

**UNPACKING SOCIETAL AND HEALTHCARE PROVIDER
PERPETUATED STIGMA REGARDING PATIENTS
WITH SUBSTANCE USE DISORDERS**

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ABSTRACT

Stigmatization remains a significant barrier to the initiation and maintenance of treatment in patients with substance use disorders, with higher levels of stigma being associated with lower levels of treatment initiation and adherence. While societal stigma is frequently discussed, less discussed are the inherent biases expressed by healthcare providers. Healthcare providers often hold comparable or even higher levels of stigma against patients with substance use disorders compared to the general population, and this can have quite a significant impact on patient care. From improper treatment decisions stemming from fear and stigmatization of the medications used for opioid use disorders, to the development of mistrust and poor/worsening self-esteem secondary to poor patient-provider interactions. The effects of stigma on the substance use disorder patient cannot be understated and must be alleviated in the coming years to ensure that patients with SUDs receive the high-quality treatment that they deserve. Several interventions have been validated to help reduce stigma within healthcare providers, subsequently improving treatment outcomes. Words matter. Patient-first language is crucial; verbiage can strongly impact how not only the provider sees the patient, but how the patient views themselves (and as we know, poor self-esteem also hinders treatment outcomes). Education and normalization of SUD medications should be done at the healthcare provider level to ensure that all providers are comfortable with these medications. As higher frequency of interactions with substance use disorders has been shown to reduce levels of stigma seen within healthcare providers, it's also crucial that trainees receive adequate exposure to this patient population. While these suggestions may take time to show effect, it's imperative that we get the ball rolling on training future generations of healthcare

providers that do not hold inherent biases and who will provide high-quality, care utilizing validated treatments.

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CHAPTER 1

INTRODUCTION

Patients with mental health disorders have historically been marginalized and stigmatized. This applies to the full, broad spectrum of mental health disorders but is especially true for patients that suffer from substance use disorders. For outsiders, substance use disorders are often viewed from a lens of poor self-control and deviance. As such, patients with substance use disorders are even more prone to being unfairly labeled as difficult, dirty, unwilling to maintain treatment, and immoral. Given this level of stigmatization, it is certainly easy to see why treatment initiation and outcomes for patients with substance use disorders have been poor throughout history and continue to be poor even to this day.

With the recent COVID-19 pandemic and the isolation brought forth by lockdowns, the spotlight on mental health issues has never been brighter; it has become a much more accepted talking point in our country. Following the rise in discourse surrounding mental health issues has been a shift in society, towards a society more accepting of individuals with mental health / substance use disorders - a society that views these issues as legitimate medical issues. Despite all of the progress that has been made over the last couple of decades, stigma remains a significant issue, especially for those who are suffering from substance use disorders. Stigma is often discussed from the perspective of broader society. Less discussed, however, is the disproportionate impact of the rampant stigma held within specific communities, namely the medical community. To

put it frankly, the stigma held and perpetuated by healthcare providers acts as a serious, potentially life-threatening barrier to the care of patients with substance use disorders.

CHAPTER 2

DEFINING STIGMA

Over the last two to three decades, stigma has been a hot topic, and for good reason. It's a concept that can have dramatically detrimental effects on an individual's life, but its actual definition has been intensely debated within academic communities. Bruce Link and Jo Phelan released a landmark piece of literature regarding the conceptualization of stigma in 2001, titled "Conceptualizing Stigma".²⁴ Prior to this article, stigma was viewed in a more one-dimensional manner, focusing on perceived individual flaws with only minor discussion on social context surrounding the characteristics and creation of stigma. As discussed in their article, much of the difficulty in concretely defining stigma is due to the broad range of social situations where the definition must be applied, the variety of disciplines that seek to define stigma in the context of their field, as well as the fact that many of those who seek to define stigma do not have the lived perspective of being stigmatized and thus miss out crucial components. In their definition of stigma, Link and Phelan identified several core characteristics that apply broadly to stigma, regardless of the context: 1) The identification of socially relevant, oversimplified human differences, 2) social differences that are viewed as undesirable and that creates an "us vs them" phenomenon, 3) a must-have component of discrimination and social status loss, and 4) a component of power differences/imbances that allow stigma to be easily perpetuated.²⁴ It's important to note the presence of social status loss, discrimination, and power-imbances in their definition, as prior to this article these were components that were often neglected. The

power-imbalance aspect is especially important, as power of the “in-group” is what, largely, makes stigma so difficult to eradicate; regardless of the context, the cooperation of the more powerful, in-group is required to remove any social stigma. These components of stigma as described by Link and Phelan continue to hold relevancy even two decades later.

