Destigmatizing Alcohol Dependence: The Requirement for an Ethical (Not Only Medical) Remedy

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Abstract

The disease model of alcohol dependence or “alcoholism” is often presented as the linchpin in addressing the condition successfully. It has been argued, for example, that adopting a medical approach will reduce the stigma that impedes the provision and acceptance of treatment. However, the medical paradigm has existed for many years without significantly affecting the negative social attitudes that surround dependence.

I argue that a reductive scientific approach is not equipped to address the socioethical tensions that dependence creates.

To lessen the stigmatization of dependence, it is important to integrate ethical analysis into policy debates on the condition.

ALCOHOL DEPENDENCE, AS part of the broader category of substance dependence, is identified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition as “a cluster of cognitive, behavioral, and physiological symptoms” and is characterized by withdrawal, tolerance, and compulsive alcohol use. The dependent continue drinking “despite evidence of adverse psychological or physical consequences (e.g., depression, blackouts, liver disease …).” Dependent drinkers experience considerable disability as a result of their chronic substance use. The biopsychosocial nature of the condition and the influence of environmental factors on its psychobiological features is well established. In this respect, the availability of substances, low socioeconomic status, and stress exacerbate the condition.

The 2009 National Survey on Drug Use and Health estimates that 15.4 million people in the United States are dependent on or abuse alcohol, and another 3.2 million have similar problems with both illicit drugs and alcohol. The prevalence of dependence has been reported as 12.5% over a life course and 3.8% in the previous 12 months (43 093 individuals). In addition to the harms it causes to individual health, Turner has highlighted that alcohol dependence is detrimental to “all Americans” either directly (e.g., via violence and automobile accidents) or through its burden on the common good. Alcohol misuse and dependence has been estimated to cost the United States $185 billion per annum.
NEGATIVE ATTITUDES TOWARD ALCOHOL DEPENDENCE

Efforts to address the individual and public health costs associated with alcohol dependence require intensified prevention and treatment initiatives. However, the provision and effect of such interventions is undermined by the negative social attitudes that surround alcohol dependence and other mental health conditions. In 1999 the surgeon general identified stigma as “the most formidable obstacle” confronting efforts to improve treatment of mental health problems.9 Indeed, it has been suggested that the “erroneous attitudes” that hamper efforts to address mental health problems “may be as harmful as the direct effects of the disease.”10 Alcohol dependence (like other forms of addiction) is among the most heavily stigmatized of mental health conditions.11,12 This predicament has led Erikson to warn,

Stigma, prejudice, anger, and misunderstanding have killed many people with “addiction,” our nation’s limited desire and resources to treat such people compound the problem.13(p13)

The role of stigma in spoiling and devaluing a person’s identity has significant ramifications for the capacity to participate comfortably in social exchanges and to access social benefits, including treatment and recovery support.14,15 Dackis and O’Brien have argued that stigma creates “formidable obstacles to a more enlightened public policy toward addictive illness.”16(p1431) In this respect, the inertia that surrounds dependence is evident in the provision of inadequate treatment of the condition in terms of its availability (actual and perceived), quality (e.g., poorly trained staff), and affordability.7,17,18 However, the difficulties negative social attitudes present for better management of alcohol dependence are particularly apparent in the gap that exists between those who require treatment of alcohol dependence and those who obtain it.19,20

The 2009 National Survey on Drug Use and Health estimated that 19.3 million people (aged 12 years and older) required treatment of an alcohol use problem (this included those who were dependent and those with other alcohol misuse problems).6 Of this number only 1.7 million were given specialist treatment, leaving 17.6 million without such treatment.6 Combined figures for 2006–2009 reveal the primary reason people did not receive treatment of their substance misuse (illicit drugs and alcohol) was lack of insurance coverage and inability to cover the costs (36.8%); another 8.8% specified that although they had insurance, the cost of treatment was not covered by their plan.6 Lack of insurance is a particular problem in the context of dependence because these in lower socioeconomic groups, who are less likely to have insurance, may be worst affected by the condition.

Despite recent changes in legislation to make insurance available to those with alcohol and drug problems, the stigmatization of the condition still poses a considerable barrier to efforts to close the gap between the treatment needs of dependent drinkers and the services available or accessible to them. For example, other reasons given by respondents to the National Survey on Drug Use and Health for not receiving treatment included not being ready to stop substance use (30.5%), the potential effect on employment from entering treatment (8.6%), the negative attitudes of neighbors associated with treatment entry (8.5%), the ability to deal with substance misuse problems without treatment (10.2%), and lack of transportation or treatment’s inconvenience (9.7%).6 Some of these explanations—including concerns about the attitudes of neighbors and the potential effect on employment—are clearly influenced by fears regarding stigma. However, even the failure to accept treatment because of an unwillingness to stop use, inconvenience of treatment arrangements, or denial that treatment is necessary may—depending on the circumstances of particular cases—be rooted in the widespread desire to avoid being labeled as an “alcoholic” or dependent drinker.7
ADDRESSING STIGMA VIA THE MEDICAL MODEL

