

# Substance Use: Addiction, Substance Use Disorder, Stigma, and SOT

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# Overview

- Setting the stage to de-stigmatize substance use, increase dialog, educate communities, and facilitate access to resources, treatment, and recovery
- What is substance use disorder?
  - Evidence and myths
  - Brief overview
  - Addiction and the brain
  - Addiction, behavior, social context
- Overview of Stigma about addiction and substance use
  - Sources of stigma
  - Words matter
- Application to refugee/SOT communities
- Challenges and successes in community outreach, education, and referral with SOT communities



# Substance use disorder

## What is Addiction? Disease? Disorder? Choice?

- High grade, cheap heroin flooded SE Asia in the 1970's
- An estimated 50% of enlisted U.S. army soldiers used opium or heroin during the Vietnam war, 10%-25% had opioid use disorder ("addicted")
- Drug testing was ordered and no one could board a plane home until negative urine test
- Army began a detoxification program
- Many soldiers stopped use, almost all who had a positive test had negative test the 2<sup>nd</sup> time
- Only 5% had a recurrence within 10 months, and 12% within 3 years, even though many were re-exposed to narcotics
- Heroin lost its appeal when the environment and context changed

# DSM-5 Diagnosis - Substance Use Disorder (SUD)

*Problematic pattern of use leading to impairment or distress within 12-month period*

- 1) Taken in larger amounts over longer period than intended
- 2) Persistent desire or unsuccessful effort to cut down or control use
- 3) Significant time spent in activities to obtain, use, or recover from effects
- 4) Craving or urges to use
- 5) Use results in failure to fulfill major role obligations
- 6) Continued use despite persistent or recurrent problems caused or exacerbated by use
- 7) Important activities given up or reduced because of use
- 8) Recurrent use in potentially dangerous situations
- 9) Use is continued despite knowledge of negative physical/psychological problems caused by use
- 10) Tolerance
- 11) Withdrawal

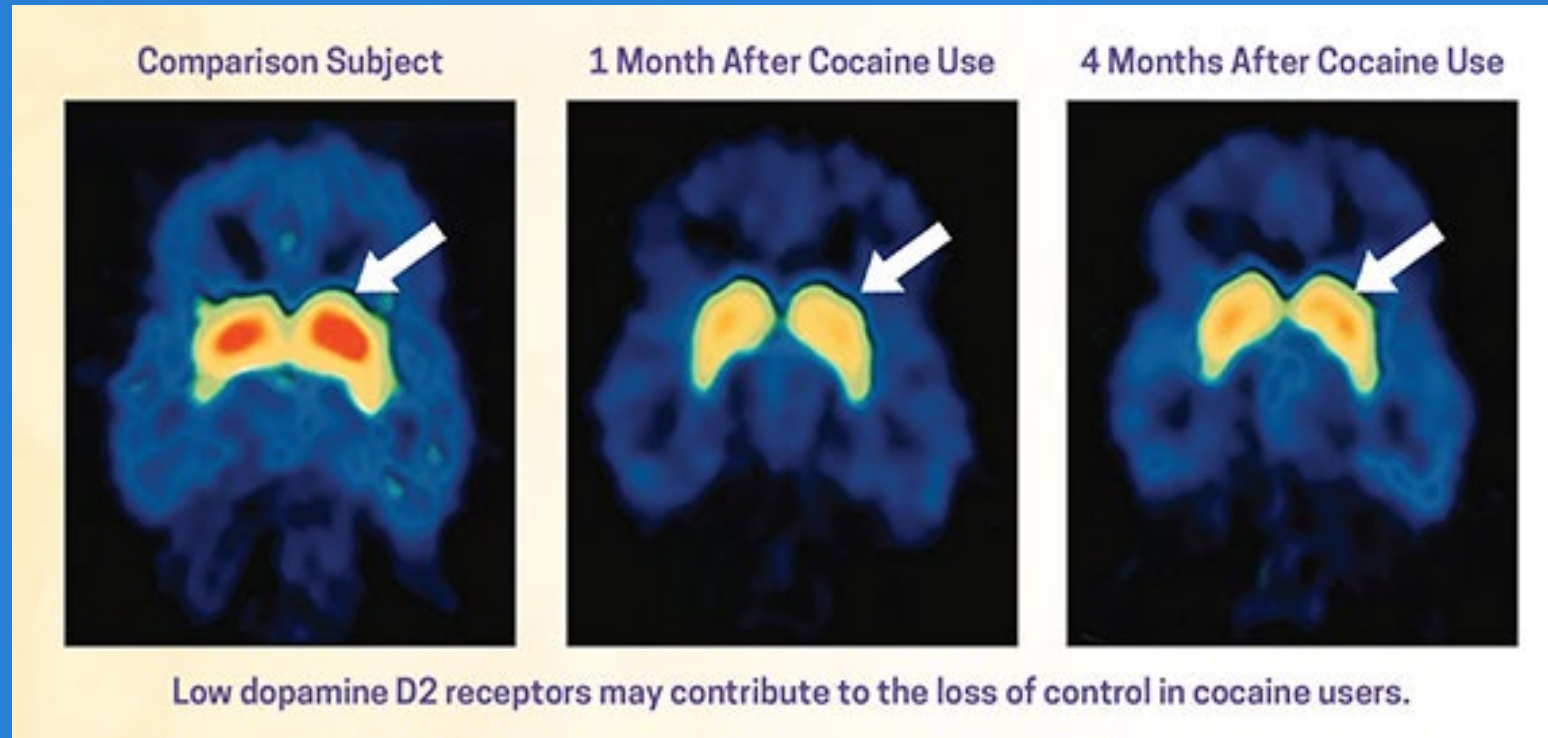
# Is this disorder a brain disease?

