Fighting the Opioid Crisis with Communication

Stigma, Treatment, Support, and Prevention

Edited by
Xiaoxia Cao

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To those affected by the opioid crisis, and to those working to end it

Preface

When I received an invitation for serving as a guest editor of this book from Dr. Robin James, Editor for Media and Communications at Palgrave Macmillan, in February 2024, the annual opioid overdose deaths were declining. Although it offered some hope, the crisis was and still is far from over. Ending the crisis undoubtedly necessitates an integrated approach of which communication is a key component. For this reason, a group of communication scholars who have made meaningful contributions to our understanding of the role of communication in exacerbating and alleviating the crisis has come together in this edited volume to share their insights into how communication can help address this deadliest drug crisis in American history.

The chapters in this book demonstrate that effective communication strategies can be deployed to prevent opioid misuse, remove barriers to opioid use disorder (OUD) treatment and recovery, provide individuals with OUD the social support they need, and mobilize support for public health-oriented policies/interventions that help combat the crisis. Given the scope of this book, it should appeal to a wide range of audiences including, but not limited to, communication students and scholars with particular interests in interpersonal or mediated (health) communication, healthcare professionals particularly those prescribing opioid medications and interacting with patients with OUD, designers of communication campaigns/interventions, media content creators, and policy makers.

As a first-time book editor, I could not have completed this book project without the guidance, encouragement, and support of Dr. Robin James, who placed confidence in me, always provided the most

straightforward answers to my questions, and made the entire project less daunting. My special thanks go to the contributors to this book. Some of them (e.g., Dr. Bagley and Dr. Wolfe) helped me assemble this excellent team of contributors by suggesting experts in the field who later became contributors; and others (e.g., Dr. Ledford) volunteered to change their writing plan to address reviewers' concerns. I was honored to work with each one of them and could not have asked for a better team!

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About the Editor and Contributors

About the Editor

Xiaoxia Cao (Ph.D., University of Pennsylvania) is an associate professor in the Department of Communication at the University of Wisconsin-Milwaukee. She is currently serving on the editorial board of Health Communication. Her research interests include health communication, media effects, persuasion, media psychology, and strategic communication.

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CHAPTER 1

Fighting the Opioid Crisis with Communication: Stigma, Treatment, Support, and Prevention

Xiaoxia Cao

1.1 Introduction

The American opioid crisis has devastating public health, economic, and social consequences. A 2024 national survey found that more than 8 million Americans aged 12 or older misused opioids in the past year, which includes prescription opioids (7.57 million), heroin (0.56 million), and illegally made fentanyl (0.67 million; Substance Abuse and Mental Health Administration 2025). Although drug overdose deaths dropped by 27% in 2024 compared with 2023, there were still more than 80,000 Americans losing their lives to drug overdoses in 2024 (Anderer 2025), and the vast majority of the deaths (i.e., 73%) involved at least one opioid (U.S. Centers for Disease Control and Prevention 2025). The opioid crisis has cost Americans more than $1 trillion a year since 2017 (Kuehn 2021). For example, illicit opioids, primarily fentanyl, alone cost taxpayers an

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estimated $2.7 trillion in 2023, including reduced labor productivity, hike in healthcare cost, and increase in crime-related expenses (The White House 2025).

In addition, the opioid crisis has strained social relationships, destroyed families, ruined childhood, and fueled crime (Brundage et al. 2019). For example, an estimated 2 million children in the U.S. were directly impacted by the crisis in 2017. These children had been living with a parent with opioid use disorder (OUD), lost a parent to an opioid-related death, had a parent imprisoned due to opioids and/or been removed from their home as the result of opioid-related issues. There is also evidence linking the rise of opioid-related crime to the increase of opioid misuse (indicated by opioid-related ER visits, hospitalization and overdose mortality; Chen et al. 2022).

This chapter begins with a review of the development of the current opioid crisis in the U.S. along with a discussion of its contributing factors, with an emphasis on the role of communication in facilitating the development. After this, the chapter lays out how communication can be part of the solution to the crisis and how each chapter in this volume contributes to our understanding of the role of communication in combating the crisis.

