Coming clean about substance use disorder: factors affecting treatment-seeking and compliance, and strategies to overcome them

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ABSTRACT

Despite the destructive scourge of substance use disorders (SUDs) increasing in the workplace, both locally and globally, those with SUD remain reluctant to seek, or comply with, treatment interventions. This paper outlines some factors underlying this and suggests strategies for overcoming them. Factors include stigma, shame, guilt and blame. Conceptual strategies are outlined to redress these issues, so that those with SUD can more freely access and participate in treatment. Strategies include: conceptualising SUD in order to empower the addict via knowledge and understanding; referencing the Disease Model of Addiction and treatment implications; focusing on the emotional regulatory function of the addictive substances; Khantzian's self-medication hypothesis; the concept of dual diagnosis; the role of trauma; and understanding recovery and relapse.

Keywords: **addiction, addiction recovery, alcohol, drugs, stigma, shame**

INTRODUCTION

Substance use disorders (SUDs) continue to soar in South Africa and internationally, with an estimated 13% of South Africans suffering from SUD during their lifetimes.[1, 2] Substance abuse is an increasingly destructive issue in the workplace. Even 15 years ago, it was found that undetected drug abusers cost their employers 25% of their wages.[2] The combined total cost of alcohol abuse to the South African economy was estimated at 10-12% of the 2009 gross domestic product (GDP). The tangible financial cost of alcohol abuse alone was estimated at R37.9 billion.[3] Negative impacts in the workplace include increased absenteeism rates, job turnover, interpersonal violence, accidents at and outside of work, fatalities, and reduced productivity.[4-6]

Despite the overall seriousness and wide-ranging destructiveness of SUD, those with substance abuse issues seldom present voluntarily for help.[7] When they do present, there is often an incomplete disclosure as to the extent of their substance use issues and the impact on all areas of their lives. This paper outlines the reasons for this and offers the occupational health worker suggestions on how to conceptualise and work with SUD, so that the affected employee has a positive and practical way forward.

The paper begins with a diagnosis of SUD and then explains common issues relating to SUD – stigma, shame, guilt and blame[8] – and their impact on help-seeking behaviour and compliance with interventions. Alternative ways of conceptualising SUD are then discussed in order to empower the affected employee via the installation of knowledge and deepening of understanding by referencing the Disease Model of Addiction and treatment implications, focusing on the emotional regulatory function of the addictive substances, Khantzian's self-medication hypothesis,[9] the concept of dual diagnosis, the role of trauma, and understanding recovery and relapse. With this knowledge, those with SUD are armed with theoretical tools to assist with the dismantling of stigma, shame, guilt and blame.

It is clear, from the DSM-5 criteria (Table 1), how addiction consumes the individual, who becomes enslaved to its tyranny and the destructive consequences of his or her actions. What might have begun in levity, becomes a trap from which most with SUD eventually long to escape.[11]

COMMON FACTORS IN SUD THAT PREVENT HELP-SEEKING AND COMPLIANCE IN INTERVENTIONS

The factors of stigma, shame, guilt and blame play a large and often unconscious role in the life of a person with SUD. These factors not only exacerbate such a person's SUD, but frequently result in him or her failing to seek treatment timeously, making an incomplete disclosure to the healthcare worker, or complying fully with his or her treatment plan.

Stigma

Stigma is considered to be one of the most common barriers to treatment-seeking for substance abusers. Stigma is defined as a moral failing – "a mark of disgrace associated with a particular circumstance, quality, or person".[12] In western society, there is a pejorative and rejecting attitude toward persons with mental illness and those with SUD. The various assumptions and social perceptions of drug users include that they are 'weak, lazy, sinful, immoral' and 'inherently flawed and bad'. The stigma varies with the substance, with alcohol being considered more acceptable than street drugs, for example.[13]

These assumptions are largely unexamined, but they and are linked to ignorance about SUD and affect how persons with SUD are treated by others, including treatment providers. Those who experience stigma

Table 1. DSM-5 diagnosis of substance use disorder[10]

- The substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Craving, or a strong desire or urge to use the substance, is present.
- Recurrent use of the substance is resulting in a failure to fulfil major role obligations at work, school, or home.
- There is continued use of the substance, despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
- Important social, occupational, or recreational activities are given up or reduced because of the use of the substance.
- There is recurrent use of the substance in situations in which it is physically hazardous.
- Use of the substance is continued, despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance is evident, as defined by either of the following:
  a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or
  b) a markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal is evident, as manifested by either of the following:
  a) The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria set for alcohol withdrawal), or b) Alcohol (or a closely-related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.
- Use a criteria count (from two to 11) as an overall severity indicator. Use the number of criteria met to indicate mild (two to three criteria), moderate (four to five), and severe (six or more) disorders.

