigma recieved from others causing shame, the individual starts to devalue and believe that how they are percieved is true (Corrigan & Watson, 2002).

The Negtative Effects of Stigma

Self-stigmatization

The affects of stigma towards individuals with substance abuse dependency are very damaging. The word 'addict' has become an identity, this sterotyping is damaging to a person's self worth and self esteem (Corrigan et al., 2006), it becomes internalised and can cause resentment and anger (Luoma et al., 2008). Stigmization within society can cause cause self-stigmization, a qualative study on individuals suffering from addiction, were asked if they were effected by how they were treated in society? (Corrigan & Watson, 2002). The study identified that the individuals that were stigmatitised, perception of social stigma towards them was considered normal to them and that they also identified with the negative sterotype of 'addict' (Corrigan & Watson, 2002).

Self-stigma can also create a major obstacle for individuals suffering from addiction in seeking treatment, it causes delays in getting treatment or even avoidance of treatment (Fung et al., 2008; Likington & Boyd, 2010). Internalised stigma can be a cause to leaving treatment prematurely (Lloyd, 2010), this has been linked to higher likelihood of death (Fugelstad et al., 2007; Magura & Rosenblum, 2001). Studies on to assess the process of self-stigmatization in alcoholism showed drinking identity influenced alcohol consumption (Gray et al,.2011) (Lindgren et al,.2013). Findings showed that individuals that identify strongly with alcohol may drink or not drink essentially to the degree that he/she believes they are able to withstand or decline from drinking alcohol, primarily you are what you believe you are (Foster et al,. 2014).Another study by Schomerus et al, 2011, revealed self-stigma to be associated with lower drinking refusal self-efficacy.

Social stigma

Public stigma are negative beliefs and opinions by individuals in society towards individuals that belong to a stigmatised groups (Corrigan & Watson, 2002), this stigma demoralises a person's characteristics because they don't conform to societal norms (Yang et al, 2007). The societal sterotypying of addicts being blameable comes from the belief that they are able to choose whether to take drugs/alcohol or not (Lloyd, 2013), even after suffering negative impacts from the drug/alcohol use, continue to use. This behaviour can be percieved by some to be weakness of character (Volkow & Li, 2004).

There have been several studies on stigma of addiction to examine the attitudes and beliefs in society in one study social stigma can be linked to internalised stigma, in a cross sectional study done on 343 women suffering from substance abuse disorder and post-traumatic stress disorder showed that younger women had applied themselves into a stereotyped group because they were more influenced by how society perceived them (Melchior et al, 2019).

Factors that Influence Stigma

Potential factors that may influence levels of stigma towards those in addiction include education (Kelleher & Cotter 2009) (Witte, T. Schroeder, C & Hackman C, 2014).

Gender (Janulis, P. Ferrari, J & Fowler, P. 2013) (Meurk et al,. 2014). Age (Gervilla et al,. 2020) (Murphy et al,. 2016) and Socioeconomic status (Room, 2005), (Wood & Elliot, 2019).

Education

In a review of 28 studies to examine the attitudes of healthcare professionals towards patients with substance abuse issues, these included 12 in Australia, 7 in UK, 5 in USA, 1 in Canada and 1 in Ireland, all showed strong negative attitudes towards patients with addiction, the studies showed that staff had predicted and believed that patients with substance abuse would be violent, manipulative and difficult to treat (Kelleher & Cotter 2009). This resulted in patients not getting the same treatment as others without substance issues, they were treated with less empathy than those who suffer from depression or diabetes (Gilchrist et al 2011).

Another study done on undergraduate students in the University of Alabama US, to examine attitudes towards individuals suffering from substance abuse disorder. This involved one group of students that were studying addiction at the start of semester another at the end of semester and another group studying a subject with no relation to addiction. This was to examine whether education of addiction had a positive effect on attitudes. The results showed that there was improvement of positive attitudes towards active users between the pre and post courses. A higher amount of students from the group that didn't study addiction reported wanting to social distance themselves from individuals with substance abuse disorder. Overall, the majority of the students were inclined to have supportive and positive

views of individuals that suffer from SUDS compared to fearful and apprehensive (Witte, T. Schroeder, C & Hackman C, 2014).

Gender and Age

Gender and Stigma, in a cross sectional study done on undergraduate college students in Michigan State University, to examine stigma of substance dependence with different substances which included alcohol, marijuana and heroin to see if there was a difference in attitudes towards individuals using these substances and if gender would be effected, participants were measured by responses to familiarity, dangerousness, fear and social distance. The results showed for alcohol, gender was the only significant variable, females were more fearful of individuals dependent on alcohol (Janulis, P. Ferrari, J & Fowler, P. 2013). Another study showed higher stigma from females than males, this study was done on 565 college psychology third level students age range 18-25 to examine attitudes towards substance abuse, one of the questions was are you more comfortable to spend time with someone with mental health problem or someone that has a drug addiction, students completed 3 measures of substance use stigma measures, and this study showed that females had a higher level of stigma towards substance users, and reported to prefer spending time with someone with mental health problems (Brown, 2010). These studies show that gender does affect stigma, females are more fearful and apprehensive towards individuals under the influence of drug/alcohol and feel uncomfortable in their presence. However, a recent study contradicted these findings, results showed older females were more liberal towards addiction due to having experienced addiction with a close family member or friend (Lytle et al,.2020), another study also showed that females were more likely to believe addiction is a disease, instead of a choice (Meurk et al,. 2014).

