Psy 270 week 5 discussion questions answers and research assignment

Week 5 DQ 2 – Due Thursday, August 26 Please post a 200 – 300-word response to the following discussion question by clicking on Reply. Discussion Question Review Ch. 10 of Fundamentals of Abnormal Psychology. Choose a theoretical viewpoint based on your readings. Answer the following questions: How does your theoretical viewpoint explain the causes of substance abuse, and what treatments does it recommend? What are some of the strengths or weaknesses of your viewpoint?

Psychodynamic theorists explain the causes or substance abuse as related to dependency issues dating back to early childhood. This view claims that a when parents fail to satisfy a young child’s need for nurturance the child will grow to be highly dependent on others for help and comfort. This dependence and need for nurturance can easily be translated into a dependence on drugs or alcohol if the child is introduced to these substances in their search for nurturing. What is known as a substance abuse personality is a response to their early deprivations according to psychodynamic theorists.

Research has in fact shown that people who abuse drugs and alcohol do tend to be more dependent, anti-social, novelty-seeking and depressive than others. A major weakness of this viewpoint is the wide range of personality traits that have been tied to substance abuse as different studies point to different traits as the key causal factors or traits that could possibly be linked to substance abuse and dependency. It is unclear from current research if any one personality trait or group of traits can be directly linked to substance abuse related disorders.

Treatment for substance abuse under the psychodynamic theory would involve the therapist guiding the patient to uncover and resolve underlying needs and conflicts which could have led to the dependency issue and substance abuse. The therapist would then try to help the individual to change their substance related style of living. This treatment style is not very effective and is usually of greater help when combined with other approaches as a part of a multi-dimensional treatment program.

A major weakness of this line of argument is the wide range of personality traits that have been tied to substance abuse and dependence. In fact, different studies point to different “ key” traits. Inasmuch as some people with a drug addiction appear to be dependent, others impulsive, and still others antisocial, researchers cannot presently conclude that any one personality trait or group of traits stands out in substance-related disorders (Chassin et al. , 2001; Rozin & Stoess, 1993).

Psychodynamic Therapies Psychodynamic therapists first guide patients with substance-related disorders to uncover and resolve the underlying needs and conflicts that they believe have led to the disorders. The therapists then try to help the individuals change their substance-related styles of living (Stetter, 2000; Hopper, 1995). Although often applied, this approach has not been found to be particularly effective in cases of substance-related disorders (Cornish et al. , 1995; Holder et al. , 1991).

It may be that drug abuse or dependence, regardless of its causes, eventually becomes a stubborn independent problem that must be the direct target of treatment if people are to become drug-free. Psychodynamic

therapy tends to be of greater help when it is combined with other approaches in a multidimensional treatment program (Galanter & Brooks, 2001; Carroll & Rounsaville, 1995). The Psychodynamic View Psychodynamic theorists believe that people who abuse substances have powerful dependency needs that can be traced to their early years (Stetter, 2000; Shedler & Block, 1990).

They claim that when parents fail to satisfy a young child’s need for nurturance, the child is likely to grow up depending excessively on others for help and comfort, trying to find the nurturance that was lacking during the early years. If this search for outside support includes experimentation with a drug, the person may well develop a dependent relationship with the substance. Some psychodynamic theorists also believe that certain people respond to their early deprivations by developing a substance abuse personality that leaves them particularly prone to drug abuse.

Personality inventories and patient interviews have in fact indicated that people who abuse or depend on drugs tend to be more dependent, antisocial, impulsive, novelty-seeking, and depressive than other people (Coffey et al. , 2003; Cox et al. , 2001; Finn et al. , 2000). These findings are correlational, however, and do not clarify whether such personality traits lead to drug use or whether drug use causes people to be dependent, impulsive, and the like. In an effort to determine causation, one study measured the personality traits of a large group of nonalcoholic young men and then kept track of each man’s development (Jones, 1971, 1968).

