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Opioid Analgesics, Stigma, Shame and Identity

Introduction

Opioid analgesics represent a well-recognised class of medicines that have gained increasing notoriety through concerns about their addiction potential (Vowles et al., 2015) increasing prescribing trends (OECD, 2019), and related harms (British Medical Association, 2017) particularly associated with their long-term use such as for chronic pain. The ubiquity of prescribed opioids is reflected in a recent analysis which found that around one in eight adults in England had been prescribed an opioid at least once annually (Marsden et al., 2019). This has been viewed as a significant public health concern, and termed an “*opioid epidemic*” with a significant risk of harm and mortality. In terms of scale, in the US during 2017 there were estimated to be around 17000 deaths related to prescription opioids (Mattson et al., 2017), and in the UK in 2019, there were over 9000 hospital admissions linked to non-heroin opioids such as codeine and morphine (NHS Digital, 2019). As well as concerns about deaths and overdose, other clinical manifestations arise in relation to loss of therapeutic effect and tolerance over time, hyperalgesia and addiction itself (Deyo et al., 2015). Between 2005 and 2017 in England, there was a 91% increase in presentations of individuals to formal drug and alcohol treatment services where an opioid analgesic only was involved (Public Health England, 2018)

In this chapter my aim is to move beyond these dominant clinical and public health foci on harm and mortality, to explore the significant psychosocial problems related to the consumption of prescription and over-the-counter (OTC) opioid analgesic medicines. I argue that affected individuals might experience significant stigma and shame through problematic use of opioid medicines themselves. In addition, such medicine use impinges on important aspects of identity, and challenges notions of coping and the management of often chronic conditions. As Eaves notes:

“Consumption of goods, including medications, is a visual and tangible means of communicating social values, performing notions of self and establishing social relationship [...] Pharmaceutical consumption is part of constructing individual and social identity” (Eaves, 2015, p. 147).

Issues of stigma, shame and identity have been represented in the literature relating to conditions like chronic pain and associated illness narratives (Åsbring & Närvänen, 2002; Denny, 2017; Frank, 2013; Newton et al., 2013; Werner & Malterud, 2003), however, my aim

in this chapter is to show that despite the importance of such studies, they have neglected the additional impact of the consumption of opioid analgesics and its effect on stigma, shame and identity.

Patients and medicines

Much has been written about patients and insights into their illnesses and associated narratives and biographies as part of the “narrative turn” in recent decades (Polkinghorne, 1988); whilst the sociological literature in particular has offered important and influential framing of patients and illness in terms of identity, shame and stigma amongst others, there is a relative lack of corresponding constructs in the more specific area of patients’ consumption of medicines. This was recognised more than two decades ago by Vuckovic & Nichter (1997) who recognised the dearth of research and literature that went beyond traditional compliance debates and failed to capture important issues such as ‘*self-identity*.’ In an authoritative review of previous research on how individuals use (and more specifically) resist medicines, Pound et al (2005) suggested that patients were often cautious in the use of medicines, and adopted either active or passive strategies and at times sophisticated lay testing strategies to evaluate medicines. The authors identified key concerns also around identity and stigma and in particular anxieties around dependence and addiction. Of particular note, however, was that this occurred not just for medicines with recognised addiction or tolerance properties – such as opioids – but with other therapeutic groups such as antihypertensives and proton pump inhibitor medicines also. Of note, however, was that identity issues were often not specifically related to addiction fears and arose more in terms of non-acceptance of a medical condition, or associated stigma, i.e., preventative asthma medicines were not taken to support patients’ denial that they had a significant and chronic illness (Adams et al., 1997) or antiretroviral medicines were not taken regularly as they highlighted a stigmatized condition (Pound et al., 2005).

