Alcohol and drug-addictions

Alexandra David – Coopé Sud 2000
Anne Carpentier, 02-2010 – 11-2011[*]

Foreword

On most of Family Development Programmes implemented by Inter Aide (IA) and Southern partner NGOs, the social workers and field workers ("Family Development Workers") are not trained to work directly on addictions. Still, in their work with the families (home-based follow-up of vulnerable families living in slums) they often have to face situations where one or several members of a family have an addiction (in the areas where IA work, the most frequent addictions are alcohol, gambling, and drugs — such as "rugby" and "shabu" in the Philippines: "rugby", is a solvent, and "shabu" is "crack", derived from cocaine).

Some field workers tend to consider addiction as "vices": we hope this paper will help them undersand that addictions are not "vices" but the symptoms of an intense suffering. We wish it will help them in their work, and make it easier for them to consider and relate to the persons with an addiction with sympathy and compassion, less fear and judgement (which, as we understand it, is only a defense against our own fears...).

As addictions are a complex issue to deal with, Family Development Workers cannot work on it directly themselves: but they should be able to identify the addiction problem, and provide non-judgemental counselling to the person and his/her family; they should also be able to refer the persons in need to specialized organisations (such as Alcoholic Anonymous or Narcotic Anonymous) when available. Ideally, such organisations should be invited (incited, convinced...) to come in the areas where Family Development Programmes operate, so that their services become accessible to the slum-dwellers.

The interventions and references presented below (such as WHO's *Brief Intervention*, etc.) are not given here as models of intervention to be implemented by Family Development Workers: they are given here as it might help the Family Development Programmes staff to acquire a clearer and more objective understanding of addictions, the different levels (misuse, abuse, dependence) and the possible corresponding interventions. They should remember that addictions are symptoms of an intense suffering, which is usually rooted in early childhood trauma, which are still unresolved and therefore active in the person's life.

This paper is an updated adaptation of two trainings made by Coopé Sud on alcohol and drug addiction. These two trainings have been merged into one to emphasize the common background which is the same with all addictions.
Some paragraphs are repeated and we have left these repetitions as we imagined that some readers might choose to read only about alcohol or only about dryg addiction.

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1. Addiction & substance abuse and misuse

All addictions are symptoms of a great suffering, of a deep feeling of ill-being.

There are many types of addictions, including addiction without substance, such as gambling, addiction to sports, to work (“workoholics”), to sex, *anorexia nervosa*... All addictions induce a modified state of consciousness (including addictions without subsance, as they modify the biochemistry of the brain) that provides a temporary relief to the constant pain.

Some addictions (usually addiction to illegal substances) are socially unaccepted (and sometimes labelled as “vices”) and people addicted to these substances are despised and discriminated.

Other addictions are or used to be socially accepted or tolerated depending on the time and place (usually legal drugs, such as tobacco, alchohol in countries where it is legal, and neuroleptic medecines, are tolerated); other addictive behavior, not always perceived as addictions, can even be socially valued (addiction to sports, to work...).
Even though society considers different addictions unequally, the process behind all addictions is similar.

In medicine, an addiction is a chronic neurobiological disorder that has **genetic, psychosocial, and environmental dimensions** and is characterized by one of the following:

- the continued use of a substance or of a behaviour, despite its detrimental effects,
- impaired control over the use of a drug (compulsive behavior),
- and preoccupation with a drug's use for non-therapeutic purposes (excessive psychological dependence to a substance or a behaviour, i.e. craving the drug).

Tolerance to a drug and physical dependence are not defining characteristics of addiction, although they typically accompany addiction to certain drugs. Tolerance is a pharmacologic phenomenon where the dose of a medication needs to be continually increased in order to maintain its desired effects. For instance, individuals with severe chronic pain taking opiate medications (like morphine) will need to continually increase the dose in order to maintain the drug's analgesic (pain-relieving) effects. Physical dependence is also a pharmacologic property and means that if a certain drug is abruptly discontinued, an individual will experience certain characteristic withdrawal signs and symptoms. Many drugs used for therapeutic purposes produce withdrawal symptoms when abruptly stopped, for instance oral steroids, certain antidepressants, benzodiazepines, and opiates.

Risk factors for substance misuse include the following:

- Psychosocial factors such as abuse and neglect in childhood
- Physical or sexual abuse (≥ 60% of drug-addicts were victims of incest or sexual abuse in childhood); neglect;
- Family history of substance misuse and early exposure to drugs (*in utero*, or through medical treatment during childhood such as Ritalin® for attention disorders — “hyperactivity”) is also a factor influencing later drug addiction.
- Social factors such as social exclusion: unemployment, discrimination, truancy and criminal activities...
- Psychosocial factors such as parental conflict, separation, divorce;
- Psychological factors, such as psychological distress, psychiatric disorder, conduct and emotional disorders.
- Living in an area of high ‘usage’.

Sources: WHO Guide to Mental Health in Primary Care: Substance misuse in young people http://www.mentalneurologicalprimarycare.org/content_show.asp?c=16&fid=1251&fc=011060

2. Bio-psycho-social factors influencing addictions.

Genetic, psychosocial, and environmental dimensions are always mingled.

Approximately 10% of any population is addicted to drugs or alcohol. Addiction crosses all socio-economic boundaries. 10% of teachers, 10% of plumbers, and 10% of Chief Executive Officers have an addiction.

The environment the person has grown in is a determining factor. In the vast majority of cases, insecure / violent / abusive environment can be found in most the childhood and teenage years of most people with an addiction. Early relational trauma such as abuse and neglect are imprinted into the neurobiological structures that are maturing during the brain growth spurt of the first 2 years of life, and therefore have both immediate and long-term effects.

