

Prioritizing evidence-based public health over clinical empathy in substance use

This perspective article is primarily a response to Alwis, Samaranayake, and Baminiwatta (2025)(1) perspective piece in SLJPsych.

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Sri Lankan activists have decisively countered tobacco, alcohol, and other drugs by systematically undermining the perceived attractiveness of these substances, whether legal or illegal. The authors fail to acknowledge the historical fact that tobacco smoking in Sri Lanka began declining prior to the enactment of the National Authority on Tobacco and Alcohol (NATA) Act. (2) Pricing of cigarettes, when adjusted for inflation even at present found to be not at the optimal level. This decline was immensely contributed by a straightforward strategy: countering industry activities and dismantling the glamorous image promoted by tobacco companies. This represents a major public health achievement.

While agreeing with the authors' assertion that most users are not representatives of the industry, it should be pointed out that evidence indicates that some users are, and a majority of social media influencers and other promoters receive direct or indirect industry funding. Targeting such actors forms a legitimate component of public health and community interventions.

Shame-based approaches: Inconclusive evidence and extrapolation risks

Shame-based approaches may produce varying effects across individuals. The limited research in this area – primarily involving clinical samples or students – has yielded inconclusive evidence. Extrapolating findings from clinical contexts to public health applications requires extreme caution. Evaluations of public health outcomes must consider impacts on broader populations, including patterns of use, reduction, promotion, and sales.

The article cited by the authors, published by Agostinelli et al., primarily examines underlying mechanisms rather than outcomes, explicitly stating that “anti-smoking communications can backfire and strengthen initial pro-

smoking attitudes when viewed by smokers”(3). Moreover, there is no robust evidence from population-level studies demonstrating the efficacy of empathy-based approaches.

The article cited to demonstrate efficacy for other messages (Lee, M. J.) involved a study conducted among university students, focusing on advertisements promoting controlled or sensible drinking. Such goals are entirely inappropriate as public health measures in populations where 80% of individuals abstain from alcohol. The Lee (M. J.) article does not evaluate a public health or clinical intervention. Rather, it examines changes in attitudinal responses following exposure to modified alcohol-promoting advertisements (4). The authors should account for the specific place, time, and cultural context in which we operate. While it is neither impossible nor unscientific to derive public health insights from basic or clinical research, uncritically adopting such findings without rigorous context-specific investigation would be detrimental.

As the Luoma et al. article notes, individuals respond differently to shame. However, what matters most is the response at the societal level: if the overall outcome is overwhelmingly favourable, it is prudent to preserve relevant cultural phenomena. The authors highlight a key limitation – that shame specifically due to substance use remains understudied – while citing evidence that it can be beneficial: “Indeed, the only study that did ask participants about shame specifically due to their substance use found that it predicted less methamphetamine use – quoted by Luoma et al as Nemoto et al., 2002”.

They also propose a clinical solution to address our concerns: “It is possible that an accepting atmosphere is key in enabling people to translate shame into positive behavioural change rather than avoidance. Shame (which

may increase awareness of a shortcoming), coupled with an accepting atmosphere (which may reduce defensiveness or a negative global appraisal of the self) could allow positive change to take place. This idea is in line with self-affirmation theory, which proposes that people seek to maintain a positive sense of self in which they view themselves as good, moral, and effective (Sherman & Cohen, 2006), a view that shame threatens. “The authors conclude that” the overall pattern of results indicates that the association between shame and substance use, per se, is weak and that models which hold that shame is invariably maladaptive need revision” (5).

Cultural protections and population-level benefits

Public health interventions must avoid inflicting adverse effects, such as shame, on vulnerable populations; this does not imply that existing cultural or social phenomena in a community should always be altered, when they serve a protective purpose. For instance, Sri Lankan women – unlike those in Western societies – remain culturally ashamed of alcohol use, a factor that effectively shields them from related harms. Interventions seeking to eliminate this shame could inadvertently increase consumption and associated risks among them.

Similarly, aversion to needles among Sri Lankan heroin users acts as a key behavioural determinant safeguarding public health. Overdose death rates in Sri Lanka remain far lower than in countries such as Australia, Switzerland, Austria, and Finland (6), (7), (8), (9). Efforts to reduce stigma around help-seeking among intravenous drug users such as needle exchange could undermine this protective factor, potentially causing harm from a public health standpoint. In our society, substance use in any form has historically been culturally unacceptable – a norm which is continuously attacked by the industry and current users, rather than by public health initiatives.

In clinical practice, we have observed numerous instances in which young patients, upon recognizing that they were misled into viewing alcohol’s effects positively, gained genuine insight and true empowerment. The shame they experienced could well be used as a tool in therapeutic intervention. Beyond these clinical observations, the sheer number of individuals deterred from any drug use by shame or perceived unattractiveness far exceeds – by orders of magnitude – the number of dependent individuals who avoid seeking clinic-based treatment.

Many developed settings appear to have standard interventions suggested by the authors of the original article. Even in such settings, the treatment gap is still high and treatment seeking is thought to be well below expected (10). Strategies for reaching and supporting those dependent on substances must be strengthened

without inadvertently increasing the prevalence of drug use through normalization and generalisation, can stem from clinical approaches misapplied to public health.

