

# Stigma in Substance Use and Mental Health Disorders

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# Learning Objectives

- 1 Understand the impact of stigma**  
Describe how stigma affects individuals with substance use and mental health disorders.
- 2 Connect stigma to treatment outcomes**  
Describe stigma's role in delayed care, treatment initiation, and treatment dropout.
- 3 Recognize stigma in clinical settings**  
Identify how clinician attitudes, language, and practices create barriers to treatment engagement and retention.
- 4 Apply person-centered strategies**  
Use non-stigmatizing language and therapeutic communication to improve treatment engagement and retention.



## OBJECTIVE 1

# How Stigma Affects Individuals

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Public stigma, self-stigma, and structural stigma; and their toll on people with substance use and mental health disorders.



# What Is Stigma?

**Stigma** comes from a Greek and Latin word for a mark burned or cut into a person to signify disgrace. Today it means labeling, stereotyping, and discrimination. It is a false belief that Addiction to Substances reflect a personal choice or moral failing rather than treatable, chronic medical conditions.

## Public Stigma

Societal stereotypes and discrimination in employment, housing, relationships, and healthcare access.

## Self-Stigma

Internalizing negative attitudes, leading to shame, guilt, and reduced motivation to seek help.

## Structural Stigma

Policies and systems: criminalization, insurance limits, siloed care that formalize disadvantage.

# Slave collar

*The BC 4/5th Century Zoninus Slave Collar which reads 'I have run away; hold me. When you have brought me back to my master Zoninus, you will receive a gold coin.'*

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The ancient penal history of stigma : 'The Penal Tattoo'  
of *Stigma: The Machinery of Inequality*



# Addiction Is Stigmatized More Than Other Conditions

A Johns Hopkins Bloomberg School of Public Health survey compared public attitudes toward drug addiction and mental illness:

**90%**

unwilling to have a person with drug addiction marry into their family (vs. 59% for mental illness)

**64%**

feel employers should be able to deny a job to someone with addiction (vs. 25% for mental illness)

**54%**

believe landlords should be allowed to deny housing over addiction (vs. 15% for mental illness)

**3 in 10**

believe recovery from drug addiction is not possible

*Source: Johns Hopkins Bloomberg School of Public Health, national survey on stigma toward addiction and mental illness.*

# The Consequences Run Deep

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## 1 Isolation & Shame

Fear of judgment leads people to conceal symptoms and withdraw from family, friends, and support systems.

## 2 Worsened Symptoms

Self-stigma and internalized blame are linked to increased substance use, hopelessness, and poorer mental health.

## 3 Criminalization

Treating drug use as a crime reinforces the stereotype of danger and disproportionately harms communities of color.

## 4 Lost Opportunities

Discrimination in employment, housing, and insurance compounds hardship and undermines recovery.