At the heart of efforts to overcome the obstacles presented by stigma in the context of dependence is work to ensure dependence is understood as a legitimate health condition, or a “brain disease.” It has been contended, for example, that “treatment parity will not be achieved until addiction is widely viewed as a disease.” Advances in neuroscience support the disease status of alcohol dependence (and other forms of addiction) and help identify improved treatment options. In the context of broader mental health conditions, scientific research has been presented as “a potent weapon against stigma, one that forces skeptics to let go of misconceptions and stereotypes.” As Leshner has explained, initiatives to improve treatment of those with addiction problems must overcome stigma and the public view that “addicts are weak or bad people, unwilling to lead moral lives.” Thus, a central aim of efforts to emphasize that dependence is a medical condition that requires treatment is to “gain ground against moralistic attitudes that stigmatize, ostracize, and often criminalize patients with addictive illness.” As the World Health Organization has acknowledged, this drive has resulted in “a long-standing conflict between moral and medical models of substance dependence.”

ENDURING NEGATIVE ATTITUDES TOWARD THE ALCOHOL DEPENDENT

It has been suggested that the turn toward seeing alcoholism as a disease meant that “alcoholics became good guys” and stigma was “washed away.” But contemporary research reveals that alcohol dependence remains a heavily stigmatized condition despite the availability of increasingly sophisticated neurobiological data. Indeed, it has been evident for some time that the medical model has not succeeded in reducing the stigmatization of mental illnesses, including addictive disorders. The World Health Organization acknowledges that although research increasingly supports the idea that alcohol dependence, like many other medical conditions, is a biopsychosocial disease, “a major difference in the case of substance dependence is the extreme stigma with which the disorder is regarded in many societies.”

The stigmatization of alcohol dependence is influenced by a range of concerns and assumptions about individuals with the condition. In their recent review of the literature, for example, Schomerus et al. have noted that the dependent are blamed for their condition and perceived as unpredictable and that alcohol dependence is less often regarded as a disease than are other mental health problems. However, others have claimed that alcoholism is widely regarded as a disease by the public but remains stigmatized despite its medical status. This suggests that the public is unconvinced by aspects of the disease categorization of dependence.

It has been suggested that uncertainty about the nature of dependence and its stigmatization is the result of difficulties in explaining complex neuroscience discoveries to the public. Leshner, for example, points to the “dramatic lag between these advances in science and their appreciation by the general public” and “a wide gap between the scientific facts and public perception about drug abuse and addiction.” Similarly, Dackis and O’Brien argue, An uneducated yet strongly opinionated public does not understand the technical field of addiction neurobiology and is more likely to conceptualize addiction as a character flaw (for example, addictive personality) than a brain disease.

However, Pescosolido et al. recently pointed to an emerging consensus on the mistaken view that neuroscience data alone is sufficient to control stigma. Neurobiological explanations of dependent drinking do not resolve the stigma associated with it because negative attitudes toward the condition are partly related to the social costs it produces and harms it inflicts on
third parties. Even if the alcohol dependent are understood to be ill rather than morally bad, the public can have legitimate concerns about the unpredictable and sometimes dangerous, violent behavior associated with the condition.\textsuperscript{29} To better manage the stigma that impedes responses to dependence, public concerns about such harms must be addressed, but in a manner that avoids increasing stigma because this could be counterproductive to reducing harms. A reductive scientific approach is not equipped to conduct the socioethical work required. Neurobiological information is the starting point for public initiatives to determine how best to respond to substance dependence, not the end of the conversation. The debate we need on the implications of state-of-the-art scientific data on substance dependence for how we should respond to the condition, including the attitudes we hold toward it, must take us from facts to the discussion of values.

As exponents of a medical approach to addiction are beginning to acknowledge, another reason for the enduring stigma surrounding dependence is the failure to examine its ethical dimensions. Erickson, for example, concurs with the view that the negative public attitudes toward substance dependence stem “from scientists’ inability to properly educate the public.”\textsuperscript{13} But he suggests that an influential factor in this is the failure to address the public’s (mistaken) concern that seeing addiction as a “disease is tantamount to releasing [addicts] from the responsibility for their behavior.”\textsuperscript{13} Similarly, Volkow, a leading exponent of efforts to ensure that addiction is not viewed as a “moral failing rather than a health problem,”\textsuperscript{30} argues that public objections to the disease concept of addiction are often related to the “complete absurdity” that the dependent lack responsibility for their condition.\textsuperscript{31} In response to such concerns, she asserts that, like those with cancer, cardiovascular disease, and diabetes, people with addictive disorders are responsible for taking the measures needed to maintain their health.\textsuperscript{30}

