



BSc Mental Health

Addictions, Substance Abuse & Psychological Dependencies

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Aims

To introduce theories of the aetiology of addiction, prevalence of addictive disorders and contemporary diagnoses of addictions.

To provide an understanding of addictions in the absence of substance misuse and consider issues relevant to specific populations.

2

Learning Outcomes

Analyse

Analyse models of addiction and addictive behaviours.

Consider

Consider contemporary diagnoses of addictions and evaluate evidence-based models of interventions for addictive behaviours.

Evaluate and examine

Evaluate and examine addictions and addictive behaviours in relation to specific population groups (e.g., youth, older adult, females).

Organise

Organise their knowledge and learning through the use of information resources, and present their work at the appropriate level.

3

Assessment

Assessment Component 1 - Coursework: 2,500 word written essay
50%

Assessment Component 2 - Practical: awareness raising video (five minutes per individual) 50%

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Addiction

The conceptualisation of addiction as a disease became prominent towards the end of the 19th century.

However, since its initiation, the **disease model** has received opponent views that have gravitated mostly on the claim that addiction does not manifest as an inevitably progressive or incurable phenomena.

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Addiction

The emergence of other classifications of addictions (ie. eating behaviours, gambling, shopping, Internet) made their way into the research field, challenging the predominant disease model view as they probed its incompatibility with explaining such emergences.

A growing number of studies on 'natural recovery' revealed that most people who quit or change their addictive behaviour do so without treatment or professional intervention.

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Addiction

Contemporary accounts of the disease model prescribe addictive behaviours as biopsychosocial phenomena.

The biopsychosocial model is an attempt to broaden the older, traditional view of addiction as a strictly biological disease by integrating psychological and social features related to the addiction.

This model thus recognizes that substance addiction and the use of drugs is induced as a result of existing factors in the society and the peer group, a cultural tendency for substance abuse, and genetic links, thereby facilitating a more complex and multifaceted understanding of addictive behaviours.

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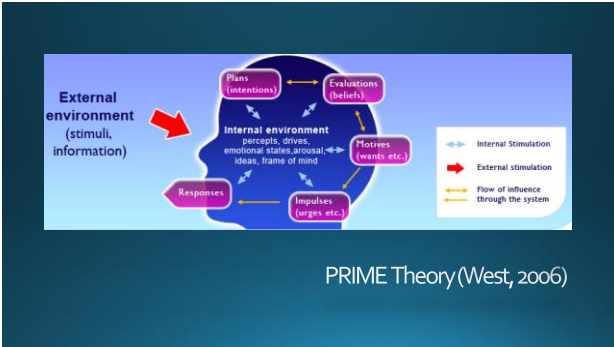
Addiction

Some still contend that this model operates within a disease paradigm, and is thereby constrained by biomedical terminology (i.e. relapse, withdrawal, chronic, recovery), which thus permeates our whole conception of addictive behaviours.

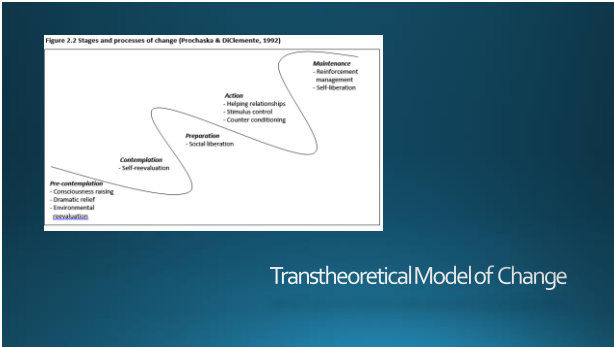
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Classical conditioning	The conditioned stimuli activate the same neuronal pathways in the brain that mediate the direct pleasurable effects of drugs, and they thereby elicit a motivational state that directly primes drug-taking behaviour (Diage, 1975).
Operant conditioning	The drug acts as a reward, or positive reinforcement, and with repetition the association between cue, response and reward becomes stronger (Silverman, 2004).
Social learning	We are instructed in cultural norms, and model the behaviour of parents and peers that all interact within socialization influences to determine initial patterns of drug and alcohol consumption (Skarlat, Rease & Dughey, 1997).
The self-medication hypothesis	Substance addiction functions as a compensatory means to modulate effects, to self-soothe from distressful psychological states and to achieve emotional stability (Khantzian, 1997).
Opponent processes theory	Addiction is the result of an emotional pairing of pleasure and the emotional symptoms associated with withdrawal. Initially, there are high levels of pleasure and low levels of withdrawal. Over time, as the levels of pleasure from using the drugs decrease, the levels of withdrawal symptoms from not taking the drug increase, providing motivation to keep using (Solomon, 1986).
Problem behaviour theory	People engage in problem behaviours such as illicit drug use in order to help them achieve personal goals. Such behaviour is seen as functional - for example, coping with failure, boredom, unhappiness, social isolation or low self-esteem (Jessor, 1991).