1.2 The American Opioid Crisis and Contributing Factors

The current American opioid crisis is not the first in history (Patel and Rushefsky 2022). The first one started in the 1860s and lasted until the 1920s, during which opioid medications such as morphine and heroin (diacetylmorphine) were widely used to treat physical and mental pain. Their use provoked a hunger for increased doses of the medications, leading to addiction. To address the problem, a law was passed in 1909 to prohibit the possession, distribution, or sale of opium for non-medical use (Spitz 2020), which was followed by the Harrison Narcotics Tax Act of 1914. The Act essentially sanctioned the use of narcotics for most medical conditions. Violators could face up to more than $50,000 in fines in modern U.S. dollars and up to 5 years in prison. The enactment of these laws began a period of opiophobia between the 1920s and 1970s, when severe pain was undertreated even among the terminally ill.

In the 1970s, opinions about opioid medications among healthcare professionals started to budge following an article published by *the Annals*

of Internal Medicine in 1973 (Spitz 2020, 83). In the article, two doctors, Richard Marks and Edward Sachar, highlighted the needless suffering of medical patients due to the underutilization of narcotics. They argued that physicians often underestimated effective doses of opioid painkillers and overestimated the addiction risk of the medical use of opioids. The article reinvigorated the discussion surrounding the use of opioids for pain management. Nonetheless, opioid painkillers were still prescribed primarily for acute pain resulting from injury or surgery or severe pain associated with cancer or terminal illnesses throughout the 1970s. Physicians were reluctant to prescribe opioids for other conditions because of a concern for addiction and the lack of evidence supporting wider prescribing practices. However, this practice would soon be challenged.

In 1980, *the New England Journal of Medicine* published a one-paragraph letter to the editor in which Jane Porter and Hershel Jick questioned the practice of using opioids mainly for treating acute pain based on their retrospective review of the medical records of 11,882 patients who had received at least one opioid painkiller during inpatient care between 1970 and 1979 (Rummans et al. 2018, 345). The review showed that only 4 of the over 11 thousand patients became addicted to opioids. This one-paragraph letter, however, failed to provide information necessary for evaluating the validity of its conclusion, such as the dose and the length of the opioid treatment received by the patients. Nonetheless, the letter was referenced over 600 times to support the use of opioids to treat chronic pain. Its wide publicity started to ease the concern for addiction associated with opioid medications. Then, in the textbook titled *Narcotic Analgesics in Anesthesiology*, published in 1982, Arther Taub claimed that the continuation of opioid therapy in patients with non-cancer pain would not increase the risk of substance abuse or psychological dependence, which compelled some physicians, professional organizations, and even the World Health Organization (WHO) to start advocating for expanding the use of opioids for pain control.

Convinced that America was "a nation awash in chronic pain that could only be relieved if only the medical profession would overcome its prejudice" and fear toward opioids, a group of medical professionals started to aggressively promote a series of claims they said were rooted in scientific evidence (McGreal 2018). One of the claims was that it was not possible for patients genuinely experiencing pain to become addicted to opioids because "the pain neutralized the euphoria caused by the narcotic" and

the drug dependence displayed by patients on opioid painkillers was "pseudo-addiction."

In 1986, two advocates for the expansion of opioid treatment, Russell Portenoy and Kathleen Foley, published their study of 38 patients with chronic non-cancer pain who received ongoing opioid treatment (Spitz 2020, 86). Their data showed that out of the 38 patients, only two with a history of substance abuse misused the drugs. Based on this observation, the two researchers concluded that addiction to opioid painkillers could be avoided if doctors screened patients for their medical history. Later, Portenoy toured the country, touting that opioids were a "gift from nature" and promoting their access was a moral obligation (McGreal 2018). He even claimed that opioids "can be used for a long time, with few side-effects, and that addiction and abuse are not a problem." Years later, when the opioid crisis was in its full-blown, Portenoy admitted that his claims were not well-founded.