regarding their drug use are less likely to seek treatment, and this results in economic, social, and medical costs. In the United States alone, costs associated with untreated alcohol addiction (including those related to healthcare, criminal justice, and lost productivity) amounted to over US$ 510 billion in 2000.[14] Even in those cases in which a person does seek treatment, the stigma associated with SUD often results in him or her minimising or lying about the severity of the substance abuse. Many fear being diagnosed with SUD because of stigma, and so avoid this by not seeking help.[15, 16]

Stigma also impacts on employment opportunities. For example, does a person 'come clean' about his or her SUD and risk not getting the job, or say nothing and live in fear of the SUD being discovered? Stigma also leads to discrimination in the areas of housing, finance, friends, family and intimate relationships. It often causes social isolation, resulting in how the person with SUD may view and treat him or herself.

Internalised 'self-stigma' can lead to low self-esteem which impacts on relationships, sense of self-worth, and can also lead to shame. Thus, stigma may ultimately be associated with poor outcomes when treating SUD.[17-19]

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Shame

By not seeking help, the addict attempts to avoid feeling the uncomfortable humiliation of shame. Shame is considered to lie at the heart of SUD and is the most painful of human emotions. It is a sense of being completely diminished or feeling insufficient. It is the self-judging of the self, and then finding oneself worthless.[20]

At its root, shame means 'hidden', and this means a person hiding his or her belief about their true nature from others. This reinforces social isolation and withdrawal and means wearing masks to hide the secret unworthiness at one's core. The person then uses substances to escape the unbearable feeling of self-perceived inadequacy. Then, when intoxicated, the person acts in shameful ways which, when remembered or when they are recounted, trigger the shame (often hidden under rage or guilt) that then causes the person to want to withdraw into the refuge of the substance again. Thus, the cycle of shame and substance abuse continues. Part of breaking this cycle, therefore, is to find a way to admit to the problem, thereby bringing it to the awareness of the person with SUD, so that it can gently be worked through. The skill and knowledge of the occupational health worker are key in this respect.

Guilt and shame

Another emotion that a person with SUD carries, and tries to avoid, is guilt. Shame is basically "I am a bad person", and guilt refers to "I did bad things and caused harm". Shame and guilt are both causes and consequences of SUD.

Although there is no evidence that substance abuse causes characterological 'personality change', it can be associated with a number of negative behaviours that might suggest that the individual is a different person. These include dishonesty, disrespect, deceit, destructive behaviour, violence and blame – before, during and/or after intoxication. These behaviours can lead to guilt and shame.

When counselling the person with SUD, one needs to remember

that guilt can have some motivating aspects, for example, in not wanting to continue hurting others. However, shame is more delicate and needs to be treated gently as it is very difficult to bear, and it needs an environment of trust and acceptance.

The antidote to both guilt and shame is forgiveness – of self and by others. Support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) which use the 12-step programme, help address the guilt and shame which are common in SUD.[23] Affected employees can be referred to these organisations, or aspects of the programme can be used in the occupational health professional's work. The idea is that the affected employee learns to take responsibility by making amends with those they have harmed.[21-23] Affected employees may not be able to complete all 12 steps initially, and we cannot expect that they will seek amends if they do not wish to do so. Recovery needs to be seen as an individual process, and the 12 steps as a tool.

Blame

Another factor affecting help-seeking and full participation during treatment is blame – by others and of the self. Most societies have blamed the person for his or her SUD; the 1952 version of DSM-1 disparagingly stated that a person with SUD had a "sociopathic personality disturbance". Persons with SUD were punished for intoxicated behaviour, and any concern for them was withheld as it was thought to absolve them of responsibility.

Questions about self-control and loss of control underlie the punitive attitude of blaming those with SUD. The concept of loss of control is considered to have been overused in addiction treatment, as it unhelpfully results in the person with SUD blaming him or herself for losing self-control, which then triggers shame and guilt, and diminishes self-esteem.[24] This leads those with SUD back to the cycle of substance misuse.

