

# Understanding and Addressing Stigma in Clinical Settings

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JOHN F. KELLY, PH.D. ABPP

FOUNDER AND DIRECTOR OF  
MGH RECOVERY RESEARCH  
INSTITUTE

ELIZABETH R. SPALLIN  
PROFESSOR OF PSYCHIATRY  
HARVARD MEDICAL SCHOOL



RECOVERY  
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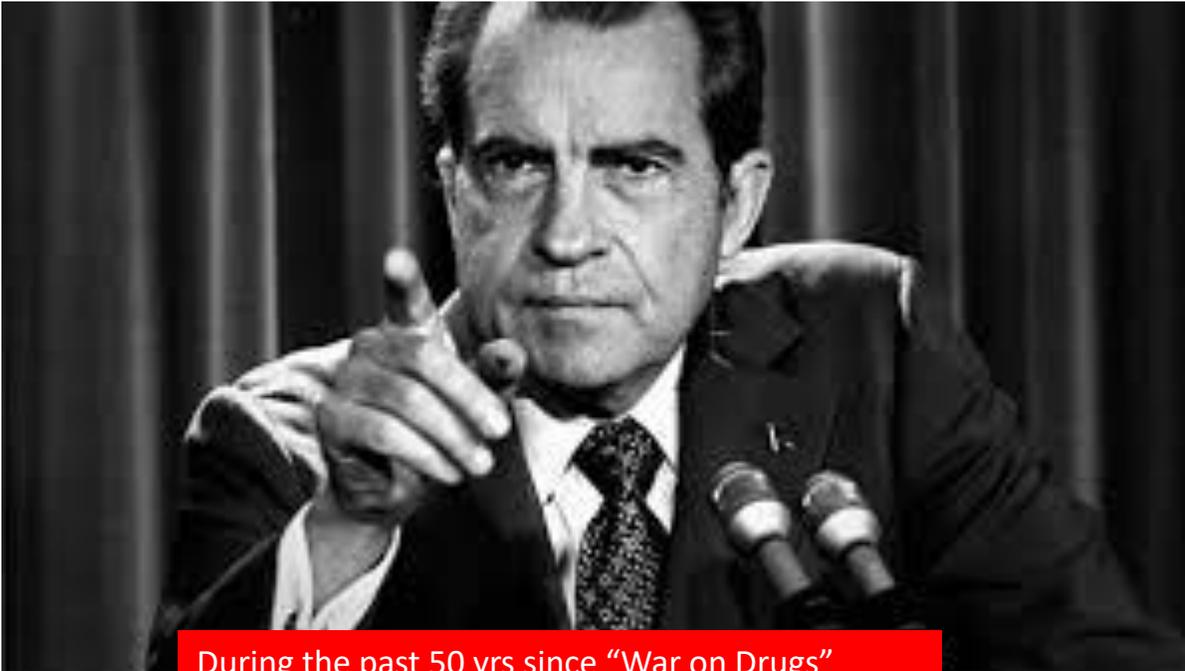


MASSACHUSETTS  
GENERAL HOSPITAL

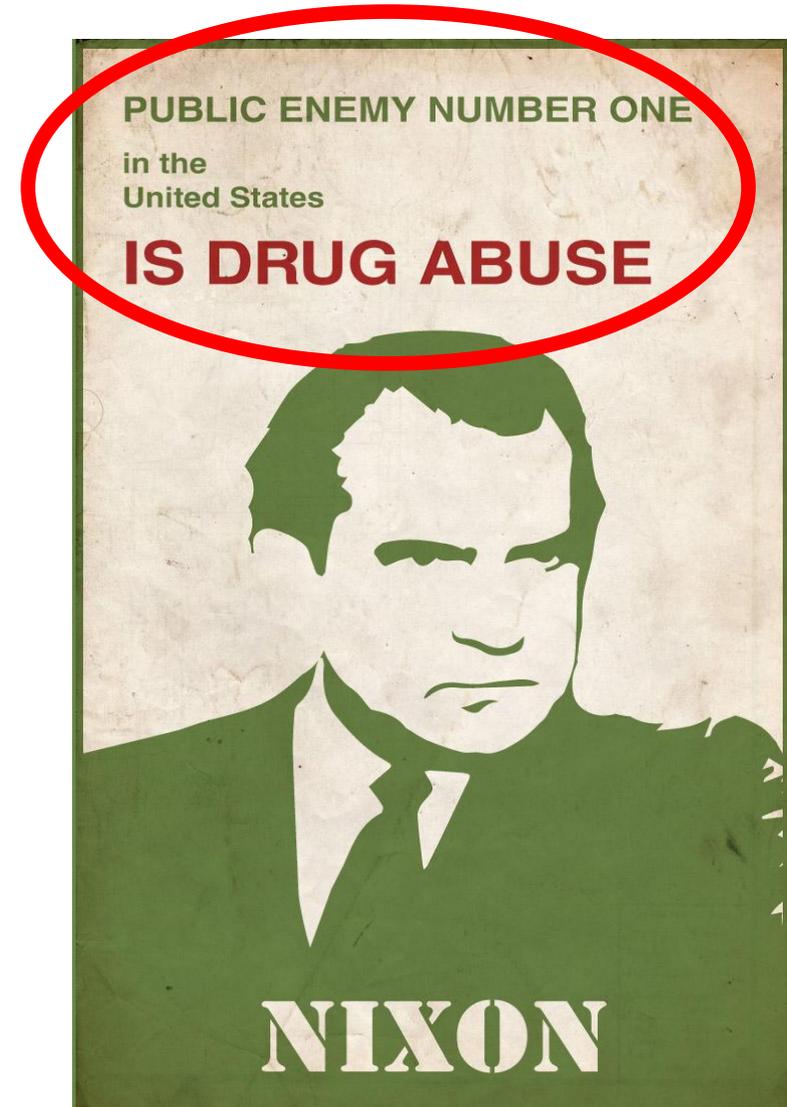


HARVARD MEDICAL SCHOOL  
TEACHING HOSPITAL

1971



During the past 50 yrs since “War on Drugs” declared, we have moved from “Public Enemy No. 1” to “Public Health Problem No. 1”



The “war on drugs” rhetoric reflected a national concerted effort to reduce “supply” but also “demand” that created treatment and public health oriented federal agencies..



