

Perceptions and Stigmatization of Opioid Abuse in Rural Communities: A Systematic Review of Social and Cultural Attitudes

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ABSTRACT

This systematic review seeks to examine how stigma around opioid use disorder (OUD) affects treatment access in rural U.S. communities. Analyzing 11 studies from the last decade, it highlights how cultural norms, particularly those that favor personal responsibility and abstinence, exacerbate stigma and discourage the use of medication-assisted treatment (MAT) and other harm reduction services. Stigma is found in both public attitudes and in healthcare settings, with some healthcare providers contributing to the problem. Recommendations include stigma-reduction programs, peer support, and expanding telemedicine. The review stresses the need for public health strategies addressing both societal stigma and medical treatment in the opioid crisis.

1. INTRODUCTION

The opioid crisis in the United States is a complex public health emergency that began in the 1990s. It started with aggressive overmarketing of prescription opioids, like OxyContin, for pain management by drug companies such as Purdue Pharma (Kolodny, 2020). This marketing and overprescription was driven both by insufficient awareness of the health risks of opiates, and pharmaceutical companies downplaying the addiction potential of these drugs. As regulations later tightened around these substances, many individuals who had become dependent turned to cheaper and more accessible alternatives. This started what is now known as the opioid crisis.

Rural communities have been disproportionately impacted by the opioid crisis due to limited access to healthcare, high levels of unemployment, and socioeconomic decline. Stigma surrounding opioid use disorder (OUD) remains a significant barrier to seeking treatment in these areas. This stigma often frames OUD as a personal failing rather than a medical condition, and manifests judgement against those with the disorder. As a consequence, this stigma can further isolate individuals and deter them from accessing life-saving interventions, including medication-assisted treatment (MAT) (Pew Charitable Trusts, 2019). MAT is defined as the use of FDA-approved medications including methadone, buprenorphine, and

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naltrexone along with counseling and behavioral therapies to treat OUD. MAT is also referred to as Medications For Opioid Use Disorder, or MOUD, in more recent literature. Both terms are used interchangeably throughout the review.

Moreover, rural regions face significant barriers in healthcare infrastructure that hinder safe and effective treatment. For example, medication-assisted treatment, which is evidence-based and associated with reduced overdose and improved retention; and harm reduction strategies, such as needle exchange programs and supervised injection sites, are either unavailable or face strong resistance from communities (Davis et al., 2019).

This systematic review seeks to examine the social and cultural stigmatization of OUD in rural areas. It conceptualizes stigma using the Stigma Theory provided by Link and Phelan (2001), which identifies five components of stigma: labelling, stereotyping, separation, status loss, and the exercise of social power. For the purposes of this review, stigma is defined across three different levels. Public stigma refers to the negative attitudes and discriminatory behaviors held by the general public toward individuals with OUD. Internalized stigma (also termed self-stigma) occurs when individuals with OUD absorb and apply negative stereotypes to themselves. This results in shame and reduced help-seeking. Structural stigma refers to the systemic ways in which social conditions, cultural norms, and institutional policies restrict opportunities and resources for marginalized groups. Throughout the review these distinctions are maintained.

2. METHODS

2.1 Eligibility Criteria:

Studies analyzed were eligible for inclusion if they met all of the following criteria:

1. Peer reviewed empirical research
2. Conducted on rural U.S. populations
3. Focused on stigma, perceptions, or sociocultural attitudes related to OUD, medication-assisted treatment, or harm reduction methods
4. Published in English after January 2000
5. Studies involving both adolescents and adults were eligible.

Studies that were excluded if they were:

1. Opinion pieces, editorials, commentaries, dissertations, conference abstracts, or other non peer-reviewed sources.
2. Conducted outside the United States or focused on non-rural populations
3. Did not address stigma or societal attitudes
4. Did not report original empirical findings

Studies were grouped for final synthesis according to the different types of stigma addressed. These included community and cultural stigma, internalized stigma, healthcare-related stigma, structural stigma, and treatment specific-stigma.

