

PSYCHOTHERAPY UPDATE

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ALCOHOL AND SUBSTANCE ABUSE

I have been alarmed by the increasing incidence of alcohol and drug abuse, especially among teenagers. Users are getting younger; even children as young as eight years old have been found using various mind-altering substances. This issue of the **Psychotherapy Update** will be somewhat different from previous issues in that rather than being an essay it will focus on giving you information about the various treatments available for alcohol and substance abuse in the hope that it may help you or someone you know obtain the treatment needed.

Drug, alcohol, and tobacco use is the cause of more deaths, illnesses, and disabilities than any other preventable health condition and seriously undermines America's family life, economy and public safety¹. For the past few decades, national surveys have consistently shown that about 10 percent of American adults have significant problems related to their own use of alcohol. In addition, about 25 percent of adults have reported that they use tobacco on a regular basis and about 7 percent use illegal drugs. The following are some additional alarming statistics¹:

- *In the 1960s, 7 percent of new female drinkers were ages 10 to 14. Today the figure is at 31 percent.*
- *Inhalant use is most prevalent among young children and usually entails inhaling household items such as shoe polish or paint thinner. More than 1,000 products widely available in households can be used as inhalants.*
- *There is a direct connection to the use of methamphetamine and the American work ethic. As many as 9.4 million Americans have used the drug at least once.*
- *Everyday 3,000 kids start smoking and a third of them will eventually die of tobacco related causes. Two of three 12- to 17-year olds who smoked cigarettes in the last year show signs of addiction.*
- *A survey of American teens found that one in four said they had a friend or classmate who had used Ecstasy; 17 percent said they knew more than one user.*
- *Two-thirds of Americans with serious substance abuse treatment needs are not being treated.*
- *6.4 percent of Americans age 12 and older used illicit drugs or misused prescription drugs.*
- *15.3 percent reported that they had engaged in binge drinking in the past month and 5.4 percent drank alcoholic beverages heavily.*

Difference between Abuse, Dependence and Addiction

Alcohol and drug use ranges on a continuum from use to dependence characterized by increasing loss of control and increasing functional impairment. The term *abuse* is a broad term that refers to any maladaptive use of a psychoactive substance. There comes a point where the use of the alcohol or drug is no longer voluntary and becomes involuntary and beyond the individual's control. When it reaches the stage where alcohol or drug use is no longer voluntary and interferes with daily functioning, we call it an *addiction*. Dr. Alan Leshner, Director of the National Institute on Drug Abuse, stated that the condition of addiction is a "biobehavioral phenomenon" characterized by a movement from a state in which

use is at least under some degree of voluntary control to a state in which use is both compulsive and uncontrollable. He characterized *addiction* as a different state from abuse. Leshner states that with addiction there are fundamental brain changes that occur with increased use. These brain changes create a need in the individual for increased, compulsive use of the substance. In addiction there is a loss of control and increasing use despite negative consequences. The term *dependence* refers to a more severe form of abuse characterized by habitual use of a substance that is taken more frequently and in larger amounts over time, leading to increasingly negative consequences.

¹ *Substance Abuse: The Nation's Number One Health Problem, by the Robert Wood Johnson Foundation*

Historically, there have been two camps regarding the understanding of drug and alcohol addiction. One camp, dominated by physicians, holds to the belief that addiction was based on a disease model. It states that there is a genetic and/or biochemical basis for addictions and that the individuals cannot consistently control their drug-alcohol behavior without total abstinence. They claim that there is no cure because addicts cannot escape the biochemical predisposition. The other camp, dominated by psychologists, believes that alcohol and drug abuse is a learned behavior and, as such, can be unlearned, change or controlled through behavioral-learning models of treatment.