In each of these studies, the participants were college students, predominantly in their early 20's. As age may also be a factor to consider when examining addiction stigma (Meurk

et al,.2014), studies should consider the age profile of their participants when examining attitudes towards addiction, in three studies focusing on age as a predictor research suggested that in the first study done in Australia showed increased age was more related to a positive attitude, participants that were 35 and above were more likely to believe that addiction is a disease compared to the 18-34 year olds (Meurk et al,.2014). However, the two other studies focused on adolescents, the first revealed that those who drank heavily, had an attitude that getting drunk was a sign of a good night, those that didn't drink heavily were more supportive of alcohol policies (Gervilla et al,. 2020) and the other study in Southern Ireland revealed that if participants had parents that were liberal about alcohol and drugs and themselves had larger consumptions of alcohol, this influenced problem drinking in adolescents (Murphy et al., 2016). It can be assumed from these studies that parents and their relationship and views can hugely influence their children's attitudes.

Social class and economic status

In a study done by on-line survey in Unviversity of Nevedo Reno, US, to examine whether public stigma towards individuals suffering from opiod addiction varied according to race, social class and gender, results showed that participants judged working class opiod users more severly than middle class. Participants that were middle class to upper class also tended to judge working class more severly. (Wood & Elliot, 2019). Another study done in Sweden to examine social equality and alcohol/drug use, results showed that lower classes are more stigmatised than those in middle and upper classes, one explanation is that lower classes have less resources, they are unable to start treatment as quickly, resulting in not being able to conceal there addictions from society (Room, 2005).

Another study on stigma of alcoholism that focused on social/relationship status, demographics, gender, and education, the data was drawn from face to face survey on 34,653

adults in the US, age range 20 and above. Results showed that stigma was significantly higher in males with lower income and lower educational level. Stigma did not differ for those married or that had been married. But stigma was significantly lower for individuals with a relative that had alcohol dependence e.g a parent, sibling, child than individuals that didn't have a relative with alcohol addiction (Keyes et al. 2010). This can also be seen with stigma towards coworkers, there is less stigma when having experienced addiction with a close family member or friend, as there is understanding and compassion (Adlaf et al,. 2009), (Allport, 1954; Pettigrew & Troop 2006; Lytle,.2018).

From the studies it is apparent that there is a major issue that needs to be addressed, stigma towards people in drug/alcohol addiction in Irish society is contributing towards individuals being trapped in the spiral of addiction by being labelled and stereotyped, where they are no longer seen as that individual but are viewed as a problem that doesn't contribute to society. Alcohol dependant people are one of the most stigmatised groups in society (Schomerus et al 2011).

Potential for Change

To start to address the issue of stigma it is important to remember that humans are very social creatures and need to feel excepted, and have social support, this has been linked to higher likelihood of someone getting help (Volkow, 2018), this can only be achieved by changing societies views of individuals in addiction (Volkow, 2018), this could be done by creating new policies for addiction to be classed as a mental health disorder (Cleary, 2017). If a change is likely to happen then the government, healthcare system and other systems in power must disallow the influences of stigma, address the devastating realities of individuals staying in addiction (Richter, Vuolo & Salmassi, 2019). In Ireland in 2017, UISCE and the Press Ombudsman issued an advisory notice to all national and local newspaper editors

where they were given key points about drug policies which included negative perceptions of substance abuse by the Global Commission Drug Policy (The Department of Health, 2018).

More education and information around drug and alcohol addiction needs to be provided to not just the young generation but also parents, it has been shown in studies that the attitude of parents especially when liberal can have a huge impact on adolescents and their relationship with especially alcohol (Murphy et al,.2016). Alcohol and drug use and dependency can have extremely negative consequences in society, in Ireland it was reported by survey of lifestyle, attitudes and nutrition 2015 (Ireland), that over half of all Irish were problem drinking (Murphy et al,.2016).

It is important that healthcare workers and other professionals that would come into contact with individuals suffering from addiction need to be provided with proper training around addiction to gain understanding, so that an individual doesn't feel judged (van Boekel et al 2013).

More interventions are needed to reduce the stigma of addiction as it is having extreme negative effects, it was reported that healthcare professionals that lacked empathy, came from not having enough knowledge and skills (Deans & Soar, 2005).

Also the use of language is important as this can have a negative influence on opinions, this could be changed in the media, for example being drug free is described as being 'Clean' which can be perceived as being hygienically clean, and if you have a positive drug test it is called 'Dirty' (Weinberg, 2000).

Education is the key to changing negative Attitudes and beliefs (Ford et al 2008). To be able to determine where in society there is the biggest need to intervene, there needs to be research, in past research there is a gap with measuring social class and stigma, this is an area that needs to be researched further to see if there is a relationship between stigma and social class and whether there are higher levels of stigma in Upper or Lower classes? Whether this

is due to levels of education, how addiction is perceived within classes or if you personally experience addiction it affects your opinions.

Conclusion

It has been established that there is a need to examine stigma in Irish society, to be able to address the problem of alcohol/drug dependence in Ireland. It can be seen by the statistics of problem drinking and increased drug use, that it is a growing concern. It can be seen in several studies, that stigma of substance abuse is present, and areas such as gender, education and social economic status does affect attitudes and beliefs. There is a need to change the attitudes of addiction of alcohol/drug from something to be feared and criminal to a mental health condition or disease, so that is it looked at with more compassion and understanding. It is important to change opinions in society so that individuals are more likely to seek treatment, stay in treatment and be more successful to stay sober. This would have huge positive benefits such as less expenditure for the consequences of drink and drug dependency such as healthcare, justice system and child welfare costs. Stigma in society needs to change as it is causing internalised stigma, which results in individuals suffering from low self-esteem and low self-worth, this then causes a person to stay stuck in a bad situation, which creates high risk of other mental health issues such as depression and suicide. This change can be achieved by educating about addiction and changing policies so that addiction is a health issue instead a criminal one. People need to feel supported by society not judged, humans are social creatures and are influenced by how they are perceived, social or internalised stigma isn't helpful for people to successfully getting the treatment they need.

