Chapter Fifteen: Substance Use Disorder: Myths and Misconceptions

People often ask how I continue to find the motivation to inspire others to believe r*ecovery is possible* when so many people still relapse, or even die, as a result of substance use disorder. My motivation comes from knowing millions of people in long-term recovery are working alongside allies like me, and the recovery community, in order to change the face of addiction. We believe education and support help eradicate the stigma and shaming judgment that often prevent people with SUDs and those who love them from reaching out for help and recovering. As a recovery coach who supports both individual clients with SUD and their loved ones, I encounter many persistent myths and misconceptions about substance use disorders. As a professional in the field, and a parent whose child has died from addiction, it's important for me to do everything I can to quell these misunderstandings about addiction so others can find help—and then succeed in recovery.

Myth: Addiction is a character defect.

The most prevalent, and perhaps most dangerous myth is the belief that addiction is a character defect and/or a moral failing. Personally, this was the hardest myth for me to overcome when I first found out that Aaron was addicted to opioids. Many people are unable to comprehend that addiction is a *progressive brain disease* that is fatal without intervention. The *Medical Dictionary* confirms addiction is a disease that worsens over time, and becomes fatal unless it is treated. The National Institute on Drug Abuse (NIDA) defines addiction as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences." These two sources echo many other medical professionals who define substance use disorder as a brain disease. Although addiction may eventually affect the personality of a person, it originates in the brain, not in one's character.

Myth: Those with substance use disorder choose addiction.

This myth supports denial, and also drives the stigma of addiction. The general public's perception is that those with a substance use disorder make a choice to become addicted because they chose to use the addictive substance in the first place. People cannot, however, predict the effect certain chemicals will have on their brains. It simply does not reason. Take allergies as an example. The first time you eat peanuts you may not experience a reaction. But, the second or third time you may have shortness of breath, hives, redness, or swelling. If your body didn't show any allergic symptoms the first time you ate peanuts, it didn't mean you weren't allergic to them. Most of the time it takes more than one exposure to a substance or food before an allergic reaction becomes evident. You chose to eat the food with peanuts, but your body's allergic reaction to the peanuts was not anything you were able to predict or choose. Using a substance once or even a couple of times, and not having it turn out the way you expected, has nothing to do with choice. The same kind of principle is in place when our brains are exposed to addictive substances.

> According to Dr. Raju Hajela, past president of the Canadian Society of Addiction Medicine, and 2011 chair of the America Society of Addiction Medicine (ASAM):
> The disease [of addiction] creates distortions in thinking, feelings and perceptions, which drive people to behave in ways that are not understandable to others around them. Simply

> put, addiction is not a choice. Addictive behaviors are a manifestation of the disease, not a cause.
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> This sentiment is echoed by Dr. Michael Miller, past president of the ASAM who says:
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> "Choice still plays an important role in getting help. While the neurobiology of choice may not be fully understood… [the person] must make choices for a healthier life in order to enter treatment and recovery… Many chronic diseases require behavioral choices… we have to stop moralizing, blaming, controlling or smirking at the person with the disease of addiction, and start creating opportunities for individuals and families to get help.

Myth: Recovery from substance use disorder is simply a matter of willpower.

Another prominent misconception about recovery from SUDs is that it is simply a matter of engaging the correct amount of willpower. Once the brain chemistry has been altered (and the time this takes varies from person to person), recovery from the addiction involves much more than simple willpower. *In fact the person's inability to engage his willpower, and stop using the mind-altering chemical, is a symptom of a substance use disorder***.** In "Principles of Drug Addiction Treatment: A Research-Based Guide," Alan Leshner, Ph.D. and former Director for the National Institute on Drug Abuse (NIDA) describes the brain disease process of a substance use disorder:

> Every type of drug of abuse has its own individual mechanisms for changing how the brain functions. But regardless of which drug a person is addicted to, many of the effects it has on the brain are similar…The drug becomes the single most powerful motivator in the drug abuser's existence. He or she will do almost anything for the drug… Research shows that long-term drug use actually changes a person's brain function causing them to crave the drug even more, making it increasingly difficult for the person to quit. Especially for adolescents, intervening and stopping substance abuse early is important as children become addicted to drugs much faster than adults and risk great physical, mental and psychological harm from illicit drug use.

At this stage of the illness, the person with the SUD *is not using* because she is enjoying the high. "Failing to stop using isn't driven by a mere lack of willpower. It's driven by the changes to structures and function of brain cells that have morphed into a 'new normal,' which requires a base-level of intoxication to function," says Dr. Leshner. They are using the substance to avoid the physical, emotional, and psychological repercussions of withdrawal. They are using to feel *normal*.

