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The stigma of alcohol-related liver disease and its impact on healthcare

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Key points

- The stigma of alcohol use disorder (AUD) and alcohol related liver disease (ALD) is a serious obstacle in healthcare for chronic liver disease.
- People with ALD are subject to public stigma (negative or discriminatory attitudes of others), self-stigma (negative attitudes, including shame, about their own condition), and structural stigma (policies that intentionally or unintentionally limit opportunities for people with ALD). Stigma can be experienced, or anticipated and avoided, all contributing to negative health outcomes.
- Stigma impairs recognition of one's own unhealthy alcohol use, increases secrecy about alcohol use, delays or impedes help-seeking, increases illness burden, impairs the quality of healthcare and endangers resource allocation for the care of people with ALD.
- Blaming people with ALD for their condition is central to ALD stigma.
- Patients often describe healthcare settings as particularly stigmatizing.
- Promulgating a dynamic model of individual and social responsibility for AUD, a continuum model of unhealthy alcohol use, and establishing training on ALD related stigma for healthcare professionals are strategies to address stigma.
- People with lived experience need to be empowered to lead action against the stigma of ALD. Trained peer counselors should be involved in medical teams at hepatology units.
- Beyond healthcare, addressing social inequality, the social dimensions of ALD risk and outcomes, and ensuring equal access to services is necessary to improve outcomes for all people with ALD.
- More research is needed on the stigma of ALD in low and middle income countries and in countries with restrictive drinking norms. Interventions to reduce ALD stigma and facilitate early help-seeking need to be developed and evaluated.

Summary (255 words)

People with alcohol related liver disease (ALD) experience stigma and discrimination. This review summarizes the evidence on ALD stigma in healthcare and its implications for people with ALD, drawing from the literature on mental illness stigma and specifically the stigma of alcohol use disorder (AUD). Public stigma, self-stigma and structural stigma all contribute to increased illness burden of ALD, failure or delay of seeking help, inferior healthcare, and negative health outcomes. Stigma can be experienced, but also anticipated and avoided, which all negatively impacts ALD healthcare. Blaming people with ALD for their condition is central to ALD stigma. Stigma affects ALD healthcare at all stages, from prevention, early detection and intervention, to allocation of scarce resources in liver transplantation. People with lived experience need to be empowered to lead action against the stigma of ALD. Promulgating a dynamic model of individual and social responsibility for AUD, a continuum model of harmful alcohol use, and establishing training on ALD related stigma for healthcare professionals are strategies to address stigma. Integrating addiction and ALD services, providing stigma-free prevention, and overcoming the frequent separation of addiction services from general healthcare are necessary. Beyond healthcare, addressing social inequality, the social dimensions of ALD risk and outcomes, and ensuring equal access to services is necessary to improve outcomes for all people with ALD. More research is needed on the stigma of ALD in low and middle income countries and in countries with restrictive drinking norms. Interventions to reduce ALD stigma and facilitate early helpseeking need to be developed and evaluated.

Introduction

When dealing with chronic liver disease, and particularly with alcohol-related liver disease (ALD), the stigma of alcohol use disorder (AUD) is the 'elephant in the room'. Many people with chronic liver disease describe the fear of being labeled an "alcoholic" as a reason not to reveal their condition to others [1]. Patients with alcohol-unrelated forms of liver disease often try to distance themselves from patients with ALD in order to avoid the stigma of alcohol dependence [1, 2]. Untreated AUD, in turn, poses the risk of delaying the "cascade of care" for ALD (screening, referral, treatment), as has been shown for other liver diseases such as HCV [3], and in chronic diseases like HIV [4].

