

## Addictive Behaviours Exam 1

### Chapter 2: Addictive Behaviours 2021A

#### Why People Use and Abuse Drugs

#### Our Innate Drive to Alter Consciousness?

##### There are four primary drives:

- (1) Hunger
- (2) Thirst
- (3) Sex (for procreation)
- (4) Our desire to alter our consciousness

#### Models, theories, and contributing factors of substance use and abuse

We cannot isolate one specific cause of alcoholism and other drug addictions. There are often multiple confounding reasons for addiction. Early models of alcoholism labeled alcoholics as inherently weak or unable to control their consumption of alcohol. One test of manliness was the ability to “hold your liquor”. Other early models focused on individual psychopathy arguing that alcoholics used alcohol in a pathological manner to block out memories of unpleasant, traumatic personal experiences that brought with them unmanageable feelings

Today, those in the alcohol/drug field generally accept that alcoholism and drug addiction have multiple causes, or etiologies. Clearly a matrix of genetic, social, psychological, and environmental factors can cause an individual to develop problems with alcohol and drugs.

#### Tension and Stress Reduction

The **Tension-Reduction Theory** is one of the most widely researched theories of drug use. Early research focused on tension reduction and relief from stress as a primary reason for alcohol and drug use. Today the tension-reduction theory is considered one aspect of drug use. Individuals consume drugs for a variety of reasons, including the simple pleasure that comes along with drug use.

The **TRT** model involves the concept of **homeostasis** or balance. The individual will use alcohol/drugs to counteract (or balance out) stress, anxiety, emotional tension and conflict-any aversive emotional state. Therefore alcohol/drugs are used as **tension-reducers**.

**Tension:** has been defined as any state that is an aversive source of motivation causing feelings of fear, anxiety, conflict and frustration due to blocked goals, stress is just a modern version of tension;

**Stress:** a physical, chemical, or emotional factor that causes bodily or mental tension and may be a factor in disease causation.

#### Stanley Gitlow

- Emphasizes an etiological model that focuses on discomfort and tolerance to stress as a major factor in the decision to use/abuse drugs
- Gitlow believes that we have biological variation in our levels of tolerance to stress and stimulation
- “The imitating stimulus could well be perceived by one individual as minimally inconvenient, while another individual could perceive the stimulus as agonizingly urgent”

#### Petrie (1960)

- Identified three basic classifications of dealing with a stimuli
  - (1) **Stimulus Reducers** perceive and react to a stimulus as if the stimulus were less than what it was
  - (2) **Stimulus Moderators** perceive and react to a stimulus as it is
  - (3) **Stimulus Augmentors** perceive and react to a stimulus as if it were more than what it was

### **Gitlow (1972)**

- Describes alcoholism as a biochemical defect. The individual processing this defect is easily agitated by stimuli, becomes uncomfortable, and uses alcohol for its sedating effect. Unfortunately withdrawal from alcohol creates an agitating effect, and the individual must drink again to relieve this discomfort

### **Trauma and Substance Use Disorders (SUD's)**

The American psychological association defines **trauma** as directly experiencing or witnessing an event that “involves actual or threatened death, or serious injury, or other threat to physical integrity, or learning that a family member or close associate has experienced such events, and has a response that involves intense fear, helplessness, or horror;

**Traumatic Stressors** that fit this definition include disasters, motor vehicle accidents, emergency worker exposed to trauma, war, rape and sexual assault, intimate partner violence (IPV) etc

### **There are two major hypotheses regarding trauma and substance use disorders;**

- (1) The existing research tends to support the first theory: substance use and abuse is an attempt by the individual to assuage feelings related to traumatic experiences. The individual self-medicates by trying to “numb out”, soothe, or escape the overwhelming feelings of pain associated with trauma
- (2) The second theory is that substance use and abuse contribute to the development of **post traumatic stress disorder** (PTSD). The use and misuse of alcohol and drugs can affect the individual in a number of ways making them more susceptible and “in harms way” for trauma

Chronic substance abuse can change neurochemistry, making the individual more susceptible to **PTSD**, the lifestyle of substance use/abuse and alcoholism/addiction puts the individual in situations that are traumatic (e.g., intimate partner violence). The **risk behaviours** that are associated with substance abuse puts the individual in situations that have significant and traumatic negative consequences (e.g., driving under the influence, drug dealing, stealing, violence, etc).

This research tends to view **self-medication theory of trauma and substance use disorders** as more likely than the high-risk hypothesis. It is important to realize that the risks of substance use disorders confound the problems of trauma. In addition these individuals often experience strong feelings of “shame” and self-deprecation that further escalates negative feelings of self.

### **The Disease Model of Alcoholism**

In 1957, the American Medical Association declared **alcoholism** a disease on the basis of three criteria; The disease model is the foundation of Alcoholics Anonymous and many other self-help programs

- (1) Alcoholism has a known etiology (cause)
- (2) The symptoms get worse over time and,
- (3) Alcoholism has known outcomes, the outcomes being dependence, physical symptoms, and eventual death

### **12-Step Alcoholics Anonymous Program**

The 12-step approach is based on the disease model. It has been described as an informal biopsychosocial spiritual model. The disease model assumes alcoholics/addicts were predisposed to addiction by genetically transmitted risk factors. The 12-step program helps the addict to overcome the terrible sense of isolation and aloneness that occurs as a result of the many negative consequences of use.

### **Genetic Influence Disease Model**

This model does not emphasize genes or specific disorders but instead assumes that multiple biological risk factors interact with psychosocial environmental factors. It also assumes that addiction is influenced by interpersonal relationships, including family, community, and culture.

### **Is Alcoholism Really a Disease?**

There is an agreement that AA and NA have helped many alcoholics and addicts to both have and maintain sobriety. As mentioned previously, the disease model takes away the shame and stigma of addiction (which is a good thing). However is it truly a disease? The 1957 AMA definition of a disease was rather broad and could fit many conditions that we would not consider a disease today. One could also argue that there are diseases caused by something outside of a persons control and there are diseases that are caused by the individuals themselves.

### **Genetic Models of Alcoholism-Adoption and Twin Studies**

**Devor (1994)** describes a developmental genetic model of alcoholism. He proposes that “alcoholism must no longer be thought of as a single disease with a cause that is either genetic or environmental but has a group of illnesses in which the influences of genes and the environment ebb and flow over the course of the at-risk lifetime.” The **logical conclusion**; is that treatment for alcoholism would be individually designed and fine-tuned to consider both pharmacological and behavioural therapies.

### **Adoption Studies-Donald W. Goodwin (1971)**

- (1) Adopted sons of alcoholic biological parents are four times more likely to become alcoholics than adoptees whose biological parents are not alcoholics
- (2) Sons of alcoholic biological parents are more likely to be classified as alcoholics at an earlier age than their peers
- (3) Daughters of alcoholic fathers, although not demonstrating a greater incidence of alcoholism, exhibit a high incidence of somatic anxiety and frequent physical complaints
- (4) Sons of alcoholics were 4x more likely to become alcoholics themselves

### **Twin Studies**

Studies of identical and fraternal twins have supported the genetic factor. Because identical twins are genetically identical but fraternal twins have no more genes in common than non-sibling twins, research should show a higher rate of alcoholism in MZ twins than DZ twins.