Myth: People with substance use disorder lack intelligence or drive.

This is evidenced by Dr. Albers' quote in Chapter Nine about stigma, and his reference to addiction being "equal-opportunity" illness. This disease does not prey only on the lazy or unintelligent. In fact, research by the National Child Development Study in the United Kingdom shows that "very bright individuals—those with IQs above 125—are more likely to take psychoactive drugs…than those with IQs below 75." Another long-term study conducted by the

British Health Service "revealed that intelligent people (IQs of 125 or greater) were also more likely to be alcoholic." The working theory is that intelligent people seek out new and novel things, and therefore are more likely to experiment with new substances.

Indeed, maintaining a steady supply of costly, and perhaps illegal drugs or alcohol, requires a great deal of intelligence and effort. As a loved one becomes hostage to her disease, we may see her do things to satisfy her cravings we never could have imagined, yet it takes an undeniable amount of drive to pull it off time and time again. As the disease progresses, and her drug use escalates from just *chasing a high* to *desperately avoiding withdrawal*, the drug-seeking behavior becomes more than a full-time job. People with SUD must be on duty to their cravings 24 hours a day, seven days a week.

Aaron said to me once, "There is never a vacation from being a junkie. It's a full-time job."

Myth: Addiction could never happen to me, or a loved one.

This myth helps sustain a sense of denial; it's the belief that people with SUDs are always "someone else"—*not me, not my child, my wife, my husband, brother, or sister.* Carol Falkowski, former Director of the Alcohol and Drug Abuse Division for the State of Minnesota, believes this denial is the most powerful myth about substance use disorders. When coupled with the stigma of misunderstanding addiction as a moral weakness, denial fuels preconceived stereotypes about those with substance use disorders. Regardless of the image people have in their heads when they picture a "typical" person with a SUD, expert research continues to show us that people with substance use disorders come from all walks of life. No group is immune.

Bridget Kuehn, senior staff writer for JAMA's "Medical News & Perspectives," reported in her survey for the May 28, 2014 issue of *JAMA Psychiatry* how the profile of those with opioid substance use has dramatically changed in the last ten years:

- In the 1960s, approximately 82 percent of users were young men (mean age 16.5 years) who began their opioid use with heroin.
- More recent users were older (mean age 22.9 years), and included men and women living in less urban areas, 75 percent of whom were introduced to opioids through prescription drugs.
- There was equal representation of whites and non-whites who used prior to the 1980s, but in the last ten years this has shifted to nearly 90 percent of the participants being white.

Although these respondents said that the "high" heroin produced was a significant factor in its selection, it was often used because it was more readily available and much less expensive than prescription drugs. Their data shows that over the last fifty years, heroin addiction has migrated from a low-income, inner-city, minority-centered problem to one primarily involving white men and women in their late twenties living in affluent suburban and rural areas.

Myth: Opioid addiction begins with heroin.

As I explored how myths about SUDs present barriers to recovery, I asked William Cope Moyers, Vice President of Public Affairs and Community Relations for the Hazelden Betty Ford Foundation, what he saw as the biggest myth concerning opioid addiction. He pointed to misperceptions about how people first come to use heroin and other opioids, saying, "Pain meds [medications] are the 'Trojan Horse' of addiction, especially among [recovering] alcoholics and addicts with long-term sobriety; you don't have to use heroin to be an opiate addict." The information and statistics in Chapter Eight confirm Moyer's concern about the pathway to opioid addiction which often begins with legal prescription pain medication. "*Americans, constituting just 4.6 percent of the world's population, have been consuming 80 percent of the global opioid supply and 99 percent of the global supply of hydrocodone, the generic name for the drug Vicodin, a prescription opioid (pain medication).*" With this level of consumption, it's not hard to understand the epidemic proportions of overdose deaths from prescription pain medication. In 2013 the Center for Disease Control (CDC) reported 16,235 deaths involving opioid analgesics (prescription pain medication). From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics (prescription pain medication) nearly quadrupled from 1.4 to 5.1 per 100,000.

Myth: Deaths from car accidents and gunshot wounds outnumber substance-use related deaths in the U.S.

Although the following statistics were already listed in Chapter Two, they bear witness to this myth.