Alcohol use disorders are currently defined somewhat differently in the ICD-11 and DSM-5. The ICD-11 [5] emphasizes a core syndrome of disordered, compulsory alcohol use (Alcohol Dependence), which is distinct from a Harmful Pattern of Alcohol Use without impaired control over consumption, and Hazardous Alcohol Use, which is conceptualized not as a disorder, but as a health risk factor [6]. The DSM-5, published by the American Psychiatric Association [7], refers to a continuum of mild, moderate and severe patterns of harmful alcohol use under the diagnosis Alcohol Use Disorder [6, 8]. ALD is by definition caused by using alcohol, but is not necessarily linked to a formal diagnosis of Alcohol Dependence or AUD [9]. In this review, we use AUD as the broader term, bearing in mind that public attitudes towards people who use alcohol are concerned less with official criteria for defined diagnostic entities, but with popular conceptions of a condition and according popular labels [10].

While many conditions are stigmatized, people with AUD are exposed to particularly severe stigma when compared to other mental and medical disorders [11, 12]. Stigma complicates conversation about alcohol in medical settings and has been shown to interfere with illness recognition and insight [13], timely help-seeking [14], treatment adherence [15]

and recovery [16]. Due to their impaired health, people with ALD are especially susceptible to these interferences, and stigma might tip the balance towards unfavorable health outcomes. ALD often affects young and middle-aged people in their prime working years [17], stressing the need for prevention and early intervention, which are hampered by stigma [18]. In this review, we summarize findings on how stigma affects people with ALD and what can be done about it. While there is a rapidly growing literature on AUD stigma [16], research on the stigma of ALD is scarce. We will start with findings from the stigma literature on behavioral health, focusing on AUD, but also including insights related to serious mental illness [19], and add the existing literature on ALD stigma, in order to identify both clinical implications and open research questions. Stigma has broad societal consequences, and often affects the human rights of those stigmatized [20]. Our review focuses on the consequences of stigma on health and health care for people with ALD.

Stigma is a social cognitive process that starts with labeling someone, (e.g., as an 'alcoholic'), thereby creating an outgroup described by this label [21]. Some labels are linked to negative stereotypes (e.g., being irresponsible, being weak-willed), evoking prejudice and negative emotional reactions toward the labelled person (e.g. feeling anger, blaming the person), resulting in status loss and discrimination of the stigmatized person [21]. Regarding ALD, <u>public stigma</u> involves negative or discriminatory attitudes that others have about people with ALD. <u>Self-stigma</u> refers to the negative attitudes, including internalized shame, that people with ALD have about their own condition. <u>Structural stigma</u>, finally, involves policies of governments or private organizations that intentionally or unintentionally limit opportunities for people with ALD [22], such as regulations regarding liver transplantation. All forms of stigma can be experienced, but also anticipated or avoided. These different modes of action can all lead to the same negative health outcomes (Table 1).

#Table 1 about here#

Public stigma: Attitudes of the public towards people with AUD or ALD

Drinking norms differ between countries [23], and so does AUD stigma (Kummetat 2022). Public stigma of AUD has been described as a 'moral' stigma, distinguishing between 'good' and 'bad' behavior, and signaling to those using 'too much' alcohol that their behavior is unacceptable and needs to change [24]. At first glance, such a punitive use of stigma might even seem to be a legitimate public health strategy: if people experience negative consequences for their behavior, they might be motivated to cut down on their drinking. However, euphemizing stigma as 'helpful' for people with alcohol use problems trivializes the harmful consequences of stigma for those with AUD or ALD that are outlined in this review and show that such a 'strategy' of culturally sanctioned stigma is fundamentally flawed [25] and unethical [26]. A recent editorial on the stigma of addiction in the *New England Journal of Medicine* criticizes the "tacit beliefs or assumptions about personal responsibility – and the false belief that willpower should be sufficient" [27], because these beliefs ignore the illness character of AUD as an often chronic, relapsing disorder, similar to other behavior related medical conditions such as hypertension, diabetes and obesity [28].

