Episodic intoxication in traditional societies

- Substance use known throughout time and cultures
- Limited access – psychoactive substances are rather rare and expensive
- Heavy societal control for who, when and where can have access to. E.g.:

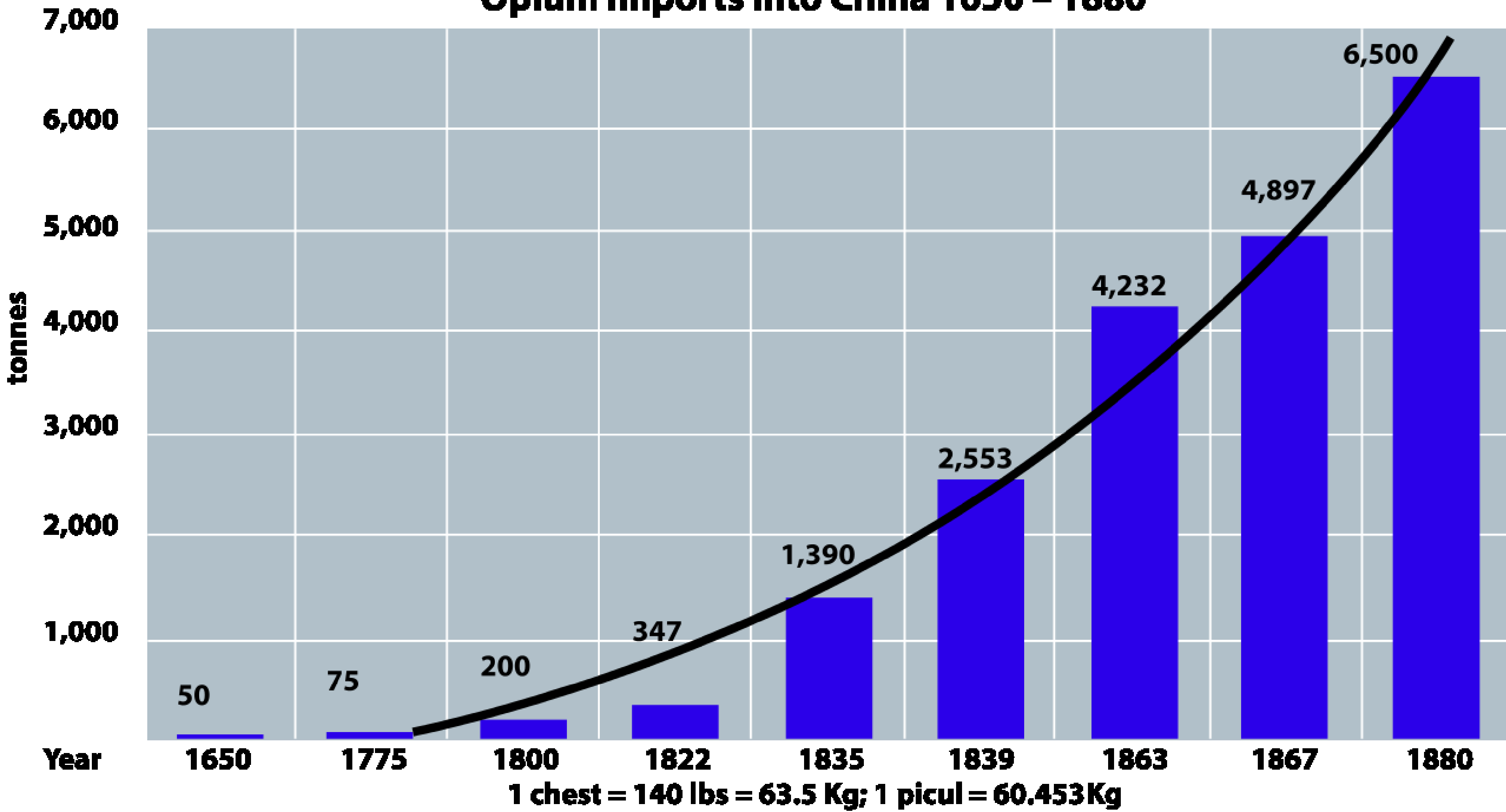
heavy drinking during festivals and important social situations

altered states of mind during religious rituals

use for medical purposes (e.g. pain relief)

Epidemic spread of drugs

- 16th century
- New discoveries and globalisation of trade
- Cheap and slave labour
- Advancement in agricultural technology
- Intensification of substances – more potent, cheaper, easily transportable, available worldwide
- 1) introduction of tobacco in Europe and Asia, 2) export of cheap alcohol to Europe, 3) export of opium to far east Asia and Europe
- First attempts to solve the problem: taxation and market limitation


Opium Imports into China 1650 – 1880
7,000
6,000
5,000
4,000
3,000
2,000
1,000
tonnes
50
75
200
347
1,390
2,553
4,232
4,897
6,500
Year
1650
1775
1800
1822
1835
1839
1863
1867
1880
1 chest = 140 lbs = 63.5 Kg; 1 picul = 60.453Kg
Source: United Nations Office on Drugs and Crime

Addiction as immoral/criminal conduct

- The first model of addiction (appeared in 16th century) and still living today
- Substance use is not seen as a disease but as a personal moral failure, sinful and criminal act
- Excessive substance use is considered as a *behaviour of choice* and not as *loss of control* and thus subject of legal action and punishment
- Understanding still preferred right-wing political ideology. E.g. *war on drugs*
- It is simple, clear and straightforward
- BUT it is oversimplification and in contradiction to current knowledge (e.g. genetic predisposition). And leading to even bigger problems - escalation of violence, organized crime networks, prisons overload

GISAG NG PANGULO NG PILIPI

http://www.nytimes.com/interactive/2016/12/07/world/asia/rodrigo-duterte-philippines-drugs-killings.html?_r=0

I HAVE WORKED IN 60 COUNTRIES, covered wars in Iraq and Afghanistan, and spent much of 2014 living inside West Africa's Ebola zone, a place gripped by fear and death. What I experienced in the Philippines felt like a new level of ruthlessness: police officers' summarily shooting anyone suspected of dealing or even using drugs, vigilantes' taking seriously Mr. Duterte's call to "slaughter them all."

He said in October, "You can expect 20,000 or 30,000 more."

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Russia

Stigma means Russia risks HIV epidemic as cases rise

Increased rate of new diagnoses in former Soviet Union runs against a global decline

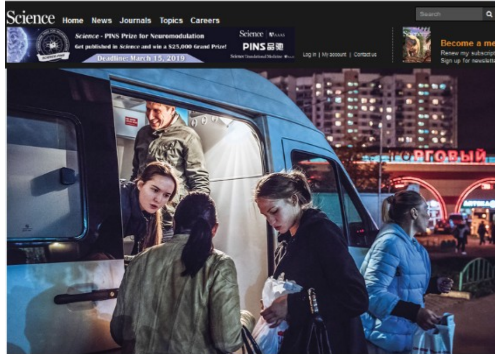
Reuters

Thu 29 Nov 2018 02.15 GMT

This article is over 1 month old

▲ The red ribbon, the international symbol for Aids awareness, on skyscrapers in Moscow for World Aids Day. Photograph: Alexander Zemlianichenko/AP

Stigma around homosexuality and drug use means Russia and some former Soviet Union countries risk developing out-of-control HIV epidemics, experts have said, after data showed a record number of new cases last year.



Volunteers from the Andrey Rylkov Foundation distribute free needles and condoms in Moscow. MAX AVDEEV/THE NEW YORK TIMES/REDUX

SHARE

Russia's HIV/AIDS epidemic is getting worse, not better

By Jon Cohen | Jun. 11, 2018 , 4:00 PM

In 2015, a dermatologist in Russia's fourth largest city, Yekaterinburg, diagnosed Katia with herpes. "I had no idea what it was," says Katia, who asked that her last name not be used. But because she had suffered repeated illnesses over the preceding 2 years and had an alcoholic ex-boyfriend who simultaneously had other girlfriends, she suspected that something more serious might be wrong. She asked the doctor to give her a referral for an HIV test. "Why?" he asked. "Are you going to marry a foreigner?"