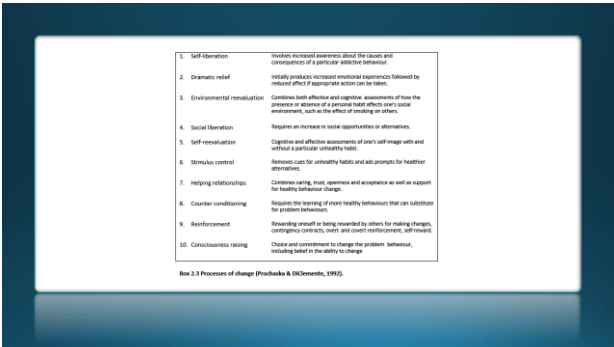
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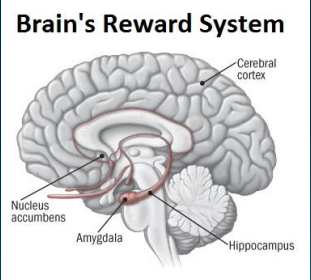


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Brain's Reward System



Cerebral cortex

Nucleus accumbens

Amygdala

Hippocampus

Biology of Addiction

<https://www.youtube.com/watch?v=XDq-LE8dG4>

*Please see Dr. Kate Williams' lecture on the biology of addiction.

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Addiction

Psychosocial Explanations:

Consumption is rewarded by feelings of pleasure and disinhibition.

Cognitions known as addictive beliefs (e.g. "I need a drink to get through the day") may also support consumption.

Consumption may be encouraged by positive portrayals of drugs and other behaviours.

Individual vulnerabilities

Social context

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Addictions,
Substance Abuse &
Psychological
Dependencies

Substance Use Disorders

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Defining Substance Use Disorders

- Addiction
- Substance abuse and dependency
- Tolerance
- Withdrawal

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DSM-5 Criteria for Substance Use Disorder

Problematic pattern of use that impairs functioning. Two or more symptoms within an one-year period:

- Failure to meet obligations
- Repeated use in situations where it is physically dangerous
- Repeated relationship problems
- Continued use despite problems caused by the substance
- Tolerance
- Withdrawal

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DSM-5 Criteria
for Substance
Use Disorder

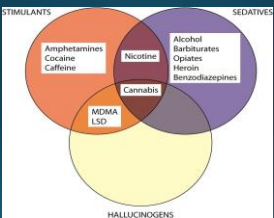
- Substance taken for a longer time or in greater amounts than intended
- Efforts to reduce or control use do not work
- Much time spent trying to obtain the substance
- Social, hobbies, or work activities given up or reduced
- Craving to use the substance is strong

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Psychiatric Disorder	% of individuals also diagnosed with a substance use disorder (SUD)
Bipolar Disorder	60.7%
Major Depression	18%
Obsessive-Compulsive Disorder (OCD)	32.8%
Panic Disorder	35.8%
Schizophrenia	47%
Bulimia Nervosa	28%
Personality Disorders	42%

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Substance overlap between
categories



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Specific
substance use
disorders

- Alcohol
- Tobacco
- Cannabis
- Stimulant use
- Sedative use
- Hallucinogens

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Adult drinking
habits in Great
Britain: 2005 to
2016 (Main
points):

- In Great Britain, 56.9% of Opinions and Lifestyle Survey respondents aged 16 years and over in 2016 drank alcohol, which equates to 29 million people in the population.
- 7.8 million people "binged" on alcohol on their heaviest drinking day.
- Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group; when they do drink, consumption on their heaviest drinking day tends to be higher than other ages.