More recently, the World Health Organization defines social stigma in medical contexts as the “negative association between a person or group of people who share certain characteristics and a specific disease”.²² While social stigma is not exclusive to mental health disorders, conditions that contain a mental health component or a component of “self-control” or “will” tend to be more heavily stigmatized. This is partially due to fundamental attribution error, where individuals attribute the SUD patient’s behavior to their own moral failings and characteristics, ignoring other relevant contributing factors. In the context of substance use disorders, social stigma manifests in several ways, including:

1. The isolation and shunning of individuals with substance use disorders.
2. The creation of a taboo nature surrounding addiction, making it difficult for individuals with substance use disorders to even initiate conversations that would lead them on to the path of recovery.
3. Mistreatment by those who are meant to care for them.
4. The creation of punitive legal policies, which act as a significant barrier to any meaningful recovery.

Going back to Link and Phelan’s definition of stigma and applying it to addiction, we see that individuals with substance use disorders are separated from other groups in

society by the presence of their addiction as well as false assumptions of lack of moralistic character and, as we'll see throughout this discussion on addiction, face social status loss and perpetuation of discrimination by the more powerful societal group (those that do not have substance use disorders).

CHAPTER 3

HOW WE VIEW ADDICTION: SCIENTIFIC AND SOCIAL PERSPECTIVES

Part of the difficulty in the conceptualization of addiction is that we simply do not understand all the complexities that make up addiction. There are several proposed frameworks to view addiction from; while many of them are backed up by biological evidence, they are not without critique.

One of the most popular models to view addiction is the biological model, in which addiction is viewed as a disease of the brain. On the definition of addiction, the National Institute on Drug Abuse characterizes addiction by stating the following:

Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences. It is considered a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control.¹⁰

Indeed, the “brain disorder” model is compelling as there is biologic evidence that points to neurologic differences in individuals that have substance use disorders, and choices involved in addiction behavior utilize different circuits compared to “normal” behavior.

This model, however, is not without critique. Discussing this model, the authors of *“Addiction and Moralization: the Role of the Underlying Model of Addiction”*⁹

highlighted several of the most common issues:

1. Addictions often involve a series of complex behaviors that many people believe cannot all be fully attributed to neurologic differences (those who are of this opinion often highlight an element of voluntary choice).⁹

2. Many individuals with substance use disorders are capable of quitting spontaneously without any outside assistance (this is more often seen in younger individuals in their twenties), which many believe would not be possible if the “brain disease” model was the full truth.⁹
3. The brain has constant structural change regardless of the presence of addiction, so it’s difficult to know whether we can attribute these changes solely to addiction itself.⁹

Another popular model is to view addiction from a “voluntary choice” perspective.^{9,4} Individuals who agree with this model tend to view addiction from a lens of significant individual responsibility and believe that individuals who continue with their addictions are doing so out of a lack of self-control and personal care. The endorsement of solely this viewpoint ignores much of the neurologic evidence that points out structural differences as well as many of the sociological factors that influence the onset and continuation of addictions.

In reality, the conceptualization of addiction is likely somewhere in the middle of the spectrum of explanations. There are valid critiques of both sides, and as such, many individuals have shifted to view addiction from a more central ground, acknowledging both the neurologic basis of addiction and the psychology that underlies addiction.

This discussion of the conceptualization of addiction highlights an important factor that contributes to the heavy stigmatization of substance use disorders: the adoption of the “personal choice” framework by the general public. Throughout history, addiction has always been viewed as a condition of gluttony and moral failure. Even as

we move forward and gain a better understanding of addiction, these misconceptions stemming from the “personal choice” model persist. Unfortunately, as we will see, healthcare providers are not exempt from internalizing stigmatizing beliefs regarding individuals with SUD’s.

CHAPTER 4
AN EXPLORATION OF STIGMA FROM THE LENS OF HEALTHCARE
PROVIDERS

When discussing social stigma within medical communities, a seeming paradox comes to light: health care providers, those who have devoted such significant portions of their lives in the pursuit of helping others, often hold stigmatizing views towards their own patients. One would think that those most well versed in health/medicine would be immune to the cultivation of such views. That is not our reality, however.