"I persisted and said, 'I'm not leaving here until I get a referral.'"

The day Katia learned the test results, she walked the streets for hours crying, unable to even find her car. The literature she received explained she had the AIDS virus and said the outlook was grim. She read that the virus, if untreated, could kill her in as few as 3 years. Katia, then 30, had a young daughter. Who would raise her? And Katia had to hide her infection from her employer—her father. "If I told my father I had HIV, he wouldn't

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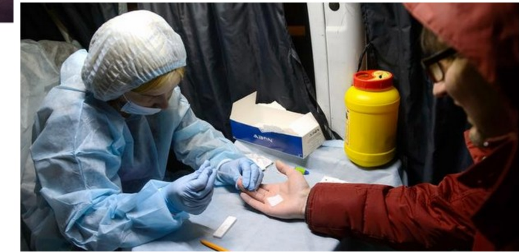
Russia: The silent HIV epidemic

HIV is on the rise in Russia. But those infected are stigmatized and often insufficiently treated. In a country where the Orthodox Church calls for abstinence, many are scared to speak about their diagnosis.



UNAIDS calculates that between 2010 and 2015, Russia accounted for more than 80% of the new HIV infections in the entire Eastern European and the Central Asian region. By Russia's own estimates, the epidemic grew 10% per year during that period, with the new infections roughly split between people who inject drugs and heterosexual transmission. At about the same time, new infections in the rest of Europe and North America dropped by 9%. By the end of 2017, the Russian Ministry of Health estimates, just shy of 1 million people were living with HIV. Even official accounts acknowledge that only one-third of those receive ARVs.

In Russia official data shows there were more than 104,000 new HIV diagnoses in 2017, taking total cases to more than 1.2 million. Experts have said this is probably an understatement.

"We don't have enough medication, we don't treat every patient," said Nikolay Lunchenkov, a doctor at the Moscow regional Aids centre. "We are increasing the number of people who receive antiretroviral therapy, but it's still not enough."

The number of HIV treatment courses bought by the Russian government rose 37% to about 360,000 last year according to the NGO Treatment Preparedness Coalition.

Addiction as immoral conduct

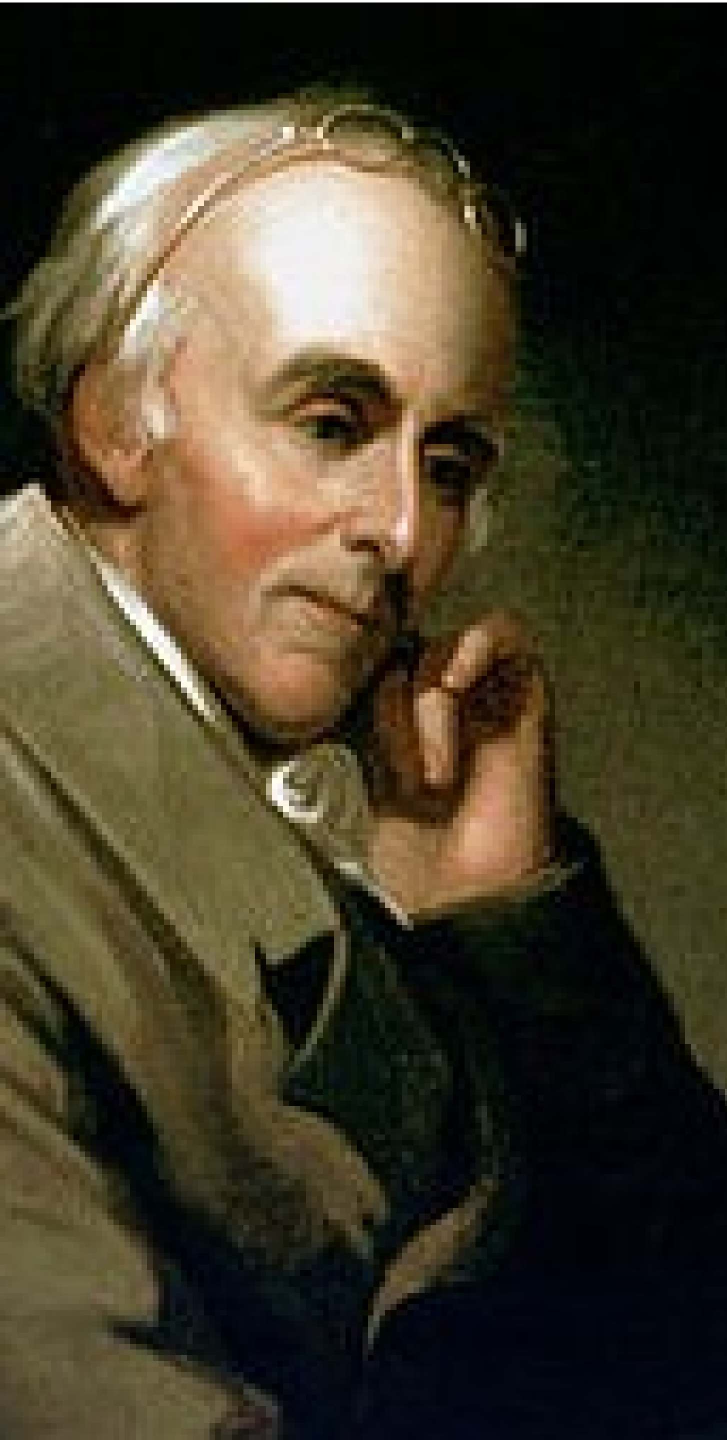
- **Believe in just world** (just world hypothesis)

- Consequences are result of one's actions (*you reap what you sow*)
- Often used as blaming of the victims of crimes, poverty etc. (*raped woman was too seductive*; *poor people are too lazy*,…)
- Connected to believe in destiny and higher order - often found in right-wing and religious ideology
- Guilt reduction, discomfort reduction (discomfort caused by empathy with victims), anxiety reduction (anxiety caused by uncertainty and unpredictable world)

- *The poor homosexuals — they have declared war upon nature, and now nature is exacting an awful retribution* (Pat Buchanan, 1983) – summary of why not doing anything with spreading HIV epidemic in US during Reagan‘s administration

Temperance model of addiction

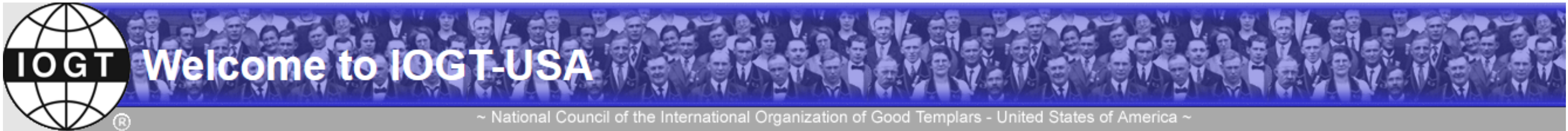
- In the most primitive form – **preternatural model** – the substances are demonic and can take possession over human mind (*demon alcohol*)
- Addict does not have ability to control him/herself
- Addiction is a form of involuntary mental condition
- It is the substance to be blamed
- It is reasonable to abstain from the use completely
- Sympathize with addicts but rejects mild users



Temperance model of addiction

- Benjamin Rush (1745-1813)
- Founding fathers of the United States
- Founding father of American Psychiatric Association
- Alcohol use is behind poverty, health issues, violence, crime, family disruptions
- Addiction is also a disease – addicts should be treated
- *Taste not, handle not, and touch not!*

International Organization of Good Templars



~ National Council of the International Organization of Good Templars - United States of America ~

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What is IOGT?

IOGT-USA is an organization of men and women of all ages who promote the ideals of temperance, peace and brotherhood. IOGT (International Organization of Good Templars) is the largest international non-governmental organization working in the field of temperance. It is a voluntary, democratic organization based on the work of committed lay people. IOGT promotes cultural and educational activities for the benefit of all.

Why IOGT?

