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Stigma and substance use disorders: A clinical, research, and advocacy agenda

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Abstract

The United States is currently experiencing an opioid epidemic, with deaths due to opioid overdoses persisting in many communities. This epidemic is the latest wave in a series of global substance use-related public health crises. As a fundamental cause of health inequities, stigma leads to the development of substance use disorders (SUDs), undermines SUD treatment efforts, and drives persistent disparities within these crises. Given their expertise in mental and behavioral health, psychologists are uniquely positioned to play a frontline role in addressing SUD stigma. The goal of this paper is to set an agenda for psychologists to address SUD stigma through clinical care, research, and advocacy. To set the stage for this agenda, key concepts are introduced related to stigma and SUDs, and evidence is reviewed regarding associations between stigma and substance use-related outcomes. As clinicians, psychologists have opportunities to promote resilience to stigma to prevent the development of SUDs, and leverage acceptance and mindfulness approaches to reduce internalized stigma among people with SUDs. As researchers, psychologists can clarify the experiences and impacts of stigma among people with SUDs over time and adapt the stigma-reduction toolbox to address SUD stigma. As advocates, psychologists can call for changes in structural stigma such as policies that criminalize people with SUDs, protest the intentional use of SUD stigma, and adopt stigma-free language in professional and social settings.

Keywords

alcohol; discrimination; opioids; stigma; substance use disorders

Introduction

We are experiencing an opioid epidemic, with deaths due to opioid overdoses persisting in many communities across the United States (U.S.). Between 1999 and 2018, 446,032 deaths were attributed to overdoses in prescribed opioids, heroin, fentanyl, and other synthetic opioids, with 46,802 of these deaths occurring in 2018 alone (Wilson et al., 2020). The current opioid epidemic is the latest wave in a series of global substance use-related public health crises, surrounding morphine, cocaine, methamphetamine, tobacco, and other substances (Brown, 1981; United Nations Office on Drugs and Crime, 2008). Moreover, the opioid epidemic does not exist in a vacuum: an additional 323,903 overdose deaths due to other substances, such as methamphetamine and cocaine, also occurred between 1999 and

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2018, including 20,565 in 2018 (Wilson et al., 2020). As a fundamental cause of health inequities (Hatzenbuehler et al., 2013), stigma leads to the development of substance use disorders (SUDs), undermines SUD treatment efforts, and drives persistent disparities within these epidemics and crises.

Given their expertise in mental and behavioral health, psychologists are uniquely positioned to play a frontline role in addressing stigma within the current opioid epidemic as well as within co-occurring and future substance use crises. They can leverage what they've learned within other contexts, including theoretical blueprints and evidence-based stigma-reduction tools, to make swift and effective progress toward understanding and addressing stigma. The goal of this paper is to set an agenda for psychologists to address SUD stigma through clinical care, research, and advocacy. To set this stage for this agenda, key concepts are introduced related to stigma and SUDs, and evidence is reviewed regarding associations between stigma and substance use-related outcomes.

Definitions, Key Concepts, and Processes

Theorists and researchers have constructed a definition of stigma, articulated key concepts related to stigma, and described processes linking stigma with health inequities across the lifespan. Within this section, these definitions, key concepts, and processes are described in the context of SUDs, with a focus on the current opioid epidemic. A conceptual framework, which builds off of previous theory and research on stigma and health inequities (Earnshaw et al., 2013; Earnshaw & Chaudoir, 2009; Hatzenbuehler et al., 2013; Quinn & Earnshaw, 2011; Smith & Earnshaw, 2017), is included to guide this discussion (Figure 1).

Social Stigma

Stigma associated with a wide range of socially devalued and discredited identities, behaviors, and other characteristics (i.e., stigmatized statuses), plays a role in substance use-related outcomes. Stigma has been conceptualized as a *social process* that exists when labeling, stereotyping, separation, status loss, and discrimination occur within a power context (Link & Phelan, 2001). Stigma is recognized to be a *fundamental cause* of health inequities (Hatzenbuehler et al., 2013). There are several features of stigma that are common, cutting across all stigmatized statuses (Birbeck et al., 2019). As examples, the *pathways* linking stigma with health inequities (Chaudoir et al., 2013; Hatzenbuehler et al., 2013; Meyer, 1995) and the *intervention tools* to address stigma (Cook et al., 2014; Rao et al., 2019) are similar across statuses. Given these common and cross-cutting features, psychologists can leverage what they have learned about stigma in a wide range of contexts (e.g., race, HIV) to understand and address stigma in the context of SUDs.

