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# 1 What is ‘Substance Misuse’?

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## INTRODUCTION

Even a cursory reading of the literature on misuse of drugs and alcohol reveals a bewildering array of ways of talking about excessive use of substances. Some authors write of ‘drug addicts’ and ‘alcoholics’; others of ‘substance misuse’ or ‘alcohol problems’; a few mention ‘use’ of substances. Behind these different terminologies lie different views about the nature of excessive use of drugs or alcohol. Understanding these different views is important for two reasons. First, it provides an important introduction to key issues within the field of addiction and problem substance use. Indeed, without an appreciation of the reasons for and significance of these different terminologies it is difficult to understand many studies in this area. Second, the terminologies involve different sets of assumptions, beliefs and values about excessive substance use. They therefore provide an important starting point for considering our own values and assumptions. For instance, a professional who calls someone an ‘alcoholic’ is – whether they are aware of it or not – making different assumptions from one who says the same individual has an ‘alcohol problem’. Informed practice therefore starts with a consideration of the words we use and the models they relate to.

We have noted elsewhere the differences between some of the common words used in this field (Forrester and Harwin, 2004). Some key definitions are:

- *Drug or alcohol use*: This term simply describes use of a substance. It does not imply that drug-taking or drinking is wrong and is therefore useful if one wants to avoid being judgemental. However, it also fails to differentiate between problematic use and non-problematic use, or between use that the individual feels is out of control and use that is occasional and that the individual can control.
- *Drug or alcohol abuse or misuse*: These terms imply that the use is harmful. They refer to use of a substance that is associated with problematic or harmful behaviour, i.e. harm is caused to the user or others, such as

children, as a result of their use. This might range from liver damage to the family having no money for food because it was all spent on alcohol. These terms make a judgement about harm, but they do not imply addiction or dependence.

- *Problem drinking or problem drug-taking*: These terms are similar to ‘misuse’ or ‘abuse’. It is important to note that the problem can come and go over time.
- *Addiction, addict or alcoholic*: These terms imply that the individual cannot easily control their drinking – they feel a sense of compulsion about their substance use. Addiction is a controversial term, with some authors feeling that it should not be used and is unhelpful because it has been associated with approaches that characterize alcohol or drug problems as an illness. This is discussed further below.

In general we refer to parental substance ‘misuse’ in this book, as the parent’s use of substances appears to be contributing to problems for their children – and therefore seems to be more than ‘use’ – but is not necessarily a physical dependency or psychological addiction, although in this chapter we often talk of ‘addiction’, as much of the literature relates to this concept. We use ‘addict’ or ‘alcoholic’ to refer to individuals who feel that they have difficulty in controlling or abstaining from use of drugs or alcohol. Yet these terms, and the theories underlying them, require further unpacking if we are to have an appreciation of their potential significance in our work with families affected by substance misuse.

## WHAT IS ADDICTION?

There are many definitions of ‘alcoholism’ or similar conditions (such as being addicted to a particular drug or drugs). Historically, the term referred to continued use of alcohol despite it causing the user health or other difficulties. More recently, medical definitions have sometimes referred to alcoholism or addiction as if it were an illness. Thus the American Medical Association defines alcoholism as:

a primary, chronic disease characterized by impaired control over drinking, pre-occupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking.

(Morse and Flavin, 1992)

Such definitions should not lull us into believing either that diagnosing ‘addiction’ is straightforward or that there is widespread agreement about the nature of ‘addiction’ or ‘alcoholism’. ‘Addiction’ is in fact a hotly contested term, with some academics denying that it is a useful label, while others see it as central to misuse of substances. Indeed, the ICD-10 (a manual defining

medical conditions) has no entry for 'alcoholism', but instead defines 'dependence syndrome'. This refers to behavioural, cognitive and physiological phenomena that may develop after repeated substance use. Typically, these include:

- a strong desire to take the drug;
- impaired control over its use;
- persistent use despite its harmful consequences;
- a higher priority given to drug use than to other activities and obligations;
- increased tolerance;
- a physical withdrawal reaction when drug use is discontinued.

In ICD-10, the diagnosis of dependence syndrome is made if three or more of these have been experienced within a year. The syndrome may relate to a specific substance (e.g. heroin or alcohol), a class of substances (e.g. opioids) or a wider range of pharmacologically different substances (World Health Organization, 2007a and b). However, it is worth noting that even this medical definition does not rely primarily on physical symptoms.

Gifford and Humphrey (2007), in a recent review of the evidence on alcoholism, highlight the contested and uncertain nature of addiction when they contend that: "Addiction" is a hypothesis, namely that a cluster of correlated phenomena are linked by an underlying process' (p. 352). What do they mean by this? Essentially, that similar behaviours are grouped together and studied as 'addiction', but that we do not currently know that these behaviours are in fact linked. Thus, for instance, one can readily see similarities between the behaviour of people with drug or alcohol problems and individuals who gamble excessively. In all these instances individuals may exhibit many of the characteristics outlined above, such as needing more of the substance, feeling a sense of compulsion, craving when not satisfying the compulsion, and so on. Influential academics have argued that these behaviour patterns can extend for some individuals to a range of other problem behaviours. Orford (2001), for example, argues that sex, internet use, overeating and possibly other behaviours may act as 'rewards' and create 'addiction' for some individuals.

