Stigma, Opioids, and Public Health Messaging: The Need to Disentangle Behavior From Identity

Stigma plays an important role in understanding successful interventions to control the opioid epidemic in the United States. Stigma has been described both as an agent to incentivize positive health behavior and as an agent of marginalization contributing to poorer health. Past scholarship has argued that stigma has positively motivated public health changes, for example, among tobacco users; it has also been associated with discrimination against vulnerable individuals, resulting in increasingly poorer health behaviors, for example in relation to HIV-prevention messaging.

The discourse on stigma may conflate the denormalization of unhealthy behaviors with wholesale rejection of individual identities. More effective interventions would counter stigma against people who use opioids in general and specifically denormalize opioid misuse. These interventions might alter the effect of public health messaging and ultimately improve outcomes.

We argue that public health educators and communication campaigns can contribute to positive social norm change and motivate healthy behaviors by incorporating strategies that attempt to disentangle unhealthy behaviors from identity. (*Am J Public Health*. 2020;110:807–810. doi:10.2105/AJPH.2020.305628)

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"Stigma" is both an area of theoretical inquiry in the social sciences and a colloquial word in everyday use. These two conceptualizations are often inconsistent or even at odds with each other, leading to some highly important discussions among academics about how best to operationalize the term. Stigma, as articulated by Goffman[1] and refined by Link and Phelan,[2] is the wholesale social rejection of an individual's identity. As Burriss eloquently noted, stigma is a cruel form of social control that "cut[s] a person off from the esteem and support of others . . . turn[ing] the individual into his own jailor; his own chorus of denunciation."[3(p475)] As with most social theory, there are certainly many layers of nuance, and there is no shortage of debate about what types of social phenomena constitute stigma, how stigma can be measured, to what degree stigma may be harmful, and even whether stigma has any utility as a means of motivating positive or healthy behaviors.

This is of particular relevance in public health, where messaging campaigns are often designed to reduce unhealthy behaviors (e.g., smoking, consuming junk food) through social disapproval or outright shaming.[3] There are recent examples of this type of campaign in the context of opioid use.[4] Some in the field have argued prominently that such efforts are an example of the positive use of stigmatization,[5] whereas others have made a compelling case that examples like these are more accurately understood as social denormalization than outright stigma: that stigma is a very narrow, very specific, and very powerful thing that possesses no positive social utility.[3]

What these debates generally miss, however, is that regardless of academic definitions of the concept, in the colloquial sense stigma is often used broadly to denote any form of social disapproval, regardless of whether it is disapproval of a person's behavior or of a person's identity. Lay discourse is filled with discussions about whether people who are asked to smoke outdoors are being stigmatized and about people feeling stigmatized because of the embarrassment they might feel when purchasing junk food (see Burris for more on the distinction between stigmatization and denormalization).[3] Although the academic perspective is split on whether this is truly stigma, the truth of the matter is that the point is moot if the lay population views stigma in this light. Instead, health communication strategies should focus on understanding which messages are harmful and which are not, which messages benefit public health and which do not.

For purposes of clarity, for the remainder of this commentary we use the terms "stigma" and "stigmatization" to mean social disapproval and rejection based on individual identity and the term "denormalization" to refer to social disapproval and rejection of specific behaviors. We offer this distinction in the spirit of developing practical guidelines or best practices for public health educators and communication campaigns. We believe this distinction may be of particular utility in the context of addressing the epidemic of opioid use disorder currently sweeping the United States.

FOCUSING ON BEHAVIOR, NOT ON IDENTITY

We suggest that, in distinguishing between denormalization and stigmatization, the former can be operationalized as focused on behavior, and the latter on identity. Denormalization has been used extensively in tobacco control and is often pointed to as key to the reduction of tobacco use rates.[6] Much of this effort has focused on

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behavior rather than identity. Indeed, an oft-spoken proverb among those who work in tobacco control is "There is no such thing as a 'smoker,' there are only people who smoke."[7] This framing intentionally creates space to decouple behavior from identity, so that unhealthy behavior (i.e., smoking) can be actively denormalized without perpetuating stigma against those who engage in it. It underscores that individuals who smoke maintain their core humanity and value as human beings, despite engaging in a socially unacceptable behavior. Once they change this target behavior, they are no longer targeted for disapproval.