Hypotheses:

1. AUDIT (alcohol use) predicts attitudes towards addiction
2. Education levels will influence attitudes towards addiction
3. Gender and age will influence attitudes towards addiction
4. Indicators of economic status (such as salary) will influence attitudes towards addiction.

Methodology

Participants

In the current study the total sample consisted of 180 (Males: n = 79; Females: n = 101) mixed age range of 18 to 55+, the majority of participants were in the 36-45 age range at 55 (30.6%) and age range 46-55 at 47 (26.1%). This was calculated using GPower statistical calculation formula (Faul, Erdfelder, Lang & Buchner, 2007) to provide the adequate sample size for in-between ANOVA. The minimum calculated sample size had to be n = 132. It is critically important for a study to have the correct sample size, to insure precision when testing a hypothesis as this provides a more accurate probability of detecting significant difference in the criterion. Also, if a sample is too small or too large it can be a waste of time, resources to perform assessments and rationale for participants and researchers Participants came from 20 different areas of Dublin and from outside Dublin but within Ireland.

Of the participants recruited; 118 (65.6%) were employed, 24 (13.3%) were students, 22 (12.2%) and 16 (8.9%) were retired. Education level completed by the participants in this study was primary level 7 (3.9%), Secondary 42 (23.3%), Third level 116 (64.4%) and Masters/Doctors+ 15 (8.3%). The salary bracket for participants was 20k 57 (31.7%), 20-40k 55 (30.6%), 41-60k 46 (25.6%), 61-80k 2 (1.1%), 81-100k 14 (7.8%) and 100k+ 6 (3.3%). The study implemented a nonprobability, convenience sampling strategy to recruit

participants, as participants were recruited online and relied on voluntary participation with consentient of not having a mental health diagnosis and being over the age of 18.

Materials

The questionnaire used in this study was comprised of demographic questions such as gender and age range, education level, salary bracket and place of residence. Two specific scales consolidated using Google Forms, a survey builder. The demographic questions were conducted to gain a general, educational and employment profile, the participants in this study were presented with questions regarding their gender, age, education level, employment status, salary bracket and place of residence.

The first scale was used to measure attitudes towards addiction was the **Perceived Stigma of Substance Abuse Scale (PSAS)** this scale provides a single total score. Reversed scored items are 1, 2, 3, 4, 6, 8 The scale total score ranges from 8-32 with higher scores indicating greater perceived stigma, measured by 4 point Likert Scale e.g Disagree, Strongly disagree, Agree and Strongly Agree (Luoma et al,. 2009).

The second scale was used to measure alcohol use was the **Alcohol Use Disorders Identification Test AUDIT** this scale has been used worldwide since 1989. It enquires about three key domains of 1. Alcohol intake 2. Potential dependence on alcohol and 3. Experience of alcohol related harm. The three domains can be scored individually but it is most usual to calculate the score for the AUDIT as a whole.

The AUDIT questions have been selected from a bank of approx. 150 questions which were used as the assessment instrument in the original World Health Organization (WHO) Study. The WHO study included countries from all socioeconomic status, different cultures, and languages, also different healthcare systems, social and political structures. No country

dominated this scale, resulting in the AUDIT having extremely strong credentials as an international instrument.

The AUDIT has 10 questions and possible responses to each questions are scored 0,1,2,3 or 4 with the exception of questions 9 and 10 which have possible responses of 0, 2 and 4. 5-point Likert Scale from 0 (Never) to 4 (Daily/almost daily). The range of possible scores is 0-40, where 0 indicates an abstainer who has never had any problems with alcohol. A score of 1-7 suggests low-risk consumption according to (WHO) guidelines. Scores from 8-14 suggest hazardous or harmful alcohol consumption and a score of 15 or more indicates the likelihood of alcohol dependence (moderate – severe alcohol use disorder). Results from the original WHO study showed that the term "drink" in questions 2 and 3 encompassed amounts of alcohol ranging from 8-13 grams, where the standard drink is defined as an amount outside the range (e.g 20 grams), it is recommended that the categories are modified accordingly (Sanders et al,.1993), (Babor et al,.2001).

Design

The research design used for the study was a quantitative, cross sectional design, that examined use of Alcohol and relationship with Alcohol (IV), Education Level (IV), Gender (IV), Age (IV) Employment status (IV) and Salary Bracket (IV) on the impact of scores on a measure of Addiction Stigma (DV).

Procedure

The majority of participants for the study were recruited through social media platforms. The questionnaire was created on google doc and then uploaded to Facebook, and WhatsApp and sent to student's emails at NCI. Most were recruited by mutual friends whereby the questionnaire link was send to their friends on Facebook.

An information sheet and consent form were provided at the beginning of the questionnaire, information about the study was provided and what could be expected in taking part such as being able to withdraw at any stage of the study but before submitting the questionnaire and once submitted data was non identifiable as no names of other identifying questions were requested. Participants were informed that responses to questionnaire would be stored securely in a password protected/encrypted file on the researcher's computer, only accessible by researcher and supervisor. Data provided would be retained for 5 years in accordance with the NCI data retention policy.

Participants were provided with option to consent by clicking 3 separate 'yes' boxes that to give consent to being 18 and over, not having a diagnosis for any psychological illness, also agreeing to take part in the study and understanding the terms.