Years later, the traits of the men who developed alcohol problems in middle age were compared with the traits of those who did not. The men who developed alcohol problems had been more impulsive as teenagers and continued to be so in middle age, a finding suggesting that impulsive men are indeed more prone to develop alcohol problems. Similarly, in one laboratory investigation, “ impulsive” rats—those that generally had trouble delaying their rewards—were found to drink more alcohol when offered it than other rats (Poulos et al. 1995). A major weakness of this line of argument is the wide range of personality traits that have been tied to substance abuse and dependence. In fact, different studies point to different “ key” traits. Inasmuch as some people with a drug addiction appear to be dependent, others impulsive, and still others antisocial, researchers cannot presently conclude that any one personality trait or group of traits stands out in substance-related disorders (Chassin et al. , 2001; Rozin & Stoess, 1993).

The Behavioral and Cognitive Views According to behaviorists, operant conditioning may play a key role in substance abuse. They argue that the temporary reduction of tension or raising of spirits produced by a drug has a rewarding effect, thus increasing the likelihood that the user will seek this reaction again (Rutledge & Sher, 2001). Similarly, the rewarding effects of a substance may eventually lead users to try higher dosages or more powerful methods of ingestion (see Table 10-4).

Cognitive theorists further argue that such rewards eventually produce an expectancy that substances will be rewarding, and this expectation helps motivate individuals to increase drug use at times of tension (Chassin et al. , 2001). In support of these views, studies have found that many subjects do

in fact drink more alcohol or seek heroin when they feel tense (Ham et al. , 2002; Cooper, 1994). In one study, as subjects worked on a difficult anagram task, a confederate planted by the researchers unfairly criticized and belittled them (Marlatt et al. 1975). The subjects were then asked to participate in an " alcohol taste task," supposedly to compare and rate alcoholic beverages. The subjects who had been harassed drank more alcohol during the taste task than did the control subjects who had not been criticized. In a manner of speaking, the behavioral and cognitive theorists are arguing that many people take drugs to " medicate" themselves when they feel tense. If so, one would expect higher rates of drug abuse among people who suffer from anxiety, depression, or intense anger.

In fact, substance abuse and dependence do appear to be fairly common among people with mood disorders (McDowell & Clodfelter, 2001; Swendsen & Merikangas, 2000). One study of 835 clinically depressed patients found that more than one-fourth abused drugs during episodes of depression (Hasin et al. , 1985). Similarly, higher-than-usual rates of drug abuse have been found among people with posttraumatic stress disorder, eating disorders, schizophrenia, antisocial personality disorder, histories of being abused, and other psychological problems (Brown et al. 2003; Brooner et al. , 1997; Yama et al. , 1993). A number of behaviorists have proposed that classical conditioning may also play a role in substance abuse and dependence (Drobes, Saladin, & Tiffany, 2001). Objects present at the time drugs are taken may act as classically conditioned stimuli and come to produce some of the same pleasure brought on by the drugs themselves. Just the sight of a hypodermic needle or a regular supplier, for example, has

been known to comfort people who abuse heroin or amphetamines and to relieve their withdrawal symptoms.

In a similar manner, objects that are present during withdrawal distress may produce withdrawal-like symptoms. One man who had formerly been dependent on heroin experienced nausea and other withdrawal symptoms when he returned to the neighborhood where he had gone through withdrawal in the past—a reaction that led him to start taking heroin again (O'Brien et al. , 1975). Although classical conditioning may in fact be at work in particular cases of drug abuse and dependence, it has not received widespread research support as a key factor in such patterns (Drobes et al. , 2001).

The Biological View In recent years researchers have come to suspect that drug misuse may have biological causes. Studies on genetic predisposition and specific biochemical processes have provided some support for these suspicions. Genetic Predisposition For years breeding experiments have been conducted to see whether certain animals are genetically predisposed to become dependent on drugs (Li, 2000; Kurtz et al. , 1996). In several studies, for example, investigators have first identified animals that prefer alcohol to other beverages and then mated them to one another.

Generally, the offspring of these animals have been found to also display an unusual preference for alcohol (Melo et al. , 1996). Similarly, some research with human twins has suggested that people may inherit a predisposition to abuse substances (Tsuang et al. , 2001; Kendler et al. , 1994, 1992). One classic study found an alcohol abuse concordance rate of 54 percent in a

group of identical twins; that is, if one identical twin abused alcohol, the other twin also abused alcohol in 54 percent of the cases. In contrast, a group of fraternal twins had a concordance rate of only 28 percent (Kaij, 1960).