More and more people realize that the use of alcohol is a major cause of accidents, interpersonal violence, family disruption and immorality. These social consequences are largely dependent upon the overall level of alcohol consumption in any society. IOGT advocates a variety of strategies to deal with alcohol use. These include general education programs, alcohol-free cultural and social alternatives. The main feature of IOGT is that it provides an alcohol-free environment for its members.

In a rapidly changing world, the efforts to care for those affected by alcohol related problems and to provide positive alternative lifestyles must continue to be given a very high priority. Fortunately, international agencies, governments and non-governmental organizations are beginning to recognize the alcohol problem. Rather than rendering IOGT and other similar organizations obsolete, this development has emphasized the importance of voluntary efforts in reducing the harm from alcohol use.

Fact of the Day:

Recent campus study: The underage students surveyed, most of whom reported that it was "easy" or "very easy" to obtain alcohol, were more likely to obtain alcohol inexpensively and more likely to drink in private settings such as dorms and fraternity parties.

IOGT was one of the first organizations that had no

XXX

I DO NOT DRINK
I DO NOT SMOKE
I DO NOT DO DRUGS

I AM STRAIGHT EDGE

XXX

Illness & personality disorder models of addiction

- Evolved in 1800s in USA – asylums in rural areas that supported people with food and shelter. No access to the substance
- People in such treatment where in miserable conditions and had to accept themselves as ill. Often moral semi-religious treatment

- Addict has a personality disorder – excessive substance user often shows array of antisocial and maladaptive behaviours.
- The person is untreatable and unrepairable
- Rise of self-help communities

12 step program – Alcoholics Anonymous

- 1939 - *Alcoholics Anonymous: The Story of How More Than One Hundred Men Have Recovered from Alcoholism*

- self-help group
- admitting that one cannot control one's alcoholism, addiction or compulsion;
- recognizing a higher power that can give strength;
- examining past errors with the help of a sponsor (experienced member);
- learning to live a new life with a new code of behavior;
- helping others who suffer from the same alcoholism, addictions or compulsions.

- newcomers to becoming aware of their lack of ability to control their behaviour (steps 1 through 3)
- to expand self-examination and incorporate the outcomes of self-reflection into actions (steps 4 through 9)
- focus on maintaining positive changes in behaviour and the recovery process. The recovery process includes attending meetings, listening to other members at different recovery stages and working with a sponsor, who is an experienced member who is encouraged to complete all of the steps (steps 10 through 12)

UNITY
SERVICE
AA
RECOVERY

MARK RUFFALO
TIM ROBBINS
GWYNETH PALTROW
JOSH GAD
JOELY RICHARDSON
PATRICK FUGIT
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STATE
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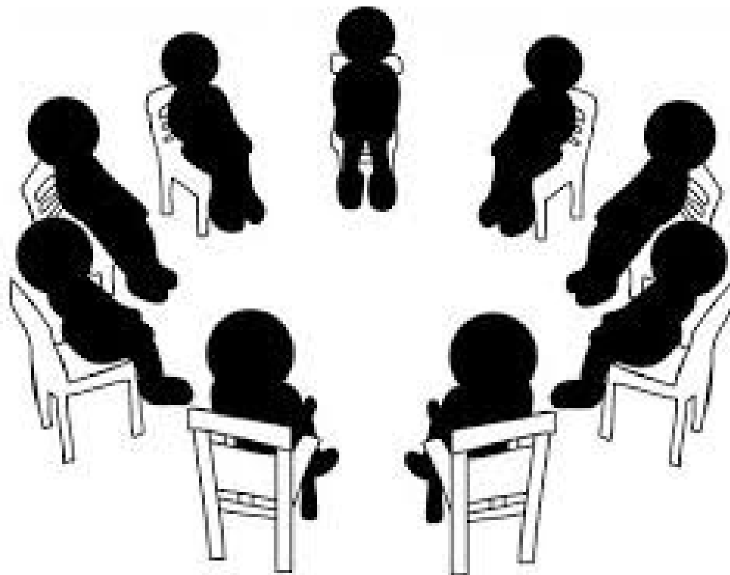


mongrel

Programs patterned after Alcoholics Anonymous

Fellowships in this section follow reasonably close variations of the Twelve Steps and Twelve Traditions of Alcoholics Anonymous.

- AA – Alcoholics Anonymous
- ACA – Adult Children of Alcoholics
- Al-Anon/Alateen, for friends and families of alcoholics
- CA – Cocaine Anonymous
- CLA – Clutterers Anonymous
- CMA – Crystal Meth Anonymous
- Co-Anon, for friends and family of addicts
- CoDA – Co-Dependents Anonymous, for people working to end patterns of dysfunctional relationships and develop functional and healthy relationships
- COSA – an auxiliary group of Sex Addicts Anonymous
- COSLAA – CoSex and Love Addicts Anonymous
- DA – Debtors Anonymous
- EA – Emotions Anonymous, for recovery from mental and emotional illness
- FA – Families Anonymous, for relatives and friends of addicts
- FA – Food Addicts in Recovery Anonymous
- FAA – Food Addicts Anonymous
- GA – Gamblers Anonymous
- Gam-Anon/Gam-A-Teen, for friends and family members of problem gamblers
- HA – Heroin Anonymous
- MA – Marijuana Anonymous
- NA – Narcotics Anonymous
- N/A – Neurotics Anonymous, for recovery from mental and emotional illness
- Nar-Anon, for friends and family members of addicts
- NicA – Nicotine Anonymous
- OA – Overeaters Anonymous
- OLGA – Online Gamers Anonymous
- PA – Pills Anonymous, for recovery from prescription pill addiction.
- SA – Sexaholics Anonymous
- SA – Smokers Anonymous
- SAA – Sex Addicts Anonymous
- SCA – Sexual Compulsives Anonymous
- SIA – Survivors of Incest Anonymous
- SLAA – Sex and Love Addicts Anonymous
- SRA – Sexual Recovery Anonymous
- UA – Underearners Anonymous
- WA – Workaholics Anonymous

Disease model of addiction

- At first, these processes were not understood. But it was assumed it is 1) brain disease and with 2) genetic susceptibility
- Addicted person is a victim of this disease - it is not chosen and it is not an act of free will
- Loss of control & craving as the common processes in addictions
- Consumption of the substance causes craving for further dozes (through at first unknown psychological and neurological mechanism)

Disease model of addiction

- Since the person is ill and suffering, he/she should be subject of medical treatment
- Treatment was based on management of medical complications (stomach ulcer, liver disease,…) and raising patient health education – supervision of a physician
- Therapy-like approach heavily influenced by 12 step program and 12-step programs take ideological support from scientific approach of disease model

Disease model of addiction

- **Addiction as a primary disease** – addiction is not understood a result of another condition (other psychiatric condition, stress,…) but rather their cause
- **Addiction as a progressive disease** - addiction is understood as a disease that has its course: 1) adaptive stage - increasing tolerance 2) dependent stage - withdrawal and maintenance usage 3) deterioration stage - resulting into major health and social problems
- **Addiction as a chronic disease** – addiction is understood as a disease that will never disappear and the person will never be fully cured. Thus complete sobriety is the only way

Disease model of addiction - pros

- Big leap in knowledge, new research
- Removes stigma from suffering people
- The classic disease model is still very simple to be understood by general public
- When addiction became a disease (alcoholism as disease was acknowledged by American Medical Association in 1954) the help became more accessible

Disease model of addiction - cons

- Despite huge advancement in knowledge, it was only poorly incorporated into this model. E.g. proofed usefulness of light substance taking contradicts chronic disease; natural remission and maturing out contradicts progressive disease; much stronger environmental factors contradict primary disease
- Ignoring context - too little emphasis on psychological and social factors
- The treatment method, although advancement at the beginning, is way behind treatments based on psychological and social models