2.2 Information Sources:

A systemic search was conducted to identify full-text articles which evaluated stigmatization around OUD and subsequent recovery in rural or remote communities in the United States. Databases included PubMed, Google Scholar, Cochrane, and PsycINFO. In addition, the reference lists of included articles were scanned to identify any studies that were not captured by the original search.

2.3 Search Strategy:

This systematic review was conducted and reported adhering to the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) 2020 guidelines (Page et al., 2021). Search strategies included using combinations of keywords relevant to OUD and stigma within rural settings. Some terms included “opioid use disorder,” “opioid abuse,” “stigma,” “rural,” “medication-assisted treatment,” “harm reduction,” and “treatment barriers.” Boolean operators (AND, OR, NOT) were used to combine concepts. Filters were applied to limit results to English-language studies published from 2000 onward. The search strategy was adapted to each database.

An example one for PubMed was as follows:

(“opioid use disorder” OR “opioid abuse” OR OUD)
AND (stigma OR stigmatization OR attitudes OR perceptions)
AND (rural OR “rural communities” OR Appalachia OR remote)
AND (“medication-assisted treatment” OR MAT OR buprenorphine OR methadone OR “harm reduction” OR “treatment barriers”)

2.4 Selection Process:

All records identified through database searching were exported and screened by the author. Titles and abstracts were screened for relevance after removal of duplicates; Articles that were identified as potentially eligible were then reviewed in full text. Screening was conducted in two stages, title and abstract screening and then full text review. Since this review was conducted by a single author, the author was the one to screen all records and full-text reports. No automation tools were used in the screening process.

A total of 341 articles were identified. Of these, 108 advanced to abstract screening, 31 full-text articles were analyzed for eligibility, and 11 studies met the inclusion criteria and were included in the final synthesis. Reasons for exclusion at the stage of full-text screening included non-rural setting, non U.S. population, lack of focus on stigma, and non-empirical design. These steps were summarized using a PRISMA flow diagram (Figure 1).

2.5 Data Collection Process:

Data were extracted from the included studies by the author using a standardized data extraction table developed for this review. Extracted data was checked against the original article text before synthesis. The review did not involve contacting study authors for missing information; when study details were unclear, only the information specifically reported in the published article was used.

2.6 Data Items

The primary outcome that was of interest to this review was the reported influence of stigma on access to opioid related treatment and recovery services in rural communities. This included stigma affecting desire to seek help, treatment initiation, retention in care, MAT uptake, harm reduction use, and perceived acceptability of treatment.

Other data items extracted from each study included author, year of publication, study title, geographic setting, study population, sample characteristics, type of stigma, and key findings. Where applicable, information about specific barriers was also extracted. If studies reported multiple relevant findings, all findings were considered.

2.7 Effect Measures:

Because this review included both qualitative and quantitative studies, effect measure varied by study design. For quantitative studies, reported measures such as odds ratios, adjusted odds ratios, percentages, and other statistics were included in the synthesis. For qualitative studies, the main findings and themes were extracted and reported narratively.

2.8 Synthesis Methods:

Due to substantial differences between study design, populations, and outcome reporting, a meta-analysis was not conducted. Instead, findings were reported using a narrative synthesis approach. First, studies were reviewed and placed into a table according to study characteristics and major findings. They were then grouped by theme.

2.9 Quality Assessment:

The methodological quality of included studies was appraised. Studies were categorized as high, moderate, or low quality based on sampling appropriateness, clarity of methods, analytic rigor, risk of bias, and relevancy to the review question.