"Because early abuse negatively impacts the developing brain of these infants, it has enduring effects. There is extensive evidence that trauma in early life impairs the development of the capacities of maintaining interpersonal relationships, coping with stressful stimuli, and regulating emotion. A body of interdisciplinary research demonstrates that the essential experiences that shape the individual’s patterns of coping responses are forged in the emotion-transacting caregiver–infant relationship. We are now beginning to understand, at a psychobiological level, specifically how beneficial early experiences enhance and detrimental early histories inhibit the development of the brain’s active and passive stress coping mechanisms". Allan Shore http://www.allanschore.com/pdf/SchoreIMHJTrauma01.pdf)

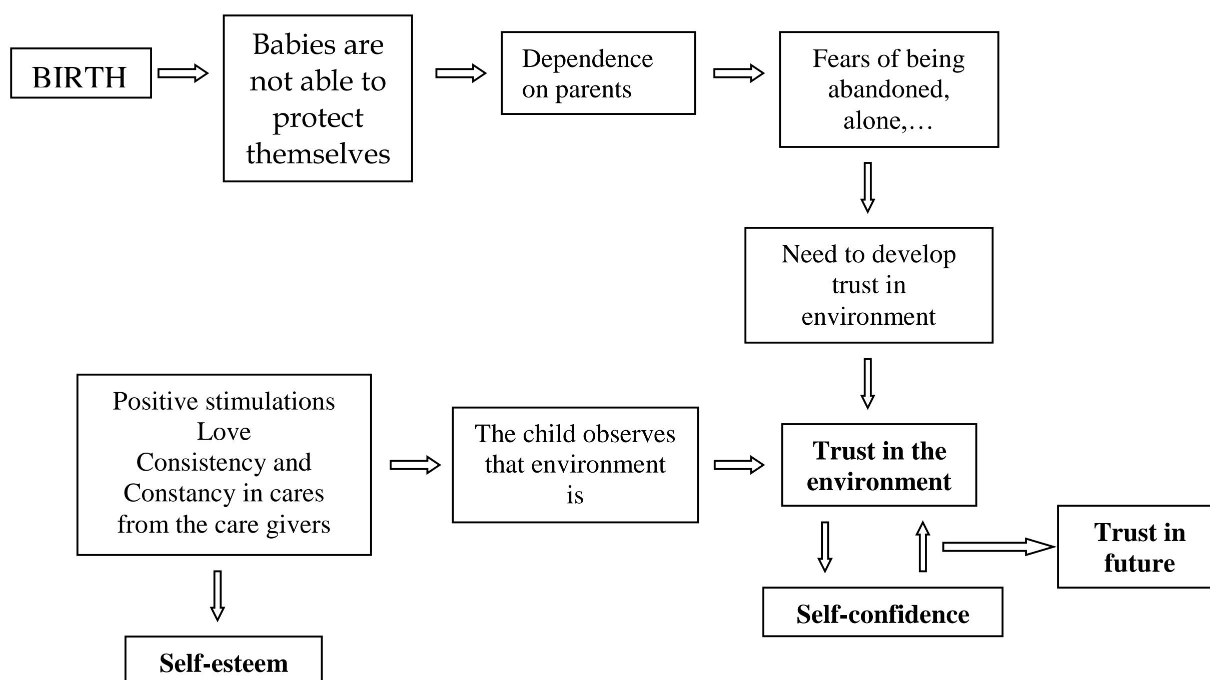
The following points are found in all types of addictions (these tendencies are observed among the majority of people with addictive behaviour, without considering the type of drug they are taking):

The insecure / violent / abusive environment people with addictive behaviour have grown in have not provided them with skills to cope with emotions (the ability to regulate the intensity of emotions is built in early infancy through the interaction with a "good enough" caregiver - See Allan Shore: *Affect Dysregulation and Disorder of the Self* - WW Norton 2003).

Disorganised, unstable family context with lack of well-established limits and inconsistency often increase the risk of addiction (it does not mean that children corning from these kinds of families settings will become drug addicted persons! It's the other way round: these kinds of family background are often found among people with addiction). In some dysfunctional families, parents do not treat their child / children as (a) separate person(s), but rather as extension of themselves, as objects they can use, beat, and abuse... Most abusive parents have suffered from unresolved trauma themselves — and the imprinting of the chaotic alterations of the parents' dysregulated affective state may be a central mechanism for the "intergenerational transmission child abuse". (NB: only 8% of people who have been sexually abused in childhood will become sexual abusers. It means that the vast majority of victims will *not* reproduce the abuse. On the other hand the vast majority of sexual abusers were abused in their own childhood).

Growing up in such insecure / violet / abusive environment may results in

- low inner security and a weak self-image,
- A high sensitivity to depression, (the addictive substance / behaviour is used as a self-medication, and acts as an antidepressant).
- Constant inner pressure, anxiety, high vulnerability to stress (also found among abusive parents...)
- Hyper sensitivity, difficulty to tolerate frustration, to regulate the intensity of emotions and deal with interpersonal relationships;
- This inability to regulate emotions can results in impulsiveness;
- High mental activity (a constant stream of thoughts, usually negative and self-depreciating thoughts) is often found among people with addictive behaviour;
- high mental activity is a way to adjust to an unstable / stressful environment, and to compensate for hypersensitivity: **high mental acuity is the first response to stress**.
- Persons with addictive behaviour may develop a tendency to self-punishing behaviours: alcohol, drugs as well as tobacco, have a destructive effect for the body, and can cause diseases and death. But one should remember that the addictive substance is first used to relieve suffering, as an attempt at "self-medication" and *not* to destroy oneself.
- Socialisation troubles and opposition tendencies towards social laws (especially in the case of addiction to illegal substance) might be observed.



Environmental factors

Birth is described as a strong and traumatic moment since before birth, babies are protected in the mother's womb where they naturally receive what they need. After birth, babies leave this protected environment : they need to adjust to the new outer environment, and to face new frustrations (for example, they have to wait before getting food, the mother[1] is not always here to protect the child,…). Babies have to face a paradoxical situation: on the one hand, babies are physically separated ("independent") from their mother, but on the another hand, because of their physical condition and their level of development, they are not able to satisfy their basic needs by themselves : they are in a position of total dependence towards their parents. Then, when they face frustrations (if their basic needs are not satisfied), they feel terrible tension, fears and anger (one can observe a baby crying, and the violence, the distress in his/her facial expression).
Because of such situation of dependence, *deep fears of being abandoned and alone* appear, since their life totally depends on other persons: if the parents leave the child and do not come back, there is a potential risk of death for the baby. Then, young children have to *build up trust* towards their parents in order to deal with the fear they are feeling when the care giver leave them. They need to experience the repetition of seeing them leaving (which causes fear and pain), then coming back, with corresponding feelings of happiness. After a while, if the parents show constancy and consistency in the cares they are providing the baby with, the child will be able to build trust. Fears of being abandoned, separated from the parents will slowly reduce, and the child will step by step accept the idea of staying alone without feeling in danger (he will learn how to deal with that situation).