## OBJECTIVE 2

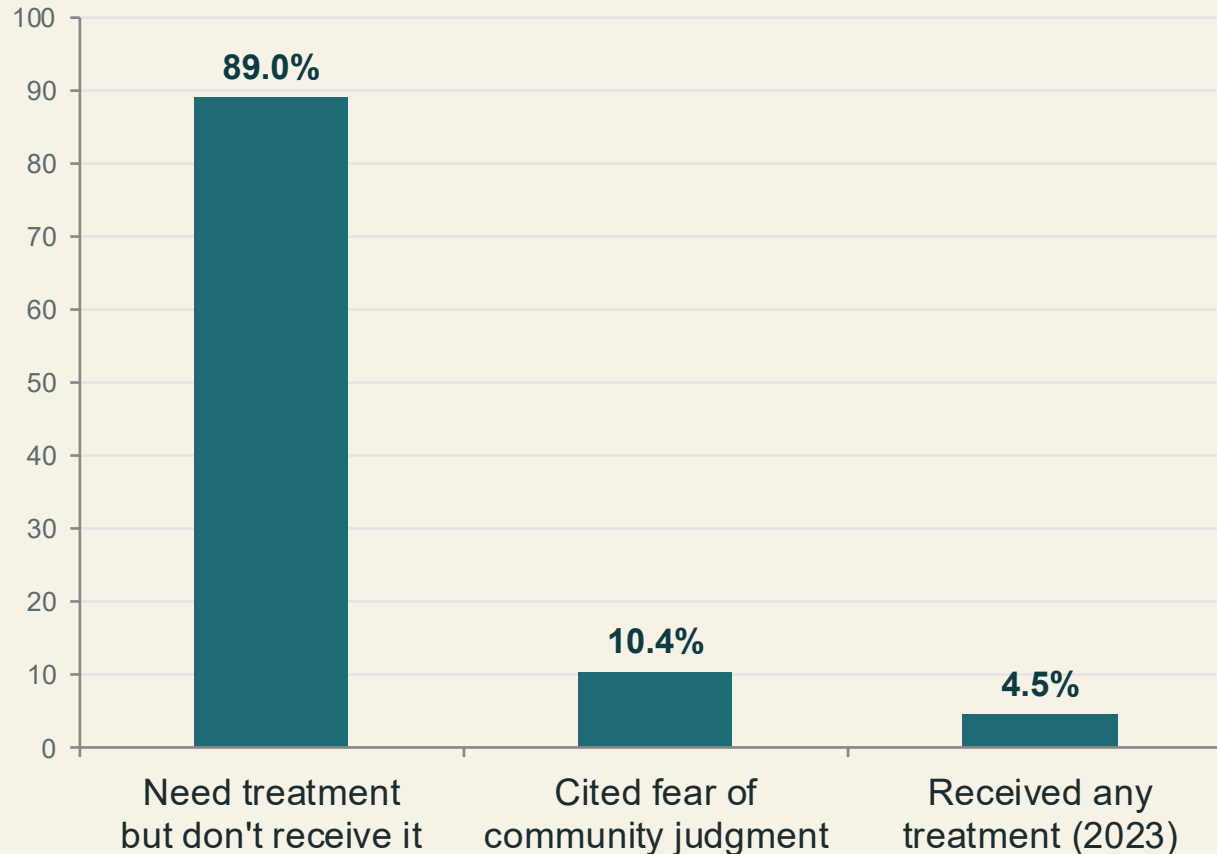
# Stigma, Treatment Initiation & Adherence

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Why stigma delays help-seeking, and how it drives treatment dropout once someone is in care.



# Most People Who Need Care Don't Receive It



## What this means



Anticipated stigma: simply expecting to be judged delays help-seeking as much as an actual bad experience.



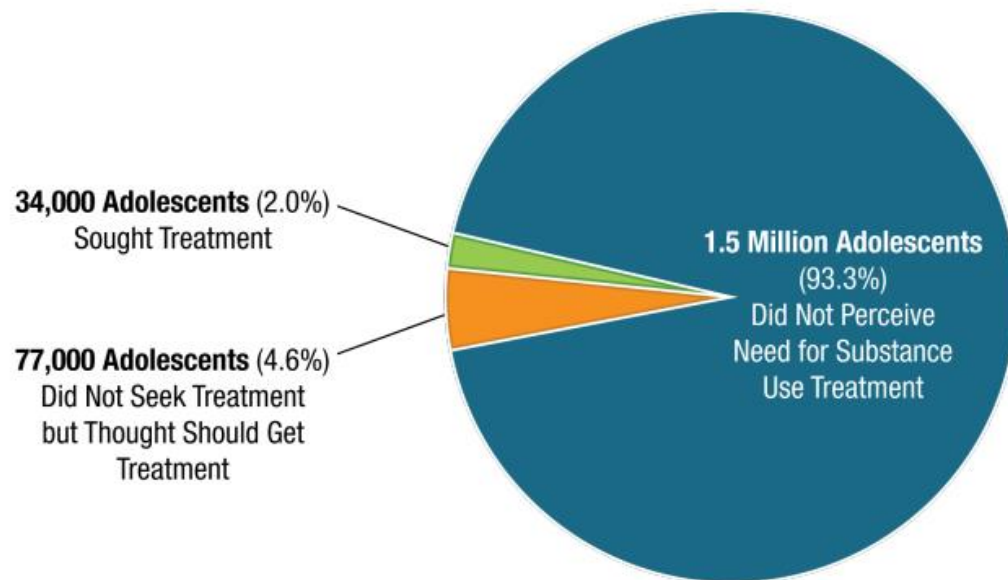
People often wait for a crisis before entering care, arriving more severely ill.