Participants were able to withdraw from the study at any point in the survey, without any consequence. (see appendix D). Participants were then required to complete the demographical questions, the perceived stigma of addiction questionnaire, followed by the alcohol use disorder identification test. Lastly after completing all questions that were mandatory to answer, once the three sections were completed a debriefing form was provided. Contact details for myself and my supervisor were provided as in the information/consent sheet, along with helpline numbers and an encouraging statement to participants to contact someone close or a support service provided if feeling at all distressed after taking part in the study. (see Appendix E for full details).

Ethical considerations

All data was collected within accordance with the ethical guidelines of NCI. The risks and benefits of partaking in the study were outlined clearly in the document provided. There was no incentive to take part and this was also explained. All participants provided informed consent to being 18 or over, not having diagnosis for any psychological illness and agreeing

to take part in study. All participants were informed that it could be possible to experience a small level of distress by taking part therefore if this did happen, helplines and support services such as Samaritans and National Helpline for Alcohol/Drug info support contact details were provided in the debrief form. Researcher and Supervisor contact emails were also provided to allow participants to ask any questions about the questionnaire or study if needed (see Appendices D & E).

Results

Descriptive and inferential statistics were conducted on each of the variables in the current study. For the descriptive statistics, frequency and valid percentages were calculated for all categorical variables; while mean, standard deviation (SD), skewness, kurtosis, maximum and minimum scores were calculated for the continuous variables (see Table 1 and 2). Tests of normality were conducted on the two continuous variables of Attitude towards Addiction and Relationship with Alcohol. The results of the Shapiro-Wilk statistic indicates that data from both scales are not normally distributed (both p's<0.05).

Table 1

Descriptive statistics of all categorical variables

Variable	Frequency	Valid %
Gender		
Males	79	43.9
Females	101	56.1
Age Range		
18-25	13	7.5
26-35	29	16.1
36-45	55	30.6
46-55	47	26.1
55+	36	20
Employment Status		
Employed	118	65.6
Student	24	13.3

Unemployed	22	12.2
Retired	16	8.9
Primary	7	3.9
Secondary	42	23.3
Third Level	116	64.4
Masters/Doctors+	15	8.3
Salary Bracket		
Under 20k	57	31.7
20-40k	55	30.6
41-60k	46	25.6
61-80k	2	1.1
81-100k	14	7.8
100k+	6	3.3
Place of Residence		

D1	9	5	D2	1	0.6	D3	3	1.7
D4	1	0.6	D5	4	2.2	D6	3	1.7
D7	15	8.3	D8	9	5	D9	2	1.1
D10	1	0.6	D11	5	2.8	D12	4	2.2
D13	6	3.3	D14	10	5.6	D15	4	2.2
D16	16	8.9	D17	7	3.9	D18	6	3.3
D22	6	3.3	D24	8	4.4	OD	60	33.3

Table 2

Descriptive Statistics for Continuous Variables of Attitude towards Addiction and Relationship with Alcohol.

Variable	*M* [95%CI]	*SD*	Range	Skewness	Kurtosis	Min	Max
Attitude Total	18.70	2.82	17	-.061	.024	11	28
Alcohol Total	16.85	5.33	31	1.38	4.498	10	41

Hypothesis 1

A Spearman's correlation was conducted to examine the relationship between attitudes and alcohol use; there was no significant association between the two variables r = -0.80, p= 0.286. A multiple regression was conducted to determine whether alcohol use was a significant predictor of attitudes when entered into a regression model with the variables including gender, age range, employment status, level of education and salary.

The results from table 3 show that the model explained 6.1% of variance in attitudes towards addiction (F (2, 179) = 2.279, p < .049). Out of the four predictor variables, employment status was found to uniquely predict attitude towards addiction to a statistically significant level (β = .241, p = .002) (see table 3 below for full details).

Table 3

Standard multiple regression model predicting attitudes of addiction total score

Variable	R	R^2	B	SE	β	*t*	*p*
Model	.248	.061					
Alcohol Total			-.009	.045	-.015	-.197	.844
Gender			-.273	.433	-.048	-.631	.529
Age			.078	.184	.033	.425	.672

Employment Status	.669	.210	.241	3.19	.002
Salary Bracket	.160	.167	.075	.961	.338

Note. R^2 = R-squared; β = standardized beta value; B = unstandardized beta value; SE = Standard errors of B; N = 67; Statistical significance: *$p < .05$; **$p < .01$; ***$p < .001$

Hypotheses 2

A one-way between groups ANOVA was conducted to determine if there were any education level differences and attitude towards addiction scores. Participants were divided into four groups according to level of education completed, these included (Primary, Secondary, Third level and Masters/Doctors+). There was no statistically significant main effect, indicating no differences in levels of attitudes towards addiction scores for the four education level groups F (3, 176) = 1.49, $p = .219$

Hypotheses 3

A two-way between groups analysis of variance was conducted to explore the impact of gender and age on levels of attitudes towards addiction, as measured by the Perceived Stigma of Substance Abuse Scale (PSAS). Participants were divided into five groups according to their age (Group 1: 18-25; Group 2: 26-35; Group 3: 36-45; Group 4: 46-55; Group 5: 55 years and above). The interaction effect between gender and age group was not statistically significant, F (2, 170) =1.56, $p = .19$. There was also no statistically significant main effect for age, F (2, 170) = 1.75, $p = .14$. The main effect for gender, F (2, 170) = 1.14, $p = .29$, did not reach statistical significance.

Hypotheses 4

A one-way between groups analysis of variance was conducted to explore the impact of salary on attitudes towards addiction. Participants were divided into six groups according to groups of salary brackets, Group 1: (Under 20k), Group 2: (20-40k), Group 3: (41-60k), Group 4: (61-80k), Group 5: (81-100k) and Group 6: (100k+). Results showed no statistical

significance in all six salary bracket groups and attitudes towards addiction. F (5, 179) = .66, p = .65.