[1] The term "parents" refers to the adults who are taking care of the child on a daily and long-term basis, who have an educative role for the child. All the persons who have a particularly close relationship with the child, with a "maternal" role, are referred to the term "mother".

This trust towards his/her affective environment is the *basis of the child's own self-confidence* (if they don't trust significant others, they cannot trust themselves). This development step is very important in terms of self-image building: experiencing positive, consistent and constant basic maternal cares will help the child develop a positive self-image and self-esteem. *Positive stimulations, constancy and consistency* will prove the environment's reliability, and the child will be able to develop trust towards outer physical and affective world (not only towards caregivers). This is the basis of the *child's trust in his /her own future*: based on such trust towards environment, the child is able to look at his/her own evolution and future with confidence and serenity.

The mother's attitude is like a mirror of the child's self : before being able to recognise himself/herself in a mirror (and appreciate or depreciate it), the child first uses the mother's face2 as a mirror of himself/herself. If the mother's facial expression reflects positive feelings and love, the child will slowly associate it to his/her own image. That's the basis of positive self-esteem. If the mother shows negative feelings, there is a risk for the child to integrate a negative image of himself and to suffer from self-depreciation tendencies. And, if the mother doesn't look at the child at all (examples of children in orphanages, who don't have any close or consistent relationship with any particular person), the child will have difficulty to build up a basic stable self-image. Feeling of identity (of "self") will be affected, the child will have difficulty to develop stability (since the environment is chaotic and inconsistent) and feeling of inner security.

3. Definitions of alcohol use, misuse, abuse & alcohol addiction

- No use or abstinence
- Occasional / recreational use (moderate use[3])
- Hazardous drinking or alcohol misuse
- Harmful drinking or alcohol abuse (medical harm without the presence of dependence) 20% of consumers
- Alcohol Dependence (5% of consumers)

Substance misuse is defined as use that is medically, legally or socially unacceptable (therefore potentially subject to changing levels of social acceptability). This might apply to 'legal' substances such as alcohol in a young person over 16 if there is potential physical or social harm caused by its use.
Hazardous drinking a concept related to harmful drinking (see below) is not included in ICD-10 (the WHO classification of diseases), but nevertheless important to screening, is hazardous use (or alcohol misuse).
Hazardous use is a pattern of alcohol consumption carrying with it a risk of harmful consequences to the drinker. These consequences may be damage to health, physical or mental, or they may include social consequences to the drinker or others. A hazardous drinker's consumption exceeds the "moderate" levels of alcohol consumption.

[2] The term "face" also refers to the mother's gesture, attitude and behaviour towards the child.
[3] "**Moderate use**" according to the WHO is no more than 1 "unit"of alcohol a day for women, 2 per day for man, less than 5 days a week. No more than 3 units on a single occasion. 1 unit = 10 grammes of ethanol (=10 ml of wine, 25 ml of beer, 5 ml of liquor). But even one drink a day can have long-term effects on health.

If there is no evidence of physical or psychological harm due to drinking and the patient is not dependent, a controlled drinking programme is a reasonable goal (eg: no more than two drinks per day, with two alcohol-free days per week)
source: WHO Guide to Mental Health in Primary Care:
http://www.mentalneurologicalprimarycare.org/content_show.asp?c=16&fid=868&fc=005015

Substance abuse: experts make a distinction between alcohol abuse and alcoholism (now referred to as alcohol dependence). Unlike people who have become dependent to alcohol, "alcohol abusers" still have some ability to set limits to their drinking. However, their alcohol use *is* self-destructive and dangerous to themselves or others.

"Not all alcohol abusers become full-blown alcoholics, but it is certainly a big risk factor. Sometimes alcoholism develops suddenly in response to a stressful change, such as a breakup, retirement, or another loss. Other times, it gradually creeps up on you as your tolerance to alcohol increases. If you're a binge drinker or you drink every day, the risks of developing alcoholism are even greater. But whether or not alcohol abuse turns into alcohol addiction, many of the problems will be the same".
(http://www.helpguide.org/mental/alcohol_abuse_alcoholism_signs_effects_treatment.htm)

The WHO classification views this catergary of user from the point of view of ***health*** *damage and defines it as* **Harmful drinking:** because alcohol abuse can produce medical harm without the presence of dependence, ICD-10 (WHO International Classification of Diseases, 10th edition) introduced the term **harmful use** into the nomenclature. This category is concerned with medical or related types of harm, since the purpose of ICD is to classify diseases, injuries, and causes of death. Harmful use is defined as a pattern of drinking that is already causing damage to health. The damage may be either physical (e.g., liver damage from chronic drinking) or mental (e.g., depressive episodes secondary to drinking).

For patients with physical complications of alcohol abuse or psychiatric disorder, abstinence from alcohol is the preferred goal. In some cases of harmful alcohol use, controlled or reduced drinking is a reasonable goal.

Alcohol dependence syndrome is a mix of mental, behavioural, and physiological symptoms. A diagnosis of dependence should only be made if three or more of the following have been experienced or shown at some time in the previous twelve months:

- a strong desire or sense of compulsion to drink;
- difficulties in controlling drinking in terms of onset, termination, or levels of use;
- a physiological withdrawal state when alcohol use has ceased or been reduced, or use of alcohol to relieve or avoid withdrawal symptoms;
- evidence of tolerance, such that increased doses of alcohol are required to achieve effects originally produced by lower doses;
- progressive neglect of alternative pleasures or interests because of alcohol use;
- continued use despite clear evidence of harmful consequences.