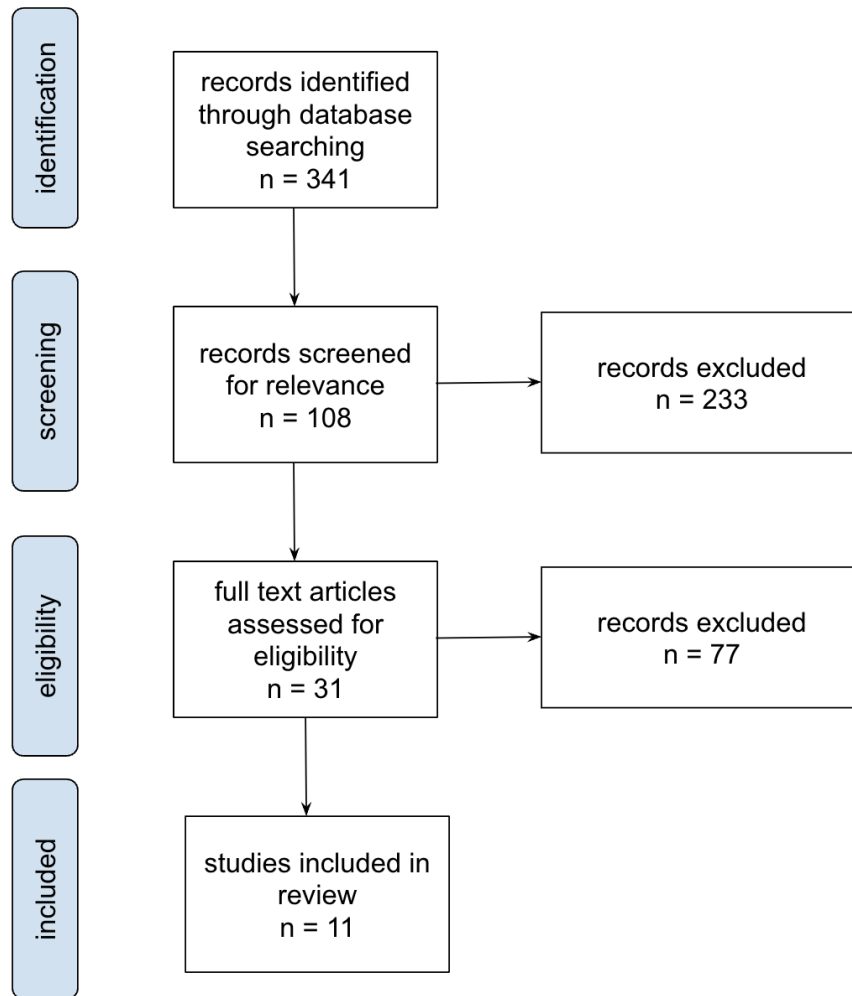


Figure 1: PRISMA flow diagram showing the screening process used for this systematic review

3. RESULTS

The 11 included studies were synthesized and grouped into five areas: community and cultural stigma, stigma within healthcare and emergency response, structural effects on treatment access, internalized stigma, and treatment-specific stigma. Across studies, stigma was reported in both interpersonal and institutional settings. This stigma was commonly associated with reduced treatment-seeking, lower perceived acceptability of medication-based treatment, and poorer support for people with OUD.

3.1 Community and Cultural Stigma

Stigma in rural communities is associated with a reduced drive to seek care for OUD, as addiction is framed not as a medical condition but rather as a personal or moral failing. In rural Kentucky, for example, fear of judgment and social rejection may be a factor leading to opioid usage in unsafe or isolated settings. This is associated with increased overdose risk. In addition, stigma and fear of legal

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consequences can also contribute to delaying or avoiding treatment (Fadanelli et al., 2020). In southern Virginia, anticipated community judgment is correlated with lower willingness to seek care. This judgement is further reinforced by religious values that portray addiction as a moral failure (Hargrove et al., 2022).

3.2 Stigma Within Healthcare and Emergency Response

Stigma within healthcare interactions is associated with reduced treatment engagement and continuity. In a study of discrimination within rural hospitals and pharmacies that included eight non-postpartum focus groups, participants most frequently identified hospitals as a place where they faced discrimination (mentioned 26 times). Some participants described that providers often assumed they were “drug-seeking” based on past medical records of OUD (Burgess et al., 2021). Emergency response systems can contribute to these experiences. Blue et al. (2021) noted that stigma among healthcare providers, including EMS personnel, can contribute to poorer care. The authors also argue that additional education and training for EMS providers may help to alleviate some of this stigma.