Increasingly, addiction workers in the field are coming to the realization that neither approach alone may be sufficient for treating a large number of addicts. For some individuals there may be a biochemical basis for their addiction, for some a behavioral basis, and for still others, both may be involved. Furthermore, these workers are recognizing that treatment isn't based on a "one size fits all" model. While the abstinence model may be appropriate for some individuals, a moderation approach may be effective for others. Addiction is a multivariate disorder with no simple solutions. By offering only one approach we put addicts in the position of either adopting the only available treatment approach, whether or not it works for them, or not receiving any treatment at all. Most professionals in the field recognize that treatment of addiction must focus on the addictive behavior itself rather than on the cause of the addiction.

Drug Abuse

Nora Volkow, MD, of the Brookhaven National Laboratory, says:

"Classically, people thought that drug addiction was a disease that involved the centers of pleasure – that people are taking the drug because it's pleasurable. But that is not the case. In fact, addicted people don't have as strong a pleasure response as people who are not addicted. Recent data are showing us that addiction entails a basic disruption of motivational circuits."

Not only does drug abuse affect the emotional centers of the brain, but also recent research shows that drug abuse alters cognitive activities such as decision-making, planning, and memory. The evidence is clear that cocaine and marijuana use affect the frontal cortex, which is the center in the brain governing cognitive activity. Such disruption in the frontal cortex might be responsible for the poor decision-making. Recent research with a gambling task tested drug abuser's making ability. Not surprisingly it was found that drug abusers made poorer decisions on the gambling task than participants in a control group.

The research is mounting that the long-term affects of drug abuse are much greater than most people believe. It is not just that these affects occur while actively using the drugs. Rather, these affects continue after drug use is discontinued. It takes a

long time for most drugs to clear one's system and there may be residual physical and psychological affects long after that.

Alcohol Abuse

Alcohol abuse is more insidious than drug abuse. Since having a drink is socially sanctioned, there is no overt reminder that the behavior may lead to trouble down the road. With illicit drugs merely using the substance is a reminder because it is illegal. Having a cocktail at dinner, drinking a beer at a ballgame, and celebrating a wedding with champagne are all socially supported and even encouraged. One can receive accolades for being able to hold one's liquor. Becoming "shit-faced" in college is a right of passage. There are many models of respected people enjoying alcohol. This is not true for other substances. Hence, it is easy to rationalize moving from the occasional beer, cocktail, or glass of wine to daily use.

It is easy to go from the meal enhancing drink to using alcohol to self-medicate for social inhibition, depression, loneliness, anxiety, and other discomforting affects. Because some people can develop a tolerance for higher levels of alcohol in their system, they may need higher doses in order to experience the same effects. One drink becomes two, two becomes three. Where one beer was good, for some people it can easily become three, four, or more during the week with a few extras on the weekend.

Unfortunately, most alcoholics are not aware that they are alcoholics until they get into some difficulty. And when there is some warning, they often deny it. Often the early signs are related to work performance, health problems, social problems, legal difficulties, financial problems, or marital difficulties.

Some people are born with a genetic and biochemical predisposition that leaves them more vulnerable to abusing alcohol. They do not receive a signal from their brain that they have had enough or too much. Rather than producing sleep, nausea or other obvious physiological effect, they develop a tolerance for large amounts of alcohol. In fact, with continued abuse they begin to crave the substance. In addition, these people find that the alcohol temporarily comforts them by reducing shyness, anxiety, depression, and inhibition. In a world where alcohol use is approved of and even encouraged, it becomes part of the culture. Alcoholics do not want to think of themselves as not able to control their drinking. They want to keep up with and be part of their social group. Declining a drink in many situations is difficult for these people. It is not until they have developed a dependence that interferes with work, family life, and social life that they begin to recognize that they have a problem. But by then it is often too late. The physiological craving for alcohol becomes so great that giving it up does not seem like an option. The centers of the brain that regulate judgment have been so affected that it takes a crisis to motivate these individuals to seek treatment.