Also in 1986, the WHO released comprehensive guidelines to expand cancer pain management (Spitz 2020, 85). The guidelines supported the notion that freedom of pain (not just severe pain), especially among the terminally ill, is a human right. They advised healthcare providers to take complaints of pain from patients seriously and treat them following an analgesic ladder that specified a standardized way of escalating pain treatment among cancer patients. The implementation of the guidelines was a huge success. Patients treated under the guidelines reported little change in functioning, and retrospective reviews of patient data found no link between the use of opioid painkillers and addiction. These observations combined with the effectiveness of opioid therapy in alleviating cancer pain and the belief that it is a human right to be pain-free led to the beginning of a slow but steady increase in the use of opioids for treating anyone experiencing pain in the late 1980s. From 1990 to 1995, opioid prescriptions increased by 2 to 3 million each year (Rummans et al. 2018, 346).

This increase was accelerated by several major developments in the mid-1990s and early 2000s that set in motion the deadliest drug crisis in American history. In 1995, the U.S. Food and Drug Administration (FDA) approved OxyContin (oxycodone extended-release), manufactured by Purdue Pharma, for the long-term treatment of moderate-to-severe pain, cancer-related or not, that lasts for more than a few days (Woodcock 2013). After receiving the green light from the FDA, Purdue Pharma started its aggressive OxyContin marketing campaigns (Rummans et al. 2018, 346). As a result, annual prescriptions of OxyContin for pain

management increased from 670,000 to 6.2 million between 1997 and 2002 (Rummans et al. 2018, 346), making it the leading opioid medication on the market (Brown and Morgan 2019, 3).

Not coincidentally, the year after OxyContin received FDA approval, the now-defunct American Pain Society (APS), an organization partly funded by pharmaceutical companies, started to push the notion of pain as the "fifth vital sign" (McGreal 2018). The president of the society, James Campbell, told members of the society that "if pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly. We need to train doctors and nurses to treat pain as a vital sign." In the same year, the American Academy of Pain Medicine (AAPM) and the APS issued a joint statement, acknowledging the role of opioids in treating chronic non-cancer pain (Rummans et al. 2018, 345). At the same time, several studies were published that documented the prevalence of untreated pain among various populations (e.g., patients with cancer, AIDS, or hospitalized in the Intensive Care Units; Rummans et al. 2018, 346). Subsequently, many states passed the Intractable Pain Acts, eliminating sanctions for physicians who prescribed opioids for long-term use and, therefore, removing a major hurdle to the massive prescription of opioids.

In 2001, new guidelines for monitoring and treating pain were issued by the Joint Commission, an organization that sets the standards and monitors the quality of patient care provided by hospitals and medical centers (Rummans et al. 2018, 347). The new guidelines emphasized the need for systematic assessments of pain experienced by inpatients along with four other vital signs (i.e., pulse, blood pressure, temperature and respiration). Pain, thus, officially became the fifth vital sign. Afterward, the Deficit Reduction Act of 2005 required hospitals to participate in the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPSS). Three out of the twenty-five questions on the patient satisfaction survey were related to pain management. Participation in the survey was directly linked to the annual payment received by hospitals via the Inpatient Prospective Payment System. Later, the results of the survey were used to decide which hospitals would receive financial rewards for providing high-quality care. Given that pain management greatly influenced the results of the patient satisfaction survey, doctors felt pressured to prescribe more opioid pain medication.

After three decades in the making, the opioid crisis was in full swing. Between 2000 and 2010, prescription opioid use quadrupled (Spitz 2020,

86). Opioid prescription per capita peaked between 2010 and 2012 when 81 out of every 100 Americans had an opioid prescription. In 2012 alone, Americans used 165,525 kilograms of opioids, relative to 46,946 kilograms in 2000, despite no change in the amount of pain experienced during that time. This dramatic increase in the use of prescription opioids for pain relief led to a surge in opioid dependence and overdose deaths in the U.S. Between 2000 and 2010, the rate of overdose deaths involving at least one opioid more than doubled from 2.9 to 6.8 per 100,000 Americans (Duff et al. 2022). This initial rise of opioid-related deaths, caused mainly by prescription opioids, is widely considered the first wave of the opioid crisis.