**Identical Twins (MZ):** genetically identical

**Fraternal Twins (DZ):** no more genetically similar than non-twin siblings

### **Twin Alcoholism Concordance Rates?**

- MZ identical twins: 71% concordance rate
- DZ fraternal twins: 32% concordance rate

### **Personality Traits and Personality Disorders**

#### **Addictive Personality;**

The concept of an **addictive personality** is a simplistic approach that makes the mistake of labeling all alcoholics and other addicts as processing personality that leads to addictive and compulsive behaviour. It is more accurate to recognize that many personality traits can make an individual vulnerable to alcoholism and drug addiction.

It is more accurate to say that individuals have **psychological vulnerability**: personality traits that make a pattern of substance dependence more likely to develop. It is difficult to identify the relationship of alcoholism and drug addiction to particular dimensions of personality, because many personality traits overlap. **Cloninger's (1987)** three dimensional model of personality has been applied to the research literature on alcohol-use disorders. Cloninger identifies three temperament constructs that correlate with alcohol-use disorders:

- (1) **Harm Avoidant**-cautious, apprehensive, fatigable, and inhibited

**(2) Reward Dependent**-ambitious, sympathetic, warm, industrious, sentimental, persistent, moody  
**(3) Novelty Seeking**- impulsive, excitable, exploratory, quick-tempered, fickle and extravagant  
A more recent study (**Hosier and Cox 2011**) of college students who drink excessively has found that novelty seeking and maladaptive motivational structure predict alcohol-related problems, beyond those predicted by their alcohol consumption alone.

**Maladaptive Motivational Structure:** described as being unable to maintain motivation to achieve goals. Hosier and Cox also found that college students who are strongly influenced by novelty seeking or maladaptive motivational behaviours were twice as likely to experience alcohol related problems.

### **Attachment and Substance Abuse**

Attachment plays a key role in being vulnerable to problems with alcohol and drugs. The bond between parent and child is a pivotal foundation in feeling safe, nurtured, and connected. Disruptions in attachment can create problems in connection. Alcohol and drugs are used to compensate for this disconnection and to alleviate feelings of shame, unworthiness, inadequacy, loneliness, emptiness, boredom, anxiety, and depression.

Edward Khantzian describes addiction as a disorder in self-regulation (reactivity) with emotions, self-care, self-esteem, and difficulty in making connection in relationships. Difficulty in interpersonal bonds disrupts self-compassion, and compassion for others. This difficulty in making connection and reactivity further fuels substance abuse problems and is fuelled further by the sense of isolation.

### **Self-Medication**

Edward Khantzian makes the case that drug use is not a random phenomenon. Instead, he says it is a purposeful attempt by the user to assuage painful affective states and manage psychological problems or disorders;

- Khantzian (1985)
- People use drugs to medicate for psychiatric disorders and painful emotions
  - Opiates: anti-rage
  - Cocaine: antidepressant, ADHD, bipolar
  - Marijuana: bipolar, schizophrenia

### **Mood and Affect Disorders**

Individuals experiencing problems in regulating their affect and mood may self-medicate with alcohol/drugs. Alcohol/drugs may be used to alleviate and self-medicate feelings of anxiety or panic, as well as other negative emotional states, including melancholia, depression, and even mania.

### **Self-Medication;**

Patients with **Chronic Dysphoria**-short term addictive effects of opioids

Patients with **Bipolar Disorder** or **Cyclothymic Disorder**-Cocaine to bring them out of depressive episodes and also enhance their endogenously produced highs

### **Seasonal Affective Disorder**

Seasonal affective disorder (SAD) is another form of depression that leads to increased alcohol/drug use especially during the “sunless” winter months in certain environments.

### **Family Model**

The family model includes all aspects of life, factors contributing to alcohol/drug use in the family include the following:

- Imbalance in parenting
- Marital troubles
- Alcoholic/addict behaviour
- Physical, sexual, emotional, violation/abuse
- Shame, abandonment, rejection

- Inability to share thoughts or feelings with family members or losing close family members; potential to cope in unhealthy ways

According to the family model of alcohol/drug use, alcohol and drug addiction and dependence are **family diseases**. The genetic predisposition to alcoholism is well documented. Probability of developing the disease of alcoholism is 4x more likely for those individuals that have one alcoholic/drug addicted parent. Probably is 8x if both parents are alcoholics/drug addicts. Children from alcoholic, dysfunctional, and shame based families are at greater risk for developing problems with alcohol/drugs. Parents with alcohol/drug problems are ill-equipped to provide the kind of patient, dedicated care necessary for children to develop and grow.

### Adolescence

As children enter adolescence, they are at risk for alcohol/drug problems. Jay Strack classifies 5 major factors in adolescent abuse of drugs using the mnemonic PEACE;

Pressure

Escape

Availability

Curiosity

Emptiness

### Poor Self-Concept

- From within to the outside world
- Lack unique, worthwhile, talents and skills
- Reduced ability to prioritize, set and achieve goals, resolve conflicts
- Struggle with trust
- Not a requirement for development of addiction

A **sense of self** is less static than self-concept, involves more choices by the individual, and is active rather than passive. A sense of self comes from within to the outside world, rather than the outside world defining who the individual is. This important point has implications for individuals who develop codependent relationships with addicts and alcoholics.

A person with a sense of self is;

- (1) A unique, worthwhile individual with emerging talents and skills
- (2) An individual who can accomplish things
- (3) An individual who can trust and be trusted, one who sets appropriate boundaries for intimacy in relationships

## Drugs and Their Effects

Drugs	Effects
Narcotic analgesics	Kill pain, numb, shut out, and slow down
CNS depressants (e.g., alcohol)	Decrease Activity, Relaxation
CNS Stimulants	Increase Activity, Excitation
Hallucinogens	Change the user's view of the world
Marijuana	Relaxation, stimulation of the senses, and stimulation of thought

### **Boredom and Altered States**

Boredom is often cited as a major factor in alcohol/drug abuse by adolescents as well as adults. As previously described, the drive to alter one's consciousness is directly related to using alcohol/drugs to counter uncomfortable feelings of boredom.

### **Types of Boredom:**

**Interpersonal:** Bored with "small talk" versus having feelings of "happiness with people"

**Existential:** Having difficulty with the meaning or purpose of life, an inability to know what will make you happy leading to a pervasive sense of meaninglessness, abandoning important life goals and dreams because of practical concerns or other pressures.

**Leisure Time:** Not being able to find rewarding things to do with leisure time

**Life:** Neglect of life goals leading to a state of emotional ambivalence

### **Impulsivity and Disinhibition**

Impulsivity/disinhibition includes traits such as sensation seeking and aggressiveness. Impulsive/disinhibited individuals are at increased risk for alcohol-related problems. The traits of disinhibition and impulsivity are increased in the children of alcoholics. Alcohol and drug use involves taking risks, some people when told no are curious and perhaps translate no into yes, this is especially true of adolescents. This risk taking behaviour itself creates feelings of rebellion, rage, aggression, self-destructiveness, and aliveness.