Discussion

The aim of this study was to examine where in society there were higher levels of stigma towards addiction. There is no question about whether stigma is occurring in Irish society, it is however crucial to examine where in society it is prominent so that it can be addressed. Research has determined that social stigma can cause self-stigmatization resulting negative outcomes seeking treatment staying sober (Broadus & Evans, 2015).

In this study the first hypotheses was to determine if attitudes towards addiction and alcohol use were correlated, results showed that the mean for alcohol was within the score for problem drinking/dependence according to WHO guidelines. A score of above 15 is moderate to severe and has a likelihood of alcohol dependence (Sanders et al,.1993) (Babor et al,. 2001).The mean for the attitudes towards addiction was also higher than expected at 18.7 mean according to the PSAS scales ranged from (8-32) so this showed a fairly high negative attitude (Luoma et al,. 2009).This result could indicate that individuals have self-stigmatization, studies have shown that it can be created from societal stigma, reason for this interest is due to what addiction can do to an individual, a family and society, if addiction was classed more as a disease, there would be less blame and judgement to an individual suffering from addiction (Meurk et al,.2014) . These negative views this has an extremely detrimental and devastating outcome to individuals seeking treatment, also being responsible creating low self-belief to stay in treatment and to continue staying sober (Fung et al,.2008; Likington & Boyd,.2010) (Lloyd,.20100. Addiction is disruptive to everyone involved but it spills out into several areas of society, in Ireland addiction has a strong link to mental health, crime, child neglect and healthcare costs.

Studies have suggested the process of self- stigmatization in alcoholism, formed a drinking identity which influenced alcohol consumption (Gray et al,.2011) (Lindgren et

al,.2013). Individuals that have a strong identity will have a self-belief about themselves that will determine their drinking outcomes, so what a person beliefs about themselves can be responsible for their actions (Foster et al,. 2014). Self-stigma can also be responsible for, lower drinking refusal self-efficacy (Schomerus et al, 2011) feeling shameful and guilty could make refusing more difficult due wanting to block it out by using alcohol. This is one of the main reasons why it is crucial to change societal attitudes towards addiction so that there isn't a knock on effect to self-stigmatization.

Another reason for the scores from the Alcohol use and attitudes to towards addiction, could be explained by individuals drinking excessively due to the culture, Ireland has one of the largest drinking cultures across 30 European countries (Delaney, 2011) and also according to the World Health Organisation has one of the highest levels of alcohol consumption in Europe (WHO,.2018). In a report by Irelands Health Research board 54% of participants, around 2.4 million Irish Adults engage in hazardous drinking compared to the European average of 28% (Lile,.2018).

It is clear that alcohol is a big part of the Irish culture and is associated with 'having the craic' so it would be classed 'normal' in Irish society to drink excessively, the catholic church would have played a role in trying to suppress and contain alcohol consumption by, for example young catholic boys and girls during confirmation to make a pledge by making a life time vow to abstain from drinking alcohol (Delaney,. 2013). Religion would have a big factor to play in causing guilt and shame about alcohol use, sermons would also preach about the 'evils of alcohol' which could be a cause of self-stigmatisation (Delaney,.2013). When taking these factors into account that having a high mean in alcohol use and a high mean in attitudes towards addiction is not surprising.

The second hypotheses measured were Education levels and attitudes towards addiction, several studies have shown that there is a relationship between how educated or uneducated a person is can affect their views to towards addiction (Kelleher & Cotter 2009) (Gilchrist et al 2011).

However, there was no statistical significance in this study, in other studies on participants that had achieved higher educational levels in the medical field showed strong negative attitudes towards patients with addiction, the studies showed that staff had already perceived ideas to how an addict would behave (Kelleher & Cotter 2009). This might suggest that they may have had a bad experience of individuals suffering from addiction seeking treatment in a medical setting. In another study it showed that when students were educated about addiction the attitudes tended to be more positive, the students that were uneducated about addiction had more negative views on individuals with substance abuse disorder (Witte, T. Schroeder, C & Hackman C, 2014). In this study the majority of participants had completed third level 64.4% of the sample, however this did not predict more negative or more positive views of addiction as there was no statistical significance. The explanation could be that educational level achieved has no influence on an individual's beliefs around addiction unless educated specifically around addiction.

The third hypotheses measured gender and age and attitudes towards addiction, in this study there was no statistical significance. Other studies revealed that gender and age were significant variables, in two studies females were had more of a negative attitude due to being fearful of individuals dependent on alcohol (Janulis, P. Ferrari, J & Fowler, P. 2013). The other study showed higher levels of stigma from females between the age range 18-25 also due to fear (Brown, 2010). A more recent study contradicted these findings, results showed older females were more liberal towards addiction due to having experienced addiction with a

close family member or friend (Lytle et al,.2020), another study also showed that females were more likely to believe addiction is a disease, instead of a choice (Meurk et al,. 2014).

In three studies focusing on age as a predictor research suggested that in the first study age range 35 and above were more likely to believe that addiction is a disease compared to the 18-34 year olds (Meurk et al,.2014). However, the two other studies on adolescents, revealed that those who drank heavily, had an attitude that getting drunk was a sign of a good night, which could indicate that they are not educated around the harmful effects (Gervilla et al,. 2020). The other study revealed that if participants had parents that were liberal about alcohol and drugs and their parents also drank heavily, this influenced problem drinking in adolescents (Murphy et al., 2016). Age can be a very influential factor to attitudes, as at a young age you look to your peers and parents for your social norms and if everyone else around you is acting and thinking a certain way than why wouldn't you, this wouldn't tend to change until you get your own experiences or receive education around alcohol/Drug use.