In the 2010s, increased concern about opioid dependence and overdose led to a series of changes that reduced opioid prescriptions (Brown and Morgan 2019, 4). In 2010, Purdue Pharma reformulated OxyContin to make it more difficult to crush or dissolve for illicit use. Prescribing guidelines, taking into consideration the risks associated with prescription opioids, were issued. Electronic prescription drug monitoring programs (PDMPs) were adopted by more states, which helped reduce inappropriate opioid prescribing by physicians and doctor shopping by patients. Subsequently, opioid prescription rates fell by 40% between 2011 and the late 2010s (Aitken 2020, 2).

While the supply of prescription opioids became more restricted, heroin became increasingly available at a record-low price (Duff et al. 2022, 1). As a result, people who misused prescription opioids turned to heroin to satisfy their craving for opioids. Subsequently, the use of heroin in the U.S. increased sharply between 2010 and 2015 (Brown and Morgan 2019, 4), which led to a nearly fivefold increase in heroin-involved overdose deaths from 1.0 to 5.9 per 100,000 people between 2010 and 2016 (Duff et al. 2022, 1). In 2015, heroin surpassed prescription opioids, becoming the leading cause of overdose deaths involving an opioid. The rise of heroin overdose deaths is often referred to as the second wave of the opioid crisis.

Fentanyl, a type of very potent synthetic opioid, started to emerge in the U.S. around 2013 (Brown and Morgan 2019, 5). In 2016, fentanyl became the leading cause of drug overdose deaths in the U.S., accounting for 29% of such deaths (Brown and Morgan 2019, 6). Between 2015 and 2020, the rate of opioid-involved drug overdose deaths—mainly caused by fentanyl—doubled from 10.4 to 21.4 per 100, 000 Americans. The rise

of opioid overdose deaths driven by fentanyl is often considered the third wave of the opioid crisis (Duff et al. 2022, 1).

Since 2019, the U.S. has been experiencing the fourth wave of the opioid crisis, characterized by drug overdose deaths driven by polysubstance misuse that involves fentanyl and stimulants such as methamphetamine and cocaine (Friedman and Shover 2023, 2477). The percentage of overdose deaths involving a combination of fentanyl and stimulants increased from 0.6% in 2010 to 32.3% in 2021, with the sharpest rise starting in 2015. By 2023, more than 800,000 Americans had died from a drug overdose involving at least one opioid since 1999 (U.S. Centers for Disease Control and Prevention 2025), making the current opioid crisis the deadliest drug crisis in American history.

Causes of the opioid crisis are many (Blanco et al. 2020). Overprescribing opioid pain medications is undoubtedly a significant contributor. This overreliance on opioids for pain management can be partly attributed to various policies. For example, government agencies have issued misguided policies on using opioids for pain management (Spitz 2020, 86). Health insurance policies usually restrict the reimbursement of more costly but less addictive pain therapy (Rummans et al. 2018, 347). Of course, as aforementioned, the easy accessibility of illicit opioids also fuels the crisis (Duff et al. 2022). In addition, many believe that the crisis has its root in social and economic upheaval characterized by "the lack of economic opportunity, poor working conditions, and eroded social capital in depressed communities, accompanied by hopelessness and despair" (Dasgupta et al. 2018, 184). Fatal drug overdoses, therefore—along with alcohol-related disease and suicide—are considered "diseases of despair" (Dasgupta et al. 2018, 183). To be specific, lower-middle-class white Americans have been experiencing reduced economic opportunities and declined living standards in the post-industrial era (Brown and Morgan 2019, 6). The social and psychological stress resulting from economic hardship has been linked to physical pain (e.g., lower back pain) that intensifies the (mis)use of opioids (Dasgupta et al. 2018, 184).