3.3 Structural Effects on Treatment Access

Stigma may also be associated with systemic institutional practices and policies that restrict access to evidence-based treatment. In Appalachia, concerns about diversion and misuse of buprenorphine contributes to reluctance among some providers to prescribe the treatment for long periods of time. This is linked to premature tapering and increased relapse risk (Richard et al., 2020). Limited treatment capacity can also be a barrier. For example, in Wisconsin, participants reported difficulty locating MAT providers. Existing prescribers often had high patient loads that made it difficult to receive timely care (Qudah et al., 2022). This was linked to patients “self-initiating” changes in their prescription opioid use that may not have been appropriate and may have made it harder for them to access future treatment. Stigma is also reflected in legal and judicial systems. In a study interviewing healthcare professionals, substance abuse treatment providers, and judges and probate officers, concerning statements were expressed. Some participants noted that judges and policy makers have said, outside of meetings, that the way to solve the opioid crisis would be to ‘just let them all die...leave them on the street, it’s fine.’ (Richard et al., 2020). This attitude towards those struggling with OUD may affect treatment access. Rural areas also often lack the healthcare infrastructure needed for sustained OUD treatment and rely more heavily on emergency services (Monnat & Rigg, 2016).

3.4 Internalized Stigma and Health Outcomes

Internalized stigma occurs when individuals absorb negative public attitudes about themselves. This is associated with differences in overdose risk and social support. In rural areas across ten states, one study found that higher levels of felt stigma were associated with increased odds of recent non-fatal overdose, and for each standard deviation increase in stigma, the odds of overdose increased by 47% (aOR 1.47, 95% CI 1.20-1.81). This persisted even after adjusting for substance use and demographics (Sibley et al., 2024). Another study suggests that among those with OUD, experiencing treatment related stigma is inversely associated with social and friend support. (Broman et al., 2023)

3.5 Treatment-Specific Stigma Toward Methadone and Buprenorphine

Negative attitudes about buprenorphine and methadone are linked to poorer retention and reduced recovery support, even in cases where treatment is available. These options may be viewed as “the last resort” or even enablers of addiction, which may narrow perceived acceptable pathways to recovery (Richard et al., 2020). Stigmatization of drug use and harm reduction further may reinforce these beliefs and may be linked to lower treatment uptake (Ezell et al., 2021).

Table of Results

Reference	Title	Methodology	Scope of Research	Research Findings	Quality Assessment	Stigma Type	Date	Thematic group
Burgess et al.	Experiences of stigma among individuals in recovery from opioid use disorder in a rural setting: A qualitative analysis	Focus groups and content analysis	Rural Maine, focusing on stigmatizing experiences of individuals in recovery	Hospitals, pharmacies, and government agencies were identified as the main locations of stigma. Pharmacists were perceived as the most frequent perpetrators. Stigma negatively affected recovery through secrecy, fear, and resignation.	-Strong qualitative relevance -Concrete findings from focus groups/content analysis -Still vulnerable to recall and selection biases High Quality	Provider stigma; Public stigma	2021	Provider attitudes & healthcare stigma

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Blue et al.	Rural Emergency Medical Service Providers Perceptions on the Causes of and Solutions to the Opioid Crisis: A Qualitative Assessment	Qualitative survey of EMS providers at a conference	Rural Minnesota and surrounding states	EMS providers recognized stigma in opioid prescribing, access to treatment, and the failure to treat opioid addiction as a disease. Stigma from healthcare providers and community members was identified as a major barrier to addressing the crisis.	- Conference based survey is weaker than focus groups -Provider experiences -Likely convenience sampling and less depth High Quality	Provider stigma; Public Stigma	2021	Provider attitudes & Healthcare Stigma
Qudah et al.	Discordance in Addressing Opioid Crisis in Rural Communities : Patient and Provider Perspectives	Focus groups and semi-structured interviews	Jefferson County, Wisconsin, focusing on barriers to patient-centered care for managing opioid use disorder and chronic pain	Patients and providers both cited limited behavioral health resources as a key barrier, but providers showed more stigma, leading to discordance in addressing the opioid crisis.	- Good fit between question and focus groups/interviews -Compares patient and provider perspectives -Vulnerable to recall and selection bias Moderate Quality	Provider stigma; Structural stigma	2022	Provider attitudes and Healthcare Stigma

