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Continuing Education

# Beyond Niceness: Rethinking Stigma Around Substance Use Disorders

Rebuilding Understanding, Reclaiming Humanity



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# Introduction

Substance use disorders (SUD) are among the most misunderstood medical conditions. Stigma within healthcare contributes to barriers in care, perpetuating feelings of shame and isolation for patients. For behavioral health professionals, this stigma undermines the therapeutic relationship, which is foundational to client progress.

This guide offers practical insights grounded in evidence to help behavioral health professionals create stigma-free environments. By re-evaluating our language, behaviors, and biases, we can promote a more compassionate and effective approach to treatment for individuals struggling with SUD.

## Purpose and Scope

This guide explores the roots of stigma, actionable methods to combat it, and strategies to foster inclusive care. Together, we can ensure our practices respect the humanity behind every client's struggle.



# Understanding Common Substance Use Disorders

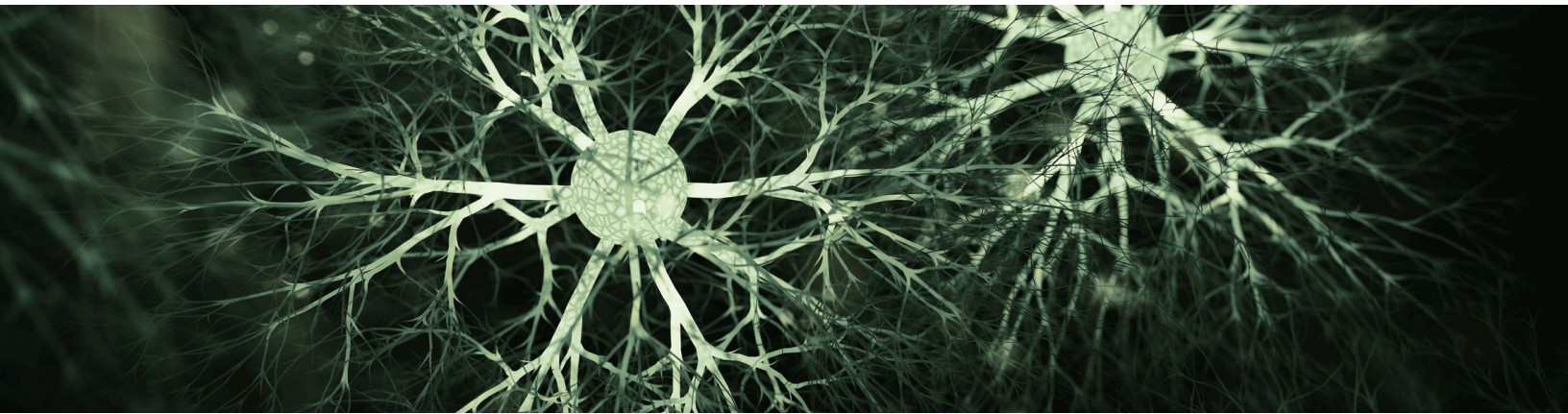
## Opioid Use Disorder

Opioid use disorder (OUD) is a complex condition characterized by a problematic pattern of opioid use that leads to significant impairment or distress. Understanding its causes, diagnostic criteria, and treatment options is the first step toward providing effective care and support for those affected. This overview summarizes key aspects of OUD, from its neurobiological roots to modern treatment approaches.

## The Development of Opioid Dependence

Chronic opioid use fundamentally changes the central nervous system. The brain's natural production of endogenous opioids decreases and eventually ceases, leading to physical dependence on external (exogenous) opioids. This process creates a neurobiological deficiency that drives compulsive drug-seeking behaviors.

The journey into opioid dependence often follows distinct stages, including initiation, continuation, withdrawal, and relapse. Certain risk factors can increase an individual's vulnerability to developing OUD. These include having a family history of substance abuse, co-occurring abuse of other substances like alcohol or marijuana, and social circles where opioid experimentation is common.