When we look at the data, it appears that when treating patients with substance use disorders, health care providers are equally if not more prone to holding and perpetuating these stigmatizing beliefs compared to the general populace. In 2016, a survey was conducted by the AAFP surrounding attitudes/beliefs regarding patients with opioid use disorders.¹ Ultimately, 361 primary care physicians were surveyed. It was found that 11.7-12.7% of PCPs attributed a patient's opioid use disorder (OUD) to perceived individual character flaws, that less than 30% of PCPs would be willing to associated with someone with OUD socially, and that only 77.6% perceived it as a chronic medical condition. It is important to note, though, that 92.2% of PCPs viewed people with OUD as capable of (with treatment, of course) returning to productive lives.¹

While unfortunate, it's clear that healthcare providers can and do hold biases against patients with substance use disorders. The next question is: in a healthcare context what are their worries and beliefs regarding these patients? When looking at health-care

provider anecdotes regarding patients with substance use disorders, a few prevalent themes come to light. Clinicians often highlighted a sense of helplessness when it comes to treating SUD patients; they reported pessimistic feelings regarding treatment outcomes for SUD patients and sometimes even stated that they felt working with these patients was a waste of time as the patients would not enact the changes that they were trying to help them make. Providers also reported a sense of lack of comfortability and feeling unsafe when interacting with SUD patients, and often worried that SUD patients were committing crimes/using substances while in medical care.²⁰ While many of these worries are valid to some degree, the strength of these worries is often overblown and are generalized to the overall population of SUD patients, rather than the few individuals that actually engage in the poor behavior that providers are afraid of. This is a disservice to patients who are genuinely seeking help and ignores the dynamic nature of personal change that often occurs within addiction. Additionally, even if these preconceptions are unconscious, they are highly detrimental to patient-provider interpersonal dynamics, as will be discussed in the coming sections.

CHAPTER 5

HOW STIGMA INFLUENCES MEDICAL TREATMENT DECISIONS

Healthcare providers hold significant power over their patients. This power, especially when misused, can have serious consequences. From the treatment of patients with opioid use disorders, we see that some physicians reject evidence-based treatments largely due to their internalized biases. In the 2016 AAFP survey discussed earlier, physicians weren't solely asked about their beliefs about the characteristics of those with opioid use disorder, they were also asked about beliefs regarding the appropriate treatments for these patients. ¹

Buprenorphine, Naltrexone, and Methadone are all validated treatments used for patients with opioid use disorder. For Buprenorphine and Methadone specifically, the use of these treatment options has been shown to improve mortality in patients with OUD by up to fifty percent. ² To emphasize it again, *these are all approved and validated treatments that are suggested within proper clinical guidelines and show mortality benefits*. Despite this, the AAFP survey indicated a hesitancy within primary care physicians to provide these treatments to their patients. Only 35% of PCPs stated that they provide OUD counseling themselves, and even less endorsed a willingness to prescribe the medications mandated by clinical guidelines; between 4 and 10 percent depending on which agent was discussed. ¹ Many of these physicians, though, endorsed a willingness to refer patients for the treatments that the physicians knew they needed. The only caveat? Many were not willing to be seen treating or even refer those patients to other physicians within their own practice. 79.7% of physician respondents stated that

they refer patients to OUD counseling but only 52.4% of physicians reported that they refer their patients to another clinician that is willing to initiate the proper treatments (ie: medications), and 67.6% of physicians were only willing to refer to physicians outside of their practice for OUD counseling (roughly 21% referred in-house).^{1,3}

These are abysmally low numbers and, ultimately, highlight the fact that the medical community is failing patients with substance use disorders. We certainly expect some level of stigma from the general populace, who are expected to be less well-versed regarding healthcare. We do not, however, expect our physicians to hold such levels of stigma and concern for self-image; especially to the extent that impacts their ability to give proper treatments to their patients. Such failing would not be accepted for any other patient populations. After all, could you imagine primary care physicians not following clinical guidelines for conditions like hypertension or diabetes?

CHAPTER 6

THE IMPACT OF STIGMA ON TREATMENT INITIATION

Stigma can take its root even prior to the initiation of any treatments for SUD. In fact, stigma plays a role in preventing the diagnosis of many patients with SUD. A European study involving over 3000 healthcare professionals from several different countries was done to assess barriers to screening for alcohol use disorder.⁶ This study involved several different countries and ultimately found that stigma was a significant barrier to the initiation of screening for alcohol use disorder (AUD), with France and Italy finding that almost half of the barriers reported by healthcare providers were stigma related.⁶ This issue, however, is not unique to these specific countries. Clinicians worldwide often report a hesitancy to initiate discussions with patients regarding substance use disorders due to the sensitive and taboo-like nature of substance use disorders. For those in the United States, the nature of substance use conversations can be paralleled to discussions regarding sex and sexually transmitted diseases with patients, which as many of us can imagine can sometimes bring up a sense of awkwardness and anxiety within the provider (especially in trainees). Anecdotally, as a medical trainee I too have felt a sense of awkwardness/anxiety when broaching these subjects. After time and experience it certainly fades and the conversations are made much easier, but for many providers the hold of stigma never fully disappears, though it commonly does lessen.