A delayed start reinforces the narrative that treatment is a "last resort," deepening stigma further.

Source: 2021 National Survey on Drug Use and Health; National Survey on Drug Use and Health, 2023.

## Perceptions of Need for Substance Use Treatment: Among Adolescents Aged 12 to 17 with a Past Year Substance Use Disorder Who Did Not Receive Substance Use Treatment in the Past Year; 2024



**1.7 Million Adolescents with a Substance Use Disorder Who Did Not Receive Substance Use Treatment**

Note: The percentages may not add to 100 percent due to rounding.

Note: Adolescents with unknown information for perceptions of need for substance use treatment were excluded; therefore, the sum of the interior pieces does not add to the whole.

**SAMHSA**  
Substance Abuse and Mental Health

# Stigma Drives Dropout, Not Just Delay

## **Non-disclosure**

Fear of bias leads patients to conceal substance use, so clinicians miss drug interactions or screening for HIV, hepatitis, and co-occurring conditions.

## **Poorer quality of care**

Providers with stigmatizing attitudes are less likely to deliver evidence-based care, even when they know a condition is treatable.

## **Racial disparities compound the effect**

Black patients face treatment delays of up to five years longer than White patients, and are less likely to be prescribed medication for opioid use disorder.

## **Reduced access to effective medications**

Medications for opioid use disorder are often mistaken for “substituting one addiction for another,” discouraging use and continuity.

## **Increased use and self-blame**

Guilt and self-stigma can reinforce drug-seeking behavior, making early dropout more likely.

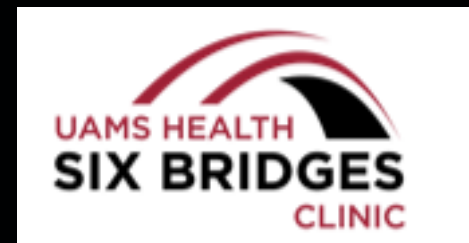


## OBJECTIVE 3

# Clinician Attitudes, Language & Practice

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How the words clinicians use and the practices they follow can perpetuate stigma or interrupt it.



# Language Changes Clinical Judgment

Clinicians read identical case vignettes describing the same person, the only difference was one word.

## “Substance Abuser”

More likely rated as blameworthy and deserving of punishment (e.g., jail) rather than treatment

## “Person with a Substance Use Disorder”

More likely as someone with a medical condition deserving of therapeutic care

*Kelly JF, Westerhoff CM. Does it matter how we refer to individuals with substance-related conditions? Int J Drug Policy. 2010;21:202–207.*

# Practices That Create Barriers

## **Diagnostic overshadowing**

Attributing new physical or psychological symptoms to the SUD or mental health diagnosis without adequate workup.

## **Discharge for a positive screen**

Treating a return to use as grounds for termination rather than as an expected part of a chronic condition.

## **Abstinence as a precondition**

Requiring abstinence before someone is “eligible” for treatment, rather than meeting people where they are.

## **Underuse of effective medications**

Withholding methadone, buprenorphine, or naltrexone due to misconceptions about “substituting one drug for another.”

## **Rigid program structures**

Short visits and inflexible rules signal that patients are less deserving of individualized care.