As we have observed, however, such findings do not rule out other interpretations (Walters, 2002). For one thing, the parenting received by two identical twins may be more similar than that received by two fraternal twins. A stronger indication that genetics may play a role in substance abuse and dependence comes from studies of alcoholism rates in people adopted shortly after birth (Walters, 2002; Cadoret, 1995; Goldstein, 1994). These studies have compared adoptees whose biological parents are dependent on alcohol with adoptees whose biological parents are not.

By adulthood, the individuals whose biological parents are dependent on alcohol typically show higher rates of alcohol abuse than those with nonalcoholic biological parents. Genetic linkage strategies and molecular biology techniques provide more direct evidence in support of a genetic explanation (Crabbe, 2002, 2001). One line of investigation has found an abnormal form of the so-called dopamine-2 (D2) receptor gene in a majority of subjects with alcohol dependence and half of subjects with cocaine dependence, but in less than 20 percent of nondependent subjects (Connor et al. 2002; Finckh, 2001; Blum & Noble, 1993). Other studies have tied still other genes to substance-related disorders (Cook & Gurling, 2001).

Biochemical Factors Over the past few decades, investigators have pieced together a general biological understanding of drug tolerance and withdrawal symptoms (Wise, 1996). As we have seen, when a particular drug

is ingested, it increases the activity of certain neurotransmitters whose normal purpose is to calm, reduce pain, lift mood, or increase alertness.

When a person keeps on taking the drug, the brain apparently makes an adjustment and reduces its own production of the neurotransmitters. Because the drug is increasing neurotransmitter activity or efficiency, action by the brain is less necessary. As drug intake increases, the body's production of the neurotransmitters continues to decrease, leaving the person in need of more and more of the drug to achieve its effects. In this way, drug takers build tolerance for a drug, becoming more and more reliant on it rather than on their own biological processes to feel comfortable or alert.

If they suddenly stop taking the drug, their supply of neurotransmitters will be low for a time, producing the symptoms of withdrawal. Withdrawal continues until the brain resumes its normal production of the necessary neurotransmitters. Which neurotransmitters are affected depends on the drug used. Repeated and excessive use of alcohol or benzodiazepines may lower the brain's production of the neurotransmitter GABA; regular use of opioids may reduce the brain's production of endorphins; and regular use of cocaine or amphetamines ay lower the brain's production of dopamine (Volkow et al. , 1999). In addition, researchers have identified neurotransmitters called anandamides (from the Sanskrit word for " bliss") that operate much like THC; excessive use of marijuana may reduce the production of these neurotransmitters (Johns, 2001; Biegon & Kerman, 1995). This theory helps explain why people who regularly take substances

experience tolerance and withdrawal reactions. But why are drugs so rewarding, and why do certain people turn to them in the first place?

A number of brain-imaging studies suggest that many, perhaps all, drugs eventually activate a single reward center, or “ pleasure pathway,” in the brain (Kelley & Berridge, 2002; Volkow & Fowler, 2000). A key neurotransmitter in this pleasure pathway appears to be dopamine. When dopamine is activated there, a person experiences pleasure. Music may activate dopamine in the reward center. So may a hug or a word of praise. And so may drugs. Certain drugs apparently stimulate the reward center directly. Remember that cocaine, amphetamines, and caffeine directly increase dopamine activity.

Other drugs seem to stimulate it in roundabout ways. The biochemical reactions triggered by alcohol, opioids, and marijuana probably set in motion a series of chemical events that eventually lead to increased dopamine activity in the reward center. A number of theorists suspect that people who abuse drugs suffer from a reward-deficiency syndrome: their reward center is not readily activated by the usual events in their lives (Blum et al. , 2000; Nash, 1997), so they turn to drugs to stimulate this pleasure pathway, particularly at times of stress.

Abnormal genes, such as the abnormal D2 receptor gene, have been cited as a possible cause of this syndrome (Finckh, 2001; Lawford et al. , 1997). Psychodynamic Therapies Psychodynamic therapists first guide patients with substance-related disorders to uncover and resolve the underlying needs and conflicts that they believe have led to the disorders. The therapists then

try to help the individuals change their substance-related styles of living (Stetter, 2000; Hopper, 1995). Although often applied, this approach has not been found to be particularly effective in cases of substance-related disorders (Cornish et al. 1995; Holder et al. , 1991). It may be that drug abuse or dependence, regardless of its causes, eventually becomes a stubborn independent problem that must be the direct target of treatment if people are to become drug-free. Psychodynamic therapy tends to be of greater help when it is combined with other approaches in a multidimensional treatment program (Galanter & Brooks, 2001; Carroll & Rounsaville, 1995). Behavioral Therapies A widely used behavioral treatment for substance-related disorders is aversion therapy, an approach based on the principles of classical conditioning.

