Recognizing Stigma Embedded in Diagnostic Criteria for Substance Use Disorders

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Editor's note: This op-ed about the enduring consequences of the moral model of addiction, was written by Tanya Freedland, MPS, LADC, a Clinical Trainer and Research Associate at the Center for Practice Transformation, and Robert Krueger, PhD, Distinguished McKnight University Professor in the Department of Psychology at the University of Minnesota, as part of this month's Special Series on Theories of Addiction.


Jordan sat on the bench outside the group room waiting for the day to be over. He was being punished for coming late to treatment because he had to drop his daughter off at school. The addiction treatment center he attended had a strict policy about being on time and Jordan's situation was no exception. So, he spent the day sitting out from treatment activities instead of receiving care. As he sat there thinking, the guilt and shame washed over him. He got himself into this mess; his daughter was with him when he was arrested and he narrowly avoided a child protection case. If he had been able to control himself, he wouldn't have to choose between treatment and his child. He felt like he had failed at everything, he couldn't even get treatment right. Thankfully advances in treatment, counselor training, and research mean treatment stories like Jordan's are getting fewer and farther between. Punitive treatment is not practiced nearly as much as it used to be and most providers are embracing a supportive holistic approach to client care.

Attitudes within the clinical treatment system of individuals with substance use disorders are shifting. However, negative public attitudes toward addiction

persist. Over the past 15 years, a worldwide effort has been made to destigmatize mental illness so that individuals may access treatment more readily and get people the mental health care they need. Yet, people who have experienced substance use disorders have not benefitted from this effort. A study examining public attitudes about mental illness and substance use disorders found substantial differences. Of the people surveyed, 78% were unwilling to work closely with someone who experiences substance use disorders, while only 38% said the same of a person with mental illness. Similarly, 90% of people were unwilling to have someone in the family marry someone with addiction and only 60% indicated that they would be unwilling to have someone with mental illness marry into their family. Conversely, when asked if they believe that discrimination is a serious problem; only 37% believed it was for substance use disorder and 62% believed it was for mental illness (Barry, McGinty, Pescosolido, & Goldman, 2014).

When we consider the historical context behind the apparent differences between mental illness and addiction stigma, this study's findings are not surprising. The moral model of addiction predominated until relatively recently in our history when a more modern understanding started to develop. The story of how the moral model developed is complicated, but put simply, the model assumes that a person who is addicted is not abiding by the norms of society and their lack of control is due to a deep and personal moral failing, not one that is either biologically driven or influenced by outside forces (Harding, 1986). People in recovery need support from people around them and the communities they live in. Societal stigma is a serious barrier to individuals seeking to recover from substance use disorders.

Our diagnostic classification system plays a role in contributing to the stigma. Sometimes referred to as the psychiatrist's bible, the Diagnostic and Statistical Manual of Mental Disorders, commonly called the DSM, underwent revision and release of the fifth edition (APA, 2013). One of the most significant changes made in this latest edition was the shift from two categories of substance use problems (substance abuse and substance dependence) to one that recognizes levels of severity within problem substance use. The current diagnostic process includes levels of mild, moderate, and severe rather than relegating problem use to one of two categories with different criteria; this system allows for a more nuanced understanding about how combinations of different criteria can lead to problems of varying severity.

This nuanced understanding extends only to the severity of substance use disorders and does not address the stigmatization endemic in the criteria themselves. While criteria for most mental illnesses focus on the internal experiences of a person, 6 of the 11 criteria for substance use disorders contain problems that associate an individual and external contexts like employment, relationships, and leisure activities. This contextualization of problems shows how much a diagnosis relies upon societal values and reifies the beliefs behind the moral model of addiction. If a person is not subscribing to these norms, they are exhibiting moral deficit or societal failure. While it is true that many people with substance use disorders have had problems in these contexts, the DSM criteria ignore the internal experiences of individuals who are having them. When we diagnose based on the lack of participation in previously enjoyed leisure activities, but don't examine the lack of pleasure that a person is experiencing in their life; we are missing out on valuable information that can aid in clinical care. Even more importantly, reframing criteria provides a lens through which someone who is suffering with a substance use disorder can be understood by the people around them and society as a whole. It is much more difficult to see someone like Jordan as morally bankrupt when we understand what he is experiencing rather than the societal costs of his illness. The stigma embedded in the diagnostic criteria must be addressed if we are to continue to see advances in the treatment of substance use disorders and shifts in the societal stigma faced by those trying to recover from addiction.

References

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Author Bios

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