However, population studies consistently show that a majority of respondents <u>blame</u> those with AUD for their condition, in contrast to other mental disorders like schizophrenia or depression [12] and other behavior-related medical diseases like diabetes [29]. Sixty-five percent of the adult population in the United States considered AUD a result of bad character, as opposed to less than 33% for depression and 39% for schizophrenia [30]. People with AUD are widely held responsible for both getting the disorder (onset responsibility) and for not getting better (offset responsibility) [12]. Other negative stereotypes associated with alcohol use include being unreliable, violent, self-pitying or weak-willed [31]. At the same time, AUD is far less frequently regarded as an illness: while 85% of a German general population sample considered someone described with symptoms of schizophrenia as having

a mental illness, only 52% felt the same about AUD [32]. Moreover, there is a strong desire in the general population to keep social distance from people with AUD, by, for instance, not having them in one's neighborhood or workplace, which is generally stronger than preferred social distance towards people with other, substance-unrelated mental disorders [12, 33], or other medical conditions [29, 34]. Liver disease in general is strongly associated with alcohol use by the general public [1, 35–37]. Compared to other medical disorders, liver cirrhosis was regarded as a highly stigmatizing condition by 61% of respondents in a Swedish population study, second only to obesity, but seen as more stigmatizing than, for example, lung cancer (46%) or diabetes (42%), which are also life-style-related diseases [35]. When asked to prioritize healthcare spending among nine medical and mental disorders, AUD had by far the lowest priority in a German population survey. Respondents were asked to select three disorders for which healthcare spending should on no account be reduced. Only 6% chose AUD, compared to 84% choosing cancer, 60% choosing cardiovascular diseases, and 41% choosing diabetes [38]. People with AUD are thus heavily blamed, are often not considered to have an illness, and have low priority regarding treatment in the eyes of the general public. From the limited research on the stigma of ALD specifically, it appears that these perceptions also extend to people with ALD, since the stigma of ALD seems closely linked to the stigma of AUD.

Attitudes of the general population translate into <u>discrimination experiences</u> by those with AUD and ALD [39]. Research on stigma experiences shows that stigma is a barrier to help-seeking and recovery [14]. Within the healthcare sector, many people with AUD report discrimination through condescending, moralizing behavior from nurses or other healthcare professionals [40]. In particular, qualitative studies show that patients with liver cirrhosis describe that medical professionals often assume they must have had AUD or other substance use disorders [1, 37, 41, 42], and they feel judged by healthcare professionals as having

caused their disease [36, 42]. This makes engaging with treatment, especially specialized alcohol treatment, more difficult: a systematic review of studies linking perceived stigma to help-seeking found numerous qualitative studies where respondents with alcohol and other substance use disorders recounted shame, embarrassment, guilt, and stigma by healthcare providers as causes for secrecy and avoidance of help [43]. A study enquiring reasons for not seeking help for their AUD used a sample of 1008 people with AUD in primary healthcare in Europe, of whom 81% did not receive specific treatment. After lack of problem recognition, stigma was the second most frequently stated reason for not seeking help [44]. In a qualitative study of 42 patients with ALD in Australia, patients described fears of being labeled an 'alcoholic' as a reason not to engage in specialty alcohol treatment, and 62% stated that stigma was the strongest reason why they did not seek treatment for AUD [45]. This applies not only to patients with AUD and/or ALD, but also to patients with a broad variety of conditions, such as hypertension, cardiovascular and digestive diseases, mental health issues or obesity: in all of these cases, patients might benefit from decreasing their alcohol intake, but may not want to disclose their drinking behaviors to health professionals because of fear of being stigmatized, while healthcare professionals may not feel comfortable asking for drinking as a behavioral risk factor [46]. A systematic review identified three key interrelated barriers to alcohol treatment as stigma and shame, lack of problem recognition and fears relating to the need to give up alcohol [47].