However, Gifford and Humphreys do not just mean that individuals can become addicted to a range of different things. Even for one substance such as alcohol, it has long been recognized that there are different patterns of addiction. Thus, we may describe a man living on the street who drinks constantly as an 'alcoholic'. His history may have included starting to drink very heavily from a young age and he may have had a pattern of heavy drinking for his whole adult life. On the other hand, a woman in her fifties may have always enjoyed drinking socially, but after the death of her husband her drinking might escalate until she feels it is out of control. She may be an 'alcoholic', yet the underlying processes involved in her developing a problem, keeping drinking and how she might best change may be very different from the man drinking heavily and living on the street.

Researchers have spent a lot of time and energy exploring factors involved in different patterns of ‘alcoholism’. Some patterns may have more of a genetic link, while others appear to be more about individual and social factors. Fortunately for the practitioner working with a family (and perhaps also for the academics writing a book for them!), it is not necessary to explore this literature in great depth. Instead, we shall briefly review debates around the nature of ‘addiction’ and its causes and then summarize some key points from Orford’s classic book *Excessive Appetites* (2001), which synthesizes different approaches to addiction. We believe that Orford’s approach provides a comprehensive framework for thinking about substance misuse problems which is sufficient as an introduction to professionals interested in working effectively with families.

## THE HISTORY OF ‘ADDICTION’

Until comparatively recently alcohol problems were seen as primarily related to weakness of character – a moral failing, not an illness – and as a consequence the response was a moral one. The ‘temperance movement’ usually encouraged complete abstinence from the evils of drink (though there were elements that campaigned for controlled or reduced drinking) (Berridge, 2005). It had a strongly Christian basis, particularly in Protestant and Nonconformist traditions. They preached to drinkers and drunks, sometimes from wagons, which they encouraged those ready to change to get on (hence the expressions ‘being on the wagon’ to describe someone who has given up alcohol and ‘falling off the wagon’ for a relapse). However, the social elements of the temperance approach are often underestimated. Temperance campaigners saw alcohol as not just an individual but also a *social* evil. They publicized the harmful effect of heavy drinking on women and children, and on society more generally, and identified the brewers and other producers of alcohol as an enemy that needed to be curbed in the interests of society at large. In the United Kingdom, the temperance movement became allied with the progressive Liberal Party, while the Conservatives increasingly represented the interests of brewers (Berridge, 2005). While the language may have changed, elements of the arguments of the temperance movement remain alive in much academic and policy debate around how alcohol use should be managed today.

From the nineteenth century a new discourse emerged which characterized alcohol as an illness. This reached its apotheosis in Jellinek’s *The Disease Concept of Addiction* in 1960. Jellinek argued that the most serious alcohol problems are best conceptualized as a disease, with a biochemical basis and an identifiable course through which the disease progresses. Jellinek identified five types of ‘alcoholism’ and argued that two of these were best

characterized as a disease, as they involved a loss of control and inability to abstain.

The concept of alcoholism as an illness has become the dominant conception of alcohol problems over the last 50 years, particularly in the USA and in the public imagination. Thus, there has been considerable research attention directed towards identifying genetic factors associated with alcoholism or 'personality types' linked to alcoholism. Depictions of alcoholism in the popular press and on television also tend to use a disease model of addiction. Perhaps most importantly, the most influential professional group working with addiction – psychiatrists – have tended to accept and promulgate a disease approach to addiction (this is particularly marked in the USA).

The disease model was also embraced and promoted by Alcoholics Anonymous (AA). AA is one of the first, and is perhaps the largest and best known, self-help groups in the world. It is estimated that it has around two million members. It has been paralleled by similar organizations dealing with different problem behaviours. These include Narcotics Anonymous (NA), Gamblers Anonymous (GA) and Workaholics Anonymous (WA). AA grew out of the temperance movement. It was founded by Bill W. and Dr Bob in 1935. The early meetings were comparatively unstructured, but over time the movement has developed a sophisticated set of beliefs and structure. AA combines a belief in problems in controlling alcohol use as an illness with a feeling that the 'cure' for alcoholics requires spiritual conversion. These ideas were set out in detail in 'the book' which outlines the 12 steps of the AA programme.

AA has been enormously successful, and literally millions of alcoholics can testify to the positive difference it has made in their life. It was the first organization in the USA to provide help for alcoholics irrespective of their ability to pay. Help is available in any place and at any time – for instance, when the alcoholic feels at risk of relapse. In its true form it is non-judgemental and accepts that often alcoholics relapse many times before achieving lasting sobriety. Even if one rejects many of the tenets of the approach, there is much that can be learnt from AA about effective intervention in relation to alcohol or drug misuse.

Yet the disease model and the AA approach have been the subject of sustained critique, and in the UK the dominant model of addiction combines social and psychological elements, with the biological approach of the disease model being generally of subsidiary interest. There are a number of criticisms of an overly simplistic application of the disease model to addiction. First, there is evidence that social structures and policies can have a profound impact on levels of 'addiction'. The best known example of this is research which has consistently shown that altering tax levels on alcohol, or changing policies around its availability, has a direct impact on the number of individuals with a serious alcohol problem (Babor *et al.*, 2003).