Individuals are repeatedly presented with an unpleasant stimulus (for example, an electric shock) at the very moment that they are taking a drug. After repeated pairings, they are expected to react negatively to the substance itself and to lose their craving for it. Aversion therapy has been applied to alcohol abuse and dependence more than to other substance-related disorders. In one version of this therapy, drinking behavior is paired with drug-induced nausea and vomiting (Owen-Howard, 2001; Welsh & Liberto, 2001).

Another version, covert sensitization, requires people with alcoholism to imagine extremely upsetting, repulsive, or frightening scenes while they are drinking (Cautela, 2000; Kassel et al. , 1999). The pairing of the imagined scenes with liquor is expected to produce negative responses to liquor itself. Here are the kinds of scenes therapists may guide a client to imagine: A

behavioral approach that has been effective in the short-term treatment of people who abuse cocaine and some other drugs is contingency management, which makes incentives (such as program privileges) contingent on the submission of drug-free urine specimens (Katz et al. 2001; Petry, 2000). In one study, 68 percent of cocaine abusers who completed a six-month contingency training program achieved at least eight weeks of continuous abstinence (Higgins et al. , 1993). Behavioral interventions for substance abuse and dependence have usually had only limited success when they are the sole form of treatment (Carroll & Rounsaville, 1995). A major problem is that the approaches can be effective only when individuals are motivated to continue with them despite their unpleasantness or demands. Generally, behavioral treatments work best in combination with either biological or cognitive approaches (Kassel et al. 1999; Whorley, 1996). Cognitive-Behavioral Therapies Two popular approaches combine cognitive and behavioral techniques to help people gain control over their substance-related behaviors. In one, behavioral self-control training (BSCT), applied to alcoholism in particular, therapists first have clients keep track of their own drinking behavior (Miller et al. , 1992; Miller, 1983). Writing down the times, locations, emotions, bodily changes, and other circumstances of their drinking, they become more aware of the situations that place them at risk for excessive drinking.

They are then taught coping strategies to use when such situations arise. They learn, for example, to set limits on their drinking, to recognize when the limits are being approached, to control their rate of drinking (perhaps by spacing their drinks or by sipping them rather than gulping), and to practice

relaxation techniques, assertiveness skills, and other coping behaviors in situations in which they would otherwise be drinking. Approximately 70 percent of the people who complete this training apparently show some improvement, particularly those who are young and not physically dependent on alcohol (Walters, 2000; Hester, 1995).

In a related cognitive-behavioral approach, relapse-prevention training, heavy drinkers are assigned many of the same tasks as clients in BSCT (Spiegler & Guevremont, 2003; Parks & Marlatt, 2000, 1999). They are also taught to plan ahead of time how many drinks are appropriate, what to drink, and under what circumstances. The approach sometimes lowers the frequency of intoxication (Foxhall, 2001). Like BSCT, it seems most effective for people who abuse alcohol but are not physically dependent on it (Meyer et al. , 1989).

The approach has also been used, with some success, in the treatment of marijuana and cocaine abuse (Foxhall, 2001; Carroll & Rounsaville, 1995). Biological Treatments Biological approaches may be used to help people withdraw from substances, abstain from them, or simply maintain their level of use without further increases (Welsh & Liberto, 2001). As with the other forms of treatment, biological approaches alone rarely bring long-term improvement, but they can be helpful when combined with other approaches. Detoxification Detoxification is systematic and medically supervised withdrawal from a drug.