- It involves the brain and the reward system, but cannot be reduced solely to the concept of brain disease
- “Despite hundreds of millions of dollars spent on neuroimaging research, we still don’t have a scan that can reliably separate addicted people from casual drug users or accurately predicts relapse.” (Szalavitz, 2016)
- Substance use DOES change the brain.
- Repeated substance use, e.g., alcohol, amphetamines, opioids, make permanent alterations to the brain and how it functions
- Weakened executive function
- Strengthened reward function

Choice to use a substance

→ Changes in the brain

→ Development of Substance Use Disorder



# Multiple levels of complexity

- One argument is that SUD “... isn’t simply a response to a drug or an experience—it is a *learned pattern of behavior* that involves the use of soothing or pleasant activities for a purpose such as coping with stress.”
- Evidence is clear that use of same substance and dose in novel situations (different context) can result in different response to substance, including overdose –context is essential to learning, e.g., heroin and soldiers
- Each dimension, genetic, neurobiological, behavioral, psychological, social must be considered
- Some dimensions are more important than others for different purposes

# SUD is a complex disorder involving behavior and the brain

- Although changing behavior can lead to improvements, substance use disorders are not simply a consequence of character flaws, weakness, or immorality
- Learning is involved, but it is more complex than that alone
- Treatment of substance use and addiction is most effective when it addresses all levels including the pharmacological and behavioral together
- Consequently, compassion, understanding of the processes that produce and maintain addiction, recognition that conceptualizing SUD isn't a choice between "bad" or "sick" is essential in treatment and recovery
- Because of the neurobiological components, it is important and useful to understand that there very often is a limitation in behavioral control
- That factor is an essential aspect of SUD

# Social and contextual vulnerabilities

- Addiction is often called a disease of isolation
- As one example, during COVID pandemic/shutdown, drug and alcohol use, binging, and overdoses increased dramatically
- Many in our SOT communities are isolated
- Increases vulnerability to developing problematic use
- Stigma reinforces isolation and is one barrier to prevention and treatment
- However, in some communities use is social

Is it a choice? Is it an illness? It is both...