Self-stigma: consequences for problem recognition, help-seeking, and self-efficacy

Assessing the negative consequences of stigma is incomplete if processes within individuals are not considered. Self-stigma denotes the internalization of public negative attitudes by someone with AUD or ALD [25, 48, 49]. People with liver disease frequently

report feelings of guilt or shame [2, 36], people with cirrhosis in an Iranian study described feeling guilty to the point of avoiding social interaction as a form of self-punishment [37].

The progressive model of self-stigma [50] explains the mechanism driving selfstigma: negative attitudes toward people with AUD are, to some extent, shared by those who develop alcohol problems. When recognizing their own alcohol use problems, these negative attitudes have to be applied to oneself – a painful step that has been shown to be associated with depressive symptoms and lower self-esteem [31, 51]. Self-stigma can lead to the "Why Try" effect [52]: "If I am weak-willed, why should I try living sober?" In people with AUD, higher self-stigma predicted lower abstinence self-efficacy [31], and longer treatment stay in residential addiction treatment [48].

There is evidence that people with problematic alcohol use try to avoid self-stigma by downplaying their drinking problems. People with unhealthy alcohol use exposed to stigmatizing descriptions of alcohol problems showed lower recognition of their own drinking problems in an U.K. online study [13]. Higher recognition of personal drinking problems, in turn, has been shown to be associated with more self-stigma in people with ALD [51]. Avoiding self-identification with the group of people with alcohol problems thus protects the self from the negative consequences of stigma [53], both in terms of self-stigma and public stigma. At the same time, however, this makes stigma a massive barrier to helpseeking, early interventions and treatment adherence in people with ALD, since problem recognition is a central precondition to address alcohol use in people with ALD.

Structural stigma: discrimination in healthcare settings

Structural stigma refers to institutional and governmental rules, policies and practices that put the stigmatized group at a disadvantage. Structural stigma becomes particularly relevant where resources are scarce, for example in liver transplantation. Here, predicting

transplant survival is essential for ethical transplant allocation. Simple rules like the 6-month abstinence rule before liver transplantation, originally introduced to allow recovery of liver disease and not as a predictor of abstinence [54], can be seen as structural discrimination of patients too ill to survive this period of time [55]. In a Swedish case-control study, abstinence prior to liver transplantation was found to be a predictor for post liver transplantation alcohol relapse, but not for patient death or graft loss comparing patients with ALD and matched liver transplanted controls without ALD [56]. The 6-month abstinence rule is especially debatable for patients with acute alcohol-related hepatitis (AAH), which has been increasingly discussed as an indication for liver transplantation in recent years [57-59]. Patients with AAH show, by definition, ongoing alcohol use, rendering them unable to receive a transplant according to the 6-month rule, despite 6-month mortality rates of approximately 75% [57]. Recent studies show acceptable relapse rates and good clinical outcomes for patients with AAH undergoing liver transplantation [58], and common criticisms of early liver transplantation for AAH have been explicitly tied to stigmatizing attitudes such as blame and stereotypes about social support and adherence to treatment regimens [57, 59]. The different handling of people with ALD and with alcohol-unrelated fatty liver disease has also been identified as a sign of structural stigma, wherein the former group has to fulfil harsher criteria to be eligible for liver transplantation [60]. If AUD is not recognized as a condition warranting specialist treatment, the frequent lack of cooperation between psychiatry and hepatology in the care for ALD patients [54] could also signify structural stigma. In fact, many patients with ALD receiving pre- or post-transplant treatment described a lack of integration of addiction services into the liver transplant program [45]. Patients spoke about a "gap between the clinical side of the transplant and the emotional difficulties" and expressed reluctance about disclosing issues concerning their AUD to healthcare workers in the transplant clinic [45]. Structural discrimination of people with AUD is particularly severe in

many former Soviet countries, where even today patients using specialist addiction services are registered and monitored in 'narcological services' [61].