Source: *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care,* WHO http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf

For most patients with alcohol dependence, physical complications of alcohol abuse or psychiatric disorder, abstinence from alcohol is the preferred goal.

Below is the "DSM IV" definition of dependence

Dependence according to the DSM IV ("Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition"), published by the American Psychiatric Association:

A definitive **diagnosis of dependence** should usually be made only if three or more of the following have been present together at some time during the previous year:

- a strong desire or sense of compulsion to take alcohol
- difficulty in controlling drinking in terms of its onset, termination or level of use
- a physiological withdrawal state when drinking has ceased or been reduced (eg tremor, sweating, rapid heart rate, anxiety, insomnia, or less commonly seizures, disorientation or hallucinations) or drinking to relieve or avoid withdrawal symptoms
- evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses (clear examples of this are found in drinkers who may take daily doses sufficient to incapacitate or kill non-tolerant users)
- progressive neglect of alternative pleasures or interests because of drinking and increased amount of time necessary to obtain or take alcohol or to recover from its effects (salience of drinking)
- persisting with alcohol use despite awareness of overtly harmful consequences, such as harm to the liver, depressive mood states consequent to periods of heavy drinking, or alcohol related impairment of cognitive functioning.

In many cultures, the labels or terms applied to excessive drinkers carry highly negative connotations. The distinctions made here about types of misuse on a broad continuum are seldom reflected in popular concepts and terminology. To avoid arousing resistance and defensiveness, it is best wherever possible to describe patients' alcohol use and drinking behaviours rather than to use personal labels. Hence, discussion of hazardous drinking or alcohol dependence is preferable to labeling a patient as a binge drinker or an alcoholic. This will help patients focus on changing their drinking behaviour without feeling hurt, ashamed and defensive about the terms being applied to them.

The AUDIT test (Alcohol Use Disorders Identification Test) identifies persons with hazardous and harmful patterns of alcohol consumption. (see References)

The CAGE test is a simple 4-question test:

Answering the following four questions can help you find out if a friend or family has a drinking problem:

CAGE test - Have you ever felt you should **C**ut down on your drinking? - Have people **A**nnoyed you by criticizing your drinking?

- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (**E**ye-Opener)

One "yes" answer suggests a possible alcohol problem. More than one "yes" answers means it is highly likely that a problem exists. If you think that you or someone you know might have an alcohol problem, it is important to see a doctor or other health care provider right away. They can help you determine if a drinking problem exists and plan the best course of action".
Sources: http://www.niaaa.nih.gov/FAQs/General-English/FAQs10.htm

- Effect of drugs depends on
  - Type of drug
  - Quantities
  - Frequency
  - Duration
  - Intake
  - People (effect different for everybody)
- Several types of intake
  - Smoke
  - Injection
  - Oral / swallow (eat, drink)
  - Inhale
  - Sniffing
  - Anal
  - Absorption
- Several effects:
  - During use
  - After use
  - Short and long term effect
- Categories of drugs
  - Stimulants (cocaine, shabu, ecstasy, cigarette, métamphétamine), which causes :
    - Hyperactivity
    - Agitation
    - Feeling strong, no sense of danger
    - Decrease of hunger
    - Decrease of sleep's need
  - Depressants (alcohol, morphine, heroin, syrup, marijuana), which causes:
    - Feeling sleepy
    - Feeling hungry
    - Feeling relax
    - Memory slow down
    - Lethargy

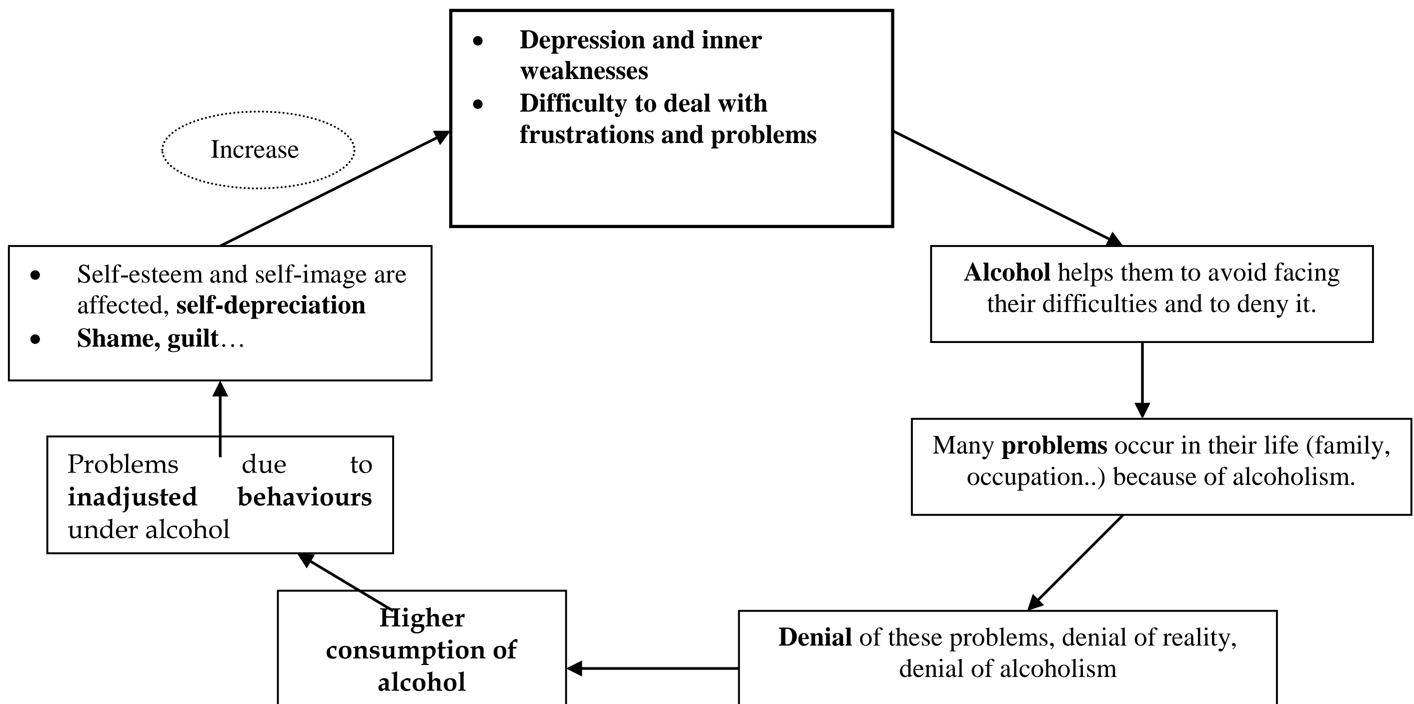
- Psychedelics (mushrooms, solvent), which causes:
  - Hallucination
  - Decrease of hunger
  - Unpredictability