Signs of Abuse

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The very nature of substance abuse is such that people do not want to admit that they have a problem. People around them do not want to admit that there is a problem, and healthcare practitioners tend to either overlook or fail to investigate the possible existence of substance abuse. Hence, the individual goes diagnosed and untreated. There are several areas in which signs of abuse may appear.

Problems in living: financial problems including poor financial decision-making; poor judgment; legal problems including traffic tickets (e.g., DUI) and accidents; occupational difficulties such as poor performance, absence, conflict; social problems such as inappropriate behavior, missed appointments, chronic lateness.

Physical effects: increased incidence of health problems, poor dietary changes, higher tolerance for substance causing increased quantity and frequency of use; experiencing withdrawal when not using; higher incidence of nausea, dizziness, vomiting; disrupted sleep pattern.

Psychological and behavior effects: emotional instability, e.g., irritability, impatience; difficulty in abstaining from use; using substances to regulate affect, i.e., to reduce social inhibition, relieve stress, reduce anxiety or depression; denial and defensiveness when substance use is suggested.

Treatments

Interestingly, the research found that all people are not affected similarly by alcohol or drug abuse. For some the cognitive centers of the brain are more affected, for others the emotional centers are more affected. And for some both centers are affected. This has profound implications for treatment. One treatment does not fit all abusers. There is no magic bullet. In order to determine the best fit for any given individual, a complete psychological history and history of abuse and treatment must be taken. This places the individual into a context in order to decide what approach or approaches may be most beneficial.

Most treatment approaches agree that the focus of treatment must be on the cessation of substance abuse. Even those experts who believe that it is possible for the alcoholic to learn to drink in moderation suggest that cessation for a period of time in the beginning of treatment is necessary in order for the patient and clinician to develop a clear picture of the role alcohol plays in the individual's life. Most approaches, however, have abstinence as their goal, especially for those individuals who have a family and personal history of chronic abuse.

The following are some of the current treatment approaches for substance abuse:

- *Individual skill-based treatments:* these approaches help clients interact more effectively with others without using alcohol or drugs. These approaches focus on coping and skills training to help clients quit or decrease abusing alcohol and drugs by teaching them strategies to address interpersonal, environmental and individual "skill deficits" that may provoke substance abuse.
- *Motivational Enhancement Treatments:* this approach is based on a model that encourages patients to explore the

consequences of drinking in a supportive, non-threatening environment. One technique, called motivational interviewing, asks patients what about their alcohol or drug use causes them difficulties, enabling clients to examine their habits objectively. Once clients see how substance abuse or dependence affects their lives, they are motivated to change.

- *Cognitive Behavioral Treatment:* CBT states that human behavior is learned through personal experience and cognitive thought patterns. Changing behavior requires learning how to think differently about situations and how to change dysfunctional behaviors that cause problems. Alcohol dependent people have learned to drink in response to specific situations. The treatment task is to identify the "alcohol triggers" and then apply techniques to develop new ways of thinking and new behavioral skills for coping with these triggers.

- *Environmental and relationship-based treatment:* in this approach family members and significant others are taught coping skills and strategies to help influence their loved one's drinking and motivation to change.

- *Behavioral marital and family treatment:* this approach works with both the individual and the spouse or family to decrease or eliminate abusive drinking-related consequence.

- *Twelve-step programs:* these inpatient or outpatient programs are based on the 12-step model of Alcoholics Anonymous except that professionals lead them. Some professionals in private practice also use such a model, while other practitioners use AA to supplement and support the work being done by the patient in individual treatment.

- *Medications:* Two medications – disulfiram and naltrexone – have been approved by the FDA for alcoholism with a third showing promise, acamprosate, which is pending approval. Naltrexone appears to be most effective with fewer side effects.

As mentioned previously, no one treatment is effective for all substance abusers. Several variables must be taken into account in order to find the treatment that is most effective for any given person. Such factors as duration of addiction, family history, degree of substance abuse, extent of disruption in the patient's life, health, degree of motivation, to mention the most obvious, must be evaluated.