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Adult drinking
habits in Great
Britain: 2005 to
2016 (Main
points):

- The highest earners, those earning £40,000 and above annually, are more likely to be frequent drinkers and "binge" on their heaviest drinking day when compared with the lowest earners.
- In 2016, similar patterns of drinking were observed in England, Scotland and Wales; of the English regions, binge drinking was more common in the north.
- Among men who "binged", normal strength beer was the most popular choice of alcohol, for females wine was the most popular choice.

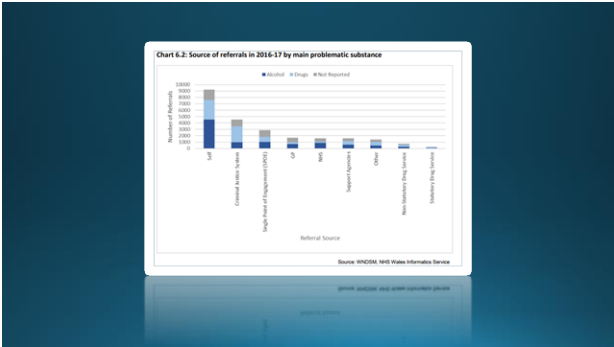
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Table 6.3 Referral activity by Ethnic Origin

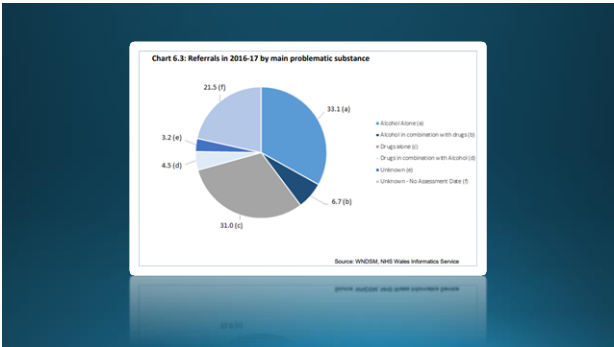
	Referral Year							
	2012-13		2013-14		2014-15		2015-16	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
White	19,005	78.1	18,687	80.4	23,239	82.2	20,146	82.5
White and Black Caribbean	44	0.2	66	0.3	40	0.1	45	0.2
White and Black African	14	0.1	17	0.1	22	0.1	11	0.0
White and Asian	19	0.1	17	0.1	23	0.1	21	0.1
Any Other Mixed Background	83	0.3	110	0.4	92	0.3	87	0.4
Indian	28	0.1	25	0.1	29	0.1	16	0.1
Pakistani	30	0.1	43	0.2	45	0.2	28	0.1
Bangladeshi	32	0.1	29	0.1	30	0.1	18	0.1
Any Other Asian Background	34	0.1	34	0.1	55	0.2	53	0.2
Caribbean	35	0.1	56	0.2	27	0.1	36	0.1
African	39	0.2	64	0.3	31	0.1	47	0.2
Any Other Black Background	32	0.1	40	0.2	74	0.3	61	0.2
Other ethnic group (a)	36	0.1	31	0.1	40	0.1	50	0.2
Client not stated (b)	4,901	20.1	4,380	17.5	4,504	15.9	3,797	15.0
Unknown (c)	1	0.0	0	0.0	4	0.0	0	0.0
Total	24,331	100	24,490	100	28,255	100	24,408	100

Source: WNCISD, NHS Wales Informatics Service

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Alcohol use disorder



≥6% UK population could be labelled as *hazardous*



drinkers

Individuals who have 5 or more standard drinks (males) or 3 or more standard drinks (females) on a typical drinking day (1)

Binge drinking is also of concern (young people)

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The physical effects of alcohol

Main constituent is ethyl alcohol which is absorbed into

the bloodstream

Initially acts to relax by affecting the neurotransmitter GABA

Second stage of intoxication includes inability to make judgements

The final physical effects include motor coordination difficulties and slowed reactions

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R: It is like [silence] when you take the first sip, it's good and it feels nice, you're funny, it is all cool and brilliant and then, there's the point when you're just trying to maintain that initial state, cause after the first few sips, you know, never, never, it is going to be experienced the same, I've always been the one, who stayed up, trying to maintain that feeling, the initial feeling...I was the one that stayed there trying to keep it going, trying to keep the party alive, it was sad, towards the end of it, it became sad cause I knew I had to finish, cause I was running out of money and drugs or buzz, and you know that feeling of impending doom like it is going to be over soon, it's going to run out, I'll have to go home...It was always the same, thrill and excitement, trying to maintain that feeling of excitement to depression and loneliness of finishing.