Second, the pattern of illegal problem drug use suggests important social causal mechanisms. In the UK widespread heroin use emerged as a social phenomenon in the early 1980s. It was strongly focused in areas of high unemployment, which had emerged in part because of Thatcherite social and economic policies. This seems unlikely to have been a coincidence. Pearson (1987a, b), in his classic work *The New Heroin Users*, developed an analysis that highlights the similarities between the social psychology of heroin addiction and the role a job performs for most people. Work provides a reason for getting up in the morning, a structure to the day, colleagues, acquaintances and friends, and a structure of rewards for endeavour and punishments for failure. In a similar way, heroin addicts have to get up to generate money for their addiction, they then have to find and buy some heroin and finally they use it. In this process, they socialize with other heroin users and achieve a position within the group of being respected (or not). Pearson does not argue that high unemployment 'causes' heroin misuse; rather, he suggests that it creates a vacuum in the lives of people that heroin can fill. As he poignantly observes, in many of the estates experiencing severe unemployment the only people walking with any urgency were those with a heroin habit to sustain (Pearson, 1987b).

Pearson's account is particularly important for understanding the importance of the wider social context of drug addiction. This often applies to alcohol problems as well. Giving up alcohol or heroin is difficult for some individuals (though others appear to find it comparatively easy). However, once an individual has stopped using they need to find something to replace it in their lives. Relapse is in part about the issue of craving, but it is also about finding a life to replace the one based on the addiction.

Even more compelling evidence of the social contribution to the development of drug and alcohol problems is provided by research on the experience of American soldiers in Vietnam (Robins, in Royal College of Psychiatrists, 2000). Heroin was widely available and cheap in Vietnam, and many soldiers developed a serious addiction to it. Yet one year after returning to the United States 95% had given up, and most reported doing so with little or no difficulty despite the fact that heroin was readily available on the streets of American cities. The change in the individual's situation, the removal of the terrible stress of participating in a bloody war and the reinstatement of the social networks that existed before service in Vietnam seemed to be enough to reduce the need for heroin for most of these individuals.

These examples point to a social contribution to both the creation and the maintenance of addiction. However, there is also evidence of important individual factors in the development of addiction. Addiction has been shown to be associated with a variety of individual issues. There is some evidence of a genetic predisposition in relation to alcoholism, though the extent and nature of the link are hotly contested. Three types of studies have been undertaken

to explore the extent of the genetic link. First, studies looking at adopted children have been used to explore the influence of biological parents compared to adoptive carers. For instance, children born to one or more 'alcoholics' and placed with families in which there is no alcoholic allow the contribution of genetic factors to be explored. However, there are limitations in this approach. The diagnosis of 'alcoholism' in birth parents can prove difficult, collecting accurate information from adoptive carers is also a challenge and the process of adoption may in itself be an environmental influence; being adopted is not the same as being born into a family, and this may influence the likelihood of a child developing an addiction. While care should be taken in interpreting such studies, they do show a genetic link to addiction (e.g. Bohmann *et al.*, 1981; Cloninger *et al.*, 1981, Partanen *et al.*, 1966).

Second, twin studies have been used to look for a genetic link to alcoholism. Twin studies compare identical twins (who are 100% similar genetically) with non-identical twins (who share only 50% of their genes). Broadly speaking these studies rely on assuming that higher rates of shared alcoholism (or other addiction) between identical twins are due to increased genetic similarity. In fact, this may not be true, as non-identical twins may have more different environments than identical twins, and more recent studies have attempted to take this into account. The findings from twin studies also suggest some genetic link for alcoholism (e.g. Kendler *et al.*, 1992; Prescott and Kendler, 1999).

Third, studies have considered family history and relationships. This approach looks at large numbers of individuals related in a variety of ways (full and half-siblings, twins, cousins, etc.) and then calculates the importance of genetic similarity in accounting for the development of alcoholism. Again, such studies tend to find a genetic component in the development of addiction (e.g. Harford *et al.*, 1992).

Taken together, these studies make a compelling case that there is some genetic link that results in an increased likelihood of individuals developing an alcohol problem. However, there are a number of caveats and limitations within the data that need to be taken into account. First, many of the studies that are often cited in this area have serious limitations and problems. For instance, some rely on small numbers, others use rather loose definitions of 'alcoholic' and most have limited information on the actual environments that individuals experience. Second, while the evidence for some sort of genetic link is comparatively strong for very heavy and early-onset drinkers, it is much weaker in relation to other forms of alcohol problem. In fact, individuals with early-onset and heavy drinking comprise only a minority of problem drinkers. Third, overall the genetic component does not generally strongly predict whether an individual will develop an alcohol problem. A fourth issue, which may contribute to this lack of specificity, is that the nature of the genetic link itself is complex; it is not a single gene such as in cystic fibrosis or sickle cell anaemia. It is more likely that there is a large number of predisposing



factors that are carried genetically, which work in different ways. For instance, biological children of alcoholics may respond differently to alcohol (e.g. making it more enjoyable for them), they may be more sociable and they may tend to take more risks. Some of these may be genetically linked in a direct way between generations, while others may be broad dispositions that could be inherited.

A crucial fifth issue is that we are only beginning to understand the interaction between genetic predisposition and environmental factors. A couple of studies provide interesting examples of the complexity of this. Jacob *et al.* (2003) looked at the children of adult twins who had histories of alcoholism in their birth fathers (the grandfathers of the children). They found that if the twin had developed an alcohol problem, their children were at increased risk of doing so too. However, the children of twins who had not developed an alcohol problem were at no increased risk of alcoholism. This suggests that environmental factors are important in protecting individuals who may be genetically vulnerable to developing alcohol problems. Buster and Rodgers (2000) looked at family relationships in predicting the development of alcoholism in a large representative sample. They found small to medium genetic components. Differences between households had a similar impact, with most of the reason for individuals developing an alcohol problem not being related to variables within the family structure.