The first step in the treatment of substance abuse, after collecting a complete psychological, health, and substance abuse history, is to focus on harm reduction. If an individual is placing him or herself, or his or her family, in immediate danger, action must be taken to reduce the impending danger. Sometimes this may require inpatient treatment and sometimes it may involve the entire family. It requires developing a plan of action that can be implemented quickly. The focus during the early sessions is on changing the addictive behavior. In order for treatment to be effective, the individual must be sober. That is the first goal. Staying sober is the bulk of the work. Once sobriety has been achieved, treatment can focus on helping the patient re-structure his or her thinking, behavior, lifestyle, and focus. Maintaining sobriety becomes a top priority especially in the early stages of treatment.

Frequently substance abusers have personality difficulties in addition to their addiction. Such concurrent psychological problems as depression, anxiety, social phobia, low self-esteem and other such personality issues, need to be addressed as well as the addiction. Alcoholics and drug abusers often use various substances as a form of self-medication to help them cope with these issues. In treatment, however, we first focus on the substance abuse and then work with the personality issues that may co-exist. Sobriety or harm reduction is the immediate goal.

Conclusion

Our typical image of an addict is someone in a back alley shooting up or a drunk tottering on the street. This depiction is grossly misleading. Addicts are often professionals in high-powered positions. They are surgeons, judges, lawyers, dentists, CEOs, business owners. They are making decisions that affect the lives of thousands of individuals and costs millions of dollars in lost productivity and through faulty decisions. Too often, these people are in denial about their abuse and do not recognize the extent to which they are cognitively impaired.

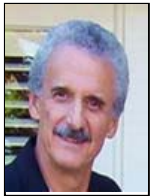
There is no one cause for substance abuse and no one treatment. Substance abuse is a bio-social-psychological problem. Genetic predisposition may be more of a factor in one individual than another. The role of brain chemistry and genetics is different from person to person. Social and psychological influences likewise vary. Hence, treatment must be tailored to each person.

The first priority in treatment should be harm reduction with eventual sobriety. When the individual is "clean and sober," s/he can collaborate in his or her treatment with full mental acuity. A treatment plan can then be devised and a determination can be made as to what factors are influencing the abuse. Then a decision can be made as to whether moderate drinking, in the case of the problem drinker, is possible. Some approaches, however, such as AA, believe that abstinence must be a lifetime commitment. Other approaches suggest that moderate drinking is possible for some alcoholics. In either case, a thorough evaluation is necessary and sober brain is required to make that decision.

GOINGS ON

Books by Dr. Dreyfus:
KEEPING YOUR SANITY: PRACTICAL ESSAYS FOR YOUR PSYCHOLOGICAL WELL-BEING
Xlibris Corporation, 2000.

SOMEONE RIGHT FOR YOU, TAB/McGraw-Hill, 1992.
Both are available through Amazon.com or directly from Dr. Dreyfus.



Dr. Edward A. Dreyfus is a Clinical Psychologist, Marriage Family Child Therapist, Sex Therapist, Divorce Mediator and Life Coach. He received his Doctor of Philosophy in Clinical Psychology from the University of Kansas and his Master's and Bachelor's degrees from the City University of New York. His credentials include: Fellow of the American Psychological Association, Diplomate in Professional Psychotherapy from the International Academy of Behavioral Medicine, Counseling, and Psychotherapy; Diplomate and Clinical Supervisor of the American Board of Sexology; Fellow of the International Council of Sex Education and Parenthood of the American University; Certified Sex Therapist of the American Association of Sex Educators, Counselors, & Therapists; Clinical Fellow, American Academy of Clinical Sexologists. He is listed in the National Register of Health Service Providers in Psychology and the National Registry of Certified Group Psychotherapists. Dr. Dreyfus has been providing psychological services in the Los Angeles-Santa Monica area for over 30 years. He offers individual psychotherapy, sex therapy, couples counseling, group therapy, divorce mediation, career counseling and life coaching.

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