Stigma associated with SUDs is theorized to serve a *societal function* of enforcing conformity to social norms surrounding non- or moderate use of substances (Phelan et al., 2008). This function of stigma applies when behaviors are viewed as voluntary and thus changeable. In the midst of the current opioid epidemic, debate has returned to the ethical question of whether stigma should ever be used to promote public health, including by preventing opioid use (Bayer, 2008). Advocates of this strategy point out that this is the function of stigma. Advocates further claim that denormalization policies, which ultimately

sanctioned stigma towards people who use tobacco, were successful in public health efforts to prevent and reduce tobacco use in the U.S. (Bell et al., 2010). Yet, this strategy has at least two critical flaws. First, it overemphasizes the role of personal control in the initiation of substance use. Environmental, social, and genetic factors play key roles in substance use initiation (Volkow et al., 2016). Stigma cannot prevent people from engaging in a behavior that they do not fully control. Second, the strategy sacrifices the wellbeing of people with SUDs, given that stigma is a barrier to their recovery efforts. An excess of shame undermines recovery; whereas enhanced self-esteem, hope, and inspiration facilitate recovery (Hill & Leeming, 2014). By blocking access to resources that facilitate recovery, stigma can also widen already-existing health inequities surrounding substance use. In the case of tobacco use, stigma had made it particularly difficult for people with limited resources to stop using tobacco (Bell et al., 2010).

Stigma is recognized to be *intersectional*. Intersectionality theory posits that individuals live with multiple interconnected statuses that represent dimensions of both marginalization and privilege (Rosenthal, 2016). Multiple, interconnected forms of stigma lead to substance use behaviors among people who are at risk of developing a SUD, such as stigma associated with sexual and gender minority identities and expressions, race/ethnicity, incarceration, socioeconomic status, physical and mental illnesses (e.g., HIV and chronic pain), and other statuses. It further recognizes that stigma associated with multiple statuses intersects with stigma associated with SUDs and SUD treatment to shape inequities along the SUD treatment cascade. At the structural level, intersectionality theory emphasizes that systems of oppression are interlocking and reinforcing. For example, racism and substance use stigma have been interwoven throughout the history of the U.S., with substance use stigma often wielded to fortify racism and vice versa (Brown, 1981; Kerr & Jackson, 2016). Racism led to harsher penalties towards the use of crack cocaine, which was associated with Black and African Americans, than powder cocaine, which was associated with White Americans, in the late 20th century (Lowney, 1994). At the individual level, intersectionality theory holds that individuals' experiences of and responses to stigma are shaped by all aspects of the self. As an example of the intersection of gender and SUD stigma, women (but not men) in recovery from SUDs report that others stereotype them as having engaged in sex work (Earnshaw, Smith et al., 2013).

Stigma Manifestations: Structural and Individual Levels

Stigma is manifested, or expressed and experienced, at the structural and individual levels. These stigma manifestations, in turn, reinforce and sustain stigma (Earnshaw et al., 2013; Link & Phelan, 2001). At the structural level, stigma is manifested within societal-level conditions, cultural norms, and institutional policies (Hatzenbuehler & Link, 2014). At the individual level, stigma is manifested among individuals who are not living with the stigmatized status of focus (referred to herein as perceivers) as well as individuals who are living with the stigmatized status (referred to as targets). Boundaries between structures, perceivers, and targets are porous, interlocking, and reinforcing. Blurring the lines between structures and individuals, individuals populate government systems that pass laws, organizations that construct policies, and neighborhoods that are home to local movements. Individuals can therefore both affect and are affected by structural change (de la

Sablonnière, 2017). Blurring the lines between perceivers and targets, a perceiver of SUD stigma may be a target of race/ethnicity or sexual and gender minority stigma (Stangl et al., 2019).

Structural Level—Substance use stigma has been manifested at the structural level within public policy, organizations, and neighborhoods throughout the history of the U.S. *Public policies* that criminalize people who use substances and have SUDs represent a particularly harmful example of structural level substance use stigma. In 1971, President Nixon declared the "war on drugs" by naming drugs as America's "public enemy number one." The war on drugs rested on the theory that drug use is voluntary and controllable, and thus can be prevented and stopped through harsh punishment (Gostin, 1990). The war on drugs has led to a steep increase in incarceration, with rates disproportionately high among racial and ethnic minorities (Moore & Elkavich, 2008; Kerr & Jackson, 2016). Once in the criminal justice system, a low proportion of people who need SUD treatment actually receive it (Chandler et al., 2009).

Stigma is further manifested within *organizational policies*, including in employment and housing contexts. Drug tests are common in many employment settings with positive results barring hiring or precipitating termination. Although the Americans with Disabilities Act provides protections for people who are in recovery from SUDs in the workplace, it does not protect people who are currently engaged in illicit drug use (Lopez & Reid, 2017). Thus, people who use substances, with active SUDs, and in the early stages of recovery from SUDs (who are at risk of experiencing a recurrence of substance use symptoms) are vulnerable to termination in many workplaces. Similarly, many housing agencies have policies denying services for people engaging in active drug use or with histories of drug use (Lopez & Reid, 2017). Such policies are legal under the Fair Housing Law, and contribute to housing insecurity and homelessness among people with SUDs. Within *neighborhood contexts*, the not in my back yard (NIMBY) movement has been leveraged to oppose local SUD treatment centers and harm reduction efforts via protest, petition, and harassment of people who use drugs (Tempalski et al., 2007).