## **Confrontational communication**

Lecturing or confronting patients about their use, rather than using collaborative, motivational approaches.



## OBJECTIVE 4

# Evidence-Based, Person-Centered Strategies

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Practical language, communication techniques, and system-level changes that improve engagement and retention.



STRATEGY 1: LANGUAGE

# Choose Non-Stigmatizing Language

| Instead of...                       | Use...                                        |
|-------------------------------------|-----------------------------------------------|
| Substance abuse / drug abuse        | Substance use disorder                        |
| Addict, alcoholic, user, junkie     | Person with a substance use disorder          |
| Drug habit                          | Addiction                                     |
| Clean (person)                      | In recovery / not currently using             |
| Clean / dirty (tox screen)          | Negative / positive (tox screen)              |
| Substitution or replacement therapy | Medication for opioid or alcohol use disorder |

*Person-first language is consistent with the DSM-5 and reduces perceived blame without minimizing the condition.*



# Therapeutic Communication Techniques

## Motivational Interviewing

A collaborative, non confrontational style that respects autonomy and draws out the person's own reasons for change.

## Trauma-Informed Care

Recognizing how past trauma including prior stigmatizing healthcare experiences shapes behavior, and prioritizing safety and trust.

## Shared Decision-Making

Involving patients in treatment planning rather than imposing a rigid protocol, increasing buy in and adherence.

*Together, these techniques replace confrontation with collaboration, the single biggest lever for improving engagement and retention in care.*

# Support Engagement at Every Level



## Integrated Care

Co-locate mental health and substance use treatment instead of requiring separate systems.



## Harm Reduction

Keep people engaged, and do not discharge for continued use or require abstinence upfront.



## Universal Screening

Screen everyone routinely so no one feels singled out or targeted.



## Peer Support

Involve people with lived experience on the care team to build trust and model recovery.



## Provider Training

Training staff on implicit bias and stigma has shown to shift attitudes and improve care quality.



## Confidentiality Protections

Limit unnecessary disclosure so fear of consequences doesn't deter honesty.

# Key Takeaways

- 1 Stigma is not a side issue, it directly harms the health and well-being of people with substance use and mental health disorders.
- 2 Stigma delays help-seeking and drives dropout once someone is in care, often at the moments they need it most.
- 3 Clinician language and clinical practices can reinforce stigma just as easily as public attitudes can.
- 4 Person-first language and therapeutic, collaborative communication measurably improve engagement and retention.

# References

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- Volkow ND. Stigma and the toll of addiction. N Engl J Med. 2020;382(14):1289-1290.
- Volkow ND, Koob GF, McLellan AT. Neurobiologic advances from the brain disease model of addiction. N Engl J Med. 2016;374(4):363-371.
- Kelly JF, Westerhoff CM. Does it matter how we refer to individuals with substance-related conditions? Int J Drug Policy. 2010;21:202-207.
- Corrigan PW, Kuwabara SA, O'Shaughnessy J. The public stigma of mental illness and drug addiction. J Soc Work. 2009;9(2):139-147.
- Barry CL, McGinty EE, Pescosolido BA, Goldman HH. Stigma, discrimination, treatment effectiveness, and policy. Psychiatric Services. 2014;65(10):1269-1272.
- Stone EM, et al. The role of stigma in U.S. primary care physicians' treatment of opioid use disorder. Drug Alcohol Depend. 2021;221:108627.
- Hadland SE, et al. Receipt of timely addiction treatment and retention in care among youths with OUD. JAMA Pediatr. 2018;172(11):1029-1037.
- SAMHSA. Results from the 2021 National Survey on Drug Use and Health: Detailed Tables.
- Office of National Drug Control Policy. Changing the Language of Addiction. Executive Office of the President, 2017.
- Hammarlund RA, et al. Effects of self-stigma and perceived social stigma on treatment-seeking. Subst Abuse Rehabil. 2018:115-136.

# Thank you!



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Questions? \*