## Diagnosing Opioid Use Disorder

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) provides specific criteria for diagnosing OUD. A diagnosis requires at least two of the following criteria to be met within a 12-month period:

- Opioids are taken in larger amounts or over a longer period than intended.
- A persistent desire or unsuccessful effort to cut down or control use.
- Excessive time is spent obtaining, using, or recovering from opioids.
- Intense cravings or urges to use opioids are present.
- Recurrent use results in a failure to fulfill major obligations at work, school, or home.
- Use continues despite social or interpersonal problems caused by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced.
- Opioid use occurs in situations where it is physically hazardous.
- Use continues despite knowledge of having a physical or psychological problem likely caused by opioids.
- Tolerance develops, requiring increased amounts of the opioid to achieve the desired effect.

Clinicians may also use assessment tools like the Clinical Opioid Withdrawal Scale (COWS) to identify and measure the severity of withdrawal symptoms, aiding in a comprehensive evaluation.



## Treatment and Management Strategies

Managing opioid dependence involves several evidence-based approaches tailored to the patient's individual needs. Medication-assisted treatment (MAT) is considered a first-line treatment, combining pharmacotherapies with counseling and behavioral therapies. Key medications include:

- **Methadone and buprenorphine:** These long-acting opioid agonists stabilize brain neurochemistry, prevent withdrawal, and reduce cravings without producing the euphoric effects of short-acting opioids. They are highly effective at reducing illicit opioid use and mortality.
- **Naltrexone:** This opioid antagonist is used after medically supervised withdrawal to help prevent relapse.
- **Naloxone:** A short-acting opioid antagonist, naloxone is crucial for crisis intervention, as it can rapidly reverse the effects of an opioid overdose, particularly respiratory depression.

These medications, when combined with psychosocial support, significantly improve treatment retention and long-term outcomes.



## Harm Reduction and Prevention

Alongside treatment, harm reduction strategies are vital for minimizing the negative health consequences associated with opioid use. These measures aim to reduce morbidity, mortality, and public nuisance. Key harm reduction initiatives include:

- **Opioid Substitution Therapy:** Enrollment in methadone or buprenorphine programs substantially reduces the risk of overdose and the transmission of infectious diseases.
- **Needle-Exchange Programs:** These programs are proven to reduce drug-related health issues by providing sterile injection equipment and promoting entry into drug treatment.
- **Education:** Informing individuals about the dangers of polydrug use and providing resources for safer practices is a cornerstone of harm reduction.

## Methamphetamine Use Disorder

Methamphetamine use disorder is a complex condition historically concentrated among White and rural populations in Western and Midwestern states. Recently, however, its reach has expanded, most notably affecting urban-dwelling gay men and individuals with existing opioid use disorders. As medical and mental health professionals, it is increasingly likely that you will encounter patients who have used or are currently using methamphetamine, making a thorough understanding of this disorder essential for effective care.

## The Scope of Methamphetamine Use

The appeal of methamphetamine often lies in its ability to produce intense euphoria, increase energy, and suppress appetite. It works by stimulating the release of key neurotransmitters—serotonin, dopamine, and norepinephrine—while blocking their reuptake, leading to heightened confidence and attentiveness.

Recent data highlights the scale of the issue, with approximately 2.5 million people aged 12 or older having used methamphetamine in the past year. This widespread use has also placed a heavy burden on healthcare systems, contributing to over 811,000 emergency department visits in a single year. Certain factors can increase the risk of developing a use disorder, including pre-existing conditions like depression, ADHD, and bipolar disorder, as well as a desire to enhance sexual pleasure.

## Effects and Co-Occurring Conditions

The effects of methamphetamine use can be divided into acute and chronic categories. Initially, users may experience increased self-esteem and a sense of well-being. However, chronic use can lead to severe consequences, including paranoia, insomnia, violent behavior, sexual dysfunction, and significant fatigue.