It therefore seems safe to conclude that there is a genetic predisposition for some individuals, but that this is mediated in complex ways through family experiences, environment and the society that the individual grows up in. Furthermore, to date the research on genetic influences has provided very little information to help in assessing or intervening to help individuals with alcohol problems. At present its significance may therefore be largely theoretical.

However, genetic elements are not the only element of individual importance in understanding the development of alcohol problems. Individual circumstances and histories also have a crucial part to play. Individuals with a drink or drug problem are more likely to have had histories of abuse or neglect (Velleman and Orford, 1999). In addition, somebody who develops an addiction of one sort appears more at risk of developing addictions of other sorts. Furthermore, there is some evidence of an inter-generational link between alcoholism in a parent and the development of alcohol problems (Velleman and Orford, 1999). This link is mediated in a variety of ways – there is a genetic element, however learnt behaviour, the influence of parents as role models and the impact of living in often unhappy households seem more important. (The interplay between risk and protective factors in influencing child welfare is discussed further in Chapter 2.) This can be seen as the opposite of the environmental protection provided by a non-alcohol misusing family that was noted above: children brought up in discordant families, par-



ticularly if one or more parents misuse drugs or alcohol, are at increased risk of developing such problems themselves.

In an attempt to synthesize these various findings Orford (2001) developed what he terms a social-behavioural-cognitive-moral model of addiction. As this is a rather unwieldy formulation, it is simpler to refer to it as Orford's model of excessive appetites. We think it a useful way of bringing together the wide range of research literature on substance misuse and addiction.

## **ORFORD'S MODEL OF 'EXCESSIVE APPETITES'**

The theory of excessive appetites is useful for two reasons. First, Orford synthesizes a range of different evidence into a coherent theory. This moves us beyond debates about whether there is an 'addictive personality' or whether poverty causes addiction, towards a model that sees a place for both, probably in interaction. Second, Orford, in common with many in the addiction field, helpfully distinguishes between processes involved in defining what an addiction is, starting potentially addictive behaviour, becoming addicted, maintaining addiction and overcoming addiction. Each of these processes is worth considering. Figure 1.1 sets out these processes and some of the factors that influence them in a simplified version of Orford's theory.

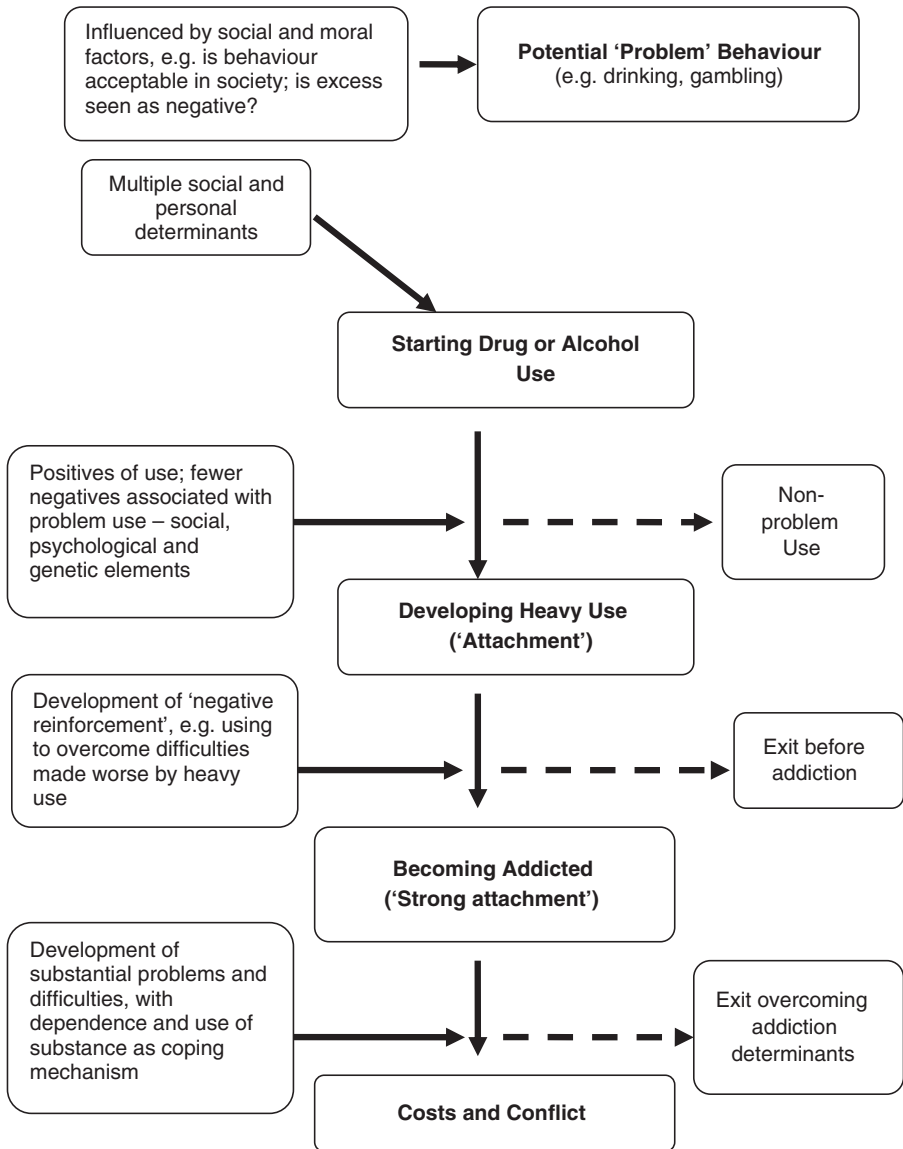
First, the 'moral' element of the model is that addiction is to some degree socially defined. Over-indulgence in some behaviours (drugs, alcohol, food or gambling) is subject to social censure. Other behaviours (e.g. working, religious observance or spending time with one's children) rarely receive such disapproval. In addition, societies vary in what they consider acceptable or unacceptable. Thus, in the UK today daily consumption of two bottles of port would be considered to be an indication of probable alcoholism. In the seventeenth century, such consumption was considered perfectly normal (Barr, 1998). This suggests that society has a role to play in defining what is an 'addiction'.