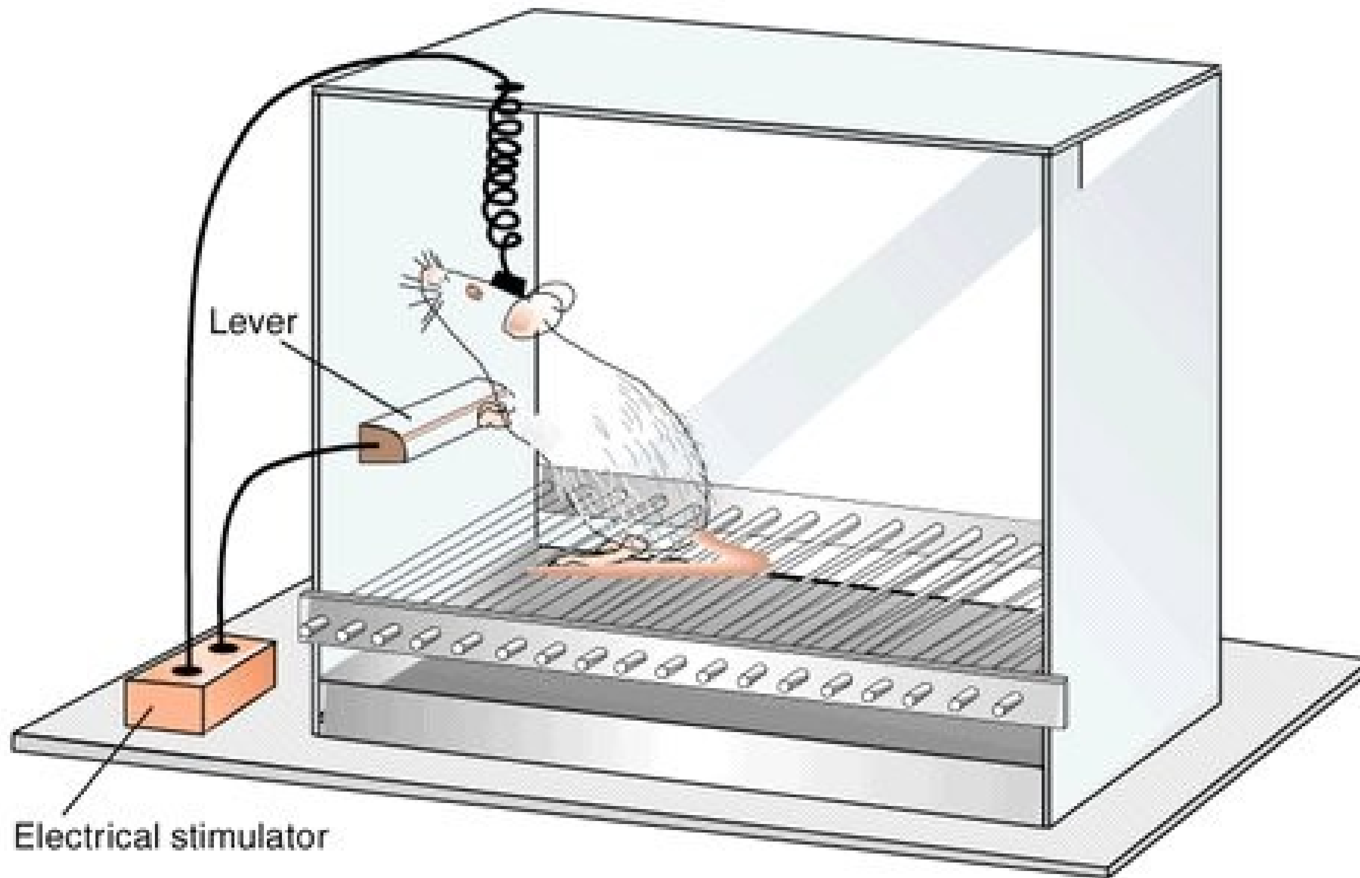
Physical dependency theory

- By suing the substance, the person can gradually develop a physical dependence
- Physical dependence is a condition in which the person needs the substance otherwise suffers from various withdrawal symptoms
- This theory assumes that addiction = physical dependence
- NOT proved – many substances do not create physical dependence nor physical withdrawal symptoms. Many addicts return to addiction after period of treatment in which they were detoxified
- Avoiding negative effects plays a role, however, more crucial proofed to be the pleasure-seeking

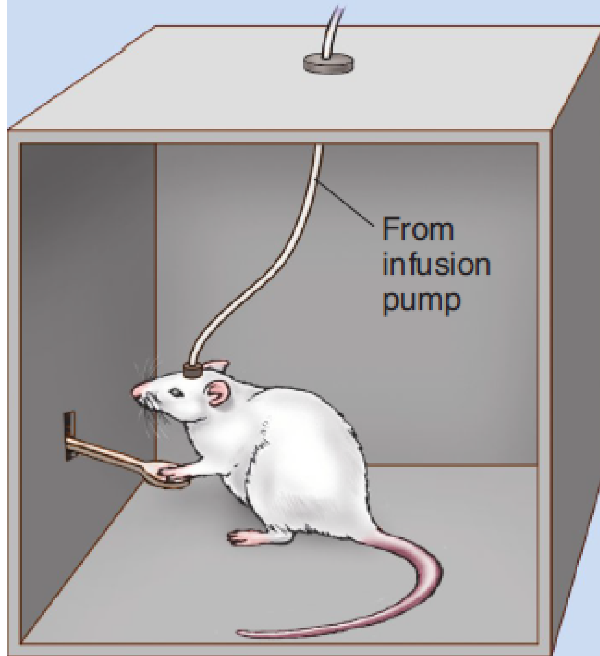
It is about (anticipated) pleasure

- **Positive-incentive theory** - all drugs have pleasurable effects. Drug taking is more about getting the positive effects rather than about removing the negative effect
- Positive-incentive value is usually much higher than hedonic value = anticipated pleasure is much higher than actual pleasure
- **Incentive-sensitization theory** – repeated exposure to potentially addictive drugs leads to various changes in brain. The most important is **sensitization** = *hypersensitivity to the incentive motivational effects of drugs and drug-associated stimuli* that creates pathological *wanting.*
- Addiction is not about the drug effect, it is about the anticipation of the effect. Addiction is motivation disorder