That said, the role of communication in facilitating the development of the opioid crisis is undeniable. The development can be partly attributed to the misunderstanding of the dangers of opioids as a pain management tool among healthcare professionals, government officials, and the public that was largely induced and perpetuated by misleading communication from researchers, professional organizations, and pharmaceutical companies. For example, the publication of questionable studies that downplayed

the addictive nature of opioid pain medications—the most prominent of which were that by Jane Porter and Hershel Jick published in 1980 and the one by Russell Portenoy and Kathleen Foley published in 1986 (Rummans et al. 2018, 345; Spitz 2020, 86)—changed the perceptions of risks associated with using opioids to manage non-cancer chronic pain among healthcare professionals, even though the findings of these studies are inconsistent with the results of more rigorous research. To make matters worse, these questionable studies were widely cited by some physicians and professional organizations (e.g., APS) to support their aggressive campaigns for expanding the use of opioid therapy (Spitz 2020).

The marketing campaigns of pharmaceutical companies also propelled the development of the opioid crisis. For example, Purdue Pharma created and distributed more than 15,000 copies of the video titled "I got my life back" to physician offices. In the video, six patients who were prescribed OxyContin for chronic non-cancer pain shared their positive experiences with the medication. The promotional video not only encouraged physicians to use the product for ongoing treatment of chronic pain but also assured them that the drug was free of side effects. In addition, the company funded pro-opioid-use educational programs and promoted research in favor of opioid use (Brown and Morgan 2019, 4). To further increase the demand for OxyContin, Purdue Pharma used TV commercials to target consumers with chronic pain including 70 million Americans with lower back pain (Leibovici 2023, 128). The marketing efforts of pharmaceutical companies are linked directly to opioid misuse and related deaths. For example, research has shown that states with higher exposure to OxyContin introduction campaigns had higher annual increases in overdose deaths since 1996 (Alpert et al. 2022). While the misleading marketing campaigns by pharmaceutical companies were attempting to put as many Americans as possible on opioid therapy, not enough effort was made by governments and health organizations to educate the public and healthcare professionals about the dangers of opioid medications, which was also responsible for the development of the opioid crisis (Spitz 2020).

In addition to influencing risk perceptions associated with opioid medications and shaping the pain management practices of healthcare professionals, communication has contributed to the exacerbation of the opioid crisis by creating barriers to OUD treatment and recovery. A survey conducted in 2022 found that only 25% of people with OUD received medications proven to substantially reduce opioid-related mortality (i.e., buprenorphine and methadone), 30% received treatment without the

medications, and 45% did not receive any treatment (Dowell et al. 2024). Moreover, people with OUD often have difficulty gaining the social support necessary for recovery and reintegration into society (Krendl and Perry 2023; Park et al. 2023).

One important contributing factor to the low treatment rate and the lack of social support is stigma toward individuals with OUD (Hammarlund et al. 2018), defined as "a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society" (World Health Organization 2001, 32). The stigma perpetuated by interpersonal and mediated communication, as discussed in Chaps. 2, 3, 4 and 5 of this edited volume, is linked to poor mental and physical health (Ahern et al. 2007), delays in seeking treatment, higher treatment withdrawal (Perry et al. 2020; Tsai et al. 2019), withholding information necessary for receiving care and support (Krendl and Perry 2023), and reluctance to carry potential life-saving medicine (e.g., Naloxone; Bennett et al., 2020) among people with drug use disorder. The stigma is also associated with increased support for discriminatory policies that make it difficult for people with OUD to reintegrate into society (Kennedy-Hendricks et al. 2017). Moreover, the stigma undermines support for public health-focused policies that facilitate OUD treatment and recovery. Hence, it is fair to say that communication fueled the growth of the opioid crisis by creating an opinion climate that was conducive to the expansion of opioid use and, at the same time, hindered the treatment and recovery of individuals with OUD.

1.3 Fighting the Opioid Crisis with Communication

To combat the opioid crisis, it necessitates to promote OUD recovery and prevention via an integrated approach, in which communication plays an essential role. To improve the well-being of chronic pain patients who benefit from opioid therapy and those with OUD, it is important to understand how chronic pain (patients), people with OUD, OUD medications, and harm reduction measures (e.g., carrying Narcan and syringe exchange programs) are being stigmatized via interpersonal and mediated communication and what language, portrayals, and message frames can be adopted to reverse the stigmatization, promote OUD recovery, and rally

support for harm reduction measures. These are the focus of Part I of this book.