### **Social Learning Theory**

A variety of models can be considered psychosocial or social learning models. The key element of these models is the social learning aspect of alcohol/drug use. **Social learning theory** also incorporates other models, such as tension reduction model. Nathan (1983) describes alcohol use as a social acquired, learned behaviour pattern, maintained by antecedent cues (classical conditioning + expectancies), consequent reinforcements (operant conditioning + tension reduction), cognitive actors, modelling influences, and the interaction of behavioural and genetic mechanisms.

### **Social Learning**

- Related to family Model
- Addictive behaviours are learned habits
- Behaviour can be affected by individuals exception of the use

### **Sociocultural Models**

**Bales (1946)** identified factors in the influence of a culture or sociological organization on rates of alcoholism:

- (1) The degree to which the culture causes acute needs for adjustment of inner tensions in its members
- (2) The attitudes towards drinking that the culture produces for its members
- (3) The degree to which the culture provides substitute means of satisfaction

### **Psychoanalytic Models**

- Drugs as Power-getting "high"
- Drugs as Self-Destruction-positive and potent view of death
- Seduction and Sexuality-aphrodisiac

### **Psychoanalytic Models-Psychoanalytic Meaning**

The traditional psychoanalytic view of alcohol/drug dependence focused on a fixation at the oral stage of development, resulting in oral and narcissistic pre-morbid personality. The dominant psychoanalytic explanation of alcohol/drug use today is that it is caused by “a structural deficit in object relations”. This means that individuals have a hard time establishing effective interpersonal relationships due to their difficulty in managing their affect (feeling) and impulse controls.

### **Alcohol/Drugs as Power**

Alcohol/drugs frequently denote power or feeling of power to users. The expression getting high symbolizes feeling above others or above one's usual self. Ironically, despite the original reason for using drugs to feel powerful, the ultimate state in the cycle of addiction makes the individual powerless.

### **Alcohol/Drugs as Self-Destruction**

Alcohol/drugs can also have a powerful meaning as weapons of self-destruction and ultimately death. A number of clinicians have described alcoholism and drug addiction as an unconscious death wish. Self-destructiveness is the failure of ego functions involving self-care and self-protection.

### **Alcohol/Drugs in Seduction and Sexuality**

Alcohol/drugs have important symbolic seduction and sexuality meanings. Practically, all drugs and alcohol have at some point been described as aphrodisiacs, unfortunately no drug is truly an aphrodisiac. Alcohol/drugs may reduce inhibitions and stimulate sexual arousal at low doses; however alcohol and drugs impair sexual performance, especially with prolonged use.

### **Existential Issues**

Existential issues have to do with limitations of existence. These can include the limitations of life itself or how long we live, the unknowns related to death and dying, the pain of poor health, health related problems and illness, etc. Drugs are a way to quiet, distract, or escape these existential issues, and to gain a temporary relief and change in focus or perspective, however it is a temporary and passive response that doesn't resolve any issues but often leads to further drug use.

### **Poor Future Orientation and Hope**

Individuals who view their future as negative might abuse drugs, having a short-range view. Many alcoholics and drug addicts report that they don't expect to live very long. Thinking that their life span is not long, they are not concerned with having good physical health.

Many adolescents have a poor future orientation because of the continued pattern of academic failure or a difficult family situation. Academic failure especially in the late elementary grades correlates highly with early antisocial behaviour and alcohol/drug abuse.

### **Hopelessness**

It is hard to identify a single factor that leads to feelings of hopelessness, such as strong feelings of hopelessness that a person gives up (even only temporarily) and stops trying to grow, achieve, and develop. Many clients feel like they are not getting anywhere despite their continued efforts.

### **Pessimism and Optimism**

Many clients recovering from alcohol/drug addiction described their fathers as “pessimists”. Their fathers (and sometimes their mothers) were extremely negative, sarcastic, shaming, critical of others, judgmental of their spouses, and others and pessimistic about the world in general.

The pessimistic attitude was not limited to fathers, many family members were fearful and worried, expressing the philosophy that others would take advantage of you and rip you off financially or emotionally. They viewed the world as hostile, as a result they approached the world defensibly, expecting to get hurt, looking for a negative.

Unfortunately this pessimistic attitude contributes to alcoholism and drug addiction and is detrimental to recovery. Pessimistic individuals can maintain abstinence from alcohol/drugs but they have difficulty trusting others or being vulnerable and real enough to get close to others.

**Matin Seligman** describes pessimism as having a very negative view of the world and interpreting events as being **permanent, pervasive and personalized**. These three p's of pessimism outline the individuals thoughts, beliefs, and attitudes about themselves and the world. They interpret a loss as permanent, verbalizing the all-or-nothing perception that "it will never get better, it will always be this way"

**Pessimism and Optimism**

<b>Pessimism</b>	<b>Optimism</b>
<b>Permanent</b>	Very Temporary
<b>Persuasive</b>	Specific
<b>Personalized</b>	External

## **Addictive Behaviours**

### **Assessment of Substance Abuse, Dependence, and Addiction**

#### **Chapter 4**

#### **Diagnostic Categories**

The diagnostic and statistical manual of mental disorders is a primary reference used by mental health practitioners to diagnose both mental disorders and substance-related disorders. Substance related disorders are divided into two major categories:

- (1) *Substance-Use Disorders*: these include substance dependence and substance abuse
- (2) *Substance-Induced Disorders*: these include substance intoxication and substance withdrawal

#### **A behavioural Definition of Addiction**

In the early 1980s, the rise in cocaine use challenged the basic framework of our definition of alcohol/drug addiction. Cocaine was previously thought to be a drug that incurred psychological dependence with no physical dependence. At that time we defined addiction as a physical dependence measured by a significant and noticeable medical withdrawal system. Although cocaine had no significant, medically noticeable withdrawal symptoms, users reported a severe addiction to it.

The **Three Basic Components** of the **Behavioural Definition** are the three c's-compulsion, control and consequences;

- (1) **Compulsion with obsession**: users think about alcohol and drugs in a vicious negative cycle; their obsessive concern and preoccupation follow an incessant use of alcohol/drugs in a continuous pattern and compulsive lifestyle.
- (2) **Control-inability to stop using the substances**: users cannot stop using the alcohol/drugs for at least 3 months and/or make feeble attempts to cut back in a stop-then-start pattern. They are unable to refuse readily available drugs.
- (3) **Continued use despite adverse consequences**: users are caught up in their addictions, illustrating the pervasive defence mechanisms of denial (rationalization and minimization). Eventually, the alcoholic/addict suffers family, social, interpersonal, economic and spiritual bankruptcy.

#### **Assessment Stages of Alcohol/Drug Use**

The most preventative measure is not to use alcohol and drugs, especially at early ages. Not smoking cigarettes at early ages highly correlates with not developing addictions later in life. Children are less likely to develop chemical dependencies in life if parents:

- (1) Do not model alcohol/drug use and encourage a healthy approach to life
- (2) Encourage children to participate in activities that enhance the development of a strong sense of self
- (3) Promote positive alternatives to drug/alcohol use
- (4) Are sensitive to what children feel while parents are setting appropriate boundaries
- (5) Provide structure, discipline and consistency
- (6) Develop a climate of discussion, which facilitates an effective exploration of values and the development of coping skills in goal setting, decision making, and conflict resolution

#### **Set and Setting**

The **three major components** of alcohol and drug use are;

- (1) The individual
- (2) The Drug
- (3) The Set and setting in which the drug is taken

Set and setting often determine the individuals reaction to alcohol/drugs. The **Set** refers to the psychological and emotional frame of mind of a person when using alcohol/drugs.