Intracranial self-stimulation



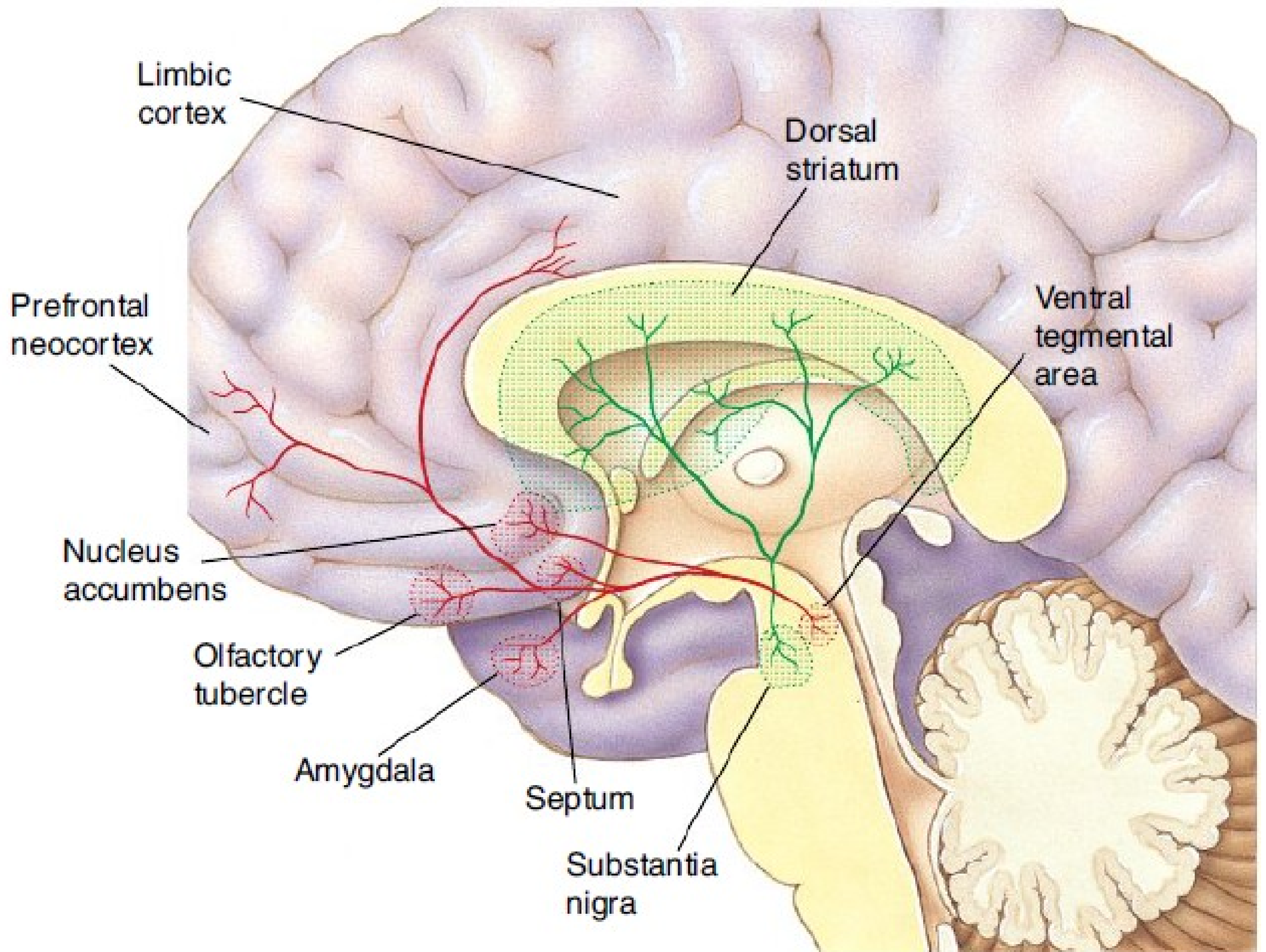
Drug Self-Administration



The rat presses the lever to self-inject a drug, either into an area of its brain or into general circulation.

Conditioned Place Preference

A rat repeatedly receives a drug in one of two distinctive compartments. Then, on the test, the tendency of the rat, now drug-free, to prefer the drug compartment is assessed.


Limbic cortex
Dorsal striatum
Prefrontal neocortex
Ventral tegmental area
Nucleus accumbens
Olfactory tubercle
Amygdala
Septum
Substantia nigra

Mesolimbic dopamine pathway

- Regulates motivation cognition and behavior and reinforcement learning – e.g. regulates behaviours related to food, drinks, safety, sex
- Primary neurotransmitter – dopamine
- The mesolimbic pathway connects the **Ventral Tagmental Area** near brainstem to the **Nucleus Accumbens** and to the **Prefrontal Cortex.** Important role plays **amygdala** and **hippocampus**

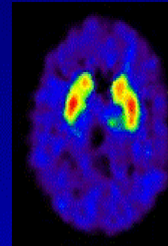
Mesolimbic pathway and addiction

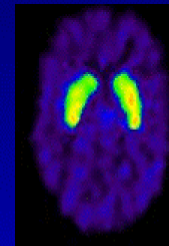
- In animals, drugs self-administered to nucleus accumbens had stronger effect and were preferred. It correlated with increase on dopamine release
- All drugs affect dopamine functions. Many drugs work as direct dopamine agonists while the rest of drugs have indirect effect
- Brain imaging technics showed massive dopamine involvement in nucleus accumbens. They also showed decrease of dopamine D2 receptors availability in addicts leading to increasing tolerance
- Mesolimbic pathway gradually sticks to the addiction object to which it is hypersensitive while under sensitive to other stimuli – *highjacked brain*

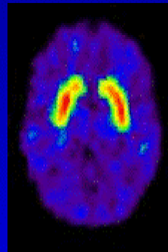
- https://www.youtube.com/watch?v=NxHNxmJv2bQ

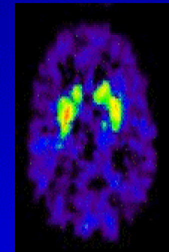
Functionally…

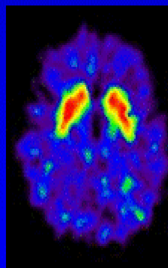
Dopamine D2 Receptors are Decreased by Addiction

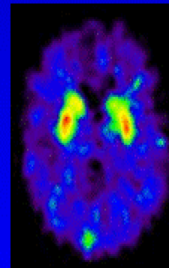


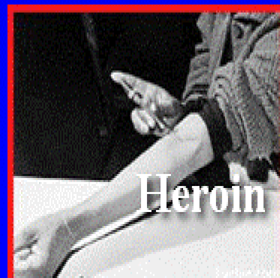


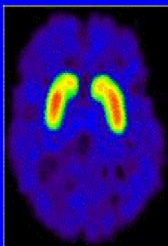


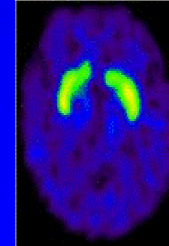




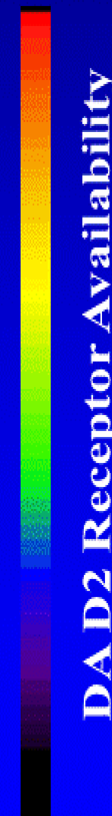








Control Addicted



Genetics and addiction

- Susceptibility model – tries to explain why some substance users develop addiction while others do not
- General heritability about 25% in mild drinking and 35% in heavy drinking (heritability estimates degree of variation of phenotypic trait in population)
- Twin studies – strong genetic factor especially in males (almost no effect in females) and especially if alcoholism started before age 20 (little effect for later life)
- In other drugs – the strongest influence of genetic factor in heroin (more than 50%), in other drugs similar to alcoholism (between 25-33%).
- Huge discrepancy in studies, e.g. women are massively under-researched

Genetics and addiction

- Genes and environment determine addiction together
- Inherited characteristic is a predisposition/risk factor, not a disease itself – addiction is a complex phenomenon with no single one determining factor
- Research on genetics of addiction is not to push people back and feel miserable of unchangeable. It is for better treatment and prevention

Genetics and addiction

- Candidate gene studies – they try to find the concrete gene that is associated with the disease
- Difficult to find such gene – many possible candidates and often contradicting results
- Uncertainty about how much unique impact these genes have

Reward-deficiency syndrome

- Kenneth Blum
- People with DRD2-A1 allele gene form (older variant) of D2 dopamine receptors are at higher risk of addictions.
- 30% of white population – they have up to 40% less dopamine D2 receptors
- Feel less reward from normal activities – need stronger impulse
- Feel more negative emotions and anxiety – take drugs to relief from negative states of mind

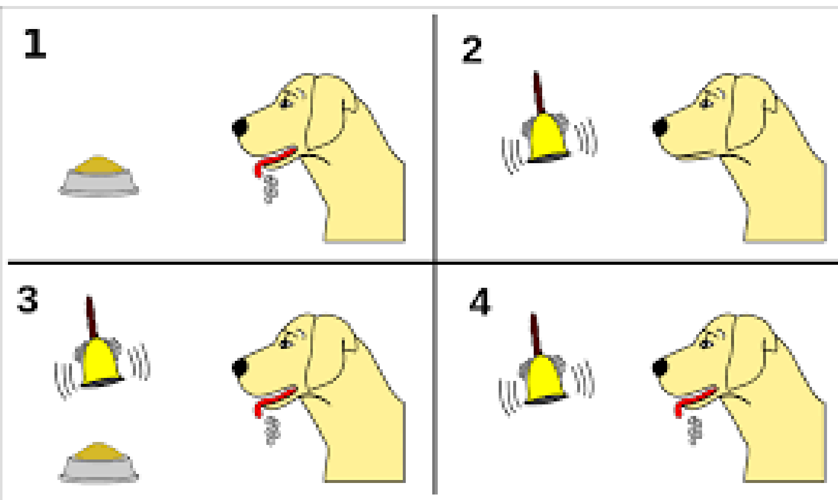
Reward-deficiency syndrome

TABLE 1
The Reward Deficiency Syndrome Behaviors (RDS)*

Addictive Behaviors	Impulsive Behaviors	Compulsive Behaviors	Personality Disorders
Severe Alcoholism	Attention-Deficit Disorder & Hyperactivity	Aberrant Sexual Behavior	Conduct Disorder
Polysubstance Abuse	Tourette Syndrome	Internet Gaming	Antisocial Personality
Smoking	Autism	Pathological Gambling	Aggressive Behavior
Obesity			Generalized Anxiety

*Reproduced from Blum et al. 1996a with permission

ADDICTION AS LEARNED BEHAVIOUR
Classical conditioning



- I. Pavlov & J.B. Watson
- Learning is a result of pairing of a unconditioned stimulus with a neutral stimulus. After repetition of such paring, original reaction to unconditioned stimulus becomes conditioned to the originally neutral stimulus.