**NIDA**

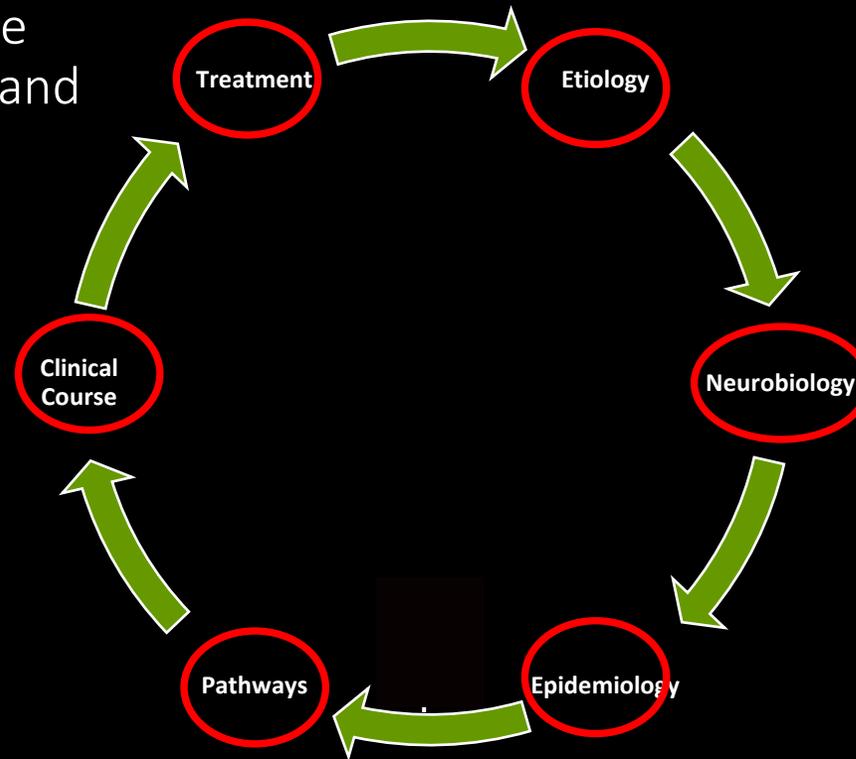
**NATIONAL INSTITUTE**

**ON DRUG ABUSE**



**CSAT**  
Center for Substance  
Abuse Treatment  
*SAMHSA*

Past 50 yrs since  
declaration of “War on  
drugs” led to large-scale  
federal appropriations and  
a number of paradigm  
shifts...



Laws passed in the past 50 yrs have moved from more punitive ones to public health oriented ones.... increasing availability, accessibility and affordability of treatment..





BRIEFING ROOM

ISSUES

THE ADMINISTRATION

PARTICIPATE

1600 PENN



HOME · BLOG

# ONDCP Hosts First-Ever Drug Policy Reform Conference

DECEMBER 11, 2013 AT 10:57 AM ET BY CAMERON HARDESTY



On Monday, Director Kerlikowske and Deputy Director... discussion at the White House on the future of drug... approximately 140 people attended to engage in a... hundreds more watched online. Limited video on de...

2013 ONDCP Director Kerlikowske declares move away from “war on drugs” toward broader public health approach



# Public Health Approaches to Addressing Drug-Related Crime: Drug Courts

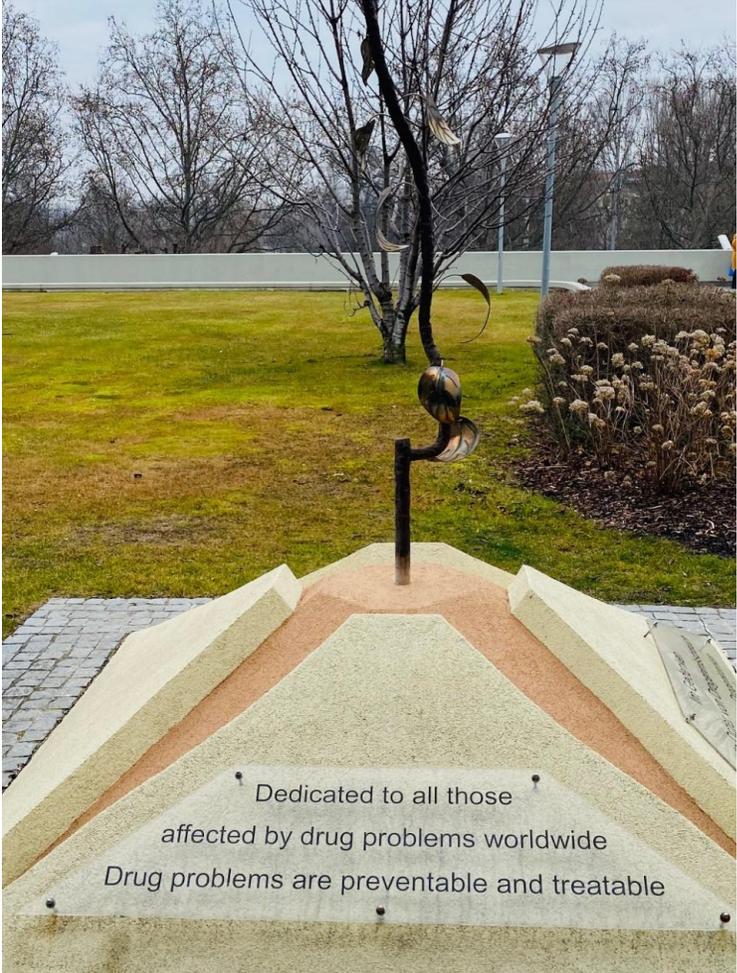


# Public Health Approaches to Law Enforcement

- Chief Campanello
  - Angel Program

“Help not  
Handcuffs”





INCREASED KNOWLEDGE ABOUT NATURE OF  
ADDICTION – ITS GENETIC INFLUENCES AND  
NEUROBIOLOGICAL IMPACTS - BUT STIGMA  
PERSISTS...

WHAT CAN BE DONE?

# What can we do about stigma and discrimination in addiction?



**Education** about essential nature of these conditions



**Personal witness** (putting a face and voice on recovery)



**Change our language/terminology** to be consistent with the nature of the condition and the policies we wish to implement to address it

# WHAT IS STIGMA?

An attribute, behavior, or condition, that is socially discrediting

# WHAT IS DISCRIMINATION?

The unfair treatment of individuals with the stigmatized condition/problem

Please see if you can correctly identify all of the pictures which feature addiction treatment facilities, and which treat other health conditions

I'm not a robot



# Stigma and Discrimination



- People with SUD often get treated in second-rate dilapidated buildings, which gives them the impression they have a second-class illness.
- Not only do people with SUD worry they will get poorer-quality care because of stigma, they also get message not worthy of high-quality care and environments where people with "*real* diseases" get treated.
- Is "good enough for addicts" good enough?