Evidence from pictorial warnings

The Agostinelli et al. article predates the implementation of discomforting pictorial warnings on cigarette packets. At present there is substantial evidence to demonstrate that these warnings exert a negative effect on smoking behaviour – even if smokers avoid looking at them directly (11). And the smokers themselves supported having them (12). What matters is not postulated psychological theory, but the actual public health outcomes of the intervention.

Nearly any tobacco-related effect can evoke shame – for instance, it is difficult to imagine a man who would not feel ashamed of experiencing impotence. If this well-established health consequence can be leveraged effectively for prevention – benefiting millions by deterring smoking – we should prioritize research into supportive measures for those affected (e.g., improving access to clinics for treatment) rather than discarding proven strategies.

Differentiating clinical from public health approaches

Periodically revisiting and critically evaluating our interventions is essential to avoid dogmatic adherence to any single approach, which – as the authors correctly note – may become ineffective over time. This does not mean abandoning proven “old” methods, which can remain effective. The Crepault et al. article, cited by the authors, clearly states that no consensus exists on optimal public health approaches to substance use disorders (SUDs) (13). Public health strategies should be differentiated from clinical approaches, which focus on treating individuals in controlled settings. The methods, tools, and underlying theories for clinical interventions often differ markedly from those employed in the public health arena, for obvious reasons.

Notably, Crepault et al. do not denounce any specific approach nor prohibit “de-glamorization” strategies, such as challenging the attractive image promoted by the industry and certain user advocates. Indeed, no group has applied de-glamorization to tobacco control more effectively than activists, who have differentiated the industry, its representatives, and its paid or unpaid affiliates (including those in the health sector) from mere users. Users themselves stand to benefit immensely from understanding these distinctions.

If certain groups underutilize help, targeted outreach or tailored measures should address this without com-

promising proven public health interventions. Across the spectrum of available strategies, empathy-based approaches – such as motivational interviewing in clinical settings – have yielded disappointing results, even in rigorously conducted trials (14) (15) (16) (17). It is thus unsubstantiated to claim that public health communications grounded in motivational interviewing principles would effectively curb substance use at a population level. The authors provide no specifics on implementation or evidence of significant benefits from such efforts. It is worth noting that failed public health approaches to substance use disorders in the past, often relied on educational models that normalized use and empathized with users in non-clinical contexts.

Clinicians, managers, and policymakers who prioritize empathy should champion public health measures that benefit the greatest number. However, as a technical intervention, empathy is confined to clinical settings; transplanting it to the public health sphere constitutes a scientific error.

Empathy-based communication undoubtedly has value in clinical practice. Yet, what is needed is robust evidence from population-level studies demonstrating the efficacy of proposed approaches, along with assurances – beyond mere theory or speculation – that they outperform existing clinical or public health strategies.

Clinical limits, de-glamorization, and “do no harm”

In clinical practice, we must develop tailored approaches to handle diverse situations, including outreach to vulnerable groups through differentiated methods. This discussion occurs within a context where established interventions are already yielding results; outcomes would naturally vary if alternative strategies for addressing substance use were adopted.

Regardless of the terminology used, effective anti-tobacco or anti-alcohol programs require de-glamorizing, denormalizing, and de-glorifying substance use-and even discussing it. In practice, this entails deploying words, images, and emotions that, depending on context, may be labelled as shaming or blaming. How else can we address deception, misinformation, or adverse effects like sexual dysfunction? Abandoning them under the pretext of harm reduction is counterproductive. Shame, guilt, and stigma must be managed in ways that preserve the far greater effectiveness of these population-level interventions (compared to any known clinical treatments).

Shame and stigma likely operate differently across disease conditions(5). Unlike tuberculosis or HIV-which lack powerful vectors glorifying, normalizing, or glamorizing infections-active industry promotion is linked to

alcohol and tobacco use, requiring different approaches. And all de-glamourisation attempt would run the risk of being interpreted as shaming or blaming.

The principle of “do no harm” must extend to the broadest possible population-not merely those in our clinics or classified as ill. Evidence demonstrates that even the most affected groups, including those with severe dependence, benefit from comprehensive public health interventions. For example, all smokers-regardless of addiction status-gain from smoke-free public spaces. Conversely, promoting clinical interventions in populations where unassisted cessation is the norm risks unintended harms. Brown-Johnson and Prochaska overlook this reality and, in fact, disseminate misinformation in their article regarding smokers’ ability to quit unassisted (18). Such claims constitute outright deception. Messaging that medical treatment is essential for cessation could undermine the self-efficacy of the much larger population that succeeds independently (19), (20).

No intervention is without risks; certain groups may be adversely affected. For instance, how can we claim that medical approaches do not undermine the majority who quit unassisted? Nor can we ignore evidence that countries with widespread substitution therapy also report higher overdose deaths and injection drug use-trends that persisted, and even intensified, at the outset of such programs, despite their continuation (21). “Do no harm” is not a mere literary flourish; it demands context-specific answers to critical questions: What harm, to whom, and how?

The Lee (M. J.) article, cited as evidence for alternative approaches, merely documents short-term attitudinal shifts toward controlled drinking in a one-off experiment among students (22). Extrapolating this to public health applications is highly questionable, given the absence of meaningful outcome measures like reduced consumption or harm.

Therefore, I propose that this article rests on misplaced assumptions: that current clinical approaches for substance users are both highly effective and harmless; that shame is universally maladaptive; that de-glamorization is unnecessary (without proposing effective alternatives); and that the advocated communication strategy benefits all affected individuals universally. These claims lack empirical foundation.

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