Those who are **relaxed**, comfortable and secure in the knowledge that they can handle possibly losing control usually have less trouble with the initial use of alcohol/drugs. Individuals that have a set that can be described as **anxious**, extremely nervous, or overly concerned while maintaining control are more prone to a negative drug reaction. If a person is **not emotionally stable**, and/or has psychiatric problems, alcohol/drug use can elaborate those problems.

Set can also be influenced by the persons mood or emotional state at the time of alcohol/drug use. The individual who is feeling down or depressed might experience a negative drug reaction similar to significant trauma, shame, and embarrassment which can also contribute to a negative experience with drugs and alcohol.

**Setting** involves not only the physical environment but also the social and interpersonal environment. **Negative drug reactions** may be the result of being in an uncomfortable setting, with unknown people who are not trusted.

### Alcohol/Drug Use-A progressive Disease

The beginning of alcohol and drug use is certainly the initial contact. Because alcohol and drug use is a progressive disease, individuals get more involved as they progress through stages. A positive **initial contact** usually leads to the next stage of drug use-**experimentation**. **Experimentation** may lead to the subsequent stages, which end in **addiction**.

### Addiction

**Addiction** is the last stage. Based on our definition of addiction and the disease model, an addict cannot return to any of the previous stages of alcohol/drug use. The best recovery strategy is to abstain from alcohol and drug use and to participate in a 12-step program.

### Phases of Cocaine Addiction

Initial Contact	“Isn’t this a great drug?”
Experimentation	“It’s sure expensive but its worth it”
Excessive Use	“I really should cut down”
Addiction	“I know I have to stop, but I can’t”

### Chronic Alcoholism/Chronic Drug Addiction

Chronic alcoholics and drug addicts spend major portions of their lives addicted to alcohol/drugs. In this late stage of **chronic addiction**, they are extremely difficult to treat. Some new approaches are required for this population. Such programs provide basic needs for shelter, food, other health-related services, and educational and counselling services. These programs for chronic alcoholics emphasize maintaining the individuals dignity, while providing access to recovery services.

### Early to Late Stages of Alcohol/Drug Use

Early Stage	Late Stage
More Freedom	Lack of Freedom
Fewer risks and less damage	More damage
Possible abuse	Present abuse

Early Stage	Late Stage
No illness	State of illness
Linear operating factors	Vicious cycles

### Vulnerability To Relapse

At each of the stages of recovery, individuals are vulnerable to relapse, or a return to alcohol/drug abuse or addiction. Therefore, all chemical dependency treatment programs must address relapse issues. Many experts agree that a longer term inpatient or residential program is much needed, experts agree that a 6-9 month inpatient program would be most effective considering the high relapse rates. In addition a 1 year outpatient program would further enhance the probability of recovery without relapse.

### Assessment For Relapse

We have diagnostic criteria for the different alcohol/drugs disorders, but no criteria for relapse, nor descriptions of the different types of relapses. This is symbolic in the need to shift more focus on relapse dynamics and relapse prevention.

### Denial-A Problem in Accurate Assessment

The denial of drug/alcohol problems is a major factor in the difficulty of assessment. There is widespread denial, not only by individuals who have drug problems but also by family members and friends, as well as society at large. It is often difficult to break through denial and have the courage to admit a problem with alcohol/drugs. Family members often experience a sense of shame or embarrassment or feelings of responsibility for the alcohol/drug problems of a family member.

### Minimization and Rationalization

The **two major defence mechanisms** used to deny problems with alcohol and drugs are **minimization** and **rationalization**.

### Consequences of minimization and rationalization?

- Neglect; emotional, physical or sexual abuse
- Loss-death, trauma, divorce or separation
- Numerous relocations and unstable home environments
- Parental dysfunction, creating feelings of parental unavailability and/or feelings of abandonment, rejection or shame

### Identification of Adolescent Alcohol/Drug Problems

The following 11 questions can help in identifying an adolescent alcohol/drug problem

- (1) **Mood.** Has the child been extremely moody or more upset than usual?
- (2) **Changes.** Are there some significant changes in the child's choice in friends, grades, dress, general hygiene, and responsibilities?
- (3) **Responsibility.** Is the child more irresponsible about his or her commitments (e.g, chores, schoolwork, friends)?
- (4) **Motivation.** Is there a noticeable decrease in motivation, interest, or activity?
- (5) **School.** Are there any signs of problems at school and difficulty studying, completing assignments and so on?
- (6) **Negative Activities.** Is the child engaging in activities that are not healthy or productive and potentially damaging?
- (7) **Lying, Stealing, and Cheating.** Is money, household objects, or personal property missing?
- (8) **Community.** Has the child been in trouble with neighbours, storekeepers, or other community members?
- (9) **Criminal Justice System.** Has the child been involved in an activity that has caused investigation or charges being made by the police?

**(10) Physical Signs.** Are there any physical signs of alcohol or drug use? Have some of the following been noticed? Has drug paraphernalia been found in the child's room?

- The smell of alcohol or marijuana on the breath or body
- Dilated pupils
- Increase in activity
- Grandiosity
- Talkativeness
- Extreme quietness
- Slurred or incoherent speech
- Bizarre behaviour
- Moodiness
- Aggressiveness and show of temper
- Fatigue, lethargy

**(11) Parents.** Do you find yourself justifying your child's behaviour? Are you saying things such as the following?

- "He or she will grow out of it"
- "This is just a stage"
- "Kids will be kids"

If so, you may be denying signs of alcohol/drug abuse. Reminder: believe the behaviour, not necessarily what the person says.

### **Alcohol/Drug Assessment**

Recovering from alcohol and drug addiction also involves the family of the alcoholic/addict. The family system is an integral part of the development of the disease. The most difficult work in recovery is dealing with family issues and relationships to help family members recover from dysfunctional patterns in the family system.

The **most important** task in assessing the potential for problems with drugs/alcohol is determining if there is any **family history** of alcohol or drug abuse and addiction. Some education for family members and the individual who may have a drug problem might also be necessary to establish a clear perception of the dimensions of substance abuse and addiction.

To access an individual's alcohol/drug problem, counsellors need the following information;

- Age of initial drug and alcohol use
- Frequency of use, amounts used, set and setting of use
- Patterns of use, binges, periods of nonuse
- Stage of current use-experimentation, integrated use, excessive use, addiction
- History of negative consequences-physical, psychological, financial, familial and spiritual
- Medical history-conditions that might be affected by use of drugs/alcohol
- Use of coffee, cigarettes and medication

### **Alcohol/Drugs and Suicide**

Another key assessment issue with alcohol/drugs is the potential for suicide. Stanton and Landau-Stanton (1985) state that the "recognition of substance abuse as a suicidal endeavour stems from as far back as 1938 when Menninger likened addiction to chronic suicide"

**Some common assessment questions for suicide are as follows:**

- (1) Is there a family history of alcoholic/drug problems, suicide, or depression?
- (2) Do you use alcohol/drugs to
  - (a) overcome bad/shameful feelings?
  - (b) deal with sleeping problems, depression, or stress?
  - (c) quiet suicidal or self-destructive thoughts?

