Stigma Reduction to Combat the Addiction Crisis — Developing an Evidence Base

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Between 1999 and 2017, more than 700,000 Americans died from drug overdoses, and escalating rates of drug addiction have contributed to recent decreases in life expectancy. To address this crisis, we must combat the stigma attached to addiction. A large body of research indicates that this stigma is persistent, pervasive, and rooted in the belief that addiction is a personal choice reflecting a lack of willpower and a moral failing. Though the severity of the stigma varies with the particular drug being used, evidence shows that stigmatizing beliefs underlie views about addiction in general. Rates of stigma are extremely high both in the general public and within professions whose members interact with people with addiction, including the health care professions. One national survey revealed that three quarters of primary care physicians were unwilling to have a person with opioid use disorder marry into their family, and two thirds viewed people with opioid use disorder as dangerous.[1]

Stigma manifests in labeling of people, negative stereotyping, status loss, and discrimination. Public stigma, which we focus on here, involves pervasive negative attitudes and beliefs that lead to societal rejection of persons with addiction. It contributes to and is perpetuated by structural stigma, which manifests in discriminatory institutional practices and policies. Self-stigma occurs when people with addiction internalize society's negative views.

Public stigma erects barriers at multiple levels. At the individual level, anticipation of being stigmatized can lead to a desire to hide one's substance use, contributing to social isolation and high-risk practices such as solitary use of drugs. Anticipated and internalized stigma may prevent someone with addiction from seeking help or engaging with treatment and other lifesaving services such as harm-reduction programs. At the health system level, public stigma contributes to underinvestment in a high-quality addiction treatment infrastructure and suboptimal care for people with substance use disorders. At the societal level, public stigma can lead to discrimination in insurance benefits, employment, and housing; cause collective not-in-my-backyard resistance to provision of community-based services; and shape public opinion in favor of punitive rather than public health–oriented solutions.

There is an urgent need to establish an evidence base regarding ways of combating the public stigma surrounding addiction. Whereas in other areas of health and medicine we rely on well-designed research studies to establish evidence of effective interventions, efforts to reduce public stigma through communication and education campaigns are seldom grounded in anything more than intuition. In the current addiction crisis, antistigma initiatives are being rolled out by health systems, state agencies, employers, and other groups in the absence of evidence on how best to reduce negative attitudes, correct misperceptions, or target messages to various audiences.

Launching stigma-reduction campaigns without rigorous pretesting of messages can lead to wasted resources and unintended consequences. The national "Disease Like Any Other" campaign offers an instructive cautionary tale. This effort aimed to reduce public stigma by framing mental illness as being on a par with other chronic diseases, such as diabetes, but it was shown to have failed to reduce — and by some measures it actually increased — stigma.[2] One possible explanation for this failure is that the campaign's emphasis on mental illness as a disease heightened the perception of its permanence, thereby increasing pessimism about the potential for recovery.

Although the evidence base for effectively combating public stigma related to addiction is vastly underdeveloped, available research points to a number of principles that can guide stigma-reduction campaigns. These principles are drawn from randomized message-testing experiments, the standard approach for testing the effects of stigma-reduction communication strategies.

First, use of "person-first" language is essential for stigma reduction. Research has shown that use of terms such as "substance abuser" is more likely to exacerbate stigma than use of person-first language such as "a person with a substance use disorder."[3] Since the 2013 release of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), people can no longer be diagnosed with "substance abuse," and health profes-

sionals should eliminate use of this term and other negative and judgmental language such as "addict," "clean," and "drug habit."

Second, emphasizing solutions appears to reduce stigma. Highlighting the availability of effective treatment helped to reduce stigma associated with HIV/AIDS, and some limited evidence suggests that such "treatment works" messaging may also mitigate addiction-related stigma.[4] Similarly, research has shown that emphasizing overdose prevention can reduce negative attitudes about harm-reduction programs.

Third, research suggests that use of sympathetic narratives — stories that humanize people with addiction — may reduce stigma, but the devil is in the details. One randomized message-testing experiment showed that a sympathetic narrative describing the experience of a pregnant woman with opioid use disorder reduced the degree to which the audience blamed the woman for her addiction.[5] However, this narrative reduced stigma only when the pregnant woman was portrayed as having a high socioeconomic status; an otherwise identical narrative about a woman of low socioeconomic status failed to reduce stigma. This finding highlights the intersectional nature of addiction stigma: negative attitudes about addiction are inextricably linked to stigma against certain races and socioeconomic classes.

Finally, stigma-reduction messages should emphasize societal rather than individual causes of addiction. Social psychologists have described a cognitive bias that comes into play here: humans tend to assume that an individual's actions depend more on intrinsic personal characteristics than on situational or societal factors. This bias may lead us to overattribute addiction to people's poor choices as opposed to factors such as poverty, a history of trauma, or structural barriers to accessing effective treatments. Research is needed to test the effects of messages highlighting societal causes of addiction.

It is essential that we build on the principles outlined above to develop a robust evidence base for determining which strategies do or do not reduce the public stigma surrounding addiction. Antistigma communication campaigns can be rigorously evaluated. Messages can be pretested, ideally using experimental methods, before a campaign is launched. Longitudinal collection of data on the attitudes, beliefs, and behaviors targeted by stigma-reduction initiatives can be conducted at baseline, before a campaign goes into the field, and at multiple follow-up points, both short and long term. A robust stigma-reduction evidence base can improve our understanding of which messages work for which groups, including the general public, medical care professionals, and others in key sectors, including criminal justice and child welfare.

To be most effective, stigma-reduction campaigns will have to be embedded in comprehensive strategies for tackling the addiction crisis. In the health care setting, stigma reduction is necessary, but not sufficient, for overcoming barriers to delivery of high-quality care for patients with addiction. Consider a hypothetical communication campaign that has been shown in a randomized experiment, conducted using an online panel of clinicians, to reduce stigma on the part of health care providers. The same campaign may work less well in a real-world setting in which clinicians are unable to get patients with addiction into effective treatment programs; the best antistigma communication campaigns are no match for the powerlessness and frustration clinicians experience in this all-too-common scenario. But when used in combination, effective stigma-reduction efforts may amplify the benefits of high-quality addiction treatment by increasing providers' enthusiasm for caring for patients with addiction and improving patients' experiences with the health care system.

As we grapple with the multigenerational impact of the addiction crisis, moving rapidly to reduce pervasive public stigma is critical. The health field can approach addiction stigma the same way we approach other leading causes of illness and death: by building and deploying a strong base of research evidence.

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