Orford suggests that there is a range of activities which can become:

so excessive that they spoil the quality of people's lives, seriously affect and give rise to concern among family and friends, are costly to individuals and families, attract terms such as 'addiction', 'dependence' and 'disease', and provoke the setting-up of mutual-help and expert-treatment systems.

(2001, p. 341)

These activities include drug use, drinking, gambling, the use of a range of other substances, binge-eating and sex. Orford also suggests that other activities, such as internet use and some forms of criminal behaviour, may be behaviours of this type.



**Figure 1.1** A simplified representation of Orford’s theory of excessive appetites.

**STAGE 1: TRYING OUT ALCOHOL OR DRUGS**

A number of individual and social factors interact to shape whether people try these activities. Crucial social factors include whether there are opportunities and social approval for the behaviour. For instance, until recently women

have drunk considerably less than men. In large part this was because they were prevented from doing so: it was socially censured and often men controlled the financial resources of the family. This is changing because today we live in a more equal society. Women have therefore claimed the right to the pleasures of alcohol use and their levels of drinking (and also illegal drug taking) are currently rising faster than men's (Alcohol Concern, 2004; European Monitoring Centre for Drugs and Drug Addiction, 2005). Inevitably, a growing minority of women are experiencing the negative side of alcohol and drug use: alcoholism, problem drinking and drug addiction. This is a good example of the way in which social changes can impact on patterns of 'addiction' – and is one of particular relevance for the impact of addiction on children. However, there are many other ways in which social context can shape individuals' exposure to problematic behaviours. Age limits for drinking and making some substances illegal shape availability and perceptions of substances (Babor *et al.*, 2003). Peer groups and older siblings can influence individuals in their attitude to a range of behaviours, including use of illegal drugs (Barnard, 2007).

Andrew Barr's *Drink: A Social History* (1998) provides a fascinating account of the ways in which social and political changes can interact to influence the availability of different substances over time. For instance, the extent of alcohol use in the UK has varied widely over different periods. The lowest levels of alcohol availability were recorded in the middle of the twentieth century, in part due to relative austerity and in part because of government controls put in place during wartime. With increasing affluence and liberalization of society, alcohol use is increasing – and alcohol problems are inevitably also on the rise (Prime Minister's Strategy Unit, 2004). Opium was used predominantly by the upper classes in the eighteenth and nineteenth centuries, but versions of it were widely available, and it was even an ingredient in 'gripe water' – a soothing elixir for babies! It was little used in the early twentieth century until a small number of addicts – generally related to the medical professions – were identified in the 1960s and 1970s. In the 1980s there was a massive increase in heroin use, and instead of being a problem for a comparatively small number of middle-class users addiction was concentrated in areas of high unemployment and associated with a range of other social problems.

Thus social factors profoundly shape the likelihood of an individual trying various substances or other addictive behaviours. How and why does drinking or drug-taking – or other 'appetitive behaviour' – move to becoming a problem?

## STAGE 2: DEVELOPING HEAVY USE OF DRUGS OR ALCOHOL

In the move from trying drugs or alcohol to developing heavy use a range of factors interact in complex ways to provide either positive or negative

reinforcement for a particular behaviour. Positive reinforcement is the reward that individuals experience from drinking or drug-taking. For most substances – or excessive appetites – there is an obvious reward. Thus, alcohol and drugs produce (generally) pleasant feelings of disinhibition or intoxication; there is the excitement of gambling or the enjoyment of eating ‘forbidden’ foods, and so on. Sargent comments: ‘Few writers appear to have recognized that pleasure is a main motivation for the use of drugs, for they are too busy seeking a deficit in the individual ...’ (1992, in Orford, 2001, p. 154). Negative reinforcement is the opposite of positive reinforcement, in that it is the relief or prevention of painful or unpleasant feelings, for instance helping someone to reduce the pain of bereavement or low self-esteem or depression.

However, crucially, individuals’ reactions to substances vary markedly. This is easily illustrated in relation to alcohol, where after consuming a few drinks one person will become sociable and relaxed, another may become sleepy, while a third may be aggressive or act irresponsibly. The focus of much research by those supporting the ‘medical model’ of addiction has been to try to identify the differences between individuals in their response to substances and thus their likelihood of becoming addicted. In truth, even at this level there are important social elements that mediate individuals’ reactions to substances. For instance, research has identified that in some cultures drinking alcohol is associated with relaxed socializing, in others it is more likely to be linked to aggressive or confrontational behaviour, while in some drinking is linked to religious rites. In these different contexts, individuals exhibit different behaviours related to similar doses of alcohol, indicating the role of social expectations in mediating the link between consumption and behaviour. Furthermore, in Western contexts individuals who are given a placebo (i.e. a drink that they believe to be alcoholic but that actually has no alcohol in it) generally behave in much the same way as those given genuine alcohol (see Hammersley *et al.*, 1992 for a discussion). This suggests that the socially created expectations of individuals and the situations in which substances are imbued have an important influence on behaviour.