For all patients, and for those with ALD in particular, healthcare settings should be supportive and should protect people from the consequences of stigma. However, patients often describe them as particularly stigmatizing. In healthcare settings, structural stigma mixes with individual attitudes of healthcare professionals. Because of their normative power and gatekeeper position in delivering healthcare, attitudes of healthcare professionals are particularly relevant [40]. Negative attitudes of health professionals towards people with AUD are common and contribute to suboptimal healthcare for these patients [39]. Patients with liver disease, including ALD, reported feeling stigmatized or discriminated against by healthcare professionals in several studies. 63% of those surveyed by Vaughn-Sandler et al. agreed with the statement that "some doctors or nurses don't like taking care of patients with liver disease" [36]. Patients in qualitative studies also reported feeling stigmatized by nurses and doctors: one described a nurse saying "we got another one of those drunks in here waiting for a liver" [1], while others felt generally blamed by providers for having caused their disease [41, 42]. Patients interviewed by Shabanloei and colleagues reported several manifestations of stigma in healthcare settings, from avoidance to being refused treatment outright [37]. Primary care providers described both stigma from other healthcare providers faced by their patients as well as stereotypes they themselves had about patients with liver disease, including lack of adherence due to substance use [62].

'Disease prestige' has been described as "the collective perception of a disease's 'worthiness'", and by extension "the degree to which the sufferer "deserves" care and support" [63]. Studies assessing disease prestige rankings have found that both physicians and medical students [64] as well as nurses [65] consistently rank liver cirrhosis as one of the four diseases with the lowest amount of prestige. Similarly, among gastroenterologists and

general practitioners surveyed about their preferences for liver transplant allocation, 33% and 40%, respectively, ranked a patient with ALD as "least deserving" of a transplant [66].

Moving for change

The stigma of AUD and of having ALD impairs recognition of own harmful alcohol use, increases secrecy about alcohol use, delays or impedes help-seeking, increases illness burden, impairs the quality of healthcare and endangers resource allocation for the care of people with ALD. Given these negative consequences of stigma, we expect people with ALD to be disadvantaged in treatment and health outcomes, contributing to health inequalities. To improve care for people with ALD, the stigma of ALD and AUD needs to be challenged (Table 2). Changing stigma has been described as consisting of three agendas: A <u>self-worth agenda</u> seeking to replace self-stigma and shame with self-esteem and agency; a <u>services agenda</u>, focusing on treatment engagement and treatment provision; and a <u>rights agenda</u>, focusing on the loss of life opportunities for people with ALD [67]. Table 2 gives an overview on potential actions against stigma.

#Table 2 about here#

Peer involvement

Although it seems counter-intuitive in healthcare, which is characterized by professional expertise and roles, anti-stigma efforts need to be led by people who are harmed by stigma. They are most credible in terms of sharing their experience of being stigmatized, and defining the imperatives of anti-stigma, pro-affirmation efforts [68]. People with lived experience are the best advocates for change.

Contact between those with and without a stigmatized condition has long been established as the cornerstone of anti-stigma efforts [69]. Interventions that include contact with individuals in recovery have been shown to be particularly effective in decreasing

stigma among providers who treat patients with substance use disorders, and among people training to become healthcare providers [70]. Peer involvement in substance use disorder treatment is increasingly recognized as a promising strategy to improve outcomes, although there is a need for more methodologically rigorous studies to determine the impact of peer recovery services on AUD outcomes [71]. Guidelines such as the UK Liver Advisory Group recommendations on referral to LT for ALD [72] usually focus on engagement with peer services outside professional services, for example in support groups, and there is good evidence on the effectiveness of groups like Alcoholics Anonymous [73]. However, including peer services in professional ALD care could extend beyond voluntary support groups. Graduated peer counselors, a new and rapidly growing profession already present in many addiction units, who can belong to medical teams at hepatology units as they already do [71], could lower the threshold of engaging with peers, facilitate problem recognition and treatment adherence in patients with ALD, and improve stigmatizing attitudes among healthcare professionals who would then experience working together with people in recovery. Involvement of trained people with lived experience in professional healthcare settings is common in mental healthcare [74], and developing, evaluating and optimizing such collaborative concepts in ALD care seems potentially rewarding.