Some detoxification programs are offered on an outpatient basis (Allan, Smith, & Mellin, 2002, 2000). Others are located in hospitals and clinics and

may also offer individual and group therapy, a “ full-service” institutional approach that has become popular. One detoxification approach is to have clients withdraw gradually from the substance, taking smaller and smaller doses until they are off the drug completely (Wright & Thompson, 2002). A second detoxification strategy is to give clients other drugs that reduce the symptoms of withdrawal (Malcolm et al. 2002; Schuckit, 1999). Antianxiety drugs, for example, are sometimes used to reduce severe alcohol withdrawal reactions such as delirium tremens and seizures. Detoxification programs seem to help motivated people withdraw from drugs (Zhao et al. , 2001; Allan et al. , 2000). However, relapse rates tend to be high for those who fail to receive a follow-up form of treatment— psychological, biological, or sociocultural—after successful detoxification. Antagonist Drugs After successfully stopping a drug, people must avoid falling back into a pattern of abuse or dependence.

As an aid to resisting temptation, some people with substance-related disorders are given antagonist drugs, which block or change the effects of the addictive drug (Welsh & Liberto, 2001). Disulfiram (Antabuse), for example, is often given to people who are trying to stay away from alcohol. By itself a low dose of this drug seems to have few negative effects, but a person who drinks alcohol while taking disulfiram will experience intense nausea, vomiting, blushing, faster heart rate, dizziness, and perhaps fainting.

People taking disulfiram are less likely to drink alcohol because they know the terrible reaction that awaits them should they have even one drink. Disulfiram has proved helpful, but again only with people who are motivated to take it as prescribed (Cornish et al. , 1995). Narcotic antagonists are

sometimes used to treat people who are dependent on opioids (Kirchmayer et al. , 2002). These drugs attach to endorphin receptor sites throughout the brain and make it impossible for the opioids to have their usual effect. Without the rush or high, continued drug use becomes pointless.

Although narcotic antagonists have been helpful—particularly in emergencies, to rescue people from an overdose of opioids—some clinicians consider them too dangerous for regular treatment of opioid dependence. These antagonists must be given very carefully because of their ability to throw a person with an addiction into severe withdrawal (Roozen et al. , 2002; Ling et al. , 2001). In recent years, so-called partial antagonists, narcotic antagonists that produce less severe withdrawal symptoms, have been developed (Amass et al. , 2000).

Recent studies indicate that narcotic antagonists may also be useful in the treatment of alcohol and cocaine dependence (Kiefer et al. , 2003; O’Brien & McKay, 2002). In some studies, for example, the narcotic antagonist naltrexone has helped reduce cravings for alcohol (O’Malley et al. , 2000, 1996, 1992). Why should narcotic antagonists, which operate at the brain’s endorphin receptors, help with alcoholism, which has been tied largely to activity at GABA sites? The answer may lie in the reward center of the brain (Gianoulakis, 2001).

If various drugs eventually stimulate the same pleasure pathway, it seems reasonable that antagonists for one drug may, in a roundabout way, affect the impact of other drugs as well. Drug Maintenance Therapy A drug-related lifestyle may be a greater problem than the drug’s direct effects. Much of the

damage caused by heroin addiction, for example, comes from overdoses, unsterile needles, and an accompanying life of crime. Thus clinicians were very enthusiastic when methadone maintenance programs were developed in the 1960s to treat heroin addiction (Dole & Nyswander, 1967, 1965).

In these programs, people with an addiction are given the laboratory opioid methadone as a substitute for heroin. Although they then become dependent on methadone, their new addiction is maintained under safe medical supervision. Unlike heroin, methadone can be taken by mouth, thus eliminating the dangers of needles, and needs to be taken only once a day. At first, methadone programs seemed very effective, and many of them were set up throughout the United States, Canada, and England (Payte, 1989).

These programs became less popular during the 1980s, however, because of the dangers of methadone itself. Many clinicians and clients came to believe that substituting one addiction for another is not an acceptable “ solution” for substance dependence (Cornish et al. , 1995). In fact, methadone is sometimes harder to withdraw from than heroin, because the withdrawal symptoms can last nearly twice as long (Blackmund et al. , 2001; Kleber, 1981). Moreover, pregnant women maintained on methadone have the added concern of the drug’s effect on their fetus (DeCubas & Field, 1993).

Despite such concerns, maintenance treatment with methadone (or with buprenorphine, a newly developed substitute drug) has again sparked interest among clinicians in recent years, partly because of new research support (Gossop et al. , 2001; Ritter, 2001) and partly because of the rapid spread of the HIV virus among intravenous drug abusers and their sex

partners and children (Cornish et al. , 1995). More than one-quarter of AIDS cases reported in the early 1990s were directly tied to drug abuse, and intravenous drug abuse is the indirect cause in 60 percent of childhood AIDS cases (Brown, 1993; NIDA, 1991).