Yet, while these social expectations are important, there are also significant variations between individuals in their response to any given substance (or other potential excessive behaviour). For a variety of reasons, related in part to the medicalization of theorizing and in part to the nature of funding for addiction research, individual aspects of addiction have been the focus of far more research than social and cultural factors. Gifford and Humphreys (2007) found 50 times as many articles relating to the keywords ‘alcoholic’ and ‘personality’ compared to articles with ‘alcoholic’ and ‘poverty’ as the keywords. Orford (2001) suggests that those likely to develop an ‘excessive appetite’ experience the behaviour in question, such as taking drugs, as more positive and causing fewer problems than individuals who are unlikely to develop an addiction.

The positive enjoyment associated with using drugs or alcohol was discussed above. However, substance use may help individuals to cope with negative emotions. Some individuals may have unhappy feelings that the substance temporarily mitigates or masks (there is a strong association between a history of abuse and substance misuse problems (Deren, 1986), and a probable link for some people with recent difficult experiences such as bereavement). On the other hand, individuals may experience fewer disincentives or restraints on use. This also operates on multiple levels. Socially, individuals may have less to lose through excessive consumption. Thus, people with happy families for whom they have responsibilities and challenging jobs that they enjoy are less likely to develop alcoholism: they have more to lose from excessive consumption. Some individuals find the negative side of drinking or drug-taking – such as the risks of being caught with illegal drugs, the hangovers or the 'down' after taking a stimulant – to be more important.

One way of conceptualizing this is that substance use and other forms of excessive behaviour provide individuals with a way of regulating their emotions. Thus, drinking and smoking, and some other addictive behaviours, may help individuals to reduce their stress levels; they may help as a form of 'self-medication' for painful or troubling emotions; they may help individuals to overcome low self-esteem, shyness or other social difficulties. In general, use of any substance tends to be associated with positive desired effects (related to pleasure) and to avoiding negative effects (for instance, coping with difficult emotions). It remains true that to date the best way of predicting the potential for individuals to start using a substance excessively is to ask them how much they enjoy using it (Orford, 2001).

Orford (2001) places little weight on genetic factors in the development of addiction. Indeed, genetic links do not appear in his book. Yet proponents of the medical model tend to emphasize individual differences at the biological or genetic level and, as discussed above, there is some evidence that they may contribute to the development of alcohol dependency. It seems likely therefore that some individuals have a genetically predetermined tendency to find alcohol more rewarding and/or to experience fewer negative effects from alcohol use. This plays a role in both individuals starting to drink heavily and in the development of an 'addiction', though only as one factor in a complicated series of processes.

### STAGE 3: THE DEVELOPMENT OF 'ADDICTION'

Thus far we have considered processes that frame excessive behaviour, such as its social and moral context, and reviewed issues linked to developing excessive behaviour, such as heavy drinking or using illegal drugs regularly. Many of the parents whose misuse harms their children may simply be heavy

or periodic binge users. However, for most there is a sense of compulsion and consequent difficulty in giving up, a feeling that is best captured by the concept of 'addiction'. What is the nature of the move from heavy use to 'addiction'? And what factors are associated with the move?

In most cases the development of addiction is a gradual process. It is something that needs to be worked at. This is not the general perception of addiction – particularly in relation to illegal drugs, but also for alcohol. In both the earlier drug education literature and popular culture there has been a tendency to portray use of illegal substances such as heroin, cocaine or crack cocaine as having the potential to lead swiftly to addiction. A wonderful – and ludicrous – example of this can be found in a notorious episode of the 1970s TV show *Starsky and Hutch*, in which Hutch is kidnapped by baddies who want to find out where his girlfriend is. The kidnapers hold Hutch and inject him with heroin over the course of a week. By the end of the week he is hopelessly addicted, indeed, he has been transformed into a stereotypical 'junkie', from the overwhelming desire for heroin to a pallid and unhealthy complexion. This episode was not screened in the UK until 1999 because of its drug-related content, however a more valid reason for not broadcasting it would have been its absurd depiction of drug addiction. The complex social and individual dynamics of addiction were ignored, and addiction was seen as something created by exposure to an addictive substance over a comparatively brief period. Central to the misunderstanding about the nature of addiction was the idea that withdrawal symptoms were synonymous with addiction. In fact, they are only one element of 'addiction'. Other, equally important elements include a reduction in other behaviours (such as non-drug-related socializing), which is linked to a prioritization of use of the substance over other interests, a more focused use of drink or drugs (to get a desired effect) and a feeling of craving when not using.

In stark contrast to the image of addiction suggested in *Starsky and Hutch*, Geoff Pearson describes the process of addiction to heroin as a slow and insidious one. He suggests that 'Heroin's advance is not like some sudden cavalry charge; more like the slow trudge of a foot army' (1987a, p. 63). Or to put it another way, addiction tends to creep up on individuals rather than coming at them head on. Each step on the path to addiction seems innocuous, yet the end-point is a sense of being trapped with behaviour that one feels one cannot control.