**Lack Of Exercise / Poor Eating Habits affect the heart:**

**Get heart disease (Chronic disease)**

**Smoking affects the lungs:**

**Get lung disease (Chronic disease)**

**Opiate Use affects the brain:**

**Get brain disease (Chronic disease)**

# Substance Use is most stigmatized “mental health” condition

- Public Stigma
  - Social and cultural negative beliefs toward those with substance use disorder (including among health care professionals)
- Self-Stigma
  - Negative beliefs about substance use individuals hold toward themselves
- Structural stigma
  - Systemic rules, policies, and practices that discriminate against individuals who use drugs

Krendl, A. C., & Perry, B. L. (2023). Stigma Toward Substance Dependence: Causes, Consequences, and Potential Interventions. *Psychological Science in the Public Interest*, 24(2), 90-126.



# Stop Talking ‘Dirty’: Clinicians, Language, and Quality of Care for the Leading Cause of Preventable Death in the United States

A patient with diabetes has “an elevated glucose” level. A patient with cardiovascular disease has “a positive exercise tolerance test” result. A clinician *within* the health care setting addresses the results. An “addict” is not “clean”—he has been “abusing” drugs and has a “dirty” urine sample. Someone *outside* the system that cares for all other health conditions addresses the results. In the worst case, the drug use is addressed by incarceration.

On December 9, 2013, the first ever national drug policy reform summit was held at the White House. A major thrust of this summit was to mark a philosophical shift away from the “war on drugs” and toward a broader public health approach. Much of the summit was devoted to addressing the stigma surrounding addiction and the under-recognized importance of language.

Stigma is defined as an attribute, behavior, or condition that is socially discrediting. It is important because of the 23

despite harmful consequences. Yet, despite evidence of a strong causal role for genetics and impairment in inhibitory control, stigma is alive and well. Research is now revealing that one contributory factor to the perpetuation of stigma may be the type of language we use.

Use of the more medically and scientifically accurate “substance use disorder” terminology is linked to a public health approach that captures the medical malfunction inherent in addiction. Use of this term may decrease stigma and increase help-seeking. In contrast, tough, punitive, language, including the word “war,” in “war on drugs,” is intended to send an uncompromising message, “You use, you lose,” in the hopes of deterring drug involvement. Accompanying this aggressive rhetoric are terms such as drug “abuse” and drug “abusers,” implying willful misconduct (ie, “they *can* help it and it *is* their fault”). This language increases stigma and reduces help-seeking.

“Substance Abuser”

Mr. Williams is a substance abuser and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs. He has been compliant with program requirements, until one month ago, when he was found to have two positive urine toxicology screens which revealed drug use and a breathalyzer reading which revealed alcohol consumption. Within the past month there was a further urine toxicology screen revealing drug use. Mr. Williams has been a substance abuser for the past few years. He now awaits his appointment with the judge to determine his status.

“Substance Use Disorder”

Mr. Williams has a substance use disorder and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs. He has been compliant with program requirements, until one month ago, when he was found to have two positive urine toxicology screens which revealed drug use and a breathalyzer reading which revealed alcohol consumption. Within the past month there was a further urine toxicology screen revealing drug use. Mr. Williams has had a substance use disorder for the past few years. He now awaits his appointment with the judge to determine his status.

**Figure 1** Randomly assigned study vignettes describing the same individual as either a “substance abuser” or as “having a substance use disorder”.

Choose  
supportive,  
nonjudgmental  
words that treat  
people with  
respect and  
compassion.