I liked to set myself, like what they call it, fire water, and you know why they call it fire water, because when I drank whisky, it burned, it used to go down burning, I used to drink it straight and I loved the feeling of it burning. It was like, setting myself on fire almost.

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I had a quarter of whisky on my way to work. Then during work, I had, between 10 and 12 another quarter of whisky. Then I had a couple of beers, and then, after lunch, between one and five, I had another quarter of whisky. So, I'll keep drinking another bottle of whisky at work, and, you know I didn't want to stop, I didn't see the problem with that. I did not sleep at all, and everyday it was the same, but I didn't see a problem with it, it was normal for me to drink and I wanted to.

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Wake up, six or seven am, throw up, and then walk to the off licence, buy a quarter of whisky and drink it, just to feel normal, everyday it was the same...I kind of knew something was wrong but, I don't know, it's the illness that is cunning and powerful...I can't explain it. My dad used to come into my room and swear at me, fuck, what you have done, why don't you stop drinking, why can, why don't you just drink beer, why you keep drinking whisky, and, and I really didn't have an answer...I was, I'm going to stop, I'll stop tomorrow. But tomorrow never came...I always thought that I can stop tomorrow.

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Effects of alcohol on physical & psychological health



WITHDRAWAL SYMPTOMS



DELIRIUM TREMENS (DTs)



KORSAKOFF'S SYNDROME



FOETAL ALCOHOL SYNDROME

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Withdrawal symptoms

- The long-term physical effects of heavy alcohol consumption include withdrawal symptoms when the body is deprived of alcohol.
- These include
 - Restlessness
 - Inability to sleep
 - Anxiety and depression
 - Muscle tremors
 - Rises in blood pressure and temperature

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Delirium Tremens(DTs)

The effects of withdrawal after extended heavy drinking over a number of years where the drinker may become delirious, experiences unpleasant hallucinations, and exhibits shaking and muscle tremors.

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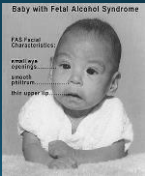
Korsakoff's syndrome

- A syndrome involving dementia and memory disorders which is caused by long-term alcohol abuse and dependency
- Can be the result of vitamin and mineral deficiencies caused by the long term excessive intake of alcohol which contains calories but is entirely devoid of nutrients

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Foetal alcohol syndrome

- Where heavy drinking by a mother during pregnancy can cause a whole range of physical and psychological abnormalities in the child, including:
 - Physical deformities
 - Heart problems
 - Stunted growth
 - Hyperactivity
 - Learning difficulties



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The course of alcohol disorders



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Risk factors for alcohol use disorders

- A family history of alcoholism
- Long-term negative affect
- A diagnosis of childhood conduct disorder
- Experiencing life stress and childhood life stressors
- Holding beliefs that alcohol has favourable outcomes

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The costs of alcohol use disorders

- Costs of alcohol-related crime and public disorder in the UK estimated at £1.5 billion per annum
- Accidents and crime are the two biggest social problems associated with alcohol misuse
- Per capita alcohol consumption predicts
 - Mortality from liver cirrhosis
 - Mortality from accidents and homicide
 - Death from suicide

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Aetiology

- The aetiology of substance dependency has to be viewed in developmental terms
- Most individuals who become substance dependent go through three developmental stages:
 - Experimentation
 - Regular use
 - Abuse & dependency

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The aetiology of substance abuse & dependency

Experimentation

Availability

Familial Factors

Peer Group Influences

Media Influences

Regular Use

Mood-Alteration Effects

Self-Medication

Long-Term Expectations & Beliefs

Cultural Variables

Abuse & Dependency

Genetic Predisposition

Long-Term Cognitive Deficits

Concurrent Psychiatric Diagnoses

Poverty

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Cultural context

- Cultural differences in frequency of drug use may mediate the transition from first use to regular use (e.g. alcohol consumption in wine-drinking societies)
- There are also cultural differences in beliefs about the effects of drugs

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