It is also common for individuals with methamphetamine use disorder to have co-occurring mental health conditions such as psychosis, major depression, anxiety disorders, and other substance use disorders. Withdrawal from methamphetamine is often characterized more by psychiatric symptoms than physical ones, which presents unique challenges for treatment.

## Pathways to Treatment and Recovery

Treating methamphetamine dependence is difficult due to high dropout rates, persistent cravings, and severe psychological symptoms. Psychosocial therapy remains the primary approach, as there are currently no FDA-approved medications specifically for this condition.

The Matrix Model is a comprehensive treatment framework that integrates cognitive, behavioral, and psychological strategies, focusing on structure, education, relapse prevention, and family involvement. Cognitive-behavioral therapy (CBT) is a cornerstone of this approach, helping individuals identify and change problematic behaviors. Tailored versions, such as Gay-Tailored CBT (GCBT), have shown positive results by addressing cultural aspects relevant to gay and bisexual men.

## Innovations in Therapeutic Approaches

Contingency Management (CM) is another effective behavioral therapy that reinforces abstinence by providing rewards, such as vouchers, for drug-free urine samples. This method has been shown to improve treatment retention and session attendance. Alongside behavioral therapies, researchers are exploring newer biologic therapies. Repetitive transcranial magnetic stimulation (rTMS), for instance, has demonstrated potential in reducing cravings and withdrawal symptoms.

While several medications like bupropion and mirtazapine have shown some promise in reducing cravings or withdrawal effects in specific studies, no single pharmacotherapy has emerged as a definitive solution. The combination of robust psychosocial support and emerging therapeutic technologies offers the most promising path forward for individuals seeking recovery from methamphetamine use disorder.

## Cocaine Use Disorder

Cocaine has been a drug of abuse for decades, but the rise of crack cocaine in the 1980s brought a new level of severity and urgency to understanding and treating its addictive properties. Cocaine use disorder is a complex, chronic relapsing disease defined by compulsive drug-seeking behavior. It leads to significant functional and molecular changes in the brain, impacting a person's life on multiple levels. Understanding the nature of this disorder is the first step toward effective treatment and recovery.

### What is Cocaine Use Disorder?

Cocaine use disorder (CUD) is a clinical diagnosis based on a pattern of behaviors that indicate a loss of control over cocaine use. According to the DSM-5, a person must exhibit at least two specific criteria within a 12-month period to be diagnosed.

These criteria include a persistent desire to cut down on use, spending a great deal of time obtaining or using the drug, and experiencing strong cravings. Other signs involve failing to meet obligations, continuing use despite social or interpersonal problems, and developing tolerance or withdrawal symptoms.





## The Effects of Cocaine on the Brain and Body

Cocaine is a powerful stimulant that produces short-term effects like euphoria, increased heart rate, and heightened alertness. However, with chronic use, the drug causes profound changes in the brain. It disrupts the dopamine system, leading to a depletion of dopamine reserves. This results in symptoms like dysphoria, anxiety, and paranoia.

Brain imaging studies show that long-term use can cause structural and functional damage to key brain regions like the prefrontal cortex, which is responsible for executive functions like decision-making and impulse control. This damage helps explain why it is so difficult for individuals to stop using the drug despite negative consequences.

## Evidence-Based Treatment Approaches

The primary goals of treatment for cocaine use disorder are to help the individual stop using the drug, remain in treatment, and prevent relapse. A three-stage psychosocial approach often forms the foundation of care, incorporating behavioral, cognitive, and psychological elements. Two prominent evidence-based therapies include:

- **Cognitive Behavioral Therapy (CBT):** This therapy helps patients identify and change destructive thought patterns and behaviors associated with drug use. Research shows CBT can improve treatment retention and lead to longer periods of abstinence.
- **Contingency Management (CM):** This approach uses positive reinforcement, such as vouchers or privileges, to reward drug-free behaviors. By providing tangible incentives for abstinence, CM increases the opportunity cost of using cocaine.