4. Addiction to alcohol: process and denial

As senn above, insecure attachement in early childhood engender a feeling of inner insecurity; inner insecurity in turn may make a person more vulnerable to depression; addictions are often an attempt to fight against depression and are used as a sort of self-medication. (Alcohol is an anti-depressant as efficient as Valium®. Tobacco also acts as an anti-depressant; this is why bupropion - Zyban®, an anti-depressant, turned out to help patients quit smoking). The modified state of consciousness obtained through any addictive substance and behaviour provides a temporay relief from suffering, and a temporary release of the contant inner pressure: **this is this temporary relief from pain & pressure that is sought through addictions. But as it only works temporarily, it has to be repeated and it becomes compulsive.**

> “That is why step by step, alcohol (or any other drug and addictive behaviour) become an important component in the person's life: it helps release the constant inner pressure they experience and provides them with a feeling of well-being and a temporary relief from their suffering. On the contrary, reality reminds them about the problems their addiction causes in their family, their job and their social life in general.
> In many countries drinking is a socially accepted behaviour (alcohol is legally sold in public shops). But somebody who drinks too much will be branded as “binge drinker” or “drunkard”, which provides a ground for denial, since noone cannot accept to be labelled as such. At the same time the social rejection of alcohol-dependent people reinforces and "confirms" their negative feelings about themselves.
> Then, quickly they have to choose between two options: reject drinking or reject reality. If they have no choice but rejecting reality, a vicious cycle sets itself: the more they drink, the more problems they have in reality, the more their self-image gets affected and the more they deny it.
> After a while, alcohol is becoming so important for them that they start to reject everything which may hinder its consumption, and denial of their addiction to alcohol increases. Denial aims at developing a wall of security so as to avoid facing their increasing negative feeling and self-depreciation, because of the behaviour they show under influence of alcohol, which provoke shame, guilt, remorse, anxiety.
>
> Denial is one of the biggest obstacles to getting help for alcohol abuse and alcoholism. The desire to drink is so strong that the mind finds many ways to rationalize drinking, even when the consequences are obvious. Unfortunately, denial often increases as drinking gets worse. Avoiding to look honestly at one's behavior and its negative effects, also exacerbates alcohol-related problems with work, finances, and relationships. It’s a vicious cycle.

At the last stage of the process, people addicted to alchohol drink in order to feel "normal" (no more to feel better), since they need to fight against their important depressed and painful emotions."[4]Vicious cycle of denial:



5. Possible interventions for alcohol misuse & addiction

As mentioned in the introduction, on most Family Development Programmes implemented by Inter Aide in partnership with Southern NGOs, the social workers and field workers ("Family Development Workers") are not trained to work directly on addictions. Still, in their home-based follow-up of vulnerable families living in slums, they often face situations where one or several members of a family have an addiction (alcohol, gambling, sniffing solvent, and "crack" derived from cocaine, called "shabu" in the Philippines).

Family Development Workers tend to consider addiction as "vices": we hope this paper will help them undersand that addictions are not "vices" but the symptoms of an intense suffering. We hope to help them in their work, and make it easier for them to consider and relate to the persons with an addiction with more compassion, less fear and judgement (which is only a defense against our own fears...).
Though Family Development Workers cannot deal directly with the issue of addictions, they need to be able to identify the addiction problem, and provide non-judgemental counselling to the person and his/her family. They should also be able to refer the persons in need to specialized organisations (such as Alcoholic Anonymous or Narcotic Anonymous) when available. Ideally, such organisations should be invited (incited, convinced...) to come in the

[4] Alexandra David, Coopé Sud 2000

areas where Family Development Programmes operate, so that their services become accessible to the slum-dwellers.

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An intervention focusing only on suppressing the symptom (alcohol or drug intake, or other compulsive behaviour such as gambling) will not be effective, as it will not take into account the deep inner suffering, the existential pain.

For patients with physical complications of alcohol abuse or psychiatric disorder, abstinence from alcohol is the preferred goal. source: WHO *Guide to Mental Health in Primary Care.*

To achieve abstinence, people with alcohol dependence need to have regular counselling and support, since getting out of alcohol dependency is difficult, painful and also requires them to make important changes in their life style (change of environment, friends, having new activities...). Interventions with former addicted persons (ex: "Alcoholics Anonymous" www.aa.org) often provide an effective help.

People who are not alcohol-dependent but who have experienced alcohol-related problems may be able to limit the amount they drink. If they cannot stay within those limits (see below), they need to stop drinking altogether.

> “Because of the specificity of the defence mechanism (denial) used in alcohol addiction, persons suffering from alcohol dependence very seldom seeking for help for their drinking problem (as they deny it). They might evoke other reasons, usually the consequences of alcohol addiction in their life: problems with their family, their job or other social difficulty. However, persons who are addicted to alchohol feel so dependent on others that they are often looking for help: because of low self-esteem, they believe they are not able to deal with their problems in reality. They are seeking support from others in order to fight their fear of being alone and abandoned. Denial then often makes the counsellor feel his / her intervention is useless since the person does not want to admit his / her real problems. That is why the first counselling sessions often appear discouraging.
>
> Trying to convince addicted persons about their dependency and pushing them to admit they have a problem is not appropriate, as it would even lower their already low-self-esteem, and in turn it will reinforce the vicious cycle consisting in denying the reality of their addiction. In the initial phase, the counsellor has to accept the person's denial (as it is an essential part of the disease), and step by step to help the person establish links between alcoholism and his / her difficulties in reality. This is a long process because the person has organised most of his / her life around alcohol and denial; the counsellor then

needs a lot of patience and tolerance. The unconditional acceptance of the alcohol-dependent person is crucial"[5].