The fourth hypotheses measured indicators of economic status (such as salary) with attitudes towards addiction, in this study there was no statistical significance with how much people earned. Other studies however, showed that participants that were from middle to upper classjudged working class opiod users more severly than middle class (Wood & Elliot, 2019). Another study showed that lower classes are more stigmatised than those in middle and upper classes, one explanation is that lower classes have less resources, they are unable to start treatment as quickly, resulting in not being able to conceal there addictions from society (Room, 2005).

Another study that showed a contridiction in the finding had higher levels of stigma from males with lower income and lower educational level (Keyes et al. 2010).

A multiple regression was conducted to determine whether alcohol use was a significant predictor of attitudes when entered into a regression model with the variables including gender, age range, employment status, level of education and salary.

The model explained 6.1% of variance in attitudes towards addiction (F (2, 179) = 2.279, $p < .049$). Out of the four predictor variables, employment status was found to uniquely predict attitude towards addiction to a statistically significant level ($\beta = .241$, $p = .002$). These results indicate that being employed my sample had a majority of 65.6% employed, the statistical significance between employment and attitude towards addiction could indicate that individuals have been exposed to other staff members or patients which could have been a negative experience as seen in a study on medical health workers, such as working in A & E and having to deal with drunken patients (Kelleher & Cotter,. 2009). This can also be seen with stigma towards coworkers, there is less stigma when having experienced addiction with a close family member or friend, as there is understanding and compassion (Adlaf et al,. 2009), (Allport, 1954; Pettigrew & Troop 2006; Lytle,.2018).

Other reasons could be that individuals that are employed may have feelings of superiotity and feel better than someone that has addiction by valuing themselves by being employed (Lytle et al,. 2018). It could also depend on policies in the workplace that empathazize methods to sensitivity and appropriateness with employees affected by substance abuse addiction. Providing education and training around alcohol and other drugs,to teach procedurers, communication, supervision and management (Roche et al,. 2015).

The limitation for this study was that the responses given in the questionnaire were entirely self-reporting, and were responsible for measuring the entirety of the scales. The questionnaire was anonymous, so it is likely that participants were honest in answering the

questions about attitudes towards addiction and alcohol use. However individuals may have felt uncomfortable about expressing their truth beliefs or in denial of their truthful alcohol use. Self-report scales makes the data prone to self-selecting bias, resulting in the answers being influenced by how the individual feels at the time, and not their overall opinions in relation to the variables being measured. It would be advised that longitudinal and experimental studies are therefore needed to achieve a more accurate result from the data received as a study done, before and after educating individuals around addiction may provide a clearer understanding of how attitudes can change but also to compare. The Perceived stigma of substance abuse scale was also not clear to how to answer, after receiving feedback from participants that took part in the questionnaire, they reported being unsure whether to answer with their personal opinion or to answer how they thought society would answer, so this should be explained better with the PSAS scale. Also originally the (ABQ) The addictive Behavioural scale (Caretti et al,. 2018) was meant to be used instead of the (AUDIT) Alcohol Use Disorders Identification Test (Sanders et al,.1993), (Babor et al,.2001). The ABQ had to be requested and permission granted to use, however the timescale didn't make this possible for this study, it would be beneficial to use this scale in the future as it is was broader than and not as specific to one type of addiction as the AUDIT.

The strengths of this study were the sample size was large enough to get an accurate measure from the variables, it was also random sampling so more of a varied sample. Both scales used were recent and widely used. Also within Irish society.