Addiction may be most stigmatized condition in the US and around the world:  
**Cross-cultural views on stigma**

Across 14 countries and 18 of the most stigmatized conditions...

Illicit drug addiction ranked 1<sup>st</sup>

Alcohol addiction ranked 4<sup>th</sup>

**Stigma, social inequality and alcohol and drug use**

ROBIN ROOM

*Centre for Social Research on Alcohol and Drugs, Stockholm University, Stockholm, Sweden*

- **Sample:** Informants from 14 countries
- **Design:** Cross-sectional survey
- **Outcome:** Reaction to people with different health conditions

# Studies have shown that...



**SUD is more stigmatized** compared to other psychiatric disorders



Compared to other psychiatric disorders, **people with SUD are perceived as more to blame** for their disorder



**Describing SUD as treatable helps**



Patients themselves who hold **more stigmatizing beliefs** about SUD **less likely to seek treatment; discontinue sooner**



**Physicians/clinicians** shown to hold stigmatizing **biases against those with SUD**; view SUD patients as unmotivated, manipulative, dishonest; **SUD-specific education/training helps**

# Stigma Consequences: Public and Personal

- **Public:**

- Public stigma can lead to:

- Differential public and political support for treatment policies
    - Differential public and political support for criminal justice preferences
    - Barriers to employment/education/training
    - Reduced housing and social support
    - Increased social distance (social isolation)

- **Personal:**

- Internalization of public stigma can lead to:

- Shame/guilt
    - Lowered self-esteem
    - Rationalization/minimization; lack of problem acknowledgment
    - Delays in help-seeking
    - Less treatment engagement/retention; lowered chance of remission/recovery

# Commonly Studied Dimensions of Stigma



**Blame** – are they responsible for causing their problem/disorder?



**Prognostic pessimism/optimism** – will they ever recover “be normal”, “trustworthy”?



**Dangerousness** – are they unpredictably volatile, a threat to my/others' safety?



**Social distance** – would I have them marry into my family, share an apartment with them, have them as a babysitter?

SO, WHY IS ADDICTION SO  
STIGMATIZED COMPARED TO OTHER  
SOCIAL PROBLEMS AND HEALTH  
CONDITIONS, AND OTHER MENTAL  
ILLNESSES?

# What Factors Influence Stigma?

Cause	Controllability	Stigma
“It’s not their fault”	“They can’t help it”	Decreases
“It <u>is</u> their fault”	“They really <u>can</u> help it”	Increases

# In terms of cause... Biogenetics

## If Drugs Are so Pleasurable, Why Aren't We All Addicted?

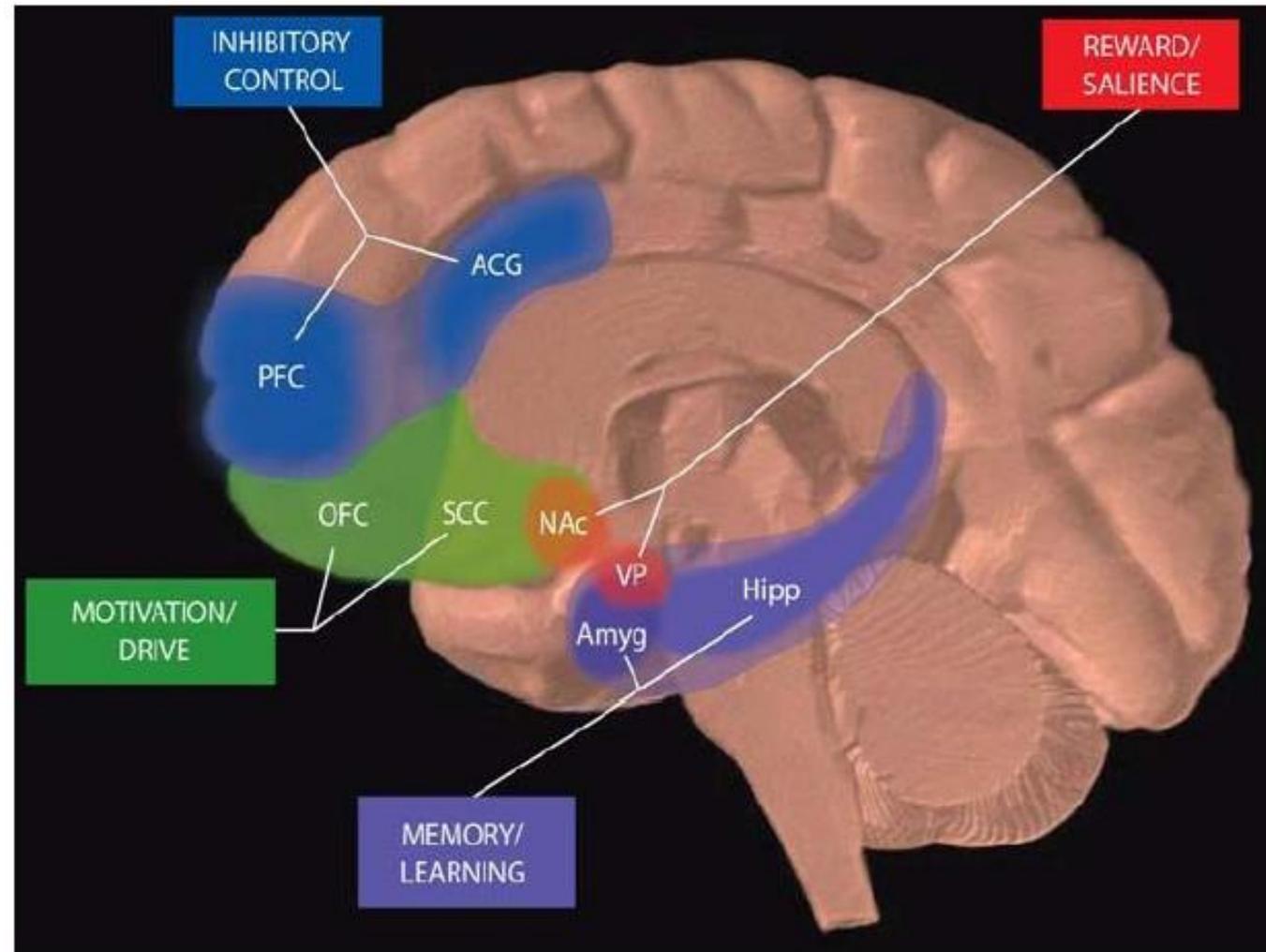
Genetically mediated response, metabolism, reward sensitivity...