- In July of 2014, the U.S. Department of Justice stated that on average 110 Americans die from drug overdoses every day, outnumbering even deaths from gunshot wounds and motor vehicle crashes.
- The Center for Disease Control, in their 2015 vital statistics, updated that number to 120 Americans dying every day from drug overdoses. They also stated that 6,748 U.S. citizens are treated in emergency rooms every day for overdose-related issues.
- The numbers average out to an overdose-related hospitalization every 13 seconds, and an overdose death every 13 minutes for American.

When I present this information in a public forum, I am always astounded at the lack of response to these numbers until I make it more personal. I place my hand on the shoulder of someone in the audience and say, "How would you feel if a hundred-twenty John Smiths (not their real name) died in an airplane crash every day, 365 days of each year, and the number kept increasing every year—because that is what has happened to deaths from drug overdoses for the last ten years."

The other approach I use is to have approximately a hundred people stand up. Then I say, "What would you do if you had a hundred family members and friends die every single day?"

This is usually (not always) when my audience begins to get nervous and stir in their seats. A few will speak up and say, "Why didn't I know this is happening?" I respond by saying I believe this lack of awareness is simply one way the continual stigma and denial about the prominence of SUDs is played out in our society. Bringing awareness about the lives being lost to this disease is the first step in changing this epidemic of deaths.

Substance use (including tobacco, alcohol, and illicit drugs) creates a price tag for the U.S. economy of over $600 billion annually in criminal justice costs, lost work productivity, and healthcare. Adler et al., states these conservative estimates in "Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)." He states that every dollar invested in substance use disorder treatment programs yields a return of between $4 and $7 in reduced substance use-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1. Emergency rooms (which are the least cost-effective), are often used for crisis intervention by those with SUDs because it is their only alternative if they don't have adequate insurance.

Not long ago, I applied for a grant-supported position, which included creating a day treatment program. During the interview, I was told one of the main measures of my success would be finding *a way to decrease (not eliminate) the number of emergency room visits* made by the homeless and jobless population I would be serving. It was their belief that a day treatment program has the potential to provide relapse prevention tools, along with the ongoing support and sense of community this population needed in order to cope with their SUDs. This in turn could reduce the number of hospital emergency rooms visits, thereby lowering the cost of care. Substance use disorder treatment *can* offer major savings to the individual and to society. When people receive the proper care, there is reduced interpersonal conflict, greater workplace productivity, and a reduced number of substance use-related accidents, including overdoses and deaths.

Myth: Incarceration is a positive intervention for substance use disorders.

We may be able to cut off access to drugs and alcohol by arresting and incarcerating people, but we can't "scare" those with substance use disorders into recovery. When threatened with arrest/incarceration, rational people modify their behavior. For those with a substance use disorder, the emotional and physical need for their substance of choice completely outweighs the threat of negative consequences. Relapse is almost guaranteed if the individual isn't motivated and engaged to recover. When the Betty Ford Foundation Institute Consensus Panel convened June 1, 2007 to define recovery, they also aligned with the concept that recovery doesn't happen by coercion. The panel stated, "Recovery is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."

In an article published in *Newsweek,* "The Case for Treating Drug Addicts in Prison," Mary Carmichael states, "Treatment can reduce recidivism rates from 50 percent to something more like 20 percent, according to the DEA [Drug Enforcement Agency]." But few prisons offer SUD treatment. Carmichael goes on to say, "According to a report released last year [2010] by the National Institute on Drug Abuse, just one fifth of inmates get some form of treatment." This is yet another area where the imprisonment of people does not work in our country.

Myth: Harm reduction tools promote substance use disorders.

While many people are familiar with abstinence-based recovery models, programs using a newer approach called "harm reduction," are not as widely known or well understood. The Fact Sheet, "Harm Reduction: Preparing People for Change," provides this explanation of harm reduction as it applies to substance use disorders.

> Harm reduction is an approach for substance use treatment that involves a set of practical techniques that are openly negotiated with clients around what is most likely to be achieved… By incorporating strategies on a continuum from safer drug use, to managed substance use, up to abstinence, harm reduction practice helps clients affect positive changes in their lives. The focus is on reducing the negative consequences and risky behaviors of substance use; it neither condones nor condemns any behavior.

In the harm reduction model, the focus is on reducing harm, not consumption, and there are no pre-defined outcomes. The individual is treated with dignity, is expected to take responsibility for his own behavior, and always has a voice in the harm reduction support he receives. Harm reduction tools include (but are not limited to): medication-assisted treatment (MAT), syringe exchanges, individual therapy and support groups for those still actively using, and the distribution of naloxone kits. Although MAT is often considered a harm reduction tool, when it is used as part of a residential SUD treatment program, or offered through outpatient clinics, there may be many more parameters around how it is initiated and monitored. The length of time and type of MAT medications used may vary greatly between people.