Unfortunately, when those committed to the medical model address ethical issues, it has been in a manner unlikely to ease the stigmatization of dependence. We have seen, for example, that Volkow claims that the responsibilities of those with cancer, diabetes, and dependence can be equated. However, the disease process of cancer can continue unabated regardless of treatment adherence and healthy, “responsible” living. But abstinence and adherence to a treatment regime in the context of dependence can halt its negative effects and progression. The unsound comparison between these conditions is unlikely to persuade the public that dependence is stigmatized inappropriately and may even prove divisive. Similarly, a ramification of the dependent being responsible for their recovery is that they can also be deemed irresponsible if they continue to drink once diagnosed. Without more detailed ethical analysis, this admission of “irresponsibility” may create further ill will toward the alcohol dependent rather than relieve stigma.

**TOWARD AN INTEGRATED MEDICOETHICAL APPROACH TO DEPENDENCE**

Initiatives to address the stigma that surrounds alcohol dependence need to acknowledge that although scientific data on the condition are important for changing public attitudes, use of this information or the evaluation of how it relates to lived experience quickly leads into the world of (ethical) values. There are many difficult ethical questions concerning how we should (ethically) respond to dependence, including how impaired control over alcohol influences the decision-making capacity of dependent drinkers and how its consequences negatively affect third parties. Efforts must be made to ensure that government, health practitioners, families, communities, and dependent drinkers are supported to think critically about the social ramifications of increasingly sophisticated neurobiological data.
To accomplish this task satisfactorily, it is necessary to integrate ethical analysis within mainstream policy debates and to reject the notion that moral and medical approaches must conflict. A first step in developing a more adequate response to the stigma is to forge a consensus on the notion that prioritizing a reductive, medicoscientific approach that sidelines the “moral model” to avoid branding alcoholics as “morally weak” is actually an obstacle to efforts to tackle stigma and improve public health. This is because the approach impedes much needed ethical examinations of the issue. Because the efforts of scientists to move into ethical terrain have been unconvincing, it is important to consider as part of the move toward an integrated approach how best practice in ethics might be attained within, for example, the work and recommendations of the National Institute for Alcohol and Alcoholism or the new addiction institute that replaces it.

One task of an integrated medicoethical approach to alcohol dependence must be to disabuse the public (and professionals) of the notion that the condition can be addressed by focusing on the behavior of individual drinkers. Science has long acknowledged the role that social environment plays in the development of dependence and its remedy. But the implications of this insight are seldom communicated consistently, and its (ethical) ramifications for the day-to-day lives of those affected by the condition have been insufficiently explored. Public advice on the Web site of the National Institute for Alcohol and Alcoholism, for example, states that families are not responsible for an alcoholic’s drinking. Although blaming families would be counterproductive, a family that, perhaps inadvertently, encourages someone with an alcohol problem to drink or cultivates a home environment that makes it hard for them to abstain because of excessive stress or the availability of alcohol could be partly responsible for any relapse that occurs. Responsibilities for preventing and controlling dependence also exist at a community level, and work is required to assess the extent to which and in what ways individuals and organizations might be accountable for alcohol misuse and the dependence of others.

Together, biomedical and ethical arguments for affording more detailed attention to social environment and social responsibilities in debates on alcohol dependence can help to dissipate the blame that falls on individual drinkers and that lies at the heart of stigma. Efforts to establish in the public consciousness that alcohol dependence is influenced greatly by social environments must, where possible, articulate this point by drawing comparisons with policy in other less contentious areas. In this respect, the social ecological framework already employed by the Centers for Disease Control and Prevention in the context of violence prevention to explain how different factors (individual, relationship, community, and social) influence risk provides a valuable way to help articulate in the public forum the complex factors that influence alcohol dependence. The approach supports efforts to realign the relationship between individual behaviors and the social environments that support them. Thus, while taking the different harms dependent drinking causes to society, third parties, and drinkers seriously, the framework would assess costs and harms within a wider context, and its less individualized focus could better manage blame and stigma.

It is important that ethical analysis contributes to efforts to address alcohol dependence within a social ecological model. This is because the ethic that has traditionally informed federal and state policies has privileged individual liberties even if this harms individual and public health. This philosophy could impede the adoption of a more socially sophisticated prevention paradigm, and efforts to modify it would benefit from ethical support. However, in the midst of continuing concerns over the detrimental effect of individual lifestyle and choices on health—most recently evident in concerns regarding the consumption of energy drinks by children—the enactment of smoking bans beginning in New York in 2003 and bans on trans fats point to shoots of an ideological shift that has begun to realign the
relationship between individual freedoms and the common good. These developments provide good foundations for the attitudinal and policy changes needed to provide better quality, more accessible, less stigmatized treatment of alcohol dependence.

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