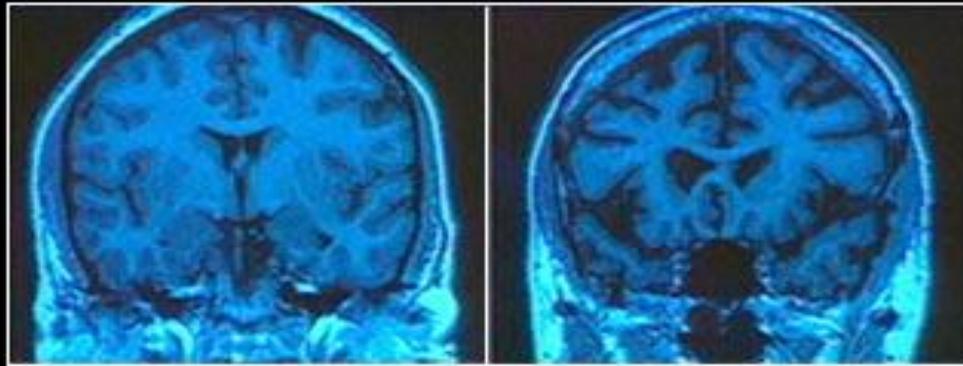


- Genetics substantially influence addiction risk
- Genetic differences affect subjective preference and degree of reward from different substances/activities

# In terms of controllability...Neurobiology

## Neural Circuits Involved in Substance Use Disorders





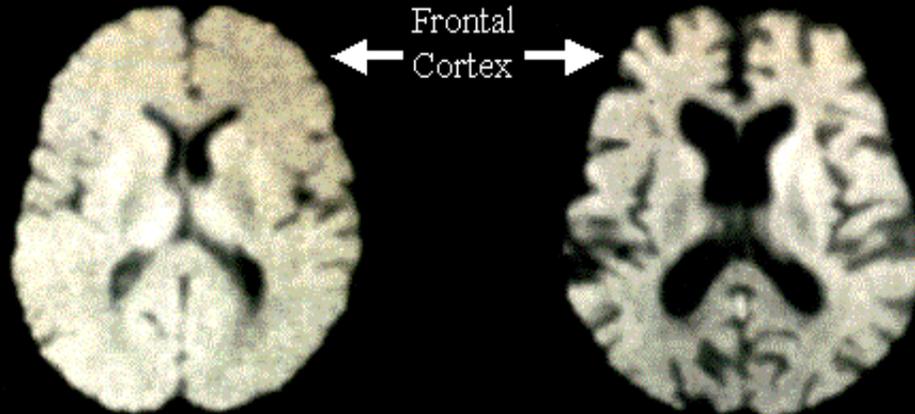
Normal  
43-year-old

Alcoholic  
43-year-old

## HUMAN BRAIN IMAGES

Moderate Drinker

Alcoholic



Axial magnetic resonance images from a healthy 57-year-old man (left) and a 57-year-old man with a history of alcoholism (right). D. Pfefferbaum



Pfefferbaum, A. (2000). The Neurotoxicity of Alcohol. In U.S. Department of Health and Human Services (Ed). *10<sup>th</sup> Special Report to the U.S. Congress on Alcohol and Health* (134-142).

# What can we do about stigma and discrimination in addiction?



**Education** about essential nature of these conditions



**Personal witness** (putting a face and voice on recovery)



**Change our language/terminology** to be consistent with the nature of the condition and the policies we wish to implement to address it

# What can we do about stigma and discrimination in addiction?



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WHEN DISCUSSING THE DISORDER  
ITSELF...

IF WE WERE TO EMPHASIZE THE  
BIOLOGICAL CAUSES (E.G., GENETICS) AND  
BIO-IMPACTS (E.G., NEUROBIOLOGY)  
WOULD IT REDUCE STIGMA?

## Biogenetic explanations as ways to reduce stigma...

- Meta-analysis of 28 experimental studies found biogenetic explanations:
  - Reduced blame, but increased...
  - Social distance
  - Dangerousness
  - Prognostic Pessimism

- First, in terms of “cause” (i.e., is it their fault?)...

Clinical Psychology Review 33 (2013) 782–794



Contents lists available at SciVerse ScienceDirect

Clinical Psychology Review



### The ‘side effects’ of medicalization: A meta-analytic review of how biogenetic explanations affect stigma



Erlend P. Kvaale<sup>a,\*</sup>, Nick Haslam<sup>a</sup>, William H. Gottdiener<sup>b</sup>

<sup>a</sup> Melbourne School of Psychological Sciences, University of Melbourne, Parkville, Australia

<sup>b</sup> Department of Psychology, John Jay College of Criminal Justice, City University of New York, NY, USA

#### HIGHLIGHTS

- Biomedical perspectives shape contemporary thinking about psychological problems.
- We quantitatively reviewed how biogenetic explanations affect stigma.
- Biogenetic explanations reduce blame, but induce pessimism about recovery.
- Biogenetic explanations do not affect desire for distance.
- Medicalization is no cure for stigma and may create barriers to recovery.

#### ARTICLE INFO

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Stigma  
Prejudice

#### ABSTRACT

Reducing stigma is crucial for facilitating recovery from psychological problems. Viewing these problems biomedically may reduce the tendency to blame affected persons, but critics have cautioned that it could also increase other facets of stigma. We report on the first meta-analytic review of the effects of biogenetic explanations on stigma. A comprehensive search yielded 28 eligible experimental studies. Four separate meta-analyses ( $Ns = 1207\text{--}3469$ ) assessed the effects of biogenetic explanations on blame, perceived dangerousness, social distance, and prognostic pessimism. We found that biogenetic explanations reduce blame (Hedges  $g = -0.324$ ) but induce pessimism (Hedges  $g = 0.263$ ). We also found that biogenetic explanations increase endorsement of the stereotype that people with psychological problems are dangerous (Hedges  $g = 0.198$ ), although this result could reflect publication bias. Finally, we found that biogenetic explanations do not typically affect social distance. Promoting biogenetic explanations to alleviate blame may induce pessimism and set the stage for self-fulfilling prophecies that could hamper recovery from psychological problems.

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# Neurobiological explanations as ways to reduce stigma...

## Neurobiological explanation studies found they increased:

- Social distance
- Dangerousness
- Prognostic pessimism
- had no effect on reducing blame

- Second, in terms of “controllability” (i.e., can they help it?)...