CHAPTER 7

STIGMA IN RELATION TO MEDICAL TRAINING

Part of stigma seems to be embedded within medical training. Interestingly, in 2019 a study was done to assess differences in views between attending physicians and trainee physicians regarding the treatment of patients with OUD (opioid use disorder).³ Random samples of 1000 physicians were selected from each group (trainee vs attending), with a participation rate of 45-54% varying between groups. It was found that the trainee physicians were more likely (76% compared to 67%) to endorse belief in the efficacy of the use of medications when treating OUD. On top of these, trainee physicians were more likely to endorse a willingness to work with populations (51% versus the 20% seen in attending physicians). Trainees were also, on average, more receptive to policy changes that loosened restrictions regarding medications used to treat OUD.³ This highlights a few important questions: Are these differences seen due to improvements in medical education? Are these differences evidence of societal shifts that are happening? Does medical education itself contribute to the development of erroneous beliefs seen within the attending physicians? During medical school, trainees receive much of their clinical exposure during their third and fourth years. During these years, trainees learn from and model the behavior of the attendings that are tasked with their education. Attitudes and behaviors displayed during this critical time in training play a significant role in the development of a trainee's attitude and clinical style. Another question, one that likely can't be answered, arises: how much does the attitude of attending physicians impact their trainee's views regarding patients with SUD's?

Both a contributing and resulting factor, lack of experience during medical education plays a role in the development and perpetuation of stigmatizing beliefs. Medical students and residents often receive subpar education when it comes to addiction, even though every provider from every specialty will likely work with a SUD patient at some point. When looking at the training of psychiatrists, who are crucial to the treatment of substance use disorders, we can even more clearly see these gaps in training. As recent as 2000, the ACGME did not place any requirements on psychiatric residency programs regarding substance use disorder education and clinical experience. It was only in 2001 that ACGME began to require all psychiatric residencies to incorporate at least one month of addiction training in their curriculum (which is still far too low).²³

Over the years, the incorporation of addiction training into medical education, at all levels, has certainly improved relative to before, but there remains room to grow. For such a significant patient population that every healthcare professional will encounter, it is important that trainees be given adequate time to work with these patients, to challenge their personal biases and learn how to cultivate the healthy provider-patient dynamic required to give these patients the high-quality treatment that they deserve. Studies have shown that increased exposure to patient groups may help reduce stigmatizing beliefs held by individuals. In 2006, a study involving 60 healthcare workers was done to assess the effect that treating individuals with Hepatitis C has on attitudes regarding patients that are injection drug users.⁵ It was found increased contact/exposure to patients with HCV was associated with more favorable attitudes towards patients that are injection drug users. Interestingly, the converse was not true; with increased interactions there was limited impact on the attitudes of HCV positive patients towards healthcare providers.

Regardless, many studies have supported the idea that increased exposure (whether it be during training or elsewhere) to stigmatized patient populations can help foster positive attitudes regarding those patient populations and can help eliminate previously held biases. As such, an important factor that will influence the trajectory of treatment outcomes for SUD patients is the overhauling of medical education/training. With the current changes that have been made, the future seems bright, but we certainly cannot take our feet off the pedal quite yet.

CHAPTER 8

STIGMA FROM THE PERSPECTIVE OF PATIENTS

Stigma not only reduces the likelihood of SUD patients to initiate treatment for their addictions, but also their likelihood to adhere to their treatment plans. When combing through several studies/papers that sought to evaluate both provider and patient perspectives regarding clinical interactions, it became clear that many patients hold a deep-seated mistrust in the medical system, often predicated on past experiences of mistreatment by healthcare providers. This mistrust led to not only hesitancy to engage in the medical system for initiation of care of any kind but also lower quality clinical interactions and higher likelihood of terminating treatment prior to completion.⁸ It also became clear that patients are much more perceptive of the body language and communicative nuances that providers brought into clinical interactions than many providers give them credit for. Patients often brought up little details/mistakes from providers that greatly influenced the way that patients perceived the provider, their treatment plan, and themselves. Additionally, almost universally, patients with substance use disorder reported experiences of clinical interactions where providers made them feel worthless and self-conscious.^{8, 13, 16} This highlights an area of medical education that's not often discussed when it comes to addiction training: there is very little emphasis on the fact that many patients with SUD are hyper-vigilant during clinical encounters. Certainly, healthcare providers are taught the sensitive nature of patients with SUD but medical education rarely stresses the true importance that a provider's conduct has on a patient's sense of comfortability and confidence within their own treatment. Another

important factor that SUD patient perspective anecdotes illuminate is the importance of understanding power imbalances within these dynamics. SUD patients often report a sense of helplessness/powerlessness during these interactions that can derail a clinical relationship if not properly accounted for. For clinicians, it's important to take heed of these clinical perspectives so that they can adjust their own conduct to craft provider-patient dynamics that are beneficial to the patient's treatment outcomes.

