Perspective

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Beyond blame and shame: Empathy-based health communication for substance misuse in Sri Lanka

V K I U Alwis, S M A N Samaranayake, A Baminiwatta

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Substance use disorders are a global public health challenge. In Sri Lanka, an estimated 23,000 deaths and 700,000 disability-adjusted life years were attributed to alcohol, tobacco and illicit drugs in 2023 (1). Substance misuse also contributes to societal issues such as domestic violence and places a serious economic burden on the country. While these detrimental impacts emphasise the necessity for a strong public health response to substance misuse, its historical context must be examined to understand the nature of this response.

The adversary of industry

Starting from the mid-20th century, the tobacco and alcohol industry was actively glamorising substance use, using false claims of health benefits, political lobbying and celebrity endorsements. Tobacco use was directly promoted in the media as associated with independence and sexual attractiveness, manipulating vulnerable young adults (2). In the face of a well-funded adversary, it would have been imperative for public health bodies to formulate a strong enough counter-narrative. This led to a global campaign of counter-advertising on tobacco and alcohol from the early 1990s (2). To counter glorification, such campaigns had to resort to a shame-based approach (3), where substance users were alternatively portrayed as ugly: *'ugly face'*, *'bad smelling'*, *'beer-fat'*, unintelligent: *'small brain'*, *'hollow inside'* and weak: *'gullible'*, *'poor personality'*. This strategy is still used by many anti-substance movements in Sri Lanka at present.

However, over the last two decades, both promotion tactics by industry and the public health approach to substance misuse have evolved significantly (4). Hence, it is critical that we revisit current shame-based approaches to substance misuse. In this perspective, we will present evidence-based, behavioural change principle-based and ethics-based arguments as to why Sri Lanka needs to shift towards an approach that centres empathy. It must be reiterated that, as mental and public health professionals, our position is unyielding on tackling industry influences. However, we believe firmly in distinguishing individuals with substance misuse separately from the drug industry, as the adversary in the fight against substance misuse is the latter and not the former.

Evidence on effectiveness

Public health approaches to substance misuse focus both on discouraging consumption among non-users and reducing or stopping consumption in existing users (4). Therefore, the effectiveness of shame-based communication approaches on both primary and secondary prevention needs exploration.

Evaluation of shame-based approaches gives inconclusive evidence for the broader population. While some studies showed a decrease in smoking intentions and practices, communication that projects unattractiveness or a social image of being manipulated was reported to be ineffective by other evaluation studies (2). There is also a growing repertoire of alternative communication styles. Positive framing utilising hope, self-efficacy and social norms, and selected negative framing techniques using fear-appeal and sadness have demonstrated efficacy (5). Studies assessing the effectiveness of substance-related communication approaches in Sri Lanka are limited.

Evidence on secondary prevention is more straightforward. Functional theories of shame have shown that it can lead to both avoidance and motivational behaviours depending on context (7). Among vulnerable and shame-prone groups, shame leads to "defensiveness, disengagement and disempowerment" (6). As in the case of tobacco users, the derogatory or threatening tone in messaging led to defensive biases, prompting users to dismiss entire health-related content, possibly to minimise their own cognitive dissonance. Tobacco counter-advertisements that were judgmental and less factual were ineffective in making smokers admit addiction issues (2).

Do no harm

Debates about shaming in the name of public health have tended to focus on efficacy rather than ethics, justice

and human dignity (6). As physicians abiding by the Hippocratic oath, our interventions, may they be clinical or public health, should be committed to do no harm. Shame has a strong positive association with problematic substance use, one as strong as that of depression (7). Interventions inciting shame are more likely to trigger a shame-substance spiral among such users, where more substance use is perpetuated to escape feelings of shame. Furthermore, they may alienate substance misusers by reinforcing stigma towards them. The internalisation of stigma may discourage help-seeking, lead individuals to attempt quitting unassisted, and hinder their recovery (3, 6).

Shame-based messaging in public health also leads to stigma among healthcare workers, which likely affects the quality of care for people with substance misuse. The use of shame and ridicule as a tool by professional entities further feeds into marginalisation and dehumanisation, especially of illicit drug users, not uncommon among the general population in Sri Lanka (8). A utilitarian 'greater good' for society, which ultimately harms individual patients, is a questionable ethical position for physicians to hold.

Substance misuse is disproportionately prevalent among marginalised populations with lower income and limited education in Sri Lanka (9). So, when shame-based approaches frame substance misuse as a personal failure, they often disregard the social determinants that affect them. The consequent stigma exacerbates existing inequities. Such approaches are thus in direct conflict with the principles of empowerment in the currently accepted bio-psycho-social model of addiction and behavioural change.

The way forward

Empathy is a foundational principle in the motivational interviewing technique for counselling patients with substance misuse. We propose expanding this principle from the clinical setting into broader health communication. A non-judgmental approach mitigates defensive reactions from misusers, enabling behavioural change, while maintaining anti-smoking attitudes among non-users. Many alternative communication strategies including positive framing techniques such as self-efficacy and hope statements will not induce stigma towards patients with substance misuse (5).

The mobilisation for empathy-based communication should happen across individual, institutional and community levels. Healthcare staff should undergo shame-sensitive communication training. Professional organisations should reject shaming as a public tool and realign their communication strategies on empathy (6). Greater advocacy efforts may be required on mass media to avoid stigmatising language when referring to individuals with substance misuse. Indirect promotions of substance that persist in Sri Lankan media (10) need to be countered with stricter regulations rather than resorting to shame-based approaches.

There is a clear necessity for more research on substance-related communication approaches and their effectiveness in Sri Lanka. Incorporating lived experience in the design of health messages will also be crucial for uptake.

Substance misuse is a multifaceted problem that needs to be tackled with both tact and empathy. We believe these actions charter a pathway for health professionals to fight industry challenges while ensuring individuals with substance misuse are not treated as collateral damage.

V K I U Alwis, Australian Centre for Health Services Innovation (AusHSI) and Centre for Healthcare Transformation, School of Public Health and Social Work, Queensland University of Technology (QUT), Australia, Department of Community Medicine, Faculty of Medicine, University of Peradeniya, Sri Lanka

S M A N Samaranayake, Mental Health Unit, Base Hospital, Kalmunai North, Sri Lanka

A Baminiwatta, Mental Health, Drug and Alcohol Services, Barwon Health, Geelong, Australia, Department of Psychiatry, Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka

Corresponding author: S M A N Samaranayake

E-mail: achini.sman@gmail.com

https://orcid.org/0009-0001-5285-5241

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