Individual Level: Perceivers—Perceivers of substance use stigma may include members of the general public, healthcare providers, police, employers, friends, family members, and others. Stigma manifestations may be explicit, when perceivers are aware of their own bias, or implicit, when perceivers are unaware of their own bias (Dovidio et al. 2008). *Stereotypes* include beliefs or thoughts about the characteristics and behaviors of people with stigmatized statuses. People with SUDs are perceived as low in both warmth and competence (Cuddy et al., 2008). People with SUDs are additionally viewed as dangerous and unpredictable, not capable of decision making, and responsible for their condition (Yang et al., 2018). *Prejudice* is an emotional reaction or feeling towards people with stigmatized statuses. Prejudice towards people with SUDs is characterized by contempt, and experienced as feelings that express moral outrage including: anger, disgust, hate, blame and resentment (Cuddy et al., 2008). Prejudice also includes fear of individuals with SUDs (Yang et al., 2018).

Discrimination spans unfair or unjust behavior directed at people with stigmatized statuses. Contempt-related emotions that underlie prejudice towards people with SUDs elicit harmful behaviors, such as those that are demeaning, condescending, and rejecting (Cuddy et al., 2008). Results of a nationally representative survey conducted in 2018 suggest that many U.S. adults are unwilling to have a person with an opioid use disorder (73.0%) or an alcohol use disorder (75.0%) marry into their family, work closely with someone with an opioid use disorder (75.9%) or an alcohol use disorder (79.7%), or become friends with someone with an opioid use disorder (45.1%) or an alcohol use disorder (40.1%) (Perry et al., in press). Additionally, people endorse policies that mandate coercive treatment and social restrictions, such as prohibiting individuals with SUDs from caring for children (Yang et al., 2018). Finally, *perceived stigma* includes perceptions of prejudice, stereotypes, and discrimination towards people with stigmatized statuses among others within one's community.

Individual Level: Targets—Targets include people living with stigmatized statuses, including people at risk of or living with SUDs. *Experienced stigma* (also referred to as enacted stigma or perceived discrimination) includes experiences of stereotypes, prejudice, and discrimination from others in the past or present. As examples, people in recovery from opioid use disorders report receiving poor or cold treatment from healthcare providers, being fired or not hired by employers, and being socially rejected or distrusted by family members and friends (Earnshaw et al., 2013). *Anticipated stigma* includes expectations of stereotypes, prejudice, and discrimination from others in the future. People with SUDs describe substantial concerns about how others will view them, ultimately undermining disclosure of symptoms and access to treatment (Earnshaw et al., 2019). *Internalized stigma* includes the extent to which people endorse prejudice and stereotypes associated with a stigmatized status and apply them to the self. Shame has been described as the "emotional core" of internalized stigma, and is common among people with SUDs (Luoma et al., 2012). Similar to people not living with stigmatized statuses, targets of stigma may also *perceive stigma* within their communities.

These stigma manifestations may also be experienced as *associative stigma* by individuals who are affiliated with others living with stigmatized statuses. Caregivers of adolescents with SUDs are viewed by some as personally responsible for the onset and relapses of their children's SUDs, incompetent, and pitiable (Corrigan et al., 2006). Moreover, caregivers report being gossiped about and socially rejected, and worry that they will be blamed for their children's SUD (Earnshaw et al., 2019). Associative stigma can impact the wellbeing of caregivers and spouses, undermining their ability to provide support to loved ones with SUDs.

Mediating Mechanisms and Substance Use Outcomes among Targets

Stigma manifestations may impact substance use outcomes among people at risk of and living with SUDs via mediating mechanisms. Based on previous stigma theory and research (Chaudoir et al., 2013; Hatzenbuehler et al., 2013; Meyer, 1995), three categories of mediating mechanisms linking stigma manifestations with substance use outcomes are highlighted: psychological responses to stigma, social isolation, and access to resources. Among people living with a range of intersectional stigmatized statuses, stigma

manifestations and ensuing mediating mechanisms may lead to substance use initiation, regular use, and problem or risky use. For this group, psychological responses to stigma may be a particularly important mediating mechanism given the prominent role of stress and coping processes in substance use. Among people with SUDs, stigma manifestations and ensuing mediating mechanisms may lead to outcomes along the SUD treatment cascade. This cascade is based on the Opioid Use Disorder Cascade of Care, which identifies diagnosis, engagement in care, initiation of medications, retention in care for longer than six months, and remission as progressive stages towards recovery (Williams et al., 2019). For this group, all three mediating mechanisms may play important roles in recovery. Extending the reach of stigma, substance use and under- or untreated SUDs can, in turn, have long-term effects on health (U.S. Department of Health and Human Services, 2016). As examples, alcohol and drug use is associated with cardiovascular, cardiopulmonary, liver, and pancreatic diseases as well as various forms of cancer. Injection drug use is associated with communicable diseases such as HIV and Hepatitis C.