(2018) 3:43  
<https://doi.org/10.1186/s41235-018-0136-1>

and Implications

ORIGINAL ARTICLE

Open Access

## Neuroscientific explanations and the stigma of mental disorder: a meta-analytic study



Amy Loughman<sup>1,2</sup> and Nick Haslam<sup>2\*</sup>

### Abstract

Genetic and other biological explanations appear to have mixed blessings for the stigma of mental disorder. Meta-analytic evidence shows that these “biogenetic” explanations reduce the blame attached to sufferers, but they also increase aversion, perceptions of dangerousness, and pessimism about recovery. These relationships may arise because biogenetic explanations recruit essentialist intuitions, which have known associations with prejudice and the endorsement of stereotypes. However, the adverse implications of biogenetic explanations as a set may not hold true for the subset of those explanations that invoke neurobiological causes. Neurobiological explanations might have less adverse implications for stigma than genetic explanations, for example, because they are arguably less essentialist. Although this possibility is important for evaluating the social implications of neuroscientific explanations of mental health problems, it has yet to be tested meta-analytically. We present meta-analyses of links between neurobiological explanations and multiple dimensions of stigma in 26 correlational and experimental studies. In correlational studies, neurobiological explanations were marginally associated with greater desire for social distance from people with mental health problems. In experimental studies, these explanations were associated with greater desire for social distance, greater perceived dangerousness, and greater prognostic pessimism. Neurobiological explanations were not linked to reduced blame in either set of studies. By implication, neurobiological explanations have the same adverse links to stigma as other forms of biogenetic explanation. These findings raise troubling implications about the public impact of psychiatric neuroscience research findings. Although such findings are not intrinsically stigmatizing, they may become so when viewed through the lens of neuroessentialism.

**Keywords:** Essentialism, Stigma, Mental disorder, Psychiatric disorder, Brain disease, Blame

### Significance

Neuroscientific explanations of mental health problems are increasingly prominent in the psychiatric and psychological literature, and they are becoming more widely endorsed by the general public. At the same time, mental health problems continue to be heavily stigmatized and there are few signs that this stigma is abating. It has been argued that biological explanations might play a role in reducing psychiatric stigma, but the evidence to date indicates that they are a double-edged sword, reducing some forms of stigma but exacerbating others. However, no previous studies have examined how the narrower set of neurobiological explanations are linked to stigma, and whether they might have less adverse links to stigma than other forms of biological

explanation (e.g., genetic explanations). The present study reports meta-analyses of correlational and experimental studies on this question, and indicates that neurobiological explanations tend to be associated with greater stigma, especially in experimental studies. These findings suggest that laypeople apprehend neuroscientific research findings with an essentialist bias that leads them to ascribe mental health problems to fixed and unchanging pathological essences. The study has implications for how neuroscientific research findings on mental health should be communicated so as to minimize adverse effects on stigma.

### Background

How people respond to neuroscientific explanations is emerging as a dynamic field of research in cognitive psychology. Researchers have explored why these explanations have a particular allure relative to mentalistic explanations (Weisberg, Keil, Goodstein, Rawson, &

\* Correspondence: [nhaslam@unimelb.edu.au](mailto:nhaslam@unimelb.edu.au)

<sup>2</sup>Melbourne School of Psychological Sciences, University of Melbourne, Parkville, VIC 3010, Australia

Full list of author information is available at the end of the article



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CAN THE USE OF CERTAIN TYPES OF MEDICAL  
TERMINOLOGY USED TO DESCRIBE DRUG-  
RELATED IMPAIRMENT ITSELF HELP REDUCE  
STIGMA AND DISCRIMINATION?

# A US national randomized study to guide how best to reduce stigma when describing drug-related impairment in practice and policy

John F. Kelly<sup>1,2</sup> , M. Claire Greene<sup>3</sup>  & Alexandra Abry<sup>1</sup> 

Department of Psychiatry, MA General Hospital, Recovery Research Institute, Boston, MA, USA,<sup>1</sup> Department of Psychiatry, Harvard Medical School, Boston, MA, USA<sup>2</sup> and Department of Psychiatry, Columbia University, New York, NY, USA<sup>3</sup>

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## ABSTRACT

**Background and Aims** Drug-related impairment is persistently stigmatized delaying and preventing treatment engagement. To reduce stigma, various medical terms (e.g. ‘chronically relapsing brain disease’, ‘disorder’) have been promoted in diagnostic systems and among national health agencies, yet some argue that over-medicalization of drug-related impairment lowers prognostic optimism and reduces personal agency. While intensely debated, rigorous empirical study is lacking. This study investigated whether random exposure to one of six common ways of describing drug-related impairment induces systematically different judgments. **Design, Setting and Participants** Cross-sectional survey, US general population, among a nationally representative non-institutionalized sample ( $n = 3635$ ; 61% response rate; December 2019–January 2020). **Intervention** Twelve vignettes (six terms  $\times$  gender) describing someone treated for opioid-related impairment depicted in one of six ways as a(n): ‘chronically relapsing brain disease’, ‘brain disease’, ‘disease’, ‘illness’, ‘disorder’ or ‘problem’. **Measurements** Multi-dimensional stigma scale assessing: blame; social exclusion; prognostic optimism, continuing care, and danger ( $\alpha = 0.70$ – $0.83$ ). **Findings** US adults [mean age = 47.81, confidence interval (CI) = 47.18–48.44; 52.4% female; 63.14% white] rated the same opioid-impaired person differently across four of five stigma dimensions depending on which of six terms they were exposed to. ‘Chronically relapsing brain disease’ induced the lowest stigmatizing blame attributions ( $P < 0.05$ ); at the same time, this term decreased prognostic optimism [mean difference (MD) = 0.18, 95% CI = 0.05, 0.30] and increased perceived need for continuing care (MD =  $-0.26$ , 95% CI =  $-0.43$ ,  $-0.09$ ) and danger (MD =  $-0.13$ , 95% CI =  $-0.25$ ,  $-0.02$ ) when compared with ‘problem’. Compared with a man, a woman was blamed more for opioid-related impairment (MD =  $-0.08$ , 95% CI =  $-0.15$ ,  $-0.01$ ); men were viewed as more dangerous (MD = 0.13, 95% CI = 0.06, 0.19) and to be socially excluded (MD = 0.16, 95% CI = 0.09, 0.23). **Conclusions** There does not appear to be one single medical term for opioid-related impairment that can meet all desirable clinical and public health goals. To reduce stigmatizing blame, biomedical ‘chronically relapsing brain disease’ terminology may be optimal; to increase prognostic optimism and decrease perceived danger/social exclusion use of non-medical terminology (e.g. ‘opioid problem’) may be optimal.