The role of opioid analgesics in pain

Opioids have been recognised as having an important role in the control of pain for millennia (Rosenblum et al., 2008) initially through naturally occurring opiates found in the opium poppy, to the extraction and identification of morphine and later development of synthetic opioids such as heroin, oxycodone and tramadol. Current clinical guidance (British Medical Association, 2017; Dowell et al., 2016) offers a more conservative understanding of the role

of opioids, particularly in the context of chronic pain. This represents the most common presentation for analgesia and is contrasted with pain arising from an acute injury or interventions such as a surgical procedure, or terminal cancer. In chronic pain, opioids are recognised as being one of several pharmaceutical therapies which also include non-opioid analgesics such as paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs), tricyclic antidepressants and most recently gabapentinoids (British Medical Association, 2017). Perhaps most importantly, however, is recognition of a range of non-pharmacological therapies, such as physiotherapy and psychological and cognitive behavioural therapies, which are recognised as having an important place in the overall management of chronic pain. Evidence suggests that opioids often do not have a significant or beneficial effect in the management of chronic pain despite their potency and position in the traditional analgesic ladder, particularly for the most common presentations such as lower back pain (Abdel Shaheed et al., 2016; Ballantyne & Shin, 2008; Deyo et al., 2015; Dowell et al., 2016).

It is tempting to think that such concerns and the lack of evidence of long-term efficacy would have a negative impact on opioid analgesic availability but there has actually been a well-recognised trend towards increasing prescribing of opioids globally (OECD, 2019). Some countries, such as the US and UK, have reported more recent reductions in prescribing but concerns remain about, for example, the rise in high strength opioid analgesics (Curtis et al., 2019) and sustained release preparations. Increasing opioid prescribing has been attributed to increasingly older patient populations *qua* consumers, for whom chronic musculoskeletal pain is more common, but also to claims of pharmaceuticalization and the under-treatment of pain (Finestone et al., 2016; Portenoy & Foley, 1986). Pharmaceuticalization extends the concept of medicalisation (where non-medical problems become medical ones) to include the role of the pharmaceutical industry and activities such as drug marketing and promotion to the public and prescribers (Abraham, 2010). The most well-known example relating to opioid analgesics is that of oxycodone and the pharmaceutical company Purdue who manufactured and marketed it. The company was heavily criticised for over-marketing – particularly their long-acting product Oxycontin – to under-trained primary care doctors in the US, and also under-representing iatrogenic addiction harms (Finestone et al., 2016; Van Zee, 2009). As Finestone et al., (2016) argue, however, it is not only the inappropriate marketing activities of the pharmaceutical industry but also more systemic failures to provide adequate non-pharmacological services and resources.

Concern about the under-treatment of pain arose in the 1970s and 1980s initially in relation to palliative care (Portenoy & Foley, 1986) and clinicians' litigation concerns regarding iatrogenic addiction. An influential campaign led to pain being considered the "*fifth vital sign*" in the US (Tompkins et al., 2017) which ushered in a trend in increased prescribing in the US in particular and eventually more widely. Further contributing to the case of under-treatment of pain was the significant problem of framing pain management and to the difficulty of distinguishing between the needs of 'genuine patients' and others using analgesics 'illegitimately' (Bell & Salmon, 2009). Analysing the existing literature, these authors argue that:

"[...] discourses on pain management and the right to pain relief reify distinctions between the 'deserving pain patient' and the 'undeserving addict', serving both to further stigmatise people labelled as 'addicts' and delegitimise claims to pain they might voice." (Bell & Salmon, 2009 p.170)

Attempts to address concerns about opioid analgesic prescribing and use have been introduced and a variety of educational, surveillance and regulatory interventions have been attempted (Compton et al., 2015). In the UK, resources such as *Opioids Aware* (Faculty of Pain Medicine, 2015) were developed to provide information and advice to both prescribers and patients. Surveillance has been used particularly in countries such as the US through prescription drug monitoring programs and even at the level of individual patient "*doctor shopping*" (Compton et al., 2015). A variety of regulatory changes have been introduced, particularly to limit supply of opioids. In Australia, for example, up-scheduling has meant that over-the-counter supply of opioids such as codeine are now prohibited and restricted to prescription supply only (Roberts & Nielsen, 2018). This resulted from recognition that compound opioid analgesic products may cause significant harm despite being less potent than prescription medicines (Frei et al., 2010). Changes in prescribing category have been addressed elsewhere. For example, in the UK, the synthetic opioid tramadol was re-classified as a Schedule 3 controlled drug some twenty years after its introduction, following concerns about increased overdose deaths (Stannard, 2019). Several years earlier, the compound analgesic co-proxamol was completely withdrawn from the market in the UK due to fatalities associated with its use (Hawton et al., 2012). In several countries including the UK, OTC opioid packaging was voluntarily changed by manufacturers to carry addiction warning messages and time limited use (Cooper, 2011; Medicines and Healthcare products Regulatory Agency, 2009).