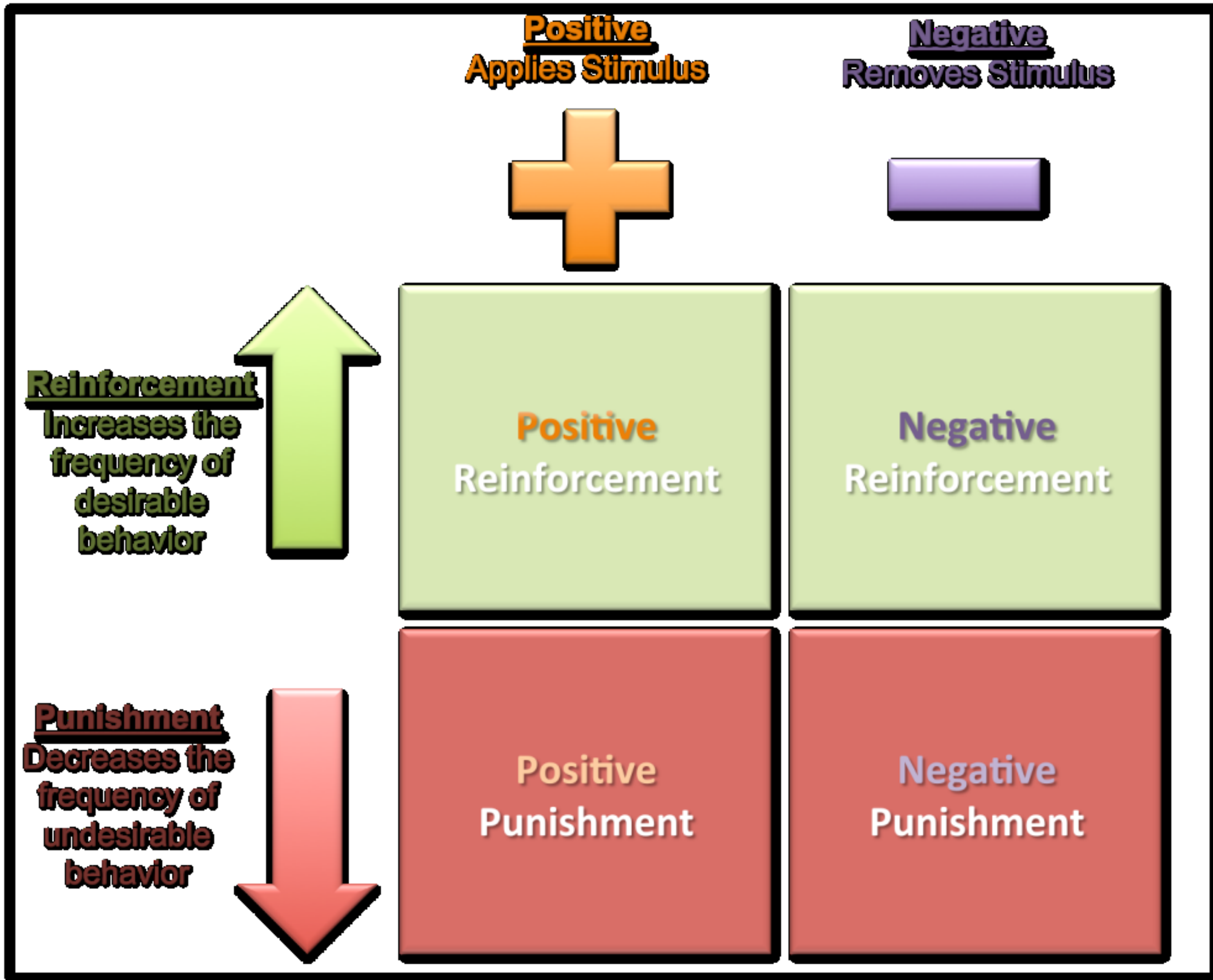
Addiction and classical conditioning

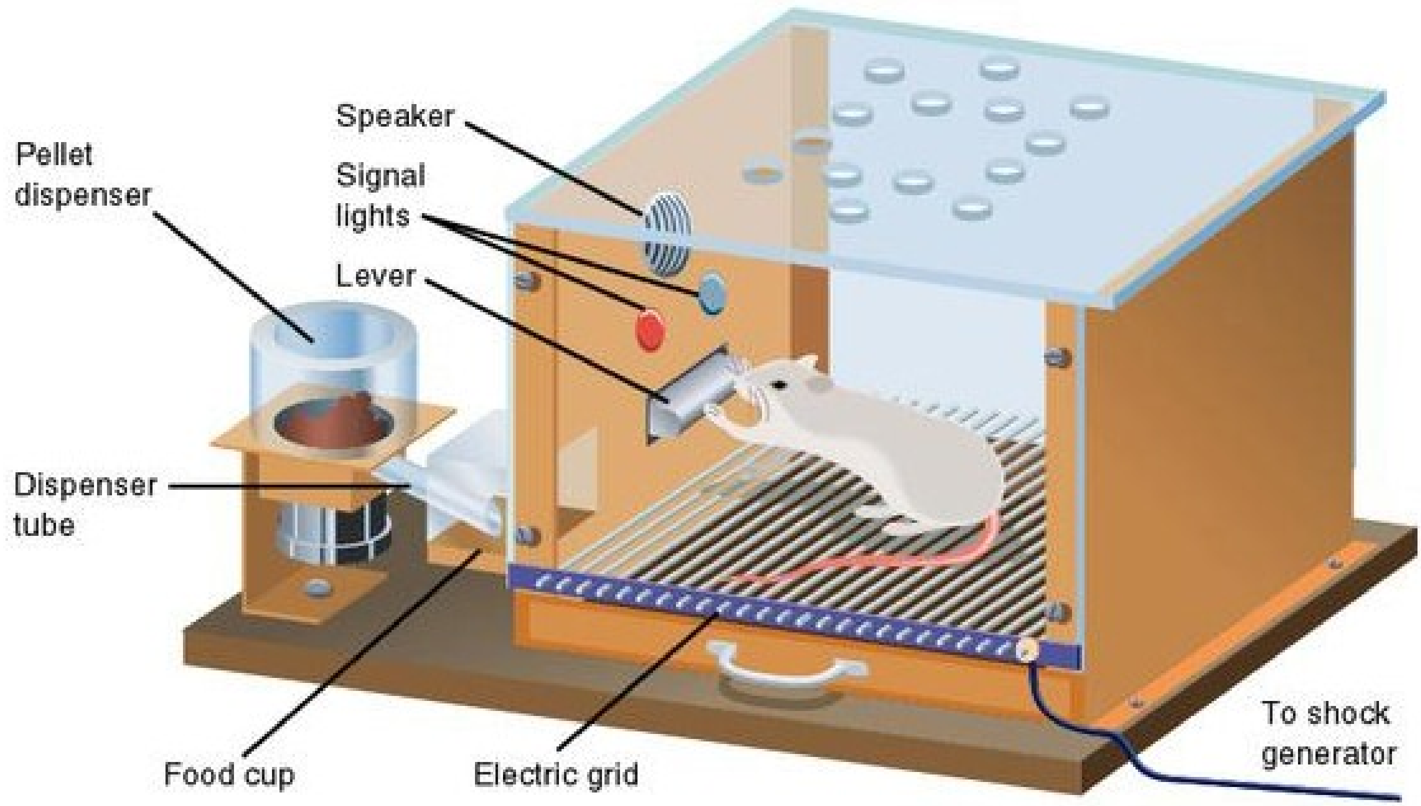
- Drug effects are strongly influenced by the context in which the drug is administered. The context usually refers to the physical environment in which the drug is given.
- Drug effect is paired with environmental stimuli – **cues** and they may trigger **craving** – overwhelming desire for the substance/behaviour
- Classical conditioning is behind key factors of addiction – craving, withdrawal symptoms, relapse
- **Conditioned drug tolerance**: tolerance and sensitization to the behavioural effects of drugs are expressed in the environment in which the drug is chronically administered but not in an environment not previously associated with the drug.