Psychological Responses to Stigma—Experiences of stigma manifestations elicit psychological responses that may lead to substance use among targets. From a stress and *coping* perspective (Miller & Kaiser, 2001), stigma manifestations are characterized as significant stressors that may elicit both *internalizing* (e.g., depression, anxiety) and *externalizing* (e.g., anger, hostility) symptoms among targets. In turn, targets may engage in substance use as a form of distraction coping to draw their attention away from distressing or uncomfortable thoughts and feelings. Supporting this perspective, depressive symptoms mediate associations between experienced and internalized stigma with multiple indicators of substance use among people living with HIV (Earnshaw et al., in press). Depressive and anxiety symptoms similarly mediate associations between experienced stigma and heavy drinking among multiracial gay and bisexual men (English et al., 2018). Anger and hostility mediate the association between experienced stigma and substance use among African American adolescents and their parents, respectively (Gibbons et al., 2010).

Similar processes appear to unfold among people with SUDs. For example, young people with SUDs report continuing to engage in substance use to cope with experienced stigma from others (Earnshaw et al., 2019). Moreover, shame (i.e., the “emotional core” of internalized stigma) is associated with treatment-seeking delays, recurrence of substance use symptoms, and treatment dropout (Luoma et al., 2012).

Social Isolation—Stigma manifestations lead to social isolation among targets, with particularly harmful implications for people with SUDs. Social connection and support are associated with outcomes that facilitate recovery, including decreases in SUD severity over time, greater retention in care, and lower psychological distress (Dobkin et al., 2002). Moreover, family engagement is a key facilitator of SUD prevention, treatment, and recovery (Ventura & Bagley, 2017). At the structural level, incarceration disrupts relationships between people with SUDs and family members (Cochran & Mears, 2013). Upon release from prison, people who are more isolated from family are more likely to engage in drug use. At the individual level, people with SUDs describe substantial social rejection from family members and friends, including not answering phone calls, not being

allowed into their homes, and even being disowned (Earnshaw et al., 2013). They note that this social rejection exacerbates self-isolation that they may have engaged in as a result of their SUD. Youth with SUDs and their caregivers additionally report not disclosing their or their child's substance use to others due to anticipated stigma (Earnshaw et al., 2019), which further contributes to social isolation of families affected by SUDs.

Access to Resources—Stigma undermines access to resources that may promote wellbeing among targets, especially those with SUDs. Underinvestment in policies that would improve the availability of, access to, and uptake of evidence-based *treatments* represents a pernicious form of structural level stigma that undermines resources that could promote recovery among people with SUDs (Wakeman & Rich, 2018). Results of the National Survey on Drug Use and Health estimated that only 3.7 of the 21.2 million U.S. adults aged 12 or older (17.5%) who needed substance use treatment in 2018 actually received it (SAMHSA, 2019). Similarly, evidence suggests that many people who could benefit from medications for opioid use disorders, which promote abstinence from opioids (Schuckit, 2016), do not receive them. One study demonstrated that less than 5% of adolescents and 23% of adults received medication in the year prior to experiencing a non-fatal overdose, and only 8% of adolescents and 29% of adults received medication in the year after (Chatterjee et al., 2019). Additionally, few people with SUDs who are incarcerated receive treatment, contributing to high rates of re-engagement in substance use upon release (Galea & Vlahov, 2002; Wakeman & Rich, 2018).

Stigma manifestations among healthcare providers can block access to effective *healthcare* for a wide range of health conditions among people with SUDs. People with SUDs and their family report receiving ineffective and negative treatment from some healthcare workers, particularly in emergency care and surgical settings (Earnshaw et al., 2013; Earnshaw et al., 2019). Additionally, organizational policies and discrimination from employers can block access to *employment* for people in recovery; employment rates among people with some types of SUDs are low (Richardson & Epp, 2016). Yet, employment is associated with better recovery-related outcomes, including abstinence from substance use and longer retention in treatment. Organizational policies and discrimination further block access to *housing*. In turn, homelessness exacerbates risks of negative health outcomes, including exposure to infectious disease (e.g., tuberculosis, HIV), engagement in health risk behaviors (e.g., trading drugs for sex), and death (Galea & Vlahov, 2002).

Moderating Factors

Moderating factors shape the ways in which stigma is manifested as well as the processes whereby stigma impacts substance use outcomes. Contextual factors situate stigma processes within places and historical times. Individual factors situate stigma within individual characteristics, including identity processes, age, and stigma course (e.g., substance use stage). Understanding where, when, and among whom stigma is experienced can elucidate how stigma is manifested and impacts outcomes. Resilience resources are factors at the structural and individual levels that may attenuate the impact of stigma on outcomes. Although they may overlap with contextual and individual factors, resilience

resources are unique in that they represent promising targets for intervention to protect individuals from the deleterious effects of stigma manifestations on substance use.