- (3) Do you have suicidal thoughts?
- (4) How will you do it? Do you have a plan?
- (5) Have you previously had suicidal thoughts and have you attempted suicide before? How frequently do these thoughts occur?
- (6) What role does alcohol/drug use have in relation to suicide? Does it make you more or less likely to follow through?
- (7) On a scale of 1-10 how likely are you to kill yourself?
- (8) How much do you want to die? To live?
- (9) What would prevent you from committing suicide?
- (10) What might occur to make life worth living?

If a client is suicidal, an extremely important question to ask is, “what would prevent you from committing suicide?” This will often lead to a dialogue and plan of action that will prevent suicide. Fortunately, the vast majority of suicidal people do not want to die as much as they want to find a way to live.

## Chapter 1: Putting Drugs in Perspective

### The lack of Understanding of Alcohol/Drug Abuse

- Historically, we have failed in our responses to the alcohol/drug problem in the United States.
- Alcohol in particular has become integrated into the fabric of the mainstream American lifestyle, causing many people to minimize its impact and its cost to American society

### Failed Approaches to Alcohol/Drug Abuse: “Scare Tactic”

- From the 1930s to 1960s, public and private responses to alcohol/drug abuse caused tremendous damage which we are still trying to overcome
- These approaches were riddled with personal emotional reactions and political biases, which denied the real dimensions of the problem
- **Scare Tactics**-a politically biased approach that alienated young people-began in 1937 and continue to this day, in a variety of forms. (i.e alcohol and marijuana scares-targeted at parents of young adults-scare people away from the drug)
- In the July 1937 issue of American magazine a marijuana scare was published, the coauthor of the article was **Henry J. Anslinger**, then commissioner of the Federal Bureau of Narcotics and Dangerous Drugs.
- After reviewing this single case and a study of the paranoid schizophrenic reactions of heavy hashish smokers in India, Anslinger, expounded on the evils of marijuana, he described marijuana as a drug that would consistently result in violent, aggressive, and paranoid behaviour, as evidenced in the single Florida case he found.
- Another scare tactic example is the 1936 movie **reefer madness**, this movie's serious intent to discourage marijuana use backfired because the situations were so absurd that the audience viewed it as humorous.
- Those using scare tactics assumed that if young people were frightened by adverse reactions to drug use, they would be too frightened to use the drug.
- In the late **1960s and early 1970s** President **Richard Nixon** declared his famous war on drugs. Nobody knew how to tactically fight this war on drugs and drug use had spread to epidemic proportions. Since Nixon's war on drugs failed funding for treatment programs was cut every year thereafter.

### Supply Side Approach-Neglect of the Demand Side

- Throughout the ensuing years, US administrations continued to fail to develop a comprehensive and cohesive drug policy. Most of the administrations put a major emphasis on the supply side of the drug problem and significantly neglected the demand side.
- Emotional and political biases of these administrations caused them to be blind to many causes of drug dependence and resulted in an adherence to a **“simple magical solution”** that was politically advantageous.

### The Myth of the “Simple,” Magical Solution

- During the Reagan administration first lady Nancy Reagan was influential in shaping the US approach to the “drug problem”. Although her intentions were well intended, the “Just Say No” approach illustrates a simplistic view to a complicated problem.
- Suggesting that adolescents and young adults can overcome the drive to alter consciousness, peer influence, the disease of alcoholism/addiction, and the many factors that influence alcohol/drug abuse by “just saying no” minimizes the obstacles to be overcome.
- Too often people search for that simple solution to an epidemic problem. Philosopher H.L. Mencken remarked that “any solution to a complex problem, that is simple, is usually wrong.”

### **Alcohol: The Most “Problematic” Drug**

- Alcohol abuse and alcoholism are major problems that are often minimized or overlooked as not being a part of the “war on drugs.” Administrations have been distracted focusing on drugs often forgetting to include alcohol as a drug.
- Alcohol is the most problematic drug we know today in terms of the sheer number of people it affects. Estimates indicate that there are more than 12 million alcoholics in the United States and that a significant number of other people meet the criteria for alcohol abuse and alcohol dependence.

### **Binge Drinking on College Campuses**

Alcohol related problems on college campuses include:

Academic difficulties, problems attending class and completing assignments, property damage, accidents and injuries, interpersonal and social problems etc.

- Excessive alcohol use is the third leading preventable cause of death in the US and more than half of alcohol consumed by adults in the US is in the form of binge drinks.
- Is a significant problem on college campuses as research indicates 40-45% of college students binge drink. At least half of the sexual assaults on college campuses involve alcohol consumption by the perpetrator, the victim or both.

### **Other Age Groups?**

- Although binge drinking is very persuasive in college age students, is not limited to this age category. According to the centre of disease control (2012) survey, six Americans die each day from “alcohol poisoning” due to binge drinking. It is reported that 76% of those deaths are aged 35-64 and a majority of them are men.

### **Sexual Assault and Rape on College Campuses-The Role of Alcohol**

- Alcohol use is most commonly associated with sexual assault on campus. Alcohol was consumed in at least half of college sexual assaults, either by the victim or by the perpetrator or both.
- Male college students who are intoxicated at high levels exhibit impaired sexual function but have increased physical aggression. Female college student (victim) intoxication increases vulnerability to penetration but does not reduce odds of injury.

### **Drinking and Driving among Young Drivers**

- Drinking alcohol and driving continues to be a major problem as evidenced by the many traffic fatalities while people are under the influence of alcohol.
- Factors contributing to young drivers greater crash risk include the following: a lack of driving experience, overconfidence, and the presence of other teenagers in the car (encouraging risky driving)
- As a result many states are instituting stricter guidelines for young drivers-such as not allowing other young people in the car for the first year of driving, issuing provisional licenses that are suspended with any traffic violation, and increasing the age at which young people can get a drivers license.

### **Intimate Partner Violence**

- It is estimated that alcohol is involved in 25-50% of cases of intimate partner violence (IPV) the psychophysiological effects of alcohol use can lead directly or indirectly to IPV. Alcohol consumption can result in impaired judgement, cognitive impairment, and numerous physical effects that can lead to violence.

### **Alcohol Related Injuries and Death**

- Accidental injury is the leading cause of death among adolescents and young adults, and binge drinking is involved in many of these accidents. For young people under the age of 21, intentional deaths include homicides and suicides that are alcohol related.

### **Systemic Problems of Drugs**

- A large proportion of the federal money available to fight the drug problem is being spent on programs and agencies that focus on reducing the supply of drugs in the US.
- Despite their efforts, there appears to be no real reduction in the availability of drugs.