Not only is methadone treatment safer than street opioid use, but many methadone programs now include AIDS education and other health instructions in their services (Sorensen & Copeland, 2000). Research suggests that methadone maintenance programs are most effective when they are combined with education, psychotherapy, family therapy, and employment counseling (O'Brien & McKay, 2002; Woody et al. , 1998). Todaymore than 900 methadone clinics across the United States dispense the drug to as many as 160, 000 patients at an average cost of $13 a day (ONDCP, 2002, 2000; Marks, 1998).

Sociocultural Therapies As we have seen, sociocultural theorists believe that psychological problems emerge in a social setting and are best treated in a social context. Three sociocultural approaches have been applied to substance-related disorders: (1) self-help programs; (2) culture- and gender-sensitive programs: and (3) community prevention programs. Self-Help and Residential Treatment Programs Many people who abuse drugs have organized among themselves to help one another recover without professional assistance.

The drug self-help movement dates back to 1935, when twoOhio men suffering from alcoholism met to discuss alternative treatment possibilities. The first discussion led to others and to the eventual formation of a selfhelp

group whose members discussed alcohol-related problems, traded ideas, and provided support. The organization became known as Alcoholics Anonymous (AA). Today AA has more than 2 million members in 100, 000 groups across the United States and 150 other countries (AA World Services, 2003). It offers peer support along with moral and spiritual guidelines to help people overcome alcoholism.

Different members apparently find different aspects of AA helpful. For some it is the peer support (Galanter et al. , 1990); for others it is the spiritual dimension (Swora, 2001). Meetings take place regularly, and members are available to help each other 24 hours a day. By offering guidelines for living, the organization helps members abstain " one day at a time," urging them to accept as " fact" the idea that they are powerless over alcohol and that they must stop drinking entirely and permanently if they are to live normal lives.

Related self-help organizations, Al-Anon and Alateen, offer support for people who live with and care about persons with alcoholism. Selfhelp programs such as Narcotics Anonymous and Cocaine Anonymous have been developed for other substance-related disorders. Many self-help programs have expanded into residential treatment centers, or therapeutic communities—such as Daytop Village and Phoenix House—where people formerly dependent on drugs live, work, and socialize in a drug-free environment while undergoing individual, group, and family therapies and making a transition back to community life (Landry, 1994).

The evidence that keeps self-help and residential treatment programs going comes largely in the form of individual testimonials. Many tens of thousands

of persons have revealed that they are members of these programs and credit them with turning their lives around (Gleick, 1995). Studies of the programs have also had favorable findings (Tonigan, 2001; Timko et al. , 2000), but their numbers have been limited (Watson et al. , 1997). Culture- and Gender-Sensitive Programs Many persons who abuse substances live in a poor and perhaps violent setting.

A growing number of today’s treatment programs try to be sensitive to the special sociocultural pressures and problems faced by drug abusers who are poor, homeless, or members of minority groups (Straussner, 2001). Therapists who are sensitive to their clients’ life challenges can do more to address the stresses that often lead to relapse. Similarly, therapists have become more aware that women often require treatment methods different from those designed for men (Knowlton, 1998; Lisansky- Gomberg, 1993). Women and men have different physical and psychological reactions to drugs, for example (Hamilton, 1991).

In addition, treatment of women who abuse substances may be complicated by the impact of sexual abuse, the possibility that they may become pregnant while taking drugs, the stresses of raising children, and the fear of criminal prosecution for abusing drugs during pregnancy (Thompson & Kingree, 1998; Cornish et al. , 1995). Thus many women with such disorders feel more comfortable seeking help at gender-sensitive clinics or residential programs; some such programs also allow children to live with their recovering mothers (Clark, 2001).

Community Prevention Programs Perhaps the most effective approach to substance-related disorders is to prevent them (Gottfredson & Wilson, 2003). The first drug-prevention efforts were conducted in schools. Today prevention programs are also offered in workplaces, activity centers, and other community settings, and even through the media (Bennett & Lehman, 2003; St. Pierre, 2001). Some prevention programs argue for total abstinence from drugs, while others teach responsible use. Some seek to interrupt drug use; others try to delay the age at which people first experiment with drugs.