Social support is another known but critical factor that greatly influences an individual's SUD treatment; a good social group with a supportive attitude can go a long way to normalizing substance use disorders and seeking treatment, preventing patients from taking on the negative labels that are perpetuated throughout society. A study was done in Denmark, where treatment (even for substance use disorders) is free of charge, to assess the association between stigma and individuals' reaction to a loved one opening up to them about their SUD.⁷ As expected, individuals who had lower levels of stigma score were significantly more helpful and influential to the initiation of SUD treatment in their loved ones. After hearing that someone close to them is suffering from a SUD, men with lower stigma scores were more likely to report that they'd develop an active plan to help and less likely to report that they'd take an avoidance strategy in this scenario. Similar results were found in women, with a lower stigma score being associated with much lower odds of endorsing avoidance. Interestingly, there was no significant association between levels of social stigma and likelihood of an individual endorsing that they'd seek out help from others within the social group.⁷ While it may be obvious, it's important to note that there are cultural differences between Denmark and the United States, so these results cannot be perfectly extrapolated onto individuals/patients within the United States.

Regardless, this study and many others like it highlight the idea that higher levels of stigma, both internal and external, negatively impacts an individual's likelihood of supporting loved ones with substance use disorders and encouraging the initiation of treatment (which influences an individual's likelihood of seeking treatment initiation). Given that we know that social support is influential to the initiation of care, it follows that cultivating a society of individuals (not just healthcare providers) that overall hold less stigmatizing views would be greatly beneficial to improving the percentage of individuals with SUD that actively choose to seek out and adhere to care for their condition.

In almost all the qualitative studies that directly quoted and analyzed SUD patient perspectives, an often-overlooked factor that can be make or break in a patient's journey to sobriety was brought to the surface: the rebuilding of a patient's self-esteem. While difficult for many of us to imagine and place ourselves in, it makes logical sense that a patient with a substance use disorder would suffer from low self-esteem. The negative attitudes of society and healthcare providers, those who are meant to take care of them, seeps into the psyche of these patients, causing negative self-talk and often a self-fulfilling prophecy. In fact, self-esteem is often one of the first barriers that the provider-patient relationship must tackle. Published in 2022, a qualitative study was conducted in Norway that assessed the provider-patient relationship and impact that the relationship had on the patient outcomes (assessed four years after inpatient hospitalization for substance use disorder).⁸ The paper offered direct patient perspectives and highlighted inpatient factors that the patients felt were important to their journey to recovery. One such factor was the sense of care and self-esteem building that the healthcare providers

brought into patient-provider interactions. Many of the patients reported that in the moment, self-esteem building (from providers) helped increase their motivations to get better and directly, positively influenced their decision making. Long term (even years after inpatient stays), patients often indicated that the attitudes of their healthcare providers stuck with them and the building up of their self-esteem helped them maintain their sobriety even years after their discharge.⁸ The authors of the paper also highlighted an important point: trust takes time. Many of the patients also reported that it took a large amount of time for them to feel safe enough to open up to their clinicians regarding life/social factors and self-perceptions that were helping perpetuate their substance use struggles. While obvious, it cannot be understated how sensitive patient-provider dynamics are for patients with substance use disorders, and how critical the establishing of trust can be to a patient's treatment outcome.

Other qualitative studies that offer SUD patient perspectives have similar findings. One such study was conducted between 2015 and 2016 by Julia Woo et. al, assessing the perspectives of eighteen patients on methadone maintenance therapy (MMT).¹³ Of these eighteen patients, fourteen of the patients reported that they have experienced some level of stigma stemming from their MMT, with the most common sources of stigma being noted as friends and healthcare workers. Sixteen out of the eighteen patients believed that the public view MMT patients negatively. One of the most interesting parts of this study, however, is the reported impacts of the perceived stigma. Over half of the patients reported that they felt ashamed to be on MMT and many stated that they go to facilities far from their area of residence so as to not run into anyone while going to MMT. This poses a huge problem, as barriers like this make long-term

adherence even more difficult. Importantly, roughly one third of the patients also noted that the stigma surrounding MMT made them wary of initiating treatment, with some stating that they waited several years due to this fear. Sadly, many of the interviewees noted that when they finally did pursue treatment, they were treated poorly by healthcare providers, often being labeled as “addicts”, immoral, and drug seeking. The patients stated that it made them reluctant to continue medical treatment, and many even hid their MMT status from other healthcare workers out of fear of poor treatment.