While there are no FDA-approved medications specifically for CUD, researchers continue to explore pharmacotherapy options that target the neurobiological components of addiction.

## The Path to Recovery

Recovery from cocaine use disorder is a long-term process that requires ongoing support. Preventing relapse is a critical component of treatment. This involves helping individuals identify and manage environmental triggers, such as contact with other drug users or high-risk situations. Comorbid conditions, particularly major depression, are common and can complicate recovery, making dual-diagnosis treatment essential.

Support systems like Cocaine Anonymous and Narcotics Anonymous, along with resources from organizations like SAMHSA and NIDA, provide invaluable community and assistance for individuals and their families on the path to recovery.



## Novel Psychoactive Substances

Novel psychoactive substances (NPS) represent one of the most significant challenges facing healthcare professionals today. These substances of abuse, either in pure form or preparation, are not controlled by international drug conventions but pose serious public health threats. Understanding NPS is crucial for effective patient care, as these substances often evade standard detection methods while causing severe toxicity that requires immediate medical intervention.

NPS emerge for several key reasons that healthcare providers should recognize. They typically enter the market when a substance shows commercial potential, has not yet been banned by regulatory authorities, or when there is increasing scarcity of an established drug.

The appeal of these substances lies in their ability to provide novel psychoactive experiences while potentially remaining legal. Many NPS have molecular structures similar to controlled substances but are slightly modified to circumvent existing drug laws, creating a dangerous cat-and-mouse game between manufacturers and regulators.

## Understanding the Six Major Categories of NPS

Healthcare professionals encounter NPS across six broad substance categories, each presenting distinct clinical challenges.

- **Stimulants** increase synaptic monoamine levels by acting as inhibitors or substrate releasers, targeting dopamine, serotonin, and norepinephrine systems. This leads to greater activation of postsynaptic receptors, producing stimulant, entactogenic, or hallucinogenic effects that can result in excited delirium and severe cardiovascular complications.
- **Synthetic cannabinoid receptor agonists (SCRA)** bind and activate CB1 receptors to produce euphoric effects but carry risks of severe agitation, psychosis, paranoid delusions, seizures, and long-term organ damage.
- **Classic hallucinogens** work through serotonin and dopamine receptor interactions, potentially causing neurological damage, seizures, and violent behavior.
- **Dissociatives** antagonize NMDA receptors, creating feelings of detachment that can lead to hallucinations, severe mood disorders, and schizophrenia-like psychosis.
- **Opioid receptor agonists** function as CNS depressants, carrying risks of respiratory depression, sedation, and the typical complications associated with opioid use.
- **Sedatives and hypnotics** suppress brain activity through GABA pathways, potentially causing respiratory and cardiac depression, confusion, and loss of coordination.



## Recognizing the Clinical Challenges

The clinical management of NPS presents unique challenges that require specialized knowledge. Standard drug toxicology screening often fails to detect these substances, making diagnosis difficult. However, NPS toxicity can be readily managed by identifying characteristic toxicity syndromes rather than relying on specific substance identification. Healthcare providers must recognize that severe NPS toxicities reflect dysregulation of autonomic, sympathetic, dopaminergic, and serotonergic systems.

Two particularly dangerous conditions require immediate recognition: excited delirium syndrome and serotonin syndrome. Excited delirium is a life-threatening state characterized by sympathetic hyperarousal, delirium, rhabdomyolysis, and violent behavior. Serotonin syndrome presents with psychomotor agitation and cognitive, neuromuscular, and autonomic symptoms, carrying a mortality rate of 10% to 15%. Both conditions require rapid, aggressive intervention to prevent fatal outcomes.



## Treatment Approaches and Management Strategies

Effective NPS toxicity management focuses on symptom-directed care rather than substance-specific treatments. Rapid sedation with benzodiazepines is essential, particularly for cathinone toxicity and serotonin syndrome. All toxicities involving hyperpyrexia require immediate aggressive cooling through high-rate IV fluids and external cooling measures. Healthcare providers should obtain standard illicit drug toxicology screening to anticipate potential drug interactions and determine monitoring needs.