Contextual Factors—Stigma unfolds within particular *cultural* contexts, which may shape stigma manifestations and outcomes of stigma among targets. Reflecting variation in structural stigma, there is variability in drug policies internationally. For example, the Philippines has drawn attention for policies that have led to the deaths of thousands of people who use drugs since 2016 (Human Rights Watch, 2019). In contrast, Switzerland and other countries have experimented with state-sponsored heroin-assisted treatment for people with heroin use disorders who have not benefited from other treatments (Fischer et al., 2007). Due to differences in structural stigma, an individual with an opioid use disorder may experience very different outcomes in the Philippines versus Switzerland. Additionally, stigma is experienced at specific *historical times*. There have been pronounced evolutions in stigma associated with stigmatized statuses including SUDs over time. For example, representing change in SUD structural stigma, laws permitting access to naloxone (i.e., a medication that can reverse opioid overdoses and was approved by the U.S. Food and Drug Administration in 1971) spread from 6 U.S. states in 2010 to 49 by 2017 (Prescription Drug Abuse Policy System, 2017).

Individual Factors—Stigma manifestations among targets are also shaped by *identity* processes. Social statuses vary in magnitude, or size and importance, within an individual's overall self-concept (Quinn & Earnshaw, 2013). Centrality is the extent to which an individual feels that a particular status defines them as a person, and salience is the frequency with which an individual thinks about a particular status. Evidence suggests that people with SUDs and other concealable stigmatized identities experience the most psychological distress when they have internalized stigma associated with a status that is highly central to their self-concept (Quinn et al., 2014).

There are developmental stages, or *ages*, when targets may be at greater risk of experiencing stigma manifestations and/or may be more vulnerable to the effects of stigma manifestations on outcomes (Gee et al., 2012). Whereas caregivers of adolescents with SUDs are often confident in their own abilities to cope with enacted stigma, some worry about their children's capacity for coping with these negative experiences (Earnshaw et al., 2019). Regarding *stigma course*, many stigmatized statuses change over time and stigma manifestations may change with them. For example, evidence suggests that internalized and anticipated HIV and sexually transmitted infection stigma is heightened immediately after diagnosis and then begins to decline over the first year of living with the diagnosis (Eaton et al., 2018). Similarly, stigma manifestations may evolve as people are diagnosed with a SUD and progress through the SUD treatment cascade.

Resilience Resources—There are resources at the structural and individual levels that promote resilience to stigma, helping to reduce the risk of developing stigma manifestations and inoculate targets from the negative effects of stigma on substance use outcomes. At the structural level, some *public policies* prohibit discrimination. For example, the Americans with Disabilities Act protects people in recovery from SUDs from discrimination in employment and other settings. An additional policy, 42 CFR Part 2, protects confidentiality

of people with SUDs from disclosures that may place them at risk of experienced stigma (Lopez & Reid, 2017).

At the individual level among perceivers, *contact* with people living with stigmatized statuses can prevent and reduce prejudice. Developmental intergroup theory suggests that prejudice may be less likely to develop among children when groups are integrated, facilitating familiarity with targets and promoting perceptions of equality between group members (Bigler & Liben, 2013). Work on the contact hypothesis demonstrates that contact can reduce existing prejudice by enhancing knowledge about targets, reducing anxiety about interacting with targets, and increasing empathy towards targets (Pettigrew & Tropp, 2008).

Among targets, *social support* and *adaptive coping* have received attention as resources that buffer targets from the deleterious effects of stigma on health (Earnshaw et al. 2015; Earnshaw et al., 2013). For example, youth experiencing race-based bullying are less likely to initiate smoking if they have at least one adult at school from whom they receive support (Earnshaw et al., 2014). Research has also identified personality characteristics (e.g., spiritual peace, self-efficacy, optimism), as resilience resources with promise to promote well-being among targets (Dulin et al., 2018). Many of these resources block the effects of enacted and anticipated stigma on negative psychological responses to stigma, such as stress and depressive symptoms, that ultimately lead to substance use outcomes.

Agenda for Future Directions

As experts in mental and behavioral health, psychologists are uniquely positioned to play a frontline role in addressing stigma to promote SUD prevention and treatment. Psychologists have remarkable reach via their roles as clinicians, researchers, interventionists, teachers, employers, co-workers, community members, friends, and family members. Below, strategies are identified for psychologists to address stigma via clinical care, research, and advocacy.

Clinical Care

Psychologists have a substantial opportunity to address stigma experienced by targets via clinical care. Psychologists can promote *resilience* among people living with stigmatized statuses to prevent the development of SUDs. As noted above, research has identified a suite of resilience resources that buffer targets from the deleterious effects of stigma on health. Within this suite, coping shows particular promise for promoting resilience because it appears to both mediate and moderate associations between stigma and substance use outcomes. Thus, promoting adaptive coping may break pathways between experiences of stigma and substance use, promoting resilience to experiences of stigma. Adaptive coping may be promoted via cognitive-behavioral therapies that help targets replace maladaptive coping responses with adaptive ones (Pachankis, 2018).

Psychologists can develop, adapt, and apply evidence-based *affirmative treatments* for targets. Pachankis (2018) has called for evidence-based affirmative treatments for sexual and gender minority populations that are tailored to address unique life experiences, including those related to stigma, that shape the mental health of these populations but are not shared

by heterosexual and cisgender individuals. Pachankis identifies key principles of affirmative treatments as: helping individuals develop insight into how stigma compromises their mental health, desensitizing individuals to negative feelings and cognitive styles that can result from stigma (e.g., shame, hopelessness), promoting resilience, and providing resources and advocacy. These principals could apply to mental health treatments for people living with a wide range of stigmatized statuses including SUDs, ultimately improving mental health outcomes and possibly contributing to the prevention and treatment of SUDs.