Anecdotally, in my own treatment of patients with SUD’s, I’ve noticed overall lower levels of self-esteem and have experienced many occasions where patients would seemingly expect negative biases from me as the provider and would reflexively and unconsciously engage in negative self-talk during our conversations. As discussed previously, during these interactions the provider has significant power over how a patient will experience a healthcare interaction, as well as how the patient will see themselves as individuals moving forward. Self-love is an important aspect of recovery. As such, it’s imperative that providers become more aware and better able to reinforce feelings of worthiness in patients suffering from addictions.

CHAPTER 9

BEST PRACTICES AND HOW WE SHOULD MOVE FORWARD

Having established the presence and realities of implicit provider side biases against patients with substance use disorder, it's important to discuss best practices and how healthcare providers should move forward. While this is a topic that is currently under research, there are some established and validated methods that reduce provider sided stigma and improve clinical interactions with patients with SUD. The necessary changes that I'll highlight all underscore the issues that were described throughout this piece of literature. Changes in language and more careful attention to patient-provider dynamics (from the side of providers) are required to boost the self-esteem and likelihood of meaningful recovery from substance use disorders. Education reform is necessary to improve the dissemination of accurate information regarding substance use disorders, which will ultimately contribute to the eradication of stigma. In a medical context, education reform is necessary to mold future healthcare providers that have not only better therapeutic relationship with their patients with substance use disorders (largely via more exposure and practice with this patient population) but that are also more likely to make proper, evidence-based therapeutic decisions. Lastly, as the group with power, individuals without substance use disorders, especially those working within healthcare, should be doing their part to advocate for the proper treatment of those with substance use disorders. Though these changes will all take significant amounts of time, we all need to do our part to get the ball rolling.

Patient First Language

The age-old adage, “sticks and stones may break my bones, but words will never hurt me”, is false. In our reality, words truly do hold significant weight. The way that patients view themselves and their providers, as well as how their providers view them, can heavily impact an individual's likelihood to seek out treatment, their likelihood of adhering to various treatment modalities, and their overall treatment outcome. As such, “patient-first” language is being increasingly incorporated into medical care. Using patient-first language involves the replacement of a provider’s current vocabulary with words and phrases that are meant to empower patients with substance use disorders and re-frame the way that they view themselves. For example, the use of words like “addicts” and “junkies” is all too common and harmful to patients. It has a negative connotation, putting patients in a box of perceived immorality. The use of these words also invokes negative emotion on the side of the provider and can, often subtly, impact the way that the provider feels about and treats their patient. On the flip side, patients are much more aware of provider-patient interpersonal dynamics than many providers give them credit for, and can recognize when providers are stigmatizing them, even if unintentionally, with their words. Additionally, we know that repeated thoughts and consistent use of certain language creates thought and speech patterns that ultimately solidify in an individual’s mind and alter their perception of self. By using patient-first language as a provider, you can not only create a much better interpersonal dynamic with patients, one with more trust and respect, but you can also positively impact the way that patients perceive themselves and their illness, creating a better foundation for successful

treatment. Additionally, the use of patient-first language by older and more experienced providers serves as a positive model for medical trainees (who will be caring for these patients in the near future) to follow in their own independent practice. Examples of patient-first language include:

Table 1. Examples of Patient-First Language

Stigmatizing Language	Patient/Person First Language
Addict / Drug Abuser	Person who uses drugs / Person suffering from substance use disorder
Relapse	Reccurence of use / Return to use
An individual who is “clean”	An individual in recovery
Clean or dirty (when referring to lab results)	Positive / Negative
Drugs (when referring to medications used to treat SUD’s)	Medications

Education

The way we teach addiction, both at a basic and advanced level, is flawed. Regarding universal education, the non-medical focused education that the general populace will receive, the current curriculum that many young individuals are learning are 1) not patient/person-first, 2) do not accurately describe and discuss addiction, 3) do not talk about socioeconomic influences, and 4) focus more on fearmongering rather teaching the facts. In order to tackle stigma long-term, even on a provider level, we need to ensure that, early on, we are reframing the way that our youth see drugs, addiction, and the personal qualities that individuals with substance use disorders have. Proper education with information and practices that are up to date is key to cultivating a future populace that is supportive of individuals with substance use disorders.