Programs may also differ in whether they offer drug education, teach alternatives to drug use, try to changethe psychological state of the potential user, seek to change relationships with peers, or combine these techniques. Prevention programs may focus on the individual (for example, by providing education about unpleasant drug effects), the family (by teaching parenting skills), the peer group (by teaching resistance to peer pressure), the school (by setting up firm enforcement of drug policies), or the community at large (by public service announcements such as the “ Just say no” campaign several years ago).

The most effective prevention efforts focus on several of these areas to provide a consistent message about drug abuse in all areas of individuals’ lives (Smith, 2001; Wagenaar et al. , 2000). Some prevention programs have even been developed for preschool children (Hall & Zigler, 1997). I think that many people who are stricken with substance abuse have undergone a traumatic event that has changed their life. These events can be such things

as: divorce, death of someone close, rough childhood, and predisposed disposition.

This idea gives them the feeling of doing things that they would normally not do. Divorce is another one of those things that people go through that causes them to rethink their life choices. A person may end up becoming an alcoholic because they feel their life has no meaning after being divorced. The same is true of someone who faces the death of someone close to them. A rough childhood can definitely cause a person to be overwhelmed by substance abuse because they want to do whatever they can to forget about the experience they have gone through.

Predisposed disposition happens to babies mostly because their parents were under the effects of substance abuse while being pregnant which puts the baby at risk for it as well. I think the treatments for substance abuse include: support groups, medications, and detoxing the system are by far the best ways to deal with substance abuse. Support groups help a person by showing that they are not the only ones going through the effects of substance abuse. Medications aid a person by numbing the urge to use certain substances.

Detoxing the system is the best way because it helps a person to get rid of the tolerance their body has gained from the substance abuse. The strength of this viewpoing is that many people would use the information but the weakness is it is not really as theoretical because it has similarities to other viewpoints. I chose the psychodynamic view which states that people with substance abuse have extremely high dependency needs. This view declares

that when parents do not gratify their children’s nurturing needs the children tend to grow up depending on others for support and comfort.

In school there are many peer pressured teenagers who need to choose whether or not to participate in the use of drugs or alcohol. A child who has not had enough support from their parents tend to fall into peer pressure more than kids who have supported their children. Therefore, a child will do whatever it takes to be accepted by others even if it is using drugs or alcohol. The person will then most likely develop a relationship with that particular substance. Some psychodynamic theorist also think that people with this type of childhood develop a “ substance abuse personality. This personality is usually people who are antisocial, depressed and more dependent. However, a weakness in the psychodynamic viewpoint is that although theorist see a similar personality trait in people who participate in substance abuse there is no concrete research that a particular trait is the main reason for substance related disorders. The psychodynamic view recommends therapy along with drug focused interventions such as regular urinalysis, drug counseling or methadone maintenance pharmacotherapy for opiod dependents. Brief therapy is recommended for patience with substance abuse also after they are clean or free of substance abuse.

The sociocultural viewpoint states that a person will see peers or family members use or abuse drugs and this is how they become curious and then can become addicted. The sociocultural viewpoint uses treatments such as self-help programs, cultural- and gender-sensitive programs and community prevention programs. The positive side to this is the programs can be very helpful and do wonders on a person’s life the down side is getting the person

to go to the meetings; they are not mandatory meetings unless ordered by a judge. With this type of treatment the person has to want to change for the meetings to be effective in the person’s life.

Women and men have different physical and psychological reactions to drugs and different reasons for continuing to use drugs, so the group meetings could be hard to go to and discuss what is going on in the person’s life. I think there is a positive in the groups and community prevention programs though because I think by informing young kids all the information about drugs and make sure they are well informed and not just simply “ don’t do drugs” A kid will only believe that for so long especially if their family and peers are doing them. . CheckPoint: Substance Abuse Due Saturday • Review the various responses from Discussion Question 2. • Respond to the following: In Discussion Question 2, you examined the various viewpoints on causes and treatments for substance abuse. With which viewpoint or viewpoints do you agree most? Why? • Provide specific examples of causal factors and treatments outlined by the respective theoretical viewpoints. • Post as a Microsoft Word attachment in the Assignment section of eCampus.