Willpower alone is often insufficient in those who have struggled with a severe SUD. These individuals will require helpful coping tools and different ways of understanding their SUD, as well as ongoing, understanding support through their recovery trajectory.

STRATEGIC CONCEPTS IN WORKING WITH SUBSTANCE USE DISORDER (SUD)

Working with those who have SUD requires knowledge, skill and sensitivity. The following approaches can help the occupational health worker in counteracting and redressing stigma, shame, guilt and blame, as well as in providing useful conceptual tools for the affected employee, which affords a common ground for both:

The Disease Model of Addiction

This model provides an antidote to shame and guilt in that it creates conceptual understanding which can assist in the management of SUD, thereby freeing the patient to embrace different ways of being, with hope and relief. In the Disease Model, SUD is seen as a disease, and not a moral failing because it is a chemical/biological issue that is primary, progressive and chronic and, ultimately, if left untreated, it is associated with a significant morbidity and mortality. It is a condition that the person learns to live with and manage.

SUD, in this framework, is characterised by an obsession to use substances, and that vulnerability will always be there, whether the person is using the substance or not, much like cancer that can be considered to be in remission.

Table 2. Comparisons of relapse rates for drug addiction and other chronic illnesses[24]

Condition	Relapse rate (%)
Drug addiction	40-50
Type 1 Diabetes	30-50
Hypertension	50-70
Asthma	50-70

Drug addiction has a similar relapse rate to common chronic conditions such as hypertension and asthma which do not have the same stigma (Table 2). SUD can be viewed like any other chronic illness, with relapse serving as an indication for renewed intervention.[25]

Not 'why the addiction', but 'why the pain?'[26]

Given that the person with SUD is likely to minimise the reporting of his or her substance use due to stigma and shame, it might be useful to elicit more information – to focus not on specific details of the substance(s) of choice, but on what the person is looking for from the effect of the substance. This focus will help to convey a non-judgemental attitude and help towards building trust and rapport with such a person, helping the occupational healthcare worker to determine their need for it. This should ideally be balanced with discussing the consequences of their substance use to help facilitate changes in their belief around substance use, and their behaviour.

Maté and Neufield say that most people respond with comments predicated on their emotional wellbeing, including: "It helped me escape emotional pain", "helped me deal with stress", "gave me peace of mind", "provided a sense of connection with others", and "gave me a sense of control."[26] For them, these answers reveal that addiction arises in a human being's attempt to solve "the problem of emotional pain, of overwhelming stress, of lost connection, of loss of control, of a deep discomfort with the self."

By having this approach in his or her toolbox, the occupational health worker avoids being trapped by stigma, shame, guilt and blame issues and, instead, has a positive way of helping the affected employee.

The Khantzian self-medication hypothesis[9]

This model adds another string to the occupational health worker's SUD bow, by linking the Disease Model of Addiction with the emotions the person with SUD is trying to regulate (self-medicate) through exploring his or her decision to choose a particular substance, and the effect of the substance on that person's emotional state.

According to Khantzian, "Individuals discover that the specific actions of various substances relieve or change a range of painful emotional states. Self-medication factors occur in a context of self-regulation vulnerabilities – primarily difficulties in regulating affects, self-esteem, relationships, and self-care. Persons with SUD suffer intensely with their feelings, either being overwhelmed with painful affects, or seeming not to feel their emotions at all".[9]

(Mis)using substances helps such individuals to relieve difficult emotions. In other words, addiction has emotional triggers and, by exploring these, one can assist the addict to find other tools and ways of coping.

Dual diagnosis

Another helpful perspective which resonates with those already discussed, and which can assist the person with SUD, is the notion of 'dual diagnosis'. Increasingly, centres that specialise in SUD have dual diagnosis units. A dual diagnosis can be managed in a sequential, parallel or integrated manner. An integrated form of treatment, where the treatment team is capable of managing both the addiction and psychiatric illness, is considered to be ideal.

There is a high incidence of SUD with a psychiatric diagnosis, where the person with SUD often also self-medicates a psychiatric condition:

- 30-40% of persons with an alcohol-related disorder meet the criteria for a major depressive episode;
- 25-50% of persons with an alcohol-related disorder meet the criteria for an anxiety disorder (especially panic disorder and phobias);
- 35% of cocaine users seeking treatment had a lifetime comorbidity with attention deficit disorder;
- 19% of opiate users seeking treatment have a lifetime comorbidity with a mood disorder.[27,28]

When working with a SUD employee, it is important to be aware of any undiagnosed psychiatric condition and to refer him or her for appropriate treatment.