Instead of this...	Say this*
Abuse Drug problem/habit	1.Substance Use Disorder (SUD), addiction (if clinically accurate) 2.Use (for illicit drugs); misuse, (for prescription drugs)
Addict Druggie/Drug Abuser Junkie	<ul style="list-style-type: none"> <li>•Person with a SUD (person with OUD if relevant)</li> <li>•Patient with a SUD (if in a clinical setting)</li> </ul>
Addicted to [ x ]	Has a [ x ] use disorder
Clean or Stayed clean	Substance-free

# Stigma, Culture, Language, SUD, and SOT

- SUD is stigmatized across cultures
  - Stigma is not unique to our refugee SOT groups
  - Degree, specificity, and manifestation of stigma varies
  - There are commonalities and unique features
- Tight knit communities may provide support
- Tight knit communities may increase secrecy and sense of shame (social stigma and self-stigma)
- Community structure may reduce isolation
- Community structure may contribute to isolation

# Connecting Cultures and our emerging approach

- Will discuss mostly specifics with Nepali/Bhutanese community
  - So far, that is the most extensive work we have done
  - Additional engagement with Sudanese community
- Conversations with cultural brokers
- Cultural brokers and case managers engaged formally and informally with community
- Discussions of concerns about family members and friends
- Discussions of broader concerns in the community with growing substance use and associate problems

# Initial, formal community outreach

- Organized afternoon event at community center (Association for Africans Living in Vermont (AALV))
  - Community partner with Connecting Cultures/NESTT
  - Many events across SOT communities
  - Cultural brokers
  - Case managers

PLEASE JOIN!

LET'S DISCUSS ALCOHOL AND SUBSTANCE  
USE.



**Is substance use affecting your  
or your loved one's relationships?**



**Is substance use interfering  
with your or a loved one's  
work or daily activities?**

**We are here to help!!  
Let's discuss how to make  
healthy choices!**

AALV - FCCM 313  
SATURDAY, OCTOBER 14, 1:30 PM-3:00PM

Tea and food will be available. If you participate in this event, a gift card will be provided!



IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT:  
URMILA CHETRI: 802-825-3658 | JEETAN KHADKA: 802-777-1735



# Community outreach event

- Overall goals
  - Increase engagement and dialog
- Provide initial de-stigmatizing education about and discussion of SUD
- Language and cultural competence
  - No words in Nepali for key factors such as dopamine, amygdala

# Framework

- Informal overview provided by cultural brokers
- Prompted discussion of observations of substance use
- Discussion of specific concerns
  - Self
  - Family members
- Addiction and the Brain
  - Overview and discussion

# Addiction and the Brain

- Balance between rational decision making (executive function) and pleasure (reward system and dopamine)
- Discussed addiction and the brain using metaphors
  - Executive function and decision making
    - “Stop system like brakes on a car”
    - Helps to stop harmful choices
  - Reward system, dopamine
    - “Go system like gas pedal in a car”
    - Pursue good feelings
    - Chemical in brain stimulated by use, feels good
  - Use leads to weaker stop system and stronger go system

# Response and follow-up

- Provided resources
  - Follow-up with AALV/CC
  - Community resources
- High level of engagement
- Acknowledgment and recognition of problem in the community
- Community requested additional community outreach to engage more broadly

# Specific factors in Nepali/Bhutanese community (participant comments)

- Drinking and tobacco use are the temporary solution to problems in the household. The primary provider of the family has a lot of burden.
- Would help to engage more women as they are primarily supporter of households
- Many men in Bhutanese community sense of brotherhood while drinking.
  - Discuss their feelings, problems, and grief with friends while drinking.
- When they are drunk may “show off” masculinity by boasting about how much they can drink still to drive
  - Many DUIs.
- Alcohol use increases domestic violence and negative effects on children and family relationships
- Many different drugs used among younger people (e.g., cocaine, opioids)

# Next steps and obstacles

- Limited treatment resources
  - Too few treatment programs
  - Inpatient severely limited by capacity and waitlists
  - Limited knowledge and implementation of cultural factors among treatment providers
  - Even fewer programs work with interpreters
  - Lack of Provide community resources for men to engage without alcohol
- Case examples to illustrate
  - Family and person engaged, but
  - Severe problem (divorce, lost job, lost insurance)
  - High need for case management and treatment (often the case)
  - Youth/young men

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# NAVIGATING PARADOX: PROVIDING TREATMENT FOR SUBSTANCE ABUSE AMONG MUSLIM REFUGEES