Responsibility and a continuum model of AUD

Blaming people for their alcohol use and the resulting medical illness is central to the stigma of ALD. Because they are held personally responsible for their conditions, people with ALD are seen as less deserving of limited healthcare resources [38, 60]. It is well established that AUD should be seen as a chronic relapsing condition in many patients, particularly with severe AUD, that may require life-long management, similar to other life-

style related disorders like diabetes type 2, hypertension and obesity [28]. Many causal factors for alcohol related disorders are beyond individual control, such as societal factors like alcohol acceptability, laws and regulatory frameworks, availability and affordability of alcohol, marketing and promotion, socio-economic factors like access to education and healthcare, housing conditions, social inequality or all forms of discrimination, or individual factors like traumatic experiences, genetic predisposition or concurrent mental disorders [75, 76]. However, personal responsibility has to be part of any treatment plan for ALD, so a nuanced concept balancing personal responsibility and responsibility of the social environment is necessary. Figure 1 illustrates a dynamic model of responsibility [77], showing that disorder severity shifts the balance between individual and social responsibility needs to be taken by the social environment, while recovery implies regaining control and responsibility for one's own substance use.

#Figure 1 about here#

A dynamic model of responsibility also implies a continuum of problem severity rather than a dichotomous distinction between 'addicted' and 'not addicted'. Particularly in patients with ALD it is apparent that the amount of alcohol intake, not the question of whether someone is addicted to alcohol or not, corresponds to individual liver damage as a continuous variable [78]. There is evidence that a continuum model of AUD is associated with lower stigma [79], at least in countries with permissive drinking cultures [32, 80]. Experimental evidence suggests that a continuum model of AUD lowers the threshold to acknowledge consequences of their own alcohol use in people with unhealthy drinking behavior [81] (Leonhard et al., submitted). A false binary between 'alcoholics' and 'non-alcoholics' may be used by people with hazardous alcohol use to protect their own drinking identities as non-problematic, but in turn inadvertently reinforces stigma by emphasizing separation and difference [82].

Consequently, promulgating a continuum underlying AUD rather than dichotomous diagnostic categories has been suggested [78], and is also reflected in the dimensional conceptualization of AUD in the DSM-5 (but not the ICD-11), which distinguishes mild, moderate and severe AUD depending on the number of diagnostic criteria met. Stressing the dynamics of responsibility and the continuum of symptom severity in AUD might lower the threshold to problem recognition and help-seeking for people with ALD, positively influence attitudes of health care professionals, and facilitate honest conversations about alcohol use in clinical settings.

Structural changes

Other necessary changes to combat stigma include a better alignment between hepatology and psychiatry or other addiction treatment services in the care of patients with ALD, thus improving care for any underlying AUD. Most people with ALD receive no or insufficient treatment for AUD [83]. One aspect of this alignment would be replacing rigid abstinence requirements before liver transplantation with more nuanced psychosocial assessments of prognostic factors for the underlying AUD [84, 85], thus reducing structural stigma. This is also reflected in recommendations of both the European Association for the Study of the Liver [86] and the American Association for the Study of Liver Diseases [87]. Beyond assessment, integrating addiction treatment in pre- and post-transplant care has been shown to be effective in reducing the risk of relapse to alcohol, regardless of the length of prior abstinence [88, 89]. Retrospective data from a large cohort of veterans in the U.S. suggests that behavioral therapy reduces risk of hepatic decompensation and long term mortality in patients with cirrhotic stage ALD [85]. Providing specialist AUD care to people with ALD will thus likely improve overall prognosis, reduce need for liver transplantation and improve long-term transplantation outcomes.