## Terminology:

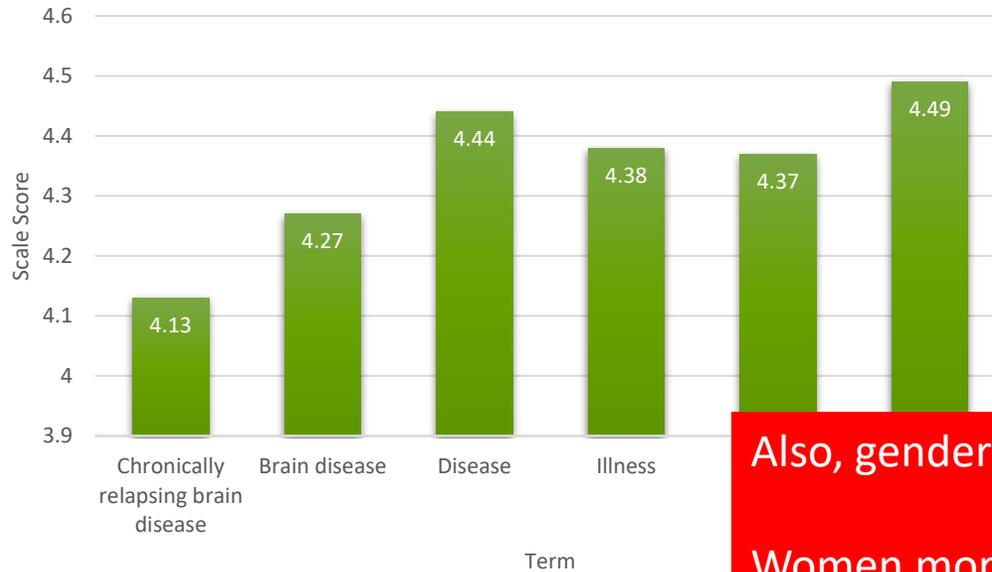
What's the best way to describe drug-related impairment to reduce stigma/discrimination?

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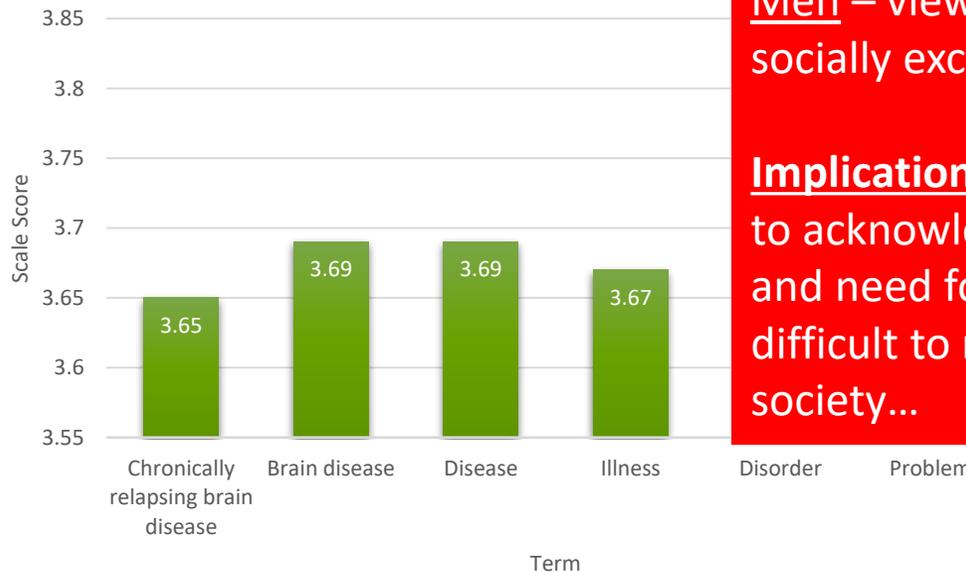
- Chronically relapsing brain disease
- Brain disease
- Disease
- Illness
- Disorder
- Problem



## Stigma (Blame Attribution)



## Prognostic Optimism (Likelihood of)



Opposite effects of the same terminology on different aspects of stigma:

- More medical terminology reduced blame the most but increased perceived danger, social exclusion, and decreased perceptions that

Also, gender effects:

Women more to blame overall for opioid impairment

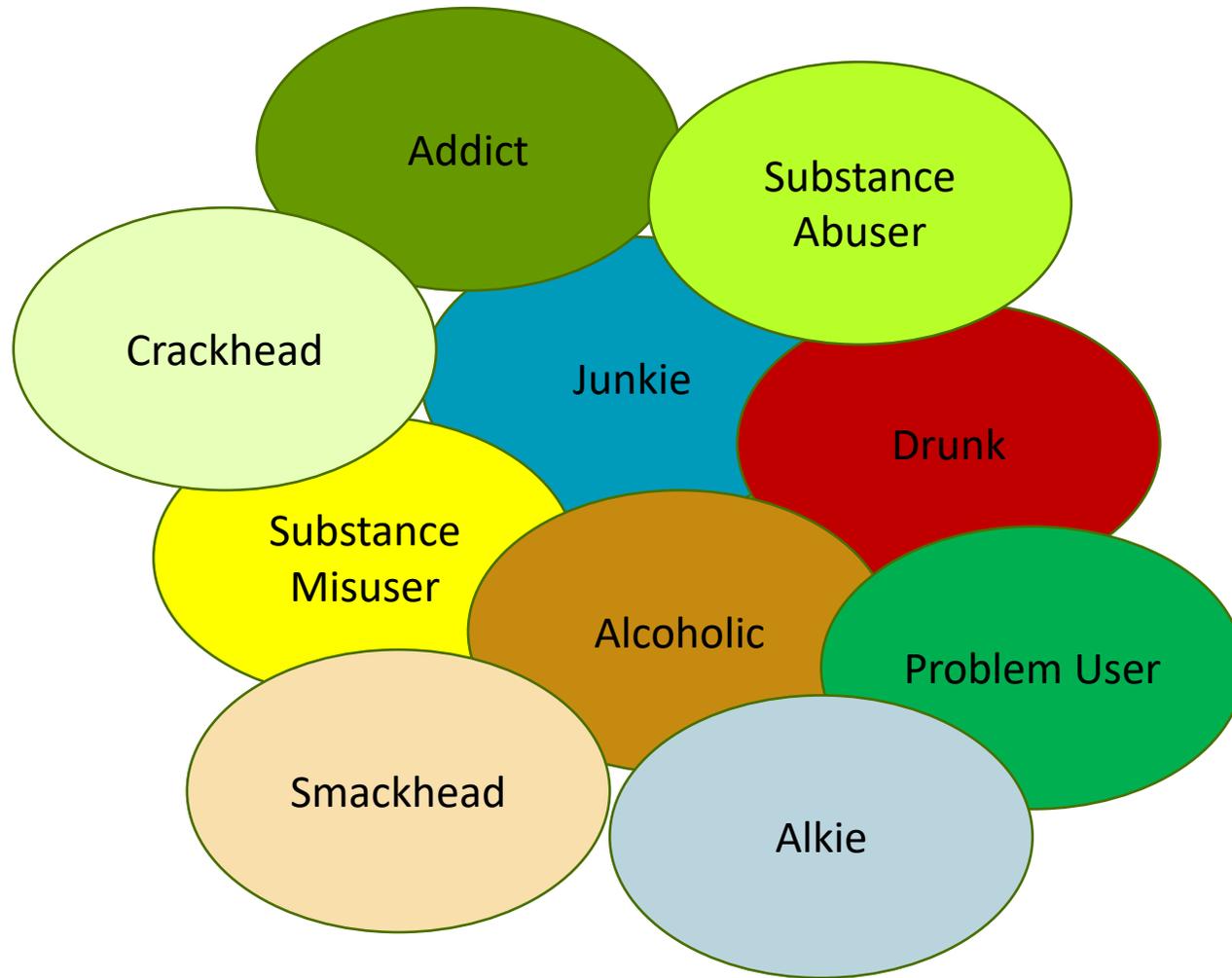
Men – viewed as more dangerous, should be socially excluded