Aaron made very positive steps in his recovery using harm reduction tools made available to him at *Access Works,* a harm reduction organization in Minneapolis, which has since lost its funding. I learned about *Access Works* when Aaron finally mustered the courage to tell me he was volunteering there, and using their syringe exchange program. I was thrilled to hear he was volunteering somewhere, but since I was completely ignorant about harm reduction and its philosophy, I was mortified to think someone was "encouraging" my son's OUD by providing him with syringes, albeit safe and clean ones.

When Aaron first told me about *Access Works*, he must have seen my shocked expression. As I opened my mouth to say, "What????" he blurted out, "Mom, *please* listen! It's the first place I have felt accepted in a long time. They even have drop-in groups where I can talk openly about my life. The people running the groups have been where I am with my use; they understand how hard withdrawal is, and how difficult it is out on the street. Seeing these guys who have been where I am, and who have reached the point where they can run these groups, makes me feel better about myself, and gives me a little hope."

Later I found out this was one of the first places Aaron learned about MAT and methadone. During one of his longest periods of recovery, he spent several hours a week volunteering not only at the *Access Works* needle exchange, but also answering the phone. He even applied for a paid position. Although he did not get the job, his experience there was very positive, and it was a great example of how harm reduction can play a very positive role in the recovery of someone with a SUD.

Myth: Long-term recovery can't happen—especially for opioid addiction.

While substance use disorder can be unrelenting, it is indeed possible to quit using, and experience sobriety. Many people have succeeded in achieving long-term recovery, and are living happy, productive lives. Bruce Larson, Director of Clinical Services at Hazelden Betty Ford Foundation, believes the biggest myth of OUD is "that long-term recovery isn't possible from opioid addiction in general, and even worse from heroin addiction." He goes on to say:

> That simply isn't true. Yes, opioid addiction is tough, chronic, and [it] can include return to use and relapse. But with good service and support over time, recovery is possible; even long-term recovery without intermittent relapses or more prolonged and complicated relapses. There are many, many, many, opioid addicts…in recovery staying clean and sober, beginning to, or already thriving in many areas of their life.

His thoughts are confirmed by statistics from the recent revolutionary recovery documentary, *The Anonymous People*, which states that 23.5 million people in the United States are living in long-term recovery from addiction to alcohol and other drugs.

The media's relentless depiction of people in active addiction, such as Whitney Houston and Charlie Sheen, and their sensationalized coverage of the deaths of others like Philip Seymour Hoffman and Amy Winehouse, continue to fuel addiction's stigma. According to *The Anonymous People* documentary, the perpetuation of "a lurid public fascination with the dysfunctional side of what is a preventable and treatable health condition" dominates what we hear and see about SUDs. This public fascination then becomes the myth that people in recovery are "damaged goods," says Adi Jaffe, Ph.D., a Los Angeles-based substance use disorder psychologist and researcher, who once used illicit drugs and was convicted of dealing drugs. The everyday people, leaders, volunteers, corporate executives, and celebrities featured in *The Anonymous People* are in long-term recovery, and are speaking out about their recovery so the public can see and hear that recovery does indeed work for millions of people.

Although Alcoholics Anonymous (AA) is the most recognizable form of self-help recovery groups, only two million out of the 23.5 million people in recovery in the United States have recovered through AA, according to the General Service Organization (GSO) of AA. (The information shown here is based on reports given by groups listed with the GSO and does not represent an actual count of those who consider themselves AA members.) "While there are plenty of cases where abusers struggle for years to overcome a drug addiction, many more cases reveal the opposite—short-term users who manage to put the past behind them and lead normal and productive lives," says, Adi Jaffe, Ph.D.

The National Institute on Alcoholism and Alcohol Abuse states that 75 percent of alcoholics recover without any treatment.

We need to spread the word about the success of recovery, and counter the media's focus on those actively pursuing their substance use. It is the responsibility of those of us in recovery, as well as those of us who are allies (addiction disorder professionals, friends and loved ones of those recovering from SUDs), to educate the public about the millions of people who are in recovery, have careers, raise families, pay taxes, and volunteer in their communities and schools. Let's honor them by spreading the hope for recovery from substance use disorders, instead of perpetuating the destructive myths fostering the denial, stigma, and shame.