For practical purposes and in this context, identity can be thought of as immutable, whereas behavior is malleable. Denormalization, then, becomes problematic when it targets an unhealthy behavior that is bound up in individual identity because it can, however unintentionally, result in overt discrimination. For example, HIV-prevention messaging has a checkered history of inadvertently, and sometimes perhaps even deliberately, stigmatizing gay men by aggressively denormalizing unprotected sex, something that could be central to some gay men's identity.[8]

THE UNIQUE STIGMA OF SUBSTANCE USE

The epidemic of prescription opioid use disorder remains one of the most pressing public health crises faced by the United States. Estimates are that nearly 130 people die per day from opioid overdoses in the United States.[9] Addressing prescription opioid misuse presents a delicate conundrum. On the one hand, there are parallels to tobacco dependence in that substance abuse is more clearly behavioral than rooted in identity, but on the other hand it is caught up in the long social history in the United States of aggressively stigmatizing people who use drugs. For generations, drug dependence in the United States has been perceived as particularly stigmatized, akin to criminal deviance. "Addict," "crackhead," "dope fiend," "junkie," and "tweaker" are some of the most pejorative terms in the English language, and those who are labeled as such rank among the most profoundly marginalized people in society. The unique severity of the opprobrium and wholesale rejection of people who suffer from drug addiction simply cannot be overstated.

It is because of this historic focus connecting drug use with identity that public health messaging on opioids must be crafted conscientiously, as it can easily result in increased stigmatization of all patients who use opioids, even when the intent is more specifically only to discourage opioid misuse. We use the National Institute on Drug Abuse definition of opioid misuse, which includes "taking a medication in a manner/dose other than prescribed; taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high)."[10] Another challenge is that, in the context of opioid misuse, even those who use opioid agonist therapies (e.g., naloxone, methadone) may face stigma, which can lead to underutilization.[11]

Although a variety of factors led to the opioid public health crisis, most instrumental is possibly the problem of chronic overprescription by providers occurring across decades, largely at the explicit urging of pharmaceutical manufacturers.[12,13] In 2012, at the height of the overprescription crisis, "U.S. pharmacies and long-term care facilities dispensed 4.2 billion prescriptions, 289 million (6.8%) of which were opioids"; half of these prescriptions came from primary care providers.[14(p 410)] Tragically, much of the effort to mitigate the resulting epidemic of addiction has focused not on reassessing clinical practice standards or pharmaceutical company practices but, rather, on rooting out drug-seeking behavior among patients.

Unwittingly perhaps, these efforts may have contributed to a climate of shame and embarrassment by failing to clearly differentiate between behavior and identity. Efforts to denormalize opioid misuse may cause collateral damage, tainting the identity of all individuals who take opioids by labeling a broad swath of patients as drug abusers or drug seekers. We argue that this overly broad approach makes a destructive public health problem even worse, discouraging treatment seeking among those who suffer from opioid use disorder and collaterally affecting patients who may have a legitimate therapeutic need for these medications to manage chronic pain. Patients with chronic pain may already experience stigma in other ways (labeled hypochondriacs, malingerers, etc.) and may be viewed with skepticism by some clinicians. An overly broad approach to denormalizing opioid addiction may exacerbate any existing mistrust and lead patients to avoid asking their providers about medications that could legitimately benefit them. Furthermore, patients with a history of opioid misuse could face additional challenges obtaining prescriptions that may be medically appropriate because of suspicion or lack of trust on the part of providers.

Indeed, evidence suggests that providers themselves often hold such negative views of patients with opioid use disorder. For example, a 2014 national survey of more than 1000 primary care providers asked about their attitudes and beliefs about patients with opioid use disorder as well as their overall knowledge of opioid use disorder. "Respondents reported high levels of desire for social distance [from opioid use disorder patients],"[15(p63)] and the majority were unwilling to work closely with these patients, viewing them as more dangerous than the general population. Strikingly, 89% of respondents felt that opioid use disorder was solely the responsibility of the individual patient rather than ascribing any responsibility to health providers, pharmaceutical manufacturers, or social or political institutions.[15]

It is precisely this unique sensitivity to drug addiction and "spoiled identity," to use Goffman's term, that makes it so important to carefully tailor the language used in public health interventions to avoid making matters worse. Research has shown that feelings of shame and social rejection can lead patients with opioid use disorder to double down on unhealthy behavior while simultaneously avoiding treatment.[16,17] In addition, patients suffering from chronic pain may be reticent to seek prescriptions or to take medications that are prescribed, even though it may be clinically appropriate for them. Psychologically, this is a defensive reaction to messaging that threatens a person's sense of identity

or brings self-worth into question. By focusing on behavior, health messaging may lay the groundwork for patients to seek treatment while reducing harm to their sense of identity, allowing them to decouple their behavior from their identity.[18]