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Dickson-Gomez et al.	“You’re Not Supposed to be on it Forever”: Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids	Qualitative interviews with key informants and people who use opioids	Rural, suburban, and urban areas in Connecticut, Kentucky, and Wisconsin	MOUD-related stigma was pervasive among providers and opioid users, especially due to fears of diversion and the belief that MOUD is just replacing one drug with another. This stigma reduces MOUD uptake and leads to tapering MOUD use prematurely.	- Includes both providers and people who use opioids -Not exclusively rural, though rural populations are a focus Moderate Quality	Provider stigma; Public stigma; Treatment stigma	2022	Provider attitudes & Healthcare Stigma
Fadanelli et al.	People, Places, and Stigma: A Qualitative Study Exploring the Overdose Risk Environment in Rural Kentucky	Qualitative interviews with rural participants, grounded theory analysis	Explores overdose risk environments in five rural Eastern Kentucky counties among opioid users aged 18–35,	Community stigma in rural areas frames OUD as a moral failing and is associated with reduced treatment access and increased overdose risk.	- Qualitative design and fit with research question - Interviews within a rural setting - Possible self report bias Moderate to High Quality	Public stigma; Community stigma	2020	Community and Social Stigma

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Hargrove et al.	A rural community's perspective on the causes of and solutions to the opioid crisis in southern Virginia	Focus groups using the SEED method, participatory research team	Rural Southern Virginia community impacted by the opioid crisis	Family dynamics, economic decline, and lack of healthcare resources contribute to opioid misuse.	-Appropriate method using participatory groups -Actual community perspectives -May reflect what people say about treatment rather than what people actually do Moderate Quality	Public stigma; Community stigma	2022	Community and Social Stigma
Ezell et al.	Stigmatize the use, not the user? Attitudes on opioid use, drug injection, treatment, and overdose prevention in rural communities	Mixed methods: semi-structured interviews with professional stakeholders and people who use drugs (PWUD)	Rural Southern Illinois, examining attitudes toward opioid use, harm reduction, and treatment programs	Stigma against opioid use and harm reduction, such as syringe exchanges and naloxone, impedes treatment and prevention efforts.	- Primarily appraised on qualitative rigor Moderate Quality	Public stigma; Structural stigma; Treatment stigma	2021	Community and Social Stigma
Sibley et al.	The relationship between felt stigma and non-fatal overdose among rural people who use drugs	Multivariable logistic regression analysis, computer-assisted survey	Rural areas in 10 U.S. states, focusing on felt stigma among rural opioid users and	Felt stigma significantly correlates with an increased risk of non-fatal overdose. Stigma reduction interventions are needed as	- Strongest quantitative study in table - Multi-state rural sample, logistic regression, adjusted effect estimate - Causation cannot be	Internalized stigma	2024	Treatment-seeking behavior