Implications: women may find it more difficult to acknowledge, admit, disclose, drug problem and need for help; men may find it more difficult to reintegrate and be included in society...

may need to be tailored to context and goal

**WHEN DESCRIBING THE PERSON SUFFERING FROM THE DISORDER...**

**CAN THE USE OF CERTAIN TYPES OF MEDICAL TERMINOLOGY USED TO DESCRIBE THE PERSON SUFFERING FROM DRUG-RELATED IMPAIRMENT HELP REDUCE STIGMA AND DISCRIMINATION?**



# Question...



People with eating-related conditions are always referred to as **“having an eating disorder”**, never as **“food abusers”**.

So why are people with substance-related conditions referred to as **“substance abusers”** and not as **“having a substance use disorder”**?

## What is language?

- A standardized collection of sounds and symbols that trigger networks of cognitive scripts, activating chains of thought that influence appraisal, attitudes, and action
- Evolves over time

Factors at play in  
choosing alcohol  
and drug –related  
clinical language ...

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**Clinical precision and accuracy** - is the terminology precise enough to convey clinically meaningful and relevant information

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**Interpretation and utility** -is the terminology understood by most people in the way it is intended; does it capture sufficient information to make it useful

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**Stigma and discrimination** - is the terminology known to induce implicit/explicit biases (stigma) that might undermine clinical/public health efforts

# Two Commonly Used Terms...

- Referring to someone as...
  - “a **substance abuser**” – implies willful misconduct (it is their fault and they can help it)
  - “**having a substance use disorder**” – implies a medical malfunction (it’s not their fault and they cannot help it)
  - But, does it really matter how we refer to people with these (highly stigmatized) conditions?
  - Can’t we just dismiss this as a well-meaning point, but merely “semantics” and “political correctness”?

Does it  
matter?



Much ado about  
nothing?



“Political  
correctness”?

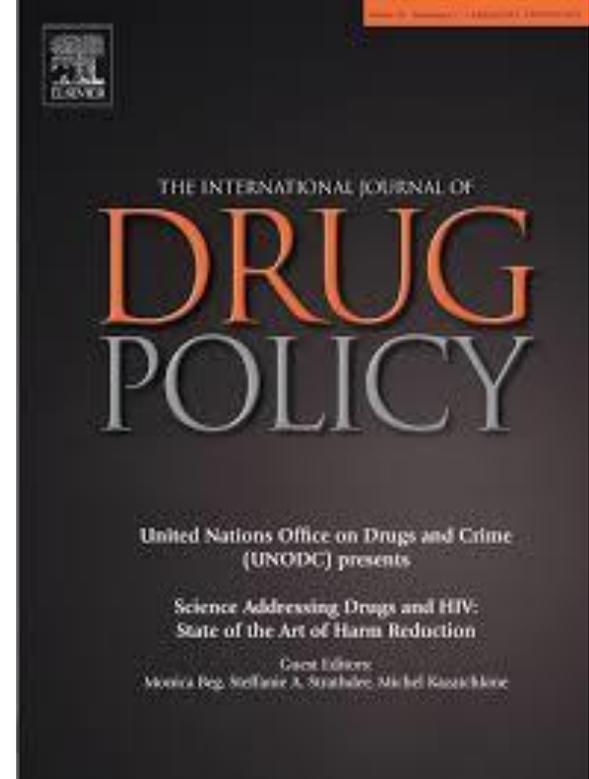


Mere “semantics”?

## Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms

John F. Kelly, Cassandra M. Westerhoff

*International Journal of Drug Policy*



How we talk and write about these conditions and individuals suffering them does matter

## “Substance Abuser”

Mr. Williams is a substance abuser and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs...

## “Substance Use Disorder”

Mr. Williams has a substance use disorder and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs...

**Compared to those in “substance use disorder” condition, those in “substance abuser” condition agreed more with idea that individual was personally culpable, needed punishment**