An ongoing concern, however, is the lack of long-term evidence of the efficacy of opioid analgesics. Despite concerns, clinical guidelines and subsequent practice still offer a place for such therapies. Central to the guidance provided to prescribers and suppliers is the recommendation of punitive surveillance strategies such as urine testing, treatment contracts, and the use of buprenorphine or take home naloxone when addiction or overdose respectively are considered a risk (Dowell et al., 2016).

Stigma, shame and identity

In much the same way that patient narratives of illness have neglected the role of medicines, other health research addressing stigma, and associated shame and identity have also tended to focus on particular conditions and not on associated medicine use. Indeed, even in the context of chronic pain and stigma, the significance of medicines has not been captured (Åsbring & Närvänen, 2002; Cohen et al., 2011; De Ruddere & Craig, 2016). In his seminal work Goffman (2009) argued that stigma arises when individuals or groups are perceived to be different and that this can occur in different ways. Drawing on medical examples, stigma can arise visibly and most explicitly in *discredited conditions* where it is clear that there is a deviance from perceived normal behaviour or appearance (such as a disfiguring skin condition or a physical disability, for example). Of particular note, though, is that stigma can also arise in *discreditable conditions*, which also have the *potential* to elicit stigma, such as someone with epilepsy suffering from an epileptic seizure in public which moves a discreditable condition to a discredited one (Scambler, 2009). Central to these accounts is the connection between stigma and identity and the notion of the ‘spoiled identity’ – one’s identity diminished through stigma. One further distinction in relation to stigma arises in the difference between felt (internal) and enacted (external) stigma; the former represents the perceived shame and embarrassment associated with stigma, whilst the latter relates to the outward experience of being treated differently due to stigma from others (Scambler, 2009). In the context of chronic pain, it has been argued that this is a stigmatising condition (Cohen et al., 2011; Eaves et al., 2015; Jackson, 2005) which is discreditable due to the ‘invisible’ nature of pain in many cases (Newton et al., 2013). Chronic pain may also be discredited, however, if there is sufficient deviance from expected behaviours and norms, and be subject to enacted stigma in such cases. Drug seeking behaviours represent key examples in the context of opioid analgesics where the individual becomes discredited through such actions. Examples of this include increasing the amount of

time spent sourcing and using opioids through visiting multiple pharmacies or requesting repeat medicines from prescribers (doctor shopping).

Shame is a term often associated with stigma, sometimes used synonymously or assumed to result from stigma (Lewis, 1998). There have been numerous definitions but central to these are often concerns with a negative evaluative emotion:

“With the experience of shame or its allied effects, we feel or believe that we do not measure up to ideals or standards that we have set for ourselves. We become aware that we are not the kind of persons we think we are, wish to be, or need to be.” (Lazare, 1987 p. 1653)

In the context of healthcare, shame has been regarded as a destructive force which can lead to adverse outcomes including addiction and loss of control (Wiechelt, 2007). It has also been recognised, however, that aspects of health and healthcare can be a cause of shame themselves and lead to chronic shame (Dolezal & Lyons, 2017). The very recognition of any *“defects of body or mind”* (Lazare, 1987 p1653)) by a patient is considered enough to lead to shame, as it involves recognition of a discrepancy and difference. This is potentially further exacerbated through the medical gaze and aspects of the clinical encounter and issues such as lay knowledge. The consumption of opioid analgesics in chronic pain can also constitute a shaming activity and this will be illustrated later in the chapter after considering the final main concept in this chapter, that of identity.