This development of addiction includes some important behavioural changes. First, it involves prioritization of use of the substance over other activities. This might start with individuals no longer engaging in other hobbies or activities and can end up with them neglecting their children and themselves in favour of their addiction. Second, the pattern of use tends to become the same every time – a change in behaviour called 'narrowing of the drinking repertoire' in relation to alcohol misuse. Thus, where an individual may have started by experimenting by drinking various alcoholic drinks in different

ways, and may have then started to drink more heavily in certain situations, for alcoholics the pattern of drinking tends to become rather similar. An alcoholic will often be drinking to achieve a particular state – whether that is a certain level of alcohol in the blood that allows them to function as they wish to or achieving oblivion by drinking until losing consciousness. For instance, during the 1930s, Winston Churchill would drink whisky throughout the day and considerable quantities of wine at mealtimes. He then spent the evenings writing a series of books that won him a Nobel prize for literature, and campaigned tirelessly against appeasement of Germany.

The development of physical dependence is also part of the 'slow trudge' of addiction. It has two elements: the first is tolerance (more of the substance is required to achieve the desired effect) and the second is withdrawal (a characteristic set of symptoms associated with ceasing to use a substance). Jellinek (1960) identified the disease of 'alcoholism' as only being present when these characteristics were identified, and thus saw them as central to the nature of addiction. In particular, the development of tolerance leads to greater consumption, while the experience or possibility of withdrawal symptoms provide potentially powerful reinforcers for maintaining substance misuse. In effect, one is rewarded for continuing to drink or take drugs, while stopping provides the punishment of withdrawal.

However, dependence should not be seen solely – or even perhaps primarily – as a physical condition. Dependence is as much about the psychological belief that one needs a substance (or behaviour). Thus, many of the symptoms associated with 'dependence' can be found in those with gambling problems and other problem behaviours not associated with physical dependence.

The centrality of dependence to addiction is crucial to the conception of addiction as an illness. As such it has been hotly contested. Orford (2001) argues that dependence does not explain how individuals develop an addiction and thus become physically dependent, that for many overcoming withdrawal is not particularly difficult and that a focus on physical dependence does not explain why people so often relapse after having overcome their initial withdrawal symptoms. Indeed, in general overcoming initial withdrawal is considerably less hard than sustaining abstinence or controlled use. Indeed, this pattern of lapse (use after abstinence) or relapse (returned to previous patterns of behaviour) is a consistent feature of addiction, with many individuals having to overcome withdrawal a number of times before they are able to maintain abstinence or controlled use. In addition, there are substances or behaviours that clearly appear 'addictive' but that do not have a strong physiological dependence. One example is gambling; another is cocaine. Cessation of cocaine – and in particular crack cocaine – use has all the hallmarks of an addictive behaviour. However, there is not the gross physiological dependency that is associated with alcohol or heroin. This poses difficulties for models of addiction that place physical dependence as central.



In truth, the situation will vary from individual to individual. However, it is worth considering further the situation of those who consider themselves to be addicted. By this stage they will generally be making considerable sacrifices to sustain their alcohol or drug problem. They may have problems in their work or family; their children and relationships are likely to be suffering; their physical health may be affected; they may be experiencing legal problems; and they are likely to have done things they are ashamed of. This is not always the case – the example of Churchill was provided earlier, and he indicates that some alcoholics appear able to sustain high levels of dependent drinking with comparatively few problems. However, this is unusual. It is much more common for those on the outside to see the severe damage that the individual is doing to himself and to others. In such circumstances, it can be almost impossible to understand why they do not do something about the problem.

### CONFLICT AND AMBIVALENCE

This leads us to a central psychological element of ‘addiction’, what Orford characterizes as ‘conflict’ and Miller and Rollnick (2002) describe as ‘ambivalence’. Addicted individuals are likely to be acutely aware of all the negative effects that substance misuse is having for them and those they care about. However, they also have powerful reasons for continuing with the problem behaviour. This may be in the form of the rewards of their addiction or the challenges and difficulties of changing.

A useful way of conceptualizing this when working with an individual can be to use the ‘decisional matrix’. This is a simple box with four sections. The top row is divided into the pros and cons of continuing as at present; the second row is for the pros and cons of changing (for instance giving up). In Figure 1.2 we have completed a box for someone addicted to heroin. The box is not meant to be a realistic illustration of how such a matrix is usually completed, but demonstrates the complex and conflicting feelings and thoughts that an addict may be going through.

In section 1 it can be seen that the individual is well aware of the problems that their heroin use is causing them and others. They list the loss of respect, sense of chaos, worry about the future and about current health, the impact on their children and the possibility of the children being removed into care. Yet they also see important positives about their heroin use. Their friends, contacts and indeed their whole life are structured around heroin use. Most importantly, using heroin makes the problems go away (even if this is a temporary effect). The quickest and easiest ‘solution’ to the problems in section 1 is to use heroin; yet this is precisely the behaviour that creates the very problems it is being used to ‘resolve’. This paradox is at the heart of addiction.

<p>For Laura, a 31-year-old White woman now six months pregnant. Laura is a heavy user of heroin and also smokes cannabis and takes crack cocaine. She has two other children, both of whom were taken into care.</p>	
<p><b>1 Good things about using heroin</b></p> <p>Helps me sleep.</p> <p>Helps me cope with feeling anxious about the baby being taken away.</p> <p>It is a world I know.</p>	<p><b>2 Bad things about using heroin</b></p> <p>The effect on the baby inside me.</p> <p>Might lose baby.</p> <p>I can't look after my baby properly.</p> <p>Need money – so I shoplift and end up in prison.</p> <p>Live in fear due to debts to dealers.</p> <p>Move house a lot.</p> <p>Feel I am doing nothing with my life.</p> <p>Health problems.</p>
<p><b>3 Good things about giving up</b></p> <p>It would allow me to look after the baby properly and do something with my life.</p> <p>Avoid all the bad things about using.</p> <p>I could return to college.</p>	<p><b>4 Bad things about giving up</b></p> <p>Going through withdrawal.</p> <p>Is giving up best for the baby?</p> <p>Even if I give up will I keep off?</p> <p>Will social workers understand how difficult I am finding it?</p> <p>How will I spend my time? Who will I spend time with?</p> <p>How will I cope with bad feelings about my childhood?</p>