### **The US Federal Government's Role in the Drug Problem**

- The strong emphasis on the supply-side funding has been neglected for demand-side programs of drug prevention, intervention, and treatment. The problem has escalated to such levels that respected government officials and other prominent individuals are considering the legalization of illicit drugs. This consideration of legalization illustrates the frustration of a segment of the American society with the lack of progress being made by the supply-side approach.
- Most publicly funded agencies are seeing their funding base diminishing, case loads increasing and severity of patients needs increasing. These programs often have long waiting lists for both inpatient and outpatient treatment services. (average wait time is amount a month for outpatient and 45 days for inpatient-more than 65,000 people are waiting to enter programs)

### **Racist Approaches to the Drug Problem**

- Historically there has been prejudice and oppression of people of colour, a scapegoating of minorities, and a neglect of substance-abuse problems in the inner city.
- Legislation on drug policy was often based more on racial scapegoating prejudices than on a concern for the harmful impact of drugs on people.
- In 1875, the goal of suppressing opium smoking and opium dens had little to do with the control of opium but more to do with the dear of interracial contact and a fear of interracial mixing of the Chinese with American women and the white working class.
- Black people are 3 times more likely to be stopped by police than caucasians
- Black people are arrested for drug offences between 2 and 11 times the rate for caucasians
- Black offenders receive sentences that are 10% longer than white offenders
- African Americans are 14% of drug users, but 56% of people in state prisons for drug offences
- Upon release: 17% of white job applicants get callbacks vs. 5% black job applicants
- Underlying assumption was that minorities were not able to control or tolerate the use of alcohol and drugs because they were inherently lazy and physically, emotionally and morally/ethically weak.
- Unfortunately, as long as drugs were confined to minority populations, funding and treatment resources were limited. It wasn't until the 1960s when white middle and upper class young adults and college students were using marijuana, hallucinogens, and other drugs, that the modern drug war began.

### **Socioeconomic Inequities**

- The inequities in socioeconomic opportunities have created bitterness, racial conflict, and a general rebelliousness and hopelessness, which fuel the desire to use alcohol/drugs. the American dream is a nightmare for those who are unable to develop feelings of competency and pride in their lives.
- The reality is that hard work and dedication can be rewarded with the attainment of each person's American Dream.
- Poverty has been identified as one of the greatest risk factors for chemical dependency and other destructive behaviours. Violent crime, school-age childbearing, and school failure are outcomes that need early interventions to prevent rotten outcomes.

### **Academic Failure and the Role of the US Education System**

- The US education system has become so neglected that the rates of academic failure and dropout are continually rising. The academic standards for students who do graduate are inferior.
- Illiteracy has increased, and the quest for knowledge and general personal and intellectual improvement is not emphasized by the average American citizen.
- The current failure of the education system results from a variety of reasons, the biggest problems are poor administration, teacher burnout, lack of adequate funding, and a bureaucratic system that promotes complacency.

## **Denial and Minimization of Alcohol/Drug Problem**

- Denial is a problem that leads to the worsening of consequences over time, not only for the substance abuser and addict/alcoholic but also for family members and friends.
- The longer a family denies and enables the alcohol/drug problems the more vulnerable the family members become to experiencing the destructive consequences of substance abuse and addiction
- Parental abuse, addiction, and alcoholism make the children in the family four to eight times more likely to develop problems with alcohol/drugs.
- Families and family members, including the alcoholic/addict often resist admitting that they have a problem, they often feel so ashamed that they maintain their addiction and continue the negative consequences in a cascading, vicious cycle.
- Early assessment of drug/alcohol problems related to dysfunctional behaviours and negative consequences may prevent a problem from getting out of control.

## **Emerging Trends**

### **Cigarettes**

- Cigarette smoking has decreased drastically, almost 50% over the past 5 years for students. However the use of electronic cigarettes is high among teens-8.7% of 8th graders, 16.2 percent of 10th graders and 17.1% of 12th graders.

### **Marijuana**

- Marijuana use did not increase despite students seeing it as less harmful. 40% of 12th graders in medical marijuana states consume edible forms of marijuana within the last year compared to 26% in non medical marijuana states.
- Daily marijuana use (smoking) decreased to 1.4% by 8th graders, compared to 2.7% 5 years ago. However daily use (smoking) increased in 10th graders. Seniors daily usage was 5.8 percent and 81% of seniors reported that it is easy to get marijuana.

### **Simulants: Adderall and Ritalin**

- Remain stable in percentages
- Decline in abuse of prescription and over the counter drugs
- Use of illicit drugs has generally declined over the past decade
- Significant decrease in alcohol use among all grades
- Significant drop in binge drinking

## **Medical Marijuana**

- There are 23 states and the district of Columbia that have legalized medical marijuana, four of them (Colorado, Washington, Alaska, Oregon) have legalized recreational marijuana use.
- Medical conditions that medical marijuana is approved for are cancer, chronic pain, severe pain, epilepsy, and disorders categorized by muscle spasms and/or nausea.
- Other medical conditions approved by some states are anorexia, arthritis, cachexia or wasting disease, migraines, hepatitis C, Crohns disease etc.
- Research on medical marijuana is limited. In Canada, where medical marijuana is legal, there were only 31 studies according to the Harvard mental health letter.

## **The Moral Legal Perspective**

- The moral legal perspective is primarily the viewpoint of law enforcement and the criminal justice system. The major focus of this perspective is to keep specific drugs away from people and people away from specific drugs.
- This approach reduces the availability of drugs and uses punishment as a deterrent in addressing the supply side of drugs not the demand side.
- This perspective is emphasized by most politicians yet this perspective alone cannot be effective. Unless we address the demand side, the moral legal perspective is ineffective.
- The moral legal perspective also encodes specific value judgements about drugs and alcohol.

### **The Medical Health Perspective**

- This perspective is held by physicians, nurses and the medical and health treatment fields.
- In this perspective, alcohol and drug use is a public health problem. Treatment focuses on the physical damage related to alcohol/drug use, abuse and dependence.
- The medical health perspective assumes that people seek good health. The perspective is also based on the assumption that health information influences attitudes and behaviours. However, information alone does not change attitudes about the use of alcohol/drugs.

### **The Psychosocial Perspective**

- The psychosocial perspective is a common viewpoint shared by a variety of agencies that specialize in addressing the demand side of alcohol/drugs.
- The services these agencies provide include the following: recovery from substance dependence, intervention and treatment services, early intervention approaches with adolescents, prevention services for young children, adolescents, adults and seniors.
- The goals of this perspective are to prevent, intervene in, and treat alcohol/drug problems.

### **The Sociocultural Perspective**

- The sociocultural perspective is held by most social agencies and institutions.
- The basic goal of this perspective is to adapt the environment to the individuals needs.
- The underlying assumption is that alcohol/drug use is due to the frustration and hopelessness of peoples lives. If users had any hope that they could attain the American dream, they would be motivated to achieve and establish a constructive place in society.
- Unfortunately, most social agencies are impersonal, bureaucratic, and rigid in dealing with their clients needs. Such agencies are poorly funded and therefore poorly staffed.

### **A Perspective of Hope**

- Perhaps the problems that spawn alcohol/drug abuse and addiction seem too difficult to overcome. The negative impact of these problems frequently gives rise to feelings of hopelessness that we can never adequately resolve these issues.
- However, there has been positive and dramatic success: millions of Americans are in recovery from alcoholism and drug addiction.