As well as shame, a further concept often referred to when considering stigma is that of identity. Whilst this represents a considerable topic in its own right and is beyond a detailed description in this chapter, in the context of health, medicines and opioid analgesics, identity is an important aspect of how individuals understand themselves and others, and their experiences of health and illness (Britten, 2008; Eaves, 2015; Vuckovic & Nichter, 1997; Whyte et al., 2002). Medicines and identity have in fact been connected previously and this has been linked in particular with the marketing of medicines and claims that medicines can powerfully shape individuals’ identities (Eaves, 2015) and as Vuckovic & Nichter (1997 p.1297) note: *“individuals come to be defined by the medicine which they consume [...]”*. This is illustrated no more so than in the substantial literature relating to addiction recovery narratives and transformational identity; substitution therapies such as methadone and buprenorphine represent important examples of how medicines have been argued to negatively influence identity transformations through their consumption (Doukas, 2011). Common to this literature

is the important presentation of self for those who formerly used illicit substances and of the need to demonstrate recovery and distancing from previous illicit discredited norms (McIntosh & Mckeganey, 2000). Substitution therapies involving methadone and buprenorphine threaten this identity reconstruction work and carry significant stigma through aspects of their supply (visibly in pharmacies and often with supervised consumption) and symbolically (in representing maintenance and not abstinence). In the context of health and related healthcare, issues of stigma, shame and identity have been considered influential ways of framing patient experiences and also applied to chronic conditions that involve pain. The role of medicines such as opioid analgesics, however, has tended to be neglected; in the next section and central to this chapter, examples of where opioid analgesic medicines are explicitly linked to identity, stigma and shame are considered.

Recognising opioid analgesic stigma, shame and identity

At the heart of this chapter is the concern that the use and consumption of medicines such as opioid analgesics does have implications for identity, shame and stigma but has been neglected in the wider literature on illness narratives and chronic pain (Newton et al., 2013), the doctor-patient relationship (Åsbring & Närvänen, 2002; McCrorie et al., 2015; Werner & Malterud, 2003) and issues of diagnosis and legitimacy (Åsbring & Närvänen, 2002). In relation to opioid analgesics more specifically, there have been occasional examples of research that has sought to explore stigma, shame and identity claims and even integrate opioids into illness narratives and these are now considered in turn.

The first example involves a study of twenty patients who attended pain clinics in Melbourne, Australia (Paterson et al., 2016), where it was found that as well as actively resisting opioid analgesic use, patients described concerns linked to identity and stigma which the authors argued were more significant than the chronic pain condition itself:

“[f]or people taking opioids for chronic pain, it is the medicine, more than the illness, which is potentially stigmatizing.” (Paterson et al., 2016 p. 724)

Drawing on Scambler's (2009) distinction between internal (felt) and external (enacted) forms of stigma, the researchers found that patients' felt stigma was linked to shame and fears about being discredited and viewed as undeserving of health care treatment, and that they made active attempts to limit disclosure and communication about their opioid use. Enacted stigma was also apparent in examples of discrediting by allied healthcare professionals such as pharmacists

and chiropractors; although such cases were not expanded on further, they appeared to cause significant distress to participants:

“Most examples of enacted stigma, where people were discredited due to taking prescription opioid, were in relation to health professionals. For example, Max described being upset when his pharmacist regularly phoned up and checked his prescription, while he stood in line with “four guys standing there waiting for their methadone.” Ben described his chiropractor as always “being very against it” without any explanation or alternative.” (Paterson et al., 2016 p724)

Stigma was also linked to perceptions of illicit drug use in this study and another involving over-the-counter codeine and dihydrocodeine misuse (Cooper, 2013; Cooper, 2011). Paterson et al also suggested that opioid medicine use was associated with concerns about identity, with examples focused on side effects and more overt embodied aspects of opioid use, related to impaired cognition or tiredness:

“For example, Ruby explained that when she started on opioids in hospital it was “like my identity wasn’t there anymore and I couldn’t think straight” which led to her being dependent on others and unable to plan her own recovery.” (Paterson et al., 2016, p.724)