6. Definition of drug-addiction

Here is the World Health Organization definition:

"Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted. The life of the addict may be dominated by substance use to the virtual exclusion of all other activities and responsibilities. The term addiction also conveys the sense that such substance use has a detrimental effect on society, as well as on the individual; when applied to the use of alcohol, it is equivalent to alcoholism" http://www.who.int/substance_abuse/terminology/who_lexicon/en/

Drug-addiction causes many troubles:

- Physical problems
- Psychiatric troubles, essentially related to the tendency to escape from reality: withdrawal, feeling of having extreme power on life events, feelings of developing supernatural capacity (due to the different perception they have of external reality when they take drugs)...
- Social troubles: difficulty in their occupation, loss of job, involvement in antisocial activities in order to get enough money to buy drugs, prostitution, fights, problems with justice...
- Affective problems: relationships with other people might get affected too.

Many theories about causes of drug-addiction have been developed. Some give physiological explanations, some others focus on psychological theories (affective and emotional factors), or socio-cultural theories stating that taking drugs is due to social deprivation, because the social environment has denied them opportunity for achievement. All these factors actually overlap.

7. Adolescence identity crisis and drug-addiction

"Substance misuse in young people should be considered in the context of 'normal' adolescent risk-taking and experimentation: 65% of young people (below 18) will experiment with illegal drugs; 96% of this experimentation is with cannabis and only 4% go on to regular abuse and long-term problems. Polydrug-use is common as part of the 'club scene' in older adolescents, so a variety of substances — legal and illegal — is used on a sporadic basis. Although substance

[5] A.David, Coopé Sud 2000

misuse in young people is very common and often ‘on–off’, it is occasionally fatal and should be taken seriously.
Substance misuse in young people can be a ‘symptom’ of an underlying psychological problem that itself requires treatment”.
http://www.mentalneurologicalprimarycare.org/downloads/primary_care/Substance_misuse_in_young%20people.pdf

Even though some drugs are widely used in some social groups, it does not mean they are not dangerous: cannabis for instance is a hallucinogen drug that can induce psychotic decompensation in young people with a schizophrenic vulnerabily. It can have durable effects on the brain, especially on immature teenage brain (brain growth is only completed between 20 to 25 years of age).

General statements about adolescence identity crisis.

> “Drug addiction generally starts during adolescence period. This is a delicate developmental stage, in-between childhood and adulthood, when the teenager is no more a child and not yet an adult. It is an identity crisis because children have to "leave" their identity as children (and all the protection it supposes) and to adjust to their new adult identity, its associated responsibilities and new social roles.
>
> Very often, adolescents still feel they are children when puberty occurs: the fast physical changes are disturbing for them, and their new interest for sexuality appears confusing because of the associated social taboos. Their environment wants them to assume responsibilities for which they might not feel ready. This context provokes fear to fail, fear of being helpless, fear of the future, environment might appear threatening... These emotional difficulties are normal up to a certain point, since such an evolution of one's identity necessarily entails profound inner changes.
>
> At that age, the peers group has a very important role, because it helps adolescents to develop new identity marks (by identifying themselves to the group) and to feel they are not alone, facing this difficult situation. Peers group has are reassurance function too, and protection again an inner feeling of emptiness, vulnerability and inadequacy. Adolescents are generally easily influenced by others, since they are seeking for new identity marks; they need social recognition and acceptance so as to clearly define their role and function in society”[6].

Adolescence is also a period where unresolved trauma of childhood can be reactivated: as it is a stage of life where many changes are taking place and many changes are possible, it is a period where such uresolved trauma can be repaired in the interaction with a "good enough" environment (family, school, community, friends & peers...). If not, addiction might be a used as a way to cope with this reactivated trauma, and to release the induced pain.

[6] A.David, Coopé Sud 2000

Adolescence is a period of “existential crisis” during which the teenager starts questionning the values, rules, taboos that were transmitted to him/her during childhood, the meaning of live, life and death, his/her own place in life and in society, and the sense of it all.
If the environment (family, school, community, peers...) cannot help the teenager go through this period of intense questionning, cannot give him/her the support and social recognition and acceptance s/he is craving for, cannot guide him/her so that s/he becomes able to find his/her own answers to these questions, then, addictions may provide him/her with an inadequate answer to very relevant existential questions: the modified state of consciousness obtained through addiction provide him/her with a temporay relief from this deep existential suffering.

Thus, when working with a person with addiction(s), it is always interesting to try and trace back to the existential crisis that is bound to be found at the period of life in which the person started being caught in an addictive behaviour. Together with learning to regulate one’s own affects & emotions — which can be done in psychotherapy, in the interaction with the psychotherapist or counsellor — recovering or discovering a meaning to life, regaining a sense of purpose, will be a great help in the process of getting rid of the addiction.

Factors influencing drug-addiction (as any type of addiction). [*part of this paragraph is repeated from § 2. Bio-psycho-social factors influencing addictions*].

As already seen above, the environment the person has grown in is a determining factor. In the vast majority of cases, insecure / violent / abusive environment can be found in drug-users' childhood and teenage years (this is true of all addictions, not only drug-addiction). As mentioned already, 60% of drug-addicts were victims of incest or sexual abuse in childhood... Then, in the context of teenage identity crisis, various factors might occur and lead to drug-taking (see § 7).
Early exposure to drugs (in utero, or through medical treatment during childhood such as Ritalin® for hyper-activity) is also a factor influencing later drug addiction.