Psychologists can leverage *acceptance and mindfulness approaches* to address internalized stigma among people with SUDs. As noted above, people with SUDs with greater internalized stigma and shame experience worse treatment and recovery-related outcomes. Luoma and colleagues have developed and tested a group-based intervention for people with SUDs targeting shame that is based on the principles of acceptance and commitment therapy (Luoma et al., 2012). This approach encourages individuals to notice and experience, rather than suppress and avoid, feelings of shame. Cognitive diffusion and acceptance techniques are then exercised, including via mindfulness and values exercises. In comparison to a group receiving treatment as usual, people with SUDs receiving the acceptance and commitment therapy intervention showed reduced internalized shame, fewer days of substance use, and higher treatment attendance four months after the intervention (Luoma et al., 2012).

Psychologists can provide support surrounding *disclosure decisions and processes* among people with SUDs. Disclosure involves the sharing of information surrounding one's SUD history, resolution, and/or treatment with other people such as family, friends, employers, healthcare providers, and acquaintances (Chaudoir & Fisher, 2011). Disclosure is an important process given that it can act as a gateway to social support, which may facilitate recovery, and/or stigma, which may undermine recovery. Yet, people in recovery from SUDs report struggling with decisions regarding whether, to whom, what, when, and how to disclose to others (Earnshaw et al., 2019). Moreover, evidence from a nationally representative sample suggests that many people in recovery from alcohol and other drug problems are uncomfortable with disclosure (Earnshaw, Bergman, et al., 2019). People who have been in recovery for shorter amounts of time and people who are disclosing to others with whom they are less close (e.g., acquaintances and co-workers) report greater discomfort surrounding disclosure. Psychologists have important roles to play in facilitating disclosure-related decision making, building disclosure skills, and supporting people through the aftermath of disclosures.

Research

Psychologists have much to contribute to understanding and addressing the role of stigma in SUDs. In comparison to other areas of stigma research, SUD stigma is arguably understudied (Corrigan et al., 2017). More research is needed to describe the processes whereby stigma manifestations impact mediating mechanisms and substance use outcomes to build a stronger understanding of how stigma impacts substance use. Additionally, more research is needed that adopts an intersectional lens and attends to moderating factors to better understand who is most vulnerable to the impacts of stigma on substance use. Specific recommendations for research are described below.

Basic social and behavioral science research can continue to clarify the experiences and impacts of stigma manifestations among people with SUDs *over time* (Corrigan et al., 2017). Much of our understanding of associations between stigma and health inequities rests on research with people with stigmatized statuses that are relatively stable over time. People are often born into a stigmatized group (e.g., minority races/ethnicities, female sex), become aware that they are a member of a stigmatized group (e.g., minority sexual and gender identities and expressions), or transition into a stigmatized group (e.g., HIV, incarceration). Their experiences of stigma manifestations may fluctuate some as their identity develops and as they transition into new environments; yet, they may also reach sustained periods of relative stability. For example, some evidence suggests that people experience heightened HIV stigma immediately after an HIV diagnosis but that this stigma decreases and begins to plateau within several months (Eaton et al., 2018). In contrast, SUDs may be considerably more dynamic stigmatized statuses. As people develop SUDs, transition into recovery, and possibly experience relapses of substance use symptoms (Kelly et al., 2017), the ways in which they experience stigma manifestations and how these stigma manifestations impact outcomes may fluctuate. To better understand the dynamic nature of substance use stigma, psychologists conducting cross-sectional research might seek to understand whether and how stigma impacts people differently at various stages of SUD development and recovery. Additionally, psychologists conducting longitudinal research can identify trajectories of stigma manifestations over the course of time. Such research can pinpoint times when people are particularly vulnerable to stigma.

To help the field make faster progress towards understanding and addressing SUD stigma, psychologists can use *validated and theory-based measures* when possible. A review of studies measuring mental illness stigma, including those measuring SUD stigma, between 2004 and 2014 highlighted a concerning trend: 444 measures of mental illness stigma had been used during this time period, 304 (68%) of which were developed for a single study and not necessarily psychometrically validated (Fox et al., 2018). Of the remaining 140 scales, only 24 had been cited at least 10 times. Thus, many researchers are creating new scales for their individual studies rather than using existing validated scales. The use of so many scales, many of which represent varying conceptualizations of stigma and/or may not be psychometrically strong, slows progress towards developing shared understanding of the impact of stigma on substance use-related outcomes. Mixed findings between studies may reflect measurement variation rather than substantive differences in associations between stigma and outcomes. Theory-based and validated measures of SUD stigma are available (Smith et al., 2016; Smith et al., 2019). By using these and other common measures whenever possible, we can make faster progress towards understanding SUD stigma as a field.