Accounts from the participants in the Paterson et al study were also analysed separately in a rare example of how opioid analgesics were presented as part of patient illness narratives (Zheng et al., 2013). Drawing on Frank's (2013) influential typology, these authors identified contrasting narratives related to chaos, restitution or quest. Initial accounts were all related to chaos and negative experiences:

“[...] all the narratives were at some point, usually near the beginning, chaos narratives i.e., they were characterized by worsening and chaotic pain and/or opioid related problems and periods of hopelessness.” (Zheng et al., 2013, p. 1830)

The authors noted, however, that whilst some remained in “*chaos*”, others appeared to progress and for some this was a partial improvement and recognised as quest narratives whilst others achieved more stability and were categorised as restitution narratives.

Problems can arise not only with prescription opioids but also with those that can be purchased as over-the-counter medicines from pharmacies and this is illustrated in a second research example where stigma, shame and complex identity issues were identified. Cooper (2011, 2013) explored this with individuals, who had self-reported problems with over-the-counter medicines in the UK, recruited via two on-line support groups – *Over-count* and

Codeinefreeme. The majority of participants had experienced problems with their changing use (and subsequent misuse) of codeine or dihydrocodeine following legitimate initial access via prescription. Of note and in contrast to several other studies reported in this chapter, was that chronic pain was not always a feature of their narratives, and their continued consumption of an opioid analgesic extended for some beyond their initial pain. Both felt and enacted stigma were apparent in examples given by participants such as when they both anticipated and experienced detection by staff at the various pharmacies they visited to obtain multiple supplies of opioid medicines. Felt stigma arose also in relation to potentially admitting their problematic use of an opioid analgesic and seeking help and treatment; many participants feared engaging with formal health care providers because of concerns that their addiction would be recorded. Participants also commonly referred to a sense of shame associated with their consumption of OTC opioids and this led to sophisticated attempts to hide their use, and to avoid detection:

“As Ailsa noted, this was bound up in issues of shame about her OTC addiction but, again, fears about identification: ‘I was ashamed as well because you don’t necessarily want to be identified. I think the people on [an online support group], I think it is more anonymous but then I think that’s a trust thing isn’t it so you know....’” (Cooper, (2011 p.57)

Issues of stigma and shame in participant’s problematic use of opioid medicines were also bound-up in conflicting identity issues for them. All recognised themselves as being “*addicted*” and often explicitly used this term and an associated addicted identity but were clear in distinguishing themselves from illicit drug users. The latter were perceived by participants to be chaotic and different in appearance and in stark contrast to themselves, despite sharing what participants perceived to be a fundamentally similar addicted identity. Participants actively constructed acceptable identity claims about themselves and although recognising their own problematic medicine misuse, presented this as a form of “*respectable addiction*” (Cooper, 2011). This was linked to stigma and shame as well as identity and enabled them to simultaneously identify as being addicted but also high functioning and socially and economically active within society.

Reinforcing these two examples, research with patients suffering from temporomandibular disorders (TMD) which involves facial pain highlights active attempts by those affected to avoid negative connotations of illness identity associated with the use of opioid analgesics. In one study, participants were selected as they used OTC non-opioid analgesics for TMD and it

was found that this was an active strategy in harm reduction in *not* using prescription medicines. Such strategies were directly related to issues of identity and stigma:

“Trade-offs between physical harm reduction and harm justification to one’s identity involved narratives of harm justification as chronic pain sufferers described their use as minimal and responsible [...] Describing medications as ‘just over-the-counter’ or ‘not real pain medication’ is social harm reduction. These phrases are uttered with the intention of minimising stigma [...]” Eaves 2015 p.152

The same participants were also found to undertake sophisticated identity management strategies which were partly linked to medicine use and the perception that consumption of medicines – and in particular prescription analgesics – was a significant threat to their stoic moral identity as someone living with chronic pain. Participants were observed to:

“[...] distance themselves from what they perceive to be a stigmatized chronic pain identity associated with medication dependency if not abuse.” (Eaves et al., 2015 p. 163)