The following points are found in all type of addictions (these tendencies are observed among the majority of people with addictive behaviour, without considering the type of drug they are taking):

The insecure / violent / abusive environment people with addictive behaviour have grown in have not provided them with skills to cope with emotions (the ability to regulate emotions is built in early infancy through the interaction with a "good enough" caregiver — See Allan Shore: *Affect Dysregulation and Disorder of the Self.* WW Norton 2003).

Disorganised, unstable family context with lack of well-established limits and inconsistency, often increase the risk of addiction (it does not mean that children corning from these kinds of families setting will become drug addicted persons! It's the other way round: these kinds of families are often found among drug-users). In some abusive families, parents do not treat their child / children as (a) separate person(s), but rather as extension of themselves, as objects they can use, beat, and abuse... Most abusive parents have suffered from unresolved trauma

themselves — and the imprinting of the chaotic alterations of the parents' dysregulated affective state may be a central mechanism for the "intergenerational transmission child abuse"[7].

As seen above for alcohol abuse, growing up in such insecure / violet / abusive environment, may result in:

- Low inner security and a weak self-image;
- A high sensitivity to depression;
- Constant inner pressure, anxiety, high vulnerability to stress (also found among abusive parents...)
- Hypersensitivity, difficulty to tolerate frustration, to regulate emotions and deal with interpersonal relationships.
- This inability to regulate emotions can result in impulsiveness;
- High mental activity (a constant stream of thoughts, usually negative and self-depreciating thoughts) is often found among people with addictive behaviour as high mental activity is a way to adjust to an unstable / stressful environment, and to compensate hyper sensitivity (which is a painful quality...). The modified state of consciousness induced by the addictive substance or behaviour provides a temporary relief to this high mental activity and "brain chatter";
- Persons with addictive behaviour may develop a tendency to self-punishing behaviours: alcohol, drugs as well as tobacco, have a destructive effect for the body, and can cause diseases and death.
- Socialisation troubles and opposition tendencies towards social law (especially in the case of addiction to illegal substance).

Regarding the low feeling of inner security: if a teenager does not live in a stable family environment that helps him develop an inner security consolidating his/her new identity, and helps him feel comfortable with this new identity, environment will justly appear unreliable, which may provoke confusion and increasing inner insecurity (here one can sec the importance of role models within and outside the family, and possibility for the teenager to establish positive identification to these models).

> "In such a context, drugs are used to provide a temporary relief from their difficulties, their abusive / violent environment and from their self-depreciating toughts. Certain drugs give them feelings of well-being or strength. The modified state of consciousness obtained through any addiction provides a temporay relief from suffering: this temporary relief from pain that is sought through addictions[8]. Attempt at escaping reality is one of the similarities with alcoholism — and is the case with all addictions. (The main

[7] Remember only 8% of people who have been sexually abused in childhood will become sexual abusers. It means that the vast majority of victims will *not* reproduce the abuse. On the other hand the vast majority of sexual abusers were abused in their own childhood.

[8] Yet, alcohol-dependence is frequently looked upon as even more despicable as drug-addiction, and alcoholics are held in contempt. May be this is party due to the facts that drugs being illegal and therefore connected to criminality, it inspires fear rather than contempt in most people. As there are many misconceptions and beliefs about drugs and their high addictive potential, drug-addicts might also be looked at as victims of the drug. Instead, as most people can drink without becoming alcoholics, they look at people who do become addicted to alcohol as "weak" people. This induces shame, and denial is a defense again this feeling of shame.
Concerning drugs addictive potential, it's interesting to know that the addictive potential of nicotine (in tobacco) is as high as (or even higher) that of heroin…

difference between these addictions to drugs and addiction to alcohol is that alcohol is legal & socially accepted or at least tolerated, while drugs are illegal — there is something with refusing social laws). For alcoholism, denial hides the destructive effects of drinking from the person's consciousness, while drug-users are usually aware of it). That is why they can easily become addicted, since if they stop taking drugs, they still have to face insecurity and depression, their low self-image, fears of future... Risk of developing dependency is high.
Since reality is felt to be too painful and difficult (and has actually been painful and difficult: remember 60% of drug addicts have been sexually abused in childhood...), these persons feels distrust or dread with regard to the future and this distrust, mingled with their low self-image, result in their difficulty to plan for the future. Sometimes, their self-image is so low, that when they cannot take drugs, some drug-addicts commit suicide: facing their own self and their negative feelings about themselves is too difficult. Then, suicide, like taking drugs, aims at escaping from the pain they experience constantly.

Also, if teenagers are asked to take drugs so as to be accepted in the peers group, they might accept, since the group helps them build their identity and make them feel accepted, may be for the first time in their life (if their family has not been "good enough", then the teenager is particularly sensitive and has special difficulty to go through the adolescence stage).

Drugs are not legally sold or socially allowed, and drug-users show opposition tendencies towards society. They feel rejected by society as they have been rejected by their parents (therefore, their affective needs are huge). They prefer to withdraw and to depend only on themselves to satisfy their need for feeling well-being, pleasure, protection, even through illusion.

These persons deny their affective dependence towards other persons and environment that has proven so painful and dangerous"[9].

Because others have proven to be so unreliable, and relationships so dangerous (remember 60% or more of drug addicts have been sexually abused in childhood...), they'd rather be dependent on a sustance than on an unreliable relationship.

8. Interventions for drug-addictions

As mentioned above for alcohol addiction, addiction (to any type of substance or behaviour) is a long and complex issue to deal with. The field workers working on the type of Family Development Programmes such as Inter Aide & Southern partners implement, cannot take such issues in charge themselves: yet they need to identify the addiction; they must be able to provide non-judgemental counselling to the person and his/her family; they must also refer the persons in need to specialized organisations (such as Alcoholic Anonymous or Narcotic Anonymous) when available. Ideally again, such organisations should be incited to come to the areas where

[9] A.David, Coopé Sud, 2000

Family Development Programmes operate, so that their services become accessible to the slum-dwellers.