Long-term management involves addressing lingering psychiatric symptoms with dopamine blockade using neuroleptics after medical stabilization. Treatment of NPS use disorders typically involves individual and group counseling, cognitive-behavioral therapy, motivational enhancement therapy, and 12-step facilitation programs.

## The Evolving Landscape and Prevention Focus

The regulatory landscape continues to evolve as the DEA places numerous NPS into Schedule I classification under the Controlled Substances Act. However, the NPS market growth is likely to continue, with emerging threats like fentanyl analogs and xylazine combinations presenting new challenges. The most effective measure against NPS-related problems remains prevention through education, particularly targeting adolescents, young adults, and the general public.

For healthcare professionals, staying informed about NPS trends, recognition patterns, and treatment protocols is essential. The intrinsic properties of these substances, their frequent adulteration with other compounds, and the prevalence of polysubstance use heighten the risks of overdose and toxicity reactions requiring urgent medical care. Your ability to quickly identify and manage these cases can literally save lives.

# The Stigma Surrounding Substance Use Disorders

## A Historical and Misguided View

SUD has been historically framed as a moral failing or lack of willpower, rather than as the medical condition it is. This misconception has perpetuated the stigma, making patients feel judged rather than supported.

## Common Forms of Stigma

- Use of demeaning language such as "addict" or "junkie."
- Implicit bias from providers (e.g., "drug-seeking" labels).
- Unreasonable expectations of recovery pace or stability.

Recognizing where stigma shows up is the first step to dismantling it.

# The Power of Language in Reducing Stigma

## Person-First Language

Words matter profoundly in shaping perception. For example, saying “*person with a substance use disorder*” instead of “*substance abuser*” places the humanity of the individual at the forefront.

## Eliminating Harmful Terms

Replace phrases like "clean" or "dirty" in drug screening contexts with factual, nonjudgmental terminology (e.g., “positive for fentanyl”). This shift reduces the implicit bias in clinical settings.

## Examples to Implement

- **Avoid:** "High-maintenance client."
- **Use:** "Client with complex treatment needs."

# Addressing Misconceptions and Implicit Bias

## Breaking Down Stereotypes

One of the most harmful myths is the belief that recovery is simply a matter of effort or willpower. Educating professionals on genetic, environmental, and neurobiological factors in SUD can challenge these biases.

## Reflecting on Personal Bias

Behavioral health providers must regularly examine their implicit biases. Are you less patient with clients using certain substances? Do you subtly express frustration or judgment during sessions? Honest self-assessment is crucial.



# Client-Centered Advocacy in Behavioral Health

## Meeting Clients Where They Are

Every individual's recovery is deeply personal. Clients may decline recommendations, but this does not justify assumptions about their willingness to heal. Advocacy means respecting their autonomy.

## Tools for Advocacy

- Normalize the use of Medications for Opioid Use Disorder (MOUD).
- Engage families in education to combat implicit biases at home.
- Reinforce that dependence is not equivalent to addiction.

# Practical Steps for Destigmatization in Care Settings

## Behavioral Changes

- Foster a welcoming office environment that avoids judgmental undertones (e.g., eye rolls, dismissive language).
- Set reasonable expectations for clients, especially early in recovery.

## Systems-Level Approaches

- Ensure policies support access to MOUD like buprenorphine or methadone without judgment.
- Standardize training in stigma reduction for all staff.

## Next Steps for Behavioral Health Professionals

Destigmatizing substance abuse requires both reflection and action. Language, provider behavior, and systemic practices all play significant roles in reinforcing or reducing stigma. Start implementing small, concrete changes today by reevaluating your communication and fostering empathetic care in every client interaction.

Join the effort to break down stigma in health care. Share these insights with your team and begin creating a culture of understanding and respect within your practice. Together, we can ensure every client receives the care and dignity they deserve.



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