SUBSTANCE USE AND TRAUMA/PTSD

There is a clear association between substance use and trauma, of which many with SUD are unaware. Rates of trauma among individuals in treatment for alcohol or other SUDs range from 50 to 70%. The prevalence of alcohol use disorders in persons with PTSD ranges from 24 to 52%, and other drug-use disorders among persons with co-occurring PTSD, approximately 22.3%.[29]

Therefore, the occupational health practitioner should investigate any earlier trauma and consider whether it could be linked to the time when the addictive behaviour began. Should there be a connection, this will contribute towards disassembling the guilt, shame, blame and stigma of SUD and will allow a focus on trauma intervention. In this way, the stigma and shame are not fixated on but rather explained, and a new direction, that of trauma counselling and its role in the SUD, can be helpfully pursued.

ABSTINENCE AND RECOVERY

Addiction has been described as an existence which is withdrawn and isolated. The person with SUD seeks to avoid the wider world, focusing on his or her substance of choice. To recover, such a person needs to broaden and reach out to the world.[10] Using the conceptual tools explained in this paper can bring much relief and hope to the person with SUD.

Recovery begins with the committed decision to stop using the substance(s) of choice, and abstinence is the first step to recovery. Recovery typically means maintaining complete abstinence from all addictive substances and activities, and abstinence arrests the disease which then remains dormant. Peer-group support is encouraged, where addicts learn recovery from role models.[30]

The increased capacity to bear, and respond differently to, difficult emotions is thereby created through connections with others, knowledge, skills development, self-awareness, support and medication.

There are many pathways to recovery, embracing, enriching and opening up many and new aspects of a person's life. Recovery has various aspects and definitions. Recovery is considered: to be self-directed and empowering; to involve a personal recognition of the need for change and transformation; to be holistic; to have cultural dimensions; to emerge from hope and gratitude; and to involve a process of healing and self-redefinition. Recovery is supported by peers and allies, and involves (re)joining and (re)building a life in the community.[31] Recovery, in addition to remission, is meant to convey an achievement of global health. Recovery, therefore, includes a desire for abstinence as well as ongoing participation in activities that support this desire.

A working definition of recovery, offered by one of the leading writers in the field, William White, is: "the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilise internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life." [32] The Substance Abuse and Mental Health Services Administration (SAMHSA) has established a working definition of recovery, viz. a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.[33]

CRITERIA OF RECOVERY

The notion of a person's recovery is consolidated by the SAMHSA's criteria for recovery. He or she:

- can address problems as they happen, without relapsing;
- have at least one person they can be completely honest with;
- have personal boundaries and know which issues are theirs and which belong to other people; and
- take the time to restore their energy – physical and emotional – when tired.[33]

RELAPSE NEEDS TO BE SEEN IN THE CONTEXT OF RECOVERY: "STOPPING IS HARD, BUT STAYING STOPPED IS HARDER" (A 12-STEP SAYING)

There is a notion that recovery ends when relapse begins. However, many patients will experience lapses which should be viewed as learning opportunities for examining what triggered the relapse, and for learning from this and recommitting to recovery. Lapses are common during the initial period of sobriety, but they should be managed appropriately to prevent any future relapses.

Recovery is a journey and not a destination, where lapses are common and do not indicate failure. Lapses do, however, provoke shame, and encouraging a timeous return to treatment is essential.[34, 35]

CONCLUSION

People with SUD, unlike other diseases, have the added burdens of stigma, shame, guilt and blame which affect both their help-seeking and compliance with treatment. These need to be addressed when working with SUD. SUD-awareness campaigns should focus on educating about SUD, rather than only the substances. This will lead to a reduction in stigma and is likely to result in more people with substance abuse issues seeking help and subsequent treatment.

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LESSONS LEARNED

- Be aware of your own assumptions around SUD.
- Dismantle stigma, shame, guilt and blame, by educating your patient about the disease model and self-medication in SUD. Certain individuals may find this helpful in understanding past behaviours and it may encourage treatment compliance.
- A person with SUD is looking for meaningful relational connection and ways to cope with and regulate difficult emotions.
- Explore whether your patient has a history of trauma and/or any psychiatric condition in addition to the SUD, and then refer to appropriate help.
- There are different pathways to addiction and recovery – one size does not fit all. Work with your patient to find the various recovery resources that best suit them.

DECLARATION

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