## Chapter 11: Disorders Co-occurring with Substance Abuse

### Definition of a Co-occurring Disorder

- The terms dual disorders, comorbid disorders, co-occurring disorders have been used to describe the condition of having both a psychiatric diagnosis and a chemical dependency diagnosis.
- The symptoms produced by the psychiatric diagnosis and the chemical dependency diagnosis can overlap. Clinically, we think of patients as existing on a continuum between purely psychiatric disorders at one end and purely chemical dependency problems on the other. Most patients lie somewhere between the extremes.
- Today it is rare to find a patient who has purely one condition, either psychiatric or chemical dependency. Research suggests that causes of mental illness such as schizophrenia, depression, anxiety disorders, and affective disorders are substantially, if not, primarily biological. Genetic research of families with a history of alcoholism has supported the biological nature of alcoholism.
- The two major co-occurring disorders covered in this chapter are (1) affective (feeling) disorders and chemical dependency and (2) personality disorders and chemical dependency.

### Serious Mental Illness (SMI) and Substance Abuse

- In 2002, there were 33.2 million adults aged 18 or older with serious mental illness (SMI). Of the adults that had SMI, 13.4 million only had SMI, and 4 million had both SMI and substance abuse disorder.
- The substance abuse tends to complicate an already complicated situation for the severely mentally ill person. These patients are very challenging and require a more organized effort to stabilize.
- Of the population of 4 million (12.2%) had a co-occurring disorder of both serious mental illness and a substance abuse disorder. Only 12% of this population received treatment for both mental health and substance abuse disorders, indicating that the limited extent of adequate assessment and treatment approaches.
- Many patients (52%) received no treatment at all, or treatment for only one disorder (34% for mental illness disorder, only 2% for substance abuse disorder)

### Depressive Mood Vs. Depressive Disorder

- It is common to feel down, sad, or even depressed after experiencing disappointment, frustration (blocked goal), setback, or trauma. Feelings of sadness, melancholia, grief, and loss are normal aspects of life. Working through grief is an essential feature of growth.
- If these feelings persist beyond the common period of time to work through them, an affective disorder may be developing.
- It is also normal to feel bad or low in early recovery from abusing alcohol or drugs. Some of this is due to withdrawal from the chemicals, but problems in mood may persist after withdrawal.
- Everyone experiences symptoms of depression from time to time. When symptoms become severe and persistent, however, a diagnosis of an affective (feeling) disorder could be warranted.
- Researchers and clinicians have used various systems of classifying depression over the years, they have recognized types and subtypes of depression.
- What differentiates these types from one another is their: **severity, frequency, duration** and **precipitating factors**. Affective disorders are different from the normal emotions of feeling down or sad.

### Vegetative Signs of Depression

- After the physiological changes have taken place, a number of biological, or physical, signs of depression emerge. These vegetative signs include disturbances in the basic biological functions that the brain regulates, they include:
- Disrupted sleep patterns, difficulty with appetite and weight regulation, decreased cognitive functioning (concentration, memory, problem solving), decreased sex drive, lack of motivation, decreased energy (anergia), and difficulty experiencing pleasure (anhedonia).

## **Denial and Depression**

- Many individuals are frightened to be labelled depressed, labeled manic-depressive (with bipolar disorder), or labeled with other affective and mood-cycling disorders. The denial of these feelings is often self-medicated with the use of drugs/alcohol in an attempt to avoid shame.
- Most people view themselves as weak and inferior in not having the will power to overcome depressive illness. Depressive disorder is a disease much like alcohol/drug addiction in that it has a known etiology, gets progressively worse, and has significant negative consequences if untreated.

## **Categories of Mood Disorders**

Common affective disorders include the following:

- Major depression
- Dysthymic depression (a low-grade depression)
- Atypical depression (depression related to sudden loss)
- Organic depression
- Bipolar disorder, formerly referred to as manic-depressive illness (severe mood swings)
- Cyclothymic (mood-cycling) disorder (a less severe form of mood swings)

## **Major Depression**

- This depressive syndrome may occur in a single episode or as repeated episodes over the years. This diagnosis generally connotes a severe depressive episode with fairly clear onset and accompanying vegetative signs.
- These individuals exhibit difficulty in the most basic of tasks (e.g., getting out of bed, brushing their teeth). Episodes of major depression typically last from 6-12 months and then clear sometimes even without treatment.
- Episodes of depression that are longer in duration require adequate and careful attentiveness and sensitivity to potential suicide attempts.

## **Persistent Depressive Disorder (Dysthymia)**

- Is a mood disorder of longer term than major depression but is a lower-grade depression.
- Patients with Dysthymia frequently comment that they have never felt complete happy, or that if they achieve a period of feeling well it is short lived.
- Anxiety symptoms, headaches and muscle tension are frequent in addition to feelings of depression

## **Atypical Depression**

- Atypical depression is not a common condition, as the symptoms and duration of symptoms are different from those of major depression and Dysthymia.
- Is frequently the diagnosis for many adult children of alcoholics. Usually a patient with atypical depression experiences intense and sudden depressions in response to interpersonal loss or threatened interpersonal loss.
- It is also different as patients with atypical depression experience an increase in appetite and sleep instead of the opposite.

## **Organic Depression**

- Depression may also occur from organic factors, such as brain tumours, head injuries, nutritional deficiencies, physical illness, or alcohol/drug use.
- Many chemically dependent patients have nutritional deficiencies as a result of increased intake, malabsorption, and poor eating habits.

## **Bipolar Disorder**

- 3 states: high, low, well
- **Mania:**
  - Continuously happy, euphoric
  - Irritable, angry, aggressive
  - Overly confident, decreased need for sleep, speeded up speech/activity
- **Depressive Episode**
  - Depressed mood, loss of pleasure, loss of energy, feelings of worthlessness, guilt, apathy, thoughts of suicide
- Bipolar disorder is the highest affective (feeling) disorder associated with co-occurring disorders. In other words, bipolar disorder is the most common affective disorder that co-occurs with substance abuse disorders.
- Some common themes found with clients who have bipolar disorder and substance abuse are: a strong emphasis on depression as opposed to mania, predominance of hopelessness, specific pattern of medication noncompliance, and patients labeling of their substance abuse as self-medication.
- Manic-depressive illness consists of repeated depressive episodes over the years; typically more brief than those in major depression.
- In addition, a manic depressive has less frequent but equally intense highs or manic episodes. A manic episode may also include delusional beliefs and disorganization of thinking. Highs may not always involve euphoria-many patients simply become more irritable and erratic in behaviour.

## **Mood Cycling Disorder**

- The frequency of the cycling and the amplitude of the highs and lows are aggravated by alcohol/drug use. A relatively low-grade mood-cycling pattern may become much more aggravated with the use of alcohol/drugs, and the symptoms may become more clinically apparent.
- Patients with a mood cycling disorder that do not have psychotic symptoms such as hallucinations and delusions may develop them with the extra push from alcohol and drug use.