- **Cue reactivity** – learned response that involves psychological and physiological reactions to drug related cues
- Cues are the most important factors of relapse
- Withdrawal model – cue reactivity should resemble withdrawal-like states (i.e. should produce opposite to the drug effect)
- Incentive model – cue reactivity should be similar to positive motivational state (i.e. should produce somewhat similar to the drug effect)
- We usually see mix of these two reactions, however, in alcohol/cocaine/tobacco/behavioral addictions incentive reaction is stronger while in heroin withdrawal reaction is stronger

ADDICTION AS LEARNED BEHAVIOUR
Classical conditioning

- B.F. Skinner
- Experience of reinforce or punishment increases or decreases likelihood of certain behaviour


Positive
Applies Stimulus
Negative
Removes Stimulus
Reinforcement
Increases the frequency of desirable behavior
Positive Reinforcement
Negative Reinforcement
Punishment
Decreases the frequency of undesirable behavior
Positive Punishment
Negative Punishment



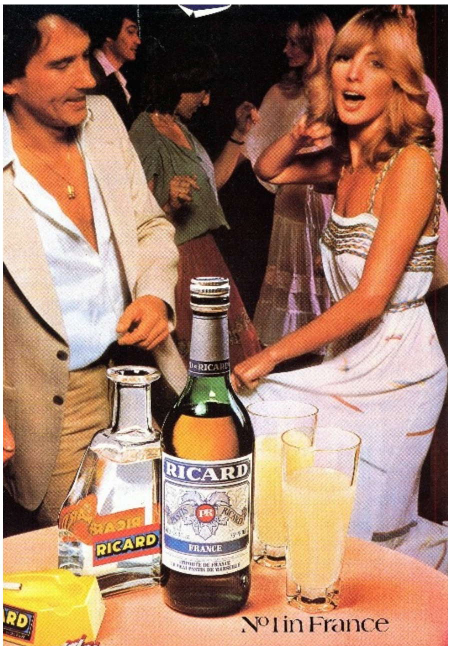
https://www.youtube.com/watch?v=I_ctJqjlrHA

- **Positive reinforcement**: drugs and certain behaviours (sex, gambling) are strongly pleasurable and serve as positive reinforcer
- **Negative reinforcement**: decreased level of drug in body unbalances physiological system - withdrawal symptoms
- **Occasional reinforcement** – somewhat randomized reward produces much stronger reinforcement - activity to get the reward increases and is more resilient to change. **Secondary reinforcement** – cues learned via classical conditioning may be experienced as reinforcers themselves

- Drugs and certain behaviours are powerfully rewarding themselves, but addiction arises through experience and repetition
- Involved processes are automated and are not reflective
- Pre-conscious cue processing - addiction related cues are mentally prioritized without knowing
- Frequently conflict between not conscious/learned motivation and conscious attitude
- Various people vary in their proneness to reward and punishment (e.g. Cloninger‘s typology of alcoholism)

ADDICTION AS LEARNED BEHAVIOUR
Social learning theory

- Albert Bandura
- Learning in social environment through observing and listening to others
- Addiction is learned through imitation of and identification with role-models
- Social identity – whom I follow, what is the group I belong to, what is the group I would like to be part of



Come to where the flavor is. Come to Marlboro Countr

https://www.youtube.com/watch?v=EJT0NMYHeGw

SELF-EFFICACY

- Albert Bandura
- Individual believe in own ability to perform certain behaviour
- High self-efficacy – set higher goals, invest more effort and energy. More resistant to stress and negative experience and able to try various coping strategies.
- Low-self efficacy – lower effort, cease treatment more quickly. Lower stress resistance, often use substances as the first coping strategy
- Learned hopelessness – opposite to self-efficacy. When the person repeatedly experience aversive stimuli. Sometimes a product of repeated abuse, trauma. Can lead to enduring negative mood states, addictive behaviours, cycles of poverty

SELF-MEDIACATION MODEL OF ADDICTION

- Taking drugs or involvement in problematic behaviour is a coping strategy with negative and unpleasant mood states and/or negative life experiences
- People with some mood disorder or problematic affect regulation are more prone to develop addiction - e.g. higher depressiveness, higher anxiety, personality disorders like antisocial or borderline
- People with experience of child abuse, trauma or childhood neglect are much more prone to develop addiction

- Psychodynamic psychology – emphasizes feelings and emotions as forces that shape our behaviour, focus on early child experience
- S. Freud – psychoanalysis - use of drugs with oral administration (alcohol, tobacco,…) are a form of regression to the first year of life (oral stage – when pleasure is experienced through mouth). Oral stage is about gaining trust in others – addicts usually have underdeveloped trust and show unhealthy relationship profiles: avoidance and/or overdependency.

- M. Klein – object relation theory
- Birth and first months are extremely stressful for the child. Chaos, anger, fear are the dominant emotions – they must be cultivated in contact with parenting figure. Parenting figure is internalised as a mental object – parent (mother) within
- Relationship with this internalized object affects social relationships throughout our lives - what develops in early childhood stays for lifetime
- Good object relation = good affect regulation (positive mood, ability to cope with unpleasant, more resilient), poor object relation = poor affect regulation.

- H. Harlow, J. Bowlby, M. Ainsworth – attachment theory
- https://www.youtube.com/watch?v=OrNBEhzjg8I

- Children internalize cognitive and affective representation of self and others based on their early attachment experiences.
- Attachment to the parenting figure (significant other) is created especially in the first 6 months.
- Attachment attitudes are persistent and lead our relationship to others and our affective regulation during our lives

Attachment Style	Parental Style	Resulting Adult Characteristics
Secure	Aligned with the child; in tune with the child's emotions	Able to create meaningful relationships; empathetic; able to set appropriate boundaries
Avoidant	Unavailable or rejecting	Avoids closeness or emotional connection; distant; critical; rigid; intolerant
Ambivalent	Inconsistent and sometimes intrusive parent communication	Anxious and insecure; controlling; blaming; erratic; unpredictable; sometimes charming
Disorganized	Ignored or didn't see child's needs; parental behavior was frightening/traumatizing	Chaotic; insensitive; explosive; abusive; untrusting even while craving security
Reactive	Extremely unattached or malfunctioning	Cannot establish positive relationships; often misdiagnosed

- Insecure attachment is strongly related to lifetime depressiveness and affective disorders, low self-esteem, lower social support. It creates fertile ground for substance use and other behavioural addictions
- Self-medication model does not explain all cases of addiction – many addicts do not have affective difficulties, insecure attachment, child trauma or neglect.

DEVELOPMENTAL MODEL OF ADDICTION

- Two main risk periods – early childhood (attachment) and adolescence
- E. Erikson – psychosocial stages of development – adolescence is about identity crisis, time of storm and stress, and increasing power of peer groups. Substance use may develop as a mean to gain status in peer groups, it may become part of personal and social **identity**
- Addiction may be understood as an **externalized pathological behaviour**. Externalized behaviour includes conduct problems (verbal and physical aggression, lying, risk taking, vandalism), ADHD, various addictions
- Any externalized behaviour may be replaced by another externalized behaviour
- Externalized behaviour may occur in childhood as a reflection of internalized disorders (anxiety, trauma, neglecting parental approach)

Addiction as rational choice

- Taken from economic theory – addictive behaviours are consumer behaviour
- We do things because they bring some benefits. We know about the negatives, but benefits out-weight them
- Cost-benefit analysis
- Weighting benefits (pleasure) and costs (e.g. money, legal consequences, health consequences). In stressful times, benefits of drugs are getting higher. Why are some substances much more often used? – their costs are not that high (it is legal, health effects only slowly accumulates over time,…).
- Assumptions are rather vague. Detailed analysis (e.g. using mathematic formulas) usually wrong. E.g. theory predicts older people to be more involved in addictions, but it is the opposite

Why do we engage in addictive behaviours?