On a more advanced level (the level of a healthcare practitioner) it's clear that more emphasis needs to be placed on the overhauling of addiction education/training. Some important changes that should be incorporated to create more well-prepared providers:

- Teaching patient-first language. While patient/person-first language is becoming increasingly taught everywhere, it needs to become more widespread in education as well as enforced during clinical rotations.
- Teaching more about treatments. More time needs to be spent learning the treatments for SUD, especially OUD, and emphasizing their validity and efficacy. These medications are currently stigmatized, causing many

practitioners to avoid using them despite their proven efficacy (and mortality benefit for some of these medications).

- More time spent with patients with substance use disorders as well as more time spent in addiction-focused rotations. Addiction training should be much broader and more involved than it currently is, given the universality of the patient population. The only way to truly learn and practice many of the principles discussed within this piece of literature is by experience; trial and error.

As established earlier, patients with substance use disorders can be extremely perceptive and often are even more aware of the interpersonal dynamics than the provider. Given the importance of the early patient-provider interactions to establish strong rapport, it's important for future healthcare providers to understand and experience the sensitive nature of these interactions to prevent them from making any significant missteps. Talking to patients with any type of mental health disorder, not just substance use disorders, can sometimes be akin to playing a real-life game of minesweeper; one wrong step and a provider can easily ruin a provider-patient relationship, reducing the overall quality of care that can be delivered. As such, it's imperative that medical education be revamped in a way to allow all trainees, regardless of their future specialization, more exposure to patients with SUD's so that they can better handle these cases when they're practicing more autonomously.

Educational changes regarding SUD treatment options need not be limited to the healthcare trainee sphere; we should be working to improve awareness and education in all areas of society. With studies suggesting that a vast portion of the general population

is not aware of Methadone/Buprenorphine and/or other medications used for substance use, and that many view medications like Methadone and Buprenorphine as simply a “replacement drug” despite their proven efficacy and mortality benefit, one area of focus should be better educational dissemination regarding the use of MAT’s and other drugs used for SUD treatment can help remove the stigma surrounding these drugs (though, it would be unrealistic to expect a complete elimination of stigma). Having easily accessible and easily digestible information regarding MAT and other topics surrounding SUDs benefits everyone, as more positive and informed attitudes will trickle down to future generations.

Enforcement of Treatment Guidelines

As healthcare providers, it is simply unacceptable for us to inject negative internal biases into our treatment decisions. Healthcare providers should be following guidelines and providing effective, validated treatments when possible. As discussed earlier, the use of medications to treat substance use disorders, especially opioid use disorders, is often neglected due to fear, anxiety, and internal biases that healthcare providers hold even though these medications have been proven to have mortality benefit for patients. Younger trainees are on average more open and accepting of these treatments and are more likely to endorse a willingness to prescribe them when clinically indicated. Currently, medical education is shifting towards curriculums that increasingly discuss the proper, ethical and empathetic management of patients with substance use disorders. As the years pass, we will likely see future generations of providers that have better

provider-patient interactions with SUD and overall have better outcomes (given the reduction in stigma). However, we cannot afford to wait for this shift. Especially for those who work within large health systems, we must work to improve the quality of treatment received by patients with substance use disorders; more education is required, and medical practices/hospital systems should be strictly enforcing the proper treatment guidelines. While it may be logistically difficult, one suggestion would be to increase the usage and integration of addiction medicine specialists into care. Frequently, substance use disorder patients come in for care by primary care providers or non-addiction-medicine specialists. Lack of experience and understanding regarding these patients can create frustration and poor clinical interactions from both the provider and patient view. As such, the utilization of expert consultants, even if just to review a patient's current treatment plan or to help with the initiation of certain medications, can help bridge these gaps in care and should be encouraged even more than it currently is.

Advocacy

Given the unique ethos that healthcare providers hold, increased advocacy on the side of healthcare providers is necessary. Currently, many medications used for SUD are being limited/restricted largely due to stigma, and many laws and current practices are punitive towards individuals with substance use disorders. Policy reform is rarely aimed at these patient populations as there is often little benefit for politicians to push for improvements. There exists a void of individuals that can stand up for those with little social power, and as such healthcare workers are even more obligated to advocate for