## **Affective Disorders and Suicide**

- The combination of depression and alcohol/drug use places patients at an even higher risk for suicide. Self-destructive acts that otherwise might be contemplated and dismissed are frequently acted on impulsively by those who are intoxicated and disinhibited.
- The vicious psychological pattern of affect (feelings) plus shame can also contribute to suicidal ideation and actions. Depressive feelings + shame = feelings of despair followed by feelings of despair + shame = suicidal ideation and then suicidal ideation + shame = suicide.
- The individual suffering from depressive illness is fearful that any negative experience will start in motion this cycle of depression to self destruction.

## **Personality Disorders and Substance Use Disorders**

### **Personality Trait versus Personality Disorder**

- In describing peoples personality we may think of traits that describe the way people behave, experience life, and interact in relationships. Personality is an important dimension that defines who we are.
- We all have a mix of personality traits, which define us as individuals. When personality traits are persistently maladaptive and lead to chronic difficulty in interpersonal, occupational, and social functioning, there is a personality disorder.
- The DSM-V recognizes 11 personality disorders and divides them into **three clusters**
- **Cluster A:** is characterized by odd and eccentric traits and may lead to psychiatric conditions, such as delusional disorder or schizophrenia. (paranoid, schizoid)
- **Cluster B:** is categorized by behaviour that is erratic, emotional or dramatic. This cluster has the strongest association with substance abuse, particularly antisocial and borderline personality disorder.

- **Cluster C:** is characterized by feelings of fear and anxiety. Substance abuse occurs in this group but not as frequently. (avoidant, dependent, obsessive compulsive).

### **Personality Disorder and Chemical Dependency Disorder**

- Personality disordered individuals may be attracted to alcohol/drugs to self-medicate feelings of discomfort, anxiety, depression, anger, grief, and even shyness.
- Four most common personality disorders were: antisocial personality disorder (21%), passive aggressive disorder (21%), borderline personality disorder (18%), and self-defeating personality disorder (18%).

### **Anti-Social Personality Disorder**

- Of all personality disorders, the strongest relationship with substance abuse is with antisocial personality disorder. Lack of concern for others, irritable, aggressive, impulsive
- Superficially charming, fiery turbulent relationships, most commonly associated with crime.

### **Childhood Precursors for ASPD?**

- Conduct disorders and ADHD in children are precursors of both substance abuse and antisocial personality disorder. Early assessment, intervention and counselling with these individuals and families is recommended to address current problems or prevent future problems.

### **Denial, Alcohol/Drugs, and ASPD**

- The shame attached to identifying ones personality traits as causing problems in life and in relationships often results in denial. It is easier to blame others for conflicts, problems, and personalty issues than it is to take responsibility.
- A major feature of a personality disorder is that the individual may not consider the personality trait that is causing conflict undesirable. The individual might attribute others complaints about them as the fault of others.
- The traditional denial defence mechanisms of rationalization and minimization are used to deny the true dimensions of a personality disorder. Integrity, honesty, and responsibility are discounted in the self-centred behaviour of the ASPD.
- Difficulty **regulating behaviours** (poor impulse control, recklessness, and a failure to anticipate consequences) and **affect intolerance** (the inability to recognize, regulate, and tolerate emotions) **lead to substance abuse.**
- Nace and associates (1983) described drugs/alcohol as providing immediate gratification followed by **regressive behaviours.**
- These regressive behaviours include;
  - **Impulsivity:** cannot delay gratification, has stimulus-bound decreased frustration tolerance; is impatient; overheats to stimulations; is inconsistent.
  - **Self-Centeredness:** is stubborn and defiant, lacks empathy, exhibits grandiosity; either overvalues or undervalues self; sees things in either/or rather than shades of grey; cant compromise; exhibits perfectionism, sees self as unique.
  - **Passivity:** is withdrawn; is isolated; feels helpless; is “mentally lazy”; avoids self-revelation
  - **Affect Intolerance:** has difficulty negotiating feelings; fears feelings; has decreased ability to endure or regulate painful emotional states.

### **Borderline Personality Disorder and Chemical Dependency**

- The second most common personality disorder that has a high incidence of substance abuse is borderline personality disorder. A number of studies have reported co-occurring substance abuse and borderline personality disorder.

- Abandonment depression is the common factor in borderline personality disorder. The term abandonment depression is used to describe a personality disorder that has six key elements (1) feelings of emptiness and void, (2) hopelessness and helplessness, (3) panic, (4) guilt, (5) suicidal depression, (6) homicidal rage.
- Someone suffering from abandonment depression probably had a highly stressful separation from their parent(s) or primary caregiver early in life (18 months-2 years)-either natural causes (illness, death, divorce, separation) or parent(s) were emotionally unavailable
- People with borderline personality disorder have a marked instability of mood, often form intense interpersonal attachments, typically feel abandoned and rejected during instances of real or perceived interpersonal loss.
- Many engage in repeated self-destructive and suicidal acts during episodes of insane depression and despair. Both nature and nurture to blame for personality disorders.
- Difficulty regulating their degree of attachment to others. They want the closeness and trust of intimacy but fear dependency, vulnerability and possible rejection.
- Lack sense of self, unstable intense relationships, emotionally unstable, impulsive, outburst of anger, suicidal threats are common, more common in women.

### **Narcissistic Personality Disorder**

The DSM-V definition of narcissistic personality disorder is “a pervasive pattern of grandiosity, need for admiration, and lack of empathy.”

- The narcissist can have many of the following qualities:
- Combine these problems with the use of alcohol and/or drugs, such as cocaine, and you have real problems;
  - A grandiose sense of self-importance
  - A preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love
  - Trouble with interpersonal relationships
  - Requires excessive admiration
  - Unreasonable expectations of others
  - Interpersonally exploitive of others
  - Lacks empathy
  - Envious of others
  - Arrogant attitude

### **Trauma and Substance Abuse Disorder**

- There are many different pathways that explain the high incidence of trauma and substance abuse disorders in adolescents, these possible pathways are;
- (1) substance abuse disorders preceding trauma because substance abuse by the adolescent increased the likelihood for the adolescent to engage in risky behaviours that cause trauma
- (2) substance abuse disorders interfere with the adolescent’s ability to cope effectively with the trauma
- (3) substance abuse disorders occur when adolescents try to self-medicate the stress symptoms of trauma

### **Treatment of Disorders Co-occurring with Substance Abuse**

- Treatment of co-occurring disorders means addressing both the mental illness and the substance abuse. Treating one and ignoring the other will only result in relapse.
- Practice guidelines for Treatment of psychiatric disorders include these:
  - (1) establish and maintain a therapeutic alliance with the client

- (2) manage the clients psychiatric (or substance use) symptoms and monitor the status of these overtime
- (3) provide education regarding the disorder(s) and treatment etc
- Working with co-occurring disorders requires a strong team approach and good communication among mental health caregivers so that the client doesn't fall between the service gaps.

### **Adolescent Co-Occurring Disorders Complicates Treatment**

- Co-occurring disorders in adolescents complicates the treatment for substance abuse. Many more issues need to be addressed in coordination with the treatment for substance use disorder (SUD). Estimates of rates of co-occurring conduct disorder with substance use disorder are 50-80%.
- The disorders that co-occur with substance abuse can be classified as
  - **Internalizing problems**-depression, anxiety, or trauma disorders, suicidal thoughts
  - **Externalizing problems**-conduct disorders, ADHD, victimization, physical violence towards others, illegal activity