- Improve social interaction
- Improved physical & sexual appearance
- Improved cognitive performance
- Improved sexual performance
- Improved self-esteem and feelings of self-worth
- Coping with stress
- Pleasure-seeking
- Sensation & novelty seeking
- Overcoming boredom
- Reduce psychiatric symptoms
- And others…

Societal risk factors

- Families – genetics, parental neglect & abuse, impaired attachment styles, modelling behaviors, parental approval
- Intimate relationships paradox - addictive behaviors often appear in both but being in a relationship is one of the main protective factors
- Gender – addiction associated with a traditional gender role in men but also with non-traditional gender roles in women.
- Environmental factors stronger in women while genetic factor stronger in men. Women have much lower chance of becoming addicted, their addiction tends to develop later but has faster progression and is more frequently associated with affective dysregulation
- Being a parent is a protective factor in women but not in men

Societal risk factors

- Peer influence is very powerful, especially in adolescence but also later in life
- In adolescent the reason is to gain better position within group hierarchy, to socialize, to be more confident in establishing romantic relationships, to decrease anxiety in general
- In later life stages the peer influence is more associated with mere availability of the substance and attitudes (norms)
- Normative substance use – each group has some unwritten rules what is considered as normal. Addicted people often think that the norm is higher that it actually is - e.g. that others drink as much as themselves
- Normative feedback (peer disapproaval) can be used for prevention and interventions

Societal risk factors

- Ethnicity – addictions and addictive behaviours are much more common in ethic minorities
- Reasons: cultural background, genetic susceptibility, more frequent poverty, discrimination and stress
- Critical sociology – addictive behaviours are more frequently and more severely sanctioned when it is in minorities, youngsters, poor, lower socio-economical status – those that have less power within the society
- The major society (that in charge) has power to label what is legal and what is illicit, what should be punished, what should be treated and even what research to support
- Availability of the drug is necessary condition for addiction however many negative effects come only because the drug is not available. Difficult question – should be substances that are now considered as illicit available (under certain conditions)?

Social developmental model

- Originated in criminology
- Explains the origins and development of delinquent behavior during childhood and adolescence
- children adopt the beliefs and behavioral patterns within 4 social units - **family**, **community** (neighborhood), **school**, **peer groups**. If the social unit has prosocial attitudes, then the child adopts a prosocial orientation; if the social unit is antisocial, then the child often manifests problem behavior
- Positive socialization is achieved when youths have the opportunity within each unit to be involved in conforming activities, when they develop skills necessary to be successfully involved, and when those with whom they interact consistently reward desired behaviors.
- These conditions should increase attachment to others, commitment to conforming behavior, and belief in the conventional order. These social bonds to conventional society prevent delinquent behavior.

Social developmental model

- Individual risk and protective factors (e.g. cognitive and emotional regulatory abilities) out-weights the social factors
- Risk factors out-weights the protective factors
- From social factors, peer influence brings the biggest risks, especially in early initiation. The biggest protective factor comes from combination of well/functioning family and good individual predisposition
- Family and community are relatively more important in childhood and early adolescence; school and peers are relatively more important in mid- and late adolescence

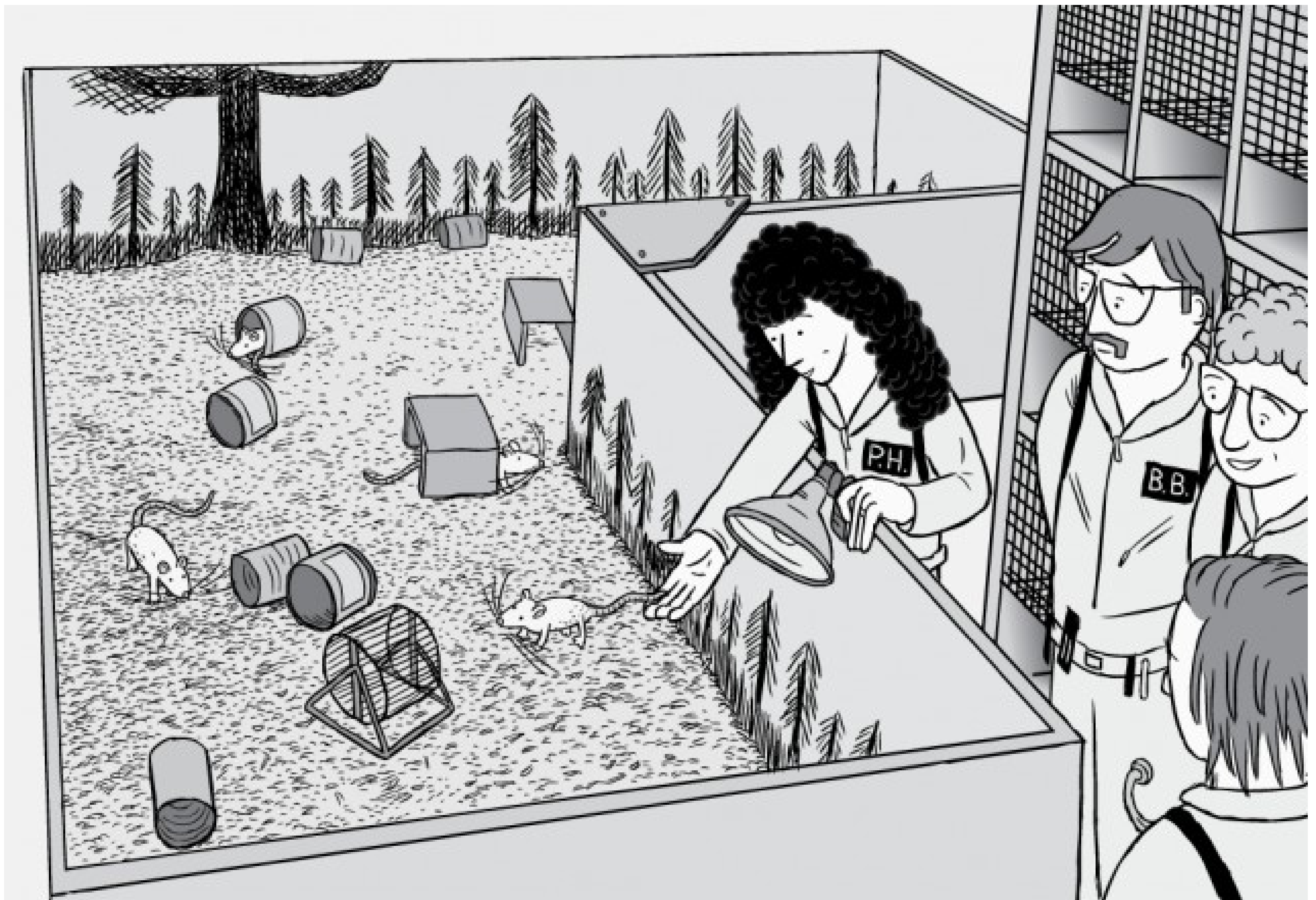
Iceland knows how to stop teen substance abuse but the rest of the world isn't listening

In Iceland, teenage smoking, drinking and drug use have been radically cut in the past 20 years. Emma Young finds out how they did it, and why other countries won't follow suit.

17 January 2017

It's a little before three on a sunny Friday afternoon and Laugardalur Park, near central Reykjavik, looks practically deserted. There's an occasional adult with a pushchair, but the park's surrounded by apartment blocks and houses, and school's out – so where are all the kids?

https://mosaicscience.com/story/iceland-prevent-teen-substance-abuse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