Psychologists can help to address stigma by adapting the *stigma-reduction toolbox* to the context of substance use, and then test stigma interventions in longitudinal, multilevel, and multicomponent studies. Decades of research has yielded a stigma-reduction toolbox that contains evidence-based tools to reduce stigma and ways to use these tools to maximize their efficacy (Chaudoir et al., 2017; Cook et al., 2014; Corrigan et al., 2017; Rao et al., 2019). Beyond the tools to address stigma among people with SUDs noted above, these tools include behavioral design at the structural level (i.e., constraining opportunities for stigma to

influence decision making, including within care settings; Bohnet, 2016), contact at the interpersonal level (i.e., facilitating interaction between perceivers with targets; Pettigrew & Tropp, 2006), and education at the individual level for perceivers (i.e., providing fact-based information to refute stereotypes; Cook et al., 2014). Many of these tools have been shown to be effective for reducing SUD stigma specifically (Livingston et al., 2012). Interventions implementing these tools should be: (1) longitudinal, because single session interventions are insufficient to generate lasting change in stigma manifestations, especially stereotypes, prejudice, and discrimination (Earnshaw et al., 2018); (2) multilevel, because stigma is manifested at the individual and structural levels, and change at one level is unlikely to be sustained without change at both levels (Cook et al., 2014; Rao et al., 2019); and (3) multicomponent, because there is no known single "silver bullet" intervention strategy that can eliminate stigma but rather many tools that can be used collectively to reduce stigma (Cook et al., 2014; Rao et al., 2019).

Psychologists might prioritize investigating stigma-based interventions to address stigma at *early ages* to prevent the development of SUDs. Evidence suggests that youth who experience bullying are at risk of substance use (Earnshaw et al., 2017), with youth experiencing stigma-based bullying (i.e., bullying associated with a stigmatized status) at greatest risk of substance use (Russell et al., 2012). This is particularly concerning given that SUDs often onset during late adolescence (National Institute on Drug Abuse, 2014). A review of stigma-based bullying interventions published between 2000 and 2015 found that such interventions have been increasing in popularity, but have been unevenly distributed across stigmatized statuses, locations, and social contexts (Earnshaw et al., 2018). Psychologists have an opportunity to work with school administrators, teachers, students, and parents to investigate stigma-based bullying interventions to prevent substance use among youth.

Advocacy

Psychologists can advocate for changes in stigma manifestations at the structural and individual levels. Psychologists can call for *changes in structural stigma*, including the repeal of public policies that criminalize people with SUDs and organizational policies that deny services to people with SUDs. They can speak out against neighborhood movements that oppose evidence-based services for people with SUDs by writing op-eds for their local newspapers, sharing their thoughts via social media, and engaging in conversation with their neighbors.

Psychologists can protest the *intentional use of stigma* to prevent and/or treat SUDs. Public health prevention campaigns have intentionally leveraged and even promoted stigma by associating substance use with criminal or unethical activity, terrorism, violence, and poor health (Corrigan & Nieweglowski, 2018). For example, the iconic "this is your brain on drugs" public service announcements imply that people's brains are fried, cracked, or destroyed by substance use. As noted above, intentionally leveraging stigma to prevent substance use is a flawed tactic insofar as it overemphasizes the role of personal control in substance use (Volkow et al., 2016). Prevention approaches are needed that work for everyone, not only people who are at low risk for substance use due a lack of environmental,

social, or genetic risk factors. Some treatment programs may heighten internalized stigma among people in recovery from SUDs by encouraging them to focus on their character defects, retrospect on ways that they have wronged others, and acknowledge their own powerlessness (Corrigan et al., 2017). Yet, shame, the emotional core of internalized stigma, undermines recovery efforts (Hill & Leeming, 2014). In contrast, treatment approaches are needed that restore self-esteem, self-worth, and hope.

Psychologists are well-positioned to *educate others* about substance use and SUDs in their classrooms and communities. Knowledge can dismantle stereotypes and misinformation about SUDs (Livingston et al., 2012). For example, people receiving medications for opioid use disorders (e.g., methadone) are often accused of swapping "one drug for another" or "one addiction for another" (Earnshaw et al., 2013). Yet, the National Institute on Drug Abuse (2019) identifies medications as important tools for facilitating detoxification and preventing symptom relapse. Similarly, people view SUDs as difficult or unlikely to resolve. Yet, many people successfully recover from SUDs (Kelly et al., 2017). Engaging in conversations and sharing resources that present scientifically-accurate information about medications and recovery trajectories may help to dispel myths associated with SUDs and their medications.