their patients with SUD. Advocating, however, doesn't always have to be done on such a high level. In fact, even things like advocating for the enforcement of proper treatment guidelines for, say, patients with OUD are a significant step forward. Interestingly, when we look at studies that outline attitudes regarding addiction between, say, the US and the UK, we see some of the positive results of our advocacy. Partially due to the higher rates of advocacy as well as larger funding and more attention placed on the issue, the attitudes of individuals in the US, especially healthcare providers, tends to be one that follows the "disease model" of addiction whereas individuals in the UK are more likely to view addiction from the "choice model", attributing addiction to personal failings.⁴ The contrast in societies is key here. We have two different societies with two different approaches to patients with substance use disorders, partially stemming from the attitudes fostered within society regarding substance use disorders. As highlighted by these studies, if we foster better attitudes towards patients with SUD, the quality of care and treatment outcomes will improve. Given that few others have a stake in the game, it's important for healthcare providers to advocate for their patients in the way they can, whether that be on an individual level or on a larger, policy level scale. This, however, brings up an important issue that links back to our discussion on education; proper advocacy is not an inherent skill and is something that needs to be emphasized and taught more within medical education/training. Certainly, advocacy can be an intimidating notion as 1) it can feel quite involved and 2) results of advocacy can take a significant amount of time to manifest. However, for any meaningful change to occur, it's important for each generation of healthcare providers to keep the torch of change lit.

CHAPTER 10

CONCLUSION

Patients with substance use disorders remain as one of the most stigmatized populations, both within medicine as well as within broader society. In this piece of literature, I gave a brief view into the window of addiction stigmatization, focusing on the impacts that stigma has on both patients and healthcare providers.

From the analysis of provider sided stigma, several issues came to light. Firstly, health care providers are just as, if not more, prone to holding biased views regarding patients with substance use disorders. These views, unfortunately, impact the care that they provide to their patients. From a patient-provider interpersonal dynamic standpoint, when providers hold stigmatizing views, even if unconsciously, their interactions with patients are significantly more likely to hold negative undertones that SUD patients are often hyper-vigilant of. As such, stigma often dooms a patient-interaction from the start, which only serves to make a patient's already difficult attempt at recovery even harder. From a treatment standpoint, stigma also seeps its way into decision making. Though many medications have proven to be efficacious for the treatment of various substance use disorders, and in some cases have been shown to have mortality benefits across several studies, they remain under-utilized. Physicians often report a sense of discomfort when asked to initiate treatment. Two principles underlie this issue: 1) lack of education and emphasis about their use, and 2) fear and stigma. Regardless of the reasoning, this issue is preventing patients from receiving the high-quality treatment that they deserve, which is completely unacceptable. Lastly, the stigma that current healthcare providers

hold influences future generations. Learners model their mentors, sometimes even when the modeled behavior is negative and detrimental. As such, the stigma that current healthcare providers hold can spread its roots into the practice of future healthcare providers, holding back crucial change that would be beneficial to patients that suffer from addictions.

From a patient standpoint, stigma acts as a serious barrier to their likelihood of initiating treatment for their addiction and decreases the likelihood of adherence to treatment plans. Through analysis of several sources that detail patient perspectives, several themes came to light. Predictably, patients are aware of and internalize the stigma that is placed against patients with substance use disorders. One of the more important themes was the fear and shame that SUD patients associate with healthcare. Often, patients with SUD's report negative past experiences with healthcare providers that make them less likely to want to initiate treatment. Even when initiated, the lack of support patients feel from their healthcare providers negatively impacts their likelihood of adhering to treatment plans. Another important point that was brought forth is self-esteem. Patients with substance use disorders internalize stigma which impacts their belief that they can succeed in recovery. Even seemingly small interactions (whether within healthcare or outside of healthcare) can have devastating impact, even years after the initial incident, on the sense of self-esteem in SUD patients. Positive interactions have the opposite impact, improving a patient's sense of self-esteem even long-term, which is crucial to the success of their recovery. Lastly, stigma can make patients ashamed of taking the medications that are important to their recovery, even causing them to go so far as to travel to different cities to hide the fact that they're taking these medications. This is

a societal issue; along with stigma, ignorance from lack of easily digestible information plays a significant role in the public perception of these medications. While difficult, normalization of the struggles of addiction as well as the usage of medications to treat it will go a long way in saving many lives.

The takeaway of this piece of literature is that the actions and perceptions of the general populace are causing significant harm to a population that is undeserving of such treatment. Compassion is necessary, not hate. As such, several changes need to be made on individual and structural levels. In the health-care sphere, healthcare providers need to be more cognizant and purposeful within their clinical interactions, so as to create an environment conducive to recovery. In the general population, changes in perception of patients with substance use disorders via information dissemination and normalization of the struggles of addiction are necessary. Though difficult and slow improving, we have seen positive changes in the realm of addiction over the last several decades. My belief is that as research improves and ignorance decreases, addiction care will become better and more humane.

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