**Figure 1.2** Decisional matrix.

In sections 3 and 4 it can be seen that ‘giving up’ is not a straightforwardly positive option. In section 3, the removal of the problems identified in section 1 is supplemented by additional positives such as the possibility of returning to college and becoming the sort of mother that their child can respect. Yet in section 4 can be seen the very great problems associated with trying to

change. Withdrawal and subsequent cravings, a feeling that one cannot overcome the addiction and a fear of how one will cope emotionally and in structuring one's life are identified as issues.

The feelings of ambivalence and associated conflict at the heart of 'addiction' are central to understanding and working with people with a drink or drug problem. From the outside (as seen by professionals or family members) it can seem quite obvious what the person should do. The harm that drinking or drug-taking is creating is clear, and the improvement in the person's life that would result from stopping seem so self-evident that it is very hard to understand why the individual does not change. This can be even more pronounced when the addict is a parent. Yet the addict is the expert on their own addiction and they will know all the arguments for changing (or not changing). However, the conflict they cannot resolve – the central ambivalence – is that for the individual there are positives about their substance misuse, or negatives about changing, that make abstaining or controlling their use very difficult.

One way of developing some understanding of this conflict is to think about a behaviour that you know you should change, but have not changed. This might include what you eat or the amount of exercise you do; it could be a bad habit that you would like to stop or a new behaviour you would like to start and stick to. Take a moment to complete a 'decisional matrix' for your own behaviour.

The chances are that an outsider would not see why you do not simply change. You should go to the gym/eat more healthily/stop biting your nails or smoking or whatever change you need to make. But from your perspective it is likely to be more complicated. You will have reasons why you do not change, relating both to the positives about your current behaviour and the difficulties and downside of changing. So, while you know you should perhaps go to the gym or start jogging regularly, it may be difficult to fit it into your busy life, you are tired when you come home, perhaps you have family responsibilities – and after all, the hour you spend watching TV is the only time you have to yourself all day. And perhaps you think, 'I'm not that unfit. And anyway, I have tried to go to the gym regularly and it never lasts more than a week.' And so on.

These types of conflicts and confusions are more pronounced for an addict, but they are not that dissimilar from dilemmas and ambivalences we all experience about making changes that we 'should' make but find difficult to. In Chapter 8 we discuss at length ways of helping individuals to explore and, if possible, resolve such conflicts. For now, the key point is that this type of conflict is at the heart of addiction and it is not completely alien from the challenges we all experience in changing 'problem' behaviours. Crucially, it means that the individual with an addiction is an expert on their own situation, for only they fully understand the pros and cons of continuing as they are or changing.

This leads us to the final stage in understanding 'addiction' – how individual overcomes it. This issue is discussed in Chapters 8 and 9, which consider effective interventions and treatments for drug or alcohol problems.

## CONCLUSIONS

This chapter has reviewed approaches to substance misuse and addiction. The differences between use, misuse, problem use and addiction were discussed, and issues relating to medical and social approaches to understanding misuse or addiction outlined. An attempt was made to consider the contribution of both individual and social factors to substance misuse and addiction. This was done through a discussion of elements of Orford's approach to the development of 'excessive appetites'. In particular, an attempt was made to differentiate between factors associated with starting the use of a substance, those linked to moving from use to heavy use and those related to becoming addicted.

Four issues stand out as being particularly important. The first is that the terminology used in relation to substance misuse problems reflects important conceptual differences in approaches to the issue. As discussed, there is a big difference between talking about someone having an alcohol problem and someone being an alcoholic, though the two may be related.

Second, it is useful to differentiate the process of developing excessive use into four stages: initial use, heavy use, addiction and stopping after addiction. Each of these stages is influenced by different factors. Crucially, factors that may have been important in moving from use to heavy use, for instance, may not be relevant for stopping or controlling use.

Third, an attempt has been made to highlight the importance of social factors in understanding addiction and problem use. There is a tendency to see addiction as an individual illness. Instead, we have argued that an interplay of individual and social factors is the key to understanding addiction. It is therefore more appropriate to see problem use or addiction as a psycho-social problem than as an individual issue requiring psychiatric or psychological treatment.

Finally, we have indicated the complexity of substance misuse. The development and maintenance of 'addiction' take place through a variety of stages, and at each stage an apparently bewildering array of factors may interact. Furthermore, for each individual the constellation of causal factors and the types of help likely to be effective are different. This may leave the professional or non-professional with a view to helping a parent with a drug or alcohol problem feeling confused. We hope that in later chapters we can provide useful suggestions for effective ways of working with parents who misuse substances. However, a sense of the sheer complexity of substance misuse may not be a bad thing. Understanding the difficult and interrelated

nature of the issues when people misuse substances is a good first step towards being able to assess and intervene effectively. It provides a solid grounding in humility from which the professional can engage with the person who is most expert in their particular circumstances: the individual with the drug or alcohol problem.

In Chapter 2, the focus shifts to how the parent's misuse of drugs or alcohol can impact on their children and the factors that exacerbate or reduce the potential harm that it can cause.