In Chapter 2, Dr. Kaynak and her colleagues review the current literature on stigma toward individuals with OUD, language used to stigmatize people with OUD, their behavior, OUD treatment, as well as the consequences of the stigmatization. The chapter ends with evidence-based recommendations for replacing stigmatizing language with person-first, non-stigmatizing language to bring about positive social changes. In Chap. 3, Dr. Ledford provides a comprehensive review of research into the portrayals of people with OUD by news, entertainment, and social media. The review analyzes the media portrayals via the lens of stigma communication and sheds light on stigmatizing media depictions of people with OUD. The chapter concludes with recommendations for creating more de-stigmatizing and humanizing portrayals of people with OUD.

Chapter 4 focuses on framing used to communicate about people with OUD, harm reduction measures, and drug policies. In the chapter, Dr. Hayes reviews studies investigating the impacts of message framing on causal attribution of OUD, stigma toward individuals with OUD, support for treatment and harm reduction programs, and opinions toward punitive or public health-oriented policy approaches to combating the opioid crisis. The chapter ends with a detailed discussion of how future framing-effects research can continue improving our understanding of the attitudinal, behavioral, and policy implications of various ways of framing OUD, OUD-related treatment, programs, and policies. In Chap. 5, Dr. Hintz and her associates report a content analysis of newspaper coverage of chronic pain (patient) in the context of the opioid crisis between 2012 and 2022. The analysis revealed the dominant frames, prominent characters, and significant events present in the coverage, which improves our understanding of the portrayals of chronic pain (patients) by the news media and sheds light on the potential harm these portrayals may cause to people with chronic pain. The chapter concludes with suggestions for improving media coverage of chronic pain (patients) to avoid harming this population while addressing the issues of opioid overprescription and misuse. Together, the four chapters in the first section of this book not only highlight the problematic practices used to communicate about OUD, individuals with OUD, OUD treatment, harm reduction measures, policy interventions, and chronic pain (patients) but also provide guidance for improving communication practices in order to destigmatize people with OUD and OUD treatment, increase support for harm reduction measures

and public health-oriented policies, and enhance the well-being of those suffering from OUD and/or chronic pain.

As one ounce of prevention is worth a pound of cure, prevention must be a crucial part of the plan for fighting the opioid crisis. Thus, Part II of this book reveals how communication can be deployed to prevent opioid misuse. In Chap. 6, Dr. Bagley and Dr. Coombs outline a host of messaging strategies—rooted in the Extended Parallel Process Model (EPPM) and the Health Belief Model (HBM)—that can be used by campaign designers to influence the audience's attitudes and behaviors and prevent opioid misuse. These strategies include, but are not limited to, highlighting the potential harm that misusing opioids may cause and improving self, response, and system efficacy through communicating tangible resources and social support that are available. Complementing the strategies detailed in Chap. 6, the study reported in Chap. 7 demonstrates how the reference focus of anti-prescription opioid messages may influence the effectiveness of such messages. Using a two-stage online experiment with two between-subjects conditions, the study tested the immediate and delayed impacts of the reference focus (self vs. self-other) of anti-prescription opioid risk narratives on the effectiveness of the narratives as well as the mediating roles of fear and anticipated guilt. Its findings suggest that self-focused risk narratives and messages arousing anticipated guilt may be effective in bringing about attitudinal and behavioral changes that reduce the likelihood of opioid misuse.

Unlike Chaps. 6 and 7, which focus on preventing opioid misuse through influencing the attitudes and behaviors of the public, Chap. 8 explores how to prevent opioid misuse by deploying communication strategies to improve the prescribing practices of healthcare professionals. In the chapter, Dr. Breckling and Dr. Tobey-Moore reveal how academic detailing (AD), a one-on-one or small-group outreach education strategy, can help healthcare professionals better implement evidence-based safer opioid prescribing practices, which include safer initiation and dosing, follow-up, and harm reduction. The chapter ends with recommendations for improving AD communication strategies and a discussion of possible future research that can help further optimize the impact of AD in the context of the opioid crisis. Thus, the three chapters in Part II of the book showcase how communication can be used to influence the knowledge, attitudes, and behavior of the public and healthcare professionals and prevent opioid misuse.