The risk of bias and stigma against patients with ALD also needs to be included early in the training for professionals caring for people with ALD [70]. This extends beyond the stigma of AUD. Intersectional stigma describes the co-occurrence of several stigmatized conditions in one individual [90, 91], thus further exacerbating health inequalities [92]. On a societal level, both the incidence and mortality of ALD are linked to socioeconomic inequality. People of lower socio-economic status showed a higher incidence of ALD in a Danish register study [93], while mortality was robustly related to both state-level inequality and individual income in a study from the United States [94]. Preventing ALD and improving ALD outcomes is a task that does not stop with the healthcare system.

Evidence gaps and open questions

Almost all relevant studies cited in this review are from a limited number of highincome countries with a very high prevalence of alcohol use and high acceptance of alcohol. The consequences of stigma might be different in countries with restrictive drinking cultures, or with a different religious or cultural background. The interrelation of alcohol stigma and culture is understudied but needs to be understood to improve healthcare for people with ALD globally. Furthermore, drinking cultures are changing, with declining alcohol use particularly in Eastern European countries, which could also initiate changes in ALD stigma. Future studies should look specifically at the impact of self-stigma and stigma experiences on outcomes after liver transplantation. Another crucial question is the influence of public stigma towards people with ALD and AUD on readiness to donate organs. While there have been concerns that people would be reluctant to donate their liver to someone with ALD, studies of public preferences regarding organ donation indicate that perceptions of prognosis and individual need are most relevant, providing an opportunity to educate the public

seeking need to be developed and evaluated. Interventions need to be tailored to relevant settings like primary and specialist healthcare, and relevant populations, like the general population or people with high-risk drinking behavior. Understanding the interplay of attitudes and health outcomes in ALD is only the beginning, but addressing stigma in its different manifestations promises to yield substantial improvements of treatment outcomes and quality of life for people with ALD.

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		Forms of stigma			
		Public stigma	Self-stigma	Structural stigma	
Mode	Enacted	Individual	Loss of self-	discrimination in	
of	stigma	discrimination	efficacy, loss of	healthcare, in resource	
action		and devaluation	self-worth,	allocation	
			shame		
	Anticipated	Secrecy,	Denial of	Non-disclosure in	
	stigma	avoidance of	problem,	healthcare settings,	
		help, delayed	misattribution of	avoidance of	
	Avoidance of	help-seeking,	symptoms,	specialized addiction	
	labelling and	social withdrawal	delayed problem-	services, non-	
	stigma		recognition and	adherence	
			help-seeking		
Result	Increased illness burden, failure or delay of seeking help, inferior healthcare,				
	negative health outcomes				

Table 1: Different forms and modes of action of ALD stigma, and their consequences for health outcomes.

Self-worth	orth Empower people with lived experience to lead actions against the stigma of			
agenda	ALD and AUDs			
	Integrate peer services in ALD care			
Services	Educate the public			
agenda	Promulgate a dynamic model of responsibility			
	Promulgate a continuum model of AUD			
	Educate professionals			
	Establish training on stigma and discrimination for professionals			
	working with patients with ALD, including contact with people with			
	lived experience			
	Initiate structural change on multiple levels			
	Implement stigma-free prevention and early detection of ALD and AUD			
	Integrate specialist care for ALD and for AUD			
	Improve primary care for people with ALD			
	Integrate AUD care into general healthcare			
Rights agenda	Ensure stigma-free guidelines for LT			
	Address social inequality, address social dimension of ALD risk and			
	outcomes, ensure equal access to services			

Table 2: Agendas for overcoming the stigma of ALD in healthcare

AUD, Alcohol Used Disorder. ALD, Alcohol related liver disease. LT, liver transplantation.

Legend Figure 1: Dynamic Model of Responsibility in Alcohol Use Disorder

AUD, Alcohol Use Disorder. Greater severity of AUD implies lower individual responsibility and higher responsibility of the social environment. Recovery as a process increases individual responsibility. Source: [77]

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Figure 1: Dynamic Model of Responsibility in Alcohol Use Disorder