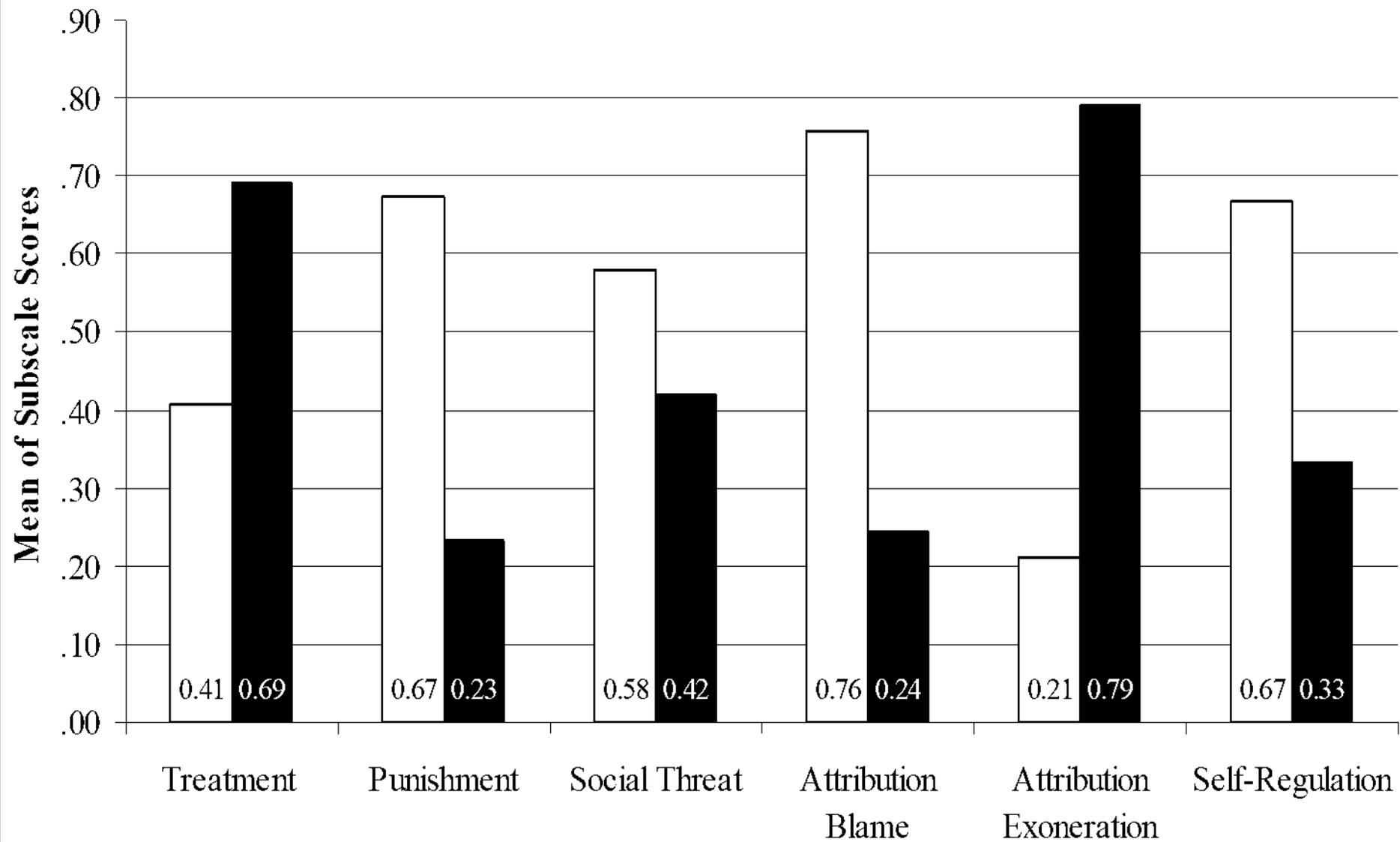
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**Does Our Choice of Substance-Related Terms  
Influence Perceptions of Treatment Need?  
An Empirical Investigation with Two Commonly  
Used Terms**

*John F. Kelly, Sarah J. Dow, Cara Westerhoff*

Substance-related terminology is often a contentious topic because terms may convey meanings that have stigmatizing consequences and present a barrier to treatment. Chief among these are the labels, “abuse” and “abuser.”





□ Substance Abuser ■ Substance Use Disorder

# Implications

- Even well-trained clinicians judged same individual differently and more punitively depending on which term exposed to
- Use of “abuser” term may activate implicit cognitive bias perpetuating stigmatizing attitudes—could have broad effects (e.g., treatment/funding)
- Let’s learn from allied disorders: people with “eating-related conditions” uniformly described as “having an eating disorder” NEVER as “food abusers”
- Referring to individuals as having “substance use disorder” may reduce stigma, may enhance treatment and recovery

## EDITORIAL

# Stop Talking 'Dirty': Clinicians, Language, and Quality of Care for the Leading Cause of Preventable Death in the United States

A patient with diabetes has “an elevated glucose” level. A patient with cardiovascular disease has “a positive exercise tolerance test” result. A clinician *within* the health care setting addresses the results. An “addict” is not “clean”—he has been “abusing” drugs and has a “dirty” urine sample. Someone *outside* the system that cares for all other health conditions addresses the results. In the worst case, the drug use is addressed by incarceration.

despite harmful consequences, a strong causal role for genetic control, stigma is alive and well. That one contributory factor may be the type of language used. Use of the more medically accurate “substance use disorder” terminology is a health approach that can

- Avoid “dirty,” “clean,” “abuser” language
- Negative urine test for drugs

[http://www.amjmed.com/article/S0002-9343\(14\)00770-0/abstract](http://www.amjmed.com/article/S0002-9343(14)00770-0/abstract)

THE AMERICAN  
JOURNAL *of*  
MEDICINE.

AJMM

# Recommended language examples...

## Don't say...

- “drug abuser”
- “alcoholic”
- “dirty urine”
- “heroin addict”

## Instead, say...

- “Person/individual/patient with a substance use disorder”
- “Person/individual/patient with an alcohol use disorder”
- “the urine was positive for....”
- “Person/individual/patient with an opioid use disorder”

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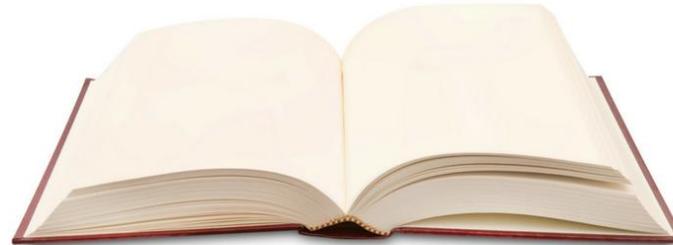
# ADDICTION-ARY

IF WE WANT ADDICTION  
**DESTIGMATIZED,**  
WE NEED A LANGUAGE THAT'S  
**UNIFIED.**

RECOVERYANSWERS.ORG



RECOVERY  
RESEARCH  
INSTITUTE



[www.recoveryanswers.org](http://www.recoveryanswers.org)

The words we use matter. Caution needs to be taken, especially when the disorders concerned are heavily stigmatized as in substance use disorders.



# Reducing Stigma in Clinical and Community Recovery Support Service Settings

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Prescribe, model and reinforce, universal use of appropriate, person-first, non-stigmatizing terminology pertaining to alcohol/drug use disorders and related problems (especially removing “abuse”/“abuser” from printed materials/websites/names as soon as possible)

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Be selective when using language as certain terminology (e.g., more biomedical) may be more or less helpful depending on stage of change

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Provide continuing education on the nature (causes and impacts) of substance use to service leadership, practitioners, and all staff, on the importance of addressing substance use disorders on clinical, ethical, humanitarian, compassionate care grounds, as well as health economics grounds

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Provide regular opportunity for interaction and exposure to recovering persons to help dismantle stereotypes and disabuse staff of faulty beliefs

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Create “recovery friendly” education and workplaces that openly and continually supports treatment and recovery for students and employees suffering from SUD including employing individuals with SUD histories



Thank you for your attention!

*Enhancing Recovery Through Science*

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