FUTURE DIRECTIONS

There are several ways that public health messaging can be improved to accomplish the twin objectives of denormalizing opioid misuse while destigmatizing substance use disorder more broadly. At the level of the individual patient, there is a real need to improve provider education. Providers can and should be more comprehensively trained to sensitively and appropriately communicate with their patients about addiction, using language in clinical encounters that denormalizes opioid misuse but that does not stigmatize the patient. As we have discussed, one of the key reasons patients do not seek treatment is they are ashamed or fear judgment from their providers. The stark findings from the surveys of provider attitudes toward opioid use and those affected only highlights this need.[15]

At an institutional level, improved practice standards are an extremely important method of addressing this crisis. There are examples of constructive efforts at all jurisdictional levels that we believe should help to create more comprehensive models for the professions as a whole. In 2016, a US Government Accountability Office report found a lack of guidance for medical personnel in the military to counter stigma related to mental health. The Office concluded that this led to service members underutilizing mental health care, and issued a series of recommendations aimed at changing negative perceptions of mental health care.[19] We argue that similar efforts should be made with regard to countering stigma related to addiction and should be broadly adopted.

In January 2017, the Federal Office of National Drug Control Policy released a memorandum that directly confronts the need to change federal terminology related to substance abuse and substance abuse disorder.[20] Such a change could be impactful if adopted consistently across federal agencies and serves as a remarkable example of the role that policymakers can play in changing how language is used at the institutional level. Another instructive example comes from the Appalachian Regional Commission, a federally funded economic development agency with expertise in opioid policy. In a report by the commission funded by the Centers for Disease Control and Prevention, extensive best practices outlined how providers should talk to their patients about opioid use disorder and included a series of recommendations for overcoming stigma.[21] Although many of the recommendations outlined are general and lacking in detail, the report is an important step in the right direction.

At the population level, public health education and communication campaigns have the potential to affect social and cultural conceptions of opioid use and opioid use disorder. One recent example is the State of Colorado's Lift the Label media campaign, which "strives to remove damaging labels and stigma that prevent those with opioid addiction from seeking effective treatment."[22] We strongly believe that the most potent work can be done to reduce stigma in these types of campaigns, because these campaigns hold the promise of addressing the structural components of stigma.[23] Furthermore, ample evidence supports the proposition that such communication strategies can have a significant positive impact.[24] Public health messaging that frames addiction as a treatable health condition rather than a personal failing has been shown to be effective at reducing stigma without normalizing unhealthy behavior.[24] This is incredibly important because one of the key structural causes of stigmatization is the overwhelmingly negative attitude of the general public toward people suffering from substance addiction.[25] Research has shown the public to be much more receptive to supporting funding to treat addiction when addiction is framed as a behavioral health issue.[25]

CONCLUSIONS

We have discussed how those suffering from opioid use disorder might be uniquely targeted by society and even providers in a way that likely worsens their unhealthy behaviors and discourages treatment-seeking behavior. Moreover, we explained that denormalization, a potentially effective method for disincentivizing opioid misuse and encouraging treatment seeking for patients with opioid use disorder, is easily conflated with the concept of stigmatization but that it can be thought of as distinct in that it targets unhealthy behaviors rather than the identity of individuals who engage in those behaviors. We acknowledge that there is a risk that denormalization efforts, if not carefully designed, could inadvertently lead to stigmatization. Finally, we provided examples of how public health policy and practice can promote positive public health changes by incorporating this conceptual framework into their strategy and their use of language.

We do not argue that denormalization efforts are always appropriate, but such interventions may, when appropriately designed, be useful in mitigating the prescription opioid crisis. Concerns about denormalization campaigns leading to inadvertent stigmatization are valid but should not preclude action on this important issue. Public health messaging on opioids should focus on decreasing unhealthy behavior, although it is essential that it also focus on proactively destigmatizing addiction, specifically so that patients are empowered to disassociate specific behaviors from their identity. In this sense, there is no such thing as an opioid addict; there are simply people who suffer from opioid use disorder. AJPH

CONTRIBUTORS

M. D. Moore was the primary author. M. V. Stanton was the senior author and supervised the research assistants. All authors contributed to the conceptualization, design, research, drafting, and revision of the article.

CONFLICTS OF INTEREST

M. V. Stanton is an advisor to Head Health and Ceres. All other authors have no financial or other interests to disclose.

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