			its correlation with non-fatal overdose	well as harm reduction services specifically for rural settings.	inferred High Quality			
Broman et al.	Social support is associated with reduced stigma and shame in a sample of rural and small urban adults in methadone treatment	Web-based survey and multiple regression analysis	Michigan-based methadone treatment program, focusing on relationships between stigma, shame, and social support	Social support inversely correlated with opioid-use-related shame and treatment-related stigma. Interventions aimed at reducing stigma may increase social support and improve treatment outcomes.	- Web-based survey -Selection bias, single-treatment program -Limited generalizability Moderate Quality	Internalized stigma; Treatment stigma	2023	Treatment-seeking behavior
Richard et al.	"You are not clean until you're not on anything": Perceptions of medication-assisted treatment in rural Appalachia	Qualitative study with interviews of healthcare professionals, law enforcement, and other stakeholders	Focuses on medication-assisted treatment (MAT) perceptions in rural Appalachian Ohio	MAT stigma persists in rural communities, with MAT seen as "trading one addiction for another." Fear of diversion and community mistrust may be linked to	CASP - Qualitative design - Relative stakeholder interviews - Limited detail on recruitment and reflexivity Moderate Quality	Structural stigma; Provider stigma; Treatment stigma	2020	Structural & Policy Barriers

				lower treatment uptake.				
Monnat & Rigg	Examining Rural/Urban Differences in Prescription Opioid Misuse Among U.S. Adolescents	National Survey on Drug Use and Health data analysis (binary logistic regression, mediation models)	U.S. adolescents aged 12–17 in rural, small urban, and large urban areas	Rural adolescents have 35% higher odds of opioid misuse compared to large urban peers. Risk factors include criminal behavior, while protective factors include strong religious beliefs and lower peer substance use.	-Large national dataset and regression analysis -Broader sampling High Quality	Structural context; limited direct stigma focus	2016	Structural & Policy Barriers

4. DISCUSSION

This review suggests that stigma related to opioid use disorder in rural communities operates across multiple levels rather than just through isolated negative attitudes. This system shapes whether people disclose OUD, seek help, remain engaged in MAT, and access emergency services when overdose risk is high. Social surveillance and fear of exposure stems from close-knit community dynamics, community beliefs shape how local institutions respond to OUD, and these same experiences of systemic injustice feed back into avoidance of care and internalize stigma. Strategies that focus only on increasing treatment availability are unlikely to be sufficient unless paired with interventions that change the social meaning of what OUD is and reduce systemic barriers that reduce access to care.

4.1 Rural stigma as “social exposure risk” rather than isolated negative attitudes

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Those with OUD in rural areas often fear the risk of being seen seeking treatment. Rural social networks are often highly interconnected, meaning that entering treatment or interacting with emergency services can feel like public disclosure rather than what is meant to be a private health decision. The perceived cost of being “known” as someone with OUD can outweigh the perceived benefits of receiving care. Evidence from multi-site qualitative work highlights how fear of exposure and loss of reputation can deter engagement from treatment (Stopka et al., 2024). This aligns with the components of labelling and separation in Link and Phelan’s stigma theory because individuals can become socially marked as different, and with status loss, because the community knowing that one has OUD may reduce social standing. Reducing stigma in rural communities requires making care pathways genuinely privacy-preserving and accessible to all.

4.2 Abstinence promotion as a gatekeeping mechanism for acceptable recovery

Abstinence-oriented recovery programs can also operate as a form of social gatekeeping. Usage of MAT may be framed as morally compromised or as evidence of weak commitment in settings where recovery is strictly associated with complete abstinence from any kind of controlled substances. This maps closely to the stereotyping component of Link and Phelan’s stigma theory and can lead to exclusion from valued peer and community spaces (Richard et al., 2020). Even when individuals know that MAT is clinically effective, they may face social penalties for using it and therefore be discouraged. Stigma reduction should include improving treatment towards those with OUD themselves, but also community programs that allow the former to seek proper, medically effective treatment (Ezell et al., 2023).

4.3 Healthcare stigma

In rural areas, provider stigma directly undermines trust in the limited healthcare infrastructure available. When patients anticipate suspicion, surveillance, or judgment, they may delay their care or disengage from MAT. “Drug-seeking” assumptions in rural hospitals and pharmacies (Burgess et al., 2021) can have outsized negative effects because alternative options are limited. Provider stigma reflects the stereotyping, status loss, and discrimination aspects of Link and Phelan’s framework. Patients with OUD may be reduced to addicted identities and may receive less respectful or trusting care.