Finally, psychologists can be mindful of *language* surrounding SUDs. Language spreads stereotypes about people with SUDs (Broyles et al., 2014). Evoking perceptions of controllability, personal responsibility, and criminality, people with SUDs are referred to as "dope fiends," "pot heads" and "addicts", who "abuse" drugs and have "dirty" urine tests (Broyles et al., 2014; Wakeman, 2013). People referred to as "substance abusers" are seen as more deserving of blame and punishment than people referred to as "having a SUD" by clinicians and members of the general public (Kelly et al., 2015). Using language that is scientifically accurate (e.g., "urine sample that tested positive for substance use" rather than "dirty urine") and person first (e.g., "person with an opioid use disorder" rather than "heroin addict") can promote perceptions of SUDs as a chronic, yet treatable, health condition. Language can also help with garnering support for policies that promote the wellbeing of people in recovery. For example, referring to "overdose prevention sites" rather than "safe consumption sites" leads to increased public support for an evidence-based harm reduction strategy wherein individuals can legally use pre-obtained drugs under medical supervision to reduce risk of overdose (Barry et al., 2018).

Conclusion

Similar to other health-related contexts (e.g., HIV, mental illness), stigma is a powerful social determinant of SUDs. Stigma can lead to the development of SUDs among people living with a wide range of stigmatized statuses, as well as undermine recovery efforts among people who have developed SUDs. Yet, we are better prepared now than ever before to address this stigma by leveraging what we know about why stigma exists, the ways in which it is manifested within structures and individuals, how it affects outcomes via mediating mechanisms, and what moderates it. As experts in mental and behavioral health, psychologists can play a frontline role in addressing stigma to prevent and treat SUDs via clinical care, research, and advocacy.

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Public Significance Statement:

This paper describes how stigma, which is a social process of devaluation and discrediting, leads to substance use and undermines the treatment of substance use disorders. It also identifies ways that psychologists can address the role of stigma in substance use through their clinical care, research, and advocacy.

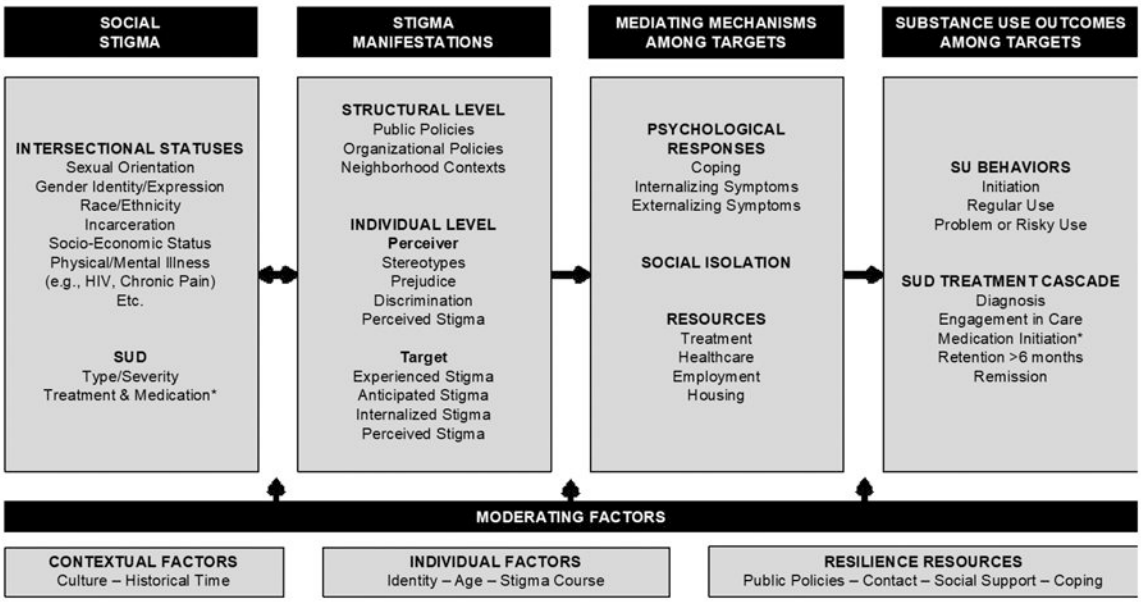

Figure 1. Substance Use Stigma Framework

Note: *Medication and medication initiation as applicable to the specific SUD

Table 1.

Key recommendations for future directions to address stigma and substance use

Clinical Care
• Promote resilience among people with stigmatized statuses to prevent development of substance use disorders
• Develop, adapt, and apply evidence-based affirmative treatments for people with stigmatized statuses
• Leverage acceptance and mindfulness approaches to address internalized stigma and promote positive treatment outcomes among people with substance use disorders
• Provide support surrounding disclosure decisions and processes among people with substance use disorders
Research
• Clarify experiences and impacts of stigma manifestations among people with substance use disorders over time
• Use validated, theory-based measures whenever possible
• Adapt the stigma-reduction toolbox to address substance use disorder stigma, and test stigma interventions in longitudinal, multilevel, and multicomponent studies
• Investigate stigma-based bullying interventions to address stigma at early ages and prevent development of substance use disorders
Advocacy
• Advocate for changes in structural stigma, including policies that criminalize people with substance use disorders and de-prioritize investments in substance use disorder treatment
• Protest use of stigma to prevent and/or treat substance use disorders
• Educate others about substance use and substance use disorders
• Adopt stigma-free language in professional and social settings