Farid Alsabeh, LLP

Arab Center for Economic and Social Services (ACCESS)

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# MUSLIM REFUGEES AND SUBSTANCE ABUSE

- Substance abuse disorders (SUD) are increasing among Muslim populations in the West (Csiernik et al. 2023)
- Common substances include:
  - Alcohol
  - Tobacco, nicotine, khat (cigarettes, vapes, and hookah)
  - Opioid abuse

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# RELIGION AND CULTURAL MATCH: DOUBLE-EDGED SWORDS

- Islamic doctrine prohibits the consumption of intoxicating substances
- Repentance in Islam involves the sincere intentions of the repentant
- Religion can play two roles:
  - Positive, protective factor, by discouraging use
  - Negative, stigmatizing factor, by discouraging treatment
- Similarly, clinician match can play two roles:
  - Positive, by establishing a shared experience and knowledge of cultural and religious norms
  - Negative, by recapitulating feelings of shame

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# COMMUNITY ENGAGEMENT

- Community resources play a vital role in the treatment and prevention of SUD among Muslim refugees
- Clinicians can engage in local places of worship to:
  - Disseminate psychoeducation
  - Develop partnerships with religious leaders
  - Find sources of social support for clients

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# TREATMENT RECOMMENDATIONS

- Identifying risk factors
- Navigating protective and risk factors unique to the Muslim refugee population
- Mobilizing community resources

# ACCESS Mission and Vision

## **Our Vision**

- A just and equitable society with the full participation of Arab Americans.

## **Our Mission**

- To empower communities to improve their health and their economic, social and cultural well-being.

# ARAB COMMUNITY CENTER FOR ECONOMIC AND SOCIAL SERVICES

Vision: A just and equitable society with the full participation of Arab Americans

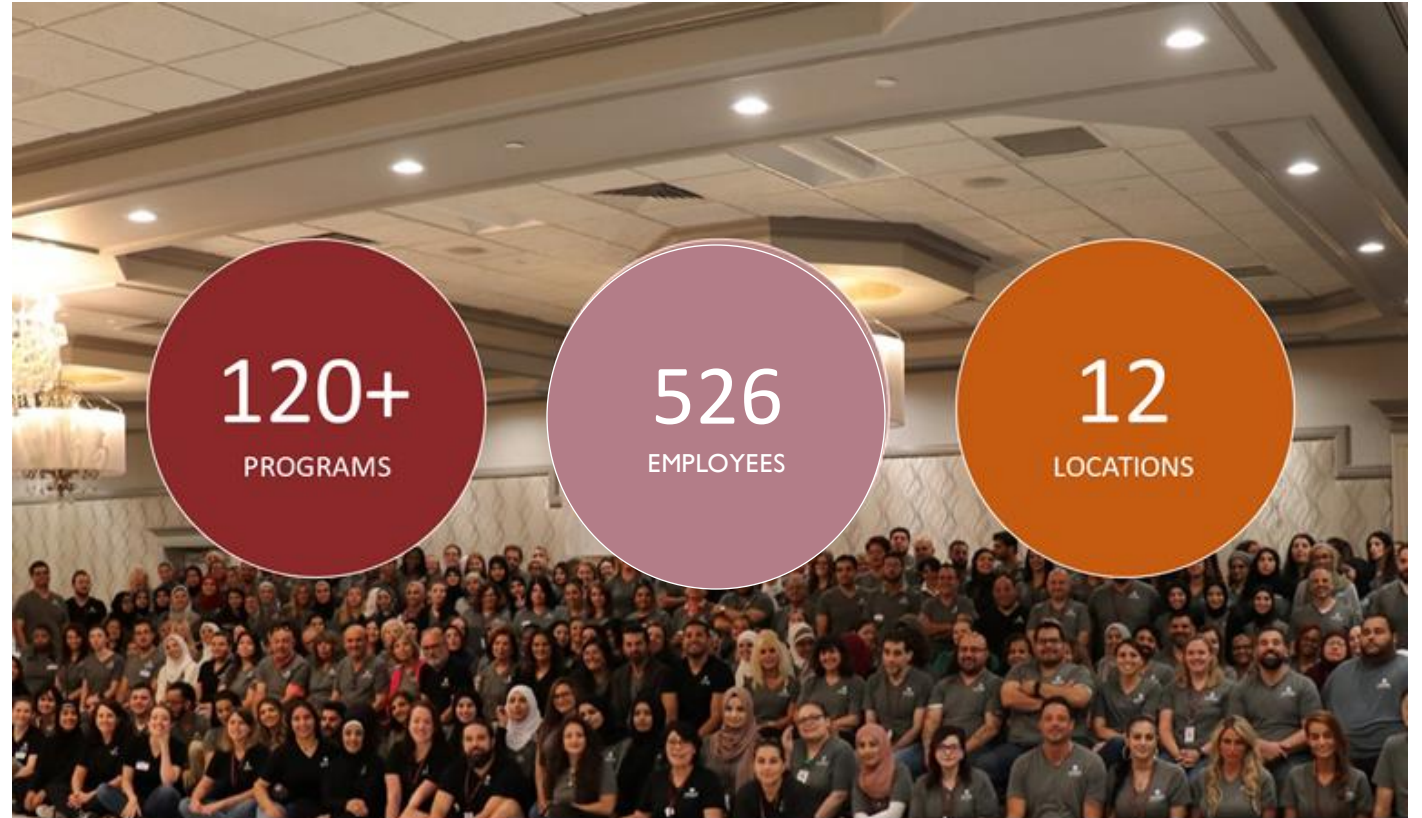
Mission: To empower communities to improve their health and economic, social and cultural well-being.