4.4 Structural constraints increase the effects of stigma

Stigma is reinforced by rural structural conditions like workforce shortages, limited prescribers, travel distance, and high caseloads. Therefore, stigma can become embedded in everyday clinical decisions and access patterns within this context. Provider concerns about diversion and hesitancy around MAT prescribing could reflect both stigma and structural insecurity. This may contribute to unstable treatment trajectories (Richard et al., 2020). Treatment scarcity and high patient loads can also indirectly intensify stigma by normalizing rushed care and limiting the time needed for trust-building and patient education (Qudah et al., 2022). Stigma can have its greatest effects when biased institutions and professionals have the authority to control access to treatment and affect prescribing practices. These barriers align most closely with Link and Phelan’s power component.

4.5 Implications for practice and policy

The evidence supports a targeted approach in which each intervention maps to a mechanism by which stigma works.

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- **Reduce exposure risk:** Expand access points that minimize public visibility, such as telehealth options or discreet medicine dispensers to address the rural “everyone knows everyone” barrier (Stopka et al., 2024). Telehealth may be particularly useful where privacy concerns are a primary deterrent. However, implementation should consider broadband and digital access constraints.
- **Change community attitudes:** Partner with trusted local messengers such as pastors or civic organizations to reframe OUD as a chronic medical condition and normalize MAT as legitimate recovery, especially in abstinence-dominant contexts (Richard et al., 2020; Ezell et al., 2021). The goal is not to displace abstinence supports, but to reduce the social penalty for medication-based recovery.
- **Treat provider stigma as a quality metric:** Interventions for providers should go beyond one-time “stigma training”. More durable change requires combining training with practice supports and leadership accountability. Evidence of drug-seeking assumptions and negative interactions in rural care settings (Burgess et al., 2021) indicate that improving patient experience is central to improving engagement.
- **Strengthen peer and recovery supports that include MAT:** To counter internalized stigma and isolation, investment in peer recovery support models and recovery groups that explicitly include MAT participants is necessary. Given the observed linkage between stigma and overdose vulnerability (Sibley et al., 2024), peer approaches could also incorporate practical overdose prevention and safety planning.

4.6 Limitations

This review has limitations that should shape interpretation. First, much of the evidence relies on self-reported experiences, which can introduce recall and social desirability bias. Second, “rural” is heterogeneous; findings may differ across Appalachian regions, agricultural communities, and frontier areas with distinct healthcare access and cultural dynamics. Third, the literature base includes relatively few longitudinal studies, limiting what can be concluded about how stigma shifts over time or how durable anti-stigma interventions are. Causal inference is prevented by this lack of longitudinal or experimental study designs. Therefore, the findings reflect associations between stigma and outcomes aligned with the observational and qualitative nature of the studies examined. Publication bias may also overrepresent settings with more active research infrastructure or high-profile overdose burdens, potentially limiting transferability to under-studied rural regions. Most studies were rated as moderate quality, with stronger evidence coming from larger quantitative analyses and well-focused qualitative studies conducted in rural populations.

Finally, another limitation of this review is that both selection and screening were conducted by a single reviewer without independent verification. While efforts were made to adhere to inclusion and exclusion criteria, the absence of a second reviewer introduces potential for selection bias.

5. CONCLUSION

This review indicates that stigma surrounding OUD in rural communities is associated with treatment

barriers at multiple levels. Across the studies, community judgement was linked to lower willingness to seek care; provider stigma was linked with mistrust and poorer care experiences; internalized stigma was associated with reduced social support and greater overdose vulnerability; and structural barriers intensified all these problems. These findings taken together suggest that reducing stigma in rural communities will require more than general awareness efforts. Some examples of more specific responses include community based messaging that reframes OUD as a medical condition or provider focused interventions that address biased assumptions in clinical care. Future research should further examine which stigma reduction strategies are most effective across different rural settings, particularly given between the differences between rural communities and the limited number of longitudinal studies in the current evidence base.

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