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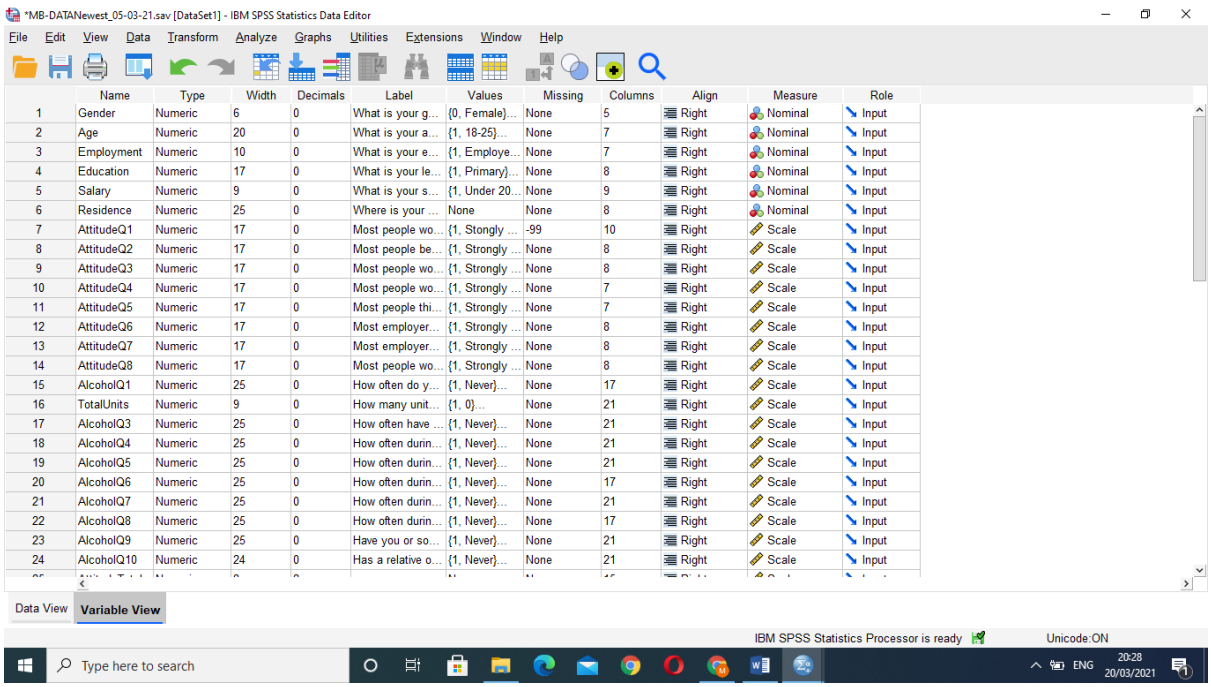
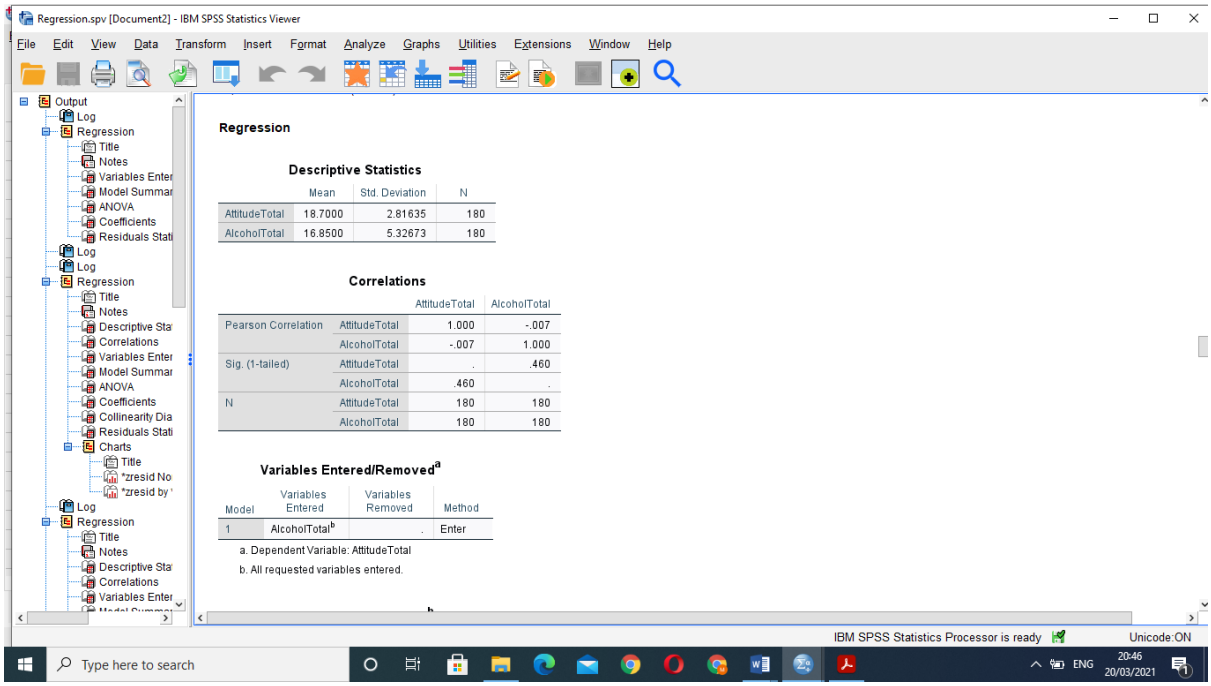
Appendix A

Evidence of data and SPSS output (full data file available upon request)

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AttitudeTotal 18.7000 2.81635 180
AlcoholTotal 16.8500 5.32673 180
Correlations
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Pearson Correlation AttitudeTotal 1.000 -.007
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b. All requested variables entered.
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Appendix B (Perceived Stigma of Substance Abuse Scale) (PSAS)

To Whom it May Concern:

Feel free to use the Perceived Stigma of Substance Abuse Scale (PSAS) in your research. If you have any questions about the scale, please email me. I would also ask that you let me know about any results you obtain using the scale and/or send me a copy of any articles that you publish that contain the scale. There is little research being conducted on stigma in addiction and so I like to try to help facilitate new research and keep abreast of what's happening. The appropriate reference is listed below.

Please also note that there was a minor error in the original publication that stated that the measure was scored using a 7-point Likert scale. The measure was actually scored using the 4-point Likert scale as used in the measure below.

Regards,

Jason B. Luoma, Ph.D. Licensed Psychologist in Oregon Director, Portland Psychotherapy Clinic, Research, and Training Center Business phone: 503-281-4852 Email: jbluoma@portlandpsychotherapyclinic.com

The scale and publication can be obtained at:

http://www.portlandpsychotherapyclinic.com/training/publications

Reference:

Luoma, J. B., O'Hair, A. K., Kohlenberg, B. S., Hayes, S. C., Fletcher, L. (2010). The development and psychometric properties of a new measure of perceived stigma toward substance users. *Substance Use and Misuse, 45, 47-57.*

Scoring

This scale provides a single total score.

Reversed scored items are 1, 2, 3, 4, 6, 8

The scale total score ranges from 8-32 with higher scores indicating greater perceived stigma

PSAS

Please read each statement carefully and circle the number below the item that indicates the degree of your agreement or disagreement with each statement. Please use the scale below, and please do not omit any item.

1. Most people would willingly accept someone who has been treated for substance use as a close friend.

1	2	3	4
Strongly disagree	Disagree	Agree	Strongly agree

2. Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.