## Waves of Arab Immigration

First wave (1880s-1920s): Employment

Second wave (1950s-1960s): “Brain-drain phenomenon”

Third Wave (1970s-Present): Chain migration, war, and political conflict



# ACCESS NATIONAL EFFORTS

## Arab American National Museum

- Est. 2005
- The only cultural institution that documents, preserves and presents the history, culture and contributions of Arab Americans

## National Network for Arab American Communities

- 27 member organizations
- 12 states

## Center for Arab American Philanthropy

- Established 2010; the only Arab American community foundation in the country
- Houses more than 200 funds
- Awarded \$16,938,444 in grants to organizations around the world
- Awarded \$1,467,960 in scholarships

## ACCESS DIVISIONS

### Health & Wellness

- Medical
- Public Health
- Behavioral Health
- Research

### Education

- Youth and Young Adult Programs
- Adult Programs
- Cultural Competency

### Youth

- Academic Enrichment
- Youth Empowerment
- Recreational Programs

### Employment Services

- Entrepreneur Program
- Career Path to Self-Sufficiency Project

### Human Services

- Basic Needs
- Immigration/Citizenship
- Translation
- Financial Stability

### National Programming

- Arab American National Museum
- Center for Arab American Philanthropy
- National Network for Arab American Communities

# ACCESS RECOVERY CENTER



- The new three-level, 51,000 square foot, shovel-ready project will provide comprehensive, wrap-around services, including:
  - 15 Crisis Stabilization Unit (CSU) Beds catering to periods of up to 72-hours
  - 10 Medical Detox Beds, and 15 Short Term Residential Beds.
  - 5 SCU Triage Beds tailored for stays within 24 hours
  - Rapid detox management
  - Short-term residential services
  - Induction and management of Medication Assisted Treatment, including buprenorphine and naltrexone
  - Bilingual/bicultural outpatient therapy and peer recovery
  - Case management and wraparound family support services
  - Arab American community outreach and engagement/stigma reduction
  - Wellness classes, including yoga and chiropractic care for pain management
  - Harm reduction and rapid overdose response services
- The Center will fill critical gaps in outpatient treatment services across Detroit, Dearborn and Dearborn Heights, particularly among underserved Arab American residents.



## CONTACT US



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