Agin, the intervention described below, as the references cited in this paper, are not given here as models of intervention to be implemented by Family Development Workers: they are given here as a help for the Family Development Programmes staff, for them to acquire a clearer and more objective understanding of addictions and of the possible interventions. They should remember that addictions are symptoms of an intense suffering, usually rooted in an early unresolved childhood trauma, and not a "vice": we hope that it will help them consider and relate to the persons who are addicted with sympathy and compassion, less fear and judgement (which, as we understand it, is only a defense against our own fears...).

One should remember that an intervention focusing only on suppressing the symptom (alcohol or drug intake, or other compulsive behaviour such as gambling) will not be effective, as it will not take into account the deep inner suffering, the existential pain.

> "Similarly to alcohol dependence, intervention with drug-addicted persons consists in helping them to follow treatment. That means a comprehensive intervention combining possible medical treatment (medication might be needed, depending on the kind of drug they are addicted to), individual and group counselling (plus, ideally for teenagers, family therapy). Regarding the kind of troubles they are suffering from, a special attitude has to be adopted by the counsellor or the educators in contact with these persons.
>
> Usually, these teenagers tend to isolate themselves (rejection is a vicious cycle for them, where they find a kind of identity too). They often express the feeling that adults "do not understand them"; because of such belief they do not ask for help, it increases their feeling of loneliness and their withdrawal.
>
> In the initial phase, interventions with former drug addicted persons (ex: "Narcotic Anonymous") are often effective, because the children/teenagers can identify themselves to these persons who are coming from the same background (they are adults who understand them, they have the same kind of history, and it provides these children with the feeling of belongingness they are missing). This kind of group meetings is especially useful to help children admit their difficulty and ask for help.
>
> The group of peers (the band, "*barcada*" in the Philippines…) is very important; it is the children's reference in order to counterbalance the lack of reliability they are feeling towards the family setting. Then, group counselling is often appropriate. The child/teenager might certainly need the group reference for some time before being able to feel enough confident to face life by himself. This is the first step in the child's treatment.
>
> To stop taking drugs entails important changes in the person's life: change of friends and peers group, having a stable work again, developing socially accepted behaviour... That means exposing themselves to the potential danger of failure, frustration or reject by the society. Support and regular counselling with a trusted adult who can help the child to deal with his new life situations is needed (sometimes, behaviour monitoring is asked by

the child who does not feel yet strong enough to face his / her problems alone). The goal is to make the child feel stronger to become more independent (contrary to addiction and dependence towards other people's cares and affection, with exposed them to possible pain and frustration), so intervention has slowly to evolve from a group approach to an individual approach.

During counselling, educators should not be 'moralising' with the children. Telling them too much about social laws and morality includes the risk of provoking an opposite effect by reinforcing their withdrawal and opposing attitude to adults, since they are not feeling understood. Their problem is not that they do not respect social laws and values; their problem is related to their experience of unreliable or painful relationships, with a negative self-image, and a tendency to deny these problems. For these adolescents, their antisocial behaviour is a way to express inner insecurity (responding to it by telling them about social laws is not appropriate because they are using it to express their inner painful feelings). We need to talk with them about their real difficulty, and help them at this level. Counsellors and educators should listen with empathy, with unconditional acceptance of the children and their problems, in order to keep a communication as open as possible, and to be able to help the child/teenager.

Informing them about the consequences of addiction is needed and important too. However, one has to be careful and check that children/teenagers do not feel too much guilty by listening to these explanations, in order to avoid increasing their inner insecurity, which might lead to an increasing withdrawal or even to the rejection of the educator.
Sports are recommended for these children/teenagers in order to provide an outlet for their inner tension (since drugs are no longer there to help them escape from it)[10]. It also aims at helping them feel their body in a new positive way (so as to deal with their self-punishing or self-destruction tendency). Expressive activities are advisable too, in order to provide the teenagers with opportunity to express their emotions and inner world in a symbolic way, which is the first step in identifying and dealing with painful feelings. Impact of creativity on self-esteem and self-confidence has been demonstrated in many studies too".[11]

As a high mental activity ("brain chatter" dominated by self-depreciating and negative thoughts) is often found among people who use drugs and alcohol, activities such as meditation, yoga, tai qi chuan, positive thinking (through sophrology techniques for instance) can also be very helpful, as such activities induce a pleasurable and relaxed state of consciousness ("alpha waves" in the brain are associated with deep physical and mental relaxation and can be induced by all kind of relaxing practices, such as meditation, yoga, tai qi, etc.) and helps to calm the contant stream of thoughts and to regulate one's own affect...

As a conclusion, we can emphasize again that when working with a person with an addiction, unconditional acceptance is a prerequisite — as shame will only reinforce the addictive process (shame arises in relation to someone else: when one is held in contempt by someone else — this contempt might have been internalized since early childhood to become self-contempt…).

[10] While remaining careful not to replace drug addiction by addiction to sports... Team sports might help reduce this risk while enhancing the youth's social skills.
[11] A.David, Coopé Sud, 2000

To understand addiction as a symptom of suffering, and an attempt at self-medication will relieve some of the guilt: the person is not actually trying to destroy him/herself, but on the contrary, s/he is trying to save him/herself and find relief from suffering — but the medication chosen doesn't work and has a real destructive effect. Knowing that persons with addictions are always hypersensitive and very frequently hyper intelligent (as they have developed a high mental acuity to adjust to a threatening, enreliable environment, and to compensate for their hypersensitivity) might also help smooth out the guilt and shame on the side of the person with an addiction — and prevent jugemental attitudes on the side of field workers / counsellors...

This attempt at self-medication can be kept as a fuel in the process of getting rid of the addiction —whereas guilt and shame should be placated. It also helps to try and trace back to the existential crisis that is bound to be found at the period of life in which the person started being caught in an addictive behaviour: addiction is a "wrong", inadequate, ineffective answer to a "right", highly relevant, existential question.

Together with learning to regulate one's own affects & emotions — which can only be done within a safe, secure and supportive relationship, such as in psychotherapy, in the interaction with the psychotherapist or counsellor — recovering or discovering a meaning to life, regaining a sense of purpose, will be a great help in the process of getting free from addiction.

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To got further: Allan Shore's articles http://www.allanschore.com/articles.php

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