1	2	3	4
Strongly disagree	Disagree	Agree	Strongly agree

3. Most people would accept someone who has been treated for substance use as a teacher of young children in a public school.

1	2	3	4
Strongly disagree	Disagree	Agree	Strongly agree

4. Most people would hire someone who has been treated for substance use to take care of their children.

1	2	3	4
Strongly disagree	Disagree	Agree	Strongly agree

5. Most people think less of a person who has been in treatment for substance use.

1	2	3	4
Strongly disagree	Disagree	Agree	Strongly agree

6. Most employers will hire someone who has been treated for substance use if he or she is qualified for the job.

1	2	3	4
Strongly disagree	Disagree	Agree	Strongly agree

7. Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant.

1	2	3	4
Strongly disagree	Disagree	Agree	Strongly agree

8. Most people would be willing to date someone who has been treated for substance use.

1	2	3	4
Strongly disagree	Disagree	Agree	Strongly agree

Appendix C (Alcohol Use Disorder Identification Test)

Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT. *The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care*. Geneva, Switzerland: World Health Organization, 1992.

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Questions Scoring system

Your score 0 1 2 3 4

How often do you have a drink containing alcohol? Never Monthly or less 2 - 4 times per month 2 - 3 times per week 4+ times per week

How many units of alcohol do you drink on a typical day when you are drinking? 1 -2 3 - 4 5 - 6 7 - 9 10+

How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you found that you were not able to stop drinking once you had started? Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you failed to do what was normally expected from you because of your drinking? Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you had a feeling of guilt or remorse after drinking? Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking? Never Less than monthly Monthly Weekly Daily or almost daily

Have you or somebody else been injured as a result of your drinking? No Yes, but not in the last year Yes, during the last year

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? No Yes, but not in the last year Yes, during the last year

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Appendix D Information and consent form

Participants Information Sheet

You are being invited to take part in a research study. Before deciding whether to take part, please take the time to read this document, which explains why the research is being done and what it would involve for you.

If you have any questions about the information provided, please do not hesitate to contact me using the details at the end of this sheet.

What is this study about?

I am a final year student in the BA in Psychology programme at National College of Ireland. As part of our degree we must carry out an independent research project.

For my project, my aim is to investigate how Irish society feels towards substance abuse? My Project supervisor is Dr Michelle Kelly a psychology lecturer in NCI and behavioural psychologist.

What will taking part in the study involve?

If you decide to take part in this research, you will be asked to complete an online questionnaire that will include some demographical questions and then questions on your beliefs and attitudes towards different aspects of addiction. There will also be questions about your relationship with alcohol.

You will not be asked any personal questions and your questionnaire will be unidentified.

Who can take Part?

You can take part in this study if you are 18 or over and have not been diagnosed with any psychological illness, it will also be nesessary to use one of the following forms of social media Facebook, Instragram. LinkedIn and Whatsapp.

Do I have to take part?

Participation in this research is voluntary; you do not have to take part, and a decision not to take part will have no consequences for you. If you do decide to take part, you can withdraw from participation at any time, once you haven't submitted it online.

One you have submitted your questionnaire, it will not be possible to withdraw your data from the study, because the questionnaire is anonymous and individual responses cannot be identified.

What are the possible risks and benefits of taking part?

There are no direct benefits to you for taking part in this research. However, the information gathered will contribute to research that helps us to understand the attitudes of substance abuse in Ireland.

There is a small risk that some of the questions contained within this survey may cause minor distress for some participants. If you experience this, you are free to discontinue participation and exit the questionnaire. Contact information for relevant support services are also provided at the end of the questionnaire.

Will taking part be confidential and what will happen to my data?

The questionnaire is anonymous, it is not possible to identify a participant based on their responses to the questionnaire. All data collected for the study will be treated in the strictest confidence.

Responses to the questionnaire will be stored securely in a password protected/encrypted file on the researcher's computer. Only the researcher and their supervisor will have access to the data. Data will be retained for 5 years in accordance with the NCI data retention policy.

What will happen to the results of the study?

The results of this study will be presented in my final dissertation, which will be submitted to National College of Ireland.

Ethics

The ethics Board at the National College of Ireland has ethically approved this project.

Who should you contact for further information?

Contact Details: Researcher: Marieke Beumer Email: x18129064@ncirl.ie

Supervisor: Dr Michelle Kelly Email: michelle.kelly@ncirl.ie

Thank you for taking the time and making the effort to take part in this study.

I confirm that I am 18+ years of age ☐

I confirm that I don't have a diagnosis for any psychological illness ☐

Do you agree to participate in this study? ☐ Yes ☐ No

Appendix E Debriefing form

Debriefing

I would like to sincerely thank you for taking the time to participate in this study. If you felt distressed or uncomfortable as a result of answering any of the questions in this study, you are encouraged to speak to someone that can help such as a friend or family member. Contact details for support services are provided below, if you should need any further support.

Support Services

Helplines:

Samaritans Ireland

Crisis Support

Web link: https//www.samaritans.org/ireland/samaritians-ireland/

Email - jo@samaritians.org.

Tel - 116 123

Free 24 hour listening service for anyone

Aware

1800 80 48 48

email info@aware.ie

Pieta House

Tel - 01 601 0000

Text HELP to 51444

Freephone 1800 247 247 24hrs

info@pieta.ie

National Helpline Drugs/Alcohol info support

Tel - 1800 459 459

Email: helpline@hse.ie

Contact Details

If you have an concerns or questions about the use of this data, or any further queries about this study please do not hesitate to contact myself Marieke Beumer email: x18129064@ncirl.ie or my supervisor Dr Michelle Kelly email: michelle.kelly@ncirl.ie

Thank you for taking the time and making the effort to take part in this study.