Before concluding this section, a related emerging issue relates to the identification of issues of stigma and identity in the use of medicines used either as alternatives for opioid analgesics when opioid substitution therapy (OST) is initiated, or where overdoses due to a continued opioid analgesic are being prevented (Dowell et al., 2016). In the former case, medicines such as methadone and buprenorphine represent opioids that have been used for many years in the management of illicit drug use (such as heroin for example) but have been increasingly used for patients who have become addicted to opioid analgesics also (Dowell et al., 2016; Independent Expert Working Group, 2017). Of concern in such cases is that it is not just the initial opioid but also the substituted one that can cause problems. As previously noted, this is a recognised issue in terms of stigma and identity reconstruction in illicit substance use (Doukas, 2011) but has also emerged as a specific problem for prescription and OTC opioid analgesic substitution. In the study by Cooper (2013), five of the twenty five participants self-reporting addiction to OTC opioid analgesics reported experiences with either methadone or buprenorphine. Although narratives were often associated with positive opioid free outcomes, they remained a contested aspect and were associated with additional stigma and an ‘addict’ identity (with this term being repeatedly used by participants to describe themselves):

“Treatment options involving specific medicines were also viewed problematically, mainly due to their association with illicit drug treatment or having supervised

consumption: 'I was turning up to [the local] drug unit for my daily dose of methadone as though I was a heroin addict [...] At that stage, I didn't think that methadone was appropriate' .” (Cooper, 2011 p.57)

Stigma and opioid treatment concerns were also identified in a wider review of literature which found that stigma linked to the use of OST and also that a sense of blame might prevent individuals seeking treatment, with adverse consequences (Cooper & Nielsen, 2017).

The other aspect related to opioid medicines is the increasing use of approaches to prevent overdose and possible deaths. This often involves naloxone, which is an opioid antagonist that can be administered and even self-administered (hence the term take home naloxone or THN) to reverse respiratory depression which is a significant risk if opioids are consumed in excessive amounts. Like OST, THN was originally promoted as a public health initiative among illicit substance misusers but is increasingly being advocated for people using opioid analgesics legitimately. In a recent study involving 46 adults in Australia who consumed opioids (including 18 who did so primarily for chronic pain), Fomiatti et al (2020) identified multiple concerns about THN which related to stigma. They identified issues around information provision and perceived risks of overdose and that for those using prescribed (licit) opioid medication, THN was a further source of stigma with negative implications for treatment seeking, like those noted earlier by Cooper & Nielsen, (2017):

“The social relations co-produced by prescription opioid consumption are different from those co-produced by illicit opioid consumption, with significant implications for how overdose risk is articulated. For this reason, it is understandable that some consumers articulate take-home naloxone as both irrelevant and stigmatising [...].”
(Fomiatti et al., 2020: p16)

Introducing these two additional related perspectives about OST and THN and manifestations of stigma and shame illustrates further complexities in relation to the use of opioid analgesics which go beyond the intended clinical and public health benefits and have been argued to link directly to patient’s motivations to seek help.

What role for opioid analgesics?

What has hopefully emerged so far in this chapter is the need to recognise not just the “*complexity of people’s lives*” but also the “*complexity of opioid therapy*” (Esquibel & Borkan, 2014 p.2581) and in particular, associated issues of stigma, shame and identity

disruption. These have been argued to be largely absent in the extant literature relating to illness narratives and particularly those involving chronic pain. Medicines are powerful and complex social phenomena which have been argued to have “*social lives*” and indeed “*biographies*” that allow them to both imbue and be imbued by different actors with significant - and potentially different - meanings across place and time (Whyte et al., 2002). In one sense, this has been shown in relation to the different settings where opioid medicine stigma, shame and identity arise, whether this is in OTC pharmacy encounters, prescribing by doctors, or in online support groups. It is also apparent across time, and in the shifting attitudes towards opioid analgesics from both a public and health care professional perspective. Although Whyte et al (2002) do not refer specifically to opioids, they argue that all medicines have social lives and are involved in important acts of co-production. Illustrating this subjectivity and providing counter-balance to the negativity of stigma, shame and spoiled identity is the identification of a legitimating role for opioid analgesics. Drawing on qualitative interviews with a sample of patients taking opioid medicines for three months or more in Rhode Island and Massachusetts in the United States, Esquibel & Borkan (2014) identified addiction concerns but importantly contrasting themes of “*validation of pain*” and the “*right to pain medicines.*” Although issues of stigma, shame and identity did not explicitly arise, patients (and also doctors) in this study, which covered a range of pain-related conditions in the outpatient hospital setting, often referred to opioid analgesics in interviews. It was noted that they:

“[...] mention pain medications when describing the pain experience, as if medications were intrinsically tied to the understanding of pain itself.” (Esquibel & Borkan, 2014 p. 2578).

What this study illustrated and others have sought to do also (McCrorie et al., 2015), is to consider the dyad of both patient and prescriber in relation to pain and opioid analgesics. Important contrasts arose and whilst opioids were considered important for patients, this was not necessarily the case for doctors. Similar themes of legitimation have also been identified among antidepressant users too (Ridge et al., 2015). The example of legitimation is arguably not a dominant one in the literature relating to opioid analgesics, although more widely in terms of pain, legitimation through medical diagnosis is an enduring and dominant theme (Åsbring & Närvänen, 2002; Denny, 2017). The “*social lives*” of opioid analgesics are argued to remain contested and often resisted in society (Pound et al 2005, Britten 2008). Through the negative associations of different forms of stigma and shame and in association with spoiled identity,

opioid analgesics represent potentially destructive forces in relation to chronic pain management in particular.

Presenting these negative consequences has implications for clinical care and management and highlights the need for caution particularly in their initiation but continued use also. Caution is clearly presented in relation to current guidance about chronic pain and opioids in particular (British Medical Association, 2017; Dowell et al., 2016) but at the heart of this chapter is the concern that *additional* psychosocial concerns such as stigma, shame and the potential spoiled identity should also be taken into consideration and are absent from the majority of current discourse. For clinicians, this hopefully offers additional insights and another perspective, and suggests that sensitivity is needed when managing the care of those who use opioid analgesics, to avoid shaming and stigmatisation in clinical encounters (Dolezal & Lyons, 2017; Lazare, 1987). For patients, it provides recognition of further aspects of opioid analgesic use that have hitherto not been widely voiced and may also serve a precautionary function for others. Facing both these groups - of opioid analgesic prescribers and opioid analgesic consuming patients - is a fundamental dilemma, namely how to optimally control and manage pain but also minimise the use of opioid analgesics. Balancing these two remains a clinical and also public health ideal but is still not supported by robust evidence on the long-term effects of opioid analgesics (British Medical Association, 2017; Juurlink, 2018); arguably, such a dilemma does not help the substantial group of legacy patients already taking an opioid analgesic, and for whom issues of stigma, shame and spoiled identity may be all too apparent. Opioid analgesic related stigma, shame and identify issues might exacerbate this enduring conflict between pain relief management and safe, controlled opioid analgesic use.

Conclusions

This chapter has offered novel insights into a highly contested topic and argued that patient narratives about pain have neglected stigma, shame and identity concerns directly related to the use of opioid medicines, and that these must be considered as linked but distinct aspects of overall experiences of pain (Denny, 2017). When considering the arguments in this chapter, caution may be needed in drawing attention to a relatively small body of research literature exploring stigma, shame and identity issues related to opioid analgesic use. Although drawing on exploratory qualitative methodologies that were not intended to be generalisable, it is further argued that more research and evidence is required to understand this issue. A final caution

also is that such analysis may inappropriately follow the law of the instrument (Maslow, 1966) and assume that illness and pain narratives and related biographies *must* include the use of medicines as if medicines are the dominant or only treatment instrument. It is important to recognise that although our societal relationship to medicines such as opioid analgesics is long and complex, and involves both negative and positive aspects, non-pharmacological treatments and support – particularly in the context of pain – should not be under-estimated.

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